



Coverage Assessment (SLEAC Report)

Badghis Province, Afghanistan.
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Action Contre la Faim

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Executive Summary

The following report presents key findings from one of a series of five provincial coverage assessments in Afghanistan, undertaken as part of a UNICEF funded ACF coverage project¹. The project assessed the coverage of the treatment of severe acute malnutrition (SAM) services across five provinces: Laghman, Badakhshan, Jawzjan, Bamyan and Badghis.

In each province the standard SLEAC (Simplified LQAS² Evaluation of Access and Coverage) methodology was used in order to achieve coverage classifications at district level and coverage estimations at provincial level. The opportunity was also taken to collect qualitative information on the factors inhibiting access to SAM treatment services as well as those acting in favour of access.

SLEAC uses a two-stage sampling methodology (sampling of villages and then of SAM children) to classify the level of needs met in a province, i.e. to what extent severely acutely malnourished (SAM) children are reaching treatment services. By also administering questionnaires to each SAM case found, whether covered (undergoing treatment) or uncovered (not being treated), a SLEAC assessment also provides information regarding factors influencing access and coverage.

It was expected that, due to patterns of insecurity and varying administrative division of provinces across Afghanistan, sampling of villages and SAM cases by district would present both practical and methodological challenges to the implementation of these SLEAC assessments. Therefore, selected provinces were divided into zones for classification rather than each district being classified, as is typically the case for SLEAC assessments. This allowed for classification of coverage with a smaller, and therefore more practically feasible, sample size and also facilitated inclusion of provinces with many smaller districts where province-wide classifications would have been impractical. The districts were grouped together based on factors such as topography and settlement type (urban or rural).

The SLEAC assessment in Badghis, conducted in December 2015, was implemented in partnership with Move Organisation (MOVE) – the Basic Package of Health Services (BPHS) implementing partner for the province. Due to long term insecurity in three districts and escalated insecurity in one more at the time of the assessment, four of the six districts in Badghis were removed from the scope of the assessment. Therefore, two zones comprised the two remaining districts and the following sampling zones were assigned:

	District(s)
Zone One	Qala-e-Naw
Zone Two	Qadis

Coverage thresholds of low ($\leq 30\%$), moderate ($>30\%$, $\leq 50\%$) and high ($>50\%$) were agreed prior to the assessment. Using the single coverage estimator, coverage was classified and found to be moderate.

The coverage estimation for Badghis province (including data from both zones) is **14.4% (CI 95% 4.15%-24.67%)**. This estimation, as well as the classifications, should be considered as reflective only of the accessible areas within the sampling frame, generally around the provincial capital city of Qala-e-Naw.

The most commonly cited barrier to access was that caregivers have little information or knowledge of malnutrition. Many caregivers of both covered and uncovered cases, who are aware of malnutrition and of the treatment services available, have had bad experiences of visiting the health facility including

¹ Measuring performance and coverage of IMAM programs in Afghanistan: rolling out of the SLEAC methodology

² Lot Quality Assured Sampling

experiencing bad behaviour from facility staff or being advised that there is no RUTF available for treatment. These are also the reasons for defaulted or relapsed cases that have been previously admitted.

Aside from caregivers of previously admitted cases, those of covered cases were generally advised of available treatment services only once they reached the health facility or by neighbours and relatives. Qualitative information from uncovered cases also demonstrated the limited level of involvement of community health workers (CHWs) in nutrition activities, including sensitization, screening and referral. Amongst uncovered cases, there was also a significant gender bias towards more female SAM cases.

In the areas assessed, the cases found included a high number of recovering cases admitted in the program. Further investigation is required to confirm whether this is due to good clinical performance (such as short lengths of stay and early treatment seeking). However, evidence of poor case-finding and repeat and rejected admissions also suggests this may include some incorrect admissions. Furthermore, the majority of cases found were admitted at a single BHC in the southern part of Qadis district.

Findings that may influence coverage positively related to the willingness of caregivers to go to the health facility (notwithstanding the existence of household level challenges such as availability of child care) for treatment of symptoms associated with SAM. There is evidence that many caregivers have visited health facilities specifically for SAM treatment at a time when RUTF was not available. There are also constructive roles of community members in sharing information about malnutrition, indicating how important other villagers, friends and relatives in particular are in facilitating a child reaching admission to SAM treatment.

A set of recommendations based on the findings from this assessment were developed in order to support the implementing partners in overcoming the barriers identified, building on favourable factors and increasing coverage. First, the quality of care provided at clinic level must be improved, by reviewing staff work load and resources for nutrition, refresher training in MUAC measurement to ensure accurate admissions, and training all staff in integrated management of acute malnutrition (IMAM) protocols. This training should aim to ensure at least the minimum information is shared with mothers and to improve the organisation and efficiency of clinics.

Second, the availability of RUTF must be improved, by reviewing process for supply with UNICEF and onward logistical distribution to district and facility level. Third, CHWs must be utilised as well as influential community figures (such as mullahs and teachers) to improve the awareness of malnutrition and treatment services by training them in key messages, and the distribution of information, education and communication (IEC) materials, and encouraging them to share these on a regular basis.

Fourth, a more in depth SQUEAC investigation should be conducted in at least one district, including quantitative data analysis to regularly monitor treatment flow at clinics, and an in depth community assessment to better understand community dynamics and tailor community mobilisation (communication, screening and defaulter follow-up) appropriately. Fifth, the effectiveness of screening and referral must be improved and enlarged , by both re-training CHWs in nutrition and engaging a wider range of actors (such as mothers, health shura and pharmacists) in screening and referral of malnourished children. Finally, physical access to treatment services must be improved through training CHWs to support caregivers in finding resources for access and the introduction of SAM services at sub-centres.

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- UNICEF for their financial support

Acronyms

ACF	Action Contre le Faim
BHC	Basic Health Centre
BPHS	Basic Package of Health Services
CHC	Comprehensive Health Centre
CHS	Community Health Supervisor
CHW	Community Health Worker
EPHS	Emergency Package of Health Services
FHAG	Family Health Action Group
IMAM	Integrated Management of Acute Malnutrition
IPD	Inpatient Department
MOVE	Move Organisation
MUAC	Mid-Upper Arm Circumference
OPD	Outpatient Department
OTP	Outpatient Therapeutic Program
PNO	Provincial Nutrition Officer
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SLEAC	Simplified LQAS Evaluation of Access and Coverage
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
TFU	Therapeutic Feeding Unit
UNICEF	United Nations Children's Fund

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1. Background and Objectives

Parts of Afghanistan have high rates of severe acute malnutrition (SAM) above emergency thresholds³, and therefore it is imperative that the health system, with the support of the international community, addresses this challenge. Since 2010 the Basic Package of Health Services (BPHS)⁴ system has included the treatment of SAM, however the response remains inadequate⁵. In 2015, strengthening the nutrition component of the BPHS/EPHS (Essential Package of Hospital Services) remains a challenge for the Ministry of Public Health (MoPH) and the implementing partners. Coverage assessments allow BPHS implementers to assess the performance of their SAM treatment services and to identify practical steps for reform.

The project, of which the current assessment is a part, intends to contribute to improving the performance of IMAM services in Afghanistan, through the provision of in-depth information on coverage, identification of barriers and boosters to access, and definition of recommendations for a durable scale up of nutrition service delivery. Provinces were identified for a SLEAC assessment according to several priority factors including: SAM prevalence rates, proportion of districts with SAM treatment services, existence of past or planned coverage assessments and geographical location.

The National Nutrition Survey (NNS) conducted in 2013 indicates a global acute malnutrition (GAM) rate of 7.3% with SAM at 3.5% in Badghis. MOVE provides delivery of all elements of BPHS and EPHS in Badghis. National IMAM reporting⁶ also shows that all six districts in Badghis have inpatient department (IPD) or outpatient department (OPD) SAM treatment services, making the province an appropriate area for a coverage assessment.

The main objectives of this assessment were to collaborate with Save the Move Organisation (MOVE) in order to:

1. Classify coverage of each zone
2. Estimate coverage in the province
3. Identify key factors influencing coverage
4. Outline evidence based recommendations
5. Train partner staff in the SLEAC coverage methodology

2. Context

Badghis province in the northwestern region of Afghanistan is made up of six districts and the capital city is Qala-e-Naw, located towards the southern region of the province. A large seventh district of Jawand in the east is now under administration of the bordering province of Faryab. Badghis has a significant secondary city, Balamughab, in the north near Afghanistan's border with Turkmenistan and where a major river runs to, through the centre of the province from Ghor. Badghis borders Herat to the south west. The province covers approximately 20,794km² and the total population is estimated to be 547,000⁷, of which the majority (c. 97%) live in rural areas⁸. The population is of multiple ethnicity comprising Uzbek, Turkmen, Pastun and Arab groups. Livelihoods are mostly agriculture-based; especially forestry, cultivation of cereal crops and some fruits.

³National Nutrition Survey 2013

⁴ A Basic Package of Health Services for Afghanistan – (2010/1389) Islamic Republic of Afghanistan, Ministry of Public Health

⁵ See Afghanistan: Back to the reality of needs, (ACF International, 2014) and European Union Final Report Nutrition Assessment (August 2014).

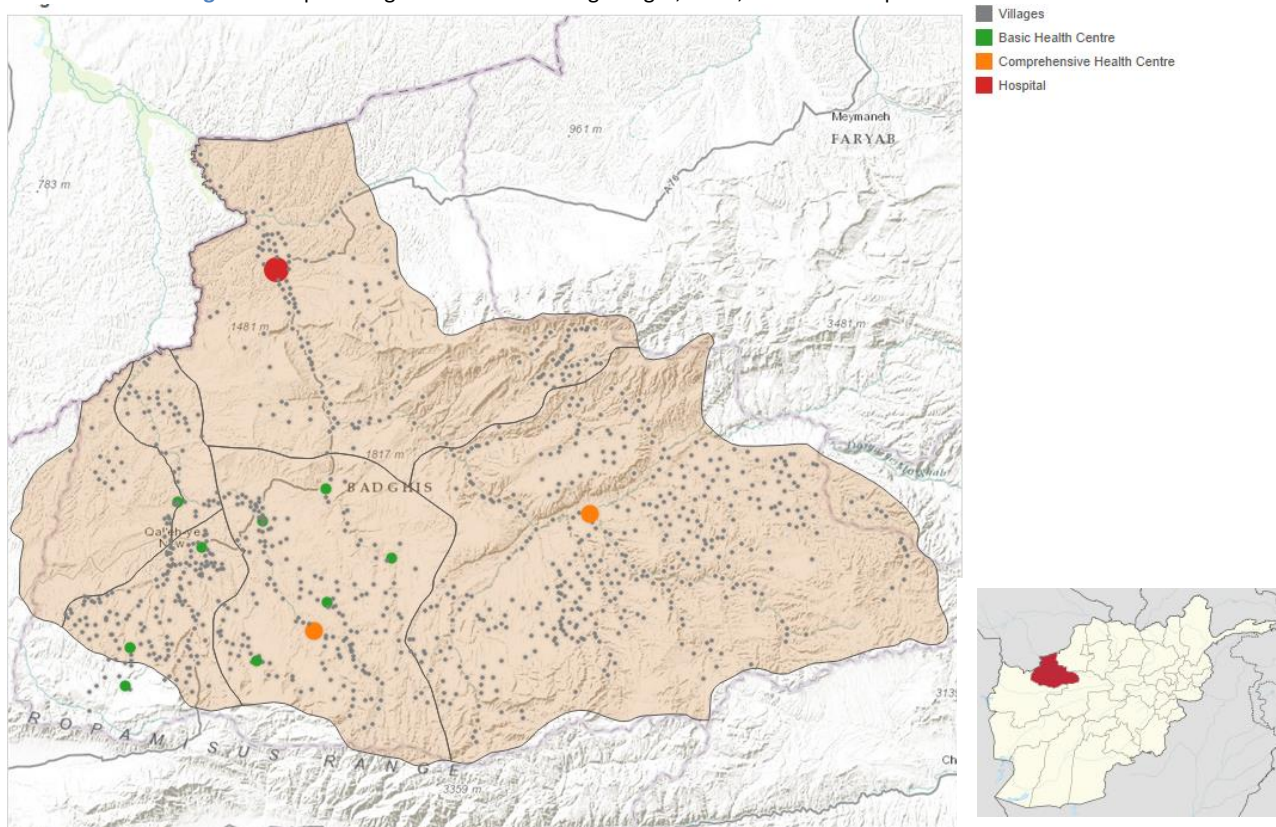
⁶ Source: UNICEF National Nutrition Cluster

⁷ Source: Population data. CSO, 2013

⁸ Regional Rural Economic Strategies, Badghis province, (RRERS)

Badghis province has high Under-5 mortality rates, long-term security problems leading to a high number of conflict induced internally displaced people (IDPs) and is prone to water related problems of both drought and flooding. It is ranked fifth in the Overall Need and Vulnerability Index⁹.

Figure 1 Map of Badghis Province showing villages, BHCs, CHCs and Hospitals



BPHS in Badghis province has been delivered by MOVE since 2005, through a number of clinical sites including one district hospital, two Comprehensive Health Centres (CHC) and nine Basic Health Centres (BHC), which deliver SAM treatment services in particularly remote or insecure areas. These are labelled in Figure 1. There are also 290 health posts, each with a pair of CHWs (one male and one female), who are supervised by community health supervisors (CHS).

3. Methodology

SLEAC is a low-resource method for classifying coverage of feeding programs over wide areas. This methodology was therefore chosen to assess the level of SAM treatment coverage in five provinces across Afghanistan by mapping areas where very high or very low coverage is achieved, and identifying the factors affecting access¹⁰.

SLEAC uses a two-stage sampling process. Stage one samples villages across the area to be classified (in this case zones). The sampling process ensures a random and spatially representative sample. Stage two samples SAM children at village level. This step ensures an exhaustive sampling of all SAM cases in each village

⁹ Overall Needs and Vulnerability Analysis, HRP 2015

¹⁰ For more technical information see: Myatt M, Guevarra E, Fieschi L, Norris A, Guerrero S, Schofield L, Jones D, Emru E, Sadler K, Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) / Simplified Lot Quality Assurance Evaluation of Access and Coverage (SLEAC) Technical Reference, Food and Nutritional Technical Assistance III Project (FANTA-III), FHI 360 / FANTA, Washington, DC, October 2012

selected. Some specific technical considerations were made to adapt the sampling to the Afghanistan context.

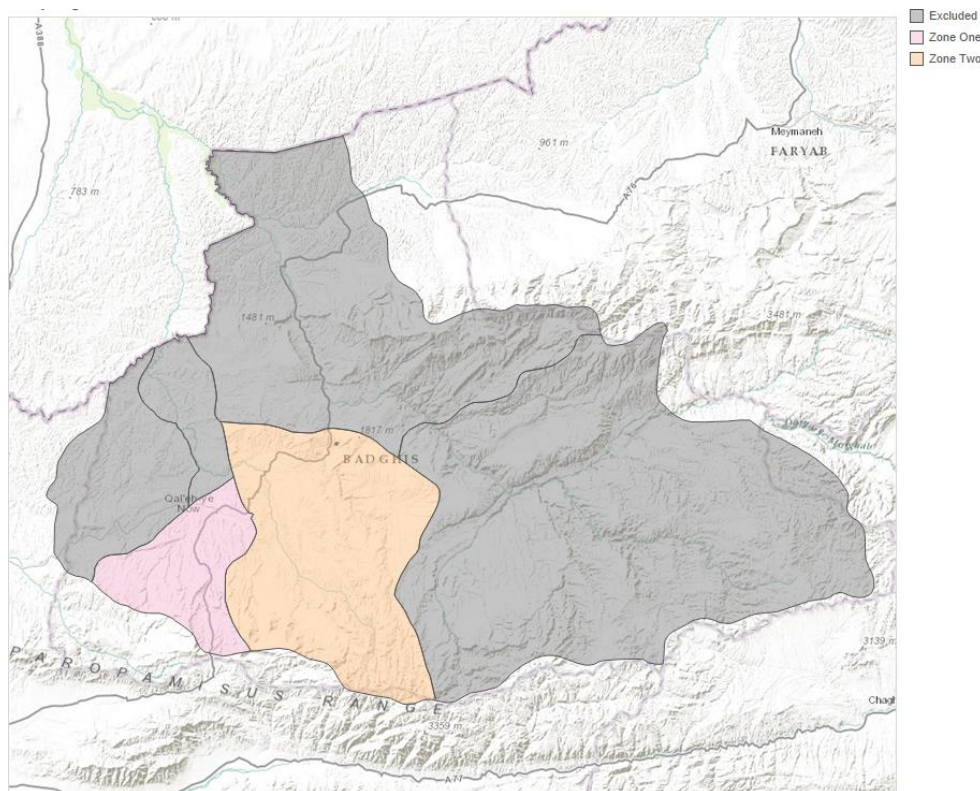
3.1. Sampling zones and estimation of required sample size

It was expected that, due to patterns of insecurity and varying administrative division of provinces across Afghanistan, sampling of villages and SAM cases by district would present both practical and methodological challenges to the implementation of these SLEAC assessments. Therefore, selected provinces were divided into zones for classification rather than each district being classified. This brought advantages such as lowering total number of cases needed, facilitating implementation in provinces with numerous small districts, and allowing inclusion of small secure parts of districts that are largely insecure and may otherwise have been excluded (e.g. Qadis).

In the case of Badghis, the security situation restricted the assessment to just two districts which were allocated as zones to complement assessments in other provinces and as shown in Figure 2. Zone One and Two are located in the southern region of the province at the border with Herat. Zone One contains the administrative provincial capital city of Qala-e-Naw:

	District(s)
Zone One	Qala-e-Naw
Zone Two	Qadis

Figure 2 District map showing sampling zones



In order to confirm that we can still reliably estimate coverage at zonal level without having to find an impractical (given time and resources available) number of SAM cases, estimated caseloads were calculated for each zone using population data, SAM rates and % population 6-59 months of age and the following formula:

$$\text{Estimated caseload} = \text{total zone population} \times \text{population 6 – 59 months} \times \text{SAM rate}$$

The SAM rate used for all calculations was 2%, which is the SAM prevalence figure for the province by the NNS and the rate commonly used for coverage assessment sampling calculations. The calculations for the estimated case load are presented in Table 1.

Table 1 Calculations for estimated caseloads, sample sizes required and no. of villages¹¹

Zone	Ave. village population	Total population	Population <59 months	SAM rate	Estimated caseload	Sample size required	Required number of villages to sample
Zone One	771	69,349	12,483	2.00	250	32	12
Zone Two	565	88,139	15,865	2.00	317	33	16
Total (all Badghis)	505	546,750	98,415	2.00	1,968		

Subsequently, the required sample size was determined using the table provided in the SLEAC technical reference (Table 2) that offers guidance on the sample size required. These are the recommended sample sizes for when using 30% and 70% thresholds. We are using a narrower range (30%-50%) which requires greater accuracy and therefore a larger sample size. However these remain useful as an estimate. We also were conservative when calculating the number of villages to sample.

Table 2 Estimated sample sizes required for classifications based on estimated caseload in service delivery unit (in this case zone)¹²

Estimated number of cases in the service delivery unit	500	250	125	100	80	60	50	40	30	20
70% standard or 30%/70% class thresholds	33	32	29	26	26	25	22	19	18	15

3.2. Stage One Sampling

The suggested sample size for a SLEAC, according to the technical reference, is 40 cases per delivery unit or unit of classification (zone in this case). However, if the estimated SAM caseload in the zone is small (less than 500) this can be reduced (See Table 2) and still allow for a reliable classification of coverage. Based on this it was calculated that we would require n=40 for both zones since both estimated case loads for both zones are >500.

In order to ensure this number of cases is reached, the number of villages required was calculated using the following formula:

$$n \text{ villages} = \left\lceil \frac{n}{\text{percentage of population} < 59\text{months} \times \text{SAM prevalence} \times \text{average village population}} \right\rceil$$

¹¹ Source: Population data. CSO, 2013

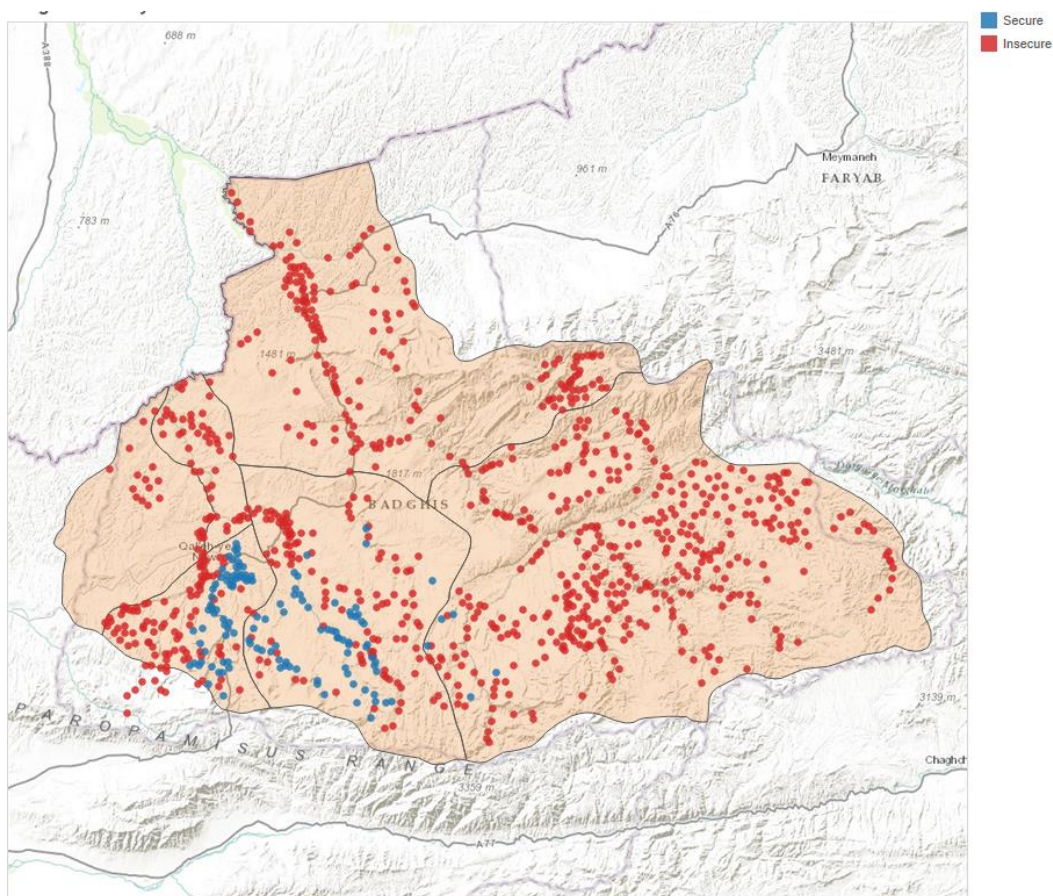
¹² Source : SLEAC/SQUEAC Technical Reference

The numbers of villages that need to be sampled for each zone are also presented Table 1.

In normal conditions, an accurate map, or a comprehensive list of villages would then be used to randomly select the required number of villages to ensure spatially representative sample. However, due to the poor security conditions in Badghis, the list of villages was first reviewed by the partner's security focal point, in order to remove villages that were inaccessible by partner staff. Villages that were in areas known to be controlled by AOGs hostile to government and outsiders were removed. In case of any doubt, additional information was sought and the program team (at community level) were consulted to determine if it would be safe to go to each village and conduct the assessment. In the case of Badghis, it was appropriate to remove some entire districts from the sampling frame (Jawand, Bala Murghab, Muqur and Ab Kamari).

By removing villages (and districts) prior to selection it meant that inaccessible villages were not selected, and we were able to best ensure spatial representivity, albeit outside of the insecure areas. In Badghis this resulted in 87% of the villages in the province being removed from the sampling frame. In the districts remaining in the scope of the assessment, 49% of villages were removed consisting 24% of villages in Zone One and 61% in Zone Two. See Annex A for a list of the villages and those removed indicated. Most of the villages located away from the provincial capital were removed as shown in Figure 3.

Figure 3 Map with insecure villages marked



This clearly presents a limitation to the current assessment, and must be considered when reading the coverage classification and estimations, and applying them to the whole of a district or the province. That said, perhaps more importantly, the qualitative information collected during caregiver interviews will still provide a useful set of information on factors affecting coverage.

Once the insecure villages had been removed, since a reliable and complete map was not available at the time, the spatial systematic sampling method (or 'list method') was used to select the required number of villages (See Table 1). With this method villages are ordered according to CHC/BHC catchment area, a sampling interval is then calculated as well as a random starting point on the list¹³. This allows for the correct amount of villages to be both selected randomly and produces a spatially representative sample. This process is done for each of the two sampling zones. A list of villages and those selected can be found in Annex A. A photograph of the selected villages and CHCs/BHCs marked on a map by the team for planning purposes can also be found in Annex B.

3.3. Stage Two Sampling

Once the villages were selected, teams were sent to each village in order to find all SAM cases and to ascertain if they were in the program or not. Recovering cases were also sought and recorded.

A team of 10 enumerators divided into five teams of two were recruited. The enumerators were trained in both door-to-door and active and adaptive case finding by the core supervision team. In village settings, active and adaptive case-finding was used. This involves teams using local knowledge to find suspected cases of SAM and therefore means that they do not need to go to each and every household. The sampling method assumes a level of social cohesion and that community members will know about the existence of SAM children in the village. Photos of malnourished children and packets of RUTF were used to assist the enumerators in finding SAM cases both in treatment and those not covered. In each village, teams continued searching for cases until they were certain that they had found all (or almost all) SAM cases.

Door-to-door case finding involves the teams going to each and every house in a given village. This is more appropriate in an urban setting, where it is assumed that due to the density of the population community members will be less aware of SAM children in the community, and therefore active and adaptive case-finding more difficult.

The case definition used was children 6-59 months old with a mid-upper arm circumference (MUAC) of <115mm or displaying bilateral pitting oedema, and children currently undergoing treatment. Enumerators were trained in measuring MUAC and testing for oedema. In each household, all children were screened in this way, and it was ensured no children 6-59 months were omitted (due to them sleeping for example). Non SAM cases that were still undergoing treatment (recovering cases) were also sought.

A recovering case is a child that is no longer SAM but has not yet been discharged from the treatment program. A SAM child is classified as a child with a MUAC of <115mm¹⁴, however cases are not discharged until a MUAC of ≥125mm has been achieved for 2 weeks¹⁵. This means that a child may still be under-going treatment although no longer be defined as SAM.

For each case found, the team ascertained whether the child was admitted into SAM treatment or not. If they were covered then the enumerator asked for proof. This meant they were required to show the packets of RUTF or a treatment card, or alternatively sufficiently describe details of the treatment and location of services (in the case RUTF and treatment cards were unavailable). Once proven, the caregiver was administered with a 'covered' questionnaire. If the SAM child was determined to not be covered the caregiver was administered with a 'non-covered' questionnaire and referred to their nearest treatment

¹³ See SQUEAC/SLEAC Technical Reference for more details.

¹⁴ SAM is also defined in terms of weight-for-height z-scores and the presence of bilateral pitting oedema, but the SLEAC assessment did not use this definition.

¹⁵ Integrated Guidelines for the Management of Acute Malnutrition, Ministry of Public Health/Public Nutrition Department (2015)

service. These questionnaire responses were used as qualitative data about what prevents or facilitates the child's admission to the program. Full versions of these questionnaires can be found in Annexes C and D.

Due to the security risk, close supervision of the teams by the survey leader was not possible during data collection at village level. In order to overcome this, and ensure the highest quality case-finding, certain measures were taken. First, during training were extra exercises such as discussing possible scenarios (for example definitions of covered and uncovered cases) and running through the active and adaptive case-finding process. The team leaders were provided with telephone credit so that they could call the survey leader when any issues or questions arose during case-finding. The survey leader also called the team leaders every morning and evening to plan and discuss their activities (such as key informants met, number of children screened and households visited, village size and how village boundaries were defined), relay findings and highlight security related information gathered to inform immediate and ongoing planning. After one full day of case-finding, the core team was brought together and each individual questionnaire reviewed to identify and discuss how they found each case and the caregiver's responses in the context of the assessment. It was not practically feasible to do this in every case but was done when appropriate.

3.4. Additional qualitative data collection

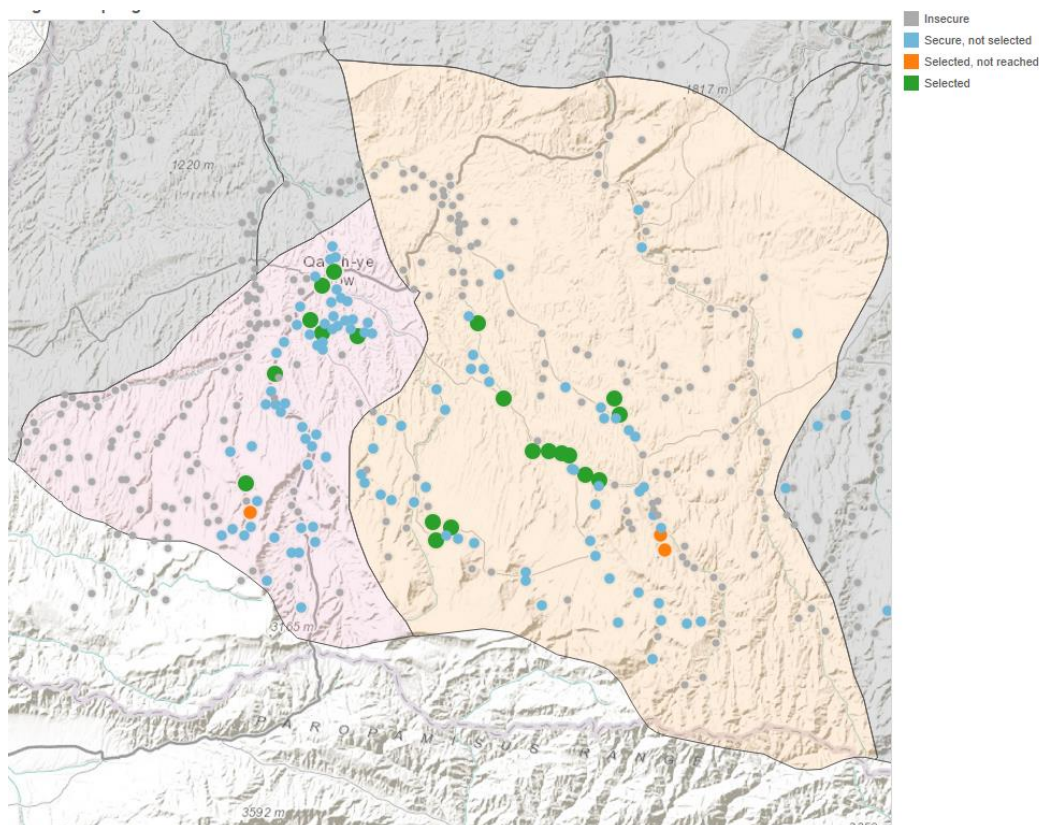
In order to go some way in overcoming limitations caused by inaccessibility, some additional qualitative information was also collected to allow some understanding of how coverage is affected in these areas¹⁶. This information was collected through three methods. First informal interviews were conducted by the survey leader with key nutrition staff of MOVE (such as Nutrition Manager, who was also part of the assessment team). These interviews focused on programming structure and overview, the informant's own activities and then further explored in detail information arising relating to challenges with SAM treatment. Second, due to the poor security situation restricting access for the survey team, it was decided to conduct short structured interviews with selected clinical staff and visitors to clinics as close as possible to the affected areas, as outlined in Annex E. At one health centre in Qadis staff refused to participate as they were too busy, but five interviews were conducted with visitors. In a health centre near Qala-e-Naw participated with interviews from five staff and eight visitors. Last, detailed discussions took place at each meeting with the field team, and notes from this and telephone conversations were taken.

4. Results

Having sampled all possible selected villages across the province a total of 65 SAM cases were found. Table 3 shows the sample sizes achieved for each zone, including required sample size, number of villages selected and number of villages reached. Due to the volatile security situation at the time of the field work, there were ongoing updates to village level security including discussion with local government authorities, and the teams were not able to visit one of the villages in Zone One and two villages in Zone Two. Any further impact on the spatial representivity of the sample of villages was thought to be limited. However, this does reiterate that results (classifications and estimates) should be understood as relating only to accessible areas. Figure illustrates the status of each village in the districts of Qala-e-Naw and Qadis.

¹⁶ See Annex E for further details

Figure 4 Map showing the two districts that remained in the sampling frame (Qala-e-Naw and Qadis) indicated those villages sampled (green), sampled (Stage 1) but aborted due to the changing security situation (orange), not selected but part of sampling frame (blue), and insecure villages removed from sampling frame (light grey).



For Zone One only 25 cases were found where 32 were required. Using analysis of precision errors, as presented in Annex F, it was decided that this data could still be used to classify coverage in the accessible areas of this zone and the results are also included for calculating the provincial coverage estimate.

Table 3 Sample sizes required and sample sizes achieved

Zone	SAM Sample size required	No. of villages selected	No. of villages reached	Sample size achieved
Zone One	32	12	11	25
Zone Two	33	16	14	40
Total	65	28	25	65

Table 4 shows that the gender ratio of the uncovered SAM cases found was significantly skewed toward female cases, and median age of SAM cases found across the province is 14 months (1 year and 2 months). In terms of the condition of cases, the median MUAC of the uncovered SAM cases found is 11.2cm across the province, and is higher in Zone One (11.3cm) than in Zone Two (10.9cm). This may indicate that there is poorer case-finding and later treatment seeking in this zone. The absence of oedema cases is expected for Afghanistan.

Table 4 Age, gender and MUAC and oedema cases per zone

	Zone One	Zone Two	Total Badghis
Median age of SAM cases (months)	15	9	11.2
Male uncovered cases	9	6	15
Female uncovered cases	14	12	26
Median MUAC uncovered (mm)	113	109	112
Number of oedema cases	0	0	0

4.1. Coverage Classification

The most reliable, and widely suited, coverage estimator currently available is the single coverage estimator. The single coverage estimator¹⁷ estimates coverage using recovering cases still being treated (as found during the assessment) and estimates recovering cases not being treated. The number of recovering cases not in the program (R_{out}) are estimated using the following formula where C_{in} = covered SAM cases, C_{out} = uncovered SAM cases and R_{in} = recovering cases in the program¹⁸.

$$R_{out} \cong \frac{1}{3} \times (R_{in} \times \frac{C_{in} + C_{out} + 1}{C_{in} + 1} - R_{in})$$

Table 5 presents of the quantities of covered and uncovered SAM cases and recovering cases found in each zone. This shows the final total of cases used to classify coverage (in accessible areas of each zone).

Table 5 Table showing results from assessment: Covered, uncovered and recovering cases found in each zone and the estimated recovering cases not in the program

Zone	Covered SAM cases (C_{in})	Uncovered SAM cases (C_{out})	Total SAM cases	Recovering cases (R_{in})	Recovering cases not in the program (R_{out})	Total cases ($C_{in} + C_{out} + R_{in}$ + R_{out})
Zone One	2	23	25	0	0	25
Zone Two	2	18	20	20	40	80
Total	4	41	45	20	40	105

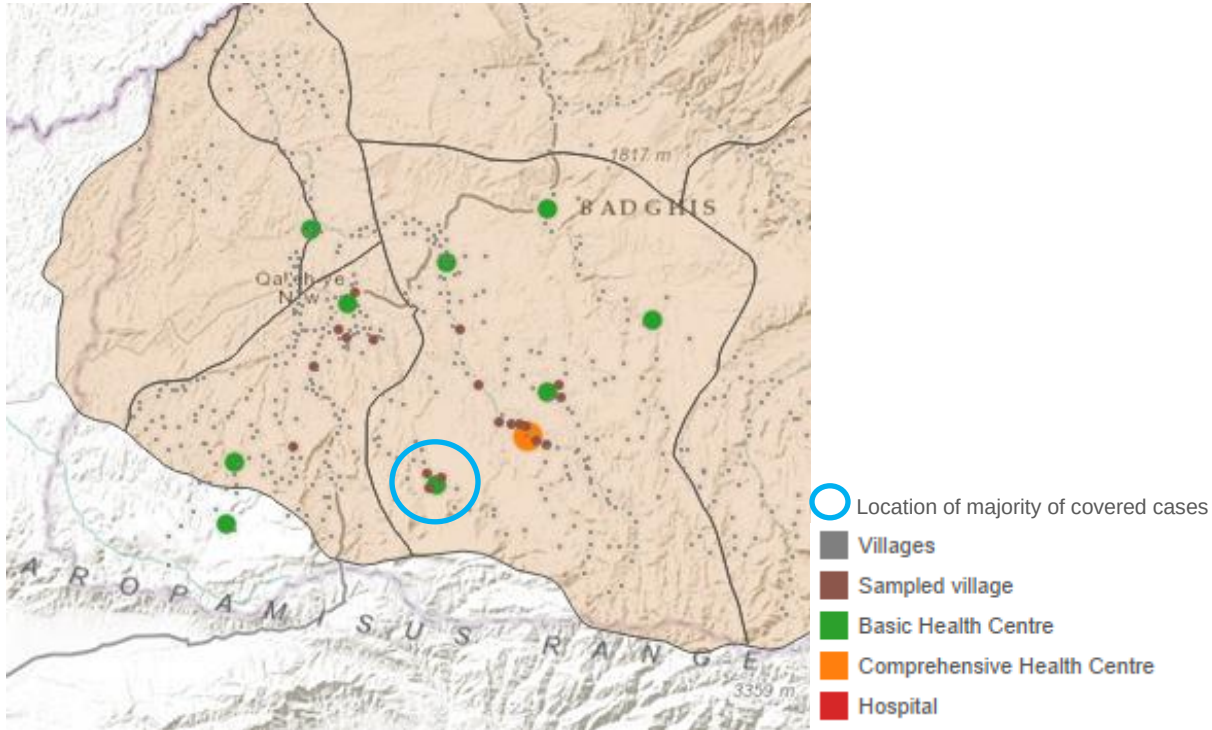
There were notably no recovering cases found in Zone One: Qala-e-Naw district and many recovering cases in Zone Two: Qadis, where the assessment teams also reported some ambiguity amongst caregivers about which program their child was admitted in (MAM or SAM). All cases recorded for the assessment, were being treated with RUTF (and not RUSF as would be the protocol for MAM cases) and so were assumed to be recovering SAM cases. The number of recovering cases found currently in the program is significantly higher in Zone Two, which may indicate good retention and short lengths of stay. Such data could also be a result of incorrect admissions. However, to confirm this conclusion a quantitative analysis at clinic level to analyse the quality of the treatment cycle for SAM cases admitted (such as retention and lengths of stay), would be necessary.

¹⁷ For more information see Myatt, M et al, (2015) *A single coverage estimator for use in SQUEAC, SLEAC, and other CMAM coverage assessments*, p.81 Field Exchange 49.

¹⁸ 1/3 is the correction factor calculated using the median length of stay for a treated SAM case (2.5 months) and an estimated length of an untreated episode of SAM (7.5 months). For more information see idem.

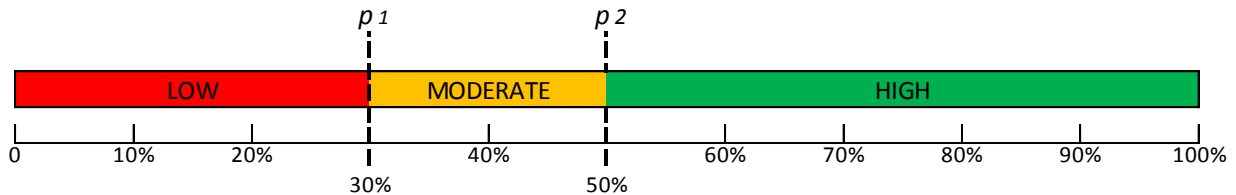
When considering results at village level, all covered cases in Zone Two (Qadis) are exclusively from four out of the 14 villages sampled. Also, the two covered SAM cases are from the fourth village (i.e. three villages account for nearly all covered cases, which are mostly recovering cases).

Figure 5 Map showing sampled villages and health facilities



Classification thresholds were decided prior to the assessment. It was decided that a three tier classification method was most appropriate, providing classification of high, moderate and low. The thresholds were set at 30% (p_1) and 50% (p_2) (see Figure 5). It was determined that these thresholds would be the most useful in distinguishing between poorly performing districts and the better performing districts. Coverage estimations from previous assessments in Afghanistan were used to forecast what levels of coverage we would expect to find.

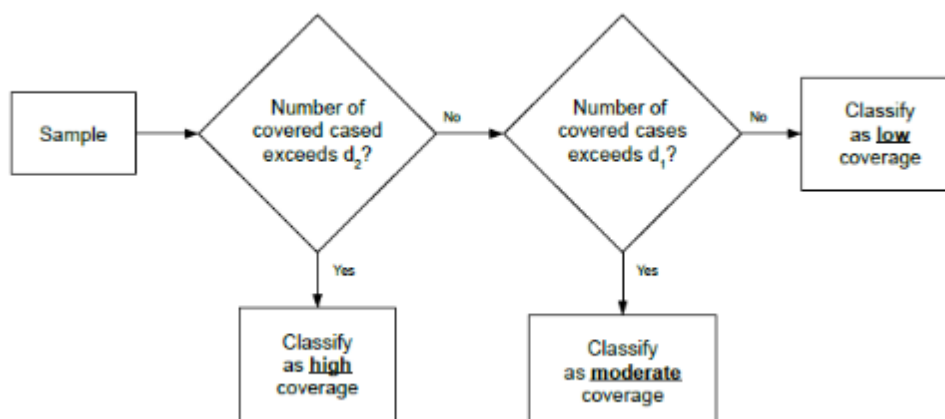
Figure 6 Diagram showing coverage classification thresholds



In order to determine the classification of coverage for each zone the decision rule (d_1 and d_2) for each classification is first calculated using the following formula where n = total cases ($C_{in} + C_{out} + R_{in} + R_{out}$), $p_1 = 30$ and $p_2 = 50$.

$$d_1 = \left\lfloor n \times \frac{p_1}{100} \right\rfloor \quad \text{and} \quad d_2 = \left\lfloor n \times \frac{p_2}{100} \right\rfloor$$

Then following algorithm is then used to determine the classification:



Because only few cases were found in Zone One (25 cases when 32 required), to classify coverage in the zone is less reliable. The calculations of errors are included in Annex F.

Table 6 illustrates the decision rules for each threshold, the total covered cases ($C_{in} + R_{in}$) and therefore the final classifications.

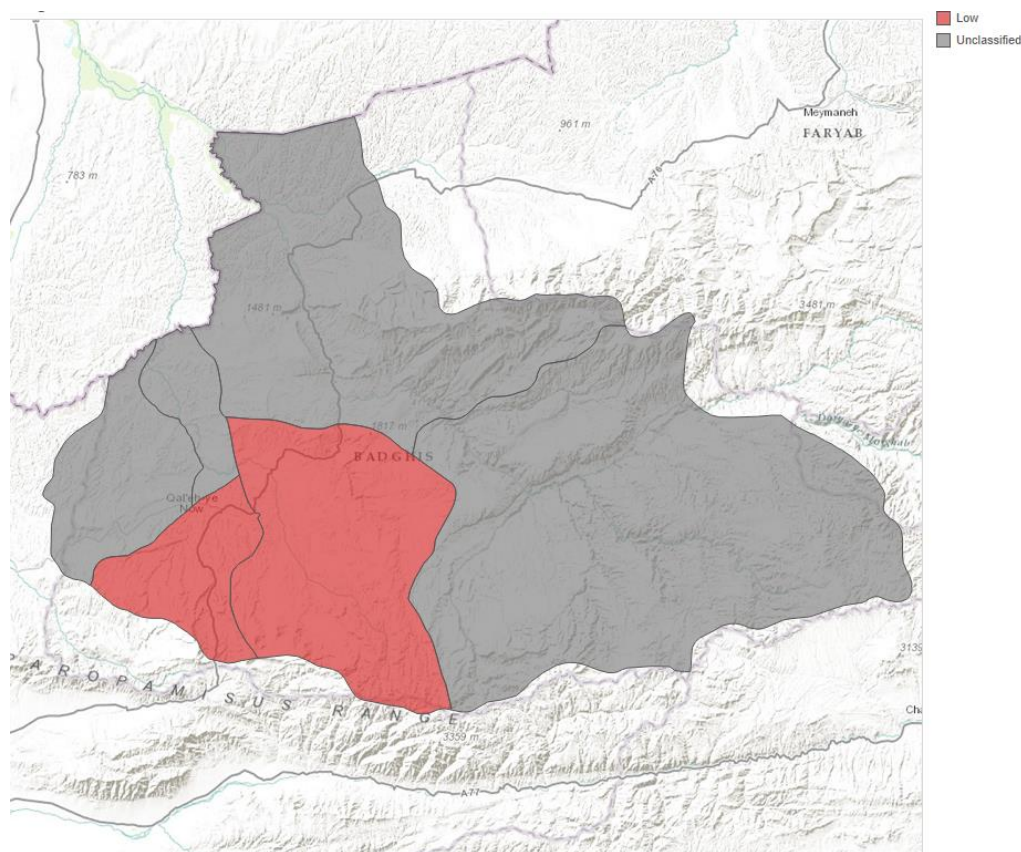
Table 6 Applying decision rule to determine coverage classifications

	Total cases (n)	d ₁	d ₂	Cases covered ($C_{in} + R_{in}$)	Coverage Classification
Zone 1	25	7	12	2	Low ¹⁹
Zone 2	80	24	40	22	Low

¹⁹ Due to the lower than expected sample size reached, classification has been made but with a higher error (11%) than normal (10%). See Annex F for the calculations

The following map illustrates the classifications.

Figure 7 Map showing coverage classifications of districts in Badghis Province



4.2. Provincial Coverage Estimation

Provincial coverage estimation (for the secure villages assessed) can also be made. In order to make this more precise, we use a prevalence estimation based on the survey results:

Table 7 Table showing calculations of prevalence rate based on survey data

	Number of villages sampled	Average village population for sampling frame ²⁰	% population under 5 ²¹	Under 5 population in sampled villages	Actual SAM (MUAC <115mm or oedema) cases found	Proportion of SAM cases by MUAC<115 or oedema
Zone One	11	771	0.18	1,526	25	1.638%
Zone Two	14	565	0.18	1,423	20	1.405%
SUM	25		0.18	2,950	45	1.53%

²⁰ Source: Population data. CSO, 2013

²¹ Source: SCA management

Therefore based on the actual SAM cases found in the surveyed villages, the % of SAM cases with MUAC <115mm is 1.53% in the surveyed villages.

In order to allocate a relevant weight to each zone in the calculation of the estimation, a weight is calculated based on the estimated SAM population of each zone using the above survey-based prevalence rate. This weighting also takes into account the villages removed from the sampling frame due to insecurity.

Table 8 Table showing calculations of weights awarded to each zone

	Total number of villages	% Villages removed	No. villages after review	Average village population	Total population (surveyed)	U5 population	% MUAC <115	Estimated Point SAM case load (MUAC) ²² (N)	weight=N/ΣN
Zone One	90	0.3	63	771	48,573	0.18	0.0153	134	0.671168482
Zone Two	156	0.73	42	565	23,798	0.18	0.0153	66	0.328831518
SUM								199	1

Having allocated a weight to each zone using the survey data, we can estimate the coverage estimation based on the survey data.

Table 9 Table showing allocation of weights to each zone and calculation of coverage estimation

	Total cases (Cin+Rin+Cout+Rout)	Cases covered (Cin + Rin)	(Cin + Rin)/n	weight* Cin+Rin /n
Zone One	25	2	0.08	0.053693479
Zone Two	80	22	0.28	0.090428667
Total	105	24		14.4%

Finally, a credibility interval must be calculated using the following formula, where coverage = 14.4% and total SAM cases found = 24:

$$\text{Lower and upper credibility intervals} = \text{coverage} \mp 1.96 \times \sqrt{\frac{\text{Coverage} \times (1 - \text{coverage})}{\text{Total SAM cases found}}}$$

So the lower credibility interval = 4.15% and the upper credibility interval = 24.67%.

Therefore the coverage estimation for the accessible villages can be estimated at **14.4% (CI 95%: 4.15%-24.67%)**. It must be noted that this does not represent coverage estimation for the 90% villages (including 4 removed districts) within the province that were removed from the sampling frame due to insecurity.

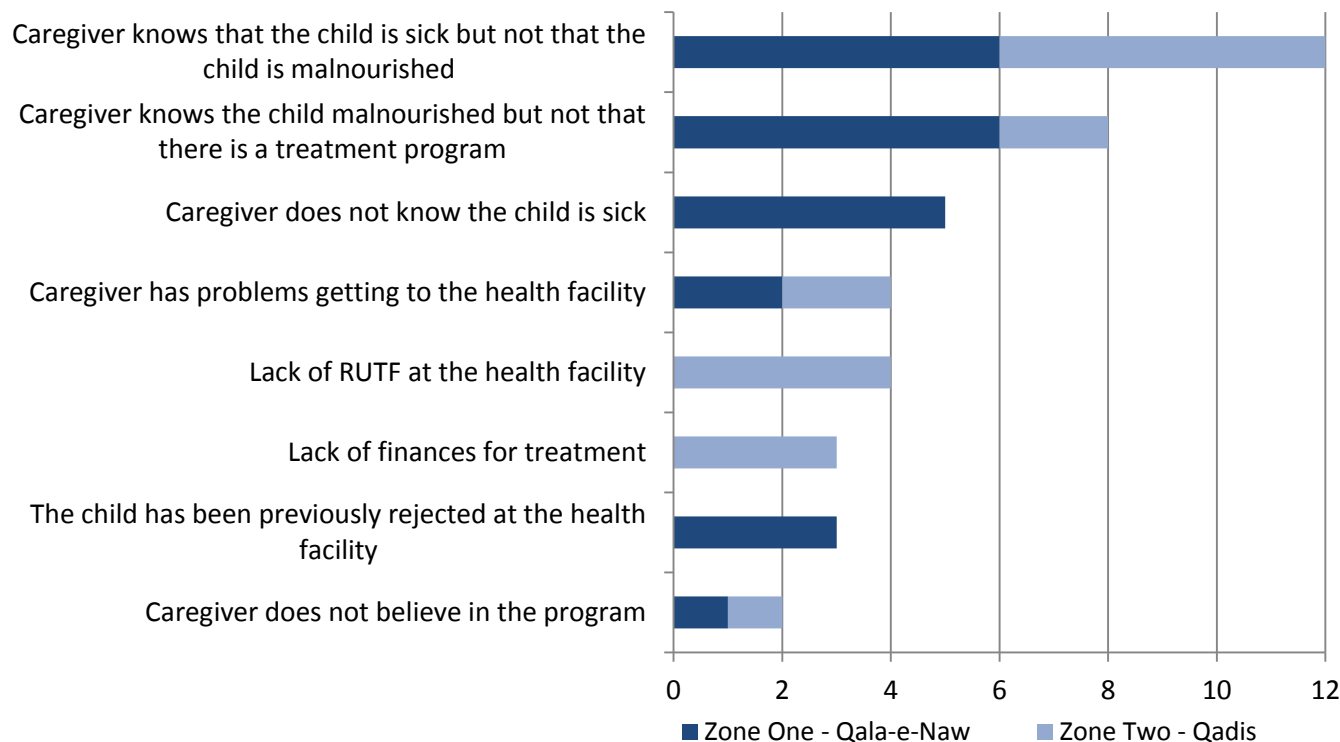
4.3. Barriers to access

Simple questionnaires, designed to determine reasons why a SAM child was not being treated, were administered to the caregiver of each uncovered case found. From these questionnaires, qualitative

²² This estimation does not take the incidence rate into account.

information related to how the caregiver accesses health services and the factors preventing them from accessing SAM treatment services was collected. This information is analysed in more detail in the following section. However in each case, primary barrier to access was determined from the responses using very simple decision logic.²³ This allows identification of the most common barriers in each zone, and therefore facilitates prioritization of the most important issues. Collectively (including both zones), the frequency of primary barriers can be shown as follows:

Figure 8 Pareto chart showing primary barriers to access in Badghis Province (n=41)



This shows that the primary barrier to access for the majority of caregivers was that, despite recognising that their child is sick, they do not recognise their child is malnourished. In Zone One, there are as many caregivers who know that their child is malnourished but are not aware of the treatment services available. Knowledge of these services is less of a barrier in Zone Two, where all caregivers also recognised that their child was sick. Where Zone One barriers are predominantly relating to awareness about the child’s condition, Zone Two barriers relate to awareness of malnutrition, but also or even more so, reported lack of RUTF supply at the health facilities of finances for treatment. The latter indicates that key messages about how the treatment works are not being shared with mothers or community. Data relating to this is explored further below. Challenges faced by caregivers not able to get to the health facility include lack of transportation and finances for the journey.

It is also notable here that there are five cases where a caregiver does not believe in the program or the child being previously rejected are primary barriers. This means that this prevents the caregiver from having their child admitted to the program even though they are aware of the condition, the treatment and are able to get to the health facility easily.

²³ See Annex G for analysis logic

5. Analysis of factors affecting access and coverage

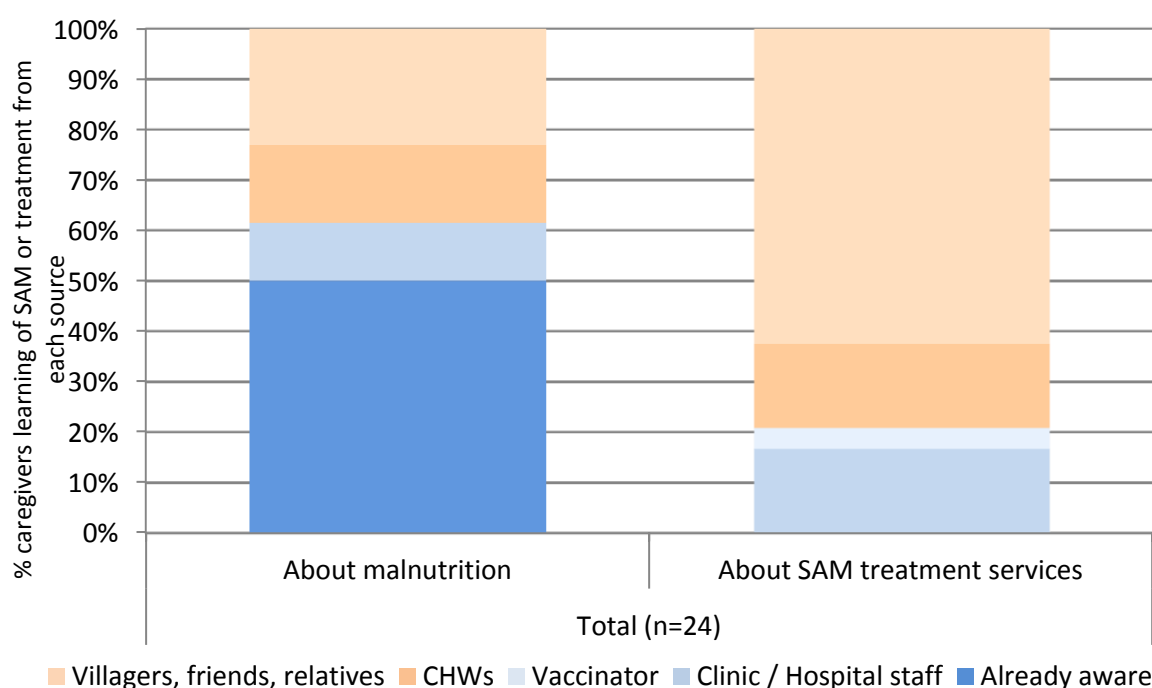
The following section presents an analysis of the key factors affecting access and coverage as described by findings from all available sources, including survey questionnaires to caregivers of SAM children, additional qualitative information collected to investigate the effect of security on coverage and supplementary interviews with staff.

The barriers presented in Figure 8 clearly indicate that the lack of understanding about the condition of malnutrition is negatively impacting access and coverage of SAM treatment services in accessible areas in Badghis. A more in depth analysis of the questionnaires administered to both covered and uncovered questionnaires allows for a more detailed view on these factors, and also the emergence of some additional elements related to coverage.

5.1. Key findings from covered questionnaires

The objective of the questionnaire administered for covered cases was to explore what factors influenced the child's admission to the treatment program. Particularly in terms of awareness, the covered questionnaires provide a means to ascertain whether caregivers had knowledge about the child's sickness and how to get treatment, and if not, how they received this information to facilitate admission. Figure 9 illustrates how covered cases were informed of the condition of their child and treatment services available.

Figure 9 Bar chart showing the source of information about malnutrition and SAM services for covered cases (n= 24)



This information reveals those who gave caregivers information about malnutrition and treatment services. We can see that **neighbours and relatives are shown to be key informants to caregivers of SAM children for information about SAM treatment services** available, and although to a lesser degree, about malnutrition.

CHWs are also sometimes informing caregivers about malnutrition and usually also advise them about the treatment available. Involvement of CHWs, however, was found in only two villages, both in Qadis and likely indicating the presence of strong CHWs there.

Many caregivers were **informed about the child's condition of malnutrition by clinic/hospital staff** once they have reached a health facility having found out about services from friends and neighbours.

There are also indications in the data that RUTF can be sourced without visiting the health facility as some caregivers suggested that it was after they used RUTF and found it to be working that they found they could receive it for free at the health facility and then went to enrol their child.

“We bought medicine from the market. Since the RUTF was working and the child was eating that happily, so we admitted her to the clinic” – Caregiver of recovering case in Dah Yak Sufla

5.2. Key findings from non-covered questionnaires

The objective of the non-covered questionnaires is to ascertain key factors preventing caregivers from admitting their child into the treatment program. From the responses the primary barrier for each case, as presented in Figure 7 above, provide an overview of the principal reason for not being treated at the time of the assessment. However, there may be several factors at play in each case that prevent the caregiver from admitting a SAM child for treatment.

In addition to the primary barriers, a summary of responses from uncovered cases shows that:

- Nearly 90% of caregivers **do recognise that their child is sick, but**
- Around two thirds (61%) of caregivers **do not recognise that their child is malnourished**
- Nearly 60% of caregivers are **aware there are treatment services available, but this varies greatly** between Zone One (where 39% are aware) and Zone Two (where 83% of caregivers are aware)
- Over two thirds (68%) of caregivers say that they have **no problems with getting to the health facility**, and nearly one half (46%) say that they have **tried or considered a visit to the health facility as a treatment** for the illness
- Nearly two thirds (63%) of **uncovered cases found were female**

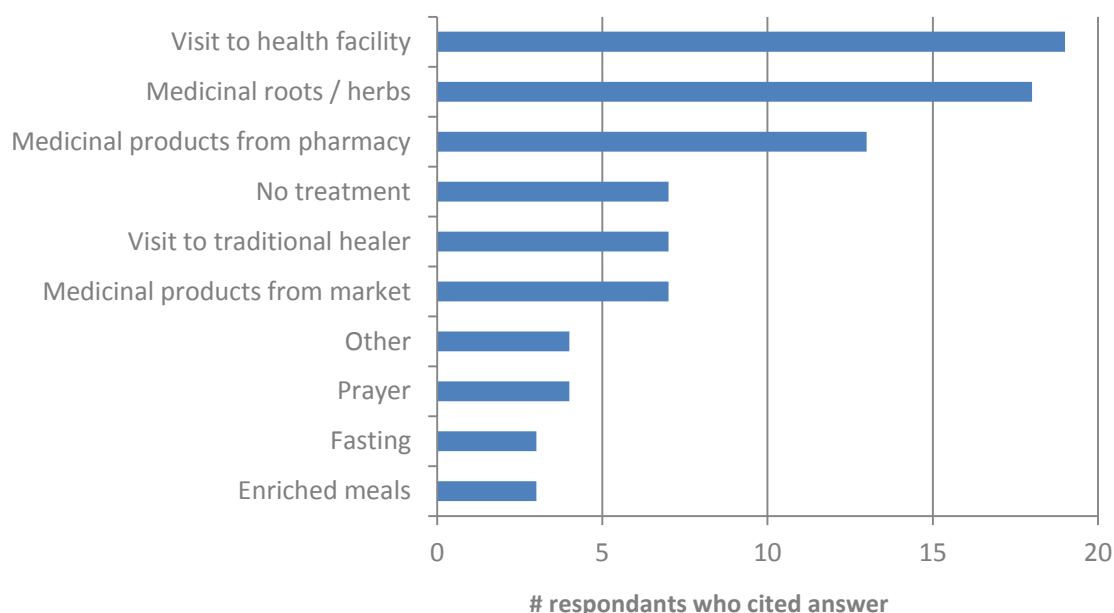
5.2.1. Lack of understanding about malnutrition

Around 88% of caregivers (36) of uncovered cases (n=41) did understand that their child is sick. And many respondents were able to list symptoms related to malnutrition (predominantly fever, diarrhoea and weight loss), with two thirds (25) recognising the child as malnourished. However, 61% of caregivers responded that they had never received information about malnutrition. Those who responded that they had, were asked what information they had received and from who, revealing that most were told only that the health facility is providing RUTF to sick and weak children, mostly by other community members.

The question was also asked whether the child had ever been screened. Nearly 40% of caregivers said that their child had been screened, and all of these screenings had been done by staff at health facilities, however these screenings occurred either within the previous one month or longer than 6 months ago, suggesting there had been a period where no screening was happening. This indicates poor case-finding in the community.

With the exception of a visit to the health facility (46% of cases), caregivers also tried traditional treatments for their child's sickness, although medicines from the pharmacy were also used, as shown in Figure 10 below.

Figure 10 Treatments tried or considered by caregivers of SAM cases not admitted to the program (n=41)



5.2.2. Awareness of the SAM treatment services

The questionnaire for uncovered cases asked whether caregivers of SAM cases know that there is a program at the health facility to treat malnutrition. In Zone One, only 39% said that they did. This corresponds with several other barriers more prevalent in Zone One including a lower number of cases saying they had ever been screened (20% in Zone One compared to nearly a half (47%) in Zone Two) and generally more difficulties to reach the health facility (see Figure 12).

There are also very high numbers of caregivers reporting that they do not have finances for treatment (61%). Given that treatment is free, this indicates that these carers have not been well informed about the treatment for SAM. If there are also errors occurring in the distribution of RUTF (shortage to clinic, supply leaking to the market or distribution to incorrect admissions), as other findings indicate may be possible, then this may result in confusion about how the program works. This would be supported by the findings that 32% of caregivers say that they do not know how to get their child admitted and 29% (nearly all in Zone One) saying that they do not believe that the program will help their child.

5.2.3. Poor quality of care

For uncovered SAM cases, very few had been previously admitted to the program. However, of these, half had defaulted due to relocation or bad behaviour from health facility staff and half were discharged as non-cured due to a lack of RUTF at the health facility. Several caregivers also mentioned as an additional comment that they had experience of visiting the health facility and being advised that there was no RUTF available to provide for treatment.

The questionnaire for uncovered cases also asked what the reasons are when they were not able to reach the health facility. Seven caregivers (30%) in Zone One replied that the staff at the health facility are rude and not welcoming. Caregivers also report that the health facility is often closed or that they have been previously rejected from the program. Discussion with the assessment team also revealed that many mothers in the communities being surveyed tried to force the teams to provide referral slips to them even though their child was healthy, thinking that they would be able to receive RUTF with it at the health facility.

Although these barriers are less prevalent in Zone Two, there is a higher presence of covered (mostly recovering) cases. In these cases there are several complaints about the lack of RUTF at health facilities causing default and relapse.

5.3. Security-related findings

The implementation of the assessment was clearly restricted due to insecurity. Using data from interviews with staff (at management and clinic level), interviews with visitors to clinics²⁴ and comprehensive field notes, an analysis of the effects insecurity has on access was made.

These investigations also revealed information about what types of insecurity are being experienced. This includes the firing of weapons nearby between armed groups and risk of kidnapping that also impacted the assessment. Results also revealed that broadly speaking the recent security instability was perceived to be improving in Badghis. However the long-term impacts of displacement and political instability were also found to impact on community access to treatment services and the impact on the provision of treatment services.

Impact on community access

In the village level security review conducted before sampling for the two districts remaining within the scope of the assessment, 57% of villages were removed from the list (30% from Zone One and 73% from Zone Two). Although the review reflected the risk associated with the assessment team travelling to these villages, this still provides an indication of where AOG presence might influence access to clinics for the community.

Even after removing villages as advised by this review, the security risk in three of the villages sampled was later advised to be too high to visit them. The assessment team was advised by local community members and authorities not to visit these three villages.

Additional interviews with visitors to clinics allowed us to explore further. When asked how nearby insecurity affects visitors to the various health facilities, many said that they do not have serious problems due to security, and that the situation was improving. However, staff interviewed clearly recognised that there were people who did not visit the facilities due to poor security.

Both staff and visitors were also asked about alternatives used by communities when security prevents travel to health facilities. Most staff said that they did not know, and some added that they cannot help them. The rest did not answer. However, visitors interviewed gave a variety of health seeking strategies including going to the city for treatment, visiting pharmacies and using private doctors. None mentioned CHWs, although when the next question asked if they know their CHW, most visitors said that they did.

Impact on provision of services

Interviews with staff at clinics and from MOVE management staff revealed that insecurity also inhibits a range of activities required for operating the OPD SAM sites, specifically those involving movement to district level, such as monitoring, training, supervision activities. Many areas in the province are too insecure for any monitoring or supervision to be conducted safely. A particular impact on BPHS implementation mentioned by management staff is that opposition groups have so much power in the region that they can apply a lot of pressure resulting in forced opening of clinics in opposition held areas. This would clearly impact the pattern of distribution of services among the population.

²⁴ See methodology section

Also during implementation of the assessment, it was found that opposition groups were in control of local functioning of telephone networks, which affected the communications with the assessment team. These obstacles were mitigated once there was an understanding found, for example, as to when the likely time would be for the network to fail each day, but clearly highlight the level of political ambiguity in the area and for organisations working there.

Also at clinic level, staff were asked whether the functioning of the facility, or the IMAM services were effected by insecurity. Three staff said that insecurity had either caused closure of the health facility in the past.

5.4. Additional barriers and boosters

Overall, visitation to health facilities in the areas included in the assessment was fairly good. Caregivers of all uncovered cases were asked when the last time they visited the health facility was, and the reason for the visit. With a range of 1 day to 12 months, the median length of time since last visit was 1 month. Figure 11 shows this is most commonly within 3 months prior to the assessment. This indicates willingness to use of the health facilities generally.

Figure 11 - Duration since last visit to health facility by caregivers of uncovered cases

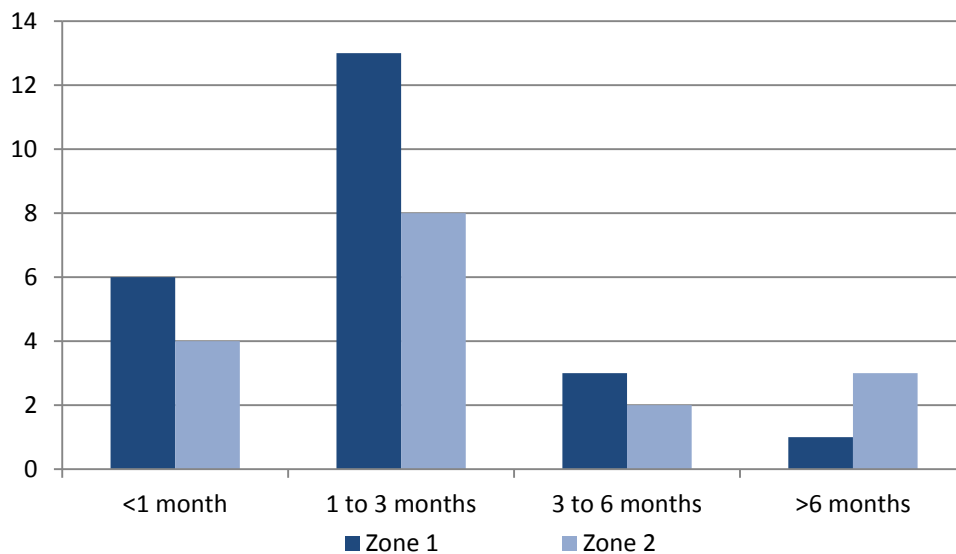
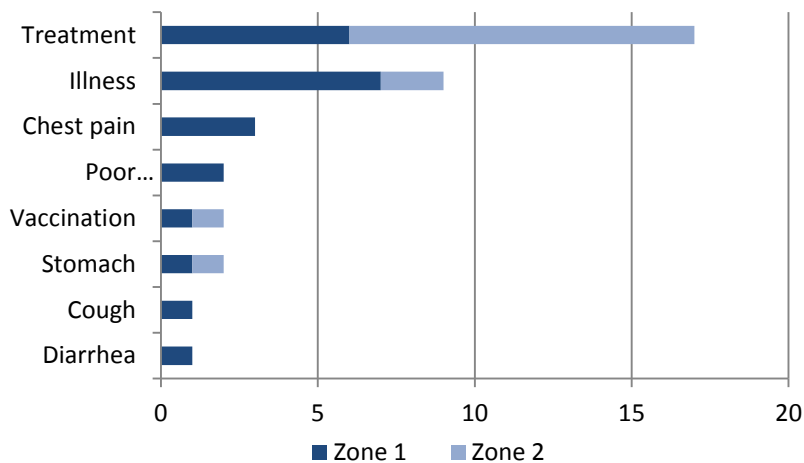


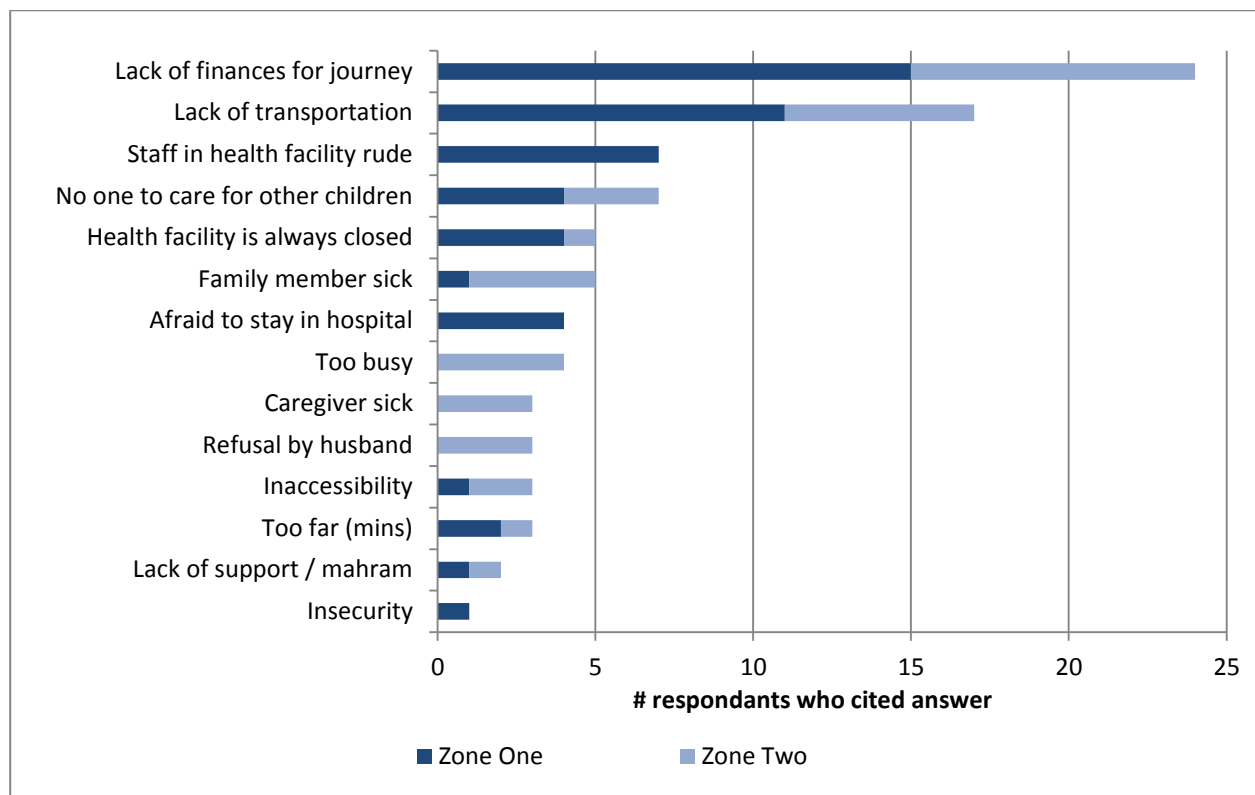
Figure 12 also shows that most of the reasons why caregivers last went to the health facility are associated with malnutrition and many even specify that their reason for visiting the health facility was for treatment, often identifying for malnutrition. This shows that caregivers are willing to make the journey to health facilities, and for malnutrition related problems or treatment.

Figure 12 - Reasons given for last visit to health facility



Furthermore, caregivers were asked what the reasons (possibly multiple) are for not going to the health facility when they cannot go. Lack of finances or transportation to make the journey clearly feature here reflecting the economic challenges in the area.

Figure 13 Factors presenting a challenge to accessing health centres as cited by uncovered cases (n=41 but multiple answers given by individuals)



There are also a number of people citing facility closure and behaviour of health facility staff as a reason for not visiting the health facility as discussed above. But there are also a number of factors relating to household level challenges, such as childcare for other children and sickness of family members. This is notably more common than physical obstacles such as distance, inaccessibility or even insecurity.

6. Conclusions

Overall, the findings show that, within the areas nearby the provincial capital, caregivers do use health facilities to address the symptoms of malnutrition. Although many are not able to identify that this is the condition the child is suffering, many are aware of the SAM treatment services available to treat the condition and are willing to visit health facilities. However often children are not able to reach admission due to poor quality of care (e.g. bad behaviour of health facility staff or lack of RUTF). Awareness of the SAM treatment services is shared well amongst community members, but there are very little screening or referral activities in the community in these areas.

These are the main contributing factors to the low coverage in parts of Badghis assessed, and an estimation of coverage in the province is **14.4% (CI 95%: 4.15%-24.67%)**. It must be clearly noted however, that this estimation incorporates results only for areas which were deemed secure enough for the assessment to access: just 10% of the villages in the province that are situated near the roads and the provincial capital city.

Further analysis on insecure areas shows that, although communities seem undeterred from using health facilities, insecurity does pose challenges to implementation of services and therefore coverage in the areas excluded is very likely to be lower than in the more secure areas and therefore likely to reduce the overall coverage of SAM services. The impact on the SLEAC assessment itself also implies a significant limitation on the results of the assessment, particularly in the reading of the classifications and estimation, which should be understood as relating only to 10% of the villages that were not removed from the sampling frame due to insecurity.

The involvement of CHWs in any nutrition activities (including screening and referral) is notably absent. Further, since social networks (neighbours, friends and relatives) are shown to be important sources of information leading to admission, they could also be utilised effectively for screening and referral. At clinic level, further quantitative investigation is required to identify the reasons for high numbers of recovering cases, since SLEAC data from the community cannot confirm good case-finding, early treatment seeking or good adherence to protocol and indications are to the contrary.

With guidance from these findings, recommendations to improve community mobilisation, programming and monitoring activities are made in the following section.

7. Recommendations

Based on the findings above and further discussions with key stakeholders such as nutrition, management and assessment staff, the following recommendations for improving access and coverage for this program have been developed. Some recommendations will act to reinforce any activities already planned by MOVE.

	Rationale	Suggested Activities
Recommendation 1: <u>Quality of care</u> Improve SAM treatment service delivery and patient care , including implementing more effective passive screening at health facilities	Evidence of cases visiting facilities without being screened and therefore admitted and rejected cases (possibly incorrectly) as well as poor delivery of RUTF, and over-worked staff.	- Train clinic staff in nutrition and IMAM guidelines and refresher training in MUAC and weight-for-height measurements. - Ensure systematic screening at clinic level for all children under-5 - Ensure minimum information on treatment is shared with caregivers (e.g. dos and don'ts for treatment, duration of treatment, reasons for admission/non-admission/discharge) - Formally review and record workload of staff members, and ensure nutrition staff have sufficient time to fulfil obligations - Organise clinic so as to allow appropriate time for each visitor and improve experience at clinic for caregivers
Recommendation 2: Improve RUTF supply and distribution in co-ordination with UNICEF	Evidence of insufficient supply of RUTF at health facilities including those near provincial capital. Evidence of RUTF availability on the market	- Review process for forecast and delivery of RUTF at provincial level - Review in facility level distribution and storage practices throughout the province - Investigate causes for possible leakage and availability of RUTF on the market including establishing at which point or points in the supply and distribution of RUTF it is being leaving supply chain
Recommendation 3: <u>Awareness of malnutrition and treatment</u> Utilize existing community networks and groups to increase awareness of malnutrition and SAM treatment services	Knowledge about malnutrition (signs and symptoms) is poor and knowledge of SAM treatment services is varied. Information is not effectively communicated by health staff and CHWs, nor effectively shared amongst community members although they show willingness to share	- IEC materials (already developed with MoPH) be distributed and use monitored. - Train CHWs to conduct regular nutrition specific (condition and treatment) education sessions with mothers and fathers - Train and engage with key community figures such as family health action groups (FHAG), health shura, vaccinators, pharmacists, maliks, mullahs and school teachers and encourage them to share key messages for recognizing the condition, screening and treatment within the community using sensitisation tools and materials.

	messages	- Collaborate with health shura to share messages about malnutrition.
Recommendation 4: <u>Monitoring</u> Conduct a SQUEAC assessment to monitor progress after six months of implementation of current recommendations and investigate facility level nutrition related activities	More in depth investigation of treatment flow and interface between clinic and community activities is required. More effective and efficient monitoring tools needed particularly to monitor effectiveness of activities being introduced (such as use of IEC materials).	- SQUEAC assessment in Qala-e-Naw in six months, further building capacity of core team for SLEAC assessment - PNO and MOVE should be involved in training for capacity building and full engagement with recommendations - Include full community assessment to better understand community dynamics and key actors in order to develop a more sophisticated community mobilization (communication, screening and follow-up) plan.
Recommendation 5: <u>Screening and Referral</u> Improve and enlarge screening and referral at community level by improving systems to support and monitor CHW activities and engaging additional actors in screening	Limited involvement of CHWs in screening, referral or sensitization, and lack of engagement with community in screening and referral.	- Re-train CHWs in MUAC and oedema screening, referrals and sensitization. - Review allocation of CHWs according to up to date population data. - Design suitable incentivisation for cases recruited and retained to cure as currently implemented to encourage follow up of defaulters. - Train mothers to regularly screen their children. Training can take place during visits to health centres and MUAC tapes should be distributed to them. - Train CHWs and other community health actors (such as health shura, vaccinators, pharmacists, maliks) in gender sensitisation
Recommendation 6: <u>Access to health facilities</u> Improve physical access to SAM treatment services	Economic and household support barriers prevent cases from being treated at current OPD SAM sites	- Train CHWs to support caregivers to source finances for transport and make arrangements that allow them to attend the OPD (such as pooling transportation and childcare). - Provide OPD SAM treatment services at additional sub-centres that are located in more remote areas

Annexes

Annex A - Full list of villages in Badghis Province

The highlighted villages are those that were sampled. NB, the villages are not ordered according to health centre catchment area as they were when the sampling was done.

District Name	Village Name (in alphabetical order)	Population	Village removed from sampling frame (1=yes, 2=no)	District Hospital (1=yes, 2=no)	CHC (1=yes 2=no)	BHC (1=yes 2=no)	Selected for sampling (1=yes, 2=no)	Removed from final sample (1=yes, 2=no)
Abkamari	Ab-e-kamari	2990	1	2	2	1	2	2
Abkamari	Agha Sofi Dahi Zangi	675	1	2	2	2	2	2
Abkamari	Aghak	327	1	2	2	2	2	2
Abkamari	Ahmad Bai	544	1	2	2	2	2	2
Abkamari	Alamcho	59	1	2	2	2	2	2
Abkamari	Anjir	0	1	2	2	2	2	2
Abkamari	Arbab Hassan	147	1	2	2	2	2	2
Abkamari	Baghak Tashbalaq	242	1	2	2	2	2	2
Abkamari	Baras	873	1	2	2	2	2	2
Abkamari	Besmullah	640	1	2	2	2	2	2
Abkamari	Bigujai	0	1	2	2	2	2	2
Abkamari	Chah Sangi	885	1	2	2	2	2	2
Abkamari	Chak Aba	557	1	2	2	1	2	2
Abkamari	Chalanak Khorad	460	1	2	2	2	2	2
Abkamari	Chashma Ghaibe	397	1	2	2	2	2	2
Abkamari	Chashma Gul Shah	462	1	2	2	2	2	2
Abkamari	Chashma Sorakhak	135	1	2	2	2	2	2
Abkamari	Chelanak	684	1	2	2	2	2	2
Abkamari	Dahan Zo	985	1	2	2	2	2	2
Abkamari	Dahestan	698	1	2	2	1	2	2
Abkamari	Dahestan Gulstan	746	1	2	2	2	2	2
Abkamari	Dahi Muradi	983	1	2	2	2	2	2
Abkamari	Dahi Zangi Awje	588	1	2	2	2	2	2
Abkamari	Darage Chashma Gul Shah	267	1	2	2	2	2	2
Abkamari	Deh-i-zangi (1)	0	1	2	2	2	2	2
Abkamari	Deh-i-zangi (2)	1142	1	2	2	2	2	2
Abkamari	Deh-i-zangi (3)	3686	1	2	2	2	2	2
Abkamari	Eashan Khail	1078	1	2	2	2	2	2
Abkamari	Gandab	461	1	2	2	2	2	2

Abkamari	Gandab Baikocha	1195	1	2	2	2	2	2
Abkamari	Ghar Zargabe	296	1	2	2	2	2	2
Abkamari	Ghulam Haider Bai	887	1	2	2	2	2	2
Abkamari	Gozar	1238	1	2	2	2	2	2
Abkamari	Gul Khana Hulya	571	1	2	2	2	2	2
Abkamari	Gul Khana Sufla	956	1	2	2	2	2	2
Abkamari	Ibrahim Gudam Dar	285	1	2	2	2	2	2
Abkamari	Karaiz Mirza	575	1	2	2	2	2	2
Abkamari	Karaiz Now	344	1	2	2	2	2	2
Abkamari	Khah Kala Bacha	192	1	2	2	2	2	2
Abkamari	Khalifa	196	1	2	2	2	2	2
Abkamari	Khalishkak	0	1	2	2	2	2	2
Abkamari	Khan Qa	937	1	2	2	2	2	2
Abkamari	Khoja Ahmdi	307	1	2	2	2	2	2
Abkamari	Khoja Bagh	210	1	2	2	2	2	2
Abkamari	Khoja Gul Baid	83	1	2	2	2	2	2
Abkamari	Khoja Pesta	82	1	2	2	2	2	2
Abkamari	Khoskak	505	1	2	2	2	2	2
Abkamari	Kocha Zard Aghzari	971	1	2	2	2	2	2
Abkamari	Kocha Zard Qaraye	1241	1	2	2	2	2	2
Abkamari	Kocha Zard Yarak	420	1	2	2	2	2	2
Abkamari	Kohna Qoul	787	1	2	2	2	2	2
Abkamari	Kok Chayel Khaja Pesta	985	1	2	2	2	2	2
Abkamari	Kok Chayel Zaid Morgh	780	1	2	2	2	2	2
Abkamari	Kokchayel Qeshlaq Kalan	1004	1	2	2	2	2	2
Abkamari	Mahka	156	1	2	2	2	2	2
Abkamari	Malakhak	192	1	2	2	2	2	2
Abkamari	Mir Hussain Khan	115	1	2	2	2	2	2
Abkamari	Mir Zarak	443	1	2	2	2	2	2
Abkamari	Mohla Gazaq Ha	1108	1	2	2	2	2	2
Abkamari	Mubarak Shah	1216	1	2	2	2	2	2
Abkamari	Mullah Abdul Karim	204	1	2	2	2	2	2
Abkamari	Nakhrob	0	1	2	2	2	2	2
Abkamari	Narab	972	1	2	2	2	2	2
Abkamari	Now Abad Pahlawanan	185	1	2	2	2	2	2
Abkamari	Now Abad Shamal Darya	1210	1	2	2	2	2	2
Abkamari	Now Abad Tagab Ismail	950	1	2	2	2	2	2
Abkamari	Now Abda Dahaan Zo	268	1	2	2	2	2	2
Abkamari	Omar Sayed Khan	0	1	2	2	2	2	2
Abkamari	Oy Mad	0	1	2	2	2	2	2
Abkamari	Pada Laghari	1838	1	2	2	2	2	2
Abkamari	Pada Nokarai	938	1	2	2	2	2	2
Abkamari	Pahlawan	0	1	2	2	2	2	2
Abkamari	Pahlawanan	484	1	2	2	2	2	2

Abkamari	Pai Pul	267	1	2	2	2	2	2
Abkamari	Pesta Sawar	248	1	2	2	2	2	2
Abkamari	Qabchaq	834	1	2	2	2	2	2
Abkamari	Qadogh Agha Zaman	492	1	2	2	2	2	2
Abkamari	Qakak	39	1	2	2	2	2	2
Abkamari	Qaraghak Tarake	840	1	2	2	2	2	2
Abkamari	Qash Balaq	1029	1	2	2	2	2	2
Abkamari	Qotoghak	235	1	2	2	2	2	2
Abkamari	Rahm Mahal	44	1	2	2	2	2	2
Abkamari	Rahmatullah	212	1	2	2	2	2	2
Abkamari	Rowi Awa	1209	1	2	2	2	2	2
Abkamari	Safid Alak	376	1	2	2	2	2	2
Abkamari	Saheb Khan	0	1	2	2	2	2	2
Abkamari	Salim Bai	430	1	2	2	2	2	2
Abkamari	Sang Khers	982	1	2	2	2	2	2
Abkamari	Sang Lo	474	1	2	2	2	2	2
Abkamari	Sar Besha	387	1	2	2	2	2	2
Abkamari	Sar Dara Shabtaq	419	1	2	2	2	2	2
Abkamari	Sar Kamar	197	1	2	2	2	2	2
Abkamari	Sarkhazak	628	1	2	2	2	2	2
Abkamari	Sena Mullah Mansor	435	1	2	2	2	2	2
Abkamari	Shaikh	123	1	2	2	2	2	2
Abkamari	Tagab Rabata	849	1	2	2	2	2	2
Abkamari	Tai Dara	913	1	2	2	2	2	2
Abkamari	Taj Paloq Zai Mirak	511	1	2	2	2	2	2
Abkamari	Tan Showi	647	1	2	2	2	2	2
Abkamari	Tay Dara Gandab	878	1	2	2	2	2	2
Abkamari	Tayel Galam	293	1	2	2	2	2	2
Abkamari	Waymat	263	1	2	2	2	2	2
Abkamari	Zangorda Zangi	493	1	2	2	2	2	2
Abkamari	Zaymat	0	1	2	2	2	2	2
Abkamari	Zemat	545	1	2	2	2	2	2
Abkamari	Zemat Bala	192	1	2	2	2	2	2
Balamurghab	Ab Barik	837	1	2	2	2	2	2
Balamurghab	Akazai	1368	1	2	2	2	2	2
Balamurghab	Almacho	222	1	2	2	2	2	2
Balamurghab	Aman Khan	0	1	2	2	2	2	2
Balamurghab	Amrochestan	746	1	2	2	2	2	2
Balamurghab	Asekzai Zarwari	231	1	2	2	2	2	2
Balamurghab	Asghari Kham Toot	458	1	2	2	2	2	2
Balamurghab	Asiab Banan Akazai	1428	1	2	2	2	2	2
Balamurghab	Aylaq Hai Nakhcheristan	3790	1	2	2	2	2	2
Balamurghab	Aylaq Neshen Jamal Zai	2294	1	2	2	2	2	2
Balamurghab	Badar Mossa Zaen	391	1	2	2	2	2	2

Balamurghab	Baghak	261	1	2	2	2	2	2
Balamurghab	Bala Murghab	1043	1	1	2	2	2	2
Balamurghab	Bazar Now	1517	1	2	2	2	2	2
Balamurghab	Bazar Now Abdul Rashid	774	1	2	2	2	2	2
Balamurghab	Best Ghola Ghai	234	1	2	2	2	2	2
Balamurghab	Bokan	0	1	2	2	2	2	2
Balamurghab	Bokan Bala	576	1	2	2	2	2	2
Balamurghab	Bokan Bala Dojari	583	1	2	2	2	2	2
Balamurghab	Bokan Chapghol	571	1	2	2	2	2	2
Balamurghab	Bokan Payen	4600	1	2	2	2	2	2
Balamurghab	Bokan Payen Purdail Khola	237	1	2	2	2	2	2
Balamurghab	Buz Bai	741	1	2	2	2	2	2
Balamurghab	Chakab	752	1	2	2	2	2	2
Balamurghab	Chalonak Bala	1075	1	2	2	2	2	2
Balamurghab	Chalonak Payen	723	1	2	2	2	2	2
Balamurghab	Chalonak Sar Tagab	182	1	2	2	2	2	2
Balamurghab	Char Sonak	410	1	2	2	2	2	2
Balamurghab	Charkh Ab	426	1	2	2	2	2	2
Balamurghab	Chilunak-i-bala	0	1	2	2	2	2	2
Balamurghab	Dahan Qoul Uzbek	489	1	2	2	2	2	2
Balamurghab	Dahan Shor Jowi Ganj	1348	1	2	2	2	2	2
Balamurghab	Dahana Shor	780	1	2	2	2	2	2
Balamurghab	Dahana Shor Morchaq	1345	1	2	2	2	2	2
Balamurghab	Dahana-i-pasab	0	1	2	2	2	2	2
Balamurghab	Dahna Shor Nari	836	1	2	2	2	2	2
Balamurghab	Dahna Shor Sanam	925	1	2	2	2	2	2
Balamurghab	Dozakh Dara	783	1	2	2	2	2	2
Balamurghab	Fath Khan	876	1	2	2	2	2	2
Balamurghab	Gala Chashma	606	1	2	2	2	2	2
Balamurghab	Ganda Ab	250	1	2	2	2	2	2
Balamurghab	Garwato Charmi Herati	1161	1	2	2	2	2	2
Balamurghab	Garwato Kandahri	1246	1	2	2	2	2	2
Balamurghab	Garwato Sarchashma	1098	1	2	2	2	2	2
Balamurghab	Gul Raikhta	1215	1	2	2	2	2	2
Balamurghab	Gulab Khail Miranzai	1107	1	2	2	2	2	2
Balamurghab	Haft Now	11	1	2	2	2	2	2
Balamurghab	Haji Agha Mohammad Khan Ghola Ghai	910	1	2	2	2	2	2
Balamurghab	Haji Akhtar Khan	877	1	2	2	2	2	2
Balamurghab	Haji Aqa Mohammad	38	1	2	2	2	2	2
Balamurghab	Haji Buranud Din Khan	0	1	2	2	2	2	2
Balamurghab	Haji Rahmatullah	483	1	2	2	2	2	2
Balamurghab	Halqa Gayem	528	1	2	2	2	2	2

Balamurghab	Hassal Khan	883	1	2	2	2	2	2
Balamurghab	Herati Hai Gardan Boreda	700	1	2	2	2	2	2
Balamurghab	Hotaki Hai Ghola Ghai	258	1	2	2	2	2	2
Balamurghab	Ishaq Zai	963	1	2	2	2	2	2
Balamurghab	Jalaly Zaien	1109	1	2	2	2	2	2
Balamurghab	Jowi Ganj Barikzai	1373	1	2	2	2	2	2
Balamurghab	Jowi Ganj Ghondak Bai	704	1	2	2	2	2	2
Balamurghab	Jowi Ganj Haji Shah Mohammad Barikzai	946	1	2	2	2	2	2
Balamurghab	Jowi Ganj Pai Khalank	305	1	2	2	2	2	2
Balamurghab	Jowi Ganj Sarkhalanak Barekzai	687	1	2	2	2	2	2
Balamurghab	Jowi Khoja	1129	1	2	2	2	2	2
Balamurghab	Jowi Khoja Dahan Morghab	1058	1	2	2	2	2	2
Balamurghab	Jowikar Achok Zai	925	1	2	2	2	2	2
Balamurghab	Jowikar Achokzai Darwesh Mohammad Yan	846	1	2	2	2	2	2
Balamurghab	Kabuli Ha	697	1	2	2	2	2	2
Balamurghab	Kabuly Hai Farari	847	1	2	2	2	2	2
Balamurghab	Kapa Baba	1687	1	2	2	2	2	2
Balamurghab	Katori	291	1	2	2	2	2	2
Balamurghab	Kham Gardak Bala	284	1	2	2	2	2	2
Balamurghab	Kham Gardak Haji Maidan	131	1	2	2	2	2	2
Balamurghab	Kham Shahzada Masood Khail	426	1	2	2	2	2	2
Balamurghab	Khasa Dar	1141	1	2	2	2	2	2
Balamurghab	Khawal Wennzai	517	1	2	2	2	2	2
Balamurghab	Khoja Morad	444	1	2	2	2	2	2
Balamurghab	Khoja Yakhdan	1050	1	2	2	2	2	2
Balamurghab	Khwaja Shorak	0	1	2	2	2	2	2
Balamurghab	Lodeyana	699	1	2	2	2	2	2
Balamurghab	Losh Ab Ab Barik	699	1	2	2	2	2	2
Balamurghab	Mahla Wasat Morchaq	1473	1	2	2	2	2	2
Balamurghab	Majamal	881	1	2	2	2	2	2
Balamurghab	Mangan	885	1	2	2	2	2	2
Balamurghab	Markaz Wolluswaly	1065	1	2	2	2	2	2
Balamurghab	Miranzai	1287	1	2	2	2	2	2
Balamurghab	Miranzai Akhizi	1188	1	2	2	2	2	2
Balamurghab	Miranzai Gardan Boreda	1330	1	2	2	2	2	2
Balamurghab	Mohammad Omer Khan Ghola Ghi	940	1	2	2	2	2	2
Balamurghab	Mor Chaq	9424	1	2	2	2	2	2
Balamurghab	Mughol Hai Ishaq Zai	1024	1	2	2	2	2	2
Balamurghab	Mullah Payen	123	1	2	2	2	2	2

Balamurghab	Mullah Wazir Arabha Pul Kohna	675	1	2	2	2	2	2
Balamurghab	Mullah Wazir Bayenzai	198	1	2	2	2	2	2
Balamurghab	Mullah Yan Bala	482	1	2	2	2	2	2
Balamurghab	Murghab	1192	1	2	2	2	2	2
Balamurghab	Nai Kata Ab Barik	515	1	2	2	2	2	2
Balamurghab	Nal Kha Nan	332	1	2	2	2	2	2
Balamurghab	Noor Zai	704	1	2	2	2	2	2
Balamurghab	Now Abad	793	1	2	2	2	2	2
Balamurghab	Now Abad Jar Gala Gow	786	1	2	2	2	2	2
Balamurghab	Now Bor	583	1	2	2	2	2	2
Balamurghab	Now Zai	697	1	2	2	2	2	2
Balamurghab	Pain Bokan	0	1	2	2	2	2	2
Balamurghab	Paitow Qoum Tark	536	1	2	2	2	2	2
Balamurghab	Panirak Bala	797	1	2	2	2	2	2
Balamurghab	Panirak Haji Badrow	203	1	2	2	2	2	2
Balamurghab	Panirak Mashahd Yan	948	1	2	2	2	2	2
Balamurghab	Panirak Mossa	4078	1	2	2	2	2	2
Balamurghab	Pul Kohna	155	1	2	2	2	2	2
Balamurghab	Pul Kohna Chakzai	305	1	2	2	2	2	2
Balamurghab	Qahr Andow	499	1	2	2	2	2	2
Balamurghab	Qahr-i-hindu	0	1	2	2	2	2	2
Balamurghab	Qal Kushta Ab Barik	492	1	2	2	2	2	2
Balamurghab	Qala Band Babi	787	1	2	2	2	2	2
Balamurghab	Rashid Khan	234	1	2	2	2	2	2
Balamurghab	Saghari Arbab Aminullah	562	1	2	2	2	2	2
Balamurghab	Saghari Arbab Majnoon	267	1	2	2	2	2	2
Balamurghab	Saghari Arbab Rawof	292	1	2	2	2	2	2
Balamurghab	Sahib Zada Bala	121	1	2	2	2	2	2
Balamurghab	Sahib Zada Payen	361	1	2	2	2	2	2
Balamurghab	Sang Zard	1236	1	2	2	2	2	2
Balamurghab	Sang Zor	256	1	2	2	2	2	2
Balamurghab	Saqab	639	1	2	2	2	2	2
Balamurghab	Sayid Azim Aqa Sayid Abad	152	1	2	2	2	2	2
Balamurghab	Sayid Mohammad Nawa Mangan	499	1	2	2	2	2	2
Balamurghab	Sayido Kha Qasim Khan	846	1	2	2	2	2	2
Balamurghab	Sayido Khan Faiz Mohammad	887	1	2	2	2	2	2
Balamurghab	Seni Haji Baran	652	1	2	2	2	2	2
Balamurghab	Seni Haji Obaidullah Obaidullah Zahori	960	1	2	2	2	2	2
Balamurghab	Shah Mira	222	1	2	2	2	2	2
Balamurghab	Shahzada Payen	844	1	2	2	2	2	2

Balamurghab	Shahzada Taymani	295	1	2	2	2	2	2
Balamurghab	Shar Chashma Amrochestan	538	1	2	2	2	2	2
Balamurghab	Shar Sharye	432	1	2	2	2	2	2
Balamurghab	Sherkat Punba	728	1	2	2	2	2	2
Balamurghab	Shor Ab	443	1	2	2	2	2	2
Balamurghab	Sor Band	216	1	2	2	2	2	2
Balamurghab	Sor Qoul	1316	1	2	2	2	2	2
Balamurghab	Tawanzai	385	1	2	2	2	2	2
Balamurghab	Towi Che Qoul Wa Aweila Mohammad Zai	194	1	2	2	2	2	2
Balamurghab	Yar Mohammad Khail Akazai	693	1	2	2	2	2	2
Balamurghab	Zadran	515	1	2	2	2	2	2
Balamurghab	Zak Zak Ghola Ghai	195	1	2	2	2	2	2
Balamurghab	Zaman	276	1	2	2	2	2	2
Balamurghab	Zaman Sar Pyl Kohna	393	1	2	2	2	2	2
Balamurghab	Zharenda	729	1	2	2	2	2	2
Jawand	Ab Khor Bala	251	1	2	2	2	2	2
Jawand	Ab Khor Payen	487	1	2	2	2	2	2
Jawand	Ab Murgh	40	1	2	2	2	2	2
Jawand	Ab Poda Abdullah Afghan	405	1	2	2	2	2	2
Jawand	Abdullah Allah Dad	41	1	2	2	2	2	2
Jawand	Abdulrashid Khan	223	1	2	2	2	2	2
Jawand	Abrejan	0	1	2	2	2	2	2
Jawand	Agha Mohammad	97	1	2	2	2	2	2
Jawand	Ahan Kashan	157	1	2	2	2	2	2
Jawand	Alam Cho	77	1	2	2	2	2	2
Jawand	Amel	227	1	2	2	2	2	2
Jawand	Amro Ghel	147	1	2	2	2	2	2
Jawand	Amrocha	59	1	2	2	2	2	2
Jawand	Arabha	0	1	2	2	2	2	2
Jawand	Arbab Modod	178	1	2	2	2	2	2
Jawand	Archa Yak	48	1	2	2	2	2	2
Jawand	Argo	352	1	2	2	2	2	2
Jawand	Ashpal	85	1	2	2	2	2	2
Jawand	Astar Ghab	743	1	2	2	2	2	2
Jawand	Ate Dost	10	1	2	2	2	2	2
Jawand	Bacha Koshak	220	1	2	2	2	2	2
Jawand	Badal	409	1	2	2	2	2	2
Jawand	Badam Too	1003	1	2	2	2	2	2
Jawand	Badrawak	471	1	2	2	2	2	2
Jawand	Bai Ya Hain Chashma	325	1	2	2	2	2	2
Jawand	Baidak	207	1	2	2	2	2	2

Jawand	Balrab	158	1	2	2	2	2	2
Jawand	Baran	120	1	2	2	2	2	2
Jawand	Bargah Showich	882	1	2	2	2	2	2
Jawand	Bay Bacha	0	1	2	2	2	2	2
Jawand	Besha	108	1	2	2	2	2	2
Jawand	Buzghalak	81	1	2	2	2	2	2
Jawand	Chahe Ghalak	0	1	2	2	2	2	2
Jawand	Chakab	32	1	2	2	2	2	2
Jawand	Chakabak	0	1	2	2	2	2	2
Jawand	Chaman Baid	563	1	2	2	2	2	2
Jawand	Chanaran	33	1	2	2	2	2	2
Jawand	Chapnal	0	1	2	2	2	2	2
Jawand	Char Band	341	1	2	2	2	2	2
Jawand	Char Howz	696	1	2	2	2	2	2
Jawand	Char Qala	76	1	2	2	2	2	2
Jawand	Chartaq	795	1	2	1	2	2	2
Jawand	Chashma Bahri	79	1	2	2	2	2	2
Jawand	Chashma Baid	596	1	2	2	2	2	2
Jawand	Chashma Char	568	1	2	2	2	2	2
Jawand	Chawak	615	1	2	2	2	2	2
Jawand	Chehl Sang	9	1	2	2	2	2	2
Jawand	Cheya	594	1	2	2	2	2	2
Jawand	Chochaka	356	1	2	2	2	2	2
Jawand	Choly Yak	22	1	2	2	2	2	2
Jawand	Dahan Abdar	499	1	2	2	2	2	2
Jawand	Dahan Darom	481	1	2	2	2	2	2
Jawand	Dahan Gharma Kharmain	115	1	2	2	2	2	2
Jawand	Dahan Shor Aw	60	1	2	2	2	2	2
Jawand	Dahana Ab Jal	792	1	2	2	2	2	2
Jawand	Dahana Ab Qarna	264	1	2	2	2	2	2
Jawand	Dahana Darzak Haji Baz Mohammad Khan	439	1	2	2	2	2	2
Jawand	Dahana Doab Payan	403	1	2	2	2	2	2
Jawand	Dahana Kharsen	305	1	2	2	2	2	2
Jawand	Dahana Kor Ab	347	1	2	2	2	2	2
Jawand	Dahi Garm	407	1	2	2	2	2	2
Jawand	Dahi Ghanch	97	1	2	2	2	2	2
Jawand	Dahi Ghoryak	296	1	2	2	2	2	2
Jawand	Dahi Mazar	288	1	2	2	2	2	2
Jawand	Dahi Posht	33	1	2	2	2	2	2
Jawand	Dahimahmod	74	1	2	2	2	2	2
Jawand	Dairest Qeshlaq Wazir Khan	389	1	2	2	2	2	2
Jawand	Danga	358	1	2	2	2	2	2

Jawand	Dar Qad	418	1	2	2	2	2	2
Jawand	Dara Bar	88	1	2	2	2	2	2
Jawand	Dara Dahi Tor	367	1	2	2	2	2	2
Jawand	Dara Khoshkak	472	1	2	2	2	2	2
Jawand	Dara Parkhin	127	1	2	2	2	2	2
Jawand	Dara Sheberghan	143	1	2	2	2	2	2
Jawand	Darwaza (1)	193	1	2	2	2	2	2
Jawand	Darwaza (2)	220	1	2	2	2	2	2
Jawand	Dehe Awgar	0	1	2	2	2	2	2
Jawand	Dehe Khan	0	1	2	2	2	2	2
Jawand	Dehe Mahmud	0	1	2	2	2	2	2
Jawand	Do Abi Pach	326	1	2	2	2	2	2
Jawand	Doab Markaz Now Abad	416	1	2	2	2	2	2
Jawand	Dod Kodyan	42	1	2	2	2	2	2
Jawand	Doshakhi	251	1	2	2	2	2	2
Jawand	Dowa	84	1	2	2	2	2	2
Jawand	Esbaq	395	1	2	2	2	2	2
Jawand	Eshpashe Bala	120	1	2	2	2	2	2
Jawand	Eshpashe Payen	103	1	2	2	2	2	2
Jawand	Gari Ab	410	1	2	2	2	2	2
Jawand	Gashak	320	1	2	2	2	2	2
Jawand	Gashbandi	57	1	2	2	2	2	2
Jawand	Gashemga	55	1	2	2	2	2	2
Jawand	Gazestan	0	1	2	2	2	2	2
Jawand	Gelak	400	1	2	2	2	2	2
Jawand	Ghal Bantaq	56	1	2	2	2	2	2
Jawand	Ghal Chashma	75	1	2	2	2	2	2
Jawand	Ghal Daraz	67	1	2	2	2	2	2
Jawand	Ghal Ghali	162	1	2	2	2	2	2
Jawand	Ghal Jach Dara Shaberghan	103	1	2	2	2	2	2
Jawand	Ghal Kashk	253	1	2	2	2	2	2
Jawand	Ghal Khazak	238	1	2	2	2	2	2
Jawand	Ghal Kocha	89	1	2	2	2	2	2
Jawand	Ghal Maikh	188	1	2	2	2	2	2
Jawand	Ghal Moshak	839	1	2	2	2	2	2
Jawand	Ghal Seya (1)	616	1	2	2	2	2	2
Jawand	Ghal Seya (2)	111	1	2	2	2	2	2
Jawand	Ghal Seya Jallaye	247	1	2	2	2	2	2
Jawand	Ghal Seya Parkhen	108	1	2	2	2	2	2
Jawand	Ghal Seya Wain	85	1	2	2	2	2	2
Jawand	Ghal Zera Bala	75	1	2	2	2	2	2
Jawand	Ghal Zera Payen	153	1	2	2	2	2	2
Jawand	Ghale Guyak	0	1	2	2	2	2	2

Jawand	Ghale Khaza	0	1	2	2	2	2	2
Jawand	Ghale Safed	0	1	2	2	2	2	2
Jawand	Ghar Gardak	692	1	2	2	2	2	2
Jawand	Ghar Haidar	204	1	2	2	2	2	2
Jawand	Ghar Sahra	382	1	2	2	2	2	2
Jawand	Ghar Wafa	64	1	2	2	2	2	2
Jawand	Gharma	97	1	2	2	2	2	2
Jawand	Gho Kalan	401	1	2	2	2	2	2
Jawand	Go Koshta	466	1	2	2	2	2	2
Jawand	Gorzowanak Bala	918	1	2	2	2	2	2
Jawand	Gorzowanak Payen	608	1	2	2	2	2	2
Jawand	Gosala Danak	316	1	2	2	2	2	2
Jawand	Gozestan Ali Shair Zai	288	1	2	2	2	2	2
Jawand	Gozestan Bala	580	1	2	2	2	2	2
Jawand	Gozestan Paitow	55	1	2	2	2	2	2
Jawand	Gozestan Payen	470	1	2	2	2	2	2
Jawand	Gul Dara	79	1	2	2	2	2	2
Jawand	Haji Abodullah Ya Darsang	539	1	2	2	2	2	2
Jawand	Haji Ghulam Nabi Khan	345	1	2	2	2	2	2
Jawand	Haji Ibrahim Kharmain	610	1	2	2	2	2	2
Jawand	Haji Yusuf Kharmain	60	1	2	2	2	2	2
Jawand	Har Qoul	29	1	2	2	2	2	2
Jawand	Hassan Kushta	72	1	2	2	2	2	2
Jawand	Hawdze Tut (1)	0	1	2	2	2	2	2
Jawand	Hawdze Tut (2)	0	1	2	2	2	2	2
Jawand	Hawz Be Bayam	124	1	2	2	2	2	2
Jawand	Hazar Maish	66	1	2	2	2	2	2
Jawand	Hazrat Mullah	523	1	2	2	2	2	2
Jawand	Hesarak (1)	33	1	2	2	2	2	2
Jawand	Hesarak (2)	174	1	2	2	2	2	2
Jawand	Howz Gawi	134	1	2	2	2	2	2
Jawand	Howz Haji Baig	55	1	2	2	2	2	2
Jawand	Howz Jowidar	81	1	2	2	2	2	2
Jawand	Howz Maseh	57	1	2	2	2	2	2
Jawand	Howz Qurban Ali	261	1	2	2	2	2	2
Jawand	Howz Toot	269	1	2	2	2	2	2
Jawand	Ishpai	329	1	2	2	2	2	2
Jawand	Jahanbaz	0	1	2	2	2	2	2
Jawand	Jar Ayoub Qarya Ghoshaldin	197	1	2	2	2	2	2
Jawand	Jar Bocha	24	1	2	2	2	2	2
Jawand	Jar Modod	155	1	2	2	2	2	2
Jawand	Jar Taka	279	1	2	2	2	2	2

Jawand	Jar Takht - O - Bakht	95	1	2	2	2	2	2
Jawand	Jawand	745	1	2	2	2	2	2
Jawand	Jejani Bala	186	1	2	2	2	2	2
Jawand	Jejani Payen	157	1	2	2	2	2	2
Jawand	Joshani	76	1	2	2	2	2	2
Jawand	Jow Ghaz	274	1	2	2	2	2	2
Jawand	Jowzak	205	1	2	2	2	2	2
Jawand	Kaftar Khan	128	1	2	2	2	2	2
Jawand	Kahri Koh Tour	850	1	2	2	2	2	2
Jawand	Kajawa	432	1	2	2	2	2	2
Jawand	Kamar Safid	52	1	2	2	2	2	2
Jawand	Kamar Shar	337	1	2	2	2	2	2
Jawand	Kamarak Zard	149	1	2	2	2	2	2
Jawand	Kandlak	411	1	2	2	2	2	2
Jawand	Kanghalak	0	1	2	2	2	2	2
Jawand	Kar Basha Bala Yaloka Safidak	90	1	2	2	2	2	2
Jawand	Kar Basha Payen	126	1	2	2	2	2	2
Jawand	Karai Zak	508	1	2	2	2	2	2
Jawand	Karash	438	1	2	2	2	2	2
Jawand	Karbasha Ghalak	112	1	2	2	2	2	2
Jawand	Karew Sowich	696	1	2	2	2	2	2
Jawand	Kargas Ghal Ya Now Abad Shakam Khaza	79	1	2	2	2	2	2
Jawand	Kashkak	334	1	2	2	2	2	2
Jawand	Kazak	82	1	2	2	2	2	2
Jawand	Kazak Kalan (1)	448	1	2	2	2	2	2
Jawand	Kazak Kalan (2)	482	1	2	2	2	2	2
Jawand	Khair Abad Dara Safid	54	1	2	2	2	2	2
Jawand	Khak Darnak	151	1	2	2	2	2	2
Jawand	Khak Safar	72	1	2	2	2	2	2
Jawand	Khakestarak	0	1	2	2	2	2	2
Jawand	Khala Jan	285	1	2	2	2	2	2
Jawand	Kham Dahi Yak	423	1	2	2	2	2	2
Jawand	Kham Jangal	364	1	2	2	2	2	2
Jawand	Kham Shana	196	1	2	2	2	2	2
Jawand	Kham Sorkhi	86	1	2	2	2	2	2
Jawand	Kham Tootak Garaba	433	1	2	2	2	2	2
Jawand	Kham Tootak Ya Gham Tagab	103	1	2	2	2	2	2
Jawand	Khar Baid	242	1	2	2	2	2	2
Jawand	Khar Goshak	113	1	2	2	2	2	2
Jawand	Khar Tootak	262	1	2	2	2	2	2
Jawand	Khargosh	209	1	2	2	2	2	2

Jawand	Kharzar	427	1	2	2	2	2	2
Jawand	Khog Kushta	120	1	2	2	2	2	2
Jawand	Khoja Abdul Hai	171	1	2	2	2	2	2
Jawand	Khoja Jangir	215	1	2	2	2	2	2
Jawand	Khola	191	1	2	2	2	2	2
Jawand	Kobash Khana	610	1	2	2	2	2	2
Jawand	Kocha Bala	407	1	2	2	2	2	2
Jawand	Kocha Darzak Qeshlaq Adam Khan	488	1	2	2	2	2	2
Jawand	Kocha Darzak Qeshlaq Akhtar Khan	281	1	2	2	2	2	2
Jawand	Kocha Payen	573	1	2	2	2	2	2
Jawand	Kolaha-i-khan	0	1	2	2	2	2	2
Jawand	Korma	89	1	2	2	2	2	2
Jawand	Kotak Ya Bai Mullayan	251	1	2	2	2	2	2
Jawand	Kushk	180	1	2	2	2	2	2
Jawand	Kushk Sabz	206	1	2	2	2	2	2
Jawand	Lakh Daraz	200	1	2	2	2	2	2
Jawand	Lakhak	359	1	2	2	2	2	2
Jawand	Lashkari	202	1	2	2	2	2	2
Jawand	Mah Shams	345	1	2	2	2	2	2
Jawand	Mahmodi	30	1	2	2	2	2	2
Jawand	Mail Now	838	1	2	2	2	2	2
Jawand	Mal Ghal	138	1	2	2	2	2	2
Jawand	Mango	57	1	2	2	2	2	2
Jawand	Marghalak	88	1	2	2	2	2	2
Jawand	Masodak	67	1	2	2	2	2	2
Jawand	Menkarak	135	1	2	2	2	2	2
Jawand	Mirza Ali	128	1	2	2	2	2	2
Jawand	Mohammad Hakim	57	1	2	2	2	2	2
Jawand	Mosharaf	86	1	2	2	2	2	2
Jawand	Mughul Harf	227	1	2	2	2	2	2
Jawand	Mulla Gul	0	1	2	2	2	2	2
Jawand	Murad Baig	82	1	2	2	2	2	2
Jawand	Murad Baik	155	1	2	2	2	2	2
Jawand	Na Yak Bala	174	1	2	2	2	2	2
Jawand	Nai Shah	263	1	2	2	2	2	2
Jawand	Nai Yak	452	1	2	2	2	2	2
Jawand	Nai Zar	132	1	2	2	2	2	2
Jawand	Naibaran	269	1	2	2	2	2	2
Jawand	Naik Bara	639	1	2	2	2	2	2
Jawand	Nal Bast	488	1	2	2	2	2	2
Jawand	Nashir Sokhta	181	1	2	2	2	2	2
Jawand	Nawar	0	1	2	2	2	2	2

Jawand	Naweshta	238	1	2	2	2	2	2
Jawand	Nawi Paya	105	1	2	2	2	2	2
Jawand	Nawi Sharif	55	1	2	2	2	2	2
Jawand	Nayak Payen	100	1	2	2	2	2	2
Jawand	Now Abad	108	1	2	2	2	2	2
Jawand	Nowras Yaftan	248	1	2	2	2	2	2
Jawand	Pai Chang	207	1	2	2	2	2	2
Jawand	Pai Dorowgh	778	1	2	2	2	2	2
Jawand	Pai Kotal	41	1	2	2	2	2	2
Jawand	Paishewl	13	1	2	2	2	2	2
Jawand	Paitow Seya Khaki Shahbazi	175	1	2	2	2	2	2
Jawand	Paitow Tabala	168	1	2	2	2	2	2
Jawand	Pala Sorkh	464	1	2	2	2	2	2
Jawand	Palangan	0	1	2	2	2	2	2
Jawand	Palta	0	1	2	2	2	2	2
Jawand	Panj Buz	217	1	2	2	2	2	2
Jawand	Panj To	86	1	2	2	2	2	2
Jawand	Parkhain	43	1	2	2	2	2	2
Jawand	Payen Koh	577	1	2	2	2	2	2
Jawand	Pesha	303	1	2	2	2	2	2
Jawand	Petawe Syakhkaki (1)	0	1	2	2	2	2	2
Jawand	Petawe Syakhkaki (2)	0	1	2	2	2	2	2
Jawand	Petawe Tawela	0	1	2	2	2	2	2
Jawand	Posht Toot	498	1	2	2	2	2	2
Jawand	Pul Kheshte Abdullah	191	1	2	2	2	2	2
Jawand	Pul-i-khishti	0	1	2	2	2	2	2
Jawand	Pushta-i-shekamba	0	1	2	2	2	2	2
Jawand	Qadoq Hai Koh Tour	637	1	2	2	2	2	2
Jawand	Qadoq Jalaye	89	1	2	2	2	2	2
Jawand	Qaisarak	66	1	2	2	2	2	2
Jawand	Qala Jowhar	37	1	2	2	2	2	2
Jawand	Qalacha	227	1	2	2	2	2	2
Jawand	Qarya Qaz	544	1	2	2	2	2	2
Jawand	Qash Dar Khoshak	275	1	2	2	2	2	2
Jawand	Qeshlaq Ab Poda Mullah Abdullah	159	1	2	2	2	2	2
Jawand	Qeshlaq Bebe Zanan	164	1	2	2	2	2	2
Jawand	Qeshlaq Ghal Zagh	86	1	2	2	2	2	2
Jawand	Qeshlaq Kohna	112	1	2	2	2	2	2
Jawand	Qeshlaqak	8	1	2	2	2	2	2
Jawand	Qeshlaqe Dotaye Burs	0	1	2	2	2	2	2
Jawand	Qeshlaq-i-dewani	0	1	2	2	2	2	2
Jawand	Qishlaqi Badgah	0	1	2	2	2	2	2

Jawand	Qodoghi Islami	381	1	2	2	2	2	2
Jawand	Qodughak (1)	0	1	2	2	2	2	2
Jawand	Qodughak (2)	0	1	2	2	2	2	2
Jawand	Qsh Kamare Zard	0	1	2	2	2	2	2
Jawand	Qurban Ali	297	1	2	2	2	2	2
Jawand	Rabat	828	1	2	2	2	2	2
Jawand	Rabatak	1171	1	2	2	2	2	2
Jawand	Rag Zard	141	1	2	2	2	2	2
Jawand	Raige	240	1	2	2	2	2	2
Jawand	Rustam Bator	38	1	2	2	2	2	2
Jawand	Sabor Khana	280	1	2	2	2	2	2
Jawand	Sahr Gul	232	1	2	2	2	2	2
Jawand	Sambakech	460	1	2	2	2	2	2
Jawand	Samha Shahid Mirza	226	1	2	2	2	2	2
Jawand	Sang Bawa	43	1	2	2	2	2	2
Jawand	Sang Kar	172	1	2	2	2	2	2
Jawand	Sangar	121	1	2	2	2	2	2
Jawand	Sangar Abkhori Wain	277	1	2	2	2	2	2
Jawand	Sar Dara	745	1	2	2	2	2	2
Jawand	Sar Darakht	179	1	2	2	2	2	2
Jawand	Sar Hesar	75	1	2	2	2	2	2
Jawand	Sar Khas	492	1	2	2	2	2	2
Jawand	Sar Khazak	145	1	2	2	2	2	2
Jawand	Sar Langar	151	1	2	2	2	2	2
Jawand	Sar Pala Sarwar Gharma	47	1	2	2	2	2	2
Jawand	Sar Shorab	158	1	2	2	2	2	2
Jawand	Sar Takht	98	1	2	2	2	2	2
Jawand	Sar Tawa	504	1	2	2	2	2	2
Jawand	Sar Zaghand	188	1	2	2	2	2	2
Jawand	Sarje	532	1	2	2	2	2	2
Jawand	Sawdagar	0	1	2	2	2	2	2
Jawand	Saya Roi	105	1	2	2	2	2	2
Jawand	Saybak	142	1	2	2	2	2	2
Jawand	Sena Zard	638	1	2	2	2	2	2
Jawand	Separi	486	1	2	2	2	2	2
Jawand	Seya Ab	563	1	2	2	2	2	2
Jawand	Seya Sangak	168	1	2	2	2	2	2
Jawand	Shah Ali	160	1	2	2	2	2	2
Jawand	Shah Dost (1)	0	1	2	2	2	2	2
Jawand	Shah Dost (2)	169	1	2	2	2	2	2
Jawand	Shahr Now	198	1	2	2	2	2	2
Jawand	Shala	35	1	2	2	2	2	2
Jawand	Shar Shar Abgarm Payen	217	1	2	2	2	2	2
Jawand	Shar Shara Abgaram Bala	208	1	2	2	2	2	2

Jawand	Shark Mohammad Azim	71	1	2	2	2	2	2
Jawand	Shayesta	216	1	2	2	2	2	2
Jawand	Shegafak	48	1	2	2	2	2	2
Jawand	Shekamba	245	1	2	2	2	2	2
Jawand	Shibij	0	1	2	2	2	2	2
Jawand	Shor Aw	29	1	2	2	2	2	2
Jawand	Shor Aw Kamandi Khan	47	1	2	2	2	2	2
Jawand	Shor Awak	830	1	2	2	2	2	2
Jawand	Shorabak	0	1	2	2	2	2	2
Jawand	Showich	698	1	2	2	2	2	2
Jawand	Siya Ghol	590	1	2	2	2	2	2
Jawand	Siz	0	1	2	2	2	2	2
Jawand	Skachak	73	1	2	2	2	2	2
Jawand	Sona	303	1	2	2	2	2	2
Jawand	Sorkhi	143	1	2	2	2	2	2
Jawand	Suj	0	1	2	2	2	2	2
Jawand	Sumsum	0	1	2	2	2	2	2
Jawand	Tagab Best Bala	539	1	2	2	2	2	2
Jawand	Tagab Best Payen	637	1	2	2	2	2	2
Jawand	Taghamak	117	1	2	2	2	2	2
Jawand	Tahkof Ya Konak Sangow	51	1	2	2	2	2	2
Jawand	Tahtegha	0	1	2	2	2	2	2
Jawand	Tai Takht	463	1	2	2	2	2	2
Jawand	Takh Bandar	161	1	2	2	2	2	2
Jawand	Takh Bat	126	1	2	2	2	2	2
Jawand	Takh Koh	282	1	2	2	2	2	2
Jawand	Takhalnaga	1118	1	2	2	2	2	2
Jawand	Takhabast	0	1	2	2	2	2	2
Jawand	Takhkuyak	0	1	2	2	2	2	2
Jawand	Takhnal (1)	0	1	2	2	2	2	2
Jawand	Takhnal (2)	186	1	2	2	2	2	2
Jawand	Takhobi	113	1	2	2	2	2	2
Jawand	Takhragi	0	1	2	2	2	2	2
Jawand	Takhrege	255	1	2	2	2	2	2
Jawand	Takhsowar	88	1	2	2	2	2	2
Jawand	Takht Baren	185	1	2	2	2	2	2
Jawand	Takht Kofe	97	1	2	2	2	2	2
Jawand	Takht Parmen	191	1	2	2	2	2	2
Jawand	Takht Zard	273	1	2	2	2	2	2
Jawand	Takhta Band (1)	210	1	2	2	2	2	2
Jawand	Takhta Band (2)	351	1	2	2	2	2	2
Jawand	Takhta Band Koh Tour	812	1	2	2	2	2	2
Jawand	Takhte Parmin	0	1	2	2	2	2	2
Jawand	Takhundi Kuhna	0	1	2	2	2	2	2

Jawand	Takhundi Naw	0	1	2	2	2	2	2
Jawand	Tanaj	150	1	2	2	2	2	2
Jawand	Tandorak	249	1	2	2	2	2	2
Jawand	Tangi Gor Dara	326	1	2	2	2	2	2
Jawand	Tanora	110	1	2	2	2	2	2
Jawand	Tar Khanak	11	1	2	2	2	2	2
Jawand	Tar Shabel	259	1	2	2	2	2	2
Jawand	Tarmi	180	1	2	2	2	2	2
Jawand	Tawa Sakht	95	1	2	2	2	2	2
Jawand	Tealak	334	1	2	2	2	2	2
Jawand	Tokhmeyan	168	1	2	2	2	2	2
Jawand	Toor Sam	30	1	2	2	2	2	2
Jawand	Yakhak	77	1	2	2	2	2	2
Jawand	Yakom Rawak	571	1	2	2	2	2	2
Jawand	Yowara Rahmat	282	1	2	2	2	2	2
Jawand	Zaghand Jow	463	1	2	2	2	2	2
Jawand	Zaghandawi	319	1	2	2	2	2	2
Jawand	Zaow	122	1	2	2	2	2	2
Jawand	Zar Zaghand	213	1	2	2	2	2	2
Jawand	Zard Aba	256	1	2	2	2	2	2
Jawand	Zard Alogak	37	1	2	2	2	2	2
Jawand	Zard Khan	158	1	2	2	2	2	2
Jawand	Zargaran	0	1	2	2	2	2	2
Jawand	Zawa	302	1	2	2	2	2	2
Jawand	Zeyarat Khoja Sorkheyan	77	1	2	2	2	2	2
Jawand	Zeyarat Shah Pair Turk	239	1	2	2	2	2	2
Muqur	Abdul Ahad Bai Kobai Shindandi	288	1	2	2	2	2	2
Muqur	Abdul Ahad Bai Komari	985	1	2	2	2	2	2
Muqur	Abdul Karim Taraki	0	1	2	2	2	2	2
Muqur	Abla-i-miranza'i	0	1	2	2	2	2	2
Muqur	Ajrim	1063	1	2	2	2	2	2
Muqur	Andari Mohammad Omer Khan	2115	1	2	2	2	2	2
Muqur	Azizan	338	1	2	2	2	2	2
Muqur	Babi Shor	707	1	2	2	2	2	2
Muqur	Balay Sen	149	1	2	2	2	2	2
Muqur	Baloch Ha Loden	502	1	2	2	2	2	2
Muqur	Bara Khana	838	1	2	2	2	2	2
Muqur	Buz Bai Sufla	861	1	2	2	2	2	2
Muqur	Chai Lapka	207	1	2	2	2	2	2
Muqur	Chashma Dozak	1961	1	2	2	2	2	2
Muqur	Dahan Babalay Omer Zai	843	1	2	2	2	2	2
Muqur	Dahana Jelo Gerak	658	1	2	2	2	2	2

Muqur	Deh-i-babula'i	0	1	2	2	2	2	2
Muqur	Deh-i-tor-i-shaykh	0	1	2	2	2	2	2
Muqur	Do Jari	295	1	2	2	2	2	2
Muqur	Farozi	607	1	2	2	2	2	2
Muqur	Heachka	979	1	2	2	2	2	2
Muqur	Jaek Ha Khoja Pesta	434	1	2	2	2	2	2
Muqur	Jahfari	759	1	2	2	2	2	2
Muqur	Jakna	741	1	2	2	2	2	2
Muqur	Jan Dosti	0	1	2	2	2	2	2
Muqur	Jangak Zar	183	1	2	2	2	2	2
Muqur	Jar Sorkh	247	1	2	2	2	2	2
Muqur	Kalan Zai	400	1	2	2	2	2	2
Muqur	Kalari	204	1	2	2	2	2	2
Muqur	Kalat Khana	717	1	2	2	2	2	2
Muqur	Kargaz Khal Tora Tarake	604	1	2	2	2	2	2
Muqur	Kargaz Khal Torake	747	1	2	2	2	2	2
Muqur	Kargaz Khal Zarin	782	1	2	2	2	2	2
Muqur	Kashaniya	645	1	2	2	2	2	2
Muqur	Khal Zardak	1181	1	2	2	2	2	2
Muqur	Khalifa Ha	475	1	2	2	2	2	2
Muqur	Kham Habasi Faretan	765	1	2	2	2	2	2
Muqur	Kham Habasi Pai Kamar	693	1	2	2	2	2	2
Muqur	Khan Doaba	103	1	2	2	2	2	2
Muqur	Khar Shenow Taraki	618	1	2	2	2	2	2
Muqur	Kulab Shor	421	1	2	2	2	2	2
Muqur	Lara Ahmad Zai	491	1	2	2	2	2	2
Muqur	Lodin	1214	1	2	2	2	2	2
Muqur	Lomri	274	1	2	2	2	2	2
Muqur	Maja Sangi	355	1	2	2	2	2	2
Muqur	Mamaka Zair Tangi	516	1	2	2	2	2	2
Muqur	Markaz Wolluswaly Sang Atash	1093	1	2	2	2	2	2
Muqur	Mazaid Sufla	160	1	2	2	2	2	2
Muqur	Meyan Koh Bala	498	1	2	2	2	2	2
Muqur	Miran Zai Jowi Kach	316	1	2	2	2	2	2
Muqur	Miran Zai Kulabi	703	1	2	2	2	2	2
Muqur	Miran Zai Zozani	1172	1	2	2	2	2	2
Muqur	Mohammad Zai	782	1	2	2	2	2	2
Muqur	Mohammad Zai Khoja Pesta	448	1	2	2	2	2	2
Muqur	Mossa Zai	399	1	2	2	2	2	2
Muqur	Muqur	2086	1	2	2	1	2	2
Muqur	Muqur Arbab Aziz	0	1	2	2	2	2	2
Muqur	Muqur-i-allahdad Khan	0	1	2	2	2	2	2

Muqur	Muqur-i-mohammad Omar Khan (1)	0	1	2	2	2	2	2
Muqur	Muqur-i-mohammad Omar Khan (2)	0	1	2	2	2	2	2
Muqur	Neyazai	206	1	2	2	2	2	2
Muqur	Noor Khail	390	1	2	2	2	2	2
Muqur	Noor Khail Abdul Wahab	599	1	2	2	2	2	2
Muqur	Qarghach Baikai	243	1	2	2	2	2	2
Muqur	Qarghach Balocha	334	1	2	2	2	2	2
Muqur	Rabat Kohna Markaz Wolluswali	539	1	2	2	2	2	2
Muqur	Sang Shandah	94	1	2	2	2	2	2
Muqur	Say Shori	552	1	2	2	2	2	2
Muqur	Sayid Azim Hotak	854	1	2	2	2	2	2
Muqur	Senjetak	307	1	2	2	2	2	2
Muqur	Sorkh Abe	785	1	2	2	2	2	2
Muqur	Tal Mohammad Jan	277	1	2	2	2	2	2
Muqur	Tangi Srna Bai	724	1	2	2	2	2	2
Muqur	Taraki Hul Ya	404	1	2	2	2	2	2
Muqur	Tayel Ghaz Ya Kandak	119	1	2	2	2	2	2
Muqur	Taymore	169	1	2	2	2	2	2
Muqur	Temoreyan	242	1	2	2	2	2	2
Muqur	Temuri	0	1	2	2	2	2	2
Muqur	Toor Shaikh	1133	1	2	2	2	2	2
Muqur	Zargar Ha	337	1	2	2	2	2	2
Muqur	Zat Ali	893	1	2	2	2	2	2
Muqur	Zat Nasir	458	1	2	2	2	2	2
Muqur	Zozan Hatak	1377	1	2	2	2	2	2
Qadis	Ab Bakhsh Hulya	1079	2	2	2	2	2	2
Qadis	Ab Bakhsh Sufla	899	2	2	2	2	2	2
Qadis	Ab Garmak	139	1	2	2	2	2	2
Qadis	Abad Yak	169	1	2	2	2	2	2
Qadis	Abdul Haq	0	1	2	2	2	2	2
Qadis	Almas Ha	476	2	2	2	2	2	2
Qadis	Aowrgarmak Toor Paichal	201	1	2	2	2	2	2
Qadis	Arbab Adaham	565	2	2	2	2	2	2
Qadis	Arbab Ali	743	2	2	2	2	1	2
Qadis	Arbab Ha	1656	2	2	2	2	1	2
Qadis	Aw Poda	326	1	2	2	2	2	2
Qadis	Awlad Mirza	921	2	2	2	2	2	2
Qadis	Baba Doste	705	2	2	2	2	1	2
Qadis	Baba Gawazuddin	107	2	2	2	2	1	2
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Qadis	Bahador Khan	221	1	2	2	2	2	2

Qadis	Baidak	55	1	2	2	2	2	2
Qadis	Bel Mohsen	604	2	2	2	2	1	1
Qadis	Borj	684	1	2	2	2	2	2
Qadis	Boya Kadanak	96	1	2	2	2	2	2
Qadis	Boya Kadanak Arbab Rahim Dad	1399	2	2	2	2	2	2
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Qadis	Boya Shash Mete	1090	2	2	2	2	2	2
Qadis	Buz Ghe	349	1	2	2	2	2	2
Qadis	Buzbai Hulya	399	2	2	2	2	2	2
Qadis	Byanza'i	0	1	2	2	2	2	2
Qadis	Chahak (1)	184	1	2	2	2	2	2
Qadis	Chahak (2)	701	1	2	2	2	2	2
Qadis	Chahe Talkhak	0	2	2	2	2	2	2
Qadis	Charaye Ab Doul Qayom	745	1	2	2	2	2	2
Qadis	Charkenk	106	1	2	2	2	2	2
Qadis	Charrayei Abdoul Qayom	745	2	2	2	2	2	2
Qadis	Chashma Safid	479	1	2	2	2	2	2
Qadis	Dahi Berenj	545	2	2	2	1	2	2
Qadis	Dahi Berenj Sar Kamar	982	2	2	2	2	1	2
Qadis	Dahi Yak Hulya	1006	2	2	2	2	2	2
Qadis	Dahi Yak Sufla	1142	2	2	2	2	1	2
Qadis	Dahi Zeyauddin	362	1	2	2	2	2	2
Qadis	Dar Band Safid	260	1	2	2	2	2	2
Qadis	Dara Boom Bala	764	1	2	2	2	2	2
Qadis	Dara Boom Meyan Kal	1288	1	2	2	2	2	2
Qadis	Dara Boom Payen	1246	1	2	2	2	2	2
Qadis	Dara Boom Tawa	673	1	2	2	2	2	2
Qadis	Dara Hazar Mashi	558	1	2	2	2	2	2
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Qadis	Farqal	871	1	2	2	2	2	2
Qadis	Farqal Arbab Madad	884	1	2	2	2	2	2
Qadis	Gargal	0	2	2	2	2	2	2
Qadis	Gazak	223	1	2	2	2	2	2
Qadis	Ghala Charkh Bala	300	1	2	2	2	2	2
Qadis	Ghala Charkh Payen	906	1	2	2	2	2	2
Qadis	Ghar Ghari	368	1	2	2	2	2	2
Qadis	Gharow	643	1	2	2	2	2	2
Qadis	Gonbad Joma Khan	664	1	2	2	2	2	2
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Qadis	Gumbaz (1)	0	2	2	2	2	2	2
Qadis	Gumbaz (2)	0	2	2	2	2	2	2
Qadis	Hafiz Baik	82	1	2	2	2	2	2
Qadis	Hagi Mohammad Ayoub	737	1	2	2	2	2	2

Qadis	Haji Abdoullah	590	2	2	2	2	2	2
Qadis	Haji Khalifa	118	1	2	2	2	2	2
Qadis	Hamai Khan Sufla	800	1	2	2	2	2	2
Qadis	Hamaly Khan Hulya	275	1	2	2	2	2	2
Qadis	Howz Sangi	246	2	2	2	2	2	2
Qadis	Jagh Boland	237	1	2	2	2	2	2
Qadis	Jangalak	354	1	2	2	2	2	2
Qadis	Jangalak Yar Hussain	684	1	2	2	2	2	2
Qadis	Jar Bashi Zad Mahmud	647	2	2	2	2	2	2
Qadis	Jar Do Dasht	255	1	2	2	2	2	2
Qadis	Jar Khazya Jar Qash	105	1	2	2	2	2	2
Qadis	Jara	128	1	2	2	2	2	2
Qadis	Jawaleq Bala	900	2	2	2	2	2	2
Qadis	Jawaleq Payen	1126	2	2	2	2	2	2
Qadis	Jowz Agha	63	1	2	2	2	2	2
Qadis	Kadanak	0	2	2	2	2	2	2
Qadis	Kalbeya	158	1	2	2	2	2	2
Qadis	Kar Keya	572	1	2	2	2	2	2
Qadis	Karaiz Agha Nezam	150	1	2	2	2	2	2
Qadis	Karaiz Haji Ibrahim	1447	1	2	2	2	2	2
Qadis	Karaiz Zekreya	762	1	2	2	2	2	2
Qadis	Kareze Zekrya	0	2	2	2	2	2	2
Qadis	Khair Khana	274	1	2	2	2	2	2
Qadis	Khair Khana Hulya	1068	1	2	2	1	2	2
Qadis	Khair Khana Sufla	898	1	2	2	2	2	2
Qadis	Khak Darwesh	614	1	2	2	2	2	2
Qadis	Khak Pala	371	1	2	2	2	2	2
Qadis	Khak Shair Mohammad	531	1	2	2	2	2	2
Qadis	Khalifa	565	2	2	2	2	2	2
Qadis	Khar Baid	1021	1	2	2	2	2	2
Qadis	Khodai Madiyan Khod Amada	936	2	2	2	2	1	2
Qadis	Khoja Chaharom	492	2	2	2	2	2	2
Qadis	Khwaja Charan	0	2	2	2	2	2	2
Qadis	Kolara	0	2	2	2	2	2	2
Qadis	Kotal Jowza	508	1	2	2	2	2	2
Qadis	Langar Sharif	1295	2	2	2	1	2	2
Qadis	Lawan Dan Langi	274	1	2	2	2	2	2
Qadis	Loka Sorkh	702	1	2	2	2	2	2
Qadis	Markaz Taht Qadis	458	2	2	2	2	1	2
Qadis	Mir Gheyas	1357	1	2	2	2	2	2
Qadis	Moqama	440	2	2	2	2	1	1
Qadis	Mukhtar	228	1	2	2	2	2	2
Qadis	Nai Yak	843	1	2	2	2	2	2

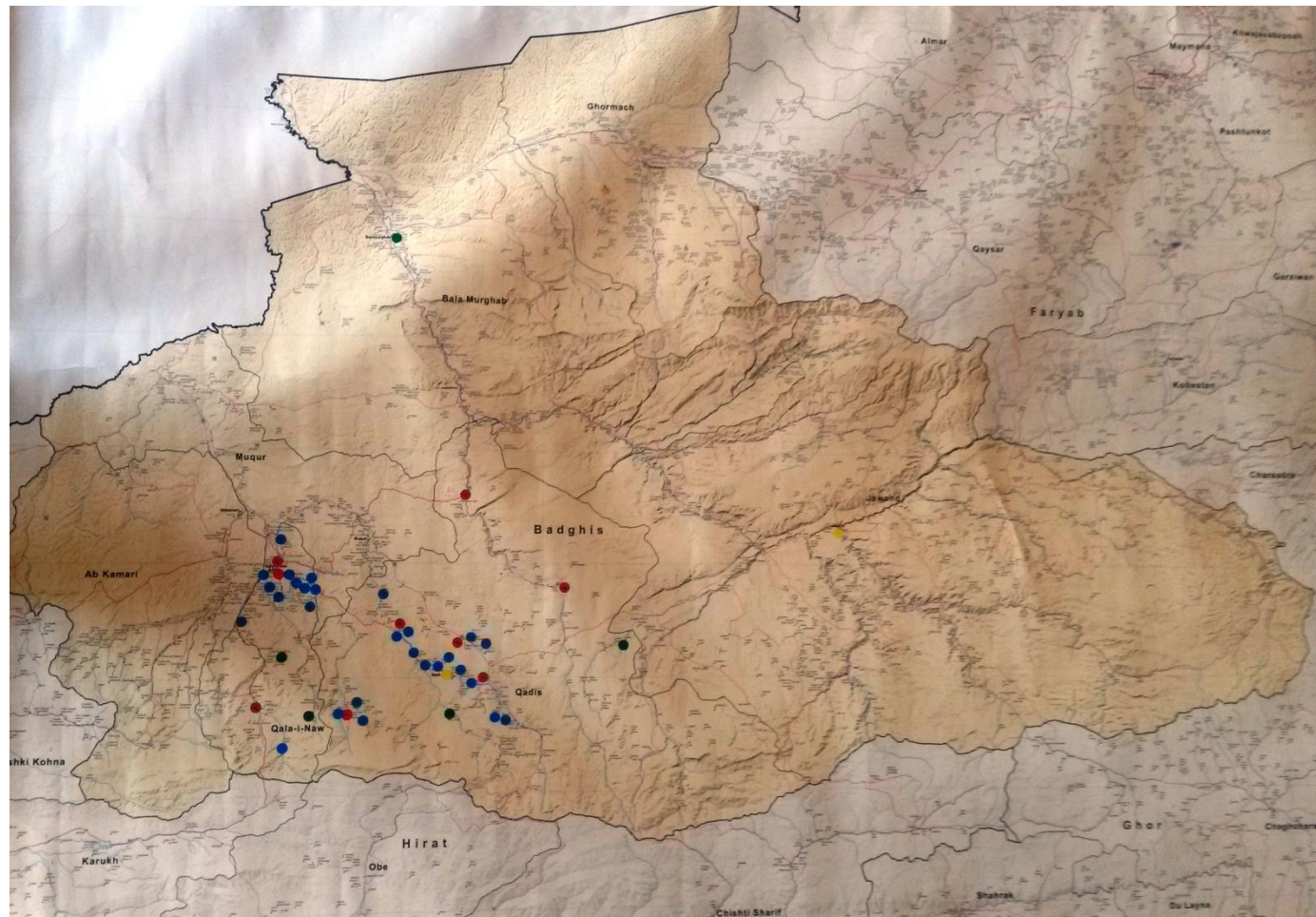
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Qadis	Najak Hazar Mesha	968	2	2	2	2	2	2
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Qadis	Namak Ha	184	1	2	2	2	2	2
Qadis	Now Abad Arbab Maqsod	158	1	2	2	2	2	2
Qadis	Nowi Mullah Gadai	257	1	2	2	2	2	2
Qadis	Omer Baik	512	2	2	2	2	2	2
Qadis	Pai Locha Ha	562	2	2	2	2	1	2
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Qadis	Pai War Payen	879	1	2	2	2	2	2
Qadis	Piwar	0	2	2	2	2	2	2
Qadis	Qadghak	189	1	2	2	2	2	2
Qadis	Qadis	2086	2	2	1	2	2	2
Qadis	Qaib Ali	777	1	2	2	2	2	2
Qadis	Qal Jalal	22	1	2	2	2	2	2
Qadis	Qapchaq Ha	638	1	2	2	2	2	2
Qadis	Qar Chaqe	1492	2	2	2	2	2	2
Qadis	Qar Chaqe Kamanje	779	2	2	2	2	1	2
Qadis	Qarchaqe Ya Zad Paiwand	1131	2	2	2	2	2	2
Qadis	Qarchaqe Zad Ghaybe	580	2	2	2	2	2	2
Qadis	Qarya Dahi Berenj	908	2	2	2	2	2	2
Qadis	Qarya Dahi Berenj Asia Bad	283	2	2	2	2	1	2
Qadis	Qarya Gulchen	692	1	2	2	2	2	2
Qadis	Qarya Mir Gheyas	39	1	2	2	2	2	2
Qadis	Qeshlaqe Nawabadha	0	2	2	2	2	2	2
Qadis	Qoul Ab Showi	168	1	2	2	2	2	2
Qadis	Qoul Chak	133	1	2	2	2	2	2
Qadis	Qoular Ha	717	2	2	2	2	2	2
Qadis	Qour Ban Ha	425	2	2	2	2	1	2
Qadis	Rabat	1070	2	2	2	2	2	2
Qadis	Rabate Kuhna	0	2	2	2	2	2	2
Qadis	Rahimak	125	1	2	2	2	2	2
Qadis	Sabz Ali	285	1	2	2	2	2	2
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Qadis	Say Goshak	88	1	2	2	2	2	2
Qadis	Saybak	210	1	2	2	2	2	2
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Qadis	Sena Zard	196	1	2	2	2	2	2
Qadis	Shah Dost	266	1	2	2	2	2	2
Qadis	Shah Mira	616	1	2	2	2	2	2

Qadis	Shahr Arman	573	1	2	2	2	2	2
Qadis	Shaikh Hamid	207	2	2	2	2	2	2
Qadis	Shekam Khaza	529	1	2	2	2	2	2
Qadis	Shor Aow	557	1	2	2	2	2	2
Qadis	Shorab Bala	513	1	2	2	2	2	2
Qadis	Shorab Khoja	200	1	2	2	2	2	2
Qadis	Shorab Payen	213	1	2	2	2	2	2
Qadis	Shorabak Dar Band Safid	343	1	2	2	2	2	2
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Qadis	Shotor Morda	328	1	2	2	2	2	2
Qadis	Sultan Ha	354	2	2	2	2	1	2
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Qadis	Tafta Buzpai	160	1	2	2	2	2	2
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Qadis	Takak	944	1	2	2	2	2	2
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Qadis	Takshak	431	1	2	2	2	2	2
Qadis	Tal Gulzar	1153	1	2	2	2	2	2
Qadis	Taraki Sufla	465	2	2	2	2	2	2
Qadis	Tealak	323	2	2	2	2	2	2
Qadis	Telak	0	2	2	2	2	2	2
Qadis	Zad Murad	763	1	2	2	2	2	2
Qadis	Zad Sallay	823	2	2	2	2	2	2
Qadis	Zakak Huleya	103	1	2	2	2	2	2
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Qadis	Zan Talaqak Ya Shewa Dan	697	1	2	2	2	2	2
Qadis	Zard Aloga Kboya Masjed Moulawy Abdul.rahman	829	2	2	2	2	2	2
Qadis	Zard Alugak Boya	630	2	2	2	2	2	2
Qala-e-Naw	Ab Garma	1451	2	2	2	2	2	2
Qala-e-Naw	Ab Garmak Ferestan	840	2	2	2	2	2	2
Qala-e-Naw	Arbab Akbar	0	2	2	2	2	2	2
Qala-e-Naw	Baghak (1)	0	2	2	2	2	2	2
Qala-e-Naw	Baghak (2)	0	2	2	2	2	2	2
Qala-e-Naw	Baghak Garzowani	356	2	2	2	2	1	2
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Qala-e-Naw	Chashma Gulak Barat	244	2	2	2	2	1	2
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Qala-e-Naw	Gharghaitu (1)	0	2	2	2	2	2	2
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Qala-e-Naw	Halka Baghak	969	2	2	2	2	2	2
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Qala-e-Naw	Khoja Qala Warja	164	1	2	2	2	2	2
Qala-e-Naw	Khoja Tawakol Abgarma	467	2	2	2	2	2	2
Qala-e-Naw	Khushmargh	0	2	2	2	2	2	2
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Qala-e-Naw	Mahsomi	184	1	2	2	2	2	2
Qala-e-Naw	Malalje Laman	723	2	2	2	2	2	2
Qala-e-Naw	Malmang Pesta	540	1	2	2	2	2	2
Qala-e-Naw	Malmanje Hamam Dara	1061	1	2	2	2	2	2
Qala-e-Naw	Masni	896	1	2	2	2	2	2
Qala-e-Naw	Mir Mirak	276	2	2	2	2	2	2
Qala-e-Naw	Momen Zai Khalifa Lacha	694	1	2	2	2	2	2
Qala-e-Naw	Najak	280	1	2	2	2	2	2
Qala-e-Naw	Najak Dema	1460	1	2	2	2	2	2
Qala-e-Naw	Nedami	668	2	2	2	2	2	2
Qala-e-Naw	Pogani	543	2	2	2	2	2	2
Qala-e-Naw	Qala Khodai Maidan Zai	107	1	2	2	2	2	2
Qala-e-Naw	Qala Qaiz	576	2	2	2	2	2	2
Qala-e-Naw	Qala-e-naw	9000	2	2	2	1	1	2
Qala-e-Naw	Qala-i-khudai	0	2	2	2	2	2	2

Qala-e-Naw	Qarghach	493	2	2	2	2	2	2
Qala-e-Naw	Qarghach Chagha	395	2	2	2	2	2	2
Qala-e-Naw	Qargheto	269	2	2	2	2	2	2
Qala-e-Naw	Sadka Anjerak	2437	2	2	2	2	2	2
Qala-e-Naw	Safid Atak	372	1	2	2	2	2	2
Qala-e-Naw	Sang Aw Band	129	2	2	2	2	2	2
Qala-e-Naw	Sangaw Bandi	0	2	2	2	2	2	2
Qala-e-Naw	Sar Chashma Qargheto	543	2	2	2	2	1	2
Qala-e-Naw	Sarchashma Baghak	1227	2	2	2	2	1	2
Qala-e-Naw	Shamal Darya	878	2	2	2	2	2	2
Qala-e-Naw	Sinjitak	0	2	2	2	2	2	2
Qala-e-Naw	Sorkh Abe Qargheto	267	2	2	2	2	2	2
Qala-e-Naw	Sorkh Qoul	325	1	2	2	2	2	2
Qala-e-Naw	Tagab Baghban Ha Ismail	591	2	2	2	2	2	2
Qala-e-Naw	Tagab Ismail Hamla	530	2	2	2	2	2	2
Qala-e-Naw	Tagab Ismail Jenab Ha	750	2	2	2	2	2	2
Qala-e-Naw	Tagab Ismail Mulayan	606	2	2	2	2	1	2
Qala-e-Naw	Tagab Khosh Morgh	1164	2	2	2	2	2	2
Qala-e-Naw	Tai Mani	148	1	2	2	2	1	1
Qala-e-Naw	Taimani Laman	706	1	2	2	2	2	2
Qala-e-Naw	Tata	406	1	2	2	2	2	2
Qala-e-Naw	Tootak	980	2	2	2	2	2	2
Qala-e-Naw	Zaft	0	2	2	2	2	2	2
Qala-e-Naw	Zaowsoni	299	1	2	2	2	2	2
Qala-e-Naw	Zat Qani	921	1	2	2	2	2	2
Qala-e-Naw	Zat Shahi	373	1	2	2	2	2	2
Qala-e-Naw	Zaw Agha	532	1	2	2	2	2	2

Annex B – Photograph of map with CHCs, BHCs, subcentres and selected villages marked by assessment team



Annex C - Questionnaire for cases in the programme (English version)

SAM CASES IN THE PROGRAMME / COVERED SAM CASES

Date: _____ Name of Child: _____ MUAC: _____

District : _____ Age: _____ Oedema? (+, ++, +++): _____

Village : _____ Sex: _____

Enumerator/Supervisor name: _____

1 How did you first know that your child was malnourished?

2 Did you try to treat your child before visiting the OTP programme?

☐ No

☐ Yes, How?

3 How did you hear about the programme?

4 Which factors encouraged you to enrol your child in OTP programme?

5a Is this the first time your child has been admitted them into OTP/TSFP programme?

☐ If Yes (**go to 6**)

☐ No, how many times has your child been admitted before? _____

5b Why has s/he returned to the programme?

☐ A. The child discontinued treatment and then returned. Why discontinued? _____

☐ B. The child was cured and relapsed. Why was he relapsed? _____

5 Do you have other children admitted in the programme?

☐ Yes, how many children? (Sick)-----

☐ No

Annex D - Questionnaire for cases not in the programme (English version)

SAM CASES NOT IN THE PROGRAMME / NON-COVERED SAM CASES

Date: _____ **Name of Child:** _____ **MUAC:** _____

District : _____ **Age:** _____ **Oedema? (+, ++, +++):** _____

Village : _____ **Sex:** _____

Enumerator/Supervisor name: _____

1a Do you know that your child is malnourished?

☐ Yes ☐ No

2a Do you think that your child is sick

☐ No (**go to 3**) ☐ Yes, do you know what illness? _____

2b What are the symptoms your child is suffering from?

- | | | |
|---|--|---|
| ☐ i. Vomiting | ☐ ii. Fever | ☐ iii. Diarrhea |
| ☐ iv. Weight loss | ☐ v. Loss of appetite | ☐ vi. Apathy |
| ☐ vii. Swelling | ☐ viii. Hair loss | ☐ ix. Skin lesions |
| ☐ x. Other, specify: _____ | | |

2c What treatment have you tried, or what treatment are you going to try to recover the illness?

- | | | |
|--|---|---|
| ☐ i. Medicinal roots / herbs | ☐ ii. Enriched meals | ☐ iii. Fasting |
| ☐ iv. Medicinal products (bought at market) | ☐ v. Medicinal products (bought at pharmacy) | ☐ vi. Prayer |
| ☐ vii. Visit traditional healer | ☐ viii. Visit to health facility | ☐ ix. No treatment |
| ☐ x. PlumpyNut (RUTF) from market | | |
| ☐ xi. Other, specify: _____ | | |

3a Are you able to take your child(ren) to the health facility easily?

☐ No ☐ Yes

3b When was the last time? _____

3c What was that for? _____

3d When you cannot go, what are the main reasons?

- | | |
|--|--|
| ☐ i. Too far; Walking distance _____
How many hours? _____ | ☐ ii. Insecurity |
| ☐ iii. Inaccessibility (seasonal flooding, etc.) | ☐ iv. Lack of transportation |
| ☐ v. Lack of support / mahram | ☐ vi. Lack of finances for the journey cost |
| ☐ vii. Refusal by husband / family | ☐ viii. A family member is sick |

- | | |
|--|---|
| ☐ ix. Caregiver is sick | ☐ x. No one to take care of the other children |
| ☐ xi. Too busy; reason: _____ | ☐ xii. Prefer traditional medicine |
| ☐ xiii. Afraid to stay in the hospital (distance from home, cost) | ☐ xiv. Health Facility is always closed. |
| ☐ xv. Staff in Health Facility are rude and not welcoming | ☐ xvi. Other, specify: _____ |

4a Have you received any information about nutrition, malnutrition?

☐ No ☐ Yes

☐ If Yes which information? _____

From whom you have received this information? _____

4b has your child ever been screened? (MUAC, Weight / Height)

☐ No ☐ Yes, screened: Where? _____ By whom?

_____ When? _____

5 Has your child previously admitted in OTP or SFP or TFU programs?

☐ No (go to 6) ☐ Yes

Why are they no longer in the programme? _____

☐ Defaulter; Why? _____ When? _____

☐ Discharged cured ; ☐ Discharged non-cured ; When? _____

☐ Other reasons : _____

6 Do you know that there is a programme at the health facility to treat malnutrition? Do you know how it works?

☐ No ☐ Yes, how do you know? _____

7 Why have you not taken your child to be treated at the health facility?

- | | |
|---|---|
| ☐ i. Difficulty getting to the health facility (see 3b) | ☐ ii. Do not believe the programme will help |
| ☐ iii. Don't know how to get child admitted to the program. | ☐ iv. Lack of finances for the treatment |
| ☐ v. Ashamed to be admitted in the programme | ☐ vi. Prefer traditional medicine |
| ☐ vii. Afraid to stay in the hospital (distance from home, cost) | ☐ viii. The problem is not serious enough |
| ☐ ix. The child was previously rejected; when? _____ | ☐ x. Lack of RUTF at clinic |
| ☐ xi. Other, specify: _____ | |

Thank the carer and provide with a referral slip.

Any additional comments/observations:

Annex E - Security Study Outline: Badghis

Justification: Certain areas are inaccessible for the SLEAC team (due to insecurity), therefore in an effort to gain an understanding of coverage in these areas, and specifically if and how the insecure nature of these areas affects access to facilities for patients and the functioning of the facilities themselves.

Overall Question: How does insecurity affect access to health care (and in particular SAM treatment)?

Methodology

- Qualitative through structured interviews
- Two sets of informants at two health facilities will be targeted including health facility staff and residents
- 2 health facilities that provide IMAM services shall be visited where surrounding villages are insecure
- 2 Staff members (ideally 1 nurse/midwife and 1 doctor who are engaged with IMAM) and 2-4 patients (men and women, preferably come for nutrition treatment) should be interviewed.

Ethics and considerations

- Security is a sensitive issue and these questions must not be administered if there is any risk is deemed to come to either the interviewees or interviewers.
- Interviewees must give verbal consent before the interview begins.

Key Questions

Mothers / clients

Are you here for the screening or nutrition program?

- Journey:
 - How did you get here today?
 - How long did it take?
 - How much did it cost you?
- What obstacles do you face in getting to the clinic?
- If insecurity affects your use of the health facilities, how? And how do you decide whether to make the journey?
- When you cannot reach health facilities, what alternatives do you use? And do you use your CHW?

Staff

Do you work with the nutrition programs here?

- Have you ever closed the OTP? Why? When? And for how long?
- Does insecurity affect the running of the OTP? How?
- Is RUTF supply ever affected? When? For how long?
- What do the community do when they are not able to visit the facility?
- Are CHW and outreach activities affected by insecurity in the area?

Annex F – Calculation of error ratios for reliability test of classifications

The suggested sample sizes in the SLEAC manual are suggested as such because it is known that with a certain SAM population (denominator) a certain sample sizes gives acceptable estimations. When the sample size is not met, the errors can be determined to see if they are acceptable and for transparency.

When using prevalence rate calculated from survey data after villages removed due to security review, the errors are still outside acceptable limits:

Table: Calculation of 10% error ratios by sampling zone using survey data

	N (using prevalence 1.53%)	old n	new n	actual n	SQRT new	SQRT actual	Ratio SQRT	10% Error
Zone One	743	32	31	25	5.54243832	5	1.10849	11.0849
Zone Two	364	33	30	80	5.50763554	8.94427191	0.61577	6.1577

In this case, as expected the 10% error is high for Zone Two and not within normal acceptable limits.

Annex G – Logical analysis for derivation of primary barriers from non-covered questionnaires

The following diagram represents the hierarchy of barriers that prevent children from reaching admission to the SAM treatment program. This logic allows allocation of a single barrier to each case and is based on the flow of standard form non-covered questionnaires for coverage assessments.

