

Protecting and improving healthcare: Community insight from Afghanistan

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Awaaz Afghanistan



World Health
Organization

Executive summary

Afghanistan's healthcare infrastructure has relied on international aid for decades. Despite progress during the US presence, the strain of Covid-19 and widespread uncertainty following the government transition in August 2021 has left the healthcare system in a precarious situation. Urban and rural communities feel uninformed about available health services. The lack of qualified medical professionals, including female health workers, contributes to people's feeling of insecurity. Ground Truth Solutions partnered with the World Health Organization (WHO) and the Awaaz humanitarian helpline to understand people's perceptions of healthcare services, including how they view things since the recent regime change. This report combines data collected between November 2021 and May 2022 from a country-wide phone survey; focus group discussions with men, women, and community leaders in Kunduz, Kandahar, Nangarhar, and Helmand provinces; and in-depth interviews with frontline health workers and health providers.

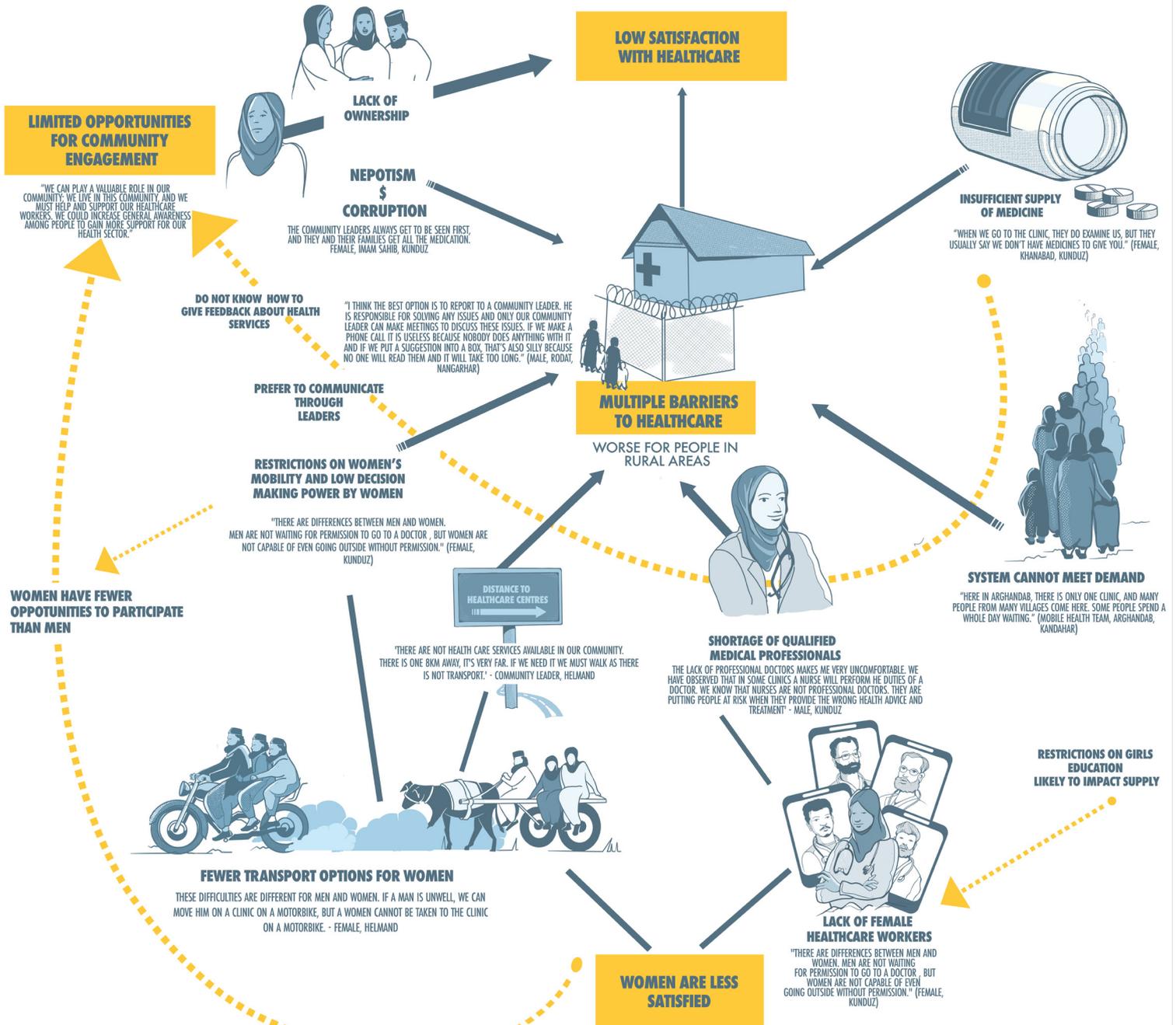
Satisfaction with and access to health services is distressingly low – and everything is worse for women and people in rural areas. Barriers to access include distance to health facilities; insufficient supplies, including basic medicines; and high out-of-pocket costs. New restrictions on women's mobility and uncertainty over what is allowed under the current government further complicate access for women. People feel strongly that access to health is unequal; however, they do not know how to give feedback about health services.

Although satisfaction with health services is low, affected communities and frontline health workers see potential to address shortcomings through community engagement. Through consultations with community members and health workers, we gathered recommendations for how communities and health workers can collaborate to reduce barriers to access and improve overall health outcomes. Humanitarians and health service providers have discussed these recommendations to ensure that support to Afghanistan's struggling healthcare system incorporates people's perceptions and priorities.

For more information, please contact Rieke Vingerling (rieke@groundtruthsolutions.org).

Key Findings

People tell us that that are unhappy with available healthcare. Healthcare fails to cover basic needs, and health services are difficult to access. The situation is worse for women and people living in rural areas.



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Background

As Afghanistan's humanitarian crisis worsens, its crumbling health system now depends almost entirely on underfunded international aid. The United Nations launched its largest ever aid appeal for one country in 2022 – 4.4 billion dollars – to meet overwhelming need as food insecurity reached a daunting scale¹.

Non-governmental and United Nations agencies provide almost 90% of all primary health services², and public health services have been hard hit by the funding freezes that followed the Taliban takeover in August 2021³. Less than one-fifth of public health facilities were fully operational in September 2021⁴. Despite improved health indicators over the last 20 years, millions of Afghans are now without access to quality health services.

This sombre picture is even worse for women. Socio-cultural norms dictate women's day-to-day lives, especially in rural areas. Women often do not have the ability to make decisions about their personal health and cannot access care unless a male accompanies them, and a female health worker is available. Only 20% of the health workforce is female, and female health workers are unevenly distributed between urban and rural areas, so rural women are double-marginalised and largely excluded from medical services.

The 2022 Humanitarian Response Plan (HRP) targets 14.7 million Afghans for health assistance. The health cluster's first objective is "to improve information and access to humanitarian lifesaving and life-sustaining equitable health services at all levels of care to people in need and most vulnerable." The HRP commits "to ensure that collective mechanisms are in place to allow affected people to provide input about their own priorities and concerns around humanitarian action, and that these priorities and concerns are considered and addressed in a meaningful way."

To ensure the priorities of affected populations are considered when providing health services, Ground Truth Solutions collaborated with the World Health Organisation (WHO) and the Awaaz humanitarian helpline to seek people's perceptions of healthcare services and whether they had changed over time with the country's new leadership. We conducted a phone survey with a random sample of 1,000 people.

We learned more about barriers to and satisfaction with health services and gathered community recommendations for improvement through 25 focus group discussions (FGDs) with male and female community members and community leaders in Kunduz, Kandahar, Nangarhar, and Helmand provinces, conducted in collaboration with Salma Consulting.

Context

The health system in Afghanistan

Afghanistan's health system comprises primary, secondary, and tertiary care services. Most primary healthcare services fall under the Basic Package of Health Services (BPHS) and secondary services under the Essential Package of Hospital Services (EPHS). The BPHS and EPHS focus on rural areas.

Health services under the BPHS and EPHS are provided by over 30 organisations including UN agencies, international NGOs, and national NGOs. In addition, there are 350 mobile health teams in 32 of 34 provinces. The Ministry of Public Health (MoPH) organises all tertiary health services.

Donor contributions account for approximately 20% of total spending on health. The World Bank, the European Commission, and USAID provide most of these funds. Direct out-of-pocket spending by households comprise 75%; other sources such as government funds make up the remaining 5%. The Afghan Reconstruction Trust Fund (ARTF) of the World Bank manages donor support.

Since the Taliban takeover, the World Bank has frozen ARTF funds, and health services are increasingly funded as humanitarian assistance instead of development aid, to bypass the de facto government.

The Sehatmandi programme organises payment for BPHS and EPHS services providers, who are paid based on performance. There is a competitive recruitment process, in which potential NGO service providers bid for how many services they can provide for a lump sum. The lowest bidder gets to provide the service, which might explain why health service budgets have shortages, are causing an increase in out-of-pocket payments, are of poor quality, and are in more easily accessible locations, excluding people in hard-to-reach rural areas.

Sources:

MoPH, Afghanistan. June 2019. "[Afghanistan National Health Accounts with Disease Accounts](#)"; Dastan, I., Abbasi, A., Arfa, C. et al. July 2021. "[Measurement and determinants of financial protection in health in Afghanistan](#)"; MoPH, Afghanistan. 2020. "[Health Financing Progress Assessment 2020](#)"; WHO. March 2022. "[Health cluster partners operational presence Afghanistan](#)"; Voa News. March 2022. "[World Bank Board OKs Using \\$1 Billion in Frozen Afghan Funds for Aid](#)".

¹ IFRC. April 2021. "[Climate Change Impacts on Health and Livelihoods: Afghanistan Assessment](#)".

² MoPH, Afghanistan. June 2019. "[Afghanistan National Health Accounts with Disease Accounts](#)".

³ BBC News. August 2021. "[Afghanistan: World Bank halts aid after Taliban takeover](#)".

⁴ WHO. September 2021. "[Acute health needs in Afghanistan must be urgently addressed and health gains protected](#)".

We focused on the views of women in rural areas, who were underrepresented in our phone survey, and complemented the FGDs with 15 key informant interviews with a range of frontline health workers, including community health workers, midwives, vaccinators, mobile health team members, the head of a BHPS clinic, and a Ministry of Public Health official. In line with the new funding structures, we aim to highlight which areas of the health system should be targeted for humanitarian funding and additional support.

We validated the findings of the phone survey and community-based consultations through bilateral discussions with health and aid providers and a workshop with health cluster members.

Sample

Quantitative survey

1,002 phone interviews

Gender

-  Women: 343 (34%)
-  Men: 658 (66%)
- Unspecified: 1 (0%)

UN region

-  Northeast: 154 (15%)
-  Central: 225 (22%)
-  East: 108 (11%)
-  Southeast: 63 (6%)
-  Southwest: 105 (11%)
-  West: 197 (20%)
-  Northwest: 150 (15%)

Age

-  18–21 years: 203 (20%)
-  22–30 years: 503 (50%)
-  31–40 years: 219 (22%)
-  41–80 years: 77 (8%)

Received aid in the last nine months

-  Yes: 234 (23%)
-  No: 767 (77%)

Qualitative discussions

25 gender segregated focus group discussions and 16 key informant interviews with 165 people

-  Community members
-  Community leaders
-  Frontline health workers

Province

-  Kunduz
-  Kandahar
-  Nangarhar
-  Helmand

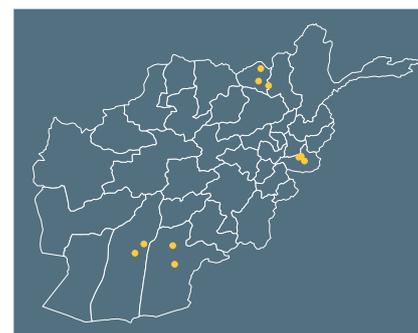
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4 gender segregated community consultations to validate findings with 49 people

-  Community members
-  Community leaders
-  Frontline health workers

Province

-  Kunduz
-  Nangarhar



Districts covered by our qualitative interviews (Kunduz, Kandahar, Nangarhar, Helmand) and community consultations (Kunduz and Nangarhar)

Key findings

Afghans are unhappy with available healthcare. Overall satisfaction is low, healthcare fails to cover basic needs, and health services are difficult to access. Although people generally prefer to seek medical advice from qualified health workers, people we talked to – especially women and people in rural areas – have difficulty reaching health services. Information gaps, access constraints, and quality issues mean people feel they cannot rely on the formal healthcare system, and they seek alternative support.

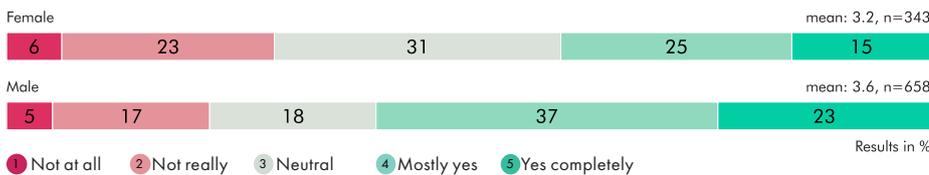
People seek alternative support due to the lack of qualified medical professionals

In qualitative discussions people say they prefer to seek healthcare and information from qualified health workers⁶, who they perceive as having the education and experience to address common and complex health concerns. This finding is in line with other studies on health-seeking behaviour in Afghanistan⁷. Despite a preference for qualified medical professionals within the formal medical system, only half of survey respondents trust health workers to provide them with the best possible care.

This may indicate that although people prefer qualified medical professionals, they are not always confident that the health workers have received proper training. Focus group participants from rural areas in all four provinces covered by the qualitative interviews believe there is a lack of skilled health workers in rural communities, a view shared by frontline health workers.



Do you trust health workers to provide you with the best possible care?



The lack of professional doctors makes me very uncomfortable. We have observed that in some clinics nurses perform the duties of a doctor. We know that nurses are not professional doctors. They are putting people at risk when they provide the wrong health advice and treatment.

(Male, Kunduz)



A barrier for people in communities is that many health workers have low capacity. For example, a nurse is often working instead of a doctor. They just don't have enough experience.

(Mobile health team, Kandahar)



We all know that many health professionals, especially doctors in Kunduz province, have fake documents. Most are not doctors, or they started medical school and never finished. Some are nurses who never graduated from nursing school and now work in hospitals. They pay money to get these certificates.

(Mobile health team, Kunduz)



In my view, many doctors don't have much knowledge. They may be inexperienced, or they have not completed medical studies. People in rural communities have become doctors by chance and do not know which medicines they should provide for which problem.

(Midwife, Kunduz)

⁶ We define health workers as people working in any type of formal healthcare setting, such as health posts, health centres, and hospitals. Health workers include midwives, nurses, community health workers, and doctors.

⁷ Harsch et al. March 2021. "[Health Literacy and Health Behavior Among Women in Ghazni, Afghanistan](#)".

When qualified medical professionals are unavailable or inaccessible, people seek advice and care from alternative sources, including people who work in pharmacies, traditional healers, and other trusted people within their networks.

Pharmacies are close to communities, have medical supplies, and do not charge service fees, but their staff are not trained to diagnose and treat most medical conditions⁸. Especially in rural areas, pharmacy staff often lack formal pharmacy training.

Traditional healers are affordable, embedded in communities, and important sources of information and care for those who cannot access formal health services. Community members say they sometimes obtain a second opinion from a healer when they are unsure about a health worker's diagnosis or treatment.

Personal networks include older family members, who people perceive as knowledgeable, and are often people's first line of care. People we spoke to – especially women – trust advice from family and neighbours when navigating healthcare. The first step is to seek the opinion of a household member, after which people decide which health solutions are most appropriate.



We take advice from pharmacies because the doctor charges fees to give us advice, which we cannot afford. They [pharmacy staff] give us advice and medicine and the advice is free. We tell them about our symptoms and they give us medicines accordingly."

(Female, Nangarhar)

⁸ Asghar et al. June 2020. "[Factors associated with inappropriate dispensing of antibiotics among non-pharmacist pharmacy workers](#)".

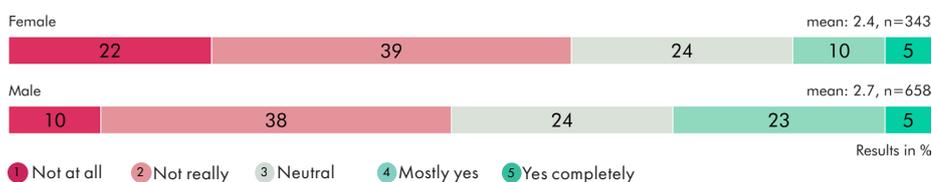
Multiple barriers to healthcare for rural communities and women

People do not know about available services

Only 15% of women and 28% of men feel informed about available health services. People cannot access care if they do not know it exists. Participants in qualitative discussions say their primary source of health information is family members, friends, and community leaders. There is no mention of health facilities or NGOs providing information on where to find different types of health services. Information on health services is correctly included as the first cluster objective in the HRP. Our findings suggest this should be urgently addressed⁹.



Do you feel informed about what health services are available to you?



Most people are poor, and they are not capable of accessing needed health care services.

(Male community leader, Kunduz).

Prohibitive costs

Getting healthcare is expensive, and most people cannot afford it. People often sell assets or household items or borrow money from neighbours or family members¹⁰ to cover health costs. In theory, primary and secondary health services, and medicine that falls under the BPHS and EPHS, are free. But funding is inadequate. As a result, patients must contribute out-of-pocket payments for medication, transportation, examinations, and visits^{11,12}.

As 97% of the population is projected to face poverty in 2022¹³, the cost of healthcare has catastrophic potential¹⁴. Along with people living in remote areas, survey respondents identified low-income households as those most likely lack access to health care. The recent Afghanistan Multi-sector Needs Assessment¹⁵ and the Humanitarian Situation Monitoring by REACH¹⁶ also found the lack of financial means to be the most significant barrier to health care.

⁹ OCHA. January 2022. "[Humanitarian Response Plan Afghanistan](#)".

¹⁰ Dastan, I., Abbasi, A., Arfa, C. et al. July 2021. "[Measurement and determinants of financial protection in health in Afghanistan](#)". BMC Health Serv Res 21, 650.

¹¹ UNHCR Afghanistan. January 2022. "[Multi Sectorial Rapid Assessment Analysis](#)".

¹² Frost, A., Wilkinson, M., Boyle, P. et al. November 2016. "[An assessment of the barriers to accessing the Basic Package of Health Services \(BPHS\) in Afghanistan: was the BPHS a success?](#)". Global Health 12, 71.

¹³ IRC. February 2022. "[Six months on from change in power, IRC warns starvation could kill more Afghans than last twenty years of war as 97 per cent of population faces poverty](#)".

¹⁴ Dastan, I., Abbasi, A., Arfa, C. et al. July 2021. "[Measurement and determinants of financial protection in health in Afghanistan](#)". BMC Health Serv Res 21, 650.

¹⁵ Save the Children. January 2022. "[Afghanistan Multi-sectoral Needs Assessment](#)".

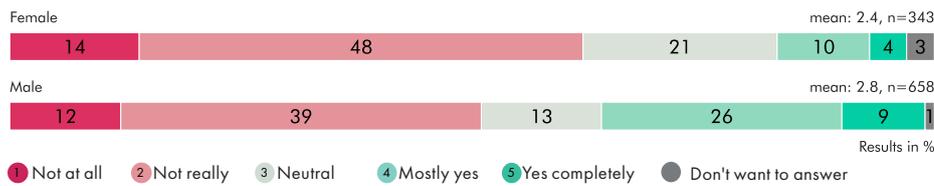
¹⁶ REACH. March 2022. "[Evolving needs – key trends. Humanitarian Situation Monitoring](#)".

Rural Afghans left out

Almost everyone in Afghanistan is in need, but survey respondents do not think all groups of society have the same access to care. People in remote areas, from low-income households, and those unconnected with the de-facto government are most often mentioned as left behind (see side bar). This is in line with findings from Médecins Sans Frontières, who also found that rural communities are left behind¹⁷. Although the BPHS design focuses on rural areas, our findings indicate that rural communities remain under-served.



Do you think that all groups of society have equal access to health services?



Bad roads, a lack of transportation, and a lack of health facilities make healthcare inaccessible to rural communities. Mobile health teams partly address these needs, but there are not enough teams to meet the demand¹⁸.

Rural communities in Nangarhar, Helmand, and Kunduz confirm the lack of health services available to them.

Restrictions on mobility complicate women's health access

We discussed gender-specific barriers to care with women in focus group discussions. Female mobility is extremely limited, particularly in very conservative communities – including the four provinces where we conducted qualitative interviews: Kunduz, Kandahar, Nangarhar, and Helmand. Under the current government, women need a Mahram, a male member of the household to accompany them when travelling beyond the home and/or immediate community. According to the Taliban, this requirement keeps women safe and upholds their dignity¹⁹. Households are also restricting females leaving homes unaccompanied for work and school because of insecurity or fear of the de facto authorities, according to a recent survey of female humanitarians and civil society leaders conducted by the Gender in Humanitarian Action (GiHA) working group²⁰.



What groups lack access to healthcare? (n=573)

- 69% People living in remote areas
- 23% People from low-income households
- 11% People who have no connections to the de facto government

Only top 3 included. The percentages do not add up to 100% because respondents could choose multiple answer options



Here in Arghandab, there is only one clinic, and many people from many villages come here. Some people spend a whole day waiting.

(Mobile health team, Kandahar)



There are no healthcare services available in our community. There is one clinic 8km away: it's very far. If we need it, we must walk as there is no transport.

(Male community leader, Helmand)



The roads are broken; you can't put a car on them. The clinic is so far, so how do we get there? That is what stops us from accessing healthcare. The government hasn't thought about us.

(Male, Helmand)

¹⁷ MSF. June 2021. "Continued struggle to access care in Afghanistan".

¹⁸ WHO. 2018. "Addressing health workforce shortages and maldistribution in Afghanistan".

¹⁹ Afghanistan Analyst Network. July 2021. "Rural Women's Access to Health: Poverty, insecurity and traditions are the main obstacles".

²⁰ Gender in Humanitarian Action Working Group. March 2022. "Periodic Rapid Perception Survey on the Shift in Social Practices and Access to Services for Women and Girls in Afghanistan".

At health facilities, women's access to care depends on the availability of female health workers, who are in short supply: only around 20% of Afghanistan's doctors and nurses are women, and this proportion is probably much lower in rural areas. It is also likely that this will worsen under the current regime²¹. Since all education beyond age 12 is now prohibited, no new female health workers are being trained²².

Our conversations revealed that neither all women, nor many men, perceive these social norms as problematic. Some suggested it is the responsibility of health service providers to accommodate local social practices and bring female health workers to people's homes. People in Helmand and Kunduz expressed a desire for more female health workers to be posted to rural areas.

An ongoing bottleneck is families' discomfort with female members continuing education and work in healthcare²³. Health interventions need to consider how to accommodate social norms to improve access to essential health services for women and other vulnerable groups, while simultaneously encouraging both the de facto government and communities to reflect on how certain norms may prevent communities from achieving commonly desired outcomes, including women's access to female healthcare workers and improved health and safety for women²⁴.

Health facilities cannot cope with demand

Even when people can afford treatment, a known lack of critical medication, understaffing, and long waiting times deter many from seeking necessary help. At rural facilities, waiting times of 4–5 hours or even full days are common, increasing the likelihood that families seek care elsewhere, such as with traditional healers. Frontline health workers acknowledge crowding and long waiting times at facilities.

They mention that because of closures and understaffing, some facilities serve three times the number of people they should for their catchment areas. Population censuses are not performed regularly enough to inform these catchment area statistics²⁵.



These difficulties are different for men and women because if a man is unwell, we can move him to the clinic on a motorbike, but a woman cannot be taken to the clinic on a motorbike.

(Female, Helmand)



Men do not wait for permission to go to a doctor, but women may not even go outside without permission.

(Female, Kunduz)



For me, the main barrier is my husband and male family members.

(Female, Kandahar)

²¹ BMJ Opinion. September 2021. "[Staring into the darkness: women health workers in Afghanistan](#)".

²² The Times. March 2022. "[Taliban ban Afghan girls from attending high school](#)".

²³ Human Rights Watch. October 2017. "[I Won't be A Doctor, And One Day You'll Be Sick](#)".

²⁴ There is significant research that links the education of reduced child and maternal deaths, improved child health and lower fertility (source: Karlsen, S., Say, L., Souza, J.P. et al. July 2011. "[The relationship between maternal education and mortality among women giving birth in health care institutions: Analysis of the cross sectional WHO Global Survey on Maternal and Perinatal Health](#)". BMC Public Health 11, 606.

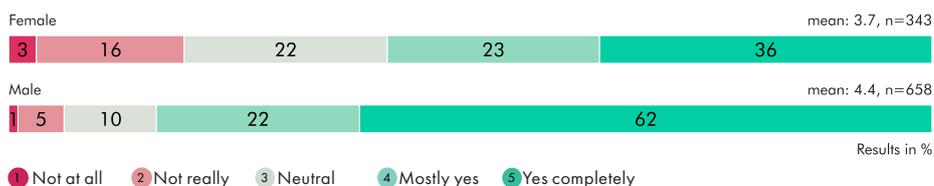
²⁵ MoPH, Afghanistan. November 2020. "[BPHS Costing final Report](#)".

Most people say safety concerns not an obstacle to healthcare

People feel safe travelling to and at health facilities, especially in rural areas. Since the leadership change, there has been less fighting and road safety has improved²⁶.



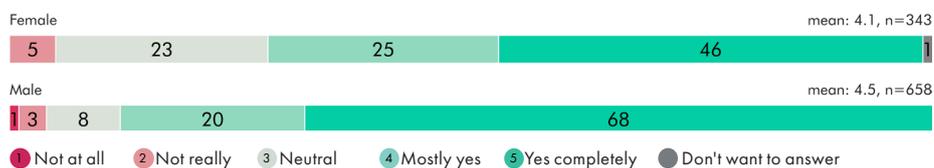
Do you feel safe when travelling to a health facility?



The 12% of people who do not feel safe travelling to health facilities say they have no one to accompany them, fear roadblocks, or are afraid of travelling after curfews²⁷. This finding, however, must be contextualised with reports that the new government is increasingly restricting women's mobility, which may prevent them even attempting a journey to a health facility. During qualitative discussions, men and women shared concerns regarding accessing health services at night, due to insecurity and a lack of transport.



Do you feel safe when you are at a health facility?



The 5% of people who do not feel safe at health facilities most commonly cited a fear of attacks on health centres, or a military presence. This percentage is lower than expected, since Afghanistan has a dark history of attacks on healthcare, such as the attack on Kabul's Dasht-e-Barchi in 2020²⁸. A few people noted concerns about the presence of landmines from previous conflicts. Respondents in all four provinces feel the risk of further violent attacks on healthcare centres is low.

The improved security environment may present new opportunities for humanitarians to reach areas that were inaccessible before and to increase meaningful engagement between humanitarians and communities. Organisations are carefully considering what is possible under the new government.

²⁶ Anadolu Agency. February 2022. "[Afghanistan sees improvement in security situation: UN](#)".

²⁷ Both previous government and the de facto government have imposed night-time curfews in most provinces in Afghanistan (source: Crisis 24. August 2021. [Afghanistan: Taliban reportedly enforcing curfew in Kabul as of Aug. 20](#)).

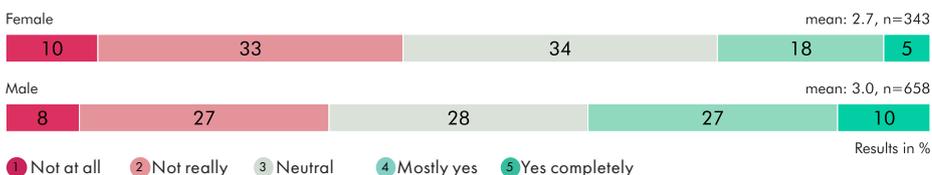
²⁸ MSF. May 2021. "[One year after the attack on Dasht-e-Barchi, Afghanistan](#)".

Satisfaction with services is lower for women

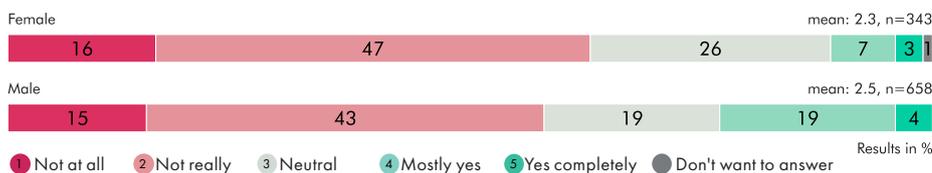
Patient satisfaction is one indicator used by the WHO to assess the quality of healthcare²⁹. In our survey, only 30% of respondents said they are satisfied with available health services, with women less satisfied than men. To identify the indicators most strongly related to satisfaction with health services, we adopted the FAIRSERV model (see side bar) and used statistical modelling to determine which indicators had the strongest association with healthcare satisfaction³⁰. Feeling respected by health workers and that health services cover basic needs are most strongly associated with general satisfaction, which explains the low satisfaction score: only 17% of those we spoke to feel that health services meet their basic needs, and just over half feel respected by health providers, with women feeling far less respected than men.



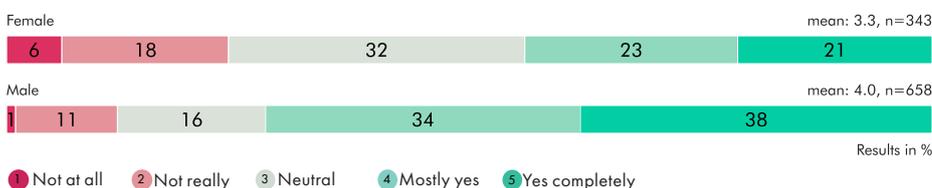
How satisfied are you with available health services?



Are you able to cover your basic health needs with the health services available to you?



Do health workers treat you with respect?



The FAIRSERV model

This FAIRSERV model asserts that the quality of a service and how fair its users perceive it determine user satisfaction. It also provides direction in what areas humanitarian actors and health providers should invest to improve services most efficiently.



Rude doctors and midwives make us feel sad and very uncomfortable.

(Female, Kandahar)

Source: Carr, C. 2007. "The FAIRSERV Model: Consumer Reactions to Services Based on a Multidimensional Evaluation of Service Fairness".

²⁹ WHO. 2018. "Delivering quality health services: a global imperative for universal health coverage".

³⁰ Structural Equation Modelling

Qualitative discussions showed, unsurprisingly, that “meeting needs” means services are nearby, free, and adequately stocked with (free) medication.

The lack of free medication is a source of frustration for people we talked to. Public health posts and clinics under the BHPS should have a supply of medicine in proportion to the population of their catchment area³¹, but communities say the quantity and variety is insufficient. They report that they receive half doses and are told to purchase medication at local pharmacies at their own expense or go without a prescription. Health workers share these concerns, but say they are powerless to influence change.

The purchase of medicines depends on donors, and donors differ in each province. How medication is purchased is therefore fragmented, because of different donor preferences and requirements³².

There is a strong sense in communities that access to healthcare is not equal. Across the four provinces, respondents highlighted nepotism as a serious problem, saying people who know health workers or powerful people like community leaders get preferential treatment. Not only are these people seen before all others, but they are perceived to get better treatment, such as full doses of medication. These views were shared by health workers in clinics as well as health workers from mobile teams. Frontline health workers confirmed that sometimes they were forced to prioritise local community leaders over everyone else, to ensure safe access and necessary permission to work in communities.



We are humans, and it is our right to have access to healthcare.

(Female, Kandahar)



When we go to the clinic, they do examine us, but they usually say we don't have medicines to give you.

(Female, Kunduz)



If I go to the clinic and face people who behave well, prescribe me medicine, and give me the drugs, I am happy. If they behave badly and tell me there is no medicine, this makes me uncomfortable.

(Female, Kandahar)



There are other barriers as well. If a patient needs ten tablets, they are provided only two, or if they need three items, they are provided only one or two. Some are not offered at all, and they are told to purchase medicines from the market.

(Mobile health team, Kandahar)



We would be given medicines for 50 patients for one day, but we would check 250 patients a day, and we could not reject the 200 patients. ... Therefore, we had no option but to distribute the medicines of 50 patients among 250 patients by giving them little.

(Health worker, Helmand)

³¹ WHO, Islamic Republic of Afghanistan. 2020. "[Health Financing Progress Assessment Report](#)".

³² Salehi, A.S., Saljuqi, A.T.K., Akseer, N. et al. October 2018. "[Factors influencing performance by contracted non-state providers implementing a basic package of health services in Afghanistan](#)".

People also describe incidences of healthcare workers redirecting patients to private clinics or pharmacies, believing this was because the referring health worker would be taking a cut of the payments.

Examples of referrals to private clinics

- A nurse conducting an initial check-up, if additional care is requested, patients are referred to the doctor's private clinic.
- Doctors prescribing a particular medicine or referring patients to a specific pharmacy, so that the doctor gets a share of the profit.
- Doctors informing patients that the clinic does not have the resources required for a thorough treatment and that to be sure their "illness is not more harmful, it would be best to go to the doctor's private clinic."

We asked our survey respondents how their perceptions of healthcare changed around Eid-al-Adha just before the Taliban took over³³. Sixty-seven percent indicate that their ability to cover their basic health needs worsened, which is unsurprising given the freezing of funds by international donors. Men and women in urban and rural areas responded similarly. Information on health services worsened too, with over half of respondents feeling less informed about available health services since Eid.



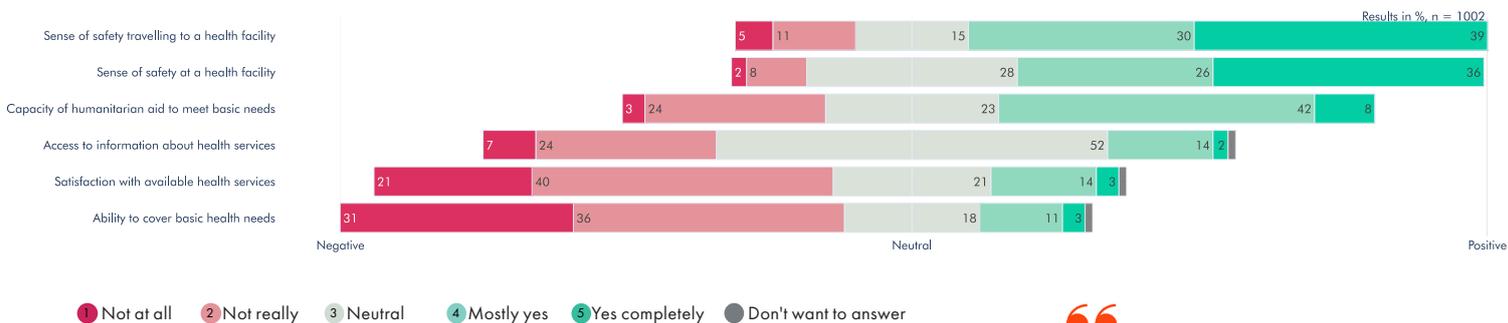
Most people are poor, and they are not capable of accessing needed healthcare services. The other problem is that most of the doctors are doing their own business. The doctors are in touch with drug stores, selling the medicine that the doctor recommends. The doctor makes much money when they give him a portion of the sales.

(Male community leader, Kunduz)



The community leaders always get to be seen first, and they and their families get all the medication. When the health teams come to us, they rush with us because they have no time, and we don't get a lot of help.

(Female, Kunduz)



I am not happy with our local clinic. Whenever I go there, I need to wait from morning until evening because those who know the doctors can visit without waiting for their turn. But we don't have anyone familiar in our local clinic; that's why we need to wait for a whole day until we visit a doctor.

(Female, Kunduz)



When we have someone sick, we take them to the clinic and hospital. In the clinic, there is much corruption. Those who know people get better services and we have to wait for a long time.

(Community leader, Helmand)

³³ We asked respondents to comment on changes around Eid-al-Adha as a proxy for the Taliban takeover in August 2021, which coincided with the regime change but was less sensitive to discuss.

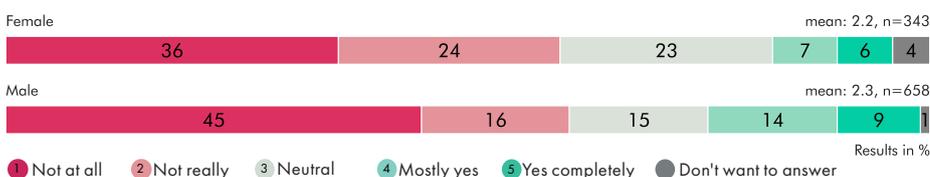
Communities and health workers want more opportunities to participate

Participation in health programming can lead to better health outcomes, a feeling of ownership of services provided, and greater equity in healthcare access. A WHO study on participation in healthcare found that reduced participation led to exclusion, an inability to properly understand community needs, and increased corruption risks³⁴.

Only 19% of people we spoke with (and only 13% of women) feel that community opinions are considered in when, where, and how providers implement health services. Qualitative discussion participants said that local authorities did not include their views when planning new clinics.

In theory, community health councils (Shura-e-Sehie) act as a bridge from communities to the health system. Health shuras are made up of community representatives and provide leadership and advice on health-related community activities (see below). When these do not function, there are often no other opportunities to participate.

Do you feel that the opinion of the community is considered when deciding where, when, and how health services are provided?



Shura-e-Sehie (community health councils)³⁵

In Afghanistan, different community committees exist for different purposes. For healthcare, there are the Shura-e-Sehie, or community health councils, whose members are selected from the community with help from community health workers. Shura-e-Sehie are supposed to provide support to health-related activities in communities, including information provision.

Women-specific health councils exist too, which are called Family Health Action Groups. They mainly promote healthy behaviour among women and their families.

Health councils struggle to have impact because they lack funding, training, and leadership. Through interviews and discussion of findings with partners, we learned that health councils are not functioning well and are not well linked to healthcare providers.

³⁴ WHO. 2019. "Participation as a driver of health equity".

³⁵ CHW Central. October 2017. "The Community-Based Healthcare System of Afghanistan".

In our interviews, many community members and leaders said they feel they can make valuable contributions to health services and are keen to help. Frontline health workers said that community leaders often spread awareness about polio vaccinations and provide permission to mobile health teams to access communities. They also see potential for community volunteers to help manage community expectations, provide health information, and accompany health workers in communities. A pilot study to increase healthcare accountability in Afghanistan demonstrated the willingness of communities with examples of people volunteering to make repairs to improve health services³⁶.

Although communities express interest in supporting health workers, most lack ownership over the type of healthcare provided. Decisions over the provision of staff, locations of clinics, and the rotation of mobile health teams exclude community members.

Most people do not know how to provide feedback

Most people (73%) do not know how to complain or provide feedback about health services. We provided focus group participants with four scenarios (see next page) of healthcare-related situations and asked them how they would provide feedback or make complaints and the men and women we spoke to overwhelmingly prefer to provide feedback through community leaders. They perceive it as a more personable platform that enables communities to engage directly with those who can provide support or rectify the issue at hand, in line with findings of the REACH Whole of Afghanistan Assessment³⁷.



Do you know how to complain or make suggestions about the health services you receive?



³⁶ Edward, A., Osei-Bonsu, K., Branchini, C. et al. July 2015. "[Enhancing governance and health system accountability for people centered healthcare: an exploratory study of community scorecards in Afghanistan](#)".

³⁷ REACH. February 2022. "[Whole of Afghanistan Assessment \(WoAA\): Multi Sectoral Needs Assessment 2022](#)".



Our community is fully committed to supporting our clinic. They want to keep us safe. And we don't need security forces around because we know the community will help us. They help us in many ways, even with social activities. For example, a few days ago, we wanted to plant trees around our clinic for summer, and all community members played an active role. Most people are very ready to help our clinic, which means that they are very satisfied with our care.

(Senior health administrator, Nangarhar)



Volunteers can really help us to resolve challenges in our work. They can provide advice to people about healthcare and vouch for our efforts. They can inform people where to get healthcare. It would help us a lot.

(Midwife, Helmand)



I think volunteers could play a valuable role in increasing general awareness. This will truly bring change to communities. However, people are not very open to working for free. Even those who listen to general awareness expect money for their time. We live in an area where nobody will listen to general messaging for free, let alone volunteer to provide it.

(Mobile health team, Kunduz)



We can introduce malnourished people and children to the clinic for treatment. We can also meet with doctors to specify a day to raise awareness in the community. We can also cooperate with vaccinators and ask people to take their children out of their homes so that every child is vaccinated.

(Male, Helmand)



We can play a valuable role in our community; we live in this community, and we must help and support our healthcare workers. We could increase general awareness among people to gain more support for our health sector.

(Male, Helmand)

Preferred Feedback Mechanisms: Scenarios

To understand preferred community feedback mechanisms, focus groups of men and women were presented with a range of scenarios. People were asked if and how they would provide feedback or make a complaint in each of these situations.

Scenario 1

There is a public clinic in the area, the doctor comes at 11 am and stops seeing patients at 12 so he can go for lunch for two hours. He then normally leaves at 3pm so he can go back to the city and work in his own private clinic.

Scenario 2

The local clinic is the closest medical centre for many kilometres. The next closest medical centre is in the district centre. At the clinic, there are only male doctors and the local government representatives and the NGOs told you to use these doctors.

Scenario 3

A guard at the district hospital is the brother of a local military chief. He gets to decide who goes into the hospital and who does not. Many people cannot get into the clinic, just because he says he does not want to let them in. You tried to bring your children, and you were turned away.

Scenario 4 (only provided to female respondents)

There is an old woman – who has had 10 children herself – in the village and she tells everyone that she knows how to have babies and how to help women give birth. Women normally get her help during pregnancy. A health worker comes to the community and tells you that the woman is not knowledgeable about maternal care and that all women need to go and see a doctor in the clinics.

The most common preference is to report any issues to a community leader and allow them to share the concern with relevant parties, such as local authorities or NGOs. This is in line with socio-cultural practices and patriarchal norms that put community responsibility and decision-making in the hands of religious and community leaders. It is not common for community members – particularly in rural communities – to speak out independently.

Respondents across all four provinces noted that when they raise concerns, they remain largely unresolved. Although community leaders take responsibility for relaying feedback to the relevant authorities, they (community leaders) explained that they have no control over what action is taken in response and are rarely provided feedback on their complaints or recommendations.

To be successful, feedback mechanisms need to have an active response mechanism so that communities know the outcome of their comments and suggestions. In short, NGOs need to focus on “closing the loop” rather than simply collecting feedback. Communities should be informed about how their feedback was understood, whether changes were made, and if changes were not made, why. This builds trust, and over time, communities will become more comfortable providing feedback.

Requests that respondents claim were reported to local authorities and government ministries included:

- More female staff
- Additional security at clinics
- New clinics
- More health workers
- More medication for patients



Yes of course we are available to help, and we would happily do it. We are honest people and want to help others to be healthy and safe. We just don't know what they want us to do?

(Female, Kunduz)



I think conducting community meetings is the most useful because if all the community agree on the same thing, then we can use the leaders as our representatives to go to officials and make requests for changes. We can trust that things will be resolved or that our leaders will try to resolve the issue if they can.

(Male, Khanabad, Kunduz)



I think the best option is to report to a community leader. He is responsible for solving any issues and only our community leader can make meetings to discuss these issues. If we make a phone call it is useless because nobody does anything with it and if we put a suggestion into a box, that's also silly because no one will read them and it will take too long.

(Male, Nangarhar)



I think making a phone call is the most useless method for tracking issues in Afghanistan. No one takes care of phones, and they don't even answer.

(Male, Nangarhar)



The best option is to report to a community leader because as I said, these leaders are responsible for resolving such issues. I think making a phone call would not be very useful because nobody takes it seriously.

(Female, Kunduz)



We can act on all issues, but the main thing is whether our action or our complaint will be fruitful or not. This is not clear. We can meet officials for every issue, but after that it is out of our hands.

(Community leader, Helmand)

The potential for women to participate in the planning and implementation of health services is limited. Qualitative discussion participants, especially community leaders and women most frequently identified managing their personal health and the health of their families as the most appropriate ways for women to contribute to the health and wellbeing of their community.

Although examples of direct interaction of community members with health workers to give feedback and to participate in healthcare planning are scarce, communities seem very motivated to engage with health services.

Communities want to be included and participate in the planning of health services. It is up to the planners and implementers of health services, UN agencies, international and national NGOs, to initiate this. Humanitarians should work with community leaders and vulnerable communities to develop systems of meaningful participation. These efforts should not be limited to community consultations, information provision, and feedback systems, but rather aim for a collaborative approach to healthcare provision. These efforts can promote more collaborative relations between healthcare providers and communities, and thus provide a safer and more conducive environment for quality healthcare.

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To an extent, this is already being done. Health service providers are already working through local health shuras and councils to develop context-appropriate methods to engage communities. An inter-agency accountability to affected populations initiative, led by OCHA, recently conducted a series of workshops with marginalised women in Bamyan, Herat, Jalalabad, and Mazar-e-Sharif to develop women-friendly community-based feedback mechanisms. These efforts should be scaled and continually refined with community feedback.



I think women could play a very important role [in healthcare] because they have to take care of the cleanliness at home, they need to cook healthy food, and they have to inform other ladies in their house about the importance of cleanliness in a house, because it could avoid diseases and it is very much needed.

(Community leader, Kunduz)



I think they could take care of cleanliness within their houses because they are responsible for it but are not capable of playing a role outside, because our current government is against women working outside. They just need to take care of their houses and their cleanliness.

(Community leader, Kunduz)



I think women are not permitted to bring changes outside, but they could take care of the cleanliness inside their houses through which we could prevent disease and health issues.

(Community leader, Kunduz)



Women can play an important role in making sure their children know how to take care of their hygiene. They can also make sure to keep a clean house. Women can advise each other about hygiene too and share advice.

(Community leader, Helmand)



We are women, we cannot do anything, but we can ask male members in our family to gather people and talk with them to address any issues.

(Female, Kandahar)



I don't think women can provide help to keep services safe. This is because we live in a traditional society, and women are not allowed to make such decisions. We don't know these things.

(Female, Kunduz).

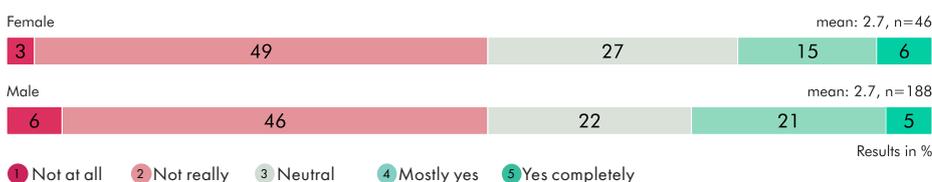
Humanitarian aid: An accountability health check

A secondary objective of this study was to support a culture of accountability to affected populations across Afghanistan’s humanitarian response. Using an automated voice response phone system, we asked people if they had received aid in the last nine months. If they answered yes, they were asked an additional sub-set of questions based on surveys conducted by Ground Truth Solutions from 2017 to 2019, aiming to understand how people affected by crisis and humanitarian field staff perceive the impact of the Grand Bargain commitments. We also included questions that aimed to understand the impact of conflict on access to aid.

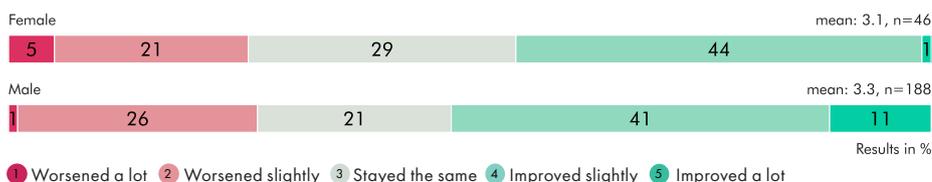
Humanitarian assistance has improved, but remains insufficient

Of the 1,002 people surveyed by phone, 234 (of which 21% were women) had received humanitarian aid in the last nine months. Of these respondents 50% say that the capacity of humanitarian assistance to cover their most important needs has improved since Eid al-Adha, a date that aligns with the government transition. While this change is positive, aid remains insufficient. Fifty-two percent of respondents indicate that available aid is unable to cover their most important needs, compared to 47% of respondents in 2019. Health needs in particular remain unmet, with only 17% of people saying that they can cover their basic health needs. These findings are echoed in the REACH Humanitarian Situation Monitoring (HSM) survey, which suggests that access to humanitarian aid has increased since the Taliban takeover, with food and healthcare cited most frequently as high-priority needs³⁸.

Do you think that the humanitarian assistance you receive covers your most important needs?



Compared to the situation around Eid al-Adha, how has the capacity of humanitarian assistance to cover your most important needs changed?



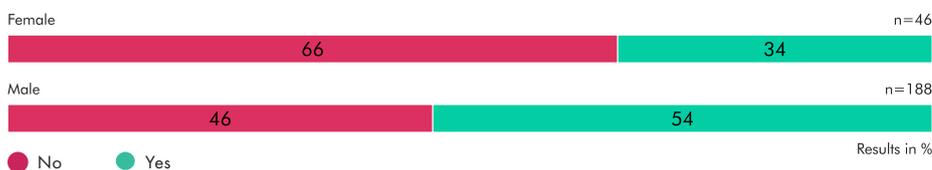
³⁸ REACH. 2022. "Evolving needs - key trends - Aug/Sept 21 - Dec/Jan 22 Humanitarian Situation Monitoring".

Targeting is unclear, especially for women

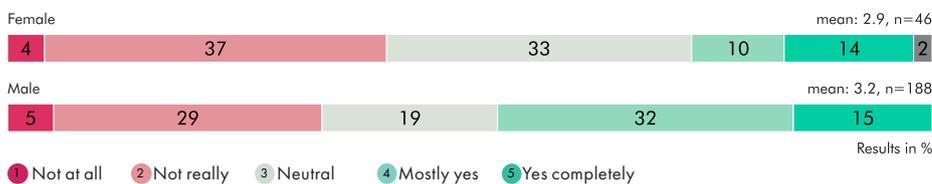
Aid is not provided in a transparent way. Women feel less informed than men about how targeting works, and only 24% of women, compared to 47% of men, think that aid goes to those who need it most. These results align with our 2019 findings. Humanitarians must ensure that efforts to inform communities go beyond the transfer of information and include following up activities to evaluate comprehension.

Information-sharing activities must be conducted at the start of project cycles and incorporate mechanisms that are appropriate for vulnerable groups, such as women.

Do you understand how humanitarian organisations decide who receives aid and who doesn't?



Do you believe that humanitarian assistance goes to those who need it most in your community?

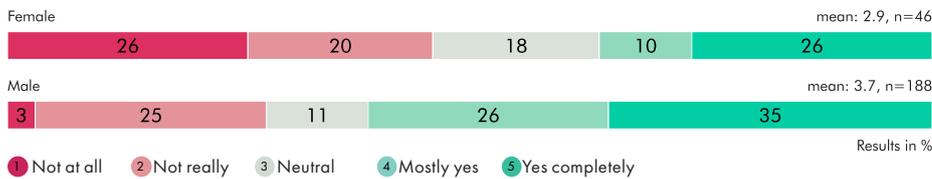


Health-related complaints are under-reported

We asked those who had received humanitarian aid to comment on how comfortable they would be providing complaints about humanitarian assistance more generally. Most men (61%), but only 36% of women, say they would feel comfortable making complaints about the assistance they receive. Women's reluctance to submit complaints and feedback is particularly worrying when considered alongside the high proportion (73%) of respondents that do not know how to submit complaints about health services and the restrictions on women's mobility described by respondents in qualitative discussions. It is important that complaint and feedback mechanisms be customised to reflect socio-cultural practices and norms, including region and community-specific practices. Additional research is needed to better understand if complaint and feedback mechanisms are used differently based on the types of issues being reported. Complaints related to health services have the potential to include highly sensitive and personal information that may require a different approach.



Do you feel comfortable making a complaint about the humanitarian assistance you receive?

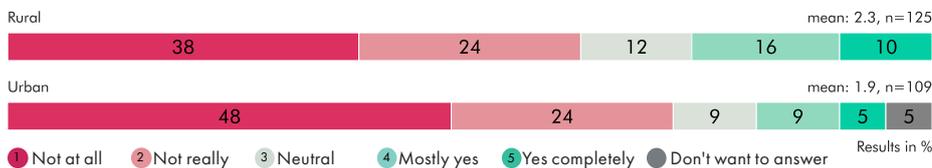


Opportunities for participation are low

People do not feel they can participate in how humanitarian assistance is provided. Both men (68%) and women (60%) do not feel their opinions are considered by aid providers. The situation is worse in urban areas where 72% of people feel their perspective is not considered. Compared to our 2019 study in which only 13% of respondents said their opinion was not considered by aid providers, these findings indicate a profound decline in community engagement. Men and women across urban and rural areas do not feel consulted. Including affected people's opinions in programming is essential to ensuring that aid helps them. As funding is unfrozen and the humanitarian response continues to scale, efforts to engage communities in decision-making must be strengthened.



Do you feel like aid providers take your opinion into account when providing humanitarian assistance?



Recommendations

Fifty-seven humanitarians and health service providers discussed our key findings in a half-day workshop. We held parallel consultations with groups of gender-segregated community leaders, members, and community health workers. The following recommendations combine direct suggestions from these consultations with our analysis of people's feedback.

Accessibility

- Strengthen the referral system between BPHS and EPHS services and improve community awareness of how the system functions.
- Maintain zero-tolerance for nepotism and corruption. Train health workers and ensure community access to complaint mechanisms.
- Invest in mobile health teams and health phonedlines for information on specialised healthcare.
- Mobilise man-woman couples (husband-wife, brother-sister, father-daughter) to become community health workers or community health volunteers.
- Promote girls' education to sustain the supply of female health workers and improve women's access to health services.
- Recruit recent female school graduates for training in healthcare.
- Engage community leaders and men to champion women's access to education and support women to work in the health sector.

Information-sharing

- Make information accessible to people with low literacy through hotlines and illustrations.
- Use pharmacies to share health information. Community priorities include:
 - Seasonal diseases
 - Hygiene practices
 - Nutrition and healthy food practices
 - Alternative/natural treatments if formal health services are unavailable
 - Information about where and what type of health clinics are available
 - Information about how to reach ambulances in emergencies;
 - Locations for healthcare or health support during night hours.
- Train older women on common health problems and where to seek care, as they are the first point of contact for younger women seeking healthcare.
- Train community health workers to effectively communicate with communities and promote key health messages.

Feedback mechanisms

- Prioritise in-person mechanisms, such as help desks.
- Commit to providing timely responses to complaints.
- Involve community leaders when designing community feedback mechanisms. Seek their endorsement of available mechanisms to improve access for women and other vulnerable groups.
- Work with traditionally under-represented groups such as women, elderly people, and persons with disabilities to develop feedback mechanisms catered to their needs.

Participation

- Facilitate mutual support between frontline health workers and community members. Frontline health workers suggested the following examples:
 - Provide shelter for health workers.
 - Accompany and vouch for health teams during community visits.
 - Mobilise households to participate in vaccination campaigns.
 - Promote participation in health information sessions.
 - community members to protect mobile health teams.
- Work with communities to identify how the shura system can support more meaningful community participation.

Funding

- Advocate for an increase in per capita spending on healthcare and for sustainable funding mechanisms for Afghanistan's healthcare system.

Methodology

We used a mixed-method explanatory design incorporating quantitative and qualitative data collection methods.

Quantitative survey

In collaboration with the Awaaz humanitarian helpline and Viamo we conducted phone surveys with people living in Afghanistan.

Design and survey tool

The survey tool was co-designed by Ground Truth Solutions and the WHO, with rounds of input from Awaaz, Viamo, the health cluster, and the Accountability to Affected Populations working group. The survey was designed to incorporate indicators of quality of care, access to care, attacks on healthcare, and complaints and participation. The indicators for quality of care were chosen based on the FAIRSERV model, a model used in consumer satisfaction research to understand what indicators of quality of care contribute most to a feeling of satisfaction with health services.

The survey tool was translated into Dari and Pashto by a translator from Viamo. The translations were reviewed by the enumerators of the Awaaz humanitarian helpline.

The enumerators from Awaaz are experienced in collecting data over the phone. To familiarise them with the work of Ground Truth Solutions, the scope of the project, and collecting perception data, they received training organised by Ground Truth Solutions.

The training included sessions on:

- Collecting perception data
- Mitigating enumerator bias
- Enumerator code of conduct
- Types of questions, including Likert-scale questions
- The survey tool and the translation of the questions into Dari and Pashto

The training was conducted in English. After this training, the survey tool was piloted in 40 interviews. After integrating the feedback from this testing phase, the survey tool was finalised.

Sampling

Our sampling strategy aimed to get a representative sample from the general population living in Afghanistan. The geographic scope was all of Afghanistan. We contacted people using random digit dialling in collaboration with Viamo. We aimed for 1,000 phone surveys, with these demographic targets:

- 50/50 gender split.
- 25/75 urban–rural split.
- 40/60 aid recipient–non aid recipient.

Target vs. actual sample

Gender	Place of residency	Aid recipient	Target sample	Achieved sample
Female	Urban	Yes	50	24
Female	Rural	Yes	150	22
Female	Urban	No	75	139
Female	Rural	No	225	158
Male	Urban	Yes	50	85
Male	Rural	Yes	150	103
Male	Urban	No	75	164
Male	Rural	No	225	307
Total			1000	1002

Data collection

The people who consented were called back to participate in a live phone survey with enumerators from the Awaaz humanitarian helpline. Data collection, including the pilot phase, took place from 27 November 2021 to 14 February 2022. The surveys were conducted in Dari and Pashto.

Weighting

We weighted data based on gender, place of residency (urban/rural), and UN region (see table below).

We calculated population estimates for UN defined regions using [WorldPop](#) data, which allows for population estimates based on satellite images, geolocated covariates, and census data. Instructions for calculation can be found [here](#). Relevant shape files were obtained from [GADM](#).

Qualitative interviews

Design

The qualitative component of the study was undertaken by Salma Consulting with guidance from Ground Truth Solutions and WHO. It focused on capturing more nuanced data from sub-populations including women and rural populations. These sub-groups were particularly hard to reach through phone surveys but remained key sources of information for understanding experiences of healthcare and opportunities for humanitarians to strengthen health services and community participation in the health sector.

The team at Salma used an exploratory cognitive framework to design and review the data from the study. The methods, sample, and tools were designed in consultation with Ground Truth Solutions and WHO. Question guides tailored to the different participant types were developed in English and translated into local languages.

Methods and sampling

We conducted focus group discussions and key informant interviews across four provinces in Afghanistan, in three districts per province. We selected Helmand, Kunduz, and Nangahar provinces based on previous incidences of attacks on healthcare, the regions' strict adherence to socio-cultural norms with the potential to limit women's access to healthcare, and safe access to urban centres and rural districts and to diverse ethnic communities in Kunduz province specifically. Kandahar was not initially included in the scope of this study but was added during data collection due to limitations in interviewing women in Helmand province.

Focus group discussions

Focus group discussions were completed with a series of respondents to capture a more nuanced understanding of social norms and attitudes regarding access and usage of health services.

Breakdown of focus group discussions

Province	Participant type	Total number of FGDs
Nangarhar Province (Jalalabad city, Surkhrod district, Rodat district)	Women	3
	Men	2
	Community Representatives	2
Helmand Province	Women	1
	Men	2
	Community Representatives	1
Kunduz Province	Women	3
	Men	2
	Community Representatives	2
Kandahar Province	Women	3
	Men	2
	Community Representatives	2
Total		25

Key informant interviews

Key informant interviews were conducted with frontline health workers, who operated across districts targeted for focus group discussions. Frontline health workers were individually invited to participate in one-on-one interviews. They were selected based on Salma's existing networks and experience with healthcare workers, and references from local NGOs.

Breakdown of key informant interviews

	Kunduz	Nangarhar	Helmand	Kandahar
Community Health Worker	1	1		2
Vaccinator	1	1		1
Midwife	1	1	1	
Department of Public Health Representative	1			
Mobile Health Team Member	1	1		1
Head of BHPS clinic		1		
Total	5	5	1	4

Data collection and analysis

Salma mobilised field teams made up of a field supervisor, senior researchers, and field staff local to the data collection areas. The teams, which included male and female researchers with previous experience in qualitative approaches, received training on the objectives of the project and how to use the translated question guides. The senior researchers and field staff facilitated the focus groups. The senior researchers, with support from senior research coordinators, conducted the key informant interviews. The focus groups and interviews were recorded and transcribed in English. NVivo was used to code and map out responses identifying key themes and trends among respondents.

Community consultations

In collaboration with Salma, we undertook community consultations with women, men, community leaders, and frontline health workers in Kunduz and Nangarhar to discuss the problems and potential solutions we identified in this study.

We organised four gender-segregated group meetings with 49 participants in which we discussed four problems and recommendations for improvement (see next page).

Results of community consultations

1

Problem: Accessing different types of health care can be challenging, and health information among communities is insufficient to make appropriate decisions.

Recommendation: Use pharmacies as sites for sourcing information about types of health care available within the district

2

Problem: Community engagement in health service provision is limited.

Recommendation: Find pathways for communities to provide additional support to FLHW to improve the quality and accessibility of health care.

3

Problem: Women have lower access to health care services than many men for reasons including:

- There are limited female health providers available to treat women.
- Women cannot access health care services outside of their community if they are alone, and it is preferred that a mahram accompanies them.
- Women need the permission of people in their household to seek medical care.

Recommendation: Support the uptake of medical careers for women in their local communities to fill the gap of a lack of female health workers.

4

Problem: Women face challenges accessing formal health care. They rely on women, particularly older women in their community, for health advice. These older women are respected because they have experience in managing illnesses, have had many children and grandchildren, and know different ways to treat them.

Recommendation: Provide older women in communities with basic health information, such as information on women's and children's health, so they can then be a source of health information for other women in their community.

The outcomes of these consultations were used in the workshop with humanitarians and health workers and included in the recommendations section.

Limitations

This research was conducted shortly after the August 2021 government transition in Afghanistan. The operational context was still uncertain, and this lack of certainty informed the research design and methodology.

Limitations that may have impacted or influenced the interpretation of the findings are outlined below.

Response biases/Variance in how survey questions were interpreted

An automated voice response was used to pre-determine if respondents had received aid. During the live calls enumerators were instructed to clarify that “aid” refers to both items and services received. However the common misconception that aid only refers to items may have influenced the number of aid recipients in the final sample. The phone survey also categorised respondents based on location. We defined urban areas as “provincial capitals” and rural areas as “districts.” This distinction however may not reflect how respondents self-identify or other frameworks for understanding demographic distribution in Afghanistan.

Sampling and challenges with phone surveys

There are inherent limitations with phone surveys. Primary among them is the lack of representativeness as households with no phones are excluded, as are groups that have traditionally limited access to household phones such as women, elderly people, and persons with disabilities. In Afghanistan, urban households are also more likely to have phones.

To mitigate the urban/rural bias, we targeted 75% people living in rural areas and 25% in urban areas, which are the quota’s applicable to the general population³⁹. To improve representation of under-sampled groups the qualitative component of the study prioritised capturing women’s voices and feedback from rural communities. We also worked with enumerators to determine the time-of-day women would mostly likely be available and instructed them to ask anyone who picked up the phone to refer the call to a female member of the household over the age of 18. These steps help to strengthen the sample, however, we were unable to obtain our goal of a 50/50 gender split. Future studies should take steps to ensure the representation of women, particularly women living in rural areas as well as elderly people, persons with disabilities, and youth, as these groups remain underrepresented in the current sample.

³⁹ World Bank. 2018. [“Rural population \(% of total population\) - Afghanistan”](#)

Women's participation in focus group discussions

On several occasions, women declined to participate in recorded focus group discussions, with some citing uncertainty around what is and is not allowed under the new government. For quality control purposes, we required all interviews to be recorded and the lack of informed consent meant we could not conduct eight interviews. To ensure adequate participation of women we decided to suspend interviews in Helmand province, and to undertake interviews in Kandahar province where women were more willing to consent to having discussions recorded. Studies that aim to include input from vulnerable groups must identify strategies to accurately collect data without compromising the safety and security of respondents. Ideally these strategies should be developed in consultation with the target community.

Identifying and engaging with frontline health workers

Requests were submitted to the Ministry of Public Health and NGOs providing health services to facilitate access to frontline health workers. However internal policies and confusion over newly established government requirements caused time delays and we had to rely on existing networks to identify respondents. Future efforts to engage frontline health workers should incorporate ample timelines to accommodate lengthy government and organisational administrative processes.



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