CARE International in Afghanistan

Program Quality Department

Rapid Needs Assessment Report

Community Health Needs Assessment - Where Health Services Are Not Accessible in “White Areas” of Ghazni, Paktya and Khost provinces

Submitted to: CARE Netherlands and ECHO

By: CARE Afghanistan’s Program Quality Department

ACKNOWLEDGMENTS

On behalf of CARE Afghanistan’s Program Quality Department, we would like to convey sincere thanks and gratitude to everyone who contributed to the completion of this Rapid Needs Assessment (RNA). Without their valuable and essential input and cooperation, this effort would not have been possible. Special thanks to the CARE Humanitarian team, PQ colleagues, provincial managers and their teams, and the stakeholders and community/household members interviewed. The efforts of all those who took part during data collection, tools design and review, data entry and report writing/reviewing is highly appreciated.

This rapid needs assessment was implemented as part of CARE Afghanistan’s community engagement and stakeholder consultations. The assessment looked into the needs and vulnerabilities of the communities residing in hard to reach areas. Additionally, CARE assessed access issues, both for the population and for CARE, in the selected communities, all of which will help inform the development of the 2020 ECHO proposal focused on improving health.

The assessment was conducted in conflict-affected communities (specifically armed opposition group (AOG) controlled areas with no outside health service provision, also called “white areas”) in 20 remote/hard to reach districts of Ghazni, Paktya, Khost provinces from 15-25 December 2019. CARE appreciates the support it received from the community members, health departments, and district level authorities who allowed CARE’s access to the very underserved and marginalized communities under AOG control.
EXECUTIVE SUMMARY

Between 15-25 December 2019, CARE Afghanistan carried out Rapid Needs Assessments (RNA) in selected communities in Ghazni, Paktya, and Khost provinces, with specific focus on communities in congested areas where conflict-affected populations reside – specifically AOG controlled areas with lack of government or NGOs providing services, including health services.

The aim of the assessment was to assess the condition of needs, vulnerabilities and access issues – both for the population and for CARE - in the selected communities within mentioned provinces to help inform a proposal to ECHO for health and some integrated GBV and nutrition interventions.

In each community assessed, the assessment teams spoke to three separate groups of individuals including male community members, female community members and key community influential. A total of 123 FGDs were conducted of which 49 where female FGDs participated by nearly 340 female community members.

Key Informant Interviews (KII) were conducted with provincial and district level authorities to discuss general emergency conditions, vulnerabilities of communities and to discuss programing and access modalities. A total of 23 KIIs were organized with representative of provincial and district level authorities including departments of Public Health (DoPH), Department of Afghanistan National Disaster Management Authorities and Department of Women Affairs (DoWA).

In addition, separate interviews were carried in district hospital assessment in order to assess; 1) PBHS catchment in the district level to avoid potential in provision of health services, 2) assess possibilities and mechanism of referral of patient from white areas to the hospital; to 3) assess level of health service the district hospital provides and 4) to assess access possibility and mapping existing key services of health provider in the targeted districts in order to identify “white areas” for health intervention particularly for primary health and trauma care.

Results of the rapid assessment in the confirmed an ongoing lack of access to basic services (with acute gaps in access to trauma care services, SRH and GBV services). Given chronic conflict, lack of humanitarian assistance, poor outlook for the population and lack of available basic services, all those interviewed emphasized a strong need to meet their basic humanitarian needs, more particularly, the existing need for health response. Both respondents and local authorities also identified health and trauma care support as priority assistance, and emphasized its criticality because of remoteness and very long distance from nearest health facilities.

The result of the assessment indicated that female are among the most vulnerable, and are rarely allowed to walk long distances to access health services. The result of the assessment also suggested that communities targeted for the assessment are walking a range of 2 – 10 hours to get to the nearest health facilities. 20 communities mentioned that it is impossible for them to go the health nearest facilities since the nearest health facilities are either located in Govt. controlled territories which is difficult for them to visit or because of very long distance they have to walk to access the health facilities. In particular, female, elders, disabled and children are rarely able to access health facilities increasing reliance on negative coping mechanisms to meet their health needs. Households headed by women or a person with
disabilities are particularly vulnerable. Almost all of the districts has been strongly impacted by both disasters and intense spikes in conflict over the last many years. A precarious security situation has only compounded critical needs; humanitarian access remains lack to operate in this volatile conflict context while the needs their humanitarian needs in all sector is very high.

PROVINCES DEFINED

GHAZNI: Located in the Central region, Ghazni is bordered by the provinces of Paktya and Lugar in the North-East, Paktika, in South-East, Zabul in the South-West, Daykundi and Bamyan in the North-West, and Wardak in the North.

It covers a land area of 22,461 square kilometers, representing 3.44% of the total Afghan territory. The province is divided into 19 districts and is home to 4.7% of the total population of Afghanistan. With its 1,080,843 inhabitants, it is the sixth most populous province in the country.

The large majority of the population (95.9%) lives in rural areas. Ghazni, the provincial capital and only urban center, houses a mere 44,383 people, which represents less than 1% of the total urban population of Afghanistan.

According to the RNA result, health services in AOG controlled districts appear to be more difficult to access. People seeking medical attention must walk between 2-10 hours for an average of 10 KM to reach health services. Given the nature of the terrain and the lack of constructed roads, it takes more time to reach the closest health unit than distances would suggest.

CARE has been working in Ghazni since 1996 and has implemented more than 50 development and humanitarian projects in the following districts: Jaghori, Nawur, Malistan, Wali Mohammad Shahid, Bahrami Shahid, Dehyak, Rashidan, Khwaja Omari, Waghz, Qarabagh, and Ghazni.

Currently CARE is present in three districts: Jaghouri, Nawor, Malistan, and Ghazni center and is implementing a community based education project funded DFAT, DFID and USAID; a Global Affairs Canada (GAC) funded humanitarian response, a Citizens Charter National Priority Program (CCNPP) where Ministries and NGOs collaborate on a single program using a programmatic approach, and a livelihood and governance project funded by USAID.
KHOST: Khost province is located in the South-Eastern region and shares important borders with the Pakistan tribal areas, including North Waziristan and Kurram Agencies. Khost is a majority Pashtun province with many cultural, commercial, and political ties with Pakistan. Khost is also bordered by the provinces of Paktya in the North and North-East, and Paktika, in the South-West. It covers a land area of 4,235 square kilometers, representing 0.65% of the total Afghan territory. The province is divided into 13 districts.

According to the RNA result, health services, particularly health centers, in Khost appear to be difficult to access. People seeking medical services must travel more than ten kilometers (or walk 2-10 hours). Again, given the nature of the terrain, it may take more time to reach the closest health unit than distances would suggest.

CARE has been working in Khost since 1993 and has implemented more than 55 humanitarian, recovery, and development programs in the following districts: Mandozai, Tani, Nadirshakot, Gurbuz and Maton. CARE has created a very effective relationship with the communities whom have provided strong support to allow CARE’s safe access to the areas where the government does not have control.

Currently CARE has presence in five districts of the province, including Mandozai, Tani, Nadirshakot, Gurbuz and Maton, and is implementing community based education (primary and secondary education for girls) and livelihood and governance projects funded by USAID and the Dutch Ministry of Foreign Affairs. Through the governance project, CARE and a local partner enhance inclusive governance and strengthen the capacity of civil society for lobbying and advocacy by increasing inclusion and meaningful participation of women and girls in the decision-making process. The livelihood project focuses on the creation of sustainable jobs and livelihoods for IDPs, returnees, and some local households through high value vegetable production, livestock and poultry production, vocational training and jobs, and school to work transition support for new high school and university grads.

PAKTYA: Located in the South-Eastern region, Paktya is bordered by the provinces of Nangarhar in the North-East, Khost in the South-East, Paktika in the South-West, Ghazni in the West, and Lugar in the North. It covers a land area of 5,483 square kilometers, representing 0.86% of the total Afghan territory. The province is divided into 11 districts—the provincial capital is Gardez.

Paktya is home to 2.2% of the total population of Afghanistan. With its 514,816 inhabitants, it is the 17th most populous province in the country. The large majority of the population (95.5%) lives in rural areas. Gardez, the provincial capital and only urban center, houses a mere 92,038 people, which represents only 0.51% of the total urban population of Afghanistan.

According to the RNA results health services in Paktya appear to be more difficult of access and communities in white areas must walk more than 2 hours (ranged 2-5 hours) to seek medical attention.

Similar to Khost, CARE has been working Paktya province since 1993 and has implemented more than 25 development and humanitarian projects in Ahmad Aba, Sayed Karam, Shawak, Laji Ahmad Khel, Merzaka, Zurmat, and Gardiz districts. CARE established very strong community contacts and effective relationships
with the communities who provide strong support to allow CARE safe access to the communities where the government does not have control.

CARE Afghanistan has been implementing the community based education model funded by DFAT, DFID, and USAID in two contexts, namely, primary community based education and lower secondary community based education within the National Education Strategic Plan (NESP) to universalize basic education for children between the 7-18-years in Paktya center.

OBJECTIVE AND METHODOLOGY OF THE RNA

OBJECTIVES

The main objective of this assessment was to assess the needs and vulnerabilities of communities residing hard to access/reach areas, and assess access issues – both for the population and for CARE - in the selected white areas within Ghazni, Khost, and Pakty to help inform the development of the 2020 ECHO proposal focused on health with integrated gender based violence (GBV) and nutrition interventions. The assessment was conducted with diversified groups in the targeted communities, including women, elderly, persons with impairments, local and provincial authorities, and district level health facilities through face-to-face focus group discussions (FGDs) and structured key individual interviews (KII). Sub-objectives for each component of the RNA are outlined briefly below per sector.

KII WITH LOCAL AND PROVINCIAL STAKEHOLDERS

CARE implemented individual interviews with provincial and district level stakeholders to gather information on the health service needs and to identify the target white areas for health interventions.

The following topics were discussed and mapped during the KII to determine the target communities:

- Communities having no access to primary health services for reasons beyond the capacity of basic package of health services (BPHS) coverage and services.
- Districts with health facilities providing BPHS, but with no capacity to cover the extra population within the coverage catchment area.
- Map the areas that get blocked during winter due to snow (road block) which impedes access to health services.
- Map white areas where BPHS services are never accessible or are located at a distance greater than two hours walking time.
- Areas where the number of IDPs are high.
- Areas where GoA cannot access but NGOs can access for humanitarian response activities.
- Within these communities, what are the available services and access constraints for local populations and humanitarian actors?
- What are the basic health, GBV, and nutrition needs?
- What have been the trends in conflict and/or natural disasters in the area (i.e. conflict, flash floods, harsh winter, etc.)
- Do we have information that would help to determine the types and amounts of materials we should have on hand to help respond to projected shocks in the coming year?
COMMUNITY HEALTH NEEDS ASSESSMENT

CARE implemented KIIs, FGDs, and household surveys to outreach diversified groups in the targeted communities, including women, elderly, and persons with impairments. The focus of the discussions were:

- To assess needs, vulnerabilities, and access issues – both for the population and for CARE
- To understand the political and social elements of vulnerable local populations in the local communities. This involved identifying the key demographics of the population and exploring their political and social characteristics to help guide humanitarian response.
- To assess and understand external and environmental barriers that purposefully or inadvertently hamper persons with disabilities in accessing and participating in humanitarian assistance and protection.
- To assess and understand the external enablers facilitating access and participation in society for persons with disabilities alongside the capacities that persons with disabilities already possess.
- To assess how the needs of the community differ by population group (i.e. women, children, people with disabilities).

CARE Afghanistan is very interested in promotion of gender equality and therefore, female FGDs were conducted where possible to understand how their situation is different to that of men. Do they have access to health services? Can they go for health assistance? How do they look after their children?

DISTRICT LEVEL HEALTH FACILITY ASSESSMENT

The assessment also included KIIs with district level health facility personnel to assess:

- BPHS catchments at the district level to verify the identified white areas provided by the provincial DoPH and to avoid potential overlap in provision of health services
- Assess possibilities and mechanisms of referral for patients from white areas to the health facilities
- To assess levels of health services the district hospital provides
- To assess access possibility and mapping existing key services of health providers in the targeted districts in order to confirm “white areas” for health interventions, particularly for primary health and trauma care.

DESCRIPTION OF CHOSEN METHODOLOGY

This RNA utilized a mixed methods approach to provide highly informed contextual information of AOG controlled/hard to reach districts and communities with potential associated difficulties of critical needs identified. Descriptive statistics on quantitative data and themes derived from content analysis on qualitative data were integrated and re-examined to further elaborate on the meanings of specific issues existing in the selected hard to reach areas of Khost, Paktya, and Ghazni provinces.
Health facility service provision for facilities nearest to the white areas were determined through extensive observation and individual interviews with staff. Data was collected from both selected communities and health facilities using face-to-face interviews and in-depth discussions.

TARGET POPULATION AND SAMPLE SIZE

CARE conducted the assessment through its Program Quality Department. Each provincial team consisted of six enumerators (three male and three female) led by Monitoring and Reporting Officers. In Ghazni the assessment was carried out by four enumerators from the Provincial Department of Public of Health to avoid political sensitivities.

The assessment utilized a mixed methods approach to gather highly informed contextual data in AOG controlled and hard to reach areas “white areas”. A five-stage sampling methodology was employed:

1. Review and consult the provincial health clusters list of hard to reach areas with no BPHS services (white areas)
2. Structured interviews with community contacts and ICRC representatives to assess accessibility and implement-ability of health interventions in locations where GoA has no or very limited access.
3. Discussions and structured interviews to identify “white areas” with each Provincial Department of Public Health.
4. Cluster random sampling of villages from the list of “white areas” in the target provinces. The selection of villages was done using ENA for SMART software2011 (version 9 July 2015) where Probability Proportionate to Size (PPS).
5. Local authorities at the District levels reviewed and approved white areas and provided address of the locations. The survey teams conducted two FGDs (one male and one female) in each community. In communities where female FGDs were not advised, the enumerators were asked to do observation and provide feedback on gender equality and the concerns thereof.

Below is list of hard to reach district and communities that were selected for this assessment with an indication of who controls where.

<table>
<thead>
<tr>
<th>Province</th>
<th>Districts (HTR)</th>
<th>Distance (hour by road)</th>
<th>Center of District</th>
<th>Communities</th>
<th>Access to center of the districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paktya</td>
<td>Jaji Aryub</td>
<td>2 hours</td>
<td>Govt. 50%</td>
<td>Govt. 70% AOG 30%</td>
<td>Possible through community support</td>
</tr>
<tr>
<td></td>
<td>Mirzaka</td>
<td>1.45 hours</td>
<td>Govt. 50%</td>
<td>Govt. 80%</td>
<td>Same as above</td>
</tr>
<tr>
<td></td>
<td>Ahmad Aba</td>
<td>0.5 hour</td>
<td>Govt. 50%</td>
<td>Govt. 90% AOG 10%</td>
<td>Same as above</td>
</tr>
<tr>
<td></td>
<td>Ahmad Khail</td>
<td>2 hours</td>
<td>Govt. 50%</td>
<td>AOG</td>
<td>Same as above</td>
</tr>
<tr>
<td></td>
<td>Zazi Aryoub</td>
<td>2.45 hours</td>
<td>Govt. 50%</td>
<td>AOG</td>
<td>Same as above</td>
</tr>
<tr>
<td></td>
<td>Gardiz</td>
<td>0</td>
<td>Govt. 50%</td>
<td>Govt. 90% AOG 10%</td>
<td>Same as above</td>
</tr>
<tr>
<td></td>
<td>Zurmat</td>
<td>2 hours</td>
<td>Govt. 50%</td>
<td>90% AOG</td>
<td>Same as above</td>
</tr>
<tr>
<td></td>
<td>Said Karam</td>
<td>45 min</td>
<td>Govt. 50%</td>
<td>Govt. 50% AOG 50%</td>
<td>Same as above</td>
</tr>
<tr>
<td>Ghanda</td>
<td>Ander</td>
<td>30 Km (3 hour)</td>
<td>AOG</td>
<td>AOG 100%</td>
<td>Possible through AOG contact/DoPH</td>
</tr>
</tbody>
</table>
### Dehak
- 20 km (2 hour commute)
- AOG, AOG 100%
- Possible / through AOG contact/DoPH

### Khogyani
- 25 km (3 hour commute)
- AOG, AOG 100%
- Possible / through AOG contact/DoPH

### Malistan
- 40 km (7 hours from Jaghuri site office)
- Govt. 100%, AOG 100%
- Possible / No issues/ but geographic barriers remain

### Jaghuri
- Can be assessed by team in the district
- Govt. 100%, AOG 100%
- Possible / No issues/ but geographic barriers remain

### Gillan
- 120 km (10 hour commute)
- AOG 100%, AOG 100%
- Possible through DoPH

### Bak
- 10/15/20 km (30 minutes)
- Govt. 30%, Govt. 60%
- Possible through Community contact/Tribal Elder

### Mando Zaiy
- 20 km (30 minutes)
- Govt. 30%, Govt. 60%
- Same as above

### Center (Matoon)
- 35 km (50 minutes)
- Govt., Govt. 60%
- Same as above

### Nader Shah Kot
- 25 km (30 minutes)
- Govt. 30%, AOG 80%
- Same as above

### Sabari
- 60 km (2 hours)
- AOG, AOG 100%
- Same as above

### Spira
- 70 km (2.5 hours)
- AOG, AOG 100%
- Same as above

### Zazi Maidan
- 35 km (1 hour)
- Govt., Govt. 60%
- Same as above

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### Target population and sample sizes:

<table>
<thead>
<tr>
<th>Target participants</th>
<th>Quantitative sample size and qualitative characteristic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female FGD n = 60</strong>&lt;br&gt;<strong>Male FGD n = 70</strong></td>
<td>- 49 FGDs and approximately 340 female community members participated&lt;br&gt;- 70 interviews were conducted with male participants of the communities</td>
<td>- Responded to health, nutrition, and GBV areas of inquiry dedicated for female interviewee&lt;br&gt;- Responded to Health and nutrition areas of inquiry&lt;br&gt;- 123 interviews were conducted in 111 communities</td>
</tr>
<tr>
<td><strong>Nearest Health facilities n = 17</strong></td>
<td>17 Health facilities with at least one individual interview with Health workers and conducting extensive observation</td>
<td>Using checklist on HF BPHS service packages</td>
</tr>
<tr>
<td><strong>Key Informant Interviews n = 12</strong></td>
<td>10 KII Interviews were conducted with representatives of provincial DoPH, Womens Affairs, IDPs, refugees, and returnees</td>
<td>Responded to interview questions dedicated for each of the target respondents</td>
</tr>
</tbody>
</table>

The number of villagers living in a single family ranged between 3 and 20 persons, with the average family size being 7 members. Forty percent (40%) from the 123 FGD were female FGDs.
The RNA questionnaires were translated into Dari and Pashto languages, which are the common local languages in the selected areas of Khost, Ghazni, and Paktya provinces - attempts to avoid ambiguous lines of inquiry, and sensitive/complex language was employed to support accurate translation into local languages.

For Ghazni, the assessment was conducted by four enumerators introduced by DoPH who had permission to access the selected communities. Although CARE coordinated the assessment with local power holders and obtained permission for the assessment, CARE preferred to use DoPH staff to carry out the assessment given the context and to avoid political sensitivities.

CHALLENGES

- For Ghazni four out the six selected districts are controlled by AOGs where they do not allow women to participate in interviews unless the enumerators are all female. Due to the remoteness of the area and enumerators being required to stay overnight in districts where there is no accommodation facilities, CARE was not able to deploy female enumerators in the following four districts: Andar, Deh-yak, Gilan, and Khogyiani (Wali Mohammad Shaheed). To ensure that data was collected on gender issues, the enumerators were asked to conduct observation and provide feedback on women’s participation in community decisions, involvement in livelihood activities, and presence of women and children in the local hospital.

- The low level of education of the majority of Ghazni, the lack of gender equity and concern over the security situation of the districts selected for this assessment reduced the number of available male and female enumerators. Therefore, CARE recruited DoPH staff enumerators who were familiar with the context and were provided with a two-day training on tools and methodologies. PQ team provided extensive monitoring on the first day of data collection conducted in selected communities. Following this, however, due to security challenges the PQ team were not able to conduct field visits in the following days to supervise the use of the approved sampling method. Instead, at the PQ team conducted review of the completed questionnaires and data entry at the provincial level, as well as debriefed the data collection teams as a means of on the job support, to maintain the overall quality of data collection.

QUICK FACTS

- The Population size of the communities in the targeted white areas averaged at 7 members per family.

<table>
<thead>
<tr>
<th>Province</th>
<th># Families in RNA location</th>
<th># Men</th>
<th># Women</th>
<th># Boys</th>
<th># Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghazni</td>
<td>22,122</td>
<td>43,672</td>
<td>48,062</td>
<td>25,519</td>
<td>30,751</td>
<td>148,004</td>
</tr>
<tr>
<td>Khost</td>
<td>24,770</td>
<td>53,159</td>
<td>54,400</td>
<td>60,490</td>
<td>62,989</td>
<td>231,038</td>
</tr>
<tr>
<td>Paktya</td>
<td>8,388</td>
<td>14,580</td>
<td>15,787</td>
<td>12,579</td>
<td>13,125</td>
<td>56,071</td>
</tr>
</tbody>
</table>
• 80 communities (representing 72% of the communities targeted by the RNA) of 111 communities targeted by this RNA are currently controlled by AOG. Access to these communities for any humanitarian intervention requires having permission from the related AOG representative or to be supported by the communities.

• For 20 of the communities assessed there are no accessible health facilities. People have to travel to district/provincial center to get health services.

• For 89 communities targeted through the assessment, participants mentioned that there are no humanitarian NGOs responding to humanitarian crises. They added, there were some projects implemented by MRRD and CARE National Solidarity Program (NSP) but due to funding or continued conflict the NGO had to phase out from their communities.

• Of 111 communities targeted, 37 communities were previously targeted by CARE International through NSP.

• For 40 communities there is no telecommunications coverage/services available.

• For the majority of the households their livelihoods depends on agriculture products, followed by livestock.

• 3% of the whole population are IDPs (2134 IDP families/14938 individuals - representing 3% of the who population) within the areas targeted through the assessment. This is because of limited livelihood options, access issues, lack of existence of humanitarian actors and conflict in the area. IDPs are tending to settle in the provincial centers having access to basic services.
Major Findings

- 94% of FGD respondents said that they walk more than two hours (range 2-9 hours) to reach the nearest available health facility in the area. Seven percent (7%) of the respondents said they cannot visit a health facility because of the security concerns.

- General population in the white areas are facing the following difficulties accessing healthcare services:
  - Limited transportation and highly costed which can not afford (long distance to facility)
  - Security concerns because of traveling long distances to reach health facility
  - Climate incident which blocks the road and impedes access frequently
Over half (54%) of the respondents stated that there is a private clinic within and/or accessible to their village, but then reported that the cost of the medicine is high and they have no financial capacity to afford it.

![Is there private clinic accessible to this location](image)

According to the data, a total of 2142 individuals, of which 77% were women and children, died due to disease over the three months prior to the assessment. The death rate is 19.6 per 1000, which is 5.9 higher than national rate of Afghanistan which is 13.7. This high mortality rate is due to ongoing conflict and lack of attention to women and children’s health due to “harmful” cultural norms and difficulties to accessing healthcare services (i.e. lack of transportation/long distances to facility, economic difficulties and negative coping mechanisms to meet their health needs).

<table>
<thead>
<tr>
<th>Province</th>
<th># Men</th>
<th># Women</th>
<th># Children</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghazni</td>
<td>99</td>
<td>102</td>
<td>184</td>
<td>385</td>
</tr>
<tr>
<td>Khost</td>
<td>315</td>
<td>278</td>
<td>479</td>
<td>1,072</td>
</tr>
<tr>
<td>Paktya</td>
<td>74</td>
<td>255</td>
<td>356</td>
<td>685</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>488</strong></td>
<td><strong>635</strong></td>
<td><strong>1,019</strong></td>
<td><strong>2,142</strong></td>
</tr>
</tbody>
</table>

In response to the follow up question of why the death rate was so high, the communities cited different reasons that are presented in the table below. The most common problem cited was economic problems to afford transportation/medicine costs, followed by access/distance issues to the nearest health facilities.

<table>
<thead>
<tr>
<th>Why not able to take patient to nearest hospital</th>
<th># Men</th>
<th># Women</th>
<th># Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Damaged Roads</td>
<td>24</td>
<td>26</td>
<td>50</td>
</tr>
<tr>
<td>Economic problems</td>
<td>194</td>
<td>294</td>
<td>517</td>
</tr>
<tr>
<td>Lack of access to health centers</td>
<td>163</td>
<td>145</td>
<td>221</td>
</tr>
</tbody>
</table>

Regarding women, the most common health problems were pregnancy related and acute respiratory infection.

- Women face some difficulties accessing healthcare services: high cost of transportation, security concerns to enter/remain in the health facility, no health facilities available in the area, and security concerns around travel to health facility.

<table>
<thead>
<tr>
<th>Health Problem for women</th>
<th>Total Response</th>
<th>% Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Respiratory Infection</td>
<td>11</td>
<td>9%</td>
</tr>
<tr>
<td>CDD Control Diarrheal Diseases</td>
<td>9</td>
<td>7%</td>
</tr>
<tr>
<td>Communicable diseases</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Reproductive Health</td>
<td>99</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>123</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

For children, the most common health problems were malnutrition (n=83), diarrheal diseases (n=94), and other communicable diseases.

- Their guardians (mostly father respondents) face some difficulties to get the children healthcare services: high cost of transportation to health facility, no health facilities available in the area, health care services are too expensive, less attention on child health, and security threat for them.

Regarding people living with disabilities, the most common health problems were acute respiratory infection, injuries, not being able to afford or no availability of specialized service for their needs. The difficult financial situation prevents them from accessing needed health care, food, and medical consumables.

When asked where do community members go if health services are not available or people cannot afford going to health facilities, 69% of the respondents reported they go traditional local healers and 14% to religious shrines. These traditional healers are not medical professionals but are well trusted by communities and are advising homemade medicines. This show a very negative coping mechanism communities are adopting to meet their health needs in the communities they are living.

<table>
<thead>
<tr>
<th>Where They Go If Health Service Not Available</th>
<th>% Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homemade medicine</td>
<td>17%</td>
</tr>
<tr>
<td>Religious shrine</td>
<td>14%</td>
</tr>
<tr>
<td>Traditional Local Healer</td>
<td>69%</td>
</tr>
</tbody>
</table>
Results from Focus Group Discussions with women in the community:

(Note: Even though collection of detailed information on GBV, women’s agency, and other women’s topics, was not possible to obtain directly from the community, given the sensitivity of the topics, the data collected at village-level make it possible to draw inferences on these issues affecting women in the community and/or their involvement in community and household decision making. For communities where female FGDs were not advised, the enumerators were instructed to do observation and collect information to inform on gender equality issues and discrimination).

- Most of the women are not easily allowed by their family to go to hospital and receive health services without Moharaam (male accompanier) and similarly, women are not allowed by their families to receive family planning or pregnancy care. Culturally, family planning is considered a sensitive topic to discuss unless communities are sensitized and female health workers are involved.
- Family planning services are not available in the districts, either due to lack of public health facilities in these geographical locations or sensitivities of the topic itself.
- Sixty percent (60%) of women responded that they last delivered at home, while 40% reported delivering in the hospital. The majority of the women who delivered in hospital were from two districts of Malistan where women are comparatively allowed by their family member to visit health facilities services.
- If women get permission to access these services, they have to take Moharram and travel long distances to hospitals which is impractical and unaffordable to most.
- Pregnant women don’t have access to pre- and post-delivery care services. To access these services, they have to travel long distances to the nearest hospital. The same issues exist for accessing basic children’s health services.
- For all of the communities surveyed there is a lack of specialized, free and/or permanent, sexual and reproductive health services (SRH) or holistic GBV response provided to vulnerable populations according to minimum international standards.
- Communities tend to impose harder rules and sanctions on women and girls according to social, cultural, and religious standards that link the reputation of the family and the honor of its members to the strict respect of gender roles and related acceptable behavior of women and girls. This include limitation over decision of women to get basic services including health and education, and engagement in household/community decisions. The result of the RNA identified that 64% of the respondents mentioned that whenever women are sick, the male members of the family decide whether to take them to hospital or not.

<table>
<thead>
<tr>
<th>Women Sick</th>
<th>d1-Province</th>
<th>Total Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family elders</td>
<td>Paktya</td>
<td>2</td>
</tr>
<tr>
<td>Family elders Total</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Father</td>
<td>Ghazni</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Khost</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Paktya</td>
<td>25</td>
</tr>
<tr>
<td>Father Total</td>
<td></td>
<td>76</td>
</tr>
<tr>
<td>Grandfather</td>
<td>Paktya</td>
<td>1</td>
</tr>
<tr>
<td>Grandfather Total</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Mother</td>
<td>Ghazni</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Khost</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Paktya</td>
<td>11</td>
</tr>
<tr>
<td>Mother Total</td>
<td></td>
<td>44</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>123</td>
</tr>
</tbody>
</table>
This lack of female empowerment is attributed to the impacts of conflict coupled with lack of humanitarian presence. The discrimination, the increased difficulties to ensure the family's wellbeing by the means usually at hand, all have created an environment where women and girls must remain increasingly confined to the private space of the house in order for the male of the family to fulfill their gender role of protector and provider of the family. The social and cultural context in the three provinces assessed (except for Jaghouri and Malistan where Hazara ethnic are living who remained open) is deeply conservative in terms of social relations and enforces practices that have a negative impact on gender equality.

Social and economic conditions for conflict affected communities are becoming harder due to the lack of humanitarian organization presence in those communities. More than 70% of communities targeted by the assessment have been controlled by AOGs for at the last five years. There is a strict prohibition for male members of the communities to work in cities or where government controls without a permit by AOG/IEA. This situation forces communities to be engaged in the conflict to be able to provide for their families.

Issues related to GBV will be difficult to work with in the conflict affected communities, considering the sensibility of the issue but the survivors can be supported in the form of basic care and referrals.

Local Health Facility and Health stakeholder interview findings:

- The major problem in the hospital is the unstable support. Currently the support is partial and does not cover the entire hospital even though the hospitals provide services to locals and IDPs, who are increasing day by day.
- The majority of the health facilities confirmed that distance, climate, and security concerns together are major obstacles for women to access health services.
- The majority of health facilities provide birth delivery services, but this service is only available during daytime. Female health worker/midwives do not stay overnight within the hospitals.
- The majority of the health facilities included in the assessment reported no attack and/or security threat facing them, but have mentioned no female are available in the health facilities over night as female doctor health workers are not allowed by the communities to stay overnight at the hospitals.
- Head of provincial health facilities emphasized they humanitarian organization to work in white area and they are available to provide required support that helps access.
- Head of the DoPH insisted their appreciation for being consulted by CARE on the project design where related to Health interventions to respond to health needs of population in hard to reach area where government can not access. They emphasized continue collaboration and coordination throughout project implementation through information sharing and/or joint planning and monitoring where applicable.
- With regards to white areas for health programing, it was insisted that DoPH offices are available to map the white area for health response and will be available to facilitate CARE access there but emphasized any nonreason-able geographic overlap for the similar type of services is not acceptable for them.
• With regards to access, the interview stakeholders, highlighted that their experience and feedback from their team, working at conflict areas, suggests that AoGs are currently welcoming any health related services and it is proved that they are supportive in this section.

• Overall, during separate interview, heads of DoPHs emphasized their continued desire to see CARE International and DoPH continue working closely together in order to jointly/practically plan on this initiative to respond to need of people in needs. It was also emphasized that they understand organizational policies and ensured that DoPH will not expect anything except for coordination and ensuring that those underserved populations are assisted.

**People with Disabilities:**

The Rapid Assessment indicated a total of 3,129 individuals in the targeted communities living with disabilities. The assessment showed that people with disabilities are more likely to have poorer overall health, less access to adequate health care, and increased risk for preventable health problems. For people with disabilities, the most common health problems were acute respiratory infection, injuries, not being able to afford or no availability of specialized service for their needs. The difficult financial situation prevents them from accessing needed health care, food, and medical consumables.

These data are important to help identify barriers to achieving good health, and to design prevention and health promotion programs aimed at reducing health disparities and improving the health of people with disabilities. Main barrier for people with disability to get health service are very poor economic condition, lack of access to health facilities and limited livelihood opportunities.