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Rural Women's Access to Health: Poverty, insecurity and traditions are the main obstacles

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[Jelena Bjelica](#)

What do good health services look like for rural women in Afghanistan? How easy or difficult is it for them to access the basic health services that do exist in their area? Does insecurity have a different impact on access to health services for women and men? To answer these questions, we interviewed nineteen Afghan women from different rural districts of the country. As AAN's Jelena Bjelica reports, the opinions and experiences these women shared show that although the reach of the health system has improved over the last two decades, poverty, insecurity and traditions continue to limit actual access for women. What also became clear in the interviews is that women are well-versed in critically assessing whether what is on offer meets their needs and expectations from the public health service.

This research is funded by the Bill and Melinda Gates Foundation (BMGF). The AAN colleagues who conducted the questionnaire were: Asadullah Sadat, Khadija Hosseini, Obaid Ali, Fazl Rahman Muzhary, Reza Kazemi, Ali Yawar Adili, Ali Mohammad Sabawoon and Rohullah Soroush.

Introduction

This report aims to shed light on what women in rural Afghanistan think about the health services in their areas and what their day-to-day experiences of accessing these services are. It is based on nineteen semi-structured interviews with women from pre-selected rural districts with a view to their being representative of the geographical, ethnic and socio-economic diversity of the country. The report's intention is to reflect the opinions of rural women on what constitutes a good health service and what they think the key issues concerning maternal and children's health are in Afghanistan.

The report opens with a description of the context based on a review of relevant public reports concerning healthcare. This section cites available quantifiable indicators including on the availability and staffing of health facilities, the average distance to reach them, maternal health indices and poverty figures. Many of the cited findings, as reported by the key organisations providing healthcare in Afghanistan, were echoed by our interviewees.

Following this section, the methodology used for the research and analysis is presented and explained. This is followed by a discussion of main findings and a conclusion.

Context: Afghanistan's health system in numbers

The reconstruction of Afghanistan's healthcare system after 2001 began from a very low baseline. In 2002, the year following the international military intervention in Afghanistan, the Afghanistan Research and Evaluation Unit (AREU) [reported](#) that Afghanistan's health system was "in a state of near-total disrepair" and that "the infant mortality rate, the childhood mortality rate and the maternal mortality ratio were among the worst in the world." A [December 2020 UK Home Office's Country Policy and Information Note on Afghanistan](#), citing several external sources, said:

In 2002, Afghanistan's health system ranked among the worst in the world... The average life expectancy was only 43 and the majority of the population was undernourished or had no access to clean water. People distrusted visits to health centres because of the lack of resources and medical staff, corruption and the great distances to health services.

Today, almost twenty years on, the health system has been significantly built up and, in terms of the quality of the services provided, is on an ascending curve. According to [a 2018 World Bank report](#), between 2004 and 2010, "health care services showed major improvements in Afghanistan, while in the period of 2011-2016 improvements continued at a slower pace." Measured in tangible indicators,

access to health has improved significantly since 2002. ^[1]The institutional architecture of Afghanistan's rural health system is the Afghanistan's Basic Package of Health Services (BPHS), a national programme that was ratified and launched in 2003 by ... Continue reading The BPHS consists of different levels of health facilities: Health Post, Health Sub Centre, Mobile Health Team, Basic Health Centre, Comprehensive Health Centre, District Hospital (for details what each of these entails see the 2009 MoPH document). Several organisations reported that large parts of the Afghan population now live within walking distance (one or two hours) of a functioning health facility. ^[2]A World Health Organisation's 2019 Afghanistan Country profile found that "in 2018, a total of 3,135 health facilities were functional, which ensured access to almost 87 per cent ... Continue reading

[A study published in the Eastern Mediterranean Health Journal in September 2018](#), however, showed large regional imbalances in healthcare provision. The study said that "the density of doctors is eight times greater in Kabul than it is in Kunar [province]," citing that there were 16.7 health workers per 10,000 people living in rural areas, compared with 36 per 10,000 in urban areas. As [AAN reported](#) in 2019, despite relatively high public expenditure on health by the standards of developing countries, healthcare across the country was generally poor and this was the case in both Taliban and government-controlled or influenced areas. Nationwide, there are 2.3 physicians and five nurses and midwives per 10,000 people, a 2011 WHO [found](#). The global average is 13 physicians and more than 20 nurses and midwives per 10,000 [people](#).

It should be noted that in Afghanistan, government-sponsored health services are to be provided free of charge, as stipulated by the 2004 Constitution.

Maternal health

In the early 2000s, after decades of conflict, poverty, lack of health services and women given birth without a doctor or midwife present, Afghanistan ranked as the country with the second highest maternal mortality rate in the world. This has improved considerably. "According to [estimates] by the United Nations, the maternal mortality rate was 1,100 per 100,000 live births in 2000 and has fallen by 64 per cent to 396 per 100,000 live births by 2015," the 2020 UK's Home Office report stated. ^[3]2015 health data are often used as the baseline, because in that year Afghanistan launched its first-ever nationwide effort to gather comprehensive demographic and health information on its citizens. ... Continue reading There are however differences between rural and urban areas here, as well. According to the same report, in urban areas, most women are assisted by a doctor or a midwife, "whereas less than half of rural deliveries are supported by a skilled birth attendant... 82.7 per cent of urban births are institutional deliveries, compared to 43.4 per cent of rural births."

[IMG | SOURCE: <https://www.afghanistan-analysts.org/en/wp-content/uploads/sites/2/2021/06/Rural-W-access-to-Health-3.jpg>]

Midwifery students in Nili, Daykundi province. Photo: Eric Kanalstein/UN Photo, July 2009.

[The AIHRC report](#) of May 2020, found that almost half (46.2 percent) of the women in their sample had not visited a hospital or health centre during their pregnancies nor had they seen a specialist doctor. 11.6 percent of women in the AIHRC sample gave birth at home without a doctor or midwife present. Over half (56.7 per cent) of the 2,610 people interviewed by the AIHRC said that women in their families had not observed [the international recommendation on birth spacing](#), ie waiting at least two to three years between pregnancies, which is meant to reduce infant and child mortality and benefit maternal health. "In addition, 15.6 per cent of women and children in the sample population have not been vaccinated [as per standard immunisation schedule – polio, measles, chickenpox, etc]," the report said. ^[4]The Lancet journal's editorial from 2020 on child and maternal health in Afghanistan said: Afghanistan still has one of the highest rates of child stunting and is one of three ... Continue reading

Poverty as an impediment to health

Poverty is a key reason for poor healthcare for many Afghans. As AAN [reported in 2018](#), the large amounts of aid disbursed since 2001 have not reduced poverty in Afghanistan in a sustained manner, ie poverty rates have gone back up when external income (aid or military spending) falls. While the rate of Afghans living in poverty decreased from [the World Bank's](#) baseline of 51.4 per cent in 2003 – ie during the immediate post-Taliban era, when aid flows were still moderate, to around 34 per cent in 2007/08, these gains were subsequently lost. The latest estimate by the Central Statistics Organization (CSO) from 2016/17 put the poverty rate at 54.5 per cent. A [Médecins Sans Frontières \(MSF\) report](#) of March 2020 said:

Widespread poverty... puts care out of reach for many Afghan people, as witnessed daily through the stories our patients tell us and in the cases that we treat. Patients describe delaying or avoiding care, or selling essential household goods in order to cover health-related expenses.

Petty corruption and the need to pay bribes to get access to healthcare means it is not actually free, as reported by health organisations working in the country. The December 2020 [UK Home Office's Country Policy and Information Note](#) quoted American Medical Overseas Relief and Afghan Health

Organization (AMOR-AHO) reports which found that although public hospitals should not charge fees for treatments:

It is a standard practice for the patient or his family to pay a bribe to the physician in order to receive treatment...This form of corruption is believed to be driving up hidden costs for patients and providing a major barrier to accessing health care for those who cannot afford the under-the-table payments often required to pay for health services.

Additionally, the shortages of medicines, which are supposed to be distributed for free, also drives many poor Afghans to despair, since this can lead to high costs, or the unavailability of needed treatment. “Stock-outs of medicines and medical equipment can occur due to the insecurity and inaccessibility of public roads. In all levels of the healthcare system, there can be shortages of life-saving medicines, even in referral hospitals,” the Home Office report said, adding that “drugs are only easily accessible in urban areas as there are a lot of private pharmacies available.”

The context for this study into women’s access of health services in rural areas is that healthcare has significantly improved since 2001, but it is far from being a modern, well-developed and fully functional health system. Resources and services are not even distributed, but cluster in urban centres Maternal and children’s health, although improved, requires further investment. Corruption also represents a key obstacle, even in the health sector. In the conclusion we will juxtapose these general context findings against the findings from the analysis of the data gathered from the interviews.

Methodology

To gather data for this research we conducted semi-structured interviews with key informants that were chosen to reflect a fairly representative ethnic and geographical spread. The interviews were conducted in a conversational manner around a set of predetermined topics, providing the researchers with freedom to prompt and develop any of the given health-related topics in the questionnaire, while still following the pre-set sequence. As such, these conversational interviews can be seen as “the joint production of accounts or versions of experiences, emotions, identities, knowledge, opinion, truth, etc.” (Rapley, 2000: 16). ^[5]Tim Rapley, ‘Interviews,’ in *Qualitative Research Practice*, Seale C. et al. (eds) (Sage: London, 2007), 15-34. The data collected from these interviews, as a result, “more less reflect[s] a reality jointly constructed by the interviewee and interviewer” (Rapley, *ibid.*).

The questionnaire was divided into five sections, each representing a health-related ‘reality’: (1) opening questions about the security, economy, governance and freedom of movement in the interviewee’s district; (2) general introductory questions about health services in the interviewee’s area, including the proximity of the health facilities and the availability of female health staff; (3) questions about actual access, including hindrances to the physical access of healthcare facilities; (4) questions about the quality of the health services; and (5) questions about maternal health.

Nine AAN Afghan researchers identified and interviewed nineteen women during the first week of April 2021. They came from a pre-selected list of districts that were, together, considered representative of the geographical, ethnic and socio-economic diversity of the country. The selection of interviewees relied on AAN’s broad network of key contacts. The safety of interviewees is a priority. This sometimes meant conducting interviews by phone or WhatsApp, rather than in person, and involved the anonymisation of interviewees so that they could speak freely and comfortably, even on what may be sensitive topics.

We interviewed the following women:

- In **central Afghanistan**, three women from three provinces: a Tajik from Kahmard district in Bamyan province; a Hazara from Kejran district in Daikundi province; and a Tajik from Shinwari district in Parwan province.
- In the **east**, two women from two provinces: a Tajik/Arab from Surkhrod district in Nangrahar province and a Pashtun from Watapur district in Kunar province.
- In **southeastern Afghanistan**, four Pashtun women from four provinces: Zurmat district in Paktia province (a Pashtun-speaking Sayed); Zazi Maidan district in Khost province; Sarhowza district in Paktika province; and Andar district in Ghazni province.
- In **northern Afghanistan**, five women from five provinces: an Uzbek from Burka district in Baghlan province; a Tajik from Dehdadi district in Balkh province; an Uzbek from Sheberghan district in Jawzjan province; a Tajik from Farkhar district in Takhar province; and an Uzbek Emam Saheb district in Kunduz province.
- In **western Afghanistan**, three women from two provinces: a Pashtun from Obeh district in Herat province, a Tajik from Du Laina district in Ghor province and a Hazara from Lal wa Sarjantal district in Ghor province.
- In **southern Afghanistan**, two Pashtun women: one from Arghandab district in Kandahar province and one from Shahjuy district in Zabul province.

To analyse the data collected in these interviews, AAN coded the most prominent key words and phrases appearing in each interview in a coding sheet developed for this purpose. The codes, ie key words, were refined through the constant comparison method (Rapley, 2000: 26) during the processing, re-reading and initial analysis of the interviews. The final coding sheet allowed us to deduce both qualitative and quantitative data on the preselected health-related topics in a structured manner. The quantitative data indicated hypothetic-deductive findings,^[6]In other words, our quantitative findings deduced from the research and analysis are not 'taken for granted truths'. and while one cannot make country-wide generalisations based on our sample, the quantitative data presented do to a certain extent allow generalised statements about common behaviour patterns within the sample.

The qualitative data was analysed from linguistic, anthropological, sociological and political perspectives. We wanted to understand the *how and what* of our interviewees' experiences, feelings and thoughts in relation to the health services in their area. The most illustrative quotes from the interviews are included in the discussion.

For the fourth section of the questionnaire, concerning the quality of health services, we used a qualitative discursive frame analysis in order to assess how the interviewees constructed meaning, ie how they understand what is a 'quality health service'. Frame analysis, which has often been used in political communication and social movements' research, is interpretive, since it allows the researcher to trace cognitive patterns and multiple meanings.^[7]Denisa Kostovicova, Seeking Justice in a Divided Region: Text Analysis of Regional Civil Society Deliberations in the Balkans in International Journal of Transitional Justice, 0, 1–22, ... Continue reading The frame analysis in this report focuses on how interviewed women understand what are good health services within their view of Afghanistan. The frames were deducted, or identified, based on a textual analysis of the interviews during the coding process through a keyword-in-context approach. We tracked the use of the key words "better" and "good" in order to identify the sentences or series of sentences in which they had been embedded (also called the 'lexical environments').

Since the data was collected through conversational semi-structured interviews, the analysis of the findings is presented in the order of the questionnaire chapters. Presenting the data per questionnaire topic, instead of regrouping them in any other order, seemed the most appropriate way to represent the findings, so as to avoid misinterpretation or out-of-context interpretation of the interviews.

Discussion of the main findings

1. Introducing the contexts in which the women live

Of the 19 women interviewed, only seven said that security in their district was good at the time we spoke to them. Of these seven women, six lived in government-controlled areas and one in a Taliban controlled area. The remaining women in the sample described security in their area as "bad" or "very bad." Some used words and phrases like "contested" and "weekly security incidents," while others said that "security is sometimes good and sometimes not." One woman said that fighting usually intensified in the summer. Another said that at the moment her area feels safe because there is no fighting, but that her village keeps changing hands and therefore, security was not good.

Out of the 19 women, 15 said they had limited freedom of movement in their area and the remaining four said they could move freely in their immediate area.

16 out of the 19 women said that the area they lived in was either poor or very poor and that their economic situation was not very good or was very bad. The three women who were the exception in this assessment were from Parwan, Paktia and Paktika; they said that in their areas the economic situation was either reasonable, average or good.

2. Availability of health services

All but one of the 19 women said that they had needed, and sought, some kind of medical treatment in the last year. Of the 19 women, eight said that a health facility was nearby (a few provided details such as "about two kilometres from my house" or "about a 10 to 15 minutes' walk"). The remaining 11 interviewees had to make their journey by car or on the back of a bike, walk a long way, or use a combination of these means of transport, to reach the nearest health facility.

The interviewee in Du Laina district in Ghor province, for example said there was no health facility in her immediate area:

There's no clinic near us. [The clinic] is far way. There are pharmacies around where we live. We've gone there to get medicines, but not for the health checks. There's a clinic in the centre of Du Laina district. There are doctors there, but it's good if you know them, so you get better treatment like blood tests and ultrasound examinations. There are also female midwives and vaccinators [in the clinic in the centre of Du

Laina district], but they keep changing from one period to another. Some of them are good and others don't know much. If women have serious problems, [the health staff in the Du Laina district clinic] refer them to the clinic in Chaghcharan [also known as Ferozkoh, the capital of Ghor province].

Some remote districts are supposed to be serviced regularly by mobile clinics, as foreseen by the BPHS plan (see footnote 1 for the explanation). Seven women out of the 19 said their districts have visits by mobile clinic or had had them in the past. Our interviewee from Du Laina in Ghor province, for instance, said:

There are mobile clinics and they come to our village. Those who work in them have no problems with the Taleban or the government. They come to a school, inform us that they are there and give advice and attention to women and children. They also come to the mosque or some local home [of people] they know. They can move around. In previous years, especially last year, they came frequently. Since last year, this has gone down somewhat, because they have some fears of getting into trouble with the Taleban or the government, [who might think that they are] giving information about the Taleban to the government, or about the government to the Taleban. But generally, they face no problems and they can work and move freely. Our area is mountainous and there are no doctors, [so] they come, gather women and provide them with information and advice on hygiene.

However, 12 out of the 19 women said there were no mobile clinics in their district, or even that they had never heard of them. For example, the woman from Zurmat district in Paktia province said that, until three years ago, they had mobile clinics. "Now, instead of mobile clinics, there are community health workers in the village," she said. "They work voluntarily." The woman from Andar district in Ghazni province said the last time she had seen a mobile clinic in her district was 25 years ago. The woman from Sheberghan district in Jawzjan province said that last year, a mobile clinic had been set up in a mosque in her village: "There were two females and three male health staff. Vaccinators also come to the village."

Eight of the interviewees said the health facility in their area was not properly staffed. For some this meant there were no female doctors (for instance in Zurmat district in Paktia). Others said there were no doctors or midwives at all (for instance, in Du Laina district in Ghor). The interviewee from Zazi Maidan district in Khost province said, "In [my village's] clinic, the midwives who are there can only solve basic problems." The woman from Arghandab district in Kandahar province said the clinic in her village has midwives and doctors, but there are more patients than they can treat. In some districts like Obbeh in Herat province, the community was serviced by a health post run by a local community health worker. Our interviewee there said:

In the clinic [a health post] in our village, there's just one doctor. His behaviour is good. He's a good man. The [other] doctor, the one I said was beaten by the Taleban, now runs a clinic and pharmacy in a lower village. He has a midwife working with him, she is his father's sister. His brother [the current doctor in the village] now runs the clinic and pharmacy in our village.

Apart from the interviewees from Obbeh in Herat, Du Laina in Ghor and Shahjoy district in Zabul province, all women said their local health facilities did have female medical staff. Most of these interviewees (13), said the female staff tended to be midwives, nurses and vaccinators. Only three interviewees – from Surkhrod district in Nangrahar province, Zazi Maidan in Khost and Burka district in Baghlan – said there was a female doctor or other female medical specialist in their area (Zazi Maidan had a gynaecologist, Burka a nutrition counsellor and the interviewee from Nangrahar did not specify the specialisation of the female staff member in her area). Some women, like the woman from Shahjoy district in Zabul province, pointed out that, although there were no female medical staff in the public health facilities, there might be some in the private clinics:

There are some female doctors in the private clinics... People who have money go there, or they go to Qalat [the provincial capital of Zabul province] or Kandahar city [in the neighbouring province] for treatment.

3. Actual access to health facilities

Seven of the 19 women said they had no problems that prevented them or family members getting the healthcare they needed. Six women – from Bamyan, Ghor, Balkh, Jawzjan, Kandahar and Zabul provinces – singled out transport-related problems, mentioning the cost and unavailability of transport, and insecure roads, as the key impediments to accessing the healthcare they needed.

There were various other reasons given for the health services that did exist being inaccessible to our interviewees. The two women from Baghlan and Ghor said poverty was the main reason preventing them getting healthcare. The interviewee from Khost said not having a *mahram* [a close male relative] available at the needed times was her biggest problem. The woman from Daikundi said the main problem for her was the lack of qualified medical staff in her area. The women from Paktika and Ghazni said the checkpoints and fighting were their biggest problem.

After the free-flowing conversation, we asked women to tell us which of several preselected issues – security, traditions, practical issues with the healthcare facility, practical issues within the home, or other problems – was most important when it came to their (not) getting the healthcare they needed

(see the table 1). More than half the women in our sample – 11 of them – mentioned either security or traditions, or both issues in the same breath, as the most significant hurdles. For example, the woman from Sarhowza district in Paktika province said:

Security is very important because whenever patients want to get to the healthcare centre, both the government people and the Taleban stop them and ask them questions... Sometimes, the Taleban block the roads for the movement of government people and don't allow patients to get to the hospital. There have been cases, where patients died because of such security problems. Therefore, I say security is very important... Traditions are also important, particularly in a society like mine. Sometimes, a very ill patient cannot reach a healthcare centre, if they have no mahram. There are traditions based on which, if a woman is pregnant, her in-laws won't allow her to visit a clinic. The reason is that it's not a tradition in their family to let a woman give birth in a hospital. In some cases, people have negative beliefs about hospitals and don't want their women to be treated there.

The woman from Burka district in Baghlan province said:

Insecurity sometimes prevents us visiting a clinic. The war has a harmful impact on us. Sometimes children get stuck in schools or we ourselves get stuck in clinics until the fighting is over. This is because the Taleban control the areas around the centre and sometimes the district centre. Traditions are a problem, too. For example, certain families believe that if you get your children vaccinated, the girls will deliver only girls once they grow up and get married, or that their children will be cowards (bi-ghairat). My own family is educated, my husband is educated, so we don't have these problems.

Two women said there were practical issues with the health facility, such as the lack of female medical staff or the limited frequency of mobile clinic visits to their area, that were the most important problems for them.

Three women said a practical issue within the home, namely poverty and lack of transport, was the main issue preventing them getting healthcare. The woman from Jawzjan recounted how, because the family had no means of transport, she had ended up helping a relative give birth on the road on way to the clinic:

Last year, the my husband's brother's wife [ewar] was in labour and there was no rickshaw available. It was close to evening prayer time. I made her get on a donkey, thinking we might come across a rickshaw on the road. She delivered on the way. I cut the umbilical cord of the baby and then we returned home. Both the baby and mother were fine and didn't face any problems. They had only 500 afghanis [about six USD] on them and it was a blessing from God that the baby was born on the way and that we returned them home. But, five years ago, our neighbour started labour pains during the night. They rode her on a donkey to the hospital and she died on the way after the baby was born. Her baby survived.

Two women said that all the listed issues were equally important for them. The woman from Shinwari district in Parwan said none represented a problem to her personally, but she did acknowledge they were often a problem for others:

I haven't faced such problems, that would stop us visiting a clinic or a doctor. Anytime I get sick, I go to a doctor. My family is not so strict that they don't allow me. However, we have neighbours whose families haven't allowed them to go a clinic or a doctor. There are reasons for that. Sometimes, they have financial problems and can't [afford to] go to a clinic. Sometime, the women didn't go to a clinic because they didn't have a mahram with them. Sometimes, doctors don't pay attention to patients, so then families don't allow women to visit a doctor. Certainly, security, bad traditions in some families, lack of proper medicine, the negligence of some doctors in hospitals and clinics, transport problems, distance, and above all financial problems cause more women not to have access to health services.

[IMG | SOURCE: <https://www.afghanistan-analysts.org/en/wp-content/uploads/sites/2/2021/06/Picture-1.gif>]

Table 1: How important are these issues in getting the healthcare you need? Credit: AAN, 2021.

As a follow-up to the question of what prevented them accessing healthcare, we asked our interviewees whether they thought these problems affected men and women differently, or in the same way. 12 women said that they affected men and women differently. The woman from Dehdai in Balkh summed up a sentiment that was shared by almost all of these 12 women:

Men don't have the problems we have. They work and have money to go to a clinic. They don't need permission to go to a doctor.

The other seven women from our sample were of the opinion that these issues affected women and men equally. They mainly cited the affect of poverty, insecurity and social inequality:

I think, in terms of security, the problems are the same for men and women. Insecurity and fighting does not differentiate.

Woman from Andar in Ghazni

Poverty affects both [men and women] in the same way. Poverty prevents both accessing a clinic or a private doctor. Insecurity also affects both of us. It prevents both [men and women] going to a medical facility.

Woman from Zurmat in Paktia

It is the same for everyone. Particularly, for those who have no car or motorbike at home.

Woman from Emam Saheb in Kunduz

In most cases, the impacts are similar. For example, security and economic problems affect both men and women in the same way.

Woman from Zazi Maidan in Khost

4. Quality of the health services

This section of the research used a discursive frame analysis, which is a methodological tool in qualitative research that investigates the cognitive frames people use and how they express them when they speak. We were looking for the cognitive frames that expressed the women's views, ideas and opinions about what constitute good health services. In practical terms, we tracked when they used the adjectives “better” and “good” when speaking about what they thought were good health services, and then analysed the context in which these words were used. The focus of the analysis was on the women's understanding of Afghanistan's health sector, which aims to be a publicly-provided, modern health service that, *based on the constitution*, should be free of charge. After analysing the women's answers about the quality of the health services, we found a pattern that pointed to three cognitive frames which featured strongly, what we have called a civility frame, a modernity frame and an equity frame. These are explained and explored in the following sections.

[IMG | SOURCE: <https://www.afghanistan-analysts.org/en/wp-content/uploads/sites/2/2021/06/Rural-W-access-to-health-2-1024x683.jpg>]

A woman holds her baby while talking to a midwife in Sar Howz clinic in the village of Tajikhan, Jabel Seraj district, Parwan province. Photo: Graham Crouch/World Bank, May 2012.

The civility frame

The first frame used by several interviewees to describe what a good health service was reflected their desire to be treated with respect. We named this cognitive pattern, the ‘civility frame’. [8]The word ‘civility’ derives from *civilis*, or “the state of being a citizen and hence good citizenship or orderly behaviour.” For example, the woman from Nangrahar said:

In my opinion, keeping a woman's secrets during the treatment is part of good health services. Patients need to be respected. Medical staff should consider the rights of patients and respect them. Clinics or health centres should meet the health requirements of the people. There should be doctors, nurses, midwives and enough medicine. There should be separate rooms for women who are going through delivery, and patients need to feel relaxed. When a patient talks about her health in detail to a doctor, she should feel comfortable. Others, particularly men, shouldn't be able to listen and hear them.

The modernity frame

The next frame that emerged, the modernity frame, reflected women's views that health services need to meet modern standards. In this frame, modernisation and progress were viewed favourably. Several interviewees identified, in detail, a variety of issues – including medical and technical equipment, staff numbers and capacity, the state of the health facilities – that they believed needed to be improved and/or modernised in order to have a good health service in Afghanistan. Within this frame women also spoke about the adequacy or inadequacy of the services, in terms of staff, equipment and facilities. The civility frame was often intertwined with the modernity frame, as is also evident from the quote above, where the woman from Nangrahar not only speaks about respect and good behaviour, but also about the adequacy of the care. Both frames also feature in this quote from the interviewee from Kahmard district in Bamyān province, who herself works as a midwife in the Kahmard clinic:

The central clinic in Kahmard should be equipped according to the needs of the people. Not only nurses and midwives should be hired to respond to the needs of women patients, but also female doctors. We don't have an ultrasound, echography or electrocardiography in the clinic; these should be provided. The only ultrasound machine we have in the district is with one of the doctors who brought it from his own private office and who charges a fee that is too high. Imagine a woman who has to travel two or three hours to the district centre and pay for transport and medicine and then the ultrasound too. The fee for the ultrasound is 350 afs [about 4.4 USD]... The services in the clinic in our area are basic and need to improve. For three years, it's been promised that the clinic in our area will become a hospital with better

services and equipment, but this promise hasn't been kept... There are three beds for children and seven beds for both men and women. We hospitalise two women in each bed and up to four children in a bed. This is not how a clinic should operate.

As also illustrated in this quote, there is a link between the modernity frame and the idea that modern services will also help deal with poverty, as an impediment to getting healthcare: by ensuring that the health system is modern and adequate, patients will not need to seek treatment outside the system, incurring debilitatingly high costs.

The need for improving health services featured in almost all interviews. 12 women in particular stressed the ways in which the provision and quality of medicines, doctors, facilities, equipment, etc need to be improved and modernised. The woman from Shinwari district in Parwan province summed this up:

The quality of medicine [here] isn't good. The facilities aren't good, there are no professional doctors and the number of district hospital staff isn't enough. They can't deal with all patients. The number of patients is high and doctors don't pay proper attention to them.

The equity frame

The equity frame that emerged from the interviews reflects a stress on the need for medical treatment to be provided without bias or favouritism. Within this frame were clear ideas about gender equality, well-expressed ideas about social equity and references to the need to provide health services without any kind of discrimination or partiality. For example, the woman from Sarhowza district in Paktika province said:

All patients should be equally treated. Women should be given assistance that is particularly for women. This is the right of mothers who are breastfeeding their children. If there are poor patients who can't afford food for their children, they should be given assistance. Assistance shouldn't be given to patients based on their connections. In other provinces, the assistance that is supposed to be given to poor women is given to the nurses or only to women who have connections in the hospital. The women who have no connections are deprived of this assistance.

The woman from Emam Saheb district in Kunduz province described a money-making scheme in the health system that increases costs for patients:

Usually, doctors prescribe medicines that are available in the market, but when writing the prescription, the doctor instructs patients where the medicines should be bought. Most of the doctors and nurses have their own pharmacy near the medical centre. If someone takes the prescription to a medical store other than the one instructed by the doctor, the people in the medical store can't read the prescription. So s/he has to take the prescription to the address that the medical worker has given.

The woman from Du Laina in Ghor talked about how she feels poverty makes her less worthy in the eyes of the doctor:

For the poor and destitute, there's little attention. If you know someone and have money on you, you get better treatment. There's little attention to the poor and destitute. They [the doctors and health workers] give you the same medication for whatever pain you have and it's up to you to get well or not. They give the same to all who approach them. Many medicines come to them, packs by packs. I don't know what the doctors and pharmacists do between themselves. They don't treat the poor and destitute much at all.

All of the women expressed views along the lines that the health system needs to be impartial, inclusive and gender sensitive. The words of the woman from Kejran district in Daikundi province sums up the general sentiment:

[A good health service] should be available to all people – men and women and children – based on their different and specific needs; it should be equally accessible to the most vulnerable population.

5. Maternal health questions

In this section of the questionnaire, we asked women about their pregnancies, whether they had experienced any problems, had sought medical attention and how that went. We also asked about their children's vaccinations and which child-related health services that are not available in their areas are important to them.

Giving birth

All but two women in our sample had given birth to one or more children (see table 2). Nine out of the seventeen women who had children – a slight majority – gave birth to all of their children in medical facilities: either in the clinic, in the hospital, or in both. Some opted to give birth in the health facility because it was safe, convenient and near where they lived, others because they had problems during their pregnancies. The woman from Lal wa Sarjangal district in Ghor said:

The first time I went to the midwife here, [but] she could not understand my problem. I was suffering from high blood pressure during my pregnancy and I also had mild bleeding. She prescribed some wrong medicine that intensified my problem. After that, I went to the clinic in the district centre and they treated the issue. However, since [the intervention] was very late, I had to go through premature labour and surgery to save my child. I am a teacher and my husband is a teacher too. We struggled to pay for the transport, the costs, the medicines and everything else. I believe the whole surgical procedure could have been avoided if I'd been diagnosed correctly and received the right treatment.

The woman from Arghandab district in Kandahar said her doctor had advised her to deliver her babies at the hospital:

All my children were born at the regional hospital in Kandahar city. During my first pregnancy, I went to the clinic in our area. When the doctors checked me, they told me to go to the regional hospital because they said I needed a lot of attention and most probably surgery during the delivery. In that case, they said, I might need blood [a transfusion]. So I went to the regional hospital and, thank God, because of the keen attention of the doctors, surgery wasn't needed and I gave birth to my first child. Since then, the doctor has told me to be careful and not to give birth at home at any time and to try to present myself at the hospital for every delivery.

Four of the seventeen women had given birth to all their children at home. The woman from Jawzjan, who had given birth to nine children at home, said:

We had a daya [informal midwife] in our village, Daya Bibi, who is an experienced woman who can help women in delivery. She wasn't linked to any hospital or anywhere else and was the only one in the village. She died about two and half years ago. Now I myself am a daya, helping women in delivery, if they don't go to hospital.

Similarly, the woman from Balkh, who had given birth to seven children at home, said:

All my children were born at home. I didn't go to any clinic or hospital during my deliveries. No doctor or midwife came to help. My mother is a daya. She helped me during all my deliveries. She is an experienced daya.

Four other women from our sample gave birth to some children at home and some at the clinic or hospital. For example, the woman from Emam Saheb district in Kunduz province gave birth to her first two children in the Kunduz city hospital and to the other three at home:

I was young and the health facilities in our area at that time were not good [so I went to the Kunduz hospital]. My other children were born at home, but with a midwife present.

The woman from Du Laina district in Ghor province delivered most of her children at home, except in the case of her twins, where she was referred to the clinic following a fall. Unfortunately, she lost her twins shortly after the delivery:

When I was pregnant, I went to the clinic [in Du Laina district centre], but my problem wasn't solved [there]. I was pregnant with twins. I had fallen on the ground and the babies had been displaced. They referred me to the clinic in the centre [Chaghcharan] where I was operated on. Some women give birth in the clinic and others who have problems are referred there. I managed to give birth to both my babies, but they died some days after childbirth... I now have three sons and one daughter. I gave birth to all of them [the living children] at home. I only gave birth to the twins in the clinic, but they didn't survive beyond a few days. I was pregnant last year too, but my baby was still born. The dayas couldn't do anything about it. The clinic wasn't near and we would have had to travel far. I wasn't able to seek any [medical] aid and advice.

The women's experiences show that poverty and remoteness often harm the chances of having a safe pregnancies, as seen in the example given by the woman from Du Laina district. They also show that many women proactively seek advice and services when needed, if they are available, accessible and affordable.

[IMG | SOURCE: <https://www.afghanistan-analysts.org/en/wp-content/uploads/sites/2/2021/06/Picture-2.gif>]

Table 2: Where did you give birth to your children? Credit: AAN, 2021.

Vaccinations and child healthcare

We also wanted to find out from the 17 women with children how they felt about the child healthcare available to them. Sixteen said that all their children had been vaccinated. Only one woman, from Farkhar district in Takhar, said that some, but not all of her children had been vaccinated (see the table 3).

[IMG | SOURCE: <https://www.afghanistan-analysts.org/en/wp-content/uploads/sites/2/2021/06/Picture-3-2.gif>]

Table 3: How many children have you vaccinated? Credit: AAN, 2021.

All 17 women said their children had been medically examined after their births, either in the hospital or clinic where they were born, or subsequently when they took children to a clinic for a check-up after the birth. Some said they received food supplements for their children from the clinic. These packages, said our interviewees, are usually given to malnourished children and mothers. The woman from Dehdadi district in Balkh province had received such help: “My sons are twins. When they were born, I didn’t have enough milk to feed them and the clinic gave me milk for them.”

Other women who come from remote and poor areas of the country, like the woman from Du Laina district in Ghor province, had not received any additional aid from the health services. She said:

We haven’t received any food packages for children. Whenever I approached the clinic, whether because I wasn’t well, or my children weren’t well, we haven’t received any food aid. [Also] all the costs are on us, including accommodation for one night or more, this is whether you have money or not. They may give you a saline IV or some other injection, [but] all the rest you have to buy and pay for. In the [provincial] centre [Chaghcharan], the clinic gave me food to eat while I was hospitalised and operated on, but not to my paiwaz [the person accompanying the patient as a carer, in this case, her husband]. I wasn’t able to eat myself, so I gave my food to my paiwaz.

Most of our interviewees said the reason they or their children had not received any assistance from the clinic was because their children were born “healthy and strong.”

Most women, when asked which child-related health services that are not available in their areas, but which are important to them, said they would like to see better equipment (for example an ultrasound machine), (more) food assistance, more timely advice and doctors who are specialised in children’s health. The woman from Sarhowza district in Paktika province, for instance, said:

The first important thing is that mothers should receive advice from doctors on how to take care of their children. The special kits ^[9]*According to our interviewee the special kits given to the mothers include: a soup, a couple of pieces of fabric to clean the newborn; a set of plastic gloves and a scissors ... Continue reading that are provided for children [no further detail given] should be given to the women who need them. Right now, such kits are given to the midwives or nurses. The doctors share the kits out between themselves, but the real women or mothers who need them are deprived of them. I think the women should also be instructed in how to feed their children. The [formula] milk that is supposed to be distributed to the women in hospitals should also be given to the women who need it.*

It is striking how high the number of women in the sample was who had sought and received professional assistance when giving birth and who had their children vaccinated. This is a further indication of how far the mother and child healthcare has improved. At the same time, there are still many problems with maternal and children health, as shown by the interviews. While most women sought professional advice and care during their pregnancies, a number did not, sometimes with bad consequences. This may be because of the lack of adequate healthcare services in their area, traditional views held by their family and in-laws, or insecurity.

Conclusion

Discussions on access to healthcare in Afghanistan tend to focus largely on restrictions caused by insecurity, with the ongoing conflict often cited as the main reason limiting access. The information gathered in this research suggests that although violence is one, it is by far not the only reason for the lack of access to healthcare for rural women. Our small, but diverse, sample of rural women were well aware of problems facing them and spoke about poverty, insecurity, conservative traditions and inadequate health facilities as blocking their access to healthcare.

More than half the women in our sample spoke about either security or traditions, or both issues in the same breath, as the most important factor preventing them getting the healthcare they needed.

More than half of our sample also describe having to travel by car or on the back of a motorbike, walk a long way or use a combination of these means of transport, to reach the nearest health facility. One third of our sample singled out transport-related problems, such as the cost, the unavailability of transport and insecure roads, as key impediments to accessing the healthcare they needed. With more than half of the Afghan population now living below the poverty line, it does not come as surprise that healthcare remains out of reach for many Afghan women, even though health services are supposed to be free. Many of the women in our sample cannot afford to get to the nearest clinic, let alone pay the costs to travel to a city for more specialist treatment. Others described the additional costs of seeking medical treatment, with corruption or the need to buy medicines in the market adding to the burden of healthcare.

Almost half of the interviewees said the health facility in their area was not properly staffed. For some this meant that there were no female doctors, for others that there were no doctors or midwives at all and for some, that the staff were present, but inadequate. This confirms what we already reported in 2019 that despite, relatively high public expenditure on health by the standards of developing countries, healthcare provision across the country remains generally poor in rural

areas, whether controlled by the Taleban or the government. The number of nurses and midwives in Afghanistan remains far below the global average. As in many other countries, medical staff are unequally distributed across the country, with most clustering in the urban areas.

The women interviewed do have a clear idea of what they want to see improved in their health service. They want better equipment, educated doctors, nurses and midwives, better-quality medicine and facilities that are more modern and have greater bed capacity. Most importantly, they want to be treated respectfully and civilly. They also want to be treated without discrimination. Several interviewees showed a strong sense of social justice, complaining how corruption undermines an equitable and effective access to health. At the same time, these women's expressed the hope that the general economic situation in their areas might improve and health services become better, more equitable and less corrupt.

There are still many issues facing maternal and children's health, as shown by our sample. While most of the women sought professional advice and care during pregnancy and delivery, there were still a number of women who did not, sometimes with bad consequences. This may be because of a lack of adequate healthcare services in their area, traditional views held by their in-laws, or insecurity. It is interesting that all the women but one in our sample with children had got all of them vaccinated. This, however, may not be representative of the situation on the ground in the country. According to the 2020 AIHRC report, about one seventh of their sample had not vaccinated their children.

It should be noted that although Afghanistan's health service has improved, women's access to health in rural areas is still hindered by insecurity, poverty, conservative traditions, lack of adequate facilities and staff, and corruption. Some of the women interviewed have endured physical and mental suffering as a result of an ill-equipped and sometimes corrupt system that has failed them, both in terms of human and technical capacities and resources it has to offer.

Edited by Martine van Bijlert, Aunohita Mojumdar and Kate Clark

Annex: Questionnaire

Rural Women Access to Health Questionnaire

General Info about the Informant

District:

Interview Type: Phone or Face-to-Face (circle one)

Key Informant: (Please specify age; current occupation and profession if any)

General Instructions for Interviewing: Let the interviewee speak freely, when they are finished probe for details and specifics. Record any anecdote or story your key informants are willing to share with you. Show in your notes whether an answer was given freely or only after having been probed.

Opening Questions:

1. Can you tell us about the area in which you live? (How is the security, the economic situation, freedom of movement, services, presence of government?)
2. With whom do you live in this house? (how many family members, etc.)

General Introductory Questions about Health Services

1. Have you or anyone in your family wought medical treatment in the last year? Where did you/they go? (Were you treated locally? Why (not)?)
3. How far/close are these medical facilities from where you live? Who controls the area in which they are located?
4. Did you ever visit a mobile clinic (ie travelling medical staff that set up a temporary clinic, for instance in a mosque)? Do they come to your area? Do you know how often they come? Where in your area do they come to see people?
5. When you went to the clinic or mobile clinic, was it properly staffed? Could the staff help you with your problem?
6. Do you know if there are any female medical staff in your district? What kind of medical staff are they? Did you ever visit them? Could they help you with your problem?

Questions about Actual Access

1. Were there any problems that prevented you, or your family, getting the healthcare you needed? What were they? What happened?

(First ask the question without any further prompting. Only when you are finished ask:

2a. How important are the following issues in getting the healthcare you need:

1. security
2. traditions
3. practical issues that have to do with the medical facilities themselves

(First ask the question without prompting. Then you can probe to see if any of this is important: lack of (female) medical staff; frequency of the mobile clinic in your area; opening hours of the clinic).

- practical issues within your own home

(Ask the question without prompting, but this could be things like: no mahram, no permission, no car, not able to leave the children alone, finances etc.)

- any other problems.

3. In your opinion, do the problems you discussed impact men and women differently, or in the same way? Which ones are different?

4. When you go to the clinic, how do you travel and with whom do you go? How difficult (risky, expensive, long journey) it is for you to reach the clinic?

Quality of Health Services Questions

1. What do you think good health services look like?

2. What is important for good health services to be provided in your area?

3. Is there anything about the quality of the health services that you are not particularly happy/satisfied about that you would like to share? Is there anything that should be improved?

4. In your opinion, when you go to the clinic, do you get deserved attention from medical staff? Do you understand everything the doctor or nurse tells you? In your opinion, are you treated well and with respect?

5. After you went to the clinic, were you able to get the prescribed medication in your district? If not, where did you get it? (Or did you not get it at all / get something different instead)?

Maternal Health Questions

1. Are you a mother?

2. Where were your children born: at home, in the clinic, in the hospital, somewhere else?

3. Did you consult a doctor or other medical staff during your pregnancy? Was it for a problem or for a general check-up?

4. For the children that were born at home, was there any assistance from a nurse or midwife? Were they linked to the local clinic or hospital?

5. Were there any problems during the pregnancy or delivery? Were you able to solve them?

6. Which kind of child-related health services do/did you receive in your area?

(First ask the question without prompting. Then you can check:

1. Vaccination (for all children or for only a few?)
2. Nutrition advice (for all children or for only a few?)
3. Any other assistance? – please specify

5. Have you ever received food packages from the clinic? Why? What do you think about it?

6. What do you think is important about the child-related health services that you have (not) received in your area? Why?

7. Is there anything else you would like to say about the health services in your district?

References[+]

The institutional architecture of Afghanistan's rural health system is the Afghanistan's Basic Package of Health Services (BPHS), a national programme that was ratified and launched in 2003 by the Ministry of Public Health (MoPH) with the purpose of developing a standardized package of basic services that would form the core service delivery in all primary health care facilities. See a 2009 [MoPH background document here](#)

A [World Health Organisation's 2019 Afghanistan Country profile](#) found that "in 2018, a total of 3,135 health facilities were functional, which ensured access to almost 87 per cent of the population within two hours [walking] distance." Afghanistan's Ministry of Public Health (MoPH), reported in April 2018 that "60 per cent of people had access to health services [within] one hour walking distance to the nearest clinic" (quoted in this [European Asylum Support Office \(EASO\) report from August 2020](#)). The Afghanistan Independent Human Rights Commission (AIHRC) in its most recent report from May 2020 on access to health and education in 32 provinces (Uruzgan and Ghor were not included in the sample) found that 53.7 per cent of their interviewees lived more than two kilometres from health centres, while 42.8 per cent lived less than two kilometres from health centres (the average walking distance per hour is about four kilometres, varying with terrain, fitness and the health of the individual). A 2017 study by [Integrity Watch Afghanistan](#) (IWA) on the state of public healthcare in Afghanistan based on inspection of 184 public health centres of different size, including two provincial and seven district hospitals in eight provinces, found that 69 per cent of health facilities surveyed by them had not been found within two kilometres of the USAID-provided geospatial coordinates, because their geolocation had been inaccurately registered in the Afghan government documents.

2015 health data are often used as the baseline, because in that year Afghanistan launched its first-ever nationwide effort to gather comprehensive demographic and health information on its citizens. For more information about the Demographic and Health Survey see [here](#).

[The Lancet journal's editorial from 2020](#) on child and maternal health in Afghanistan said:

Afghanistan still has one of the highest rates of child stunting and is one of three countries where polio remains endemic [it is now two, Pakistan being the other]. Nutrition and childhood immunisation programmes must be protected. Afghanistan is still widely regarded as one of the most difficult countries in which to be a woman. Women and girls are vulnerable to discrimination and attention to female adolescent health and protection of reproductive health is key. Much of maternal and childhood morbidity and mortality are concentrated in poor and remote populations and in areas where many mothers have no education.

Tim Rapley, 'Interviews,' in *Qualitative Research Practice*, Seale C. et al. (eds) (Sage: London, 2007), 15-34.

In other words, our quantitative findings deduced from the research and analysis are not 'taken for granted truths'.

Denisa Kostovicova, *Seeking Justice in a Divided Region: Text Analysis of Regional Civil Society Deliberations in the Balkans* in *International Journal of Transitional Justice*, 0, 1-22, Oxford University press, 2016.

The word 'civility' derives from *civilis*, or "the state of being a citizen and hence good citizenship or orderly behaviour."

According to our interviewee the special kits given to the mothers include: a soup, a couple of pieces of fabric to clean the newborn; a set of plastic gloves and a scissors for cutting the umbilical chord.

References

Endnotes:

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ecoi.net summary:

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