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AFGHANISTAN PRIVATE SECTOR HEALTH SURVEY

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CONTENTS

ACKNOWLEDGEMENTS.....	i
ACRONYMS.....	v
INTRODUCTION.....	vii
I. THE 2008 AFGHANISTAN PRIVATE SECTOR HEALTH SURVEY.....	1
II. RESEARCH DESIGN AND SAMPLING.....	3
III. THE CONFIGURATION OF PRIVATE HEALTH CARE.....	7
IV. HOUSEHOLD PROFILE.....	31
V. HOUSEHOLD UTILIZATION OF PRIVATE AND PUBLIC PROVIDERS.....	45
VI. WOMEN'S AND CHILDREN'S HEALTH.....	65
VII. RECOMMENDATIONS.....	95

TABLES

Table III.1. Types of Public and Private Sector Health Providers Mentioned in Household Interviews, by Province.....	8
Table III. 2. Types of Private Health Providers Interviewed, by Province.....	9
Table III.3. Topics of Training Attended by Private Sector Providers (within the previous year) .	12
Table III.4. Availability of Specific Types of Health Care by Province.....	13
Table III.5. Availability of Multi-Service Menus Overall and for Central vs. Rural Districts.....	15
Table III.6. Availability of Service Menus by Province.....	15
Table III.7. Availability of Specific Types of Health Care by Provider Type.....	16
Table III.8. Demographics and Selected Socioeconomic Characteristics of Private Health Care Providers by Province.....	17
Table III.9. Provider Availability by Province:Days per Week and Hours per Day.....	19
Table III.10. Estimated Caseload (Household Visits in the Previous Week) by Provider Type and Mode of Practice.....	20
Table III.11. Estimated Caseload (Household Visits in the Previous Week) by Province and District.....	21
Table III.12. Sources of Startup Support for Private Health Care Providers.....	23
Table III.13. Sources of Support for Private Health Care Providers to Continue Providing Service Once Practice Is Established.....	24
Table III.14. The Outlook of Private Health Care Providers.....	25
Table III.15. Pro Bono Services to Needy Groups.....	27
Table III.16. Private Health Care Facilities: Overall and for Central vs. Rural Districts.....	28
Table IV.1. Household Interviews by Province and District.....	31
Table IV.2. Size of Households Surveyed*.....	32
Table IV.3. Average Household Size by Province and Type of District.....	32
Table IV.4. Ages of Household Members by Gender.....	33
Table IV.5. Average Age and Education of Head of Household by Province.....	34
Table IV.6. Average Educational Attainment of Household Members by Gender and Age Group	35
Table IV.7. Household Members Who Have Attended School by Age Group.....	36
Table IV.8. Primary Source of Household Income by Province.....	37
Table IV.9. Transportation Available to Households By Type of District.....	38
Table IV.10. Household Information Technology by District Type.....	39
Table IV.11. Household Possessions by District Type.....	40

Table IV.12. Distribution of Households by Wealth Quintile by Province and Type of District	40
Table IV. 13. Household Water Sources by Province and Type of District	42
Table IV. 14. Main Household Toilet Facility by Province (Percent)	43
Table V.1. Household Health Visits Since Nawrooz by Type of Problem and Type of District	45
Table V.2. Household Visits to Public and Private Providers by Reason for Visit and Type of District	47
Table V.3. Type of Provider Visits by Length of Time Household Has Lived in Village	49
Table V.4. Household Visits to Private and Public Health Care Providers Since Nawrooz	50
Table V.5. Household Visits to Public and Private Health Care Providers by Province and Type of District	50
Table V.6. Locations of Private and Public Health Care Providers by Province	52
Table V.7. Proportions of Visits to Public and Private Providers within Own Village	53
Table V.8. Travel Time to Health Provider and Mode of Transportation Used	54
Table V.9. Details of Household Visits to Specific Provider Types	55
Table V.10. Health Needs Addressed in Visits to Private and Public Providers	56
Table V.11. Services Received from Private and Public Health Care Providers	57
Table V.12. Cost of Health Visit by Type of Provider	58
Table V.13. Average Cost of Health Care Visit by Provider Type	59
Table V.14. Type of Provider and Average Cost of Visit by Health Need Addressed	60
Table V.15. Household Visits to Private and Public Health Care Providers by Wealth	61
Table V.16. Rating of Service Quality for Visits to Private and Public Providers	62
Table V.17. Rating of Outcomes from Visits to Private and Public Providers	63
Table VI.1. Demographics of Female Respondents	66
Table VI.2. Pregnancy Status of Respondents by Age Group	67
Table VI.3. Household Antenatal Care Sought for Pregnancy Within the Previous Two Years, by Province and Type of District	67
Table VI.4. Reasons for Not Seeking Antenatal Care By Province and Type of District	68
Table VI. 5. Provider Used for Most Recent Pregnancy By Province	69
Table IV.6. Patterns of Antenatal Care Visits	70
Table VI.7. Type of Information Provided During Antenatal Visits By Private and Public Providers	71
Table VI.8. Type of Information Presented During Antenatal Visits for Women Who Sought Care Early or Late	72
Table VI.9. Degree of Difficulty in Getting Help with Pregnancy Problems	72
Table VI.10. Difficulties Getting Help for Pregnancy-Related Problems by Type of District	73
Table VI.11. Crucial Postnatal Services Received	74
Table VI.12. Women's Assessment of Private and Public Providers in the Community	75
Table VI.13. Immunization Status of Children Aged 1-2	76
Table IV.14. Most Serious Children's Health Problems as Reported by Female Respondents, by District Type	78
Table IV.15. Difficulties Getting Help for Serious Children's Health Problems By Type of District	79
Table VI.16. Visits to Private Providers for Urgent Child Health Problems, by Type of District	79
Table VI.17. Difficulties in Getting Help for Children's Health Problems from Private and Public Providers	80
Table VI.18. Perspectives on Improving Health Care for Women	81

ACRONYMS

AHS	Afghanistan Health Survey
APSHS	Afghanistan Private Sector Health Survey
BHC	Basic health clinic
BPHS	Basic package of health services
CHC	Community health clinic
CHW	Community health worker
EPHS	Essential package of hospital services
FP	Family planning
MCH	Maternal and child health
MoPH	Ministry of Public Health
MRRD	Ministry of Rehabilitation and Rural Development
NGO	Nongovernmental organization
NRVA	National Rural Vulnerability Assessment
TB	Tuberculosis

INTRODUCTION

COUNTRY CONTEXT

The health system in Afghanistan has improved dramatically since 2002/1381 with the creation and implementation of the basic package of health services (BPHS) and later the essential package of hospital services (EPHS).¹ The Ministry of Public Health (MoPH) acts as a steward for these programs, contracting most services out to nongovernmental organizations (NGOs) to provide primary through tertiary health care services throughout the country. Introduction of the BPHS and the EPHS created a cohesion in the public health system that had previously been absent.²

In 2006 the Afghanistan Health Survey (AHS 2006) became the first survey after the BPHS was implemented to estimate priority indicators for health. It estimated an infant mortality rate of 129/1,000 and an under-5 mortality rate of 194/1,000—significant progress compared to the rates before the BPHS was put in place. However, health status in Afghanistan is still among the worst in the world. For instance, less than a third of pregnant women received antenatal care, only 19% had a delivery assisted by a skilled birth attendant, and only 15% delivered in a health facility.³ This is mainly because the vast majority of health care workers are male, and stringent cultural practices prevent many women from seeing male health care providers. Thus, the MoPH has placed substantial importance on training and placing female health care providers at every public health facility, from community health workers (CHW) at health posts in villages to midwives in health centers to female medical doctors for tertiary care. The number of female staff has doubled since 2004 because the BPHS not only offers incentives for hiring female health care workers, it has made that a performance indicator.⁴

Regulation of the Private Sector

The Afghanistan Constitution of 2004 affirms in Article 52 that “the state is obliged to provide free means of preventive health care and medical treatment, and proper health facilities to all citizens of Afghanistan in accordance with the law” and “the state encourages and protects the establishment and expansion of private medical services and health centers in accordance with law.” The mission of the MoPH is “to improve the health of the people of Afghanistan through provision of quality health services and promotion of healthy life styles in an equitable and sustainable manner.” Its goal is to develop the health sector to improve the health of the people of Afghanistan, especially women and children... [and] strengthen the Ministry of Public Health’s ability to create a favorable policy environment and to manage and deliver a wide array of health services within communities, at all levels of the health system throughout the country.

The National Health Policy states that private health care facilities are a vital part of the national health care system (Article 10).⁵

These laws call for a robust health care system and encourage the development of the private sector as an integral part of the system. The MoPH must build constructive relationships with the

¹ MoPH, Basic Package of Health Services for Afghanistan, 2005/1384.

² MoPH, National Health Policy 2005–2009 and National Health Strategy 2005–2006: A Policy to Accelerate Implementation. 2005/1384.

³ MoPH, Afghanistan Health Survey, 2006/1385 (Johns Hopkins University).

⁴ MoPH, Human Resources for Health Policy 2008–2012 (Draft), General Directorate for Human Resources, August 6, 2008/1387.

⁵ MoPH, Public Health Strategy for the Afghanistan National Development Strategy, March 2007/1386.

private sector to ensure compliance with all laws. Health care needs in Afghanistan are immense; to resolve them the private sector must be considered a partner in the health system. Even though currently only 13 districts out of 359 do not contain a BPHS facility, demand far exceeds the resources, so most people seek a private provider for health care. The situation is even more dire for women given the severe shortage of female providers, especially doctors and nurses. Nationally, although with considerable variations between provinces, the percentage of female health providers is 24% and of nurses it is 15%. A recent analysis of the health care workforce in Afghanistan concluded that the need for female health workers is staggering. Currently, the demand for female physicians is more than triple the number available, for community midwives it is four times more, and for female nurses almost seven times more.⁶

Thus the private sector must be considered a partner of the public health system in Afghanistan if improvements in access, coverage, and workforce are to be achieved. However, it is fragmented and poorly regulated. There are no regulatory controls for checking the quality of pharmaceutical products or whether health care providers are properly trained. There is no accreditation system for private medical providers; only a Midwifery Education Accreditation Board exists. The MoPH has begun a process to ensure that all health professionals are trained by programs that meet educational and technical standards for their field and is establishing semi-autonomous accreditation boards for medicine, nursing, pharmacy, and other health professions. The goal of accreditation is to ensure that both providers and facilities at all levels provide high-quality care to patients and set up controls against negligence.

The MoPH has appointed a quality assurance committee to set technical standards for improving delivery of health services at all levels, but it also needs to draft standards of care for all facilities, public and private, and train its staff to enforce them. The ministry needs Parliament to create a legal enabling environment so it can not only carry out a mandate to regulate the private sector but also work in unison with the sector to ensure comprehensive public health. Thus, it is crucial to have a legal structure in place to enforce health standards and regulations throughout the country and clarify private sector participation in the health system.

The 2007 Public Health Strategy states that it is vital to bring private providers into the health system and that the MoPH must regulate private facilities. Accreditation is indispensable to ensure that health care providers are trained to satisfactory standards; that individuals upon graduation meet minimum performance standards and are periodically reaccredited; and that health care facilities meet specific standards of quality and availability of resources. A priority of the MoPH is to get the Medical Council Act enacted, establish the Secretariat, and specify its functions, such as maintaining a national register for medical providers. The Medical Council Act will protect the public by reducing the risk of harm from health care professionals and clinical facilities. Now that there is a Midwifery Council, a Medical Council must be given priority.⁷

Meanwhile, although private providers are not accredited, a sign of progress in regulating the private sector is a training program managed by the USAID-funded project Compri-A. This program aims to provide standard training to pharmacists—poorly qualified individuals, even children, work in pharmacies throughout the country. When they complete training, the pharmacists are awarded a certificate of quality to display in their pharmacies; 500 have already been trained.

The MoPH has already taken steps to collaborate with the private sector through joint public and private sector workshops that assessed the policy environment for private providers. These workshops served to strengthen the relationship and give a voice to the private sector. As a result,

⁶ King, Geoff, Afghanistan Health Workforce, 2008/1387.

⁷ MoPH, Public Health Strategy for the Afghanistan National Development Strategy, March 2007/1386.

at the end of 2006/1386 the Public-Private Partnership Task Force was created, bringing together a variety of stakeholders from both sectors. The task force successfully lobbied the MoPH to recognize the private sector as an ally that significantly helps to advance national public health goals. The MoPH is now in the final stages of consolidating several private sector offices scattered throughout the ministry into a Private Sector Directorate within the General Directorate for Policy and Planning.

The main purpose of a unified Private Sector Directorate is to take the lead in drawing up policies, regulations, and standards to guide the operation and expansion of private sector services. Creating a consolidated office with direct authority will help strengthen the health sector by bringing the private sector into the public realm. This enabling policy will give the private sector the necessary tools to better estimate returns on the investments it must make to comply with regulatory framework and increase the quality and coverage of health services. It will allow the private sector to provide better health services and manufacture financially sustainable health products.⁸ The MoPH will benefit by regulating the private sector as it takes advantage of its comparative advantage in organizing and managing the efficient production of health products and certain services while concentrating its own efforts in areas where the private sector is weak, such as delivering health services to the poor and marginalized.

The Department of Curative and Diagnostic Services in the MoPH has created a workgroup to develop rules and regulations covering private clinical establishments in Afghanistan. The intent was to establish minimum standards for clinical facilities in the private sector and provide for high-quality health care for the public. The regulations are governed by the Private Clinical Establishment Act, whose main objectives are

1. To create an investor-friendly atmosphere to attract private involvement in clinical establishments
2. To draft regulations to ensure patient safety and to monitor and control the service delivery of all current and future private clinical establishments in Afghanistan, such as hospitals, nursing homes, polyclinics, private clinics (medical and dental), laboratories, and radio-imaging clinics
3. To ensure that such institutions meet their social responsibility to serve a percentage of the poor population

This act establishes clear regulations for registering providers and clinical facilities, guiding bylaws for the operation of clinical facilities, and guidance and standards on qualifications for health care providers and the resources required for a clinical facility. The act declares that “no person shall establish or maintain any clinical establishment unless s/he holds a valid certificate of registration.”⁹

⁸ MoPH, National Policy for the Private Sector’s Health Sub-Sector, 2008–2012 (Draft), General Directorate of Policy and Planning, June 2008/1387.

⁹ MoPH, Afghanistan Private Clinical Establishments Control and Regulation Act (DRAFT BILL), Department of Curative & Diagnostic Services, 2008/1387.

I. THE 2008 AFGHANISTAN PRIVATE SECTOR HEALTH SURVEY

The 2008 Afghanistan Private Sector Health Survey (APSHS 2008) was designed to explore issues that arose from the AHS 2006 related to the role of the private sector in Afghanistan's health service delivery system. The intent was for the findings to form the basis for strategic planning to enhance and strengthen the system. The main issues studied were types of private providers in rural communities; patterns of household utilization of private and public providers; and qualifications, service capacity, economic context, and outlook of private providers.

The rationale for the study emerged from the AHS 2006 findings that 57% of persons seeking health care went first to a private provider, 67% went to private providers for their second visit, and 83% went to private providers for their third visit.¹⁰ A related concern was that publicly funded health care providers might in fact be charging persons seeking health care for access to services that were to be provided at no cost.

The AHS 2006 study also raised concerns about cost as a barrier to seeking health care. Almost a quarter (23.5%) of respondents said they could not afford the cost of treatment and another 11.1% said they could not afford the cost of transportation to services. While few AHS 2006 respondents raised issues of service quality (only 2.6% listed low quality of service as a reason for not seeking care), a clear-cut concern was the quality of service provided by a partially informal private health care subsystem.

ADDITIONAL CONSIDERATIONS

Given the reality of health care in Afghanistan, which relies on a mix of public and private sector individuals and facilities for health promotion and response to a broad range of health needs, a central question in APSHS 2008 was the dynamics of health care system utilization: Which households use which providers? For what sorts of problems? And for what reasons? Given the realities of contemporary rural Afghanistan, it was also essential to examine geographical variations in the configuration of health care service and in household utilization of services.

An additional research priority has, understandably, been the structure of the private sector health care system (although it might more accurately be characterized as “domain,” since no one considers it systematic). From a practical perspective, this realm of inquiry inevitably entailed attention in the study to the business environment in which private providers work—financing, revenue, fees, and other sources of support, and access to capital.¹¹ To effectively support MoPH strategic planning, it is of course clear that one aspect of the inquiry would need to be review of how private providers have been trained and their training needs.

Given the dramatic disparities in resources, population density, and institutional functioning between urban and rural areas of Afghanistan, it was decided that the study should focus on rural areas.

¹⁰ AHS 2006, Table 6.4.

¹¹ Memo from Tekabe Belay, Senior Economist (Health), World Bank, October 6, 2008.

II. RESEARCH DESIGN AND SAMPLING¹²

The study was designed to consist of linked samples of households and providers to ensure that the research would adequately represent the actual configuration of the private health care providers used by households sampled in the rural villages in the study. Thus, the sample of providers was generated in the course of interviews with households about the local providers they went to.

A random sample of households was surveyed in each of 28 rural villages, ranging in size from 50 to 250 households.¹³ Analysis of the demographic and socioeconomic characteristics of the households surveyed indicates that the 776 households where interviews were completed were representative of households in rural Afghanistan. Interviews were also completed with 152 private providers identified by these households. This sample is generally representative of private providers in rural areas but may slightly under-represent nonprofessional care providers, such as mullahs and traditional birth attendants.

The household survey included separate, concurrent interviews with the head of the household and a woman in the household. The head of household interview focused on securing detailed information on household members and the conditions in which they live, and an overview of the household's health care system utilization, health care access issues, and experiences in encounters with private and public sector providers. The interviews with women focused on maternal and child health (MCH).

PROVINCES SURVEYED

The research priority was to represent the diversity of local health care systems in different types of area in rural Afghanistan, since the study schedule and security did not permit multistage random sampling of provinces, districts, villages, and households. Consequently, five provinces were identified to assure regional diversity for the study sample: Baghlan as representative of the northern region, Badghis in the northwestern region, Nimroz in the southern region, Laghman in the eastern region, and Loghar in the central region.

DISTRICTS SURVEYED

APSHS was conducted in 14 rural districts within the five provinces.¹⁴ Two strata of districts were created: Denser population districts consist of the central districts in which provincial capitals are located but not the capital city itself. These central districts typically have population densities that are higher than in outlying rural districts but lower than in the five areas generally considered to represent urban Afghanistan (Kabul, Kandahar, Jalalabad, Mazar-i-Sharif, and Herat).

All other districts in these provinces were considered to represent a rural district stratum, where access to health care is generally more difficult and coverage by health care providers is lower. However, due to operational requirements for successful completion of data collection within just

¹² A more detailed discussion of the sample design is available in the methodological appendix.

¹³ Population size was estimated based on MPH data.

¹⁴ The survey was initiated in 15 districts but completed in only 14 due to receipt of a "night letter" at BRAC's office in the Central District of Puli Allam threatening the survey team and the later murder of IRC workers in the district. Thus the Loghar sample has no central district data but does have data from two rural districts. Full survey implementation was not feasible even in the other two districts as it was considered too dangerous for female interviewers to participate.

three weeks, extremely remote districts were excluded if security was considered inadequate to allow survey staff to safely and reliably collect information following the procedures in the study design.

VILLAGES SURVEYED

In each district two villages were randomly selected for surveying. To be in the sample, villages had to be within six hours roundtrip travel time from the provincial capital, because operationally it was not feasible to arrange lodging in the villages for the survey teams.¹⁵ In the central district villages were chosen randomly. In the rural districts nonadjacent villages were chosen randomly from MoPH data on rural villages by estimated population, which was used to generate estimates of number of households in each village. The minimum size for a village to be selected was an estimated 50 households, so the sampling ratio was no higher than 56% taking into account an allocation of 28 interviews per village.¹⁶ In the final sample, the villages ranged in size from 50 to 247 households with an average of 117 households.

Although the initial sampling design required field staff to identify whether the randomly selected districts were secure or not, the interviewers' experience was that some districts that had been considered secure were not in fact uniformly so. This required replacement of some randomly selected villages when it was discovered that they were controlled by antigovernment groups and interviewers would not be welcome.¹⁷

HOUSEHOLDS SURVEYED

Given the complex social relations in rural Afghan villages, which are not always homogeneous in ethnicity, language, or tribal/clan affiliation, the research design called for a relatively large sample of households in each village—28 in all; this resulted in sampling fractions ranging from 1:2 to 1:9. This provision assured that the household sample would represent the behavior of diverse local households in seeking health care and elicit diverse opinions about local private sector health care providers.

To further assure that the village-level household sample would represent a diversity of health-care-seeking behavior, village team leaders mapped villages into four quadrants with two

¹⁵ Rural villages in Afghanistan do not have commercial lodging, so lodging the surveyors who were based in provincial capitals would have had to be negotiated in individual homes; this was not feasible, particularly since the survey teams included women. It is not clear exactly how this criterion for including a village in the sample affects the representativeness of the survey—since data are not available for all villages in each of the districts and provinces in the study. However, it is likely that most of the very remote rural villages fell below the minimum size criterion.

¹⁶ The village minimum size requirement resulted in exclusion from the sampling frame of 16% of the population of Badghis, 18% in Baghlan, 11% of the population of Laghman, and 20% of the population of Loghar (based on MoPH data on estimated population). A tabulation of Nimroz village sizes to assess the impact of these criteria was not available. The excluded villages and households are the most remote ones in the country, so it can be assumed that for them access to health care is more difficult than for the study households—although the study households are very similar to those surveyed in NRVA 2005 (which may have a similar bias toward underrepresentation of very small remote rural hamlets).

¹⁷ Village security issues arose in all the study provinces except Baghlan) resulting in replacement of 7 villages of the 30 initially selected—in 5 of the 10 districts in the sample. We do not believe that the replacements (which followed established replacement procedures and were random) significantly affected the representativeness of the village sample with respect to analyses that assume that the village sample represents the district—except, of course, that antigovernment villages were excluded. Noncompletion of interviews in the two sampled villages of Puli Allam in Loghar was due to what was essentially deterioration in security in the province.

“distance rings”—more or less a bulls-eye categorization of households in the village—and household quotas were set to assure that the 28 households interviewed would be chosen from eight different subareas of each village (i.e., an inner and outer ring in each of the four quadrants).

Interview teams consisted of male-female pairs of interviewers so that it would be possible to talk to a woman in the household as well as the male head of household. Heads of household aged 18–65 who had given informed consent were interviewed. Of 787 households initially contacted, 778 consented—a refusal rate of 1.2%.

While the heads of household were being interviewed, female interviewers conducted a supplemental interview with the spouse or the primary caretaker for children about the health-care-seeking behavior of the women in the household. The procedure was to sample the first spouse of child-bearing age, and if she was not willing to be interviewed, ask if there was another woman available who would be. In the 778 households covered, 667 interviews with women were completed, i.e., in 86% of all households and in 100% of the households surveyed outside Loghar, where security conditions precluded participation of female interviewers.

PRIVATE PROVIDERS SURVEYED

Study specifications were that providers identified by local households as ones they had visited since Nawrooz, the beginning of the Afghan year in which the survey was conducted, would be interviewed. All private providers identified at the village level who provided health care services within the 15 sample districts were to be interviewed. There were some practical constraints on implementing this sample design. Some providers were not available (e.g., were in Kabul) or were unwilling to be interviewed. Moreover, interviewing the very high proportion of providers who were not located within the villages proved challenging operationally.¹⁸ Ultimately, 152 private providers were interviewed.¹⁹

STUDY IMPLEMENTATION

Planning for the current study was initiated in May 2008. Research design, sampling strategy, and instrument development took place in June. The planning was careful to assure comparability with two important previous studies—the 2005 National Rural Vulnerability Assessment (NRVA), a multistakeholder collaborative survey conducted by the Ministry of Rehabilitation and Rural Development (MRRD) as the basis for planning for rural initiatives, and AHS 2006, which provides a detailed profile of rural health needs and a broad analytic framework for examining health system utilization, particularly for MCH.

Due to an extremely demanding schedule, particularly the requirement to complete data collection by the end of August, translation of survey instruments and final revisions of instrumentation took place in mid-July concurrently with training of provincial survey managers. The survey instruments and procedures were very briefly piloted and final revisions were made before village team leaders were trained in the last week of July 2008, and the survey was begun in the second week of August. Data collection ended August 28, 2008.

¹⁸ In some cases it was not possible to determine whether a provider mentioned in an interview was in fact located within the district where the household was located. There were also some unanticipated discoveries—the most notable being the heavy reliance of Baluchi in Nimroz on Iranian health care providers because they can cross the national border relatively unimpeded.

¹⁹ Seven interviews with “private providers” (4% of those conducted) were excluded from the analysis because the data analysts concluded that these respondents were not in fact private but were actually public employees, such as CHWs, subcenter personnel, or district hospital staff. It should, however, be recognized that the dividing lines between the public and private sector (as detailed later) are fuzzy. It was ultimately determined that 14% of bona fide private providers also work in the public sector.

Deteriorating security in Afghanistan caused substantial problems for the study—in designing the sample, implementing the sampling design, collecting data, and transporting it from rural areas to Kabul. Although design specifications required that the sampled districts be deemed “secure,” initial field reconnaissance (consisting of consultation with local provincial staff, local village shuras, and community leaders) revealed that some of the villages randomly selected in apparently secure districts were not safe. These were replaced with villages randomly drawn from the CSO sampling list initially used. As noted, survey implementation in Loghar province was ultimately curtailed due to receipt of a “night letter” threatening the survey team, followed with the murder of a team of international NGO personnel on the road to Kabul the next week.

THE STRUCTURE OF THE REPORT

The current report is organized into six sections. The first describes the configuration of the private health care system and the context in which it operates, the private providers themselves, the services they offer, their previous training and training needs, and the infrastructure. This section also examines the economic and social context in which private providers work and their outlook for the future.

The composition of households is a crucial factor in understanding the demands placed on the health care system for services. The second section of this report describes the household population surveyed to provide perspective on the individuals, households, and communities of rural Afghanistan who use, and support, private health service providers.

The third section describes patterns of household health care system utilization. It begins with examination of general household health needs and patterns of behavior in seeking health care. In the fourth section, the analysis examines in some depth special issues related to MCH within the household and efforts to secure medical assistance and health care to respond to these needs.

The fifth section summarizes the findings of the study and their implications for strategic planning and policy development. The final section presents recommendations related to strategic considerations and practical next steps in working to strengthen the private sector component of the health care service delivery system.

III. THE CONFIGURATION OF PRIVATE HEALTH CARE

As in all societies, the health care system in rural Afghanistan has a distinctive mix of providers—some in the public sector, some in the private sector— with varying degrees of training, and different specializations in terms of services provided and clientele. Although this Afghanistan Private Sector Health Survey (APSHS 2008) focused on the private sector, it did generate some information on utilization of public health facilities in the rural districts surveyed.

All the communities surveyed were rural within the taxonomy used in AHS 2006 and other surveys. However, the study sampling design distinguished between central and rural districts. Central districts are those where the provincial capital is located, though the sampling was designed to exclude the provincial capital itself from the central sample; instead, it randomly select two communities from the central district that were not themselves the capital although they might be near it.²⁰ The villages surveyed ranged in size (based on MoPH estimates) from 50 to 250 households; consequently, even the sampled communities in the central districts, although typically somewhat larger than those in rural districts, were by most standards too small to be considered “urban.”²¹

Health care system dynamics can be understood as stemming from the distinctive health care needs of a population, the provider mix and resources in any service catchment area, and the patterns of referrals that govern movement of individuals through the system. System configuration and patterns of individual and household utilization obviously interact dynamically and (like all markets) are in constant flux, so it is impossible to separate them.²² This report begins by looking at the health care system and then went on to describe rural households, their efforts to secure health care, and the outcomes. This is not to imply that “the system” is a higher priority than the service population—simply that understanding the configuration and resources available in the system is a useful basis for understanding health care-seeking behavior.

Provider Diversity

APSHS 2008 generated basic data on household utilization of different public and private health care providers by asking the head of the household at the start of each interview to list any provider anyone in the household had visited during the previous five months, since the start of the year in which they were interviewed.²³ However, given time and security constraints in August 2008, it was not feasible to interview all the providers identified. Therefore, the study yields a household-based overview of health care system diversity (public and private providers) and a more detailed profile of providers based on interviews with a sample of the universe listed

²⁰ Provincial capitals are often themselves quite small.

²¹ For example, in Nimroz, the four villages surveyed in rural districts ranged from 50-61 households while the two villages surveyed in the central district of Zaranj, ranged in size from 77 to [please complete]

²² As the report discusses later, the social dynamics and economic context of the rural villages in Afghanistan in which this survey was conducted are different in significant ways from standard market economies. In particular, there is more of an interplay between social, civic, and financial capital, which is an important factor in the functioning of the health care system and in understanding the fuzzy boundaries between “private” and “public”—both of which have civic dimensions.

²³ This is since the start of the solar year, beginning at the spring equinox, Nawrooz 1387, i.e., March 21, 2008.

by households.²⁴ Household interviews suggest that private providers are more extensively utilized than public health care resources, as was found in a recent study by Johns Hopkins University for the MoPH.

Table III.1 tabulates the number of households identifying different types of providers as ones members of the household had visited. This is essentially a weighted snapshot of the types of providers in the system that reflects the share of household visits of each provider (and consequently each distinct type of provider) in the household catchment area. Like the AHS 2006, the tabulation shows more reliance on private than on public providers, but the pattern is even more pronounced. As in the 2006 study, the most prevalent type of health care provider is physicians in private practice.

TABLE III.1. TYPES OF PUBLIC AND PRIVATE SECTOR HEALTH PROVIDERS MENTIONED IN HOUSEHOLD INTERVIEWS, BY PROVINCE						
Provider Type	# Times Mentioned (%)	Proportion Providers Mentioned by Province				
	Overall	Badghis	Baghlan	Laghman	Loghar	Nimroz
	1,871	547	304	423	263	333
Private Sector	1,395 (75%)	474 (87%)	194 (64%)	309 (73%)	214 (81%)	204 (61%)
Physicians—solo practice	1,240 (66%)	391 (76%)	174 (57%)	297 (96%)	208 (79%)	170 (51%)
Private health clinics and hospitals ²⁵	25 (1%)	2 (<1%)	2 (<1%)	2 (<1%)	2 (<1%)	17 (5%)
Physicians—practice in pharmacy	31 (2%)	16 (3%)	13 (4%)	1 (<1%)	1 (<1%)	---
Pharmacies (without physician on staff)	22 (1%)	10 (2%)	2 (<1%)	1 (<1%)	1 (<1%)	8 (2%)
Traditional birth attendants and midwives	14 (1%)	5 (1%)	1 (<1%)	1 (<1%)	2 (<1%)	5 (1%)
Nurses	6 (<1%)	1 (<1%)	---	5 (2%)	---	---
Traditional healers (including mullahs)	57 (3%)	49 (9%)	2 (<1%)	2 (<1%)	---	4 (1%)
Public Sector	476 (25%)	73 (13%)	111 (36%)	114 (27%)	49 (19%)	129 (39%)
District hospital	123 (6%)	26 (5%)	11 (3%)	34 (8%)	23 (9%)	29 (9%)
Comprehensive health center or subcenter	161 (9%)	37 (7%)	62 (20%)	36 (9%)	18 (7%)	8 (2%)

²⁴ A cumulative total of 1,881 providers of one sort or another were listed as a source of health care for a household family member (provider type was unclear for 10). The individual household lists correspond to about 450 unique providers. From this list, 163 private providers were interviewed during the survey.

²⁵ The tabulation of private clinics and hospitals for Nimroz is higher than elsewhere because it includes visits to Iranian providers. Apparently Baluchis have little difficulty crossing the border for health care.

TABLE III.1. TYPES OF PUBLIC AND PRIVATE SECTOR HEALTH PROVIDERS MENTIONED IN HOUSEHOLD INTERVIEWS, BY PROVINCE

Provider Type	# Times Mentioned (%)	Proportion Providers Mentioned by Province				
		Overall	Badghis	Baghlan	Laghman	Loghar
Basic health center	185 (10%)	9 (2%)	35 (11%)	44 (10%)	8 (3%)	89 (27%)
Health post/CHW	7 (<1%)	1 (<1%)	3 (1%)	---	---	3 (1%)

*For private and public providers. The tabulation may include duplicate mentions of a provider (when several households identify the same provider.)

**The Loghar tabulation underrepresents midwives and traditional birth attendants because threats against the team precluded inclusion of female interviewers, and the survey was truncated in one of three sample districts for security reasons.

The province-to-province variations in provider mix are less pronounced than had been expected—physicians in solo practices were the predominant provider in every province except Baghlan and Nimroz where BHCs (31%) and CHCs (29%) made up about one-third of the providers mentioned. In contrast to urban centers like Kabul, pharmacies do not appear to be major providers in rural areas (see Appendix B), perhaps because they are not economically viable in such small communities.

PRIVATE SECTOR HEALTH CARE SYSTEM CONFIGURATION AND DIVERSITY

Tabulation of information from the survey of private providers offers an alternative perspective to the household-based view of private sector diversity, which is based on “size”/“importance” of each type of health care provider for local service delivery. This tabulation complements the perspective based on number of visits because it represents the sample of private providers for whom there is fairly detailed information. Table III.2 shows the private provider mix based on interviews with providers themselves.

Table III. 2. Types of Private Health Providers Interviewed, by Province							
Provider Type	#of Private Providers (%)	Number of Total by Province (%)					
		Overall	Badghis	Baghlan	Laghman	Loghar	Nimroz
PRIVATE PRACTICE ONLY		152	53	26	35	11	27
Physicians—solo practice	97 (64%)	15 (29%)	23 (88%)	34 (97%)	11 (100%)	14 (52%)	
Private health clinic or hospital	5 (3%)	---	1 (4%)	---	---	4 (15%)	
Physicians—practice in pharmacy	5 (3%)	4 (7%)	--	--	--	1 (4%)	
Pharmacies without a physician on staff	4 (2%)	1 (2%)	--	--	--	3 (11%)	
Midwives and traditional birth attendants	28 (17%)	23 (44%)	2 (8%)	--	--	3 (11%)	

Table III. 2. Types of Private Health Providers Interviewed, by Province						
Provider Type	#of Private Providers (%)	Number of Total by Province (%)				
PRIVATE PRACTICE ONLY	Overall	Badghis	Baghlan	Laghman	Loghar	Nimroz
Nurses	2 (1%)	1 (2%)	--	1 (3%)	--	--
Traditional healers (including mullahs)	11 (10%)	9 (17%)	--	--	--	2 (7%)
Private providers who also work in the public sector	21 (14%)	4 (8%)	2 (8%)	3 (9%)	5 (45%)	7 (26%)

Table Notes:

1. See Appendix B for the table with an added row to differentiate traditional birth attendants from midwives. Please note that the definitional distinctions about types of providers were not always clear in respondents' minds.
2. For private providers only. In two cases provider type was listed as "other" and did not fit into a type classification. Another seven interviews were with public providers-- CHWs in Badghis (3) and Baghlan (1), subcenter personnel in Loghar (2), and a provider in a district hospital in Loghar (1).
3. The Loghar tabulation may underrepresent midwives and traditional birth attendants because threats against the team precluded inclusion of female interviewers and the survey had to be truncated in one of the sample districts for security reasons.

There is, as might be expected, some fuzziness in the understanding of household respondents about whether specific providers who worked both at a public institution, such as a district hospital, and in private practice should be characterized as a public sector or a private sector provider. The survey team reviewed household characterizations of providers and characterized them not only on their own representation but also on their patients' characterization. About one in seven (14%) can be considered as working in both a public facility and in private practice.²⁶ As is discussed later in the analysis of private provider sources of support for delivering health care services, there was no evidence that health care personnel working in both were abusing their positions at public institutions; to the contrary, it appeared that in some instances (as is the case in other countries) the roles were complementary. Virtually all (90%) of the 21 providers who practice in both settings are physicians; one provider of dual status was characterized as a "pharmacy with a physician" and one was a CHW.

District Differences in System Configuration

As expected, there are several significant differences between the private provider mix in the more rural and in the central districts surveyed. For example, 55% of private providers in rural districts are physicians in solo practice versus 69% in central districts (which are nonetheless still quite rural). The only providers identified that were private hospitals or private health clinics, i.e. somewhat larger and more developed entities, were in central districts. Not surprisingly, the rural districts were more likely to rely on traditional birth attendants than the central ones.

²⁶ In reviewing how different households characterized providers as public or private, we assessed how definitive each characterization was and determined that 3 (2%) could not be definitively determined.

FORMAL PREPARATION OF PRIVATE PROVIDERS

The extent of formal training of private sector health care providers naturally varies greatly by provider type. Almost all the physicians (96%) said they had formal training. (However, the honorific “Doctor” does not by any means imply that a person has the training typically received by physicians.) While there were few pharmacy operators in the survey area, most of those (83%) also had formal training of some sort. Only 57% of the midwives had formal training; and none of the traditional birth attendants did.

District Differences in Formal Training

There are significant differences in the amount of formal training of providers by district. In the central districts, 82% had formal training in their field versus only 58% in the rural districts.

Seeking health care from a private physician in a rural area does not necessarily assure high-quality professional attention. About one-third have some sort of medical training—e.g., as a nurse, physicians’ assistant, or paramedic; “training in a related field”; “2 years college in Pakistan”—but no MD degree. One striking difference between rural and central district practicing physicians is that very few in rural areas mentioned an area of medical specialization, while some in the central districts had been certified in a specialty such as internal medicine, ear-nose-throat, obstetrics, or gynecology.

Private physicians were also asked if they had within the past year received any formal training in various priority areas of public health concern. Only 29% of them had received training on tuberculosis (TB) and DOTS, and 31% had received training in diagnosis and treatment of malaria. The responses from other providers, such as nurses and pharmacists, suggest some had received TB or malaria training, but they are too few to generalize from.

An impressive one-third of the physicians (33%) and two-thirds (67%) of the midwives had received recent MCH training. However, MCH training had not reached the traditional birth attendants interviewed; only one (representing 6% of those interviewed) had had such training. As with infectious disease training, it appears that MCH training extended into the private informal sector; proprietors of pharmacies, a private hospital operator, a private nurse, and a mullah all had had some training.

Providers who had attended recent training sessions were asked to rate them on how well they prepared trainees to address the problems they actually confronted in their practice. In general, the ratings were quite positive. The majority of trainees in each of the broad areas said it had prepared them well or very well for the demands they currently faced. However, about one in seven said the training they received was less than adequate (TB-13%, Malaria-17%, MCH care-18%).

Private providers were asked to explain what other kinds of training they had received. Not many had had other training, but the trainings they had received appeared to be relevant and useful. Topics covered included several highly relevant to public health (e.g., the importance of clean water, malnutrition, mental health, family planning (FP), immunizations); specific diseases (e.g., cholera, diabetes, HIV, and kidney and heart disease); and a range of medical specialty topics (e.g., ultrasound, emergency surgery, deliveries). Table III.3 details training topics mentioned.

About one-third of all those who had attended training said that it had prepared them well but that they would like more; many of those who had rated their training as not very good or merely adequate might also be interested in refresher/remedial training.

Table III.3. Topics of Training Attended by Private Sector Providers (within the previous year)		
Training Topic	Physicians in Solo Practice (n=97)	Other providers (e.g., Pharmacists, Private Hospitals, Midwives (n=55))
Malnutrition, nutrition	5	
Administration and management, including information systems	5	
Public health/systemic issues: clean water, family planning, immunizations		3
Mental health, opium withdrawal, drug abuse treatment, and psychotherapy	4	
Ultrasound technology, ECG technology	3	1
Education, information communication seminar	3	
Infectious diseases: cholera, polio, HIV	2	1
Emergencies: CPR, emergency surgery		2
Delivery		1
Systemic conditions: diabetes, kidney and heart disease, respiratory disease	1	2
Disabilities	1	
LPP	1	
Training of trainers (topic not specified)	1	

The unevenness of private provider training, coupled with their willingness (even eagerness) to participate in continuing education courses suggests that MoPH investments in training would do well to give priority to upgrading the skills of private as well as public providers, especially in more rural districts.

SERVICES AVAILABLE FROM PRIVATE PROVIDERS

Private sector health care providers were asked (Provider Survey, Q. B4.1) about the types of services they provide to the communities they serve. These responses were examined to determine if there were significant differences in the availability of specific services by province or between rural and central districts in the five rural provinces surveyed.²⁷

Availability of Various Services

Table III.4 shows the proportion of private providers offering specific types of service in the different provinces. There are many differences in availability, but some specialized services, such as dental and diagnostic services based on use of X-ray, ultrasound, or laboratory analyses, were seldom available anywhere. Immunizations were also rarely available.

²⁷ The 2006 AHS defined rural as any area outside major cities. Within this taxonomy, despite some variation, all the districts surveyed here were rural.

Table III.4. Availability of Specific Types of Health Care by Province						
Services Provided	% of Private Providers Surveyed who Provide each Service					
	Overall	Badghis	Baghlan	Laghman	Loghar	Nimroz
Curative-General						
Routine physical exam	72.0%	37.5%	86.2%	91.7%	92.9%	92.3%
Diagnose and prescribe drugs	67.1%	33.9%	82.8%	88.9%	85.7%	80.8%
Provide drugs	30.3%	25.5%	22.2%	38.9%	50.0%	39.6%
Mental health or counseling services	30.2%	15.4%	14.3%	47.2%	14.3%	57.7%
Maternal and Child Health						
Family planning information	25.8%	14.3%	32.1%	30.6%	55.6%	26.9%
Healthy family information	45.9%	30.8%	50.0%	33.3%	55.6%	36.4%
Immunizations	7.1%	5.4%	14.3%	2.8%	22.2%	4.0%
Antenatal care	41.4%	50.2%	42.9%	25.0%	44.4%	36.0%
Deliver babies	31.1%	43.4%	35.7%	16.7%	16.7%	24.0%
Postnatal care	35.8%	45.3%	39.3%	19.4%	50.0%	32.0%
Specialized Services						
Laboratory tests	10.7%	1.9%	28.6%	16.2%	---	3.8%
Diagnostic X-ray or ultrasound	2.7%	---	10.7%	---	---	4.0%
Dental services	7.4%	11.5%	7.1%	5.6%	---	3.8%
Surgery	19.5%	15.1%	25.0%	30.6%	---	11.5%
Public Health Services						
TB diagnosis and/or treatment	13.5%	7.5%	35.7%	8.8%	14.3%	7.7%
Malaria diagnosis and/or treatment	33.6%	15.1%	50.0%	60.0%	42.9%	15.4%

*Bolded lines are those where there is a statistically significant difference in availability of service by province (chi-square $p < .05$). The provincial sample of providers who offer services that are not commonly available (e.g., surgery, X-ray diagnosis, laboratory tests) is not large enough to show statistically significant differences unless there are striking disparities in availability.

As can be seen in Table III.4, Nimroz seems to have more curative and family health services available but slightly fewer maternal health services; however, it has the most mental

health/counseling services. Baghlan appears to have generally the widest availability of diverse services—better than average for almost all services, as well as a high proportion of providers who are prepared to diagnose or treat malaria and TB. Laghman also had several areas of strength, most notably in mental health counseling.²⁸ Badghis shows the most clear-cut disparity, with resources constrained in most areas other than maternal health.

The availability of individual services was also analyzed by type of district. Surprisingly, only one statistically significant disparity emerges: rural providers were more likely to provide patient drugs themselves than those in central districts (40.3% vs. 23.0%).²⁹ This would appear to be a reasonable adaptation to local needs.

Availability of Service Menus or “One-Stop” Clusters

The information on proportion of providers offering different types of services was also analyzed in terms of “packages”—clusters of services available from providers. This analysis, which differs from the simpler analysis of individual services offered, suggests the difficulty faced by patients seeking one-stop health care. This can be considered a significant indicator of private health system quality in an area, since it is related to the difficulty families are likely to experience in navigating the health care system where information and referral systems are minimal.³⁰ Availability of one-stop services relates both to costs households incur in seeking health care and to its quality, since lack of referrals compromises continuity of care.

These service menus for clusters of related services—which are not mutually exclusive—were framed to reflect different sorts of services that might reasonably be clustered together. They were defined as follows:

Basic Primary Health Services: routine physical examinations, diagnosis, prescribing medication, provision of healthy family information, antenatal care, and postnatal care.

Enhanced Primary Health Services: the basic primary health services package plus additional desirable primary health care services—FP, immunizations, x-ray for diagnosis, and TB and malaria diagnosis and/or treatment.

Basic Maternal Health Services: a one-stop shopping package for maternal health: antenatal care, delivery, and postnatal care.

Enhanced Maternal and Child Health Services: basic maternal health services plus FP, healthy family information, and immunizations.

One-Stop Prescription and Drug Service: providers who diagnose conditions, prescribe drugs, and themselves provide the drugs.

Key Public Health Services: providers who diagnose and/or treat both tuberculosis and malaria.

Table III.5 shows the availability of each of these clusters of services in the central and rural districts surveyed and throughout the area where the survey was conducted. In general, beyond

²⁸ The interviews with women in households suggest that Laghman has a much stronger than average public health service, at least in the areas surveyed.

²⁹ Chi-square $p < .05$

³⁰ The availability of a specific cluster of services does not, of course, say anything about the quality of service; the previous discussion of proportion of providers with and without formal training in their field may be a better indicator of quality of service (but not necessarily—since quality of formal training received is unknown). Another factor in quality of health care is, of course, infrastructure and there are limitations across the board there—as indicated by the small proportion of providers who have laboratory or other diagnostic resources.

sheer capacity as indicated by ratios of providers to population and aggregate service capacity as indicated by visits per week or month for a particular geographic area, there are serious gaps in the availability of what might be considered more comprehensive services.

TABLE III.5. AVAILABILITY OF MULTI-SERVICE MENUS OVERALL AND FOR CENTRAL VS. RURAL DISTRICTS			
Service Package	% of Providers Providing Services		
	Overall	Central Districts	Rural Districts
Basic primary health services	15.5%	19.5%	9.8%
Enhanced primary health services	0.7%	1.2%	---
Basic maternal health services	24.3%	21.8%	27.9%
Enhanced maternal and child health services	8.1%	9.2%	6.6%
One stop prescription and drug services	23.0%	16.3%	32.3%
Key public health services	10.9%	14.0%	6.6%

* Statistically significant differences highlighted (chi-square $p < .05$)

Table III.6 shows variations from province to province in availability of each service menu. The analysis here is consistent with the analysis of availability of individual services: availability of each cluster is somewhat better in Baghlan and Nimroz than in the other three provinces and is somewhat worse (except for basic maternal health services) in Badghis.

TABLE III.6. AVAILABILITY OF SERVICE MENUS BY PROVINCE						
Service Package	% of providers surveyed who provide each service					
	Overall	Badghis	Baghlan	Laghman	Loghar	Nimroz
Basic primary health services	15.5%	11.3%	21.4%	8.3%	16.7%	28.0%
Enhanced primary health services	0.7%	---	3.6%	---	---	---
Basic maternal health services	24.3%	32.1%	35.7%	5.6%	16.7%	24.0%
Enhanced maternal and child health services	8.1%	3.8%	7.2%	11.1%	---	16.0%
One-stop prescription and drug service	23.0%	17.3%	18.5%	33.3%	42.9%	19.2%
Key public health services	10.9%	3.8%	35.7%	9.1%	14.3%	---

* Statistically significant differences highlighted (chi-square $p < .05$)

Service Profiles for Selected Types of Providers

Analysis of the data on service availability included examination of the typical menu of services offered by providers of different types—physicians in solo practice, traditional healers and

mullahs, and traditional birth attendants (see Table III.7).³¹ Physicians in solo practice are indeed the mainstay of the private health care delivery system, but as can be seen in Table III.7, midwives and traditional birth attendants usefully supplement the maternal health services they provide. The data showing that physicians are less prevalent in antenatal care, deliveries, and postnatal care than midwives and to a more limited degree traditional birth attendants suggest that careful consideration needs to be given about whether to invest in increasing physicians' role in this area, increasing the numbers of specialized maternal health providers (midwives and potential paraprofessionals, such as antenatal care providers), or perhaps both—especially in recruiting and training female physicians.

While physicians in solo practice provide a fairly broad range of services, it appears that strategic in-service training initiatives might expand the scope of their practice, especially in providing FP and healthy family information and giving immunizations. Although these physicians are the most experienced private health care providers, their resources for accurate diagnosis are very limited, due to either infrastructure problems or lack of training.

TABLE III.7. AVAILABILITY OF SPECIFIC TYPES OF HEALTH CARE BY PROVIDER TYPE³²				
Services Provided	% Offering the Service			
	Physicians in Solo Practice (n=86)	Traditional Healers and Mullahs (n=14)	Traditional Birth Attendants (n=23)	Midwives (n=7)
Curative–General				
Routine physical exam	95%	50%	---	86%
Diagnose and prescribe drugs	92%	36%	---	71%
Provide drugs	29%	29%	4%	14%
Mental health or counseling services	41%	14%	4%	14%
Maternal and Child Health				
Family planning information	30%	---	---	29%
Healthy family information	60%	21%	4%	71%
Immunizations	6%	---	---	14%
Antenatal care	32%	7%	74%	100%
Deliver babies	16%	---	96%	100%
Postnatal care	28%	7%	74%	100%
Specialized Services				
Laboratory tests	13%	---	---	---

³¹ The number of cases of providers of other types (e.g. nurse, private hospital, private clinic) did not allow meaningful analysis of the service profile of these groups.

³² This tabulation is based on 130 interviews (90% of the total of 145 interviews) where information about provider type and services available was unambiguous.

TABLE III.7. AVAILABILITY OF SPECIFIC TYPES OF HEALTH CARE BY PROVIDER TYPE³²				
Services Provided	% Offering the Service			
	Physicians in Solo Practice (n=86)	Traditional Healers and Mullahs (n=14)	Traditional Birth Attendants (n=23)	Midwives (n=7)
X-ray or ultrasound for diagnosis	2%	---	---	---
Dental services	8%	14%	4%	---
Surgery	25%	7%	---	14%
Public Health Services				
Provide TB diagnosis and/or treatment	20%	---	---	---
Provide malaria diagnosis and/or treatment	51%	7%	---	---

Table III.7 shows potential enhancements to public health efforts in diagnosis and treatment of TB and malaria. There is across the board a lack of capacity for providing dental services—a serious problem.

DEMOGRAPHICS OF PRIVATE PROVIDERS

Three-quarters (76%) of private providers are males and the rest (24%) females. However, because the women are concentrated in midwifery—as trained midwives or traditional birth attendants—only one out of seven (14%) of professionally trained providers are women.

Table III.8 shows variations in demographics and selected socioeconomic characteristics of providers by province; all the differences are statistically significant. However, there are no significant differences in the amount of time spent outside the community—on average 5.7 years.

TABLE III.8. DEMOGRAPHICS AND SELECTED SOCIOECONOMIC CHARACTERISTICS OF PRIVATE HEALTH CARE PROVIDERS BY PROVINCE						
	Characteristics of Providers					
	Overall	Badghis	Baghlan	Laghman	Loghar	Nimroz
% Female	24.0%	37.3%	24.1%	8.1%	16.7%	25.9%
Mean age	43.2 years	47.4 years	41.6 years	44.2 years	36.3 years	38.7 years
Mean time in community	11.4 years	14.0 years	13.5 years	10.4 years	3.3 years	8.8 years
% with formal training	71.2%	30.4%	96.6%	97.3%	92.9%	81.5%

* Statistically significant differences highlighted (chi-square $p < .05$ for categorical variables, Anova for means).

Private providers tend to be middle-aged. Only 7% are under 30 and only 5% are over 60. There are no notable differences in age among types of providers, except that traditional birth attendants are older: 52.9 on average. Midwives are on average younger (42.7) and traditional healers and

mullahs are only very slightly older than the average provider (mullahs 46.2, traditional healers, 44.5).

Experience Outside the Community and Reasons for Current Location

Afghanistan is a country with a good deal of internal migration, as is evident from the experience of private providers in local villages and elsewhere. Slightly more than half of the private providers interviewed (52%) had worked somewhere outside their current community, though the other 48% had never worked in health care anywhere else.³³ However, even those who had worked outside the community had typically spent less years working elsewhere (an average of 5.7) than in the local community (an average of 12). The majority (57%) had been working in the community where they were currently located since before 2002. Thus, despite some recent influx of new providers, many providers have been there for many years, even through periods of conflict and social upheaval. Those who have worked continuously in a village for years are, of course, a valuable resource for community health improvement. However, many would probably benefit from training to familiarize them with more recent knowledge.

Physicians in solo practice, private health clinics, or private hospitals were more likely than others to have worked somewhere else (69%). In contrast, only 43% of midwives and 20% of traditional healers and traditional birth attendants had done so. More than one-third (38%) of the mullahs who were providing health care had worked elsewhere. This pattern has implications for both diversity of experience and for consideration of ways in which to best deploy the current supply of private providers. Traditional birth attendants and physicians in rural districts were slightly less likely to have ever worked outside their current community than those in central districts, but the difference was not statistically significant.

The diversity of experience of those who had worked elsewhere was striking—a useful reminder of the dynamic interplay between rural villages and urban areas in Afghanistan, as well as neighboring Pakistan and Iran. Almost half (46%) of the private providers who had worked outside the village had worked in a more urban area, Kabul or a provincial capital, before coming to their current community.

Interviewers asked those who had located in their current community from somewhere else what factors entered into the decision to set up practice there. As in other areas of Afghan life, returning refugees make up a significant subgroup; one out of seven (15%) said that they had worked abroad—usually in Pakistan. More than half (57%) of those who had worked outside the village said that family considerations or discussion with the *shura-i-sehie* or a community leader had affected their decision to return or to relocate from somewhere else to establish a practice in the village. One-quarter (24%) said that the local *shura-i-sehie* had asked them to relocate and one-third (33%) mentioned that a village leader had done so. Apparently both informal and formal social pressures helped convince them to practice in rural areas, which tend to be less attractive to professionals.

Although half (48%) of the providers who had worked elsewhere mentioned market forces (“there seemed to be a need and I filled it”), only half of these suggested this was the only factor in their decision without mentioning social forces from family or village leadership. The most effective strategy for enhancing rural health care service delivery will probably be an integrated one that addresses cultural and social as well as economic issues that affect providers’ decisions about where to practice.

There were no significant differences among provinces or types of provider in the reasons given by respondents for locating in the village where they currently practiced.

³³ Provider Question B2a.

TIMES OF PROVIDER AVAILABILITY

Table III.9 shows the availability of private providers in terms of days a week and hours a day; there are significant differences between provinces. In most provinces, more than four out of five providers offer service 6-7 days a week; however, here, as in other areas, Badghis lags behind. In Loghar and Nimroz a much higher proportion of providers are open more than 8 hours a day. About one out of five providers (18%) is essentially on call all the time, 12 or more hours a day.

TABLE III.9. PROVIDER AVAILABILITY BY PROVINCE: DAYS PER WEEK AND HOURS PER DAY					
Province	Days per Week		Hours per Day		
	Part-time (1-5 days)	Full-time (6-7 daysweek)	1-4 hours	5-8 hours	>8 hours
Badghis	41%	59%	44%	35%	11%
Baghlan	14%	86%	26%	63%	11%
Laghman	8%	92%	28%	53%	17%
Loghar	11%	89%	44%	22%	34%
Nimroz	11%	89%	12%	50%	38%
Overall	20%	80%	31%	47%	22%

* Statistically significant differences highlighted (chi-square $p < .05$).

Providers in central districts (91%) were much more likely to be open 6–7 days a week than their rural counterparts (64%). In the rural districts, one in six providers (18%) was only available 1–2 days a week.

Providers in central districts are less likely to be open for only 1–4 hours a day (25%) than those in rural districts (38%); in rural districts a fairly substantial number of providers (21%) said they were available only 1–2 hours a day; however, similar proportions of central district and rural providers (24% vs. 21%) were on call full-time.³⁴ Essentially, more of the central district providers kept to fairly standard daily schedules, offering 5–8 hours of service daily.

PROVIDER STAFFING

Three-quarters (76%) of private health care providers worked on their own without any staff support. As might be expected, midwives, nurses, mullahs, traditional healers, and traditional birth attendants all worked alone. About one-third (31%) of the physicians in solo practice or a private clinic or hospital had staff, and slightly less than half (45%) of the pharmacy proprietors employed staff.

The staff of most (74%) of the physicians in solo practice who did have staff were other medical professionals—another physician or physician’s assistant, a nurse, or a midwife. However, about one-quarter (27%) of the “medical professional” support staff did not have formal credentials. In most cases, physicians in solo practice had only one additional provider with them.³⁵

³⁴ The differences in number of hours of service availability in central and rural districts is statistically significant ($p < .05$).

³⁵ Of the 27 physicians classified as being in solo practice who did have staff, 18 had 1–4 other medical professionals on staff but one had 11 and another had 19, skewing the mean of professionals per physician. These two outliers might actually be considered private clinics.

A similar proportion (81%) had nonprofessional support staff in addition to medical professionals. Two-fifths (41%) had administrative staff involved in greeting or some form of patient service; however, very few (only 14%) had staff assigned to managing medical records. Slightly less than one-third (30%) had staff responsible for ordering or maintaining supplies or some other form of logistical support. One-quarter (24%) relied on a mix of part-time and full-time staff for administrative support.

PROVIDER CASELOAD

Providers were asked to estimate the numbers of households they served.³⁶ Table III.10 shows caseloads and variations in caseload by provider type and whether the provider was a sole practitioner (since presumably providers with staff support would have greater service capacity in terms of household visits per week). Not surprisingly, there are significant differences in the service capacity of those in solo practice (75%) and those who have staff support.

TABLE III.10. ESTIMATED CASELOAD (HOUSEHOLD VISITS IN THE PREVIOUS WEEK) BY PROVIDER TYPE AND MODE OF PRACTICE	
	Mean Household Caseload (Standard Deviation)
Provider Type	
Private MD (n=78)	82.5 (137.6)
Traditional healer (n=6)	31.3 (45.2)
Pharmacy without MD (n=5)	19.6 (28.3)
Midwife (n=6)	16.5 (11.8)
Mullah (n=7)	7.3 (10.2)
Traditional birth attendant (n=11)	4.6 (4.8)
Mode of Practice	
Practitioner with staff support (n=100)	113.2 (195.6)
Solo practitioner (n=34)	50.8 (80.1)

* Means are not computed for provider types with <5 cases.

** The differences in caseload by types of provider and mode of practice are statistically significant.

There are also variations in caseload related to provider type and mode of practice, and significant differences in caseload between provinces and districts within provinces (see Table III.11).

³⁶ This question was referenced to the prior week (“Please give an estimate of the number of families or households that you have served last week”). It is not clear whether providers actually attempted to estimate caseload for the reference week or simply estimated “in general” how many households they served. There are a total of 134 cases with valid data on mode of practice and caseload but the analysis of caseload by provider type only compares provider types with >5 cases and valid information on provider type, i.e. 113 cases.

TABLE III.11. ESTIMATED CASELOAD (HOUSEHOLD VISITS IN THE PREVIOUS WEEK) BY PROVINCE AND DISTRICT	
Province and District	Mean Household Caseload- (Standard Deviation)
Badghis	28.3 (41.9)
Qala-I-Naw—central (n=15)	28.5 (51.5)
Ab Kamari (n=11)	33.8 (41.7)
Qadis (n=11)	22.5 (28.2)
Baghlan	181.4 (222.8)
Pule-I-Khumri—central (n=22)	192.1 (239.3)
Dana-I-Ghori—rural (n=4)	122.5 (85.4)
Dushi—rural (n=0)	(no local providers)
Laghman	64.9 (75.1)
Mihtarlam—central (n=23)	86.0 (85.0)
Alingar—rural (n=8)	13.1 (15.8)
Qarghayi—rural (n=5)	51.0 (32.1)
Loghar	42.2 (47.1)
Pul-I-Alam—central (---)	(survey not completed)
Baraki Barak—rural (n=5)	14.0 (4.4)
Mohammad Agha—rural (n=4)	77.5 (53.8)
Nimroz	17.3 (21.3)
Zaranj—central (n=21)	11.8 (15.8)
Chakhansur—rural (n=2)	33.5 (44.5)
Kang—rural (n=3)	45.0 (21.8)

Providers in central districts generally have higher average caseloads because more of them have staff support—32% vs. 14% of those in rural areas).

STARTING UP A PRIVATE HEALTH CARE PRACTICE

The economic context of private business in rural Afghanistan is obviously quite different from that of market economies in even slightly developed countries. On the one hand there are virtually no functioning formal credit organizations; on the other hand costs are often quite low (especially if a family owns its own home and at least some family members are involved in agriculture).

Interviewers asked private providers about how they got their practice up and running and their sources of economic support. About one in five (20%) said it had been “very difficult” to start their practice; however, more than twice as many (43%) said it had not been difficult at all. There were no significant differences in difficulty of startup by type of provider.³⁷ However, providers without formal training were slightly more likely to say that they had found it very difficult to start their practice—29%, versus 18% of those with formal training.³⁸

Standard analyses of the socioeconomic dynamics of rural communities in areas with very weak market economies are not entirely satisfactory. In those conditions, there are complex interactions between resources of social, civic, and financial capital. In communities like those of rural Afghanistan with very strong family and clan-based social networks and complex histories of changing alliances, the resources available to prospective health care providers (or, viewed alternatively, the pressures exerted on an individual to engage in one type of work or another) are more than purely economic. At the same time, of course, there are no functioning formal financial institutions in most of the communities sampled in this survey.

Table III.12 tabulates provider accounts of sources of support for their startup.³⁹ It demonstrates that most providers rely on multiple sources of support for getting their practices started. For all providers, startup is from the beginning at least partially supported by the market, despite villagers’ low incomes. However, portions of the startup costs are borne by the providers personally or by their relatives or friends. While community social networks are not a major source of support for startup, these contributions are nonetheless likely to be significant when providers are trying to make ends meet in economically precarious communities.

³⁷ For many analyses the survey sample is not large enough to discern whether there are significant differences among types of provider because such a high proportion of the providers are of one type, private physicians. A larger sample stratified by provider type would be necessary to definitively examine the economic conditions experienced by different types of providers.

³⁸ Chi-square $P < .05$.

³⁹ About one-third of the providers surveyed as private (non-public) health providers function in traditional roles (e.g. mullahs, traditional birth attendants) and even those who appear to be functioning in a “modern” role (doctor in private practice) may not have adequate, or any, formal qualifications but whose de facto role as a “doctor” is sanctioned by village leaders and patients.

TABLE III.12. SOURCES OF STARTUP SUPPORT FOR PRIVATE HEALTH CARE PROVIDERS

Relative Importance of Each Source of Support	Sources of Startup Support (% of Providers Responding)					
	Market	Personal Social Networks		Community Social Networks		External
	Patient Fees	Own Savings	Help from Relatives or Friends	Village Leaders or Shura	Other Providers	Local NGOs or Microfinance
Provided most of the support	15%	23%	5%	2%	1%	---
Provided a large amount but not the primary source	30%	21%	9%	8%	7%	4%
Provided a small amount	19%	32%	30%	17%	12%	12%
Was not a significant source of startup support	36%	24%	56%	73%	80%	84%

* % are computed based on proportion of respondents who answered this section of the survey—82–85% depending on the specific question.

NGOs operating in the community and external microfinancing sources provide some assistance for startup, but less than the market or personal and community social networks. Nonetheless, the fact that NGOs and external microfinancing resources provide at least small amounts of help to get providers started (and, as it turns out, continuing in practice) is good news—in essence evidence of a rudimentary model of public-private partnering.

There are some differences in the sources of startup support for practitioners with formal training and those without. Those with formal training were substantially more likely (60%) to have relied on patient fees for most or a large amount of support during startup than providers without formal training (3%). However, those with formal training are also more likely to have said they relied on their own savings to start their practices (50%) than those without (30%), and all those who reported that “other community providers,” “local NGOs,” or external microfinance programs provided most or a large amount of support had received formal training. It may be that providers with formal training (primarily physicians) may have incurred more costs in getting going and were more likely to be bona fide startups than those without, who were more often local traditional health care providers.

SUSTAINING AN ESTABLISHED PRACTICE

The responses of private providers about sources of economic support for ongoing provision of services underscore the unusual circumstances of most rural villages of Afghanistan, where the boundaries between the private and public sectors of civic life are fuzzier than in developed countries.

While respondents are private health care providers, only part of their continuing support is derived from patient fees. This is in part because (as is discussed in detail later), more than nine out of ten providers (94%) exempt some groups in the community from paying fees for the services they receive. Essentially, their remuneration for this provision of pro bono services is in the form of social capital. Looked at in another way, social pressures to provide such service stem from local community cultural mores and norms of mutual reciprocity.

The unusual patterns of sources of support for continuing provision of health services presented in Table III.13 are also not what might be expected. The fact that only a minority of private providers seem to be supported primarily by patient fees, together with the similarity of sources of support during startup and during current operations, may also reflect the fact that in some senses many are in an extended period of startup as Afghanistan reconstructs itself. However, 31% of those interviewed are mullahs, traditional healers, or traditional birth attendants—not at all typical “business people”—and even the providers who might appear to be typical “businesses” (physicians operating practices with staff support, and pharmacies) are operating within a semitransitional societal context where building their practices is deeply intertwined with the endeavor of rebuilding the community.

TABLE III.13. SOURCES OF SUPPORT FOR PRIVATE HEALTH CARE PROVIDERS TO CONTINUE PROVIDING SERVICE ONCE PRACTICE IS ESTABLISHED

Extent of Contributions	Sources of Support					
	Market	Personal Social Networks		Community Social Networks		External Financing
	Patient Fees	Own Savings	Help from Relatives or Friends	Village Leaders or Shura	Other Providers	Local NGOs or Microfinance
Most support from this source (>50%)	30%	22%	3%	1%	1%	2%
Contributed quite a bit but not most (21-49%)	17%	37%	7%	4%	5%	2%
Contributed to a small extent (<20%)	22%	29%	31%	20%	12%	7%
Did not contribute at all (0%)	31%	12%	59%	75%	82%	89%

Here, it is important to look at the disparities between the sources of support for continuing services of providers with formal and those with only informal preparation. Almost two-thirds (63%) of those with formal training said that most or quite a bit of their support derived from patient fees, compared to only 7% of those without formal training.

In Afghanistan, as in other extremely poor peasant economies, a good deal of economic activity consists of bartering. In Afghanistan, this can include “payments” in the form of social capital (prestige) as well as cash or formal financial instruments (e.g., promissory notes). Social capital is in these communities a tangible commodity because there are very strong ties of mutual reciprocity. Presumably, for example, health care providers—e.g., midwives, traditional birth attendants, or “doctors” (perhaps with inadequate or no credentials)—despite receiving inadequate financial remuneration for their efforts may in the future call on their reserves of social capital for help in hard times or even in ordinary circumstances, such as rebuilding the wall of an adobe house.

Another factor that may contribute to the unusual pattern of sources of support for continued practice is the ambiguity about the status of health care practitioners who may be employed by the public sector, often via an NGO implementing partner which works with the MoPH. From this perspective, the public health infrastructure, rather than being seen as a service network in competition with private health care, might best be seen as a small business incubator, providing part of the initial impetus (although family considerations are also definitely important) for

trained health care providers to settle in rural areas where they know in advance that community economic resources will not support a practice as lucrative as may be feasible in urban areas.

This study sought to address the issue of public-private sector overlap by treating health practitioners employed in the public sector as private providers if they treated patients outside normal clinic or hospital hours, but there is some measure of ambiguity about categorizing a health care provider as private, public, or both. As has been demonstrated in a variety of studies (e.g., AREU), public sector employment in the context of Afghanistan’s organizational practices and attitudes must be conceptualized more in terms of payment for holding a position or post than payment of a certain amount of money per hour; public officials and employees involved in providing public services—e.g. teachers, police—routinely have other business activities.

Despite concern that public health care workers may be charging fees for access to publicly funded services, Tables III.12 and III.13 suggest a somewhat different public/private intersection in which some free services provided by “private” providers outside their duty hours in a publicly funded institution may be essentially subsidized by public financing, which provides financial support to the provider that makes it possible for him or her to provide free services to many “private” patients (see Appendix D). Thus, the very substantial amount of free or very low-cost service provided by health care providers who may in some senses be part of both the public and the private sector is actually catalyzed by public funding. In this model, accurate assessment of the return on public investment must include not only services provided within the formal public service delivery system but also free services provided via market mechanisms that are somewhat akin to the private sector but that do not necessarily involve financial transactions. Interestingly, the same proportions (>90%) of providers with and without formal training waive fees for one or several subpopulations of persons with special needs or fewer resources.

THE BUSINESS OUTLOOK FOR PRIVATE PROVIDERS

Providers were asked about their assessment of their current situation and future plans regarding provision of health services. The questions were structured to elicit their opinions about several clusters of factors related to future outlook. Table III.14 summarizes information on their general outlook and the differences in outlook between providers in rural and in central districts

TABLE III.14. THE OUTLOOK OF PRIVATE HEALTH CARE PROVIDERS		
Indicators of Future Outlook	Agreement/Disagreement Mean Rating (% who Somewhat or Strongly Agree)* 4=strongly agree; 1=strongly disagree	
Current Economic Considerations and Future Plans		
Negative----→Positive	Can't make money because supplies are too expensive.	2.2 (44% agree)
	Can't make money because cost of doing business is too high.	2.3 (41% agree)
	Things are OK—we're doing OK.	2.9 (66% agree)
	Things are OK and I'd like to expand my work to provide <u>other medical services</u>	3.2 (83% agree)
	Things are OK and I'd like to expand my work to <u>other villages</u> .	2.9 (69% agree)

TABLE III.14. THE OUTLOOK OF PRIVATE HEALTH CARE PROVIDERS	
Indicators of Future Outlook	Agreement/Disagreement Mean Rating (% who Somewhat or Strongly Agree)* 4=strongly agree; 1=strongly disagree
Likelihood of Continuing Practice	
In 5 years I'll still be doing this.	2.7 (60% agree)
I'll still be doing this 5 years from now but don't know about 10 years.	2.5 (55% agree)

* Based on a 4-point scale where 4=strongly agree, 3=somewhat agree, 2=disagree a little, and 1=strongly disagree.

It appears that private providers have a surprisingly positive outlook given the circumstances in which they work: two-thirds (66%) agree that “things are OK; we’re doing OK,” and only 9% strongly disagreed. The fact that about two-fifths (41% to 44%) feel they “can’t make money” is not inconsistent with the positive assessment of the others.⁴⁰

As part of this line of questioning about sustainability and possible expansion, providers were asked whether they agreed with a statement about potential government investments in strengthening the private health care sector—“I want more training and government support because there is too little support from other professionals.” The overwhelming majority (84% of the respondents) said that indeed they did want such support; they agreed strongly (41%) or somewhat (44%) with this statement. Only 5% disagreed—which could indicate that there either was enough support already or that they did not want training.

CONSTRAINTS ON POSSIBLE EXPANSION

In assessing what would constrain their ability to expand their practice either geographically or in the scope of health services provided, survey respondents rank-ordered various factors. Respondents were asked to assess factors as “a giant” constraint (which it might not be possible to overcome); “a significant” one (which it might be possible to overcome); or one that could probably or definitely be managed. About half of all respondents—presumably those who had thought most about possible expansion—identified one or several factors that would affect their ability to expand.⁴¹ Of those who did identify constraints on expansion, less than one in five considered them almost insurmountable; the majority, quite reasonably, felt that there might be ways to overcome the barriers they would face in attempting to expand.

Constraint #1. Finding and Maintaining Adequate Trained Staff: 28% identified this as “giant.”

Constraint #2. Village Infrastructure: 24% identified this as “giant.”

Constraint #3. Operating Costs: 19% identified this as “giant.”

Constraint #4. Taxes: 14% identified this as “giant.”

⁴⁰ There is an apparent overlap of about 7–8% who feel both that “things are OK” and that they “can’t make money.” This fuzziness is to be expected since the two categories of “agreement” include a number who somewhat agree.

⁴¹ Proportions of respondents who stated they “didn’t know or couldn’t say” how important a factor might be in expansion ranged from 46% to 48% of those interviewed, depending on the factor in question.

Constraint #5. Supervision/Management Issues: 13% identified this as “giant.”

Constraint #6. Community Support: 13% identified this as “giant.”

Constraint #7. Ministry Requirements: 13% identified this as “giant.”

Despite the somewhat positive assessment of the current situation in their practice, it deserves note that several survey respondents (4% of the total; 50% of those who noted a significant “other” factor regarding possible expansion) mentioned security as a concern.

Fee Structures

Afghan society, particularly in smaller rural areas, continues to incorporate some aspects of traditional social dynamics while at the same time being transformed into a more “modern” society where production of goods and provision of services take place primarily within a well-demarcated economic arena.

Table III.15 tabulates private provider reports about types of patients for whom they waive fees.

TABLE III.15. PRO BONO SERVICES TO NEEDY GROUPS	
Type of Patient	% of Providers Granting Waivers to this Group
Poorer people	81%
Orphans	77%
Widows	58%
Physically disabled	57%
Pregnant women	17%
Elders	21%
Pre-school age children	12%
School-age children	12%

FACILITY INFRASTRUCTURE

Facility infrastructure is likely to affect the quality of service and the efficiency with which providers can serve their patients. As might be expected, the health care facilities in which private providers work do not uniformly have the infrastructure typically envisioned for such facilities.

Table III.16 provides an overview of typical facility infrastructure. It also highlights the disparities between the rural and central district locations surveyed, both of which are entirely ex-urban, although there are notable differences in population density and community infrastructure.

TABLE III.16. PRIVATE HEALTH CARE FACILITIES: OVERALL AND FOR CENTRAL VS. RURAL DISTRICTS			
	% of Providers with Infrastructure of Listed Type		
Features of Physical Infrastructure	Overall	Central Districts	Rural Districts
Heating for patient waiting areas during winter	64%	72%	53%
Source of electricity—electrical mains	25%	40%	2%
Source of electricity—generator	33%	36%	29%
Source of electricity—other	12%	7%	16%
No electricity	30%	17%	50%
Mean hours per week electricity is available (if on electric mains)	72.8 hrs	---	---
Water source—piped	27%	31%	20%
Water source—pump/well	48%	55%	38%
Water source—other (unprotected or surface or tanker)	26%	14%	43%
Telephone at facility (landline, mobile, or satellite)	83%	92%	72%
Telephone within 10 minutes	6%	6%	5%
Telephone more than 10 minutes distant	11%	2%	22%

* Statistically significant differences highlighted (chi-square $p < .05$).

** No comparison of central/rural differences in mean hours of electricity per week because only one rural provider received power from electrical mains.

The one area where infrastructure is adequate is telecommunications, given the high proportion of providers who have a telephone at the facility. The fact that almost one-third have no electricity underscores how infrastructure problems compromise capacity to deliver services, since lack of electricity constrains use of technology as well as hours of operation.

UNDERSTANDING THE PRIVATE HEALTH CARE SYSTEM IN RURAL AREAS

This section underscores the need to look not simply at a national strategy for strengthening the health care system in rural Afghanistan but, more important, at a strategy that is flexible enough to respond to the diversity between provinces and between more and less densely-populated areas. However, effective strategies also require focus. The analyses of data from interviews with private providers presented here suggest that they indeed complement the services available through public providers.

However, many private providers would benefit from training to strengthen and broaden their skills. Private providers help make some degree of health care available to rural households that would otherwise have no way to address their families' health needs, but few provide the full range of services needed to actually assure that these families can become healthy families. Even more important than increasing the number of service outlets is the need to fill in the service gaps in current service menus, for example, by providing training and incentives to private providers who make basic maternal health services available.

The age of private providers is a real concern. Afghanistan, like other developing countries, will need to find a way to provide incentives to young professionals to locate in remote rural villages with few amenities. Given the intertwined social, personal, and social factors that enter into providers' decisions to locate in one place or another, the current analyses strongly suggests a need to flesh out a health care personnel supply strategy that does not consist simply of siloed initiatives but that is instead an integrated strategy addressing all the factors involved in locating a practice. Experience in other contexts suggests that targeted efforts to involve promising local students in health-oriented careers who will return home once they have received professional training will be more effective than efforts to convince urban providers to relocate to rural areas.

Like all of Afghanistan, and most of the country's professionals, private health care providers in the villages surveyed are struggling economically. They are motivated and willing to work long hours, but the size of the villages in which they practice cannot support them. These providers are remaining in the villages in large measure as a result of the intervention of social networks. Their response to the "market" is not purely economic, although it does include an impressive flexibility in providing waivers for disadvantaged persons needing health care; it is also sociocultural. Effective central government strategies will need to examine ways to better mobilize social and civic capital to complement the meager economic incentives for health care providers with the requisite technical skills to serve their patients well.

IV. HOUSEHOLD PROFILE

The survey covered 778 households in five provinces. Two of the completed interviews were rejected by provincial-level supervisors based on the quality of the data, resulting in a total data set of 776 completed household interviews (see Table IV.1). The data cover households in the provinces of Badghis, Baghlan, Laghman, Loghar, and Nimroz.

The survey was conducted in the central district of all the provinces except Loghar and in two randomly chosen rural districts of each province. Thus, about twice as many heads of households were surveyed in rural districts as in central districts. (Surveying in the central district of Loghar was suspended due to immediate security risks.)

The demographic and educational profile of the households surveyed is quite similar to that reported in the most comprehensive survey of rural Afghanistan (NRVA 2005), which suggests that this survey is representative, at least in general demographic and socioeconomic profile, of the rural population of Afghanistan.

Province	Total		Central		Rural	
	Number of Households	Percent of Total	Number of Households	Percent of Province	Number of Households	Percent of Province
Badghis	168	21.6	56	33.3	112	66.7
Baghlan	165	21.3	55	33.3	110	66.7
Laghman	166	21.4	56	33.7	110	66.3
Loghar	110	14.2	-	-	110	100.0
Nimroz	167	21.5	56	33.5	111	66.5
Total	776	100.0%	223	28.7	553	71.3

HOUSEHOLD SIZE

The size of surveyed households ranged from 2 people to 52, with the majority reporting between 5 and 9 (see Table IV.2). Household size was calculated based on the number of both family and nonfamily members reported.⁴²

⁴² Section B (Household Grid), Head of Household Survey.

TABLE IV.2. SIZE OF HOUSEHOLDS SURVEYED*		
Members	Number of Households	Percent of Households
2	16	2.1%
3	19	2.5%
4	51	6.7%
5	81	10.7%
6	107	14.2%
7	126	16.7%
8	102	13.5%
9	83	11.0%
10	62	8.2%
More than 10	109	14.4%
Total	756	100.0%

* Data were incomplete for 20 households.

The average size for those households with complete data is 7.9 people and varies slightly between provinces (8.9 in Laghman. 6.6 in Nimroz). Except in Baghlan, there are also divergences in household size between central and rural districts.

TABLE IV.3. AVERAGE HOUSEHOLD SIZE BY PROVINCE AND TYPE OF DISTRICT		
Province	Average Household	
Badghis	8.6	
Central	10.3	
Rural	7.8	
Baghlan	7.7	
Central	7.8	
Rural	7.6	
Laghman	8.9	
Central	9.4	
Rural	8.6	
Loghar	8.1	
Nimroz	6.6	
Central	7.0	
Rural	6.4	
Total	7.9	
Central	8.6	
Rural	7.7	

n=756 households.

The mean household size is slightly larger than the mean of 6.8 reported in AHS 2006 but is quite close to the 7.5 rural mean reported in NRVA 2005. The divergence with the AHS may be because the methodology for that survey required interviews with all households in a compound, whereas this survey interviewed only the primary household, which is likely to be larger than satellite households in compounds.

HOUSEHOLD COMPOSITION AND PROFILE

Demographic detail on individual household members was recorded for those who reported family and nonfamily members in the Household Grid. Data for 5,626 people were recorded in the grid. Respondents reported another 513 individuals (8% of the total household) living in their households for whom there is no demographic data.⁴³

Household members under 20 make up 55.3% of the individuals recorded on the Household Grid. More than half the 0-4 age group (52.1%) is female (see Table IV.4) but the male/female gender ratio overall increases to 2.7 by the 65 and older age group.

Age Group	Total		Male		Female		M/F Gender Ratio
	Total #	Total %	#	%	#	%	
0-4	675	12.5%	323	47.9	352	52.1	0.92
5-9	867	16.1%	454	52.4	413	47.6	1.10
10-14	808	15.0%	427	52.8	381	47.2	1.12
15-19	631	11.7%	357	56.6	274	43.4	1.30
20-24	414	7.7%	251	60.6	163	39.4	1.54
25-29	346	6.4%	198	57.2	148	42.8	1.34
30-34	295	5.5%	154	52.2	141	47.8	1.09
35-39	286	5.3%	146	51.0	140	49.0	1.04
40-44	255	4.7%	138	54.1	117	45.9	1.18
45-49	210	3.9%	116	55.2	94	44.8	1.23
50-54	167	3.1%	94	56.3	73	43.7	1.29
55-59	95	1.8%	68	71.6	27	28.4	2.52
60-64	125	2.3%	80	64.0	45	36.0	1.78
65+	211	3.9%	154	73.0	57	27.0	2.70
Total	5,385	100.0%	2,960	55.0	2,425	45.0	1.22

⁴³ In practice the very large size of some Afghan households makes it difficult to create a household grid large enough to include all household members. Thus, as was done in AHS, interviewers asked (Question B8b) if there were any people in the household the respondent had not been able to mention in the detailed discussion of household members. These are the individuals for whom demographic and health visit data are not available.

Age distribution and gender ratios are comparable to those reported in NRVA 2005.⁴⁴

Head of Household—Educational Attainment

All heads of households were male. Their average age was 46.2 years and the average level of education 3.5 years (Table IV.5). Average education varies considerably by province, from 1.6 years in Nimroz to 6.5 years in Loghar. There are also differences between the mean level in the rural and the central districts in provinces Badghis and Laghman, though not in the other two where rural and central districts could be compared.⁴⁵

TABLE IV.5. AVERAGE AGE AND EDUCATION OF HEAD OF HOUSEHOLD BY PROVINCE		
Region	Average Age	Average Education
Badghis	48.6	2.6
Central	49.1	4.0
Rural	48.4	1.9
Baghlan	48.1	2.7
Central	48.8	2.7
Rural	47.7	2.7
Laghman	42.6	5.3
Central	46.5	6.8
Rural	40.5	4.6
Loghar	48.1	6.5
Nimroz	44.4	1.6
Central	43.8	1.6
Rural	44.7	1.6
Total	46.2	3.5
Central	47.1	3.8
Rural	45.9	3.4

Overall Household Educational Attainment

Average years of education by household age group are shown in Table IV.6. There have been continuing, though uneven, increases in the amount of schooling for males but little improvement for females. However, the substantially higher levels of schooling for girls aged 10–14, many of whom are still in school, and 15–19, most of whom have completed their schooling, is promising.

The serious educational disparities in Afghanistan are an important consideration in addressing health service issues, particularly those related to navigating the system to effectively resolve

⁴⁴ NRVA 2005 shows 53% of the rural population as being younger than 18; adjusting the 15–19 group to make the findings comparable, the current survey finds 50.6% falling into this age group. The gender ratio here shows 1% fewer females than reported for all rural areas in NRVA 2005.

⁴⁵ No comparison was feasible in Loghar since no interviews were conducted in the central district.

health problems and to designing health education curricula for women and for men. The typical primary school reading curriculum used until 2006 throughout Afghanistan up to Grade 4 is unlikely to provide the skills necessary for understanding even basic health-related materials.⁴⁶ As Table IV.6 suggests, most male household members have reading skills that are barely adequate to understand basic health-related material and few women have even this level of reading comprehension. These findings are consistent with the 23% rural literacy rate and the female/male literacy gap found in NRVA 2005 (MRRD/CSO 2007).

TABLE IV.6. AVERAGE EDUCATIONAL ATTAINMENT OF HOUSEHOLD MEMBERS BY GENDER AND AGE GROUP			
Age Group	Male	Female	Age Group as a Whole
5–9	1.2	0.9	1.0
10–14	4.0	2.3	3.2
15–19	5.2	1.9	3.7
20–24	4.7	0.6	3.1
25–29	4.4	0.5	2.7
30–34	4.0	0.1	2.1
35–39	4.1	0.5	2.4
40–44	3.9	0.6	2.4
45–49	4.8	0.1	2.7
50–54	3.6	0.3	2.2
55–59	2.4	0.0	1.7
60–64	2.1	0.2	1.4
65+	2.0	0.4	1.6
Overall HH	3.6	1.0	2.5

Note that the schooling received by male heads of household in the 30–45 age range—those growing up during the worst years of conflict—is less than that of some of the older and all of the younger men.

The average education of household heads and members is, of course, substantially affected by the proportions who have not attended school at all. Table IV.7 reports the proportions of males and females in each age group who did and did not receive schooling.

⁴⁶ Kissam and his colleagues conducted a detailed analysis of the de facto primary school curriculum, i.e. textbook content, for all primary school grades in order to develop a curriculum-referenced instrument to assess student mastery of basic subject matter. Discussion of the typical competencies targeted (but not always achieved given teacher and student absenteeism and limited teacher qualifications in rural areas) can be found in reports on student achievement provided to USAID in 2005 and 2006.

TABLE IV.7. HOUSEHOLD MEMBERS WHO HAVE ATTENDED SCHOOL BY AGE GROUP

Age Group	Male				Female				Total				*Total #
	Never Attended		Attended		Never Attended		Attended		Never Attended		Attended		
	#	%	#	%	#	%	#	%	#	%	#	%	
5-9	235	53.3	206	46.7	247	61.3	156	38.7	482	57.1	362	42.9	844
10-14	96	22.6	328	77.4	182	48.7	192	51.3	278	34.8	520	65.2	798
15-19	124	35.1	229	64.9	185	68.0	87	32.0	309	49.4	316	50.6	625
20-24	108	43.2	142	56.8	143	89.9	16	10.1	251	61.4	158	38.6	409
25-29	89	45.4	107	54.6	132	90.4	14	9.6	221	64.6	121	35.4	342
30-34	86	56.2	67	43.8	137	97.9	3	2.1	223	76.1	70	23.9	293
35-39	73	50.0	73	50.0	128	94.1	8	5.9	201	71.3	81	28.7	282
40-44	75	54.3	63	45.7	105	91.3	10	8.7	180	71.1	73	28.9	253
45-49	55	47.4	61	52.6	89	98.9	1	1.1	144	69.9	62	30.1	206
50-54	54	58.7	38	41.3	68	97.1	2	2.9	122	75.3	40	24.7	162
55-59	46	68.7	21	31.3	27	100.0	0	0.0	73	77.7	21	22.3	94
60-64	62	78.5	17	21.5	43	95.6	2	4.4	105	84.7	19	15.3	124
65+	116	76.8	35	23.2	53	93.0	4	7.0	169	81.3	39	18.8	208
Total	1,219	46.8	1,387	53.2	1,539	75.7	495	24.3	2,758	59.4	1,882	40.6	4,640

*Percentages and totals include only those individuals on the household grid for whom both age and educational data were reported; both age and educational data were reported for only 51% of the individuals.

The proportions of children aged 6–13 in surveyed households who have attended school (61% of boys and 39% of girls) are somewhat higher than those reported in NRVA 2005 (44% for males and 27% females aged 6–13); however, this may reflect unique characteristics of the provinces surveyed.

This tabulation of household educational attainment also shows slightly higher proportions of school-age children having attended school than the AHS 2006 reports on children *currently* attending school; this is inevitable because this survey asked about years of school completed and AHS asked about current school attendance. The divergence actually appears to suggest considerable agreement on the education of children and youth aged 5–19.⁴⁷

⁴⁷ In the current survey, we found 2.8% more males and 7.0% more females in the 5-9 age group had attended school than AHS found to be currently enrolled. In the 10-14 age group 8.7% more males and 4.3% females had attended school than were currently enrolled according to AHS. Finally, in the 15-19 age group we found 16.6% more males had attended school than were currently attending according to AHS and 12.8% more females with some school attendance than currently enrolled. These findings are consistent with recent analyses of primary school dropout (Naumann and Kissam 2006; Mansoori 2007). In particular the widening gap between “some school attendance” and “current attendance” in the 15-19 year old group is understandable since few youth in this age group continue into secondary school—especially in rural areas where there is often no post-primary school.

Household Income

Heads of households were asked about the primary source of household income.⁴⁸ Of the households responding, over half (53.8%) indicated their income was primarily from agriculture (Table IV.8). The percentage was naturally lower in central districts than in rural districts and varies significantly by province (e.g., Badghis 82.3% to Nimroz 20.4%). The distribution of households whose primary source of income comes from service, professional, technical, or salaried employment varied similarly. In Badghis, only 1.8% of households and in Nimroz 24.6% derive income from this sort of work.

TABLE IV.8. PRIMARY SOURCE OF HOUSEHOLD INCOME BY PROVINCE

	Agriculture		Rearing Animals		Other Labor		Business/ Trading		Service, Professional, Technical & Salaried		Remittance		Other		Total Households
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	% HH	#
Badghis	135	82.3	12	7.3	5	3	3	1.8	3	1.8	-	-	6	3.7	164
Central	48	90.6	3	5.7	-	-	1	1.9	1	1.9	-	-	-	-	53
Rural	87	78.4	9	8.1	5	4.5	2	1.8	2	1.8	-	-	6	5.4	111
Baghlan	106	65.0	3	1.8	33	20.2	1	0.6	10	6.1	1	0.6	9	5.5	163
Central	39	72.2	2	3.7	4	7.4	-	-	5	9.3	-	-	4	7.4	54
Rural	67	61.5	1	0.9	29	26.6	1	0.9	5	4.6	1	0.9	5	4.6	109
Laghman	83	50.6	2	1.2	16	9.8	10	6.1	19	11.6	10	6.1	24	14.6	164
Central	20	37.0	1	1.9	4	7.4	4	7.4	12	22.2	1	1.9	12	22.2	54
Rural	63	57.3	1	0.9	12	10.9	6	5.5	7	6.4	9	8.2	12	10.9	110
Loghar	55	50.0	5	4.5	15	13.6	21	19.1	10	9.1	1	0.9	3	2.7	110
Nimroz	34	20.4	12	7.2	65	38.9	9	5.4	41	24.6	-	-	6	3.6	167
Central	-	-	2	3.6	25	44.6	6	10.7	21	37.5	-	-	2	3.6	56
Rural	34	30.6	10	9	40	36	3	2.7	20	18.0	-	-	4	3.6	111
Total	413	53.8	34	4.4	134	17.4	44	5.7	83	10.8	12	1.6	48	6.3	768
Central	107	49.3	8	3.7	33	15.2	11	5.1	39	18.0	1	0.5	18	8.3	217
Rural	306	55.5	26	4.7	101	18.3	33	6	44	8.0	11	2	30	5.4	551

⁴⁸ Question C-1A Head of Household Survey

About one-quarter (23%) of the households reported a secondary source of income that supplemented their income—most often agriculture (7.9%) or rearing animals (7%). These findings are entirely consistent with NRVA 2005; only 2% fewer households in the current survey derived their income primarily from agriculture than in the NRVA tabulations.⁴⁹

The households in this APSHS survey also relied slightly less on remittances (2%) than NRVA 2005 rural households (6%). In 1.4% of the households, remittances, while not a primary source of income, supplemented other sources.

Nimroz is the province that diverges most from the others. A much higher proportion of households there derive their income from service, professional, technical, or salaried work or “other labor,” especially in the central district of Zaranj.

Household Transportation

Table IV.9 shows types of transportation available to households.⁵⁰ Almost half (42%) of those responding said they had no form of transportation other than walking. The most common form of transportation other than travelling by foot was by animal (reported by 33%) or bicycle (18%). Of households answering the question about types of transportation available, about 17% reported two or more types of transportation other than walking.

TABLE IV.9. TRANSPORTATION AVAILABLE TO HOUSEHOLDS BY TYPE OF DISTRICT						
Types of Transportation	Central District Households		Rural District Households		Total Households	
	#	%	#	%	#	Total%
None, walk	92	42.4%	245	44.6%	337	43.4%
Donkey/horse/camel	56	25.8%	194	35.2%	250	32.5%
Bicycle	37	17.1%	100	18.1%	137	17.8%
Motorcycle/bike	52	24.0%	80	14.5%	132	17.2%
Car/van/truck	28	12.9%	78	14.2%	106	13.8%
Tractor	9	4.1%	2	0.4%	11	1.4%
Shared vehicle	3	1.4%	9	1.6%	12	1.6%
Jitney/bus nearby	2	0.9%	5	0.9%	7	0.9%
Other	1	0.4%	6	1.1%	7	0.9%
Total	217	100%	551	100%	768	100%

*The sum of column percentages exceed 100% because households reported access to multiple modes of transportation.

Table IV.9 confirms the general assumption that transportation is a significant constraint on household access to health care in rural Afghanistan. Fewer households in this survey (18%) than in the NRVA 2005 rural tabulations (32%) own a bicycle, but slightly more (17% vs. 13%) own a motorcycle. Also, more households in the current survey than in NRVA 2005 (14% vs. 1%) say

⁴⁹ There are minor definitional divergences in the NRVA 2005 and these tabulations—between “income from agricultural activities” (NRVA) and “main source of household income” (current survey).

⁵⁰ Question C3, Head of Household Interview.

they have a car or truck available to them.⁵¹ In both surveys, negligible numbers of households own a tractor.

The question in the current survey regarding “transportation available to the household” differs somewhat from the AHS question about actual mode of transportation used to travel to the nearest health facility. For instance, considerably more households in the current survey report having an animal for transportation than households in AHS reported actually using an animal to reach the nearest health facility. This divergence may actually provide evidence of positive health system responses to household needs—it appears that a significant proportion of health providers can be reached by foot, especially for visits where a patient is not seriously ill, even though the household may have another mode of transportation available.⁵²

Household Access to Media and Communication Technology

Table IV.10 lists the types of communications technology that are available within households. Over half those responding (59%) have a radio, but only 16% have a television. Over half (54%) reported having access to a cell phone. More than eight out of ten (82%) in both rural and central districts reported they had a watch or clock. Although 11% of households said they had an electric generator, only 3% reported having a refrigerator.

Household Technology	*Total		Central		Rural	
	#	% HHs with	#	% HHs with	#	%
Radio only	360	46.8	78	35.1	282	51.6
Both radio & TV	93	12.1	48	21.6	45	8.2
Television only	33	4.3	26	11.7	7	1.3
Mobile phone	393	54.1	125	60.1	268	51.6

* Only 1% of households did not answer the question about owning a radio or television; 6% did not answer the question about mobile phones.

Similar proportions of rural and central district households have mobile phones, although there are slightly more mobile phone households in the central district. This is quite likely very positive news with respect to health care management and suggests that more reliance on telephone communications with patients may be a viable option for both public and private providers.

Similarly, the relatively high proportion of households with radios is good news for designing cost-effective health promotion campaigns. The NRVA 2005 found that 77% of rural households had radios, though this survey shows only 59%. However, television ownership is somewhat higher in the current survey than in the NRVA 2005 rural tabulation (16% vs. 8%). This may be due to the availability of television signals in the specific provinces surveyed.

In NRVA 2005 only 8% of households were found to have mobile phones but 54.1% have one in the current survey. This is consistent with the prediction made in the NRVA report that mobile phone penetration would rise. However, it may also be that the provinces surveyed probably have

⁵¹ There may be differences in wording between the surveys.

⁵² This is consistent with the AHS 2006 report that about one-third (32.1%) of health care visits require less than an hour’s walk.

better telecommunications infrastructure than other rural provinces in Afghanistan and thus there are market pressures for households to own a mobile phone (one would not be useful in a rural province like Dai Kundi).

Household Possessions and Wealth Index

AHS 2006 included an inventory of household possessions; in the current survey, households were asked whether they owned these same items.

Possessions	Total		Central		Rural	
	#	% With	#	% With	#	%
Clock/watch	633	81.6	182	81.6	451	81.6
Pressure cooker	543	70.0	170	76.2	373	67.5
Sewing machine	466	60.1	141	63.2	325	58.8
Electric generator	83	10.7	40	17.9	43	7.8
Refrigerator	23	3.0	17	7.6	6	1.1

The possessions owned by households in the current survey are similar to those reported by households surveyed in AHS 2006 except that there appear to be very slightly more affluent households; equivalent proportions had a clock or watch but 13% more had a pressure cooker, 8% more a sewing machine, 4% more an electric generator, and 2% more a refrigerator.

A composite index of variables was constructed as a single indicator of wealth. Indices among the individual households ranged from the lowest of -04 to the highest of 10.5. Households were coded accordingly to where they fell among the wealth quintiles (1 being the poorest, 5 the wealthiest).⁵³ Table IV.12 shows variations in household wealth by province.

Province	1 st (Poorest)		2 nd		3 rd		4 th		5 th (Wealthiest)		Total #
	#	%	#	%	#	%	#	%	#	%	
Badghis	30	20.3	43	29.1	41	27.7	26	17.6	8	5.4	148
Central	2	3.9	13	25.5	18	35.3	14	27.5	4	7.8	51
Rural	28	28.9	30	30.9	23	23.7	12	12.4	4	4.1	97
Baghlan	38	25.3	39	26.0	31	20.7	24	16.0	18	12.0	150
Central	9	18.4	9	18.4	12	24.5	10	20.4	9	18.4	49
Rural	29	28.7	30	29.7	19	18.8	14	13.9	9	8.9	101
Laghman	29	19.2	30	19.9	30	19.9	28	18.5	34	22.5	151
Central	7	14.0	2	4.0	8	16.0	13	26.0	20	40.0	50
Rural	22	21.8	28	27.7	22	21.8	15	14.9	14	13.9	101

⁵³ See Appendix X for details on construction of the household wealth index.

TABLE IV.12. DISTRIBUTION OF HOUSEHOLDS BY WEALTH QUINTILE BY PROVINCE AND TYPE OF DISTRICT

Province	1 st (Poorest)		2 nd		3 rd		4 th		5 th (Wealthiest)		Total
Loghar	4	3.7	2	1.9	12	11.1	29	26.9	61	56.5	108
Nimroz	40	26.7	33	22.0	25	16.7	32	21.3	20	13.3	150
Central	10	19.2	9	17.3	8	15.4	13	25.0	12	23.1	52
Rural	30	30.6	24	24.5	17	17.3	19	19.4	8	8.2	98
Total	141	19.9	147	20.8	139	19.7	139	19.7	141	19.9	707
Central	28	13.9	33	16.3	46	22.8	50	24.8	45	22.3	202
Rural	113	22.4	114	22.6	93	18.4	89	17.6	96	19.0	505

* Sixty-nine (9%) households have missing data for at least one component of the index and are not included in the tabulation.

Households in central districts are generally better off than those in rural districts, and there are clear differences in wealth distribution from province to province. Loghar has a substantially higher proportion of well-off households than the other provinces; households in Badghis and Nimroz are relatively economically disadvantaged. The differences seem to be consistent with density of professional (nontraditional) private health care providers in the different provinces, in which Badghis being particularly disadvantaged. However, the disparity in income between households in central and rural districts is particularly striking in Nimroz.

HOUSEHOLD SOURCE OF WATER

Source of water is an important factor in household health. The current survey asked heads of household about the source of water for their household for comparison with the NRVA 2005 data.⁵⁴ Overall, the households in the current survey had significantly better access to safe water than those surveyed in 2005: 50% compared with only 26% in NRVA 2005.⁵⁵ This finding reflects in part differences in areas sampled (NRVA found great variation from province to province in availability of safe water, as well as urban/rural variation). However, the finding is also quite interesting in that many households (22%) reported access to water from a public handpump or tap. This finding undoubtedly reflects infrastructure improvements completed in 2005–2008.

Table IV.13 details household water sources by province and type of district.

⁵⁴ 17% of the households reported multiple sources of water, e.g., a cistern for rainwater plus a covered well in the compound.

⁵⁵ Loghar, reported in NRVA 2005 as one of the provinces with the best access to safe water (49% of households), was an outlier in the current survey also: 86.4% of households reported access to safe water. This high proportion stems in part from the fact that 56.4% reported access to water from a public hand pump or tap.

TABLE IV. 13. HOUSEHOLD WATER SOURCES BY PROVINCE AND TYPE OF DISTRICT

Province and District Type	Water Sources Generally Considered Safe					Water Sources Generally Considered Unsafe					
	Piped into Household	Rainwater into Cistern	Tanker/truck	Public Handpump/ Tap	Covered Well in Compound	Covered Well Elsewhere	Open well in Compound	Open Well Elsewhere	river/stream / pond/lake/ dam	Other	Total HHs Reporting
Badghis	17.8%	1.8%	1.2%	4.3%	1.2%	11.0%	1.8%	2.5%	65.6%	0.0%	163
Central	50.0%	0.0%	0.0%	12.5%	1.8%	21.4%	1.8%	5.4%	14.3%	0.0%	56
Rural	0.9%	2.8%	1.9%	0.0%	0.9%	5.6%	1.9%	0.9%	92.5%	0.0%	107
Baghlan	3.0%	0.6%	0.0%	26.1%	7.9%	10.3%	10.9%	5.5%	44.8%	1.8%	165
Central	1.8%	1.8%	0.0%	23.6%	20.0%	21.8%	20.0%	16.4%	18.2%	0.0%	55
Rural	3.6%	0.0%	0.0%	27.3%	1.8%	4.5%	6.4%	0.0%	58.2%	2.7%	110
Laghman	1.2%	0.6%	0.6%	15.3%	31.9%	27.6%	11.0%	11.7%	23.3%	0.6%	163
Central	3.6%	1.8%	1.8%	17.9%	51.8%	23.2%	10.7%	3.6%	8.9%	0.0%	56
Rural	0.0%	0.0%	0.0%	14.0%	21.5%	29.9%	11.2%	15.9%	30.8%	0.9%	107
Loghar	2.7%	0.0%	0.0%	56.4%	25.5%	10.9%	2.7%	2.7%	8.2%	0.0%	110
Nimroz	3.6%	0.6%	31.3%	19.3%	7.8%	28.9%	3.0%	25.9%	0.6%	0.0%	166
Central	10.9%	1.8%	90.9%	5.5%	5.5%	1.8%	3.6%	5.5%	0.0%	0.0%	55
Rural	0.0%	0.0%	1.8%	26.1%	9.0%	42.3%	2.7%	36.0%	0.9%	0.0%	111
Total	5.9%	0.8%	7.2%	22.0%	14.1%	18.3%	6.1%	10.2%	29.9%	0.5%	767
Central	16.7%	1.4%	23.0%	14.9%	19.8%	17.1%	9.0%	7.7%	10.4%	0.0%	222
Rural	1.5%	0.6%	0.7%	25.0%	11.7%	18.7%	5.0%	11.2%	37.8%	0.7%	545

Source: Household Interview, Question C7; 13% of the households reported one than more source of water – responses are inclusive.

Household heads were also asked if they did anything to make their water safer. Relatively few households—15%—did so. When water was treated, chlorine was used more than twice as often as boiling (by 1% of households vs. 4% who boiled their water).⁵⁶

Household Heating

Virtually all the households surveyed (98%) heated their homes with firewood; stoves burning straw, ping, or manure; or brush, leaves, or grass.

Household Sanitary Facilities

As NRVA 2005 found, the most prevalent type of toilet facility was an ordinary vault latrine, used by more than two-thirds of the households (69%). Except in Badghis, where households in rural districts were less likely to have a traditional vault latrine than those in the central district (49% vs. 86%), there were no significant differences in proportions of households with vault latrines. However, one in five households in rural districts (20%) had no latrine or toilet, but only a negligible proportion of households in central districts (2%) went to the fields. Table IV.14 details sanitary facilities by province. The proportion of households with flush toilets is clearly very low—at the same levels reported in NRVA.

⁵⁶ In 3.0% of the households, the heads said they didn't know if anything was done to the water; this probably means that nothing was done.

TABLE IV. 14. MAIN HOUSEHOLD TOILET FACILITY BY PROVINCE (PERCENT)

	Field/outside house	% Traditional pit	% ordinary Vault latrine	% improved Vault Latrine	Flush	Other	Total
Badghis	22.7	11.7	61.7	3.9	-	-	154
Baghlan	16.3	14.4	67.5	-	0.6	1.3	160
Laghman	16.0	6.2	76.5	-	1.2	-	162
Loghar	-	-	98.2	1.8	0.0	-	109
Nimroz	15.1	27.6	49.3	2.6	5.3	-	152
Total	14.9	12.6	69.1	1.6	1.5	0.3	737

* Four percent of the households did not report toilet data.

V. HOUSEHOLD UTILIZATION OF PRIVATE AND PUBLIC PROVIDERS

Interviewees were asked about visits of household members to health care providers and the types of health problems that had occurred in their household since Nawrooz, the beginning of the Afghan year in which the survey was conducted, i.e., 1387; thus the reference period for retrospective tabulation of health-related visits was five months.⁵⁷

FREQUENCY OF VISITS TO HEALTH CARE PROVIDERS

The most common type of health issues (see Table V.1) that led an individual in a household to seek health care were related to adults who were sick (in 77% of households a sick adult had sought help) followed by children who were sick (67% of households). The next most common reasons for visits were children needing routine health care (50% of households) and adults needing medicine (42% of households).

TABLE V.1. HOUSEHOLD HEALTH VISITS SINCE NAWROOZ BY TYPE OF PROBLEM AND TYPE OF DISTRICT						
Reason for Visit	Total (n=776)		Central (n=223)		Rural (n=553)	
	#	%	#	%	#	%H
Illness						
Sick adult	596	76.8%	159	71.3%	437	79.0%
Sick child	517	66.6%	153	68.6%	364	65.8%
Routine Visit						
Adult needing routine health care	243	31.3%	66	29.6%	177	32.0%
Child needing routine health care	388	50.0%	113	50.7%	275	49.7%
Advice, Medication, Maternal Health						
Adult needing advice	162	20.9%	64	28.7%	98	17.7%
Adult needing medicine	323	41.6%	100	44.8%	223	40.3%
Antenatal/pregnancy care	251	32.3%	66	29.6%	185	33.5%
Injury						
Injured adult	130	16.8%	36	16.1%	94	17.0%
Injured child	96	12.4%	37	16.6%	59	10.7%

*In each cell, households seeking care are those in which at least one person of a given type (e.g., adult) was reported seeking assistance for the specified type of problem (e.g. injury).

The most striking differences in health system utilization between households in rural and in central districts are related to visits for adults seeking health-related advice and adults seeking

⁵⁷ Nawrooz occurs at the spring equinox, March 21; the survey took place in the middle of August. The question on health visits (and illness and injuries) was references to Nawrooz to facilitate recall and to have a longer “look-back period” than one month since there were likely to be month-to-month variations in health care use.

health care for an injury. The higher rate of rural households seeking care for an injury may be the result of different risk factors and a higher incidence of injuries in rural areas.

Although virtually all households had had some need for health-related assistance, including routine visits or visits for advice, during the five months since Nawrooz, over one-third (38%) of the individuals living in these household did not have any illness or injury which required medical assistance.⁵⁸

The overwhelming majority (98%) of household members who had an illness or injury did in fact seek assistance. However, in Badghis, an under-resourced province, almost 5% of household members who were ill or injured failed to seek assistance—probably because it was not feasible to do so. In general, persons in rural households (2%) who were ill or injured were somewhat less likely to actually seek needed assistance than those in central district households (1%).⁵⁹

VISITS TO PUBLIC AND PRIVATE PROVIDERS BY REASON FOR VISIT

Heads of household were also asked if the person with the health problem had sought help from a public or a private provider. For almost all cases, more households sought help at private providers. The primary exception is that 81.5% of households where children needed routine health care went to a public provider; only 31.9% of adults sought routine care from a public provider.

Visits for antenatal care were fairly evenly divided between public (46%) and private (54%) providers. It also seems that households are more likely to seek help at public providers for children's illnesses (41.4% sought help from a public facility) than for adult illnesses (28.6%) and for children's injuries (42.4%) than for adult injuries (35.2%).

This pattern suggests that the private and public health care systems in rural Afghanistan are actually complementary, since public providers receive more visits for basic primary care—children's health problems and routine care—than for adult health problems. This would appear to be a function of the public system's focus on preventive health and maternal-child health and a de-emphasis of curative medicine.

Less important to health care planning than distribution of visits to private and public providers is the analysis of types of individuals who go to each and the types of assistance they seek. The data from the current survey can be seen as providing welcome news that the public health services delivery system has assumed an identity as the provider of MCH services while the private sector has specialized to some extent in responding to adult illnesses and injuries.

“Perfect” or total specialization would, of course, not be an optimal system configuration since it is desirable for households to have some flexibility in health care choices—going to providers nearer to their homes who seem well-suited to the specific issue for which they are seeking help, etc. For example, pregnant women probably seek antenatal care from traditional healers and traditional birth attendants as well as public health personnel if they have a prior relationship with them or a linguistic, ethnic, or tribal affinity. It should also be remembered that some private

⁵⁸ Some proportion of these individuals may have had a minor illness but did not consider it to be one which merited seeking assistance from a health care provider.

⁵⁹ The findings from the current survey regarding individuals seeking medical assistance are not directly comparable with those from AHS 2006 because the proportion reported here as not seeking care is the percentage of the household members who were ill or injured who said explicitly that they needed care but did not seek it; in contrast, the AHS 2006 survey reports households (not individuals) who failed to seek care for any reason, including the belief that the illness or illness was not severe enough to warrant seeking help.

providers waive fees for pregnant women as well as other needy subpopulations in their communities, such as orphans, or those deserving of special assistance, such as elders.

Table IV.2 provides a detailed tabulation of rural and central district household reasons for visits to health care providers and whether the visit was to a public or private provider.

TABLE V.2. HOUSEHOLD VISITS TO PUBLIC AND PRIVATE PROVIDERS BY REASON FOR VISIT AND TYPE OF DISTRICT						
Households Seeking Health Care	Households Seeking Help for Each Type of Health-related Need					
	Overall		Central Districts		Rural Districts	
	#	%	#	%	#	%
Illness						
Sick adult (n=594)						
From a public provider	170	28.6	50	31.6	120	27.5
From a private provider	424	71.4	108	68.4	316	72.5
Sick child (n=510)						
From a public provider	211	41.4	56	37.3	155	43.1
From a private provider	299	58.6	94	62.7	205	56.9
Routine Visit						
Adult needing routine health care (n=238)						
From a public provider	76	31.9	16	25.8	60	34.1
From a private provider	162	68.1	46	74.2	116	65.9
Child needing routine health care (n=378)						
From a public provider	308	81.5	88	81.5	220	81.5
From a private provider	70	18.5	20	18.5	50	18.5
Advice, Medication, Maternal Health						
Adult needing advice (n=165)						
From a public provider	57	34.5	20	33.9	37	34.9
From a private provider	108	65.5	39	66.1	69	65.1
Adult needing medicine (n=317)						
From a public provider	59	18.6	26	27.1	33	14.9
From a private provider	258	81.4	70	72.9	188	85.1
Antenatal/pregnancy care (n=248)						
From a public provider	114	46.0	30	46.2	84	45.9
From a private provider	134	54.0	35	53.8	99	54.1

TABLE V.2. HOUSEHOLD VISITS TO PUBLIC AND PRIVATE PROVIDERS BY REASON FOR VISIT AND TYPE OF DISTRICT

Households Seeking Health Care	Households Seeking Help for Each Type of Health-related Need					
	Overall		Central Districts		Rural Districts	
	#	%	#	%	#	%
Injury						
Adult (n=125)						
From a public provider	44	35.2	16	47.1	28	30.8
From a private provider	81	64.8	18	52.9	63	69.2
Child (n=92)						
From a public provider	39	42.4	15	44.1	24	41.4
From a private provider	53	57.6	19	55.9	34	58.6

DECISIONS ABOUT WHERE AND WHEN TO GET HEALTH CARE

As might be expected, the overwhelming majority of decisions regarding where to get health care were made by the head of household or an elder (82% of households). However, in about one out of eight households (12%), health care decisions were made jointly by the heads and their wives. Here Nimroz is a distinct outlier—one-third (33%) of households reported that heads of household and their spouses made joint decisions about health care; Nimroz also differed in that 4% of the households said the household member having the health problem decided where to go for help or advice—something that happened in only a negligible number of households elsewhere.

An individual household's mode of decision-making seems to have a modest impact on decisions to go to private or public providers—households relying on joint decision-making were slightly more likely to rely on public providers. The most notable difference is in decisions related to seeking help for an injured child: 72% of households with joint decision-making turned to a public provider, compared to only 43% of those where the head of household made health-related decisions alone. This finding deserves further investigation but should not be considered definitive: the number of households where there is joint decision-making is small, and they are disproportionately located in Nimroz province, which differs from the four other provinces in other respects.

A household's approach to health care decision-making seems to be related to the number of visits made to providers during the 5-month look-back period to Nawrooz—1.3 visits per household member in households where the head made the decision compared to 1.0 in households where the decision was made jointly. However, the ratio of visits to public and private providers is quite similar in both types of household. This finding also must not be considered definitive because of the small number of households making joint decisions and their concentration in Nimroz.

TIME IN VILLAGE AND PROVIDER CHOICE

During more than two decades of conflict Afghanistan experienced massive emigration to Iran and Pakistan and then repatriation of large numbers of refugee families who returned post-2001. Moreover, during the periods of most intense conflict and up to the present day, there have been

unusually high levels of internal migration as a result of drought, village and clan network interactions, and conflict.

An extensive body of research points to social capital as a determinant of health status in general and how individuals navigate service delivery systems specifically. To examine this issue this ASPHS compared the health care-seeking behavior of households that had lived in the villages for different periods of time.⁶⁰ These variations may in fact be one of the factors underlying province-to-province disparities in health care system utilization, since the situation differs greatly from province to province; proportions of “newcomers”—households living in a community for less than six years—varied from 3% in Badghis to 62% in Nimroz. The proportion of newcomer households in villages in Loghar was 8%, in Baghlan 20%, and in Laghman, 31%.

There were significant differences in the use by newcomers and long-term village residents of different types of local providers, as Table V.3 shows.

TABLE V.3. TYPE OF PROVIDER VISITS BY LENGTH OF TIME HOUSEHOLD HAS LIVED IN VILLAGE			
Types of Household Visits	Newcomer (0–5 years)	Established (> 5 years)	All
	Average	Average	Average
Total Visits to Private Providers	4.2	8.0	7.0
Traditional private	0.2	1.1	0.8
Professional private	4.1	6.9	6.2
Visits to public providers	2.2	1.9	2.0
Visits per Household Member	1.0	1.3	1.2
Private providers	0.7	1.0	0.9
Public providers	0.3	0.3	0.3

*Average number of visits is computed based on information from head of households' tabulations of household visits to all providers over the previous five months in Section A of the household survey with visits/household member being adjusted by tabulations of household size from Section B.

Newcomers in general use local health care resources, particularly traditional private providers, less heavily than established families (Table V.3). However, their households rely more on public providers than do established families and much less on private providers.

When utilization is adjusted for household size, newcomer households use public providers to the same extent as established households but private providers much less. Patterns of the use of private and public sectors reflect the reality of a society in transition—although the rate of change varies from village to village.

DIVERSITY IN RELIANCE ON PRIVATE AND PUBLIC PROVIDERS

Having reported reliance on private and public providers for different sorts of health needs (see Table V.3), it is also useful to examine the diversity of household preferences regarding visits to private and public providers (see Table V.4). Over half the households surveyed (55%) reported

⁶⁰ Based on responses to Q. 13 of the Household Head interview

visiting only private providers while about one-third (32%) reported visiting both public and private providers.⁶¹ Only about 10% of the households visited public providers exclusively.

TABLE V.4. HOUSEHOLD VISITS TO PRIVATE AND PUBLIC HEALTH CARE PROVIDERS SINCE NAWROOZ		
Providers Visited	Households	%
Private only	429	55.3%
Public only	77	9.9%
Both private and public	254	32.7%
Unknown providers	4	0.5%
No provider visits	12	1.5%
Total	776	100.0%

Only 12 households reported no visits to a health care provider (2%); 4 did not indicate the type of provider they had visited.

Table V.5 shows the proportions of households in each province (and in rural and central districts) who visit only private, only public, or both private and public providers.

The proportion of households visiting only private providers is highest in Badghis (73%) and Loghar (73%) and lowest in Baghlan (36%). Baghlan is the province with the highest percentage of households (21%) that visited public providers exclusively. In contrast, in Badghis no households rely exclusively on the public sector for health care.

These variations from province to province in reliance on public and private providers, in addition to differences in types of providers sought out for different sorts of assistance (see Table V.2), suggests that the private and public sectors of Afghanistan's health care system are more complementary than competitive.

TABLE V.5. HOUSEHOLD VISITS TO PUBLIC AND PRIVATE HEALTH CARE PROVIDERS BY PROVINCE AND TYPE OF DISTRICT											
Region	Private Only		Public Only		Both Private and Public		Unknown Providers		No Visits to Providers		Total
	#	%	#	%	#	%	#	%	#	%	
Badghis	122	72.6	-	-	45	26.8	-	-	1	0.6	168
Central	27	48.2	-	-	29	51.8	-	-	-	-	56
Rural	95	84.8	-	-	16	14.3	-	-	1	0.9	112
Baghlan	60	36.4	34	20.6	61	37.0	2	1.2	8	4.8	165
Central	29	52.7	4	7.3	17	30.9	1	1.8	4	7.3	55
Rural	31	28.2	30	27.3	44	40.0	1	0.9	4	3.6	110

⁶¹ Interviewees were asked to name up to 12 different health care providers that people in their household had visited since Nawrooz (Section A). Each provider was categorized as private or public whenever possible.

TABLE V.5. HOUSEHOLD VISITS TO PUBLIC AND PRIVATE HEALTH CARE PROVIDERS BY PROVINCE AND TYPE OF DISTRICT

Region	Private Only		Public Only		Both Private and Public		Unknown Providers		No Visits to Providers		Total
	#	%	#	%	#	%	#	%	#	%	#
Laghman	76	45.8	16	9.6	71	42.8	1	0.6	2	1.2	166
Central	37	66.1	7	12.5	11	19.6	1	1.8	-	-	56
Rural	39	35.5	9	8.2	60	54.5	0	0.0	2	1.8	110
Loghar	80	72.7	6	5.5	23	20.9	0	0.0	1	0.9	110
Nimroz	91	54.5	21	12.6	54	32.3	1	0.6	-	-	167
Central	37	66.1	2	3.6	16	28.6	1	1.8	-	-	56
Rural	54	48.6	19	17.1	38	34.2	0	0.0	-	-	111
Total	429	55.3	77	9.9	254	32.7	4	0.5	12	1.5	776
Central	130	58.3	13	5.8	73	32.7	3	1.3	4	1.8	223
Rural	299	54.1	64	11.6	181	32.7	1	0.2	8	1.4	553

The differences in reliance on private and public providers in central and rural districts suggest that these patterns reflect not only preferences but the accessibility of private or public providers.

ACCESS TO HEALTH CARE PROVIDERS

Location of Providers

Interview responses regarding providers visited by any household member included information on type of provider (public or private and specific type—e.g., private MD, midwife, BHC, district hospital) and on whether the provider was located within the village or elsewhere. Since all the villages surveyed were small it is not surprising that more than two-thirds (72%) of health care visits required travel outside the village, although often the distance was not great.

There were some differences from province to province in proportions of providers, whether public or private, located within villages. In Badghis only 13% of health care providers were within the village, but in Loghar, two-thirds (67%) were. In the other three provinces the proportions of providers inside and outside the village were similar; in Baghlan 24% of the providers, in Laghman 25% and in Nimroz 31% of the providers were within the village.

There is no clear-cut pattern of whether public or private providers are more likely to be located within a village and thus more easily accessible. Table V.6 shows the numbers and proportions of provider visits within and outside the village and variations in location of public and private providers in different provinces.

TABLE V.6. LOCATIONS OF PRIVATE AND PUBLIC HEALTH CARE PROVIDERS BY PROVINCE						
Province and Location of Provider	Health Care Visits to Providers Within and Outside Village Where Household Is Located					
	All Provider Visits		Visits to Private Providers		Visits to Public Providers	
	#	%	#	%	#	%
Badghis	578	100.0	526	100.0	52	100.0
Within village	77	13.3	73	13.9	4	7.7
Outside village	501	86.7	453	86.1	48	92.3
Baghlan	310	100.0	202	100.0	108	100.0
Within village	74	23.9	40	19.8	34	31.5
Outside village	236	76.1	162	80.2	74	68.5
Laghman	439	100.0	332	100.0	107	100.0
Within village	111	25.3	56	16.9	55	51.4
Outside village	328	74.7	276	83.1	52	48.6
Loghar	276	100.0	239	100.0	37	100.0
Within village	185	67.0	168	70.3	17	45.9
Outside village	91	33.0	71	29.7	20	54.1
Nimroz	343	100.0	255	100.0	88	100.0
Within village	105	30.6	73	28.6	32	36.4
Outside village	238	69.4	182	71.4	56	63.6
Overall Survey Area	1,946	100.0	1,554	100.0	392	100.0
Within village	552	28.4	410	26.4	142	36.2
Outside village	1394	71.6	1144	73.6	250	63.8

*Based on Section A, Q. A.4.3. Provider type is missing for 25 provider visits.

The most notable differences in location of public and private providers were in Laghman, where 51% of public provider visits but only 17% of private provider visits were within the village. Public providers were also more often located in the village than private providers in Laghman and in Nimroz, but the patterns are not so pronounced. Conversely, in Loghar 70% of private provider visits took place within the village but only 54% of public provider visits. In Badghis, where health care system resources are spread thin, neither private nor public providers are concentrated within the sampled villages, and public providers were slightly less accessible.

As in many other respects, the district-to-district variations in infrastructure within a province are as great as or greater than the differences between provinces. For example, in Baghlan only 3% of the health care visits of households in Dhana-i-Ghori district were to providers within the village but in Dushi 40% were. Interestingly, households in surveyed villages in central districts were

less likely to go to providers in their own village than households in rural districts—most probably because they go instead to providers in the provincial capital, which is in their district.⁶²

Overall, Table V.6 suggests that public providers have made a positive impact on accessibility of health care in most provinces, even if most visits for health care are still to private providers.

Quite remarkably, while slightly more than one-quarter of all visits to providers were to facilities within the village where a household lived, 75% of the visits to MoPH-funded subcenters and 51% of the visits to MoPH-funded BHCs were within the village. However, as might be expected, 89% of the visits to a MoPH-funded district hospital required travel beyond the village.

Table V.7 zooms in on another facet of the patterns of public and private provider location within or outside the villages surveyed and what this means for households seeking help with different types of health needs.

TABLE V.7. PROPORTIONS OF VISITS TO PUBLIC AND PRIVATE PROVIDERS WITHIN OWN VILLAGE				
Type of Health Need Addressed	Visits Within Village by Type of Provider			
	Public		Private	
	#	%	#	%
Illness				
Help for a sick adult	52	31.7%	53	12.6%
Help for a sick child	69	33.2%	37	12.5%
ROUTINE				
Routine visit for adult health issue	35	46.1%	31	19.5%
Routine visit for a child health issue	108	36.4%	18	27.3%
Advice, Medication, Maternal Health				
Health advice for an adult	12	27.9%	6	6.0%
Visit for medication	12	21.4%	22	8.8%
Visit for pregnancy-related care	30	28.0%	17	12.9%
Injury				
Visit for an injured adult	11	27.5%	4	5.0%
Visit for an injured child	10	27.8%	6	11.5%

Even though private providers have a larger share of the health service market, public facilities more often are the local health care provider.

Travel Time to Health Care Providers

In Section D of the Head of Household interview, which elicited detailed information on a sample of all household visits (up to three initial visits and three referrals), survey respondents were asked for information on the amount of time it took household members to get to where they could receive health care. A total of 1,673 initial provider visits were detailed.

⁶² The survey sampling procedures required that villages sampled in central districts *not* be the provincial capital.

The information on household member travel time to secure health care underscores the complementarity of the private and the public sectors in Afghanistan’s health care system. More than three-quarters (78%) of all visits were to providers less than an hour from the home—in part because public providers appear to fill in gaps where private providers are unavailable, and vice versa. There were still disparities, however, between central and rural districts: more than half of health-related visits in central districts (51%) required 20 or less minutes travel time, while in rural districts only 38% did so. Also, in rural areas only 19% of the visits to public providers required travel of 1 hour or more but 29% of the visits to private providers took that long.

Visits to public and private providers appear to involve similar amounts of travel—although in central districts slightly more of the visits to public providers involved minimal travel time (60% under 20 minutes compared to 51% in rural districts). However, it must be noted that in 5% of the health encounters, a very long travel time was required to secure help—1% required at least four hours. Table V.8 provides details on the mode of transportation used to get to nearby, more distant, and very distant health care providers.⁶³

TABLE V.8. TRAVEL TIME TO HEALTH PROVIDER AND MODE OF TRANSPORTATION USED													
Visits to Providers by Distance and Mode of Transportation													
Time to Reach Provider	On Foot		By Donkey/Horse/Camel		By Bicycle		By Motorbike/Motorcycle		By Car/Van/Truck		Other/ Can't Say		Total #
	#	%	#	%	#	%	#	%	#	%	#	%	
1–20 mins.	289	50.1	42	7.3	7	1.2	81	14.0	155	26.9	3	0.5	577
21–40 mins.	164	39.9	9	2.2	5	1.2	46	11.2	185	45.0	2	0.5	411
41–60 mins.	59	25.0	36	15.3	2	0.8	20	8.5	119	50.4	-	-	236
Subtotal < 1 hr.	512	41.8%	87	7.1%	14	1.1%	147	12.0%	459	37.5%	5	---	1,224
(1–2 hrs.)	35	13.4	75	28.7	1	0.4	5	1.9	143	54.8	2	0.8	261
(2–4 hrs.)	6	9.0	24	35.8	-	-	4	6.0	32	47.8	1	1.5	67
(> 4 hrs.)	-	-	9	47.4	-	-	-	-	9	47.4	1	5.3	19
Subtotal > 1 hr.	41	11.8%	108	31.1%	1	0.3%	9	2.6%	184	53.0%	4	1.2%	347
% of All Trips*	553	35.2%	195	12.4%	15	1.0%	156	9.9%	643	40.9%	9	0.6%	1571

* Totals include all trips for which there were data about travel time and mode of transportation to provider—6% of the visits did not have complete data and are not included in the table above.

Thus trips to health care providers that are an hour or less away from a home are typically made on foot or by car or van—even though only one in eight families (14% of households) have their own car or van. As might be expected, more of the trips to providers who are extremely close (1–20 minutes distant) are made on foot.

In terms of access to health care, attention should focus on the subgroups that do not have transportation to get to more distant facilities, i.e., the 11.8% of visits where a person needing

⁶³ AHS 2006 asked about “routine” mode of transportation for households while in the current survey we asked about modes of transportation available to the household and mode of transportation actually used for visits to health care providers. Therefore, the tabulations are not comparable.

care travels an hour or more and the 35.2% where they must go by donkey, horse, or camel. Clearly, reliance on bicycles, motorbikes, or motorcycles is unsatisfactory for visits where an adult or child may be ill or injured; one-third of households (32.6%) have a bicycle, motorbike, or motorcycle but only 10.9% health visits use this mode of conveyance.

VISITS TO HEALTH CARE PROVIDERS

Interviewees were asked to give details about their health encounters for household visits for up to three individual providers. Table V.9 tabulates the specific types of providers households identified in the detailed discussion of health care visits.⁶⁴

TABLE V.9. DETAILS OF HOUSEHOLD VISITS TO SPECIFIC PROVIDER TYPES		
Type of Provider	Encounters Described	% Total
Private	1,305	78.0%
Private MD	1,171	70.0%
Private health clinic	8	0.5%
Private hospital	18	1.1%
Pharmacy with MD	57	3.4%
Pharmacy without MD	26	1.6%
Midwife	5	0.3%
Nurse	6	0.4%
Mullah	12	0.7%
Traditional healer	2	0.1%
Public	358	21.4%
Community health worker	6	0.4%
District hospital	76	4.5%
Subcenter	65	3.9%
Basic health clinic	139	8.3%
Community health clinic	72	4.3%
Unknown	10	0.6%
Other	4	0.2%
Missing	6	0.4%
Total	1,673	100

Health Needs Addressed in Visits

Households were asked the main reason for visiting the providers named (see Table V.10 for the results). More than three-fourths of the providers were visited for a new illness (76%); most of the rest were for follow-ups to a previous illness (14%). New illnesses accounted for the majority

⁶⁴ The types of providers listed in the detailed discussions fairly adequately represent the mix of visits to public and private providers but slightly underrepresent visits to mullahs and traditional healers.

of visits to both private and public providers but made up slightly more of the visits to public (84%) than to private providers (76%).

TABLE V.10. HEALTH NEEDS ADDRESSED IN VISITS TO PRIVATE AND PUBLIC PROVIDERS

Reason for Visit to Provider (In descending order)	Total		Private		Public	
	#	%	#	%	#	%
New illness	1,239	75.8	944	73.7	295	83.6
Followup/previous illness	233	14.3	199	15.5	34	9.6
Refill prescription	38	2.3	36	2.8	2	0.6
New injury	30	1.8	27	2.1	3	0.8
Followup/chronic	18	1.1	17	1.3	1	0.3
Prenatal care	18	1.1	14	1.1	4	1.1
Advice – mental health	12	0.7	9	0.7	3	0.8
Birth/delivery	10	0.6	8	0.6	2	0.6
Postnatal care	9	0.6	9	0.7	0	0.0
Followup/injury	7	0.4	3	0.2	4	1.1
Women's issue—other	5	0.3	4	0.3	1	0.3
Child's vaccination	5	0.3	3	0.2	2	0.6
Advice—physical	3	0.2	3	0.2	0	0.0
Other	3	0.2	3	0.2	0	0.0
Child routine checkup	2	0.1	1	0.1	1	0.3
Advice—childrearing	2	0.1	1	0.1	1	0.3
*Total	1634	100	1281	100	353	100

* Table totals do not include 2% of the provider visits for which there was incomplete data.

Services Received

Households were also asked to list the specific services they received when visiting health care providers and could list multiple services for a single visit. Table V.11 shows the proportion of visits in which each specific service was received. For example, 73% of all visits resulted in the patient receiving medicine, but only 0.5% involved diagnostic services using X-ray technology.

The types of services received during visits varied somewhat by type of provider. For example, medicine was given in 86% of patient visits to public providers but in only 70.4% of visits to private providers.

Other services that show a difference are physical therapy (32% of visits to private providers, 44% to public providers); vaccination (8% of visits to private providers, 15% to public providers); surgery (2% of private visits, 6% of public visits); and hospitalization (4% of private visits, 11% of public visits).

Table V.11 also shows some characteristic constraints of health care in Afghanistan: in relatively few visits to either private or public providers was laboratory-based, X-ray, or other diagnostic technology used. Tertiary care is also rare—few visits included hospitalization or surgery. Fairly

clearly, public providers are relied upon more for secondary and tertiary care and, as envisioned by the MoPH, for immunizations.

TABLE V.11. SERVICES RECEIVED FROM PRIVATE AND PUBLIC HEALTH CARE PROVIDERS						
Services Received	Visits in Which Specific Service Was Provided					
	Overall		Visits to Private		Visits to Public	
	#	%	#	%	#	%
Medicine provided	1227	73.3%	919	70.4%	308	86.0%
Examination/assessment	1079	64.5%	849	65.1%	230	64.2%
Diagnosis	1064	63.6%	858	65.7%	206	57.5%
Physical therapy	578	34.5%	422	32.3%	156	43.6%
Advice only	282	16.9%	212	16.2%	70	19.6%
Laboratory testing	262	15.7%	205	15.7%	57	15.9%
Referral/Rx	254	15.2%	210	16.1%	44	12.3%
Vaccinations	155	9.3%	100	7.7%	55	15.4%
Vitamins provided	117	7.0%	101	7.7%	16	4.5%
Hospitalization/treatment	94	5.6%	55	4.2%	39	10.9%
X-ray	75	4.5%	57	4.4%	18	5.0%
Surgery	50	3.0%	29	2.2%	21	5.9%
Other diagnostic test	14	0.8%	9	0.7%	5	1.4%
Other intervention	9	0.5%	7	0.5%	2	0.6%

*Column percentages do not total 100% because multiple services can be received in a single visit.

Referrals after Visit to Initial Provider

AHS 2006 reported that very few visits to health care providers resulted in follow-up visits or referrals to other providers; only one of five patients (20%) had a follow-up visit with the same provider or via a referral.

This APSHS also found referrals to be very low—only 6.6% of initial visits for which there is detailed information resulted in referrals.⁶⁵ Among the few referrals that were made, the overwhelming majority by private providers (88%) were to other private providers. Even where public providers made referrals, the majority (60%) were to private providers.⁶⁶ Essentially, in the villages surveyed there is no robust health care “system” but simply an aggregation of health care providers.

As this report discusses later, the low level of referrals is problematic because only a very small proportion of rural providers offer comprehensive services, so it is unlikely that patients are not

⁶⁵ This tabulation is not directly comparable with AHS 2006 findings about follow-ups since heads of households in this survey were asked specifically about “referrals,” i.e. about being sent from one provider to another; thus, the tabulation excludes follow-up visits to the same provider.

⁶⁶ This finding is consistent with the AHS 2006 finding that 68.5% of visits to “2nd providers” were to private providers; in this survey 82.2% of referrals, whether from a public or a private provider, were to private providers.

being referred because their full range of health-related needs are being addressing by the initial provider.

Three-quarters (73.9%) of the patients referred to another provider actually went.⁶⁷

HEALTH CARE COSTS

Visits to Private and Public Providers

Heads of household were asked about the costs of their visits to public and private providers. Table V.12 shows the proportions of private and public providers offering free or cheap services (0–50 Afs); moderately-priced services (51–100 Afs); and “expensive” services (>100 Afs). A total of 1,495 trips discussed (about 90%) included data about the cost of the visit.

TABLE V.12. COST OF HEALTH VISIT BY TYPE OF PROVIDER						
Fee for Visit (Afghanis)	Visits to Public and Private Providers by Cost Category					
	Private		Public		Total—All Visits	
	#	%	#	%	#	%
No charge	47	3.9	121	42.2	168	11.3
1–50 Afs.	71	5.9	88	30.7	159	10.7
Subtotal—free or cheap	118	9.8%	209	72.9%	327	22.0%
51–100 Afs.	580	48.1	30	10.5	610	40.9
Subtotal—moderately-priced	580	48.1%	30	10.5%	610	40.9%
101–250 Afs.	172	14.3	22	7.7	194	13.0
251–500 Afs.	187	15.5	15	5.2	202	13.5
501–750 Afs.	51	4.2	3	1.0	54	3.6
751–1,000 Afs.	62	5.1	3	1.0	65	4.4
1001+ Afs	35	2.9	5	1.7	40	2.7
Subtotal—expensive	507	42.0%	48	16.6%	555	37.2%

* Three visits to unknown providers were not included here.

As should be the case, the vast majority of visits (73%) to public providers are free or affordable. However, it also deserves note that private providers provide a small but significant amount of pro bono services.⁶⁸

In examining what household accounts of fees paid tell us about the private health care market, it is noteworthy that relatively few of the private visits (12%) cost more than 500 Afs. Overall, although in general visits to private providers were more expensive than those to public facilities, more than half (58%) were cheap or moderately priced.

⁶⁷ Various reasons, including distance, cost, and lack of confidence in the likely quality of service were given for not following through with a referral, but the number of cases where there was lack of follow-through on referrals (31) was not of an adequate size to meaningfully tabulate predominant reasons.

⁶⁸ As discussed below, many private providers waive fees for particularly needy individuals—usually poorer people, orphans, widows, and physically disabled persons.

Visits to Different Types of Provider

Table V.13 shows the mean cost of visits to different types of health care provider based on the sample of household visits for which detailed information was reported.

TABLE V.13. AVERAGE COST OF HEALTH CARE VISIT BY PROVIDER TYPE		
Type of Provider	Number of Visits with Cost Information	Average Cost (AFs)
All Private Providers	1,205	348
Private MD	1,076	339
Private health clinic	8	136
Private hospital	17	562
Pharmacy with MD	56	254
Pharmacy without MD	25	935
Midwife	5	160
Nurse	6	583
Mullah	10	240
Traditional healer	2	50
All Public Providers	287	144
Community health worker	5	122
District hospital	65	358
Subcenter	61	48
BHC	104	81
CHC	49	89
Other	3	607
All visits	1,492	308

*Mean costs are rounded to the nearest Af.; does not include three visits to unknown providers.

It appears from Table V.13 that market forces serve to control the costs of private health care services. Although private providers charged more than twice as much on average than public providers, their charges are still clustered in the moderate cost range. Visits to facilities identified as either private or public district hospitals are more expensive than other visits, presumably because the health problems that led to those visits were more serious and more services were provided. In general, a visit to a public hospital costs about two-thirds as much as a visit to a private hospital, though for all types of visit public visits cost only 41% as much as private visits.

Visits for Different Health Needs

Naturally, the cost of a health care visit is related not only to who provides the service but also to what the visit is for. Table V.14 shows different types of health care visits and offers useful insights into the price structure of the private and public sectors in Afghanistan. As might be hoped, public providers offer MCH services that are much more affordable than those of private providers; the price differentials for curative health services are not as dramatic.

TABLE V.14. TYPE OF PROVIDER AND AVERAGE COST OF VISIT BY HEALTH NEED ADDRESSED

Reason for Visit To Provider	Mean Cost of Visit (Afs)		
	Overall	Private	Public
New Illness/injury/problem	237	274	98
Follow-up illness/injury/prescription	611	620	543
General advice	209	244	68
Women's health	221	243	33
Routine children's health	75	113	0
Total	306	344	148

*Mean costs are rounded to the nearest Af.

AVERAGE PER CAPITA AND HOUSEHOLD EXPENDITURES FOR HEALTH CARE

The data on costs for health care visits for the sample where heads of household provided detailed information coupled with data on numbers of visits during the five-month reference period provide a basis for estimating average per capita and household costs for health care. The estimated mean annual per capita cost for health care is 881 Afs, and mean annual household expenditures on health care are 6,815 Afs.⁶⁹ Although, these estimates are not fully comparable to estimates based on data collected in AHS 2006, the current higher estimates would be consistent with the contribution of two years of inflation and with efforts to make public health facilities more self-sustaining.

ECONOMIC WELL-BEING AS A FACTOR IN UTILIZATION

Total number of household visits to public and private health care providers was analyzed in relation to income. The Household Wealth Index was constructed by weighting multiple variables that describe the households in this survey (see Chapter IV) and aggregating them into quintiles (see Table IV.12). Table V.15 demonstrates that household wealth affects the number of visits to private providers more than visits to public providers.

⁶⁹ These estimates are higher than those reported in the AHS 2006. However, AHS 2006 reports only median, not mean, expenditures and estimates health care costs on the basis of numbers of illnesses or injuries rather than visits. Although routine visits for maternal and child health care are cheaper than visits for illness or injury, it is important to include these routine costs in estimates of household costs; not including these resulted in a downward bias on the AHS 2006 estimates of annual and per capita health care costs. However, the current survey asked heads of households about charges for visits—without asking about costs for travel to secure health care or lodging where it was necessary. Also, the cost estimates are based on interview detail regarding a sample of three visits and follow-up visits whenever there were any; this is likely to have exerted an upward bias on the current cost estimates, since interviewers sought to elicit information on “significant” visits to health care providers. Another source of divergence is that AHS 2006 estimates of annual costs are based on only a one-month rather than a five-month reference period. Finally, there are the differences in definition of household already mentioned. Therefore, it is not possible to determine whether health care costs are rising or whether the differences stem from the survey sample.

TABLE V.15. HOUSEHOLD VISITS TO PRIVATE AND PUBLIC HEALTH CARE PROVIDERS BY WEALTH						
Household Visits	1st (poorest)	2nd	3rd	4th	5th (wealthiest)	Overall
Total Private Visits	5.32	5.78	8.67	7.50	8.36	7.10
MD	4.59	4.89	7.01	5.85	6.90	5.83
Private clinic	--	0.01	--	0.07	0.04	0.02
Private hospital	0.06	0.05	0.01	0.13	0.03	0.06
Pharmacy with MD	0.23	0.43	0.47	0.20	0.19	0.30
Pharmacy without MD	0.04	0.13	0.07	0.15	0.10	0.10
Midwife	0.03	--	0.02	0.03	0.01	0.02
Nurse	--	0.07	0.07	--	0.04	0.04
Mullah	0.36	0.16	0.83	0.93	1.05	0.66
Traditional Healer	0.01	0.03	0.19	0.13	--	0.07
Total Public Visits	2.06	2.42	2.50	1.84	1.73	2.11
Community health worker	--	--	0.21	0.09	--	0.06
District hospital	0.28	0.41	0.32	0.56	0.36	0.39
Subcenter	0.30	0.38	0.49	0.27	0.58	0.40
BHC	1.05	0.81	0.68	0.48	0.60	0.73
CHC	0.43	0.81	0.80	0.45	0.19	0.54
Unknown Provider	0.11	0.08	0.03	0.08	0.18	0.10
All Visits	7.49	8.27	11.20	9.42	10.26	9.31

Household wealth is closely correlated with numbers of visits to private providers but not with visits to public facilities. The dynamics of health care system utilization are, however, complex. There may be other factors that interact with household wealth that also affect health care-seeking behavior. For example, the education level of households, as indicated by the ratio of persons in the household who have any schooling divided by total household size is much lower (0.16) in the 1st quintile (the poorest) than in the 5th (0.56). Moreover, the wealthier households are also larger—mean household size in the 1st quintile is 6.7 persons and in the 5th it is 9.2 persons—and older—mean average age of a household in the 1st quintile is 20.1 vs. 24.5 in the top quintile.

A full exploration of these dynamics is beyond the scope of this report, but clearly it is important to examine in depth the actual social and economic dynamics of health care utilization before drawing definitive conclusions about optimal strategies for strengthening the system.

HOW HOUSEHOLDS RATED THE QUALITY OF PRIVATE AND PUBLIC HEALTH CARE

Tables V.16 and V.17 provide alternative indicators of household head assessment of the service encountered in visits to private and public providers: how they viewed the *quality* of service received and the *outcomes*. Satisfaction with both private and public services was overall quite positive. However, because the public services were more often accessed in response to a serious problem, e.g., one requiring surgery, hospitalization, or physical therapy, essentially they had to meet a higher standard. The evidence seems to be that their services are generally considered to be of equivalent quality as those of private providers even though the problems presented to them may well have been more refractory.⁷⁰

Rating of Quality

Table V.16 shows responses when heads of household were asked to rate the quality of the services a household member received during the visits discussed with interviewers. Most visits, whether to public or private providers, were rated “Adequate” (68%) or “Very Good” (20%).

TABLE V.16. RATING OF SERVICE QUALITY FOR VISITS TO PRIVATE AND PUBLIC PROVIDERS						
Rating	Total		Private		Public	
	Number	%	Number	%	Number	%
Positive	385	24.1%	312	25.0%	73	21.1%
Excellent/couldn't be better	64	4.0	54	4.3	10	2.9
Very good/but could be better	321	20.1	258	20.7	63	18.2
Neutral	1,087	68.2%	845	67.7%	242	69.7%
Adequate	1,087	68.2	845	67.7	242	69.7
Negative	118	7.4%	88	7.0%	30	8.6%
Not very good	89	5.6	65	5.2	24	6.9
Terrible	29	1.8	23	1.8	6	1.7
Undetermined	5	0.3%	3	0.2%	2%	0.6%
Total	1,595	100	1248	100	347	100

⁷⁰ Given the levels of educational attainment of rural households in Afghanistan it is not clear what specific frame of reference is used in determining customer satisfaction; nonetheless, even without a basis for very specific expectations, health care customers can, of course, make an informed judgment as to how they are treated and at least a general assessment of how satisfactory the outcome of a visit may be.

Rating of Outcomes

As Table V.17 shows, heads of households were quite positive about the outcomes of their visits and there were no significant differences between their rating of private and public providers.⁷¹

TABLE V.17. RATING OF OUTCOMES FROM VISITS TO PRIVATE AND PUBLIC PROVIDERS						
Rating	Total		Private		Public	
	Number	Percent	Number	Percent	Number	Percent
Positive	1,269	75.8%	986	75.6%	279	77.1%
Definitely, helped a lot	501	29.9	411	31.5	88	24.3
Probably helped, improvement noticed	768	45.9	575	44.1	191	52.8
Negative or Negligible	227	13.6%	190	14.6%	37	10.3%
Definitely not worth cost/effort; no good resulted/maybe some bad	22	1.3	20	1.5	2	0.6
Maybe worth the cost/effort, but not much good resulted	108	6.5	91	7.0	17	4.7
Maybe, can't see much difference	97	5.8	79	6.1	18	5.0
Undetermined Outcomes	177	10.5%	129	9.9%	46	12.7%
Can't/won't say	29	1.7	22	1.7	7	1.9
Missing	148	8.8	107	8.2	39	10.8
Total	1,673	100	1,305	100	362	100

⁷¹ The slight differences in proportions of household heads who did not provide information on their satisfaction with private and public providers may possibly reflect some reluctance to go on record as criticizing a government-funded organization.

VI. WOMEN'S AND CHILDREN'S HEALTH

Women and children are particularly vulnerable and have special health care needs not only in response to illness or injury but also as part of the routine processes of pregnancy and birth for women and growing up for children.

Interviews with heads of households provided a broad overview of household composition, possessions, and health care system utilization. Interviews with women in the households provided additional detail and insights on women's health care issues and health care system use. Given their primary role in child-rearing, these discussions also included queries about health issues and interactions with providers.

Women were only interviewed in four of the five provinces after security conditions deteriorated in Loghar. In those four, women were interviewed in 100% of the households surveyed. Because virtually all households included several women, interviewers agreed with the household members about who would be most appropriately interviewed—usually the wife of the head of household.⁷² Of the 668 female interviews conducted, only one was rejected because of data quality.

DEMOGRAPHICS OF FEMALE SURVEY RESPONDENTS

The overwhelming majority of women interviewed (95.7%) were currently married; 3.1% were widowed; and the marital status of 1.2% was not recorded. Their mean age was 35.3 years, and 95.5% had children. Table VI.1 provides additional demographic detail on the respondents and shows that the sample of women interviewed for APSHS 2008 is generally representative of adult women in rural Afghan households. However, because of the sampling procedure (a bias toward interviewing the socially appropriate respondent), the sample is slightly older than the population as a whole.⁷³ In AHS 2006—which had a downward age bias because it was restricted to women under 50—72% were between 20 and 39. In the APSHS 2008 sample, 60% are in that age group. However, in both surveys the majority of respondents were married women of child-bearing and child-rearing age.

⁷² In households where the male head of household had more than one wife, interviewers were asked to interview the senior wife. However, due to time and logistical constraints, if she was not available a surrogate, e.g. an older woman or a daughter, was sometimes interviewed. Thus the female respondents are not necessarily representative of the adult female population in the survey area.

⁷³ The sample is not directly comparable to the AHS 2006 sample where eligible female respondents had to be between 10 and 49 and to have been married. APSHS 2008 had no requirement for marriage or maximum age, although, as in AHS 2006, the sampling procedure was designed to maximize the number of female respondents of child-bearing age.

TABLE VI.1. DEMOGRAPHICS OF FEMALE RESPONDENTS				
Age Group	Number of Female Interviews	%	Average Age at Marriage	Average Number of Children
14–19 years	24	3.6	15.13	2.21
20–29 years	172	25.8	15.96	3.63
30–39 years	229	34.3	15.97	5.77
40–49 years	154	23.1	15.86	6.79
50–59 years	62	9.3	16.48	5.23
60–69 years	22	3.3	15.23	5.18
70 + years	4	0.6	17.33	3.50
Total	667	100	15.94	5.24

The age of female respondents did not vary significantly by province except that it was slightly higher in Badghis, where the average was 38.1 rather than 35.3. Similarly, the average number of children does not vary greatly from province to province except for Laghman, where it was 6.2 children. There is also minimal variation in women's age at marriage.

Population demographic profile, of course, is an important driver of health care demand. As Table VI.1 shows, fertility in these rural areas of Afghanistan is very high. Not only are the numbers of children per woman an important indicator of child health care needs, they are also an important indicator of the demands placed on women in caring for children and their health.⁷⁴

WOMEN'S LITERACY

A minuscule proportion of the female respondents is literate; 94% said they were completely illiterate.⁷⁵ Of the remaining 6%, only one-fifth (1% of all the respondents) said they could read fairly well or with facility. The literacy rates are so low it is difficult to make solid comparisons, but it does seem clear that women in rural districts have even lower literacy rates than those in central districts; 69.5% of the women in rural districts said they could not read at all while 91.1% of the women in central districts gave this response. Clearly, this is a barrier to women effectively navigating health education and care either for themselves or their children.

PREGNANCY

Consistent with the high fertility rate, almost one-third of the women interviewed (32%) were currently or had been pregnant in the survey period, and another quarter (23%) had been pregnant in the previous year. Thus, during any two-year period more than half (55%) of the women in a typical rural household will need care related to healthy pregnancy and childbirth.⁷⁶ Of those currently pregnant, only 3% had never been pregnant before. Table VI.2 provides details on pregnancies. As might be expected, fertility is highest in the youngest age cohort.

⁷⁴ It is not clear whether the decline in numbers of children reported in the older groups (50+ years of age) reflects decreased fertility during years of conflict or that queries about the number of children correctly elicited responses enumerating only living children. The latter seems more likely.

⁷⁵ The literacy rate of women in the current survey is substantially lower than the 13% reported for rural women in NRVA 2005.

⁷⁶ This may be a very slight underestimate of pregnancy needs since 3% of women in aged 14–39 would not or could not say when they were last pregnant. Assuming that some of these non-responses were due to difficulty in recall (quite likely, due to the higher proportions of older women in this category) but that some were due to unwillingness to discuss pregnancy, an additional 1% may have been pregnant within the past two years.

TABLE VI.2. PREGNANCY STATUS OF RESPONDENTS BY AGE GROUP														
Age Group	Pregnant at Time of Interview		Pregnant in Current Year but not now		Pregnant Last Year (1386)		Pregnant >2 Years Ago		Never Pregnant		Won't Say		*Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	% Total
14–19	8	36.4	4	18.2	5	22.7	3	13.6	2	9.1	0	0.0	22	3.5
20–29	51	30.5	29	17.4	52	31.1	20	12.0	11	6.6	4	2.4	167	26.3
30–39	54	24.2	18	8.1	64	28.7	69	30.9	9	4.0	9	4.0	223	35.1
40–49	21	15.0	11	7.9	21	15.0	55	39.3	19	13.6	13	9.3	140	22.0
50+	4	4.8	5	6.0	2	2.4	45	53.6	12	14.3	16	19.0	84	13.2
Total	138	21.7	67	10.5	144	22.6	192	30.2	53	8.3	42	6.6	636	100

* No pregnancy data were reported in 5 percent of the interviews.

Household Practice in Seeking Antenatal Care

Table VI.3 shows the extent to which women in rural households sought antenatal care, which is arguably the most important aspect of access to pregnancy-related health care. Readers should keep in mind that female respondents were asked to talk about the experiences of other women in the household as well as their own. Thus, the analyses of issues relating to women's and children's health presented must be understood as referring to the experiences of women in the household, not necessarily individual respondents.

TABLE VI.3. HOUSEHOLD ANTENATAL CARE SOUGHT FOR PREGNANCY WITHIN THE PREVIOUS TWO YEARS, BY PROVINCE AND TYPE OF DISTRICT									
Province	Nobody Did		Some Did, Some Did Not		Everybody who Was Pregnant Did		Won't/Can't Say		Total
	#	%	#	%	#	%	#	%	#
Badghis	65	52.0	52	41.6	5	4.0	3	2.4	125
Central	20	44.4	18	40.0	5	11.1	2	4.4	45
Rural	45	56.3	34	42.5	0	0.0	1	1.3	80
Baghlan	35	31.0	55	48.7	18	15.9	5	4.4	113
Central	16	37.2	18	41.9	6	14.0	3	7.0	43
Rural	19	27.1	37	52.9	12	17.1	2	2.9	70
Laghman	34	27.0	21	16.7	65	51.6	6	4.8	126
Central	13	34.2	4	10.5	15	39.5	6	15.8	38
Rural	21	23.9	17	19.3	50	56.8	0	0.0	88
Nimroz	17	14.0	53	43.8	48	39.7	3	2.5	121
Central	5	12.8	24	61.5	9	23.1	1	2.6	39
Rural	12	14.6	29	35.4	39	47.6	2	2.4	82
Total	151	31.1	181	37.3	136	28.0	17	3.5	485
Central	54	32.7	64	38.8	35	21.2	12	7.3	165
Rural	97	30.3	117	36.6	101	31.6	5	1.6	320

*This analysis is limited to pregnancies within the previous two years due to considerations relating to recall for longer look-back periods.

In almost one-third (30%) of the households, no one sought antenatal care and in more than a third (37%) not every pregnant woman did so is a matter of concern—although the current survey suggests that progress is still being made in this area.⁷⁷ This is a worrisome finding. AHS 2006 reports that women receiving antenatal care increased from 5% in the MICS 2003 survey to 13% in NRVA 2005 to 32% in AHS 2006; these results are at least as good as in 2006 and probably much better. For instance, assuming that in households where some women went for antenatal care, half went and half did not, that would suggest an antenatal care rate of about 45%.

Perhaps of more concern is the clear-cut evidence of regional disparities: in more than half (52%) of the households in Badghis, no one sought antenatal care, while that was true in only one in seven households (14%) in Nimroz . Conversely, the fact that in half the households in Laghman (51%) everyone who was pregnant sought antenatal care suggests it might be useful to look there to understand what factors are making the difference, especially since (see Table VI.3) there is significant room for improvement in access to antenatal care even where prevailing practices are much more favorable, as in Laghman and Nimroz.

Reasons for not Seeking Antenatal Care

Female respondents in households where no one sought out antenatal care were asked why not. Table VI.4 shows their responses.

TABLE VI.4. REASONS FOR NOT SEEKING ANTENATAL CARE BY PROVINCE AND TYPE OF DISTRICT												
Province	Not Needed		Too Expensive		Too Far		Too Hard to Arrange to Get There		Won't Get Good Care		Other Reason	
	#	%	#	%	#	%	#	%	#	%	#	%
Badghis	13	14.8%	22	25.0%	48	54.5%	2	2.3%	1	1.1%	2	2.3%
Baghlan	11	21.1%	10	20.0%	19	36.5%	9	17.3%	2	3.8%	1	1.9%
Laghman	24	54.5%	3	6.8%	6	13.6%	4	9.1%	5	11.4%	2	4.5%
Nimroz	10	55.5%	2	10.5%	1	5.3%	3	15.8%	1	5.3%	1	5.3%
Total	58	28.7%	37	18.3%	74	36.6%	18	8.9%	9	4.5%	6	3.0%

* About one-third of the respondents gave more than one reason.

Table VI.4 has some immediate practical implications: It appears that distance to provider is the primary constraint on seeking antenatal care, particularly if this category is combined with the concerns shown in the next column about difficulties in arranging travel (possibly exacerbated by a belief that routine care might not justify the travel cost or obligations that might be incurred). This can be addressed by continuing to increase sources of antenatal care to facilitate access.

Women's feeling that antenatal care is not needed is, of course, a prime example of an issue that can and should be effectively addressed by health education efforts. Such efforts might also impact the households where it is felt that antenatal care is too expensive, possibly because its value is underestimated). The findings here underscore the need for a coordinated and conceptually integrated health promotion strategy for maternal health: the reasons for not seeking

⁷⁷ This finding is consistent with but not directly comparable to AHS 2006. That survey reported proportions of women seeking antenatal care ("over 32%"); this one reports proportions of households in which *no* woman sought care (31.1%) and in which some and some did not (37.3%). Both studies found that at least one-third of women do not get antenatal care.

antenatal care interact, and the most effective public health response strategy will be one that addresses the entire complex of conceptual and logistic constraints on securing antenatal care.

The good news in examining these responses from households where no one seeks antenatal care is that concerns about quality of medical care are not a major constraint.

Choices among Antenatal Care Providers

Where females in the household had gone for antenatal care, the respondent was asked where they had gone during the most recent pregnancy. Table IV.5 shows the pattern of their choices. Women's responses about antenatal care visits correspond closely to head of household accounts of household utilization of private and public providers for different sorts of problems.⁷⁸

In general, there is more reliance on public facilities for antenatal care than for addressing other sorts of health issues. This may be because (see Table V.14) the cost differential between visits to private (243 Afs) and public (33 Afs) providers is greatest for women's health issues, many of which are pregnancy-related.

TABLE VI. 5. PROVIDER USED FOR MOST RECENT PREGNANCY BY PROVINCE										
Type of Provider	Women Going to Specific Type of Provider During the Most Recent Pregnancy in the Household									
	Badghis		Baghlan		Laghman		Nimroz		Overall	
	#	%	#	%	#	%	#	%	#	%
Private	51	96%	31	44%	47	53%	52	48%	181	58%
Private MD	24	45.3	12	16.9	43	47.8	36	33.0	115	35.6
Private hospital	-	-	-	-	-	-	3	2.8	3	0.9
Private health clinic	-	-	-	-	1	1.1	-	-	1	0.3
Midwife	16	30.2	12	16.9	-	-	13	11.9	41	12.7
Nurse	1	1.9	-	-	-	-	-	-	1	0.3
Traditional birth attendant	4	7.5	3	4.2	-	-	-	-	7	2.2
Other private provider	6	11.3	4	5.6	3	3.3	-	-	13	5.6
Public	2	4%	39	56%	41	47%	57	52%	139	42%
BHC	-	-	5	7.0	13	14.4	45	41.3	63	19.5
CHC or CHW	-	-	34	47.9	-	-	-	-	34	10.5
Subcenter	1	1.9	-	-	19	21.1	1	0.9	21	6.5
District hospital	1	1.9	1	1.4	11	12.2	11	10.1	24	7.4

There are no major differences in rural women's utilization of private or public providers, but in Badghis, as for other health problems, there is more reliance on private providers. In Baghlan and

⁷⁸ The analysis of head of household reports of household members' visits antenatal care is based on Section D of the household interview; it indicated that 54% of the visits for antenatal care or help with delivery during the prior five months were to private providers while women's accounts show 857% [please provide correc number] are. The minuscule difference may be because the women's questions were referenced to antenatal care during the most recent pregnancy in the household only (during the prior two years) and the head of household question was referenced to the five-month look-back period to Nawrooz.

Nimroz, as for other health problems, there is more reliance on BHC or CHC personnel for antenatal care—quite probably because they are more accessible there than in other provinces.⁷⁹

There are significant differences between rural and central districts in the ratio of visits to private and public providers for antenatal care. Women in the central districts of Baghlan, Laghman, and Nimroz were much more likely to seek antenatal care from a private provider than women in rural districts. More than three-quarters (76%) of central district households went to private providers while in rural districts less than half (43%) did.

Patterns of Visits for Antenatal Care

Although in principle antenatal care should be systematic and continuous, allowing for routine monitoring of a pregnancy through term, in actuality women's approaches to seeking antenatal care vary, as Table VI.6 shows.

TABLE IV.6. PATTERNS OF ANTENATAL CARE VISITS	
Pattern	Percentage of Pregnancies
More Interaction with Provider	69.2%
Visits throughout pregnancy (1 st , 2 nd , 3 rd trimester)	23.4%
Visits early and late (1 st and 3 rd trimesters)	16.9%
Visits middle and late (2 nd and 3 rd trimesters)	17.2%
Visits early and middle (1 st and 2 nd trimester)	11.7%
Less Interaction with Provider	30.9%
Visit 1 st trimester only	11.4%
Visit 2 nd trimester only	6.2%
Visit 3 rd trimester only	13.3%

On average women visited antenatal care providers 2.7 times during their most recent pregnancy. There were only minor differences in the frequency of natal visits to public (average of 2.6 visits) and private providers (average of 2.9 visits).

No dramatic differences in the proportions of pregnancies in which there were problems were reported between women with higher (45%) or lower (50.5%) levels of interaction with providers, but women who went for antenatal care only during the first trimester did seem to have more problems than the others.⁸⁰

⁷⁹ In Badghis, it is clear from both interviews with providers and the women's interviews, the majority of pregnancy-related visits were to female pregnancy/birth specialists, but there seem to be definitional ambiguities about distinctions between midwives (who presumably have special medical training) and traditional birth attendants (who presumably do not).

⁸⁰ More than two-thirds (68%) of the women who sought antenatal care only during the trimester of pregnancy (n=35) had problems. The relationship between receipt of antenatal care, reports of pregnancy-related problems, and pregnancy outcomes cannot be determined from the findings of the current study because of the small size of the subgroups in each care pattern and the small number of women who had negative outcomes). Several countervailing processes may well be in play, such as increased recognition of problems among women who have more intensive interactions with antenatal care providers and perhaps better efforts to address those problems; however, women's decisions to seek antenatal care are probably also affected by their current self-assessment or previous experience of problems during pregnancy.

Antenatal Visits as a Venue for Health Education

Women respondents were asked about the kind of information they or other women had received in the course of their visits for antenatal care. Table VI.7 reports the types of information received by providers. There are no major differences. It is encouraging that a substantial proportion of both types of providers used the visits to discuss issues related to children's and family health—breastfeeding, immunizations, and family spacing.⁸¹

TABLE VI.7. TYPE OF INFORMATION PROVIDED DURING ANTENATAL VISITS BY PRIVATE AND PUBLIC PROVIDERS			
Type of Information Received	% of Women who Received each Type of Information at some Point in Their Antenatal Visits		
	Private Providers	Public Providers	All Visits
Related to Pregnancy			
Blood pressure	41.0%	46.4%	42.7%
Swelling body/hands/face	30.1%	26.4%	29.0%
Headaches/blurred vision	27.1%	27.1%	27.7%
Bleeding	21.1%	23.6%	22.3%
Related to Child or Family Health			
Immunization	77.1%	84.3%	80.6%
Breastfeeding	48.8%	46.4%	48.7%
Child spacing	27.7%	33.6%	30.6%

Note: Women could report multiple types of information. Information provided in visits to providers where it was unclear what type of provider was being discussed (2.5% of the responses) is not included in the tabulation.

Public antenatal care providers seem to have been slightly more diligent in explaining the symptoms of pregnancy-related problems and what to do if they occurred. About one in five (20%) of the women remembered that antenatal care had included this sort of information—slightly more of these had gone to a public provider (25%) than to a private provider (19%).

The survey also examined the types of information female respondents said women in their households had received when the woman had gone to the antenatal care provider during the first trimester and when she had not.⁸² There are significant differences in the information conveyed (or recalled) by the two groups; Table VI.8 shows these differences.⁸³

⁸¹ This finding diverges substantially from AHS 2006 where it is reported that only 41% [please provide correct number] of the women were counseled on breastfeeding and 11% on child spacing.

⁸² In 63% of the pregnancies, the women visited an antenatal care provider during the first trimester.

⁸³ Inevitably there are methodological uncertainties in questions relating to survey respondents' recall of information like this. Higher rates of recall, as are reported here, may indicate that this subgroup was provided more information, the information was presented more thoroughly or effectively, or the sub-group who seeks antenatal care early is more attentive or has better recall. There may also be other factors, for example, younger, less knowledgeable women may have gone for antenatal care earlier in their pregnancies than older women who had already had several children.

TABLE VI.8. TYPE OF INFORMATION PRESENTED DURING ANTENATAL VISITS FOR WOMEN WHO SOUGHT CARE EARLY OR LATE			
Type of Information Received	% of Women who Received each Type of Information at some Point in their Antenatal Visits		
	Early Visits 1st trimester)	Later Visits (not 1st trimester)	All Visits
Related to Pregnancy			
Blood pressure	45%	28%	37%
Swelling body/hands/face	37%	13%	26%
Headaches/blurred vision	30%	18%	24%
Bleeding	25%	14%	20%
Related to Child or Family Health			
Immunization	84%	70%	77%
Breastfeeding	56%	35%	46%
Child spacing	36%	19%	28%

* Women could report multiple types of information, Information provided in visits to providers where it was unclear what type of provider was being discussed (2.5% of the responses) is not included in the tabulation

Getting Medical Attention for Problems During Pregnancy

In about one-third (31%) of the pregnancies discussed in interviews, women had experienced some sort of problem. Table VI.9 reports these effort to secure medical consultation or attention to the problem.

TABLE VI.9. DEGREE OF DIFFICULTY IN GETTING HELP WITH PREGNANCY PROBLEMS		
Difficulty of Getting Help	Total	
	#	%
Very easy, knew where to go, went and got help	10	4.7
Fairly easy, knew where to go, but had to wait to get in	50	23.7
Somewhat difficult, did not really know where to get help	61	28.9
Very difficult, could not find anyone, eventually did	36	17.1
Did not get any help, eventually dealt with it myself	54	25.6
Total	211	100

Women who had sought help were asked what difficulties they had experienced in securing assistance for the problem. Virtually all (97%) reported some kind of constraint; they generally listed more than one type. Table VI.10 shows the main difficulties women experienced in seeking medical attention. Not surprisingly, cost and distance were the major problems. What might be considered structural problems with the health system—distance, cost, long waiting times to secure service—were a universal concern. However, in about one in seven (15%) cases, women mentioned some sort of problem related to the provider’s competency or resources for effectively responding to the woman’s needs. Women in both central and rural districts reported problems related to cost of care and travel, but long waits or problems with how women were treated or the quality of care were much more common for women in rural districts.

TABLE VI.10. DIFFICULTIES GETTING HELP FOR PREGNANCY-RELATED PROBLEMS BY TYPE OF DISTRICT						
Difficulties	Central		Rural		Overall	
	#	%	#	%	#	%
Related to System Configuration/Cost						
Distance and cost	51	68.9%	72	67.3%	123	68.0%
Distance, but not cost	10	13.5%	19	17.8%	19	16.0%
Cost, but not distance	13	17.6%	15	14.0%	28	15.5%
Related to System Capacity						
Long wait (with or without other problems)	12	14.8%	31	24.8%	43	20.9%
Long wait but no other problems	9	11.1%	21	16.8%	30	14.6%
Related to Provider Competency/Resources						
One or more problems related to provider competency, resources, behavior	8	9.9%	24	19.2%	28	15.5%
Provider knowledge – Didn't know what to do, or how to do it	3	2.0%	9	7.2%	12	5.8%
Equipment – Didn't have something needed or equipment didn't work	1	0.7%	9	7.2%	10	4.9%
Supplies – Didn't have supplies needed	1	0.7%	11	8.8%	12	5.8%
Provider Attitude – Not treated well	4	2.6%	8	6.4%	12	5.8%

*Based on responses from 206 female interviews who mentioned difficulties (virtually all of those who sought care for problems during pregnancy). Respondents could mention more than one difficulty – the average was 1.98.

Outcomes of Pregnancy-related Problems

In 24% of the cases where a problem during pregnancy was cited, the problem resolved itself. In another 61%, the problem was resolved by the provider—a gross but fairly clear-cut indicator of the value of antenatal care.

Thus in about one out of seven cases—the remaining 14%—the problem remained unresolved. In slightly more than half of these, in the opinion of the women the problem was not serious. In the other half, in 3% of the cases a problem considered serious was not unresolved, and in 4% the woman or child died. Continuing efforts to extend the reach of antenatal care may well reduce the extent of these problems, but it is important to interpret these negative outcomes in the overall context of maternal health. The incidence of 7% of serious negative outcomes within the group of 231 pregnant women reporting some sort of pregnancy-related problem translates into an incidence of 22.6 serious problems/1,000 pregnancies and an incidence of 1,200/100,000 maternal or child death.⁸⁴

⁸⁴ Because the focus of the current study was on utilization of health care resources, where a mother or child had died, interviewers did not probe as to whether the decedent was the mother or child. Therefore, this calculation can only be interpreted as providing an upper estimate of maternal deaths in childbirth, i.e. <1,200 per 100,000. This is, however, much lower than the 1,800/100,000 maternal mortality rate reported for Afghanistan for 2005 (See, Countdown Coverage Writing Group, “Countdown to 2015 for maternal, newborn, and child survival: the 2008 report on tracking coverage of interventions”, *Lancet*, April 19, 2008.

Deliveries⁸⁵

Only 33% of the women who had been pregnant had received skilled medical help with delivery from a physician, midwife, or traditional birth attendant. In 7% of the cases where there was a skilled attendant, the mother also received help from a family member or neighbor.

In 50% of deliveries, the mothers were helped only by one or several women in their social network—38% from members of the household, 9% from family members who did not live in the household (e.g., an aunt or mother living separately), and 19% from a neighbor or friend.⁸⁶ The remaining 25% of the women said they gave birth without help from anyone.

There was remarkably little difference in the help received between households in rural and central district areas, but households in central districts were slightly more likely to rely on some sort of “professional” help, not just family and neighbors.

Postnatal Care

Women respondents were asked about their health care visits or the visits of other women in the household for postnatal health care and about the sorts of health services they received. Table VI.11 tabulates those services. There were no significant differences between women living in rural or in central districts.

Postnatal Care Services (n=267)	Total	
	#	%
Breastfeeding advice	193	72.3%
What to do for a child with diarrhea	69	25.8%
Vaccine/Immunization advice	258	96.6%
Child received BCG immunization (shot in left shoulder)	145	54.3%
Child received OPV immunization (drops in mouth)	151	56.6%
Child received DPT immunization (shot in thigh)	129	48.3%
Child received measles immunization (shot in right arm)	110	41.2%
Vitamin A capsules for mother (red capsule)	68	25.5%
Something else	5	1.9%
Can't say what it was	4	1.5%

*Multiple answers were possible.

The good news here is that women are getting information about the importance of breastfeeding; the bad news is the few women who received (or remembered receiving) Vitamin A.

⁸⁵ This question (Q. C-11) was answered by 485 of the women living in households where someone had been pregnant. As with other questions about pregnancy, the woman was asked about her own pregnancy and only if she had not herself been pregnant was she asked about pregnancies of other women in the household. The tabulation excludes 13 “don’t know” responses presumably referred to pregnancies of other women in the household.

⁸⁶ The subtotals of women in different domains of a woman’s social network who helped with deliveries is greater than the proportion of deliveries where someone from the social network provided assistance because in some cases women from different subgroups helped out—e.g. another woman in the household and a neighbor.

The significance of this finding for assessing progress in immunizations campaigns is discussed below, but it is to be expected that rates of immunization vary substantially from province to province. The current survey suggests that the maternal child health service delivery system in rural Badghis is much weaker than in other areas and that those in Nimroz and Laghman are better than average, with Baghlan falling between.

Opinions on Best Providers for Pregnancy-Related Services

Women were asked to name the health care providers they thought gave the best assistance with various pregnancy-related health needs: general advice, antenatal care, actual delivery, and treatment of delivery-related complications. They could identify a provider as being the best or second best they knew of for one or more services.

Table VI.12 reports the number of times public or private providers were mentioned as “best” for each type of service. It should be recognized, however, that identification of the “best” local providers reflects women’s interactions with the actual universe of providers in any given village. Since public providers make up only 25% of all household visits, the assessment reported here does not indicate that private providers are a great deal better—only that they are considered somewhat better; if private and public providers were assessed as equally good the ratio of “best” ratings should be 75/25.

TABLE VI.12. WOMEN’S ASSESSMENT OF PRIVATE AND PUBLIC PROVIDERS IN THE COMMUNITY		
Local Provider Rated as “Best” (1st or 2nd preference) for Pregnancy- Related Services	% of all Identifications of “Best” or “2nd Best”	
	Private	Public
Pregnancy-related service (n=361 responses)	79.8%	20.2%
General advice (n=203 responses)	79.3%	20.7%
Antenatal care (n=240 responses)	81.2%	19.8%
Actual delivery (n=125 responses)	88.3%	16.7%
Delivery complications (n=159 responses)	76.7%	23.3%

The assessment is primarily based on personal or household information. In response to a question about whether the respondent, someone in the household, or a friend had gone to the provider in question or whether the rating was based simply on general belief in the village, 82% of the women said that they had themselves gone to the provider they had identified as “best”; another 13% said that someone in the household had. Thus, in only 5% of the cases was the opinion based simply on the opinions of women in the respondent’s social network.

FAMILY PLANNING

More than half (56%) of the female respondents were familiar with at least one FP method.⁸⁷ The proportion of women who knew about FP planning methods varied substantially by province, from a high of 80% in Nimroz to a low of 32% in Baghlan. Women in Badghis and Laghman

⁸⁷ The AHS 2006 reported that 36.7% of respondents know about “modern” or traditional FP methods, but notes that this may be an underestimate.

were close to the average, with 75.6% of the respondents in Badghis and 56% of those in Laghman saying they knew about FP methods.

Of those women who knew about FP, slightly less than half had heard about it primarily from friends or family and a similar proportion had gotten information from health providers (42%). One in seven (15%) drew on information from both. As might be expected, the youngest women, aged 14–19, and those aged 50 or more were more likely to have heard about FP methods from family than providers. Media-based FP initiatives had minimal impact—only 5% had gained FP information from radio, TV, or printed matter.

Women were asked which providers they thought would be the best to go to for information on contraception. Three out of four (75%) referred to private providers. However (see Table III.7), only one quarter of private providers (26%) offer FP information. Women’s listing of preferred providers of FP corresponds very closely to the provider survey information; the high number of responses regarding private providers who are good for FP information stems from the fact that the same provider is mentioned by numerous households in a village. This means that the number of preferred providers is not consistent with demand—but it is probably generally well known where one can go for contraception advice.

Yet there are serious constraints on access to effective contraception assistance. Of all the FP providers—both public and private—that women mentioned, about one out of seven (18%) were said to provide only *information* on FP, not *help*; and even among the minority who said a provider offered help, there are ambiguities about what “help” means, since only 4% of the providers were said to actually provide contraceptive supplies (condoms, IUDs, pills, injections, female sterilization). Presumably, the help given when contraceptives are not available is merely information on “natural” methods of contraception.

CHILDREN’S HEALTH CARE

Immunizations

Women were asked what immunizations children in the household aged 12 to 24 months had received and whether they were from a public or private provider.⁸⁸ The intent was not to secure precise data on the immunization rate for children but to examine household immunization practices.⁸⁹ Table VI.13 shows the immunization status of households.

Type of Immunization	% of Households Reporting			
	All Children Immunized	Some, not all Immunized	None Immunized	Respondent Cannot say
BCG	37.5%	31.2%	22.8%	8.5%
OPV	45.7%	31.3%	12.3%	10.6%
DPT	37.6%	27.0%	23.1%	12.3%
Measles	35.1%	28.5%	24.6%	11.8%

⁸⁸ In principle BCG and DPT immunizations are provided by MoPH-funded facilities, while OPV and measles vaccine may be available via a campaign.

⁸⁹ Inevitably, given that OPV and DPT consist of a series of three vaccinations and there is a succession of over immunizations over the child’s first year of life ideally (as detailed in AHS 2006), determining the immunizations received by an infant imposes a burden on respondents. In this broad portrayal of household health care-seeking behavior and outcomes, it was only necessary to generate rough indicators of specific services received.

More than a quarter (29 %) of the households reported that all the children in the household had received all their vaccinations, but 10% reported that no children had been vaccinated.⁹⁰ This suggests modest but significant progress in immunization programs since 2006.⁹¹ In three of the four provinces where women were interviewed there were no striking differences between rural and central districts in the immunization of children in households, but in the rural districts of Badghis far fewer children had been immunized.

Respondents' reports indicated that 92% of the BCG, 92% of the OPV, 93% of the DPT, and 94% of the measles immunizations were done by public providers. The exact percentages are somewhat uncertain because some respondents are uncertain about the immunization status of children in the household or whether the immunizer was public or private.

The proportion of households reporting that all, some, or none of the children living there had been immunized was similar for each vaccine—possibly because survey respondents were not clear about the differences in vaccines or because if providers who immunize children with one vaccine generally immunize them with all.⁹² However, there are disparities. In Badghis, for example, in only 9% of the households were all the children said to have received measles vaccine but in 37% of the households all the children were said to have received the BCG vaccine.

There were also differences in household immunization rates for different provinces. Nimroz had the highest rate of all children being vaccinated (60–80% of households), followed by Laghman (37–57%), with Badghis lagging far behind (9–37%). The low rates of immunization in Badghis are also reflected in disproportional amounts of households where some but not all children have been immunized.

The findings related to households in which some but not all children are immunized (often for some but not all the targeted diseases) underscores the importance of paying attention not only to macro-level statistics on populations but also to how patterns of household health care behavior affect the well-being of targeted populations. In addition to strengthening the formal service delivery system, health promotion efforts must be directed to mobilizing social networks (such as women within households and neighborhoods) to improve community health.

Children's Health Problems

To give context to the examination of health care system responsiveness to children's health needs, respondents were asked about the three most serious illnesses or injuries or other health problems children in their household had experienced since Nawrooz⁹³ (see Table VI.14).⁹⁴

⁹⁰ This tabulation is based on the 90% of households where the respondent provided a response. The reported rate of children who received all their vaccinations is very slightly higher than the rate reported in AHS 2006 (reported as 27%) and the rate of households where children had received no vaccinations was slightly lower (reported as 14%).

⁹¹ The reported rate of households where all children are vaccinated is statistically equivalent to that of AHS 2006. The main progress would seem to be that households where no children were vaccinated has decreased because they are now households where some but not all children have been vaccinated. However, there are, of course, issues about the immunization status of children in households where the respondents could not answer the question.

⁹² BRAC provincial survey managers felt that rural households had minimal understanding that there are immunizations with different vaccines and ability to distinguish between them, and that generally female respondents would know (and therefore report) only whether children in the household "had their shots."

⁹³ This question, of course, mirrors the question asked about visits from the household for any member's health problem, adult or child. In the female survey, however, because of concerns about burden, the information gathered on children's health problems is less detailed than in the general household survey.

TABLE IV.14. MOST SERIOUS CHILDREN'S HEALTH PROBLEMS AS REPORTED BY FEMALE RESPONDENTS, BY DISTRICT TYPE						
	Overall		Central		Rural	
	#	%	#	%	#	%
Diarrhea, vomiting, fever, dysentery, flu, other urgent	537	46.8%	165	45.6%	372	47.3%
Respiratory illness	186	16.2%	56	15.5%	130	16.5%
Nonurgent symptoms or illness	152	13.2%	46	12.7%	106	13.5%
Malaria	51	4.4%	19	5.2%	32	4.1%
Typhoid	30	2.6%	11	3.0%	19	2.4%
Injury	24	2.1%	6	1.7%	18	2.3%
Mental disorders	4	0.3%	2	.6%	2	.3%
Measles	2	0.2%	1	.3%	1	.1%
Tuberculosis	3	0.3%	---	---	3	.4%
Other/miscellaneous	21	1.9%	6	1.7%	15	1.9%
Can't say/don't know	138	12.0%	50	13.8%	88	11.2%
Total	1148	100.0%	362	100.0%	786	100.0%

There are no significant differences between types of children's health problems in the rural and the central districts.

Access to health care was better than might be expected. In half (49.6%) of the instances of children's illness or injury, women respondents said it was very or fairly easy to know where to go, although usually they had to wait to have the child seen. Only 11% stated it was very difficult to access health care, although another 8% ended up without help—either because they gave up or the problem resolved itself. The remaining one-third rated accessing health as “somewhat difficult.” Table VI.15 details the types of difficulties mentioned. As with access to health care during pregnancy, problems of distance and cost are often linked. Cost of children's health care is more of an issue in the central than in the rural districts. As with pregnancy-related health care, while cost is less of a problem in rural districts, long waits (indicative of insufficient system capacity) are more of a problem. Provider quality does not seem to be a major difficulty.

⁹⁴ Respondents' descriptions of health problems were summarized and later coded into 14 clusters to permit meaningful analysis. See Appendix Y for the range of initial post-codes (63 in total—including adult and children's illnesses and injuries and routine health needs, e.g. antenatal care) and the 14 summary clusters.

TABLE IV.15. DIFFICULTIES GETTING HELP FOR SERIOUS CHILDREN'S HEALTH PROBLEMS BY TYPE OF DISTRICT						
Difficulties	Central		Rural		Overall	
	#	%	#	%	#	%
System Configuration/Cost						
Distance and cost	134	57.8	358	69.6	492	66.0
Distance, but not cost	33	14.2	67	13.0	100	13.4
Cost, but not distance	54	23.3	59	11.5	113	15.1
System Capacity						
Long wait with or without other problems	30	12.9	156	30.3	186	24.9
Long wait but no other problems	26	11.2	125	24.3	151	20.2
Provider Competency/Resources						
One or more problems related to provider competency, resources, behavior	13	5.6	66	12.8	70	10.6

While women encounter difficulties in securing health care for their children, their accounts of the outcomes of visits for serious health problems is very positive. In 92% of the visits for respiratory illness and 86% of the visits for another urgent reason, such as diarrhea, the women said the provider successfully resolved the problem; 4% of the children were said to have recovered on their own.⁹⁵

Providers of Children's Health Care

Rural families were more likely to take children to private providers (76% of visits) than central district families, but the difference varies greatly from province to province. Table VI.16 details these differences. Laghman and Nimroz seem to have the strongest public health systems given their higher penetration in rural areas.

TABLE VI.16. VISITS TO PRIVATE PROVIDERS FOR URGENT CHILD HEALTH PROBLEMS, BY TYPE OF DISTRICT			
Province	Visits to Private Sector Provider in Rural Districts	% of Visits to Private Sector Provider in Urban Districts	Ratio of Private Sector Provider Utilization in Rural to Central Districts
Badghis	100%	87%	1.15
Baghlan	71%	68%	1.04
Laghman	66%	84%	0.78
Nimroz	75%	89%	0.84

Households were much more likely to take children to private providers for respiratory or other urgent illnesses. More than eight out of ten (84%) visits for respiratory illness were to private providers, as were 80% of the visits for urgent illnesses or symptoms. Slightly fewer visits to

⁹⁵ In 4 out of 1,083 cases where full information on outcomes was available, the child died, a mortality rate of 4.3/1000.

private providers were for nonurgent symptoms and illnesses (74%).⁹⁶ However, because there are more private providers overall, this finding, like the one on sources of pregnancy-related care, should be understood to reflect a slight, not a dramatic, preference for private providers.

As with other types of health problems it seems that a major factor in decisions to take children to public or private providers is availability rather than concerns about quality of service, since private and public providers are rated comparably for quality. Although cost is almost always a consideration in rural communities, in their efforts to facilitate access to health care private providers do show price flexibility via waivers for needy individuals and families.

There were, however, differences in the difficulties women faced in getting children's health care needs met when they went to private or to public providers. Not surprisingly, almost twice as many women mentioned cost, though not distance, as a difficulty with private rather than public providers, and many more women mentioned distance and cost together. All in all (see Table VI.17), the advantages of public providers seem to be affordability and accessibility, but they are somewhat offset by a slightly lower quality of service.

TABLE VI.17. DIFFICULTIES IN GETTING HELP FOR CHILDREN'S HEALTH PROBLEMS FROM PRIVATE AND PUBLIC PROVIDERS				
Difficulties	Private Provider Visits (n=572)		Public Provider Visits (n=132)	
	#	%	#	%
System Configuration/Cost				
Distance and cost	401	70.1%	55	41.5%
Distance, but not cost	54	9.4%	44	33.3%
Cost, but not distance	99	17.3%	12	9.0%
System Capacity				
Long wait, (with or without other problems)	128	22.3%	47	35.6%
Long wait but no other problems	110	20.2%	35	26.5%
Provider Competency/Resources				
One or more problems related to provider competency, resources, behavior	49	8.8%	26	19.6%

A long wait was mentioned as a problem in almost two-thirds (62%) of the visits to public providers but in less than half (42%) of those to private providers. This appears to reflect both high demand for low-cost public health services and their limited service capacity.

Unfortunately, problems related to provider competency or resources or staff treatment of families were reported at more than twice the rate for visits to public providers (20%) as to private providers (9%). This deserves further investigation.

RESPONDENT SUGGESTIONS FOR IMPROVING WOMEN'S HEALTH CARE

At the close of interviews, women were asked a set of structured questions about ways to improve women's health care; they were also encouraged to offer suggestions about ways to improve women's health as well as general health in their village. Table VI.18 reports their answers. There was solid but not universal support for further investments in building up the public health care

⁹⁶ The number of visits for other illness or health problems is too small to permit meaningful comparison

delivery system; this was deemed a higher priority than providing better training to private providers, although there was modest support for that possibility.

TABLE VI.18. PERSPECTIVES ON IMPROVING HEALTH CARE FOR WOMEN					
Options	% of Women in Favor				
	Overall (n=667)	Central (n=220)		Rural (n=447)	
		#	%	#	%
Antenatal Care					
Fund more trained midwives.	370	108	49.1%	262	58.6%
Build public health clinic or hospital closer.	309	64	29.1%	245	54.8%
Provide more training for midwives.	312	114	51.8%	198	44.3%
Give public health workers more training.	156	40	18.2%	112	25.1%
Give private clinic MDs, nurses, and staff more training.	92	20	9.1%	72	16.1%
No suggestion on this topic	80	36	16.4%	44	9.8%
More medicines, supplies	3	1	---	2	---
Deliveries					
Fund more trained midwives.	355	109	49.5%	246	55.0%
Build public health clinic or hospital closer.	294	99	45.0%	195	43.6%
Provide more training for midwives.	287	70	31.8%	217	48.5%
Give public health workers more training	166	36	16.4%	130	29.1%
Give private clinic MDs, nurses, and staff more training.	85	19	8.6%	66	14.8%
No suggestion on this topic	88	42	19.1%	46	10.2%
More medicine, supplies	2	1	---	1	---
Other—female doctor	1	---	---	1	---
Postnatal Care					
Fund more trained midwives.	274	89	40.5%	185	41.4%
Build public health clinic or hospital closer.	299	102	46.4%	187	41.8%
Provide more training for midwives.	215	50	22.7%	165	36.9%
Give public health workers more training.	178	45	20.5%	133	29.8%
Give private clinic MDs, nurses, and staff more training.	118	30	13.6%	88	19.7%
No suggestion on this topic	101	40	18.2%	61	13.6%
Place more public health workers in village (CHWs).	8	3	1.4%	5	1.1%
Other—need clean water,	4	2	0.9%	2	0.4%

Women living in rural districts were generally even more supportive of each type of possible investment in improving antenatal care, support for deliveries, and postnatal care than those living in central districts. Not surprisingly, rural women were much more likely (29%) to stress the importance of building new facilities—a closer public health clinic or hospital—than women in central districts (5%). But in terms of providing better support for deliveries rural women stressed better training for midwives more than building a closer facility. The responses about the utility of the strategies for each of the subsets of pregnancy-related health care needs seem to reflect a general view that upgrading midwives’ skills makes a good deal of sense.

SUMMARY OF FINDINGS AND CONCLUSIONS

This section presents the most salient findings from the current study and summarizes the implications of these findings. The next chapter sets out recommendations for next steps

Survey Area as Representative of Rural Conditions

The five provinces surveyed (Badghis, Baghlan, Laghman, Loghar, and Nimroz) represent a diverse range of rural conditions in Afghanistan. Badghis clearly has the weakest health care delivery system and minimal representation of public providers; Nimroz, Baghlan, and Laghman have more robust health care systems and public components. The districts surveyed in the five provinces are diverse in terms of ethnicity and language.

The survey sampling design provided opportunities to examine conditions in more and less remote rural districts—although all districts were, in terms of standard classification, “rural,” i.e., nonurban. The survey sample of 28 households per village assured that different types of household in each village were represented, and therefore different types of household decisions about health care providers and satisfaction with services received.

The survey was implemented in 28 villages in 14 districts within the five provinces.⁹⁷ Although the villages are clearly rural, ranging in size from 50 to 250 households, the smallest, most remote villages in Afghanistan are underrepresented, as are the larger communities of provincial capitals that are officially classified as “rural” but have larger populations and more health care resources.

Whether the sample of randomly selected households surveyed was representative was assessed by comparing household characteristics to those reported for rural areas in the most recent National Rural Vulnerability Assessment (NRVA 2005):

Household size—Mean household size of surveyed households is 7.9 persons, close to the mean of 7.5 reported in NRVA 2005.

Age and gender distribution—51% of household members were under 18, compared to 53% in NRVA 2005. The current survey shows slightly fewer females (45%) than NRVA 2005 (46%). Inevitably, women’s and children’s needs are an important driver of demand for health-related services.

Pregnancy and fertility—In more than half the households (55%) there was at least one woman pregnant at the time of the interview, previously during the current year, or during the year before (i.e. over a span of 17 months). Female survey respondents reported, on average, 5.24 children.

Educational Attainment—The households in the current survey are similar in educational profile to rural households surveyed in NRVA 2005. Average educational attainment of age cohorts 15 and older was 2.0–5.2 years for males and 0–1.9 years for females. Only 6% of adult women in the households are literate. Consequently, utilization of print material for health education is likely to be ineffective. More school-age boys (61%) and girls (39%) are enrolled in school in the

⁹⁷ The central district of Loghar, Puli Allam, was dropped from the survey due to security threats.

current survey than in NRVA 2005, where 44% of boys and 27% of girls in rural were reported as enrolled. This is largely because school enrollment is higher in Nimroz than in other southern provinces.

Livelihood—Like the households reported in NRVA 2005, 58% of the households reported their primary source of income was from agriculture or livestock. These households were, however, slightly less likely to rely on remittances (2%) than those surveyed in NRVA 2005 (6%).

Transportation—Households in the current survey are less likely to have a bicycle (18%) than those surveyed in NRVA 2005 (32%) but slightly more likely (17% vs. 13%) to have a motorcycle. The surveyed households also are much more likely to have access to a car or truck (14%) than those surveyed in NRVA (1%).

Radio and TV—Households surveyed were slightly less likely to have radios than rural NRVA households (69% vs. 77%) but more have televisions (16% vs. 8%).

Mobile phones—Mobile phone penetration in rural areas appears to have increased dramatically since 2005. In the current survey 54% of the households had a mobile phone compared to 8% in NRVA 2005. This may, of course, be related to the availability of a phone signal in the districts sampled in the current survey and in NRVA 2005.

Access to safe water—Half of the households in the current survey (50%) had access to safe water compared to only 26% in NRVA 2005. This may represent infrastructure progress but it is more likely to reflect the circumstances in the villages surveyed. The current survey found remarkable disparities between households in central districts and in rural districts, as well as variations from province to province. (NRVA 2005 reported similar variation in the availability of safe water.)

Toilet facilities—About 70% of households in both the current survey and the NRVA 2005 rural sample had a vault latrine and in both negligible numbers of households had flush toilets.

Based on the profile of the 776 households in the current study, it is likely that the findings are generally representative of conditions in rural villages throughout Afghanistan. However, it is important to recognize how much conditions vary from province to province and even from district to district in the 359 districts of the country. In particular, the health care resources available to households in remote villages isolated from other districts in a province are likely to be less adequate than those in the current survey area.

Health-Related Needs

Households in the rural areas surveyed are large, averaging 7.9 persons per household. Their needs for health care are various—not just attention to sick or injured children and adults but also advice on general issues of health and routine visits for immunizations or antenatal care. Virtually every household had experienced some need for health care during the five months from the beginning of the year (since Nawrooz, 1387) to the date they were interviewed.

Heads of household were asked to inventory each household member's needs for health-related services (illnesses and injuries and visits for advice or some other routine health service) during this period. The most prevalent need was treatment for a sick adult. In 77% of the households at least one adult had needed attention. The next most prevalent needs were related to children's illnesses, which occurred in 66% of the households. However, households also needed to visit health providers for routine health care. In 50% of the households, one or more children had needed routine care and in 31% an adult needed routine attention.

Fortunately, households had fewer medical needs related to injuries. Only one in six (17%) reported a need for medical attention for an injured adult and one in eight (12%) for an injured child.

Rural households are not only large; virtually all include women of child-bearing age. In 56% of the households at least one woman had been pregnant during the past two years, and 22% of the female respondents were pregnant when they were interviewed, which underscores the high need for antenatal care, delivery assistance, and postnatal care.

Health-seeking behavior is similar in households in rural and in central districts, but for rural households, seeking advice for adult health issues was much less common than in the central districts. In almost all (98%) of cases where an adult or a child was ill or injured, the household actually sought help. However, in Badghis, the province with the least health care resources, 5% of health needs remained unmet.

Utilization of Providers

In rural areas of Afghanistan private and public health care systems are largely complementary. However, the specific health care resources available to households, and consequently household utilization of private and public providers, vary from province to province.

The private and public components of the health care system seem to be semispecialized, but accessibility appears to be much more important than financial considerations in virtually all household decisions about where to seek care. The following specific observations about household patterns health-seeking behavior deserve attention:

Reliance on Private Providers: This APSHS study suggests there is even greater reliance on private providers than has previously been reported: 75% of all household visits were to private providers. But it also shows substantial variations from province to province: only 61% of household visits in Nimroz were to private providers compared to 87% in Badghis.

Variations Within Households and in Relation to Type of Health Care Needed: Public providers are the primary health resource for children's routine health care (82% of visits), but private providers are the primary source of care for adults who are ill (71% of visits) or who need medicine (81% of visits). However, public providers play a particularly significant role in antenatal care (46% of all visits).

Geographic Variations in Reliance on Private or Public Providers: There are significant differences between provinces and between rural and central districts in household utilization of private and public providers. In the rural districts of Badghis, for example, 85% of households rely only on private providers; in rural districts of Baghlan, 28% do. Variations in proportions of households going to private providers only, to both public and private providers, and to public providers only underscore province-to-province differences in the availability of public health resources.

Health Care in Pregnancy and Childbirth

For strategic planning purposes, household practices related to antenatal care and delivery are as important as the actual proportions of women who receive antenatal care or professional assistance during deliveries, because health promotion efforts and social marketing need to be focused on changing household and community social behavior, not just individual—individual behavior is heavily conditioned by prevailing practices. Consequently, this APSHS study explored this in terms of issues women encountered in seeking pregnancy-related health care. The most significant findings in this area are the following:

Household Practices Regarding Antenatal Care: In 29% of the surveyed households, every woman who was pregnant sought antenatal care; in 38%, some women sought antenatal care and others did not; and in the remaining 33% none of the women did. Even more important than overall practices is the evidence of regional differences in antenatal care practices. In 52% of the households in Badghis no one sought antenatal care; in only 14% of the households in Nimroz no one did. This pattern suggests the need for targeted public health campaigns explaining the utility of antenatal care even for women who have had children before and feel they do not need it. Generally, the current study shows the same proportions of women seeking antenatal care as the AHS 2006 survey (32%).

Reasons for Not Seeking Antenatal Care: Women's reasons for not seeking antenatal care varied greatly from province to province. In Laghman and Nimroz 55% of the women who failed to seek antenatal care felt that did not need it, while 57% in Badghis and 54% in Baghlan said it was too far or too hard to make arrangements to get to a care provider. These findings demonstrate the need for special efforts to improve accessibility to antenatal care, taking into account factors related to geography and local travel arrangements as well as availability of antenatal care.

Providers Used for Antenatal Care: 58% of the women who sought antenatal care went to a private provider (36% of them to a physician). The other 42% went to a public health facility—usually a BHC or CHC (in 30% of the cases).

Patterns of Antenatal Care: Asked about the timing of their visits for antenatal care (1st, 2nd, 3rd trimester), 24% followed an optimal pattern by seeking antenatal care during each trimester, but 31% visited a provider during only one—11% during the 1st trimester, 7% during the 2nd, and 13% during the 3rd.

Securing Medical Assistance for Pregnancy-related Problems: Of the women interviewed, 31% reported experiencing some sort of problem during pregnancy. Of these, 17% said it had been very difficult to secure medical assistance and 26% said they never succeeded in securing help. Thus, about one in eight of the pregnant women (12.5%) apparently had significant difficulties with pregnancy-related problems. Distance and cost of medical assistance were mentioned together as constraints on getting help by 68% of the women; cost was mentioned as the only problem by 16%. About one in six women (16%) reported a problem related to the quality of assistance they received (provider knowledge, equipment, supplies, attitude/behavior).

Severity and Outcomes of Pregnancy-Related Problems: In 24% of the cases where a pregnant woman experienced a problem it resolved itself, and in 61% the woman said the provider had resolved the problem. But this means that in about one out of seven cases (14%) pregnancy-related problems were not resolved. The women considered about half of the unresolved problems to not be serious, but that means in 7% of the cases the unresolved issue was indeed serious. In 3.8% of the problem cases, the informant said the woman or the baby died—an incidence of 1,200/100,000 of maternal or child death.

Delivery: A skilled birth attendant had been present in 33% of the deliveries. In slightly less than one-quarter (percentage?) of the deliveries, the mother was said to have given birth on her own. In the remaining cases and in about 20% of the cases where there was a skilled birth attendant, the mother had been assisted by women from her social network.

Perspectives on Private and Public Providers of Pregnancy-Related Services: Asked to identify the best local providers of pregnancy-related services, women's responses indicate that public and private providers are generally considered to be equally good—although more private providers are identified as “best” because there are more of them.

Family Planning and Children's Health

The current survey generally tends to confirm the estimates of AHS 2006 regarding indicators assessing public health campaigns to make FP information available and to increase rates of children's immunization. However, immunization rates in the survey area may be somewhat lower than reported in 2006. Although the public health system is vital to making affordable care available for children's illnesses and injuries, unfortunately waits are often long and households report more problems with quality of care than for private providers. The most relevant study findings regarding FP and children's health are the following:

Women's Awareness of Family Planning Methods: More than half (56%) the women interviewed said they were familiar with at least one FP method, but there were substantial variations from province to province. In Nimroz, 80% of the women said they knew something about FP; in Baghlan, only 32% did. In the other provinces about half of the women were aware of FP. However, two out of five of those who knew about FP had gained their knowledge primarily from talking to friends or family, so their information may well be incomplete or inaccurate. Few women (5%) mentioned hearing about FP from media. Clearly, there is considerable room for strategic improvements in this area. A major constraint on women's access to complete and accurate FP information is that only 26% of the private providers offer such information. This study suggests the public health system is making a useful contribution by making FP information more available.

Children's Immunizations: Public providers give 93% of the immunizations. Women's reports of infants receiving a BCG, OPV, or DPT immunization as part of postnatal care suggest slightly lower immunization rates than reported in AHS 2006, since only 54% of the infants received BCG, 57% OPV, and 48% DPT. In 29% of the households all children in the age range had received all their immunizations, but in 10% no children had been vaccinated. OPV coverage appeared to be somewhat higher than for other immunizations; in 51% of the households the woman interviewed said that all children had received their OPV vaccinations and in 35% some children had. Measles coverage appeared to be somewhat lower, with all children immunized in only 35% of the households and none in 25%. The lower rate of vaccination reported here compared to AHS 2006 stems in part from the particularly fragile health care system in Badghis, where all children had received measles vaccine in only 9% of the households and BCG in only 37%.

Seeking Care for Children's Health Problems: Female respondents were asked about the three most serious child health problems their household had encountered in the previous five months. About half (47%) of the nonroutine problems reported appeared to require urgent attention, due to diarrhea, vomiting, and fever, and another 2% related to injuries children; one out of six (16%) of the illnesses mentioned related to respiratory problems. A small but significant proportion of children (4%) were said to have had malaria, 0.3% tuberculosis, and 0.2% measles. Women reported many less difficulties in securing health care for their children from public than from private providers. Distance and cost were mentioned as dual problems for visits to 70% of the private providers but only 42% to public providers. Cost was mentioned as a problem for 17% of children's visits to private providers but only 9% to public providers. However, distance (without problems related to cost) was more often a problem for visits to public providers (33% of visits) than to private providers (9% of visits). Not surprisingly, a long wait was mentioned as a problem in almost two-thirds (62%) of visits to public providers but in less than half (42%) to private providers.

Capacity of the Private Sector to Respond to Household Health Needs

Private health care providers, like public providers, are stretched thin. They generally work in small practices with few or no staff. Health care system capacity is also limited by the limited

professional training rural providers have received. Nonetheless, the study strongly suggests that private providers are working diligently to address household health care needs in areas where there are at best only minimal cash economies.

Size of Practice: This study of small rural villages shows that market conditions there do not support large, well-developed practices; 76% of all private providers surveyed worked without any staff support. All the traditional private providers—traditional birth attendants, midwives, nurses, mullahs, and traditional healers—that households visited worked on their own, as did 72% of the physicians in solo practice. The one-quarter of physicians in solo practice who did have staff support usually employed only one or two other medically trained staff (other physicians, physicians’ assistants, nurses, or midwives). Even among providers with staff, only 13% have staff to maintain medical records.

Caseloads: Doctors in solo practice, who make up at least two-thirds of private providers, had an average weekly caseload of 82 patients. As might be expected those who practiced without any staff support were serving fewer patients (an average of 51 patients a week) while those with staff served more (averaging 113 patients).

Formal Training: Although 96% of the doctors surveyed said they had received formal medical training, this was not always an MD degree; one, for example, had been trained as a nurse, another as a physician’s assistant, and another as a paramedic. Of the pharmacy proprietors 83% had formal training. Only 57% of the midwives had formal training, and none of the traditional birth attendants did. The availability of private providers with training varied greatly by district: in central districts 82% of the private providers had training compared with only 58% in rural districts. Investments in training would thus be very likely to yield immediate improvements in both quality of care and cost-effectiveness as medical issues would probably be dealt with more efficiently.

Private Provider Availability for Service: An impressive proportion of private providers (86%–92%) were available to respond to health problems 6-7 days a week in provinces other than Badghis; in Badghis the proportion was only 59%. About 47% were available 5-8 hours a day and another 22% were essentially on call—available more than 8 hours. The estimated 14% of private providers who also work in the public health system are thus not available during hours of public health facility operation. Where there is an overlap, the private practices essentially supplement services delivered by public entities, while public salaries allow providers to practice their profession in rural areas where fee-based service delivery is only marginally viable.

Adequacy of Private Health Care

A key issue in assessing the current capacity of the private health care system to respond to the needs of rural households relates to the range of private services available. The current study analyzed both the availability of *specific* health-related services, such as diagnosis of illness, surgery, dental care, and immunizations; and *packages* of services: basic primary health care; enhanced primary health care (essentially a full range of primary health care services including adequate diagnostic technologies); basic maternal health services (antenatal care, delivery, postnatal care); and enhanced MCH care (including in addition to basic services, FP, healthy family information, and immunizations).

This analysis has serious implications for MoPH strategic planning. Most private providers offer very basic curative health services; very few offer the full range of services that would be required to assure that a household could go to a single primary provider to meet the diverse health care needs of everyone in the household. Specific issues deserving consideration include the following:

Inadequate Diagnostic Services: Very few rural private providers can give patients access to the laboratory tests needed to assure a sound diagnosis of some acute or chronic illnesses; only 11% have the capacity to conduct standard laboratory tests, and only 3% have specialized technologies, such as X-ray equipment or ultrasound. Also, few of the rural providers have specialized medical training, although a small proportion reported they had attended in-service training in one or more specialty areas (e.g., cardiology, kidney disease).

Inadequate Availability of Basic or Enhanced Primary Health Services: Only one out of six providers (16%) offer the menu of services necessary for addressing basic primary health care needs: routine physical examinations, diagnosis and prescriptions, provision of healthy family (preventive) health care information, and provision of antenatal and postnatal care. Less than 1% offer enhanced primary health care, which is the basic package plus FP, immunizations, X-ray-based diagnosis, and diagnosis and treatment of tuberculosis or malaria.

Inadequate Availability of One-stop Maternal Health Services: Only 24% of private providers offer a full basic one-stop package of maternal health services (antenatal care, delivery, and postnatal care), and just one in 12 (8%) offer an enhanced one-stop package of MCH services that also includes FP, healthy family information, and immunizations.

Inadequate Prescription and Drug Services: Residents of rural areas have substantial difficulties in following through on a diagnosis. Only 23% of the private providers offer one-stop service for diagnosis, prescription, and provision of medications.

Inadequate Dental Services: Only 7% of providers offer dental services; bad dental health is likely to be extremely prevalent.

Disparities between Rural and Central Districts: The package of basic primary health care services is twice as available in the central districts of the provinces surveyed as in the rural districts (20% vs. 10%). In contrast, twice as many providers in rural districts offer one-stop prescription and drug services (32% vs. 16%).

Uneven Delivery of Training: One-third of the physicians and two-thirds of the midwives had recently received MCH training. Although this is likely to have a positive impact on quality of care, the training has not reached traditional birth attendants. Physicians also reported receiving training in such areas as health practice administration or record-keeping, nutrition, and mental health (including drug abuse treatment). A few physicians had also been trained in ultrasound or ECG technology or infectious diseases.

The Societal Context for Private Providers

The current study provides useful insights about the work of private providers in rural villages of Afghanistan; the reality is that the conceptual dividing line between private and public sectors typical of developed countries is not appropriate in Afghanistan. Because very few small rural villages in Afghanistan have a robust local economy, strategic planning for building up health care in rural areas cannot assume that standard market dynamics govern private provider decisions. An important strand running through discussions with private providers during the survey is that planning to strengthen Afghanistan's health care service delivery system must look not simply at the "business environment" and standard economic indicators but also at the interplay between financial, social, and civic capital. The social capital inherent in family, tribal, and village networks may be as important as economic factors in private provider decisions to establish and continue service in small rural villages.

This APSHS study provides welcome indications that private providers in rural villages are satisfied with their roles in these communities despite marginal earnings; they are generally eager to enhance and expand their health care work. This in turn suggests that investment in carefully

targeted and easily accessible training would be likely to draw private providers and contribute significantly to the quality of care in rural villages.

Some findings from this study that deserve careful consideration in articulating a strategy to maximize the contributions of private providers to health care in rural Afghanistan are the following:

Private Providers Are Deeply Embedded in Village Life: 48% of private providers had never worked outside the village where they were currently located. Even when those who have moved to a village from somewhere else are added, 57% have been working in their current location since before 2002.

Social/Civic Networks Influence Decisions to Practice in a Village: If those who had worked outside the village, 57% said that family considerations or discussion with the *shura-i-sehie* or a community leader had influenced their decision to return or to relocate to the village. Almost half (46%) of the private providers who had worked outside their village had previously worked in an urban area, such as Kabul, Jalalabad, or a semi-urban provincial capital. There is no doubt that social environment, as much or more than economic considerations, affects provider decisions about where to work; only 27% of the providers who located or relocated in a village gave *only* an economic reason for their decision.

The Demographic Profile of Current Private Providers Matters in Strengthening Rural Health Care: The fact that current private providers are middle-aged (on average 43.2) indicates that rural areas are not drawing adequate numbers of younger health professionals. It also highlights the urgent need for high-quality accelerated training programs for health workers as an alternative to ineffective long-term university preparation. A key issue will be how many young adults who leave the village to secure an education can be induced to return. The current study found that women comprise only 24% of private providers and only 14% of professionally-trained physicians, pharmacists, and nurses. Increased recruitment and training of female health workers will be a necessary component of future strategy.

Economically Private Health Care Provision Is only Marginally Viable But Social Networks Help Retain Providers: Patient fees are the primary source of support for only 47% of private providers, though it is important to keep in mind that they include a significant proportion of nonprofessional health care workers (traditional birth attendants, mullahs, traditional healers). While only 7% of providers without formal training said their support came from patient fees, 63% of these rely primarily on patient fees to support their practice. Community social networks are also a significant source of matching support for health care, since 20% of the private providers said that village leaders or *shura* members provided some support for their practice, and another 6% said they received quite a bit or most of their support from this source.

Further research into the extent of bartering and how social network forces leverage support for health care in rural villages would be very helpful for guiding strategies for mobilizing social capital as an input into the health care delivery system.

Private Providers Respond to Community Social Needs: Virtually all the private providers interviewed said they provided pro bono services to needy individuals: They waived fees for “poorer people” (81%), orphans (77%), widows (58%), and physically disabled persons (57%). Small but significant minorities waived fees for elders (21%) or children (12%). The widespread practice of waiving fees appears to make health care more affordable and accessible for rural villagers, though it undoubtedly decreases revenue from private practice.

Private Providers Are Generally Positive About Their Practice and Would Like to Expand: Two-thirds of the private providers believed that their current situation was “OK”; only 9% strongly disagreed. More than two-thirds also wanted to expand by serving other villages (69%) or

providing a broader menu of health-related services (83%). The interest in expanding the types of services provided is particularly important for MoPH's strategic planning, since there are currently few providers who offer an adequate range of services to respond to MCH care needs or to facilitate patients getting the medications they need once they are diagnosed. This suggests that demand for training is likely to be high and courses in rural areas would be well-attended.

Village and Facility Infrastructure Constrain Service Delivery by Private Providers: Lack of heating for patient waiting areas and lack of electricity are likely to be significant constraints on the ability to deliver services, especially in winter. Only 55% of private providers in the rural districts had winter heating for patient waiting areas and virtually none had village electricity. One-third addressed the lack of electricity by having a generator, but this requires significant expenditures that eat into their already marginal earnings.

A positive and unexpected finding was that 83% of the providers had a telephone and another 6% had access to one nearby. This suggests that systematic efforts to provide consultation and advice by phone would be viable if procedures were streamlined so that providers could easily secure this sort of technical support.

There Are Severe Constraints on Diversification and Expansion: Some 28% of private providers considered the challenge of recruiting and maintaining adequately trained staff as a major factor impeding their expansion, and 24% cited village infrastructure as a constraint. Both these issues can be directly addressed by investments by MoPH in training support staff or by an agency like MRRD in village infrastructure. A small but significant proportion (13%) mentioned the level of community support as a constraint on expansion. Asked about other constraints, 4% mentioned security; it is important to recognize in assessing this response that the survey was conducted only in villages that were already considered to have security that was adequate to assure the safety of interviewers.

Household Decisions on Where to Secure Health Care

In most households (83%), the head of household was said to make the decisions about where to seek health care. However, in 12% of households such decisions were made jointly by husbands and wives. Here cultural factors appear to play a role; in one-third of the households in Nimroz, where there is a large Baluchi population, husbands and wives made health care decisions jointly.

Households where decision-making was shared more often sought health care than those where the head of the household made the decision on his own; in joint decision-making households, there were 1.3 visits per household member to a provider during the 5 months before the interview; where the head of household made decisions, there were only 1.0 visits.

The following findings relating to household health care decision-making are of particular importance:

Length of Residence in a Village and Health Care–Seeking Behavior: Given the density and power of social networks in rural Afghan villages, it should be assumed that they play an important role in the decisions of individual households about where to go for care. This was examined by correlating household decisions to go to private or public providers with their length of residence in a village. “Newcomer” households, those that had lived in a village less than six years, made fewer visits (an average of 4.2 in the previous five months) to private providers than “established” households that had lived in the village for six or more years (an average of 8.0). Newcomer households went more often to public providers (an average of 2.2 visits) than established households (1.9 visits). This appears to be part of a process of national modernization, quite probably driven in part by the experiences of refugees and internal migrants returning to rural villages, since these are the households that have lived a shorter time where they currently reside. It would be extremely useful to explore the specific social interactions that modulate

numbers of visits for health care and decisions to go to specific providers, but it is likely to be related to both knowledge and trust/social distance. Further information on this topic will be useful for designing effective social marketing campaigns to enhance preventive health care.

Location of Providers: Probably because the villages surveyed were quite small (50 to 250 households), 72% of visits to health care providers required going outside the village. Households were particularly likely to rely on a public provider when there was one in the village where they lived: 36% of visits to public providers were within the village but only 26% of the visits to private providers, though the percentages varied by location. In Badghis, only 13% of visits were to providers within the village, but in the rural districts of Loghar, 67% were; in Baghlan province, in general only 3% of household health care visits were within the local village, but 40% of the visits in Dushi district were.

Travel Time to Health Care Providers: Travel for 78% of health care visits reported took less than an hour and 37% took 20 minutes or less. There were, however, disparities in accessibility of health care by type of district. It appears that even those households that do not have a car, van, or truck secure access to one when it is necessary for health care, since 37% of the trips for health care that took less than an hour were via car, van, or truck, as were 53% of the longer trips. However, in one out of eight cases where travel took an hour or more, patients travelled by foot, and in one out of three cases they travelled by donkey, horse, or camel.

Costs of Visits to Private and Public Providers: Households reported that 73% of their visits to public providers were free or cheap, costing 50 Afs or less, and that 11% were moderately priced at 51–100 Afs. However, only 10% of visits to private providers were free or cheap though 48% were moderately priced. Although private care is more expensive than public care (where nominal fees have now been instituted), market forces seem to keep costs relatively affordable. In only 11% of visits to private providers and 4% of visits to public providers were the costs reported as being 500 Afs or more.

Public Providers and Affordable Making Maternal and Child Health Care: When costs of visits are compared, public providers are clearly making MCH care more affordable. Visits to public providers for women's health issues are reported to cost on average 33 Afs, compared to 243 Afs for visits to private providers. All reported visits to public providers for routine children's health problems were said to be free, while such visits to private providers cost on average 113 Afs.

Most Expensive Types of Health Care Visits: Costs rise when medications must be purchased. Visits to pharmacies without MDs, presumably to purchase medication, cost on average 935 Afs—by far the most expensive type of visit. As might be expected, the most expensive visits to public providers were to district hospitals, where the average cost was 358 Afs. Visits for follow-up on an illness or injury or to get a prescription were also expensive, averaging 620 Afs when the patient went to a private provider and 543 Afs for a public provider.

Service Quality as a Determinant of Provider Choice: Head of household ratings of the quality of service suggest that the public and private sectors provide similar quality. Private providers were more often rated as providing “excellent” service (25% vs. 21% for public providers) and less often as providing “not very good” or “terrible” service (7% vs. 9%), but in the assessments of outcomes, public providers have a slight edge, with outcomes from visits to them being rated negatively slightly less often (10%) than outcomes for private providers (15%). However, female respondents mentioned problems related to provider competency or resources or treatment of families in connection with children's visits at almost twice the rate for visits to public providers (20%) as for private providers (9%). All in all, though, the evidence suggests that convenience (travel time) and cost play a much larger role in household decisions about where to seek health care than perceived quality of service or health outcomes.

Household Wealth as a Determinant of Health Care Utilization: The number of visits households make to private providers is only imperfectly correlated to wealth, and the number of visits to public providers is not correlated with household wealth at all. Observation of a clear-cut relationship between household wealth and choice of a public or private provider is confounded by the fact that the poorest quintile of households has, as might be expected, more illnesses per household member (an illness ratio of .58 visits/person for the poorest quintile vs. .47 visits for the wealthiest), even though the wealthier households are larger (8.1 members in the 5th quintile vs. 6.3 persons in the 1st). It is possible that differences in numbers of health care visits are related to changing patterns of health care system utilization over the life cycle—especially since visits for children’s health care cost less than for adult illnesses. Further research is needed to adequately explore this hypothesis.

CONCLUSIONS

The private and public sectors of Afghanistan’s rural health care service delivery system are complementary, each facilitating access to health care, while at the same time each is partially specialized: public health facilities play a particularly important role in providing such routine but valuable services as children’s immunizations and antenatal care; private providers are the mainstay for adult illnesses and injuries.

Initiatives to build up Afghanistan’s rural health care delivery system will need to recognize that private providers locate in local villages for a variety of reasons but primarily in response to social pressures, because economic conditions do not make rural health care profitable. Analysis of efforts to strengthen both the public and the private sectors will need to give careful attention to the challenges of recruiting and retaining trained health care personnel in rural areas.

This study suggests that the overlap between the public and private sectors is not a problem but a fortunate development. The 14% of private providers who also work in the public health system are quite probably being sustained in part by their earnings from that work while providing genuinely needed additional capacity in their private practices.

The standard conceptualization of private providers being motivated entirely by financial considerations does not describe the complexity of interactions shaping rural health care in Afghanistan. Most private providers offer a remarkable amount of pro bono service, even though patient fees provide only marginal support. While the public health care system provides more affordable services, especially in its specialty areas, market forces and social pressures appear to limit the fees charged by private providers so that access to private health care is more affordable than might be expected. A strategy for building a cost-effective health care delivery system and enhancing the quality, accessibility, and reliability of service will need to pay careful attention to social dynamics as well as standard financing considerations.

While the presence of private providers in rural areas is crucial to access to health care, not all providers—even those practicing as physicians—are adequately trained. In particular, very few are able to offer the one-stop services for primary care or MCH care that would provide assurance that households could really have their health needs reliably met. The landscape with respect to health care delivery is similar to that in other areas of Afghan life in that the availability and quality of services is uneven. A particular concern is that few of the private providers in rural areas have access to adequate laboratory or diagnostic technology. Investments to expand the scope of services private providers can offer as well as the density of providers would clearly be very cost-effective, because uneven availability of services shifts costs to families with sick or injured children or adults. There is clear-cut evidence that investments in training to enhance the skills of current private providers would attract high enrollment and begin to address quality assurance problems.

In part because private providers are embedded in village social networks, their outlook is quite positive, despite the marginal economics of providing health care to small rural villages. The overwhelming majority would like to expand both the menu of health services they offer and their service delivery area. They are firmly attached to the villages in which they currently work, but for a small but significant minority security is an issue. Because so many private providers work on their own, expanding their practices to add support staff will be an important aspect of system enhancement. Finding and keeping adequately trained staff is a real issue. A particularly promising strategy may be to recruit young adults from rural villages who are interested in health careers, support their education at a university or with a specialized provider of vocational training in a health specialty area, and provide incentives for them to return home to practice.

Facility and village infrastructure also constrain service effectiveness and efficiency, particularly lack of heating and electricity for health care facilities. An obvious approach to this sort of problem would be low-cost or no-cost loans for private facility upgrades.

This study highlights the importance of going beyond national-level analyses of service delivery systems to recognize and respond to the diversity of local communities in Afghanistan. It found significant differences from province to province in health care system utilization, many of which are closely related to system configuration. For example, households in Badghis experience difficulties in many aspects of their efforts to secure health care, the health care system in Nimroz and Baghlan is stronger in many respects, and so is Laghman's MCH care system. Distinctive local patterns of population distribution, topography, transportation resources, and security all require attention. Clearly, the more remote rural areas generally have less access to health care; there is a need for policy attention to trade-offs between practicality and cost-effectiveness, since unit cost will inevitably be higher in more remote areas.

VII. RECOMMENDATIONS

This study has elicited some initial insights into effective strategies for the MoPH to strengthen both private and public providers delivering health care in Afghanistan's rural areas. Key components in such initiatives would be training of current providers, enhanced recruitment of rural health care technical and professional workers, and financial investments to reinforce service delivery capacity and the skills of private providers in rural areas.

The objective of investments in training should not be solely to improve the quality of health services (although this is a central objective); designing a menu of training opportunities will require careful attention to how these interventions will affect household searches for timely and affordable health care.

Potentially, training can lead to improvements in both the efficiency of health care service delivery and its efficacy, but only if course offerings are designed to fill in gaps in services and round out the menu of services each provider can offer. This would ensure that basic family health care would attend to children's illnesses and be a fulcrum for providing FP planning information, promoting immunization, and giving families information on good nutrition and health generally that they can use to change their behavior.

TRAINING FOR HEALTH WORKERS

Training should be a core component of strategies to strengthen private health care in Afghanistan. From this study it is possible to identify two priority areas: (a) training to deepen the skills of professionals (physicians, nurses, and pharmacists) practicing in rural communities; and (b) training to provide mid-career opportunities for traditional providers to acquire skills that would enhance the quality of services they provide to their patients.

Training for Current Professionals

The professional training of current private providers is uneven in scope and quality. It is likely that only a minority of them, even those who are physicians, are prepared to address the full range of health problems their patients experience. The highest priority for training should be to help providers who have expertise in one or several areas to broaden their practice so as to provide more comprehensive service for their patients. For example, special attention might be given to comprehensive primary care and family health service delivery. Investing in this type of training can be expected to yield immediate benefits to rural households in the form of fewer difficulties in navigating the health care system, lower costs in going from one provider to another, and improved health outcomes as a result of better continuity of care.

It will be important that training for health professionals in rural areas be easily accessible—probably in district centers. Potential trainers are likely to be in constant demand, and participants have neither the time nor financial resources to travel far or participate in training that lasts longer than a week.

Training curricula can and should be modular and oriented toward improving the practical ability of current providers to effectively diagnose and treat illness, communicate effectively with their patients about courses of treatment, and help them work out strategies to deal with chronic illness and to engage, to the maximum extent possible, in healthy behaviors within the ever-present resource constraints. It will be crucial to invest in expert curriculum design—using sound principles for identifying clear-cut learning objectives and customizing the curriculum to build functional competencies for day-to-day activities—rather than rely on curriculum design by committee or consensus. The quality of training (particularly initial offerings) is an important

element in cost-effective intervention, since the most appropriate model for addressing private provider learning needs would be to provide training at no cost but to require participants to pay their own travel and per diem costs.

Training for Current Nonprofessionals

Traditional birth attendants, healers, mullahs, and other health care providers represent valuable social as well as human capital. An important strand in strategically reinforcing rural health service delivery will be retaining traditional providers and upgrading their knowledge and skills. The wealth of social capital inherent in the extended family and tribal networks to which traditional health providers belong is likely to make them particularly effective in promoting health.

Assessment of Training Impacts

It would be desirable to assess specific gaps or areas of flatness in the knowledge and skills of prospective trainees both before and after training. The objective of such assessment should not be simply to attempt to quantify value added by the training; more important would be using the pull of free training to engage private providers in diagnostic assessment of their own strengths and weaknesses and in thinking through how their participation in particular modular training sessions would allow them to expand the range of services they provide and thrive economically by building a reputation for quality. At the same time, such diagnostic assessment of the pool of trainees provides crucial insights for design of future and refinement of existing curricula.

RECRUITING HEALTH CARE PROVIDERS

Collaboration with Local Schools

The demographics of the current pool of private providers underscore the importance of recruiting new entrants into the health care workforce. There is currently a practical opportunity to develop a low-cost collaborative and innovative strand of workforce recruitment and preparation. The Ministry of Education is adding post-primary education, grades 7–9, in many rural villages. These schools, which now offer motivated students opportunities to move beyond acquiring basic reading, writing, and math skills, could become a venue for “health academies” within or attached to them that could prepare health care assistants—entry-level positions for teenagers interested in health careers.

Such an initiative might include student internships with both public facilities and local private providers, giving students an opportunity to contribute to community efforts to address local health needs while they learn skills that give them a practical foundation for moving into specializations (as lab technician, dental assistant, nurse assistant for routine health care) or professions (as nurses, physicians, or pharmacists).

Cross-agency collaboration is not common in Afghanistan, and even collaborative efforts within agencies can be troubled. The MoPH should seek to build partnerships with the Ministry of Education at the national level while moving forward to engage provincial and district education officials with the novel idea of creating a practical customized learning program designed to give students an orientation to health careers and the basic skills in reading, writing, and computation needed within the health care work environment (e.g., for patient records, measurement, and computation). If there is a lack of interest or roadblocks within the public sector, the MoPH could, as it has done in delivering basic health care services, turn to NGOs to offer local health academies to secondary-school students.

Special encouragement and support to recruit young women into health careers would be wise, but the program should also offer opportunities for young men. Despite serious gender disparities in the health care workforce, educational opportunities cannot be exclusionary.

Recruiting, Retaining, and Retraining Health Providers

The most effective strategy to recruit and retain a qualified health care workforce in rural areas will be to concentrate on local recruitment. Students from rural villages who have received professional or technical training in a demanding health care occupation are more likely to return to their villages and remain there than urban students are to migrate there, even when the latter are offered financial or other incentives. An obvious approach is to give the most promising local students scholarships to attend university-level health-related training in urban areas. Local youth recruited into health care professions who return to their home village or district will be more likely than outsiders to use their social networks to establish and maintain successful practices. When they return they will have both the knowledge and local familiarity to become highly effective communicators and health promoters.

Mid-career professional training opportunities, in addition to short-term training courses, should be made available to traditional health care providers who are committed to substantially upgrading their skills so as to expand their practice. Such opportunities might include general professional training (e.g., leading to certification as a nurse) and other sorts of medium-term specialized training in areas where need is high (e.g., counseling, FP, children's health issues).

A health service commitment might be a requirement of scholarship awards, with recipients required to return to their home villages for a time, perhaps 2–3 years, as health care providers.

NO-COST LOANS OR SUBSIDIES FOR PRIVATE PROVIDERS

It appears that for private providers the primary, or perhaps only, access to capital is through informal relationships. They reported that family and village social networks were a significant source of support. The overwhelming majority is very small individual proprietorships rather than established businesses as those are typically understood.

While it was not feasible to design this study to generate detailed and reliable information on financial issues for private providers, it did identify some obvious examples of areas where very modest but carefully targeted infusions of capital could have a significant impact. Depending on MoPH policy and administrative preferences, these could be structured as either direct subsidies or no-cost loans.

Subsidies

For Heating Medical Offices and Patient Waiting Areas: Very few private facilities had heating. Lack of heat is a real constraint on service delivery in cold areas during the winter. Very modest subsidies for heating facilities might result directly in a 10%–20% increase in provider ability to deliver services during the winter.

For Distributing Prescription Drugs and Other Supplies at Low Cost: Survey data on the relatively high costs of visits to secure prescription medications and the scarcity of rural pharmacies suggest that targeting financing to encourage provision of one-stop services in which diagnosis, prescription, and provision of medications were combined would impact both the quality of care (more timely medication, less misuse of leftover prescription drugs) and household health care costs (lower costs for travel). If FP is identified as a priority, subsidies might encourage providers to stock contraceptive supplies. Strategic distribution of certain nonprescription medical supplies might also justify subsidies.

For Acquisition of Diagnostic Technology: The small proportion of private physicians with basic laboratory facilities compromises the ability to accurately diagnose and treat illness. While discussion of minimum expectations and objectives for laboratory or other diagnostic technology is needed, some investment in building a basic diagnostic technology infrastructure would be justified. This is one of the areas where programmatic investment would need to be coordinated—technology is not useful without properly trained staff, and trained staff can contribute little without the technology. Ideally, provision of low-cost lab kits would be accompanied by training in standardized procedures for handling blood or urine samples or cultures and in the significance of lab tests, for example, for prescribing the optimal antibiotic.

*For Better Medical Record-Keeping—*Very few private providers have medical records staff, and the exact type and quality of the records maintained is not clear, but this seems to be a significant weakness in service delivery. Medical records clerical training sponsored by NGOs or public entities (or as part of the suggested health academies attached to local secondary schools), coupled with subsidies for crucial office equipment and supplies (folders, low-cost duplication where electricity is available, paper) would be likely to enhance the quality of care. Again, such investments would ideally be coordinated: Building an individual provider's medical record-keeping capacity is not as useful as building the capacity of all providers in a community and using that opportunity to explore ways to improve local referral systems (which appear to be minimal everywhere).

Balanced Scorecard Monitoring as a Condition of Subsidies: Providing targeted subsidies to private providers will be a cost-effective way of enhancing the capacity of the health care delivery system. It also has the advantage of establishing a positive context for collaborative rather than confrontational efforts to improve service quality. Private providers receiving subsidies should be required to accept monitoring and evaluation (M&E) using the approach articulated in the Balanced Scorecard Toolkit.

While the Balanced Scorecard Toolkit was designed as a tool for M&E of public facilities, it would appear to be easily adaptable to use with private providers. It is, however, crucial to recognize that the primary purpose of M&E of private providers should not be to generate yet more reports on health system functioning, but should rather be (a) to engage providers themselves in a systematic process of self-assessment oriented toward organizational improvement, and (b) to generate insights into provider training and other developmental needs. Engaging individual providers in self-assessment is a key principle of M&E and organizational development. Generating information on provider skills development needs is vital to designing responsive, effective, and efficiently targeted customized curricula that will achieve identified system improvement goals.

With the Balanced Scorecard, Domains A (Patient Satisfaction/Perception of Quality Indicators), Domain C (Capacity for Service Provision—modified for different types of private providers), and portions of Domains D and E are most relevant for private providers. Domain B is probably not appropriate, and some of the indicators and components of other domains are clearly relevant only to public facilities. Adapting the Toolkit to monitoring private providers might best be accomplished by a task force with members who represent MoPH M&E staff, policymakers, health care specialists, and a variety of rural private providers.

CROSS-CUTTING CONSIDERATIONS

It will be important in both the short and the long term to seek the optimal balance between innovation and practicality. Novel initiatives definitely deserve careful consideration, but attention must also be given to reducing their complexity and the burden of implementing them. As part of MoPH efforts to integrate different strands of its strategy into a coordinated campaign to strengthen private health care in rural areas, the following deserve special attention:

Population and Community Diversity: No “one size fits all” strategy will work for Afghanistan, which is an extraordinarily heterogeneous country. Diversity within provinces is as dramatic as diversity between them, as evidenced by the differences between the remote rural and central district areas of provinces and differences in health care system configuration and utilization in different provinces. Decentralization might well be a key strategic element to balance the need for local engagement in and support of initiatives with the need for simplicity and a streamlined and equitable approach to building up the private sector. Effective strategies almost always include a balance between building on strengths and overcoming weaknesses.

Private Providers as Resources for Promoting Health: It is unwise to consider public health facilities and campaigns as the only venue for health education and promotion. Private providers are a particularly valuable resource, and investments to prepare them to be more effective health promoters and motivate them to become more consistent and proactive agents of health-enhancing change will probably be very cost-effective. The evidence from this study suggests that media health campaigns are not effective in rural Afghanistan. Because private providers are embedded in local family, tribal, and village networks, they can call on resources of social capital to convey messages that actually change household attitudes, aspirations, beliefs, and behavior.

Coordination of Strategic Interventions: The recommendations presented here address several major strands of action for increasing the capacity and quality of rural private health care providers: training, recruitment, professional skills upgrade efforts, and targeted loans and subsidies. It is important to assure that these are well-coordinated to assure maximum return on investment. A good example relates to promoting private one-stop services. This will require close coordination between training initiatives and targeted investment across all areas of health care specialization (e.g., increasing use of improved diagnostic technology, delivery of comprehensive family health services). A profusion of siloed, competing initiatives is an ever-present and serious risk—in part because none actually get implemented or, if they do, they are poorly implemented.

Continuing Research Oriented Toward Specific Intervention Objectives: Research typically adds value to initiatives not just by answering questions put by planners and policymakers but also by pointing to new hypotheses and articulating new practical questions. For instance, both the AHS 2006 and the current study show low levels of patient referrals. This is not because most private providers can provide comprehensive services—quite the contrary. Further research is needed to adequately understand why referrals are so low and, most important, what to do about it. Are referrals low because there are no places to which to refer patients? Because of deficiencies in provider diagnostic skills or resources? Because of longstanding habits of practice? In this case (and in other areas of planning to enhance health system functioning), well-targeted, low-cost studies probably using a mixture of qualitative and quantitative methods are needed.

All-encompassing research initiatives will usually not provide the type of insights that support design of effective strategic interventions. To do this it is necessary to identify pressure points where the impact of intervention will be amplified. This is seldom a simple analysis, and there are particular requirements for the models used to guide such planning. In particular, even very satisfactory black-box models that examine correlations between high-level indicators fail to provide sound guidance for action, because the insights into the social and economic dynamics of community or service delivery system change are not specified. Affordable continuing research, including participatory research, will be needed to supplement the standardized reporting systems used to generate data for monitoring.

Carefully Phased Implementation: Due to the urgency of making rapid improvements in the well-being of rural Afghan households, there will be constant and insistent pressures to roll out ambitious campaigns too fast. Particularly for interventions to build up the private component of health service delivery, it will be necessary to emphasize accountability and integrity. The best

way to accomplish this is to start small with pilot projects and then expand them into demonstrations based on what they do well and where they go wrong. The very real risks of investing in an ineffective or unreliable intervention should not deter such investments; they should simply serve to emphasize the need for well-articulated approaches to quality assurance.

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