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Main findings of a demonstration social audit of health services in Bagrami and Qarabagh districts

Anne Cockcroft, Neil Andersson, Candyce Hamel, Noor Ansari,
Amir Khan, Khalid Omer, Umaira Ansari and Amar Dass

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CIETcanada

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Summary

Social audits document community experience and views of public services, providing information for health planners to address community perspectives. A demonstration in two districts explored the feasibility and utility of this approach in the Afghanistan context. The exercise demonstrates a tool for policy that can help to raise the quality of health services and to minimize system leakage. It illustrates some of the dynamics and the type of data generated by a community based social audit, as well as the human resource and other practical implications for implementation at provincial level.

Methods

CIET demonstrated social audit in collaboration with the Afghanistan Ministry of Public Health (MOPH). The Ministry selected Bagrami and Qarabagh districts for the demonstration; both are within Kabul province and have relatively good security and easy access. We drew a stratified random sample of 15 sites from each district: one nomad community for each district; five urban sites in Bagrami district and two in Qarabagh district; with nine rural sites in Bagrami and 12 in Qarabagh.

In each site, the field team surveyed 100-120 contiguous households having at least one child under the age of five years. Survey instruments included a household questionnaire, a community profile record, and an institutional review of health facilities.

Field teams mainly made up of women undertook the household survey from July to August 2008. After preliminary analysis, facilitators conducted a male and a female focus group discussion in the sample communities. Dari speakers pre-coded open questions in Peshawar and the CIET team undertook data entry with its trained operators in Karachi.

We calculated weighted frequencies of indicators, with weights to adjust for any over or under sampling of estimated urban and rural populations. We used CIETmap open source software to multivariate analysis of individual and service level variables related to the main outcomes, with an adjustment to allow for the cluster sampling.

Findings

Interviewers collected data from 1639 households in Bagrami and 1644 households in Qarabagh district. Some 66% of households in Bagrami and 50% of households in Qarabagh had enough food in the house in the last week.

Household rating and use of health services

Some 42% of household respondents in Bagrami thought health services available in their area (including both government and private services) were good or very good, and 47% thought they were bad or very bad. In Qarabagh, 57% rated available health services as good or very good, and only 36% (563/1604) rated them as bad or very bad. In Bagrami, especially in rural areas, a household with enough food was more likely to rate health services as good.

Some 25% of households in Bagrami considered health services had improved in the last 12 months, 44% thought they were the same, and 24% thought they had got worse. In Qarabagh, 41% thought health services had improved, 42% thought they were the same, and 14% thought they had got worse. About half of households across the two districts were willing to pay for service improvements; households with enough food were more likely to be willing to pay.

Only 17% of respondents in Bagrami and 30% of respondents in Qarabagh knew how to complain about the health services they usually used.

Nearly two thirds (63%) of households in Bagrami usually used a government health facility for treatment of a health problem; 36% usually used a private facility. Of those usually using a government facility, 69% used a facility run under the strengthening mechanism (SM) arrangement (SM facility), 20% used a facility run directly by the Ministry of Public Health (MOPH) (MOPH facility), and 6% used a facility run under contract by an NGO (NGO facility). In Qarabagh, nearly all households (93%) usually used a government facility; only 5% usually used a private facility. Of those usually using a government facility, all used an NGO facility.

In Bagrami, households with enough food or an educated head were less likely to use a government facility, while rural households with a government facility nearby were more likely to use it. Focus groups suggested that many people preferred to use private facilities if they could afford to. On the other hand, nearly all households in both districts said they used a government facility for childhood immunisations.

Experience and costs of using health services

We asked about the most recent visit to a health facility by a family member during the last six months. In Bagrami, just over half (58%) used a government health facility, and 40% used a private facility. Of those who used a government facility, 63% went to an SM facility, 20% an MOPH facility, and 6% an NGO facility. In Qarabagh, nearly all (92%) used a government health facility, and just 7% used a private facility. All those who used a government facility went to an NGO facility.

Waiting times tended to be shorter in private facilities. More patients waited less than 30 minutes in Bagrami government facilities (31%) than in Qarabagh government facilities (12%).

Among users of government health services:

- two thirds paid for travel to and from the facility, at a median cost of 50 Afghanis in Bagrami and 100 Afghanis in Qarabagh;

- one fifth paid for a ticket in the facility, at a median cost of 5 Afghanis;

- one in six paid for treatment or investigations in the facility, at a median cost of 100 Afghanis; and

- three quarters incurred costs outside the facility, for medicines and investigations, at a median cost of 200 Afghanis in Bagrami and 250 Afghanis in Qarabagh.

Despite the perception voiced in focus groups that poor people are forced to use government services, the costs of treatment and investigations in government facilities, for those who paid, were the same as these costs in private facilities. And the costs for medicines etc outside the facility among users of government services were not much less then those incurred by users of private services. Focus groups revealed that it was not uncommon for people to take loans or sell livestock to pay for the costs of government services.

Satisfaction with health services used

Among users of government health facilities, 78% said the way the person treating them received them was good or very good, 5% thought it was neither bad nor good, and 17% thought it was bad or very bad. Among users of private facilities, 95% thought the way they were received was good or very good, 1% said it was neither bad nor good, and 4% said it was bad or very bad.

Among users of government health facilities, 44% said the quality of care was better than they expected, 38% said it was as expected, and 18% said it was worse than expected. Among users of private facilities, 64% thought the quality of care

was better than they expected, 25% said it was as expected, and 11% said it was worse than expected.

Overall, among users of government health facilities, 67% were satisfied with the quality of care, 5% were neither satisfied nor dissatisfied, and 29% were dissatisfied. Among users of private facilities, 78% were satisfied with the quality of care, 5% were neither satisfied nor dissatisfied, and 16% were dissatisfied. A government facility user was more likely to be satisfied with the quality of care in urban areas, if their household head was *not* educated, if their household had enough food, and if they waited less than 30 minutes to be seen.

Corruption in health services

Many people in both districts did not respond to questions about perceptions and experience of corruption in health services. Of those who responded, over a third in Qarabagh thought the level of corruption was staying the same, and only 8% thought it was increasing. A somewhat higher proportion in Bagrami (18%) considered corruption was increasing over the last 12 months.

Some 21% of respondents in Bagrami and 11% in Qarabagh declined to answer the question about whether any household member had been asked for an unofficial payment in a health facility. Of those who responded, 85% (1097/ 1290) in Bagrami and 74% (1078/1459) in Qarabagh denied they had ever been asked to make an unofficial payment.

Focus group participants suggested that the level of corruption in government health services was probably much higher than the findings of the household survey indicated. They said corruption is an everyday experience in society, including in health services. They said people in the household survey were loath to answer the questions about corruption, fearing their answers

may get back to the services and jeopardise their chances of care in the future.

Pregnancy and delivery care

Interviewers collected information from mothers of children less than 60 months old.

Contact with CHW
Some 38% of mothers in Bagrami and 50% of mothers in Qarabagh had had contact with a CHW. A Bagrami mother was more likely to have seen a CHW if she had some education, and if her household head had some education.

Care during pregnancy
Some 78% of mothers in Bagrami and 77% in Qarabagh reported at least one antenatal check-up during their last pregnancy. But only 29% of mothers in Bagrami and 33% of mothers in Qarabagh had the recommended four or more antenatal care visits during their last pregnancy. A mother was more likely to have had the recommended four antenatal checkups if she had any education, if her household had enough food, and if she had ever seen a CHW.

Many mothers -- 64% in Bagrami and 73% in Qarabagh -- reported they took iron/folate tablets during their last pregnancy. But only 4% in Bagrami and 6% in Qarabagh iron/folate tablets for two months or more during their last pregnancy. Most mothers (75% in Bagrami and 80% in Qarabagh) received at least two doses of tetanus toxoid (TT) during their last pregnancy.

Women commonly ate less than usual during pregnancy. In Bagrami, 23% of mothers ate more food than usual during their last pregnancy, 29% ate the same amount as usual, and 47% ate less than usual. In Qarabagh, 15% of mothers ate more food than usual during their last pregnancy, 39% ate the same amount as usual, and 44% ate less than usual. Most mothers reported they did *not* reduce their routine heavy work during their last pregnancy; just 37% of mothers in Bagrami

and 36% of mothers in Qarabagh reduced their routine heavy work during the pregnancy.

Delivery
Home delivery was common. Some 46% of mothers in Bagrami delivered at home, 34% delivered in a government facility, 19% delivered in a private facility, and 1% delivered in a hospital outside Afghanistan. In Qarabagh, 48% of mothers delivered at home, 49% delivered in a government facility, 1% delivered in a private facility, and 2% delivered in a hospital outside Afghanistan. A mother was *less* likely to have delivered her last baby at home if she was aged 30 years or younger, if her household head had some education, if her household had enough food, and if she had had any antenatal checkups.

Child feeding and immunisations
Breast feeding was nearly universal and nearly all children had been given colostrum. In Bagrami, half the children were breast fed for the recommended 24 months. In Qarabagh, two-thirds of the children were breast fed for the recommended 24 months. There was no difference between male and female children in duration of breast feeding. In both Bagrami and Qarabagh, over 90% of children were given other liquids before the recommended age of six months. In Bagrami, one fifth of children, and in Qarabagh one in ten children, had solid foods added to their diet before the age of six months.

Childhood immunisation rates were high. According to maternal report, over 90% of children aged 12-23 months in both districts had received BCG vaccine, polio vaccine, and measles vaccine. Some 66% of children aged 12-23 months in Bagrami and 77% in Qarabagh had received three doses (or a full course) of DPT injections.

Commentary

With the support of the MOPH, the demonstration social audit explored the feasibility and utility of the social audit approach in the Afghanistan context. Under sometimes difficult conditions, the team successfully completed household data collection, focus group discussions, and data entry and analysis.

People who could afford to do so preferred using private health services, in line with trends in other countries in the region. Few people knew how to complain about health services, even amongst users of government services.

Despite an official policy of free health services in government facilities, some users paid for services in government facilities, and they did so at levels similar to the charges in private facilities. These unofficial payments place a strain on household finances, and have become a source of frustration.

A review of payments in health facilities is indicated.

Background

Health services in Afghanistan

Public health services have been rebuilt in Afghanistan since 2001, when they were in a state of near total collapse. Recent reviews suggest there have been improvements over the period, but much remains to be done[1] [2]. A household survey in 2006 claimed improvements in under-five and infant mortality rates compared with figures from 2000[3].

A key focus has been on improving access of the population to basic health services. A Basic Package of Health Services (BPHS) developed in 2002 was revised in 2005[4]. The government increased access of the population to these basic services mainly through a franchising approach, contracting NGOs to provide the services in collaboration with donor partners[12].

More recently, the Ministry of Public Health (MOPH) developed a scheme known as Strengthening Mechanism (MOPH-SM) whereby the central Ministry contracts Provincial Health Offices (PHOs) to provide the BPHS in some provinces, in the same way as NGOs are awarded contracts[12]. Recent claims have at least 82% of the population now covered by BPHS[12] -- although this really means the estimated 82% of the population live in districts covered by contracts to provide the BPHS[12].

The two districts designated by the MOPH provide health services in different ways. In Qarabagh, the district hospital and most of the five basic health centres (BHCs) are run by a contracted NGO. In Bagrami, the two comprehensive health centres (CHCs) and most

[1] Waldman R, Strong L, Wali A. Afghanistan's health system since 2001: condition improved, prognosis cautiously optimistic. Afghanistan Research and Evaluation Unit. Briefing Paper Series. December 2006

[2] Sabri B, Siddiqi S, Ahmed AM, Kakar FK, Perrot J. Towards sustainable delivery of health services in Afghanistan: options for the future. Bulletin of the World Health Organisation 2007; 85: 712-718

[3] Afghanistan household survey 2006. Kabul: Johns Hopkins Bloomberg School of Public Health and Indian Institute of Health Management Research, 2007

[4] Ministry of Public Health, Islamic Republic of Afghanistan. A Basic Package of Health Services for Afghanistan, 2005/1384

of the BHCs are run under the MOPH-SM scheme.

Community based Health Workers (CHWs) have an important role in the BPHS[5] [6]. It is important to gather information about the coverage and impact of CHWs in areas where they operate. Both districts have a system of CHWs. The demonstration offers an opportunity to measure the coverage of women by CHW contacts, as well as the content and impact of the visits, especially in relation to pregnancy and delivery care and knowledge and practice about childhood immunisations.

At no stage was there any suggestion that the findings from the demonstration will be in any way generalizable across Afghanistan. But choosing two districts with different arrangements for provision of their basic health services does at least offer a contrast of neighbouring districts close to Kabul.

Given the security situation in much of the country, reliable representative community-based data about use and experience of health services in Afghanistan are hard to come by. Most information about the functioning of the health services is facilities-based. Repeated cycles of the Balanced Score Card survey of facilities across the provinces of the country claim improvements over time in many functions, in staff views and experience, as well as high and improving ratings of the service from patients using the facilities[7].

The authors of a review of progress in health services point out that having facilities on the ground and able to provide the BPHS does not mean that everyone has access to or chooses to

[5] Policy on Community Based Health Worker (CHW). Islamic Transitional Government of Afghanistan, Ministry of Health, 2003

[6] Ickx P. Rapid assessment of community health worker knowledge compared with knowledge of doctors and nurses. REACH, 2006

[7] Ministry of Public Health Monitoring and Evaluation Dept, Johns Hopkins University Bloomberg School of Public Health, Indian Institute of Health Management Research. Afghanistan Health Sector Balanced Scorecard National and Provincial Results. Round Three 2006. Ministry of Public Health, 2007

use these services. They note that "Research at the community and household level is very important to determine other reasons why some people do, and others do not, make use of the health services available"[12].

The people who do *not* use public health services are often the most disadvantaged; if we want to find out about their health status, their views about the available services, and their reasons for not using the public health services, we need to ask them directly. This information from communities is an important complement to the information from services and service users; putting the two kinds of information together can allow rational planning of services to reach and serve the needs the highest proportion of the population in the areas covered by the services[8].

Therefore the social audit provides an important missing piece of the jigsaw of information about health services in Afghanistan. Part of the purpose of the demonstration social audit is to show how this linking of social audit data with facilities-based data could work.

The social audit

The demonstration social audit in two districts aims to explore the feasibility and utility of the social audit approach in Afghanistan. A demonstration could open an informed dialogue on the process, fine-tuning it as necessary to suit local needs, and define and develop linkages with existing data collection and monitoring processes. A longer term view was that a larger project might extend the social audit to the country, and build Afghan capacities to make this a sustainable process that improves health delivery for all citizens, especially the most vulnerable.

A social audit documents community experience and views of public services, providing

[8] Cockcroft A, Andersson N, Milne D, Hossain MZ, Karim E. What did the public think of health services reform in Bangladesh? Three national community-based surveys 1999-2003. *Health Research Policy and Systems* 2007, 5: 1 (http://www.health-policy-systems.com/content/5/1/1)

information for health planners to address community perspectives. Developed in the 1980s, this governance support tool has now evolved and established as a well-tested methodology[9] [10] [11] for generating local evidence, promoting local ownership and starting collaborative initiatives among local and provincial stakeholders.

The tool can identify system leakage mechanisms; it can build community stake-holding and strengthen public services. A household survey links to institutional reviews and key informant opinions. Evidence-based discussions with stakeholders (communities, local service workers) and a second-order aggregation of results lead to locally informed strategies for dealing with under-performance (from the population perspective) of public services. Its application here is as a vehicle for communities to have a say in the delivery of health services, and for planners to understand the household decision-making context.

This pilot exercise intends to demonstrate a tool for policy makers that can raise the quality of health services and minimize system leakage. It will demonstrate some of the dynamics and the type of data generated by a community based social audit, as well as the human resource and other practical implications for implementation at provincial level.

[9] Andersson N, Martinez E, Cerrato F, Morales E and Ledogar RJ. The use of community-based data in health planning in Mexico and Central America. *Health Policy and Planning* 1989; 4:197-206.
[10] Andersson N, Evidence-based planning: the philosophy and methods of sentinel community surveillance . CIET, EDI/World Bank, 1995.
[11] Andersson N, Roche M. Gender and evidence-based planning: the CIET methods. *Development in Practice*, 2006; 16: 141-152

Methods

Ministry of Public Health collaboration and ethical review

The Ministry of Public Health (MOPH), as the main government body responsible for health sector activities in Afghanistan, nominated a senior focal point within MOPH for the social audit. The ministry also notified an eight-member project steering group to provide policy guidance and government liaison for the project. The steering group included representatives from the two districts designated for the demonstration social audit.

The Institutional Review Board (IRB) of the MOPH reviewed the project proposal. In March 2008 CIET submitted the proposal and gave a presentation to members of the MOPH and IRB. The IRB issued formal approval of the project on 27 May 2008.

The household sample

Locating the sample sites on the district maps

In consultation with the MOPH, we purposively selected Bagrami and Qarabagh districts for the demonstration social audit. Both are within Kabul province and have relatively good security and easy access.

According to the Central Statistical Office, the population of Qarabagh district is 69,500 and that of Bagrami district is 50,500 -- the whole population considered to be rural. The district local authorities provided updated lists of communities in each district. We discussed the population data in detail with a group from the project steering committee and local district representatives. This group noted that both districts have urban as well as rural communities, and a small nomad population. According to their local knowledge, they estimated that 35% of the population in Bagrami district and 10% of the population in Qarabagh district live in urban communities. They also suggested including one

nomad community in the sample from each district, to represent the small nomad population. The group updated the list of communities in the two districts and categorised each one as urban (including semi-urban), rural or nomad.

We drew a stratified random sample of 15 communities from each district. We separated the communities into urban, rural and nomad groups. We randomly selected the sample from these groups: one nomad community for each district; five urban communities in Bagrami district and two in Qarabagh district; nine rural communities in Bagrami and 12 in Qarabagh. With the help of the district representatives, we marked the location of the sample communities on district maps downloaded from a government website. Figures 1 and 2 show the location of the sample communities in each district. The grey areas (not covered by the survey) have harsh, mountainous terrain and little or no population.

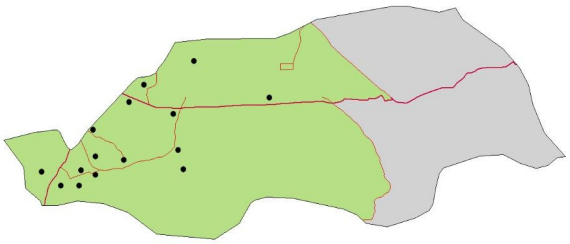

Figure 1. Sample sites and main roads in Bagrami

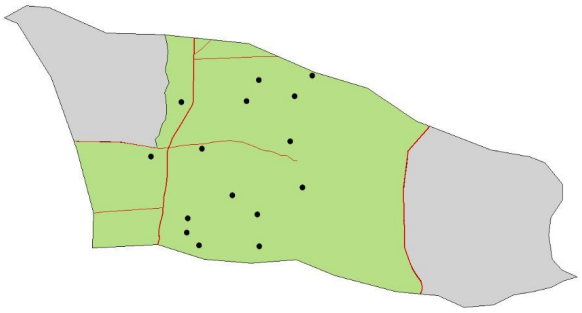

Figure 2. Sample sites and main roads in Qarabagh

In each sample community, the field team surveyed around 120 contiguous households having at least one child under the age of five years. Radiating from a randomly selected starting point, they visited contiguous households until they reached the target number. There was no sub-sampling. If the eligible households in the primary community were exhausted before completion of the target, the team moved to the next nearest community to complete their target.

Weighting of the sample

Although we selected a sample with proportions of urban and rural communities approximating that estimated in the actual population, this was not exact. To ensure the sample proportions of urban and rural reflected those in the population, we calculated weights and applied these when calculating district estimates. We grouped together urban and semi-urban communities, and included the nomad population with the rural population.

A meeting of the design working group

Survey instruments

Based on a list of key issues and indicators from the MOPH, and with input from the IRB, we developed the instruments for the survey. We translated them into Dari and Pashto, with back translation to check for any loss of meaning during translation.

The *household questionnaire* had three sections. The first section asked about basic demographic and socio-economic conditions of the household, and their perceptions, use, and experience of health services. The second section asked each mother within the household (having at least one child of age less than five years) about her contact with community health workers, and her last pregnancy, including antenatal and delivery care. The last section asked about breast feeding, feeding practices, and vaccination status, for each child under the age of 60 months.

The *community profile* covered access and conditions in the community, and health services available to the community.

The *institutional review* collected information from government health facilities used by the sample communities.

Piloting

In July 2008 we trained a fifteen-member design team in Kabul, drawn from both the districts, to help with piloting. The team comprised mostly women. It included teachers, social workers, community and civil society representatives, and two research officers from the MOPH. The team, under the supervision of CIET, piloted the instruments in non-sample urban and rural settings in and around Kabul for four days. This helped to identify flaws in phrasing, translation and interpretation of questions and to check the flow and timing of the questionnaire. We modified and updated the instruments until we were satisfied they were working well.

Training and data collection

Government officials and representatives of civil society in the districts helped to identify potential candidates for field teams. In order to form four field teams, two for each district, we invited about seventy people from the districts to participate in the training. We selected for the teams those who were most suitable, both technically as well as for their attitude. We undertook training for Bagrami district in Kabul and for Qarabagh within the district. Each training consisted of class room and field practice sessions over a period of three days, followed by a full-day mock field exercise. The medium of instruction was Pashto, with explanation in Dari when needed.

Field team members entering their vehicle

Each of the four field teams had 12 members: eight female and two male interviewers, led by one female quality control coordinator and one male logistic control coordinator. Some members from the design team participated as field team members.

Data collection took place from July to August 2008. Security guards accompanied each field team to the field sites. They were familiar with the local areas, and they guided the field teams to the communities and to move in and around the communities. Fieldwork usually started at or before 7am and continued until 3pm or 4pm.

Quality control during field data collection

Two CIET personnel supervised the overall data collection. The two research officers from MOPH assigned to the project helped local field assistants to monitor the teams in the field.

Focus group discussions

In November 2008, after preliminary analysis of findings from the household survey, we developed a guide to feedback and discuss issues arising from the household survey with separate focus groups of men and women.

We trained men and women, many of whom had participated in the household survey, in facilitation and recording of focus groups. They undertook field practice with the guide.

The teams returned to the same communities that participated in the household survey and undertook separate male and female focus groups in each community.

Data management and analysis

Interviewers recorded responses in Dari. Trained Dari-speakers pre-coded responses to open-ended questions in Peshawar, supervised by the CIET team. The CIET team randomly double-checked some of the assigned codes. Trained operators in the CIET DMU in Karachi, Pakistan, undertook double data entry, with validation to reduce keystroke errors. When required, one Dari speaking person translated question responses into Urdu. Further cleaning looked for logical inconsistencies and out of range responses, with checking back to the original data registers as necessary. We created composite and recoded variables as necessary for analysis.

Analysis relied on CIETmap open-source statistical and geomatics software. Initial analysis generated weighted frequencies of the main indicators. Further analysis examined factors related to outcomes of interest, in bivariate analysis and then in multivariate models. Associations are expressed as the adjusted Odds Ratio (OR) and its 95% confidence interval. We adjusted the 95% CI to allow for the cluster sampling, and in this report we quote the cluster adjusted values (95% CI_{ca}). When the 95% CI_{ca} does not cross unity(1.00) this is equivalent to an association being “significant at the 5% level”.

A small group, including CIET personnel and Dari speakers, reviewed the focus group reports in Peshawar, identified themes in the discussions, and extracted relevant quotes.

Findings

The information base

Households

Table 1. Distribution of sample households by type of location

	Bagrami n=1639	Qarabagh n=1644
Urban	18% (288/1639)	10% (204/1644)
Semi-urban	14% (230/1639)	0% (0/1644)
Rural	61% (1000/1639)	82% (1320/1644)
Nomad	7% (121/1639)	7% (120/1644)

The trained field teams collected data from 1639 households in Bagrami district and 1644 households in Qarabagh district (Table 1).

The average number of people in each household was 6.72 (SD 2.7, n1639) in Bagrami district and 6.69 (SD 2.4, n1644) in Qarabagh district. In Bagrami district there was an average of 3.43 (SD 1.7, n1639) males in the household, ranging from 1 to 15, compared with 3.42 (SD 1.5, n1644), ranging from 1 to 11, in Qarabagh district. Households in Bagrami district had an average of 3.29 (SD 1.7, n1639) females, ranging from 1 to 13, while households in Qarabagh district had an average of 3.27 (SD 1.5, n1644) females, ranging from 1 to 12.

In Bagrami district the most common language spoken at home was Dari, spoken in 77% (1258/1639) of households, followed by Pashto, spoken in 22% (368/1639) households, and Farsi in 1% (12/1639). In Qarabagh district the most common language spoken at home was Dari, spoken in 59% (968/1644) households, followed by Pashto in 40% (661/1644), and Farsi in 1% (15/1644).

Housing structure and size

Nearly all the households had a roof made of wood: 90% in Bagrami and 92% Qarabagh.

The average number of rooms in a household excluding the kitchen, bathroom and store was 2.67 (SD 1.3, n1615), ranging from 1 to 7 rooms, in Bagrami district, and 2.53 (SD 1.2, n1627), ranging from 1 to 7 rooms, in Qarabagh district. In Bagrami district the average number of people per room was 3.04 (SD 1.8, n1634) and in Qarabagh district the average number of people

per room was 3.09 (SD 1.6, n1632). Some 19% (307/1634) of the households were categorised as crowded (more than 4 people per room) in Bagrami district, and 17% (288/1632) were categorised as crowded in Qarabagh district.

Household respondents

The mean age of household respondents was 30.13 years (SD 7.8, n1638), ranging from 14 to 70, in Bagrami district, and 32.39 years (SD 10.2, n1644), ranging from 15 to 95, in Qarabagh district. In Bagrami district, in 88% (1437/1639) of houses the respondent was the wife of the household head. In Qarabagh district, in 77% (1271/1643) of houses the respondent was the wife of the household head. In both districts virtually all the household respondents were female.

Household heads and breadwinners

The household head was male in 98% (1600/1639) of the households in Bagrami district and 88% (1449/1644) in Qarabagh district. The mean age of the household head was 39.64 years (SD 12.4, n1637) in Bagrami district and 41.13 years (SD 12.7, n1626) in Qarabagh district. Some 43% (687/1588) of the household heads in Bagrami district, but only 19% (265/1365) of household heads in Qarabagh district, had completed primary education or above.

Table 2. Occupation of the main household breadwinner

	Bagrami n=1618	Qarabagh n=1627
Un-skilled worker or daily wage laborer	29% (468/1618)	34% (553/1627)
Skilled worker	25% (401/1618)	18% (296/1627)
Farmer	15% (237/1618)	20% (324/1627)
Shopkeeper	13% (204/1618)	15% (250/1627)
Professional/businessman/ armed forces personnel/works abroad	4% (71/1618)	4% (61/1627)
Pesh imam/teacher/community leader/ government servant	15% (237/1618)	9% (143/1627)

In 29% (462/1618) of the households in Bagrami district, the main breadwinner was a daily wage labourer or jobless, and in 15% (237/1618) a farmer. In 33% (541/1627) of the households in Qarabagh district, the main breadwinner was a daily wage labourer or jobless, and in 20% (324/1627) a farmer (Table 2). Some 71% (1150/1618) of the household breadwinners in Bagrami and 66% (1074/1627) of the household breadwinners in Qarabagh district had what was categorised as a “good” occupation in terms of

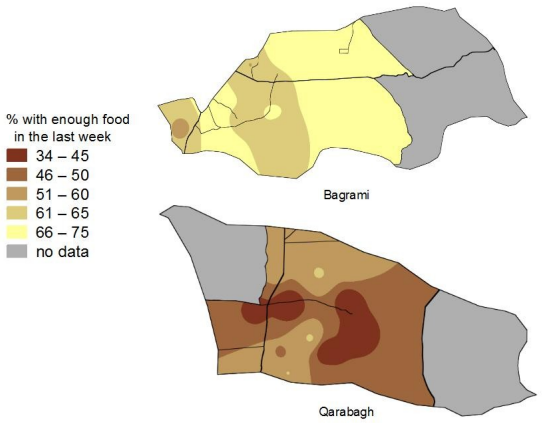

Figure 3. Households with enough food in the last week

likely earnings. Annex 1 includes a table of the reported occupations of household breadwinners.

Income and food security

Some 59% (964/1633) of the household respondents in Bagrami district stated that the overall income of household members was sufficient to meet household expenditures, while 48% (779/1641) of household respondents in Qarabagh district reported sufficient income to meet household expenditures.

Some 66% (1067/1621) of household respondents in Bagrami district reported they had enough food in the house in the last week. In Qarabagh district, only 50% (810/1622) of respondents said they had enough food in the house last week. (Figure 3)

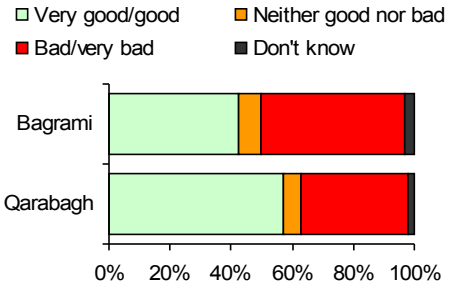

Figure 4. Household ratings of health services in area

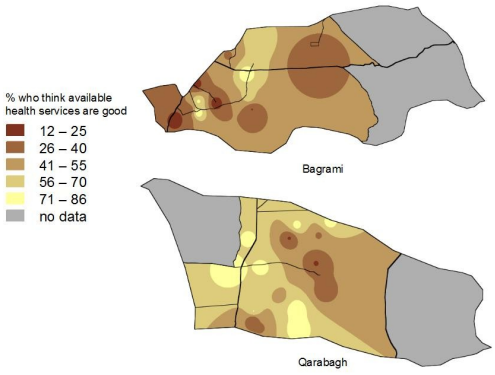

Figure 5. Households who think health services are good

In Bagrami, especially in rural areas, a household with enough food was more likely to rate health services as good.

Household perceptions about health services

Rating of health services

Some 42% (681/1610) of respondents in Bagrami district thought the health services available in their area (including both government and private services) were good or very good, while a similar proportion (47%; 757/1610) thought they were bad, very bad or that there was no service in the area, 7% (116/1610) said they were neither good nor bad and 3% (56/1610) did not know how to rate them (Figure 4).

In Qarabagh district, 57% (917/1604) of respondents rated available health services as good or very good, and only 36% (563/1604) rated them as bad, very bad or that there was no service in the area, 6% (99/1604) thought the services were neither good nor bad and 2% (25/1604) did not know how to rate them (Figure 4).

Figure 5 shows the variation in rating of health services across the two districts.

The cluster adjusted analysis indicated the difference in the rating of health services between the two districts could have occurred by chance. In Bagrami, after multivariate analysis, households reporting enough food in the last week (ie not the poorest households) were more likely to rate available health services as good, compared with households without enough food in the last week. This effect was stronger in rural areas (OR 3.95, 95% CI_{ca} 1.94-8.06) than in urban areas (OR 2.10, 95% CI_{ca} 1.08-4.08). In rural areas, the less poor households were four times more likely to rate available health services as good. In Qarabagh, none of the household level variables was significantly associated with the household rating of available health services, nor was there a significant difference between urban and rural sites.

"What can I say, sister? Everybody is treated badly at government hospitals." (Female group, Bagrami)

"There are 5000 families in this village, and there is not a single clinic operating here." (Male group, Bagrami)

"Once I had very high blood pressure. I went to the hospital but the doctor told me he did not have the equipment to check my blood pressure." (Female group, Qarabagh)

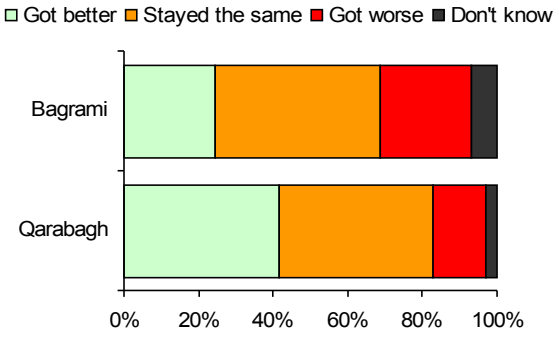

Figure 6. Views of health services over the last 12 months

In Bagrami: a household with enough food was more likely to think health services had improved.

In Qarabagh: an urban household was more likely to think health services had improved.

"Health facilities were better last year. They have become terrible this year." (Female group, Bagrami)

"Health facilities are deteriorating on a daily basis." (Male group, Bagrami)

"The attitude of doctors has considerably improved now. They examine us better as well." (Female group, Qarabagh)

"People who say health services have improved are either bribing hospital workers, or else they have contacts there." (Female group, Qarabagh)

Focus groups of men and women discussed why many people did not think health services in their area were good. They voiced a number of complaints about services, including lack of access to facilities, lack of medicines and equipment, and poor treatment in facilities.

Some 25% (373/1528) of respondents in Bagrami district considered the health services in their area had improved in the last 12 months, 44% (675/1528) thought the services had stayed the same, 24% (376/1528) thought they had got worse, and 7% (104/1528) could not say how services had changed. In Qarabagh district 41% (635/1533) of respondents considered health services had improved, 42% (635/1533) respondents thought they had stayed the same, 14% (220/1533) thought they had got worse, and 3% (43/1533) could not say how services had changed (Figure 6).

Respondents in Bagrami were significantly less likely than respondents in Qarabagh to think health services had improved in the last 12 months (OR 0.48, 95% CI_{ca} 0.31-0.73). In Bagrami, taking other conditioning factors into account, in rural sites only, households with enough food in the last week were more likely to think health services had improved (OR 3.49, 95% CI_{ca} 2.50-4.88) as were households where the head had some education (OR 1.69, 95% CI_{ca} 1.21-2.37). In Qarabagh, only one factor remained associated with thinking services had improved; households in urban areas were more likely to think services had improved than those in rural areas (OR 2.01, 95% CI_{ca} 1.35-2.99).

Focus groups of men and women in the two districts considered the findings about how many households thought health services had got better or worse. Many people in the Bagrami groups agreed that health services had got worse in the last year. In Qarabagh groups expressed mixed feelings about the change in service quality in the last year.

Table 3. Suggested changes to health services

	Bagrami n=1570	Qarabagh n=1543
Nothing	5% (84/1570)	6% (91/1543)
Increase doctors/health workers/better qualified	12% (192/1570)	17% (268/1543)
More/better health services	52% (820/1570)	32% (489/1543)
Better accountability/ monitoring	1% (9/1570)	1% (18/1543)
More/better medicines	7% (112/1570)	16% (245/1543)
Clean/better hygiene	0% (4/1570)	0% (3/1543)
Good behaviour/pay attention/ guide patients	2% (38/1570)	9% (141/1543)
Better access/facilities nearer	12% (195/1570)	17% (257/1543)
No corruption	0% (0/1570)	0% (2/1543)
More pay/incentives to doctors	7% (116/1570)	2% (29/1543)

Suggestions for changes in health services

Table 3 shows the changes suggested by household respondents when they were asked what one thing they would want to change about the health services. Many respondents were not able to give a specific response beyond "more services" or "better services". This was the response of 52% (820/1570) in Bagrami and 32% (489/1543) in Qarabagh. Some respondents asked for more doctors and health workers and some wanted easier access to facilities.

Willingness to pay for improvement in health services

Among those who gave a response about willingness to pay for improved health services, some 52% (836/1595) of respondents in Bagrami district said they would be willing to pay, or to pay more, for improvement of health services. In Qarabagh district 46% (722/1573) of respondents said they would be willing to pay, or to pay more, for improvement of health services.

A household with enough food was more likely to be willing to pay for improvements in health services, especially in Bagrami.

The difference between the two districts in reported willingness to pay could have been due to chance. In Bagrami, taking other factors into account, less poor households (with enough food in the last week) were four times more likely to be willing to pay, compared with households without enough food (OR 4.55, 95% CI_{ca} 2.75-7.53). Similarly, in Qarabagh, less poor households were more likely to be willing to pay, compared with the poorest households (OR 1.62, 95% CI_{ca} 1.02-2.59).

Complaining about health services

Interviewers asked respondents if they knew how to complain about the health services they usually used and if they had ever made a complaint. Only 17% (252/1454) of respondents in Bagrami district knew how to complain about the health services they usually used. Even fewer, just 3% (50/1463) of respondents, had ever made

a complaint about the health services they usually used. In Qarabagh district, 30% (476/1587) of respondents knew how to complain about the health services they usually used. Some 15% (238/1589) of respondents had ever made a complaint about the health services they usually used.

A household was more likely to know how to complain about their usual health facility:
>if they usually used a government facility
>if they lived in Qarabagh district

In a multivariate analysis, combining the two districts, two factors were significantly associated with knowing how to complain about the usual health service used. A household which usually used a government facility was more likely to know how to complain (OR 2.28, 95% CI_{ca} 1.55-3.34). A household in Bagrami was less likely to know how to complain than a household in Qarabagh (OR 0.62, 95% CI_{ca} 0.46-0.83)

Figure 7 shows the variation across the two districts in knowledge of how to complain about health services.

The field teams visited 12 health facilities serving the sample communities. Only two had a system for patient complaints (a complaints box) and both of these facilities were Kabul.

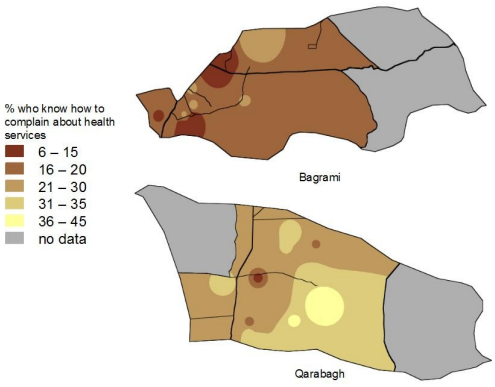

Figure 7. Knowledge of how to complain about health services

Household use of health services

First choice of facility for health problems

Nearly two thirds (63%; 1003/1587) of respondents in Bagrami district reported that they usually go to a government health facility to seek help for a health problem, and as many as 36% (569/1587) said that they go to private health facilities. A few respondents mentioned other sources of care (see Annex). Of those respondents who said household members usually go to a government health facility to seek help for a health problem, 69% (691/1002) mentioned a facility run under the strengthening mechanism (SM) arrangement (SM facility), 20% (202/1002) mentioned a facility run directly by the Ministry of Public Health (MOPH) (MOPH facility), and 6% (59/1002) mentioned a facility run under contract by an NGO (NGO facility).

In Qarabagh district, there was a different picture. Nearly all (93%; 1524/1630) of respondents said household members usually go to a government health facility, and just 5% (87/1630) said they go to private health facilities. A few respondents mentioned other sources of care (see Annex). Of those respondents who said household members usually go to a government health facility, all (100%; 1523/1524) mentioned an NGO facility.

Figure 8 shows the variation across the two districts in the proportion of households usually using a government facility for treatment of health problems.

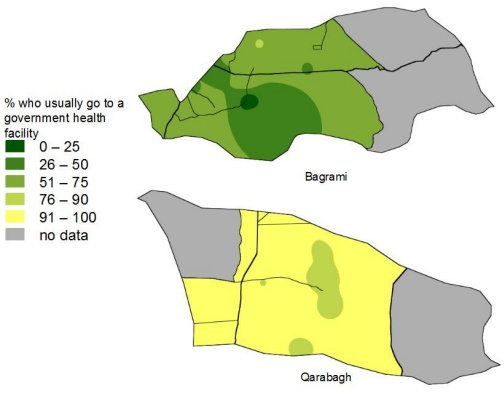

Figure 8. Households choosing a government health facility

In Bagrami, we examined in multivariate analyses the factors relating to choosing a government rather than a private facility for treatment of health problems. In urban sites, households with enough food in the last week (less poor households) were *less* likely to choose a government facility (OR 0.30, 95%CI_{ca} 0.27-0.33), as were households where the head

In Bagrami urban areas, a household was *less* likely to use government health services:
>if the head was educated
>if they had enough food.

In Bagrami rural areas, a household was:
>*less* likely to use government health services if the head was educated
>*more* likely to use government services if there was a facility nearby.

"Government health facilities don't offer medicine, competent doctors, gynaecologists, and ambulance services. And the doctors are not punctual. That's why we go to a private clinic." (Female group, Bagrami)

"Doctors in government facilities are illiterate. They give whatever medicine they like to their patients, without knowing what it is for." (Male group, Bagrami)

"Private clinics take a lot of money. But they give effective medicines. They are better." (Female group, Bagrami)

"Doctors at government facilities don't think their patients are also human." (Male group, Bagrami)

"People have to go to government clinics because they are poor. The rich go to private clinics." (Male group, Qarabagh)

"If I had money I would not have gone to the government clinic. Government clinics are for the poor only." (Male group, Qarabagh)

"We prefer government health services. But they should be able to offer proper diagnosis, effective medicines and good management." (Female group, Qarabagh)

Table 4. Time for return journey to usual health facility

	Bagrami n=1550	Qarabagh n=1585
Less than 30 minutes	18% (275/1550)	6% (97/1585)
30-60 minutes	47% (732/1550)	37% (585/1585)
More than an hour up to three hours	29% (442/1550)	51% (803/1585)
More than three up to eight hours	6% (100/1550)	6% (95/1585)
More than eight up to 24 hours	0% (1/1550)	0% (4/1585)
More than a day	0% (0/1550)	0% (1/1585)

had some education (OR 0.49, 95% CI_{ca} 0.43-0.56). The presence of a government health facility within 5 Km of the community did not mean households were more likely to use a government facility. In rural sites, households were *less* likely to choose a government facility if the head had some education (OR 0.50, 95% CI_{ca} 0.26-0.96). They were *more* likely to choose a government health facility if there was one within 5 Km of the community (OR 1.38, 95% CI_{ca} 1.05-1.82).

Focus groups of men and women in the two districts considered why so many households in Bagrami usually use private facilities, and why so few in Qarabagh usually use private facilities. In Bagrami many people pointed to the inadequacies of government facilities as the reason for choosing private facilities. They also complained about the attitude of doctors in government facilities. In Qarabagh, people indicated they went to government rather than private facilities because they could not afford the costs of private care. They said that the service at government facilities should be improved.

Travel times for visiting health facilities

In Bagrami district 18% (275/1550) of respondents said it took less than 30 minutes for return travel to the facility they usually used for health problems and two thirds said it took less than 60 minutes. In Qarabagh district, travel times were longer: only 6% (97/1585) of respondents said it took less than 30 minutes for return travel to the facility, less than half had a return journey of less than 60 minutes, and half travelled for one to three hours. (Table 4).

Choice of facility for childhood immunisation

Nearly all (95%; 1496/1574) of households in Bagrami usually took children to a government health facility for immunisation, and 4% (60/1574) usually took them to private health facilities (Table 5). Of those respondents who used a government health facility for childhood immunisation, 73% (1085/1494) went to an SM facility, 22% (322/1494) went to an MOPH facility, and 4% (62/1494) went to an NGO facility.

Also in Qarabagh district, nearly all (95%; 1539/1622) of households usually took children to a government health facility for immunisation, and 1% (17/1622) usually took them to private health facilities (Table 5). Of those respondents who went to a government health facility for childhood immunisation, all (100%; 1539/1539) went to an NGO facility.

Table 5. Usual type of facility used for childhood immunisations

	Bagrami n=1574	Qarabagh n=1622
Nowhere	0% (5/1574)	0% (8/1622)
Government health facility	95% (1496/1574)	95% (1539/1622)
Private health facility	4% (60/1574)	1% (17/1622)
Hospital abroad	0% (4/1574)	0% (2/1622)
Vaccination team	1% (9/1574)	3% (56/1622)

Experience of using health facilities

Type of service used and when used

In Bagrami district, nearly all 97% (1515/1560) of households who responded to the question had at least one member who sought help for a health problem within the last six months. And 96% (1414/1476) of households in Qarabagh district who responded to the question had at least one member who sought help for a health problem within the last six months. The type of service used for the last visit to a health facility closely reflected the type of service households reported as their usual choice.

In Bagrami district, just over half (58%; 905/1550) of households used a government health facility the *last time* a household member sought help for a health problem, 40% (625/ 1550) used a private facility, and 1% (10/1550) used traditional healers. A handful used other sources of care (see Annex). Of those households who used a government health facility the last time a household member sought help for a health problem, 63% (565/904) went to an SM facility, 20% (183/904) went to an MOPH facility, and 6% (57/904) went to an NGO facility.

In Qarabagh district, by contrast, nearly all (92%; 1472/1605) of households used a government health facility the *last time* a household member sought help for a health problem, just 7% (110/1605) used a private facility, and 1% (22/1605) used traditional healers. A handful used other sources of care (see Annex). Of those households who used a government health facility the last time a household member sought help for a health problem, all (100%; 1467/1472) went to an NGO facility.

Figure 9 shows the variation across the two districts in the the proportion of households who used a government health facility the last time someone needed help for a health problem.

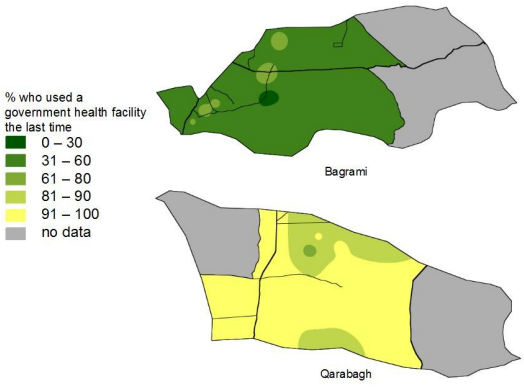

Figure 9. Households who used a government facility last time

Type of health problem and characteristics of service users

This section describes the experience of the last household member who went or was taken to a health facility within the last six months. Where possible this information was obtained directly from the person who used the services, or in the case of children from the carer who took the child to seek medical care.

The most common health problems for which male and female household members in the two districts sought help are shown in Table 6.

Table 6. Most common health problems for which household members sought help

	Bagrami n=1479	Qarabagh n=1374
Preventive services	2% (25/1479)	15% (204/1374)
Diarrhoea/dysentery	28% (411/1479)	18% (242/1374)
Acute respiratory infections/ measles	19% (275/1479)	11% (157/1374)
Fever/malaria	12% (171/1479)	8% (111/1374)
Gynaecological problems	10% (145/1479)	13% (184/1374)
Cardiovascular problems	4% (60/1479)	5% (75/1374)
Accidents/injuries/poisoning	3% (43/1479)	4% (58/1374)
Miscellaneous acute illnesses	11% (163/1479)	11% (147/1374)
Miscellaneous chronic illnesses	13% (186/1479)	14% (196/1374)

In Bagrami, in 41% (626/1459) of the reported health facility visits, the family member seeking help or taken for help was male. In Qarabagh district, 26% (356/1386) of service users were male.

The average age of those who sought help was 14 years (SD 15, n=1497) in Bagrami and 17 years (SD 15, n=1380) in Qarabagh. Many of the services users were children. In 66% (989/1497) of the reported health facility visits in Bagrami and 54% (742/1380) of those in Qarabagh, the person for whom help was sought was less than 18 years old. And in 43% (638/1497) of visits in Bagrami and 36% (501/1380) in Qarabagh, the person for whom help was sought was aged less than five years.

Waiting time at health facility

Across both districts, the mean waiting time in a government health facility was 103 minutes (SD 124, n=2038) while in a private health facility it was 51 minutes (SD 63, n=667). Among those who visited a government health facility, the mean waiting time was 78 minutes (SD 125, n=519) in an SM facility, 62 minutes (SD 69, n=170) in an MOPH facility and 124 minutes (SD 129, n=1255) in and NGO facility.

The proportion of patients waiting less than 30 minutes to be seen in government and private health facilities in the two districts are shown in Table 7. Among those visiting government facilities, a patient was more likely to wait less than 30 minutes in a Bagrami facility than in a Qarabagh facility ((OR 3.27, 95% CI_{ca} 2.75-3.89).

Table 7. Waiting time less than 30 minutes in government and private facilities

	Bagrami n=1401	Qarabagh n=1304
Government facility	31% (256/830)	12% (145/1208)
Private facility	48% (275/571)	35% (34/96)

Costs of using health services

Cost of travel

Some 59% (881/1481) of service users in Bagrami district and 76% (1066/1407) in Qarabagh district paid to travel to and from the health facility on the most recent visit. Across the two districts, some 66% (1387/2103) of government service users and 73% (498/681) private service user paid for travel. The proportions who paid for travel to government and private facilities in the two districts are shown in Table 8.

Table 8. Payment for travel to government and private facilities

	Bagrami	Qarabagh
Government facility	49% (409/834)	77% (978/1269)
Private facility	74% (430/581)	68% (68/100)

Among all service users who paid to travel the median cost of travel to and from the health facility was 80 Afghanis (SD 433, n=846) in Bagrami district and 100 Afghanis (SD 360, n=1061) Afghani in Qarabagh district.

Table 9 shows the median cost of return travel to government and private health facilities used in the two districts.

Table 9. Median costs of return travel to the health facilities (in Afghani)

	Bagrami	Qarabagh
Government facility	50	100
Private facility	100	100

Costs within the facility

Payments for ticket or registration fee

Across the two districts, some 22% (468/2100) of users of government health facilities reported they paid for a ticket, and 44% (300/678) of users of private facilities said they paid for a ticket or registration fee. Among those who used a government facility, 6% (31/524) paid for a ticket in SM-facilities, 21% (37/172) in MOPH facilities, and 30% (395/1309) in NGO-facilities. The proportions of users who paid for a ticket in

Table 10. Proportions paying for ticket in government and private facilities

	Bagrami	Qarabagh
Government facility	10% (82/838)	31% (386/1262)
Private facility	44% (254/579)	44% (254/579)

government and private facilities in Bagrami and Qarabagh are shown in Table 10.

Among those who reported how much they paid, the median cost of a ticket in a government facility was 5 Afghanis (n=461); the median cost in a private facility was 100 Afghanis (n=289).

Table 11. Median costs of a ticket in government and private health facilities
(in Afghani)

	Bagrami	Qarabagh
Government facility	5.00	5.00
Private facility	100.00	100.00

Table 11 shows the median cost of a ticket in government and private health facilities in the two districts.

Payments for investigation and treatment

Across both districts, 16% (324/2098) of users of government health facilities paid for treatment and investigations in the facility, as did 58% (399/685) of users of private facilities. Among users of government facilities, 7% (37/523) paid for treatment and investigations in SM-facilities, 27% (47/172) paid in MOPH facilities, and 17% (220/1308) paid in NGO facilities. The proportions of users who paid for investigations and treatment in government and private facilities in Bagrami and Qarabagh are shown in Table 12.

Table 12. Proportions paying for treatment and investigations in government and private facilities

	Bagrami	Qarabagh
Government facility	14% (113/838)	17% (211/1262)
Private facility	62% (364/585)	35% (35/100)

The median amount paid by those users who paid for treatment and investigations was 100 Afghanis (SD 740, n=294) in government health facilities, and also 100 Afghanis (SD=10,128, n=390) in private facilities. In government facilities, the median amounts paid were 100 Afghanis (SD 165, n=34) by users of SM facilities, 50 Afghanis (SD 463, n=46) by users of MOPH facilities, and 100 Afghanis (SD 835, n=197) by users of NGO facilities.

Table 13. Median amounts paid for investigations and treatment in government and private health facilities
(in Afghani)

	Bagrami	Qarabagh
Government facility	100	100
Private facility	100	100

Table 13 shows that the median amounts paid for investigations and treatment in the two districts were the same in government and private health facilities, among those who paid anything.

Payments outside the health facilities

Across the two districts, most people who used health facilities had to make payments outside

the facility, mainly to purchase medicines or for further investigations. Some 77% (1590/2081) of those who used a government facility, and 97% (664/686) of those who used a private facility made payments outside the facility. Among those who used a government facility, some 80% (417/522) of those who used an SM-facility had to pay outside, 83% (140/168) of those who used an MOPH facility, and 73% (941/1297) of those who used an NGO facility.

The proportions of users who had to make payments outside the facility after visits to government and private facilities in Bagrami and Qarabagh are shown in Table 14.

Table 14. Proportions paying for medicines etc outside government and private facilities

	Bagrami	Qarabagh
Government facility	83% (695/832)	72% (895/1249)
Private facility	98% (577/586)	87% (87/100)

Among users of government facilities who paid outside the facility, the median amount was 200 Afghanis (SD 807, n=1584). Among users of private facilities who paid outside the facility, the median amount was 300 Afghanis (SD 7813, n=664). For government facility users, the median amount paid in Afghanis outside the facility was 200 (SD 331, n=414) for users of SM facilities, 180 (SD 1719, n=140) for users of MOPH facilities, and 250 (SD 772, n=938) for users of NGO facilities.

Table 15 shows the median amounts paid for expenses outside the health facilities in the two districts, for visits to government and private health facilities.

Table 15. Median amounts paid for expenses outside the health facility, for visits to government and private health facilities

(in Afghani)

	Bagrami	Qarabagh
Government facility	200	250
Private facility	350	300

Community views about costs of using government health services

Focus groups of men and women in the two districts considered and discussed the findings about payments in government health facilities (as well as outside the facilities for medicines etc).

> "We pay in government facilities as much as in private facilities. Everyone knows about the policy of free health services but it is not happening here." (Female group, Bagrami)
>
> "We know about the policy of free medicines. But they ask us to pay informally or give them a bribe." (Male group, Bagrami)
>
> "Nothing is free here. You see these facilities only look good from a distance." (Female group, Qarabagh)
>
> "The government announces that everything is free. But we are even charged for a bottle of syrup." (Male group, Qarabagh)

Group participants confirmed that "everyone is aware" of the policy of free treatment in government facilities but they were equally clear that this policy is not followed in practice. This

was a source of frustration, cynicism, and sometimes anger.

"We pay for ultrasound and blood tests in the health facility." (Female group, Bagrami)

"They charge money for taking a ticket." (Male group, Bagrami)

"They charge 50 Afghanis for an eye check up." (Female group, Qarabagh)

"We give bribes to the birth attendant in hospitals." (Female group, Bagrami)

"We pay only doctors and caretakers." (Male group, Bagrami)

"We only pay the birth attendant and the gynaecologist. No one else demands money from us." (Female group, Qarabagh)

"We pay all the personnel in the facility." (Male group, Qarabagh)

The groups described the sorts of things they had to pay for in government health facilities, ranging from a small payment for the ticket, to payments for medicines, investigations and procedures. They were aware that some of these payments were unofficial, or bribes. They identified the range of people they might have to pay, from the doorman to the doctor. The groups showed a mixture of resignation, frustration and anger about the payments they had to make.

"If money is not available we have to sell our livestock or take loans." (Male group, Bagrami)

"We have to sell dry fruit or sheep and also take loans." (Female group, Qarabagh)

Group participants explained that payments for using government health facilities could pose a serious strain on family resources. Sometimes they had to take loans or sell assets in order to find the money.

Opinions about quality of care from the health services

Reception by the person giving treatment

Across the two districts, among 2097 users of government health facilities, 78% (1639) considered the way the person treating them received them was good or very good, 5% (94) thought it was neither bad nor good, 17% (361) thought it was bad or very bad, and 0% (3) could not give an answer to this question. Among 681 users of private facilities, 95% (649) thought the way they were received was good or very good, 1% (3) said it was neither bad nor good, and 4% (28) said it was bad or very bad. Figure 10 shows the ratings of the reception in government and private facilities.

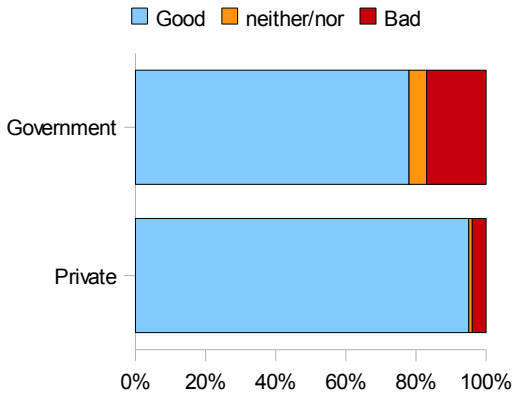

Figure 10. Perceived reception in government and private facilities

Table 16. Service users who thought their reception was good or very good, in government and private health facilities

	Bagrami n=1421	Qarabagh n=1357
Government facility	80% (671/836)	76% (968/1258)
Private facility	96% (557/581)	93% (92/99)

Table 16 shows the proportion of service users who considered the way they were received was good or very good in the two districts, in government and private facilities. Service users in both districts rated the way they were treated more positively in private facilities.

A user of health facilities was more likely to be happy with their reception by the person treating them:
>if they used a private facility
>if they used a facility in an urban site
>if they were from a household with enough food

In a multivariate analysis, combining both districts, three factors were significantly associated with rating the reception in the facility as good or very good. A user of a government facility was less likely to rate their reception as good compared with a user of a private facility(OR 0.18, 95% CI_{ca} 0.10-0.35). A service user in an urban site was more likely to rate their reception positively (OR 4.10, 95% CI_{ca} 1.50-11.19), as was a service user from a less poor household (with enough food in the last week) (OR 1.61, 95% CI_{ca} 1.18-2.20)

Among service users visiting a government health facility, 77% (404/526) of those who visited an SM facility, 83% (141/171) of those who visited an MOPH facility, and 77% (1005/1304) of those who visited NGO facility rated their reception as good or very good.

Quality of care compared with expectations

Across the two districts, among 2094 users of government health facilities, 44% (916) said the quality of care was better than they expected, 38% (784) said it was as expected, and 18% (385) said it was worse than expected. Among 680 users of private facilities, 64% (432) thought the quality of care was better than they expected, 25% (169) said it was as expected, 11% (73) said it was worse than expected, and 1% (6) could not rate it. (Figure 11)

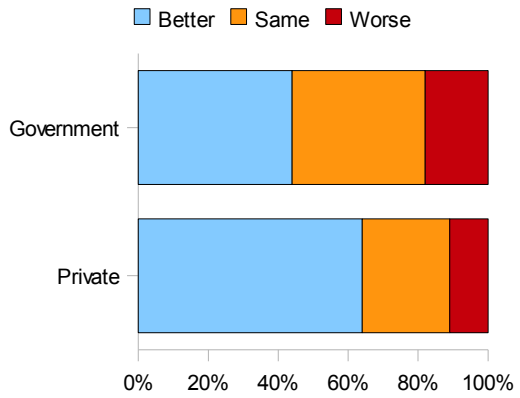

Figure 11. Quality of care compared with expectations

Table 17 shows the proportions of service users who felt the quality of care they received was better than expected in the two districts, in government and private health facilities.

Table 17. Service users who felt quality of care was better than expected, in government and private health facilities

	Bagrami n=1417	Qarabagh n=1357
Government facility	37% (312/837)	48% (604/1257)
Private facility	68% (396/580)	35% (36/100)

In a multivariate analysis combining both districts, the only factor that remained significantly associated with finding the quality of care better than expected was the type of health service used. A user of a government health facility was less likely to report the care was better than expected compared with a user of a private facility (OR 0.45, 95% CI_{ca} 0.33-0.61).

A user of a private facility was more likely to think the quality of care was better than expected, compared with a user of a government facility.

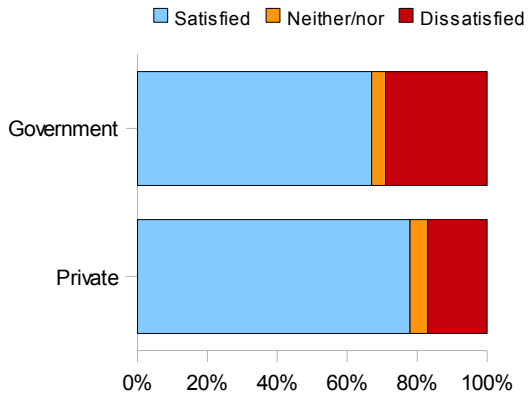

Figure 12. Overall satisfaction with quality of care

Table 18. Service users who were satisfied or very satisfied with their care, in government and private health facilities

	Bagrami n=1426	Qarabagh n=1359
Government facility	67% (563/841)	67% (845/1258)
Private facility	84% (487/583)	47% (46/99)

A user of a government facility was more likely to be satisfied with the quality of care:
>if they were from an urban area
>if their household head was *not* educated
>if they waited less than 30 minutes to be seen

Among service users visiting a government health facility, 31% (162/523) of those visiting an SM facility, 42% (72/172) of those visiting an MOPH facility, and 47% (622/1304) of those visiting an NGO facility reported the quality of care was better than they expected.

Satisfaction with quality of care

Across both districts, among 2102 users of government health facilities, 67% (1408) were satisfied with the overall quality of care, 5% (94) were neither satisfied nor dissatisfied, and 29% (597) were dissatisfied. Among 683 users of private facilities, 78% (533) were satisfied with the quality of care, 5% (35) were neither satisfied nor dissatisfied, and 16% (112) were dissatisfied. (Figure 12)

Table 18 shows the proportions of service users who were satisfied or very satisfied with the care they received in the two districts, in government and private health facilities.

Overall, a user of a government health facility was less likely to be satisfied with the care than a user of a private facility (OR 0.56, 95% CI_{ca} 0.40-0.80). Considering users of government health facilities, a multivariate analysis found four factors significantly related to satisfaction with care. A service user from a household with an educated head was less likely to be satisfied (OR 0.67, 95% CI_{ca} 0.53-0.86). A service user from a household with enough food in the last week was more likely to be satisfied (OR 1.61, 95% CI_{ca} 1.32-1.98), as was a service user who did not have to wait more than 30 minutes to be seen (OR 2.32, 95% CI_{ca} 1.57-3.44), and a service user from an urban area (OR 2.24, 95% CI_{ca} 1.01-4.93).

Among service users visiting a government health facility, 62% (323/524) of those who visited an SM facility, 69% (120/173) of those who visited an MOPH facility, and 67%

Table 19. Main reasons why service users were satisfied with the service they received

	Bagrami n=1068	Qarabagh n=841
Good behaviour	27% (289/1068)	22% (187/841)
Good medicines	20% (211/1068)	20% (167/841)
Good/qualified doctors	6% (66/1068)	20% (172/841)
Good care/ treatment/facilities	44% (472/1068)	37% (314/841)
No other choice	1% (6/1068)	0% (0/841)
Paid fee or charges	2% (24/1068)	0% (1/841)

Table 20. Main reasons why service users were dissatisfied with the service they received

	Bagrami n=309	Qarabagh n=392
Lack of good quality medicines	28% (87/309)	15% (58/392)
Bad treatment or problem not solved	23% (72/309)	27% (106/392)
Lack of staff/over crowding	12% (38/309)	18% (69/392)
Bad behaviour/ corruption	19% (60/309)	27% (108/392)
Lack of facilities/ poor access	14% (45/309)	13% (49/392)
Paid fee or charges	2% (7/309)	1% (2/392)

(881/1307) of those who visited an NGO facility were satisfied with the care they received.

We also asked household respondents about their reasons for satisfaction or dissatisfaction with the overall care they received. Table 19 shows the main reasons given by service users who reported they were satisfied with the service they received, in the two districts. Table 20 shows the main reasons given by services users who reported they were dissatisfied with the service they received. More details of the reasons given for satisfaction and dissatisfaction are shown in the Annex.

Corruption in health services

Public perceptions about corruption

Table 21. Household opinions about changing level of corruption in health services over the last 12 months

	Bagrami n=1497	Qarabagh n=1558
Increasing	18% (266/1497)	8% (120/1558)
The same	32% (480/1497)	39% (600/1558)
Decreasing	26% (383/1497)	27% (422/1558)
Don't know	25% (368/1497)	26% (416/1558)

Table 21 shows household perceptions about the change in level of corruption in health services over the last 12 months in the two districts, among those respondents who gave an answer to this question. Over a third in Qarabagh thought the level of corruption was staying the same, and only 8% thought it was increasing. A somewhat higher proportion in Bagrami (18%) considered corruption was increasing over the last 12 months.

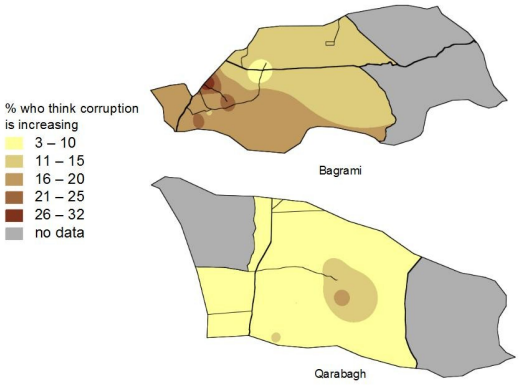

Figure 13. Household perception of increasing corruption in health services

Figure 13 shows the variation across the two district in the proportion of households who thought corruption in health services had increased over the last 12 months. The perception of increasing corruption in health services was more prevalent in the south east of Bagrami.

Table 22. Main forms of corruption mentioned by households

	Bagrami n=1415	Qarabagh n=1475
Gifts or in kind payments	0% (7/1415)	5% (70/1475)
Bribes or cash payments	4% (50/1415)	22% (328/1475)
Disappearance of medicines from facilities	6% (79/1415)	2% (32/1475)
Poor care, staff not fulfilling duties	6% (82/1415)	3% (38/1475)
Queue jumping	5% (65/1415)	0% (6/1475)
Favouritism	7% (97/1415)	4% (53/1475)
Bad behaviour	1% (16/1415)	0% (5/1475)
Crowding land extortion	1% (12/1415)	0% (4/1475)
Don't know of any form/hasn't seen anything	71% (1007/1415)	64% (939/1475)

We also asked respondents about the main forms of corruption they were aware of in health services. Table 22 shows the main forms of corruption mentioned by households in the two districts. The great majority of respondents were not able or not willing to specify a type of corruption they were aware of.

When *focus groups* of men and women considered and discussed these findings, it became clear that many people in the household survey may have avoided talking about corruption in health services, for fear that doing so might compromise their chances of treatment in the facilities in the future.

"We are afraid the doctor would turn against us if we were to say anything about this." (Male group, Bagrami)

"Taking or giving bribes is an eveil deed. We don't want to say anything about this." (Female group, Bagrami)

"We cannot say anything against the doctor. We are afraid he might treat us rudely the next time we go to see him." (Male group, Qarabagh)

Table 23. Suggestions for what could help prevent unofficial payments in health services

	Bagrami n=1330	Qarabagh n=1310
Nothing/only god can help	33% (444/1330)	12% (156/1310)
Conduct inquiry/monitoring	4% (51/1330)	27% (353/1310)
Increase health staff	1% (9/1330)	7% (89/1310)
Establish complaint system	12% (162/1330)	17% (225/1310)
Increase salary or give incentives	1% (8/1330)	15% (193/1310)
Cooperation/coordination of senior officials	2% (22/1330)	2% (29/1310)
Increase supply of medicine	1% (15/1330)	5% (65/1310)
Appoint highly qualified doctors	0% (1/1330)	1% (13/1310)
Replace corrupt staff	0% (0/1330)	0% (4/1310)
More health facilities	0% (3/1330)	1% (10/1310)
No need/system is fine	8% (113/1330)	5% (66/1310)
Don't know	38% (502/1330)	8% (107/1310)

"Taking bribes has become a part of our culture. Only god can help us now." (Female group, Bagrami)

"The entire country is corrupt. Doctors are part of it." (Male group, Bagrami)

"Some people might think that you people are from the intelligence services. They are afraid of telling you the truth." (Female group, Qarabagh)

"The entire government is corrupt, Nothing will happen even if we do complain about it." (Male group, Qarabagh)

"The government should try to do something about it. If the doctors' salaries are increased, they might stop asking for bribes." (Male group, Bagrami)

"The government should be familiar with what goes on inside each hospital." (Male group, Qarabagh)

"All the current doctors should be fired and replaced with new ones." (Male group, Qarabagh)

Unofficial payments

Table 23 shows the main suggestions from household respondents in the two districts for what could help prevent unofficial payments in health services. In Bagrami district in particular, many respondents felt helpless to suggest anything to tackle the problem.

We asked if anyone in the household had ever been asked or expected to make an unofficial payment for health care. Some respondents declined to answer this question: 21% (349/1639) in Bagrami and 11% (185/1644) in Qarabagh. Of those who responded, 85% (1097/1290) in Bagrami and 74% (1078/1459) in Qarabagh specifically denied they had ever been asked to make an unofficial payment. Some 15% (193/1290) in Bagrami and 26% (381/1459) in Qarabagh admitted that someone in the household had been asked to make a payment or were unsure if someone had been asked.

Participants of the *focus groups* of men and women, who considered and discussed the findings from the household survey, suggested that the level of corruption in health services, particularly in government health services, was probably much higher than the findings of the household survey indicated. They said that, in fact, corruption is an everyday experience in the society, and this is reflected in corruption in health services. But they felt powerless to do anything about the corruption. They said people are loath to talk about corruption in general and their experiences of it in particular, for fear of the consequences. They did have some suggestions for how to reduce corruption in health services, although these were mainly a call for some sort of "government action" and either increased incentives for doctors or action against doctors.

Many of those reporting being requested to make an unofficial payment said the last time was within the last month, and nearly all said the last time was within the last year. Table 24 shows

Table 24. Time since last request for an unofficial payment, among households reporting ever being asked

	Bagrami (31)	Qarabagh (249)
Less than 1 month	46% (14)	54% (133)
1-6 months	32% (10)	22% (56)
6-12 months	19% (6)	15% (38)
More than 12 months	3% (1)	9% (22)

that for the great majority of households who reported they had ever been asked for an unofficial payment, and could specify when, the last request was within the last six months.

In Bagrami district, 87% (49/56) of respondents who reported being asked for an unofficial payment, and gave details, said the most recent request was in a government facility, and 13% (7/56) said it was at a private facility. In Qarabagh, 97% (355/366) of respondents reporting a request for an unofficial payment said the most recent request was in a government facility, and 3% (11/366) said it was in a private facility.

Table 25. Most common purposes of requested payments, among those who reported requests and gave details

	Bagrami n=34	Qarabagh n=331
Delivery	9% (3)	45% (150)
Medicines	44% (15)	35% (115)
Gratuity/gift	26% (9)	14% (46)
Checkup/consultation	15% (5)	5% (8)
Investigations	6% (2)	1% (2)

The most common purposes of the requested payments in the two districts are shown in the Annex. Many people who reported being asked for a payment, and gave details, reported the payment simply as a gratuity or gift, while others were able to specify for what element of treatment the payment was requested (Table 25).

For those respondents who had been asked to make an unofficial payment, in Bagrami district, the mean amount requested on the last occasion was 930.73 (SD 3065.0, n24) Afghani, with a minimum of 10 and a maximum of 15000. In Qarabagh district, the mean amount requested was 253.67 (SD 252.7, n336), with a minimum of 5 and a maximum of 2000.

Pregnancy and delivery care

Interviewers collected information from all mothers in the households of children less than 60 months old. The average age of the mothers interviewed was 29.86 years (SD 7.3, n1656) in Bagrami district and 30.10 years (SD 7.7, n1662) in Qarabagh district. Some 9% (143/1608) of mothers had complete primary education or above in Bagrami district and 4% (64/1584) in Qarabagh district had completed primary education or above.

The average number of births for each mother was 4.41 (SD 2.6, n1650), ranging from 1 to 14 in Bagrami district and 4.04 (SD 2.3, n1660), ranging from 1 to 14 in Qarabagh district. Some 45% (737/1650) of mothers in Bagrami district and 39% (647/1660) of mothers in Qarabagh district had given birth 5 times or more. The average number of pregnancies among the mothers was 5.10 (SD 2.9, n1650), ranging from 1 to 20 in Bagrami district and 4.68 (SD 2.6, n1656), ranging from 1 to 16 in Qarabagh district. In Bagrami district the average number of pregnancies that did not proceed to births was 0.68 (SD 1.1, n1648). In Qarabagh district the average number of pregnancies that did not proceed to births was 0.64 (SD 1.1, n1656).

Community Health Workers (CHW)

Contact with CHW

Some 38% (624/1656) of mothers from Bagrami district had had contact with a CHW and 50% (820/1665) of mothers from Qarabagh district had had contact with a CHW. Of those mothers who had had contact with a CHW, the last time was on average 8.86 (SD 12.4, n598) months ago, ranging from 1 to 60 months ago, in Bagrami district, and 2.74 (SD 4.8, n722) months ago in Qarabagh district, ranging from 1 to 48 months ago. Figure 14 shows the variation across the districts in mothers' contacts with CHWs.

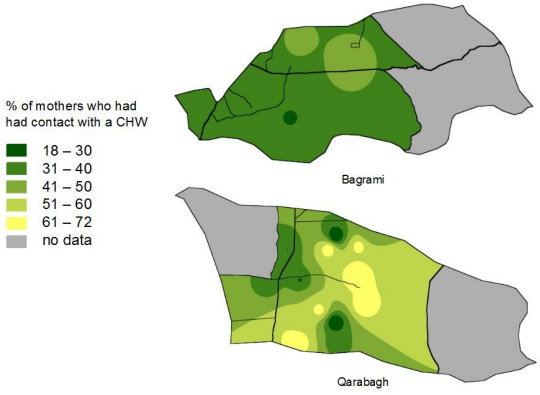

Figure 14. Mothers who had had contact with a CHW

In Bagrami a mother was more likely to have seen a CHW:
>if she had some education
>if her household head had some education
>if her household had enough food

In Qarabagh a mother was more likely to have seen a CHW:
>if her household had enough food

Overall, a mother in Bagrami was less likely to report having seen a CHW, compared with a mother in Qarabagh (OR 0.62, 95% CI_{ca} 0.41-0.94).

In Bagrami district, in a multivariate analysis three factors were significantly associated with the likelihood of a mother having seen a CHW. A mother who had any education herself was less likely to report having seen a CHW (OR 0.55, 95% CI_{ca} 0.39-0.77), as was a mother from a household where the head had some education (OR 0.68, 95% CI_{ca} 0.53-0.86). A mother from a household with enough food in the last week was more likely to report having seen a CHW (OR 2.09, 95% CI_{ca} 1.36-3.20). In Qarabagh district, only one factor remained in the model. A mother from a household with enough food in the last week was more likely to report having seen a CHW (OR 1.35, 95% CI_{ca} 1.10-1.65).

Of the mothers who had had contact with a CHW, 52% (310/598) of mothers in Bagrami and 85% (618/722) of mothers in Qarabagh district had been in contact with a CHW within the last three months.

Some 76% (338/443) of the community health workers whom mothers had last been in contact with in Bagrami district were female. In Qarabagh district also 76% (449/586) of the CHWs the mothers had last been in contact with were female.

Information from CHW

The interviewers asked mothers what information the community health workers provided about nutrition before and after pregnancy, breast feeding, and childhood immunisation.

Nutrition: Some 18% (253/1398) of mothers in Bagrami district and 37% (556/1517) of mothers in Qarabagh district had been provided with information about nutrition from a CHW. Table 26 shows the common sorts of information the

Table 26. Type of information about nutrition during and after pregnancy provided by CHWs

	Bagrami n=253	Qarabagh n=556
Eat more	19% (48/253)	6% (36/556)
Quality diet	53% (135/253)	55% (310/556)
Drink more	4% (11/253)	1% (4/556)
Yes, not specified	24% (59/253)	37% (206/556)

CHWs provided. Most commonly, the CHWs advised about the quality of diet.

Breast feeding: In Bagrami district 19% (261/1397) of mothers had been provided with information about breast feeding from a CHW, and 38% (565/1515) of mothers in Qarabagh district had been provided with such information. Table 27 shows the common sorts of information the CHWs provided. Mainly the CHWs simply advised mothers that they must breastfeed.

Table 27. Type of information about breast feeding from a CHW

	Bagrami n=261	Qarabagh n=565
Creates immunity	3% (9/261)	1% (3/565)
Must breast feed	70% (182/261)	63% (360/565)
On demand feeding	0% (0/261)	0% (1/565)
Good for child health	1% (2/261)	0% (0/565)
Free of cost	0% (1/261)	0% (0/565)
Yes, not specified	26% (67/261)	36% (201/565)

Immunisations: Some 21% (297/1415) of mothers from Bagrami district had been given information by a CHW about childhood immunisations. In Qarabagh district 39% (603/1546) of mothers had been given information by a CHW about childhood immunisations. Table 28 shows the common sorts of information about immunisation provided by CHWs. They usually simply advised mothers that they should ensure their children completed the course of immunisations.

Table 28. Type of information about immunisations from a CHW

	Bagrami n=297	Qarabagh n=603
Prevents diseases	4% (11/297)	1% (4/603)
Complete course of vaccines	83% (246/297)	66% (404/603)
Yes, not specified	14% (40/297)	33% (195/603)

Pregnancy care

Some 57% (941/1654) of mothers of children under 60 months old in Bagrami district had given birth in the last two years, and 77% (1272/1654) within the last three years. In Qarabagh district 54% (888/1651) of mothers had given birth in the last two years, and 71% (1168/1651) within the last three years.

Antenatal checkups

Among those who responded to the question, 78% (1232/1580) of mothers from Bagrami district reported having at least one antenatal check-up during their last pregnancy. In Qarabagh district 77% (1244/1614) of mothers reported at least one antenatal check-up during their last pregnancy. Figure 15 shows the variation across the two districts in the proportion of mothers who had any antenatal checkups during their last pregnancy.

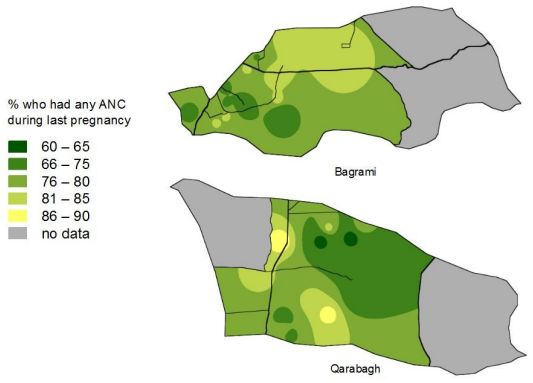

Figure 15. Mothers with any ANC during last pregnancy

A mother was more likely to have had an antenatal checkup during her last pregnancy:
>if she was aged 30 years or less
>if she had any education
>if she had ever seen a CHW

In a multivariate analysis combining the two districts, three factors were significantly associated with having any antenatal checkups. Younger mothers (aged 30 or less) were more likely to have had an antenatal checkup (OR 1.15, 95% CI_{ca} 1.00-1.32), as were mothers who had any education (OR 2.63, 95% CI_{ca} 1.72-2.29), and mothers who reported any contact with a CHW (OR 1.73, 95% CI_{ca} 1.31-2.29). The strongest association was with education of the mother.

Some 29% (420/1479) of mothers had the recommended four or more antenatal care visits during their last pregnancy in Bagrami district, and 33% (489/1499) of mothers had four or more antenatal care visits during their last pregnancy in Qarabagh district.

A mother was more likely to have had the recommended four antenatal checkups:
>if she had any education
>if her household had enough food
>if she had ever seen a CHW

In a multivariate analysis combining the two districts, three factors were significantly associated with having the recommended four antenatal checkups. Mothers who had any education were more likely to have had four antenatal checkups during their last pregnancy (OR 1.92, 95% CI_{ca} 1.30-2.82), as were mothers from households reporting enough food in the last week (OR 1.28, 95% CI_{ca} 1.01-1.62), and mothers who reported any contact with a CHW (OR 1.32, 95% CI_{ca} 1.09-1.61).

Some 20% (307/1548) of mothers in Bagrami and 28% (447/1573) in Qarabagh district had gone for an antenatal check-up during the first three months of their last pregnancy.

The main reasons why women did not attend for antenatal care in the two districts are shown in Table 29. Common reasons included lack of permission from the family, no perceived need, and poor access to health facilities.

Table 29. Main reasons why women did not attend for antenatal care

	Bagrami n=206	Qarabagh n=194
Good care at home	1% (2/206)	0% (0/194)
No permission	32% (65/206)	33% (64/194)
Unable to go (because of illness)	10% (20/206)	6% (12/194)
Poverty/no money	2% (5/206)	9% (18/194)
Healthy - no need	26% (53/206)	7% (14/194)
No health facility or far away	25% (51/206)	42% (81/194)
Lack of info/unaware	5% (10/206)	3% (5/194)

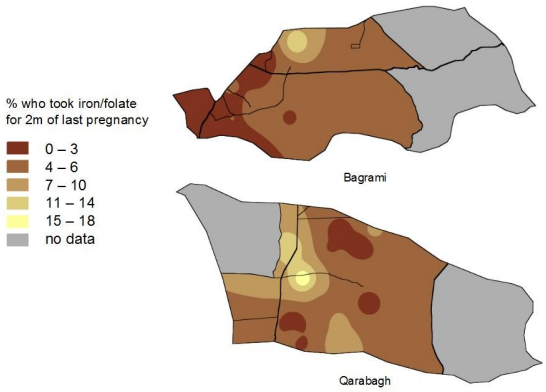

Figure 16. Mothers who took iron/folate for 2m in last pregnancy

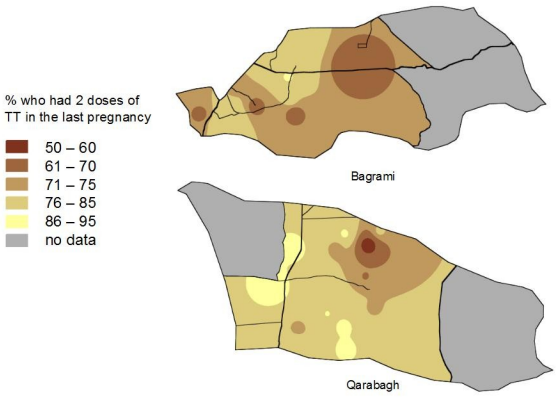

Figure 17. Mothers who had 2 doses of TT during last pregnancy

Iron supplements and tetanus toxoid doses

Some 64% (995/1553) mothers in Bagrami and 73% (1166/1593) mothers in Qarabagh district reported they took iron/folate tablets during their last pregnancy. However, among those who provided the information, in Bagrami district only 4% (53/1461) of mothers took iron/folate tablets for two months or more during their last pregnancy. In Qarabagh district only 6% (83/1395) of mothers took iron/folate tablets for two months or more. Figure 16 shows the variation across the two districts in the proportion of mothers who took iron/folate for two months during their last pregnancy.

Some 85% (1359/1605) of mothers in Bagrami district and 88% (1421/1610) in Qarabagh district received at least one dose of tetanus toxoid (TT) during their last pregnancy. Some 75% (1056/1409) of mothers received at least two doses of TT during their last pregnancy in Bagrami district, and 80% (1061/1325) of mothers received at least two doses of TT during their last pregnancy in Qarabagh district. Figure 17 shows the variation across the two districts in the proportion of mothers who had two doses of tetanus toxoid during their last pregnancy.

Food intake

Eating less food than usual was a common practice among pregnant women in both districts. In Bagrami district some 23% (383/1656) of mothers ate more food than usual during their last pregnancy, 29% (472/1656) ate the same amount as usual, and 47% (781/1656) ate less than usual. In Qarabagh district some 15% (245/1665) of mothers ate more food than usual during their last pregnancy, 39% (641/1665) ate the same amount as usual, and 44% (732/1665) ate less than usual.

Some 27% (431/1624) of mothers in Bagrami district and 26% (431/1630) of mothers in Qarabagh district avoided some types of food

during their last pregnancy. Among those mothers who avoided some types of food, the types of food avoided during pregnancy are shown in the Annex. In both districts, meat was the most common type of food avoided. Some 55% (900/1624) of mothers in Bagrami district and 55% (900/1624) of mothers in Qarabagh district ate more of some types of food during pregnancy. Among those mothers who ate more of some types of food during pregnancy the types of food that they ate more are shown in the Annex.

Some 72% (1183/1636) of mothers in Bagrami district and 65% (1055/1627) of mothers in Qarabagh district avoided certain types of food after delivery. The foods that were avoided are shown in the Annex. Most commonly avoided were sour foods in Bagrami and spicy foods in Qarabagh, as well as water and soft drinks. Some 83% (1358/1634) of mothers in Bagrami district and 78% (1271/1626) of mothers in Qarabagh district ate some types of food more after delivery. The types of food reportedly eaten more after delivery are shown in the Annex.

Reducing routine heavy work

Most mothers reported they did *not* reduce their routine heavy work during their last pregnancy. About a third -37% (552/1502) - of mothers in Bagrami district reduced their routine heavy work during the pregnancy. Similarly, in Qarabagh district 36% (582/1613) of mothers reduced their routine heavy work during the pregnancy.

A mother was more likely to have reduced heavy work during her last pregnancy:
>if her household head had some education
>if she had ever seen a CHW

In a multivariate analysis combining the two districts, two factors were significantly related to reducing heavy work during pregnancy. Mothers from a household where the household head had some education were more likely to reduce their heavy work during pregnancy (OR 1.27, 95% CI_{ca} 1.04-1.56), as were mothers who reported having contact with a CHW (OR 2.50, 95% CI_{ca} 2.01-3.11).

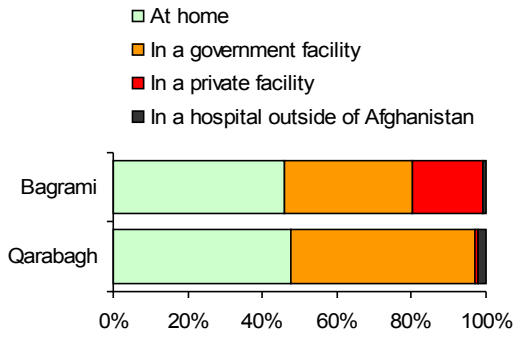

Figure 18. Place of delivery

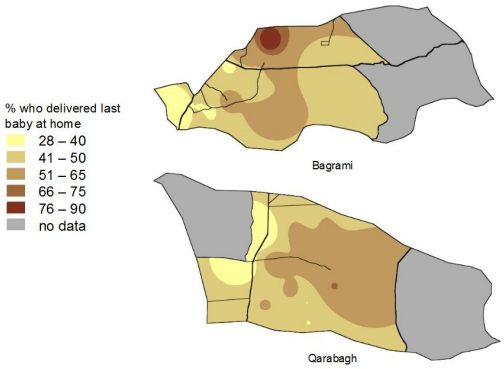

Figure 19. Mothers who delivered last baby at home

A mother was less likely to have delivered her last baby at home:
>if she was aged 30 years or younger
>if her household head had some education
>if her household had enough food
>if she had had any antenatal checkups

Among those mothers who reported they did reduce their heavy work during pregnancy, the timing was different between the two districts. Some 9% (47/536) in Bagrami and 45% (247/555) in Qarabagh reduced their heavy work in the first trimester. In Bagrami 28% (148/536), and in Qarabagh 83% (462/555), reduced their heavy work before the third trimester.

Delivery care

Place of delivery

In Bagrami district some 46% (705/1540) of mothers delivered at home, 34% (530/1540) delivered in a government facility, 19% (292/1540) delivered in a private facility, and 1% (13/1540) delivered in a hospital outside of Afghanistan. In Qarabagh district 48% (766/1610) of mothers delivered at home, 49% (794/1610) delivered in a government facility, 1% (17/1610) delivered in a private facility, and 2% (33/1610) delivered in a hospital outside of Afghanistan. Figure 18 shows the place of delivery in the two districts.

Figure 19 shows the variation across the two districts in the proportion of mothers who delivered their last baby at home.

In a multivariate analysis combining the two districts, four factors were significantly associated with the place of delivery. A mother from a household with enough food in the last week was less likely to have delivered at home (OR 0.64, 95% CI_{ca} 0.55-0.75), as was a mother from a household where the head had some education (OR 0.80, 95% CI_{ca} 0.67-0.95), a mother aged 30 years or younger (OR 0.74, 95% CI_{ca} 0.61-0.88), and a mother who reported having any antenatal checkups (OR 0.38, 95% CI_{ca} 0.29-0.51).

Table 30. What was put on the cord after cutting

	Bagrami n=1542	Qarabagh n=1621
Nothing	28% (438/1542)	33% (540/1621)
Tincture	13% (199/1542)	13% (208/1621)
Cotton/bandage	26% (401/1542)	27% (442/1621)
Clip	14% (218/1542)	12% (188/1621)
Antimony (surma)	5% (74/1542)	10% (156/1621)
Antibiotic	14% (210/1542)	4% (68/1621)
Oil	0% (1/1542)	0% (2/1621)
Don't know	0% (1/1542)	1% (17/1621)

Treating the umbilical cord

Some 72% (1103/1541) of mothers in Bagrami district put something on the cord after cutting it. In Qarabagh district 67% (1064/1604) of mothers put something on the cord after cutting it. Table 30 shows what was put on the umbilical cord after cutting.

Some 42% (648/1541) of mothers in Bagrami district and 38% (608/1604) of mothers in Qarabagh district reported putting something "safe" on the umbilical cord after cutting. Items considered safe include nothing or an antibiotic.

Health status of delivered babies

In Bagrami district some 100% (1640/1644) of the babies were reported to have survived and were well, while 1/1644 survived but were disabled, 1/1644 lived a short time and 2/1644 were stillborn. In Qarabagh district some 99% (1616/1629) of the babies were reported to have survived and were well, none survived but were disabled, 2/1629 lived a short time and 1% (11/1629) were stillborn.

In Bagrami district 24% (401/1646) of babies were reported by their mothers to be very small or small at birth, and 76% (1245/1646) were considered normal or big. In Qarabagh district 27% (445/1635) of babies were reported by their mothers to be very small or small at birth, and 73% (1190/1635) were considered normal or big.

Child care and immunisations

The questionnaire collected information about children who were less than 60 months old: 2359 children in Bagrami and 2215 in Qarabagh. Some 52% (1221/2355) of these children in Bagrami district and 52% (1160/2212) in Qarabagh district were male.

In Bagrami district 24% (539/2292) of children were reported by their mothers to be small for their age, 56% (1292/2292) were normal size, and 20% (461/2292) were big for their age. In Qarabagh district 24% (514/2147) of children were reported by their mothers to be small for their age, 65% (1392/2147) were normal size, and 11% (240/2147) were big for their age.

Breast feeding and weaning

This section considers children under the age of 60 months old.

Initiation of breast feeding

In Bagrami district, nearly all children (96%; 2264/2350) were breast fed. Nearly all were given colostrum (first milk) after birth: 97% (1183/1218) of male children and 96% (1077/1128) of female children. Some 69% (761/1097) of male children and 64% (654/1016) of female children were put to the breast within one hour of birth.

In Qarabagh district, nearly all children (98%; 2160/2202) were breast fed. Nearly all were given colostrum after birth: 98% (1132/1152) of male children and 98% (1025/1047) female children. Some 81% (772/949) of male babies and 77% (677/882) of female babies were breast fed within one hour of birth.

Duration of breast feeding

In Bagrami district, among children aged 25-59 months, the average duration of breast feeding was 20.69 months (SD 6.3, n694) among male children and 20.43 months (SD 6.5, n637) among female children. Half the children were breast fed for the recommended 24 months: 51% (357/694) of male children and 51% (324/636) of female children.

In Qarabagh district, among children aged 25-59 months, the average duration of breast feeding was 22.03 months (SD 5.7, n636) for male children and 22.23 months (SD 5.8, n590) for female children. Nearly two-thirds of the children were breast fed for the recommended 24 months: 66% (423/638) of male children and 65% (381/588) of female children.

The analysis of duration of breast feeding includes those children over 24 months old still being breast fed. For such children the duration of breast feeding is taken as equal to their age on the day of survey.

Table 31 shows the breast feeding status of children aged 0-24 months at the time of the survey in the two districts. The main reduction in the proportion still breast fed seems to be at about 18 months old, in both districts.

Table 31. Proportion still breast feeding among children aged less than 24 months

		Male n=990	Female n=888
Bagrami	Under one month old	100% (11/11)	100% (8/8)
	1-3 months old	100% (35/35)	100% (38/38)
	4-6 months old	97% (68/70)	98% (51/52)
	7-9 months old	100% (56/56)	100% (41/41)
	10-12 months old	87% (82/94)	94% (96/102)
	13-18 months old	75% (103/138)	76% (82/108)
	19-24 months old	35% (37/106)	45% (56/123)
Qarabagh	Under one month old	100% (12/12)	89% (7/8)
	1-3 months old	100% (35/35)	100% (34/34)
	4-6 months old	98% (49/50)	100% (47/47)
	7-9 months old	100% (56/56)	100% (50/50)
	10-12 months old	93% (66/71)	96% (70/73)
	13-18 months old	87% (100/116)	87% (93/107)
	19-24 months old	16% (22/140)	31% (30/97)

Adding other liquids and solid foods

Although breast feeding was almost universal in both districts and was of reasonable duration, exclusive breast feeding was rarely practised beyond the first month or so.

In Bagrami district, among children aged 6-59 months old, the average age of adding other liquids to the diet was 1.76 months (SD 2.1, n1116) for male children and 1.65 months (SD 2.1, n1021) for female children. Nearly all children were given other liquids before the recommended age of six months: 99%

(1104/1117) of male children and 98% (1005/1023) of female children.

In Qarabagh district, among children 6-59 months old, the average age of adding other liquids to the diet was 3.32 months (SD 3.0, n1038) for male children and 2.94 months (SD 2.9, n904) months for female children. Nearly all children were given other liquids before the recommended age of six months: 95% (989/1040) of male children and 96% (872/908) of female children.

Table 32 shows the exclusive breast feeding status of children aged less than six months old at the time of the survey. Figure 24 shows the distribution of children aged 6-59 months who were exclusively breast fed fro first six months.

Table 32. Proportion still being exclusively breast fed among children less than six months of age

		Male n=160	Female n=144
Bagrami	Under one month to two months old	25% (9/35)	26% (7/27)
	2 to 5 months old	7% (3/44)	13% (6/47)
Qarabagh	Under one month to two months old	24% (9/37)	42% (12/29)
	2 to 5 months old	21% (9/44)	25% (10/41)

Although children received other liquids into their diet early, they received solid foods relatively late.

In Bagrami district, among children aged 13-59 months, the average age of adding solid foods to the diet was 6.35 months (SD 2.7, n935) for male children and 7.08 months (SD 4.4, n853) for female children. Some 21% (200/935) of male children and 21% (176/853) of female children had solid foods added to their diet before the age of six months.

In Qarabagh district, among children aged 13-59 months, average age of adding solid food to the diet was 7.35 months (SD 3.0, n912) for male children and 7.21 months (SD 3.1, n818) for female children. Just 5% (48/912) of male children and 9% (73/818) of female children had solid foods added to their diet before the age of six months.

Table 33 shows when solid food was added to the diets of children aged 0 to 12 months old at the time of the survey.

Table 33. Proportion not taking solid foods among children aged 0-12 months old

		Male n=457	Female n=369
Bagrami	Under one month old	100% (10/10)	100% (8/8)
	1-2 months old	94% (17/18)	100% (14/14)
	3-4 months old	80% (20/25)	91% (19/21)
	5-6 months old	21% (10/48)	28% (9/32)
	7-9 months old	9% (5/55)	5% (2/38)
	10-12 months old	1% (1/90)	1% (1/68)
Qarabagh	Under one month old	89% (9/10)	100% (7/7)
	1-2 months old	100% (16/16)	100% (15/15)
	3-4 months old	92% (23/25)	78% (13/17)
	5-6 months old	51% (13/26)	56% (18/32)
	7-9 months old	19% (11/58)	20% (9/46)
	10-12 months old	0% (0/76)	1% (1/71)

Frequency of eating

Children who were still being exclusively breast fed were breast fed on average 10.04 (SD 6.7, n25) times in the last day in Bagrami district and 9.00 (SD 4.6, n30) times in the last day in Qarabagh district. Children who had not yet had solids added to their diets were breast fed on average 9.95 (SD 5.2, n115) times in the last day in Bagrami district and 9.03 (SD 4.5, n104) times in the last day in Qarabagh district.

Children still being breast fed, but also receiving solid foods, ate on average 2.79 (SD 1.3, n530) times in the last day in Bagrami district and 3.05 (SD 1.3, n494) times in the last day in Qarabagh district. Children who were no longer being breast fed ate on average 3.67 (SD 1.3, n1143) times in the last day in Bagrami district and 3.88 (SD 1.1, n991) times in the last day in Qarabagh district.

Childhood immunisation

For the majority of children, especially in Bagrami, the mother reported she was the person who made the decisions about immunisation: 78% (1835/2359) of children in Bagrami district and 57% (1267/2215) of children in Qarabagh district. The father was the decision maker for 9% (206/2359) of children in Bagrami and 11% (248/2215) of children in Qarabagh. The mother and father were reported to make the decision jointly for 0% (10/2359) children in Bagrami district and 15% (336/2215) in Qarabagh (Table 34).

Table 34. Person who decided about immunisations for the child

	Bagrami n=2244	Qarabagh n=2012
Mother	82% (1835/2244)	62% (1267/2012)
Sister	0% (2/2244)	0% (0/2012)
Father	9% (206/2244)	13% (248/2012)
Other relatives	0% (5/2244)	1% (12/2012)
Other non-relatives	0% (0/2244)	0% (2/2012)
Grand father	0% (3/2244)	0% (7/2012)
Grand mother	8% (175/2244)	2% (31/2012)
Decision not made	0% (7/2244)	1% (14/2012)
All family members	0% (0/2244)	5% (91/2012)
Mother/father both	0% (10/2244)	17% (336/2012)
Don't know	0% (1/2244)	0% (4/2012)

We collected information about the immunisation status of children from the mother or carer; the interviewers did not ask to see the immunisation card, but they did use local terms for each immunisation and mentioned whether it was drops (as in the case of polio) or an injection, and the site of the injection. The reported immunisation rates were high: over 90% for all vaccines other than the full course of DPT.

BCG

In Bagrami district 99% (429/433) of children aged 12-23 months had received BCG. In Qarabagh district 97% (353/363) of children aged 12-23 months had received BCG.

DPT

Some 66% (279/421) of children aged 12-23 months in Bagrami district had received three doses (or a full course) of DPT injections. In Qarabagh, 77% (249/326) of children had received three doses (or a full course) of DPT injections.

Polio

Some 99% (429/432) of the children aged 12 to 23 months in Bagrami district and 99% (354/356) of children aged 12 to 23 months in Qarabagh district had received vaccine in the last 12 months. The average number of times children received polio vaccine in the last 12 months in Bagrami district was 4.31 (SD 1.9, n414) and 4.09 (SD 1.7, n284) in Qarabagh district.

Measles

In Bagrami district some 93% (387/415) of the children aged 12 to 23 months had received measles vaccine. In Qarabagh district 93% (331/356) of the children aged 12 to 23 months had received measles vaccine.

Commentary

The social audit process

"I feel it (social audit) gets into details that we might need. They (CIET) can help us with getting information we don't have from other sources ." (Mr. Faizullah Kakar, deputy minister MOPH, Kabul, March 2008)

"We (MOPH) want the social audit proved as a successful and useful process. I guarantee full support of MOPH and you people (CIET) will ensure technical inputs and support. Together we will make the social audit process a success." (Dr Sayed Fazel Rabbani, senior advisor to minister and nominated social audit focal point in MOPH)

The demonstration social audit was indeed able to "explore the feasibility and utility of the social audit approach in the Afghanistan context". It was clear from the positive reaction and active collaboration of the MOPH that they appreciated the utility of the approach in supporting their efforts to identify problems with delivery of health services and plan for improvements. The particular topics covered in the demonstration social audit were those suggested by the MOPH.

Another intention was to "define and develop linkages with existing data collection and monitoring processes". This theme ran through the whole process of the demonstration social audit, again facilitated by the MOPH. Some of the existing monitoring processes are embedded in the MOPH; for example the Balanced Score Card mechanism for monitoring of health facilities. The CIET team had discussions with representatives of the team responsible for the BSC mechanism when presenting the demonstration social audit project to the MOPH in early 2008, and during the process of ethical review of the project by the IRB of the MOPH. We believe the data produced from the BSC and the social audit are complementary and together can help to give a more complete picture of health services in the country.

While the process of the demonstration social audit was largely successful, we faced a number of challenges. The two districts selected for the project – Bagrami and Qarabagh – are both relatively peaceful and secure and with relatively easy access. Nevertheless, security concerns meant the field teams had to be accompanied by security guards and had to finish field data collection and return to base within daylight hours. The CIET team from Pakistan had to travel by air from to Kabul because the road from Peshawar to Kabul was unsafe. It was

challenging to ensure quality control in the field; the field teams were new to this data collection process, with its strong emphasis on collecting accurate and unbiased information from household respondents. When introducing the social audit in a new setting it is usually important for an experienced CIET person to accompany each field team, but in this case the security situation precluded this. Data entry took place in the CIET Data Management Unit in Karachi, Pakistan, and was undertaken by an experienced team of operators. However, this meant that the open-ended questions had to be first pre-coded by Dari speakers in Peshawar.

The findings

The extent to which the findings of this demonstration social audit can be generalised is necessarily limited because it took place in only two districts, purposively selected for their relative security and ease of access from Kabul. Nevertheless, the two districts did have government health services provided by different mechanisms and this allowed some contrasts to be made. The findings also provide pointers for areas of concern that could be explored further in a larger social audit, covering more districts, even if not fully nationally representative.

The analysis of data and the presentation of findings in this report is intended to demonstrate the *sort* of analysis that is possible. The implications of certain findings described in this report deserve further comment.

Choice of government or private health services

A notably higher proportion of households in Bagrami (over a third) than in Qarabagh (less than 10 percent) reported they usually used a government health facility for treatment of a health problem. This probably reflects the greater access in Bagrami to the private facilities in Kabul. In both districts, discussions in focus groups suggested that more households would

use private facilities of they could afford to do so, because they believed the quality of care in private facilities would be better. In Bagrami, where we could analyse this, the better-off households (those with enough food and those with a head that had some education) were indeed more likely to use private facilities. In rural parts of the district, access made a difference, and households were more likely to choose a government facility if there was one nearby.

From this one social audit we cannot examine the trends over time, but it is likely that in Afghanistan, as in other countries in the region, there is a continuing move away from government health services by those that can afford private services[5], leaving only the poorest households to use the government facilities. These remaining service users are less likely to be in a position to negotiate for better quality of services. In this demonstration social audit we found that few people knew how to complain about the health services they usually used, and even fewer had ever lodged a complaint. Interestingly, households who usually used government health facilities were more likely to know how to complain, even though hardly any of the facilities visited by the teams had any form of complaints procedure in place. Even allowing for the greater use of government services in Qarabagh, residents of this district were more likely to know how to complain about services than residents of Bagrami; we do not know why this is.

Type of government health service
Across the two districts, the *type* of government facility used reflected essentially what was available in each district. Thus all households in Qarabagh who said they usually used a government facility mentioned a facility run by the NGO operating in that district. In Bagrami, two thirds of households usually using a government facility mentioned a facility run by the provincial health department under the

Strengthening Mechanism arrangement, one fifth mentioned a facility run directly by the MOPH, and 6% mentioned a facility run by the NGO operating in this district. To a large extent, therefore, comparisons of the views and experience of government health services between the two districts compare services provided by the SM and MOPH with services provided by an NGO.

Rating of available health services

The overall rating of available health services by households across the two districts includes both government and private services available to them. Such overall ratings are affected by a complex mixture of factors and are susceptible to rapid changes, for example in response to a negative media report about services or a negative experience of a family member or neighbour. One factor emerged as associated with households' overall rating of health services; those households with enough food in the last week were more likely to rate services positively. This perhaps reflects their greater ability to access services, as well as perhaps better treatment in those services they do access. In the focus group discussions two common themes were “poor people have no choice of service” and “poor people are treated badly in government health services”.

Satisfaction with services received

Satisfaction ratings based on a specific recent contact with health services are less affected than overall satisfaction ratings by external factors, but still result from a mixture of personal and service factors, and the interplay between them. Prior experience and expectations make a difference.

In multivariate analyses examining the effects of both individual and service factors, we attempted to tease out the main factors associated with three ratings by service users: their rating of how they

were received by the person treating them, their rating of the service quality in relation to their expectations, and their satisfaction with the overall quality of the care they received.

Among users of government health services, three-quarters rated the quality of their reception as good, four out of ten said the quality was better than they expected, and two thirds were overall satisfied with the quality of care. All of these three ratings were more positive among users of private health facilities, including the rating of quality being better than expected. One might have predicted that expectations of government services would be lower and therefore more easily exceeded by actual experience but this was apparently not the case.

We found that overall satisfaction among users of government services was related to a mixture of personal factors and services factors: a shorter waiting time increased the chances of being satisfied, and users from less poor households were more likely to be satisfied. The higher satisfaction in urban areas might reflect other service factors that were better in urban clinics than in rural clinics. Interestingly, users from households with a head who had some education were *less* likely to be satisfied; perhaps they look for higher standards.

User ratings such as these, put together with information from services themselves, can be a useful barometer over time of how services are performing and serving the needs and wishes of the population. Used carefully, such ratings can be part of the way of assessing the quality of service overall and the quality of service from different service providers.

Costs of using health services

In a poor country such as Afghanistan, costs of health services are a crucial consideration. Often the main costs considered are those borne by the service providers, yet out of pocket costs to the

service users are important. They limit access to services by the poorest households, and lead to frustration and resentment among service users and non-users.

According to official policy in Afghanistan, services in government health facilities (including those run directly by the MOPH, and those run under the Strengthening Mechanism or by a contracted NGO) are provided free of charge. However, the findings of the social audit confirmed that in practice those who used government health services often had to bear considerable direct monetary costs, in addition to such costs as loss of work time for daily wage earners. Among users of government health services: two thirds paid for travel to and from the facility, at a median cost of 50 Afghanis in Bagrami and 100 Afghanis in Qarabagh; one fifth paid for a ticket in the facility, at a median cost of 5 Afghanis; one in six paid for treatment or investigations in the facility, at a median cost of 100 Afghanis; and three quarters incurred costs outside the facility, for medicines and investigations, at a median cost of 200 Afghanis in Bagrami and 250 Afghanis in Qarabagh.

In the context of a supposedly free service, these costs are considerable. Despite the perception voiced in focus groups that poor people are forced to use government services, the costs of treatment and investigations in government facilities, among those who paid, were the same as these costs in private facilities. And the costs for medicines etc outside the facility among users of government services were not much less then those incurred by users of private services. The focus group discussions confirmed that these costs can place a serious strain on already precarious family finances; people have to take loans or sell livestock to find the money.

These findings suggest that a review of actual charges in government health facilities is needed, especially as most of these charges are apparently not officially sanctioned.

Corruption in health services

It was apparent from the findings on costs of using health services that many users are in fact paying unofficial charges. Despite this, household respondents were loath to talk about corruption in health services, declining to answer the questions about this, or responding that they "knew nothing about it". Especially in Bagrami, a sizeable minority of respondents could not or would not answer questions about the types of corruption they knew about, or their own family's experience of being asked for unofficial payments or bribes.

The focus group discussions helped to explain the findings from the household survey and the apparent reluctance to answer questions about corruption. The participants explained they knew services in government facilities were supposed to be free of charge, and they were aware of being made to pay for things supposed to be free, or having to pay direct bribes to service providers. However, they said people in the household interviews were afraid to reveal this to the interviewers, as they were worried that whatever they said would get back to the services and jeopardise their chances of getting any service in the future. They feared the interviewers were from the health services, or from the security services.

This sort of climate of fear and suspicion allows corruption to flourish and can thwart attempts to tackle the problem. It was clear from the focus groups that people see corruption in the health services as a manifestation of a high level of corruption in society generally. On a more positive note, tackling corruption in health services is probably easier and less dangerous than tackling corruption in the police or justice services, and it could provide a starting point for a more general campaign against corruption.

Care in pregnancy and delivery

Three quarters of mothers of children under 60 months old had at least one antenatal checkup during their last pregnancy, but less than a third had the recommended four antenatal checkups. It was not surprising that mothers from less poor households were more likely to have antenatal checkups. It was encouraging to note that mothers who had seen a community health worker (CHW) were more likely to report having antenatal checkups. But we cannot be sure that the CHW contact lead to the antenatal checkup; indeed the mother may have seen a CHW because she went to her for her antenatal checkup. Contacts with a CHE were again more common among mothers from less poor households and those who had some education. It is not clear why they were more common in Qarabagh (one half of mothers) than in Bagrami (a third of mothers).

There remains a need to advise mothers during pregnancy. For example, only a third of the mothers reported they reduced their routine heavy work during their last pregnancy.

Delivery at home is still common, with almost half the mothers reporting their last delivery took place at home. Those who had seen a CHW were more likely to deliver in a facility but we cannot tell if this was because they saw the CHW, or that both seeing the CHW and facility delivery were because of more careful behaviour.

Child feeding and immunisations

As expected, breast feeding was nearly universal and of reasonable total duration. However, other liquids were added early, so that truly exclusive breast feeding was rarely practised for more than a month or so. Solids were added much later, with only a minority of infants being given solids before the age of six months.

The reported rates of childhood immunisation were high, with over 90% of children aged 12-23 months reportedly having received all the vaccines, with the exception of the full course of DPT, which was reported for less children (two thirds in Bagrami, three quarters in Qarabagh). The high rates may reflect the relatively easy access to these two districts from Kabul. We did not ask where the children were immunised, whether in a clinic or by a visiting team. We estimated the immunisation status from the maternal report only; some authors have reported that this can over estimate immunisation status in some circumstances.

Next steps

The process of socialising the evidence from the social audit began with the feedback and discussion of the findings in the community focus groups. The preliminary findings were shared with the MOPH in late 2008 and this report is intended as a way of taking further the discussion of the findings, including in relation to other sources of information about health services in the country.

In this single cycle of the social audit in two districts, the extent of capacity building that was possible was necessarily limited. Nevertheless, we were able to train four field teams in techniques of data collection from households and focus group facilitation and recording. Nominees from the MOPH participated in the design, field data collection and quality control and will hopefully continue to participate as the findings are discussed. They and other members of the MOPH expressed that they found even this process useful for building capacities.

The MOPH has expressed interest in participating in a capacity building process that will allow them to undertake the rollout of the social audit to other areas of the country. Much of the training could take place outside Afghanistan, in Pakistan or elsewhere.