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# A Qualitative Study to Explore the Effects of Gender on Women's Access to Healthcare Services in Afghanistan

Dissertation submitted in partial fulfillment of the requirements for the Degree Master of Public Health at the University of Liverpool

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## Declaration

No portion of this dissertation has been submitted as part of the fulfillment of a degree from the University of Liverpool or any other University or institution of learning

Signature: 

## Abstract

**Background:** Gender as a cross cutting issue has an important role in determining health of a particular population and for Afghanistan it is more important because of a very high maternal mortality –a female attributed situation. Despite some progress toward improving gender-imbalance, Afghanistan still has long way to overcome this.

**Aim:** To explore factors which are attributable to gender in regards to women's access to utilization of health services in Afghanistan. The ultimate aim is to contribute to improving women's access to healthcare by building on evidence for policy formulation at local and national levels.

**Methods**: As part of a social constructionism approach, qualitative methodology was adopted through conducting 10 in-depth interviews with indviduals from program management, clinical and community levels. The participants were recruited as part of purposive sampling in 5 provinces from 3 communities, 3 health facilities and 3 organizations. The collected data underwent thematic content analysis (TCA).

**Results:** A total four themes emerged through TCA. Although Afghanistan is a traditional scoeity, lack of female health providers was not perceived an immediate major threat in access to health serices. It is rather the quality of services which often discourages women access to health services. Lack of women empowerment, poverty, transportation problems, and poor attitude of health staff were some of other crucial barriers restricting access to health services.

**Conclusions:** The study marked an important shift in the paradigm of people toward women access to health services in Afghanistan where it is believed services offered by male doctors are not acceptable for women. As per the study findings, it is simply not true on many accounts. To ease access to health services, Afghanistan needs to maintain a balanced approach both on supply-side and demand-side factors. Apart from training community helath workers, improving quality of services and behavior of staff in HFs are other crucially important measures related to supply side factors. On demand side factors, community health awareness particularly in men about women health could prove highly vital for women's health.

**Keywords:** gender, barriers, qualitative, access, quality

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## Acronyms

| | |
|---|---|
| AHO | Alliance of Health Organizations |
| AMI | Aid Medical International |
| BDN | Bakhtar Development Network |
| FGD | Focus Group Discussion |
| GDI | Gender Development Index |
| IDI | In-depth Interview |
| IRB | Institutional Review Board |
| MCH | Mother and Child Health |
| MDG | Millennium Development Goal |
| MoPH | Ministry of Public Health |
| WHO | World Health Organization |
| MICS | Multi Indicator Cluster Survey |
| MOHE | Ministry of Higher Education |
| ORCD | Organization for Research and Community Development |
| TCA | Thematic Conent Analysis |

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# Chapter 1

## 1. Introduction

According to David et al. (n.d.) it is widely recognized that individuals at health service-planning and policy making level admit that gender has a very important determining role on health status of a particular individual. This means that exploring the role of gender in accessing health services which would be instrumental in paving the way for designing interventions aimed at lifting the due barriers is paramount.

This qualitative study aimed at exploring new ways about role of gender in accessing health services with an ultimate aim of equitable health service provision was conducted in five selected provinces of Afghanistan. Although the country has progressed substantially in improving its health indicators but it is still reckoned as one of the developing countries of the world with poor health indicators (WHO, n.d.). Contextually, the study conducted on this topic further built on the findings of few studies conducted in Afghanistan and other countries having similar settings although all of them were not of exactly similar nature.

Improving maternal health –female attributed health issue -- is of particular importance because it constitutes a great burden on human development. For example, loss of approximately 500,000 maternal deaths (pregnancy-related) occuring annually has a domino effect on child health as well as the overall productivity of its inhabitants. Thus overall economy of a country is indeed an area requiring immediate attention (EndPoverty2015, nd). This is while improving maternal health and reducing child mortality are two important millennium development goals (MDGs) (Lule, et al, 2005). Very importantly, these two goals are more inter-related. Exploring news ways for improving health by taking gender into account would not only be useful in improving maternal health but also exerting a positive effect on child health especially in the first years of children (ibid) when women remain the caretaker of them.

The findings of this study in Afghanistan are of particular importance because it is a country where women are are stripped of many of their basic rights. In the meantime, maternal mortality is very high and women have very difficult access to healthcare services because of social, traditional and economic reasons (Shinwari, 2009). This qualitative research has been exactly aligned with this need as it has been aimed at adding up what is already known as well as further exploring effects of gender on women's access to healthcare services in Afghanistan. Of course new information collected through this study will be crucially

important not only at policy level but also at community level which will pave way for promoting interventions implemented at community level.

According to WHO (n.d.), many factors such as gender differences and related inequalities determine access to healthcare. In contrast, as a measure for mitigating the negative impact of these factors, mainstreaming gender is regarded a crucial strategy for offering equitable healthcare programs successfully. UN Women (n.d.) views gender mainstreaming a globally accepted intervention. It views such mainstreaming as crucially important for achieving gender equality in all aspects of life. According to Gender Debate (n.d.), the fact is that gender mainstreaming is a cross cutting and thus through this it is ensured that perspectives pertinent to gender and having a particular focus on gender equality is centrepiece to all activities ranging from policy development, research, advocacy/dialogue, making laws, allocating resources, planning, implementation and monitoring of programs and projects. This study conducted in 5 provinces of Afghanistan is of particular relevance with the Afghan society where inequalities in health opt to be unfairly gender biased especially in rural areas (NPR, 2012).

## 2. Current Situation in Afghanistan

Afghanistan is located in South Asia neighbouring Pakistan in the South-East, Iran in West, and Central Asian Governments (Tajekistan, Uzbekistan and Turkmenistan) in North and China in East. According to WHO (n.d.), the health status of Afghan population is unacceptably at worst level. Very ironically, Afghanistan is lagging far behind its neighbouring countries which enjoy three to five-fold better health indicators. Maternal death rate still remain up to 1,600/100,000 lives per year especially in remote provinces (WHO, n.d., cited UNICEF, 2002) and the overall rate of fertility is 6.3. Communicable diseases are on the top of the epidemiological profile and the country usually grapples with frequent epidemics particularly diarrhoea and other communicable diseases. Acute and chronic malnutrition is at record level pervasive in the country (WHO, n.d., cited MICS, 2003).

According to Dr. Shinwari (2009) Afghan people are strongly adamant on their classical customs and religious beliefs and while most of them are detrimental to their health especially for women. The situation has been further compounded by the fact that Afghan society is predominately a patriarchal one where most of the decisions even about the health

of women are made by men. This has inflicted a negative impact on the country genuinely restricting its development and at worst mostly women are affected negatively.

On positive side, Oxfam International (n.d.) highlights significant achievements as a result of investments in women over the recent years. As compared to ten years ago, more girls are enrolled in school (a 480-fold increase). In addition, more young women --approximately 40,000 young girls-- benefit pursuing their higher education at university level. The trend of the enrolment of girls/women has steadily gone higher each year (Afghan MoHE, 2013). Wonderfully, the expectancy of life has remarkably improved (Rehman, 2012) and women have had good achievements in the political life in Afghanistan (Sudhakar & Worden, 2010). There are more than 70 women-led organizations that are involved in countering gender-based violence and discrimination against women (AWN, 2010). Most of these achievements could be attributed to the political commitment in Afghanistan where Afghan Constitution and official Afghan policies, subject to thorough reviews, guarantee equal rights both for men and women (Bauck, P, et al, 2011). Although evidence toward solving this problem has been made somehow available but it is well-known that further improvement is always desirable. Additionally, the available solutions to gender-based health-related inequities need to be re-examined through a perspective that is gender-centred at different levels in society (WHO, 2010, p15). The findings of this research would build on the available evidence and would be effective in further enhancement of women's access to healthcare in Afghanistan.

According to David, et al (n.d.), the existing data to explore the link between utilizing health services and gender is surprisingly very minimal. This warrants generating evidence through exploring facts that how health services to be provided in a more sensitive manner so that gender-related barriers are lifted out and services are equitably accessed.

## 3. Public Health Context

This is true that the life of both men and women are adversely affected by poor health alike, certain gender-specific inequalities exist and unfortunately Afghanistan is one of the worst-hit countries. Such a circumstance in effect creates situations of health disparities attributed significantly to gender roles (Word Bank, n.d.; Medina (n.d.). Indeed statistics highlight such disparities where Afghan women in general experience lower level of premature death than men by a ratio of 104:100. Apart from a very high maternal mortality (Morgan, 2008), literacy rates of female-to-male stands at 0.4 and school enrolment is pegged at 41.8% (for

females) which is viewed clear-cut indication of overall gender based inequities in Afghan society. Meanwhile, statistics also corroborate that inequities are equally evident in human health resources; i.e., only 40% of health facility staffs directly engaged in the provision of health services in HFs are female; likewise, only 24% of HFs have at least one female health worker (ibid.). Further, socio economic status of women is reflected terrible as gauged by the gender development index (GDI) which is around 0.310. This is one of the highest in the world (InfoSeries, n.d.). All these represent huge disparities potentially leading to gender-based inequities in access to healthcare services.

In contrast, currently, some programs exists in addressing gender-based inequities in health in Afghanistan (Kareemzada, n.d.), but very few of them have been based on scientific research findings and there is still enough room be covered so that health inequality could be fixed in an evidence-based manner through scientifically underpinned approaches. This could be done via interventions driven at level of sound policy formulation (WHO, 2002) to effectively yield positive impact at community level. Efforts toward achieving this goal could significantly be enhanced through the involvement of male partners as part of an extensive cooperative and supportive environment for women (Sadeghipour, 2006).

As stated, in a bid for improving equal access to healthcare, it is imperative to explore linkages between policy makers and the groups at community level (Iwere, 2000). Ensuring gender equity is not only crucial for reducing poverty but is also significantly instrumental in achieving other MDGs (Grigorianconsultants, n.d.). To do so, evidence needs to be generated to further explore how gender-imbalance affects access to health services. The findings of the research in this regard would be highly useful in designing practical corrective actions as part of an extensive intervention aimed at fixing gender inequalities. Based on country's perceived needs especially women in accessing health services (Kareemzada, n.d.), this qualitative study was conducted in five provinces of Afghanistan.

This research is aimed at exploring perceptions about gender and its impact on use of health care among people who influence the delivery of health care (including public officials and community leaders), people who provide health care, and people who use health care (including clients and community members) in Afghanistan. This is in reaction to gaps in existing programs that allegedly espouse strengthening 'gender' 'quality' and 'access' within clinical settings which are inter-related as per examples put forward by Hardee (2005) from countries such as India, Kenya, and Guatemala which share similar concerns as Afghan

society does. However, according to Shenwari (2009) 'access' barriers with regards to gender are often related to contextual community beliefs and norms, which are deeply rooted in culturally prescribed gender roles (e.g. that women cannot make decisions about seeking health services on their own; that women should not travel alone; that unmarried women and girls should not use reproductive health services; etc.). In order to improve access, service delivery systems may need to explore linkages with individuals and groups in the community, in order to offer services that better address and/or contribute to changing the gender norms of the community. However, as stated above, many of the existing programs designed to address issues related to access, quality or gender relations have not yet been fully explored in the context of Afghanistan. It is deemed that the findings of this study will be significant in identifying patterns in gender related barriers to access to health services in Afghanistan. A better understanding of the impact of gender roles on seeking and receiving health care – including possible differences among different regions of the country – will enable health officials to design interventions to better achieve its mandate of bringing gender equity in health services.

## 4. Literature Search Strategies

The literature search was initiated by exploring the digital Library of the University of Liverpool which has readily available electronic databases related to public health i.e. PubMed, Global Health. Aimed at finding relevant articles, key words contained „gender", „access", „healthcare", „qualitative research", „South Asia", and „Afghanistan". It was ensured the search yield results on literature conducted in the last 10 to 15 years.

There were a lot of articles found through this yet only 15 of them were to provide relevant information on gender barriers to healthcare. Only 4 studies were of qualitative research nature which aimed at exploring role of gender in accessing healthcare in Afghanistan. There were 7 references which were related to the world leading organizations such as UNFPA, Word Health Organization (WHO), and UNICEF. Meanwhile, documents that were locally available were received from the Resource Center located in Afghan Ministry of Public Health.

**Table 1: Literature Search Articles**

| | | | |
|---|---|---|---|
| SN | Title of Article | Title source | Key theme |

| | | | |
|---|---|---|---|
| 1 | Qualitative Research on Gender Barriers to Improved Maternal Health. | MoPH Resource Center/HSSP | Health Services |
| 2 | Report from the CDC: Mental health of women in postwar Afghanistan | PubMed | Health policy |
| 3 | A population-based assessment of Women's mental health and attitudes toward women | PubMed | Women Mental Health |
| 4 | Validity in Qualitative Research | PubMed | Methodology |

**5. Literature Review**

Although there are some studies on how gender inequality affects access to health services in Afghanistan, few of them are similar to the study under discussion. A qualitative research conducted by Shinwari (2009) in Afghanistan aimed at exploring gender barriers against improved health of mothers revealed a very terrible situation. This survey was conducted in Badakhshan, Baghlan, Bamyan, Daikundi, Faryab, Hirat, Logar, and Paktia provinces of Afghanistan. According to Shinwari (2009), the situation is not favourable for women in terms of their limited access to health services and have most of the times been subject to permission from their male partners or any other decision maker in their family.

Moreover, a similar study conducted on this topic in similar developing countries as cited earlier illustrate variability in access to health services due to gender difference, suggesting this is a consistent issue in developing countries (Silvester et al., 2005). This study highlighted how access to treatment services of HIV/AIDs is affected by aspects of gender dimensions where gender based inequities tends to negatively affect women. This inequity exists because women are more vulnerable to poverty, highly dependent on their male counterparts, has of lack education and are subjected to high levels of stigma (ibid).

Further, a study by Amowitz et al (2003) in Afghanistan explored the prevalence of depression among women in Taliban-controlled areas in which women's movements was more restricted compared to non-Taliban controlled areas. It showed that depression was 50% higher in the former region than the latter. This difference could be chiefly attributed to gender-based negative discrimination which was most common in Taliban-controlled areas.

Another study by Cardozo, et al, (2005) highlights a desperate need for addressing the mental health needs of women in Afghanistan where a huge gap exists in making sound evidence-based decision making at policy level.

All these studies indeed underscore the attribute of gender as an impediment toward meeting overall health equity goals especially between the sexes in the context of conservative societies such as that in Afghanistan. Therefore, considering the highlighted gender-based inequities in health outcome and access to health care in Afghanistan, need arises to understand salient gender based factors so as to enhance women's equitable access to healthcare in Afghanistan.

In the view of a critical analysis of all studies conducted on the theme under discussion, it has been known that women have remained disadvantaged in terms of access to services. However, there is still much left to bolster the credibility of the details and description why and how gender-based barriers have put women in disadvantage and how they could be overcome. In addition, validity and theoretical adequacy are the most important hallmark of qualitative research (Whittemore, et al, n.d.). This could be applied in almost all studies conducted in this topic as there is still much left to add up to the validity of all research findings conducted in this regard as well as build on the theoretical validity of them. For example, the research conducted by Dr. Shinwari (2009) has explored some ways how to prevail gender effects in order to ease the access of women to health services yet his findings needs to be further consolidated and reinforced.

# Chapter 2

## 2.1. Research Question

*How does gender affect women's access to healthcare services in Afghanistan?*

## 2.2. Aim and Objectives of the Study

The study was aimed at exploring factors that are attributable to gender in regards to women's access to utilization of health services in Afghanistan. The ultimate aim was to contribute to improving women's access to healthcare by building on evidence for policy formulation at local and national levels.

The intended specific objectives included the following:

1. To review literature on current perspectives and practices pertaining to the gender-inequality and gender mainstreaming into health programmes in Afghanistan and other Islamic societies similar to Afghanistan.
2. To explore through in-depth semi-structured interviews how knowledge and understanding of the concepts of health care access and gender varies among different levels of staff within various health care organizations and across HFs and communities in the 5 provinces in Afghanistan.
3. Using Thematic Content Analysis (TCA), to explore how knowledge and understanding of the concepts of health care access and gender vary across HFs and communities of different regions in 5 provinces in Afghanistan.
4. To disseminate the findings of this study at the community and national levels to be used for legislation by the Ministry of Health to enhance equitable access of women to healthcare services.

## 2.3. Epistemological Approach

In many theories i.e. empiricism, social constructionism, the main epistemological approach that has dominated research activities over the past couple of years has been positivism (KnowledgeBase, n.d.). This has been more applicable and contextual in social science (Green and Thorogood, 2004). Overall, interpretivism has been the main approach adopted in this study.

Thus, taking a critical position, social constructionism has prevailed in conducting this research. The collected data does not only reflect a reality constructed by the interviewees but

also describe the status quo in the form of an inherent reality in Afghan context. Nevertheless, what has been collected as part of this study has been merely as a result of the culture and social interactions (Green and Thorogood, 2004). As stated by Green and Thorogood (2004) and (Lindgren & Packendroff, 2006), the approach used as part of this study provides enough room that while making a conclusion from the collected data is not based on value-free principles, the social atmosphere has played a role in the design and developing research question. The fact that tendency has been toward the fact that gender plays a role is greatly regarded as the acknowledgement of the feminist position.

According to Alderson (1998), it is very much vital that an individual conducting a research have an idea which is deemed to be highly instrumental in guiding the entire research from data collection, processing and interpretation. However, any unfair bias needed to be avoided to a reasonable extent. The researcher preconceptions and bias about the issue under discussion has greatly been subject to transparency and clear reflection making it cautiously part of the study (Mantzoukas, 2005).

## 2.4. Methodology:

### 2.4.1. Study Design

The methodology used in conducting this research was 'in-depth interviews'. The rationale behind this method was to elicit elaborated understanding of the perspectives of the following category people about the topic under discussion:

1. Program managers
2. Health service provider
3. Community members/clients

The selected method allowed the researcher to create theory from the data collected via in-depth interviews (Jupp, 2006). Moreover, 'in-depth interviews (IDIs)' has been selected a method of choice in this research because, as stated by Powell and Single (1996), IDIs are highly instrumental in understanding the implication of the issue under discussion in health system when existing knowledge would need further elaboration. Through this, the research further built on shedding light on issues pertinent to generating knowledge so that policies at higher level and practices at the community level could be reshaped and any pertinent problems in regards to the relation of gender and access to health services could be effectively minimized.

### 2.4.2. Study Setting:

The provinces where the study conducted were: Kabul, Baghlan, Jalalabad, Herat and Daikundi provinces. The selected districts have been selected not only for convenience reasons but also because they represent the entire country in terms of geographic and ethnic distribution (Bhavnani, et al, 2012). Therefore the interpretation based on the findings of the interviews conducted in these provinces could give enough insight about the issue under discussion.

**Figure 1: Provinces of Afghanistan where study was conducted**


Source: Afghanistan Online (www.afghan-web.com): provinces are highlighted by researcher

**Daikundi Province:** According to SAARC (n.d.) this province is a remote province with treacherous geography has a population 477,544 males outnumbering females in all of its 8 districts with the most probability of higher maternal mortality. Although there is relatively little cultural resistance to women's education, taking part in public life for women is still a problem. However the severity security threats could be relatively minimal.

**Kabul Province** is the capital of Afghanistan and, as of 2005; the total population has been estimated as 2,425,067 males outnumbering females. A total 643 doctors and 4790 nurses were registered as employees by the Ministry of Health. While only one third of men are

literate, almost half women in this province are illiterate (WFP, n.d.). Major ethnic groups are Pashtun, Tajik and Hazara.

**Ningarhar Province** is one of the eastern provinces of Afghanistan which has a population 1,342,514 where males are outnumbering females. Approximately 87% constitute the rural population. As of 2005, the province had had 343 doctors and 443 nurses. Only 3/5$^{th}$ of the men population is illiterate the situation is worse for women where only 1/7$^{th}$ having basic literacy skills. Major ethnic groups include Pashtuns (UNDP, n.d.).

**Herat Province** is located in the west of the country bordering with Iran and Turkmenistan. Its total population has been estimated as 1,762,157 with males outnumbering female in a relatively small margin. Tajik is the dominant ethnic group. As of 2005, there was approximately 40 HFs staffed with 262 doctors and 228 nurses. Literacy rate is estimated as 43% for men and 28% for women. Major ethnic group is Tajik (UNDP, n.d.).

**Baghlan Province** is located in the north of the country on the main route connecting the capital with north and north east. It has a total population 741,690 with male outnumbering females. There province has established healthcare system. The literacy rate for men is 29% and for women it is 12%. Major ethnics groups are Tajik, Pashtun and Uzbeks (UNDP, n.d.).

### 2.4.3. Sampling Approach:

Three category people (program manager, clinical staff and community members) were chosen for in-depth interviews as part of a purposeful convenient sampling procedures from the target provinces: Baghlan, Herat, Ningarhar, Daikundi and Kabul provinces. The samples taken from these provinces contained the major ethnic groups of the country: Pashtuns, Tajiks and Hazaras which could be regarded one of the important strengths of the study.

#### 2.4.3.1. Sample exclusion/Exclusion Criteria

To ensure findings of the study are applicable to the context of the country and any confounding factors are effectively mitigated, the following categories were excluded from the survey:

- Persons below having age less than 18 years old

- Ones who have not recently over the past few years have not lived in the area i.e. they were in exile in other countries and have recently returned
- Foreign workers working in the province
- Individuals who declined to participate in the study

On the contrary, the most important inclusive criteria were:

- Local female or male permanent residents of the areas who have not travelled abroad for long time
- Having age more than 18 years old
- Have been in interaction with various ethnic groups of the country. For example, clinic staff who have clients who has experienced providing services to all major ethnic groups and have had understanding about their culture, habits and traditions.

**2.4.3.2. Sample size**

Apart from two in-depth interviews as field testing the tool, a total 10 in-depth interviews were conducted –each interview having duration of 25 to 30 minutes.

**2.4.3.3. Sample Recruitment**

The researcher received from the Afghan Health NGO Organizations (AHO) working in collaboration with the Ministry of Public Health a list of all non-governmental organizations which are implementing HFs in the target provinces. In the view of the list, and with the permission of NGOs working in the province, the researcher activelyrelevant people i.e. program managers, HFs and community members in the catchment areas in the target provinces. It was informed extensively that is no associated coercion and taking part in the survey is completely voluntary.

The following table indicates the list of informants in each province.

**Table 2: List of informants in each province**

| Province | Institution | Designation | Gender | In-depth interviews |
|---|---|---|---|---|
| Kabul | NA | Client | Male | 1 |
| | MOPH | MD | Male | 1 |
| | | | | **2** |
| Baghlan | BDN | Program Manager | Male | 1 |
| | BDN | Clinical staff | Female | 1 |
| | | | | **2** |
| Herat | BDN | Program staff | Male | 1 |
| | BDN | Client | Male | 1 |
| | | | | **2** |
| Jalalabad | HNTPO | Program Staff | Male | 1 |
| | NA | Client/Community member | Male | 1 |
| | | | | **2** |
| Daikundi | AMI | Midwife | Female | 1 |
| | ORCD | Program Staff | Male | 1 |
| | | | | **2** |

As illustrated in the table above, a total 2 female and 8 male were interviewed. To ensure the distribution of potential respondents is fair, two persons from each province were selected. In-depth interviews took place with a total 4 program staff, 2 clinical staff, and 4 clients/community elders. The interviewed staff were from five different organizations active in the mentioned provinces.

**Table 3: Description of respondents**

| | |
|---|---|
| Sex | Eight of them were male, two of them were female |
| Age | Between age 24 to 50 |
| Marital Status | Eight of the all 10 were married, two of them were singles |
| Occupation | Four of them were doctors, one was midwife, one was clinician, two were social scientists, two were ordinary community members/clients |
| Household family size | All 10 had type Afghan family size ranging 5-7 persons |
| Income range | Two of them had more than $2,000 per month income. The remaining had average income of around $ 700 per |

| | |
|---|---|
| | month. |
| Organization (for organization respondents only | The respondents were from four different organizations implementing projects in the target provinces |
| Position (for organization respondents only) | Four of them were program managers, 4 were clinicians and two were clients (ordinary community members). |

**2.4.3.4. Data Collection Methods**

In-depth interviews (IDIs) constituted the major data collection method. Using IDIs, the researcher was allowed to elicit detailed information about few specific issues and was highly effective in understanding the perception of the key informants (Britten, 1995) by making probing questions. Focus group discussions (FGD) were neither planned nor conducted as this methodology was not deemed suitable in the study context because the interviewer was male and had to be actively involved in interaction with both male and female participants which posed many cultural barriers by having group conversations with female participants. Even if it were feasible in some areas, more accurate information could not be collected. According to University of Waterloo (n.d.) possible censoring especially in the form of self-censorship where people cannot talk openly about certain topics is regarded one of the important limitation of FGDs. This is very much true in Afghan society where many people feel shy when they are asked to talk about a very sensitive issue such as family planning, abortion, etc. in front of others. Instead, IDIs provided more profound insight, more flexibility, and the recruitment was faster and easier (Hitchcock, 2011).

An interview guide was used as an important data collection tool to make sure not only to mitigate the negative impact of the limitations of IDIs but to elicit more detailed and relevant information. With using interview guides, the researcher effectively secured that collected data is not prone to bias and the endeavor is not time consuming by using appropriate interview guides designed for every category of participants (Boyce & Neale, 2006).

The interview guides were developed in line with the objectives of the research aimed at guiding interviews with different category of staff. There were three types of interview guides designed for conducting interviews with the following category people:

1. Program managers (Appendix 3a)
2. Clinical staff (Annex 3b

3. Community member or potential clients (Annex 3c)

The interview guide contained questions related to the following main topics:

1. Personal history
2. Type of services offered for both sexes
3. Knowledge of interviewees about services offered
4. Perception of interviewees about the quality of services offered
5. Exploration of current status with regards to access to health services
6. Viewpoints of interviewees about the improvement of services offered

To achieve the validity of questionnaires and ensure the interview guide was working well, it was piloted on two independently selected participants (one program manager and one on community elder) who did not form part of the study samples. At the end of the interviews participants were asked whether they were feeling comfortable the way questions were asked from them. The research found feedback from the subjects who underwent field test as highly insightful to go further with data collection. Although the pilots did not reveal any major problems with the guide, yet provided significant insight to the researcher how the interviews should proceed with participants. The following modifications were brought to the guide after pilot:

1. One question was reworded
2. Two questions were merged

The researcher attempted to generate sufficient data using the guide and always attempted to use probing questions to make sure enough relevant data is collected.

**2.4.3.5. Ethical Considerations:**

The ethical clearance from the University of Liverpool Laureate was obtained on 04 September 2012 (Annex 3) In addition, the Afghanistan Afghan Institution Review Board (IRB) granted local ethical clearance on 03 September 2012 (Appendix 2).

**Informed consent**

To make sure the participation in the study has been voluntary and no type of coercion was involved a written informed consent was received from every participant. This was done as informed consent is regarded as a pre-requisite for the participation of a person in a research

activity (Ortiz, et al., n.d.). In addition, the interviewee was fully assured in written that their anonymity, confidentiality will be respected (Annex 5). To abide the Afghan cultural norms where male cannot talk to women who have no prior acquaintance (Bagboy, 2010), only female participants who did not have any problem to be interviewed by a male researcher was vetted. Selecting female participants from Daikundi and Baghlan where interaction between male and female is relatively less of an issue was done to make sure information could be elicited from female by a male researcher.

#### 2.4.3.6. Analytical Approach

Thematic content analysis (TCA) through which was data was coded and categorized into merging themes aimed at eliciting shared elements in responses across participants was adopted (Anderson, 1997).

### 2.5. Data management and analysis

Among all IDIs only two of them could be recorded because most of the interviewees rejected their voices be digitally recorded. At a manageable level, this posed challenges and forced the researcher to take quick and comprehensive notes during the interview which later could be transcribed for analysis purposes. The fact that researcher and the subjects shared the same language and the researcher was fully acquainted with culture, tradition and local settings of the provinces where the interviews took place, not recording their voice did not compromise the quality or reliability of data collected. Sharing same culture between interview and subjects provided a value-added advantage taking into account that the researcher was actively involved in eliciting messages from the interviews throughout the interviews (Green and Thorogood, 2004).

Aimed at guaranteeing the confidentiality and anonymity, the interview notes were coded and they were secured in a cabinet that was locked. The entered data was put in place in a password-protected folder which was safe from unauthorized access.

TCA was the main approach which was used for analyzing the collected data. As part of a systematic approach for categorization, all transcripts underwent coding. The first step aimed at facilitating the analysis, was developing a template table in which each set of interview data was accommodated. All interview data were organized in separate tables. Afterwards, considering the nature of analysis, a separate sheet was developed for labeling themes called

as 'theme codebook'. This sheet contained a common description of the major themes as well as various classifications within each theme (Table 4). Numerical data, in a separate column, was used for coding each theme and category. This numerical coding allowed the researcher to identify patterns as part of a sorting exercise (La Pelle, 2004). This was effectively done using the Microsoft excel software. A sample of the coding of transcripts is attached as Annex 6.

The coding framework below has been underpinned by taking into consideration the theoretical perception and none of the codes were defined in advance. Instead, they were extracted from the opinion of subjects who were interviewed as part of this research. For example, viewpoint of older and younger generation was labeled as 'valued' and code was assigned from their perspective. The researcher then endorsed it as a reality.

**Table 4: Theme Code Book illustrates how the analysis was undertaken**

| Codes | Categories | Themes |
|---|---|---|
| 1.1.1 traditional role of men and women | 1.1. Gender roles perception of communities | 1. Role of community context |
| 1.1.2 change in the role of women over the last 10 years | | |
| 1.2.1. social barriers | 1.2 Communities reasoning the barriers to accessibility | |
| 1.2.2. economic barriers | | |
| 1.2.3 geographical barriers | | |
| 1.3.1 Women health action groups | 1.3. Women and decision making | |
| 1.3.3. Awareness about health | | |
| 2.1.1 Services to men | 2.1. Types of services by Age & Sex | 2. Repercussions of Client engagement context |
| 2.1.2 Services to women | | |
| 2.1.3 Services to adolescents | | |
| 2.2.1 couples health | 2.2 clients satisfaction about services | |
| 2.2.2 privacy | | |
| 2.2.3 behavior of staff | | |
| 3.1.1 Women-owned NGO | 3.1. Organizational Structure of NGOs providing services | 3. Organizational behavior toward |

| | | |
|---|---|---|
| 3.2.1 Incentives for women seeking services | 3.2. NGO initiatives to gender mainstreaming | gender equity |
| 3.2.2. Gender policy implementation | | |
| 3.2.3 support to female staff | | |
| 4.1.1. Integrate gender into the national capacity building program<br>4.1.2. Involve community members in policy formulation | 1. Gender policy awareness | 4. Recommendations towards improved access |
| 4.2.1. Consider gender in all aspects of service delivery<br>4.3.2. Make female-friendly environment | 2. Improvement Quality of services | |

# Chapter 3

## 3. Results

The themes that have been drawn from the interviews are part of the planned TCA approach. The findings of the research have been in line with the set objectives. This chapter covers the perception of all participants into the following principle themes which were classified further into sub-themes:

1. Role of community context
2. Repercussion of client engagement context
3. Organizational behavior toward gender equity
4. Recommendations towards improved access

### 3.1. Role of Community Context

3.1.1 Gender roles perception of communities

All participants perceived the role of community context especially the inherent characteristics rooted from tradition and religion as highly influential in determining access of women and men to health services. According to their perception, although some positive change has occurred over the last ten years in the role of men and women, even then the later are relatively in disadvantage in having access to health services in almost all provinces as compared to men.

> *P (6): Yeah (...) some crucial barriers do exist. For example, women cannot afford transportation, or have to walk long distances, or cannot travel without a male member*

> *P (7): Women cannot go without **permission** of husbands and mother in law.*
> *P (8): There is greater role from mother-in-law who controls health seeking behavior of an women in a family. If someone doesn't have mother in-law then husband is the sole controller.*

Although almost all of them believed that men and women should have equal access to health services, ground realities unfortunately, as per their statements did not reflect this. Almost all participants believed that Afghanistan still has long way achieving gender-based equality in terms of access to health services. Certain religio-cultural conditions determine this aspect as indicated in the comments below:

*P (8): To some extent, this might be possible; but (…) complete gender mainstreaming in health when both men and women will equally enjoy health services is also not feasible. Afghanistan is a traditional and religious society. Therefore men should go to male doctors and female should go to female doctors*

*P (3): No.. Basically, there shouldn't be any problem in providing services to men and women on equal basis. But in Afghanistan being a woman is unfortunately a problem. Although both men and women have equal rights but there are some barriers. This is actually due to lack of education {What are the barriers?} for example, they are not given drive to go to health facility unless they have escort (Mahram). Or if a women travel alone, society doesn't view her a good women.*

For reasons pertinent to community context one of the interviewers stopped short of answering some highly sensitive questions especially with regards seeking family planning services. Even after being probed, one of the male participants rejected to give an answer. The question he was expected to answer was whether he would allow giving contraceptive or family planning services to a single male or female adolescent. He apologized for giving an outright answer to this question. This meant that traditional values had tremendously been influential in determining the way how people think. [Field notes; 01 December 2012]

In addition, two female participants despite of being educatedcould not make a direct eye contact with the researcherduring the interview. This indicates how women at all levels are subject to traditional and social sanctionsmaking them unable to express their feelings openly or give elaborated responses [Field Notes on 22 November 2012]. This is because men by culture and tradition of Afghan people tend to be family bread winners and thus have major role in decision making in house or within community to eclipse women role and have them be considered as second class citizens (Voice of Women Organization, n.d.).

### 3.1.2. Community reasoning the barriers accessibility

In all interviews conducted, a particular significance was narrated as community reasons in outright manner and both men and women stressed that health services are essential for keeping their families healthy, it has been consistently found from all interviews that poor economic situation --as a result of which families cannot afford transportation cost-- has been

regarded as an important barrier. This has been further worsened by long walking distances, and lack of proper roads and infrastructure. This has not only been a barrier for women but for men and adolescents too.

> *P (6): Yeah (…) some crucial barriers do exist against women's access apart from cultural barriers. For example, women cannot afford transportation, or have to walk long distances, or cannot travel without a male member*
> *P (7): There is one point (…). That is poverty. If services in the nearby clinic are not readily available for any good reasons, a man may also have problem in seeking services from a clinic located far away.*

Nevertheless, one interviewer stated that apart from economic problems, lack of awareness is another crucial barrier in accessing health services. Neither patient him/herself can understand nor does know her/his family members when health services should be sought.

> *P (9): I think only 20% of women and their mother-in-laws or other relatives will be aware of danger signs related to pregnancy*

> *P (1): [Although] I have seen that many women have awareness about danger signs. But (…) there are a lot of women from rural areas do not have awareness*

### 3.1.3. Women and decision making

The fact that women health has been negatively affected has been recognized in almost all interviews. They knew that community health committees should comprise females as their members have been created in order for women be promoted in decision making. In these forums, women and men could get together, discuss and exchange experiences. However, the two community members interviewees acknowledged that the number of female members in such forums are comparably less than that of male members

> *P (7): There is a community health committee around health facility in our area. It is has both male and female…It has a total 10 members which only[…] three of them females*

> *P (10): It is mixed… it has a total 9 members which only one of them is female*

In all interviews, it was found that women are so marginalized that they cannot go out without the permission of their husband or other family members. One interviews even said that apart from the husband's permission, endorsement of the mother-in-law is also required in some instances.

> *P: (7) Health-seeking behaviors are controlled by male members. Let me explain to you my own situation. I am living with my wife and child separately but next to my parents. I **gave permission to my wife** to go health facility for seeking services. Despite that she approached her mother-in-law for a second permission.*

> *P(1) Men (...) usually do not prevent women from accessing health services when they are really sick from health facilities (...) but [they] have to wait for men to be escorted to health facility located far from their house.*

## 3.2. Repercussion of Client engagement index

### 3.2.1. Types of services by Age & Sex

All interviewees , except the two community elders, stated that health services are delivered in accordance with the policy of the Afghan Ministry of Public Health which is the implementation of Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS). In line with these policies, services offered in all provinces have been similar, the quality of services being delivery has been perceived different though.

> *P(1) Yes (...) our clinic is basic health center. According to BPHS, we offer ante-natal, deliveries and post-natal services. We also offer family planning, health education and other services. We also offer general medical services in OPD section*

> *P(3): In our health facilities, all services are offered according to the Basic Package of Health Services which is comprised of seven components. But they vary from each level of health facilities. (comprehensive health centers, basic health centers, sub health centers).*

All interviewees stated services sought by women are all related to delivery, mother and child health care, immunization and family planning. All people interviewees mentioned provision of these types of services to female patients.

Male health seekers primarily seek Outpatient Department (OPD) services that are provided to them in form of medical interventions and health education.

> *P(1): To male (…) health education and OPD services are offered.*
>
> *P(4): Men usually come for the treatment of common diseases treated in Outpatient Department Services. They come for counseling in family planning. Moreover, they come for receiving treatment on tuberculosis and other common diseases*

Interviews with all people showed that these services do not represent different schemes for the adolescent boys and girls. Except that singles adolescents are stripped of receiving family planning and reproductive health services for cultural reasons.

### 3.2.2. Client Satisfaction about Services

Few participants stated that women usually shun seeking services because of the unavailability of female staff or unavailability round-the –clock quality services in HFs. Unavailability of quality services has been considered as another important barrier in accessing to health services especially by women for conducting deliveries.

> *P(9): Well(…) we do so by providing health education and importance of the problems they have. In fact, we tell them quality services would be available all the time when they approach.*
>
> *P (4): O:kay. We explain to them the benefits and dangers related to their problems and the importance of subsequent visit. More importantly, we seek the confidence of clients so that they would accept what they are told*

It was stated that when there is no female staff in a health facility, females will not feel privacy. In addition, it will not be possible to offer services to couples. Couples prefer to receive counseling and other services from a female staff only.

*P (7) Another obstacle is usually lack of female staff in clinics. I (…) feel ok if my wife is examined by a female doctor*

*P (10): (…) the only problem in accessing services by women is that most of the clinics do not have sufficient female doctors.*

## 3.3 Organizational behavior toward gender equity

### 3.3.1 Organizational Structure of NGOs providing services

Among the interviewed staff from all organizations, all stated that a male was the chief executive of their respective organizations. Only one participated stated his organization's deputy is female.

*P (5): Women have to work together with men as they need to have income for living. The deputy of our organization is female*

Interviews with all program level people showed that women should be an integral part of the structure of their organizations. However, the fact that male outnumber in each organization has been consistent in all provinces. The main reason stated for this was lack of education among women which is due to cultural traditions putting women severely in disadvantage.

### 3.3.2. NGO initiatives to expand gender mainstreaming

Overall, all five program level participants supported initiatives to promote gender mainstreaming and expressed they would have no problem to work in an environment or workplace where both men and women would work together. However, one participant did not tend to allow his female family member to work in an environment where both men and women work together.

*P(8): I have no problem to see men and women working together in the same environment, however, I will not allow my own female family member to work with men in the same office as they have to do their job at home.*

*P (4): To ensure men and women have access to services at an equal level, both men and women need to work shoulder on shoulder in the same office*

*P (3): We offer positive discrimination in hiring female staff. In addition, we train eligible literate girls as community midwives.*

The challenges presented by all participants were same. They all stated that lack of educated women has been the major problem toward gender mainstreaming. Aimed at promoting gender equality, they stated a sort of positive gender discrimination is being considered in staffing.

*P (8): Big challenge is low literacy among women, this itself leads to another challenge which is shortage of female staff in clinics and organizations*

*P (8) If we increase the education and literacy level of female, this would solve many of the problems*

### 3.4. Recommendations towards improved access

Almost all participants had very good suggestions for ensuring equitable access to health services. All participants stated that education of females and male could have crucial role in prevailing individual roles. All stated that providing health education and working through change agents such as religious leaders and community elders aimed at bringing positive change in the behavior of people especially related to women towards seeking health services. All participants stated that training community midwives has been effective strategy for improving access to health services by women which they suggested to suggest. One participant suggested that policies aimed at gender mainstreaming for improving access should be adopted in the context of Afghanistan and believed that policies in the western standards cannot work. Another participant stated that providing transportation services could also be effective in improving access.

*P (8) I think (..) one way is to increase the education level. (…) another thing is to increase the number of female staff (…) another most important thing is to consider strict privacy in clinics*

*P (3): If we increase the education and literacy level of female, this would solve many of the problems*

In summary, results of the research explained have been appropriate to the research question and intended objectives. The findings revealed specific factors such as related to culture, tradition, and religious as a result of which women were unfairly disadvantaged in Afghanistan. The research covered many aspects related to gender-related barriers. These findings could offer significant insight for shaping future policies aimed at providing equitable service provision.

# Chapter 4

## 4. Discussion, Conclusion & Recommendations

Aimed at understanding and exploring factors that are attributable to gender in regards to women's access to health services in Afghanistan, this qualitative research is offering a significant insight to drive actions at all levels –policy, service delivery and community in Afghan public health context. The findings of the research have been focused around four themes: (1) community context, (2) client engagement context, (3) organizational behavior; and (4) suggestion for the improvement of access.

This chapter will further describe the implications of these findings in connection with the current situation and what has already been available via similar studies conducted before. The chapter will also highlight strengths and weaknesses of the study and will include some lessons learned. The findings of the research chiefly cover the public health relevance of the topic. In addition, recommendations for next steps aimed at policy formulation by the Ministry of Public Health or conducting further research endeavors constitute integral part of this chapter.

### 4.1. Implications of the main findings

#### 4.1.1. Perception about service delivery

Exploring the perception of clients, health services providers and program managers, it was revealed that factors pertinent to traditional and culturally inherent traits are not the only significant barriers against women's access to health services. Yet there are certain other factors at health facility and program level i.e. quality of services provided, behavior of staff and commitment for mainstreaming gender at organization level that equally determine the level of access to health services as well as their quality.

Although community perception about gender-based role has improved significantly over the last 10 years but enormous challenges exists against women's to access health services compared to men. In all provinces it was noticed that both men and women are influenced by Afghan tradition. All participants stated that the reasons for a low percentage of couples coming for seeking services is not because they do not need services yetan major reason is traditional barriers which make men not to feel comfortable to accompany his wife and visit a clinic for couple counseling. This revelation as part of this research is in absolute contrast to Management of Health Science (2007) which states that reasons behind low level of

counseling is lack of courage in women in talking to their husbands or inability of convincing husbands to accompany them for couple counseling particularly for family planning use.

Very interestingly, as per the perception of community, a health facility may not be well utilized by female clients unless it has at least one female health worker. The abstinence from services of a clinic which is exclusively staffed by male only typically represents the inherent tradition of Afghan society where men do not feel comfortable his female family member be examined by a male health worker.

On a positive note, none of the participants –be it a community member, or clinician or manager- was against promotion of gender equality in health. The improvement in the social status ofwomen over the last 10 years is indication of this assertion. Nevertheless, on the contrary, almost all participants were not convinced that a complete gender mainstreaming in all aspects of life could be feasible in Afghan society.

**4.1.2. Client management at health service delivery**

Although lack of awareness, geographical, and socio-economic factor were narrated consistently by all participants as barriers but behavior of staff as part of client management efforts for health services was a significant factor in affecting delivery of health services to clients. Despite the interviewed clients did not mention it, the fact that good behavior toward clients is crucial was acknowledged by the selected clinical staff who were interviewed as part of this research.

The research found that displaying friendly attitude by staff towards client has highly been instrumental not only in enhancing utilization of services and access to them by clients particularly female but also been potentially effective in exploring the cases of violence against women when they refer to health facility for issues other than related to violence against them. The interview with one of the clinical staff, revealed that when a woman receives a passionate treatment from a female health worker, the client does not hesitate to tell the entire story around her health which is in turn effective in drawing a correct diagnosis and treatment.

This revelation is in line with the findings of Lachwinder et al (2012) who have stated that apart from less efficient and/or unavailability of services, lack of proper attitude and behavior

of health staff towards clients tremendously contributes to poor access and utilization of services by women in Afghanistan.

On the other hand, if all due barriers such as geographical, and economical problems are virtually managed; and the staff would display proper attitudes toward clients, the research found that some reservations in providing certain types of services to clients will still exist due to religo-cultural reasons. For example, for providing family planning and abortion services the client should meet certain conditions such as being married (for receiving family planning services) and concrete justification from criminal and justice department dominated by religion (for receiving abortion related services).

### 4.1.3. Organizational level commitment toward gender equality

The fact that interviewed program managers were not aware of Afghan national gender mainstreaming policies indicated that organizational commitment toward improving gender equality is not well-informed. Even, the statement of one participants implied that basic reforms to be applied in the existing polies as they have been designed by international advisors who have not been fully exposed to Afghan context and the involvement of national experts and community members from the grassroots level has been very limited.

Another implication acknowledging the fact that organizational commitment toward improving gender equality is sloppy is the lack or absolute unavailability of female staff in the organizations of the ones who were interviewed as part of this research. Furthermore the fact that community health committees comprised of community elders consisting of 10 members around each clinic at community level have insignificant number of female (8:2) clearly indicated that the decision making power lies with men and women are either not involved or marginally involved.

This revelation is in odds with Better Policies for Better Lives (n.d.) which stresses on mainstreaming of gender as a cooperative activity within organizations and not merely a game dominated by a single player.

Very astonishingly, although almost all interviewed did not mention any problem in men and wormen together, the research found there is still long way ahead. The responses of one program manager who did not express any problems with working with females in the same

organization but does not favor to have his own family member to co-work in an environment where male work further require research could substantiate the finding. However, the research could not reveal why a person, even highly educated, in Afghan context does not want his female family member to work in the same organization or workplace where men also work. As this was not the scope of this study, it truly necessitates conducting more specific and in-depth research to identify other hidden factors.

### 4.1.4. Recommendations towards improved access

All recommendations revealed by this research are somehow interrelated and were around the following three important areas:

1. Policy level
2. Expanding and improving education opportunities with a particular focus on girls
3. Improving quality of services through HFs

As per the interview with one of the participants, the reason why policies developed by the Afghan government have not yielded desired results is because they have been developed with the sole assistance of international advisors in which Afghan experts have either not been involved or have a limited and passive role. Thus they are not fully compatible with the culture and tradition of Afghan societies. This is an important point to note because it is exactly in line with the statements of Ventevogel, et al (2011) who state that the Afghan health policies particularly in health care should undergo extensive revisions based on the lessons learned. This is because current policies do not properly meet the health needs of people.

Another important recommendation was improving the education level of people particularly females. As lack of female staff was considered a major hindrance in accessing to health services by women, this barrier could be effectively resolved if the education level of women is comparable with that of male. Although Afghan Ministry of Public Health has recently started the program of training eligible literate candidates as community midwives (Afghan Midwives, n.d.) but the major challenge would still exist. The challenge is lack of girls with at least basic literacy skills. Thus, education should be promoted and a particular focus to be placed on girls education. Since it is outside the scope of the Ministry of Public Health, establishing a strong coordination with Ministry of Education is very important.

According to the interviews the quality of services has been greatly compromised because of lack of qualified staff who cannot maintain provision of services according to the needs of clients. This portrays that not only women would require advanced trainings but male health workers are also in need. One of the participants of the study stated that in order to promote quality of services, it would be useful to send master health trainers from the capital to staff of HFs located in rural areas who have limited opportunities for capacity building. This itself substantiate that both male and women health workers require extensive programs of capacity building which could result on promoting quality of services provided and ultimately enhancing access and utilization of services (WHO, 2006). This is while the study also found out that some men did not have reservations in sending their females to even a male doctor if they believe the doctor was qualified enough and could provide quality treatment.

## 4.2. Strengths and limitations of the study

### 4.2.1 Research design

The fact that in-depth interviews constituted the bulk of the methodology of this study, per se is considered as an important strength. This is because through in-depth interviews the researcher is in a better position to dig into getting the viewpoints of participants which could allow the research to draw conclusions based on exploring the settings where the study is conducted (Green and Thorogood, 2004). A value added to the strength of the methodology could be attributed to the fact that both researcher and participants shared similar socio-cultural traits putting the research in a position to exercise good skills in interaction with participants socially. The fact that research had deep understanding about the traditions, culture and characteristics of the geographical areas where the study was conducted, setting a comfortable environment where participants could freely express their views was a comfortable task for the researcher. Through this, research overcame to extract the viewpoints of all participants in a friendly and open atmosphere. In addition, the researcher and participants shared the same language and thus there was no need for translation. According to Green and Thorogood (2004), translation can sometimes lead to different interpretation. In the view of this, since there was no need for translation, this effectively ruled out the chances of misinterpretation as well as interference with the flow of interview making the probing a highly effective practice.

Nevertheless, the influence of a male researcher interviewing with female respondent in a traditional society like Afghanistan is acknowledged as a limitation of this study.

The influence of an outsider should be acknowledged as well. The fact that all female respondents were interviewed in presence of one of her close family members whom she could trust, there must have not been an optimized open environment she could have expressed her ideas freely. This is because traditionally and religiously it is not permitted that a male interviews a female without the presence of a third person –generally a male relative of the female participant.

Apart from that, limitations in non-verbal communication especially with female respondents could also be acknowledged in this study. This is because the male researcher did not only have to keep distance from the female respondent but also female respondent could not maintain a face to face eye contact with the male researcher due to cultural sanctions in Afghan society where men and women do not maintain direct social interactions in life.

The fact that I myself have had similar background and working experience with that of the program managers who were interviewed, this itself might have created potential bias towards the findings chiefly because of the researcher's curiosity about the issue. This simply meant that the researcher positionality had a significant influenced throughout the study. However, declaring a social constructionism epistemiological approach enabled the researcher to set a firm basis for conducting meaningful interviews in an interactive manner when participants felt comfortable in answering all questions. All interviews conducted as part of this study was focused on exploring the opinion of people at various levels i.e. program manager, client, health service provider in the social context of the target geographical locations of Afghanistan. By being curious on the topic and encouraging discussions during the interviews, an appropriate atmosphere was created to find out how issues related to gender affect access to health services particularly for females in Afghanistan. The discussions also focused to find out how corrective measures could be designed accordingly. To achieve this, participants were encouraged to share their own experiences. The response from participants was highly encouraging. Even one of the participants shared experience of his own family on his own wish.

The research did not have any issue with regards to any types of bias including recall. In addition all necessary measures including approval from the Institutional Review Board (IRB) were taken to take ethical issues into consideration and the researcher faced no major challenge.

### 4.2.2 Rigour

With regards to rigor in this research all cautions as highlighted by (Ryan, n.d.) have been taken into consideration. As advised by Ryan (n.d.), the researcher has strived rigor is not confused with measurement precision. Meanwhile, great caution has been exercised in claiming why the selected methodology for collecting data and analysis are more rigorous. In addition, certain limitations have been admitted and standards and rigors have not been associated with each other.

In the view of this, a systematic step-wise approach has been followed to ensure rigor of analysis. The fact that the researcher and participants shared the same language and all data received were accurately noted and full scripts were made including translations to the English language for cross-check and quality assurance purpose indicated that reliability of the research findings was strictly secured. The fact that the research was conducted by one person –same researcher-, itself was an important measure for ensuring reliability (Green and Thorogood, 2004).

Despite some limitations in assuring validity due to shortage of time, required measures were in place by giving sufficient description about research setting and validating the statements made by participants by themselves by repeating to them after each question. A validity check as advised by Green and Thorogood, 2004) could not be performed due to shortage of time. Through this, it would have been possible that the research findings were taken back to participants and a consensus was made on the outcomes.

### 4.2.3 Lessons Learned

A research of qualitative type was a favorable choice to complement the available insights about gender related factors in accessing healthcare services. It allowed to establish a good linkage between the knowledge and local context. Exploring the perception of participants as part of a social constructionist viewpoint has given further new insights on the topic. Although as per the nature of such studies, the findings could not be generalized to the entire population (Green and Thorogood, 2004), yet can be highly instrumental in guiding relevant actions at policy, service delivery and community levels.

The researcher has opted Thematic Content Analysis because only one person was involved in conducting the research–data collection, transcript development, analysis. Else, grounded theory approach could have been an alternative if more than one person were involved in this research. As per Leavy (2004), grounded theory approach is constitutes a set of strategies as part of induction strategy aimed at analyzing data. This approach is highly effective in giving a good structure and arrangements for data collection and analysis. The analysis is chiefly based on synthesis which leads to building theories as part of a theoretical analysis starting from individual experiences toward more conceptual elements about the topic.

Future studies on the topic needs to be in a larger scale by taking multiple methods of qualitative research such as focus group discussions, document reviews, etc. A mixed of methodology would be more exploratory as compared to in-depth interviews. According to the Science of Improving Lives (n.d.) discovery would have been explored if focus group discussion methodology were adopted which is now lacking as only IDIs were conducted.

As stated by Lisa et al (n.d.) to make sure the findings of a research reflect a true situation and are certain in nature, triangulation is required. Through researcher will be compelled to adopt consistency in data sources, and approach in undertaking the study. The triangulation should address data collection, investigator, theory, methodologies and environment where the study takes place. Nevertheless the fact that various category of people (community members, clinicians and program managers) were interviewed is considered a notable strength of the study which could be a lesson learned for conducting similar studies in future. Taking these multiple categories had the findings be more extensive representing a variety of insights.

### 4.3. Public Health Relevance

Afghan Government has established Afghanistan National Development Strategy (ANDS) which has been based on the Millennium Development Goals (MDGs). Gender-equity has been acknowledged as a cross-cutting issue in all achieving all goals as stipulated by ANDS. As per ANDs to be achieved by 2013, the priority interventions in all sectors including public have been highlighted. ANDs actually serve as a roadmap for all national level actions including efforts toward gender equity and improving mothers' health and reducing maternal mortality. Gender equality as an important goal of ANDS has been acknowledged as a cross

cutting issue in all aspects of life. ANDS promotes gender equity as an effective approach for reducing maternal mortality (ANDS, 2008).

In the view of this, the findings of this research have exactly been aligned with the efforts as guided by ANDS –the national level development efforts. This is because it explores role of gender in access to health services and how corrective actions could be taken to avoid due barriers in this regard.

## 4.5. Recommendations

Based on this study, a number of recommendations aimed at improving access to health services particularly by women through exploring factors related to gender, the following recommendations could be drawn:

### 4.5.1. Revision of the existing policies according to Afghan context

The existing policies need to be reviewed and examined how they are developed. If the involvements of Afghan experts have not been prominent, MOPH needs to establish taskforces comprised of Afghan experts to adjust them according to the lessons learned and changing context of Afghanistan.

An important feature of the policy revision should be inclusion of people from grassroots level especially female representative of community women groups representing women as potential beneficiaries. This infact is inline with the recommendation drawn by Dr. Shinwari (2009) who, based on his study findings, recommends that a strategy need to tackle different aspects of women/grils health.

### 4.5.2. Learning for Life Basic Literacy Programs

One of the crucial factors both impeding uptake and delivery of health services is lack of education and low literacy particularly among female. Many women cannot make decisions about their health because they are illiterate impeding their ccess to information materials. For the same reason, many HFs face problems in having feamel staff. Although working in education sector is solely beyond the scope of the MOPH, but effective coordination is needed between various stakeholders to explore short term and long term interventions aimed at increasing the literacy level of women. This will help creating a pool of female candidates

to be trained as community midwives. Dr. Shinwari (2009) based on his qualitative study also recommend increasing the women's education level.

### 4.5.3. Promoting Quality of Health Services

As per the revelation of this research, supply side factors restricting access to health services could be tackled by promoting quality of health services. This has direct relationship with mitigating gender-based barriers and utilization of services. In many instances, gender related barriers may not be significant if the qualities of services are up to the expectation of served communities. This is what Bernstein et al (2003) also acknowledges that low quality of services could lead to lower utilization of healthcare services.

### 4.5.4. Further Research

Although this study has explored many areas related to the role of gender in accessing health services, and certain recommendations and lessons learned have been drawn, further investigations are required. Although the research revealed that revision of policies, promoting quality of services and improving education level of girls and women is crucial for prevailing gender-based barriers, subsequent studies are needed to further explore how these recommendations could be materialized. An important feature of further researches would be to determine the effectiveness of the involvement of grassroots level community members in policy development and revision phase.

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# Appendixes

## Appendix 1. Outline Proposal

**Title:**

Exploring the effects of gender on women's' access to healthcare services in Afghanistan

**Introduction**:

According to WHO (n.d.), access to healthcare can be determined by factors such as gender differences and gender inequalities where gender mainstreaming is viewed as an important strategy for implementing successful and equitable health care programs. According to the UNWomen (n.d.),gender mainstreaming is a globally accepted strategy for promoting gender equality and involves ensuring that gender perspectives and attention to the goal of gender equality are central to all activities - policy development, research, advocacy/ dialogue, legislation, resource allocation, and planning, implementation and monitoring of programs and projects.This is particularly relevant in Afghan society where inequities in health tend to be gender biased especially the rural areas (NPR, 2012). It is essential therefore to understand that while poor health affects both women and men alike, there are specific gender-based inequities in Afghanistan that creates situations of health disparities between the sexes attributed significantly to gender roles (Word Bank, n.d.; Medina (n.d.). Indeed statistics highlight these gender based disparities where Afghan women in general experience lower level of premature death than men by a ratio of 104:100, while maternal mortality stands at 1600/100,000 live birth (Morgan, 2008). Literacy rates of female-to-male stands at 0.4 and school enrolment is pegged at 41.8% (for females) and 73.7% (for males); indices that are indicative of overall gender based inequities in Afghan society. These inequities are equally evident in human health resources. For instance, within health facilities, only 40% of health care facilities staff arefemale. Likewise, only 24% of health facilities have at least one female physician, female nurse and/or midwife (ibid.). Further, the gender development index (GDI) reflecting poor social and economic status of women is 0.310 which is highest in the world (InfoSeries, n.d.). All these represent huge disparities which could lead to gender-based inequities in access to services. Thus solutions to gender-based health-related inequities need to be re-examined and understood through a "gender based perspective" at different levels in society. Although programs exists in addressing gender-based inequities in health in Afghanistan (Kareemzada, n.d.), need still exist for health equity to be achieved through sound policy formulation (WHO, 2002). Efforts toward achieving this goal could significantly be enhanced through the involvement of male partners as part of an extensive cooperative and supportive environment for women (Sadeghipour, 2006).In order to improve health care access, service delivery systems may need to explore linkages with individuals at the policy level and with groups at the community level (Iwere, 2000). These strategies are crucial toward not only reducing overall poverty, but contribute toward achieving other MDGs targets (Grigorianconsultants, n.d.).

**Literature Review:**

Although there are some studies on how gender inequality affects access to health services in Afghanistan, none of them are similar to the proposed study. Moreover, a similar study conducted specifically on this topic in countries such as Uganda, Kenya, Malawi, and India illustrate variability in access to health services due to gender difference, suggesting that this is a consistent issue in developing countries (Silvester et al., 2005). This

study highlighted how access to treatment services of HIV/AIDs is affected by aspects of gender dimensions where gender based inequities tends to negatively affect women. This inequity exists because women are more vulnerable to poverty, lack education and are subjected to high levels of stigma (ibid). Further, a study by Amowitz et al (2003) showed that the prevalence of depression among women in Taliban-controlled areas in which women's movements was restricted compared to non-Taliban controlled areas shows that depression was 50% higher in the former region than the latter. Another study by Cardozo, et al, (2005) highlights a desperate need for addressing the mental health needs of women in Afghanistan where a huge gap exists in providing for sound evidence-based decision making at policy level. These studies indeed underscore the attribute of gender as an impediment toward meeting overall health equity goals especially between the sexes in the context of conservative societies such as that in Afghanistan. Therefore, considering the highlighted gender-based inequities in health outcome and access to health care in Afghanistan, need arises to understand salient gender based factors so as to enhance women's' equitable access to healthcare in Afghanistan.

**Aim**

The aim of the study is to identify gender-based factors which affect women's access to healthcare services in the context of Afghanistan in order to develop evidence-based policy actions at both local and national levels.

**Research Question**

How does gender affect women's access to healthcare services in Afghanistan?

**Objectives**: The specific objectives of the research are as following:

1. To review literature on current perspectives and practices pertaining to the gender-inequality and gender mainstreaming into health programmes in Afghanistan and other Islamic societies similar to Afghanistan.
2. To explore through in-depth semi-structured interviews how knowledge and understanding of the concepts of health care access and gender vary among different levels of staff within various health care organizations and across health facilities and communities in the 5 provinces in Afghanistan.
3. Using Thematic Content Analysis (TCA), to explore how knowledge and understanding of the concepts of health care access and gender vary across health facilities and communities of different regions in 5 provinces in Afghanistan.
4. To disseminate the findings of this study at the community and national levels to be used for legislation by the Ministry of Health to enhance equitable access of women to healthcare services.

**Epistemological Approach**

Interpretivism will be the epistemological approach adopted for the proposed study. As such, it will ensure that the data collected is a reflection of the ground realities in line with the subjective socially inherent accounts (Green and Thorogood, 2004). Through this, the varied experiences of key respondents about the issue under study will be crucial in revealing gender-related implications in relation to access to health services. Considering the nature of any qualitative research, this study will be underpinned by the rules of non-positivist epistemiologies (ibid). In addition, it will be made sure that the researcher's preconceptions and bias will become part of the study and made transparent via reflection (Mantzoukas, 2005). To ensure that the difference of gender, race, age, and beliefs about the topic between the researcher and respondents do not affect the data

collection process, interview guides will be employed using open ended questions and will ensure researcher role is confined to that of a facilitator.

**Positionality:** The study will be influenced by my personal socio-cultural and religious beliefs in terms of power imbalances due to my male gender status as well as my occupation (being as medical doctor). In addition, the fact that I come from an urban area, interviewing rural clients will impact on the research. To address this issue of my positionality in respect to the study, I will ensure rapport is established at the onset with stakeholders in the community and consider recruiting a female research assistant from the locale to ensure participation in the study, especially among female subjects.

**Methodology**

**Study Design and Rational for Choice of Methods:** This study is qualitative in design employing an exploratory research design which is best suited to explore 'how' related topics (Green & Thorogood, 2009).**Settings:** The data will be collected from 10 health facilities located in 5 zones in Kabul, Baghlan, Jalalabad, Herat and Daikundi provinces. In each zone one health facility will be from a rural area and another from that of urban (exact HFs will be randomly selected in consultation with stakeholders). NGO managers, MOPH provincial staff, and clinical supervisors will be interviewed in their offices. **Sample definition:** The study will be conducted in a manner that subjects of both genders from all ethnic groups notably the Pashtun, Tajik, Hazara, and Uzbeks, are recruited in line with exclusion/inclusion criteria. The study will involve 10 in-depth interviews (IDIs) with the following purposively sampled respondents: 2 program staff (1 man, 1 woman), 2 clinic staff (1 man, 1 woman), 3 clients (2 men, 1 woman), 3 elders (men only).**Inclusion/Exclusion criteria**: Those below 18 years of age, migrants from other countries, foreign workers, and individuals who decline to participate in study will not be included in the study. Only local residents (male and female above 18 years of age) in both rural and urban areas will be included in the study. **Recruitment:** The researcher will seek the assistance of NGO Managers and Ministry of Health (MoH) officials of these target provinces to provide a list of HFs staff, NGOs Supervisors, Provincial MOPH staff in the target zones. At all levels, recruitment will be made by actively searching for volunteers among clients of the selected HFs through word-of-mouth, ensuring that potential participants understand that participation is voluntary.**Data collection methods:** Semi-structured questions will be developed to guide the discussion. The interview will be audio recorded which will later transcribed for analysis purposes. A female translator may be involved to assist the researcher during interviews with female participants in order to enhance data collection. **Instruments:** Interview guide will be the main tool employed for collecting data.Interview guides will be designed in consultation with relevant stakeholders and appropriately used while being sensitive to the socio-cultural contexts of the participants **Field Testing:** The interview guides will be pre-tested with 2 participants (one health professional and a female client). Modifications to the interview questions will be undertaken based on the outcome of the pilot. **Analytic Approach:** As highlighted by Woods (2006), the research will compile all transcripts of interviews and notes during interviews sessions. Thematic Content Analysis (TCA) will be employed to analyse data which will coded and categorized into emerging themes to elicit communality in responses across participants (Anderson, n.d.).

**Ethics**

Fully respecting the rights of every participant, all collected data will be secured and locked for at least 5 years. Anonymity the participants will be ensured in the analysis by the use of identity codes or pseudonyms, and ensure informed consent prior to participation (Connolly, 2003). To abide by cultural norms, the researcher will involve a female translator/facilitator who will assist in conducting interviews with female participants. To ensure compliance, close relatives of female clients (mother-in-law, son, etc.) will be allowed during the interview sessions so as to adhere with cultural norms and enhance the comfort of female respondents. To comply with local level ethical obligations, the researcher will approach specific organizations to gain letters of consent for recruitment. Informed consent forms will be used to ensure voluntary participation. Ethical approval will equally be obtained from the UoL Ethics Committee.

**The research outcomes**

An understanding of the determinants of access to quality of health care will provide a scope to improve the practice at community level. It will also influence future policy decisions to ensure equitable distribution of health services among men and women. In general, girls/women will benefit from the findings.

**Timeline**: Approval of the Proposal – end of April; Ethic approval/Literature Review – May; Developing questionnaires, field testing and Literature Review – end of May; Data Collection – June; Data Cleaning/Analysis & Finding Development – July; Draft Dissertation August; Final Submission – September

**Cost**: This will be a self-sponsored activity. The budget is expected to cover participants' transport cost (USD 1,000), female assistant/facilitator, stationery and translation services ($1,000) and $ 100 dissemination.

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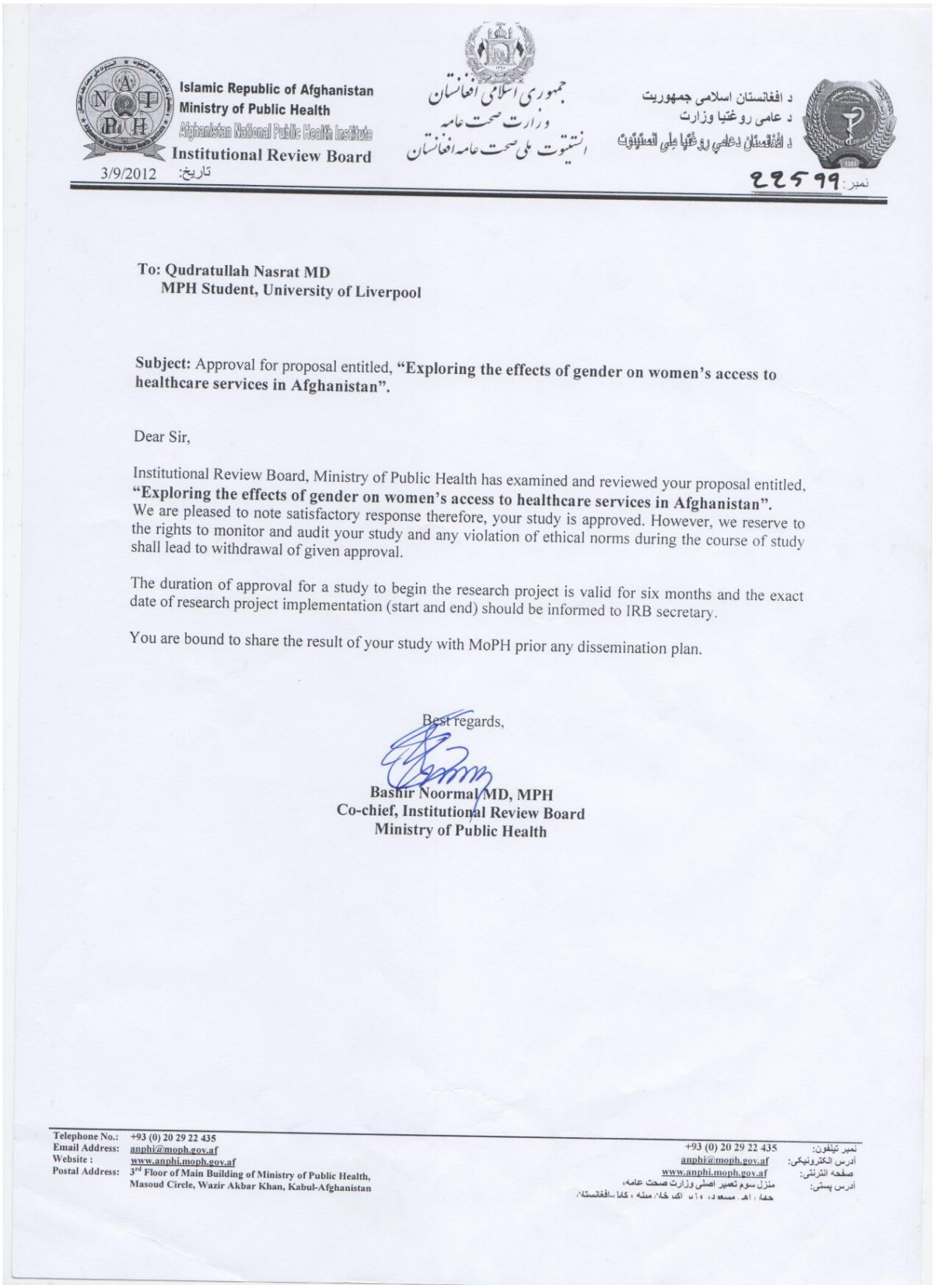
## Appendix 2: Ethical Local Approval from Institutional Review Board (IRB),



Islamic Republic of Afghanistan
Ministry of Public Health
Afghanistan National Public Health Institute
Institutional Review Board

جمهوری اسلامی افغانستان
وزارت صحت عامه
انستیتوت ملی صحت عامه افغانستان

د افغانستان اسلامی جمهوریت
د عامی روغتیا وزارت
د افغانستان د عامي روغتيا ملي انستيتوت

تاریخ: 3/9/2012

نمبر: ۲۲۵۹۹

**To: Qudratullah Nasrat MD**
**MPH Student, University of Liverpool**

**Subject:** Approval for proposal entitled, **"Exploring the effects of gender on women's access to healthcare services in Afghanistan".**

Dear Sir,

Institutional Review Board, Ministry of Public Health has examined and reviewed your proposal entitled, **"Exploring the effects of gender on women's access to healthcare services in Afghanistan".** We are pleased to note satisfactory response therefore, your study is approved. However, we reserve to the rights to monitor and audit your study and any violation of ethical norms during the course of study shall lead to withdrawal of given approval.

The duration of approval for a study to begin the research project is valid for six months and the exact date of research project implementation (start and end) should be informed to IRB secretary.

You are bound to share the result of your study with MoPH prior any dissemination plan.

Best regards,

**Bashir Noormal MD, MPH**
**Co-chief, Institutional Review Board**
**Ministry of Public Health**

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جنب اداره مسعود، وزیر اکبر خان، منطقه، کابل-افغانستان

## Appendix 3. Ethical Approval University of Liverpool

**Subject :** Dissertation Proposal Approved

**Date :** Fri, Apr 27, 2012 12:49 AM CEST

**From :** **Jane Earland <jane.earland@my.ohecampus.com>**

**To :** Qudratullah Nasrat <nasrat.nasrat@my.ohecampus.com>

**CC :** Robert Bishop <Robert.Bishop@ohecampus.com>, Satwinder Rehal <satwinder.rehal@my.ohecampus.com>, Jane Earland <jane.earland@my.ohecampus.com>

Dear Qudratullah,

I am happy to inform you that your dissertation proposal has been approved and
I would like to confirm to you that your final submission date for your dissertation is 28 Oct 2012.

Your Dissertation Advisor Satwinder Rehal is in class to provide you with advice and guidance, but the responsibility for the content of your dissertation and your ability to meet this goal is yours.

On behalf of Laureate Online Education and The University of Liverpool I would like to wish you every success in this challenging part of your studies.

Kind regards,

On behalf of the Director of Online Studies

StudentID: 15522896

## Appendix 4: Interview Schedules/Guides

**INTERVIEW SCHEDULE**
**Project: Exploring the effects of gender on women's access to healthcare services in Afghanistan**

**INTERVIEW DETAIL**

Participant Code #:

Site: Day: Date:

Interview start time:
Interview end time:

participant informATION

- Male:
- Female:
- Age [age bracket]:
- Occupation:
- Household family size:
- Income range [option]:
- Organization [for organization respondents only]:
- [Note if the respondent is representing an NGO, MoPH, community or private clinic]
    - Position/job title
    - Years in service

**GUIDING QUESTIONS**

**a. SERVICE ORGANIZATION**

1. This project seeks to explore the effects of gender on women's access to healthcare services in Afghanistan. For a start, what are the key health challenges women or females in the country experience?

2. Are these gender based challenges to accessing healthcare explicitly acknowledged in national policies?

3. How are these challenges being addressed at the national and or local levels?

4. If not, why are these challenges not being adequately addressed?

5. According your opinion, what do you think is needed to address the above challenges?

6. Would you say that being a woman or female has an effect in accessing healthcare services in Afghanistan? If yes, please comprehensively describe these effects.

7. How can health services and the system consider improving healthcare access to women?

8. What do you think is needed to meet the gaps in seeking health care among women? ie. How best can the gaps be addressed and meet the MDG target at the least for the country?

9. What is your opinion on 'gender mainstreaming'? How if at all is this applicable to the Afghani context?

10. What do your opinion regarding gender mainstreaming for health?

11. Does Afghanistan have a policy on gender mainstreaming for health? If yes, what are stipulated therein?

12. If not, should Afghanistan adopt this framework for increasing access to healthcare among women? If yes, how? If not, why not?

13. What services are provided within your program/health facility?

14. Approximately how many clients does your health facility see per week?

15. Do you serve both women and men? If not, why?

16. Approximately what percentage of your clients are:
Female _____% Male _____%
17. What is the youngest age of your female clients?

18. What is the youngest age of your male clients? *(If men are served)*

19. Approximately what percentage of couples comes to the clinic together for services?

20. What services do you offer couples?

21. Do they [couples] come together when seeking services? If separate, why?

22. What issues are of concern in serving couples and how do you address them? If there are gaps in services, how can these be served better in the Afghanistan context?

23. Do you serve adolescent girls (ages 10-18)? If yes, what specific services? If not, why not? Are there conditions to serving adolescent girls e.g. have to be married, or accompanied by an elder etc?

24. What issues are of concern in serving adolescent girls and how do you address them? If there are gaps in services, how can these be served better in the Afghanistan context?

25. Do you serve adolescent boys (ages 10-18)? If yes, what specific services? If not, why not? Are there conditions to serving adolescent boysls e.g. have to be married, or accompanied by an elder etc?

26. What issues are of concern in serving adolescent boys and how do you address them? If there are gaps in services, how can these be served better in the Afghanistan context?

27. Do you employ an engendered environment at the workplace/organization? If yes, how has gender mainstreaming being incorporated within the organization. If not why not?

28. How is the organization enhancing access to healthcare services among women/females?

29. If at all, what are the challenges the organization faces in providing a gender mainstreamed access to health care services?

30. Lastly, how can the organization improve providing a gender mainstreamed access to health care services?

**b. INTERVIEW GUIDE (Service Delivery)**

***NOTE: Modify the following questions according to the range of clients at the clinic/served by the program, e.g. female, male, adolescents, couples)***

1. What services do your female clients primarily seek?

2. What services do your male clients primarily seek?

3. What services do your adolescent clients primarily seek?

4. What services do couples that come to the clinic/health center together primarily seek?

5. Have there been any instances in this clinic that a man insists on accompanying his wife/partner throughout the clinic visit? If so, what is the clinic/health facility's policy on males accompanying their wives/partners throughout the clinic visit?

*6.* How would you rank—as high, good or in need of improvement—the quality of the services provided by your program/health facility *1) voluntary choice of contraceptives by clients, 2) information provided, 3) client-provider interactions, 3) technical competence of providers, 4) acceptability of services to clients, and 5) continuing care for clients?*

*7.* In counseling, do you or other staff in your health facility ask **female and male** clients about: *(probe: if yes, what is asked and how?)*

   a. Their relationship with their partner or partners that may bear upon contraceptive or STD-related decisions?
   b. Their risk of contracting a sexually transmitted infection?
   c. Their ability to negotiate condom use with their partner?
   d. Their ability to negotiate other contraceptive use with their partner?
   e. Their ability to care for themselves (e.g. nutrition, micronutrients) during pregnancy
   f. Their ability to seek care in pregnancy (e.g. prenatal care, a plan for having a skilled attendant at the birth) and ability to pay for services and supplies (e.g., contraceptives, vitamins and antibiotics)
   g. Their experience of threat of violence or abuse (for men: their use of violence or abuse against their partner)?

8. Are pregnant women, husbands, and mother-in-laws aware of danger signs for pregnant women?

9. In counseling, do you have visual materials? If yes, do you use them for counseling clients?

10. How do you encourage the clients to make return visits for follow ups?

11. Do you explain everything related to the chosen option of care? How do you ensure that the client understands?

12. In the case of violence, do you or your staff look for outward signs that a woman has been the victim of emotional/psychological abuse or physical violence?

*13.* What do you or your program do if a client notes a problem in any of these areas (see items a-f in the previous question)? *(Probes: services within the program or health facility or referral to other programs or health facilities, subsidized or free services and supplies for those who cannot afford them?)*

14. Are there specific things that you do now or have done recently to improve the quality of your services for women? For men? For adolescents?

15. Are there specific things that you do to make your services more accessible to women? To men? To adolescents? *(Probes: different hours; different space, such as latrines and waiting/exam rooms; different providers; subsidized or free services and supplies; outreach services to those who cannot come to the facility).*

16. When thinking about the future, what are your suggestions for improving the quality of and access to services for women? Men? Adolescents?

### c. COMMUNITY INTERVIEW GUIDE

Please think about the community that is served by this program/health facility. I would like to ask you some questions about the community and positions of men and women in this community.

Describe what men and women do in the community. For example, what type of work do men and women do? What do men and women do in the household? What roles do women and men play in community leadership?

Other than physical differences, what are the three most important differences between what men and women can do in the community? *(probe: making decisions about resources such as money and land or other decisions in the household or about children's schooling or heathcare, ability to move around outside of the home?)*

Have there been any changes in men's and women's roles and activities over the past 10 years? If so, what types of changes have taken place between men and women in the community?

Are there any obstacles in the community that affect women's access to the services of your program/health facility *(probe for access: geographic, economic, psychosocial)?*

How are health-seeking behaviors controlled in the household? Who are the male and female gatekeepers? Who makes decisions about female patient's body and health needs (e.g. herself, family members, health personnel, etc)?

*(If applicable for men)* Are there any obstacles in the community that affect men's access to the services of your program/health facility *(probes for access: geographic, economic, psychosocial)?*

*(If applicable for adolescents)* Are there any obstacles in the community that affect adolescents' access to the services of your program/health facility *(probes for access: geographic, economic, psychosocial)?*

Is there a health community at the health facility level? At health post/community level? If yes, what kind? Male only?Female only? Mixed? Please explain why (if no female community). If mixed, what is the percentage of women in the mixed community? Are the communitys functioning? If not, why?

How does a female CHW communicate with a male-only Community? How does a female-only communicate communicate with a male-only community?

## Annex 5: Participant Informed Consent Form

UNIVERSITY OF LIVERPOOL

**INFORMED CONSENT FORM FOR RESEARCH STUDIES**

**Title of Research Project:** Exploring the effects of gender on women's' access to healthcare services in Afghanistan

**Researcher(s):** Qudratullah Nasrat

| | **Please initial box** |
|---|---|
| 1. I confirm that I have read and have understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | ☐ |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. | ☐ |
| 3. I understand that, under the UK's Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish. | ☐ |
| 4. I understand that I will not be identified or identifiable in any report subsequently produced by the researcher | ☐ |
| 5. I accept that taking part in an study intervention is voluntary and confirm that any risks associated with this have been explained to me | ☐ |
| 6. I agree to take part in the above study. | ☐ |
| 7. I agree to having the interview/focus group digitally recorded | ☐ |

| Participant Name | Date | Signature |
|---|---|---|
| _____ | _____ | _____ |
| Name of Person taking consent | Date | Signature |
| Qudratullah Nasrat | | |
| _____ | _____ | _____ |

Researcher Date Signature

**The contact details of lead Researcher (Principal Investigator) are:**

House 326, Hammam Steet, Karta –e Parwan, Kabul, Afghanistan; Phone:+93 (0) 799217125;
qnasrat@gmail.com

## Appendix 6: Illustration of Interviews

**Transcript notation**
'R' stands for researcher, 'I' for interpreter and 'P' for participant
Text in *italics* in 2nd column is a translation
(…) pauses
Text in **bold** stressed words/phrases
O:kay (colon in word) prolonged word
{ } researcher's description and annotations
[ ] overlapping speech

**5. Client engagement context**
Example of Participant 9

| | Original Verbatim | Translated Verbatim | Coding |
|---|---|---|---|
| I | Ba clinic kei shuma kar maikonaid, murajeen unas braai kudam khedamat mayaad | *What services women seek from your health facility?* | 2.1.2 |
| P | Balai a (…) dar clinic e ma ziadatar madara wa atfal as. (…) qabl az weladat, weladat, bad az wledat, family planning, talimat sehe, wa dar bakhsh sarapa nez khedamat arza meshod. | *Yes (…) our clinic is basic health center. We offer ante-natal, deliveries and post-natal services. We also offer family planning, health education and other services. We also offer general medical services in OPD section* | |
| I | Marda braai che murajea maikona? | *What service men seek from your health facility?* | 2.1.2 |
| P | Ba marda (….) talimat sehe dada meshod, wa sarapa arza meshod. | *To male (…) health education and OPD services are offered.* | |
| I | Nawajawan bakhater kodam khedamat murajea maikona | *What services do adolescent seek?* | 2.1.3. |
| P | Ma kho omomi najawana talimat sehe medadaim, baz baz ba shoba e marbuta eshan refer maikrdaim, (…) agar nurse e mardana nabasha (…) khedamat pansman nez arza maikonaim | *We offer health education to all including adolescents. Then we are referring them to the relevant deptt according to their need (…) even if male nurse is unavailable we offer dressing services to adolescents* | |
| I | Kudam khedamat e ast kai bari couple arza maigrdad | *What services are offered to couples?* | 2.2.1. |
| P | Ba couple (…) ham khedamat ejra maikoniam. Masalan khedamat family planning dar hazor dasht mard o zan da **mahramiat** anjam medaim. (…) hatta ma shwhar hai shan nez yagan waqt ejaza metaim ki dar waqt waladat hazar basha | *To couples, we also offer services. For example, family planning services are offered to both wife and husband in a private environment. Even we sometimes allow husbands to be present during delivery with their wives* | |

| | | | |
|---|---|---|---|
| I | Aya shuma kodam wakht dedaid ke yak mard besiar pafeshari bekonad kai ba hamrai khanum khod dar jerian visit mawjod basha. Baz policy e clinic e shuma che ast dar maured en hadisat chest? | *Have there been any instances in this clinic that a man insists on accompanying his wife/partner throughout the clinic visit? If so, what is the clinic/health facility's policy on males accompanying their wives/partners throughout the clinic visit?* | 3.2.1 |
| P | Bala:y (…) ma sanad esh darm. Ma ejaza maidadam ba shawharaish. Chun ma course gender ra gereftaim policy ma ejaza maidad ke anha ra dar jerian e visit banaim hamra ba khanam hai shan | *Yeah. I have documented such incidences. As I had received training on gender awareness, I usually allowed the husbands of women to be present during visit and deliveries* | |
| I | Shuma kaifiat arza khedamat e sehe ra tawasot clinic tan (dar ertebat ba entekhab e agahana method hai family planning, dadan malomat, danesh takhneki karmandan, qaboliat e khedamat tawasot murajia konindagan way taqeeb khedamat) chitor arziabee maikonain? | *How would you rank—as high, good or in need of improvement—the quality of the services provided by your program/health facility 1) voluntary choice of contraceptives by clients, 2) information provided, 3) client-provider interactions, 3) technical competence of providers, 4) acceptability of services to clients, and 5) continuing care for clients?* | 2.2. |
| P | Khedamat clinic e ma besiar khob ast (..) clinic ma **model** as ke markaz amoz bari dega clinica bod. Dar har arsa besiar khob bod | *The services of our health facilities are very high quality as it is a model clinic. And is a center for other people to come and learn from here.* | |
| I | Kodam khedamat ra ba couple arza mekonain. | *Which services are offered to couples?* | 2.2.1 |
| P | Khedamat e ke ba couple arza megardad (…) omdatan family planning mebasha, wa (…) hamchunan mashort dar mured amraz e zahrwei ast | *Services that are usually offered to couples are related to family planning. And, meanwhile, counseling to couples is another major part of the services offered to couples* | |
| I | Aya khanum hai hamila ra y shawhar e shan, ya khoshi hai shan, da maured khatarat hamilagi agahi daran? | *Are pregnant women, husbands, and mother-in-laws aware of danger signs for pregnant women?* | 3.1.2 |
| P | Bali agahi daran (…) {chand fesad agahi darad} wala ma kho darinja 7 sal kar mekonam, ziataresh agahi | *Yeah. They have awareness (…) {how much percentage?} I have been working in this area for the last 7* | |

| | | | |
|---|---|---|---|
| | dara. Besiar kam mardum astan ke agahi nadaran (…) anha aksaran az dehat mebasha | *years, [Although] I have seen that many women have awareness about danger signs. But (…) there are a lot of women from rural areas do not have awareness* | |
| I | Ba manzoor mashawaret ya arza e khedamat shoma az wasil basarai ham estefada maikonain? | *In counseling, do you have visual materials?* | 1.3.3. |
| P | Balai (..) amin kaghaza chart ha wa postar ha dashtaim chi ax eshan neshan medadaim | *Yes, we had charts, posters which we are using during counseling* | |
| I | Shuma chito marizan ra bari visit badi tashweq mainkonain? | *How do you encourage the clients to make return visits for follow ups* | 3.2.2 |
| P | On ha ra maigoim ke (…) darwaza e clinic baz ast (…) {kho dega che?} dawa metaim, (**rawia e khob** mekonaim), talimat medadaim, (…) mahramiat eshan ra nega maikradaim. | *We are telling them that the door of clinic is open to you {what else?} we are demonstrating good behavior, we give health education, (…) we also strictly maintain privacy.* | |
| I | Aya shuma dar maured har method family planning ke murajee anra entekhab mekona, malomat kafee metain? Wa baz chito mutmaeen maishain ke anha fahmedan? | *Do you explain everything related to the chosen option of care? How do you ensure that the client understands?* | 3.2.2 |
| P | Dar maured har method malomat kafi medadaim (..) dar dafter e ma 1 takhta ast tamam method ha model haish daronja ast. Ba:z ekhtiar ra ba onha metaim ke kodam esh ra entekhab kona. | *About every method, we give them information (..) in my office there is a board containing all samples of family planning. Then they were allowed which method to choose.* | |
| I | Dar sorat e khoshonat, shuma ya kodam staff e shuma alaim mashhood khoshonat ra dar khanom hai ke murajia mekonan mebainaid? | *In the case of violence, do you or your staff look for outward signs that a woman has been the victim of emotional/psychological abuse or physical violence?* | 2.2.3 |
| P | Ba:lay (…) yak mareezam bodam, hamela dar (…) ma ke rawia e khob kardam (…) o raz e del khod hamraim kard (…) wa jai ra neshan dad ke az sabb khoshonat az taraf e shwhar shuda bod. | *Yeah (…) I had a client which was pregnant. She came for counseling; but when I displayed good behavior with her, she told me of the violence done against her by her husband. We did so by displaying sympathy and good* | |

| | | | |
|---|---|---|---|
| | | *behavior* | |
| I | Shuma ya edarai clinic e shuma che mekonad dar sorateki kodam murajia koninda kodam mushkel ra dar khedamat bebenad? | *What do you or your program do if a client notes a problem in any of these related to health service delivery?* | |
| P | Baz dafter ra dar jerian metaim (…) walai (…) dar clinic e ma eto mushkel kam mibasha. | *We put the supervisor assigned by office in the picture (...) but such problems are very rare in our clinic* | |
| I | Darinawakher clinic che kar ha ra anjam dada aid? | *Are there specific things that you do now or have done recently to improve the quality of your services for women? For men? For adolescents?* | 3.2.1 |
| P | (…) ma bakhatari azenke khedamat jami shwad ma dar maured arza khedamat rawani nez tawajo kardaim | *(...) our clinic did not have mental health services. We recently started offering mental health services by our health facility* | |
| I | Aya eto kar hai mushakhas ra anjam medehaind ke dastrasi ba khedamat tawasod marda, khanam ha, ya nawajawan ziat shwa. | *Are there specific things that you do to make your services more accessible to women? To men? To adolescents?* | 3.2.1. |
| P | (…) ma kho dar bakhsh e khod tauri sakhta bodain ke taman e khedamat ra yakjai megereftand | *Aimed at helping women, I did my best that every women client receive services at one time rather than making queues for receiving different type of services* | |
| I | Kodam pishnehad braai behbod khedamat darain? | *When thinking about the future, what are your suggestions for improving the quality of and access to services for women? Men? Adolescents?* | 3.2.1 |
| P | (…) ba nazar em (…) clinic aga ambulance dashta basha, besiar khob mesha. | *We suggest a vehicle is provided to our clinic to be used as ambulance* | |