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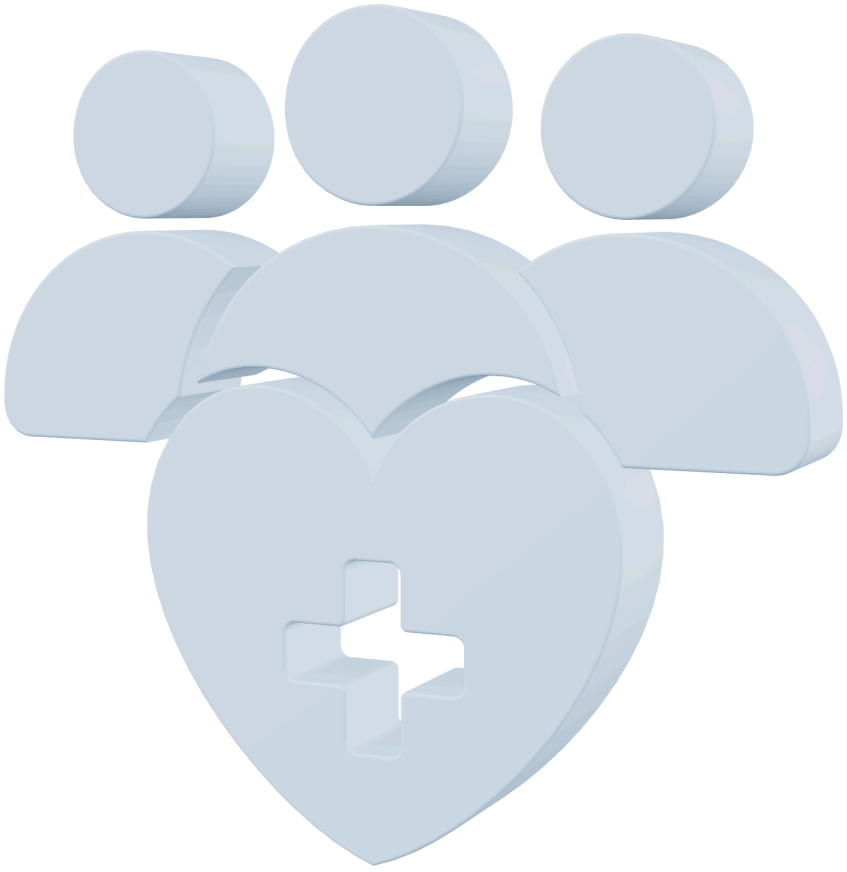
Norwegian Red Cross

# 2025

# Needs Assessment and Outcome Monitoring

## In Health Facilities Across 14 Provinces of Afghanistan



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# Executive Summary

The Afghan Red Crescent Society (ARCS), established in 1934, remains the largest humanitarian actor in Afghanistan, with a nationwide network of seven regional offices and 34 branches. Supported by the Norwegian Red Cross since 2002, ARCS currently manages 96 health facilities—including one district hospital, 46 basic health centers, 28 sub-health centers, 11 mobile health teams, and several vaccination posts—providing critical primary healthcare across the country.

Food insecurity remains severe: 3.5 million children under five are acutely malnourished, including 867,000 with severe acute malnutrition, while 1.2 million pregnant and lactating women face nutritional deficiencies. In provinces such as Badakhshan, Balkh, Ghor, and Nangarhar, food insecurity is classified at IPC Phase 3 (Serious). Overall, 28% of the population, 12.4 million Afghans, face acute food insecurity.

Protection risks are also widespread. Women and girls remain highly vulnerable to early marriage, gender-based violence, and exclusion from public services. Households resort to negative coping strategies, including child labor, migration, and debt. Climate shocks, droughts, floods, and deforestation, further compound vulnerabilities, with 25,000 families affected by floods in 2024 alone.

Despite these challenges, ARCS and other humanitarian partners provide life-saving assistance. Mobile health teams, cash transfers, and community-based services continue to reach vulnerable households. Yet, the humanitarian response remains underfunded, with only 16% of the 2024 appeal covered. Without increased resources and gender-sensitive programming, Afghanistan's most vulnerable populations will remain trapped in cycles of crisis.

***Demographic Overview:*** Norwegian Red Cross in collaboration with Afghanistan Red Cresent Society (ARCS/National Society – NS) conducted Needs Assessment and Impact Monitoring May-June 2025. The assessment covers 14 districts across seven regions, combining 1,680 household surveys, 28 focus group discussions, and 42 key informant interviews. Findings reveal a health system under immense strain. Nationwide, Afghanistan has only 4.6 doctors, nurses, or midwives per 10,000 people. Rural areas face extreme shortages of female health workers, and restrictions on women's education and aid work sharply limit access to care, particularly for women and children. The assessment provides a detailed snapshot of household demographics and living conditions across 14 districts. The findings highlight a population that is large, youthful, and highly vulnerable. The total sample includes 1,816 individuals, with a gender distribution of 60% male and 39% female, while less than 1% identify otherwise. The age profile is overwhelmingly dominated by 25-35 years, with children and adolescents negligibly represented.

Education levels remain low across surveyed areas. Illiteracy is widespread, reflecting decades of conflict and systemic exclusion from schooling. 61% of respondents have no formal education, while only 20% have primary level education. The educational gap directly affects livelihoods, household resilience, and access to health services.

Household sizes vary widely, ranging from small units of 4–5 members to extended families with 12 members. The average household consists of seven individuals, underscoring the strain on already limited resources. Female-headed households are present in all districts, though their proportion remains low. Decision making in vast majority of households rests with men, as 80% - 99% households are male-headed (by decision making)

The assessment also shows an overall displacement of 18%. Mazar Sharif indicates the highest displacement (40%) followed by Jalalabad (38%), Tarinkot (32%), Qalat (32%), and Taimaskan (KBL, 24%), potentially due to Conflict, natural disasters, or economic collapse, indicating increased vulnerability, with families losing access to land, stable shelter, and community safety nets.

Disability prevalence in surveyed districts is low but uneven: visual impairment affects 1–4%, highest in Mazar Sharif (4%); hearing impairment 1% overall, peaking at 4% in Mazar Sharif; physical disability 2%, with 5% in Faiz Abad; and intellectual/learning disability 1%, highest in Ferozkoh (2%). These rates contrast sharply with the 2019 Model Disability Survey (The Asia Foundation), which found approximately one-fourth (24.6%) suffer from mild disability, while almost half (40.4%) have moderate levels and 13.9% are estimated to have severe disabilities. Pregnant and lactating women make up 4% of survey population, with Ferozkoh highest (7%) and Jalalabad lowest (1%). Key informant interviews (KIIs) stress that disabled women, elderly women, and PLW face compounded vulnerabilities, worsened by cultural norms and lack of gender-sensitive health services.

Households across surveyed districts face deep financial strain, earning on average USD 106 but spending USD 151, leaving a 45% deficit corresponding to the national shortfall of USD 48 (UNDP 2022). Districts such as Dandona (143% deficit), Ferozkoh, and Ab Qamari (89% each) are under the most pressure. Debt is widespread as 33% of households report high debt and another 33% medium debt, with Gardiz, Ali Abad, and Tarinkot showing over 40% high debt prevalence. Coping strategies are severe, with 40–50% of households selling assets, peaking at 70% in Tarinkot and 68% in Dandona. Families also report child labor (57%), early marriage (42%), and distress migration, particularly from Ab Qamari. These findings show systemic poverty and reliance on negative coping mechanisms, underscoring the urgent need for cash support, debt relief, and livelihood recovery programs.

The assessment presents a comprehensive picture of healthcare access, maternal and child health, nutrition, referral systems, and overall satisfaction with services across 14 districts of Afghanistan. Quantitative evidence from households, combined with qualitative data, reveals systemic weaknesses, financial barriers, and gendered constraints that undermine the delivery of equitable healthcare. Healthcare access remains inconsistent and unequal. While most districts report on the existence of health facilities, the majority of households find these services out of reach. As a result, self-treatment and reliance on informal providers are common. Households report frequent recourse to self-medication or traditional healers, particularly when the costs of travel and consultation are too high. This exposes vulnerable populations to risks from unregulated care, inappropriate dosages, and delayed treatment for serious conditions.

Nutrition is a critical concern. Among surveyed households, 76% of eligible children are enrolled in nutrition programs indicating significant access to nutrition services. High enrollment suggests that the nutrition programs are functioning effectively in the surveyed districts.

Child immunization data shows some encouraging, yet uneven, gains (83% fully vaccinated). However, such gains are disproportionately higher than Afghanistan's national immunization statistics (42.6%, UNICEF). Among those not fully vaccinated, 68% of children reportedly received measles vaccines and 79% complete the DPT3 series. However, in districts with limited outreach, coverage falls below 60%. Gaps in coverage leave thousands of children vulnerable to preventable diseases, especially in provinces already facing high malnutrition and weak immunity.

71% of respondents report accessing ARCS/NS health facilities suggesting strong operational presence in the districts. The referral and ambulance system are one of the weakest parts of the healthcare chain. Only 41% of households report having access to ambulance services. Even where ambulances are technically available, 57% of users describe frequent delays or the need to pay out-of-pocket for fuel, drivers, or unofficial charges. In districts like Uruzgan and Badakhshan, ambulance availability drops below 25%, leaving communities without reliable emergency care.

Families often turn to private vehicles or rented transport during emergencies, incurring costs that can exceed a household's monthly income. This practice not only delays care but also imposes crippling financial burdens. In maternal emergencies, these delays can mean the difference between life and death.

Nevertheless, serious concerns persist. 47% of respondents complain about medicine shortages, while 39% emphasize the absence of female staff as a critical barrier. The shortage of diagnostic tools, laboratory facilities, and essential drugs also affects community trust in sustained treatment outcomes. Households appreciate ARCS's presence but recognize that services in some areas need improvements.

***Health Services:*** The evidence points to a healthcare system under strain. Structural weaknesses (distance, unaffordability, workforce gaps, and weak referrals) prevent the system from serving the most vulnerable. Gender-specific barriers, particularly the absence of female providers, exacerbate maternal and child health challenges.

At the same time, ARCS facilities demonstrate resilience and community value. Despite systemic constraints, ARCS-supported health facilities enjoy significant trust and appreciation. 98% of households express satisfaction with services provided. 90% of households feel safe, suggesting a strong sense of security at ARCS facilities. This highlights the critical role of ARCS in maintaining a fragile healthcare lifeline. Mobile health teams, health camps, and vaccination posts are particularly valued, as they extend services into otherwise unreachable communities. The high satisfaction rates indicate that communities recognize ARCS as a lifeline, despite limitations. To strengthen outcomes, investments are needed in:

- Expanding the number and training of female health professionals.
- Scaling up nutrition and therapeutic feeding programs.
- Improving ambulance coverage and referral networks, especially in rural districts.
- Ensuring reliable medicine and supply chains.

***Health and Protection:*** The assessment highlights serious protection risks facing communities across the 14 districts, with women, children, people with disabilities, and internally displaced persons (IDPs) most affected. Households report high exposure to violence, restrictions on rights, and limited access to protective services.

While protection remains a major concern as secondary evidence shows certain community groups experience or at high risk of various kinds of violence, only 16% of households report experiencing or observing any kind of violence. 69% reporting no violence experience or observation indicates underreporting ue to stigma, fear, cultural sensitivities about disclosing such information. 57% of respondents view ARCS health staff as capable of handling violence cases. 32% of respondents express their unawareness about such capability. Women and younger girls, followed by elderly persona and younger boys, appear as most at risk of violence and community FGDs confirm GBV as major concern as well.

Overall, 48% of respondents express awareness about providing feedback to the ARCS/NS, whereas 36% are unaware. This highlights the need for two-way communication and visibility of feedback mechanisms.

The findings paint a stark picture of protection deficits across surveyed districts. Gender-based violence, child labor, and forced displacement converge to erode community resilience, while the absence of formal reporting systems leaves survivors without recourse. Addressing these issues

requires strengthening local protection mechanisms, expanding child protection programs, and ensuring targeted support for women and people with disabilities.

***Health and Climate Change:*** The assessment finds that communities across the 14 districts are highly aware of climate change impacts, with 97% of respondents noticing shifts in weather patterns. The most common perceptions include rising temperatures (60%), more frequent extreme weather events (55%), and altered rainfall patterns (48%).

Communities also connect climate change directly to health. 73% of respondents believe climate change has a "high" or "very high" impact on household health, with concerns highest in Ab Qamari (99%) and Ferozkoh (94%). Reported impacts include increased disease outbreaks, drought-related illnesses, and disruptions to health services. Looking ahead, 71% expect climate change to have very high or high impacts on health in the future, underlining widespread concern about worsening conditions.

These findings suggest an urgent need for climate-resilient health programming, including localized risk communication, disaster preparedness in high-risk areas, and integration of climate-health data into national systems. Without such measures, climate stressors threaten to deepen existing health vulnerabilities and overwhelm fragile local systems.

***Health and Cash Assistance:*** The assessment finds that humanitarian assistance plays a crucial role in sustaining communities across the 14 districts, but access and adequacy remain uneven. Overall, fewer households (16%) report receiving cash assistance monthly or occasionally mainly from UN agencies followed by the I/NGOs. ARCS/NS assistance is reported by 13% of respondents, while government social protections schemes cover only 11% assistance. The average amount received by the respondents is USD 136. Communities express concern over the adequacy and timeliness of assistance. 10% of recipients state that aid covers their needs persistently, while 50% state meeting their needs partially. 36% say it meets their needs rarely or does not meet their needs at all. This indicates economic vulnerability of surveyed districts. Food, clothing, health, transportation, and WASH are among the frequently unmet needs of the household. Delays in delivery, limited coverage in remote districts, and insufficient quantities remain recurring challenges. For example, districts such as Ab Qamari and Ferozkoh record the lowest satisfaction levels, with over 40% of households reporting that aid arrives late or inconsistently.

Equity in aid distribution also emerges as a concern. Vulnerable groups such as widows, people with disabilities, and displaced households report lower levels of access compared to others in their communities.

At the same time, communities emphasize the importance of ARCS's role in bridging gaps where state services are absent. 84% of households are satisfied and recognize ARCS assistance as vital

for their survival, particularly in remote areas where government presence is weak. However, expectations for greater consistency and expanded coverage remain strong.

In summary, while humanitarian aid provides lifelines, it remains insufficient to address widespread needs. Strengthening delivery systems, ensuring timely and equitable distribution, and prioritizing vulnerable groups are critical steps to improving the effectiveness and fairness of humanitarian programming.

The assessment highlights wide disparities across the 14 surveyed districts in health access, economic well-being, protection, and climate-related vulnerabilities. While progress is evident in some areas, systemic gaps remain deep, particularly for women, children, and marginalized groups.

***Key Trends and Recommendations:*** Access to health services is relatively strong, with 93% of households reporting the presence of mobile or fixed facilities. Yet, this masks sharp inequities. Jalalabad, Qalat, and Faiz Abad enjoy high coverage, but Jaghato and Tarinkot lag significantly, with only 45% and 54% coverage respectively. Although 98% of respondents express satisfaction with ARCS-supported care, problems such as long wait times and lack of medicines persist in Ali Abad, Mazar Sharif, and Taimaskan. Encouragingly, nearly 90% of users feel safe accessing services, though women in districts like Faiz Abad (BDK) express lower perceptions of safety.

Economic vulnerability is acute. In Dandona, Ferozkoh, and Ab Qamari, households face income deficits ranging from 89% to 143%, driving widespread negative coping strategies: 57% report child labor, 42% early marriage, and up to 70% asset sales in Tarinkot. Despite this, only 3% of households receive regular monthly aid, while 30% access occasional assistance. Across communities, 75% prefer cash-based support, with near-universal preference in urban districts like Jalalabad and Mazar Sharif, while more vulnerable districts lean toward in-kind aid.

National nutrition and child health indicators are concerning. However, in ARCS program districts, out of 3,459 children under five, 76% of eligible children are enrolled in nutrition programs. By districts, the enrollment rate varies across districts such as Faizabad (99%), Qalat (94%), Mazar Sharif, Faiz Abad (BDK), Tarinkot, and Dandona also reflect high enrollment such as 71% - 89%. Districts some districts show moderate enrollment i.e. 51-66%. Lowest enrollment (36%) revealed in only one district (Ab Qamari). like Aliabad (66%), Gardiz (61%), Jalalabad (59%), with moderate enrollment. Disparity among districts may be attributed to a combination of logistical constraints, such as limited health workforce capacity or irregular supply chains, and softer barriers like lack of awareness, caregiver misconceptions, or community hesitancy to engage with formal services. These areas reflect a scenario where programs are established but may require deeper penetration into hard-to-reach zones or marginalized groups.

Protection risks are pronounced. Women are identified as the most vulnerable group in 39% of cases, followed by young girls (23%). Violence is reported against both communities and health workers, with Faiz Abad (BDK), Ali Abad, and Gardiz standing out as hotspots. Over 30% of respondents confirm the absence of any protection services, leaving many without recourse.

Climate impacts exacerbate these vulnerabilities. In high-altitude or drought-prone districts such as Ferozkoh and Ab Qamari, over 90% believe climate change severely affects their health, compared to far lower awareness in Qalat and Taimaskan. With 71% anticipating worsening future health impacts, communities demand stronger integration of climate and health responses.

Finally, access to markets is uneven. While 40% report full access to essentials, in districts like Jaghato, Shotol, and Ferozkoh over 80% of households travel more than 30 minutes to reach markets, burdening women, elderly, and disabled groups.

Overall, the findings reveal a stark duality: while satisfaction with health services is broadly high, inequities in access, economic fragility, weak protection systems, and climate risks continue to drive vulnerability. Targeted interventions are urgently needed in underserved districts, with an emphasis on equitable health, protection, and livelihood support.

# 1. Introduction

Afghan Red Crescent Society (ARCS), established in 1934, has developed into the largest humanitarian organization in Afghanistan. With (7) Seven regional offices and 34 provincial branches throughout the country.

ARCS carry out numerous interventions all over the country using their community volunteers and staff to reach those most vulnerable among the underserved and displaced communities.

- Healthcare service provision
- Disaster Risk Reduction and Management
- Healthcare in Danger (HCiD) and Safer Access Framework (SAF)
- Dignified Burials
- *Marastoon*s program

Since 2002, Norwegian Red Cross (NoRC) continues to be an important partner of the ARCS. NoRC has been supporting the ARCS programs in the areas of Health, medical Logistics, WASH, and financial development, through multilateral and bilateral working arrangements. NoRC started to scale up ARCS's primary healthcare program in 2022, this response occurred at a time when the country was facing one of the worst humanitarian crises in its living history. The aim of this primary healthcare response of NoRC was to support the National Society to increase the delivery of primary healthcare service delivery, particularly reaching the most remote areas where healthcare services were already weak before the crisis. Currently, NoRC assists ARCS to provide primary healthcare services by supporting 96 HFs including 1 District hospital (DH), 46 Basic Health Centers (BHCs), 28 Sub Health Centers (SHCs), 11 Mobile Health Teams (MHTs) 7 Health Camps and 4 Vaccination Posts.

# 2. Purpose of Assessment, Timeframe, Thematic Areas Covered, Target area, and Key Population Groups

The NoRC, in collaboration with ARCS, conducted a comprehensive needs assessment and outcome monitoring across seven regions and 14 provinces of Afghanistan. The targeted provinces include Kabul, Panjshir, Paktiya, Ghazni, Kunar, Nangarhar, Mazar Sharif, Jawzjan, Badakhshan, Kunduz, Badghis, Ghor, Zabul, and Urozgan.

The assessment employed both qualitative and quantitative data collection methods. It involved 1,680 surveys with community members, 28 FGDs with male and female community members, and 42 KIIs, comprising 14 with heads of health facilities, 14 with National Society public health focal points, and 14 with community leaders, amounting to a total of 1,750 data collection points.

The primary objective of this assessment is to gather and document data on the needs of affected populations in the specified locations. The findings will offer valuable insights into the local context and humanitarian needs while providing key recommendations. This evidence-based approach is intended to support informed decision-making and contribute to the effective design and implementation of future programs.

# 3. Humanitarian Context of Selected Districts

This section provides a thematic overview of humanitarian conditions in 14 Afghan districts using province-level data where district-level data is unavailable. The analysis includes healthcare, nutrition, protection (including gender), economic conditions, climate-induced risks, and humanitarian assistance. Districts have been matched with their corresponding provinces to ensure accurate contextual representation.

## 3.1. Health Access and Healthcare Infrastructure

Afghanistan's healthcare system continues to suffer from decades of conflict, underfunding, and political instability. While major cities such as Mazar Sharif (Balkh Province) and Jalalabad (Nangarhar Province) benefit from relatively developed healthcare infrastructure including regional hospitals and referral systems, the situation is drastically different in rural provinces like Ghor (Ferozkoh, Jaghato), Badghis (Ab Qamari), and Uruzgan (Tarinkot). In these areas, healthcare access is severely limited due to poor road connectivity, ongoing conflict, and the absence of trained medical staff—particularly female health workers.

Despite urban advantages, facilities such as Mazar Sharif Regional Hospital struggle to cover operational costs including staff salaries, medicine procurement, and oxygen supply due to diminishing donor funding and administrative hurdles, illustrating how even urban centers are under stress.[1]In rural provinces, the scarcity of skilled birth attendants, sometimes under 5 per 10,000 population, amplifies risks: for instance, Badghis Province has seen safe birth attendance rates stagnate in the mid-teens while access to clean water plummeted to between 1–15% over recent years. Compounding that, Afghanistan currently has one of the lowest densities of health workers in the Eastern Mediterranean region, with just around 4.6 doctors, nurses, or midwives per 10,000—far below international thresholds.[2]

The 2024 nationwide ban on women's medical education further exacerbated the health crisis for women and children, who are culturally restricted from seeking care from male practitioners. In provinces like Ghor, humanitarian partners managed to provide reproductive and maternal health services to over 7,600 individuals but needs remain significantly unmet.[3]

[1] Doctors Without Borders, https://www.doctorswithoutborders.org/latest/dying-reach-health-care-afghanistan?utm_source=chatgpt.com
[2] https://en.wikipedia.org/wiki/Health_in_Afghanistan?utm_source=chatgpt.com
[3] https://en.wikipedia.org/wiki/Healthcare_in_Afghanistan?utm_source=chatgpt.com

## 3.2. Nutrition and Food Security

Widespread malnutrition remains one of the most critical humanitarian concerns in Afghanistan. As of mid-2024, over 3.5 million children under five suffer from acute malnutrition, including nearly 867,000 with severe acute malnutrition (SAM). Additionally, over 1.2 million pregnant and lactating women face acute nutritional deficiencies.[4]

Provinces like Badakhshan (Faiz Abad), Balkh (Mazar Sharif), Ghor (Ferozkoh), and Nangarhar (Jalalabad) are disproportionately affected and are classified under IPC Phase 3 (Serious), indicating alarming levels of food insecurity.[5]

Nationally, Afghanistan scored 30.8 on the 2024 Global Hunger Index—placing it among the world's most severely hunger-stricken countries.[6] Moreover, Save the Children highlights that nearly 6.5 million children are facing crisis or emergency levels of hunger in 2024, with about 28% of the population, 12.4 million people, experiencing acute food insecurity.[7] Despite the presence of over 3,300 operational nutrition sites between January and June 2024, only 41% of the target for child malnutrition treatment and 52% for pregnant and lactating women was achieved, showing a significant shortfall in outreach or capacity.[8]

## 3.3. Protection and Gender Dynamics

Protection and gender dynamics in Afghanistan have sharply deteriorated, especially since the resurgence of restrictions on female mobility, employment, and access to education. In provinces such as Uruzgan, Badghis, and Paktia (Gardiz), enforcement of traditional gender norms has resulted in the near-complete exclusion of women from public life. Female-headed households are particularly vulnerable, lacking both community protection mechanisms and institutional support.

In displacement hotspots such as Balkh, Jalalabad, and Tarinkot, protection risks escalate with the breakdown of traditional safety nets. Protection actors have also warned that policies curtailing female aid workers severely limit reach of essential services for women and girls, exacerbating the risks of gender-based violence, child marriage, and psychosocial distress.[9]

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[4] https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_Afghanistan_Acute_Malnutrition_June2024_May2025_Report.pdf?utm_source=chatgpt.com

[5] https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_Afghanistan_Acute_Malnutrition_June2024_May2025_Report.pdf?utm_source=chatgpt.com

[6] https://www.globalhungerindex.org/pdf/en/2024/Afghanistan.pdf?utm_source=chatgpt.com

[7] https://apnews.com/article/91a1e7550711f32bb37c9de187a3423d?utm_source=chatgpt.com

[8] https://www.unicef.org/media/159801/file/Afghanistan-Humanitarian-SitRep-Mid-Year-2024.pdf?utm_source=chatgpt.com

[9] https://en.wikipedia.org/wiki/Persecution_of_Hazaras?utm_source=chatgpt.com

## 3.4. Economic Conditions and Livelihoods

Economic conditions across the selected provinces are marked by fragility and limited diversification. In rural regions such as Ab Qamari (Badghis), Dandona (Panjshir), and Jaghato (Ghazni), subsistence farming and livestock rearing are the primary means of livelihood, but these sectors are highly vulnerable to drought, disease, and market fluctuations. While inflation has seen deflation in food prices recently, it has not translated to improved purchasing power, as unemployment and low wages remain debilitating.[10]

In urban and peri-urban centers like Mazar Sharif and Jalalabad, although opportunities for trade and informal labor exist, economic activity remains stunted. Households increasingly resort to negative coping strategies such as child labor, debt, and meal reductions—decisions that erode future resilience and entrench poverty.[11]

## 3.5. Climate-Induced Risks and Environmental Challenges

Climate-induced risks are now one of the primary drivers of humanitarian need in Afghanistan. The country faces chronic exposure to droughts, flash floods, and extreme temperature variations, affecting both rural livelihoods and urban infrastructure. In 2024, floods impacted more than 25,000 families nationwide, with heavy casualties and destruction reported in Badakhshan (Faiz Abad) and Ghor (Ferozkoh).[12] Conflict-induced deforestation has compounded these environmental shocks, creating a cycle of degradation and disaster that continues to harm rural communities, especially in provinces like Badghis and Ghor.[13] Declining groundwater levels across Kabul and surrounding districts like Taimaskan and Dandona further accentuate these vulnerabilities, undermining essential water access for both households and agriculture.[14]

**Humanitarian Assistance and Ongoing Response**

Humanitarian assistance remains critical for over 23 million Afghans in 2025, representing more than half the national population. Key actors—including UN OCHA, Action Against Hunger, and the ICRC—continue to deliver essential services in provinces such as Balkh, Ghor, Badakhshan, and Nangarhar. However, these efforts face significant constraints, including movement restrictions, funding shortages, and security risks. Only about 16% of the 2024 humanitarian

[10] https://en.wikipedia.org/wiki/Badghis_Province?utm_source=chatgpt.com
[11] https://www.ecoi.net/en/file/local/2115677/Info%2Brequest_Afghanistan%2B2024.pdf?utm_source=chatgpt.com
[12] https://www.msf.org/critical-gaps-paediatric-and-neonatal-care-afghanistan%E2%80%99s-northern-provinces?utm_source=chatgpt.com
[13] https://en.wikipedia.org/wiki/2020_Afghanistan_flood?utm_source=chatgpt.com
[14] https://en.wikipedia.org/wiki/2020_Afghanistan_flood?utm_source=chatgpt.com

response plan funding has been secured.[15] The exclusion of female aid workers has diminished service reach and quality, particularly for women and girls.

Despite these challenges, innovative solutions such as mobile health teams, digital cash transfers, and community-based service points have shown promise in reaching vulnerable populations, signaling pathways for maintaining humanitarian delivery under restrictive conditions.[16]

[15] https://apnews.com/article/91a1e7550711f32bb37c9de187a3423d?utm_source=chatgpt.com

[16] ECOI.nehttps://www.ecoi.net/en/file/local/2115677/Info%2Brequest_Afghanistan%2B2024.pdf?utm_source=chatgpt.comt+1

# 4. Methodology and Sampling Approach

The Norwegian Red Cross (NoRC) conducted a comprehensive needs assessment and outcome monitoring survey across seven regions of Afghanistan (Center, Central South East, East, North, North East, West, and South), covering 14 provinces: Kabul, Panjshir, Paktiya, Ghazni, Kunar, Nangarhar, Mazar-e-Sharif, Jawzjan, Badakhshan, Kunduz, Badghis, Ghor, Zabul, and Urozgan.

Using mixed methods approach, qualitative and quantitative techniques were used for the assessment. A structured household survey questionnaire was developed and uploaded to Kobo Toolbox, allowing ARCS staff and volunteers to gather data directly in the field using mobile phones and tablets. While key informant interviews and focus group discussions were also conducted.

Trained data collection teams engaged with community members, primarily those benefiting from health services, in several provinces using structured questionnaires to ensure consistency and reliability in data collection. Alongside the quantitative survey, focus group discussions (FGDs) and key informant interviews (KIIs) were also conducted, facilitated by experienced moderators with the support of note-takers, creating space for participants to share perspectives in depth. All data was gathered in local languages to ensure clarity and cultural sensitivity, then transcribed and translated into English to enable thorough analysis and interpretation.

Depending on access and security, participants were selected randomly. The collected data was securely uploaded to Kobo's server, then reviewed and analyzed using tools like Excel and SPSS. Throughout the process, the PMER team provided oversight to ensure data quality, while also making sure all ethical considerations, such as informed consent and confidentiality, were fully respected.

Data collection was carried out in different types of health facilities and respective communities including:

- District Hospitals (DH)
- Basic Health Centers (BHC)
- Sub Health Centers (SHC)
- Mobile Health Teams (MHT)

A mixed-method approach was applied using both quantitative and qualitative tools. The following standardized tools were employed:

1. Survey with Community Members: To capture perceptions, access, and satisfaction with health services.

2. Focus Group Discussions (FGDs) with Community Members: To obtain in-depth insights into community health needs, challenges, and service utilization.
3. Key Informant Interviews (KIIs) with:
    a. Heads of Health Facilities: To assess service capacity, gaps, and resource availability.
    b. National Society (NS) Public Health Focal Points: To understand coordination, oversight, and implementation aspects.
    c. Community Leaders: To explore community-level perspectives, cultural considerations, and barriers to healthcare access.

An analysis framework was first developed to guide the process, ensuring clarity in approach and consistency in application. Quantitative data collected through community surveys was carefully imported into statistical software, where it was subjected to both descriptive and comparative analysis to highlight trends, patterns and differences across groups and locations. At the same time, qualitative insights from FGDs and KIIs were systematically coded using thematic analysis, allowing the research team to capture nuanced trends, challenges, and community-driven recommendations. Finally, findings from both quantitative and qualitative sources were triangulated, strengthening the reliability and validity of the overall conclusions by cross-verifying evidence from multiple perspectives.

Before beginning data collection, informed consent was carefully obtained from all participants, ensuring they understood the purpose of the study and their voluntary involvement. Throughout the entire process, confidentiality and anonymity were strictly maintained to protect participants' identities and safeguard sensitive information. In addition, every stage of engagement was guided by cultural sensitivity and grounded in humanitarian principles, with particular attention to respecting community norms, traditions, and the dignity of respondents. This approach not only upheld ethical standards but also fostered trust between the research team and community members

## 4.1. Sampling

Household survey was conducted using a representative sample, whereas purposive sampling was used for qualitative approach. Purposive sampling was used to carefully select health facilities and participants, ensuring that the study captured perspectives across different regions and facility types. Within the communities, participants were chosen to reflect diversity in gender, age, and socio-economic background, allowing for a more comprehensive understanding of local realities. To respect cultural norms and encourage open dialogue, focus group discussions (FGDs) were organized separately for men and women in settings where this approach was most appropriate. Table-1 provides details of representative sampling summary by district.

*Table 1: Quantitative Survey Sample*

| District | Sample Per Area | % Representation | Maximum Margin of Error |
|---|---|---|---|
| Ab Qamari | 125 | 7% | 8.7% |
| Ali Abad | 121 | 7% | 8.9% |
| Dandona | 124 | 7% | 8.7% |
| Faiz Abad (BDK) | 239 | 13% | 6.3% |
| Ferozkoh | 126 | 7% | 8.7% |
| Gardiz | 136 | 7% | 8.4% |
| Jaghato | 130 | 7% | 8.6% |
| Jalalabad | 121 | 7% | 8.9% |
| Mazar Sharif | 122 | 7% | 8.9% |
| Qalat | 130 | 7% | 8.6% |
| Shotol | 138 | 8% | 8.3% |
| Taimaskan (KBL) | 153 | 8% | 7.9% |
| Tarinkot | 151 | 8% | 7.9% |
| **Aggregate** | **1,816** | **100%** | **2.3%** |

## 4.2. Limitations

While the needs assessment and outcome monitoring survey provided valuable insights, several limitations should be acknowledged:

- **Sampling Constraints:** Purposive sampling of health facilities and participants may have introduced selection bias, and findings may not be fully generalizable to all regions and populations.
- **Cultural Barriers:** Cultural sensitivities, particularly around engaging women in FGDs, posed constraints on data collection and may have influenced responses.
- **Response Bias:** As data was collected through interviews and discussions, some participants may have provided socially desirable answers rather than fully accurate reflections of their experiences.
- **Language and Translation Issues:** Data collected in local languages required translation into English, which may have led to minor loss of context or nuance.
- **Time and Resource Limitations:** Limited timeframes and resources constrained the depth of data collection and analysis, particularly for qualitative components.

# 5. Outcome Indicators

## 5.1. % of Targeted people with access to primary health care services

Among the 3,962 individuals who reported needing care, 2,883 (73%) received healthcare from a professional such as a doctor, nurse, or community health worker. This 73% service coverage highlights a moderately strong healthcare system response but still indicates that 27% of those in need did not receive appropriate care, primarily due to reliance on self-treatment, traditional remedies, or lack of access. Districts like Jaghato (45%) and Tarinkot (54%) had the lowest care access rates, suggesting operational and geographic challenges.

## 5.2. % of Targeted people satisfied with the quality of health care services received

Satisfaction with healthcare services was overwhelmingly positive. 98% of respondents reported some level of satisfaction with services received from ARCS/National Society facilities, 67% were highly satisfied, 26% satisfied, and 5% moderately satisfied. Only 1.5% of respondents expressed dissatisfaction, underscoring the trust and appreciation communities have for the services provided. Districts such as Jalalabad, Shotol, and Dandona reported the highest satisfaction levels, while Ali Abad and Mazar Sharif reflected comparatively lower satisfaction, mainly due to issues related to wait times, equipment, and staff professionalism.

## 5.3. ARCS/NS health facility utilization

When asked whether the facility visited was operated by the ARCS/National Society, 71% of respondents confirmed that their care was received from an ARCS-operated facility. However, 14% said no, and another 14% were unsure, which signals a need for improved visibility and branding of ARCS services in certain districts. Districts such as Ferozkoh, Tarinkot, and Ali Abad showed strong recognition of ARCS presence, whereas high “Don’t know” rates were observed in Mazar Sharif, Qalat, and Jaghato.

## 5.4. Aspects of ARCS/NS facility services that were dissatisfactory

Among the small number of respondents who were dissatisfied, the following aspects were most frequently cited:

- Distance to the facility – 17%
- Long waiting times – 14%
- Non-functional equipment – 11%
- Inconvenient opening hours – 10%

- Facility inaccessibility (e.g., lack of ramps) – 11%
- Quality of medication – 10%

These concerns were especially noted in Taimaskan (KBL), Mazar Sharif, and Ali Abad, indicating infrastructure and operational weaknesses in these areas.

## 5.5. % of healthcare facilities with climate adaptation measures Taken

In most areas, respondents noted that climate and health-related actions are not formally or visibly applied. Where actions do exist, they are either in the form of informational WhatsApp messages circulated by the Directorate of Information or part of trial programs in two northern provinces—Samangan and Faryab. Even these trial programs are not specifically climate-focused, but rather initiatives in health or disaster preparedness that tangentially relate to climate risks. Overall, there is no clear evidence of coordinated, standalone climate-health interventions being implemented on a scale. Furthermore, participants were generally unsure about whether the listed actions had been carried out in their respective areas, pointing to a lack of awareness, tracking, or visibility of such programs at the community level.

However, these initiatives remain experimental and limited in geographic and thematic scope. There is no direct implementation of standalone climate-health interventions. Health-related responses tend to occur reactively and are not explicitly labeled as climate actions, despite being triggered by climate-related events (e.g., heatwaves, floods). Participants did not demonstrate deep awareness of which climate-health actions were underway. This suggests that even when such programs exist, local communities may not recognize them as integrated climate-health interventions, pointing to a gap in community engagement and communication

Women's roles in community health and caregiving were not mentioned in relation to climate-health programming, revealing a missed opportunity for gender-inclusive design.

Any future rollout of climate-health actions should explicitly include female health workers and women community members. Tailored awareness campaigns should be created for women, particularly in remote and rural settings. Ensure climate-health indicators are disaggregated by gender, allowing proper monitoring of impacts on women and girls.

## 5.6. % of Targeted people aware of protection services available in the community

The data shows low awareness of protection services, with 30% of all respondents reporting that no protection services were available in their community. Key services like community centers, safe houses, legal aid, and women/girl-specific spaces were absent or scarcely available in most districts. Districts such as Shotol (70%), Ferozkoh (41%), Qalat (40%), and Tarinkot (50%) reported

the highest service gaps. Additionally, 11% of respondents answered “I don’t know,” reflecting poor visibility and communication around existing services.

## 5.7. % of Targeted people who reported feeling safe when accessing health services

A combined 89.9% of respondents felt either “very safe” or “safe” when accessing ARCS or National Society health services. Districts such as Shotol, Qalat, and Jalalabad reported the strongest safety perceptions. However, Taimaskan (KBL), Ali Abad, and Faiz Abad (BDK) had larger proportions reporting only “moderate safety,” suggesting localized security concerns or gender-related access issues that require follow-up.

## 5.8. % of Households who reported being able to meet their basic needs

Only 10% of households reported that they are “always” or “most of the time” able to meet their basic needs. 50% stated that they can meet their needs only “sometimes,” while 36% reported that they can “rarely” or “never” meet their needs. Districts with the highest levels of economic vulnerability include Dandona (78%), Tarinkot (79%), Ali Abad (66%), and Ferozkoh (67%). This high level of deprivation highlights the urgent need for expanded cash assistance and livelihoods support programs.

# 6. Demographic Overview

The dataset presents the gender breakdown of 1,816 respondents across 14 districts, disaggregated into male, female, other, and prefer not to answer categories.

Overall, the sample for the survey comprised 712 females (39%), 1,100 males (61%), 2 individuals who identified as 'other' (0.1%), and 2 who preferred not to answer (0.1%). This distribution reflects a male-dominated respondent pool, with males accounting for approximately 61% of the total surveyed population. Given that the survey covers health, cash, and protection themes, often impacting women differently, the underrepresentation of women may have implications for the reliability of gender-sensitive findings and should be addressed in future assessments.

Several districts had an overwhelming male majority, due contextual and cultural access limitations (see Table-2)

*Table 2: HH Survey Respondents by Sex*

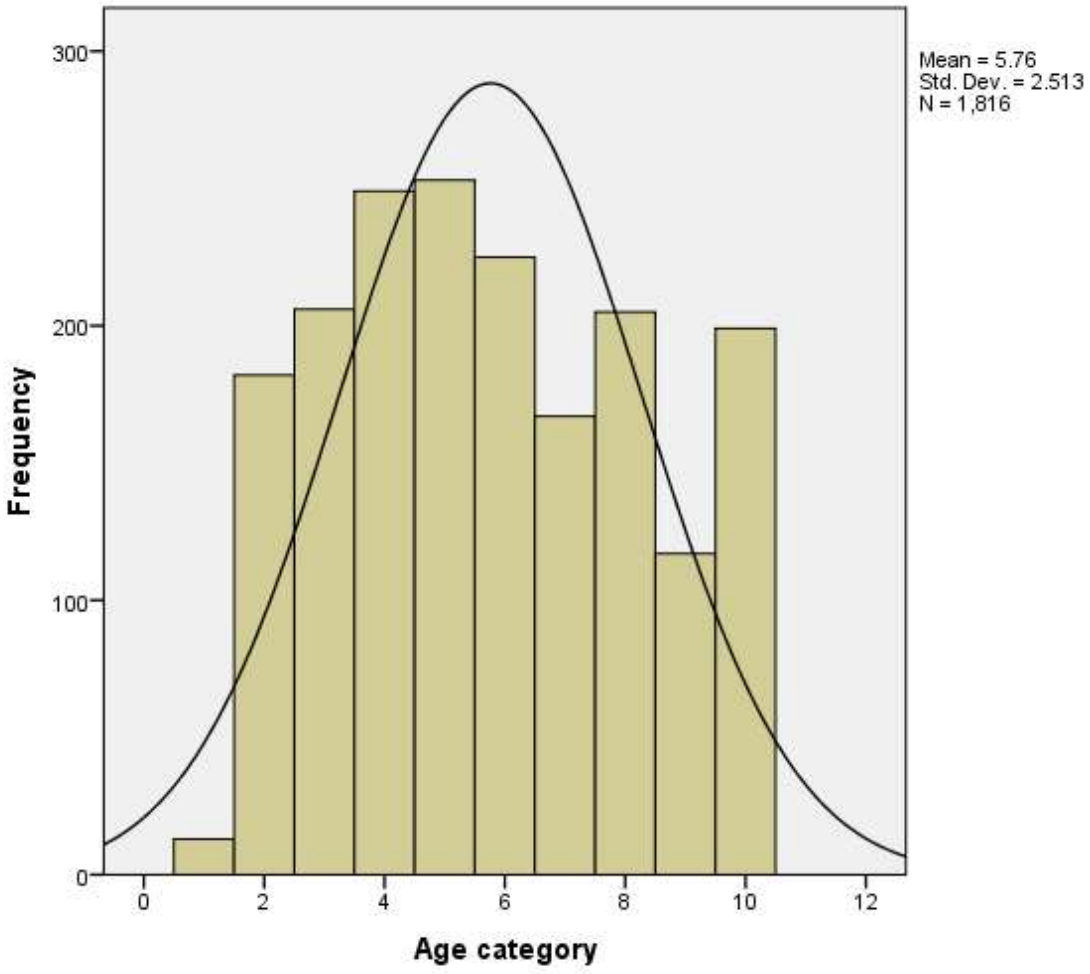
| District | Male | Female | Other | Prefer not to answer | Total |
|---|---|---|---|---|---|
| Faiz Abad | 65.5% | 33.6% | | 0.8% | 100% |
| Ab Qamari | 55.2% | 44.8% | | | 100% |
| Mazar Sharif | 65.6% | 33.6% | 0.8% | | 100% |
| Jaghato | 61.5% | 38.5% | | | 100% |
| Ferozkoh | 21.4% | 77.8% | 0.8% | | 100% |
| Faiz Abad | 70.8% | 29.2% | | | 100% |
| Taimaskan (KBL) | 62.1% | 37.9% | | | 100% |
| Dandona | 66.7% | 33.3% | | | 100% |
| Ali Abad | 67.8% | 32.2% | | | 100% |
| Jalalabad | 70.2% | 29.8% | | | 100% |
| Gardiz | 54.0% | 45.3% | | 0.7% | 100% |
| Shotol | 49.3% | 50.7% | | | 100% |
| Tarinkot | 73.5% | 26.5% | | | 100% |
| Qalat | 64.6% | 35.4% | | | 100% |
| **Aggregate** | **60.6%** | **39.2%** | **0.1%** | **0.1%** | **100%** |

Ferozkoh's high female representation could indicate a stronger presence of women-led households, possibly due to displacement, male migration, or better access for female enumerators. Shotol and Gardiz may have benefited from gender-sensitive enumeration practices.

Non-binary or confidential responses came from two individuals identified as “Other” (1 each from Mazar Sharif and Ferozkoh), and two identified as “Prefer not to answer” (1 each from Faiz Abad (BDK) and Gardiz).

## 6.1. Respondents' Age Group

Respondents' ages are grouped into ten categories (1-10) i.e., 16-17, 18–24, 25–30, 31–35, 36–40, 41–45, 46–50, 51–55, 56–60, and 60+ years. Following graph shows distribution of different people of these categories




The 16–17 age group is negligibly represented (<0.1%), suggesting very few adolescent youth/minors were included in the sample. The 60+ group ranges from 11% reflecting a moderate presence of elderly respondents. Mostly respondents lie between categories 4 and 5 of age (25-30,31-35) as shown in above histogram graph.

## 6.2. Respondents' Education Status

The educational profile of respondents is largely dominated by those with no or limited formal education. No Formal Education dominates with 61%, indicating a very low educational attainment across the sample population. Primary education follows at 20%, showing basic literacy is present but not widespread. Secondary education accounts for 11%, and university

degrees are only 3%, reflecting limited access to higher education. Vocational/technical training is minimal at 2%, suggesting a gap in practical skill development.

District-wise, Faiz Abad, Ab Qamari, Ferozkoh, Tarinkot, Qalat all report over 5% with no formal education, indicating severe education access issues. Mazar Sharif and Ali Abad show comparatively higher primary and secondary education rates. Taimaskan (KBL) stands out with diverse educational attainments, including the highest share of vocational training (1%) and university graduates (<1%). Gardiz has the highest "prefer not to answer" rate at 2%, possibly reflecting sensitivity or stigma.

The educational profile of the surveyed districts corresponds to national education patterns to a large extent. National statistics from multiple sources indicate No Formal Education 67%, Primary Education Completion 14%, Secondary Education Completion 13%,[17] University Level Education (Bachelor's or above, age 25+) 4%,[18] and Technical/Vocational Education (Secondary-level TVET) 0.7%.[19] Compared to these national statistics, the sample's No Formal Education rate (61%) is slightly lower, and Primary Education share (20%) is higher, suggesting better access to basic education in the surveyed areas during the time gap between two datasets. However, Secondary (11% vs. 13% nationally) and University attainment (3% vs. 4% nationally) are marginally lower, indicating continuing barriers to higher education. The sample's Vocational/Technical Training rate (2%) is above the national average, but both figures remain lowest. Overall, the sample appears broadly representative of the national education profile, with slight variations that may reflect local education access differences.

## 6.3. Household Size

The average household size across districts ranges from 6.5 to 12.1 members, indicating generally large family units. Dandona (12.1), Qalat (11.9), Jalalabad (11.4), Ali Abad (11.2) have the largest average household sizes, suggesting extended or joint family living arrangements are common. Faiz Abad (BDK), Jaghato, Ferozkoh, Tarinkot, Shotol have averages between 8.0 and 9.3, representing moderately large families. Mazar Sharif (6.5) and Taimaskan (7.4) report smaller household sizes, likely reflecting urban settings or nuclear family

*Table 3: Average HH Size*

| District | Household Size |
|---|---|
| Dandona | 12.1 |
| Qalat | 12 |
| Jalalabad | 11.4 |
| Ali Abad | 11.2 |
| Gardiz | 10.7 |
| Ferozkoh | 9.2 |
| Tarinkot | 9.2 |
| Faiz Abad | 9.1 |
| Jaghato | 9.0 |
| Faiz Abad | 8.9 |
| Shotol | 8.1 |
| Ab Qamari | 7.5 |
| Taimaskan (KBL) | 7.4 |
| Mazar Sharif | 6.5 |
| **Aggregate** | **9.4** |

[17] Afghanistan DHS (2015).
[18] CEIC Educational Attainment Data for Afghanistan (2022).
[19] UNESCO UNEVOC Country Profile Data for Afghanistan.

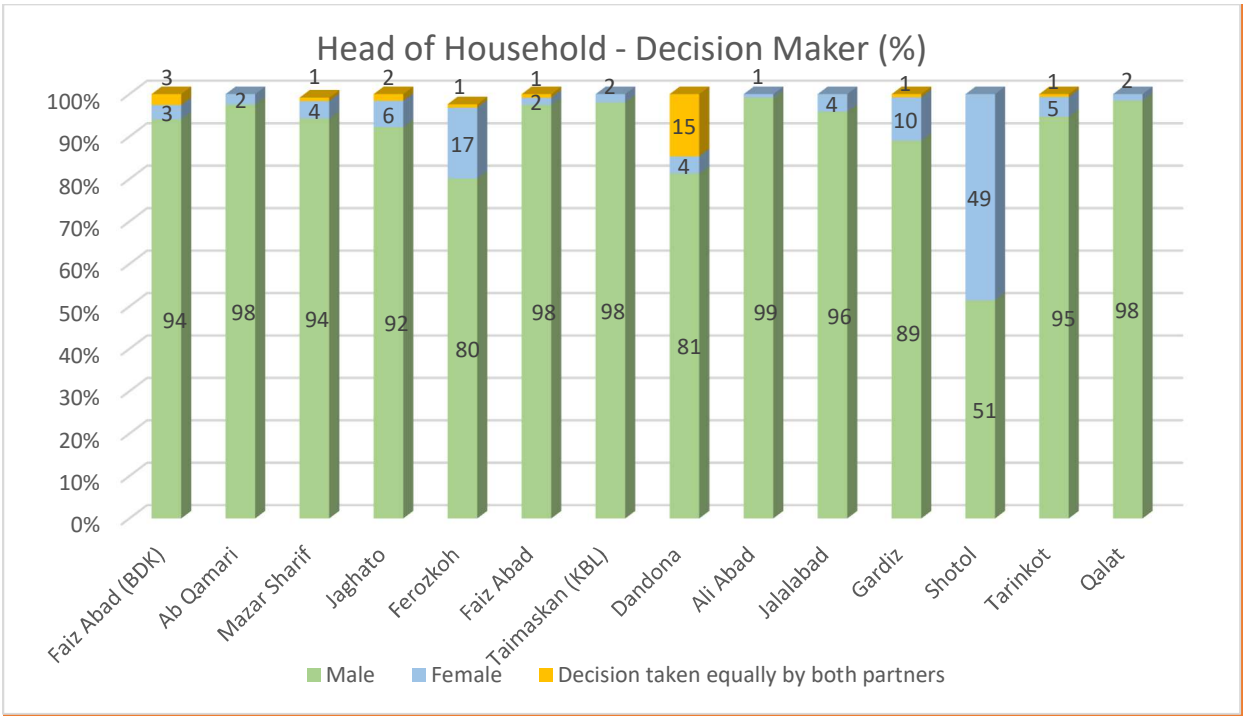
structures.

The data suggests the prevalence of large households, which may have implications for housing needs, food security, health service delivery, and resource distribution, especially in rural or less urbanized districts

## 6.4. Head of Household (Decision Makers)

Across all districts, the vast majority of households are reported as male-headed (by decision making), with percentages ranging from 80% to 99%, except in case of Shotol where decisions are taken almost equally by females and males. This indicates that men are overwhelmingly seen as the primary decision-makers in the surveyed households, reinforcing traditional gender roles in Afghan society.

*Figure 1: HH Head - Decision Maker*




Female-headed households are rare in almost all locations. The only district with a notable female representation is Shotol, where female heads (49%) match male heads (51%), an unusual balance not observed elsewhere. In most other districts, female-headed households are 1% - 6%, highlighting the limited leadership role of women in domestic decision-making. Ferozkoh and Gardiz show slightly higher number of women decision makers 17% and 10% respectively.

Very few households reported shared decision-making between partners (1% - 4%), with the highest being just 15% in Dandona. This suggests that collaborative or egalitarian decision structures within households are not common in the surveyed areas.

World Bank Group's gender data indicates 1.7% of Afghan women as heads of household.[20] Majority of districts closely correspond to this data except Ferozkoh (17%), Jaghato (6%), Gardiz (10%), and Dodana, Tarinkot (5%) reflecting comparatively higher number of women as household heads. Shotol appears as an outlier with almost equal women and men as decision makers. Shoto results do not conform to the norm and contextual realities.

Overall, the data clearly reflects a gender imbalance in household decision-making power, with men occupying nearly all headship roles. Women's roles as heads or joint decision-makers remain exceptionally limited, except in a few districts like Shotol, which appears to deviate from the norm. This pattern illustrates deep-rooted sociocultural norms around gender and authority in family structures across the surveyed regions.

FGDs members of Jalalabad, Gardiz, Kabul, Shotol, Ali abad etc. described that in most communities, men are traditionally seen as the primary decision-makers for household financial matters. This structure is deeply rooted in cultural norms where the eldest male, father or husband, typically holds authority over expenses. However, in families where women are widows or the primary earners, they often take full responsibility for managing the household finances as stated by few members including Faizabad, Jaghato. A few participants noted gradual changes, particularly in households where women generate income through small businesses like tailoring or receive direct support from NGOs. In such cases, women may either manage the money independently or be more involved in joint decisions with their husbands.

## 6.5. Respondents' Residence Status

The data reflects the composition of surveyed populations across various districts based on displacement status, highlighting the predominance of local or host community members in all areas. In most districts, respondents from the local population constitute between 75% - 98%. Ab Qamari and Faiz Abad report the highest proportions at 98% and 96% respectively, indicating strong representation from stable, non-displaced communities.

*Table 4: Respondents' Residence Status*

| District | Local/Host Community | Internally Displaced Person borders) | Refugee | International Voluntary Migrant |
|---|---|---|---|---|
| Ab Qamari | 98% | 2% | - | - |
| Faiz Abad | 96% | 4% | - | - |
| Faiz Abad (BDK) | 92% | 4% | 3% | 1% |
| Shotol | 86% | 1% | 1% | 1% |
| Jaghato | 85% | 12% | 2% | 2% |
| Ali Abad | 85% | 5% | 6% | 3% |

[20] https://genderdata.worldbank.org/en/indicator/sp-hou-fema-zs?utm_source=chatgpt.com

| District | Local/Host Community | Internally Displaced Person borders) | Refugee | International Voluntary Migrant |
|---|---|---|---|---|
| Dandona | 78% | 18% | - | 2% |
| Taimaskan (KBL) | 75% | 24% | 1% | - |
| Ferozkoh | 72% | 21% | 4% | 3% |
| Gardiz | 70% | 22% | 1% | - |
| Tarinkot | 65% | 32% | 3% | - |
| Jalalabad | 62% | 38% | - | - |
| Qalat | 60% | 32% | 7% | 1% |
| Mazar Sharif | 59% | 40% | 1% | - |
| **Aggregate** | **77%** | **18%** | **2%** | **1%** |

Internally displaced persons (IDPs) are present in all surveyed districts, although in relatively small proportions. Significant number of respondents report them as IDPs in Tarinkot (32%), Jalalabad (38%), Qalat (32%), and Mazar Sharif (40%), the highest among all surveyed areas. This suggests that these districts may be experiencing higher levels of internal displacement, potentially due to conflict, insecurity, or environmental pressures. Other districts such as Dandona, Taimaskan (KBL), Ferozkoh, and Gardiz, reflect some level of displacement, though at lower levels ranging from 18% -22%. Other districts such Ab Qamari (2%), Faiz Abad (BDK, 4%), Faiz Abad (4%), Ali Abad (5%), and Shotol (1%) indicate small proportion of IDPs, suggesting more stable local conditions.

The presence of refugees is minimal (1% - 3%) in half of the districts. None of the respondents report an international migrant status in Ab Qamar, Faiz Abad, Taimaskan (KBL), Ferozkoh, Gardiz, Tarinkot, and Jalalabad. The highest number is reported in Ali Abad (6%) and Qalat (7%). In other districts, refugees' presence turns out between 1% - 4%.

There is no notable representation of international voluntary migrants in any district, with half of the districts reporting no migrnats including Ab Qamari, Faiz Abad, Taimaskan (KBL), Gardiz, Tarinkot, Jalalabad, and Mazar Sharif. This absence suggests that returnees or transnational migration dynamics were not a significant part of the surveyed population.

In summary, the survey sample is largely composed of host community members, with a modest representation of IDPs and negligible involvement of refugees or international returnees, painting a picture of localized displacement and community stability in most districts.

## 6.6. Vulnerable Individuals in Household

This dataset aimed to identify the presence of vulnerable individuals within households across surveyed districts, including Pregnant and Lactating Women (PLW), and individuals with various types of disabilities.[21]

[21] Third-person reported data. Not assessed using any standard disability assessment tool for visual, hearing, and learning disability.

*Table 5: Household Members with Special Conditions (Vulnerability)*

| District | Visual Impairment | Hearing Impairment | Physical Disability | Intellectual/ Learning Disability | Pregnant/ Lactating |
|---|---|---|---|---|---|
| Faiz Abad (BDK) | 3% | 2% | 3% | 0% | 4% |
| Ab Qamari | 2% | 1% | 2% | 1% | 6% |
| Mazar Sharif | 4% | 4% | 3% | 1% | 6% |
| Jaghato | 3% | 1% | 2% | 1% | 5% |
| Ferozkoh | 1% | 1% | 4% | 2% | 7% |
| Faiz Abad | 3% | 3% | 5% | 0% | 3% |
| Taimaskan (KBL) | 1% | 1% | 1% | 1% | 2% |
| Dandona | 2% | 2% | 2% | 1% | 6% |
| Ali Abad | 1% | 2% | 3% | 1% | 5% |
| Jalalabad | 1% | 0% | 1% | 0% | 1% |
| Gardiz | 1% | 1% | 2% | 0% | 5% |
| Shotol | 0% | 0% | 3% | 1% | 4% |
| Tarinkot | 3% | 2% | 2% | 1% | 5% |
| Qalat | 1% | 1% | 1% | 1% | 3% |
| **Aggregate** | **2%** | **1%** | **2%** | **1%** | **4%** |

Across all surveyed districts, 1% - 4% of household members are reported as visually impaired. in their household except Shoto where none reported visual impairment. Mazar Sharif has the highest proportion (4%), followed closely by Faiz Abad (BDK), Faiz Abad, Jaghato, and Tarinkot (all 3%). Almost half of districts show only 1% visual impaired persons are reported. These figures indicate the need for disability inclusion strategies, particularly targeted eye care support in higher-reporting districts.

A total of 1% of surveyed household members are reported having hearing impairment. The highest rates were seen in Mazar Sharif (4%), Faiz Abad (3%). Dondana, Faiz Abad, Ali Abad, and Tarinkot indicate 2% household member suffering from hearing disability. Rest of districts report as small as 1% hearing impaired household members. Shotol, and Jalalabad indicate no such disabled person. This suggests either a low presence or possible gaps in awareness/recognition of hearing impairment. Districts with higher reporting may benefit from community-based hearing support services and assistive devices.

Physically disabled category shows 2% prevalence overall. Faiz Abad (5%) and Ferozkoh (4%) stand out as highest reporting districts, whereas Taimaskan (KBL), Jalanabad, and Qalat are the lowest reporting districts (all 1%). In Faiz Abad), Mazar Sharif, Ali Abad, and Shotol 2% household member are reported as physically disable. Rest of districts reported 1%, showing low presence across the board. Physical disability, being the most frequently reported after PLW suggests a broader need for inclusive infrastructure and mobility aids in high-prevalence areas.

Overall, intellectual and learning disability is reported in 1% of household members. Ferozkoh is the highest reporting district, such as 2%. Most of other districts have reported only 1% household members with learning disability except Faiz Abad (BDK), Faiz Abad, Jalalabad, and Gardiz where no learning-disabled household member is reported. Under reporting many suggest lack of awareness of the respondent about intellectual or learning disability due to invisible nature of the disability.

Model Disability Survey of Afghanistan (MDSA) 2019[22] indicates significantly higher prevalence of disabilities in Afghanistan. According to the report, about one-fifth (21.1%) of Afghan adults aged 18+ years old experience no disability, approximately one-fourth (24.6%) suffer from mild disability, while almost half (40.4%) have moderate levels and 13.9% are estimated to have severe disabilities. The survey data does not correspond to the systematically assessed disability data of MDSA 2019. This suggests either rarity or cultural stigmas leading to underreporting. Perception and awareness of respondents about various types of disability is also a key factor that may have impacted the reporting. Disability, including intellectual and learning disabilities, is under-identified in low- and middle-income countries due to limited awareness, stigma, and lack of diagnostic infrastructure.[23] This may indicate a critical need for awareness and specialized services in recognizing and supporting cognitive impairments.

Key informant interviews (KIIs) with Public Health Focal Points (PHFPs) point out gender aspects of disabilities. They highlight disabled women, and elderly women face double vulnerabilities, first as women, and then due to their age or physical limitations.

PHFPs also identify women and girls facing disproportionate vulnerabilities. They indicate that women and adolescent girls face elevated health risks during climate-induced emergencies (e.g., floods, heatwaves, displacement), including higher exposure to waterborne diseases due to their primary roles in water collection and caregiving. They also hint that in many communities, cultural food hierarchies prioritize men and boys, leaving women and girls more vulnerable to malnutrition, particularly during food shortages or droughts.

Across all surveyed districts, 4% of respondents reported at least one pregnant or lactating woman in their household. Ferozkoh has the highest proportion (7%), followed closely by Ab Qamari, Mazar Sharif, Dandona, each reporting 6% PLW. In Faiz Abad (BDK), Jaghato, Faiz Abad, Ali Abad, Gardiz, Shotol, Tarinkot, and Qalat, 3% - 5% are PLW. This highlights a potential need for maternal and child health services. PLW in Taimaskan are fewer as 2%. Jalalabad reports the

[22] https://asiafoundation.org/wp-content/uploads/2020/05/Afghanistan_2019-Model-Disability-Survey.pdf?utm_source=chatgpt.com
[23] World Health Organization & World Bank. (2011). *World Report on Disability*. WHO Press. https://www.who.int/publications/i/item/9789241564182

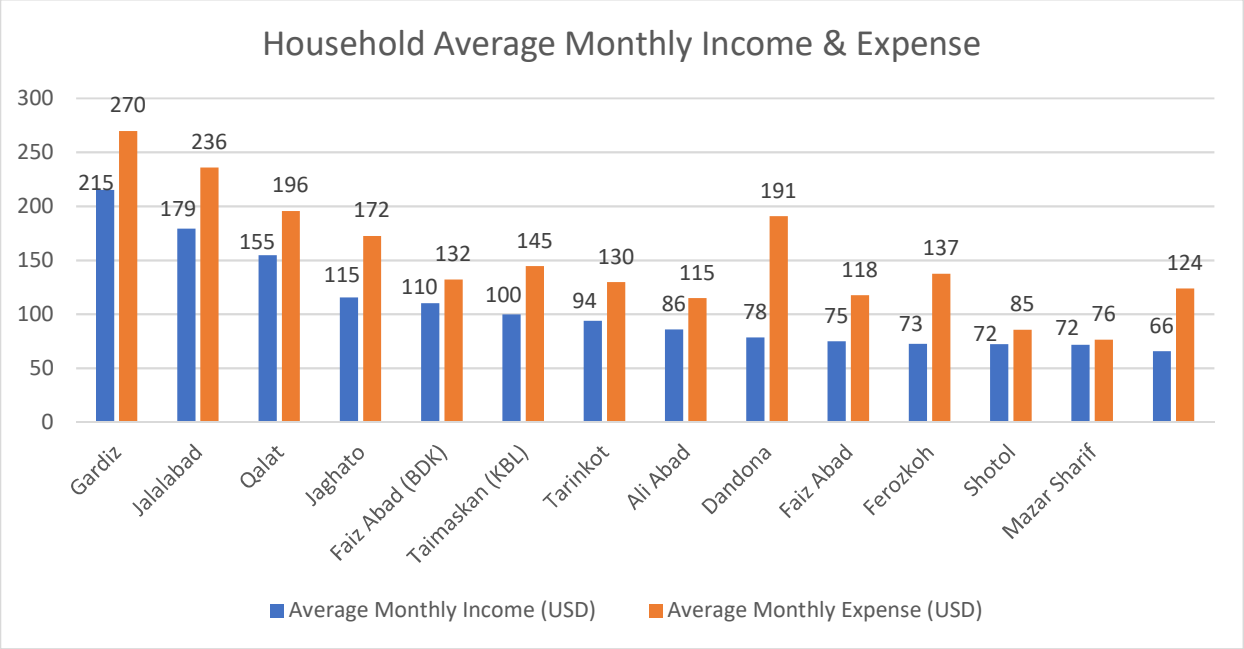
lowest PLW (1%). This indicates possible underreporting due to cultural barriers, such as feelings of shame when discussing women's issues in front of outsiders, especially unfamiliar men.

Community leaders of Ferozkoh, Gardiz, and Tarinkot identify that women particularly pregnant and lactating women (PLW), children, people with disabilities (PwDs) and poor people are among most vulnerable groups during KIIs. A consistent theme across provinces is the lack of gender-sensitive healthcare services, particularly for pregnant and lactating women that adds to their vulnerability.

## 6.7. Average Monthly Income and Expense

These two interlinked datasets assess the economic condition of households by exploring their monthly income and expenses. The difference between the two gives us net monthly savings (or deficits), which reveals financial stability and vulnerability at the household level.

*Figure 2: Household Average Monthly ncome Vs. Expense (USD)*




Across all surveyed districts, the average household income is USD 106. According to the UNDP's *Afghanistan Socio-Economic Outlook 2023*, the average monthly household income in Afghanistan during August–September 2022 was AFN 6,489, equivalent to approximately USD 75 at that time, and importantly, 55% of households reported expenditures exceeding income, resulting in an average monthly deficit of AFN 4,217 (~USD 48). The average household expense across the districts is 151, leading to an overall monthly deficit of 45. Most of the focused districts fall near the national deficit of USD 48 per month, except Dandona (USD 112) which is significantly higher than the national deficit data of UNDP.

This negative gap highlights a systemic issue of income insufficiency, where households are spending significantly more than they earn, pushing them into debt, reliance on aid, or informal borrowing.

Gardiz, Jalalabad, Qalat and Jaghato appear highest by income among others, conversely, Mazar Sharif, Shotol, and Ferozkoh are the lowest reported HH income districts.

The consistent and high deficit across all the districts esp. Dandona (143%), Ferozkoh and Ab Qamari (89%), Faizabad (57%), and Jaghato (49%) indicates several important socio-economic challenges.

Households in Dandona, Ferozkoh, and Jaghato are under severe financial pressure and could be prioritized for cash-based assistance programs. Mazar Sharif and Shotol appear financially resilient, though close monitoring is advised. Districts like Gardiz and Jalalabad exhibit high economic activity but also reflect the pressures of inflation and potentially high family dependencies. The data confirms that most households are running at monthly deficits, threatening long-term financial sustainability unless income-enhancing or cost-reducing strategies are implemented.

*Table 6 HH Average Monthly Income Deficit:*

| Average Monthly Income Deficit | |
|---|---|
| **District** | **Deficit (USD)** |
| Dandona | 143% |
| Ferozkoh | 89% |
| Ab Qamari | 89% |
| Faiz Abad | 57% |
| Jaghato | 49% |
| Taimaskan (KBL) | 45% |
| Total | 42% |
| Tarinkot | 38% |
| Ali Abad | 34% |
| Jalalabad | 32% |
| Qalat | 27% |
| Gardiz | 25% |
| Faiz Abad (BDK) | 20% |
| Shotol | 18% |
| Mazar Sharif | 7% |

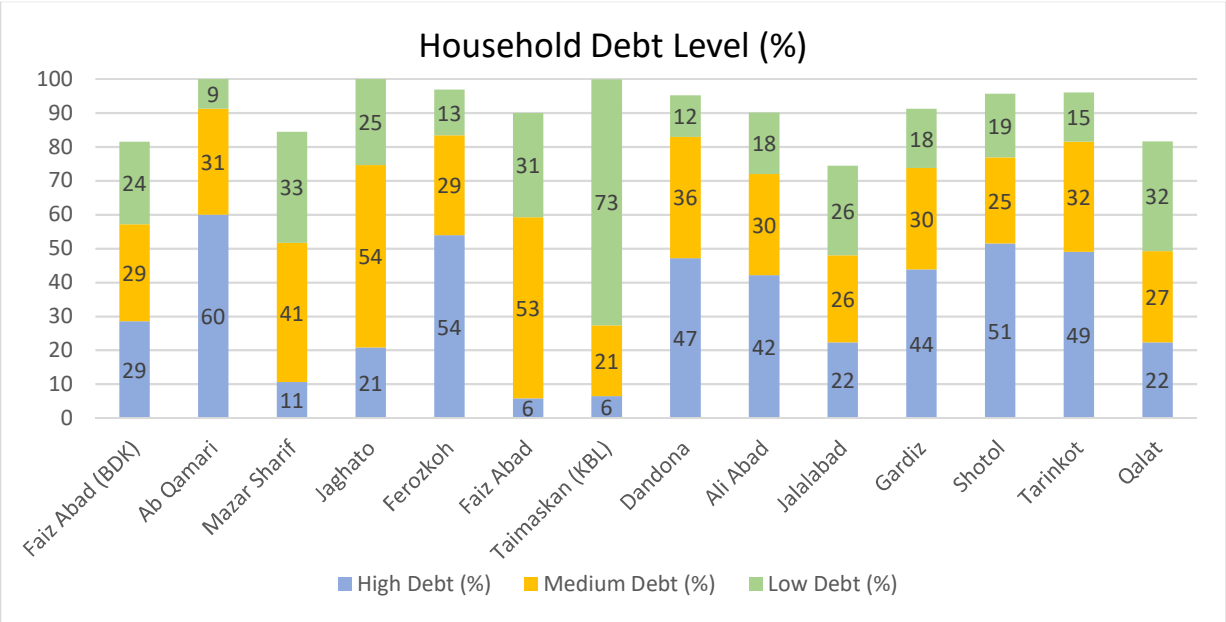
## 6.8. Household Debt Burden

This variable assesses the prevalence and perceived burden of household debt across different districts. Understanding the level of indebtedness is crucial for evaluating household economic vulnerability, coping mechanisms, and their reliance on external financial sources (formal or informal) to meet essential needs. The presence of different degrees of debt helps in identifying both the depth and breadth of financial stress among communities.

Overall, 33% of households fall under high, and 33% under medium debt categories. 25% of surveyed households fall under low debt category, and almost 8% households either “Don’t prefer to answer” or respondent “did not know” the details about debt.

Across all districts, high debt responses range between 6% to 60%. Districts Gardiz, Ali Abad, Dandona, Tarinkot, Shotal, Ferozkoh, and Ab Qamari show larger high debt prevalence (42% - 60%) indicating a high and persistent financial stress in half of surveyed districts.

*Figure 3: Household Debt Level*




Overall medium debt burden seems same as high debt. In Mazar Sharif (41%), Jaghato (54%), and Faiz Abad (53%) are highest medium debt reporting districts. Rest of districts report medium debts between 21% to 36%. This suggests many households carry a manageable, yet notable, financial burden. Low debt also remains widespread with Taimaskan (KBL) reporting highest (73%) and Ab Qamari lowest (9%) medium debts. In rest of surveyed districts, low debts is indicated between 12% to 33%. Low debt presence may reflect either improved financial literacy or low borrowing capacity, which is not necessarily a positive indicator. Districts showing lower prevalence of low debts are higher on medium and medium and high debts such as Ab Qamari indicating 9% low debts but 31% and 60% medium and high debts respectively.

Districts with the highest High Debt percentages raise concerns about severe financial stress. It may reflect heavy borrowing for food, health, or livelihood support. These areas might benefit from debt relief or livelihood recovery interventions. The low debt districts suggest small, routine borrowing. Areas with minimal debt concerns (most medium or low debts) suggest some capacity to manage obligations.

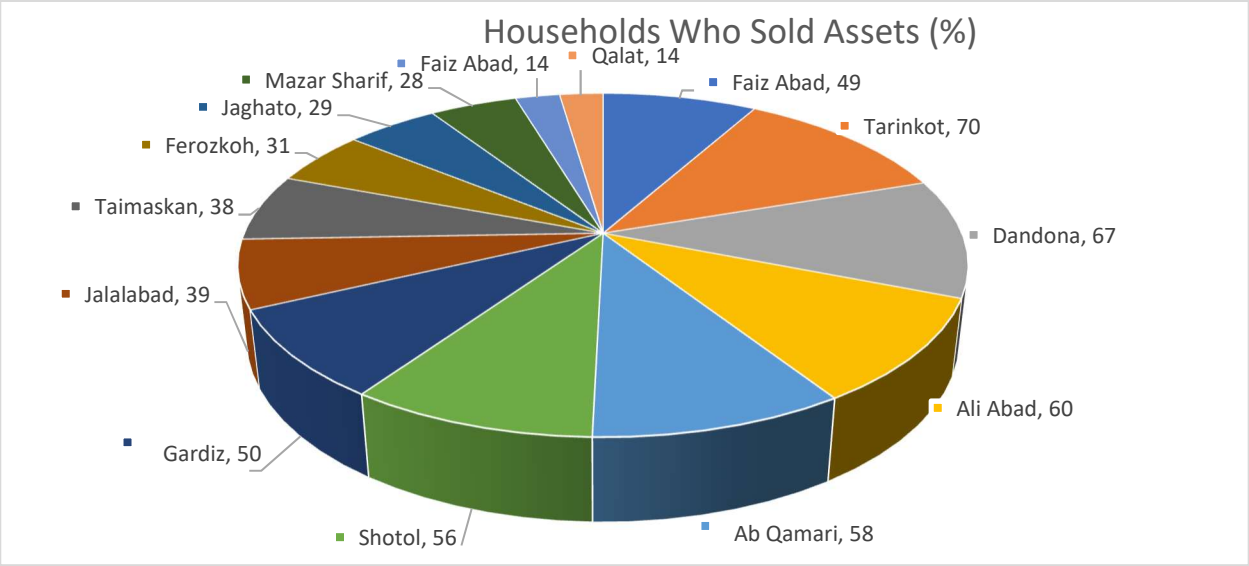
Overall, the data shows that debt is widespread but varies in severity. Certain districts are experiencing high-risk borrowing behaviors, while others maintain controlled debt exposure. These findings call for tailored financial support programs, debt management training, and possibly microcredit access in vulnerable areas.

## 6.9. Financial Coping Strategy

This question investigates the financial coping strategies adopted by households in response to economic distress, particularly the need to liquidate assets due to debt. Selling assets is often a

last-resort mechanism, indicating acute financial vulnerability and a lack of formal safety nets or access to sustainable income.

*Figure 4: Households Who Sold Assets*




A high proportion of households across most districts have sold assets potentially due to debt or managing financial burden. The highest figure is from Tarinkot (70%), while the lowest is from Qalat (14%). This highlights stark differences in economic resilience across districts. The average "Asset Sold" response across all districts hovers around 40–50%, indicating that asset sales are a widespread coping strategy. Districts such as Tarinkot (70%), Dandona (68%), Ali Abad (60%), and Ab Qamari (58%), Shotol (56%), and Gardiz (50%) report high levels of asset liquidation, pointing to severe financial distress. HHs in these areas may be facing chronic poverty, requiring cash assistance, livelihood restoration, and debt mitigation programs. Mid-range (20-40%) districts such as Jalalabad, Taimaskan, Jaghato, Ferozkoh, and Mazar Sharif may imply growing debt pressures without reaching critical distress levels. These areas may benefit from preventive economic strengthening to ensure resilience is maintained.

Focus group discussion (FGDs) respondents consistently reported that economic hardship has driven families to adopt severe negative coping strategies. Child labor is rampant, with many children, particularly boys, taken out of school and made to work in farming, construction, or tailoring. Early marriage of girls is also widely practiced by reducing family financial burdens or repaying debts. In many cases, families have resorted to borrowing, selling household items, or mortgaging land and property. Food insecurity has forced people to reduce food intake, and essential expenses like healthcare and education are often sacrificed. Some families are unable to send sick members to clinics, leading to untreated illnesses and even fatalities.

In extreme cases, families have sold assets such as land, goats even children as reported in Faizabad.

> *"Some families sell their children or make them do hard labor due to lack of resources and poverty. A father who had six children, because of poverty, married off his 15-year-old daughter to be able to pay off part of his debt."*
> Faizabad Community FGD participants

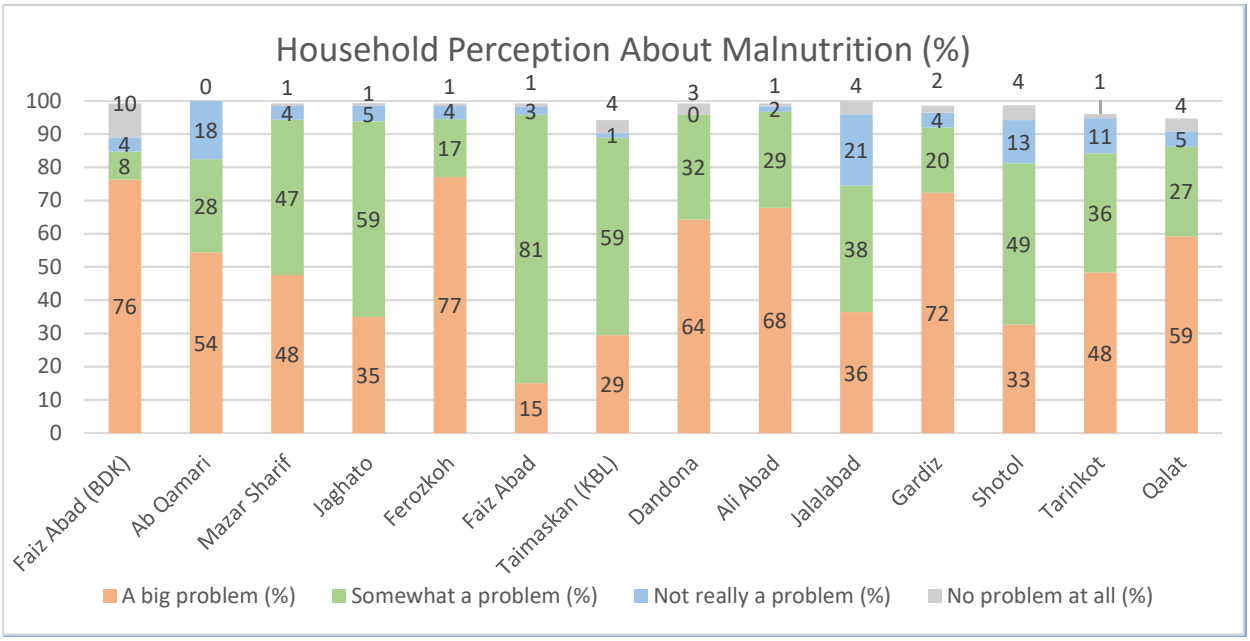
There are instances to send youth on illegal migration routes to Iran and Turkey as reported by both male and female FGDs respondents in district Ab Qamari. These behaviors were reported across all community segments, but poorer households, those without livestock or land, and female-headed or orphaned households were most severely affected. Some participants also highlighted cutting down trees for winter heating fuel, delaying weddings, and increasing household conflict due to unmet needs.

# 7. Health Access – Findings

## 7.1. Perception about Malnutrition

Understanding local perception is crucial as it influences health-seeking behavior, community engagement in nutrition programs, and demand for nutritional services. To understand community perception regarding the prevalence of malnutrition in their respective districts the respondents were asked whether they considered malnutrition to be a problem.

*Figure 5: Household Perception about Malnutrition*




Across the surveyed districts, most respondents acknowledge that malnutrition is a significant or moderate concern, though the intensity of concern varies. Some districts perceive malnutrition as a major public health issue, while others report it as less pressing. Overall, surveyed districts report that almost 51% respondents believed that malnutrition is a “big problem” in the area and 38% households reported that malnutrition is a “somewhat a problem” whereas 9%, believed that malnutrition is “not really/not at all” a problem along with 1.8% respondents snot preferring to answer.

Ferozkoh (77%), Faiz Abad (76%), Gardiz (72%), Ali Abad (68%), and Dandona (64%) reported the highest levels of perceived risk. These areas may be witnessing more visible signs of malnutrition or have less effective health programming. Jaghato, Taimaskan, and Shotol show a more nuanced or subdued perception, which may not necessarily correlate with reality and should be addressed through community awareness and education. Where low perception exists, it may not mean better health status but instead reflect limited health literacy or reduced exposure to outreach

services. The education status of HHs complements this argument as most of the respondents are not highly educated.

In the areas where both perception and data confirm serious malnutrition challenges, targeted nutrition education campaigns, assessing and strengthening monitoring, and tailored community mobilization and engagement strategies (resonating with local realities), could be effective measures.

Qualitative data gathered through Public Health Focal Points (PHFPs) KIIs also highlight that in recent years, communities across Afghanistan have experienced a rise in both communicable and non-communicable diseases. Common diseases reported include diarrhea, malnutrition (especially protein deficiency), tuberculosis (TB), measles, scabies, typhoid, cold and respiratory infections, high blood pressure, diabetes, and zoonotic diseases.

Faiz Abad, Mazar Sharif, Jaghato, Ali Abad and Jalalabad PHFPs pointed out that malnutrition was one of serious challenge amongst other above mentioned reported diseases, which was affecting health of pregnant/lactating women and children <5.

Qualitative data collect indicated that in many communities, cultural food hierarchies prioritized men and boys, leaving women and girls more vulnerable to malnutrition—particularly during food shortages or droughts.

> "Over the past five years, many diseases have affected the people…These have caused an increase in severe malnutrition cases and even child mortality. The most vulnerable groups in the community are mainly women and children."
>
> "In our area, some families delay the marriages of their youth due to low income, reducing food expenses, which has made malnutrition a common problem, …."
>
> RHO Mazar Sharif

In Badghis province, compared to other provinces in Afghanistan, climate change has caused more severe droughts, leading to greater water scarcity and air pollution. Diseases such as malnutrition and diarrhea caused by unsafe water have increased.

Ali Abad SHC Director, Tarinkot and Dandona Heads of ARCS clinic reported that "child malnutrition/acuate and moderate malnutrition was amongst the five most common types of illness for which patient visits the clinic" and it was also stated that treatment of malnutrition cases was amongst most demanded services at mobile and fixed healthcare center as reported by SHC Director and Head of ARCS clinic of Ali abad, Qalat, Gardiz districts respectively.

Heads of clinics of district Faiz Abad, Qalat, Jalalabad, Gardiz, Tarnikot, and Dandona reported that acute malnutrition was amongst top 5 causes or a contributing cause of mortality in healthcare in the community.

Focus group discussion (FGDs) men, women, girls' and boys' participants also reported that malnutrition was especially prevalent among pregnant and breastfeeding women and children under five, in the area, due to reduced food availability and lower prioritization of women's nutritional needs during food scarcity

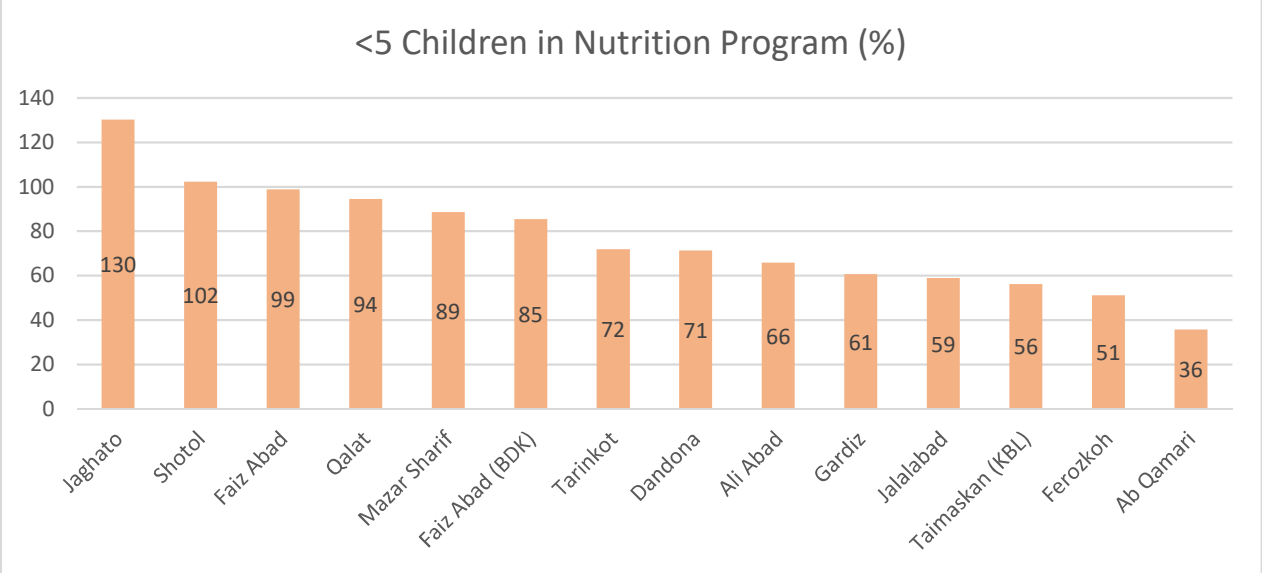
In Qalat, male FGDs identified a dire need for services related to diarrhea, fever, skin diseases, hypertension, and malnutrition. They also shared that their income did not cover all the basic needs of their family. That caused mental health issues, increased malnutrition among mothers and children, and increased debts, making it difficult to repay those debts.

In Jalalabad, female FGDs members shared about delayed marriages of youth in some families due to low income, and reduced food expenses causing malnutrition.

## 7.2. Under-5 Children Enrollment in Nutrition Programs

This variable explores the prevalence of malnutrition interventions targeting children under five years of age across districts, specifically assessing how many of these children are enrolled in nutritional support programs. These programs are typically designed to treat and prevent acute malnutrition and improve overall child health outcomes.

*Figure 6: Under-5 Children Enrolled in Nutrition Program*




Total 3,459 under-5 children are reported in the households surveyed. Among those, 1418 children are found eligible[24] for nutrition programs (based on national stunting rate as criteria). 1,081 eligible children (76%) are reported as enrolled in nutrition programs. This figure indicates

[24] Eligibility criteria: 41% of total under-5 children is considered eligible. According to UNICEF Afghanistan, 41% children are stunting and 9.5% wasting, implying half of children suffer from malnutrition.

significant outreach, coverage, or access to nutritional services, especially in hard-to-reach areas or among marginalized groups.

Afghanistan already struggles with high rates of acute malnutrition, over 3.5 million children under five suffer from acute malnutrition, including nearly 867,000 with severe acute malnutrition.[25] Malnourished children are far more vulnerable to infections like measles, and incomplete immunization schedules compound these risks. At the same time, sociopolitical restrictions on women's mobility and healthcare participation since 2021 continue to erode service accessibility, particularly for female caregivers who play a central role in child health-seeking behaviors.[26]

The enrollment data for children under-5 in nutrition programs across surveyed districts reveal disparities in coverage and accessibility, offering insight into both program strengths and areas requiring targeted improvement. Districts such as Faiz Abad and Qalat stand out with remarkably high enrollment i.e. Faiz Abad reporting 99%, and Qalat 94%. Jaghato and Shotol exceed enrollment at 130% and 102% respectively, indicating either enrolling children beyond eligibility criteria, or applying a different eligibility criteria (inclusion of children from surrounding areas not originally counted as eligible.) Mazar Sharif, Faiz Abad (BDK), Tarinkot, and Dandona also reflect high enrollment such as 71% - 89%. These numbers suggest that the nutrition programs in these areas are functioning effectively and have successfully mobilized communities to participate. the figures also reflect strong program visibility, acceptance, and likely efficiency in outreach and service delivery.

Ali Abad (66%), Gardiz (61%), Jalalabad (59%), Taimaskan (KBL, 56%), and Ferozkoh (51%) indicate moderate enrollment of <5 children in nutrition programs. While these rates are above the halfway mark, they point to number of eligible children who remain outside the coverage of essential nutrition interventions. This moderate performance may be attributed to a combination of logistical constraints, such as limited health workforce capacity or irregular supply chains, and softer barriers like lack of awareness, caregiver misconceptions, or community hesitancy to engage with formal services. These areas reflect a scenario where programs are established but may require deeper penetration into hard-to-reach zones or marginalized groups.

Ab Qamari reports the lowest enrollment (36%) in nutrition programs among surveyed districts, despite high realization/perception of malnutrition as a problem (82%). This low rate likely reflects substantial challenges in program implementation, ranging from accessibility issues due

[25] Integrated Food Security Phase Classification (IPC). *Afghanistan: Acute Malnutrition Analysis (June 2024 – May 2025).* IPC, 2024. https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_Afghanistan_Acute_Malnutrition_June2024_May2025_Report.pdf

[26] UNOCHA. *Afghanistan Humanitarian Update.* UNOCHA, December 2024. https://www.unocha.org/afghanistan

to terrain or insecurity, to limited community trust or engagement with health systems. This may also be linked to remoteness, service delivery gaps, or cultural norms that hinder utilization, especially if there is a shortage of female health workers or poor awareness of child nutrition needs.

The variability in enrollment rates across these districts underscores the importance of localized strategies. In high-performing districts, efforts should focus on maintaining coverage levels, verifying data accuracy, and documenting best practices. In moderately performing districts, program adjustments may be needed to strengthen community outreach, improve referral systems, and close access gaps. Meanwhile, districts with low enrollment demand urgent intervention to understand and overcome barriers, improve service availability, and rebuild community trust in nutrition programs. Equitable access to child nutrition services requires a nuanced, data-driven approach that recognizes the diverse operational environments and social dynamics within each district.

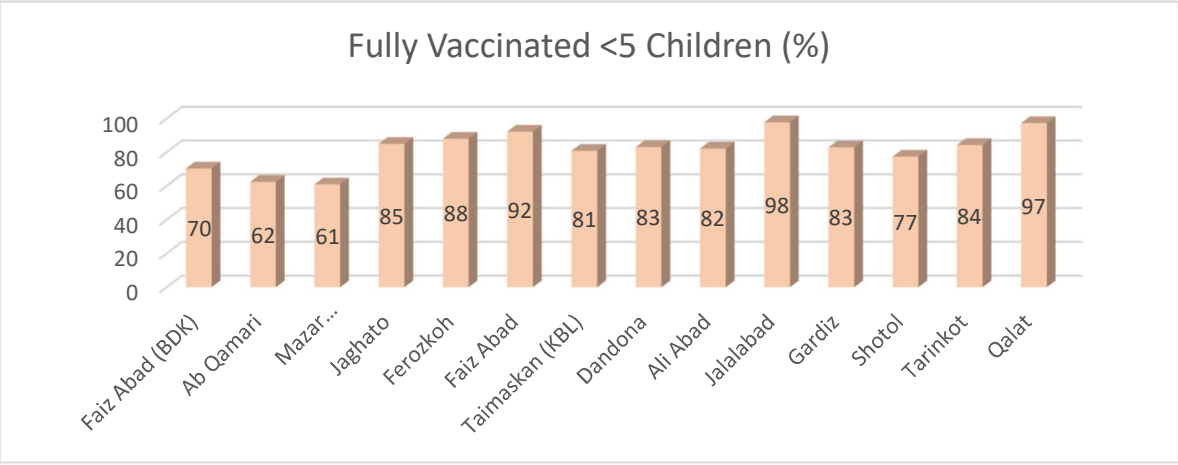
## 7.3. Children's vaccination status

The data presents a breakdown of under-5 children's immunization coverage across 14 districts, specifically examining total number of under-5 children, those reported as fully vaccinated, those who received DPT3/Penta3, and those who received at least one measles vaccine dose.

### 7.3.1. Full Immunization Coverage

Of the 3,459 under-5 children, 2,874 (83%) were reported as fully vaccinated (reported data, vaccination cards were not checked during the data collection). This figure is generally encouraging, indicating that at least 8 in 10 children are perceived to have completed their immunization schedule. Districts with the Highest Full Immunization are Jalalabad (98%), Qalat (97%), Faiz Abad (92%) and Ferozkoh (88%). These high rates suggest strong immunization program acceptance or reporting by communities in these areas.

*Figure 7: Under-5 Children Vaccination Status*



However, such high rates contrast sharply with the number of children receiving key vaccines like DPT3 and measles, which are core benchmarks of complete immunization coverage. This reveals a critical inconsistency. The specific indicators for key antigens (DPT3 and Measles) are alarmingly low, indicating likely misreporting, misinterpretation of "fully vaccinated," or systemic delivery gaps in actual antigen administration

Public Health Focal Points (PHFPs) stated during the KII that over the past five years, communities across various Afghan provinces had faced numerous public health challenges including mental health problems, diabetes, hypertension, and low vaccination coverage, often hindered by insecurity and poor health infrastructure. Children, especially girls, were frequently identified as the most at-risk group, not only due to biological vulnerability but also due to poor vaccination coverage. Jalalabad, Ali Abad, Kabul, and Ferozkoh PHFPs reported limited vaccination coverage due various factors including security concerns, lack of awareness among communities, lack of systematic vaccination campaigns, misperception about vaccination and resistance from religious leaders. Role of female health workers and volunteers was reported positively in this regard.

The analysis of vaccination coverage across the selected Afghan districts reveals both promising achievements and significant concerns when contextualized against the national backdrop. At the national level, Afghanistan records one of the lowest immunization rates in South Asia. According to UNICEF, only 42.6% of children aged 12–23 months are fully immunized, and nearly one in six children under the age of five has not received any routine vaccination at all.[27] This obvious reality underscores persistent systemic weaknesses, including fragile health systems, insecurity, vaccine supply interruptions, and gender-related barriers that prevent mothers and female caregivers from accessing services.

In contrast, the district-level dataset suggests much higher levels of coverage. On average, 83% of children across the studied districts are reported as fully vaccinated, a figure nearly double the national average. Districts such as Jalalabad (98%), Qalat (97%), and Faiz Abad (92 %) demonstrate particularly strong performance, with high proportions of children completing their full immunization schedules. These figures are encouraging and suggest that targeted efforts in these regions, whether through routine health services or intensified campaign-style interventions, are yielding results.

However, the data also highlights critical disparities. For example, Ab Qamari (62%) and Mazar Sharif (61%) show substantially lower coverage compared to other districts. This is particularly in case of Mazar Sharif (urban hub), where the expectation of stronger infrastructure and easier access to services contrasts with the reality of lower completion rates. One explanation may lie

[27] UNICEF. *Afghanistan: Country Office Annual Report 2023.* UNICEF, 2023/UNICEF USA. *Afghanistan: Children in Crisis.* UNICEF USA, 2024. (https://www.unicefusa.org/stories/afghanistan-children-crisis)

in intra-urban inequalities, with children in informal settlements, displaced populations, or marginalized communities being left behind, despite the presence of better-resourced health facilities in central areas.

### 7.3.2. DPT3/Penta3 Vaccine Coverage

This variable, coverage with DPT3 only (overall 79%), offers additional insights into systemic gaps. In districts such as Ali Abad (171%), Qalat (140%), and Jalalabad (117%), the reported figures far exceed the expected population size of eligible children. While such anomalies may indicate overreporting or errors in data collection (such as relying only on reported number of vaccinated children without checking or verifying from vaccination card), they also suggest that children outside the core vaccination age cohort, possibly older unvaccinated children, are being reached through catch-up campaigns. By contrast, in places like Mazar Sharif (11%) and Faiz Abad (37%), DPT3-only coverage is relatively low, which may point to challenges in initiating or sustaining the immunization series.

### 7.3.3. Measles Vaccine Coverage

A similar trend is observed with measles-only vaccination (overall 68%). Districts such as Ali Abad (147%), Qalat (110%), and Gardiz (91%) show very high numbers of children receiving measles vaccines without completing the full vaccination schedule. This suggests that while national and international campaigns have successfully delivered measles doses, often prioritized due to recurrent measles outbreaks, these efforts are not being systematically integrated with follow-up services to ensure full immunization. In effect, large numbers of children may remain protected against measles but vulnerable to other preventable illnesses such as pertussis, diphtheria, and polio. Conversely, in districts like Faiz Abad (31%) and Tarinkot (38%), the gap between measles-only and full vaccination is narrower, which suggests stronger continuity of care and better routine service uptake.

Taken together, the data demonstrates a complex immunization landscape. On one hand, surveyed districts perform much better than national averages, reflecting localized strengths in service delivery and campaign outreach. On the other hand, discrepancies between “fully vaccinated,” “DPT3-only,” and “measles-only” highlight systemic weaknesses, especially in ensuring continuity across the entire vaccine schedule. The reliance on mass measles campaigns, while valuable for outbreak prevention, has not translated into comprehensive protection. This undermines broader child health outcomes, particularly in a country where child mortality rates remain among the highest globally.

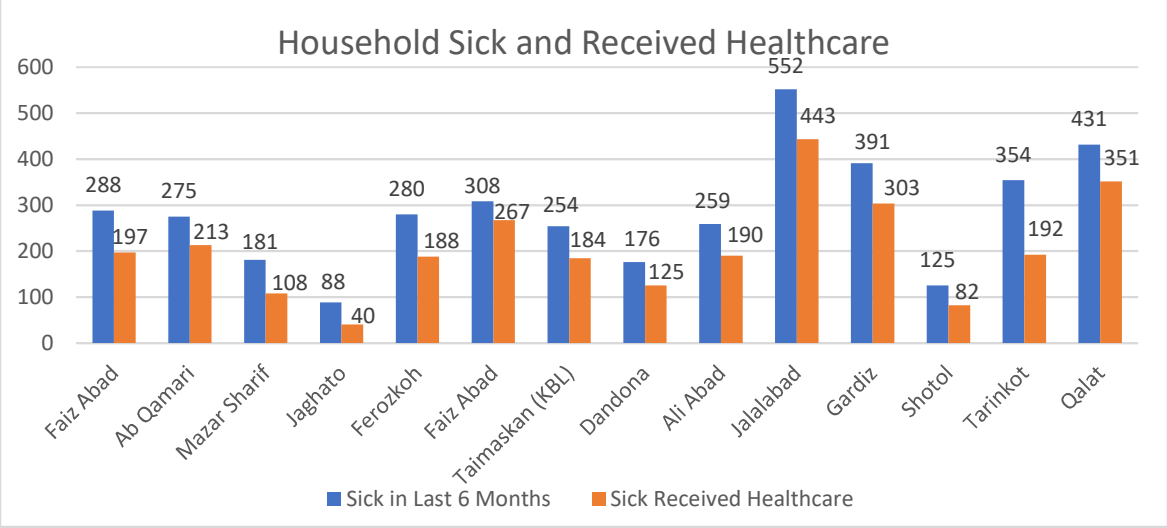
In conclusion, the district data provides an optimistic snapshot compared to the national baseline, but it also underscores the fragility of immunization systems in Afghanistan. Ensuring that children not only receive one or two vaccines but complete their full immunization schedule is

critical for long-term public health gains. Bridging gaps between campaign outreach and routine services, improving data quality, and addressing gendered barriers in healthcare access will be essential for sustaining and scaling progress.

## 7.4. Non-Hospital Care Needed vs. Received (Last 6 Months)

This data set provides insights into both the prevalence of non-hospital illnesses and the accessibility of outpatient or primary health care services in each district. The data also includes the percentage of sick individuals who received care, which reflects service accessibility, affordability, and possibly perception of care effectiveness.

*Figure 8: Households Sick and Received Healthcare*




Across surveyed districts, 3,962 individuals reported sick cases in the last six months. Among those reported sick 2,883 received care translating to an aggregate care access rate of 73%.

This means that nearly 1 in 4 people (27%) who needed outpatient or basic health services did not receive them, indicating critical gaps in primary healthcare access across several districts.

According to Global Service Coverage Index (SCI) thresholds (SDG Indicator 3.8.1), 12 out of 14 surveyed districts fall under high coverage (60-79%). Jaghato (45%) and Tarinkot (55%)

Districts such as Faiz Abad (87%), Qalat (81%), Jalalabad (80%), and Ab Qamari (77%) exhibit high service coverage, aligning with the "High" SCI Scale classification. This suggests these areas have strong program reach and possibly better implementation infrastructure by the health program implementers.

Jaghato (45%) and Tarinkot (54%) are rated as "Medium," indicating moderate service delivery, which may not be sufficient given their needs. These districts might face geographic, security, or capacity challenges.

*Table 7: District Coverage on Global SCI Scale*

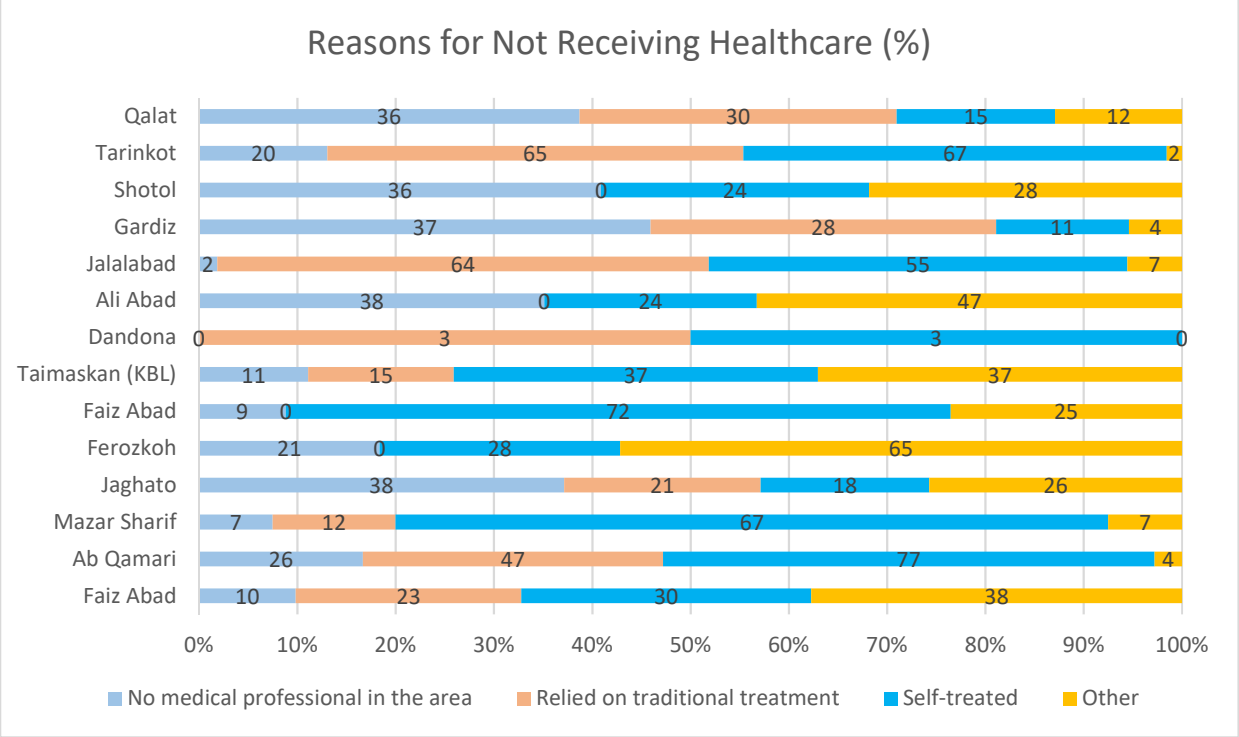
| District | Coverage | SCI Scale |
|---|---|---|
| Jaghato | 45% | Medium |
| Tarinkot | 54% | Medium |
| Mazar Sharif | 60% | High |
| Shotol | 66% | High |
| Ferozkoh | 67% | High |
| Faiz Abad | 68% | High |
| Dandona | 71% | High |
| Taimaskan (KBL) | 72% | High |
| Ali Abad | 73% | High |
| Ab Qamari | 77% | High |
| Gardiz | 77% | High |
| Jalalabad | 80% | High |
| Qalat | 81% | High |
| Faiz Abad | 87% | High |

## 7.5. Reasons for Not Receiving Healthcare

Respondents were asked to indicate reasons why individuals who were sick did not seek or receive care from a medical professional. The responses reflect barriers to healthcare access including no medical professional in the area, reliance on traditional treatment, self-treatment, other unspecified reasons, and refer not to answer.

This data reveals structural and behavioral gaps in the healthcare system, from lack of providers to cultural reliance on traditional methods, as well as instances of autonomous or informal care practices.

*Figure 9: Reasons for Not Receiving Healthcare*




Overall, self-treatment (41%) appears to be top reason, indicating that many people chose or were forced to manage illness at home without formal medical consultation. Traditional treatment was also significant (26%), pointing to entrenched cultural practices or a lack of accessible clinical services. 20% of respondents cited no medical professional in the area, a clear indicator of infrastructure or staffing gaps. "Other" reasons accounted for 21%, and 15% preferred not to answer, which may reflect sensitivity, stigma, or lack of understanding.

Summary of key reasons is presented in Table-10 below:

*Table 8: Summary - Key Reason for Not Opting Medical Healthcare*

| District | Key Reasons Identified for Not Accessing Healthcare |
|---|---|
| Ab Qamari | Self-treatment (77%), traditional care/treatment (47%) |
| Mazar Sharif | Self-treatment (67%) |
| Tarinkot | Self-treatment (67%), traditional care/treatment (65%) |
| Ferozkoh | “Other” reasons dominate (65%) |
| Qalat | High lack of providers (36%), high traditional care (30%) |
| Jaghato | High lack of providers (38%), Other (26%) |
| Dandona | 94% “Prefer not to answer” – severe data limitation |
| Ali Abad | High provider absence and “other” reasons (47%) |

Reports of traditional treatment suggest some clinical alternatives exist, but people still handle illness independently or ambiguously. This also suggests cultural preference or inaccessibility of modern medicine, and mixed health-seeking behaviors.

Districts like Jaghato, Qalat, Gardiz, Ali Abad, and Shotol indicate 36% – 38% absence of medical professionals. Mobile clinics and community health workers could help. In Tarinkot and Jalalabad, traditional care/treatment is 65% and 64% respectively, suggesting strong cultural adherence. Programs should consider community engagement and trust-building before introducing modern medicine instead of unspecialized traditional medication. In Ab Qamari, Mazar Sharif, and Faiz Abad, over 60% self-treated, indicates possible affordability issues or limited awareness about dangers of self-medication. The frequent "other" and "prefer not to answer" responses may hint at complex or sensitive factors like cultural barriers, gender norms, political instability, or insecurity.

Triangulation of this data with the variable 'Having Access to Healthcare' suggests that not seeking medical care from a professional may be more of a choice than a result of access barriers. The access data (see Figure Access-4), shows that over 90% of respondents have access to healthcare across the districts, except Faiz Abad (BDK) and Ab Qamari where 83% and 69% have access.

## 7.6. Barriers to Accessing Healthcare Services

This variable captures the primary reasons why certain individuals in surveyed households were unable to access the healthcare they required. The dataset provides insight into the types and prevalence of structural, economic, and safety-related barriers that restrict access to healthcare across 14 surveyed districts. The barriers have been categorized under ten specific challenges. Here's a detailed breakdown and interpretation of trends and regional disparities:

### 7.6.1. Structural Availability of Health Facilities

19% of respondents reported the complete absence of health facilities. The issue is most severe in Qalat (62%), Gardiz (57%), Ali Abad (43%), Dandona (50%), and Shotol (50%), suggesting widespread infrastructural gaps in these areas. This is especially critical because a lack of facilities implies reliance on distant or informal health providers.

### 7.6.2. Health *care* facilities are destroyed or closed

A relatively low percentage of respondents reported destruction (3%) or closure (1%) of health facilities. These reports came mainly from Ali Abad, Gardiz, and Jaghato, where up to 14% noted either damage or closure. While not widespread, such issues often coincide with conflict-affected or remote districts.

Community leaders identify missing critical health services such as diagnostics, emergency maternity care, and round-the-clock facilities as one of the structural issues. As stated by

Taimaskan (KBL) community leader pointed out non-existence of any clinic or health services in their area.

### 7.6.3. *Health* System Capacity Constraints

#### *7.6.3.1. Limited opening hours*

Only 4% of respondents flagged limited operational hours as a barrier, with Jaghato (29%) and Shotol (50%) as outliers. These districts may have healthcare providers that are either understaffed or irregularly functioning.

Limited operating time is also identified as an access issue by Faizabad community leaders during KII. They also highlighted shortage of medicines in ARCS clinic and lack of services during nighttime, especially in the maternity ward.

#### *7.6.3.2. Insufficient staff and medication*

A minority noted staff shortages (2%) or lack of medicines (10%), but they were significant in Taimaskan (KBL) and Ali Abad, where 14–43% highlighted gaps. Such shortages contribute to delays, overburdened staff, and reduced quality of care.

Lack of gender-sensitive healthcare services, particularly for pregnant and lactating women comes out as a consistent theme in community leaders KII across provinces. Clinics either lack female medical staff or do not provide essential services like antenatal checkups, delivery care, or emergency obstetric support as stated by Ferozkoh community leader.

In several areas, women have to travel long distances for childbirth or for basic gynecological care, something not all families can afford or allow. This puts maternal and newborn health at significant risk.

Community leaders, in several cases, also indicate women opting to delay or avoid treatment due to the absence of female staff or fear of stigma, stated by Ferozkoh. Ab Qamari MHT Director stated that people demand health services in every department, but medicines and doctors are not sufficient to meet the demand of community.

#### *7.6.3.3. Economic barriers*

##### 7.6.3.3.1. Healthcare is too expensive

Reported by only 3% of respondents overall, but as high as 14% in Jaghato and Gardiz. This indicates pockets of economic exclusion that may disproportionately impact low-income households or those needing frequent care.

#### 7.6.3.3.2. Transportation fees are too high

Reported by 1% overall, this was not identified as a major widespread issue but may still affect remote households disproportionately in areas such as Ab Qamari (5%). This also comes out in PHFP KII in Jalalabad which is hindering health referral in case of emergency service.

### *7.6.3.4. Physical and Geographic Access Barriers*

#### 7.6.3.4.1. Long distance to healthcare facility

A major concern, cited by 37% of all respondents, making it the most common barrier. Ab Qamari (79%), Tarinkot (50%), and Ali Abad (29%) show the highest levels, revealing geographic isolation and poor road connectivity. This is a crucial indicator of vulnerability in emergencies and maternal care.

#### 7.6.3.4.2. Safety and insecurity in accessing healthcare

Reported by only 2%, this was more evident in Ab Qamari (3%) and Qalat (8%). Though less prevalent, this remains an important consideration in conflict-prone or insecure regions, where even the availability of health services doesn't guarantee access.

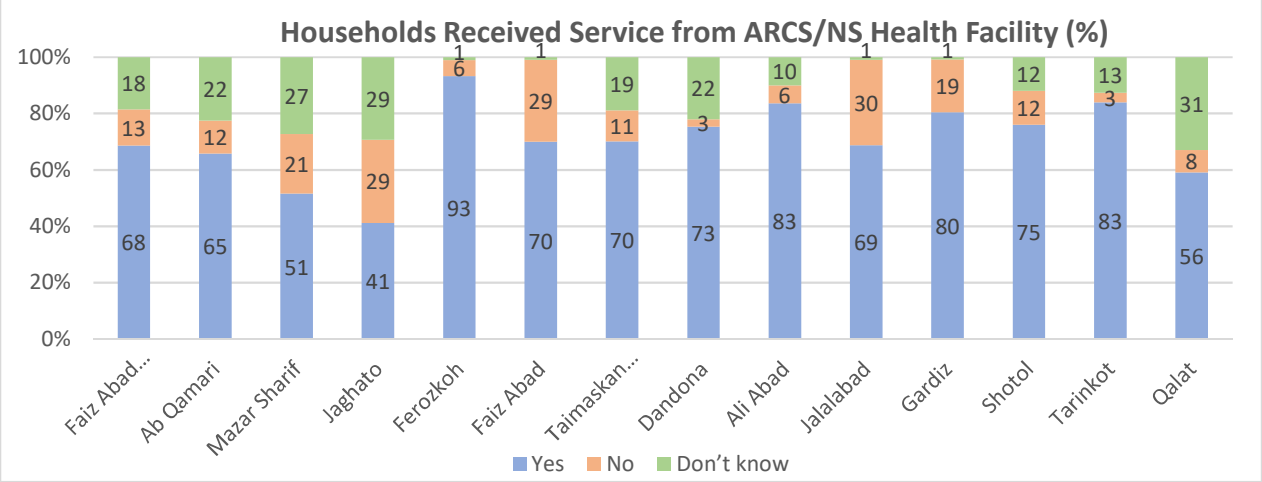
The analysis underscores systemic barriers, particularly financial hardship and transportation limitations, that hinder access to essential health services. Insecurity further compounds these issues in conflict-prone areas requiring a multi-sectoral response involving health, transportation, and protection actors.

Head of health facility KIIs in Qalat, Ferozekoh, Ali Abad, and Faizabad reveal that either lack of sufficient restrooms or toilets do not meet safety standards (e.g. no locks, poor lighting) as stated by Qalat Head of clinic.

## 7.7. Access to ARCS/NS Operated Facilities

This variable aims to assess the community-level visibility and utilization of health services provided by the ARCS/NS, capturing how widespread and recognized their services are across surveyed districts.

*Figure 10: Households Received Service from ARCS/NS Health Facility*




Overall, 71% of respondents confirm that the healthcare facility they used is operated by ARCS, whereas 14% reported not using ARCS facility, and 14% do not know whether they used ARCS facility or not.

This suggests that the ARCS has a strong operational presence in most of the surveyed regions. ARCS health facilities are widely utilized and recognized. However, a notable 28% (No + Don't know) indicates either limited visibility, low branding of ARCS services, or lack of respondent/public awareness of who manages the healthcare facility.

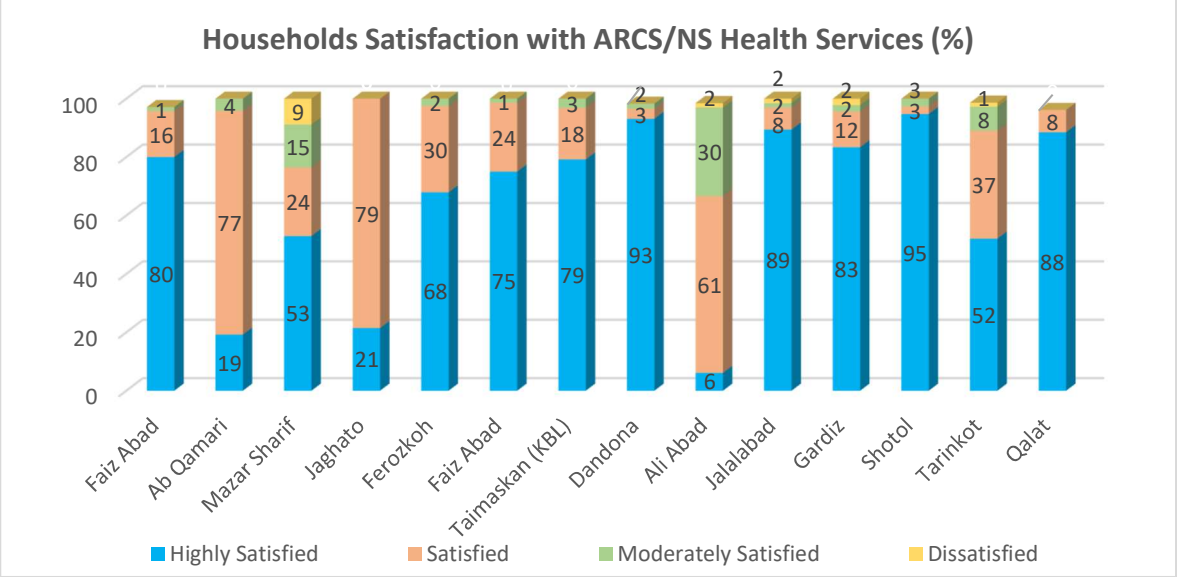
Districts like Ferozkoh, Tarinkot, and Ali Abad show exemplary outreach and service identity, which could serve as models for replication. High uncertainty levels (over 20% "Don't know") in districts like Qalat, Ab Qamari, Dandona, Mazar Sharif, and Jaghato suggest a need for greater visibility and clear branding.

Community leaders during KII broadly claim access to healthcare to be non-discriminatory, yet in practice, barriers exist for women, the poor, and those in remote areas. Critical health services such as diagnostics, emergency maternity care, and 24/7 facilities are largely missing, forcing families to travel far, if they can afford it. According to community leaders, most health and community service planning fails to account for women's unique needs.

## 7.8. Satisfaction with ARCS healthcare facility

This variable assesses the perceived quality, responsiveness, and user satisfaction of health services delivered by fixed or mobile clinics, including those operated by the ARCS/NS. Understanding satisfaction levels helps identify service delivery strengths and gaps that may require adjustments.

*Figure 11: Households Satisfaction with ARCS/NS Health Service*




The overall sentiment across districts was overwhelmingly positive. 98% of respondents reported satisfaction with ARCS/NS services to varying degrees i.e. 67% highly satisfied, 26% satisfied, and 5% moderately satisfied. Only 1% expressed "Dissatisfaction" and less than 1% high dissatisfaction.

These results show high levels of trust and appreciation for the current healthcare services, especially considering the challenging environments in which many facilities operate.

Among the survey districts, Shotol, Dandona, Jalalabad, Qalat, and Gardiz reflect exemplary satisfaction levels, serving as best practice examples. Ali Abad and Mazar Sharif show relatively poor satisfaction, highlighting quality, accessibility, or service delivery issues. Districts like Jaghato and Ab Qamari show generally good performance, but not excellence, suggesting areas for incremental improvements.

### 7.8.1. Dissatisfaction Aspect

Those dissatisfied were asked which aspects of ARCS/NS healthcare services they found unsatisfactory. This question aims to unpack the specific dimensions of dissatisfaction related to healthcare services. It provides a granular view of areas where clinics, whether fixed or mobile, may be underperforming, such as accessibility, staff behavior, infrastructure, or operational factors.

Across all districts, the key reasons for dissatisfaction were:

i. Distance from home – 17%

ii. Time spent in the waiting room – 14%

iii. Functioning of equipment – 11%

iv. Opening hours not suitable – 10%

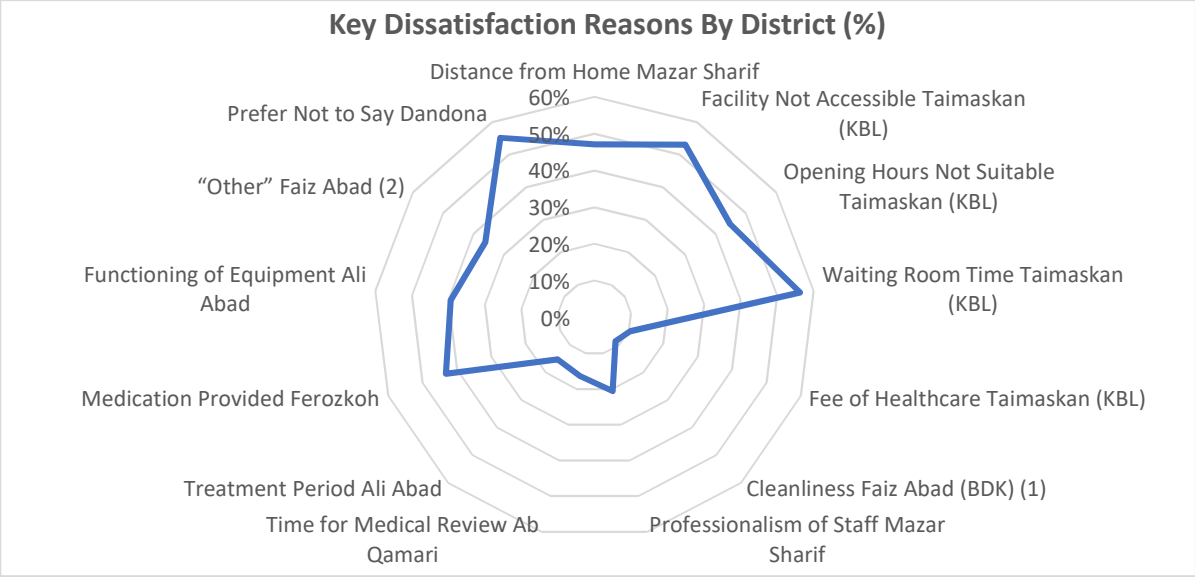
v. Facility not accessible – 11%

vi. Medication provided – 10%

vii. Other reasons – 9%

Interestingly, other reasons such as cleanliness, fees, and unprofessionalism of staff were less frequently cited such as 3%, 1%, and 5%, suggesting relatively stronger performance in those areas.

*Figure 12 Key Dissatisfaction Reasons By District*

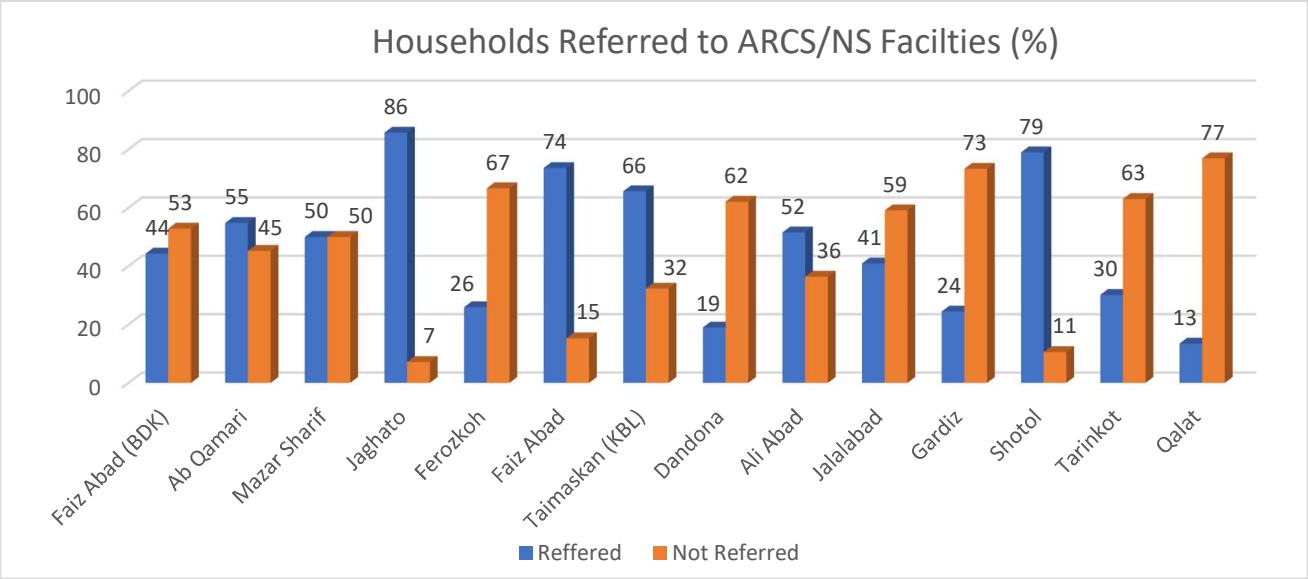



Districts like Taimaskan (KBL) and Mazar Sharif stand out as having the most widespread service dissatisfaction, across access, operational, and infrastructure concerns. Ali Abad, Ferozkoh, and Ab Qamari report dissatisfaction primarily related to equipment, treatment, and medication, indicating quality-related concerns. Districts like Jalalabad, Qalat, and Shotol report minimal dissatisfaction, reflecting comparatively effective and responsive service environments.

## 7.9. Referral Pathway to ARCS/NS

This dataset explores referral pathways to healthcare services, helping understand community mobilization, outreach effectiveness, and whether formal or informal actors are supporting access to healthcare. The responses are categorized into referrals by a volunteer/community worker, someone else (e.g., relatives, neighbors), who are not referred to, and those uncertain or unwilling to answer.

*Figure 13: Households Referred to ARCS/NS Facilities*




Overall, 50% of respondents reported not being referred to by anyone. 24% said they were referred to by a volunteer/community worker. 20% were referred to by someone else, such as family, friends, or neighbors. Whereas 5% were unsure, and 1% preferred not to answer.

This suggests that about half the population is self-motivated in seeking healthcare, while the other half relies on community networks or local volunteers, which is a moderately strong indication of community engagement or health literacy.

Districts like Jaghato, Shotol, Taimaskan, Faiz Abad (BDK), and Mazar Sharif show robust referral mechanisms, particularly through volunteers or formal community workers. These areas demonstrate higher levels of community engagement and organized outreach, potentially linked to stronger Red Crescent presence or NGO partnerships.

Gardiz and Qalat, on the other hand, reflect low volunteer engagement and high self-referral, indicating missed opportunities for early care guidance, and warrant targeted community mobilization initiatives.

The significant percentage (24%) of referrals by volunteers across surveyed districts is a positive indication that with structured support, community health promotion systems can work effectively, especially in remote or underserved

*Table 9: District Referral Rate*

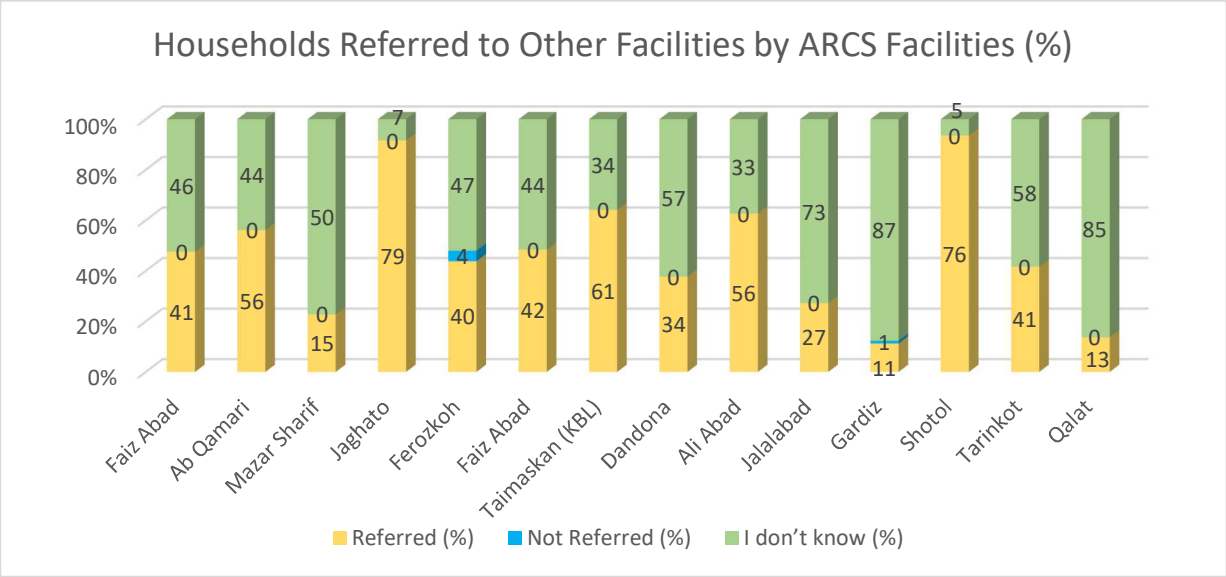
| District | Referral Rate |
|---|---|
| Jaghato | 86% |
| Shotol | 79% |
| Faiz Abad (BDK) | 74% |
| Taimaskan (KBL) | 66% |
| Ab Qamari | 55% |
| Ali Abad | 52% |
| Mazar Sharif | 50% |
| Faiz Abad | 44% |
| Jalalabad | 41% |
| Tarinkot | 30% |
| Ferozkoh | 26% |
| Gardiz | 24% |
| Dandona | 19% |
| Qalat | 13% |

districts.

## 7.10. Referral by ARCS/NS Facilities to Other Facilities

This variable aims to assess whether the healthcare facilities being accessed by households (fixed or mobile clinics) are effectively functioning within a referral system — crucial for linking primary care with more specialized or higher-level services.

*Figure 14: Households Referred to Other Facilities by ARCS/NS Facilities*




Overall, 41% of respondents across all districts reported being referred to another health facility. A slightly higher proportion, 51%, said they did not know whether a referral occurred — reflecting major gaps in communication or patient awareness. Only 8% preferred not to answer, which is relatively low.

This implies that while referrals are happening in around 4 out of 10 cases, over half of the surveyed households lack clarity on whether they were referred, a potential concern regarding information sharing and transparency within the referral system.

Districts Jaghato and Shotol stand out for their exceptionally high referral rates (above 75%). These figures suggest strong integration between primary-level care and specialized facilities/tertiary healthcare, and potentially well-trained frontline health workers recognizing cases needing escalation. Taimaskan, Ali Abad, and Ab Qamari also demonstrate good functionality of referral pathways, with rates above 55%.

Gardiz (11%), Qalat (14%), and Mazar Sharif (15%) show limited referral practices, or alternatively, a lack of awareness among the population about referrals. This is reinforced by high "don't know" responses (Gardiz: 86.7%, Qalat: 84.6%, Mazar Sharif: 50%). It may also indicate that either

complex cases are not being referred, or that facilities are not equipped with clear referral protocols or patient communication tools. These findings raise questions about communication breakdowns in healthcare interactions. In places like Gardiz and Qalat, where less than 15% reported receiving a referral and over 80% did not know, there's a clear disconnect between provider and patient regarding case referral.

Districts with high "Prefer Not to Answer", Mazar Sharif (35%), Shotol (18%), Faiz Abad (BDK, 13%), and Faiz Abad (14%) may imply privacy concerns or distrust in health systems, particularly if these respondents had negative experiences or uncertainty around being referred.

There is wide variance in referral systems functionality between districts. High-performing districts like Jaghato, Shotol, and Taimaskan can be studied for best practices.

The high proportion of "don't know" responses points to significant gaps in communication and documentation practices. Facilities must ensure patients and caretakers understand:

- Why are they referred,
- Where they are referred to,
- What services are expected at the next level.

Building capacity for healthcare staff in interpersonal communication and case documentation could greatly improve referral clarity. The variation also suggests a lack of standard operating procedures (SOPs) across clinics — these should be harmonized.

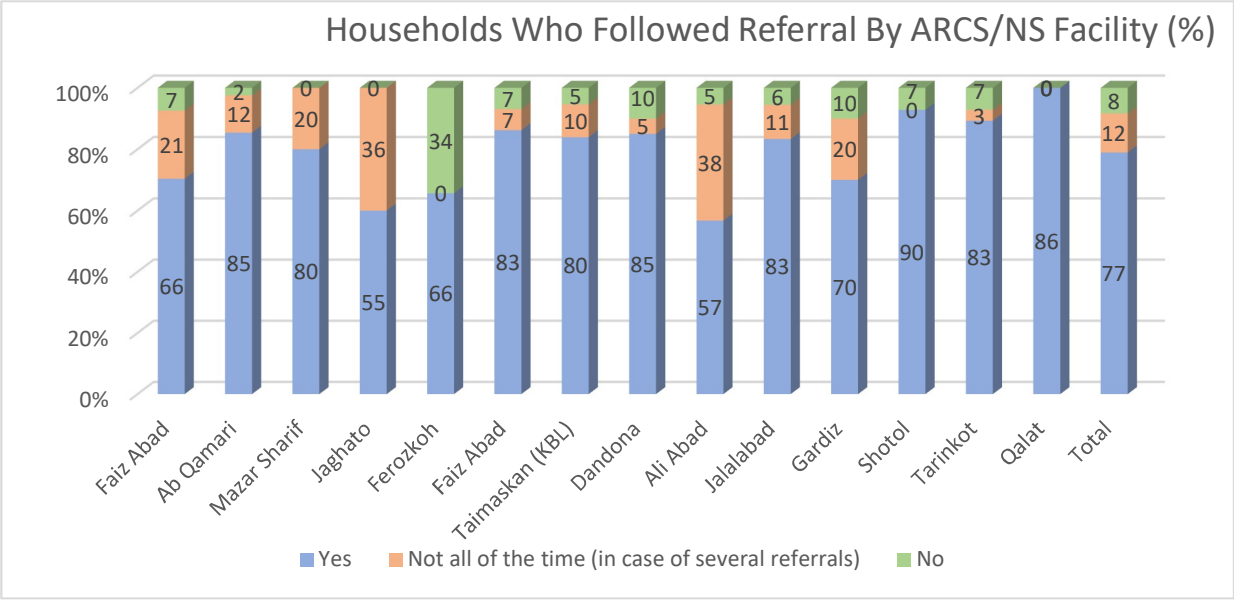
## 7.11. Following Referral to Secondary/Specialized Healthcare

This dataset assesses compliance with health referrals, an important indicator of health-seeking behavior, trust in medical advice, and access to specialized services after primary-level care. It also reflects the functionality of referral systems and potential barriers to follow-up care.

Across all districts, 77% of respondents reported they followed the referral recommendations and went to the specialized facility. 12% followed recommendations but not always, indicating multiple referrals where some were not acted upon. 8% did not follow the referral recommendation at all. 2% said they did not know, and 1% preferred not to answer.

This overall compliance rate (more than 3 in 4 households) is encouraging, suggesting that most households trust and act on health provider advice. However, the presence of partial compliance and non-compliance highlights areas for further support and investigation.

*Figure 15: Households Who Followed Referral by ARCS/NS Facility*




Districts Shotol, Ab Qamari, Dandona, Jalalabad, Tarinkot, Faiz Abad and Mazar Sharif show strong adherence to referrals (80% above compliance) implying trust in health systems, adequate accessibility (geographic and financial), perceived benefit of secondary/specialized care, and possibly good communication by health workers during the referral process.

Although above 60%, districts Taimaskan, Gardiz, Ferozkoh and Faiz Abad (BDK) show room for improvement, particularly in Gardiz and Ferozkoh, where refusal or uncertainty rates are relatively high.

Ali Abad had high rates of "not all the time" (38%), suggesting that households receive multiple referrals but are selective in acting on them—likely due to costs, distance, or skepticism. Jaghato, though having no direct "no" responses, had 36% partial compliance and 9% prefer not to answer, indicating hesitation and possibly limited access or trust, not practical to follow, due to affordability or geography, or overwhelming or poorly explained, leading to inconsistent follow-through.

Districts with high “I Don’t Know”, Qalat (14%) and Faiz Abad (7%), indicate possible information gaps, lack of communication between health facilities and patients, or sensitivity around referral experiences, especially in conservative or underserved communities.

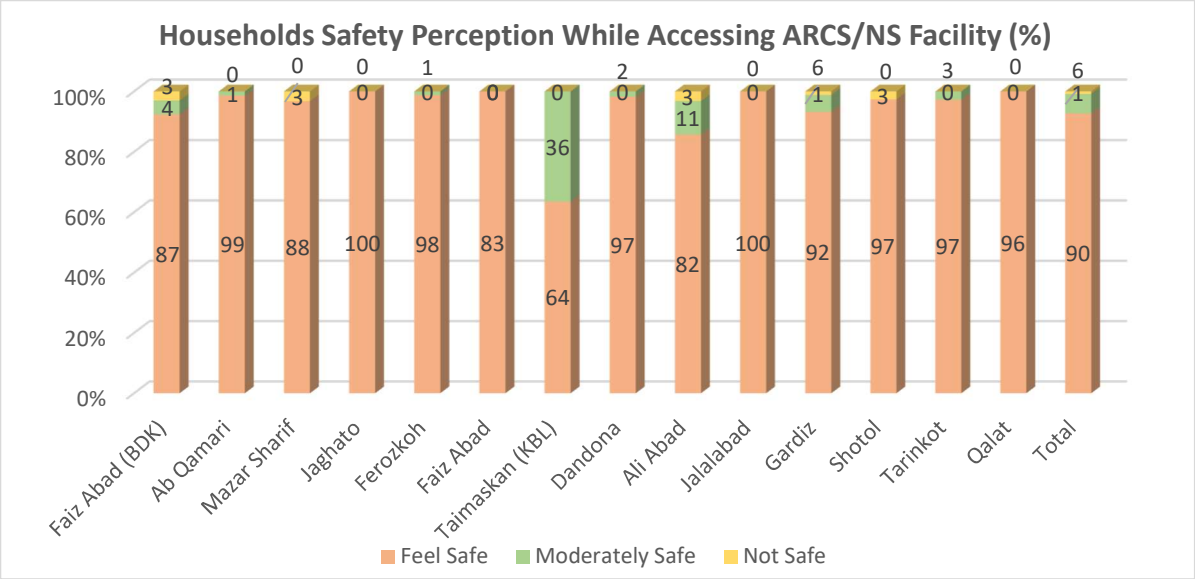
Overall, 3 out of 4 households complying with referrals shows a positive trend. Partial compliance needs attention and further inquiry into why referrals are not always followed. Invest in Patient Education: Many “don’t know” responses signal a need to ensure that referrals are clearly explained and documented, thus investment in patient education may be needed. Barrier

mapping in targeted assessments in low-compliance districts can reveal whether distance, costs, or sociocultural norms hinder access. Programs offering ambulance or transport reimbursement could enhance referral follow-through, especially for remote or disadvantaged households.

## 7.12. Safety Perception Accessing ARCS/NS Health Facility

This variable is essential to assess the perception of physical and psychological safety while accessing health services — a factor that directly impacts healthcare-seeking behavior, especially in fragile and conflict-prone settings like Afghanistan.

*Figure 16: Households Safety Perception While Accessing ARCS/NS Facility*




The combined 90% (Very Safe + Safe) suggests a strong sense of security while accessing ARCS-supported facilities, reflecting trust in the organizations, community acceptance, and good operational security measures. However, pockets of moderate safety concern and a few instances of negative perception require attention.

Districts Shotol, Qalat, Dandona and Jalalabad are exemplary in how secure and trusted the health facilities are perceived to be. No respondents here marked “not safe.” Ferozkoh and Gardiz show robust safety perception but still register a small share of respondents who felt less than completely safe. Ab Qamari stands out with a high “Safe” (74%) but low “Very Safe” (24.7%), indicating a sense of comfort but not complete assurance.

Taimaskan (KBL), Ali Abad, Faiz Abad, and Faiz Abad (BDK) reflect a more nuanced safety perception, where a portion of respondents either feel uncertain or moderately secure, and in some cases—like Ali Abad and Faiz Abad (BDK) express actual insecurity or reluctance to speak about their experience. In Taimaskan (KBL), over one-third of respondents reported feeling only "moderately safe", which is significant and might signal local security concerns, gender-specific

apprehensions, or perceived risks in accessing facilities (e.g., harassment, checkpoints, etc.). These findings emphasize the importance of local security dynamics, community relations, and possibly gender-based safety concerns. Even isolated safety issues need follow-up to maintain trust and ensure no one is deterred from seeking care.

High overall Safety (90%) is a positive indicator of ARCS's community engagement and operational setup. Districts Taimaskan (KBL), Ali Abad, and Faiz Abad with elevated moderate and negative safety perceptions require deeper qualitative inquiry (FGDs, KIIs), gender-segregated data reviews (safety concerns may disproportionately affect women), and coordination with local authorities and volunteers for safety assurance.

For communication & Visibility messaging around facility ownership, neutral and humanitarian nature may be strengthened, especially in areas where "I don't know" responses are high.

To address hesitation & fear, districts with high "Prefer not to answer" (e.g., Faiz Abad and Qalat) may benefit from community engagement or discreet patient feedback mechanisms to voice concerns without stigma. The organization may conduct safety perception surveys regularly to track trends and adapt interventions accordingly.

## 7.13. Frequency of Healthcare Utilization

This dataset provides insight into both the frequency of healthcare utilization and the diversity of healthcare providers accessed by respondents over the past year. The combination of volume and variation of visits also helps to understand the health burden, availability, trust levels, and possibly service gaps in local health systems.

*Table 10: Frequency of Healthcare Utilization*

| District | Visits to a ARCS/NS Healthcare Facility in 12 Months | Visits to Other Health Facilities in 12 Months |
|---|---|---|
| Faiz Abad (BDK) | 293 | 188 |
| Ab Qamari | 324 | 196 |
| Mazar Sharif | 194 | 117 |
| Jaghato | 146 | 55 |
| Ferozkoh | 516 | 121 |
| Faiz Abad | 289 | 117 |
| Taimaskan (KBL) | 354 | 306 |
| Dandona | 675 | 141 |
| Ali Abad | 343 | 143 |
| Jalalabad | 1,565 | 452 |
| Gardiz | 829 | 194 |
| Shotol | 337 | 165 |
| Tarinkot | 338 | 280 |

| | | |
|---|---|---|
| Qalat | 1,118 | 448 |
| **Total** | **7,321** | **2,923** |

Respondents reported total 7,321 visits to ARCS/NS facilities, 2,923 visits to other facilities in the last 12 months across all districts. This reflects an average of approximately 4 and 2 visits per year to each ARCS and other health facilities respectively. ARCS visits are two times more than visits to other facilities, indicating ARCS facilities as first choice. It further indicates good quality services at ARCS facilities compared to other facilities.

High utilization districts Jalalabad, Qalat, Gardiz, and Dandona stand out with high visit volumes, suggesting higher health needs or good access. However, in Dandona and Gardiz, high repeat visits at fewer facilities may indicate service limitations or the need for expanded facility networks.

Balanced access districts like Ali Abad, Shotol, and Faiz Abad show usage patterns close to the overall average, indicating predictable and stable access behavior.

Low utilization or dispersed access in Taimaskan and Tarinkot show high numbers of different facilities accessed but lower visit totals, suggesting inconsistent or unsatisfactory care at each visit or highly mobile population.

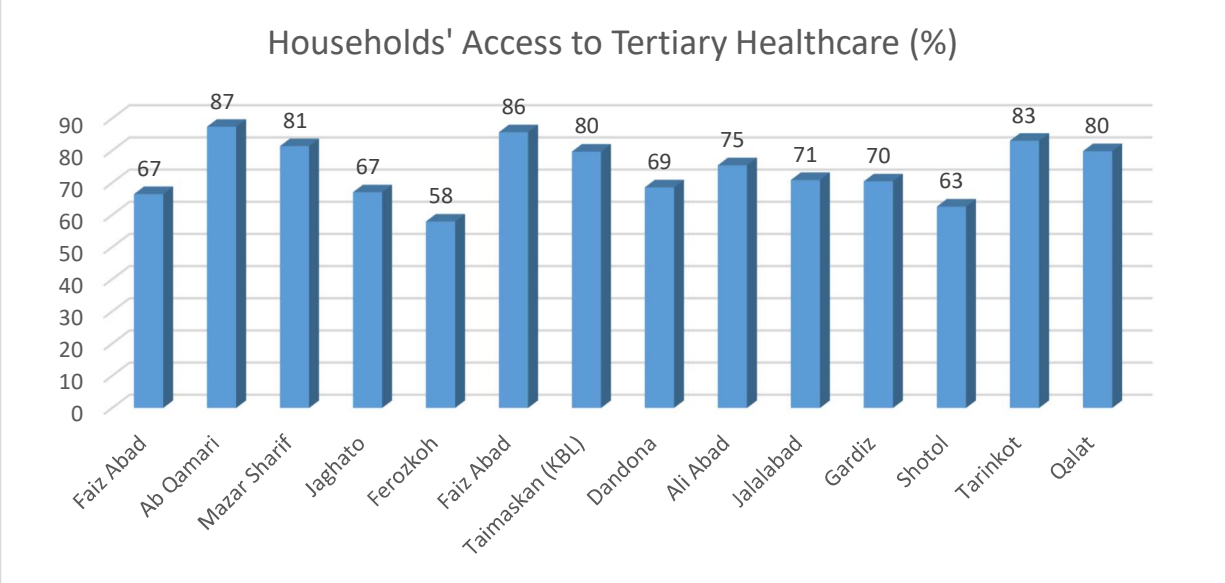
Very low access districts Jaghato and Mazar Sharif report the lowest number of health visits, which may be due to security concerns, low facility density, or community preferences for alternative medicine/traditional healers.

To understand fragmentation in healthcare delivery and reasons for switching providers, qualitative follow-up in districts with high diversity of facility visits (e.g., Taimaskan, Tarinkot) may be helpful. In places like Dandona, Ferozkoh, and Gardiz where high visit counts are concentrated in fewer facilities, assessing facility burden is essential. Referral tracking strengthening between facilities and across the public–private/ARCS continuum may ensure continuity of care.

## 7.14. Access to Tertiary or Specialized Healthcare

This dataset assesses critical access to secondary and specialized healthcare, often more difficult to secure in fragile, rural, low income, or conflict-affected areas. The data offers insight into demand for hospitalization and the adequacy of support received.

*Figure 17: Households' Access to Tertiary Healthcare (%)*




Across all districts, 1941 household members needed hospitalization/specialized care. Out of those in need of specialized care, 1,457 HH members received support every time. Overall, 75% of individuals needing specialized medical care were able to access it consistently when required. This suggests that 1 in 4 individuals requiring hospitalization or advanced care could not receive consistently a significant gap in essential medical service availability or access.

Districts with highest fulfillment rates (over 75%), Ab Qamari (87%), Faiz Abad (86%), Tarinkot (83%), Mazar Sharif (81%), and Qalat (80%) showed strong performance in accessing specialized services. These figures indicate relatively effective referral systems, hospital accessibility, or financial/social ability to complete treatment pathways.

Districts with moderate access (fulfillment between 65–75%), Ali Abad (75%), Jalalabad (71%), Gardiz (70%), Dandona (69%), Faiz Abad BDK (67%), Jaghato (67%) demonstrate noticeable service gaps i.e. up to one-third of individuals could not obtain repeated or consistent access to specialized care. Potential barriers may include financial constraints, lack of specialist presence, or weak referral management.

Districts Ferozkoh (58%) and Shotol (63%) had the lowest fulfillment. This is particularly concerning as over 40% of people in need in these districts did not receive required care. These figures may reflect geographical isolation, facility limitations, or security issues that inhibit access.

Assessing high need versus high delivery, Tarinkot reported the highest number of hospitalization cases (254) and an above-average fulfillment rate (83%), indicating both high demand and relatively strong response capability. Faiz Abad (BDK) had the second-highest hospitalization load (200) but only 67% received full care, pointing to capacity limitations or financial access barriers.

The data suggests investments in secondary health facilities in districts like Ferozkoh and Shotol, where service gaps are most visible. In areas with high hospitalization load (e.g., Tarinkot, Faiz Abad BDK), additional support in facility expansion, staff training, and patient referral pathways can improve coverage. Further qualitative research is required to understand why 25% of people needing specialized care could not access it, whether due to cost, lack of services, referrals, or security. Emergency transport, hospital bed availability, and diagnostic infrastructure should be prioritized in low-performing districts.

## 7.15. Barriers Faced to Access Tertiary Healthcare

This variable investigates access-related barriers to tertiary or specialized healthcare. Barriers are grouped into themes: availability of alternative health facilities, structural or operational issues, financial barriers, geographic and physical barriers, and unspecified or "other" barriers.

### 7.15.1. Availability of alternative health facilities

Mazar Sharif (57%), Ab Qamari (46%), and Ali Abad (32%) report the highest availability of alternative health facilities, indicating relatively better service coverage. Ferozkoh (7%), Faiz Abad (10%), and Tarinkot (14%) show the lowest availability, highlighting service gaps in these locations. Districts with low availability may face higher dependency on limited health infrastructure, risking service overload or reduced access in case of emergencies.

### 7.15.2. Structural or operational issues (destroyed/closed facilities, staff & supplies)

Facility destruction or closure is not widespread but notable in Gardiz (36% destroyed), Jaghato (20% destroyed, 7% closed), and Ali Abad (11% destroyed). These reflect areas impact possibly by conflict or natural disaster. Staff shortages are most common in Ali Abad (32%), Shotol (29%), and Tarinkot (25%), significantly impairing service delivery quality. Medication shortages are among the most commonly reported challenges. Tarinkot (46%), Ali Abad (37%), and Mazar Sharif (29%) top this category. These structural and supply-side limitations point to systemic under-resourcing and highlight the need for investment in staffing and essential drugs.

### 7.15.3. Financial barriers

High cost of healthcare services is a frequently cited concern, especially in Tarinkot (39%), Taimaskan (42%), and Ferozkoh (44%). Expensive transportation compounds the problem in Jalalabad (29%), Ali Abad (16%), and Gardiz (11%). The data underscores that financial constraints—both direct and indirect—are among the leading barriers to care in several provinces.

### 7.15.4. Geographic and Physical Barriers

Long distances to health facilities are especially problematic in Ali Abad (16%), Taimaskan (19%), and Qalat (20%). Safety concerns while accessing services are less frequently mentioned but still appear in Faiz Abad (8%), Taimaskan (13%), and Jalalabad (14%). These findings are consistent with other studies in Afghanistan shown that remoteness, poor road infrastructure, and insecurity disproportionately limit access to healthcare services in rural and mountainous areas, especially affecting women and marginalized communities.[28]

### 7.15.5. Unspecified or "Other" Barriers

"Other" reasons for difficulty in accessing healthcare are highly reported in Faiz Abad (70%), Ali Abad (42%), and Ferozkoh (44%). These may include cultural norms, gender-based barriers, social stigma, or quality of care issues, warranting deeper qualitative exploration.

### 7.15.6. Prefer Not to Say / Non-Disclosure

High percentages of respondents opt "Prefer not to say" in Dandona (71%), Faiz Abad (30%), and Qalat (33%). This may indicate sensitivity of the topic, fear of reprisal, or lack of trust in the survey process. It underscores the importance of building trust with communities and ensuring confidentiality in future assessments.

The data paints a complex picture of healthcare access across surveyed districts. Supply-side challenges (staffing, medication, and facility conditions) are most acute in Ali Abad, Shotol, and Tarinkot. Financial barriers are prominent in Tarinkot, Taimaskan, and Ferozkoh. Geographic and safety concerns limit access in Taimaskan, Jalalabad, and Qalat. Alternative service availability provides some relief in Mazar Sharif and Ab Qamari but remains weak elsewhere.

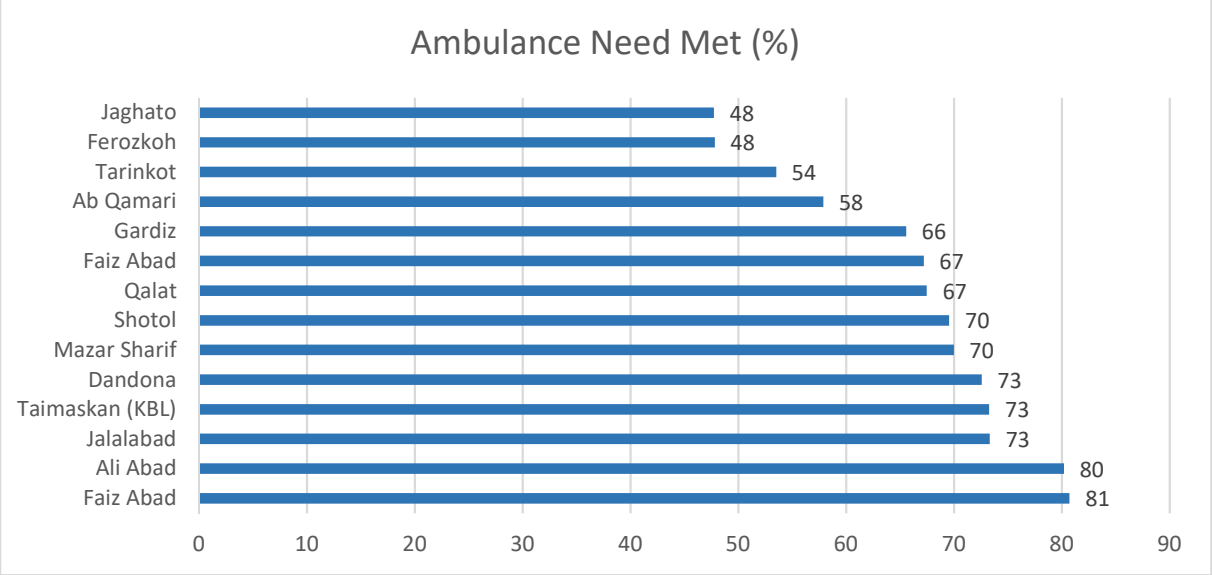
Efforts to improve access must adopt a multi-pronged approach, combining infrastructure investments, financial support, community engagement, and decentralization of health services to reach the most vulnerable.

## 7.16. Medical Transportation/Ambulance Service Fulfillment

This data examines the need for ambulance or medical transport services in the last 12 months and evaluates how many of those in need actually received appropriate care, offering insight into the functionality and equity of emergency health systems in the surveyed districts.

[28] EMERGENCY/CRIMEDIM 2022–23; HRW 2023; Afghanistan Analysts 2025

*Figure 18: Ambulance Need Met*




Across all districts, 1,064 respondents required ambulance/medical transportation, and 724 received the required support within 30 minutes starting from call for service to reaching the health facility. This cumulates an overall service fulfillment rate of 68%. This means nearly one-third (32%) of individuals who required ambulance-supported care did not receive the required medical attention, indicating a substantial gap in emergency health response.

Faiz Abad and Ali Abad reflect strong performance with 81% and 80% success rates respectively, indicating relatively reliable emergency response.

Jalalabad, Taimaskan (KBL), Dandona, Mazar Sharif, and Shotol demonstrate significant demand and reasonable capacity yet leaves 27% - 30% requesters underserved.

Qalat, Faiz Abad (BDK) and Gardiz perform relatively low with 66-67% fulfillment rate, living behind one-third of in need individuals. This indicates lacking ambulance availability, effective referral systems, or suffering from delays in response due to remoteness or conflict.

The gap between demand and successful delivery of care points to inequities in resource distribution, referral systems, and possibly delays in dispatch and response.

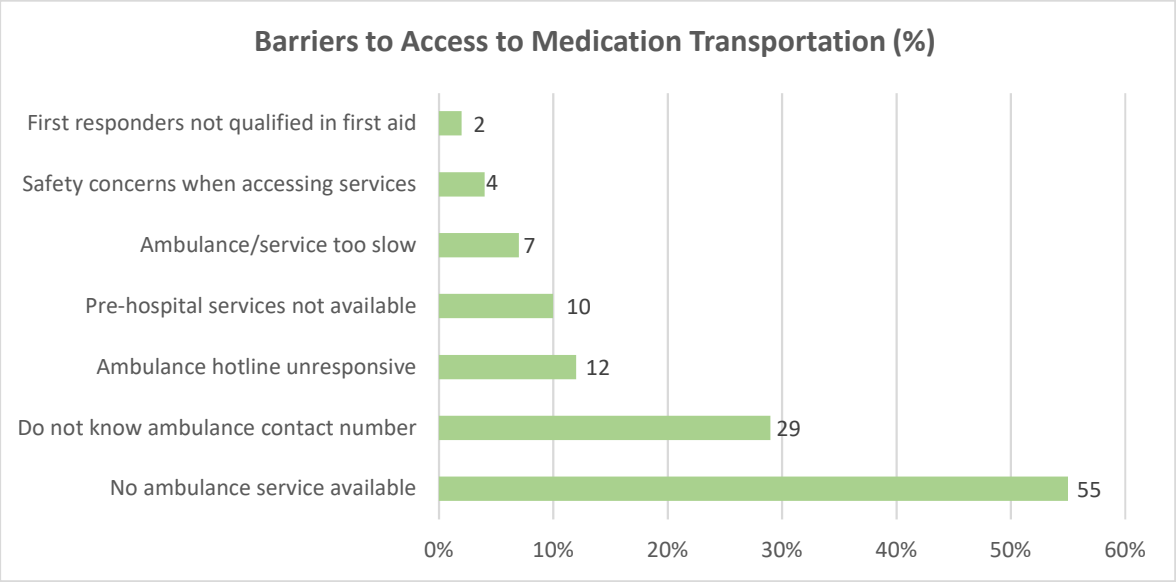
The data is highlighting the need to scale up ambulance coverage and invest in local community-based referral mechanisms in poorly performing districts, invest in dispatch systems and community first response to reduce delay times and bridge care access gaps, and prioritize mobile clinic coordination in Ferozkoh, Jaghato, and Tarinkot to better serve high-risk, underserved zones.

Across the board, FGDs participants highlighted lack of ambulance services in their regions, particularly in remote villages. In most areas, there are no ambulances attached to the local ARCS health clinics, and people rely on private transport or rented vehicles, often at a high financial and emotional cost. This is especially burdensome in emergencies, such as during childbirth or critical illness. However, Jalalabad, Shotal, and Taimaskan (KBL) FGDs members informed that ambulance service was available in their area, and they knew how to access the service.

### 7.16.1. Barriers to Access to Medical Transportation/Ambulance

This dataset explores the barriers preventing access to medical transportation/ambulance service, especially emergency or referred care, as reported by households. The responses highlight critical gaps in ambulance services, emergency communication, and first response infrastructure.

*Figure 19: Barriers to Access to Medication Transportation*




The most common issue was the non-availability of ambulance services, followed by lack of awareness of ambulance contact numbers and unreliable emergency hotlines.

The data reveals widespread, multifaceted issues in ambulance accessibility across surveyed districts, driven by infrastructure gaps, communication failures, and socio-cultural factors:

Ab Qamari and Faiz Abad (second entry) report 100% absence of ambulance services, indicating complete lack of emergency response infrastructure. Dandona, Ali Abad, Shotol, and Tarinkot similarly face severe service gaps, with 60–93% citing unavailability, lack of pre-hospital care, or contact issues. Jaghato stands out with 85% reporting no ambulance and additional concerns like lack of contact knowledge (27%), non-functional hotlines, and unqualified staff, exposing deep systemic dysfunction.

Gardiz and Taimaskan (KBL) exhibit moderate but diverse barriers, from contact unavailability and slow response to safety concerns, highlighting urban complexity and trust issues. Ferozkoh, while reporting low outright ambulance unavailability (9%), shows extremely high information and awareness gaps (68% unaware of contact numbers), suggesting infrastructure underutilization due to communication failure.

Mazar Sharif reports 67% without ambulance access and 33% citing slow service, likely reflecting urban congestion or overloaded emergency systems. Jalalabad and Qalat show high levels of "other" and "prefer not to say" responses, possibly hinting at hidden social barriers like gender norms, cost stigma, or lack of community trust. Faiz Abad (BDK): Presents a mixed profile, with 68% lacking ambulance service, and others noting unknown contacts, unanswered calls, and safety issues. This indicates a blend of infrastructure gaps and cultural/financial limitations.

Widespread Ambulance Unavailability remains a major barrier, particularly in rural and mountainous districts. Communication and Awareness Gaps undermine service utilization even where infrastructure may exist (e.g., Ferozkoh). Urban Areas face system overload, slow service, and trust issues, especially in Taimaskan and Mazar Sharif. Social and Cultural Barriers, evident from high "other" and "prefer not to say" responses—require community-level sensitization and inclusive outreach.

To enhance the access and efficiency of medical transportation, program may deploy community-based ambulance systems in underserved districts, create awareness campaigns to distribute emergency contact numbers widely, improve the responsiveness of ambulance hotlines via digital tracking and feedback loops, train and certify first responders to ensure confidence in pre-hospital services, and address non-infrastructural barriers, such as safety concerns and cultural norms, through community engagement and feedback.

### 7.16.2. Response Time of Medical Transportation Service

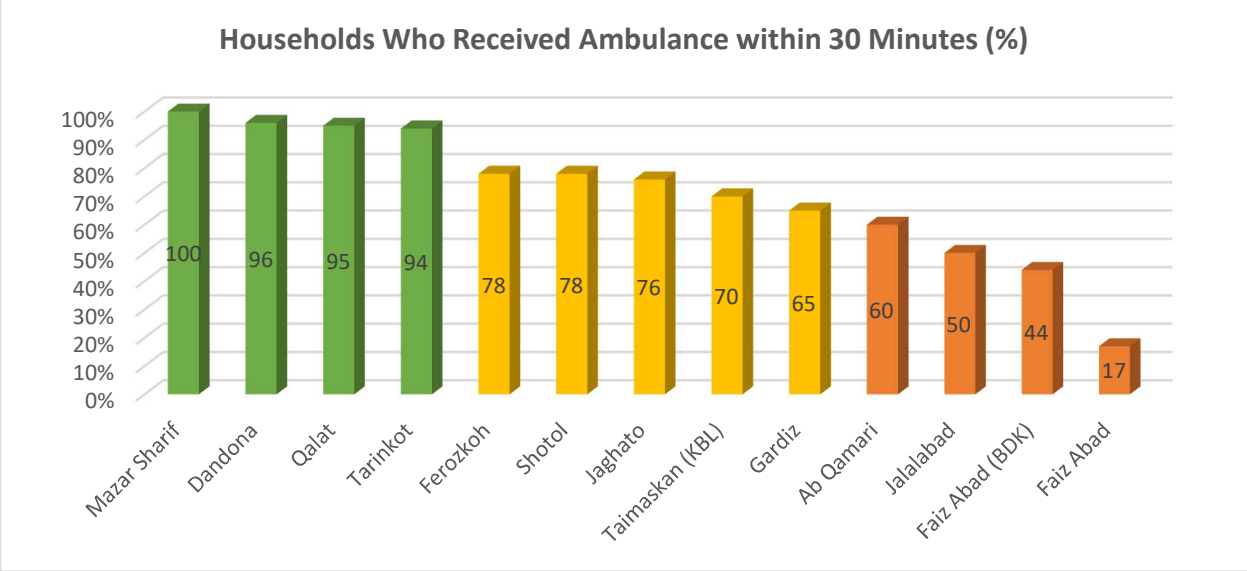
Timely availability of the ambulance is a critical indicator of the accessibility and efficiency of emergency health services, especially ambulances or other pre-hospital care mechanisms. This dataset assesses the response time and total travel duration for individuals who required medical transportation.

Across surveyed districts, the shortest response time reported is 16-30 minutes (37%), followed by 0-15 minutes (25%). While 62% of responses fell within 30 minutes, a concerning 38% of trips took more than 30 minutes, which could be critical in emergency cases. Only 25% had access within 15 minutes, the ideal golden window for many urgent interventions.

In Mazar Sharif, Dondana, Tarinkot and Qalat, over 94% of respondents received emergency care within 30 minutes with minimal delays beyond 45 minutes. These are best performing districts on response time. This indicates a strong urban infrastructure or compact rural settlements,

reliable ambulance or community health worker presence, efficient healthcare staff, or proximity to healthcare facilities. Other districts may benefit from the best practices of best performing districts. Further investigation into minimal delays beyond 45 minutes will help in understanding the underlying causes and improve where causes could be controlled.

*Figure 20: Households Who Received Ambulance within 30 Minute*




Districts Gardiz, Taimaskan (KBL), Ferozkoh, Jaghato, and Ab Qamari fall under moderately performing districts with 60-80% response within 30 minutes and lower delay time of 30-60 minutes. This implies mixed topography (urban–rural divide), ambulance services available but inconsistent, and partial infrastructure and staff constraints.

The programs may focus on expanding fleet of ambulances or motorbike responders in rural stretches, improve community awareness on emergency contact numbers, establish dispatch coordination centers or integrate with national hotlines, and consider community first responder training for remote areas

Districts Faiz Abad (BDK), Faiz Abad, and Jalalabad are poor performing districts on response time with less than 50% reach emergency care in 30 mins. Over 30% experience 46–60 min delays. This indicates urban sprawl or difficult terrain, service congestion or poorly coordinated emergency pathways, knowledge or trust gaps in health infrastructure, or emergency staff performance issues.

Health programs may consider route optimization for ambulance dispatches, improve inter-facility referral systems, introduce public awareness campaigns for hotline use, monitor and reduce service bottlenecks through operational audits.

Ali Abad is the worst performing districts on emergency response time with only 27% reached within 30 minutes, 48% took 46–60 minutes, 23% took over 60 minutes. Significant delay in

response impacts the efficiency of emergency response system adversely. The lowest response suggests severe infrastructure gaps, possibly mountainous or dispersed settlement patterns, weak ambulance presence or response coordination, poor monitoring of services, and non-responsive feedback mechanism.

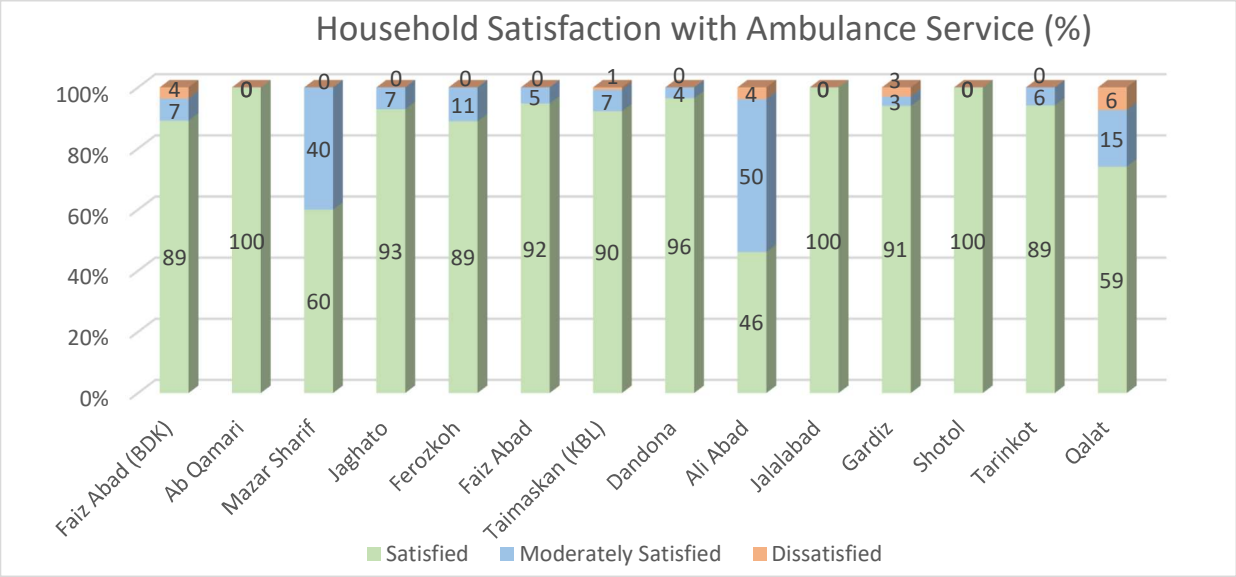
Immediate investment in ambulance infrastructure, deployment of mobile health units or motorcycle emergency teams, identification and prioritization of high-risk zones for rapid response services, and engagement with community leaders to improve awareness and trust, and a responsive feedback response mechanism may improve the access to quality healthcare.

Overall, health program implementers may integrate emergency transport into national disaster preparedness frameworks, develop a national ambulance registry and GPS-based dispatch system, create referral and triage guidelines for local clinics to minimize unnecessary transport delays, and promote community-based health volunteer networks for remote or hard-to-reach zones to enhance the impact of health programming.

### 7.16.3. Satisfaction with Medical Transportation

This variable assesses the overall satisfaction of respondents with the quality of healthcare services received, particularly important for evaluating patient experience, trust in providers, and potential for continued service utilization.

*Figure 21: Household Satisfaction with Ambulance Service*




Overall, 85% of respondents expressed positive satisfaction (56% highly satisfied, 29% satisfied), which is a strong endorsement of the services. However, 11% were only moderately satisfied,

suggesting room for quality improvements. Very low dissatisfaction (2%) indicates overall trust, but even minimal dissatisfaction in health contexts can lead to reluctance to seek care.

District Jalalabad with 100% highly satisfied exceptional results, indicates flawless delivery of services. Shotol's 100% satisfaction (95% highly satisfied, 5% satisfied) level prompts very high trust and appreciation of care. Dandona with 96% satisfaction (89% high satisfied, 7% satisfied) reflects consistent and quality healthcare access. Faiz Abad (BDK) reports 89% satisfaction (78% highly satisfied, 11% satisfied), showing strong performance in user experience. These districts set standards for excellence. Taimaskan (KBL) achieves 90% satisfaction (69% high satisfied, 21% satisfied), suggesting high-quality care with only 1% dissatisfaction. Jaghato represents 93% satisfaction but with 43% highly satisfied and 50% satisfied, and Gardiz reports 91% satisfaction (59% highly satisfied, 32% satisfied), indicating good services, but not exceptional, and a potential to elevate quality and care environment.

In Tarinkot 89% of respondents are overall satisfied (50% highly satisfied,39% satisfied), 6% moderately satisfied, and 6% did not respond), which worth attention and indicate need for improvement in service.

Mazar Sharif, Ali Abad, and Qalat, report mixed ratings (higher moderate satisfaction or Negative responses), indicating inconsistent experiences or service variability, limited staff, poor equipment, or long waiting times, lack of trust or sensitive dissatisfaction that must be further investigated, or varying quality across sites within the same district.

To meet the client expectation and raise their level of satisfaction, the health programs may consider conduct focused follow-up assessments in Ali Abad, Qalat, Tarinkot, Ferozkoh, and Mazar Sharif to identify precise causes of dissatisfaction (e.g., poor staff attitude, long waiting times, poor cleanliness), sharing and replicating best practices from top-performing districts like Jalalabad and Dandona across lower-performing areas. They may implement feedback mechanisms at health facilities to capture real-time client experiences and act on them swiftly and build capacity and offer refresher training to staff on patient-centered care, especially in mixed-performing districts.

## 7.17. Healthcare Financial Burden

This dataset captures the financial burden of accessing healthcare, an essential lens to understanding economic vulnerability, especially in humanitarian contexts. The expenditure covers transportation, accommodation, medicine, consultation, and other support services.

*Table 11: Healthcare Financial Burden*

| District | Transpor-tation | Food | Accommo-dation | Social Care | Consultation Fee | Medicines | Other | Total |
|---|---|---|---|---|---|---|---|---|
| Faiz Abad (BDK) | 16% | 17% | 13% | 9% | 12% | 26% | 6% | 100% |
| Ab Qamari | 24% | 4% | 3% | 1% | 10% | 49% | 9% | 100% |
| Mazar Sharif | 33% | 13% | 4% | 2% | 12% | 36% | 0% | 100% |
| Jaghato | 24% | 17% | 14% | 7% | 16% | 19% | 4% | 100% |
| Ferozkoh | 18% | 5% | 2% | 0% | 7% | 68% | 0% | 100% |
| Faiz Abad | 29% | 3% | 1% | 0% | 8% | 25% | 35% | 100% |
| Taimaskan (KBL) | 29% | 32% | 1% | 1% | 11% | 26% | 0% | 100% |
| Dandona | 39% | 14% | 2% | 2% | 11% | 31% | 0% | 100% |
| Ali Abad | 22% | 8% | 8% | 1% | 5% | 28% | 27% | 100% |
| Jalalabad | 23% | 13% | 6% | 10% | 21% | 28% | 0% | 100% |
| Gardiz | 20% | 8% | 8% | 2% | 23% | 39% | 1% | 100% |
| Shotol | 14% | 65% | 2% | 1% | 3% | 15% | 1% | 100% |
| Tarinkot | 27% | 13% | 6% | 2% | 5% | 45% | 2% | 100% |
| Qalat | 17% | 3% | 1% | 20% | 7% | 53% | 0% | 100% |
| **Aggregate** | **22%** | **16%** | **4%** | **4%** | **11%** | **39%** | **4%** | **100%** |

Overall, Medicines (39%) represent the largest share of expenditure at the aggregate level, highlighting the substantial health-related financial burden on households. This suggests either a high prevalence of illnesses or reliance on out-of-pocket medical spending due to limited free or subsidized health services. Transportation (22%) is the second-largest national category, underscoring the significance of mobility costs in accessing markets, services, and healthcare, especially in rural or remote districts. Food (16%) stands third, which is lower than expected for a humanitarian context, possibly reflecting subsistence food production, food aid coverage, or prioritization of other urgent expenses like medicines. Accommodation, social care, and other expenses each consume smaller shares, suggesting that shelter costs may be less burdensome for households owning their homes or relying on extended family arrangements.

At district level, Dandona (39%), Faiz Abad (BDK) 29%, Faiz Abad (29%), and Taimaskan (29%) show the highest transport expenditure, likely due to remoteness and poor infrastructure increasing travel costs for markets, work, and health services. This is a critical barrier where distance-sensitive interventions, such as mobile clinics or transport subsidies, could be impactful.

Ferozkoh (68%), Qalat (53%), Tarinkot (45%), Gardiz (39%), and Ab Qamari (49%) show alarmingly high proportions of household budgets going to medicines. These figures point to high health service costs, possibly due to the lack of affordable public services and reliance on private pharmacies.

Shotol (65%) stands out with extreme food cost dominance, indicating either market dependency or lack of food assistance. Taimaskan (32%) and Faiz Abad (BDK) (17%) also show above-average food costs, which could reflect rising market prices or poor household production capacity.

Jaghato (14%), Faiz Abad (BDK) (13%), and Ab Qamari (3%) show variable trends. In most rural districts, accommodation costs remain low (0–3%), likely due to ownership of dwellings, while certain urban-linked areas face higher rental burdens. Qalat (20%) is exceptionally high, suggesting unique local dynamics, such as high dependence on care for elderly or disabled family members. Most other districts report minimal spending (0–4%). Faiz Abad (35%) and Ali Abad (27%) allocate large shares to “other” expenses, indicating possible unclassified costs like debt repayment, ceremonies, or seasonal agricultural expenses.

Health expenditure dominance suggests that healthcare financing mechanisms need urgent attention, particularly in Ferozkoh, Qalat, and Tarinkot. Transport costs in Dandona, Faiz Abad, and Taimaskan highlight mobility barriers that may be linked to service access inequality. Food insecurity concerns are most acute in Shotol, suggesting targeted food security interventions or market stabilization measures. High “other” costs in certain districts point to the importance of exploring local expense drivers, these could include cultural or debt-related spending patterns.

# 8. Health and Protection – Findings

Violence against healthcare providers represents a serious challenge to the safety, accessibility, and quality of health services. Responses from surveyed districts reveal varying degrees of verbal, physical, and material violence encountered or witnessed by respondents. While the majority report no such experiences, significant outliers exist, raising concerns about the safety and working conditions of medical staff in certain districts.

*Table 12: HH Experience or Observation of Violence*

| District | Verbal Violence | Physical Violence | Material Violence | Other Violence | No Violence | Don't know | Prefer Not to Answer |
|---|---|---|---|---|---|---|---|
| Faiz Abad (BDK) | 24% | 13% | 5% | 17% | 10% | 38% | 4% |
| Ab Qamari | 2% | - | 1% | 4% | 54% | 40% | - |
| Mazar Sharif | - | - | 2% | 2% | 89% | 7% | 2% |
| Jaghato | 1% | 4% | 8% | 2% | 76% | 12% | - |
| Ferozkoh | 10% | 3% | 2% | 2% | 74% | 10% | - |
| Faiz Abad | | 1% | 1% | 5% | 90% | 4% | |
| Taimaskan (KBL) | 3% | - | 1% | 2% | 93% | 1% | - |
| Dandona | 1% | - | 2% | | 63% | 32% | 2% |
| Ali Abad | 26% | 4% | 2% | 17% | 34% | 18% | 3% |
| Jalalabad | 3% | | | 2% | 93% | 3% | 1% |
| Gardiz | 4% | 7% | 5% | - | 36% | 40% | 10% |
| Shotol | - | - | - | - | 88% | 11% | 1% |
| Tarinkot | 7% | 1% | 5% | 1% | 74% | 11% | 2% |
| Qalat | 17% | 2% | 8% | - | 80% | 2% | - |
| **Aggregate** | **7%** | **2%** | **3%** | **4%** | **69%** | **16%** | **2%** |

This dataset assesses HH members' experience or observation of various types of violence. Overall, only 16% of respondents report experiencing or observing verbal, physical, or material violence. This relatively low direct reporting could indicate either genuinely low incidence or significant underreporting due to stigma, fear, or cultural sensitivities about disclosing such information.

The largest proportion, 69%, reported no violence experience or observation. While this may seem positive in numbers, it must be interpreted cautiously especially in humanitarian contexts where social norms, lack of trust, and security concerns can lead to non-disclosure.

A notable 18% responded with "Don't know" (16%) or "Prefer not to answer" (2%). These responses point to possible barriers such as limited awareness of what constitutes violence,

reluctance to disclose sensitive information to enumerators, or cultural norms discouraging open discussion of violence, especially gender-based violence.

Triangulation of reported data with other secondary sources/studies reveal significant gaps or underreporting on this variable. According to DHS Afghanistan 2015 data analysis, over 52% of women experienced at least one type of inmate partner violence (IPV), with 33.01%, 49.07%, and 8.99% experiencing emotional, physical, and sexual violence, respectively. The regression results show that armed conflicts were significantly and positively associated with the experience of all types of IPV. In addition, the association between armed conflicts and the experience of emotional IPV was positively moderated by women's attitudes towards IPV.[29] UN-Women Afghanistan reported 34.7% of women aged 15–49 experiencing physical and/or sexual violence by a current or former intimate partner in the previous 12 months.[30]

From the secondary data comparison, underreporting of violence data is evident. A focused study on violence against children (VAC) assessed perceptions of community and religious leaders in Kabul, Jalalabad, and Torkham. It found that religious and community leaders underreported violence against children by approximately 30–40% compared to other professional groups. Business owners also significantly underreported VAC in the workplace, despite admitting to acts of discipline that included physical contact.[31]

Regarding violence against health workers, 31 incidents in 2019 affecting healthcare workers, including deaths, kidnappings, and threats, according to Insecurity Insights.[32] This indicates that violence against healthcare workers exists, however, that has not been reported specifically, or potentially covered under "Other violence" category.

Head of health facility revealed that reporting of GBV cases remains extremely limited, largely due to cultural taboos, social stigma, and lack of trust in the system as mentioned by "Jaghato" and Ab Qamari Heads of clinics. In most facilities, cases of violence against women and girls are either not observed or not reported, although some heads acknowledge physical violence and early/forced marriage as common issues as stated by Ali Abad, Mazar Sharif and Dandona heads of clinics.

An increasing trend in violence is reported in a few locations, with poverty, illiteracy, and lack of awareness cited as contributing factors. According to Heads of health facilities Qalat and Ali Abad, security incidents targeting health staff were rare but concerning. In a few cases, health workers, particularly females, faced threats or harassment from the community or armed groups. In

[29] Armed conflicts and experience of intimate partner violence among women in Afghanistan: analysis of the 2015 Afghanistan DHS data by Abdul Ghani Khatir, Tingshuai Ge, Tolulope Ariyo, and Quanbao Jiang.
[30] UN-Women Data Hub
[31] Violence Against Children in Afghanistan: Community Perspectives
[32] Violence Against or Obstruction of Health Care in Afghanistan in 2020

Ferozkoh and Qalat, most facilities have reporting mechanism but no documented incident are made available.

When interpreting survey data for this variable, due attention should be given to the potential underreporting in the data, and complementary sources should be consulted to obtain a more accurate understanding of the ground reality.

Faiz Abad (BDK) (24%) and Ali Abad (26%) report the highest instances of verbal violence, suggesting tense or hostile community-provider interactions. Gardiz and Ferozkoh also reflect moderate levels of verbal violence (4–10%). Most other districts (e.g., Jalalabad, Shotol, Taimaskan) report minimal or no verbal aggression.

Physical assaults are less frequent but still present. Faiz Abad (BDK) report 13%, the highest. Gardiz (7%) and Jaghato (4%) followed with notable lower rates. Other areas like Ali Abad, Qalat, and Ferozkoh show limited yet present threats. The presence of physical violence may reflect heightened community frustration, lack of accountability, or institutional breakdown during service disputes or emergencies.

Material violence (e.g., destruction of property, theft, sabotage) is most reported in Jaghato (8%), Faiz Abad (BDK) (5%), Gardiz, Ali Abad, and Qalat (2–8%). Material violence typically correlates with localized conflict, protests, or disruptions in care, potentially tied to long wait times, resource shortages, or denial of care.

The “Other” category sees substantial entries in Faiz Abad (BDK) (17%), Ali Abad (17%), Gardiz (10%). While not specified, this could suggest psychological threats, gender-based intimidation, or culturally sensitive mistreatment not captured under standard categories.

The highest shares of respondents reporting no incidents of violence are found in Mazar Sharif (89%), Shotol (88%), Jalalabad (93%), Taimaskan (KBL, 93%), Faiz Abad (2nd entry) (90%). These figures suggest more peaceful community-health provider dynamics, possibly supported by better communication, higher service satisfaction, or more robust healthcare infrastructure. As mentioned above, this may be due to potential under reporting.

Ab Qamari (40%), Gardiz (40%), and Ali Abad (18%) show elevated "I don't know" responses. This may indicate a lack of community dialogue, stigma, or limited public visibility of healthcare interactions. It also reflects potential gaps in community reporting mechanisms, especially in conservative or conflict-sensitive regions.

Urban areas like Mazar Sharif, Jalalabad, and Taimaskan (KBL) generally report lower violence and higher safety, possibly reflecting better service availability and trained personnel. In contrast, rural or contested zones like Gardiz, Faiz Abad (BDK), Jaghato, and Ali Abad reflect more frequent

tensions, potentially root in unmet expectations, weak state presence, or structural health system gaps.

While 69% of respondents report no incidents of violence, a notable minority (7%–24%) reported various forms of violence, with verbal aggression most common. District-level variations show how local socio-political dynamics, trust in health systems, and resource access shape public attitudes and behaviors. The presence of violence, especially physical or material, warrants urgent response measures, including community engagement for trust-building, health worker protection protocols, grievance redressal systems, conflict sensitivity training for frontline staff, strengthened law enforcement-health coordination.

## 8.1. Healthcare Staff Capability to Handle Violence

This variable aims at understanding how communities perceive the healthcare system's ability to manage violence, particularly violence against healthcare providers or within health facilities, is crucial in conflict-prone settings or settings where social acceptance of various forms of violence (e.g. gender-based, children and minorities) is a norm. The analysis across districts reveals a mixed picture, with wide variation in perceptions, significant uncertainty in many areas, and a concerning portion of respondents identifying the healthcare staff (HCS) as a contributor to escalation.

Overall, 27% of respondents consider the HCS "Highly Capable", and 30% "Capable". Conversely, 6% say it is "Not capable/usually contributing to escalation", and 2% say it is "Not capable at all/usually responsible for escalation". However, a significant 32% responded with "I don't know", indicating limited awareness or visibility of the health system's conflict response efforts.

Highly capable responses districts Dandona (77%) and Gardiz (59%) report the highest confidence in the health system's ability to manage violence effectively. Shotol (50%) and Taimaskan (KBL) (30%) also demonstrate relative confidence. These areas may benefit from stronger health governance, visible protective mechanisms, or more responsive local health leadership.

Capable but not highly capable districts Faiz Abad (BDK) (47%), Faiz Abad (80%), and Qalat (50%) report substantial "capable" responses. These reflect moderate trust but also possibly recognition of gaps in capacity or preventive measures.

In terms of perceived inadequacy or escalation role, alarmingly, some communities explicitly view the HCS as part of the problem. Jalalabad (75%) and Qalat (29%) say the HCS is "not capable or escalating violence". Tarinkot reports 17% expressing either category of HCS-linked escalation. These views suggest failures in grievance handling, staff behavior, or security incident response.

High levels of uncertainty appear in five districts. Mazar Sharif (83%), Jaghato (59%), Taimaskan (50%), Ferozkoh (48%), and Ali Abad (47%) responded with "I don't know". This suggests lack of

community engagement or communication on how incidents are managed, possibly few visible mechanisms (e.g., security staff, conflict resolution protocols) in place, low public trust or information flow, especially in regions with fragile health infrastructure or where health providers operate under risk.

Concerning districts Jalalabad, Ali Abad, and Tarinkot stand out for their high levels of negative or uncertain responses, suggesting priority attention is needed. These areas may face weak governance, inadequate referral and response frameworks, community-provider tensions, and lack of protective presence (e.g., local authorities, community-based mediation).

This dataset is complemented largely by the KII data of Heads of health facilities. All Heads identify that community health volunteers and health staff were untrained in managing SGBV cases, conducting awareness campaigns, or handling conflict situations except Taimaskan (KBL), where staff was reported as trained in handling such situations. In Tarinkot and Dandona health volunteers were mentioned as well trained to identify, manage, and prevent cases of sexual violence.

PHFPs also pointed out that female community health workers (CHWs) were often undertrained or unsupported along with staff who received training but need refresher as stated by “Ghazni” and Ab Qamari. PHFPs with exception of Taimaskan (KBL) and Mazar Sharif stated that ARCS was always ready and active in various sectors in their areas, however, female health staff lacked tailored training opportunities. They also mentioned that workload and shift planning often overlooked gender-specific needs like maternity leave or safety.

Health programs as short-term measures may benefit from establishing violence incident reporting systems in all health facilities, publicizing protocols for staff protection and community complaint mechanisms, training healthcare providers in de-escalation and cultural sensitivity. They may adapt long-term interventions such as engaging communities in dialogue on trust-building with HCS, monitoring high-risk zones and deploying mobile protection or mediation teams, and integrating protection actors with health services, especially in volatile districts.

## 8.2. Perceptions of Targeted Violence in Communities

This variable explores the perceived prevalence of violence targeting specific groups or individuals within communities. The responses provide insight into the social climate, tensions, and the visibility of discrimination or conflict-related incidents.

Across districts, 32% of respondents believe violence against specific groups is either “very common” (12%) or “somewhat common” (20%). Conversely, 49% report that such violence is “not common.” However, a notable 17% say “I don’t know”, suggesting limited awareness,

normalization of such events, or fear in discussing the topic due to cultural or political sensitivities.

Among high-concern districts, Shotol stands out with 34% “very common” and 23% “somewhat common”—the highest total (57%) indicating frequent targeted violence. This aligns with earlier data on low satisfaction with services and poor system responsiveness, suggesting broader community tension or marginalization. Faiz Abad (BDK) reports 44% perceive violence as common, with 26% “very common”. This indicates concern over targeted threats, possibly linked to healthcare access disparities, ethnic divisions, or gender-based concerns. In Jalalabad 50% view such violence as common. In Qalat 41% perceive it as common, with 6% “very common” and 35% “somewhat common.” These urban or semi-urban districts might face tensions related to migrants, returnees, or resource pressures.

Several districts report a majority believe violence against specific groups is not common: Ali Abad (69%), Taimaskan (KBL) (61%), Tarinkot (56%), Gardiz (55%), and Jaghato (53%) all reflect a majority perception of peace and cohesion. These areas may enjoy greater intergroup tolerance, possibly less reporting visibility, or cultural or political sensitivities.

Several districts show significant uncertainty. Faiz Abad (BDK) report 41% answered “I don’t know”. Ab Qamari (33%), Mazar Sharif (25%), Ferozkoh (22%), and Qalat (16%) also reflect high uncertainty. This indicates limited access to information, fear of speaking, or perceived complexity of local violence. Urban/peri-urban districts (Jalalabad, Qalat, Mazar Sharif) may face greater diversity, competition over services, or migration flows, leading to more visible tensions.

For humanitarian/health actors it is essential to increase monitoring in high-concern districts to detect and address trends of targeted violence, establish or strengthen community-based protection committees for minority or at-risk groups, link protection referrals with healthcare access and psychosocial support where needed. For community engagement programs may facilitate dialogue sessions on coexistence and inclusivity, and include community leaders, youth, and women in anti-discrimination campaigns.

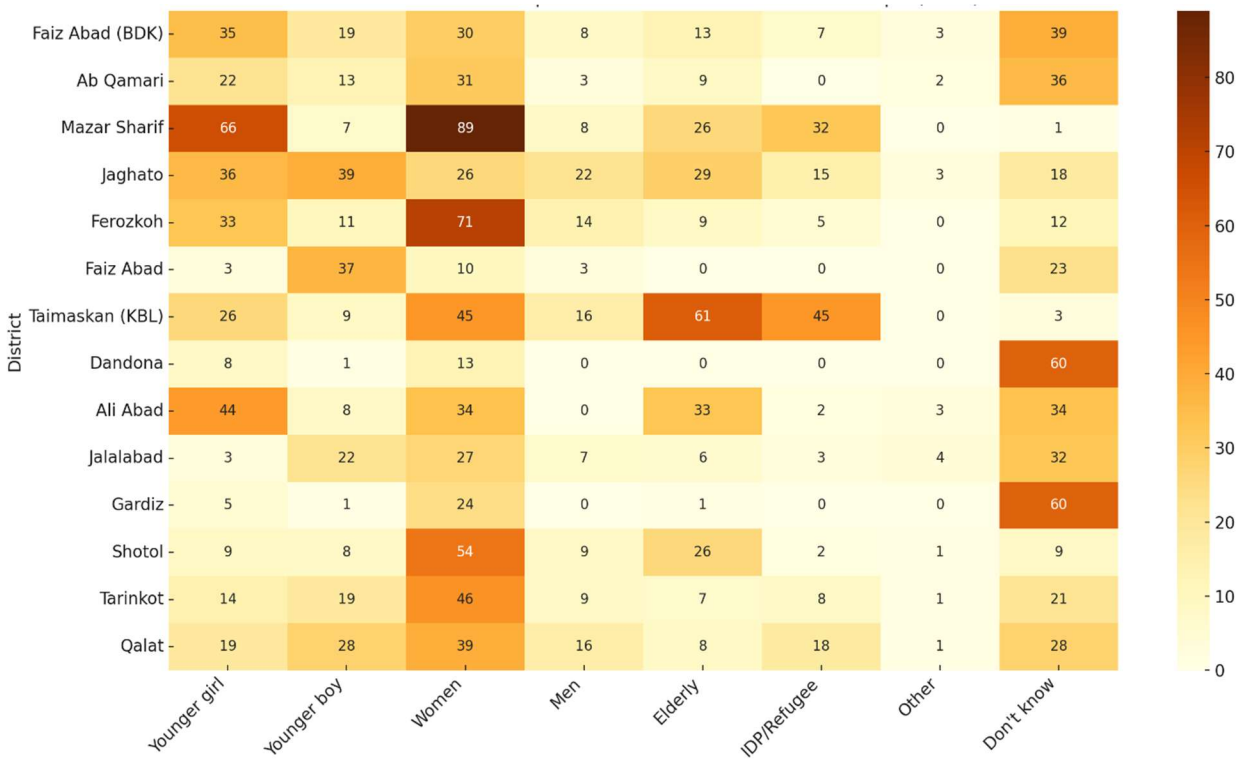
## 8.3. Most Affected Population from Violence

This dataset seeks to identify which population groups or individuals are perceived to be the most affected by violence in each district surveyed. The responses provide critical insights into how different communities experience and perceive vulnerability to violence, and they highlight significant gender, age, and displacement-related disparities.

*Women* are most frequently identified as the group most affected by violence across all districts, cited by 39% of respondents overall.

Gender-based violence (GBV) remains a major concern for community members as highlighted during FGDs, particularly for women and children (including girls and boys), for early and forced marriages, domestic violence, and economic coercion as reported in Jaghato, Mazar Sharif, and other district.

*Figure 22: Population Group Most Affected from Violence*




Mazar Sharif (89%), Ferozkoh (71%), Shotol (54%), and Taimaskan (45%) all record high concern for women's vulnerability. In Ali Abad (34%) and Tarinkot (46%), women are again highly represented. Younger Girls as a Key Vulnerable Group

Overall, 23% of respondents report that *younger girls* are the most affected by violence. Particularly high concern is observed in Mazar Sharif (66%), Ali Abad (44%), Faiz Abad BDK (35%), Jaghato (36%). This finding is critical in highlighting gender-based violence (GBV) against minors, especially in conflict-affected or fragile districts.

Only 16% cited younger boys and 9% cited men as the most affected. Younger boys were more prominent in Jaghato (39%) and Faiz Abad (37%). Men were highlighted in Taimaskan (16%), Qalat (16%), and Jaghato (22%), possibly indicating local political or economic-driven male targeting.

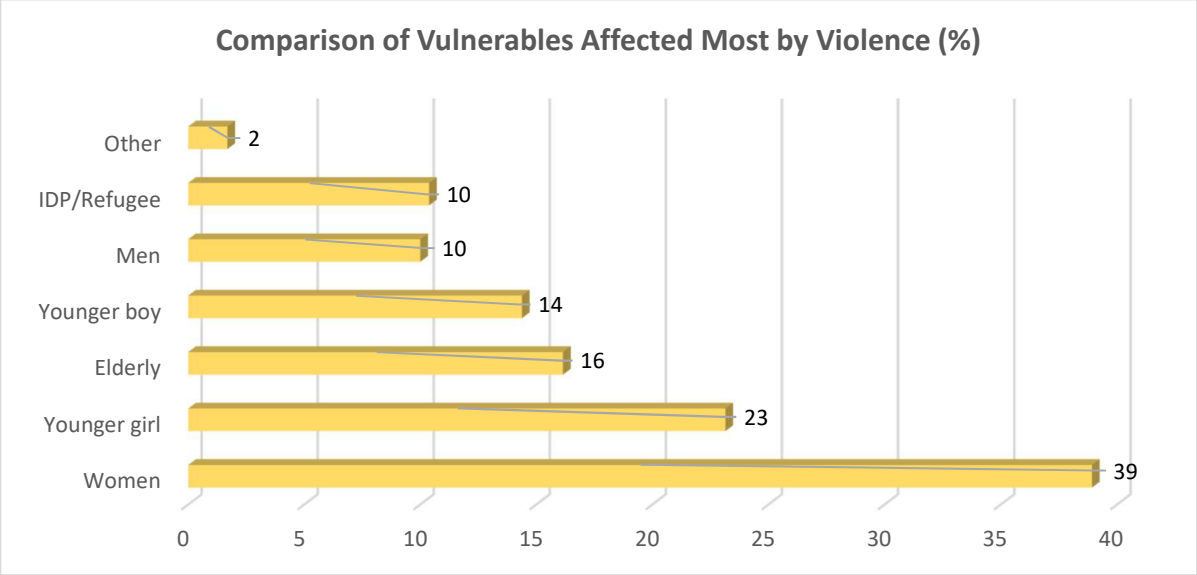
Mazar Sharif result for violences against younger girls (69%) and boys (7%), when combined, closely corresponds to violence against children (VAC) data in Afghanistan. In VAC study

conducted in Afghanistan, 71% of children reported experiencing physical violence is some form in the past year. Home was the most likely location of violence. The overwhelming majority of parents reported using physical violence as a discipline method.[33] This indicates potential underreporting in rest of the provinces due to factors including acceptance of violence against children as norm (method of disciplining).

Elderly were identified by 17% overall, with notable mentions in Taimaskan (61%), Jaghato (29%), and Shotol (26%). IDPs/Refugees were cited by 10%, with key Mazar Sharif (32%), Taimaskan (45%), and Qalat (18%). This suggests a heightened exposure to violence or systemic neglect among displaced and older individuals.

"I don't know" responses remain significant at 26%, indicating either limited visibility, awareness, or willingness to comment—most notably in Faiz Abad (BDK - 39%), Ab Qamari (36%), and Dandona (60%). "Prefer not to answer" was also recorded in 7% of responses—reflecting sensitivities around violence-related issues.

*Figure 23: Comparison of Vulnerable Affected Most by Violence*




To address the issues of violence against specific groups, following step may be impactful:

- Tailored Protection Measures: The high identification of women and girls suggests a need for *expanded GBV prevention, response mechanisms, and psychosocial support services*.

[33] Violence against children in Afghanistan: Concerns and opportunities for positive change, Patrick O'Leary, Cate M Cameron, Ali Lakhani, Jodie M Osborne, Luana de Souza, Kristen Hope, Mohammad, Naimi, Hassan Khan, Qazi S Jawad, Sabir Majidi

- IDPs and Elderly Inclusion: Humanitarian actors should integrate *elderly- and displacement-sensitive protection approaches* into programming.
- Community Education & Safe Reporting: The prevalence of "don't know" and "prefer not to say" answers suggest stigma, fear, or lack of reporting mechanisms. Protection partners must build trust through community-based awareness, anonymous reporting, and survivor-centered care.

## 8.4. Availability of Safety-Enhancing Services in the Community

This dataset aims to assess the presence of community-level safety-enhancing services, which are critical to protecting vulnerable groups, responding to violence, and enhancing social cohesion, particularly in conflict- and displacement-affected settings.

30% of all respondents report that no safety service is available in their community, the most common response across surveyed districts. The issue is especially severe in Shotol (70%), Ferozkoh (41%), Qalat (40%), Tarinkot (50%), Ab Qamari (35%), Jaghato (32%). This underscores a widespread protection gap, particularly in rural, insecure, or hard-to-reach areas.

Overall, 18% respondents report availability of community centers. Faiza Abad rests at top reporting 57% availability, followed by Jaghato and Ali Abad with 39% availability. Conversely, the service is reportedly missing in Ab Qamari and nominally available in Shotol (11%), and Tarinkot (6%).

Legal Assistance is reported to be available by 18% of respondents in aggregate. In Gardiz 59%, Ail Abad 27% and Faiz Abad 26% availability is reported. However, it is still absent or nearly absent in half of surveyed districts, showing a justice gap.

Across surveyed districts, 10% of respondents report that safe houses existed in their districts. Safe houses are relatively more available in Taimaskan (36%), Dandona (31%), andGardiz (40%). However, such service is completely absent in Faiz Abad, Ferozkoh, Ab Qamari, Jalalabad, and several others.

Child, Women Support Services are nominally available in surveyed districts i.e. 5% only. Notably present only in Jalalabad (30.6%) and Faiz Abad (BDK, 12%), but very low or non-existent in most districts.

Women and Girl Safe Spaces also exist nominally (4%) in the surveyed districts. Available mainly in Jalalabad (21%), Taimaskan (16%), and marginally elsewhere.

Overall, existence of psychological support is reported by only 7% of respondents. This service is most present in Faiz Abad (BDK, 24%), Jalalabad (19.8%), and Taimaskan (16.3%), but nearly non-existent in Ferozkoh, Dandona, Ali Abad, and Qalat.

The data identifies critical gaps including:

- Widespread Absence of Multi-Sectoral Services: Most communities lack a full suite Whole-of-Family (WoF) safety services. Few districts offer more than 3–4 types.
- Inconsistent Legal and Civil Documentation Support: Without legal aid and documentation, many vulnerable groups—especially IDPs, women, and children—remain exposed to risks.
- Urban-Rural Divide: Services are slightly more concentrated in semi-urban areas like Jalalabad, Faiz Abad, and Taimaskan, but largely missing in rural and conflict-prone districts.
- Low Awareness or Service Visibility: "I don't know" responses averaged 11%, peaking in Ab Qamari (30%), Dandona (34%), and Gardiz (8%). This indicates a communication and outreach gap, even where services might be available.

Qualitative data collected through FGDs and KII also highlight the lack of safety services in the communities surveyed. Per community FGD findings in Jalalabad, Faizabad, and Shoto, protection services are virtually nonexistent, and survivors of violence, especially women and children, have little or no access to justice, shelter or safe spaces, medical support, or psychosocial support. In Taimaskan (KBL), male FGD members mentioned about existence *Amr-Bil-Ma'aroof*" department under Ministry of Interior for handling such cases, however, females were not aware of this department.

Per health facility Heads KII data, referral pathways for survivors are mostly absent or unknown. Only a few health centers indicated the existence of SOPs or referral mechanisms, and many lacked linkages to specialized protection services. SGBV related services like safe spaces, psychosocial support, and legal aid are either nonexistent or not accessible in most areas with exception of Qalat and Jalalabad where Heads of ARCS clinics stated that health services related to protection and sexual violence were available. Additionally, mental health support was also mentioned by Jalalabad Head of clinic. Tarinkot and Dandona Heads of ARCS clinics stated that incidents of sexual violence did not exist. However, safe places, mental support, legal assistance, and health services were available for women and girls.

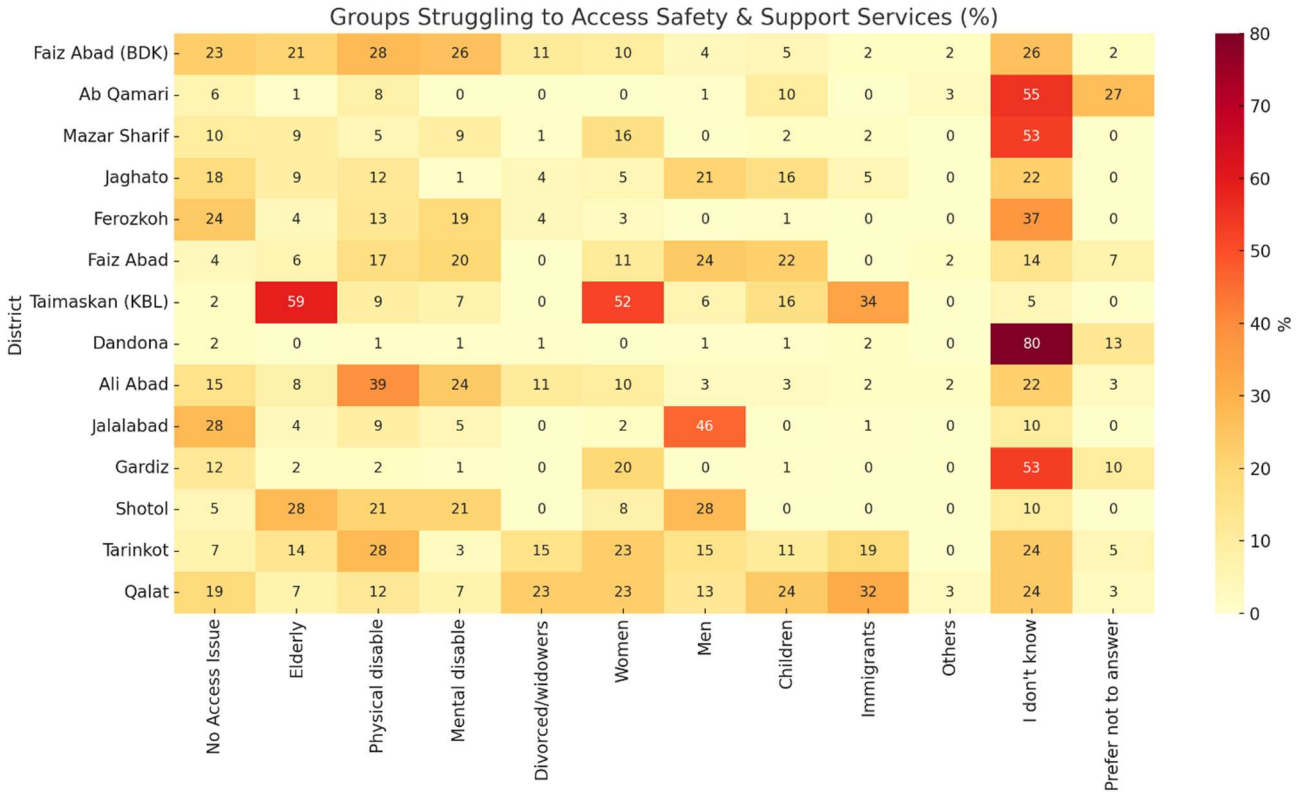
Need for improving access to protection services is evident from the data. Health programs could benefit from actions such as establishment of basic service hubs in underserved districts like Shotol, Qalat, and Ferozkoh; investment in women- and child-specific safe spaces and psychosocial support in response to earlier findings of gender-based violence vulnerability; scaling up legal assistance, civil documentation, and safe houses, especially in displacement-

affected areas, and where services exist, significantly improve visibility and community awareness.

## 8.5. Community Groups' Access to Safety Services

This data explores inequalities and challenges in accessing available safety and support services (e.g. community centers, safe spaces, psychosocial support, legal aid).

*Figure 24: Groups Struggling to Access to Safety & Support Services*




31% of respondents overall select "I don't know", and an additional 5% chose "Prefer not to answer", indicating a high degree of uncertainty about service accessibility among community members. This is particularly high in districts like Ab Qamari (55%), Mazar Sharif (53%), Gardiz (53%), and Dandona (80%), suggesting either poor outreach, lack of visible/accessible services in those areas, or lack of awareness about the safety and support services.

Most frequently reported groups struggling to access services include persons with physical disabilities (14%) and females (15%). Other groups highlighted include elderly (13%), persons with mental disabilities (10%), males (11%), immigrants (8%), children (8%), and divorcees and widows (5%).

District Taimaskan (KBL, 59%) cite issues for the elderly, 52% for females, and 34% for immigrants, indicating multiple access barriers across vulnerable groups. Ali Abad raises high concerns for

people with physical disabilities (39%), mental disabilities (24%), and divorcees/widows (11%). In Faiz Abad (BDK), A broad range of barriers are also reported such as physical disability (28%), mental disability (26%), elderly (21%), and females (10%).

Shotol and Tarinkot show more than 20% identified barriers for people with disabilities, elderly, and females. Qalat has the highest diversity of reported access issues, with 9 groups reported to face barriers (especially females, children, elderly, and immigrants).

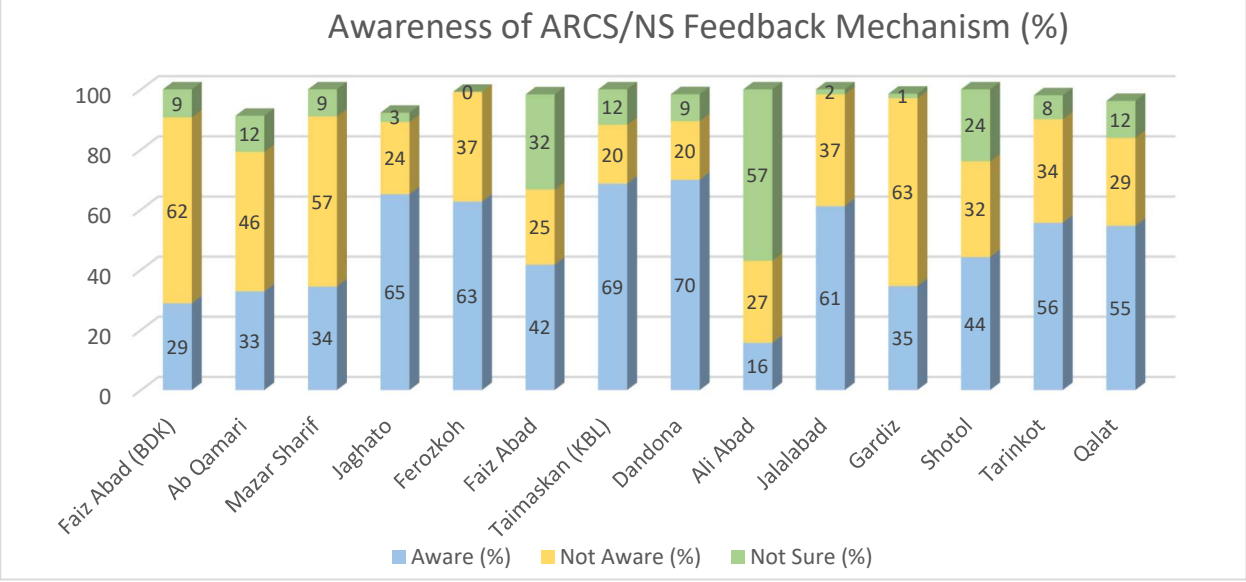
Some areas, such as Dandona, Jaghato, and Ab Qamari, report lower rates of perceived access issues. However, these results might reflect limited service availability or lower awareness, rather than true equity in access.

The high uncertainty, combined with consistent identification of marginalized groups facing barriers, especially females, people with disabilities, and immigrants, indicates uneven service reach and poor inclusion. Districts like Taimaskan, Ali Abad, Qalat, and Tarinkot require targeted interventions to ensure inclusive service delivery. It also underscores the need for community sensitization, information dissemination, and inclusive design of services

## 8.6. Awareness of Feedback Mechanisms for ARCS/NS

The ability of affected populations to provide feedback or suggestions is a key indicator of accountability, transparency, and participatory program development. This variable seeks to determine the extent to which individuals across the surveyed districts are aware of mechanisms to communicate their views to the National Society.

*Figure 25: Awareness of ARCS/NS Feedback Mechanism*




Overall, 48% of respondents report that they are aware of how to provide feedback to the ARCS/NS, while 36% said they do not, and 13% were not sure. An additional 2% preferred not to

answer. This shows that more than half of the population is either unaware or unsure of how to give feedback, indicating a significant gap in two-way communication mechanisms.

Taimaskan (Kabul) (69%) and Dandona (70%) have the highest levels of awareness regarding how to provide feedback. Other districts with relatively high awareness include Jaghato (65%), Ferozkoh (63%), Jalalabad (61%), Tarinkot (56%), and Qalat (55%). This indicates a generally confident understanding of feedback options. This also suggests National Society outreach efforts are more effective in more accessible areas.

Among low awareness districts, Ali Abad shows a strikingly low rate of awareness (only 16%) and the highest percentage of people unsure (57%), which may indicate a breakdown in outreach or communication efforts. Similarly, Faiz Abad (BDK) (29%), Mazar Sharif (34%), and Gardiz (35%) reflect low levels of awareness, with more than 60% in some cases saying they do not know how to provide feedback.

Uncertainty prevails in certain districts with regards to feedback mechanisms. A significant proportion of respondents from Ali Abad (57%), Faiz Abad (32%), and Shotol (24%) are not sure how to provide feedback. This points out to either a lack of visibility of feedback channels or weak communication between communities and service providers. Ab Qamari has 9% preferring not to answer, which may warrant further qualitative inquiry into community attitudes toward providing feedback (e.g., fear, mistrust, irrelevance).

Urban districts such as Taimaskan (KBL) and Jalalabad report higher awareness,

The high levels of uncertainty or lack of awareness in districts like Ali Abad, Faiz Abad (BDK), and Shotol highlight the need for enhanced community engagement and more visible, accessible, and inclusive feedback channels.

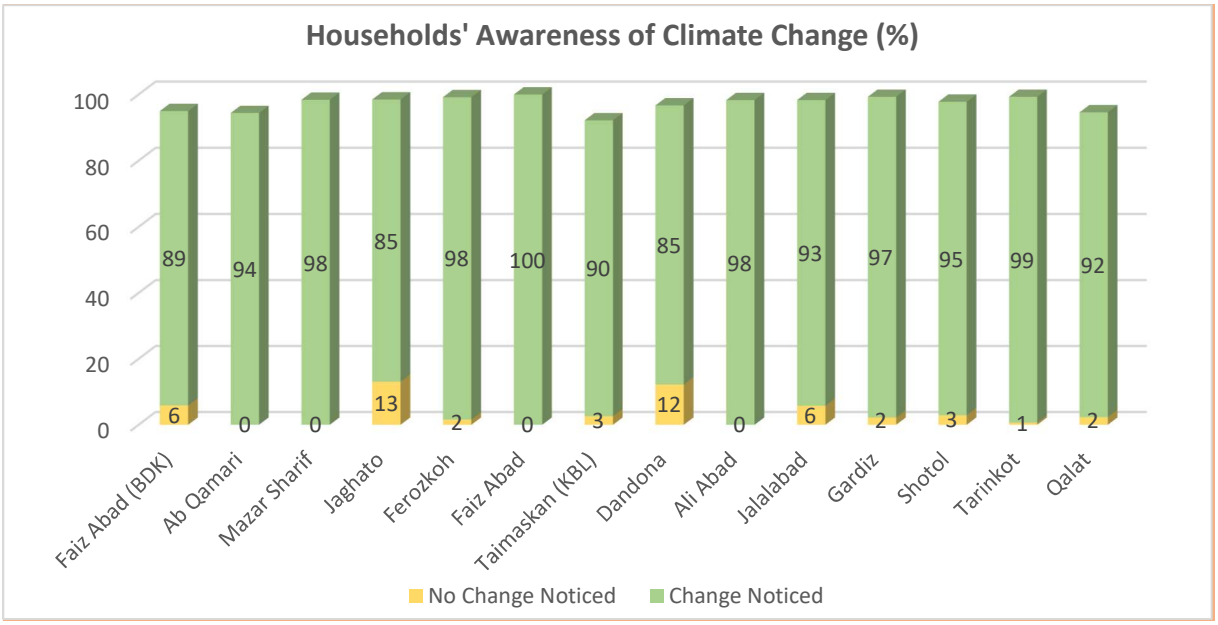
ARCS/NS require measures that address the gaps in transparent feedback. They need to strengthen feedback systems visibility by installing visible suggestion boxes, posters, and signage in all health facilities using local languages and visual aids where literacy is a barrier. Community awareness campaigns are also beneficial such as conducting community sessions to explain how to give feedback and what happens to it, and engaging community leaders and volunteers to disseminate this information more widely. Ali Abad, Faiz Abad, Shotol, and Ab Qamari need priority attention to close the feedback awareness gap. In districts with high “don’t know” or “prefer not to answer” responses, ARCS/NS may consider conducting focus group discussions to understand trust levels in existing mechanisms.

# 9. Health And Climate – Findings

## 9.1. Perception of Changes in Weather Pattern

This dataset aims to assess community perceptions of climate variability and change over time. Understanding local perceptions is critical for designing risk-reduction strategies and climate-resilient interventions, especially in fragile contexts where institutional climate data may be limited.

*Figure 26: Households' Awareness of Climate Change*




Regarding general awareness of climate change impacts, 97% of respondents report noticing *changes* in weather patterns, indicating high overall awareness or experience of climate change effects across surveyed communities. The most commonly perceived changes include changes in temperature (60%), more frequent and severe weather events (55%), changes in precipitation (48%), and shifts in seasonal patterns (22%). Rising sea levels/coastal erosion (6%) is much less frequently reported, expected given the large inland nature of the surveyed districts. "Other" effects (1%) has very low response rate.

High recognition of climate change effect comes from districts Ferozkoh and Tarinkot. In Ferozkoh 76–87% of respondents note temperature, precipitation, and extreme weather changes. In Tarinkot 91% reported more frequent and severe weather, and 70% noted precipitation changes.

Ali Abad, Gardiz, and Dandona also report high levels of observed change across all dimensions (especially temperature and extreme events).

Moderate awareness with mixed patterns is found in Jaghato showing high perception of precipitation (51%) and extreme weather (38%), but lower temperature change (39%). Faiz Abad (BDK) has relatively lower perception of diverse climate impacts, with most people (77%) noticing only temperature changes.

Low awareness or limited experience is reflected in Shotol, standing out as having lower perception levels across all dimensions, with only 20% noticing temperature change and just 14% precipitation change. However, 41% still report sea level/coastal erosion, this may require follow-up for accuracy or clarification. Qalat also shows lower-than-average sensitivity to seasonal and extreme weather changes, despite 89% citing temperature change.

Rising sea levels or coastal erosion is cited by only 6% of respondents overall, mostly from Shotol (41%) and Dandona (22%). This may also imply awareness due to social media or access to global/regional news on climate impacts. “Other impacts” is cited by just 1% overall.

Temperature change is the most commonly observed across all districts (national avg. 60%), with Mazar Sharif (92%), Qalat (89%), and Ferozkoh (76%) reporting particularly high rates. Precipitation and extreme events are also widely reported, with strong overlap in Ferozkoh, Tarinkot, and Dandona. Seasonal pattern shifts are noted by about 1 in 5 respondents overall but up to 52% in Gardiz and 41% in Taimaskan (KBL).

Low climate change awareness or weak signals are more noticeable in Ab Qamari, Shotol, and Faiz Abad (BDK), though some localized concerns still exist.

Climate resilient programming is essential esp. in countries that are affected by climate change including Afghanistan. Possible areas of support may include:

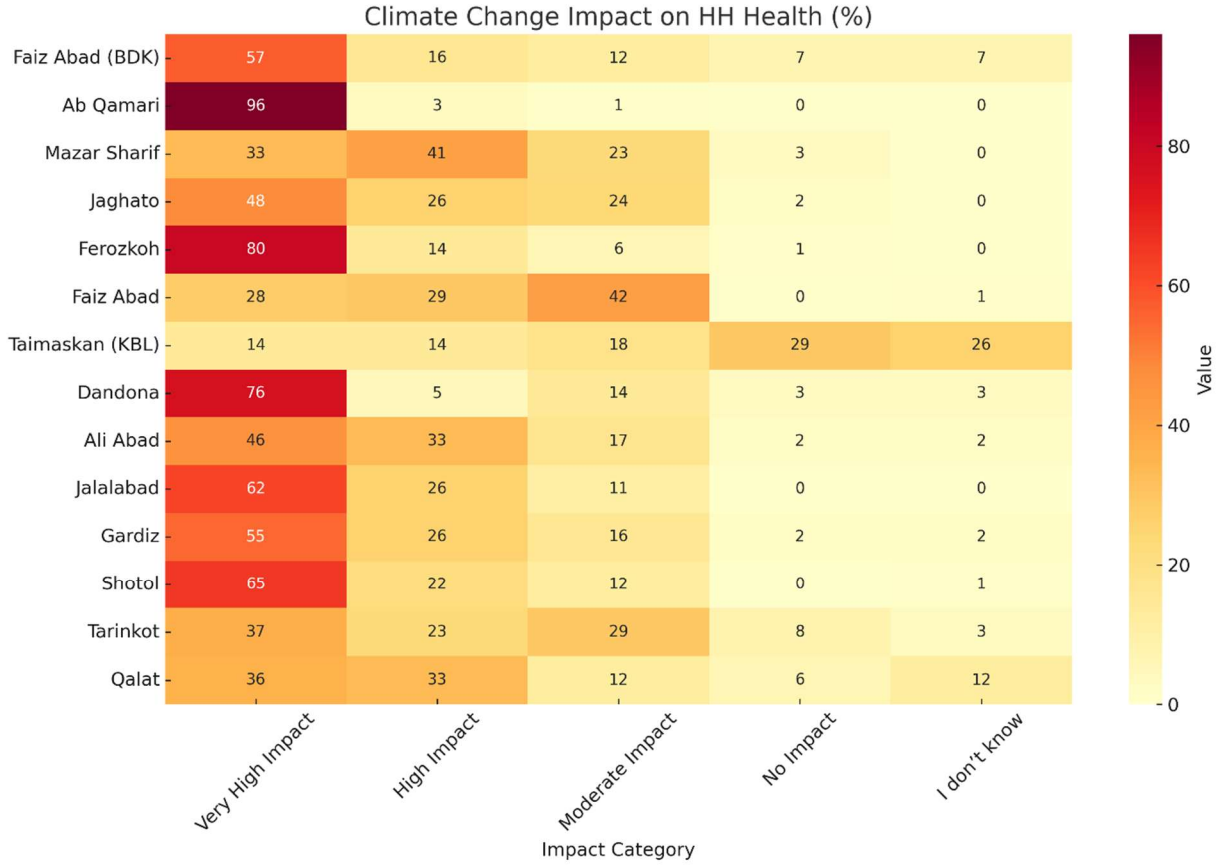
- Localized Climate Risk Communication: Districts with lower awareness (e.g., Shotol, Faiz Abad BDK) may need targeted climate awareness campaigns using local examples and accessible messaging.
- Disaster Preparedness Investments: Areas reporting frequent/severe events (e.g., Ferozkoh, Tarinkot) should be prioritized for early warning systems, contingency planning, and community disaster risk reduction (DRR) training. This is complemented by recommendations made by PHFPs during the KIIs. They urged to fill in significant gaps existing in climate-health data use, forecasting, and early warning mechanisms.
- Season-Sensitive Livelihood Programming: With season shifts being noticed, programs supporting agriculture, livestock, and water access must adjust to altered planting/harvesting calendars and rainfall unpredictability.

- Integration of Climate into Health Systems: Partial integration into DHIS2 and health planning systems reported by PHFPs. They recommended full integration of climate in DHIS2.

## 9.2. Perceived Impact of Climate Change on Health

This variable explores community perceptions regarding the impact of climate change on personal and communal health. These insights help align public health preparedness, resilience building, and community-based adaptation strategies with local realities.

*Figure 27: Climate Change Impact on HH Health*




The data reflects a widespread recognition of health impacts of climate change. A combined 73% of respondents believe that climate change has a “very high” (51%) or “high” (22%) impact on health in their communities. Only 5% believe there is no impact, while 4% reported uncertainty. This strong perception underscores growing awareness that climate shifts are influencing health outcomes, whether through disease outbreaks, water scarcity, heat stress, malnutrition, or changing air quality.

Among surveyed districts, Ab Qamari shows extremely high concern: 96% said the impact is “very high,” and 3% said “high.” Similarly strong concern is evident in Ferozkoh (80% very high, 14% high = 94%), Dandona (76% very high), Shotol (65% very high, 22% high), Jalalabad (62% very high, 26% high = 88%), and Gardiz (55% very high, 26% high = 81%)

These districts likely face more visible and immediate effects of climate-related health stressors such as droughts, dust storms, heatwaves, waterborne diseases, or food insecurity.

Mazar Sharif and Jaghato have more balanced or moderate responses, with notable proportions recognizing moderate impact i.e. Mazar Sharif: 33% very high, 41% high, 23% moderate, and Jaghato: 48% very high, 26% high, 24% moderate

Districts reflecting low perceived impact include Taimaskan (KBL), standing out for its relatively low concern (only 14% see a very high impact, 29% report no impact, and 26% said they don’t know). This may indicate lower climate health literacy, or less exposure to direct health impacts from environmental changes. Qalat also had mixed perceptions (36% very high, 33% high, but 12% responded “I don’t know”) suggesting a possible information gap. Faiz Abad responses lean toward moderate impact (42%), with fewer very high (28%) and high (29%) responses.

The perception of health being affected by climate change is almost universally acknowledged, but the intensity varies. Districts like Ferozkoh, Ab Qamari, Dandona, Jalalabad, and Shotol may already be experiencing visible or recurring environmental health crises. Conversely, districts like Taimaskan (KBL) may require enhanced health risk communication and climate-health linkage education, especially if impacts are subtle or delayed.

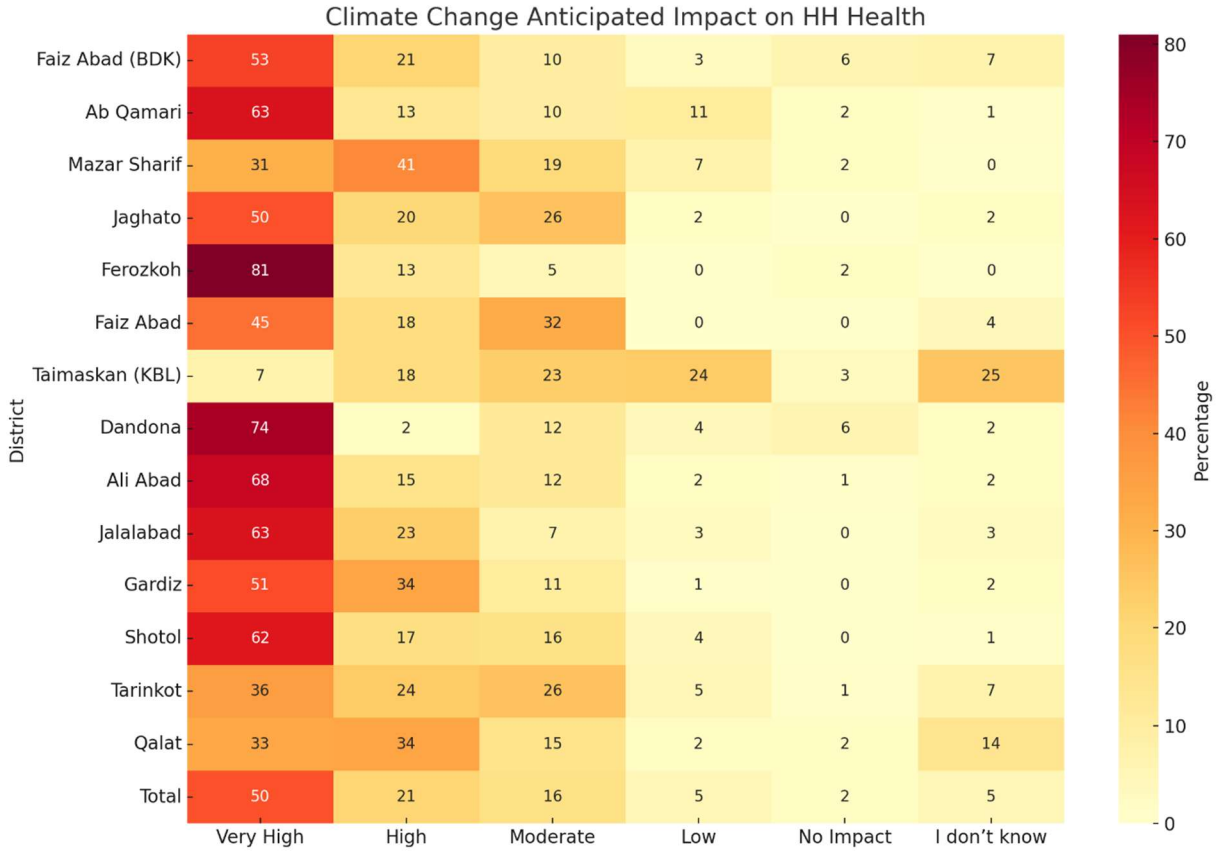
KIIs with PHFP highlighted impacts of climate change on health. The responses indicate that climate-related events have significantly disrupted health systems in many provinces, though some isolated cases reported minimal effects. The impacts span infrastructure, staffing, medicines, funding, and service delivery quality, limited and discontinued operation for mobile health team and increased disease burden such as diarrhea in summer and cold in winter, and drought related illnesses in Jaghato, Ferozkoh, Ali Abad, Jalalabad, Gardiz, Tarinko, and Qalat.

The analysis highlights need for health & climate integration in programming. Health programming in high-concern areas should include climate-sensitive components, such as water purification, disease surveillance, and community heatwave/cold stress protocols. Climate-aware health messaging through awareness campaigns in low-awareness districts like Taimaskan and Qalat should clarify how climate variables influence respiratory diseases, nutrition, vector-borne diseases, and mental health. Districts with “very high impact” perceptions can benefit from early warning systems, local data monitoring, and climate adaptation planning in primary health services.

## 9.3. Anticipated Impact of Future Climate Change on Community Health

This variable explores forward-looking perceptions whether respondents believe future climate change will significantly affect the health of individuals and communities. The responses shed light on climate risk awareness, health vulnerability perception, and potential community engagement in climate-resilient programming.

*Figure 28: Climate Change Anticipated Impact on HH Health*




Majority expect strong health impacts of climate change. A resounding 71% of all respondents believe future climate change will have a "very high" (50%) or "high" (21%) impact on health in their communities. Only 7% believe it will have low or no impact, while 5% said "I don't know." This reflects strong public concern about worsening health conditions if climate patterns intensify, including from heat stress, water scarcity, disease vectors, extreme events, and malnutrition.

Majority of districts showed "very high and high" levels of anticipated impact, suggesting significant lived experience or understanding of climate-health dynamics. These include Ferozkoh (94%), Dandona (76%), Ali Abad (83%), Jalalabad (86%), Ab Qamari (76%), Shotol (79%), Gardiz (85%), and Jaghato and Faiz Abad (BDK) over 70%. These districts may be experiencing frequent

or intensifying climate stressors or have stronger community awareness around climate-health relationships.

Moderate or mixed concern districts like Mazar Sharif showed more moderate concern -- 31% “very high,” 41% “high,” 19% “moderate” – indicating recognition of risk, but not necessarily acute urgency. Faiz Abad leans towards moderate expectations – 45% “very high,” but 32% said “moderate” impact.

Lower awareness or uncertainty reflects in data for Taimaskan (KBL) and Qalat. Taimaskan (KBL) has the highest level of uncertainty – only 7% “very high,” and 25% responded “I don’t know”, 24% said “low impact” – suggesting possible disconnect between environmental change and health awareness. Qalat also showed mixed concern with 14% “I don’t know,” and only 33% “very high.” These areas may require targeted risk communication and education linking climate trends to local health impacts.

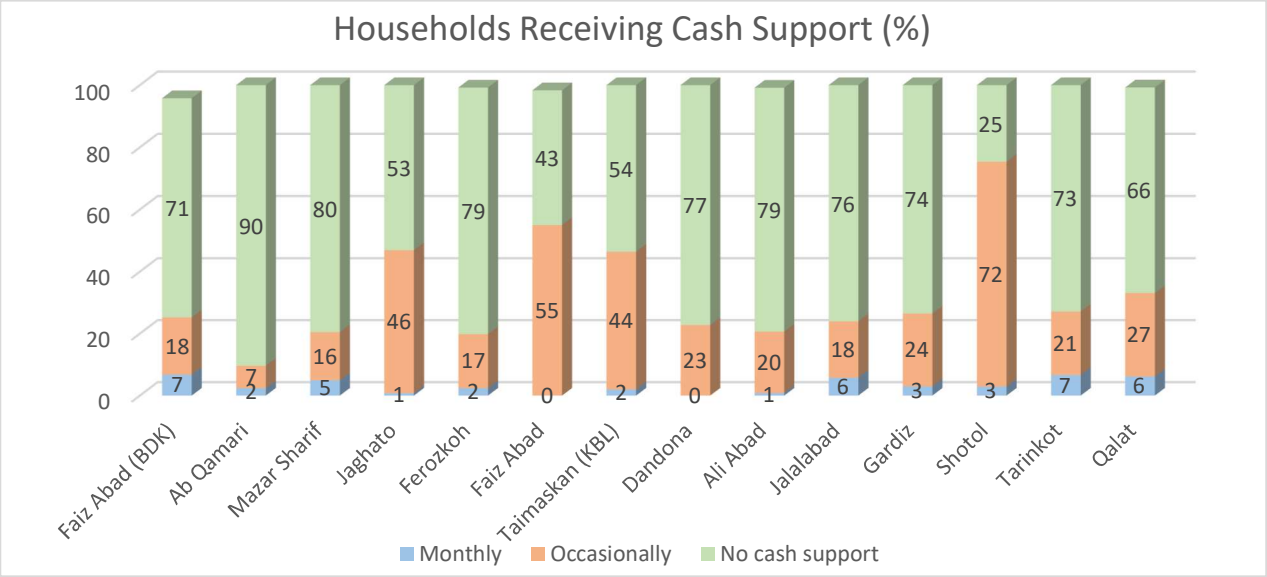
The above variation and contrast among the districts highlight significant geographic variation in climate-health foresight. Urban districts or areas with limited exposure to extreme events may underestimate risks, whereas more exposed or resource-strained districts recognize the vulnerability of health infrastructure and services.

In addition to earlier suggested intervention for climate health programming, prioritization of high-risk districts, health system preparedness and climate adaptation actions are necessary to minimize or mitigate the climate induced risks to health.

# 10. Health and Cash Assistance – Findings

This data aims to assess the extent of financial assistance (cash support) being received by households across surveyed districts. It captures both regular (monthly) and intermittent (occasional) support, which is critical in understanding the economic coping strategies available to vulnerable communities.

*Figure 29: Households Receiving Cash Support*




Across surveyed districts, only 3% of respondents receive monthly support, and 30% receive it occasionally. A significant 67% of households receive no cash support at all, which reflects limited reach of financial aid or social protection mechanisms.

In Shotol 72% receive occasional support, the highest among all districts. In Faiz Abad 55% reports occasional cash assistance but no monthly assistance, suggesting wider one-time interventions rather than long-term support. In Jaghato 46% respondents receive occasional support, but only 1% monthly, reinforcing this pattern. These areas may have been targeted during specific emergencies or seasonal interventions (e.g., winterization, Ramadan, floods), but lack sustained social safety nets.

Districts with notable monthly support include Faiz Abad (BDK) and Tarinkot with 7% monthly support– the highest for sustained cash flow. In Jalalabad 6% of respondents receive monthly assistance. While still low, these rates indicate some localized programs offering regular support, perhaps through national society safety nets or coordinated donor programming.

Districts with lowest support access include Ab Qamari, Mazar Sharif, Ali Abad, and Gardiz. They have very high “No” responses (74%–90%) and near-zero monthly coverage. In Ab Qamari, 90%

receive no support, and only 9% receive it at all (occasional). These areas may be underserved or excluded from cash programs, possibly due to logistical challenges, funding gaps, limited awareness of entitlements, or policy/eligibility restrictions.

Underserved cash assistance also points out protection considerations. Only 3% receive regular monthly support, which indicates extreme fragility in household coping capacity and economic resilience. Marginalized groups, including people with disabilities, widows, and IDPs, may be disproportionately affected in districts with no cash aid. Cash support has documented protection impacts—helping families meet basic needs, access healthcare, and reduce exposure to negative coping strategies (e.g., early marriage, child labor).

Community leaders KIIs report decrease in frequency and coverage of cash programs. Where it exists, cash is mainly delivered in person. Ali Abad, Ferozkoh and Taimaskan reported no current cash assistance in their communities. However, Jagatho, Ab Qamari, and Faiz Abad community leader reported various ongoing cash assistance programs. According to the KIIs findings, across the communities, assistance from authorities and organizations has been inconsistent, minimal, or altogether absent in many areas. The most common forms of assistance include food distribution (especially flour), cash transfers (either unconditional or via cash-for-work schemes), basic health services, medicine provision, vaccinations, and some targeted support for small businesses or livestock. However, many respondents noted that this assistance is sporadic and limited in coverage, with only a few households benefiting. In Jalalabad, male FGD members reported NGOs and UN organizations providing cash assistance including Norwegian organization, WFP and others.

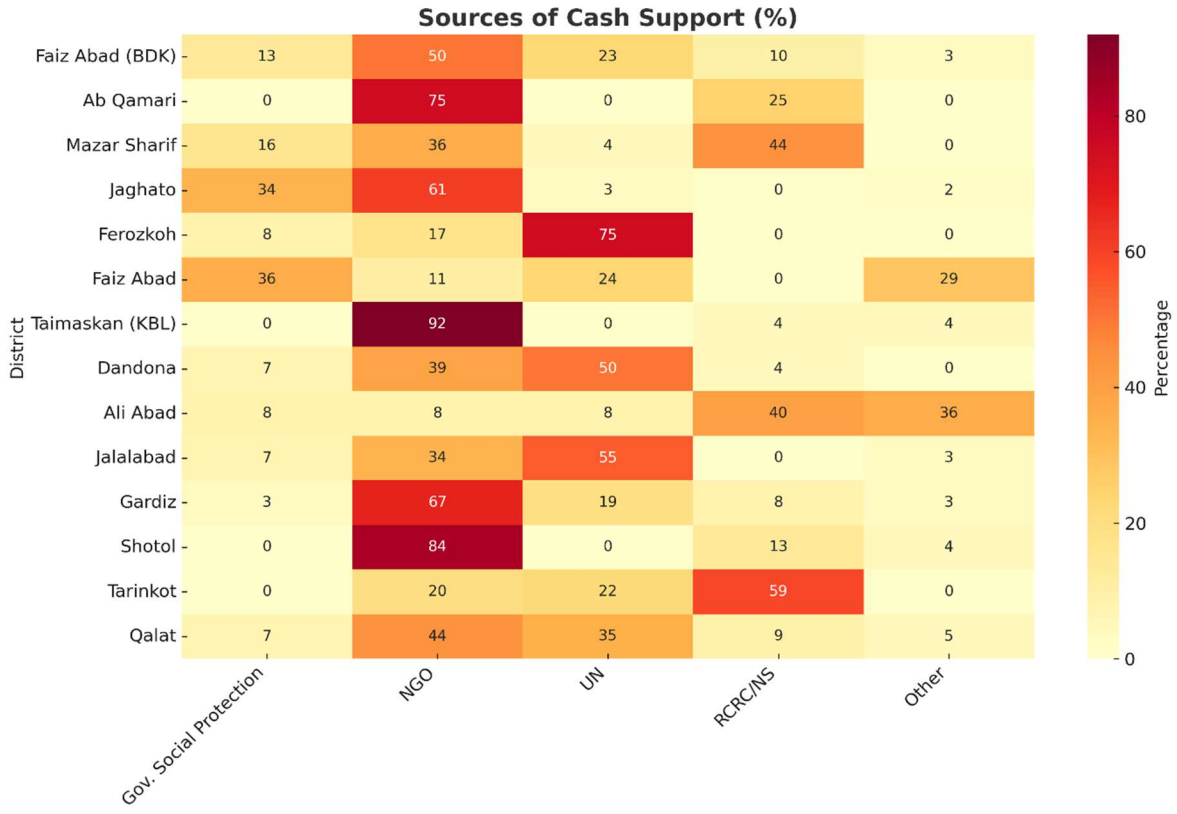
To address the economic vulnerabilities, community can benefit from following strategies and interventions:

- Expand Monthly Cash Assistance Programs: Prioritize vulnerable districts with no ongoing support and integrate them into multi-month assistance pipelines to build resilience.
- Strengthen Targeting & Inclusion: Improve targeting mechanisms to include excluded groups (e.g., elderly, female-headed households, IDPs), especially in areas like Ab Qamari and Ali Abad.
- Link Cash with Protection Services: Use cash programs as an entry point to protection, linking them with child protection, gender-based violence (GBV) services, and climate resilience initiatives.
- Improve Community Awareness: Strengthen feedback and complaint mechanisms to ensure that cash support reaches the intended beneficiaries transparently and equitably.

## 10.1. Source of Cash Assistance

This dataset sheds light on the providers of cash-based support across surveyed communities. It helps identify the leading actors involved in social safety nets and humanitarian financial aid, including the government, NGOs, UN, and ARCS movement.

*Figure 30: Sources of Cash Support*




NGOs appear as the primary source of cash assistance. Across the board, 52% of cash support recipients identify NGOs as their main source. This highlights the critical role of NGOs in providing direct financial relief, especially in areas underserved by public systems.

UN agencies also show strong but variable reach. 18% overall report receiving cash from the UN, indicating a strong but targeted presence.

Highest cash support is reported in Ferozkoh (75%), Jalalabad (55%), and Dandona (50%). These areas likely benefited from emergency responses by agencies like WFP, UNHCR or UNICEF, or other I/NGOs especially in response to climate disasters, displacement, or humanitarian assistance.

Government social protection assistance is very limited. Despite its potential for scale, only 11% overall report receiving support from government schemes. This signals limited coverage or

accessibility barriers in the public social safety system. Faiz Abad (36%) and Jaghato (34%) report relatively higher access to state social protection mechanisms.

## 10.2. ARCS/National Society Involvement

NS and ARCS cash support is cited by 13% overall. Higher presence appears in Tarinkot (59%), Ali Abad (40%), and Mazar Sharif (44%). This reflects focused efforts by Afghan Red Crescent or IFRC in these areas—possibly as part of community-based response to disasters or health needs.

Other Sources (potentially local philanthropists, Zakat, etc.) contribute 7% in cash assistance. "Other" sources may include support by local philanthropists, community solidarity mechanisms (*Zakat*/charities/*sadaqa*), informal transfers or remittances, local government support or private aid.

NGO and UN cash aid dominates in the absence of comprehensive public safety nets. National Society programs are strategically important in disaster-prone or remote areas and should be scaled with coordination. Areas like Ali Abad, Qalat, and Tarinkot show diversity in sources, which can support layered programming and multisectoral integration. Lack of government social protection presence, except in limited districts, reflects critical policy and capacity gaps.

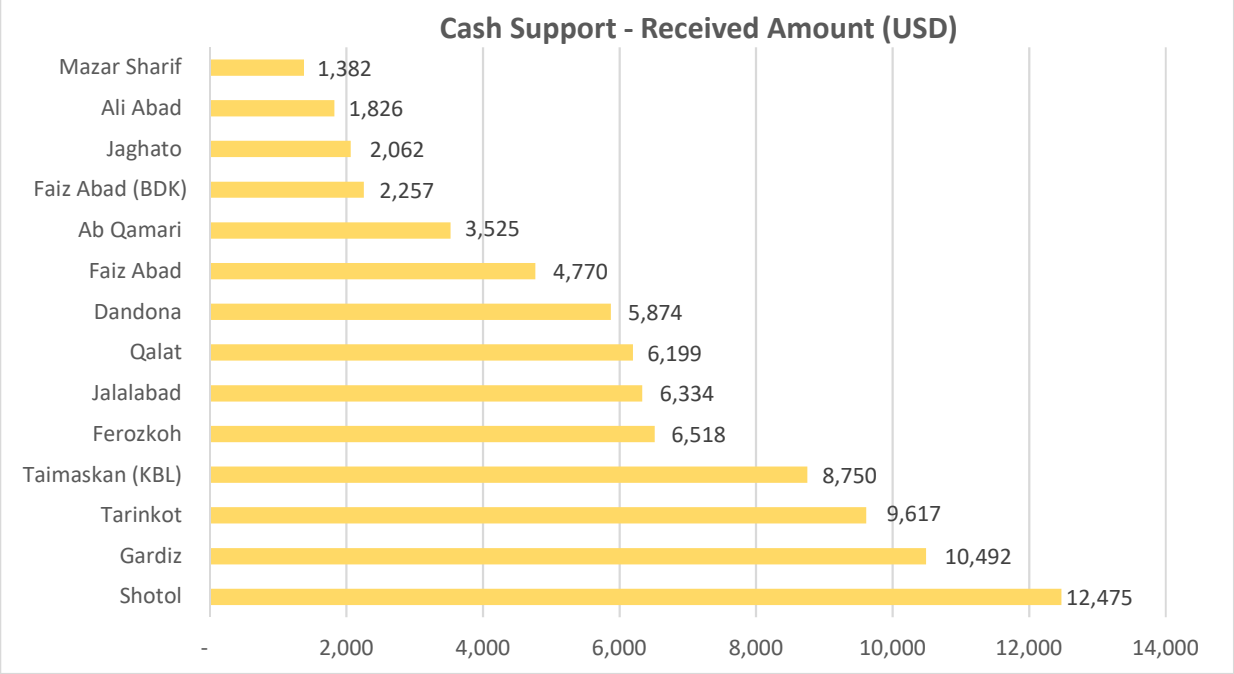
Government, humanitarian and development agencies/INGOs may consider following recommended actions to expand the cash assistance:

- Invest in Localization: Support local National Society infrastructure to deliver more predictable and localized cash assistance.
- Strengthen Public–NGO–UN Coordination: Reduce duplication and promote harmonized eligibility systems.
- Expand Government Social Protection: Technical assistance to ministries to design shock-responsive programs and registry systems.
- Ensure Inclusivity: All cash programs must integrate protection-sensitive targeting, including people with disabilities, widows, and displaced populations.

## 10.3. Annual Cash Assistance Received

This variable provides a quantitative snapshot of the total amount of financial support received by households across 14 districts in the past year. It reflects the scale of humanitarian cash support, its geographic distribution, and potential inequities or need-based prioritization across different areas.

*Figure 31: Cash Support - Received Amount*




Overall, USD 136 (average) is received by each reporting respondent. Among surveyed districts, Shotol (USD 12,475) and Gardiz (USD 10,492) recorded the highest receipts. This could be due to a higher number of beneficiaries in these locations, more frequent disbursements, higher per capita transfers due to displacement, protection risks, or multi-sectoral vulnerabilities, and geographic prioritization by UN/INGOs/government.

Taimaskan (KBL), Tarinkot, Jalalabad, Ferozkoh, Qalat, Dandona received above average (USD 5,000 – 10,000) support. These districts likely had wider humanitarian presence or were prioritized for ongoing assistance, possibly due to recent climate events, health system gaps, or IDP inflows.

Mazar Sharif, Ali Abad, Jaghato, and Faiz Abad (BDK) remain below average (USD 5,000) on cash assistance. This may indicate limited access to aid actors, lower reported need or under-registration, and a programmatic focus on non-cash interventions in these locations.

While total values are known, household size data per district is not available. Per capita distribution analysis is needed for fair comparison as some areas may receive more overall but less per person.

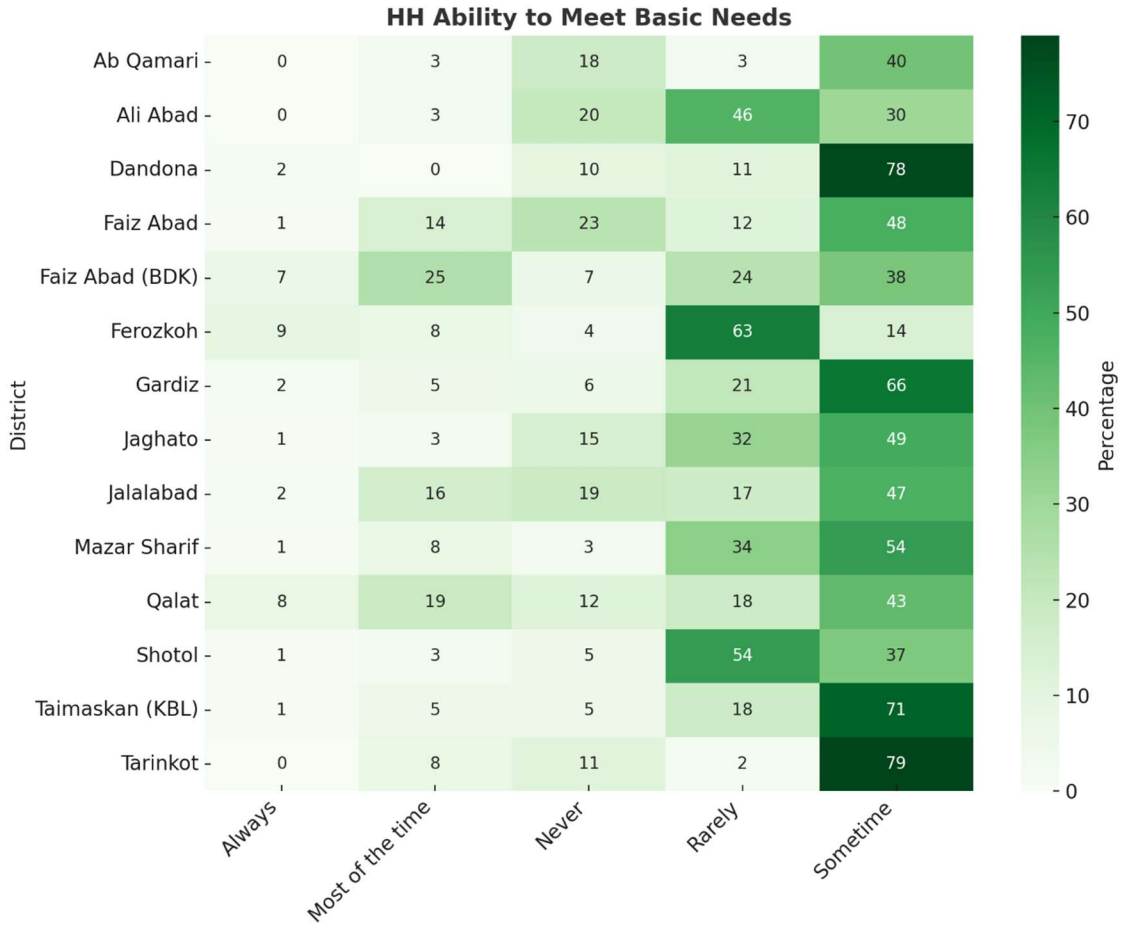
High volume districts like Shotol, Gardiz, and Taimaskan should be further analyzed to confirm if cash aid aligns with severity of needs, or if some districts are overserved while others are missed. Districts like Mazar Sharif and Ali Abad, despite known vulnerabilities, receive comparatively less and may need targeting review or better registration mechanisms. Follow-up with household size,

type of support (one-time vs regular), and linkages to health or climate shocks can enrich this analysis.

## 10.4. Ability to Meet Basic Needs

This variable gauges economic resilience, food security, and overall well-being among households across various districts. It offers critical insight into poverty levels, the effectiveness of humanitarian aid, and potential triggers of protection vulnerabilities such as health deterioration, displacement, or child labor.

*Figure 32: Households' Ability to Meet Basic Needs*




Overall, only 10% of households consistently meet their basic needs ("Always" + "Most of the time"). Half (50%) can only do so intermittently, and over one-third (36%) report struggling "Rarely" or "Never" indicating high vulnerability.

High vulnerable districts likely experience a combination of chronic poverty, displacement, climate stress, and weak market access. They may be prioritized for cash assistance, livelihood

interventions, and targeted protection services (see Table-14).

*Table 13: Highly Vulnerable Districts w.r.t. Unmet Needs*

| District | Needs Met (Rarely + Never) | Remarks |
|---|---|---|
| Tarinkot | 79% | Support-dependent with seasonal shifts. |
| Dandona | 78% | Similar trend—economically marginal. |
| Taimaskan | 71% | Transitional coping but unstable. |
| Ferozkoh | 67% | Very high rates of chronic deprivation. |
| Ali Abad | 66% | Access and livelihood constraints. |
| Gardiz | 66% | Long-term vulnerability. |
| Shotol | 59% | Food and income insecurity. |
| Jaghato | 47% | Extreme economic vulnerability. |
| Jalalabad | 36% | High burden despite urban proximity. |
| Faiz Abad (BDK) | 31% | Moderate distress levels. |

These households are on the edge of survival, often one shock away (e.g., illness, price rise, or flood) from falling into severe deprivation.

Among surveyed districts, only two reflect as relatively Better-Off, these are Faiz Abad (BDK, 32% "Always" + "Most of time") and Qalat (27%). Both districts are comparatively better and indicate some resilience, possibly due to aid. Even in these districts, only a minority consistently meet basic needs.

50% of households across districts meet their basic needs only intermittently, reflecting precarious livelihoods and insufficient regular support. Vulnerability is widespread but especially acute in Ferozkoh, Shotol, and Jaghato.

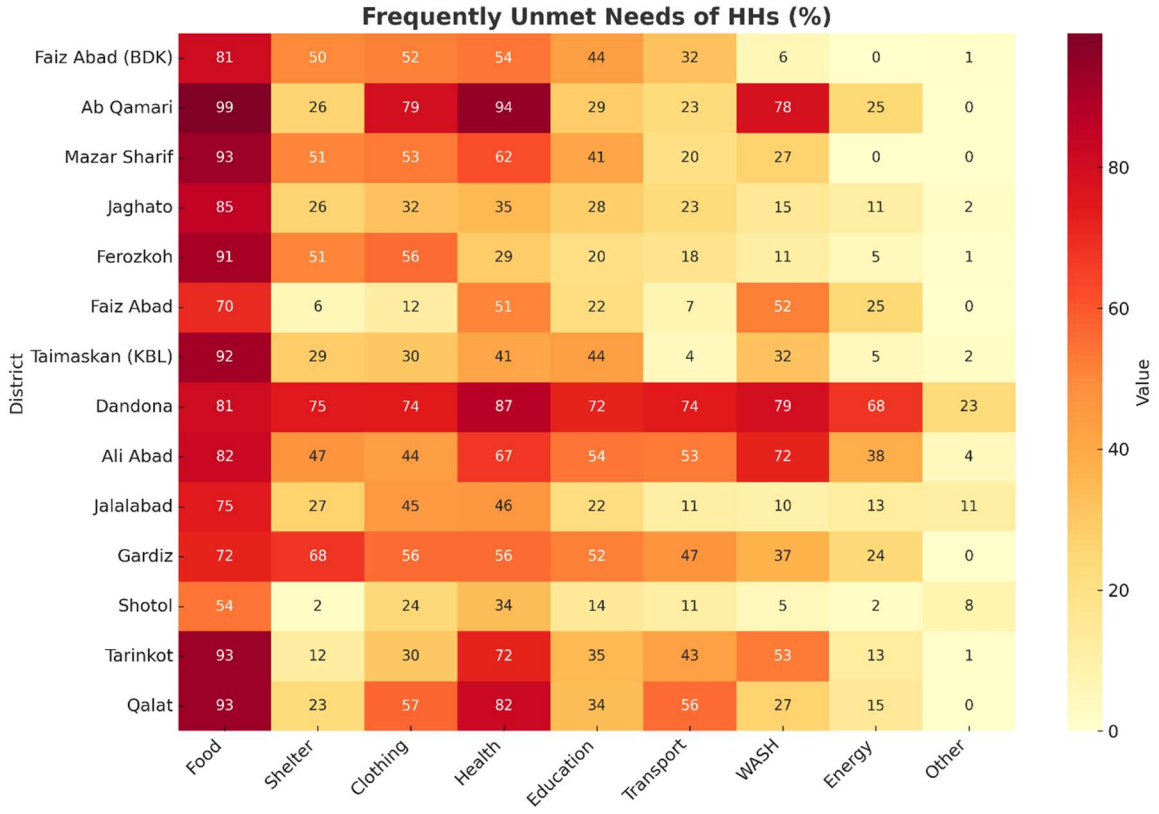
Geographic targeting for cash-based interventions should factor in these deprivation levels, especially where basic income is lacking despite existing cash programs. Linkages between cash assistance and ability to meet needs should be explored: e.g., Shotol receives high cash but still reports low satisfaction with meeting needs indicating potential issues with targeting, amount, or inflation/market access.

In districts with the highest "Rarely" and "Never" responses, multipurpose cash assistance should be scaled up, ensuring regular and predictable support in districts like Jaghato, Ali Abad, and Shotol. Livelihoods and market access support, especially in remote districts with weak coping capacity should be complemented with cash. These districts need to be prioritized for food security assessments, especially as climate risks rise.

## 10.5. Frequently Unmet HH Needs

This dataset presents the percentage of households in various districts reporting unmet needs across nine key domains: food, shelter, clothing, health, education, transport, WASH (Water, Sanitation, and Hygiene), energy, and other essential services. The analysis identifies both the critical shortages affecting specific districts and the cross-cutting trends across Afghanistan.

*Figure 33: Frequently Unmet Needs of Households*




Food emerges as the most consistently reported unmet need across districts. The highest levels are recorded in Ab Qamari (99%), Tarinkot (93%), Qalat (93%), Ferozkoh (91%), and Taimaskan (92%). Even the lowest value, Shotol at 54%, indicates that more than half of households in all districts face significant food access issues. This points to widespread food insecurity, likely linked to economic hardship, disrupted markets, and possible climate-induced agricultural decline.

Shelter inadequacies are particularly acute in Dandona (75%) and Gardiz (68%), while Faiz Abad records the lowest (6%). The stark variation suggests localized factors possibly displacement, disaster impact, or infrastructure destruction driving demand for shelter support in certain areas.

High levels of unmet clothing needs are concentrated in Dandona (74%), Qalat (57%), and Gardiz (56%), which may be linked to economic inability to purchase clothing and limited market access. The lowest is Faiz Abad (12%), suggesting localized coping capacity or better availability.

Health-related unmet needs are critically high in Ab Qamari (94%), Dandona (87%), and Qalat (82%). In contrast, Ferozkoh (29%) reports the lowest proportion. The large disparity indicates uneven healthcare access, with certain provinces possibly lacking medical facilities, trained personnel, or affordable services.

Educational needs are most acute in Dandona (72%) and Ali Abad (54%). Districts like Ferozkoh (20%) and Jaghato (28%) report lower levels, but even these indicate a considerable proportion of households unable to meet educational needs—likely due to school closures, cost barriers, and gender-related restrictions.

Transport gaps are especially high in Dandona (74%) and Ali Abad (53%), suggesting mobility barriers that can further restrict access to markets, health services, and livelihoods. Taimaskan (4%) records the lowest level, possibly due to better infrastructure or proximity to service hubs.

WASH needs are severe in Ab Qamari (78%), Dandona (79%), and Ali Abad (72%), indicating chronic water scarcity or inadequate sanitation facilities. Districts such as Faiz Abad (6%) and Shotol (5%) show lower deficits, potentially reflecting better infrastructure or natural resource access.

Energy-related unmet needs are widespread, with Dandona (68%), Ali Abad (38%), and Qalat (15%) showing significant deficits. Several districts report low or negligible needs, suggesting varied access to electricity or alternative energy sources.

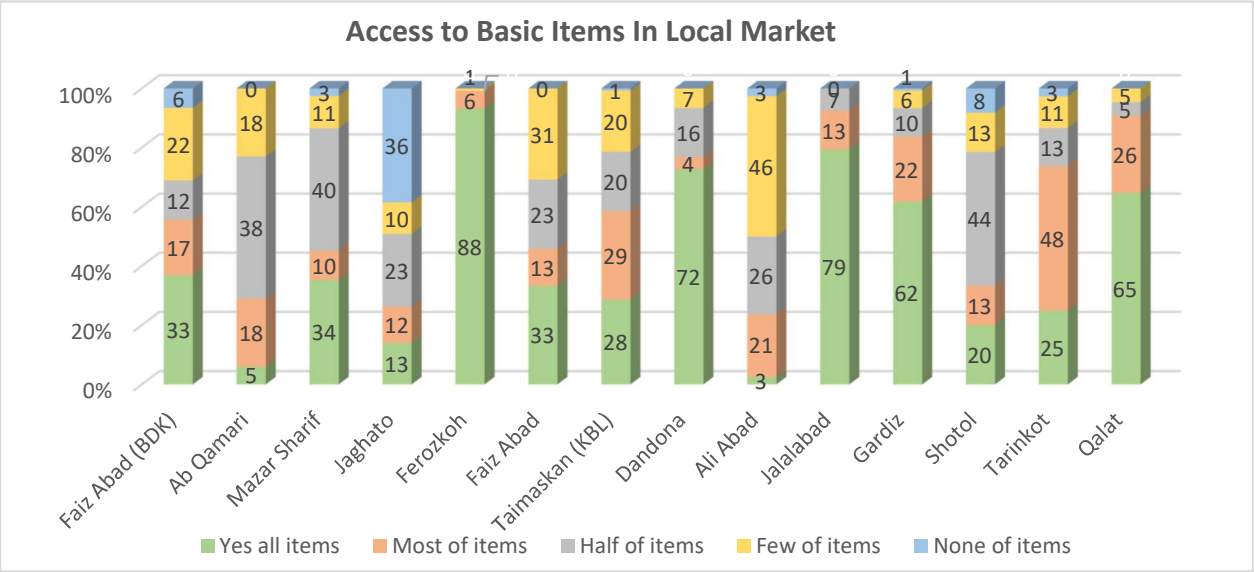
Other essential needs likely including communication, livelihood inputs, and household goodsare highest in Dandona (23%) and Jalalabad (11%), indicating that beyond the major categories, certain localities face broader livelihood vulnerabilities.

Dandona consistently records among the highest percentages across almost all categories, indicating a multi-sectoral crisis, and critical humanitarian priority. Ab Qamari's extreme food & health needs, near-universal reporting of unmet food (99%) and health (94%) needs marks this as a severe crisis zone. Districts such as Faiz Abad and Shotol record comparatively lower unmet needs in several sectors, suggesting localized resilience or better service coverage. Districts with high food insecurity often also report high health and WASH needs, indicating compounding vulnerabilities. Transport deficiencies correlate with higher unmet needs in other sectors, highlighting the role of physical access in service availability.

## 10.6. Access to Basic Items in Local Markets

This dataset assesses the availability of essential goods—such as food, hygiene products, medicine, and household supplies—within respondents' local markets. The availability of such items is a key indicator of supply chain functionality, market integration, and community resilience, particularly in crisis or post-crisis settings.

*Figure 34: Access to Basic Items In Local Market*




Overall, 60% of respondents cannot find all required items, with over one-third (38%) reporting access to only half or fewer of the items.

Districts standing out as well supplied include Ferozkoh (88%), Jalalabad (79%), Dandona (72%), Qalat (65%), and Gardiz (62%). This indicates exceptionally well-stocked possible access to reliable supply lines, urban settings (likely facilitate better availability), possibly central or trade-connected, good supply infrastructure, or strong market functionality. These districts report high availability and may serve as supply chain hubs for more vulnerable areas.

Mazar Sharif (54%), Taimaskan (41%), and Tarinkot (25%) appear as moderately struggling districts. This reflects improving access but still inconsistent. These locations show pockets of scarcity and potential seasonal fluctuations in item availability.

Ali Abad (48% few or none), Jaghato (10% few + 36% none = 46%), Shotol (21% few/none), and Ab Qamari (18% few + 38% only half = 56%) indicate market scarcity. These areas likely face logistical blockages, insecurity, or are underserved due to remoteness, infrastructure collapse, or market failure. They may require external support (e.g., mobile markets, in-kind assistance).

Ferozkoh stands out as highly functional across multiple indicators despite protection challenges—possibly linked to active humanitarian presence. Ali Abad and Jaghato consistently report poor economic and service access, suggesting multi-sectoral vulnerabilities. Taimaskan (KBL) and Tarinkot show mixed results, suggesting access varies by neighborhood, timing, or household capacity.

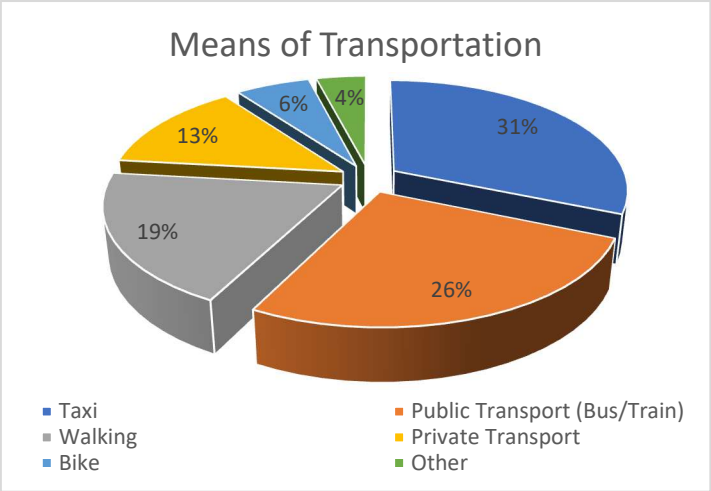
Programs need to focus on targeted market support (e.g., vendor vouchers, restocking grants, infrastructure repair) is needed in Ali Abad, Jaghato, Shotol, and Ab Qamari. Mobile markets or

community-based distribution models can improve reach in under-served districts. Supply chain resilience and transport corridors require strengthening to facilitate consistent access.

## 10.7. Modes of Transportation to Reach Markets

This variable aims at understanding how people access markets helps assess physical accessibility, mobility barriers, and economic conditions within and across communities. Transportation methods can also reflect levels of infrastructure development, geographic remoteness, and financial constraints.

*Figure 35: Overall Means of Transportation to Market*




Taxi and public transport (57% together) are the two most common transport methods, while nearly 1 in 5 walk to reach markets, indicating significant dependency on non-personal means.

Walking prevalence indicates either high poverty, lack of public services, or centralized market structures. This could pose a barrier during bad weather, disability, or conflict.

In Shotol (82%), Dandona (74%), Gardiz (70%), and Qalat (68%) of respondents report are relying on taxi or private transport to access market. This indicates high reliance on taxis and private transportation, possible due to limited walkable access. Taxi use suggests better infrastructure and affordability but may burden vulnerable populations with high transport costs, especially in emergencies or high inflation periods.

Public transport reliance is strongly reflected in Taimaskan (KBL, 56%), Ab Qamar (57%), and Mazar Sharif (48%). Public transport access supports market engagement and mobility, but capacity, safety, and affordability should be further assessed.

In Ali Abad 47% respondents selected “Other” indicating either unconventional transport means (e.g., donkey carts, communal pickups) or data misreporting. Faiz Abad indicates very mixed modal use with high percentages across nearly all categories. Jaghato shows high dependence on both taxis (48%) and public transport (47%) which may reflect multi-nodal mobility or fragmented access.

While using various modes of transportation, women, elderly, and persons with disabilities may face increased hardship in districts esp. those with high walking reliance. Cash assistance

programs could consider transport stipends or transport vouchers in Ferozkoh, Tarinkot, and Shotol.

Market placement strategies should ensure access via multiple modes, especially in mountainous or conflict-prone districts.

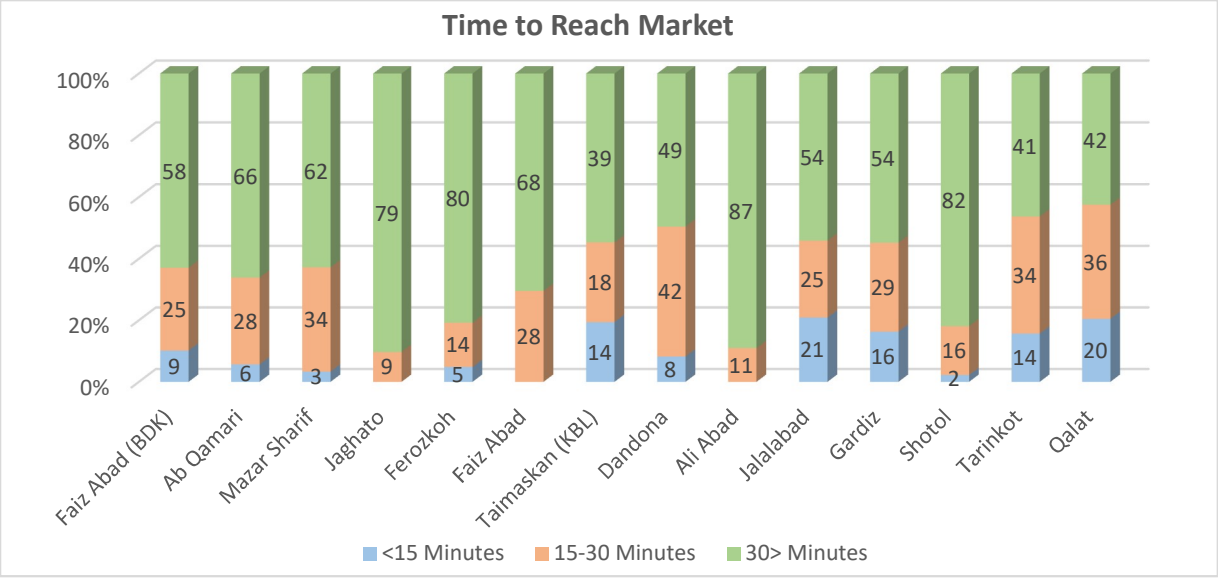
Programs may consider following as effective measures to improve market access:

- Improve last-mile access in districts where walking is dominant but burdensome.
- Subsidize public transport fees or introduce community shuttles in areas with low vehicle ownership.
- Include mobility questions in vulnerability assessments to tailor interventions by age, gender, and ability.
- Map transport corridors and congestion spots to inform urban planning and market development.

## 10.8. Time to Reach the Market

This data reflects the time required for a person responsible for purchasing basic items to reach the market, categorized into three time-brackets: less than 15 minutes, between 15–30 minutes, and more than 30 minutes. This indicator serves as a proxy for physical market accessibility and can highlight logistical, infrastructural, and geographic inequalities across districts.

*Figure 36: Time to Reach Market*




The majority of respondents (50–87%) in most districts require more than 30 minutes to reach a market. Very few respondents (0–21%) report access within 15 minutes, indicating limited

immediate access to essential goods and markets. Several districts reflect moderate access (15–30 minutes), but the overall trend leans toward longer market commute times.

Following districts show significant time burdens, indicating remoteness, poor road infrastructure, or lack of local markets.

- Ali Abad: 87% of respondents take more than 30 minutes to reach markets, with no one accessing under 15 minutes, indicating severe isolation.
- Ferozkoh: 80% require more than 30 minutes; only 5% reach in under 15 minutes, consistent with known mountainous and rugged terrain.
- Jaghato: 79% exceed 30 minutes; complete absence of under-15-minute access, signaling a lack of nearby commercial infrastructure.
- Shotol: 82% take more than 30 minutes; only 2% access within 15 minutes, possibly due to geographical constraints or dispersed settlements.
- Ab Qamari: 66% exceed 30 minutes, high delay with no fast access reported.
- Faiz Abad (2nd entry): 68% need more than 30 minutes, confirming similar issues in both entries of Faiz Abad.

Group of districts listed below show moderate access time i.e. within and beyond 30 minutes. These include:

- Taimaskan (KBL): 39% report more than 30 minutes, but 14% access within 15 minutes, showing a mixed profile, likely due to urban proximity in Kabul.
- Dandona: 49% exceed 30 minutes, but 50% report access within 30 minutes, moderate conditions with some efficient linkages.
- Tarinkot: 41% take over 30 minutes, while 48% access within 30 minutes, improved performance, but still partial accessibility gaps.
- Gardiz: 54% exceed 30 minutes; 45% reach within 30 minutes, borderline moderate, but still warrants attention.
- Jalalabad: 54% exceed 30 minutes, but 46% access within 30 minutes, similar to Gardiz, but urban congestion may be a factor.

Among surveyed districts only two districts reflect better market access. These are:

- Qalat: 42% exceed 30 minutes, but 56% access within 30 minutes, including 20% within 15 minutes, one of the best-performing districts.

- Faiz Abad (BDK): 58% take more than 30 minutes, 34% reach within 30 minutes, a mixed situation but better than many others.

Long access times increase the cost and frequency of essential purchases, disproportionately affecting women, elderly, and disabled household members. Poor access reduces exposure to market diversity, leading to reliance on limited or overpriced items, reduced dietary diversity, and greater economic vulnerability. Markets more than 30 minutes away impose burdens on household time management, especially in crisis-affected and climate-vulnerable communities.

For enhancing convenient and rapid market access, programs may consider the following:

- Support local market development in underserved districts like Ali Abad, Shotol, Jaghato, and Ferozkoh to reduce travel burdens.
- Improve road and transport systems, especially in districts with high mountainous terrain or poor connectivity.
- Promote mobile markets or vendor outreach programs, particularly in hard-to-reach areas.
- Consider cash and voucher assistance delivery methods that do not require physical access to distant markets.

## 10.9. Coping Mechanisms in Communities

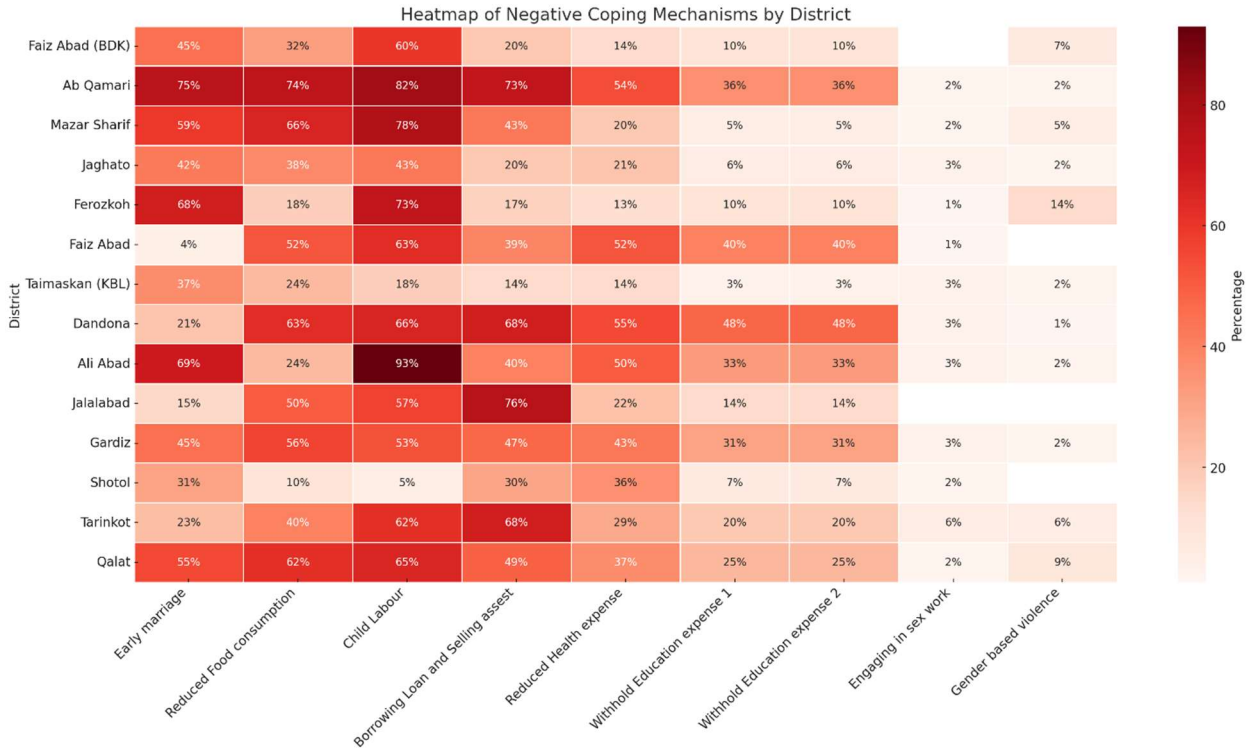
This variable asked the respondents to indicate which coping strategies are being used in their communities due to ongoing economic or social hardships. The analysis reveals a concerning prevalence of negative coping mechanisms, particularly among vulnerable districts.

Overall, child labour (57%) is the most frequently reported coping mechanism across the surveyed districts, indicating a widespread reliance on children for income generation. Ali Abad (93%), Ab Qamari (82%), and Mazar Sharif (78%) report highest, whereas, Shotol (5%), and Taimaskan (18%) reflect very low prevalence of child labour.

Reduced food consumption (43%) and borrowing loans/selling assets (43%) are common economic coping strategies. The concern is alarmingly high in Ab Qamari (74%), Mazar Sharif (66%), Dandona (63%), and Qalat (62%), that points to ongoing food insecurity and economic depletion.

Early marriage (42%) was also frequently mentioned across the districts. Ab Qamari (75%), Ali Abad (69%), Ferozkoh (68%) report highest incidences of early marriages. This is a critical child protection concern that increases vulnerability for children esp. adolescent girls.

*Figure 37: Negative Coping Mechanisms by District*




Reduced Health Expenses (32%) and Withholding Education Expenses (20%) show households sacrificing long-term well-being and development. Withholding education is especially high in Faiz Abad (40%), Dandona (48%), and Ali Abad (33%).

Engagement in Sex Work (2%) was reported at a low level overall, but any presence of this strategy is deeply concerning. The prevalence is reported in Jaghato (3%), Ali Abad (3%), Taimaskan (3%), and Tarinkot (6%).

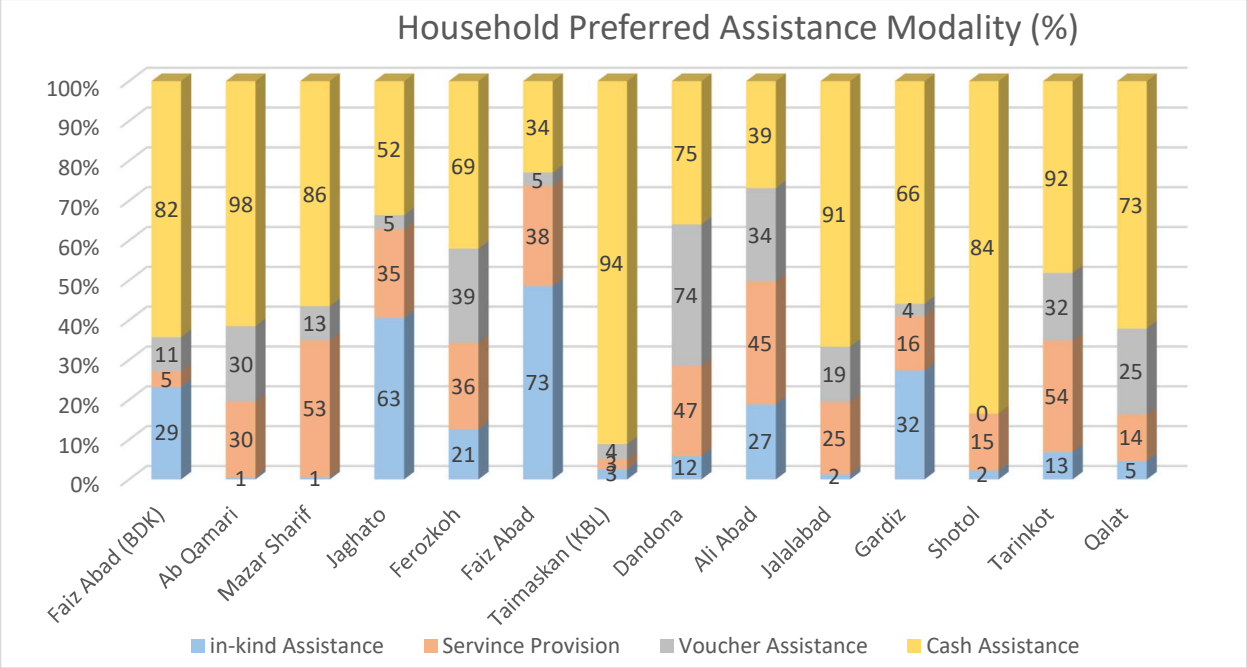
Gender-based violence (GBV) (4%) as a reported coping issue was relatively lower but present in Faiz Abad (BDK - 7%), Ferozkoh (14%), and Qalat (9%). This indicates social breakdown and the need for protection services. Low responses to GBV should not be confused with non-prevalence of incidences. Due to cultural barriers, and social acceptance of GBV, response to GBV questions remains masked and under reported.

District-wise, Ab Qamari, Ali Abad, and Mazar Sharif show high exposure to nearly all coping strategies, suggesting significant socio-economic distress. Shotol and Taimaskan (KBL) report lower levels across most coping strategies, possibly indicating better resilience or support systems. Urban centers like Jalalabad and Gardiz have moderate levels of multiple coping mechanisms but also report high levels of borrowing and child labor.

## 10.10. HHs' Preferred Assistance Modality

This dataset provides valuable insight into community preferences for assistance modalities across different districts. Overall, cash assistance is by far the most preferred support modality, reflecting a strong desire for flexible, self-directed aid.

*Figure 38: Household Preferred Assistance Modaility*




Cash assistance is preferred by 75% of respondents across all locations, signaling a broad consensus on its effectiveness in addressing individual needs. Service provision (29%) and voucher assistance (21%) follow as the next preferred modalities. Only 20% prefer in-kind support, indicating a shift away from traditional humanitarian distribution models.

By districts, Ab Qamari (98%), Taimaskan (94%), Jalalabad (91%), Tarinkot (92%), and Mazar Sharif (86%) stand out with the highest cash assistance preference. These areas may have markets capable of meeting local needs or populations seeking autonomy in addressing specific challenges. Dandona shows a more balanced preference with 75% for cash, 74% for vouchers, and 47% for services, suggesting that a hybrid approach might be most suitable. Ferozkoh also shows a strong mixed-modality preference: 69% for cash, 39% for vouchers, and 36% for services. Faiz Abad (73%) and Jaghato (63%) report significantly higher preference for in-kind assistance, possibly due to limited purchasing power or less functional market systems. Mazar Sharif (53%), Ali Abad (45%), and Tarinkot (54%) show relatively high demand for direct service provision, indicating structural needs that go beyond financial assistance alone (e.g., health, education, or psychosocial services).

While generally less preferred, voucher assistance sees strong demand in Dandona (74%) and Ferozkoh (39%), suggesting specific commodity needs that can be met via targeted support without full cash liquidity

Cash-first programming is likely to be highly effective in most districts, provided market access is functional. Hybrid modalities (combining vouchers, service provision, and some in-kind elements) may be necessary in Dandona, Ferozkoh, and Ali Abad. In-kind support may still be necessary in Jaghato and Faiz Abad, perhaps due to logistical constraints, protection risks, or lack of market access. Context-specific interventions are essential a one-size-fits-all modality will not work uniformly across Afghanistan.

Detailed programming choices for implementers of cash assistance are listed below:

- Prioritize Cash Assistance in Most Districts: Implement cash-based programming in districts with high preference (Ab Qamari, Taimaskan, Jalalabad, Tarinkot, Mazar Sharif). Ensure cash delivery mechanisms are secure, inclusive, and linked to functioning local markets.
- Adopt Hybrid Modalities in Mixed-Preference Areas: In Dandona, Ferozkoh, and Ali Abad, combine cash, voucher, and service-based assistance to match diverse needs. Use needs assessments to define the right mix for each area and population group.
- Support In-Kind Assistance Where Markets Are Weak: Maintain or scale in-kind support in Jaghato and Faiz Abad, where purchasing power or market functionality may be limited. Complement with supply chain strengthening and community-based service delivery.
- Scale Up Service Provision in Structurally Underserved Districts: Address critical infrastructure gaps (e.g., health, education, protection) in Mazar Sharif, Ali Abad, and Tarinkot through expanded public services or NGO support. Integrate services with other modalities to ensure accessibility and coverage.
- Use Voucher Programs for Targeted Commodity Needs: Deploy voucher systems in Dandona and Ferozkoh where specific goods are needed (e.g., hygiene kits, fuel, school supplies) and liquidity may pose a risk.
- Ensure Context-Sensitive Design: Avoid one-size-fits-all programming. Tailor modality choices to local market capacity, security conditions, and community preferences.
- Monitor and Adapt Regularly: Establish feedback loops and market monitoring to adjust delivery modalities based on evolving conditions and community input.

According to community FGD findings, cash assistance is generally preferred due to its flexibility, but it doesn't always shift gender dynamics positively. In some cases, cash received by women is confiscated or misused by male relatives (e.g., sons purchasing luxury goods instead of household necessities). Though some communities have begun to shift dynamics where women receive and manage cash aid. Yet in others, women have begun playing more active roles in budgeting and

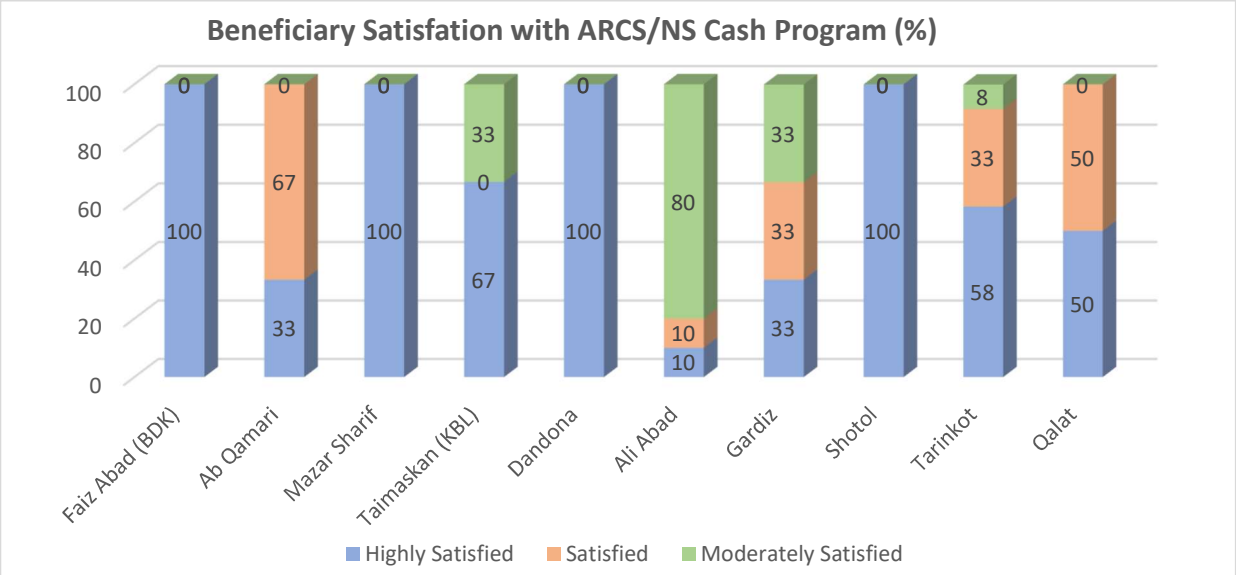
prioritizing needs. Where cash-for-work programs are offered, women advocate for inclusive designs that also consider their capacity and responsibilities, such as caregiving and mobility restrictions.

FGD members from most of districts preferred to receive Cash as support modality. In few districts such as Taimaskan (KBL), FGD members preferred service provision particularly for health and nutrition of their family. While some humanitarian programs targeted widows and female-headed households, many women still struggled to access aid independently, community FGDs highlighted. Restrictions on mobility, lack of identity documentation, and digital illiteracy prevent them from benefiting fully from services like cash assistance, especially where banking or mobile systems are used.

## 10.11. Beneficiary Satisfaction with ARCS or NS Cash Assistance Program

This question evaluates community satisfaction with the ARCS or national society's cash assistance interventions, reflecting both performance and public perception. The response scale is highly satisfied, satisfied, and moderately satisfied.

*Figure 39: Beneficiary Satisfaction with ARCS/NS Cash Program*




High satisfaction levels are reported in the majority of districts, with several such as Faiz Abad, Mazar Sharif, Dandona, and Shotol showing 100% “Highly Satisfied” responses. Ali Abad and Gardiz are the only districts with substantial levels of moderate satisfaction, suggesting potential concerns with program design or implementation. Taimaskan, Tarinkot, and Qalat show mixed satisfaction, which may indicate program success but also room for improvement in specific delivery components.

*Table 14: District-wise Interpretation of Satisfaction Levels*

| District | Highly Satisfied | Satisfied | Moderately Satisfied | Key Interpretation |
|---|---|---|---|---|
| Faiz Abad | 100% | 0% | 0% | Extremely positive perception; effective program delivery and relevance. |
| Ab Qamari | 33% | 67% | 0% | Generally satisfied; room to improve the experience to increase "high satisfaction." |
| Mazar Sharif (Sajadia) | 100% | 0% | 0% | High alignment with local needs; effective targeting and delivery. |
| Taimaskan (KBL) | 67% | 0% | 33% | Reasonably positive; minor concerns may exist regarding adequacy or access. |
| Dandona | 100% | 0% | 0% | Excellent reception; likely a strong operational model to replicate elsewhere. |
| Ali Abad | 10% | 10% | 80% | Major dissatisfaction; strong indication of program gaps (amount, fairness, targeting). |
| Gardiz | 33% | 33% | 33% | Split perception; may reflect uneven access or differing community experiences. |
| Shotol | 100% | 0% | 0% | Exceptional satisfaction; suggests good community engagement and logistics. |
| Tarinkot | 58% | 33% | 8% | Largely satisfied; some concerns, but overall a well-received program. |
| Qalat | 50% | 50% | 0% | Balanced positive views; no major dissatisfaction reported. |

## 10.12. Beneficiary Perception and Experience about ARCS/NS Cash Support Program

This data reflects beneficiaries' perceptions and experiences regarding the ARCS/National Society's cash support program. Key performance indicators assessed include information quality, fairness of selection, distribution efficiency, and staff behavior.

### 10.12.1. Information Quality (Adequate and Accurate Information)

Respondents expressed high satisfaction in Faiz Abad (BDK) (67%) and Qalat (75% adequate) with the adequacy and accuracy of information they received from ARCS staff. Mazar Sharif and Ab Qamari show contrasting views. Mazar Sharif reports only 18% agreement on adequate info but 82% for fairness, indicating that fairness perception may be influenced by local social norms, not transparency. Taimaskan (KBL) and Tarinkot show extremely low levels of information satisfaction, suggesting communication breakdowns. This reflects that in many districts, communication efforts during the cash rollout were either limited or ineffective.

### 10.12.2. Fairness in Beneficiary Selection

Beneficiaries report strong agreement in Mazar Sharif (82%), Faiz Abad (67%), and Taimaskan (33%) with fairness in beneficiary selection. Tarinkot (17%) and Ali Abad (30%) suggest moderate dissatisfaction. Ab Qamari and Shotol show low or no data, possibly indicating community disengagement or limited program coverage. Moderate dissatisfaction may imply lack community engagement that may be undermining trust.

### 10.12.3. Amount and Distribution Suitability

Tarinkot reports the highest adequacy (42%) and suitability of distribution (54%), yet reports low satisfaction with fairness, suggesting logistical strength but poor communication or social tensions. Ali Abad shows consistently low satisfaction across all indicators, including adequacy (10%) and accuracy of received amount (20%). The indicate that where operational procedures are timely, the amounts distributed may not be meeting needs.

### 10.12.4. Safety and Accessibility

Only Tarinkot (38%) and Ali Abad (40%) report moderate agreement on feeling safe during cash collection. Distance to collection points is cited by only 21% in Tarinkot and 10% in Ali Abad as not being too far, indicating that logistics need improvement in these areas.

### 10.12.5. Staff Professionalism and Communication

Dandona is the only district with 100% satisfaction with staff professionalism and communication, albeit with no disaggregated responses. This may possibly a small or homogenous sample. Ali Abad stands out with 40% agreement that staff explained communication channels, but only 20% found staff professional. Tarinkot (29%) and Mazar Sharif (27%) had mixed views on staff behavior. This points out need for staff training and community interaction improvement strategies in most locations.

ARCS can benefit from the following strategies and actions to fill in the gaps identified.

- Strengthen Community Communication:
    - Use multi-channel outreach (radio, SMS, community elders) to improve information quality in districts like Tarinkot, Ali Abad, and Shotol.
    - Provide clear, visual communication on selection criteria, amounts, and grievance redress.
- Improve Beneficiary Selection Transparency:
    - Engage community representatives in selection validation (especially in Taimaskan, Qalat).

    - Monitor exclusion errors in districts reporting low fairness scores.

- Tailor Cash Amounts to Household Needs:
    - Consider localized Minimum Expenditure Basket (MEB) analysis to adjust cash amounts, especially in Ali Abad and Ab Qamari.
- Enhance Distribution Safety and Accessibility:
    - Explore mobile cash solutions or doorstep delivery in remote and insecure districts.
    - Design safe access points especially where women and elderly are involved.
- Train Staff on Accountability and Communication:
    - Strengthen capacity of field staff on Code of Conduct, feedback mechanisms, and inclusive behavior.
    - Regularly audit frontline interactions and promote gender-sensitivity.
- Pilot Hybrid Modalities:
    - In underperforming areas like Ali Abad and Ab Qamari, test voucher or in-kind support in parallel to cash to bridge gaps in market or trust.

# 11. Key Trends and Variations Across Different Locations and Community Groups

The assessment revealed significant disparities in access to services, community vulnerability, economic well-being, and satisfaction levels across the 14 surveyed districts. While overall indicators suggest some promising developments, particularly in access to healthcare and satisfaction with services, the variations across geographic and social lines reflect uneven development, systemic gaps, and complex community dynamics.

## 11.1. Health Services Access and Community Satisfaction

Access to healthcare services is relatively high across the surveyed regions, with 93% of respondents reporting the presence of mobile or fixed facilities within reach. Districts such as Jalalabad, Qalat, and Faiz Abad showed high coverage and utilization rates—suggesting strong outreach, infrastructure, or trust in services. However, in contrast, districts like Jaghato and Tarinkot lagged significantly, with only 45% and 54% coverage respectively, indicating substantial service delivery gaps. These gaps were attributed to a combination of factors including the absence of health professionals, geographic inaccessibility, reliance on traditional healers, and financial barriers.

Perceptions of safety in accessing ARCS-supported health facilities were broadly positive, with nearly 90% feeling “safe” or “very safe,” particularly in districts like Shotol, Qalat, and Jalalabad. However, districts such as Ali Abad and Faiz Abad (BDK) reflected lower safety perceptions, hinting at community tensions or local security concerns, especially for women and vulnerable groups.

Satisfaction with the quality of care provided by ARCS/National Society clinics is exceptionally high overall, with 98% of users reporting satisfaction. Yet, district-level discrepancies surfaced. Shotol, Jalalabad, and Dandona reported exceptional service satisfaction, while Ali Abad, Mazar Sharif, and Taimaskan (KBL) had notably lower satisfaction ratings due to long wait times, malfunctioning equipment, and limited medication availability.

## 11.2. Economic Vulnerability and Cash Assistance

The economic landscape remains fragile, with the majority of households operating under a persistent monthly deficit. Households in Dandona, Ferozkoh, and Ab Qamari reported income shortfalls of 89% to 143%, far exceeding national averages. The consequence of such financial strain is evident in the widespread adoption of harmful coping strategies, including child labor (reported in 57% of communities), early marriage (42%), and the sale of household assets to manage debt. Districts such as Tarinkot (70%), Dandona (68%), and Ali Abad (60%) reported the highest rates of asset liquidation.

Despite this, access to consistent financial assistance is limited. Only 3% of households reported receiving monthly support, while 30% reported occasional assistance—often seasonal or emergency-based. Shotol reported the highest level of occasional support (72%), yet economic indicators suggest the support is insufficient. On the other hand, districts like Ali Abad, Mazar Sharif, and Gardiz—with high economic distress—reported little or no financial aid, indicating targeting gaps in aid distribution mechanisms.

Notably, the community preference for assistance overwhelmingly favored cash-based support, with 75% of respondents identifying cash as their preferred modality. In districts with market functionality, such as Jalalabad, Mazar Sharif, and Taimaskan (KBL), cash was nearly universally preferred. However, in Jaghato and Faiz Abad, in-kind assistance remained the preference, highlighting either market constraints or deeper vulnerabilities.

## 11.3. Nutrition and Child Health

Nutrition services remain inadequately accessed. Despite the presence of 3,459 under-five children across the districts, only 31% were enrolled in nutrition programs. Enrollment rates were highest in Jaghato (53%) and Shotol (42%) and critically low in Ab Qamari (15%), Ferozkoh (21%), and Taimaskan (23%). The low outreach in high-need districts is alarming and points to the need for enhanced service coverage and community sensitization.

## 11.4. Emergency Services and Transport Access

Access to emergency services remains inconsistent. While 68% of households that requested ambulance services received them, the remaining one-third did not, posing critical risks during emergencies. Ali Abad was the worst-performing district, with only 27% of cases receiving timely ambulance response (within 30 minutes), and a significant number waiting over 60 minutes. In contrast, Mazar Sharif, Qalat, and Dandona reported the highest response efficiency, suggesting better infrastructure and service coordination.

The primary barriers to ambulance access included complete unavailability, lack of awareness about contact information, and slow service. In Ferozkoh, 68% of households didn't know the ambulance contact number despite lower unavailability rates, showing a breakdown in community communication. In mountainous and remote districts like Jaghato and Dandona, lack of availability and long distances further exacerbated health risks.

## 11.5. Protection, Gender, and Violence

Across all districts, women and girls were consistently identified as the most affected by violence and protection risks. Women were identified as the most vulnerable group in 39% of cases, followed by young girls (23%), particularly in Mazar Sharif, Ali Abad, and Faiz Abad. This aligns

with the high prevalence of early marriage and child labor in these same districts, reflecting gendered impacts of poverty and insecurity.

Furthermore, 32% of respondents believed that violence targeting specific groups was common, with Shotol, Faiz Abad (BDK), and Jalalabad ranking highest in this perception. Alarmingly, reports of violence against health providers, including verbal, physical, and material violence,were noted in districts like Faiz Abad (BDK), Ali Abad, and Gardiz. The perception that healthcare systems are contributing to or incapable of addressing such violence was notably high in Jalalabad and Qalat, where significant portions of respondents perceived the health system as escalatory or incapable of managing violence.

The availability of protection services is highly limited. Over 30% of respondents reported the absence of any safety-enhancing services in their communities, particularly in Shotol, Ferozkoh, and Qalat. Legal services, psychosocial support, safe houses, and women/girls' safe spaces were largely unavailable in most districts. Where services existed, they were often invisible or poorly communicated. This was evident in the 31% of respondents who did not know whether vulnerable groups had access to support services.

## 11.6. Climate Perception and Impact on Health

Perceptions of climate change and its health impacts varied significantly. In high-altitude or drought-prone districts such as Ferozkoh, Ab Qamari, and Dandona, over 90% of respondents believed that climate change had a "very high" impact on their health. Conversely, in Taimaskan (KBL) and Qalat, awareness was much lower, with a significant number reporting "no impact" or "don't know." Temperature change was the most recognized climatic effect (60% average), followed by more frequent and severe weather events (55%).

A substantial 71% of respondents across all districts believed future climate change would negatively affect their health, underscoring the urgency for climate-health integration in programming. Nonetheless, the variation in perceived risk implies that localized climate communication and education are essential, particularly in urban and peri-urban areas where awareness is lower.

## 11.7. Market Functionality and Accessibility

Physical access to markets remains a challenge in many districts. While 40% of respondents reported access to all essential items, over 60% reported only partial access, especially in Jaghato, Ali Abad, and Shotol. Travel time to markets exceeded 30 minutes for over 60% of respondents across districts, with districts like Jaghato, Ferozkoh, and Shotol reporting over 80% taking more than 30 minutes. In such areas, transportation costs and physical strain become barriers to market access, especially for women, elderly, and persons with disabilities.

Modes of transportation also reflect economic and infrastructural constraints. While taxis and public transport were common in some urbanized districts, reliance on walking, especially in Ali Abad and Ab Qamari, indicated significant mobility limitations. These access issues compound household vulnerability in times of inflation or supply chain disruptions.

# 12. Evidence-Based Recommendations

## 12.1. Strengthen Health Service Delivery

- Invest in underserved districts: Improve health facility staffing, supplies, and infrastructure in Jaghato, Ali Abad, and Ferozkoh. These districts report poor access, satisfaction, and emergency response.
- Improve ARCS visibility: Use community campaigns and signage to enhance visibility and trust in ARCS services, especially in districts with high "Don't Know" responses (e.g., Mazar Sharif).
- Enhance referral systems: Standardize referral documentation and communication protocols in low-performing districts (Gardiz, Qalat).

## 12.2. Expand Protection and Inclusion Services

- Establish Protection Hubs: Prioritize districts with no services (e.g., Shotol, Qalat, Ferozkoh) for integrated centers offering psychosocial, legal, and child protection support.
- Barrier-Sensitive Programming: Incorporate inclusive designs for women, elderly, and disabled persons. Districts like Taimaskan and Qalat need urgent targeting due to high reported access barriers.

## 12.3. Address Economic Vulnerability Through Scalable Cash Assistance

- Scale up regular cash programs: Shift from occasional to sustained support in high-deficit districts like Dandona, Ferozkoh, and Ab Qamari.
- Integrate cash with livelihoods: Pair cash with vocational training, debt relief, and small business grants, especially in areas with frequent asset sales and child labor.
- Use community feedback: Enhance feedback mechanisms in districts like Ali Abad and Shotol to improve transparency and inclusion.

## 12.4. Strengthen Nutrition and Immunization Systems

- Close Enrollment Gaps: Increase under-five enrollment in nutrition services in Ab Qamari, Taimaskan, and Ali Abad through mobile units and outreach.
- Correct Immunization Records: Align reported full immunization with actual antigen delivery; train enumerators and conduct spot audits.

## 12.5. Improve Emergency Response and Market Access

- Deploy Community Ambulance Systems: In underserved zones (e.g., Jaghato, Ferozkoh), deploy community-based transportation models and provide hotline training.
- Facilitate Market Access: Improve road infrastructure, introduce mobile markets, and provide transport stipends in high-travel-time districts like Ali Abad and Shotol.

## 12.6. Climate-Responsive Health Programming

- Mainstream Climate Adaptation: Integrate climate-health education in community programs, particularly in low-awareness zones (Taimaskan, Qalat).
- Early Warning and DRR: Launch early warning and disaster risk reduction (DRR), Anticipatory Actions and Health interventions in highly vulnerable districts (Ferozkoh, Tarinkot).

## 12.7. Protection from Violence

- Conflict-Sensitive Health Facilities: Train health workers on conflict de-escalation and healthcare in danger (HCiD), especially in districts reporting high verbal/physical threats.
- Community-Based Protection Networks: Establish community-led violence monitoring and protection support, with special focus on women, girls, and IDPs.