



Commissionerate Afghan Refugees (CAR)
Khyber Pakhtunkhwa, Peshawar

INTERNATIONAL
RESCUE
COMMITTEE

**HEALTH STATUS REPORT OF AFGHAN
REFUGEES IN KHYBER PAKHTUNKHWA,
PAKISTAN**



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LIST OF ABBREVIATIONS

ARs	Afghan Refugees
ACC	Afghan Citizen Card-holder
BoS	Bureau of Statistics
BCC	Behavior Change Communication
CAR	Commissionerate of Afghan Refugees
CHW	Community Health Worker
DRIVE	Document Renewal and Information Verification Exercise
DHQ	District Headquarters Hospital
DHIS	District Health Information System
EPH	Essential Package of Health Services
FGD	Focus Group Discussion
GP	General Practitioner
HAU	Health Access and Utilization Survey
HMC	Hayatabad Medical Complex
IOM	International Organization of Migration
LHW	Lady Health Workers
MICS	Multiple Indicator Cluster Survey
MHP	Mental Health and Psychological Social Support
OPD	Outpatient Department
KII	Key Informant Interview
POR	Proof of Registration
PDH	Project Directorate of Health
PD	Pakistan Demographic & Health Survey
RV	Refugee Village
RHC	Rural Health Centre
TH	Tehsil Headquarters Hospital
TT	Tetanus Toxoid
UN	United Nations
UHC	Universal Health Coverage
UNHCR	United Nations High Commissioner for Refugees

PREFACE

For over four decades, Pakistan has generously hosted Afghan refugees, demonstrating remarkable resilience and solidarity in the face of protracted displacement. Through collaboration with the Government of Pakistan, the United Nations, and various international partners International Rescue Committee in Pakistan has provided essential social services, including healthcare, to these displaced populations. Over the years, the approach has evolved into strategic investments aimed at strengthening the public health system for both refugees and host communities.



The International Rescue Committee (IRC) Pakistan is honored to present this comprehensive report, shedding light on the health status and challenges faced by Afghan refugees residing in Khyber Pakhtunkhwa province of Pakistan.

Despite significant strides, Afghan refugees continue to grapple with unique vulnerabilities, compounded by high levels of poverty and limited access to essential services of Health, education and livelihoods. This report documents the health status, drawing from a robust methodology that includes desk reviews, primary data collection, and consultations with key stakeholders and affected communities.

The findings of the report underscore the urgent need for contextualized interventions to address the multifaceted health needs of Afghan refugees. From access barriers to financial constraints, the report highlights critical areas requiring immediate attention and action. Notably, it emphasizes the pivotal role of community-level healthcare interventions, advocating for the establishment of a community-based health networks within refugee settlements to benefit both Afghan refugees and host communities.

Furthermore, the report offers pragmatic recommendations aligned with global frameworks such as the UN Global Compact on Refugees and initiatives like the Universal Health Coverage (UHC) strategy adopted by the Khyber Pakhtunkhwa government. These recommendations span various levels of healthcare delivery, from community-based initiatives to policy advocacy, aiming to enhance access, quality, and inclusivity in healthcare services for Afghan refugees.

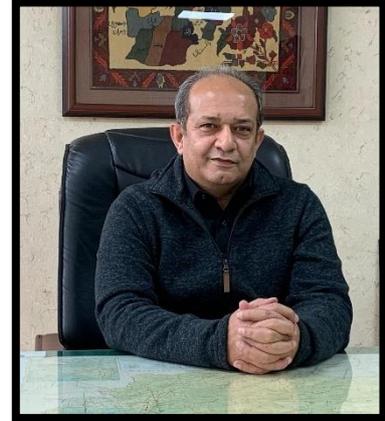
The report serves as a call for concerted efforts from stakeholders such as government agencies, humanitarian actors, and the international community to uphold the rights and dignity of Afghan refugees. By implementing the recommendations outlined we can peruse a course towards a more equitable and resilient healthcare system, ensuring that no one is left behind.

We extend our deepest gratitude to the Commissionerate for Afghan Refugees (CAR) KP for their leadership, collaboration and support in conducting this study. Together, we affirm our commitment to leaving no one behind and building a healthier, more inclusive future for all.

Shabnam Baloch
Country Director (International Rescue Committee-Pakistan)

FOREWORD

The Afghan refugee crisis, spanning over four decades, represents one of the most protracted and complex displacement scenarios of our time. Amidst the challenges of displacement, the issue of healthcare for Afghan refugees in Pakistan emerges as a critical concern, demanding urgent attention and action. Pakistan, with its long-standing tradition of hospitality, has been a steadfast host to Afghan refugees. Despite its economic and social pressures Pakistan has demonstrated unparalleled generosity and hospitality in hosting Afghan refugees and adhered to the highest standards of protection and facilitation.



The "First Health Status Report for Afghan Refugees" provides a comprehensive overview of the current health landscape confronting Afghan refugees residing in Khyber Pakhtunkhwa. Through meticulous research and analysis, this report highlights the multifaceted challenges faced by Afghan refugees, ranging from access to healthcare services to socio-economic determinants of health.

One of the report's key findings underscores the critical need for targeted interventions to address the unique vulnerabilities of Afghan refugees, including issues such as child marriage, limited access to education, and financial barriers to healthcare. Furthermore, the report highlights the strain on Pakistan's healthcare system, exacerbated by the influx of Afghan refugees, and the imperative of aligning interventions with global frameworks such as the UN Global Compact on Refugees.

The report offers a set of actionable recommendations, grounded in evidence-based approaches, and informed by international best practices. From strengthening community-level healthcare interventions to advocating for policy changes at the highest levels, the recommendations outlined in this report provide a roadmap for enhancing the health outcomes of Afghan refugees in Pakistan.

In line with our commitment to addressing the pressing needs of Afghan refugees, Commissionerate Afghan Refugees pledges its collaboration with the International Rescue Committee Pakistan. Together, we vow to work collaboratively for implementing the recommendations outlined in this report, ensuring that Afghan refugees receive the care and support they deserve. Through our partnership, we strive to foster innovative solutions and advocate for systemic change.

As we navigate the complex terrain of humanitarian crises, let us heed the call to solidarity and compassion. The health and well-being of Afghan refugees are not only a moral imperative but also a reflection of our shared humanity. It is my sincere hope that this report serves as a catalyst for meaningful dialogue and collaborative action towards building a healthier and more inclusive future for all.

Muhammad Abbas Khan
Chief Commissioner

EXECUTIVE SUMMARY

Background:

Pakistan has hosted Afghan refugees for more than four decades, accommodating a substantial population, including both registered and unregistered individuals. The nation hosts 1.28 million registered Afghan refugees¹, alongside nearly one million unregistered Afghan nationals². Over more than four decades, Pakistan's collaboration with the Government of Afghanistan, the United Nations, and various international partners has been crucial in providing essential social services, including basic healthcare, to the displaced Afghan population. This support has shifted from a 'care and maintenance' approach to strategically investing in strengthening the public health system, aiming for a more significant impact on the health of both the refugee and host communities. Presently, Afghan refugees have equal access to primary, secondary, and tertiary healthcare services in Pakistan, on par with Pakistani nationals³. Nonetheless, the unique vulnerabilities of the refugees, high levels and poverty and low levels of education across this population segment warrants specific measures to cater for their health needs.

This study was conducted to document the current health status of Afghan Refugees and was carried out with the financial support of IRC in collaboration with the Commissionerate for Afghan Refugees (CAR) KP. The study design included a detailed desk review, review of secondary data and gathering of primary data from a variety of sources, including key informants, consultations with Afghan Refugees and host communities to better understand their health needs and barriers they face.

Key Findings:

1. Khyber Pakhtunkhwa (KP) accommodates a substantial proportion i.e., 52.3% of registered Afghan refugees in Pakistan, totaling 670,524 individuals⁴.
2. More than a fifth (21.5%) of the Afghan refugee population in Pakistan falls into the youth category i.e., aged 15-24 years⁵. Child marriage and child labor are prevalent, and access to education remains one of the most critical issues disproportionately affecting girls⁶ and a staggering 82% of working children do not attend school⁷. Overall, 69% of the PoR cardholders reported having no education.
3. 92.9% of PoR cardholders (age 15 years and above) declared no income or earnings below the Pakistan minimum wage threshold of 25,000 rupees per month.
4. Currently, it is assessed that registered ARs' access to the national health services in Pakistan is at par with Pakistani nationals. It is noteworthy that Pakistan's healthcare system is struggling to meet the needs of its own citizens and is ranked 154 out of 189 countries and approximately 70% of healthcare costs are paid directly by patients. Pakistan's total health expenditure⁸ per capita in 2020 was USD 38 which

¹ DRIVE Report 2022 <https://reporting.unhcr.org/pakistan-drive-report>

² Global Trends Report 2022 | UNHCR

³ RAHA Fact Sheet. 10 Years of RAHA. UNHCR.

⁴ DRIVE Report 2022 <https://reporting.unhcr.org/pakistan-drive-report>

⁵ DRIVE Report 2022 <https://reporting.unhcr.org/pakistan-drive-report>

⁶ Afghanistan Situation - Regional Refugee Response Plan (RRP) 2022

⁷ Socio-Economic Survey of Afghan Refugees Living in Pakistan, DRC May 2023

⁸ Total health expenditure refers to the sum of all health expenditures within a specific region, typically a country, during a defined period. This includes all spending, both public and private, on healthcare goods and

is significantly lower than the USD 86 as informed by WHO as a minimum requirement.⁹

5. Majority of community members (63%) stated that Afghan women/girls are not allowed to receive medical checkups/treatment from male healthcare providers¹⁰. This particular cultural aspect will necessitate careful consideration of the planning of healthcare delivery for Afghan Refugees.
6. Most of the RVs are in the vicinity of a public sector health facility, and only a third of PHC facilities were located at 8 km or above from the refugee villages in KP.
7. Above 90% of refugee households incurred out-of-pocket expenses for healthcare services even at the 'first point of contact'. In terms of difficulties they encountered, 50% reported that they could not afford fees for antenatal care, 39% reported that the facility was too far and 28% reported long waiting times.¹¹
8. In KP, the tertiary care hospitals function as independent entities and revenue generation is a KPI for these MTIs. The main source of their revenue generation is from Sehat Sahulat insurance scheme. Since ARs not covered by Sehat Sahulat insurance scheme, this assessment predicts access challenges for ARs in future when the revenue generation policy is implemented more strictly.
9. Data obtained from Hayatabad Medical Complex for the year 2022 shows a 6-fold increase in admissions from Afghan patients during the year compared to previous years. Average cost per admission was PKR 31,395. Of the 2.96 billion rupees spent during the year, 28.0% was spent on treating cardiovascular diseases. The mean cost of treating cases of ischemic heart disease was PKR 89,919.¹²
10. HAUS data shows that 7% of ARs were hospitalized during the year preceding the survey. Among these, overall, 34.5% used Public Sector Hospitals. However, it is noteworthy that in comparison, 52% of the unemployed refugee households visited public sector hospitals, highlighting the critical lifesaving role of public institutions for refugees.
11. Access to information remains a major issue and 75% of the refugees were not aware that refugees can receive free life-saving hospital care during a medical emergency within the MOH and/or UNHCR referral network.
12. The level of institutional deliveries among Afghan Refugees stands at 83%, but only 52% of the newborns received a birth certificate. In comparison, the rate of institutional deliveries among Pakistani citizens in KP is at 68%¹³.
13. 85% of refugee children have a vaccination card and almost all (94%) of children receive these services from public sector.
14. Only 13% of refugee women reported using a contraceptive method despite the considerably high rates of institutional deliveries among ARs (83%).
15. Pakistan's burden of pre-existing mental illnesses prior to COVID-19 was extremely high (with up to 10-16 million individuals with severe conditions and up to 50 million with mild problems) while the MHPSS service providers possessed negligible capacity to deal with the total caseload. Consultations with Afghan communities also highlight a high prevalence of mental health related issues among ARs.
16. 17% of refugees have a chronic disease, and a large proportion of them turn to private sector for medicines or other related health services, which puts a lot of financial

services, such as hospitals, physicians, long-term care, and pharmaceuticals. It encompasses spending by individuals, governments, and insurance companies.

⁹ <https://www.macrotrends.net/countries/PAK/pakistan/healthcare-spending>

¹⁰ HH Survey Data

¹¹ HAUS Data

¹² Third Party Evaluation of the Sehat Card Plus Khyber Pakhtunkhwa. GIZ and AKU. May 2023.

¹³ MICS KP 2019

burden on the already impoverished families, who have very limited livelihoods opportunities.

Recommendations: The recommendations of this report are aligned with:

1. The 2018 UN General Assembly endorsed 'Global Compact on Refugees'. Among others, the Global Compact aims to ease pressure on host countries and sets out to ensure that assistance is delivered, to the extent possible, through appropriate local and national service providers. It also entails a commitment from states and relevant stakeholders to support the refugee hosting countries in, inter alia, expanding and enhancing the quality of national health systems to facilitate access by refugees and host communities, as well as in capacity development and training opportunities for refugees who could be engaged as health care workers, aligning with national regulations and policies.¹⁴
2. At the province level, KP government has committed to deliver health services to its population by adopting the concept of UHC (Universal Health Coverage) and has finalized a province specific UHC Benefit Package. The recommendations for this study are also aligned to this strategic shift.

The following specific recommendations can be considered for improving health outcomes

The literature review, primary and secondary data, and the synthesis of the findings crystallize that Afghan Refugees living in Pakistan are accessing both preventive and curative services, mostly using Pakistan's public sector health facilities, especially for preventive services. While there might be positive indications of improved health coverage and access to facilities for Afghan refugees in Pakistan, it's crucial to consider the variability in healthcare provision, resource constraints, and challenges associated with geographic and information accessibility levels, impacting the adequacy and quality of healthcare services available to Afghan refugees. The detailed recommendations are given in Section 4 of the report, and the notable ones at various levels of healthcare delivery system are highlighted below:

COMMUNITY LEVEL:

The foundational level of the UHC package is the community level healthcare. It is important to highlight that the support of LHWs is not available within the RVs. Establishing a CHW network within the RVs in line with the UHC package which can deliver the 21 identified 'Immediate Priority' interventions will be cornerstone of this this tiered healthcare system.

Supporting community interventions via CHWs involves linking them to nearby health centers, investing in tailored BCC for Afghan refugees (ARs), and focusing on youth, girls, and women. Reviving CHW network needs comprehensive training aligned with EPHS/UHC in KP. Priority services for ARs include FP, Nutrition, and MHPSS. It is recommended to establish referral facilities in remote Refugee Villages. CHWs should be Afghans, from the camp, with strategies tailored for rural and urban settings and strengthen postpartum FP services.

Estimated cost of delivering the 21 'Immediate Priority interventions at the community level s USD 3.74/person/year¹⁵.

¹⁴ <https://www.unhcr.org/about-unhcr/who-we-are/global-compact-refugees>.

¹⁵ Third Party Evaluation of the Sehat Card Plus Khyber Pakhtunkhwa. GIZ and AKU. May 2023.

PHC CENTER LEVEL:

Public sector PHC level facilities (BHUs and RHCs) catering for the needs of refugee populations work under severe resource constraints and struggle to cope with this additional workload. These facilities will require additional support to extend uninterrupted services for both host and refugee communities. In areas where RVs are located away from public sector facilities, alternate service delivery arrangements need to be considered and based on the needs of the setting, the option of camp level service delivery will be required at the refugee villages in remote and inaccessible locations.

The estimated cost of delivering the 35 'Immediate Priority' interventions as per UHC package is USD 3.28/person/year.

Findings of this study suggest special consideration for the following areas: a) Advocate for RV elders' inclusion in DoH's PCMCs to strengthen rights-based health programming. b) Strengthen health facility-CHW ties. Consider appointing an Afghan Community Health Supervisor in Afghan-serving public health facilities. c) Invest in emergency response capacity aligned with MISP standards. d) There is a need to target capacity building for Afghan-specific health conditions, e.g., Cutaneous Leishmaniasis, and extending these interventions to host communities.

Additionally, it is recommended to mobilize outreach visits effectively for refugee communities. Document MHPSS learnings and collaborate with KP's DoH Mental Health Unit for capacity enhancement.

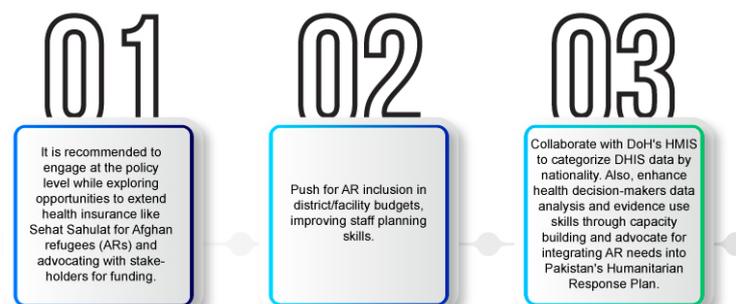
HOSPITAL LEVEL:

The funding gap keeps widening and political governments are forced to make decisions that lead to tough situations. The 2023 third Party Evaluation of the Sehat Card Plus in Khyber Pakhtunkhwa documents a significant reduction in medical care component of mean out-of-pocket expenditure for inpatient services for Sehat Card users (PKR 1,006 ±9248) as compared with nonusers (PKR 30,042 ±69014). Moreover, the level of catastrophic health expenditure among households with Sehat card was significantly lower for users (14%) compared to nonusers (35%).

Inclusion of the AR families in this insurance scheme will enable refugees access to specialized care from public and private sector facilities without any interruption.

The premium paid by the Sehat Card Plus KP is set at PKR 2,849 per family.¹⁶

POLICY LEVEL:



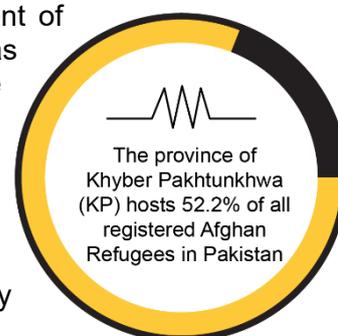
¹⁶ Third Party Evaluation of the Sehat Card Plus Khyber Pakhtunkhwa by Department of Community Health Sciences, Aga Khan University, Karachi May 2023

SECTION 1: INTRODUCTION

BACKGROUND

Pakistan is ranked as the fifth largest host country for refugees globally, accommodating a significant population of displaced individuals. The nation provides refuge to 1.28¹⁷ to 1.7¹⁸ million registered Afghan refugees, in addition to approximately one million unregistered Afghan nationals¹⁹. Registered Refugees or Proof of Registration (PoR) cardholders enjoy entitlements such as access to health and education facilities as well as the ability to open bank accounts²⁰. Notably, almost one-third (32%) of PoR cardholders reside in designated Refugee Villages (RVs) while the remaining 68% live in a mixed setting with the host communities²¹. The province of Khyber Pakhtunkhwa (KP) stands out as the primary host, accommodating 52.2% of all registered Afghan refugees in Pakistan²².

For more than four decades, Pakistan has demonstrated remarkable generosity through caring for millions of Afghan refugees. Since the initial displacement of the Afghan population into Pakistan in 1979, the collaboration between the Government of Pakistan, the United Nations, and other international partners has been instrumental in delivering essential social services to these displaced individuals, including basic healthcare. UNHCR's Refugee Health Strategy (2014-18)²³ shifted the organization's approach from 'care and maintenance' towards strategically investing in strengthening the public health system for a greater impact on refugee and host community health. Presently, Afghan refugees access Pakistan's primary, secondary, and tertiary healthcare at par with Pakistani nationals.²⁴



In 2018, the UN General Assembly officially endorsed the Global Compact on Refugees, signifying a pivotal milestone in the international response to displacement crises. Among others, the Global Compact aims to ease pressure on host countries while empowering refugees to become self-reliant. It sets out to ensure that the basic health needs of refugees are met; and that assistance is delivered, to the extent possible, through appropriate local and national service providers. It also entails a commitment from states and relevant stakeholders to support the refugee hosting countries in, inter alia, expanding and enhancing the quality of national health systems to facilitate access by refugees and host communities, as well as in capacity development and training opportunities for refugees who could be engaged as health care workers, aligning with national regulations and policies.²⁵

The healthcare status of Afghan Refugees in Pakistan has gradually improved over the period, especially in terms of access, utilization, and health literacy. However, the socio-economic pressure due to the deteriorating economic situation of the country has raised concerns not only for the refugees but also for the host community.

¹⁷ Document Renewal and Information Verification Exercise (DRIVE) Report 2022 -

<https://reporting.unhcr.org/pakistan-drive-rep>

¹⁸ Global Trends Report 2022 | UNHCR

¹⁹ Ibid

²⁰ DRIVE Report 2022 - <https://reporting.unhcr.org/pakistan-drive-rep>

²¹ Ibid

²² Ibid

²³ <https://www.unhcr.org/media/global-strategy-public-health-unhcr-strategy-2014-2018-public-health-hiv-and-reproductive>

²⁴ RAHA Fact Sheet. 10 Years of RAHA. UNHCR.

²⁵ <https://www.unhcr.org/about-unhcr/who-we-are/global-compact-refugees>.

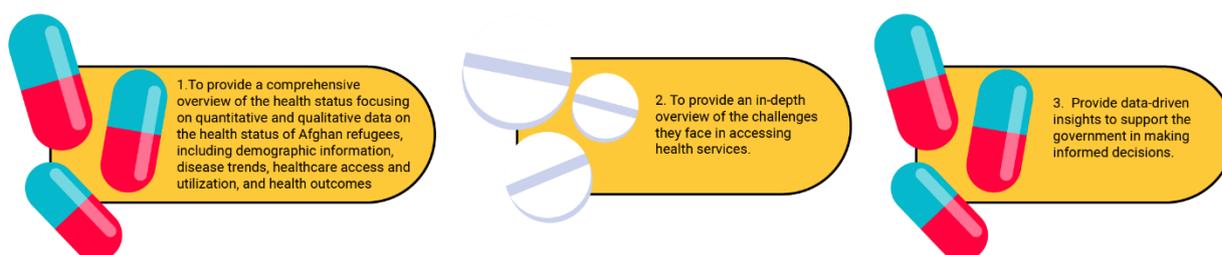
This Annual Health Status Report of Afghan Refugees in Pakistan is an output of the study commissioned by the International Rescue Committee (IRC) focusing on refugees residing in KP province for the year 2022.

THE ASSIGNMENT

The IRC has signed a Memorandum of Understanding (MoU) with the Commissionerate for Afghan Refugees in KP. One of the commitments in this agreement included support for generating a Health Status Report (HSR) of Afghan Refugees residing in Khyber Pakhtunkhwa.

OBJECTIVES OF THE STUDY

The specific objectives of the assignment, as per its terms of reference were:



STUDY METHODOLOGY

The study employed a mixed method approach, combining both primary and secondary data sources along with an extensive literature search to achieve the study's objectives.

During the inception phase of the assignment, a mapping exercise revealed that tertiary care hospitals and some vertical programs maintain records of their client nationality. To access this data, we worked in collaboration with the Institute of Public Health and Social Sciences of Khyber Medical University (KMU). KMU works closely with Medical Teaching Institutions. Through our partnership with KMU, we were able to access data from Hayatabad Medical Complex (a tertiary care hospital in Peshawar) and the Provincial TB control program. In addition, UNHCR conducted a comprehensive 'Health Access and Utilization Survey (HAUS)' in 2022, with the survey report currently in its finalization stages. The study team requested access to the survey's raw data, which was granted by UNHCR.

As part of the primary data collection, the consultants conducted Key Informant Interviews and Focus Group Discussions with key stakeholders and Afghan Refugees. Furthermore, the team conducted a rapid household survey of 76 households in three districts of KP. Additional insights were sought through telephone interviews with male and female health workers from the refugee camps who had previously worked with CAR. The survey gathered information from 41 of the 47²⁶ (87%) of Refugee Villages in KP. This survey was primarily focused on assessing the challenges related to distance, costs, and accessibility faced by Afghans residing in the RVs while seeking healthcare through public sector health facilities.

The description hereunder briefly explains each method employed in further detail.

²⁶ As per data shared by UNHCR Islamabad.

A. LITERATURE REVIEW

A comprehensive and meticulous desk review of existing literature and secondary sources was undertaken to gain a broader understanding of the demography and conditions of Afghan citizens residing in Pakistan. The literature review also explored the Pakistan government's regulatory mechanisms as well as the support systems and institutions in place, including the development organizations actively engaged in addressing the needs of Afghan refugees in Pakistan, with a particular focus on KP province.

The literature review explored the secondary data sources published by the Government of Pakistan, UNHCR, IOM, academia, and other national and international humanitarian organizations and stakeholders. Throughout the review process, additional literature was also identified using manual searching and cross-referencing of bibliographies. The literature review also included looking at the overall health governance in Pakistan and KP, the legislative environment for refugees, socio-cultural aspects like women empowerment, and social relationships between hosts and refugee communities. This thorough literature review helped identify the key questions explored in the primary data as well as in the secondary data review.

B. SECONDARY DATA SOURCES

The following secondary data sources were used as part of this assignment:

1. UNHCR Health Access and Utilization Survey (HAUS), 2022²⁷:

This extensive survey reached 1,330 Afghan Refugee households and gathered information from a total of 8,264 family members. The sample population included PoR cardholders from across Pakistan and assessed health outcomes and access to health services for refugees in Pakistan. It is worth noting that the survey report was not finalized at the time of conduct of this assignment and the consultant requested UNHCR for access to raw data, which was granted. Analysis of raw data from this relevant and recent survey has played a pivotal role in shaping the findings presented in this report.

2. Inpatient and outpatient data from Hayatabad Medical Complex (HMC):

Data for the year 2022 was acquired from HMC through our partnership with KMU. The data includes monthly figures for the Outpatient Department (OPD) and Inpatient Admissions (IPD), segregated by nationality of the clients.

3. Data from Provincial TB Control Program KP:

The data received from the Provincial TB Control Program pertained to the total number of OPD cases, suspected TB cases, and confirmed TB cases, categorized according to the nationality of the clients for the year 2022.

4. PDH HMIS data 2022:

The Project Directorate of Health (PDH) under CAR KP supported limited community-level consultation and referral services in 14 RVs. The PDH HMIS captures basic data concerning both preventive and curative healthcare interventions.

²⁷ <https://microdata.unhcr.org/index.php/catalog/810>

5. Pakistan Demographic & Health (PDHS) Survey 2019²⁸:

PDHS data exclusively pertains to the Pakistani population. The team used this data to conduct comparative analyses, examining the status of Afghans among the host population.

6. Multiple Indicator Cluster Survey (MICS) 2019 (KP)²⁹:

The Bureau of Statistics (BoS) carried out the Multiple Indicator Cluster Survey (MICS) with a sample size of 23,740 households from 1,187 sampled clusters across 32 districts of KP, which included seven newly merged districts. Like the PDHS dataset, this data was used to compare the situation of Afghans about the indicators of the host population.

7. Refugee and Migrant Health:

The data from the study on the Disease Status of Afghan Refugees and Migrants in Pakistan was also collected and analyzed, primarily to conduct a comparative analysis.³⁰ The dataset included demographic information and the status of different infectious and non-infectious diseases.

C. PRIMARY DATA COLLECTION

1. Key Informant Interviews:

A total of 25 key informant interviews (KIIs) were conducted using a semi-structured research tool to explore the nuances of enablers and barriers in accessing healthcare. The KIIs aimed to comprehensively understand the different dimensions of health access and utilization. The insights gathered from key informants were cross-referenced with the findings from the literature review and secondary data analysis to identify the specific needs of the ARs. The details of the KIIs done during the study are given in Annex VI.

2. Focus Group Discussions:

A total of 9 FGD sessions were conducted with refugees and neighboring host communities in the districts of Kohat, Peshawar, and Haripur. Participants of the FGDs included refugee women and elders residing in the RVs. In each FGD there were approx. 5-7 individuals.

Location	Groups		
Haripur	Women	Men	Host Community (Males)
Peshawar	Women	Men	Host Community (Males)
Kohat	Women	Men	Host Community (Males)

3. Telephone Interviews with Health Workers from RVs:

These interviews were conducted with 41 health workers (HWs) of which 11 were women, from the concerned RV, who possessed in-depth knowledge of the ground-level situation and who had been involved in health service delivery in RVs. The vast majority (88%) of the respondents were health workers, while the remaining 12% were members of CAR administration in the RVs or the district.

²⁸ <http://nhsrc.pk/dashboards/pdhsselect.html>

²⁹ MICKP-2019 published in 2021

³⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6616124/#:~:text=Most%20prevalent%20reported%20infectious%20were,affected%201.08%25%20of%20Afghan%20refugees.>

4. Rapid Household Survey:

As mentioned above, this survey focused on Afghan Refugees residing in RVs in the districts of Peshawar, Haripur, and Kohat. This survey served to collect information about the healthcare-seeking behaviors of ARs using a randomized sampling technique. A total of 76 questionnaires were administered with equal numbers of men and women through this survey at the household level.

D. DATA ANALYSIS AND REPORT WRITING

In this research, we have employed a robust methodology for the analysis of both quantitative and qualitative data, ensuring a comprehensive and well-rounded approach to data interpretation and reporting. Our approach involved the extraction of data from various primary and secondary data sources, followed by a comparative analysis of indicators wherever possible. To ensure the quality of data, comprehensive training was done with the data collection team. After each field visit, a debrief session was done to capture the challenges faced by the team and address them accordingly.

The analysis of quantitative data was done using MS Excel and Power BI. Before the analysis, the team cleaned and organized the data sets to eliminate errors and inconsistencies to ensure the reliability of our analysis. The analysis helped the team generate descriptive statistics and data visualization including tables, charts, and graphs, which were used to enhance the visual interpretation of quantitative data, determining the trends, and drawing comparisons. An experienced Statistician/Data Analysis Expert was also engaged for quality assurance of the data analysis and reviewed the datasets along with the analysis for accuracy, completeness, reliability, and preciseness.

Before the analysis, the qualitative data was coded using thematic analysis methods, followed by the identification of key themes, patterns, and trends to draw meaningful insights and conclusions. This analysis helped the team in interpreting the context and nuances of responses, allowing us to provide a deeper understanding of the research questions. Participant quotes and selected in-depth analyses were used to strengthen the argument, where needed.

The utilization of data from various primary and secondary data facilitated the team in the triangulation of findings that involved cross-referencing and cross validating the data obtained from different data sources. This enhanced the reliability of our results and allowed the team to gain a more comprehensive and well-rounded understanding of the key issues.

Before finalizing this report, the team shared the preliminary findings with CAR and IRC, and the feedback provided by them was used to further refine our analysis which is presented in this report. The analysis, discussion, and recommendations of this study are kept operational, suggesting strategic interventions for effectively dealing with issues relating to ARs in KP.



E. LIMITATIONS OF THE STUDY

While the datasets used in compiling this Annual Health Status Report provide rich and extensive insights, the reader is cautioned to acknowledge the following limitations:

1. Published literature on Afghan refugee health is scarce. While every effort was undertaken to gather information about registered ARs in KP for the year 2022, the team had to use literature focusing on Afghan citizens across Pakistan and in other geographical locations.
2. The situation in Afghanistan has remained volatile and variations in the economic, political, and security context in Afghanistan have influenced the movement of ARs across the border. After the fall of Kabul to the Taliban in 2021, some of the repatriated refugees have returned to Pakistan. Consequently, various players use different data sources for estimating the refugee population. To the extent possible, the assignment team has used UNHCR and CAR figures in this report. However, the denominator used in other published sources may vary, or at times is not explicitly mentioned. This aspect will explain some of the variations in different figures quoted.
3. Afghan nationals in Pakistan have different legal statuses in Pakistan i.e., PoR cardholders, Afghan Citizen Card holders, unregistered refugees, and visa holders. This aspect adds to the complexity of separating Afghan Refugees, who are the primary population of concern for this study.
4. As mentioned earlier, Pakistan health statistics do not record the nationality of the clients, especially for PHC services. As a result, the analysis presented in this report has used available secondary data from selected players, who were willing to share data with the assignment team.
5. The comparison between the AR and host population was possible for a limited number of indicators, and that too needs to be understood with two sets of limitations. Firstly, all the indicators that are recorded for the host population are not captured in AR population surveys, secondly, the survey years do not match in most cases.
6. Although refugees are using public sector health facilities, the existing Health Management Information System (HMIS) does not allow data segregation by nationality of the clients. Consequently, while both Afghan Refugees and host communities utilize public sector health facilities, there is no available data concerning the frequency and type of services utilized.
7. Source-specific limitations are a) DHIS data – no Segregation by nationality, b) HMC and TB control program data can only identify Afghan citizens, c) HAUS³¹ – Covers ARs across Pakistan, though KP makes up 52% of the sample surveyed, d) MICS and PDHS are for 2019 no new data available, e) PDH HMIS Data – for 14 camps only and limited services.



³¹ HAUS data set also includes ARs from both rural (36% living in Refugee Villages and 30% in rural areas mixed with host population) and urban settings (34% of the sample across Pakistan)

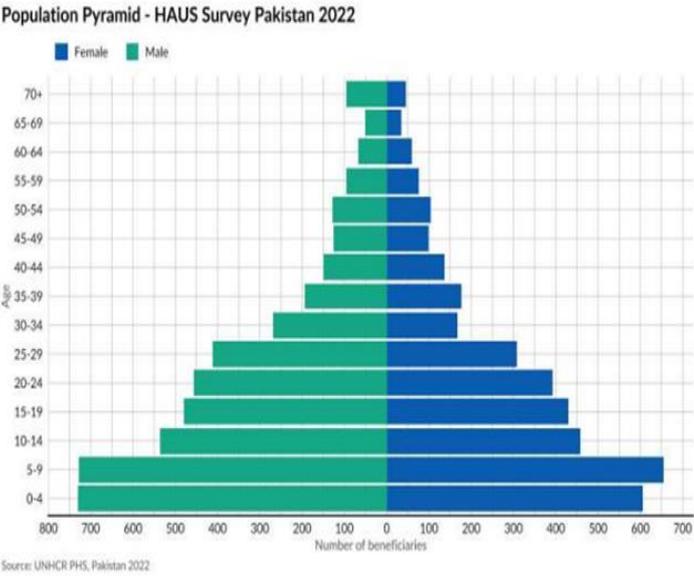
SECTION 2: FINDINGS AND DISCUSSION

The following findings have been derived from multiple sources, each with its sampling framework, timelines, and focus areas as stated in the previous section. Since the objective of this study is to map the health status of Afghan Refugees using all available data sets, we have not delved into a comparative analysis of these sources. As a result, although we have identified the data source in each instance, it should be noted that in places the text and the graph will be referring to different sources. It is, therefore, recommended to read the following section while keeping this aspect in mind.

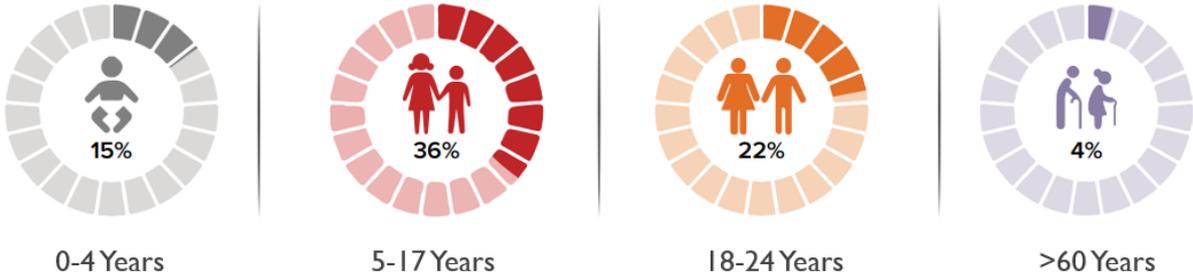
DEMOGRAPHICS

Of the 1.28 million PoR cardholders registered through Document Renewal and Information Verification Exercise (DRIVE) 2022, KP hosts a substantial majority, with 52.3% of them, accounting for a total of 670,524 individuals. Except for Quetta, which ranks as the second highest, four of the KP districts³² are among the top 5 districts of residence for Afghan Refugees.

The population pyramid of the refugees living in Pakistan exhibits a significant tilt towards the younger age groups. More than half (51.5%) are children below 17 years of age while those between the ages of 18-49 make up another substantial segment at 39.8%. In contrast, the proportion of the population above 50 years of age is only 8.5% of the total refugee population.



Age Groups PoR Cardholders



Following the 1979 exodus of Afghans to Pakistan, several refugee camps were established across the country. Over time, these camps evolved into what are now known as Refugee

³² These include Peshawar, Nowshera, Haripur, and Kohat. Data source: DRIVE Report.

Villages (RVs). In KP, the proportion of refugees residing in RVs is 50% compared to 32% across Pakistan. The remaining half lives in a mixed setting with the host communities.

In addition to the registered Afghan Refugees mentioned above, it is estimated that approximately 775,000 unregistered Afghans are currently residing in the country.

SOCIO-ECONOMIC & CULTURAL PROFILE

A. EDUCATION

Overall, 69% of the PoR cardholders reported having no education. Notably, the gender disparity in educational access is evident, with female refugees facing even greater barriers to education compared to their male counterparts (66% vs 72% respectively)³³. Informal religious education emerged as the most common source of education for PoR cardholders (13% of the PoR population), followed by formal primary education reported by another 10%³⁴.



UNHCR Camp School in a RV, KP.

During discussions in focus group settings, several participants highlighted economic factors as one of the main reasons attributed to the lack of school attendance by Afghan refugee children. They also raised concerns about the limited opportunities for refugees to integrate into the formal job market in Pakistan upon completing their education.



DRIVE

According to the data from Document Renewal and Information Verification Exercise (DRIVE) 2022, the number of Afghan Refugees having POR cards in Pakistan was 1.28 million with a male to female ratio of 53.1 against 46.9 respectively. 84% of the PoR cardholders were born in Pakistan.

B. LIVELIHOODS

According to the DRIVE report, 92.9% of PoR cardholders (age 15 years and above) declared no income or earnings below the Pakistan minimum wage threshold of 25,000 rupees per month. Further breakdown of this shows that 59% of the eligible population reported zero



The Invisible Carpet Weaving Women in RV, KP.



The proportion of females among those who declared no income is almost twice that of the men (284,355 individuals against 146,560 individuals respectively).



monthly income, 17% reported income levels less than 10,000 rupees and another 16.8%

³³ DRIVE Report 2022 <https://reporting.unhcr.org/pakistan-drive-report>

³⁴ Ibid

reported income levels between 10,000 and 25,000 rupees. Only a mere 1.3% reported monthly income levels of 50,000 rupees or higher.

While the DRIVE report did not delve into monthly family expenses, the data from the 2023 livelihoods survey revealed that over a third (36.6%) of respondents reported living expenses ranging from 10,000 to 25,000 rupees per month. Only 3.8% conveyed that their living expenses are less than 10,000 while a large proportion (41.7%) specified their expenses falling between 25,000 to 50,000 rupees³⁵.

“With very little power to negotiate, least education, and vocational skills, the refugee population is more vulnerable to exploitation while engaging with an “in-formal” economy for their livelihoods. The dis-empowered populations of 49% Afghan refugee children who are out of school are likely to be the primary victims of this cyclical exploitation and keeps them in the poverty trap’.

Quote from Key Informant

A significant proportion of the Afghan refugees who earn an income (44%), work as daily wage labor in the informal labor market³⁶. Child Labor is also a common phenomenon, and the DRIVE report documents that 14,680 individuals, representing 14% of the total individuals with a reported specific need and 1.1% of the overall PoR population were engaged in child labor³⁷.

C. SOCIO-CULTURAL FACTORS

In terms of ethnicity, the vast majority of the PoR cardholders (86.4%) belong to Pashtun tribes, followed by Tajiks (5.1%) and Uzbeks (3.1%)³⁸. Afghan society is known for its conservative and patriarchal values. As per the household survey data in three KP districts, 63% of the survey respondents reported that Afghan women/girls are not allowed to get medical checkups/treatment from male doctors. Likewise, the FGDs indicated the same finding and many CHWs also cited it as a key barrier for Afghan women. This particular cultural aspect will necessitate careful consideration of the planning of healthcare delivery for Afghan Refugees.

63% of respondents said that Afghan women/girls are not allowed to get medical checkup/treatment from male doctors.

Source: Household Survey Data

D. HOUSING

The average family size of the Afghan Refugees ranges from 4.6³⁹ members per family to 6.2⁴⁰ members. A recent livelihoods survey conducted in three districts of Peshawar, Haripur, and Kohat reveals that 81% of the refugee population reside in Kacha housing structures made from mud or stone⁴¹, demonstrating the overall low socio-economic profile and their living conditions with a resultant water and sanitation-related diseases (see sections below for

³⁵ Conducted by Beyondsolutions Pvt. Ltd for Koei Research and Consulting with JICA funding.

³⁶ DRIVE Report 2022 <https://reporting.unhcr.org/pakistan-drive-report>

³⁷ Defined as children working for more than five hours per day.

³⁸ DRIVE Report 2022 <https://reporting.unhcr.org/pakistan-drive-report>

³⁹ DRIVE Report 2022 <https://reporting.unhcr.org/pakistan-drive-report>

⁴⁰ UNHCR Health Access and Utilization Survey 2022

⁴¹ Conducted by Beyondsolutions Pvt. Ltd for Koei Research and Consulting.

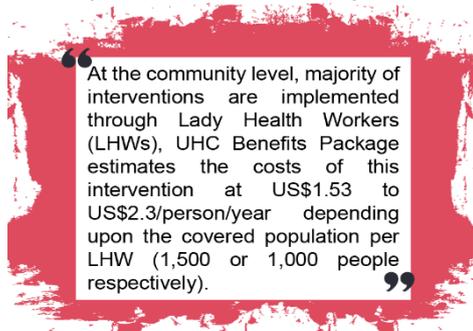
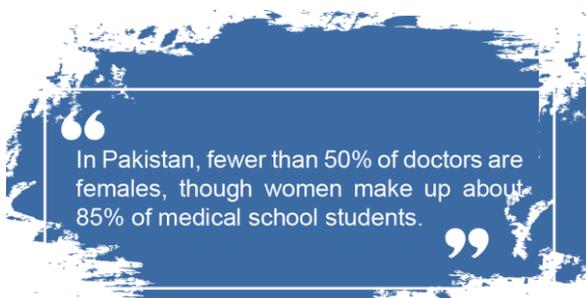
details). The same survey reports that 56% of refugees lived as nuclear families and 44% lived in a joint family system.

AVAILABLE HEALTH CARE DELIVERY SYSTEM

As mentioned earlier, there is no separate system of provision of health services to Afghan Refugees, with the exception of very limited services provided by CAR and partner NGOs in selected camps. Instead, they access healthcare services through the same health system that serves the population of Pakistan. To gain a comprehensive understanding of the healthcare landscape and the obstacles encountered by the healthcare delivery system, it is beneficial to provide a broad overview of the healthcare infrastructure in both the country and specifically in KP. It is important to note that the availability of health services for Afghan Refugees and/or host populations will be a function of the “wellness” of the health system of the country.

A. PAKISTAN’S HEALTH SYSTEM – KEY STATISTICS

- The Lancet’s Healthcare Access and Quality Index ranks Pakistan’s healthcare system at 154 out of 189 countries⁴².
- Pakistan’s total health expenditure per capita in 2020 was US\$ 38⁴³ or 1.6% of its GDP⁴⁴.
- With low levels of public spending, up to 70% of healthcare costs are borne as out-of-pocket expenses by patients.
- Pakistan has a 1.45 ratio of health professionals (physicians, nurses, midwives, and LHWs) per 1,000 people, just one-third of the health workforce goal of 4.45. Among them majority of them prefer to settle and work in the Urban areas which leaves the rural population at the mercy of either traditional healers or quacks. The scarcity of doctors in rural areas can limit the availability of preventive care and health education, add costs for the people seeking health support, and contribute to affecting health outcomes.



B. HEALTHCARE DELIVERY SYSTEM - KP

Healthcare services in KP are delivered through a combination of public and private institutions, including hospitals, clinics, and General Practitioners (GPs). Many communities benefit from the services provided by the ‘Lady Health Workers’. In addition, there is a range of traditional healers and unlicensed medical practitioners who provide services. The quality

⁴² [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)30994-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30994-2/fulltext)

⁴³ <https://www.macrotrends.net/countries/PAK/pakistan/healthcare-spending>

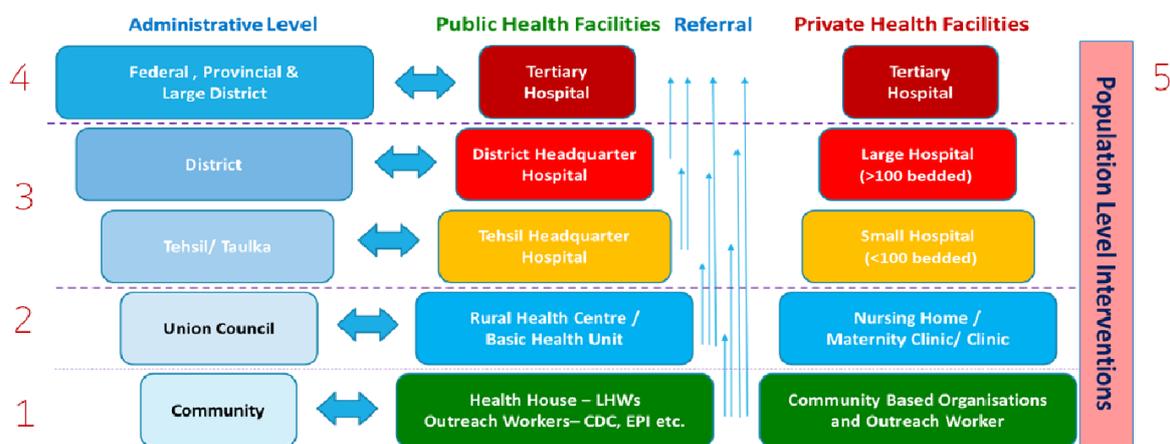
⁴⁴ https://www.sbp.org.pk/departments/stats/PakEconomy_HandBook/Chap-11.9.pdf

and availability of healthcare are generally much better in cities than in rural areas. Approximately 70% of healthcare costs are paid directly by patients, and catastrophic healthcare expenditures can push households into poverty, especially in rural areas.⁴⁵ The quality and accessibility of healthcare services vary widely across the country. Data from the last round of the National Health Accounts show that out of pocket spending in Pakistan, as a percent of the total health expenditure, is 58% (NHA 2018). Government spending as a proportion of current health expenditure is less than 32%. A recent study has estimated that almost 13.2% of the population is estimated to be vulnerable to financial catastrophe due to healthcare payments.⁴⁶



BHU in Hangu RV.

The government provides healthcare services through a three-tiered healthcare delivery system and community-based interventions. The former includes Basic Health Units (BHU), and Rural Health Centers (RHC) forming the core of the primary healthcare centers. Secondary care including first and second referral facilities providing acute, ambulatory, and inpatient care is provided through Tehsil Headquarter Hospitals (THQs), and District Headquarter Hospitals (DHQs) which are supported by Tertiary Care mostly annexed with teaching hospitals. Services are augmented through a range of public health programs through the healthcare delivery system and population-level interventions. The figure below⁴⁷ shows a mapping of healthcare delivery through the public and private sectors in KP.



Public & Private Healthcare Delivery System in Khyber Pakhtunkhwa
Reproduced from UHC Benefits Package KP

In recent years, the KP Government introduced a Micro-health Insurance Program (Sehat Card Plus) for all the citizens of the province. Under the program, more than 7.2 million families of KP are getting free inpatient healthcare services, and services to the beneficiaries are offered free without out-of-pocket payment (up to a maximum limit of Rs. 1.0 million per family

⁴⁵ DFAT Country Information Report, 2022. Pakistan.

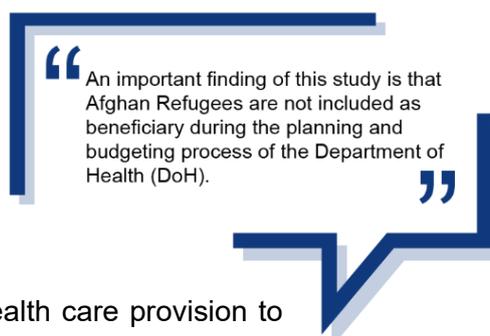
⁴⁶ Third Party Evaluation of the Sehat Card Plus Khyber Pakhtunkhwa by Department of Community Health Sciences, Aga Khan University, Karachi May 2023

⁴⁷ Reproduced from UHC Benefits Package for KP, 2021

per year)⁴⁸. However, due to the burden on the health system Afghan Refugees are not included in any of the health schemes.

REFUGEES' ACCESS TO HEALTHCARE

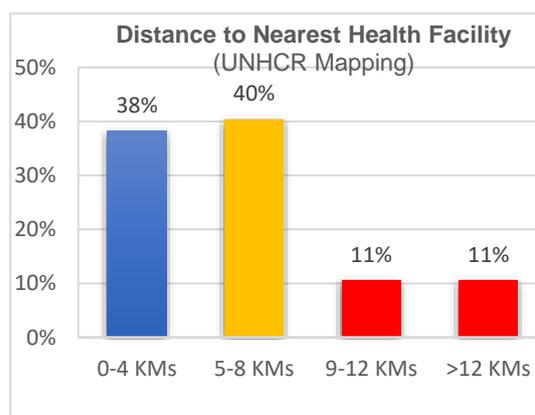
The Government of Pakistan has enabled registered Afghan refugees to access Pakistan's primary, secondary, and tertiary healthcare – as given in the figure above. However, due to the protracted nature of the conflict in Afghanistan, combined with Pakistan's increasing population and its severe economic constraints, the burden on its health system has been phenomenal.⁴⁹



UNHCR has been the primary supporting agency for health care provision to ARs. Until 2014, it worked with the Pakistan government to support camp-specific service delivery mechanisms. As part of strategically moving away from the service delivery model⁵⁰, support for BHUs phased out gradually. Currently, it is assessed that registered ARs' access to the national health services in Pakistan is at par with Pakistani nationals including the national vaccination program, tuberculosis control, and HIV prevention and treatment⁵¹. Nonetheless, consultations with refugee communities highlight challenges in accessing treatment for which public sector facilities received limited supplies e.g. rabies, snake bite, and hepatitis.

A. PHYSICAL ACCESS

RV mapping data received from UNHCR shows that more than three quarters (78%) of refugee villages had access to a public health facility within a distance of 8 Kilometers while 22% of the RVs were located between 9-12 kilometers (11%) or above (11%). Our telephonic interviews with health workers (primary data) in 41 RVs of KP reveal that 44% of the referral facilities (Rural Health centers or higher-level facilities) are located at less than 9 kilometers, while in 56% of these RVs, the nearest public health referral facility is more than 9 kilometers away. It is noteworthy that the UNHCR mapping covers all levels of health facilities while the health worker survey data focuses on mapping of referral facilities in the public sector, i.e., RHC and above.



Patients in RVs may need to travel long distances to reach a healthcare facility or specialist, incurring travel costs and time off work. This can act as a barrier to seeking medical attention, leading to health issues worsening before they're addressed. This can add economic burden which affects the individual as well the community.

⁴⁸ <https://sehatsahulat.com.pk/about-programme/>

⁴⁹ RAHA Fact Sheet. 10 Years of RAHA. UNHCR.

⁵⁰ <https://www.unhcr.org/media/global-strategy-public-health-unhcr-strategy-2014-2018-public-health-hiv-and-reproductive>

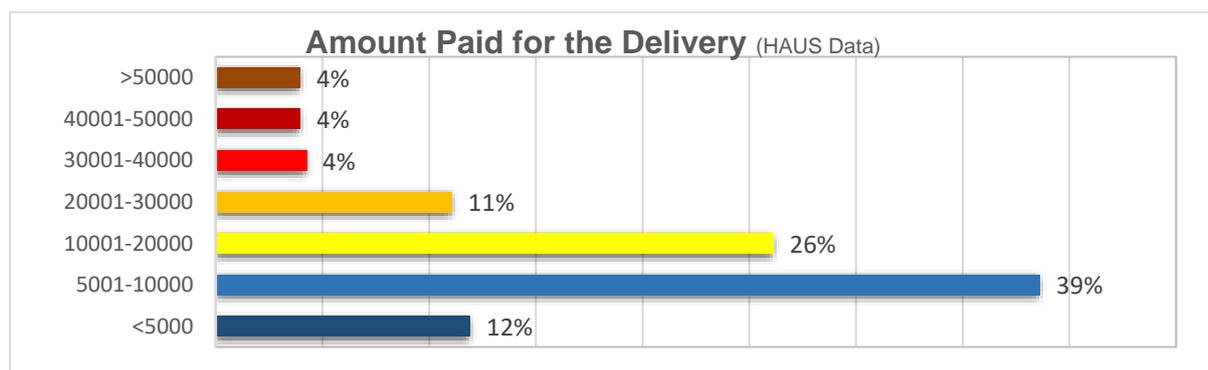
⁵¹ Health care for Afghan refugees and migrants in Pakistan (nation.com.pk)

B. FINANCIAL ACCESS

Multiple data sources have documented that Afghan Refugees incur out-of-pocket payments for various healthcare services. According to HAUS data, more than 90% of households incurred out-of-pocket expenses for healthcare services even at the 'first point of contact'. Of these, 65% reported using their wages (41%) or family savings (24%) to cover these expenses, while one-third of the refugees (31%) reported borrowing money to cover their healthcare expenses. According to the FGDs with the refugee communities, many respondents highlighted that the cost of seeking health services remains a key factor in the decision on health services.

In terms of difficulties they encountered, 50% reported that they could not afford fees for antenatal care, 39% reported that the facility was too far and 28% reported long waiting times. Mothers living in urban locations were more likely to complain about affordability (00% compared to 67% in rural locations and 33% of those living in camps). However, 42% of mothers living in camps complained of long waiting times.⁵²

As will be discussed in subsequent sections, the level of institutional deliveries among Afghan Refugees stands at 83%⁵³, with 77% of these reporting that they had to pay for delivery services⁵⁴. Remarkably, over three quarters (76%) of the respondents reported paying an amount of 5,000-30,000 rupees, and another 12% paid over 30,000 rupees.



Among those who opted for delivery at home, the primary reason as reported by over half of the respondents (53%) was the family's preference followed by high costs associated with clinic or hospital delivery in 33% of respondents as the reason behind this choice⁵⁵.

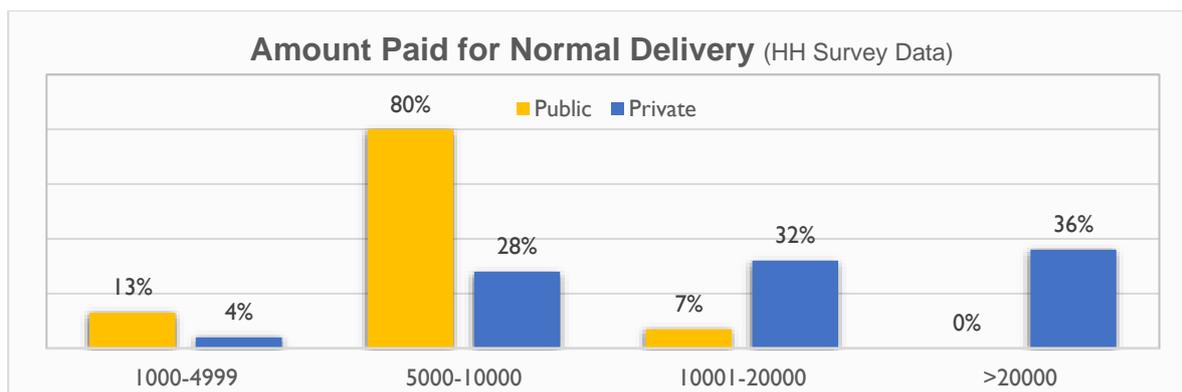
Moreover, findings from the household survey conducted by the consultants show that for public sector deliveries, 93% of families reported a cost of less than 10,000 rupees. In comparison, private sector costs for normal vaginal delivery were reported to be above 10,000 rupees in 68% of cases, signifying a marked difference in healthcare expenditure between the two sectors.

⁵² HAUS Data

⁵³ In comparison, the rate of institutional deliveries among Pakistani citizens is 48%.

⁵⁴ UNHCR Health Access and Utilization Survey 2022

⁵⁵ Ibid



Seven percent of the mothers reported that their newborn baby needed to be admitted or kept in the hospital for special care. Costs reported by families are given in the table below.

Amount Spent (Neonatal Admissions)	Count	%
No cost	3	9%
<10,000	9	27%
10,000-20,000	11	33%
21,000-50,000	7	21%
>50000	3	9%
Total	33	100%

According to the Health Access and Utilization Survey data, a total of 7% of the respondents had been hospitalized during the year preceding the survey. Among these, a striking 94% revealed that they had to pay out of their pocket during the hospitalization. Notably, 60% reported incurring costs of 5,000 to 20,000 rupees while only 9% paid less than 5,000 rupees.

As highlighted in the preceding section, Afghan Refugees are not covered under the Sehat Sahulat insurance scheme. In KP, the Tertiary Medical Institutes significantly rely on this scheme as a revenue source. Although Afghan patients have not been denied any services in these institutes, concerns have been raised by experts regarding the potential negative incentives for the hospitals to cater to Afghan patients. This stems from the fact that revenue generation is a key performance indicator (KPI) for these hospitals, which could inadvertently affect their willingness to prioritize the care of Afghan patients.

The prevalence of chronic diseases among Afghan Refugees is 17%. Of these, 80% reported having access to medicines and care. A sizeable proportion of the refugees suffering from chronic diseases reported accessing medicines and other related services for their chronic condition from private sector. The UNHCR HAUS survey data estimates this figure at 74%. This is in contrast to other services like routine OPD and preventative services, where public sector services are mostly used. The situation above needs to be interpreted with three important caveats in mind, a) public sector facilities continually receive less supplies of these medicines and struggle to meet the need of the local population themselves, b) level of awareness of services and the entitlement of refugees to use these services is quite low among ARs and c) Refugee communities have very limited livelihood opportunities and hence higher level of poverty. All of the above points are discussed in detail in relevant sections of this report.

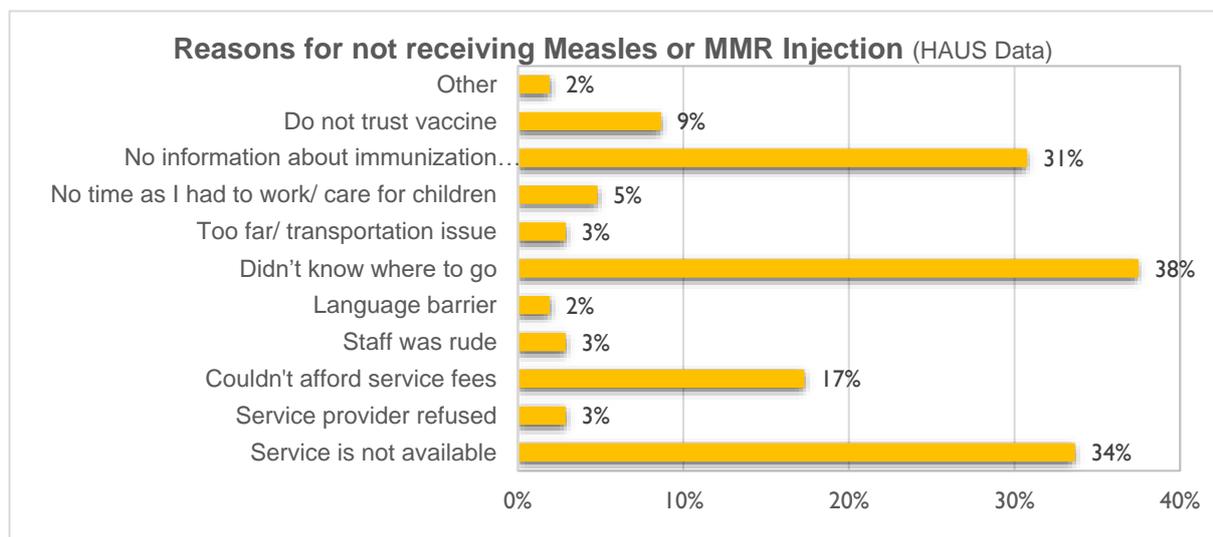
More than a third (39%) of respondents reported spending less than 5,000 rupees per month for medicines, while another 39% pay between 5,000 and 20,000 rupees per month. Most (72%) of those with no access to medicine or care for their chronic disease mentioned cost as the reason for lack of accessing health services. The healthcare system is already strained

and provision of uninterrupted supply of medicines for chronic diseases (like blood pressure and diabetes) is even difficult to ensure for Pakistani population to receive.

C. ACCESS TO INFORMATION

Access to health information not only benefits individuals but also entire communities. When communities have accurate health information, they can collectively address public health concerns, promote healthy behaviors, and support each other in seeking appropriate care. According to HAUS data, three-quarters (75%) of the survey respondents were not aware that refugees can receive free life-saving hospital care during a medical emergency within the MOH and/or UNHCR referral network. This was more prevalent amongst those who arrived before 2020, as 79% were not aware of this provision, while this was surprising, emphasizes the need for awareness raising on availability of services in public health institutions.

Similarly, when asked about the reasons why their child did not get the measles or MMR vaccine, 69% mentioned that they did not know where to go or did not know about the immunization schedule. One-third (34%) mentioned the non-availability of services and 9%

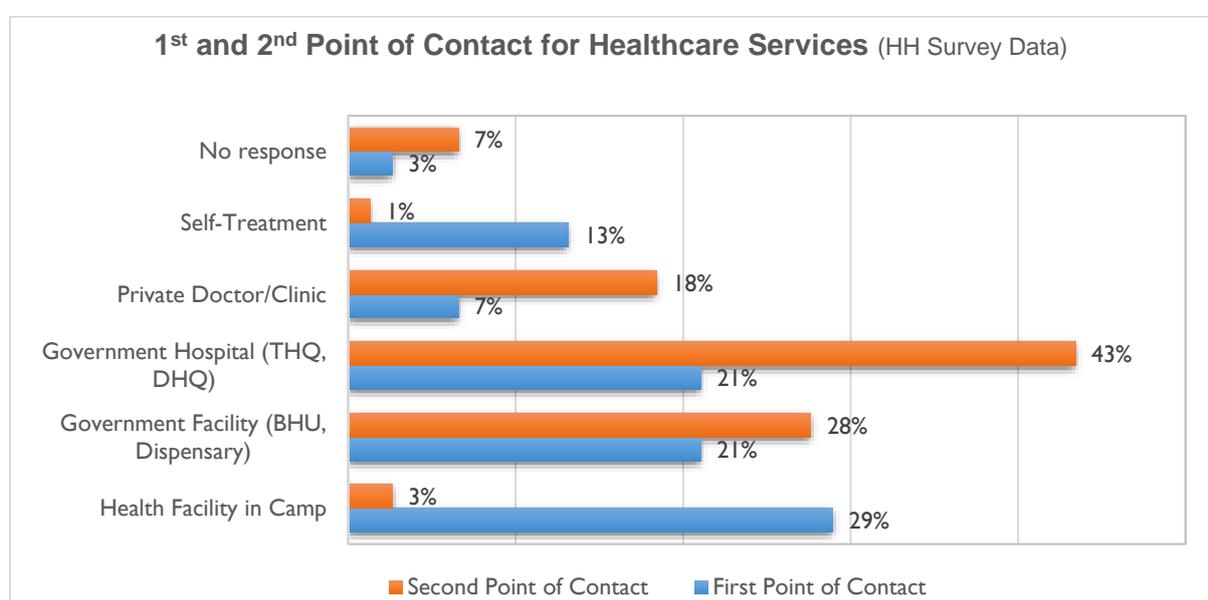


mentioned that they did not trust vaccines. The mistrust of vaccinations is also an issue faced by the health community while working to eradicate Polio. Therefore, it is important to highlight that access to reliable and accurate health information helps combat myths and misinformation that can lead to improper self-treatment or delay in seeking professional help.

HEALTH CARE SEEKING BEHAVIORS

Health-seeking behaviors among Afghan refugees in Pakistan vary due to a multitude of factors, including cultural differences, socioeconomic status, access to healthcare, and their refugee status. According to the FGDs with women, they initially resort to traditional or home remedies due to cultural practices or limited access to formal healthcare. Traditional healing methods, herbal treatments, or advice from community elders might be sought first.

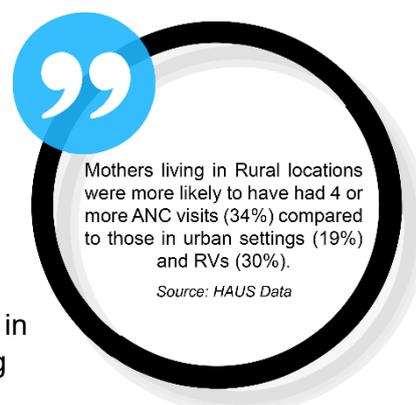
In contrast, findings from the survey conducted by consultants revealed that the primary and secondary points of contact for the majority of Afghan refugees seeking healthcare services were public health facilities, with 42% choosing them as the first point of contact and 71% selecting them as the second point of contact. The community elders during the FGDs shared that Afghan refugees often rely on community networks for information about healthcare services. Word-of-mouth recommendations and advice from fellow refugees or community leaders play a significant role in their health-seeking decisions.



MATERNAL NEWBORN AND CHILD HEALTH

A. ANTENATAL CARE

According to HAUS data, 65% of the AR mothers (women who were pregnant during 2022) interviewed (n=457) had received antenatal care during pregnancy, which is notably lower than the national average for Pakistan (86%), as reported in the last PDHS. Among those who did receive antenatal care (297 in total), 55% paid 1-3 visits to the clinic to receive antenatal care, followed by 28% who paid 4 or more visits. Remarkably, the vast majority (93%) of these reported that they did not encounter any difficulties in accessing antenatal care. Among those who reported facing difficulties, 39% mentioned distance or transportation, 50%

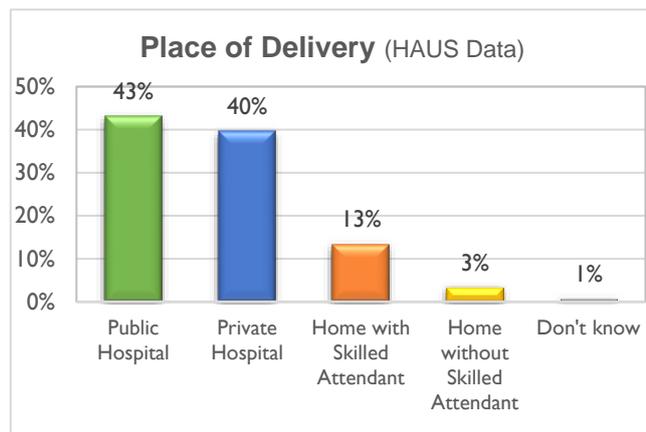


mentioned costs, and 28% cited waiting time as their reasons for these difficulties.

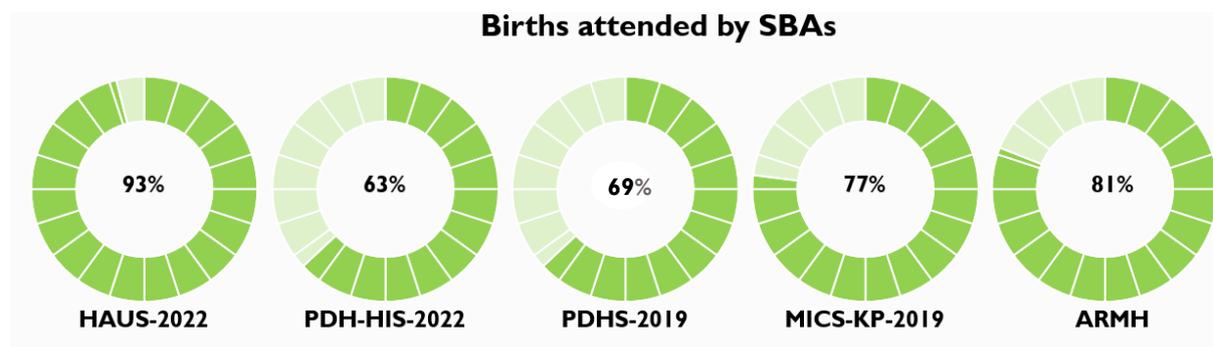
The Project Directorate Health for Afghan Refugees (PDH) HMIS data for the year 2022 reveals that 66% of the mothers with livebirths during the year had complete ANC coverage, of whom 71% received two or more doses of tetanus toxoid (TT) vaccination. This data suggests a positive trend in maternal healthcare awareness and access to healthcare services. It implies that a significant portion of mothers in this specific population had both the opportunity and the knowledge to seek and receive adequate prenatal care, including TT vaccination.

A. NATAL CARE

Among Afghan refugees, the percentage of deliveries attended by Skilled Birth Attendants (SBA) stands at 96%. Of these, 43% of the deliveries took place in a public hospital, followed by 40% in a private hospital. Only 16% of deliveries took place at home, of which 13% were facilitated by Skilled Attendants and 3% by Non-Skilled Attendants⁵⁶. In comparison, for the Host population in KP, PDGHS 2019 data indicates that 62% of deliveries took place at the health facilities.



Several factors can contribute to the higher proportion of deliveries taking place in the private sector but the most important ones mentioned are a) the need to have a functioning referral system from community to health facility level, b) the need for an effective communication campaign linking refugee villages to public sector health facilities and c) supporting refugees to access public sector facilities confidently and without barriers.⁵⁷



The proportion of complicated deliveries requiring emergency Caesarean Section was 5% while 88% were normal vaginal deliveries. Another 6% of the deliveries were planned C-sections⁵⁸.

⁵⁶ UNHCR Health Access and Utilization Survey 2022

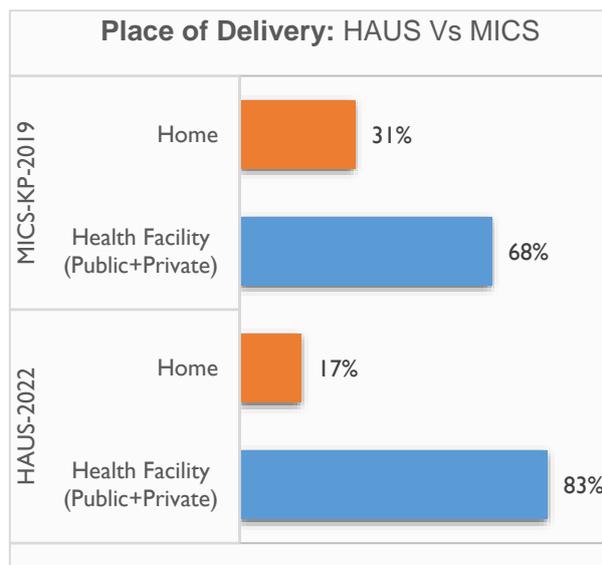
⁵⁷ FGDs with women.

⁵⁸ UNHCR Health Access and Utilization Survey 2022

The following considerations were reported to have led to the family's decision to stay at home during delivery:

- a. 'Families' desire to have the delivery at home' reported by most respondents (53%),
- b. 'Cost of delivery at the clinic or hospital (39%)',
- c. 'Distance from the clinic or hospital (16%)'.

Mothers living in refugee camps were more likely to mention the cost of delivery in the hospital as the main reason for delivering at home (53%, compared to 38% of those who lived in an urban location and 18% in rural locations)⁵⁹. The FGDs with refugee women strongly reinforced the above findings and also added that language is also a barrier for the women which leads them to agree with the option of stay-at-home delivery.



B. NEONATAL CARE

An overwhelming majority of mothers (85%) reported initiating breastfeeding their child immediately after birth.⁶⁰ The literature review indicates that awareness-raising has been a key factor in motivating this behavior.

A small proportion of mothers (7%) reported that their newborn baby needed to be admitted or kept in the hospital for special care. Among the newborns admitted to hospitals, a majority (55%) stayed for a duration of 3-5 days, while 21% had shorter stays of less than 2 days. The cost borne by families was significant, with more than half (54%) reporting to have spent between 10,000 and 50,000 rupees⁶¹.

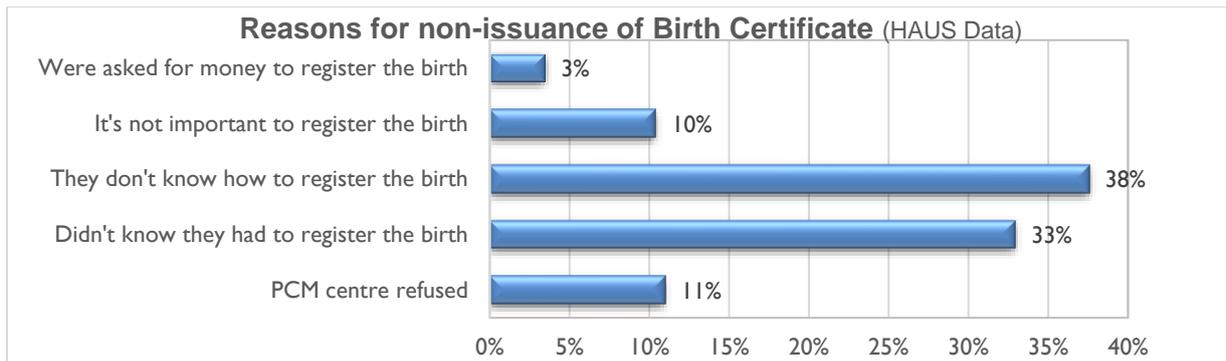
More than half (52%) of newborns among refugees received a birth certificate (HAUS data). In comparison, KP MICS reports a birth registration of 30% among the host population.

More than half of the responding mothers (52%) in HAUS reported that their child was issued a birth certificate. More than two-thirds of mothers whose children did not receive a birth certificate either were unfamiliar with the registration process (38%) or unaware of the need for birth registration (33%). Additionally, 11% of the mothers reported that the facility staff declined to issue a birth certificate, while a similar number (10%) mentioned that they did not consider it important.

⁵⁹ HAUS data

⁶⁰ HAUS data.

⁶¹ Ibid

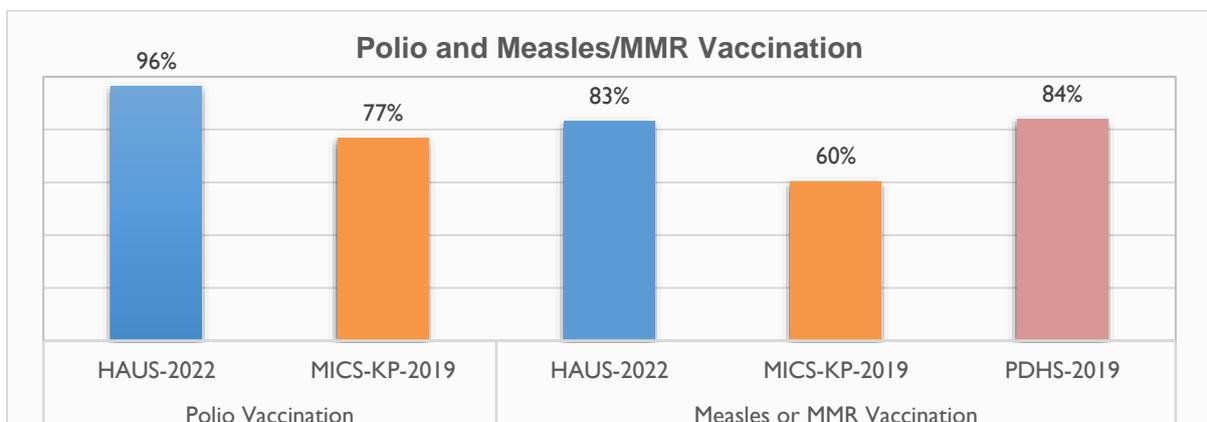
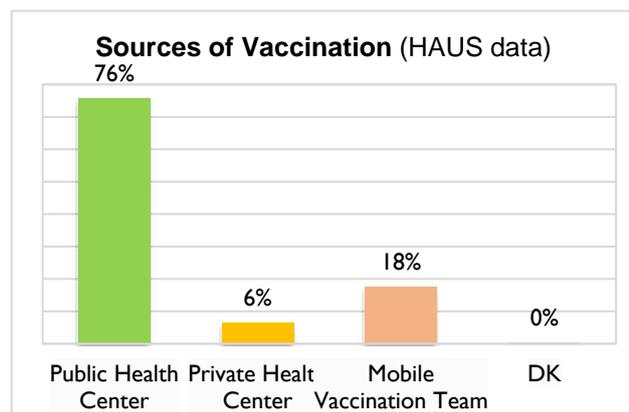


C. POSTNATAL CARE

According to PDH HMIS data for 2022, 68.7% of refugee women with live births received postnatal care within 42 days following delivery. In comparison, HAUS data indicates that only 33% of the AR mothers and their newborns received postnatal care after delivery, mainly when there is no complication. Of those who received postnatal care, nearly half (47%) received services from public sector facilities and a similar proportion (43%) received these services from private hospitals. This cost puts high pressure on the families due to their meager livelihood opportunities and higher levels of poverty. The majority of the mothers (51%) paid only one visit to PNC and 36% paid two visits⁶².

D. CHILDHOOD IMMUNIZATIONS (EPI)

According to HAUS data, a significant 85% of mothers reported that their children possess an immunization card. Three-quarters (76%) of these children received their vaccination from public health centers, followed by 18% from Mobile Vaccination Teams, and the remaining 6% from Private Health Centers. Our HH survey data shows that 93% of refugees living in RVs received EPI services from public sector facilities and 5% from mobile vaccination teams.



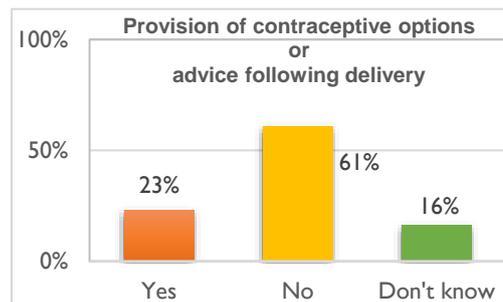
⁶² UNHCR Health Access and Utilization Survey 2022

The coverage of Measles or MMR vaccine, among refugees, stands at 83%⁶³. Similarly, PDHS data reports overall coverage of 81.46% for fully immunized children. A comparison of children who received measles or MMR vaccination is given in the graph. The data from HAUS-2022 and PDHS-2019 show a similar trend of vaccination, while the KP MICS data demonstrates a lower trend, at 60%.

“Although very few issues were reported in relation to childhood immunizations, key informants mentioned that they face issues in accessing care or vaccination for diseases like Hepatitis, snake bite and Rabies.”

FAMILY PLANNING SERVICES

Out of the 1,658 women interviewed in HAUS regarding their current use of contraceptive methods, only 13% responded positively. Remarkably, almost all (95%) of these users availed these services from public sector facilities. Women in refugee villages were more likely to be provided with contraceptive options (27%) compared to those living in rural locations (18%) or urban locations (22%).



Despite the considerably high rates of institutional deliveries among ARs (83%), the proportion of mothers who received Postpartum Family Planning counseling remains significantly low. Merely 23% of mothers were offered contraceptive options or advice post-delivery and 61% reported that they did not receive such advice⁶⁴. In comparison, MICS KP reports the post-delivery FP counseling at 14% for the local population. This denotes a substantial missed opportunity.

NUTRITION

Malnutrition continues to be a significant concern among Afghan women. According to a study on Afghan refugee women in Punjab, Afghan refugees have a high chance of being malnourished; the chances of death for these Afghans are 25 times higher every year from undernourishment and poverty than those from violence. The majority of these women have extremely low hemoglobin levels, which indicates iron deficiency as well as low body mass index for their age⁶⁵.

ADOLESCENT AND YOUTH HEALTH

More than a fifth (21.5%) of the Afghan refugee population in Pakistan falls into the youth category i.e., aged 15-24 years⁶⁶. As per DRIVE data, 99% of these youth were born in Pakistan. Notably, the level of education among this age group is higher than the average level of education of the general PoR population, with 49% compared to 31%, respectively. Nonetheless, gender inequalities result in lower levels of education, fewer work opportunities,

⁶³ UNHCR Health Access and Utilization Survey 2022

⁶⁴ Ibid

⁶⁵ Nutritional and health status of Afghan refugee women living in Punjab: A cross-sectional study - Fatima - 2023 - Food Science & Nutrition - Wiley Online Library

⁶⁶ DRIVE Report 2022 <https://reporting.unhcr.org/pakistan-drive-report>

and lower levels of participation in decision-making processes for women and girls. Child marriage and child labor are prevalent, and access to education remains one of the most critical issues disproportionately affecting girls⁶⁷. According to a household survey conducted by the Danish Refugee Council in KP, a staggering 82% of working children do not attend school⁶⁸.

Youth participating in community consultations have raised concerns about limited opportunities to study, lack of employment and career opportunities even after completing their education, and the economic pressures they face within their families. Due to limited access to the formal labor market, one of the foremost challenges for Afghan graduates remains their job placement.

Incidents of violence against children and gender-based violence are largely under-reported, and access to justice for refugee girls and women is often impeded by the lack of family/community support. Instances of intimate partner violence, child, early and forced marriage, and denial of resources are prevalent. The IRC's Health Facility Assessment survey reveals that during the previous 3 months preceding the survey, a total of 10 sexual violence cases were reported across the assessed 12 health facilities (2 in Peshawar and 8 in district Swat). Alarming, none of these cases reached case management within three days of the incident⁶⁹; thus, highlighting the gap that needs immediate redressal.

MENTAL HEALTH AND PSYCHOSOCIAL SERVICES

The prevalence of diagnosed mental health conditions in Pakistan has increased significantly in the last few decades, largely attributed to both the current violence in Pakistani society and disruption in its social structure.⁷⁰ This has had a damaging effect on the psychological health of the host community in general and particularly on Afghan refugees, given their uncertain future and increasing restrictions on their mobility, affecting their ability to provide and receive economic and social services. Most people affected by emergencies will experience distress (e.g., feelings of anxiety and sadness, hopelessness, difficulty sleeping, fatigue, irritability or anger and/or aches and pains). The WHO estimates that the prevalence of common mental disorders such as depression and anxiety is expected to more than double in a humanitarian crisis.⁷¹

In Pakistan, the capacity for providing mental health services is already low. With no established model for mental health care in rural settings across the country—even for the local population—people living in these refugee villages become more vulnerable, considering the increased incidence of mental disorders in emergency settings and limited mobility and resources. This can lead communities to seek treatment from traditional healers and religious leaders, which may lead

“Research and expert analysis indicate that Pakistan's burden of pre-existing mental illnesses prior to COVID-19 was extremely high (with up to 10-16 million individuals with severe conditions and up to 50 million with mild problems) while the MHPSS service providers possessed negligible capacity to deal with the total caseload.”

Source: Exploring the Impact of Coronavirus Outbreak on Mental Health and Psychosocial Support Needs in Pakistan September 2020

“According to a 2020 article in the medical journal 'The Lancet', Pakistan has fewer than 500 psychiatrists serving a population of 200 million. More than 90% of people with common mental health disorders go untreated.”

⁶⁷ Afghanistan Situation - Regional Refugee Response Plan (RRP) 2022

⁶⁸ Socio-Economic Survey of Afghan Refugees Living in Pakistan, DRC May 2023

⁶⁹ Sexual and Reproductive Health Facility Assessment Report, IRC 2023

⁷⁰ Khalily MT., (2010). Developing an integrated approach to the mental health issues in Pakistan. Journal of Interprofessional Care. 24(2):168-72

⁷¹ Charlson F, van Ommeren M, Flaxman A, et al. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. Lancet 2019; doi: 10.1016/S0140-6736(19)30934-1

to negative consequences or the sharing of inaccurate information regarding the causes and treatment of mental health conditions.⁷² An early needs identification study conducted by IRC in 2022 indicates that access to mental health and psychosocial services in surveyed districts of Lower Dir and Nowshera was 9% and 11% respectively⁷³.

During the FGD sessions, many refugees highlighted the high levels of mental stress and anxiety they face, particularly as a result of the uncertainty surrounding their future and the cumulative strain imposed by the challenges of daily life. Most of their concerns affecting their mental health relate to issues about lack of basic services, livelihoods, and poverty.

A household survey conducted by the International Medical Corps shows that Afghan refugees are experiencing a variety of mental, neurological, and substance use (MNS) conditions. Consequently, depression, anxiety, and drug misuse were more commonly reported by members of this community.⁷⁴ Some of the major issues related to mental health as identified by this need assessment⁷⁵ are given below:

DEPRESSION (KHAFGAAN):

According to community members most of the elders faced the issue of sadness, aggression and intolerance. It affects their daily life and productivity. They are unable to focus on their work and family matters. Sometimes they think that life should be ended. Due to these issues, they take the least interest in household responsibilities, avoid social gatherings and recreational activities, and remain isolated and sad, which disturbs their work life as well. Common symptoms shared by the community were suicidal ideation, overthinking, disturbed appetite, constant stress, weeping, hopelessness, self-harm, and irritation.

SUBSTANCE USE:

Due to the lack of jobs and educational facilities people are involved in substance use. The main drugs used in the community are heroin, ice (crystal methamphetamine), hashish (chars), and Majoon. According to the community members, some people are also using alcohol. Drug misuse is affecting youth, whereby they are becoming more aggressive. According to the community, the main cause of becoming a drug user is peer pressure.

EMOTIONAL ABUSE AND GBV:

The issue of bullying is very common in the RVs; people call one another bad names and bully them for their color and caste. There are instances of forced marriages and GBV issues in the community as well. Threats of divorce are common examples of emotional abuse toward women.

⁷² MHPSS Needs Assessment. IMC. 2021. Pg 4.

⁷³ Early Needs Identification Survey of Afghan Refugees in Flood Affected Districts of KP and Baluchistan, IRC, September 2022.

⁷⁴ MHPSS Needs Assessment. IMC. 2021

⁷⁵ The assessment was done in Haripur, Lower Dir, and Mansehra.

COMMUNICABLE DISEASES

The incidence of communicable diseases varies based on various factors, including living conditions, access to healthcare, vaccination coverage, and the overall health infrastructure in refugee camps or settlements. Communicable diseases are a concern in such populations due to close living quarters, limited access to healthcare, and potential challenges in maintaining hygiene standards. However, specific statistics on the incidence of communicable diseases among Afghan refugees in Pakistan were not readily available or frequently updated. The TB Control Program was run as a focused program and has the relevant data available, therefore, it has been elaborated in the following section.

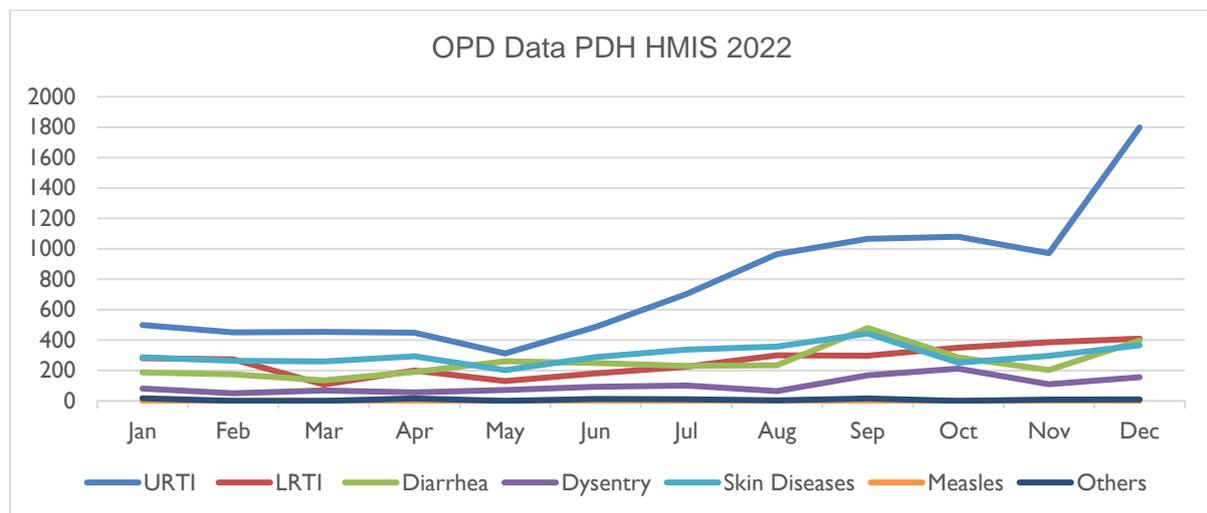
Data from the Provincial TB Control Program shows that during the year 2022, a total of 111,032 suspected TB cases were identified in KP province, with 12,514 of these cases involving Afghan nationals. Among the 49,519 confirmed TB cases, 1.9% (n=923) were Afghans.

“ Afghan TB patients without a PoR card are required to obtain written confirmation from their relatives who are registered, the Refugee Village Administrator and the religious leader of the RV before they are registered for treatment.

Source: KII PTB

” The provincial TB control program, funded by the Global Fund's Multi-Country Grant for TB, plays a crucial role in supporting TB control efforts among Afghans residing in 35 RVs in KP. The program offers essential services including free medicines and diagnostic services and even provides multi-nutrient food supplements (Ensure™) during the initial 8 weeks of the TB treatment.

The program has employed field workers (with a ratio of one worker for every 10,000 people), who support activities in the camps. Of the 50 health workers employed, only 3 are Afghans and the remaining are Pakistani nationals.



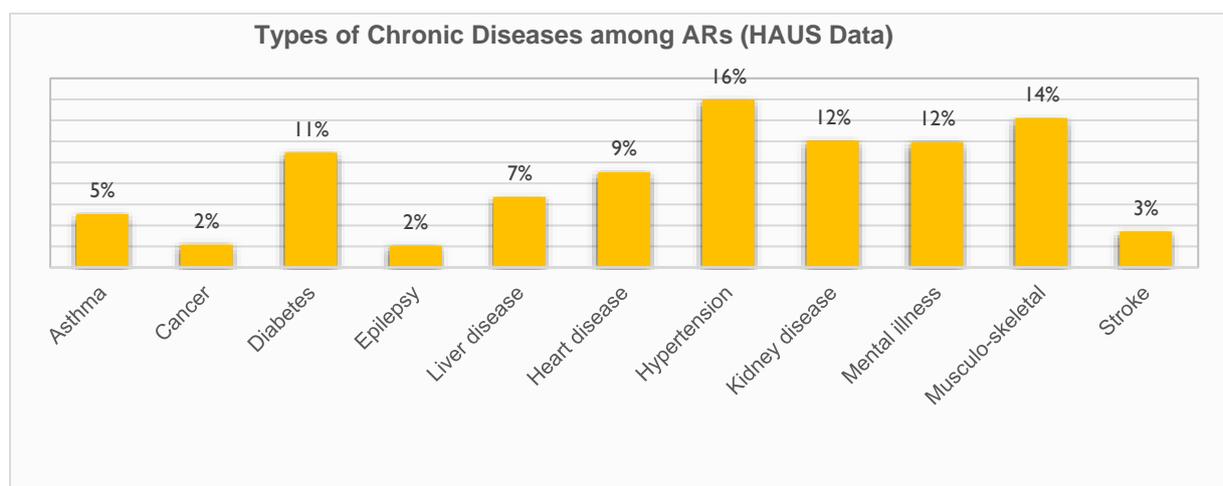
According to the data shared by PDH for 2022 show that Upper and Lower Respiratory Tract Infections (URTI and LRTI), Diarrhea, Dysentery, Skin Diseases, and Measles were reported frequently and were the most common morbidities. The data shows that URTI and LRTI have the highest incidence rate, which is contributed by overcrowded living conditions, poor ventilation, and compromised immune systems, which are common in refugee camps or densely populated areas. Also, skin diseases were reported frequently which result from poor hygiene, inadequate sanitation, and limited access to medical care. Fungal infections, scabies,

and dermatitis are common in settings where cleanliness and access to proper hygiene facilities are compromised.

NON COMMUNICABLE DISEASES (NCD)

Among the 8,244 individuals surveyed in HAUS, 17% (n=1437) reported having a chronic disease. The survey data reveals that 16% of refugees reported having Hypertension, 14% reported musculoskeletal issues, 12% each mentioned mental illness and kidney disease, and 11% had diabetes. Further details of the chronic diseases reported are given in the table. Notably, refugees living in KP were more likely to report chronic conditions compared to other provinces, with 66% in KP compared to 55% in Punjab, 50% in Sindh, and 54% in Baluchistan.

A vast majority of the respondents (80%) reported that they have access to medicine or other health services for their chronic condition, while 18% reported 'no access'. Households living in camps are more likely to report having a chronic condition (70%, compared to 55% of those living in urban settings and 57% living in rural locations). Refugees who live in refugee camps are also less likely to have been able to access medicines and health services for chronic diseases (78%, compared to 81% in rural areas and 83% in urban settings).⁷⁶



For those who cited 'no access', a predominant reason was the financial burden, with 72% expressing cost-related concerns. The average amount of money used for purchasing medicines for their chronic conditions varies, with 39% mentioning a monthly cost of up to 5,000 rupees. Another 24% reported a monthly expenditure of 5,000 and 10,000 rupees. According to a post cash disbursement study conducted by IRC 21% of the Afghan Refugees used the cash assistance for meeting their health needs.⁷⁷ All the given data strongly indicate the implications of financial burden of chronic diseases on the lives of the Afghan Refugees.

⁷⁶ HAUS data

⁷⁷ Post Distribution Monitoring – Multipurpose Cash Assistance. IRC. February 2023

DISABILITIES



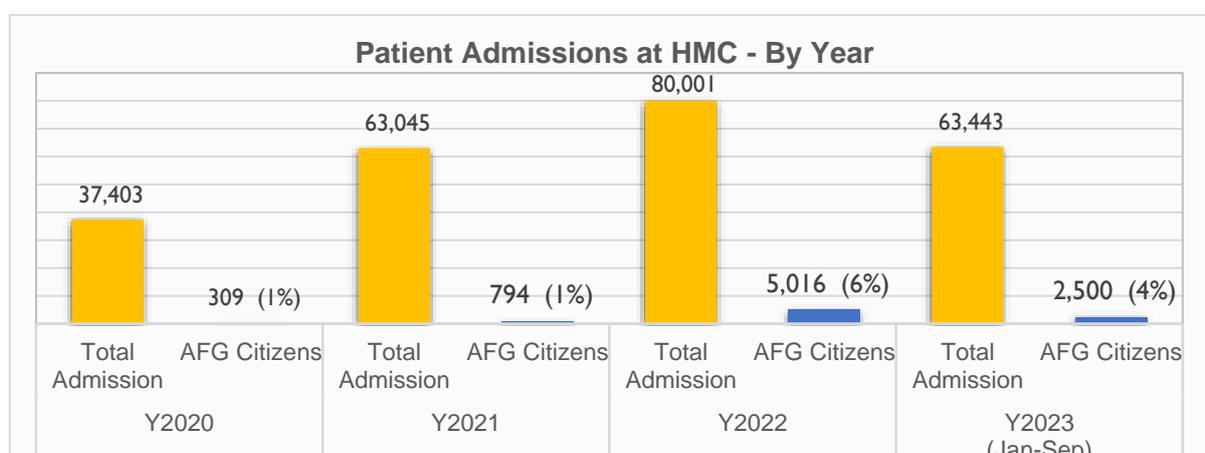
Impairment Cause	Count	%
Natural	122	54%
Accident	59	26%
War	4	2%
Violence	6	3%
Other	21	9%

According to the HAUS data, 2.7% of the surveyed refugees reported having disabilities. Of these, more than half (56%) reported physical impairment, and 24% reported mental impairment. The reported causes of impairment show that 26% of disabilities were accident related and 3% were caused by violence. Further details are given in the table.

HOSPITAL SERVICES

Consultations with Afghan community and discussions with various key informants have confirmed that Afghan patients are provided with equal care and compassion as their Pakistani counterparts. Afghan patients are entitled to same facilities as the host population and pay similar fees, regardless of nationality. Khyber Teaching Hospital in Peshawar has treated 21,669 Afghan patients for various ailments between July 1, 2022, and June 30, 2023⁷⁸. Similarly, Lady Reading Hospital in Peshawar extended medical care to around 22,000 Afghan patients during the same timeframe. Specialized cardiac care hospital (Pakistan Institute of Cardiology) has a dedicated counter for Afghans and served 1,108 Afghan citizens⁷⁹

Data obtained from Hayatabad Medical Complex for the year 2022 shows that a total of 23,906 OPD patients or 2% of the total OPD clients for the year were Afghan nationals. HMC admissions data for the year 2022 shows a 6-fold increase in admissions from Afghan patients during the year compared to previous years (see graph). Average cost per admission was PKR 31,395. The KP government spent PKR 2.96 billion on 94,387 patients of which 0.83 billion (28.0%) were spent on treating cardiovascular diseases. The mean cost of treating cases of ischemic heart disease was PKR 89,919.⁸⁰



⁷⁸ <https://www.thenews.com.pk/tns/detail/1097534-healthcare-for-afghan-refugees>

⁷⁹ Ibid

⁸⁰ Third Party Evaluation of the Sehat Card Plus Khyber Pakhtunkhwa. GIZ and AKU. May 2023.

UNHCR's Health Access and Utilization Survey data shows that an overall, 7% of the respondents were hospitalized during the year preceding the survey. Hospitalization rate was slightly higher (8%) for KP compared to 4% in Baluchistan and Sindh. More than half (52%) of the unemployed refugee households visited public sector hospitals. Respondents living in rural locations were more likely to go to private facilities (74%), compared to those living in refugee villages (62%) or urban settings (59%). Satisfaction levels for care received at the secondary facility were lower for those households living in an urban location (88%), compared to those living in rural areas (93%) or villages (96%).⁸¹

FUNDING LANDSCAPE

The long-standing presence of refugees has placed pressure on already fragile infrastructure and service delivery systems in Pakistan. The severe socio-economic impact of COVID-19 and the deteriorating economy of Pakistan indicates that the need for international support and burden-sharing has never been greater.

The needs of Afghan refugees extend far beyond the current support offered through the below-mentioned programs. These refugees have faced extraordinary challenges and hardships, fleeing conflict and instability in their home country, and they require comprehensive assistance to rebuild their lives in their host nations. Interviews with CAR officials have revealed that budget constraints pose a significant obstacle to meeting the expansive needs of Afghan refugees. It is essential to recognize the urgency of addressing these budgetary limitations in order to provide the necessary resources and support for these vulnerable populations, enabling them to find stability, security, and opportunities for a brighter future in their new communities.

In the Sehat Sahulat card a family can use up to 400,000 PKR for priority health care services and 60,000 PKR for secondary health care services. Family can benefit from the card till cash limit is available. Additional financial limits are allocated to family in life threatening conditions



and in case of maternity. However, Pakistan due to its funding constraints have only been spending less than 3% of its GDP on Health over the last decade. If Pakistan government decides to include ARs within its health insurance it will need to have international support.

Notably, the situation for Afghan refugees in Pakistan is compounded by the absence of a designated budget allocation to meet their needs. Despite hosting one of the largest populations of Afghan refugees in the world, Pakistan faces the challenge of providing essential services and support to these displaced individuals without a dedicated financial framework. This funding gap has the potential to strain the resources of both the Pakistani government and humanitarian organizations, making it even more pressing to secure the necessary financial commitments to ensure the well-being and integration of Afghan refugees

⁸¹ UNHCR Health Access and Utilization Survey 2022

within the country. Review of available online information identifies the following funding streams/projects focusing on support for Afghans in Pakistan:

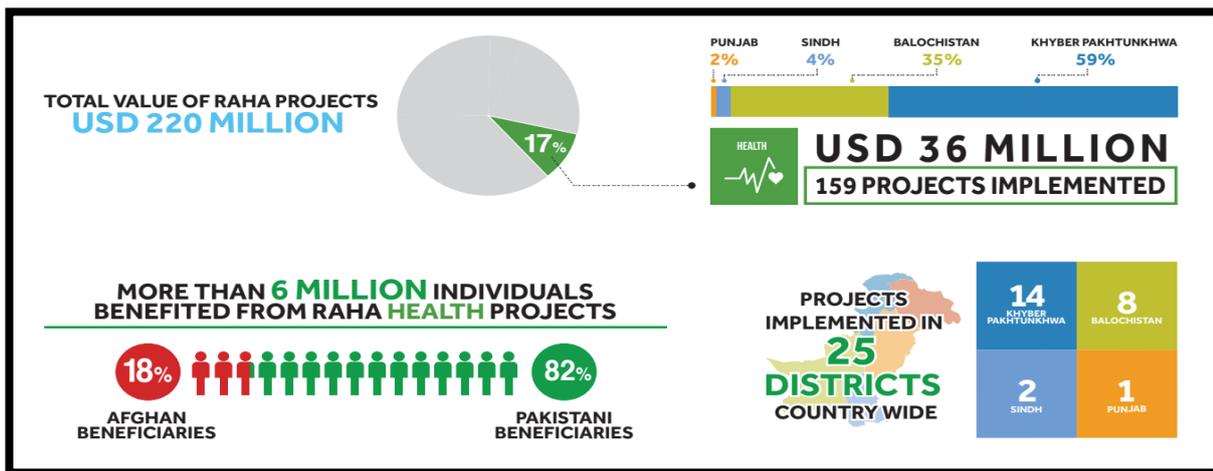
UNHCR RAHA (REFUGEE-AFFECTED AND HOSTING AREAS) PROGRAM

In line with UNHCR's Solutions Strategy for Afghan refugees, the health interventions of RAHA project channel vital investments into Pakistan's public healthcare system to enhance its absorption capacity and the quality of services provided. This approach benefits both refugees and their host communities.

RAHA project has supported 6 million individuals through a funding portfolio of \$220 million, of which \$36 million was spent on (159) health projects. RAHA health interventions benefitted both host communities (82%) and Afghan refugees (18%)⁸². However, due to the rising population, weak health delivery system, and severe economic constraints the gap between the demand and supply of health services is widening. Adding to that, the recent displacement of 2021 from Afghanistan, has further increased, the funding requirements for health and nutrition, which were estimated to be \$ 52.61 million⁸³.

With a funding portfolio of 220 million USD, of which 36 million was spent on 159 health projects, supported 6 million individuals (82% host communities and 18% Afghan refugees).

Source : <https://www.unhcr.org/pk/wp-content/uploads/sites/103/2021/04/RAHA-Factsheet-Health.pdf>



A. PAKISTAN REFUGEE RESPONSE PLAN

After a very long time, some positive interventions from donors in shape of Refugees Response Plan (RRP) have been received in 2021. The proposed RRP is planned to spend \$310 million in one year through 32 Implementing Partners including UNHCR for refugees and the local population.⁸⁴

B. NATIONAL HEALTH SUPPORT PROGRAM

The National Health Support Program (NHSP) is being funded by the World Bank with an aim to strengthen the equitable delivery and quality of essential health services at the primary

82 RAHA Fact Sheet Health: <https://www.unhcr.org/pk/wp-content/uploads/sites/103/2021/04/RAHA-Factsheet-Health.pdf>.

Figure reproduced from the source.

83 PRPR Afghanistan. 2021. UNHCR.

84 PRPR Afghanistan. 2021. UNHCR.

healthcare level in support of Universal Health Coverage. The NHSP (P172615) would be co-financed by US\$42 million from the Global Financing Facility for Women, Children, and Adolescents (GFF). The GFF component is focused on providing catalytic financing to leverage and increase the domestic resources for health alongside the WB financing and aligned external financing. The relatively small grant is multiplied by Pakistan's own commitments, generating a large return on investment, contributing to lives saved and to the accumulation of human capital. At the core of the GFF operating model is a country-led governance structure and a costed prioritized investment case which, in Pakistan, supports the case for UHC. Though this project is not exclusively supporting ARs, but it is important to mention it here as it aims to strengthen the institutional capacity of the health system in KP which is under strain due to the presence of large number of ARs.

B. USAID SUPPORT

Since 2002, the United States has provided more than \$273 million (nearly Rs 62 billion) in humanitarian assistance for Afghan refugees in Pakistan and Pakistani host communities. In Fiscal Year 2022 alone, the U.S. provided nearly \$60 million (more than Rs 13 billion) in assistance to the refugees and their host communities.⁸⁵ The U.S. assistance was utilized to improve Pakistani healthcare services and boost nutrition programs in areas hosting Afghans; improve water, sanitation, and hygiene infrastructure; and support recovery from the health and economic effects of the COVID-19 pandemic.

C. UK GOVERNMENT SUPPORT

The UK is working with other donors to support Pakistan and UNHCR to protect and support Afghan refugees in Pakistan. Pakistan has also received World Bank IDA 18 forced displacement funds which are now being spent in refugee hosting areas by the government.⁸⁶ Since late 2021, the UK has provided £7 million to WFP, UNICEF, UNHCR and IFRC to support preparedness and response for the arrival of new refugees from Afghanistan to Pakistan in the wake of the Taliban's takeover. In addition, the UK is a member of 'The Core Group' of donors which aims to provide sustained engagement and solidarity with the Afghan refugee situation and includes those who intend to make concrete commitments to support Pakistan's Solutions Strategy for Afghan Refugees (SSAR). The SSAR seeks to find solutions to support voluntary repatriation, sustainable reintegration, and assistance. One of its key aims is to ensure that services for refugees are integrated into Pakistan's development and service delivery.

D. FUNDING GAP

Historically, international donors and humanitarian organizations have contributed to assist Afghan refugees in Pakistan. Funding has often fallen short of the actual needs, creating challenges in providing education, healthcare, and livelihood opportunities for refugees. These organizations have faced their own budget constraints, affecting their ability to deliver services effectively.

In recent years, the players responding to health needs of Afghan Refugees in KP (and across Pakistan) have faced consistent funding shortfalls. These funding gaps have had a direct impact on the quality and availability of services provided to Afghan refugees, including healthcare, education, and shelter, and as demonstrated in this report, have strained the

⁸⁵ <https://pk.usembassy.gov/united-states-provided-nearly-60-million-in-2022-for-afghan-refugees-in-pakistan-and-pakistani-host-communities/#:~:text=Since%202002%2C%20the%20United%20States,Pakistan%20and%20Pakistani%20host%20communities.>

⁸⁶ House of Commons International Development Committee, Third Special Report of Session 2022– 23.

meagre resources available for the host population. International partners have issued Pakistan-specific funding appeals to address the situation of Afghan refugees in the country. These appeals have highlighted the growing needs of this population and the funding required to meet those needs.

Pakistan's total health expenditure⁸⁷ per capita in 2020 was USD 38 or 1.6% of its GDP. This is significantly lower than the USD 86 as informed by WHO as a minimum requirement.⁸⁸ The Universal Health Coverage Benefit Package of KP estimates that implementing 35 priority interventions at the PHC level in KP will cost USD 3.28 per capita per annum.

In 2021, the KP Government conducted a costing of the 'Universal Health Coverage Benefit Package' adjusting the Essential Package of Health Services as per localized evidence. The table below (reproduced from the mentioned document) provides cost estimates for each level of care as per EPHS categories:

Platform	Immediate Priority Interventions	Unit Cost (\$)/ person/ year (inclusive of health system cost)	DALYs Avert
1. Community level	21	3.74	530,138
2. PHC centre level	35	3.28	1,255,150
3. First level hospital	42	9.28	925,205
District EPHS	98	16.30	2,710,492
4. Tertiary hospital	22	8.15	342,263
5. Population level	12	4.47	++
All five platforms	132	28.92	3,052,755 ++

⁸⁷ Total health expenditure refers to the sum of all health expenditures within a specific region, typically a country, during a defined period. This includes all spending, both public and private, on healthcare goods and services, such as hospitals, physicians, long-term care, and pharmaceuticals. It encompasses spending by individuals, governments, and insurance companies.

⁸⁸ <https://www.macrotrends.net/countries/PAK/pakistan/healthcare-spending>

SECTION 4: RECOMMENDATIONS

The literature review, primary data and synthesis of the findings crystallize that Afghan Refugees living in Pakistan are accessing both preventive and curative services, mostly using Pakistan's public sector health facilities, especially for preventive services. While there might be positive indications of improved health coverage and access to facilities for Afghan refugees in Pakistan, it's crucial to consider the variability in healthcare provision, resource constraints, and challenges associated with geographic and information accessibility levels, impacting the adequacy and quality of healthcare services available to Afghan refugees.

The recommendations of this report are aligned with:

1. The 2018 UN General Assembly endorsed 'Global Compact on Refugees'. Among others, the Global Compact aims to ease pressure on host countries and sets out to ensure that assistance is delivered, to the extent possible, through appropriate local and national service providers. It also entails a commitment from states and relevant stakeholders to support the refugee hosting countries in, inter alia, expanding and enhancing the quality of national health systems to facilitate access by refugees and host communities, as well as in capacity development and training opportunities for refugees who could be engaged as health care workers, aligning with national regulations and policies.⁸⁹
2. At the province level, KP government has committed to deliver health services to its population by adopting the concept of UHC (Universal Health Coverage) and has finalized a province specific UHC Benefit Package. The recommendations for this study are also aligned to this strategic shift.

Without inclusion in planning and budgeting, refugees face barriers in accessing critical services such as healthcare, education, and livelihood support. Their specific needs might be overlooked, leading to a lack of resources allocated for their well-being. This exclusion might lead to a prolonged dependency on aid, impacting both the refugees and the host country's resources. The funding gap keeps widening and political governments are forced to make decisions that lead to tough situations. The 2023 third Party Evaluation of the Sehat Card Plus in Khyber Pakhtunkhwa documents a significant reduction in medical care component of mean out-of-pocket expenditure for inpatient services for Sehat Card users (PKR 1,006 ±9248) as compared with nonusers (PKR 30,042 ±69014). Moreover, the level of catastrophic health expenditure among households with Sehat card was significantly lower for users (14%) compared to nonusers (35%).

The following specific recommendations can be considered for improving health outcomes.

COMMUNITY LEVEL

The foundational level of the UHC package is the community level healthcare. It is important to highlight that the support of LHWs is not available within the RVs. Establishing a CHW network within the RVs in line with the UHC package which can deliver the 21 identified 'Immediate Priority' interventions will be cornerstone of this this tiered healthcare system.

⁸⁹ <https://www.unhcr.org/about-unhcr/who-we-are/global-compact-refugees>.

Estimated cost of delivering the 21 'Immediate Priority interventions at the community level is USD 3.74/person/year⁹⁰.

Specific recommendations related to community level healthcare delivery, based on the findings of this study are:

1. Support delivery of community level interventions through CHW network while ensuring that the CHWs are linked to nearby BHUs / RHCs.
2. Invest in the design and implementation of a strategic BCC intervention considering the unique requirement of ARs in both urban and rural settings while keeping in mind the specific requirements of youth, girls and women. A key component of this strategy needs to focus on care seeking and options available for refugees, using a rights-based angle.
3. The revival of the CHW network should include carefully crafted training and capacity building program. Also, the package of services to be delivered needs to be at par with the EPHS/UHC package implemented in KP.
4. Based on information presented in this report, key priorities for a tiered healthcare service delivery for ARs should include FP, Nutrition, and MHPSS.
5. Establish and support community level referral facilities, especially in RVs in remote locations.
6. Ensure that CHWs are Afghans and from the camp. Consider adapting different strategies for rollout of community-based services in rural and urban settings.
7. Strengthen Postpartum FP counselling and service provision.

PHC CENTER LEVEL

Public sector PHC level facilities (BHUs and RHCs) catering for the needs of refugee populations work under severe resource constraints and struggle to cope with this additional workload. These facilities will require additional support to extend uninterrupted services for both host and refugee communities. In areas where RVs are located away from public sector facilities, alternate service delivery arrangements need to be considered and based on the needs of the setting, the option of camp level service delivery will be required at the refugee villages in remote and inaccessible locations.

The estimated cost of delivering the 35 'Immediate Priority' interventions as per UHC package is USD 3.28/person/year.

Findings of this study suggest special consideration for the following areas:

1. Advocate for inclusion of the RV elders in the Primary Care Management Committees (PCMCs) established through DoH for public sector health facilities. Invest in capacity building of these committees on human rights-based health programming.
2. Support health facilities to strengthen linkages with CHWs. Considering the additional workload of CHWs from refugee population, appoint a Community Health Supervisor (CHS) or a Female Health supervisor (FHS) from Afghan communities in the public HFs catering for Afghan.
3. Invest in capacity strengthening of HF to respond to the essential needs of refugee and host population during emergencies. These capacity strengthening interventions

⁹⁰ Third Party Evaluation of the Sehat Card Plus Khyber Pakhtunkhwa. GIZ and AKU. May 2023.

should be based on the Minimum Initial Services Package (MISP) standards and protocols.

4. Develop and implement targeted capacity strengthening interventions for facilities in areas where unique conditions (e.g., Cutaneous Leishmaniasis) are present among Afghans. Ensure that the surveillance and control interventions are extended to the affected host communities as well.
5. Ensure adequate dissemination of and community mobilization of the scheduled outreach visits from the public sector actors among refugee communities through CAR.
6. The study authors feel that learnings from the refugee program in this area will strengthen this emerging field for refugee and host populations. Document learnings from MHPSS interventions implemented in refugee programs and work with Mental Health Unit at DoH KP for enhancing their capacities.
7. For ensuring access of Afghan women to family planning services, the stakeholders will need to work with Population Welfare Department so that the existing mechanisms of Family Health Days or mobile camps from nearby BHU or PWD facilities are extended to RVs.

HOSPITAL LEVEL

The funding gap keeps widening and political governments are forced to make decisions that lead to tough situations. The 2023 third Party Evaluation of the Sehat Card Plus in Khyber Pakhtunkhwa documents a significant reduction in medical care component of mean out-of-pocket expenditure for inpatient services for Sehat Card users (PKR 1,006 ±9248) as compared with nonusers (PKR 30,042 ±69014). Moreover, the level of catastrophic health expenditure among households with Sehat card was significantly lower for users (14%) compared to nonusers (35%).

Inclusion of the AR families in this insurance scheme will enable refugees access to specialized care from public and private sector facilities without any interruption.

The premium paid by the Sehat Card Plus KP is set at PKR 2,849 per family.⁹¹

POLICY LEVEL

1. Explore feasible options for the extension of Sehat Sahulat program or a similar insurance package for ARs. As per the third-party evaluation of the Sehat Card Plus (SCP), a large proportion of non-users of the scheme (44%) were not eligible due to citizenship and domicile, and 19% due to not having CNIC or B-form.
2. Develop and implement an advocacy strategy with key stakeholders for allocation of financial resources for ARs. As per the above-mentioned evaluation, 'the Sehat Card Plus KP offers substantial financial risk protection to its users. The mean out-of-pocket expenditure for SCP users was PKR 6,551 (medical = PKR 1,006, and non-medical PKR 5,546), which was significantly lower than the mean expenditure of PKR 34,639 (medical = PKR 30,042, non-medical = PKR 4,563) for SCP nonusers.
3. Advocate with relevant stakeholders for the inclusion of ARs in the district and facility budgeting and planning exercises. Develop capacities of the district and facility health staff on needs-based planning and budgeting.

⁹¹ Third Party Evaluation of the Sehat Card Plus Khyber Pakhtunkhwa by Department of Community Health Sciences, Aga Khan University, Karachi May 2023

4. Work with HMIS unit of the DoH and other relevant stakeholders to ensure that the routine data collected through DHIS can be segregated by the nationality of the clients.
5. Strengthen capacities of health decision makers in data quality and use for evidence led decision making.
6. Explore the possibility of integrating the needs of the AR in Pakistan's Humanitarian Response Plan.

ANNEX I: TOOL: KEY INFORMANT INTERVIEW

Key Informant Name: _____

Department / Organization: _____

Designation: _____

Date of Interview: _____

Interview Modality: _____

Introduction:

Thank you for participating in this health assessment questionnaire. This questionnaire aims to better understand the health issues faced by Afghan refugees in Pakistan. Your responses will be kept confidential and will contribute to improving healthcare services for the refugee community. This health assessment is being done for the Commissionerate of Afghan Refugees, KP, and is being executed by the International Rescue Committee (IRC).

My name is _____ and I am working as a consultant for IRC. There are no benefits for anyone who takes part, and no negative consequences for anything that is said in the discussion. Anyone who takes part is free to stop taking part at any time. The discussion will take about 30 -45 minutes.

Are you willing to participate in this KII? Yes No

Interviewer name

1. Please provide a brief overview of your organization and role and your engagement with Afghan Refugees.
2. What types of healthcare services are available to Afghan refugees in Pakistan (reference year is 2022)?

Probe:

PHC – a) Curative Services - Treatment of Common Diseases and Illnesses, TB, Hepatitis, HIV/AIDS, COVID and b) Preventive Services – Maternal Health (ANC, Natal Care, PNC, FP), Child Health (EPI and Nutrition) and Health Information.

Referral Care – Referral mechanisms and available support.

3. Which services are generally available within refugee camps, which ones are sought from the private sector, and which services are received from public sector?

4. Which services were provided through your institution / department in 2022?

Probe: Details of Services
 Delivery Mechanisms and

Funding Arrangements i.e., source, amount, duration
Recording and reporting mechanisms

5. Are these services accessible to refugees regardless of their location or legal status?

Are there any specific challenges for refugees in accessing these services?

If yes, give details and examples.

Policy / Strategy Level:

6. Which policy/strategy level initiatives have positively or negatively affected access of Afghan Refugees to Basic Services?

Probe: Political Commitment and Security Concerns
Initiatives Like UHC and Health Insurance Scheme
Inclusion of ARs in Planning and Budgeting Cycle
Resource Constraints
Coordination Challenges

7. In your opinion, what are the feasible options for integrating AR Healthcare delivery within KP's Health System?

8. What are your practical recommendations and what challenges you foresee?

Cultural Sensitivity:

9. Can you please tell me about the cultural peculiarities of Afghan Refugees which act as barriers in accessing healthcare?

Probe: Do women need to travel with male family members to seek healthcare?
Are women comfortable to be seen by male care providers?

10. How is language and communication addressed when providing healthcare to Afghan refugees?

11. Are healthcare providers trained to be culturally sensitive and respectful of Afghan refugees' traditions and values? [Probe: legal status]

Healthcare Affordability:

12. Are healthcare services provided to Afghan refugees free of charge, or are there any associated costs?

13. Are there any mechanisms in place to ensure that refugees or those who cannot afford to pay receive the necessary medical service?

Healthcare Data and Monitoring:

14. How is healthcare data collected, monitored, and reported for Afghan refugees? Are Afghan Refugees included in HMIS? If yes, how. If no then how can they be included?

Feedback Mechanisms:

15. Is there a system in place to gather feedback from Afghan refugees about their experiences with healthcare services?

How is this feedback used to make improvements to the healthcare system?

16. Is there transparency in sharing data about the health status of refugees and the effectiveness of healthcare services?

ANNEX II: TOOL FGD - ELDERS

Introduction: Thank you for participating in this health assessment exercise. This activity aims to better understand the health issues faced by Afghan refugees in Pakistan. Your responses will be kept confidential and will contribute to improving healthcare services for the refugee community. This health assessment is being done for the Commissionerate of Afghan Refugees, KP and is being executed by the International Rescue Committee (IRC). My name is _____ and I am working as a consultant for IRC. There are no benefits for anyone who takes part, and no negative consequences for anything that is said in the discussion. Anyone who takes part is free to stop taking part at any time. The discussion will take about 30 -45 minutes.

We have selected a few participants to ask if they would like to participate. Everyone is free to decide if they would like to answer.

Do you have any questions? Yes: ----- No: -----

Are you willing to take part in this discussion? Yes: ----- No: -----

If 'No', thank the respondent for their time and end the interview.

Remember you are free to not answer any question that you don't want to.

Profile of participants

Code	Name	Age	Profession	Legal Status	Current Place of Residence
R-1					
R-2					
R-3					
R-4					
R-5					

Please answer the following questions to the best of your ability.

Section 1: General Information

1. How long have you been living as a refugee in Pakistan?
2. Number of Dependents (children, elderly, etc.)

Section 2: Health Conditions

1. Do you or any of your family members have any chronic health conditions? (Diabetes, Hypertension, Heart disease, etc.)
2. Does anyone in your family have been treated for TB? From where? What were the costs paid?
3. Have you or any family members been diagnosed with mental health issues such as depression, anxiety, or PTSD?

4. Are there any specific health concerns that you feel are prevalent among Afghan refugees in Pakistan?

Section 3: Access to Healthcare

1. Have you utilized healthcare services since arriving in Pakistan?
2. Which type of healthcare facility have you visited in the last year, 2022? (Government hospital, NGO clinic, Private clinic, None)
3. How satisfied are you with the quality of healthcare you received?
4. What factors affect your decision to seek medical care? (Cost, Language barrier, Cultural differences, Distance to healthcare facility, Fear of deportation, Other)

Section 4: Healthcare Barriers

1. What are the challenges that you and your family face in accessing healthcare services? (Language barrier, financial constraints, Lack of awareness, Discrimination, Other).
2. Have you encountered any difficulties in obtaining medications or medical supplies in the last year, 2022?

Section 5: Healthcare Information and Education

1. How do you usually obtain information about health and healthcare services? (Radio, TV, Community leaders, Healthcare workers, None)
2. Would you be interested in health education workshops or programs tailored for Afghan refugees?

Section 6: Additional Comments

Please provide any additional comments or suggestions related to healthcare services for Afghan refugees in Pakistan.

Thank you for taking the time to complete this questionnaire. Your input is invaluable in helping us address the healthcare needs of Afghan refugees in Pakistan. Your responses will remain confidential and will be used for research purposes only.

ANNEX III: TOOL FGD - WOMEN

Introduction: Thank you for participating in this health assessment exercise. This activity aims to better understand the health issues faced by Afghan refugees in Pakistan. Your responses will be kept confidential and will contribute to improving healthcare services for the refugee community. This health assessment is being done for the Commissionerate of Afghan Refugees, KP and is being executed by the International Rescue Committee (IRC). My name is _____ and I am working as a consultant for IRC. There are no benefits for anyone who takes part, and no negative consequences for anything that is said in the discussion. Anyone who takes part is free to stop taking part at any time. The discussion will take about 30 -45 minutes.

We have selected a few participants to ask if they would like to participate. Everyone is free to decide if they would like to answer.

Do you have any questions? Yes: ----- No: -----

Are you willing to take part in this discussion? Yes: ----- No: -----

If 'No', thank the respondent for their time and end the interview.

Remember you are free to not answer any question that you don't want to.

Profile of participants

Code	Name	Age	Education	Legal Status	Current Place of Residence
R-1					
R-2					
R-3					
R-4					
R-5					

Please answer the following questions to the best of your ability.

Section 1: General Information

1. How long have you been living as a refugee in Pakistan?
2. Marital status (Married, Single, Widow)
3. Number of family members (children, elderly, etc.)

Section 2: Health Conditions

1. Do you or any of your family members have any chronic health conditions? (Diabetes, Hypertension, Heart disease, etc.)
2. Have you or any family members been diagnosed with mental health issues such as depression, anxiety, or PTSD?

3. Are there any specific health concerns that you feel are prevalent among Women Afghan refugees in Pakistan?

Section 3: Access to Reproductive and Child Health Services

1. Are you currently pregnant or have you been pregnant in the past year? Were you satisfied with the services provided to you?
2. Where do Afghan women prefer to seek support for delivery? How much do you pay for a normal delivery and for a C-section surgery?
3. Do you have children under the age of 5? If yes, have they received necessary vaccinations and healthcare services? From where?
4. Have you been able to access pre-natal and post-natal services?
5. How satisfied are you with the quality of healthcare you received in 2022?
5. What factors affect your decision to seek medical care? (Cost, Language barrier, Cultural differences, Distance to healthcare facility, Fear of deportation, Other)

Section 4: Healthcare Barriers

1. Are there any challenges you face in accessing healthcare services? (Language barrier, financial constraints, Lack of awareness, Discrimination, Other).
2. Have you encountered any difficulties in obtaining medications or medical supplies?
3. How do you usually obtain information about health and healthcare services? (Radio, TV, Community leaders, Healthcare workers, None)

Section 5: Additional Comments

Please provide any additional comments or suggestions related to healthcare services for Afghan refugees in Pakistan.

Thank you for taking the time to complete this questionnaire. Your input is invaluable in helping us address the healthcare needs of Afghan refugees in Pakistan. Your responses will remain confidential and will be used for research purposes only.

ANNEX IV: FGD – HOST COMMUNITY

Introduction: Thank you for participating in this health assessment exercise. This questionnaire aims to better understand the health issues faced by Afghan refugees in Pakistan. Your responses will be kept confidential and will contribute to improving healthcare services for the refugee community. This health assessment is being done for the Commissionerate of Afghan Refugees, KP, and is being executed by the International Rescue Committee (IRC).

My name is _____ and I am working as a consultant for IRC.

There are no benefits for anyone who takes part, and no negative consequences for anything that is said in the discussion. Anyone who takes part is free to stop taking part at any time. The discussion will take about 30 -45 minutes.

We have selected a few participants to ask if they would like to participate. Everyone is free to decide if they would like to answer.

Do you have any questions? Yes: ----- No: -----

Are you willing to take part in this discussion? Yes: ----- No: -----

If 'No', thank the respondent for their time and end the interview.

Remember you are free to not answer any question that you don't want to.

Profile of participants

Code	Name	Age	Sex	Profession	Place of Residence
R-1					
R-2					
R-3					
R-4					
R-5					

Section 1: General Information

1. Marital status (Married, Single, Widow)
2. Number of family members (children, elderly, etc.)

Section 2: Health Conditions

1. Have there been any specific health concerns that have arisen since the arrival of Afghan refugees?
2. What is the availability of healthcare facilities and services in this community?
3. Are Afghan refugees able to access the same healthcare services as the local population?

Section 3: Health Barriers

1. Are there any challenges refugees face in accessing healthcare services? (Language barrier, financial constraints, Lack of awareness, Discrimination, Other).
2. Have you encountered any difficulties in obtaining medications or medical supplies due to the presence of refugees?
3. How do you usually obtain information about health and healthcare services? (Radio, TV, Community leaders, Healthcare workers, None)

Section 4: Social Cohesion

1. How can the host community and Afghan refugees collaborate to address health issues collectively?
2. How can the community work together to reduce stigma and promote mental well-being?
3. What cultural considerations should be taken into account when designing healthcare programs for both communities?

Section 5: Additional Comments

Please provide any additional comments or suggestions related to healthcare services for Afghan refugees in Pakistan.

Thank you for taking the time to complete this questionnaire. Your input is invaluable in helping us address the healthcare needs of Afghan refugees in Pakistan. Your responses will remain confidential and will be used for research purposes only.

ANNEX V: KII TOOL CHS/ CHW/ RVA

Title: Mapping of Access to Public Sector Health Facilities by Afghan Refugees in KP Province

Introduction: This survey aims to understand the distance, access challenges, and barriers faced by Afghan refugees in accessing healthcare through public sector health facilities in KP Province, Pakistan. Your valuable insights will guide policy and practice to improve healthcare access for this population. Your participation is voluntary, and all information will remain confidential.

Section A: Background and Camp Information

1. Name of the Health Worker:
2. Previous/Current Title or Role:
3. Years of Experience Working with Refugees in this camp:
4. Camp Name:
5. Settlement Camp Population:
6. Location (District):

Section B: Service Availability Mapping

7. Are there any healthcare services available in this settlement (Ref Year is 2022)? Yes: _____ No: _____

8. If yes, please describe the services currently available within the settlement. [If service is not available within the camp, please fill the last column]

Service Type	Provided by	Frequency	If not available in the camp, where do people go to seek these services?
Treatment for Common Diseases			
ANC, PNC			
Delivery Care			
Family Planning			
EPI Vaccinations			
TB Treatment			
Referral			
Others			

9. Can you please help me map the nearest Public (government) Health Facilities used by camp residents:

Facility Name & Type	Distance from Settlement (in km)	Mode of Transportation	Cost in PKR	Travel Time (Minutes)

10. If camp residents need hospitalization, where do they go and how far away is that facility?

Section C: Access Challenges

11. What cultural or language barriers have you observed in healthcare access from government health facilities?

12. Have there been challenges related to documentation or legal requirements for refugees? Please describe.

13. Do refugees receive all services at the Government healthcare facility (HF) like the local population? If not, please specify the differences.

14. In your opinion, are public sector health facilities equipped to meet the specific needs of refugees?

If not, what is missing?

Closing: Thank you for your time and insights. Your input is vital in helping to understand and improve healthcare access for Afghan refugees in KP Province.

ANNEX VI: KEY INFORMANT INTERVIEWS

Organization	Name	Designation/Department
Hayatabad Medical Complex	Dr Shahzad Akbar	Medical Director
Hayatabad Medical Complex	Awal Khan	Director Nursing
TB Control Program	Dr Haroon Altaf	Provincial Director
Multi Country Grant for TB Control	Pervaiz	Coordinator
Association for Community Development	Dr Naveed Akmal	CEO
Provincial Directorate for TB Control	Dr Ismael	Advisor
Provincial Directorate for TB Control	Asif Kamal	Assistant Director IT
KMU	Dr Khalid Rehman	Director, Institute of Public Health & Social Sciences (IPH&SS)
IMS	Dr Zaheer Zafar	Director.
Blue Veins	Qamar Naseem	Coordinator
Blue Veins	Ayub Khan	Program Manager
UNHCR	Dr Amman Ullah	Health Program
IMC	Rafiullah Khan	Technical Specialist MHSP
USAID	Dr Ismaeel	Advisor TB Control
UNHCR Islamabad	Dr Pervaiz Shukat	Public Health Officer
GIZ	Dr Bilal Khan	Snr Technical Advisor - Health
GIZ	Dr Hameeda Iqbal	Health Program
CAR	Ehsan Ullah	Director
CAR	Dr Tehseen Fatima	Director
CAR	Fakhar e Alam	Commissioner KP
CCAR	Abbas Khan	Chief Commissioner
IRC	Farhat Wariach	Head of Office KP
IRC	Dr Bisma Imran	Health Program

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Commissionerate Afghan Refugees (CAR)
Khyber Pakhtunkhwa, Peshawar

