

Undertaking rapid assessments in the COVID-19 context: Learning from UNICEF South Asia

Rapid assessment of the socio-economic impact of COVID-19 in Herat Province, Afghanistan



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A Case Study

Context

Afghanistan's first case of COVID-19 was registered in Herat Province in February 2020. With increasing number of returnees from Iran, Herat became a COVID-19 hotspot and restrictions on movement were introduced to mitigate the risk of transmission. In Afghanistan, as elsewhere, the most vulnerable groups to bear the brunt of the crisis were considered to be women, adolescents and children, facing reduced access to contraceptive supplies and therefore risk of unwanted pregnancies,¹ increase in maternal and child deaths² and gender-based violence.^{3,4} Home to the highest number of the country's poor people,⁵ Herat Province was particularly vulnerable to the socio-economic impact of the pandemic.

To address the large data gap and inform the COVID-19 response of the Government of Afghanistan and multiple UN agencies, UNICEF conducted this rapid assessment. Given the vulnerable position of women and children, the rapid assessment had a particular emphasis on understanding the situation of these vulnerable groups, including people with disability. More specifically, the objective was to generate evidence on: knowledge, attitudes and practices (KAP) around COVID-19; the socio-economic impact of the pandemic on the welfare situation of vulnerable groups; the services available to women and girls; and, finally, gendered coping mechanisms and changes in intra-household relationships and decision-making power.

¹ United Nations Population Fund. New UNFPA projections predict calamitous impact on women's health as COVID-19 pandemic continues. 28 Apr 2020. <https://www.unfpa.org/press/new-unfpa-projections-predict-calamitous-impact-womens-health-covid-19-pandemic-continues>

² UNICEF. As COVID-19 devastates already fragile health systems, over 6,000 additional children under five could die a day, without urgent action. <https://www.unicef.org/press-releases/covid-19-devastates-already-fragile-health-systems-over-6000-additional-children>

³ <https://globalhealth5050.org/the-sex-gender-and-covid-19-project/the-data-tracker/?explore=country&country=Afghanistan#search>

⁴ Thornton Jacqui. Covid-19: Millions of women and children at risk as visits to essential services plummet BMJ 2020; 369 :m2171 <https://www.bmj.com/content/369/bmj.m2171>

⁵ https://www.mppn.org/wp-content/uploads/2019/03/AFG_2019_vs9_online.pdf

Implementation arrangements

The rapid assessment was conducted by UNICEF, Afghanistan, with the support of Assess, Transform, Reach Consulting (ATR), a national research firm with experience in data collection across the country. UNICEF designed the assessment and ATR implemented the survey. The study was conceptualized in March 2020, and further designed and contracted from April to June 2020. Data collection was conducted from 10 July to 6 August 2020, followed by analysis in September and reporting in November 2020. The target population was households with men, women, adolescents and children, community health workers (CHWs) and community leaders. The approximate cost of the assessment was USD 80,000.

Data collection and analysis

This cross-sectional assessment used a mixed methods approach, drawing on three data sources: a KAP survey administered to 1,278 male and female respondents aged 18 years and above (616 female and 662 male); key informant interviews (KIIs) with five female CHWs⁶ and ten community leaders who are members of the health *shura*⁷; and 56 observations of areas around selected community health facilities.

To mitigate risk of COVID-19 infection, and in the context of the volatile security situation and intensifying conflict in Afghanistan, data collection was conducted remotely to a large extent, demonstrating that despite challenges remote data collection is possible even in complex contexts like Herat. The KAP survey and KIIs were conducted via phone.⁸ An existing database of phone numbers was leveraged (see below), and CHWs, who knew the communities and had access to them, were recruited and trained to collect additional phone numbers from community members and community key informants. Whilst direct observation—by definition—had to take place in-person, the same

local CHWs were trained to conduct the direct observations avoiding the entry of external field teams in the community, and therefore mitigating the risk of spreading the virus.

The telephone survey, which was translated into the local language, included around 70 questions and lasted approximately an hour. It covered the main themes of the study.⁹ The KIIs covered most of the same themes but also expanded on specific topics. In particular, female CHWs were asked about the impact of the pandemic on the provision, availability and use of health services and challenges faced. The direct observations provided information on actual behaviour, as compared to reported practices, and included, among others, observations of COVID-19 preventive practices (e.g. safe distancing). The mixed methods approach enabled a more comprehensive understanding of the main assessment themes and allowed for data triangulation. For example, interviews with community leaders allowed an exploration of the needs and engagement regarding COVID-19 from a community perspective. Triangulation proved to be valuable as there was a difference in COVID-19 practices reported in the survey and those in observations and KIIs; possibly because of the social desirability bias in responses, and the way questions/concepts were translated and understood by respondents (e.g. on risk perception and domestic violence).

The rapid assessment had a strong emphasis on gender and equity. Many questions specifically focused on the impact of the pandemic and challenges for women, adolescents and children.¹⁰ In addition to emphasizing analysis by gender, the survey examined challenges and coping by members of the households living with disability. Furthermore, women featured strongly as respondents. To achieve an equal representation of women and men as part of the survey, extra

⁶ In Afghanistan, community-based health care is provided through health posts/community health facilities served by CHWs, which are linked to supporting health facilities. <https://chwcentral.org/the-community-based-healthcare-system-of-afghanistan/>

⁷ Each community with a health post has a health committee—the Shura-e-sehie. Shura members are selected by the community. Health shuras provide leadership and support to all health-related activities in their community. <https://chwcentral.org/the-community-based-healthcare-system-of-afghanistan/>

⁸ Data for the telephone survey were collected using SurveyCTO software. The SurveyCTO programme ensured smooth transfer of data with no risk of data loss or corruption and allowed access to the raw data in real-time.

⁹ Knowledge, risk perception, hygiene practices and sources of information related to COVID-19; the impact of the pandemic on income, livelihoods and food security; and, support received from the Government and coping strategies.

¹⁰ For example, the survey asked about major COVID-19 related challenges for women, men and children separately.

phone numbers of women were collected via CHWs. Initially interviews were planned only with female caregivers in the household, but later it was decided to interview an equal proportion of men and women respondents because in the cultural context of Afghanistan women have limited access to mobile phones, may lack the time and privacy to respond to remote surveys and men are often decision-makers in the household. Data on domestic violence were collected, although the study recognized its limitations as it is not always easy to share such information over the phone with someone who is not known and may put women in danger. Therefore, it recommended specific studies on gender-based violence and suggested, in order to better understand women's contexts and sensitive issues, follow-up interviews at a convenient time proposed by women. Prominent female community members could also be included as key informants. Finally, because of the strong focus on the situation of women and children, female enumerators were used as well as female CHWs.

Because of the sensitive nature of some of the topics included in the rapid assessment, external ethical review was obtained. The UNICEF global Long-Term Agreement (LTA) for ethical reviews was used rather than a local Internal Review Board because of the long process the latter requires. Only respondents in the existing database who had consented to participate in future surveys were contacted for the telephone survey. Data collection was undertaken with the highest consideration of confidentiality. CHWs were trained to collect the data following guidelines for physical distancing and data collection in the context of COVID-19.

Data quality assurance was incorporated in the rapid assessment in several ways. Among others, the supervisor regularly verified the survey data being collected, 10-15% of the survey interviews were monitored through call-backs, and the data were monitored in real-time through the use of Survey CTO software. However, because of the time-sensitivity of the rapid assessment, the telephone survey questionnaire could not be rigorously pre-tested. This might have indicated that the

survey length could be a challenge and allowed for improved translation of questions.

Sampling

The sample size target for the quantitative survey was 1,200 respondents from 19 districts in Herat Province, covering six urban, three peri-urban and ten rural districts. A few smaller districts with less than 50,000 population were excluded from the sampling plan.¹¹ The sample size was divided in equal urban, peri-urban and rural strata (400 respondents each) to allow for disaggregated analysis at the strata level with a margin of error of less than ± 5 and 95% confidence level. Subsequently, the strata sample size was allocated to the districts more or less in proportion to their population size.



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The community health facility served as the primary sampling unit (PSU), while communities within their catchment area constituted a secondary sampling unit (SSU). Out of the 118 health facilities identified in Herat Province for this rapid assessment, 29 facilities were sampled. Subsequently, two to four communities per health facility and 20 households per community were selected. The health facility was used as a PSU because the available sample frame was organized with the health facility as the sampling unit (see below). Health facilities and communities were selected through a combination of purposive and convenient sampling, while

¹¹ Three districts were excluded. This was for two main reasons: first, the household phone numbers in selected districts were not collected in an accessible database and, second, for security and logistical constraints (ATR, 2020, Rapid Welfare Monitoring Assessment of COVID-19 Impact).

households, with at least one female respondent per household, were randomly selected from each of the chosen communities.

The sampling frame for the telephone survey was constructed from an existing database of household phone numbers in Herat Province collected during a previous UNICEF-led evaluation¹² in September and October 2019. As this database did not cover all the districts and urban areas in Herat, CHWs attached to selected health facilities were recruited to enrol 620 additional respondents in the survey (via the random walk approach) and collect their contact details to update the sampling frame.

CHWs, who knew the community well, further purposively selected key informants in their area and collected their phone numbers. Ten health facilities were selected through simple random sampling and from these, one community leader, who was a member of the health *shura*, was interviewed. As all the community leaders were male, five female CHWs were also interviewed.

The actual sample size achieved for the phone survey was 1,279 because of oversampling to ensure sufficient female representation. A challenge was to reach women respondents in rural areas (women comprise 47.4% of rural respondents in Afghanistan; however, only 45% of the rural sample were female respondents).¹³ As fewer women have access to a mobile phone, they remain hidden and it is difficult to speak to a female member of the household if the phone is answered by a male. To reach women respondents and talk to them directly, the database was reviewed to locate female-headed households. At the same time, a sample quota for women respondents in the survey was established and female CHWs were tasked with locating additional eligible respondents in their catchment area. Given that contacting female respondents has been a challenge in national surveys as well, in future to enrol women respondents, in addition to a contact number for the household, women's phone numbers also need to be collected.

Despite limited network connectivity with phone numbers out of reach or switched off, and no telecommunication company working in one area due to the presence of the Taliban, the targeted sample size per health facility in the catchment area was mostly achieved. Two communities had to be replaced with two others in the same district due to network issues. Due to the length of the questionnaire, non-completion of the survey was a risk. To mitigate this, an incentive of 50 AFN in phone credit was provided. To avoid the risk of biasing people's responses, the incentive was only mentioned after consent for the survey was provided. Therefore, the payment was not a direct incentive to participate but functioned as an incentive to complete the survey.

Overall, only nine selected respondents refused to be interviewed and 25 interviews were rejected due to quality issues such as incomplete surveys. The monetary incentive may have contributed to the high response rate (although not the initial interest to participate); as well as the fact that some of the respondents were drawn from an existing project database, people were interested in taking part in the study given that COVID-19 was considered a critical issue, and more than one phone number was collected from respondents.

Partnerships

UNICEF collaborated with ATR to implement the assessment. It led and conceptualized the study, developed the survey tools, provided the sample frame of a previous evaluation and supported the roll-out of the survey. ATR further operationalized the design (e.g. sampling) and was responsible for data collection, data analysis and report preparation.

As physical movement and access to communities was a major issue in the context of the political insecurity in Afghanistan and the lockdown situation, ATR, who had a presence on the ground in most areas of the country, and the experience and resources to conduct surveys in the country, mobilized its networks to implement the

¹² Over 10,000 phone numbers were collected for UNICEF's Community Based Nutrition Package, IHSAN project, which were used as a sample frame for the evaluation of the project.

¹³ ART, 2020, Rapid Welfare Monitoring Assessment of COVID-19 Impact.

assessment. However, given the limited capacity for data collection and analysis, these processes took time (see below). A lesson learned is that UNICEF could have proactively engaged with other UN agencies and mobilize additional resources and capacity, which could have improved the timeliness of the assessment.

The assessment was implemented in coordination with the Ministry of Public Health (MoPH), Government of Afghanistan. The Government's vast network of CHWs was leveraged for the assessment, and the Community Based Health Coordination Department, MoPH, through the Herat Department of Public Health and Agency for Assistance and Development of Afghanistan (AADA), an NGO in Herat, facilitated coordination with CHWs in selected areas.

Agility/timeliness

While this was conceptualized as a 'rapid' assessment, the process took around eight months from conceptualization to reporting. While UNICEF had a comprehensive database of households with phone numbers for Herat Province that could be quickly mobilized, data collection and analysis took longer than anticipated. As the survey tool was long, it required time to administer, and to process and analyse the data. There is a need to be strategic in prioritizing the information that can be collected in a rapid assessment in a short period of time. During analysis it became clear that some of the information gathered in the survey was not required and was not analysed. In a subsequent national survey in Afghanistan conducted by UNICEF and Viamo, a global social enterprise that specializes in mobile technologies for data collection and ICT for development, a shorter tool with focused questions was designed.

While UNICEF began working with ATR to design the study before formal contracting to speed up its roll-out, the procurement and contracting process via UNICEF's supply systems took approximately a month. To make the process more agile, an LTA should be in place, particularly to recruit providers for data collection. For example, the existing LTA for



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ethical reviews allowed ethical review to be obtained in 13 days, which is still long when rapid roll-out of data collection is needed but relatively short compared to when no existing arrangements are in place. In a subsequent survey, UNICEF Afghanistan leveraged UNICEF's global arrangement with a remote survey provider to implement a national survey. Moreover, the data collection process itself should be agile so that it can be quickly activated. UNICEF is working with the Afghanistan National Statistics Information Agency (NSIA) to establish Multiple Indicator Cluster Survey Plus (MICS+),¹⁴ which will ride on the Demographic and Health Survey (DHS) framework and set up a more robust process for rapid data collection, including building capacity and setting up computer systems and basic equipment, and operationalizing it.

Use of findings

Data is perishable, particularly in the fast-changing pandemic situation. The preparation of the draft report was delayed, and by the time the report was finalized, the data were not as useful as they could have been if they had been presented earlier. Nonetheless, UNICEF pre-empted the finalization of the draft report and presented findings from initial analysis at the UNCT Working Group on Gender. Furthermore, UNICEF programmes used the data internally. However, opportunities have been missed to influence the response package to COVID-19 in Afghanistan.

¹⁴ http://mics.unicef.org/methodological_work/7/MICS-PLUS

Summary learnings

The strengths, challenges, learnings and innovations related to the implementation of this rapid assessment are summarized in the table below.

Table: Herat, Afghanistan, rapid assessment: Summary Learnings

Strengths	Challenges
<ul style="list-style-type: none">• Mixed methods approach enabled comprehensive understanding of the situation and allowed for data triangulation to validate accuracy of the findings.• Gender focus in the questionnaire and gender-sensitive data collection permitted analysis by gender and coverage of women's perspective.	<ul style="list-style-type: none">• The survey length, contracting process, prioritization of information to be collected and complex political context required time, which meant that findings could not be disseminated in a timely manner.• Due to time constraints the questionnaire could not be rigorously pre-tested, which could have optimized the tool in terms of length and translation of the questions.
Learnings and innovations	
<ul style="list-style-type: none">• Triangulation of results from multiple data sources (survey, KIIs, observations) can be valuable in addressing the social desirability bias in responses.• Rapid assessments require prioritization of information that need to be collected in a short period of time.• Need to pre-position data collection systems for a rapid response e.g., having an LTA in place for enumerators/data collectors, and working with NSIA on the MICS+ approach.	

For more information visit:

UNICEF Regional Office South Asia website <https://www.unicef.org/rosa/>

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