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ENABLERS AND BARRIERS EXPERIENCED BY PUBLIC HEALTH PROFESSIONALS AND SOCIAL WELFARE WORKERS DURING HUMANITARIAN ACTIVITIES IN CONFLICT AREAS OF KHYBER PAKHTUNKHWA: A QUALITATIVE EXPLORATORY RESEARCH STUDY

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KEYWORDS

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ABSTRACT

Background: Public health professionals and social welfare workers face challenges when providing humanitarian and welfare services in conflict zones. **Objective:** To explore the enablers and barriers experienced by PHPs and SWWs in the provision of services in the conflict zones of Khyber Pakhtunkhwa (KPK). **Methodology:** The qualitative exploratory study was conducted using an exploratory design by conducting interviews with 11 public health professionals and eight social welfare workers working across eight districts of the province. Interviews were conducted online in Urdu and Pashto, translated into English and transcribed for verbatim and thematic analysis. **Findings:** The mean age of the study participants was 33.63 ± 10.06 years. Thematic analysis reported four major themes related to barriers, including security volatility and negative security risks, socio-cultural resistance and gender constraints, logistical deficits and infrastructure failure, and institutional disregard and occupational trauma. The enablers were traditional tribal and religious gatekeeper engagement, tactical and culturally grounded community strategies, and moral altruism and indigenous social leverage. **Conclusion:** Findings of the study reported that active militancy, military operations, clashes, target killings, delayed administrative clearance, restrictions on female mobility, resistance against female empowerment, vaccine hesitancy, infrastructure deficits, and lack of continuity in mobile connectivity and electricity supplies have been common issues, while positive community engagement, the positive role of religious scholars, and cultural norms of hospitality have been enablers of humanitarian services in the study settings.

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Introduction:

Public health professionals encompass a large and varied group of scientists, educators, specialists from different fields, and field workers, whose activities are geared towards the protection and improvement of the health of entire communities and populations.[1] Such workers include epidemiologists, biostatisticians,[2] health education specialists, as well as environmental health scientists, community health workers (CHWs),[3] public health professionals and nurses, policymakers, administrators and social welfare organisations.

Public health professionals are important in finding out the patterns, causes, and diseases in the population, as well as helping in the collection, organisation, and analysis of data and metrics related to community health.[4] Likewise, health education specialists help in the development of programmes which can lead to healthy living, improve quality of life, and lead to disease prevention.[5] During the consequences of climate change, environmental disasters, earthquakes, epidemics, and pandemics of diseases, the role of public health professionals and social welfare workers, as individuals and their organisations as entities, are crucial for ensuring the equitable distribution of healthcare resources to populations.[6]

Pakistan has a long history of humanitarian work; for instance, in the formative years of the country, the All-Pakistan Women's Association (APWA) by Begum Ra'ana Liaquat Ali Khan, [7,8] and the Muslim Women's Association by Mohtarma Fatima Jinnah,[9] established institutions which worked on public health camps, clean water distribution, and vocational training for refugee women. In the years 1951 to 1953, the Government of Pakistan requested assistance from the United Nations, and thus, in 1952, the United Nations Technical Assistance Administration started professional social training courses in the country.[10]

Likewise, the rise of indigenous NGOs has a long history in the country, including Dr Akhtar Hameed Khan's Orangi Pilot Project in Karachi.[11] Similarly, religious and state welfare funds, such as the Zakat and Ushr Ordinance of 1980 and Pakistan Bait-ul-Mal funds,[12] were followed by disaster response in the era of 2000 to 2010, notably the 2005 earthquake in the areas of Kashmir, Balakot, and Battagram, which caused very serious devastation to infrastructure and human lives. This was followed by assistance from multiple welfare organisations from all over the world arriving in the country and providing humanitarian support.[13,14]

This widespread disaster in the country was followed by the establishment of the National Disaster Management Authority (NDMA).[15]

Likewise, the Lady Health Workers (LHW) Programme was initiated, which deployed more than 100,000 community health workers who provide healthcare counselling, routine immunisation, vaccination of pregnant women, and coverage for populations at risk of infectious diseases at their doorsteps.[16] In very recent history, from 2023 onward, the Sehat Sahulat Programme, the Benazir Income Support Programme (BISP), and the inclusion of multiple United Nations agencies, like the World Health Organisation (WHO), UNFPA, and the World Food Programme (WFP), along with

international NGOs such as the International Rescue Committee (IRC) and Action Against Hunger/Action for Humanity, have been providing consecutive support to populations at risk in different areas of the country.[12,17,18]

Comparatively, Khyber Pakhtunkhwa (KP) has been prone to refugee crises, as millions of Afghan refugees migrated into the province, alongside internally displaced persons (IDPs) due to Talibanization, militancy, and ongoing military operations lasting for more than the last two decades, causing serious devastation to the population.[19,20] Simultaneously, frequent climate disasters like flash floods, hard-to-reach remote areas, and healthcare disparities have made Khyber Pakhtunkhwa a hotspot for international and welfare organisations to operate their services.[21,22]

Currently, large organisations providing humanitarian assistance in the province include the Sarhad Rural Support Programme (SRSP), the Al-Khidmat Foundation Pakistan, government-assisted programmes, and influential women-led initiatives such as the Aurat Foundation, alongside the Barkhurdar Foundation and local welfare trusts. Likewise, international humanitarian agencies working in the province include the Alliance 2015 partners, Malteser International, International Rescue Committee, Pakistan Red Crescent Society, the Social Welfare Society developed by Khyber Medical College, Frontier Science Foundation, and other programmes associated with Afghan refugee support.[23,24]

Humanitarian organisations, public health agencies, and social welfare workers have experienced many critical challenges while operating their services in conflict zones, including the Waziristan belt in North and South Waziristan districts, with a history of counterterrorism operations, suicide bombings, and targeted attacks.[25,26] Also, the border and tribal districts, such as Bajaur, Mohmand, Kurram, and Orakzai, have been hotspots with multiple incidents of cross-border firing from Afghanistan, where periodic attacks have devastated routine life and caused serious casualties and mortalities in the region.[27]

The districts of Bannu and Lakki Marwat have also experienced sporadic attacks from multiple sectors, causing accessibility restraints, the emergence of no-go areas, and hostilities within the population against international NGOs and institutions. Thus, this causes severe barriers to the operations of these humanitarian and welfare organisations.[28]

The current study aimed to explore the experiences of public health professionals and social welfare activists working in humanitarian and welfare organisations operating in the conflict zones of Khyber Pakhtunkhwa, and to identify what enablers and barriers are experienced during the operation and deployment of humanitarian services.

Methods:

Study Design

The qualitative exploratory study using semi-structured in-depth interviews was conducted from March 2025 to June 2025 in the Newly Merged Districts (NMDs) of Khyber Pakhtunkhwa (KP). The study was based on the interpretivist paradigm, assuming that humanitarian work and experiences are based on the lived experiences of people involved in the project.[29] The exploratory descriptive design helped in understanding the work experiences of employees involved in humanitarian activities in the conflict-affected districts of KP. As the aim was to understand the enablers and barriers rather than measure them, the qualitative exploratory design best suited the study aims and objectives.

Study Standards

The study was carried out in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) 32-item checklist,[30] while the overall structured Standards for Reporting Qualitative Research (SRQR) were considered.[31] The socio-ecological model was utilised as a framework to assess the individual, interpersonal, organisational, community, and policy-level experiences in terms of enablers and barriers among the participants included in the study.

Study Settings

The study was conducted in conflict-affected districts of KP: Bajaur, Orakzai, North Waziristan, and South Waziristan, including Bannu, Lakki Marwat, and the areas of Parachinar and Tirah bordering neighbouring Afghanistan. From a historical perspective, these areas have been associated with mass displacement of refugees across the border, military operations, IDP movements, and ongoing militancy for more than two decades. Due to the hostile environment in the area, international organisations and national humanitarian institutions have faced several barriers. For this qualitative investigation, 19 employees across different hierarchical levels working in four national and two international partner organisations were involved in the study. In accordance with the policies of the humanitarian and social welfare institutions, the names and details of the organisations were kept confidential.

Population and Sampling Strategy

A purposive sampling technique with a maximum variation strategy was used to help attain the widest possible range of experiences across different types of roles, genders, and employment in different districts. Details about the study were shared online with administrators and public relations officers of the humanitarian and social welfare organisations operating in the study settings, which were then circulated to employees of the organisations. Interested participants had the opportunity to contact the primary data collectors through email.

Based on the eligibility criteria, which required participants to be at least 18 years of age, irrespective of gender identity, with a minimum educational qualification of intermediate level, and working for more than the past one year in their current role, participants were recruited into the study. Exclusion criteria included employees of the organisations in the study settings working remotely or not consistently deployed with responsibilities in the conflict zones of KPK. Participants who did not provide consent for audio recording of the interviews were also excluded. Through purposive sampling, initially seven participants were recruited, and snowball sampling was utilised as a secondary strategy to assist in recruiting further interviewees, resulting in a final sample size of 19 interviews.

Furthermore, details for six additional potential participants were maintained on a reserve list to be interviewed if data saturation was not attained with the initial 19 participants. During the preliminary stages of data analysis, it was confirmed that data saturation had been reached; therefore, the 19 interviews were deemed sufficient for thematic analysis. Data saturation was considered on the basis of recurrent codes and themes and the nature of the data, as there were no more novel themes emerging from the participants' responses.[32]

Table 1: Details of the Study Participants

Type of Respondents	Work Domains	n
Public Health Professionals (n=11)	Polio vaccinators	3
	Routine Immunisation teams	2
	Infectious diseases program workers	2
	Lady Health workers	2
	Climate change and natural disaster responders	2
Social Welfare workers (n=8)	Primary education project workers	2
	Orphan care home workers	3
	Behaviour change interventionists	3

Data Collection

One-to-one interviews were conducted with selected participants through audio calls and audio recording. Interviews were conducted in the local languages of Pashto and Urdu, and were translated into English by two experienced translators. The duration of the interviews lasted from 30 minutes up to 45 minutes. An interview guide was developed earlier and was checked by two experienced qualitative researchers. At the time of the interview, two interviewers were present: one for asking questions and the other for maintaining the recording and audio settings. Consent was obtained earlier for audio recordings, and participants were assured of the confidentiality of the recorded interviews.

Data Analysis

Recordings were transcribed verbatim into the English language by two experienced qualitative researchers. All the transcripts were anonymised for names, places, geographical locations, or any sensitive and identifiable information recorded during the recordings, and were stored on an encrypted, password-protected device accessible only by the primary data collectors and the corresponding author of this study.

After transcription, coding, and further qualitative data analysis, data accessibility was provided to all the authors. In the participant information sheet, the study participants were assured, and it was communicated to all the authors, that the audio recordings would be discarded upon approval and publication of the study.

Interview Guide

The interview guide was developed with details about the introduction, background, and consent, with a short description, including the study questions categorised into questions related to barriers and enablers. The interview guide has been provided in the Urdu language in the appendices.

Data Analysis

Data were analysed using reflexive thematic analysis across six phases. (1) Familiarisation with the data was performed by repeated readings of the transcripts and listening to audio recordings. (2) This was followed by the generation of initial codes. (3) Themes were identified by two experienced qualitative researchers. (4) The developed themes were reviewed against coded extracts and were further evaluated for matching with the entire data set. (5) The themes were defined and named. (6) All the themes were written up in a clear table for thematic analysis.[33] An inductive approach was used to develop codes from the data. It was followed by a deductive step where all the developed themes were mapped under the socio-ecological framework.[34] All the themes were organised into categories of barriers and enablers and were compared between public health professionals and social welfare workers.

Results:

The study interviewed n=19 participants, including 11 public health professionals and 8 social welfare workers (Table 1). Eleven participants (57.9%) were male, and eight (42.1%) were female. Participants worked in eight districts of Khyber Pakhtunkhwa: Khyber (n = 5), South Waziristan (n = 3), Bannu (n = 3), North Waziristan (n = 2), Orakzai (n = 2), Lakki Marwat (n = 2), Kurram (n = 1) and Bajaur (n = 1). Their field experience ranged from 2.5 to 9.0 years (mean 5.3, SD 2.0). The mean age of the study participants was 33.63 ± 10.06. Public health participants included polio vaccinators (n = 3), routine immunisation staff (n = 2), infectious disease project staff (n = 2), lady health workers (n = 2) and disaster and climate relief workers (n = 2). Social welfare participants included WASH and education facilitators (n = 2), orphan care workers (n = 3) and gender,

behaviour change and protection specialists (n = 3). Interviews lasted 30 to 45 minutes and were conducted in Pashto and Urdu languages, later translated to English.

Table 1: Sociodemographic information of the Study participants

ID	Sector	Cadre / Current Role	Gender	Qualification	District Setting	Experience (Years)
P01	Public Health	Polio Vaccinator	Female	Diploma	Khyber	7.0
P02	Public Health	Polio Vaccinator	Male	Intermediate	North Waziristan	3.0
P03	Public Health	Polio Vaccinator	Male	Intermediate	South Waziristan	3.5
P04	Public Health	Routine Immunisation Field Staff	Male	Paramedical Diploma	Bannu	3.0
P05	Public Health	Routine Immunisation Field Staff	Male	Paramedical Diploma	Khyber	3.7
P06	Public Health	Malaria Program Manager	Male	MBBS, MPH, MBA	South Waziristan	9.0
P07	Public Health	Infectious Disease Surveillance Clerk	Male	Bachelors	North Waziristan	4.0
P08	Public Health	LHW	Female	Certification	Khyber	8.5
P09	Public Health	LHW	Female	Certification	Orakzai	3.0
P10	Public Health	Disaster & Climate Relief Worker	Male	Bachelor	Bannu	5.2
P11	Public Health	Disaster & Climate Relief Worker	Male	Bachelor	South Waziristan	5.5
P12	Social Welfare	WASH & Primary Education Facilitator	Female	Bachelor	Orakzai	6.0
P13	Social Welfare	WASH & Hygiene Promoter	Female	Intermediate	Khyber	2.5
P14	Social Welfare	Orphan Care Centre Supervisor	Male	Master	Bannu	7.5
P15	Social Welfare	Orphan Care Centre Field Officer	Male	Bachelor	Lakki Marwat	6.9
P16	Social Welfare	Orphan Care Support Worker	Male	Intermediate	Lakki Marwat	4.25
P17	Social Welfare	Gender & Behavioural Change Specialist	Female	Master	Khyber	7.1
P18	Social Welfare	Community Advocacy Trainer	Female	Bachelor	Parachinar / Kurram	4.7
P19	Social Welfare	Protection & Rights Counsellor	Female	Master	Bajaur	6.2

Overview of Themes:

The qualitative thematic analysis resulted in a total of seven themes and 21 sub-themes. For the barriers, four main themes were developed, as reported in Table 2, including the structural volatility and active security risks, socio-cultural resistance and gender-related constraints, logistical deficits and infrastructure failure, and institutional disregard and occupational trauma. While related to enablers, three main themes emerged, including traditional tribal and religious gatekeeper engagement, tactical and culturally grounded community strategies, and moral altruism and indigenous social leverage.

Among the barriers, the main sub-themes were the security situation, including clashes between militants and the military forces, as well as the targeted killings of community elders, which led to hostilities in the area and IED threats as well. Likewise, the administrative delays related to NOCs and clearance were also reported by n = 17 participants. Due to security issues, most of the administrations of the welfare organisations, as well as from the government side, were reluctant in the provision of security clearances. Related to socio-cultural resistance, the restrictions on female mobility, and likewise the Western-phobia and the rumours related to vaccinations, and the lack of interest of people in the programs were common experiences. Factors related to female empowerment led to specific barriers in the work of the public health professionals.

In the same way, the logistical support, which included the geographical locations and the infrastructure and facilities, for instance, the continuous load shedding and power cuts, cold chain breakdown, and the lack of proper infrastructure for vaccines and other essential medication in the rural health centres, were reported as significant sub-themes. In the same way, the stockouts of essential kits and medications and the geographical locations, the hard-to-reach areas, were reported as key challenges. The fourth and important main theme was institutional disregard and occupational trauma, which were reported as lower pay amounts, delays in approval and availability of stipends, and the lack of insurance as important revealed sub-themes. Likewise, chronic emotional and professional fatigue, physical and psychological well-being, and the lack of resources and facilities to provide such services to the employees working in these areas were reported as experiences of barriers.

Table 2: Thematic Summary of Barriers and Enablers Identified by Key Informants (N = 19)

Category	Theme	Sub-themes	Participants contributing (n)
Barriers	Structural Volatility & Active Security Risks	[a] Clashes, target killings, and IED threats [b] Delayed administrative clearances (NOCs) [c] Checkpoint transit delays and mobile blackouts	n = 17

Barriers	Sociocultural Resistance & Gendered Constraints	[a] Strict female mobility norms requiring [b] Ideological vaccine hesitancy and boycott rumours [c] Backlash against female empowerment programs	n = 15
Barriers	Logistical Deficits & Infrastructure Failure	[a] Severe power cuts and cold-chain breakdowns [b] Frequent stock-outs of essential kits and medicines [c] Rugged Mountain terrain	n = 14
Barriers	Institutional Disregard & Occupational Trauma	[a] Low pay, delayed stipends [b] Lack of insurance [c] Chronic emotional fatigue and absent psychosocial care	n = 16
Enablers	Traditional Tribal & Religious Gatekeeper Engagement	[a] Endorsements from village and community leaders [b] Involvement of the families and friends of the community elders [c] Customary asylum and dispute mechanisms	n = 18
Enablers	Tactical & Culturally Grounded Community Strategies	[a] Reframing programs through faith concepts [b] Inclusion of local women [c] Local schoolteachers, LHW, and volunteer network mobilisation	n = 16
Enablers	Moral Altruism & Indigenous Social Leverage	[a] Importance of welfare work in Islam [b] Shared linguistic fluency and tribal kinship protection [c] Traditional codes of hospitality	n = 19

Among the enablers, the endorsements from the village elders and the community leaders, who were actively participating in the projects and were providing their social support, were reported as the main enabling factor by n = 18 interviewees. Likewise, the involvement of the family and friends of the community elders and the influential people in the community led to an increase in

the people's interest and attainment of the resources and services provided by welfare organisations. Other important sub-themes related to enablers were the reframing of programs through faith concepts and the inclusion of local women, as well as the importance of welfare work in Islam, as Islam as a whole provides consistent teachings in the Quran and Hadith about the importance of cooperation, coordination, and good communication among its believers, and also with the other people living in the communities and surroundings and neighbourhoods. Thus, reframing these teachings into the concepts of social welfare work and the activities of the organisations led to more interest and attainment of the organisational services. Details of the themes and fees have been reported in Table 2, and the thematic map has been provided in Figure 1.

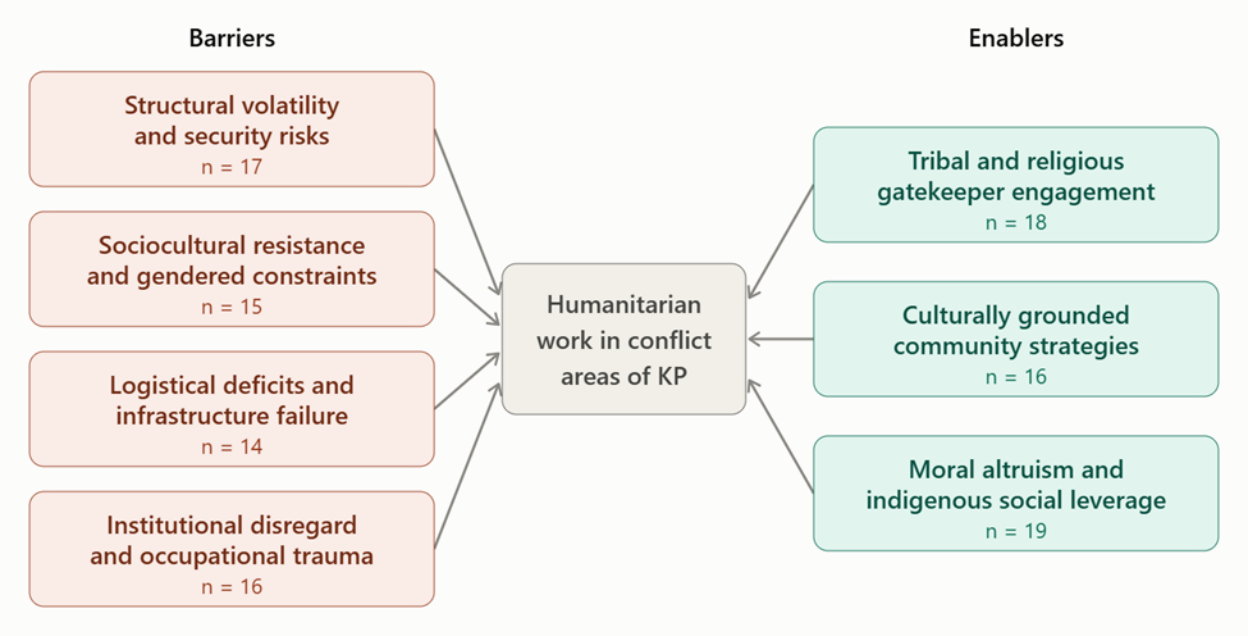


Figure 1: Thematic Map of Enablers and Barriers of public Health and social welfare work in conflict areas

Discussion:

The current study was conducted to explore the experiences of public health professionals and social welfare workers working in the conflict areas of Khyber Pakhtunkhwa. The thematic analysis was further focused on finding out the enablers and barriers experienced by such workers. The study included 19 professionals: 11 public health and eight social welfare workers, including polio vaccinators, routine immunisation teams, professionals working in infectious disease programs, LHWs, climate change and national disaster program workers, the community awareness and health awareness workers, the urban care home workers, and behavioural change interventionists.

Data were collected in eight different districts of the province, including Khyber, South Waziristan, Bannu, North Waziristan, Orakzai, Kurram, and Bajaur. The study was able to develop four themes related to barriers and three main themes related to enablers, while the 21 sub-themes were developed from N = 19 participants. The most important themes included infrastructure issues, security threats, socio-cultural resistance in the areas, gender-related issues, the lack and unavailability of logistics and logistics-related failures, while institutional disregard and occupational trauma were the main themes. Among the enablers were the traditional, tribal, and religious aspects of the society, which helped in effective communication and coordination with the community members, as well as the culturally grounded strategies which helped in the inclusion of the community members towards the organisation's services.

Findings of the current study are parallel to recent research investigations in the area. A study related to the peacebuilding narratives in conflict zones, which elaborated insights from non-governmental organisations (NGOs) working in Afghanistan and Pakistan, reported some important themes, including the strategic framing of peace and the complexities of Afghanistan and Pakistan in the districts on both sides of the borders, as well as the civil narratives in Pakistan and barriers to sustaining peace.[35] Thus, the findings conclude that the experiences of enablers and barriers reported by the participants in the current study are widespread phenomena that have been reported and affirmed by other relevant research findings as well.

Likewise, in the last decade, there has been a history of violent attacks on schools, specifically on girls' schools and educational institutions, and at that time, NGOs played a constructive role in enabling and ensuring the educational attainment of the affected population. The continued armed conflict disrupted the educational services of thousands of children, specifically girls. While in such situations, the evidence affirms the need for effective measures for resuming education, improving school enrolment, as well as psychosocial support and the promotion of quality of education in these areas,[36] which is not possible without the inclusion of the local community elders and the national and international partners.

In the same way, the role of NGOs, the Frontier Crime Regulation (FCR) Act, cultural norms, and basic rights of the population living in the conflict zones have been reported as themes related to social welfare work in the Conflict zones of KPK.[37] The quantitative evidence also elaborated on issues that people in such areas question the availability of other basic healthcare and life necessities, other than services provided by humanitarian organisations. While they simultaneously question the interest of NGOs and the national and international institutions taking very specific interest in some issues while ignoring most of the basic life support and rights of the population.[38]

In the current study, religious beliefs, faith, the inclusion of religious scholars, and the facilitation of religious sentiments were found to be contributing factors towards the acceptability of humanitarian and welfare organisation services in the community. It has been documented in the literature that human behaviour towards the acceptability of healthcare services is influenced by religious beliefs. In Pakistan, specifically, immunisation services tailored towards polio eradication

have remained a key public health challenge. In prior years, the government has used a variety of interventions to increase the accessibility of public health workers and to counsel populations that are resistant to vaccination or refuse it.[39,40]

The current study was helpful in finding out and exploring the barriers and enablers associated with public health professionals and social welfare workers during the provision of humanitarian services in the conflict zones of Khyber Pakhtunkhwa. The findings have reported specific interventions. Furthermore, the findings have explored several important themes, which are the most common issues faced by healthcare professionals, public health professionals, and social welfare workers while providing their services to populations in need in the conflict zones.

The study has several limitations. First, regarding the limited sample size, the $N = 19$participants sample was sufficient to meet the methodological requirements of the qualitative design. However, the study involved a heterogeneous population with different academic backgrounds, experiences, and professional competencies, which leads to the need that a larger sample size could be more helpful in elaborating further essential themes and sub-themes from the qualitative analysis. As the study was conducted in conflict zones, the researchers were unable to physically visit and interview the participants. Thus, all the interviews were conducted online, and due to a lack of constant and consecutive internet connectivity because of technological issues, the interviews were required to stop and resume multiple times, which led to a disruption of focus for the interviewers and interviewees as well.

Future research studies should explore the influence of the reported themes of the current study through quantitative analysis to find out if there is any significant association of these themes with the outcome of ongoing projects through inferential statistics. Meanwhile, qualitative researchers can further extend the findings of the study and can utilise a more inclusive sample size to include more participants from public health and social work backgrounds, and to further explore the needs and requirements in the conflict zones for the successful implementation of humanitarian services. The findings will be helpful for public health students, public health professionals, social sciences students, project planners, and academia. Based on the findings of the current study, future studies can extend the research findings and further explore these significant associations.

Conclusion:

Public health professionals and social welfare workers working in the conflict zones of Khyber Pakhtunkhwa, including the newly merged districts, face structural volatility and active security risks in terms of militant clashes, military operations, target killings, delayed administrative clearances, and electricity and mobile connectivity issues. Restrictions on female mobility, vaccine hesitancy, and resistance to female empowerment programs have been commonly reported barriers faced by humanitarian organisations. Enablers included the active participation of community leaders, the positive role of religious scholars and institutions, empowerment of the community, counselling towards humanitarian services with Islamic religious guidelines and teachings, and the cultural aspects of hospitality.

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Interview Guide

Part I: Introduction & Informed Consent

Welcome to this interview and thank you for your time. This qualitative research study explores and analyses the experiences, observations, barriers, and enablers you have encountered while serving as a public health professional or social welfare worker in conflict-affected areas of Khyber Pakhtunkhwa.

With your permission, we will audio-record this interview to ensure we capture the nuances of our conversation accurately. Please be assured that all information you provide will be kept strictly confidential, and your anonymity will be maintained. The data collected will be used exclusively for academic and research purposes, and all recordings will be securely discarded upon the completion of the study. If you agree to these terms, may we begin the interview?

Part II: Professional Background & Work Dynamics

Q1: Could you please describe your current designation, your core responsibilities, and the specific program or Organisation you are associated with? How long have you been serving in this role, which specific districts or areas do you operate in, and what is the composition of your team?

Q2: How were you deployed or assigned to this particular area, and what is the primary nature and objective of the services you are providing here?

Q3: Can you elaborate on your daily field activities? What specific duties do you perform, and what is the general ground environment like where you work?

Part III: Experiences in Conflict Zones & Barriers

Q4: When providing services in areas with ongoing military or security operations, what practical and operational difficulties do you face during curfews, checkpoints, mass displacements, or general restrictions on movement?

Q5: Could you recall a specific, highly challenging incident you or your team encountered while working in the field? What was the ground situation at that time, and how did you or your team respond to it?

Q6: What are the major barriers and challenges that hinder you or your team from delivering effective services in the field?

Q7: When faced with such severe barriers or security threats, how do you and your team overcome them to maintain your performance and ensure the continuity of your work?

Q8: Overall, what impact do these challenges, barriers, and security restrictions have on the general population of the area and the specific individuals receiving your medical or relief services?

Part IV: Facilitators, Enablers & Strategies

Q9: Can you share a specific instance or campaign where you or your team performed exceptionally well despite highly unfavourable or dangerous conditions? How was this success made possible?

Q10: What are the internal and external factors (enablers) that keep you and your team steadfast and reinforce your performance in difficult situations?

Q11: How do influential community figures, such as political leaders, religious scholars, and tribal elders, facilitate or support your work and service delivery in the field?

Q12: How do you and your Organisation build trust among the residents of this conflict-affected area, and how do you sustain that mutual trust over a long period?

Q13: How do other relevant stakeholders, such as the health department, other NGOs, law enforcement or military agencies, and local leadership coordinate and cooperate with you?

Part V: Recommendations & Future Strategies

Q14: If you were given the opportunity or authority to make a fundamental change to current policies, field procedures, or crisis response strategies, what positive changes or interventions would you recommend?