Presented in this rumour bulletin:
Beliefs that natural treatments or backyard remedies can cure COVID-19, and fears and concerns that people seeking care at health centers are at significant risk of being harmed. These rumours were selected from an analysis of 695 pieces of community feedback. While mentions of health centres only represent a small portion of the feedback gathered they are often rated with a higher risk level due to the potential to deter the community for seeking healthcare for COVID-19 or other serious conditions.

Rumour by Thematic Category

Around 13% of the feedback references religion or a hoax: either that Muslims should not believe in the virus, or that it is typhoid or the common flu. Rumours also persist that the pandemic is an elaborate hoax by foreign governments or the Afghan government in order to access funds. However, rumours and feedback on the theme of treatment/cures and preventative for the virus continue to grow and at 45% of the data gathered, were the most commonly occurring themes.

Many of them claim that onion, ginger, lemon, honey, black seeds, black tea and even drugs such as opium, are preventative or cures for COVID-19. While some natural remedies such as ginger may help to alleviate symptoms there is no approved preventative or cure for the virus and the community risks turning to miracle cures which may contain harmful substances.

Other commonly occurring themes include COVID-19 impacts where much of the feedback was around unemployment, economic hardship, lack of access to education, mental health, violence and lockdowns which demonstrate the concerns that people have in the recent resurgence of cases and the possibility of future hardship.

How we do it:

This rumour bulletin is a collaborative exercise and is produced on behalf of the RCCE working group in Afghanistan. It includes analysis of data contributed by the International Organization for Migration (IOM), Norwegian Refugee Council (NRC), The Jihanjert International Assistance (JIA), Coordination of Rehabilitation and Development Services for Afghanistan (CRDSA), Rural Rehabilitation Association for Afghanistan (RRO) and Afghan Youth Service Organization (AYSD), from 7 October – 2 December 2020, and from Internews media partners: Nai Supporting Open Media in Afghanistan, Pajhwoq Afghan News and Salam Watandar.

Rumours, perceptions, beliefs and concerns were collected through face to face collection, social media listening, listening groups and broadcast audience interactions between 7 October 2020 and 2 December 2020 by humanitarian actors, and between 10 November 2020 and 24 November 2020 by media partners.

Data is assigned a COVID-19 theme* and risk level**. Selection for this bulletin is based on a risk assessment matrix accounting for frequency of the theme, believability of the rumour and potential impact on the community and humanitarian and health services.

Rumour tracking provides insights of what communities may be concerned about regarding COVID-19 and can be used to align communication and engagement activities with community information needs. It is a qualitative and limited process, done on a rolling basis, intended to provide timely insights into trending and high risk perceptions. Feedback collected is not necessarily representative of all groups and cannot be presumed to be exhaustive.
WHY DOES IT MATTER?

- Without a proven cure, it is natural for communities to turn to home remedies and natural treatments they commonly used for other conditions. In times of uncertainty using a treatment that feels safe and familiar can be very comforting and give a person a sense of control. The use of home treatments also helps to cement the idea that the virus is ‘normal’ within their existing reality, negating the need for extraordinary prevention measures. These beliefs may also be coping mechanisms against disease in volatile and low-resource environments such as Afghanistan, where the health infrastructure has been undermined during years of conflict.

- While the use of traditional remedies for mild cases is often not a danger in itself, beliefs in such remedies can increasingly prevent people from seeking medically approved testing and treatment, especially as mistrust in health care services and western medicine increases. Multiple calls in social media to avoid health services and undertake treatments at home have been identified.

- The limited public health resources and testing capacity as well as stigma associated with the virus may be other reasons that are driving people to turn to natural remedies. The likelihood that vaccination is still far away and that only 20% of Afghan people may receive an official vaccine may be also turning people to believe in natural remedies and in treatments such as Alokozai’s drops or ‘snake oil’ which claim to be miraculous. In addition, financial limitations can make perceived affordable treatment options very attractive.

- It is important to continue tracking these beliefs as they may pose additional risks to already vulnerable communities and expose them to harmful and addictive substances such as narcotics. Despite the several attempts to have Alokozai arrested, discussion on social media indicate that he is planning out to roll out further distribution of his treatment. This is critical, as its wide use could lead to increased addiction rates in a country where more than three million people already suffer from drug problems (Latifi, 3/9/2020). These numbers are especially acute among women and children, as the rates of drug abusers among these groups continue rising (Islamic Republic of Afghanistan Ministry of Counter Narcotic and UNODC, 9/12/2015).
**WHAT CAN HUMANITARIAN/HEALTH COMMUNICATORS DO?**

**ACKNOWLEDGE TRADITIONAL APPROACHES TO HEALTH AND DISEASE** and complement communities’ knowledge with science-based recommendations that are tailored to their situation and means. Communities may find comfort in home remedies used within their families for decades, especially if their access to health services is hindered, and often there is no danger in the use of many traditional remedies. Communication around natural treatments should not automatically dismiss their attempts to well-being but it should focus on reinforcing the idea that while these treatments may make people feel better (alleviate symptoms) they are **not cures** for the disease.

**BE REALISTIC** – in many scenarios, at-home care for mild cases of COVID-19 is acceptable. Health systems cannot, and should not, accommodate every case. **Focus communications on actionable information** - helping the community to understand what they can do to help a patient feel more comfortable while they recover and what signs to look for if the patient might require hospital care. Include information about alternative systems of support to access the necessary care i.e. referral mechanisms, out-of-pocket financial support for services, etc.

Support multi-partner communication campaigns through relevant channels and appropriate formats to delegitimize Alokozai’s “treatment”. Use the testimonies of those families who trusted the herbal remedy and suffered negative consequences – either treating COVID-19 or suffering from addictions. However, avoid focusing communications only on Alokozai’s “treatment”, and discuss with communities the dangers of taking any untested substance from an unverified source. There will be many people looking to sell or push remedies and benefit from the communities’ anxieties in this time, so generally increasing awareness of how to recognize fraudulent information and behaviour can be beneficial.

Listen carefully and identify groups which may be at high risk of falling prey to Alokozai’s drops. Hold dialogues with the communities now as a prevention measure for the potential increase in distribution. People may feel tempted to try this remedy if their peers are trusting its effects so it is essential to raise awareness on the damaging impacts of its use and the risks that narcotics pose to individuals, especially children.

**WHAT ARE PEOPLE SAYING**

**Female, 46-60, Bagrami district, Kabul province, Central region**

“When we get sick, we should not go to the doctor because they are giving us their own medicine. Even if we are not sick they will kill us. Some of our friends say that the doctor vaccinated a patient and the patient died.”

The health care system in Afghanistan has been shattered by decades of conflict, disasters and protracted displacement. Despite considerable progress in the health status of the population, Afghanistan continues to report health indicators that require improvement and people continue to face significant challenges to access care. Nationally, 30% of the population lack access to basic services. Health centres are often understaffed, under-trained, under-resourced and in many cases face threat of direct attacks and other forms of violence. Corruption and hidden costs for patients continue to place a burden on the poorest among the Afghan population (MSF, March 2020). Violence, poor transportation and widespread poverty are some factors further hampering access to healthcare centres. People who manage to arrive at clinics often do so with their illness quite advanced.

COVID-19 has exacerbated the already weakened health system and its limited capacity to deal with major disease outbreaks. Acute shortages of beds, ventilators, oxygen and personal protective equipment have been reported, including lack of staff in critical units of care. Healthcare workers struggle to respond to needs as hospitals are increasingly overcrowded (The Lancet, 28/11/2020).

Against this backdrop and lack of reliability in the health system, it is understandable that many Afghans with symptoms prefer to wait out the illness rather than risking a visit to the hospital and waiting for long hours (The Lowy Institute, 12/08/2020). Many people appear to avoid receiving formal healthcare altogether and prefer to rely on home remedies as described in the previous section or opt to risk the outcomes of receiving healthcare outside of the home (The Lancet, 28/11/2020).

The full scope of the crisis is unknown due to extremely limited testing capacity, lack of people coming forward for testing and the lack of a national death registry. The balance on deaths in hospitals is still uncertain. It is likely that people are presenting late to health facilities with more progressed cases of COVID-19: the mortality rate of those admitted to health centres has increased from 2% during the first wave to 8-10% more recently (WHO). As of 20 December 2020, the coronavirus death toll is 2,110 but health officials concede that this number may be indeed higher given the estimations of people who may have contracted the virus. (OCHA: 20/12/2020; Zucchino & Abed, 20/12/2020).

Health Information Systems indicators show that there has been a significant decrease in the utilization of healthcare services during 2020 – particularly hospitalizations, referrals and surgical interventions – which reflects the burden on the healthcare system but also potentially an avoidance of healthcare services by the public.
WHAT CAN HUMANITARIAN/HEALTH COMMUNICATORS DO?

Acknowledge the challenges that people may be facing when trying to access health care services and listen to the concerns that are preventing them from seeking care. Promote networks of support that can address their fears of movement in insecure environments or the lack of transportation, so people do not postpone their visit to the health care center.

Community health workers are strong allies within the communities. As part of the health outreach personnel, they can help demystify hospitals and clinics and bring a trusting face to the communities while building additional confidence in the health system. Their familiarity with the different groups may be used to bring tailored messages that encourage people to seek care when needed and use preventive measures.

Work with respected local leaders and information influencers to safely visit hospitals and see the medicine supplies, and spend time answering their questions and concerns. These influencers can be a valuable tool to encouraging their communities to increase trust in the medical system.

Local media can also play a role in demystifying what happens when a COVID-19 patient is admitted to hospital. Partner with media to help them to show their audience what a hospital is like, interview doctors, nurses and other carers to humanize them and highlight the challenges they are also facing in the pandemic. Profile patients who have recovered from COVID-19 to share their story. Explain what treatment is given, what is the environment like and how can the community recognize when professional care is needed?

Continue to track rumours and perceptions: Barriers to essential health services (e.g. polio vaccinations) – such as reasons underpinning rejection of services – and drivers of mistrust need to be better understood over time. Evidence generated so far has focused on barriers such as limited direct access to services, but a deeper understanding of the perceptions in terms of the motivators or drivers of change is essential to develop appropriate mitigation strategies.

Continue to communicate: Encourage the use of preventative measures (mask wearing, social distancing, avoiding crowded places, handwashing); people exposed to the virus or those with mild symptoms should self-isolate for at least one week. Where there is any concern over the severity of the symptoms including shortness of breath should be encouraged to contact healthcare facilities for assistance or attend a healthcare facility.

WHY DOES IT MATTER?

While there is no reported evidence of intentional malpractice by healthcare workers in relation to COVID-19, these kind of rumours are not new to public health emergencies and this pandemic has already triggered increasing mistrust in healthcare workers and in health systems across the world. The rumour that patients are being harmed, rather than healed in healthcare settings have been monitored by Internews in numerous pandemics, such as recent Ebola outbreaks in DRC. While common, these rumours are already having a serious impact on the likelihood of people seeking care when critically ill. As of 20 December 2020, the Ministry of Health announced that coronavirus death toll is 2,074 however, health officials concede that this number may be indeed higher given the estimations of people who may have contracted the virus and are not included in the official count as they died at home and were buried without official testing.

In Afghanistan, these rumours may be triggered by the genuine limitations of the health care system itself, the documented distrust in authorities and corruption faced by vulnerable communities when accessing health services (Bak 2020, MSR 2020).

Inequality arising from financial capacity to purchase or access healthcare presents a major barrier for access to healthcare services. Private facilities are much less available, particularly in rural areas, and are more costly, and people do not trust public health facilities (Kermani, 29/6/2020).

People may risk their own mortality and morbidity if they believe a COVID-19 diagnosis will require isolation or hospitalization, which in turn may threaten their livelihood. Stigma and distrust of healthcare workers has only increased in the COVID-19 crisis. Poor facilities which people only attend when they are very ill, reports of the burden on the healthcare system during the pandemic and the perception that one will be denied a traditional funeral in the case of death may also be contributing to increased fear and anxiety around accessing healthcare. People may discontinue seeking care for COVID-19 or other serious conditions, increasingly supporting the belief that home treatments are the only alternative. Yet these rumours can also contribute to create further distrust in the health response and in public health messaging and advice, which was already acute since the first lockdown was lifted (Zucchino & Abed, 20/12/2020).
**How is risk defined?**

Risk is measured by the Rooted In Trust Team based on a range of factors including: a) cultural relevancy, b) timing, c) online engagement, d) the believability of a rumor, and most importantly, e) the potential negative impact a rumor may have on the health, well-being, and safety of local communities or service providers.

**HIGH RISK:** A rumour that is very likely be believed among the community with potentially severe impacts resulting in serious harm to an individual or group such as inciting violence or creating widespread fear or panic. High risk rumours may actively encourage avoidance of testing and treatment, or harm towards health workers and other service providers.

**MEDIUM RISK:** A rumor that has the potential to be believed among the community which poses moderate negative impacts to a community or an individual's health, well-being, or safety. Medium risk rumors may have a moderate impact on health-seeking behaviors.

**LOW RISK:** A rumor that is either unlikely to be believed among the community or which would cause minimal negative impacts to a community or individual's health, well-being, or safety or to the pandemic response.

---

References


KIT Royal Tropical Institute. 29/12/2017. ‘The Quiet Dawn of Afghanistan’s Health Systems after Conflict’.


Ministry of Public Health Afghanistan Facebook page.


---

*What themes do we use to categorize rumours?*

- **Testing**: Rumours about testing procedures, efficacy etc.
- **Cause/Origin**: Posts questioning the cause or origins of COVID-19.
- **Treatment/Cure**: Treatment methods, potential or so far unproven cures.
- **Preventative**: Substances or at-home remedies used to prevent contraction or transmission of the virus.
- **Vaccine**: Discussion of vaccines, vaccine trials or vaccination processes and plans.
- **Religion**: Religion and/or religious beliefs or practices.
- **Reinfection**: Information regarding reinfection, reemergence, or relapse in people or animals.
- **Symptoms**: Information describing confirmed or so-far unconfirmed symptoms of COVID-19.
- **Hygiene**: Hygiene practices or products. Advice on so-far unproven hygiene measures to control spread.
- **Travel**: Travel bans, restrictions, road closures, or shutdowns.
- **Prejudice/Stigma**: Expressions of xenophobic, racist, or prejudicial content linked to transmission or contraction of the virus.
- **Healthcare**: Health care options or access to services.
- **Government**: State-mandated regulations or shut-downs related to the virus.
- **Transmission**: Information regarding how COVID-19 spreads.
- **Immunity**: Who can or cannot contract COVID-19 or who is at heightened risk of complications.
- **Impacts**: Any content that claims uncorroborated impacts, either on an individual or the larger community.
- **Hoax**: Claims COVID-19 is not real, a hoax or conspiracy or no longer an issue.
- **Organization**: Information regarding national or local government, or international or local organisations.
- **Food**: relates to food availability or food security (rather than food as a treatment)
- **Other**: For any content that doesn’t fall into the other thematic categories.

---

Have you addressed these rumours successfully where you are working? This bulletin is designed to be a conversation starter among humanitarian, health and government actors. If you have resources, advice or a case study to share, please get in touch! For more information about this bulletin, the Rooted In Trust project, or to learn how to contribute to, or access, these data sets, please contact: Mary Menis, Internews Humanitarian Liaison Officer, mmenis@internews.org

**Have you addressed these rumours successfully where you are working?**