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The Continued Struggle to Access Medical Care in Afghanistan



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Cover picture: Inside the neonatal Intensive Care Unit (ICU) at Boost Hospital, Helmand's primary provincial hospital in the capital Lashkar Gah. © ANDREW QUILTY

Executive summary

After 40 years of conflict, Afghanistan faces yet another period of instability in 2021. Peace negotiations between the Afghan government and the Islamic Emirate of Afghanistan (IEA, also known as the Taliban) have made little to no progress since they began in September 2020. Fighting between government forces and armed opposition groups continues to claim thousands of civilian lives each year while crippling public infrastructure. Violence and insecurity are pervasive throughout the country and show no sign of abating. Healthcare facilities in Afghanistan are attacked more often than almost anywhere in the world, forcing their temporary or permanent closure and depriving millions of access to vital medical services. The humanitarian crisis, compounded by the health and socioeconomic shocks of the COVID-19 pandemic, is worsening throughout the country.

This briefing paper, produced by international medical humanitarian organisation Médecins Sans Frontières/Doctors Without Borders (MSF), features new medical data and accounts from patients, caretakers and MSF clinical staff in Helmand, Herat, Kandahar and Khost provinces. In surveying these groups, MSF found that Afghans today are struggling to access basic necessities, including medical care, as a result of violence and insecurity, poverty, and an under-funded and under-resourced health system. Every day, Afghans must undertake dangerous journeys across active frontlines and mined roads, through checkpoints and areas controlled by armed groups to seek medical care. They are often unable or too afraid to leave their homes, and, when medical emergencies happen, such delays can prove fatal.

MSF brought these issues to public attention in reports released in 2014 and 2020. We publish this new briefing to show that the persistent barriers that Afghans face when seeking healthcare continue to this day.

Poverty in Afghanistan is on the rise. The COVID-19 pandemic has worsened the financial hardship for Afghans. Many have lost their livelihoods as a result of border closures, reduced commercial activity and job losses, and are receiving less in overseas remittances. It is getting harder and harder to feed

themselves and their families, as consumer prices soar. Many Afghans still rely heavily on humanitarian assistance to survive. Direct medical and non-medical costs put healthcare further out of reach for people living in poverty. In responding to our survey, patients and their caretakers reported having to borrow money, sell household goods or reduce spending on other essentials, such as food, in order to afford treatment, medicines and transportation. Many were unable to seek or continue their treatment, with disastrous consequences to their health. MSF is one of the few organisations in Afghanistan offering medical services completely free of charge.

In recent years, the international community has touted the achievements of Afghanistan's healthcare delivery model, despite strong evidence that the health system is unable to meet Afghans' basic medical needs. Public health facilities in Afghanistan are under-funded and under-resourced, lacking qualified personnel, equipment, medicines and medical supplies. Actors, such as MSF, have stepped in to fill important gaps in health service provision. However, the situation is not sustainable, as humanitarian needs multiply and add further pressure on to already overburdened medical facilities. When desperate patients turn to private facilities, in the hope of receiving better medical care, they accrue crippling debts and no guarantees of quality treatment.

At the end of 2020, international donors announced considerable reductions in future funding assistance for the country, and some placed conditions on that assistance. This will increase the pressure on the fragile public health system and on health partners to meet the rapidly growing medical needs of the Afghan population

National and international stakeholders must recognise that basic services, such as healthcare, are insufficient and incapable of addressing Afghans' immediate needs, and that now is not the moment to reduce humanitarian support to Afghanistan. Access to quality and affordable medical care for all must be made an urgent priority.

Introduction

2021 marks yet another period of instability in Afghanistan, with intensifying hostilities and a worsening humanitarian crisis, compounded by the COVID-19 pandemic and its socio-economic impact. National and international actors engaged in negotiations on the political future of the country must not overlook the dire conditions in which many Afghans live and the daily struggles they face in accessing basic necessities, including healthcare.

This briefing provides an updated overview of MSF's concerns regarding chronic barriers to accessing both routine and lifesaving medical care in Afghanistan, and the inability of the health system to respond to the needs of the population. MSF first brought these issues to public attention in the 2014 report, **'Between rhetoric and reality: The ongoing struggle to access healthcare in Afghanistan'**. Published as international coalition forces were preparing to pull out from Afghanistan, it exposed the gap between donor narratives on the success of the healthcare model in Afghanistan and the unmet medical humanitarian needs witnessed by MSF. In 2020, MSF published another report, **'Reality check: Afghanistan's neglected healthcare crisis'**, which showed that there had been no progress in improving Afghans' access to healthcare and that, in some areas, the situation had deteriorated.

Large parts of the population in Afghanistan are unable to access functioning medical facilities near their homes or obtain quality, free medical care. The distances they have to travel, the dangers of armed conflict, violence and insecurity, pervasive poverty, and the costs of receiving medical care remain the most difficult access barriers for Afghans to overcome. At the same time, under-funded and under-resourced healthcare facilities are unable to deliver basic services. Each day, MSF teams in Afghanistan witness the disastrous consequences of these barriers on patients' health.

At the end of 2020, international donors – whose decisions have shaped the current model of healthcare financing and delivery in Afghanistan – announced considerable reductions in future funding assistance for the country, and some linked that assistance to politically motivated conditions.¹ This will increase the pressure on the fragile public health system and on health partners to meet the rapidly growing medical needs of the Afghan population.

Among the 80 patients and caretakers surveyed in MSF-supported medical facilities in February 2021:

- 74 per cent identified cost as a key barrier to seeking healthcare (relating to travel, overnight accommodation, treatment and medication).
- 40 per cent identified healthcare costs as one of the most pressing financial pressures on their household (payment for surgery and medical treatment, including chronic diseases).
- 56 per cent had borrowed money from relatives or acquaintances to cover the costs of healthcare, and 38 per cent said that they had sold household goods or animals.
- 46 per cent reported delaying healthcare in the past year and 31 per cent had suspended ongoing treatment, mainly due to medical costs and insecurity.
- 33 per cent said that violence and insecurity was one of the main obstacles to reaching medical care.

¹ European Union External Action Service, 2020, https://eeas.europa.eu/sites/default/files/key_principles_paper_final_handover.pdf



MSF's work in Afghanistan 2020–2021

MSF is a medical humanitarian organisation, which operates under the principles of independence, impartiality and neutrality. Since the 1980s, MSF has provided medical care throughout Afghanistan, in areas under the control of a variety of political and armed factions. Currently, MSF runs projects in five provinces:

- **Helmand:** MSF supports the emergency, surgery, maternity, inpatient, neonatal and paediatric departments in the 300-bed Boost hospital in Lashkar Gah. Data for 2020: around 111,600 patients admitted to the emergency room, 28,800 patients admitted to the inpatient department, 18,000 deliveries assisted, 5,000 major surgeries performed, and 2,200 children treated for severe acute malnutrition.
- **Herat:** MSF runs an outpatient clinic and outreach activities for internally displaced people (IDP) and host communities. MSF also runs an inpatient therapeutic feeding centre (ITFC) and COVID-19 triage at the Herat Regional Hospital (HRH). Earlier this year, MSF ran a 32-bed COVID-19 treatment centre. Data for 2020: around 70,500 consultations at the outpatient clinic, 1,700 children treated for severe malnutrition and 350 patients treated at the COVID-19 treatment centre (now closed).
- **Kandahar:** MSF provides screening and treatment for patients with drug-sensitive and drug-resistant tuberculosis (DS-TB and DR-TB). Data for 2016–2020: around 119,700 DS-TB screenings, 10,300 DS-TB consultations, 740 patients treated for DS-TB and 174 patients treated for DR-TB.

- **Khost:** MSF runs a 60-bed maternity hospital; one of the busiest in Afghanistan. Data for 2020: around 14,400 deliveries assisted and 1,700 newborns admitted to the neonatal unit.
- **Kunduz:** A wound care clinic ran from 2017 to April 2020, when activities were suspended due to COVID-19, and since 2015 MSF has been supporting a district advanced post in Chardara. Construction is currently underway of a new trauma hospital in Kunduz to provide life- and limb-saving care for injuries caused by violence and accidents. Data for January to April 2020: around 8,500 dressing sessions and 830 emergency trauma consultations.
- **Kabul:** In June 2020, MSF was forced to close its activities in Kabul's 100-bed Dasht-e-Barchi hospital following the murder of mothers, children and staff in the MSF-supported maternity ward. Until the 12 May attack, the MSF team in the hospital had assisted around 5,600 deliveries in 2020.

In all locations MSF provides medical care free of charge. MSF currently employs 2,000 Afghan staff and 100 international staff around the country. In Afghanistan, MSF relies solely on private funding and does not accept funds from any government for its work. In 2020, MSF's total expenditure in Afghanistan was \$35.3 million.

Methodology

This briefing is a continuation of the two previous MSF reports on access to healthcare in Afghanistan, which focused first on Kabul, Helmand, Khost and Kunduz provinces (2014), and then on Helmand and Herat provinces (2020).

This briefing is based on responses provided by 80 male and female patients and caretakers, which shed light on the current obstacles preventing access to healthcare. These individuals were surveyed over two weeks in February 2021 in MSF projects in Helmand, Herat, Kandahar and Khost provinces. Adding to this, 16 semi-structured interviews were carried out with patients, caretakers and MSF staff between October 2020 and March 2021. Additional health data and indicators were collected from the 2020 and 2021 medical reports of health facilities supported or run by MSF.

The results of the surveys and interviews cannot be extrapolated as countrywide results due to the narrow sample size and convenience sampling (as opposed to random sampling) method. Data collection focused exclusively on patients who sought treatment at MSF medical facilities and did not include patients from the wider population who may have chosen to go elsewhere. However, combined with the MSF medical data collected for the 2014 and 2020 reports, the results do provide a picture of the barriers to accessing healthcare that exist in Afghanistan. Since the patients and caretakers who participated in our research were able to access healthcare in one of MSF's facilities, the results may underestimate the true extent and types of barriers facing those who never managed to reach us.



People in front of the main gate of the Boost hospital in Lashkar Gah. © ELISE MOULIN

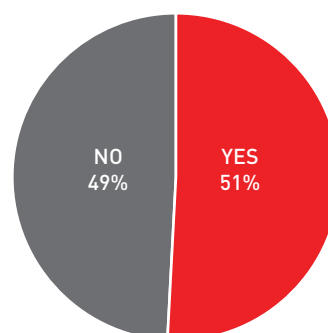
Humanitarian context 2020–2021: Violence, economic hardship and uncertainty

The magnitude and severity of health and humanitarian needs in Afghanistan are overwhelming, with people affected across regions, gender and age. War, political instability and the ongoing COVID-19 pandemic have had a devastating impact on the population.

In 2021, the political situation remains uncertain, and the fighting shows no signs of abating. An agreement signed between the United States (US) and the Islamic Emirate of Afghanistan (IEA, also known as the Taliban) in Doha in February 2020 paved the way for a further reduction in the number of US troops stationed in Afghanistan, with all foreign troops expected to leave by 1 May 2021. It also began a process of peace negotiations between the Afghan government and the IEA, which formally commenced in September of that year. So far, the negotiations have not produced any meaningful results and have not put an end to the violence. On the contrary, during the final three months of 2020 the number of civilian casualties increased in comparison to the same period in 2019, mostly as a result of improvised explosive devices (IEDs) and targeted attacks. In 2020, **8,820 civilian casualties were recorded, including 3,035 deaths and 5,785 injured**. Almost half of the victims were women and children.² In what the IEA has viewed as a violation of the Doha agreement, the Biden administration announced in April 2021 that US troops would completely withdraw from Afghanistan by 11 September of this year. The impact of this decision and the end of a 20-year-long international military presence on political and security dynamics in the country remains to be seen.

In 2020, **violence forced around 400,000 Afghans to flee their homes**.³ Displaced people face inadequate living conditions and struggle to secure jobs and basic necessities, heightening their feelings of vulnerability and uncertainty about the future. Around half of the patients and caretakers surveyed in February 2021 had been forcibly displaced at least once in the previous 12 months.⁴

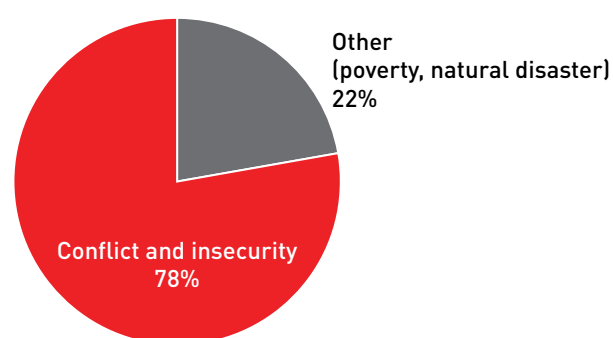
In the past year, have you or your family experienced displacement?



Source: MSF survey, MSF facilities in Helmand, Herat, Kandahar and Khost, 2021

In all four provinces where MSF conducted the survey, the majority of those affected by displacement cited ongoing fighting between the government and armed opposition groups (AOGs), insecurity or direct threats against their family as reasons for leaving.

Why were you displaced?



Of the 41 respondents who experienced displacement in the past year, four cited two reasons for being displaced, i.e. the total number of responses for this question was 45.

Source: MSF survey, MSF facilities in Helmand, Herat, Kandahar and Khost, 2021

² UN Assistance Mission in Afghanistan, Afghanistan: Protection of Civilians in Armed Conflict Annual Report 2020, February 2021, https://unama.unmissions.org/sites/default/files/afghanistan_protection_of_civilians_report_2020_revs3.pdf

³ UN OCHA, Internal Displacement Due to Conflict, <https://www.humanitarianresponse.info/en/operations/afghanistan/idps>

⁴ The highest displacement rates were reported by MSF patients and caretakers in Herat, Helmand and Kandahar provinces: 75, 70 and 55 per cent of respondents respectively.

"I am from Badghis province. The reason we came here is because of the fighting between the Taliban and the government. The Taliban and government are not establishing peace with each other. The government kill the Taliban and when the Taliban find the opportunity, they kill the government. Poor and innocent people have been suffering and try not to come between them."

Female patient, MSF outpatient clinic, Herat province.

According to the United Nations, an estimated **18.4 million Afghans will require humanitarian assistance in 2021, six times more than four years ago.**⁵ Afghanistan is also facing shortfalls in expected rainfall and a moderate-to-high risk of drought, which will further affect people's livelihoods and access to food, and could force more families from their homes.

The COVID-19 pandemic has placed additional strains on the health system. Since the beginning of the outbreak in Afghanistan, **nearly 57,000 people have tested positive for COVID-19 and 2,487 have died.**⁶ As of mid-February 2021, **at least 90 health workers had died from the disease.**⁷ Since cumulative sample numbers are relatively low and testing is limited to government centres in cities like Kabul, the true scale of COVID-19 transmission countrywide is likely to be much higher.



Noor Ahmad Nasrat, health promoter, speaking to a patient in MSF's COVID-19 treatment centre, Gazer Ga, Herat.

© WASEEM MUHAMMADI

It is difficult to determine the full scale of the impact of the pandemic on Afghanistan's healthcare system. COVID-19 has necessitated movement restrictions and caused delayed and interrupted healthcare. It has reduced the capacity of medical facilities to maintain regular services, due to the high numbers of infected health workers on sick leave, further disrupted immunisation campaigns, and worsened already-chronic vaccination gaps. It has also led to community reluctance to seek healthcare due to fears of contracting the virus while in medical facilities.

From the outset, medical facilities in Afghanistan, including those supported or run by MSF, were directly affected by the COVID-19 pandemic. In Herat, as many staff became infected and could not provide care, MSF made the decision to reduce the number of beds in the ITFC, halving the hospitalisation capacity for several weeks in 2020. Our volume of activity and response to malnutrition decreased significantly during this period.

The socio-economic impact of the pandemic has been immense. Patients surveyed shared their experiences of job losses, reduced income, falls in remittances, increased debt and worsening food insecurity, all of which may then negatively impact access to healthcare.

"We migrated from Faryab province one and a half years ago. We don't have proper water, winter supplies or any medicine. Our children go to sleep without food, hoping to receive some the next day. We don't have money to buy anything. There is no market for jobs in Herat. People work for 500 and 1,000 Afghanis (the equivalent of US\$6.50 and US\$13) per day, we are ready to work for 20 Afghanis (US\$0.26)."

Male patient, MSF outpatient clinic, Herat province.

At the Afghanistan Conference at the end of 2020, donors pledged US\$12 billion for the period 2021–2024, far less than the US\$15.2 billion pledged in 2016 for 2017–2020. International funding cuts are adding to the already substantial challenges faced by healthcare and humanitarian actors working in Afghanistan.

⁵ UN OCHA, Afghanistan: COVID-19 Multi-Sectoral Response, Operational Situation Report, 18 February 2021, https://reliefweb.int/sites/reliefweb.int/files/resources/operational_sitrep_covid-19_18_february_2021_final.pdf

⁶ Ministry of Public Health of the Government of Afghanistan, 6 April 2021, <https://moph.gov.af/dr/%D8%AA%D8%AD%D9%84%DB%8C%D9%84-%D8%A2%D8%AE%D8%B1%DB%8C%D9%86-%D8%A7%D8%B1%D9%82%D8%A7%D9%85-%DA%A9%D9%88%D9%88%DB%8C%D8%AF-19-%D8%AF%D8%B1-%D8%AC%D9%87%D8%A7%D9%86-%D9%88-%D8%A7%D9%81%D8%BA%D8%A7%D9%86%D8%B3%D8%AA%D8%A7%D9%86>

⁷ UN OCHA, Afghanistan: COVID-19 Multi-Sectoral Response, Operational Situation Report, 18 February 2021

Attacks on healthcare

In the last two decades, all parties to the conflict, including armed opposition groups (such as the IEA), the Afghan government and international coalition forces, have demonstrated a deadly lack of respect for International Humanitarian Law. There have been direct attacks and threats against healthcare facilities, personnel and patients; killings; abductions; indiscriminate attacks causing collateral damage; and the forced closure of medical facilities.

The number of attacks against healthcare facilities in Afghanistan is among the highest in the world.⁸ In addition to creating a climate of fear, such attacks severely limit access to vital medical services by forcing health providers to suspend or discontinue activities. The World Health Organization (WHO) estimates that **up to three million people were deprived of essential health services in 2020 as a result of health facilities forced to close by parties to the conflict.**⁹

Attacks on healthcare – MSF's experience in Afghanistan

On 12 May 2020, several armed men forced their way into the MSF-run maternity ward of the Dasht-e-Barchi hospital in Kabul. They shot dead 24 people, including 16 mothers, an MSF midwife, and two children aged seven and eight.

A month later, MSF closed its project in the hospital, which had served one million people – most of them from the Hazara community. The Dasht-e-Barchi maternity ward had been one of MSF's largest maternal healthcare projects worldwide, with almost 16,000 deliveries in 2019. This assault by unidentified perpetrators shocked the country and the rest of the world for its brutality.

On 3 October 2015, a wave of targeted air strikes by US Armed Forces destroyed the main building of the MSF trauma

hospital in Kunduz. The consequences of the attack were devastating: 42 people were killed, including 24 patients, 14 staff and four caretakers. The attack greatly reduced the availability of lifesaving care in the region and left an indelible mark on MSF in Afghanistan. MSF has been gradually re-establishing its operations in Kunduz since 2017.

On 2 June 2004, five MSF staff members were killed in an ambush on a clearly marked MSF vehicle in the northwest province of Badghis. When no arrests were made following this targeted assassination, MSF left Afghanistan, shutting facilities in 13 provinces, where over 1,400 staff had provided medical care. MSF returned to Afghanistan in 2009.

⁸ WHO, Surveillance System for Attacks on Health Care, <https://extranet.who.int/ssa/Index.aspx>

⁹ UN Assistance Mission in Afghanistan, Afghanistan: Protection of Civilians in Armed Conflict. Annual Report 2020, February 2021.



The entrance to the psychosocial unit and office of the Dasht-e-Barchi maternity in Kabul, after the attack on 12 May 2020. © FREDERIC BONNOT

Conflict, violence and insecurity: caught between the frontlines

In 2021, Afghans seeking medical assistance are forced to take extreme risks and face insecurity, violence and criminality to reach healthcare facilities. This is consistent with MSF findings reported in 2014 and early 2020, with current trends indicating a potential deterioration of the situation.

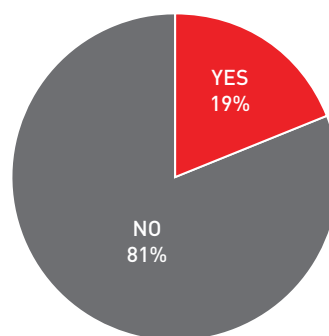
Patients and caretakers say that they weigh up various factors – including the possibility of mined roads and IEDs, ground fighting, checkpoints and criminality – before seeking medical care. A third of those surveyed by MSF identified violence and insecurity on the roads as a key obstacle to seeking healthcare in 2020. In Helmand, in particular, this was cited by 60 per cent of respondents. Movement at night is often impossible, even for ambulances, and the few taxi drivers willing to take the risk charge enormous amounts.

“My son and one other person were injured when their generator caught fire; he was burnt. We came straight here. A journey that should take one hour took four hours. We come from Marja district. There is another clinic three hours’ drive from our village, but the quality of care is not good. From 5pm until the morning the road is closed and you cannot come, even if you’re dying you cannot come. The landmines are activated at night and there is only one road. Sometimes people passing get caught up in the fighting on the frontline. Our area is surrounded by armed groups and even sometimes during the day we cannot travel.”

Male caretaker, Boost hospital, Helmand province.

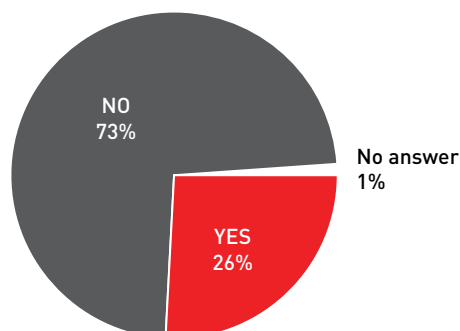
Patients trapped on the wrong side of the frontline arrive at medical facilities in critical condition due to delays, which results in an increased number of deaths. Few health facilities operate around the clock and it is common for some clinics to close at noon. Since many patients wait until daylight to take the road, due to insecurity, they do not always make it in time to see a doctor. On average, 26 per cent of patients and caretakers surveyed in February 2021 said that they had lost a family member in 2020 due to a lack of access to healthcare. In Helmand province, where violence is a major factor, this rose to 45 per cent.

2013: In the past year, has a family member or close friend died as a result of their lack of access to healthcare?



Source: MSF survey, MSF facilities in Helmand, Kabul, Khost and Kunduz, 2013

2021: In the past year, has a family member died as a result of their lack of access to healthcare?



Source: MSF survey, MSF facilities in Helmand, Herat, Kandahar and Khost, 2021



Ahmadullah with his nephew Samiullah, 12 years old, who suffered a gunshot wound to the head on 4 May 2021. © MSF/TOM CASEY

“My pains started in the evening. I thought they would go away. When the call to prayer was given in the late evening, they started to worsen. I told the men in my family that we should go to hospital. They said that we will be attacked on the way and that I should tolerate it until the next day. If I had come to hospital, maybe I would not have lost my child. Because of the insecurity, I lost my child. There are no taxis in Khost province. If you do not have a family car, you have no access to cars in the villages. Even if you have a car, you cannot drive it because of security problems.”

Female patient, MSF maternity hospital, Khost province.

In Kandahar city, the majority of the patients enrolled in the MSF DR-TB treatment programme come from the neighbouring provinces of Helmand, Uruzgan, Zabul and Paktika. Every month, they must make long journeys, at times crossing multiple frontlines, for their treatment. As a mitigating measure, MSF provides accommodation, and supplies patients with a buffer stock of medicines in case they cannot move due to fighting.

“There were problems and security issues on the way to Kandahar. Sometimes we would wait for one or two days due to fighting or due to constant rain and flooding during winter. There have been times when we have waited for five hours for the fighting between the Taliban and security forces to stop. The one-hour journey would become five hours long. The road was secure in the past. Sometimes, we have to travel through the mountains and we feel very tired and in pain.”

Male patient, MSF TB treatment centre, Kandahar province.

Furthermore, health facilities have limited capacity to treat traumatic injuries and emergency cases. The influxes of war-wounded and internally displaced people can put additional strain on already overburdened facilities and risks a reduction in overall services.

Between 11 and 14 October 2020, MSF witnessed the devastating impact of armed conflict on the civilian population and health providers in and around Lashkar Gah city in Helmand province. The MSF-supported Boost hospital admitted 68 patients, including women and children, who had been injured by shelling, blasts and gunshots. They were referred

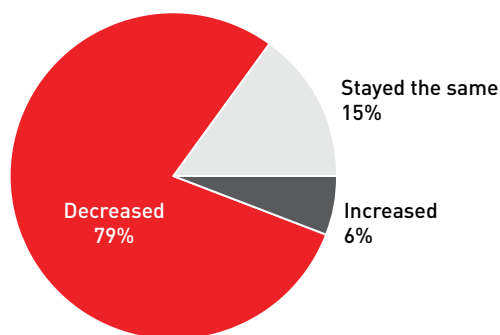
to MSF by Emergency, an Italian NGO providing free surgical care for the war-wounded, as they faced a surge of patients.

In 2021, hostilities escalated again in Helmand. Between 3 and 11 May, Boost hospital admitted the overflow of patients from Emergency and treated 93 people for war-related injuries.

Poverty puts healthcare beyond reach, especially for Afghans in rural areas

In 2020, the World Bank projected that the poverty rate in Afghanistan would increase between 61 and 72 per cent over the year.¹⁰ It is estimated that 80 per cent of those who do work have precarious jobs¹¹ and earn low wages. Among patients surveyed in February 2021, 79 per cent declared that their family income had decreased in the past year.

In the past year, has your family income increased, decreased or stayed the same?



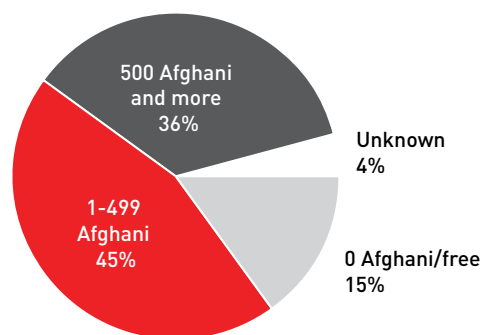
Source: MSF survey, MSF facilities in Helmand, Herat, Kandahar and Khost, 2021

The economic crisis, exacerbated by the COVID-19 pandemic and related public health mitigation measures, is widely felt in Afghanistan. Higher prices for food and other goods, combined with lower wages and earnings, are driving large parts of the population deeper into poverty and food insecurity. As most Afghans depend on agriculture to make a living, they are vulnerable to frequent natural disasters such as flooding and drought.

As poverty worsens across the country, Afghans are struggling to afford basic necessities, including healthcare. Among the patients and caretakers surveyed in February 2021, 40 per cent identified healthcare costs (payment for surgery and other medical treatment, including chronic conditions) as one of the

biggest financial pressures on their household. Over a third of respondents paid more than 500 Afghani (the equivalent of US\$6.50) in transport costs from their home to MSF health facilities. This is more than three times the US\$1.90 purchasing power parity earned each day by about 40 per cent of the employed population in Afghanistan.¹²

How much did you pay to reach this MSF facility?



Source: MSF survey, MSF facilities in Helmand, Herat, Kandahar and Khost, 2021

"We lost one of our family members due to lack of money. We were asked to pay the clinic 1,500 Afghanis (around US\$19.50) but we had less than 20 Afghanis (US\$0.26). We consider 1,000 (US\$13) or 1,500 Afghanis to be like a million, but it is nothing for them. We are living in the desert with no shelter. We have received no support. No one can live a morning in this desert, but we have been living here for days, weeks and months."

Male patient, MSF outpatient clinic, Herat province (quoted above).

An estimated **75 per cent of Afghans live in rural areas**.¹³ Many are cut off from health services by distance and poor roads and infrastructure, especially in contested areas and areas that are outside of government control.

¹⁰ World Bank Group, Surviving The Storm: Afghanistan Development Update, July 2020, <https://reliefweb.int/sites/reliefweb.int/files/resources/Afghanistan-Development-Update-Surviving-the-Storm.pdf>

¹¹ UNDP, Afghanistan Country Page, <https://www.af.undp.org/content/afghanistan/en/home/countryinfo.html> Islamic Republic of Afghanistan Central Statistics Organization, Afghanistan Living Conditions Survey 2016–17, https://reliefweb.int/sites/reliefweb.int/files/resources/alcs_2017.pdf

¹² Asian Development Bank, Poverty Data: Afghanistan, 2019, <https://www.adb.org/countries/afghanistan/poverty#:~:text=Poverty%20Data%3A%20Afghanistan,die%20before%20their%205th%20birthday>

¹³ UNDP, Human Development Reports: Urban Population, 2019, <http://hdr.undp.org/en/indicators/45106>



The Shahrak-e Sabz informal settlement for displaced people, located on the outskirts of Herat City. © ANDREW QUILTY

“There is no doctor in our village. There is one person who knows how to read and write, and they have started dispensing medication, but if you take that you get worse. In the town three hours’ drive away, there are some private clinics, but they’re no good. We live in the desert with no access to healthcare. And there are economic issues. Some people can’t find the money to get help even if they have a patient at home; they wait for God to do something. I told a nurse from my district who works here to find a health worker to come and work in the village and I will give them my house.”

Male caretaker, Boost hospital, Helmand province (quoted above).

Some patients reported buying less medicine than the prescribed amount to limit their expenses or because they had been unable to pay the full cost.

“There are patients that cannot buy all the drugs because of financial problems; they buy half of them and then they cannot buy the rest. Where they live, there is no medical facility to provide TB medication. They come here because MSF gives medicine free of charge.”

MSF nurse, MSF TB treatment centre, Kandahar province.

In February 2021, the overwhelming majority (81 per cent) of the patients and caretakers surveyed said they had experienced financial difficulties as a result of spending on healthcare. To reach and pay for medical care, 56 per cent said that they had been forced to borrow money in the last year, and 30 per cent had to reduce spending on other essential needs, such as food. This is consistent with trends recorded by MSF in both 2014 and 2020.

Delayed and obstructed access to healthcare results in serious medical complications or death

Many Afghans in need of medical care face long waits and complicated journeys to overcome obstacles related to violence, insecurity and cost; during which time their health condition may seriously deteriorate. This can lead to dangerous coping strategies, which MSF has recorded over the past eight years.

In February 2021:

- 46 per cent of patients and caretakers surveyed said they had delayed seeking medical care when they were ill or injured in the past year, mainly due to costs and insecurity
- 31 per cent had to suspend ongoing treatment, mainly due to costs and insecurity

At MSF facilities, our medical teams regularly witness the consequences of late arrival, especially among children, women, and patients with chronic diseases.

When MSF assessed the hospital in Lashkar Gah in 2010, we found a 30 per cent mortality rate. This was largely as a result of low staff numbers, and patients who were unable to reach the hospital before their condition had become life-threatening. In 2020, the mortality rate was seven per cent. While more patients are able to reach the hospital in time than before, some patients continue to arrive with advanced medical conditions. In 2020, in the Boost hospital paediatric intensive care unit nearly 50 per cent of child deaths due to severe acute malnutrition occurred within 24 hours of admission – many had come too late and at a very advanced stage of the illness.

“The cases I see in our emergency room are very often in a critical condition. One major problem is that many of the children are brought to our facility by their families when they are already very sick, and sometimes it is too late for us to save them. The reasons for the late arrival are dire economic conditions and travel from very remote areas that are affected by conflict. The families decide to take the costly, strenuous and dangerous trip to Lashkar Gah only once their children need urgent medical care. Conflict and poverty are also the reasons that generally lead to malnourishment among children in the region.”

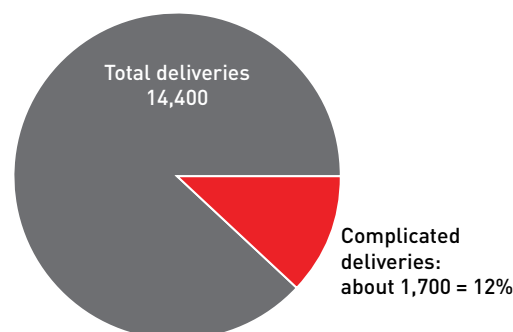
MSF doctor, Boost hospital, Helmand province.

The situation is similar in other MSF facilities. In 2020, patients travelled to the regional public hospital in Herat province, where MSF runs an ITFC, from distant districts and

neighbouring provinces, such as Farah (235 km away), Ghor (172 km) and Badghis (160 km). They travelled long distances when hours can mean the difference between life and death for ill or injured people.

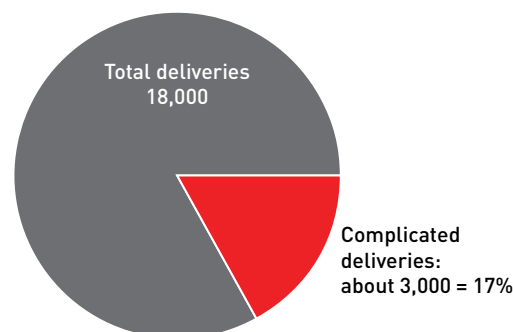
Similarly, 42 per cent of the mothers who gave birth at the MSF Khost maternity hospital last year came from other districts within the province. In Afghanistan, many deliveries take place at home without a skilled birth attendant. MSF teams frequently admit women in serious condition who have attempted to deliver at home and suffered complications, such as post-partum haemorrhage.

Deliveries at MSF Khost maternity hospital



Source: MSF medical data, MSF maternity hospital, Khost province, 2020

Deliveries at Boost hospital



Source: MSF medical data, Boost hospital, Helmand province, 2020



A medical team preparing for surgery in the operating theatre, Boost hospital, Lashkar Gah © TOM CASEY

“One of my aunts died during childbirth. At midnight she went into labour and her husband asked his mother to come and assist her, and they tried and tried. At 8am, they decided to go to Mirwais Regional Hospital. From the district where they live, it takes three to four hours to reach the hospital. When she arrived, she had lost so much blood that she died.”

MSF nurse, MSF TB treatment centre, Kandahar province.

Nearly half of patients and caretakers surveyed in February 2021 stated that their illness or injury, or that of the person they are caring for, either did not improve or worsened because of delays in seeking healthcare or suspending ongoing treatment.

TB, for instance, is a disease associated with high mortality rates when patients are not given adequate treatment. The virus is easily transmissible in enclosed and overcrowded spaces, therefore putting people living in IDP or refugee camps, as well as women and young children who are often confined to the home, at high risk. To be cured, patients must complete the full TB treatment regimen, which lasts six to nine months. This can be particularly difficult for those who need to travel hundreds of kilometres to reach the nearest treatment centre. Those who interrupt or default on their treatment or take low-quality drugs can develop DR-TB, which is equally contagious and deadlier. At least 2,400 cases of DR-TB were registered in Afghanistan in 2019,¹⁴ with many more Afghans likely affected but who could not be reached or diagnosed. By providing housing and food, and reimbursing transportation costs for patients coming from far away, MSF aims to lift, or at least minimise, access barriers for DR-TB patients, allowing people to complete their treatment.

¹⁴ Sophie Cousins, Tuberculosis hits more men than women. But not in Afghanistan, The New Humanitarian, 24 February 2021, <https://www.thenewhumanitarian.org/news-feature/2021/2/24/tuberculosis-hits-more-women-in-afghanistan>

A health system failing to provide satisfactory care

Public healthcare in Afghanistan is based on the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS), which were designed by international donors to cover primary healthcare needs and improve secondary and tertiary medical services.¹⁵ Under the BPHS, about 80 per cent of public health services are contracted out to international and national NGOs, with the remainder provided by the Afghan Ministry of Public Health.¹⁶

The WHO reported that, as of 2018, 3,135 healthcare facilities were termed “accessible”. This meant that 87 per cent of the population could access one of them with less than two hours travel from their home.¹⁷ However, quantity is only one part of the equation. MSF’s findings in 2014, 2020 and in this briefing show that availability and proximity do not equate to access when patients cannot cover the cost of consultations, drugs, tests or transportation. Major gaps persist in the quality and functionality of the health system.

Most of the patients and caretakers surveyed in February 2021 had travelled to an MSF medical facility instead of to one closer to their home (whether public or private) in response to a recent illness in their household. In Helmand and Khost, the rate was 80 per cent. People avoided going to nearer facilities for a variety of reasons. These included the requirement to pay for medication, the poor quality of services provided, disrespectful treatment of patients, a lack of attentive staff or necessary medication, and overcrowding.

“There is a public health centre close to my home. They don’t write your name and they make you wait, and then they say that they don’t have the medication that you need. I went one time to that health centre to get vaccinated, but the staff shouted at me and I never went back. At the public clinic, the doctors only give you three or four tablets; they say that you are lying about being sick or about your child being sick, and that you don’t need more medication.”

Female patient, MSF maternity hospital, Khost province (quoted above).

Among the surveyed patients and caretakers who had visited a public medical facility in the last year, 45 per cent said they were not satisfied with the services provided. While their experience of the health system may be subjective, these patients and caretakers are not alone in identifying the shortcomings of public healthcare delivery. An assessment of the public health system, conducted by the Ministry of Public Health and published in November 2020, identified performance gaps and challenges, and made recommendations to donors, authorities and service providers for improving primary healthcare.¹⁸ The Balanced Scorecard Report, the external monitor for the BPHS system, published in September 2020, identified similar concerns. It pointed to BPHS patients as being less satisfied due to challenges with obtaining medication, waiting times, gaps in knowledge of medical personnel, and less equitable access to healthcare services, with fewer poor people seeking the BPHS services.¹⁹

Many Afghans tend to perceive private healthcare as providing a more reliable quality of service. In our February 2021 survey, 95 per cent of patients and caretakers said they had visited a private medical facility in the past year at least once, compared to 80 per cent who had visited a public facility. The main reasons given for choosing private care included more attentive and experienced medical personnel and better-quality medication. However, the private healthcare system in Afghanistan, which has expanded in recent years, is plagued by its own set of challenges and is not a cure for the dysfunctions of the public healthcare system. Half of the respondents stated that they had to borrow money from relatives or acquaintances to cover the costs of private healthcare in the last year. Sixty-one per cent of those surveyed who visited private facilities said they were not satisfied with the service they received, primarily due to the high cost of medication and fees. The overall dissatisfaction rate was thus higher than for public medical facilities.

¹⁵ In 2019, the BPHS and EPHS were merged into the Integrated Package of Essential Health Services (IPHS).

¹⁶ WHO, Afghanistan Country Profile, <https://www.who.int/hac/crises/afg/background/profile/en/>

¹⁷ WHO, Afghanistan: Health System, <http://www.emro.who.int/afg/programmes/health-system-strengthening.html>

¹⁸ Ministry of Public Health of the Islamic Republic of Afghanistan, Independent Assessment of the Design and Performance of Primary Health Care in Afghanistan, November 2020.

¹⁹ Ministry of Public Health of the Islamic Republic of Afghanistan, The Balanced Scorecard Report, Basic Package of Health Services (BPHS), BSC 2020 – Round 2, September 2020.

"I felt sick last year and then took TB medication for six months and felt OK. But when I stopped the medication, my symptoms came back. I knew about TB because my mother died from it, but I didn't really know the symptoms. When I fell sick, I went to a couple of private doctors; one told me I had gastritis and another that I had a liver problem. I went to a public health centre near my home, and they gave me medication that I took for eight days, but then I discovered the medication had expired. I went to another medical facility and they gave me different medicine, for TB. When my symptoms came back, I returned to the facility. I was referred to Mirwais Regional Hospital and was examined and diagnosed with DR-TB."

Female patient, MSF TB treatment centre, Kandahar province (quoted above).

Many of the problems facing public health providers and BPHS/EPHS implementers contracted to deliver medical services relate to gaps in the healthcare financing model. Though technical expertise is one of the criteria evaluated when assigning contracts, a lot of weight is put on cost-effectiveness. Some NGOs have sought to outbid each other to deliver medical care with the lowest (often unrealistic) price per capita. As insufficient resources are allocated to BPHS/EPHS implementers and medical facilities run by the Ministry of Public Health, the entire public health system in Afghanistan is under-funded. This has left many public medical facilities without sufficient staff and medical supplies, and directly impacts the quality of care they can provide. This was a major complaint of patients and caretakers who then sought assistance at MSF facilities.

At times, facilities have no qualified medical staff at all, according to patients and caretakers that MSF surveyed. A shortage of female health workers is especially problematic in BPHS facilities, which are meant to offer mother and child health services, and is a common reality in remote or insecure areas of Afghanistan. For cultural and safety reasons, it is difficult for female doctors, nurses and midwives to work in areas where they do not have family to stay with or accompany them. This, combined with the limited cultural acceptance of male healthcare providers for women, continues to pose a serious obstacle to access to essential antenatal, obstetric and postnatal care.

"A few days ago, we admitted a patient with eclampsia to the maternity hospital. Patients with pre-eclampsia and eclampsia usually show symptoms during their pregnancy like headaches, difficulty urinating and abdominal pain. But people are poor and live far away, and are not able to go to the doctor for check-ups. Health workers in the villages are not gynaecologists or educated midwives. Women can stay home during their pregnancy without receiving antenatal care. If a woman with complications arrives at the hospital early, we can treat her. But if a woman has a ruptured uterus in the village and starts bleeding internally, she will not arrive in time – she will die."

MSF nurse, MSF maternity hospital, Khost province.

Inconsistent staff attendance is another concern for patients and caretakers. MSF has heard stories of people travelling long distances to reach a public medical facility, only to find that the doctors there do not work after midday. They are turned away and told to return the following morning. For many, this is simply not an option.

Furthermore, 55 per cent of the patients and caretakers surveyed in February 2021 reported having to pay for the drugs, medical supplies, tests and equipment that will be used in their medical care. This effectively places basic health provisions further out of reach for people who cannot afford the extra costs.

"I travelled seven hours from my home to come to Khost city. Our family is very poor. My husband works in the mountains; he breaks stones. We don't have money for healthcare. It is only when we find the money that we come to Khost for treatment. Money is the biggest obstacle we face. One time I had pain in my abdomen and I went to see the private doctor in my village. He asked me to pay before giving me medication; we had to wait four days to find the money so I could receive the medication. Another time my baby was sick. The doctor expected money immediately and we didn't have it. It was seven or eight days later that we were able to borrow money from a neighbour, and when we went back to the doctor, my baby was very poorly."

Female patient, MSF maternity hospital, Khost province (quoted above).

Ruptures in drug supplies at public medical facilities are frequent. Patients and caretaker respondents described doctors in public health facilities who referred patients to their own private clinics where they would sell them the drugs they needed.

According to the WHO, standard TB drugs, which fall under the BPHS system, should be available free of charge countrywide.²⁰ However, serious concerns remain about the quality of the drugs in the market and the challenges related to quality of diagnostic services and staff.

"I am from Uruzgan province. I was sick for a long time. I tried different medicines from doctors there. They would help me improve just for five days and then I would get sick again. My disease reached the point where I could not even fold a turban on my head and could not pray. Then, I came to the MSF hospital and they did complete medical tests and started me on a treatment. With the help of God and MSF's hospital treatment, my health has improved."

Male patient, MSF TB treatment centre, Kandahar province (quoted above).

Overall, the patients and caretakers MSF surveyed painted a grim picture of the public healthcare services available in Afghanistan, at the primary level in particular. Trust in the private system drives many Afghans to private clinics or hospitals, where they face costs they can barely afford for care, whose quality is not always guaranteed. Some favour local solutions, from traditional remedies to home deliveries, which run the risk of patients developing complications far from a functioning

medical facility. Others risk their lives to reach free medical facilities supported or run by organisations such as MSF.

Perspective

Following the onset of the COVID-19 pandemic in 2020, MSF adapted its medical facilities and protocols to reduce COVID-19 transmission and protect the health of staff and patients. However, these changes unintentionally created additional barriers for Afghan women in particular. For example, the MSF Khost maternity hospital restricted its admissions criteria to women with obstetric complications in need of emergency care and implemented a no-caretaker policy inside the hospital. Following this, the hospital saw a 40 per cent drop in patient numbers in early June 2020. Changes in health-seeking behaviour were observed throughout Khost province; the total expected number of institutional deliveries in Khost was less in 2020 compared with 2019. MSF estimates that around 5,000 women chose to deliver at home last year instead of going to a medical facility. MSF has since relaxed its admission criteria to include non-emergency patients and has begun allowing female caretakers back inside the hospital. The number of deliveries at the MSF Khost maternity hospital is rising once again and will likely soon reach pre-pandemic levels.

It is essential that all health actors in Afghanistan, including MSF, take a step back and critically review their programmes and the health outcomes they deliver to ensure that within their model of care patients' needs remain the priority.



Kimberly Morris, a neonatal nurse, examining a baby in the newborn unit of MSF's maternity in Khost. © ELISE MOULIN/MSF

²⁰ WHO, Afghanistan: Tuberculosis, <http://www.emro.who.int/afg/programmes/stop-tuberculosis-stb.html>

Conclusion

Over the years, MSF has continued to expose the discrepancy between the promises of the donor-promoted model of public healthcare delivery and the reality on the ground. While Afghans struggle to overcome barriers to access healthcare, including armed conflict, insecurity and costs, public health facilities are under-funded, under-resourced and unable to provide care that meets their needs.

Despite widespread poverty, many Afghans feel compelled to seek medical care at private health facilities. The staff there are perceived to be more experienced and attentive, and to offer better quality medication and shorter waiting times than public health facilities. However, treatment in private facilities leaves many Afghans, who are unable to cover their medical expenses, in significant debt.

Faced with barriers to accessing both public and private medical facilities, people resort to dangerous coping strategies, such as delaying seeking healthcare or interrupting treatment, and face the risk of severe complications or death.

The experiences of the Afghan healthcare system that patients shared with MSF during the surveys and interviews compound our observations and the medical data collected from MSF-supported health facilities.

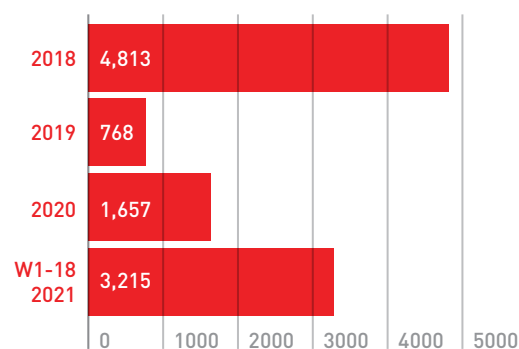
In 2020:

- Half of child deaths in the Boost hospital paediatric intensive care unit that occurred as a result of severe acute malnutrition occurred within 24 hours – in many cases, the patients had arrived too late.
- The majority of the children treated for measles at Boost hospital had not been vaccinated – a consequence of ongoing gaps in immunization coverage in the country. More than half of measles patients arrived with complications like pneumonia and were admitted to the isolation ward.
- The majority of the women who were admitted to Boost hospital with obstetric complications came from distant districts and arrived in a critical condition.
- At the MSF Khost maternity hospital, postpartum haemorrhage was one of the most common obstetric complications, followed by antepartum haemorrhage, prolonged labour, preeclampsia and eclampsia, and obstructed labour.

Based on our assessment of needs in the country, MSF has made the operational choice to focus on secondary level healthcare services in five provinces: Helmand, Herat, Kandahar, Khost and Kunduz. Every day, MSF treats high numbers of severe cases that put our teams and facilities under strain and raise concerns about our own capacity to maintain standards of care.

The average monthly bed occupancy rate in Boost hospital's general paediatric ward was 107 per cent in 2020 and reached 177 per cent in the first two months of 2021 partly due to an influx of measles cases in children. About 3,215 children were treated in the first 18 weeks of 2021, nearly twice as many children as in the whole of 2020, and a third were admitted due to complications.

Number of patients treated for measles at Boost hospital since 2018



After the Afghan Ministry of Public Health led a measles vaccination campaign in Helmand province in late November 2018, the trend of measles cases seen in Boost hospital dropped in 2019. Numbers have been rising again since 2020.

Source: MSF medical data, Boost hospital, 2018–21

In Khost province, between 2016 and 2019, 80 per cent of all facility-based deliveries for which we have data happened at the MSF maternity hospital. In no functioning health system should a single medical facility, in particular one that is privately run, cover the overwhelming majority of obstetric needs of a province.

Organisations like MSF continue to fill important gaps in the healthcare system in Afghanistan. Yet, this situation is not sustainable.

As the armed conflict continues and the humanitarian crisis escalates, all organisations and health providers, both public and private, must considerably increase their capacity to respond to Afghanistan's health needs. Adequate humanitarian funding is only one part of the answer. Donors and

policymakers must take an honest look at the shortcomings of the current model of healthcare delivery in Afghanistan and work to make quality care available, accessible and affordable to all, especially the most vulnerable.

MSF in Afghanistan

Médecins Sans Frontières (MSF) began working in Afghanistan in 1980, but left the country in 2004 when five staff members were killed in Badghis province. In October 2009, MSF returned to Afghanistan due to serious concerns about the deterioration of access to quality healthcare for Afghans because of the conflict. Since MSF's return, we

have prioritised increasing access to high quality medical services, with a strong focus on secondary healthcare. To ensure its independence, MSF does not accept funding from any government or international agency for its programmes in Afghanistan, relying solely on private donations from around the world to carry out its work.



Dr Bart Scharuwen and nurse Marzia with a malnourished child in the inpatient therapeutic feeding centre, Herat regional hospital.
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