

ACCESS TO CARE IN AFGHANISTAN

PERSPECTIVES FROM AFGHAN
PEOPLE IN 10 PROVINCES



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EMERGENCY ONG Onlus is an independent non-governmental organisation. It provides free, high-quality medical and surgical treatment to victims of war, landmines and poverty. It promotes a culture of peace, solidarity and respect for human rights. Since 1994, EMERGENCY has worked in 20 countries around the world, providing free medical care in accordance with its core principles: equality, quality and social responsibility. EMERGENCY has treated over 12 million people.

CRIMEDIM, Center for Research and Training in Disaster Medicine, Humanitarian Aid and Global Health is an interdisciplinary academic centre of the Università del Piemonte Orientale. CRIMEDIM's projects revolve around health system resilience strengthening, access to care as well as community preparedness and response to emergencies and disasters, both in high-income countries and fragile and conflict-affected settings. CRIMEDIM has a long lasting experience in capacity-building for disaster preparedness and response at different levels within the health sector, as well as in enhancing research in emergency and disaster risk management. For these reasons, it was appointed as a WHO Collaborating Centre for Training and Research in Emergency and Disaster Medicine in 2016.



EMERGENCY
MEDICINE, HUMAN RIGHTS AND EQUALITY



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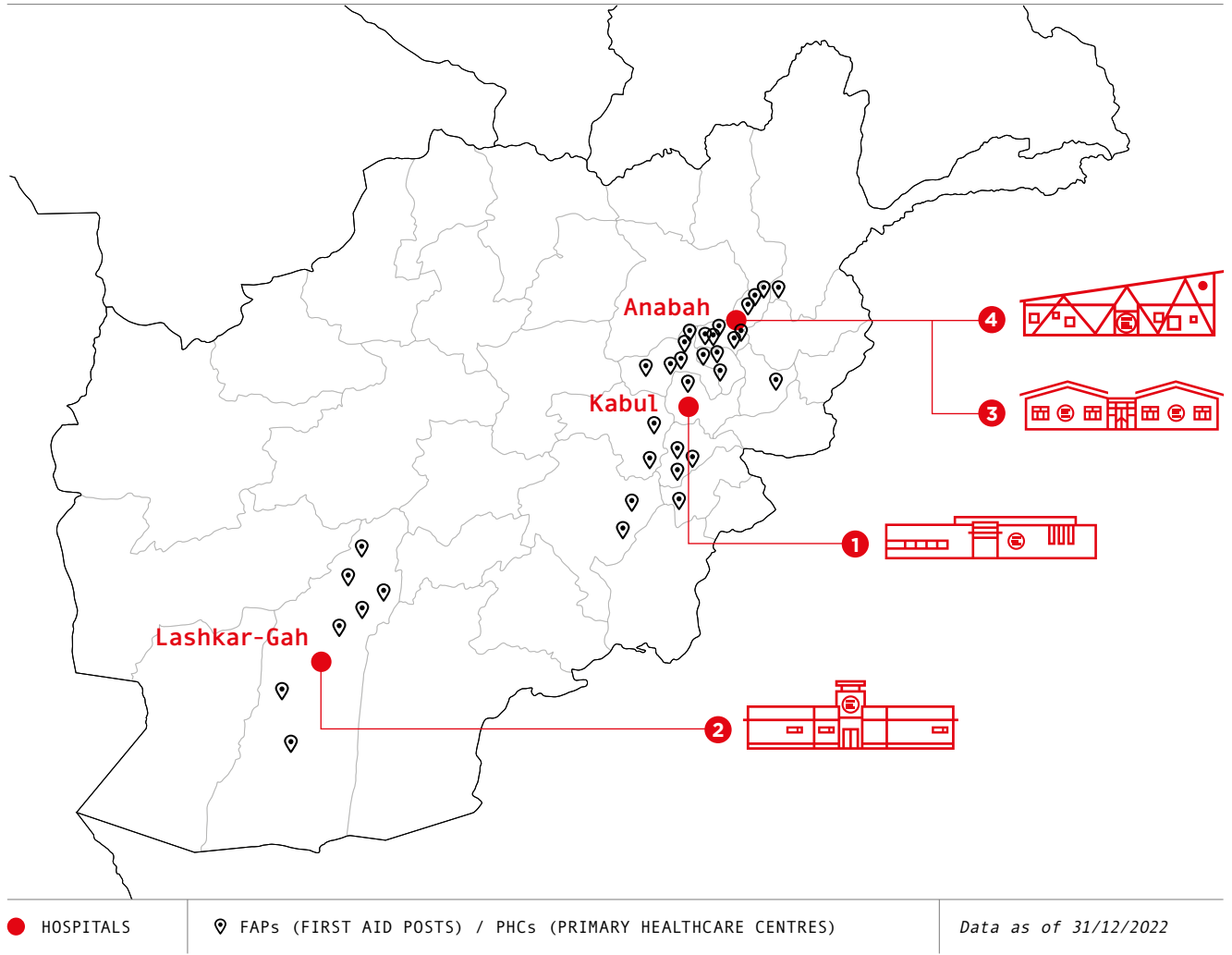
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EMERGENCY IN AFGHANISTAN

ACCESS TO CARE IN AFGHANISTAN: PERSPECTIVES FROM AFGHAN PEOPLE IN 10 PROVINCES



FAPs AND PHCs 📍

Since 1999

15 PHCs in Panjshir: Abdara, Anabah, Anjuman, Dara, Dasht-e-Rewat, Gulbahar, Hesarak, Kapisa, Khinch, Dayek, Oraty, Paryan, Pul-e-Sayyad, Said Khil, Sangi Khan;


12 FAPs in Kabul: Andar, Barakibarak, Chark, Gardez, Ghazni, Ghorband, Mehterlam, Maydan Shahr, Mirbachakot, Pul-e-Alam, Sheikhabad, Tagab; **7 PHCs in Kabul** in 2 orphanages (male and female) and 5 prisons; **7 FAPs in Lashkar-Gah:** Grishk, Sangin, Marjia, Musa Qala, Garmsir, Nad Ali, Shoraki.



SURGICAL CENTRE FOR WAR VICTIMS 1

Kabul, since 2001

Emergency room, clinics, 3 operating theatres, sterilisation unit, intensive care, sub-intensive care, wards, physiotherapy, CT scanner, radiology, laboratory and blood bank, pharmacy, classrooms, playroom, technical and cleaning services.

 WAR SURGERY

 100 BEDS


 412 LOCAL STAFF



SURGICAL CENTRE FOR WAR VICTIMS 2

Lashkar-Gah, since 2004

Emergency room, 2 operating theatres, sterilisation unit, intensive care, wards, physiotherapy, radiology, laboratory and blood bank, pharmacy, classrooms, playroom, technical and cleaning services.

 WAR SURGERY, TRAUMATOLOGY

 93 BEDS


 320 LOCAL STAFF



SURGICAL AND PAEDIATRIC CENTRE 3

Anabah, since 1999

Emergency room, 2 operating theatres, sterilisation unit, intensive care, wards, physiotherapy, radiology, laboratory and blood bank, pharmacy, classrooms, playroom, technical and cleaning services.

 WAR SURGERY, EMERGENCY SURGERY, GENERAL SURGERY, TRAUMATOLOGY, PAEDIATRICS

 78 BEDS

 344 LOCAL STAFF



MATERNITY CENTRE 4

Anabah, since 2003

Obstetric triage and first aid, clinic with ultrasound, 2 operating theatres, sterilisation unit, intensive care and post-natal ward, neonatology unit with newborn intensive care, labour room, delivery room, technical and cleaning services shared with the Surgical and Paediatric Centre.

 OBSTETRICS, GYNAECOLOGY, NEONATOLOGY

 99 BEDS

 166 LOCAL STAFF



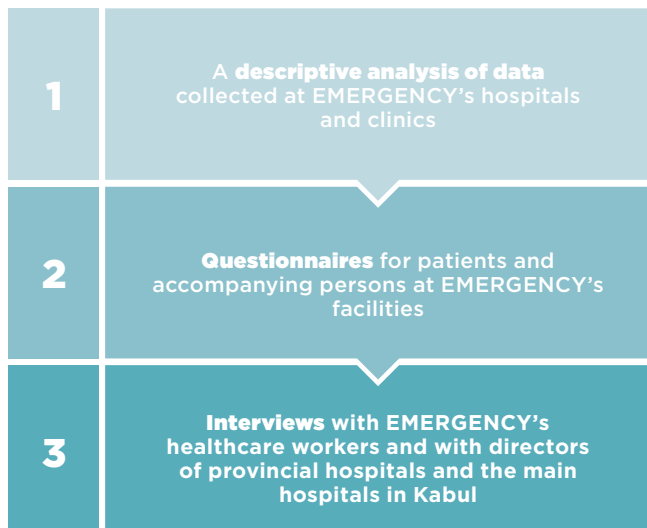
OVERVIEW

Following the change of government in August 2021, Afghanistan's international assets have been frozen, the current authorities banned from international institutions, international forces withdrawn and most diplomatic delegations, mainly Western ones, evacuated from the country. In a country that formerly depended on international aid for 75% of public spending¹, the impact on Afghan civilians, who are bearing the brunt of a rise in poverty and a dearth of essential services, is severe. The inheritance of a long war, a staggering economic crisis, natural disasters and climate change, as well as the Covid-19 pandemic, have caused unprecedented levels of need.

The 2022 Humanitarian Needs Overview describes health as the area with the highest number of people in need in Afghanistan: 18.1 million people across all 34 Afghan provinces have severe or extreme health needs². Due to conflict and remoteness of rural areas, however, data and statistics have been scattered and incomplete, which in the past has made it difficult to form a clear picture of the health needs of the Afghan people, including the true extent of barriers to care³.

Since August 2021, areas that were restricted due to conflict have become more accessible, offering a unique opportunity to achieve a more thorough understanding of the situation of access to care in Afghanistan. For this reason, in June 2022, EMERGENCY and CRIMEDIM started a mixed-methods study of **access to health services in 10 Afghan provinces**.

The report examines the main barriers to access care in Afghanistan in recent years, and how these have changed since August 2021. It proposes an approach in three phases, combining qualitative and quantitative methods:



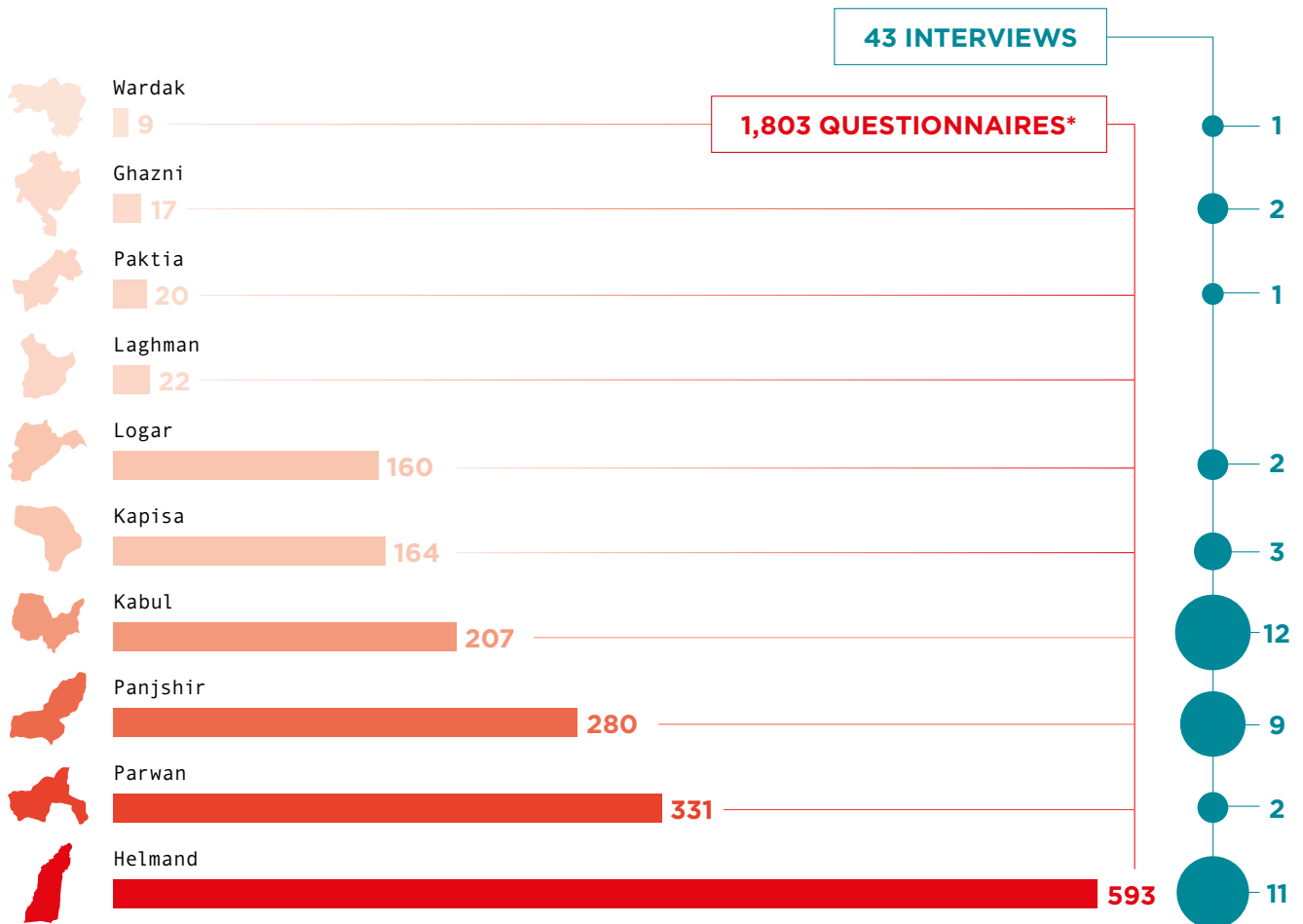
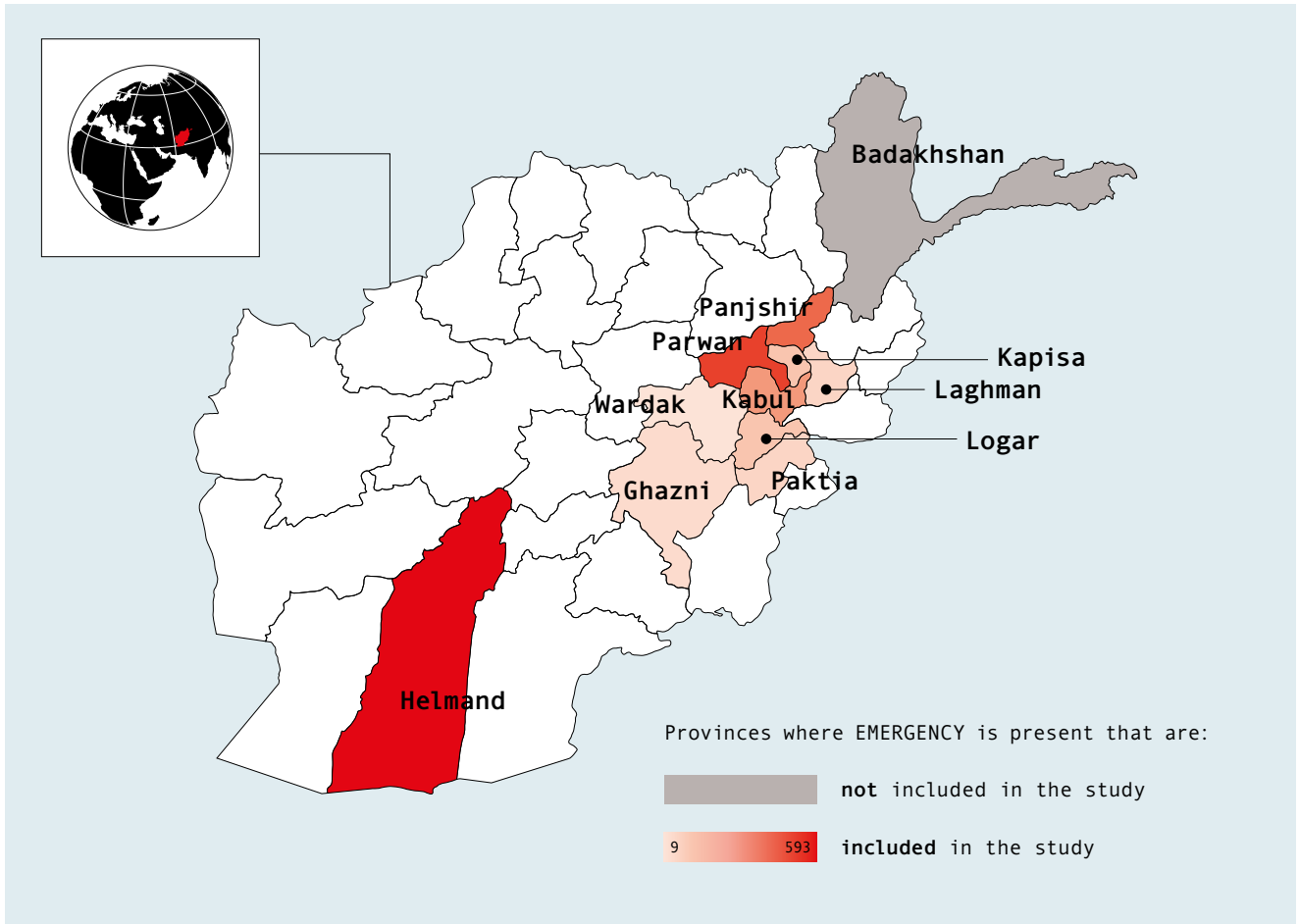
Combining these methods allows understanding access to care from the points of view of both **beneficiaries and healthcare providers**.

An up-to-date assessment of access to care will help inform the discussion on adjustments to **planning and financing of health services**. Its results may help **change the narrative** about Afghanistan and **give voice to Afghans** in discussions about health and the response to their health needs. Building on the findings of the study, the report also includes a set of **recommendations** for relevant national and international stakeholders, in order to **increase access to care** in both urban and rural areas and **improve health service provision**, to make the **Afghan health system more sustainable and resilient**. Finally, this study will contribute to keeping Afghanistan and the needs of the **Afghan population high on the global agenda**.

OUTREACH

- ▶ **10 provinces**, where EMERGENCY operates, included in the study that are home to nearly **15 million Afghans** (37% of national population)
- ▶ **1,807 anonymous questionnaires to patients in 20 EMERGENCY's facilities** (17 FAPs/PHCs and 3 hospitals)
- ▶ **32 semi-structured interviews with EMERGENCY's staff** at hospitals and clinics
- ▶ **11 semi-structured interviews with hospital directors**
 - 8 directors of provincial hospitals
 - 3 directors of main Kabul hospitals

THE STUDY GEOGRAPHICAL COVERAGE BY PROVINCE



*Out of 1,807 valid questionnaires, 4 did not respond to the question "location"

STUDY FRAMEWORK: OUR CONCEPTUALISATION OF ACCESS TO CARE

Access to care has been defined as the opportunity or ease with which individuals are able to use appropriate health services in relation to their need⁴. Assessing the level of access to care by patients in a health system is vital for proper planning and allocation of resources. It serves to identify underserved populations and ultimately to improve healthcare provision and work towards universal health coverage.

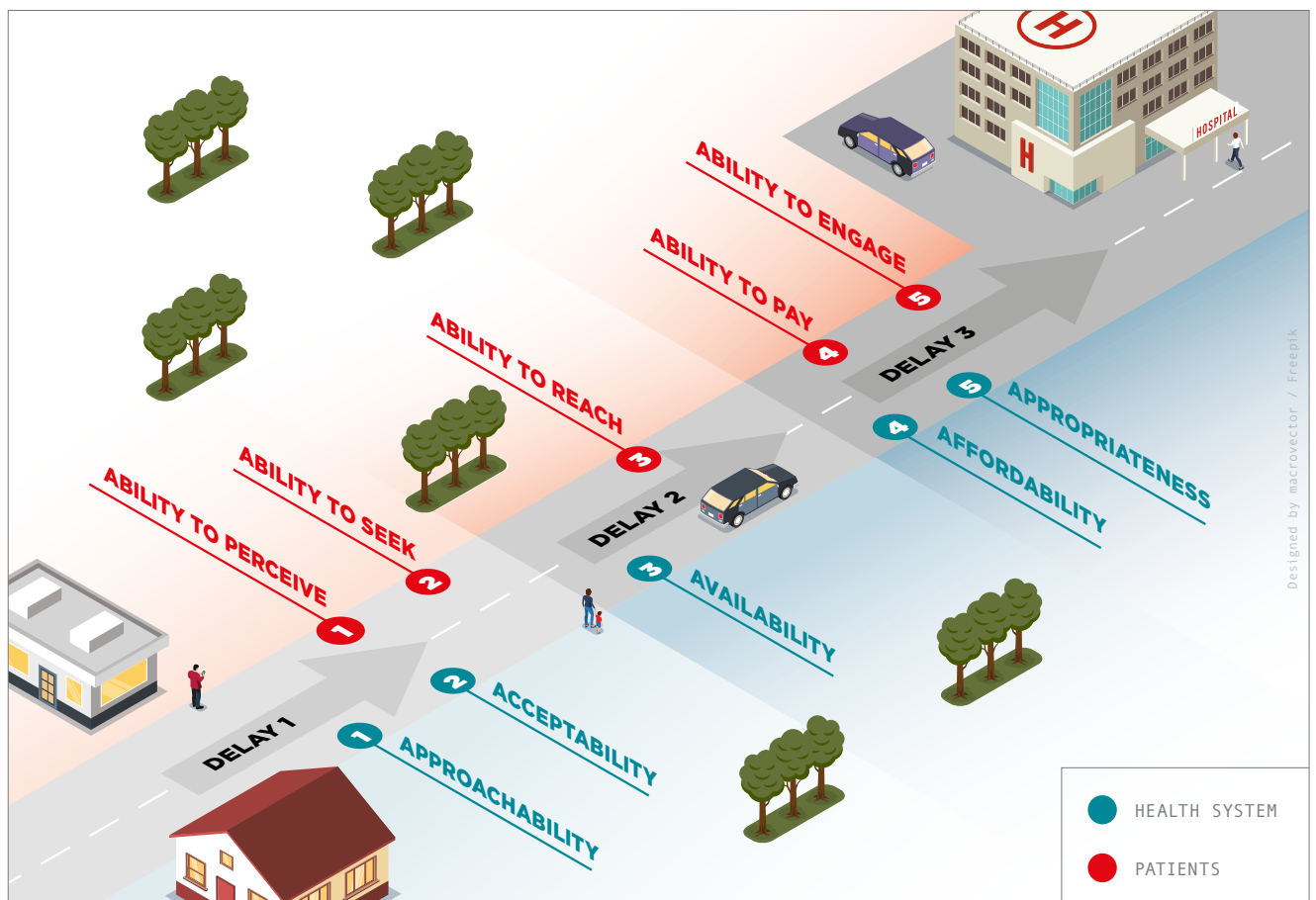
For a comprehensive understanding of access to care, two aspects need to be taken into account:

1. Sociological characteristics of individuals, such as a person's economic assets, social status, knowledge of healthcare, or the distance between one's residence and health facilities. Each of these characteristics will

have an effect on whether a person chooses to seek healthcare. For example, if a person is unaware that an illness can be treated or if they lack the resources even to visit a clinic, they face barriers to accessing appropriate care.

2. The characteristics of the health system, such as opening times of clinics, the adequacy of staff and the distribution of health facilities across a territory.

FIG. 1 - ACCESS TO CARE INTEGRATED FRAMEWORK



*See Fig. 2 for an explanation of each dimension of access to care

*FIG. 2 - ACCESS TO CARE INTEGRATED FRAMEWORK



In order to get the best possible understanding of the challenges faced by Afghan people seeking medical attention, the research team combined the above two aspects in a single framework, drawing on two different conceptualisations of access to care from the relevant literature (see Fig. 1 - 2).

The first model (Levesque et al., 2013)⁵ integrates factors from both the demand side (individuals, community members, patients) and the supply side (the health system). According to the authors, for each of the health system-related dimensions of access to care there is a corresponding individual dimension.

The second model (Dawkins et al., 2021)⁶ describes three delays that can occur in a patient's pathway to care.

There can be a delay:

- 1) in the patient's decision to seek care;
- 2) in reaching an adequate facility; and
- 3) in receiving care once at the facility.

The research methodology for the whole project is based on this combined framework, which allows the research team to see problems through the eyes of both patients and healthcare providers, and ultimately to elaborate recommendations specific to the situation in Afghanistan.

METHODOLOGY

EMERGENCY and CRIMEDIM carried out a mixed-methods study from June to December 2022. Data collection in the field took place in September and October 2022, and data analysis and drafting of the report between November 2022 and February 2023.

The research consisted of three phases, combining quantitative and qualitative methodologies:

- 1. Phase 1: Analysis of health-related data from EMERGENCY's facilities**, to assess work at EMERGENCY's hospitals and clinics in recent years and record any notable changes since August 2021.
- 2. Phase 2: Questionnaires for patients and accompanying persons at EMERGENCY's facilities**, to identify barriers to access to care in recent years and record notable changes since August 2021.
- 3. Phase 3: Interviews with EMERGENCY's staff and directors of hospitals run by the Ministry of Public Health**, to investigate challenges in healthcare provision and ultimately to identify whether any changes have occurred since August 2021.

In the **first phase**, monthly aggregate data on surgical, maternal, and paediatric care was analysed. Descriptive statistics were used to explore significant trends, taking into account EMERGENCY's three hospitals in Afghanistan and its First Aid Posts (FAPs) and Primary Healthcare Centres (PHCs). In September 2022, discussions were held between EMERGENCY's staff in Afghanistan and the research team in order to interpret trends and analyses.

In the **second phase**, the research team developed a questionnaire with 67 questions, based on the study framework. In addition to demographic information, the questionnaire encompassed multiple-choice and ranking questions about access to care. The questionnaire was translated from English to both Pashto and Dari, and then transferred to a digital smartphone platform (KoboCollect).

The questionnaire was administered at a sample of EMERGENCY's facilities, selected to take into consideration provincial coverage, workload, social relevance or impact of conflict. A sample size calculation was done considering the average number of outpatient visits to each selected facility in previous months. Depending on the expected sample size for each facility, one or more members of EMERGENCY's staff were recruited at each facility to administer the questionnaire to patients. The recruited staff attended training sessions held by the research team,

which covered ethical considerations and instructions for using the KoboCollect application.

It took approximately 20 minutes to complete the questionnaire. Respondents were informed of the purpose of the study and gave their verbal consent to participate anonymously. The research team closely monitored the data collection progress and offered support in the compilation during their field mission. Questionnaire data was collected over the period from mid-September to the end of October 2022.

In the **third phase**, the research team developed a semi-structured interview guide composed of open-ended questions on access to care, as well as questions about current challenges in the health system and recommendations for the future. A list of interviewees was compiled through convenience sampling, including EMERGENCY's staff members and directors of hospitals run by the Ministry of Public Health at provincial and national level. Interviewees were recruited with the aim of achieving as much geographical coverage and variety in terms of gender and role as possible.

Interviews with EMERGENCY's staff took place at the organisation's facilities, while those with hospital directors were conducted at their hospitals or at EMERGENCY's hospital in Kabul. The average length of the interviews was one hour. According to each interviewee's personal preference, the interviews were conducted anonymously or not. Two separate consent forms and a privacy notice were provided to authorise the use of interviewees' personal details and image on the published material. Whenever requested, interviewees also received the interview guide in advance, to allow them to read the questions beforehand and have reasonable time to decide how they wanted the interview to be conducted.

A descriptive analysis of health-related data from EMERGENCY was done using Excel and Stata software in September 2022. Questionnaire data was entered into an Excel database and analysed in November 2022 by using Stata. Interview recordings were anonymised and transcribed verbatim using an online platform (Sonix), then imported into a qualitative data analysis software (Atlas.ti) and thematically analysed between October and November 2022.

After independent analysis of the findings of each phase, the results of the three phases were combined to validate the results and formulate recommendations specifically tailored to the situation in Afghanistan.

All relevant ethical principles were considered when collecting, storing and managing data in all phases of the research. This project was officially endorsed by the Afghan Ministry of Public Health.

STRENGTHS AND LIMITATIONS

This study was conducted following a rigorous scientific methodology and with full respect for the rights of the participants. To inform similar studies in the future, some methodological considerations are made in this section. Among the limitations of this study is the impossibility of generalising the findings to the whole population of Afghanistan, because the sample is made up of individuals who have visited EMERGENCY's facilities at some point, which necessarily means they have had an advantage over those who have never accessed care. It is therefore likely that the results underestimate the barriers to access to care for the Afghan population as a whole.

To reduce sample selection bias, patients were asked about general barriers to access to care, not necessarily those faced when accessing EMERGENCY's facilities, and they were questioned about obstacles that their family members or close friends may also have experienced. On this point, it is important to highlight that 60% of questionnaire respondents said they had frequently sought care at government facilities in the past year, which gives the research team confidence that the study results do not solely address barriers to accessing EMERGENCY's health services.

Although it was attempted to reduce sample selection bias to a minimum, it could not be eliminated entirely. Nonetheless, with a view to generalisability, data was collected in different locations, in provinces with different historical, socio-economic and geographical profiles, and in both urban and rural areas.

For the interviews, participants were selected through convenience sampling in order to form a diverse group in terms of gender, job and geographical location. Although the number of respondents was high and data saturation was reached, it must be clarified that the results of the interviews represent the points of view and perspectives of a restricted number of stakeholders. It should also be acknowledged that there might have been some degree of reluctance among interviewees to share information that could be considered negative or politically sensitive. Nonetheless, considered in the light of Afghanistan's peculiar situation, these results constitute a precious source of evidence, given the paucity of qualitative studies conducted in Afghanistan on such a large sample.

Adopting a mixed-methods approach was key for data triangulation and validation, and to obtain a thorough understanding of access to care from multiple perspectives. The use of quantitative and qualitative data collection techniques allowed us to overcome the limitations that characterise the two methodologies if used in isolation. Data triangulation could also be done from different perspectives, namely those of hospital directors, healthcare workers (HCWs) and patients. The reliance on well-known theoretical frameworks for the elaboration of data collection tools and interpretation of results allow the findings of this study to be compared with those of other studies in Afghanistan or in other similar contexts.

This study managed to reach respondents from very remote areas of Afghanistan, people hardly reached by international researchers in the past 20 years. This wide distribution increases the relevance of the findings to everyone living in Afghanistan. None of this would have been possible without the involvement of EMERGENCY's dedicated local staff, who committed to the success of the project by collecting data in the field and regularly updating the research team about their progress. It is important to note that the data collectors felt empowered and enthusiastic taking an active part in this study, and they reported that patients enjoyed participating in the study because they felt their voices were finally being heard.





ACCESS TO CARE IN AFGHANISTAN: PERSPECTIVES FROM THE PROVINCES

THE SITUATION IN AFGHANISTAN

Afghanistan has been affected by conflict for over 40 years. Between December 2008 and 15 August 2021, United Nations Assistance Mission in Afghanistan (UNAMA) counted 118,443 civilian war victims⁷. Since the Taliban's takeover, a humanitarian crisis has unfolded. The inheritance of a long war, poverty, corruption, weak institutions, the impact of natural disasters and climate change already resulted in a fragile social fabric. International sanctions and the freeze of Afghanistan's international assets abroad have put an extreme strain on a country that already relied on international aid for 75% of public finance and 40% of its GDP⁸.

Out of a population of approximately 40 million⁹, the UN Office for the Coordination of Humanitarian Affairs (OCHA) has estimated that in 2023 28.3 million people are in need of urgent humanitarian aid, in order to survive¹⁰; nearly half of Afghans face acute food insecurity¹¹ and 97% were at risk of falling below the poverty line by the end of 2022¹². On 31 March 2022, the United Nations launched an appeal for \$4.4 billion – the highest such amount ever for a single country – to help Afghanistan, which fell short, reaching only \$3.3 billion¹³. In 2022, Health received 62.6% of the funding requested for the sector.

“It is unacceptable and unconscionable that the people of Afghanistan have had to live with the prospects of either bombing or starvation, or both.”

Former UN High Commissioner for Human Rights,
Michelle Bachelet

Since the end of the war, security has significantly improved. In fact, UNAMA reports a 77.5% decrease in security-related incidents¹⁴. This has allowed international and national NGOs to reach communities in remote areas that were previously restricted. Moreover, improved security has increased mobility within the country.

Nonetheless, violence still plagues Afghanistan. Attacks on minority groups have increased, in particular against the Shia Hazara ethnic group, with most episodes being attributed to ISIS-K. Explosive hazard contamination is still among the highest in the world. Unexploded ordnance continues to threaten the lives and livelihoods of Afghans,

as land contamination can expose farmers to danger. Exposure to such a risk is particularly serious in a country where 70% of the population live in rural areas and 80% of people's livelihoods depend directly or indirectly on agriculture¹⁵.

Due to the protracted conflict, munitions and small arms have become increasingly widespread and easily accessible. At the same time, the rampant economic crisis and unemployment have encouraged people to turn to harmful coping mechanisms in order to survive. Seven hundred thousand Afghans are estimated to have lost their jobs in the second half of 2022¹⁶. Unemployment can revive land and family disputes and trigger criminal behaviour or extremism.

Internal displacement and cross-border movement increased between January and August 2021 as the fighting worsened, but they have decreased since the change of government¹⁷. According to UNHCR, 2.2 million Afghans are estimated to be in Iran and Pakistan, while another 3.5 million are internally displaced. Among those who have left the country, over 100,000 are skilled professionals. Brain drain has further compromised the local capacity to deal with a complex and multi-layered humanitarian crisis.

Humanitarian health organisations do not report significant changes to their activities due to brain drain. However, restrictions on women's mobility and participation in society have been reported as challenges to operating in the country¹⁸. Although health is one of the sectors in which active participation by female staff is currently allowed, the ban on secondary and university education for girls, as well as the recent ban on work with NGOs for women, are likely to create a generational gap within the future health workforce.

Multiple shocks – including recurrent droughts, floods and earthquakes – have eroded the resilience of local communities, whose lives are being made even more challenging by harsh winter temperatures and worsening food insecurity. Under these circumstances, and lacking alternatives to provide for its people's livelihoods, Afghanistan's prospects of self-reliance are crumbling.

THE AFGHAN HEALTHCARE SYSTEM

Decades of almost incessant conflict and violence have dismantled much of Afghanistan's social infrastructure, including the country's health system.

By 2002, Afghanistan had some of the poorest health indicators of any country in the world, particularly in the areas of infant, child and maternal mortality. Under these circumstances, continued support from non-governmental organisations (NGOs) has been crucial to maintaining the health system and indispensable for the delivery of basic health services. In 2011, it was estimated that 70% of health-related services in the country, particularly at the primary care level, had been implemented by aid organisations¹⁹.

In an attempt to centrally coordinate the multitude of services offered by NGOs, and to maintain provision of adequate health services for the Afghan population, especially in remote and isolated areas, a reform of the Afghan healthcare system was begun in 2003 and revised at later stages²⁰.

The aim of the reforms was to expand the quality and coverage of health services, ultimately giving equal access to care in both rural and urban areas despite widespread limitations in infrastructure. A standardised package of primary and curative services (i.e., Basic Package of Health Services, BPHS) at the primary and secondary levels was released. Maternal and newborn health, child health and immunisations, nutrition, control of communicable diseases, mental health, disability and provision of essential drugs are included in the BPHS list as essential services. In addition, the BPHS also specifies how and where these services are to be delivered, following a semi-hierarchical

structure with a Health Post (HP) at the bottom up until the District Hospital (DH) at the top, each designed to cover a specific range of population and services²¹ (see Fig. 1).

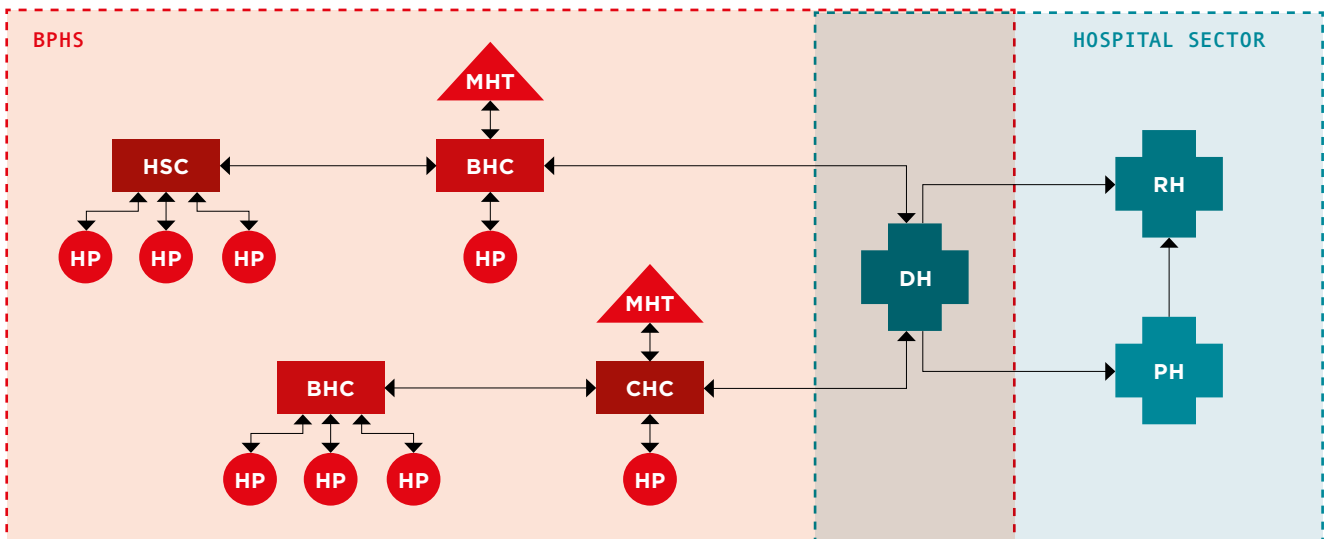
In 2005, the Ministry of Public Health complemented the BPHS with an Essential Package of Hospital Services (EPHS), a standardised package of essential services according to each hospital's type, size and catchment area. District hospitals are the link between BPHS and EPHS and serve as the first level of referral hospital for primary care facilities. In the BPHS and EPHS, the Ministry specified all the services, staffing and equipment expected at every level of the Afghan health system²².

NGOs were contracted by the Ministry of Public Health to deliver both BPHS and EPHS, with a view to making provision of services more uniform among the many healthcare providers²³ and strengthening cooperative referral mechanisms between the facilities at different levels under the leadership of the Ministry.





FIG. 1 - THE LINK BETWEEN BPHS AND THE HOSPITAL SECTOR



BHC - Basic health centre
Antenatal care, delivery and post-natal care, treatment of most common communicable diseases (malaria, tuberculosis), integrated management of common childhood illnesses

CHC - Comprehensive health centre
Management of some obstetric complications, management of complicated cases of malaria and childhood illnesses, outpatient care for mental health patients, laboratory facilities

MHT - Mobile health team
Extension of BHC services

DH - District Hospital
Inpatient and emergency services, major surgery under general anaesthesia, comprehensive emergency obstetric care, comprehensive mental health outpatient and inpatient care

HP - Health post
Facility with limited curative care, provision of health education services, basic pre-/post-natal care

HSC - Health sub-centre
Basic curative care, immunisation, family-planning, TB case detection

PH - Provincial Hospital
Inpatient and emergency services, major surgery (general obstetrics and gynaecology, paediatrics), physiotherapy, basic laboratory, blood bank, basic X-ray and ultrasound services

RH - Regional Hospital
General and specialist surgical, obstetrics, gynaecology, paediatrics and medical services, specialist services (e.g. ophthalmology, ENT services, dental, endoscopy), CT scan (Kabul only)



HEALTH PROFILE

Despite persistent conflict and poverty, improvements in health outcomes have occurred in Afghanistan since the implementation of the reform. The number of functioning primary healthcare facilities more than doubled and the quality of services in public hospitals improved²⁴.

However, Afghanistan's health situation is still dire.

Distribution of health facilities is uneven across the 34 Afghan provinces, which has left 13.3 million people underserved in 2022, according to WHO Afghanistan. The 2022 Humanitarian Needs Overview corroborates this finding, stating that 10.8 million Afghans lacked access to basic primary healthcare services. The dearth of health workforce is long-standing, with only 8.7 physicians, nurses and midwives per 10,000 inhabitants²⁵. Access to specialised care is even more critical, as specialists mostly concentrate in urban areas. More than 1 in 10 health facilities is partially functioning or non-functioning, the main causes of dysfunctionality being the lack of equipment, finances, medical supplies and staff²⁶.

Afghanistan continues to have some of the worst health indices in the world. The country ranks low in the human development index, at 180 out of 191. Neonatal and maternal mortality rates are still among the highest in the world, with 35 deaths per 1,000 live births and 638 deaths per 100,000 live births, respectively²⁷. These rates are likely to deteriorate unabated: as of October 2022, 4.7 million children, and pregnant and lactating women were estimated to be at risk of acute malnutrition²⁸. Vaccination rates are still stagnating, particularly in conflict-affected provinces, where outbreaks of measles have put the population under constant additional strain. It is therefore not surprising that over 40% of deaths are still caused by maternal, prenatal and communicable conditions²⁹.

Despite the end of the war, trauma care remains a top priority in the country, as stated by the World Health Organization in its 2022 report on trauma care services³⁰. From August 2021 to August 2022, inpatient cases for trauma amounted to nearly 40 a day, and included road traffic accidents, occupational injuries and gunshot wounds. Unfortunately, although the Afghan health system was originally designed with a view to facilitate effective referrals, just under 11% of injured people are transferred by ambulance to hospitals.

The burden of non-communicable diseases (NCDs) is steadily rising, although they account for only 36% of all deaths in the country³¹. This may be due to a lack of awareness among the population and underdiagnosing

due to the limited availability of tests for early detection and of diagnosis and monitoring at the primary healthcare level.

With no history of a functioning integrated healthcare system and a fragile socio-political state, there is still much to be done to overcome barriers to access to care in Afghanistan, and a coordinated healthcare infrastructure has yet to take shape in the country.





EMERGENCY'S ACTIVITY IN AFGHANISTAN SINCE AUGUST 2021

EMERGENCY has maintained continuous operations in the country since 1999, offering the population free, high-quality care. EMERGENCY currently runs three hospitals, in Anabah, Kabul and Lashkar-Gah. All three hospitals are linked to a network of 40 First Aid Posts (FAPs) and Primary Healthcare Centres (PHCs), spread across 11 provinces. This network ensures the stabilisation and safe referral of patients in need of urgent care via an ambulance network that runs day and night; it also provides basic primary healthcare.



In **Anabah**, Panjshir valley, north-east of Kabul, EMERGENCY opened a **Surgical Centre** in 1999 to provide life-saving care to victims of war and landmines. Since 2002, admission criteria have also included civilian trauma and emergency and elective general surgery.



In 2003, EMERGENCY expanded its activities and opened a **Paediatric Centre and a Maternity Centre** next to the Surgical Centre. The EMERGENCY staff have provided continuous care, even throughout the exacerbation of fighting in the valley in 2021, during which nearly 1,000 paediatric patients were admitted and almost 3,000 surgeries performed.



In **Kabul**, EMERGENCY opened a **Surgical Centre for War Victims** in April 2001 and further expanded it in 2015. The hospital has remained a crucial facility in Kabul, despite the increasing episodes of violence recorded in the capital throughout the years of conflict. Specialising in war surgery, it is a key facility for treating injuries mostly from firearms but also from mines, explosive devices (shells) and knives. The centre also relies on a widespread network of FAPs and PHCs in eight provinces.



In **Lashkar-Gah**, in Helmand province, EMERGENCY opened a **Surgical Centre** in 2004. This area has been one of Afghanistan's most volatile regions over the last two decades, with large numbers of violent incidents and casualties. The centre specialised in war surgery and civilian trauma for patients under the age of 14. At the peak of conflict, admission criteria to the hospital had to be changed to cover only those in need of urgent, life-saving treatment, due to the significant increase in war-wounded patients. Also in Lashkar-Gah, the main reasons for admission have been wounds from bullets, mines, explosive devices (shells) and knives. Since April 2022, admission criteria were changed to include civilian trauma. The network linked to the Surgical Centre is made up of FAPs only.

EMERGENCY's hospitals in Lashkar-Gah, Kabul and Anabah are also centres for postgraduate training in surgery, paediatrics, gynaecology and anaesthesia, as officially recognised by the Ministry of Public Health.

For analytical and descriptive purposes, this report refers to the three hospitals and their FAPs and PHCs collectively as "referral areas" or "areas".

KEY FINDINGS



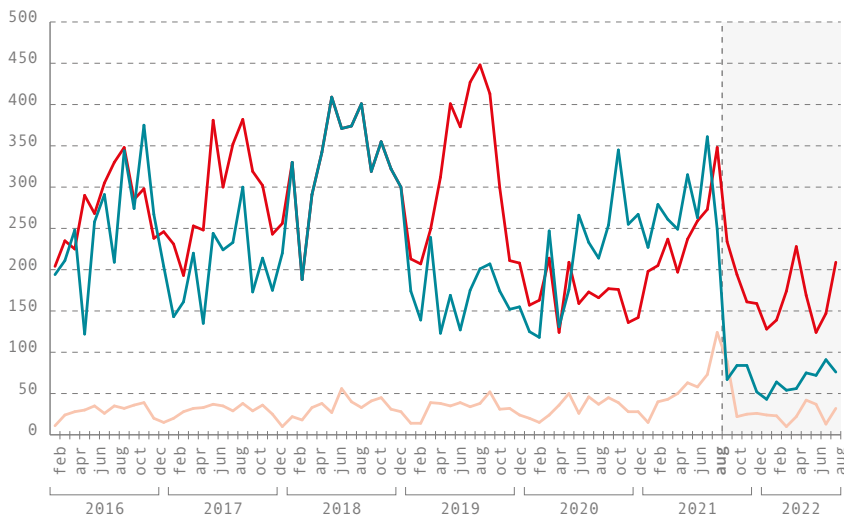
- 1** The change of government and the increase in fighting in August 2021 affected the workload at EMERGENCY's hospitals, with a negative peak in admissions for almost all types of health service. Yet all three centres recovered their activity soon after the initial shock, with admissions returning to normal figures as early as September 2021.
- 2** Maternal and paediatric admissions to EMERGENCY's Anabah hospital were not greatly affected by the change of government; after a drop in August and September 2021, figures related to the use of maternal and paediatric services were typical by October.
- 3** Until the events of August 2021, most admissions were due to war-related injuries (i.e., from shells and mines), hence the increase in the number of surgical admissions, FAP consultations and referrals, especially in the Lashkar-Gah and Kabul referral areas. After the cessation of conflict, civilian trauma became the main health need of patients at EMERGENCY's facilities, so admissions criteria were expanded to include such patients. This demonstrates EMERGENCY's ability to adapt to a changing context and reflects the high burden of civilian trauma (falls from heights, road traffic accidents, etc.) on the health of the Afghan population.
- 4** Despite the cessation of the conflict in August 2021, admissions due to violence (i.e. stab and bullet wounds) remain a concern in the Anabah and Kabul areas, linked potentially to frequent crime and family disputes, together with the availability of weapons³², and contamination from landmines and unexploded ordnance in the country.
- 5** The rate of consultations at the PHC level and the number of vaccinations remained constant even after the events of August 2021. Patients used EMERGENCY's PHC services mainly for acute presentations of communicable diseases.

TRENDS AND FIGURES AT EMERGENCY'S FACILITIES

SURGICAL CARE

Over 23 years of activity, EMERGENCY has been able to observe the evolution of the Afghan conflict and its direct and indirect consequences on people. For instance, the worsening of the conflict affected the workload at healthcare facilities, as the intensity of fighting led to more barriers to reach health facilities, higher numbers of war-wounded patients and its greater cruelty made wounds more severe.

At EMERGENCY's three Surgical Centres, admissions for adults due to bullet, shell, mine and stab wounds reveal a pattern over the years, increasing in summer and decreasing in winter. After July 2021, the number of such admissions increased, reaching a peak in August 2021. From September 2021 until the end of the year, they sharply decreased, hitting their lowest number since 2016. Although diminished, surgical admissions for adults due to bullet, shell, mine and stab wounds appear to be on the rise since early 2022.



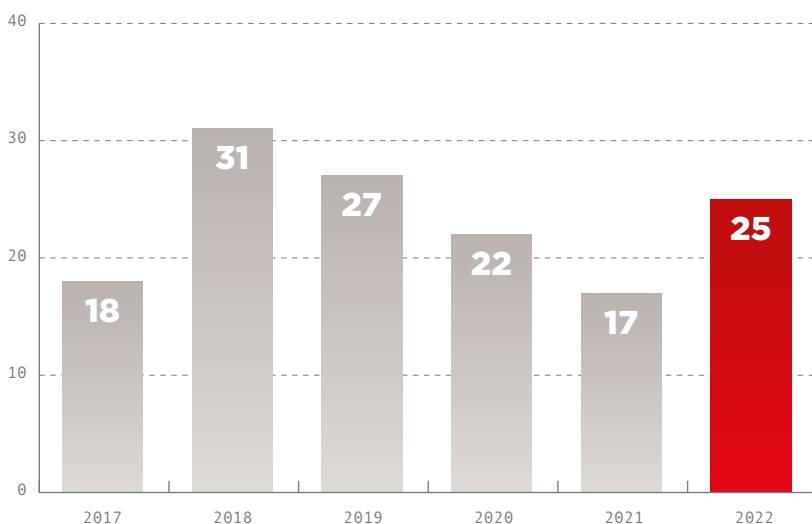
ADULT ADMISSIONS FOR SURGICAL OPERATIONS DUE TO BULLET, SHELL, MINE AND STAB WOUNDS

— Lashkar-Gah
— Kabul
— Anabah

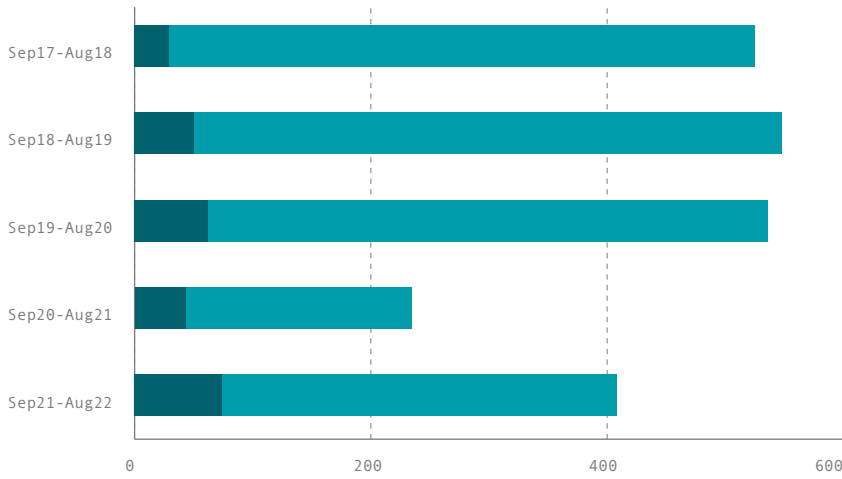
When disaggregating data across the three hospitals according to the type of injury, a major drop can be seen in admissions to **Lashkar-Gah** hospital for bullet, shell and mine wounds. Conversely, admissions for stab wounds did not decrease after August 2021. Rather, a slight increase in admissions for stab wounds can be seen after the change of government.

Admissions to the **Kabul** and **Anabah** hospitals for bullet and shell wounds remain a concern. Despite the end of war, violent attacks on civilians are still recorded in the provinces.

On the same note, the number of violent incidents resulting in a large influx of patients is still high in **Kabul** despite the cessation of conflict after August 2021. The victims of these incidents are increasingly younger and female.

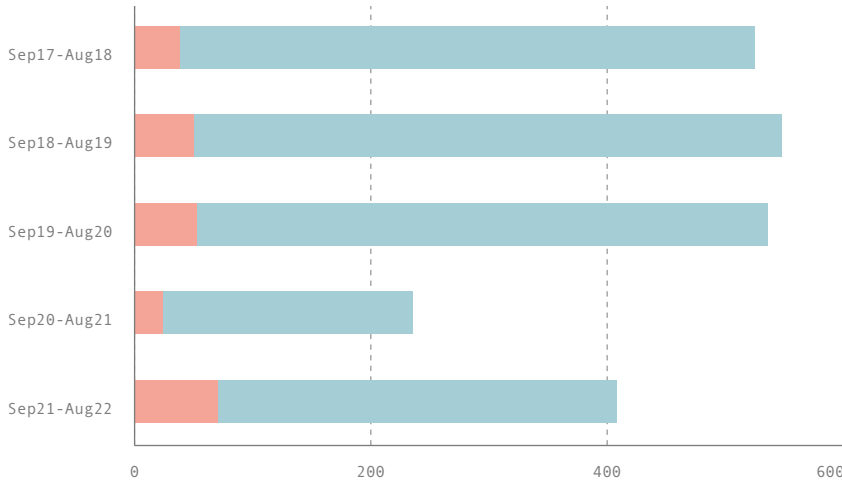


NUMBER OF VIOLENT INCIDENTS REFERRED TO EMERGENCY'S SURGICAL CENTRE IN KABUL



NUMBER OF PATIENTS DUE TO VIOLENT INCIDENTS DIVIDED BY AGE

Age < 15
Age > 15

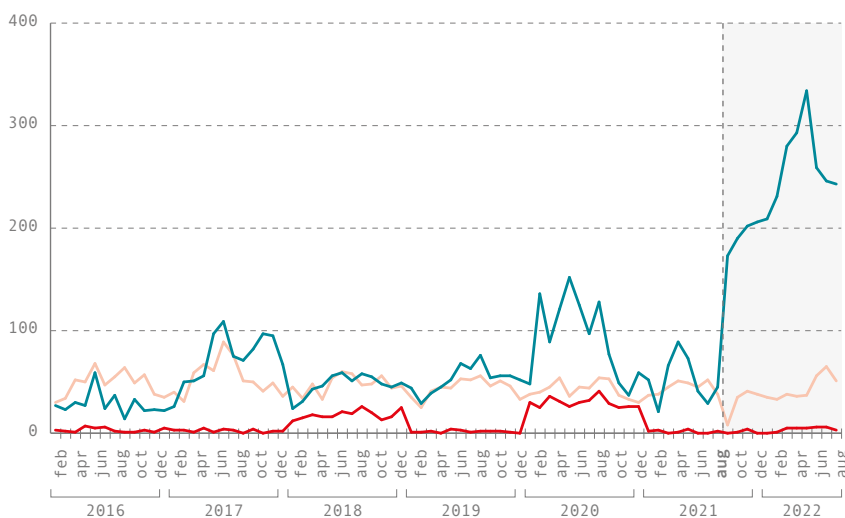


NUMBER OF PATIENTS DUE TO VIOLENT INCIDENTS DIVIDED BY SEX

Female
Male

Since August 2021, surgical admissions for war-wounded patients have begun to decrease. This has made it possible to revise admission criteria to treat civilian trauma. As a result, after a modest decrease following August 2021, civilian trauma admissions have increased at all three of EMERGENCY's hospitals. In the summer of 2022, civilian trauma admissions reached their highest recorded peak since 2016.

In particular, the sudden drop of war-wounded patients in **Lashkar-Gah** prompted EMERGENCY to extend admission criteria in April 2022. Also in **Kabul**, adult surgical admissions for civilian trauma showed an increase in the aftermath of the events of August 2021. A similar pattern can be seen in surgical admissions of children with civilian trauma at all three hospitals. The trend shows a sharp increase in admissions of children with civilian trauma after August 2021, particularly in Lashkar-Gah. Overall, it appears that the need for civilian trauma care is high and that the EMERGENCY hospitals in Lashkar-Gah and Kabul were able to convert their activity swiftly in order to meet the changing needs of the population.

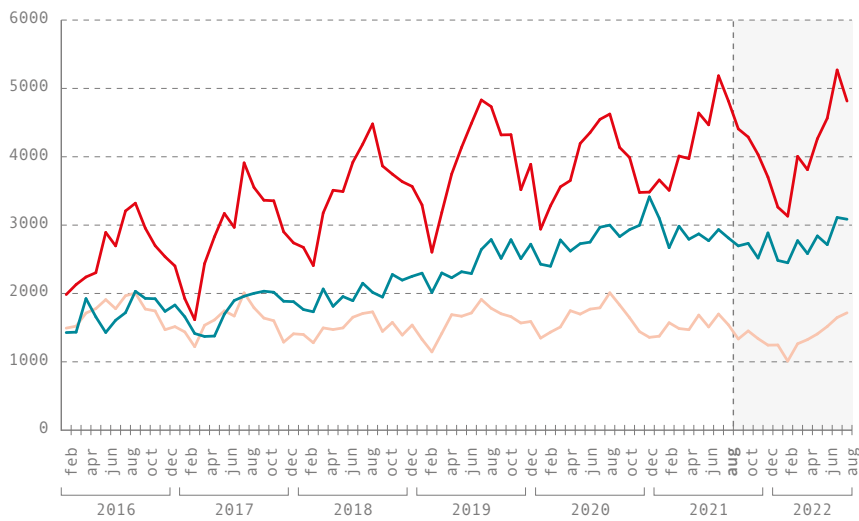


NON-WAR-RELATED SURGICAL ADMISSIONS (<14 YEARS) DIVIDED BY EMERGENCY'S HOSPITALS

Lashkar-Gah
Kabul
Anabah

FIRST AID POSTS

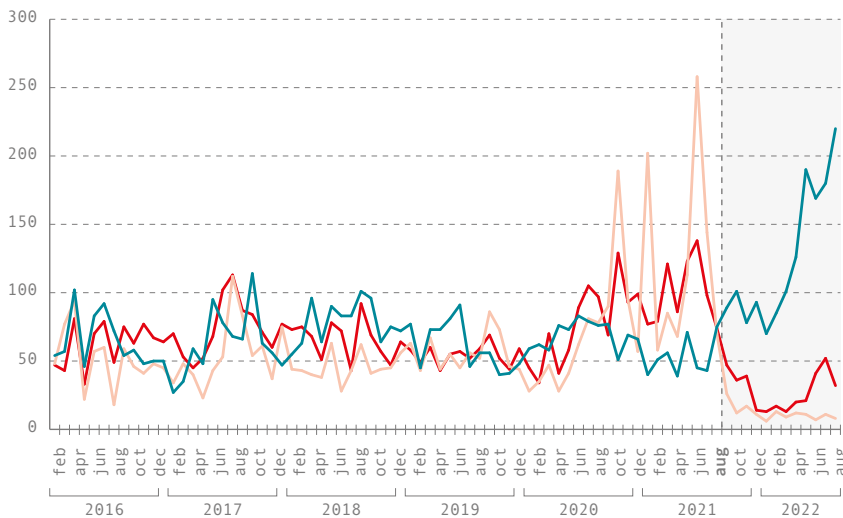
Data from the FAPs in the three main areas of Anabah, Kabul and Lashkar-Gah show an increase in the total number of patients seen for trauma-related reasons, even after the cessation of the conflict in August 2021. Reflecting the hospital trends for surgery, Kabul's FAPs saw a seasonal pattern in the number of consultations, with an increase in summer and a decrease in winter.



CONSULTATIONS AT ALL FAPS

— Lashkar-Gah
— Kabul
— Anabah

When analysing the reasons for consultation at the FAP level, it may be observed that until August 2021, consultations were predominantly for war-related injuries, but after the official cessation of conflict, consultations for non-war-related injuries (e.g. civilian trauma) increased sharply, particularly in Lashkar-Gah.



REASONS FOR CONSULTATIONS IN LASHKAR-GAH

— Total Non-war related wounds
— Total Shell/Mine wounds
— Total Bullet/Stab wounds

In this same context, **the number of referrals from FAPs to all EMERGENCY and government-run hospitals** increased in the summer of 2021.

The number of referrals to all of EMERGENCY's hospitals is again increasing since the beginning of 2022.

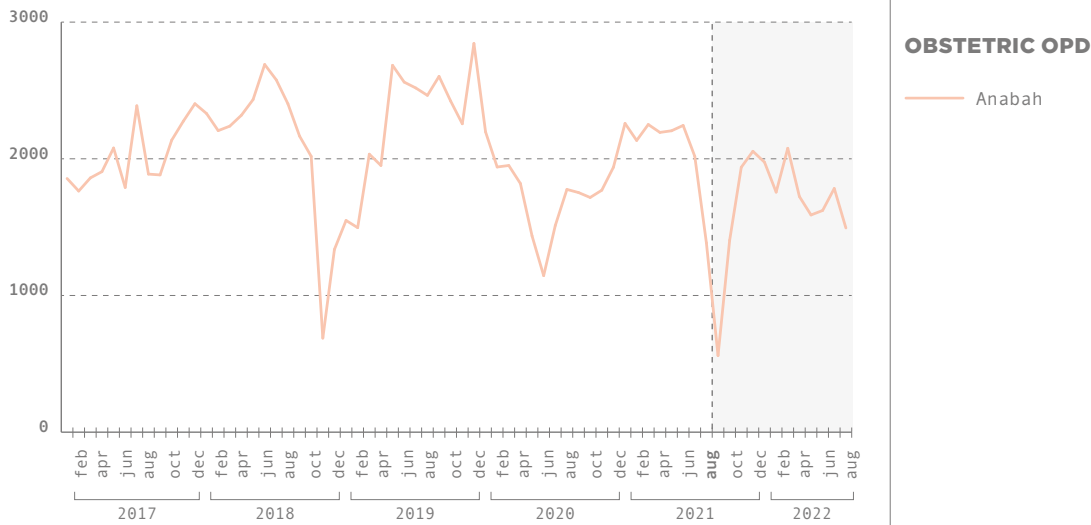
Taken altogether, the data from the FAPs confirm what was seen at the hospital level.

Until August 2021, the burden of disease was mainly due to war-related injuries, hence the increase in the number of surgical admissions, FAP consultations and referrals. After the cessation of conflict, civilian trauma represents the main health need of the population at EMERGENCY's facilities.

MATERNAL CARE

No relevant changes were recorded in pregnancy-related admissions at the Anabah Maternity Centre, with the exception of a temporary reduction just after the events of August 2021, when movement into and out of the Panjshir valley was limited.

A similar trend can be observed for pregnancy-related OPD visits at the Anabah hospital.



Over the years, the trend in admissions for maternal care (obstetric admissions and OPD visits) has been unstable. The change of government in August 2021 did not cause any lasting change in use of maternal care services.

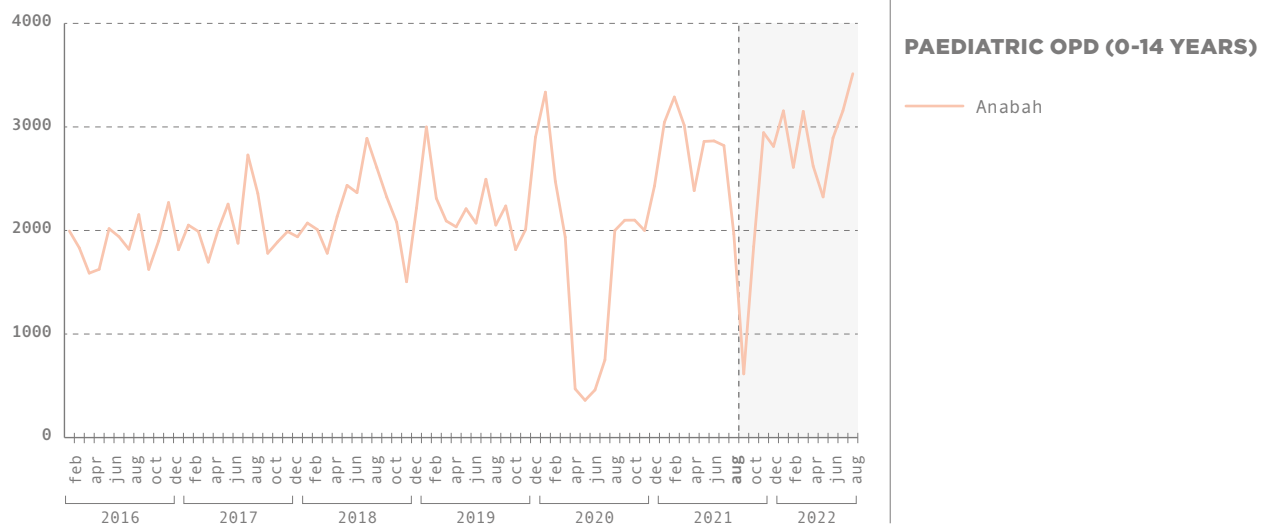
Despite the admission rates for women to the Anabah Maternity Centre not changing drastically since August 2021, changes in the time of day that patients come to the hospital have been reported. Fewer women are now coming to the Anabah Maternity Centre at night-time.

Other events seem to have influenced access to maternal care to a similar extent over the years. For example, a sudden drop in admissions can be seen in November 2018, which is attributed to an outbreak at the Anabah Maternity Centre resulting in the death of 12 newborns and the subsequent decision to close the department temporarily to investigate the incident.

PAEDIATRIC CARE

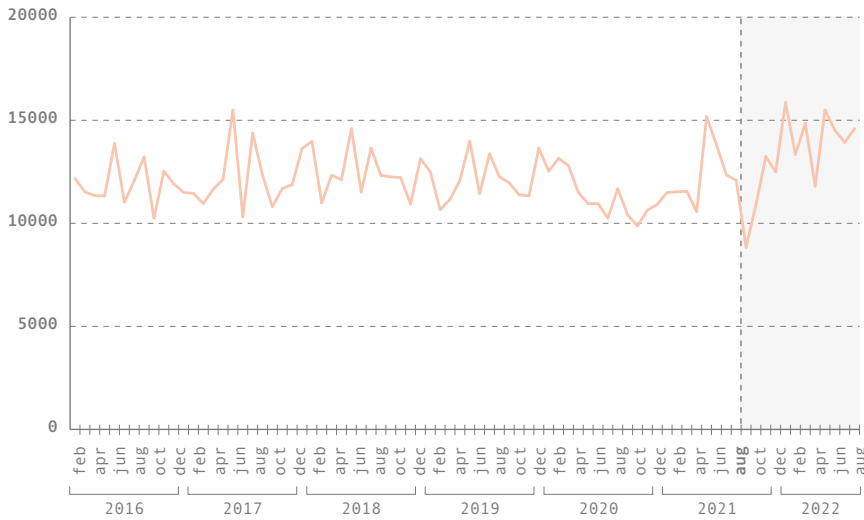
Paediatric OPD visits are steadily increasing in 2022 after a drop in admissions in August 2021.

A more ample drop was recorded between January and July 2020, probably because of Covid-19, which was a lasting shock to the health system, unlike the more sudden shock related to the August 2021 fighting. Interestingly, the figures of vaccinations in Panjshir did not change after the events of August 2021.



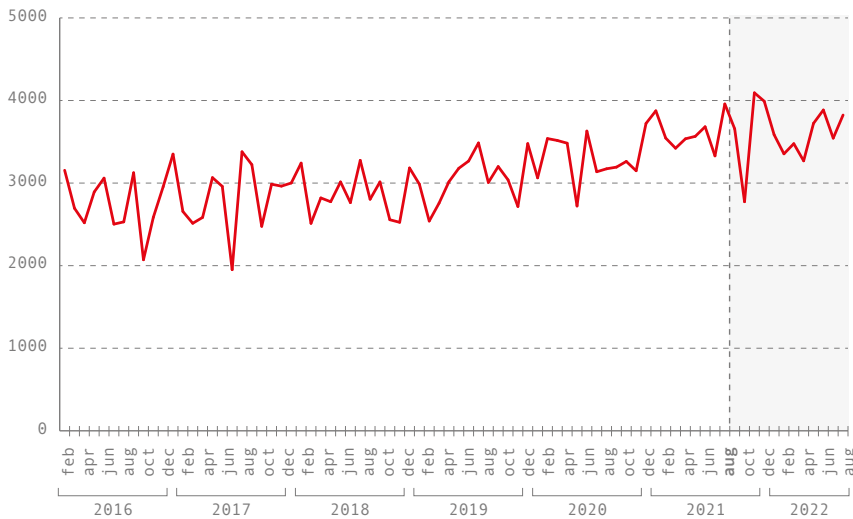
PRIMARY HEALTHCARE CENTRES

Data from EMERGENCY's facilities providing PHC services – two in the Kabul area and 11 in the Anabah area – show no recorded relevant changes after August 2021. In all the provinces concerned (Kabul, Panjshir, Parwan, Kapisa and Logar), the total number of PHC consultations even showed a small increase.



PHC FIRST VISITS IN ANABAH REFERRAL AREA

— Anabah

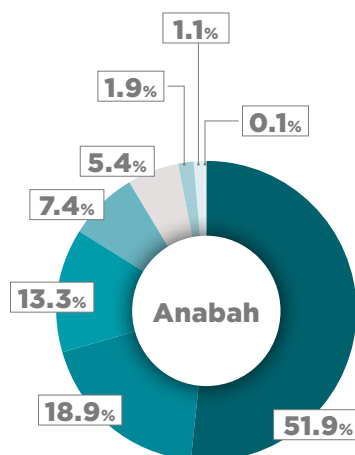
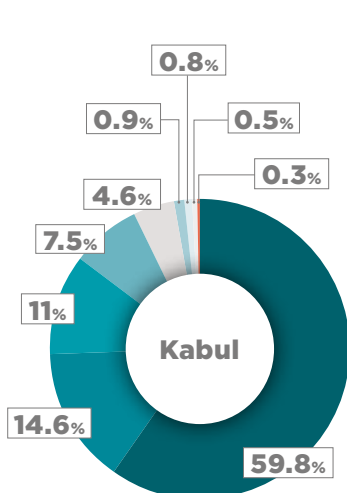


PHC VISITS IN KABUL REFERRAL AREA

— Kabul

Burden of disease

When analysing the reasons for consultation at the PHC level, it may be observed that patients arriving with acute ailments (i.e. acute respiratory, gastrointestinal and urinary tract infections) made up the vast majority of the sample in all facilities. Only 0.9% and 1.9% of the patient cohort in the Kabul and Anabah areas, respectively, were diagnosed with a non-communicable disease, namely arterial hypertension.



DIAGNOSES AT PHCs KABUL AND ANABAH IN 2022

- Acute respiratory infections
- Body pain
- Acute Gastrointestinal infections
- Urinary tract infections
- Dental problems
- Hypertension
- Moderate/Severe malnutrition
- Tuberculosis
- Psychiatric diseases



ACCESS TO CARE FROM THE POINT OF VIEW OF PATIENTS

KEY FINDINGS

1 In the past year, people have generally said they felt “safe” or “very safe” when visiting health facilities, the main reason being safer health facilities, less stigmatisation, more welcoming staff and better staff composition. The percentage of those feeling “unsafe” was higher in Panjshir than in Kabul and Lashkar-Gah. The majority of participants said their sense of safety when visiting health facilities increased after the change of government in August 2021.

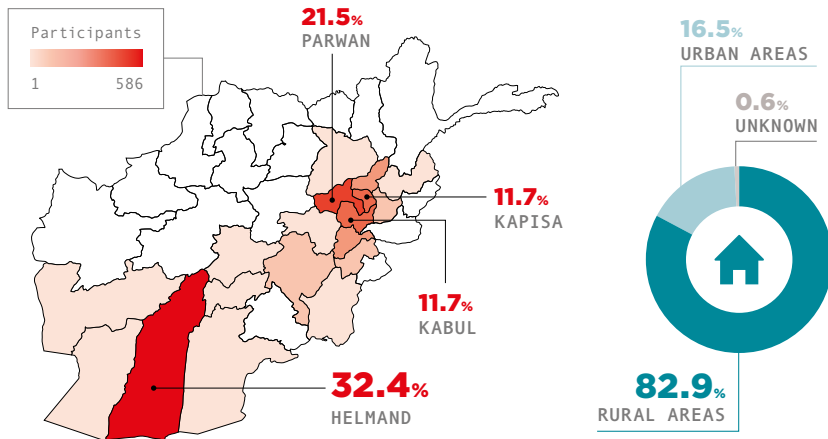
2 The cost of medicines, treatment and transport to health facilities are the primary barriers to access to care, and the majority of participants consider costs “expensive” and “very expensive”. Notably, the ability of the majority of participants to pay for care decreased after the change of government in August 2021.

3 After the change of government, access to health-related information has improved for the majority of participants, the main reasons being more safety, more outreach activities, more ease of transport, more access to media and the internet, and more trust in healthcare messaging. Moreover, participants report that their ability to reach health facilities has remained the same. This suggests that the economic crisis and high transport costs still prevent people from reaching health facilities.

4 Being female, being separated, widowed or divorced and not being the head of a household were factors independently associated with a decreasing ability to access care after the change of government. Living in Logar, Parwan and Panjshir provinces has also been identified as an indicator of worsened access to care over the past year.

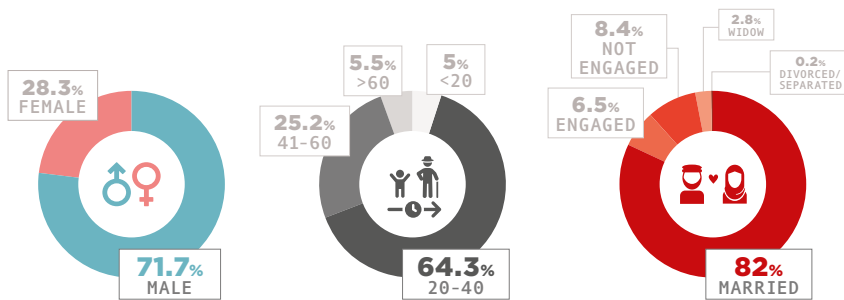
5 Among the participants in EMERGENCY’s three areas (Anabah, Kabul and Lashkar-Gah), those who sought care at the Anabah hospital were more likely to state that their access to care worsened after August 2021 than those who sought care at the Kabul and Lashkar-Gah hospitals.

PROFILE OF PARTICIPANTS



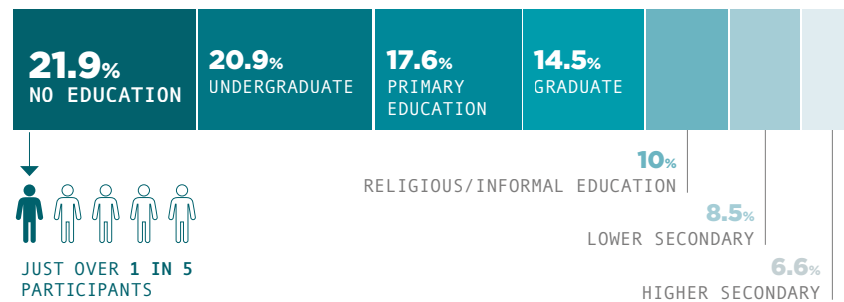
ORIGIN

The participants came from 18 different provinces, the most common being Helmand (32.43%), Parwan (21.47%), Kabul (11.68%) and Kapisa (11.68%). 82.9% lived in rural areas.



GENDER, AGE AND MARITAL STATUS

The majority of participants were male (71.7%) and fell in the 20-40 age range (64.3%). Slightly over 80% of them said they were married.



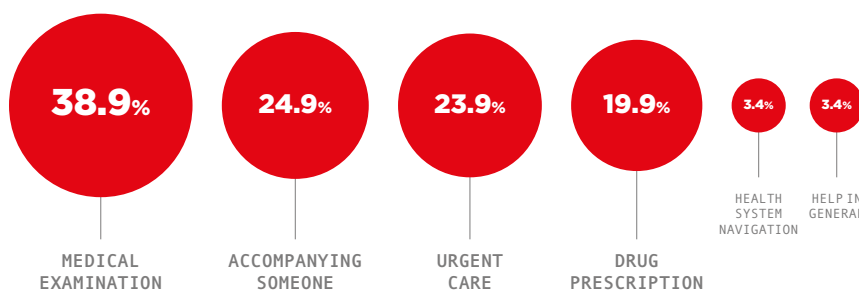
EDUCATION

Just over 1 in 5 participants had received no education (21.9%), followed by 20.9% participants with undergraduate education and 17.6% with only primary education.



EMPLOYMENT

Up to 30% of participants were subsistence farmers, 20.2% were unpaid family workers and 20% were self-employed.



REASONS FOR VISITING EMERGENCY'S FACILITIES



FINDINGS FROM QUESTIONNAIRES ABOUT ACCESS TO CARE

INFORMATION ABOUT DATA COLLECTION*

In total, 1,832 questionnaires were completed by patients – or people accompanying them – at EMERGENCY’s facilities. After 25 invalid responses were excluded, the final sample size for the questionnaire was 1,807 (more information on the geographical coverage and response rates by location can be found in the outreach section, p. 5).

PERCEPTION AND USE OF THE HEALTH SYSTEM

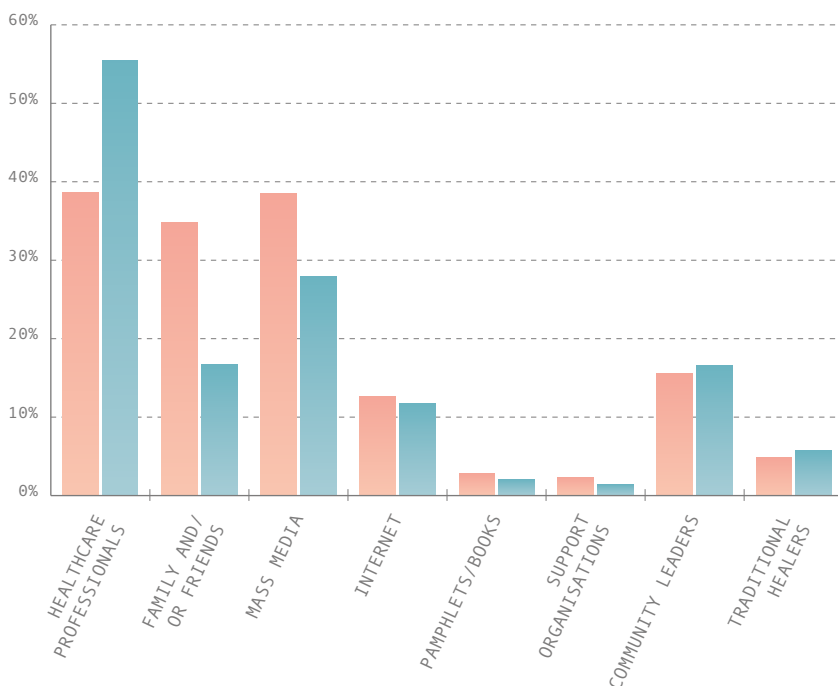
When asked about the type of health facility they had visited most often in the past year, participants predominantly mentioned basic health centres (37.5%), district hospitals (30.8%), health posts (29.2%) and provincial or national hospitals (22.9%). Basic health centres appear to have been the first option for participants seeking care in the areas of Anabah (49.1%) and Kabul (58.5%). By contrast, the majority of people seeking care in the Lashkar-Gah area (50.8%) said that health posts were their most visited facilities in the past year.

*Patients were asked about general barriers to access to care, not limited to EMERGENCY’s facilities, and questioned about obstacles that their family members or close friends may also have experienced.

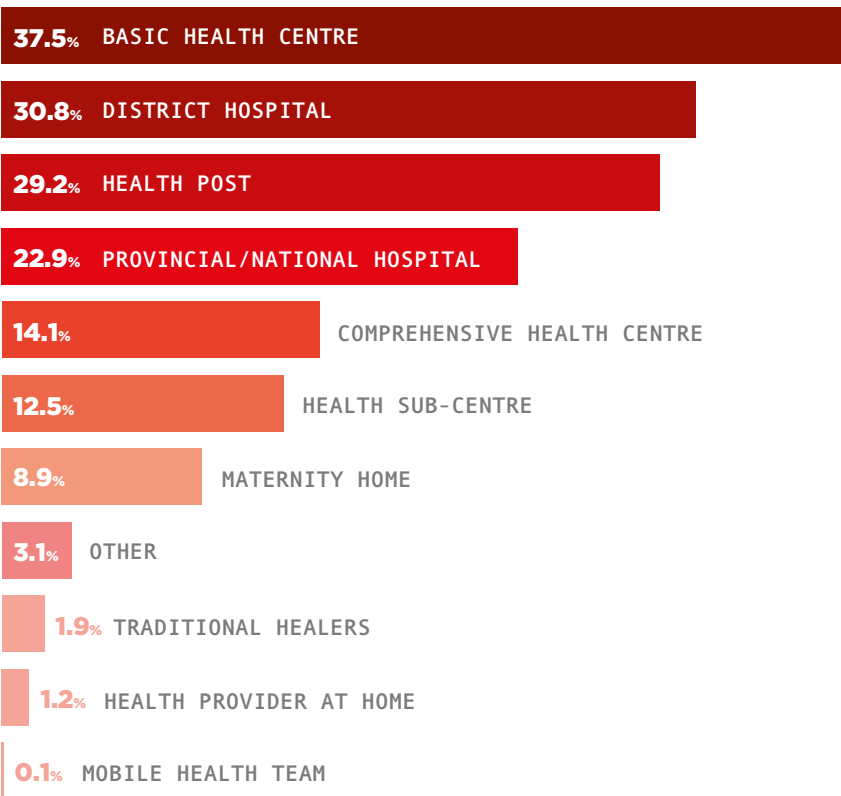
MAIN SOURCE OF INFORMATION

For half of the participants, healthcare providers are their main source of health information, followed by mass media (31%), family and friends (21.9%), community leaders (16.3%) and the internet (13.7%), and to a lesser extent traditional healers (5.5%), pamphlets or books (2.4%) and support organisations (1.7%). Female participants tend to rely on family or friends (34.8%), mass media (38.5%) and the internet (12.7%) to a greater extent than their male counterparts (16.8%, 27.9% and 11.7% respectively), and on healthcare providers (38.7%) to a lesser extent than their male counterparts (55.4%).

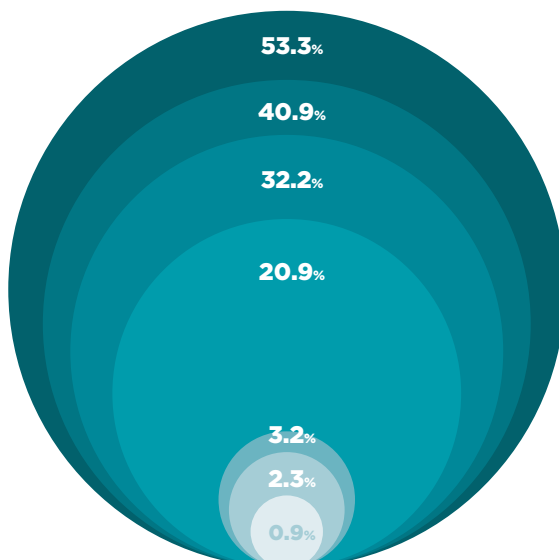
Female
Male



Although 70.8% of participants considered health information “accessible” and 71.9% considered it “understandable”, **men were more likely to consider information “accessible” (73.1%) and “understandable” (74.7%) than women (65% and 64.6% respectively)**. Level of education proved to have a significant impact on access to and understanding of health information, with less educated people coming up against more constraints.



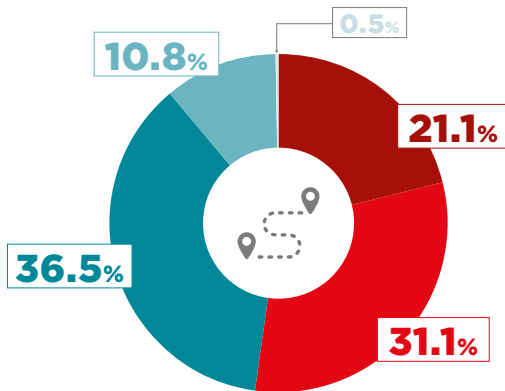
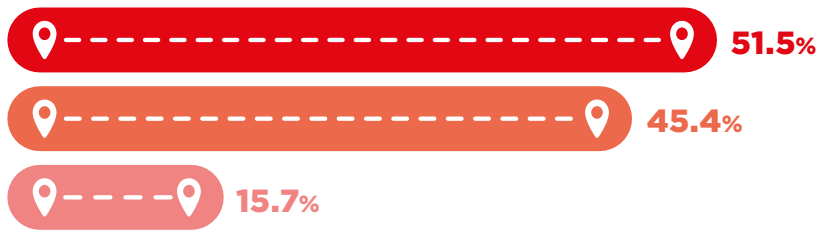
WHAT HEALTH FACILITY DID PEOPLE VISIT MOST IN THE PAST YEAR?



HOW DO PEOPLE USUALLY REACH HEALTH FACILITIES?

- WALK
- TUK TUK
- PRIVATE CAR OR SIMILAR
- BIKE
- ANIMAL
- PRIVATE BUS OR AMBULANCE
- PUBLIC AMBULANCE

Almost 80% of participants sought care at the health facility closest to their home in the past year. Those who did not seek care at the closest facility gave the following main reasons: safety issues (48.8%), high costs (35.4%), too many Covid-19 cases (28.4%) and a lack of trust in the quality of services (26.8%).



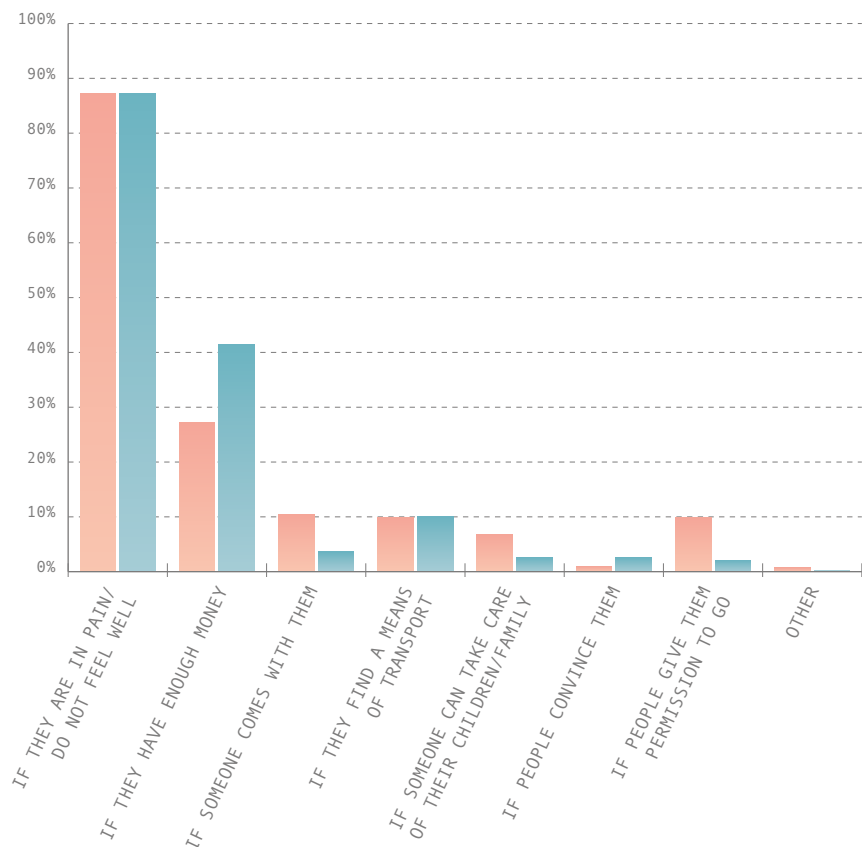
TRAVEL TO SEEK CARE

- GO TO ANOTHER PROVINCE
- GO TO ANOTHER CITY
- GO TO ANOTHER COUNTRY

TRAVELLING FROM HOME TO THE HEALTH FACILITY

- VERY CHALLENGING
- CHALLENGING
- NORMAL
- EASY
- VERY EASY

When asked about the factors influencing their decision to go to see a doctor, the majority of participants said they seek care when they are in pain or do not feel well (87.4%); the second most common factor was having enough money to go (37.5%). A greater proportion of female participants described a need to have someone accompanying them (10.9%), to have someone taking care of their children (6.8%) and to receive permission to go (9.8%) than among male participants (3.6%, 2.6% and 2.1% respectively).



WHEN DO PEOPLE GO TO SEE A DOCTOR?

- Female
- Male

CONCERNS WHEN ACCESSING CARE

42.6% of participants said they had faced obstacles when accessing care in the past year, the main reasons being that they felt in danger because of conflict (52.4%), they could not afford to see a doctor (40.3%), they feared the Covid-19 pandemic (25.8%), the health facility was too far (14.5%), they felt in danger from crime (9%), the health facility was not designed for people with disabilities (7.9%), there was danger from natural disasters (4.2%), or they were in danger of being discriminated against (3.5%). **Up to 22.6% of participants mentioned that at least one family member or friend had died in the past year because of a lack of access to care.**

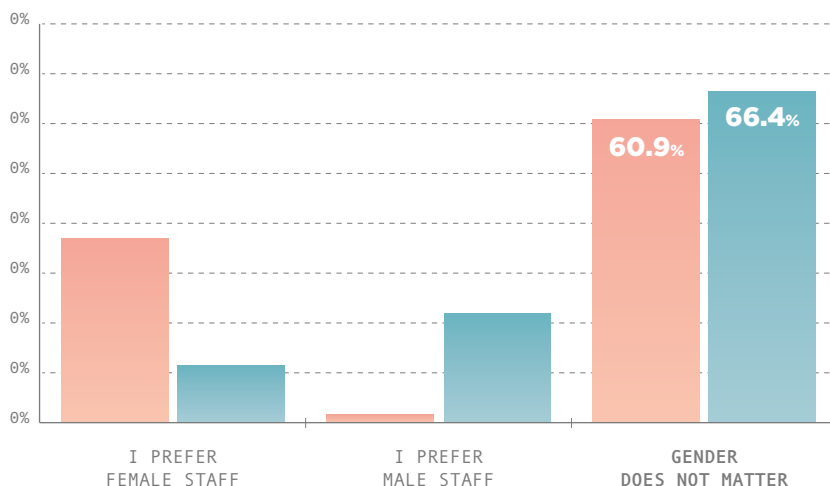
The percentage of people who have faced obstacles in accessing care in the past year in the Lashkar-Gah area (54.5%) was higher than in the Anabah and Kabul areas (38.7% and 33.6% respectively). Day labourers and subsistence farmers were significantly more likely than public sector workers to state that they had faced obstacles to accessing care in the past year.

Safety remains an important factor in access to care in Afghanistan. **When asked how safe they feel when seeking health services, most participants considered themselves “very safe” (43.2%) or “safe” (38.3%).** While 78.3% of people in the Lashkar-Gah area said they had felt “very safe” in the past year, the percentages of people feeling “very safe” in the Anabah and Kabul referral areas were lower (at 20.5% and 34.9% respectively). In fact, **11.9% of participants seeking care in the Anabah area said they had felt “unsafe” in the past year, but this percentage was much lower among people seeking care in the Kabul (1.3%) and Lashkar-Gah areas (0.7%).**

In the past year, the majority of participants were faced with delays when accessing medicines (46%) and diagnostic tests (44.5%). Overall, 55.3% of participants did not have access to any medicine in the past year, with the highest proportion in the Kabul area (68.3%), followed by the Lashkar-Gah (50.4%) and Anabah (49.9%) areas. Those who mostly sought care at government facilities were significantly more likely to have faced a delay in accessing medicines than those who mostly visited EMERGENCY’s facilities in the past year.

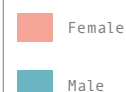
PERCEPTION OF STAFF BEHAVIOUR AND COMPOSITION

The vast majority of participants evaluated staff behaviour as “very good” (41.2%) or “good” (39.4%). Yet 240 participants (13.3%) said they had felt offended or stigmatised when seeking care in the past year. When asked their reasons, the following grounds were given: ethnicity (59.6%), mental health disorders (24.7%), income or social status (13.2%), disability (9.8%), gender (6.8%), level of education (4.3%) and religion (1.3%). The percentage of people seeking care in the Lashkar-Gah area (23.8%, 141) who felt offended or stigmatised in the past year was higher than in the Anabah and Kabul areas (9%, 66, and 6.7%, 32, respectively).



GENDER PREFERENCE FOR THE HEALTH FACILITY STAFF

With regard to staff composition, 65% of participants (60.9% of women and 66.4% of men) stated that the gender of healthcare staff did not matter to them.



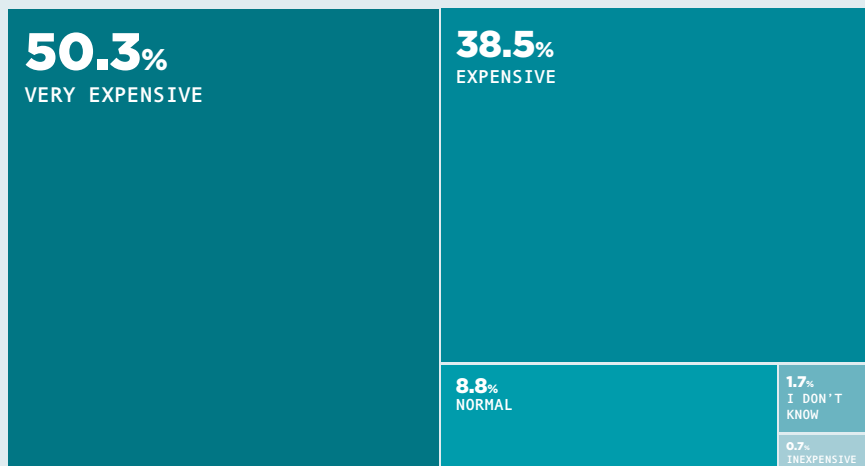
A correlation was found between gender preference and level of education, with less educated people being significantly more likely to express a gender preference than people with a higher level of education.

FINANCIAL BARRIERS AND AFFORDABILITY

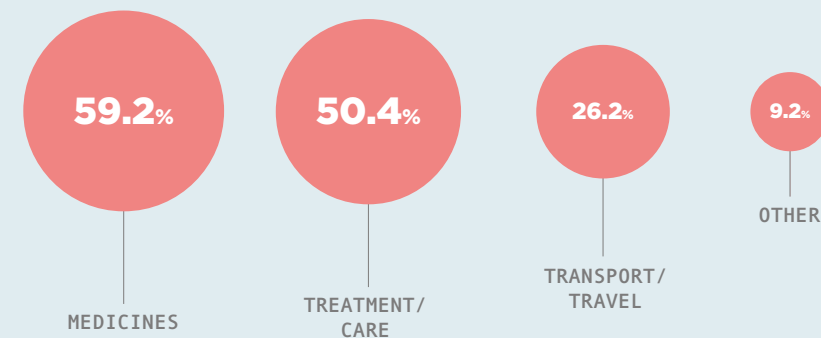
Financial barriers were frequently mentioned by participants. Up to 51.3% of participants said they had spent less money on food and clothes in the past year in order to pay for healthcare, 86.6% faced financial difficulties due to spending on healthcare, and more than 50% considered healthcare costs “very expensive”.

Over the past year, day labourers and subsistence farmers were significantly more likely than public sector workers to spend less money on food or clothes to pay for healthcare and to postpone care due to costs.

When asked what they had spent the most money on, participants mentioned medicines (59.2%), treatment/care (50.4%) and transport/travel (26.2%). Notably, 70.3% of participants said that they had postponed care due to costs and 86.5% had needed to borrowing money to pay for healthcare in the past year.

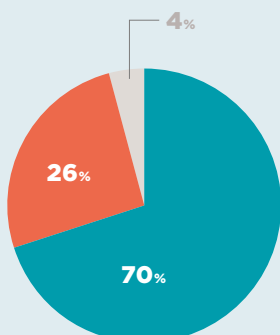


HOW DO PEOPLE DESCRIBE HEALTHCARE COSTS?

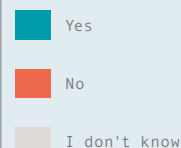
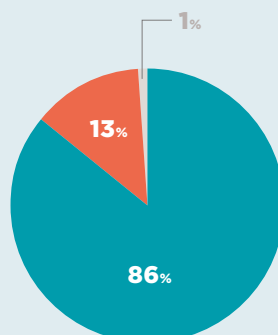


WHAT DID PEOPLE SPEND MOST MONEY ON?

DID PEOPLE POSTPONE CARE DUE TO COSTS IN THE PAST YEAR?

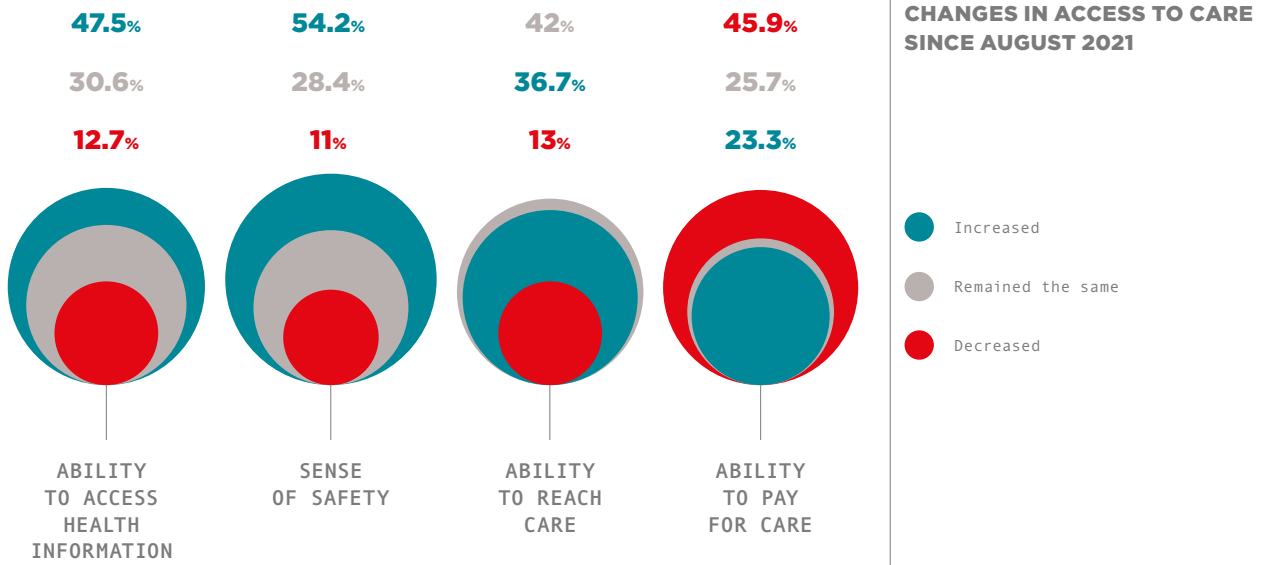


WERE PEOPLE FORCED TO BORROW MONEY TO PAY FOR HEALTHCARE IN THE PAST YEAR?



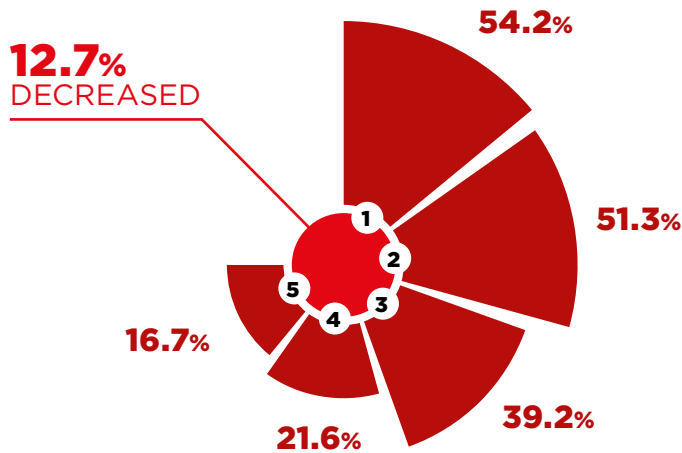
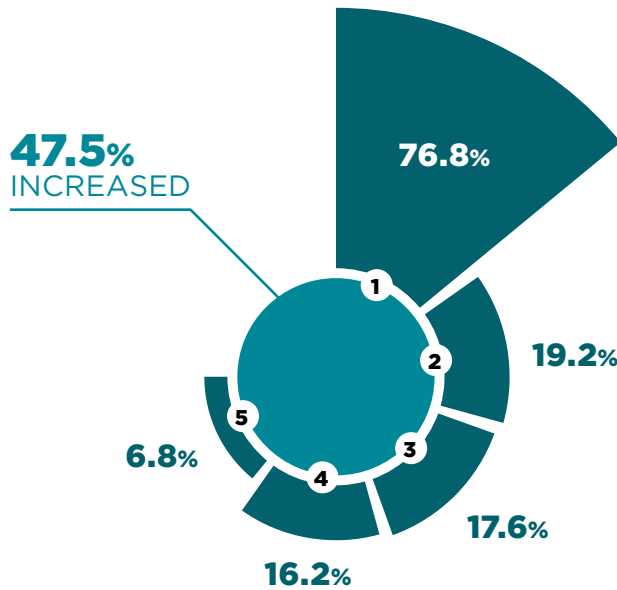
CHANGES IN ACCESS TO CARE SINCE AUGUST 2021

The following section outlines the main factors predicting a deterioration of access to care, in order to identify the most vulnerable categories of people and the main barriers encountered when seeking care in the past year.



ABILITY TO ACCESS HEALTH INFORMATION

Most participants (47.5%) said their ability to access health information had increased, followed by those who said it had remained the same (30.6%) and those who said it had decreased (12.7%).



The ability to access health information decreased particularly among certain categories of people, namely: women (19%) compared to men (10.2%); separated, widowed or divorced people (23.6%) compared to married (13.3%); those who are not the head of a household (14.6%) compared to those who are (11.3%).

Geographic location was found to be related to the ability to access health information. Likewise, 1 in 2 participants living in Baghlan (50%) and 1 in 4 participants in Ghazni (25%) and Logar (26.9%) saw their ability to access health information worsen in the past year, compared to 1 in 15 participants living in the capital city (6.7%).

Participants who described constraints in finding or understanding health information were 3 times as likely to say their ability to access health information had decreased as were other participants.

Obstacles to accessing care also proved to have a negative impact on ability to access health information. Specifically, 46.5% of those feeling “unsafe” when visiting a health facility were almost 8 times more likely than other participants to say their ability to access health information had decreased.

THE MAIN REASONS FOR AN INCREASED ABILITY TO ACCESS HEALTH INFORMATION

- 1 MORE SAFETY
- 2 MORE OUTREACH ACTIVITIES
- 3 MORE EASE OF TRANSPORT
- 4 MORE ACCESS TO MEDIA AND THE INTERNET
- 5 MORE TRUST IN HEALTHCARE MESSAGING

THE MAIN REASONS FOR A DECREASED ABILITY TO ACCESS HEALTH INFORMATION

- 1 FEWER OUTREACH ACTIVITIES
- 2 MORE DIFFICULTY OF TRANSPORT
- 3 LESS SAFETY
- 4 LESS ACCESS TO MEDIA AND THE INTERNET
- 5 LESS TRUST IN HEALTHCARE MESSAGING

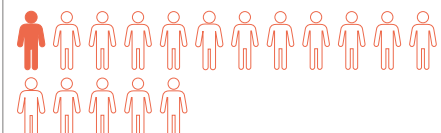
BAGHLAN



GHAZNI AND LOGAR



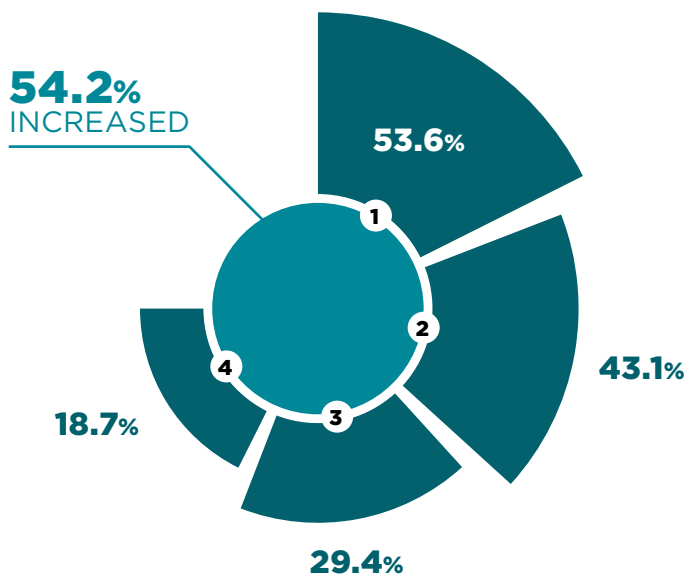
KABUL



Finally, dissatisfaction with the gender composition of healthcare staff and perceived discrimination when seeking care were associated with a decreased ability to access health information.

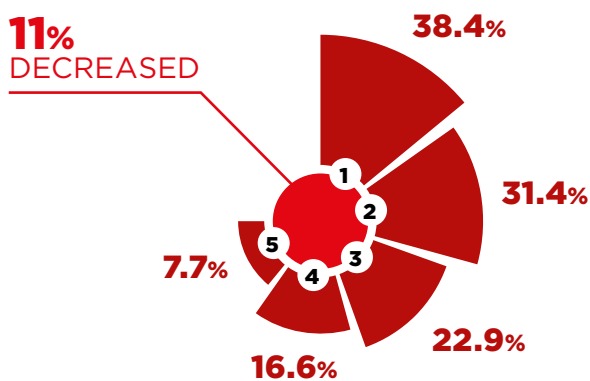
SENSE OF SAFETY WHEN SEEKING CARE

54.2% of participants said their sense of safety when seeking care had improved in the past year, while 28.4% found it unchanged and 11% said it had worsened.



THE MAIN REASONS FOR AN IMPROVED SENSE OF SAFETY WHEN SEEKING CARE

- 1 SAFER HEALTH FACILITIES
- 2 LESS STIGMATISATION
- 3 MORE WELCOMING STAFF
- 4 BETTER STAFF COMPOSITION

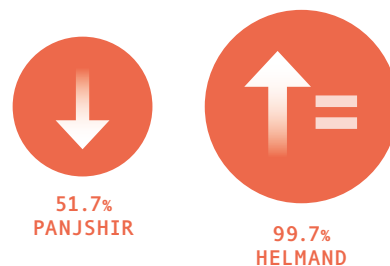


THE MAIN REASONS FOR A DECREASED SENSE OF SAFETY WHEN SEEKING CARE

- 1 MORE DANGEROUS HEALTH FACILITIES
- 2 THE COVID-19 PANDEMIC
- 3 WORSE STAFF COMPOSITION
- 4 LESS WELCOMING STAFF
- 5 MORE STIGMATISATION

Female participants, those separated, widowed or divorced, and those who are not the head of a household were more likely to feel a decreased sense of safety when seeking care after the change of government. In particular, **women were 4 times as likely as men to say their sense of safety when seeking care had decreased.**

24.1% of participants who sought care at EMERGENCY's Anabah hospital said their safety had worsened, compared to 5.2% of those seeking care at EMERGENCY's Kabul hospital. Likewise, **51.7% of participants living in Panjshir and 16.8% in Parwan said their sense of safety had decreased. Conversely, 584 participants (99.7%) living in Helmand said their sense of safety had increased or not changed.**



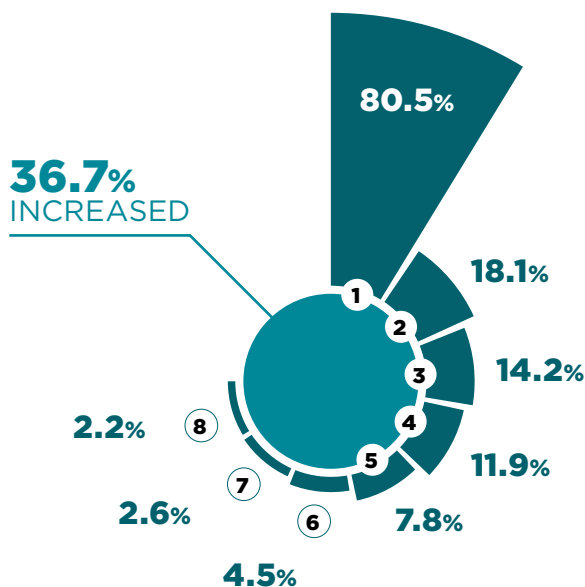
72.7% of participants who said they did not feel safe when visiting health facilities also said their sense of safety had decreased in the past year. Similarly, those who described obstacles to seeking care or delays in accessing it were more likely to say their sense of safety had decreased.

The appropriateness of health services was found to influence people's sense of safety when seeking care. Those who stated a preference for female healthcare staff (19.8%) and those dissatisfied with the gender composition of the health staff (21.1%) were more likely to say their sense of safety had decreased than those who did not care about the staff's gender composition (10.4%) or were satisfied with the staff composition (9.4%). Moreover, 42.4% of those who had felt offended or stigmatised when seeking care also said their sense of safety had decreased in the past year.

In addition, 17.8% of individuals who suffered delays when accessing surgery or other procedures and 15.1% of those who suffered delays when accessing diagnostic tests said their sense of safety when seeking care had decreased.

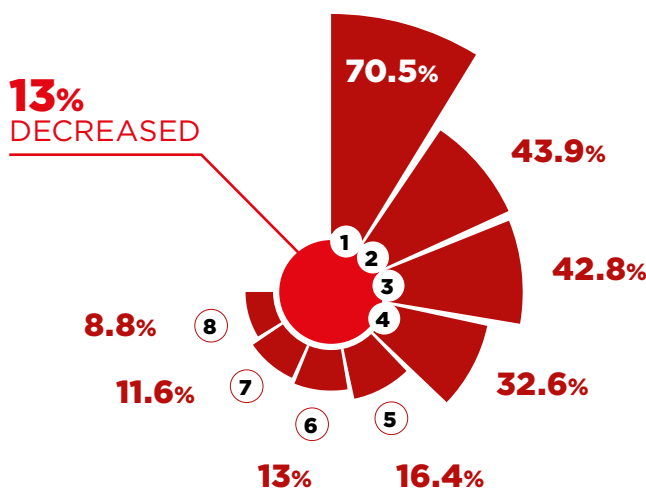
ABILITY TO REACH CARE

36.7% of participants said their ability to reach care had increased since August 2021, while 13% said it had decreased. The highest percentage of participants (42%) said it had remained the same.



THE MAIN REASONS FOR AN INCREASED ABILITY TO REACH CARE

- 1 LESS FEAR
- 2 CLOSER FACILITIES
- 3 BETTER OPENING HOURS
- 4 BETTER MOBILITY
- 5 BETTER TRANSPORT
- 6 LOWER COSTS
- 7 BETTER APPOINTMENT MECHANISMS
- 8 BETTER AMBULANCE SYSTEMS



THE MAIN REASONS FOR A DECREASED ABILITY TO REACH CARE

- 1 HIGHER COSTS
- 2 FEWER FACILITIES
- 3 WORSE TRANSPORT
- 4 MORE FEAR
- 5 RESTRICTED MOBILITY
- 6 WORSE OPENING HOURS
- 7 WORSE APPOINTMENT MECHANISMS
- 8 WORSE AMBULANCE SYSTEMS

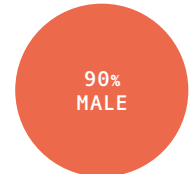
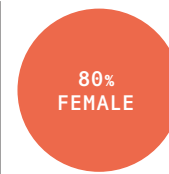
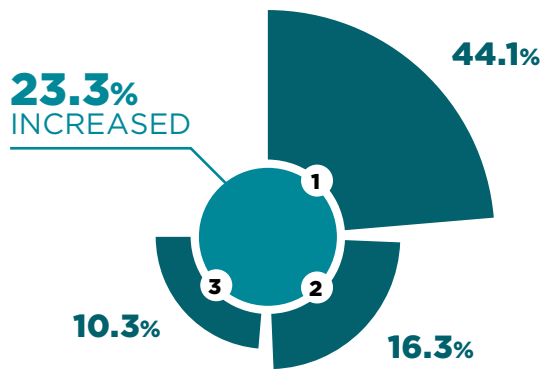
80% of female participants said their ability to reach care had increased or not changed since August 2021, compared to 90% of men; nevertheless, women were twice as likely as men to say their ability to reach care had decreased.

Participants living in Logar and Panjshir were, respectively, 3 and 7 times more likely to believe their ability to reach care had decreased than those living in Kabul. Conversely, 89.6% of participants living in Kabul and 96.8% of those living in Helmand said their ability to reach care had increased or not changed.

Those who sought care in another city and in another province in the past year were more likely to say that their ability to reach care had decreased. This data is corroborated by the fact that participants who described travelling to seek care as “challenging” were 5 times as likely to feel their ability to reach care had worsened in the past year. Moreover, only 5.5% of those who did not travel to seek care said their ability to reach care had decreased.

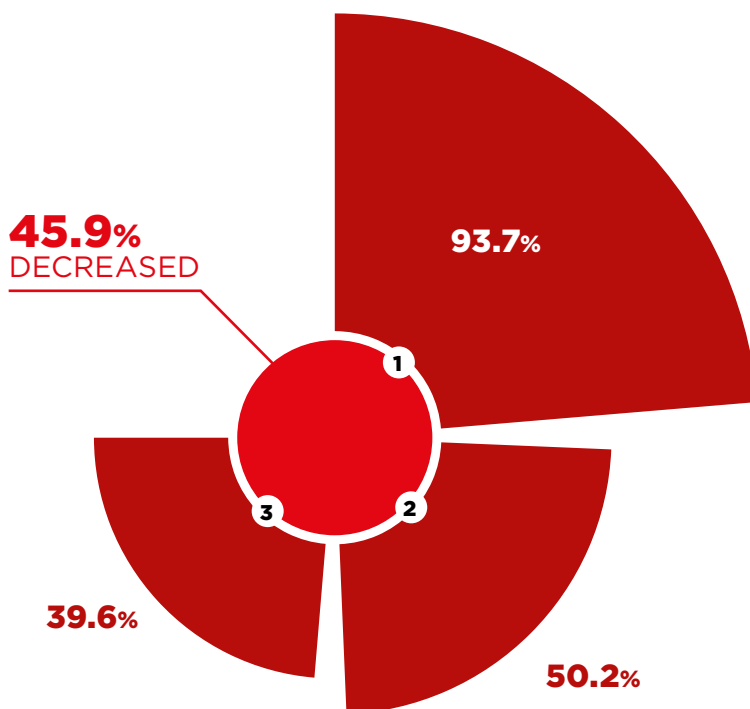
ABILITY TO PAY FOR CARE

23.3% of participants said their ability to pay for healthcare had improved since August 2021, 25.7% found it unchanged and 45.9% said it had worsened.



THE MAIN REASONS FOR AN INCREASED ABILITY TO PAY FOR HEALTHCARE

- 1 BETTER INCOME
- 2 FEWER COSTS
- 3 CHEAPER TRANSPORT



THE MAIN REASONS FOR A DECREASED ABILITY TO PAY FOR HEALTHCARE

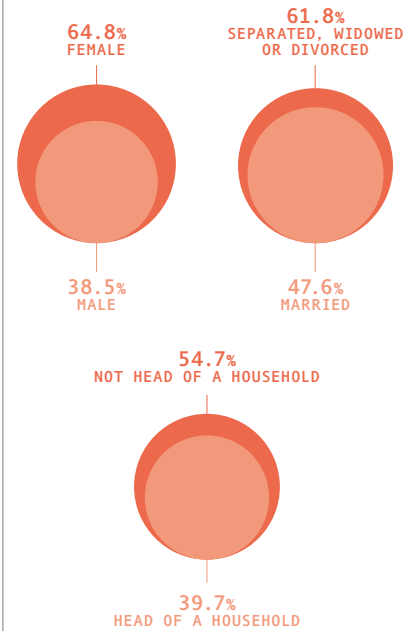
- 1 WORSENERD INCOME
- 2 HIGHER COSTS
- 3 MORE EXPENSIVE TRANSPORT

Affordability of care significantly affected certain categories of people more than others. In particular, in the past year, **the ability to pay for healthcare worsened for 64.8% of female participants, compared to 38.5% of male participants; for 61.8% of separated, widowed or divorced individuals, compared to 47.6% of married individuals; and for 54.7% of those who are not the head of a household, compared to 39.7% of those who are.**

Participants living in Kapisa (75.8%), Logar (70.2%), Panjshir (80.4%) and Parwan (68.7%) were more likely to feel their capacity to pay for care had decreased in the last year, while only 7.4% of participants living in Helmand perceived such a decrease.

Satisfaction with health services proved to be correlated with participants' ability to pay for care: 67.4% of participants who were "unsatisfied" with health services said their ability to pay for care had decreased, compared to 44.3% of those who were "satisfied". Similarly, half of those who faced financial constraints to spending on healthcare (49.6%) and those who borrowed money to pay for healthcare (48.4%) found healthcare less affordable in the past year.

Finally, 57.4% of those who encountered delays in accessing diagnostic tests and 62.3% of those who encountered delays in accessing surgery and other procedures in the past year complained of a decreased ability to pay for healthcare.



PARTICIPANTS' RECOMMENDATIONS ON HOW TO IMPROVE ACCESS TO CARE

Several strategies for improving access to care were suggested by participants. Ranked according to their frequency, these were: improvement in the quality of health services (64.2%), an increase in the number of health facilities (54.4%), a reduction of care costs (38.9%), an increase of female staff (35.3%), a reduction of **travel costs (29.4%), a reduction of travel times (28.5%) and improved attitude among staff (23.6%).**

IMPROVEMENT OF QUALITY OF SERVICES

64.2%

INCREASE IN NUMBER OF FACILITIES

54.4%

REDUCTION OF CARE COSTS

38.9%

INCREASE IN FEMALE STAFF

35.3%

REDUCTION OF TRAVEL COSTS

29.4%

REDUCTION OF TRAVEL TIME

28.5%

IMPROVEMENT OF STAFF ATTITUDE

23.6%

WHAT ARE WAYS TO IMPROVE ACCESS TO CARE IN AFGHANISTAN?





ACCESS TO CARE IN AFGHANISTAN: PERSPECTIVES FROM AFGHAN PEOPLE IN 10 PROVINCES

ACCESS TO CARE FROM THE POINT OF VIEW OF HEALTHCARE WORKERS

KEY FINDINGS

- 1** Afghanistan is experiencing a massive and chronic dearth of various categories of HCWs, especially in rural areas, particularly as many have left the country since August 2021. In addition, training for HCWs is generally considered to be poor. Healthcare facilities are lacking essential medical equipment and supplies and are usually located in substandard buildings. All this prevents facilities, especially in rural areas, from providing adequate care to the population. District and provincial hospitals struggle to guarantee basic services and treatment itself is substandard. Aware of these constraints, people often bypass facilities at the appropriate level, going straight to the larger, central hospitals and thereby aggravate the chronic congestion of patients at the tertiary level in Afghanistan.
- 2** People's ability to pay for healthcare has drastically reduced in the past year and many families struggle to make ends meet. Although basic health services are ostensibly free for all patients in all government hospitals, patients may be forced to make out-of-pocket payments for consumables, medicines and transport, which leads some to delay seeking care in the first place, at the expense of their health.
- 3** People's ability to reach healthcare facilities has improved in Kabul and Lashkar-Gah but worsened in Panjshir, where episodes of fighting have harmed mobility. Consequently, in the Kabul and Lashkar-Gah areas there has been an increase in patients visiting healthcare facilities.
- 4** The type of patient coming to hospital has also changed since August 2021: the burden of war-wounded patients has decreased, leaving civilian trauma and road traffic accidents the main causes of admission. Furthermore, the number of patients arriving with mental health disorders and malnutrition has increased. Estimates of the prevalence of NCDs are too low due to a lack of awareness among both patients and HCWs. Unfortunately, treatment for many NCDs is still only offered at private facilities, on condition of out-of-pocket payment, so the risk of underdiagnosis is high.

ABOUT THE SAMPLE

Forty-three workers were involved in the interviews. Eleven were directors of national or provincial hospitals run by the Ministry of Public Health, in nine Afghan provinces. The remaining interviewees (32) were on EMERGENCY's staff: five field officers, six FAP supervisors, nine nurses (of whom three were head nurses), two pharmacists (one of them a pharmacy assistant), four surgeons (one of them a surgical resident), one gynaecologist, two midwives, one paediatrician, one anaesthetist and one physiotherapist. Overall, 10 out of the 43 interviewees were female.

FINDINGS FROM INTERVIEWS ABOUT ACCESS TO CARE

AFGHANISTAN SINCE AUGUST 2021

Interviewees described general changes in Afghan society since August 2021 that have led to changes in healthcare provision and access to care, revealing chronic challenges.

The major changes relate to **the end of the war** and improved security in the country. Interviewees had noticed a marked **decrease in blasts and mine explosions in cities**, although they said **violence persists in the form of shootings and knife fights** over land and family disputes. **Interviewees in Lashkar-Gah reported the most dramatic decrease in fighting** and described roads that had been battlefields for the past 20 years reopening. Conversely, **interviewees in Panjshir witnessed an escalation of conflict**. Two interviewees, one working in the Kabul area and one in the Anabah area, reported that the number of mass casualty incidents has decreased since August 2021. Overall, despite an increase in the sense of security in the country, tensions remain and **people are afraid that the situation could again deteriorate**.

The end of the war has led to **improved mobility within the country**, something mentioned especially by interviewees in Helmand and Ghazni provinces. While in the past, people were confined to their own districts, now they can get to urban areas more easily.

“For example, from Marjah, now it takes half an hour in an ambulance to reach Lash. But in the past there were three or four battlefields they had to pass through. They were spending three hours, sometimes four hours, coming from Marjah.”

Tawoos, Lashkar-Gah Field Officer, EMERGENCY

Nevertheless, interviewees reported that roads are still challenging to drive on because they are ruined from past explosions. In Panjshir province, security concerns still hamper mobility, pushing more and more people **to move to Kabul** or other safer areas.

Interviewees often talked about the rampant **economic crisis** and **hunger** affecting Afghanistan. Poverty is driven by **unemployment**, on the rise since many international NGOs left the country. This was particularly damaging for people in Panjshir, who were predominantly working for international NGOs and the government. Farmers faced huge economic losses too, as recent disasters such as **drought and floods have destroyed crops in many areas**. Withdrawal restrictions mean **people's savings are stuck in banks**. This situation is aggravated by a spike in prices that has made food inaccessible for the majority of Afghans. As an example, it was reported that while in the past they could buy 5 kg of oil for 500 afghanis (the Afghan currency), now the price has gone up to 1,200 afghanis. To cope with this challenging situation, many **families have been selling their belongings** to pay for food; otherwise, **men are going abroad to look for a job**, leaving women alone to lead households in Afghanistan.

Some interviewees mentioned that **discrimination against ethnic minorities has increased**. One interviewee also perceived that the humanitarian response to natural disasters was uneven among provinces and less favourable to minority groups. Other vulnerable groups that have been mentioned by interviewees are internally displaced people, Kuchi people (pastoral nomads from southern and eastern Afghanistan), poor farmers living in extremely remote areas and **women, whose rights – especially the right to education – have been eroded recently**.

HEALTHCARE PROVISION IN AFGHANISTAN: CHRONIC AND RECENT CHALLENGES

HEALTH WORKFORCE

Since August 2021, **many HCWs have left Afghanistan**, especially nurses and midwives, further aggravating a chronic dearth of medical workers in the country:

“We lost our specialists, our good doctors, our good engineers. They left the country, and this is a great loss for our country. Hopefully, we will return to those conditions in 20, 30 years. It's really a great loss for us. We are losing one or two generations.”

Dr Shakeeba, Anaesthesia Resident,
Kabul Surgical Centre, EMERGENCY

The number of HCWs leaving the country was particularly high in the first weeks after the change of government but then decreased due to the difficulty of obtaining a passport or visa. Furthermore, a decrease was reported in the number of people applying to medical school: while in the past there were between 500 and 1,000 students applying to become doctors, this number has now reduced dramatically to between 100 and 150. The shortage of HCWs has always been more pronounced in rural districts than in urban areas and has affected both public and private facilities.



“The population of Logar province is approximately 700,000 people.

But we only have two surgeons and one orthopaedist. This means that if there is only one surgeon, he is doing 10 surgeries a day and there is no rest for him.”

Dr Sedeq, Provincial Hospital Director, Logar

According to the interviewees, there is a chronic shortage of **doctors** in the surgical (orthopaedics, neurosurgery, gynaecology), imaging (radiology), clinical (internal medicine, paediatrics) and technical (anaesthesia, pathology) fields. A severe shortage of **nurses, physiotherapists, laboratory and radiology technicians** was also mentioned by many interviewees. Notably, most of them agreed that the lack of **biomedical engineers** is one of the most pressing issues. It was frequently mentioned that many devices had remained broken and unrepaired for a long time, due to a structural lack of technical support in the hospitals.

The HCWs who did not leave Afghanistan after August 2021 were met with the challenges of **low salaries and irregular payments**, which were particularly damaging in light of the economic crisis. As a result, HCWs generally have a second

or even a third job at private facilities to boost their salaries. This need for money prompts some HCWs into **illicit activity**, as interviewees frequently reported:

“If you go with a prescription for ceftriaxone, an antibiotic, and this costs 100 afghanis, the pharmacist will charge 300 afghanis, so that 100 goes to the doctor, 200 to the pharmacy.”

Hanif, Kabul Field Officer, EMERGENCY

Despite some improvements over the years with regard to HCWs' training and skills, **the level of knowledge** among them is still unsatisfactory according to many interviewees, especially in rural areas. Training of HCWs at universities generally focuses more on theory and lectures rather than on practical skills. In particular, HCWs' knowledge of the aetiology and prevention of NCDs, as well as management of emergency cases, has always been considered to be poor. On a positive note, it was reported that the new government has made agreements with foreign countries like Pakistan and Qatar about scholarships. On this front, however, some interviewees were sceptical, believing that the lack of specialist centres in the country will result in specialists being unemployed in the future.



MEDICAL EQUIPMENT

All interviewees considered the availability of medical equipment in Afghanistan to be a critical and chronic issue:

“In Panjshir, if you take the provincial hospital we have here, the facility, let's say, we have only 15% of the machines we need.”

Dr Shams Serwari,
Director of Rokha Hospital, Panjshir

Medical equipment was said to be either completely lacking, insufficient for the facilities' needs or obsolete. Some provincial hospital directors said they **lacked laboratory equipment** (i.e., for complete blood counts, electrophoresis and creating laboratory cultures) or the entire apparatus for sterilisation. In some cases, operating theatres were said to lack adequate medical machinery, like monitors and essential devices needed for standard operations, such as electric drills, C-arm machines and laparoscopy tools.

The lack of diagnostic imaging devices, like ultrasound machines, CT scanners and MRI machines, was a critical issue for the majority of interviewees. HCWs were reported to be sending all patients in need of a CT scan to Kabul from all its neighbouring provinces (which include Paktia, Wardak, Panjshir and Logar). In Logar, there is a CT scanner still sitting untouched; it cannot be activated because no technician has been able to install it. The lack of **equipment for haemodialysis and invasive cardiology procedures** was also mentioned as an important challenge.

The majority of the interviewees considered the **ambulance system** an urgent matter. The number of ambulances is generally inadequate for the size and workload of facilities, and they often have insufficient fuel. At the Parwan hospital, only two out of four ambulances are active. A very challenging situation was described in Helmand, where every district hospital has just one ambulance on hand, even at night, despite high volumes of patients.

CONSUMABLES AND MEDICINES

The scarcity of consumables and medicines across Afghanistan was another critical issue mentioned by all interviewees. Right after the change of government, a temporary disruption in stocks of medicine was reported; later, the confirmation of international funds for the humanitarian response meant that drug procurement and importation could be resumed. Nonetheless, many reported that a one-month stock generally lasts for 10 days. The most important challenges mentioned related to **procurement of narcotics, anaesthetics, intravenous fluids and consumables** such as nasogastric tubes, cannulas, tape and bandages.

Some interviewees reported an intensification of regulations and controls on medicines and consumables imported into the country. In particular, the Ministry of Public Health's laboratories now test samples of drugs arriving in Afghanistan. Due to the limited capacity of public laboratories, such controls slow down the process of medicines arriving to hospitals and hamper the arrival of specific types like narcotics, pregabalin and Methergine (also typically used by drug abusers) and ones that have been donated to NGOs. Allegedly, these stricter regulations aim to encourage the procurement of medicines produced by local factories, despite the latter still being small and struggling to cover hospitals' basic necessities. Government checks on clinics in the country have also intensified, to ensure compliance with national standards and to regulate the number of medicines being supplied to each clinic.

Some interviewees expressed doubts about the **quality of the medicines** available. In some cases, allergic reactions have been recorded and concerns were raised about the way that drugs are transported and stored, which might affect the quality of the products:

“The quality of the medicines, if you see generally in Afghanistan, is not so good. All the medicines that you can find – even in the city – are low quality.”

Gullbudin, Head Nurse,
Lashkar-Gah Surgical Centre, EMERGENCY

INFRASTRUCTURE

The **condition of facilities and buildings** has been described as largely and historically inadequate by all interviewees, a fact that poses an enormous challenge to the provision of quality healthcare. Buildings were described as too small and too old. The majority of healthcare facilities were built more than 40 years ago, in accordance with the population's size and needs at the time:

“Our hospital has 10 times more beds than it was built for, and it is still not enough because the demand is so high. There was a corridor in the previous plan, now they use it for the maternity ward.”

Staff member at Provincial Hospital

Many interviewees agree that many healthcare facilities are housed in buildings that were not originally designed for medical use. They are former private houses, now subject to rental contracts with government authorities, as a consequence of which their electricity, water and sanitation systems are far from adequate. Some healthcare facilities have no warm water or no system for its storage. One of the interviewees recalled carrying out a surgical operation by the light of mobile phones, on a hot summer night with no cooling or ventilation system.



“We do not have a heater for the patients. At night we need something to heat the room for the children. But sadly we don't have one.”

Dr Naser Ahmad Rahmani,
Provincial Hospital Director, Paktia

Unfortunately, since most facilities are located in private houses or very old buildings, they are rarely renovated or retrofitted.

PROVISION OF HEALTH SERVICES

Interviewees unanimously agreed that the **distribution of healthcare facilities** is a challenge in Afghanistan. Some rural areas have fewer healthcare facilities than bigger cities or central Kabul, since in the past healthcare facilities were traditionally built in the heart of cities. This disparity has been aggravated since August 2021 by people moving into areas that used to be battlefields and therefore lack any medical facilities. To make matters worse, many hospitals have been shut down due to a shortage of staff. In the view of many interviewees, **it is still possible to die today in Afghanistan because there are no health services, or no adequate ones, in the local area:**

“They don't have a facility to go to near home. In the remote areas, there are no health facilities. My village, by the name of Qulaj, in the Siah Gard district of Parwan province, has about 1,000 families living there. There is no health post there.”

Dr Zamir Afzali,
Provincial Hospital Director, Parwan

Those facilities that are running often have poor hygienic conditions. They may also be **poorly organised**. In some districts, healthcare facilities may only open during the day, leaving local people with no health assistance during the night, something that was reported more by interviewees from Helmand. Some districts that are hard to reach may be served by mobile teams that are only available a few hours a day.

The **inadequate referral paths between healthcare facilities** are one of the biggest problems in the coordination of different levels of care according to many interviewees. At times, patients cannot be transferred to any healthcare facilities from their district because there is no ambulance or no fuel. At other times, patients are transferred in understaffed and ill-equipped means of transport. This contributes to patients going straight to larger hospitals in bigger cities for care, instead of more appropriate facilities with lower levels of care closer to home.

When asked about changes in the quality of health services since August 2021, the interviewees had mixed opinions. **Some believed the quality of services had improved**, because of the increased security in the country and greater support from NGOs in the form of running costs. **Other interviewees thought the quality of services had worsened**, because facilities were underfunded and the number of patients had increased.

Overall, the quality of health services remains unsatisfactory for Afghan people. **Adequate medical assessments** are rarely carried out due to the overload of patients. Interviewees said that the time allocated to each patient has recently decreased and that some facilities are now simply giving medicines away to patients, acting like pharmacies. The **quality of care given for NCDs** is the most problematic, since private facilities are the only place where people can get specialist treatments, for which they must pay. As an example, when arterial hypertension is diagnosed for the first time, the patient will be treated and stabilised at a public clinic, but follow-up consultations would occur at a private facility. Moreover, health education and prevention activities are scarce due to time constraints and poor knowledge and awareness among HCWs.

Management of complex emergency cases was also mentioned as a critical issue in the quality of care, even at regional and national hospitals. For example, major trauma is sometimes managed in ill-equipped ambulances without intravenous cannulas or oxygen tanks. Treatment of comatose or confused patients at Jamhuriat Hospital, the national referral hospital for adults in Kabul, may be challenging given its substandard ICU. Difficulties may arise when treating children with suspected meningitis at Indira Gandhi Children's Hospital, the national referral hospital for children, given the impossibility of performing the recommended diagnostics. An emergency delivery may have to wait at Malalai Hospital, the national referral maternity hospital, if three caesarean sections are being performed there at the same time. A heart attack sufferer in Helmand province can only receive the gold-standard treatment of angioplasty in a private hospital in Kandahar or Kabul. According to some interviewees in Helmand, maternal care and the management of emergency pregnancy-related conditions are extremely problematic, frequently leading to deaths.

Similarly, people have to turn to private clinics or travel long distances to larger cities when in need of specific diagnostic services like a CT scan or MRI. As an example, patients with severe head trauma might be taken to Kabul from a neighbouring province in order to be admitted to a large tertiary hospital or – if it is a less severe case – to have a CT scan performed at a private clinic, at their expense, or be seen by a neurosurgeon. They would then be taken back to the hospital after the examination is finished, to have an operation or for further observation. In the likely event of an unavailable ambulance, patients would then be asked to arrange private transport with the help of relatives, who have to bring them back, together with their report, to the original provincial hospital. Many of the HCWs interviewed highlighted how such a lack of organisation in the management of head trauma, especially at more rural healthcare facilities, prevents patients from getting timely and effective treatment, leading to enormous delays in these time-sensitive clinical conditions. At times, a preventive craniotomy even had to be performed (“by blind eyes”) without a CT scan, as one could not be promptly obtained.

When it comes to the **quality of surgical care**, lack of expertise and of adequate infrastructure make open surgery almost always the only option, even for simpler procedures that would ideally be performed through laparoscopy (e.g., kidney stones, appendectomy, gall-bladder removal). Follow-up of patients after operations is also unsatisfactory according to some interviewees, who believe this is a common reason for patients to rely on EMERGENCY's facilities. Sometimes HCWs working at public facilities refer trauma patients straight to EMERGENCY's hospitals, especially the most serious cases.

According to many interviewees, **more and more patients have been turning to EMERGENCY's facilities in the last few years** as a consequence of increasing poverty and the inability of the public health system to provide adequate care. Patients generally come to EMERGENCY's facilities asking for medicines, such as painkillers and antibiotics, that they cannot receive from public hospitals, where medicines provided usually last only a few days. Transport is among the main issues that make patients resort to EMERGENCY's services. Pregnant women in labour frequently ask to use the organisation's ambulances to be taken to the nearest public hospital.

Some interviewees advocated a greater focus on **elective surgery**, given that hardly any hospital in Afghanistan performs such operations. Patients therefore turn to private facilities or continue on symptomatic medicines, with an increased risk of complications or emergency operations at a later stage.





THE VIEWS OF HEALTHCARE WORKERS ON THE EPHS AND BPHS PACKAGES

Many of the interviewed provincial hospital directors **claimed to be working according to the EPHS guidelines and in line with the BPHS**. Even though all interviewees recognised the need for Afghanistan to be equipped with common guidelines to standardise inpatient clinical care and the referral system, several issues were raised with regard to the current EPHS/BPHS system. All interviewees agreed that the current guidelines **are in need of urgent revision**. In their view, the EPHS provides guidelines for staffing, equipment and drugs for each type of healthcare facility by relying on numbers and statistics that are not representative of the current situation in Afghanistan.

According to the interviewees, the unsuitability of the guidelines to the population's current needs has had many negative consequences.

First of all, hospitals and clinics have not been planned according to geography and population density, leaving large pockets of the population without adequate health assistance. For example, some interviewees mentioned that, even though EPHS/BPHS guidelines envisage mobile teams to increase coverage for hard-to-reach populations, there are generally too few of them to cover current needs. Sometimes they have to travel long distances to reach their final destination, running the risk of working for only a few hours and therefore helping very few patients.

Secondly, hospitals may not provide the specific services that are currently needed by the population because they happen to be absent from the EPHS guidelines.

This is particularly the case for provincial hospitals, where, according to the interviewees, specialists in orthopaedics, ophthalmology and ear, nose and throat are greatly needed, but still not included in the EPHS for this level of care.

Thirdly, the number of hospital beds and the supplies of medicines to public clinics required by the EPHS/BPHS guidelines are much lower than the current needs of the population. All healthcare facilities are in a situation of chronic under-performance and inadequate solutions sometimes address these deficiencies, such as placing multiple patients in a single hospital bed.

Fourthly, the standard number of HCWs in hospitals according to EPHS/BPHS guidelines is not adequate to the current needs of the population.

Interviewees raised some concerns when asked about the way the **system for contracting NGOs is organised**. They mentioned that not every NGO that is allowed to work in Afghanistan is obliged to adhere to the EPHS/BPHS system. As a consequence, NGOs that are not contracted by the Ministry of Public Health may offer the same services as contracted ones, leading to an unnecessary duplication of services. At times, the quality of care provided by some NGOs involved in the EPHS/BPHS system was called into question by some interviewees. Some have very limited capacity when it comes to providing services and others may refrain from setting up additional services or spending extra-budgetary funds because those services are not included in the EPHS/BPHS package. This contributes to the large discrepancies among Afghan provinces in health services.

ACCESS TO CARE IN AFGHANISTAN SINCE AUGUST 2021

There was agreement that, due to the economic crisis and unemployment, the **ability to pay** for healthcare has drastically worsened since the change of government. Although basic healthcare services are ostensibly free in all public facilities for all patients, who only have to pay a fee of 20 afghanis to access services, interviewees reported that patients or their relatives have to buy medicines and consumables themselves if they want to be treated in public hospitals. Patients may, at times, be forbidden entry to hospital premises when they are not accompanied by a relative who can go and buy the consumables and medicines they will need during their stay. Although predating the change of government, this situation is reported to have deteriorated after August 2021 and to have particularly affected those undergoing surgical operations, those needing treatment for NCDs and those using rural hospitals, which are lacking in consumables and have only basic medicines, such as intravenous fluids, paracetamol and common antibiotics. With regard to treatment of NCDs, medicines for diabetes and arterial hypertension are generally unavailable in provincial hospitals and, when they are available, are not free of charge for patients. Chemotherapy options, when available, are only accessible to patients who can afford expensive payments. Patients may sell some of their property or borrow money from family or other people in order to pay for them, in which case they often prefer to travel abroad to Pakistan for treatment. Many patients who are prescribed a specialist check-up do not attend because of the expense; to save money, they may go straight to the local pharmacist to find a solution to their health condition rather than to a doctor.

Despite health literacy having gradually improved, pockets of the Afghan population still have a limited **ability to perceive** their own health needs. Many interviewees believe that this lack of knowledge particularly affects geographically remote people and women, and predominantly concerns NCDs. People frequently resort to some kind of symptomatic medicines for many years rather than begin a clinical investigation. Interviewees reported that, after the change of government, the tendency to delay care until a health condition becomes urgent has grown. Many interviewees recalled a multitude of patients putting off treatment and resorting to symptomatic medicines for gall-bladder inflammation, kidney stones, complex bone fractures and large wounds.

Women were reported to be a vulnerable category with regard to their knowledge of health information and ability to perceive their health needs. At times, pregnant women come to facilities at the end of their pregnancy without having had any antenatal consultation in the previous nine months. When they do contact a healthcare facility, women recognise the beneficial effects of health checks in pregnancy.

Generally, many interviewees reported increased mistrust of HCWs working in private and government clinics in Afghanistan. Conversely, a great deal of trust is placed in international NGOs. In the interviewees' opinion, Afghans perceive these as trustworthy and reliable on account of the hygiene, the medical devices and staff's friendly behaviour, especially at night.



“Sometimes we ask the patients why they didn’t go to the closest children’s hospital. Coming here from Kabul takes almost three hours. They usually answer that the staff didn’t take care of them very well. There are two or three patients in one bed and they didn’t treat us very well.”

Dr Tareq, Paediatrician,
Anabah Paediatric Centre, EMERGENCY

A great improvement in people’s **ability to reach** healthcare facilities has emerged from the interviews and it has mostly affected people in Helmand and Ghazni provinces. If before August 2021 several battlefields stood between the districts and referral hospitals in cities, today mobility has improved and people can more easily travel across provinces to reach healthcare facilities and receive care. Despite the improvement in mobility, a huge obstacle to reaching distant healthcare facilities remains the cost of transport, unaffordable for the majority of Afghan families. Mixed responses were provided regarding women’s ability to reach healthcare facilities: while some interviewees said that the number of visits has increased for women, who are now able to come to the hospital even at night, others reported that women do not feel safe to seek care anymore, especially in the Panjshir area:

“When they bring the child, we ask the mother: ‘Why didn’t you bring the baby two days ago when he started feeling sick?’ And they say: ‘It is dangerous and we don’t have transport.’ Since last year the situation has been very bad for all mothers in Kapisa, Parwan and Panjshir. But for Panjshir it is the worst.”

Nadera, Paediatric Nurse,
Anabah Paediatric Centre, EMERGENCY

Individuals living in large cities have fewer costs and generally encounter fewer hurdles en route to hospital. Those living in mountainous areas or in underserved communities have to face rough terrain, poor road conditions or road closures and harsh weather conditions, walk several hours or use makeshift means of transport.

Patients may ask EMERGENCY’s HCWs to keep them as inpatients for follow-up and dressing because transport to follow-up clinics closer to home would be too expensive.





BEING A WOMAN IN AFGHANISTAN

Women are a particularly vulnerable category in Afghanistan and face **specific obstacles** when seeking care. During the interviews, the most frequently mentioned obstacle was their **limited freedom, since they require permission from their husbands to access care**.

According to some interviewees, **fighting and insecurity are among the reasons preventing women gaining access to healthcare facilities**. This finding was highlighted in a previous study conducted by EMERGENCY in 2018 at the Anabah Maternity Centre³³. These barriers to access to care are particularly daunting for pregnant women, who often have to reach clinics on foot, by bicycle or motorbike, in the absence of adequate transport. **Pregnant women living in remote areas** are particularly at risk because their closest clinics are often poorly equipped for adequate maternal care. **Cases were reported of women in labour dying while trying to reach a healthcare facility**.

Due to financial constraints, pregnant women often do not seek antenatal care, delay seeking it or visit a facility only when their life is threatened. Financial problems also prevent them from getting adequate nourishment. According to the interviewees, the quality of health services for pregnant women is particularly low. For example, there is only one ultrasound machine for the whole Malalai Maternity Centre in Kabul, which has an average of 200 OPD consultations daily.

The current restrictions on female participation in society pose a risk to the improvements in women's health education that have been achieved over the years. Some interviewees said that **women and girls have been banned** from several stages of school and, in some instances, **young girls have been forced to get married at a young age**. A **lack of female teachers** was also reported, with surgeons giving gynaecology lectures because of a dearth of female gynaecologists who would be better qualified to do so.

CHANGING PATTERNS OF DISEASE IN AFGHANISTAN

The majority of the interviewees said that, since August 2021, **the number of patients visiting public healthcare facilities has increased**. This has happened for three main reasons: 1) people are poorer and can no longer afford to go to private clinics or abroad for healthcare; 2) many NGO-run clinics have closed because the NGOs have left the country; 3) better security is allowing people to see a doctor more than in the past. Only people from Panjshir reported a decrease in the number of patients visiting healthcare facilities, because there is fighting in the area and many people have moved to other provinces. Overall, interviewees reported that **patients visiting healthcare facilities come from farther away**, which means that individuals can more easily travel across provinces to seek care.

As for the health condition of patients, several interviewees reported an **increase in mental health problems**, especially depression and anxiety, as people became exasperated with poverty and unemployment. Some interviewees mentioned that the increase in anxiety has led to more people having high blood pressure. Conversely, **other interviewees said that the prevalence of mental health problems has remained stable over the years**. Many interviewees reported seeing an increase in malnutrition, which makes people more prone to infectious diseases, and a few reported seeing a **rise in cancer patients**.

Malnourishment, dehydration and pneumonia were described as endemic among Afghan children, who are often brought to the hospital only at a late stage, **due to financial barriers or a lack of health education. Outbreaks are very common because children are vaccinated at low rates**.

What has uniformly been reported as the biggest change in the burden of disease is a **reduction in war-wounded patients**, that is patients injured by mines, shells or bullets. Notably, interviewees reported that **war-wounded patients have been replaced by civilian trauma patients, especially ones who have fallen from a height (particularly children) or had a road traffic accident**.

“Road traffic accident patients have increased because there are no traffic laws. Everyone comes from the villages by motorcycle, by car, and they don’t know the traffic laws.

You create a disaster by adding another car, another bicycle to the road. So, that’s why the road traffic accident level is going up.”

Dr Shakeeb, Supervisor at Ghazni FAP, EMERGENCY

Stab wounds have risen because of an increase in land and family disputes, intensifying after the war. At the same time, **the number of mine injuries has decreased because of the demining work** carried out over the years by international NGOs.

INTERVIEWEES’ RECOMMENDATIONS ON HOW TO IMPROVE ACCESS TO CARE

Several strategies to strengthen the national healthcare system and improve access to care were reported by interviewees. These are:

- ▶ Improving the availability of **liquidity** through strong financial reforms that support **vulnerable categories**, e.g., agricultural workers.
- ▶ Establishing a **healthcare funding system** in which patients make partial contributions to healthcare costs, calculated on the basis of their income.
- ▶ **Health system reforms** that overcome current EPHS/ BPHS challenges with a clearer repartition of services and a stronger coordination between different levels of care and provinces.
- ▶ Strengthening **community-based care** in rural areas, with a more thorough assessment of the distribution of healthcare facilities, and **provision of primary health services**.
- ▶ Strengthening **health education** projects, to help people navigate the health system and to encourage road safety.
- ▶ Increasing the number of HCWs, especially **female staff and biomedical engineers and in areas that are hard to reach**.
- ▶ Providing **high-quality, practical training** for HCWs, especially targeting adult and paediatric emergency medicine and trauma management.
- ▶ Increasing the **availability of medical equipment**, such as ambulances and monitors, as well as of diagnostic imaging procedures (e.g., digital X-ray machines, CT scanners).
- ▶ Improving **procurement of medicines** by streamlining drug importation policies, while supporting local factories.
- ▶ Allocating more financial resources to **health infrastructure** and ensuring that premises are adequate.



DISCUSSION AND GENERAL CONSIDERATIONS OF THE STUDY RESULTS

This study shows how several factors influence each dimension of access to care in Afghanistan. In light of this, we cannot conclude with absolute certainty whether access has improved or worsened overall. People's ability to get information about health and to reach care have increased or remained the same. Their sense of safety has improved, but most participants' ability to pay for healthcare has decreased in the past year.

Peace and economic stability – or conversely conflict and poverty – are the most important factors influencing people's ability to access care in Afghanistan.

Although the war ended in the summer of 2021, in areas where episodes of fighting still occur, access to care continues to be significantly influenced by security issues, regardless of political and institutional changes.

Since August 2021, **security** conditions in Afghanistan have generally improved. On former frontlines, such as in Ghazni and Helmand provinces, people can now move easily and safely to seek care thanks to the end of hostilities, the re-opening of roads and demining work. By contrast, in areas where episodes of conflict are still recurrent, like the Panjshir valley, patients still feel unsafe when seeking care and many HCWs have decided to move away to Kabul or other safer regions, meaning there are fewer of them in the area.

Over its 24 years of activity in Afghanistan, EMERGENCY has predominantly focused on war surgery, observing the consequences of war on its patients in the process. Recent changes in the country have been reflected in the activities of EMERGENCY's facilities. The Surgical Centre in Lashkar-Gah – which has treated over 30,000 war-wounded patients since it opened – is now fully devoted to **civilian trauma**. Meanwhile, **victims of explosions and violence** – the latter often linked to crime and land or family disputes – continue to fill EMERGENCY's wards in Kabul. This is the **legacy of a 40-year conflict**, which has made violence an ever-present feature of life in Afghanistan. Active fighting may have stopped but political and economic instability feed further tension and fear among the Afghan people, who are afraid the situation might deteriorate again.

Economic crisis and unemployment have replaced war at the top of the list of every-day concerns for Afghans. Afghanistan's economic downturn preceded the change of government, international isolation and sanctions, but the decrease in aid inflows, and the collapse of the country's financial and banking sector have brought unprecedented levels of economic insecurity. Despite the

4.3 billion US dollars invested annually as development assistance in Afghanistan between 2002 and 2020³⁴, the international community has not been able either to increase Afghanistan's independence from international aid or to improve the resilience of local communities, who are extremely vulnerable to all the shocks the country faces.

According to the results of both questionnaires and interviews, the impact of the economic crisis on people's access to care has been dire. The **costs of healthcare itself and of transport** to healthcare facilities are now people's **main barriers** to access to care. Despite public healthcare facilities ostensibly being free of charge, stocks of drugs and consumables do not meet the increasing demand from patients, who are often forced to pay for medicines and treatment. In fact, the majority of those who participated in the study said their ability to pay for care had decreased since August 2021, the main reason being a drop in their income. Patients said they had often been forced to **postpone care on the grounds of cost** in the past year, which could pose a serious risk to their health.

It should be noted that, **as a general pattern, Afghans tend to see a doctor when their condition is in an acute phase**. Data from EMERGENCY's PHCs in the Anabah and Kabul referral areas confirm this: indeed, between 65% and 70% of conditions seen at the PHCs are in an acute phase. On the one hand, this could be due to people's inability to perceive their own health needs and could be addressed by initiatives of health education and prevention. On the other hand, HCWs have observed an increasing tendency in recent months to put off care and resort to merely symptomatic medicines because of cost restraints.

FOCUS ON WOMEN'S ACCESS TO CARE

Afghanistan is a challenging place for women. Women and girls have been progressively excluded from public life. In particular, they are banned from attending secondary school and university. On 24 December 2022, the Afghan authorities also ordered local and international aid organisations to ban female staff from working until further notice; although unwritten exemptions have been made for women working in health and education, some female HCWs who played a key role in initiatives of maternal and child healthcare were not allowed to return to work³⁵. Fortunately, EMERGENCY's 365 female workers (21% of



its staff in the country) have been given such exemptions. This is crucial as they are a fundamental component of the organisation's teams and make it possible to treat female patients.

This is especially the case at EMERGENCY's Maternity Centre in Anabah, a hospital run entirely by 114 women and currently training 12 gynaecology residents. In light of this, any attempt to prohibit education and work for Afghan women is expected to cause a **long-term shortage of female HCWs**, which will have serious repercussions on the sustainability of maternal and paediatric services, including EMERGENCY's, as well as on the national health system.

These concerns were confirmed in the interviews and questionnaires, which indicates that monitoring the situation of Afghan women, especially through the lens of health, is still an urgent priority. In fact, **being female is among the most common factors in decreased access to care over the past year**, and interviewees described **women as a vulnerable group, particularly when it comes to the management of pregnancy and maternal care**.

According to the scientific literature, maternal mortality is a key indicator for the overall health and well-being of women³⁶ and **Afghanistan has among the highest such mortality rates globally**³⁷. This is due to many factors, among which the lack of clinics offering obstetric care in rural areas stands out. Other causes include the lack of emergency transport, economic difficulties, understaffed and ill-equipped healthcare facilities, but also poor health awareness and social norms that limit women's autonomy and mobility. For these reasons, pregnant women often come to healthcare facilities at the end of their pregnancy without ever having had any antenatal care consultations.

On a favourable note, **maternal care at EMERGENCY's facilities was not affected by political events**, in keeping with the organisation's impartial, neutral and independent mandate. However, it was reported that fewer women come to the Anabah hospital at night-time; this is likely due to their sense of unsafety when seeking care, which has greatly increased since August 2021 among residents of the Panjshir valley.

Contrary to the research team's expectations, **the gender composition of HCWs was irrelevant to most respondents**, including women. These findings have been corroborated at EMERGENCY's PHCs in the Kabul and Anabah areas. An analysis was carried out to investigate whether the presence of female staff at PHCs influenced the number of consultations for female patients; it was found that there is no correlation and that the proportion of consultations for female patients has remained stable over time regardless of the gender composition of the staff.

Several interpretations may be offered. Firstly, in situations where the priority is treatment, personal preferences take second place. Secondly, at EMERGENCY's facilities, it has been observed that patients' preferences for gender composition at HCWs apply only to certain specialities, like obstetrics and gynaecology, and not to healthcare in general.

FOCUS ON THE HEALTH SYSTEM

The end of the conflict together with improved mobility within the country caused an increase **in the number of people accessing health services**, especially in the Kabul and Lashkar-Gah areas. Plagued by decades of conflict and a series of natural disasters, the Afghan health system is struggling to respond to the rising needs of the population, and this has brought to the surface chronic issues that have challenged the health sector over the years.

Unavailability of medicines was identified as a major issue by both patients and HCWs, with nearly half of questionnaire respondents experiencing a delay in accessing medicines in the past year. Fighting during the change of government caused **temporary disruptions to procurement of medicine**, as international funds were suddenly interrupted and could only resume in November 2021 with support from the UN's Central Emergency Response Fund³⁸. Delays still occur, due to **chronic underfunding and heightened controls and regulations by the central authorities**. When medicines are supplied, they are not enough to cover the health needs of the population, since the supply for each facility is based on population estimates that are lower than the actual numbers.

The **shortage of medical equipment**, including essential diagnostic imaging devices, hampers the provision of high-quality health services. When such equipment is on hand, it is either inadequate or left untouched because there are no technicians able to use it or to fix it when it breaks. This explains the delays experienced by almost 45% of participants when receiving a diagnostic test in the past year. The **ambulance system is particularly inadequate**; not only are there too few ambulances to cover the population's needs, but there are also often problems of insufficient fuel. The unreliability of the ambulance system resulted in very few patients choosing this means of transport to reach a health facility. The soaring costs of fuel also weigh on patients who have to reach healthcare facilities by their own car or motorcycle. It is indeed not surprising that, **despite the conflict ending, patients did not report any increase in their ability to reach healthcare facilities**.

The **departure of some HCWs** in the months of the change of government exacerbated an already dire situation of long-understaffed facilities and underqualified, underpaid staff. When it comes to **salaries**, participants highlighted how the support of NGOs was crucial to restoring salaries for staff in most public hospitals. It should be kept in mind, however, that this might not be a uniform result across the country, since data from a 2022 questionnaire by Johns Hopkins University shows that out of 131 participating HCWs, more than half said their payments had been irregular since August 2021³⁹.

HCWs appear to be better prepared to manage acute emergency cases than to provide continuous care for NCDs. In turn, patients themselves are unaware of their own need for chronic care and have been shown to use primary care services mainly for acute presentations of communicable diseases. Furthermore, it has been shown that many patients arriving at EMERGENCY's PHCs complain of "body pain", which is considered a **proxy indicator for poor mental health**^{40,41}. With the end of the conflict and a potential lengthening of life expectancy in

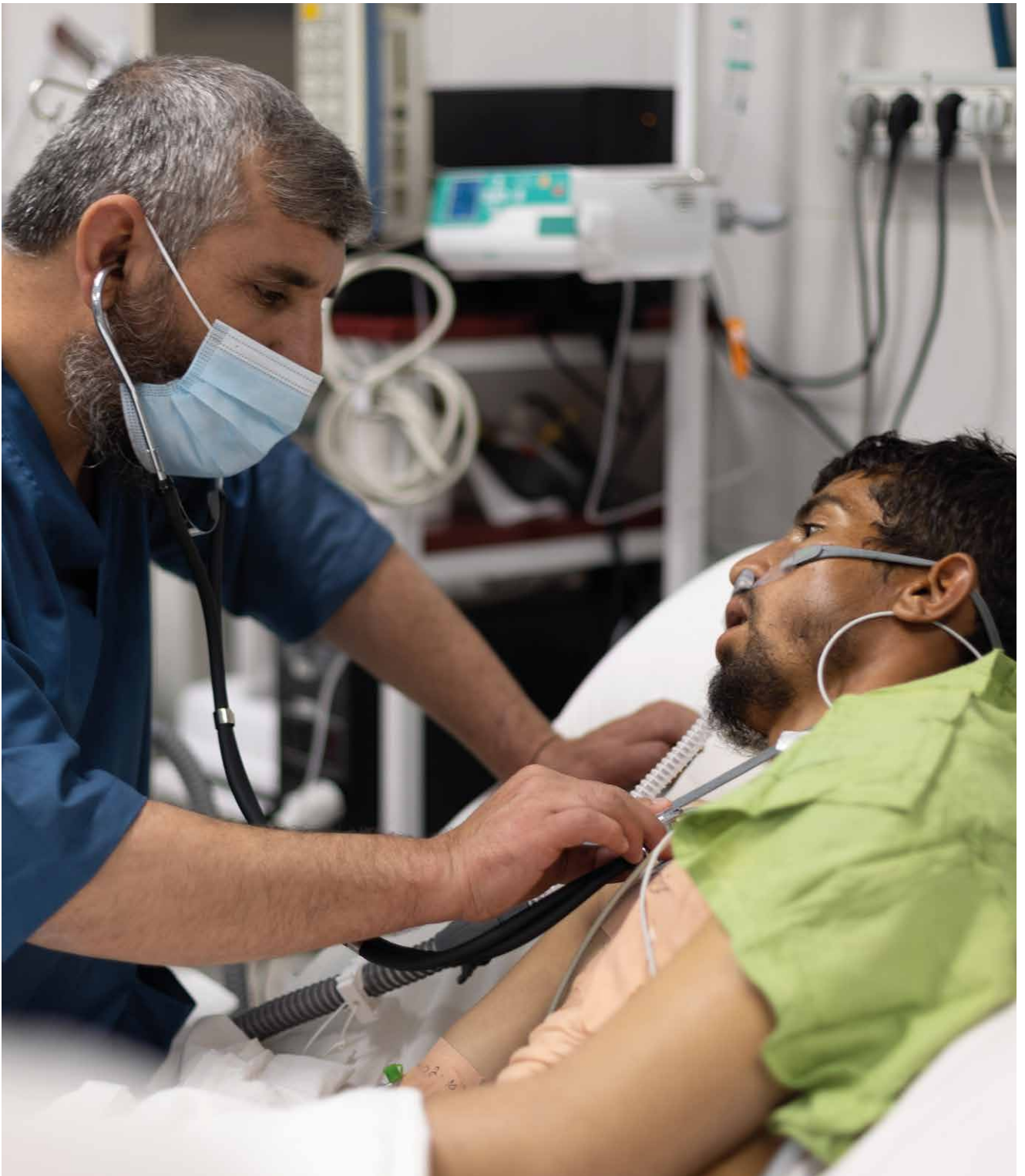
Afghanistan, it is expected there will be **an increasing need for NCD care in the future**. Awareness-raising campaigns, NCD-related capacity-building and strengthening of primary care could therefore be necessary steps for the future of the Afghan health system. With this in mind, **EMERGENCY has decided to gradually convert its FAPs in the Lashkar-Gah area into PHCs in order to meet the changing and most urgent needs of the local communities**.

A major problem in the provision of proper healthcare in Afghanistan is the **scattered distribution of healthcare facilities and the inadequacy of lower-level care**, which causes the overload of patients on hospitals in urban areas. Interviewees pointed to the **inadequacy of the BPHS/EPHS system** as the main cause; the system appears to be in need of urgent revision to bring it into line with the population's current needs. Healthcare facilities are described as **understaffed, ill-equipped and inadequately supplied** in relation to their catchment area. This was often mentioned in discussions about the sustainability of the health system. Overall, interviewees agreed that 20 years of war and foreign presence in the country had not brought about any sustainable advances in the country. The fact that Afghanistan is still **entirely dependent on international aid for healthcare** is considered the biggest obstacle to building a sustainable health system; when asked what would happen if the international community left the country, the majority of interviewees agreed that the whole health system would surely collapse.

Systemic challenges are particularly relevant, as access to care from the point of view of patients is reflected in the status of the health system. This means that **access to care can improve if the system as a whole is strengthened**. Ways to make the health system more resilient and integrated include **improving and increasing the number of healthcare facilities that provide different levels of care** (primary, secondary and tertiary), developing a functional referral system between these levels, **improving the abilities of HCWs and technical staff** (e.g., biomedical engineers), and **investing in higher education and research**. This integrated approach is endorsed in the literature, which considers investing in surgical care to be affordable, life-saving and favourable to economic growth⁴³. **Investing in surgical care has a knock-on effect on the entire health system**, improving the level of care in all health sectors, including intensive care, and increasing the structural capacity to handle more complicated medical challenges.

Despite the awareness of the challenges and obstacles in Afghanistan, **there is a great sense of hope and willingness to rebuild the country**. Notably, when asked about possible ways to improve access to care in Afghanistan, **participants were most likely to support improving the quality of health services**; improving the quantity of services provided came second. HCWs, on the other hand, proposed macro-level solutions, mentioning **international recognition of the current government, increases in liquidity and broader health system reforms**.

KEY RECOMMENDATIONS



1 The international community should keep Afghanistan high on their priorities and commit to the country's political, economic and social stability through a **pragmatic, flexible and constructive engagement** with the Afghan authorities, placing the needs of the Afghan people at the centre of everything.

2 Humanitarian aid cannot replace the normal functions of the economy. The **9 billion US dollars of Afghan reserves**, whether held by the United States, the Swiss-based Afghan Fund or in European banks, should be fully and immediately released to Da Afghanistan Bank (DAB) with a view to **macro-economic stability**. Technical assistance to restore DAB's role as an independent institution and financial regulator should be guaranteed under the aegis of international financial institutions and UNAMA.

3 We welcome the approach to Afghanistan put forward by the international donor community, which reinforces humanitarian, "do-no-harm" and non-discrimination principles, while continuing to ensure humanitarian funds to avoid disastrous consequences for people in need. Bearing in mind the 2022 funding gap, however, we urge the international community to **commit generously to the 2023 Afghanistan humanitarian appeal** - the world's largest at 4.6 billion US dollars - to meet the targets described here.

4 Humanitarian aid is indispensable to provide relief, but does not address chronic, structural deficits or the root causes of vulnerability. Embracing the **triple nexus**, development programmes, technical assistance and investment in economic stabilisation and recovery should be resumed to rebuild a country devastated by conflict and working towards positive peace. **Funding should be multiyear and focus on capacity-building**, with a view to overcoming the dependency on aid that has characterised Afghanistan so far.

5 The international community and the Afghan authorities should continue to **invest in health** as a priority in order to give the Afghan people a future, rebuilding essential services and laying the foundations for a healthier social fabric. Healthcare can provide **employment**, including to **women**, whose meaningful participation should be unimpeded, to ensure the right of everyone to be treated is fulfilled without discrimination.

6 **The meaningful participation of women and girls** in all spheres of public life is crucial to build inclusive, peaceful and resilient societies. This cannot leave the **right to education** aside. Denying education means depriving Afghanistan of a generation of women and girls who could strengthen the economy, public health and stability. We call upon the Afghan authorities to revoke this decision with immediate effect and to restore access to all levels of school and university for girls and women.

7 International stakeholders should engage with the Afghan authorities to **regulate pharmaceutical manufacturing and empower local suppliers** so that they comply with international standards, increase their production to meet the country's needs, guarantee the provision of high-quality medicines, and replenish facilities on time.

8 Distribution of medical equipment in the country should ensure that **essential diagnostic devices** are available in every province and that timely diagnostic services are available to the population without delays. Staff need to be taught **technical and biomedical skills** so that existing equipment can be made use of and fixed quickly when broken.

9 Brain drain should be tackled by investing in **higher education and capacity-building programmes**, to improve **quality and quantity** in all medical and technical professions. Moreover, proper and sustainable allocation of funds is needed to guarantee favourable working conditions and salaries for HCWs and support staff working in Afghanistan.

10 **Prevention, treatment and management of NCDs** should be fostered to address the neglected needs of the population. Awareness-raising campaigns, capacity-building for HCWs and a broader process of **strengthening primary healthcare** are necessary steps to ensure the continuity of care and to encourage people to use lower levels of care, thereby preventing overcrowding at provincial and district hospitals. Health promotion, proactive engagement and appropriate communication with communities are of paramount importance in improving access to care in Afghanistan.

11 Efforts should be made to reduce the burden of civilian trauma. At the same time, **funds should continue to be allocated to trauma and surgical care** to ensure free, quality treatment and rehabilitation for these types of patient. It is also necessary to invest in **preventing** civilian injuries, primarily falls from heights and road traffic accidents.

12 With the support of the international community, the Afghan authorities should work on **urgently reforming the BPHS/EPHS system** to meet the actual needs of the Afghan people. The distribution of facilities, allocation of medicines and biomedical equipment, allocation of staff and clinical guidelines should be revised, at all levels of care. The quality of healthcare facilities should be increased generally, as patients should be able to trust and go to the facility closest to their home, without having to travel great distances to reach larger, city hospitals. Furthermore, an **adequate and effective referral system** by ambulance with doctors and the necessary equipment on board is a priority in creating an integrated, functioning health system.

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