REALITY CHECK

Afghanistan's Neglected Healthcare Crisis

March 2020

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

CONTENTS

Cover photo
A child living in an informal settlement for displaced people on the outskirts of Herat city gets a check-up from a doctor at MSF's Kahdestan clinic. The health team at the clinic offers medical consultations, as well as screening and treatment for malnutrition, and childhood vaccination.

EXECUTIVE SUMMARY

Over 40 years of conflict and instability have left Afghanistan's economy and infrastructure in ruins and millions dependent on humanitarian assistance.[1] The international medical humanitarian organisation Médecins Sans Frontières (MSF) finds that Afghans today still struggle to get access to healthcare due to pervasive violence, widespread poverty, and a weak public health system. Morbidity and mortality rates remain high. This briefing paper features the stories of patients, their caretakers, and our staff in Herat and Helmand provinces to illustrate the many obstacles people face in their efforts to get medical care.

While international attention has recently focused on the potential impact of a peace agreement between the United States and the Islamic Emirate of Afghanistan (IEA, also known as the Taliban) and the anticipated resumption of intra-Afghan talks, it remains too early to know whether these developments will translate into meaningful peace on the ground. A sustained reduction in violence going forward would certainly provide much needed relief—as civilian deaths and injuries due to armed conflict almost doubled between 2009 and 2019, with a record high death toll in 2018.[2]

It is important to understand that violence not only kills directly but also indirectly, through the disruption of access to healthcare. Active fighting and indiscriminate violence create a climate of fear among civilians and often contribute to delays seeking care. Staff at MSF-supported facilities in Afghanistan regularly witness the impact that such delays can have, sometimes making the difference between life and death. Women and children are particularly vulnerable.

Attacks on healthcare have continued unabated in recent years, forcing many hospitals to suspend vital medical services or shut down entirely. The result is that even more people are denied access to basic medical services. Armed conflict also obstructs vaccination campaigns, particularly for polio and measles.

Millions of people in Afghanistan are food insecure. In 2019, teams at Boost hospital in Lashkar Gah, Helmand, treated 3,997 children for severe acute malnutrition, one of the main causes of mortality in the province. Recurring natural disasters have exacerbated the impact of years of war. In 2018 a prolonged drought affected two-thirds of the country, destroying agricultural land and livestock. The drought was followed by flash floods in 2019, which added financial hardship for thousands of people who lost their homes and their livelihoods. Afghanistan is among the countries most vulnerable to the effects of climate change, including the increased risks of drought and flooding.[3]

Widespread poverty also puts care out of reach for many Afghan people, as witnessed daily through the stories our patients tell us and in the cases that we treat. Patients describe delaying or avoiding care, or selling essential household goods in order to cover health-related expenses. While MSF provides health services free of charge, a growing number of medical facilities in the country have begun collecting user fees as part of a cost recovery approach, which makes care unaffordable for many.

As local, national and international stakeholders look ahead to build a more stable future for Afghanistan, they must acknowledge that the country's humanitarian situation has not improved and, in some areas, has worsened in recent years. An urgent priority now must be to ensure greater access to free, high-quality healthcare and respond to the acute medical needs.

[1]According to the Humanitarian Needs Overview for Afghanistan in 2020, 9.38 million people are in need of humanitarian assistance, compared with 6.3 million in 2019. https://www.humanitarianresponse.info/en/operations/afghanistan/document/afghanistan-humanitarian-needs-overview-2020
[2]2019 Quarterly Report on the Protection of Civilians in Armed Conflict, UNAMA, October 2019, https://unama.unmissions.org/protection-of-civilians-reports
[3]Climate Change Adaptation Afghanistan, UNDP, https://www.af.undp.org/content/afghanistan/en/home/projects/CCAP-Afghanistan.html

MSF staff treat an infant in the neonatal intensive care unit at Boost hospital in Lashkar Gah, Helmand. © Kadir Van Lohuizen/NOOR

SUMMARY OF KEY FINDINGS

(Based on MSF survey results from Herat regional hospital in Herat province and medical data collected at Boost hospital in Lashkar Gah, Helmand province. See Methodology section.)

HERAT REGIONAL HOSPITAL

41% of caretakers and patients surveyed stated that a family member, friend or neighbour had died in the past two years due to lack of access to medical care.

Postponing medical care due to financial pressure is a dangerous coping strategy adopted by **89%** of patients and caretakers surveyed; **43%** stated they had postponed medical care more than three times over the past two years.

BOOST HOSPITAL

During the first six months of 2019, **44%** of the children who died within 24 hours of arrival in the paediatric intensive care unit (PICU) had arrived too late and at a very advanced stage of illness.

Of 3,680 measles cases treated in the first seven months of 2018, **48%** were admitted to the isolation ward due to severe complications.

INTRODUCTION

The crisis in Afghanistan is one of the world's most complex humanitarian emergencies, characterised by escalating conflict, recurring natural disasters, widespread internal displacement, and major public health needs. The country ranks 170 out of 189 in the latest United Nations Human Development Index.[4]

Over the last decade, armed conflict has killed more than 32,000 civilians and injured as many as 60,000.[5] Civilian deaths and injuries due to armed conflict nearly doubled between 2009 and 2019, with a record high death toll in 2018 and a spike in violence in the third quarter of last year.[6] Attacks on healthcare and disruptions to the health system have continued unabated. Despite efforts at peace negotiations over the course of 2019, there was little respite from the fighting across much of the country. Meanwhile, the prevalence of extreme poverty has also increased.

MSF has observed clear negative trends since 2014, when the organisation published a comprehensive report documenting the limits on access to healthcare: "Between Rhetoric and Reality: The Ongoing Struggle to Access Healthcare in Afghanistan"[7]. Six years later, this briefing paper shows that there has been no improvement in access to healthcare for the country's population, despite the efforts of health actors, including the Ministry of Public Health (MoPH). If anything, for many the situation has gotten even worse.

Healthcare personnel and facilities have been targeted amid the intensification of the conflict,

MSF's Kunduz hospital was bombed by US forces in 2015. © Andrew Quilty

exacerbating the challenges to access. In 2018, Afghanistan ranked third in the world for the greatest number of attacks on healthcare, after Palestine and Syria, with 91 attacks reported by the World Health Organization (WHO).[8] Attacks continued in 2019[9], with 119 incidents reported across 23 provinces as of the end of December. The direct targeting of healthcare facilities and personnel by all parties to the conflict not only causes immediate deaths and injuries, but also forces many hospitals to suspend vital medical services or shut down entirely. The result is that even more people are denied access to basic healthcare services.

MSF's experience before and since its return to work in Afghanistan in 2009 is that the public impression about internationally supported gains in the health system often diverges significantly from the reality on the ground. This briefing paper features the stories of our patients, their caretakers, and our staff to illustrate the many obstacles people face in their efforts to access healthcare.

[4] Human Development Report 2019, UNDP, http://www.hdr.undp.org/sites/default/files/hdr2019.pdf
[5] "Civilian deaths from Afghan conflict in 2018 at highest recorded level", UNAMA, 24 February 2019, https://unama.unmissions.org/civilian-deaths-afghan-conflict-2018-highest-recorded-level-%E2%80%93-un-report
[6] 2019 Quarterly Report on the Protection of Civilians in Armed Conflict, UNAMA, October 2019, https://unama.unmissions.org/protection-of-civilians-reports
[7] "Between rhetoric and reality—the ongoing struggle to access health care in Afghanistan", MSF, February 2014, https://www.msf.org/sites/msf.org/files/msf_afghanistan_report_final.pdf
[8] Surveillance System for Attacks on Health Care, WHO, 2019, https://publicspace.who.int/sites/ssa/SitePages/PublicDashboard.aspx
[9] "Afghanistan: Attacks on Health Care in 2019 as of 22 October", WHO, https://reliefweb.int/sites/reliefweb.int/files/resources/afghanistan_attacks_on_health_care_in_2019_20191022.pdf

METHODOLOGY

OBJECTIVES

The main objective of this briefing paper is to identify barriers to access to healthcare in Afghanistan based on the experiences of the local population in two provinces, Helmand and Herat. The paper highlights the impact that armed conflict has on people's ability to reach a medical facility, and the impact of widespread poverty among communities further limiting their access to medical care.

METHOD

Primary data for this briefing paper was collected through semi-structured interviews and questionnaires conducted with patients, caretakers and staff in facilities supported by MSF in Helmand and Herat provinces between November 2018 and May 2019. Convenience sampling was chosen for data collection due to restrictions impeding wider outreach. Routinely collected MSF medical data and indicators were used in an aggregate manner to provide additional information on the impact of barriers to healthcare faced by our patients and their communities.

While we believe the conclusions here are valid for other parts of the country, it is important to understand the limitations in the scope of the data collection. Testimonies and data were collected from two of six provinces where MSF works across the country: Boost hospital in Lashkar Gah city in Helmand province, Herat regional hospital in Herat city, and MSF's clinic for internally displaced people (IDP) just outside Herat city, in Herat province. MSF also runs medical projects in Kabul, Kandahar, Khost, and Kunduz provinces, covering maternal health, multidrug-resistant tuberculosis and wound care.

In Boost hospital, MSF conducted 84 semi-structured interviews among staff, patients and caretakers between February and March 2019. In Herat regional hospital, a survey was conducted over two weeks in November 2018. A total of 180 people responded to the face-to-face administered questionnaire. Another 16 semi-structured interviews were collected in Herat regional hospital and in the IDP clinic on the outskirts of Herat city in November 2018, January 2019 and May 2019. One focus group discussion was held in the IDP clinic in Herat province in May 2019.

Although the number of individuals sampled (n=280) was significant enough to allow consistent themes to emerge, convenience sampling is a non-probability technique. As not all members of the population had the opportunity to participate in the study, generalisations and sampling variability are considered less reliable than in probability sampling. The findings in this briefing should be considered indicative rather than representative.

DATA ANALYSIS

Microsoft Excel was used to clean and analyse data obtained from the questionnaires while Nvivo 12 was used to support discourse and text analysis of data from the semi-structured interviews. Finally, all references that could disclose information about the identity of interviewees, including districts of residence, were removed.

THE HUMANITARIAN COSTS OF CONFLICT

After more than 18 years of conflict since October 2001, the humanitarian situation in Afghanistan is bleak. The conflict has spread throughout the country, as government forces and armed groups fought for control over an increasing number of districts. Sustained hostilities have had disastrous consequences for the Afghan people, including widespread displacement and increased poverty levels.

Violence not only kills directly, but also indirectly through the disruption of access to healthcare. Many of our patients, their caretakers and even the staff working in medical facilities supported by MSF have experienced unthinkable levels of violence, and bear the physical and mental scars of the various cycles of conflict that have ravaged Afghanistan over the past 40 years.

"Three months ago, fighting started. My son was 12 years old. He went outside the house and was shot. We couldn't go to the hospital because of the fighting, and we also didn't have a car. He bled a lot. Then the police took us to the hospital in their car. But it was too late, and he died."

—Caretaker, inpatient therapeutic feeding centre, Boost hospital, Lashkar Gah, Helmand

Women and children gather in the female inpatient ward in Boost hospital, Lashkar Gah, Helmand. © Kadir Van Lohuizen/NOOR

Women and children are disproportionately affected by the conflict in Afghanistan—not only in terms of casualties, but also when it comes to displacement, financial difficulties, and lack of access to essential services such as healthcare. MSF patients tell stories of their sons, daughters and grandchildren, for whom they desperately tried to find medical care; for some of them, by the time they reached a hospital, nothing could be done.

The number of civilian casualties has increased in recent years, even as international attention to the conflict has wandered. In 2018, the United Nations Assistance Mission in Afghanistan (UNAMA) documented a record high number of 3,804 civilian deaths.[10] In total, UNAMA documented 10,993 civilian casualties (3,804 deaths and 7,189 injured), representing a 5 per cent increase in overall civilian casualties and an 11 per cent increase in civilian deaths compared to 2017. In 2019, UNAMA documented 10,392 civilian casualties (3,403 deaths and 6,989 injured)—the sixth year in a row that the number of civilian casualties exceeded 10,000.[11] During a spike in violence in the third quarter, from 1 July–20 September 2019, casualties increased by 42 per cent compared to the same period in 2018.

Even in the western city of Herat, which enjoys a greater degree of stability, albeit fragile, than other urban centres in the country, many people have been affected by violence. More than half (55 per cent) of patients and caretakers surveyed at Herat regional hospital stated that recent violence related to conflict or insecurity had caused suffering to themselves or to members of their family or community within the past two years. The leading causes of violence cited were ground fighting (49%), criminality (16%) and attacks using improvised explosive devices, or IEDs (14%).

Causes of violence

Ground fighting	49%
Criminality	16%
Suicide / non-suicide IED attack	14%
Landmine / war remnant	7%
Aerial bombing	2%
Tribal fighting / family feud	1%
Not specified	11%

Source: MSF survey, Herat regional hospital, 2018

"In the districts there is fighting, and IEDs are placed on the roads at night, so sometimes patients cannot travel.... When these patients wait for night to pass and then come here, they arrive already dead."

—MSF midwife, maternity ward, Boost hospital, Lashkar Gah, Helmand

MSF staff supporting the emergency room (ER) in Herat regional hospital also treat patients with conflict-related trauma injuries who have had to take long, dangerous journeys from neighbouring provinces to get there. For example, on 12 November 2018 five children were brought to the ER in Herat hospital. When fighting erupted, they had run for safety, but a rocket hit their hiding place. It took their families five hours to reach the hospital as there was active fighting in their home province of Farah. Similarly, on 13 May 2019, a 10-year-old child was rushed to Herat hospital by his parents. While the boy was leading his family's sheep to pasture, he had picked up an explosive device that detonated in his hand.

IEDs and aerial operations have caused large numbers of casualties across the country. The use

[10] 2018 Annual Report on the Protection of Civilians in Armed Conflict, UNAMA, February 2019, https://unama.unmissions.org/sites/default/files/unama_annual_protection_of_civilians_report_2018_-_23_feb_2019_-_english.pdf
[11] 2019 Annual Report on the Protection of Civilians in Armed Conflict, UNAMA, February 2020, https://unama.unmissions.org/protection-of-civilians-reports

"We couldn't leave at night because there are checkpoints on the way, and the [people there] would shoot if they see a car coming because they don't know if it's the [enemy]. In our area there is no private or public clinic. We are scared to leave at night, so we always have to wait until daytime to go to the hospital.... With everyone in our family, ***when they are sick, we wait, even if the person is dying.*** *There is no end to this war."*

—Caretaker, maternity ward, Boost hospital, Lashkar Gah, Helmand

of suicide and non-suicide IEDs was the leading cause of civilian casualties, responsible for 42 per cent of all civilians killed and injured during the first nine months of 2019.[12] The use of indiscriminate violence by parties to the conflict has put civilians carrying out day-to-day activities at extremely high risk of maiming and death.

In the southern province of Helmand, the use of IEDs on the roads to kill or disrupt opposing forces is widespread. Patients from faraway districts as well as our own staff tell us of the devastating impact of IED explosions that injured their relatives, neighbours and friends.

"When my child started being sick, we waited for one day to see if he would improve... the fighting started so we had to wait for another day and another night. Then we came with our motorbike, we left the house at 8 a.m. and we arrived here at 4 p.m."

—Caretaker, general paediatric ward, Boost hospital, Lashkar Gah, Helmand

Since 2001, Helmand has been one of the provinces most severely and regularly affected by the conflict. Years of violence have left Helmand with disrupted traditional structures, opportunistic groups and individuals who are fighting for influence, control of the drug trade, political power and financial gain. Most people living here face significant difficulties regarding access to healthcare, partly due to insecurity as well as a lack of functioning healthcare facilities.

"One woman was in labour and she came for delivery. She was crying a lot, so we asked what happened. She said her sister-in-law, who was also pregnant, had started bleeding the night before, around 11:30 p.m. There was fighting, so they couldn't leave the house. They waited until the fighting stopped, and then they had to find a car to rent. By the time they found one, her sister-in-law had died because of the bleeding. [Our patient] said her contractions started because she became very afraid, and she was crying a lot. Her husband took her to the hospital, but then he had to return home to help his brother with the burial preparations."

—MSF staff, Boost hospital, Lashkar Gah, Helmand

The effects of active fighting and indiscriminate violence permeate every aspect of life, affecting health-seeking behaviours and fostering a climate of fear among civilians. Many of our patients at Boost hospital in Lashkar Gah, the provincial capital, have to weigh several factors before even embarking on a journey to the hospital, including whether the roads have been mined or whether there are checkpoints along the way. Such concerns regularly cause delays in seeking care.

[12] 2019 Quarterly Report on the Protection of Civilians in Armed Conflict, UNAMA, October 2019, https://unama.unmissions.org/protection-of-civilians-reports

At Boost hospital, an MSF paediatrician and a nurse use the light of a smartphone to examine a newborn child suffering from malnutrition.
© MSF/Elise Moulin

"Patients from the districts who are hospitalised for 24 hours often leave earlier because they are afraid of travelling at night. Sometimes the patients or their babies are [in] critical [condition], maybe because they experienced a lot of bleeding, but even in these cases they leave earlier."

—MSF staff, Boost hospital, Lashkar Gah, Helmand

The medical staff working in the facilities supported by MSF regularly witness the impact that delays on arrival have on patients' health—which, at times, can make the difference between life and death. In Helmand province, when fighting intensifies, fewer people are able to reach Boost hospital, and the ones who do sometimes arrive in desperate condition.

Delays in receiving quality medical treatment have a particularly severe impact on the most vulnerable segments of the population. During the first six months of 2019, almost half (44 per cent) of the children who died within 24 hours of arrival in the paediatric intensive care unit (PICU) in Boost hospital had arrived too late and at a very advanced stage of illness.

Women are particularly at risk of dying from preventable causes related to pregnancy and childbirth. Newborns also incur greater health risks. The number of complicated deliveries, maternal mortality and neonatal mortality have remained at around the same high levels over the past 10 years, mainly due to persistent problems with lack of access. For example, the rate of still births in Boost hospital in 2019 was at 54 per 1,000 births, much above the reported national average (26.7 per 1,000 births[13]). When women finally do manage to reach the hospital to deliver, it is often already too late. Staff in the maternity ward at Boost hospital have witnessed the dramatic consequences of the conflict on such normal events as pregnancy and childbirth.

Fighting not only hinders people's ability to reach a health facility, it also has a severe impact on their medical care. In Helmand, for example, it is not

[13] Global Health Observatory data repository, stillbirth rate, data by country (Afghanistan), WHO, https://apps.who.int/gho/data/view.main.GSWCAH06v

Patients and caretakers enter Afghanistan's Boost hospital, one of the largest facilities supported by MSF worldwide. © MSF/Elise Moulin

uncommon for MSF staff to see patients having to discontinue their treatment in Boost hospital because they fear it is too dangerous to travel long distances at night or when fighting is suspected to resume.

Armed conflict has also obstructed vaccination campaigns, particularly for polio and measles. Around a third of children under the age of one receive no immunisations at all[14], and Afghanistan remains one of only three countries in the world where polio is yet to be eradicated.[15] In the medical facilities where MSF works, we periodically witness the serious impact of missed vaccinations and barriers to healthcare access. For example, measles outbreaks are recurrent in Afghanistan due to very low vaccination coverage. In the first seven months of 2018, 3,680 measles cases were treated inside Boost hospital in Lashkar Gah, out of which 1,772 cases were admitted to the isolation ward due to severe complications of the disease. After a measles vaccination campaign led by the Ministry of Public Health (MoPH) and conducted in the province in late November 2018, the trend of measles cases seen in Boost hospital dropped in 2019 to 95 cases per month.

Barriers to healthcare faced by the population not only impact vaccination coverage but also affect the prognosis of patients who are infected.

"I remember a very severe measles case. She was a young girl, 10 or 11 years old. She was coming from Musa Qala. Her family tried twice to pass the checkpoint and take her to the hospital, but they were not allowed to cross. They didn't have a facility offering vaccination services near their home. On the third attempt, they were finally allowed to cross the checkpoint and reach the hospital—a whole six days after the measles symptoms had started. ***Her skin had turned completely black and her temperature was so high.*** *To cool her down, they had covered her in wet blankets. Her lips were completely cracked, and she was crying. At the ER she received immediate treatment, and she was put in isolation. Her prognosis was really bad but finally, slowly, in the end she got better."*

—MSF staff, Boost hospital, Lashkar Gah, Helmand

[14] "1 in 3 children still unimmunized in Afghanistan", UNICEF, 25 April 2018, https://www.unicef.org/afghanistan/press-releases/1-3-children-still-unimmunized-afghanistan
[15] Global Polio Eradication Initiative, http://polioeradication.org/where-we-work/afghanistan/

WIDESPREAD POVERTY PUTS HEALTHCARE BEYOND REACH

The period between 2012 and 2017 in Afghanistan was characterised by a severe slow-down of economic growth, partially attributed to the combined effects of the reduction of international military forces and consequent decline in international spending, the downscaling of aid and the intensification of conflict. Poverty levels in Afghanistan more than doubled between 2007 and 2016, and currently more than 80 per cent of the country's population is living below the internationally applied poverty line.[16] Unaffordable medical care is having a direct and severe impact on the wellbeing of Afghan people, an issue that we witness daily through the stories our patients tell us in the health facilities we support across the country. While poverty levels are highest in rural areas, even in Herat city the vast majority of patients and caretakers (84 per cent) surveyed in Herat regional hospital stated having great difficulties in making ends meet.

The intensification of conflict witnessed in 2017 and 2018 had a direct impact on both education and employment, making it even more difficult for people to enter the skilled labour market. In 2018, a quarter of the overall labour force was believed to be unemployed, while 80 per cent of employment is insecure, as many are daily workers or are self-employed.[17]

The lack of resources and capacity within the public health system along with high costs for care and medicines continue to undermine access to healthcare in Afghanistan. Health facilities, including secondary and tertiary structures, are often understaffed, under-trained, and under-resourced. Furthermore, corruption and hidden costs for patients are creating major barriers for access to healthcare. Many people cannot afford to pay "under-the-table" costs and informal fees requested at clinics where healthcare should be provided free of charge.[18] The gaps in donor funding for the public health system remain unaddressed, putting increasing pressure on non-governmental organisations (NGOs) providing free medical care and effectively forcing humanitarian organisations to fill gaps in routine healthcare provision.[19]

The financial situation for large segments of the Afghan population is likely to be even worse than what recent statistics show. According to the latest Integrated Food Security Phase Classification (IPC) forecast for November 2019 to March 2020, an estimated 11.29 million people (37 per cent of the Afghan population) are likely to experience "severe acute food insecurity", while around 600,000 children are at risk of death due to malnutrition.[20] From January to December 2019, more than 87,000 children were treated in Boost hospital, 3,997 of them for severe acute malnutrition (SAM), which is one of the main causes of child mortality in Helmand. Malnourished children suffer from weakened immune systems, making them less resistant to endemic diseases such as measles and more vulnerable to the consequences of poverty and insufficient access to healthcare.

On top of the staggering levels of direct violence, general insecurity and high rates of poverty,

[16] Humanitarian Response Plan for Afghanistan 2018–2021, OCHA, December 2019, https://reliefweb.int/sites/reliefweb.int/files/resources/afg_2018_2021_humanitarian_response_plan_2020_update_lr.pdf
[17] The World Bank in Afghanistan, 13 October 2019, https://www.worldbank.org/en/country/afghanistan/overview
[18] Frost, A., et al., "An assessment of the barriers to accessing the Basic Package of Health Services (BPHS) in Afghanistan: Was the BPHS a success?", Globalization and Health, 2016, 12:71
[19] Humanitarian Needs Overview [2019], OCHA, https://reliefweb.int/report/afghanistan/[2019]-afghanistan-humanitarian-needs-overview, December [2018]
[20] "Around 600,000 Afghan children face death through malnutrition without emergency funds: UNICEF", UN News, 24 May 2019, https://news.un.org/en/story/2019/05/1039091

A child is assessed for malnutrition at MSF's Kahdestan clinic on the outskirts of Herat city. © Andrew Quilty

recurring natural disasters have exacerbated the crisis in parts of the country. Afghanistan is routinely cited among the countries most vulnerable to the effects of climate change, including the increased risk of drought and flooding.[21, 22] In 2018, prolonged drought affected two-thirds of the country, destroying agricultural land and livestock. The drought was followed by flash floods in 2019, which added financial hardship for thousands of people who, along with their livelihoods, also lost their homes.

For people living in conflict-affected Badghis province, for instance, the drought was the final push forcing many to leave their home areas. A prolonged period of below average rainfall, following years of conflict and the absence of basic services, exhausted their coping mechanisms and forced them to relocate to settlements for internally displaced people nearby. Many have settled on the outskirts of larger cities like Qala-e-Naw and Herat where they depend on humanitarian assistance.[23]

In addition, sanctions on Iran and the subsequent slowdown of its economy have affected the large numbers of Afghans living and working there, and supporting their families across the border. Since 2018, an unprecedented number of Afghans in Iran have lost their jobs and been forced to return to their home country. This has reduced remittances to many families, sometimes their sole source of income, including for patients at the MSF clinic in Kahdestan informal IDP settlement on the outskirts of Herat city.

Barriers to healthcare access

Cost	81%
Distance	10%
Insecurity – active fighting	5%
No one to accompany the patient to a medical facility	3%
Insecurity – criminality	1%

Source: MSF survey, Herat regional hospital, 2018

In Herat regional hospital, 41 per cent of caretakers and patients surveyed in November 2018 stated that a family member, friend or neighbour had died over the past two years due to lack of access to medical care. Cost was cited as a barrier to accessing healthcare by 81 per cent of respondents.

"Affording healthcare has become more difficult because the cost of the medicines is increasing day by day."

—Patient, Herat regional hospital, Herat city, Herat province

MSF patients and their families tell us how poverty affects all aspects of their lives, including access to healthcare. This is particularly evident in a

[21] Humanitarian Needs Overview 2020, OCHA, December 2019, https://reliefweb.int/sites/reliefweb.int/files/resources/afg_humanitarian_needs_overview_2020.pdf
[22] Notre Dame Global Adaptation Initiative, Country Index, https://gain.nd.edu/our-work/country-index/rankings/
[23] Global Report on Internal Displacement, Internal Displacement Monitoring Centre, Norwegian Refugee Council, 2019, p. 36

country such as Afghanistan, where household out-of-pocket expenditure is estimated to cover 77.4 per cent of the total health expenditure.[24]

"Because of our financial situation I cannot go to the doctor regularly. The price of medicines changes according to the pharmacy, and it's difficult to know where to buy them. My husband is a daily worker. This week he only made AFN 500 [US$6.50]."

—Caretaker, Herat regional hospital, Herat city, Herat province

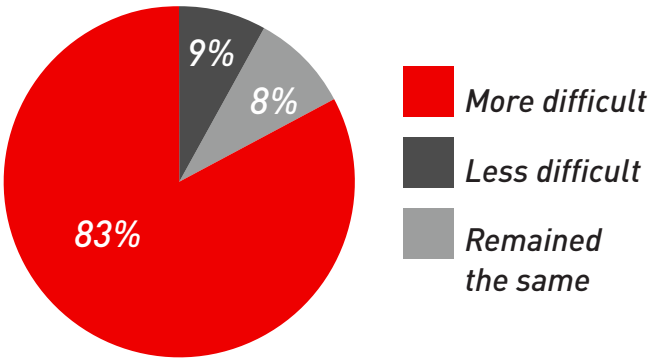
As many as 88 per cent of people surveyed said they had faced financial difficulties as a result of spending on medical care. Of that number, only 9 per cent stated they had experienced financial difficulties "rarely."

"My son has a bad infection from a cut on his toe. He is hospitalised here. They gave me a prescription for medicines, but I have no money to buy them. I tried to borrow it, but no one could give me any. My job is to bake bricks in the summer. In the winter I have a cart to transport things for people, but this winter I can't find work."

—Caretaker, Herat regional hospital Herat city, Herat province

When asked whether being able to afford medical care over the past two years had become more or less difficult, a staggering 83 per cent said that it had become more difficult. The heightened difficulty in accessing medical care appears to be a direct result of the increased financial hardship experienced by many in Afghanistan.

Ability to afford medical care



Source: MSF survey, Herat regional hospital, 2018

Poverty is not only a barrier in terms of direct medical costs—such as buying drugs and medical equipment, paying for diagnostic tests or other formal and informal fees—but also indirect costs, such as paying for transportation. In the health facilities supported by MSF, most patients, particularly the ones who have had to embark on long journeys, tell us of the hurdles they face even to afford a seat in a shared car or petrol for vehicles to get there. At times, the

"We live in Nad Ali district. It's far from the hospital, so many times when someone is unwell, we try to treat him at home.... There is no public clinic in the district, or maybe I don't know of it. When we come here by car the driver takes AFN 150 [US$2] per person, so even if someone is very sick, we need to wait to have money for the car.... For this child we had to borrow money in the end, to rent the car to come here. At night, if anyone is unwell a seat in the car can cost even AFN 300 [US$4], so only those with money can pay. ***Those who don't have money just die."***

—Caretaker, general paediatric ward Boost hospital, Lashkar Gah, Helmand

[24] Global health expenditure database, WHO, 2016, http://apps.who.int/nha/database/ViewData/Indicators/en

inability to afford urgent transport to the few functioning, often distant, health facilities has fatal consequences for people in dire need of healthcare. Many people die at home or on their way to the hospital.

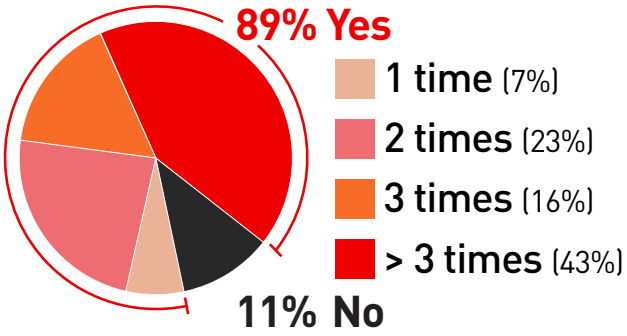
"Patients are also poor; they don't have money to rent a car. In the past we used to keep mothers for 24 hours after delivery, now we keep them just for four hours—but many don't want to stay because the price of the rented car will increase the longer it's kept. We tell the mothers that the baby will be under observation for longer if they stay, and that they would also be under medical observation for longer, and that this is good in case complications emerge. But they can't leave the car waiting for too long, and they can't send it back otherwise they would have to rent another one."

—MSF staff, Boost hospital, Lashkar Gah, Helmand

Extreme poverty is also having an impact on the continuation of treatment. In the medical facilities we support, we witness this not only in relation to late arrivals but also in instances of patients defaulting from treatment. At times, patients cannot stay at the hospital long enough to ensure that they will not incur health risks after discharge, simply because they cannot afford the car rental for an extra hour.

Postponing medical care due to financial pressure on the household is a dangerous coping strategy adopted by the majority of the patients and caretakers (89 per cent) surveyed in Herat regional hospital, with almost half of them (43 per cent) stating they had postponed medical care more than three times over the past two years. Reducing spending on essential needs, such as food and clothing, is another coping strategy

In the past 2 years, did you postpone medical care because of cost?



Source: MSF survey, Herat regional hospital, 2018

"My son is in dialysis, and he needs it three times per week, but the regional hospital only provides it for free once per week. The other two times we have to go to the private clinic. And if it wasn't for the people that give us some money to help, we wouldn't be able to pay.… They can't provide dialysis here three times per week because they have too many patients. Because we have to pay for my son's treatment, we cannot pay for clothes for the winter and food."

—Caretaker, MSF clinic, Kahdestan informal IDP settlement, Herat province

"To come to the hospital in the city, we have to rent a car … so it's very expensive. My baby was very sick, but we had to wait for the rain to stop and to have money for the car. We borrowed money from our relatives, and we came here. We waited for eight days to come here."

—Caretaker, inpatient therapeutic feeding centre ward, Boost hospital, Lashkar Gah, Helmand

Abdul Jalil brings his son Ramin to MSF's Kahdestan clinic after going to a public hospital, where he could not afford to buy the drugs prescribed.
© Ahmadullah Safi/MSF

observed among patients and their communities by MSF staff in Afghanistan. Indeed, four out of five people surveyed at Herat regional hospital claimed to have had to deprive themselves and their household of essential items in the past two years in order to pay for health-related costs.

Borrowing money or selling household goods, including essential ones, to pay for medical care is also a strategy adopted by many people living in the catchment areas of health facilities supported by MSF. This often results in additional financial hardships, such as debt.

Even among the urban population in relatively stable Herat city, borrowing money and selling one's belongings in order to pay for healthcare

"My children were sick, and I couldn't take them to the clinic in the city because we don't have money. Two or three months ago I had to borrow money from relatives to take my children to the doctor, and now we have debt."

—Caretaker, MSF clinic, Kahdestan informal IDP settlement, Herat province

"I have a granddaughter who was sick. I took her to the paediatric hospital. They told me that she had to stay inside the hospital for 40 days. I didn't have money for the treatment, so I sold my tent to pay."

—Community leader, Kahdestan informal IDP settlement, Herat province

appear to be common. Indeed, among people surveyed in Herat regional hospital, borrowing money was cited as a source of payment used to cover health-related costs by 63 per cent of respondents, while selling goods was cited by 11 per cent of them.

Sources of payment for medical care [25]

Borrowed money	63%
Savings	26%
Sold goods	11%

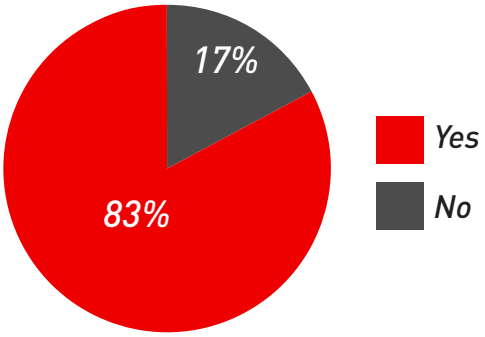
Source: MSF survey, Herat regional hospital, 2018

[25] Of the 180 respondents, 21 cited two payment sources, i.e. the total number of responses to this question was 201.

A PUBLIC HEALTHCARE SYSTEM STRAINING TO MEET THE NEEDS

There undoubtedly has been progress in healthcare provision in Afghanistan in recent years, yet significant gaps remain. The stories of our patients and staff provide meaningful insight into just how substantial the access issues are. In the context of reduced international funding for public health, there is mounting pressure on countries like Afghanistan to start paying for their own health services, often at an unrealistic pace and regardless of their actual capacity to do so. This leaves an inevitable funding gap, which some countries look to patients to fill through "user fees."

In the past 2 years, did you reduce spending on essential needs to be able to cover health related costs?



MSF survey, Herat regional hospital, 2018

"The public clinics and the paediatric hospital are not free. When you arrive, they ask you for AFN 20 [US$0.30]. Then, if the patient needs hospitalisation, they charge another fee. If they need medicines, they give prescriptions."

—Community leader, Kahdestan informal IDP settlement, Herat province

Despite the serious barriers to healthcare facing many Afghans, a cost recovery approach, implemented through the collection of user fees in some secondary and tertiary medical facilities in the country, started being enforced in December 2018. This is likely to further limit people's access to healthcare given that many were already forced to reduce spending on essential needs to cover health-related costs.

"In terms of facilities, there are plenty of services but they all cost. At the hospital now there are user fees, and people still have to pay for investigatory tests and the medicines. We followed a child last week, he had a mine injury. His dad was able to pay to get him here and for the surgery, but he didn't have any money left to pay for medicines. We see a lot of patients that are turned away [from other hospitals] because of the user fees."

—MSF staff, Herat regional hospital Herat city, Herat province

Of particular concern is the fact that income-based exemptions, as set forth in the guidelines issued by the Government of Afghanistan, do not seem to be applied consistently. We observed that patients who cannot afford medical expenses are nevertheless asked to cover new fees, often in addition to drugs and equipment used for their medical treatment at the hospital. At times they are turned away if unable to pay.

The current public health system evolved from reconstruction efforts, starting in 2003 when the MoPH and international donors—the World Bank, US Agency for International Development and the European Commission—introduced the

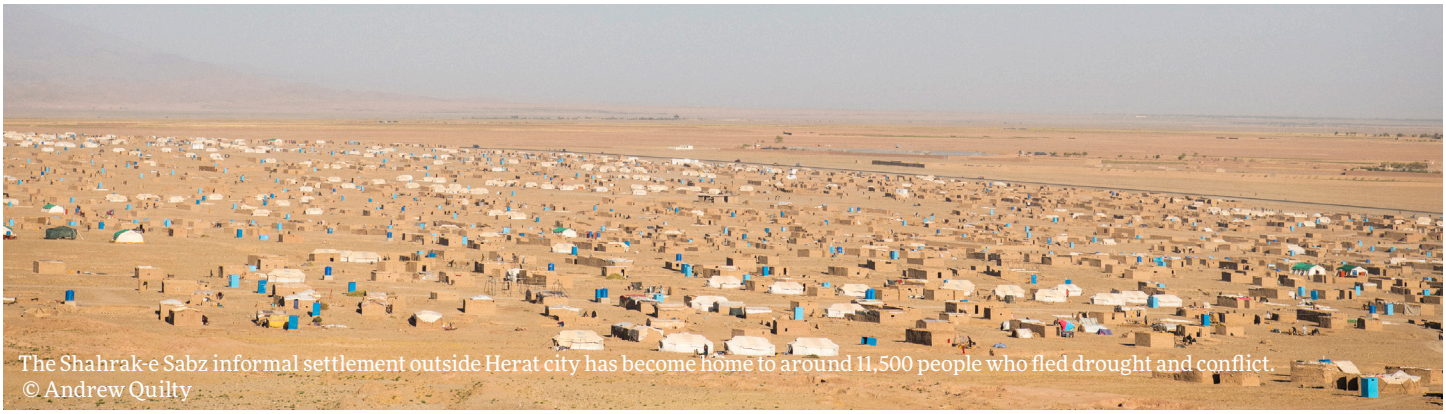
A doctor checks on an elderly patient in Boost hospital, Lashkar Gah, Helmand. © Kadir Van Lohuizen/NOOR

Basic Package of Health Services (BPHS). This programme aimed to deliver basic healthcare by contracting out service delivery to international and national NGOs. The BPHS system initially became popular for implementation in post-conflict countries (such as Cambodia, Rwanda and Uganda) but was introduced in Afghanistan despite the ongoing conflict.[26] In 2005, the Essential Package of Hospital Services (EPHS) was implemented to improve secondary and tertiary medical care in hospitals across the county.

The implementation of the BPHS/EPHS system is supported through performance-based partnership agreements.[27] It is meant to cover about one-third of the country and focuses on increased access to maternal and child health services. Although technical expertise is one of the factors evaluated when assigning contracts, much weight is put on cost-effectiveness. This has led NGOs to outbid each other to deliver with the lowest, often unrealistic, price per capita. As a result, many public medical facilities are not equipped with enough staff and medical supplies, and patients often need to buy drugs and equipment themselves that will be used for their medical care. This effectively moves basic health provisions further out of reach for people who cannot afford the extra costs.

[26] Frost, A., et al., "An assessment of the barriers to accessing the Basic Package of Health Services (BPHS) in Afghanistan: Was the BPHS a success?", Globalization and Health, 2016, 12:71
[27] Sehatmandi project, Afghanistan Ministry of Public Health, 2019, https://moph.gov.af/index.php/en/sehatmandi-project

CONCLUSION



The Shahrak-e Sabz informal settlement outside Herat city has become home to around 11,500 people who fled drought and conflict.
© Andrew Quilty

The escalation of conflict in Afghanistan in recent years has taken a heavy toll on civilians, both in terms of conflict-related casualties but also with regard to increased barriers to access to healthcare. Since MSF published a report in 2014 documenting the limits on access to healthcare, there remains a discrepancy between the official narrative regarding the Afghan health system and what our patients are experiencing on the ground. Violence has intensified over the past six years, and still has a significant impact on how our patients can access healthcare.

Direct medical and non-medical costs also limit people's ability to access medical care, especially now that more than 80 per cent of the population lives below the internationally applied poverty line. Consequently, large parts of the population are being left behind, and morbidity and mortality rates are high. The situation is even worse for the large numbers of displaced people. NGO hospitals providing free medical care are under great pressure to fill the gaps. The sharp increases in poverty, displacement and returns together with the escalation of the conflict are likely to further limit Afghans' access to healthcare.

With pervasive violence and widespread poverty across the country, focusing on cost-recovery rather than on ensuring effective access to free, high-quality healthcare is premature. This approach increases the risk of preventable deaths, particularly among the most vulnerable segments of the population. When planning and implementing health-related programmes, international donors and local stakeholders must acknowledge that the humanitarian situation in Afghanistan has not improved, and in some areas has worsened in recent years.

High levels of insecurity and extreme poverty continue to put healthcare out of reach for too many people. All actors need to do more to strengthen and safeguard access to medical services across the country. While long-term development remains an important objective, there has been a consistent failure to recognise the hard realities on the ground and the daily challenges of people still struggling to survive. Ongoing acute humanitarian needs must be adequately addressed. As donors look towards the next pledging conference planned for this year, they should provide necessary humanitarian funding and develop robust transition mechanisms to move gradually from humanitarian to development aid.

The international community must stop ignoring Afghanistan's healthcare crisis and start providing sufficient assistance to reach an increasingly vulnerable population.