

BETWEEN RHETORIC AND REALITY

THE ONGOING STRUGGLE TO ACCESS HEALTHCARE IN AFGHANISTAN

February 2014

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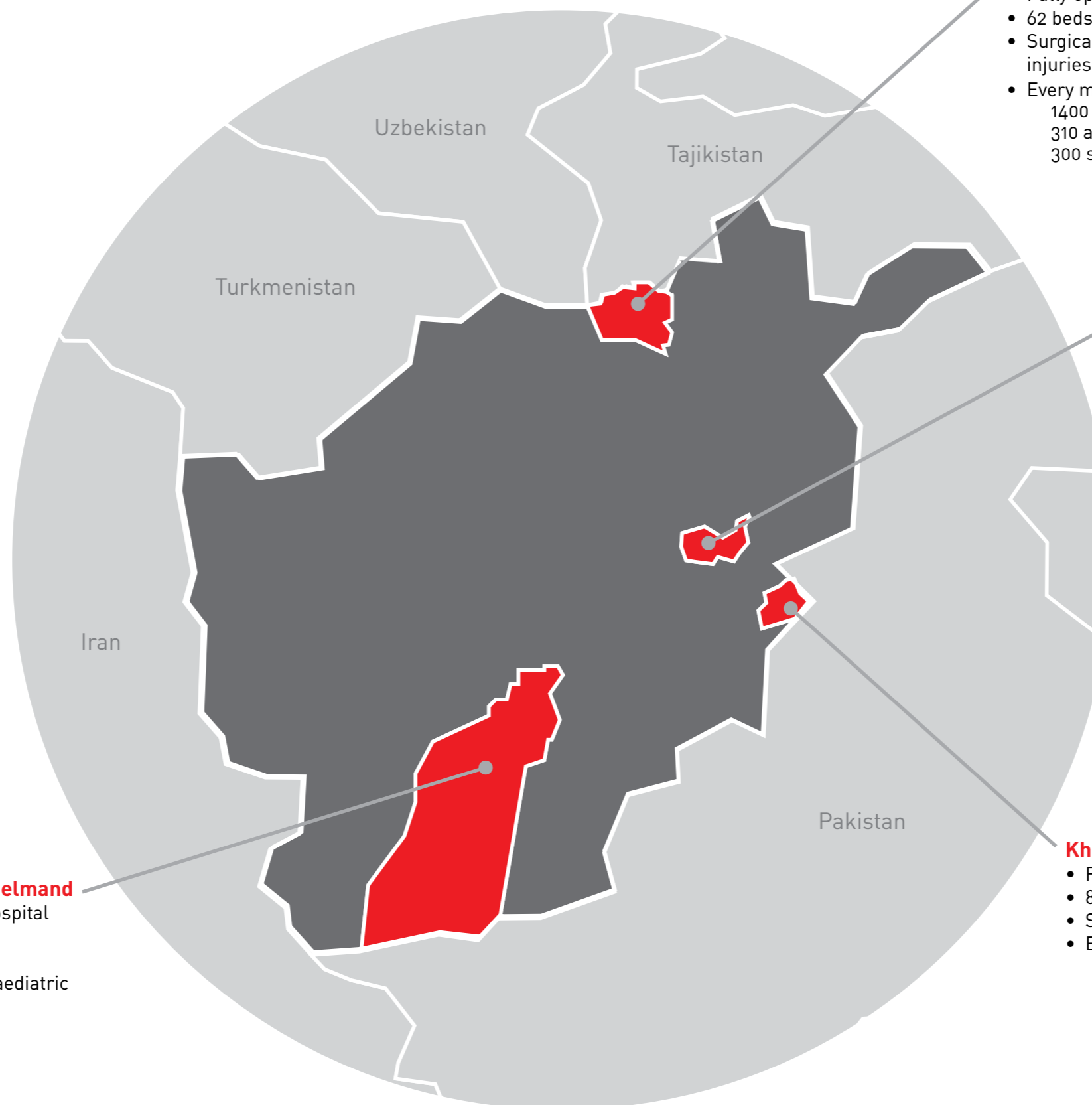
MSF IN AFGHANISTAN

Médecins Sans Frontières (MSF) is a medical humanitarian organisation that operates under the principles of independence, impartiality and neutrality.

MSF has been working in Afghanistan since the early 1980s. Following two decades of emergency medical care provision in Afghanistan, MSF left the country in 2004 after the brutal murder of five of our colleagues. MSF returned in 2009 as humanitarian needs had markedly increased, along with the deteriorating security conditions.

MSF runs a surgical trauma centre in Kunduz in the north, as well as a maternity hospital in Khost to the east of the country. MSF also works to support the Afghan Ministry of Public Health in Ahmad Shah Baba Hospital in eastern Kabul, and in Boost Hospital in Lashkar Gah, in Helmand in the south. In all locations MSF provides quality medical care free of charge.

MSF currently has 1,600 Afghan staff and 70 international staff working in the country. In Afghanistan MSF relies on private funding only and does not accept funds from any government for its work.



Kunduz Trauma Centre

- Fully operated and managed by MSF since 2011
- 62 beds
- Surgical care for general trauma and conflict-related injuries
- Every month:
 - 1400 ER consultations
 - 310 admissions
 - 300 surgeries

Ahmad Shah Baba District Hospital, Kabul

- MSF supporting Ministry of Public Health hospital since 2009
- 69 beds
- Outpatient, inpatient, maternity, emergency, surgery, paediatrics, therapeutic feeding and mobile clinics services
- Every month:
 - 9100 outpatient consultations
 - 4400 ER consultations
 - 1300 admissions
 - 1050 deliveries
 - 90 surgeries

Khost Maternity Hospital

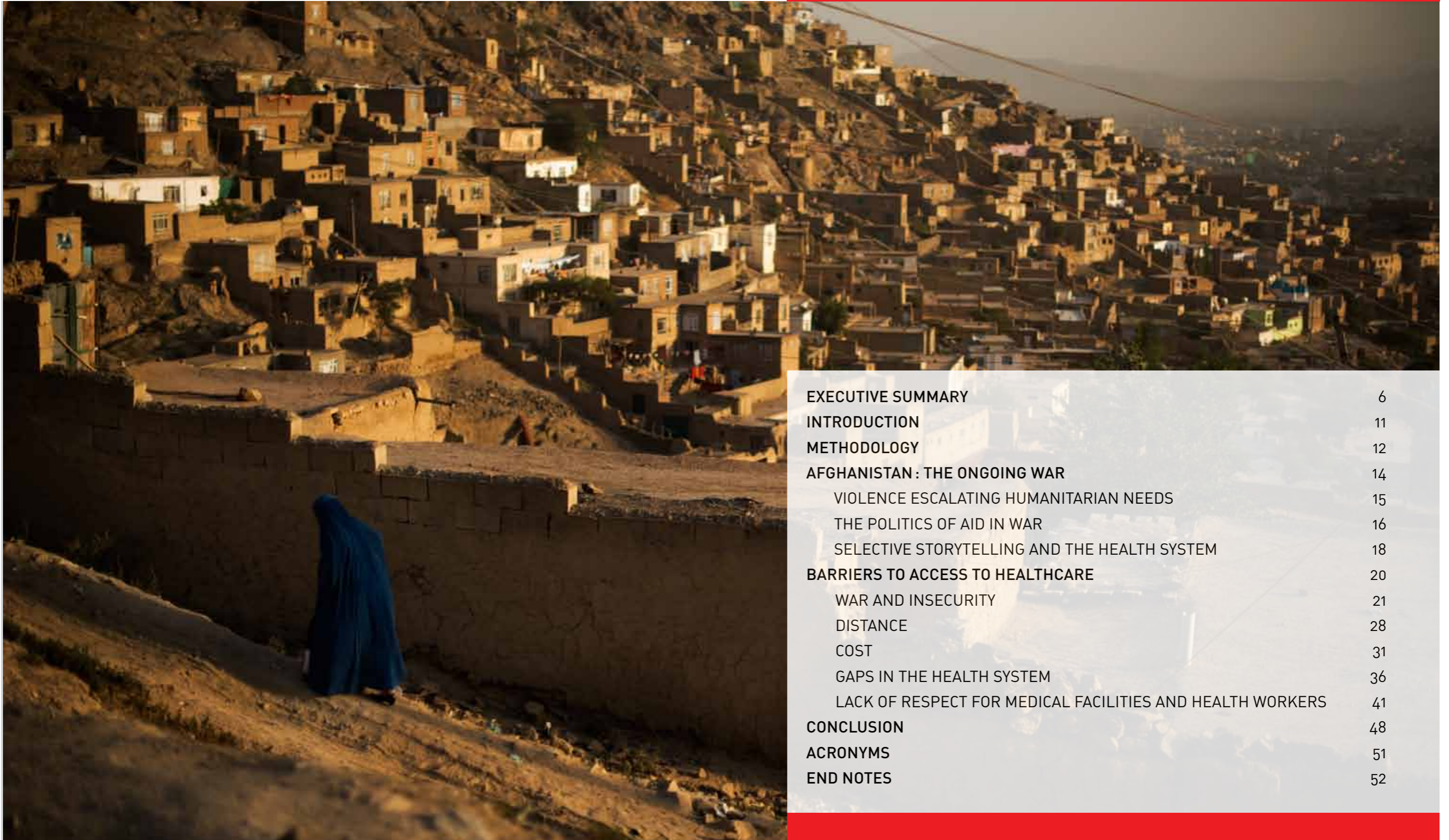
- Fully operated and managed by MSF since 2012
- 83 beds
- Specialised maternal and neonatal care
- Every month:
 - 1100 admissions
 - 1000 deliveries
 - 45 surgeries

Boost Provincial Hospital, Lashkar Gah, Helmand

- MSF supporting Ministry of Public Health hospital since 2009
- 250 beds
- Inpatient, maternity, emergency, surgery, paediatric and therapeutic feeding services
- Every month:
 - 5400 ER consultations
 - 900 admissions
 - 740 deliveries
 - 470 surgeries

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EXECUTIVE SUMMARY



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2014 is another crucial year for Afghanistan: after 12 years, the US-led NATO military intervention in the country has entered its final phase, and presidential and provincial elections are scheduled for April. As the bulk of international troops withdraw before the end of the year, the world's attention is rapidly turning elsewhere. What interest remains in Afghanistan is firmly fixed on military drawdown, security transition and pre-electoral wrangling. Conspicuously lacking is a focus on the daily reality for Afghans, trapped in an escalating conflict – indeed 2013 was reportedly the second most violent year for civilians since 2001.

As coalition forces pull out, their leaders attempt to define the legacy of the international intervention in Afghanistan. Alluring narratives of success – crafted to suit political and military

agendas – abound. When it comes to healthcare provision, much investment and progress has undoubtedly been made since 2002. However, official accounts of Afghanistan's health system habitually emphasise achievements, yet neglect unmet medical humanitarian needs.

For MSF, the overly optimistic rhetoric about healthcare success often diverges significantly from the reality our teams see on the ground. However, a dearth of reliable statistics makes it difficult to gain a comprehensive view of the true extent of needs. To build a clearer picture of people's ability to access healthcare, MSF conducted research in the four hospitals where our medical teams work – in Helmand, Kabul, Khost and Kunduz provinces. Over a six-month period, a survey and interviews were carried out with more than 800 patients and their caretakers

to help better understand the extent of the barriers people face when trying to obtain medical care.

The results are grim. Statistics and personal accounts highlight the devastating impact of the ongoing war on Afghan communities. In a country with some of the highest mortality rates in the world, the conflict is causing widespread disruption to health services, particularly in remote areas.

People's stories reveal the war's toll on civilians: an entire family blown up by a landmine as they travelled home from hospital with a new baby; villages caught between the attacks and the demands of multiple rival armed groups; people forced to hold night-long 'death watches' over sick or injured loved ones as fighting rages outside, in the hope of safely reaching medical care the next day.

KEY FINDINGS:

Impact of ongoing violence and insecurity

- Within the previous 12 months, one in four people (29%) had either experienced violence themselves, or had a family member or friend who had experienced violence.
- One in four people (23%) had a family member or friend who had died as a result of violence within the preceding year.
- The vast majority (87%) of the violence and deaths were caused by the continuing armed conflict. The remaining deaths and violence were the result of criminality or personal or communal feuds.

Impact of lack of access to healthcare

- One in five people (19%) had a family member or close friend who had died as a result of their lack of access to healthcare within the preceding 12 months.
- The three main barriers to accessing healthcare, which had resulted in subsequent death, were: lack of money and high costs (32%); long distances (22%); the armed conflict (18%).

Dangerous journey to healthcare

- For those who managed to reach a health facility, various obstacles had to be overcome. The main obstacle for one in two people (49%) was related to the conflict.
- Even though those interviewed had made it to hospital on the occasion of the survey, one in eight people reported that on other occasions during the preceding year they had not been so lucky. In Helmand and Kunduz, two in five people reported that obstacles had either completely blocked them or seriously delayed them from reaching MSF health facilities at least once during the preceding year.
- Three times out of four (74%), the obstacle that had delayed or blocked them from travelling to an MSF hospital was active fighting or insecurity at night.

Distance and cost as barriers

- Distance was a major barrier to patients reaching health facilities in all locations. In Kabul and Kunduz, it was cited by patients as the main obstacle. One third of those interviewed in Kunduz reported that distance had been a significant difficulty when bringing wounded patients for emergency care.
- One in ten people (12%) had travelled for more than two hours by motor transport, often on perilous tracks and roads, to reach hospital. In Kunduz, one in four people (27%) had travelled for more than two hours with a seriously injured person to reach the trauma centre.
- Two in three people (66%) described their household as poor to extremely poor, living on around US\$1 a day. Yet people had paid an average of US\$40 for healthcare during a recent illness in their household, with one in four spending more than US\$114.

- Two in five people (44%) had been forced to borrow money or sell goods to obtain healthcare during a recent illness.

Perceptions and use of the health system

- Four in five people (79%) had bypassed their closest public clinic during a previous illness in the preceding three months, mostly because they believed there were problems with the availability or quality of staff, services or treatments found there.

These findings confirm that prevailing success stories about the health system frequently mask the extent of the barriers impeding access to affordable, quality medical assistance for too many Afghans. The majority of people interviewed said they struggle to access medical care, due to a combination of insecurity, distance and high costs.

Although the number of health facilities in Afghanistan has increased considerably over the past decade, people reveal that there are still too few affordable or properly functioning health facilities that they trust close to them. A focus on improving both coverage and quality of health facilities is necessary, particularly in the most insecure areas, where basic and lifesaving medical care is often non-existent, prohibitively expensive or inaccessible.

For those who do manage to reach health facilities, their journeys are often fraught with fear and danger as they contend with landmines, roadblocks, checkpoints, harassment and crossfire. Paying large amounts to cover these journeys, as well as paying for doctors' fees, medicines, laboratory tests and inpatient care, pushes many people into untenable debt. As promised under the national free care policy, it is thus critical that public health centres ensure free medical care is available to everyone.

With the number of people treated for wounds inflicted by weapons in Afghanistan rising by 60% in 2013, the lack of services and facilities for those affected by the intensifying conflict is especially concerning. In particular, the absence of a properly functioning referral system between basic health centres and district or provincial hospitals prevents wounded civilians, or women experiencing complications in labour, from accessing critical surgical care.

All parties to the conflict, as well as a range of criminal groups, continue to engage in activities that create obstacles to accessing healthcare. Active fighting, the occupation of health facilities by armed groups, deliberate delays and harassment at checkpoints, and attacks on medical vehicles and personnel all create unacceptable barriers for sick or wounded people in need of medical assistance.

The announcement by the Government of Afghanistan that a number of health facilities, along with schools, have been designated as registration centres and polling stations for this year's election is a further sign of health facilities being used for purposes other than meeting medical needs. This places the health facilities at increased risk of attack, damages the perception of health centres as neutral spaces to provide medical care, and puts the lives of health workers and patients in danger.

While destruction and disruption of services disproportionately affects those living in remote conflict-affected areas, the insecurity also prevents international humanitarian agencies, including MSF, from providing a sustained or adequate response in these locations. This means the most vulnerable people are left to fend for themselves.

To better ensure that quality care reaches those communities most in need, it is vital that health and humanitarian organisations prioritise negotiating

their access with all sides in the armed conflict. At the same time, all parties to the conflict must do far more to ensure that neutral and impartial care can be safely provided to wounded and sick people, including those actively involved in hostilities.

Over the past decade, decisions on where and how to provide assistance have too often been based on desires for stabilisation, force protection or 'winning hearts and minds', at the expense of adequately addressing people's most pressing needs. Every effort needs to be made to untangle humanitarian aid and action from political and military objectives.

It is striking how far the accounts of ordinary Afghans differ from prevailing narratives of progress. Packaging the intervention into a simple success story risks obscuring the reality of the ongoing war and people's increasing humanitarian needs. MSF's report highlights the experiences of our patients in order to galvanise an improved response to their situation. MSF remains committed to providing free, quality care in all the locations where we work, and will continue to strive to reach the most vulnerable people.

As troops pack their bags, and donor and media interest in the country wanes, it is vital to prioritise actions that can deliver tangible results for the Afghan population. Now is the time to face up to the reality of their situation in order to save lives and alleviate their suffering.



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INTRODUCTION

Embroiled in war for almost 35 years, Afghanistan is locked in a complex crisis with staggering economic, political and social problems. 2013 was reportedly one of the most violent years since the US-led NATO military intervention began in 2001.

By the end of 2014, the bulk of US and British soldiers are expected to withdraw, with the NATO-led International Security and Assistance Forces (ISAF) having finalised the handover of total responsibility for security to the Afghan National Security Forces (ANSF) in 2013.

Provided a bilateral security agreement (BSA) is approved between the US and Afghanistan, the US is expected to keep an estimated 10,000 troops in Afghanistan, with NATO allies providing additional troop support after 2014. However, talks around the BSA have stalled, fuelling uncertainty about what post-2014 will bring. At the same time, critical presidential and provincial council elections are slated for early April 2014.

In the meantime, hardly a week passes without casualties or severe injuries from bomb attacks, shootings, landmines or drones. Humanitarian needs continue to grow, as the ongoing conflict exerts a devastating toll on the civilian population.

As the Coalition Forces pull out, their leaders struggle to define the intervention's legacy in Afghanistan. Alluring narratives of success – crafted to suit political and military agendas – abound. The world's attention is firmly fixed on military drawdown, security handover and pre-electoral wrangling, with the daily battle to survive for hundreds of thousands of people too often relegated from the headlines.

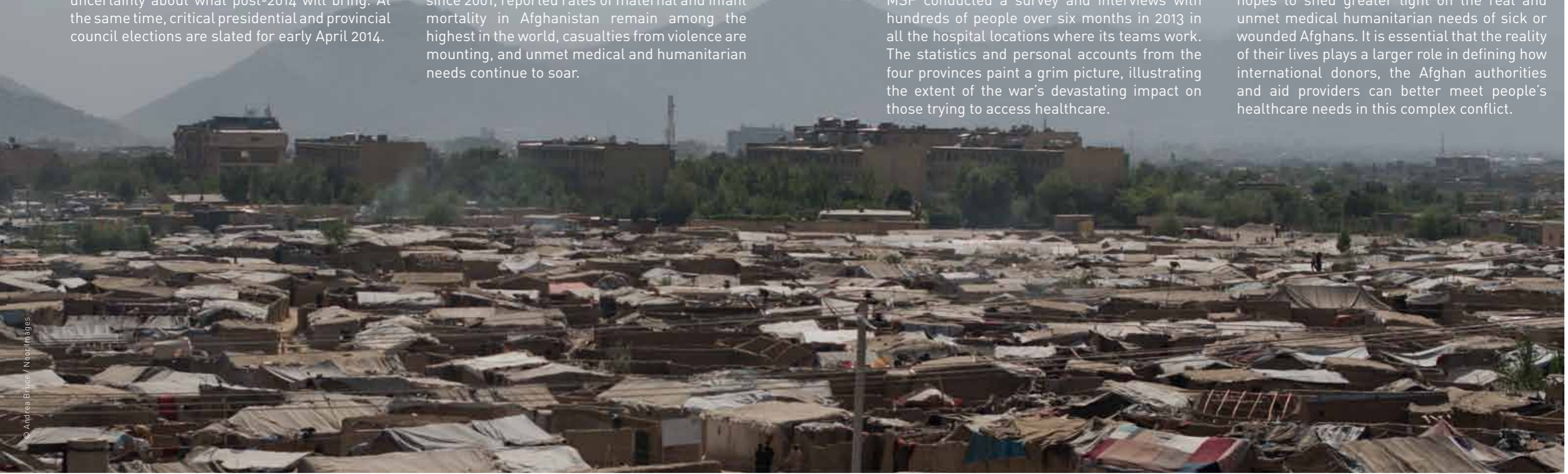
In the search for a success story, healthcare is repeatedly held up as a glowing example of state-building efforts. Even though progress has undoubtedly been made in healthcare provision since 2001, reported rates of maternal and infant mortality in Afghanistan remain among the highest in the world, casualties from violence are mounting, and unmet medical and humanitarian needs continue to soar.

A dearth of reliable statistics makes it impossible to gain a clear picture of the true extent of suffering in numerous areas of the country. Much of the available data is either weak, disputed or excludes the most insecure areas. This is compounded by the fact that access for humanitarian organisations to remote and insecure areas has been shrinking over the last decade. Many aid providers are bunkered inside main cities and towns, unable to deliver or monitor assistance in insecure zones.

MSF's own experience before and since its 2009 return to Afghanistan is that the upbeat rhetoric about internationally supported gains in the health system often diverges significantly from the reality on the ground. In an effort to build a more comprehensive and informed picture of the reality of people's lives and their capacity to obtain quality, affordable medical assistance, MSF conducted a survey and interviews with hundreds of people over six months in 2013 in all the hospital locations where its teams work. The statistics and personal accounts from the four provinces paint a grim picture, illustrating the extent of the war's devastating impact on those trying to access healthcare.

The research exposes the reality for communities in these provinces trapped between multiple sides in an unpredictable, violent conflict: long perilous journeys risking life and limb to get malnourished babies, pregnant women or injured loved-ones to medical aid; clinics without enough drugs, qualified staff or electricity; abandoned development projects including half-constructed hospitals; mounting debt to pay for treatment; and the distressing impact that decades of violence and insecurity is having on people's material and mental states.

With the conflict spreading to once-stable areas of the country, and ominous indications that the war will only intensify in many places, along with lawlessness and displacement, the humanitarian situation in Afghanistan today cannot be overlooked. With this research, MSF hopes to shed greater light on the real and unmet medical humanitarian needs of sick or wounded Afghans. It is essential that the reality of their lives plays a larger role in defining how international donors, the Afghan authorities and aid providers can better meet people's healthcare needs in this complex conflict.



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METHODOLOGY

OBJECTIVES:

The main objective of this research was to generate insight into the barriers to accessing healthcare through existing health structures, as a result of the current context, conflict and aid system in Afghanistan, in order to:

- Deepen MSF's understanding of the context and realities faced not only by our patients but also their families and communities.
- Ensure that MSF's operations remain oriented to respond to people's most pressing health needs.
- Raise awareness of the continuing humanitarian and medical situation in Afghanistan.
- Share the findings with other actors involved in Afghanistan to feed into reflections on how to improve access to essential healthcare for those most in need.

METHODS:

The methods of information collection from patient sources used between mid-June and end-October 2013:

- Cross-sectional survey among 700 patients (or caretakers) in four different provinces (Kabul, Kunduz, Khost and Helmand), using a quantitative, pre-tested questionnaire.
- 12 semi-structured focus group discussions among patients (or caretakers), with similar background/characteristics in four locations.
- 35 semi-structured individual interviews with patients (or caretakers), with a minimum of eight individual interviews in each of the four locations.

Additional information was collected from:

- Health data and indicators from medical reports of health structures supported by MSF.
- Several interviews with key interlocutors within each of the four locations and at country level, exploring national policy and contextual factors.

- Brief literature review on health services in Afghanistan since 2001, including grey literature.

LOCATIONS:

Data collection was exclusively conducted in locations where MSF operates and among patients and caretakers within health facilities run or supported by MSF.

DETAILS OF PATIENT SAMPLING:

In each project location, a minimum of 175 questionnaires were completed, and eight semi-structured individual interviews, and between three and five focus groups were held. The sample size (n=175) from each of the four provinces was chosen to get sufficient statistical power to compare patients from inside and outside the district where the hospital was located in a particular province, but also to draw comparisons between the provinces. Patients and caretakers from all departments within the four hospitals were interviewed. Convenience sampling was used, either in the wards or in outpatient consultation areas. The only selection criteria for participants was whether they had someone else in their household – besides the one currently in care – who had been sick or injured in the past three months.

For the semi-structured individual interviews, participants were asked if they wanted to continue the interview once they had completed the questionnaire. For the focus groups, participants were divided into male and female for cultural reasons. Participants were attributed to a group based on rural versus urban origin and on whether they were living in or outside the district where the hospital was located. Each focus group had a minimum of five and a maximum of ten people. The Research Coordinator facilitated each focus group, with conversations usually held in Pashtu translated by a male or female Afghan interviewer.

DATA COLLECTION:

An MSF Research Coordinator supervised the research in the four project locations. Three male and three female Afghan interviewers were recruited, to conduct surveys and interviews for male and female interviewees respectively. All interviewers were trained over one day. They administered the questionnaire in the relevant local language (predominantly either Pashto or Dari). The questionnaire was tested in Ahmad Shah Baba hospital in Kabul. In each project location, the research work was carried out within 15 working days.

DATA ANALYSIS:

The data retrieved from the questionnaires from the four project locations was entered in an Excel database between October and November 2013. Some variables were categorised to facilitate the analyses. The median and interquartile ranges (IQR) were calculated for numeric variables and proportions for numerical variables. Analyses were performed with Stata (version 11.2). Focus group discussions and individual interviews were transcribed by the Research Coordinator. The grounded theory approach was employed for data analysis.

ETHICS AND CONSENT:

All interviewees gave informed oral consent to participate. Individual responses were treated in such a way as to assure confidentiality and non-traceability. Agreement to conduct the research in Ministry of Public Health (MoPH) hospitals in Kabul and Helmand was sought and received from the MoPH in both locations.

LIMITATIONS AND POTENTIAL BIAS:

The assessments were made in four locations in Kabul, Kunduz, Khost and Helmand provinces. These locations were chosen on the basis of MSF's presence there, and in hospitals supported or run by MSF. Security conditions meant it was impossible for the research team to run a population-based assessment in the wider community.

The results of these assessments cannot therefore be extrapolated as countrywide results. Nevertheless, the view they provide from the four locations can give a reasonable indication of some of the access barriers to healthcare that people might face in other areas of Afghanistan.

The sample of people interviewed was all with patients or caretakers within MSF-supported health facilities, except for one day of semi-structured interviews with a mobile clinic team in Kabul. This likely resulted in selection bias as patients surveyed already had access to healthcare, having managed to reach the hospital where MSF was working. Thus, the research likely underestimates the extent and type of barriers facing those who might never make it to an MSF hospital.

Moreover, the fact that all of the four hospitals are located in the main city in the central district of their respective provinces introduces another possible bias of urban versus rural population.

In order to reduce user selection bias, patients were questioned about the health seeking behaviour and results for other individuals in the household during a previous period of illness, i.e. a different person than the current patient in care at the time of the interview, with a different illness than the current reason for seeking care. While this reduces bias towards households relatively more likely to access healthcare, it cannot entirely eliminate it.

In addition, people surveyed knew this research was being done by MSF, which could also introduce possible social desirability bias into the research. Furthermore, data were not always complete for all the variables collected, which potentially resulted in non-respondent bias. Finally, in certain places in this report we analyse subsets of the interviewed population, which can sometimes result in small numbers, leading to an increased probability that chance influences those findings.

AFGHANISTAN: THE ONGOING WAR

"All my children grew up with this war. They are somehow used to the fighting and bombing. Of course they are afraid, but they know that they need to stay inside and never to go out of their room in case a bullet or a rocket hits them. They know what to do when the fighting is here."

Female, 23 years, displaced to Girishk district by violence in Nad Ali, Helmand province

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Afghanistan is a country at war, with large swathes of its territory engulfed in violence. Despite some positive developments over the past 13 years, it remains a highly aid-dependent state, characterised by widespread poverty, illiteracy, unemployment, corruption,¹ a weak formal economy and a growing informal and illegal economy.

By 2010, more than US\$30 billion worth of development and humanitarian assistance had been injected into the country, and almost ten times as much in military aid.² However, Afghanistan ranks 175 out of 186 countries and territories on the Human Development Index;³ and seventh-worst country of 160, based on the extent of its humanitarian needs and vulnerability.⁴

Armed conflict continues to rage between the Government of Afghanistan (GoA), together with its international allies, and various armed opposition groups (AOGs). 2013's traditional 'fighting season', from early April until October, saw a purported 41% increase in the number of attacks by AOGs compared to the previous year.⁵ Taking full combat lead from the international coalition security forces mid-year, the Afghan National Security Forces (ANSF) suffered high numbers of casualties in 2013, with a 79% increase compared to the previous year's fighting season.⁶ Far from being defeated, the insurgency has vowed to continue to escalate its armed opposition.

"This fighting season is bad. Everyone is thickening and raising the walls around their homes. We're trying to build them up from three metres to five metres, so the rockets and the bullets don't enter our houses. Now, when the bullets fly, they meet the wall instead of my family."

Male, 40 years, farmer, Nad Ali district, Helmand province

The withdrawal of international combat troops is expected to bring a sharp deflation of the fiscal war bubble, as lucrative businesses propped up by military spending crumble. Eighty-five percent of the Afghan public budget comes from abroad, with the vast majority flowing into the security sector.⁷ The Afghan economy had been growing by nearly 10% annually in recent years, but saw that drop to 3.1% in 2013.⁸

Growth in the economy is forecast to tumble further, largely as a result of the decline in foreign aid,⁹ including international development assistance, despite pledges from international donors at the 2012 Tokyo Conference.¹⁰ This is worrying for a country with an unemployment rate hovering between 35 and 40%^{11,12} and where more than one-third of the population lives below the poverty line.¹³

In 2012 all humanitarian aid for Afghanistan sunk by half.¹⁴ Between 2010 and 2012, USAID contributions for Afghanistan already fell from US\$4.5 to \$1.8 billion.¹⁵ At the start of 2014 the US Congress announced its intention to slash development aid by half in the coming years.^{16,17} Any serious reduction in development and humanitarian assistance would be profoundly disruptive, placing further stress on the country's economy, as well as adversely affecting essential humanitarian and development work.

VIOLENCE ESCALATING HUMANITARIAN NEEDS

"The Taliban, the international forces and the army are enemies to each other. But every day, it is more than these enemies that die. Every day, it is the common people who die."

Male, 19 years, student, Girishk district, Helmand province

Although the precise figure is disputed, it is clear that there has been an alarming upsurge in civilian casualties, as the war has worsened. Since 2009, violence has been on the increase, with 2013 providing a recent and stark example of its impact on civilians. According to the UN, civilian casualties increased by 14% in 2013 compared to the previous year.¹⁸ The year saw the highest combined figure for deaths and injuries of civilians since 2009. 2013 was also the worst year since 2009 for women and children, with an increase of 34% of their deaths and injuries when compared to 2012.¹⁹

The December 2013 declaration by British Prime Minister David Cameron hailing "mission accomplished"²⁰ for British troops, and proclaiming that a "basic level of security" had been achieved in Afghanistan, is also a recent example of the gaping chasm between rhetoric and reality. This politically expedient discourse is at complete odds with what so many Afghans actually experienced in 2013 – rising violence and insecurity.

An estimated 630,000 people are internally displaced in Afghanistan, with 124,000 of them newly displaced in 2013 alone.²¹ In addition, some 2.6 million Afghans are currently refugees in neighbouring countries, with 1.6 million of them in Pakistan.²² OCHA estimates that in 2014 more than half a million people in Afghanistan will need emergency shelter and non-food assistance.²³

On top of death, injury and displacement due to conflict, Afghans must contend with poverty, food insecurity, malnutrition and disease. It's estimated that one in ten children dies before the age of five, mainly from preventable diseases.²⁴ National statistics also reveal that a staggering 36% of the population cannot meet their basic requirements such as access to food, clean water, clothing and shelter.²⁵

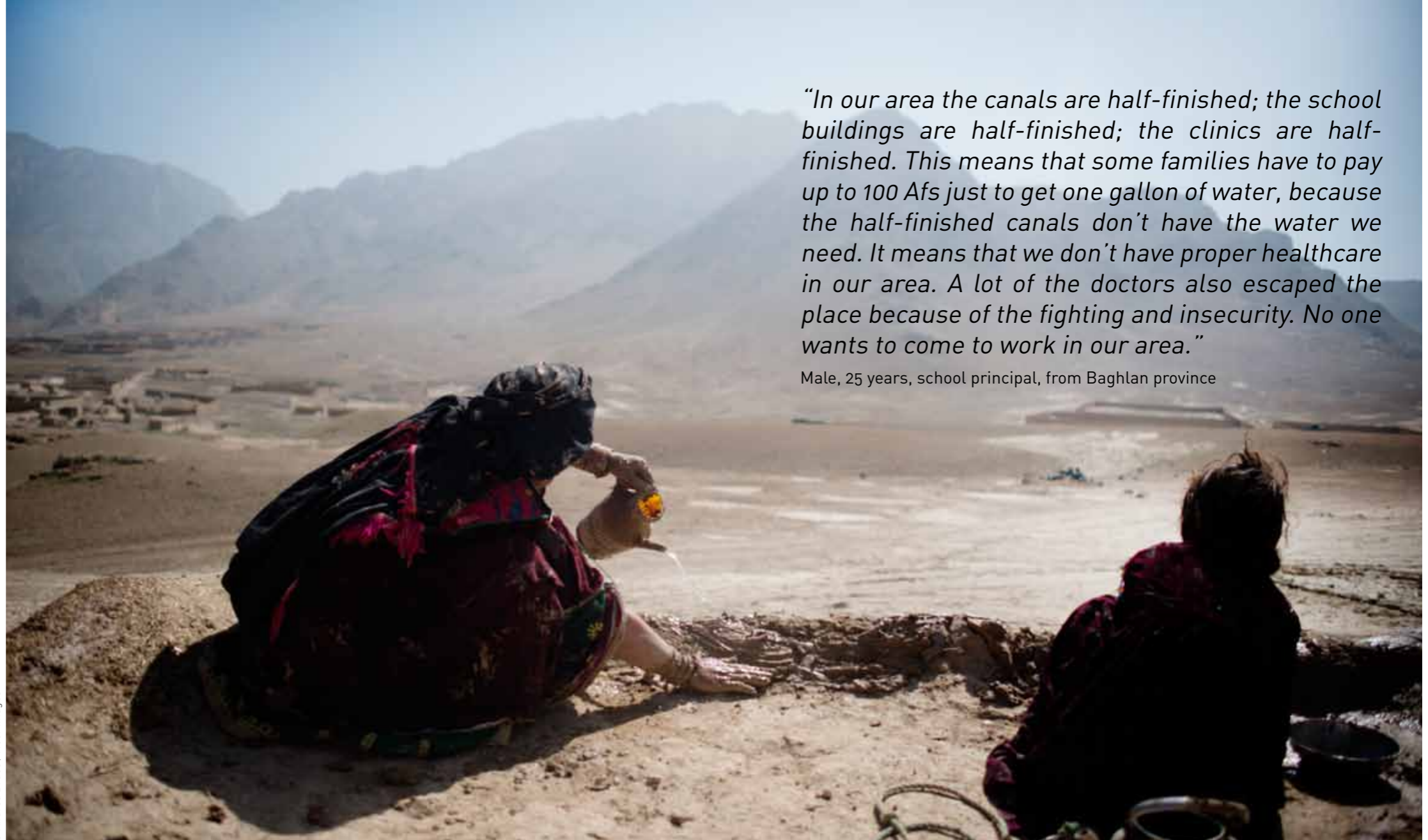
THE POLITICS OF AID IN WAR

Throughout much of the war, the biggest international donor countries – which are also belligerents – have directed the bulk of aid in line with their ‘stabilisation’ objectives, through a counter-insurgency strategy (COIN). Donors have transformed aid dollars into a form of ammunition in their quest to defeat the armed opposition. By using aid as a military tool, donors have often failed to adequately prioritise help for the most vulnerable first, provide effective assistance or place beneficiaries’ interests over their own political and military ones.

Foreign military commanders, wedded to COIN’s doctrinal framework to “clear, hold and build”²⁶ conflict-areas, were given the power to direct billions of dollars into development projects through Provincial Reconstruction Teams (PRTs), or to deliver aid directly themselves. For instance, about US\$1.5 billion in US-military controlled Commander’s Emergency Response Program (CERP) funds were spent from 2004 to 2011.²⁷ Additionally, 26 PRTs, consisting of a mix of military, diplomatic, development and civilian components, were tasked with providing the “build” in COIN efforts. Linked to ISAF and under military control,²⁸ PRTs were to deliver peace dividends designed to win ‘hearts and minds’, often in the form of so-called Quick Impact Projects.

Aid provision thus became threat-based rather than needs-based, with a disproportionate share directed towards insurgency-affected areas where international troops were present, regardless of whether this was where the greatest needs were to be found.²⁹ Trust in the effectiveness of aid was also harmed. It quickly transpired that the military and donors had implicated aid and its providers in the conflict for very questionable results. The Quick Impact Projects were rapidly dubbed “quick impact, quick collapse” ventures, with various tales of expensive, unsustainable reconstruction projects that are now barely functioning.^{30,31,32,33}

Furthermore, military involvement in activities traditionally implemented by aid agencies blurred the boundaries between both groups, with serious ongoing consequences for the perception of the neutrality and independence of aid. This increased the risks for aid workers operating in an already insecure and volatile environment.³⁴ In 2013, the number of aid workers



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“In our area the canals are half-finished; the school buildings are half-finished; the clinics are half-finished. This means that some families have to pay up to 100 Afs just to get one gallon of water, because the half-finished canals don’t have the water we need. It means that we don’t have proper healthcare in our area. A lot of the doctors also escaped the place because of the fighting and insecurity. No one wants to come to work in our area.”

Male, 25 years, school principal, from Baghlan province

killed in Afghanistan more than tripled,³⁵ making the country the most quantitatively dangerous place in the world for relief work.

Many non-governmental organisations (NGOs) were seen as choosing sides in the war, with AOGs viewing aid in general as too far aligned with the objectives of one side of the conflict.^{36,37} Dangerous rhetoric by international forces implying that aid NGOs were part of the ‘soft power’ efforts of a nation-building project, further compounded the damage.³⁸ With some exceptions, a large number of international NGOs actively played a role in the stabilisation agenda themselves, accepting funding earmarked to places where troops from their donor countries were deployed. They took an opportunistic approach, side-lining their humanitarian expertise and principles for the sake of the development funding available.

A premature and politically motivated definition of the context since 2003 as ‘post-conflict’ suited the US-led coalition and the Afghan government it supported. Acknowledging the extent of the humanitarian crisis did not. As part of their stabilisation strategy, donors over-emphasised support to systems building and strengthening to enhance the popular legitimacy of the Afghan government as a service provider for its people. While supporting systems is essential work, it should not come at the expense of responding to the immediate needs created by the conflict. Relief aid has represented only a fraction of the total official development assistance provided to Afghanistan. Despite the large amounts of aid pledged to Afghanistan since 2001 – around \$90 billion³⁹ – humanitarian financing makes up less than 7% of non-security international assistance.⁴⁰

The ramifications of how aid was politicised continue to impact the population’s access to assistance today, including healthcare. Political priorities are still too often placed ahead of addressing needs, as illustrated by the Government of Afghanistan’s recent announcement that some health facilities and schools will be used as registration centres and polling stations for the 2014 elections. With the current political process strongly contested by AOGs, voting centres are at high risk of being attacked, as was the case in previous elections.⁴¹ This puts patients and the staff working in these health centres at increased risk, ultimately making it dangerous for patients to receive the care they need.

SELECTIVE STORYTELLING AND THE HEALTH SYSTEM

Using selectively chosen data to emphasise progress, health has regularly been held up as one of the “best performing reconstruction areas”⁴² in the country, and even hailed as “the best thing the US did in Afghanistan.”⁴³ Such exuberant claims jar with MSF’s research with patients about their access to healthcare and with what MSF teams witness on the ground in the four provinces where they run or support hospitals. The official discourse too often shrouds the complex reality on the ground, glossing over the flaws of a health system overly-oriented towards a ‘post-conflict’ approach whose design frequently fails to meet patients’ needs.

When the ‘reconstruction’ project began in Afghanistan more than a decade ago, unregulated private healthcare provision dominated the market.^{44,45} The public health system barely functioned, with at least 70% of the limited health services provided by NGOs.⁴⁶ As part of reconstruction, the political imperative was to provide basic health services as quickly as possible. Contracting out to non-state providers, such as NGOs, was proposed as the way to do this.

In 2003, the MoPH and donors – namely the World Bank, USAID and the European Commission – introduced the Basic Package of Health Services (BPHS), to be implemented through contracting services out to both international and Afghan NGOs. Secondary level services – above district hospital level, which is included in the BPHS – were developed in 2005. Called the Essential Package of Hospital Services (EPHS), it was created to improve and define the secondary services for provincial and later regional hospitals.⁴⁷

There has been significant investment in the health system since then. In a 2013 survey⁴⁸ half of those interviewed across the country expressed satisfaction with clinics and hospitals (52%) and half (50%) with medicines available in their local area. Between 2002 and 2010 there was an estimated tenfold increase in annual disbursements of official development assistance for health.⁴⁹ However, it is the patients using the system who continue to finance the bulk of health expenditure, with out-of-pocket expenses from Afghan households accounting for 83% of all health expenditure in 2010.⁵⁰

The BPHS contracts are now the foundation of the Afghan health system. Most reports indicate that they have allowed basic health services to be scaled up in the country, which was important and necessary.⁵¹ Coverage assessments showing the spread of health centres indicate progress; however, the actual extent of service coverage has been questioned. There are recurring problems with the availability of medicines, basic quality indicators and adequate (especially female) staffing, while there are continuing high levels of out-of-pocket costs for patients.^{52,53, 54, 55, 56}

Health statistics from Afghanistan are notoriously unreliable. Constraints in monitoring – caused in particular by the remote control support of health facilities – mean that data from the most insecure areas are often excluded from statistics. This introduces a persistent bias that is likely to contribute to overly positive country averages. Contradictory household assessments,⁵⁷ the lack of independent crosschecks, and reports by foreign consultants who often do not leave Kabul and reproduce data provided to them without monitoring for accuracy, all raise serious questions about data reporting.

In 2011, the World Health Organization (WHO) estimated a life expectancy at birth of 60 years, a maternal mortality ratio of 460 per 100,000 live births, and an under-five mortality ratio of 101 per 1,000 live births.⁵⁸ While such general health data indicate an improvement since 2002, nevertheless mortality rates remain consistently and substantially worse than other countries in the region. In addition, the problems encountered when interpreting the coverage of the BPHS also occur when interpreting general health data from Afghanistan, as population estimates are unreliable and most data are based on modelling. For instance, when mortality estimates were adjusted for expected reporting biases, the under-five mortality ratio doubled, jumping to 209 per 1,000 live births.⁵⁹

Claims that 85% of people in the country now have access to healthcare compared to 9% in 2001 are repeatedly trotted out.⁶⁰ This is despite limitations in the assessments for such statistics, with some areas not adequately included, particularly rural or remote areas and those in the southern region.^{61,62,63}



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Such positive claims are also at odds with research conducted for the International Committee of the Red Cross (ICRC) in 2009, which estimated that more than half the population had little or no access to basic services, including healthcare.⁶⁴ Additionally, in 2013, in a countrywide survey, when asked to identify the biggest problems facing Afghanistan at the local level, healthcare was cited 13% of the time.⁶⁵

Reconstruction of the health system has largely been intended to demonstrate the benefits of the international military intervention and the capacities of the newly established Afghan government. The story about healthcare risks being skewed by the persistent efforts of donors, the international community and the government to show peace dividends. It is predicted that the number of people in need of access to health services in Afghanistan will increase from 3.3 to 5.4 million in 2014.⁶⁶ If the health system is unable to meet those needs, the stakes for the Afghan population will be extremely high.



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BARRIERS TO ACCESS TO HEALTHCARE



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The statistics and stories from MSF's research over six months in 2013 with hundreds of patients in Kunduz, Kabul, Khost and Helmand provinces make it clear that prevailing success stories about healthcare provision often mask the severity of the barriers that impede access to affordable, quality medical assistance for too many Afghans.

People's perceptions and experiences of the health system provide insight into the multiple barriers that can hinder or prevent access to healthcare in the four locations. Interviews also underline that there is no homogenous reality for people across Afghanistan. Barriers to access to healthcare vary across provinces, and so too does their impact. Even within different districts of the same province, the obstacles people face can vary depending on a wide range of factors.

However, while the degree of problems may differ from district to district or province to province, there are clear commonalities across the four locations, particularly in terms of the heavy impact the war has on health and on delaying or preventing access to healthcare.

"This latest pregnancy was different, because of the conflict. The baby died inside her almost three weeks ago. I am here today to find out if my wife is okay and what happened. There was a bomb outside our neighbour's gate, and when it exploded my wife lost our baby. And there is nothing I can do about this. It's not normal, but in a way it is normal, because we are used to all this violence. But it is no life. We just exist, surviving the insecurity – which is the mother of all our problems."

Male, 50 years, farmer, from Tagab district, Kapisa province

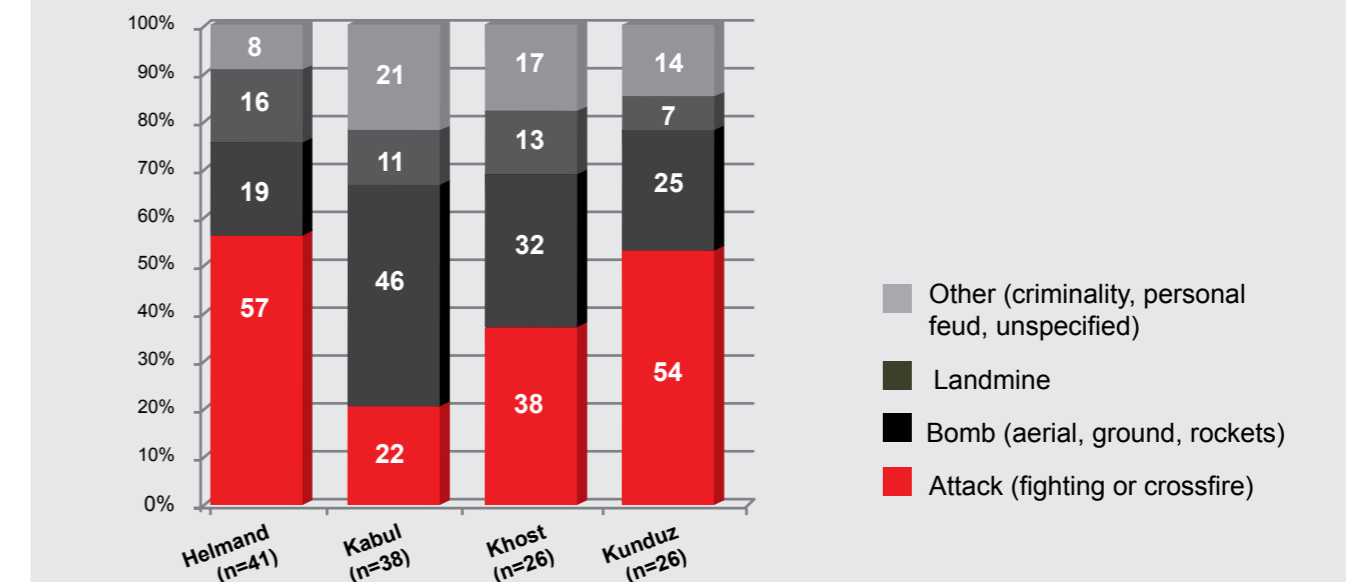
WAR AND INSECURITY

The conflict creates dramatic barriers that people must overcome to reach basic or life-saving medical assistance. It also directly causes death, injury or suffering that increase medical needs. In each of the four locations, at least one in five people had either been a victim of violence themselves within the last 12 months, or knew someone in their family or village who had died as a result of violence. This was as high as one in three people in Khost, where a quarter of all those interviewed knew someone who had died as a result of that violence, the vast majority (86%) as a result of the armed conflict. In all locations the ongoing war was the main cause of violent death over the past year, with civilians repeatedly caught up in direct attacks, crossfire, bombings or landmine explosions.

TABLE 1: Experience of violence within the last 12 months

| Did you, your family, or a neighbour suffer from violence? | Helmand n = 179 | Kabul n = 199 | Khost n = 183 | Kunduz n = 189 |
|--|--------------------|------------------|------------------|-------------------|
| Yes | 28.5% | 23.1% | 34.4% | 30.2% |
| Violence resulting in death of family or neighbour | | | | |
| Yes | 23% | 21% | 27% | 19% |
| Cause of violence, as percentage of all violence suffered | | | | |
| The armed conflict | 92% | 79% | 83% | 86% |
| Other – criminality or personal feuds or unspecified | 8% | 21% | 17% | 14% |

FIGURE 1: Type of violence experienced within last 12 months by family or neighbours of 131 patients



During the 2013 fighting season, the percentage of patients treated in MSF's trauma centre in Kunduz for war-related wounds, as opposed to accidental injuries, increased to 13% between July and September, from 9% in the previous three months. This rise was a direct result of the high level of violent incidents in the region, though it can also be linked to greater awareness of the trauma centre among the population. During that same time, up to 9% of patients MSF admitted had to be referred to other hospitals, primarily because the trauma centre had reached full capacity and had no more available beds. In response, MSF is increasing the number of beds for injured patients from 62 to 92 over the next year.

The violence also leads to displacement, as people seek refuge elsewhere, increasing their risk of deteriorating health. In Helmand more than one in three people had been displaced by violence since the US-led NATO intervention began in 2001. The majority of them had been displaced since 2009, with just over one in four people (26%) forced to flee their homes due to conflict since then.

TABLE 2: People displaced inside Afghanistan since 2001

| Displaced in Afghanistan since 2001 | Helmand n = 179 | Kabul n = 200 | Khost n = 193 | Kunduz n = 189 |
|---------------------------------------|--------------------|------------------|------------------|-------------------|
| Yes | 46% | 37% | 14% | 12% |
| Reason why they were displaced | | | | |
| Conflict and violence | 82% | 31% | 26% | 57% |
| Other (natural disaster/work/nomadic) | 18% | 69% | 74% | 43% |

"We are from Wardak province and came here to Kabul because of the conflict and violence. We still have some relatives in Wardak who didn't flee. There is still a lot of fighting between the government and the opposition groups back there. If the fighting stops one day, then I will go back to Wardak, where I was born. There are a lot more trees and green pastures there than here in Kabul. But we won't go back until the fighting ends."

Female, 36 years, from Wardak province, living in District 12, Kabul

"Last year one of my brothers was taking a patient from Nawzad [district] to the hospital in Lashkar Gah. There was a terrible bomb on the road. Three people were in the car - my brother, the patient and the patient's relative. They all died."

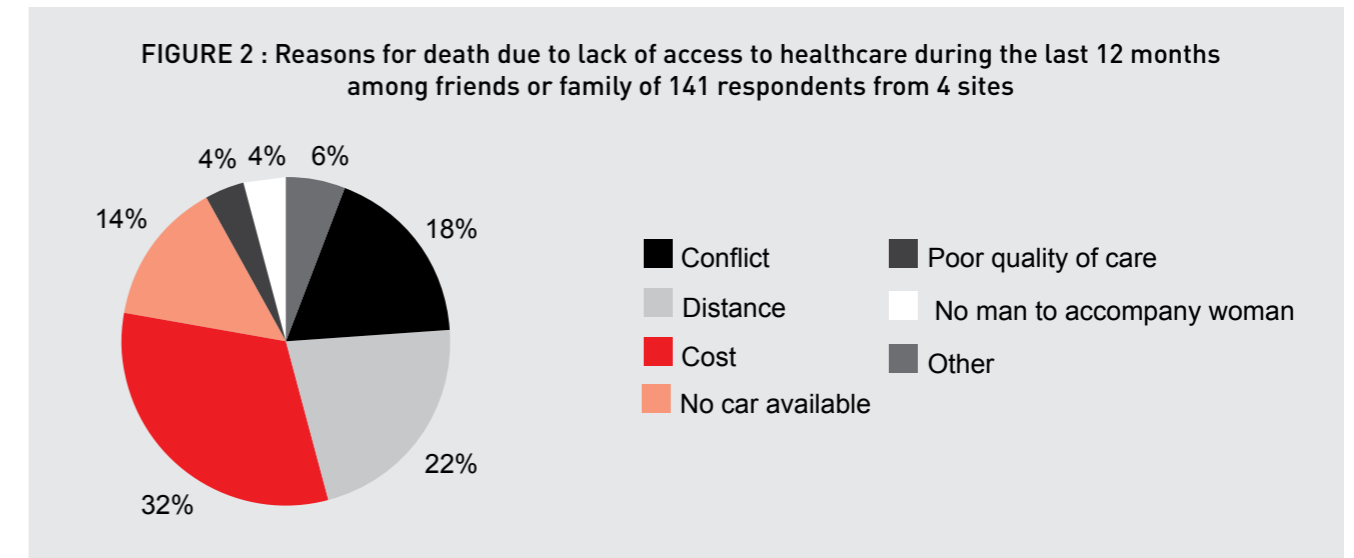
Male, 22 years, farmer, from Nawzad district, Helmand province

Violence not only maims and kills directly, but also indirectly, by impeding access to healthcare. Significant numbers of people in each location, as high as one in four in Khost, knew someone in their family or a close friend who had died within the last year as a result of lack of access to adequate healthcare. When not the main reason, the conflict was always a major cause

of why now-deceased family members had been unable to access adequate healthcare. In Helmand, people interviewed attributed almost one in three (32%) of the deaths to conflict-related reasons preventing sick or injured family members from reaching medical care, either at all or in enough time to save their lives.

TABLE 3: Death in family due to lack of access to healthcare in last 12 months

| Did anyone in your family or close friends die due to lack of access to healthcare within the last year? | Helmand n =179 | Kabul n =198 | Khost n =189 | Kunduz n =188 |
|--|-------------------|-----------------|-----------------|------------------|
| Yes | 16% | 13% | 26% | 19% |
| Reasons for lack of access to healthcare and subsequent death. | n =28 | n =25 | n = 49 | n =39 |
| Conflict barrier: Fighting, insecurity, no night travel | 32% | 8% | 14% | 21% |
| Financial barrier: Cost | 18% | 28% | 57% | 13% |
| Distance barrier: Proximity | 11% | 20% | 19% | 33% |
| Availability barrier: No/inadequate healthcare | 25% | 20% | 2% | 18% |
| Quality barrier: Poor quality staff, drugs, services | 4% | / | 6% | 5% |
| Cultural barrier: No one to accompany/no permission | 11% | / | / | 5% |
| Other/Not specified | / | 24% | 2% | 5% |



"In the last years, violence has blocked us coming to health centres and hospitals more than a hundred times I think. There is constant violence around my village. We never know how much fighting each week will bring. The fighting doesn't stop when there are injured people, so we can't get them to a doctor. So we wait, and then they die, and the fighting continues. Even if you are able to move with your wounded you still have to get through roadblocks, checkpoints, questioning and harassment before you can reach the hospital."

Male, 25 years, school principal, from Baghlan province

For those who make it to a health facility their journey is often fraught with danger and difficulty. In all locations, a significant percentage of patients had faced problems reaching the hospital where MSF worked – up to 89% of people in Khost. A staggering four out of five people in

Helmand had experienced a conflict-related barrier as their main obstacle to reach Boost hospital. Problems connected to the conflict were also the chief difficulties in reaching MSF’s trauma centre in Kunduz for three out of five injured patients.

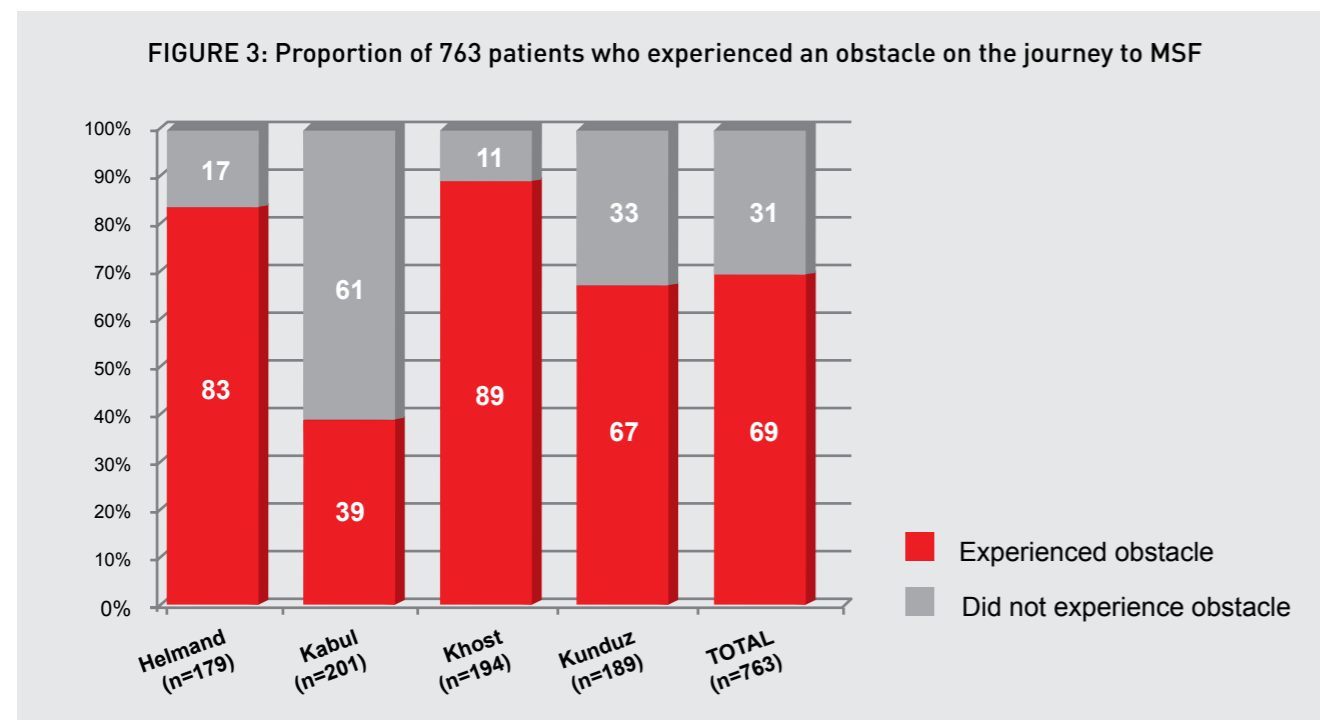
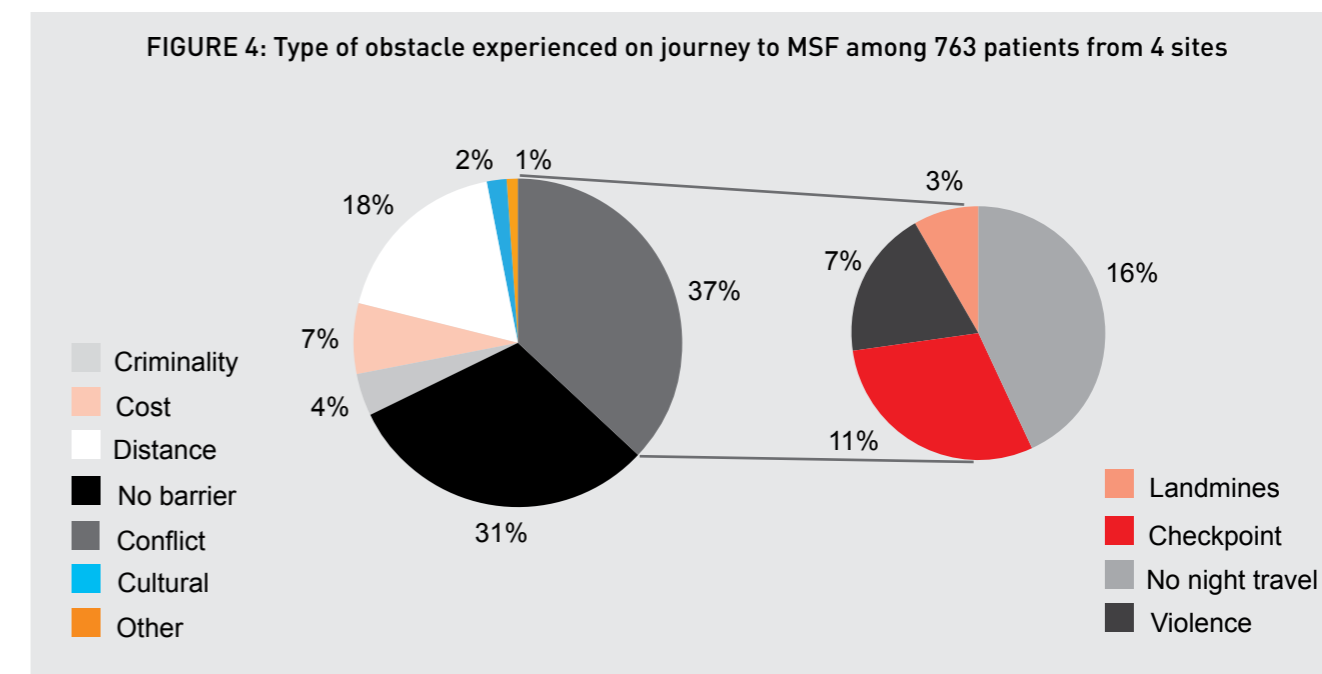


TABLE 4: Main obstacle faced on journey to MSF for current illness

| Main obstacle faced on most recent journey to MSF | Helmand n=149 | Kabul n=79 | Khost n=172 | Kunduz n=127 | TOTAL |
|---|------------------|---------------|----------------|-----------------|-------|
| Conflict | 80% | 9% | 46% | 59% | 53% |
| Criminality | 2% | / | 12% | 8% | 7% |
| Cost | 2% | 13% | 23% | / | 10% |
| Distance | 13% | 62% | 17% | 32% | 26% |
| Cultural | 3% | 14% | / | 1% | 3% |
| Other | / | 2% | 2% | / | 1% |

“There is no doctor in our village. There is no transport to get us to one, especially at night, even if we dared to move with all the fighting and shelling. If we could find a car we would put ourselves in danger to bring the seriously injured people. But we usually can’t find a car, so we do some basic care ourselves to help them stay alive until morning. I’ve learned first aid, and others in the village have also learned how to clean wounds and put on bandages. This is all we can do, until it’s possible to bring the wounded to a hospital.”

Male, 48 years, cook and farmer, from Dasht-e-Archi district, Kunduz province



The problems they faced on their most recent journey to a hospital where MSF works were not isolated to that time of the year. When asked about difficulties created by insecurity to reach MSF over the preceding 12 months, a substantial number of people in Helmand and Kunduz had also experienced significant challenges. On different occasions over the last year, violence and insecurity had either delayed or stopped more than two in five people in both those locations from reaching the hospital when

needed. The main causes of delays or blockages across all four projects were active fighting between armed groups and the impossibility of night travel due to insecurity on the roads.

Those who live in districts furthest away from the provincial capital are under-represented in the sample of people MSF interviewed. However, of those interviewed, it was clear that they frequently face a more difficult reality than those living in the provincial capital.

TABLE 5: Obstacles from insecurity to reach MSF over the last 12 months

| Delays or blocks to access MSF from insecurity | Helmand n=179 | Kabul n=199 | Khost n=192 | Kunduz n=189 |
|---|------------------|----------------|----------------|-----------------|
| Yes | 45% | 8% | 15% | 45% |
| Type of insecurity mentioned that blocked or delayed access to MSF | n=80 | n=16 | n=29 | n=84 |
| Active fighting or insecurity from conflict | 59% | 37% | 35% | 58% |
| No night travel (due to risk of violence or criminality) | 15% | 44% | 24% | 25% |
| Landmines | 11% | / | 17% | / |
| Criminality | 3% | / | 10% | 12% |
| Roadblocks or checkpoints | 7% | 13% | / | 5% |
| Other / not specified | 5% | 6% | 14% | / |

“There is nothing the community can do. We are caught between both sides. And so we pick sides. Half of us support the government, half of us support the Taliban. The middle people will not survive. You have to pick a side or you will be the first to suffer and you will not have anyone to help you. The people in the middle are in danger from both sides”.

Male, 48 years, cook and farmer, from Dasht-e-Archi district, Kunduz province

While official Afghan sources claim that the AOGs have just five of the 416 district centres in Afghanistan under their permanent control, this statistic ignores the reality of life outside the immediate district centre, where government control has less reach.⁶⁷ Those in the peripheral areas are more likely to be trapped between the inexorable pressures of the insurgency and the international or national military forces. This in turn makes it more difficult for them to access healthcare.

“Where I live has too many explosions and attacks. The community begs the Taliban not to fight from our village, because after the government side comes to punish us, but they don’t listen. We’re so tired of all of the killings, the violence and the fear.”

Male, 48 years, farmer, Sabari district, Khost province

In Helmand, those interviewed from Lashkar Gah, the provincial capital, were considerably less likely to cite the threat of violence as a barrier to reaching the hospital, than those living in other districts. All the people from Musa Qala, a northern district of Helmand province, cited violence as the main barrier to reach MSF – a rate of six times more than those already living in Lashkar Gah district. The higher threat of violence for those living outside the provincial capital is due not only to

the longer journey to the hospital where MSF works, but also because several districts in Helmand province experience frequent and intense periods of fighting.

“Just eight months ago, when I was coming back home to our village from seeing the doctor in the centre of Girishk district, thieves stopped us and stole everything – the tyres from our car, the money in my husband’s pocket, his phone. We’re not the only ones this happens to. The roads are dangerous.”

Female, 22 years, from Girishk district, Helmand province

While not as significant a barrier as the armed conflict, criminality also poses persistent problems for people on their journey to MSF. Though rarely cited on its own as the main problem they encountered, criminality was often included in the explanation of why people picked the inability to travel at night as their main barrier. Additionally, at least one in 20 people in each location mentioned thieves and bandits as part of a listing of multiple problems they had to contend with when traveling.

“Criminality is increasing day by day. We don’t know which groups they belong to always but criminals are definitely on the rise. Too many people have been armed. Those who have weapons are the ones creating all the insecurity. There are lots of groups with lots of different interests in this area. And those who want to destabilise the situation here just give weapons to militias, to criminals, and everything gets worse.”

Male, 30 years, farmer, from Imam Sahib district, Kunduz province

There are complex sets of reasons why people delay seeking medical help, including a lack of awareness about illnesses, symptoms and available treatments; lack of transport; and lack of money. However, the threat of violence, insecurity and criminality en route can also result in people delaying the trip to a health facility until their medical condition has deteriorated to the point of endangering their health or even lives.

In Kunduz more than one in five people (23%) had been forced to wait more than 12 hours before first seeking medical treatment for their injury. In Helmand close to half (46%) of patients interviewed had waited more than a week before seeking care for their condition, while over one in five (22%) of them had waited more than two weeks. In both Helmand and Kabul, 60% of people with a malnourished child presented for medical care more than one month after symptoms first began. In both locations, four out of five people (79%) with fever had waited more than a week before seeking treatment.

For some patients, hours can mean the difference between life and death. Trauma patients with serious injuries usually need to arrive within a ‘golden period’ – one hour after the incident – for a surgical intervention that will prevent their death. The chances of survival for pregnant women with postpartum bleeding after a difficult delivery at home decrease dramatically if they do not arrive at a health facility within two hours.

“A few months ago a woman in my village was pregnant. She had problems and needed to get to a hospital to deliver. There was fighting at night so we couldn’t bring her here. She and her baby died that night.”

Female, 28 years, from Bak district, Khost province

The inability to travel at night due to insecurity has particularly severe consequences for seriously injured people or women in complicated labour. Families are forced to hold ‘death-watches’ over their sick or wounded loved ones throughout the night, hoping they will survive until morning when it might be safer to reach a doctor. Patients reported that many pregnant

women, babies and injured civilians do not survive the wait – either dying during the night, on the journey the next day, or shortly after they reach the medical facility.

“It is too dangerous to go out at night. So we can’t bring someone to the doctor once it’s dark, even if their sickness or injury is serious. We can’t move at night or all of us would be killed on the road. So, we prefer that they die quickly rather than having to suffer through the night only to die the next day or on the way. This is our reality.”

Male, 50 years, farmer, from Tagab district, Kapisa province

Furthermore, the current conflict impacts the ability and willingness of healthcare providers to work in the most insecure areas. Patients frequently spoke of medical staff and ambulance drivers who were too afraid to travel to the most insecure zones. This is especially true for female health workers. Many patients spoke of no-go areas for government health workers and even private doctors, resulting in entire communities being left without access to essential healthcare.

As well as causing fear for health workers, the conflict continues to take a serious toll on people’s mental health,⁶⁸ with estimates of up to 60% of the population, mostly women, suffering from psychosocial problems or mental health disorders.⁶⁹

“I had 14 children, and I lost half of them. They were killed during the conflicts. I lost four boys, three daughters, and a husband. They were too young to die. So many of my people have died from the wars here... We are scared. My heart and head are full of thoughts. Sometimes my heart gets so heavy that I have to find someone to talk to so I can try to clear it out, clear out my life. I try to laugh for my family because I must stay sane for them. I laugh to forget or I would go crazy with all the deaths.”

Female, 44 years, from Kunduz district, Kunduz province

DISTANCE

“The public clinics are all too far away from us, because no one wants to risk working here. I don’t think there are any public clinics in our area. Maybe the government built some somewhere, but I haven’t seen any with my eyes and I haven’t heard of them with my ears.”

Male, 55 years, farmer, Musa Qala district, Helmand province

Today, 57.4% of the Afghan population lives within one hour’s walking distance of a public health facility, according to national statistics.⁷⁰ This is a dramatic increase from only 9% in 2001.⁷¹ Indeed, in the four locations the majority of those MSF interviewed said that there was some form of health facility, whether public or private, within an hour’s travel of their homes. However, with urbanisation pushing more people towards towns and cities, figures showing that more people now live closer to them are to be expected.⁷²

A health centre that exists is not the same as one that is used or that actually functions well in practice. Thus, the proximity of a physical structure on its own is not enough to guarantee access to healthcare. The availability, accessibility and acceptance of the services are also critical factors in determining the utility and usage of health structures for a community. Turning a building into a functioning health facility requires consistent presence of qualified staff, regular supplies of quality drugs, and the possibility to reach and use the centre safely and securely.

In all four locations the majority of those interviewed had not gone to their closest public health facility during a recent episode of illness in their household. In Helmand and Khost, as many as eight or nine out of every ten people had not used the public system, despite the fact that it promises free care. They avoided their nearest public clinic or health post for a variety of reasons, mostly linked to negative perceptions of both the quality and availability of staff, treatments or services on offer.

This means that people travel further, often far more than an hour’s walk, to obtain the healthcare they need, increasing both costs and risks during the journey. One quarter of the war-wounded and seriously injured patients in Kunduz had travelled between two and six hours by car before reaching the hospital. Of those interviewed in Helmand, two out of every five (44%) had travelled more

than an hour by vehicle to reach the hospital. More than one in ten had travelled over two hours by motor transport.

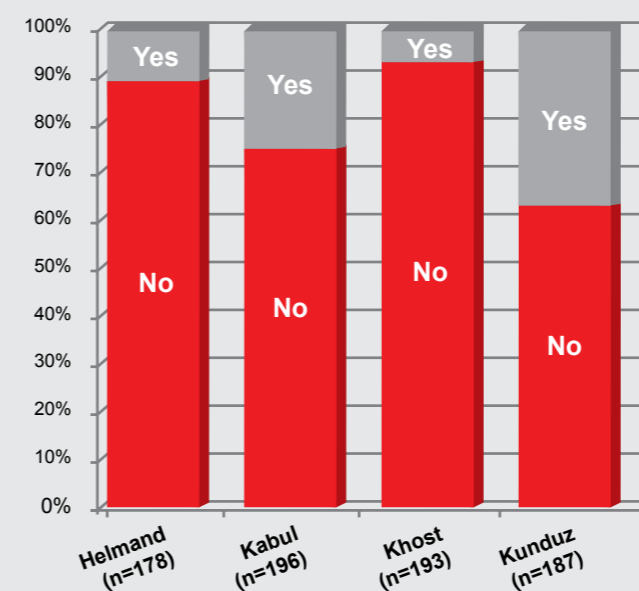
Patients in both Kabul and Kunduz cited distance as the main obstacle to reaching MSF. Almost one third of those interviewed in Kunduz explained that the long distance to the trauma centre had been a significant difficulty when trying to bring wounded patients to emergency care. Before MSF opened the trauma centre in 2011, people suffering from severe injuries were forced to make the even longer and more dangerous journey to Kabul or Pakistan – or visit expensive private clinics – to receive treatment. Consequently, few patients obtained the specialised care they required, resulting in debilitating injury or avoidable death.

Last year, one fifth of all the injured patients treated in the trauma centre had travelled from provinces outside Kunduz province. Yet, despite the presence of the centre – still the only specialised surgical centre of its kind in the northern region – the journey for limb- or life-saving care in the north remains impossible for too many. People interviewed in Kunduz frequently spoke of seriously wounded civilians in their communities who had been unable to reach MSF’s trauma centre.

“Where we live is too far away from clinics for injured people to reach them on time to save their lives. There is no proper system to treat people while they are being transferred to a clinic. There is no ambulance, no doctors to go with them. So, by the time you finally reach a clinic, the person is already dead. They die from their injuries on the way.”

Male, 25 years, student, from Ishkashim district, Badhakshan province

FIGURE 5: Proportion of patients that used the closest public health facility during previous illness



“We live in the mountains in Samangan province. It’s far away from here [Kunduz city]. It took us more than half a day to get here. We walked, travelled by donkey and then took a taxi, but the majority of the journey was on foot. My relative couldn’t afford [the transport] to bring his injured son here. So I borrowed the money from people I knew and travelled with him instead. To pay back the money, I will have to sell many more nuts. There is no other way.”

Male, 43 years, farmer, Khuram Wa Sarbagh district, Samangan province

An absence, or a perception of the lack, of treatments and services for their conditions sometimes even pushes people to seek care in other countries. In Kabul one in five (21.6%) people had travelled outside the country to seek the care they required, the vast majority of them (90%) heading to Pakistan. In Kunduz and Khost, almost one in ten (9.6%) and one in 12 people, respectively, had gone to Pakistan to seek treatment for an illness of someone in their household in the preceding three months.

“We don’t want to have to travel this far. If there was decent healthcare near us, believe me, we wouldn’t come here. In the districts, you find simple shopkeepers distributing the drugs, drugs that harm you. We don’t have the qualified staff and we don’t have the proper clinics. So, people are forced to travel as far as Lashkar Gah and take all the risks.”

Male Shura focus group member, from Lashkar Gah district, Helmand province

The long distances people must travel to seek care not only delay the provision of urgently needed treatment, but also force them to undergo perilous and costly journeys. Due to insecurity, people risk further injury and even death on the journey as they struggle with violence, criminals, crossfire, landmines, checkpoints and roadblocks.

“A few months ago [August 2013] my pregnant cousin came to MSF [maternity hospital] to deliver her baby, accompanied by three of our male relatives. On the way home they were all so happy because of the new baby. Their car hit a landmine in our district. Every one of them died.”

Female, 23 years, from Sabari district, Khost province

The insecurity means that people often prefer to travel to medical care in large groups, seeking protection in numbers.

“Six of us had to travel here because the roads are dangerous at night, and we need lots of people with us to be safe. On the way we were checked by the insurgents three times and by a police commander another time. We only arrived at your hospital with our injured three hours later. It should normally take just one hour and 30 minutes to get here from where we live, but with all the checkpoints it took double that.”

Male, 30, farmer, Dasht-e-Archi district, Kunduz province

The distance is even more of a problem during the winter:

“When one of our people is too sick with a fever, we have to try to get him to the hospital quickly. So we carry him in our arms and then we go by donkey. Then we just hope that he can last the journey. A lot of children die on the way before we reach the hospital. Especially in the winter, when most of the fever sicknesses occur and the snow makes it impossible to pass. For four months we have snow and then it’s too difficult to get to any hospitals. It can take between ten and 11 hours and the patient can die on the way.”

Male, 43 years, farmer, Khuram Wa Sarbagh district, Samangan province

In Afghanistan, distance is a composite barrier: the longer people have to travel to access healthcare, the greater the risk that they will encounter additional barriers on the way. Each extra moment on the road potentially exposes them to more direct or indirect violence, pushes up the cost of the journeys, and delays them obtaining the care they need.

“When the fighting starts around us the roads to Lashkar Gah are blocked. So we can’t get to the hospitals here. No one is allowed to pass. The most serious patients try to get to Pakistan, but they need lots of money for that. The biggest problem is the pregnant women without money – when security conditions are bad those women who can’t afford to get to Pakistan die. For those who have the money for Pakistan, the journey is also dangerous. They must deal with a lot of harassment from thieves and criminals on the way.”

Male, 38, Farmer, Garmsher District, Helmand province



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COSTS

“There is nothing we can do. We are the poor people. They will destroy us with their fighting.”

Male, 30, farmer, Dasht-e-Archi district, Kunduz province

According to the World Bank, more than one third of people in Afghanistan live below the national poverty line of less than US\$1.25 per day,⁷³ and as much as half the population is at high risk of impoverishment.⁷⁴ Additionally, there are important differences between rural and urban areas, with 25% of rural compared to only 2% of urban populations categorised as living in the poorest fifth of the population.⁷⁵

Among the people MSF interviewed, at least 60% lived on less than US\$1 per person per day, with half of patients in Helmand and Kabul living on the equivalent of just US\$0.60 or less. Even this can be an underestimation of poverty levels for the most vulnerable people in those locations, as those unable to find the means to reach the MSF-supported hospitals might be excluded from the survey. Additionally, MSF projects are located in urban areas and receive fewer patients from the rural areas, where people generally have less wealth.

TABLE 6: Household expenditure per day per person as reported.

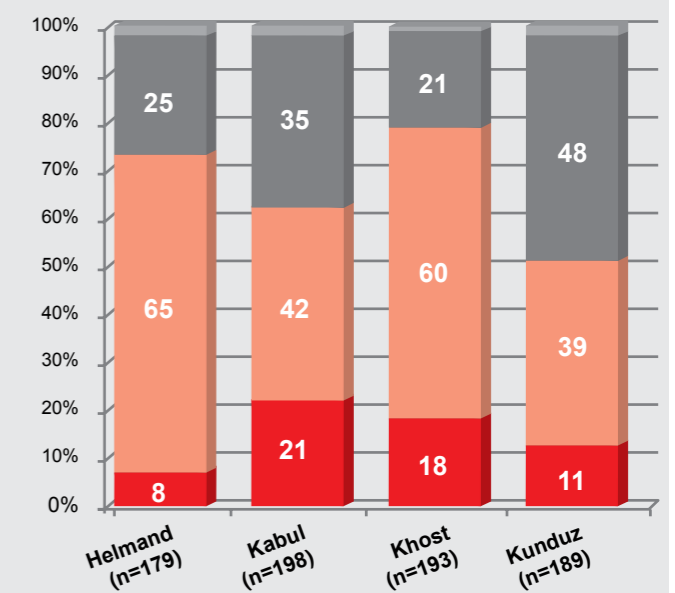
| In USD equivalent | Helmand | Kabul | Khost | Kunduz |
|---|------------|------------|------------|------------|
| Median (50% of people live on less than this amount) | \$0.6 | \$0.6 | \$1.2 | \$0.8 |
| 75% of people live on less than | \$0.9 | \$1.1 | \$1.7 | \$1.3 |
| % of people living on less than \$1 per person per day | 80% | 71% | 40% | 61% |

A significant proportion of the population struggles to make ends meet, let alone pay for healthcare. Among the people surveyed, at least half described their household economic situation as poor, very poor or extremely poor – all categories that meant they had problems to pay for healthcare. In Helmand and Khost, as many as three in four people described their household as poor or very poor. The interviewees in Kabul had the biggest category of very to extremely poor, with one in five people (21.2%) describing themselves as such.

“In January [2013], my nephew was sick. He had terrible diarrhoea. We were too poor to bring him to a doctor. He was nine months old and he died.”

Female, 25 years, from Khost Matun district, Khost province

FIGURE 6: Household economic situation as described by 759 respondents



Extremely poor = begging, no home; **Very poor** = there is sometimes not enough food available. Face serious problems paying for healthcare and school; **Poor** = enough money for food, but face problems paying for healthcare; **Moderate** = enough money for food, healthcare, school; **Good** = enough money, even for some luxuries.

However, even the poorest people often paid considerable amounts to try to meet their healthcare needs, either for direct medical costs, (doctors' fees, drugs, hospitalisation or laboratory tests), or for other non-medical costs (transport to and from the health facility, accommodation and food for relatives who accompany a hospitalised patient).

For a recent illness in the last three months, other than the one that they were in the hospital for at the time of the interview, the median cost for the total expenditure on healthcare went from US\$28 in Helmand up to US\$68 in Kabul. Such high totals for Kabul can be attributed to the fact that at least one in five people had travelled to Pakistan to seek healthcare for the recent illness.

"I've already paid so much to help my daughter. Now I've run out of money. I spent it all on private doctors or travelling to them. We came here [to Boost Hospital] because it's free. Yet when she was discharged we needed to stay here in the town, near the hospital, to bring her for daily follow-up appointments. So, even though the healthcare here is free, it still costs money for me to stay close to it."

Male, 39 years, mullah, Garmsher district, Helmand province

TABLE 7: Total direct (medical and non-medical) costs incurred for a recent illness

| (Median and IQR* in equivalent USD) | Helmand | Kabul | Khost | Kunduz | All 4 sites |
|-------------------------------------|--------------------------|---------------------------|--------------------------|---------------------------|---------------------------|
| Direct medical costs | 21 (IQR 9-48) | 55 (IQR 20-161) | 23 (IQR 12-45) | 48 (IQR 15-116) | 32 (IQR 12-84) |
| Direct non-medical costs | 4 (IQR 0-15) | 14 (IQR 4-38) | 6 (IQR 2-20) | 5 (IQR 1-34) | 6 (IQR 2-29) |
| Total costs | 28 (IQR 11-59) | 72 (IQR 25-223) | 32 (IQR 15-67) | 63 (IQR 19-145) | 40 (IQR 16-114) |

Note: These are the median values among those people who reported paying these types of costs. As some people did not recall specific details of direct and indirect expenses within the total cost reported, the combination of median values of direct and indirect costs reported might differ from the total costs reported.

Note: Direct medical costs = doctor, drugs, hospital, laboratory; Direct non-medical costs = transport, food and accommodation for the people who accompany a hospitalised patient.

Note: IQR = the interquartile range, often called the 'middle fifty'. It is the data between the upper quartile (Q3 or 75th percentile) and the lower quartile (Q1 or 25th percentile). The IQR uses 50% of the data. For example, if the median spent on drugs was US \$20 that would mean that half the people spend \$20 or less on drugs, and half the people spend \$20 or more on drugs. If the accompanying IQR was (10 - 50), this would mean that a quarter of the people spend \$10 or less on drugs and

another quarter spend \$50 or more on drugs.

TABLE 8: Selection of three expenses, medical and non-medical, incurred for a recent illness

| (Median and IQR* in equivalent USD) | Helmand | Kabul | Khost | Kunduz |
|-------------------------------------|----------------------------|-----------------------------|----------------------------|----------------------------|
| Drugs | 21 (IQR 10 - 48) | 44 (IQR 26 - 151) | 19 (IQR 10 - 38) | 45 (IQR 17 - 99) |
| Doctors' fees | 4 (IQR 2 - 5) | 7 (IQR 4 - 12) | 3 (IQR 2 - 5) | 5 (IQR 3 - 8) |
| Transport | 6 (IQR 2- 20) | 15 (IQR 4 - 38) | 8 (IQR 3 - 19) | 11 (IQR 4 - 36) |

Medication consistently ranked as one of the highest costs people incurred. In Kunduz and Kabul, more than half of those interviewed had paid more than US\$44 on drugs during a previous illness episode. Those who went to Pakistan as the first step in seeking treatment across all four locations paid a median of US\$193 on both medical and non-medical costs. The majority, about 60%, was on drugs. With an interquartile range (IQR) of 116 - 341, one in four of them paid more than US\$341. The high costs of drugs can be attributed to the fact that people in Pakistan sought care with private doctors for chronic diseases such as cancer, hypertension or hepatitis.

A non-medical cost such as transport is also a significant drain on people's financial resources. In general, the median cost ranged from US\$6 to US\$15 across the different locations. In each location one in four people paid more than US\$19 on transport to and from healthcare providers for an illness during the preceding three months. In Kunduz and Kabul, one in four people had paid more than US\$35. For those who went to Pakistan as a first step, the transportation costs usually accounted for a quarter of their total expenses (median cost for transport US\$48; IQR, 29-90).

"If someone is sick at night and they don't own a car, they can't move. It's usually not possible to rent a taxi at night, as the drivers are too afraid to work. They are afraid of thieves, the Taliban, the army, the police. So people are trapped and have to wait until morning. During the day the cost of transport is 500 PKR [US\$5]. If you somehow find a car at night, then it's 4000 PKR [US\$38]."

Male, 19 years, student, Girishk district, Helmand province

In the most insecure areas, transport costs increase even further, particularly if people feel the need to travel in groups for safety once it gets dark.

"If we have a pregnant woman and we need to get her to a maternity centre in Kunduz town it's not always possible. It's too dangerous. But if the pregnant woman is in too much pain, and something is wrong, then we will have to travel, even close to night, to try to save her and the baby. Then it's like we're going to a wedding ceremony there are so many of us moving together. There is safety in numbers, so we go in a big group to escape the armed men. If they see too many people, they don't attack. But if there is only one or two of us, the bandits will get us."

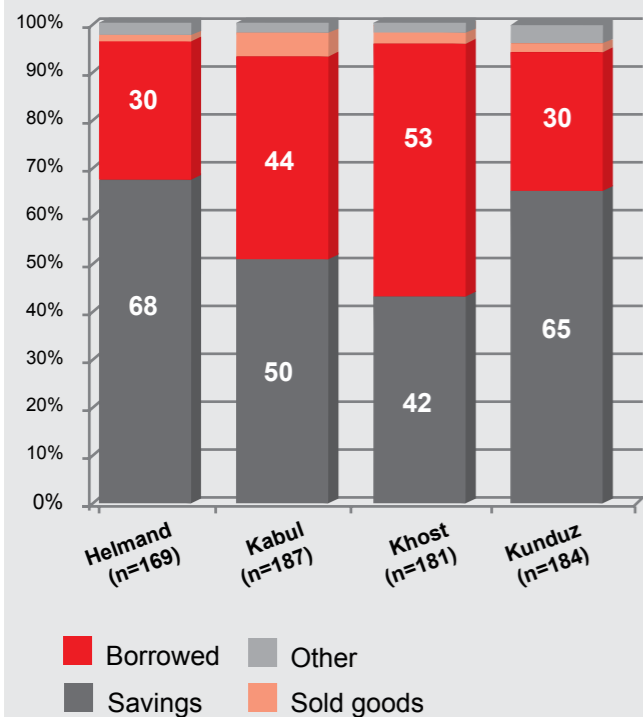
Male, 25 years, Imam Sahib district, Kunduz province

Considering the socio-economic status of the patients, these are enormous sums of money that involve significant personal sacrifice to cover. Of all those who went to Pakistan for their first step, only 35% were able to pay the medical and non-medical expenses with their own savings; the remaining 65% had been forced to borrow the money or sell goods.

In general, the amounts spent on seeking healthcare inside Afghanistan make a dramatic cut into people's finances.⁷⁶ An MSF assessment of health facilities in Lashkar Gah, Helmand, in July 2013 found that a normal delivery for women at a private clinic ranged from US\$90 to US\$150, with a caesarean section costing between US\$200 and US\$250, which is beyond the financial reach of many.

The costs associated with accessing healthcare for an illness in their household in the last three months pushed many patients and their families in all locations into debt, or forced them to sell their goods and assets. The amounts varied per location, with more than half of people in Khost and half in Kabul engaging in some form of 'distress financing' to cover the costs of a recent illness in their household. Evidently, the search for healthcare in Afghanistan puts far too many households at serious risk of impoverishment.

FIGURE 7: Source of payment for healthcare costs among 721 respondents



“In our village there is no one else to buy our house, our lands, so how could we get enough money together in order to leave and get closer to clinics? We don’t have the money to move to the city. We don’t have the money to even come to the city. We need the government to put qualified doctors in clinics closer to our homes to help solve our problems. We shouldn’t have to travel so many hours to the city and spend so much on traveling when the roads are dangerous.”

Male, 43 years, farmer, Khuram Wa Sarbagh district, Samangan province

Even when medical services and treatments are provided for free – as is the case in all the hospitals where MSF works in Afghanistan – non-medical costs can be a serious barrier to seeking healthcare. The expense of getting to free care can be a critical obstacle to overcome when making the decision about whether to seek care or where to deliver a baby.

“In my village a pregnant woman had pains and needed to deliver. Her family didn’t have the money to pay for transport to bring her here [MSF maternity hospital], or for a private female doctor closer by. They rushed around trying to find people to borrow money from. By the time they had enough money to move to here it was already late. On the way, bleeding started, fast and hard. She and her baby died before they got here. This happens to many women.”

Male, 38 years, teacher, from Jaji Maidan district, Khost province

For women who came to deliver in MSF’s maternity hospital in Khost, the median cost of transport was US\$9.6 (IQR 4.8 to 19.2). Three quarters of those interviewed in Khost had an average of less than US\$1.2 to spend a day, and almost 60% of the households had no savings to pay the healthcare costs of the current pregnancy. Thus, the cost of transport to reach even free care would have been a significant burden to these women. It is likely that there are many other women across Khost province who simply cannot come to the maternity hospital due to prohibitive transport costs, in addition to insecurity on the road.

For seriously injured people arriving in MSF’s trauma centre in Kunduz, almost two in five people (38%) had paid more than US\$6, with one in ten people paying more than US\$50, mostly on transport costs. Up to now, security conditions outside the district capital have meant that MSF has not yet been in the position to run its own ambulance service in the districts of the province in order to collect wounded people closer to where they are injured. At the same time, clinics in neighbouring districts or provinces do not yet have well-functioning referral systems and ambulances.



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Seventy-four of the seriously injured patients interviewed had been referred from another health facility to the MSF trauma centre rather than coming directly. The median cost they paid was US\$18, with one quarter of them paying more than US\$36. The lack of a fully functioning referral system in the area causes delays in reaching emergency medical care for war-wounded and injured people. It also forces people to spend money on transport that at least one third of people interviewed in Kunduz did not have. This is a serious problem for patients, which MSF will need to address.

Considering the amounts that people are forced to borrow, it is critical that healthcare centres ensure free care is provided in reality. However, patients regularly reported that this was not always the case in many of the public facilities they visited. Across all four locations, more than half (56%) of patients who visited a public facility ended up paying for all the medication they needed. Of those people, 27% paid for the medication inside the public facility itself, 60% purchased it in a private pharmacy, and 12% bought it in the market.

When people did not obtain the medications they were prescribed, the main reasons were that they could not afford it, or that the drugs were unavailable in the health facility. Almost half (47%) in Kunduz to three out of five (60%) people in Kabul failed to get the medication they needed because of financial problems.

“When we go to the [public facility] the liquids and injections are free. There is a pharmacy inside the hospital, but if you have to get things there, then you have to pay. And sometimes they just don’t have the drugs in the hospital pharmacy, so then we have to go outside to the market and buy the drugs there.”

Female, 41 years, Kunduz district, Kunduz province

GAPS IN THE HEALTH SYSTEM

The health system in Afghanistan is a work in progress. Despite positive steps, significant gaps remain in the delivery of quality, affordable healthcare, including for those in need of emergency medical aid. There is substantial work ahead to continue improving the health system and to better adapt it to the needs of the population.

Violence, prohibitive costs and distance all conspire to delay or prevent people from accessing the healthcare they need. Unfortunately, for many who manage to overcome those barriers, upon reaching the health facility they report that they discover that it is closed, defunct, or provides inadequate services. In this way, the current health system, as it is, poses several barriers to effective access to healthcare.

“There is no proper care for injured people close to us. There are no proper facilities where we live. In the nearest hospitals and clinics [in Baghlan province] the doctors can only give ‘spicy’ [poor quality] tablets. Those clinics don’t have any dressings, no injections, just counterfeit tablets in packets. When our people are bleeding, spicy tablets won’t help them survive.”

Male, 25 years, from Baghlan province

In every location the majority of people had not visited their local public clinic at any stage during a recent illness. Their perception of the quality of staff and services available in the facility was frequently the main deciding factor. Many people had major complaints about the quality of both private and public medical facilities and practitioners in their areas.

In Helmand, three quarters of people went to a private facility as their first step during a recent illness in their household. Only one in five went to a public health facility. Of those who went to private facilities, more than half (57%) did so because they perceived that it was the best quality. The second biggest reason (38%) was because the private health facility was the closest one to them.

In Kunduz more than half (56%) of those interviewed chose to go to a private healthcare provider first, with just two out of five (38%) people choosing a public facility. Again, of those who went to private, the majority (64%) did so as they deemed it to be of better quality, with the next main reason (28%) being that the private facility was closer to them.

People’s perception of quality was also the main reason they avoided going to their closest public health facility. For at least one third of people in all locations, a presumed lack of quality was cited as the main reason they went to private facilities, rather than a closer public one. In general, people were most concerned and critical about what they perceived as a lack of appropriate drugs, qualified staff, waiting times and staff conduct in the public health system.

Long waiting times, combined with opening hours that do not always fit with the reality of people’s medical needs, seem to push patients away from the public health system.

“The government clinic in our area is only open until 12pm. So if we have a seriously injured person or a pregnant woman with complications, we can’t go there in the afternoon. And we can’t travel at night. We have to wait for the next day until the road is secure. Most of the pregnant women who die do so because they can’t reach a hospital in time to save them.”

Male, 77 years, Lashkar Gah district, Helmand province

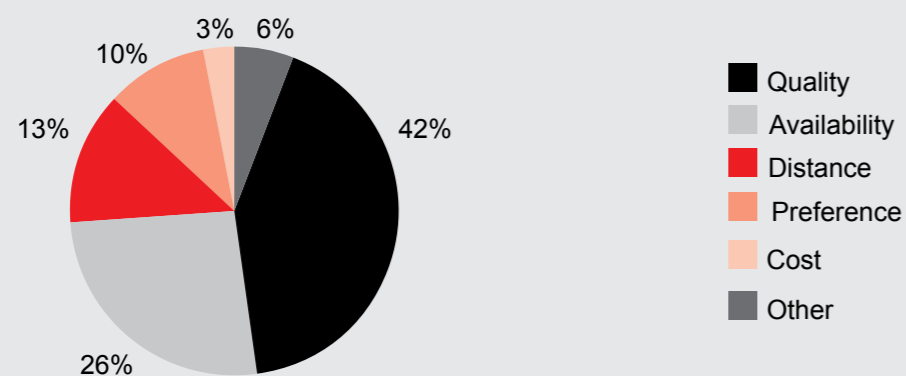
Issues with staff quality and conduct were also frequently cited as a source of frustration in both private and public practices.

“In my area, there’s just one private doctor and he used to fix tyres. He didn’t study medicine, but has one big medical book in Pashto. When I went to see him with head pains he told me to look up the book myself to find a treatment. That’s not a doctor! How can he treat anyone who is seriously sick?”

Male, 22 years old, farmer, Nawzad district, Helmand province

The past reputation of the public health system, coupled with patient preferences and assumptions about poor quality, may sometimes lead people to avoid their closest public clinic, even if it is working well. For instance, an MSF assessment of the public clinics in Lashkar Gah district in July 2013 showed that general primary healthcare provision in much of the district appeared to be functioning well. At the time of the visits, all the public health centres were open and providing consultations free of charge and seemed to have adequate levels of

FIGURE 8: Main reason given for not going to the closest public health facility among 599 respondents from 4 sites



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patient attendance. Due to security constraints, the assessment was not carried out in the other districts of Helmand. MSF cannot, therefore, confirm the situation in the other districts of the province, including the rural areas, where there are usually fewer staff and less monitoring capacity, and where the population frequently spoke of feeling underserved.

Perceptions are by definition, highly subjective, and thus more difficult to quantify than issues related to availability, since a service or a structure is either there or it is not. However, patient perception must not be discounted. Across all four locations, it is clearly one of the key influencing factors about whether people will use a service or not. Additionally, it is clear from their examples that there can often be serious quality problems in their closest public clinics.

Despite the fact that the BPHS has increased coverage by creating more health facilities in more districts, the quality of what is available inside the building remains of fundamental concern for people when choosing where to seek healthcare. This is especially pertinent considering that the BPHS has often been criticised for prioritising quantity and coverage strategies over quality,⁷⁷ and in spite of several tools that monitor the quality of services.⁷⁸

Whether the current levels of financing for the BPHS can realistically ensure the necessary quality is regularly questioned. Particularly the existing policy of awarding BPHS contracts for service provision to the lowest cost NGO provider, with the risks that brings of undermining the quality of services on offer.^{79,80,81} Where quality is low, or perceived to be low, community distrust in the public system will only increase, pushing them further towards private providers, where many spend money they simply do not have.

The distrust of the public system is often accompanied by a misplaced trust in the private system. Enormously powerful and unregulated, it too comes with its own set of problems in terms of quality and cost for patients. Medicine is a lucrative business for private providers in Afghanistan, and some elements of the private medical sector can be quite unscrupulous. While people regularly chose private as the option of quality, many spoke of overprescribing, misdiagnosing and even malpractice from the side of the private practitioners that they visited.



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It is therefore essential that public health facilities offer quality care as an accessible and affordable alternative.

“Before coming here, we’d gone to private doctors about four times. The public clinics are too far away from us. But the private doctors couldn’t help. It was too serious. And they never suggested that we come to another bigger hospital for help. They never referred us forward. They just told us to come back again and again to them even though they couldn’t fix him.”

Male, 55 years, farmer, Musa Qala district, Helmand province

In addition to quality, problems with the availability of staff, drugs and opening times were usually the second biggest reason people bypassed their public clinic. One in ten people interviewed in Kabul and Helmand cited a lack of treatment for their particular condition as a reason why they did so. In Kunduz, as many as two out of every five people believed their closest public medical facility could not assist them with their illness. People in need of more specialised care – including wounded people, women with complicated pregnancies, malnourished children and people with chronic diseases – especially reported facing serious difficulties finding treatment at their closer public clinics.

Those from Kabul and Kunduz who travelled to Pakistan sought care mostly in private health facilities at great cost. They were in search of treatments for conditions that they believed the secondary and tertiary hospital system in

Afghanistan was ill-equipped to cater for, such as cancer, diabetes, kidney disease, hypertension, heart disease or hepatitis.

Even for injuries directly related to the conflict, there is a worrying lack of services and facilities. In 2013, the number of people treated for weapon wounds rose by 60% in Afghanistan, while the need for trauma care in the country far exceeds existing capacity to provide it.⁸²

People also highlighted the lack of a proper public referral system to transfer wounded people and pregnant women from smaller health posts to hospitals as another serious gap. This increases the distance, security and cost barriers they must overcome to reach appropriate care.

“After the fighting there are always six to 20 injured people who need medical help. But there’s only one government hospital in the district, with no ambulance system to carry the wounded and no oxygen. When we take our wounded to this hospital, they don’t have the treatment they need. They can’t help them enough, so then we have to try to get the injured people to the centre of the province or even to the next province. They often die on the way.”

Male, 21 years, from Laghman province, living in District 12, Kabul

Though the public system promises free care, in practice people revealed that this is not always the case, and they often had to pay for drugs and some doctors’ fees. In addition, there are also other hidden charges and accusations of corruption. In all four locations, people spoke of doctors in public clinics pushing patients to their more lucrative after-hours private practices. People also regularly complained of government clinics in remote areas selling drug supplies to the local pharmacy so that patients could not find the drugs in the clinic and were then forced to pay for medicine at the pharmacy.

“We didn’t have any government clinic near us until recently. Now there are always crowds of sick people there but no good quality doctors to treat them properly. Also, in the public clinic there is a lot of queue jumping and corruption. You have to pay the doctors a bribe to be seen. They don’t really care about the patients. They are just waiting in their office for the day to end so they can go home.”

Female, 33 years, Marjah district, Helmand province

Informal charges for patients are particularly worrying considering that cost was the second most important consideration, after proximity, for those who chose a public health facility over a private one. More than one in six people in Kunduz, and one in eight people in Helmand, who chose to seek healthcare in a public structure did so because it was considered the cheapest. However, the drugs were not always available or free at those public clinics, thereby driving up their medical bills.

“There is a problem with the government clinics in our area. They are supposed to be free, but that’s not the reality. Even if you can see the doctor for free, when you need medicines or tests, the doctors push you towards their own private clinics. They tell you they don’t have the drugs or the equipment in the government clinic but that they have everything in their own private practice. Once they get you to their private clinic, then you pay, pay, pay. This happens again and again to the poor people because no one is monitoring these clinics.”

Male, 40, mullah, from Gharmsher district, Helmand province

A consequence of the insecurity is that many health centres are managed by remote control, and monitoring reports can be submitted without the facts being checked on the ground. In this way, the conflict and violence not only block the population’s access to healthcare, but can also facilitate the continuation of bad practices. Extra support for these remote facilities, where patients reported the most striking problems, might increase further accountability towards the communities these clinics serve, and avoid further loss of community trust in Afghanistan’s health system.

“There are public clinics in our districts, but there are no medical staff and no medicines inside. We need people to monitor these clinics. We need the government or NGOs to monitor them. Someone needs to monitor them, because the clinics in the districts don’t work. And most people know this, so they don’t go there, and they spend all their money on private, or they travel far.”

Male, 57 years, farmer, Marjah district, Helmand province



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LACK OF RESPECT FOR MEDICAL FACILITIES AND HEALTH WORKERS

All warring parties, as well as an increasing number of criminal groups, continue to engage in activities that create serious obstacles to accessing healthcare for sick or injured Afghans.

Under International Humanitarian Law, medical facilities retain a protected status, as long as they are exclusively devoted to care of the wounded and sick. In 2013 there was a sharp increase in military intrusions into health facilities in the country, with 80% of those incidents attributed to pro-government forces using health centres as bases for military operations.⁸³ These statistics are already worrying, but it is likely that many incidents go unreported and that there are multiple armed groups involved. Such intrusions damage the perception of health facilities as neutral, impartial spaces for healthcare provision. They also expose health facilities to risk of direct attack from armed opposition groups, endangering the lives of patients and medical staff.

In 2012, 450 health facilities closed – temporarily or permanently – for reasons of insecurity; up by 40% compared to 2011.⁸⁴ With health providers already unable to operate properly, either permanently or temporarily, in 58 districts of the country,⁸⁵ any further disruption will have grave consequences. The announcement by the Government of Afghanistan that some health facilities, along with schools, have been designated as registration centres and polling stations for this year’s election is dangerous. Clinics must not be used as a platform for a political process or as tools to advance state-building goals; they must be safe locations where sick people can get the medical care they need.⁸⁶

With voting centres at high risk of being attacked, as was the case during the 2009 election, this decision could again place the lives of health workers and patients in direct danger. Safety concerns could result in patients avoiding those health centres, forcing them to travel further to another public or private clinic, increasing the delays, costs and security risks they endure.

“Both sides will usually let you pass when you’re on the road and they see you have an injured person, as long as the injured person is not a fighter or a government worker. If the injured people are on the side of the government, if they are government workers, then they will die. The insurgents won’t allow them to pass to the hospital or to live. But if you are a wounded civilian who is not connected to the government, then the insurgents will let you pass.”

Male, 18 years, from Laghman province, living in District 12, Kabul

Under International Humanitarian Law, every party to the conflict must do its best to provide special protection and care to sick and injured civilians and combatants, of which the right to medical assistance is a fundamental provision. Health professionals also have obligations to provide health services in an impartial way to people affected by, or involved in conflict, without distinction based on race, ethnicity or political affiliation.

While people spoke of many instances where they were given safe passage by the different sides of the conflict, there are still too many incidences of the warring parties failing to fulfil their obligation to ensure access to medical assistance.



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“A lot of injured people die because of the delays in trying to reach the hospital. The police will stop cars transporting the injured. If they see you have an injured woman they don’t stop you for too long. But if there are injured young men, then they will stop the car and question them to find out how they got the injury. And these injured men can die at the checkpoints, before ever getting to the hospital. It doesn’t matter if the injured is a civilian, if he is an injured man, he can be stopped and delayed.”

Male, 25 years, from Baghlan province

Locating military outposts or checkpoints in the vicinity of a clinic make it more difficult for health professionals to provide health services to those affected by, or involved in, conflict. In Kunduz, the Afghan National Directorate of Security opened an office in 2013 across the road from MSF’s trauma centre. Community representatives have explained that the presence of this military office so close to the hospital prevents people wounded in combat operations from seeking health services there, for fear of suspicion of involvement in the conflict, or of arrest. People spoke of similar fears in other areas of the country:

“If you manage to make it to the government hospital, there is more trouble waiting for you. If you bring a wounded man to the public hospital, the government will send an investigation team. They will accuse the injured man of being on the side of the insurgents and will interrogate him. They try to find out which party the man belongs to, who he might be supporting. So injured men don’t want to go to the hospital, because they are worried about the investigation teams.”

Male, 18 years, shop assistant, from Laghman province living in District 12, Kabul

For sick or wounded Afghans, going to a government-run clinic or receiving assistance from groups affiliated with the counter insurgency strategy can also bring the risk of retaliation from the armed opposition groups (AOGs). When health and other public services are linked to political agendas and strategies of the belligerent parties, doctors and patients are exposed to increased risks.

“I can’t go to the government doctor in my area because of the insurgents and other problems. They don’t like us to go to clinics supported by the government. If I go there, maybe the insurgents will arrest me and ask why I went, what I was doing there. Anyway, even if we were allowed to go, the people working in those clinics are not proper doctors.”

Male, 22 years, farmer, Nawzad district, Helmand province

“We can’t go to the government clinics. The insurgents don’t want us to. They don’t want this government. They want their own government. They tell us that we should not take from this government or give to this government. So they don’t want us to use the government clinics or they think that we support the government. But sometimes we have to. When we do, they ask us why we went there. We have to explain that we didn’t have money to go somewhere else. Sometimes that’s enough reason for them, but if they don’t like you already, you will be in trouble.”

Female, 43 years, and brother-in-law, 48 years, Sabari district, Khost province

Even when the armed opposition may not have specific problems with people seeking treatment in a public clinic, patients may still avoid it based on fear and rumours about possible consequences. Violence – whether actual, threatened or simply rumoured – creates significant barriers to accessing healthcare. Several patients spoke of avoiding the government clinics in their district and embarking on long trips to other districts, and even other provinces, to find a hospital where no one knew them.



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“There is no government hospital in our area. If there were one, the other side would not want us to use it because it belongs to the government. I had to come here to this hospital like a thief, like a criminal, in secret, so people from the village wouldn’t know. My son would have died if I hadn’t brought him here, but when I get back maybe I will be questioned and harassed because I came here to this town. Though now everyone back in the village is probably too busy with all the fighting to have time to wonder where I am.”

Male, 55 years, farmer, Musa Qala district, Helmand province

In addition to the various AOGs, rising criminality increases the volatility and insecurity of the environment for health workers and patients alike. Violence against aid workers is growing, with the 2013 Aid Worker Security Report reporting that Afghanistan was the most dangerous country for aid workers.⁸⁷ From January to June 2013, 125 incidents of violence were recorded – an increase of 78% on the previous year. As of early December, the UN had recorded 237 incidents against humanitarian personnel, facilities and assets. These accounted for 36 deaths, 24 detentions, 46 injuries and the abduction of 72 personnel.⁸⁸ Violations against health workers and facilities are also reported to be on the rise.⁸⁹

Attacks on ambulances and health facilities deprive the population of much-needed medical services. Following the explosion of a small device in April 2012 inside its Khost maternity hospital, in which seven people were injured, MSF was forced to suspend its maternal health



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services in the province, depriving women and children of urgently needed healthcare for the preceding nine months. MSF reopened the hospital in December 2012 following a show of strong support and reassurances by the local community and all relevant parties.

Violence in Afghanistan injures patients and medical workers, as well as destroying medical structures. Moreover, healthcare professionals flee their posts, vaccination campaigns end abruptly, and clinics close, sometimes leaving entire communities without access to adequate services. International organisations providing healthcare have also been forced to review their activities, tighten security regulations and reduce personnel. This compromises the quality of the aid provided and weakens their ability to assess needs and monitor effectiveness.

Today MSF is able to provide medical care to thousands of patients through four hospitals in

four very different provinces, but still there are unknown needs outside the provincial capitals that the organisation is currently unable to assess or address due to security concerns.

“Two years ago we had an ambulance in our area, but then armed men stole it. Now there’s nothing to transport the patients. Now you have to pay for taxis. Even if the government gave another ambulance to our area, they wouldn’t find anyone to drive it. Any driver knows he would risk being attacked because he’s working for the government.”

Male, 25 years, shop owner, from Musa Khel district, Khost province

EXTRA BARRIERS FOR WOMEN

“For people like us who live far away [from the centre of the district], there are lots of problems. Because of the violence and fighting yesterday I had to wait until morning to travel here with my pregnant wife. Because of the delay her condition deteriorated. She collapsed three times, and now she is seriously sick.”

Male, 37 years, from Nahri-I-Saraj district, Helmand province

In Afghanistan, women and children have a distinctly higher burden of illness and death, with the higher mortality rate for women mainly due to causes related to pregnancy and childbirth. While the maternal mortality ratio reportedly declined from 1,000 per 100,000 live births in 2000 to 460 per 100,000 live births in 2010,⁹⁰ the country is still one of the most dangerous places in the world to give birth. During childbearing years, one in 42 Afghan women is likely to die of causes related to pregnancy and childbirth.⁹¹

When women and girls need to access healthcare, they must overcome specific obstacles, in particular the dire shortage of qualified female medical staff in the country, especially in rural areas.⁹² The limited acceptance of men as healthcare providers for women means that the lack of female midwives, nurses and doctors poses a clear obstacle for many women.

Maternal healthcare services are not well distributed across the country and the majority of women do not have adequate access to essential obstetric care. In general, qualified specialists prefer to live and work in big cities, which leaves large gaps in healthcare provision in the rural areas. The conflict further aggravates this, with the limited pool of female doctors and midwives even more reluctant to work in the insecure areas. In provinces with USAID-funded projects, for example, 60% to 70% of rural health facilities reported a lack of female health professionals.⁹³

Even if public clinics do have a female midwife, nurse or a doctor, the clinics' opening hours do not fit with the medical reality of labour. Many clinics in the more remote areas are only open in the morning, according to patients. Consequently, women reported that when they or their relatives go into labour or experience bleeding in the late afternoon or night, they are often unable to find free care nearby and are forced either to travel a long distance, at greater risk and cost, or to deliver at home.

“I'm here today with my pregnant daughter-in-law. She started to have complications yesterday but we didn't have the money for transport, so it took too much time before we could come. I travelled in danger to get here as fast as I could. Two months ago I came here with my niece. There was too much fighting to travel to the hospital, so she delivered at home, but the baby died. Before we could get her here for help we had to wait nine hours for the violence to stop. She is alive today. But that same day her baby died, our other relative was killed during the violence.”

Male, accompanying 26-year-old pregnant daughter-in-law, from Gurbuz district, Khost province

Only 20% of women in Afghanistan aged 15-24 are literate, and that number is three times lower in rural areas.⁹⁴ Low literacy rates, a lack of knowledge of health problems and practices, and restrictions on their movement and access to money also limit women's ability to access proper or timely health services for themselves and their children.

“Two of my sons died when they were very small – one when he was five months old and the other when he was only ten days. They both had fever and diarrhoea. We didn't know what was wrong with them – we had no knowledge. When we took the five-month-old boy to the public hospital in Kabul, the doctor there said it was too late. He died in the hospital.”

Female, 35 years, from Kapisa province

Women in most areas of Afghanistan require consent from their husbands in order to visit a health facility. Once consent is obtained, they are usually obliged to be accompanied by a male relative. If there is no male available, this can delay or prevent the visit to a healthcare provider. In the case of childbirth, it can mean that a woman will deliver at home instead of in a health facility with a skilled birth assistant, increasing the risk of morbidity or mortality from complications.

“We live in a village far away from here. It's cheaper to live the further from the centre you are. My mother has diabetes and when she gets sick we need to bring her all the way into the centre for care. Many times we can't go because we can't find a man who has enough time to accompany us. Even when she was injured this time, it was really difficult for us to get here, because we had no man to come with us.”

Female, 43 years, Kunduz district, Kunduz province

MSF's specialised maternity hospital in Khost tries to overcome some of the specific barriers women face. In order to help reduce the high maternal mortality rate in the area, the hospital provides a safe environment for women to deliver their babies free of charge, and opens up access to women who would otherwise be excluded from healthcare. In 2013, staff performed close to 12,000 deliveries in 2013.

In Khost, MSF tries to have an all-female medical team providing care to the patients. However, the dearth of qualified female medical workers living in or willing to relocate to Khost remains a major challenge, even if the presence of MSF international staff helps fill the gap. However, it is clear that many more Afghan female medical staff will need to be trained in order to expand access to appropriate medical care for women.

Given that those furthest away from the provincial centre often face greater barriers to access healthcare, the focus for the Khost hospital in 2014 is on improving access for pregnant women facing complications in peripheral districts. MSF will train local health workers already working in those areas to promptly identify danger signs and facilitate the safe transportation of these patients to MSF's hospital. This should improve access to the maternity hospital, but there will likely still be many women in the most remote areas who face barriers relating to distance, cost or security that will continue to block them from reaching the hospital.

CONCLUSION

MSF's research reveals the complex and grim reality facing patients who, in addition to dealing with the ongoing conflict, must also overcome financial and geographical barriers to access the medical care they need. It highlights the destructive impact of the conflict, as the war injures and kills civilians, interrupts basic services, and impedes access to those services that continue to function. Currently, healthcare provision is insufficiently geared to meet rising medical and emergency needs in Afghanistan, particularly those stemming from the conflict.

The research reveals the serious and often deadly risks that people are forced to take to seek both routine and emergency care. They risk landmines, checkpoints, harassment and active fighting on their journeys to deliver a baby, find treatment for a malnourished child, or save a wounded relative.

Insecurity meant that MSF could only speak to patients already inside the four hospitals where its teams work. As a consequence, the research likely under-represents the extent of the barriers faced by the poorest people living furthest away from the provincial capitals, particularly those in the most insecure areas. Beyond MSF's reach, large numbers of people continue to suffer illness or injury without recourse to medical care.

Since 2002, some important progress has been made in healthcare provision, and this needs to be built on. Official accounts of Afghanistan's health system, however, habitually emphasise achievements while neglecting unmet medical humanitarian needs. It is remarkable how far the prevailing narratives of progress differ from the accounts of ordinary Afghans. This report highlights their experiences of obtaining medical aid, in order to galvanise an improved response to their situation.

Patient stories expose a wide gap between what exists on paper in terms of healthcare facilities and services in their areas, and what is available in reality.

Although the number of health facilities in Afghanistan has increased over the past decade, people in the four locations reveal that there are still too few properly functioning or affordable health centres close to them that they trust. Serious shortcomings in the referral system between rural clinics and district or provincial hospitals mean many Afghans do not have adequate access to secondary-level care, including lifesaving emergency surgery. Pregnant women with complications continue to die, while the wounded risk their condition deteriorating when forced to travel long distances to seek medical care.

People report that they must regularly pay for drugs and often pay for informal doctors' fees in public health facilities. Given the extreme poverty of many of those interviewed, it is vital that the national policy of free care is properly implemented. Medicines and consultations must be free to ensure that medical expenses do not deter patients from seeking essential healthcare. Even when care is free – as in all MSF projects in Afghanistan – non-medical costs such as transport and accommodation still pose major hurdles for patients and their families.

Quality, or the perception of quality, was the main reason why people went to private health facilities – which often they could not afford – or why they undertook long journeys at great risk to reach clinics that they hoped would offer better care than their closest public one. A focus on improving both the coverage and quality of health facilities is necessary, particularly in the most insecure areas, where basic and lifesaving medical care is often non-existent, prohibitively expensive or inaccessible.

There must be an improved response to reach civilians trapped in conflict and those in the more remote regions, otherwise they will continue to fail to receive the assistance they need. Considering the volatile security situation outside provincial capitals, existing rural health facilities need to remain open and properly functional. Better monitoring and evaluation of public facilities on the ground to improve services would help in this regard.

The destruction and disruption of services disproportionately affects those living in militarily contested areas. However, insecurity and limited access to those communities by authorities and humanitarian agencies, including MSF, prevents a sustained or adequate response. This means the most vulnerable are left to fend for themselves.

In an increasingly insecure environment, aid providers must acknowledge the harsh reality that humanitarian assistance is not reaching enough of the people who need it. Humanitarian agencies, including MSF, will need to address the prevalent 'bunker' mentality that results in too many organisations concentrated in main towns and unable to access the most insecure areas. In such a volatile, politicised context, ensuring that emergency care is brought closer to people will be challenging, but it is essential. As part of this, health and humanitarian agencies have to prioritise negotiating access with all sides in the armed conflict.

Where healthcare cannot feasibly be moved closer, medical aid providers need to address the obstacles for transferring sick or injured people to care by establishing better functioning referral mechanisms. In the areas where it is able to work, MSF is trying to address access issues through various strategies. By increasing the number of mobile clinics in the outskirts of Kabul, it is extending its reach into communities and moving beyond its hospital walls. By improving the referral of patients in Helmand, Kunduz and Khost, MSF teams try to ensure that people's journeys are less costly and less risky. MSF will continue to make efforts to increase its acceptance among all armed groups and to ensure safe access in order to reach more of the most vulnerable people.

The need to increase access to insecure areas underlines the importance of both pragmatic and principled approaches. The provision of both relevant, effective basic services and of humanitarian assistance must be expanded in a truly neutral, impartial and independent manner. Aid provision must be more clearly untangled from military and political agendas.

Decisions on where and how to provide assistance have too often been based on desires for stabilisation, force protection, 'winning hearts and minds', or garnering political support amongst the public back home. In the post-2014

donor strategies, it is imperative that assistance to civilians, in the form of humanitarian or development aid, is focused on addressing the actual needs, and is not contingent on troop presence or the outcome of political negotiations.

International donors and aid providers must urgently address serious shortcomings in healthcare provision. Healthcare policies have frequently been overly focused on developing a health system fit for a post-conflict Afghanistan of tomorrow, rather than one that also adequately meets the pressing needs of people today. A better balance is required between supporting the necessary development of the health system to meet basic and emergency needs, and ensuring the increased provision of independent humanitarian assistance.

Aid providers and belligerents alike must safeguard the neutrality and impartiality of aid. Parties to the conflict need to do far more to ensure that independent, neutral and impartial healthcare can be provided to all wounded and sick, including to those who were actively involved in hostilities. In accordance with International Humanitarian Law, medical personnel and facilities must be respected at all times. Health facilities must not be used to advance political and military objectives or requisitioned for purposes other than providing care to the sick and wounded.

With donor and media interest in the country predicted to wane following troop withdrawal at the end of 2014, a renewed focus on the real experiences of the Afghan population is essential. Any desire to package Afghanistan into a simplified political or military success story risks masking the reality of the ongoing conflict and the suffering of hundreds of thousands of people who do not have access to adequate medical assistance.

As troops pack their bags, MSF sees a war that still rages in many parts of the country and a failure to meet people's increasing medical and humanitarian needs. It is critical to prioritise the delivery of tangible results to alleviate suffering. While the international community may seek refuge in rhetoric, the Afghan people have to deal with the harsh reality.



ACRONYMS

| | |
|-------|---|
| ANSF | Afghan National Security Forces |
| AOG | Armed Opposition Group |
| BPHS | Basic Package of Health Services |
| BSA | Bilateral Security Agreement |
| CERP | Commander's Emergency Response Program |
| COIN | Counter-Insurgency |
| EPHS | Essential Package of Hospital Services |
| ER | Emergency Room |
| GoA | Government of Afghanistan |
| ICRC | International Committee of the Red Cross |
| IQR | Interquartile Range |
| ISAF | International Security Assistance Force |
| MoPH | Ministry of Public Health |
| MSF | Médecins Sans Frontières |
| NATO | North Atlantic Treaty Organization |
| NGO | Non-Government Organisation |
| OCHA | Office for the Coordination of Humanitarian Affairs |
| PRT | Provincial Reconstruction Team |
| UN | United Nations |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

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