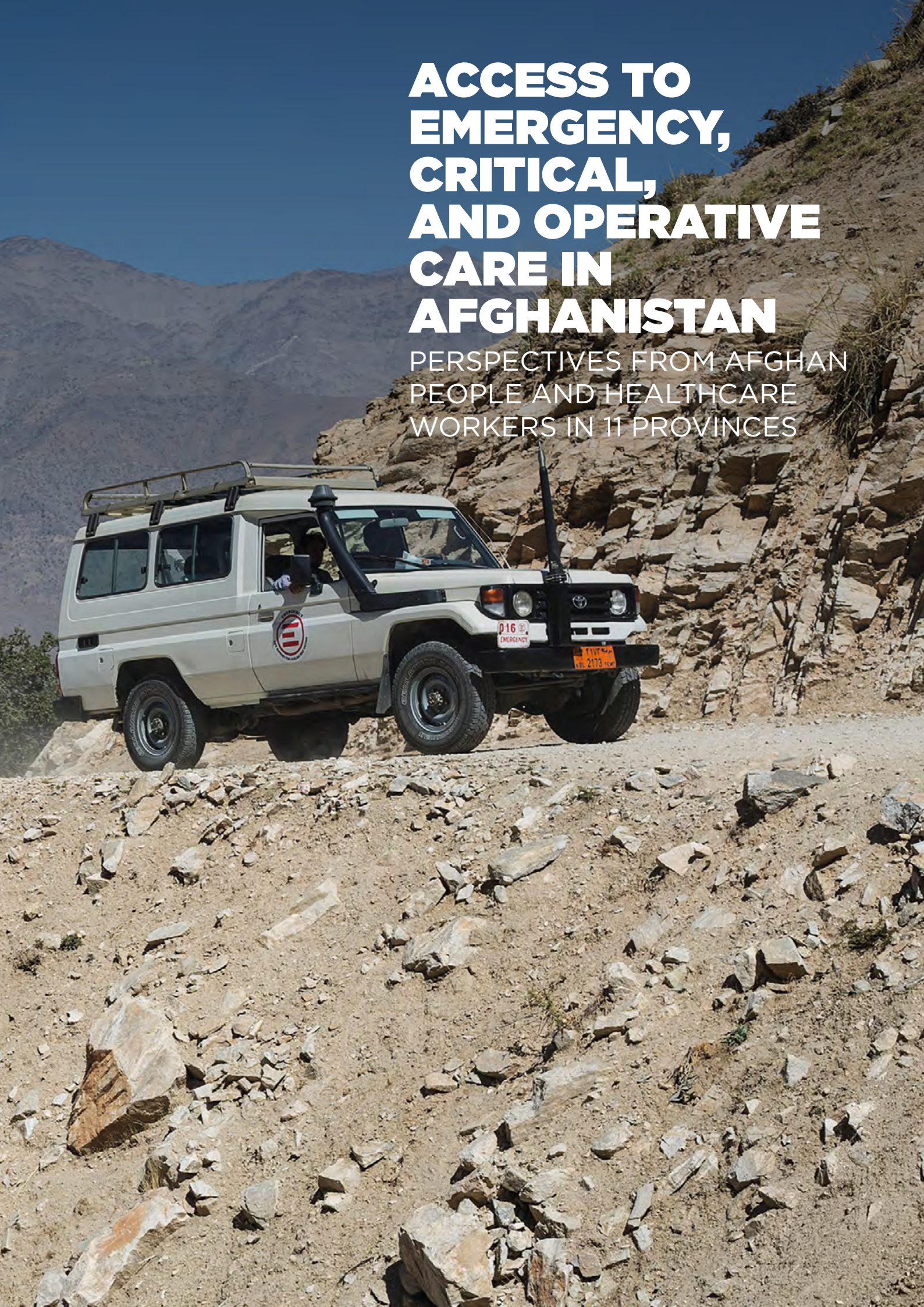

ACCESS TO EMERGENCY, CRITICAL, AND OPERATIVE CARE IN AFGHANISTAN

PERSPECTIVES FROM AFGHAN PEOPLE AND HEALTHCARE WORKERS IN 11 PROVINCES

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EMERGENCY ONG ETS is an independent non-governmental organisation. It provides free, high-quality medical and surgical treatment to victims of war, landmines and poverty. It promotes a culture of peace, solidarity and respect for human rights. Since 1994, EMERGENCY has worked in 21 countries around the world, providing free medical care in accordance with its core principles: equality, quality and social responsibility. EMERGENCY has treated over 13 million people.

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

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MEDICINE, HUMAN RIGHTS AND EQUALITY

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CRIMEDIM CENTER FOR RESEARCH AND TRAINING IN DISASTER MEDICINE, HUMANITARIAN AID AND GLOBAL HEALTH

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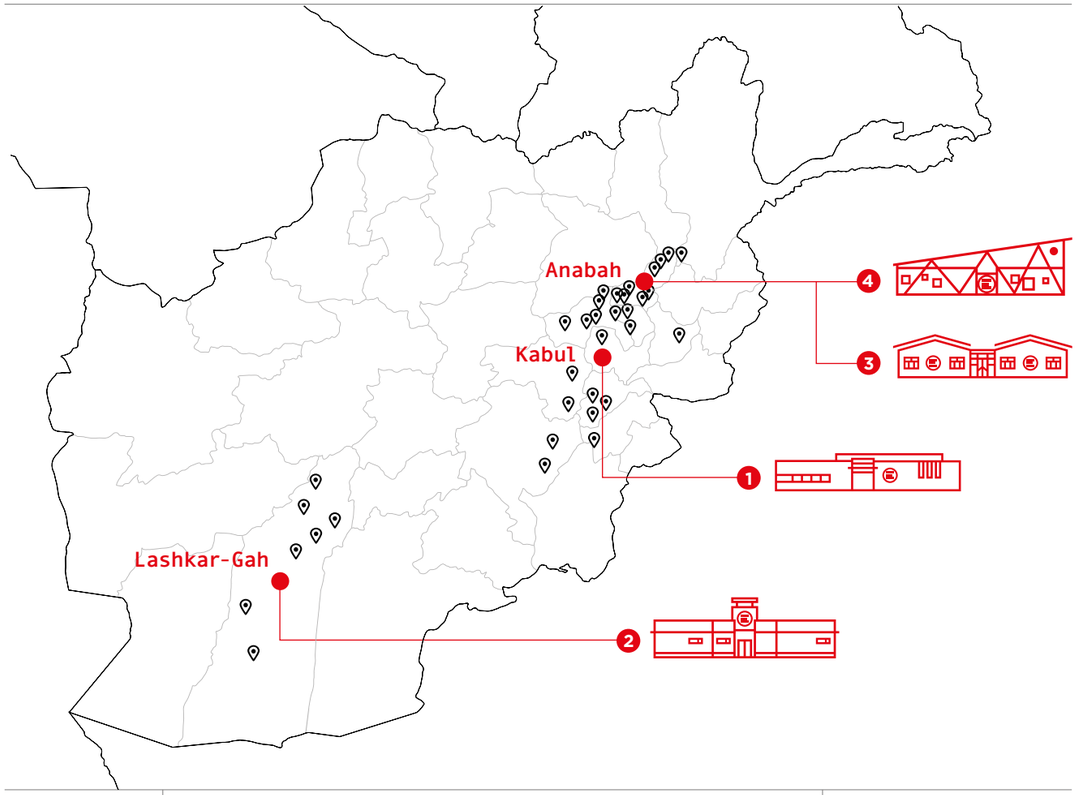

HOSPITALS | FAPs (FIRST AID POSTS) / PHCs (PRIMARY HEALTHCARE FACILITIES) | *Data as of 31/12/2024*

FAPs / PHCs

Since 1999

15 Facilities in Panjshir: Abdara, Anabah, Anjuman, Dara, Dasht-e-Rewat, Gulbahar, Hesarak, Kapisa, Khinch, Koklamy, Oraty, Paryan, Pul-e-Sayyad, Said Khil, Sangi Khan; **12 Facilities in Kabul:** Andar, Barakibarak, Chark, Gardez, Ghazni, Ghorband, Mehterlam, Maydan Shar (Jalrez), Mirbachakot, Pul-e-Alam, Sheikhabad, Tagab; **7 Facilities in Kabul** in 2 orphanages (male and female) and 5 prisons; **7 Facilities in Lashkar-Gah:** Grishk, Sangin, Marjia, Musa Qala, Garmsir, Nad Ali, Shoraki.

PRIMARY CARE | **427** LOCAL STAFF


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SURGICAL CENTRE FOR WAR VICTIMS 1

Kabul, since 2001

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

WAR SURGERY, TRAUMATOLOGY

100 BEDS | **412** LOCAL STAFF

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SURGICAL CENTRE FOR WAR VICTIMS 2

Lashkar-Gah, since 2004

Emergency room, outpatient department, 3 operating theatres, sterilisation unit, intensive care, wards, physiotherapy, radiology, laboratory and blood bank, pharmacy, classrooms, playroom, technical and cleaning services.

WAR SURGERY, TRAUMATOLOGY

93 BEDS | **320** LOCAL STAFF

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SURGICAL AND PAEDIATRIC CENTRE 3

Anabah, since 1999

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

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

78 BEDS | **344** LOCAL STAFF


© Stephanie Glinski

MATERNITY CENTRE 4

Anabah, since 2003

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

OBSTETRICS, GYNAECOLOGY, NEONATOLOGY

99 BEDS | **166** LOCAL STAFF


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OVERVIEW

Afghanistan's health system, weakened by over four decades of conflict, economic instability, and chronic underfunding, faces unprecedented challenges in meeting the healthcare needs of its population. The political transition of August 2021 further exacerbated these issues, triggering a humanitarian crisis and disrupting already fragile health services. While improved mobility has allowed more people to seek care, healthcare facilities — particularly in rural and peripheral areas —remain underresourced, understaffed, and often inaccessible due to financial and geographic barriers.

Emergency, critical, and operative (ECO) care services are vital for saving lives and addressing Afghanistan's evolving disease burden, marked by a rising prevalence of noncommunicable diseases, persistent maternal health risks, and high rates of trauma-related injuries. Yet, ECO services are inadequate, hindered by poor infrastructure, workforce shortages, ineffective referrals, and high costs for patients. **Limited access to these services often results in preventable morbidity and mortality**.

Investigating access to ECO care in Afghanistan is critical due to the distinctive challenges posed by its **post-conflict state, fragile health system and widespread socio-economic disparities**. Strengthening the planning and provision of ECO services will support aligning Afghanistan's current and future health reforms with its disease burden and population health needs.

In this context, EMERGENCY's longstanding and widespread presence, along with the broad range of health services provided at its facilities — encompassing surgery, anaesthesia, critical care, obstetrics and primary care, complemented by a robust system of referrals — offer a privileged point of observation on the status of ECO care in Afghanistan.

This report adopts a **mixed methods approach**, combining analysis of health records, patient and staff questionnaires, stakeholder interviews, and facility assessments, **to capture both patient and provider perspectives** on access, quality, and delivery of ECO services.

The findings aim to **inform national and international stakeholders on critical gaps, advocate for the inclusion of ECO services in health programming documents, and promote strategies for a more integrated, accessible, resilient and functional health system**. The report aims to ensure that the need for robust ECO care remains central to discussions on Afghanistan's health future.

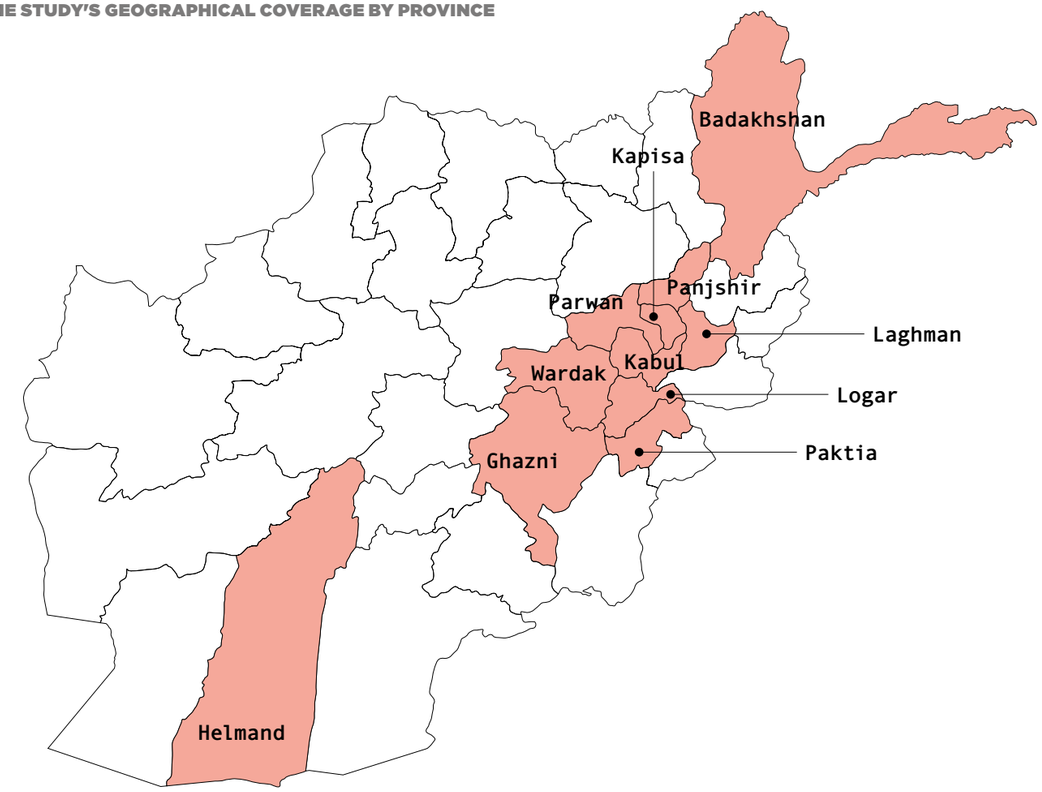
Afghanistan's post-conflict phase presents a **unique opportunity to invest in developing ECO care capacity**. This research is both timely and relevant to address health inequities in a context of significant humanitarian need, contributing to global health knowledge on care delivery in post-conflict and resource-limited settings.

1	A **descriptive analysis of data** collected at EMERGENCY's hospitals and clinics
2	**Questionnaires** to patients and caregivers and key informants among EMERGENCY staff to explore barriers and facilitators influencing access to ECO services.
3	**In-depth interviews** with directors, chief surgeons, chief gynaecologists from government-run hospitals
4	**Assessment** of government-run hospitals **across 11 provinces** using the HHFA checklist

OUTREACH

- **11 provinces,** included in the study - home to nearly **16 million Afghans** (39% of total population)
- **1,551 anonymous questionnaires to patients in 20 EMERGENCY facilities** (17 FAPs/PHCs and 3 hospitals)
- **32 questionnaires completed by key informants** among EMERGENCY staff
- **11 semi-structured interviews at government-run hospitals** with provincial hospital directors, chief surgeons, and chief gynaecologists
- **Assessment conducted in 11 government-run hospitals** using the HHFA checklist

THE STUDY'S GEOGRAPHICAL COVERAGE BY PROVINCE



STUDY FRAMEWORK: EMERGENCY, CRITICAL AND OPERATIVE CARE

Emergency, Critical and Operative (ECO) services are key components of a comprehensive healthcare system[1]. They encompass a range of services that are essential for addressing acute, life-threatening conditions, mitigating morbidity, and improving survival rates, particularly in low-resource settings. These services include a range of interventions, such as out-of-facility emergency medical services, facility-based emergency care, hospital critical care units, and surgical and anaesthesia services. Delivered across diverse settings, **community facilities, prehospital care, primary care, and hospitals, ECO services are integral to a comprehensive primary healthcare approach, ensuring access to timely and quality care for all** (see Fig.1).

Emergency services provide immediate care for acute injuries, illnesses, or sudden exacerbations of chronic conditions, including road traffic accidents, trauma, acute infections, obstetric emergencies, and disaster-related injuries. These services are designed to reach patients at the site of the emergency, stabilise their condition on the spot, manage life-threatening situations, and facilitate timely referrals or transitions to appropriate levels of care.

Critical services focus on the management of critically ill patients who require intensive monitoring, specialised medical interventions, and life support systems to prevent organ failure or death. Key components of the critical services system are intensive care units, ventilatory support, and advanced cardiovascular monitoring, which are often limited in low-resource settings due to a lack of trained personnel and specific equipment.

Operative services provide surgical and anaesthesia care, including elective, emergency, and life-saving surgeries, along with perioperative and postoperative care. These services address a wide range of conditions requiring surgical intervention and encompass elements like surgical procedures, anaesthesia, sterilisation, and postoperative recovery. **Access to safe, timely and affordable surgical care is an essential component of universal health coverage** (UHC), especially in low- and middle-income countries (LMICs).


Laura Salvinelli

FIG. 1 - EMERGENCY, CRITICAL AND OPERATIVE CARE

A combination of frameworks and methodologies was used to study the topic from a holistic perspective that incorporates both patient and health system viewpoints. This approach was essential to capture the key elements relevant to ECO care. The methodologies were designed to intertwine and complement one another, ensuring the study's objectives were met while providing comprehensive insights into the specific areas outlined by the selected frameworks.

For a visual representation, please refer to the study's framework graphic at the end of this paragraph.
The following frameworks were employed:

- The **4-delay model in access to surgery**, introduced by Odland et al.[2], expands on the original 3-delay model [3] to comprehensively address barriers to surgical care. The first delay occurs when patients fail to seek care, often due to a lack of awareness, cultural beliefs or financial constraints. The second delay arises from challenges in reaching care, such as inadequate transportation, long travel distances or unsafe travel conditions, particularly in rural areas. The third delay involves barriers to receiving care after reaching a facility, including resource shortages, overcrowded facilities or insufficient surgical staff. The fourth delay focuses on the provision of quality care, highlighting issues like inadequate training, poor adherence to clinical guidelines or insufficient postoperative monitoring. This framework emphasises the need to address these interconnected barriers to ensure timely, safe and effective surgical care, particularly in resource-limited settings.


Maya Art


Francesco Pistilli

- The **Hirner framework**[4] categorises dimensions of accessibility to emergency care in low- and middle-income countries using five key aspects: *accommodation* (i.e., the organisation of healthcare services and how well they accommodate patients' needs), *availability* (i.e., presence of essential services), *accessibility* (i.e., physical reachability), *affordability* (i.e., economic capacity of patients to pay for healthcare services without financial hardship) and *acceptability* (i.e., alignment of healthcare services with patients' cultural beliefs, values and expectations). These dimensions provide a comprehensive framework for evaluating access to emergency care in LMICs and underscore the presence of multifaceted barriers, thereby providing actionable insights for strengthening health systems.

- The **four elements of surgical access** proposed by the Lancet Commission on Global Surgery[5] (LCoGS) provide a framework for evaluating and improving surgical care in global health. These elements are (1) *timeliness*, because surgical care must be available within a reasonable timeframe to prevent complications and reduce morbidity and mortality; (2) *capacity*, because adequate infrastructure, equipment and trained personnel must be available. When they are lacking, access remains limited even with facilities present; (3) *safety*, because surgical procedures must be performed in environments that minimise risks, including infection prevention, proper sterilisation and adherence to clinical protocols; and (4) *affordability*, because surgical care should be financially accessible to ensure that patients do not face catastrophic health expenditures or financial hardship as a result of seeking care.
Together, these four elements emphasise the need for a holistic approach to improving surgical access, focusing

not just on availability but also on ensuring that care is safe, timely and affordable. This framework is critical in addressing the global surgical inequities faced by LMICs.

The integration of the 4-delay model, the Hirner framework, and LCoGS's surgical access elements in this study offers a comprehensive approach to understanding access to ECO care in Afghanistan. This combination addresses multiple dimensions of barriers, incorporating patient-level challenges, systemic inefficiencies and broader contextual factors. The Hirner framework provides a lens for evaluating accessibility dimensions, the 4-delay model highlights critical barriers along the care-seeking pathway and the LCoGS elements emphasise capacity, timeliness, safety and affordability of surgical care. By uniting these frameworks, the study bridges patient experiences with health system perspectives, offering valuable insights into the continuity of care.

This approach enhances the **reliability of findings through triangulation** and allows for the **formulation of actionable recommendations tailored to the Afghan context**, ensuring both academic rigor and practical relevance.

FIG. 2 - INTEGRATION OF EMERGENCY, CRITICAL AND OPERATIVE SERVICES

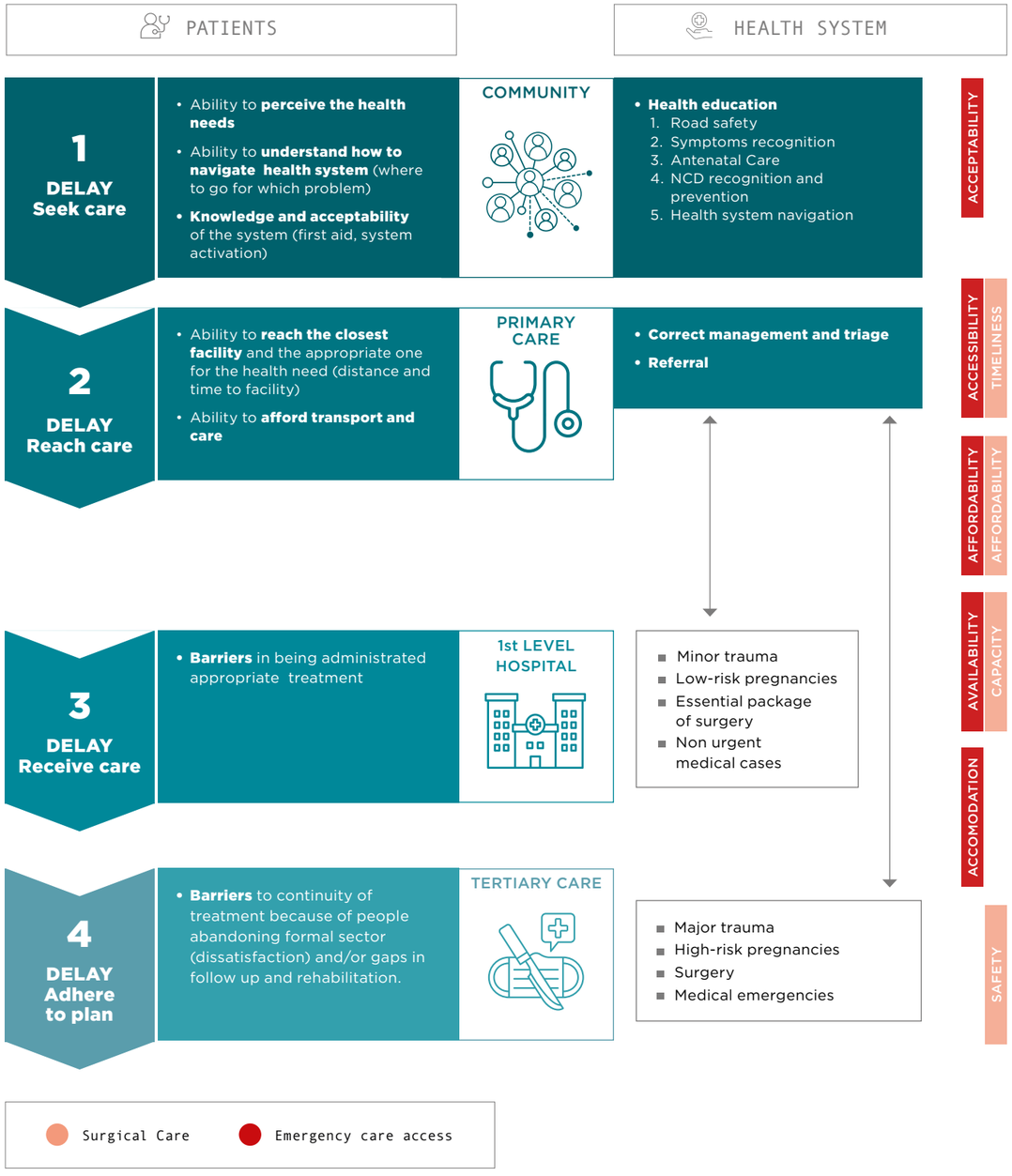


FIG. 3 - EXPLANATION OF THE FRAMEWORK

CONCEPT	DEFINITION
1 DELAY — Seek care	Barriers in recognising illness and knowing what to do and where to go[2].
2 DELAY — Reach care	Barriers in physically arriving at a health facility, typically due to lack of transportation or high costs[2].
3 DELAY — Receive care	Barriers in being administered appropriate treatment, typically due to inability to pay, poor quality of care (e.g., lack of equipment, long waiting time)[2].
4 DELAY — Adhere to care	Barriers to continuity of treatment because of people abandoning the formal sector (dissatisfaction) and/or gaps in follow-up and rehabilitation[2].
TIMELINESS • Time of transport	Accessibility of facilities in a timely manner, thanks to efficient transport system[5].
CAPACITY • Presence of services (i.e., ICU, Blood Bank)	Presence of skills, resources, materials and procedures to meet surgical care needs[5].
SAFETY • Guidelines • Training procedures	Presence of robust safety procedures and safety mechanisms for surgical care[5].
AFFORDABILITY • Cost of service	Capacity of families to access surgical care without incurring catastrophic expenditures[5].
AVAILABILITY	The relationship between emergency services and those seeking emergency care (n. of emergency beds per catchment area, presence of technology specific to emergency, presence of emergency physicians 24 h per day, % of clinicians with emergency training)[4].
ACCESSIBILITY	The proximity (in time and space) of a patient to emergency care (distance to closest emergency care facility; time to closest emergency care facility; available transport[4].
AFFORDABILITY	The cost of emergency services and care, relative to patient's ability to pay (cost to access initial service, cost of individual services specific to emergency, overall emergency cost)[4].
ACCOMMODATION	The way emergency services are organised (time of operation, level of training and services able to be rendered) relative to a patient's need[4].
ACCEPTABILITY	Relationship between a patient's individual belief system and larger sociocultural attributes and their willingness to seek emergency care[4].

METHODOLOGY

EMERGENCY and CRIMEDIM conducted a mixed-methods study from June to December 2024. Field data collection occurred in September and October 2024, followed by data analysis and report drafting from December 2024 to May 2025.

The research comprised four distinct phases, integrating both quantitative and qualitative methodologies. This comprehensive approach aimed to provide a detailed understanding of the challenges and opportunities in improving access to essential ECO services in Afghanistan.

- **Phase 1: Analysis of existing data** from EMERGENCY's health facilities revolving around access to ECO services.
- **Phase 2: Administration of questionnaires to patients, caretakers and EMERGENCY staff** to explore barriers and facilitators influencing access to ECO services.
- **Phase 3: In-depth interviews with directors, chief surgeons, chief gynaecologists, and other key stakeholders from district, provincial, and regional governmental hospitals** to gain insights into the state of Afghan ECO services from healthcare providers' perspectives.
- **Phase 4: Evaluation of Afghan regional and provincial hospitals** across 11 provinces using the Harmonized Health Facility Assessment (HHFA)[6] checklist produced by the World Health Organization (WHO) to map coordination and integration within the health system concerning ECO services.

The first phase focused on gathering demographic data and information on the disease burden of individuals accessing EMERGENCY's network of First Aid Posts (FAPs) and Primary Healthcare Centres (PHCs), who were subsequently referred to EMERGENCY hospitals or government-run hospitals for surgical, maternal or medical care. The analysis incorporated baseline historical trends and preliminary insights into the country's ECO needs.

In the second phase, the research team developed two questionnaires based on the study frameworks. One was designed for patients and their caregivers, while the other targeted key EMERGENCY staff. Both questionnaires were administered at EMERGENCY's facilities across 11 provinces, encompassing the FAPs and PHCs to capture perspectives from both urban and rural communities. The questionnaires assessed factors influencing patients' ability to seek, reach, receive and adhere to ECO care, with a particular focus on surgical care (including injuries, elective procedures and maternal care). They provided insights into barriers, delays, facilitators, affordability and the perceived quality of emergency care. To ensure accuracy and cultural relevance, the questionnaires were translated and thoroughly explained to selected surveyors. These surveyors, following initial training and mentorship, independently administered the questionnaires to patients and staff involved in surgical care within EMERGENCY's facilities.

In the third phase, the research team developed a semi-structured interview guide and conducted interviews with directors, chief surgeons and chief gynaecologists from district, provincial and regional governmental hospitals in the provinces where EMERGENCY operates. These interviews were facilitated with the support of EMERGENCY's staff in remote areas, broadening the study's scope and outreach. The interviews provided valuable information on the accessibility and availability of referral systems for emergency cases (including injuries and surgical, obstetric and medical emergencies) and explored the timeliness, capacity, safety and affordability of surgical care. This included assessments of general surgery, anaesthesia, obstetric care and the integration of services with primary care and community-level care. By capturing the perspectives of public service providers and stakeholders, the study identified specific requests and needs reflective of the complexities and diversity of local Afghan communities.

In the fourth phase, the research team adapted and implemented a simplified version of the WHO HHFA surgical tool in the same selected health facilities targeted in Phase 3. This tool was used to evaluate critical aspects of surgical care provision, including staff conditions, availability of essential supplies and structural readiness, categorised by the facility's level of care (primary, secondary or tertiary). The assessment specifically focused on the availability of Bellwether procedures[7] (i.e., emergency laparotomy, caesarean section and treatment of open fractures), as well as essential surgical procedures[2]. Data collected offered insights into surgical capacity, safety and affordability, while providing a deeper understanding of the third delay in accessing surgical care: receiving timely and appropriate treatment.

A descriptive analysis of health-related data from EMERGENCY was conducted using Excel and R Studio in January 2025. Questionnaire responses were entered into an Excel database and analysed with R Studio during the same period. Interview recordings were transcribed verbatim using the online platform Sonix, then imported into Atlas.ti for thematic analysis, which was carried out between November and December 2024. Following independent analyses of the findings from each phase, the results were synthesised to validate the conclusions and develop recommendations specifically tailored to the Afghan context.

This research received **ethical approval from the Afghanistan Institutional Review Board**, and all relevant ethical principles were strictly adhered to in the collection, storage and management of data across all phases of the study. The project was **officially endorsed by the Afghan Ministry of Public Health**.

STRENGTHS AND LIMITATIONS

This study was conducted using a rigorous scientific methodology and with full respect for the rights of participants. To inform future research, this section outlines key methodological considerations.

One limitation of this study is the inability to generalise the findings to the entire population of Afghanistan. The sample comprises individuals who accessed EMERGENCY's facilities, which may reflect an advantage over those who have never received any type of care. Consequently, the results likely underestimate the barriers to ECO care faced by the broader Afghan population. To mitigate sample selection bias, participants were asked about general barriers to accessing ECO care, not only those experienced when visiting EMERGENCY's facilities. Respondents were also encouraged to share obstacles faced by their family members or close friends. While efforts were made to minimise sample selection bias, it could not be eliminated. Nonetheless, data collection occurred in diverse locations, including provinces with varied historical, socio-economic and geographical contexts, as well as in both urban and rural areas. The mixed-methods approach was pivotal for data triangulation and validation, enabling a comprehensive understanding of access to care from multiple perspectives. Combining quantitative and qualitative methodologies helped overcome the limitations inherent in using either approach alone. Data triangulation was achieved by gathering insights from various perspectives, including hospital directors, healthcare workers and patients.

Furthermore, the reliance on established theoretical frameworks for data collection and interpretation ensures that the findings are comparable to those of other studies in Afghanistan or similar settings. This study successfully reached respondents in remote areas of Afghanistan, many of whom have been inaccessible to international researchers over the past decades. This broad geographic reach enhances the relevance of the findings to the wider Afghan population.

The involvement of EMERGENCY's dedicated local staff was crucial to the project's success, as they collected field data and provided regular updates to the research team. Notably, **the data collectors expressed a sense of empowerment and enthusiasm in contributing to the study, and patients reported feeling valued** as their voices were finally being heard. This collaborative effort underscores the **importance of local engagement in producing meaningful and impactful research**.

Francesco Pistilli

Francesco Pistilli

THE HEALTH SITUATION IN AFGHANISTAN

Afghanistan's health system has been severely impacted by more than four decades of war. For years, much of the country's resources have been directed to defence and military operations rather than to improving healthcare[8], to the extent that non-governmental organisations (NGOs) have provided more health services than the state[9].

The end of the conflict, and associated improvement in internal mobility, led to an **increase in the number of people accessing health services**. However, these health services – especially those in the most remote areas – often have inadequate or insufficient resources, lack essential equipment and supplies in relation to their catchment area, and are frequently housed in buildings not originally designed for medical use[10]. As a consequence of the inadequacy of lower-level care and the scattered distribution of healthcare facilities – which left **14.3 million people in need of health aid**[11] – patient overload is seen mainly in larger, urban hospitals. Furthermore, there is a **dearth of healthcare workers**. Many left the country following August 2021, worsening the widespread, chronic understaffing. The professionals who remained in the country are often insufficiently trained, especially in the management of non-communicable diseases and emergency cases[12].

From the perspective of patients, the impact of the economic crisis on access to care has been dire. **The costs of healthcare and transportation to healthcare facilities are currently the main barriers** associated with accessing care. Despite public healthcare facilities ostensibly being free of charge, patients are often required to pay for medicines and treatment in public hospitals. Consequently, patients are often forced to postpone care due to cost.
Access to basic health services is particularly challenging for women and girls, who over the past few years have been progressively excluded from public life. **Being female is one of the most common factors associated with decreased access to care** in Afghanistan, especially for pregnancy and maternal care. Among the restrictions, women and girls have been prevented from attending secondary schools and universities, which translates to an economic loss of at least 500 million USD over the last 12 months and is expected to have considerable direct and indirect impacts on the health of Afghans[13].

In recent decades, Afghanistan's disease burden has changed[12]. It was previously dominated by communicable diseases and high numbers of maternal and child deaths, but this pattern has since evolved into a triple disease burden of mortality to encompass non-communicable diseases (NCDs):

1. Despite the formal end of the conflict, **trauma care** remains a top priority in the country, as stated in the WHO report on trauma care services[14].
   From January to September 2023, inpatient cases for trauma amounted to 19,479 – over 70 a day – and included road traffic accidents (12,954), burns (3,856), gunshot wounds (1,652) and explosions (1,017).
   Unfortunately, although the Afghan health system was originally designed to facilitate effective referrals, in actuality just 20% of patients are transferred by ambulance to hospitals. In addition, the WHO estimated that conflict left around 800,000 Afghans (2.7% of the population) with a range of severe disabilities[15].

2. The **burden of NCDs** is steadily rising and represents the leading factor contributing to mortality in the country[16]. Despite their importance, they are still not included in the package of essential health services.
   The quality of care given for NCDs is inadequate[12], since there is limited availability of diagnostic tests and monitoring capabilities at the primary healthcare level. Private facilities are usually the only place where people can access specialist treatments, for which they must pay. There is also a lack of awareness among the population given that health education activities are very rarely implemented[12].

3. The lifetime risk of **maternal mortality** in Afghanistan is 1 in 33, significantly higher than the global average of 1 in 190[17]. In 2019, pregnancy complications and related procedures were responsible for 64.2% of deaths among girls and women aged 15–19 and 69.9% among those aged 20–24. This is due to many factors, among which the lack of clinics offering obstetric care and the lack of emergency transport or adequately equipped facilities in remote areas stand out. Moreover, access to sexual and reproductive health services is becoming increasingly difficult due to restrictions on women's mobility beyond their homes, compounding risks to their health and wellbeing[12].


Francesco Pistilli

THE AFGHAN HEALTHCARE SYSTEM AND GLOBAL FRAMEWORKS FOR ECO SERVICES

By 2002, Afghanistan had some of the poorest health indicators of any country in the world, particularly in the areas of infant, child and maternal mortality. Under these circumstances, **continued support from NGOs** has been crucial to maintaining the health system and indispensable for the delivery of basic health services. In an attempt to centrally coordinate the multitude of services offered by NGOs and to maintain provision of adequate health services for the Afghan population - especially in remote and isolated areas - a reform of the Afghan healthcare system was begun in 2003 and revised at later stages[18].

The reforms aimed to expand both the quality and coverage of health services, ultimately providing equal access to care in both rural and urban areas despite widespread limitations in infrastructure.
A standardised package of primary and curative services (Basic Package of Health Services, BPHS) at the primary and secondary levels was released.

In 2005, the Ministry of Public Health complemented the BPHS with an **Essential Package of Hospital Services (EPHS), a standardised package of essential services according to each hospital's type, size and catchment area**. NGOs were contracted by the Ministry of Public Health to deliver both BPHS and EPHS, seeking to make the provision of services more uniform among the many healthcare providers and to strengthen cooperative referral mechanisms between facilities at different levels under the leadership of the Ministry.

Since Afghanistan embarked on these reforms, **the BPHS and EPHS have been the cornerstones of the health sector.** Although the BPHS was meant to be reviewed every 3–4 years, it has not been updated since 2010, despite epidemiological changes and an evolving disease burden in the country[16].
In 2019, the Ministry of Public Health and its partners developed **integrated package of essential health services (IPEHS)** to streamline, integrate and update the BPHS and EPHS. Unfortunately, the IPEHS has never been implemented.

Most development financing was paused following the political transition in August 2021, including for the health sector, thus limiting the provision of basic services. Donors and other partners managed to avert a complete collapse of the BPHS/EPHS system by channelling emergency funding through UN agencies to continue to allow the contracting of NGOs. Following this phase, NGOs were contracted through the *Health Emergency Response (HER) project*, funded by the World Bank and with UNICEF as implementing partner.

Recently, the **Health Sector Transition Strategy 2023–2025**[16] (HSTS) was developed collaboratively by Afghanistan's Ministry of Public Health alongside WHO, UNICEF, ICRC and local implementing partners. The strategy aims to reduce avoidable morbidity and mortality in the short- to medium-term by expanding the coverage and quality of health services while strengthening the resilience of the health system. The strategy prioritises the inclusion of ECO care in the essential health services package.
It underscores the need to expand service coverage to underserved regions and promote cross-sector collaboration for sustained progress in Afghan health.

This focus aligns with the **76th World Health Assembly Resolution**[19] on integrated ECO care for universal health coverage (UHC) and health emergency protection. The resolution calls for universal, free-of-charge access to ECO services, the integration of ECO care into essential health service packages and the adoption of a people-centred approach linking communities, primary care and surgical care systems. It also emphasises robust healthcare worker training and the strengthening of research initiatives.
This approach supports the vision of the **Lancet Commission on Global Surgery**[5], which advocates for surgical, anaesthesia and obstetric care, including operative, perioperative, and non-operative management, as a fundamental component of resilient health systems.
The Commission emphasises the inclusion of surgical care in essential health service packages, recognising its critical role in achieving UHC and enhancing health system resilience.

Giulio Piscitelli

FROM THE 2022 REPORT

KEY FINDINGS

In recent years, EMERGENCY has adapted its humanitarian intervention to address the evolving needs of the Afghan health system. Building on the findings of a comprehensive research study conducted in 2022, EMERGENCY has leveraged data-driven insights to inform its approach. The study[12] revealed several key trends influencing access to care, which have guided the organisation's efforts to strengthen trauma care and address NCDs at the primary care level, while promoting collaboration with all relevant stakeholders.

The research[12] highlighted that, while security conditions in many areas have improved, economic instability and systemic healthcare challenges have created new barriers to care. Among the key findings:

1 **TRAUMA CARE REMAINS ESSENTIAL:** Despite the cessation of active conflict, trauma remains a major healthcare priority. Patients continue to require care for injuries stemming from road traffic accidents, falls and violence, reflecting the legacy of decades of instability.

2 **RISING BURDEN OF NCDS:** Afghanistan's evolving health profile underscores the importance of addressing chronic diseases such as diabetes, hypertension and mental health conditions, which have long been neglected due to the focus on acute care.

3 **CAPACITY-BUILDING AT ALL LEVELS:** Training for healthcare workers across all levels of the health system emerged as a pressing need, both to address skill gaps and to mitigate the effects of 'brain drain,' which has worsened since 2021.

4 **STRENGTHENING SEXUAL AND REPRODUCTIVE HEALTH (SRH):** Access to SRH services, particularly maternal care, remains a challenge due to systemic and societal barriers. Afghan women and girls face numerous obstacles, including mobility restrictions, economic constraints and their progressive exclusion from public life.

EMERGENCY'S STRATEGY AFTER 2021

STRATEGY

In response to these findings, EMERGENCY has launched a multi-pronged strategy aimed at strengthening Afghanistan's health system while continuing to deliver high-quality care in line with its principles and standards of care.
The bulk of this strategy is:

1 **PRIORITISING TRAUMA CARE:** While focusing on systemic changes, EMERGENCY remains committed to its core expertise in trauma and surgical care. Facilities such as the Surgical Centres in Kabul and Lashkar-Gah continue to provide life-saving treatment for trauma patients, ensuring that victims of violence, road accidents and other injuries receive the care they need.

2 **INVESTING IN TRAINING:** Along with the provision of care, training is a core pillar of EMERGENCY's strategy. EMERGENCY is developing targeted programmes for healthcare workers, from community health workers to surgery, anaesthesia, gynaecology and paediatrics residents in close collaboration with Ministry of Public Health. These programmes focus on both technical skills and broader capacity-building, such as health system management and patient-centred care.

3 **STRENGTHENING PRIMARY CARE FACILITIES:** Recognising the need for a more resilient and integrated health system, EMERGENCY has initiated a comprehensive review of its primary care facilities to determine which remain operationally and strategically relevant in the post-war context. A critical component of this strategy is improving the integration between primary care facilities and hospitals, as well as fostering stronger collaboration with all relevant stakeholders. This whole-of-health-system approach is essential for creating a seamless continuum of care that meets the diverse needs of Afghan communities.

4 **EXPANDING NCD AND SRH CARE:** EMERGENCY is working to expand its services beyond acute care. EMERGENCY is equipping its primary care facilities to better handle the diagnosis, treatment and management of NCDs and to ensure consistent maternal and reproductive healthcare, through the deployment of ultrasound machines and proper referral paths to the hospital level. This shift also involves raising community awareness and promoting health education to encourage early detection and treatment.

Laura Salvinelli

EMERGENCY'S ACTIVITY IN AFGHANISTAN: DATA FROM HEALTH FACILITIES

This section aims to **describe the burden of injuries in the regions of Afghanistan served by the three EMERGENCY hospitals** in Anabah, Kabul and Lashkar-Gah.
The analysis is based on monthly aggregated clinical records extracted from the databases of EMERGENCY's primary care facilities and hospitals.

Aggregated secondary data were obtained on patient flows to EMERGENCY's FAPs and PHCs in the regions served by EMERGENCY's hospitals in Anabah, Kabul and Lashkar-Gah. Aggregated secondary data were obtained on patient flows from EMERGENCY's FAPs and PHCs to EMERGENCY's hospitals in Anabah, Kabul and Lashkar-Gah and other hospitals. The data encompassed several key variables, including the **number of patients treated, referral patterns and destinations, outcomes, demographic details** (age and gender).

The analysis focuses on data collected during the years 2022 and 2023. Data from 2021 were excluded to minimise confounding effects associated with the change of government in August 2021, ensuring a more accurate representation of the healthcare landscape in the current post-conflict context.

Giulio Piscitelli

BURDEN OF INJURIES

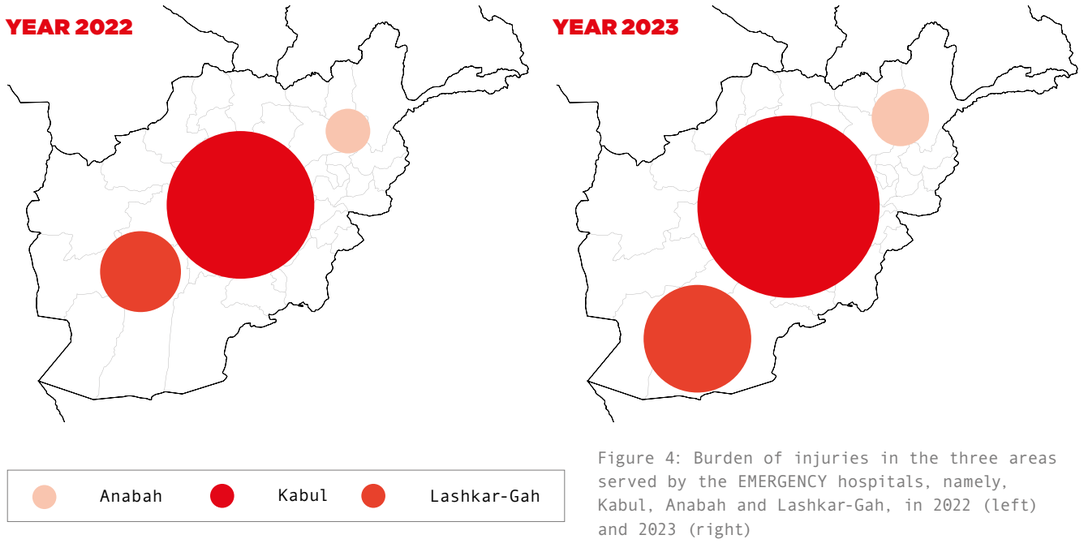
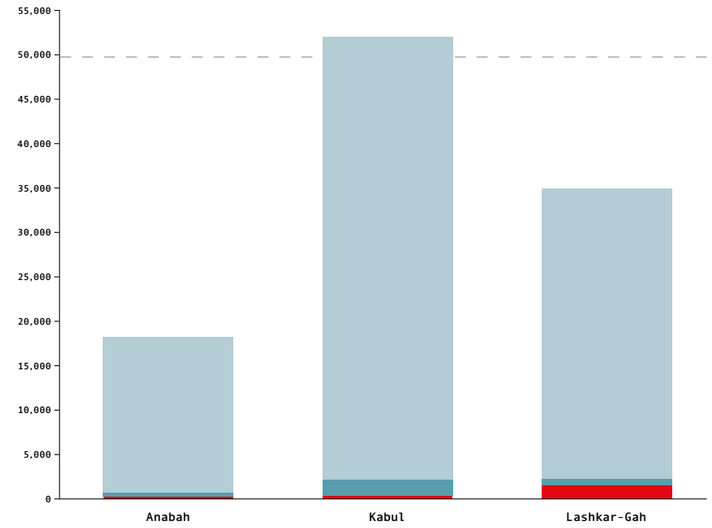


Figure 4: Burden of injuries in the three areas served by the EMERGENCY hospitals, namely, Kabul, Anabah and Lashkar-Gah, in 2022 (left) and 2023 (right)

REFERRALS

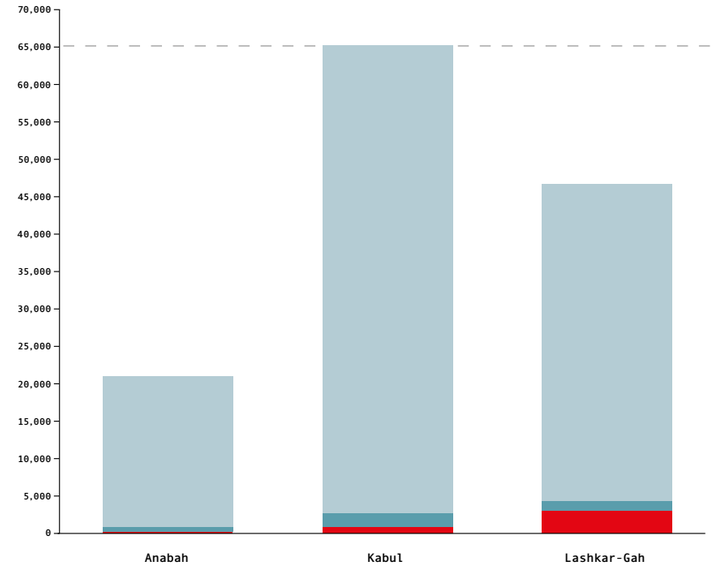
EMERGENCY's FAPs provided a total of 584,648 consultations in 2022. Of the 105,223 injuries received, 123 (0.12%) died at the clinics, 5,270 (5%) were referred to higher levels of care, and **99,953 (94.9%) were treated on-site**. The Kabul region reported the highest number of trauma cases (51,988), followed by Lashkar-Gah (34,984) and Anabah (18,251). In 2023, EMERGENCY's FAPs handled a total of 599,426 consultations, with 124,858 cases attributed to injuries. Of all the injured cases, 116 (0.09%) deaths were recorded, 8,009 (6.4%) were referred to higher levels of care, and **116,849 (93.6%) were treated on-site**. As in 2022, the FAPs in the Kabul region admitted the largest number of injured patients (62,453), followed by Lashkar-Gah (42,346) and Anabah (20,059).



TRAUMA CASES AT FAPs IN YEAR 2022

- Referred injuries to EMERGENCY
- Referred injuries to other hospitals
- Not referred injuries

Chart 1: The chart depicts the number of trauma patients that presented with injuries and their referral patterns in the three assessed regions in 2022.



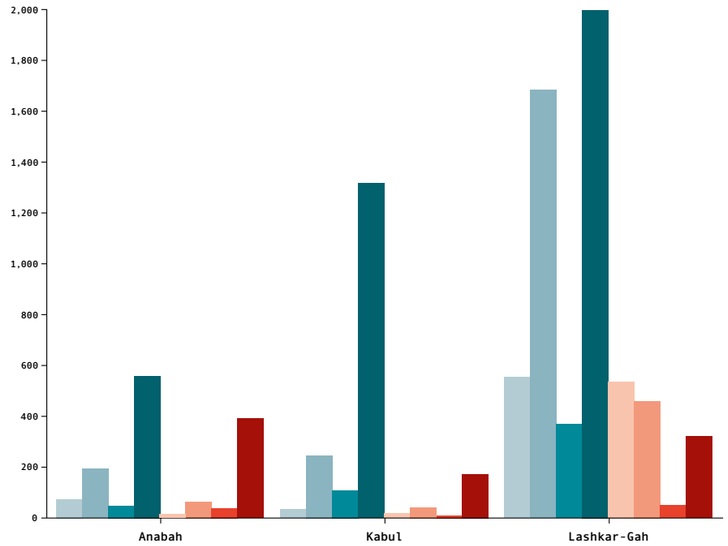
TRAUMA CASES AT FAPs IN YEAR 2023

- Referred injuries to EMERGENCY
- Referred injuries to other hospitals
- Not referred injuries

Chart 2: The chart depicts the number of trauma patients that presented with injuries and their referral patterns in the three assessed regions in 2023.

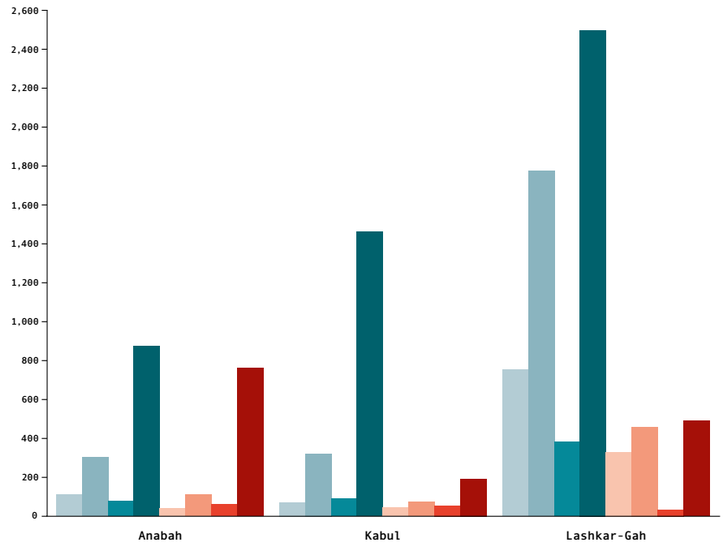
HOSPITALS

EMERGENCY's hospitals in Anabah, Kabul and Lashkar-Gah collectively admitted 9,311 patients in 2022 and 11,409 in 2023.
In both 2022 and 2023, the three hospitals recorded significantly **higher trauma admissions among male patients, especially adults over 18 years of age**. This pattern is most evident in Kabul and Lashkar-Gah, **suggesting greater exposure of men to violence or injury-related risks**. Lashkar-Gah also reported a high number of paediatric admissions, particularly among children aged 6–14, pointing to **persistent vulnerabilities and risky exposures in younger populations**. These trends highlight the **ongoing burden of violence and trauma across age groups** and underscore the importance of ensuring adequate trauma care capacity tailored to local needs.



TRAUMA PATIENTS ADMITTED AT HOSPITALS BY AGE IN 2022

- Children 0-5 years old
- Children 6-14 year old
- Boys 15-17 years old
- Men > 18 years old
- Children 0-5 years old
- Children 6-14 year old
- Girls 15-17 years old
- Women > 18 years old



TRAUMA PATIENTS ADMITTED AT HOSPITALS BY AGE IN 2023

- Children 0-5 years old
- Children 6-14 year old
- Boys 15-17 years old
- Men > 18 years old
- Children 0-5 years old
- Children 6-14 year old
- Girls 15-17 years old
- Women > 18 years old

Chart 3 and 4: The table depicts the number of injured individuals treated in the three EMERGENCY hospitals, disaggregated by age and gender in 2022 and 2023.

ACCESS TO ECO CARE FROM THE POINT OF VIEW OF PATIENTS

KEY FINDINGS

1 **WIDESPREAD DIFFICULTY ACCESSING ECO CARE:** Over 61% of respondents described access to emergency, surgical, and maternal care as either "Difficult" or "Very difficult". This figure was even higher among women. Women reported greater barriers in both hospitals and primary care settings, with 73.3% of women in primary care describing access as challenging, versus 61.4% of men.

2 **TRANSPORTATION AND DISTANCE:** 79.1% of respondents had to travel to another city, province, or even country for surgical care. For maternal care, this was true for 76.2% of respondents. Walking and private cars were the most common transport means. Public ambulances were rarely used, highlighting infrastructure gaps with public emergency services.

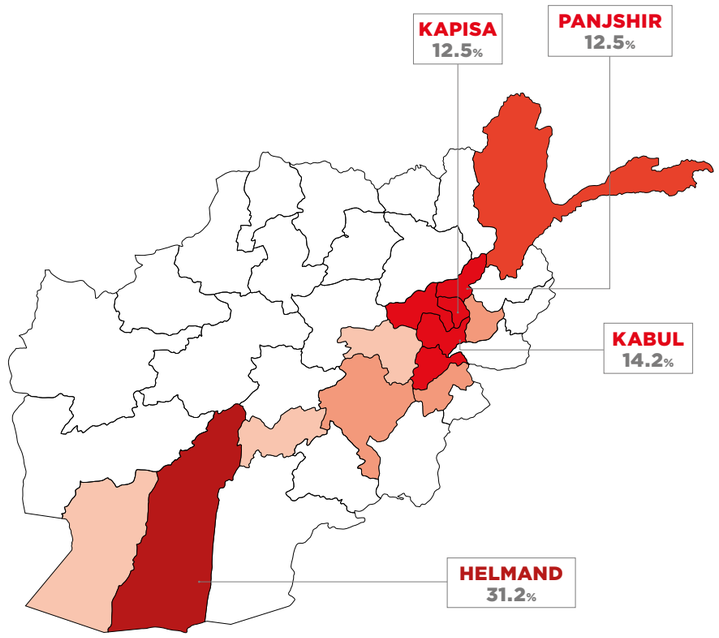
3 **FINANCIAL BARRIERS:** 57.5% of participants sometimes faced financial difficulties when seeking ECO care, and 54.4% reported general problems paying for healthcare. Most considered ECO services expensive or very expensive. 66% had to borrow money or sell belongings to cover emergency care costs.

4 **DELAYS AND MISSED CARE FOR MANY:** About 40.1% of respondents delayed seeking care, primarily due to cost and distance. Furthermore, almost 30% of respondents reported that a family member or friend suffered a disability due to delayed or inaccessible ECO care, and 5.5% reported a death.

5 **INFORMATION GAPS:** Nearly 45% of respondents found it difficult or were unsure about how to find emergency health information. Only 32% knew of an emergency number for transport. Those with no education were significantly less likely to understand or access health services.

In total, 1,600 questionnaires were completed by patients – or by people accompanying them – at EMERGENCY's facilities. After 49 invalid responses were excluded, **the final sample size for the questionnaire was 1,551**.
Patients were asked about **general barriers to access to ECO care**, not only at EMERGENCY's facilities, and about obstacles that their family members or close friends may also have experienced.
Respondents were asked general questions on access to ECO care, as well as questions addressing **access to emergency, surgical and maternal services** in order to assess specific gaps and barriers. **All participants were asked questions on maternal care**; this was to include perceptions on barriers and consider possibile differences between women and their men family members.
This chapter follows the questionnaire structure as described above.

PROFILE OF PARTICIPANTS

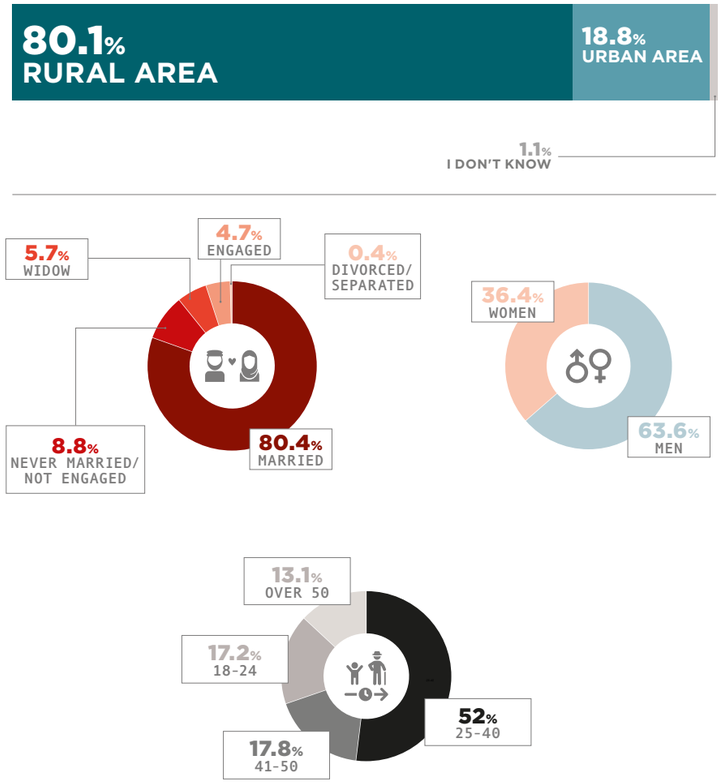


ORIGIN

The participants came from 13 different provinces, the most common being Helmand (31.2%), Kabul (14.2%), Kapisa (12.5%), and Panjshir (12.5%). 80% lived in rural areas.

DISTRIBUTION OF PARTICIPANTS BY PROVINCE

1 — 484



DISTRIBUTION OF PARTICIPANTS BY RESIDENCE (AREAS)

Rural area
I don't know
Urban area

GENDER , AGE AND MARITAL STATUS

The majority of participants were men (63.6%), while a substantial proportion (36.4%) were women. Additionally, the vast majority (80.4%) reported being married.

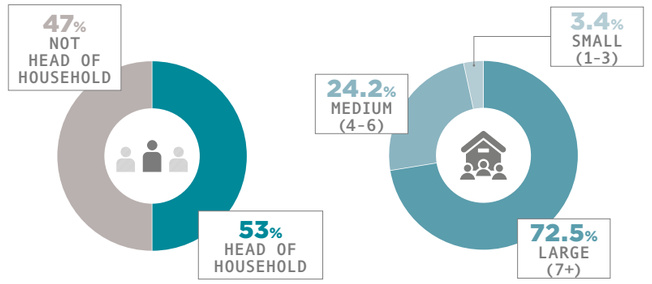
Most participants were between 18 and 40 years old, with a substantial proportion in the 25-40 age range.

EDUCATION

The largest proportion of participants had no formal education (34.9%), followed by those with an undergraduate degree (21.4%) and primary education (18.2%). Graduate-level participants accounted for 10.1%, while lower and higher secondary education levels were less common.

EMPLOYMENT

The most common employment status among participants was subsistence farming, with over a quarter (27.2%) engaged in this occupation.
A considerable proportion were self-employed (18.7%) or unemployed (18.4%). Day labourers accounted for 11%, while unpaid family workers represented 9.1% of the sample.



HOUSEHOLD STATUS, CATEGORY

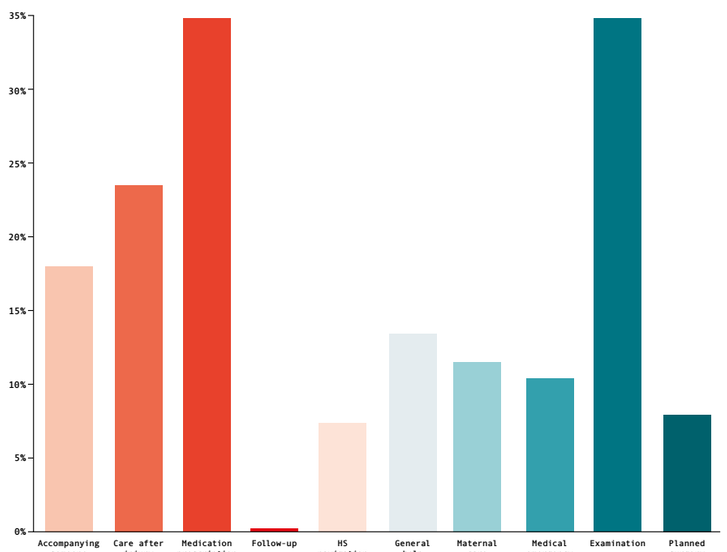
A slight majority of respondents (53%) identified as the head of their household, while 47% reported that they were not. The average household size among respondents was 10.3 people. The most common household size was 8 people.

REASON FOR SEEKING CARE

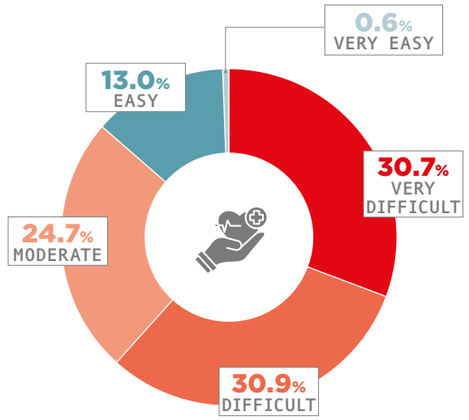
The most common reasons for seeking care were medical examinations (34.8%) and medication prescriptions (34.8%). Emergency-related needs were also frequent, with 23.5% of respondents requiring care following an injury or trauma. Non-urgent medical visits were also prevalent, with 18% of respondents accompanying someone to the facility and 13.4% seeking general assistance. Maternal or pregnancy-related care was cited by 11.5% of participants, while 10.4% sought medical attention for a non-traumatic emergency. Less commonly reported reasons included planned surgical procedures (7.9%), navigation of the healthcare system (7.4%) and follow-up care (0.2%).

The majority of respondents (67.8%) sought care for a single reason, while nearly one-third (32.4%) reported multiple reasons for their visit.
This suggests that most healthcare visits were driven by a primary concern, but a substantial proportion of patients had multiple healthcare needs during the same visit.

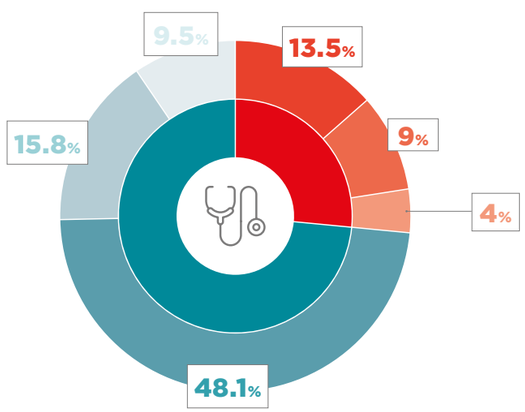
REASONS FOR SEEKING CARE



ACCESS TO EMERGENCY, SURGICAL AND MATERNAL CARE



When disaggregating by gender, **women were more likely to report greater difficulties accessing care compared to men**: 68.8% of women respondents rated access as "Difficult" or "Very difficult," while 57.8% of men respondents reported similar difficulties (29.8% and 28%, respectively). Men reported moderate ease in accessing care in 28.4% of cases, compared to 18.2% of women.



ACCESS IN 2023

The data reveal that access to emergency, surgical and maternal care posed significant challenges for many respondents: over 61% of participants reported experiencing difficulty accessing care, with 30.9% indicating it was "Difficult" and 30.7% describing it as "Very difficult".

DISAGGREGATION OF ECO CARE BY FACILITY TYPE

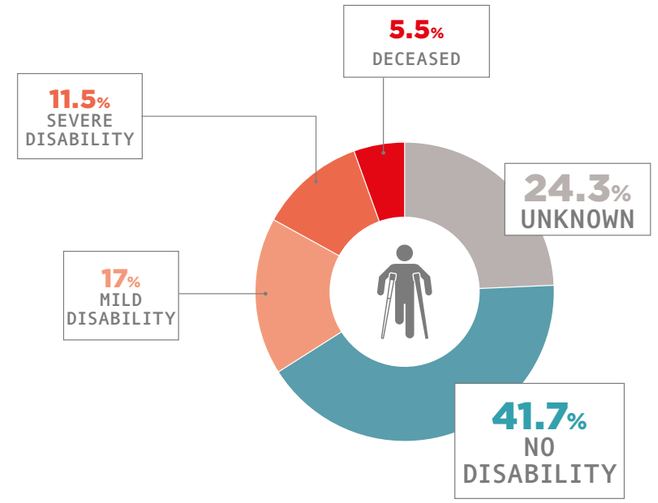
Overall, respondents perceived greater difficulties in accessing ECO care at primary care level than at hospitals, possibly due to the limited availability of such services in primary care settings.

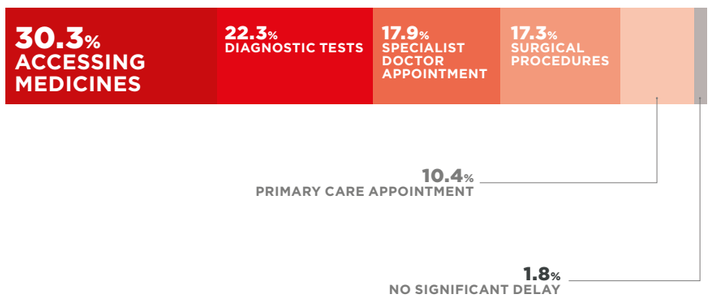
- Hospital
- Challenging
- Moderate
- Manageable
- Primary care
- Challenging
- Moderate
- Manageable

INTERACTION BETWEEN FACILITY TYPE, GENDER AND EASE OF ECO CARE

When disaggregating the **perceived ease of access to ECO care by gender and facility type**, data show that **women reported more difficulties** in both hospital and primary care settings. Among women attending hospitals, 56.3% found access to care challenging, compared to 47.6% of men.
The difference was even larger in primary care facilities, where 73.3% of women rated access as challenging, compared to 61.4% of men. The association between facility type and perceived ease of access to ECO care was statistically significant for both men and women. However, the effect size was larger for women than for men, suggesting that **facility type played a stronger role in shaping women's access to care**.

CONSEQUENCES OF A LACK OF ECO CARE





A significant portion of respondents reported delays in accessing various healthcare services in the past year. **The most common delay was in obtaining medicines, affecting 30.3% of respondents**. Delays in accessing diagnostic tests were also prevalent, impacting 22.3%, followed by delays in surgical procedures (17.3%) and appointments with specialist doctors (17.9%). Primary healthcare appointments saw delays for 10.4% of respondents. Notably, only 1.8% of participants reported experiencing no significant delays, underscoring widespread barriers to timely healthcare access.

DISABILITIES FROM LACK OF CARE

1 in 3 respondents reported disability or death as consequences of the inability to access emergency, surgical or maternal care for their family members or close friends.

DELAYS IN ACCESSING HEALTHCARE SERVICES

UNDERSTANDING HOW TO NAVIGATE THE HEALTH SYSTEM

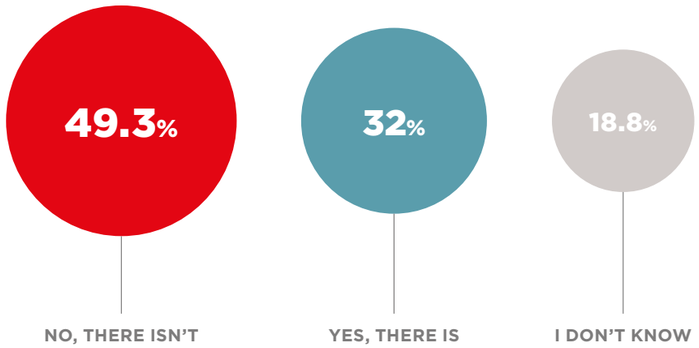
Awareness of emergency care numbers varies significantly across provinces. Urban areas like Kabul demonstrate higher levels of knowledge, while remote or rural provinces such as Badakhshan and Kapisa display limited awareness or higher uncertainty.

In Kabul, 65.9% of respondents knew that an emergency number exists, reflecting its urban setting and more developed healthcare infrastructure.

In Paktia, 95% of respondents were aware of the emergency number. In contrast, 97.4% of respondents in Badakhshan reported that no such number exists. Similarly in Kapisa, 65.6% believed no emergency number is available.

Provinces like Parwan, Kapisa and Logar showed high levels of uncertainty, with 33.5%, 31.8% and 22.2% of respondents, respectively, indicating they did not know whether an emergency number existed.

Helmand and Panjshir both presented a mixed scenario. In the former, 44.7% believed no emergency number exists, 39.2% were aware of one and 16.1% were unsure. In the latter, 54.9% stated no number exists, 33.2% were aware of one and 11.9% were uncertain.

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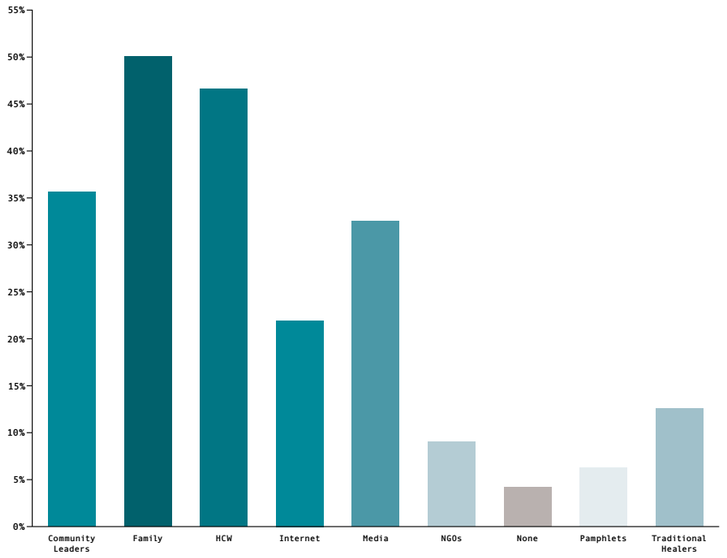
AWARENESS OF AVAILABILITY OF EMERGENCY NUMBER

Nearly half of the respondents (49.3%)reported that no emergency care number exists, while 32% indicated awareness of such a service. However,18.8% were unsure whether an emergency number was available.

AWARENESS OF AVAILABILITY OF EMERGENCY DEPARTMENTS

Among the respondents, **awareness concerning the availability of 24/7 emergency departments varied significantly across provinces in Afghanistan**. 82.6% of respondents from the Kabul area reported awareness of such facilities, Other provinces like Logar (88.3%), Maidan Wardak (87.5%), and Laghman (80.0%) also demonstrated high awareness.

Conversely, provinces such as Badakhshan (100%) and Kapisa (56.9%) reported that no such emergency departments were available, indicating potential gaps in emergency healthcare infrastructure or limited awareness among respondents. Provinces like Helmand (62.1%) and Panjshir (46.1%) reflected mixed responses.



Women respondents reported obtaining health information more frequently from healthcare workers (26.5%) than men (18.3%). Men respondents cited family members (24.5%), community leaders (18.1%) and media sources (15.2%) more often than women (20.2%, 13.2% and 14.3%, respectively). Additionally, 11.1% of men accessed information from the internet, compared to 8.2% of women, while NGOs were a more common source among women (5.9%) than men (3.1%).

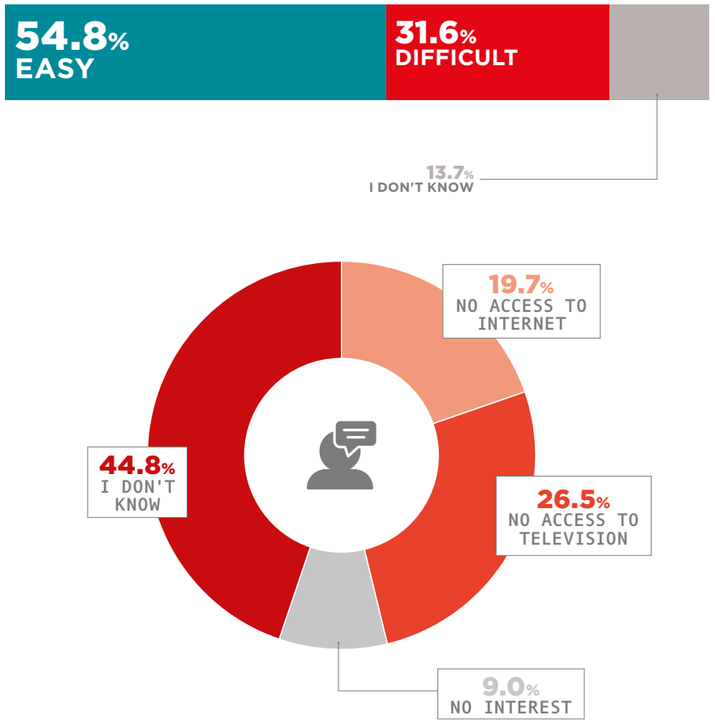

Laura Salvinelli

SOURCES OF HEALTH INFORMATION

Family members were the most common source of health information, cited by 50.1% of respondents, followed closely by healthcare workers (46.6%) and community leaders (35.6%). Media sources, such as radio or television, were referenced by 32.5% of respondents, while 22% relied on the internet. Less frequently cited sources included traditional healers (12.6%), NGOs (9.0%) and pamphlets (6.3%), while 4.2% of respondents reported having no source of health information.

HEALTH INFORMATION ON EMERGENCY AND SURGICAL CARE: ACCESSIBILITY OF INFORMATION

When asked whether information about health services in case of an emergency was easy to find, more than half of respondents (54.8%) reported that accessing health information during emergencies was easy. However, **a significant proportion (31.6%) found it difficult** to obtain such information, highlighting potential gaps in communication and dissemination of emergency healthcare resources. Additionally, 13.7% of respondents were unsure about the accessibility of health information, suggesting either limited engagement with healthcare services or a general lack of awareness about available resources. Among those who faced difficulties, **the most common barrier was not knowing where to find the information** (44.8%), followed by a lack of access to television (26.5%) and the internet (19.7%). A smaller group (9%) expressed no interest in seeking such information.




Francesco Pistilli

ACCESS AND BARRIERS TO HEALTH INFORMATION IN EMERGENCIES

HEALTH INFORMATION ON EMERGENCY AND SURGICAL CARE: ACCESSIBILITY OF INFORMATION BY GENDER AND EDUCATION

Women respondents reported finding health information easier to understand, with 57.1% indicating it was easy, compared to 53.4% of men respondents. Conversely, 33.6% of women and 30.5% of men found health information difficult to understand. Uncertainty was higher among men, with 16.2% indicating they didn't know whether health information was accessible, compared to 9.3% of women.

Those with higher education were more likely to report ease in accessing health information. Among graduates, 75% believed information is easy to be found, compared to 64.6% of those with higher secondary education and 67.1% of undergraduates. Conversely, **respondents with no education faced greater challenges**, with only 42% finding the information easy to access, while 38.3% reported difficulties. Similarly, among those with primary education, half (50.7%) found information easy to access, but over a third (34.9%) reported difficulties. The proportion of respondents who didn't know or felt unsure about the ease of understanding health information was higher in groups with lower educational attainment.
For example, 19.7% of those with no education were unsure, compared to only 6.4% of graduates. **These patterns suggest that individuals with higher education levels are more likely to report that health information is easy to find, while those with lower educational backgrounds encounter more difficulties in accessing relevant health resources**.

With regard to the comprehensibility of health information, a notable proportion of respondents (i.e., 13.8% of the women and 11.5% of the men) indicated uncertainty about the clarity of health information, while one in three stated that health information was difficult to understand.

PERCEPTION OF STAFF BEHAVIOUR

The majority of respondents (61.9%) reported having no complaints about the attitudes of emergency care providers, indicating a generally positive perception of care. Additionally, 17.7% felt mostly well treated, though they noted that there was room for improvement in provider attitudes.

Negative experiences were evenly reported by men (7.0%) and women (6.9%). Men more frequently expressed the need for improvement despite a majority in both groups reporting overall positive experiences.

These results highlight that while the majority of respondents had favourable experiences, a segment of the population continues to perceive the need for significant improvements in patient-provider interactions within emergency care settings.


Giulio Piscitelli

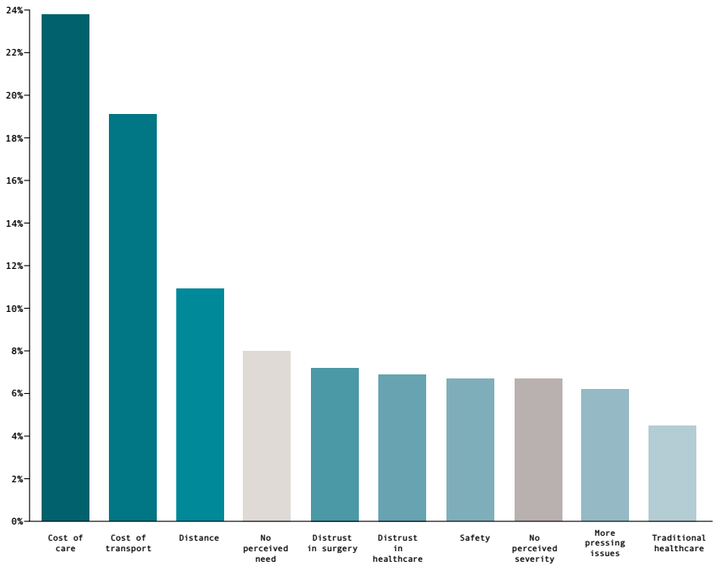
DELAYS IN SEEKING CARE

59.9% NO | **40.1%** YES

HAVE YOU EVER EXPERIENCED DELAY IN SEEKING CARE?

REASONS FOR DELAY

About 40.1% of respondents reported delaying care, while 59.9% did not experience any delays seeking care. Among those who did delay care, their **primary concerns included financial barriers**: 23.8% cited a lack of money to afford care, and 19.1% mentioned transportation costs. **Geographical challenges were also notable**, with 10.9% stating that health facilities were too far away. Other reasons included a lack of perceived need (8%), distrust in surgical procedures (7.2%), general distrust of the health system (6.9%) and safety concerns (6.7%). Traditional medicine and more pressing personal issues were less commonly cited, accounting for 4.5% and 6.2% of responses, respectively.

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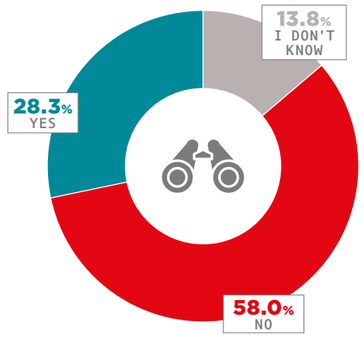
FEELING INSECURE OR SCARED TO SEEK CARE



HAVE YOU EVER FELT INSECURE OR SCARED TO SEEK CARE IN THE PAST YEAR?

Women reported feeling scared to seek care more frequently (35.4%) compared to men (24.3%). Conversely, men were more likely to report not feeling scared (63.7%) compared to women (47.9%). A slightly higher percentage of women (16.7%) indicated uncertainty ("I don't know") compared to men (12.0%). These results highlight that women may experience greater apprehension over seeking care than men.

INSECURITY WHEN SEEKING CARE: INFLUENCE OF PROVINCE

Sense of safety altered significantly according to province, emphasising the meaningful impact of geography on perceptions of safety when accessing healthcare services. Respondents from Kabul reported the highest levels of fear, with 47.9% expressing concerns about seeking emergency or surgical care. **In Helmand, 41.7% of respondents felt scared to seek care, reflecting persistent challenges in this region**. Similarly, Badakhshan showed considerable levels of fear, with 30.8% of participants expressing concerns about safety. In contrast, Kapisa and Laghman reported very low levels of fear, at 3.6% and 4%, respectively. Logar also reflected a more confident population, with 83.1% stating they did not feel scared to seek care, indicating relatively stable healthcare conditions or trust in the system. Finally, provinces such as Parwan and **Panjshir displayed notable levels of uncertainty**, suggesting mixed experiences regarding healthcare access and safety in these regions.

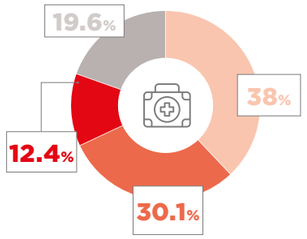
INSECURITY WHEN SEEKING CARE: INFLUENCE OF MARITAL STATUS

Married respondents were the largest group and showed relatively lower levels of fear compared to other groups, with 27.6% reporting feeling scared, while 59.9% did not. **Widowed individuals had the highest proportion of fear, with 42.5% reporting feeling scared to seek care, suggesting that this group may face specific vulnerabilities or barriers**. Those who were never married but engaged, or never married and not engaged, reported moderate levels of fear (25% and 27.6%, respectively). These findings highlight that widowed individuals appear to be at a higher risk of experiencing fear when accessing care, while married respondents may have more support or confidence in navigating the healthcare system.

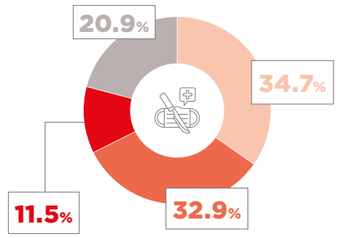
SEEKING CARE - DID YOU HAVE TO TRAVEL ?

The data highlight significant barriers faced by respondents when seeking emergency, surgical and maternal care. For emergency or urgent care, 38% of respondents had to travel to another city, 30.1% to another province, and 12.4% even to another country, while only 19.6% reported no issues accessing care. Similarly, for surgical care, 34.7% sought services in another city, 32.9% in another province and 11.5% abroad, with just 20.9% encountering no access problems. When it comes to maternal care, 35.8% travelled to another city, 30.6% to another province and 9.8% abroad, while 23.8% reported no issues.

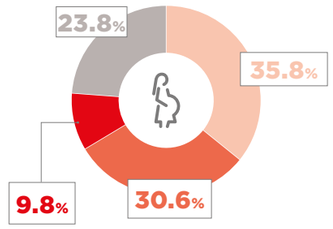
EMERGENCY CARE



SURGICAL CARE



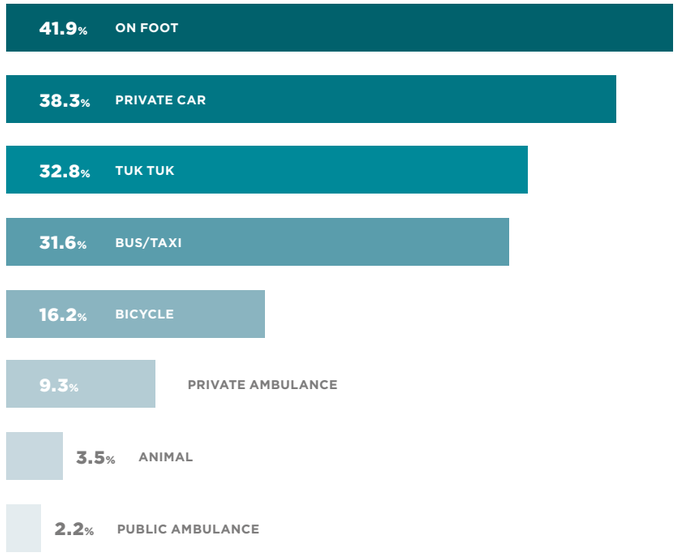
MATERNAL CARE



Pie charts 5, 6, 7: The charts depict the issues faced when seeking emergency/urgent care (left), surgical care (right) and maternal care (below).

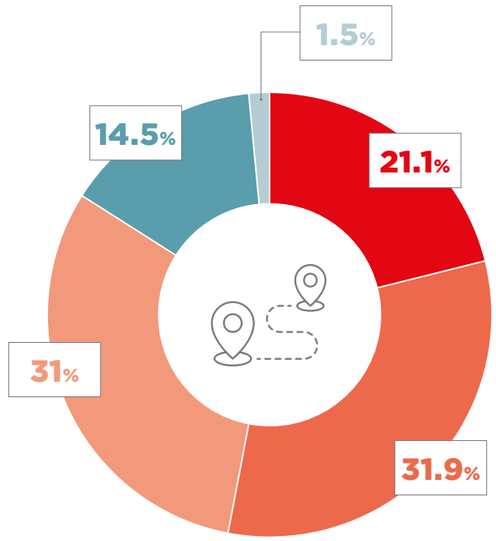
The reasons reported by respondents for not accessing nearby services highlight multiple barriers. The most common barrier was that the necessary service was not provided (28.7%), followed by high costs (17.7%) and lack of trust in care quality (16.5%). Other concerns included distrust in health workers (9.2%), security issues (8.6%) and a lack of perceived need (7.8%). Additionally, facility closures (7.0%) and staff behaviour (4.4%) were cited as contributing factors. These findings suggest that **both availability and trust in the healthcare system play a significant role in access to emergency care**.


Laura Salvinelli



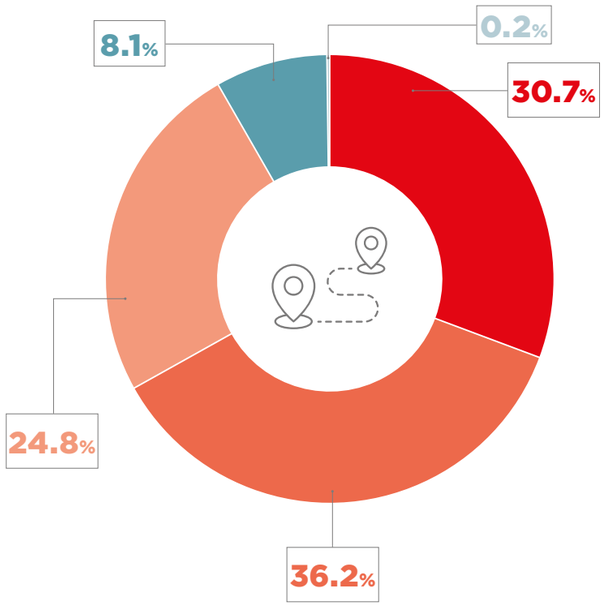
HOW DO PEOPLE USUALLY REACH HEALTH FACILITIES?

More than half of respondents perceived travelling to primary care as challenging (31.9%) or very challenging (21.1%). Conversely, 31% of participants described their travel experience as normal, while 14.5% found it easy. Respondents from urban areas reported significantly easier travel: 41.9% described it as normal, and 26.5% as easy, while only 8.6% found it very challenging. These differences suggest that transportation remains a considerable hurdle for Afghans living in rural areas.



TRAVELLING FROM HOME TO PRIMARY CARE

The majority of respondents reported using public transport (bus or taxi) to reach higher-level healthcare facilities, accounting for 46.9% of responses. **This was followed by walking combined with car usage (40%)**, indicating a reliance on mixed modes of transport and likely due to the unavailability of direct transport options. Tuk-tuks combined with walking were used by 21.1% of respondents, highlighting their significance in areas where more formal transportation options may be lacking. **Private ambulances were accessed by 11.2%, while public ambulances were accessed by only 7.4%**, suggesting limited availability or trust in emergency medical transport services. Less common modes of transportation included bicycles (8.3%), walking alone (17%) and animal-based transport (2.8%), reflecting the challenges faced by those in rural or remote areas with limited infrastructure.



TRAVELLING TO HOSPITAL

The difference in perception by area of residence is further confirmed at the hospital level, with respondents from rural areas reporting travel as "very challenging" or "challenging" more often than those from urban settings.

- Very challenging
- Challenging
- Normal
- Easy
- Very easy


Francesco Pistilli

FINANCIAL BARRIERS AND AFFORDABILITY

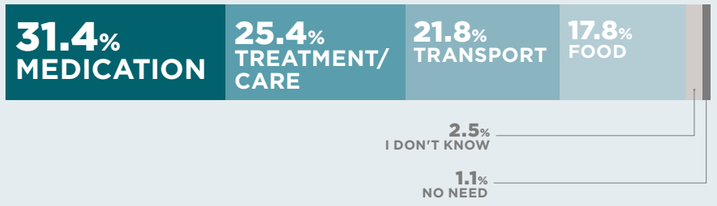
More than half of respondents (57.5%) reported sometimes experiencing financial difficulties in reaching ECO care facilities, which usually includes both travel costs and healthcare services payments. A smaller proportion faced these challenges rarely (17.1%), while regularly encountering financial difficulties was reported by 10.7% of participants. Notably, 14.7% of respondents stated they never experienced financial difficulties accessing these services. This highlights that **while financial barriers are common, they affect individuals to varying degrees**.

HAVE YOU EVER EXPERIENCED PROBLEMS PAYING FOR HEALTHCARE SERVICES?

Across all three types of care - emergency, surgical and maternal - respondents overwhelmingly perceived costs to be very expensive or expensive. Specifically, **47% of respondents rated emergency care as very expensive, with similar sentiments reflected for maternal (47.2%) and surgical care (47.3%)**.
A significant portion also categorised costs as expensive: 38.3% for emergency care, 37.5% for maternal care and 36.2% for surgical care. This indicates that **over 80% of respondents consistently found healthcare costs to be financially burdensome across all care types**.
In contrast, only a small minority perceived healthcare as inexpensive or very inexpensive, accounting for less than 2% of responses in all categories. Normal cost perceptions remained low as well, with about 9-10% of respondents finding emergency, surgical or maternal care costs to be reasonable.

ARE YOU WORRIED ABOUT THE ABILITY TO PAY FOR MEDICAL BILLS IN CASE OF AN EMERGENCY?

WHAT DID PEOPLE SPEND MOST ON?



POSTPONEMENT OF SURGICAL INTERVENTION

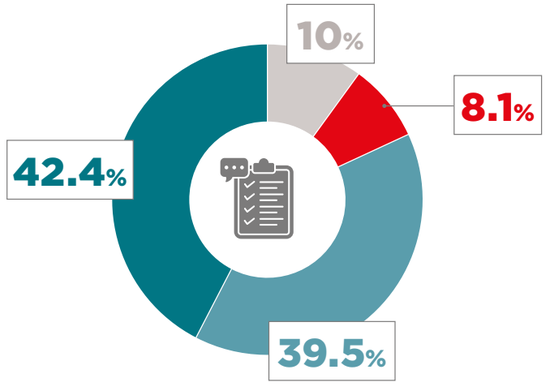
Nearly half of respondents (47.7%) reported that they never had to postpone an operation due to cost in the past year, suggesting that financial barriers did not affect their surgical care access. However, **26.4% postponed an operation once, while 14% delayed it twice, and 11.9% reported postponing operations three times or more**. These figures highlight that a significant portion of individuals face recurring financial obstacles when seeking surgical care.

A significant proportion of respondents reported being forced to borrow money or sell goods to afford healthcare services in the past year. The highest burden was observed for emergency care, with 66% of respondents indicating they had to resort to such measures, followed by 61.2% for surgical care and 58.2% for maternal care. Conversely, a smaller proportion of respondents were able to manage healthcare costs without borrowing or selling assets, with 25% for emergency care, 30.1% for surgical care and 32.6% for maternal care reporting no financial distress. Consistently across all care types, 8 to 9% responded with "I don't know," reflecting potential uncertainty or lack of awareness about the financial decisions within their households.

FOLLOW-UP CARE

The majority of respondents reported that follow-up visits were arranged after their operations, with 42.4% attending follow-ups at the same hospital where the operation was performed and 39.5% at a local PHC closer to their place of residence. However, **10% of respondents were unsure if a follow-up was arranged, and 8.1% indicated no follow-up**. When asked about their ability to attend the follow-up, 81.9% confirmed they were able, while 6.9% could not and 11.2% were uncertain. For those unable to attend, **the primary barriers were financial constraints, with 66.1% citing a lack of money for transportation**. A further 30.6% mentioned distance as a significant factor, and a small percentage faced family permission issues (3.2%).

WAS A FOLLOW UP VISIT ORGANISED AFTER THE OPERATION?

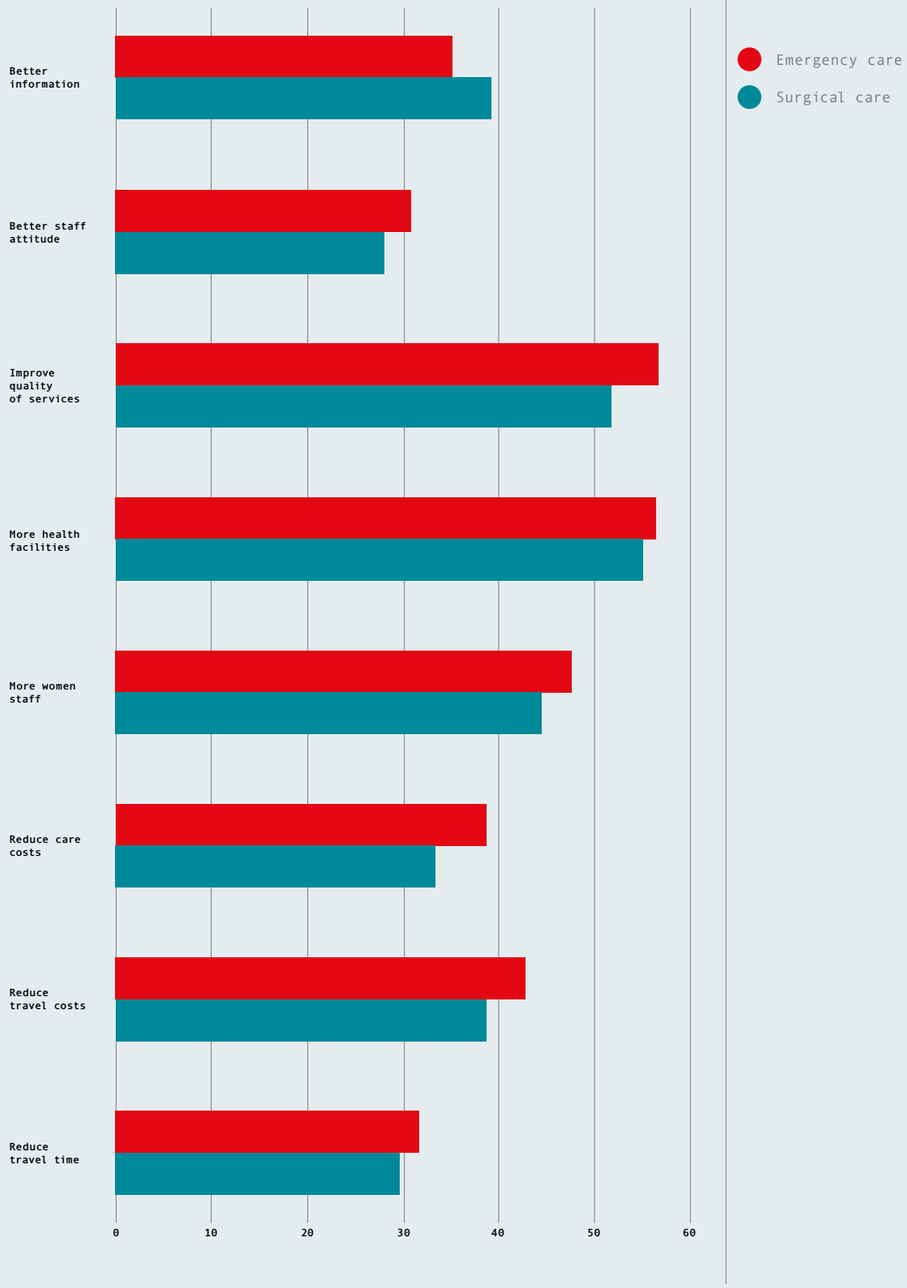


REASONS FOR NOT ATTENDING FOLLOW-UP VISITS


Stefanie Glinski

RECOMMENDATIONS FOR IMPROVING EMERGENCY AND SURGICAL CARE

The data highlight key areas where respondents believe access to **emergency** and **surgical care** can be improved. For **emergency care**, the most frequently suggested improvements were enhancing the **quality of services** (56.5%) and increasing the **number of health facilities** (56.3%). A significant proportion also emphasised the need for **more women staff** (47.5%) and reducing **travel costs** (42.7%). Similarly, in **surgical care**, the top suggestions were increasing the **number of health facilities** (54.9%) and improving the **quality of services** (51.6%). The need for **more women staff** (44.4%) and reducing **travel costs** (38.6%) were also prominent. Interestingly, while the patterns of suggested improvements were similar for both care types, slightly **more respondents prioritised improvements in emergency care**, particularly in areas like **quality of services** and **availability of women staff**.

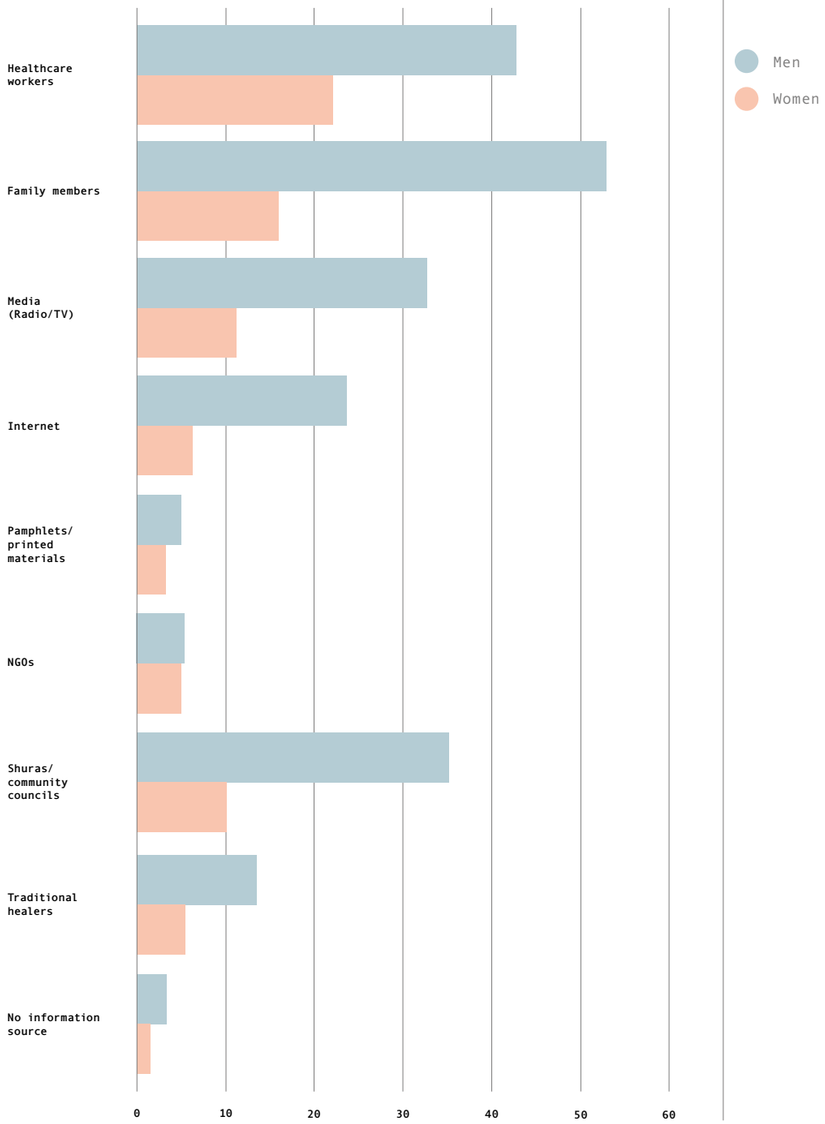


FOCUS ON MATERNAL CARE (ANALYSIS OF WOMEN AND MEN RESPONDENTS)

Both women and men respondents were surveyed regarding maternal care. **The inclusion of men participants was predicated upon the acknowledgment of their role as determinants within the household concerning the health and well-being of their women family members**. In particular, most men respondents (66.2%) identified as the husband of a pregnant woman.

ACCESSIBILITY OF INFORMATION ABOUT PREGNANCY

When asked about the main source of information about health services during pregnancy, **women respondents cited healthcare workers as the most frequent source** (22.1%). **Family members and media followed** with 15.9% and 11.2%, respectively. **A notable portion of respondents sought information from shuras/community councils** (10.1%) **and traditional healers** (5.4%), reflecting the influence of local community structures and traditional practices. Modern channels like the internet were used by 6.3%, and NGOs accounted for 5% of the information sources.



Among men respondents, the family was the most common source of information regarding pregnancy, cited by 52.9% of participants. **This was followed by healthcare workers** at 42.7%, and shuras/community councils at 35.1%. The media also played a significant role, with 32.7% of respondents relying on radio or television for pregnancy-related information. The internet was cited by 23.6%, while traditional healers accounted for 13.5% of the responses.

The findings highlight the **pivotal role of healthcare professionals and community networks in health information access, while also indicating disparities between women and men family members regarding reliance on media and technology**.

UNDERSTANDABILITY OF INFORMATION ABOUT PREGNANCY

More than half of women respondents (57.2%) reported finding health information during pregnancy easy to understand, while nearly one-third (31.9%) found it difficult and 10.9% were uncertain. Among those who experienced difficulties, the most common reason cited was not knowing where to find the information (50%), followed by the lack of access to television (27%) or the internet (12.7%).

A significant portion of men respondents (43.5%) reported that pregnancy-related health information is too complicated. Another 39.5% cited difficulty in understanding medical terms, highlighting a potential gap in health literacy. Additionally, 16.7% mentioned lack of time as a barrier to properly reading health information.

These findings suggest the **need for simplified, accessible and time-efficient health communication strategies to improve maternal health awareness**.

CONCERNS WHEN SEEKING MATERNAL CARE

The data present gender-based perspectives on concerns when seeking maternal care. **Among women respondents, 36.8% reported experiencing concerns that delayed their decision to seek maternal care**, while 63.2% stated they did not face such concerns. **Among men respondents, a lower proportion (27.7%) reported awareness of such concerns**, while 51.2% said no concerns delayed care. Additionally, 21.1% of men responded "I don't know," indicating a potential gap in awareness about maternal health challenges within their households or communities.

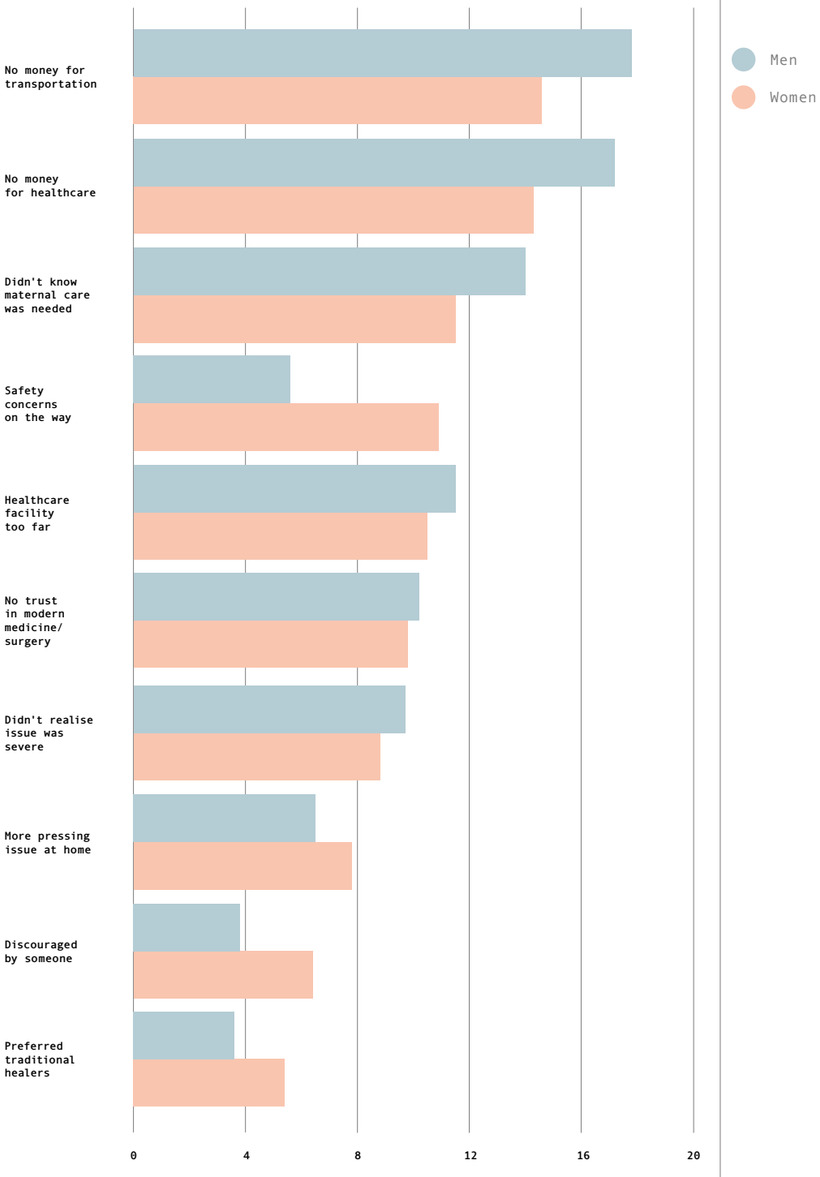
This contrast suggests that **women may experience and recognise these delays more directly, while men may be less aware**.

HAVE YOU EVER HAD ANY CONCERNS THAT DELAYED DECISION TO SEEK MATERNAL CARE?

HAVE YOU EVER HAD ANY CONCERNS THAT DELAYED DECISION TO SEEK MATERNAL CARE?

MAIN CONCERNS WHEN FEELING SCARED TO SEEK MATERNAL CARE

Among men respondents, 15.9% reported feeling scared or insecure when seeking maternal care for their family members or close friends, while 14.5% stated they did not know and a significant 69.6% reported no fear. Compared to men, **a higher proportion of women respondents (40.3%) expressed fear**, with fewer respondents (45.4%) stating they did not feel insecure and 14.3% unsure. These results highlight that a significant portion of women experience apprehension or barriers when accessing maternal healthcare services. **Financial constraints were the most cited concerns for both women and men respondents**, considering both transportation costs and medical expenses. **Lack of awareness of the need of maternal care ranked third, while safety concerns presented gender-based perspective**, with women citing it more times than men (10.9% and 5.6%, respectively).



CONSEQUENCES FOR PREGNANCIES

A higher proportion of women respondents (28.4%) reported having experienced or known of a reported loss of a baby during pregnancy compared to men respondents (17.1%). Notably, uncertainty was higher among women (22.7%) than men (16.4%), possibly reflecting a more complex or personal understanding of the issue.

Women respondents reported a higher awareness of reported maternal deaths during pregnancy cases (23.6%) compared to men respondents (13.4%). Meanwhile, a greater percentage of men (71.4%) stated that they did not experience maternal deaths compared to women (58.1%), indicating that men were less likely to report this data. The proportion of respondents who answered "I don't know" was slightly higher among women (18.3%) compared to men (15.2%). These figures highlight both the **prevalence of adverse maternal outcomes** and the **uncertainty many women face when reflecting on maternal health experiences**.

Overall, the gender-based differences suggest that women are more aware of maternal and foetal loss, likely due to their personal experiences, social networks and direct involvement in reproductive health matters. In contrast, men respondents were more likely to report not knowing or not having observed such cases.


Stefanie Glinski

DISABILITY DUE TO PREGNANCY REASONS

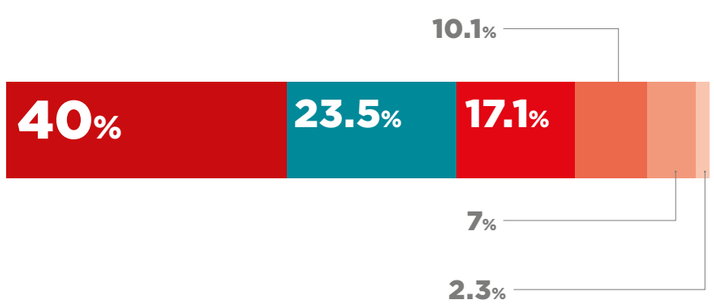
The majority of men respondents (40.1%) reported knowing no cases of disability due to the lack of maternal care, while 30.7% indicated awareness of moderate disability and 6.7% reported cases of severe disability.
A notable proportion (19.3%) responded that they did not know, reflecting some uncertainty or lack of direct knowledge on the issue.

Nearly half of women respondents (45.8%) reported no disability due to the lack of maternal care, while 22.4% experienced moderate disabilities, such as needing assistance with self-care or being limited in work activities. Severe disabilities, including bedridden conditions, were reported by 10% of respondents.

The discrepancies between men and women respondents suggest that women may have a closer connection to these experiences, potentially due to their direct involvement in maternal health or community networks. **Variations could also result from a different perception of disability between genders**.
The proportion of respondents reporting maternal deaths due to pregnancy-related reasons was slightly higher among women (5.0%) than men (3.3%), again suggesting that women may have more direct awareness of such cases.

MENSTRUAL HEALTH

The data reveals that **40% of women respondents reported being unable to access healthcare for menstrual problems due to lack of money for healthcare**, making it the most common barrier. 17.1% cited transportation costs as a limiting factor, while 10.1% faced issues related to the availability of facilities, personnel or equipment. A smaller proportion (7%) indicated they had no time to seek care, and 2.3% reported avoiding healthcare due to fear or lack of trust.
On a positive note, 23.5% of respondents stated that they regularly access healthcare for their menstrual issues.
Men respondents confirmed the perceptions of women with similar data.
These findings suggest that economic barriers are the primary obstacles to menstrual healthcare, with **availability and trust also playing a role**.



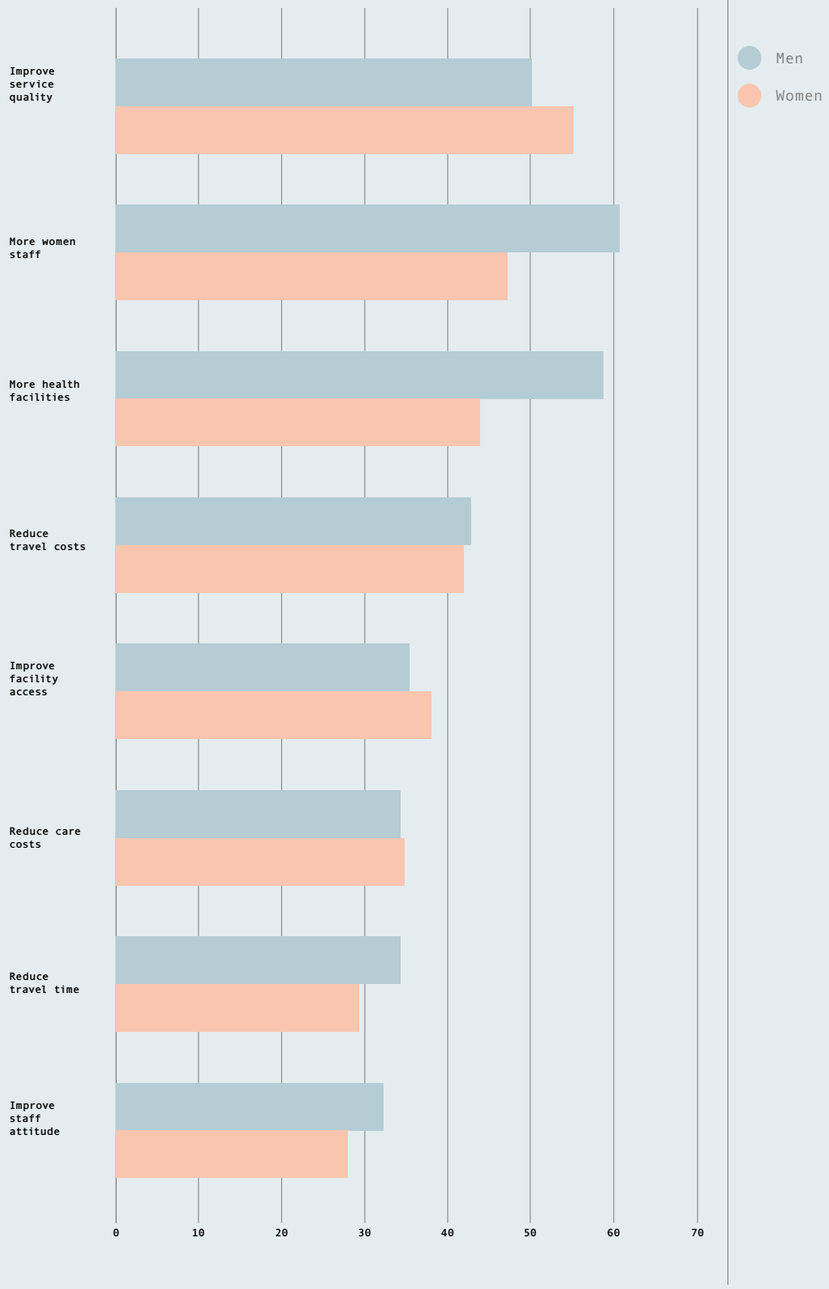
WERE YOU ABLE TO ACCESS HEALTHCARE FOR MENSTRUAL PROBLEMS?

- No, no money for healthcare
- Yes, I regularly have healthcare for my menstrual problems
- No, no money for transport
- No, not available (facility/personnel/equipment)
- No, no time
- No, because of fear/no trust


Giulio Piscitelli

HOW TO IMPROVE MATERNAL CARE

The majority of women respondents highlighted improving service quality (55.1%) as the most crucial factor for enhancing maternal health. This was followed by calls for more women staff (47.2%), more health facilities (43.9%) and reducing travel costs (41.9%), emphasising the importance of affordability and culturally sensitive care.
Men respondents recommended increasing women healthcare staff (60.7%), increasing the number of health facilities (58.8%), improving service quality (50.1%) and reducing travel costs (42.8%).
Improving information about facility access, reducing care costs and travel time, as well as improving staff attitudes, were also highlighted.
These findings indicate that **improving service quality, financial accessibility, and the availability of women staff and facilities are seen as crucial steps** to enhancing maternal healthcare.



Lynzy Billing

ACCESS TO ECO CARE FROM THE POINT OF VIEW OF LOCAL EMERGENCY STAFF

KEY FINDINGS

1 **GEOGRAPHIC AND FINANCIAL BARRIERS:** Many patients must travel long distances, sometimes to another city, province, or even country, to access ECO care. These journeys are often considered "challenging" and are compounded by the high costs of transportation, treatment and medications, which frequently lead to delaying or avoiding surgery due to an inability to pay.

2 **LIMITED AVAILABILITY AND AWARENESS OF EMERGENCY TRANSPORT:** Only a minority of staff report the existence of a known emergency number, and ambulance availability is perceived as insufficient in several provinces. In emergencies, patients often reach facilities autonomously.

3 **INCONSISTENT TRAINING IN EMERGENCY MANAGEMENT:** Healthcare workers are unevenly considered as adequately trained, with a portion of respondents being unsure about their capacity.

4 **FOCUS ON COMMUNITY AWARENESS:** Community understanding of what constitutes a medical emergency is inconsistent, indicating a need for stronger health education.

5 **PERSISTENT BARRIERS TO ACCESSING MATERNAL CARE:** Pregnancy complications were frequently cited as the outcomes of inadequate access to timely maternal care, alongside costs and travel burdens. There is a clear call for more women staff, better service quality and more facilities to improve maternal outcomes.

To complement the patient survey, a parallel questionnaire was given to a conveniently selected cohort of local EMERGENCY staff members, with the aim to elicit their perspectives on the obstacles encountered by their community in accessing ECO services in Afghanistan.

Respondents work at the facilities that were selected for the patient questionnaire. Selection criteria included geographical coverage, representing highly populated and/or remote areas, along with the workload of the facility. Attention was given to gender balance and minorities.

PROFILE OF RESPONDENTS

Of the 34 EMERGENCY staff members contacted, 32 returned the completed survey, with respondents having an average age of 38 years (ranging from 23 to 61 years). **The majority of respondents are men (n = 21), but women account for 34% of the sample**. Most respondents work in FAPs (n = 18), followed by hospitals (n = 11), clinics engaged in both first aid and primary care (n = 2), and PHCs (n = 1).

The respondents are **distributed across various provinces**, with the largest representation coming from Kabul (n = 10), followed by Logar (n = 4) and Helmand (n = 4). Other provinces are Kapisa (n = 3), Maidan Wardak (n = 2), Ghazni (n = 2), Laghman (n = 2), Paktia (n = 2), Panjshir (n = 2) and Parwan (n = 1).

Regarding marital status, 26 (81%) participants are married, while six (19%) are unmarried and not engaged. **A higher proportion of participants reside in rural areas** (n = 20) compared to urban areas (n = 12).

EMERGENCY AND CRITICAL CARE

A majority of respondents (n = 22; 71%) reported that patients never express feelings of insecurity or fear when seeking care. Conversely, a minority indicated that patients experience these feelings frequently.[2]

More than half (58%) of staff members reported encountering patients who needed to travel to another city to access the required emergency services, 32% knew of patients who had to travel to another province for emergency care and 19% reported patients that had to go to another country to receive the necessary treatment.[3]

When asked about the availability of an emergency care number for emergency transportation, 10 (31%) respondents confirmed its existence and indicated that patients are aware of it. Six (19%) respondents acknowledged the presence of the number but emphasised the need for increased community-level dissemination. Eleven (34%) respondents reported that no such number exists, with these respondents being located in the Ghazni, Kapisa, Laghman, Logar, Maidan Wardak and Panjshir provinces.

Most (72%) staff members reported that they have never encountered providers requesting money for transporting patients in emergency situations, nor for treatment (75%).

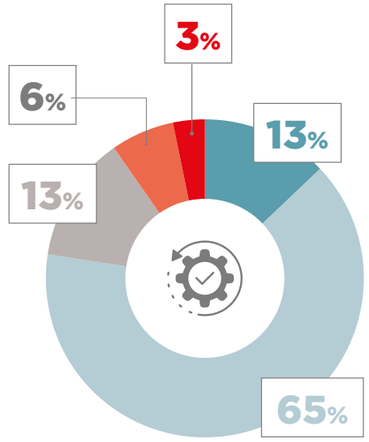
When asked about the presence of a hospital with a 24/7 emergency department in their district and awareness among patients, 27 (84%) staff members confirmed both aspects. Four (13%) respondents acknowledge the presence of the hospital but suggested that there should be greater dissemination of this information at the community level, with these respondents being located in the Ghazni, Kabul, Paktia and Parwan provinces. **Twenty (63%) staff members believe that healthcare workers in their community are adequately trained to manage emergency cases, while five (16%) reported that they do not consider healthcare workers to be sufficiently trained**, followed by seven (22%) respondents who are unsure.

Staff members were asked what would typically happen if someone had an urgent health issue in a family living in a remote district. **Twenty-five respondents out of 31 (81%) said that patients might use the car and bring the patient to the nearest facility**.

Only four (14%) respondents said that in an emergency situation patients would first seek treatment from a traditional healer; these respondents are located in the provinces of Kabul, Kapisa and Paktia.

Overall, **21 (66%) respondents believe members of their community understand what qualifies as an emergency condition, five (16%) do not, and six (19%) are unsure.** Additionally, 27 (84%) respondents confirm that people accept ambulances as an emergency means of transportation.


Stefanie Glinski



ARE YOU SATISFIED WITH THE EMERGENCY SERVICES AVAILABLE?

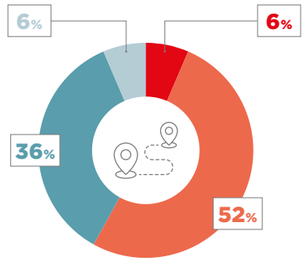
- Very satisfied
- Satisfied
- Neither satisfied nor unsatisfied
- Unsatisfied
- Very unsatisfied

OPERATIVE CARE

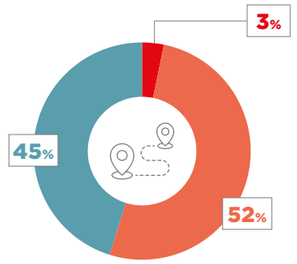
Twenty-one respondents reported that their patients delay seeking emergency and operative care due to various concerns, with six (21%) indicating that the delays occur frequently, 13 (45%) occasionally and two (7%) rarely. Out of these 21 respondents, 17 reported delays of surgical operations. The primary concern cited was the lack of financial means to afford care.

Forty-eight percent of staff members reported encountering patients who needed to travel to another city to access the necessary surgical services, **45% reported hearing of patients who had to travel to another province, and 24% indicated that patients had to go to another country**.

PRIMARY CARE



HOSPITAL



HOW DO YOU CONSIDER THE PATIENTS' JOURNEY FROM HOME TO A FACILITY TO RECEIVE SURGICAL CARE?

- Very challenging
- Challenging
- Normal
- Easy

The most common means of transportation for patients referred to a secondary or tertiary facility are: private car and public transport.

28 (93%) staff members consider surgical care expensive or very expensive and 18 (62%) reported always or frequently witnessing patients experiencing financial difficulties as a result of spending on ECO care. Notably, **25 out of 30 respondents said that patients would be very worried or worried about affording their medical bills if they underwent an operation**. It follows that nine respondents said that patients postpone surgery because they are not able to afford it often (32%) or occasionally (61%).
When asked to select what a person would spend the most money on for a surgical operation, respondents selected: medications, treatment, transportation and food.


Laura Salvinelli

According to the respondents, access to surgical care could be improved by increasing the number of health facilities (n = 26), reducing travel costs (n = 24), improving the quality of services (n = 24), deploying more women staff (n = 24), reducing care costs (n = 23), reducing travel time (n = 22), improving staff attitudes (n = 19) and increasing information on how to access care (n = 19).

MATERNAL CARE

In cases of pregnancy-related complications, staff members identified the primary sources of information for the population as health providers (n = 25), followed by family and/or friends (n = 22), social media and the internet (n = 17), NGOs (n = 15), mass media (n = 14), community leaders (n = 13) and pamphlets or books (n = 2). Overall, **26% of staff members reported encountering patients who needed to travel to another city to access maternal care, 37% reported hearing of patients who had to travel to another province, and 15% indicated that patients had to go to another country**. For three (10%) staff members, maternal care is very expensive, and for 22 (76%) it is expensive.

Ten (35%) staff members reported being aware of frequent maternal deaths due to inadequate access to timely and safe maternal care, while nine (31%) believed this occurs rarely. **Similarly, 16 (55%) staff members reported awareness of frequent foetal loss** due to barriers in accessing maternal care. Additionally, 10 out of 29 (35%) respondents indicated that women often suffer disabilities due to limited maternal healthcare access.

According to the respondents, access to maternal care could be improved by increasing the number of health facilities (n = 26), deploying more women staff (n = 25), reducing travel time (n = 23), reducing travel costs (n = 23), reducing care costs (n = 23), improving the quality of services (n = 23), improving staff attitude (n = 20) and increasing information on how to access care (n = 15).

Mathieu Willcocks

ACCESS TO ECO CARE FROM THE POINT OF VIEW OF HEALTHCARE PROFESSIONALS

KEY FINDINGS

1 SUBOPTIMAL CARE AT THE COMMUNITY LEVEL: Patients and their families face not only the financial strain of indirect costs, such as purchasing medications and arranging private transport, but also the emotional toll of navigating a system that fails to serve them adequately. Communities are left without an emergency care system that addresses their needs, as referrals are primarily limited to interhospital transfers.

2 GAPS IN EMERGENCY RESPONSE SYSTEMS: Ambulance systems are underdeveloped, with insufficient vehicles and poorly trained staff, particularly in rural areas. This leads to delays in patient transport and worsens outcomes, especially for trauma and obstetric emergencies.

3 INFRASTRUCTURAL CHALLENGES: Hospitals are severely strained by overcrowding and a lack of critical resources, such as diagnostic equipment, ICUs and adequately equipped operating theatres. Many facilities are also extremely old, and face unreliable water and electricity supplies, further compromising care delivery.

4 TRAINING AND CAPACITY DEFICITS: Healthcare workers lack adequate training in managing emergency, anaesthesia and critical care, and NCDs, particularly in geographically remote and underserved areas.

5 BARRIERS TO MATERNAL CARE: Limited health education and poor community engagement contribute to delays in seeking care for maternal conditions. This, combined with inadequate antenatal and emergency obstetric services at the primary care and hospital level, results in preventable complications and poor outcomes.

6 WEAK FOLLOW-UP SYSTEMS: Discharge and follow-up processes are poorly coordinated, with many patients failing to receive postoperative care in closer-to-home facilities. This gap significantly affects patient recovery and overall outcomes, especially in surgical and critical care cases.

7 SYSTEMIC AND STRUCTURAL ISSUES: Outdated guidelines, such as the Essential Package of Hospital Services, are misaligned with the current patient load and healthcare demands. Additionally, the lack of culturally appropriate spaces, particularly for women, and the absence of robust triage systems hinder effective service delivery.

Francesco Pistilli

Eleven in-depth interviews were conducted with twenty key informants, including directors, chief surgeons and chief gynaecologists, from district, provincial, and regional governmental hospitals across 11 provinces. Efforts were made to achieve a balanced gender representation, with women participants included in all but three interviews. Women's representation was typically ensured by the inclusion of a chief gynaecologist in the interview.

GENERAL OVERVIEW OF ECO SERVICE DELIVERY IN AFGHANISTAN

Interviewees described how ECO services are organised in each facility. They revealed major differences in infrastructure, capacity and staffing. These differences create a **fragmented system with bottlenecks at many levels**, making it harder to provide effective ECO care.

At the community level, there is a widespread **lack of awareness** about how to navigate the healthcare system, particularly for emergency cases. This is further exacerbated by a **lack of trust in closer-to-home facilities**, which are often ill-equipped to handle the growing healthcare demands following the end of the conflict. These facilities face critical limitations in infrastructure, expertise and resources, prompting many patients to seek treatment directly at higher-level hospitals. **Community-based services are scarce**, and remote areas frequently lack sufficient access to essential ECO care, especially in physically isolated areas.

Primary care facilities, expected to act as gatekeepers, face similar challenges. They are hindered by inadequate resources, including **poorly equipped and understaffed ambulance systems** that primarily serve as referral transport between hospitals. Referral pathways themselves are disorganised, and while innovations such as emergency hotlines and information-sharing networks are being piloted in Kabul, fragmentation becomes more pronounced in peripheral areas. The burden of NCDs frequently strains the system further, with patients often presenting to emergency rooms or operating theatres with advanced complications resulting **from undiagnosed or late-diagnosed conditions**. According to many interviewees, this frequently results in **delayed interventions, poorer outcomes and added pressure on an already overstretched health system**.

At the hospital level, key components of ECO care, such as emergency departments, operating theatres and intensive care units, are present but inconsistently available or varying in quality and capacity. District and provincial hospitals, in particular, struggle with **insufficient infrastructure and a shortage of specialised personnel**. Notably, hospitals across all levels appear to be relatively **well-prepared for mass casualty incidents**. This preparedness, shaped by years of conflict and frequent road traffic accidents, is supported by protocols and plans. Most interviewees demonstrated a clear understanding of these procedures when discussing their hospital's response to sudden influxes of patients during such emergencies. However, this emphasis on emergency preparedness often comes at the expense of routine care. Elective surgical cases are frequently delayed, underscoring a **system heavily oriented towards managing extraordinary events while remaining fragmented and inadequately equipped to address the everyday demands of patient care**.

BARRIERS AND FACILITATORS TO ACCESSING ECO CARE

The analysis of the interviews highlights several significant barriers faced by patients at the community level in accessing ECO services in Afghanistan, particularly by those living in rural and underserved areas. One prominent challenge is the **community's widespread unawareness of the meaning of a medical emergency**. Many individuals fail to recognise the severity of conditions in cases of acute abdominal pain or during pregnancies, leading to delays in seeking care. Many patients and their families are unaware of the services available, and they often turn to **local pharmacists**, who may lack a licence to practise, or informal providers, who are more accessible but lack the necessary expertise to manage emergencies effectively. Such a detour often worsens patients' conditions before they eventually seek professional medical help.

"First the people there don't have the information about what these cases are or where you should go. So they are going to the pharmacist and the pharmacist does [that] for the money. They are giving some things. So after that it becomes a complication. So they are coming to the hospitals. […] We have this kind of doctors that they are not doctors, but they act as doctors."

Chief Surgeon — Kabul

Economic challenges further compound these barriers. While many ECO services in hospitals are said to be free, indirect costs such as **transportation or costs for diagnostic tests** pose significant obstacles for many. Even the cost of fuel for private transport can deter families from seeking care. Interviewees frequently described instances where financial constraints have prevented patients from accessing timely medical services. Additionally, the reliance on out-of-pocket expenses to purchase medicines or consult local pharmacists adds to the economic burden, especially when these initial steps fail to resolve the problem, requiring patients to pursue hospital care at a later stage.

"There are communities or households according to my experience that can't even afford the money for the fuel or to get a car and to reach the hospital, how can they do during an emergency?"

Chief Surgeon — Kabul


Francesco Pistilli

Gender norms disproportionately affect women, who often face additional delays due to restrictive societal expectations and limited autonomy in decision-making, especially for emergency maternal conditions. Moreover, for cultural and social reasons, **women may hesitate to disclose their health issues until the situation becomes severe**, and in some cases, they are not believed by men family members.

"We have a lot of emergencies, but often there's no female doctor available, especially at night. Families sometimes prefer to wait until morning rather than let their daughters be seen by a male doctor."

Chief Gynaecologist —
Provincial Hospital Laghman

Geographical challenges also play a critical role in limiting access to ECO services, as patients often lack reliable transportation infrastructure. Many rural and remote areas are located far from healthcare facilities, requiring patients to travel long distances to reach district or provincial hospitals. This is particularly problematic for time-sensitive emergencies, where **delays can lead to severe complications or fatalities**. In some instances, families must walk for hours or transport patients in private vehicles or informal means of transport across challenging roads to access care, especially during winter.

Despite these barriers, some **facilitators** enable access to care at the community level. Structured community health initiatives, such as **health shuras and community health workers, may play a pivotal role in improving health literacy and access to care** by raising awareness about ECO services and guiding patients to appropriate facilities. These community engagement efforts, when actively supported, can mitigate some of the access challenges, particularly in remote settings. As one interviewee explained:

"So at least now the mullahs, they are telling [the people] in the mosque to [not] first go more than 40 [mph] because there is a lot of accidents."

Chief Surgeon — Kapisa

By disseminating practical advice to the community, such as encouraging safer driving practices or helping navigate the health system, these community members might promote beneficial public health messages to reduce road traffic accidents and help improve access to care and health literacy in the community.

*"We have this Health Shura of this hospital […] and most of the time we are discussing these issues with them. And these people [patients] are getting aware [of what to do], thanks to our health Shura.
We have also community health supervisors or community health workers. In some cases, they are providing health-related education."*

Chief Surgeon — Logar

The analysis of the interviews reveals significant challenges in the ambulance and referral systems in Afghanistan, underscoring the **absence of a formalised prehospital medical network**. In most hospitals, ambulances are generally too few to cover large populations.
They are often underequipped, lacking basic life-support equipment such as oxygen or monitoring devices, compromising their ability to stabilise patients during transport. The situation is further complicated by staffing issues, as some **hospitals report having ambulances available but no health staff or not enough drivers to operate them**, a fact that severely limits their ability to respond effectively to emergencies. For example, one hospital reported having four ambulances but only two drivers available at any given time:

*"They have four ambulances but only two drivers.
So, they use two ambulances one day, and the other two the next.
The ambulances are mainly used to transport patients who need CT scans, MRIs, or other tests at different hospitals."*

Hospital Director — Ghazni

Francesco Pistilli

In most cases, **ambulances are used exclusively for inter-hospital referrals rather than as a community-level resource**, creating gaps in the continuum of emergency care. Patients, especially those involved in road traffic accidents or facing obstetric emergencies in remote areas, often lack timely medical assistance before reaching a health facility. These delays can worsen injuries or medical conditions, with **serious consequences for patient outcomes**.

"We have an ambulance system in our community, available at both the comprehensive health centre and district hospital levels. However, below the comprehensive health centre level, there is no ambulance service. While the system functions at higher levels, it does not reach very remote areas, where no ambulance service is available."

Hospital Director — Paktia

The absence of **community-level ambulance services** not only leads to delays in care but also erodes trust in the healthcare system. This leaves **communities without reliable access to emergency services, perpetuating a vicious cycle of low health literacy, mistrust, reduced utilisation of services, and limited knowledge and awareness**. One respondent explained the process for handling emergency cases in villages:

> ***"If there is an emergency case in the village, the people put this person in a private car, if there is one available; [...] then they send it to the health facility. After that, our staff take [the person] from the health facility by ambulance to the hospital. If there is no private car available in the village, they call the health director, they contact us, we order to the nearest health facility to that area, then our ambulance go to the area and get that patient and bring it to the hospital. "***
>
> Chief Surgeon — Wardak

This account highlights several **critical gaps in the prehospital system**. Communities often rely on private vehicles to transport emergency patients to the nearest health facility. This not only delays care but also compromises patient safety, as **medical support is unavailable during transport**. In cases where private cars are not accessible, the process becomes even more complicated, requiring coordination through the health director to dispatch an ambulance from the nearest facility. These delays are symptomatic of a fragmented response system that relies on ad-hoc arrangements rather than a streamlined, community-level ambulance service.

With regard to **inter-hospital referrals**, interviewees highlight that this is oftentimes poorly organised, leading to inefficiencies in transferring patients between facilities. **Communication between hospitals is often unreliable**, with referring facilities rarely notifying the receiving hospitals in advance. As one interviewee explained, *"They prepare just a referral sheet. They don't call,"* (Interview 10), leaving the receiving hospital unprepared for incoming patients. Even in cases where emergency contact numbers exist, like in Kabul, they are inconsistently used or calls may go unanswered, further complicating the process. This **lack of coordination** often results in patients being turned away, particularly when critical information or documentation is incomplete. For instance, one interviewee described a case where a regional hospital refused to admit a patient with a foreign body aspiration because it lacked the capability to perform the necessary bronchoscopy.
The ambulance driver had to notify the referring hospital about the rejection, forcing the patient to be redirected to a private hospital, which caused unnecessary delays and increased costs. These rejections often stem from resource constraints, such as the lack of available beds or necessary equipment. Such disruptions not only delay critical care but also impose **significant emotional and financial burdens on patients and their families, as well as on healthcare workers who must find alternative solutions**. Moreover, the **absence of standardised protocols for triaging and referring patients** further exacerbates these challenges, leading to missed opportunities for timely care.

Despite these barriers, some facilitators enable access to care. Functional ambulance systems in certain hospitals, when available, improve the timeliness of care. In **Kabul**, there are promising practices, such as the **introduction of a dedicated telephone number** that communities can call to request ambulance services or a WhatsApp group that hospitals use to streamline interhospital referrals and communication. However, these initiatives are still inconsistently used, limited to the capital, and are not available to most communities in other regions.


Francesco Pistilli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Francesco Pistilli

At the **primary care level**, interviewees highlighted the **pivotal role of frontline healthcare workers** and the challenges they face in providing timely, life-saving interventions. One significant barrier is the **lack of adequate training for healthcare workers in stabilising critically ill patients during emergencies**, particularly in geographically remote areas where timely referral to higher-level facilities is crucial. Limited awareness and expertise in managing NCDs further complicates patient outcomes.
Interviewees stress the importance of **health education and community engagement strategies** that need to be coordinated at the primary care level. These are **particularly critical in maternal health**, where insufficient awareness and poor access to antenatal care contribute to preventable complications and delays in seeking care.

At the hospital level, the delivery of ECO care faces a complex interplay of barriers and facilitators, with significant variability across facilities. **Emergency departments are universally available** in all surveyed hospitals; however, their **quality and capacity vary widely depending on the level of the facility**. While national and some regional hospitals are relatively better equipped and staffed, district and provincial hospitals often struggle with insufficient infrastructure, inadequate supplies and a lack of specialised personnel, including emergency physicians, anaesthesiologists, surgeons and nurses. Therefore, emergency departments at the district level are less reliable than their higher-level counterparts. Interviewees highlight how this suboptimal situation in emergency departments in the country is critical, and may lead to delays in diagnosis and treatment, overcrowding and compromised patient outcomes, particularly for critical cases.

Despite being a vital component of the ECO care framework, **intensive care services** remain severely underdeveloped across public hospitals in Afghanistan. Most facilities lack designated ICU wards, and even where such units exist in name, they are **poorly equipped, with critical gaps in life-saving resources** such as ventilators, oxygen delivery systems, suction devices, patient monitors, and defibrillators. Frequent **power outages** further compromise patient safety, with health workers reporting the use of phone flashlights during surgeries and unreliable backup generators. In some hospitals, oxygen is rationed among patients due to insufficient cylinder availability. The **absence of trained ICU personnel, including anaesthesiologists and critical care nurses**, exacerbates these challenges, especially outside major urban centres. Facilities commonly rely on **undertrained technicians or general staff** to manage critically ill patients, often without formal protocols or sufficient supervision. The hospital director of one district hospital in Panjshir explicitly stated that the ICU was removed despite its utility due to a lack of resources.

Post-operative monitoring is also inadequate, with patients being returned to general wards immediately after surgery due to a lack of recovery areas or monitoring capacity. One provincial hospital reported plans to establish a fully functioning ICU, but such investments remain isolated. Training gaps, especially in critical care protocols and equipment use, are prominent in rural and underserved areas.

Altogether, the findings illustrate how critical care remains one of the most fragile components of the hospital system, with significant gaps in infrastructure, staffing, and preparedness limiting the ability to respond effectively to severe and life-threatening conditions.

Operating theatres are present in most hospitals but also exhibit wide disparities in their functionality and capacity. In higher-level facilities, multiple OTs may cater to various surgical specialties, enabling them to handle a range of procedures, both emergencies and elective cases, at the same time. Conversely, district hospitals typically have a single OT, which must manage both emergency and elective cases. Emergency cases represent the vast majority considering the burden of road traffic accidents in the country, therefore **the focus on emergencies often results in the postponement of elective procedures**, creating a backlog and further straining the system.
The lack of specialised surgical staff including nurses and anaesthesiologists, and insufficient sterilisation equipment, exacerbates delays and risks during surgery.

GAPS AND NEEDS IN ECO SERVICE DELIVERY

Key gaps and needs in ECO service delivery in Afghanistan arise from resource constraints, systemic inefficiencies and infrastructural challenges.

In terms of **resource constraints**, hospitals frequently **lack essential equipment such as CT scans, ventilators and blood analysers**, which significantly undermines the quality of care, particularly for trauma and obstetric emergencies. The lack of essential diagnostic tools, such as CT scans, MRIs and functional laboratory facilities, severely hampers decision-making and timely intervention. In many cases, patients must be referred to other facilities for diagnostic procedures, leading to delays that worsen outcomes.

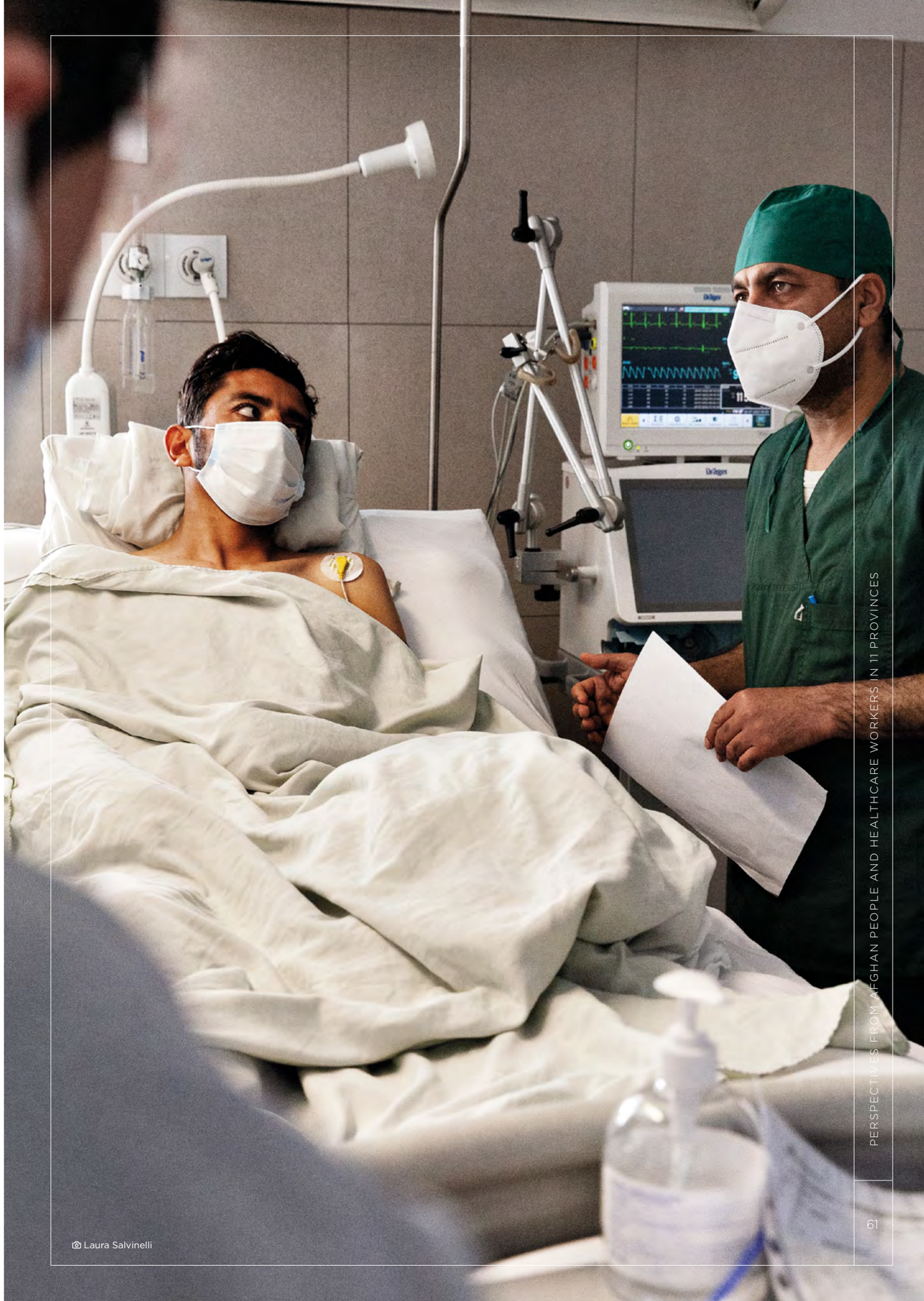
Ambulances are often poorly equipped, limiting prehospital care and making it difficult for patients in remote areas to reach health facilities promptly. This inadequacy is compounded by **weak referral systems**, resulting in delays that jeopardise patient outcomes.

Systemic inefficiencies further hinder service delivery. While some hospitals have triage systems in place, their functionality and consistency vary widely. Smaller facilities often lack structured triage protocols, while larger hospitals struggle to effectively implement existing systems due to overcrowding, insufficient resources, and inadequate staff training. **Poorly coordinated discharge and follow-up systems** exacerbate the problem, with patients often failing to receive necessary postoperative care in closer-to-home facilities. Additionally, **outdated guidelines**, such as the Essential Package of Hospital Services (EPHS), were designed for smaller, more stable patient volumes and are now misaligned with the current demand. The end of the war has improved mobility across the country, leading to increased patient volumes in facilities that are ill-equipped to manage them, further straining already limited resources. Staff training and capacity-building are significant areas of need. **Hospitals report gaps in staff expertise, particularly in advanced surgical and critical care practices**.
Inconsistent adherence to clinical protocols compromises care quality, while a lack of ongoing professional development leaves healthcare workers unprepared to manage complex cases. Rural and underserved areas face the greatest challenges, where healthcare professionals often lack access to updated training and mentorship.

> ***"We need trainings, in general surgery, trauma, trauma life support, at all levels of the health system."***
>
> Chief Surgeon — Laghman

Infrastructure remains a critical bottleneck. Overcrowding in hospitals has emerged as a pervasive issue, with facilities unable to accommodate the increase in patients. The strain is felt across all levels of care, from community health centres to tertiary hospitals, creating bottlenecks in the health system and delaying care at critical points.
This lack of space affects not only inpatient capacity but also emergency wards, operating theatres and outpatient departments, leading to delays and compromised care quality. Some hospitals are forced to repurpose other areas to accommodate patients, creating logistical and safety concerns. Many hospital buildings are in disrepair due to decades of conflict, limited funding and lack of routine maintenance. This includes issues such as deteriorating electrical systems or an unreliable water supply, all of which directly impact the quality and safety of care, especially in emergency and operative settings. Moreover, many hospitals were designed without considering local needs, leading to **insufficient waiting areas, triage zones and culturally appropriate spaces for women**.

> ***"Sometimes the power goes out in the middle of surgery. We use phone flashlights or wait until the generator starts. It's dangerous for the patient."***
>
> Female Doctor — Provincial Hospital Helmand



Laura Salvinelli

ASSESSMENT OF ECO CARE IN 11 HOSPITALS

The checklist consisted of **four sections of multiple-choice questions**, each addressing key aspects of ECO services offered by the 11 hospitals interviewed.

The **first section** gathered general information on the **safety standards** of surgical and emergency care, including maternal and critical care, as well as the **training levels** of medical staff.

The **second section** examined **emergency and critical care services**, focusing on the organisation of emergency units, staff deployment, infrastructure and the availability of essential supplies for assessing and managing life-threatening conditions (i.e., airway, breathing, circulation – the ABCs of emergency care).

The **third section** explored **surgical services**, assessing whether facilities were equipped to perform both minor and major operations, including the essential Bellwether procedures[7]. It also looked at the structure, staffing and availability of necessary surgical supplies.
The **final section** focused on **obstetric and gynaecological care**, assessing the capacity of healthcare facilities to provide essential maternal health services.

While all 11 healthcare facilities participated in the assessment, some did not answer all questions, leading to some gaps in the data.

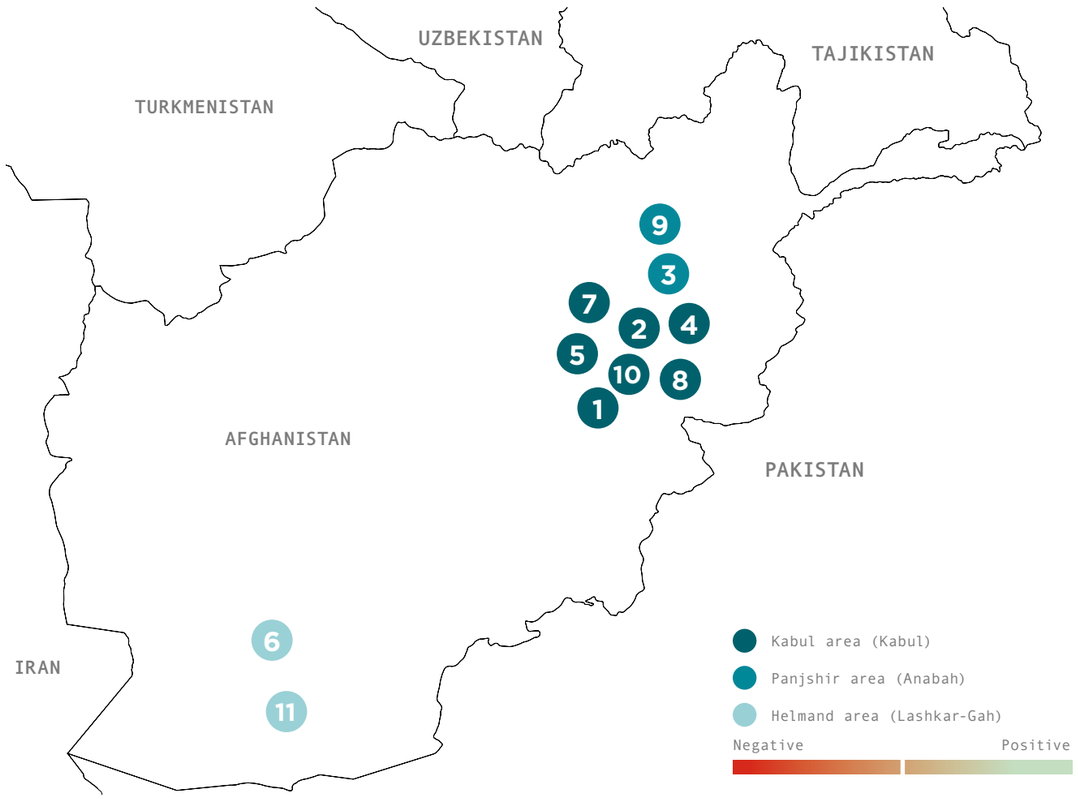


Figure 5: Geographical representation of the surveyed hospitals

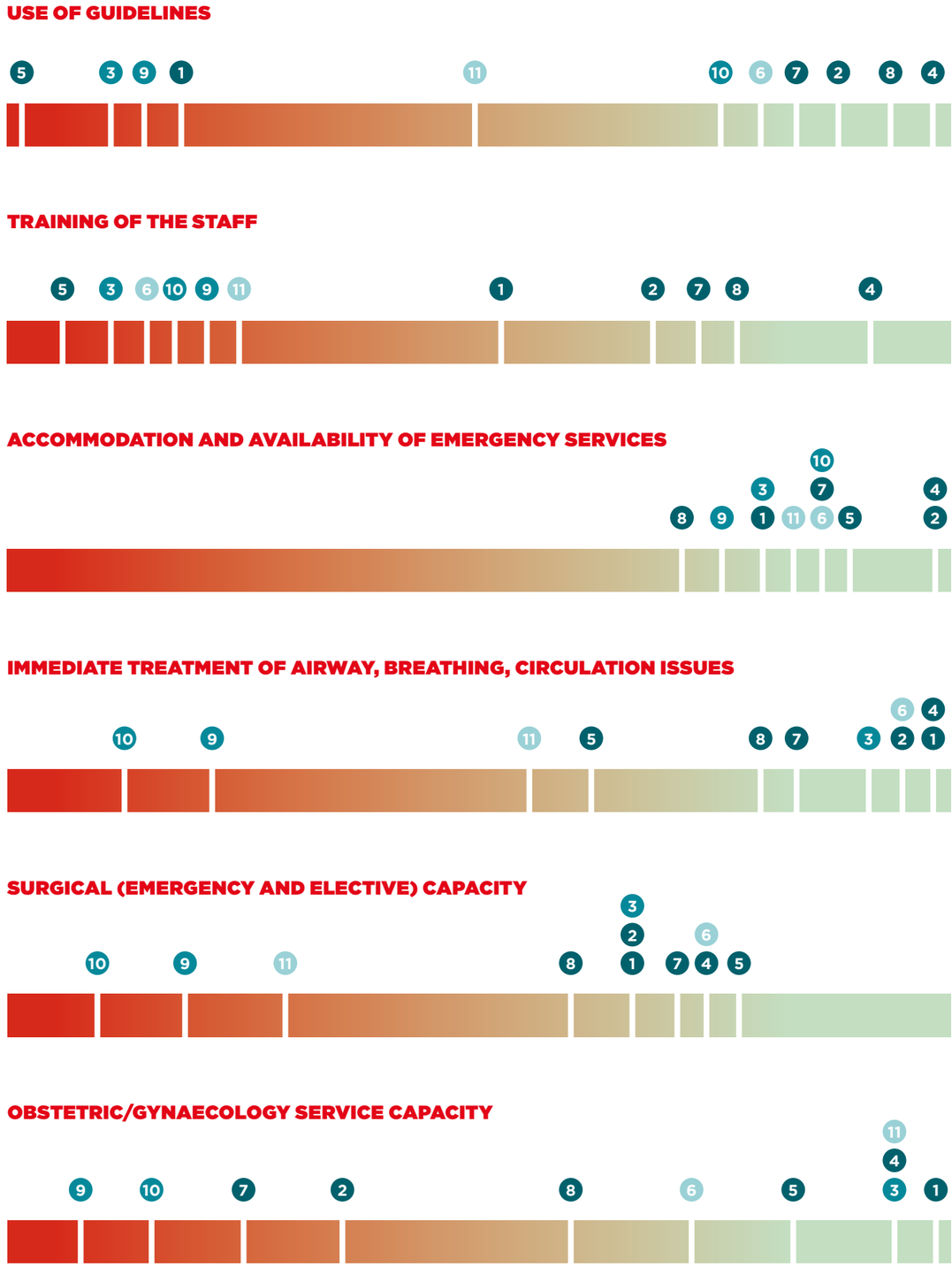


Figure 6: Representation of checklist assessment of services

GENERAL INFORMATION

FACILITY OVERVIEW

The checklist survey was conducted alongside the interviews, gathering full or partial responses from **two regional hospitals, six provincial hospitals and one district hospital**, as categorised under Afghanistan's Essential Package of Hospital Services.[17] There was also participation by a **maternal regional hospital in the Kabul area and a maternal district hospital in Lashkar-Gah**, both primarily offering obstetric and gynaecological care.

All surveyed hospitals reported providing emergency, critical and surgical care — both emergency and elective procedures, and major and minor surgeries — along with obstetric and gynaecological services. Every facility confirmed that emergency and critical care services are available 24/7.

SAFETY MEASURES

Most hospitals reported implementing guidelines and protocols for emergency and critical care. However, one provincial hospital stated that it lacked any formal guidelines whatsoever in this area. For surgical care, the WHO Surgical Safety Checklist is used by one regional hospital, four provincial hospitals and the maternal district hospital. Of the others, one regional and two provincial hospitals do not have a safe surgery protocol, and two facilities did not provide a response. National guidelines for anaesthesia and for emergency obstetric care are followed by five and nine hospitals, respectively.

There are notable differences in the use and training of triage tools across facilities. Eight hospitals reported using a structured triage system — five follow the Advanced Trauma Life Support (ATLS) protocol for trauma care, and four follow the Advanced Cardiac Life Support (ACLS) protocol. However, only four hospitals provide regular training sessions on triage procedures. Notably, neither of the maternal hospitals surveyed offer any triage training to their staff.

Quality and safety monitoring systems are in place in the maternal regional hospital and four provincial hospitals. Seven facilities conduct morbidity and mortality review meetings or similar discussions for quality improvement. However, **only one hospital met all the checklist requirements for guideline implementation**, while significant gaps were observed in both regional and provincial hospitals. As illustrated in Figure 6, the adoption of guidelines varies significantly across different Afghan provinces.

TRAINING OF STAFF

None of the surveyed facilities is officially recognised as a resident training centre, though most hospitals reported offering some form of periodic training. Four provincial hospitals provide training in basic surgical skills, including the Bellwether procedures (i.e., emergency laparotomy, long bone fracture repair, caesarean section). Training in maternal care is available in ten hospitals, while five offer instruction in basic anaesthesia principles. However, three provincial hospitals did not report whether they provide anaesthesia training.
Overall, as shown in Figure 6, **training in ECO services remains severely limited** across the surveyed facilities, with no hospital covering the full range of training topics included in the checklist.

EMERGENCY AND CRITICAL CARE SERVICES

EMERGENCY DEPARTMENT OVERVIEW

The second section of the checklist assessed the organisation and availability of emergency and critical care services. While most hospitals had basic emergency supplies, some reported major shortages, particularly for managing cardiopulmonary emergencies and isolating infectious patients.

All 11 hospitals confirmed that they provide 24-hour emergency services and have established some referral mechanisms, albeit – as confirmed in the interviews – lacking in rapidity, efficiency and resources. **Most facilities reported ambulance availability for patients' transfer within 15 minutes**, though one regional and one provincial hospital stated that average wait times exceeded one hour. Nine hospitals have radio or phone systems for internal and inter-facility communication. However, this contrasts with interview findings, where hospital directors reported that patient transfers often occur without prior notice to the receiving facility.

Four hospitals stated they do not have isolation areas for patients with infectious diseases.

Two facilities reported that they never have an emergency medicine specialist on call. However, nursing staff are available 24/7 in all 11 hospitals, and general practitioners are on duty around the clock in eight facilities.
Radiology, laboratory and pharmacy services operate 24/7 in most hospitals.

EMERGENCY AND CRITICAL CARE SUPPLIES

All hospitals confirmed having personal protective equipment (PPE) for sterile procedures (gowns, gloves, disinfectants), as well as resuscitation supplies (airway management tools, oxygen, pulse oximeters and vasoactive drugs). Medical supplies, including narcotics, antibiotics, and tourniquets for haemorrhage control, were also available in all facilities.
However, some critical gaps were identified. Chest tubes were unavailable in the maternal district hospital, while two provincial hospitals and the maternal regional hospital did not provide information on this. One provincial hospital lacked clean water and intravenous fluids for fluid resuscitation. CPAP devices were unavailable in two provincial hospitals and the maternal district hospital. One provincial hospital reported insufficient PPE and patient monitoring devices. Tetanus toxoid vaccines were unavailable in two of the surveyed hospitals.

There are also major gaps in advanced radiology capabilities across the surveyed facilities. While X-ray machines were available in all hospitals and ultrasound services were absent in just one, **CT scanners were available in only one regional hospital, and MRI machines were not available in any facility**.

Additionally, the maternal regional hospital and two provincial hospitals provided only partial responses on the availability of radiology and emergency supplies.

Francesco Pistilli

OPERATIVE AND OBSTETRIC CARE

The surgical capacity of healthcare facilities varied widely across regions. In general, **regional hospitals reported a greater ability to perform both minor and major surgeries compared to provincial and district hospitals**. The district hospital did not report data on most major surgeries, particularly those related to trauma and general surgery.

As expected, **maternal and gynaecological hospitals offered a more limited number of surgeries compared to general hospitals**, as they do not provide trauma or general surgical services. This reflects their specialised focus on women's health and maternity care. Regarding Bellwether procedures, all 11 hospitals confirmed the capacity to perform caesarean sections and emergency laparotomies on a 24-hour basis. While all hospitals provide both minor and major surgeries, none was able to offer the full range of surgical procedures defined in the World Bank's Essential Surgery Package or the list of essential surgical procedures identified by Odland et al., both key indicators of a health system's surgical capacity.

Four health facilities, including the district maternity hospital, reported that they do not perform male circumcision. This maternity hospital also does not offer catheter placement procedures. Vasectomies and skin grafts are done in only three hospitals. All regional and provincial hospitals that are not specialised confirmed they do perform common surgeries like tubal ligation, surgery for ectopic pregnancy, removal of the uterus (i.e., hysterectomy), appendix removal, gallbladder surgery, emergency surgery for injuries, and insertion of chest tubes. One provincial hospital does not perform amputations or use external devices to stabilise broken bones (i.e., external fixation). Only one regional hospital offers brain surgery. Cleft lip repair and cataract surgery are available in just one of the two regional hospitals. Heart bypass surgery is available in two hospitals, while angioplasty (i.e., a procedure to open heart arteries) is available in only one. None of the hospitals surveyed offer minimally invasive (laparoscopic) or cancer-related surgeries. Most hospitals, except the maternity hospitals, also perform more complex intestinal operations such as the removal of parts of the intestine (i.e., colectomy). However, two hospitals do not offer tracheostomy (e.g., opening the windpipe), and only three hospitals (one regional and two provincial) perform thyroid surgery. Major chest surgery for trauma is done in only two hospitals. The district hospital did not provide information on these procedures. No hospital reported offering full thoracic surgery services.

OBSTETRIC AND GYNAECOLOGICAL SERVICES

Abortion services are available in all surveyed facilities, and all but one regional hospital confirmed providing emergency obstetric and newborn care. Additional data on obstetric and gynaecological services were only fully obtained from eight hospitals, as the district hospital, one provincial hospital, and the maternal regional hospital provided only partial information.

Among the non-specialised regional hospitals, one does not provide thermal protection, skin-to-skin contact, immediate breastfeeding within one hour, or rooming-in for newborns, nor does it offer vacuum extraction-assisted vaginal delivery. **All other services included in the WHO Checklist are available in the regional hospitals**. Among the provincial hospitals, two facilities reported not offering delayed cord clamping, and one does not provide skin-to-skin contact or immediate breastfeeding. The maternal district hospital confirmed offering all services.

SURGICAL SUPPLIES AND INFRASTRUCTURE

All surveyed facilities confirmed having 24-hour access to oxygen. Each hospital reported the presence of a postoperative recovery room, as well as essential surgical equipment, including pulse oximeters in the operating rooms, personal protective equipment (PPE) for sterile procedures, patient monitoring tools and resuscitation equipment. Definitive airway management materials for adults were also available in all hospitals.

Among the eight hospitals that provided complete responses regarding obstetric and gynaecological services, all reported having adequate supplies, skilled staff and infrastructure to manage complicated deliveries.

SURGICAL SAFETY AND TRAINING

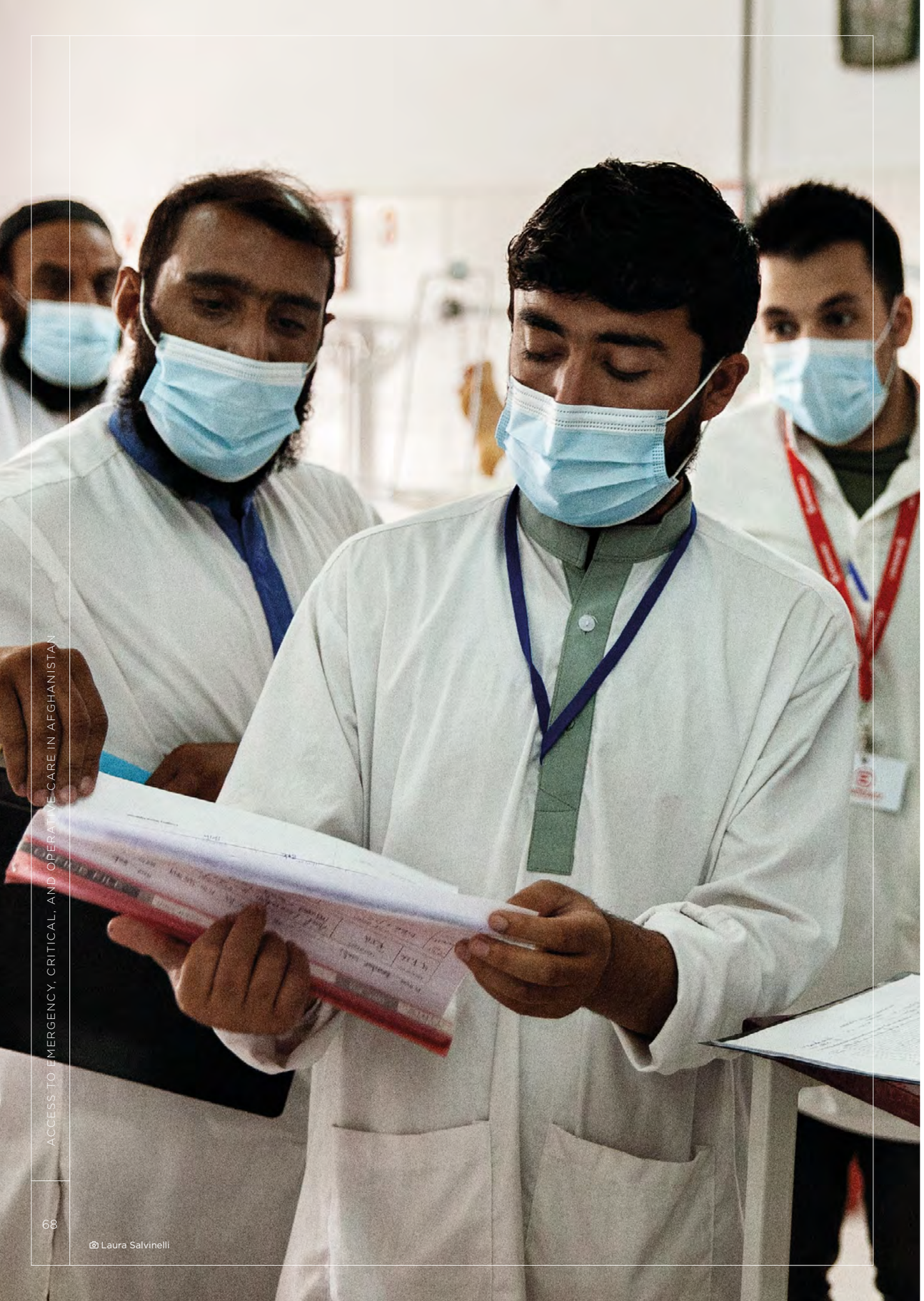
Sterility of surgical materials is maintained through standardised protocols in all but three hospitals. Training in emergency laparotomy and caesarean section is conducted across all facilities. However, the same hospital that lacks the capacity to perform open long-bone fractures also reported a shortage of specialised surgical staff. One provincial hospital indicated a lack of trained anaesthesia staff. **The perioperative mortality rate reported by the surveyed hospitals ranged from 0% to 3%**.

FINAL OBESERVATIONS

Emergency services are a critical entry point for patients requiring urgent or life-saving care, yet remain highly constrained in many public hospitals across Afghanistan. **Triage systems are inconsistently applied**, with some facilities lacking designated triage staff or standardised protocols altogether. In several hospitals, emergency units are **staffed by general practitioners or junior personnel** without specific training in emergency care, limiting their ability to rapidly assess and stabilise critical patients. As a result, patient prioritisation is often informal and reliant on individual discretion, which can lead to delays, misclassification of clinical urgency, and inappropriate case management.

Regional hospitals generally offer a broader spectrum of surgical services compared to provincial and district hospitals, which mainly handle minor surgeries, aligning with the Essential Surgery Package. Despite this, significant gaps persist in the provision of both surgical and anaesthesia services across the surveyed hospitals in Afghanistan. **While most facilities can provide basic surgical care, none reported offering the complete range of essential surgeries**, as defined by international guidelines and the Afghan Essential Package of Services. Notably, **critical life-saving neurosurgical and thoracic procedures were entirely absent** from the services available in the surveyed hospitals. This absence, along with the lack of the full range of essential surgeries, underscores serious limitations in the country's emergency and critical care capabilities. Furthermore, while **emergency obstetric care is widely available**, the lack of essential newborn care practices in some hospitals, such as immediate skin-to-skin contact and breastfeeding initiation, further highlights the challenges in ensuring comprehensive maternal and neonatal care.


Stefanie Glinski



Laura Salvinelli

DISCUSSION

ECO services are essential components of a comprehensive healthcare system. This report explores access to ECO services across 11 Afghan provinces using a mixed-methods approach.
The results highlight several key challenges but also identify positive aspects on which practical, operational recommendations can be built. These are discussed in detail below.

AWARENESS AND HEALTH-SEEKING BEHAVIOUR

At all levels of analysis, from patients to hospital directors, there is a **widespread lack of awareness regarding emergency conditions**, including both their initial recognition and how to navigate the healthcare system for their treatment. **Information about emergency care is primarily shared by healthcare workers**, though patients also report that **family members and shuras play a crucial role** in their healthcare decisions. This is particularly evident among women patients, who often rely heavily on family advice. Hospital directors also note that **many patients turn to local pharmacists or informal providers**, such as traditional healers to receive health-related information and guidance. However, these individuals typically lack the necessary expertise to manage emergencies or a licence to practise, highlighting a regulatory gap within the system. **Significant varied responses exist regarding the awareness of emergency contact numbers and the presence of 24/7 emergency departments**. Most of EMERGENCY's staff confirmed knowledge of an **emergency number and the presence of a hospital with a 24/7 emergency department**, but emphasised the **need for greater community awareness**. Indeed, the majority of patients were either unaware of an emergency number or could not confirm its availability, while awareness of emergency departments varied across provinces. This demonstrates a critical gap in ECO services and public health communication, highlighting the need for better awareness and for more effective organisation and delivery of ECO services.

HEALTHCARE QUALITY AND SAFETY

Perceptions of ECO service quality and safety vary widely among different stakeholders. **Patients of both genders report concerns about inadequate service quality and safety**, particularly in peripheral or rural areas where access is already more difficult. Hospital directors and department heads echo these concerns, citing a **lack of trained personnel, medical supplies and infrastructure** as key obstacles to delivering critical care. Moreover, the **significant variation in safety perceptions of patients across provinces** indicates that improving access to ECO care necessitates location-sensitive mitigation efforts and thorough risk assessment involving local community input.

Guidelines for ECO services are often outdated, misaligned with current patient needs or entirely absent. Many hospitals fail to provide adequate training, as confirmed by the HHFA checklist. At the same time, training opportunities are scarce and insufficiently supported. The triage systems in emergency departments are inconsistent, poorly trained staff and lack uniformity across the country.

Improving the quality of ECO services was also among the key recommendations of EMERGENCY's staff members, along with the need to increase the number of facilities. Although some respondents considered that staff in their community are adequately trained for emergencies, this could be the result of the presence of an EMERGENCY facility in the area with dedicated and well-trained personnel.

GENDER GAP

Data collected at EMERGENCY's facilities suggest that the burden of trauma cases disproportionately affects men and boys compared to women and girls. This disparity is possibly due to cultural and normative limitations on women and girl's mobility and participation in public life. Although fewer in number, women remain a particularly vulnerable group within this context. A significant gender gap exists in access to ECO services, with **women patients facing the greatest challenges**, particularly in maternal and obstetric healthcare. Women rely on family members for health-related information and report higher levels of fear when seeking care compared to men. The perception of safety when seeking care has highlighted **widows as a particularly vulnerable group**.

There is also a striking uncertainty regarding pregnancy outcomes. **Up to 20% of women respondents reported being unsure whether they had experienced pregnancy loss** in the past. Similarly, 16% of men respondents were unsure if their family had experienced such a loss. This reflects deep challenges in personal and familial understanding of reproductive health.

Hospital directors and department heads further confirm these gender disparities. **Societal restrictions limit women's autonomy in decision-making and healthcare-seeking behaviours**, leading to delays in disclosing health issues and, ultimately, in receiving care — sometimes with life-threatening consequences.

FINANCIAL BARRIERS

Although ECO services are officially free of charge in Afghanistan's public sector, this claim does not align with patient and staff experiences. While transport and food expenses were expected to be the primary costs in a free system (Lancet Commission on Global Surgery), patients reported that **medications, treatment and transport were their biggest financial burdens**. **One in four patients delayed an operation once** and many were forced to borrow money or sell belongings to afford healthcare.

The discrepancy likely stems from the way healthcare financing operates in practice in Afghanistan. In some instances, staff members reported that patients are required to purchase medical supplies out-of-pocket before procedures can be performed. While the actual procedures themselves remain free — meaning no direct payments to the hospital staff or facility— the burden of purchasing necessary materials shifts the financial responsibility onto the patients.

These financial barriers in the Afghan health system have been recognised since the change of government in 2021, as already highlighted in previous studies published in 2022.[12, 20, 21]

TRANSPORTATION AND AMBULANCE SYSTEM

Significant delays in reaching healthcare facilities, as well as gaps in Afghanistan's prehospital care system, further hinder access to ECO services. **Many patients reported having to travel across cities, provinces, or even to other countries to receive care**, a finding confirmed by staff members. However, while hospital directors and patients frequently cited walking as the primary mode of transportation, staff members mostly reported private cars as the main means of travel. This discrepancy suggests a bias in staff perception, as they likely interact only with those patients who successfully reach the facility. As reported by the hospital directors, many patients first walk from their homes to a main road, where they then seek public or private transport to reach healthcare facilities.

Transportation barriers also contribute to delays in continuity of care, as approximately **20% of patients reported being unable to attend follow-up visits**, primarily due to financial constraints or insurmountable distances.

Although an ambulance system exists, it is severely limited in both availability and quality. **Ambulances are primarily used for referrals between facilities** rather than for transporting patients from their homes to healthcare facilities. Even in Kabul, the best-served area, hospitals have only one or two ambulances available per day. Furthermore, **ambulance personnel often have minimal training**—some are still undergraduates—while in many cases, the driver is the only personnel present. Additionally, communication of referrals in advance is often lacking, as patients are transferred without prior consultation with the receiving facility or adequate medical documentation. These inefficiencies create further gaps in care and hinder co-ordination among healthcare providers.

INTEGRATION OF DIFFERENT LEVELS OF CARE

Patients often arrive at hospitals in critical conditions, particularly those with exacerbated NCDs such as decompensated diabetes, high blood pressure or kidney failure. These conditions are frequently diagnosed only when they have become severe, with patients often unaware of their condition until it becomes life-threatening. **Many seek emergency care only after their condition has significantly deteriorated**, which increases the risk of complications. This delay in diagnosis can result in postponed surgical interventions and worse ECO outcomes.

The **chronic under-management of these conditions at the primary care level**, along with healthcare workers' limited awareness and expertise in managing chronic conditions, contributes significantly to poorer patient outcomes. Another major issue at the primary care level is the insufficient training of healthcare workers in stabilising critically ill patients during emergencies.
This is particularly problematic in remote areas, where timely referrals to higher-level facilities are crucial but often delayed. Addressing these issues requires improving health education and community engagement as well as increasing healthcare workers' knowledge, particularly in the management of NCDs and maternal health. **Lack of awareness and poor access to care lead to preventable complications and delays in seeking necessary care**, which could be mitigated with better organisational infrastructure and support at both the community and healthcare levels.

CONCLUSION

Afghanistan's healthcare system faces substantial gaps and barriers at every stage of ECO service delivery. Patients frequently delay seeking care due to personal concerns or **restrictive societal norms**—particularly among **women**. These delays often concern chronic conditions such as NCDs which, due to the lack of care, forces patients to seek emergency services when their condition is exacerbated. Once they decide to seek treatment, they encounter **significant transportation and financial obstacles**. Even when patients reach a facility, they often find that the necessary services are unavailable. Referrals to other facilities are further delayed due to a lack of ambulance services or the inability to afford transportation. In cases where treatment is available, it may be too costly or delivered under unsafe conditions due to **inadequate training or outdated guidelines**. Finally, follow-up care remains a challenge, with 20% of patients unable to attend their necessary post-treatment visits.

In order to strengthen the health system, it is important to adopt a **whole-of-health-system approach, integrating and coordinating all components** to optimise service delivery and minimise duplication. Each level of the health system, from community to primary to hospital care, must be equipped with the necessary personnel, infrastructure and resources to provide quality care as close as possible to people's everyday environments. Additionally, a **functional referral and counter-referral system** is crucial, supported by the **theoretical and practical training** of healthcare workers to enhance their skills and capacity. Given that financial barriers are a key obstacle to seeking care in Afghanistan, healthcare services should be **free-of-charge for patients to guarantee an equal and universal access to care**.
Investing in ECO acts as a catalyst, both for the broader improvement of the healthcare system and for saving lives.

Massimo Grimaldi

RECOMMENDATIONS

1 The international community must ensure **ECO care is a priority in health, humanitarian, and development efforts**, with the necessary funding allocated to save lives and foster a robust health system through a **whole-of-health-system approach and a triple nexus strategy**. To contribute to the economic restoration of the country and help Afghans establish their livelihoods and resilience, the international community should also advocate for **the release of the $9 billion in Afghan reserves** held by the US, the Afghan Fund in Switzerland, and European banks.

2 The Afghan authorities should work on **urgently reforming the BPHS/EPHS** and **revising the contracting system of NGOs** to ensure consistent, equitable and adequate healthcare provision across the country. Crucially, without a comprehensive approach that addresses fragmentation, prevents duplication, and reinforces the continuum from community-based services and primary care to intermediate and hospital levels, services will remain unevenly distributed, leaving persistent 'white areas' with no coverage.

3 The Afghan authorities should **improve the accessibility and quality of ECO care** at all levels, building an accessible, integrated, coordinated, and resilient health system, where patients can confidently seek care at their nearest facility. Special attention should be given to reducing the financial burden on patients, working towards the provision of **healthcare services free-of-charge**.

4 The Afghan authorities should invest in **higher education and capacity-building** to improve treatment and life-saving diagnoses. To ensure quality care, **continuous training with standardised protocols** should be hosted in adequate facilities, particularly focusing on critically understaffed sectors like **emergency management, NCDs, anaesthesia, and critical care**.

5 **Improving infrastructure, supplies, and working conditions** in underfunded hospitals should be prioritised. To enhance staff retention and the quality of ECO care, fair pay and proper resources for ECO staff should be ensured. **Collaboration between the public and private sectors** should be improved to expand access to timely, affordable and safe ECO services by mutually compensating in case of scarcity of staff, supplies or infrastructure.

6 Recognising the significant vulnerabilities women face in accessing and seeking care, including greater fear and more barriers than men, **increasing the number of women healthcare workers** is crucial to improve access to emergency, surgical, and maternal care. We urge the Afghan authorities to **rescind current bans and ensure girls' and women's rights to education and the labour market**, as these actions are vital for reducing mortality and morbidity and for strengthening the economy, public health, and societal stability.

7 A **functional and integrated ambulance network that serves both communities and facilities** and ensures adequate coverage across provinces should be established to strengthen the national prehospital emergency care system. This should include a **unified national emergency number**, a **coordinated dispatch system** and the deployment of **well-equipped and properly staffed ambulances** to ensure timely response and equitable coverage across all provinces. **Inter-facility referrals and counter-referrals** should be improved by standardized channels and protocols.

8 A solid **follow-up recruitment strategy** should be established to include flexible appointment scheduling in time and in space (e.g., to be performed at the primary care level) able to adapt in cases where patients are not able to attend, to minimise lost-to-follow-up.

9 **Community awareness of emergency care** should be improved by educating the public, destigmatising seeking medical care (especially for women), engaging informal social networks like shuras, and discouraging reliance on unregulated providers.

10 To address the neglected needs of the population, fostering the **prevention, treatment, and management of NCDs** is recommended. This includes encouraging preventive check-ups for chronic diseases by promoting early detection and treatment to prevent severe complications or worse surgical outcomes requiring emergency intervention.

REFERENCES

[1] Tadesse L, Abdullah NH, Awadalla HMI, D'Amours S, Davies F, Kissoon N, Morriss W, Onajin-Obembe B, Reynolds T. A global mandate to strengthen emergency, critical and operative care. Bull World Health Organ. 2023 Apr 1;101(4):231-231A. doi: 10.2471/BLT.23.289916. PMID: 37008261; PMCID: PMC10042088.

[2] Odland ML, Abdul-Latif AM, Ignatowicz A, Alayande B, Ofori BA, Balanikas E, Bekele A, Belli A, Chu K, Ferreira K, Howard A. Equitable access to quality trauma systems in low-income and middle-income countries: assessing gaps and developing priorities in Ghana, Rwanda and South Africa. BMJ global health. 2022 Apr 1;7(4):e008256.

[3] Barnes-Josiah D, Myntti C, Augustin A. The "three delays" as a framework for examining maternal mortality in Haiti. Social science & medicine. 1998 Apr 15;46(8):981-93.

[4] Hirner S, Dhakal J, Broccoli MC, Ross M, Calvello Hynes EJ, Bills CB. Defining measures of emergency care access in low-income and middle-income countries: a scoping review. BMJ Open. 2023 Apr 17;13(4):e067884. doi: 10.1136/bmjopen-2022-067884. PMID: 37068910; PMCID: PMC10111883.

[5] Meara JG, Leather AJ, Hagander L, Alkire BC, Alonso N, Ameh EA, Bickler SW, Conteh L, Dare AJ, Davies J, Mérisier ED. Global Surgery 2030: evidence and solutions for achieving health, welfare, and economic development. The lancet. 2015 Aug 8;386(9993):569-624.

[6] Harmonized health facility assessment (HHFA): comprehensive guide. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.

[7] O'Neill KM, Greenberg SL, Cherian M, Gillies RD, Daniels KM, Roy N, Raykar NP, Riesel JN, Spiegel D, Watters DA, Gruen RL. Bellwether Procedures for Monitoring and Planning Essential Surgical Care in Low- and Middle-Income Countries: Caesarean Delivery, Laparotomy, and Treatment of Open Fractures. World J Surg. 2016 Nov;40(11):2611-2619. doi: 10.1007/s00268-016-3614-y. PMID: 27351714.

[8] Hameed MA, Rahman MM, Khanam R. The health consequences of civil wars: evidence from Afghanistan. BMC Public Health. 2023 Jan 23;23(1):154.

[9] Andersen CT, Ayoya MA, Luo D, Samaha H, Shafique F, Chopra M. Afghanistan's health system is under duress, but has not collapsed. The Lancet. 2023 Feb;401(10376):554–5.

[10] Safi, N., Anwari, P., & Safi, H. (2022). Afghanistan's health system under the Taliban: key challenges. The Lancet, 400(10359), 1179-1180.

[11] UN OCHA Afghanistan Humanitarian Needs and Response Plan 2025, December 2024 https://www.unocha.org/publications/report/afghanistan/afghanistan-humanitarian-needs-and-response-plan-2025-december-2024.

[12] CRIMEDIM and EMERGENCY NGO – Access to care in Afghanistan. Perspectives from Afghan people in 10 provinces. 2023. Available at: https://en.emergency.it/wpcontent/uploads/2023/03/EMR_ACCESS_TO_CARE_IN_ AFG_28_03.pdf.

[13] UNICEF – Press release – available at https://www.unicef.org/rosa/press-releases/depriving-girls-secondary-education-translates-loss-least-us500-million-afghan#:~:text=KABUL%2C%2015%20August%202022%20%E2%80%93%20Keeping%20girls%20out,GDP%2C%20according%20to%20a%20new%20analysis%20by%20UNICEF., August 2022.

[14] World Health Organization Afghanistan, HeRAMS, Health Resources and Services Availability System (HeRAMS) Available at: https://dashboard.whe-him.org/index.php/herams/.

[15] WHO EMRO Available at: https://www.emro.who.int/afg/programmes/mental-health.html#:~:text=Decades%20of%20conflict%20have%20left,rural%20and%20informal%20urban%20settlements .

[16] Health Sector Thematic Working Group – WHO – USAID – World Bank – Health Sector Transition Strategy 2023-2025.

[17] World Bank, "Towards Economic Stabilization and Recovery", Afghanistan Development Update, April 2022.

[18] Afghan Ministry of Public Health. 2009. A Basic Package of Health Services in Afghanistan.

[19] World Health Organization - SEVENTY-SIXTH WORLD HEALTH ASSEMBLY WHA76.2 Agenda item 13.1 May 2023 – Integrated emergency, critical and operative care for universal health coverage and protection from health emergencies. Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA76/A76_R2-en.pdf.

[20] Lamberti-Castronuovo A, Valente M, Bocchini F, Trentin M, Paschetto M, Bahdori GA, Khadem JA, Nadeem MS, Patmal MH, Alizai MT, Miccio R. Exploring barriers to access to care following the 2021 socio-political changes in Afghanistan: a qualitative study. Conflict and Health. 2024 Apr 24;18(1):36.

[21] Valente M, Lamberti-Castronuovo A, Bocchini F, Shafiq Y, Trentin M, Paschetto M, Bahdori GA, Khadem JA, Nadeem MS, Patmal MH, Alizai MT. Access to care in Afghanistan after august 2021: a cross-sectional study exploring Afghans' perspectives in 10 provinces. Conflict and Health. 2024 Apr 22;18(1):34.

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