

Adapting and Sustaining: Responses to the Taliban Takeover and Health System Disruption in Afghanistan

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The challenges of delivering health services in fragile, conflict-affected and vulnerable (FCV) settings experiencing humanitarian crises, protracted emergencies and insecurity are myriad and significant.¹ In Afghanistan, these challenges were amplified by the Taliban's August 2021 government takeover which resulted in a rapidly evolving security situation, border closures, donor funding disruptions, international staff evacuations, and banking interruptions.^{2,3,4} Despite these challenges, utilization of primary care services at the community level not only continued during the months following the government change, but even increased compared to same time period the previous year.⁵ Examining how the health system and providers coped, adapted and sustained service delivery in the wake of the Taliban takeover can elucidate which mechanisms and structures facilitate continuation of health service delivery and prevent disruptions during political shocks in FCV settings.

In this study, we conduct key informant interviews to investigate what happened to Afghanistan's health sector and health service delivery following August 2021. We explore both enabling environment (i.e., governance, financing and social norms) and health system (i.e., supply and demand) factors within the scope of the study. The health sector, similar to other sectors in Afghanistan, was facing significant challenges even prior to the government takeover. We highlight factors that likely minimized disruptions and facilitated adjustments to the new operating realities. We hope that this study provides insights for policymakers, donors and implementers operating in Afghanistan as well as other FCV environments, where major power shifts may occur.

Background

For decades, the Afghan health system has been characterized by fragmented services across public hospitals, private clinics, and externally funded non-governmental organizations (NGOs).^{6,7} Since November 2001, the health system has relied on a contracting out model, with the Basic Package of Health Services (BPHS) implemented by NGOs.⁸ Up to June 2021, this contracting out model was under the stewardship of the Afghan Ministry of Public Health (MoPH) through Performance-based Partnership Agreements,⁹ including the Afghanistan Reconstruction Trust Fund's Sehatmandi project,¹⁰ with service delivery devolved to NGOs.⁴

When the Taliban overtook the government in August 2021, the health system (heavily dependent on donor financing) suddenly faced the prospect of funding suspensions.³ Additionally, delays in service provider contract renewals that existed even early in the summer of 2021 heightened fears around the prospect of widespread health service interruptions.³ There were both warnings and reports of a collapse of health services in the country.^{3,11,12,13} With this threat looming, international advocacy efforts to secure interim funds and ensure continuity of services kicked into gear.

On September 20, 2021, the Global Fund agreed to sustain the delivery of essential services across 2,200 facilities in 31 provinces by providing an initial interim bridge fund of US\$15 million through the United Nations Development Program (UNDP); subsequently the UN Emergency Fund allocated an additional \$45 million.^{14,15} To address the critical gap in hospital services beyond the scope of the Sehatmandi project, the UN and International Committee of the Red Cross (ICRC) injected emergency funding to cover operating costs.⁴ This allowed donors time to plan how to transition from Sehatmandi to the new UNICEF-administered Health Emergency Response (HER) project and continue supporting the

Afghan health sector in these new circumstances.

In spite of these significant efforts, over 25 million people in Afghanistan were estimated to be in need of humanitarian assistance by March 2022.¹⁶ Just over a year later, this estimate grew to almost 29 million.¹⁷ In this context, the demands on the health system and on those who deliver health services in Afghanistan continue to be immense.

Methods

Sampling, data collection and analysis

We conducted in-depth interviews with key informants currently working at global, national or local level (including one rural, heavily conflict-affected setting and one urban setting) as well as individuals who worked within the country prior to the Taliban takeover in 2021 – either for the MoPH or an implementing partner. We used purposive sampling to identify participants with expertise in health policy or experience working in underserved areas of the country, supplemented with snowball sampling to expand beyond our initial sampling of participants. We solicited participants' perspectives on the status of the health system and health services following the regime change in August 2021, particularly with respect to disruptions/continuations, supply (e.g., functioning of facilities/community-based services, availability of trained providers, medicines and other commodities, and quality of care, service delivery modalities), demand (e.g., financial, gender and other access barriers for community members), strategy, policy, and funding.

Interviews lasted approximately 60 minutes each and were conducted using Zoom (audio only) by MB-R and AS between October 2022 and February 2023. Based on participants' preferences, interviews were conducted in English, Pashto and/or Farsi. All recorded audio interviews were translated (when necessary) into English and transcribed by an independently contracted firm. Field notes were transcribed if participants requested that the interview not be recorded. Audio recordings and transcripts were stored securely on password-protected computers, only accessible to the research team. MB-R and ED used an iterative approach guided by the tenets of Framework Analysis to analyze the data, starting with an initial coding framework, with ongoing refinement and analysis of themes as new insights emerged from the interview data. Data were analyzed within the qualitative data analysis software Delve (<https://delvetool.com/>).

Ethics

Informed consent was obtained from each participant. All interviews were conducted in a manner pursuant with the study's approved Institutional Review Board application for research with human subjects which was received from Princeton University. To maintain ethical research practices and to ensure privacy, participant identities were kept confidential. Participant data were stripped of personally identifiable information and stored in password-protected folders on the research team laptops. Study methods and results are reported following the Standards for Reporting Qualitative Research (SRQR).

Results

We conducted 20 key informant interviews. Participants spanned a variety of professional backgrounds, roles within the health system and locations (table 1).

Table 1: Characteristics of key informants interviewed, October 2022 - February 2023

Characteristic	Description
Role within the health system	6 - International organization staff/consultants 4 - Women's/reproductive health professional association staff 2 - National non-governmental organization and community service organization staff 1 - Former Ministry of Public Health official 7 - Health service delivery professionals (social mobilizer, medical supplies distributor, midwife, nutrition counselor, nurse, pharmacist and physician)
Interview language	11 - Pashto and Farsi 9 - English
Gender	10 - Women 10 - Men
Work location when interviewed	8 - Kabul-based 9 - Other provinces 3 - External to Afghanistan

Interviews revealed substantial variations in how health service delivery was affected by the fall of the Kabul government including both factors that supported continued health service delivery and factors that contributed to disruptions.

Factors supporting continued health service delivery

External funding and operational flexibility

With many international actors reluctant or unable to engage directly with the Taliban administration, the UN was mandated by UN Security Council Resolutions 2596 and 2626 to engage all parties on humanitarian issues and lead discussions on the way forward for the health system.^{18,19} Participants described the significant role that the UN played in mobilizing donors in the early days after the fall of the previous administration, negotiating access and coordinating communications.

“During [September to November 2021], the traditional donors of the health system, including World Bank, USAID, EU, joined UN meetings, [but] not meetings with Taliban. They started negotiating [about] how things could happen after the end of these three months.”

International organization staff/consultant

Several participants described the advocacy that took place to negotiate funding resumption and health system restructuring in the days and weeks following August 2021.

“We had lots of meetings at that time, and the only message that we wanted to convey to the World Bank was that, “Please don’t [stop] funding at least the health sector.” Even if this is now under the umbrella of the Taliban, but the services are for people. We started advocating for that one, so [there were] lots of publications, [including several] arguing that the health sector is non-political and should be seen completely separate from the context of the politics of Afghanistan, and donors should continue.”

Former Ministry of Public Health official

“It was a chaotic situation, and the whole health system was on the verge of a collapse. NGOs started advocating. First of October, we had a commitment from the UNDP to resume funding the health system.”

National non-governmental organization staff

While bilateral and multilateral donors were negotiating solutions to the funding freeze triggered by the Taliban takeover, others were able to maneuver with greater flexibility due to their continued funding availability.

“We are not under the same rules and regulations, which obviously gives us the flexibility. For us, I don’t even think I think for a moment, I was like, “Oh, my God, what if ... we end up ... stopping the services?” That simply did not happen.”

International organization staff/consultant

Continued care provision by local implementing organizations and health workers

Concurrently, local implementing organizations continued providing services many settings.

“ I think at the system level there was a clear disruption, but at the health service delivery level, the services were provided. Health facilities were open. People were utilizing the services. I think it’s good to see what happened and why that disruption did not happen fundamentally and deeply into the system. ”

Former Ministry of Public Health official

“ The services did not stop. It was operational in the district centers and rural areas. I know for sure [that of] the 78 health facilities that I was responsible for, operation did not pause. Only in a few health facilities where the midwives were shaken and had left the health facilities without informing their supervisors, the service delivery was disrupted. Services in the rest of the health facilities were unaffected. ”

Women’s/reproductive health professional association staff

This same participant noted that many NGOs continued operating in spite of the significant financial uncertainty they faced during the transition period. Another participant noted that previous experience delivering health services in Taliban-controlled regions lessened concerns regarding the change in operating environment after August 15th.

“ These NGOs who are running the health service delivery, who are providing the services, they were used to this with the Taliban. They were working in all provinces where the rural areas were governed by them, by the Taliban in [the] past 10 or maybe 15 years. ”

International organization staff/consultant

Related to the ongoing efforts of implementing NGOs to continue service provision when external health funding paused and the fate of service delivery implementation contracts remained uncertain, was the decision of health workers to continue working, despite not being paid to do so, and in some cases in spite of the risks to their own personal safety.

“ Health workers were not new to running out of supplies. They were not new to not getting their salaries. For them, it was just business as usual but with the additional sort of mental insecurity about, “Oh my God, they’re saying that there will be no more funds. ”

International organization staff/consultant

“ [Starting even before the Taliban takeover,] we didn’t receive our salaries for three months. Despite the lack of pay and the escalating conflict, we continued our duties... When the police station was targeted, the effects of the explosion were felt in our office, causing broken windows. We huddled under the tables, shaken with fear as we sought refuge. Despite these extreme conditions, we still showed up to work but were not paid. The salaries for those three months were ultimately written off. ”

Women’s/reproductive health professional association staff

Additional findings regarding the reasons health workers decided to continue providing care despite these obstacles are described below under “Health Worker Motivation and Coping Strategies.”

Flexibility of contracting out arrangements

Once funding for the health system was set to resume, the existing structure of health service delivery through contracting out arrangements facilitated the transfer of responsibilities and stewardship. With donors no longer routing funds through the Afghan Ministry of Public Health and Ministry of Finance, the contracting out system meant that bridge funding could be routed directly from multilateral donors to UN agencies, who could then pay implementing NGOs to continue providing services at healthcare facilities.

“ What was good was that the Global Fund and the UN continued with the same system. They continued using NGOs – many of the same NGOs. They continued with the same package of services that had been delivered before. They continued with many of the same ways of paying. Not completely the same but making sure that there were sufficient payments and such. We were able to transition the system across three different financing modalities without causing too much disruption on the ground as it [otherwise] might [have]. ”

International organization staff/consultant

“ I think one is that, as you know, [essential health services were] being provided by NGOs from the very get-go, ever since the early 2000s. It was [therefore] much easier ...to shift ... financing away from the government and directly to the NGOs or indirectly to the UN institutions. That was a major reason why... the system was able to be resilient and carry on. ”

International organization staff/consultant

Performance based monitoring

Participants had differing views on the role of pay-for-performance systems in supporting continuation of service delivery despite uncertainty within the health system. As one International organization staff/consultant stated, “[Because] payment is linked with performances, the NGOs are trying to maintain or sustain those performances, the utilization of services. That’s one of the [reasons] that the utilization has not been affected as much as it may have been expected.” This view was tempered, however, by a key informant who believed that such a system incentivizes inflated performance reports.

“We do need to incentivize these indicators. [However,] if we incentivize, we give incentive to produce fake data. I do agree with the concept of performance management, or pay-for-performance, but pay-for-performance requires specific capacity to be able to monitor.”

International organization staff/consultant

Improved security

In communities that had been previously heavily affected by conflict, the transition allowed NGO staff greater mobility and access and, as a result, health service delivery increased.

“Before the fall, the Taliban already had greater control in Helmand, which is why there was always fighting between the government and Taliban forces. The conflict has stopped, which is one of the positive impacts here. In the past, vaccinators and other health workers would travel fearfully and avoid going deep into rural areas for safety and security reasons. But this is not a primary concern now.”

Health service delivery professional

“Access to the health facilities – it has increased. Why is that? It’s because, first, the health facilities have been renovated and functionalized, and people can access ... them. For the white areas [active conflict areas] where there weren’t any health facilities in the past, now there are other mechanisms that are put in place to provide services, for example, establishment of mobile health and nutrition teams in different provinces.”

National non-governmental organization staff

“ I have been to [community in a formerly conflict-affected] district. Nothing was working in those areas. The phone was not working. There was no clean water. The area was located far from the health facility. And we chose that area for [our work] because of its rural location. We managed to identify 29 similar sites that are located far from the health facilities. Women in these areas did not have access to basic services in the past. ”

Women’s/reproductive health professional association staff

Factors that disrupted health services

Participants also several described factors that impeded delivery and utilization of health services following and even prior to the government change in August 2021.

Damage to healthcare facilities

Intensification of the conflict in advance of the Taliban takeover inflicted damage on health infrastructure in several areas of the country, and in some cases, the damage remained following the transition.

“ Especially during the summer of 2021, we had a lot of destruction. Thirty-seven out of 87 health facilities were completely [destroyed]. In some cases, we did not have anything left except ruined buildings. ”

National non-governmental organization staff

“ After the fall, these facilities were renovated, [but] not all the hospitals that were damaged. In some places the [district hospitals were] unusable because of the damage sustained when conflict intensified. ”

Women’s/reproductive health professional association staff

Limited availability of medical supplies

In the early months after the Taliban takeover, participants noted that NGOs and other internationally funded organizations had sufficient supplies to continue providing routine care. However, stock issues emerged shortly thereafter due to uncertainties regarding imports and the inability of traders to make overseas payments.

“ We had enough in stocks, so we didn’t run into any major challenges for the first few months after the fall. But afterward, the shortage started. The first five or six months were ok. Most of the suppliers had enough in their stocks. But after that, everything changed. ”

Women’s/reproductive health professional association staff

“ We are heavily reliant on imported products across all sectors, including health. After the fall of the previous government, the banking system was paralyzed, which restricted medical suppliers from sending money outside the country to purchase medical supplies. This issue was and still is a major bottleneck. ”

Health service delivery professional

Direct implementation by government

Prior to the Taliban takeover, contracting out through the BPHS program was the predominant model of health service delivery in 31 of the country's 34 provinces. Participants indicated that in the early days following the fall of Kabul, essential service delivery in provinces outside the scope of BPHS – and therefore implemented directly by government – faced significant challenges. One participant explained:

“ Kabul Health Services were completely supported by the government, by the Republic, before the Taliban. All the health workers in Kabul are civil servants and [had] much more challenges to sustain those finances, sustain those services than we had with the [BPHS]. ”

International organization staff/consultant

Participants who had been collaborating closely with the previous MoPH also reported disruptions due to restrictions with donor funding.

“ At that time, we had a lot of funds for our department, for running, for monitoring, for ensuring all the activities, and for some additional support of capacity building. That was stopped [after the fall of the government]. That was stopped because there was some specific limitation that no one can financially support the [new] government. ”

International organization staff/consultant

Change of MoPH leadership and policies

In addition to the service delivery challenges noted above, the transition in national leadership resulted in new coordination and capacity challenges between international actors and the MoPH.

“ It is not a full engagement or maybe optimum engagement with the government. There is engagement at maybe a technical level, not above that. You can say that there is no discussion or joint discussion on how to move forward on how to strengthen the health system. There's just a quick fix. ”

International organization staff/consultant

“ Having a meeting in the ministry was very different back then than it is now. Because now you’re just dealing with people that simply do not understand the basics. And some of them are even doctors, but even the doctors that they have brought on board have political agendas, have religious agendas. So the technical aspect is just pretty much... it’s pretty much nonexistent. ”

International organization staff/consultant

As UNICEF assumed the stewardship role over the contracted out health system, donors’ engagement efforts focused on coordinating with the MoPH without providing the Taliban with direct decision-making power. At the same time, the new government sought to establish its new leadership role.

“ The HER project was supposed to start from November 1st until December 31st [2022], but still there are struggles back and forth, and the Ministry of Public Health is not agreeing with certain decisions and some of the selections despite ... them having their observers in the whole procurement process that was conducted by UNICEF. They disagree with some of the decisions, and that’s why there is no contract as of yet. ”

National non-governmental organization staff

“ They still behave like an anti-government element. They don’t feel responsible that they are the one to provide services for the people of Afghanistan. They are the one that should facilitate the work of the international organizations, but they still put conditions on international organizations, “Give me this, this, this, this. Then I will allow you to go and vaccinate a child there. ”

International organization staff/consultant

“ When the discussion reached to a level, the [MoPH] issued a letter to all governors in the provinces. If the NGO does not have the authorization from the Ministry of Public Health, they cannot operate in the province. Close them down. This was the extreme. I was witnessing this. In such a situation, how you cannot engage the existing administration in decision making? ”

International organization staff/consultant

Indeed, this has caused distress for implementing organizations as have the ensuing policy changes and restrictions. Participants – even those with previous experience working in Taliban controlled areas – described additional bureaucratic hurdles and delays as a result of recent Taliban efforts to closely control health operations at a local level.

“ We had to renew our memorandum of understanding between the NGOs and the Ministry of Public Health. Also, now for every project, regardless of who funds this, we must seek a no-objection certificate from the Ministry of Public Health. Unless we have such a certificate in hand, we will not be allowed to start our operations and the project implementation at the provincial level. This is a big challenge, and it is really delaying things. ”

National non-governmental organization staff

At times local NGOs found themselves negotiating sometimes opposing instructions from donors and authorities on the ground. One participant argued that trust-building between donors and local NGOs is critical to enable NGOs to be effective in navigating the complex environments in which they operate.

“ In most cases, we found negotiating a path forward with donors harder than with the local authorities. I don’t blame them. They were under strict instructions. However, to get things done, moving beyond rigid guidelines and prioritizing whichever approach ensures improved outcomes is necessary. ”

National non-governmental organization staff

Health Worker Motivation and Coping Strategies

While various factors in the enabling environment, and supply and demand factors within the health system itself, have influenced health service delivery in post-August 2021 Afghanistan, perhaps the most critical of these supporting continued service delivery has been the commitment of the health workforce itself. We explored the reasons behind this commitment as well as their coping strategies.

Motivational factors

Health workers in Afghanistan have long shown strength and resilience in the face of challenges, including during the longstanding conflict prior to August 2021.

“ The oath we took with our conscience – and God perhaps – gave us the determination to work in crisis situations and face numerous restrictions, including family limitations. We remained firm and fearless. A pregnant colleague in her eighth month of pregnancy would still show up to work as a Reproductive Health officer on a BPHS+ project. When the window glass shattered during an attack, I quickly ran to her and held her in my arms to calm her down. I pulled her towards me, just as the broken glass barely missed her. ”

Women’s/reproductive health professional association staff

In the aftermath of the Taliban takeover, the role that providers played (despite uncertainty regarding their contracts and many months of missed pay) was critical to the continuity of health service delivery across the country. Female health workers faced additional challenges due to fears regarding new policies and restrictions that the Taliban would implement. One participant described what she did to motivate female health workers to continue in the days following the change in government.

“I went to the Ministry and, in front of the Taliban’s health commission and through the media, called on midwives and nurses to return to work. I emphasized that we work for the health of mothers, children, and the community, not for governments, which gave the nurses and midwives some reassurance and confidence to return to their jobs.”

Women’s/reproductive health professional association staff

This sentiment was echoed by other key informants who discussed feelings of patriotism, duty and responsibility towards their communities as underpinning the reason health workers continued working.

“I lived under the previous Taliban regime and saw how difficult it was to access good care. As a medical professional, I take an oath to serve, no matter the circumstances. So, it was time to put my beliefs into practice. That said, I was anxious and afraid of what would happen to me and my family and friends.”

Health service delivery professional

“Believe me, they didn’t have anything to eat. They were on night duty. The hospital couldn’t provide them anything to eat. They didn’t have salaries, but among all of these things, these women stayed committed for the other women, [they knew they] were providing help to them.”

Women’s/reproductive health professional association staff

“As a health worker living in a village, you cannot see a child is dying of a disease and you know how to manage it, and then you don’t do it because you don’t receive your salary. It’s a moral responsibility for them.”

Former Ministry of Public Health official

In addition, some healthcare providers may have felt pressure to return to work in order to meet specific pay-for-performance metrics and ensure future compensation, or to ensure clients for their private practices.

“In the P4P, there was some conditions. ... If they’ll not achieve, they will receive 50 percent of their budget, and 20 percent will be cut from their fund. It is for motivating them to do the best job and improve the performance. ”

International organization staff/consultant

“This is a reality that when someone – nurse, doctor, technician – is working in a public health facility, there is a referral system [that] exists between their private practice, and their public practice. If they don’t go to the public hospital, that will affect their private practice as well. ”

International organization staff/consultant

A few participants also noted that, for many providers, there was no other viable option than to return to work following the government takeover.

“They have to live in this country. They have to work, to continue, to not lose their job, their contract with the government. Because of this – they came and they were providing services for the pregnant women and the children, and at the maternity hospital they were working and providing services during that very bad situation, bad time. ”

International organization staff/consultant

“Some of these health workers were owed their backpay for months. I think it was a mixture of commitment to the cause and perhaps, probably, also hope that in the future they would get paid and the work they put in now would get reimbursed in the future, as well. ”

International organization staff/consultant

“Some will answer ‘We are Afghans, we love our country, we stayed.’ But I look at it this way: what other option existed for them to leave? They went to work hoping to get paid. By going to work, maybe they had a forty to fifty percent chance to get paid. But staying at home, this chance reduced to zero. ”

International organization staff/consultant

Coping Strategies and Ongoing Concerns

Reactions to, and experiences in, the new working environment varied for health workers based on their gender, context and exposure to social changes and restrictions after the fall of Kabul. Female health workers described some of the ways in which they have been disproportionately impacted.

“I am done with the [medical] residency and only need to take the exit exam, but unfortunately, the Taliban have banned it until further notice. I was fully prepared and had studied for it. Today, I was supposed to be in Kabul for the biometrics.”

Health service delivery professional

“There is a deliberate campaign to remove women from leadership positions in the health sector, especially in key decision-making offices. Women are also being removed from serving as technical board members where their voice is needed. The new policy requires that organizations with executive boards, technical boards, or advisory councils exclude women from their lists.”

Women’s/reproductive health professional association staff

“The strange part and change I felt was that when I called our male colleagues, they would not answer. Everyone was afraid. But after a few tries, I was able to connect with a colleague and asked about returning to the office. They told us it was okay, but we had to wear an appropriate hijab. I told them that it really didn’t matter to us because we were wearing the same proper hijab even before the Taliban took over.”

Health service delivery professional

On December 21, 2022, when the Taliban banned women from working with NGOs across the country, the only sector that received an exemption was the health sector. While the exemption was not formally communicated, MoPH officials provided assurance to service providers. In return, service providers made changes to comply with the restrictions but this brought additional challenges. One common concern that emerged was around the Mahram policy, which requires female health workers to be accompanied by a male chaperone from their immediate family. While these restrictions were not new for health workers in some areas of the country, many highlighted the challenge of having Mahrams accompany health workers for long periods of time to remote areas where employment opportunities for the Mahrams themselves are limited.

“ Some rural areas lack access to essential services due to logistical, travel and operational challenges. Getting midwives to these rural areas is tricky because if they take their Mahram, they will have no job opportunities. For example, I recently spoke with a midwife in [X community] who said she works in a health facility, but her Mahram has been with her for over six months and has no job. He is caring for the house while she works at the health facility. This is a huge problem and challenge. If a midwife is deployed to a rural area, her children need access to school, and her male family member needs a job. ”

Women’s/reproductive health professional association staff

“ My husband is with me and has been unemployed for ten years. The reason appears to be that the project cannot hire two people from the same family. This has resulted in many negative effects, including depression. Many midwives working in rural areas are accompanied by their unemployed husbands, which is negatively impacting the men. ”

Women’s/reproductive health professional association staff

Participants also highlighted the Mahram policy’s effect on the training of high-quality personnel, by limiting female health workers from opportunities to improve their technical skills.

“ We get picked up from and returned to our houses by the designated office vehicle. But that doesn’t mean we don’t have problems. Like in the past, we try to solve them. One major change is that previously we would have a technical team from Kabul evaluate our teaching by sitting in the class and closely monitoring how I teach and convey the course content. They would then provide feedback. But now that is not possible. ”

Health service delivery professional

“ [Another] challenge is the relationships and the connections between Afghanistan and other countries because doctors need to develop. They need to, day by day, become updated, but a female doctor is not allowed to go outside of country, even for the purpose of study, or even for the three days without a man. ”

Women’s/reproductive health professional association staff

With increased restrictions keeping female health workers from interacting with their male colleagues, participants described using digital technologies such as phone calls or WhatsApp messages to substitute for in person interactions. Participants also mentioned that their supervisors had preemptively put in place restrictive measures to avoid potential backlash by the Taliban regarding female working spaces.

“Whenever we would go to a colleague’s office to talk about work, we would first text to make sure we let them know if it was okay to visit. But we were instructed to try our best to solve everything via phone and avoid visiting offices because the Taliban might have their people watching our movements.”

Health service delivery professional

Despite the Taliban’s ban on women working in local and international NGOs, which severely impacted all other sectors since December 22, 2022, the health sector was noticeably treated differently.

“We didn’t go to work for two days. But soon, they realized that if they went ahead with their plan for female health workers to stay home, who would treat the female patients?”

Health service delivery professional

Beyond the operational concerns created by these restrictions, participants shared their reflections on the mental toll.

“I see the challenge of the shrinking space for female health workers, especially as it relates to the southern region [of the country], and the motivational damage. I think every little infringement has a very deep psychological impact on health workers.”

International organization staff/consultant

“Safety has improved, but [there is a] psychological, constant psychological fear. I think the best way to say it: Before August 15, there was much more of the focus of women on physical survival. Now, I think it has shifted to psychological and emotional survival.”

International organization staff/consultant

And finally, one participant expressed her fears about what the new laws and restrictions imposed on female health workers would lead to in the future.

“The first big challenge is that we don’t want to be the last generation of female doctors. We need another generation. We need another generation to come to study to develop and become female doctors. When schools are closed, when girls couldn’t even go to the school, how can I be hopeful that when I become retired, when I become old, there will be another female doctor to provide help for a female?”

Women’s/reproductive health professional association staff

Additional challenges affecting the health system under the Taliban-run government

While new policies and restrictions exacerbate Afghanistan’s health system and health service delivery challenges, participants described additional challenges which, if left unaddressed, will further negatively impact the health sector.

Loss of qualified healthcare professionals

Several participants lauded the dedication of Afghanistan’s health workers and the tremendous sacrifices they make to deliver lifesaving care under the most challenging of conditions. It was also noted that the dangers health workers, and particularly female health workers, regularly face might drive these same professionals to leave the country.

“They do not have security in our country, so we feel that, okay, I’m working. I am a doctor, a female doctor. The government tells me to go work, but I feel that I’m not secure when I’m walking into the street. I don’t know when the bomb will explode, when I will lose my family members. When I leave the home in the morning, night I come. I’m not sure that I can see all of my family members, we can be together one more time or not. This is the biggest challenge that we have. Every day, we do not have security, so I have to leave the country... even go to Iran, Pakistan, or even just stay jobless, but at least stay alive.”

Women’s/reproductive health professional association staff

Others cautioned that the exodus of qualified personnel, or of qualified personnel being replaced, will impact the availability of quality services.

“We lost a technician who ran our lab, which was a big loss as there aren’t many qualified technicians capable of operating the technology.”

Health service delivery professional

“ Qualified and experienced staff are being replaced by new and inexperienced officials, such as replacing nursing managers with extensive experience with recruits who don’t know the system. Such actions are bound to impact the health system negatively. ”

Women’s/reproductive health professional association staff

In addition to current losses, Taliban restrictions on female education are expected to compound the shortage of qualified health professionals in the country.

“ In 2002 and ’03 and ’04, we did not have enough female health workers, particularly midwives and nurses. We had to sign an agreement with Tajikistan, and we brought lots of female nurses from Tajikistan to Afghanistan. They were actually providing services. I believe if this situation continues, we might end up with a similar situation that after three or four years, we might ask neighbor countries to send us resources – female, I mean. ”

Former Ministry of Public Health official

Dependency on external funding

The Afghan health system’s reliance on external donor funding and the risk that this poses to the availability of services in the face of shifting global priorities was evident following the Taliban takeover.

“ Our service delivery... is very much donor dependent. All the payments – the salary payments or the running cost – everything was paid by the donors. When they announced that they’re not going to support the service delivery anymore, so all of us – so everything stopped. ”

International organization staff/consultant

“ Even today, if UNICEF stops, everything will stop. It’s not sustainable at all. It hasn’t been sustainable in the past. We don’t have any other financing mechanisms in place. There is no insurance mechanism. I can’t expect those to happen even now because we are not in a stable country. ”

National non-governmental organization staff

“When we want ownership and sustainability, we need to invest. Government was unable to invest domestic resources in health. Funding was coming from donors. Donors had their own conditions. Sometimes genuine condition, sometimes not correct condition, based on some misunderstanding.”

International organization staff/consultant

Widespread economic hardship

Finally, the severe financial strain that much of the Afghan population experienced after the Taliban takeover and the country’s associated banking problems meant that the population able to afford private health services drastically declined in the months following August 2021. This resulted in a significant increase in utilization of public health services, which in turn placed an additional strain on health service delivery.

“The purchasing power of people has drastically decreased, and their first choice is to avoid visiting a private clinic. They would instead go to a public hospital, endure all the problems, and wait for hours and days to avoid paying for the doctor’s fee. It is not that they don’t seek quality or good care, but simply because they have to make tough decisions on what to prioritize since most people have lost their jobs or income sources.”

Health service delivery professional

“Patients rushed to public hospitals, leading to increased patient loads and negatively impacting maternal health. For example, in [X province], gynecologists were overwhelmed due to the increased patient load and the hospital’s lack of capacity to respond.”

Women’s/reproductive health professional association staff

Discussion

We documented the perspectives of various stakeholders to identify factors that facilitated or hindered health service delivery in Afghanistan following the Taliban government takeover in August 2021. We focused our investigation on essential health services delivered by implementing NGOs and thus did not engage key informants working in secondary or tertiary/hospital-based services or for the private sector, for-profit sector. Although we did engage a wide range of stakeholders working at global, national and local levels, the inputs of additional key informants may have produced different views on facilitating or constraining factors.

The Afghan health sector presents a compelling case of adaptability in the face of crisis. Despite the anticipated^{3,20} and reported^{11,21} total collapse of the health system due to the shift of power, various factors enabled services to continue within the country. First, because NGOs were largely responsible for delivery of essential health services prior to the government takeover, donors were able to contrive a stopgap solution to the crisis of legitimacy of the Taliban government. This entailed providing funding and resources to NGO implementers via UNICEF, effectively relegating the functions of the MoPH and facilitating continuity and resumption of services more quickly than might otherwise have happened. The dedication and motivations (some altruistic, some financial) of frontline health workers also enabled services to continue in some settings during the transition. In essence, the persistence of these NGOs and health workers acted as a buffer, insulating the delivery of essential health services from the crisis and reluctance of donors to fund health projects directly through government channels.

Other studies have reported that public health service utilization continued and even increased in some settings following the Taliban takeover.^{5,22} Participants in our study corroborated this, attributing increased utilization to improved security, shifts from private to public services due to economic hardship and reduced ability to afford private health services.

Participants in our study also highlighted factors that hindered health service provision following the government takeover: poor infrastructure (particularly in severely conflict-affected areas) and challenges procuring essential medicines and supplies from outside of the country. These have been noted elsewhere as well.²³

Our findings suggest several implications for future service delivery in Afghanistan and other FCV contexts at risk of political and societal disruption. First, contracting out can be an effective service delivery model to continue health services during a government shock in such settings. Contracting out is already common in many low-income and conflict-affected countries, although an important critique is that the quality and consistency of care provided by different service providers can vary,²⁴ as can the accountability and sustainability of health services when external support wanes and the government is unable to sustain operations through the national budget.^{25,26} In Afghanistan, a November 2020 independent assessment of the design and performance of primary healthcare recommended that – given the contested governmental authority in many areas – it would be prudent to continue contracting out services to ensure continued access to care among disadvantaged communities.²⁷ Additional concerns regarding stopgap solutions such as contracting out are that these approaches hinder efficiency,²⁸ government capacity building,²⁹ and in some cases, even the quality of care.³⁰ Future initiatives that rely on contracting out should incorporate monitoring and evaluation activities to

identify and develop strategies to mitigate these potential problems.³¹ The extent to which it is preferable – and feasible – to concurrently build government institutional capacities while investing in contracting out activities should also be considered.

Second, strong collaboration among donors, international health agencies, and local NGOs resulted in an interim strategy for the health system in a relatively tumultuous but short period of time. Such a strong effort across partners facilitated the rapid resumption of health services³² and likely saved many lives. In FCV settings experiencing shocks – whether due to political turmoil or health emergencies such as the COVID-19 pandemic – multi-partner, inclusive coordination is critical for robust preparedness and response, and may be fostered by coordination structures with clear roles and responsibilities, sufficient resources and capacity, and leadership.³³

Third, flexible and agile donor protocols and guidelines are crucial to success in FCV contexts during crisis. The situation that unfolded after the fall of Kabul was highly unpredictable and erratic. With the reduced presence of international actors and donors, NGOs had to engage with the new authorities to navigate the changed implementation landscape, establish trust, negotiate access, and seek permission to resume activities. However, local actors' ability to do these things is influenced by the degree of decision-making power conferred to them. Such an approach centers on fostering trust and rapport with local authorities, ensuring access to hard-to-reach areas, and mitigating the impact of personnel or leadership changes that may occur following a shift in power on program activities.

Fourth, the agility of the Afghan health sector to continue operations in the aftermath of Kabul's fall suggests that it may have a role to play as a conduit for wider humanitarian efforts, for example, relating to nutrition, water, sanitation and hygiene, food assistance and agriculture. International donors, policymakers, and aid organizations can prioritize the health sector as an 'entry point' for conversations with regimes regarding broader humanitarian efforts, capitalizing on the sector's sanctity and neutrality. Concurrently, the international community must actively advocate for health to be seen as a sector that warrants protection from political disruptions while also considering potential risks and devising strategies to ensure that the quality and consistency of health services are maintained during periods of crisis and transition.

Despite the resilience that health service delivery in Afghanistan has shown following the recent transition of power, extraordinary challenges remain in the daily provision of healthcare services across the country, as well as in stakeholders' ability to strengthen the health system in the longer term. Decades of conflict have imposed a significant toll on health infrastructure and will require significant investment to improve their operational capacity. In addition, support for health services at the local government level varies, posing challenges for health workers who must navigate conflicting or changing guidance from authorities, donors and implementers. Importantly, the operating space for female health workers continues to shrink, while bans on female education call into question the future of the female health workforce. This compounds the concerns surrounding the loss of trained and experienced providers more broadly. Finally, the profound economic crisis in which the country finds itself increases the pressure on public healthcare systems and the need for immediate humanitarian responses across all sectors.

Future research should aim to determine which specific investments are most critical to ensure the provision of quality health services, particularly in the most disadvantaged settings of the country, as well as which opportunities to facilitate more sustainable,

institutionalized approaches within the health sector in Afghanistan should be prioritized. Such evidence could help shape future implementation strategies for effective engagement and enduring resilience in the health sector within Afghanistan as well as other FCV contexts.

Conclusion

Afghanistan's health sector, along with other sectors in Afghanistan, faced multiple challenges even prior to the change in government in August 2021. Some of these challenges were exacerbated by the country's regime change but this study highlights several factors that facilitated functional adjustments to the new operating realities. In navigating challenges in FCV contexts like Afghanistan, innovative, bold and evidence-based solutions to sustain health service delivery must be pursued. Such solutions should integrate robust financing and monitoring, and engagement of those working at local levels in order to ensure quality care and effective reach to the most vulnerable communities.

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