AFGHANISTAN: STARTING FROM SCRATCH

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Abstract

Afghanistan competes with Liberia and Sierra Leone for the last place on the international lists and will depend on external aid for many years, but is slowly moving ahead, not without constraints and contradictions. The Government is trying to fulfill his commitment to ensure an equitable access to the services and an improvement of the health status of the people. This paper offers a glance of the situation of the health system in Afghanistan. Beyond information and comments that are specific for the country, it presents some issues that can be challenging for those concerned with the international health co-operation and with the development of the health systems in areas with limited resources.

Introduction

The endless sequel of wars that plagued Afghanistan started more than thirty years ago. Now, for the first time since 1978, the country has the chance of rebuilding its health system in the frame of a political and civil reconstruction that is unfortunately still far from complete.

Afghanistan is a landlocked, beautiful country that, due to its geographical position, has been for centuries a crossroads for commercial trade and the object of the interested attention of its neighbours. The reasons for the recent turmoil are complex and both internal and external factors played an important role. Today it is difficult to affirm that Afghanistan is enjoying freedom and democracy: its stability is (or should be) secured by the presence of more than thirty thousand foreign soldiers, half of them engaged in covered war operations along the Pakistan border. The ethnic divide is tangible: Pashtun, Tajik, Hazara can barely consider each other as a part of the same nation and are struggling for power. Too many armed "militia" still control the provinces, where local commanders aspire to maintain their authority, very often based on the wealth coming from the opium traffic. The recently elected President Karzay is doing his best to demonstrate that he is not only the mayor of Kabul nor he is a puppet of the USA.

In spite of all this, Afghanistan is moving ahead and, in the health sector, is doing a positive and real effort to fulfill the declared commitment to ensure an equitable access to services and an improvement of the health status of the people.

This paper is based on the personal experience of the author, an Italian doctor who has been in charge of an hospital-based project in Kabul since July 2004 and from January 2005 is posted in the northern Province of Baghlan as technical advisor to the Provincial Health Office. It offers a glance on the health situation in Afghanistan and raises some issues that are supposed to be of general interest for those involved in health co-operation.

Health status in Afghanistan

Afghanistan competes with Liberia and Sierra Leone for the last place on the world tables of health and development indicators. Basic data are easily found on the World Health Organisation (WHO) website and elsewhere, although their reliability is questionable, in a country where the Health Information System is virtually non-existent and even the total population is a matter for hypothesis which is about 23 million people.

Afghanistan is not a tropical country, but malaria, that was rather well controlled, is spreading again, with 4 million cases per year (30 % due to P.Falciparum). Cutaneous Leishmaniosis is rather common. Seventy thousand new cases of Tuberculosis are registered every year. HIV infection is reported rare, and
information about it is scarce. The most frequent diseases are gastrointestinal and respiratory infections, related to poor living conditions and poor hygiene. Injuries and deaths caused by landmines are also common. The figures are decreasing steadily from the 200 or more cases reported per month in 2002. As it always happens in similar situations, the number of accidents affecting children, mainly due to unexploded devices, are increasing. The Orthopedic Centre of the International Committee of the Red Cross (ICRC) in Kabul, with a record of more than 60.000 people treated for war injuries, is now accepting for rehabilitation victims of other, "non violent" health problems like strokes and congenital malformations.

A figure that is difficult to believe and accept is the maternal mortality rate. A survey made by UNICEF in the remote area of Badakshan reported a shocking 6.000 deaths/100.000 live births.

Poverty and war are not enough to explain this scourge. It is certainly related to the physical and cultural obstacles coming between women and a properly assisted delivery. Local traditions, more than the Islamic religion, require the approval and the presence of the father or husband, for a woman to go to a clinic. There the women should be attended by female staff. But female staff are extremely scarce (and forbidden to work during the Taliban years). As a result the vast majority of deliveries take place at home and without any chance for a prompt referral.

Table 1: Afghanistan main indicators (various sources)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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<tbody>
<tr>
<td>Life expectancy at birth</td>
<td>42.5 years</td>
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<tr>
<td>Infant mortality rate</td>
<td>165/1000</td>
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<tr>
<td>Under five mortality rate</td>
<td>250/1000</td>
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<tr>
<td>Maternal mortality rate</td>
<td>1700/100.000</td>
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<tr>
<td>Acute malnutrition</td>
<td>3.5 - 11 %</td>
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<tr>
<td>Stunting</td>
<td>45 - 59 %</td>
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<tr>
<td>Immunization coverage</td>
<td>20-47 %</td>
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<tr>
<td>Access to health care</td>
<td>30 %</td>
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<tr>
<td>Access to safe water</td>
<td>23 %</td>
</tr>
<tr>
<td>Access to adequate sanitation</td>
<td>12 %</td>
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<tr>
<td>Population/health facility (average)</td>
<td>45.000</td>
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<tr>
<td>Doctor/population ratio</td>
<td>1/1.700 (Kabul) up to 1/450.000 in provinces</td>
</tr>
</tbody>
</table>

Afghanistan is divided in 34 Provinces and 330 Districts. Basic health services should be provided by the virtually non existent Health Posts, by Traditional Birth Attendants and local healers, operating without any formal integration and effective support. The first structured level of health care is the Basic Health Centre (a sort of Dispensary delivering mainly out-patient services), followed by the Comprehensive Health Centre (where diagnostic facilities and in-patients beds should be available) and by District Hospitals (usually serving more than one district and a population between 100.000 and 300.000). The referral function is entrusted to the Provincial and the Regional Hospitals (for larger catching areas). Maldistribution is a major concern: Kabul has 1,28 beds for 1.000 people, whereas in the provinces the average is 0,22.

Per capita health expenditure is about 30 USD (Purchasing Power Parity?) per year, half of it as a contribution from the users (100 % out of pocket). Fees for service are widely applied and strongly encouraged by the technical advisors of the Ministry. In Baghlan they are usually 3 to 5 Afganis (50 Afg = 1 USD) payed at the arrival in OPD, with no further charge. The sum is affordable for almost everybody, but the true cost is represented - especially in urban areas - by the payment under the counter and by the referral to the private sector: for diagnostic investigations (laboratory, X Ray, even a TC Scan if requested), for purchasing drugs or simply to see and pay the same doctor who will then admit the patient "free of charge" in his public (private?) hospital.

Health co-operation

The Hospital where I was posted in July 2004 is called Karte Seh (that means District Three) but it has been renamed Istiqlal (independence). It results from the merging of a maternity and an internal medicine ward, rehabilitated by a British NGO, and a surgical ward built by the Italian Cooperation, for a total of 165 beds. The surgical ward is the heir of a well-known Surgical Hospital run by the International Committee of the Red Cross for more than fifteen years and dedicated mainly to the victims of war. It includes a ward for the treatment of paraplegic patients and a burns unit.

What struck me from the beginning was the poor coordination of the whole structure.

Several months after the official opening, there are still two separate X Ray services (totalling no more than five exams per day), two separate drug stores, two separate electricity networks. Particularly surprising was the failure to provide for a sound heating system. Kabul is at about 1800 meters above
the sea level. It is very hot in summer and very cold in winter. I was told that electricity had to be supplied soon from the Municipality, but since this did not materialize, the only way that I found to avoid patients hypothermia was to drill the newly painted walls with dozen of chimneys for diesel stoves.

In a post conflict situation, with a local Government extremely weak, a coordination of the chaotic international help is necessary and the UN agencies are in the best position to offer such help. Unfortunately in Afghanistan they show very often their worst image: a multitude of white cars and well payed staff, with very few concrete achievements. The true and leading authority here are the United States and they have their own priorities and criteria for action.

One of those criteria, largely adopted - as I can see in Baghlan Province -, is to entrust each health service (hospital, clinic or even a district) to a cooperation agency or to a local NGO, usually supported with foreign funds. There are no common rules for such contracts. In any case the Ministry of Health withdraws any further allocation, except the basic salaries, assuming that the private "owner" will provide all the other needed resources. It is worth noting that the basic salaries are still around 35 USD per month, with very little differences for qualification and seniority. This implies that all the supporting projects include an "incentive" policy, especially targeted to enhance the employment of female staff and the availability of personnel for the most remote areas. Even so, it happens that the Hospital of Pul i Kumri (capital city of Baghlan), with 100 beds, has at present 35 "doctors" (the qualification is not always clear), 15 of them officially posted to peripheral Health Centres, but very reluctant to stay in places difficult to reach and easily blocked by the snow. A high number of "doctors" also crowds the corridors of Istiqlal Hospital, ostensibly, to use the label of a respected surgical centre and to exploit it in the many and more profitable private health business polluting Kabul.

It is far too easy to criticize. The situation of the country is really difficult. The Afghan Government is not yet able to collect taxes from all Provinces and, by the way, half of the national wealth comes from illegal trade. International aid remains far below the pledged levels and the tsunami threatens now to divert resources and interest towards other, more image-rewarding spots in Asia.

With no money to spend and a system disrupted by twenty years of fierce internal fighting, the Ministry of Health is probably inclined to accept the idea that little is better than nothing and that contracting private agencies, leaving them with the burden of fund raising, allowing or encouraging users fees, can at least ensure that "some" health services are available. Universal accessibility will, hopefully, follow.

Contracting services

The contracting scheme was recommended by a Joint Donors' Mission in 2002 and is known as Performance Based Partnership Agreement. The Italian Project for Istiqlal Hospital is also based on a Memorandum of Understanding, signed in July 2004, where the amount of financial support is clearly specified (for incentives, drugs, fuel and other non medical items). It was clear from the beginning that the funds were not matching the budget of the Hospital, but since nobody was concerned, I assumed that the Ministry of Health would be willing to provide for the difference. Then started the diesel game. The Agreement established an amount of 2.500 USD per month for fuel and maintenance. In November the Italian Cooperation accepted to increase the amount to 5.800 USD. In December, almost 12.000 USD were spent for diesel alone, half of that for the unplanned heating. The Ministry did nothing beyond suggesting to shift to the sawdust stoves.

The problem was similar but more complex for the drugs supply. Afghanistan has a national policy for drugs and well defined standards for the various levels of health services. However, it doesn't have a centralized purchasing system nor a working Central Medical Store. The agencies in charge of hospitals and clinics follow their own way. In our case the legacy of the Red Cross was particularly cumbersome. International Committee of Red Cross (ICRC) is able to make international tenders and keeps in Kabul a well supplied warehouse. They have plenty of staff for every sector, from laboratory to blood bank or the maintenance of generators. The former Karte Seh Hospital was very well nursed and the Director had only to call ICRC, to solve a stock-out in the pharmacy or for an urgent request of toilet paper. The shift to a "normal" co-operation project was shocking for them - and for me - and none of us has fully recovered as yet. For purchasing drugs and any other items we must turn to the private market, looking for an acceptable balance between cost, quality and timing. But the budget is limited and nobody is happy.

The poison was in the initial agreement. Even for the battered Afghan health system a contract should be a contract and nobody should expect to have a 100 %
of service with a budget barely covering 50% of costs. Probably it could be clearer to agree on a simple budget support, without any direct involvement in providing services. Or, it would be better as a condition proposed by an American University to take the responsibility of Wazir Akbar Hospital in Kabul: they want the power of "hiring and firing".

The newly appointed Minister of Health seems well intentioned. Among his first steps he decided a revision of the drug market, imposing a strict control on the trading licences. At the counter of some pharmacies, I could find boys no more than 12 years old, proudly dispensing pills picked from chaotic shelves full of items of dubious origin and unknown expiry date.

Within a month, there will be also a scrutiny of all Provincial Health Directors, to ensure (as a hopeful Deputy Director told me) that in future everybody will be appointed only for her or his professional merits.

Since the end of 2001 the MoH was also able to produce a statement on the National Policy for Health (with abundant quotations of the Primary Health Care principles), followed by a National Essential Drugs List (February 2003), a Basic Package of Health Service (March 2003), a National Salary Policy for NGOs (August 2003) and an Essential Package of Hospital Services (August 2004, draft). The common feature of the documents is the clear purpose to achieve a working frame and common standards, in other words to start rebuilding a system. However, the policy of contracting services to private agencies, albeit probably not avoidable at present, makes these documents rather hollow.

The Provincial Health Coordination Committee of Baghlan, very often deserted by the UN representatives, is a useful place for meeting and exchanging ideas, but the stewardship of the Director remains very weak and the instructions of a Ministry unable to pay the bill are accepted with benevolent carelessness by the "stakeholders".

**Stethoscopes and guns**

There is another aspect of the situation that is worth describing. It is peculiar to Afghanistan but consequences for other places in the world can be foreseen in the near future. Provincial Reconstruction Teams (PRT) have been settled, with a military and a civil component. The countries participating to the "stabilization" of Afghanistan take responsibility for local security and for the coordination of the reconstruction and development activities.

The Baghlan PRT has been entrusted to The Netherlands. The same Dutch soldiers patrolling the roads come, with the same machine guns, to inspect the progress of the repairs of the Hospital roof. More resources and a remarkable efficiency are so made available, but the mix is not convincing (at least for me). It seems a direct progeny of the "war for democracy". Probably it will make easier to reconstruct the roads or to rehabilitate the health services. But the "empowerment" of civil society and of the public administration will be difficult to achieve as long as it does not make any difference between holding a stethoscope and holding a gun.

In general, the political agenda and the related vision of the U.S. Government dominate the scene. The Ministry of Health itself is largely influenced by its American advisors, but very unfortunately it is difficult to state that the USA have the best record for assisting Afghanistan - or any other country - in ensuring an equitable health system.

In any case that achievement is far away. The Policy Statement of the Ministry says that "donor financial support will be crucial for at least five years to come". A WHO advisor is more straightforward: "Afghanistan has to start from the scratch - without anywhere near the funds required to ensure a satisfactory health status for the Afghan people ... it is likely that it will continue to share the bottom rungs of the human development ladder for decades to come" (Girardet E and Walter J, 2004).

The author can be contacted through this journal.

**References**