

Issues Paper Series

The Public Health System in Afghanistan



Afghanistan Research and Evaluation Unit

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About the Afghanistan Research and Evaluation Unit (AREU)

The Afghanistan Research and Evaluation Unit (AREU) is an independent research institution that conducts and facilitates quality, action-oriented research and analysis to inform policy, improve practice and increase the impact of humanitarian and development programmes in Afghanistan. It was established by the assistance community working in Afghanistan and has a management board with representation from donors, UN agencies and NGOs.

Fundamental to AREU's purpose is the belief that its work should make a difference in the lives of Afghans. AREU is the only humanitarian and development research centre headquartered in Afghanistan. This unique vantage point allows the unit to both produce valuable research and ensure that its findings become integrated into the process of change taking place on the ground.

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Executive Summary

Afghanistan's health system is in a state of near-total disrepair. Standard health indices, including the infant mortality rate, the childhood mortality rate and the maternal mortality ratio, are among the worst in the world. As the new interim government re-establishes and slowly strengthens social services, it finds itself facing a multitude of technical, managerial and operational problems that need to be clarified before they can be solved. This report outlines the major issues currently facing the public health sector, discusses the roles of government, United Nations (UN) agencies, donors, and non-governmental organisations (NGOs), and makes recommendations for how some of the more pressing problems might be resolved.

Among the more glaring problems that continue to affect the ability of the Transitional Administration of Afghanistan to bring about rapid and lasting improvements in the health status of its population are:

- a grossly deficient, even absent, infrastructure;
- a health system that is top-heavy with doctors who are not trained to deal with priority, community-level problems, and who lack public health expertise;
- poorly distributed resources;
- health care delivered on a project basis by many distinct, relatively uncoordinated service providers, as opposed to health care delivered in accordance with a clear and coherent national health policy; and
- lack of practical, useful and coordinated information systems for management decision-making.

Despite these problems, there are positive factors that may allow the government and its partners to make reasonably rapid progress. These include a relatively high level of government commitment, donor interest (at least for the present), technical and financial assistance from the UN, a strong and committed community of NGOs and a (limited) record of successful implementation of public health programmes in the form of mass poliomyelitis and measles vaccination campaigns.

An April 2002 Joint Donor Mission (JDM) to Afghanistan considered options for re-establishing and strengthening the country's public health services. Its principal recommendations were to develop a Basic Health Services Package that would form the essential content of the health system and to manage the delivery of those basic services through the development of performance-based, contractual agreements with NGOs.

The Basic Health Services Package, currently under development by the Ministry of Public Health (MoPH) and its advisers, consists of seven major elements:

- Maternal and newborn health
- Child health and immunisation
- Public nutrition
- Control of communicable diseases
- Mental health
- Disabilities
- Essential drugs

At the time of this report, the cost of the proposed package had not yet been calculated. In addition, there are several outstanding issues regarding prioritisation of the services in the package that should be explored further. For example, though mental health and disabilities are important sources of morbidity and are deserving of the attention of the public health community, they require a relatively high degree of specialisation for intervention and make a small contribution to excess preventable mortality; they could, for these reasons, be considered as secondary priorities. Other issues include "vertical" versus "horizontal" programmes, the level of implementation of various interventions and the need to pay adequate attention to particularly vulnerable populations.

Whatever the final composition of the Basic Health Services Package, there are a number of activities that are common to all of the proposed interventions and services. These include health education, training, operational research, information systems and programme management. With particular regard to the latter, the

performance-based partnership agreements (PPAs) are discussed in detail. Their perceived advantages and disadvantages are reviewed, and recommendations are made in regard to their eventual implementation. The implications of these PPAs for each of the major actors - the Ministry of Public Health (MoPH), the donors, the UN agencies involved in health and the NGOs - are detailed.

Although it will be quite difficult to make rapid progress, this report concludes that there is reason to be cautiously optimistic about the future of Afghanistan's public health system and its ability to improve the health status of its grossly

underserved population. The key elements for a successful public health programme in this post-conflict environment include the establishment of realistic goals and objectives, the careful prioritisation of services and activities and the development of efficient and effective management and information systems that allow for the close monitoring of progress - or lack of it - at every level, from the community through to secondary and tertiary care facilities. But one can only be optimistic if the most important prerequisites of all - a stable government, peace and security - are assured.

Recommendations

The following recommendations on general issues of basic health policy and the content and management of the Basic Health Services Package are derived from the many interviews conducted for this report; several are already being implemented:

General Recommendations

1. The MoPH, together with its advisers, should develop specific policies and guidelines to govern the public health system in Afghanistan at an early stage of its development to allow all actors in the health system to work toward achieving the same goals and objectives.
2. The authorities in Afghanistan should consider convening a "loya jirga" that includes each of the major groups of actors for health (MoPH, UN, NGOs and private practitioners) in the months following the next JDM to exchange information and to ensure the investment of all relevant groups.

Recommendations on Content

3. The MoPH should not set itself up for failure by promising to deliver more than it can. It should review the priorities of the Basic Health Services Package, particularly mental health and disability services, and develop a schedule for phasing in its components, taking into account the financial, technical and operational realities of the current situation.
4. Following the completion of appropriate studies, clear policy guidelines should be developed and enforced for the treatments of choice for pneumonia, malaria and malnutrition.
5. Primary care services should be "pushed down" to the community level.
6. The needs of highly vulnerable populations, particularly returnees, the internally displaced and conflict-and-drought-affected populations, should not be ignored.

Recommendations on Management

7. NGOs should be more involved in the next JDM and full participation of the donor community should be assured.
8. A representative delegation of the public health community in Afghanistan should be sent on a study visit to Cambodia where the PPA scheme is currently being implemented.
9. Alternatives to province-wide PPA contracts for health services should be considered.
10. The place of specialised, vertical programmes (e.g. tuberculosis control, leishmaniasis control, and perhaps support and rehabilitation of the disabled) should be carefully reviewed.
11. A functional health information system that emphasises accurate, timely and actionable information should be created.
12. A research agenda to inform policy-making and service delivery should be developed and implemented, with particular emphasis on household health practices, care-seeking behaviours and household expenditures on health.

I. Introduction

When one considers the most frequently cited health statistics in Afghanistan - infant mortality (165/1000 live births/year), maternal mortality (1700/100,000 live births/year) and life expectancy at birth (46 years) - it would be easy to conclude that, for the future, the only way is up.¹ However, without a carefully designed and expertly managed public health system, an ability to identify, address and monitor the most common health problems of the population, and a way to ensure the quality of both preventive and curative services, it is possible that Afghanistan will be relegated to the bottom of the UNDP Human Development Index for years to come. The challenges facing the re-development of Afghanistan's health system are well known and have been frequently discussed in international circles during the past six months. This report focuses specifically on the elements of the health sector, as observed in May-June 2002, that require additional consideration and short- to-medium-term action to establish the conditions for effective health system management and health care delivery.

At the time this issues paper was conceived by the Afghanistan Research and Evaluation Unit (AREU), there was great concern that the international assistance community would adopt an urban-centred, tertiary care approach to health sector re-development.² Therefore, the key term of reference for the team was, "to analyse the overall approaches being adopted by these agencies, particularly in relation to their adoption of the public health model versus more curative approaches."

Shortly after their arrival, team members determined that, for the most part, this concern

was unfounded. The draft *Aide-Memoire* of the Joint Donor Mission (JDM) to Afghanistan on the Health, Nutrition and Population Sector was the dominant document under discussion, and it had a clear and forceful public health orientation.³ The *Aide-Memoire* built upon the classical primary health care orientation of the National Health Policy, written in February 2002. After reviewing the principle features of the health system as it existed in Afghanistan in early 2002, the *Aide-Memoire* strongly urged the redistribution of health services to provide equitable access in underserved areas, the development of a standardised package of basic health services that would form the core of health care delivery in all primary health care facilities (see Section II), and the development of a set of measurable indicators that would allow for the regular monitoring of progress toward clearly defined health sector objectives. All these are standard features of the public health approach.

The most striking feature of the *Aide-Memoire* is its recognition of the limitations of the MoPH's capacity to deliver health services to its entire population and the inefficiency of a civil-service-based health system in the form of its recommendation that a strong partnership be developed between the MoPH and the private sector. The pillar of this partnership would be performance-based partnership agreements (PPAs) under which the government would contract with the private sector (local and/or international NGOs and/or other private sector entities) for the delivery of specified health services to the population (see Section III).

In May 2002, the PPA proposal had been endorsed in principle by the Afghan Assistance Coordination

¹ These figures, cited in the *Aide-Memoire* of the JDM to Afghanistan on the Health, Nutrition, and Population Sector (9 April 2002 draft), are attributed to the United Nations Children's Fund (UNICEF) and the World Health Organisation (WHO). The life expectancy figure is from the National Health Policy, February 2002. There is widespread agreement that available nationwide health statistics in Afghanistan are inaccurate, and the health status of the population, by all commonly used statistical indicators, is abysmal.

² The international assistance community, to the extent that it is a "community," includes multilateral and bilateral donors, UN agencies and the large and diverse group of national and international NGOs. Among these NGOs are those who have been working in Afghanistan for years and whose approach to assistance is for the most part "developmental," those who arrived during the post-September 2001 "emergency period" and are primarily "relief" oriented, and combinations of the two.

³ The JDM was led by the World Bank (WB) and the World Health Organisation (WHO). Members of the team included representatives from Department for International Development (DFID), the European Union (EU), the United States Agency for International Development (USAID), the Asian Development Bank (ADB), UNICEF and the United Nations Population Fund (UNFPA).

Authority (AACA) and by the MoPH, but had not yet been developed in detail nor adequately presented to the NGO community. The *Aide-Memoire* is honest and clear about the problems - potential and real - facing effective implementation of its proposals, but a proposed second JDM has been postponed until mid-July. In the interim, both enthusiasm and concern have been voiced by members of the NGO community.

One of the roles of the AREU team was, by default, to try to discuss the salient features of the proposal with the NGO community and others in Kabul and in the eastern region, and to elicit their reaction. Toward the end of this consultation, at the request of some of the NGOs, the research team held a meeting to review the important features of the proposed PPAs, and to discuss them in light of experience gained in other post-conflict settings. In addition, a well-attended formal debriefing for representatives of the MoPH, the donor community, the UN agencies and the NGOs was held to discuss issues and findings. This report presents these findings and observations based on the proposal of the JDM, the content of the current Basic Health Services Package, a review of the plans and programmes of a number of donors, UN agencies and NGOs, and other important aspects of the health care system in Afghanistan.

The research for this report was limited in scope and depth by a number of important constraints. First, time did not allow the team to contact as many people as anticipated. Although a large sampling of respondents from governments, donors, UN

agencies and NGOs was interviewed, important and influential commentators may have been missed. A list of persons contacted can be found in Appendix A. Second, travel in Afghanistan was quite difficult during the time of our research. Access to many areas was by plane and required a lengthy stay-over in Peshawar or in Islamabad, Pakistan. For this reason, a four-day visit to Jalalabad, of which most of two days were spent on the unpaved road connecting that city with Kabul, was the only field trip undertaken. Although Nangarhar (the province in which Jalalabad is located) is one of the relatively economically advantaged and, in terms of health



Courtesy of WHO

care, one of the better served areas of Afghanistan, and can therefore not be said to be representative of the rest of the country, the trip was informative and enlightening in many respects. Third, the scope of work was broad. The team found most issues concerning food security and food assistance to be beyond our capacity and so concentrated on the management and delivery of preventive and curative health services including, to a moderate degree, nutrition supplementation programmes. Finally, the rapid turnover of international staff in most international agencies (UN and non-governmental) meant that in many cases those to whom we spoke were relative newcomers to Afghanistan (although their agencies may have been in country for many years), and could not give information with the historical perspective that might have lent additional depth to this report.

In spite of these limitations, this report covers the main issues facing the re-development of the health sector in Afghanistan. We have divided the report into two main sections - issues concerning the proposed content of the health system, and issues affecting its management. Though those who are currently working in Afghanistan are far more familiar with these issues

and their potential consequences, this report aims to provide a synthesis of the information provided by those we interviewed, through the direct observations made in hospitals, basic health centres and maternal/child health (MCH) centres, and by consulting other documents and texts before and during the trip to Afghanistan. The goal of the team was to produce a report to both serve as a reference and help organise the current issues for those currently working in the health sector, and provide a short, digestible orientation for those who have yet to arrive. Although it may seem bold, where we feel comfortable doing so, we make recommendations for future action. This report is intended to be a positive commentary on what has been done to date in the short time that the Interim Administration (IA) has governed Afghanistan. These are dynamic and turbulent times in Afghanistan. The way forward may frequently seem obscure and fraught with insurmountable obstacles, natural and man-made. We are cautiously optimistic about the future of the health sector in Afghanistan, always on the condition that: 1) there be peace throughout the country; and 2) there be a stable and legitimate government capable of setting sound technical and managerial policies and commanding the respect of those who will be responsible for implementing them.

II. The Basic Health Services Package for Afghanistan

Content

The recent JDM recommended a number of next steps to the MoPH and its local partners. Not surprisingly, because a standardised set of services is one of the hallmarks of the public health approach, one of the earliest of these steps was the definition of the essential package of services to be made available throughout the public health system in Afghanistan. This basic package would be responsive to epidemiological imperatives of the country, addressing those problems that are indicated by available data or by consensus opinion to impose the greatest burden on the population in terms of morbidity and mortality. But epidemiological criteria were not the only ones to be applied. The basic package would contain only those health problems for which safe and effective interventions are currently available. It would seek an equitable balance between

interventions that are cost-effective and those that are important to a large segment of the population (where there are differences between the two). Finally, it would balance the quality of health services with the extent to which those services can be offered at the most peripheral areas of the system - that is, low-cost, basic services for all, versus more expensive, more sophisticated services for a relative few. In order to help define the package, an Advisory Committee to the MoPH has been formed. The Committee consists of the MoPH, the three UN agencies involved in health (WHO, UNICEF, UNFPA), and Management Sciences for Health (MSH), which is providing technical assistance to the MoPH in the areas of policy and management and which will soon be initiating a grants programme to NGOs for relevant health programmes and representatives of the NGO community. The proposed package seems mostly reasonable

The Basic Health Services Package

In summary, the proposed Basic Package of Health Services contains the following components:⁴

- Maternal and newborn health
 - Antenatal care
 - Delivery care
 - Postpartum care
 - Family planning
 - Care of the newborn
- Child health and immunisation
 - Expanded Programme on Immunisation (EPI) services (routine and outreach)
 - Integrated Management of Childhood Illnesses (IMCI)
- Public nutrition
 - Micronutrient supplementation
 - Treatment of clinical malnutrition
- Communicable diseases
 - Control of tuberculosis
 - Control of malaria
- Mental health
 - Community management of mental health problems
 - Health facility-based treatment of outpatients and inpatients
- Disability
 - Physiotherapy integrated in the Public Health Care (PHC) services
 - Orthopaedic services expanded to hospital level
- Supply of essential drugs

⁴ As detailed in the May 2002 document, A Basic Health Services Package for Afghanistan - Second Draft, Document for Discussion.

in its content and addresses many (but by no means all) of the major public health problems of Afghanistan. A detailed and well-reasoned discussion of each of the individual items, with appropriate questions regarding the extent to which they can be implemented, is presented in the draft document (e.g., which antigens should be included in the EPI and what degree of specialisation is required for the implementation of mental health problems). A large part of the document is devoted to the delivery of the different components of the essential package at different levels of the health system - community, health centre and hospital.

The draft report also discusses the many constraints to the implementation of the proposed package, essentially concluding that, "...although each one of the components listed in the basic package proposed can be regarded as modest, providing the whole range of services has proven too big a challenge for most developing countries." As confirmed by the MoPH, it will also prove too big a challenge for Afghanistan in its current form.

At this early stage of redevelopment of the Afghan health system, the adoption of modest goals and objectives, rigorous prioritisation of interventions and the strict discipline required to maintain a focus on a quite narrow range of activities are essential. The health status of the Afghan population at this time is quite poor and it is a sad but true reality that there are no quick fixes. Much can be done in a short time, but it is a near certainty that the health status of the population will remain poor for years to come. The bitter pill that must be swallowed by all those working in the Afghanistan health sector is that even if peace and political stability are achieved, the legacy of 20 years of war and political instability that resulted in the destruction of the health infrastructure of the county, and the failure to develop an adequate cadre of technically competent health workers will be present for the foreseeable future. The short-term and mid-term outcomes of the numerous activities being conducted in the health sector today, even if they could be highly coordinated, delivered in a most efficient manner and distributed equitably

A concerted effort over a long period of time is what will be required to bring down mortality rates in a sustainable manner and return the health of the people of Afghanistan to the state of health to which they have every right.

throughout the country, can lead only to a relatively better situation, but not to a good one. A concerted effort over a long period of time is what will be required to bring down mortality rates in a sustainable manner and return the health of the people of Afghanistan to the state of health to which they have every right.

For a fuller discussion of the issues involved in the implementation of an essential package of services, the official document, when it is completed, should be consulted. Here we

highlight a few of the major considerations that should be taken into account for each of the technical programmes currently under consideration, and for the delivery of the proposed basic package as a whole.

Maternal and Newborn Health

The maternal mortality ratio in Afghanistan, while undetermined, is believed to be among the highest, if not the highest, in the world. The most quoted figure is 1700 maternal deaths per 100,000 live births per year. A research study



John Isaac for UNICEF

aimed at getting a more accurate figure for maternal mortality is currently being implemented by a team from the U.S. Centres for Disease Control and Prevention (CDC). The broad application of the Safe Motherhood Initiative (SMI) of the WHO and UNICEF, with particular emphasis on the provision of emergency obstetrical care, is a proven intervention that could, in time, bring about an important reduction in maternal mortality.

UNICEF recently conducted an assessment of the resource needs required to implement the SMI in Afghanistan.⁵ The team made several recommendations that are generally applicable to all of the public health programmes that will be included in the Basic Package of Health Services. Specifically, they suggested that a strong and immediate emphasis be placed on the training of intermediate and lower-level health workers, that technical and financial support be given to NGOs working on the SMI, and that MoPH capacity in the area of maternal and newborn health be strengthened.

In the medium term, it is interesting that the team suggested that the principal objective of the SMI in Afghanistan be to increase the proportion of births attended by skilled health personnel (trained and qualified traditional birth attendants (TBAs), auxiliary midwives, midwives or female physicians). In order to achieve this objective, they urged the development, by consensus of the actors in the Afghanistan health system, of a National Reproductive Health Policy with standards and guidelines for the delivery of a minimum set of essential reproductive health services. The implementation of these services should be closely and carefully monitored by the development and inclusion of a set of specific indicators in the routine health information system, complemented by periodic, special surveys.

The team made recommendations regarding the provision of antenatal care. These included tetanus toxoid immunisation, supplementation of the diet of pregnant women with iron and folic acid and malaria prevention (but, notably, no mention is made of presumptive treatment for malaria twice during pregnancy in areas and at

times of high incidence - an intervention that has proven to be inexpensive and effective). The team also discussed health education about the danger signs of pregnancy, delivery in the presence of a skilled birth attendant, and emphasis on immediate breastfeeding, including colostrum and exclusive breastfeeding for six months.

But perhaps the most important of the recommendations, especially in the Afghanistan context, is that emergency obstetrical services be extended through the training and deployment of appropriate staff. TBAs trained to recognise obstetrical complications, close linkages between TBAs and local health facilities and regular monitoring of TBA performance is crucial to the success of the SMI initiative. Equally important is the observation that Afghanistan currently has too many male physicians and not enough well-deployed midwives, nurses and female physicians. This situation should be redressed in the mid-term future.

The level of care at which services could be offered is not specifically discussed in the SMI report. Maternal deaths from obstetrical complications are not predictable and can require sophisticated care including parenteral antibiotics, blood transfusions and/or surgical delivery (Cesarean section). Because of the difficulties of physically accessing health facilities, women living in remote areas may not be able to take advantage of these services even if they are available at the hospital level. It is critical, if maternal mortality is to be reduced, that TBAs and other staff working in the community and at the basic health centres be trained to recognise the warning signs of complicated delivery, and that they be able to quickly refer the patient to a level of care where comprehensive obstetrical care is available. Strong consideration must be given to training non-physicians in appropriate life-saving obstetrical techniques, including surgery, as is being done with considerable success in a few other countries. It should also be mentioned that it is not enough to have community-level recognition of impending problems and facility-based competence to deal with those problems. Transport between the two needs to be assured, and this poses a huge problem in Afghanistan.

⁵ Dalil S., Fritzier M., Ionete D., McIntosh N., O'Heir J., Stephenson P. Assessment of Services and Human Resource Needs for the Development of the Safe Motherhood Initiative in Afghanistan. Conducted by JHPIEGO for UNICEF/Kabul. 2 May 2002.

The issue of “pushing down” services to the most peripheral level of care and into the hands of non-physicians is discussed further below. It is critical to the effective implementation of the Basic Health Services Package in Afghanistan.

Although the Basic Health Services Package groups maternal health and newborn care, there is relatively little emphasis on the latter. Of course, ensuring tetanus toxoid vaccination during pregnancy, together with the other elements of the SMI, would go far to improving newborn survival rates. Proper initiation and maintenance of breastfeeding is of unparalleled importance. However, in any case, a high proportion of infant mortality occurs during the newborn period (see below). On the other hand, both the diagnosis and the treatment of many potentially fatal conditions of the newborn are difficult, expensive and beyond the reach of most health facilities in Afghanistan. It would not be inappropriate, at this time, to concentrate on reducing infant and child mortality from the most common causes of illnesses, and addressing the problems of the newborn period at a later date.

Child Health and Immunisation

More than one-fourth of children born in Afghanistan do not reach their fifth birthday. This appalling statistic is due to a variety of factors, which include: incorrect household behaviours (especially inadequate breastfeeding); incorrect treatment of common, but potentially life-threatening illnesses, such as diarrhoea; little recognition of the early warning signs of severe respiratory infection and severe malaria; poor health care-seeking practices; inadequate health care at the community/basic health centre levels; and lack of access to health services.

The implementation of the measles mortality reduction strategy that targets children from the age of six months in specific geographic areas, combined with the delivery of vitamin A supplementation to children less than five years old, can have a substantial impact, if sustained.

Nevertheless, Afghanistan has recorded recent successes in the area of childhood immunisation, extending polio vaccination widely throughout the country and making measurable progress through the implementation of a measles mortality reduction strategy consisting largely of mass vaccination campaigns. According to some, it is unlikely, at the time of this report, that many Afghan children remain unvaccinated against polio, and the number of cases detected, even in light of intensified surveillance, has been decreasing. According to others, substantial



Courtesy of WHO

pockets of unvaccinated children remain. Nevertheless, it seems likely that important progress has been made over the last few years. If one can judge from the experience of other countries in difficult circumstances, the success of National Immunisation Days may well eliminate polio from Afghanistan in the next year or two and make a major contribution to the global eradication effort. But eradicating polio will not contribute to reducing child mortality, to which this disabling (and sometimes fatal) disease makes a relatively small contribution. In contrast, the implementation of the measles mortality reduction strategy that targets children from the age of six months in specific geographic areas, combined with the delivery of vitamin A supplementation to children less than five years old, can have a substantial impact, if sustained.

These “vertical” campaign-oriented programmes have shown that, with appropriate guidance and assistance, the Afghan health system can perform at a high level. But the ongoing provision of routine, community-based and facility-based preventive and curative programmes is, in some ways, more challenging.

The major causes of childhood mortality in Afghanistan, in addition to measles, are diarrhoea, pneumonia and malaria, compounded by malnutrition. For each safe, effective and cost-effective treatment can be made available. These diseases are the subjects of the WHO/UNICEF IMCI initiative.

The objective of IMCI is to address the major causes of childhood mortality in an integrated, holistic fashion. IMCI works

1. At the community level to promote appropriate household behaviours;
2. At the basic health centre level to ensure the accurate assessment, diagnosis and effective treatment of potentially life-threatening diseases;
3. At the hospital level to provide tertiary care to severe cases; and
4. At the level of the health system to implement in-service training, regular monitoring and supervision throughout the health services and periodic evaluation.

An essential element of IMCI is its training course for intermediate health workers. Following an intensive initial study phase during which the key elements of the IMCI treatment algorithm are adapted to the national/local context, training of health workers begins. The training course is long (13 days) and includes considerable practical (by-the-bedside) instruction. Experience has

shown that the number of health workers that can be trained in a short period of time is relatively small.⁶

Fortunately, the epidemiological characteristics of Afghanistan may allow training of health care workers in the appropriate care of the major killer diseases of children to proceed more rapidly. Although health workers trained in IMCI may be able to provide more effective clinical care, it is also possible to provide training to address the most commonly occurring conditions. In

Afghan health care professionals need to be trained in the use of modern, cost-effective interventions, and these interventions need to be made available where they will have the greatest impact: in, or as close as possible, to the communities where the diseases occur.

Afghanistan there are distinct seasons, each with a characteristic disease profile. Diarrhoea and malaria are primarily diseases of summer; pneumonia has a higher incidence in winter. Until the adaptation of the

generic IMCI programme can be completed and until a sufficient number of trainers can be trained, “vertical,” season-oriented training of clinic-based health workers and health education messages appropriate to the time of year should be developed.

The need for this training (both pre-service and in-service) is clear. After 20 years of conflict, Afghanistan has been left with an over-medicalised corps of health personnel that has not been able to stay abreast of recent advances in knowledge and medical practice. A bulletin, circulated by an NGO currently supporting health care in Afghanistan, quotes a professor of pediatrics as saying that “...cotrimoxazole, besides having no risk, is beneficial in controlling...diarrhoea in children.” Both of these points are incorrect: cotrimoxazole, an inexpensive antibiotic, does have risks and is not effective for the treatment of diarrhoea in children. Childhood diarrhoeal deaths have been substantially reduced (by more than one million per year) in developing countries by abandoning the use of antibiotics and “intestinal disinfectants” in favour of even less expensive, truly without risk, oral rehydration salts. Afghan health care professionals need to be trained in

⁶ This is true for most programmes that have large training requirements - the SMI assessment cited above suggests that it would take almost a year to develop a cadre of about 12 trainers who could then begin training midwives and auxiliaries in competency-based emergency obstetrical care. IMCI's training requirements are also quite burdensome. Building capacity is a slow process, and rushing it results in the delivery of sub-standard health care.

the use of modern, cost-effective interventions, and these interventions need to be made available where they will have the greatest impact: in, or as close as possible, to the communities where the diseases occur.

Public Nutrition

The interventions specified in the current draft of the Basic Health Services Package are micronutrient supplementation and the treatment of clinical malnutrition. The former presumably means the administration of vitamin A capsules to children and iron/folate tablets to pregnant women. Vitamin A supplementation has been shown to reduce childhood mortality due to a number of diseases including diarrhoea and pneumonia. It has become a common intervention in tropical developing countries. In Afghanistan, vitamin A supplementation has been provided, together with polio vaccines, during the National Immunisation Days. No studies of vitamin A levels are available, but it is assumed, rather than documented, that there is a high prevalence of vitamin A deficiency in children. However, a nutrition survey in Badghis Province found a relatively low 2.6% of children with at least one clinical sign of vitamin A deficiency.⁷ Other vitamin deficiencies, including riboflavin deficiency and vitamin D deficiency (rickets), are at least a potential problem in Afghanistan, and outbreaks of vitamin C deficiency (scurvy) have been documented quite recently. Whether or not dietary supplementation with these vitamins will be provided through routine prevention services



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at MCH clinics and basic health centres is not clear.

All women should receive supplements of iron and folic acid during their pregnancies. This standard intervention should be routinely initiated and monitored at MCH clinics and by community health workers (CHWs) and TBAs at the community level. Compliance rates vary greatly and studies should be done to determine the degree to which Afghan women are supplementing their diets during pregnancy. The prevalence of anemia in

⁷ Woodruff B., Reynolds M., Tchibindat F., Ahimana C. Nutrition and Health Survey, Badghis Province, Afghanistan, February-March 2002. UNICEF/Afghanistan and U.S. Centres for Disease Control and Prevention. It should be mentioned, though, that recognition of the early stages of clinical vitamin A deficiency by relatively untrained workers may not be very reliable.

pregnancy should also be determined in different regions of the country, as anemia is a risk factor for maternal mortality.

The treatment of clinical malnutrition is not a straightforward issue. Malnourished children can be detected through a system of growth monitoring and promotion when they are brought to a health facility for other illnesses, or through active, community-based nutrition surveillance. Many nutrition supplementation programmes are currently being supported by UNICEF and implemented by various NGOs throughout the country. Most of these detect children who are less than 80% of the median weight-for-height of reference populations and provide them with vitamin-fortified cereals and vegetable oil to take home (programmes discussed provided two kilograms for a two-week period). Although no one is sure who actually consumes the food supplements in the home, the theory is that increasing the household food supply will allow the child to eat more and resume normal growth. Supplementary feeding programmes are currently being provided in a patchy distribution in Afghanistan. Their effect is not yet clear and monitoring and evaluation systems are incomplete.

Although they are based on the detection of acute malnutrition, a much more important problem in Afghanistan seems to be very high levels of stunting, or chronic malnutrition (57.5% according to the UNICEF/CDC survey in Badghis Province). Underlying causes undoubtedly include poor breastfeeding practices and inappropriate complementary feeding in children under six months old and during the weaning period. In other words, although both vitamin supplementation of healthy children and pregnant women and the treatment of clinical malnutrition in children are appropriate elements of the Basic Health Services Package, the important problem of chronic under-nutrition will not be adequately addressed by them. Rather, important behaviour change interventions in the area of child feeding also need to be developed. An analysis of stunting in Afghanistan using the widely-accepted UNICEF conceptual framework for causes of malnutrition might be revealing.

An interesting phenomenon in Afghanistan is the documentation of relatively high levels of child mortality in the absence of high levels of acute malnutrition. This unusual phenomenon should be investigated and the potential role of micronutrient deficiencies explored.

Finally, an interesting phenomenon in Afghanistan is the documentation of relatively high levels of child mortality in the absence of high levels of acute malnutrition. This unusual phenomenon should be investigated and the potential role of micronutrient deficiencies explored.

Communicable Diseases

Malaria

Malaria is endemic in Afghanistan. As indicated above, it occurs seasonally, with transmission from April-November throughout the country. Although most malaria is due to *P. vivax*, which remains sensitive to chloroquine, about 15% is due to *P. falciparum*, which is felt to make an important contribution to child mortality.

P. falciparum in Afghanistan appears to be largely resistant to chloroquine, which nevertheless remains the drug of choice. Resistance to sulfadoxine/ pyrimethamine (SP) has been documented at low levels and

needs to be carefully monitored.

Research into malaria prevention has been carried out by HealthNet International (HNI), in conjunction with the London School of Tropical Medicine and Hygiene. Demonstrations of the cultural acceptability of impregnated bed nets and their effectiveness in blocking the acquisition of malaria infection have led to large bed net distribution programmes in parts of the country. HNI has been involved in the distribution of more than 450,000 impregnated bed nets to date. Work is also being done on the effectiveness of impregnated clothing (chadors), on cattle sponging and on stocking ponds with the larvicidal fish, or gambusiae, in an attempt to reduce mosquito breeding sites.

However effective these technical interventions may prove to be, malaria control will depend on the system of health services delivery that is developed. At present, there appear to be two systems for dealing with the occurrence of malaria at village level. In one, community health workers are taught to recognise the symptoms of malaria, but they are not allowed to provide treatment -

they refer suspect cases to the nearest health facility where the definitive diagnosis is made by microscopic examination of a blood smear before treatment is given.⁸ In the other, CHWs can diagnose and provide treatment (chloroquine is the only anti-malarial currently proposed for use at the community level in the draft Basic Health Services Package). There are advantages and disadvantage to each approach, but given that that severe *P. falciparum* malaria can kill within 24 hours, combined with the difficulty that much of the Afghan population has in accessing health facilities, a strong case can be made for community-level diagnosis and treatment (see below).

Tuberculosis

Tuberculosis (TB) is generally considered to be an important cause of adult mortality in Afghanistan. Mortality is felt to be disproportionately high in women because of their relative lack of access to care, especially for chronic conditions such as TB. A number of agencies, including WHO, MedAir, German Medical Service, and Médecins Sans Frontières (MSF), are running specialised (vertical) anti-TB programmes in different parts of the country. Although the globally accepted Directly Observed Therapy Short-Course (DOTS) strategy is widely recommended in Afghanistan, and has been successful under the watchful eye of the NGOs in some parts of the country, it will be a challenge to implement it widely.⁹ As with so many disease control programmes, success depends on accurate diagnosis of a large proportion of cases, an adequate and regular supply of effective drugs, and appropriate action at the community level. Regular monitoring and periodic evaluation are indispensable.

As is the case with malaria control, the vaccination campaign and the proposed national micronutrient fortification programmes mentioned above, tuberculosis control in Afghanistan will require a mix of specialised technical expertise and assistance at the higher levels of the system, and well-informed strict implementation of national policies and strategies at the village and health facility levels. This mix of “vertical” and “horizontal” programmes is discussed below.



Courtesy of WHO

Leishmaniasis

Other specialised programmes, even ones that are currently being pursued in Afghanistan, are not included in the Basic Health Services Package. Leishmaniasis is a serious, but not fatal, disease that occurs throughout large parts of Afghanistan, including urban areas. Though treatment is available, it is quite expensive and would have to be provided through external funding for the foreseeable future. HNI is currently supporting a leishmaniasis clinic in Kabul. WHO is also involved in disease control activities.

⁸ For this system to work effectively, trained laboratory technicians must be available in all health facilities. Although HNI is undertaking an extensive programme of monitoring and reinforcing diagnostic capability, this is not being done on a national level. In some areas, the use of newly available, very reliable, rapid diagnostic tests might be considered, although they are, at this point, relatively expensive.

⁹ DOTS involves a series of activities, ranging from diagnosis through monitoring of the TB situation and evaluation of programme effectiveness. The main feature of the intervention is the requirement that anti-tuberculosis drugs be taken under the supervision of someone other than the patient - a relative or community health worker, for example. The purpose of directly observed therapy is to improve compliance rates.

Blindness

The International Assistance Mission (IAM) is an NGO that specialises in eye care. It conducts eye camps in parts of Afghanistan and provides surgical procedures, for a fee, in a variety of settings. The services are clearly necessary and sought after, but require a high degree of specialisation that is not apparently compatible with a more generalised primary health care approach. IAM is privately funded, to a large degree, by the Christofel Blinden Mission of Germany, and does not rely heavily on public resources.

HIV/AIDS

HIV/AIDS control is a subject that must figure in all discussions of public health. To date, no formal activities are being conducted in this area, though some health education, mostly through mass media, is said to be occurring. The MoPH has not yet organised itself to address HIV/AIDS and no mention is made of it in the Basic Health Services Package in any way. Yet, Afghanistan is certainly threatened by the introduction of the HIV virus, with so many people returning from Iran, Pakistan and other

countries. Recently, reports of the detection of a number of cases have been circulating. Afghanistan is in a position to prevent the widespread transmission of HIV/AIDS in its population. But to do so it will have to organise HIV/AIDS prevention activities and begin to educate people about the modes of transmission.

In a conservative, religious culture where sex is not openly discussed, broaching the subject must be done in a sensitive, careful way. The time to start HIV control activities is now. Information regarding HIV seroprevalence may be available through the International Committee of the Red Cross (ICRC), or other NGOs that are supporting surgical services (including blood transfusion) in parts of the country. Screening of blood collected for transfusion could be done on an anonymous and unlinked basis. Other opportunities for blood screening, such as antenatal care clinics, could also be used to establish a baseline seroprevalence rate and to monitor changes. Safe blood handling

and transfusion techniques, as well as universal precautions in clinical settings, could be instituted in short order and should be.

Other Diseases

Consideration needs to be given to specialised, vertical disease control programmes that are not part of the Basic Health Services Package. Other programmes, including the detection and control of diseases of epidemic potential, such as bacterial meningitis, viral hemorrhagic fevers, typhoid fever and others that are known to pose a threat in Afghanistan, also need to find a place within the MoPH.

Mental Health

There is general agreement that mental health problems are highly prevalent in Afghanistan today. After twenty years of conflict,

characterised by the uprooting of millions of people and massive destruction of private and public property, and the total disruption of the lives of two generations of Afghans, this is not surprising. Several studies have documented high levels of depression

The majority of mental health needs could probably be met by a return to normal life. Community development activities, such as the opening of schools, the creation of income-generating activities and increased security and stability, would probably alleviate the mental health problems of the vast majority of Afghans.

characterised by various degrees of loss of motivation through suicidal ideation. There are undoubtedly many people in Afghanistan who would benefit from psychotropic medications. In fact, the abuse of these sedatives is widely reported. Opium abuse is also reported to be an important problem, even among women. In addition, many people who do not require medication would benefit from a strong system of social support through which they could be helped to cope with the ongoing stresses to which they are subjected. But the majority of mental health needs could probably be met by a return to normal life. Community development activities, such as the opening of schools, the creation of income-generating activities and increased security and stability, would probably alleviate the mental health problems of the vast majority of Afghans. As of now, it is not clear what the mental health interventions of the Basic Health Services Package would look like. The assessment, diagnosis and

treatment of patients requiring prescription medications is definitely too specialised for implementation at the community level and probably surpasses the capacity of most basic health centres. At best, one could recommend that patients in need of specialised care be referred to higher levels of the system. Although mental health problems were mentioned frequently at the National Health Sector Planning Workshop in March, it is not clear that there is a safe and effective set of interventions currently available to deal with the problem through a primary health care approach. NGOs currently engaged in psychosocial activities should make reports of their accomplishments public, and technical expertise should be sought for the design of mental health programmes that make sense in the Afghan context.

Disability

It is well-known that physical disability that interferes with people's abilities to earn money and to take care of themselves and their families is an important problem in Afghanistan. War-related disabilities, including mine injuries, have been important, but other causes of disability, including cerebral palsy and polio, are reported by some to outnumber these by as much as four to one. One of the most prominent agencies currently working in the area of disabilities that we were able to meet with in preparing this report is the ICRC, which has been in Afghanistan since 1986. ICRC works primarily with handicapped war survivors, of which it estimates there are about 200,000. UNDP's Comprehensive Disabled Afghans Programmes (CDAP), whose future is now uncertain, covered a wider range of disabilities than the ICRC. SERVE, the Sandy Gall Afghanistan Appeal, and a number of other agencies are also working to provide rehabilitation services to those in need.

It is not clear how disabilities will be included in the Basic Package of Services. ICRC has expressed a desire to have the manufacture of prosthetic and other devices decentralised from its six centres to more peripheral locations. Physiotherapy services could also be provided at peripheral facilities of the health system but, as is the case for mental health services, a certain degree of expertise that would surpass the capacity of most basic health centres might be necessary. It seems reasonable to suggest that, for the time

being, disability services be omitted from the Basic Health Services Package. Further studies regarding the appropriate interventions at different levels of the system and the cost of providing these services should be undertaken and the possibility of phasing in these services at a later date considered. In the meantime, ICRC and the other agencies addressing the problem of disability should be encouraged to continue their activities, to expand them to rural hospitals if possible, and to help the MoPH develop a long-term strategy for dealing with this important problem.

Essential Drugs

The selection of a list of essential drugs is always controversial. The medicines needed for the implementation of the Basic Package of Health Services are fairly straightforward. Choices need to be made with regard to antibiotics, antimalarials and antituberculosis medications as a function of the epidemiological characteristics of the diseases, available finances and cultural acceptability. More difficult, though, is the inclusion of drugs that do not correspond to the interventions of the Basic Health Services Package. The provision



John Isaac for UNICEF

of these other essential drugs is of paramount importance if the public health system is to retain credibility and earn the trust of the public. But it is important to choose only those medications that can be safely and effectively used at the levels of the system for which they are designated.

For the time being, 18 items are listed for use at the community level, ranging from condoms and gentian violet to cotrimoxazole and anti-tuberculosis drugs. Thirty-four items are listed for the basic health centres and 65 for the rural hospitals, including those used for anesthesia, the treatment of severe malaria and other tertiary care problems.

In summary, the Basic Health Services Package is a fundamental part of the public health approach to health system development in a post-conflict setting. The package currently being debated in Afghanistan includes a number of interventions that are of indisputable priority, but it may be quite ambitious for immediate implementation. Some of the interventions that are currently included should be reconsidered. The MoPH's expressed preference for phasing-in the package should be accepted and a schedule for this progressive introduction of services should be worked out soon. The MoPH has asked MSH to cost out the current package in its entirety. This costing exercise should provide guidance to the MoPH and its partners in finalising the definition of the package and its schedule of implementation.

Leading Issues

What Does a Basic Health Services Package Mean?

During the course of discussions with MoPH, donors, UN agencies and NGOs, it became clear that the concept of a basic package of services meant different things to different people. For some, the interventions in the Basic Health Services Package should be the only ones to be implemented in health facilities. For others, additional interventions, especially medical care of adult males, was important for the credibility of the system. Other specialised services, such as dentistry, eye care and so forth, were also seen as "essential," though there was general agreement that these might not be supportable through the national MoPH budget or donor donations to it. For others, the Basic Health

Services Package represented a "minimum package" of interventions that would be guaranteed at all appropriate levels of the health system, but that would form only a core, not the entirety, of what would be available through the public health system. Finally, the view most forcefully articulated by the few MoPH representatives interviewed was that the Basic Health Services Package represented what would be available in the most underserved parts of the country - those areas where, for the variety of reasons mentioned throughout this paper, even these few essential interventions are not currently available. In other areas, especially urban areas, the MoPH would continue to try to provide the fullest possible range of services.

In fact, the strictest interpretation of the public health approach would be that only those services that are included in the Basic Health Services Package should benefit from public funding. A different set of interventions could be offered at different levels of the system, of course. Nevertheless, all publicly funded health services would be offered in strict conformance with the policies and strategies detailed by the MoPH and its implementation partners for addressing the (for now) seven areas. This concept, while difficult to swallow, is quite important if the health indicators of Afghanistan are to improve.

Unfortunately, few Afghan health personnel are trained in public health. An interview with six Kabul-based hospital physicians (one general practitioner, two internal medicine specialists, one ear, nose and throat (ENT) specialist, one dermatologist, and one OB/GYN/general surgeon) was revealing. Their concerns were entirely patient - rather than population - oriented. They asked what one does for diabetes, for hypertension, for breast and/or cervical cancer, among other relatively common chronic diseases of adults. As clinical practitioners, they expressed the view that the lives of individuals affected by these conditions are as important as those who suffer from the more common conditions. The MoPH, the staff of which is also drawn from the clinical community, is undoubtedly sympathetic to the sentiments expressed by the group of physicians described above.

And they should be. Making choices between public health programmes is a relatively detached, office-based activity. The ethical dilemma is

much more real to the clinician who is faced with the difficult task of telling a patient that nothing can be done, even when effective interventions are available in other parts of the world. This same debate is now being conducted in the global humanitarian literature. Afghan political and health officials, together with their funding and implementing partners, will have to decide on a policy-making level what the Basic Health Services Package means. Fundamentally, the choice is between a minimal core of activities that will be guaranteed throughout a health system that will continue to provide maximal care to all, no matter how costly, and a small package of affordable services that will provide the most care to the most needy people, but that will deny others access to the care they need.

“Vertical vs. Horizontal” Programmes

Should the interventions included in the final version of the Basic Health Services Package be provided by polyvalent health workers or by specialists in the details of each programme concerned? That is, should every facility have a TB control officer, a malaria control specialist, an epidemiology (EPI) nurse, one or two people trained in IMCI, a nutritionist, a physiotherapist, a mental health practitioner and so forth, or should one health worker be capable of providing multiple services? Experience shows that programmes are more effective when they have dedicated personnel and a distinct management structure. On the other hand, having separate supervisors, vehicles, reporting systems and implementing personnel for each programme is clearly duplicative and inefficient.

Obviously, specialists will not be available at the community level, where most basic health care in Afghanistan will have to be provided. Here, there is no choice but to have a polyvalent worker capable of implementing a small core of manageable tasks. At the basic health centre as well, staff will usually be limited, sometimes only to one male and one female worker. As one goes up the line, however, it may be possible to increasingly specialise until, in the regional or

national MoPH, each programme should have an individual responsible for formulating policy, testing and communicating strategies, overseeing a specific part of an integrated information system, coordinating training programmes and so forth. This kind of system, from central specialist to peripheral generalist, might be called “diagonal.” It is clearly best-suited to the needs of Afghanistan, but the roles of each category of worker at each level of the primary health care system will have to be clearly specified and frequently monitored.

Levels of Care (“push-down” of services)

As implied above, one of the crucial tasks of the MoPH in regard to the Basic Health Services Package will be to determine who can do what. As discussed in the maternal health section above, physical access to services is a major constraint to primary health care in Afghanistan. In order to partially overcome this problem, it seems important to provide as many basic services as

Physical access to services is a major constraint to primary health care in Afghanistan. In order to partially overcome this problem, it seems important to provide as many basic services as possible where the health problems are most prominent - in the villages themselves.

possible where the health problems are most prominent - in the villages themselves. However, some of the interventions specified in the Basic Health Services Package are sophisticated and beyond the reach of

community health workers. Opinion differs as to which these are.

Nevertheless, it seems reasonable, in the Afghan context, to recommend that the MoPH allow CHWs to treat certain conditions for which care might not be sought in a sufficiently timely manner at fixed health facilities. For example, training a CHW to diagnose diarrhoea and to provide instruction to a mother in oral rehydration is obvious. Allowing diagnosis and treatment of malaria in the community is perhaps more problematic: purists would insist on microscopic confirmation of each case in order to minimise the development of antimalarial drug resistance. However, one could allow CHWs to provide chloroquine as a first-line treatment (most malaria in Afghanistan is due to chloroquine-sensitive *P. vivax* infection). If clinical improvement is not noted within 24 hours, patients can be referred to the basic health centre. Along the same lines, though strong objections have been raised in

some countries to allowing village volunteers to treat childhood pneumonia with antibiotics (usually cotrimoxazole), this would be desirable in Afghanistan. Only time can tell if CHWs can learn to assess and diagnose pneumonia on the basis of rapid breathing, and to dispense antibiotics in a way that is understandable to the caretaker. Finally, among these examples, the question of whether or not non-physicians should be allowed to perform surgery, especially Cesarean sections, is discussed above. The issue of level of care is quite important in Afghanistan's heavily medicalised health system in which doctors have maintained control over many interventions that could be performed by less highly-trained workers. The health system will probably have to become more flexible, more permissive and more creative in the future. Nevertheless, all new policy decisions, except those that have been indisputably successful in other countries, should be tested in pilot areas and evaluated before their final adoption.

Special Needs of Vulnerable Populations

In addition to the development of a Basic Health Services Package, an effective public health programme makes sure that the needs of the most vulnerable segments of the population are adequately addressed. In Afghanistan, these include returned refugees, internally displaced, and drought-affected people. Basic needs, according to minimum standards as outlined in documents such as the Sphere Project, must be met.¹⁰ Population-based mortality and nutrition surveys, such as those carried out in Badghis Province and planned for the rest of Afghanistan, should be used to establish baseline rates. Where rates are higher than commonly accepted threshold values, rapid intervention in these areas should be prioritised.

The number of returning refugees from Pakistan has been far higher than predicted - by mid-May 2002 about 500,000 returnees had been registered by UNHCR. UNHCR is providing up to US \$100 per family (more for those travelling long distances), but unless adequate food, water and shelter are provided to all along the path of return, the health status of this population could deteriorate rapidly. Even later, unless returnees are re-

integrated into villages in rural Afghanistan there is a risk that peri-urban shantytowns could develop, with the inadequate water and sanitation and relative inaccessibility to health care services that usually accompany these situations.

Finally, the plight of women in Afghanistan, featured prominently in many reports, should also be highlighted here. Reproductive health, including family planning needs in addition to safe motherhood is often neglected in the early stages of health system reconstruction. Other health problems, caused in part by the low status of women in Afghanistan (e.g. high mortality from tuberculosis) need to be identified and addressed. Finally, poor household health behaviours, including care-seeking behaviours, need to be changed through intensive, but effective, health education campaigns.

Afghanistan shares an important characteristic with other post-conflict settings. Although it is struggling to rehabilitate its structural and human infrastructure through the slow and steady process of development, it still has a substantial number of "pockets of vulnerability" where relief, not development, should be the order of the day. The objectives of these two spheres of activity, the intensity of effort required to attain those objectives, the technical interventions and the timeframe for reducing excessively high rates of morbidity and mortality can be quite different. It is the job of the MoPH, the donors and the implementing partners to address both relief and developmental needs simultaneously. This will be a real challenge for a country where political stability is still not ensured, where many donors have expressed interest, but not yet commitment, and where many NGOs have institutional philosophies and capabilities that enable them to work in either relief or development, but not in both.

Common Denominators

One useful characteristic of the Basic Health Services Package is that all of the interventions that will eventually be adopted in the final version have a common set of cross-cutting characteristics

¹⁰ According to information provided by one NGO, a direct correlation has been established between sub-standard quantities of water at the Chaman refugee camp in the Balochistan province of Pakistan and the incidence of bloody diarrhoea.

that can be planned for at the national level. The content of these features will be different for each programmatic element, but the skills required to deliver that content are similar.

Research into the attitudes and practices of the population regarding their own health and that of their children could provide very useful information for the planning and implementation of health education activities.

different sources, and initial positive behaviours need to be reinforced in a variety of ways in order to bring about lasting change. The use of mass media should be explored.

Community Education

Although little data is available, household behaviours for health are said to be in need of substantial change in Afghanistan. According to informants of this report, prevention is rarely practiced. This is true even of basic requirements such as breastfeeding, which is of reasonable duration, but is started late and is not exclusive for an acceptable time. Recourse to traditional remedies for almost all of the proposed diseases of epidemiological importance are common, but are of questionable impact.

In general, care-seeking behaviour is not well documented. The proportion of people whose primary source of health care is in the traditional/religious system, the private medical/pharmacy sector or the public health system is not known at this time. Of course, many people “shop around” for health care, moving between the systems or taking advantage of the strengths of each.¹¹

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Research into the attitudes and practices of the population regarding their own health and that of their children could provide very useful information for the planning and implementation of health education activities.

Both national and international NGOs are providing a great deal of health education at MCH and basic health facilities. But the communication of good behaviour is frequently not enough. Messages need to be reinforced on a regular basis, from

There is a tradition of health education by radio in Afghanistan, especially through the REACH programming of the BBC. The *Aide-Memoire* suggested the development of radio programmes for women as a quick impact project, and UNICEF is currently planning to use radio for delivering health messages. Again, the content of the messages can be varied, but the need for health education at community level is pervasive.

Training

Building human capacity was probably the most commonly cited need of the Afghan public health system. There are a number of reasons why human capacity of the system is currently deficient. Medical education under the Soviet regime was not responsive to the public health needs of the population. As evidenced by discussions with Afghan doctors, the emphasis was on curative care and notions of public health are poorly developed.

As mentioned above, medical progress has not been well incorporated into Afghan medical schools. Salaries are very low. There are real disincentives for doctors to move to rural areas. Finally, there are too many doctors in relation to other categories of health workers that might be better suited, for a variety of reasons, to provide basic health services to the population.¹² Other important reasons for limited capacity include the more general collapse of an already limited educational system, compounded by the Taliban ban on girls' education, and the brain drain of many of the best and educated immigrating to the West.

¹¹ The sectors themselves are not very distinct. In Kabul for sure, and undoubtedly elsewhere, all government doctors maintain private practices in order to augment their meagre salaries. Other cross-system activities also take place. Anecdotally, one informant told us that a mullah in the south of Afghanistan was known to give women injections of Depo-Provera upon request.

¹² There are currently about 4,000 doctors in Afghanistan and another 7,000 medical students. This is undoubtedly more than the number of trained community health workers in the country. The primary health care pyramid has been stood on its head.

To redress this situation, plans are being implemented to vastly increase the number of mid-level health workers, including nurses, midwives and auxiliary midwives. Two- and three-year pre-service training programmes in Kabul are being heavily supported by USAID and UNICEF and are being implemented by IMC and other partners. There are plans underway to extend pre-service training to the other major regions of the country. Nevertheless, pre-service training is a long-term project.

There is a need to develop sound in-service training programmes for all categories of health worker, including physicians. Much of this work is underway and more is planned, but for the most part it is occurring in an uncoordinated and project-wise fashion. The MoPH should devise a coherent training strategy for implementation by NGOs and other partners. Again, content should be tailored to the Basic Health Services Package.

Capacity to conduct appropriately selected and designed research should be developed and donors should prioritise supporting operational research and not just project implementation.

Health Information Systems (HIS)

The other prominently mentioned deficiency of the Afghan health system on which all contacts agreed is the quasi-total lack of usable information. As with so many other features of the system, some information is available on a project-by-project basis, but little systematically collected data is used to formulate national policies and strategies or to guide programmatic activities.

There are numerous surveillance activities underway, though. The WHO/UNICEF-led polio eradication effort is a good example in this regard. The polio surveillance effort should be expanded, and the system should be made to accommodate reporting on other important conditions. This is being planned. The measles mortality reduction strategy has also made a concerted effort to improve reporting. Nevertheless, reports of diseases, even when reporting is limited to a small number of major conditions and diseases of epidemic potential, are only helpful to a limited extent. Process indicators, designed to inform on the progress of programmatic strategies, also

need to be incorporated into effective health information systems (HIS).

Most of the organised, coordinated, national-level information activity is taking place through AIMS (Afghanistan Information Management Service), an apparently successful innovation of UNDP and UNOCHA. Still, information that will be most useful in reducing the poor health indicators of Afghanistan will be information that can be

collected, analysed, interpreted and used at the most local level possible. It is gratifying to see the extent to which basic health centres and MCH clinics (at least the ones we

visited) are aware of their geographical catchment areas, their target populations and some of their coverage results. This kind of local information for local use needs to be expanded throughout all projects currently operating, and eventually to national programmes that intend to implement the Basic Health Services Package.

Operational Research

Throughout this document the need for information has been stressed. Targeted research is important to the development of appropriate policy in post-conflict health systems.

In Afghanistan, little is known about the following areas at the present time:

- Household health practices, including breastfeeding, weaning, treatment of childhood illnesses;
- Care-seeking behaviours;
- Household expenditures on health by type of provider;
- Levels of mortality and malnutrition;
- Prevalence of major micronutrient deficiencies, specifically iron, iodine and vitamin A;
- Rates of seroconversion (development of immunity) to measles vaccine at six months of age;

- Rate of impregnated bed net use in most areas of the country;
- Means of redistributing resources geographically;
- Resistance to antibiotics and antimalarials;
- Incidence, diagnosis, treatment and proportional mortality of childhood pneumonia;
- Seroprevalence of HIV in the general population high-risk subsets; and
- Cause of disability, including land mine injuries, birth injuries and motor vehicle accidents, among others.

This list could be much longer, as additional problems are recognised. Capacity to conduct appropriately selected and designed research should be developed and donors should prioritise supporting operational research and not just project implementation.

Programme Management

The final element that all public health programmes have in common is the need for strong management. Policy formulation and the development of effective strategies are an important part of management, but they need to be complemented by strong oversight, periodic monitoring and well-designed, constructive evaluation. The MoPH is admittedly weak in this area and will require substantial external assistance over the next few years. Some of this assistance is already in place, at least for the short term, but additional commitments by donors will be required. Given the ideas currently being proposed as to how services would be delivered in Afghanistan, the managerial role of the MoPH is paramount.

One first step in effective management is the definition of clear,

realistic objectives. The National Development Framework (NDF), seeking early results, mentions that child mortality in Afghanistan should be cut by half in two years, clearly an impossible dream. In post-conflict settings, the quest for rapid results in order to maintain the interest of the donors has competed with the recognition that the rebuilding of political, economic and social systems is a slow process and that rushing things only increases the likelihood of an unsatisfactory



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In post-conflict settings, the quest for rapid results in order to maintain the interest of the donors has competed with the recognition that the rebuilding of political, economic and social systems is a slow process and that rushing things only increases the likelihood of an unsatisfactory outcome.

outcome. While the health sector does not work in isolation and needs to be sensitive to political concerns, decisions must be made as to what the MoPH is trying to achieve. Setting quantifiable objectives will, to a certain extent, dictate the interventions and strategies to be implemented.

For example, setting a national objective of mortality reduction of children and pregnant women requires different interventions than one of ensuring minimum services in all areas of the country, including those that are currently underserved. Working in concert with the

international community to eliminate polio from Afghanistan requires a different level of resources and very different strategies than training an adequate number of mid-level health workers to

provide basic services. Certainly a mix of process and outcome-oriented objectives can, and should, be developed. But no matter how many different agendas they seek to accommodate, these objectives should be realistic, well defined and clearly articulated. Only then can a set of appropriate interventions and strategies be developed.

A word is in order regarding coordination, another important aspect of effective management, sometimes referred to as the “slowest common denominator.” Coordination in Afghanistan has been difficult to date.¹³ This has been true not only between the actors, but within the groups themselves. There is potential for disagreement between different bodies of government, for example, such as between the AACA and the line ministries, and between the several line ministries that have responsibility for the provision of health services, including the MoPH and the Ministry of Higher Education. There are other ministries that are involved in health as well. Donor coordination is always a potential - and usually a real - problem. Donors consulted during the course of writing this report seemed generally satisfied with the level of informal donor coordination, though most felt that the formal mechanisms which have been formed are less productive.

The UN agencies are, to a certain extent, vying for prominence. With different institutional histories in Afghanistan, and generally unproven records, they are struggling to establish relationships of trust with the government, donors and NGOs. If the performance-based contract scheme (see Section III) is put into place, even in modified form, the role of the UN agencies will be further called into question. On the other hand, given the lack of managerial and technical

expertise in the MoPH, it seems reasonable to suggest that the UN agencies provide substantial assistance in at least an advisory, if not a more active, capacity. UNICEF seems particularly capable of filling this role, and it has organised a series of admirable research and programmatic activities. These roles, including national level information gathering through surveys and the development of routine information systems; the design and implementation of national level technical intervention programmes, such as those planned in micronutrient supplementation; safe motherhood and measles vaccination initiatives; and the assignment of technical advisers to the MoPH should continue. The desired role of the UN agencies in the health sector should be made more explicit in the next JDM and funding for these agencies should be allocated.

Finally, NGO coordination is in a typical state of affairs. There are a number of NGO coordinating

While information exchange is a clear necessity in the dynamic and constantly changing situation of Afghanistan, NGOs do need to be included in the decision-making processes of government and the UN to the degree that their presence in the field warrants.

bodies for both international and national NGOs, and the need to coordinate the coordinators is an issue that was mentioned by several of them. Established NGOs and new arrivals, relief-oriented and development-oriented

NGOs, primary health care and specialised agencies, government-funded and privately financed, all should be represented by the coordinating bodies. This is difficult, if not impossible. In fact, one of the principal coordinating structures, the Agency Coordinating Body for Afghan Relief (ACBAR), has found itself performing a function of information exchange far more than one of providing leadership and representation of the NGO “community.” While information exchange is a clear necessity in the dynamic and constantly changing situation of Afghanistan, NGOs do need to be included in the decision-making processes of government and the UN to the degree that their presence in the field warrants.

¹³ See Stockton N., Strategic Coordination in Afghanistan. AREU, June 2002, and Schenkenberg van Mierop E., NGO coordination and some other relevant issues in the context of Afghanistan from an NGO perspective. 9 April 2002.

III. Managing the Health System

Whatever the final content of the Basic Health Services Package, delivering health services to the population will pose an enormous challenge to the MoPH. Many of its facilities - from hospitals to basic health centres - were destroyed over the years. The rehabilitation and re-equipping of these structures will be a costly and time-consuming undertaking. Even locating them, taking stock of the personnel assigned to them, and making an inventory of the services offered will be difficult.

WHO, using its Health Mapper programme, has made one attempt to do so. An Infrastructure and Health Atlas of Afghanistan was produced in February 2002. It details the location of the known functioning and non-functioning basic health centres, showing that the former are concentrated for the most part in and around Kabul and in the eastern region. Although these are the areas of highest population density in Afghanistan, it is worth noting that the ratio of basic health centres to population ranges from approximately one per 40,000 in the central and eastern regions to approximately one per 200,000 in the south. Nineteen districts had no health facilities at all. A more comprehensive, active survey of all health facilities and associated resources is currently being planned by MSH. It is scheduled to begin in July and to be completed in September 2002.

Even without a detailed inventory of facilities and health care personnel, it is clear to all that while the more densely populated parts of the country may be adequately served, in quantity if not in quality, there is a woeful shortage of functional health service delivery points and health personnel in most of the country. For personnel, the unequal distribution of resources is true for all levels of care, from traditional birth attendants (of which there are only 30% of the estimated number required) to physicians (of

which more than 50% of the approximately 4,000 are said to be in Kabul alone). Of Afghanistan's 33 provinces, only 11 currently have the capacity to deliver emergency obstetrical care.

The majority of health care in Afghanistan is provided at present through NGOs. It is estimated that more than 80% of functional health facilities have some form of NGO involvement. The number of NGOs working in the health sector is large, the scope of their work varies considerably and, for the most part, they are undertaking to deliver services in discrete project areas. NGOs are providing support in the form of physical rehabilitation of premises, equipment, salary support for personnel, training and direct service delivery. While some are working through MoPH and/or Ministry of Higher Education auspices, many have bypassed government structures and are operating independently (albeit with government permission). While most NGOs are working to provide general primary health care services, some are quite specialised, for example, IAM for eye care, ICRC for surgical and orthopaedic services, HNI for malaria and leishmaniasis control, MedAir and MSF for TB control, and others.

Although a number of NGOs are attempting to address the needs of particularly underserved areas in the central and southern parts of the country, the overall distribution of NGO activities is uneven, with a concentration in the urban areas and areas near the Pakistani border. Many NGO activities began as cross-border operations, headquartered in Pakistan, and their reach extended only to the eastern and, to a lesser extent, the north-eastern areas of Afghanistan. The conflict over much of the past 15 to 20 years dictated which areas could be accessed by even the most daring organisations. Logistical constraints also played an important role in determining the deployment of personnel and services.

If an efficient and effective national health system is to be developed in the coming years, the following four considerations will need to be addressed:

1. The lack of managerial and service delivery capacity within the MoPH;
2. The lack of physical infrastructure and appropriately qualified personnel;
3. The poor distribution of resources; and
4. The relatively uncoordinated and undirected efforts of the NGOs that are providing the bulk of health care services.

A draft of the *Aide-Memoire* of the JDM to Afghanistan on the Health, Nutrition, and Population Sector (9 April 2002) presented a proposal for resolving these problems. The JDM suggested that basic services could be rapidly extended to underserved areas (and throughout the country) by the adoption of a management system structured around PPAs between the MoPH and the NGOs and/or other private sector elements.

Under the PPA scheme, the MoPH would be responsible for establishing health care priorities for the Afghan population and defining a basic package of services (discussed above) that would form the core of health facility activities throughout the country. Quantifiable, time-linked targets for improvements in health service delivery and, presumably, population health status would also be established. The MoPH would prepare “requests for proposals” from the NGO community and invite competitive bids for contracts to provide essential health services to underserved areas. It is suggested that one contract be awarded per province, with the NGO contractee responsible for the provision of all health services - from hospital management to community-level care. Awards would be made in a transparent manner.¹⁴ The NGO awardee would be paid on a per-capita basis for the provision of health services, but only if its performance was acceptable in relation to the predetermined indicators, as evaluated by both the MoPH and independent audits.

The PPA scheme is seen to have the following real and potential advantages, as outlined in the *Aide-Memoire*, which states that PPAs would:

- allow the government to take advantage of the presence of international and local NGOs in the health sector, to more clearly define a common set of services and to promote adherence to a national health policy;
- establish a more formal, hopefully constructive, relationship between the government and the NGOs;
- ensure a more equitable distribution of health services;
- contribute to the decentralisation of decision-making, by situating day-to-day operations at the provincial level; and, perhaps most importantly,
- allow the MoPH to restrict its functions to the management of the NGO contracts and to forgo, to a large extent, the direct delivery of health services through a large and cumbersome civil service corps, if scaled-up to cover a substantial portion of the country.

The potential disadvantages of the PPA approach (some of which are outlined in the *Aide-Memoire*) are also numerous. Obviously, the burden of developing and managing large contracts is enormous. The MoPH does not possess the skills to do so and substantial technical assistance would undoubtedly be required over a long period of time. The potential for the award process to be influenced by personal relationships, bribes and other forms of corruption is always present. The system will probably be expensive for the government, since the NGOs constitute a middleman that would not be present if the MoPH were to provide services directly. (On the other hand, preliminary results from the Cambodia experience show that household expenditures on health were lowered as people made greater use of the higher-quality, lower-cost public facilities and sought health care in the higher-cost private sector less frequently). Finally, and especially significantly in the Afghan context, monitoring and assessment of NGO performance, the principal element of the contract, requires the regular collection and analysis of accurate data, something which is essentially non-existent at present. The PPA approach in Cambodia is described in more detail and the results of an early, independent evaluation are presented elsewhere.¹⁵ In brief, utilisation of facilities, especially by the poor, antenatal care visits, tetanus toxoid immunisation coverage and childhood vaccinations, all increased dramatically in the contracted

¹⁴ Although details are not given in the *Aide-Memoire*, when the PPA approach was implemented with the assistance of the ADB in Cambodia, each bid consisted of two proposals, one technical and one financial. A panel consisting of representatives from the MoPH, UN, and the NGO community judged the technical merit of each bid. When more than one bid was determined to be technically acceptable, financial proposals were opened publicly and the contract awarded to the lowest bidder.

¹⁵ Bhushan, I., Keller S., Schwartz B. Achieving the Twin Objectives of Efficiency and Equity: Contracting Health Services in Cambodia. ERD Policy Brief #6, Asian Development Bank, March 2002.

facilities. Quality of care in both health facilities and hospitals also improved, though it is not clear what criteria were used to determine this. Finally, as mentioned above, though government costs were higher, household expenditures were lower in the contracted districts than in control districts.

These results are encouraging, though they are characterised by the authors as “preliminary and indicative,” and no data regarding curative care are presented. However, it is not clear to what extent the Cambodia experience can be replicated in Afghanistan. Some of the implications of its adoption for the various actors in the health sector are outlined below.

It is extremely difficult to get hard data regarding the cost of providing health services in Afghanistan.

What is certain, however, is that external funding, currently estimated at 80%, will be required for many years to come.¹⁶ The *Aide-Memoire* estimated the requirement for delivering hospital and basic health services to be between US \$230 and

US \$310 million over the next five years, and the rehabilitation and equipping of existing infrastructure an additional US \$100 million. The World Bank will undoubtedly be one of the largest donors to the PPA scheme and a funding proposal is currently being prepared. The European Commission (EC) is considering a contribution of similar magnitude, perhaps about US \$10 - \$15 million per year for the next five years (following on a contribution of approximately 20 million euros this year). Other donors have not yet determined their funding levels for health, but it is expected that additional funding will become available from a considerable number of bilateral donors. It will be needed.

Whatever final amount becomes available, a high degree of donor coordination will also be desperately needed. Although it has been

proposed in other countries that donors contribute to a common fund in order to allow ministries of health to implement their national plans, this mechanism has proven difficult to put into practice for a variety of reasons, mainly involving donor requirements for accountability. Bilateral, direct funding from donors to NGOs can certainly be done under the PPA scheme, as long as donors respect both the technical content of the MoPH national plan for expanding services, i.e., the Basic Package of Health Services, and the contractual agreements agreed upon by the MoPH and the NGOs. Extensive donor funding of a large variety of activities and services outside of the Basic Health Services Package and/or funding of NGOs based on criteria other than the performance criteria developed by the MoPH can only serve to undermine the credibility of the MoPH and its

Extensive donor funding of a large variety of activities and services outside of the Basic Health Services Package and/or funding of NGOs based on criteria other than the performance criteria developed by the MoPH can only serve to undermine the credibility of the MoPH and its ability to manage the health sector, and interfere with its ability to achieve its objectives.

ability to manage the health sector, and interfere with its ability to achieve its objectives. If the principal actors in the health sector are to be the government as managers and the NGOs as implementers, the role of the three UN agencies (WHO, UNICEF, UNFPA) that are

currently involved in the health sector is called into question. Of course, they will continue to be called upon to provide technical assistance to the MoPH, both in the design of the contract terms and in the bidding process as well as in their areas of technical expertise, but their role as “lead agency,” or “secretariat,” for the health sector is less clear. Whether or not an implementing function would be reserved for them in the national vaccination programmes, other areas of communicable disease control, nutrition and safe motherhood, would need to be worked out. It should be mentioned that at the time of this report no UN agency had yet been designated as the overall secretariat of the health sector.¹⁷

When this report was being prepared, the NGOs were, for the most part, uninformed about the

¹⁶ Report of the National Health Sector Planning Workshop (16-19 March 2002). Ministry of Public Health.

¹⁷ After data had been collected for this report, but during its preparation, WHO was designated as the secretariat for health and UNICEF was given responsibility for nutrition, childhood vaccinations and safe motherhood. UNFPA will be responsible for reproductive health in general.

JDM proposal. At the request of a number of them, a meeting was held to present, albeit briefly and incompletely, the main points of the PPA as described in the *Aide-Memoire* and the Cambodia evaluation report (see above). From this meeting, and from interviews with individual representatives of a considerable number of NGOs (see Appendix A for a list of interviewees), it was clear that the NGOs recognised the problems that the PPA scheme is meant to address. There was consensus that the proposal had considerable merit on paper, but there were questions regarding the feasibility of its implementation in the Afghanistan context. This was true even with the understanding that in a competitive bidding process there would be “winners” and “losers,” and that the system seemed to favour those larger NGOs that had longer experience in Afghanistan. Some NGOs responded favourably to the idea that it might be to their advantage to form formal or informal partnerships with others working in complementary areas in order to be more competitive. It should be pointed out, though, that the sample of NGOs, (both international and national), interviewed as part of this analysis is hardly representative of the large NGO community currently working in the health sector in the country.

Perhaps the most important observation from the NGOs is that, like the government, they also do not possess the capacity to provide even basic services across the levels of the health system on a provincial basis. Even the largest of the health providers in the country, the Swedish Committee for Afghanistan (SCA), supports only basic health centres. Though their representative expressed a positive attitude toward the government contracting approach, recognising that it was

Perhaps the most important observation from the NGOs is that, like the government, they also do not possess the capacity to provide even basic services across the levels of the health system on a provincial basis.

a way to increase government control and to unify a fractured health system, he felt that SCA would have to limit its current geographical scope in

order to provide services at more than one level of the system. Similarly, other NGOs expressed reluctance to take responsibility for the delivery of services over a large area. Different NGOs suggested that contracts be limited to the provision of services at specific facilities, on a district-by-district basis, or for a cluster of districts where the number of facilities within a district was particularly small.

It was suggested that NGO representatives sit with the MoPH when the technical terms of the contracts and the performance indicators are being designed. NGOs, by virtue of working at the community level, may have a better idea of the kinds of services that are most required and most desired by the communities, of the most effective service delivery strategies, and of reasonable expectations for performance. Leaving the MoPH and its advisers in complete charge of the design process, it was suggested, would be



Sarah Telford for UNICEF

¹⁷ After data had been collected for this report, but during its preparation, WHO was designated as the secretariat for health and UNICEF was given responsibility for nutrition, childhood vaccinations and safe motherhood. UNFPA will be responsible for reproductive health in general.

a “top-down” approach that should be avoided. Similarly, it was pointed out that the perceived advantage of decentralisation accorded to the PPA scheme might, in fact, be a detriment. NGOs reported that local health officials, at province and district levels, already see themselves as being “in charge.” Unless they were part of the contracting process and fully informed of the agreements made between the NGOs and the MoPH, central and provincial MoPH authorities might have different sets of demands and requirements. Improved and effective communications between the different levels of the MoPH would have to be established. Finally, the acceptability of a formal contractual agreement with government in light of the advocacy and witnessing role of NGOs and their function as independent observers of the scene in a country as politically complicated and as fragile as Afghanistan was mentioned.

The experience of one NGO with which the PPA proposal was discussed in some detail, HNI, is worthy of mention for a variety of reasons. For one, HNI is currently implementing two PPA agreements in Cambodia and has considerable experience with the system. HNI is also currently supporting two distinct kinds of programmes in Afghanistan. One is a primary health care programme in Shinwar district in Nangarhar Province in the eastern region. HNI is providing support to the University Hospital at the regional (provincial) level, to a rural 40-bed hospital in Ghani Khel that serves a cluster of districts with a population of approximately 300,000, and to two basic health centres that form the base of the PHC pyramid, or “cluster.” The other major HNI activity in Afghanistan is technical support to malaria control. A specialised team has been promoting, monitoring and evaluating the use of impregnated bed nets and other materials, cattle sponging and larva-eating fish. They have been researching

Although a sense of urgency is conveyed by the aide-memoire and calls are made for “quick” and “rapid” action, a longer-term vision might serve the country best. The limited existing capacity on the part of both government and NGOs, the multiplicity of actors and the cautious eye through which most donors are viewing the current situation, suggests that a slow, phased-in approach might be more warranted.

and monitoring antimalarial drug resistance patterns and contributing to the development of national malaria control policies.

The primary health care “cluster” seems tailor-made for the PPA process, assuming that the performance indicators are designed according to reasonable expectations that might be informed by the HNI experience (and others) to date. Interestingly, HNI reports that the initial contracts in Cambodia significantly underestimated the rapid increase in utilisation of government facilities that took place after the NGO contracts were awarded. As a result, because the contractual payments were made on a per-capita basis for services offered, and because they had to serve a substantially greater number of people than that for which they had contracted, HNI lost a considerable amount of money. They urge that safeguards be built into the contracts in Afghanistan until appropriate baselines can be established. Nevertheless, and in spite of the fact they their contract gave them only management oversight, not control, of health service delivery in their districts, HNI feels that their experience was quite positive.¹⁸ They recognise the advantages in the short- to medium-term of a small, but capable, MoPH that would be involved in policy making, monitoring and supervision, but to a much lesser extent in service delivery. Similarly, they feel that a public/private partnership system would allow for systems to be “jump-started” in order to provide services into rural areas quickly. Finally, the closer involvement of NGOs with the MoPH at a national level would allow for capacity-building and an eventual, but unforeseeable at this time, transfer of responsibilities back to the government.

On the other hand, the role of the technical, “vertical,” malaria programme is less clear.

HNI tries to provide technical support to all government and NGO malaria control efforts at present. Technically

¹⁸ In Cambodia, two kinds of contracts were offered: In one, “contracting-in,” - the kind HNI had - NGOs gave technical and managerial support to civil service staff and inputs were provided through normal government channels. HNI reportedly had difficulties with drug deliveries, timely payment of salaries, etc. In the other, “contracting-out” model, NGOs had complete control over resource provision and health service delivery, and they hired their own staff.

specialised programmes, such as HNIs and others mentioned above, are not currently provided for in the PPAs. They need to be.

In summary, the PPA proposal of the JDM seems acceptable to the principal actors in Afghanistan's health sector and seems, in principle, to address some of the major existing problems. At this stage, its designers need to be further informed of the characteristics of Afghanistan's political structure (when that becomes clearer and more stable) and the capacity of its line ministries. Although a sense of urgency is conveyed by the *Aide-Memoire* and calls are made for "quick" and "rapid" action, a longer-term vision might serve the country best. The limited existing capacity on the part of both government and NGOs, the multiplicity of actors and the cautious eye through which most donors are viewing the current situation, suggests that a slow, phased-in approach might be more warranted. They also need to

understand better the capabilities and limitations of the proposed principal partners to the MoPH: the international and national NGOs that are currently providing the majority of the health services. The NGOs need more information regarding the current proposal and the past performance of PPAs, its benefits and disadvantages, and its short- and longer-term implications for their work in Afghanistan and elsewhere. Although there is little doubt that when large contracts are offered, many organisations will be tempted to bid, it would be in the best interests of the MoPH to ensure that the larger and the most proven of the NGOs are willing to participate. In order to ensure their full participation, the next JDM should try to elicit their full participation, at least at a public discussion of the proposal. It would also be constructive for the JDM to provide a number of alternatives to the scheme that is currently under discussion.

IV. Recommendations

Many of the above recommendations are derived from interviews conducted for this report, and several are already in the process of being implemented.

General Recommendations

1. The MoPH, together with its advisers, should develop specific policies and guidelines to govern the public health system in Afghanistan at an early stage of its development in order to allow all actors in the health system to work toward achieving the same goals and objectives. At present, most health care delivery in Afghanistan is done on a project-by-project basis. NGOs or other entities, including UN agencies involved in health design, seek funding for and implement ideas that they feel meet the needs of the population in accordance with broad guidelines laid down by donors. Although the MoPH has issued an excellent statement of general principles that clearly articulates the primary health care approach, there are no specific policies regarding primary health care programmes that can guide the activities of health service delivery organisations or coordinate their actions. The elaboration of a Basic Health Services Package is a step in this direction.
2. The authorities in Afghanistan should consider convening a “loya jirga” for health in the months following the next JDM. This might take the form of a meeting of representatives of each of the major groups of actors - MoPH, UN, NGO, and private practitioners - for a true exchange of information and the joint development of policy and implementation guidelines. Communications between the actors has been a problem. There have been attempts to coordinate the activities of the NGOs, UN organisations and the government through formal and informal mechanisms of information exchange. However, these have not been effective, and there has been insufficient communication between these categories of contributors to the health

system. In other post-conflict settings it has been useful to have periodic, general meetings to review and discuss health policies to develop consensus around future activities and to hear about obstacles from the field. These meetings serve to keep everyone informed, to create a spirit of cooperation and consensus and to promote a participatory style of work. Ensuring the investment of all groups in the future of public health in Afghanistan would be a first step in ensuring its success.

Recommendations on Content

3. The Ministry of Public Health should not set itself up for failure by promising to deliver more than it can. Although the draft Basic Health Services Package is an important step towards prioritising the essential work of the health system, there are enormous competing demands for more than the system can handle. No one ever feels comfortable designating important areas of work as “non-essential.” Yet the hard reality is that according to most of those interviewed during this consultation, the Basic Health Services Package, as it is currently composed, cannot be implemented, at least not all at once. The MoPH should develop a schedule for phasing in the components of the package and a review of priorities, particularly mental health and disability services, taking into account the financial, technical and operational realities of the current situation. However, donors should understand that in order to be credible, the MoPH will have to try to satisfy the needs of its entire population. NGOs should try to ensure that the appropriate technical expertise is available to deal with those problems that are designated as highest priority.
4. Following the completion of appropriate studies, clear policy guidelines should be developed and enforced for the treatments of choice for pneumonia, malaria and malnutrition. The management of common childhood communicable diseases and

malnutrition should be the subject of an intensive training programme for intermediate-level and community-based health workers. While implementation of the WHO/UNICEF IMCI initiative would be ideal, the process is time-consuming and quite training-intensive. On an interim basis, shorter, more focused training efforts can be launched to take advantage of the seasonal occurrence of some of the target diseases.

5. Primary care services should be “pushed down” to the community level. This includes the management of diarrhoea, the initial treatment of malaria and pneumonia and the assessment and referral of obstetrical emergencies. The level at which primary health care services are offered is a crucial issue in Afghanistan because of the difficulty in accessing facility-based services. Such an approach will require that non-physicians use drugs and perform procedures that have previously been restricted to medical personnel. Because women are often more adept at community health work, including vaccination, an appropriate proportion of women should be trained to do these jobs. The issue of payment to community health workers for performing these services also needs discussion and resolution.
6. The needs of highly vulnerable populations should not be ignored. Although the current emphasis is on rehabilitation and development, there are a considerable number of returning refugees, internally displaced and conflict- and drought-affected populations whose needs may be different from those of most Afghans.

Recommendations on Management

7. NGOs should be more involved in the next JDM and full participation of the donor community should be assured. NGOs are relatively uninformed regarding the details and the implications of the PPAs, the principal feature of the JDM's recommendations. Bilateral agreements between donors and implementing NGOs should be allowed and encouraged, but the donors should respect the programmatic priorities of the MoPH and not pursue their own policies and programmes independently. Competition between government and international donors can be avoided if donors are committed to the same principles as the MoPH.
8. A representative delegation of the public health community in Afghanistan should be sent on a study visit to Cambodia where the PPA scheme is currently being implemented, and where there is substantial experience in rehabilitating post-conflict health systems.
9. Consider alternatives to province-wide health services. At present few, if any, NGOs are capable of implementing health services at a provincial level in Afghanistan, as suggested by the PPA scheme and proposed in the draft Joint Donor Mission *Aide-Memoire*. Alternatives may include contracting services on a facility-by-facility basis (or for a cluster of facilities), contracting at a district level or lower, or contracting several NGOs to provide services at different levels of the system within a single province.
10. The place of specialised, vertical programmes should be carefully considered. NGOs that are not providing general primary health care services, (e.g. tuberculosis control, leishmaniasis control, and perhaps support and rehabilitation of the disabled), are providing valuable services. The MoPH should oversee and manage these activities. NGOs working in these areas should be accountable to the MoPH and to the public they serve.
11. A functional health information system should be created, emphasising accurate, timely and actionable information. It should build on the surveillance systems that have been put in place by the polio eradication initiative, though indicators of maternal health, nutrition and food security and programmatic (process) indicators for all priority health activities will require different information parameters.
12. A research agenda to inform policy-making and service implementation should be developed and implemented. Operational

research is frequently neglected, and because relatively little is known about household health practices, care-seeking behaviours, and household expenditures on health in Afghanistan, particular emphasis should be put on these subjects. Other potential priority research areas are found in the body of this report.

The public health system in Afghanistan has a long way to go if the health parameters of the

Afghan population are to improve. A concerted, long-term partnership between government, donors, UN and NGOs is a prerequisite for continued progress. These recommendations are offered in the spirit of fostering as comprehensive and as participatory a process as possible. With the sustained commitment, dedication, and intensive effort of those involved in public health, the health status of the Afghan population can improve substantially over the next few years.

Appendix A

List of Contacts

Afghan Assistance Coordination Authority (AACA)

Leader, Nicholas, Representative

Ministry of Public Health (MoPH)

Fahim , Dr. Abdullah, Director of International Relations

Ibrahim, Dr. Fazel M., Regional Director for the Eastern Region, Jalalabad

United Nations

Borrel, Annaliese, Technical Adviser to the Ministry of Health, UNICEF

Crowley, Joe, Field Officer, Afghanistan Information Management Service (AIMS - UNDP)

Fleerackers ,Yon, Epidemiologist, WHO

Gachiri, Joyce, Director Sub-Regional Office, UNICEF (Jalalabad)

Grandi, Filippo, Chief of Mission, UNHCR

Hanna, Iskandar N., Polio Programme Consultant, WHO

Huff-Rousselle, Peter, Country Representative, UNFPA

Ionete, Denisa-Elena, Project Officer, Maternal and Child Health, UNICEF

Modol, Xavier, PHC Consultant, WHO

Mojadedi, , Farooq National EPI Trainer, WHO

Momin, A. M. Deputy WR, WHO

Salama, Peter, Head of Health and Nutrition, UNICEF

Governments & Donor Institutions

Cautain, Jean-Francois, Programme Coordinator, EC

Freckleton, Anne, Programme Manager, DFID

Hayward, John, Head of the Office, ECHO

Jacob, Francoise, Correspondent, ECHO

Kvitashvili, Elizabeth, General Development Officer, USAID

Lynch, Ellen, Health Officer, USAID (IOM)

Paro, Amy, USAID/OFDA

Sondorp, Egbert, EC

Tully, Anne, World Bank

NGOs

Anastacio, Anita, Country Director, Mercy Corps International (MCI)

Andersson, Hans Ronny, Health Delegate, ICRC (Jalalabad)

Brigham, David, Programme Coordinator, IMC

Combes, Jerome, Head of Mission, Action Contre la Faim (ACF)

Coux, Isabelle, Médecins du Monde (MDM)

Douilliez, Caroline, Communication Delegate, ICRC

Durrani, M. Naeem, Technical Coordinator, Malaria & Leishmaniasis Control Project, HNI (Jalalabad)

Dutreix, Georges, Head of Mission, MSF

Erasmus, Panna, Programme Director, Malaria & Leishmaniasis Control Project, HNI

- Gardezi, M. Asif, Senior Health Field Officer, ICRC
- Ickxx, Paul, MSH
- Jabarkhail, Anwarulhaq, Country Director, IMC
- Mindling, Tim, Deputy Executive Director, International Assistance Mission IAM
- Nassiry, Ashraf and Stanekzai, Masoom, Agency for Rehabilitation and Energy Conservation in Afghanistan (AREA)
- Newbrander, William, MSH
- Noorullah, Ihsan, Regional Coordinator, Ibn Sina (Jalalabad)
- Norwegian Afghanistan Committee (NAC, Jalalabad)
- Purves, Ian, Executive Coordinator, ACBAR
- Solter, Steven, MSH
- Van Eijdsen, Nicolien, Administrator, HNI (Jalalabad)
- Wann, Jan-Erik, Regional Director, SCA
- Wilder, Andrew, Director, AREU
- Afghan Doctors
- Jalil, Dr. M., Internal Medicine, Jamuriat Hospital
- Joyenda, Dr. Feraidoon, Internal Medicine, Ibn Sina Emergency Hospital
- Musly, Dr. Gulnoor, Obstetrician & Gynecologist, Rabia Balkhy Hospital
- Parwani, Dr. Wakil, Dermatologist, Ibn Sina Emergency Hospital
- Sadat, Dr. Said Abdullah, General Practitioner, Ibn Sina Emergency Hospital
- Safi, Dr. Hafizudin, Chief of ENT, Ibn Sina Emergency Hospital
- Meeting with NGOs Concerning PPAs
- Anastacio, Anita, Representative, MCI
- Brigham, David, Programme Coordinator, IMC
- de Jong, Esmee, Liaison Officer, HNI
- Oberircher, Dan, Representative, IAM
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Site Visits

Basic Health Centre, Batikot District (Jalalabad)

Ghani Khel Rural Hospital (Jalalabad)

Ibn Sina MCH Clinic (Jalalabad)

University Hospital (Jalalabad)

Appendix B

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Appendix C

Abbreviations and Acronyms

AACA	Afghan Assistance Coordination Authority
ACBAR	Agency Coordinating Body for Afghan Relief
ACF	Action Contre la Faim
ADB	Asian Development Bank
AIMS	Afghanistan Information Management Service
AMI	Aide Medicale International
AREA	Agency for Rehabilitation and Energy Conservation in Afghanistan
AREU	Afghanistan Research and Evaluation Unit
CDAP	Comprehensive Disabled Afghans Programme
CDC	US Centres for Disease Control and Prevention
CHA	Coordination of Humanitarian Assistance
CHW	Community health worker
CRS	Catholic Relief Services
DFID	Department for International Development (U.K.)
DOTS	Directly Observed Therapy Short-Course
EC	European Commission
ECHO	European Commission Humanitarian Aid Office
ENT	Ear, nose and throat (specialist)
EPI	Expanded Programme on Immunisation
EU	European Union
GAA	German Agro Action
HIS	Health information systems
HNI	Health Net International
IA	Interim Administration
IAM	International Assistance Mission
ICRC	International Committee of the Red Cross
IDP	Internally displaced person
IMC	International Medical Corps
IMCI	Integrated Management of Childhood Illnesses
IOM	International Organisation for Migration

JDM	Joint donor mission
MCI	Mercy Corps International
MCH	Maternal and child health
MDM	Médecins du Monde
MoPH	Ministry of Public Health
MRCA	Medical Refresher Centre for Afghans
MSF	Médecins Sans Frontières
MSH	Management Sciences for Health
NAC	Norwegian Afghanistan Committee
NCA	Norwegian Church Aid
NDF	National Development Framework
NGO	Non-governmental organisation
OFDA	Office of Foreign Disaster Assistance (U.S.)
PHC	Primary health care
PPA	Performance-based partnership agreements
SC/US	Save the Children/U.S.
SC/UK	Save the Children/U.K.
SCA	Swedish Committee for Afghanistan
SMI	Safe Motherhood Initiative
SP	Sulfadoxine/pyrimethamine
TB	Tuberculosis
TBA	Traditional birth attendants
TDH	Terre des Hommes
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Assistance to Afghanistan
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation

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