

**HEALTH SERVICES DELIVERY IN AFGHANISTAN: PRESENT AND FUTURE  
PERSPECTIVES**

**(14<sup>th</sup> June 2000, Islamabad)**

**A CONFERENCE JOINTLY ORGANISAED BY**

<b>United Nations Development Programme for Afghanistan</b>	<b>The World Bank</b>
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**(In co-operation with WHO, UNICEF, SCA, ACBAR and Ibn-i-Sina)**

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## **1. Background to the Health Conference**

In the absence of a representative recognised government, Afghanistan's social and economic problems continue to grow, a state that is rapidly getting compounded due to the increasing isolation of the country in the international community. As a consequence of this and of the protracted war, the country has failed to fulfil its obligations towards its international commitments on global treaties and instruments signed and/or ratified by earlier Afghan governments. The country is also in arrears to the multilateral financial and lending institutions including the World Bank and the IMF and under these circumstances, since early 80s, does not have access to Bank's formal financial instruments. Also, like all UN agencies and most countries, the WB does not have a formal relationship with the Taliban movement's self-proclaimed government. In view of the continuing conflict and the absence of a recognised government, the international lending institutions are bound by their policies of not considering Afghanistan for any of their regular projects at this stage.

However, most international institutions, including multilateral financial bodies, are supporting projects that augment their informed understanding of the present economic situation in Afghanistan and to strengthen the assistance community analysis of key economic, social and recovery/development issues. One purpose of this exercise is to develop strategies that will later assist these institutions in contributing meaningfully in preparation of the post-conflict assistance to Afghanistan. Afghanistan Watching Brief (AWB) is one such project which is funded by the WB with regular cost sharing through UNDP, and executed by UNOPS. It is under this project that the present Health Conference was held.

Afghanistan Watching Brief project is part of a global initiative that designates Afghanistan, a country locked in conflict for the last twenty years with a complex situation, where some areas have been at peace for a number of years and a modest degree of economic recovery is occurring, as a pilot for the World Bank's "Watching Brief" strategy for countries in conflict. The key objective of this project is to build and augment the assistance community's knowledge base about Afghanistan, informed through rigorous analysis and research on various aspects of Afghan situation, including economic recovery, reconstruction and social development.

AWB is implemented by UNDP with financial assistance from the World Bank. Currently this project is undertaking a number of research studies in important areas such as mine action, agriculture, international trade, socio-economic impact of remittances and vulnerability assessment. Besides, under another component of this project a capacity-building programme for Afghan women NGOs based in Peshawar is also being run.

Health, being one of the key areas of international assistance to Afghanistan, was chosen in recognition of the expressed need to bring together the various experiences made by UN agencies and NGOs on health services delivery in Afghanistan. Central to this exercise was the objective to synthesise these experiences into doable recommendations and feed them in to the existing health co-ordination and strategic planning mechanisms at national and regional level for follow up action.

The key objective defined for the Health Services Delivery Conference is also in line with the Strategic Framework for Afghanistan (SFA), an agreed framework to a synergistic approach which links the three pillars of international community's role in an emergency situation like Afghanistan (i.e. assistance, human rights and political/peace-building). By defining the principles, goals and institutional arrangements for a more coherent, effective and integrated engagement of assistance community, SFA provides a common conceptual tool to identify, analyse and priorities the key issues on the basis of shared principles. The strategy to operationalise the assistance pillar of SFA known as Principled Common programming (PCP) is both a challenge and an opportunity for the assistance actors who are tasked to make a qualitative difference to the lives of Afghan people.<sup>1</sup> The Health Services Delivery Conference, organised jointly by UNDP and the World Bank with active support from technical health agencies from UN and NGO community including WHO, UNICEF, Swedish Committee, ACBAR, and Ibn-i-Sina, is one in the series of concerted efforts to contribute in achieving the collectively owned objectives for PCP.

This conference is one in a series of other planned conferences and workshops under this project aimed at bringing together policy and programme expertise on Afghanistan for the purpose of information sharing and using these events to review existing strategies in different sectors to improve them.

## 2. Objectives and Themes of the Conference

The most immediate *objectives* of the conference included:

- To create a common and comprehensive understanding of present health services delivery in Afghanistan;
- To identify key gaps, problem areas and suggest effective strategies to address the major issues in health services delivery;
- To define roles and responsibilities of different partners/stakeholders in this area.

Following are some of the broad *themes* or issues and concerns that the conference explored, deliberated upon, and has made recommendations for future actions for.

### a) *Integration of EPI and MCH with PHC:*

One critique of the Project Framework for Minimum Primary Health Care (PFMPHC) is that the vaccinators are supported separately from other health services through a separate Regional EPI Management Teams-REMT structure. This is believed to have caused problems of supervision and has also impinged on effective and efficient utilisation of resources. The critical

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<sup>1</sup> The three main objectives of PCP include: a) achieving policy clarity in assistance programmes, b) fostering cost effectiveness in the assistance community's activities, by maximising linkages and synergies between disparate programmes and minimising duplication, and lastly c) providing a balanced assessment of the impact of our collective efforts. All these three are expected to contribute to the broader efforts to achieve peace in the country.

issue is: how can vaccinators be integrated into the clinic/health facility they staff so that the EPI programme becomes an integral part of the PHC programme? The conference attempted to examine this question from the perspective of:

- Co-ordination
- Human Resources
- Financial Resources

Questions like who needs to do what, when; should nurses be trained to immunise and doctors to supervise; do we need to train any new vaccinators were among the issues tabled in the conference.

Traditional Birth Attendants (TBAs) role in the Afghan Primary Health Care system is well established. This is especially so in delivering health services (both of preventive/promotional and curative nature) to the Afghan women whose access to health services is circumscribed by the traditional cultural practices affecting Afghan women's mobility in the public arena. As envisioned by the PFMPHC, TBAs are trained and supervised by the staff of the C2 clinic. Currently, many different agencies are training TBAs and very few are supervising them or building functional linkages between them and the nearest available formal health services. What steps need to be taken to standardise this process? This question also needs to be examined from the three dimensions mentioned above (i.e. Co-ordination, Human Resources, and Financial Resources). The related question of who needs to do what, when are also crucial. The Conference was also tasked to assess if the new method for selection and training of TBAs developed last year in the Eastern Region has been successful and whether this approach could be replicated in other regions or not.

*b) Regional Distribution/Disparity of Health Facilities*

“The project framework is designed to maintain and strengthen basic health services to the communities... with a goal to use available resources to reach every village with the basics” (p. 4). “Priority for allocation of project resources – including training, health education, and basic drugs – will go to under-served areas” (p. 9). “The project seeks to maintain and strengthen a system for providing a basic and equitable level of PHC access and care for 12-13 million rural Afghans, in the face of severe budget constraints” (p. 10). Project objectives include - to encourage rationalisation of services already provided, particularly by enhancing co-ordination between NGOs and Government, and relocation of overlapping services by current providers” (p. 6).

The above goals of regional equity and rationalisation of health resources have been taken up by the Principles of Common Programming, yet we are far from the goal as shown in the situation analysis. The Conference was challenged to identify examples of good co-ordination to improve regional distribution and how they can be replicated? What would it take in terms of Human and Financial Resources to provide enough Basic Health Centres (BHCs) to provide a minimum package of health care to the whole country? How can we envision this for Afghanistan? How can communities become more involved? What training institutions need to be rehabilitated?

Another relevant topic currently being debated is concerning the training of health workers, standardisation of curriculum, length of training, etc. along with the standardisation of criteria for positions – e.g. what training is necessary to become a “mid-level health worker,” or “laboratory technician”, etc. How can we make training more uniform, effective and efficient - where is it done, by whom, for whom, etc. are all questions that can be best addressed through better and improved co-ordination and integration. How can this be achieved?

Different missions to Afghanistan have noted that private “dispensaries” are available in almost all the areas, even where there is no other facility. How can we engage the private sector in public health activities? Would this improve equity and accessibility of services or reduce it? What steps should be taken to explore this further, by whom, when, at what level?

c) *PHC Management and Field Supervision*

One key aspect of the Minimum Framework is the idea of decentralisation, the establishment of Regional Health Management Teams, and “a neutral and impartial technical oversight body for co-ordinating health activities in the region.” The underlying assumption of this idea is having “Regions” identified in the same manner with same functional boundaries by all agencies involved. Obviously, data collection and planning do not make sense if the “regional” data does not come from the same provinces.

One of the key questions to address and resolve in this connection is: what are the benefits and constraints to having common regions identified? If desirable, what steps should be taken to achieve this goal, by whom, when?

An unfulfilled objective of the PFMPHC is to have regular supervision of the health clinics. “Regional Health Management Groups will monitor areas with poor health and lack of services....will monitor patterns of medicine use, to identify anomalies in epidemiology, management of care, and/or use of drugs, and to follow these up with action” (p. 9). Mechanisms of supervision provided in the Framework included having the health workers report on a semi-annual basis at the time of “re-supply” and having two supervisors per province who would visit every health facility at least three times per year” (P. 19).

What methods of supervision currently are in place and how can they be improved from the perspective of Co-ordination, Human Resources, Financial Resources? This requires further specific decisions regarding who needs to do what, when, at what level.

### **3. Methodology and the proceedings of the Conference**

The conference was structured in three sessions. The first session, after the opening comments of representatives of the World bank and the UNDP, was followed with an over-view of the health situation of the country with a special focus on health services delivery; and a paper

highlighting key constraints and issues faced in the health services delivery in Afghanistan. Following is the synthesis of the Conference proceedings and the major outputs.

### **3.1 Overview of Health Services Delivery in Afghanistan**

For the past two decades Afghanistan has remained a country in crisis, with infrastructure and social capital mostly destroyed, its economy crippled, and a continuing downward spiralling of social and economic conditions. The 1996 UNDP Human Development Report placed Afghanistan 169<sup>th</sup> out of 175 countries in the Human Development Index. Due to lack of statistical data, Afghanistan's status has not appeared in the subsequent UNDP Human Development Reports. Although international assistance is provided to Afghanistan (US\$ 217.6 million during 1999 - according to *Consolidated Appeal 1999*) by the UN system, NGOs and various donors, continuing conflict and a serious deficit of gender equality and equity as well as human rights have led to an uncertain future of international assistance. This assistance is considered to be critical as lifeline for the majority of civilians who are living the socio-economic consequences of war.

The basic statistics for Afghanistan show extreme economic and social underdevelopment. Afghanistan is a tribal-rural society. Three-quarters of the population lives in rural areas, with 85% estimated to be dependent on agro-based economy for their livelihood and survival. Contamination of agricultural land, villages and roads with landmines and UXOs (Unexploded Objects) has negatively impacted the social and economic recovery process of the Afghan economy and the delivery of basic services. The following summarises some of the critical social indicators in Afghanistan.

Over the last two decades, nearly 400,000 persons including women and children have become physically disabled as the direct or indirect consequence of war, i.e. amputations and polio.<sup>2</sup> An equal number of men, women or children have other forms of disabilities, such as deafness, blindness, mental and psychological disabilities. It is estimated that about 3% of the 21 million population of Afghanistan suffer from some form of disability (CDAP/UNOPS/UNDP). Landmine and war injuries make up some 18% of the total admissions in the hospitals of some regions. Landmine injuries alone are estimated to consume nearly 30% of hospital resources in provincial hospitals of the affected areas. Afghanistan's infant mortality rate is one of the highest in the world, 165 per 1000 live births, while 257 of every 1000 live births die before they are five. Maternal mortality rate is estimated to be 1700 per 100,000 live births, the second highest in the world, with nearly 99% of deliveries taking place at home and only 9% being attended by trained personnel. Only 12% of pregnant women have access to maternal and emergency obstetric care to address the immediate cause of mortality and morbidity among children and women through emergency relief. The infant and maternal mortality rate, as one of the best proxy indicators of social and economic development of a society, clearly show the appalling state of affairs in Afghanistan. Around 42% of children under one year are fully immunised. Life expectancy at birth is estimated to be about 41 years for males and 42 for females. Tuberculosis

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<sup>2</sup> The health/medical agencies' data (of UN and NGOs) varies considerably regarding the health statistics in Afghanistan, including disabilities and amputation caused by landmines and polio. This problem invariably effects the analysis and thus the planning decisions for interventions and actions in the health sector.

alone kills an estimated 15,000 persons per year with 75% of the total reported TB cases being of women of prime reproductive age group, i.e. between 14 to 45 years.

Likewise, safe drinking water supply is available to only 24% of the total population, with an estimated coverage of 43 percent of the urban and 18 percent of the rural population. Coverage with adequate excreta disposal facilities is estimated to be around 12%. The combination of poor environmental and personal hygiene and low coverage of safe drinking water has contributed to the unacceptably high incident of waterborne diseases in Afghanistan. Acute diarrhoea accounts for over 20% of all deaths. Currently there is only about one health centre and/or clinic for every 100,000 population.

### ***3.2 Major issues/Constraints encountered in health services delivery***

There has been very little investment made in building public infrastructure and the economy. This has resulted in a lack of opportunity for employment, education and a consequent lack of hope or confidence in the future of the country. The MoPH is not in any position to institute, provide or maintain sufficient Public Health services, nor is it likely to be able to do so, as long as the conflict continues. Many of the health facilities have been destroyed in the war, and a majority of the current facilities are supported by NGOs, which are dependent on external funding. Trained health manpower has been lost both due to factors related with war-induced deaths and out-migration. There is little development of trained manpower. Personnel trained for short periods as an emergency response in the war have continued to make the bulk of health providers available today in the country as doctors, nurses, technicians, etc. There are reports of misuse and irrational use of drugs, IV fluids and others. Often these are the only medical care providers available to the rural populace.

As said earlier there are insufficient numbers of appropriate health facilities compared to the population size and the demand from health care system. Referral facilities and providers of secondary and tertiary care are few and often located in the provincial capitals; the difficult terrain, broken roads and lack of transport makes referral even more problematic and quite inaccessible for majority of the population. There is relative measure of peace and security in some areas of the country but the restrictive measures adopted by the authorities especially instituted against women, limiting educational and employment opportunities increases their marginalization and renders them more vulnerable. Whereas the whole populace of Afghanistan has poor health, women and children continue to have high morbidity and mortality rates.

Following points summarise some of the key issues that hamper the effective and efficient delivery of health services in Afghanistan:

- ☛ Improper utilisation of the health services
- ☛ In-accessibility
- ☛ Logistics problems specifically related with physical terrain, road conditions and security
- ☛ Lack of vision and strategy to ensure sustainability of health services delivery and management

- ☛ Serious lack of trained and qualified human resources especially women health care personnel
- ☛ Lack of systematic and regular supervision
- ☛ Except EPI and SMI, weak co-ordination at sub-sectors level.

Given the mammoth task that public health managers and technicians have at hand, some of the key questions that need immediate addressing include the following. It is proposed that these questions are raised at technical co-ordination committee level, the national health co-ordination mechanism, so that policy decisions are taken on these issues by MOPH together with assistance community players engaged in public health work in Afghanistan:

- ◆ How can we address the shortage of skilled health workers specially women public health workers?
- ◆ What training courses are necessary for the existing health workers, of different levels?
- ◆ What can we do to address the serious gap in the initial training especially for women health workers?
- ◆ How can training curricula be standardised?
- ◆ How can we strengthen training centres?
- ◆ How can we efficiently utilise the existing resources?
- ◆ What has been achieved up till now and what are the good lessons learned?
- ◆ What baseline data is available for Afghanistan?
- ◆ How can we have access to a reliable baseline data and appropriate Health Information System?
- ◆ How to make health services equitable?
- ◆ How to make health services accessible to the vulnerable group i.e. women and children?
- ◆ Is lack of health education an issue in hospitals? If yes, how to introduce the program in hospitals?
- ◆ Can we find resources for establishment of secondary care at district level and to establish an appropriate referral system?
- ◆ How to establish an effective supervision and monitoring system? Is there a model system for supervision and monitoring of health activities?
- ◆ How to mobilise the community to be more involved in their health care? Is there a good example of grass-roots community based health care program?
- ◆ Most of the health programs are short term and service delivery-oriented where communities are not involved. Is there any solution?
- ◆ Are we satisfied with the present system for co-ordination of health activities? If not, how to improve co-ordination among the existing health-care providers?
- ◆ How to encourage and establish co-ordination with other sectors?

## 4. Recommendations

Following are the recommendations made by the Conference participants on the key themes of the Conference. The participants were divided into three working groups namely, co-ordination, human resources and financial resources.

### 4.1 *Co-ordination:*

- ◆ Negotiate agreement on consistent and common regional boundaries. Currently different organisations divide the country in different number of regions for their operational and functional purposes to plan and organise their resources and activities. However, experience demonstrates that different regional boundaries used by different health players create problems for co-ordination, as well as for jointly operated and managed programmes.
- ◆ Develop a joint and clear policy framework to guide decisions on capacity building in health sector, a need to be addressed from various angles -- especially with reference to capacity building of the health technical authorities.
- ◆ Revisit Minimum Framework for PHC, as part of an exercise to develop an overall situation analysis of health sector, with the aim to assess the goals defined for Afghanistan and check their validity, i.e. do the PHC goals in Minimum Framework correspond the real demand and reflect the reality or not.
- ◆ Develop and implement on pilot basis a joint strategy for community involvement in health sector programmes, the strategy must build on experiences made by different organisations, among other things, on approaches to increase grass roots involvement and ownership of public health agenda.
- ◆ Ensure that all co-ordination effort in the health sector lead to joint sectoral analysis, joint needs assessment and common planning exercises at regional level

### 4.2 *Financial Resources:*

- ◆ Undertake situation analysis of the available financial resources to PHC and compare it against health care needs and the deficit in right to health experienced by different social groups.
- ◆ Develop a national joint multi-year plan for PHC (preferably for 5 years), also identify potential sources of resources and how (as well as who will) to mobilise these resources.
- ◆ Develop and implement a national strategy to standardise approaches used for cost-recovery.
- ◆ Develop standards for remuneration of PHC staff.
- ◆ Develop and install unified and transparent reporting system of verification of financial resource of PHC.

### 4.3 *Human Resources:*

- ◆ Create a more attractive working environment for skilled and experienced public health providers to stay in their jobs, through a mix of better training opportunities and on-the-

job courses, including skills development in communication, improved salary structures, etc.

- ◆ Engagement and dialogue between assistance community and the public health authorities, to allow full participation of women public health care providers, negotiate relaxation of official policy on women's restricted mobility, on being trained by male technicians and trainers, etc.
- ◆ Develop a national policy framework on Human Resource Development (HRD), this could be achieved by strengthening TCC in becoming more effective policy-making body.

## **5. Next Steps**

The Conference concluded by outlining following steps to follow-up the outcome and recommendations of the Conference.

It is decided that the small group constituted for the background preparatory work of the Conference would act as the follow-up task force. They would present the recommendations to the next Technical Co-ordination Committee for Health at national level. TCC would prioritise the recommendations and identify individuals/organisations to take lead in co-ordinating and organising the outcome of the recommendation assigned to them.

There would be a follow-up meeting in six months time to assess the progress made against the prioritised recommendations.

## **Annexes**

- ◆ Presentations
- ◆ List of participants
- ◆ Invitation letter