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INTRODUCTION

Afghanistan’s health system: Moving forward in challenging circumstances 2002–2013

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In one of the many small villages that hug the rugged mountainsides of Takhar province in north-eastern Afghanistan, a group of mothers has gathered in a mud-brick home within a walled compound. Although the room is dark, with the only light coming from the doorway, it is abuzz with excited chatter. The women have gathered with Aziza, their community health worker (CHW). CHWs are a key building block of the Afghan health system that now brings basic health services to small villages throughout the country.

Taj Bibi, at 17 years of age, has already lost two infants. Today, she nurses her five-month-old baby. ‘Until my mother and I received information about how to care for our new babies, we followed our old customs of taking the baby from me after birth and giving it a bath, even in the winter. We did not know how important it was to keep the new baby warm by keeping it with the mother’.

Fatima describes how she and her family have benefited from the simple information and interventions brought by the CHW: ‘Before, my children were often getting sick with diarrhoea, but Aziza has explained how to wash our hands often with soap. My children are much less sick than in past years’.

Sedquddin, the head of the local health community council, the health shura, says ‘We are protecting more of our children from diseases with shots [immunisation], so fewer of them die. The CHW also helps us to recognise the seriousness when a baby or child has a cough or fever in the winter. Our CHW gives the proper medicine so we had fewer cases of children with cough and fever dying in my community this past winter’.

This Supplement to the Journal of Global Public Health is devoted to the re-development of the health system in Afghanistan beginning in 2002. It discusses the processes that were adopted by the Ministry of Public Health and its partners, and the activities of the non-governmental organisations that, for the most part, were responsible for overseeing the delivery of health services to the population. It also presents an overview of the results that were obtained during the ensuing 10 years. It is fitting, therefore, that this volume begins with the vignettes presented above. All of the improvements to the system

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and the way those improvements were achieved are meaningless unless they have a clear and lasting impact on the people the system is intended to serve. There is ample evidence, from qualitative studies such as the one cited above, as well as from measured trends of key health indicators, that they have had meaningful impact.

The challenge of working in fragile and post-conflict states has been well documented (Department for International Development [DfID], 2005; Horton 2014; Nabarro, 2004; Pavignani & Colombo, 2009; Spiegel, Checci, Colombo, & Paik, 2010). The rehabilitation of a moribund health system, such as the one that existed in Afghanistan prior to 2002, and the realisation of tangible improvements in the health status of the population is fraught with difficulties, both expected and unforeseen (Chakrabarti, 2004; Health and Fragile States Network, 2009; Newbrander, Waldman, & Shepherd-Banigan, 2011; Organisation for Economic Co-operation and Development [OECD], 2008; Vaux & Visman, 2005). So the successful development of Afghanistan’s health system since 2002 is a fascinating case study: access to basic health services has expanded from less than 10% to over 60% of the population, maternal and child mortality have been reduced by more than half, and life expectancy has increased.

The eight articles included in this Supplement document the development of a responsive health system and provide useful lessons on the vision, strategy, policies and processes that had to be developed in order for real and constructive change to occur. As a whole, they depict a mosaic of a health system being rebuilt: from setting policies to selecting high-impact services; from scaling up these services in a mostly rural population to ensuring equity during their implementation; from being conscious of costs to taking steps to ensure sustainability, this Supplement covers a lot of ground. By documenting the experience of Afghanistan, this Supplement also provides hope for other fragile and conflict-affected states; it shows that progress, though challenging, is possible.

A key factor in Afghanistan’s success was the determination of the leadership of the Afghan health system at the Ministry of Public Health (MOPH). Its confidence in moving forward was due, to a large degree, to its decision to function principally as the steward of the health system and to establish and oversee the delivery of a set of clear priorities: the Basic Package of Health Services (BPHS). The process by which the MOPH established those priorities is documented by Newbrander, Ickx, Feroz, and Stanekzai (2014).

In 2002, Afghanistan’s abysmal health indicators (Newbrander et al., 2014) necessitated that the MOPH deal with urgent health needs immediately, even as the priorities of the health system were being established. The rapid and systematic way in which excessively high morbidity and mortality rates and the elevated incidence rates of diseases from which they resulted were reduced is examined by Rasooly et al. (2014) and Ikram et al. (2014).

Orienting a fledgling health system to show demonstrable improvement in health indicators requires more than appropriate interventions. The involvement and participation of communities, working in partnership with the Ministry and local health facilities, were the basis for scaling up the training of CHWs. Mayhew, Ickx, Stanekzai, Marshal and Newbrander (2014) demonstrate the effectiveness of this approach in addressing Afghanistan’s chronic malnutrition problems in Improving nutrition in Afghanistan through a community-based growth monitoring and promotion program: A pre-post evaluation in five districts.

Cultural factors, including the traditional practices of women, families, communities and society, can create barriers to access to care. Samar et al. (2014) examine how ways can be found to address harmful behaviours that can impede the successful implementation of priority health services.

In 2002, the MOPH, in consultation with its partners, determined that contracting with non-governmental organisations would be the most effective means of rapidly
extending the BPHS to the population under the stewardship of the Ministry. An assessment of two variations on the provision of the BPHS is discussed by Blaakman, Salehi, and Boitard (2014).

Ensuring donor alignment with the national Ministry’s priorities was essential. Dalil et al. (2014) provide insights into the factors that rallied and unified partners around the MOPH’s vision. The result was a more effective use of aid through long-term donor commitment.

Taken as a whole, this volume paints a quite positive picture of the development of the health system in Afghanistan over the past decade. To be sure, some have questioned the accuracy of that portrayal, and for three good reasons. First, a substantial proportion of the funding that was required for the rebuilding of the health system and for the implementation of its functions came from Western Governments and the international financial institutions, especially the European Union, the US Agency for International Development, and the World Bank. Similarly, much of the technical assistance offered to and accepted by the Ministry of Public Health can be traced to the same sources. Given the quest to legitimise the fledgling Afghan Government, the magnitude of their investments, and the risks that accompanied those investments because of the highly politicised atmosphere in which the reconstruction of Afghanistan is taking place, it is understandable that some might suspect that the donors and their agents may have exaggerated the achievements and diminished the importance of some of the failures. But while there may very well be some truth to the contention that ‘public health care cannot remain immune from powerful market forces, nor from contextual determinants outside the health field’ (Michael, Pavignani, & Hill, 2013), this susceptibility does not by itself negate the very real progress that is documented in the articles that comprise this Supplement.

Second, the process of ‘contracting out’ health service delivery had not been done before on as large a scale as was done in Afghanistan. It could, in some ways, be considered to be a ‘great experiment’. The Government of Afghanistan, the non-governmental agencies with which it entered into contractual agreements and some of the major donors themselves expressed different levels of scepticism regarding the system that was eventually adopted (Palmer, Strong, Wali, & Sondorp, 2006) Still, to its credit, from the start the government insisted on finding a way to fulfil its role as steward of all aspects of the health system, from policy development to monitoring and evaluation while recognising that it simply did not have the human resources to be able to deliver services from central to peripheral levels. Entering into contractual agreements whereby external agencies (for the most part) would implement its policies seemed to offer a way to ensure this, and the system has survived the scrutiny to which it was appropriately subjected.

Third, some have questioned the accuracy of the data that have been generated and is reported in this volume and elsewhere. Some of the ‘baseline’ data, such as the maternal mortality ratio of between 1600–2200 per 100,000 live births reported by the 2002 Reproductive Age Mortality Survey (RAMOS) (Bartlett, Mawji, & Whitehead, 2005), have been publicly challenged as being unbelievably high. Similarly, the pregnancy-related mortality ratio of 327 per 100,000 live births reported by the 2010 Afghanistan Mortality Survey is deemed to be both too low in absolute terms and to represent an unexplainable improvement over the ‘baseline’ should it, indeed, be accurate or near-accurate. Similar discrepancies have been postulated for the reductions reported for child mortality (Hill, 2012).

While each post-conflict state is unique in its own way, this class of countries is also characterised by certain common features. In all of them, generating accurate data has been a problem that has been difficult to surmount. No single survey result should be
taken at face value – non-sampling errors, real or suspected, have complicated the interpretation of mortality data from many post-conflict states. Many data points will be required before a reasonably certain depiction of the health status of the Afghan population can be developed. Data reported from the routine health management information system provide evidence of increases in the number of priority services provided to the population and improved utilisation of those services at health facilities. Other databases provide insight into improvements of the quality of service provision. These data do not provide direct evidence of reductions in child or maternal mortality, but they do indicate that necessary, if not entirely sufficient, conditions exist for gains on the order of those reported in recent surveys to be made. The articles in this Supplement do their best to show how things look at a time when the health system is emerging from a particularly unstable and relatively chaotic state into one of greater stability when more predictable trends might emerge. In this situation, some errors of measurement are to be expected and thoughtful analysis applied to the data should allow for their useful and constructive interpretation.

In summary, then, Afghanistan offers an opportunity from which both best practices can be shared and lessons can be learned. Some of those best practices, notably the Basic Package of Health Services, have already been put to good use in other countries emerging from conflict, such as Liberia. Mistakes made in Afghanistan will be avoided if lessons learned from them are developed through thoughtful analysis and reflection and applied judiciously to other post-conflict settings, always mindful of context.

The papers in this special issue make a definite contribution to advancing the learning process by providing insights and verifying the soundness of some of the approaches adopted in post-conflict Afghanistan. This volume also provides something that is often overlooked as an important result from the successful collaboration of a diverse set of actors – evidence that rapid and substantial improvements in the public health of a conflict-affected population are attainable.

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Note

1. Compiled from discussions in focus groups of mothers, women, men, families, and village elders in five provinces conducted by the staff of BASICS/Afghanistan, a USAID-funded child survival project, from 2008 to 2011.

References


