Lessons From the Health Sector in Afghanistan: How Progress Can Be Made in Challenging Circumstances

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and cognitive techniques emphasizing anger management have been widely used and have been successful in the treatment and management of violence.12

Conclusion
The available evidence suggests that persons with severe mental illness who are involved in treatment have a lowered risk of arrest and violence because of the reduction of their psychiatric symptoms and substance abuse.2 However, in general, many of the individuals most in need of psychiatric treatment are least likely to believe they need it and adhere to it.14 Therefore, if the incidence of violence in incarcerated persons with severe mental illness is to be reduced, a means must be found to involve them in treatment.

Mental health courts can provide access to treatment and the necessary coercion to ensure that violent, mentally ill offenders adhere to therapy and consequently reduce their risk of future violence. These courts can require treatment, including medications, structured housing, and substance abuse treatment. Such modalities may enhance the structure in these persons’ lives. Enforcement of treatment regimes applied by mental health courts can increase adherence to therapy.14 This may be accomplished by having case managers monitor the treatment plan and by having the mentally ill offenders return to court for periodic review. Mental health courts can be a powerful force to reduce violence and recidivism. By applying the principles of therapeutic jurisprudence, these courts can protect society and improve the lives of mentally ill offenders who have been violent.

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NEWS FROM AFGHANISTAN HAS TENDED TO FOCUS on suicide bombings, the insurgency, and opium production. Relatively less attention has been paid to socioeconomic developments and how day-to-day life has been affected by the ongoing insecurity and the large development effort. The lack of interest in developments in Afghanistan’s health sector is unfortunate because there are some potentially useful lessons to be learned for other countries confronting violence, insecurity, or deep poverty.

Beginning with the Communist takeover in 1978, Afghanistan has endured long years of war that have devastated most parts of the country and left more than 1 million Afghans dead.3 In 2002, after the fall of the Taliban, the under 5-year mortality rate for children was estimated at 257 per 1000 live births,2 and the maternal mortality ratio was estimated at 1600 per 100 000 live births. In mountainous Badakhshan province in northeast Afghanistan, the ratio was 6507 maternal deaths per 100 000 live births, more than 15 times higher than in Kabul.3 Difficult health conditions for women were also found in western Herat province.4

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During the 1980s and 1990s, much of the health services in rural areas, where 80% of the population lives, were provided by nongovernmental organizations (NGOs) that worked “cross-border,” mostly from Pakistan. The NGOs, funded from various external sources, provided services that were often of good quality, but the coverage was modest with approximately 1 functioning primary health care facility per 50,000 population.3

The activities of the NGOs were generally uncoordinated and unfocused. Successive Afghan governments during the 1980s and 1990s had little interest, ability, or inclination to coordinate the activities of the NGOs, partly because they did not control large parts of the countryside. The NGOs for their part were reluctant to be guided by governments that were not generally recognized internationally and were widely regarded as systematically abusing human rights.

As a result of the modest availability of services, lack of clear objectives, unclear geographic responsibility, and absence of explicitly articulated national priorities, provision of primary health care services was low. A multiple indicator cluster survey carried out in 2003 (reflecting the situation in 2001 and 2002) found low rates of skilled birth attendance (6.0%), contraceptive prevalence (5.1%), prenatal care coverage (4.6%), and child immunization coverage (19.5%) had received 3 diphtheria-pertussis-tetanus [DPT] immunizations) in rural areas.6

Confronted by an uncoordinated and poorly performing health care system, the Afghan Ministry of Public Health (MOPH) instituted a few key policies, the most important of which were defining a package of priority health services as the basic package of health services, contracting with NGOs to deliver the basic package of health services, and prioritizing monitoring and evaluation of health sector performance. The basic package of health services focuses on primary health care interventions such as child immunization; micronutrient supplementation and nutrition screening; tuberculosis and malaria control; prenatal, obstetrical, and postpartum care; family planning; and basic curative services, including integrated management of childhood illnesses.7

Contracting with NGOs was done on a large scale by the MOPH. Currently 82% of the entire population lives in districts where primary care services are provided by NGOs under contracts with the MOPH or through grants to the NGOs from a limited number of donors.8 Depending on the source of financing, there are some differences; however, there are important commonalities, and the approaches appear to be getting more similar over time. All grants and contracts focus on delivery of the basic package of health services as defined by the MOPH, assign clear geographical responsibility to the NGOs (typically for whole provinces with populations ranging from about 150,000 to 1 million), employ competitive selection of NGOs, involve convergence toward similar indicators based on the basic package of health services, and invoke a credible threat of sanctions in case the NGOs do not perform well (an international NGO had its contract terminated by the MOPH). About a quarter of the contracts (27%) are with international NGOs.

The approximate cost of delivering the basic package of health services is US $4 per capita per year, although the contracts and grants differ slightly in scope. These costs also do not include support provided by vertical programs such as immunization or tuberculosis control. Nonetheless, the current cost of delivering the basic package of health services is not high and compares with the experience of contracting in other low-income countries.9

The Afghanistan MOPH and its development partners have invested a lot of time, effort, and resources in regular and independent monitoring and evaluation of health sector performance. This has been accomplished through household surveys, health care facility assessments, and strengthened health management information system.

The results thus far have been encouraging. There has been a 1.36% increase in the number of functioning primary health care facilities from 496 facilities in 200210 to 1169 facilities in 2007 and an increase in the proportion of those facilities having female physicians, nurses, or midwives from 24.8% to 83.0%.10 The health management information system indicates that there has been nearly a 4-fold increase in the number of outpatient visits from 0.23 visits per capita per year in 2004 to 0.94 in 2007. Comparing the results from household surveys conducted in 2003, 2005, and 2006 for rural areas that could be surveyed in 2006 (ie, in 29 of 34 provinces representing about 75% of the rural population11), there have been significant improvements in the coverage of reproductive and child health services. For example, the percentage of children aged 12 to 23 months who had received 3 doses of DPT vaccine increased from 21.2% in 2003 to 34.6% in 2006, and the percentage of pregnant women receiving at least 1 prenatal visit increased from 8.0% in 2003 to 32.4% in 2006. Even indicators that typically change slowly improved. For example, the percentage of deliveries attended by a physician or midwife increased from 9.0% to 18.9% from 2003 to 2006. The results of the 2006 survey lag by about 1 year (with the exception of contraceptive prevalence rate), so it is possible that rates of current coverage are higher.11

Even as the number of health care facilities was increasing and security was deteriorating, the quality of care improved significantly. Independent assessments were conducted in more than 60% of rural health centers and used to construct an index of quality of care that examined a large number of areas, including staffing; the knowledge of physicians, nurses, and midwives; the quality of observed patient–health worker interactions; and drug availability.12 The overall index derived from these health care facility assessments increased 32% from 2004 to 2007, representing an improvement larger than 1 SD at baseline.10
It appears that health outcomes in Afghanistan also have improved in the last 6 years. The 2006 household survey found that the infant mortality rate was 129 per 1000 live births and the under 5-year mortality rate was 191 per 1000 live births. The United Nations estimates for these indicators in 2002 were 165 and 257, respectively, which represents a 22% and 26% decline, respectively, in these rates.

Even though it is difficult to be certain that the apparent decline in under 5-year mortality is the result of improvement in health services, the link is plausible and alternative explanations seem unlikely. There has been a large increase in the use of health services, both curative and preventive. At the same time, there has been a measurable improvement in the quality of care provided. The large increase in coverage, usage, and quality of health services has occurred contemporaneously with a significant decrease in under 5-year mortality rate.

Other observers, even those who are skeptical about long-term contracting with NGOs, also conclude that the available data indicate that Afghanistan has made progress in the health sector during the last 6 years despite worsening security. These improvements provide some lessons for other countries.

Establishing a basic package of health services has served a useful role in Afghanistan by ensuring a continued focus on the delivery of effective health interventions, guaranteeing that adequate resources and effort were dedicated to improving coverage of services to the large rural population, and avoiding excessive diversion of scarce public funds to services only available to better-off city-dwellers.

Contracting with NGOs has worked well in Afghanistan and has proved to be a rapid way for the government to gain and maintain policy leadership. By setting priorities, allocating geographical responsibility, providing financing, and carefully monitoring performance, the MOPH has been able to provide direction to what was previously an uncoordinated and chaotic system. By giving NGOs a fair degree of autonomy but holding them accountable for achieving national priorities, it has addressed serious constraints such as scarce human resources, lack of physical facilities, and logistical challenges.

Carrying out regular, independent, and rigorous monitoring and evaluation of health sector performance is expensive. However, it is a key aspect of the stewardship function and has allowed the MOPH to identify problems, act quickly to resolve them, and track whether progress has actually been achieved.

The improvements in health outcomes and services are encouraging, but there is still a lot of work to do and the challenges are daunting. Despite the problems, the recent experience in Afghanistan suggests that important progress in strengthening health service delivery can be achieved even in challenging circumstances.

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