



ACBAR Advocacy Series

NGO voices on health



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Introduction

The Afghanistan Pilot Participatory Poverty Assessment (APPPA) is a project that, through civil society involvement, aims to collect, document, disseminate and advocate the 'voices' of poor Afghans for inclusion in the upcoming Afghanistan National Development Strategy (ANDS), and more broadly throughout civil society. APPPA will achieve this through a research component and an advocacy component.

This paper is one of a series of advocacy papers produced in the advocacy component, the purpose of which is to improve the quality of civil society—including non-governmental organizations (NGO)—engagement in sectoral debates and to provide recommendations for implementation of sectoral activities. This will be achieved through the presentation of the perspectives of the NGO community in relation to sectors identified, during the APPPA research component, as priorities by APPPA-target communities. For a more comprehensive understanding of the issues identified, further inquiry and discussion is advised.

Based upon the sectoral priorities identified by APPPA-target communities, a number of national and international NGOs working within the health sector were approached for interviews and to participate in a subsequent round table discussion. The issues emerging from these interviews were tabled for validation in the roundtable discussion, which also allowed participants to prioritize issues and propose recommendations. The resulting draft advocacy paper was then circulated for comments to ACBAR's membership who provided feedback for integration.

It should be noted that this paper does not reflect an exhaustive investigation of the sector's technical areas, nor can it be presumed that the issues presented are held by consensus among the diverse range of NGOs consulted.



Significant advances have been made in the health sector in Afghanistan in terms of increased human capacity and infrastructure and in the provision and accessibility of the Basic Package of Health Service (BPHS).

Yet the damage to Afghanistan's healthcare sector after decades of war—on top of a very basic healthcare foundation—is substantial, and much more progress is necessary if Afghanistan's healthcare statistics are to be improved. Afghanistan has a low life expectancy of forty-seven years for men and forty-five years for women, and one in six women dies while giving birth¹. Additionally, one in four children dies before reaching his or her fifth birthday².

Core government annual expenditures on public health are roughly constant at about 0.8% GDP. In 2007, the Ministry of Finance core budget approval for spending on projects in the Health and Nutrition Sector was 92.77 million USD. Fifty-four projects totalling 149.27 million USD were proposed by the MOPH³.

Continued improvements in the health sector are of crucial importance if the overall health and wellbeing of the Afghan population is to improve. This paper aims to explore emergent issues in the sector as identified by national and international NGOs.

NGOs interviewed identified five priority issues that need to be addressed in order to improve the healthcare sector. These priority issues, all calling for continued increases or improvements, are:

1. The overall capacity of the Ministry of Public Health
2. The number of skilled providers
3. Access to healthcare
4. Quality of healthcare provision
5. The public's knowledge and awareness of health issues

NGOs Consulted

Action Contre La Faim (ACF), Afghan Health and Development Services (AHDS), Agha Khan Health Service (AKHS), Bakhtar Development Foundation (BDF), CONCERN, Coordination of Humanitarian Assistance (CHA), IBNSINA, Johns Hopkins Program for International Education Gynecology Organization (JHPEIGO), Johns Hopkins School of Public Health (JHSPU), Management Sciences for Health (MSH), Medair, Merlin, Save the Children – US (SC-US), Swedish Committee of Afghanistan (SCA), STEP Health and Development Organization (STEP), and Terre Des Hommes (TDH).

¹ Government of Afghanistan (2007) Afghanistan National Development Strategy (ANDS): Health and Nutrition Sector Strategy, 2008-2013, GOA: 2007.

² UNICEF (2007) State of the World's Children, UNICEF: May 2007.

³ Government of Afghanistan (2007) Afghanistan National Development Strategy (ANDS): Health and Nutrition Sector Strategy, 2008-2013, GOA: 2007.

THE OVERALL CAPACITY OF THE MINISTRY OF PUBLIC HEALTH (MOPH)

“Total dependency on external funding renders the whole health sector extremely vulnerable to political considerations and to the availability of enough funding to satisfy the growing needs and demands,” – NGO Staff Member.

Afghanistan’s public health sector is largely supported by donor funds, and it is estimated that, of the MOPH’s 2006/2007 budget of roughly 117 million USD, donors contributed 90%⁴.

To decrease its reliance on donor funding, the MOPH is currently examining options to add fee-for-service mechanisms to the health care delivery system. For the public health sector to sustain itself, it is estimated that there needs to be a 70% cost recovery rate⁵.

A 2006 National Health Service consumer survey done by Johns Hopkins revealed that annual per capita “out of pocket” health care expenditure was roughly 28.5 USD. The study found that over of quarter of sick household members attested that health care costs placed an undue stress on their ability to maintain their households⁶.

“Total dependency on external funding renders the whole health sector extremely vulnerable to political considerations and to the availability of enough funding to satisfy the growing needs and demands,”
-NGO staff member

Basic Package of Health Services

The Six Elements of the BPHS:

1. Maternal and Newborn Health: Antenatal Care, Delivery Care, Postpartum Care, Family Planning and Newborn Care.
2. Child Health and Immunization: Extended program on immunization services, integrated management of childhood illnesses.
3. Public Nutrition: Prevention, assessment and treatment of malnutrition.
4. Communicable Disease Treatment and Control: Control of TB, Malaria and HIV/AIDS.
5. Mental health: Mental Health education and awareness, case detection and identification and treatment of mental illness.
6. Disability: Disability awareness, prevention, education, assessment and referrals.

The Ministry of Public Health (MOPH), Basic Package of Health Services, MOPH: 2005

NGOs interviewed voiced their concerns about the Afghan public’s ability to pay for healthcare services. One NGO staff member interviewed stated: “We are implementing the BPHS, but primary healthcare is very expensive. Even now it isn’t affordable. If you look at income levels in Afghanistan, even the BPHS would be expensive for Afghans to afford”

Another priority issue identified by NGOs is the lack of regulation on prescription and medication usage in the public and private sectors. NGOs stated that there is an over-reliance on medicine usage in Afghanistan, in part, because many Afghans believe that medicines will cure any ailment. Therefore, doctors over-prescribe to an over-dependent population. Doctors also over-prescribe because they will make more money.

Key Recommendations

Recommendation: NGOs advocate the crucial importance of involving taxpayers and the private sector in MOPH health sector revenue source discussions. Furthermore, NGOs state that whatever healthcare financing policy is instituted, it is vital that the policy does not too adversely affect the most vulnerable. Considering families' ability to pay for health care is essential.

Recommendation: NGOs suggest that the MOPH could develop prescription and medication regulatory criteria, and define the terms of reference for, and contract with, an independent regulatory body to monitor regulations in the public and private sector.

NUMBER OF SKILLED PROVIDERS

More than two decades of war in Afghanistan have created an acute lack of qualified healthcare personnel, especially women. Many health care professionals that do exist are not informed of contemporary public health and medical practice advances and doctors "are not trained to deal with priority, community problems, and...lack public health expertise."⁷

Although advances have been made since 2002, and NGOs, under the MOPH's stewardship, have made gains in pre-service training of professional healthcare providers, a resounding priority emerging from interviews with NGOs and is that there is still an overall lack of skilled healthcare providers. NGOs did acknowledge the success of the Midwifery and Community Midwifery Education model in producing qualified midwives, but questioned the adequacy of advances in increasing the number of professionals in other public health specialty-areas, particularly doctors and nurses.

Rural areas especially lack skilled providers. Qualified doctors, nurses and midwives opt not to practice in rural areas for a variety of reasons, not least of them political instability and low standards of living. Healthcare professionals with families choose not to work in rural villages specifically because their own children would not receive the quality of education they could receive in a town or city.

One long-term hope to ameliorate this problem is the education of rural children and young people to become health care professionals. However, lacking access to quality education and training opportunities, these youth cannot compete with young adults in Kabul and other urban areas for medical school and higher education entrance exams. Rural areas are not producing many health care professionals, and the problem continues.

Key Recommendations

Recommendation: The MOPH should develop trainings for other healthcare professions at the community-level based on the Midwifery and Community Midwifery Education model. Incentives should be put in place for these professionals to work in their villages or towns of origin.

Recommendation: The MOPH and Ministry of Higher Education (MOHE) should coordinate to identify human resource needs in the health sector, and base medical school and allied health science school admittance on these needs. To meet the growing need for more qualified health care professionals—especially females—the MOHE could increase the quota of females and applicants from rural areas that they accept into medical school, and midwifery and nursing programs. The MOHE could also offer accelerated "bridge" courses for those who do not meet the standard entrance requirements so more females and rural individuals are able to begin medical school, nursing and midwifery programs.

NGOs also suggest that the MOHE reduce the time period that it takes to train nurses by condensing curriculum and reducing the number of vacation days nursing students receive.

Recommendation: The MOPH could work with the MOHE to prepare high school students for higher education in the medical and allied health field by developing pre-professional career tracks and milestones to guide performance, commitment and retention.

⁴ Government of Afghanistan (2007) Afghanistan National Development Strategy (ANDS): Health and Nutrition Sector Strategy, 2008-2013, GOA: 2007.

⁵ AREU (2007) Sector Reform in Public Health, Education and Urban Services – Evidence from Kabul and Herat. AREU: July 20, 2007.

⁶ Government of Afghanistan (2007) Afghanistan National Development Strategy (ANDS): Health and Nutrition Sector Strategy, 2008-2013, GOA: 2007.

ACCESS TO HEALTHCARE

One of the Afghanistan Compact Health Benchmarks is for the BPHS to cover at least 90% of the population. Current estimates figure that the BPHS is being offered in districts in which roughly 82% of the population lives. Shortly after BPHS implementation in 2002, 9% of the population could access the BPHS. The increased accessibility of the BPHS is a commendable accomplishment, and a sign of promise.

This increase in coverage is owed largely to the functionality of health facilities in the National Healthcare System, and to volunteer Community Health Workers (CHW) who work at the community level and deliver basic BPHS care from their own homes, which function as community Health Posts (there are 8500 Health Posts nationwide). A Health Post should cover a catchment area of 1,000-1,500 people, which is equivalent to 100-150 families, and is ideally staffed with both a male and female CHW.

Yet many NGOs interviewed stated that a priority issue is that many Afghans still cannot access healthcare services, especially Afghans living in extremely remote and mountainous areas.

“Difficult terrain and isolation of certain provinces represent a nightmare for health planning. Establishing the facility network envisaged by the BPHS is extremely inadequate in responding to the needs of populations living in remote, isolated and mountainous areas,”
-NGO Staff Member

Health facilities of the National Healthcare System: Health Posts (8500), Sub Health Center (121), Basic Health Center (666), Comprehensive Health Center (376), Comprehensive Health Center Plus (16), District Hospitals (49), Provincial Hospital (30), Regional Hospital (4), and National Hospital (20).

Government of Afghanistan (2007) Afghanistan National Development Strategy (ANDS): Health and Nutrition Sector Strategy, 2008-2013, GOA: 2007.

“Difficult terrain and isolation of certain provinces represent a nightmare for health planning. Establishing the facility network envisaged by the BPHS is extremely inadequate in responding to the needs of populations living in remote, isolated and mountainous areas,” NGO Staff Member.

NGOs further stated that catchment areas for health facilities are too large, thus preventing those living far away from health facilities from accessing services. Those living in remote areas must pay more for obtaining health services. For instance, an individual living in an inaccessible area would incur transportation costs to travel to a clinic. He could also experience lost earnings.

“About 82% on the map have access to BPHS. But practically, when you go to the ground, you see that much less of the people have access,” NGO Staff Member.

NGOs identified the physical lack of clinics and of female staff; cultural, including gender-based, barriers to use; and low levels of health awareness and overall knowledge as contributing factors to continued limited access. Remote and extremely difficult-to-access areas have an even greater challenge in obtaining services.

Inadequate transportation and weak unmonitored referral systems prevent patients from accessing appropriate levels of care. Other barriers to access are security and poor infrastructure.

Key Recommendations

Recommendation: The MOPH could give implementing partners discretion to modify the health care delivery structure in an NGO's catchment area based on coverage needs and accessibility (rather than population size).

Recommendation: The per capita cost of health care needs to be adjusted to consider accessibility to services, particularly for very remote areas, and also to consider special needs regarding specific health conditions, for example endemic malaria in some areas.

Recommendation: Communities need to be more strongly supported to develop systems to transport patients to and from clinics. The development of transport and communication systems is a prerequisite for a functional referral system. The development of transport does not rest only on the deployment of hardware such as ambulances and expensive radio sets, but on the establishment of procedures and rules that can be implemented at the clinic level and understood by beneficiaries.

Recommendation: Referrals and follow-up care need to increase. All health care providers need to be aware of all services that exist at each level of the BPHS and referral systems need to work in both directions. A key element of proper referral is that a patient's records must be transferred through all levels so health care providers are aware of all treatments and necessary follow up care.



⁹ Government of Afghanistan (2007) Afghanistan National Development Strategy (ANDS): Health and Nutrition Sector Strategy, 2008-2013, GOA: 2007.

QUALITY OF HEALTHCARE PROVISION

NGOs attributed low quality health services to many factors. Outdated medical curriculum without a public health component is being taught in medical schools and, as a result, many doctors are entering the workforce without the skills or knowledge they need to address Afghanistan's public health priorities.

NGOs commented that healthcare professionals do not receive enough training or funding to train others. NGOs specified mental health and disability as an area extremely lacking of educated and qualified staff with capacity to address these conditions and severely inadequate monetary support as well.

Traditional Birth Attendants (TBA) constitute a cadre of non-professional healthcare providers and in some remote areas are a community's only available health service option. Yet many TBAs cannot access trainings, and thus, are unqualified to provide services. While TBAs are excluded from the formal health structure, there is no formal mechanism to include them. For example, encouraging TBAs to refer women to skilled providers is not a formal practice.

Cultural barriers still prevent women health care professionals from equally benefiting from education and training opportunities because many are not allowed to travel alone to training sites and many cannot attend trainings because of their household and family responsibilities.

Facility staffing shortages contribute to poor quality service provision. NGOs stated that some Comprehensive Health Centers often have only one qualified midwife who must, in addition to her duties, also manage the facility and staff. Professional clinic staff shortages also increase a CHW's workload and responsibilities, and s/he is often unable to handle all the additional responsibilities because s/he lacks knowledge, skills and time.

Lack of supervision—both male and female—also contributes to a decrease in the quality of service provision. For instance, women CHWs often do not have female supervisors. Because cultural norms prevent men from going into the homes of women who are not their relatives, women CHW's work is often unmonitored and mistakes that could be picked up during routine supervisory visits go undetected.

NGOs also stated that lack of monetary remuneration prevents CHWs from being fully accountable to the communities they serve. NGO staff asserted that many CHWs wait for people to come to Health Posts (i.e. their own homes) when CHWs should be making home visits to provide services.

Key Recommendations

Recommendation: Medical school health curriculum must be updated and should include a public health component.

Recommendation: Health facility managers need to ensure that master trainers and those receiving training courses are sharing the knowledge and skills they learn at workshops, seminars, courses, etc. to colleagues, not least by ensuring that funds are available for on-the-job trainings, workshops, etc.

Recommendation: MOPH and donors need to follow through with funding and standards for mental health, primary eye care and disability care and any other additions to the BPHS.

Recommendation: TBAs who demonstrate promise and who meet entrance requirements should be encouraged to become CHWs, or, if they possess necessary levels of high school education, nurses or community midwives.

Recommendation: Supervisors should update a CHW job description every time a task is added, and the CHW should be given adequate training for each new task. CHWs need to be encouraged to go and see the community, i.e., do outreach, rather than wait for the community to come to them. The current system for training and utilizing CHWs needs to be reviewed to ensure that their functions are understood. The MOPH/BPHS standard that CHWs should be appointed by their community and NGOs should select CHWs in consultation with community members should be more rigorously followed to ensure that CHWs are dedicated and accountable to their communities.

Recommendation: NGOs state that the issue of CHW compensation should be addressed by the MOPH as the MOPH seeks to further rationalize and pay for public health services in the future.



THE PUBLIC'S KNOWLEDGE AND AWARENESS OF HEALTH ISSUES

“People need to be knowledgeable enough and empowered enough to address their own health issues rather than relying on doctors and medicines to cure simple ailments.” – NGO Staff Member.

NGOs referenced a lack of knowledge—of overall health and especially reproductive health—as a barrier to the public’s general know-how and ability to respond to their own health care needs. NGOs cited a lack of schooling and insufficient health education in school as reasons communities do not have basic knowledge.

Gender barriers also play an enormous role in lack of education. One NGO member commented: “Some women are so isolated and alone and have such little power in their life, especially in rural areas. Women cannot question or think ‘I can I do it better next time.’”

Key Recommendations

Recommendation: Increased public health messages on radio and television, in mosques, with community leaders and during public awareness campaigns can help disseminate knowledge and should occur more frequently.

Recommendation: Health education and promotive healthcare components of the CHW curriculum should be considered for adaptation and incorporation into school curricula so children can further advocate what they learn at home.

Key Recommendations and Conclusions

The capacity of the Ministry of Public Health: MOPH health sector revenue source discussions must involve taxpayers and the private sector, and considering the people's ability to pay for health care is essential. The MOPH could develop prescription and medication regulatory criteria, and define the terms of reference for, and contract with, an independent regulatory body to monitor regulations in the public and private sectors.

The number of skilled providers: To combat the lack of healthcare professionals, especially women, and specifically in rural areas, the MOPH could develop trainings to train healthcare professionals based on the successful Community Midwifery Education model, and including the requirement that these professionals be employed, after education/training, in their villages or towns of origin.

The MOPH should coordinate with the MOHE to recruit students in the health field based on human resource needs for healthcare providers. The MOHE could increase the quota of females and applicants from rural areas that they accept into medical school, and midwifery and nursing programs. The MOHE could offer accelerated "bridge" courses for those who do not meet the standard entrance requirements so more female and rural individuals are able to begin medical, nursing and midwifery programs.

Access to healthcare: Catchment areas for health facilities are too large, and those living in remote areas must pay more for obtaining health services. Inadequate transportation and weak referral systems prevent patients from accessing appropriate levels of care.

BPHS implementing partners should be given discretion to modify the health care delivery structure in an NGO's catchment area based on coverage needs and accessibility, and the per capita cost of health care needs to be adjusted to reflect needs and accessibility to services. A method to transport patients to and from clinics would help people access health services.

The quality of healthcare provision: Medical health curricula should be updated and should include a public health component. Master trainers must transfer knowledge to others, and health facility managers need to ensure that ample funds are provided to hold knowledge sharing workshops, seminars, courses, etc to colleagues. MOPH and donors should follow through with funding and standards for mental health, eye-care and disability. TBAs who show promise and who meet entrance requirements should be trained as CHWs, professional nurses and midwives.

Supervisors should assess a CHW's workload to determine if she can handle additional tasks. CHWs should be appointed by their communities to increase dedication and accountability. NGOs state that the issue of CHW compensation should be addressed by the MOPH as the MOPH seeks to further rationalize and pay for public health services in the future.

The public's knowledge and awareness of health issues: More public health messages through the media can increase people's awareness of health issues. Health education and promotive healthcare components of CHW curriculum should be incorporated into school curricula so that children can further advocate what they learn at home.



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