

**Improving the Delivery of Maternal Health Services in Afghanistan**

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As the popularity of continued involvement in Afghanistan begins to decline and talk of a coordinated exit becomes more prevalent, international efforts to contain Afghanistan's health crisis develop a new sense of urgency. Despite struggles to improve health, there has been significant progress in certain areas. Programs that target specific diseases have boosted immunization rates. Tremendous strides have also been made in expanding access to care in rural areas. But serious challenges remain, in particular maternal health. If not properly addressed, Afghanistan will remain at the bottom of the rankings on maternal mortality. Given the conditions for women in Afghanistan, a health issue in such urgent need cannot afford to be ignored.

In this paper, I argue that comprehensive delivery of health services must include a stronger commitment to lowering mortality rates through innovative and targeted methods. Efforts to improve the health sector must take a "diagonal" approach, using low-skilled health workers as community-level representatives while working to continue the sector-wide improvements currently underway. While the sector-wide approach has expanded access to care and improved oversight of services delivered, it has not produced improvements in key health indicators such as maternal health. Health experts must work to bridge the divide between vertical approaches that target particular indicators and horizontal approaches that focus on the health system as a whole.

Mortality rates will remain high and improvements in the health sector will go unnoticed if further efforts are not made to promote the utilization of health services, especially by pregnant women. Working to further incorporate pregnant women into the health sector will result in declining mortality rates and will further legitimize the efforts of the central government by demonstrating its capacity to provide essential public services.

Keeping in mind Afghanistan's immense health crisis and the need to improve its deficient managerial capacity, the most sensible approach to improving the health system should be neither exclusively vertical nor horizontal but rather a combination of both, with a focus on vertical efforts to educate pregnant women about the need to utilize health services and promote healthy lifestyle choices relating to breastfeeding and nutrition.

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## PREFACE

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## 1.0 INTRODUCTION

Nearly a decade after the collapse of the Taliban regime in Afghanistan and hundreds of millions of dollars spent on reconstruction efforts, the nation's health statistics are still some of the worst in the world. Afghanistan has been experiencing a public health crisis for many decades. In the early years of the post-Taliban era, reports showed that one child in four died before the age of five.<sup>1</sup> Currently, Afghanistan is home to the second highest maternal mortality rate in the world.<sup>2</sup> It also has the fourth highest rate of reported malaria cases outside of sub-Saharan Africa, made worse by forced migration and internally displaced persons.<sup>3</sup>

The United States has spent over \$4 billion on development in Afghanistan since 2002, according to the United States Agency for International Development (USAID).<sup>4</sup> On health programs alone USAID has spent or allocated \$628 million, according to the annual budgets from fiscal years 2002 through 2009.<sup>5</sup> The World Bank, another major contributor to reconstruction efforts in Afghanistan, committed over \$1.5 billion to development projects from

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<sup>1</sup> Richards, Tessa and Little, Ruth. "Afghanistan needs security to rebuild its health services." *British Medical Journal*, Vol. 324, No. 7333. 2002, p. 318

<sup>2</sup> "Maternal mortality rate high in Afghanistan: U.N." Reuters India. 26 January 2009.

<sup>3</sup> "Malaria indicators survey." Ministry of Public Health. Islamic Republic of Afghanistan. 2009, p. i

<sup>4</sup> USAID Afghanistan Mission Website, About USAID/Afghanistan, <http://afghanistan.usaid.gov/en/Page.About.aspx>

<sup>5</sup> Ibid, Programs, Health, <http://afghanistan.usaid.gov/en/Program.28.aspx>

2002 to 2008.<sup>6</sup> The European Commission (EC), the third major donor, has committed €1.65 billion (\$2.13 billion) to Afghanistan from 2002 until 2009.<sup>7</sup> Despite the commitment of billions of dollars to improve health conditions in Afghanistan, the nation's staggeringly high mortality rates have not seen a significant decline. Though some health experts are optimistic that mortality rates will improve in the future, it is not clear whether the reduction will be statistically significant – if it even happens at all.

As the popularity of continued involvement in Afghanistan begins to decline in the United States and talk of a coordinated exit becomes more prevalent, international efforts to contain Afghanistan's immense public health crisis develop a new sense of urgency. But with an overwhelming majority of health care funds coming from the international community rather than from within Afghanistan and with the prevalence of health workers employed through non-local organizations such as the International Committee of the Red Cross (ICRC), efforts to provide Afghanistan with a sustainable health system seem to be many years away.

Afghanistan's health crisis is not limited to specific health maladies, however. The nation's health system infrastructure is in a particularly dire state, though considerable improvements have been made in the past few years. Many hospitals are falling apart, few have electricity and running water, and the terrain surrounding many facilities is so damaged as to leave them inaccessible. Skilled health professionals are uncommon, female health workers in particular are incredibly scarce, and most health facilities are badly understaffed.

This grim reality raises an important question: keeping in mind the limited resources available in Afghanistan, how can public health be improved in the short term, while still tending to long-term needs? In other words, what kind of strategy would be most appropriate for a

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<sup>6</sup> "Country Update." The World Bank in Afghanistan. 2008, p. 2

<sup>7</sup> "Afghanistan state of play July 2009." European Commission. 2009, p. 1

government seeking to tackle an immense public health crisis in the short term while also working to develop a health system that is cost-effective, accessible, and maintainable?

Despite struggles to improve health care outcomes, there have been significant improvements in certain areas. Programs that target specific diseases have been very successful in boosting immunization rates for polio and measles. Tremendous strides have also been made in improving the health sector by working to expand access to care, especially in rural areas. But serious challenges remain that need to be tackled, in particular maternal health. If not addressed in the short term, Afghanistan will remain at the bottom of the rankings on maternal mortality and other related indicators such as neonatal health. Maternal health is a key indicator that can significantly impact broader issues of health, such as child health, nutrition, and overall life expectancies. Though there has been dramatic improvement in quality of health services, mortality rates remain astronomically high. Unless they are adequately addressed and prioritized, it is possible that these numbers could begin to increase once more, keeping Afghanistan among the worst nations for human development.

One reason maternal mortality has not been adequately addressed is largely due to the international community's approach to reforming health services in the country. Specifically, donors have mostly taken a broad horizontal approach that works to improve health services sector-wide and focuses on improving the managerial capacity of facilities at the expense of targeting specific crises. A sector-wide or horizontal approach to improving health services is one that works to address the infrastructure of health delivery as a whole and improve the health sector so that the entire population benefits. In contrast, a vertical approach focuses on a specific demographic population or disease and works to improve a particular health issue, usually within a specified timeframe. While horizontal efforts to improve health in Afghanistan have

demonstrated considerable progress and are worth continuing, such efforts often lack the ability to effectively improve narrower issues such as maternal health. Given the dismal conditions for women in Afghanistan, a health issue in such urgent need cannot afford to be ignored.

In this paper, I argue that comprehensive delivery of health services in Afghanistan needs to include a stronger commitment to lowering mortality rates through innovative and targeted methods. Efforts to improve the health sector must take a more inclusive “diagonal” approach, incorporating low-skilled health workers as community-level representatives while working to continue the sector-wide improvements currently underway. While the horizontally-driven sector-wide approach has expanded access to care and improved oversight of services delivered, it has not resulted in recognizable improvements in key health indicators such as maternal and child health. Instead, health experts must work to bridge the divide between vertical approaches that target particular indicators and horizontal approaches that focus on the health system as a whole.

Mortality rates will continue to remain high and the benefits of improving the health sector will go unnoticed by the Afghan people if further efforts are not made to promote the utilization of health services, especially among pregnant women. Working to further incorporate at-risk populations such as women with children into the health sector will result in declining mortality rates and further work to legitimize the efforts of the central government by demonstrating its capacity to provide essential public services.

Keeping in mind Afghanistan’s wide array of health crises and the need to improve its deficient regulatory and managerial capacity, the most sensible approach to improving the health system in Afghanistan should be neither exclusively vertical nor horizontal but rather a combination of both, with a focus on vertical efforts to educate pregnant women about the need

to utilize health services and promote healthy lifestyle choices relating to breastfeeding and nutrition.

Currently, the number of door-to-door community health workers trained in midwifery techniques and maternal health is very low. In order to address this, the Ministry of Public Health (MoPH) in Afghanistan should work to increase the quality of training given to traditional birth attendants (TBAs), work to incorporate them into the health system, and utilize their role as members of local communities to improve health conditions for women in rural provinces. It is only through a rigorous and targeted effort to promote the utilization of health facilities during childbirth while simultaneously working to improve those services across the health sector that Afghanistan will see reductions in maternal mortality and improvements in overall health.

## **1.1 CENTRAL POINTS ADDRESSED BELOW**

The first section of this paper provides a more detailed breakdown of health conditions in Afghanistan, works to describe key crises, and provides further information on the conditions of health facilities. The second section puts the public health crisis in a historical context, detailing the conditions of health care delivery in the preceding forty years, the health effects of decades of political instability and struggle, and the systematic dismantling of health services that took place under the rule of the Taliban. Many of the Taliban's efforts to establish oppressive political rule focused specifically on weakening and marginalizing the role of women in society, an effort often cited as the reason for Afghanistan's severe crisis in the area of women's health. This section then describes current obstacles that impede the effort of improving health, such as the rising insurgency, the ongoing drug trade, and corruption.



The next three sections work to detail the complex structure of delivering health services nationwide. The first of these sections describes the relationship between foreign aid donors and the central government; the second describes the relationship between the central government and the provincial government; and the third describes the relationship between the central government and non-governmental organizations (NGOs) working to deliver health services. The sixth section details how the delivery of services works at the provincial level and explains the different types of health facilities and the services they offer. The seventh section describes efforts to improve the accessibility of these services by providing as many services as possible at the local level.

On a national level, the central government has worked to improve health services in Afghanistan, standardize measures of care, and expand the geographical scope of services. These efforts comprise the Basic Package of Health Services (BPHS), a staple of the Afghan government's health policy and the sector-wide strategy to improve services, which is addressed in a later section of this paper.

In order to assess the improvements in efforts to expand access to and quality of health services, the government worked with outside contractors to develop the Balanced Scorecard (BSC), an indicator that measures year-to-year improvements in health objectives. The BSC is a vital tool for assessing sector-wide improvements in health services, and is discussed in greater detail later on. Sample BSCs are included at the end of this paper.

Though the BPHS is a horizontal effort to improve services across the entire health sector, it relies heavily on vertical campaigns in the short-term. The MoPH has announced its intention of fully incorporating these campaigns into the sector-wide BPHS. These vertical programs are discussed in a section below. Despite the success of vertical campaigns and of horizontal efforts

to improve the health sector, both approaches include certain limitations that weaken their ability to address the broader issue of health. These limitations are discussed in a later section, which further provides evidence for the need of a more comprehensive approach to improving the delivery of services.

Finally, the paper describes efforts to further train and utilize TBAs in outreach campaigns intended to educate pregnant women on the importance of health services and healthy lifestyle practices. This section also reviews the effectiveness of TBAs in improving maternal health and emphasizes the need to further incorporate TBAs and outreach efforts into the health system to ensure a more comprehensive approach to improving health.

## 2.0 THE PUBLIC HEALTH CRISIS IN AFGHANISTAN

Health conditions in Afghanistan are among some of the worst in the world, with some of the lowest human development indicators and the most abhorrent hospital conditions imaginable. Though there has been considerable progress in the past decade to improve conditions for the delivery of health services, life in Afghanistan remains a daily struggle and many essential services remain in short supply. In 2002, the average adult life expectancy was 46 years and one child in four died before the age of five.<sup>8</sup> Only eight percent of women received prenatal care and over 50 percent of children were chronically malnourished.<sup>9</sup>

The prime causes of Afghanistan's staggering under-five mortality rate (U5MR) are treatable diseases and conditions with a degree of severity seldom seen in the modern developed world. Pneumonia accounts for 25 percent of childhood deaths; diarrhea accounts for 19 percent.<sup>10</sup> When diarrhea during the neonatal period of childhood is included, that number is even higher – neonatal causes of death including diarrhea in newborn children account for 26 percent of Afghanistan's mortality rate for children under five. Malaria, measles, and daily malnutrition contribute to Afghanistan's high childhood mortality rates as well, and debilitating diseases like polio impact the lives of many Afghan children today.

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<sup>8</sup> Richards, Tessa et al. "Afghanistan needs security to rebuild its health services," p. 318

<sup>9</sup> Sharp, Trueman W. and Burkle Jr., Frederick M. and Vaughn, Andrew F. et al. "Challenges and opportunities for humanitarian relief in Afghanistan." *Clinical Infectious Diseases*, Vol. 34, Supplement 5. 2002, p. S218

<sup>10</sup> World Health Organization Mortality Country Fact Sheet 2006, Afghanistan

Conditions for women in Afghanistan appear to be just as grim, with Afghanistan claiming the second highest maternal mortality rate (MMR) in the world.<sup>11</sup> While malnutrition is a problem in Afghanistan across the board, it is particularly cause for concern among pregnant women, who are often deficient in vital supplements such as iron and folic acid. Women have also been shown to be at exceptional risk for tuberculosis (TB), a major contributor in adult mortality rates.<sup>12</sup> There is little to no

**Table 1: Maternal Mortality Rates Worldwide**

1	Sierra Leone	2,100
2	Afghanistan	1,800
3	Niger	1,800
4	Chad	1,500
5	Somalia	1,400
6	Angola	1,400
7	Rwanda	1,300
8	Liberia	1,200

Source: "Maternal mortality in 2005." WHO, UNICEF, UNFPA, and the World Bank. 2005, pp. 23 - 27

existing research on the prevalence of HIV/AIDS in Afghanistan although there is reason to fear that an outbreak is not inconceivable in the future.

There is also an immense mental health crisis that often goes unnoticed and untreated, with high rates of severe and unreported depression and suicide after decades of war and turmoil. One study published by the American Medical Association (AMA) found that one in five non-disabled Afghan respondents reported having a mental illness.<sup>13</sup> Among disabled respondents the number was closer to one in three. Twenty-six percent of respondents reported experiencing eight or more traumatic experiences throughout their lives, with experiences ranging from lack of food, shelter, and water to illness and lack of medical care. Other commonly reported traumatic experiences included serious injury from fighting, landmines, exposure to rocket attacks, assaults by members of the Taliban, torture, bombardments by Coalition forces, forced separation from family members, and a need to flee suddenly.

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<sup>11</sup> "Maternal mortality rate high in Afghanistan: U.N." Reuters India. 26 January 2009.

<sup>12</sup> Waldman, Ronald and Hanif, Homaira. "The public health system in Afghanistan." *Afghanistan Research and Evaluation Unit*. 2002, p. 11

<sup>13</sup> Cardozo, Barbara Lopez and Bilukha, Oleg O., Crawford, Carol A. Gotway et al. "Mental health, social functioning and disability in postwar Afghanistan." *Journal of the American Medical Association*. Vol. 292, No. 5. 2004, p. 579

The AMA study concluded that the prevalence of symptoms of depression, anxiety, and post-traumatic stress disorder (PTSD) were high “even when compared with those symptoms of other communities traumatized by war and conflict” such as Kosovo.<sup>14</sup> Signs and symptoms of depression were found to be more prevalent among women – particularly widows and mothers. Some researchers have suggested that inadequate maternal health care plays a considerable role in depression among mothers in Afghanistan, although other explanations – such as social conditions for women – could certainly be a significant factor.<sup>15</sup>

While it is perhaps naïve to rank and order the wide array of crises in Afghanistan due to the severity and need for urgency inherent in each of them, it seems clear that maternal health is a keystone indicator that ties in to many of Afghanistan’s most severe health problems.

Further efforts to increase the number of trained midwives, to decrease the number of pregnancies performed without supervision, and to train families to recognize warning signs during a pregnancy will help to reduce Afghanistan’s staggeringly high MMR and

U5MR, reduce the number of premature births, and ensure greater child health during neonatal stages. Since children born prematurely are more likely to die before the age of five and children who are not breastfed adequately are far more likely to be stunted or malnourished, the role of community health workers (CHWs) and TBAs to train new and expectant mothers how to

**Table 2: Health statistics for women**

Indicator	#
Female life expectancy	44
Literate adult females as a % of males	29
Females as a % of males attending primary school	60
Females as a % of males attending secondary school	33
Contraceptive prevalence (%)	10
Antenatal coverage (%), at least once	16
Delivery care coverage (%), skilled attendant at birth	14
Delivery care coverage (%), institutional delivery	13
Maternal mortality ratio	1,800

Source: UNICEF Afghanistan Statistics

<sup>14</sup> Ibid. p. 583

<sup>15</sup> Dittmann, Melissa. “Rebuilding mental health in Afghanistan.” *American Psychiatric Association*. Vol. 35, No. 11. 2004, p. 34

properly look after a newborn child is extremely significant and could help lower malnutrition rates and child mortality rates even further.<sup>16</sup> Women are also at a higher risk for contracting TB and malaria and are more vulnerable to depression, three significant crises in Afghanistan. The MoPH, in a policy paper on health priorities, listed maternal and newborn mortality as the number one health indicator in need of improvement.<sup>17</sup>

Afghanistan's health crisis can be seen inside the nation's health system as well. In 2002, the World Health Organization (WHO) estimated that six million people lacked or had limited access to medical care.<sup>18</sup> While there has been considerable progress in reducing the number of people without access to health services, even the most optimistic estimates put the goal of nationwide access to health facilities many years in the future.<sup>19</sup> Despite the fact that a mere seven percent of the population resides in Kabul, a quarter of the nation's doctors are located in the capital, leaving rural regions badly understaffed. The distribution of doctors in Afghanistan's provinces is dramatically uneven, with 3.1 doctors for every 1,000 people in northern Balkh province and a mere 0.01 doctors for every 1,000 people in central Uruzgan province.<sup>20</sup>

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<sup>16</sup> Waldman, Ronald et al. "The public health system in Afghanistan," p. 10

<sup>17</sup> "National Health Policy 2005 – 2009 and National Health Strategy 2005 – 2006: A policy and strategy to accelerate implementation." Ministry of Public Health. Islamic Republic of Afghanistan. 2005, p. 21

<sup>18</sup> Richards, Tessa and Little, Ruth. "Afghanistan needs security to rebuild its health services," p. 318

<sup>19</sup> "Country Cooperation Strategy for WHO and Afghanistan, 2006–2009." World Health Organization. Regional Office for the Eastern Mediterranean, p. 28

<sup>20</sup> Evans, Anne and Manning, Nick and Osmani, Yasin et al. "A Guide to Government in Afghanistan." The World Bank and the Afghanistan Research and Evaluation Unit. Washington, D.C. 2004, p. 139

The WHO's Global Atlas of the Health Workforce estimates that in 2005 there were 5,970 physicians and 14,930 nurses and midwifery personnel in Afghanistan, with no statistic on the number of CHWs or TBAs.<sup>21</sup> This would equate to a national average of 0.20 physicians for every 1,000 people and 0.50 nurses and midwifery personnel for every 1,000 people. By comparison, using neighboring countries, Pakistan has .8 physicians and .45 nurses and midwifery personnel for every 1,000 people while Turkmenistan has 2.64 and 4.98, respectively. The WHO further reports

**Table 3: Health workers per 1000 people by country**  
*Unless otherwise indicated, data uses 2005 statistics*

	Physicians	Nurses and Midwives	Community Health Workers	Other Health Workers
Afghanistan	.20	.50	--	--
Cambodia <sup>1</sup>	.16	.85	--	--
Haiti <sup>2</sup>	.25	.11	--	--
Myanmar <sup>3</sup>	.36	.98	.99	.04
Niger <sup>3</sup>	.02	.23	--	.04
Pakistan	.80	.45	.42 <sup>3</sup>	.12 <sup>3</sup>
Rwanda	.02	.45	1.48 <sup>3</sup>	.06
Somalia <sup>4</sup>	.04	.11	--	.06 <sup>6</sup>
Sudan <sup>4</sup>	.30	.90	.17 <sup>3</sup>	.59
Turkmenistan <sup>3</sup>	2.64	4.98	--	1.64 <sup>5</sup>
Uganda	.12	1.31	.19	.53
Viet Nam <sup>5</sup>	.56	.77	--	--
Zambia <sup>3</sup>	.12	2.01	--	.30
Zimbabwe <sup>3</sup>	.16	.72	.04	.06

1. Measured by 2000 statistics
2. Measured by 1998 statistics
3. Measured by 2004 statistics
4. Measured by 2006 statistics
5. Measured by 2002 statistics
6. Measured using 2005 statistics, other Somalia measurements indicated above

Source: World Health Organization, Global Atlas of the Health Workforce,  
<http://www.who.int/globalatlas/>

that a minimum of 63,000 health workers is needed in order to provide basic essential care, making Afghanistan's health system critically understaffed.<sup>22</sup>

One survey from 2002 found 1,038 health facilities in the entire country – or one for every 24,000 people. Another survey found that in southern Afghanistan the ratio was closer to one

<sup>21</sup> World Health Organization, Global Atlas of the Health Workforce, 2005 statistics, <http://www.who.int/globalatlas/>

<sup>22</sup> Richards, Tessa et al. "Afghanistan needs security to rebuild its health services," p. 318

health facility for every 200,000 people.<sup>23</sup> By 2009, the total number of health facilities across Afghanistan had increased to 1,701, although the number of health facilities province-by-province is still very unequal, with 31 facilities in Samangan and only 12 in Uruzgan, despite their similar population sizes.<sup>24 25</sup> As of 2006, 95 districts – only one third of the total number of districts in Afghanistan – exceeded the MoPH’s minimum goal of 1 facility for every 30,000 people.<sup>26</sup> Nineteen districts in Afghanistan had no health facilities whatsoever and in 22 of Afghanistan’s 33 provinces there were no health facilities with the capacity to perform emergency obstetrical care (EOC). Only half of the nation’s health facilities have safe drinking water, just over a quarter have electricity, and just over a third do not have toilets for staff or patients.<sup>27</sup>

## 2.1 THE BROADER CONTEXT OF THE HEALTH CRISIS

The health crisis in Afghanistan did not begin in 2001 with the commencement of the ongoing war. It is the result of many decades of bad governance, instability, corruption, terrorism, war, and crime. Afghanistan has struggled to improve health services for many years, but there have been numerous obstacles that delayed or prevented these efforts from yielding positive results. In order to fully understand the reasons for the health crisis and, in particular,

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<sup>23</sup> Waldman, Ronald et al. “The public health system in Afghanistan,” p. 21

<sup>24</sup> “List of active health facilities by province.” Ministry of Public Health. Islamic Government of Afghanistan. 2009, p. 2 – 3

<sup>25</sup> Population statistics. Central Statistics Organization. Islamic Republic of Afghanistan. 2009

<sup>26</sup> “Health Systems Profile: Afghanistan.” Regional Health Systems Observatory. World Health Organization. 2006, p. 34

<sup>27</sup> Riphenburg, Carol J. “Post-Taliban Afghanistan: Changed outlook for women?” *Asian Survey*. Vol. 44, No. 3. May – June 2004, p. 414



the crisis in women's health, the topic of health must be viewed in a historical context and include related issues such as war, education, infrastructure, crime, and regional security.

### **2.1.1 The Health System in a Historical Perspective**

Though health conditions in Afghanistan in earlier decades were, in many respects, better than those in the Taliban and early post-Taliban eras, Afghanistan has been dependent upon the international community in issues of health for many decades. The WHO and the United Nations Children's Fund (UNICEF) were operating in Afghanistan as early as 1957, working to address issues of maternal and child health, health in rural regions, and mounting campaigns against smallpox, malaria, and tuberculosis.<sup>28</sup> The Ministry of Public Health and Social Affairs, a precursor to today's MoPH, spent considerably on disease prevention efforts, and most of the vaccines used in such efforts were produced locally.<sup>29</sup> International organizations worked regularly in Afghanistan and supplied the nation with physicians, nurses, medication, and medical equipment. Following the ratification of the 1964 Constitution, which declared it to be the duty of the state to construct new health facilities, the health ministry began the construction of new hospitals in sixteen provinces.

In 1973, Mohammad Daoud Khan, first cousin of King Mohammad Zahir Shah, overthrew the monarchy, led by his cousin, in a military-led coup with backing from Afghan communists. Daoud suspended the Constitution and quickly distanced himself from the communists that helped bring him to power, angering many of his supporters.<sup>30</sup> The communists felt betrayed

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<sup>28</sup> Buck, Alfred A. and Anderson, Robert I. and Kawata, Kazuyoshi et al. "Health and Disease in Rural Afghanistan." York Press. Baltimore, MD. 1972, p. 4

<sup>29</sup> Ibid, p. 5

<sup>30</sup> Evans, Anne et al. "A Guide to Government in Afghanistan," p. 5

and staged a 1978 military coup that toppled Daoud's government. A new communist regime was established under the leadership of Nur Mohammad Taraki and Hafizullah Amin, which worked to implement a wide set of economic and political changes, such as land reform, advancing equal rights for women, and the elimination of debts among peasantry.<sup>31</sup> These reforms were not well received by most Afghans, who saw the communist regime as being at odds with Afghanistan's social norms. Furthermore, forced redistribution of land by the communists who sought to collectivize agriculture was a direct threat to the livelihood of most Afghans who lived in rural areas.

After a series of uprisings and revolts that nearly toppled the still weak regime, the Soviet Union sent in troops in December of 1979 to quell the insurgency. The result of this invasion was another decade marred by war, violence, and political instability. Many of the nation's doctors and health workers fled the country at this time, resulting in the largest refugee exodus in recorded history.<sup>32</sup> Prior to 1978 there were an estimated 1,000 physicians in Afghanistan, with 84 percent of them located in Kabul. By 1985, approximately 750 successfully sought asylum in Europe and the United States, roughly 200 were operating out of Pakistan, and likely no more than 50 doctors remained in the country.<sup>33</sup> In total, an estimated six to eight million people fled Afghanistan for Pakistan and Iran during the decade of Soviet occupation.<sup>34</sup>

In the 1980s, French NGOs including Médecins sans Frontières established illegal medical facilities in Peshawar and throughout Afghanistan. Neither the Pakistani government nor the ruling communist regime in Afghanistan permitted such activities, but international health

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<sup>31</sup> Ibid

<sup>32</sup> Physicians for Human Rights. "The Taliban's War on Women: A health and human rights crisis in Afghanistan." Physicians for Human Rights. Boston, MA. 1998, p. 1

<sup>33</sup> O'Connor, Ronald W. "Health Care in Muslim Asia: Development and disorder in wartime Afghanistan." University Press of America. Landham, MD. 1994, p. 28

<sup>34</sup> Jones, Seth G. and Hilborne, Lee H. and Antohny, C. Ross et al. "Securing Health: Lessons from nation-building missions." RAND Corporation. Santa Monica, CA. 2006, p. 189

workers in Pakistan on tourist visas routinely smuggled medical supplies in their luggage and stored them in safe houses owned by sympathetic mujahideen fighters.<sup>35</sup> Due to unrelenting air attacks by Soviets, many areas of Afghanistan remained unreachable for health workers, and operations were largely run through Peshawar with a focus on refugees. Workers continued to supply services for Afghan refugees in Pakistan's Northwestern Frontier Province (NWFP) and some NGOs such as the Swedish Committee for Afghanistan worked to provide some basic services inside Afghanistan, though these services were mostly limited to the peripheral provinces near the Pakistan border.<sup>36</sup>

By 1985, mujahideen fighters resisting the Soviet invasion occupied 90 percent of Afghanistan, but these areas were still not safe from attacks: ongoing air raids by Soviet planes and helicopters kept the country in a constant state of unrest.<sup>37</sup> Health workers operating out of mobile health facilities risked life and limb on a daily basis: one in seven health workers died as a result of military actions in 1985.<sup>38</sup> It was further estimated that a mere 3 percent of Afghans living in mujahideen-controlled regions had access to health services at this time, and many regions had no health facilities at all.<sup>39</sup> The few health facilities that did operate regularly in Afghanistan had little ability to handle surgical care, and patients needing complex procedures had no choice but to seek services in neighboring Pakistan and Iran. In total, between Afghan organizations and international NGOs, estimates put the number of trained medical personnel

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<sup>35</sup> O'Connor, Ronald W. "Health Care in Muslim Asia," p. 7

<sup>36</sup> Ibid, p. 13

<sup>37</sup> Ibid, p. 23

<sup>38</sup> Ibid

<sup>39</sup> Ibid, p. 25

operating in Afghanistan in 1985 at fewer than 2,000.<sup>40</sup> Of these workers, over three quarters were trained in little more than first aid.

Seeking to repair Afghanistan's fractured health system and provide treatment to those in need, seven political parties worked together to form a coalition that became known as the Alliance Health Committee (AHC).<sup>41</sup> NGOs operating out of Pakistan formed a coalition of their own in 1986, known as the Coordination of Medical Committees (CMC). Despite significant personal differences between the two agencies, the CMC and the AHC worked together to provide medical care for wounded soldiers, the civilian population, and to improve their operating capacity across the war-torn provinces. The AHC, which provided salaries to medical workers operating in Afghanistan, trained health workers over the next year and deployed them across the country in most of Afghanistan's provinces.

After the Soviets announced their intention to withdraw their forces in 1988, rival political forces in Afghanistan struggled to take control. The existing communist regime struggled to remain in power until 1992 but, without the continued assistance from the Soviets, it soon collapsed, leaving Kabul to the mujahideen government and a civil war.<sup>42</sup> Those who expected stability to come along with the transition of authority were quickly disappointed. Regional militias struggled for power, warlords occupied rural provinces and extorted taxes from residents, and fighters actively participated in drug smuggling and arms trafficking. Throughout much of the war-torn country there was no indication that anybody had power and the authority of the state ceased to exist. This situation lasted until the mid-1990s.

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<sup>40</sup> Ibid, p. 27

<sup>41</sup> Ibid, p. 30

<sup>42</sup> Evans, Anne et al. "A Guide to Government in Afghanistan," p.6

In November of 1994, a group of rural Afghan Pashtun youths, who received their religious education in Pakistan rose to prominence as a military and political force in Afghanistan and quickly gained political control of the country. This group, known as the Taliban, recruited its members mostly from refugee camps and religious madrassas.<sup>43</sup> The Taliban as a movement promised good governance and freedom from corruption. Nearly two years later, in September 1996, the Taliban had taken control of Kabul and begun to declare a series of laws and edicts restricting the rights of Afghan citizens, especially women. Women were no longer permitted to work outside the home, receive schooling, or be seen in public without the accompaniment of a male escort and without being covered from head to toe in a burqa, a body-length garment with a small screen from which to see, breathe, and speak.<sup>44</sup> Women without husbands or living fathers were often left helpless in this environment, and older widows in particular suffered severely.

Health facilities were segregated by gender, and women were left with only one hospital in all of Kabul, which was ill-equipped, understaffed, and lacking basic drugs and medical services.<sup>45</sup> Female medical workers were prohibited from working in any other hospitals, and nurses often reported being beaten by Taliban guards who were stationed at many health facilities throughout the city. After an immense international uproar, the ICRC worked to pressure the Taliban into lifting its restrictions on segregated health facilities, which it eventually did, though it left other restrictions on the conduct of women intact. Male doctors were prohibited from treating women entirely and were forbidden from treating children located in

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<sup>43</sup> Physicians for Human Rights. "The Taliban's War on Women," p. 2

<sup>44</sup> Ibid, p. 3

<sup>45</sup> Ibid, p. 2

female wards of hospitals. Due to the severe shortage of female doctors, this often meant death for children hospitalized with ill mothers.<sup>46</sup>

When the non-profit organization Physicians for Human Rights (PHR) visited the Rabia Balkhi Hospital in Kabul – once the only hospital that treated women – they found deplorable conditions. Many women had not received medical attention at all and some women reported that they had not been attended to for ten days.<sup>47</sup> In a report on conditions for women in Afghanistan, PHR wrote that, to the best of their knowledge:

No other regime in the world has methodically and violently forced half of its population into virtual house arrest, prohibiting them ... from showing their faces, seeking medical care without an escort, or attending school.<sup>48</sup>

PHR researchers in Afghanistan conducted a series of studies on women's health and found a shocking result: 53 percent of women reported being at one point seriously ill but unable to seek medical care due to Taliban policies.<sup>49</sup> Some of the most common reasons for their inability to access medical services ranged from the inability to find a chaperone, restrictions to their mobility due to Taliban law, a lack of female physicians in hospitals, health facilities refusing to treat them, and an inability to afford treatment.<sup>50</sup> PHR also found that Taliban policies had crippling effects on women's mental health: 81 percent of respondents reported a "decline in mental condition," and found that cases of major depression, PTSD, anxiety, and frequent suicidal thoughts were extremely common.<sup>51</sup>

No reliable records exist during this time that would indicate the prevalence of maternal deaths, but it is widely assumed that the levels were extremely high. Statistics during this era

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<sup>46</sup> Ibid, p. 7

<sup>47</sup> Ibid, p. 6

<sup>48</sup> Ibid, p. 2

<sup>49</sup> Ibid, p. 6

<sup>50</sup> Ibid, p. 7

<sup>51</sup> Ibid, p. 9

were lacking all around: a nationwide census had not been conducted since 1979, and this effort was never completed due to the exodus of refugees after the Soviet invasion.<sup>52</sup> To date, a census for Afghanistan has not been completed since the 1970s. This has been a significant hindrance to aid efforts, since international organizations have to rely on data that is less reliable to estimate the size of regional populations.

In 1997, UNICEF began implementing health programs in four provinces aimed at improving maternal health and strengthening EOC services. These efforts were based on the objectives of the Safe Motherhood Initiative (SMI), a global effort to improve maternal health that will be detailed later in this paper. Three years later, a consultant hired by UNICEF assessed the efforts and noted that the program was “still very much in its infancy” and that deplorable conditions in health facilities were still prevalent.<sup>53</sup>

On 11 September 2001, the terrorist group al-Qaeda, operating out of Afghanistan with close ties to the Taliban, launched a series of coordinated terrorist attacks against the United States, killing nearly 3,000 people in New York City, Washington, D.C., and Shanksville, Pennsylvania. The United States and its allies declared war on the Taliban in Afghanistan and, on 7 October 2001, began launching targeted strikes and air raids.<sup>54</sup> By 13 November 2001, the Taliban had fled Kabul and the city quickly fell to coalition and Afghan forces. The coalition of troops fighting in Afghanistan included every member state of the North Atlantic Treaty Organization (NATO) and other allied forces from around the world, collectively known as the International Security Assistance Force (ISAF). Since 2001, the U.S., Afghan, and coalition partners have fought against a resurgent Taliban.

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<sup>52</sup> “Afghan census postponed for two years: UN.” Reuters. 8 June 2008

<sup>53</sup> Ibid

<sup>54</sup> “The 9/11 Commission Report.” National Commission on Terrorist Attacks upon the United States. 2004, p. 337

### 2.1.2 Reconstruction and Development in a Fragile Environment

Security conditions in Afghanistan remain a major cause for concern and play a significant role in weakening the availability of health care, especially in remote and rural areas. Among the major security concerns are issues relating to terrorism, the resurgence of the Taliban, corruption, and the cultivation of poppy seeds. Despite the continued presence of hundreds of thousands of international troops, security remains a pressing issue and many Afghans in rural provinces do not feel as if the international community is doing enough to address the issue. According to recent surveys, Afghans reported feeling that lack of security was the most pressing issue facing their country.<sup>55</sup> But boosting security forces cannot be seen as a project exclusively reserved for international forces.

In 2008, the Afghan National Army (ANA) included 80,000 troops, while the Afghan National Police (ANP) had even fewer, with only 70,000 officers.<sup>56</sup> This made Afghanistan home to one of the lowest soldier-to-inhabitant ratios in a post-conflict setting. However, the past two years have seen a significant increase in the number of ANA troops, with their numbers climbing to 94,000 near the end of 2009.<sup>57</sup> NATO, which has been training ANA troops and ANP officers, aims to hand over control of security to Afghan forces by the year 2014.<sup>58</sup>

The security shortage in Afghanistan has raised doubts about the country's ability to fend off a resurging Taliban presence. There has been a considerable reorganizing of Taliban forces in recent years, and areas such as Kandahar and Helmand have remained Taliban strongholds. Seth Jones, a policy expert at the RAND Corporation, emphasized the need for a stronger presence of

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<sup>55</sup> Mullen, Rani D. "Afghanistan in 2008: State building at the precipice." *Asian Survey*. Vol. 49, Issue 1. 2009, p. 29

<sup>56</sup> *Ibid*, p. 30

<sup>57</sup> "Q&A: Foreign forces in Afghanistan." BBC News. 17 June 2010.

<sup>58</sup> "Taliban denounce Kabul meetings as sign of failure." NPR Online. 21 July 2010.



government and security forces in rural areas in order to effectively deter the rising insurgent presence. Lack of governance in rural provinces was one of the major reasons for the initial rise in Taliban insurgency, according to the Afghan intelligence agency National Directorate of Security.<sup>59</sup> In Helmand province, an area that was heavily dominated by Taliban forces before the recent troop surge, government presence was said to be virtually non-existent. “Given sustained security and assistance,” Jones wrote, “villages across this swath of territory might have sided with the government” but, due in large part to low levels of troops and government officials, villagers have shown more support for insurgents.<sup>60</sup>

To combat the Taliban insurgency, NATO troops have recently launched major offensives in these areas and are working to secure regions previously still under the Taliban reign. Military offensives in Kandahar and the Helmand region of Marja are two essential components of the recent troop surge intended to counter the rising insurgency. Of the 30,000 new US troops deployed to Afghanistan in 2009, roughly 9,000 are being deployed to Helmand province. 21,000 new troops from the US and other NATO allies are being sent to Kandahar, and an additional 4,000 troops will be spread throughout the country to assist in efforts to train the ANA and the ANP.<sup>61</sup> The offensives in these regions have led to an increase in violence, but military experts remain confident that the counter-insurgency efforts will work to improve security within the coming months.

The insurgency has also resulted in a sharp rise in suicide bombings. The number of suicide bombings recorded in Afghanistan has increased dramatically over the years, from only one in

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<sup>59</sup> Jones, Seth G. “The Rise in Afghanistan’s Insurgency: State failure and jihad.” *International Security*. Vol. 32, No. 4. 2008, p. 33

<sup>60</sup> Ibid, p. 34

<sup>61</sup> “Q&A: Foreign Forces in Afghanistan.” BBC News. 17 June 2010.

2002 to 140 in 2007.<sup>62</sup> A report released by the UN in mid 2010 estimated that Afghanistan currently experiences an average of three suicide bombings per week.<sup>63</sup> Attacks using improvised explosive devices (IEDs) have also seen a sharp increase. In 2003, there were 83 reports of IEDs either exploding or being successfully disarmed. By 2009, that number had increased to 7,000.<sup>64</sup> In the month of January 2010 alone there were 1,000 reports of IEDs being used in Afghanistan.<sup>65</sup> NATO troops and the Afghan government have been working to address the rise in IED attacks through several strategies: increasing the training of ANA troops in the dismantling of explosives, working to foster collaboration with locals knowledgeable of bomb-making efforts in their areas, and banning the possession or sale of ammonium nitrate, a major component in the manufacturing of IEDs.<sup>66</sup>

The close relationship between the insurgency and poppy seed cultivation greatly complicates efforts towards improving regional security. Afghanistan is practically the world's sole supplier of opium, with 90 percent of the world's opium coming from poppy seeds cultivated in Afghanistan. Cultivation is a major component of the underground economy in Afghanistan, which makes up roughly a third of the nation's GDP. One recent opinion poll in Afghanistan found that drug traffickers were viewed as one of the biggest threats to security, second only to the Taliban.<sup>67</sup> Poppy seeds are the primary source of money for the Taliban, and the primary financial cause of the ongoing insurgency.

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<sup>62</sup> Jones, Seth G. "The Rise in Afghanistan's Insurgency," p. 36

<sup>63</sup> United Nations Security Council. "Report of the Secretary-General pursuant to paragraph 40 of resolution 1917." 16 June 2010.

<sup>64</sup> "U.S. troop surge focuses attention on roadside bombs." USA Today. 2 February 2010

<sup>65</sup> "DoD tries to counter IED surge." Politico. 8 April 2010

<sup>66</sup> "Afghanistan's Karzai bans ammonium nitrate fertilizers, key ingredient to roadside bombs, or IEDs." Wall Street Journal. 3 February 2010

<sup>67</sup> Popular opinion poll in Afghanistan. BBC News and ABC News. 2009, p. 8

The past few years have shown some improvement in efforts to reduce poppy seed cultivation, which is now mostly limited to the southern and western provinces of Afghanistan. USAID estimated in 2009 that 20 of Afghanistan's 34 provinces were free of poppy cultivation.<sup>68</sup> 2008 saw a 19 percent reduction in poppy cultivation, and 18 provinces were declared poppy-free.<sup>69</sup> There were only 13 poppy-free provinces in 2007, and the number was lower still in 2006, with only six of the 34 provinces being declared poppy-free.<sup>70</sup>

Many assessments have found that poppy seed cultivation has been nearly eliminated entirely in the northern and eastern provinces. Studies have also found that, while opium-free provinces tend to be among the poorest in the country, they are also some of the safest. Helmand province, which produces two-thirds of the nation's poppy, is considered to be one of the least safe provinces and has a strong Taliban presence.<sup>71</sup> An estimated 93 percent of Helmand's population participates in the narco-economy, and police forces frequently levy taxes on poppy revenues rather than prevent the practice. But even in Helmand, once referred to as the "bread basket" of Afghanistan due to the considerable profits yielded from poppy cultivation, counter-narcotic efforts are showing signs of progress. Land used to cultivate poppy seeds in Helmand declined by a third in 2009, and officials in Helmand were aiming to further reduce cultivation by fifty percent this year.<sup>72</sup>

For many Afghans, poppy cultivation is a necessity, since it employs so many people and is such a major contributor to the nation's economy. In the initial effort to boost counter-narcotic efforts in Afghanistan, US officials advocated spraying chemicals from airplanes on poppy fields

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<sup>68</sup> Agriculture Sector Profile. USAID in Afghanistan. 2009, p. 1

<sup>69</sup> Mullen, Rani D. "Afghanistan in 2008," p. 35

<sup>70</sup> Ghufran, Nasreen. "Afghanistan in 2006: The Complications of Post-Conflict Transition." *Asian Survey*. Vol. 47, Issue 1. 2007, p. 94

<sup>71</sup> Mullen, Rani D. "Afghanistan in 2008," p. 36

<sup>72</sup> "Pushing alternative crops in Afghan opium fight." Reuters. 27 November 2009

to kill crops. This effort was met with resistance from the Karzai administration, which feared that the use of air raids would result in a backlash of opposition from farmers in rural regions and would risk empowering the Taliban further.<sup>73</sup> Opinion polls conducted in Afghanistan found an overwhelming 91 percent of Afghans supported the eradication of poppy fields, but only 13 percent supported doing so through the spraying of chemicals.<sup>74</sup>

Recently, US officials have backtracked on their support for chemical spraying, acknowledging that such efforts are potentially counterproductive and not cost-effective.<sup>75</sup> While officials remain committed to reducing the dependence of farmers on the cultivation of poppy, efforts have expanded to include campaigns to promote the cultivation of alternative crops. USAID has been working to provide loans to farmers that grow pomegranates, grapes, and apricots and provides the materials and tools necessary to produce high-value crops.<sup>76</sup> Saffron, a crop in high demand with a wide array of uses, has become a common source of revenue for farmers in the northwest, and may help reduce the nation's agricultural dependence on poppy.<sup>77</sup> The economic advantage of poppy cultivation has also seen a marked decline. A few years ago, a hectare of poppy seeds in Afghanistan produced 27 times the profits of wheat.<sup>78</sup> In 2009, the gap in profits decreased to a ratio of one to three.

Another major issue that restricts reconstruction efforts in Afghanistan is the rampant corruption. The problem is so endemic that the 2009 Corruption Perceptions Index, run by the NGO Transparency International, ranked Afghanistan the second most corrupt country in the

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<sup>73</sup> "Bucking US, Afghanistan won't spray heroin." MSNBC. 25 January 2007

<sup>74</sup> Popular opinion poll in Afghanistan. BBC News and ABC News. 2009, p. 20

<sup>75</sup> "Afghanistan's poppies pose dilemma." USA Today. 31 March 2009

<sup>76</sup> "Agriculture Sector Profile." USAID in Afghanistan. 2009, p. 1

<sup>77</sup> "Saffron uproots poppies on farms in Afghanistan." San Francisco Chronicle. 1 March 2009

<sup>78</sup> "Pushing alternative crops in Afghan opium fight." Reuters. 27 November 2009

world.<sup>79</sup> Services provided by the public sector are widely seen as the most corrupt, which serves as a major financial obstacle to people living in poverty. One poll from 2009 found that 63 percent of respondents felt that corruption among local government officials and police was a major problem in their area, and 71 percent felt that corruption had either increased or remained the same in the past year.<sup>80</sup> Another survey found that bribery was common in all major public services, including in dealings with the judiciary, the ANP, municipality officials, and healthcare services.<sup>81</sup> Some of the findings of this survey can be found in Chart 1 below, which breaks down the prevalence of bribes by the nature of contact with government officials.

The number of respondents who reported never having to pay bribes for healthcare services is higher than for any other government service except in dealings with the Afghan army. At the same time, however, the total number of respondents who reported having to pay bribes for healthcare services in all cases, most cases, or in isolated cases combined was higher than for any other government service across the board. The reason for this discrepancy was because the study showed that fewer respondents reported not having had contact with healthcare services than with any other service.

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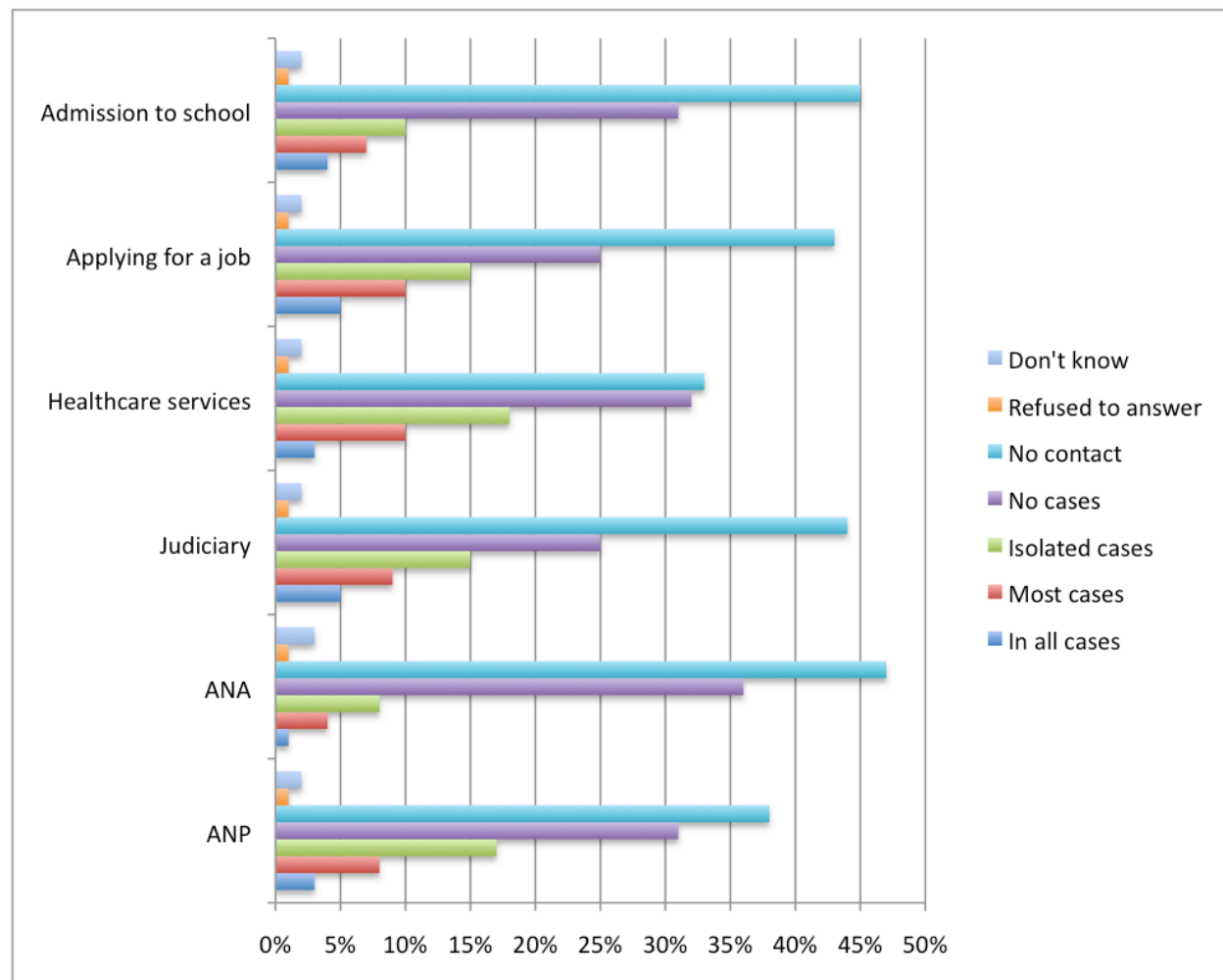
<sup>79</sup> Corruption Perception Index. Transparency International. 2009

<sup>80</sup> Popular opinion poll in Afghanistan. BBC News and ABC News. 2009, p. 9

<sup>81</sup> "Afghanistan in 2009: A survey of the Afghan people." The Asia Foundation. 2009, p. 185

**Figure 1: Corruption among government officials**

“Whenever you have contacted government officials, how often *in the past year* have you had to give cash, a gift or perform a favor for an official? If you had contacts with such officials in the past year, was it in all cases, most of the cases, in isolated or in no cases?”

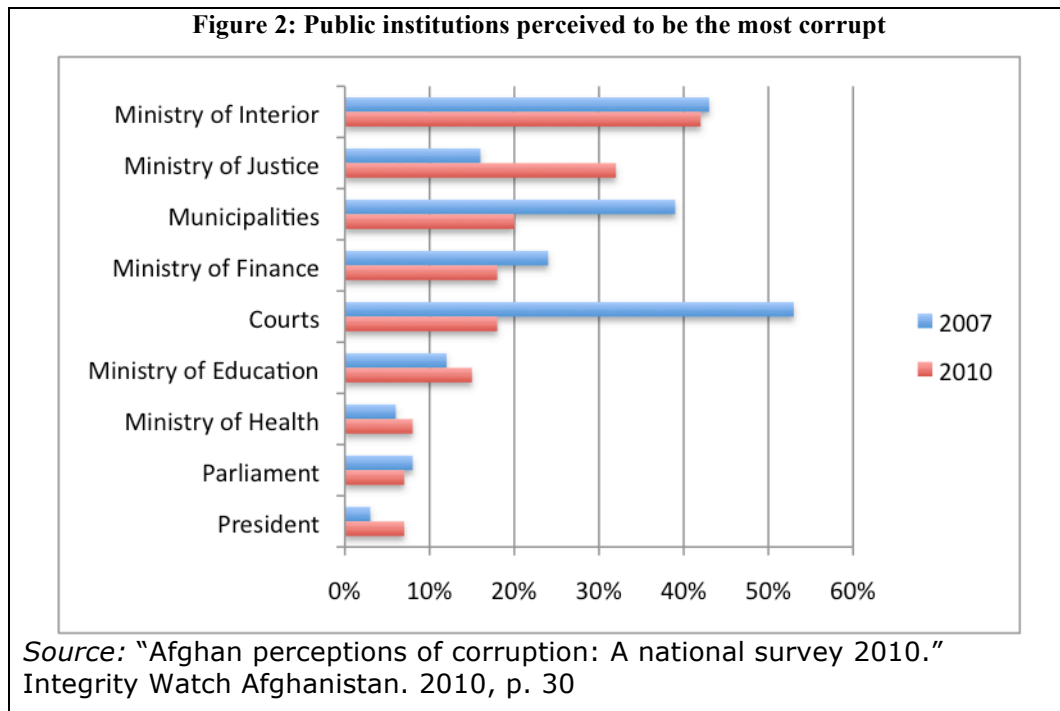


Source: “Afghanistan in 2009: A survey of the Afghan people.” The Asia Foundation. 2009, p. 185

Another study from 2010 noted that the most expensive bribes are paid for services such as education and health, with average bribes for health services amounting to \$143 per household.<sup>82</sup> Though bribes for health services may not be the most common form of corruption, this amounts to a considerable portion of a family’s budget, considering the average Afghan household of 7.3

<sup>82</sup> “Afghan perceptions and experiences of corruption: A national survey 2010.” Integrity Watch Afghanistan. 2010, p. 11

family members makes an average income of \$3,665 per year. This makes the issue of corruption a considerable obstacle in efforts to expand services and boost the utilization of health facilities. Overall, however, the same study found that the MoPH was perceived as one of the least corrupt public institutions as Chart 2 demonstrates.



While there may appear to be signs of progress in efforts to improve security and quell the illegal drug trade in Afghanistan, the endemic nature of corruption in public services remains a significant impediment to efforts to improve the daily lives of the Afghan people. Bribery and corruption by public officials stem from the low wages of public sector employees, lack of accountability, ineffective law enforcement, and widespread poverty.<sup>83</sup> In order to fully see demonstrable improvements in the living conditions of the Afghan people, the central government must commit itself to the cause of reducing corruption in public services and strengthening the supervisory authority of the nation’s anti-corruption agency, the High Office of

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<sup>83</sup> Mullen, Rani D. “Afghanistan in 2008,” p. 29

Oversight and Anti-Corruption (HoO). The agency, established in 2008 at the behest of President Karzai, is the nation's "highest office for the ... implementation of administrative procedural reform."<sup>84</sup>

One major component of the HoO is the Department of Asset Registration, which monitors the income of public officials. Currently, asset declarations must be made upon being hired for the public service, once per year, prior to the last day of employment, and upon court order.<sup>85</sup> Though the process of expanding asset monitoring is being phased in over time, the only officials required to declare assets during the initial phase are the president, the vice presidents, cabinet ministers, and the heads of state institutions such as the attorney general and the chief justice.<sup>86</sup> By the fall of 2010 this will have expanded to include deputy ministers, members of Parliament, and governors. However, mayors, district administrators, high-ranking officials, and employees of financial departments will not be required to declare assets until late 2011. The HoO must work to expand the assets registration program and ensure that public officials working in agencies reputed to engage in routine bribery are subjected to regular examinations of income.<sup>87</sup>

The central government must also work to ensure that the procedures of obtaining public services, such as medical treatment, are displayed publicly in facilities to ensure that people have access to necessary information. If not, the issue of corruption will continue to be a considerable obstacle in efforts to expand the utilization of health services.

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<sup>84</sup> Introduction. Website of the High Office of Oversight and Anti Corruption. Islamic Republic of Afghanistan

<sup>85</sup> "Public officials' asset declaration strategy." Department of Asset Registration. High Office of Oversight and Anti-Corruption. Islamic Republic of Afghanistan. 2009, p. 6

<sup>86</sup> Ibid, p. 5

<sup>87</sup> "Afghan perceptions and experiences of corruption: A national survey 2010." Integrity Watch Afghanistan. 2010, p. 15



### 3.0 UNDERSTANDING THE HEALTH SYSTEM IN AFGHANISTAN

The collapse of the Taliban regime in 2001 left the already unstable nation of Afghanistan in an extremely fragile state with failing infrastructure and a public health system that was ill-equipped and overburdened. Roads and bridges in Afghanistan were nothing more than rubble after decades of war and neglect, rendering access to medical care nearly impossible for many families. After the establishment of a governing Interim Authority in late 2001, a major effort ensued to revitalize the public health system, improve quality of care, and to extend outreach to rural communities. In order to effectively tackle Afghanistan's immense health crisis, the World Bank, the WHO, and Afghanistan's central government worked to standardize health objectives on a national level and define the scope and limitations of the MoPH.

While these efforts were still coming into fruition, a 2002 report from the Afghanistan Research and Evaluation Unit (AREU) described Afghanistan's then-current health system as being in a "state of near-total disrepair" and provided recommendations of content and management in future efforts to reform health services in the country.<sup>88</sup> Among those recommendations were the need to improve consistency in health goals and objectives among all actors in the health system, the need to address health crises such as pneumonia, malaria, and malnutrition, and the significance of community-level health services in primary care treatment.

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<sup>88</sup> Waldman, Ronald et al. "The public health system in Afghanistan," p. i

The Joint Donor Mission (JDM), led in early 2002 by the World Bank and the WHO, advocated expanding the geographical scope of health services to improve access in remote areas of the country, a systemic indicator that would allow for adequate monitoring of improvement in health objectives, and a standardized set of health services that would form the backbone of the country's health policy.<sup>89</sup> That same year, the MoPH announced the development of the Basic Package of Health Services (BPHS), which worked to standardize health care policies on a national level, expand coverage in underserved regions, and vowed to address major health crises such as maternal and newborn health, immunization, nutrition, and mental health.<sup>90</sup> The BPHS was not intended to be a panacea for the war-torn nation's health crisis; the overall objective was to address "only those health problems for which safe and effective interventions are currently available," the AREU wrote.<sup>91</sup> The details and the success of the BPHS will be discussed in a later section.

In an effort to reduce cost and relieve some of the pressure from the new and incipient government, donor proposals for a reformed health system written in the early post-Taliban era limited the role of the central government to being more of a regulator and a steward of health care provided by the private sector rather than a provider itself. The result, some have said, is the establishment of a health ministry that "no longer does things, but concentrates on making sure that things get done."<sup>92</sup> While such an approach has had many critics who argued that assuming a government to be ineffectual would hinder its capacity to gain legitimacy at the community level, the government itself supported such a strategy, acknowledging its inability to

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<sup>89</sup> Ibid, p. 1

<sup>90</sup> "A Basic Package of Health Services for Afghanistan." Transitional Islamic Government of Afghanistan, Ministry of Health. 2003, p. 5 – 7

<sup>91</sup> Waldman, Ronald et al. "The public health system in Afghanistan," p. 4

<sup>92</sup> Ridde, Valéry. "Performance-based Partnership Agreements for the reconstruction of the health system in Afghanistan," p. 6

singlehandedly tackle the immense public health crisis in Afghanistan in a timely and effective fashion.<sup>93</sup> There was a general consensus that the MoPH lacked the capacity to deliver health services in all levels of care on a nationwide basis, a concern that was no doubt justified considering the demonstrable instability and weak public sector in Afghanistan. As a result, the current health system is a complex mixture of the public and private sectors, for-profit and not-for-profit organizations, international agencies and local involvement.

The Minister of Public Health is appointed by the President and confirmed by both houses of the Afghan Parliament.<sup>94</sup> Currently, the acting Minister is Dr. Suraya Dalil, appointed to the position without parliamentary confirmation in 2010 after the parliament rejected most of Karzai's cabinet.<sup>95</sup> <sup>96</sup> The Minister runs the High Council, the highest decision-making body within the MoPH, and has the final say in policy issues.<sup>97</sup> Aside from the Minister, the High Council includes the three deputy ministers. At a lower level, the High Council meets weekly in collaboration with the Executive Board, which consists of the Minister and her deputies, advisers, general directors, and key program managers. Overall, the MoPH consists of 1,400 health experts and support staff, who work in Kabul and other provinces.

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<sup>93</sup> Waldman, Ronald et al. "Afghanistan's Health System Since 2001," p. 5

<sup>94</sup> "Governance of MoPH." Office of the Minister. Ministry of Public Health. Islamic Republic of Afghanistan, pp. 1 – 2

<sup>95</sup> "Dr. Suraya Dalil introduced as Deputy Minister for Policy and Planning and Acting Minister of Public Health." Ministry of Public Health Online. 19 January 2010.

<sup>96</sup> "Afghan lawmakers reject most of Karzai's Cabinet picks." CNN Online. 16 January 2010.

<sup>97</sup> "Governance of MoPH." Office of the Minister. Ministry of Public Health. Islamic Republic of Afghanistan, p. 1

### 3.1 RELATION BETWEEN FOREIGN AID DONORS AND THE CENTRAL GOVERNMENT

The largest international contributors to the public health system in Afghanistan are agencies such as the World Bank, the EC, and USAID. United Nations (UN) agencies such as UNICEF, the WHO, and the World Food Program provide medical assistance alongside local and international NGOs such as the ICRC and Médecins sans Frontières.<sup>98</sup> External aid accounts for over 70 percent of health system funding.<sup>99</sup> In 2002, the MoPH's operational budget detailed sources of health financing, with an estimated \$126 million – 78 percent of overall revenue for health financing – coming from donors, UN agencies, and non-local NGOs. A further \$18 million – 11 percent – came from government expenditures, and another \$17 million was generated through user fees generated from private sector treatment.<sup>100</sup>

Although UN agencies play a pivotal role in providing treatment to those in need, they have not been particularly active in setting the agenda for health policy in Afghanistan.<sup>101</sup> The biggest actor in defining health policy in Afghanistan has been the World Bank, which proposed the general framework for the health system in place in Afghanistan today.<sup>102</sup> On the provincial level, the World Bank funds medical care for eight provinces in collaboration with NGOs and three provinces in collaboration with the MoPH's Strengthening Mechanism, which will be

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<sup>98</sup> Sharp, Trueman W. et al. "Challenges and opportunities for humanitarian relief in Afghanistan," p. S220

<sup>99</sup> Ibid

<sup>100</sup> Health Systems Profile: Afghanistan. Regional Health Systems Observatory. World Health Organization. 2006, p. 25

<sup>101</sup> Sondorp, Egbert. "Case Study 1: A Time-Seried Analysis of Health Service Delivery in Afghanistan." *DFID Health Systems Resource Centre*. 2004, p. 7

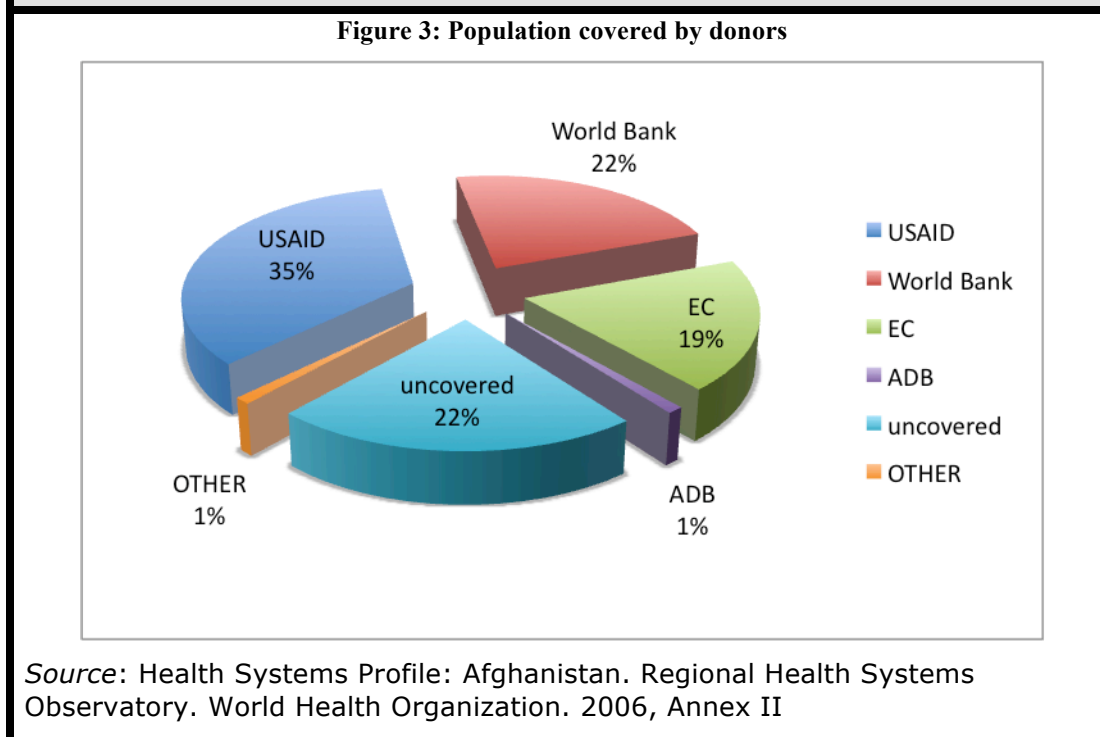
<sup>102</sup> Ibid, p. 10

detailed in a later section. USAID covers 13 provinces – seven of them in collaboration with the World Bank – and the EC covers ten.<sup>103</sup>

**Table 4: Breakdown of donor contracts in Afghanistan**

	Districts	Population	Contracts' costs	NGOs contracted	International NGOs
<b>USAID</b>	134	7,034,910	\$58,419,407	19	10
<b>World Bank</b>	90	4,689,300	\$47,653,014	6	4
<b>EC</b>	80	3,994,200	\$32,702,179	9	6
<b>ADB</b>	11	294,500	\$2,868,006	3	2
<b>Others</b>	8	273,800	-	2	2
<b>Total</b>	323	16,286,710	\$141,642,607	39	24

*Source:* Health Systems Profile: Afghanistan. Regional Health Systems Observatory. World Health Organization. 2006, Annex II



The estimated total expenditure per capita on health in Afghanistan has increased dramatically in the past decade from \$3 in 2001 to \$11 in 2002 to \$29 in 2008.<sup>104</sup> At the same time, however, out of pocket expenditures on health as a percentage of private expenditure on

<sup>103</sup> Sabri, B and Siddiqi, S and Ahmed, AM et al. “Towards sustainable delivery of health services in Afghanistan: options for the future.” *Bulletin of the World Health Organization*. 2007, p. 713

<sup>104</sup> East Mediterranean Region Health System Observatory. Country Information: Afghanistan. Country Data. World Health Organization

health decreased dramatically as well, making up 97.3 percent of private expenditure costs in 2001 and only 60.2 percent in 2008. Data detailing health expenditures can be found in Table 5 below.

Despite the fact that funding for the health system has always been lacking, some experts believe that reductions in funding are likely in the near future.<sup>105</sup> As the central government increases its ability to collect tax revenue across the provinces, more of this money can be pooled towards ministries with a stronger financial need – such as the MoPH – but it is likely that additional tax revenue will not add to the health budget but rather replace and subsequently reduce international and external funding.<sup>106</sup> Projected tax revenue data for Afghanistan for recent and upcoming years can be found in Table 6 below.

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<sup>105</sup> Waldman, Ronald and Strong, Lesley and Wali, Abdul. “Afghanistan’s health system since 2001: Condition improved, prognosis cautiously optimistic.” *Afghanistan Research and Evaluation Unit*, Briefing Paper Series. 2006, p. 2

<sup>106</sup> “Health Systems Profile: Afghanistan.” Regional Health Systems Observatory. World Health Organization. 2006, p. 26

**Table 5: Health expenditure data for Afghanistan, 1999 – 2008**

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Per capita total expenditure on health at an average exchange rate (US\$)	4	3	3	11	11	14	-	-	20	29
Per capita govt. expenditure on health at an average exchange rate (US\$)	1	1	1	4	4	2	-	-	3.9	10
Total expenditure on health as a % of GDP	3.2	2.8	3.2	6.7	6.5	4.4	-	-	5.2	8.1
General govt. expenditure on health as a % of total expenditure on health	1.5	1.5	1.9	-	39.5	16.9	-	-	20	33.2
Private expenditure on health as a % of total expenditure on health	98.5	98.5	98.1	58.9	60.5	-	-	-	-	-
General govt. expenditure on health as a % of total govt. expenditure	1.6	1.6	1.6	7.4	7.3	2.3	-	-	3.3	5.5
Out of pocket expenditure on health as a % of private expenditure on health	98.2	98	97.3	75.9	76.5	-	-	-	-	60.2

Source: East Mediterranean Regional Health System Observatory. Country Information: Afghanistan. Country Data. World Health Organization.

**Table 6: Tax revenue projections for Afghanistan**

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
GDP average annual growth rate (%)	15%	12%	10%	9%	8%	8%	7%	7%	7%	7%
GDP annual total (\$ million)	5,000	5,750	6,440	7,084	7,722	8,339	9,006	9,637	10,311	11,033
Population annual growth rate (%)	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
Population (million)	25	25.9	26.8	27.7	28.7	29.7	30.7	31.8	32.9	34.1
Per capita GDP (\$)	200	222	240	256	269	281	293	303	313	324
Tax Revenue as % of GDP	0%	0%	4%	4%	10%	10%	10%	10%	10%	10%
Tax Revenue	-	-	258	283	772	834	901	964	1031	1103
Health share of Gvt Budget	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%
<b>Projected additional Health exp. (\$million)</b>	-	-	<b>18</b>	<b>20</b>	<b>54</b>	<b>58</b>	<b>63</b>	<b>67</b>	<b>72</b>	<b>77</b>
<b>Projected additional Health exp. (\$ p.c.)</b>	-	-	<b>0.7</b>	<b>0.7</b>	<b>1.9</b>	<b>2.0</b>	<b>2.1</b>	<b>2.1</b>	<b>2.2</b>	<b>2.3</b>

Source: Health Systems Profile: Afghanistan. Regional Health Systems Observatory. World Health Organization. 2006, p. 26

### 3.2 RELATION BETWEEN THE CENTRAL AND PROVINCIAL GOVERNMENTS

In the early years after the establishment of the Interim Government and even after the ratification of the Constitution in 2004, Afghan President Hamid Karzai was frequently mocked for his inability to establish authority nationwide, with critics referring to him as the “mayor of Kabul.”<sup>107</sup> In reality, however, the structure of governance in Afghanistan makes it, “in theory, fiscally and administratively one of the most centralized countries in the world.”<sup>108</sup> A considerable degree of power and authority is granted to the president, who appoints the governors of provinces and districts, the mayors of cities, and the directors of independent offices without subject to confirmation by parliament. The appointment of ministers to the presidential cabinet does require the approval of the parliament, but even this process is tainted by the fact that the president is also responsible for appointing one third of the parliament’s upper house, despite its status as an independent branch of government.<sup>109</sup>

The government was designed from the very beginning with the intention of being strongly centralized, since Coalition forces in Afghanistan feared that a weak central government with little authority would be unable to keep the country from falling back into conflict. But policy experts have since begun to see this as one of the biggest flaws in the structure of Afghan governance, and have advocated for further decentralization. Decentralization as a strategy to improve governance in Afghanistan has been a cause advanced by the United States, and the central government has proposed a plan to improve sub-national governance and provide

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<sup>107</sup> Robinson, Simon. “Karzai’s Kabul: Fit for a King?” TIME Magazine Online. 2002

<sup>108</sup> Lister, Sarah. “Understanding state-building and local government in Afghanistan.” Crisis States Research Centre. Working Paper No. 14. 2007, p. 4

<sup>109</sup> Cookman, Colin and Wadhams, Caroline. “Governance in Afghanistan: Looking ahead to what we leave behind.” Center for American Progress. 2010, p. 7



budgetary authority to provincial councils.<sup>110</sup> Whether the relatively recent goal of decentralization will be implemented in the near future or remain a proposal is currently unclear, but it appears likely that the topic will continue to gain attention in the coming years.

One exception to the strongly centralized nature of Afghan governance is Herat province, which has largely remained outside the authority of Kabul. In many respects, Herat province has been a success story in efforts to improve health services in fragile parts of the world. With 84 working health facilities in 2009, Herat is home to the fourth largest number of health facilities per province throughout Afghanistan.<sup>111</sup> The WHO estimates that Herat possesses the third lowest U5MR and the second lowest MMR in the country.<sup>112</sup> Herat has one doctor for every 5,713 people, as compared to one for every 14,967 in Afghanistan as a whole, and more facilities offer maternal and child than most other provinces.<sup>113</sup> There is also a considerable number of NGOs working in the health sector in Herat, which is likely a result of the province’s relative peace and security. In education, Herat ranks second highest for the number of children enrolled in primary

**Table 7: Under-five mortality rankings by province, lowest to highest**

1	Kabul	155
2	Wardak	180
3	Herat	180
4	Nangarhar	180
5	Logar	190
6	Lagman	190
27	Nuristan	270
28	Bamyan	270
29	Kunduz	270
30	Badghis	300
31	Uruzgan / Daikunde*	300
32	Baghlan	300

*Source:* World Health Organization, “Best Estimates” Provincial Fact Sheets  
**\*NOTE:** Data was collected before Uruzgan and Daikunde were two separate provinces

<sup>110</sup> Cookman, Colin and Wadhams, Caroline. “Governance in Afghanistan: Looking ahead to what we leave behind.” Center for American Progress. 2010, p. 37

<sup>111</sup> “List of active health facilities by province.” Ministry of Public Health. Islamic Government of Afghanistan. 2009, p. 1

<sup>112</sup> Best estimates provincial fact sheet: Herat.” UNICEF in Afghanistan

<sup>113</sup> “A guide to government in Afghanistan: case study: Herat province.” Afghan Research and Evaluation Unit. 2004, p. 21

schools and third for the number of girls enrolled.

Much of this, it can be said, is the result of Ismail Khan, former governor of the Herat province. Khan, a former mujahideen commander, rose to power during the Soviet invasion as an officer in the national army.<sup>114</sup> After the Soviet withdrawal, Khan claimed control of Herat until his arrest by the Taliban in 1995. Khan escaped from prison in 2000 to join the Northern Alliance and overthrow the Taliban regime, winning him the hearts of the people of Herat. He was appointed as provincial governor by Karzai after the establishment of the Interim Government, and remained in power until 2004. During this time, Khan developed the reputation of an austere political leader, with many supporters praising his ability to control security conditions in the province and many critics accusing him of keeping peace through crackdowns on personal freedoms. Khan also has control of his own private police force, which enforces strict codes of daily conduct and claims the authority to punish “vices” among the people of Herat.<sup>115</sup>

He was accused by the Ministry of Finance of collecting over \$300 million in customs duties without submitting much of the revenue generated to the central government.<sup>116</sup> By law, all non-municipal revenue collected by provinces must be remitted to the central government and included in the national budget, with provinces acting merely as tax collectors.<sup>117</sup> Instead, Khan reinvested this money into Herat province. Khan largely disregarded demands from Kabul that he remit customs revenue and took full advantage of the military and economic power he wielded in Herat, declaring himself the “Emir of Western Afghanistan.”<sup>118</sup> On occasion, he

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<sup>114</sup> “Profile: Ismail Khan.” BBC News. 13 September 2004

<sup>115</sup> “All our hopes are crushed: Violence and repression in western Afghanistan.” Human Rights Watch. 2002, p. 14

<sup>116</sup> Evans, Anne et al. “A Guide to Government in Afghanistan,” p. 14

<sup>117</sup> Ibid, p. 71

<sup>118</sup> Ibid, p. 14

refused to allow officials appointed by Karzai to work in Herat, despite the fact that he had no legal authority to determine such a matter.<sup>119</sup>

But despite his authoritarian style, Khan is widely cited as a key ally in efforts to improve security conditions in the western province, which is considered to be one of the safest in the country. Afghan troops working to improve security were not deployed to Herat until the spring of 2004, and prior efforts to control the province were handled by Khan's personal army.<sup>120</sup>

Unlike in other provinces in Afghanistan, people in Herat feel safe enough to wander the streets in the evening, an indication of how significantly security conditions in Herat improved under the hand of Khan.<sup>121</sup>

In their efforts to reclaim parts of Afghanistan after the fall of the Taliban, many of Khan's fellow warlords engaged in atrocities and massacres as a way of establishing control. With Khan, however, there is no reason to believe that he engaged in such activities.<sup>122</sup> Khan also has not been linked to the profitable drug trade in Afghanistan, which has nearly been eradicated in his part of the country. Instead, Khan looked after his province financially with the money he secured from trade with Iran. Upon the announcement by Karzai that Khan was being removed from his post as provincial governor, many Heratis rioted in the streets and several people were killed. Though Khan no longer serves as governor, his removal was in some sense not a firing but a promotion: Khan currently serves as acting director of the Ministry of Energy and Water.<sup>123</sup>

While the extent to which Khan's rule improved health indicators in Herat is not entirely clear, it does seem likely that, despite his reputation, Khan's reign has had some positive effects

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<sup>119</sup> "All our hopes are crushed: Violence and repression in western Afghanistan." Human Rights Watch. 2002, p. 13

<sup>120</sup> "General Ismail Khan." Military: Countries: Afghanistan. GlobalSecurity.org

<sup>121</sup> "Profile: Ismail Khan." BBC News. 13 September 2004

<sup>122</sup> Johnson, Thomas H. "Ismail Khan, Herat, and Iranian Influence." *Strategic Insights*. Vol. 3 Issue 7. 2004, p. 2

<sup>123</sup> Rubin, Alissa J. "Many Karzai Afghan Cabinet choices are rejected." *The New York Times*. 2 January 2010

on the province. It might even be reasonable to argue that the success in Herat demonstrates how ineffective the standard political system in Afghanistan really is and how it suffers from a bureaucratic “top-down” mentality. With this in mind, it would be imprudent for the central government not to explore whether there are positive benefits to further financial decentralization. The central government could work to improve provincial autonomy in experimental provinces to see if they result in improvements in health conditions.

### **3.3 RELATION BETWEEN THE CENTRAL GOVERNMENT AND NON-GOVERNMENTAL ORGANIZATIONS**

As mentioned earlier, the role of the MoPH in health policy is limited to one of a regulator of health services rather than a provider. Instead, many of the actual providers of health care come from the private sector. The private sector as outlined in the World Bank’s plan includes both for-profit and not-for-profit NGOs, which submit tenders, and a committee selects the recipients of contracts. While NGOs are encouraged to compete with each other in the bidding process to ensure the lowest possible cost, all organizations are required to meet the standards defined by the MoPH to ensure quality of care.<sup>124</sup> The role of NGOs in the delivery of health care in Afghanistan is so fundamental that one early estimate suggested that as much as 80 percent of health facilities operate with some degree of NGO involvement.<sup>125</sup>

To provide further financial benefits to health workers and boost their incentive to work, many donors and NGOs offer additional “incentive payments” or “top-ups” in addition to their

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<sup>124</sup> Ridde, Valéry. “Performance-based Partnership Agreements for the reconstruction of the health system in Afghanistan.” *Development in Practice*, Vol. 15, No. 1. 2005, p. 5

<sup>125</sup> Waldman, Ronald et al. “The public health system in Afghanistan,” p. 21

regular government salaries. Due in part to the MoPH's limited budget and the wealth that NGOs can accumulate from international donors, many health workers receive supplemental incentive payments that rival government wages. The Afghan Red Crescent Society (ARCS), for example, paid all staff 50 percent more than their government salaries.<sup>126</sup>

**Table 8: Base salary scales for BPHS health workers**

General Practitioner	\$170	Based on daily 5 hrs work in a standard health center
Surgeon	\$450	With postgrad diploma in Surgery Based on daily 8 hrs work incl. on-call
Surgeon	\$600	With postgrad in obstetric surgery Based on daily 8 hrs work incl. on-call
MD	\$200	Based on daily 8 hrs work incl. on-call
Dentist	\$170	University-level training Based on 5 hrs work
Nurse	\$110	18+ months of basic medical training Based on daily 5 hrs work
Assistant Nurse	\$90	12 - 18 months basic medical training Based on daily 5 hrs work
Midwife	\$140	Three year midwifery training Based on daily 5 hrs work
Auxiliary Midwife	\$125	Between 1.5 and 2 yrs basic training Based on daily 5 hrs work
CHW	<i>no salary</i>	To be determined by community Advised maximum \$21 per month
Vaccinator	\$80	Based on 5 hrs work per day (including outreach)
TBA	<i>no salary</i>	Receives some payment for services rendered by clients

*Source: National Salary Policy for Non-Governmental Organizations Working in the Afghan Health Sector. Salary Policy Working Group. 2003, p. 25*

One consequence is that health

workers could begin to feel responsible to the donors rather than to the government.

Furthermore, the use of incentive payments have resulted in a severe inconsistency of pay where health workers employed through one NGO may make considerably less than those employed by another. Another concern is that the discrepancy in pay will result in an employment exodus from government facilities.<sup>127</sup> To combat this, the MoPH worked in collaboration with some donors and NGOs to develop the Salary Policy Working Group, which has worked to regulate and standardize levels of pay for health workers.<sup>128</sup> Among the policies put in place by the Working Group is one governing incentive payments, which states that “performance incentives

<sup>126</sup> Evans, Anne et al. “A Guide to Government in Afghanistan,” p. 136

<sup>127</sup> Ibid

<sup>128</sup> Ibid

should apply to facilities and not to individuals,” and “funds for incentives should not exceed 10% of the payroll costs of the individual facility.”<sup>129</sup>

Doctors are also allowed to work in the public sector while also running independent private practices. It is not uncommon for a doctor to work a morning shift in a public facility and then work the afternoon at a privately run facility. Though some critics fear that such a policy results in doctors deliberately working fewer hours than the required minimum at public facilities, others believe that the policy softens the demand for higher government wages and reduces financial stress on the MoPH, since doctors can often times earn higher wages from their private sector jobs.<sup>130</sup>

In provinces receiving funding from the World Bank, the mechanism through which care is contracted out is called a performance-based partnership agreement (PPA). With a PPA, an NGO in a particular province receives funding through a contract agreement signed with the World Bank designed to measure improvements in treatment. Upon meeting the objectives of the contract, NGOs are eligible for a bonus worth ten percent of the value of the contract, given out in increments. In provinces contracted through the World Bank, one contract is generally awarded for each province, and the financial value of the contract is determined on a per-capita basis.<sup>131</sup> In districts contracted through other agencies such as USAID, the EC, or the Asian Development Bank (ADB), contracts are more likely to be limited to districts or clusters of districts.<sup>132</sup>

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<sup>129</sup> “National salary policy for non-governmental organizations working in the Afghan health sector.” Salary Policy Working Group. 2003, p. 10

<sup>130</sup> Evans, Anne et al. “A Guide to Government in Afghanistan,” p. 137

<sup>131</sup> Waldman, Ronald et al. “The public health system in Afghanistan,” p. 22

<sup>132</sup> “Afghanistan: The role of contractual arrangements in improving health sector performance.” World Health Organization, Regional Office for the Eastern Mediterranean, p. 8

The WHO, which has largely left policy planning to the World Bank, endorsed the PPA structure in a report on Afghanistan, saying that “it is not easy to see how service delivery can be expanded at a significant pace without contracts with NGOs” due to their prevalence in the health sector.<sup>133</sup> Though academic research on this subject is fairly limited for the time being, many comparisons have been made between the PPA structure in Afghanistan and the Cambodian health care system, which offers a similar performance-based system.<sup>134</sup> Cambodia was used as a model for improving health services in Afghanistan due in part to its status as a post-conflict society and also due to the success of such efforts there. The PPA method in Afghanistan was modeled after the Cambodian system, which found that contracting out health services to NGOs resulted in better quality of care and higher patient satisfaction than services delivered by the government itself. Furthermore, the Cambodian PPA model with NGOs resulted in health services that were more equitable, cost-effective, and easier to implement.<sup>135</sup>

The World Bank and the WHO first proposed a model for Afghanistan similar to the PPA model in Cambodia in the JDM proposal in early 2002.<sup>136</sup> Initially, the MoPH and NGOs in Afghanistan were skeptical of the proposal, since the government felt that delivering health services was a responsibility of the state and NGOs were used to working independently in Afghanistan without any state monitoring. NGOs were further aware of how a PPA model would inevitably result in “winners” and “losers” in the granting of contracts, and that some NGOs would have natural advantages that would make them more likely to receive grants.<sup>137</sup>

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<sup>133</sup> “Health Systems Profile: Afghanistan.” Regional Health Systems Observatory. World Health Organization. 2006, p. 29

<sup>134</sup> Ibid, p. ii

<sup>135</sup> “Afghanistan: The role of contractual arrangements in improving health sector performance.” Regional Office for the Eastern Mediterranean Region. World Health Organization. 2006, p. 5

<sup>136</sup> Waldman, Ronald et al. “Afghanistan’s health system since 2001,” p. 5

<sup>137</sup> Waldman, Ronald et al. ““The public health system in Afghanistan,” p. 24

Despite this, both the public and private sector in Afghanistan understood the need to improve services and how limited each would be if it acted independently.

The MoPH and NGOs agreed to work in collaboration when drafting contracts so that NGOs could be aware of the terms and conditions of a PPA.<sup>138</sup> The reasons for this were twofold. First, NGOs, by virtue of working at the community level for decades, had a better understanding of conditions in rural regions and were aware of what services were lacking in health facilities.<sup>139</sup> Second, experts urged that the MoPH include the NGOs in the planning stages to ensure that the terms and expectations of improving health services were not designed in a “top-down” fashion without the advice of the organizations in charge of actually delivering such services.

Due to the disorganized nature of many local for-profit and not-for-profit actors in the Cambodian private sector, the initial round of contracts were given exclusively to international NGOs with zero local involvement.<sup>140</sup> The result, some feared, was that the health system would be dependent on international assistance and fail to promote more efficient local NGOs. Fortunately, this has not been the case in Afghanistan. In fact, an AREU report detailing the health system in Afghanistan expressed concerns that international NGOs might end up leaving too soon once efforts move towards health sector development rather than emergency response.<sup>141</sup>

Furthermore, the report notes that as of May 2006, 27 NGOs have received contracts through the health system. This included 11 national NGOs and 16 international NGOs. While these numbers indicate that international NGOs have the advantage over local ones, it is not the one-

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<sup>138</sup> Bousquet, Christine. “Linking relief, rehabilitation, and development programme (LRRD) in Afghanistan: Performance-based contracting for health service delivery in post-conflict Afghanistan: Is there still a case for debate?” Groupe URD. 2005, p. 14

<sup>139</sup> Waldman, Ronald et al. “The public health system in Afghanistan,” p. 24

<sup>140</sup> Soeters, Robert and Griffiths, Fred. “Improving government health services through contract management: a case from Cambodia.” *Health Policy Planning*, Vol. 18, No. 1. 2003, p. 81

<sup>141</sup> Waldman, Ronald et al. “Afghanistan’s health system since 2001,” p. 17



sided exclusively international situation that was seen in Cambodia. NGOs with the necessary expertise are also relatively scarce in Afghanistan, which is why international NGOs tend to be favored. The report goes on to note that 52 grants had been given as of December 2006, 21 of which were given to national NGOs, 27 to international ones, and four to consortium organizations that are both national and international. While 34 percent of funds have been given to national NGOs, that number reaches 51 percent if consortium organizations are included along with the national NGOs. Unlike in Cambodia, the concerns of an exclusively international private sector in health care delivery seem unwarranted.

The Dutch non-profit HealthNet TPO, a merger between HealthNet International (HNI) and Transcultural Psychological Organization (TPO), was one NGO contracted through the PPA model in Afghanistan.<sup>142</sup> Prior to its merger with TPO, HNI worked in Cambodia to provide health services under the PPA system.<sup>143</sup> When the PPA model was proposed in Afghanistan in 2002, HNI pointed out a major flaw in the terms of the contracts written in Cambodia. Payments for services offered in health facilities in Cambodia were determined on a per-capita basis, and the budget of the contract put a limit on the number of individual payments based on an estimated number of people that would utilize health services. The actual increase in the number of patients ended up being significantly higher than expected, and HNI lost a considerable amount of money. As a result, HNI urged that contracts in Afghanistan include safeguards intended to ensure that non-profits did not end up losing money in the contracting scheme. Despite this unfortunate experience, HNI agreed that the PPA system had a lot of merit and noted that their overall experience with PPAs in Cambodia was generally positive.

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<sup>142</sup> Project Countries. HealthNet TPO Online

<sup>143</sup> Waldman, Ronald et al. "The public health system in Afghanistan," p. 24

## Performance-Based Partnership Agreements in Cambodia

Cambodia, an extremely rural country highly dependent upon agriculture, is one of the poorest countries in South East Asia.<sup>1</sup> Political instability, genocide, and warfare mar the history of the impoverished nation, leaving its average life expectancy at a low of 54.4 years. Health care in the country was in a fragile state up until the 1990s, with most patients seeking self-treatment from informal drug sellers rather than government health facilities. One study found that roughly 90 percent of health care transactions took place in patients' homes rather than at health clinics.<sup>2</sup> One reason for the low demand of health facilities was the widespread distrust of such places, caused by long waiting lines, disrespectful staff, drug shortages, and misleading costs. In 1995, Cambodia's Ministry of Health began a major overhaul of the health system, which included working to rebuild infrastructure and health facilities and charging user fees to further fund the reform process and gain confidence in the quality of services.

In 1998, Cambodia acquired a loan from the ADB, which allowed them to experiment with different systems of reform. These included a contracting-out approach with private contractors, a contracting-in approach, and a continuation of the existing policy.<sup>3</sup> Contracting-out gave contractors complete control over both the staff and the budget of a health facility whereas contracting-in gave less control to contractors with more regulation by health authorities at the national and provincial levels.

In districts in experimental groups, contracts broke down the payment of health workers into three parts: 55 percent of wages were a basic monthly incentive payment, 15 percent was based on punctuality and regular job attendance, and 30 percent was a performance bonus, dependent upon the "degree to which the monthly financial targets for the department or health facility were fulfilled."<sup>4</sup> Initially it was found that the 30 percent performance bonus was inadequate and failed to promote any change in behavior among health workers.

By late 2000, district managers allowed health facility managers to provide their workers with competitive sub-contracts to further encourage performance improvements among health workers. A year later, surveys by the Ministry of Health showed that experimental districts consistently outperformed control districts and that districts that contracted out performed better than districts that contracted in.<sup>5</sup> Further studies showed that out-of-pocket health expenditures decreased by 40 percent in one district, despite the "substantially increased" user fees and a decrease in user fee exemption.<sup>6</sup> Providing quality care at a reasonable cost, it is assumed, boosted demand and allowed for health care distribution to be more affordable and reliable across the board.

<sup>1</sup> Soeters, Robert and Griffiths, Fred. "Improving government health services through contract management: a case from Cambodia." *Health Policy Planning*, Vol. 18, No. 1. 2003, p. 74

<sup>2</sup> Ibid, p. 75

<sup>3</sup> Ibid

<sup>4</sup> Ibid, p. 77

<sup>5</sup> Ibid, p. 78

<sup>6</sup> Ibid

### 3.4 HEALTH CARE DELIVERY AT THE PROVINCIAL LEVEL

Like most other departments within the central government, the MoPH's primary office in Kabul bears all of the responsibility for policy-making, determining structural organization, and staffing high-level employers throughout the ministry and its provincial and regional offices. Medical workers of the highest level – grades one and two– are typically appointed by the President, with the central government's health minister appointing staffers grades three through five.<sup>144</sup> Junior staffers – grade six and below – are typically appointed by the provincial governor or by MoPH staff at the provincial level. Provincial Health Departments (PHDs) hire lower level staff, transfer staff between health facilities, and collect basic

**Table 9: BPHS recommended staffing, by type of health facility**

Health Facility Level	Staff Categories	Number of Staff Needed
<b>Health Post</b>		
	Community Health Worker	1
	Traditional Birth Attendant	1
<b>Basic Health Center</b>		
	Nurse (male)	1
	Midwife/Auxiliary Midwife	1
	Vaccinator	2
	Support Staff (Cleaner, Guard)	2
<b>Comprehensive Health Center</b>		
	Doctor (male)	1
	Doctor (female)	1
	Midwife	2
	Nurse (female)	1
	Nurse (male)	1
	Lab Technician	1
	Pharmacy Technician	1
	Vaccinator	2
	Administrator	1
	Support Staff (Cleaner, Guard)	4
<b>District Hospital</b>		
	Doctor (male physician)	2
	Doctor (female ob/gyn)	2
	Surgeon	1
	Anesthetist	1
	Pediatrician	1
	Nurse (female or male)	10
	Midwife	4
	X-ray technician	1
	Lab Technician/BB	2
	Pharmacist	1
	Dentist	1
	Dental Technician	1
	Vaccinator	2
	Administrator	1
	Support Staff (Cleaner, Guard)	7
<i>Source: "A Basic Package of Health Services for Afghanistan." Transitional Islamic Government of Afghanistan, Ministry of Health. 2003, p. 41</i>		

<sup>144</sup> Evans, Anne et al. "A Guide to Government in Afghanistan," p. 137

health data. Staffers in PHDs can be disciplined or fired by the provincial health director. The roles and responsibilities in health care delivery by level of governance can be seen broken down in Table 14 at the end of this paper.

There are essentially three levels of health care provided in Afghanistan. In the smaller villages, community health

1	General Practitioner – Doctor
2	Medical & Nursing Specialties
3	Dentist
4	Dental Technician
5	Nurse
6	Assistance Nurse
7	Midwife
8	Auxiliary/Community Midwife
9	Pharmacist
10	Pharmacy Technician
11	Lab Technician
12	Assistant Lab Technician
13	X-Ray Technician
14	Anesthetist
15	Physiotherapy Technician
16	Health Inspector/Sanitarian
17	CHW/Vaccinator
18	TBA
<i>Source: "A Basic Package of Health Services for Afghanistan." Transitional Islamic Government of Afghanistan, Ministry of Health. 2003, p. 40</i>	

workers (CHWs) and traditional birth attendants (TBAs) provide services at designated health posts (HPs). In larger villages and throughout districts there are basic health centers (BHCs), comprehensive health centers (CHCs), and district hospitals. At the highest level are the provincial and regional hospitals, which are considerably larger.<sup>145</sup> Different health facilities in Afghanistan provide different services, depending on whether the facility in question is a regional hospital, a provincial hospital, a district hospital, or something smaller and more specific.<sup>146</sup> A structural breakdown of health facilities in Afghanistan detailing specific medical services offered can be found in Table 15 at the end of this paper.

At the lowest level, CHWs and TBAs provide health services out of their homes, which are classified by the MoPH as HPs.<sup>147</sup> CHWs provide curative care services including diagnosis and

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<sup>145</sup> "Health Systems Profile: Afghanistan." Regional Health Systems Observatory. World Health Organization. 2006, p. 35

<sup>146</sup> Evans, Anne et al. "A Guide to Government in Afghanistan," p. 132

<sup>147</sup> "A Basic Package of Health Services for Afghanistan." Transitional Islamic Government of Afghanistan, Ministry of Health. 2003, p. 7

treatment of malaria, diarrhea, and acute respiratory infections (ARI), distribution of contraceptives, and nutritional services. The roles of TBAs are to be able to recognize danger signs during pregnancies, to provide care for standard deliveries, and to refer women to health centers when necessary. The BPHS mandates that there be one HP staffed by one CHW and one TBA for every 1,000 to 1,500 people.<sup>148</sup>

BHCs, stationed in larger villages and most districts, are expected to contain a nurse, a midwife, and vaccinators, and should provide services from antenatal care to delivery, and from immunization services to the distribution of essential drugs. The BPHS further mandates that there be approximately one BHC for every 15,000 to 30,000 people on average.<sup>149</sup> CHCs, which cover between 30,000 and 60,000 people, offer services for more complex pregnancies, severe childhood illnesses, and inpatient services. These facilities are staffed with doctors, nurses, midwives, and laboratory and pharmacy technicians. District hospitals are expected to cover between 100,000 and 300,000 people and provide nearly all services available through the BPHS.<sup>150</sup>

The health facilities with the widest array of health services offered operate on the regional, provincial, and district levels, with BHCs, CHCs, and sub-health centers providing a more limited list of services. Facilities with the least amount of services offered are maternal and child health clinics (MHCs), expanded program of immunization clinics (EPIs), and rehabilitation centers. The limited services at these facilities are obviously more of an indication of specialization and not a result of poor staffing or lack of equipment, though this is of course a problem in most health facilities in Afghanistan. While the overlap in services provided at the

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<sup>148</sup> Ibid

<sup>149</sup> Ibid

<sup>150</sup> Ibid, p. 8

provincial and district level is intended to ensure that most facilities provide essential services, this does result in some conflict and uncertainty in assigning responsibilities and allocating funds to different health facilities.<sup>151</sup>

At a typical provincial health department (PHD), the structure is often times set up without considerations to the staffing needs and shortages in the area, with more inter-facility departments than workers to staff them. Many departments within a PHD consist of merely one or two people, and some are so lacking in equipment and functionality as to serve little purpose at all. As mentioned in an earlier section of this paper, just over one quarter of health facilities in Afghanistan have electricity – a necessary functional requirement for the storing and cooling of blood. Most blood banks in hospitals, therefore, are only operating when both a donor and a patient are simultaneously present.<sup>152</sup> A structural setup of a typical PHD can be found in Figure 5 at the end of this paper.

The degree of shortages and deficiencies in a particular PHD varies depending upon the size and stability of a particular province, with rural provinces being more understaffed and lacking in basic needs such as electricity. For this reason, it is most sensible to train health workers in rural provinces in a broader array of techniques to make up for staff shortages while promoting and advocating specialization in training in urban provinces such as Kabul province. Though such an approach may leave a wide gap in urban-rural equity of care, such a gap is no doubt inevitable due to the severe inequality of dispersion of health workers in Afghanistan.

In remote provinces, recruiting and retaining qualified health workers is significantly more challenging. Rural hospitals are much more likely to be understaffed despite the increased incentives for workers in rural areas. Previously, rural health workers were not paid more than

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<sup>151</sup>Evans, Anne et al. “A Guide to Government in Afghanistan,” p. 74

<sup>152</sup> Ibid, p. 134

their urban counterparts, despite the fact that many staffers in rural areas felt this would strongly increase their ability to recruit and retain health workers in the region.<sup>153</sup> After the establishment of payment standards by the Salary Policy Working Group, however, hospitals are now encouraged to provide “rural hardship incentives,” which use a series of tiered measurements to determine what percentage of a health worker’s salary will be offered as an additional bonus.<sup>154</sup> Such criteria include ratios such as the physician density per 10,000 population and the midwife density per 10,000 population as well as measurements such as the distance to the provincial health center or the availability of a safe water source near a worker’s place of residence. More significantly, the rural hardship incentive for female health workers is double that of male health workers, since female health workers are so scarce in rural regions. Female health workers, who are an essential element in efforts to curb Afghanistan’s high MMR, often require additional security and spousal employment if they are to work in rural areas, which are often more dangerous and socially conservative in their outlook towards women’s rights.

Lacking from the structure of many PHDs, however, are essential outreach staff that work within communities, such as CHWs and TBAs. Since most CHWs and TBAs operate their services out of their houses, their affiliation with provincial health facilities can be fairly limited. The job description of CHWs as outlined by the MoPH requires them to work “under the supervision” of BHC staff, but it is not clear to what extent this relationship is carried out consistently in districts.<sup>155</sup> Most outreach workers in the health sector are employed and trained

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<sup>153</sup> Ibid, p. 137

<sup>154</sup> “National salary policy for non-governmental organizations working in the Afghan health sector.” Salary Policy Working Group. 2003, p. 8

<sup>155</sup> “A Basic Package of Health Services for Afghanistan.” Transitional Islamic Government of Afghanistan, Ministry of Health. 2003, p. 47

separately by NGOs that specialize in such procedures, but lack consistency in the length and quality of training.<sup>156</sup>

Considering the extremely high number of births performed without a midwife and the number of pregnancy-related maternal deaths, PHDs should work to streamline training and outreach by CHWs and TBAs. In 2002, UNICEF assembled a team to assess the maternal health crisis in Afghanistan. The team strongly urged for increased training of midwives, TBAs, and female physicians in order to reduce the number of births performed without the attendance of health workers. In order to properly do so, the team proposed the establishment of a National Reproductive Health Policy in Afghanistan, with standardized guidelines for the delivery of reproductive health services.<sup>157</sup>

TBAs, though often untrained and illiterate, make up a sizable portion of health workers in Afghanistan. Due to their lack of literacy and medical expertise, many policy experts have discouraged the training of TBAs around the world in an effort to promote the use of more qualified midwives. The MoPH in Afghanistan has proposed such a strategy as well, suggesting in 2003 that the “training of TBAs as birth attendants be discontinued” to ensure that pregnant women have access to skilled midwives during birth.<sup>158</sup> The importance of effectively trained TBAs in efforts to improve maternal health will be discussed in a later section.

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<sup>156</sup> Ibid, p. 135

<sup>157</sup> Waldman, Ronald et al. “The public health system in Afghanistan,” p. 6

<sup>158</sup> “Maternal health services at the community level in Afghanistan: Who should provide these services?” Reproductive Health Task Force. Ministry of Health. Transitional Islamic Government of Afghanistan. 2003, p. 4



### 3.5 THE BASIC PACKAGE OF HEALTH SERVICES

In March 2002, the MoPH, in an effort to overhaul the health system in Afghanistan, worked to define major health priorities, obstacles, and objectives, and defined a specified set of primary health care services that would be provided nationwide through health facilities. This set of services, known as the Basic Package of Health Services (BPHS), standardized health care policies on a national level, expanded coverage in underserved regions, and focused on addressing major health crises such as maternal and newborn health, immunization, and nutrition. “The concept of the Basic Package,” wrote the MoPH in its initial 2003 description of the role of the BPHS, “is that all of the services in the package should be available as an integrated whole, rather than being available piecemeal or as individual services or only through vertical programs.”<sup>159</sup> In this respect, the BPHS is a horizontal approach to improving health in Afghanistan, working to improve the health sector as a whole. There are seven key elements that make up the BPHS: maternal and newborn health, child health and immunization, nutrition, communicable diseases, mental health, disability, and the supply of essential drugs.<sup>160</sup>

Prior to 2002, health facilities were still run mostly by NGOs, but they did so without regulation and monitoring by the MoPH.<sup>161</sup> Donors would provide funds directly to NGOs and would define contractual obligations without consulting with the MoPH. Under the new system put in place by the BPHS, the MoPH is closely involved in supervising and collaborating in the process of contracting out and delivering primary care. In addition to the BPHS, which sets the

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<sup>159</sup> “A Basic Package of Health Services for Afghanistan.” Transitional Islamic Government of Afghanistan, Ministry of Health. 2003, p. 5

<sup>160</sup> “Country Cooperation Strategy for WHO and Afghanistan, 2006–2009.” World Health Organization. Regional Office for the Eastern Mediterranean, p. 28

<sup>161</sup> “Afghanistan: The role of contractual arrangements in improving health sector performance.” World Health Organization, Regional Office for the Eastern Mediterranean, p. 2

standards for the delivery of primary care in Afghanistan, the MoPH developed the Essential Package of Hospital Services (EPHS), which provides standards for the delivery of secondary and tertiary care.<sup>162</sup> The EPHS complements the BPHS, providing standards of hospital care in major urban centers.<sup>163</sup>

There are two methods of health care delivery under the BPHS: the contracting out of services to NGOs – the most common approach – or delivery of care provided by the MoPH itself under the BPHS’ Strengthening Mechanism (BPHS-SM). The BPHS-SM allows for the MoPH to operate in selected safer provinces as more than just a regulator of health services. In these provinces – Parwan, Panjshir, and Kapisa in particular – the MoPH is the provider of health services.<sup>164</sup> The reason for this is essentially twofold: it provides the MoPH with experimental districts in which it can test its own effectiveness and efficiency at delivering health care services and it prepares the MoPH for one possible longer-term approach to health care delivery. Since the MoPH cannot assume that it can rely on the assistance of international NGOs forever, it needs to be prepared for a scenario in which NGO involvement is reduced or phased out completely over time and must therefore work to strengthen its own capacity to deliver health care services.

Health services provided by the MoPH are free, in compliance with the Constitution of Afghanistan.<sup>165</sup> Some NGOs and international donors have required consultation charges or partial payment for drugs prescribed in order to recover some costs, however.<sup>166</sup> While the government opposes charging patients for the cost of x-rays and laboratory tests, some provinces

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<sup>162</sup> “Health Systems Profile: Afghanistan.” Regional Health Systems Observatory. World Health Organization. 2006, p. 35

<sup>163</sup> “Fact Sheet: Health Care Delivery.” United States Agency for International Development, Afghanistan. 2009

<sup>164</sup> *Ibid*, p. 16

<sup>165</sup> Constitution of the Islamic Republic of Afghanistan, Article Fifty-Two

<sup>166</sup> Evans, Anne et al. “A Guide to Government in Afghanistan,” p. 134

charged user fees nonetheless to raise extra funding to combat other health emergencies in their area. The MoPH put a stop to this in 2008, however, and called for a discontinuation of user fees all together.<sup>167</sup> The WHO estimated in a 2006 report that user fees contributed to approximately one tenth of total health spending in Afghanistan.<sup>168</sup>

The MoPH's efforts to overhaul the health system in Afghanistan have produced some impressive results: in 2002 it was estimated that only nine percent of the Afghan population had access to health services.<sup>169</sup> By 2005, however, that number increased to 77 percent of the population covered under the BPHS.<sup>170</sup> Five percent of the population covered by the BPHS was being provided services directly from the MoPH under the BPHS-SM.<sup>171</sup> The WHO noted in one report that the MoPH's efforts to expand coverage is not only impressive due to the significant increase in the percentage of citizens covered under the BPHS, but because the effort has included a focus on providing care to the more "remote and far-flung areas" of Afghanistan.<sup>172</sup> By the end of 2008, coverage under the BPHS had expanded further to include 82 percent of the population.<sup>173</sup> In a 2006 development strategy report published by the central government, the MoPH vowed to extend the BPHS to cover 90 percent of the population by the

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<sup>167</sup> Johns Hopkins University Bloomberg School of Public Health. "Afghanistan Health Sector Balanced Scorecard." 2008, p. 8

<sup>168</sup> Health Systems Profile: Afghanistan. Regional Health Systems Observatory. World Health Organization. 2006, p. 28

<sup>169</sup> Acerra, John R. and Iskyan, Kara and Qureshi, Zubair A. et al. "Rebuilding the health care system in Afghanistan: an overview of primary care and emergency services." *International Journal of Emergency Medicine*. Vol. 2, No. 2. 2009, p.79

<sup>170</sup> "Health Systems Profile: Afghanistan." World Health Organization. 2006, p. 17

<sup>171</sup> "Afghanistan: The role of contractual arrangements in improving health sector performance." World Health Organization, Regional Office for the Eastern Mediterranean, p. 2

<sup>172</sup> Health Systems Profile: Afghanistan. World Health Organization. 2006, p. 17

<sup>173</sup> Acerra, John R. et al. "Rebuilding the health care system in Afghanistan," p. 78

end of 2010.<sup>174</sup> A WHO report released the same year put the timeline for the 95 percent coverage goal at the end of 2015.<sup>175</sup>

Without a doubt, the MoPH has made significant progress in expanding coverage – nearly tenfold in less than ten years. One important thing to note, however, is the broad definition of terms such as “coverage” and “access” when the MoPH says that a percentage of the population lives in a district covered by the BPHS: having access to services covered under the BPHS is defined as living within a two hour walk from a health facility.<sup>176</sup> In this respect, there is certainly still considerable room for improvement in improving the delivery of health services and expanding regional coverage. At the same time, however, expanding regional coverage does not ensure that the quality of services offered is sufficient. To assess the quality of services, some mechanism must be used to measure individual indicators and track year-by-year improvements. That mechanism, the Balanced Scorecard, is discussed below. But even improving the quality of services does not necessarily result in improvements in overall health, since communities who do not utilize health services will not experience the benefits of such improvements. This problem will be discussed later on.

### **3.6 MEASURING SUCCESS THROUGH THE BALANCED SCORECARD**

In order to fully measure the success of efforts to improve the delivery of health care, the JDM, led by the World Bank and the WHO, called for the use of a system of indicators. This

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<sup>174</sup> “Afghanistan national development strategy: an interim strategy for security, governance, economic growth & poverty reduction.” Islamic Republic of Afghanistan. 2006, p. 141

<sup>175</sup> “Country Cooperation Strategy for WHO and Afghanistan, 2006–2009.” World Health Organization. Regional Office for the Eastern Mediterranean, p. 28

<sup>176</sup> Acerra, John R. et al. “Rebuilding the health care system in Afghanistan,” p. 79

would allow for the MoPH to regularly monitor progress towards achieving the predetermined health objectives of the BPHS, identify areas with severe deficiencies, and work to boost managerial capacity in health facilities. The Balanced Scorecard (BSC) was set up to allow the MoPH to do precisely that, giving the Ministry the role of monitoring and measuring improvements in health indicators. The BSC measures 29 indicators in order to assess the quality of treatment. These indicators include such things as immunization rates, prenatal care, and patient satisfaction.<sup>177</sup>

Between 2004 and 2008, Johns Hopkins University's Bloomberg School of Public Health and the Indian Institute of Health Management Research worked with the MoPH to assess conditions in health facilities in provinces across Afghanistan. For each of the 29 indicators, the BSC contains specific attainable benchmarks. Year-to-year success is measured by the rate of improvement in individual indicators.<sup>178</sup> The upper-level benchmark of any given indicator is set to the level that at least six provinces achieved in 2004 – the equivalent of the top twentieth percentile – while the lower benchmark of the indicator is set to the level achieved by the province above the lowest quintile in 2004.

Data from the national-level findings can be found in Table 16 at the end of this paper. Each statistic is in percentage-form and individual cells within the table are color-coded to indicate whether they fell above or below the upper or lower benchmarks. Cells colored green signify that a specific indicator was ranked above the upper benchmark while cells colored red signify that a specific indicator was ranked below the lower benchmark. Cells colored yellow signify that a specific indicator was ranked between the upper and the lower benchmarks. The national-

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<sup>177</sup> Eldridge, Cynthia and Palmer, Natasha. "Performance-based payment: some reflections on the discourse, evidence and unanswered questions." *Health and Policy Planning*, Vol. 24. 2009, p. 162

<sup>178</sup> Johns Hopkins University Bloomberg School of Public Health. "Afghanistan Health Sector Balanced Scorecard: National and Provincial Results." 2006, p. 1

level findings are a combined average of each province, however, and therefore the data in Table 16 is not able to fully capture province-by-province differences in the quality of health facilities. The full BSC contains similar data broken down by individual provinces with detailed analysis of different findings in each of the six categories: patients and community, staff results, capacity for service provision, service provision, financial systems, and overall vision.

In the province of Nangarhar, for example, the percentages of facilities providing care in compliance with the services expected in the BPHS increased from 6.5 percent in 2004 to 71.2 percent in 2008, marking a significant improvement in efforts to standardize care nationwide.<sup>179</sup> This can be found under indicator 24 on Table 17 at the end of this paper. Nangarhar fell below the lowest quintile for this indicator in 2004 and 2005, but has consistently scored well above the upper benchmark since 2006, giving it a spot in the upper quintile for this particular indicator. In all five years studied, Nangarhar reached or surpassed the upper benchmark in assessments of laboratory functionality, meeting minimum staff guidelines, and the number of facilities in the province with a register of patients with TB, as shown in indicators 9, 10, and 17 on Table 17. Laboratory functionality in particular has been very successful in Nangarhar, with the score for this indicator more than doubling by 2008 when compared to 2004.<sup>180</sup>

On the other hand, overall patient satisfaction, assessed through observations of patient-provider interactions and exit interviews and shown in indicator 1 on Table 17, has markedly declined. Improvements in drug availability – indicator 7 on Table 17 – have been relatively stagnant, and facility infrastructure – indicator 15 of Table 17 – was deficient in 2005 and 2006 but has since shown signs of improvement.

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<sup>179</sup> Johns Hopkins University Bloomberg School of Public Health. “Afghanistan Health Sector Balanced Scorecard.” 2008, p. 89

<sup>180</sup> Ibid, p. 90

In the 2008 BSC, the methodology for measuring health worker knowledge was revised to include an assessment of the knowledge of vaccinators, resulting in two separate incomparable indicators for this measurement: indicators 11 and 11a on both tables. This change was made as a result of input from the MoPH, donor agencies, and NGOs working to provide services under the BPHS.<sup>181</sup> In addition to this change, the new mean score excludes indicators assessing the availability of user fee guidelines and exemptions for poor patients – indicators 25 and 26 on both tables – due to the efforts by the MoPH to eliminate user fees entirely. For this reason, the two sample BSCs below include two mean scores: one using all 29 indicators from 2004 until 2007 and the other using only 26 of the 29 indicators for the year 2008, though mean scores have since been recalculated for the previous four years to exclude these three indicators. In indicators where data is unavailable due to this change in methodology, cells have been shaded grey and are marked as not being compatible with that particular indicator.

Between 2004 and 2008, the MoPH witnessed significant improvements in the ability to attain most benchmarks in just about every province. In 2008, the national median score of the 26 consistent indicators was over 70 percent, a 20 percent increase from 2004.<sup>182</sup> Aside from Kabul, every province's mean score exceeded 60 percent, and Kabul's score was less than four percentage points below at 56.1 percent.<sup>183</sup> Excluding Kabul, every province has seen an increase in mean score of at least ten points in the past five years, and 15 provinces have seen an increase in over 20 points. 22 of the 29 observed provinces experienced improvements from 2007 to 2008. Though the results for Kabul in 2008 were disappointing, it has performed very

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<sup>181</sup> Ibid, p. 8

<sup>182</sup> Ibid, p. 49

<sup>183</sup> Ibid, pp. 49, 75

well in previous rounds of the BSC and surpassed 62 percent of the upper benchmarks in 2006.<sup>184</sup>

The national median province met 57.7 percent of the upper benchmarks of each indicator in 2008, compared to a mere 15.4 percent in 2004.<sup>185</sup> In particular, improvements were notable in the availability of antenatal care, the number of new outpatients received at BHCs, the number of facilities with a TB register, and the ability of facilities to provide care based upon BPHS standards.<sup>186</sup> Other areas that demonstrated considerable progress included the accessibility of essential drugs and family planning services, laboratory and equipment functionality, provider knowledge, and staff training. The indicator assessing time spent with patients, which had been declining considerably in 2005 and 2006, saw a dramatic uptick in 2007 and increased further in 2008. There were, however, declines in the indicator tracking the disposal of sharp objects, facility infrastructure, and equity of satisfaction between the poor and non-poor, although this last decrease was very slight.<sup>187</sup> Despite the gap in satisfaction between poor and non-poor recipients of treatment, the analysis indicates that overall patient satisfaction is generally high.

Overall, the BSC has been a valuable tool to measure improvements in the availability of health services. It has demonstrated the success in efforts to expand the BPHS and improve the delivery of services. Further, it allows for provinces to be aware of the areas in which they are lacking and provide them with attainable goals towards which to aim. But improvements in the quality of services do not equate to an improvement in the quality of overall health. The BSC is not an indicator used to measure improvements in MMR, nor is a reduction in such an indicator

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<sup>184</sup> Ibid, p. 76

<sup>185</sup> Ibid, p. 8

<sup>186</sup> Ibid, p. 7

<sup>187</sup> Ibid, p. 15



necessarily a goal. Instead, it focuses on improving the services and facilities that can result in indirect reductions in MMR.

In this sense, improvements in the availability of antenatal care and family planning services does not mean that maternal health will improve, since improvements will only materialize if there is a considerable increase in women utilizing health services and facilities for issues related to maternal health. The most recent report from the United Nations Population Division estimated that only 18.6 percent of Afghans used contraceptives, with 8.1 percent using birth control pills and 5.4 percent using condoms.<sup>188</sup> Furthermore, according to the 2003 Multiple Indicator Cluster Survey (MICS) organized by UNICEF, nearly 90 percent of births are performed in the home rather than in health facilities, and three out of four births are attended only by relatives and friends rather than trained health workers.<sup>189</sup> The MICS also found that only 16 percent of women receive antenatal care from a doctor or nurse.<sup>190</sup> Most women either visited relatives and friends for antenatal care or did not receive any such care at all. In this sense, improvements in the quality of health services for women will do little to improve overall health if women do not fully utilize such services.

### **3.7 VERTICAL PROGRAMS AS COMPLEMENTS TO THE BASIC PACKAGE**

For the time being, some major health issues such as immunization, nutrition, and malaria, TB, and HIV/AIDS control are not fully integrated into BPHS, and are often handled vertically in collaboration with UN agencies such as UNICEF, WHO, the United Nations Population Fund

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<sup>188</sup> World Contraceptive Use: 2009. Fertility and Family Planning Section United Nations Population Division.

<sup>189</sup> Multiple Indicator Cluster Survey: Afghanistan. UNICEF. 2003, p. 2

<sup>190</sup> Ibid, p. 6

(UNFPA), and the Global Fund. These agencies work to provide technical assistance in the delivery of these services and sometimes fund vertical programs of their own.<sup>191</sup> Though the MoPH fully intends to continue its long-term goal of expanding the BPHS both in content and geographic coverage, the central government will “continue to strengthen the vertical programs and campaigns that ensure blanket coverage of simple but effective interventions such as salt iodination, polio, and tetanus immunization and vitamin A distribution.”<sup>192</sup>

In the 2003 publication of the BPHS, the MoPH wrote that the ministry “recognizes that the massive task of rebuilding the national health system means that it may not have all the resources required to implement all of the BPHS elements simultaneously.”<sup>193</sup> In particular, the MoPH noted, efforts to address mental health and disabilities make a “smaller contribution to reduction of preventable mortality in comparison with other elements of the BPHS,” and therefore have a status as “second-tier” services in the BPHS.<sup>194</sup> While the reasoning behind this decision is perhaps sensible and the ability for the MoPH to improve services across the entire sector will no doubt take some time to fully phase in, the prevalence of severe depression in Afghanistan – especially among women – makes the issue of mental health one in urgent need of attention. The MoPH has since announced its intention to integrate the aforementioned vertical programs into the BPHS and to work to improve services for mental health, care for the disabled, and HIV/AIDS prevention.<sup>195</sup> In the summer of 2010, the MoPH began working in collaboration with HealthNet TPO to train health workers in mental health topics including depression,

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<sup>191</sup> “Afghanistan: The role of contractual arrangements in improving health sector performance.” World Health Organization, Regional Office for the Eastern Mediterranean, p. 2

<sup>192</sup> “Health Systems Profile: Afghanistan.” World Health Organization. 2006, p. 7

<sup>193</sup> “A Basic Package of Health Services for Afghanistan.” Transitional Islamic Government of Afghanistan, Ministry of Health. 2003, p. 9

<sup>194</sup> Ibid

<sup>195</sup> “Afghanistan: The role of contractual arrangements in improving health sector performance.” World Health Organization, Regional Office for the Eastern Mediterranean, p. 7

anxiety, psychosis, learning disabilities, and substance abuse disorders as a part of its effort to further integrate mental health services into the BPHS.<sup>196</sup> In total, 19 doctors and 13 doctors received training. These efforts are laudable and the MoPH should work to further expedite the incorporation of mental health services into the BPHS.

In this sense, efforts to expand the BPHS in both scope and breadth exemplify the key question of improving the delivery of health care: is it more effective to rely on vertically-driven health programs in the short term to improve health conditions at the expense of improving the health sector across the board, or is it more effective to emphasize an expansion of both services and coverage sector-wide at the expense of targeting particular topics in health that require the most urgent need? The fact that the MoPH has relied so consistently on assistance from UN agencies since 2002 while working to improve the delivery of health services sector-wide is an indication of the ministry's perspective: both approaches have their merits and both approaches work well to save lives. Rather than view vertical programs as a sound short-term solution and a sector-wide approach as the long-term goal, however, the MoPH should work to incorporate the most effective portions of each approach into a more comprehensive health strategy. This will be discussed in greater detail later on.

Without a doubt, the BPHS is a sector-wide approach to improving health care in Afghanistan. A sector-wide approach has been the intention of policymakers from the start and continues to be the long-term objective. In the short-term, however, the MoPH has utilized available resources in a practical and sensible manner by relying on assistance from UN agencies to launch and implement targeted vertical programs with a focus on health crises such as immunization and nutrition. These efforts have produced significant improvements in

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<sup>196</sup> "To provide psychiatry services in provincial hospital, a number doctors received training." Ministry of Public Health Online. Islamic Republic of Afghanistan. 10 July 2010.

immunization rates and demonstrated that, despite the fact that a vertical program's narrow focus can limit its ability to provide comprehensive improvements in health, such efforts have successfully brought health services into the homes of at-risk communities, especially pregnant women and children.

### **3.8 IMMUNIZATION CAMPAIGNS AND VERTICAL PROGRAMS**

Efforts to eradicate measles and polio through vertical campaigns have shown considerable signs of success. In 2000, prior to the collapse of the Taliban, 35 percent of target populations in Afghanistan were vaccinated against measles and 32 percent had received three doses of the polio vaccine, the amount necessary to ensure nearly 100 percent seroconversion and immunity.<sup>197</sup> While that percentage is relatively low, measles and polio vaccination rates under the Taliban regime were boosted significantly in central Afghanistan by a targeted immunization campaign organized by UNICEF and the WHO from the summer of 2001 until the spring of 2002.<sup>198</sup>

Vaccination teams in Afghanistan operated out of mosques to establish fixed-post vaccination sites. Due to the trusted role of mosques in Afghan society, vaccinators were able to keep people informed of the location of the vaccination post, aware of its hours of operation, and willing to visit the site. No mosques refused to be used as an immunization site, allowing for

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<sup>197</sup> World Health Organization Vaccine-Preventable Diseases Monitoring System. Immunization Profile – Afghanistan, 2009 statistics

<sup>198</sup> Dadgar, N. and Ansari, A. and Naleo, T. et al. "Implementation of a mass measles campaign in central Afghanistan, December 2001 to May 2002." *The Journal of Infectious Diseases*. Vol. 187, Supplement 1. 2003, p. S187

response teams to have a consistent strategy across the country.<sup>199</sup> Another benefit of mosques as fixed-post sites was the presence of loudspeakers at most locations, which were used to inform residents of vaccination efforts in their community.

Through the targeted immunization campaign in central Afghanistan, response teams vaccinated as many as 200 children per day, covering an estimated 77 percent of age-eligible children. Two of the five central-region provinces had coverage of over 90 percent and two had coverage of over 80 percent.<sup>200</sup> Coverage in Kabul was rather low – 62 percent – but it is believed that the population of the region was lower than estimated as a result of many families fleeing the city in late 2001. Vaccination for children ages five through twelve was also lower than expected, but there is reason to believe that stunting could explain the discrepancy.

“Consistent misclassification of children as younger than their true age would inflate the number of children aged 6 – 59 months vaccinated and decrease the number in the 5- to 12-year age group,” the study notes.<sup>201</sup>

By 2008, 75 percent of targeted populations were vaccinated against measles and 85 percent were vaccinated against polio nationwide.<sup>202</sup> Efforts to increase immunization percentages throughout Afghanistan’s 329 districts have shown success year after year, as Chart 4 below demonstrates. These annual increases in immunization rates are the work of vertical campaigns – run by UN agencies working as a complement to the BPHS – that systematically target particular health crises and work to reduce their urgency.

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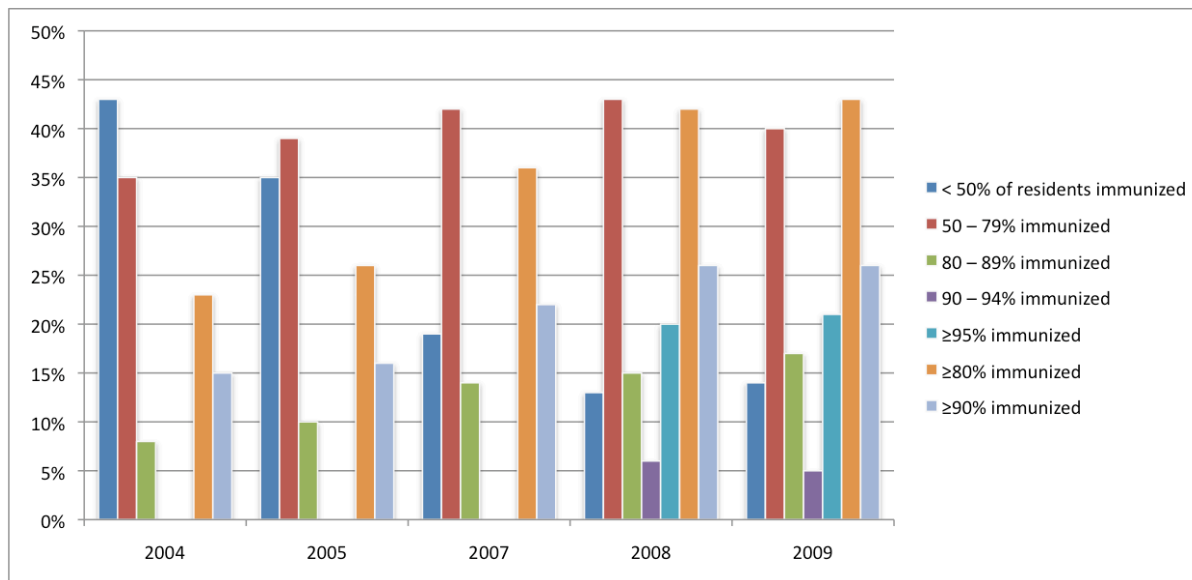
<sup>199</sup> Ibid, p. S188

<sup>200</sup> Ibid, p. S189

<sup>201</sup> Ibid, p. S190

<sup>202</sup> World Health Organization Vaccine-Preventable Diseases Monitoring System. Immunization Profile – Afghanistan, 2009 statistics

**Figure 4: Annual\* Percentages of Districts Vaccinated Against Measles, by Percentage of District's Population Covered†**



Source: World Health Organization, Immunization Profile – Afghanistan

\*NOTE: Statistics for 2006 are unavailable, no districts reported immunization efforts to the WHO for this year  
 †NOTE: Statistics for earlier years appear to contain gaps and redundancies while statistics for later years appear to add up to more than 100% due to year-to-year inconsistencies in record keeping. For the years 2004, 2005, and 2007, statistics are broken down into the categories of: less than 50%, 50 – 79%, 80 – 89%, ≥80%, and ≥90%. For the years 2008 and 2009, statistics include additional breakdowns of 90 – 94% and ≥95%. For this reason, the percentages of the green, purple, and cerulean-colored bars are included in the orange-colored bar, and the purple and cerulean-colored bars are included in the teal-colored bar on the far right.

Other vertically-driven immunization campaigns have shown considerable signs of progress. In 2009, a team of 20,000 health workers vaccinated 2.8 million children in three days, using a brand new polio vaccine that immunizes against two separate strains of the disease.<sup>203</sup> Not only was this campaign successful based on the number of children vaccinated given the short timeframe, but the efforts were endorsed by the Taliban insurgency in a written letter of support issued through the ICRC.<sup>204</sup> Anti-government insurgents fighting in Afghanistan rarely negotiate with aid agencies, and have even killed aid workers in targeted attacks.<sup>205</sup> Vaccinators also

<sup>203</sup> “Immunization campaign in Afghanistan aims to eradicate polio and empower women.” UNICEF online: Afghanistan Newline. 18 February 2010.

<sup>204</sup> “Afghanistan: Taliban gives nod to polio immunization in south.” IRIN News. 14 September 2009

<sup>205</sup> “Taliban kill 5 in attack on aid group.” Los Angeles Times. 3 July 2010

worked to expand National Immunization Days (NIDs) throughout Afghanistan, with six separate NIDs in 2009 alone.<sup>206</sup>

Overall, policy experts were optimistic that the efforts to boost immunization rates in Afghanistan were showing signs of success. “The success of National Immunisation Days may well eliminate polio from Afghanistan in the next year or two,” wrote Ronald Waldman and Homaira Hanif, two policy experts at the AREU. Waldman and Hanif, acknowledging that polio does not significantly contribute to Afghanistan’s high mortality rates, continued: “In contrast [to efforts to eradicate polio], the implementation of the measles mortality reduction strategy that targets children from the age of six months in specific geographic areas...can have a substantial impact, if sustained.”<sup>207</sup>

These vertical campaigns have done more than just boost immunization rates: it provided people who often do not utilize health services with necessary preventative treatments and worked to further solidify the presence of health workers at the community level. In this sense, vertical campaigns have been essential in efforts to reach out to at-risk communities and further legitimize the role of health workers in remote areas.

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<sup>206</sup> “Afghanistan: Taliban gives nod to polio immunization in south.” IRIN News. 14 September 2009

<sup>207</sup> Waldman, Ronald et al. “The Public Health System in Afghanistan,” p. 7

#### **4.0 POLICY AND FUTURE PLANNING**

Without a doubt, considerable progress has been made in improving the quality and scope of services delivered in health facilities in Afghanistan. In particular, the availability of care has been expanded significantly in a very short period of time, year-to-year improvements have been steady across most provinces, and the MoPH has made great strides in working to standardize care nationwide to ensure that the residents of each province have access to the same services. But improvements in health systems alone do not result in improvements in overall health. Mortality rates in Afghanistan remain high and the benefits of improving the health sector risk going unnoticed by the Afghan people if further efforts are not made to promote the utilization of health services, especially by pregnant women. Working to further incorporate at-risk populations such as pregnant women into the health sector will result in declining mortality rates and further work to legitimize the efforts of the government by demonstrating its capacity to provide essential public services. In keeping with this, several issues must be considered and addressed in order to ensure that health is addressed in a comprehensive and all-inclusive fashion.



#### 4.1 THE DOWNWARD PUSH OF SERVICES TO THE COMMUNITY LEVEL

Despite considerable progress in efforts to improve access to health services, many Afghans live in regions where health facilities are extremely scarce. In Uruzgan, for example, the province shares one provincial hospital, five CHCs, five BHCs, and one sub health center, the lowest amount out of any province.<sup>208</sup> Uruzgan also has a low level of doctors, with 0.01 for every 1,000 people.<sup>209</sup> Not surprisingly, Uruzgan also has the second highest U5MR in the country, with three out of every ten children not living long enough to reach the age of five.<sup>210</sup> As a partial solution, the MoPH must work to provide as many health services as possible in smaller health facilities to ensure that residents of remote regions have access to services. While many of the services provided by the MoPH require a level of expertise that exceeds the training of CHWs and TBAs, emergency care services that do not require extensive medical training must be placed in the hands of health workers at the community level to ensure a broader expansion of care.

Ensuring that CHWs and TBAs are trained to diagnose and treat potentially fatal conditions such as diarrhea through oral rehydration, pneumonia through antibiotics, or malaria through chloroquine will help to keep mortality rates low.<sup>211</sup> The primary strain of the malaria virus in Afghanistan is *P. vivax*, which makes up roughly 80 percent of recent diagnoses and is sensitive to chloroquine.<sup>212</sup> While the chloroquine-resistant *P. falciparum* is believed to be on the rise, malaria-related mortality rates could decline through diagnosis and treatment in nearby facilities

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<sup>208</sup> “List of active health facilities by province: Uruzgan.” Ministry of Public Health. Islamic Republic of Afghanistan. 2009, p. 1

<sup>209</sup> Evans, Anne et al. “A Guide to Government in Afghanistan,” p. 139

<sup>210</sup> “Best estimates provincial fact sheet: Uruzgan.” UNICEF in Afghanistan

<sup>211</sup> Waldman, Ronald et al. “The Public Health System in Afghanistan,” p. 15

<sup>212</sup> Wallace, Mark R. and Hale, Braden R. and Utz, Gregory C. et al. “Endemic infectious disease in Afghanistan.” *Clinical Infectious Diseases*. Vol. 34, No. 5. 2002, p. S173

followed by a referral to a BHC if the condition has not improved within 24 hours.<sup>213</sup> In an assessment of the Afghan health system, AREU experts Ronald Waldman and Homaira Hanif discussed the merits of pushing down health services, arguing that the health system will “probably have to become more flexible, more permissive and more creative in the future” in order to improve the delivery of basic services.<sup>214</sup>

## 4.2 LIMITATIONS OF HORIZONTAL AND VERTICAL APPROACHES

The use of vertical campaigns to address immunization and, at a broader level, child health in Afghanistan has demonstrated just how successful policymakers can be when working to combat particular crises within the broader field of health. But vertical campaigns come with a considerable number of burdens and limitations. The most obvious limitation of a vertical program is the potential resulting gap in quality of care if one particular issue is targeted at the expense of an effort to improve the system as a whole. In an assessment on recent efforts by the WHO to expand collaboration with organizations in the private sector, critics of such an effort feared that the result of such collaboration could be the presence of “islands of excellence in seas of underprovision.”<sup>215</sup> Such concerns may be aptly used to describe vertical programs in health systems, since efforts to target issues such as immunization vertically “does not address health as more than the absence of disease.”<sup>216</sup> Vertical programs also run the risk of creating

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<sup>213</sup> Waldman, Ronald et al. “The public health system in Afghanistan,” p. 15

<sup>214</sup> Ibid, p. 16

<sup>215</sup> Buse, Kent and Waxman, Amalia. “Public-private health partnerships: a strategy for WHO.” *Bulletin of the World Health Organization*. No. 79. 2001, p. 750

<sup>216</sup> Magnussen, Lesley and Ehiri, John and Jolly, Pauline. “Comprehensive versus selective primary health care: Lessons for global health policy.” *Health Affairs*. Vol. 23, No. 3. 2004, p. 170

redundancies and duplication, since such programs are often managed by separate organizations rather than in collaboration with other actors in the field of health. This, of course, results in wasted funding, which is already scarce.

But horizontal sector-wide approaches also come with certain risks. Though vertical programs might be wasteful and result in gaps in quality of care, efforts to improve the health system as a whole do not necessarily result in improvements for mortality rates if health services are not being effectively utilized. “The logic of doing a few things well rather than many things badly is undeniable,” one author said while discussing the merits of vertical programs.<sup>217</sup> Another author noted that, while vertical programs may result in “fragile, isolated islands of sufficiency,” horizontal programs may lead to “generalized insufficiency,” with no signs of progress anywhere.

Sector-wide approaches to improve health, such as the BPHS in Afghanistan, are fairly new approaches that only began to pick up steam in the 1990s – due in part to advocacy for such an approach by the World Bank – and remain largely untested worldwide. Efforts to improve health in a horizontal fashion tend to rely heavily on leadership and regulation by the national government of a developing country, as is the case in Afghanistan. This requires a government with the managerial capacity to effectively lead – an area in which a state as fragile as Afghanistan is admittedly deficient. Such an approach further risks the possibility of being implemented in a top-down bureaucratic fashion, something that may be a cause for concern in Afghanistan.

However, efforts to improve conditions sector-wide run the risk of neglecting the main health priorities in a region. Indeed, a recent report from the organization Advocacy to Control

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<sup>217</sup> Goodburn, Elizabeth and Campbell, Oona. “Reducing maternal mortality in the developing world: sector-wide approaches may be the key.” *British Medical Journal*. Vol. 322, No. 7291. 2001, p. 918

Tuberculosis Internationally (ACTION) assessing the ability of sector-wide reforms in health to address TB in sub-Saharan Africa found that “the World Bank and its development partners urgently need to adjust their approach to [sector-wide approaches] if [they] are to effectively and efficiently produce better health outcomes.”<sup>218</sup> ACTION’s report continued, stating that it was “difficult to find evidence that [sector-wide approaches] were enabling improvements in health outcomes” at all, let alone in efforts to combat the transmission of TB.<sup>219</sup> Moreover, ACTION argued, since this approach is intended to improve health conditions sector wide, their findings on the inability for a sector-wide approach to show improvements in combating TB raise doubts about its ability to effectively tackle any individual health indicator within a system as a whole.<sup>220</sup> With these findings in mind, the BPHS in Afghanistan – a sector-wide approach by definition – should include a stronger focus on maternal health, since conditions for mothers in Afghanistan are the most in need of attention.

This disagreement is one of the defining fights of health policy: vertical health programs may work in the short term to improve health indicators but these improvements may not be sustainable without continuous efforts directed towards improving the health sector across the board; at the same time, efforts aimed at improving the health system run the risk of ignoring particular crises that require the most urgent need, and can only be successful if people actually further utilize the services that are being improved.

As a middle approach to this debate, many policy experts have recently been advocating for what is considered to be a “diagonal” approach to improving health: using vertical and targeted

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<sup>218</sup> Skolnik, Richard and Jensen, Paul and Johnson, Robert. “Aid Without Impact: How the World Bank and Development Partners are Failing to Improve Health Through SWAps.” *Advocacy to Control Tuberculosis Internationally*. 2010, p. 4

<sup>219</sup> Ibid

<sup>220</sup> Ibid, p. 2

outreach efforts intended to seek out at-risk communities and further incorporate them into the improving health sector. This approach, which would require teams of workers participating in the type of door-to-door efforts seen in vertical campaigns, would work to educate rural communities about the need for health services, particularly in regard to topics such as maternal and child health, HIV/AIDS prevention, and nutrition to combat preventable diseases. At the same time, governments and donor agencies can work to improve the conditions of the health sector, make facilities more accessible, expand the availability of health services, and improve the managerial capacity of facilities.

Julio Frenk, former Minister of Health in Mexico and current Dean of the Harvard School of Public Health, urged in a 2006 speech to the WHO in Kenya for the consideration for a diagonal approach to health services and called for policy experts to transcend the “false dichotomies” of the horizontal-vertical debate.<sup>221</sup> The result, Frenk continued, would be a comprehensive strategy that uses “explicit intervention priorities to drive the required improvements into the health system” and place the topic of health at the center of a broader social agenda.<sup>222</sup>

But such an initiative – working to implement community-level door-to-door efforts intended to boost the utilization of health services in Afghanistan – would require considerable manpower and the continued presence of health workers in local communities to keep referral rates high. Currently, the number of women in Afghanistan who give birth under the attendance of a health worker, either trained or untrained, is disturbingly low, and births performed within the home make up the vast majority of cases. This is due in part to cultural practices and in part to lack of awareness of the need for medical care and the potential risks and complications of a pregnancy.

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<sup>221</sup> Frenk, Julio. “Bridging the divide: comprehensive reform to improve health in Mexico.” WHO Commission on Social Determinants of Health. 2006, p. 4

<sup>222</sup> Ibid, p. 5

There is little doubt that the low number of births performed with the presence of a skilled attendant presents a considerable obstacle in efforts to reduce mortality rates.

What is needed in Afghanistan, therefore, is an increased number of community-level health workers – ones with knowledge of and experience in dealing with pregnancy, even if they possess little to no training. Unfortunately, due largely to the regressive policies of the Taliban, which forbade women the right to work outside the home or enroll in schools, there are few female workers operating in the health sector at all. Efforts to further train female health

workers have been slow, since training takes many years and many Afghan women are illiterate. This places efforts to improve health conditions in Afghanistan in a considerable bind: mortality rates will not see any

**Table 11: Percentage of births attended, by skill level of health worker**

Type of Attendant	% of Births Attended
Doctor, midwife, nurse	8.0%
Trained or untrained TBA	8.8%
Relatives, friends, others	83.1%

*Source:* "Maternal health services at the community level in Afghanistan: Who should provide these services?" Reproductive Health Task Force. Ministry of Health. Transitional Islamic Government of Afghanistan. 2003

significant improvement without further efforts to increase the percentage of births performed outside of the home, cultural sensitivities make it difficult for such efforts to be done by men, and female health workers are incredibly scarce.

Considering these obstacles, the central government must work to further incorporate women into the health sector and utilize every available resource to increase the percentage of births performed under the attendance of a health worker with some degree of experience in childbirth if it hopes to see any reduction in maternal mortality. To improve these efforts, the central government should work to further incorporate the efforts of TBAs into the health system, streamline their training, and supervise their activities. These women are often the first point of contact between pregnant mothers in rural communities and the health sector as a whole and

should be used as part of a vertical outreach campaign to further educate mothers on healthy lifestyle practices.

As part of a diagonal approach to improve health in Afghanistan, the central government could use TBAs as local messengers, emphasizing the need for the utilization of health services, the warning signs of a pregnancy, and the importance of breastfeeding. TBAs can also work to provide vitamins and nutrition to pregnant mothers and infants, educate about the prevention of sexually-transmitted infections (STIs), or even to supply pregnant women with delivery kits of basic supplies. Just like vaccinators in vertical immunization campaigns, TBAs can travel door to door to provide women with the basic services they need to be healthy.

TBAs must be used to fill in the gaps that result from the severe shortage of qualified midwives in Afghanistan. Furthermore, though it is obviously not desirable, TBAs should be prepared to handle pregnancies in cases where women either refuse to give birth outside of the home or simply cannot do so in a health facility due to inaccessibility. TBAs are often illiterate and lack the necessary medical expertise to handle complex pregnancies and provide EOC, but the MoPH must accept that having attendance by an untrained or poorly trained worker is likely better than having no attendance at all. Starting as early as the 1970s, UNFPA began working to further improve the training of TBAs in an effort to improve maternal and child health worldwide. This effort soon became known as the Safe Motherhood Initiative.

### 4.3 THE SAFE MOTHERHOOD INITIATIVE AND TRADITIONAL BIRTH ATTENDANTS

In 1987, public officials from developing countries across the world met with representatives from UNFPA, the World Bank, and the WHO in Nairobi, Kenya to discuss issues of maternal health. This meeting, known as the International Conference on Safe Motherhood, was the first conference of the Safe Motherhood Initiative (SMI), and the first summit in which the international community focused exclusively on women's issues and maternal health.<sup>223</sup> By the mid 1990s, however, efforts to seek a global consensus on issues of safe motherhood began to fall apart due to resistance from donors towards funding broad and complex programs on women's health, heated debates surrounding the contentious issue of abortion, and a lack of commitment from political leaders unwilling to prioritize an agenda that advanced the conditions of women.<sup>224</sup>

Women's rights advocates emphasized the need for a broad approach to reduce maternal mortality, advocating for a wide array of goals for the SMI, some of which were feasible and others perhaps a bit quixotic. These ideas included topics ranging from the education of young girls, the prevalence of early marriage, and the social standing of women in society – issues that, despite being clearly linked to women's health, resided outside of the scope of any one UN agency or national health ministry. Many of the goals of the SMI were so broad as to require collaboration between ministries of health, education, and women's affairs – agencies that often compete with one another for funding rather than collaborate for projects. Due to the structure of

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<sup>223</sup> "Safe Motherhood Initiative in Afghanistan: Summary of assessment findings and recommendations." UNICEF. 2000, p. 4

<sup>224</sup> Starrs, Anne M. "Safe motherhood initiative: 20 years and counting." *The Lancet*. Vol. 368, No. 9542. 2006, p. 1132



UN agencies, the topic of maternal health was, in many respects, a crisis without a home. UN efforts on health rely on agencies such as the WHO, which does not specialize exclusively in women's health, UNICEF, which focuses on children, and UNFPA, which focused more on population growth than reproductive health until the 1994 International Conference on Population and Development.<sup>225</sup>

By the end of the first decade, the results of the SMI were widely seen as being unsuccessful. Critics noted that countries implementing policies based on the recommendations of the SMI had failed to demonstrate reductions in their MMR.<sup>226</sup> Others argued that, due to the overly broad goals of the SMI, the approach was burdened by efforts to seek too many reforms in too many sectors in too short of a time frame.<sup>227</sup>

In many countries, including Afghanistan, a goal of the SMI was to improve the training of TBAs in an effort to reduce MMR.<sup>228</sup> Though most TBAs are illiterate and lack basic medical training, most are older women with children of their own and are trusted members of the communities in which they live.<sup>229</sup> There is considerable variation in training techniques throughout the world and the depth and style of training may vary based upon the instructor in charge of such a training program. Individuals, NGOs, or national and local governments can serve as TBA trainers and often possess standards and objectives unique to their institution. Training can last for several days or several months, and can include routine supervision and updates in education and techniques. Some TBA training programs also include services such as

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<sup>225</sup> Ashford, Lori S. "What was Cairo? The promise and reality of ICPD." Population Reference Bureau. 2001.

<sup>226</sup> Liljestrand, Jerker and Pathmanathan, Indra. "Reducing Maternal Mortality: Can We Derive Policy Guidance from Developing Country Experiences? Critical Elements in Reducing Maternal Mortality." *Journal of Public Health Policy*. Vol. 25, No. 3/4. 2004, p. 302

<sup>227</sup> Starrs, Anne M. "Safe motherhood initiative," p. 1131

<sup>228</sup> "Safe Motherhood Initiative in Afghanistan: Summary of assessment findings and recommendations." UNICEF. 2000, p. 9

<sup>229</sup> "Support to traditional birth attendants." United Nations Population Fund. 1996, p. 1

prevention, screening, and referral, though most TBAs are not trained to handle maternal or neonatal complications such as postpartum hemorrhage or birth asphyxia.<sup>230</sup> Due to their lack of medical training, however, TBAs often work in resource-poor environments and lack essential materials and skills to handle EOC.

In just a few years, however, experts grew skeptical that training TBAs would demonstrate any significant reduction in MMR, and the effort was widely viewed as wasteful and ineffective by the late 1990s.<sup>231</sup> Along with the general consensus that the SMI had failed to produce demonstrable results, many countries began to scale down efforts to train TBAs in favor of training skilled midwives.<sup>232</sup> Afghanistan was one of these countries and expressed concerns that TBAs “do not possess the necessary skills to manage the obstetrical complications that can result in maternal mortality.”<sup>233</sup>

This decision to discontinue the training of TBAs in many countries and the consensus that the SMI has been unsuccessful may have been premature, however. A recent study on the effectiveness of TBA training to reduce maternal and perinatal mortality in Pakistan found that effective training of TBAs led to a 30 percent reduction in stillbirths and neonatal deaths.<sup>234</sup> The study found similar results for MMR reduction with a 25 percent decline in maternal death. Some of the findings from this study can be found in Table 13 below. However, despite the

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<sup>230</sup> Sibley, LM and Sipe, TA and Brown, CM et al. “Traditional birth attendant training for improving health behaviors and pregnancy outcomes (review).” *The Cochrane Collaboration*. No. 3. 2007, p. 2

<sup>231</sup> “Maternal Health Services at the Community Level in Afghanistan: Who should provide these services?” Transitional Islamic Government of Afghanistan, Ministry of Health, Reproductive Task Force. 2003, p. 2

<sup>232</sup> Starrs, Anne M. “Safe motherhood initiative,” p. 1130

<sup>233</sup> “Maternal Health Services at the Community Level in Afghanistan” Transitional Islamic Government of Afghanistan. 2003, p. 2

<sup>234</sup> Jokhio, Abdul Hakeem and Winter, Heather R. and Cheng, Kar Keung. “An intervention involving traditional birth attendants and perinatal and maternal mortality in Pakistan.” *The New England Journal of Medicine*. Vol. 352. 2005, p. 2096

study's large sample size, the number of maternal deaths in the study was relatively small.<sup>235</sup> As a result, the authors admitted, the study does not necessarily demonstrate a decline in MMR, though the study was not designed to detect a variation in such a small and difficult indicator to measure.<sup>236</sup> After all, though maternal mortality is an urgent global concern, it is statistically infrequent and therefore extremely difficult to accurately monitor.

**Table 12: Maternal and perinatal deaths and mortality rates according to study group**

	Singleton births*				Women
	Perinatal deaths – no. (no. per 1,000 live births and stillbirths) <sup>†</sup>	Stillbirths – no. (no. per 1,000 live births and stillbirths) <sup>‡</sup>	Neonatal deaths – no. (no. per 1,000 live births) <sup>§</sup>		Maternal deaths – no. (no. per 100,000 pregnancies) <sup>¶</sup>
<b>Intervention Group</b>					
<b>Cluster 1</b> (N = 3253)	232 (71)	130 (40)	102 (33)	Cluster 1 (N = 3408)	6 (176)
<b>Cluster 2</b> (N = 3835)	361 (94)	227 (59)	134 (37)	Cluster 2 (N = 3980)	15 (377)
<b>Cluster 3</b> (N = 2622)	230 (88)	126 (48)	104 (42)	Cluster 3 (N = 2704)	6 (222)
<b>Total</b> (N = 9710)	823 (85)	483 (50)	340 (37)	Total (N = 10,092)	27 (268)
<b>Control Group</b>					
<b>Cluster 4</b> (N = 2686)	266 (99)	149 (55)	117 (46)	Cluster 4 (N = 2794)	11 (394)
<b>Cluster 5</b> (N = 1947)	296 (152)	178 (91)	118 (67)	Cluster 5 (N = 2061)	8 (388)
<b>Cluster 6</b> (N = 1879)	224 (119)	143 (76)	81 (47)	Cluster 6 (N = 1965)	7 (356)
<b>Cluster 7</b> (N = 2477)	291 (117)	168 (68)	123 (53)	Cluster 7 (N = 2612)	8 (306)
<b>Total</b> (N = 8989)	1077 (120)	638 (71)	439 (53)	Total (N = 8989)	34 (360)

\* Perinatal outcomes are for singleton births only  
† Perinatal deaths were defined as stillbirths or live-born infants who died within 28 days after birth  
‡ Stillbirths were defined as fetuses born after six months that never showed signs of life  
§ Neonatal deaths were defined as live-born babies who died within 28 days after birth  
¶ Maternal deaths were defined as death of the mother during pregnancy, delivery, and up to six weeks postpartum, excluding deaths known to be due to injury or accident

*Source: Jokhio, Abdul Hakeem and Winter, Heather R. and Cheng, Kar Keung. "An intervention involving traditional birth attendants and perinatal and maternal mortality in Pakistan." The New England Journal of Medicine. Vol. 352. 2005, p. 2097*

<sup>235</sup> Ibid, pp. 2094, 2097

<sup>236</sup> Jokhio, Abdul and Winter, Heather and Cheng, K.K. et al. "Strategies for reducing maternal mortality." *The Lancet*. Vol. 368, No. 9553. 2006, p. 2122

The resulting reductions in stillbirths and neonatal deaths were significant, however, and have reignited the debate over the effectiveness of TBAs in the health sector. Separate from improvements in mortality rates, the study also found that more women in the experimental group were referred to health facilities due to recognized complications during pregnancy, an indication that TBAs could further work to improve the utilization of health facilities by pregnant women.<sup>237</sup>

The authors of the study noted that:

International bodies have moved away from further consideration of the role of TBAs in favour of skilled birth attendants for all. This stance might be the ideal to work towards, but evidence of successful implementation of this approach is so far rare and many years are likely to pass and many more mothers and babies to die, especially in rural parts of developing countries, before this ideal is achieved. The medical and traditional birth systems could be integrated rather than seen as mutually exclusive.<sup>238</sup>

Another recent report on the effectiveness of TBA training to improve maternal health noted that the results of the aforementioned study “provide evidence in support of TBA training in a rural setting with a functional health system.”<sup>239</sup>

In India, where efforts to train TBAs have gradually been phased out over the past decade, some health experts are advocating the reincorporation of TBAs back into the health sector. With the looming deadline for completion of the Millennium Development Goals, health experts in India are hoping that, despite their lack of medical training, TBAs can provide some basic services to pregnant women, alleviating some of the workload from scarce skilled midwives.<sup>240</sup>

Advocacy for renewed training of TBAs is not limited to India, however. Anthony Costello, head of the Centre for International Health and Development at University College London,

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<sup>237</sup> Ibid, p. 2096

<sup>238</sup> Jokhio, Abdul and Winter, Heather and Cheng, KK et al. “Strategies for reducing maternal mortality.” *The Lancet*. Vol. 368, No. 9553. 2006, p. 2122

<sup>239</sup> Sibley, LM et al. “Traditional birth attendant training for improving health behaviors and pregnancy outcomes (review),” p. 2

<sup>240</sup> Devraj, Ranjit. “Return of traditional birth attendants urged to meet MDG 5.” Inter-Press News. 14 October 2009

voiced his skepticism of the consensus that TBAs are an ineffective approach towards improving maternal health in a 2006 piece in *The Lancet*, arguing that international agencies and experts have persuaded governments to discontinue TBA training “without robust evidence” that such an approach is ineffective.<sup>241</sup> “Traditional birth attendants are not a substitute for midwives,” Costello wrote, “but they are the main provider of care during delivery for millions of women, especially in settings where mortality rates are high.”

Now, more than a decade after experts declared that the goals of the SMI – such as the training of TBAs – had been unsuccessful, the trend appears to be moving back in the direction of the SMI. Ann Starrs, founder of Family Care International, has said that, though progress has been slow in reducing MMR and that mistakes were made in the initial years of SMI policy planning, the SMI has worked to make maternal health a key issue in global health. “The perception that the Safe Motherhood Initiative failed is perhaps understandable from a superficial perspective,” Starrs wrote, “but that perception is nevertheless unfounded and unacceptable.”<sup>242</sup>

In Afghanistan, where TBAs are common, skilled midwives are scarce, and maternal mortality is overwhelmingly high, policy experts are turning to the SMI for answers. Waldman and Hanif noted in their assessment of health in Afghanistan that the goals of the SMI, with a “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.”<sup>243</sup> UNICEF has been running SMI projects in select provinces in Afghanistan for well over a decade. After the U.S. invasion of Afghanistan and subsequent collapse of the Taliban regime, UNICEF assessed the health conditions in Afghanistan in order to determine the progress of the SMI.

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<sup>241</sup> Costello, Anthony and Azad, Kishwar and Barnett, Sarah. “An alternative strategy to reduce maternal mortality.” *The Lancet*. Vol. 368. 2006, p. 1477

<sup>242</sup> Starrs, Anne M. “Safe motherhood initiative,” p. 1130

<sup>243</sup> Waldman, Ronald et al. “The public health system in Afghanistan,” p. 6

#### 4.4 THE SAFE MOTHERHOOD INITIATIVE IN AFGHANISTAN

In an effort to reduce maternal mortality in Afghanistan in 1997, UNICEF began implementing health programs in four provinces: Logar, Laghman, Farah, and Balkh.<sup>244</sup> These programs, which aimed to reduce maternal mortality, focused on strengthening EOC, improving management and supervision in maternal health, and boosting community involvement. Three years later, UNICEF recruited an external consultant to assess the results of the efforts in these provinces and to suggest recommendations for the future, as mentioned earlier in this paper. The results were fairly critical, citing an “underperformance and shortfall on the side of UNICEF Afghanistan to view the Safe Motherhood Initiative as a programme ... and to give it the time and effort that it rightly warrants.”<sup>245</sup> Despite having three years to produce results, the assessment noted, the SMI in Afghanistan was “still very much in its infancy.”<sup>246</sup>

The report recommended a broad array of efforts to improve maternal health conditions, including the development of national training materials for EOC, the implementation of an immunization campaign against maternal and neonatal tetanus, the creation of a list of drugs and equipment needed to equip health facilities, and continued training of women in midwifery skills.<sup>247</sup> The most interesting recommendation, however, was that UNICEF in Afghanistan work to develop effective communication strategies that will result in a “behavior change,” sensitize men and women to the warning signs of a pregnancy, and support women’s access to medical care.<sup>248</sup> The report stressed that such efforts must be done with the active participation of local leaders and members of the community and could utilize quotations from the Quran to

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<sup>244</sup> “Safe Motherhood Initiative in Afghanistan,” UNICEF, p. 5

<sup>245</sup> Ibid, p. 6

<sup>246</sup> Ibid

<sup>247</sup> Ibid, pp. 16 – 18

<sup>248</sup> Ibid, p. 16

validate their goals. Such an effort would be in keeping with a vertical education and outreach campaign.

Despite how critical the overall report was, it did note some accomplishments in efforts to improve maternal health, including the training of 33 TBAs by the MoPH and another 35 TBAs by NGOs located in Logar province.<sup>249</sup> The report urged for further efforts to connect the work of TBAs to nearby clinics, provide TBAs with more supplies, and implement regular refresher courses to ensure continued quality of training. In particular, the poor linkages between health facilities and TBAs working at the community level were cited as one of the major constraints for improving conditions of maternal health in all provinces.<sup>250</sup> The Dutch non-profit HNI, which was working to deliver health services in Nangarhar province, was cited for its “innovative” method of providing health services, which involved clustering small districts together under similar management and working in close collaboration with TBAs.<sup>251</sup> “This is one example that may be replicated in other regions and the concepts within this model may be applicable” to provinces covered by the SMI efforts, the report noted.<sup>252</sup>

In 2002, after the collapse of the Taliban government and the establishment of the Interim Government, UNICEF assessed conditions of the SMI once again, but this time they surveyed more than just the four provinces covered under the SMI. For provinces not covered under the SMI, conditions were in worse shape and criticism was particularly harsh. “The almost total lack of use of recommended international infection practices limits the quality of all basic and

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<sup>249</sup> Ibid, p. 9

<sup>250</sup> Ibid, p. 15

<sup>251</sup> Ibid, p. 10

<sup>252</sup> Ibid

comprehensive [emergency obstetrical care] services being provided,” wrote the consultant surveying conditions in Kabul.<sup>253</sup>

In Laghman province, which had been covered by the SMI, the assessments were not as dire. The hospital in Laghman provided EOC services on a 24-hour basis, but the consultant suggested that their “ability to respond quickly and appropriately to obstetrical emergencies should be strengthened” through refresher trainings.<sup>254</sup> The consultant further noted that Mehtarlam Hospital in Laghman had “functional management systems in place for drug procurement” and operated an “outpatient antenatal care department offering full service,” including tetanus immunization, nutrition, health education, and bed-net distribution.<sup>255</sup> The consultant did express concerns of overcrowding in the facility, and recommended that workers seek to reorganize available space. Overcrowding, it was feared, could lead to patients being discharged too quickly, defeating the purpose of delivery with a skilled attendant.<sup>256</sup>

Conditions in Badakhshan province were reviewed much more critically, however. The mountainous terrain makes much of the province inaccessible, and it is located in the northwestern most corner of the country, rendering it even more isolated. The consultant in Badakhshan urged for the development of a new MCH unit in the provincial hospital to provide basic maternal services.<sup>257</sup> The hospital was also lacking a generator, lighting, and basic surgical equipment.

Throughout the report, assessments of conditions in provinces covered under the SMI seemed less critical than those of provinces that remained uncovered. One exception to this was

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<sup>253</sup> Dalil, Suraya and Fritzler, Mark and Ionete, Denisa-Elena et al. “Assessment of the services and human resource needed for the development of the safe motherhood initiative in Afghanistan.” UNICEF Afghanistan. 2002, p. 29

<sup>254</sup> Ibid, p. 32

<sup>255</sup> Ibid, p. 31

<sup>256</sup> Ibid

<sup>257</sup> Ibid, p. 38



in the assessment of Herat province, where the consultant praised the hospital's training techniques and guidelines, in-house training room, stock of emergency supplies, and health education materials.<sup>258</sup> Among the likely reasons for the superior conditions in Herat are the province's considerable wealth from customs revenue generated from trade with Iran and the efforts of then-governor Ismail Khan to improve security.

Across all provinces, the UNICEF report urged immediate action in efforts to update and standardize training manuals for health workers, shorten the length of midwife training, strengthen the capacity of the MoPH on issues of maternal health, and begin an experimental program for training midwives using low-literacy approaches over a one-year duration.<sup>259</sup> The overall goal of the final recommendation was to provide the country with auxiliary midwives with medical training in basic essential skills.

Despite the report's urging for more skilled midwives, it praised the work of TBAs in Afghanistan and noted the considerable achievements in TBA training in the previous few years. "Successful SMI programs in Afghanistan consider TBAs an integral part of ...their programs," the report noted.<sup>260</sup> The report went on to note the success in efforts to develop a system of training TBAs within their communities, boosting supervision of TBA training, and providing TBAs with regular refresher trainings. In addition, the report noted achievements in linking them to health facilities and improving their access to essential materials supplies.

It is certainly still the case that the effectiveness of TBAs in reducing mortality rates and improving maternal health is unclear. Detailed studies that measure their effectiveness are scarce and those working to shed further light in this field face considerable obstacles. Assessing the

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<sup>258</sup> Ibid, pp. 56 – 57

<sup>259</sup> "Safe Motherhood Initiative in Afghanistan," UNICEF, pp. 14 – 16

<sup>260</sup> Dalil, Suraya and Fritzler, Mark and Ionete, Denisa-Elena et al. "Assessment of the services and human resource needed for the development of the safe motherhood initiative in Afghanistan." UNICEF Afghanistan. 2002, p. 8

rate of maternal death is difficult by itself due to the size of the ratio; assessing improvements over a period of time using a minimum of one experimental group and one control group require an immense sample size, and may still fail to shed light on the issue. But the body of evidence showing that improving TBA training improves health outcomes overall is quickly growing, and the consensus that TBAs are ineffective is beginning to fade.

It would seem that the efforts of the SMI in Logar, Laghman, Farah, and Balkh have shown signs of success. In comparison to other provinces, Logar and Laghman

have the fifth and sixth lowest MMR nationwide, while Farah is ranked eighth. Balkh remains near the national average, however. It is difficult to tell if the conditions in these provinces have improved as a result of the SMI or if the real cause is something unrelated to health policy, such as security or funding. But provinces working under the SMI have mortality rates ranked just below the larger and wealthier provinces of Kabul, Herat, and Kandahar, despite having considerably fewer health facilities. Kabul and Herat had 137 and 84 health facilities in 2009, respectively.<sup>261</sup> Logar and Laghman, on the other hand, had 34 and 43, while Farah had even fewer at just 29 health facilities in the area. In addition, Logar and Laghman have two of the highest rates of expectant mothers receiving antenatal care, with Laghman ranked fifth overall and Logar ranked second only to Kabul. Laghman also has the fourth lowest percentage of

**Table 13: Maternal mortality rankings by province, lowest to highest**

1	Kabul	700
2	Herat	900
3	Kandahar	1,100
4	Nangarhar	1,100
5	Logar	1,200
6	Laghman	1,200
7	Nimroz	1600
8	Farah	1600
<b>AVG.</b>		
	Helmand	1,800
29	Badakhshan	2,200
30	Takhar	2,300
31	Badghis	2,300
32	Ghor	2,300

*Source: World Health Organization, "Best Estimates" Provincial Fact Sheets*

<sup>261</sup> "List of active health facilities by province." Ministry of Public Health. Islamic Government of Afghanistan. 2009

births performed in the home, indicating that an unusual number of women utilize health facilities in this province.<sup>262</sup>

#### **4.5 RECONSIDERING THE CONSENSUS ON TRADITIONAL BIRTH ATTENDANTS**

Despite a growing body of evidence to the contrary, many policy experts in Afghanistan and around the world remain skeptical that TBAs can be used effectively in campaigns to improve maternal health. Instead, they argue, governments should prioritize the training of skilled midwives in an effort to phase out the use of TBAs in health services. The reasons for this are fairly compelling. TBAs lack adequate medical training and have no knowledge of how to perform EOC; they often operate without supervision or association with health facilities in the area and are rarely subject to refresher trainings; most are illiterate and have little in the way of education; and they operate in poor working conditions and lack access to vital materials, equipment, and medicine. Given how severe Afghanistan’s health crisis really is, given the nation’s astronomical rate of maternal mortality, and given the fact that only one child in four lives to the age of five, it would be enormously reckless to declare that a resource as common and potentially valuable in efforts to improve maternal and neonatal health “ineffective” without first investigating the connection further.

Yet the MoPH did just that in a publication on the delivery of maternal health services in 2003, stating that, in keeping with “international consensus,” TBAs do not meet the necessary

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<sup>262</sup> Best estimates provincial fact sheet: Laghman.” UNICEF in Afghanistan

criteria that would allow for them to play a role in maternal health, citing their lack of “necessary skills to manage the obstetrical complications that can result in maternal mortality.”<sup>263</sup> As a result, the MoPH proposed that the training of TBAs be discontinued, and that “TBAs be invited to participate in CHW training, thus becoming female CHWs.”<sup>264</sup> This approach, while perhaps desirable, sounds impractical. In the outlined job description for CHWs as defined in the BPHS, the selection criteria notes that “basic literacy is advantageous,” but notes that it is not a requirement.<sup>265</sup> The vast majority of TBAs are illiterate, and most are of an age that makes developing skills in basic literacy difficult. Nonetheless, the MoPH report on the delivery of maternal health proposes that illiterate TBAs be able to “participate in specifically-designed CHW training programs for low to no literacy.”<sup>266</sup> Due to the urgent need for more health workers in Afghanistan, the MoPH has reduced the number of years of required training for midwives from three years to two.<sup>267</sup> While boosting literacy rates is certainly an important goal, it seems counterintuitive for these efforts to further delay the utilization of workers in the health sector, especially when the training of such workers in the field of maternal health is being cut short.

Policymakers in Afghanistan must come to accept that health workers in all provinces are scarce, and that female health workers in particular are in very short supply. Rather than discontinuing the training of TBAs, the MoPH should work to further establish a relationship between skilled midwives, CHWs trained in delivery, and TBAs. The number of women who

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<sup>263</sup> “Maternal health services at the community level in Afghanistan: Who should provide these services?” Reproductive Health Task Force. Ministry of Health. Transitional Islamic Government of Afghanistan. 2003, p. 2

<sup>264</sup> Ibid, p. 4

<sup>265</sup> A Basic Package of Health Services for Afghanistan.” Transitional Islamic Government of Afghanistan, Ministry of Health. 2003, p. 49

<sup>266</sup> “Maternal health services at the community level in Afghanistan: Who should provide these services?” Reproductive Health Task Force. Ministry of Health. Transitional Islamic Government of Afghanistan. 2003, p. 4

<sup>267</sup> Dalil, Suraya and Fritzler, Mark and Ionete, Denisa-Elena et al. “Assessment of the services and human resource needed for the development of the safe motherhood initiative in Afghanistan.” UNICEF Afghanistan. 2002, p. 14

give birth under the attendance of a health worker, either trained or untrained, is disturbingly low, and efforts to improve maternal health must work to improve skilled attendance during birth. But the need to further address maternal health and the severe shortage of resources that allow such an effort to work do not allow for the MoPH to take any method of improving maternal health off the table. Actors in the health field must take advantage of every available resource if they hope to see any reduction in maternal mortality. If they do not, they may find themselves improving the conditions of a health sector that continues to be underutilized.

Working to improve outreach to rural women, educate about the need for skilled assistance during birth, the importance of breastfeeding, or the symptoms that indicate that a pregnancy has become problematic does not require any advanced medical training. All of these are services for which a TBA is not only fully qualified, but ones in which she has an advantage, given her trusted status in her community. Efforts to further train TBAs in midwifery skills, boost literacy rates, and to provide further medical training are commendable and should be continued. But in regions where skilled midwives are scarce and MMR is exceptionally high, utilization on TBAs is essential and the goal of ensuring that all pregnancies take place under the supervision of a trained midwife seems impractical.

It seems unwise to view efforts to improve maternal health through a dichotomy that does not reflect the conditions in Afghanistan. While the presence of a trained midwife during a delivery would no doubt be preferable to the presence of an untrained TBA, the scarcity of female health workers with necessary medical training makes the first option entirely unattainable for most Afghans. The dilemma is more aptly presented as one between the attendance of a TBA with little to no training but some previous experience in delivery or having nobody present but the

father and family. Viewed from this perspective, the role of a TBA as a messenger and a representative of the health system at the community level should be further strengthened.

In a 2006 report by the AREU assessing the improvements in health services since 2001, the authors noted that, “health service delivery in a post-conflict context can also help legitimize a fragile government. This in turn can contribute to long-term political stability – a pre-condition for the fullest possible implementation of health policies and programmes on a national scale.”<sup>268</sup>

Furthermore, the report noted:

It stands to reason that one way for a government to reduce the risk of a country regressing back to widespread conflict is to increase its legitimacy in the eyes of the population. To achieve this, the government needs to show that it is capable of fulfilling one of the key functions of an effective state – providing essential services such as health and education. ...A post-conflict health system should also consider adopting the political objective of contributing to long-term peace by helping improve the perception of the fragile government, thereby contributing to its legitimization.<sup>269</sup>

Improving the legitimacy of the state, they argued, requires putting a further emphasis on expanding outreach at the community level and working to better understand “people’s health-seeking behavior.”<sup>270</sup> The activities of TBAs such as educating mothers about the need for proper breastfeeding and nutrition and the importance of EOC for complicated pregnancies would work to advance such a goal.

Working to decrease reliance on TBAs as an actor in the health sector weakens the connections between communities and health services and further exacerbates the shortage of health workers in Afghanistan. Instead, the MoPH should seek to streamline the role of TBAs into the delivery of services at the community level and utilize their social standing as a strategy to reduce the workload of skilled midwives. This objective would allow for efforts to improve

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<sup>268</sup> Waldman, Ronald et al. “Afghanistan’s health system since 2001,” p. 11

<sup>269</sup> Ibid, p. 12

<sup>270</sup> Ibid

the delivery of health services to be fully comprehensive, with improved community-level engagement while efforts to improve the health sector continue. It would be in keeping with efforts to further make the approach to improving health services diagonal, since the primary role of TBAs would be to encourage women to seek out health services, particularly in cases that require EOC. Lastly, it would work to advance the priorities of the MoPH, which puts reducing maternal and newborn mortality at the top of its list of health priorities in its National Health Policy statement.<sup>271</sup>

The MoPH further mentions in the National Health Policy statement that it aims to halve its MMR from its 2003 rate of 1,600 deaths per 100,000 live births by 2015, and halve it again by 2020.<sup>272</sup> While it is difficult to say with any certainty what the MMR in Afghanistan is today, it is doubtful that these goals will be achieved in this timeframe. In Sri Lanka and Malaysia, two countries that successfully halved their MMR over a decade on several occasions, two major explanations for this success were the political stability and the strong presence of health services in rural regions, two things that are still in the making in Afghanistan.<sup>273</sup> Neither of these countries relied on TBAs to reduce MMR, but the circumstances were also considerably different: the shortage of female staff was likely not as pronounced, health services were likely in better shape, security was far better, and MMR was considerably lower.<sup>274</sup> At the start of efforts to reduce MMR in Sri Lanka in 1947, the rate was two thirds of what it is currently in Afghanistan.<sup>275</sup> In Malaysia, the rate was less than a third of what Afghanistan currently faces. Reducing maternal mortality, even by a modest amount, will take many years, especially in a

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<sup>271</sup> National Health Policy 2005 – 2009 and National Health Strategy 2005 – 2006: A policy and strategy to accelerate implementation.” Ministry of Public Health. Islamic Republic of Afghanistan. 2005, p. 21

<sup>272</sup> Ibid, p. 14

<sup>273</sup> Liljestrand, Jerker et al. “Reducing Maternal Mortality,” p. 303

<sup>274</sup> Ibid, p. 306

<sup>275</sup> Ibid, p. 301

state as fragile as Afghanistan, and must include the use of every available resource in order to boost the utilization of services.



## 5.0 CONCLUSION

Despite the ongoing conflict, the delivery of health services has improved significantly in the past several years. There have been a considerable number of obstacles and challenges that have slowed down and impeded this process. Infrastructure in Afghanistan has been abhorrent ever since the Soviet invasion. The scars caused by decades of war can be seen not just on the faces of Afghans, but on the very terrain itself, which remains riddled with landmines that further degrade the health and safety of the Afghan people. Years of oppression by the Taliban left an entire generation of women illiterate, with no education, no work experience, and no feeling of value to society. The rising insurgency and resulting bombings have kept security conditions in Afghanistan relatively unstable. The cultivation of poppy continues to fund anti-government militia groups that terrorize rural communities. Corruption runs rampant throughout all divisions of the public sector, further hampering the utilization of public services.

But despite all this, health facilities in provinces throughout Afghanistan have demonstrated significant improvements year after year with relative consistency across indicators intended to assess the delivery of health services. The coverage of these services has expanded dramatically over a very short period of time, and near-universal coverage could possibly be attainable in as little as five years. Immense strides have been taken to expand immunization and reduce the prevalence of diseases such as malaria, measles, TB, and polio. It is possible that, in just a few

years, the results of these immunization campaigns will be reduced rates of mortality for children under five.

In Kabul, these efforts have been successful in large part due to the presence of security forces that improve the accessibility of health services. Herat, however, has seen similar signs of progress without relying as much on funds, assistance, or instruction from Kabul, indicating that further improving the political autonomy of wealthier provinces could result in better health conditions. It remains unclear to what extent the centralized political structure of Afghanistan hinders improvements in health by being too “top-down” or if this is even a problem at all.

In 2002, the AREU described the state of health services in Afghanistan as being in a state of “near total disrepair.”<sup>276</sup> Just four years later, the organization declared that the “MoPH has made considerable progress in making the BPHS accessible to most Afghans,” but noted that, while independent evaluations indicated “improvements in quality of care,” it was not yet known whether or not the health status of the Afghan population had improved, as such statistics needed to be measured over a longer period of time.<sup>277</sup> In other words, there has been great progress in improving health in Afghanistan sector-wide, but the resulting improvements in mortality rates have not yet been confirmed. While it should come as no surprise that mortality rates are lagging indicators, it seems likely that mortality rates will continue to remain high and the benefits of improving the health sector will go unnoticed to many Afghans if further efforts are not made to promote the utilization of health services, especially among pregnant women.

The successes of the BPHS and the improvements across the health sector are significant and should not be quickly brushed aside. But such efforts will not achieve the broader goal of improving overall health if health facilities remain under-populated by the communities that need

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<sup>276</sup> Walman, Ronald et al. “The Public Health System in Afghanistan,” p. i

<sup>277</sup> Waldman, Ronald et al. “Afghanistan’s health system since 2001,” p. 2 – 3

care the most. In this respect, an exclusively horizontal approach to improving health is fairly limited. There are concerns among experts that maternal health often goes ignored in sector-wide efforts towards improvement of health services. One report suggested that a possible outcome of the implementation of such an approach might be that “some key activities that are essential to improving maternity care might not be covered,” including the reviewing and updating of obstetric protocols and training in specific techniques such as manual vacuum aspiration.<sup>278</sup> While the authors of this report endorsed the implementation of a sector-wide approach as a way of improving failing public health systems, they did so with the insistence that such an effort include “indicators of safe motherhood” as a condition for funding, something that they noted has been lacking in previous sector-wide strategies.<sup>279</sup>

Despite these concerns, advocates of horizontal, sector-wide approaches to improving health make a compelling case by insisting that improvements in certain health indicators will be inhibited if the health system as a whole is failing. They further insist that such efforts can make the delivery of health care more sustainable and cost-effective – two goals that need to be prioritized in long-term efforts of improving health care in Afghanistan. In Afghanistan, where the health system as a whole is in bad shape and mortality rates are incredibly high, the MoPH cannot afford to rely on one approach or the other, but must rather find a comfortable middle ground by assuming the responsibility of engaging in targeted efforts to incorporate at-risk communities into the health sector while continuing to improve the failing system as a whole. The MoPH must therefore work to further expand outreach at the local level using residents of the community as liaisons in order to improve the utilization of health services and adequately

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<sup>278</sup> Goodburn, Elizabeth and Campbell, Oona. “Reducing Maternal Mortality in the Developing World: Sector-Wide Approaches May Be the Key.” *British Medical Journal*, Vol. 322, No. 7291. 2001, p. 919

<sup>279</sup> *Ibid*, p. 920

address the nation's mortality rates. Such a job does not require using workers with advanced medical skills, making TBAs the perfect candidates for the job.

While the central government should continue to advance the training of TBAs in midwifery in order to ensure that deliveries are performed with skilled attendance, this goal should not be seen as one that is in conflict with promoting the role of untrained TBAs in health. These ideas are not mutually exclusive and should not be viewed as such. Instead, the MoPH should work to further incorporate TBAs into the health system, streamline the objectives and roles of TBAs, and use their presence in small communities to its full potential.

The MoPH must further recognize that the process of training skilled midwives will continue to be sluggish and that operating under the assumption that this is achievable in the short-term is impractical. Women and newborns will continue to die at alarming rates so long as unsupervised births continue to be the norm. In the short-term, the MoPH must come to accept that underserved regions lacking skilled female health workers will have to rely on TBAs in the delivery of newborns and the provision of nutritional supplements to mothers and children. There is a widespread international consensus that such efforts are inadequate and ineffective in improving maternal health. But more recent evidence is casting doubt upon this claim, and the evidence supporting this consensus is not convincing enough to justify disregarding a resource with much potential in a part of the world where female health workers with any degree of training are immensely scarce. The central government must work to further incorporate the work of TBAs into the health system, standardize their training, and supervise their activities in an effort to implement a community-level door-to-door campaign intended to boost the utilization of health services in Afghanistan.

Such a program would be in keeping with a diagonal approach to improving the health sector, using targeted outreach efforts intended to seek out at-risk communities and further incorporate them into the improving health sector. The overall goal of such a campaign would be to educate rural communities about the need for health services, particularly in regard to maternal and child health and appropriate healthy lifestyle choices, such as breastfeeding and nutrition. The central government and donor agencies can simultaneously work to improve the conditions of the health sector as a whole, making facilities more accessible, expanding the availability of health services, and improving the managerial capacity of facilities.

The result would be an improvement not just in health systems or disease prevention alone, but an improvement in overall health. Using TBAs as foot soldiers in a campaign to promote health education and the utilization of services would make use of “explicit intervention priorities to drive the required improvements into the health system,” an essential component in comprehensive improvements in health.<sup>280</sup> The most likely route to success in efforts to improve health in Afghanistan must include moving past the false dichotomies of horizontal and vertical and must further reflect the conditions and the reality in which these efforts are taking place.

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<sup>280</sup> Frenk, Julio. “Bridging the divide: comprehensive reform to improve health in Mexico.” WHO Commission on Social Determinants of Health. 2006, p. 5

## **APPENDIX A**

### **ADDITIONAL TABLES, CHARTS, AND FIGURES**

**Table 14: Roles and responsibilities in health care delivery in Afghanistan by level of governance**

Level of administration	Budget-funded		Funded externally
Ministry of Health (Kabul)	<ul style="list-style-type: none"> <li>• Health policy-making</li> <li>• Authorizing “organigram” (staffing)</li> </ul>	<ul style="list-style-type: none"> <li>• Contracts with NGOs</li> <li>• Private sector regulation</li> <li>• Recruitment of staff grades</li> </ul>	External funding is pervasive across the sector and is found at all levels of administration and for all functions.
Regional health departments (western provinces only)	<ul style="list-style-type: none"> <li>• Aggregating health data</li> <li>• Donor coordination (within the region)</li> </ul>	<ul style="list-style-type: none"> <li>• 1–5</li> </ul>	
Province	<ul style="list-style-type: none"> <li>• Regional hospital services:</li> <li>• Outpatient services</li> <li>• Inpatient services</li> <li>• Surgery</li> <li>• Antenatal care</li> <li>• Delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Postnatal care</li> <li>• Immunization</li> <li>• Rehabilitation</li> <li>• Health Education</li> <li>• X-ray</li> <li>• Diagnostic lab</li> </ul>	
	<ul style="list-style-type: none"> <li>• Reallocation of staff between facilities</li> <li>• Recruitment of staff grades 6-10</li> <li>• Contracting out services</li> <li>• Procurement of drugs and supplies</li> </ul>	<ul style="list-style-type: none"> <li>• Primary health care</li> <li>• Facilities management: buildings, vehicles</li> <li>• Provincial health plans</li> <li>• Collecting basic health data</li> <li>• Quality control of services</li> </ul>	
	<ul style="list-style-type: none"> <li>• Provincial hospital services:</li> <li>• Outpatient services</li> <li>• Inpatient services</li> <li>• Surgery</li> <li>• Antenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul>	<ul style="list-style-type: none"> <li>• Immunization</li> <li>• Rehabilitation</li> <li>• Health education</li> <li>• X-ray (sometimes)</li> <li>• Nutrition</li> <li>• Diagnostic lab</li> </ul>	
	<ul style="list-style-type: none"> <li>• Rehabilitation facilities:</li> </ul>	<ul style="list-style-type: none"> <li>• Surgery</li> <li>• Rehabilitation</li> </ul>	
District	District health plans		
	<ul style="list-style-type: none"> <li>• District hospital services:</li> <li>• Outpatient services</li> <li>• Inpatient services</li> <li>• Surgery</li> <li>• Antenatal care</li> <li>• Delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Postnatal care</li> <li>• Immunization</li> <li>• Some nutrition services</li> <li>• Health education</li> <li>• Some X-ray services</li> <li>• Diagnostics lab</li> </ul>	
	<ul style="list-style-type: none"> <li>• Basic health centers:</li> <li>• Outpatient services</li> <li>• Some limited surgery</li> <li>• Antenatal care</li> <li>• Some delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Postnatal care</li> <li>• Immunization</li> <li>• Some nutritional services</li> <li>• Health education</li> <li>• Some diagnostic services</li> </ul>	
	<ul style="list-style-type: none"> <li>• Sub-health centers:</li> <li>• Outpatient services</li> <li>• Some limited surgery</li> <li>• Some antenatal care</li> </ul>	<ul style="list-style-type: none"> <li>• Some postnatal care</li> <li>• Immunization</li> <li>• Health education</li> </ul>	
	<ul style="list-style-type: none"> <li>• Maternal and child health clinics (MCHs):</li> <li>• Outpatient services</li> <li>• Antenatal care</li> </ul>	<ul style="list-style-type: none"> <li>• Postnatal care</li> <li>• Immunization</li> <li>• Nutrition</li> <li>• Health education</li> </ul>	
	Expanded program of immunization (EPI) clinics:		
	<ul style="list-style-type: none"> <li>• Immunization</li> <li>• Some nutrition services</li> </ul>		

Source: Evans, Anne et al. “A Guide to Government in Afghanistan,” p. 133

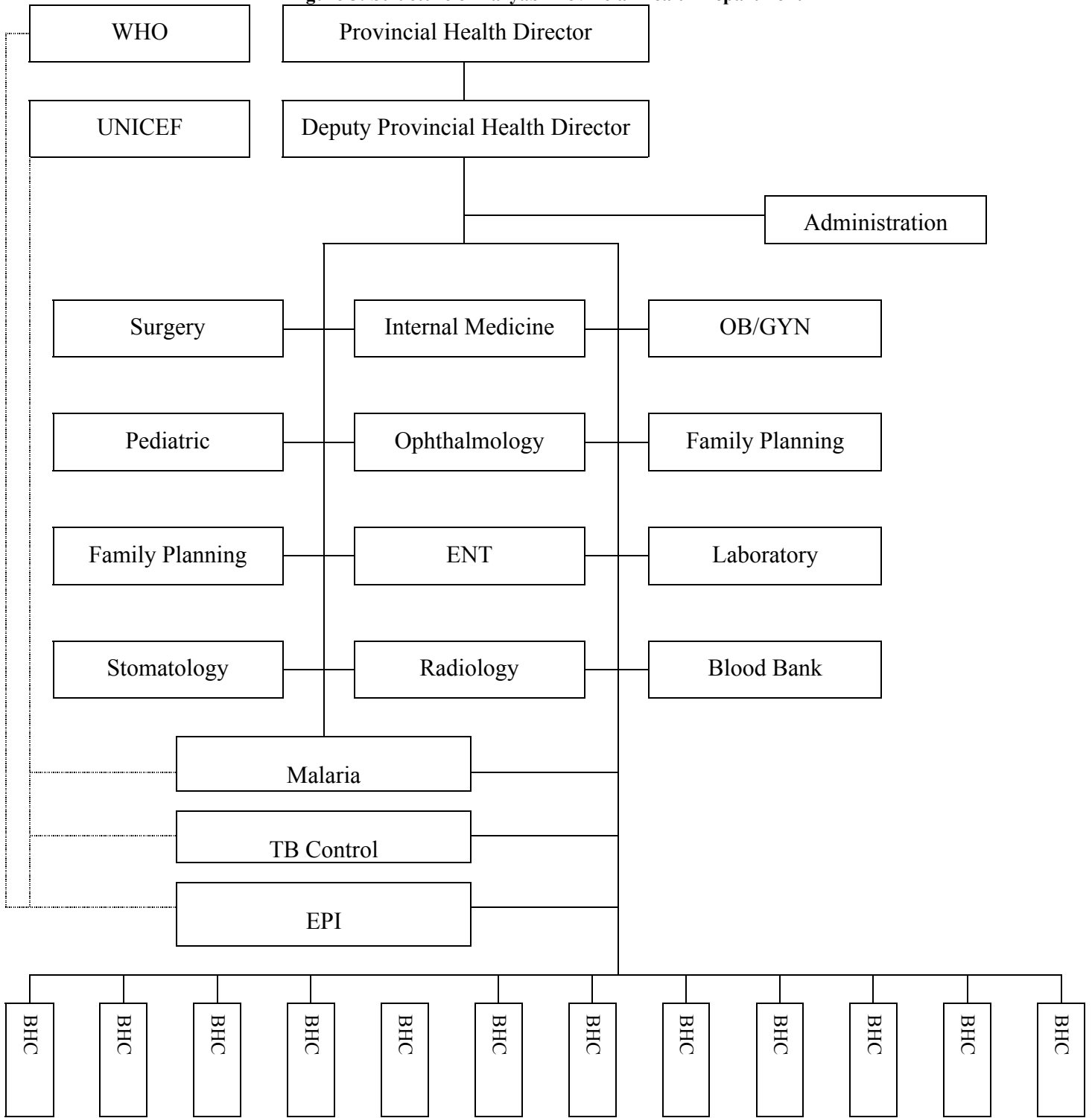
**Table 15: Functional responsibilities of different health facilities in Afghanistan**

	<b>Outpatient services</b>	<b>Inpatient services</b>	<b>Surgery (any)</b>	<b>Antenatal care</b>	<b>Delivery</b>	<b>Postnatal care</b>	<b>Immunization</b>	<b>Nutrition</b>	<b>Rehabilitation</b>	<b>Health education</b>	<b>X-ray</b>	<b>Diagnostic lab</b>
Regional hospital	x	x	x	x	x	x	x		x	x	x	x
Provincial hospital	x	x	x	x	x	x	x	x		x	some	x
District hospital	x	x	x	x	x	x	x	some		x	some	x
Basic health center	x		some	x	some	x	x	some		x		some
Sub-health center	x		x	some		some	x			x		
Maternal and child health clinic (MCH)	x			x		x	x	x		x		
Rehabilitation center			x						x			

Source: Evans, Anne et al. *A Guide to Government in Afghanistan*, p. 132



**Figure 5: Structure of Faryab Provincial Health Department**



Source: Evans, Anne et al. *A Guide to Government in Afghanistan*, p. 135

Table 16: Afghanistan Health Sector Balanced Scorecard National Results of Provincial Performance 2004 – 2008

		National Median <sup>a</sup>					Benchmarks		Percent of Provinces Meeting Lower Benchmark					Percent of Provinces Meeting Upper Benchmark				
		2004	2005	2006	2007	2008	Lower <sup>b</sup>	Upper <sup>c</sup>	2004	2005	2006	2007	2008	2004	2005	2006	2007	2008
<b>A. Patients and Community</b>																		
1	Overall Patient Satisfaction	83.1	86.3	86.0	77.7	81.0	66.4	90.9	81.3	96.7	96.7	93.3	93.1	18.8	26.7	20.0	3.3	20.7
2	Patient Perception of Quality Index	76.0	76.2	80.3	77.6	77.5	66.2	83.9	81.8	96.7	96.7	96.7	100	18.2	10.0	33.3	10.0	44.8
3	Written Shura-e-sehie activities <sup>d</sup>	34.2	54.5	66.4	86.0	94.3	18.1	66.5	81.8	83.3	93.3	100	100	18.2	26.7	50.0	90.0	93.1
<b>B. Staff</b>																		
4	Health Worker Satisfaction Index	63.5	64.1	68.1	69.0	69.1	56.1	67.9	81.8	86.7	93.3	93.3	96.6	18.2	33.3	53.3	56.7	62.1
5	Salary Payments current	76.7	90.0	81.3	90.7	82.7	52.4	92.0	81.8	96.7	83.3	83.3	82.8	18.2	43.3	33.3	46.7	41.4
<b>C. Capacity for Service Provision</b>																		
6	Equipment Functionality Index <sup>e</sup>	65.7	67.0	78.7	83.8	88.4	61.3	90.0	81.8	73.3	86.7	100	100	0.0	0.0	3.3	100	100
7	Drug Availability Index	71.1	83.7	85.7	81.0	86.3	53.3	81.8	81.8	100	100	96.7	100	18.2	56.7	53.3	46.7	58.6
8	Family Planning Availability Index	61.4	70.0	82.9	93.7	94.9	43.4	80.3	81.8	90.0	100	100	100	18.2	23.3	53.3	93.3	93.1
9	Laboratory Functionality Index (Hospitals & CHCs)	18.3	36.3	43.3	58.5	64.5	5.6	31.7	81.8	100	100	100	100	18.2	66.7	83.3	100	96.6
10	Staffing Index – Meeting minimum staff guidelines	39.3	58.0	66.9	63.9	72.1	10.1	54.0	81.8	93.3	96.7	100	100	18.2	60.0	76.7	76.7	79.3
11	Provider Knowledge Score <sup>*</sup>	53.5	69.0	68.7	68.7	N/A	44.8	62.3	81.8	100	100	100	N/A	18.2	86.7	76.7	80.0	N/A
11a	Revised Provider Knowledge Score	N/A	N/A	N/A	N/A	79.3	71.5	86.0	N/A	N/A	N/A	N/A	82.7	N/A	N/A	N/A	N/A	20.7
12	Staff received training in last year	39.0	74.3	68.9	68.5	71.1	30.1	56.3	81.8	93.3	96.7	100	96.6	18.2	90.0	70.0	73.3	72.4
13	HMIS Index	67.7	65.8	74.9	91.5	92.4	49.6	80.7	81.8	70.0	76.7	100	100	18.2	16.7	43.3	70.0	82.8
14	Clinical Guidelines Index	34.8	48.9	61.6	78.3	83.9	22.5	51.0	81.8	93.3	100	100	100	18.2	46.7	70.0	93.3	100
15	Infrastructure Index	55.0	44.6	48.7	54.6	54.1	49.3	63.2	81.8	33.3	46.7	70.0	69.0	18.2	10.0	6.7	16.7	24.1
16	Patient Record Index	65.6	63.2	69.4	70.0	69.9	56.1	92.5	81.8	70.0	93.3	93.3	93.1	18.2	3.3	3.3	6.7	20.7
17	Facilities having TB register	15.8	20.6	37.4	53.7	62.9	8.3	26.6	81.8	83.3	96.7	100	100	18.2	36.7	86.7	100	100
<b>D. Service Provision</b>																		
18	Patient History and Physical Exam	70.6	73.5	82.2	83.1	83.9	55.1	83.5	81.8	100	96.7	100	96.6	18.2	26.7	43.3	50.0	51.7
19	Patient Counseling Index	29.6	35.1	36.6	48.7	48.0	23.3	48.9	81.8	90.0	93.3	96.7	96.6	18.2	16.7	13.3	46.7	44.8
20	Proper sharps disposal	62.2	52.0	77.5	84.4	75.4	34.1	85.0	81.8	76.7	73.3	90.0	93.1	18.2	10.0	33.3	50.0	31.0
21	Average new outpatient visit per month (BHC > 750 visits)	22.2	32.3	55.0	57.4	84.2	6.7	57.1	74.2	83.3	93.3	96.7	100	19.4	40.0	46.7	50.0	79.3
22	Time spent with patients (> 9 min)	18.0	6.2	7.0	18.4	19.7	3.5	31.2	81.8	70.0	80.0	83.3	86.2	18.2	3.3	3.3	23.3	41.4
23	BPHS facilities providing ANC	62.0	79.3	84.9	95.3	95.2	28.9	82.8	81.8	93.3	93.3	100	100	18.2	40.0	56.7	90.0	89.7
24	Delivery care according to BPHS	25.4	22.3	42.3	59.5	71.2	10.5	39.3	81.8	76.7	90.0	100	100	18.2	20.0	60.0	90.0	93.1

<b>E. Financial Systems</b>																		
25	Facilities with user fee guidelines*	90.6	86.7	82.5	95.9	N/A	80.3	100	81.3	72.4	51.7	72.4	N/A	31.3	31.0	31.0	44.8	N/A
26	Facilities with exemptions for poor patients*	84.7	93.1	100	100	N/A	64.4	100	81.3	89.7	82.8	96.6	N/A	25.0	37.9	55.2	79.3	N/A
<b>F. Overall Vision</b>																		
27	Females as a % of new outpatients	55.2	57.3	57.8	60.0	60.0	46.5	59.7	81.8	96.7	93.3	96.7	96.6	18.2	20.0	46.7	53.3	48.3
28	Outpatient visit concentration index	50.5	50.6	51.2	50.0	50.0	50.0	50.0	81.8	79.3	86.2	82.8	82.1	18.2	31.0	27.6	27.6	89.3
29	Patient satisfaction concentration index	49.9	49.8	49.8	49.6	49.6	50.0	50.0	81.8	96.6	82.8	96.6	89.3	18.2	3.4	3.5	0.0	7.1
<b>Composite Scores</b>																		
30	<b>% of Upper Benchmarks Met</b>	17.2	31.0	41.4	55.2	N/A	10.3	30.8	84.8	100	96.7	100	N/A	18.2	60.0	83.3	93.3	N/A
31	<b>% of Lower Benchmarks Met</b>	82.8	89.7	93.1	96.6	N/A	75.9	89.7	78.8	80.0	90.0	100	N/A	21.2	53.3	50.0	83.3	N/A
	<b>Mean scores across indicators 1 through 29</b>	53.2	59.0	65.4	70.2	N/A	48.8	56.5	75.8	86.7	96.7	100	N/A	18.2	70.0	86.7	96.7	N/A
<b>Revised Composite Scores</b> <i>Indicators listed above with an asterisk (*) are not included in the revised composite score</i>																		
32	<b>% of Upper Benchmarks Met</b>	15.4	28.8	38.5	51.9	57.7	7.7	26.9	97.0	100	100	100	100	27.3	66.7	86.7	96.7	100
33	<b>% of Lower Benchmarks Met</b>	84.6	88.5	92.3	96.2	96.2	69.2	88.5	87.9	90.0	93.3	100	100	30.3	56.7	80.0	93.0	93.1
	<b>Revised mean scores across indicators 1 through 29</b>	50.4	57.1	61.8	69.0	71.7	46.2	54.9	81.8	90.0	100	100	100	18.2	66.7	86.7	100	100
Total number of BPHS Facilities		617	629	630	N/A	N/A												
Number of BHCs		323	368	385	N/A	N/A												
Number of CHCs		243	218	203	N/A	N/A												
Number of District Hospitals		51	43	42	N/A	N/A												

Sources: Johns Hopkins University Bloomberg School of Public Health. "Afghanistan Health Sector Balanced Scorecard." 2008, p. 15

Johns Hopkins University Bloomberg School of Public Health. "Afghanistan Health Sector Balanced Scorecard: National and Provincial Results." 2006, p. 5

GREEN Score Above Upper Benchmark   YELLOW Score Between Benchmarks   RED Score Below Lower Benchmark   GREY Not Applicable

<sup>a</sup> Score between the bottom and top quintiles   <sup>b</sup> Highest score in bottom quintile   <sup>c</sup> Lowest score in the top quintile   <sup>d</sup> Shura-e-sehie, community health forums

<sup>e</sup> Benchmark fixed at 90%

**Table 17: Afghanistan Health Sector Balanced Scorecard Provincial Results 2004 – 2008: Nangarhar Province**

		Benchmarks		Nangarhar				
		Lower <sup>a</sup>	Upper <sup>b</sup>	2004	2005	2006	2007	2008
<b>A. Patients and Community</b>								
1	Overall Patient Satisfaction	66.4	90.9	85.5	75.5	70.0	60.4	66.3
2	Patient Perception of Quality Index	66.2	83.9	76.0	73.8	67.5	64.1	75.2
3	Written Shura-e-sehie activities <sup>c</sup>	18.1	66.5	46.9	15.7	36.4	80.0	95.8
<b>B. Staff</b>								
4	Health Worker Satisfaction Index	56.1	67.9	64.1	62.3	64.5	68.1	66.2
5	Salary Payments current	52.4	92.0	66.0	85.2	39.9	97.4	53.2
<b>C. Capacity for Service Provision</b>								
6	Equipment Functionality Index <sup>d</sup>	61.3	90.0	74.1	53.3	76.7	85.1	85.9
7	Drug Availability Index	53.3	81.8	65.3	68.4	55.1	76.8	76.5
8	Family Planning Availability Index	43.4	80.3	49.8	50.3	86.1	81.0	87.8
9	Laboratory Functionality Index (Hospitals & CHCs)	5.6	31.7	33.9	36.2	52.0	62.4	69.9
10	Staffing Index – Meeting minimum staff guidelines	10.1	54.0	59.8	57.4	64.4	71.5	76.6
11	Provider Knowledge Score*	44.8	62.3	58.3	62.8	76.9	74.6	N/A
11a	Revised Provider Knowledge Score	71.5	86.0	N/A	N/A	N/A	N/A	79.3
12	Staff received training in last year	30.1	56.3	42.0	53.5	56.4	74.8	55.9
13	HMIS Index	49.6	80.7	54.7	42.2	82.5	92.0	91.7
14	Clinical Guidelines Index	22.5	51.0	58.6	42.7	82.8	72.3	89.0
15	Infrastructure Index	49.3	63.2	53.2	44.9	48.6	53.5	51.1
16	Patient Record Index	56.1	92.5	59.5	57.3	65.9	66.0	70.2
17	Facilities having TB register	8.3	26.6	46.7	42.8	75.6	88.0	62.9
<b>D. Service Provision</b>								
18	Patient History and Physical Exam Index	55.1	83.5	55.6	56.0	76.4	84.8	80.7
19	Patient Counseling Index	23.3	48.9	21.2	17.3	32.6	46.6	60.4
20	Proper sharps disposal	34.1	85.0	64.0	8.7	100	71.8	63.2
21	Avg. new outpatient visit per month (BHC > 750 visits)	6.7	57.1	80.0	91.7	100	86.7	100
22	Time spent with patients (> 9 min)	3.5	31.2	22.5	3.8	6.9	27.4	13.0
23	BPHS facilities providing ANC	28.9	82.8	53.3	54.7	91.9	92.0	87.5
24	Delivery care according to BPHS	10.5	39.3	6.5	4.2	48.1	47.6	71.2
<b>E. Financial Systems</b>								
25	Facilities with user fee guidelines*	80.3	100.0	86.0	86.5	92.6	95.9	N/A
26	Facilities with exemptions for poor patients*	64.4	100.0	85.4	87.2	87.8	88.0	N/A
<b>F. Overall Vision</b>								
27	Females as a % of new outpatients	46.5	59.7	59.0	58.2	60.5	60.1	65.5
28	Outpatient visit concentration index	50.0	50.0	47.9	48.1	48.1	47.7	49.9
29	Patient satisfaction concentration index	50.0	50.0	49.3	49.3	49.7	49.8	49.0
<b>Composite Scores</b>								
30	% of Upper Benchmarks Met	10.3	30.8	17.2	17.2	44.8	55.2	N/A
31	% of Lower Benchmarks Met	75.9	89.7	86.2	75.9	93.1	89.7	N/A
	Mean scores across indicators 1 through 29	48.8	56.5	56.0	51.4	65.4	71.3	N/A
<b>Revised Composite Scores</b> <i>Indicators with asterisks (*) not included in revised composite score</i>								
	% of Upper Benchmarks Met	7.7	26.9	19.2	15.4	46.2	57.7	46.2
	% of Lower Benchmarks Met	69.2	88.5	88.5	73.1	92.3	88.5	96.2
	Revised mean scores: indicators 1 through 29	46.2	54.9	53.7	48.2	63.0	69.5	69.8
	Number of Facilities			24	25	25	25	25
	Number of observations of patient-provider interactions			234	237	249	246	250
	Number of exit interviews			233	252	249	246	243
	Number of health workers interviewed			55	61	67	84	94
	Number of CHWs interviewed			3	35	33	89	N/A

Sources: Johns Hopkins University Bloomberg School of Public Health. "Afghanistan Health Sector Balanced Scorecard." 2008, p. 89  
 Johns Hopkins University Bloomberg School of Public Health. "Afghanistan Health Sector Balanced Scorecard: National and Provincial Results." 2006, p. 32

GREEN Score Above Upper Benchmark    YELLOW Score Between Benchmarks    RED Score Below Lower Benchmark    GREY Not Applicable

<sup>a</sup> Highest score in the bottom quintile

<sup>b</sup> Lowest score in the top quintile

<sup>c</sup> Shura-e-seshie, community health forums

<sup>d</sup> Benchmark fixed at 90%

## APPENDIX B

### ABBREVIATION INDEX

**ACTION** – Advocacy for Controlling Tuberculosis Internationally  
**ADB** – Asian Development Bank  
**AHC** – Alliance Health Committee  
**AMA** – American Medical Association  
**ANA** – Afghan National Army  
**ANP** – Afghan National Police  
**ARCS** – Afghan Red Crescent Society  
**AREU** – Afghanistan Research and Evaluation Unit  
**ARI** – Acute Respiratory Infection  
**BHC** – Basic Health Center  
**BPHS** – Basic Package of Health Services  
**BPHS-SM** – Basic Package of Health Services Strengthening Mechanism  
**BSC** – Balanced Scorecard  
**CHC** – Comprehensive Health Center  
**CHW** – Community Health Worker  
**CMC** – Coordination of Medical Committees  
**EC** – European Commission  
**EOC** – Emergency Obstetrical Care  
**EPHS** – Essential Package of Hospital Services  
**EPI** – Expanded Program of Immunization Clinic  
**HIV/AIDS** – Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome  
**HNI** – HealthNet International  
**HoO** – High Office of Oversight and Anti-Corruption  
**HP** – Health Post  
**ICRC** – International Committee of the Red Cross  
**IED** – Improvised Explosive Device  
**IMR** – Infant Mortality Rate  
**ISAF** – International Security Assistance Force  
**JDM** – Joint Donor Mission  
**MHC** – Maternal and Child Health Clinic

**MICS** – Multiple Indicator Cluster Survey  
**MMR** – Maternal Mortality Rate  
**MoPH** – Ministry of Public Health  
**NATO** – North Atlantic Treaty Organization  
**NGO** – Non-Governmental Organization  
**NID** – National Immunization Day  
**NWFP** – Northwestern Frontier Province  
**PHD** – Provincial Health Department  
**PHR** – Physicians for Human Rights  
**PPA** – Performance-based Partnership Agreement  
**PSI** – Population Services International  
**PTSD** – Post-Traumatic Stress Disorder  
**SMI** – Safe Motherhood Initiative  
**STI** – Sexually Transmitted Infection  
**SWAp** – Sector-Wide Approach  
**TB** – Tuberculosis  
**TBA** – Traditional Birth Attendant  
**TPO** – Transcultural Psychological Association  
**U5MR** – Under 5 Mortality Rate  
**UN** – United Nations  
**UNFPA** – United Nations Population Fund  
**UNICEF** – United Nations Children’s Fund  
**US** – United States  
**USAID** – United States Agency for International Development  
**WHO** – World Health Organization

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