TITLE

Health Financing and Access to Health Care for Women in Afghanistan : Evidence from a NGO intervention

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ABSTRACT

Due to the scarce evidence on public health practice in Afghanistan, this paper try to demonstrate that, following a participative health financing evaluation, a Non Governmental Organization (NGO) has implement some positive actions to increase access to health care in Afghanistan.

INTRODUCTION

Context

After twenty years of conflicts, chances for development in Afghanistan are impaired by the worsening health condition of the population. Social indicators are among the worst in the world (under five mortality rate about 257/1000 live births), especially for women (maternal mortality rate about 1600/100.000 live births, literacy levels at 16%). One afghan women is dying every 20 minutes as a result of complications in childbirth or pregnancy and expenses are one of the important barriers to institutional deliveries[1]. Improvement of the health situation of the population is made difficult: lack of trained professionals, cultural constraints that limit the access to health care for women, insufficient number of health facilities and high illiteracy levels with lack of knowledge about health care.

NGOs are in charge of the large majority of the health facilities in rural areas. A French medical NGO, Aide Médicale Internationale (AMI), is acting and working in Afghanistan since the early eighties. Since 1996, AMI implemented the program of "Support to the Health Care System in three provinces (Kunar, Logar, and Laghman) in the Eastern Region of Afghanistan", which is a multi-branch health program funded by the European Union. One of the general objectives of that program is to improve access to health care for the most vulnerable groups, especially women. For that purpose, AMI is providing financial, technical and logistical support to three provincial hospitals and six clinics and organizing training and information activities for the communities.

A health financing evaluation

Health care granted by the NGOs in Afghanistan was free of charge until the middle of the nineties. The huge humanitarian disaster provoked by the Soviet invasion of the country could easily justify this matter. But as the situation changed, AMI started to try cost sharing by user fees payment in 1994.

The dilemmas which stem from a healthcare programme's need to ensure both equity (access for the poorest versus needs and financial capacity) and efficiency (financial sustainability) of the financing schemes are frequent in developing countries. Therefore, in summer 2001, a participative evaluation was organized concerning the implementation of user fees in AMI's programme. Since 1994, this was the first study that was able to measure the equity in health financing scheme in Afghanistan. This evaluation was a perfect moment for the NGO staff to understand, with scientific data in the context of Afghanistan, that user fees, as numerous studies showed it[2-5], are ineffective and inequitable. As well as an economic study (financial sustainability), detailed documentary analysis and interviews with various stakeholders, two surveys were conducted. The first survey targeted randomly 120 households in 12 villages around four healthcare facilities. The second survey (bed census[6]) took place over a 24 hour period among all hospitalised patients. Complete results of this evaluation could be found elsewhere[7], and especially results about the ineffectiveness of user fees system in terms of sustainability (revenues from user fees represented just 4.2% of the running costs of the surveyed hospital and from 9.7% to 10.2% of the ones of the two surveyed clinics).

Concerning the equity of the user fees system, the household survey showed that healthcare is the fifth largest spending category of the households (7.37%), with most of the expenditures (66.69%) devoted is on purchasing of medicines. Over 75% of the families surveyed are in debt. Debts paid back during the last month (n=23) mainly concerned food (58.3%) and healthcare expenses (25.83%). On average, the households declared that they have a debt of 16.421.287 AFS, nearly equivalent to three times their annual healthcare expenditure.

To further clarify the impact of user fees in terms of equity, the ratio between the households' healthcare expenditure and total wealth was calculated. This ratio is a perfect indicator of equity in healthcare financing schemes[8]. The survey showed that the ratio represented on average 14.42%, with a median at 6.78%; 56.4% of households having a ratio greater than 5%. A ratio of 5%, which is usually taken to indicate the population's ability to pay for healthcare, is therefore exceeded for the general population, with a greater extent for the poor and the sick[9]. Indeed, survey results showed also that the poorest households spent proportionally four times more than the richer households to provide healthcare for their families (29.70% versus 7,02%; p=0,000).

In conclusion, this participative evaluation showed, as numerous studies[2-5], that user fees are inappropriate to finance a health system. In short, payment for health care services by the users provides very marginal economic benefits and is the most retrograde financing system. As for local mutual insurance schemes, they are still embryonic, of external origin and, for the time being cover very few people[10]. Above all, they fail to provide for the poorest section of the population. In general, the mechanisms enabling indigent people to access health care are insufficiently developed, not always socially acceptable, very rarely organised and, where they do exist, are subject to frequent abuses[11]. A health care system financed primarily through public funds remains the ideal arrangement to ensure equitable access to quality health care. The right for free access to health care is now clearly included in the new afghan Constitution.

Changes implemented

Following this evaluation and the evidence of ineffectiveness and inequity of the health financing system in AMI health facilities, many decisions were taken by AMI staff in order to increase the use of health services, and by the same way the equity of the system. It's has been argued elsewhere that the links engaging evaluator and participants through participatory evaluation was essential to influence the NGO staff and for the successful effort to adopt and adapt results[12] following the different stages of knowledge utilization.

As advised[11,13], changes were implemented in the field of financial and geographical accessibility. All changes were decided and implemented in a participative way and most if not all of them received a great welcome from the medical and administrative staff. Four reasons could be the cause of that welcome: i) staffs were aware of the difficulties of access to health care for the Afghan population after many years of conflicts, ii) staffs believed (and understood) that international aid is available and in order to provide free services, iii) some of them remembered the time, before or at the beginning of the war, when governmental health services and NGO services were (supposed to be) free, iv) as the cost-recovery system was something new, people were not really aware about sustainability topics (at least 90% of the health facilities budget are funded by NGO).

The following changes were thus implemented in order to decrease the financial contribution of the patients and thereby increase the equity of the system:

- *Increase the awareness in the communities:*
  Community health committees were established for each health facilities (HF). Those committees were composed by elders (exclusively men) from surrounding villages. Many discussions were organized regarding i) the relevance and importance to use HF, especially for women and children, ii) the underlying assumptions concerning the cost-recovery system, iii) the utilization of user fees for HF and iv) the importance to establish an exemption system for worst-off.
- *Increase the awareness for the hospital staff about the relevance of exemption scheme:*
  Even if the decision-makers for exemption were still the medical staff and not the communities themselves as it should ideally be, the staff was oriented on the importance of i) exemption schemes even in a cost-recovery system and ii) reduction of the past linkages. A management system was organized for this purpose.
- *Free access to some health services:*
  All reproductive health care services, nutrition care services and transports of patients with the ambulance of the hospital for reference became free of charge. This decision was taken in a participative way with all HF directors. As it was not possible in a first time to run all services for free, even if it was the will of some of the directors, only services that were frequently used by vulnerable population (i.e. women and children) were selected in order to encourage the utilization of HF by those groups.
- *Free access to some drugs and better drug management:*
  Most of preventive drugs became free of charge: anti-malarial drugs, mebendazole, ORS, iron, folic acid, vitamin A and family planning items. This list of drugs was made in order to increase the utilization of preventive health service. In addition, thanks to the improvement of drug management system, the percentage of days without 10 essential drugs in the hospital decreased largely from 2000 to 2003 (data not presented).

METHODS

The impact of these changes in terms of financial accessibility to health care at the provincial hospital will be demonstrated through some data collected in the health facility. Number of outpatients (OPD), deliveries, antenatal care (ANC) and postnatal care (PNC) consultations were collected from the AMI's health system information. The consultations rates were calculated with population data from Ministry of Health. Other indicators were collected through a Bed Census[6] in August 2001 (n=39) and November 2003 (n=32).

RESULTS

Table 1 shows an improvement of service utilization between the year 2001 and 2003 and Table 2 a reduction of the costs for IPD patients and thus a better financial accessibility to health.

Table 1 : Utilisation of different types health services and different categories of patients in Mehterlam hospital from 2001 to 2003

	Oct 00 - Sept 01	**Oct 01 - Sept 02**	**Oct 02 - Sept 03**	**2003/2001**
Total OPD consultations	40 088	60 777	88 258	2.2
Male	7 991	11 125	18 249	2,3
Female (including ANC/PNC)	15 237	17 510	21 348	1,4
Children < 15 years old	16 860	32 142	48 661	2,9
OPD District Rate by inhabitant	*0,30*	*0,44*	*0,62*	2.1
ANC consultations	2 069	3 560	4 802	2,3
PNC consultations	37	222	312	8,4
Deliveries	1 271	1 596	2 711	2,1

Table 2: Comparison of the results of the two beds census in 2001 and in 2003

	August 2001	**November 2003**	***P value***
Percentage of exempted people	8	28	*NA*
Official IPD rate (in AFG*)	20.000	20.000	*NA*
IPD cost declared by patients (in AFG)	340.000	28.000	*0,000*
Percentage of patients who found prices expensive	82	46	*0,002*
Percentage of patients who had sufficient resources to pay	18	58	*0,001*

*All financial data are expressed in old Afghanis (AFG). The financial reform of 2003 replaced the old notes with new ones with smaller figures. 1,000 old Afghanis equal to 1 new Afghani.

DISCUSSION

Different biases were identified, which need to be taken into account for the interpretation of the results exposed in the two tables:

1. Concerning the increase of the number of consultations

After September 11th 2001 and American forces invasion, Taleban were obliged to leave the country which induced two causes of increase of the utilization of health services:

- A huge number of refugees from Pakistan came back to the eastern region with new resources and knowledge. To avoid this bias, consultation rates were calculated according to the population number of the district. However, the quality of population data in a post-conflict country is never perfect.
- The reductions of Taleban and conflict influences were in favour of population movement due to a better security.
- The director of the hospital changed between 2001 and 2003, which can also have an influence on the number of consultations.

2. Concerning the financial accessibility for patients

- The incentive from the Taleban forces to impose some free services for their fighters or relatives disappeared and hospital staff was freer to decide and manage the exemption scheme.
- Even if no clear data is available, it could be said that the wealth of the population has increased. Employment market became larger in public and private sector, fluidity of commercial and business exchange enlarged (inside and outside the country), demand for agriculture products and outputs increased and the cultivation of poppy spread-out and the sales of opium increased dramatically.

All these existing biases, especially the great changes in the context of Afghanistan between 2001 and 2003, make it difficult to prove that the actions implemented by AMI (awareness of staff and communities about the problematic of user fees, better management of the exemption schemes, free access to some drugs and some services, better drug management,…) are 100% responsible of the increase of the utilization of health services. As this type of evidence is difficult to obtain in developing countries (see the debate around the Cameroon experience[14,15]), it is largely impossible in a conflict country as Afghanistan. If the changing context of the country contributed probably to the increase of OPD rates during these 2 years (refer to Table 1), it seems that this increase concerns mainly men and children (2.3 and 2.9 times more consultations vs 1.4 times more consultations for women). This means that the changing context with the flight of Taleban, had probably an impact on men and children and not so much on women's accessibility to health. This can be easily explained by the fact that free movements of women in Afghanistan are limited more because of deeply-rooted cultural reasons, especially in rural areas, than because of Taleban prohibition.

However, *the accessibility did not increase just because of the changing context.* Table 1 shows a clear increase of the ANC and PNC consultations (2.3 and 8.4 times more consultations). If not influenced by the changing context as explained above, the only factors that could have make them improve are the actions taken by AMI and especially the fact that ANC and PNC consultations became totally free of charge (in a household survey made in 2004, 100% of the families declared not having paid any fee for preventive consultation). This increase of ANC and PNC had obviously an impact also on the number of deliveries attended at the hospital (2.1 times higher).

CONCLUSION AND POLICY IMPLICATIONS

Some of the following ideas should permit the NGOs and other organisations working in Afghanistan to increase the access of health care for the population and especially for the women. Some of them are in discussion at the moment in Afghanistan in a specific Task Force and the implementation of a health care financing pilot research in some provinces will be useful to create some evidence.

The lessons learned are:

- Implementing a program and an evaluation in a participative process and involve community in the decision making process are key factors,
- Even if international literature was clear regarding the equity and effectiveness impact of user fees in health financing, it was essential to provide contextual and local evidences to aware program staff on the implication of different kinds of mode of payment.

The policy and research implications are:

- Increase the capacity of the Ministry of Heath in terms of health financing knowledge and its implications,
- Organize the harmonisation of payment practices and supervision, including private practices,
- Authorise and supervise local retention of funds, managed by community health committees, to be used to improve quality and accessibility of healthcare services,
- Increase the level of activities (i.e. training) and rationalization of prescription-making,
- Apply a sliding fee scale, according to the patient's place of residence,
- Implement action researches on community exemption system, i.e. the communities have to identify the poorest and inform them about the free access,
- Implement action researches regarding the relevance of a risk sharing scheme.

KEY FINDINGS

- The relevance of a participative approach in program evaluation and implementation
- The importance of contextual and local evidences to aware program staff
- The relevance to provide free of charge preventive care

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