Over more than two decades of conflict, Afghanistan's health system came to depend heavily on assistance from donors and non-governmental organizations (NGOs). When the Taliban fell in November 2001 the health system was in a state of collapse; Afghanistan's health indicators were amongst the worst in the world. National Health Policy is to deliver an essential package of health services to the entire population. It is acknowledged that reconstruction of the health system will depend on donor financial support and NGO involvement in health programmes. An example is Médecins du Monde's involvement in health system rehabilitation in the Ghor province. Investing in health can contribute to peace, stability and political transition. Security, needed for reconstruction and for NGOs to continue their crucial work in health, has recently deteriorated in parts of Afghanistan. Joint Regional Teams to provide security to outlying areas have been announced by the US. There is concern that their proposed humanitarian and development role could compromise perception of the neutrality and impartiality of NGOs.

KEYWORDS Afghanistan Healthcare Non-governmental organizations Post-conflict reconstruction

Rebuilding the health sector is absolutely crucial for the future stability and socio-economic development of Afghanistan ... Investing in health, among other social services, is investing in peace and prosperity.

Gro Harlem Brundtland

Introduction

When the Taliban fell in November 2001 following US-led military action, Afghanistan had suffered 23 years of conflict and its health system was in a state of collapse. After the fall of the Taliban Médecins du Monde assessed health needs in the Ghor province and set up a new project in the provincial capital, Chaghcharan, part of which was to assist in rehabilitation of the only hospital in the province. I joined the project team as doctor in February 2002. This article describes the overall health and healthcare context in Afghanistan and my experience of the project in Chaghcharan.
The Afghanistan Health System

Afghanistan is a landlocked country, at the crossroads of Asia. It consists mainly of mountain and desert and only about one-tenth of its land is cultivable. With a population of around 22 million, it has long been one of the poorest countries in the world, near the bottom for average per capita income and in the Human Development Index of the United Nations Development Programme (UNDP). The country has suffered much conflict during its history. In 1979, one year after a military coup, Soviet troops invaded Afghanistan; they withdrew ten years later after heavy conflict with the anti-Soviet mujaheddin. Civil war continued, with the Taliban holding power over most of the country from 1996 until US-led military action in October 2001. The Taliban fell and under the Bonn Agreement an Interim Administration was set up with Hamid Karzai as Chair. After the loya jirga in June 2002 the Afghan Transitional Authority was formed with Karzai as President. Nationwide elections are due to be held by June 2004, but security is fragile and there have been two attempts on the life of President Karzai.

In the period between the 1930s and the Soviet invasion Afghanistan underwent modest economic and social development concentrated in urban areas. The urban/rural divide is still an important problem and is most marked in relation to Kabul. Before the Soviet invasion in 1979 there was already quite a large hospital sector with lesser provision of health services in rural areas. Following this, in areas controlled by the Soviets, urban hospital capacity was increased and mid-level practitioners (Feldchers) were trained and introduced by the Ministry of Public Health (MoPH). At the same time the influx of Afghan refugees into Pakistan led to donors setting up cross-border health services, mainly staffed by community health workers and volunteers. The MoPH on the one hand and the donors and non-governmental organizations (NGOs) on the other ran their services without communication and the legacy of this division is contributing to difficulties in integration today. The Soviets attempted to reduce support for the mujaheddin through depopulation of rural areas and this included the destruction of schools and health facilities. Consequently, when the Soviets withdrew, 60 per cent of rural health centres had been destroyed, infant mortality had increased and life expectancy fallen. The civil war continued with destruction of Afghanistan’s limited infrastructure and there was a breakdown of state and civil society. As government social services ceased to function, United Nations (UN) agencies and NGOs assisted in provision of essential social services with NGOs providing almost all the resources to run health services in Afghanistan. According to a World Health Organization (WHO) report in 2000, only about one-third of the population had access to local health services.

In the West much attention has been given to the position of women and women’s rights in Afghanistan. In 1994, even prior to the Taliban,
there were restrictions on women’s dress and women working. During the years of conflict women suffered rape and forced marriage under warring factions. As the Taliban took power over most of the country, controlling 90 per cent by 2001, their decrees included restrictions on women’s behaviour and dress and on the work of female physicians, which severely curtailed women’s access to healthcare. Violations could result in public beatings. In 1997 women patients were segregated into separate hospitals, in Kabul to one partly-built, minimally equipped hospital. Protest internationally and from the aid community alleviated this situation by the end of 1999. From Daud’s republic in the early 1960s until the late 1970s education of women had increased, with women attending universities and participating in work. Before the Taliban took power almost half of doctors in Afghanistan were women, but under the Taliban training of women as doctors and nurses was initially curtailed. In 1999 Taliban restrictions eased, allowing women to work as doctors and nurses treating only women. However, given the small numbers of medical staff overall, there was a lack of qualified female personnel and in 1999 some female medical students were allowed to continue their studies at Kabul University. WHO supported the re-opening of the nursing schools in Herat in 1999 and Kandahar in 2000.

Throughout more than 20 years of conflict the education and training of health workers had not been standardized and there was no co-ordinated plan related to the needs of Afghanistan. At the time of the fall of the Taliban the existing health system was in a critical state, buildings had been destroyed or not maintained and there was a severe shortage of health personnel with many dead, disabled or having fled into the diaspora and not replaced. UNDP reports one physician for every 50,000 people in Afghanistan. Basic health centres are lacking in many districts and overall there is only one per 90,000 population. WHO gives a figure of 6 million Afghans without access to basic healthcare. Nearly half of hospital beds in Afghanistan are in Kabul, which has 100 times more doctors per capita of population than a province such as Bamyan. It is important to note that some of the more remote areas in Afghanistan have never been part of the formal health system and people have relied on traditional practitioners.

Health of the Afghan Population

The deterioration of the health system has contributed to the poor health status of the Afghan population with health indices amongst the worst in the world, particularly for women and children. Other important factors affecting health were identified at a workshop on health services held in November 2001 and co-hosted by UNDP, the World Bank and the Asian Development Bank. These included the armed conflict, discrimination against and abuse of women, and a prolonged drought together with collapse of the economy. Another factor identified was displacement of the
population, both internally and as refugees in neighbouring countries, due to conflict and drought. Lack of sanitation and safe water were also recognized as important. In January 2001 the UN reported that only about one-third of districts had reproductive health services and overall immunization coverage was only 30 per cent; one-quarter of children died before the age of five as a result of pneumonia, diarrhoeal disease, measles and other communicable diseases; and estimated maternal deaths from pregnancy related causes were 16,000 per annum. Mortality from malaria is still a problem: there are an estimated 300,000 to 450,000 cases of potentially fatal falciparum malaria a year, with mobile populations being more susceptible. Measles is a continuing cause of death in Afghanistan, mostly affecting children under 15 years and related to low immunization coverage. WHO has reported tuberculosis as a major killer in Afghanistan with up to 70,000 new cases and 15,000 deaths a year. There is an annual risk of infection of three per cent with nearly three-quarters of cases being women, ascribed to early marriage, frequent pregnancies, lower intake of food, more physical work and poorly ventilated houses. The WHO Directly Observed Treatment Short-Course (DOTS) expansion programme was interrupted by the war; DOTS coverage was only 18 per cent in 2000. WHO has now restarted the programme but movements of internally displaced and returning refugees will limit effective treatment of these groups.

In November 2001 the World Bank reported that the protracted drought and breakdown of state and civil society had led to famine and starvation deaths. A recent food security study indicated that the drought is likely to continue for a year or two in the south and the central highlands and found that late-stage coping mechanisms such as selling land or livestock were common. Prioritization of water for human and animal health and continuation of food aid, with cash for work, were recommended. Despite the food security crisis in September 2002, Action Against Hunger reported the suspension of some ‘food for work’ programmes as the World Food Programme is suffering shortages – food provisions have been pledged but not delivered. Malnutrition and nutrient deficiencies remain a serious problem. Half of children under five are stunted, due to chronic malnutrition, and acute malnutrition affects ten per cent. Anaemia in pregnant women and iodine deficiency are common and scurvy has been reported.

There is an extreme lack of reproductive healthcare and Afghanistan has the second highest maternal mortality in the world. Only 15 per cent of deliveries are attended by trained health workers; these are mostly traditional birth attendants, only eight per cent are skilled attendants. In three-quarters of the country women have no access to essential obstetric care and in one-third of districts there are no maternal or child health services. A recent study showed that about 40 per cent of deaths in women of reproductive age were due to maternal causes, such as haemorrhage and
obstructed labour, and indicated that about three-quarters of maternal
deaths could have been avoided. Only five per cent of these women who
died had been delivered by a skilled attendant and only four per cent had
used family planning in the past.\textsuperscript{18}

As already indicated, Taliban discrimination against women had
profound effects on women's health. A survey in 1998 in Kabul found the
health of a majority of women had deteriorated and women had poor
access to healthcare.\textsuperscript{7} Mental health problems became widespread, affecting
increasing numbers of women due to poverty, the realities of war and being
confined to home. There were no mental health services for women.\textsuperscript{4} There
are estimated to be 700,000 widows in Afghanistan and over 30,000 in
Kabul alone.\textsuperscript{4,9} WHO reports that 5 million people in Afghanistan are likely
to suffer psychosocial distress: depression, anxiety and psychosomatic
problems. There is an extreme shortage of mental health professionals and
mental health problems have been long unattended.\textsuperscript{19} The reported number
of psychiatrists in early 2001 was eight, but it is not clear whether these are
still in Afghanistan.\textsuperscript{20}

Afghanistan is one of the most heavily mined areas in the world. Since
1992 it is estimated that anti-personnel mines have killed more than 20,000
people and injured more than 40,000 others. Eighty per cent of these
casualties are civilian, many of them women who work in agriculture.\textsuperscript{4} US-
led military action has added to the burden of unexploded ordnance. In
January 2002 UNDP reported between 150 and 300 new casualties each
month from mines and unexploded ordnance. De-mining and mine
awareness training is still under way.\textsuperscript{10}

Since repatriation began in February 2002 more than 1.8 million
refugees have returned from Pakistan and Iran and this is exacerbating
pressure on health facilities and food aid supplies.\textsuperscript{21}

\textbf{Reconstruction of the Health System}

WHO asserts that investing in the health sector and health recovery can
reduce the risk of conflict and can support peace and stabilization.\textsuperscript{1}
However, reconstruction and the building of trust in government and
public institutions, including health services, cannot be effective without
security and political stability. The political context in which reconstruction
of the health system is undertaken, and how humanitarian agencies engage
with this, can influence the way the health system is restructured. This may
in turn have political implications.

The West isolated and de-legitimated Afghanistan under the Taliban
regime as a 'rogue state'. At the same time the humanitarian agencies
tended to see their work in Afghanistan as supporting a 'failed' state. The
contradiction between political and humanitarian actors led to aid being
provided in the form of small-scale relief and assistance programmes.\textsuperscript{2}
Afghanistan's economy could be described as having become a 'war
economy'. UNDP has typified Afghanistan as a country where resources have been diverted to conflict, the economy criminalized, the country fragmented and in which national institutions have collapsed.\textsuperscript{11} It is argued that in a ‘war economy’ semi-legal and illegal activities can motivate conflict between factions and sustain faction leaders in power. In Afghanistan the key illegal commodity is narcotics. After such prolonged conflict there is a very real risk of continuing entrenched violence. Experience elsewhere indicates the need for demobilization and the curbing of war economies.\textsuperscript{22}

By the late 1990s Afghanistan had become the largest opium poppy producer in the world; in some provinces almost all households sold opium for income. The Taliban ban in July 2000 reduced the incomes of those dependent on this trade.\textsuperscript{8,11} Since the fall of the Taliban poppy cultivation has re-started. Measures have been taken for the destruction of poppy crops, for compensation and to try to provide alternative income sources. However, in 2002 opium production was estimated to be potentially 3,400 metric tonnes, approaching the level before the ban.\textsuperscript{21} Conflict is likely to persist in a situation where there is income from opium, ease of conscription of people living in poverty and high per capita numbers of personal weapons.\textsuperscript{23}

The manner in which the international community engages with Afghanistan and maintains its relationship is very important. It has been argued that for lasting peace in Afghanistan there will have to be a successful political transition and that this will be significantly influenced by how the UN’s political, assistance and human rights objectives interconnect. The 1998 Strategic Framework for Afghanistan provided the UN with a new role, involving greater coherence between political and aid missions with human rights a third institutional pillar. The review of the Strategic Framework concluded that aid cannot fill a wider policy vacuum and that for long-term stability the climate of impunity needs to end and human rights issues need to be addressed.\textsuperscript{24}

For the Transitional Authority questions about a culture of impunity and human rights issues are very much alive. Warlords hold official positions in government, which makes addressing human rights abuses problematic. Lakhdar Brahimi, UN special envoy to Afghanistan, is reported to have said that the government was too fragile for further investigations of alleged human rights abuses at the time of the surrender of the Taliban.\textsuperscript{25} It is in the context of these more general issues that the specific questions arising in health sector reconstruction are considered.

The World Bank presented an approach paper preparing for Afghanistan’s reconstruction in November 2001 at the time the Taliban fell. It was acknowledged that NGO programmes would be crucial in the short term and that reconstruction activities in some regions would be difficult for security reasons. It also emphasized a private sector orientation in post-conflict reconstruction with avoidance of centralized bureaucracies.\textsuperscript{5}
Following the Bonn Agreement and the establishment of the Interim Administration on 22 December 2001, the World Bank published a preliminary needs assessment in January 2002. The assessment made by the World Bank, UNDP and the Asian Development Bank stressed the need for physical security, removal of the threat of mines and action to end the war economy promoted by those involved in opium production. This would include organization of a security force, demobilization and alternative employment for ex-combatants. The assessment identified the most urgent mission in health being to revive preventive and public health services, to provide basic immunization programmes and communicable disease control. It also emphasized maternal and child health, the need for health and hygiene education and recognized the need for refresher training for health workers, many of whom are women. Funding to cover recurrent costs of basic functions of government, including salaries of health workers, would need to come from the international community.26

The National Health Policy Statement of the MoPH acknowledges the importance of rebuilding the health sector within a context of good governance for the socio-economic development and future peace and stability of Afghanistan. Because of the state of the economy donor financial support for the health system over the next five years is acknowledged as crucial. It commits the MoPH to attainment of the goals of Health for All: the enjoyment of the highest standard of health as a fundamental right for every human being. This is to be based on primary healthcare, with the national health sector organized to ‘deliver an Essential Package of Health Services to the entire population’, including establishment of a referral system to deal with emergency and obstetric care. The Basic Development Needs approach of integrated community development will be used and community participation will be supported in all phases from planning to provision, monitoring and cost sharing. Training of health workers will be standardized and expanded, in particular of community health workers to serve in rural and deprived areas.6,12

Putting policy goals into action under current constraints presents a challenge to the MoPH. The statement is not explicit as to how policy will be implemented, nor whether the MoPH sees its function as providing services itself or buying services from agencies like NGOs or for-profit providers. A private sector orientation and lean government is one of the principles of reconstruction strategy set out by the World Bank.5 In any event, the for-profit private sector of health workers running small clinics and pharmacies is growing and will need some form of regulation, which will present the MoPH with a complex task.12

It is estimated that over the next ten years $2.2 billion will be needed to provide even a minimum package of healthcare to the Afghan population.13 Specific funds for providing a basic package of services, available from participating donors for the next three years, could lead to a significant improvement in health service delivery if used correctly.18
WHO reports that its work in complex emergencies has seen health recovery support peace and stability. Such work has involved the redefining of health districts along functional rather than ethnic lines, joint health training for former enemies and local cross-community health initiatives. The MoPH policy statement does not explicitly say how restructuring the health sector would effect the political transition in Afghanistan. However, it does acknowledge the right of every citizen to achieve optimal health through equitable social and economic development, to address major determinants of health and that promoting health education would be part of empowerment and social mobilization. Its policy will be to strengthen women's rights by encouraging women to train and work in the health sector and to ensure that the health system and its health workers respect people's right to be treated with dignity and respect.

**Current Context of Reconstruction**

At the request of the interim government a joint donor health, nutrition and population mission visited Afghanistan from March to April 2002 and in July 2002. The mission included representatives of bilateral and multilateral donors, WHO, the United Nations Children’s Fund (UNICEF) and the United Nations Fund for Population Activities. The donor mission’s objectives were to agree with the government a framework of assistance, an investment programme and a government-led mechanism for partner co-ordination. In July 2002, following field visits, the donor mission reported that where health centres exist they provided reasonable services but they were predominantly in urban or accessible areas, leaving much of the population under-served, and that NGO support to healthcare is critical to continued provision. Though the government appeared not to have decided whether it wanted to be the major provider of services, the MoPH seemed to be recruiting additional health workers and re-hiring staff dismissed by the Taliban. The donor mission found existing health facilities overstuffed and recommended a halt to recruitment until there was a coherent human resources policy, including recruitment of female health and medical graduates. The donor mission stated that the policy of the government was to provide all health services free of charge. The donor mission’s opinion was that savings could be made from cutting over-staffing. It recommended that the MoPH and NGOs levy no new user-charges and phase out existing charges unless they meet certain standards. It was agreed that the key objectives of the health, nutrition and population sector are to reduce the rates of infant and maternal mortality, fertility and child malnutrition, but it was also felt that these impact indicators would be unlikely to improve in the next few years and would need long term monitoring.

At the time of the first joint donor mission NGOs were involved in about 84 per cent of health facilities. Based on work in other post-conflict
situations, there will be a need for the MoPH to work systematically to expand essential services to provide an estimated 1,000 new health facilities in rural areas. The MoPH itself lacks capacity to implement policy; previous MoPH health workers are in major urban areas and predominantly male with inappropriate skills. It was acknowledged that both the MoPH, in overall authority, and NGOs are needed to address the huge health needs of Afghanistan. The way forward may be Performance-based Partnership Agreements with NGOs, which have been used successfully in other post-conflict situations.\textsuperscript{12,18}

Overall, coverage of essential services is very poor and needs rapid expansion if the health status of the population is to be improved and if there is to be confidence in the Transitional Authority's ability to reconstruct.

**Chaghcharan**

The World Bank made a Preliminary Needs Assessment for Recovery and Reconstruction in Afghanistan in January 2002. Its report stated that 'it is difficult to understate the low base from which reconstruction will begin'.\textsuperscript{26} This rang very true for the healthcare situation in the central province of Ghor shortly after expulsion of the Taliban in late 2001. Médecins du Monde made an exploratory mission to Ghor and found that for an estimated 800,000 population of the province there were one hospital, six dispensaries and three maternal and child health centres. Much of the province was without any healthcare facilities and those few existing had been damaged and looted during the recent conflict. Having identified such great need, Médecins du Monde set up a project funded by the European Commission Humanitarian Aid Office at the provincial capital, Chaghcharan, starting in February 2002. I joined the project team as doctor for four months from February to June 2002.

Ghor province is one of the poorest provinces of Afghanistan. It is mountainous semi-desert with severe winters and had suffered drought for the previous three years. Many people in the province survive on food aid and cases of scurvy have been reported. Though there was some rain in 2002 which brought improvement in the food situation, the population of Ghor still experiences a high level of food insecurity. As a consequence of the drought, the livestock that provided the major income for the province have been decimated. Some cultivation of opium poppies in the province has restarted as a source of income. As a result of the drought and the consequent impoverishment and lack of food, around 50,000 people from the province, including nomadic Kuchi, left Ghor province for camps for the internally displaced in the west and south of Afghanistan. Large numbers returned in 2002 despite the food insecurity.

Ghor was the scene of confrontations between the Taliban and pockets of mujaheddin resistance. The most recent fighting occurred between August and November 2001. The Taliban finally left Ghor province in the
second week of November 2001 and about 70 people were reported to have died in their retreat from Chaghcharan. Ghor was not bombed during the US-led campaign, but some areas had been mined at earlier times and de-mining is still sometimes needed. At the time of our project, security was through the local commander of the division of the Afghan army in the province of Ghor, to whom it was necessary to refer a number of security incidents affecting the hospital.

The MoPH hospital in Chaghcharan was well constructed when built at the time of President Daud in the mid-1970s, but lack of maintenance during 23 years of conflict left the hospital without piped water or a functioning sewage system, without electricity or heating, with a leaking roof and many broken windows. The staff had had no salaries and the hospital no funds since September 2001, leading to poor morale and frequent absences. Most medical and nursing staff undertook some private activity in the afternoons in the bazaar. The training of staff had been of variable length and often some time ago; some older nursing staff had difficulty reading and writing. During the previous winter there were no in-patient admissions, as there was no heating in the wards and temperatures fell to minus 15°C. Only a handful of operations had been carried out over the winter. There were no female medical or nursing staff and no reproductive health services for women. Women in the area were reported as dying in labour. Out-patient sessions were overcrowded and the referral hospital in Herat was at least two days away by a hazardous road that was often impassable in winter. There were no diagnostic facilities and only irregular stocking of the pharmacy with donations of basic medications from UNICEF.

The diseases commonly seen at the hospital were those of poverty, a poor restricted diet, poor water quality and lack of sanitation: tuberculosis, malnutrition, diarrhoeal disease, respiratory infections and digestive disorders. Some patients had mine injuries, others gunshot injuries following personal feuds or from being caught in crossfire between warring factions. Common causes of death in the province were pneumonia, diarrhoea, malnutrition, conditions of pregnancy and post-partum, typhoid, tuberculosis and liver disease.

As Chaghcharan Hospital was the sole hospital in the province some patients arrived nearly moribund after journeys of several days by donkey or improvised stretcher. In winter such journeys in a mountainous region become impossible.

Médecins du Monde’s project involved working with the hospital staff to rehabilitate the buildings; to help the hospital staff raise the functioning of the hospital and level of care provided and to supply essential medicines and basic equipment. The project also provided training for the nursing and medical staff. All this work was very much in partnership with the Director of the hospital, also the MoPH representative for Ghor province, and the staff. My role was to accompany the hospital’s three doctors, surgeon and
three assistant doctors during their out-patient clinics and in-patient rounds and to discuss patients’ diagnoses and treatment. I also provided interactive training sessions on issues such as the use of antibiotics and intravenous fluids and began training on the diagnosis and treatment of common diseases.

There was an urgent need to develop reproductive health services for women at the hospital. Yet it proved impossible to recruit any Afghan female doctors or translators to come and work in Chaghcharan. There are very few overall and they are unwilling to come and work in what is perceived as a remote and very traditional area. Any Afghan woman coming to work in Chaghcharan would have to bring a male family member to live there with her and accompany her. A female gynaecologist was therefore recruited from France to join the project team to begin a gynaecological clinic at the hospital and to start training local women as midwives and health educators. She also began training local traditional birth attendants in safe delivery and the male hospital surgeon in caesarean section and basic gynaecological operations.

When I left the project in June 2002 staff morale had improved, the level of care provided at the hospital had been raised and the range of services extended. In-patients were being admitted and a gynaecological service had been set up with some attended deliveries. The training in reproductive healthcare would allow services for women to be continued by local staff. The out-patient clinics were better organized, a formulary of essential medicines for out-patients had been developed and there was an improved administrative structure. The project will continue until July 2003, but the expatriate staff left in November 2002 for reasons of security because evacuation is difficult in winter. Afghan staff continue the work alone until expatriate staff return in March 2003.

Médecins du Monde’s project is an example of post-conflict NGO support for a healthcare facility that was struggling to provide care in an under-served area, to improve and extend its services. Experience of the situation in Chaghcharan indicates that for the MoPH to achieve provision of an essential package of health services to the entire population of Afghanistan presents an enormous task. The role played by NGOs in supporting the work of the MoPH will be essential.

**Conclusion**

The joint donor mission described a ‘vibrant NGO sector’, ‘budding commercial sector, and a high level of political commitment’ providing ‘powerful opportunities to develop effective and client responsive health services’.\(^1\) In order to build up capacity and gain credibility by satisfying expectations of the people of Afghanistan, the Afghan authorities need funds. However, to gain funds they need to demonstrate their capabilities.

WHO reports that empirical evidence suggests that investment in health can reduce the risk of conflict at the same time as mitigating its effects.\(^1\)
WHO recommends that in post-conflict situations the health sector can take the opportunity to reform past systems and structures that could have contributed to economic and social inequalities and conflict. A broad understanding of the conflict and victims and political actors, a full consideration of human rights issues and a wide public health approach is needed.\(^{27}\)

In post-conflict Afghanistan reconstruction of the health sector depends on peace and security, on an ending of impunity and integration of human rights into health programmes. Continuing international commitment and support are essential to this process. Reconstruction will depend on flows of donor funds and NGO and agency activity as well as the evident commitment of the people of Afghanistan. President Hamid Karzai recognizes the Afghan people’s urgent need to see change and for promises to be kept. Many regions remain under the influence of warlords, leading to lawlessness, robbery and pillage. Lakhdar Brahimi, the UN’s most senior official for Afghanistan, has reported that security in Afghanistan had ‘deteriorated seriously’. There were reports of an increase in banditry in the centre, north and south-west and some aid offices had been evacuated. Though the US was reported to support extending the mandate of UN peacekeepers, British diplomats were reported as saying that this was impracticable as no nation was ready to provide troops or funds.\(^ {28}\)

New arrangements have now been announced by the US for Joint Regional Teams to address security concerns through negotiations rather than a military presence and to increase the development and humanitarian input of the US-led coalition. The UN and NGOs are concerned that this will lead to the coalition military being seen as associated with the aid community. This in turn could lead to apparent compromise of the aid community’s neutrality and impartiality, making their work difficult and potentially putting aid workers at risk.\(^ {29}\) If the security situation continues to deteriorate this will affect Afghanistan’s efforts to restructure, rehabilitate and expand its health system and the crucial ability of the NGOs and agencies to work to support it.

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References

A list of further relevant resources is available from the author.


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