A year in Afghanistan — Herat hospital paediatric ward

AFGHANISTAN'S recovery from decades of conflict continues. Currently, the majority of health care is provided by national or international non-governmental organisations (NGOs); estimates suggest that over 80% of health facilities have some form of NGO involvement.[1] However, ensuring access to the population poses great difficulties for such NGOs.[2] The recent killing of five Médecins Sans Frontières (MSF) workers highlights the fragility of the ability to respond. Moreover, the acute shortage of healthcare workers in the western provinces compounds the problem. The World Health Organisation suggests that there are 0.8 physicians and 0.1 midwives per 10 000 population.[3] Although accurate data is scarce in a context of nearly continuous armed conflict and displaced populations, current estimates place Afghanistan's infant mortality rate at 165 per 1000 live births, and the mortality rate among children under 5 years of age at 257 per 1000 live births. This is among the highest in the world.[4]

MSF began supporting the paediatric ward of the hospital in Herat city (capital of Herat province) in July 2000. This 400-bed hospital is the only non-military hospital for a province nearly twice the size of Wales. The support consists of international staff, training for the local staff, provision of medical supplies, and a Therapeutic Feeding Centre (TFC). We reviewed the data from 1 year's admissions to highlight the current challenges to paediatric care in Afghanistan.

Between November 2002 and October 2003, 7886 patients, of whom 40 % were female, were admitted to the paediatric ward. Although 71% came from the city of Herat, 27% came from other districts of Herat province, and 2% from other provinces.

Over 70% of children are diagnosed with infectious diseases such as acute gastroenteritis, acute respiratory infection (ARI), septicaemia, meningitis and typhoid. Additional causes of morbidity included anemia (191 cases), dysentery (186 cases), renal/urinary tract infections (160 cases), and drug poisoning (151 cases). Malaria, cholera and tuberculosis were also recorded. Neonatal admissions are virtually all due to birth asphyxia or sepsis.

The ward has severe technical limitations. Laboratory support consists of basic blood, urine and CSF tests, but these are rarely available and quality assurance is unheard of. Radiographs can be obtained but rarely for emergencies, and are of poor quality. No post mortems are performed in the hospital, preventing better understanding of causes of death.

Most diagnoses are made on clinical grounds. The younger doctors' educational opportunities have been severely limited by the conflicts of recent years, so diagnosis and treatment are often unreliable. The standard of clinical medicine is very variable and is often dependent on experience outside of Afghanistan.

The availability of doctors is problematic: although there are over 26 doctors registered at the paediatric ward, often a doctor is not available. This is mainly due to the present government salaries, which are between 1500 and 2000 Afghanis per months (US$ 30–40). This salary makes working in the private sector attractive. Unless extra incentives are paid by international organizations, many wards have doctors from 8am to 1pm only, and few or none during weekends and holidays. Similarly, over the past two decades many doctors fled fighting and emigrated; training during the Taliban government period was limited, especially for women, and Afghan doctors have had to make due with meagre training, support, and wages.

Throughout the year, TFC admitted 514 children, with ages ranging from 20 days to 11 years. Admission criteria are <70% weight for height, <110 mm middle upper arm circumference, or a clinical diagnosis of kwashiorkor. Admissions peaked concurrently with seasonal peaks in diarrhoea and ARI.

Many patients left early (39%) — mainly because each child's carer (almost always the mother), for whom provision is made at the TFC, felt obliged to attend to household duties. Women are often not allowed to stay far away from their houses for the amount of time usually required for a child at the TFC to recover fully (20–30 days). Parents must often choose between caring for one child intensively at the hospital or their other children at home, especially as families are often large. Expanding services to include home-based therapeutic feeding to additional districts is desirable but has been constrained by human resources limitations and security concerns.

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4. UNICEF. State of the world's children. 2004 http://www.unicef.org/publications/index_18109.html (accessed 11 Mar 2004).
5. Chin J. *Control of communicable diseases manual.* 17th edn. Washington, DC. American Public Health Association, 2000.

Some 478 deaths occurred, of which 399 (83%) occurred in the first 24 hours after admission to the hospital. The greatest single cause of mortality was ARI (146 deaths) followed by septicaemia (110 deaths). The strongest contributing factor is late presentation, as most deaths occur within the first 24 hours after admission to the ward. Being a long distance from the hospital, self-treatment, or failed treatment in the private sector, are underlying causes of late presentation.

The morbidities and mortalities seen in the paediatric ward are a barometer for larger public health needs. These include, at the tertiary level, improving the pediatric ward to provide good level secondary care for sick children, although impact on <24 hour mortality can only be limited as the main reason is late referral. This needs to be urgently addressed on all levels – health education for caregivers, private practitioners, doctors in provincial hospitals, and the transport system. In addition, the fact that mothers, especially from rural areas, caring for a child in the hospital cannot stay away from their families for too long must be addressed. Only then will chances of survival for extremely ill children improve dramatically.

At a community level, safe drinking water and greater health literacy are critical for disease prevention. The level of diarrhoeal disease underscores the need for water and sanitation improvements. In addition, certain beliefs are thought to contribute to waterborne illness in infants, as some mothers consider colostrum unhealthy, and only give tea and bread to infants in their first 40 days of life.

The upgrading of technical capacity, training of healthcare workers, and retention of quality medical staff is a high priority, and needs to be treated with urgency. Such an improvement in the accessibility and quality of care will only be possible given adequate commitment from the government of Afghanistan and international partners.

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The doctors they deserve

'Societies get the doctors they deserve' writes Raymond Tallis in *Hippocratic Oaths*, his important new analysis of 'medicine and its discontents'.[1] As an experienced clinician — he is professor of geriatric medicine at Manchester — Tallis is intimately familiar with the realities of contemporary medical practice in Britain. As the author of a number of critiques of fashionable irrational philosophies (such as postmodernism), he is well qualified to appraise the bleak ideology currently permeating the National Health Service.[2] He offers an acerbic assessment of the current crisis of the medical profession.

Over the past 20 years, doctors have been disparaged as paternalistic and authoritarian. In common with other professions, their claims of commitment to public service have been dismissed as a disguise for venal self-interest, and their professional organisations exposed as monopolistic cartels against the consumer.[3] Under New Labour, in particular, the medical profession has been subjected to the full rigours of market-inspired reform and modernisation. Doctors have been smitten with 'the triple-edged sword of transparency, accountability, and regulation'. In an increasingly fractious relationship, the 'demonised doctor–perpetrator' now confronts the 'canonised patient–victim'. The assumption that doctors are untrustworthy, nurtured by a series of scandals, has encouraged a process of political interference in medicine that is likely to prove wasteful, corrosive and destructive.

As Tallis observes, 'an aggressively consumerist society will breed defensive consumerist physicians'. Furthermore, as he perceptively points out, ' "defensive medicine,, is much worse than it sounds'. It is 'a desperate euphemism for a profound corruption in the doctor–patient relationship', 'a betrayal of the professional ethos', that implies abandoning paternalism for 'something much worse — inhumanity'. The Hippocratic principle 'First do no harm' is supplanted by the new ethical imperative: 'First cover your ass and damn the harm'. It is ironic that the principle of informed consent — which has become something between a dogma and a fetish for contemporary medical reformers — will be undermined by this process, as patients will not know the primary reason for the intensive programme of investigations and interventions to which they are subjected.

The medical profession has offered little resistance to the drive to deprofessionalise doctors. While commitment and continuity of care have been undermined by trends towards shift working, part-time working, and the abandonment of out-of-hours responsibilities, doctors have appeared more concerned about their work–life balance than with defending professional autonomy. The dumbing down of medical education and training, and the intrusion of third parties — insurance companies, government agencies, lawyers — into the doctor–patient relationship have contributed to the degradation of the profession. As medicine is transformed from being a calling into a business, a new generation of doctors faces a future of slavishly following protocols, and a working life of clock-watching and box-ticking.

Professor Carol Black, president of the Royal College of Physicians, recently expressed concern that the growing proportion of women doctors might lead to a decline in the professional status of medicine.[4] Tallis offers an interesting aside relevant to the ensuing controversy over the 'feminisation' of medicine. He notes that, despite the increasing numbers of female consultants and GPs — with their widely acknowledged superior qualities of empathy — and despite, too, the formal training of medical students and junior doctors in communication skills, complaints about failings in this area have continued to grow. The key issue here is not the sex of the doctor, but the inherent difficulties of the doctor–patient relationship, 'the incommensurability of the personal experience of illness and the scientific understanding of it'. However, whether a doctor is male or female, the real threat to professional values arises from the shift away from taking genuine responsibility for the welfare of the patient, towards the formal discharge of contractual obligations towards a customer.

In the same spirit in which he has championed the ideas of the Enlightenment against theories that disparage reason and diminish human subjectivity, Tallis challenges today's doctors to take a stand against the current onslaught on professional values. Although a staunch opponent of pessimism, he warns that the cost of failure may be high: 'The doctor as intellectual leader, as clinical pioneer, and as advocate for the patient and the service, as the midwife of the future as well as the servant of the present, may well become a thing of the past.'

References
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