An Afghanistan experience

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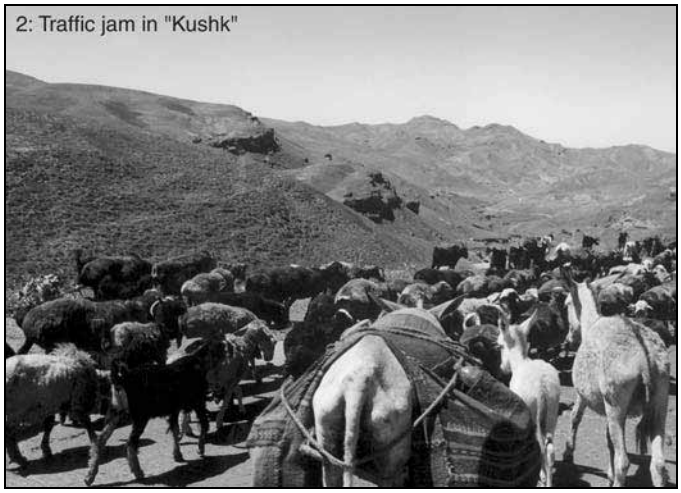
THIS IS A brief account of my six months in Afghanistan in 2003. I worked as the Médecins Sans Frontières (MSF) project doctor in the western province of Herat, spending alternate weeks in Herat City and in Kushk-e-Kohna, a sparsely populated district some two hours north of the provincial capital by four-wheel drive. I arrived in February, just over two years after the US-backed overthrow of the Taliban. Herat is now controlled by its Emir and Governor, Ismail Khan, who rules beyond the reach of Afghanistan's central government. With a private army of sixty thousand men and control of customs revenue from trade with Iran, it is no wonder he has not, despite invitation, joined the government of Hamid Karzai. His unchallenged power and the considerable wealth at his disposal have in fact made Herat relatively more stable and prosperous than the rest of the country.

It is February, and the winter snows are just thinning as I arrive to work in the mobile clinic in Kushk-e-Kohna, which I affectionately call "Kushk", or "palace", in the local language of Farsi. The name clearly harks back to a more prosperous time, for there is no palace to be found in this district of sixty thousand people. The inhabitants have mud-brick houses and live mostly off subsistence farming, growing wheat (Box 1) and raising livestock (Box 2). They have lived like this for generations, and life was little different under the Taliban, although now it is evident that young girls are going to newly built schools. There are only two doctors for the entire population — myself and an Afghan doctor recently recruited by MSF. Dr Mohammad Amin has recently graduated, and is enthusiastic about working with MSF, learning English and broadening his knowledge. Before 2003, locals had to gamble on the only "healthcare" available — drugs sold in private pharmacies by untrained "drug sellers".

And so it is that after a week I begin getting used to the hundreds of patients presenting every day, many having walked for hours, thronging around the makeshift consultation room and desperately pressing to be seen (Box 3). The mobile clinics are situated across the district, with MSF's base in the district centre of Kooklam. We visit one or two


1: Melting snows and sprouting wheat


2: Traffic jam in "Kushk"

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3: At the mobile clinic


4: Our three-car convoy

villages each day, staying until dusk. Each clinic is one to two hours' drive from Kooklam over rough terrain and is visited every two weeks.

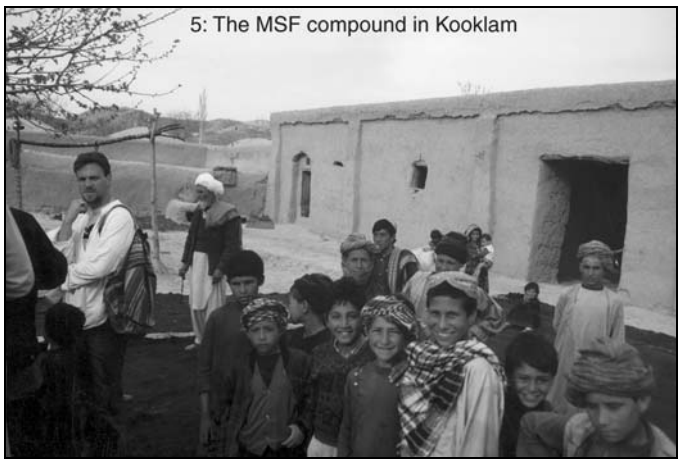
The crowds are becoming more manageable as we begin using mass consultations to get through the large numbers of patients, seeing thirty at a time and triaging by casting an eye across the crowd to identify the seriously unwell. In so doing, Jodie, the expatriate Australian nurse who is assisting me, spots an unconscious child and distressed father. The four-year-old is clearly very unwell. His head is arched back, and the petechial rash across his upper chest confirms the diagnosis of meningococcal meningitis for us. Without pathology services or a hospital nearby, we treat him with an intramuscular dose of oily chloramphenicol, which will slowly be absorbed over the next week. We urge the boy's father to take him to Herat City Hospital, but he doesn't have the four dollars to hire a taxi, nor can he leave his wife and children unaccompanied at home. Afghan culture dictates that any woman must be accompanied by her husband or a male relative, and so her husband stays. I find it difficult to overcome the sense of despair and helplessness in treating an often fatal illness in a day clinic, but hope for some response regardless. It is therefore with joy and surprise that we see little Nazamuddin two weeks later, alive and well, on our return to the village for another round of consultations. I had not seen chloramphenicol used like this before, but am told that it has been used successfully in meningococcal outbreaks in Sub-Saharan Africa.

Our feeding program runs concurrently in the old storeroom next door. Forty children are getting supplementary food and standardised medical care today. They receive a corn/soy/bean mix, iron/folate tablets, vitamin A, mebendazole and antibiotics on their first presentation. They are treated for malaria if febrile. Any severely malnourished children (who should really be in a hospital), will at least get some treatment to optimise their chances while remaining at home, and will be seen by us on a fortnightly basis. These children will get oily chloramphenicol, the wonder-drug, when they first present, and a special nutritional supplement, PlumpyNut, of which they are quite fond. It is a so-called "ready-to-use therapeutic food" containing peanut.

Jodie oversees the activities, but the Afghan staff have it running like clockwork, undressing and weighing the children, crushing their tablets into a paste, and giving parents cards to pick up the food bags and to record their children's progress. Our health educator is speaking to the crowds about hygiene and diarrhoea. The outreach workers are busy screening new patients for malnutrition, and occasionally I review one who appears particularly unwell.

Tuberculosis seems to occur everywhere. Many patients have bought antituberculous drugs from local pharmacies, taken them for a few weeks, then stopped taking them because of the expense. No-one has been formally diagnosed, and several don't have TB at all, but the fear of it is great, as they have seen relatives become weak and die. Patients I diagnose can't go to Herat, where MSF's directly observed short-course treatment (DOTS) TB program[1] has just commenced. So all I can do is entreat them not to buy more TB combination blister packs from Pakistan, telling them that they will get resistant TB and that they should wait for a rural TB program to start (although this is certainly years away). I wish I could offer them the services of our Herat TB program, which is a runaway success — I am heartened to see many patients who were initially brought to us in wheelbarrows now looking completely well. For me, their deep gratitude is humbling and heart-warming.

The consultations *en masse* become an unexpected forum to talk to Afghan women about their mental health. There is one psychiatrist for the entire province of two million


5: The MSF compound in Kooklam

people, so discussing mental health is unheard of in this conservative, desperately poor district. When women present in great numbers, all complaining of "body pain", we decide to see them together to explain the nature of their illness. Body pain, as a complaint, is hardly known in Western countries, yet is a common complaint of southern Asia and the Middle East. Women, and sometimes men, report months or years of head, shoulder, back, leg and arm pain. In a country that has suffered twenty-five years of civil war, it is clear that psychological trauma, grief and personal loss contribute greatly to how this problem manifests.[2] I therefore find myself in an unusual position — male, foreign and non-Muslim, yet privy to the private traumas of rural Afghan women.

Some have lost husbands, and many, many have lost children. Nasima is heavily pregnant and pleads with me to keep her child alive, as she has lost eight previous children in pregnancy or in the first year of life. In Afghan society, no woman is complete without bearing children. Through her clothes, I feel her abdomen. I feed my stethoscope under her clothing to auscultate, without revealing her skin. Through all this she keeps her headscarf across her face, and speaks quietly from behind her hand. We prescribe what we give all women in late pregnancy: ferrous sulfate, folate, and multivitamins. It is a rural tradition to cut the umbilical cord using the heel of a shoe, with its obvious risk of causing neonatal tetanus. We therefore urge her to visit the MSF clinic in the district centre for her first tetanus vaccine, and advise against the traditional practice. Unfortunately, the four-hour ride by donkey to the clinic is a difficult prospect for a woman eight months pregnant.

There are other misconceptions to overcome. Afghan women throw away colostrum, critical for a newborn, giving a child water or tea for two to three days. Such ideas are entrenched, but as expatriates we are regarded somewhat as magicians, and listened to intently.

Abdul Rafour, a man in his forties, is being led into our dusty consultation room. He removes his dark glasses, and we realise he has no eyes. His face is a patchwork of scars. He has been a victim, some years earlier, of one of Afghanistan's ten million landmines. He complains to me of deafness and inability to sleep, and it is soon clear that he suffers from post-traumatic stress disorder and bilateral chronically perforated ear drums. What can I do for him? Nothing at all. I call the next patient in.

Today's drive home takes two hours in a three-car convoy (Box 4), mostly along a dry riverbed. I listen to my portable CD player as I take in the serene vista of the foothills of the Hindu Kush mountain range. There are twelve of us squeezed into the landcruisers: expats and Afghanis, drivers, a translator, a feeding centre supervisor, outreach workers, a health educator, a registrar, a doctor's assistant and a scooper for the food distribution. We're all sitting on or around our portable gear: tables, chairs, mats, medication, dressings, height boards and scales. On the way home there is more room, as we have distributed over three hundred kilograms of food during the day. Arriving at our compound (Box 5), we play cards, then volleyball. I fit in a quick snooze and some reading by lantern light until dinner (rice, eggplant, tomato and bread). I go to bed early, to the familiar, vibrant singing of the Afghan staff outside.

Afghanistan has given me a profound insight into the challenges of aid work in a country ravaged by twenty-five years of civil war. The US-led attack on the Taliban in 2001 was only the most recent trauma in a long history of terrible conflict. What is emerging now is a tenuous and fragile peace, with ongoing conflicts between rival warlords, guerilla attacks by Al Qaeda and Taliban remnants, and no effective unified government or military force.

In this context, the challenges of aid work are only partly medical. Many of the obstacles to bringing health to the Afghan people have to do with politics, security, culture and trust. For Afghanistan, the first incremental steps are being made to tackle the appalling health situation, but there needs to be a foundation of stability, security, economic growth and basic education before significant inroads can ever be made. It is a country with a burden of disease that is mostly preventable, a country poisoned by land mines, and where the fundamental right of access to basic medical care is still an unattainable aspiration for most. Most importantly, if Afghanistan is to leave behind its tragic past, its plight must not be forgotten by the international community.

References

1. Médecins Sans Frontières (Doctors Without Borders). Search for "directly observed short-course treatment" (DOTS). Available at: www.doctorswithoutborders.org (accessed Oct 2003).
2. Helman CG. Culture, health and illness. 4th ed. New York: Arnold Publishers, 2001.

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