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Country Cooperation Strategy

**For WHO and Islamic Republic of
Afghanistan**

2005 to 2009

TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS

EXECUTIVE SUMMARY

SECTION 1. INTRODUCTION

SECTION 2. COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

- 2.1. Demography and main health problems
- 2.2. Socio-economic and political context
- 2.3. Other determinants of health
- 2.4. History of evolution of the national health system
- 2.5. Current health status
- 2.6. National health policy and priorities
- 2.7. Current health system
- 2.8. Challenges to national health development
- 2.9. Some key issues related to health sector
- 2.10. Summary of achievements and key health development challenges

SECTION 3. DEVELOPMENT ASSISTANCE AND PARTNERSHIP: AID FLOW, INSTRUMENTS FOR COORDINATION

- 3.1. National Development Priorities
- 3.2. National Budget
- 3.3. Health and Nutrition Program
- 3.4. External assistance
- 3.5. Promotion of partnership and instruments for coordination.

SECTION 4. CURRENT WHO COOPERATION

- 4.1. Background
- 4.2. Key areas of collaboration
- 4.3. WHO country office human resources
- 4.4. Fellowships, meetings, seminars

SECTION 5. WHO POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS.

- 5.1. Operating framework
- 5.2. Country level functions
- 5.3. Strategic directions
- 5.4. WHO Global priorities
- 5.5. Regional priorities

SECTION 6. STRATEGIC AGENDA: PRIORITIES JOINTLY AGREED FOR WHO COOPERATION IN AND WITH AFGHANISTAN FOR 2005-2009

- 6.1. Introduction
- 6.2. Overall health sector policy and sector management
- 6.3. Health system development
 - 6.3.1. District health system
 - 6.3.2. Human resource development
 - 6.3.3. Health care financing
- 6.4. Reproductive and Child Health
- 6.5. Health Education, prevention and promotion
- 6.6. Mental health
- 6.7. Control of communicable diseases
- 6.8. Emergency preparedness and response.

SECTION 7. IMPLEMENTING THE STRATEGIC AGENDA: IMPLICATIONS FOR WHO SECRETARIAT.

- 7.1. Implications for the Country Office
- 7.2. Implications for the Regional Office and Headquarters.

References/Bibliography

ANNEX 1. WHO CCS Team Members to Afghanistan

ANNEX 2. List of people met

ANNEX 3. Briefing Note on Modalities for Health Care Financing

ANNEX 4. Afghanistan Health Sector Balanced Score Card 2004

ANNEX 5. List of Revised Millennium Development Goal, Targets and Indicators for Afghanistan

ANNEX 6. MoPH Organogram

ACRONYMS AND ABBREVIATIONS

ADB	Asian Development Bank
ARTF	Afghan Reconstruction Fund
ARDS	Afghan Reconstruction and Development System
BHC	Basic Health Center
BPHS	Basic Package of Health Services
CCA	Common Country Assessment
CCS	Country Cooperation Strategy
CHC	Comprehensive Health Center
CHW	Community Health Worker
CSO	Central Statistical Office
DH	District Hospital
EC	European Commission
EPHS	Essential Package of Hospital Services
GCMU	Grant Contract and Management Unit
GDP	Gross Domestic Product
HP	Health Post
JHU	Johns Hopkins University
JPRM	Joint Program Review Mission
ICRC	International Committee for Red Cross
MDG	Millennium Development Goals
MICS	Multiple Cluster Survey
MoPH	Ministry of Public Health
MOI	Ministry of Interior
MRRD	Ministry of Rural Rehabilitation and Development
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
NRVA	National Risk and Vulnerability Assessment
NRVS	National Risk and Vulnerability Survey
PHD	Provincial Health Department
PIP	Public Investment Program
PPA	Performance based Partnership Agreement
PRR	Priority Reform and Restructuring
REACH	Rural Expansion of Afghan Community based Health Care
SWAp	Sector wide Approaches
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UNODC	United Nations Organization for Drug control
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
WFP	World Food Program

EXECUTIVE SUMMARY

The Country Cooperative Strategy (CCS) is strategic framework for WHO technical cooperation with a member state for a period of 4-6 years. The CCS for Afghanistan was developed in July 2005 through a period of two weeks of intensive consultation with senior officials in the Ministry of Public Health (MoPH), with representatives of major donors to the health sector and with WHO staff based in the country. This consultation process was preceded by a detailed situation analysis of the health sector by a team specially constituted for this purpose with in the MoPH.

Since the beginning of 2002, the MoPH has made significant progress in charting the direction of the health sector for the medium term period. It has formulated a clear and well defined national health policy for 2005-2009 and a national health strategy for 2005-2006. The three broad elements of health policy aim: at implementing health services using the basic package of health services (BPHS), the essential package of hospital services (EPHS) and the establishment of prevention and promotion programs; reducing morbidity and mortality by improving the quality of maternal and reproductive health and the quality of child health initiatives and at building institutional capacities through the promotion of institutional and management development, strengthening human resources especially of female staff and by strengthening health planning, monitoring and evaluation at all levels of health care.

Some of the major health development challenges include: an abysmally high maternal, infant and under five years mortality rates; wide spread nutritional deficiency associated with food insecurity made worst by the recent drought; high incidence of communicable diseases notably malaria and tuberculosis; poorly developed health infrastructure; security concerns and lack of communication further limit access to health care and extreme shortage of trained health manpower specially at mid level and female health workers of all categories.

The MoPH has made the tactical decision to deliver health services through donors directly contracting NGOs for delivery of services as outlined in the BPHS, or as in the case of funds received from the World Bank, through a grant contracting management unit with in the MoPH. These contracts with NGOs are known as performance based partnership agreements (PPA). The MoPH, through a contract with Johns Hopkins University, has established system for monitoring the implementation of the contracts. It appears that amount of services delivered to the population over the last year has increased substantially, with a significant increase in the number of functioning basic health centers and comprehensive health units and in female health workers. In the coming years attention will be to be paid also increase the coverage of services and to improving the quality of care. It is clearly early to see the impact of the services provided so far on health outcomes.

It appears that the model of donor-contracting with NGOs to deliver services is likely to continue for several years to come. Being concerned with financing the health care system in the country (which is at present being largely funded through donor support) the MoPH has initiated studies to assess to possibility of generating resources through the

introduction of standardized user charges and /or through setting up community health funds.

The CCS team after undertaking an analysis of the health sector situation and in close consultation with national authorities, identified the following strategic priorities for the coming five years (2005-09):

- *Overall Health Sector Policy and Sector Management*
- *Health System Development including Health Care Financing, Human Resource Development and District Health Systems.*
- *Control of Communicable Diseases*
- *Reproductive and Child Health*
- *Health Education, Prevention and Promotion.*
- *Mental Health*
- *Emergency Preparedness and Response*

The strategic approaches for each of the above mentioned priorities have been spelled out in the full report.

In order to effectively implement the strategic agenda in the coming years, the Organization needs to strengthen its country office in Afghanistan with new competencies and ensure the timely provision of high quality technical and administrative support from its regional office and headquarters.

The CCS formulation in Afghanistan was immediately followed by the Joint Government WHO Program Review Mission and thus provided an unique opportunity for translating some of the findings of the CCS in to detailed programming for the coming biennium 2006-07.

Section 1. INTRODUCTION

The WHO Country Cooperation Strategy (CCS) is a reference framework at the country level for WHO's cooperation with Afghanistan for the next four years for use to improve the country's health sector performance. In developing the CCS, the country's needs and expectations are considered within the regional and global priorities of WHO. The key principles governing WHO's quest for new strategic agenda at the country level are:

- Greater focus on those programs for which WHO has the greatest relative advantage.
- More emphasis on WHO's role as policy advisor.

- Wider partnerships and greater attention to partners' strategies and activities.
- Maintenance of the visibility and credibility of WHO and differentiation of WHO's work and performance from that of the government.
- Guidance for achieving the health sector related millennium development goals (MDGs).

Within the four global, strategic objectives of (i) reducing excess mortality, morbidity and disability; (ii) promoting healthy lifestyles and reducing risk factors; (iii) developing health systems; and (iv) framing policies that are enabling for the health sector, WHO identifies five distinct functions for its country offices:

- Supporting long term implementation of routine activities.
- Catalyzing adaptation of strategies; seeding large scale implementation.
- Supporting research and development; monitoring health sector performance
- Sharing information and knowledge; providing policy options; standards; advocacy.
- Providing policy advice; influencing policy, action and spending.

The CCS process in Afghanistan started in Kabul in May 2005 with a preliminary communication between the Ministry of Public Health (MoPH) and the WHO Country Office in Kabul and an analysis of the complex health sector situation in Afghanistan, typical of post conflict countries. The triangular relationship between donors, health service providers and the regulator (MoPH) in the context of Afghanistan's war and conflict experience and the current policy environment in which reconstruction of infrastructure and restructuring of the government including the health system has been prominent, was briefly analyzed. In June 2005 the MoPH formed a twelve member team from its various departments to serve as a resource and provide the needed documents and data to the WHO CCS consultant so that first hand information was available for writing and referencing the CCS document. This team under the leadership of H.E. Dr Faizullah Kakar, Deputy Minister of Health for Policy, Planning and Preventive Medicine, developed a detailed draft of Section 2 of the CCS document that was emailed to member of the WHO CCS team members before their departure for Kabul.

The CCS team arrived in Kabul on the 10 July 2005 and began its work with a briefing from Dr Riyad Musa Ahmed, WHO Representative in Afghanistan. During its stay in Kabul the CCS Mission met with: H.E. Dr F. Kakar, and members of his team on several occasions and with representatives of the major donors to the health programs including UNICEF and UNFPA. The list of people met is given in Annex 2. The team was also received by H.E. Dr Syed Mohammad Amin Fatimie, Minister of Health, Government of Afghanistan who provided valuable guidance on major issues facing the health sector and about the national health priorities. Throughout their stay the CCS team interacted with WHO staff assigned to the country office and received useful input for their work.

Before the CCS team left Kabul, a preliminary draft of the CSS document was shared and discussed with H.E. Dr F. Kakar. He made a few suggestions about the contents of the strategic agenda that have been incorporated in the final draft. It was clarified that the components of the strategic agenda could be modified to accommodate any changes in the national priorities during the four years, during the formulation of second generation

of CCS. In view of the situation in Afghanistan, it was agreed that the period covered by the CCS would be 5 years i.e. 2005-2009 and it so happens that this is also the period covered by the National Health Policy prepared by the MoPH.

It was appreciated that the size of this CCS document is considerably larger as compared to the CCS documents of other countries in the region. However, it was felt it was in view of the rapid developments in the health sector during the last 2-3 years and its complexities, it was important to capture all the information made available to the CCS team to serve as a bench-mark against future reports. It was also agreed with the MoPH that the Section 2 of the document would be considered as a 'living document' to be updated and modified frequently in light of future developments.

A unique feature of the CCS mission to Afghanistan was that the Joint Government/WHO Programming Mission (JPRM) for 2006/07 immediately followed it and thus it provided an opportunity for the main findings of the CCS to be made available to the JPRM team. Soon after their arrival in Kabul the JPRM team received a detailed briefing from Dr Riyad Musa Ahmed, WR, Afghanistan, on the process and the outcome of the CCS. Furthermore, a member of the CCS mission from WHO Headquarters participated in the JPRM discussion and was thus able to contribute from the CCS perspective. The connection between the formulation of CCS and JPRM was further enhanced through the active involvement of H.E. Dr F. Kakar and his team in both activities. During the preliminary discussions in JPRM, it was clarified to the MoPH team that the strategic agenda developed as part of CCS should be seen as a 'vision' for a medium term (4-5 years) period and need not be strictly reflected in the budgetary allocations under respective programs in the JPRM exercise.

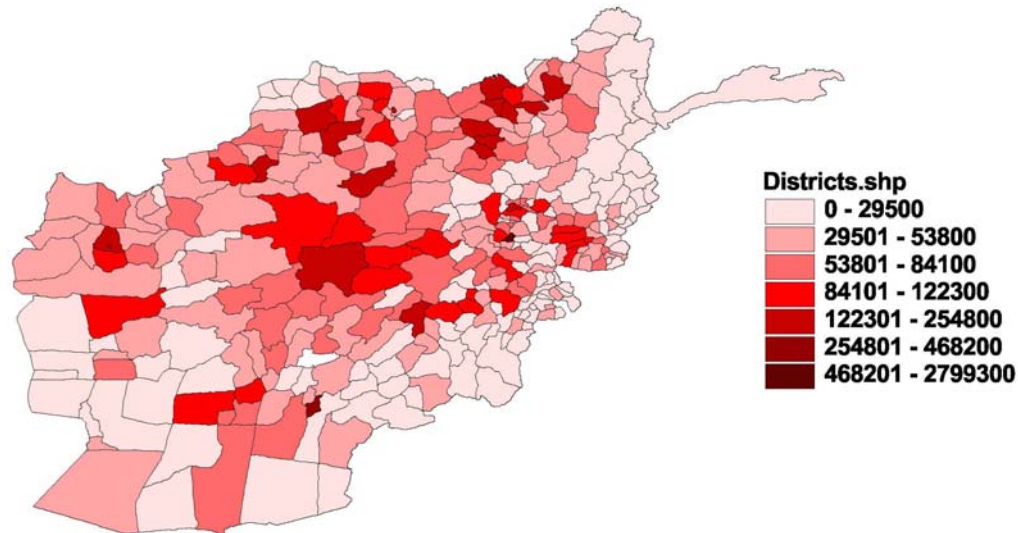
Acknowledgments: The efforts made by the National Team under the supervision of H.E. Dr F. Kakar, in preparing a detailed report on the country health situation (reflected in Section 2 of this document) is deeply appreciated and gratefully acknowledged. The CSS team would also like to record its thanks to the staff of the WHO country office for generous assistance in facilitating its work.

Section 2. GOVERNMENT AND PEOPLE: HEALTH AND DEVELOPMENT CHALLENGES

2.1. Demography and main Health Problems

According to data from the Central Statistic Office (CSO) Afghanistan's population is 22.2 million (CSO 2003/2004). According to available demographic data (of course to be revisited once a proper census is carried out), the distribution of the population varies dramatically across country. In 2001, the 77 districts with a population density below 20 inhabitants per square kilometer hosted 13% of the country population, scattered over 55% of the country area. In the 120 districts with a density inferior to 30, totaling 70% of the country area lived 24% of the country population. 34% of the total population lived in the 71 districts with density above 100 inhabitants. The population density is shown graphically in the map given below.

Population Density



57 % of the population is below 18 years of age with a life expectancy for female of 45 and for men of 47 years. Life expectancy of men exceeds that of women, a phenomenon that is solely observed in Afghanistan and that might have its cause in an unprecedented high maternal mortality (TWG 2005). With an estimated Total Fertility Rate of 6.3 per woman and an average population growth rate of 2.5 % per year, the population of Afghanistan is increasing very rapidly (MICS 2003).

The key problems facing Afghanistan and its health system are (i) high levels of infant (165/1000) and under five (257/1000) mortality rates; (ii) one of the world's highest maternal mortality ratios (1600/100,000 live births); (iii) elevated levels of malnutrition throughout the population; (iv) high incidence of communicable diseases; (v) inequitable distribution of quality health services; and (vi) low capacity to implement effective and efficient health services at all levels of the health system (MoPH 2004).

Box 1: Health Status

Under 5 mortality 230/1000 live births

Infant mortality 165/1000 live births

Maternal mortality 1600/100,000 live births

Acute malnutrition 6-12%

Chronic malnutrition 50%

Iron Deficiency Anemia 71% in pregnant women

TB 70,000 new cases/year

TB Annual Risk of Infection 2.25%

HIV/AIDS

Life expectancy 42.6

(CDC/UNICEF/MoPH 2002, MoPH 2004, UNICEF MICS 2003)

2.2. Socio-economic and Political

Context

Afghanistan's social indicators, which were low even before the 1979 Soviet invasion, rank at or near the bottom among developing countries, preventing the fulfillment of rights to health, education, food and housing. Since the fall of the Taliban almost three years ago, important progress has been achieved in all sectors, but much remains to be done in order to reach a significantly strengthened social infrastructure, realize the rights to survival, livelihood, protection and participation, and reach the Millennium Development Goals (MDGs).

The 2004 Human Development Index of the United Nations ranks Afghanistan at 173 of 178 countries; only a few countries in sub-Saharan Africa are behind. At the end of major conflict in 2002, Afghanistan had a per-capita income of less than US\$ 200, one of the lowest in the world. About 70 % of the population lived in extreme poverty, and Gross Domestic Product (GDP) stood at only US\$4 billion (UNDP 2004).

Over last two years, Afghanistan's formal economy has performed strongly, albeit starting from a very low base. Non-drug GDP has increased more than 50 % percent, primarily reflecting the recovery of agriculture from severe drought, a revival of economic activity and the initiation of reconstruction. Recent positive growth performance has been supported by the Government's sound macroeconomic policies – a highly successful currency reform, a prudent “no-overdraft” policy prohibiting domestic financing of the budget deficit, a conservative monetary policy that brought inflation down to 10 % annually, and good management of the exchange rate. Progress also has been made in mobilizing domestic revenue and in trade and financial sector reforms (United Nations System 2004).

Regarding *employment*, although no specific survey on employment has been conducted, the overall jobless rate is 32% (IRC Labor Market Information Survey, 2003 and as quoted in Common Country Assessment for the Transitional Islamic State of Afghanistan, UN System Kabul, October 2004). Unemployment is highest (42%) in the central region. Among youth aged 16-25 years of age, 26% across all regions are unemployed. On account of socio-cultural reasons and lack of opportunities, women cannot participate in many economic activities and are exploited in terms of division of labor.

The following four factors have been identified as inhibiting employment and economic growth: weak state of national institutions; lack of support services including key infrastructure and market access; lack of access to capital and financial services and lack of advanced entrepreneurial skills, knowledge and technology.

The key to long-term economic development will be a strong local private sector. The informal economy in Afghanistan continues to be dominant, accounting for 80 to 90 % of the total economy; women work primarily in this sector. The legal portion of the sector is centered on agriculture, commerce, manufacturing, handicrafts and transport. However, illicit activities include the extensive opium production that blights Afghan society, along with widespread unauthorized timber harvesting and mineral extraction.

Table 1: Selected Human Development Indicators in Afghanistan and neighboring countries

	GDP per capita (US\$) (2002)	Life expectancy at birth (years) (2002)	Human poverty index (2002)	Gender development Index (2002)	Population without access to improved water source (%) (2000)	Literacy rate Total (2002)
Afghanistan	190	44.5	59.3	0.300	60*	28.7*
Pakistan	408	60.8	41.9	0.471	10	41.5
Iran	1,652	70.1	16.4	0.713	8	77.1

Source: United Nations Development Program: Human Development Report 2004

As an alarming example of the informal economy's considerable growth, poppy cultivation for opium production has rebounded to near-record levels. In 2003, opium comprised about one-third of total GDP, including drugs. The scope for expanding poppy production and deepening the skills base represents a major economic concern (United Nations System 2004).

Afghanistan provides an estimated three-fourths of the world's heroin and produced 19 times more opium poppy in 2003 than in the last year of Taliban rule. The country has begun refining the poppy, making a large portion of the production apparatus domestic. In 2002, revenues from the drug trade were estimated to be worth US\$1.2 billion, equivalent to total international assistance that year. Also, despite higher output in 2003 – the harvest in this year increased 6 percent compared to 2002 – the aggregate value of the harvest declined to US\$1.02 billion, equal to a decrease of 15 percent (UNODC 2003).

2.2.1. History

Afghanistan became a nation-state, with its present boundaries, in response to pressures from the expanding British Empire to the south, and the Russian Empire to the north. The country's efforts to resist subjugation were largely successful, though Britain for a time, asserted the right to control Afghanistan foreign policy. By 1919, this vestige of foreign interference was removed, and Afghanistan became a member (in many cases a founding member) of the United Nations and other international bodies. Throughout its development, the centralized state structure has co-existed uneasily with a fragmented traditional society. The interplay- and at times conflict-between the two has been one of the recurrent themes of modern Afghan history.

The period of governance of various emperors and governments in Afghanistan are described as follows:

King Amir Abdur Rahman Khan (1880-1901), Amir Habibullah Khan (1901-1919), Amanullah (1919-1929), Mohammad Nader Shah (1929-1933), Mohammad Zahir Shah (1933-1973), Mohammad Daud Khan (1973-1978), Noor Mohammad Taraki and Hafizullah Amin (1978-1979), Babrak Karmal (1979-1986), Najibullah (1986-1992), Mujahedin (1992 – 1996) and the Taliban (1996-2001), Transitional Islamic

Government of Afghanistan (2001-2004), Islamic Republic of Afghanistan since October 2004.

Following the collapse of Taliban in 2001, an Interim Authority was appointed after the Bonn Agreement and later on the Islamic Transitional Government was established by the Loya Jirga, the traditional assembly with representatives from all over the country. In October 2004 the first elections took place successfully and peacefully in Afghanistan confirming President Karzai in office.

2.2.2. Current Administrative and Fiscal Structures

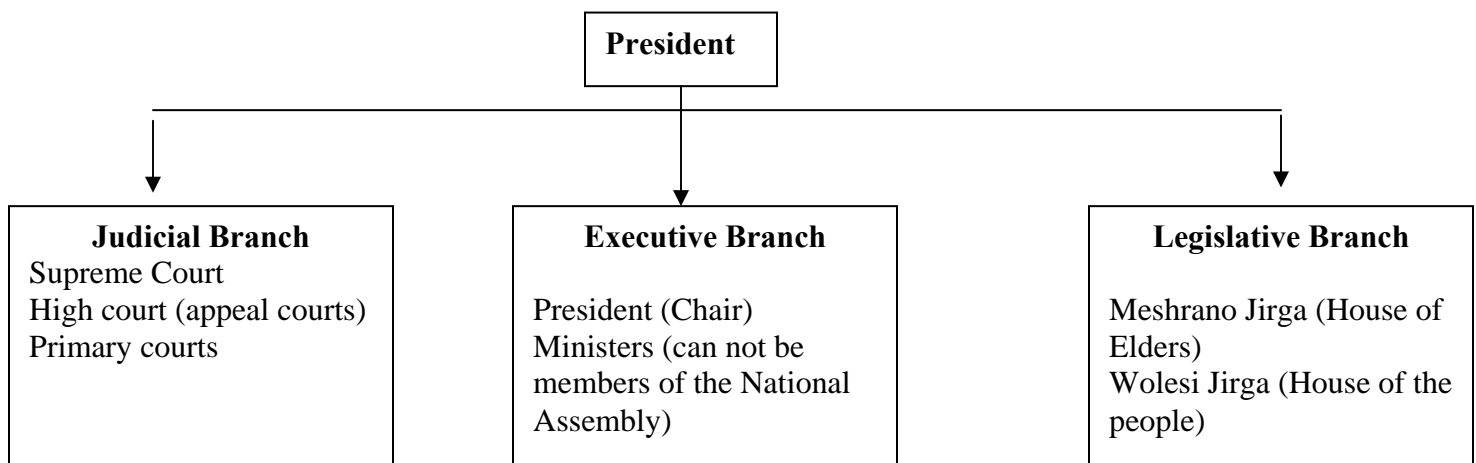
The consequence of this complex history is that the structure of government is unitary; all political authority is vested in the government in Kabul. The powers and responsibilities of the provincial and district administrations are determined (and therefore may be withdrawn) by central government. Though provinces and districts are legally recognized units of sub national administration, they are not intended to be autonomous in their policy decisions other than through some flexibility in implementing centrally determined programs. However there have been some attempts at establishing local participative bodies. Article 3, Chapter 8 of the 2004 constitution specifies that a provincial council is to be formed in every province, with elected members, and Article 5, Chapter 8 specifies that district and village councils are to be elected.

There are four types of sub national administration:

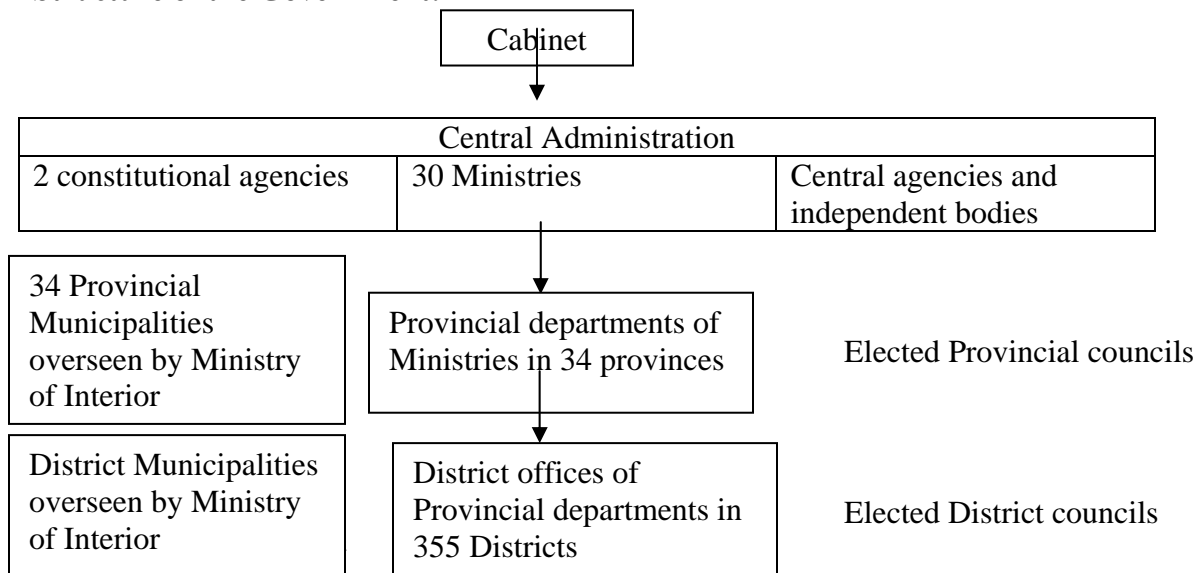
34 provinces; approximately 355 districts; each province contains between 3 (the minimum) and 27 districts. Each province in principle contains one provincial municipality. Each district contains at most one rural municipality, some have none.

Municipalities are in principle a separate level of government in that they have some limited autonomy in budget execution and in budget preparation. However the Ministry of Interior (MOI) controls their staffing establishment and approves their budgets.

Chart 1: Structure of the Administration



Structure of the Government:



Source: A guide to Government in Afghanistan by the World Bank and Afghanistan Research and Evaluation Unit (AREU), and Afghanistan National Human Development Report 2004

2.3. Other Determinants of Health

Other determinants of health encompass those conditions that can be attributed to the low socio-economic status of many Afghans and other cross-cutting issues like the lack of physical infrastructure (rural roads, electricity, water and sanitation) low levels of education, narcotics) and low status of women that impede the improvement of the health status (Securing Afghanistan's Future 2004).

2.3.1. Vulnerability

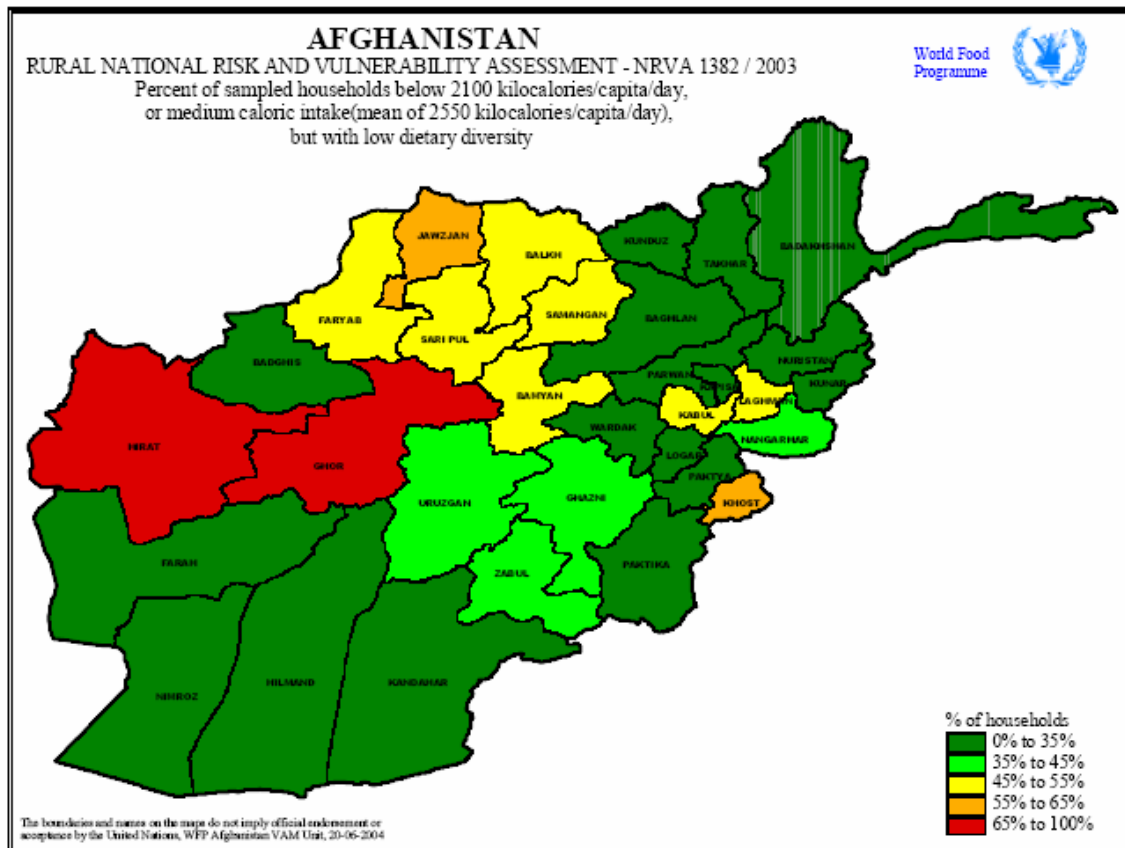
A large size of Afghanistan's population belongs to vulnerable groups that have limited equitable access to health care. As per definition suggested by the World Bank, vulnerable groups are 'those individuals or households that are not able to take advantage of income generating opportunities and are poor' (The World Bank 2004). Among vulnerable groups there are female headed households, people with physical or mental disabilities, people who live in geographically isolated areas, landless, orphans, but also children, women, nomads, elderly, internally displaced persons, returnees. Large parts of the country are still under the control of commanders and warlords and out of reach of assistance, despite urgent needs.

The vulnerability can manifest itself in form of inadequate and imbalanced food intake resulting in adverse health effects. Vulnerability can lead to behavioral and social problems, lack of power and absence of resources, being misused or mistreated, suicide and antisocial activities.

The National Risk and Vulnerability Assessment (NRVA) 2003 conducted by the Ministry of Rural Rehabilitation and Development (MRRD) and the World Food

Program (WFP) in rural Afghanistan reveals that 38% of the households have a caloric intake of less than 2500 kcal / capita / day with very poor dietary diversity, 34% of households more than 2100 kcal /capita / day but mainly from oils and fats, 16% of households have again similar caloric intake but with a higher contribution from dairy products, 12% with equivalent caloric consumption have a good diversity of food.

The two maps given below show respectively the percent of sampled household below 2100 kilocalories per capita per day and the percent of sampled house hold with low diversity.



A study carried out in urban areas (Kabul, Jalalabad and Herat) examined the forms and determinants of vulnerability in cities. They comprise income failure (people with disabilities, elderly, widowed, female headed families), food insecurity (families with high dependency rates, less diverse income sources, women with disabilities, daughters), bad health (working children, poor housing, disabled people especially women, war victims), social exclusion and disempowerment (Schuette 2004).

2.3.2. Poverty

Among all other determinants of ill-health, income poverty has the strongest impact on health outcomes. Poverty is associated with malnutrition, a high fertility rate, lack of access to clean water, unsanitary conditions, food insecurity, poor household caring practices, heavy work demand, a high level of female illiteracy, and a low access to curative and preventive health services. Poverty in Afghanistan is complex and involves low assets (physical, financial and human), years of insecurity and drought, cultural traditions, and poor infrastructure and public services. More than half of rural Afghans cannot afford a food consumption level of 2,100 calories per day. The Government is currently formulating an 'Interim Poverty Reduction Strategy' that will be a part of the 'National Development Strategy' (NDS) for Afghanistan.

2.3.3. Gender

The low status of women affects more sectors than only health. The school enrollment rate for girls is almost half of that of boys in rural areas. The link between girls' education and maternal health and well-being for families has not yet been recognized. Major discrimination against women persists in the workplace, primarily because of cultural constraints. Afghan women could be well-positioned to play a part in the informal economy, which requires flexibility; at the same time, it requires mobility, which many women do not have. The majority of rural Afghan women who work for income do so within their homes; however, women who engage in wage labor earn substantially less than men, and sometimes less than children (Tufts University 2004). Inequalities for women also are extensive with regard to inheritance practice, which provide for a lesser share for a female inheritor compared to a male or, in the case of a widow, to her in-laws or children (United Nations System 2004).

2.3.4. Education

A large number of Afghans between 8 and 33, particularly women and girls have been deprived from education as a consequence of war, civil unrest and dislocation (United Nations System 2004). Illiteracy rates vary significantly between urban and rural areas and between male and female. Almost half of the men and more than 85% of women in Afghanistan are illiterate (UNICEF 2004). Disparities have also been observed between provinces, reflecting the conservative, tribal societies where gender segregation is common (Kabul Province school enrollment 76% Uruzgan Province 19%) (United Nations System 2004) The number of girls' schools is still insufficient. After the fall of the Taliban many reopened girls schools have been destroyed by Taliban or local military fractions. Major challenges in the field of education include: poor institutional capacity to plan and manage education programs; poor quality of education and out dated

curriculum, shortage of qualified teachers, particularly women and lack of training and shortage of spaces for learning and essential teaching learning material.

2.3.5. Water and Sanitation

Outside the cities only about 30% of households have access to safe drinking water; in some provinces such as Bamyan, Bahglan and Sar-I-Pul the figures are less than 10 % (United Nations System 2004). The NRVA reveals that 28% of households have no toilet facility with the rest of households reporting having a traditional latrine (WFP 2004). Sanitary means of excreta disposal likewise are scarce. Sanitations systems in major cities are lacking, resulting in a high number of water borne diseases especially during summer months (e.g. outbreak of Cholera).

The MoPH has signed a contract with Johns Hopkins University (JHU) to carry out a field evaluation of safe water system that involves treatment of drinking water with dilute sodium hypochlorite at the point of use (i.e. in the household). The field experiment will randomly assign 60 clusters of 30 household each, to one of the five treatment arms: (i) new wells with hand pumps so there are less than 30 families per well; (ii) home chlorination training and equipment provided by an NGO with experience in promoting home water treatment; (iii) hygiene education in group sessions by an NGO that specializes in hygiene education; (iv) home chlorination supplies and training, hygiene education and new wells and (v) a control group.

2.3.6. Disability

WHO estimates that between 4 and 7% of the Afghan population is physically disabled. Preliminary data from a nation wide disability survey collected in two provinces confirm the trend of 4%. War-related disabilities are quoted for 25% of all affections; other causes include cerebral palsy and poliomyelitis (ANHRA 2003). Less than 1% of health facilities have prosthesis technician and prosthesis-making equipment whereas only 10% of all health facilities offer physical rehabilitation services (Securing Afghanistan's Future 2004).

2.3.7. Food security

Access to food of sufficient quantity and quality to lead an active and healthy life is inadequate. Food security has improved this year compared to the past years when the country was experiencing a drought but still remains alarmingly high in many parts of the country. Access to food is limited due to remoteness, bad roads and transportation, seasonal variation and low food production. Families cannot afford to purchase food as needed due to the low income and large family size. Diversity of food is very poor due to unavailability of different food items, low purchasing power, and low levels of nutrition related education. The devastation caused by the drought has left more than 5 million Afghanis dependent on survival on food aid and assistance from UN and private relief organizations

2.4. History of Evolution of Health System in Afghanistan.

Despite the fact that Afghanistan remained calm and stable in 1960s -1970s, the health status of the people especially women and children occupied no higher rank as compared to other countries in the region. Health care was widely provided by the government which was largely absent or at abysmal levels in rural areas. In urban areas the health system was dominated by hospitals and large number of health workers. The services were curative oriented and only 1- 4 % of national budget was allocated to the health system.

Starting from a very weak foundation, the public health system has even deteriorated in the years of war that followed .The health system was more centralized under the control of local Mujahideen Commanders. NGOs emerged in the mid 1980s providing health care services for Afghan refugees and starting cross border operation in Afghanistan and gradually expanded their activities by establishing health facilities in rural areas. The outbreak of civil war and the lack of a centralized government resulted in a fragmented health care system. This situation continued under with the emergence of Taliban. During this period women's access to health services became even worse. Despite the restriction of Taliban on girls' education, NGOs played a pivotal role in returning female health workers to the sector. At time when the Taliban fell, NGOs provided 80% of health services in Afghanistan.

In early 2002, the MoPH embarked on a new policy and in May 2002 the first draft of a Basic Package of Health Services (BPHS) was designed. By April of 2003, a costing exercise for providing the BPHS (annual per capita cost \$4.55) was finalized and incorporated into the final draft (Strong 2004). The Ministry made the choice to restrict its role to (i) monitoring and evaluation; (ii) coordination of donors inputs; (iii) strategic planning (iv); setting technical standards (v); regulating of the for-profit private sector (vi); and (vii) coordination and regulation of the NGO sector (Securing Afghanistan's Future 2004). For delivering services, the Ministry opted for the contracting out approach to NGOs who over the time had become an integral part of the health sector.

2.5. Current Health Status

Key Health Indicators for Afghanistan

	Value	Year	Source
Total Population	22.2 million	2003-2004	CSO
Population Growth Rate (%)	1.92	1980-2001	CSO
Women, 15 - 49	5.11 million	2003-2004	CSO
Under five children	4.44 million	2003-2004	CSO
Life Expectancy at Birth (for female)	45 years	2003	PRB
Life Expectancy at Birth (for male)	47years	2003	PRB
Crude Birth Rate (Per 1000 Population)	48	2001	CSO

Crude Death Rate (Per 1000 Population)	17.2	2002	BUCEN-IDB
Total Fertility Rate	6.3	2003	MICS
Contraceptive Prevalence Rate (%)	21.9	2004	PSI
Maternal Mortality Ratio (per 100,000 live births)	1600	2002	MMR
Antenatal Care by Doctor, Nurse, Midwife (%)	16.1	2003	MICS
Assisted Delivery by Health Professional (%)	14.3	2003	MICS
Under - 5 Mortality Rate (per 1,000 live births)	165	2004	UNICEF
Infant Mortality Rate (per 1,000 live births)	230	2003	MICS
Exclusive Breastfeeding (under 4 mos.; last 24 hours)* (%)	96.1	2003	MICS
DPT3 Vaccination Rate (%)	54	2003	WHO/UNICEF
Measles Vaccination Rate (%)	49.7	2003	WHO/UNICEF
Polio Laboratory Confirmed Cases	8 Cases	2003	WHO/UNICEF
Tetanus Toxoid Vaccination (for Pregnant Women) (%)	40	2003	WHO/UNICEF
HIV Prevalence ,Adult (%)	0.01	2000	UNAIDS
TB Estimated Number of Cases	69,849	2002	WHO/TB
TB Case Detection Rate (%)	19	2002	WHO/TB
TB (DOTS) Treatment Success Rate (%)	84	2001	WHO/TB
Population at risk for Malaria	12 million	2004	MOH/NMP
Population per hospital bed	Low 1100 High 16000	2002	CSO
Household access to drinking water from pump or protected spring(%)	40	2003	MICS
Household with access to sanitary latrine	67	2003	MICS

2.5.1. Maternal Health

Health conditions for women in Afghanistan appear among the worst in the world, and women's health has reached a critical stage. Access to health care for Afghan women dropped precipitously under the Taliban and remains extremely limited, in large part because of a lack of female health workers. Nine in ten rural women deliver babies at home without skilled birth assistance or proper referral services to save lives through essential and emergency obstetric care. The high fertility rate, coupled with early marriage and issues of access to modern family planning measures and health facilities, has taken a devastating toll on the health of both mothers and children.

Among Afghan women of childbearing age who die, almost half will die from complications of pregnancy. This results in a very high mortality rate of a range from 1,600 to 2200 maternal deaths per 100,000 live births. Badakhshan happens to have the highest ever recorded maternal mortality risk in the world, 6500 / 100,000. This translates into an estimate of 25,000 women dying every year or one woman dies in Afghanistan every 27 minutes of pregnancy-related complications. Among the newborns of mothers who died, only 1 out of 4 has a chance of surviving their first birthday.

2.5.2. Child Health

Infant mortality stands at 165 deaths per 1,000 live births, while the under-5 child mortality rate is 230 per 1,000 live births – both also among the world’s highest. Major causes of morbidity and mortality among children include measles, diarrhea, acute respiratory infection, malaria and micronutrient deficiencies such as scurvy. Chronic malnutrition, resulting from food insecurity, inadequate caring practices and inadequate health and sanitation environments, is widespread; between 40 and 60 % of Afghan children are stunted or chronically malnourished. 20% of children have a low birth weight. 85, 000 children under five die from diarrhea each year. The vast majority of children do not have access to essential health care and provision of quality care to sick children is serious challenge.

2.5.3. Food security

Access to food of sufficient quantity and quality to lead an active and healthy life is inadequate. The food security improved this year compared to the past drought years but still remaining alarming in many parts of the country. Access to food is limited due to remoteness, bad roads and transportation, seasonal variation and low food production. It is not affordable for families to purchase food as needed due to low income and large family size. Diversity of food is very poor due to unavailability of different food items, low purchasing power and low level of nutrition-related education. This devastation has been compounded by the severe drought that has left more than 5 million Afghans dependent for survival on food aid and assistance from United Nations and private relief operations.

2.5.4. Nutrition

Among Afghan preschool children 6-59 months of age, over half (54 per cent) were found to be stunted in growth, an indicator of chronic malnutrition; 39 per cent were classified as underweight; and almost 7 per cent were wasted, an indicator of acute malnutrition. Based on WHO classifications (WHO, 1995), Afghanistan is a country with “very high” prevalence of stunting and a “high” prevalence of underweight among its preschool population. The 7 per cent prevalence of wasting among Afghan preschool children is nearly three times the expected prevalence of 2.3 per cent in a reference population, and thus places Afghanistan in the “medium” prevalence for wasting. The prevalence of overweight was 1.7 per cent among 6-59 month olds, which is less than the expected 2.3 per cent.

The prevalence of underweight among non-pregnant Afghan women 15-49 years of age was almost 20 per cent, which is a medium prevalence of adult underweight based on the WHO classification (WHO, 1995). It is likely that the prevalence of underweight is underestimated as women were wearing clothes while being weighed, which would have increased their weight. A smaller proportion of non-pregnant women were overweight (12 per cent) and only 3 per cent were obese

Factors contributory to malnutrition include: food insecurity at household and community level; the prolonged drought situation in past few years along with long standing war effect on agriculture; seasonal variation of food availability; large families with low income; low

purchasing power for quality foods due to poverty; poor health nutrition education to know the use of balanced foods; gender discrimination in relation to food consumption; improper breast and complementary feeding practice and co-existence of diseases like diarrhoeal disease, ARI, Malaria, Dysentery, Worm infestation, TB etc.

Table 2: Prevalence of various nutrition related parameters by population group

Target Group	Median Urinary Iodine (µg/L)	Urinary Iodine Deficiency (% <100 µg/L)	Received Vitamin A Capsule within last 6 months (%)	Anemia ¹ (%)	Stunting ² (%)	Underweight ³ (%)	Wasting ⁴ (%)
Preschool Children 6-59.9 mos.	--	--	81.0	37.9	53.7	39.3	6.7
Children 7-11.9 yrs	49.0	71.9	--	--	--	--	--
Non-pregnant women 15-49.9 yrs	42.0	74.7	--	24.7	--	20.8	--
Men 18-60.0 yrs	--	--	--	7.1	--	--	--

¹ Anaemia defined as Hb<11.0 g/dL in children, Hb<12.0 g/dL in women, and Hb<13.0 g/dL in men (Hb adjusted for altitude, pregnancy status and cigarette smoking)

² Height-for-age Z-score <-2

³ Weight-for-age Z-score <-2 in preschool children, and BMI <18.5 in non-pregnant women

⁴ Weight-for-height Z-score <-2

-- Not applicable

Source: National Vitamin and Mineral Deficiency Survey, Afghanistan, 2004. MoPH, UNICEF, CDC

3.3.10. Anaemia

Anaemia prevalence among children 6-59 months old was 38 per cent. Children 6-24 months old had the highest prevalence of anaemia at 50 per cent. The prevalence of anaemia among preschool children in Afghanistan is of moderate and high public health significance, respectively (WHO/UNICEF/UNU, 2001). The prevalence of anaemia among non-pregnant women was 25 percent, indicating a moderate public health problem. Anaemia prevalence among Afghan men was 7 per cent. This is close to the expected prevalence of 5 per cent in a reference population (CDC, 1993) and indicates that anaemia is not a major public health problem in Afghan men. The low prevalence of anaemia among men, but moderate to high prevalence of anaemia among women and children indicate that iron deficiency is likely the main cause of anaemia among the latter two population groups in Afghanistan.

5.3. Communicable Diseases

Tuberculosis is an extremely serious health and development problem in Afghanistan as it affects young adults particularly females. The burden of tuberculosis is enormous and Afghanistan is one of the 22 high TB-burdened countries in the world. The annual

incidence is 76,000 cases, with a high proportion of women. There are 23,000 deaths from TB every year. In 2004 the proportion of new TB cases detected and cured under DOTS is estimated at 21% (National Tuberculosis Program). The National Tuberculosis Control Program has so far progressed slowly similar to other post conflict situations.

The EPI program was introduced in Afghanistan in 1978. However, major progress has been achieved since 2001 when the MoPH introduced need based structural changes in the program. Over the years in spite of efforts aimed at enhancing the access the immunization coverage remains at best around 50-65%. In 2002 a nationwide measles mortality reduction campaign was conducted and with a follow up campaign in 2004 that resulted in a reduction in the number of reported cases of measles from 88762 in 2001 to 466 in 2004. Similar achievements were made in the area of maternal and neonatal tetanus elimination where the number of reported cases dropped from 596 in 2002 to 81 in 2004. Regarding polio eradication initiative, active surveillance for Acute Flaccid Paralysis (AFP) has been established and functioning well. Since 1998 successive rounds of supplementary immunization activities (SIA) e.g. NIDs, sub-NIDs and mop-up campaigns have been conducted. Up to end July 2005 only four cases of wild poliovirus (P 3) have been reported, two each from Hilmand and Uruzgan province. The circulation of wild poliovirus has become more localized in areas bordering with Pakistan.

The number of reported cases of malaria was 626 839 in 2002 and the trend persisted in 2003 with 585 602 cases. However, as a result of improved case management, scaling up of effective control, measures by MoPH and partner organizations, the reported number of cases decreased in 2004 to 261 456. Nearly 6% of cases are positive for *P.falciparum*.

2.5.5. Mental Health

In the recent decades Afghanistan faced a series of long term disasters deeply affecting the coping mechanisms of the population and the capacity of the health care system to respond to the mental health needs. Over 2 million Afghans are estimated to suffer from mental health problems. Due to the long period of conflict it is estimated that most Afghans suffer from levels of stress disorder. Mental diseases have not been addressed over the last decades in Afghanistan and little is known about the disease pattern in Afghan society.

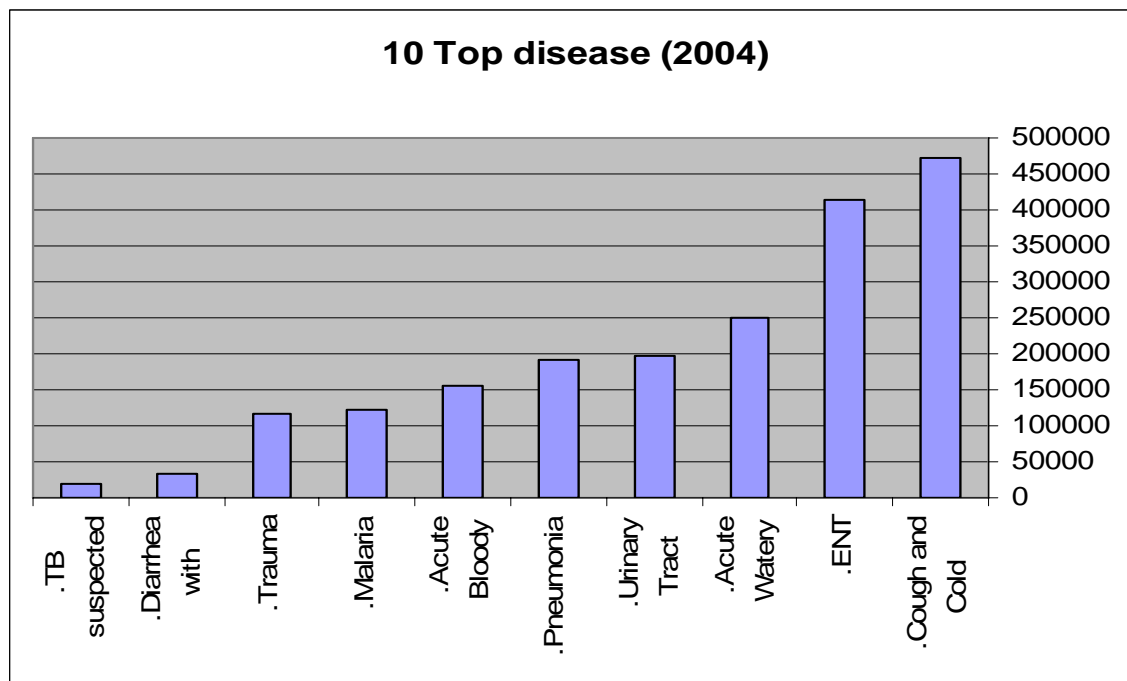
The few publications from the pre-war period about mental health and mental health care in Afghanistan give the impression that Afghanistan was not very different from any other developing country in the region. (Gobar 1970; Waziri 1973) The start of the violence in the late 1970 led to the migration of many mental health professionals. Little is known about the early effects of the war on the mental health status of the Afghans during the Russian occupation and the armed resistance of the *mujahedeen*. In the refugee camps in Pakistan clinicians reported that they saw many patients with anxiety and depressive symptomatology. (Mufti 1986; Dadfar 1994)

A review of studies conducted during the Taliban regime reveals high rates of anxiety and depression amongst women. In a survey of 160 Afghan women in Kabul and Pakistan during the Taliban regime 42% had symptoms diagnostic of posttraumatic stress disorder, 97% had major depression, 86% had severe anxiety. The vast majority (84%) of the women reported that one or more family members were killed during the war (Rasekh

1998). A study conducted in 2000 by the Physicians for Human Rights compared the mental health status of women living in Taliban-controlled area versus that in a non-Taliban controlled area. Major depression was far more prevalent among women living in Taliban controlled area (78%) than among women living in a non-Taliban controlled area (28%) (Amowitz 2003). Even more alarming were the high rates of suicidal ideation (65% in Taliban controlled area versus 18% in the control area) and actual suicidal attempts (16% in the Taliban controlled area and 9% in the non-Taliban controlled area). High rates of depression and anxiety among women are also found in a qualitative study in Taliban controlled villages near Herat in Western Afghanistan (De Jong 1999). These high rates of psychiatric morbidity may be related to Taliban policies of gender segregation and denial of basic human rights to women. The fall of the Taliban regime, however, has not resulted in an improvement in the mental health status of the population. A nation wide survey conducted in the first year after the US - led invasion found high levels of depression symptoms (male: 59.1 %, female: 73.4%), anxiety symptoms (male 59.3%, female 83.5%) and Post Traumatic Stress Disorder (male 32.1 %, female 48.3%). Respondents with physical disabilities had a higher chance of developing psychopathology (Lopez 2004). An in-depth survey in Nangarhar Province conducted in 2003 confirmed the high figures of depression and anxiety, in particular among women, with elevated scores on depression questionnaires in 58.4% of all women and anxiety symptoms in 78.2%, and PTSD symptoms in female 31.9% % (Scholte 2004). The study found a clear relation between the number of traumatic events and the likelihood of developing psychopathology. A recent study among widows in Kabul reported depression symptoms among 78.6% (CARE 2004).

So far the treatment of mental health problems is limited to medication; therapeutic care is widely unknown and there are few number of mental health specialists. Yet the MoPH needs to formulate a strategy how to overcome cultural-specific barriers to treat mentally sick persons and how to adapt treatment models that are not compatible with Afghan traditions and belief.

Chart 2: Top Ten Diseases in Afghanistan



2.6. The National Health Policy

Following the ‘Interim Health Strategy 2002 to 2004’, the Ministry of Public Health developed a National Health Policy for 2005 to 2009 and a National Health Strategy for 2005 to 2006. This document describes the overarching course of actions the Ministry will take for the following five years, outlining its national health policy goal, objective and priorities. Since the Government’s Public Investment Program of 2004 clearly states the need for an accelerated implementation of national priorities, the national health policy responds to this by outlining 19 priorities that are translated into strategic actions, outputs and responsibility to close the gap between policy and implementation.

The overall goal of the health policy is *‘to develop the health sector to improve the health of the people of Afghanistan, especially women and children, through implementing the basic package of health services and the essential package of hospital services as the standard, agreed-upon minimum of health care to be provided at each level of the health system’*.

The National Health Policy Objective for this period is to reduce the high levels of mortality and morbidity by: (i) improving access to quality emergency and routine reproductive and child health services; (ii) increasing the coverage and quality of services to prevent and treat communicable diseases and malnutrition among children and adults; (iii) strengthening institutional development and management at central and provincial levels to ensure the effective and cost-efficient delivery of quality health services; (iv) further developing the capacity of health personnel to manage and better deliver quality health services including services for diagnosis and treatment of mental health disorders.

2.6.1. Working Principles of the Ministry of Public Health 2005 - 2009

The values held by the Ministry of Public Health are incorporated into the following seven working principles -- the moral rules or strong beliefs intended to guide the everyday work of the entire Ministry. The principles listed below are of equal importance, with none taking priority over any other:

1. Treating all people with dignity, honesty and respect and considering healthy life as a basic right of every individual.
2. Making evidence-based decisions.
3. Ensuring equitable access to, and provision of, quality, basic, essential health services.
4. Being honest, transparent and accountable.
5. Improving the effectiveness, efficiency and affordability of health care.
6. Giving priority to groups in greatest need, especially women, children, the disabled and those stricken with poverty.
7. Promoting healthy lifestyles and discouraging practices proven to be harmful.

2.6.2. National Health Policy Outcomes

Focusing the health policy on accelerated implementation is expected to result in the following six outcomes by 2009:

- Maternal mortality ratio reduced from 1,600 to 1,300.
- Infant mortality rate reduced from 140 to 115
- Under-five mortality rate reduced from 230 to 180
- Prevalence of acute malnutrition among children under five years of age lowered from 7% to less than 5%
- Control and surveillance system for infectious diseases established
- Integrated mental health support and care services developed at all levels of the health system

2.6.3. National planned outputs 2005-2006 and Priorities

By the end of 2006, the Ministry intends to achieve the following five outputs:

- 34 provincial and 55 district hospitals providing 24 hour emergency obstetric coverage
- An increase in DPT3 coverage (from national base line as of December 2004) from 66% to 80% by the end of 2006, and to 90% by the end of 2007; a 20% reduction in prevalence of malaria (2004 level: 261,000 cases); and polio transmission stopped
- Increased efficiency and effectiveness of the Ministry of Public Health at all levels and in particular, at the provincial level
- Improved quality of patient care, especially essential obstetric care, newborn care, care of children under five and mental health disorders.

The Ministry of Public Health will aim to have quality support services that are equitable, affordable and sustainable, including those for laboratory services, blood safety, referral, pharmaceuticals, equipment and medical supplies. It will establish capacity for the maintenance of facilities, equipment and transport.

The 19 priorities that have been formulated in order to achieve the policy's goal and objective are grouped as follows:

Box 2: National Health Policy Priorities 2005 to 2009

Implementing health services

- *Implement the basic package of health services
- *Implement the essential package of hospital services
- * Establish prevention and promotion programs, including mental health
- * Develop capacities for implementing mental health activities
- Promote greater community participation
- Improve coordination of health services
- Strengthen the coverage of quality support programs

Reducing morbidity and mortality

- *Improve the quality of maternal and reproductive health care
- *Improve the quality of child health initiatives
- *Strengthen the delivery of cost effective integrated communicable disease control programs, especially for TB
- Reduce prevalence of malnutrition and increase access to micronutrients.

Institutional development

- *Promote institutional and management development at all levels
- *Strengthen human resources development, especially of female staff
- *Strengthen health planning, monitoring and evaluation at all levels
- Develop health financing and national health accounts
- Strengthen provincial level management and coordination
- Continue to implement PRR
- Establish quality assurance
- Develop and enforce public and private sector regulations and laws

Source: National Health Policy 2005 to 2009

Ten out of these nineteen priorities are considered to be top priorities and marked with an asterisk (*).

2.7. Current Health System and Achievements

2.7.1. Institutional Development

During 2002-2004, the Ministry of Public Health made impressive post conflict achievements. Numerous policies and strategies to guide the health system development and investment have been elaborated, including a national health policy 2002, the Interim Health Strategy 2003, the National Health Policy 2005 to 2009 and National Health Strategy 2005 to 2006, the National Salary Policy, the Basic Package of Health Services (BPHS), the Essential Package of Hospital Services (EPHS), the Recommended Human Resource Development Policy and the Reproductive Health Strategy.

The MoPH is undergoing Priority Reform and Restructuring (PRR) and important progress has been made both at central and provincial level. A Grants Contracts and Management Unit (GCMU) has been established with an oversight role on donors

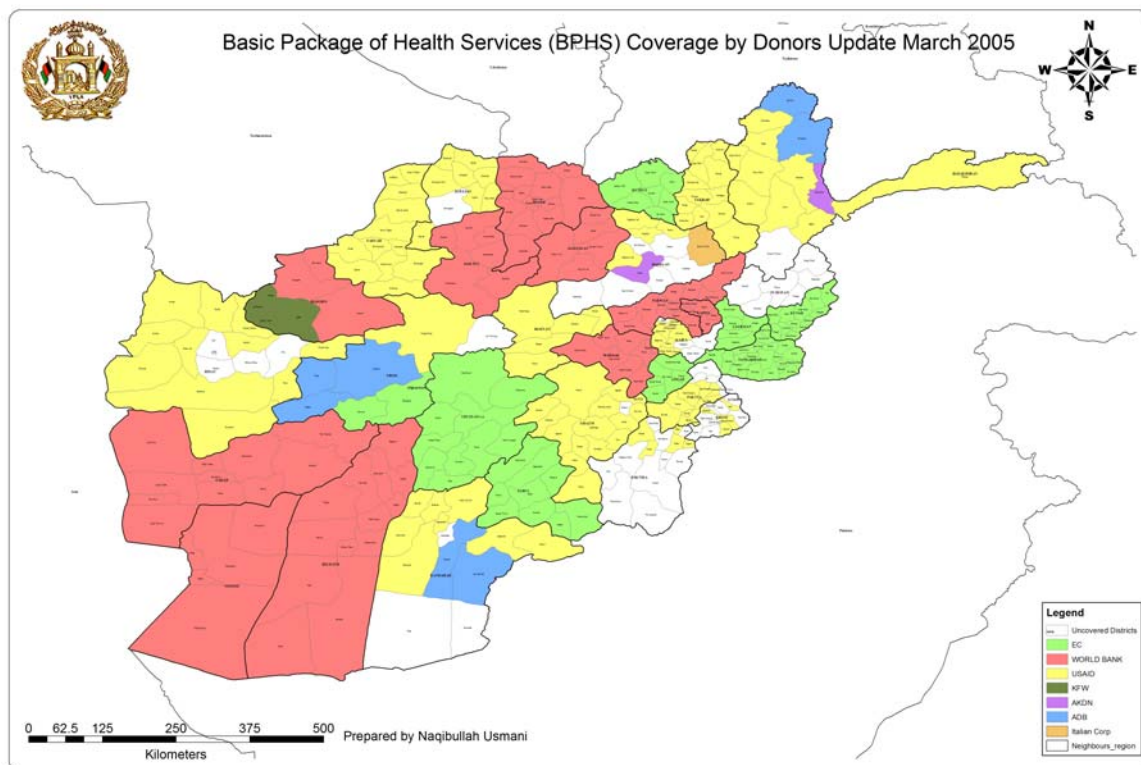
monies. National consultants in GCMU and other departments support the stewardship role of the MoPH.

A fairly transparent and ‘flat’ governance system for the health sector is in place. Consultation with development partners/donors is assured through various consultative and technical advisory groups as mentioned in more detail under Section 2.17.13.

2.7.2. Basic Health Services

The Ministry made the choice to abstain from implementing basic health services and decided to subcontract health service delivery to NGOs. The intervention of the three major donors (EC, USAID, World Bank) was coordinated successfully for a common approach in service delivery provided in the form of the BPHS and geographical division of the country to prevent duplication. As of today about 77 % of the Afghan population lives in areas covered by basic health services (including the three provinces where the Ministry is the implementing body). The Ministry is targeting 95% coverage to be achieved by 2015, also the deadline for achievement of the MDGs. In eight World Bank covered provinces the number of health facilities increased by 60%, 2700 Community Health Workers (CHWs) have been trained, 50% among them are women.

Map 1: BPHS funding status by donor as of June 2005



Source: GCMU June 2004

The BPHS is a package of cost-effective curative and preventive interventions. It was developed in 2002 and started implementation in 2003. It has a strong focus on conditions that affect women and children and is delivered to all Afghans, regardless of

where they live, their ethnicity or gender and aims at reducing the high levels of morbidity and mortality. It contains seven essential elements for the delivery of basic health care services: maternal and newborn health, child health and immunization, nutrition, communicable diseases, mental health, disability and supply of essential drugs. The BPHS is the key priority of the health sector and reflects main values and principles of the Ministry, to ensure equity and to be pro-rural.

The BPHS is offered at four standard levels of health facilities within the health system:

- A Health Post (HP) is staffed with one female and one male Community Health Worker (CHW) who cover a catchment area of 1000 to 1500 people, equivalent to 100 to 150 families.
- A Basic Health Center (BHC) is staffed with one nurse, a midwife or community midwife, and vaccinators, covering a population of 15,000 to 30,000 people.
- A Comprehensive Health Centre (CHC) has more staff than a BHC, including both male and female doctors, male and female nurses, midwives, and laboratory and pharmacy technicians. It covers a population of 30,000 to 60,000 people.
- A District Hospital (first referral hospital, DH) serves up to four districts and a population of 100,000 to 300,000 people. It is staffed with doctors, including female OB / GYNs, surgeon, anesthetist, and pediatrician; midwives; lab and X-ray technicians; pharmacist; dentist and dental technician. Interventions for malaria include all of CHC.

The total number of different Health Facilities in 2005 and their distribution according to the provinces is given below

Year	Regional Hospital	Provincial Hospital	District Hospital	Comprehensive Health Centre	Basic Health Centre
2005	16	31	70	402	593

Source: HMIS database 2005

Health Facilities Per Province: July 2005

Number of active health facilities by type

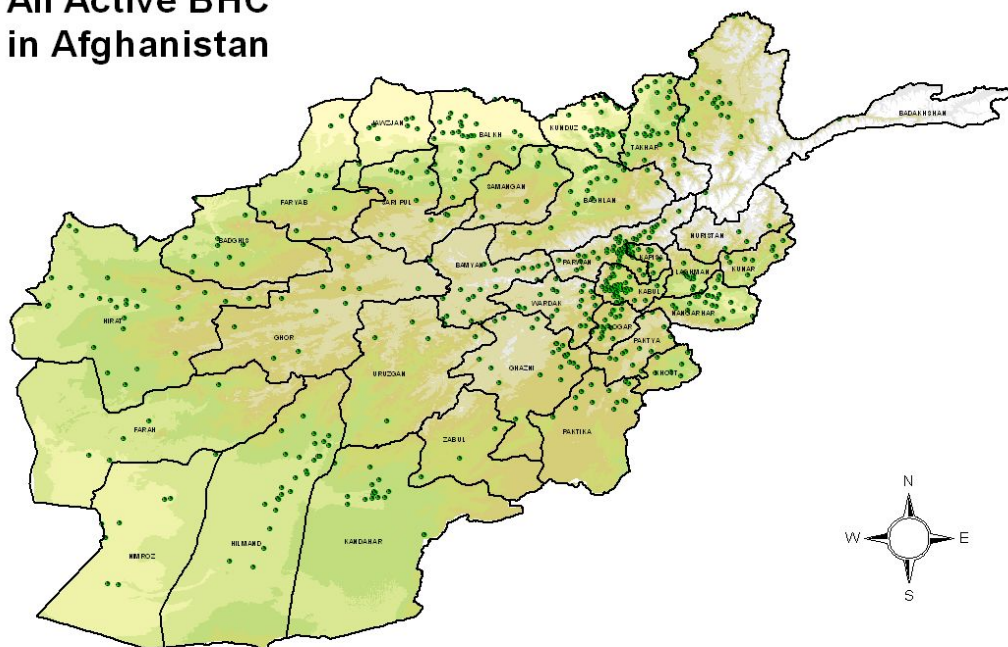
Province Name	District Hospital	CHC	BHC
01 KABUL	8	42	60
02 KAPISA	1	8	18
03 PARWAN	1	14	46
04 WARDAK	3	8	22
05 LOGAR	2	6	20
06 GHAZNI	3	25	23
07 PAKTYA	1	9	14
08 NANGARHAR	3	27	28
09 LAGHMAN	0	13	10
10 KUNAR	1	11	9
11 BADAKHSAN	0	14	27

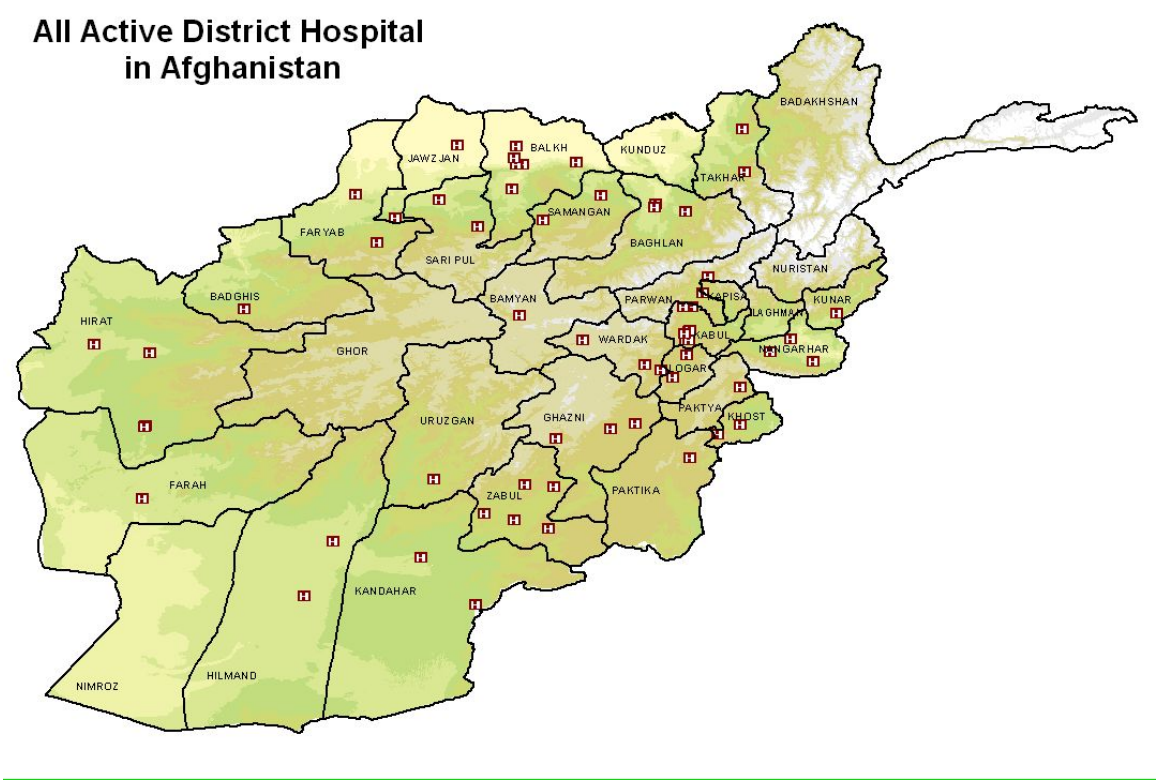
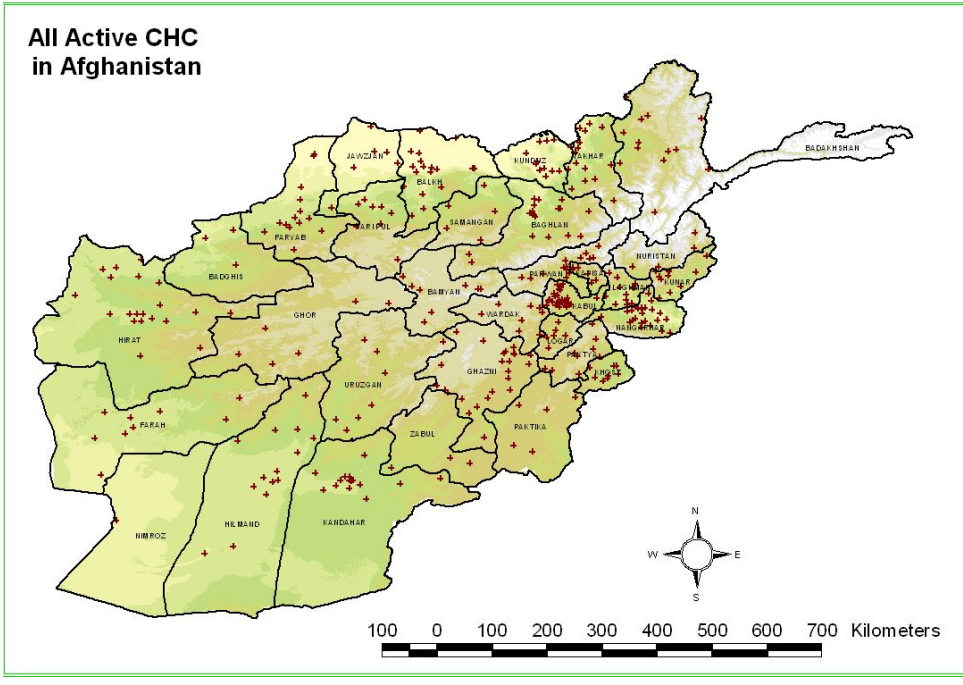
12 TAKHAR	2	15	33
13 BAGHLAN	3	21	21
14 KUNDUZ	0	14	25
15 SAMANGAN	2	5	8
16 BALKH	8	19	39
17 JAWZJAN	2	6	12
18 FARYAB	2	15	11
19 BADGHIS	1	4	12
20 HIRAT	4	29	31
21 FARAH	1	9	5
22 NIMROZ	0	1	8
23 HILMAND	3	17	29
24 KANDAHAR	3	16	22
25 ZABUL	5	4	3
26 URUZGAN	1	9	5
27 GHOR	0	6	14
28 BAMYAN	1	8	22
29 PAKTIKA	1	6	16
30 NURISTAN	0	5	6
31 SARI PUL	2	8	17
32 KHOST	2	8	6

Source: HMIS MoPH

The three maps given below show the distribution of BHC, CHC and DH in the country.

All Active BHC in Afghanistan





Certain flexibility has been encouraged in implementing the BPHS in order to respond to specific needs and conditions such as staffing a BHC with a medical doctor. Table no – provides a summary of the donor support for expansion of BPHS in the country

Table 5: Contract / Grant summary for the expansion of the BPHS as of July 2005

Donor	Total No. Provinces	Total No. Districts	No. Contracts/grants awarded	Total Spent	Total population served	Percentage of popln covered by donors	Average per capita costs**
USAID	14	134	31 grants (19 NGOs)	\$ 58,419,406	4,800,324	34	\$4.49
IDA/WB	8	73	8 contracts (7 NGOs)	\$37,016,983	3,582,347	18	\$3.62
	3	17	1 contract with MOH under MOH-SM	\$10,635,941	1,106,953	4	\$4.1
EC	8	80	12 grants (8 NGOs)	\$ 32,702,179	4,155,600	18	\$4.70
ADB	2***	11	3 grants (3 NGOs)	\$ 2,868,006	202,800	1	\$6.00
Other	3	12	3 grant (3 NGO)	4,000,000	355,900	2	
TOTAL	33	327	58	\$145,147,515	14,203,924	77	\$4.5

Source: Grant and Contract Management Unit, MoPH

2.7.3. Sub-contracting

Currently there are five donors supporting contracting out: World Bank, Asian Development Bank, USAID, EC, and KFW. Various mechanisms are used by these donors to contract NGOs. The World Bank channels its funds through the Ministry of Finance to the Ministry of Health who is the responsible for contracting competing NGOs. The Asian Development Bank (ADB) and USAID have sourced out this process to an NGO whereas the EC undertakes this work itself.

World Bank contracting involves a bidding process with selection being made based on quality and cost criteria, and funds are awarded on a lump sum basis. The contracts have varying time frames with the longest three years. They are performance-based with financial bonuses of up to 10% for meeting and exceeding pre-determined targets. Contracts that receive WB funds and are currently managed and overseen by the Grant and Contract Management Unit (GCMU) at the Ministry on are valued at US\$ 37 million.

Management Sciences for Health (MSH), the implementing NGO for USAID, with its REACH (Rural Expansion of Afghan Community based Health Care) program has elements of performance-based payment but uses a grant as opposed to a contract. The EC is providing grants that are not performance-based and NGOs define their own log frame and indicators. The EC envisions moving towards service contracts, following the WB model.

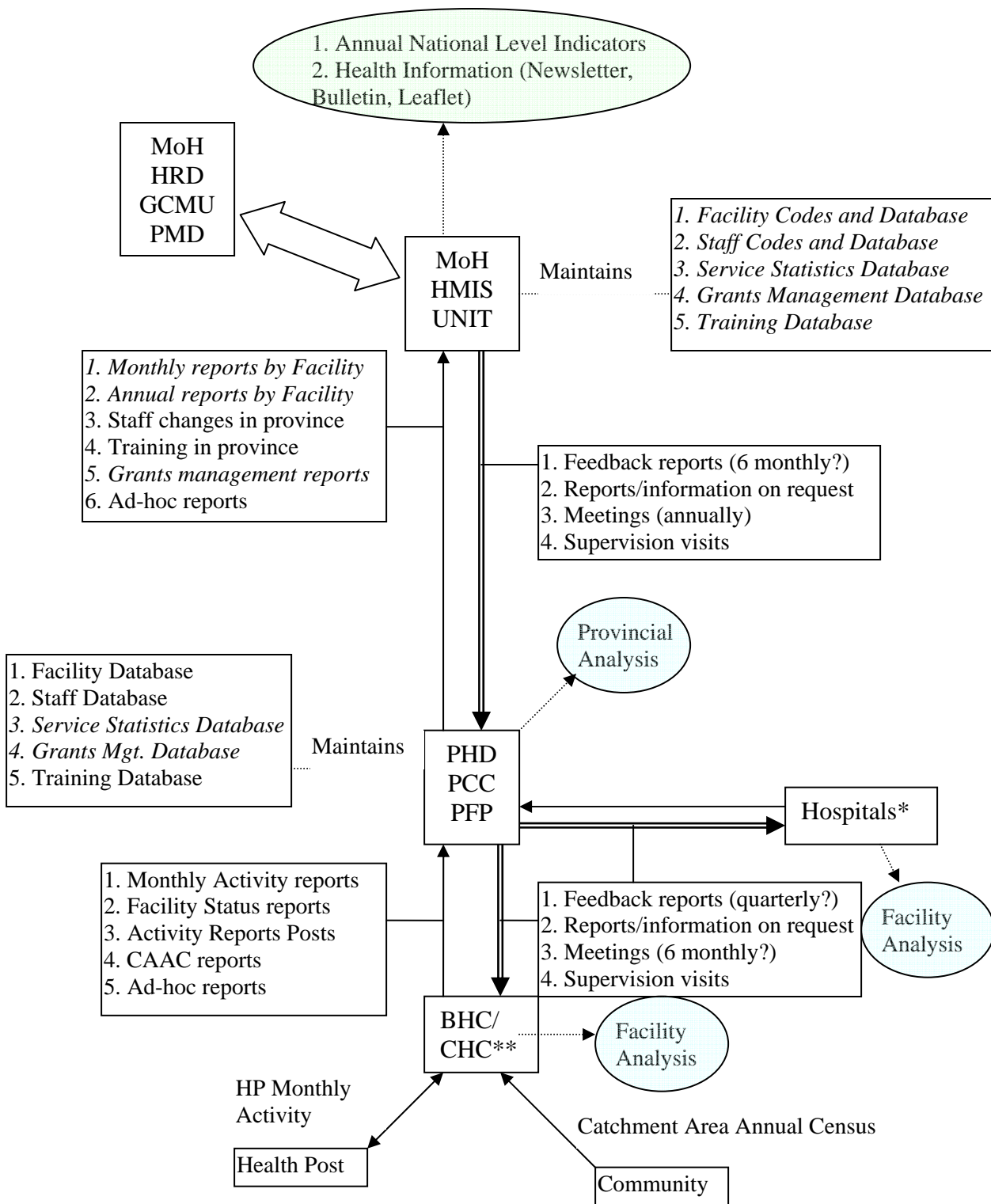
2.7.4. Strengthening Mechanisms

The BPHS is implemented by the Ministry of Public Health in three provinces, Kapisa, Parwan and Panshir. The project is supported by the so called MoPH Strengthening Mechanisms (SM). Based in the GCMU, 11 national consultants are overseeing the project, including advisors for each province covering finance, health care finance (pilots) and health technical advisors. Until now more than 700 essential and supportive staff were recruited through the PRR process. In these three provinces 23 new health facilities have been established and are functional. 26 facilities have been taken over from previously working NGOs. CHW and CMW training has been sub-contracted to specialized NGOs. 6 vehicles (pick-up) and 3 ambulances have been purchased internationally whereas 6 generators have been procured nationally. Procurement is handled though the Afghan Reconstruction and Development System (ARDS). Due to existing governmental structure the process is slower than in contracted projects. However, important progress in this project is observed and substantial amount of training is provided to Provincial Health Teams.

2.7.5. Monitoring and Evaluation

The Health Management Information System HMIS has been developed in 1990 by a small number of NGOs experienced with working in Afghanistan. After 2001, it has been revised and is now used in all provinces for collecting routine data. The current system involves facility status report, notifiable diseases, monthly integrated activity report and a monthly aggregated activity report. The information flow chart is given below.

HMIS Information Flow Chart



In order to obtain technical assistance in carrying out health facility assessments, evaluation of health workers practices, community feedback methods and household surveys to monitor and evaluate health services, the Ministry has signed a contract with a Third Party Evaluator, the Johns Hopkins University (JHU) and its partner, the Indian Institute of Health Management Research (IIHMR). A first baseline survey of the National Health Services Performance Assessment (NHSPA) was conducted in mid 2004. This survey was of health facilities and their catchment areas and was conducted in 33 of the 34 provinces.

The JHU team was contracted to not only conduct the health and community assessments annual, but to also conduct rapid facility assessments semi-annually in WB and EC supported provinces. Further more, JHU and partners were tasked to provide technical assistance to the Monitoring and Evaluation Unit of the MOPH in order to develop a national monitoring and evaluation framework including indicators.

The first result of this partnership of the MOPH and JHU was the *Afghanistan Health Sector Balanced Scorecard*. This is a document which summarized the results of the 2004 NHSPA and which provides a framework to efficiently look at multiple areas of the health sector at a given point of time in 2004. While the Balanced Scorecard (BSC) concept was developed for its use in industry and business, it is the first time that it is being applied to the health system. This new and innovative approach is in line with the MOPH's vision of making evidence based decisions.

The general findings of the NHSPA are that the MoPH is meeting its commitment to serve women and the poor. Despite this achievement, patient perception of quality is perceived, as 'poor' and the status of labs and TB services are 'poor' throughout the nation. Drug availability in general is 'good', as is the use of the Health Information Management System and patient records. There is great variation in the performance of the provinces and there is much room for improvement. The scores of the Health Balanced Scorecard are given in Annex --. The second nation wide round of health facility assessment is planned for September 2005.

2.7.6. Hospital Reform

Since 2003 additional efforts have been concentrating on the hospital sector in Afghanistan since it is vital for improving the health status of Afghans and complementary to the BPHS. The MoPH has conducted a National Hospital Assessment (NHA) in 2003 to identify the priority needs of the hospital sector in Afghanistan. According to the NHA the following main problems and priorities has been identified:

- Afghanistan has a relatively low number of hospitals and hospital beds compared to other countries with a comparable level of income. The ratio of 1 bed for 1000 people as recommended by World Health Organization (WHO) is not reached in any province of Afghanistan, including Kabul, the capital.
- The distribution of hospital facilities and services is uneven, with large parts of the population unable to access referral facilities.
- The distribution of hospitals and hospital beds is severely skewed in Afghanistan: 21 hospitals and 9.96 beds per 10,000 population in Kabul; 3 hospitals and 0.61 beds per 10,000 population in Uruzgan Province; 1 hospital and 0.77 beds per 10,000 population in Ghor Province; 1 hospital and 0.9 beds per 10,000 people in Nuristan Province. There is also a 400-bed Military Hospital; a 100-bed Police

- Hospital and a 150-bed Security forces Hospital in Kabul (not in the MoPH structure).
- The physical condition of facilities is acceptable, but they often lack adequate supply of water and electricity.
 - Hospitals are under- equipped and their equipment is not adequately maintained.
 - Hospital facilities are under-utilized; with average occupancy rates below 50%.
 - Hospitals are generally over-staffed, particularly in the large urban areas, but only few facilities have an adequate number of female staff to provide acceptable services to the whole population they are supposed to serve.
 - Among services proposed to patients, delivery care and emergency obstetric care are particularly poor, as shown in the table given below.

Table 4: Emergency Obstetric Care: Services, Equipment & Human Resources 2003

Total EOC beds	857
Total Patient seen in EOC (monthly average)	22,652
Number of delivery(monthly average)	7,961
No of Caesarian Section (average per month)	428
Obstetric Operating Tables	27
Surgical lights	39
Caesarian Section Kits	20
Gynecologists	365

Source: Afghanistan National Hospital Assessment 2003

To have an impact on the reduction of morbidity and especially maternal and early childhood mortality, an effective referral system towards hospital services is required that provides good quality services (secondary and tertiary levels). As a first step following the development of a ‘Hospital Policy for Afghanistan’s Health System’, an Essential Package of Hospital Services (EPHS) has been prepared and approved by the Executive Board. The package aims on standardizing hospital services and on guiding donors and NGOs in their support to the hospital sector. Currently most of the secondary and tertiary hospitals are operated by the Ministry; some are supported by donors (USAID 4 provincial hospital, EC 1 partially) or / and NGOs. The main problems to be addressed are the lack of management and clinical skills of the hospital staff, the misdistribution of hospitals in the country and an extreme weak referral system.

The long awaited reform process in the hospital sector will embark with a project proposal that the Ministry has elaborated for implementing the EPHS in five provincial hospitals. The Afghan government has allocated 10 million US dollars from its discretionary funds to improve hospital services. This project, if successful, will be a unique opportunity for the Ministry to demonstrate its willingness of bringing organizational reform processes forward by addressing one of the most difficult components of the sectors. The Ministry of Health will have full ownership of this project. The proposed approach will help other stakeholders in the health sector to engage in the hospital reform process. The project finally will contribute to the Ministry’s overall goal, to reduce high levels of morbidity and mortality.

2.7.7. Grant Contract and Management Unit

For strengthening the capacities of the MoPH in regard to the management of programs and projects such as tracking of support to the national budget, implementation and management of projects including their monitoring and reporting, a Grant Contract and Management Unit (GCMU) was established. This unit has functioned very effectively since its establishment in March 2003. Comprised of 2 international advisors and 12 local consultants working both in the GCMU and other parts of the MoPH, the scope of the work encompasses the finalization of bidding documents with all donors and following complex procurement procedures including the tendering, evaluation and negotiation of numerous contracts in a very transparent manner. The GCMU initially consisted of only 4 national consultants, however it was agreed that more staff were required in order to strengthen other MoPH departments that are important for the successful functioning of the contracting process such as monitoring and evaluation and health care financing. So far the GCMU has served as an effective way to bring service delivery closer to the government. Indeed, with a national consultant heading the GCMU it is Afghan staff that are dealing with day-to-day issues and have been actively involved in the contracting process. Moreover, GCMU members stress that they represent the MoPH and deal with all donors from this perspective.

It is anticipated that by middle of next year, other major donors (US AID, EC, ADB) would begin to channel their funds through the GCMU.

2.7.8. Information gathering

Important information has been gathered for evidence based decision making such as the Afghanistan National Health Resource Assessment (ANHRA), the Multiple Cluster Survey (MICS) 2003 and its re-analysis 2005, a Maternal Mortality survey, a nutrition survey, the National Hospital Assessment, the baseline round of the National Health Facility Performance Assessment and a semi-annual Rapid Assessment Survey of health facilities in EC and WB covered provinces. A National Risk and Vulnerability Survey (NRVS) will be carried out in the near future; the MoPH could incorporate main health related questions.

2.7.9. Human Resource Development

The impact of 20 years of war on the education and training of health workers is presenting the MoPH with major challenges and has led to the creation of a General Directorate of Human Resources to analyze the situation and develop strategic approaches to addressing these problems.

A Human Resources Database has been set up and registration of health workers has commenced, this will act as the basis for future licensure of health workers.

A process of testing and certification has been set up to assess the level of knowledge and skills of health workers trained outside the government health system, shows that on average 70% of nurses, midwives, laboratory technicians and pharmacy technicians are failing to achieve the minimum required standards and require extensive retraining. Of

all health workers applying for testing and certification more than 50% were found to have fake certificates or certificates which did not meet the national required standard.

Of those achieving the required standard of professional competence, most do not meet the old government requirement of 12 years schooling in order to be employed by MoPH. This is leading to major problems, particularly in remote provinces where clinically competent health workers cannot work in government service. It will take 5-10 years for the Institute of Health Sciences to produce sufficient numbers of graduates as required to cover the BPHS and EPHS, however these graduates refuse to work in rural areas. The GD HR and the HR Task force are working to develop strategies to address these major problems.

2.7.10. Health Sector Reform and Decentralization

In its policy statement, the Ministry is asserting its commitment to strengthen health service management capacities and to gradually decentralize operational and financial responsibilities and authorities to the provincial level. In all provinces a 'Provincial Health Coordination Committee' (PHCC), has been set up, led by the Provincial Public Health Director, involving all relevant partners in the health sector in the respective province. Its main objective is to coordinate the activities of all stakeholders in achieving the MoPH's priorities, particularly the expanded delivery of the BPHS. In most of the provinces a decentralized planning exercise has taken place that in future will be embedded in the provincial component of the 'National Capacity Building Plan for Central and Provincial Ministry of Health Public Administration Staff' (Ministry of Health 2004).

At the same time, an administrative reform, the Priority Reform and Reconstructing Process (PRR) of the health sector is underway. The selection of new staff is based on merit-based recruitment and at the central MoPH level has already been completed

In order to address the severe impact on the health workforce that resulted from more than 20 years of war the Ministry has established a General Directorate for Human Development. Significant progress has been made over the last year:

- A PRR proposal for the entire Ministry of Public Health has been elaborated and submitted to the Civil Service Commission
- In total 872 different categories of health staff has been recruited through the PRR process, including the three SM provinces

2.7.11. Restructuring and reorganizing the MoPH

A new organogram for the MoPH has been recently developed (Annex 6) and is awaiting approval by the Cabinet.

2.7.12. Health Financing

There is consensus that the national resources allocated for the health sector are not adequate and that without participation of the communities the health care provision will not be sustainable. However, there is considerable disagreement among stake holder about what to do about user charges or other approaches to community health care financing.

The national constitution states that health facilities will be provided free of charge to the public. This needs to be defined by the upcoming parliament of Afghanistan. The MoPH's current interpretation of this article in the constitution is that the government will provide the physical infrastructure of health without charging the local population and that 'health facility' doesn't include health services. As far as the health services are concerned, preventive services such as EPI, family planning, ante and post natal care and care during delivery and health education will be provided free of charge.

A task force for health financing and sustainability has elaborated a national cost sharing policy in the short term. To achieve equity and make care accessible to all there will be exemption mechanism (i) for those who are poor and (ii) preventive and promotive services (e.g. immunization, maternal delivery, antenatal care, family planning, treatment of TB, and nutrition interventions. In the future when antiretroviral for HIV/AIDS are needed these will also be provided free.

In order to formulate an informed and evidence based health financing policy, the MoPH with support from Johns Hopkins University is carrying out a randomized controlled study of three different approaches in eleven provinces of the country. These approaches are: completely free services; standardized user charges in keeping with MoPH's guidelines and a Community Health Funds (CHF) which is essentially a pre-payment scheme controlled by the community. Final results should be available around September 2006 and should provide high quality evidence for effective policy formulation.

A briefing note on the above mentioned three modalities that summarizes the current thinking of the MoPH on this subject is given in Annex --.

2.7.13. Coordination

The MoPH firmly believes that decision making has to be the extent possible evidence based with active involvement of stakeholders through a variety of coordination mechanisms. With this in view the Ministry has established Working Groups and Task Forces that are led by relevant technical departments in the Ministry and assemble individuals from the donor community who can bring in additional value. Drafted documents are then presented to the Consultative Group (CG), a forum that has been initiated by the Ministry of Finance and established in most of the Ministries. The Consultative Group for Health and Nutrition (CGHN) is widely considered as the most effective; the Ministry of Public Health is the leading ministry of the sector; other 'line ministries', UN agencies, main donors, principal NGOs and the International Security Assistance Forces (ISAF) are members of this coordination mechanisms. The main purpose of the CG is (i) to advise the Ministry on the development of strategic policies

and measurable output and outcome indicators; (ii) to assist with the preparation of Public Investment Programs, including resource mobilization; (iii) to assist with accelerating the implementation of the National Development Budget (NDB); (iv) to assist with the monitoring and evaluation of implementation progress, including data collection for the tracking of aid flow; (v) to prepare a sector profile – led by the chair ministry with the Ministry of Finance Development Budget & External Relations (DBER) Unit and (vi) to share information.

Documents shared and discussed with CG members then are revised by the Technical Advisory Group (TAG), led by the Deputy Minister, consisting of a limited number of selected and appointed individuals who have proven to contribute specific technical input. The most senior level of the Ministry, the Executive Board, is the final and highest level of decision making process for approving policies and strategies.

The National Technical Coordination Committee (NTCC) meets on monthly basis and involves all stakeholders of the sector. It is an information sharing forum to up-date partners on on-going issues and disseminates new policies in the health and nutrition program. A coordination meeting for NGOs that are subcontracted by the MoPH with World Bank funds and EC NGO grantees meet every month to discuss lessons learnt from the BPHS implementation and findings from their quarterly technical reports after compilation by the GCMU.

Increasing pro-active leadership of the Ministry has resulted in being widely considered one of the most progressive and reform-minded Afghan ministries. It has acquired the trust of other Afghan ministries, international donors, multilateral agencies and non-governmental organizations.

The above mentioned coordination mechanisms established by the MoPH at Central and Provincial level are summarized in the table given below.

Coordination mechanism	Purpose	Members	Frequency of meetings
<i>Central Level</i>			
Consultative group on health and nutrition (CGHN)	<ul style="list-style-type: none"> Coordinating the activities of line ministries, donors, UN agencies and NGOs Giving advice to senior management of MOPH for decision making Reviewing policy documents, contracts, proposals, etc 	Line Ministries, major donors, UN agencies and representative of NGO-BPHS implementers	Once a month
Working Consultative group on health and nutrition (WCGHN)	<ul style="list-style-type: none"> As above 	As above except line ministries	Once a week
Joint donor missions (JDM)	<ul style="list-style-type: none"> Assessing needs, coordinating activities and agreeing on common principles for implementation 	MOPH and all donors	There have been 3 JDMs

Coordination mechanism	Purpose	Members	Frequency of meetings
National technical coordination committee (NTCC)	<ul style="list-style-type: none"> Sharing information; providing opportunities to NGOs to raise their concerns to ensure the transparency of decision by the MOPH 	MOPH, donors, UN agencies and all NGOs	Once a month
Taskforces and working groups (TFs & WGs)	<ul style="list-style-type: none"> Producing technical documents e.g., policy documents, guidelines, etc; providing an opportunity for the NGOs to contribute 	MOPH technical units, NGOs, UN agencies and sometimes donors	Once a week
Technical advisory group (TAG)	<ul style="list-style-type: none"> Acting as a buffer between the EB and CGHN or WGs reviewing policy documents, guidelines, etc 	Experts appointed in their right as experts. They do not represent agencies	Once a week
Executive board (EB)	<ul style="list-style-type: none"> Highest level of decision making in the ministry; endorsing documents 	HE the Minister, the Deputy Ministers and General Directors	Once a week
<i>Provincial Level</i>			
Provincial health coordination committee (PHCC)	<ul style="list-style-type: none"> Coordination of activities at the provincial level 	Provincial health department, NGOs and other provincial level stakeholders	Once a month

2.8. Challenges to National Health Development

2.8.1. Peace and stability

Every step taken toward reducing poverty and achieving broad-based economic growth can be a step toward conflict prevention. However, peace, security and justice for all in Afghanistan are still far from being achieved. The security situation in some areas has even deteriorated despite the presence of international troops and an ongoing security sector reform but peace and stability are preliminary conditions for the successful implementation of the health and nutrition program. In 2004 more than 40 health and reconstruction workers have been killed in Afghanistan. (Lancet 2005). The murder of five health workers from the international health NGO ‘Medecins sans Frontiers’ (MsF) in the Western region of Herat led the agency to completely cease all operations and to leave the country. Up to now the government has not undertaken steps to detain the responsible. A growing threat has been spelled out against Afghan women who work for international aid agencies, culminating in the killing of three female NGO workers in the northern province of Baghlan. Increasing and continuing insurgent attacks especially in the south and southeast regions continues to indicate the growing confidence of anti-

governmental elements and raises the possibility of ex-Taliban factions establishing a secure political foothold in the area. In those provinces the implementation for basic health services is far behind the target. Political instability might lead to a withdrawal of the donor' community and endanger their financial commitment. However, providing physical security for health workers lies beyond the MoPH's capacities of mitigation.

Relevant challenges in Afghanistan thus stem from at least three sources: a resurgence of Taliban and al-Qaeda activity along the southeastern border; the huge increase in poppy production and trade; and constraints to reconstruction, particularly with regard to Disarmament, Demobilisation and Reintegration of armed factions as well as development of capacity in the security/law enforcement and judicial sectors. The continued existence and legitimacy of warlords throughout Afghanistan compounds all three issues, as does the continuing proliferation of small arms. Incidents of armed violence that affect civilians occur in the contexts of coalition military activities, terrorist activities, factional fighting and violence, and commander violence (forced recruitment, forced labor, extortion of money, physical assaults). Increased narcotics production particularly contributes to the worsening security situation and must be tackled through reduction of supply, demand and harm.

2.8.2. Respect of Human Rights

Availability and access to health services is a basic human right. This is also the right to education, to food and encompasses more general the right to survival, livelihood, social protection and participation.

2.8.3. Landmines

Landmines and Unexploded Ordnance (UXO) constitute a structural impediment to the development of Afghanistan, the result of more than two decades of mine use by many armies and factions. According to the obligations under the Mine Ban Treaty, Afghanistan must destroy all stockpiled anti-personnel mines by March 2007 and must clear all mines by March 2012.

2.8.4. Human resource development and Female Health Workers

The Taliban's restriction on education for girls prevented female health workers from obtaining higher education and this has been a major constraint for the current government to ensure increased access to health care services provided by female health workers that are widely accepted by the communities.

The testing process for mid level health workers revealed an unexpected percentage of candidates that failed a basic theoretical testing (among Kabul midwives more than 90% failed the test). The knowledge of these staff requires up-grading and retesting. The Ministry's policy of equipping BPHS facilities with an adequate number of 3 year training graduates poses an additional problem since most of health workers from rural areas have been training in other systems than the governmental (e.g. NGO) and do not meet the Ministry's requirements.

The Ministry has abandoned deploying Traditional Birth Attendants and instead favors staffing BHCs with Community Midwives. However, since the training period of Community Midwives is 18 months, interim solutions have to be identified. In some areas of the country female health workers from neighboring countries (Uzbekistan, Tajikistan) are being hired and the National Salary Policy foresees special incentives for women to work in rural and remote areas.

2.8.5. Financial dependency

In the foreseeable future the Afghan government will be dependent from external funds. The current funding gap for BPHS is UD \$ 33.75 million US dollars and for the whole development program in Health and Nutrition it is US \$ 132.01 million.. A cost sharing scheme in a post conflict situation is not likely to recover substantial returns. Domestic revenue mobilization will remain a major challenge although Afghanistan's economy had a very good start after the end of the war. However, since the informal sector accounts for more than 80% of the national economy, politically stable conditions are crucial for attracting private investors and developing the agricultural and industrial sector.

2.8.6. Quality of care

After the quick expansion of basic health services to more than two thirds of the population, focus should now be given to improving the quality of health services. Many factors have to be considered to address this issue such as up-grading and improving the knowledge of health workers through, making drugs available, and developing quality care standards. Regular and constructing monitoring and supervision is crucial for improving quality of services. The Ministry is currently developing a national monitoring and evaluation system that will address the lack of unified monitoring tools that provide information on program progress and that contribute to render health services more effective. At the same time simple but effective interventions such as exclusive breastfeeding and administering zinc to children with diarrhea diseases have been proven to significantly reduce mortality but have only recently been put by UN agencies into the centre of attention (Qadir et al 2005).

2.8.7. Lack of physical infrastructure

Lack of means of transportation and appropriate infrastructure further reduces the access to health care of many people living in rural areas of Afghanistan. According to ANHRA, most facilities are within 40 minutes walking distance from a paved road. Long hours of traveling on donkeys, camels, or by walking are especially critical for women who need emergency obstetric care and for seriously sick people. Lack of electricity (in health facilities), improved water supplies and sanitation systems have an impact on ill-health.

2.8.8. Natural disasters and epidemics.

Afghanistan is a country that is prone to natural disasters such as earthquake, floods, drought, land slides, outbreak of epidemics. The Office of Disaster Preparedness (ODP) prepared national plan on disaster preparedness and response. ODP is coordinating body at government level. Based on that plan each of the relevant ministries is responsible for resource mobilization, inter-sectoral coordination/cooperation and action during emergencies.

The department of EEPR / MoPH is responsible for any type of disaster preparedness and response in health sector. This department has the full support of UN and other international organization (WHO, UNICEF, ICRC and NGOs). Main factors playing role for increasing the vulnerability of the Afghan population are:

- Natural / geographical situation (mountainous & harsh winter and hot summer).
- Poor infrastructure (lack of roads) making many areas inaccessible during winter
- High illiteracy rate and low community awareness (how to combat with disasters)
- Poor water and sanitation system; low community awareness;

Over the last three years the country has experienced the outbreaks of Pertussis, Diphtheria, Cholera, CCHF (Crimean Congo Hemorrhagic Fever), Measles, Scurvy and Leishmaniasis. An earthquake killed more than 1000 people in Nahrin district of the Northern Province Baghlan in 2002. The last winter was associated with the high morbidity and mortality due to cold weather, Pertussis and Measles.

Table 6: Death Toll due to Disasters

Disaster	Date	Location	# of people killed
Earthquake	30-May-1998		4,700
Epidemic	10-Apr-2002		2,500
Earthquake	Feb-1998		2,323
Earthquake	10-Jun-1954		2,000
Earthquake	25-Mar-2002		1,000
Earthquake	1-Feb-1991		545
Epidemic	Jan-2000		507
Earthquake	16-Dec-1982		500
Flood	2-Feb-1991		415
Land Slide	27-Mar-1995		354

Source: National Plan of Office for Disaster Preparedness

Table 7: Population Affected by Disasters

Disaster	Date	Location	# of people affected
Drought	May-2001		3,800,000
Drought	Apr-2000		2,580,000
Drought	1973		600,000
Flood	Jul-1978		271,684
Flood	Jan-1972		250,000
Drought	1972		235,000

Epidemic	Jan-2002		200,000
Flood	Jun-1988		161,455
Earthquake	11-Feb-1999		124,867
Drought	1971		120,000

Source: National Plan of office for Disaster Preparedness

2.8.9. Achieving the Millennium Development Goals

The Millennium Development Goals (MDGs) represent a diagnosis of the causes of poverty and the agreed priorities for alleviating poverty. The MDGs provide a framework for quantifying many of the desired outcomes and building agreements about the actions for achieving them (World Bank 2005). The Government of Afghanistan is committed to achieving these goals and is currently working on formulating a National Development Strategy that will entail an Interim Poverty Reduction Strategy and intermediate targets for achieving the MDGs. However, it was necessary to ‘afghanize’ the target for the MDGs and the MDGs as such. The years between 1978 and 2001 are perceived as being ‘lost to development’ (Islamic Republic of Afghanistan 2005), where economic growth stagnated whilst other countries made significant progress towards achieving the MDGs. The government therefore set as its new timeline 2020 for achieving the MDGs, having 15 years like other countries. Other MDG targets are not relevant to Afghanistan (e.g. target 10: have halted by 2015 and begun to reverse the spread of HIV/AIDS) and have been adapted to the Afghan context. A new goal has been added on ‘Enhancing Security’, generally perceived as a preliminary condition for ensuring progress in reconstructing the country (see Annex 4).

In a Technical Working Group (TWG) meeting on June 26, 2005, it was agreed that e.g. Maternal Mortality and Infant Mortality will be reduced by 50 % until 2015. However, the Ministry of Public Health is still committed to reach the global targets by 2020. Unlike in other fragile states where international commitments often bypasses the state system (High-Level Forum on the Health MDGs 2004), external assistance in Afghanistan has been channeled through national frameworks, spelled out in the National Development Framework 2002 and coordinated through the consultative group process.

Currently the Ministry with support from UN agencies is developing a two-years strategy plan on reducing maternal mortality, meeting intermediate targets in line with the MDGs (United Nations 2005). Major challenges for achieving the global target of reducing prevalence and death rates associated with tuberculosis encompass a volatile security situation, insufficient integration of TB control activities into BPHS services, lack of qualified staff and a laboratory network, insufficient referral and quality assurance system.

Substantial support to the control of Tuberculosis, Malaria and HIV/AIDS will be provided by the Global Fund. For HIV/AIDS the set target has little relevance to the Afghan context due to the estimated low prevalence (according to UNAIDS, based on a modeled estimate HIV/AIDS rate was a 0.01% pf the population in 2000). However, due to the low prevalence Afghanistan’s population is at high risk of uncontrolled spread. Focus should be given on IEC measure for the population between 15 and 49 years of

age. To reduce the prevalence of malaria 60% of the population at risk will need bed nets in order to reach the threshold of herd immunity.

Table 8: MDG Health Targets for Afghanistan

MDG	2004 level	Target 2015
Reduce child mortality*	Under 5 mortality rate: 230 per 1,000 live births Infant mortality rate: 140 per 1,000 live births	Under 5 mortality rate: reduced by 50%, 115 per 1,000 Infant mortality rate: reduced by 50%, 70 per 1,000
Improve maternal mortality*	Maternal mortality ratio: 1600 per 100,000 live births	Maternal mortality ratio: Reduced by 50%, 800 per 1,000,000 live births
Combat HIV/AIDS, malaria and other diseases	Polio: 10 Malaria: 261,000 new cases; 18% of population in high-risk areas use bed nets (2004) TB: 321 cases per 100,000 HIV/AIDS: estimated 0.01% prevalence in 2000	Polio: 0 cases 60% of population use bed nets by 2010; 80% by 2015 80% TB: 70% of TB will be detected and 85% treated successfully under DOTS by 2015; 48 / 100,000 cases HIV/AIDS: < 0.5% of population aged 15 – 49 are HIV positive

Source: Afghanistan and the MDG 2005: report of the TWG 3, sub-group A (child mortality), B (Maternal Health), HIV/AIDS, Malaria and other diseases

*The Technical Working Group for Health agreed on a ‘Median Scenario’ taken from the MICS 2003, considering the impact of measles mass vaccination campaigns, taking into consideration data from MICS 1997 and trying to remove the urban bias.

2.8.10. Future role of MoPH and NGOs

The Ministry of Public Health together with the Ministry of Rural Rehabilitation and Development has entered into a major purchaser-provider relationship for service delivery. Contracting-out has not been done before at a large scale like it is being carried out in Afghanistan. Evidence from other post-conflict countries like Cambodia show that services contracted-out are provided more effectively and efficiently but results are generated from much smaller scale of implementation. Rigorous evaluation of current contracts, grants and MoPH SM project is required to guide the Ministry’s decisions on whether taking the responsibility for delivering services. It is hoped that the new NGO law will define NGOs positions as needed and experienced partners in bringing relief programs further towards reconstruction and development processes.

2.9. Some key issues facing the health sector.

2.9.1. Fragmentation

The current health system is currently fragmented in terms of a harmonized approach to resources as well as the service delivery. This may largely be the result of multiple actions, implemented by central and local health authorities, donors, humanitarian and development agencies, NGOs. Additionally, the proliferation of vertical programs (mostly in the area of control of communicable diseases) has compounded the prevailing fragmentation. To overcome this fragmentation, effective coordination is needed. This will achieve efficiency gains.

The fragmented settings prevailing in the health sector makes it difficult to carry out a proper analysis of patterns and trends, as well as the comparison of different situations across country. There is a pressing need for standardization for items like the layout of health facilities, training curricula, therapeutic guidelines, staffing patterns, salary structure, budgeting criteria etc. .

The MoPH does appreciate, that given the diversity and the number of the partners, it can be difficult to reach consensus on certain issues. The MoPH has established a blueprint for effective coordination (2.7.13.) that is evolving. It should be noted that coordination of discrete, concrete, pressing issues or specific intervention is easier. Coordination is a labor-intensive and an expensive endeavor, with high opportunity costs, which needs dedicated resources.

2.9.2. Distortions in the allocation of available resources.

The current biases in provision of health services are due to historical and political reasons, hence not easy to deal with on mere technical grounds. Most NGOs work at local level, thus lacking a national perspective. The MoPH lacks the information and the resources needed to redress the resulting inequalities, through a rational allocative process. Thus, services are concentrated in urban areas, in zones of relative high population density, and along the borders with Pakistan and Iran. Meanwhile, in the whole central region (with the exception of Kabul), with low population density, health services are virtually inaccessible to most people. Correcting these imbalances requires reliable information, and a particular concern about equity. To redistribute NGO interventions across the country can turn out to be a very slow process, as many NGOs have developed special relationships with particular settings and will be reluctant to move. But new NGOs and new projects implemented by established NGOs should be resolutely directed to underprivileged areas.

2.9.3. Contracting out service delivery.

There has been much discussion about the future role of NGOs in delivery of health services in Afghanistan. While some of the MoPH leadership would prefer to build a nation wide public health sector, directly involved in service delivery at all levels throughout the country, they acknowledge the capacity gap deterring the ministry to do so. The second Joint Donor-UN Mission on Health, Nutrition and Population, carried out in March 2002, produced a set of recommendations, the most important of which was the

split between the functions of purchaser and provider of health services. The mission suggested that such mechanism could be used to expand services in Afghanistan. Although unfamiliar with the method and the terminology, the MoPH pointed out the obvious, i.e. that health authorities lack the skills needed to manage such complex tool such as: pricing activities and services according to different working conditions and level of care; drafting contracts; managing the bidding process, and establishing and using benchmarks to monitoring the performance of the NGOs in the field. Equally important is the almost absolute lack of experience of most NGOs, about managing relatively complex systems, such as referral, supervision and supply functions. The MoPH has accepted to try the so-called Performance-based Partnership Agreements (PPAs) as a pilot experience in priority un-served and underserved areas. The World Bank volunteered to provide the funding. An Essential Package of Health Services was formulated and approved (this is currently being revised and the revised version will be used in the future contracts) and was used to draft the contracts. The cost of delivering this package in per capita terms is around US \$ 4.5.

The CCS team understanding from the various discussions with MoPH staff was that in the medium term the NGOs would continue to play a vital role in the delivery of the BPHS under the stewardship of the MoPH. The fact that MoPH is investigating different financing options was a clear indication that the public sector could possibly assume a larger burden of delivery of BPHS in the coming yearshealth

2.9.4. Decentralization in the present context.

As everywhere else in the world, decentralization is energetically advocated, particularly by donor agencies, as essential component of a reform package. In the unique settings of Afghanistan, this prescription looks particularly arguable. The country is fragmented, the grip of the central government over peripheral (legitimate or not) authorities is feeble, most financial resources are controlled by non-state parties. What remains to be devolved to the periphery by the central government is thus unclear. Perhaps, the main argument is that Afghanistan is not in the condition of reforming its administration, before it has built a functioning one in the first place. The first priority is therefore to build management capacity at all levels and functioning links between them. Without this capacity in place, no decentralized set-up is likely to deliver on its promises. And some of the major distortions affecting the health sector, such as uneven coverage and the proliferation of unplanned private sector, require a strong central leadership.

The distribution of responsibilities between central government and provinces is a politically charged and highly contentious process (particularly in present Afghanistan) and is not decided on technical grounds and or by a single sector in isolation. Whatever the outcome of this struggle, the future health sector will need performing management systems to function properly. And the ultimate mix between centralized and decentralized mandates should be arrived at according to feasibility, equity, effectiveness, efficiency, simplicity and common sense, rather than to ideological considerations.

2.9.5. The potential role of Community Health Workers.

These providers of basic health services are considered in several policy documents as the foundations of the health system, perspective which worldwide has enjoyed enormous

popularity during the 80s. However, as experience from different settings and countries accumulated, the original expectations were progressively downscaled to more modest levels. From decades of international experience, a few conclusions can be regarded as fairly firm:

- Whereas small-scale schemes have been often successful, few, if any, national programmes have established themselves as unqualified success stories.
- Even successful schemes have been difficult to sustain, due to the high operational costs which they are prone to incur.
- CHWs are more effective and sustainable when collaborating closely with performing formal health services, able to provide supervision, drugs, in-service training and referrals. CHWs should be conceived as complementing and extending well-established formal health services, rather than replacing them, at least in the long run.
- In situations where no formal health services can be implanted (such as in very remote and war-affected areas), CHWs can provide a temporary and partial answer to some of the existing health problems, but their role should not be unnecessarily exaggerated. In the context of Afghanistan, CHWs have reportedly played a crucial role in delivering services in very difficult conditions, often where no alternatives were available. However, as the situation normalizes and formal health services expand their coverage, their scope is likely to be accordingly reduced, to operate mainly in low-density, poorly-accessible areas.

2.9.6. Constraints in strengthening post-conflict health systems

There are no quick fixes to the disruption caused by decades of war: “extraordinary” operational standards and vertical approaches may be justified in wartime, but are inefficient, disruptive and unsustainable during the rehabilitation period.

The biggest obstacle to post conflict health system is the threat of renewed conflict. To date, post-conflict Afghanistan has been remarkably stable and despite change in the stewardship of MoPH, there has been let up in the rapid build up capacity to deliver basic health services both in cities and in rural areas. It is expected that with more female health workers e.g. community mid-wives being trained and progressive increase in quality of care provided, the utilization of health facilities would improve. It remains to be seen if the introduction of some kind of ‘user charges’ would lead to a drop in the utilization rates.

2.9.7. Formulating a National Health Policy: value, constraints and limitations.

Political instability, inadequate resources, limited access to the field, have all frustrated the aspirations of policy makers. In fact, no field evaluation of the results of implemented policies has been found. Hence, to assess the merits of policies proposed but not field tested is of limited value. For the same reason, to formulate a new relevant and realistic health policy in the absence of implementing experience, while relying on such a weak information basis, is largely an abstract exercise, where ideology can overcome common

sense. The future political settings, still to be defined, add further hurdles to sound policy making. Recently, the MoPH, assisted by the WHO, has produced a National Health Policy (NHP), which reflects the constraints facing policy makers in today's Afghanistan. It focuses on technical matters (on which consensus is more easily attainable) rather than on actual policy issues. Thus, while there is a substantial level of detail on EPI or DOTS strategies, very little is said on critical subjects such as health sector financing, size and functions of the MoPH, decentralization, or approach to service delivery. Given this picture, a realistic, experimental and incremental approach to policy making seems in order. Identifying a reduced set of serious structural problems and approaching them without preconceptions should provide opportunities and stimuli for learning by doing, in personal as well as organizational terms. Thus, discrete policies would materialize at sub-sector level, to be integrated later, when capacity and knowledge have significantly expanded, into a consistent whole. Some elements of the future national policy will address the dilemmas of equity, efficiency, effectiveness, sustainability, relevance, roles etc. Despite the obvious need for collective learning, it is far from granted that health authorities will be offered the time and the space for it. Rather, multiple pressures converge to demand to health authorities clear policies, quick implementation, and solid results

2.9.8. Financing the health sector

To estimate the financial envelope likely to be available during the next 5-10 years is crucial to set a clear resource constraint to health sector development, to force decision-makers to choose among several competing priorities and to discourage the formulation of unrealistic plans. As government revenues are presently considered negligible, the health sector mainly depends on external support, estimated to be in the order of US\$ 50-60 million per year, for its financing. With the improvement of the situation and the recovery of the government capacity to raise taxes, a small if increasing share of health sector expenditure should be shouldered by the public purse. Reportedly, the allocation to health in the first government budget will be 6% of the total. To forecast how external financing will evolve over the next year is problematic, as donor behavior and preferences have varied dramatically over time and in relation to different countries, in ways not always understandable on rational grounds. The starting point is that the present level of per capita spending of external financing seems one of the lowest in the world, and vastly inadequate considering the magnitude of the health problems and the costs induced by the reconstruction of Afghanistan. The present per capita allocation looks even meager when considering the extreme fragmentation characterizing the sector and the inefficiencies induced by it, as well as the extra operational cost incurred because of mandatory security measures. In short, not much health care can be delivered with this resource package. Pending the outcome of the study on options for health financing, considering the extreme poverty of the population, no significant increase in the already existing cost-sharing mechanisms is recommended in the short term.

The rapid growth of private for-profit providers is an indirect sign of the willingness (and ability) to pay for services that are perceived of higher quality. In view of the potential of the private sector to grow further, the MoPH should sooner than later think about developing mechanism/regulations to avoid malpractices by private health providers.

2.9.9. Strengthening management systems

There is a pressing need to strengthen management through out the health care system in order to reduce waste and improve efficiency. This implies addressing the following components, at central, regional / provincial and district levels

- Information systems
- Financial management
- Human resources management
- Supply management
- Referral systems
- Integration of vertical programs initially at the district level

2.1.10. Summary of the Achievements and Challenges in National Health Development

The Ministry of Public Health during the last three years, while in a post conflict situation, has made significant and commendable progress in determining the direction of health sector and formulating policies at the national level to guide the future development and investment in this sector. *Some of these achievements are listed below.*

- Elaboration of a national health policy (2002), interim health strategy (2003), the national health policy for the period 2005 – 2009 and a national health strategy for 2005-2006.
- The national health program reflects the national health priorities i.e. reduction in the under five and maternal mortality; addressing the widely prevalent malnutrition; prevention and control of communicable diseases; ensuring equitable distribution of health services and capacity building with emphasis on wider aspects of health system development.
- The principles of health strategy are consistent with national development framework and it emphasizes the stewardship role of the MOPH rather than direct implementation (at least in the medium term).
- Recognizing the need to deliver basic health services quickly through out the country, especially in the under served rural and relatively in accessible areas, the MOPH has developed the BHPS and EPHS.
- As the MOPH did not have enough resources of its own to deliver these packages (BHPS and EPHS) in a relatively short time and realizing that the government would not be able to spend the resources made available to the health sectors by the donors quickly enough to achieve results in the short term, it was decided to deliver the health services through NGOs under a contracting mechanism (performance based partnership agreements).

- The establishment of a Grant and Contract Managing Unit in the MOPH to deal with funds from the World Bank. This unit is responsible for inviting proposals, reviewing them according to the established criteria and in a transparent manner, awarding the grants and disbursement of funds. By the middle of 2006, it is expected that all external funds would be channeled through this mechanism.
- Restructuring of the MOPH and the new organogram is expected to be approved shortly by the cabinet.
- Considerable emphasis is being placed on independent monitoring and evaluation of the performance of health facilities and of health workers and on assessment of community satisfaction with the services provided.
- The development of effective coordinating mechanisms to ensure the full involvement of donors and other government sectors in development of policies and in monitoring of programs. The establishment of these mechanisms has resulted in much closer collaboration amongst donors, including the UN agencies involved in health development, than has been known to exist in countries receiving substantial external funds.

The country still faces some formidable health challenges that reflect on the one hand the poorly developed health infrastructure that has been neglected for decades and the extreme economic conditions experienced by the country as a result of war and natural disasters such as the recent drought. Based on the information mentioned in the earlier parts of this section and discussion with MoPH staff and with representatives of major donors to the health sector, *the following is a summary of some of the main health challenges confronting the health sector of Afghanistan as perceived by the CCS mission to the country.*

- Continued provision of high quality technical support to the MoPH in the areas of health policy formulation and sector management to meet the needs of the rapidly evolving development of the health system and the possible emergence of new challenges in the near and medium term.
- Insufficient national resources for supporting the implementation of the BPHS and EPHS coupled with dependency on external funds, the quantum of which in the medium to long term cannot be predicted with any precision.
- Devising sustainable policies for health care financing based on people's ability and willingness to pay. A cost-sharing scheme in the post conflict situation is unlikely to recover substantial funds and domestic revenue mobilization will remain a challenge.
- Strengthening the regulatory/standard setting, legislative and monitoring functions of the MoPH. In other words the stewardship/governance functions of MOPH.

- Lack of an adequate physical infrastructure (including roads and affordable transport systems, provision of electricity and safe water supply), equipment and medical supplies, further reduces the access to health care of many people living in rural areas especially those that are located in remote and inaccessible parts of the country.
- Lack of standardization in various components of the health system such as training curricula, therapeutic guidelines, staffing patterns in health facilities. With standardization it would be easier to make comparison between different health facilities through out the country.
- The role of public sector in delivery of BPHS and EPHS in the medium to long term. A rigorous evaluation is required to assess the effectiveness and efficiency of the contracting mechanism through which the MOPH has entered into a major purchase- provider relationship with a number of NGOs for service delivery. The outcome of such an evaluation would guide the MOPH in deciding whether to take this responsibility itself in the future.
- Development of a referral policy and of plans to implement it. While an excessive burden is being placed on the secondary and tertiary facilities by patients with complaints that can and should be handled at the community or basic health centers, the seriously ill patients are being deprived of care at these facilities due to the lack of an operating referral system.
- Acute shortage of trained health manpower, especially of female mid level health workers and midwives. It is difficult to recruit staff to serve in rural areas. Skilled health staff is concentrated in urban areas. Staffing patterns and salary structures are out of date. Serious distortion in workforce composition with insufficient number of nurses and allied health personnel. In addition, formal systems for registration of health personnel and accreditation of health facilities are yet to be established.
- The Taliban's restriction on education for girls has prevented the development of female health workers. The MOH has abandoned deploying TBAs and favors staffing the BHCs with community midwives, however, as it takes 18 months to train them, therefore, there is currently an acute shortage of this category of health workers.
- Quality of care is a pressing issue, now that the BPHS has been made available to nearly 70% of the population. Ongoing systems for supervision and for monitoring and evaluation need to be established.
- Lack of managerial capacity at all levels of health system and the absence of clear demarcation of functional responsibilities between central, provincial and district levels of health system.

- Excessive burden of communicable diseases such as TB, malaria and vaccine preventable diseases (while considerable progress has been made in eradicating poliomyelitis, the best reported coverage with routine immunization is still around 60%). Even though the number of HIV/AIDS cases is still low (around 320), however, in view of the experience of other developing countries including those recovering from crisis, the disease can spread rapidly.
- A very high maternal mortality that can be attributed mostly to the lack of antenatal and postnatal care and of trained midwives.
- Wide spread malnutrition and deficiency of micronutrients in girls and women of child bearing age and in children under the age of five years associated with food insecurity. Poverty prevents families from acquiring even the minimum amount of food intake.
- Largely as a result of years of almost constant conflict associated with economic deprivation, mental health disorders such as anxiety and depression are widely prevalent and there is a lack of trained personnel to diagnose and manage these conditions which are further aggravated due to the lack of drugs for their treatment. With wide spread poppy production in the country, the drug dependency is rising.
- Limited capacity of the government to prepare for and respond to natural and man made disasters.
- Lack of awareness amongst medical practitioners about medical ethics and of the need to treat patients with compassion.
- Absence of a well designed IEC plan and strategy for communicating health messages to all sections of the population with special emphasis on the needs of young children, girls and women of childbearing age.
- Clean water supply and sanitation facilities are available to a minority of the population that are mostly located in urban settings. However, this issue is being dealt by sectors other than health.

Section 3. Development Assistance and Partnership: Aid flows, Instruments and Coordination.

3.1. National Development Priorities

The ‘International Conference on Reconstruction Assistance to Afghanistan’, held in Tokyo in January 2002, was the first meeting where national strategies, priorities and policy directions have been discussed to guide aid assistance of development partners in rebuilding Afghanistan. Conclusions made during this conference laid the foundation for the *National Development Framework* (NDF), a comprehensive document identifying three pillars, accommodating twelve Public Investment Programs (PIP). The ‘Health and Nutrition Program’ is located under the first pillar, the pillar for human & social capital.

Table 9: The Three Pillars of the National Development Framework (4/2002)

Humanitarian, human & social capital	Physical reconstruction & natural resources	Private sector development, governance & security
Refugee return	Transport and communications	Trade & investment
Education and vocational training	Water and sanitation	Governance & public administration
Health and nutrition	Energy & natural resource management	Security and rule of law
Livelihoods & social protection	Urban development	
Cultural heritage, media & sport		

In the NDF six priorities had been identified for the health sector: (i) decrease infant and child morbidity and mortality (ii) decrease maternal mortality; (iii) combat malnutrition; (iv) decrease incidence of communicable disease; (v) improved equitable distribution of quality health services, and (vi) enhanced capacity of MOH to implement effective and efficient health services.

Two years later, at the Berlin conference in March 2004 (Afghanistan and the International Community - a Partnership for the Future), *Securing Afghanistan’s Future* was presented, a framework that addresses how to move from a short-term relief intervention to a long-term programmatic approach. This document tried to overcome flaws and shortcomings in financial flows resulting from the first pledging Tokyo conference.

The NDS is the Government of Afghanistan’s overarching 5-years strategy for promoting growth, generating wealth and reducing poverty and vulnerability. It will provide the framework for the development of Government policies, and guide the allocation of resources and programmes towards these goals. The preparation of the NDS will involve consultation within the Ministries, with the private sector, civil society/NGO representatives, and the international community. It is hoped that broader and deeper discussion will result in the best possible national strategy for reducing poverty – *and* a strategy that is well-understood by many, enjoys greater ownership, and as a consequence influences behavior, the allocation of resources, policy, institutional reform, and the

implementation of programmes and projects (source internet). It will have a medium term fiscal framework for three years and accommodating eight pillars. Health will be located under the pillar: ‘Human Capital & Gender Equity’.

3.2. National Budget

The 1383 approved National Budget for the Islamic Republic of Afghanistan amounts to 4,833.4 million USD, financing both Operating Budget (core services and recurrent costs such as salaries and government buildings) and Development Budget (investment projects such as infrastructure reconstruction, development projects, security and rule of laws). The Transitional Administration of Afghanistan initialized the preparation of a first National Development Budget (NDB) in 2002/2003 for the fiscal year 1381. This process increasingly strengthened the role of the government as decision maker in the reconstruction process rather than the donor community. The preparation of the NDB follows the priorities as outlined in the NDF. It has three parts: the Public Investment Programme (PIP), the Project Summary Sheets and the Project Documents. The PIP gives an overview over the vision of the programme, needs to be addressed and expenditures required to deliver a prioritized set of investments.

Box 3: National Priority Programme

New programmes as of summer 2004:

- National Skills Development Priority Programme
- National Rural and urban Water (Drinking Water) Priority Programme
- National Vulnerability Priority Programme
- National Urban Priority Programme
- National Agriculture Priority Programme
- National private Sector Priority Programme
- National Justice and the Rule of Law Programme

These complete the Government’s existing priority programmes listed below:

- National Emergency Employment Programme (NEEP)
- Irrigation and Power Programme
- National Solidarity Programme (NSP)
- Afghanistan Stabilization Programme
- Transportation Programme
- Feasibility Studies Programme
- Education and Vocational Training
- Health and Nutrition

The operational budget is funded by the government’s revenue and external resources that are earmarked for specific programmes such as the Afghanistan Reconstruction Trust Fund (ARTF). The ARTF was established in April 2002 in order to create a coordinated funding mechanism to finance priority expenditures for Afghanistan’s reconstruction. Three categories of expenditure were identified as eligible through the fund: (i) recurrent costs including salaries and non-project technical assistance; (ii) investment activities and programs, and (iii) salaries for returning Afghans who were living abroad. The fund is administered by the WB with a management committee consisting of ADB, UNDP, IDB

and the WB. The ARTF represents an attempt to give the government more control over the allocation of funds to development priorities. If funds go into the government's account, this contribution is considered as '*Core Budget*'. This is the case for the ARTF but also for projects outside the ARTF funded by the World Bank and the Asian Development Bank. For Afghanistan this strategy is unique since donors are normally reluctant to fund recurrent and operational costs.

The Afghanistan Reconstruction Trust Fund (ARTF) provides a coordinated way for donors to help the Government of Afghanistan. Funded by donor countries, and jointly managed by international aid agencies, the Trust Fund helps with priority projects and programs to rebuild Afghanistan and facilitate the return of skilled expatriate Afghans to the country. It also provides short-term emergency funding for salaries of civil servants.

ARTF supports the recurrent and capital costs of the Government and finances priority projects and programs to rebuild Afghanistan and facilitate the return of skilled expatriate Afghans to the country. ARTF promotes a more equitable distribution of international assistance and emphasises ownership and leadership by the government. It supports a Government-proposed program of investments prioritised from within the national budget. The advantages of ARTF include:

- promote the transparency and accountability of reconstruction assistance
- help reinforce the national budget in order to align the reconstruction program with national objectives
- reduce the burden on limited government capacity while promoting capacity-building over time
- help fund the recurrent budgetary expenditures required for the government to function effectively.

The Trust Fund is jointly managed by the World Bank, the United Nations Development Programme, the Asian Development Bank, and the Islamic Development Bank. The ARTF succeeds the United Nations Development Programme Trust Fund.

3.3. Health and Nutrition Programme

For 2002-3 (Afghan year 1381) the PIP for Health and Nutrition was \$173M. By 2003-4 (Afghan year 1382) it was estimated a total of \$320.52M was required to fund all 46 programs under health and nutrition. Delivery of the BPHS was to account for \$90M of this total (28% of the PIP), with projects aimed at improving the quality of hospital services accounting for 14% and enhanced capacity of the MoPH at 17%. Despite this shift in focus away from curative, hospital based care towards basic preventative health care, there was a 61% gap in funds to implement priority programs (MoPH 2003).

The NDB 1384 for Health and Nutrition reflects the priorities of the program and is divided into five sub-programs: (i) BPHS; (ii) EPHS; (iii) Special Health Programs; (iv) Capacity building of Human Resources; (v) Administrative Reform and Management. For the fiscal year 1384 a total amount of 281.70 million US \$ has been identified as expected requirement. Since the current funding allocation is 115.61 million US \$, the

funding gap is 166.38 million US \$. The biggest amount required is expected to be the BPHS, followed by the hospital sector (EPHS).

There are many donors that support the health and nutrition program. The main donors are USAID, EC, World Bank. World Bank funds flow to a bank account held by the Ministry of Finance and can then requested by the Ministry of Public Health. Funds for contracting from USAIDS and the EC are overseen by the donor and directly provided to the implementing agency. Other main donors are UNICEF, WHO and UNFPA.

Table 10: Sub-Programme Health and Nutrition proposed expenditure 1384 (US\$m)

Sub-Programme	1384 Existing Projects			1384 New Projects			1384 Overall		
	Exp Reqs	Funding Allocati on	Unmet Exp Reqs	Exp Reqs	Funding Allocati on	Unmet Exp Reqs	Exp Reqs	Funding Allocati on	Unmet Exp Reqs
Basic Package of Health Ser-vices (BPHS)	160.19	85.48	74.70	1.09	0.16	0.93	161.27	85.64	75.63
Essential Package of Hospital Services (EPHS)	17.70	10.45	7.25				17.70	10.45	7.25
Special Health Programmes	15.77	6.07	9.70	1.05	0.20	0.84	16.82	6.28	10.54
Capacity Building of Human Resources	3.14	3.14	0.00	11.32	5.16	6.16	14.46	8.29	6.16
Administrative Reform and Management	20.27	3.15	17.12	51.47	1.79	49.68	71.73	4.94	66.79
PROGRAMME TOTAL	217.07	108.30	108.77	64.92	7.31	57.61	281.98	115.61	166.38

Source: Public Investment Programme 1384

3.4. Specific Assistance

3.4.1. Global Alliance for Vaccine and Immunization

The Global Alliance for Vaccine and Immunization (GAVI) support started for Afghanistan in late 2003. GAVI is providing support for Immunization Services Strengthening (US\$ 7.2 million) and Safety of Immunization Injection (US\$ 1.6 million). GAVI also is committed to provide support for the introduction of Hepatitis-B vaccine in Afghanistan's routine immunization schedule.

3.4.2. Global Fund for Malaria, Tuberculosis and HIV/AIDS

The Ministry of Public Health is the Principal Recipient of two Global Fund grants for Afghanistan. The goal of the first grant from Round 2 is to develop the national health sector capacity for communicable disease control (with special reference to TB, malaria and HIV/AIDS) by strengthening management and administrative functions of the MoPH, together with building partnerships and developing new mechanisms for technical support and coordination. Implementation of this grant is for 18 months worth \$3.1 millions (from December 1, 2004 to May 31, 2006). For Round 4 the Global Fund approved (June 2005) a second grant for scaling up Afghanistan's Response to TB Control worth \$3.4 million. The goal of this grant is to detect 70% of the expected pulmonary sputum positive cases and have a success rate of 85% in the areas covered by

DOTS. Direct beneficiaries from both grants will be the people affected by AIDS, TB and malaria with limited access to health services; MOPH supervisors, BPHS health staff and CHWs; and the private sector. The total Afghan population will benefit indirectly from the improved control measures for AIDS, TB and malaria

Table 11: The Global Fund (Fights AIDS, TB and Malaria); approved expected and newly applied budget for Afghanistan; years 2005-2010

Rounds	Status	Budget (USD)					
		Year 1	Year 2	Year 3	Year 4	Year 5	Total
R2 (integrated)	Approved (December 2004)	3,125,605 (18months)	0	0	0	0	3,125,605
R4 (TB)	Approved (July 2005)	1,027,891	1,358,835	1,067,114	0	0	3,453,840
R5 Malaria	Newly applied	7,825,177	9,268,157	6,895,432	4,665,645	3,577,305	32,231,719
R5 HIV	Newly applied	3,674,717	2,684,908	2,715,210	3,081,961	0	12,156,796
R5 HSS (Health System Strengthening)	Newly applied	1,040,580	939,510	735,110	444,160	855,110	4,014,470
Total						Grand	54,982,430

3.4.3. Promotion of Effective Partnerships

The Ministry of Public Health is the national steward for the health sector in Afghanistan. It is interested, therefore, in the principles of partnership and collaboration with all stakeholders sector wide and in having as complete a picture as possible of who is doing what, where and why in the health sector. Besides staff working in health facilities and professional associations, this includes communities, private not-for-profit and for-profit organizations, bilateral and multilateral agencies, the UN organizations, academia and research organizations. This stakeholder involvement is to make the best use of limited resources in working towards achieving equitable and sustainable improvements in health. This sector wide development approach is seen as the first possible step towards adopting a sector wide approach (SWAp) and the pooling of all resources. Information on different coordination mechanisms established by the MoPH has already been provided in Section 2.17.13.

In the near future main donors are planning to channel funds for the BPHS through the government, following the World Bank approach. The Ministry of Public Health with the GCMU has proofed having effective and transparent mechanisms to manage and oversee grant contracts. It is an important step into the direction of ownership and institutional development.

Section 4: Current WHO Cooperation.

4.1. Background

The Basic Agreement between WHO and the Government of Afghanistan was signed in January 1959. The salient points of the 1959 agreement are as follows:

- WHO shall render technical advisory assistance to the Government, subject to budgetary limitation or the availability of the necessary funds. WHO and the Government will mutually agree on the plans of operation for the carrying out of the technical advisory assistance. The technical advisory assistance may consist of making available the services of experts selected by the organization and responsible to the organization. WHO shall organize and conduct seminars, training programmes; award scholarships and fellowships; prepare and execute pilot projects, tests, experiments or research in such places as may be mutually agreed upon.
- The government and the organization shall consult together regarding the publication, as appropriate, of any findings and reports of experts that may prove of benefit to other countries and to the Organization. Active collaboration shall be ensured by the Government in the furnishing and compilation of findings, data, statistics and such other information as will enable the Organization to analyse and evaluate the results of the programme of technical advisory assistance.
- The government agrees to provide all personnel, materials, supplies, equipment and local expenses necessary for the technical cooperation, including counterparts to long term staff or short term consultants, and premises/facilities for technical activity in the Ministry.
- The government will keep WHO informed of the progress of the technical cooperation actively. Such reports are required and will be prepared periodically by or on behalf of the government and submitted to the parties.

WHO Office was established with a minimal staff in the sixties in Kabul and in the eighties was relocated to Quetta, then to Peshawar. In the nineties, WHO main office was relocated to Islamabad from where it operated its programmes through nine WHO sub-offices inside Afghanistan. In February 2002, WHO main office was again relocated to Kabul, and was working through eight sub-offices in Afghanistan and one support office in Islamabad till early 2005. On account of shortage of budget, two offices have been closed down and another two will be closed by the end of 2005. Only four sub-offices will continue operating in Jalalabad, Herat, Mazar-i-Sharif and Kandahar. The main office is located in Kabul. The WHO support office has moved to the WHO Pakistan office in NIH compound in Islamabad and has only two support

staff who are facilitating the travel and other financial issues as required. The present WHO main office in Kabul has its own building in the UN compound. The office is equipped with up to date IT equipments such as four Compaq server machines (Domain controller server, ISA server, Exchange server and Back up domain server), Telenor V-Sat system for internet access, GPN lines, international lines and fax, Codan HF Radio system and mobile sets, VHF repeater and handsets as well as 50 computers, 25 printers, 15 scanners. The international staffs are accommodated in two WHO guest houses in Kabul which are MOSS compliant.

4.2. Key areas of collaboration

WHO Afghanistan works in close collaboration with the Ministry of Public Health, UN agencies and NGOs and is rendering its technical, financial and material assistance through its main office and sub-offices inside Afghanistan.

The priority programme areas of WHO include: Polio eradication initiative; human resource development for health; basic development needs programme; expansion of the integrated disease control activities such as malaria, tuberculosis, acute respiratory infections, diarrhoeal diseases, vaccine preventable diseases, rabies and leishmaniasis; activities to improve maternal and child health with particular emphasis on the promotion of safe motherhood initiative, water and sanitation programme and emergency preparedness and response.

The country office has a biennium regular budget of around US \$ 4 million. The regular budget has been static since the past four biennium. The table below shows WHO programmes and the budget for the last two biennium (2002-2003 and 2004 – 2005)

Table 1: WHO Afghanistan Programme Summary 2002-2003 and 2004-2005

	EMRO Classification	Workplan Title	2002-2004		2004-2005	
			RB	OS	RB	OS
1.4	Emergency preparedness and humanitarian action	Emergency preparedness and response	291,000	380,000	120,000	2,530,000
2.1	HR policy planning and management	Training of Health professionals	261,000		310,000	600,000
3.1	Evidence and information for policy	Evidence and information for policy	30,000		50,000	39,000
4.1	Health care delivery	Primary health care	1,779,000	31,000	1,870,000	150,000
4.3	Sustainable development approaches: a) Women and development b) Community based	Sustainable development approaches	250,000		250,000	620,000
5.1	National drug policies based on essential drugs	Essential drugs programme	40,500		50,000	8,000
5.3	Health laboratory support and health technologies	Health laboratory support - Laboratory services	135,000		90,000	420,000
5.3	// //	Imaging technology (X-Ray)			45,000	70,000
6.1	Promotion of healthy lifestyles	IEC	102,500	100,000	98,300	132,000
6.1	// //	Mental Health			42,000	358,000
6.1	// //	Nutrition			60,000	51,000

7.1	Reproductive health and family planning: a) Reproductive health b) Making pregnancy safer	Reproductive health (making pregnancy safer)	331,200	500,000	340,000	240,000
7.1	// //	Women Health			5,000	60,000
7.2	IMCI	Promotion of child health	50,000		216,000	304,000
7.2	Adolescent Health	Adolescent Health			3,000	60,000
8.2	Water supply and sanitation	Water supply and sanitation	471,000	64,000	500,000	50,000
9.1	Polio eradication	Vaccine preventable disease control and immunization	82,000	4,657,500	99,500	-
10.1	Tuberculosis	Control of Tuberculosis and Leprosy (STB and CTD)	100,000	635,000	100,000	2,222,000
10.2	Malaria	Roll Back Malaria (including Leishmaniasis)	291,700	819,000	300,000	3,600,000
10.3	AIDS and STD	HIV/AIDS/STD	24,000		-	80,000
11.1	Diseases surveillance and control	Diseases surveillance and control	23,000	40,000	23,000	40,000
	Total		4,263,000	6,726,560	4,451,800	9,104,000

Source: JPRM 2002-2003 and JPRM 2004-2005

Note: The budget above shown are planned budget for the two biennium. Although, RB budget was received in full, only around US \$ 3 - 4 million was obtained from other sources mainly to Polio Eradication program, Roll Back Malaria (received US\$ 1.9 million for last two biennium) and Stop TB program.

4.3. WHO Country Office Human Resources

Since its establishment in the sixties, the office has expanded over time. However, there is a great need to have more national and international staff in some of the programmes, such as nutrition, IMCI and reproductive health, which are the priority programmes of MoPH. Because of the security situation in the country, an international security officer is required full time for WHO to inform and guide the staff in security matters.. Moreover, the post of Public Relations Officer is a necessity to liaise with the various government ministries, UN and donor agencies as well as the media.

Currently, there are five fixed term staff including the WHO Representative, one Medical Officer (PHC), one Technical Officer (RH), one Administrative Officer, one Administrative and Finance officer (Polio). One post for Medical Officer (Polio) is vacant. Polio eradication programme is supported by nine STCs. One STP is assisting in the Roll Back Malaria programme, one TLP in Stop TB programme and one STP in Admin/logistics TB. One TLP for HRT/Nursing is vacant. The nationals are mostly on SSA contracts assisting in various programmes. Four National Health coordinators (SSAs) are posted in four sub-offices of WHO. Other contracts for the general support staff include TLG, FTG, LTG and STG. The table below shows the type of contract and the number of staff in each category

Table 2: Category and Number of staff

Type of Contract	Number of staff (existing)	Remark
Fixed term staff including WR (FTP)	5	1 fixed term post (Medical Officer-Polio) vacant
Short term professional (STP)	2	
Term limited professional (TLP)	1	1 TLP HRT/Nursing vacant
Short term consultants (STC)	11	1 STC/ TB vacant
Fixed term general service staff(FTG)	4	
Term Limited general service staff(TLG)	4	
Short term general service staff (STG)	10	
Long term general service staff (LTG)	3	
Special service agreement (SSA)_	106	
Agreement for performance of work (APW)	83	In Polio (10), TB (46) and Malaria (27)
Total	230	

Source: Admin/finance, WHO Afghanistan

4.4. Fellowships, meetings, seminars

The table below shows the number of fellowships awarded in various disciplines, and number of workshops/seminars attended by the MoPH staff and nationals from different departments and NGOs from 2002 to 2005.

Table 3:

Year	Number of Fellowships	Number of participants	Number Workshops/ Meetings	Number of participants
2002	3	7	11	19
2003	9	37	36	82
2004	7	22	55	119
2005 (till June '05)	3	4	36	69
Total	22	70	138	289

Source: Human Resource Unit

Resource Mobilization:

The WHO Representative takes a deep interest in fund raising and in this regard has formed a Proposal Writing Committee in the office that is responsible for preparing the proposals and submit to the donors for consideration of funding.

Section 5

WHO policy framework: global and regional directions

5.1. Operating Framework

Health systems in developing countries are becoming more complex. The role of the state in provision of health care is diminishing rapidly with the private sector and civil society becoming active and important players. Also, globally a number of development organizations and financial institutions have become heavily involved with health development activities in developing countries. It was, therefore, timely for WHO to respond to this changing environment by calling for new ways of working with its member states.

WHO has adopted a broad approach to health within the context of human development with a particular focus on the links between health and poverty reduction. It is assuming a greater role in establishing wider national and international consensus on health policies and strategies and standards through managing the generation and application of research, knowledge and expertise. At the country level, through the CCS process, it is envisaged that:

- WHO collaboration will be more strategic and focused on fewer priority areas, which will be an amalgam of global, regional priorities and national priorities.
- Increased emphasis will be given to WHO's role as a policy adviser and broker.
- Opportunities will be sought for increasing and strengthening partnerships with other international and national agencies, including non-governmental organizations working in the field of health.
- Innovative approaches will be sought to increase the effectiveness of WHO support.
- Attempts will be made to ensure the utilization of the knowledge and skills present in the country for WHO's normative work.

5.2. Country Level Functions

For carrying out WHO operations at the country level, the following five distinct functions have been identified:

- Catalyzing the adoption and adaptation of technical strategies: seeding large-scale implementation.
- Supporting research and development; monitoring health sector performance.

- Information and knowledge sharing; providing generic policy options; standards; advocacy.
- Providing specific policy advice; serving as broker; influencing policy; action and spending.

It should be noted that the sequence in which the above functions are listed is not an indication of their priority. In fact, the relative importance of these functions would vary from country to country depending on its state of development and strategic priorities identified for collaboration with WHO during the process of formulation of CCS.

5.3. Strategic Directions

WHO's current (2002-2005) General Program of Work lists the following four inter related strategic directions to provide a broad framework for focusing WHO's technical work.

Strategic direction 1: reducing excess mortality, morbidity and disability especially in the poor and marginalized populations.

Strategic direction 2: promoting healthy life styles and reducing risk factors to human health that arise from environmental, economic, social and behavioural causes.

Strategic direction 3: developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair.

Strategic direction 4: framing an enabling policy and creating an institutional environment for the health sector and promoting an effective health dimension to social, economic, environmental and developmental policy

5.4. WHO Global Priorities

Based on the analysis of major challenges in international health, the WHO has established a set of global priorities. These priorities reflect strategic choices with regard to areas in which WHO has an advantage compared to others or where there is a need to build up capacity. These priorities have been selected as there is a potential for significant change in burden of disease with existing cost effective mechanism and they include health problems with major impact on socio economic development especially on the lives of the poor.

The selected global priorities as stated in the General Program of Work for 2002-2005 are as follows:

1. Malaria, tuberculosis and HIV/AIDS: these three major communicable diseases pose a serious threat to health and economic development and have a disproportionate impact on the lives of the poor;
2. Cancer, cardiovascular diseases and diabetes: there is a growing epidemic of these diseases I the poor and transitional economies;

3. Tobacco: a major killer in all societies and rapidly growing problem in developing countries;
4. Maternal health: the most marked difference in health outcomes between developed and developing countries show up in maternal mortality data and it is difficult to reduce maternal mortality with out a well functioning health system;
5. Food safety: a growing public health concern with potentially serious economic consequences;
6. Mental health: five of the ten leading causes of disability are mental health problems. Major depression is the fifth contributor to the global burden of disease and may be second by 2020;
7. Safe blood: both a potential source of infection and major component of treatment. Crucial in the fight against hepatitis and HIV/AIDS;
8. Health systems: development of effective and sustainable health systems underpins all the other priorities. Demand is substantial from member states for support and advice on health sector reform;
9. Investing in change in WHO: a prerequisite for WHO to become a more efficient and productive organization and one capable of response with in an increasingly complex environment. The development of new skills, systems and process is central to the effective management of WHO's core functions.

5.5. Regional Priorities

The Eastern Mediterranean (EM) Region has the demographic profile of the developing region. It is a low middle income region. Poverty and unemployment affects a large number of people in the Region. Communicable diseases are still prevalent in the least developed countries and TB, Malaria and HIV/AIDS are major killers. A number of countries in the region are in a state of conflict and emergency. Malnutrition is still a significant problem in economically less fortunate countries. The water scarcity is a Region-wide challenge. Also, the lack of adequate safe water supply and proper sanitation are major health hindrances in the least developed countries, which constitute a large percentage of the population in the Region. Similarly, the rapid urbanization and increase in car ownership have resulted in severe air pollution in major cities of the Region. The solid wastes management, particularly hazardous and medical wastes, is particularly weak in a significant number of countries of the Region.

An epidemiological shift is being witnessed in the EM Region. Currently, due to changes in lifestyles the non-communicable diseases constitute 40% of the disease burden. It is projected that by the year 2020 the share of burden for non-communicable diseases will increase to 60% which is creating a double burden, of both communicable and non-communicable diseases. Maternal mortality is still unacceptably high in some countries. The average maternal mortality ratio for the Region in 2001 was as high as 330 per

100,000 live births, while over 60% of infant deaths occur in the neonatal period in most countries. Food borne diseases are also on the rise and represent a major public health challenge. The rapid change in lifestyles of many countries is having a clear impact on stress and mental health-related conditions.

The health system including governance, quality assurance, service delivery, health regulation and medical technologies and medicine need major strengthening in almost all countries. The health financing is a major emerging issue in the Region. In lower income countries most of the expenses are borne by people. The middle-income countries have a mix of private and public sector. In these countries in some instances there is a surplus of trained manpower, such as physicians. In high-income countries the major share of the health expenses is borne by governments. The health information system in almost all countries needs to be strengthened. Nursing picture is rather gloomy both in terms of adequate numbers in poor countries and their career structure.

In light of the above situation, EMRO has identified certain priority areas for its collaboration with the member states. These were spelled out in the program budget for the period 2004-2005 which was endorsed by the EM Regional Committee at its 49th session held in October 2002 (EM/RC/49/R.2). The priorities include the following:

Health protection and promotion

- Promotion and development of healthy lifestyles through programmes such as the Tobacco Free Initiative, healthy communities, villages and cities, action-oriented school health activities, health of special groups and health education.
- Strengthening of national and regional initiatives to improve nutritional status through raising awareness of individuals and the community and control of micronutrient deficiencies.
- Integration of health promotion aspects with clinical approaches at all levels of the health care system, such as in the example of the regional initiatives to integrate at the primary health care level maternal, child and adolescent health, prevention and control of noncommunicable diseases and mental health activities.
- Promotion and strengthening of environmental health initiatives, particularly those relating to water safety and security, environmental health impact assessment, food safety and healthy environments for children and development of intersectoral activities in this respect.

Community development

- Addressing the underlying determinants of health and poverty as essential to ensuring sustainable development and sustained health improvements in the long term. Community-based initiatives such as basic development needs (BDN), healthy cities, healthy villages and women in health and development are among the priorities adopted by countries. In all these initiatives special emphasis is given to strengthening and enhancing the role of women as major stakeholders in achieving and sustaining the desired health and development goals.
- Efforts to facilitate achievement of the Millennium Development Goals, aiming to halve the number of people living in absolute poverty by the year 2015. This will include the

development of various policies and plans such as Poverty Reduction Strategy Papers, to create supportive political, physical and economic conditions for all segments of the population to produce a positive impact on the overall quality of life. Concerted efforts are being made to make health systems better oriented to the needs of the poor by giving greater attention to promoting health throughout the life span, and reducing inequities in health status.

Disease control

- Improvement of epidemiological profiles using quantitative methods, such as burden of disease assessment and forecasting techniques. Efforts should be made to strengthen national and regional capabilities in epidemiology and national information systems through developing national and subnational registries for priority health problems. Efforts should also be made to benefit from epidemiological research studies in designing health policies and strategies. Priority diseases that are the main contributors to the disease burden and at the same time are amenable to intervention strategies will be identified.
- An integrated approach in communicable disease control programmes through ensuring political commitment, integrating cross-cutting control activities, scaling-up disease-specific control activities, and developing synergy of managerial processes.
 - Essential packages of services for prevention and control of priority diseases and indicators to monitor and evaluate these programmes will be developed.
 - Integration of cross-cutting control activities will cover at least communicable disease surveillance, epidemic preparedness and response including developing early warning and surveillance systems, infection control and containment of antimicrobial resistance, integrated human resource development, health education and advocacy, and operational research.
 - Scaling-up of disease-specific activities includes immunization programmes, tuberculosis control, malaria control, HIV/AIDS/STD prevention and control, elimination and eradication of specific diseases.
- Immunization programmes maintained and strengthened, with particular focus on countries that have lower immunization coverage and problems in certification of poliomyelitis eradication. The Regional Office will pursue its policy aimed at achieving self-sufficiency in vaccine production.
- Integrated management in control of noncommunicable diseases. Particularly attention will be paid to quality assurance programmes and to emerging needs, such as palliative care for cancer patients and health of the elderly.

Health systems and services development

- Promotion of a culture of strategic thinking in decision-making, using evidence-based policies and strategies, and development of important components of the stewardship function, such as regulation, public–private mix management, coordination, etc.
- Strengthening decentralization of health systems through capacity-building and technical expertise, and supporting district health systems through institutionalization of the district team problem-solving approach and development of sustainable management through national management effectiveness programmes.

- Improving quality in health service delivery through implementation of a programme of continuous quality improvement based on quality standards for individuals, departments and organizations against which performance will be measured.
- Support to accreditation initiatives, such as multidisciplinary assessments of health care functions, organizations and networks, as an important approach for improving the quality of health care structures.
- Enhancing national information systems in order to provide necessary data on spending on health, particularly on private services, making use of household expenditure and utilization surveys and national health accounts analysis.
- Testing of the WHO framework and tools for health system performance assessment and development of an observatory in the Regional Office to assess, manage and monitor health sector reforms.
- Development and decentralization of laboratory activities, health imaging technology, blood safety and blood transfusion.
- Strengthening of the essential drugs programme and ensuring use of essential drugs lists by most countries while promoting rational drug use and traditional medicine.
- Improvement of coordination for human resources development and promotion of continuing education for health personnel at the various levels of the system. Efforts will focus on developing innovative approaches for human resources development, including community-oriented health personnel education.

Section 6: Strategic agenda: priorities agreed for WHO cooperation in and with Afghanistan for 2005-2009.

6.1.Introduction

The strategic agenda has come into being taking into consideration the history of Afghanistan with conflict raging for the last many years, the enormous effort which has been made during the last three years to bring the country out of this scenario and into mainstream development among the nations of the world with overall development of governance institutions based on a new constitution and the rehabilitation of public institutions among them the Ministry of Public Health.

The situational analysis has provided the evidence for needs and priorities. The National Health Policy has served as the main policy reference and the BPHS and the EPHS have provided important strategic direction. Important development partners are supporting the implementation of the BPHS and the EPHS. The unit set up so far in the MoPH: the Grant Contract Management Unit for management of contracts for one agency: the World Bank. This procurement arrangement is already under consideration for managing funds from

other agencies. The movement towards pooling of funds and common management arrangements is therefore already a reality with a potential to develop into a Sector Wide Approach. The UN reform has reached the point of joint programming through the CCA/UNDAF. The mainstream aid effectiveness has also been consulted. The latest input from the MoPH has been important for shaping and focusing future WHO collaboration.

An important focus of WHO in the strategic agenda will be overall sector policy development and sector management. That means positioning WHO as a key overall policy advisor in health policy and health system development and overall sector management. Advice and technical support to forging a closer collaboration between partners and the MoPH whenever opportunities arise form part of WHO support for sector management. Emphasis in the strategic agenda is also on those specific areas which need to be emphasized since they either contribute to responding to priority pathologies or constitute national concerns which require further development in order to prepare for national policies, strategies and plans, e.g. mental health. WHO programmes will be continued since they form part of a global drive, e.g. polio eradication.

Emergency Preparedness and Response has been considered because Afghanistan has a history of not only man-made disasters but also frequent natural disasters: droughts, floods, earthquakes etc. let alone the rapid response capacity which is required when outbreaks occur.

Behind this is the overall WHO's mandate and sphere of competencies in the organization. The concerted action of partners in health development including WHO can only have an impact as intended if certain key assumptions are made. A prevailing peace scenario together with continued substantial funding from international partners are both critical assumptions.

Taking the above into account and the detailed situation analysis covered in Section 2, the CCS Mission considered that the Strategic Agenda for the next 4 years should be composed of the following components. The order in which the components are listed does not necessarily indicate their relative priority.

- *Overall Health Sector Policy and Sector Management*
- *Health System Development including Health Care Financing, Human Resource Development and District Health Systems.*
- *Control of Communicable Diseases*
- *Reproductive and Child Health*
- *Health Education, Prevention and Promotion.*
- *Mental Health*
- *Emergency Preparedness and Response*

Strategic Objectives and Approaches for each of the above component is given in the following pages.

6.2. Overall health sector policy and sector management

Strategic objective: By the end of the period covered by the strategic agenda there will be agreement on overall national health policies with further development of existing policies and development of new ones according to the what is required for having a comprehensive set of policies for effective delivery of health services to the population. In addition to the existence of policies, such policies will be implemented through general institutional development and sound sector management which will include further development in the way partners work with the MoPH through pooled funding and common management arrangements for key functions such as procurement of health services through NGOs with verification of performance.

Strategic approach: The MoPH has been very active in policy and strategy development. A National Health Policy exists and basic packages for service to be delivered mainly through contractual arrangements with NGO are operational. Policies/strategies either have been developed for specific areas, e.g. National Malaria Strategic and a national Medicine Policy, or are in development. Further development in additional areas can be foreseen, mainly as part of further development of a comprehensive health system, e.g. a human resource development policy and strategies. WHO will position itself as a key policy adviser for overall policy developments. This will require a close monitoring of needs for development of policies and proactive action. Policy advice will be provided by the WCO, the Regional Office or through assistance from HQ.

Sector management refers to the capacity of the MoPH to effectively manage the sector at all levels in particular at central and provincial level. It also refers to the capacity of the MoPH to manage the partnerships with partners. Presently there are various developments ongoing to strengthen overall management functions as well as technical management areas, e.g. reproductive health. In order to take this development further, WHO can position itself to advice on institutional development and can provide specific technical assistance as required, the aim being to have an adequate institutional set up and to be able to perform relevant sector management functions at all levels bearing in mind that the MoPH will have to perform its stewardship and oversight functions. A starting point could be to take stock of the institutional development situation and from there to design a road map for how to implement institutional and management changes as required.

In the area of partnership management, there is already in place a structure for managing World Bank funded NGO service provider contracts (GCMU). The experience with this unit is by and large very good. Therefore it has the potential to develop into a common contract management arrangement for other agencies as well (EC, Asian Development Bank, USAID). In the future there is the potential for other donors to use the same mechanism. Developments are already ongoing. There are various coordination mechanisms in place to facilitate coordination between partner and the MoPH for different purposes. WHO can position itself in this important development scenario with the purpose of exploring way and means of further rationalizing the way partners operate in collaboration with the MoPH. There are already key elements in place for a Sector Wide Approach (SWAp) such as a National Health Policy with important strategies already in place. The role of the MoPH is

well defined as the national entity to lead the development in the sector (stewardship and oversight and sector management and to some extent service delivery). There is an expressed willingness on the part of some partners to move towards more effective collaboration with the MoPH. There is a service procurement function in place and there is a movement towards common monitoring and accountability mechanisms. All this provides opportunities for further development. WHO can position itself at the centre of these opportunities and can take part in the discussion in relevant fora. WHO can also provide advice and can provide technical assistance as required for moving towards a sector wide approach. This will not happen overnight but opportunities for further development are there to be explored by WHO, partners in collaboration with MoPH

6.3. Health System Development

It was clearly evident that rapid development of health system to ensure an equitable availability of quality health care to the population of Afghanistan was a high priority for the MoPH and in view of WHO's comparative advantage in this area it decided to include this as one of the elements of the Strategic Agenda during the coming 4-5 years.

The over all organization of health system involving the public sector, communities, private sector, NGOs and the external donors is still evolving. It is anticipated that the external donors and NGOs will continue to play an important role during the next 5-10 years. The private sector, mostly unregulated at the moment, is growing rapidly and is set to play an important role in health care in the urban settings during the coming years.

Strategic objective: By the end of the period covered by the strategic agenda, it is expected that the leadership within the MoPH dealing with health systems would be strengthened specially in the area of planning and provision of health services of good technical quality that respond to the needs of the communities and contribute to improved equity through greater coverage and make efficient use of resources.

Within the broad area of 'health system' there were several components that were considered for intensified collaboration between the government and WHO. Some of these were: sustainability; human resource development; options for health care financing and cost containment; continuous improvement in quality of care; decentralization and strengthening of district health systems; effective integration of disease control programs within health system; optimum role of the private sector, including NGOs, in the delivery of health care (public- private mix); management capacities at provincial and district level; effective and efficient management of secondary and tertiary care hospitals and accreditation of health facilities.

In view of: the pressing situation regarding human resources (as already mentioned in section 2 of this document); the need to make some efforts at reducing reliance on external support for the health sector during the coming years and to promote decentralization and integration at peripheral levels of health care, it was decided to focus on human resources development (including policy formulation and planning, production in balanced quantity and relevant quality, ensuring optimum utilization and management) and on health care financing and on district health system during the period covered by

the preset CCS. The selection of these three areas in no way minimizes the importance of other areas some of which were mentioned above.

6.3.1 District Health System

The health system in Afghanistan is currently fragmented and not well integrated due to the multiplicity and diversity of service providers and the weak managerial and financial capacity of the MoPH specially at the provincial level. It is highly desirable that public health programs are integrated and able to deal with the person and family in a holistic manner and similar tools for training health workers, for monitoring and supervising their performance and similar clinical guidelines for treating common disorders etc should be used through out the country. The District Health System (DHS) is a strategy for ensuring equity, integration of various health related interventions, enhancing efficiency, effectiveness and for institutional development. It integrates services at the level of the health unit, health center and district hospital and approaches the health of the community through a holistic family approach. WHO would support the MoPH in introducing this strategy initially in selected districts on a pilot scale.

Prior to introducing the district health strategy, a systematic analysis of the functions, processes and out comes of the health system including patterns of utilization of health facilities, quality of care, unit costs in different settings etc would be carried out. This situation analysis is quite valuable in taking a DHS perspective, addressing for example the distribution, quantity and quality of care, utilization patterns, revenue, and unit cost in different settings and districts run by NGOs, public or private sector.

After the above assessment has been carried out, the management structure and the responsibilities of the staff serving in the pilot districts and at the related provincial health departments would be reviewed and revised in light of the assessment and to meet the new needs envisaged under the DHS. Following a revision of the term of reference for the staff, there may be a need for building the capacity in the provincial health departments to support the districts in implementation of their plans in areas such as: policies and strategies district health system; monitoring and supervision; management of human and financial resources; ensuring quality of care and accreditation.

A set of norms and standards for delivering health care including standard lists of drugs, equipment and furniture would be developed, implemented and monitored. WHO can help in developing a set of clinical practice guide-lines for provision of services under the BPHS.

The DHS would adopt the national policy for referral. In this connection, it is critical that the contractual agreements for BPHS and EPHS should ensure continuity of care when cases are referred to the district or provincial health facilities specially when more than one NGO is involved.

Quality Improvement and Accreditation program is one of the corner stones of the DHS. Health facility accreditation is a public seal of approval of their performance and should encourage self-monitoring and continuous improvement. An “Accreditation system” for better quality of services is feasible especially when there are skilled surveyors working

on the set of quality standards and quality indicators that assures the compliance of contractees to the preset standards. Accreditation needs to be gradually developed firstly by developing capacity of teams or an institution at provincial level. An institution could be commissioned to perform the quality assurance as an alternative. WHO would provide technical support for developing a system for accreditation for health facilities adapted to the local needs and in establishing other elements of the DHS such as supervision, unified system of data collection and dissemination.

6.3.2. Human Resources Development

The restructuring of the Afghan health workforce is a major, long-term endeavor, which should be carefully planned and adequately resourced. Given the main weaknesses discussed above, the central feature of human resource development needs to be the pursuit of better and more appropriate competences for present and future health workers. This approach implies a resolute move away from the tradition of under resourced, emergency training that has prevailed in the past.

The **strategic objective** for this component of the strategic agenda would be to ensure that the performance of the health system is improved through strengthening the planning, development and management of health workforce in order to achieve greater equity, coverage, access and quality of care at different levels of health system

The **strategic approaches** that would be employed to achieve this objective would aim at not only building managerial capacities at different levels of health care but also at improving the skills of health care providers at different levels and would include the following:

- The formulation of a national policy and strategic plan for development and management of human resources. Adapting guidelines that are available for this purpose could facilitate this process.
- The existing training institutes for health professionals (which are under the Ministry of Education) and for allied health personnel (that are under the administrative control of MOPH) should be carefully evaluated with regards to their curricula and policy governing the intake of students and where necessary they should be revised to take into account the evolving health needs of the population and of the health system. In case it is decided that the medical colleges would remain with the Ministry of Education, than it would be necessary to establish an effective working mechanism between the two ministries so that the above mentioned assessment and subsequent revisions are carried out smoothly.
- Restructuring and strengthening training institutes for allied health personnel. One or two medical schools (possibly the oldest, established ones) should continue with the training of new doctors and few of the remaining medical schools should concentrate on providing refresher courses to active health workers. The remaining medical schools could be converted into training institutions for allied health personnel.

- Review job descriptions of the existing categories of health personnel and where needed clarify them or develop new job descriptions.
- Design an in-service training programme for practicing health workers. It should include a component devoted to the conversion of suitable health workers holding unofficial qualifications into fully qualified cadres, through qualifying examinations and the provision of specifically designed bridging courses. Upgrading the workforce will be a huge effort to be sustained over many years, needing thorough preparation. The first step to start such a programme is to assemble an inventory of active health workers, complete with data about their initial training, their professional experience, participation in in-service training etc
- In view of the well-known reluctance of the health professionals to serve in rural and isolated areas of the country, necessary policies should be developed to serve as an incentive for health personnel to serve in these areas and to ensure equitable recruitment policies, procedures and salary structure. WHO would also collaborate in upgrading and strengthening the existing system for registration of various categories of health personnel and in developing a program for continuing medical education. WHO would also extend its collaboration to MOPH in developing comprehensive systems for supervision of various categories of health staff and for periodic appraisal of their performance.
- The training of intermediate-level health cadres deserves a high priority. Special attention needs to be paid to making the nursing and midwifery professions attractive to prospective students, so as to redress the gap expected to materialize when the expansion of hospital and maternity care takes place
- The extreme shortage of female health workers (particularly nurses and midwives) in the country is critical in view of the cultural traditions that female patients prefer being attended by female health workers. This shortage also contributes to the alarmingly high rates of maternal mortality. WHO would assist in MOPH in drawing up plans for a rapid development of these categories of health personnel and support the establishment of relevant training facilities and programs. In this connection the current endeavors of different partners e.g. HNI, MSH-REACH etc who have embarked on training female health workers, should be critically evaluated with an ultimate view of harmonizing their efforts to have a uniform and standard training guidelines for the female workforce through out the country.
- On a longer-term basis, in order to prepare and attract females to join the health work force, the MOPH in collaboration with other relevant authorities should develop a plan to promote the enrollment of girls in schools so that they can acquire the minimum educational qualifications to join the health workforce. In this connection attention should also be paid to develop training facilities for this category of health work force on a provincial basis so that the students are close to their homes and families and ultimately to their place of work.

The CCS mission recognized that program specific training of various categories of health personnel is being actively pursued in the country as a component of the existing WHO collaborative programs and expect that this will continue in addition and in harmony with the approaches mentioned above.

6.3.4. Health Care Financing

The way that health systems are financed and organized is a key determinant of a population's health and well-being. In Afghanistan, this is a central issue as the country is recovering from a post conflict situation and has embarked on an ambitious program for provision of basic health care to the entire population that is presently being largely financed by donors.

With increase in expectations for better health care from the community (especially for specialized hospital based care in urban areas), the country will soon be faced with escalating costs for health care. Like many other developing countries it appears that health financing in Afghanistan relies heavily on out-of-pocket payment and it constitutes a large fraction of the total health expenditure (around 50%), placing a high financial burden on an already impoverished people. The government in collaboration with one of the major donors has already initiated studies to develop options for cost recovery (see section 2.7.12. and Annex – for details of the options being studied).

The **strategic objective** of this component would be to critically review the current health care financing situation in the country and to develop options for health financing that engenders reliance on sustainable national resources and provides equitable protection against financial risk and promotes social protection.

The strategic approaches would include: WHO in close collaboration with its partners, notably the World Bank, would promote the use of analytical tools and a knowledge based approach for developing equitable health care financing options suitable to the national needs and aspirations. In this connection WHO would make available regional and international experiences, evidence and best practices in implementing various financing and social protection options including the appropriate mix between the public and private sectors. Collaboration would be extended to strengthen the capacities of the MOPH to obtain relevant information and its use in formulating options for financing, through provision of training in national health accounts methodology and in the field of health economics. In view of the currently heavy reliance on donor funding for financing BPHS and the un-certainty about the quantum of this support in the medium to long term, WHO would assist the government in developing scenarios for health care financing with different levels of donors support in the years to come.

6.3.5. Reproductive and Child Health:

6.3.5.1. Reproductive Health

Strategic objective: By the end of the period covered by the CCS the MoPH together with collaborative partners will have achieved a reduction in maternal morbidity and mortality through better access to ante-natal care, to basic emergency care and to comprehensive obstetric care.

Strategic approaches: WHO has been very active in supporting the MoPH in the evolution of reproductive health and services in Afghanistan in collaboration with other UN agencies, bilateral agencies and NGOs. WHO has been instrumental in designing priority action in the BPHS. Much effort has gone into providing norms standards and best practices for incorporation in the official technical guidelines for making Pregnancy Safer. WHO has been vocal and active in ensuring better training of female staff of which there is a desperate shortage. WHO has also emphasized the importance of the recruitment, training and supervision of community midwives. WHO has also advocated for integrated reproductive health services including maternal care, family planning and attention to infections relevant to reproductive health. The health system capacity for attending to obstetric emergencies is critical for reducing maternal morbidity and mortality as is community and family awareness for better access to relevant services.

WHO will assist the MoPH to bring together all the elements that constitute a good reproductive health response. Many such elements do already exist but will need further development and will have to be brought together as a comprehensive and consistent package guided by a comprehensive policy, emphasizing the critical strategies and transformed into good quality services adequately supported by critical mass of adequately trained female reproductive health workers, well supervised and with flexibility to priority problems in distinct geographical areas. WHO will continue to provide norms, standards for adaption into further development of national guidelines. Emphasis will continue to be on assisting the MoPH to increase the number of female staff by incorporation the RH items in all curricula for the training of medical and paramedical staff. Support will also be provided to the establishment of training centres for community midwives.

In order to increase the demand for RH services a joint advocacy and communication package will be developed for emphasizing social, legal and policy barriers to utilization of maternal health services making use of the tools developed by the WHO for this purpose. Support will also be provided to innovative approaches to further facilitate women's access to relevant information and services using WHO developed tools for working with individuals, families and communities.

Family planning will be addressed by adaptation of a package to be used for advocating access (IEC) to and use of family planning services. This will involve training of service providers in collaboration with the MoPH and other service providers.

WHO action will be adequately coordinated with other UN organizations in particular UNFPA and UNICEF. WHO will work with the MoPH to further coordination and collaboration between the agencies supporting RH.

A Demographic and Health Survey (DHS) is in the early stages of planning. WHO should be part of the forum for defining which areas to be covered and for defining the tool for data collection.

A substantial reduction in maternal morbidity and mortality will require a substantial investment in health infrastructures, in roads and in communication.

6.3.5.2. Child Health

As already mentioned under Section 2, the child health indicators remain amongst the lowest in the world. Within the EM region, Afghanistan accounts for a large proportion of all the under five deaths. The **Strategic objective** according to the target set by the MOPH is to *reduce by 50%, between 2003 and 2015, the under five mortality rate, and to further reduce it to 1/3 of the 2003 level by 2020.*

In order to address this issue, the **strategic approaches would cover:**

- WHO would continue to provide technical support in close coordination with partners for planning and for expanding the implementation of Integrated Management of Childhood Illnesses (IMCI) in the country including increasing the IMCI training coverage and support for follow up and supervision. In this connection training sites will be established/upgraded to increase the pool of facilitators at the provincial and district level.
- Emphasis will be placed on developing appropriate tools/mechanisms for supervision and monitoring in order to ensure that the quality of training is matched by the quality of care delivered.
- As mentioned under 6.3.1, it will be important to integrate IMCI activities with other health related interventions targeted at children and women of child bearing age at the community levels and at the BHU and CHC.
- Similarly for successful implementation of IMCI referral practices would need to be established and continuity of care of the sick children closely monitored.
- Through WHO's active participation in the Food and Nutrition Task Force established by the MoPH, and other coordination fora established by the MoPH, efforts should be made to develop a national policy for child health development for program planning and implementation as well as for advocacy and generating additional resources.
- Through the above mentioned mechanism(s) WHO would support efforts to generate additional resources to initiate and support new interventions aimed at improving family and community practices targeting child health including the development of appropriate health education packages aimed at mothers and young children.
- Technical and policy support would be provided for the development and implementation of policies and strategies for protecting adolescents from disease and from behavior and conditions that pose a risk to health notably from smoking, drug abuse and HIV/AIDS.

6.3.6. Health Education, Prevention, and Promotion

Rationale

Even before the war started with the Soviet invasion in 1979, the Afghan health sector was characterized by a comparatively large hospital sub-sector, fairly high-quality services and reduced presence in rural areas (with the important exception of some disease control programs, such as smallpox, malaria, leishmaniasis and tuberculosis). Moreover, the perpetual inclination of successive governments to institutional based (hospital based in most cases) care created a milieu for NGOs (which are currently the major healthcare providers) to resort also to institutional based care in most cases-with little or no emphasis on prevention and promotional aspects. As health services became almost totally dependent on the numerous NGOs, the modest (both in content and volume) health activities carried out inside Afghanistan came to depend on the presence, mandate, preferences, and willingness to take risks of NGOs-most of the times overlooking the important preventive and promotive aspects of healthcare. Several interesting efforts aimed at introducing rational planning criteria met serious implementation hurdles, generated by war disruption, political imperatives and fragmented decision-making.

In the backdrop of the fast evolving situation in the health sector in the country and the desire and the willingness of the main actors (led by the MOPH) to increase the access of the people to quality healthcare and also their endeavor to reduce the enormous burden of diseases (mostly from communicable diseases), preventive and promotive aspects of healthcare have a major place to be part and parcel of the overall health systems. The political case making for prevention and promotion through health education is further substantiated by the fact that geographical distribution of available facility based services may not find its way to most of the people living in rural and remote areas.

Strategic Objective:

The strategic objective is to consciously construct opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health so as that communities live a longer and healthier life.

Strategic Approaches

- **Incorporating preventive, promotive and educative elements in the wider health system reform agenda:** Preventive strategies with clearly defined terms of reference and roles and responsibilities need to be clearly spelled out in the wider health sector reform agenda the MoPH and other partners has been contemplating. WHO comparative advantage in this particular strategic objective can be of value in assisting MoPH designing a prevention and health education strategy.
- **Developing comprehensive health education packages for different levels:** A comprehensive effort at the national and provincial levels is essential to design health education packages for different level of audience (community, schools, special groups, etc). The strategic objective is to include the health education

component at the programmatic level right from the outset. A more cohesive approach would be to develop prevention and promotional packages aimed at educating the different set of audience for the major issues/challenges faced by people in the country.

- **Partnering with Media and other players:** Long-term sustainable partnership with media (whatever forms of media are used by general public) needs to be established informing the community about the good personal health practices as well as about how best the available health services can be availed. Certain players in the field of healthcare focusing on health education in the country may prove to be a greater resource in this regard.
- **Establishment of Health Education/Health Protection Department (s):** A strategic decision has to be made by the MoPH to establish a national level health education/health protection department and replication at the provincial level with an explicit aim of providing resources, technical guidance and monitoring the activities at the national, provincial and district levels. WHO can provide technical guidance on the method of how such a department (s) can be established also spelling out the roles and responsibilities at different levels.
- **Strengthening advocacy through community awareness and action:** Community awareness, once achieved (to a certain degree) would also play a catalytic role in sustaining and enhancing the political commitment for keeping health education and prevention high on political agenda.
- **Addressing the social determinants of health through active community participation and awareness and achieving MDGs:** Health *per se* would not improve unless the social determinants of health are targeted. Basic Development Need Programme (BDN) and other CBI initiatives (run by MoPH in collaboration with WHO) provides an opportunity to provide the enabling environment and potential scope to inform and empower community to address the social determinants of health. The process of community awareness and empowerment through this mechanism has immense potential for reaching most of the MDGs.
- **Risk perception and harm reduction:** For communities to live a longer and healthier life, risk perception and identification and changes in the lifestyle play a more constructive role. Government, partners and communities need to be oriented and convinced about the importance of looking at different risk factors and avoiding them. A healthy lifestyle is a valuable resource for reducing the incidence and impact of health problems, addressing the risk factors, for recovery, for coping with life stressors, and for improving quality of life..

6.3.7.Mental health:

Strategic objective: By the end of the period covered by the strategic agenda the MoPH will have carried out a comprehensive situation analyses which will have been translated into a national policy, strategies and plans (implementation started) for addressing the needs of people with mental disorders through the health system and through advocacy for community acceptance.

Strategic approach:

Mental health problems have been documented before, during and after the period of conflict. There is ample evidence to suggest that mental health was and still is a widespread problem in Afghan society. Mental health services are practically non-existent apart from medication done mostly by non-specialist doctors.

Mental health has been included in the BPHS but so far there has been no attempt to comprehensively address this problem area. The MoPH has requested WHO to address mental health more comprehensively with a view to finding the most appropriate medium-term solution.

Over the next four years the MoPH will perform a comprehensive situational analyses, develop and agree on a policy and strategies for how to address the needs of people with mental health problems. This will include plans for incorporating an adequate response to mental health into the health system and into general advocacy for more community acceptance of people with mental health disorders. WHO will provide the necessary support for this to happen. WHO will also provide support the establishment of appropriate institutions and for incorporating mental health into the curricula for the training of relevant health staff. WHO can provide support for the establishment of a “patients” association for people with past or/and present mental health problems and for other people with an interest in this area. Attention will be paid to the special needs of women with mental health problems as a result of years of neglect, social exclusion and stressful life situations.

The foreseen development in this area will have to take into account the competing priorities in the foreseeable health development arena in Afghanistan and use this scenario for focused attention to the most pressing problems such as the major mental health pathologies. It will be a long development period before all mental health problems can be addressed adequately.

Comment: Mental health has been singled out in the strategic agenda because of the emphasis placed on this by the MoPH corroborated by the recent scattered studies. It can be argued that mental health should be incorporated under “health systems”.

6.3.8. Control of Communicable Diseases.

The current epidemiological situation regarding communicable diseases has been summarized in section 2 of this document. Tuberculosis, malaria, leishmaniasis, and vaccine preventable diseases account for most of the disease burden. There is of course the ever-present threat of emerging infectious diseases.

The **broad strategic objective** for this group of disease would be reduce morbidity, mortality and disability through the adaptation of proven and well established interventions.

Strategic Approaches:

WHO's collaborative efforts in the field of malaria will be guided by the global strategy for malaria control and principles of the Roll back malaria initiative. In the short term the aim would be to meet the immediate needs of the vulnerable populations in the worst malaria affected areas and in the medium to long term the aim would be to adopt measures to build an effective integrated and decentralized malaria control program. Technical and managerial capacities will be developed in the staff serving in the different departments of the national malaria control program and support will be provided for developing a system for monitoring and evaluation of the program through the establishment of an appropriate information system. Another important area for support will be to ensure the timely provision of anti-malarial drugs and other supplies required for control of malaria at various levels of health care system.

WHO would continue to support and further strengthen the national control program for tuberculosis. Special emphasis will be placed on improving the quality of services to increase the low case detection in the country. Only about 20% of the health facilities in the country are implementing DOTS. Successful expansion of DOTS will remain a challenge for years to come. Therefore, during the next four to five years WHO efforts will be directed towards continued provision of technical support (development of policies and strategies, adapting available guidelines for all programmatic areas and capacity development both at individual and institutional level), resource mobilization and strengthening partnership amongst the number of agencies (donors, NGOs, public and private sector) involved in control of TB. Guidance will be provided to tackle multidrug-resistance tuberculosis.

Regarding vaccine preventable diseases, support will be provided for implementing the multiyear plan of action for the period 2006-2010 that aims at achieving and maintaining coverage more than 90% at the national level and at least 80% coverage in each district, reduction of mortality due to measles by 90% till the end of 2010, elimination of MNT in all districts by the end of 2007 and the introduction of hepatitis B vaccine in 2006. The country has achieved marked progress in eradicating poliomyelitis. During the current year only four cases of wild poliovirus have been reported. The Organization would continue to provide the support required for implementing the various activities related to the polio eradication initiative.

As mentioned earlier there is a real danger that HIV/AIDS may obtain a foothold in the country and spread rapidly. WHO in collaboration with other partners would assist the national authorities to develop their strategies for HIV/AIDS/STD prevention and care including access to antiretroviral therapy and strengthen surveillance for HIV/AIDS to generate more reliable data. Innovative strategies would need to be developed, keeping in view the culture and traditions of the country, to deal with the stigma and discrimination related to HIV/AIDS.

The Organization would assist the national authorities in epidemic preparedness through setting up an early warning, surveillance and response system, improved laboratory capacity and field epidemiology training. The AFP surveillance system that exists through the country would be further expanded to serve as a building block for nation wide system for surveillance of communicable diseases including emerging infectious

diseases. In addition to the above, WHO would facilitate the participation of relevant national authorities in the Global Outbreak Alert and Response Network and in appropriate implementation of the revised International Health Regulations.

6.3.9. Emergency Preparedness and Response

Strategic objective: By the end of the period covered by the CCS, the MoPH will have a better capacity for Rapid Needs Assessment and Initial Response to situations which require such capacities. Such abilities will be dispatched in close collaboration with relevant partners.

Strategic approach: Afghanistan is located in a geographical zone prone to be hit by natural disasters: earthquakes, drought, flooding, extremely cold winters etc. There are various outbreak situations occurring frequently affecting many people. The overall coordination is with the Office of Disaster Preparedness at the government level. In the MoPH there is a Department of Disaster Preparedness and Response. Several international agencies play an important role in responding to such situations. The health sector in any disaster situation has a special role to play and hence the importance of having an adequate assessment and response capacity.

WHO has important critical functions in crisis situations:

- Measuring ill health and assessing needs;
- Coordinating joint action for health;
- Filling - or ensuring that others fill - critical gaps in health response; and
- Revitalizing and building capacity in health systems;

It is within that mandate and sphere of competencies that WHO can work with the MoPH to strengthen its capacity for managing crisis situations including outbreaks. That will be done by further WHO support for building capacity in the MoPH possibly in collaboration with other agencies. WHO will in particular work with the MoPH and other agencies to further strengthen the surveillance system. WHO can assist in developing a policy and adequate strategies for this to happen.

Internally in WHO at country level existing capacities will be streamlined for it to be able to assist the MoPH at any time to make an initial assessment and designing an adequate early response. This may also include assisting the MoPH to coordinate action. Emergency supplies delivered timely at the location where needed, is the hallmark of quality emergency response. WHO country office will assert its ability to deliver emergency supplies in collaboration with the rest of the organisation. WHO may be required to provide staff to work in emergencies and should be able to respond locally and mobilize adequate human resources from the rest of the organization. WHO will also be able to assist the MoPH to integrate early response in the health system in collaboration with the many NGO service providers active in the country. WHO will also assist the MoPH to design and manage medium and longer term rehabilitation.

This CCS is cognisant of the development in WHO towards increasing WHO engagement in crisis situations.

Section 7: Implementing the strategic agenda: Implications for WHO Secretariat, follow-up and next steps at each level.

The CCS, Afghanistan has provided a timely opportunity to the Government, as represented by the MoPH, and WHO to discuss and delineate jointly the broad area for collaboration during the next 4 years (the period of 4 years was adopted in view of the specific situation of Afghanistan). The MoPH took the entire responsibility for producing a detailed situation analysis based on the latest data. It is anticipated that implementation of the strategy will go a long way in strengthening and streamlining WHO's collaborative program within the country and reinforce its leadership role in all matters related to health development. This strengthened presence will also enable the country office to meet the expectations of the MoPH in a more effective and prompt manner.

7.1. Implications for the country office

As the country is still in the recovery phase from the effects of the events that occurred during the last two to three decades and the MoPH is making energetic and commendable attempts to deliver health care with generous support from external donors, therefore, it is imperative that the WHO country office in Afghanistan and its sub-offices are further strengthened administratively and technically to support the MoPH in meeting the current and the near term health challenges.

Due to the unique situation in the country, WHO's collaborative program will be a mix of all the country level functions (providing scientific policy advice; catalyzing the adoption and adaptation of technical strategies; supporting routine implementation according to national needs; advocacy, information and knowledge sharing and actively engaged in developing partnership with other stake holders in the health sector) in varying proportions.

In order to implement the strategic agenda, additional and stronger human resources would be needed particularly in the areas of health policy formulation and analysis, overall health sector management with special emphasis on the functions of monitoring and evaluation, health financing, human resource development, and advocacy. Human resources capacity in support of programs related to the MDGs (such reproductive and child health) would also need to be strengthened.

In view of the above, the CCS team felt that it was timely to carry out a scientific assessment of the competencies and skills mix that that would be needed in the WHO Country Office to implement the strategic agenda in the coming years. However, pending the implementation of such a study and of its recommendations, the following specific suggestions regarding human resources are made at this time.

- Due to a variety of demands (including heavy representational duties) being placed on the WR's time, consideration should be seriously given to assigning a Deputy WR in Afghanistan.
- In view of the increasing need of assistance to the MoPH in the areas of formulation of evidence based policy and in the overall health sector management, almost on a daily basis, it would be worth to seriously consider assigning a health policy advisor with experience in health sector management and in dealing with major donors, to the MOPH
- As competing and heavy demands are being placed on the program managers in the WHO country office, a specialist information officer is needed to ensure the visibility of the Organization. The presence of such a professional would also help in resource mobilization.
- The need for recruiting STCs of a high technical quality and experience for various WHO collaborative programs was very evident. However, it has not been easy to recruit such type of STCs. Provision of high quality technical expertise would lend additional credibility and weight to WHO leadership in the country. This has implications for staff serving in the WHO regional office and headquarters who, in the absence of suitable STC, should provide the necessary technical back stopping to the country programs.

The Organization is already implementing the policy of expanded delegation of authority to the WR from the regional office. Consideration could be given to further expansion of financial and administrative authority to the WR in Afghanistan to facilitate responses to the program needs that often arise at short notice and demand a quick response.

One of the comparative advantage of WHO in Afghanistan has been its country wide presence through its sub-offices. Their strengthening with adequate human and material resources is vital for the implementation of the collaborative programs.

WHO has good working collaborative relationship with other UN agencies involved in health related and developmental activities in Afghanistan and WHO staff had actively participated in the formulation of the recently completed UN Development Assistance Framework (UNDAF). There is currently, considerable interest in having the program planning cycle of all UN agencies of similar duration (three years). Should this happen it will certainly make the joint programming between the different UN agencies represented in Afghanistan much easier.

In view of the important role being played by the NGOs in Afghanistan, a state of affairs that is likely to continue, there is a need for much closer interaction between them and WHO. Some of these NGOs have well qualified staff who have been in Afghanistan for long and have acquired considerable experience in executing programs difficult circumstance and can serve as a source of information to supplement WHO's own expertise and corporate knowledge.

7.2. Implication for WHO Regional Office and Headquarters

Several of the above mentioned implications for the Who Country Office also have direct implications for the WHO Regional office and Headquarters.

It is expected that the WHO Regional Office and Headquarters would continue to assign a high priority to the program in Afghanistan by providing additional resources, particularly from extra-budgetary sources, to the extent possible and ensuring technical support of a high quality promptly to the programs included in the strategic agenda.

REFERENCES

Amowitz LL, Heisler M, Iacopino V 2003: *A population-based assessment of women's mental health and attitude toward women's human rights in Afghanistan*. Journal of Women's Health 12:577-87

CARE 2004: *A survey among widows attending a humanitarian assistance programme*. Kabul, CARE International/IRC

Centre for Economic and Social Rights 2001: *Key Human Vulnerabilities. Afghanistan Fact Sheet 3*. New York

Dadfar A 1994: *The Afghans; bearing the scars of a forgotten war*. In: AJ Marsella et al (eds). *Amidst peril and pain. The mental health and well being of the world's refugees*. Washington: American Psychological Association, 125-139

De Jong E 1999: *Mental Health Assessment Ghurian and Zendah Jan Districts, Herat Province Afghanistan*. Amsterdam/Kabul, Medecins sans Frontiers Holand.

Gobar AH 1970: *Suicide in Afghanistan*. British Journal of Psychiatry. 116: 493-6

Islamic Republic of Afghanistan 2005: *Afghanistan's 2020 Vision. Achieving the Millennium Development Goals. Draft Outline of the MDG Report 2005*.

Lancet 2005: *A crucial time for Afghanistan's fledgling health system*; www.thelancet.com; Vol 365 March 5, 2005

Lopez Cardozo B, Bilukha OO, Crawford CA, Shaikh I, Wolfe MI, Gerber ML, Anderson M 2004: *Mental health, social functioning, and disability in postwar Afghanistan*. JAMA 292: 575-84

Ministry of Health / Management Sciences for Health. September 2002. *Afghanistan National Health Resources Assessment*

Ministry of Health 2004: *Capacity Building Plan for Central and Provincial Ministry of Health Public Administration Staff*. Final Version, May 2004.

Ministry of Health 2004: *Public Investment Programme 1384* as part of the NDB

Mufti KA 1986: *Psychiatric Problems in Afghan Refugees*. Bulletin of the Royal college of Psychiatry 10:6

Qadir, A; Sharma, H; Raza I; Dadgar N A: *Workshop Report; Building Consensus for Improving Routine Immunization Coverage and the Coverage of Evidence Based Child Health Interventions in Afghanistan; Intercontinental Hotel Kabul; 5-7 June 2005*

Rasekh Z, Bauer HM, Manos MM, Iacopino V 1998: *Women's health and human rights in Afghanistan*. JAMA 280:449-55

Scholte WF, Olf M, Ventevogel P, de Vries GJ, JAnsveld E, Lopes Cardozo B, Gotway C 2004: Mental health problems following war and repression in Eastern Afghanistan JAMA 292: 585-593

Schuette, Stefan 2004: *Urban Vulnerability in Afghanistan: Case Studies From Three Cities*; Afghanistan Research and evaluation Unit

Securing Afghanistan's Future: Accomplishments and the Strategic Path Forward. A Government / International Agency Report; March 2004.

Strong L 2004: Health Policy in Afghanistan: *a Review of he Process between November 2001 and September 2003*

Technical Working Group 2004: *Afghanistan and the Millennium Development Goals 2005*. Report of the Technical Working Group 3, Sub-group B: Maternal Health

Tufts University, Feinstein International Famine Center 2004: *Human Security and Livelihoods of Rural Afghans 2002 - 2003*

UNODC (UN Office for Drug Control) and Counter Narcotics Directorate of the Government of Afghanistan, October 2003: *Afghanistan Opium Survey*

United Nations Development Report 2004: *Afghanistan National Human Development Report 2004*

United Nation 2005: United Nation Joint Programme Document for Maternal Mortality Reduction in Afghanistan 2006-2008; draft June 27, 2005

United Nations System, Kabul, October 2004: *Common Country Assessment for the Islamic Republic of Afghanistan*

Waziri R 1973: *Symptomatology of depressive illness in Afghanistan*. American Journal of Psychiatry 130: 213-17

WHO East Mediterranean Office (EMRO) 2005: *Health System Profile, Country Afghanistan; Date May 14, 2005*

World Bank, July 2005: *Targets and Indicators for MDGS and PRSPs: What Countries Have Chosen to Monitor*; The Development Data Group; Development Economics Vice-Presidency.

World Food Programme, December 2004: *The National risk and Vulnerability Assessment 2003 Rural Afghanistan*

UNICEF2004: Multiple Indicator Cluster Survey 2003

ANNEX 1. WHO CCS Team Members to Afghanistan

Dr Riyad Musa Ahmed, WHO Representative in Afghanistan
Dr Ahmed Abdul Latif, Regional Adviser, Health Care Delivery, WHO EMRO
Dr Jaffar Hussain, Medical Officer, Healthy Life Style Promotion, WHO EMRO
Dr Ole Frank Nielson, CCO, WHO Headquarters
Dr Javid Hashmi, Consultant, Program Planning and Monitoring, WHO EMRO.

ANNEX 2. List of person met by the CCS Team

H.E. Dr Sayed Mohammad Amin Fatimie, Minister of Health, Governemnt of Afghanistan
H.E. Dr Faizullah Kakar, Deputy Minister, Policy, Planning and Preventive Medicine, Ministry of Health, Government of Afghansitan
Dr Mohammad Daud, Program Management Officer, Ministry of Health
Dr Mohammad Ashraf, HMIS Officer, Ministry of Health
Dr Habib, National Consultant, Grant Contracting Management Unit, Ministry of Health
Dr Partamin, Program Manager, Global Fund, Ministry of Health
Mr Athanase Nzokirishaka, Deputy Representative, UNFPA, Afghanistan
Mr T.Savelli, Chief of Party, MSH/REACH, Afghanistan
Dr Mubarak Shah Mubarak, Manager, MSH/REACH, Afghanistan
Mr Sikander Khan, Senior Program Coordinator, UNICEF, Afghanistan
Mr Chris Hirbayashi, Head of Program, UNICEF, Afghanistan
Mr James Griffin, Senior Health Advisor, US AID, Afghanistan
Dr Noriko Fujita, Chief Advisor, Reproductive Health, JICA, Afghanistan
Dr Tadao Hayakawa, Advisor TB Control, JICA, Afghanistan
Ms Esmee De Jong, Health and Disability Task Manger, European Commission Delegation to Afghanistan
Dr Katja Schemionek, EC Technical Assistant to Ministry of H, Afghanistan.
Dr Kayhan Natiq, Health Program Unit, World Bank, Afghanistan

ANNEX 3. Briefing Note on Modalities for Health Care Financing

I. Community health fund (plus small co-payment)

As part of the health financing pilots in PPA provinces, the Ministry of Public Health (MOPH) of Afghanistan will pilot a Community Health Fund (CHF) around pre-selected BHCs and CHCs. The fund is a voluntary pre-payment scheme that will cover all services at the BHC, CHC, and district hospital levels. The objectives of the CHF, as well as the details of its operation, are described below.

Objectives of the Community Health Fund:

- Increase available funding for health services
- Provide incentives to improve quality of care
- Initiate and increase the feeling of community ownership and local accountability of the health facility
- Improve financial access to health care
- Develop and enhance community solidarity

In the longer term:

- Establish a local funding base to move toward services that are self financing and sustainable
- Facilitate the exit strategies of humanitarian assistance organizations

1) Subscription

- a) *Type of enrollment* – subscription to the community health fund will be *voluntary* and open to all members of the designated facility catchment area – no restrictions will be set regarding who can join the fund.
- b) *Unit of membership* – Membership will be on a household basis. In some areas, the fund may have different categories of enrollment according to the number of members in each household, as follows:
 - 1-5 household members
 - 6-10 household members
 - 11 or more household members
- c) *No waiting period initially* – In order to encourage initial enrollment, there will not be a waiting period for households joining the scheme to receive services. However, after the scheme is up and running, the fund managers may wish to consider a one-month waiting period for new members to receive services. The purpose of this probationary period will be to limit adverse selection and prevent people from joining the fund only when they need health services.

2) Services covered

- a) *Services covered* – As noted above, funds will be designed around the catchment area of the pre-selected pilot basic health centers (BHCs) and comprehensive health centers (CHCs). Services covered will include all services offered as part of the Basic Package of Health Services (BPHS) of Afghanistan, including services at the BHC, CHC, and district hospital (DH) levels.

As an incentive for community members to join the fund, it will also cover inpatient services at the district hospital *when patients who are fund members have a referral from the BHC or CHC*. It is expected that relatively few patients will present for treatment at the district hospital after referral from the BHC or CHC and therefore the cost of caring for these referred patients at the district hospital will be manageable. The cost of treating these referred patients at the district hospital will be borne by the PPA NGO.¹

¹ In most cases where the district hospital is managed by the PPA NGO, it can provide services for free to fund members to keep the fund administration and financial management as simple as possible; in later years, once the CHF systems are established, the CHF may evolve to contract with referral facilities, including district and provincial hospitals. In circumstances where the nearest DH is not run by the PPA NGO, some arrangements may need to be made for the PPA NGO to reimburse the organization managing the DH.

3) Contributions

- a) *Timing of collection* – Households will contribute on an annual or twice-annual basis to the CHF. Contributions will be collected after the harvest, or at a time when community members feel they are best able to pre-pay for health services.
- b) *Method of collection* – Premiums will be collected by the fund enrollers/promoters, which include NGO community mobilizers; CHF committee members; community health committee members; community health workers (CHWs) and other authorized collectors.
- c) *Premium levels* – The annual premium for the CHF will be set in consultation with the PPA NGOs and the communities around the CHF facilities. An initial contribution level, roughly in the range of 300 to 500 Afghanis for a household with 1-5 members, will be proposed after analysis of data around the PPA pilot facilities from the 2004 National Health Services Performance Assessment and from other sources of information on the catchment area. This proposed premium level will be discussed with the community to determine if it is feasible or if alternative contribution levels should be explored. Some communities may wish to consider a two-tiered pricing system with a lower price for poorer families and a higher price for better-off community members.

Contributions therefore will be based on two dimensions at most pilot sites: 1) household size; and 2) ability to pay. A matrix outlining the proposed relative contribution levels is below – more specific contribution levels will be determined at a later date.

Table 1: Proposed relative premium levels for CHF			
	Economic Status		
Household Size	Very poor	Poor	Less Poor
1-5	No payment	50%	100% ²
5-10	No payment	75%	150%
11+	No payment	90%	200%

- d) *Co-payments* – Fund members will be required to pay a small co-payment when using health services in order to limit moral hazard (overuse of health services by consumers who are protected from the costs of using health care, e.g., by insurance). The co-payment will be 1 Afghani per consultation and will cover all services required during the visit.
- e) *Drugs* – Drugs will be provided free of charge to fund members visiting the pilot health facility, based on established prescription patterns for an established list of infectious diseases.

² This will serve as the reference payment category; in most locations, this annual premium will be 300 to 500 Afghanis.

4. Creation of a cost sharing system for non-community health fund members

- a) *User fees and drug charges for non-fund members* – Patients who are not members of the CHF will be required to pay user fees when they access care at the pilot health facility. The level of these user fees will be set relatively high – on the order of 50% of the consultation fees charged in the private sector, plus cost sharing for drugs (50% of the wholesale cost of the drugs to the NGO) – in order to encourage enrollment in the fund.

5. Exemptions

- a) *Services* – Certain preventive and promotive services will remain free, even for non-fund members who must pay user fees at the health facility (see section above). Services that will remain free for all community members include: EPI; antenatal care; well baby visits; TB-DOTS; family planning; delivery; and life threatening conditions (until patients are stabilized and ability to pay can be assessed).
- b) *Categories of exempt households* – As noted above, the very poorest households in each community will be exempt from paying a contribution fee. If a tiered pricing system is used, poor households will be eligible for reduced premiums. In addition, female-headed households will be exempt from the community health fund contribution and will be eligible to join the fund for free.
 - a) *How are exemptions made?*
 - i) Exemptions will be made by the CHF committee/representatives at the village level, in collaboration with the village arbob/mulik, who will compile a list of families who qualify for full exemption and partial exemption/reduced fees.
 - ii) For catchment areas that have microfinance programs, the CHF committee/PPA NGO may wish to consider using the results of the microfinance surveys to classify families socioeconomically into categories of contribution levels.

6. Management of funds

- a) *CHF committee* – A committee for the facility catchment area will be established to promote, manage, and oversee the CHF. Committees will build on existing mechanisms whenever possible, for example the community health committee (shura-e-sehie), the National Solidarity Program's Community Development Committee (CDC), or other existing community mechanisms. If the NGO has established community health committees, the CHF committee will ideally be comprised of a subset of these members. At minimum, management committees should be comprised of the following members:
 - Facility in-charge
 - 2 additional members of health facility staff, including at least one female staff³

³ In some communities, presence of female staff on the CHF committee may not be feasible; in these areas, it may be possible to consider a separate CHF committee comprised of women from the facility and community.

- 5-8 members of community (ideally also members of the community health committee), including at least one woman⁵
- 1 Community Health Worker (CHW)
- PPA NGO representative(s) (the CHF advisor)
- Other relevant members, including NSP Community Development Council (CDC) members from catchment area villages

The CHF committee will be established by the PPA NGO. PPA NGOs will work through the committees to raise awareness among community members about the scheme and market the scheme's benefits. The CHF committee and its members, as well as other PPA NGO staff, will hold extensive meetings with the community to explain how the scheme works and to finalize the premiums, balancing community acceptance of the level of payment with potential for raising revenues.

In addition to the larger CHF committee for the pilot facility catchment area, CHF committees or representatives will be selected for each village or group of villages within the catchment area. These village CHF representatives or committees will assist with community mobilization, awareness raising, and CHF enrollment within each village in the pilot facility catchment area.

- b) *Use of funds* – Decisions on use of the funds from the scheme will be made by the CHF committee. Funds will be retained for use in the community and facility and can be used for activities in the following four categories:
- 1) Facility operations and quality improvements: A portion of the funds collected will be used at the pilot facility for operations and quality improvement initiatives. Potential use of funds includes: 1) general maintenance and operations of health facility; 2) improvement of drug supply, including establishment of emergency fund for acute drug shortages; 3) incentives for attracting/retaining female staff; 4) incentives for staff to extend hours (e.g., for deliveries); and 5) other quality initiatives. The funds may be used to pay health facility staff an occasional bonus for rewarding/motivating good performance; this bonus must be contingent upon community satisfaction with the quality of services provided by health facility staff. **No more than 5% of CHF revenues may be used toward staff bonuses.**
 - 2) Community support and programs: A portion of the funds may be used in the community for activities such as: 1) transportation fund to improve access to health facility; 2) stipend for community health workers (CHWs); 3) health education programs and other health-related community activities.
 - 3) Fund administration and management: As noted above, money for the management and administration of the CHF will come from money collected from the fund. Based on experience of community health funds in other countries, administrative costs are expected to be in the range of 12%⁴. The

⁴ M. Desmet et al. 1999. "The potential for social mobilization in Bangladesh: the organization and functioning of two health insurance schemes." *Social Science & Medicine* 48: 925-938; Atim, C. 1999.

CHF committee and, in particular, the Financial Manager/Treasurer, will be responsible for documenting and tracking the administrative and management costs of the CHF.

- 4) Reimbursement to referral facilities (CHC, district hospital): It may be possible to consider using a portion of the money collected for the CHF to reimburse the referral facilities, including the nearest CHC and the district hospital. This step, however, may come only at a later stage, once administrative and financial management systems are fully functional and the CHF has been operational for some time.
- c) *Administrative systems* – The PPA NGO and the CHF committee will be responsible for implementing administrative systems that will track enrollment and relevant information on fund members. In addition, systems will be established at each pilot facility to tie information on fund members into the existing HMIS system. Draft administrative systems for adaptation will be provided by JHU/MOPH.
- d) *Financial management systems* – As noted above, the PPA NGO and CHF committee will track information on fund revenues and expenditures in order to determine: 1) total revenue raised through premiums (and co-payments); 2) total expenditures of the fund; 3) administrative and management costs of the fund. Draft financial systems for adaptation will be provided by JHU/MOPH.

7. Supervision and Monitoring of fund

- a) *Primary responsibility for supervision and monitoring* – the primary responsibility for supervision and monitoring of the CHF will lie with the PPA NGOs. In most cases, this responsibility for CHF monitoring will lie with NGO supervisors.⁵
- b) *Supervision and monitoring guidelines* – Common supervision and monitoring guidelines, for example in the form of checklists, for the CHF will be provided for use by the relevant NGO personnel.
- c) *Evaluation of CHF* – the advisory group will develop a detailed plan for evaluation of the pilots one year to 18 months post implementation

II. Standardized user fee and exemption system

Executive Summary

The user fee guidelines will be based on the ten basic principles of the cost sharing policies stipulated by the Ministry of Public Health, as follows:⁶

“Social movements and health insurance: a critical evaluation of voluntary, no-profit insurance schemes with case studies from Ghana and Cameroon.” *Social Science & Medicine* 48: 881-896

⁵ The specific supervision personnel and procedures may vary by NGO depending on existing supervision capacity and structures, but common supervision and monitoring guidelines will be provided.

⁶ The MOPH cost sharing policy is approved by the Technical Advisory Group (TAG) but pending approval from the Executive Board as of February 2005.

1. Everyone who needs care must receive care regardless of ability to pay
2. People should not have to sacrifice necessities in order to pay for care
3. Quality of care must be the same for paying and non-paying patients
4. Monitoring of the utilization of health services will be done to ensure that any decrease in utilization after introduction of fees is due to decrease in “unnecessary care” and not due to barriers of access.
5. Fees will be charged for curative care but not for promotive, preventive and emergency care.
6. To ensure that the poor continue to receive necessary care, there will be waivers for the poor.
7. Fees collected at a facility will be used by that facility to make improvements, offer additional services or hire additional staff to extend service hours.⁷ In some cases there may be a portion of the revenues sent to the provincial health department to promote extending the BPHS to other underserved districts in the province.
8. Use of the fees generated by cost sharing will be overseen by a formal mechanism that includes representation by the community and the health facility’s staff.
9. Cost sharing revenues are additional—revenue generated is supplemental to the MOH or NGO budget. This is additional revenue and does not replace or reduce the government budget.
10. Administration of the cost sharing system must be simple and efficient.

Objectives of user fee pilot

- Increase available funding for health services
- Provide incentives to improve quality of care
- Initiate and increase the feeling of community ownership and local accountability of the health facility
- Improve financial access to health care
- Develop and enhance community solidarity

In the longer term:

- Establish a local funding base to move toward services that are self financing and sustainable
- Facilitate the exit strategies of humanitarian assistance organizations

Fee types and levels⁸

- There will be two types of user fees: 1) an all-inclusive flat service fee (one fee for OPD services and a higher fee for IPD admission); and 2) a fee for medications, which will be a percentage of the wholesale drug price paid by the NGO.

⁷ In the user fee intervention, fees may also be used in the community to support community-related health activities. Sharing of revenues with the provincial health department would not be a potential part of the user fee intervention until the second phase.

⁸ Please refer to Figure 3 for an overview of the proposed fee ranges.

- One service fee will be charged per illness episode; if patients require follow-up visits for the same illness/condition (classified as “re-attendance”, as opposed to “new visit” in the HMIS), they will not be charged additional service fees. However, additional medication fees may be charged if patients require additional medications during follow-up visits.
- Fee levels will be within the range specified by MOPH/JHU, and the actual level will be determined by the socioeconomic status of the catchment area.
- Fee levels at the same type of facility, e.g., a CHC, must be the same for all the facilities included in the pilot in a given province.
- If possible, user fees will also be implemented in the referral district hospital for the pilot facilities to encourage appropriate use of health services. In a given province, fees should always be higher at district hospitals than at CHCs, and higher at CHCs than BHCs for facilities included in the pilot.

Exemptions (for services and types of patients)

- There will be two types of exemptions: 1) for all patients using certain types of preventive and promotive services; and 2) for selected patients using any services at the pilot facility.
- Preventive/promotive services, including EPI; antenatal care; well-baby visits; TB-DOTS; family planning; delivery; and treatment for life threatening conditions (until patients are stabilized and ability to pay can be assessed), will be free for all patients.
- Patients from very poor and female-headed households will be exempt from user fees and can access all services at the pilot facilities for free
- Exemptions will be made at the household level. Using a list of criteria to aid their decisions, accepted forums/leaders in each village in the catchment area (e.g., the *shura* or the *imam*) will compile a list of households in the village who qualify for exemptions.
- The user fee subcommittee will have the right to review and potentially overturn any decisions made by the village on the household exemption status.
- In addition, households will have the right to appeal exemption decisions made by the village committee/leader; they may do so at with the user fee subcommittee, with their CHW, or at the health facility itself.

Administrative systems

- The service fees will be collected by the facility registrar/administrator when patients enter the health facility; medications fees will be collected by the pharmacy when medications are dispensed to patients.
- Inpatient fees will be collected by the IPD registrar; in some facilities, depending on staffing patterns, the IPD fees will be collected by the OPD registrar if there is not a separate IPD registrar.
- The facility registrar/ administrator will be responsible each day for collecting fees from all relevant departments (e.g., the pharmacy) and entering information about patient types and fees collected in the facility income book.
- Administrative and financial systems will be put in place to help: ensure safekeeping of revenues; promote careful accounting for revenues collected; and prevent fraud.

Management of user fee revenue

- A user fee subcommittee, which will be a sub-set of the community health committee, will be responsible for overseeing and managing the user fee system, including making decisions about revenue use.
- The user fee subcommittee will be composed of, at minimum: 1) at least five CHC members, including at least two women, if possible; 2) at least two facility staff, including the in-charge, and the registrar/administrator; 3) PPA NGO representative. Other potential members of the committee include CHWs.
- Revenue from user fees must not substitute in any way for the regular facility budget – all revenue generated from user fees will be additional to the regular facility budget.
- All decisions about revenue use and actual purchases must follow standard protocols and be documented accordingly.
- All revenue raised through the user fee system will be retained for use at the facility and in the community. Funds may be used for activities that improve the quality of health services and/or expand access to services. Potential uses include the following:
 1. Facility operations and quality improvements: Potential use of funds includes: 1) general maintenance and operations of health facility; 2) improvement of drug supply, including establishment of emergency fund for acute drug shortages; 3) incentives for attracting/retaining female staff; 4) other quality initiatives. The funds may be used to pay health facility staff an occasional bonus for rewarding/motivating good performance; this bonus must be contingent upon community satisfaction with the quality of services provided by health facility staff. **No more than 5% of CHF revenues may be used toward staff bonuses.**
 2. Community support and programs: A portion of the funds will be used in the community for activities such as: 1) transportation fund to improve access to health facility; 2) stipend for community health workers (CHWs); 3) health education programs and other health-related activities in the community.
 3. Administration and management of the user fee system: While the PPA NGO will need to document the administrative and management costs of the user fee intervention prior to its full implementation (e.g., training for facility staff, community mobilization costs, etc.), the user fee subcommittee will be responsible for documenting and tracking the administrative and management costs of the user fee policy once fully implemented.⁹
 4. Other potential uses in Phase II: It may be possible to consider expanding the use of revenues collected from user fees for other purposes not specified in the initial guidelines (such as cross-subsidizing poorer facilities) during the second phase of the user fee system, depending on the results of the pilots evaluation.

Training and implementation

⁹ Relevant administrative and management costs include, among others: (re)printing of relevant forms; the time of the administrator to collect user fees and administer exemptions, etc.

- After an initial training for key administrative and financial staff from each PPA NGO, the PPA NGO will need to conduct further awareness raising so that all health facility staff fully understand the user fee system and the details of how it works.
- The PPA NGO and health facility staff will hold extensive dialogue with the community health committee, and will form a user fee subcommittee; the subcommittee will subsequently undertake more intensive awareness raising in the catchment area about the new user fee system.
- Communities must be made aware: why user fees are necessary; what will be done with the revenue collected; who will decide what user fees are used for; how much people will have to pay; and the exemption system.
- Details about the new user fee system, including the actual fee levels and the exemption system, will be posted in a public area in the health facility.

Monitoring and supervision

- The PPA NGO, with assistance from JHU/MOPH, will be responsible for regular monitoring and supervision of the user fee system.
- The PPA NGO monitor/supervisor will conduct regular visits, as well as unannounced “spot checks” to the pilot facility to monitor the user fee system, using standardized guidelines and a checklist.
- The user fee system is intended to be transparent and responsive; all user fee subcommittee meetings will be open to any community member wishing to sit in.

Phased system

- The user fee system will be implemented in a phased manner. Phase I will cover implementation until the initial evaluation, approximately one year after. Phase II will potentially expand the user fee system and may include the following:
 - Increase in service fees (contingent on affordability by the community)
 - Implementation of fees for ancillary services, such as laboratory tests and x-rays
 - Implementation of a daily hospital fee (with an upper limit), as opposed to a one-time admission fee
 - Expand the potential use of revenue to other purposes not specified in the original guidelines (depending on the results of the evaluation)

Figure 3: Proposed Fee Levels for User Fee Intervention

PHASE I: 1-12 MONTHS				
	Service Fee	Medication Fee	Laboratory Fee	X-Ray Fee
Inpatient admission fee				
District hospital	10-20 Afs	5-15% wholesale cost		
CHC	5-15 Afs	5-15% wholesale cost		
Outpatient Fees				
District hospital	5-10 Afs	10-50% wholesale cost		
CHC	3-7 Afs	10-50% wholesale cost		
BHC	2-5 Afs	10-50% wholesale cost		

Phase I use of revenue: 100% of revenue generated by user fees will be used for quality improvements at the pilot facility and in the community; decisions on revenue use will be made by the user fee subcommittee.

PHASE II: 12-24 MONTHS				
	Service Fee	Medication Fee	Laboratory Fee	X-Ray Fee
Inpatient admission fee¹				
District hospital	15-25 Afs	5-15% wholesale cost	2-5 Afs	10-30 Afs ¹⁰
CHC	10-20 Afs	5-15% wholesale cost	2-5 Afs	
Outpatient Fees				
District hospital	8-13 Afs	10-50% wholesale cost	2-5 Afs	10-30 Afs
CHC	6-10 Afs	10-50% wholesale cost	2-5 Afs	
BHC	5-8 Afs	10-50% wholesale cost	2-5 Afs	

Phase II use of revenue: while the majority of revenue will be used for quality improvements at the pilot facility and in the community, the potential uses of user fee revenue may be expended to include purposes not specified in the original guidelines for Phase I (depending on the results of the pilot evaluation).

¹⁰ Inpatients requiring multiple x-rays (e.g., for a fracture) will pay a one-time x-ray fee, as charging for each x-ray could quickly become unaffordable.

I. Free services

Background

The health financing pilots in PPA provinces will include three interventions: 1) standardized user fee system; 2) community health fund; and 3) free services. Free services is considered an intervention, as the majority of NGOs (70% nationwide, and 5 of the 6 PPA NGOs) are currently engaging in some type of cost sharing for service delivery. The Ministry of Public Health (MOPH) wishes to pilot free services as an intervention to study the impact of free services on communities' financial access to and use of services, as well as on the quality of services.

Objectives

- Compare free services with the other two pilot interventions – community health fund and standardized user fees – in order to determine performance in terms of:
 - Ensuring access to services, particularly among the poor
 - Ensuring rational use of health services
 - Improving quality of health services
 - Developing and increasing the feeling of community ownership of the health facility

Executive Summary

- Services will be free for all users of the pilot health facility; no fees of any kind will be collected. Any previous cost sharing system will be discontinued.
- At facilities implementing the free services pilot, facility staff will initially be briefed on the user fee pilots and why free services are being piloted at the health facility.
- The catchment area community must be well informed of the implementation of free services; the PPA NGO and health facility staff will initially work with the existing health facility-community interface (e.g., the community health committee) to inform the community about this change; the CHC members will, in turn, work in collaboration with CHWs and other community members to inform all villages in the catchment area about implementation of free services.
- The facility will continue to receive the same budget as previously; there will not be additional budget for the facility to compensate for any lost revenues from a discontinued cost sharing scheme.
- Regular monitoring of the facility will take place to ensure that fees are not being charged and that the catchment area community is aware that services are now free. In addition, monitoring will help ensure sound administrative systems are in place in order to facilitate evaluation of the free services pilot in the future.

Depending on the relative success of these models, the MOPH will select one of these and propose to the government for approval given the parliament defines the statement in the constitution similar or closely similar to our.

ANNEX 4: Afghanistan Health Sector Balanced Scorecard 2004

National Results of Provincial Performance

	Measure	N	National Median	Minimum	Bottom Quintile	Top Quintile	Maximum
A. Patients & Community							
1	Overall Patient Satisfaction (Score = 4/4)	5443	62.7%	0.0%	40.2%	79.9%	96.2%
2	Patient Perception of Quality Index (Score > 34/36)	5397	23.5%	0.8%	5.8%	38.3%	65.7%
3	Written Shura-e-sehie activities in community	598	32.4%	0.0%	10.7%	58.8%	84.4%
B. Staff							
4	Health Worker Satisfaction Index (Score > 62/76)	1309	14.7%	0.0%	3.8%	32.6%	62.6%
5	Salary payments current	1517	42.1%	15.8%	31.2%	57.6%	66.9%
C. Capacity for Service Provision							
6	Equipment Functionality Index	570	62.5%	31.2%	56.2%	68.8%	83.3%
7	Drug Availability Index	580	72.1%	10.4%	51.5%	82.2%	99.3%
8	Family Planning Availability Index	555	61.2%	0.0%	43.5%	76.0%	91.0%
9	Laboratory Functionality Index (Hospitals & CHCs)	284	28.8%	0.0%	12.7%	45.9%	58.4%
10	Staffing Index -- Meeting minimum staff guidelines	606	36.8%	0.0%	0.0%	55.1%	69.7%
11	Provider Knowledge Score	1502	51.3%	21.7%	44.7%	57.5%	72.0%
12	Staff received training in last year	1,539	37.3%	0.0%	24.8%	55.0%	78.0%
13	HMIS Use Index	566	73.3%	39.1%	60.7%	89.3%	96.5%
14	Clinical Guidelines Index	460	39.2%	12.9%	26.9%	51.3%	69.2%
15	Infrastructure Index	569	51.9%	21.4%	43.8%	60.9%	92.6%
16	Patient Record Index	2624	66.6%	39.5%	53.0%	94.9%	100%
17	Facilities having TB register	605	11.8%	0.0%	6.5%	20.9%	47.1%
D. Service Provision							
18	Patient-Provider Care Index	2060	54.0%	38.4%	40.9%	65.2%	91.5%
19	Proper sharps disposal	600	46.4%	2.6%	28.0%	86.7%	100%
20	Average new outpatient visit per month (BHC > 768 visits)	202	10.0%	0.0%	0.0%	57.1%	100%
21	Time spent with patient (> 9 minutes)	2908	22.2%	0.0%	10.0%	57.1%	100%
22	BPHS facilities providing antenatal care	606	57.7%	7.9%	21.4%	76.0%	100%
23	Delivery care according to BPHS	606	13.9%	0.0%	3.5%	34.3%	56.6%
E. Financial Systems							
24	Facilities with user fee guidelines	424	93.4%	19.5%	71.7%	100%	100%

2	Facilities with exemptions for poor patients	%	417	74.8%	22.5%	51.6%	100.0%	100%
F. Overall Vision								
2	Females as % of new outpatients	%	527	55.7%	39.1%	48.6%	61.2%	67.8%
2	Outpatient visit concentration index	CI (-1 to 1)	5,194	-0.038	0.119	0.018	-0.104	-0.185
2	Patient satisfaction concentration index	CI (-1 to 1)	5,160	-0.002	0.046	0.019	-0.018	-0.048
Composite Scores								
2	Percent of Upper Benchmarks Achieved	%	33	18%	0%	7%	29%	43%
3	Percent of Lower Benchmarks Achieved	%	33	82%	54%	71%	93%	100%
0								
KEY								
Score Below Bottom Quintile				RED				
Score Between Bottom & Top Quintiles				YELLOW				
Score Above Top Quintile				GREEN				

Number of Facilities	618
Number of BHCs	314
Number of CHCs	241
Number of BPHS Hospitals	51
Number of Other facilities	12
Number of Patient Observations	5852
Number of Exit Interviews	5730
Number of Health Workers	1569
Number of CHWs	167
Number of Households	12904

ANNEX 5: List of Revised Millennium Goals, Targets and Indicators for Afghanistan

<u>GOAL 1:</u>	<u>Eradicate Extreme Poverty and Hunger</u>
Target 1:	<i>The proportion of people whose income is less than US\$1 a day declines by 3% per year between 2005 and 2015</i>
Indicators:	1. Proportion of population below US\$1 per day 2. Poverty gap ratio (incidence x depth of poverty) In order to provide some basic courses in health systems and management, this initiative seeks to make use of locally available technical experts as well as those provided by the London School of Hygiene and Tropical Medicine. 3. Share of poorest quintile in national consumption
Target 2:	<i>The proportion of people who suffer from hunger declines by 5% per year between 2005 and 2015</i>
Indicators:	4. Prevalence of underweight children under 5 years of age 5. Proportion of population below minimum level of dietary energy
<u>GOAL 2:</u>	<u>Achieve Universal Primary Education</u>
Target 3:	<i>Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling</i>
Indicators:	6. Net enrolment ratio in primary education 7. Proportion of pupils starting Grade 1 who reach grade 5 8. Literacy rate of 15- to 24-year olds
<u>GOAL 3:</u>	<u>Promote Gender Equality and Empower Women</u>
Target 4:	<i>Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015</i>
Indicators:	9. Ratio of girls to boys in primary, secondary and tertiary education 10. Ratio of literate females to males (15- to 24-year-olds)
Target 5:	<i>Reduce gender disparity in economic areas by 2020</i>
Indicator:	11. Ratio of female to male Government employees
Target 6:	<i>Increase female participation in elected and appointed bodies at all levels of governance to 30% by 2020</i>
Indicator:	12. Proportion of seats held by women in national, provincial and district representative bodies
Target 7:	<i>Reduce gender disparity in access to justice by 50% by 2015 and completely (100%) by 2020</i>

GOAL 4: Reduce Child Mortality

Target 8: ***Reduce by 50%, between 2003 and 2015, the under-5 mortality rate, and further reduce it to 1/3 of the 2003 level by 2020***

Indicators: 15. Under-5 mortality rate
16. Infant mortality rate
17. Proportion of 1-year-old children immunised against measles

GOAL 5: Improve Maternal Health

Target 9: ***Reduce by 50%, between 2002 and 2015, the maternal mortality ratio, and further reduce the MMR to 25% of the 2002 MMR by 2020***

Indicators: 18. Maternal mortality ratio
19. Proportion of births attended by skilled health personnel
20. Reduce total fertility rate (births per woman) by 30% by 2020
21. Proportion of women receiving professional antenatal care

GOAL 6: Combat HIV/AIDS, Malaria and Other Diseases

Target 10: ***Have halted by 2015 and begun to reverse the spread of HIV/AIDS***

Indicators: 22. HIV prevalence among 15- to 49-year olds
23. Condom use rate of the contraceptive prevalence rate
24. % of population aged 15-49 with comprehensive correct knowledge of HIV/AIDS
25. Contraceptive prevalence rate
26. Proportion of blood samples screened for HIV/AIDS and STDs
27. Proportion of women's unmet needs for family planning met
28. Proportion of IV drug users in treatment for their addiction

Target 11: ***Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases***

Indicators: 29. Prevalence and death rates associated with malaria
30. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures
31. Prevalence and death rates associated with tuberculosis
32. Proportion of TB cases detected and cured under DOTS

GOAL 7: Ensure Environmental Sustainability

Target 12: ***Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources***

Indicators: 33. Proportion of land area covered by forest
34. Ratio of area protected to maintain biological diversity to surface area
35. Energy use (kg. oil equivalent) per US\$1,000 GDP (PPP)
36. Carbon dioxide emissions (per capita) and consumption of ozone-depleting CFCs
37. Proportion of population using solid fuels

Target 13: ***Halve, by 2015, the proportion of people without sustainable access to safe drinking water and sanitation***

Indicators: 38. Proportion of population with sustainable access to an improved water source, urban and rural
39. Proportion of population with access to improved sanitation, urban and rural

Target 14: ***By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers***

Indicator: 40. Proportion of households with access to secure tenure

GOAL 8:	<u>Develop a Global Partnership for Development</u>
Target 15:	<i>Deal comprehensively with the issue of foreign aid through appropriate measures to enable Afghanistan develop sustainably in the long term</i>
Indicators:	41. Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 42. Proportion of bilateral ODA of OECD/DAC donors that is untied 43. ODA received as a proportion of its GNI 44. Proportion of ODA provided to help build capacity
Target 16:	<i>Develop an open, rule-based, predictable, non-discriminatory trading and financial system includes a commitment to good governance, development and poverty reduction</i>
Indicator:	45. Percentage of total export to countries with which Afghanistan has a preferential trade agreement
Target 17:	<i>Develop and implement strategies for decent and productive work for youth</i>
Indicator:	46. Unemployment rate of young people aged 15-24 years, each sex and total
Target 18:	<i>In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries</i>
Indicator:	47. Proportion of population with access to affordable essential drugs on a sustainable basis
Target 19:	<i>In cooperation with the private sector, make available the benefits of new technologies, especially information and communications</i>
Indicators:	48. Telephone lines and cellular subscribers per 100 population 49. Personal computers in use and Internet users per 100 population
GOAL 9:	<u>Enhance Security</u>
Target 20:	<i>Reform, restructure and professionalise the ANA</i>
Indicator:	50. Security and defence spending as a percentage of GDP comparable to other countries emerging from conflict and with similar threat levels
Target 21:	<i>Reform, restructure and professionalise the ANP</i>
Indicator:	51. Citizens' confidence in the ANP's ability to provide security and access to justice comparable to other countries coming out of conflict. Indicated initially by increased numbers of complaints, subsequently by reduction in numbers of complaints that are substantiated and finally a reduction in the need to make complaints
Target 22:	<i>Disarm, disband and reintegrate all non-statutory armed groups by end 2010</i>
Indicators:	52. Reduce or forcibly disband 60% of illegal armed groups by end 2005 53. Reintegrate 90% of those disbanded into society by 2010 54. Citizens report 90% reduction of intimidation and coercion by illegal groups by 2006
Target 23:	<i>Destroy all mine stocks by 2007 in accordance with legal commitment to Ottawa Land Mine Treaty 2003</i>
Indicators:	55. Canton all non-government held heavy weapons by 2006 56. Reduce the number of communities to be negatively impacted by the effects of mines and unexploded ordnance to zero by 2015
Target 24:	<i>To implement an effective national counter-narcotics strategy by end 2005</i>
Indicators:	57. Reduce by 75%, by 2015, the area under poppy cultivation 58. Reduce % of farmers reliant on poppy for their livelihood by 50% by end 2006

Source: Afghanistan's 2020 Vision. Achieving the Millennium Development Goals. Draft Outline for the MDG Report 2005. July 2005.

MoPH Organogram

