Annual Report 2005

World Health Organization
AFGHANISTAN

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Primary Health Care

1. Introduction

Although evidence in health gains in Afghanistan is still limited, the government has made significant progress in certain areas. The Ministry of Public Health MoPH has been able to assert its stewardship in the health sector. Nonetheless, coordinating the large number of donors and health supporting agencies still remain a big challenge. The MoPH in its stewardship role recognizes the importance of developing the necessary capacity for coordinating donor's efforts and monitoring the health care services provided through contracting NGOs and through its own Strengthening Mechanism (SM) initiative implemented in selected provinces.

The role of the ministry at present has dual features, i.e. providing leadership and delivering health services. The latter is confined to mostly provincial and national hospitals. Moreover, the ministry is engaged in delivering Basic Package of Health Services (BPHS) at the district level of three provinces out of the 34 provinces known as "the Strengthening Mechanism Project". The contracting-out initiative remain the overarching strategy for increasing basic health services. The government is satisfied with the initiative and do not anticipate any alternative mechanism for delivering health care services in the near future.

Providing services in the form of a defined package through out-sourcing was seen as a quick fix for expansion, efficiency and coverage of basic services. Hence, the progress made in 2005 alone was indeed remarkable. The ministry estimated that 77% of the total population has access to the basic package. The number of provinces with functioning facilities increased from 60% to 73% followed by a significant increase of the number of female staff particularly in remote areas from 25% to 65%. The increase of female health workers is commended by the government and its partners, and it has been described as a major success against one of the biggest challenges facing the health sector reconstruction.

The contents of the BPHS being delivered to the population in the rural area does not in fact cover all the health care needs but it addresses the major cause of morbidity and mortality with focus on maternal health and child health . Immunization coverage has significantly increased which is a proxy indicator for access and apparently the utilization of services. Nonetheless, there are enormous differences with respect to performance of the health care delivery system between the 34 provinces. The majority indeed requires further consolidation of efforts in organization of services, in mobilizing community participation and in monitoring the program implementation.

2. Programme Objectives

Overall: The national health policy articulated that Afghanistan would pursue the concept of primary health care to ensure that quality services reach the needy at an affordable cost. The policy has categorized the priority areas into three major headings:

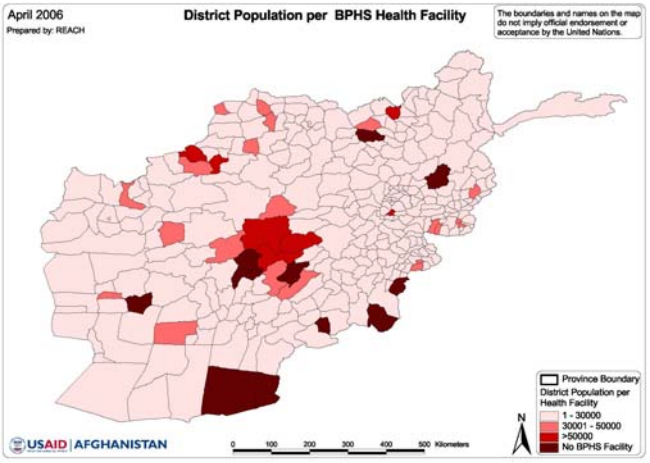
i) Service delivery: this refers to the implementation of BPHS and Essential Package of Health Services (EPHS), Promotion of greater community participation and establishment of prevention and promotion programmes.

ii) Reducing morbidity and mortality: this one associates improving the quality of maternal and reproductive health care, improving the quality of child health initiatives, strengthening the delivery of cost effective integrated communicable diseases control programmes and reducing prevalence of malnutrition.

iii) Institutional development: intends to promote institutional and management development at all levels, focus on human resource development, strengthening the planning, monitoring and evaluation functions, initiating health financing and national health accounts, establishing quality assurance and lastly develop and enforce public and private sector regulations and public health laws

Specific Objectives:

- Continue the delivery of selected primary health care services or in other words packaged services (BPHS) to cover all districts
- Launch the EPHS with the purpose to provide and strengthen referral systems in support to the BPHS
- Build the capacity of the provincial health management teams (PHMTs) to ensure capable leadership at this level
- Establish provincial public health coordination mechanisms to rationalize efforts and resources and to support the District Health Management Teams (DHMTs)
- Continued efforts in improving Health Management Information system (HMIS) to collect proper data and use it by all concerned for appropriate decision-making.



4. Programme achievements:

a) At Central or National Level

The MoPH specialized unit for the contracting of primary health care services, known as the **Grant and Contract Management Unit (GCMU)** has acquired extensive experience in management and leadership of the contacting initiative. The unit is responsible for soliciting project proposals from NGOs, evaluating the technical as well financial components of the proposals, selecting eligible NGOs to deliver the health package and to monitor implementation. The process is quite tedious and requires support from other partners. WHO and experts from funding agencies have participated in USAID-supported Performance Partnerships Grant (PPG), which is the largest donor of the external assistance to the health sector. In addition, the GCMU have been able to appropriately manage and monitor other grants provided by the World Bank (WB) and partly by the European Commission (EC). In summary, the ministry has succeeded to build its capacity to deal with donors, coordinate the assistance, manage huge public health projects and take ownership of the health system reconstruction.

The HMIS Unit is dedicated to collate key health data that emanate from district and provinces and use it for planning and for intervention. Over the last few years, the unit has transformed into a huge data-base that functions as the grand memory chip of the ministry. In order to avoid delays, the unit receives a copy of the data from the implementing NGOs on periodic basis and analyzes the data thereafter. The main onus of the unit is to provide feedback to the provinces so that data is not just collected but it is used for decision-making and for making choices with respect to programme implementation. The HMIS unit is only receiving data from the BPHS's project being executed by 35 NGOs throughout the country. It develops district health mapping to demonstrate the profile of the

districts including the demographic values. The data in this unit is also available to all partners, including donors for their use.

The Essential Drugs Unit is very vital to the overall health system in the country. While pursuing its specific mission and working side by side with other departments, it has been instrumental in reviewing, formulating and finalizing the national Essential Drug List (EDL) as part of translating the national policy into concrete action. The EDL has been endorsed by the government and was communicated with health partners. The availability of quality drugs, especially in primary health care services has dramatically improved over the last three years. Some donors are directly responsible for procuring medicines from outside to health projects. The quality test laboratory in the ministry has been capable of performing quality test and indeed providing in-service training to its staff. The National therapeutic Committee (NTC) which was formed in 2003 has been functional and was fully responsible in reviewing and updating the essential drug list and treatment protocols. Training on rational drug use for health workers was organized and conducted in many provinces.

The Human Resources Development is deemed as the engine of the health care delivery system in any country. Afghanistan government has focused not only the advancement of training human resources but it has exercised significant efforts on human resources management process. The application of Priority Reform and Restructuring (PRR), which is a merit-based selection method of public health cadres and programme managers, has made the ministry quite distinctive among all line ministries. The government acknowledged the performance of the MoPH and recognized them as a model in the application of the PRR process. It is an-going initiative applied to all government institutions to ensure that competent managers are put in place.

The HRD has revised the national policy through a broader consultation with relevant stakeholders. WHO has fully supported the process and is engaged in providing technical as well material support in collaboration with partners. Curriculum development for nurses and allied science was at the center of all efforts involved in professional development. Competency-based curricula, faculty development and educational standards were taken into account. This endeavor deemed as the backbone of the capacity building initiative was quite successful. Other key areas such as educational policy, accreditation of schools and clinical standards have been accomplished.

b) At Provincial Level

The capacity building initiatives at provincial level has acquired a great momentum in 2005. Health supporting agencies developed the mechanism and the technical approach to building the capacity of the MoPH which inter alia included:

- Assist provincial public health offices in developing health services ownership, participatory decision making, planning, monitoring and supervision.
- Establish and strength Provincial Public Health Coordination Committees (PPHCC) as forums for sharing information and coordinating activities
- build and strengthen skills in using HMIS for planning and decision-making
- Support two-way information flow between field and policy-making levels
- USAID-REACH project implemented Fully Functional Service Delivery Point (FFSDP)—a standard-based-evaluation and needs-based-technical assistance tool to improve delivery of quality primary health care at the health facility
- Facilitate decentralization of the health care system

With the technical and financial assistance of USAID-REACH project, the main achievements in 18 provinces included:

- Development of provincial planning process and three year provincial health plans in 18 provinces for 950 NGO, MoPH central and provincial staff and community members

- Developed and implemented PPHCC action plans to improve family planning and immunization coverage
- Trained 308 NGO, central and provincial MoPH staff in FFSDP in 219 NGO health facilities
- Trained MoPH and NGO grantee staff in HMIS data use
- Rolled out provincial HMIS in all 13 REACH provinces, installed HMIS data in 11 PHMTs
- Installed an HMIS HUB in Herat PHMT.

c) At District Level

The District Health Management Teams (DHMTs) supported by implementing NGOs has improved their quality management. The REACH project conducted a study in which they found that the overall service delivery point (health facilities) at the district level have significantly improved. Almost all districts have functional DHMTs with clear workplans, and monitoring system. The study was conducted in 76 health facilities of which 42 were Basic Health Centers (BHCs) 32 Comprehensive Health Centers (CHCs) and 2 First Referral Hospitals or District Hospitals (DHs). Out of the 76 facilities, 58% were found to have an appropriate delivery room. 89% of all facilities have adequate clinical waste disposal system, 42% of all facilities have the full required female staff, and 56% of the 76 facilities have the required number of midwives. On staff training, out of the 76% health facilities evaluated 89% of the facilities keep a copy of the staff training needs assessment report.

Significant improvement has been made on HMIS report, mapping and catchment area map. Identifying the various geographical sections of the health facility (HF) catchment area with provider responsible for the delivery of services is done in 87% of HF evaluated. 94% of HFs are formally partnering with Community health Committee (CHC). Out of the 76 HFs evaluated 92% had a referral register in place and 97% of the HFs have proper referral forms. On availability of clinical guidelines for major areas of BPHS, 50% of HFs have now a complete set of clinical guidelines related to BPHS. On monitoring coverage, 42% of HFs are now able to draw a monitoring coverage graph for key components of BPHS such as, Antenatal Care, Postnatal Care, TT vaccination, Institutional delivery, Family planning DPT3 and BCG.

The Community-Based Health Care System (CBHC)

The concept of Community Health Workers (CHWs) in support to the BPHS was seen as indispensable and has made tremendous achievements. It is an integral part of the health care delivery system. The health post which is the lowest level is run by CHWs. The process took quite a long time to carry out an effective reform in CBHC system. All the 28 NGOs implementing the BPHS are currently training CHWs using a new national CHW training manual. In fact, Afghanistan has moved away from using TBAs as formal or informal primary health care workers. However, TBAs can be trained as CHWs if they fulfill the selection criteria.

The CBHC framework is based on a trilateral system, where on one side the Shura or village council takes their role, the CHW on the second and the health facility on the third side. The key function of CHWs include: treating patients, IEC/BCC, environmental hygiene, MCH and Family Planning, Community mapping, participating monthly meeting, collecting basic data and referring patients to the health facility. The CBHC initiative has enabled the overall health system to improve the capacity of individuals, families, and communities protect their health.

The majority of health posts have a functional Shura-e-Sehie, the community maps assist the CHWs and the Shura to promote MCH & Birth-spacing services and literacy courses known as Learning for Life Programme (LLP) is widely accepted and implemented as part of CBHC system. One of the lessons learned in this system is the need for more female as well as male Community Health Supervisors (CHS) and great demand for literacy training.

Constraints

Not all districts and provinces have the same level of performance with respect to health care delivery. Majority of health facilities still lack adequate resources or support to deliver quality services. Remoteness and indeed security problems are of great concern. The latter has been deteriorating and expanding to more districts. Health workers have been targeted and delivery of health services has been seriously affected in these areas. There is still a great concern that security may still further deteriorate in this year and health workers may abandon the area.

Although the overall female recruitment in health facilities has improved, many districts still struggle with the unavailability of female staff. Some NGOs are recruiting female nurses and midwives from neighboring countries to cover their needs. The community approach and community support have greatly improved however the initiative is not smoothly working in some districts. Services have been expanding, more clinics have been constructed and coverage has increased. But appropriate utilization of these services is constrained by apparently distance of health facilities to the community, ability to pay fee for service, inadequate community awareness, unavailability of female health providers in many places and probably of some cultural limitations.

Basic Development Needs (BDN)

I. Introduction:

BDN is fundamentally a simple Community Based approach based on three aims: organizing the community, building its capacity and promoting self-reliance, self-management and self-sufficiency. In Afghanistan the BDN approach for sustainable socio-economic community development has been initiated since 1996, despite national wide instability and capabilities .

The BDN program in 2005 has expanded to 4 new villages and one new province in the country and has been strengthened in terms of community active participation, capacity building of the community, health promotion of the communities, reporting system and financial management.

II. Objectives:

A. Overall Objective: To Improve the health status of the communities through organizing local resources for development.

B. Programme Focus and Specific Objectives:

- To raise awareness among communities as well as the government authorities on self-help, self-managed and self-sustainable schemes for better quality of life;
- To promote participatory approach in an organized manner to integrated socio-economic development;
- To develop enter-partnership within the community for sustainable development;
- To encourage inter-sectoral collaboration among line departments for the support of health;
- To advocate for health as the core strategy for human development; and
- To realize the inclusion of BDN as one of the national development strategies in the national development plan.
- To encourage the communities to take proper participatory action toward the achievement of health for themselves and their families as well to solve their health related problems.
- To promote healthy lifestyles among the communities.
- To reduce the poverty among the communities and encourage and support the communities and the authorities to develop proper and sustainable strategies for poverty reduction.

III. Achievements/Activities:

The following table illustrates key programme activities and what has been archived.

A. Achievements at National Level:

No.	Activities	Achievements/Outputs
1	Conducted a national workshop on BDN concept, methodology and strategy for all the BDN provincial team members in Kabul.	•All the participants were briefed on the concept of BDN and its role in the promotion of socio-economical situation of the families and reduction of poverty. •The BDN Staff were specifically trained on reporting system and financial management of the BDN. •The BDN staff will be able to promote BDN implementation in their respective provinces in a better strategy.

2	Strengthened and consolidated programme monitoring and supervision activities.	• The National BDN staff was given on job training in the field. • The BDN staffs were trained on the reporting system. • The BDN staff were persuaded for doing proper financial management of the BDN program. • The communities were briefed to accelerate the loan re-imbursement process, which is basic element for the keeping of revolving fund in the community. • The VDC meetings in the BDN related villages were attended and the community members were briefed on the BDN concept. • The BDN staffs and the community members were specifically trained on sanitation and environmental issues.
3	Supported the CBHC (Community Based Health Care) department at the Ministry Of Public Health. An APW was issued for the CBHC Coordinator in order to support him with some incentive.	▪ The CBHC department of the MoPH will be able to initiate and strengthen the community based health care programs in the country.
4	One Proposal for funding was written and submitted to WHO EMRO	Some fund was approved by the EMRO at the end of 2005 and was utilized for the benefit of the program in the different areas.

B. Key findings during programme supervision and monitoring activities:

- The Village Development Committees in in all of 31 villages of the country were active and operational, holding their monthly meetings. The VDCs are the key part of the BDN in the village, they were supervised by our BDN team and they were given technical assistances. In some areas where the VDC members were not so much active, they were replaced with some good people by the community and they were re-organized. The VDCs regulary discussed the main problems of the community, but they were not much focusing on the health aspect of the community, so they were briefed by the National BDN Coordinator through his visits about this issue. Also the sanitation and the management of waste disposal was very poor in many villages, so it was discussed by the BDN teams in the VDC meetings and they were advised to pay proper attention to this issue.

- The portfolio process of the loans was strengthened in some areas such as Bamyan, Kabul and Nangarhar, some loans were collected and re-distributed to the other clients. Although it is still a challenging issues in some areas due to stream poverty and some other issues.

- Some refresher training workshops were organized on the PHC/BDN, health and nutrition for the capacity building of the VDCs, CRs and health staff in the BDN areas. The health staffs in the BDN related health centers along with the VDC and TST members were together trained on the BDN concept, methodology and PHC/BDN linkages. The CRs in most of the villages were trained on health, nutrition and their role on health promotion. They were briefed to work as a CHW in their respective areas and focus on hygiene and sanitation issues and report to the VDC members about any health problems.

- The establishment of fruit orchards project was completed by the joint support of WFP in WHO in Kabul and Ghazni BDN areas. Exactly it was an excellent project appreciated by the community.

- The partnership at provincial and district level was also good in most of the areas. The BDN teams had joint projects on fruit orchards, literacy, vocational trainings with WFP in Kabul,

Ghazni, Herat, Badakhshan and Bamyan and as well as some health joint programs with the NGOs implementing the BPHS and MoPH.

- The BDN program was supervised from time to time tri-laterally by the BDN National Coordinator, BDN team members and the VDC/TST members.

- Post-intervention surveys were conducted in some of the BDN villages like in Herat to know about the impact of the program; the result was compared with the base-line survey. The result of the survey was good, some significant achievements were gained.

C. Expansion of the BDN to new areas:

1. **New Provinces**: **Kandahar** was a new province where we became able to initiate the BDN program for the 1st time in Nov 2005 in Siddiqullah Qalachah of Dand district there. Actually the program was very difficult to start there due to some cultural behaviors and ignorance but after many discussions with the community the program was started. The community was organized, A VDC was formed, the TST, VDC and CRs were trained. Also some amount were given for the income-generation projects.

2. **Existing Provinces**: In the existing provinces where we had our program already, we expanded the program to some new districts/villages as follows:

   a. **Nangarhar**: We expanded the program to 2 new villages Bakhtan/Miran village of Surkhroad district and Vallayati village of Behsud district. TST, VDC and CRs were trained and organized, Also Some income-generation projects were supported in terms of loan distribution.

   b. **Bamyan**: the program expanded to Deh-Khudaidad village of Saighan district. The community was organized, the VDC, TST and CRs were trained, Also some income generation projects were supported in terms of loan distribution.

   c. **Herat**: the program expanded to Benafsh Darah village/Karokh district. The Community was organized, the TST, VDC and CRs were trained and also some budget was provided for the support of income generation projects.

Summary table of the BDN areas in Afghanistan

Region	Province	District	Village/area
Central	Kabul	Paghman	Chandal Baye
		Mosayee	Mosaye Ulia
	Bamyan	Markaz-e-Bamyan	Hyderabad
			Shah Fauladi
		Saighan	Deh-Khudaidad
Eastern	Nangarhar	Behsud	Tamirat
			Khushkunbad
			Abdian
			Wallayati
		Bati Kot	Char Dehi
			Ghazi Abada
		Chaperhar	Terilay
		Surkhroad	Bakhtan/Miran
Southeast	Ghazni	Deh Yak	Rabaat
			Kunder-Mehter
		Jaghatu	Jermatu
Western	Herat	Guzzarah	Rawza Bagh
			Tallas
		Enjil	Nawin
			Ghaizan
		Karokh	Qala-i-Sharbat
			Benafsh Darah
Northeast	Badakhshan	Argo	Wahdat
		Faizabad	Layaba
			Deh Kalan
			Chatta
		Yaftal	Naland
		Bahark	Dashti Ferakh
		Jurm	Nawi Jurm
		Shuhada	Jui Bar
Southern	Kandahar	Dand	Sidiqullah Qalachah
6	7	20	31

IV. Some Vital Statistics on the BDN Achievements

The following table shows some vital statistics achieved during 2005 only in BDN targeted areas:

- The enrollment of eligible children (5 -12) in school has increased from 53% to 74%
- The percentage of Pregnancies assisted by trained birth attendants increased from 29% to 59.3%
- The immunization coverage in the children of under 1 year has increased from 26% to 65.8%.
- The malnutrition rate among children under 5 years has been reduced from 11% to 5%.
- The number of Youth gained skills has increased from 187 to 949.
- The Female literacy rate has increased from 4% to 12.4%.
- The number of families having access to safe drinking water has increased from 4746 to 11000.
- The IMR (Infant Mortality Rate) has decreased from 102/1000 to 64/1000 liver births.
- The monthly average income of the families has increased from 23 US$ to 47 US$.
- The number of families benefited from the BDN Program has increased from 3,179 to 5,500.
- The coverage of TT immunization among pregnant women has increased from 12% to 39%.
- The number of families using sanitary latrines has increased from 4,075 to 7400.

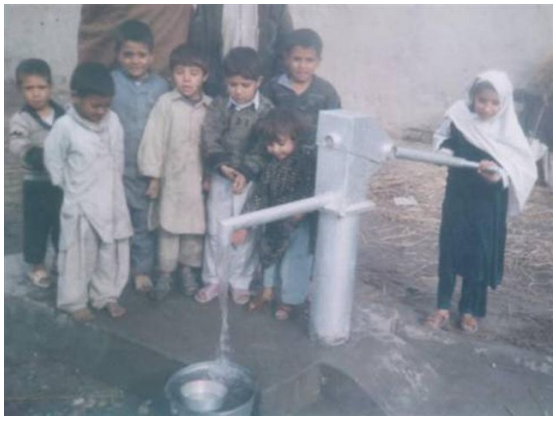
Note: All the above information has been collected from our baseline survey while we started the BDN program and from the post-intervention surveys, reports of the VDC, CRs and the health centers in our BDN Villages) and furthermore all the above information is only related to the villages where BDN is implemented

VI. Constraints

- Lack of ownership of the program by the government
- Weak loan recovery due to extreme poverty in some communities.
- Difficulties in transportation and security situation.
- Personal preferences, especially by influential people of the communities, at the time of listing the priority basic needs on some occasions
- Lack of fund to support large social and Income-generation projects.
- Low motivation of the communities to work voluntarily.

Photos taken from the BDN areas in Afghanistan during 2005

Tailoring Training Course for the empowerment of women in Hyderabad village/Bamyan



A bore well with hand pump installed by BDN in Abdian village/Behsud dist. Nangarhar

A Health Post run by BDN/Community in Kunder village/Deh Yak district/Ghazni

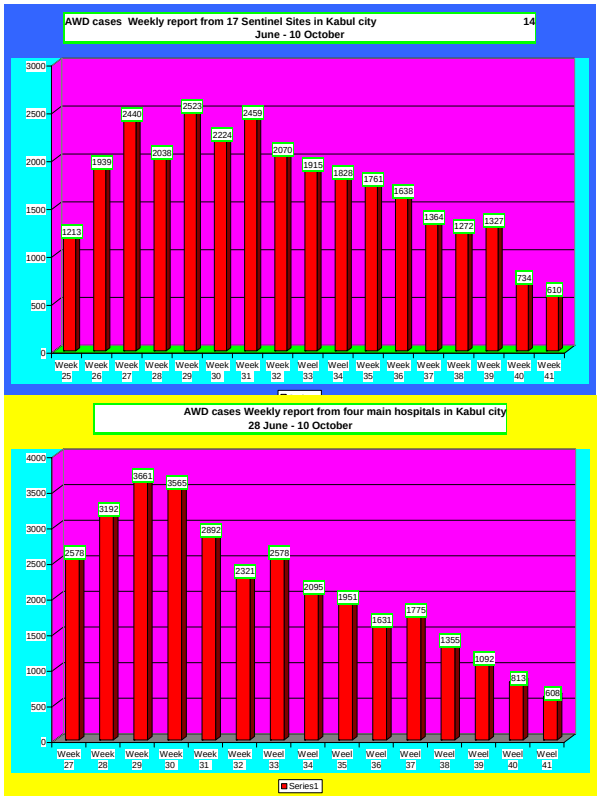
A joint WHO/BDN/WFP project in Jurm district of Badakhshan. The food stuff is distributed to the trainees of literacy training course.

Emergency & Humanitarian Action/ Communicable Diseases Surveillance and Response

Background:

Emergencies or natural and non-natural disasters are a daily or regular problem in Afghanistan. Outbreaks of epidemic prone disease like acute watery diarrhea/cholera, acute respiratory infections (AWD), whooping cough, measles, and diphtheria are almost permanent threats for the Afghan population.

Natural disasters like earthquakes, floods, avalanches, landslide, sand storms and droughts strike the country since decades. The victims of earthquake in Rustaq, Shahribuzorg and Nahrin districts in 1989, 1999 and 2003 has killed 7500 people and caused high number injured and homeless. Man-made disasters like land mines; fires, gunshots and rockets are still threat the live and health of the people. Suicide attacks added to the security threats even if the peace building process has taken enormous steps since last few years. Since 2003 totally around 3,570000 refugees returned home (UNHCR assisted returnees). Around 40,000 IDPs still exist. Majority of IDPs are living in IDPs camps in the south and southeastern part of the country. 23% of the total population of the country is still uncovered by the basic package of health services (BPHS). Remote and mountainous areas become isolated in winter due to heavy snowfall. Some of these areas have not access to health service delivery in winter and the only possible intervention is deploying emergency health teams by aircrafts. MoPH Afghanistan successfully responded such emergency situation in 2005. Coordination of emergency preparedness and response has the key role in humanitarian emergency assistance. This coordination has been successfully achieved through provincial emergency preparedness and response taskforces all over the country in 2005. Partners like WHO MoPH Unicef and BPHS implementing NGOs has the membership of this taskforces. WHO had the main coordinating and leading role for emergency preparedness and response.



Goal:

To decrease mortality and morbidity from disasters and health emergencies/diseases outbreaks.

Objectives:

To strengthened national capacity for effective disaster preparedness and response

To strength the capacity of MoPH for timely outbreaks investigation and response

Achievements:

During the summer, outbreaks of diarrheal diseases/Cholera affected >140,000 people and killed 160 persons. Due to poor water sanitation system, lack of resources for applying effective control measures the disease has rapidly spread to the different province and has taken longer than expected. The case fatality rate was very low and case management was effective. The surveillance figures of AWD in Kabul are inserted below:

WHO conducted refresher trainings on AWD surveillance, AWD/Cholera case management and hygiene education/communication for the chlorination teams. Totally around 100 health staff of MoPH has trained. In addition to that WHO supported sample collection, transportation and lab confirmation of cholera cases. The hygiene education/communication and chlorination campaign was also supported by other partners e.g. Unicef, MSH-REACH and other NGOs. ARI is one of the two main killers of Afghan population (ARI and AWD).

The financial balance was minus for EHA in 2005. WR Afghanistan used other sources for emergency response. One NEHK, 20 Cholera kits, 40 Pneumonia kits with some additional antibiotics (Erythromycin) supplied by WHO regional office and HQ.

The outbreaks of Measles and Pertussis was also reported but the extent of the problems were limited and local health authorities could cover the situation by the support of NGOs and international organizations working in field. Rabies was another important health concern in 2005. WHO provided around 4000 vials rabies vaccine and 15kg strychnine. Anti rabies vaccine has used for post exposure prophylaxis and strychnine was used for stray dogs elimination by MoPH in coordination with other partners e.g. WFP, Municipality.

Deworming campaign was another important activity in 2005. This campaign was jointly supported WFP and Unicef and WHO. Our contribution for the deworming program was training of the national and provincial deworming focal points and provision of 1000,000 tablets of Mebindazole 500mg. Totally 5,424,022 school age children has treated in 2 rounds of dewormin campaign.

The government of Afghanistan assigned national commission for the preparedness and response of Avian Influenza. Two subcommittees are working under the national commission (technical committee and financial committee). WHO has membership of the national commission and the technical committee. WHO has played key leading role in the AI preparedness and response. Ministers of Public health, Agriculture and the director of national environmental protection authority, MoI, MoD, MoF, ministry of Information/culture and Municipality of Kabul has the membership the national commission. The technical working group started their work in September 2005 and developed the AI preparedness and response national plan.

The HMIS training for the provincial HMIS focal points jointly supported by WHO and MSH-REACH. The following national health taskforces actively participated by WHO: HMIS taskforce (a proposal has submitted to Health Metric Network project/EMRO and $150,000 has approved to be used for strengthening HMIS in Afghanistan), Hospital management taskforce (Developing EPHS and Hospital reform projects are the main achievements), Hospital Infection Prevention taskforce (developing the national policy/strategy on hospital infection prevention and control is one the main achievements), Water sanitation taskforce, and emergency preparedness and response taskforce. The healthy school and school in health component of the UN joint program are also technically supported.

Partnership and coordination:
WHO has played strong coordination rule for emergency preparedness and response. To respond emergency WHO and MoPH had close coordinated efforts with all involved stakeholders. Existence of provincial emergency taskforces is a good example of this mechanism. During the emergencies we were able to mobilize resources from other sectors and organizations like Unicef, NGOs and different governmental ministries through close coordination. The role of community was also considered in all coordination mechanisms especially during situation assessment and response.

Challenges and constraints:
Since mid 2004 EHA has faced serious shortage of resources. For emergency response WR Afghanistan and EMRO and HQ supported some of our important and life saving activities. This response was in terms of provision of some supply and fund.

At the government side we have trained many staff in side and outside the country by conducting training workshops and courses. Due to lake of enough salaries many of MoPH staff at medium level and some of them at low level lost their jobs and joined other organizations. The government almost always relies on the resources of international organizations especially for the provision of emergency health supply and cost of the emergency response operations. MoPH has developed two important strategies for the health service deliveries by the name of BPHS (basic package of health services) and EPHS (essential package of hospital services). These services are mainly providing by NGOs through contract in and contract out mechanisms. The EPR parts in theses mechanisms considered weak. The available resources for BPHS and EPHS can meet the routine needs. For emergency response the need from international organizations/community is still huge. A long time is needed to over come on this dependency.

EPI

Introduction / background

After 22 years of socio-political upheaval, the DPT3 coverage rate in 2001 was 37%. From 2001 to 2005 routine coverage has shown an overall upward trend of DPT1 up to 85% indicating improvement in access to health services.

Indicators	2001 (%)	2002 (%)	2003 (%)	2004 (%)	2005 (%)
DPT-1	55	58	65	81	85
DPT-3	37	47	54	66	77
Drop-out Rate	19	18	18	17	14

Program goals / objectives

The table below provides a comparison of the program objectives for the EPI Multi-Year Plan of 2001-2005 and the progress on realization of the objectives by end of 2005.

The objectives of the Ministry of Public Health (MoPH) for the EPI Multi-Year Plan of 2001-2005 were:	The status of progress in achieving each of the objectives by end of 2005 is summarized below:
1. To achieve and sustain 80% coverage of childhood immunizations of all antigens (DPT-3) among children aged 0-11 months by the end of 2005.	1. Routine coverage gradually improved and reached 85% DPT1 and 77% DPT3 in year 2005.
2. To interrupt poliovirus transmission in the country by the end of 2004	2. Lowest number of polio cases (4) was achieved in 2004 and transmission is localized to the Southern provinces but there were 9 polio cases in 2005.
3. To eliminate neonatal tetanus by end of year 2005 in at least 80% districts of Afghanistan.	3. Coverage of pregnant women with TT2+ increased in 2005 in 317 districts and number of recorded cases dropped dramatically from 95 in 2004 to 41 in 2005.
4. To reduce measles morbidity rate by 33% and mortality by 50% by the end of year 2005.	4. Campaigns in 2001-2003 had appreciably reduced the number of reported measles cases to 559 in 2004 but due to continued low routine coverage, 8 measles outbreaks were recorded in 2005, with total cases 699.
5. To introduce Hepatitis –B vaccine in EPI by the end year 2005 under the GAVI initiative.	5. Preparation for introduction of Hepatitis B vaccine (DPT-HepB) by January 1, 2006.

Key program achievements in 2005

The main achievements in 2005 can be summarized as follows:

1. Management and capacity building:

(Please see below for partnership and coordination.)

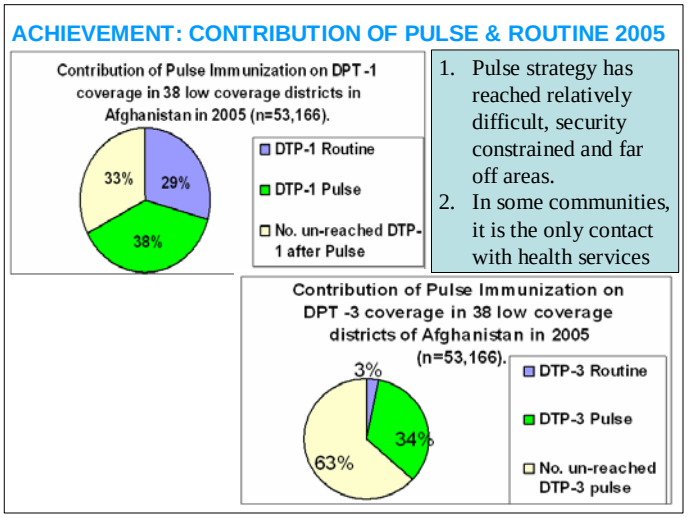
- District micro-planning of routine EPI in 301 districts (91.4%).
  - Refresher Training Courses for (497) vaccinators on EPI and safety of immunization injections, safe waste disposal and detecting and reporting of AEFI
  - Strengthening of Supportive supervision by using a standard tool for supportive supervision in (171) districts. The analysis of the checklist shows out of (232) supervisory visits (83 %) of EPI centers were following safe injection practices as per WHO standards and injection safety National policy.
  - Developing Standard operation Procedures for vaccine management and conducting vaccine management training courses for (66) staff including DPT-HepB topics.
  - Production, distribution of EPI posters and calendar with EPI messages.

- The Hepatitis B vaccine combined with DPT is to be introduced in mid 2006.
  - Brochure on DPT-HepB vaccine in local languages for health staff has been developed.

- Calendar with clear messages on safety of immunization injection and safe waste disposal (14 messages and pictures) in local languages developed and printed (10,000 copies) and distributed to all vaccinators and health facilities.

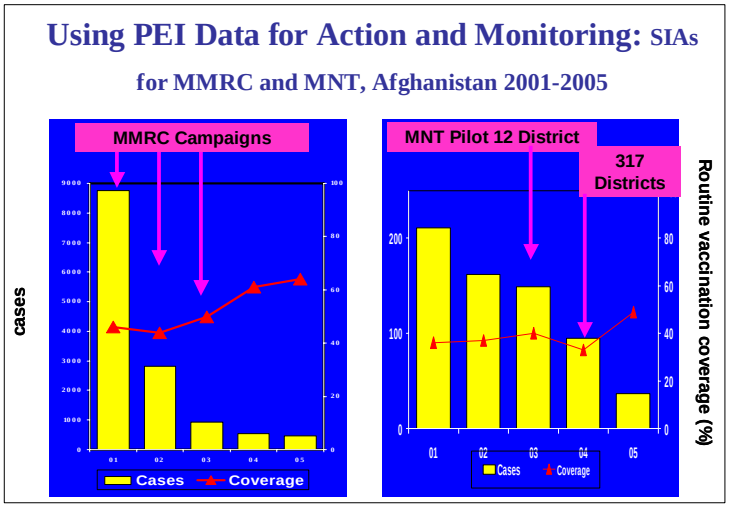
2. Service Delivery

- Conducting successive rounds of SIAs for polio eradication
- Increasing routine immunization coverage of DPT3 in 38 districts, classified as hard-to-reach and un-served areas, from 3% to 37% through implementation of RED (Reach Each & Every District) approach and introduction of pulse immunization.
- Introduction and conducting pulse immunization in (52) districts.
- Expansion of EPI centres from 871 in year 2004 to more than 1000 centres in year 2005.
- Strengthening cold chain system: Construction of provincial vaccine storage facilities by the support of UNICEF.
- Strengthening immunization safety: All EPI centers/ teams provided with required number of AD syringes and safety boxes (UNICEF support). 100 % of EPI teams are using AD syringes for vaccine injections.



3. Surveillance and data management

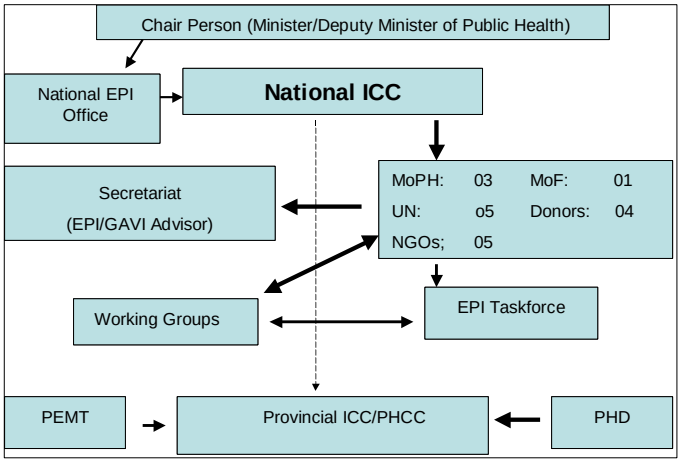
- Active surveillance of AFP through experienced and high quality network
- Using AFP Surveillance Network to document reduction in cases of Measles and NNT as response to MNTE and MMRC activities and requirement for future activities.
- Improve EPI data management and provision of feedback to the provinces.
- Establishment surveillance system for of Adverse Events Following Immunization (AEFI).
    - .AEFI surveillance guidelines translated in local languages and printed/ distributed.
    - 312 focal points, 81 provincial EPI management team managers and supervisors have been trained on AEFI immunization surveillance and safety of injections.



- Progress toward Measles case based surveillance; Development of Measles case-based Surveillance guidelines; Establishment of first Measles Lab in Kabul.
- Training courses on Measles case-based surveillance and surveillance of AEFI held for (393) focal points, PEMT managers and supervisors. Initiating lab-based measles surveillance and case-based reporting

Partnership and coordination

- The National Interagency Coordination Committee consisting of different government line ministries, UN agencies and donors continues to meet regularly to decide on EPI policy and planning issues.
- Regional EPI Review workshops were held in all regions and a National EPI Consensus workshop with active participation of line ministries and donor and NGO communities.
    - Consensus on strengthening of integrated approach with focus on provision of integrated child survival intervention both in BPHS (Basic Package of Health Services) health facilities (one point services delivery) and at the community level (sustainable outreach and joint intervention). Pilot implementation of the approach in MoPH Strengthening Management (SM) project.
    - Through advocacy meetings with donors and involvement of donors in the exercise the EPI Financial Sustainability Plan was revised and accepted.



- MoPH- Afghanistan submitted a proposal to GAVI for support for introduction of DPT-Hep B vaccine in immunization schedule. All conditions for approval of the proposal such as provision of realistic target and indicators and major revision of FSP were met and the proposal was approved.

- MoPH has received the GAVI reward for increased DPT3 coverage every year since initiation: 2003, 2004, and 2005.

Challenges/ constraints

Afghanistan National Immunization Program achieved 85% coverage with first dose and 77% coverage with three doses of DPT in year 2005.

- These data reveal that the problem of **access** still exists in about half of the provinces, which have reported DPT-1 coverage of less than 80% in year 2005. Better micro-planning and more investment of financial and human resources are needed to improve access to address the limited number and poor distribution of EPI centres and the low number of vaccinators (one vaccinator per 14000 population)
- Effective Information Education and Communication (IEC) strategies are also needed to tackle the problem of **utilization** evidenced by the high drop out rate across the country with only 22% of the districts achieving 80% or better DPT3 coverage rate.
- Both access and utilization as well as responsiveness could improve through further **decentralization** and strengthening of Provincial/District management functions (administration, planning, logistics, training, supervision and monitoring) and supporting Provincial/District structures to maintain as well as expand service delivery through the fixed points, outreach and Pulse/SOS/ operations. One point service delivery approach (both in fixed and outreach sites) should be supported.
- Strengthening of **cold chain** system through establishment of vaccine storage facilities at the provincial level and proper planning for replacement of old equipment and responding to assessment for certification of national cold chain storage should be undertaken.

Integrated Management of Childhood illnesses (IMCI)

Summary Report of the Expansion Phase in Afghanistan

Introduction and background:

The ministry of public health of Afghanistan together with its national and international partners strive to implement the Basic package of health services (BPHS) which is the main vehicle for health service provision in Afghanistan, it include interventions to achieve the health priorities. Reducing the child morbidity and mortality is one of the top priorities and to overcome with this matter the WHO and UNICEF's Integrated Management of Childhood Illnesses(IMCI) strategy which is one of the most important elements of BPHS, was introduced to the ministry of public health in April 2003. The MoPH issued a policy statement adopting the IMCI, and its steering committee, an IMCI working group and an IMCI central unit was formed.

IMCI addresses the management of acute respiratory infections, diarrhea, malaria, measles and malnutrition, which are the main factors responsible for the high mortality and morbidity among children under five years of age. In addition, this strategy combines curative, preventive and promotional strategies to effectively combat with the issues affecting the well-being of children in facility and community settings. IMCI leads to improved identification of illnesses in health care settings, ensures appropriate and where needed combined treatment of these major illnesses, and rationalizes referral of severely sick children. In addition, the approach incorporates significant disease prevention through promotion of key family practices and enables the caregivers to accurately manage children when they need home care for illnesses.

Achievements:

This report is intended to present progress made in IMCI during the year 2005. To implement IMCI after the introduction phase seven clusters/districts were selected for the early implementation phase which was finished in November 2004. The Ministry of Public Health decided to review this phase. the review took place during the period 18-27/12/04. the review objectives were: to assess how well Afghanistan was able to implement its plans and intentions, identify the main problems and feasible solutions, identify ways to strengthen and sustain IMCI implementation as a main strategy to improve the quality of care for children and summarize lessons learned in the early implementation and produce a set of recommendations for the expansion phase. During the review a three years (2005-2007) draft plan for IMCI expansion prepared and it has been decided to expand IMCI in seven provinces plus 13 provinces which was committed for IMCI implementation by USAID/REACH

1.1. Improving health workers skills:

IMCI central unit decided to expand IMCI in seven following provinces during expansion phase these are as follow:

1: Kabul 2: Nangarhar 3: Maidan 4: Parwan 5: Balkh 6: Laghman 7: Kapisa

Later on it has been decided to remove the Laghman and instead add the Panjshir province in the action plan. the reason was that the implementing NGOs in the Laghman province were not ready for IMCI implementation. Based on decision taken in review workshop 37 of trainings planned to be conducted by IMCI department during the year 2005 in selected 7 provinces for expansion. During expansion phase IMCI central unit a long with other partner provided technical support and to date 415 health workers working in the health facilities have been trained by IMCI department. Nine facilitation technique training courses conducted in which 82 potential facilitators received the facilitation technique training course and 58 facilitators received follow up after training. During the expansion phase the generic training materials were used to train health workers, IMCI case management courses were conducted as planned and 90% of the health facilities in the expansion areas have at least one trained health worker. The health workers working in Kabul, Nengarhar, Parwan, Panjshir , Wardak and Kapisa provinces received follow up after training visits with feedback given.

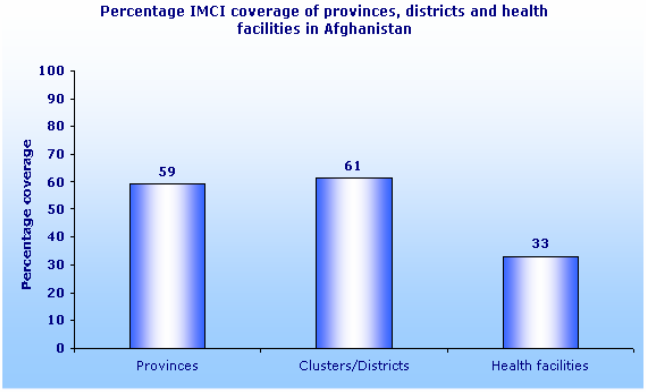
WHO supported technically and financially the 11 days case management courses for Kabul provinces.

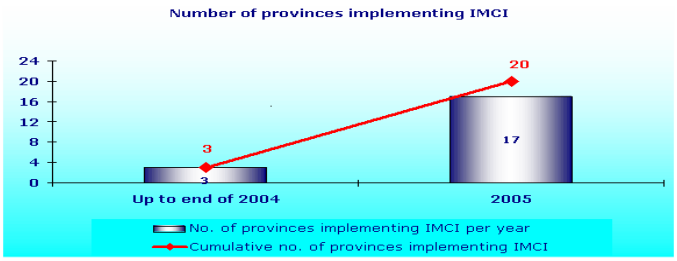
The following table presents the Number of health workers trained in IMCI case management:

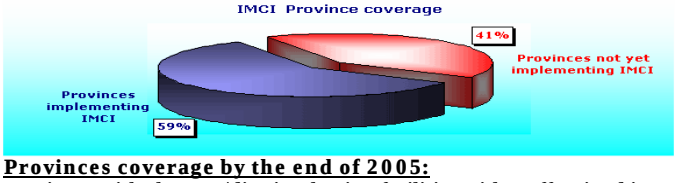
Implementer Organizations	Provinces	# of Health workers trained in case management courses	# of Health workers trained in Facilitation technique training courses	# of Health workers trained in F/UP after training courses
IMCI central unit	Kabul	60	2	
	Nangarhar	43		
	Maidan-Wardak	62	7	
	Balkh	33	17	
	Parwan	48	11	9
	Kapisa	40	5	3
	Panjshir	21	6	6
Total		307	48	18

The following table presents the number of health workers trained by IMCI implementing partners(NGOs):

Implementer Organizations	Provinces	# of health workers trained in IMCI case management courses	# of Health facilities that have more than 60 % trained health workers
AKDN	Baghlan	58	28
	Badakhshan	42	25
	Takhar	51	39
IMC	Bamyan	34	13
	Ghazni	17	12
	Kabul	54	21
	Balkh	16	16
CHA	Farah	13	13
	Hearat	25	16
	Faryab	26	19
	Ghor	15	10
IbnSina	Paktya	63	13
	Paktika	25	10
	Kandahar	14	7
	Khost	12	9
Total		465	251





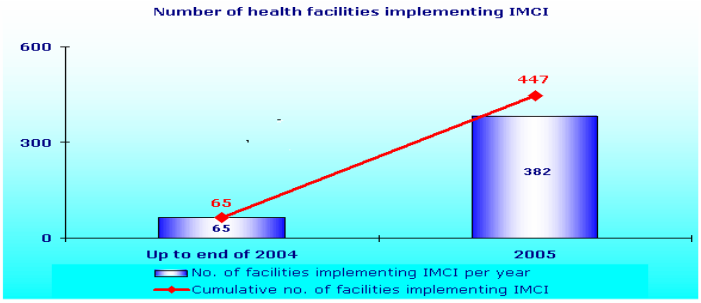


Charts show the IMCI coverage as of end of 2005:

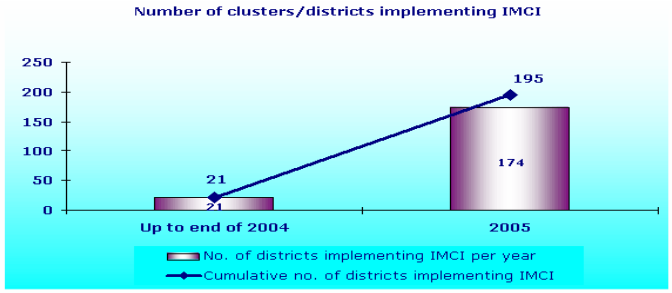
IMCI Coverage of provinces, districts and health facilities by end of 2005:

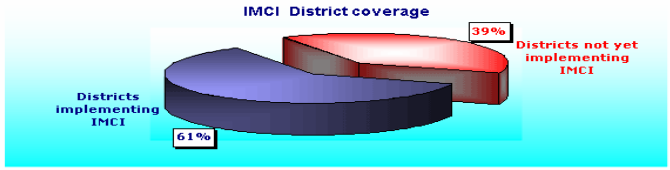
Provinces coverage by the end of 2005:

Provinces with clusters/districts having facilities with staff trained in IMCI



Health Facility Coverage by the end of 2005:
Out patient health facilities with health providers trained in IMCI





District Coverage by the end of 2005

1.2. Improving Health system:

All IMCI recommended drugs are included in the essential drug list. IMCI recommended drugs were available in most of the health facilities in the expansion areas. Drugs are free of charge in almost all health facilities and it has provided by the implementer NGOs.

1.3. Improving Family and Community Practices:

Although since implementation of IMCI in this component of IMCI there was not enough activities but based on the UNICEF's commitment to support this component a pilot project of C- IMCI with the support of Save the children of US save the children US in four districts of Kabul and Bulkh provinces implemented .
However the health workers dealing children in the piloted areas for C-IMCI trained on IMCI, there is a need for the activities to be systematical organized.

3. Conclusions:

Despite the challenges e.g. lack of fund during Expansion Phase 2005 the progress made during the year 2005 is satisfactory. This is more apparent in the training component activities, though most of the health facilities have not been followed up. It is required to have the real picture of IMCI implementation in Afghanistan thus, conducting follow up after trainings for the implementing partner NGOs and reinforcing the skills of health workers in their areas is necessary.
The IMCI pre-service, referral training and training of supportive staff is lagging behind due lake of fund.
There is need to revise IMCI package and some changes need to bring in the package.
The poor coordination between IMCI unit of MoPH and HRD caused to hire people as IMCI provincial focal points with out considering needed skills which were suggested by IMCI. However, efforts are in progress to tackle this issue and train them. The HRD department has taken the responsibility of building their capacity.
There is a great problem of timely submitting the reports by implementing partners to IMCI central office, though it was requested through official correspondence but the IMCI office couldn't receive complete reports from REACH, and most of the activities are based on the data collected during follow up after training rounds.
The C-IMCI pilot project is in progress it will be concluded in March 2006, however, the experience will be documented to be expanded.

IMCI expansion to other Province and to achieve National coverage by 2007 shall continue to 5-8 provinces per year. It is also quite crucial to keep quality while expanding. However, the availability of financial resources and managerial capabilities of the selected provinces and partners will determine the actual pace of expansion.
The suggested provinces to implement IMCI for the year 2006 are as follow:

- Logar
- Laghman
- Kuner
- Samangan
- Kunduz
- Sar-e-Pul
- Di-Kundi

Polio Eradication Initiative

Introduction:

Afghanistan is administratively divided into 7 regions and 34 provinces. Central, Eastern and parts of Western & Northern regions are among the most densely populated areas of the country. Lowest administrative division is the district. For the vaccination campaign Polio Eradication has developed the micro-plans dividing districts into Clusters. Each Cluster is managed by a Cluster Supervisor supervising 5-7 vaccination Teams. For AFP Surveillance purpose, PPOs are placed at the provincial level.

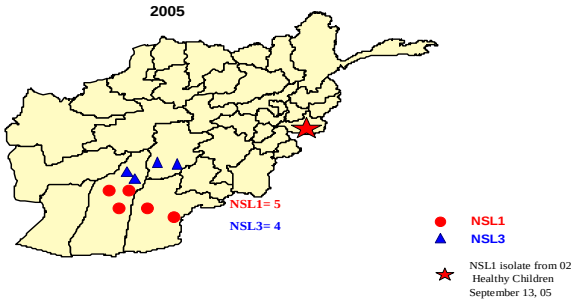
Each region is supported by team of International and National Staff. The team consists of International Technical Officer (STCs), Regional Polio Officer (RPO), Assistant Regional Polio Officers (ARPO) and Provincial Polio Officers (PPO). RPOs and ARPOs are mainly responsible for supervisory support while PPOs carry out the field activities related to AFP Surveillance and SIAs in their assigned provinces/districts. There are 7 STCs, 9 RPOs, 12 ARPOs and 63 PPOs distributed in various parts of the country to carry out PEI activities.

Polio virus Epidemiological Situation:

Afghanistan has made significant progress towards polio eradication and during year 2005 and first quarter of 2006; all the regions of the country are polio free except the Southern region which shows the localization of polio virus circulation in well defined parts of Southern region. In 2005, Southern region had evidence of type 3 (NSL3) in the first half and type 1 (NSL1) of polio virus in the second half of the year with occurrence of 9 confirmed polio cases (4 NSL3 and 5 NSL1). Last polio case of NSL3 type was from Musa Qala (Hilmand) with onset in first week of June 2005.

Figure 1

P1 & P3 Poliovirus Isolates-2005 Afghanistan

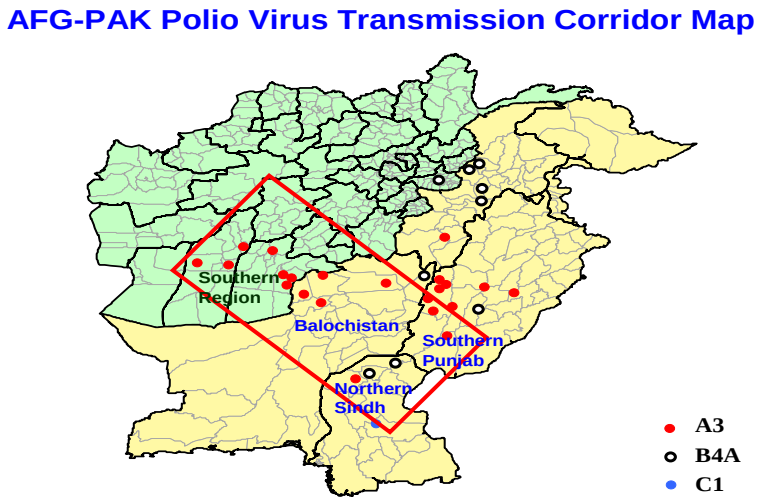


Circulation of NSL1 started with occurrence of first case on October 29, 2005 in Nade Ali district of Hilmand Province and this was followed by two more cases of NSL1 from Lashkargah and Sangin districts of Hilmand province with onset on November 6, and December 11, 2005 respectively (Fig 1). Two more cases of NSL1 were isolated from Spinboldak and Panjwai districts of Kandahar province with onset on December 16 and December 30 respectively.

Occurrence of NSL1 polio cases in series with an interval of few weeks in between reflects an epidemic situation in localized parts of Southern region. Genetic sequence study demonstrates a close link between transmission in the Southern Region and three transmission zones in Pakistan (the zone in Balochistan, the northern Sindh

transmission zone, and the southern Punjab zone). This transmission forms a single axis from southern Afghanistan, through Balochistan, to northern Sindh, with connections to southern Punjab (Fig 2).

Figure 2



Cross Border Coordination:
Afghanistan & Pakistan Polio Eradication programs are sharing the AFP surveillance data regularly every week Cross border notified AFP cases are investigated jointly. Focal points at the national and regional levels are identified and information is matched and updated regularly.
At the border crossing points, Torkhum & Spinboldak, vaccination teams are posted for the vaccination of the traveling children with their families.
Dates for the SIA activities are synchronized and the third day of the Afghanistan side and the first day of Pakistan campaign is same vaccinating the border populations simultaneously.

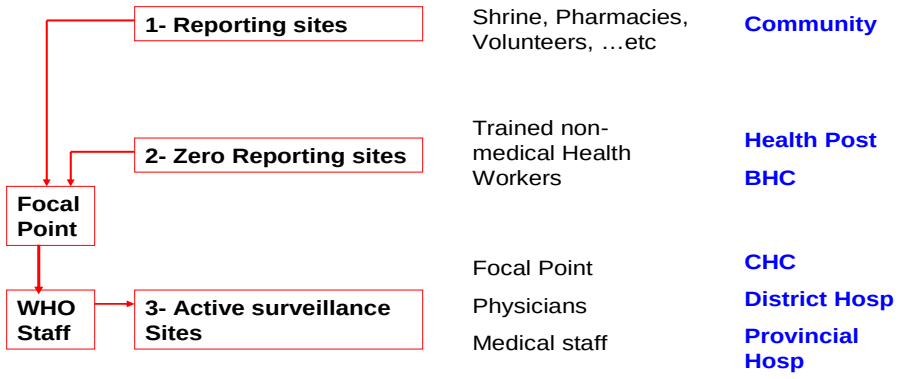
2. AFP Surveillance:

Health care services in Afghanistan are delivered through public and private sectors. Most of the health care services in public sector are provided by NGOs, in accordance to Basic Package of Health Services (BPHS), through Provincial hospitals, Comprehensive Health Centers (CHC) and Basic Health Centers (BHC). Private medical practitioners, Quacks, Faith healers and Shrine keepers are the main service provider in private sector. AFP surveillance network includes most of the main health care providers and is spread all over the country. Besides this, network also includes community based Reporting Volunteers including pharmacies, teachers, Mullahs and community notables (Fig 3).

Each district has at least one AFP surveillance Focal Point, who is usually the in-charge of Health facility or a pediatrician and is responsible for case notification, investigation, facilitating specimen collection and shipment process and submission of zero reports. AFP cases detected by health facilities, private practitioners or community based reporting volunteers (pharmacies, faith healers etc) are referred to concerned focal point in their district. Tertiary care hospitals and Provincial Hospitals usually have more than one focal point. Focal points are also responsible for timely notification of AFP cases to Provincial EPI Team including WHO PPO, who carries out the field visit in the area of residence of reported case for detailed investigation and to ensure that all steps of investigation are carried out by the focal points.

Figure 3

AFP Surveillance Structure Afghanistan
Community Based



Active visits are done by WHO staff and are prioritized according to number of attendance and whether it is inpatient or outpatient

Private sector could be in any of these groups

2.1 Characteristics of AFP cases

Expected annual number of AFP cases for Afghanistan was at least 155 while a total of 827 AFP cases were reported during 2005 compared to 688 AFP cases reported during 2004. Out of total 827 cases, there were 9 confirmed, 4 compatibles while rest were discarded as non polio. Of the total 9 confirmed cases, 4 had isolation of P3 type (NSL3) while 5 had P1 type (NSL1) of polio virus. All the confirmed cases are in the southern region of the country.

The characteristics of AFP cases (Table 1) show that all age groups were reported with range of 0-180 months. Comparison of median age for confirmed/compatible cases with non polio cases shows that the confirm cases were significantly younger than the non polio and had comparatively lesser number of OPV doses. Analysis by gender reflects that male and female AFP cases were reported in almost the same ratio (51:49) among non polio cases but there is predominance of male (60%) among the cases confirmed for polio during 2005.

Table 1

Characteristics of AFP
Confirmed , Compatibles and Non-Polio AFP cases

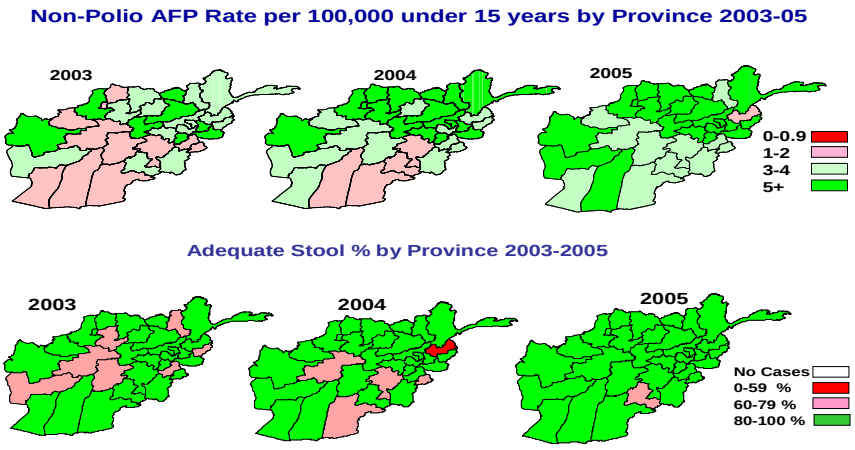
Criteria		Confirmed				Compatible				Non Polio			
		Y03	Y04	Y05	Y06	Y03	Y04	Y05	Y06	Y03	Y04	Y05	Y06
Age in month	Mean	39	30	23	19	21	30	52	-	56	53	51	52
	Median	21	27	20	18	16	N	23	-	40	36	36	36
	Range	7-120	16-48	10-42	10-30	13-40	24-36	7-156	-	0-196^	0-196^	0-180	0-174
Gender	M%	62	75	56	60	75	75	75	-	55	57	51	54
	F%	38	25	44	40	25	25	25	-	45	43	49	46
OPV Doses routin & SIAs	Mean	6	8	9	5	5	1	7	-	9	11	12	12
	Median	6	6	9	1	6	N	5	-	8	10	12	11
	Range	0-14	3-18	4-17	0-12	0-10	0-1	2-15	-	0-30	0-35	0-34	0-36

^ AFP cases with age more than 15 year = one in 2003 from Hirat & one in 2004 from Kunduz
N= No median could be calculated because count <3

2.2 AFP Surveillance Indicators:

Comparison of **Non Polio AFP rate** per 100,000 children below 15 years of age and percent of adequate specimens shows a substantial improvement from 2003 to 2005, at national, regional and provincial level (Fig 4). Although Southern region has shown

Figure 4



significant progress but the S**tool Adequacy** percentage of Zabul province remains below the desired level of 80%. The country has also shown improvement in other AFP surveillance indicators including **early case detection** while **% of specimens with Entero Virus and Sabin like virus** is also up to the mark showing the technique and process of stool specimen collection and shipment is of satisfactory level, in general.

Moreover, and in-depth analysis of surveillance indicators by province for Southern region (Table 2) shows that the age of AFP cases in Kandahar and Zabul province range between 11-156 months reflecting the possibility of missing some very young infants.

Table 2

Surveillance indicators 2004-2005 Southern Region

Prov	EXP	AFP Report		Non AFP Rate		ADEQ %		No of M/F		EV%		GBS No		Median OPV		Median Age		Age Range
Year		04	05*	04	05*	04	05*	04	05*	04	05*	04	05*	04	05*	04	05*	2005*
KDH	8	18	35	2.4	4.3	74	83	10/8	16/19	16	36	4	13	7	10	34	30	11-168
Hilm	10	25	57	2.4	4.9	100	87	15/10	31/26	32	20	10	15	8	10	26	30	1-108
Uruz	5	18	17	3	3.0	82	91	11/7	11/6	29	25	3	3	8	9	30	36	8-144
Zabul	2	5	10	2.1	5.0	80	70	1/4	6/4	40	11	0	2	9	7	23	44	11-144
Nim	1	3	3	2.7	3	100	100	2/1	3/0	0	0	1	0	13	12	8	36	30-84
Reg	26	69	122	2.7	4.3	88	86	39/30	62/60	25	23	18	33	7	10	33	30	1-168

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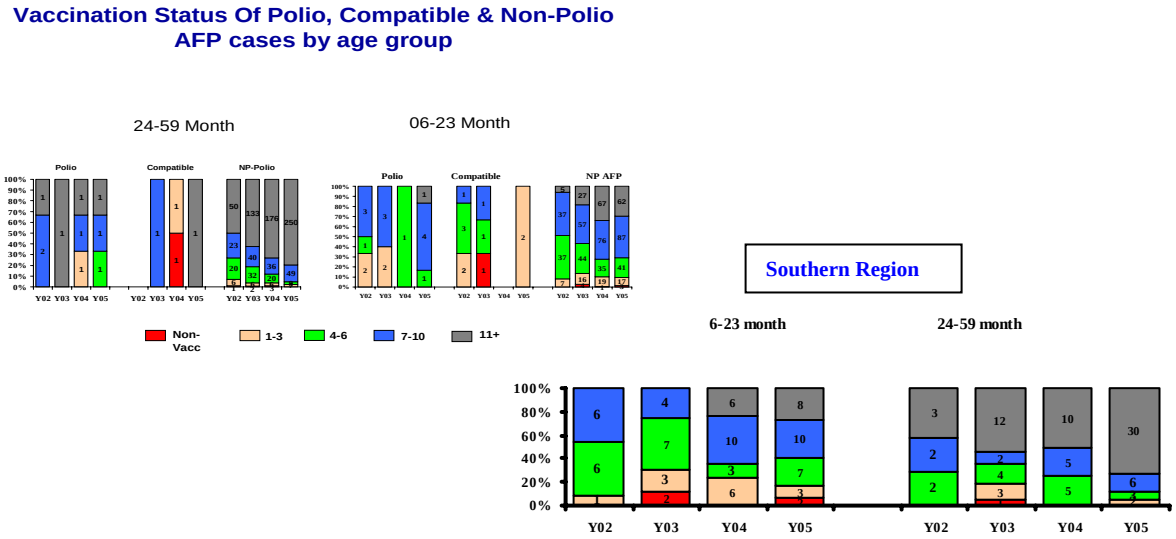
2.3 Vaccination Status of AFP cases:

Vaccination of AFP cases by class and by age group shows a decreasing pattern of children who did not receive any OPV dose or received less than expected doses in general among the non polio AFP cases. However same pattern is not evident among 6-23 months children in Southern region (Fig 5) showing the probability of missing this age group during campaign.

Figure 5



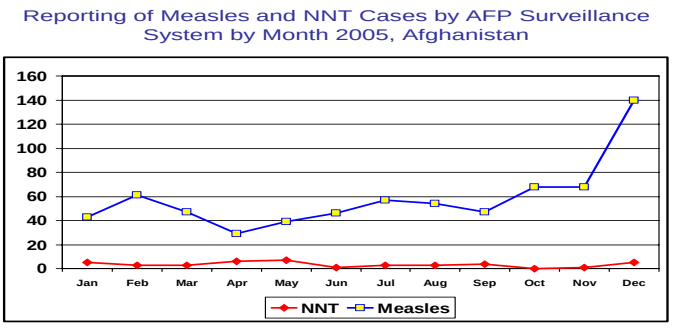
2.4 Routine Immunization Status of AFP Cases:
The analysis of routine immunization status of AFP cases and comparison over period of year shows that overall routine immunization coverage has some degree of overall progress but it varies from region to region. However, routine immunization status of AFP cases from southern region is indicative of very low routine coverage (<20%).

2.5 Diagnosis of Non polio AFP cases:
Thirty percent of discarded AFP cases were labeled as GBS during 2005 while Hemiplegia and other diseases like Meningitis and Encephalitis are main diagnosis for the discarded AFP cases. Although rate of GBS remain around 30% during last 3 years but due to lack of expertise at district and provincial level, the quality of diagnosis remain a challenge in Afghanistan.

2.6 Quality of Active Surveillance and Zero Reporting:
Completeness of Active surveillance and Zero reporting was above 80% for most of the region but during the field reviews in Eastern and parts of Southeastern region it was found that the quality Active surveillance visits, documentation of active surveillance and Zero reports are not up to the required standards and is one of the area needs further improvement. Moreover it was also observed that the linkage between the focal points and community based reporting sites needs further strengthening.

2.7 Reporting of Measles and NNT cases:
AFP surveillance also supports reporting of Measles and NNT cases and all the focal points and PPOs are submitting monthly report on number of reported cases for these diseases. There were 699 cases of Measles reported through active surveillance and 41 NNT cases during 2005 (Figure 6).

Figure 6



In summary, reporting and distribution of AFP cases, analysis of AFP surveillance indicators, characteristics of AFP cases and detection of wild virus in some of the difficult security affected areas reflects the presence of an overall satisfactory performing system in the country. However, the Reporting

Volunteers and Focal Points needs to be further encouraged to find cases among very young children (<11 month), particularly in South, South east and Western regions. Also there is need to further improve the quality of active surveillance visits and further strengthen community based infrastructure.

Supplemental Immunization Days:

During 2005, four rounds (March, April, September and November) of House to House National Immunization Days (NIDs) were held, targeting almost 7.3 million children of age below 5 years of age in the country. Vitamin A was also administered during April and November NID rounds to children of eligible age (6-59 months). Besides the NIDs, additional vaccination rounds, Sub NIDs and Mop-ups, were conducted in Southern, South eastern and Eastern regions of the country. A total of 9 supplemental immunization (SIAs) rounds were conducted during 2005 in Southern region which includes 4 NIDs and 5 SNIDs and targeted almost 1.12 million children.

Although district is the lowest administrative sub-unit of the country but for operation of house to house vaccination campaign, the district is further subdivided into well demarcated areas called *Clusters*. Each cluster has one supervisor with 5-6 vaccination teams. The area of assignment for each team is termed as sub-cluster which consists of number of villages to be covered by each team each day. Each district has at least one District Coordinator (D.C) who is responsible for district level advocacy and social mobilization, training of supervisors, review of plans with cluster supervisors, vaccine and logistic supply and campaign monitoring.

Campaign activities are monitored in two phases; first, during the campaign to assess the quality of campaign and take action in the field. Secondly, monitoring after the campaign through independent monitors to assess coverage and identify poorly covered areas and take immediate corrective actions.

Extra efforts in Southern Region:

A number of interventions are done in 2005, to overcome the situation, particularly the prevailing serious security situation in the region, and to improve quality of campaigns. These include enrolling persons from within the Districts as member of District support team (DSTs), increased the number of monitors to the ratio of 1 monitor per cluster in high risk districts. These monitors were selected from within the communities through NGOs serving in the area. This strategy was adopted to ensure the mobility of teams and quality of monitoring in security affected areas. Cluster micro-plans were revised to ensure that each team has clearly assigned area for each day of campaign.

Series of advocacy meetings with Provincial Governors, District Shuras and community notables from high risk districts were held. A high level delegation of Minister of Public Health and Country Representatives of WHO & UNICEF also visited Kandahar to hold advocacy meeting with all the Provincial Governors.

A planning and communication workshop was held with Provincial Directors, PEMTs, District Coordinators, DSTs and member of Ulema Shura from high risk districts. This workshop was held in Kandahar with the objective of identifying weaker areas and suggesting solutions through discussion and group work. All the recommendations of this workshop are implemented including revisions of micro-plans, increasing the number of DSTs, increasing and enrolling Monitors from the communities, cluster level advocacy meetings in high risk districts and increasing the air time for radio and TV announcements.

In order to strengthen planning and monitoring, additional support was provided in high risk districts through deploying WHO PPOs from other regions of the country and staff from MoPH Kabul.

Training sessions, besides other, focused on strategy to cover the Not Available children and volunteers were encouraged to record these children at the back of their tally sheets to ensure that all missed children has been vaccinated at the end of campaign. Permanent finger markers are introduced from November round. Teams

were specifically trained to standardize practice of marking the children after vaccination. This intervention proved to be of great help in monitoring and identifying missed children.

A Polio Control Room was established in Kandahar REMT (MoPH) office during the campaigns to monitor the daily progress and take immediate action, when required. The control room was equipped with mobile phones with list of telephone numbers of DSTs, PPOs and PEMTs and selected District coordinators. All the micro-plans and other important information were displayed in the control room. Regular communications were made with provincial teams in other provinces to encourage and monitor the progress. Polio control room was in close coordination with Radio Kandahar, a key partner, that regularly announced to encourage the parents for vaccination of their children and requested the public in identifying the missed houses and areas and report to polio control room. A formal telephone calls log register was maintained by the control room.

A coordination meeting was arranged at with the Polio team across the border to ensure the vaccination of returnees and traveling families and clearly demarcate the responsibilities for some of the villages along the border with Balochistan province of Pakistan.

Post Campaign Assessment (PCA):

Independent monitors (University, Medical Schools Students, Teachers, and NGOs Staff) are trained according to guidelines to carry out PCA. All the districts are subjected to PCA and 25-50 % clusters are sampled in each district while 100% clusters are sampled in districts labeled as "high-risk". At least three team areas (Sub-clusters) are sampled within the selected cluster. Ten houses are sampled in each team areas to assess the coverage.

Analysis of PCA data for the last three rounds from September 2005 to March 2006 is carried out by District and Cluster levels and by age group. Snow bound areas in Central, Western and Northern regions and Badakhsan were not included in March 2006, due to heavy snow fall and the campaign in these areas was delayed.

Table 3

Post SIAs Assessment, Afghanistan Sep05-Mar06

Region	Sep-05				Nov-05				Mar-06			
	Total Dist Monitored	Dist <95	% of dist <95	Range of dist <95	Total Dist Monitored	Dist <95	% of dist <95	Range of dist <95	Total Dist Monitored	Dist <95	% of dist <95	Range of dist <95
Badakhshan	21	0	----	------	15	0	0	----				
Southeast	57	21	37	60-94	56	4	7	88-93	49	2	4	86-94
West	41	3	7	92-94	40	1	3	94	32	1	3	92-100
East	34	3	9	93-94	37	0	0	----	28	1	4	94-99
Central	51	3	6	80-94	50	0	0	----	31	1	3	94
South	47	3	6	92-94	46	7	15	83-94	39	6	15	84-94
Kunduz	30	1	3	91	31	0	0	----	28	0	0	------
Mazar	47	15	32	68-94	46	12	26	79-94	36	8	22	85-95

Analysis by district and age group (Table 3) shows that overall quality of campaign in the country was of satisfactory level with most of the districts achieving coverage above 95% among children of both age groups (0-11 and 12-59 months). However, the proportion of districts with PCA coverage less than 95% was higher in Southern, Northern and parts of Southeast regions. The coverage among very young (0-11 m) children was affected more in these areas reflecting that this age group has higher probability for being missed by the teams.

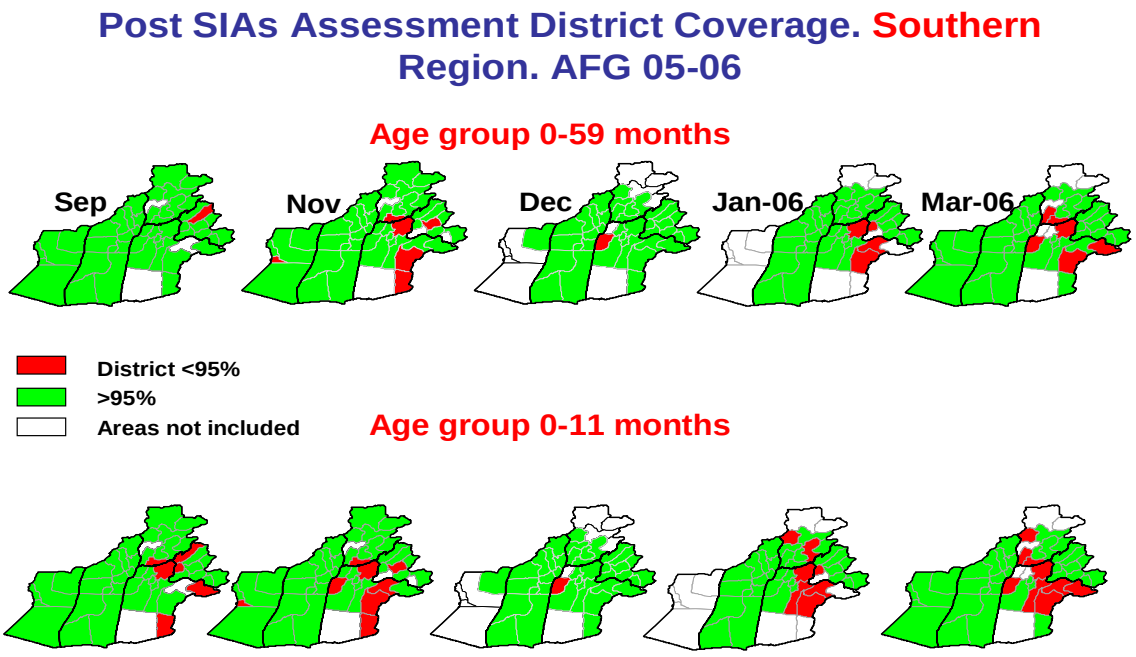
In order to assess the magnitude of problem among low performing districts and for appropriated corrective measure, the PCA data is analyzed to identify districts with higher proportion (>10%) of clusters below 95%. Most of the districts with 11-20% or more than 20% clusters below 95% were in parts of Southern and Northern regions (Fig7).

Also the analysis shows that the Southeast region has shown significant progress and the proportion of districts below 95% is reduced from 37% in September to less than 10% in November and March rounds while it is inverse in Southern region where the proportion of underperforming districts increased from less than 10% to almost 15%. Although Northern region has shown some degree of improvement in the quality of campaign but the proportion of districts with coverage below 95% remains above 20% (Table 3).

An in-depth analysis of **Southern region** (where nine rounds of SIAs were conducted in 2005 and where the polio virus circulation is ongoing) by province, by district and by age group shows that although substantial improvement with some degree of consistency has been achieved in Hilmand and Uruzgan province of the region but the quality of campaigns in Kandahar and Zabul province remain inconsistent, particularly in Kandahar province where the proportion of districts and clusters below 95% is increasing which shows that the campaign quality in Kandahar province has declined substantially. This decline in Kandahar is more evident along the districts with Pakistan border including Spinboldak, Maruf, and Arghistan. Moreover, Maywand, Panjwai and Shawalikot districts of Kandahar province also lack the consistency in the quality of campaign during the last number of rounds. Secondly, the proportion of young children missed during the campaigns, particularly in these districts were higher than the older age group (12-59), allowing the accumulation of pools of susceptible (Fig 7).

Moreover, due to serious security situation in Zabul province the campaign was not implemented on regular basis in parts of Shamulzai, Shinkai, and Daichopan and Atagar districts.

Figure 7



PEI Challenges:

Management Issues:

Non participation of the BPHS NGOs, selection of in appropriate District Coordinators and Supervisors in some of the districts, particularly in Kandahar province, attendance of service providers in trainings and unfair distribution of financial resources, lack of accountability particularly in Southern region are other major challenges in achieving the quality of campaign. Although gradual improvement has been made and its effects are evident in the province of Hilmand.

Security Issues:

Southern region is one of the worst security affected areas in the country where the security situation changes on almost day to day basis, particularly in Zabul province, parts of Kandahar, Hilmand and Uruzgan province. The precarious security situation adversely affect the quality of campaign particularly supervision and monitoring by WHO PPOs and other external monitors. The security becomes worst during Poppy harvesting season (April-July). Although a number of interventions has been done through involvement of local communities but security still poses a major challenge in achieving quality of campaign required to interrupt the circulation. The other worst security affected areas are the Kunar province and Khost provinces of Eastern and Southeastern regions respectively.

Proportion of Female Volunteers:

Due to the social and cultural barriers the proportion of female teams remain minimal particularly in the peripheral districts where each household has multiple families and the lack of female teams increases the possibility of missing very young children.

In Summary, the overall quality of campaign has improved with most of the districts and clusters achieving the coverage above 95% in the country. However, quality of campaign in Southern region, particularly in Kandahar and Zabul provinces needs major improvement, particularly the vaccination of young infants (0-11 Months). Security and management issues poses the biggest challenge and continuous innovative efforts are being carried out to overcome these issues to and achieve quality of campaign required to stop the circulation of polio virus.

Reproductive Health

INTRODUCTION

Women and children especially girls in Afghanistan have distinctly higher burden of illness and death. One in seven Afghan women die of pregnancy and childbirth related causes. Study by CDC/UNICEF (2002) confirmed the elevated mortality ratio at 1600/100,000 live births at the national level and at 6500 per 100,000 live births in certain deprived areas such as Badakhstan province. Shortage of skilled attendants, low coverage of MCH and family planning services, poor condition of the health facilities along with shortage of essential equipment and supplies, lack of functioning referral system are the major factors contributing to the unacceptably high maternal and infant mortality rates. The major causes of maternal mortality are found to be haemorrhage, obstructed labor, pregnancy-induced, hypertension, anaemia, malaria and sepsis. The percentage of preventable maternal deaths is 74%.

Coverage of tetanus-toxoid vaccination for pregnant women is estimated at 40%.The contraceptive prevalence rate is only 2 % with only 29% of basic health facilities providing 3 methods of contraception. Maternal health care services are not equally distributed and majority of the women especially from the rural areas do not have access to essential obstetric care. The access to ANC is 12 % and the Basic Primary Health Care facilities providing basic RH is only 17 %. In the health facilities where only male health personnel are available, utilization of the health services by women is very low because of social and cultural barriers. Traditions in Afghanistan make treatment of women by males difficult and serve as a constraint for women seeking health care. Increasing female representation in the health care sector is one way to address that constraint. The existing few female health personnel need refresher training to upgrade their skill and knowledge in basic health care provision including essential drugs and treatment as well as maternal health and emergency obstetrics care. There is no emergency service available to transport the women to the referral facilities when complications arise. 90% of deliveries take place at home. Only 15% of deliveries are attended by trained health personnel. Total fertility rate per woman is 6.3 (MICS 2003) and life expectancy at birth is 42.5 (MICS 2003). Female literacy rate in Afghanistan, one of the lowest in the world, is estimated to be 1-2% in rural areas where 80% of the total population reside. There is no confirmed data on STI prevalence in the country. However, information from clinical records particularly from private clinics in large towns suggest that there are perhaps high levels of sexually transmitted diseases.

GOAL/OBJECTIVES

The overall goal is to reduce the maternal and newborn morbidity and mortality by increasing availability of and equitable access to reproductive health services with special emphasis on essential obstetric care; to improve use and quality of reproductive health services and to improve knowledge and decision making in the community.

The major priorities for the Ministry of Health MOH with regard to reproductive health in Afghanistan are:

Birth spacing - to reduce the number of times that women are exposed to the risk of pregnancy.

Skilled attendance at birth - to improve the quality and proximity of care to pregnant women during the antenatal, delivery and postpartum periods.

Increase access to and availability of quality emergency obstetric care services.

WHO supports the MoPH, along with other partners, in the areas of: policy, strategy and programming planning, assessment and programme review, capacity building and implementation, monitoring and evaluation, building partnerships and interagency cooperation and advocacy and resource mobilization.

ACHIEVEMENTS

Technical support to MoPH

- **Review/update of National RH Strategy**

WHO technically supported the MoPH, along with other partners working in RH sector, in reviewing and updating the National Reproductive Health Strategy.

- **Introduction of the WHO MPS and FP guidelines and tools**

Complications of pregnancy pose substantial dangers to the health of women in Afghanistan. Prompt and appropriate treatment of these complications is an essential intervention for reducing maternal morbidity and mortality. As adaptation and implementation of **evidence based practices related to family planning and making pregnancy safer** will improve service delivery and will enable skilled attendants to provide quality maternal and newborn health services to women and infants, WHO introduced the evidence based WHO Making Pregnancy Safer and Family Planning guidelines and tools through a workshop in December 2005 to the MoPH and key stakeholders. The adaptation process was discussed during the workshop and plan for implementation was developed with the recommendations of all key stakeholders. An adaptation working group has been formed in January 2006 and the adaptation work is in progress.

The essential practice guide: Pregnancy, Childbirth, Postpartum and Newborn care (PCPNC) and Decision Making Tool for Family Planning Clients and Providers (DMT) have been translated into Dari and were distributed during the workshop. The generic guideline has been translated into Dari to facilitate the adaptation process and a final adapted version will be produced in due course(after completion of adaptation of the guidelines). It is planned to pilot these guidelines in three provinces and after evaluation expanded to other provinces.

Support to Training in Emergency Obstetric Care

As a support to training in emergency obstetric care, WHO has provided 2500 copies of the Dari version of the **WHO IMPAC Book: MANAGING COMPLICATIONS IN PREGNANCY AND CHILDBIRTH** in 2005 to different stakeholders including MoPH, UN agencies and NGOs for use in their training in Emergency Obstetric Care. This manual has been endorsed by the Ministry of Health as the National Standard Guidelines.

Community Midwifery Education Programme

To increase access of women to skilled attendance at birth especially in the rural areas, and to make essential obstetric care available as close to people's home as possible, WHO Afghanistan has supported the training of community midwives in two provinces, Bamyan and Badakshan.
The training of community midwives in Bamyan has started in September 2004 and in Badakshan in February 2005. Twenty females each from different districts of Bamyan and Badakshan provinces have been selected to be trained as community midwives and the duration of the training course is 18 months. Upon completion of training, these community midwives will be deployed in their own community with responsibility delegated for the management of obstetric complications. Cases which are beyond their competency will be referred to the nearest health facility.

WHO has equipped the Bamyan and Badakshan Community Midwifery Training Centers with the **teaching learning materials including training models.** Office equipments including **two computers, two printers and one Toshiba Photocopier** each were also provided to the training centres. WHO provides incentive to the trainees from both provinces. As well, WHO provides incentive to the Program Coordinator and three trainers from Badakhshan province.

The community midwifery education program is being implemented in partnership with MOPH, USAID/REACH and AKDN. Ministry of Health and Provincial Health Directorate, WHO, USAID/REACH and AKHS-A are supervising and monitoring the program.

The first batch of 20 students from Bamyan have graduated in March 2006 and the students from Badakhshan will complete their training in June 2006. It is planned to have a graduation ceremony in July 2006.

Strategic Assessment of family planning/birth spacing services in Afghanistan

WHO is supporting the MoPH in their effort to improve the family planning/birth spacing programme in Afghanistan using the "WHO Strategic Approach to Improving the Quality of Care of Reproductive Health Services" as a model. As the first phase of the strategic approach, WHO carried out the Strategic Assessment of Birth Spacing Services in four provinces of Afghanistan from June to August 2005. The findings have been analysed and the results were disseminated to the MOPH and other key stakeholders through a workshop in December 2005. A plan for next steps has been developed according to the findings during the workshop. The national family planning strategy has been revised in early this year based on the findings of the assessment.

Strengthening Service Delivery Capacity

To improve and strengthen the maternal and child health care service delivery, WHO has provided in 2005 around 300 kg of MCH supplies and equipment especially the essential obstetric care supplies and equipment to 2 referral hospitals (provincial and district) and 10 Basic Health Centres which are serving around 150,000 women of children bearing age and 250,000 under five children in 3 provinces of Afghanistan.

Capacity Building

- With the support of WHO, one Family Planning Officer from Women's and Reproductive Health department of Ministry of Public Health acquired training in Gender and Rights in Reproductive Health in Sudan in 2005.
- Reproductive Health Director, MoPH, participated in the WHO/UNFPA joint regional workshop on guidelines for Making Pregnancy Safer and Family Planning, where the evidence based guidelines were introduced and a plan for implementation in the country was developed.
- The staff of RH departments were trained in carrying out the strategic assessment of birth spacing services. The staff has gained knowledge and skill in conducting qualitative research as well as analysing the findings of the assessment.

Joint Programming on Reduction of Maternal Mortality

Under UNDAF, a framework for reduction of maternal mortality in Afghanistan by 20% from the present level by the year 2008 has been prepared jointly by WHO, UNICEF, UNFPA and UNIFEM. A work plan table has been prepared as well. The activities, the implementation timeline, the budget, the responsible UN agency and the government partners are identified in the work-plan table. To avoid duplication and overlapping of the activities, clear responsibilities of each agency has been agreed upon and defined in the work plan. The lead agency/agencies identified in the work plan will mobilize resources for the identified activities, develop detailed annual action plan with relevant partners and implement the activities.

Resource Mobilization:

A proposal for "Saving Lives of Afghan Women" has been prepared and submitted to donors in 2005. The proposal has been approved by the Norwegian government at end of 2005.

CHALLENGES:

The major challenges in the implementation of safe motherhoods and family planning program includes limited human resources, inadequate fund and materials, insecurity in some areas and insufficient coordination among partners limiting the effectiveness of both individual contributions and concerted efforts.

Tuberculosis Control

Background:

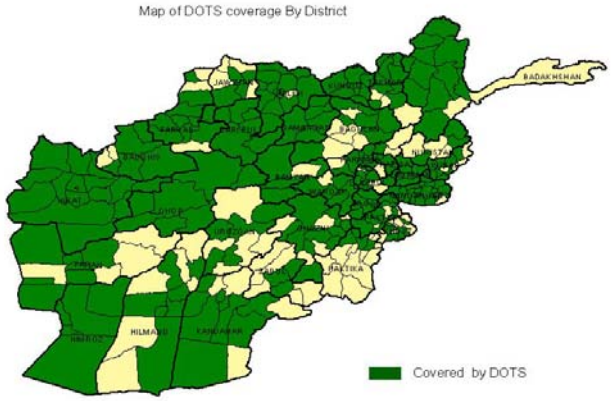
Tuberculosis (TB) is a major problem of public health in Afghanistan. Afghanistan ranks at the 17th position among the 22 high TB burden countries at global level. It has the highest incidence rates due to TB in WHO Eastern Mediterranean Region. WHO estimates that every year more than 95,000 new cases occur and 26,000 of them die due to TB in Afghanistan. Over 50,000 of TB cases would be women in their reproductive age, a highly vulnerable group, which accounts for 65% of all cases of TB presenting to public clinics.

KEY INDICATORS

Population (thousands)*	28,574
TB burden (2005 estimates)	
Incidence (all cases/100 000 pop/yr)	333
Incidence (ss+/100 000 pop/yr)	150
Prevalence (all cases/100 000 pop)	661
Mortality (deaths/100 000 pop/yr)	92
New TB cases multidrug-resistant (%)	1.8
Previously treated TB cases multidrug-resistant (%)	25

Source: WHO report on Global TB Control 2006

*World population prospects-2004. NY, UNDP 2005.



The WHO recommended TB Control strategy, widely known as DOTS, was accepted by MOPH as the national policy for TB Control since 1997. DOTS expansion was accelerated in 2001 owing the mobilization of the funds from Norway, Italy and Canada and with technical assistance of WHO. With the support of donors Afghanistan has continued to make tremendous progress in their fight to bring TB under control, despite the serious economic and social difficulties, and incomplete expansion of health services.

MONITORING DOTS

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	
DOTS coverage (%)	--	--	12	11	14	15	12	38	53	68	81	81
DOTS notification rate (new and relapse/100 000 pop)	--	--	6	14	14	30	41	53	51	64	104	76
DOTS notification rate (new ss+/100 000 pop)	--	--	3	8	7	12	19	25	24	29	47	35
DOTS case detection rate (new and relapse), (%)	--	--	2	4	4	9	12	16	15	19	31	23
DOTS case detection rate (new ss+),(%)	--	--	2	5	5	8	13	17	16	19	32	23
DOTS treatment success rate (new ss+), (%)	--	--	45	33	87	86	84	87	86	89	---	....

CSO Population WHO Population

Activities supported by the project

Human resources development

A large number of health personnel have been trained with the support of WHO in country and abroad. Efforts were made to include training on DOTS in pre-service and in-service trainings and staff initially trained more than two years before are also invited for refresher courses. Around 1300 health personnel (doctors, nurses and laboratory technicians) were trained on DOTS implementation and expansion. In addition, 90 health professionals were trained on various aspects of DOTS in Iran, Pakistan, India, Egypt and Italy.

WHO also assisted the NTP in conducting a national workshops on operational and strategic planning in 2005.These workshops aimed to scale-up DOTS in post-conflict Afghanistan by adopting a more aggressive approaches toward to DOTS expansion and quality improvement of TB services.

Upgrading technical leadership

The Project supported the strengthening of the NTP technical capacity by recruiting international TB expert as well as establishing a network of 76 national TB experts. The TB team has been constantly working in close collaboration with all stakeholders including the BPHS partners in the development of human resources and managerial capacity, strengthening of partnerships, resource mobilization and in coordination of TB activities with the ongoing health sector reconstruction in Afghanistan.

Laboratory network development

According to NTP, there are 409 laboratories providing TB diagnostic services in the country. The WHO has purchased and distributed 100 microscopes, reagents and other materials including slides for microscopy and sputum containers. With the support of JICA and GFATM TB laboratories nationwide were assessed and a manual for direct sputum smear microscopy was updated. A new guidelines for “Standard Operating Procedures for Sputum Microscopy” to improve case detection and follow up of TB treatment cases was developed.

Supervisory system development

The NTP with the support of WHO has introduced two monitoring systems: the monitoring visits with review meetings and NTP surveillance.

According to the NTP policy guidelines each Regional TB Coordinator is required to visit each province and Provincial TB Coordinators are required to visit all health facilities at least once a month to identify existing problems and identify additional support needs for DOTS. The central unit also makes supervisory visits to the region and provinces. The M&E Unit has developed special checklists for supervisory visits to BHCs, CHCs and District Hospitals to assess availability, knowledge and training of health workers, management and administration, equipment, funding and infrastructure, availability and quality of services. In 2005 WHO has supported about 5000 DOTS supervisory field visits.

By the support of WHO Quarterly DOTS review meetings at national and regional levels were regularly conducted.

NTP has established a TB surveillance system for tracking of TB case finding and treatment outcomes from all DOTS facilities. WHO made available printing and distribution of NTP forms for recording and reporting on DOTS that are being used by implementing partners. In addition, by WHO support a computer based Electronic District Registry was developed and piloted in LEPCO clinics in Mazar-i-Sharif.

Logistics system development

Due to limited capacity of MOPH, WHO was given the mandate for the procurement and logistics of TB medicines and laboratory supplies since 2001. Since then a regular supply of anti-TB drugs and laboratory materials was secured through the help of WHO.

Moreover, with the support of Japanese government, rehabilitation of National Warehouse for TB and other communicable diseases (Malaria and HIV) in the premises of MOPH central warehouse is carried out and regional store rooms in Kunduz and Ghazni established.

Health Education, Advocacy and Social Mobilization

WHO assisted the NTP in carrying out a nationwide campaign on TB on the occasion of World TB Day on 24th of March in 2005. Mass gatherings, sports events, dramas, talks by prominent figures and former patients took place in various parts of Afghanistan.

Moreover, in order to reach the poorest and most vulnerable layers of the population, the WHO has supported two NGOs working in different areas: CARE International to assist some 10,000 widows in Kabul, and COOPI to work in the very remote Province of Nimroz.

Heading towards MDGs

Tool development (operational research)

In Afghanistan, there is disproportionate female predominance among TB patients that has been a concern for NTP and many partners. From 2001-2004, there are more female cases compared to males for any form of TB (female to male ratio ranges from 1.5:1 to 2.1:1). WHO assisted the NTP in conducing an operational research on "TB and Gender" in cooperation with the University of Trieste, Italy. The study has explored the social and cultural aspects of TB in Afghanistan. Findings of report disseminated to MOPH together with all TB implementing partners in order to address effectively TB problems in women of Afghanistan and presented at IUATLD conference in Paris in November 2005.

Coordination and Partnership Development

In the complex post-conflict situation in Afghanistan, close co-operation between the MoPH/NTP, donors, NGOs and other partners involved in TB control at all levels is essential for strengthening, implementing and expanding the DOTS strategy. The TB Working Groups, a National TB Board, an Inter-agency Coordination Committee (ICC), Country Coordination Mechanism (CCM), Regional and National Review Meetings were used as coordinating platforms among partners.

ICC Meeting Kabul 2005

Achievements

Since 2002, under the new transitional Afghan government, the NTP has taken major steps to improve its managerial and technical capacity and secure external technical assistance and resources in order to implement the DOTS strategy.

Political support is strong and TB control is considered a national health priority. The government, MoPH and relatively large number of stakeholders have clearly stated TB to be one of the priority diseases within the 18 priorities listed in the National Health Policy 2005-2009 and associated strategies. For this reason, TB control activities are included in BPHS are to be performed by doctors, nurses and community health workers (CHWs) after training and receiving regularly supervision.

During the period 2000-2004 the MoPH approved "The Guidelines for Tuberculosis Control Programme in Afghanistan" as the official policy, objectives, strategy, organization, activities and procedures for TB control throughout the country. By February 2005 guidelines were revised to align the main components for DOTS expansion with updated international standards.

In July 2005, a National TB Board (NTB) was established consisting of united nation organizations, donors, government sector and technical agencies to support TB control policy and planning.

Afghanistan officially endorsed the Millennium Development Goals (MDGs) in March 2004 and in September 2005 with the support of WHO the NTP developed a five-year National Strategic Plan for TB Control with associated budget, and prepared a year operational plan with all stakeholders to achieve 100% DOTS coverage by the end 2006.

Nutritional support has been issued to TB patients and health personnel through assistance of World Food Program (WFP).

WFP Food Distribution to TB patients, Mazar 2005

DOTS coverage

The estimated population having access to DOTS facilities in Afghanistan has steadily increased from 2 million (14%) in 1999 to 17 million (81%) in 2005.

Coverage by District

The number of districts with health facilities applying DOTS has risen by 76%, over 5 years - from 36 units in 2001, to 343 units in 2005.

DOTS Status by Districts. Afghanistan, 2001 – 2005

Year	*Country Districts (n)*	*Districts Applying DOTS*	
2001	330	36	11 %
2002	330	70	21 %
2003	330	126	38 %
2004	388	178	46 %
2005	388	343	89%

Source: WHO NTP 2005.

Coverage by Health Facility

The total number of health facilities applying DOTS has increased from 36 in 2001, to 525 in 2005, reflecting a 48% increase over four years.

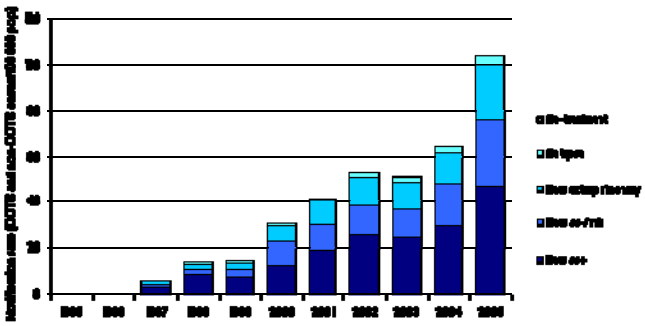
DOTS Status by Health Facilities. Afghanistan, 2001 – 2005

Year	Health Facilities (n)	Health Facilities Applying DOTS (n)	
2001	1,013	36	3.5 %
2002	1,013	79	7.7 %
2003	1,013	131	12.9 %
2004	1,013	202	20 %
2005	1018	525	52%

Source: NTP 2005.

Case detection

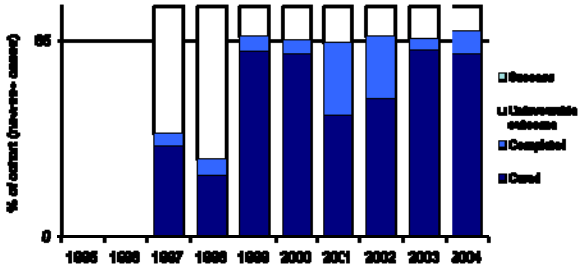
There is a steady increase in detection of new TB cases from 9,581 or 14% in 2001 to 21,844 cases or 31% in 2005 through expanding DOTS coverage within the BPHS system.



Notifications have increased dramatically since 1997 as DOTS services have expanded

Treatment outcomes

Afghanistan has observed treatment success above or close to 85% target since 1999 and proportion confirmed high in 2004 being 89%.



Treatment success above or close to 85% target since 1999 proportion confirmed high in 2004 cohort

Planned activities

DOTS expansion to 100% population coverage and integration of TB control activities within all tiers of BPHS is the focus for the near future. Continuing coordination, creation of partnerships and acceleration of DOTS expansion through adoption of new approaches such as PPM-DOTS and Community- based DOTS are going to be the key elements. National guidelines on collaborative TB /HIV activities will be developed. Provision of nutritional support from WFP to TB patients and health- care personnel will continue. With the support of WHO and JICA NTP is started the establishment of laboratory network with EQA in 2 pilot regions, Hirat and Mazar-i-Sharif; these projects will further strengthened. Advocacy and Social Mobilization strategy (ASCM) will be developed and implemented. Operational research priorities will be set.

For future sustainability and ownership, it is essential to continue strengthening and building capacity of the NTP staff and systems at both central and provincial levels in different disciplines.

Challenges

The main challenges facing DOTS expansion are keeping continued interest and commitment of all stakeholders, ensuring high- quality DOTS service through implementation of BPHS by more than 40 national and international NGOs, improving network of primary health – care facilities that currently leaves large parts of the country undeserved, especially during the winter, creating the appropriate methodologies for involvement of private sector and community participation, integrating community- based DOTS run by NGOs in to NTP, improving coordination between the NTP and development of government policy on TB/HIV collaborative activities, establishing of functional laboratory network with National Reference Laboratory, planning and implementing ACSM activities in areas where access is made difficult by poor security or by geographical barriers, overcoming strong reliance on external aid for NTP operations, reducing workforce turnover and improving technical skills of existing staff.

Roll Back Malaria (RBM)

Overview:

All the antimalaria activities planned and conducted during 2005 were continua to the priority interventions thought to be viable and effective for a sustained RBM movement in post-war Afghanistan. The said interventions included i. short-term measures to meet the immediate needs of the vulnerable populations in the worst malaria affected areas and ii. medium to long-term measures to build an effective integrated and decentralized malaria control program.

To improve the quality of treatment for malaria patients, the ministry of public health with technical assistance from WHO developed in 2003 **the national malaria treatment protocols for Afghanistan**. The protocols included artimsinin-based combination therapy (ACT) for the treatment of confirmed falciparum malaria.

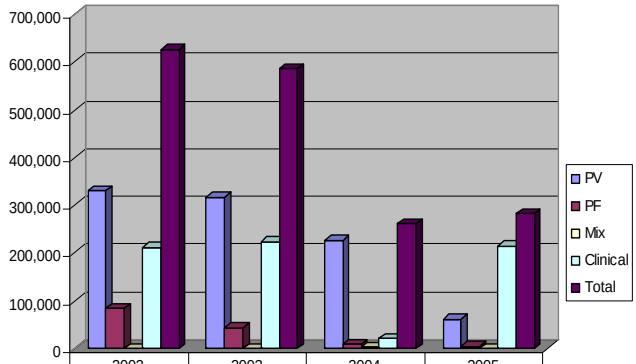
The Ministry of Public Health and the national malaria leishmania control program (NMLCP) had undergone an important restructuring process in 2005. The malaria/leishmania and TB control programs were put under the directorate general of the preventive medicine and primary health care. New malaria organizational charts, roles and functions and job descriptions for NMLCP (drafted by RBM/WHO) were also approved.

To develop and maintain national competence that is capable to provide strategic direction to NMLCP, developing malaria policy at the national level, and setting standards, norms and indicators for monitoring the progress of operational activities, etc. the Ministry of Public Health decided to keep the NMLCP vertical at the Central and Provincial level and fully integrate it below the Provincial level.

Malaria situation during 2005:

With the expansion of the BPHS facilities nationwide, the malaria surveillance system (HMIS and epidemiology unit of the NMLCP) was able to detect suspected as well as laboratory confirmed malaria cases from vast areas in the country for the first time in almost three decades. Despite the fact that two of the four levels of the BPHS has no microscopy services yet, it is evident that the burden of malaria over the past four years is in the decline as a result of improved case management, scaling up of effective control measures (namely ITNs) by the MOPH and partner organizations, and due to the drought in some parts of the country.

Officially reported malaria cases 2002-2005



	2002	2003	2004	2005
PV	330,083	316,697	227,683	61,781
PF	83,783	44,243	9,212	5,017
Mix	745	0	3,513	0
Clinical	212,228	224,662	21,048	215,090
Total	626,839	585,602	261,456	281,888

1. Meeting the immediate needs of the vulnerable population

To enable the MOPH to provide access to preventive measures and prompt and appropriate treatment of malaria to the populations at risk of malaria in targeted areas, WHO supported the following activities during 2005:

1.1 Printed and widely disseminated the national malaria treatment protocols for Afghanistan and facilitated the required training/ orientation to the MOPH staff.
1.2 Supplemented effective anti-malarial supplies that included:
- Provision of antimalaria supplies (drugs including ACT, laboratory reagents, RDTs, and other consumables) before the start of the active transmission season in May 2005.
- Distribution 28,000 Long Lasting Bed Nets in Kunduz and Takhar provinces.
- Pre-positioned antimalarial supplies needed for emergent situations (e.g. malaria outbreaks and unfavorable political situations such as the threats of the opposition to abort the parliamentary elections which was held at the peak of the 2005 falciparum malaria transmission season)

2. Building an effective integrated and decentralized malaria control program.

A comprehensive package aimed at rebuilding and strengthening Afghanistan's national malaria control program was set by WHO/RBM since 2002. The package focused on strengthening WHO presence and provision of enabling environment for capacity development for RBM that includes developing strategies and guidelines, producing the necessary personnel through intensive human resource development program, strengthening infrastructure, managing and sustaining the trained workforce addition to strengthening other technical aspects of the national malaria control program.

2.1 Strengthening WHO presence:

WHO/RBM country team endeavored during 2005 to implement the RBM comprehensive package in close collaboration with other RBM partners. The country team comprised one international short-term professional (STP), three national officers, a secretary and a driver.

2.2 Development of strategies and guidelines:

Following the development of some national strategies and guidelines during 2003 namely the malaria treatment protocols, the ITNs strategy, the flaciparum malaria outbreak guidelines and the COMBI strategy, the RBM partners lead by the Minister of Public Health had also successfully developed in April 2005, the National Strategic Plan (SP) for Malaria Control (2006-2010). The participants to the 6-day national SP workshop represented the central and provincial health authorities, 4 line ministries (MRRD, MOWA, MOI, and MOE), Kabul medical college, 16 BPHS implementing partners, UN agencies (WHO and unicef), GFMU, addition to the facilitators' group from WHO/HQ, WHO/EMRO, LSHTM and HNI. The exercise was funded by USAID/WHO and the GFMU.

2.3 Human resource development program:

By the end of 2005, the national malaria control program was 100% staffed with malaria managers at the central and provincial levels (27 in total) who were all trained on "Planning and Management of Malaria Control Programs". These malaria managers benefited a two-month diploma course through an intensive fellowship training program organized by RBM/EMRO in collaboration with WHO Regional training Center, Bandar Abbas, Iran.

Other HRD activities during 2005 included:

a. Development of a standardized national malaria training curriculum in collaboration between MOPH, WHO and the Global Fund Management Unit (GFMU).
b. National training programs for 70 Health Professionals on the management of simple and severe malaria in line with national treatment protocols (WHO, MOPH/NMLCP and GFMU).
c. Completion of the 3rd and final phase of the training for 7 national laboratory master trainers (TOT) course in WHO/EMRO Regional Training Centre, Iran. (2005).
d. The laboratory master trainers facilitated national training programs for 30 microscopists in the diagnosis of malaria by light microscopy including species differentiation using thin film preparations, and on microscope maintenance (MOPH, GFMU Sep-Dec 2005).
e. The national NMLCP manager participated in the following inter-country meetings:

- Workshop on Home Management of Malaria, EMRO, Cairo, Egypt. May 2005.
- 5th Inter-country Meeting of National Malaria Program Managers, Cairo, Egypt May 2005.
- Inception Meeting on the Malaria Elimination Initiative in the WHO European Region, Tashkent, Uzbekistan, 18 - 20 October 2005.

2.4 Strengthening NMLCP infrastructure

a) The National malaria and Leishmania institute

In 2005, WHO/RBM mobilized additional resources from USAID (**$ 500,000**) to construct the malaria institute in Kabul city as the headquarters of the NMLCP as well as the national venue for malaria/leishmania training, epidemiology and research. The project is expected to complete by August 2006.

b) The central malaria/TB warehouse:

To support the logistics component for both the NMLCP and the TB control program, WHO managed to mobilize **$ 120.000** from the Japanese Embassy and the NGO Hope worldwide for the MOPH to reconstruct its malaria/TB central warehouse in preparation for the huge supplies expected from the GFATM (R 4 for TB & R 5 for malaria).

2.5 Managing and sustaining the trained workforce:

To retain the trained NMLCP managers, WHO/RBM managed since early 2003 to secure regular income for all of them from USAID funds in the form of incentive support against field work with clear TORs (APW contracts). The rationale is to compensate the low salaries paid to them by MOPH.

2.6 Strengthening other technical aspects of the national malaria control program:

2.6.1 Drug efficacy studies and updating treatment guidelines:

The regular monitoring of the therapeutic efficacy of the anti-malarial drugs in the national treatment protocols continued in 2005 in 3 of the four sentinel sites established for this purpose (Faryab, Nengarhar and Takhar provinces). The results showed 100% Adequate Clinical and Parasitological Response (ACPR) for the Artemisinin-based combination therapy (ACT).

2.6.2 Epidemics detection and control:
- Printing the Dari version of the field guide for malaria epidemic assessment and reporting booklet.
- Training program on malaria Epidemic Preparedness & Response (EPR) for a team of two NMLCP doctors from each of the 14 malaria priority provinces.

2.6.3 Strengthening malaria surveillance and M&E:
- Nomination of 3 doctors from NMLCP, HMIS and GFMU as national focal points for RBM/M&E
- Development of RBM/M&E indicators for BPHS and EPHS by the M&E advisory group (MOPH,WHO, GFMU, JHU and MSH/REACH)
- Development of integrated monitoring and supervision checklist for malaria, TB and HIV/AIDS (jointly by the relevant taskforces).
- Development of integrated database for Malaria, TB and HIV/AIDS by WHO and GFMU.

2.6.4 Operational research:
- A WHO sponsored baseline study on malaria in pregnancy was completed in Nangarhar province by the NGO HNI.
- A WHO/TDR study to evaluate an eight week primaquine regimen for the radical cure of vivax malaria is ongoing in the eastern region by HNI.

2.6.5 Resource mobilization:
- Afghanistan's proposal to round 5 of the GFATM in May 2005 was approved in September 2005. The NMLCP is expected to receive 28 million US dollars over the coming 5 years.
- WHO/RBM received USD 800,000 from USAID in response to a proposal submitted to consolidate the national malaria strategic plan during 2006.

Program failures:
Though planned in the 2004-2005 biennium, the initiation of entomological surveillance and development of IVM strategy were not implemented due to delay in the recruitment of the appropriate staff (3 entomologists) by the MOPH.

Leishmaniasis Control

Objectives:

The overall objective of the program is to provide technical support to the national control program that leads to the reduction in the incidence of the disease by providing early diagnosis and prompt treatment and protecting the non-immune from all leishmaniasis forms.

To achieve this target, MOPH and WHO managed to create a mechanism of coordination among the partners involved in the field of Leishmaniasis in Afghanistan by establishing a Leishmania taskforce (LTF) within the framework of the vector-borne diseases working group. The LTF endeavors to achieve two specific objectives:

1. Enhancing the capacity of the MOPH to effectively manage and supervise the antileishmania activities and evaluate the outcome.
2. Coordinating the efforts of all the partners to stimulate donors for supporting the program and to consider it as one of the major health problems in Afghanistan.

Activities and Achievements:

- WHO supported the ministry of public health in the establishment of National Malaria and Leishmania Control Program (NMLCP) through intensive human resource development program, strengthening infrastructure, managing and sustaining the trained workforce addition to strengthening other technical aspects including resource mobilization for the national program.

- WHO continued its support to many diagnostic/treatment centers in Kabul and other major cities in the form of antileishmanial drugs and other consumable supplies.

- In October 2005 WHO received commodities (Pentostam and LLTNs) worth **€ 200,000.00** from the Belgian Government in response to its proposal for emergency interventions to "Control the Cutaneous Leishmaniasis Epidemic

in Kabu"l. The local partners in this project are MOPH, HealthNet International, the Japanese Cooperation (TODAI) and the Afghan Massoud Foundation. This project is limited to the immediate activities of the diagnosis and treatment of cases, and massive IEC messages to accompany targeted distribution of mosquito nets to quickly reduce the transmission and to relieve the effects of the epidemic. Three rounds of CL prevalence survey were planned to accompany this project. The purpose of these surveys is to map the most affected areas (target) and also to evaluate the planned interventions. The first round of the survey was conducted during the period 08-18 October 2005. Based on the results of the survey and due to delay in the arrival of the commodities to the country, the project was rescheduled to start in May 2006.

- A second proposal for **€ 180,000.00** was prepared during the visit of Dr. Jorge Alvar, the MO/Leishmaniasis Control, WHO/HO to Kabul in March 2005. The proposal titled **"Stabilizing Plan for the Program against Cutaneous Leishmaniasis in Afghanistan"** was submitted to **La Caixa Foundation, Spain** and was approved. This proposal endeavours to reinforce the combative measures against the epidemic and to give stability to the control program in the future.
- The taskforce is currently negotiating the Technical Advisory Group (TAG) to consider including leishmaniasis in the BPHS (at the district hospital level in targeted areas). The TAG members have unanimously accepted the idea and requested the taskforce to provide additional information regarding the targeted areas and the cost implications of this move.

Human Resource Development (HRD)

Background:

The Human Resources aspects of post conflict HRD in Afghanistan, as in other countries which have experience 20+ years of conflict, are vast and complex.

The HR workforce situation was confused with little accurate data available. There were large population movements with the returning refugees. The situation was further compounded by an apparent oversupply of doctors with an estimated 11,000 medical students coming through medical schools which were severely degraded and provided inadequate training.
There were inadequate numbers of nursing , midwifery and allied health workers with a particular sever shortage of female health workers. This was further compounded by the issue of false certification of many people claiming to be health workers.

The HR system in the MOH was based on the 1960-70 model of Personnel and Training, all other HR functions were splintered throughout the ministry without any coordination

Achievements
Work on HR issues has been undertaken collaboratively with a number of partners including MSH/REACH, Aga Khan Foundation, JICA etc.

Human Resources systems were established which include:

- Establishment of a HRD focal unit at General Director Level which coordinates all aspects of HRD which were previously splintered throughout the ministry
- Establishment of a Semi-Autonomous Testing and Certification Board which has implemented a system of testing and certification for 9 categories of nursing, midwifery and allied personnel to establish equivalencies
- Development of strategies to address the upgrading requirements of health workers who do not meet the required level of competency.
- Revision of the 2003 Human Resources Policy to address the rapidly changing environment within the health sector.
- Establishment of a Human Resources Database and System of National Registration of Health workers
- Establishment of a Capacity Building Working group to address capacity building for Institutional Development
- Establishment of system for accreditation of Midwifery Education
- System for accreditation for nursing Education currently being finalized
- Nursing and Midwifery pre-service curricula have been redeveloped and upgraded.
- Establishment of a competitive transparent system for implementing Civil Service Recruitment

MoPH in Afghanistan is the only ministry in Government to have established these HR systems and standards which has resulted in the Civil Service Commission identifying the MOPH as one of the lead ministries in the government to implement Civil Service Reform.

Improving the Teaching in the Institute of Health Sciences

Background:

Institute of Health Sciences (HIS) trains nurses and other allied personnel for the Ministry of Public Health. When Agha Khan Development Network (AKDN) started to support the School of Nursing and midwifery, a Memorandum of Understanding was signed between W.H.O and AKDN in which it was stated that W.H.O will help in the improvement of teaching in the other schools of I.H.S.

Goal of the Program

The goal of the Program is to improve the teaching in HIS.

The Key Program Achievement

The Key Program Achievement in the Year 2005 was as follows:

1. Revision of the Curriculum of the School of Medical Technology

In the Past the School of Technology was for three years after the completion of high school. In the new policy of the Ministry of Public Health the duration of the School of Technology has been reduced to two years. Therefore a review of the Curriculum was needed. To do this through several meeting with the Teachers of School of Medical Technology, first the job description of the graduates of the School was specified .Based on the job description we decided to make a competency based Curriculum for the School. For example we decided that our graduates to be able to work in a histopathology laboratory, therefore we introduced the subject of Histopathology Techniques in the Curriculum. In order to make teaching hours available for the new subject and be able to teach the important subjects in two years instead of three, we deleted obsolete topics from the details of the curriculum such as small pox. More over, we replaced some unnecessary subject by subject which they need in their works, such as replacing pharmacology by analytical toxicology and mathematics by Physical Sciences or deleted some subject completely such as internal medicine and surgery. In all the subjects more emphasis was placed on practical teaching.

The details of the curriculum was written in English and also translated into Dari.

For the implementation of the curriculum the teachers need up to date teaching materials. Since analytical toxicology and physical sciences are new subject W.H.O Educationalist wrote a book on Physical Sciences and on analytical toxicology according to the curriculum in Dari for them. The analytical toxicology contains all the available antidotes with their dosage and methods of their administrations which could be used by the doctors and nurses for treating cases of poisoning. The Physical Sciences could be used by all the students joining the IHS. W.H.O office in Kabul has printed one thousand of each and has delivered them to IHS and all the students and teachers have received them. One of the teachers volunteered to teach the physical sciences for which he was trained by W.H.O during the winter vacation.

A book on laboratory procedure written in Dari by W.H.O educationalist has been made available for the students.

One of the teachers volunteered to teach. Histopathology Techniques in the school which had never been taught before. W.H.O encouraged and helped him to write a book in Dari according to the new curriculum which contains all the techniques of histopathology including making a

museum and perform an autopsy. Arrangement was made for him to go to the histopathology laboratory of Kabul Medical University for one month and learn the techniques practically.

W.H.O Educationalist has encouraged and helped other teachers to write books on other subjects. According to the revised curriculum, uptill now the following books have been written and are taught.

1. Anatomy and Physiology
2. Blood Banking
3. Hematology
4. Immunology and Serology
5. Mycology
6. Histopathology Techniques
7. Bacteriology (IN Progress)

Functional Rehabilitation of the Multipurpose Laboratory of I.H.S

In the laboratory there was a dozen of new microscope, a partially functional electrical centrifuge, one non functional colorimeter and Microlab. There was no usable reagent, no practical teaching could be done in the laboratory.

With the equipment, glassware and chemicals found in the store, the chemicals W.H.O transferred from Jalalabad to I.H.S, the ten binocular microscopes and other laboratory equipment WHO ordered for the Multipurpose laboratory of IHS, some equipment and reagents USAID (Reach) purchased for this laboratory, now the Multipurpose laboratory of Institute of Health Science is fully functional. The students of IHS can get their practical training in this laboratory.

A series of Refresher courses for district laboratory technicians organized by USAID (Reach) are going on in the I.H.S. The participants are getting their practical training every afternoon in this laboratory.

The teachers of school of Medical Technology need further practical training for the implementation of the new curriculum.

Recently the Provincial Reconstruction Team renovated the building of the I.H.S. I took the opportunity to renovate the store-room in such a way that half of the room became a storage place for laboratory equipment and supplies and the other half will serve as laboratory for training of trainers and research.

It is hoped that in this laboratory we will be able to improve the competency of teachers and as a result raise the standards of teaching in the Institute of Health Sciences.

2. Course of Anesthesia for Nurses

I.H.S decided to offer a one year Anesthesia Course for Nurses who have studied for nine years in high schools and three years in school of nursing in HIS and have worked for two years in

the one of the health facilities of the Ministry of Public Health. W.H.O was asked to prepare a curriculum for the nurse anesthetist. The curriculum of nurse anesthetist was printed down from internet and was adapted to the condition of Afghanistan. This course is in progress in the I.H.S.

3. A two year Course of Dental Prosthesis

A two year Course of Dental Prosthesis is going to be offered in I.H.S. The Ministry of Public Health has requested W.H.O for a short term consultant to prepare the curriculum for it. The recruitment of the consultant is in Progress.

Constrains

The main constrain in the year of 2005 was the limitation of funds for printing the teaching materials in the local language of Afghanistan and purchase of reagents for practical work in the laboratories.

Mental Health

Introduction:

In a country of around 25 million people, 80% are living in the rural areas and have suffered from years of civil war and severe draught. Life expectancy for men was 44.2 and for women 45.1 in the year 2000. 25% of children die before reaching the age of five and 50% of children are malnourished. There are estimated to be 500,000 widows in the country, creating a need for women to head their households and generate income to provide for their family. Estimated 150,000 disables live in Afghanistan. Estimated 20-30% of the population suffers from mental disorders. There is no or very basic mental health services available in rural areas. More over lack of information on health and cultural factors creates more barriers for communities to contact health services.

There is an overall lack of capacity within the Ministry of Public Health to carry out planning and implementation of the health promotion programs. There is lack of policy and guideline on mental health. It is observed that few NGOs are involved in mental health activities. Community mental health services do not exist in the country. Mental health services are centralized in a 60-bedded hospital in capital. There are some 25 partially trained junior psychiatrists, 22 clinical psychologists and 20 partially trained nurses working in the hospital. No psychiatric social worker service exists.

Following activities were planned to answer mental health problems in the country:

- Provision of administrative support for existing facilities and making them functional,
- To train mental health staff on Community Mental Health through fellowships, national training activities.
- Initiate Community Mental Health services,
- Provision of essential medicine,
- Involvement of community and religious leaders in metal health activities,
- Conduct training for PHC Doctors,
- Recruitment of expatriate professionals to provide support in training and delivery of services.

Expected results were as follows;

- Improved mental health services at different levels will reduce morbidity of psychological disorders,
- Access to mental health services and psychiatry bed for admission increases,
- Mental Health services will be offered at community level,
- Reduced morbidity of psychological disorders ensure better interpersonal performance for patients in community,
- Availability of neuropsychiatry drugs will improve attendance in health facilities,
- Availability of services at different levels will reduce expenses and saves time,
- unnecessary treatments and investigations prevented
- Greater awareness on mental health will be achieved to treat and prevent psychological disorders,
- Community participation and support for patients and their families ensures better care.

II. Activities:

A. Demand Reduction Working Group

There has been many activities on demand reduction in collaboration with other organization active in the field including Counter Narcotics Ministry. Harm Reduction Policy related to injecting drug use and HIV/AIDS was finalized in Feb 2005 in Demand Reduction Working Group. Also initial draft for Demand Reduction Glossary was developed for review and comments from related agencies to use standard terminology in addressing substance use issues.
General Treatment guidelines for substance use disorders were drafted for submission which includes three main phases of interventions e.g. Motivation, Detoxification and After-care.

B. Review of Mental Health part of EPHS:

Mental Health Task force reviewed Mental Health component of Essential Package for Hospital Services (EPHS). The review included following issues related to mental health:

- Staffing: psychologist, psychosocial counselor.
- Services: Pharmacotherapy, psychosocial interventions.
- Category of diseases: Based on ICD-10, Chapter V.
- Essential Medicine: Antidepressants, Antipsychotics, Anxiolytics, Antiepileptics, Anticholinergics etc
- Beds allocation: District hospital 5-10, Provincial 10-20, Regional 30 and National Hospitals 150.

C. WHO-AIMS survey

Mental Health system assessment was carried out in Afghanistan based on WHO Instrument for Assessment of Mental Health System (WHO-AIMS) developed by WHO Geneva, Mental and Substance Abuse Department in 2004. Data were collected in three phases and after collection all data were entered into Data entry sheet. Based on data entry sheet a final report was developed and publication of the report is expected in early 2006.

D. Mental Health Nursing survey

Mental Health Nursing survey was based on questionnaire developed by WHO HQ.

E. Mental Health Needs Assessment workshop

First Mental Health Needs Assessment Workshop, based on WHO-AIMS finding was organized in December 2005. The workshop was open with HE Dr. Fatemi, Minister of Public Health and participant from different NGOs attended. The main objective was drafting National Mental Health Strategic Plan for Afghanistan. After finalization the draft was submitted to Ministry of Public Health for comments.

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F. National Mental Health Strategic Plan (NMHSP)

The plan was developed in December 2006 which highlights following main areas:

1. Psychological First Aid for adults and Life skills Education for children
2. Public Mental Health Education
3. Support to families of mentally ill patients
4. Integration of Mental Health in Basic Health Care
5. Mental Health Human Resources development
6. Support and establishment of psychiatric treatment facilities

7. Support to voluntary organizations working in the field of mental health
8. Mental Health Legislation
9. Research Support in Mental Health
10. Administrative support for mental health Unit in MOH
11. Supply for Mental Health Facilities

III. Future Plans

Development of mental health policy and national mental health program along with strengthened mental health department and regional mental health centers promote sustainable services in the country. Trained mental health staff and WHO expertise ensures continue until mental health dept will be able to ensure the sustainable service through out country.

Increased National Capacity in Mental Health and increased skills and knowledge of different categories of health staff and others e.g. doctors, midlevel, volunteers, patients family etc will improved community mental health services. Increased number of Mental Health Centers in country ensures mental health services at the community level. Improved skills and knowledge of families on caring of mentally ill members e.g. schizophrenia and other chronic mental disorders, also availability of essential psychotropic medicine and supply at primary care level prevents relapse and exacerbation among chronic cases.
Mental Health Information system and integration of services in 40 % of primary health care facilities (including training of PHC staff) together with public education on mental health and patients' human right could help to increase access to mental health services in the country. Finally coordinated and sustained efforts are needed to strengthen the mental health system in Afghanistan.

Following documents are available:

1. Executive Summary National Strategic MH Plan
2. EPHS Revision of Mental Health Component
3. Summary of Mental Health System Assessment in Afghanistan, WHO-AIMS