World Health Organization

WHO AFGHANISTAN COUNTRY OFFICE 2019

ACRONYMS

AfDHS	Afghanistan Demographic and Health Survey
AFP	Acute flaccid paralysis
AHS	Afghanistan Health Survey
ALS	Advanced Life Support
ANC	Antenatal care
ANDS	Afghanistan National Development Strategy
ANSA	Afghan National Standards Authority
ARI	Acute Respiratory Infection
ART	Anti-retroviral therapy
BCC	Behaviour change communication
BCG	Bacillus Calmette–Guérin vaccine
BEmONC	Basic Emergency Obstetric and Newborn Care
BLS	Basic Life Support
BPHS	Basic Package of Health Services
CBMM	Community Based Management of Malaria
CBRN	Chemical, Biological and Radio-nuclear
CCC	Control and Command Centres
CCHF	Crimean-Congo haemorrhagic fever
CCM	Country Coordinating Mechanism
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CDC	Centre for Disease Control and Prevention
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHC	Comprehensive health centre
CHW	Community Health Worker
CIMCI	Community Integrated Management of Childhood Illness
CL	Cutaneous leishmaniasis
CMYP	Comprehensive Multi-Year Plan
CPHL	Central Public Health Lab
CRPD	Convention on the Rights of Persons with Disabilities
CRVS	Civil Registration and Vital Statistics
DEWS	Disease Early Warning and Surveillance System
DHS	Demographic Health Survey
DOTS	Directly Observed Treatment
DTP	Diphtheria-tetanus-pertussis vaccine
ENC	Essential Newborn Care
EOC	Emergency Operation Centre
EPHS	Essential Package of Hospital Services
EPI	Expanded Programme on Immunization
EPR	Emergency Preparedness and Response
ETAT	Emergency Triage and Treatment
EVD	Ebola Virus Disease
FLW	Frontline workers
FP/BS	Family Planning / Birth Spacing
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender-based violence
GBVIMS	Gender-Based Violence Information Management System
GDF	Global Drug Facility

GGM	Good Governance for Medicines
GII	Gender Inequality Index
GMS	German Medical Services
HepB-Hib	Hepatitis B Vaccine / Haemophilus Influenzae Type B Vaccine
HMIS	Health Management Information System
HRH	Human Resources For Health
HRMIS	Human Resource Management Information System
HSS	Health System Strengthening
HTA	Health Technology Assessment
ICU	Intensive care unit
IDP	Internally displaced person
IDSR	Integrated Disease Surveillance and Response
IDUs	Injecting drug users
IEC	Information, Education and Communication
IEHC	Interagency Emergency Health Kits
IGME	UN Inter-agency Group for Child Mortality Estimation
IHR	International Health Regulations
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IPV	Inactivated Polio Vaccine
IRM	Insecticide Resistance Monitoring
ISO	International Organization for Standardization
ITN	Insecticide-treated bed net
JEE	Joint External Evaluation
JUNTA	Joint United Nations Team On AIDS
KAP	Knowledge, attitudes and practices
KMU	Kabul Medical University
LEPCO	Leprosy Control Organization
LLIN	Long Lasting Insecticidal Net
MAIL	Ministry of Agriculture Irrigation and Livestock
MCM	Mass Casualty Management
MDR	Multidrug resistant
MDT	Multidrug therapy
MERS-CoV	Middle East Respiratory Syndrome Coronavirus
MHT	Mobile Health Team
MIS	Malaria Indicator Survey
MLIS	Malaria and Leishmaniasis Information System
MMR	Maternal Mortality Ratio
MNDSR	Maternal and Newborn Deaths Surveillance and Response
MoHE	Ministry of Higher Education
MoPH	Ministry of Public Health
MPR	Malaria Programme Review
NACP	National AIDS Control Programme
NAPHS	National Action Plan for Health Security
NCDs	Non-Communicable Diseases
NDMP	National Disaster Management Plan
NEAP	National Emergency Action Plan
NERPH	National All Hazard Emergency Response Plan for Health
NIDs	National Immunization Days
NLEP	National Leprosy Elimination Programme
NLSP	National Leishmaniasis Control Strategic Plan
NMHRA	National Medicine and Health Products Regulatory Authority

NMLCP	National Malaria and Leishmaniasis Control Programme
NRVA	National Risk and Vulnerability Assessment
NTD	Neglected Tropical Disease
NTP	National Tuberculosis Programme
OPV	Oral polio vaccine
OST	Opioid Substitution Therapy
PBF	Performance-based funding
PCR	Polymerase chain reaction
PCV	Pneumococcal Conjugate Vaccine
PEI	Polio Eradication Initiative
PHC	Primary Health Care
PHEIC	Public Health Emergency of International Concern
PLHIV	People living with HIV
PPP	Public Private Partnership
PTT	Permanent Transit Team
RED	Reach Every District
RI	Routine Immunization
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendance
SDGs	Sustainable Development Goals
SEHAT	System Enhancement for Health Action in Transition
SIA	Supplementary immunization activity
SOP	Standard Operating Procedures
SPR	Slide positivity rate
STEP	WHO STEP: Wise approach to non-communicable disease risk factor surveillance
STH	Soil Transmitted Helminthiasis
TAG	Technical Advisory Group on Polio
TB	Tuberculosis
TCS	Trauma Care Service
TFU	Therapeutic feeding unit
TT	Tetanus Toxoid
UNODC	The United Nations Office on Drugs and Crime
VL	Visceral leishmaniasis
WHE	WHO Health Emergencies Programme

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Afghanistan Health Indicators

#	Indicators	Value	Year	Source
1	Total population (million)	29.7	2018	NSIA*
2	Percentage of population under 15	47.7	2017	ALCS
3	Percentage of population above 65	2.7	2017	ALCS
4	Life expectancy at birth, female/male (year)	63.2/ 63.6	2017	IHME
5	Total fertility rate	5.1	2018	AHS
6	Infant mortality rate (per 1,000 live births)	52	2018	UN IGME**
7	Under five mortality rate (per 1,000 live births)	68	2018	UN IGME**
8	Neonatal mortality rate (per 1,000 live births)	40	2018	UN IGME**
9	Maternal mortality ratio (per 100,000 live births)	1,291 680	2015 2017	AfDHS 2015** Est.UN/WHO
10	Contraceptive (modern) prevalence rate by percentage	17.4	2018	AHS
11	Skilled antenatal care by percentage (at least 1 visit)	63.8	2018	AHS
12	Percentage of last birth protected against neonatal tetanus	39.6	2018	AHS
13	Institutional deliveries by percentage	56.3	2018	AHS
14	Exclusive breastfeeding under age 6 months (percentage)	57.5	2018	AHS
15	Third dose of pentavalent vaccine crude coverage (Card + History) (12-23 months) (percentage)	60.8	2018	AHS
16	Measles vaccination coverage (Card + History) (12-23 months) (percentage)	64	2018	AHS
17	All basic vaccinations coverage (Card + History) (12-23 months) (percentage)	51.4	2018	AHS
18	Children received vitamin A in last 6 months (6-59 months) (percentage)	70.9	2018	AHS
19	Density of physicians (per 10,000 population) (2015)	2.7	2015	MOPH
20	Density of nurses and midwives (per 10,000 population)	3.2	2015	MOPH
21	Total health expenditure as a percentage of GDP	9.5	2014	NHA

22	Government expenditure on health as a percentage of total expenditure on health	5	2014	NHA
23	Share of out of pocket spending on health by percentage	73	2014	NHA
24	Adult literacy rate (15 years of age and over)	34.8	2017	ALCS
25	Population using improved drinking water sources by percentage	63.9	2017	ALCS
26	percentage of population using improved sanitation facilities	53	2017	ALCS
27	Poverty headcount ratio at $1.25 a day (PPP)	54.5	2014	ALCS
28	Gender Development Index (GDI) rank	168	2017	UNDP Human Development Report

Sources: Afghanistan health survey (AHS), Afghanistan Demographic and Health Survey (AfDHS), Afghanistan Mortality Survey (AMS), Afghanistan living conditions survey (ALCS), Institute for Health Metrics and Evaluation (IHME), Afghanistan National Health Accounts (NHA), National Statistics and Information Authority (NSIA), Afghanistan Ministry of Public Health(MoPH), The United Nations Inter-agency Group for Child Mortality (UN IGME).

* Population estimate is based on the socio-demographic statistics department of NSIA. However, according to UNFPA and Flowminder 2017, the population estimation is 35.715 million.

** The 2015 Afghanistan Demographic and Health Survey (DHS) reported maternal mortality at 1,291/100,000 live births and neonatal and under-five child mortality rates of respectively 22 and 55/1,000 live births. However, pregnancy-related deaths seem to be overestimated, while child deaths may be underreported. The AfDHS mortality data has been reviewed by global experts, including UN agencies, to produce adjusted estimates based on global UN models (UNIGME). The review has already been completed for NMR, IMR, and CMR, and MMR is expected to be published by February 2019.

World Health Organization in Afghanistan

Presence and Role

WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.

WHO is staffed by 23 international and 370 national professional and support staff. The country office is located in Kabul and there are sub-offices in Kandahar, Jalalabad, Herat, Mazar-i-Sharif, Faizabad, Gardez and Kunduz.

In Afghanistan, WHO works to improve the health and wellbeing of all Afghans by preventing and reducing mortality, morbidity and disability and by strengthening health services. Under the leadership of the Ministry of Public Health (MoPH) and in close coordination with national and international partners, WHO's support focuses on building capacity through technical assistance in policy formulation and strategic planning as well as by providing training, implementation and management support across all public health interventions. In certain programme areas WHO also facilitates the implementation of activities on the ground, such as polio eradication, health emergencies, epidemic control and outbreak response as part of humanitarian assistance.

In addition to the health sector, WHO's cooperation involves higher education and humanitarian response including health emergencies, food security and nutrition, and water and sanitation. National partners include MoPH, the Ministry of Education and Higher Education, the National Statistics and Information Authority, the Ministry of Finance, academic and research institutions, private sector and civil society organizations, humanitarian, and multilateral and bilateral development partners.

Current Work and Achievements

WHO's work in Afghanistan is guided by a two-year cycle. The WHO-MoPH Joint Country Plan for the current biennium 2018-2019 was developed based on a number of priority areas selected by MoPH, involving key departments and partners active in the health sector. Throughout the implementation phase, regular meetings and reviews take place with MoPH and respective departments, to assess achievements and make adjustments when needed in order to be responsive to the changing environment, emerging trends, new developments and general country needs.

The budget for WHO's assistance to Afghanistan in 2018-2019 amounts to around 135 million USD. The WHO-MoPH Joint Country Plan 2018-2019 focuses on polio eradication, health emergencies, communicable and non-communicable diseases, reproductive, maternal, newborn, child and adolescent health, gender-based violence, nutrition, and health systems. These specific areas and related programmes are described in the following pages. WHO assists MoPH in the coordination of all key stakeholders, using a sector-wide approach with the aim to move towards universal health coverage in Afghanistan.

Significant progress over the last decade and a half has resulted in substantial declines in infant, child and maternal mortality rates in Afghanistan. The provision of public health services, with a focus on primary health care, expanded substantially under challenging circumstances. Achievements in education, water and sanitation are also noteworthy. Despite this progress, many of Afghanistan's health indicators remain extremely worrisome. There are imbalances across socio-economic levels with a clear urban/rural divide. There is an urgent need to improve the quality and expand the coverage of health and hospital services.

Capacity Building and Health Sector Coordination

WHO prioritizes the national capacity development in all its programme areas through the provision of in-country, regional and global training and technical assistance in technical and normative areas relevant to Afghanistan.

WHO co-chairs an active Health Development Partners' Forum, assisting the Ministry of Public Health (MoPH) with coordination of all key stakeholders, to increase and guide the overall resource envelope for health and improve the effectiveness of the current investments.

WHO's support is harmonized and aligned with the MoPH National Health Policy and Strategy (2016–2020), the Government of the Islamic Republic of Afghanistan – National Peace and Development Framework (2017–2021), and the ONE UN for Afghanistan (2018–2020) document.

Even though the public health approach in Afghanistan is comprehensive and innovative, there still are significant gaps and efficiency gains to be addressed. The lack of investments in public health continues to be the largest obstacle for further progress. There is a need to substantially increase domestic and international resource mobilization.

WHO's Key Strategic Priorities in Afghanistan

Polio Eradication: WHO is a key partner in polio eradication with a focus on maintaining a sensitive surveillance system and supporting supplementary immunization activities in planning, training and quality assurance through a network of field-based staff. With partners, WHO conducts National Immunization Day campaigns three times a year, vaccinating more than 9.5 million children under five years of age in all districts, and Sub-National Immunization Days targeting nearly 6 million children in high-risk districts six times a year. Immediate responses to confirmed cases are carried out through mop-up campaigns to contain and eliminate transmission.

Health Emergencies: As the Health Cluster lead, WHO supports the implementation of humanitarian response and recovery measures to natural and man-made disasters by providing medicines, medical supplies, logistical and technical support. With Cluster partners, WHO works to strengthen trauma care and mass casualty management as well as provide emergency primary health care to vulnerable, displaced, and disaster-affected populations in underserved areas. In areas affected by disasters, WHO supports service provision through the establishment of temporary and static health facilities. Working to reduce the risks to people and health facilities, WHO supports national and provincial emergency preparedness and response strategies, policies and guidelines along with the Ministry of Public Health. WHO also provides technical assistance to WASH and Nutrition Clusters in humanitarian response. The WHO-supported Disease Early Warning System (DEWS) surveys, detects, and assists in the management of infectious disease outbreaks in all provinces.

Communicable Diseases: WHO provides technical support to the Ministry of Public Health (MoPH) in developing national policies, strategies and guidelines for communicable disease control, assessing the disease burden and in the monitoring and evaluation of disease control programmes, including HIV/AIDS, hepatitis, tuberculosis, malaria, leishmaniasis, leprosy and other neglected tropical diseases. WHO also provides support for diagnosis and treatment as needed. WHO supports the Expanded Programme on Immunization (EPI) around the country to combat vaccine-preventable diseases.

Noncommunicable Diseases (NCDs): WHO assists MoPH in determining the burden of and risk factors for NCDs and supports the implementation of a national strategy for the prevention and control of NCDs. WHO supports the implementation of the WHO Framework Convention on Tobacco Control and strengthens national capacity in developing action plans for nutrition. A nation-wide nutrition surveillance system has been operationalized in all 34 provinces and WHO supports the strengthening of therapeutic feeding units (TFUs) through the procurement of medicines and supplies as well as staff capacity building.

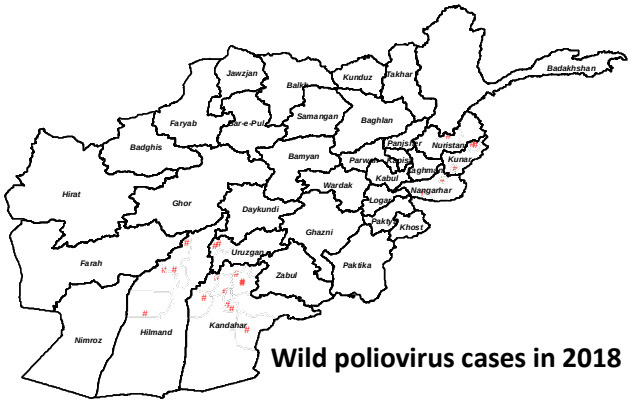
Promoting Health throughout Life: WHO supports MoPH in the delivery and monitoring of Reproductive, Maternal, Newborn, Child and Adolescent Health and Family Planning (RMNCAH) services through national capacity building and development of policies, programmes and plans, updating clinical guidelines and standards, introducing and revising training packages for service providers. WHO promotes and advocates for the adoption and implementation of evidence-based, life-saving and cost-effective RMNCAH interventions and commodities, including in humanitarian settings. WHO also supports MoPH in mainstreaming gender and human rights into health policies and interventions and training healthcare providers on the provision of care to survivors of gender-based violence (GBV). Between 2015 and 2018, 3,979 health care providers were trained on the WHO/MoPH GBV Treatment Protocol. A further 565 received refresher training and 230 had manager training. By 2020, over 6,500 healthcare providers will be trained in all 34 provinces.

Health Systems: WHO supports the development of key aspects of health systems such as financing, planning, human resource development, health information, monitoring and evaluation, research and health promotion, as well as strengthening health innovation and technology. Supporting the implementation of the International Health Regulations (IHR) and responding to Public Health Emergencies of International Concern (PHEIC) are key areas of WHO's work. WHO supports the establishment of the Medical Council and Drug Regulatory Authority and strengthens laboratory capacity and food safety standards. WHO provides technical assistance and support for System Enhancement for Health Action in Transition (SEHAT) to expand the coverage and improve the quality of health services delivered through the MoPH Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS). WHO also supports MoPH in the coordination of health stakeholders, facilitating the transition towards universal health coverage in Afghanistan.

Contact World Health Organization Afghanistan:
Dr Richard Peeperkorn, WHO Country Representative, Phone: +93 796 337 652 Email: peeperkornr@who.int
Web: www.emro.who.int/afghanistan **Facebook:** World Health Organization Afghanistan **Twitter:** @WHOAfghanistan

Polio Eradication Initiative

(Polio Eradication Initiative)



Wild poliovirus cases in 2018

Situation Update: Transmission of wild poliovirus in 2018 is restricted to the Southern and Eastern regions in Afghanistan. 21 polio cases were reported in 2018 from six of Afghanistan's 34 provinces. Of these cases, 15 are from the Southern region, including nine from Kandahar province with spillover transmission from Helmand and Uruzgan. The Southern region is facing major issues related to inaccessibility. More than 840,000 children have missed vaccination opportunities since May 2018, which makes responding to detected polio transmission difficult. Inaccessibility coupled with vaccination refusal in some communities, particularly in and around Kandahar, makes polio eradication challenging. The six cases in the Eastern region are part of northern corridor transmission zone, which extends from Nangarhar, Kunar and Nuristan in Afghanistan to KP/FATA in Pakistan.

The programme continues to implement the National Emergency Action Plan (NEAP) for Polio Eradication, and has developed a framework of change to address the remaining challenges in the Southern and Eastern regions and achieve interruption of transmission. The country has maintained strong poliovirus surveillance and, in most districts, children's immunity to the virus has significantly increased.

The Technical Advisory Group (TAG) reviewed progress towards polio eradication in May 2018 and noted three critical roadblocks to stopping transmission of the virus: children missed due to inaccessibility, refusals, and gaps in campaign quality in areas with security challenges. The TAG noted that if accessibility can be improved in a sustained way, the programme is on the right track to stopping transmission.

Achievements:

- Three National Immunization Days (NID) and seven Sub-National Immunization Days (SNID) were conducted in 2018, targeting around 10 and 6 million children respectively. For every new case, the programme conducted three case response campaigns in areas surrounding where the case was detected.
- As of end October 2018, a total of 11,480,437 children under five years of age were vaccinated by Polio Transit Teams (PTT), with a monthly average of 1,148,044 children. During the same period, 862,415 children were vaccinated by Cross-Border Teams, most of which were at the Friendship Gate and Torkham borders between the Southern and Eastern regions of Afghanistan with Pakistan. In addition, UNHCR repatriation centres vaccinated 17,982 children and IOM vaccinated 191,427 children.
- In accessible areas, campaign qualities have improved. The percentage of lots that passed by Lot Quality Assessments improved from 87.5% in the October 2017 NID to 96% in the August 2018 NID.
- In response to increases in polio cases and positive environmental samples in 2018, the Emergency Operations Centre (EOC) developed a supplement to the NEAP called the Framework for Change. The Framework is a midterm correction to the plans outlined in the 2018 NEAP and will drive the creation of the 2019 NEAP.
- For inaccessible areas in the Southern region, a contingency plan is being implemented which includes doing site-to-site vaccination, IPV-OPV vaccination, placing permanent transit teams at all exit points and including OPV in the pre-planned measles campaign.
- For addressing refusals in the Southern and Eastern regions, a refusal oversight committee and refusal resolution committee have been formed to implement cluster-specific approaches to address refusals, along with other measure such as engaging local influencers, religious scholars, medical professionals and the Islamic Advisory Group (IAG).
- Cross-border coordination with Pakistan on the Northern and Southern corridors continues to be strengthened.

Programme Risks and Challenges:

- The continued ban on house-to-house campaigns in large parts of the Southern region.
- In the Eastern region, small pockets of inaccessible children and high population mobility between Afghanistan and Pakistan.
- Pockets of refusal, particularly in and around Kandahar as well as in the Eastern region.
- Sub-optimal campaign quality in some key areas under control of AGE, due to management issues.
- Low EPI coverage in areas that are at high risk of polio transmission.

Way Forward:

- Maintaining programme neutrality, and gaining and maintaining access for vaccination.
- Implementing thematic changes set out in the Framework for Change. Addressing refusals, improving campaign quality and focusing on missed children.

World Health Organization Contact:
Dr Hemant Shukla, Team Leader, Polio Eradication Initiative Afghanistan, Phone: +93 793 70 0192, Email: shuklah@who.int
Dr Samiullah Miraj, Polio Eradication Programme Officer, Phone: +93 705 984 066, Email: mirajs@who.int

Health Emergencies/Health Cluster

(Health Emergencies)

Situation Update: Afghanistan suffers from one of the world's longest protracted complex emergencies due to conflict, natural disasters and mass population movements. In 2018, drought affected two-thirds of Afghanistan, leaving 3.6 million people in need of urgent humanitarian assistance. In addition, increasing conflict in different regions resulted in higher numbers of internally displaced people and trauma cases (figure 1). Nearly 800,000 displaced people have returned from Pakistan and Iran and the number is expected to increase in the coming year. Around 1.9 million people are now in need of humanitarian health services and additional emergency service support. In 2018, trauma cases increased by 24% compared to the same time last year.

In 2018, WHO recorded 85 attacks on healthcare in Afghanistan. Healthcare services were directly targeted in many of these incidences. Afghanistan currently ranks third in term of the severity of attacks on healthcare.

Figure 1: Incident and casualty trend by target type

Achievements:

WHO EHA

- Enhanced leadership and institutional capacities, including the development of National Disaster Management Plan and the National Emergency Response Plan for Health, built up national and regional Control and Command Centres (CCC), Information Management System (IMS) and Emergency Preparedness and Response (EPR) Committees at all levels.
- Scaled up trauma care service in high-risk areas, including supporting 47 hospitals with trauma care capacities through mass casualty management (MCM) plan development, space arrangement, equipment, capacity building and the upgrading of 15 regional and provincial hospitals for improved blood transfusion services.
- Trained a total of 2,547 medical staff and community health workers (CHWs) on advanced and basic life support (ALS and BLS), triage, ambulance services, safe blood transfusions, mental health and health risk assessment.
- Provided life-saving medicines and supplies to over 2 million people affected by conflict and natural disasters, including 74 Italian Emergency Trauma Kits, 512 basic Interagency Emergency Health Kits and 85 supplementary IEHK, 446 Acute Respiratory Infection (ARI) kits,50 diarrhoea kits and loose medicines.

Health Cluster

By September 2018, WHO and Health Cluster implementing partners reached 2,017,922 beneficiaries (of whom 1,217,837 were women and girls).

- Provided emergency health services to more than 85,000 men, women, boys and girls in Herat, Badghis and Ghor in response to the immediate needs resulting from drought at displacement sites and areas of origin.
- Expanded trauma care service to 18 provinces with First Aid Trauma Posts and Trauma Care Units.
- Provided emergency health services at all border crossings for returnees from Pakistan and Iran. In 2018, more than 600,000 consultations were provided to returnees.
- Responsible for reporting attacks on health facilities and healthcare workers as well as related advocacy messages.

Programme Risks and Challenges:

- Ongoing conflict results in the movement of more than 1 million people, increasing the need for humanitarian health services.
- Ongoing food insecurity continues to exacerbate needs for health provision for populations on the move and around the country.
- Funding pledges are unpredictable due to extended emergencies in the region, reducing the response capacity.
- Insecurity and limited accessibility to emergency locations in high-risk provinces and damage to hospitals hamper the effort to provide essential emergency health services, capacity building and monitoring activities in conflict-affected areas.

Way Forward:

- Establish standardized needs assessment methodology to improve the monitoring and reporting of WHO and partner projects.
- Institutionalize emergency risk analysis and response at all levels (villages, district and provincial).
- Strengthen MoPH capacity to coordinate and respond to protracted and acute health emergencies.
- Improve coordination with development partners to ensure sustainable and durable solution to humanitarian crises.

World Health Organization Contact:
Dr Dauod Altaf, Director of Health Emergencies, Phone: + 93 782 200 342, Email: altafm@who.int
Dr David Lai, Health Cluster Coordinator, Phone: +93 781 764 906, Email: laidavid@who.int
Dr Ghulam Rafiqi, Emergency Officer, Phone: +93 705 612 381, Email: rafiqig@who.int

Epidemic Outbreaks and Response

(Health Emergencies)

Situation Update: Communicable diseases account for more than 60% of all outpatient visits and more than half of all deaths in Afghanistan. The primary objective of communicable disease surveillance and response (CSR) is the reduction of morbidity and mortality associated with communicable diseases in Afghanistan, the management of dangerous emerging/re-emerging pathogens, the prevention of the global spread of Public Health Emergencies of International Concern (PHEICs) and the enhancement of global health security through the implementation of the International Health Regulations (IHR-2005). Technical assistance to MoPH has been provided for the implementation of the National Disease Surveillance and Response (NDSR) system including Early Warning component, zoonosis prevention and control, avian and pandemic influenza control and prevention as well as overall capacity building.

Investigation of a measles outbreak in Asmar district of Kunar province

Achievements:

Emerging and re-emerging infectious diseases

- Prepared an Action Plan for the prevention and control of Crimean-Congo hemorrhagic fever (CCHF). Initiated immediate preparedness measures against CCHF through MoPH and MAIL. Epidemiological and vector surveillance has been enhanced and awareness raising activities were conducted.
- Trained 110 members of provincial Rapid Response Teams (Surveillance, CDC department and BPHS NGOs). Topics included Pandemic, Epidemic Preparedness and Response covering surveillance, EPR, outbreak investigation, emerging/re-emerging diseases (including EVD and MERS-CoV), IHR-2005, PHEIC, avian, pandemic and seasonal influenza.
- 720 health staff, 300 veterinary staff and 480 butchers trained and oriented on CCHF in 12 provinces. Radio spots on CCHF were aired in 12 provinces and Pandemic and Epidemic Preparedness and Response training was conducted for animal health staff.

National Disease Surveillance and Response

- Investigated and responded to more than 4,000 outbreaks since 2007. Of these,770 outbreaks were detected and responded to in 2018 alone.
- Surveillance sentinel sites were expanded to 573 sites as of December 2018 covering almost 90% of districts.
- Community-based surveillance and surveillance by private health sector has been expanded countrywide to strengthen event-based component of surveillance system.

International Health Regulation 2005

- National Action Plan for Health Security (NAPHS) was drafted based on the recommendations of Joint External Evaluation (JEE) of IHR core capacities.
- Strengthened capacity of surveillance provincial officers on the detection and management of chemical, biological and radio-nuclear (CBRN) incidents.
- Included PHEIC and IHR core capacity requirements in the National Disaster Management Plan - Health Sector (NDMP).
- Provided technical inputs to NFP on WHO IHR emergency committee meetings for polio, MERS-CoV, EVD and Zika.

Programme Risks and Challenges:

- Lack of sustainable financial resources to further develop human resources; ongoing insecurity hampering people's access to health services.
- Difficulty in implementing the IHR-2005 due to multi-sectoral coordination issues and the lack of funding.
- Limited in-house human resource capacity in laboratory and field epidemiology.

Way Forward:

- Establish e-surveillance to enhance real-time detection and reporting of outbreaks and timely response.
- Further expand community surveillance and enhance surveillance in private health facilities.
- Evaluate the National Disease Surveillance and Response System and re-prioritize diseases under surveillance.
- Strengthen epidemiological and laboratory surveillance for influenza and other emerging and re-emerging diseases.
- Fund advocacy work for National Action Plan for Health Security (NAPHS) and its execution.

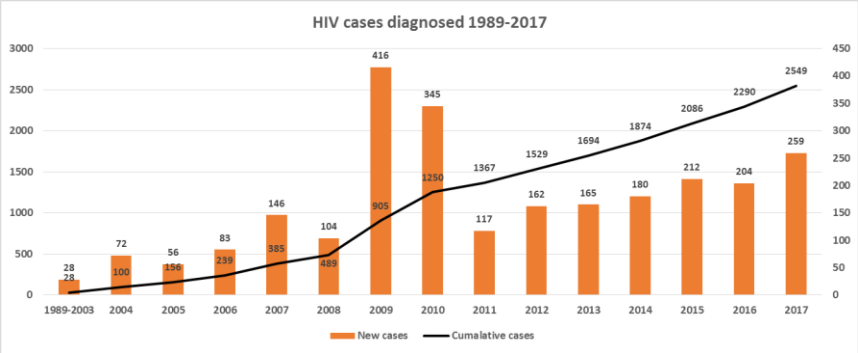
World Health Organization Contact:
Dr Mohammad Nadir Sahak, CSR National Professional Officer, Phone: +93 782 200 348, Email: sahakm@who.int
Dr Najibullah Safi, Programme Manager, Health System Development, Phone: +93 777 890 855, Email: safin@who.int

HIV/AIDS/Hepatitis

(Communicable Diseases)

Situation Update: Afghanistan has a low HIV prevalence among the general and key population groups except for injecting drug users (IDUs). HIV prevalence among IDUs has been as high as 4.4%. If effective prevention interventions are not scaled up to reach adequate coverage, Afghanistan is likely to soon experience a concentrated HIV epidemic among IDUs. The 2009 UNODC Drug Use Survey in Afghanistan reveals that almost one million Afghans use drugs. In addition to IDUs, population groups living with HIV include prisoners, female sex workers, and men who have sex with men. In 2017, the number of people living with HIV (PLHIV) in Afghanistan was estimated to be 5,900, of which 23.7% were women and 3.4% children. By the end of 2017, the Afghanistan National Programme for control of AIDS/HIV, STI & Hepatitis (ANPASH) reported 2,549 HIV-positive cases cumulatively. By December 2017, 800 PLHIVs were enrolled for treatment.

The National Strategic Plan, Investing in the response to HIV - 2016 – 2020, focuses its response on the following priority areas: **Priority Area 1**: Enhancing accessibility, coverage, quality, efficiency and effectiveness of HIV prevention interventions among key populations at high risk, vulnerable populations and the general population
Priority Area 2: Expanding accessibility and coverage of comprehensive and integrated HIV treatment, care, and support for people living with HIV and their families
Priority Area 3: Documentation and utilization of strategic information for informed and evidence-based decision-making
Priority Area 4: Creating a supportive and enabling environment for a sustained and effective national response to HIV and AIDS
Priority area 5: Strengthening governance and programme management at national and provincial levels



Achievements:

- Provided continuous technical support to ANPASH in programme implementation, monitoring and resource mobilization.
- Availed technical expertise to revise and finalize National HIV Testing Services guideline.
- Allocated technical support to develop hepatitis C testing and treatment guidelines, and facilitated training of clinicians on hepatitis C management.
- Put forward technical assistance to develop policy to address stigma and discrimination in healthcare settings.
- Extended further technical assistance to develop the first National Strategic plan on Hepatitis 2017–2021.

Programme Risks and Challenges:

- Limited availability of skilled health staff to support PLHIV.
- Low awareness of HIV among general and key populations, cultural barriers to disseminating information and scaling up prevention.
- Stigma towards the disease among the general population and health workers, impeding access to health facilities for testing and treatment.
- Lack of HIV testing and counselling services and anti-retroviral therapy services in all provinces.

Way Forward:

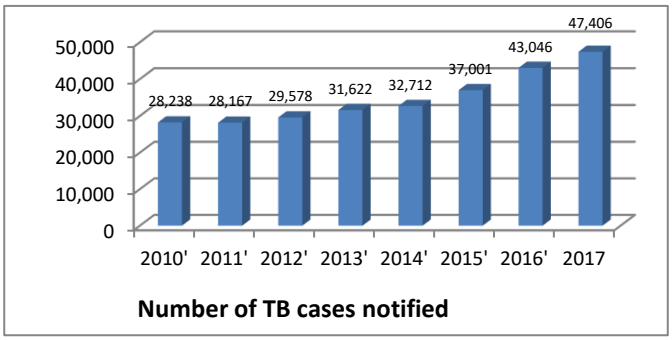
- Increase access to HIV and hepatitis testing and treatment.
- Scale up evidence-based prevention, including Opioid Substitution Therapy (OST).
- Update guidelines, keeping in line with global guidance.
- Monitor patients on ART.
- Strengthen TB/HIV collaborative activities.
- Facilitate resource mobilization.

World Health Organization Contact:
Dr Supriya Warusavithana, Programme Manager, Phone: 0782 200 350, Email: warusavithanas@who.int
Dr M. Reza Aloudal, National Profession Officer, Phone: 0782 200 389, Email: aloudalm@who.int

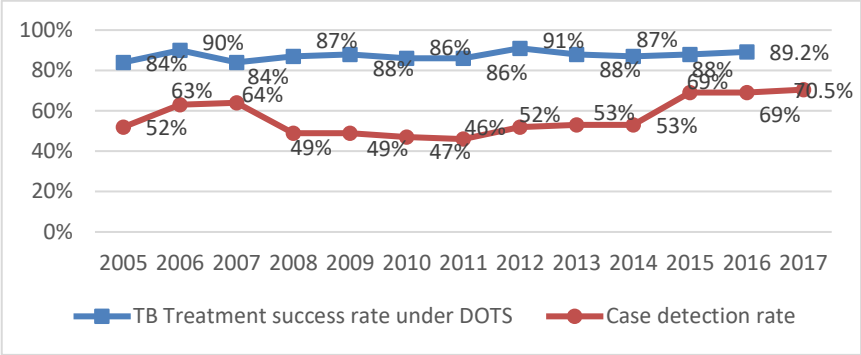
Tuberculosis

(Communicable Diseases)

Situation Update: Tuberculosis (TB) continues to be a major public health challenge in Afghanistan. Medicines and diagnostics are made available free of charge in the country. 65,000 cases and 11,000 deaths were estimated to be caused by TB in Afghanistan in 2016. In 2017, 47,406 cases were detected and enrolled on treatment. Out of all health facilities (2,857), 71% are providing Directly Observed Treatment (DOTS) services.



In 2017, a total of 392,272 presumptive cases were tested for TB. Among the new cases, 19,479 (41.1%) were bacteriologically confirmed, 13,029 (27.5%) clinically diagnosed, and 12,329 (26%) were extra pulmonary cases. 9,732 (20.5%) of TB cases were children. Of all TB cases, 56% were women. Of all TB-diagnosed patients, 70.6% were in the productive age group (15-64 years), and 52.3% of women were in the reproductive age group (15-44 years). Contact tracing was conducted for 84% of respiratory symptomatic cases, and among them 22,939 (93% of children in contacts) were put on isoniazid preventive therapy (IPT). A total of 22,591 (47.6%) TB cases were screened for HIV and 7 cases (0.05%) reported TB/HIV co-infection, and 201 multidrug-resistant TB (MDR-TB) cases were diagnosed and enrolled for management. The treatment success rate for all cases in 2016 was 89.2%.



Source: NTCP Annual Report 2017

Achievements:

- Made available an uninterrupted supply of TB medicines and laboratory consumables worth of USD 3.6 million.
- Provided ancillary drugs for management of adverse drug reactions.
- Trained nearly 960 health staff on TB drug management and facilitated 196 mentoring visits by NTP staff during 2015-17.
- Developed/revised technical guidelines and standard operating procedures.
- Mobilized 2-year grant from the Global Drug Facility (GDF) to treat 9,861 cases using new TB pediatric formulations (2016-2017).
- Mobilized USD 8.6 million from the Government of Japan/JICA to support 50% of FLDs and 60% of SLDs for the period 2018-2020.
- Facilitated the mobilization of USD 10.6 million from the Global Fund for 2018-2020.
- Renovated TB Central Drug Stores, Kabul and storage at NTP, Afghan-Japan Communicable Disease Hospital and provincial TB stores.

Programme Risks and Challenges:

- Cultural barriers and stigma around TB.
- Deteriorating security situation affecting access to services.
- Inadequate human resources capacity at the health facility level and lack of quality assurance in laboratory services.

Way Forward:

- Partnership development and resource mobilization.
- Scale up of pharmacovigilance of anti-TB medicines.
- Further innovations to improve case detection.
- Strengthen the management of childhood TB and Programme Management of Drug Resistant TB (PMDT).
- Build the capacity of NTP staff on conducting implementation science research.
- Scale up management of multidrug resistant TB.
- Strength TB/HIV collaborative activities.

World Health Organization Contact
Dr Supriya Warusavithana, Programme Manager, Phone: 0782 200 350, Email: warusavithanas@who.int
Dr M. Reza Aloudal, National Profession Officer, Phone: 0782 200 389, Email: aloudalm@who.int

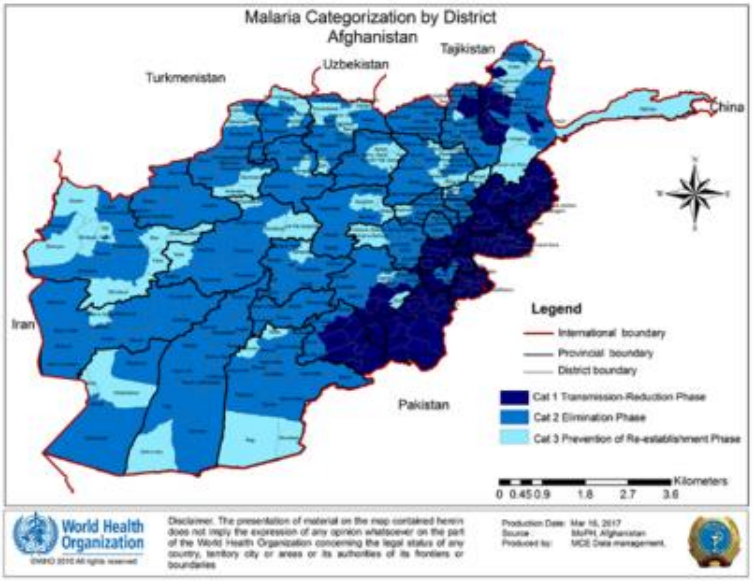
Malaria

(Communicable Diseases)

Distribution of malaria nets

Situation Update: Afghanistan has the world's third-highest malaria burden. The country accounts for 11% of cases in the WHO Eastern Mediterranean region. In Afghanistan, 95% of malaria cases are attributed to Plasmodium falciparum (P.f.) and 5% to Plasmodium vivax (P.v.). Over 76% of Afghans live in at-risk areas. There are 123 districts at high risk and 213 districts at low risk of malaria, with eastern Afghanistan having the highest burden. In 2017, 91% of confirmed P.f and 89% of P.v. cases were reported from six provinces: Nangahar, Laghman, Kunar, Nuristan, Khost and Paktika. Ten malaria deaths were reported from Nangahar (seven cases), Kabul (two cases) and Kunar (one case), while a significant reduction, particularly in P.f., is noted in the northeastern, northern and western regions. In 2017, the incidence rate of confirmed malaria cases was 8 per 1,000 and slide positivity rate (SPR) was 17.64%.

According to 2015 AfDHS, while 26% of households own at least one insecticide-treated bed net (ITN), only 3% of households have enough nets to cover all household members (assuming 1 ITN per 2 people). Few children under five years of age and pregnant women – the most at-risk groups – slept under an ITN. There was a gap between ownership and use of ITNs: only 17% of children under age five and 15% of pregnant women in households with a net used the net the night before the survey. In 2016-17 around 2.8 million ITNs were distributed, which should have helped improve the situation.



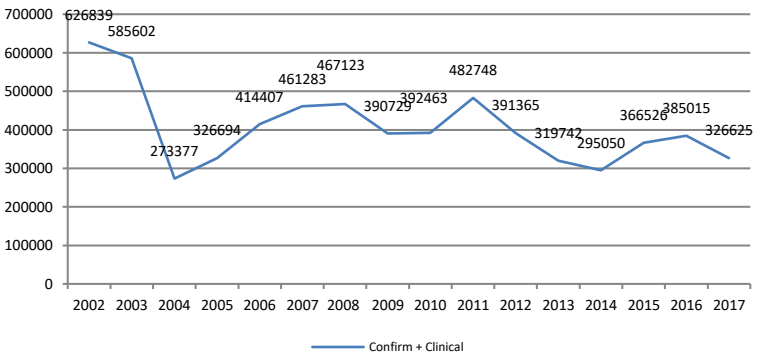
Achievements:

- Provided technical support for the assessment of malaria surveillance systems.
- Technical and financial support was provided to pilot the Malaria and Leishmaniasis Information System (MLIS) to improve surveillance.
- Facilitated assessment on insecticide resistance patterns.
- Trained 59 master trainers on MLIS in the scaling up of implementation.
- Conducted monitoring and evaluation of malaria control and elimination activities through CCM oversight committee.
- Revised National Malaria Treatment guidelines.
- Facilitated and coordinated the revision of the National Malaria Strategy – 2018-2022.
- Provided information education materials for health facilities to enhance public awareness.

Programme Risks and Challenges:

- Limited financial support to cover all components of the National Strategy, specifically a lack of support for the implementation of the Pf elimination programme in recommended provinces.
- Limited skilled staff at service delivery and programme management levels.
- Weakness in the monitoring system, especially with quality assurance of laboratory services.
- Poor health-seeking behaviour in communities.

Total Reported Cases Confirm + Clinical 2002-2017



Way Forward:

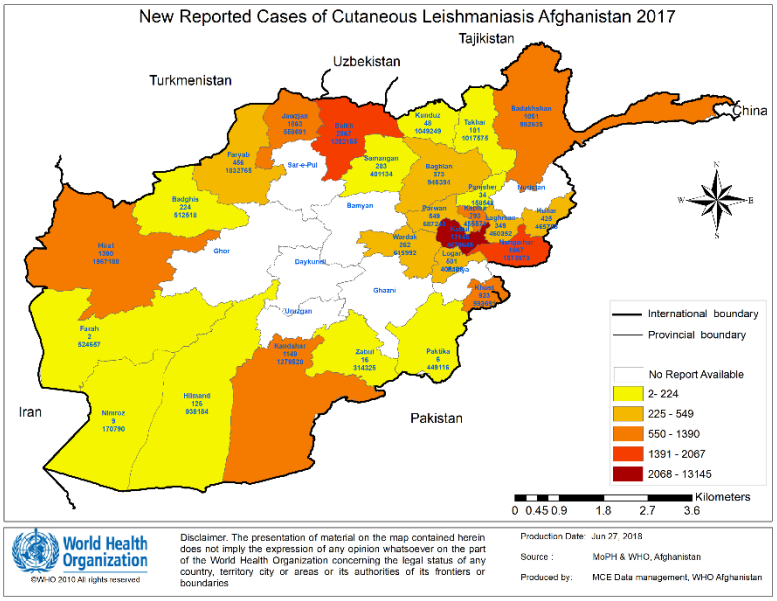
- Ensure universal coverage with malaria diagnosis and case management through strengthening the capacity of health facilities and Community-based Management of Malaria.
- Ensure effective coverage by Long Lasting Insecticidal Nets (LLINs) in high-risk provinces.
- Enhance the capacity of National Malaria Control Programme staff on programme management, service delivery and M&E.
- Regular monitoring of malaria drug efficacy and insecticide resistance.

World Health Organization Contact:
Dr Supriya Warusavithana, Programme Manager, Phone: 0782 200 350, Email: warusavithanas@who.int
Dr Naimullah Safi, National Professional Officer, Phone: +93 782 220 830 Email: safina@who.int

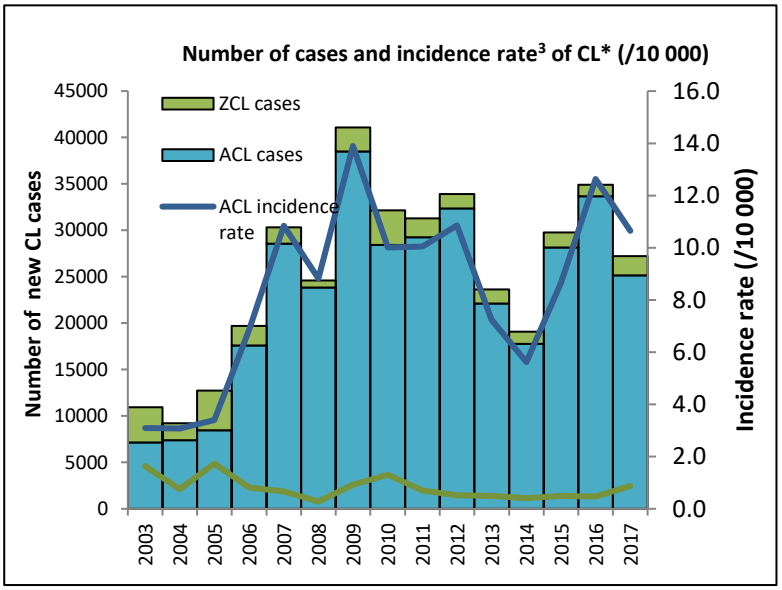
Leishmaniasis

(Communicable Diseases)

Situation Update: Afghanistan has a high burden of cutaneous leishmaniasis (CL), especially in Kabul. Around 23.6 million people are at risk of CL in 24 of 34 provinces that are reporting the disease. Over 27,000 new CL cases were reported in 2017. Kabul has a high burden of CL, with over 13,000 new cases reported in 2017 (48% of total). When leishmaniasis is not promptly treated, it can lead to disfiguration and disability and poses a high social burden, resulting in stigma and marginalization, especially for women.



In Afghanistan CL mainly affects the poorest people. Due to improved surveillance, the number of reported cases of visceral leishmaniasis (VL), a severe and sometimes fatal form of the disease, increased in recent years. Leishmaniasis case management was recently integrated into BPHS/EPHS, but still there are still some gaps in drug availability and the quality of drugs provided by BPHS/EPHS implementers in some endemic areas. The National Malaria and Leishmaniasis Control Programme (NMLCP), as a technical department of MoPH, is responsible for leishmaniasis control. WHO supports the capacity building of health staff and development of a leishmaniasis surveillance system to enhance its proper integration and implementation through BPHS health service delivery. Targeted interventions include disease control in at-risk communities by diagnosis and treatment, provision of drugs, support for the implementation of the National Strategic Plan, expansion of the regional and international network of expertise, community engagement and operational research.



Achievements:

- Trained 937 health staff (doctors and nurses) from BPHS health facilities on management of leishmaniasis and surveillance.
- Enhanced leishmaniasis surveillance under an integrated surveillance module, Malaria and Leishmaniasis Information System (MLIS).
- New IEC materials (1,600 posters for health facilities and 1,000 leaflets for communities) developed, printed and distributed.
- Strengthened leishmaniasis surveillance with training of health staff and provision of recording and reporting tools (1,100 registry books and 100,000 patient cards).

Programme Risks and Challenges:

- Lack of adequate financial resources to support the leishmaniasis programme.
- Lack of skilled staff at programme management and service delivery levels.
- Poor health-seeking behaviour in communities.

Way Forward:

- Support the National Control Programme in resource mobilization and capacity-building initiatives as well as with implementation of the national control strategy.
- Raise public awareness on leishmaniasis prevention and control.

World Health Organization Contact:
Dr Supriya Warusavithana, Programme Manager, Phone: 0782 200 350, Email: warusavithanas@who.int
Dr Naimullah Safi, National Professional Officer, Phone +93 782 220 830 Email: safina@who.int

Expanded Programme on Immunization (EPI)

(Communicable Diseases)

Situation Update: Immunization plays a pivotal role in reducing mortality and morbidity from vaccine-preventable diseases in Afghanistan. The Ministry of Public Health (MoPH) has strengthened its commitment to improving people's access to immunization services. Over the past years, cold chain capacity has expanded, new life-saving vaccines have been introduced, vaccination coverage has expanded for traditional and new and under-utilized vaccines, and immunization is among the government's top health priorities. However, overall immunization coverage remains low with disparities throughout the country, particularly between rural and urban areas and secure and insecure zones. Among children under five, the most vulnerable are those living in hard-to-reach communities.

A mobile vaccination team on their way to a village to carry out an outreach session

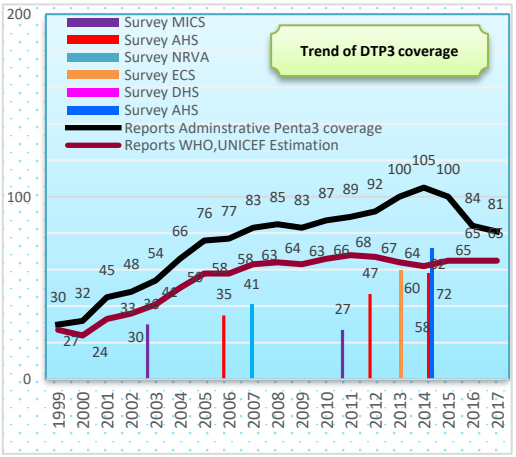
Achievements:

Despite a challenging situation in terms of access and utilization of immunization services, routine immunization (RI) has made the following progress:

- Currently 11 antigens are in public use against vaccine-preventable diseases.
- Expanded health centres providing immunization services from 1,575 in 2015 to 2,926 in 2018. 400 new vaccinators have been trained to meet the needs of the programmes mainly in remote areas.
- Updated/revised the RI immunization strategic plan (cMYP15-19) as a key immunization programme management tool.
- Carried out a comprehensive external immunization programme review and made recommendations to improve coverage.
- As part of AHS 2018, all RI indicators were included in the survey. Preliminary national DPT3 containing vaccine coverage is 60 per cent.
- Carried out an immunization data quality assessment and made plans to improve data quality.
- Application for rotavirus introduction was approved and the vaccine was introduced into national immunization programmes.
- Vaccine and cold chain capacity increased to accommodate all routine vaccines and vaccines for SIAs.
- The 1st round of national measles SIAs conducted in 2018, reaching 14 million children aged between 9 months and 10 years.
- The national measles/rubella lab was accredited by WHO. Measles/rubella lab quality control/genotyping was conducted and the circulating measles genotype (B3) identified.
- With lab support, national measles/rubella surveillance has achieved the capacity required to detect MR cases/outbreaks and take timely corrective actions. Further, MR, CRS, Rotavirus, IBD and intussusception surveillance with lab support has been expanded to four regional children's hospitals and labs.

Programme Risks and Challenges:

- Poor utilization of immunization services due to low BPHS coverage.
- Disparity in distribution of healthcare services between rural and urban areas: health services are unavailable in many areas
- Deteriorating security, resulting in difficulty in accessing health services.
- Weak management and accountability.



Way Forward:

- Strengthen government ownership and closely monitor BPHS NGOs' performance.
- Expand RI services to reach as-yet unreached populations.
- Strengthen the Reach Every District (RED) approach and establish a country-tailored approach to improving data quality at all administrative levels, conducting a Data Quality Self-assessment (DQs), and using data.

World Health Organization Contact:
Dr. Abdoulghafoor Abdulshakoor, WHO EPI Manager, Phone: +93 700 025 888, Email: abdulghaoora@who.int

Noncommunicable Diseases and Tobacco Control

(Noncommunicable Diseases)

Situation Update: The burden of noncommunicable diseases (NCDs) is escalating in Afghanistan. NCDs are the cause of more than 35% of mortality (2010 Afghanistan Mortality Survey, AMS). In detail, major causes of mortality include cardiovascular disease (women 17.9%, men 14%), cancer (women 8.3%, men 7.3%), diabetes mellitus (women 2.7%, men 3.7%), and respiratory disease (women 2.3%, men 1.9%). Among women, the leading causes of death are infectious/parasitic and cardiovascular disease (18% each) followed by respiratory infections (15%).

NCDs share common preventable and modifiable risk factors such as smoking, unhealthy diets, physical inactivity and excessive consumption of alcohol. Tobacco use is a major risk factor. Based on WHO data in 2016, 8.4% of Afghans had diabetes, 13.9% were overweight and 2.4% obese. According to WHO age-standardized estimates (2013) on the prevalence of smoking among those aged 15 years or older, 35% of Afghan men are smokers and an estimated 5% of deaths were attributable to tobacco. The Afghanistan Demographic Health Survey (2015) showed that around 3% of households in Afghanistan had a family member diagnosed with cancer. Households in rural and urban areas were as likely to report family members diagnosed with cancer. Among households with at least one member diagnosed with cancer, 21% reported breast cancer, followed by liver cancer and duodenal cancer (19% each). Around 16% reported lung cancer and 5% cervical cancer.

Achievements:

- Conducted STEP NCD risk factor survey.
- Coordinated the joint WHO/IAEA imPACT mission on cancer control and management and finalized the report.
- Initiated a pilot programme on NCD management at Primary Health Care level using WHO NCD-Emergency kits according to WHO Packages of Essential NCD Interventions (PEN) and the Global Heart initiative.
- Facilitated the establishment of the Inter-ministerial Committee for Tobacco Control and multi-sectoral committee for NCDs.
- Strengthened the implementation of tobacco control law in restaurants and hotels in the municipality of Kabul.
- Trained two people from the Ministry of Finance to implement tobacco taxation policy.
- Trained more than 75 police officers on tobacco control law.
- Trained 75 school principals and teachers on preventing tobacco use among children.
- Supported the development of IEC materials to raise awareness of NCD risk factors.

Programme Risks and Challenges:

- Lack of commitment from the health sector to create an enabling environment to move forward on NCD prevention and control strategy.
- Low levels of awareness of NCD risk factors in the community.
- Inadequate funding for the implementation of the NCD strategy, and a need for multi-sectoral engagement in advancing the strategy.

Way Forward:

- Advocate to obtain political and community commitment for NCD prevention and control.
- Mobilize multi-sectoral engagement to implement the NCD strategy.
- Support the implementation of the WHO Framework Convention on Tobacco Control.
- Facilitate the integration of essential NCD interventions into community healthcare using standardized WHO tools.
- Provide technical guidance to develop and implement a cancer control strategy.
- Integrate the management of NCDs into healthcare settings.

World Health Organization Contact:
Dr. Supriya Warusavithana, Programme Manager, Phone: 0782 200 350, Email: warusavithanas@who.int

Mental and Disability Health

(Noncommunicable Diseases)

Situation Update: Devastated by decades of war, instability and poverty, many Afghans suffer from mental health and psychosocial problems. Despite significant need, healthcare facilities attending to mental health issues are scarce. Mental health is one of the components in the existing framework of the Basic Package of Health Services (BPHS). Inclusion of mental health and psychosocial care into BPHS is an important step towards ensuring that psychosocial problems and mental disorders are recognized and managed by primary healthcare personnel. Currently, psychosocial counselors provide services in most comprehensive health centres (CHCs). The lack of trained psychiatrists, psychiatric nurses, psychologists and social workers presents a serious challenge for mental healthcare service delivery. Nationwide, only 320 hospital beds in the public and private sector are available for people suffering from mental health problems.

Women are particularly affected by mental health problems in Afghanistan

Decades of conflict have left an estimated 800,000 Afghans (2.7% of the population) with a range of severe disabilities. The main categories of disability are physical (37%), sensory (26%) and multiple disabilities (46%). Between 60-80% of people with disabilities live in rural and informal urban settlements.The provision of rehabilitative services to people living with disabilities is hindered by a lack of institutional expertise, trained practitioners and skilled teachers, and by weak community knowledge and physical barriers to treatment. The remoteness of services and lack of funding often hampers access to services for vulnerable groups. Only 21 out of 34 provinces have physical rehabilitation services within both the BPHS and EPHS. The majority of services for people with disabilities are provided by international and national NGOs.

Achievements:

- Gender-based violence (GBV) unit conducted Training of Trainers on mental health care for survivors of intimate partner and sexual violence with the technical assistance from HQ/EMRO.
- Emergency Health Unit facilitated training of psychosocial counsellors on psychosocial first-aid.
- Supported the revision of Afghanistan's Mental Health Strategy.
- Supported the development of the National Suicide Prevention Strategy for Afghanistan.

Programme Risks and Challenges:

- People with mental health and substance abuse disorders are not the only ones who experience stigma and human rights violations: mental health care providers in the formal and informal sectors also report this.
- Despite the high number of people suffering from mental health problems in the country, the mental health services available are limited and of low quality.
- Inadequate financing of mental health and psycho-social interventions.

Way Forward:

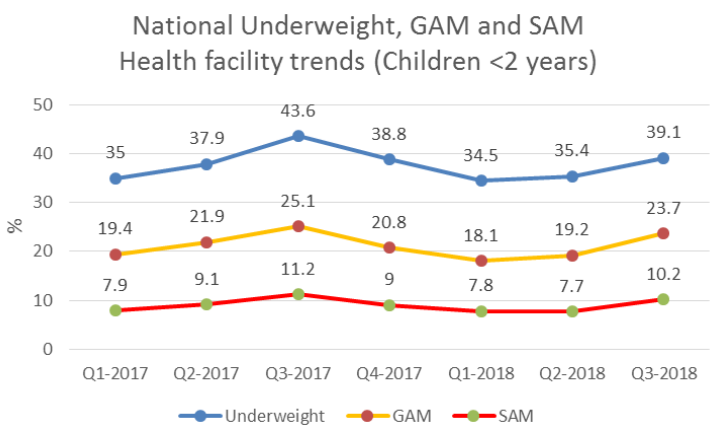
- Support the rolling out of integrated mental health services in BPHS/EPHS, including substance use prevention and treatment up to the PHC level.
- Support the monitoring and supervision of mental health services and activities by BPHS implementers.
- Develop mental health IEC/BCC materials to increase community awareness of mental health problems.

World Health Organization Contact:
Dr. Supriya Warusavithana, Programme Manager, Phone: 0782 200 350, Email: warusavithanas@who.int

Nutrition

(Noncommunicable Diseases)

Situation Updates: The trend analysis of national nutrition sentinel surveillance (NNSS) data from health facilities and community sentinel sites across the country shows a slight increase in acute malnutrition levels and underweight rates in Q3-2018 compared to Q2-2018. Global Acute Malnutrition (GAM) rates were higher in Q3-2018 (23.7%) compared to Q2-2018 (19.2%). Severe Acute Malnutrition (SAM) rates increased in Q3-2018 to 10.2% compared to Q2-2018 (7.7%). Underweight rates increased from 35.4% in Q2-2018 to 39.1% in Q3-2018). The Afghanistan Nutrition Cluster expects that the effects of the 2017 drought will likely result in an increase in the acute malnutrition caseload from November 2018 to April 2019(the next harvest period) particularly for children under five years of age.



Achievements

- Continued support to sentinel-based nutrition through 175 health facilities and communities.
- The 2018 quarterly nutrition surveillance bulletin was used to forecast expected trends in caseloads of acute malnutrition and appropriate response planning.
- Trained 187 health workers in order to strengthen service readiness and the availability of inpatient management of Severe Acute Malnutrition (SAM) in response to drought.
- Provided support to 35 Therapeutic Feeding Units (TFUs) and trained 284 health workers have been trained on inpatient management of SAM in 2018.
- Provided support on functionalising the Nutrition Monitoring and Evaluation framework for the implementation of the National Nutrition Strategy.
- Supported MoPH in developing the Infant and Young Child Feeding (IYCF) strategy.
- Supported development of nutrition modules in pre-service training curriculum for health cadres in tertiary institutions.

Programme Risks and Challenges:

Insecurity and geographical constraints remain the greatest barriers towards optimal implementation and monitoring of nutrition interventions at health facilities, compounded by inadequate coverage of services. The protracted emergency situation and dynamic situation requires real-time information on the nutritional status of children, which is not always possible to acquire due to the weak integration and follow-up of nutrition information systems.

Way Forward:

- Continuous support to strengthen inpatient management of severe acute malnutrition services through training and kits distribution
- Continue to support the strengthening of nutrition information systems and the improved analysis and use of data
- Support efforts to tackle the double burden of nutrition (under- and over- nutrition) through evidence generation, development of strategies and guidelines and implementation plans.
- Support coordinated efforts to support government interventions through the ONE UN approach.

World Health Organization Contact:

Dr Mohammad Qasem Shams, Nutrition Programme Officer, Contact: +93 799 375 529, shamsm@who.int
Mr Chinjekure Admire, Technical Officer, Contact: +93 784 916 419, chinjekurea@who.int

Indicators	NSS 2013	ADHS 2015	AHS 2018
Percentage of children with chronic malnutrition (stunting)	40.9		36.6
Percentage of children with acute malnutrition	9.5		5.0
Percentage of children with underweight	25		18.7
Percentage of children overweight	5.4		4.0
Percentage of children ever breastfed		98	98.6
Percentage of children breastfed within 1 hour of birth		41	63.7
Percentage of exclusive breastfeeding	58.4	43	57.5
Percentage of complementary feeding	59.9		
Percentage of children 6-23 months with minimum acceptable diet		15	
Percentage of women of reproductive age 15-49 years underweight (BMI <18.5)	9.2		
Percentage of women of reproductive age 15-49 years overweight (BMI 25-29.9)	20.7		
Percentage of women of reproductive age 15-49 years obese (BMI ≥30)	8.3		
Percentage of unmarried adolescent girls age 10-19 years underweight	8		
Percentage of unmarried adolescent girls age 10-19 years overweight	11.6		

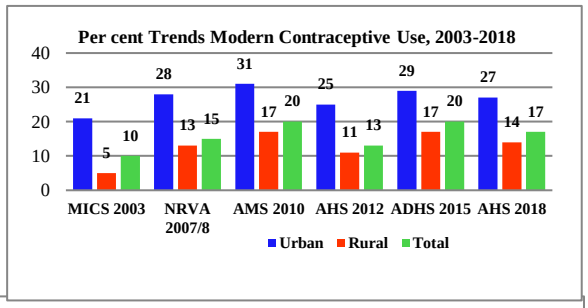
Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)

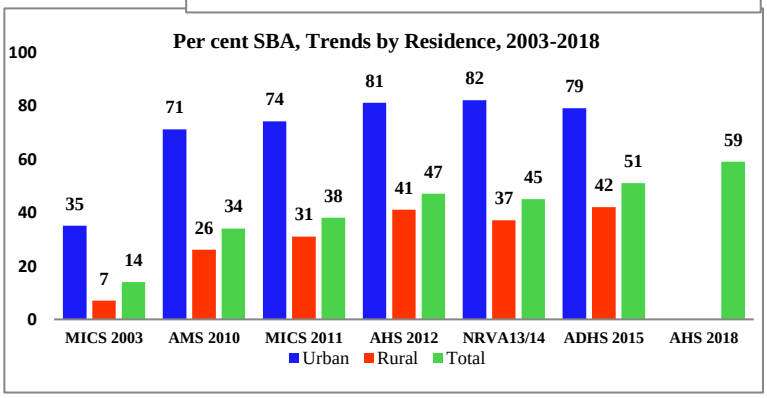
(Promoting Health throughout Life)

Situation Update: There is a significant increase in the utilization of antenatal care (ANC) and skilled birth attendance (SBA) in the last 10 years, from 31% and 24% (NRVA 2007/8) to 64% and 59% (AHS 2018) respectively. Under-5 child, infant and neonatal mortalities have reduced respectively from 175, 119 and 74 per 1,000 live births in 1990 (IGME) to 68, 52 and 39 in 2018 (IGME). The 2015 AfDHS reported a very high maternal mortality ratio at 1,296/100,000LB[1], a low Caesarean section rate (2.7%) and unchanged modern contraceptive prevalence for the last 10 years (20%). Maternal and child mortality remains among the highest in the region. Haemorrhage is the leading cause of maternal deaths (56%), followed by eclampsia (20%) obstructed labour (11%), and sepsis and infections (5%). Infectious diseases such as sepsis/meningitis (20%), pneumonia (17%), diarrhoea (14%), and other infections (12%) account for 63% of deaths among children under five years of age (AHS 2018).

Achievements:

- Supported the updating of Family Planning (FP) clinical guidelines, service standards, provider job aids and in-service training package.
- Trained 50 master trainers and over 450 health personnel on BEmONC, CEmONC, ENC, IMNCI, FP/BS, ETAT, MNDSR and adolescent health.
- Supported MoPH in strengthening RMNCAH programmes on FP, CRVS and MNDSR and improving subnational training capacity on CEmONC, BEmONC, IMNCI, ETAT, and Essential and Advanced Newborn Care.
- Introduced and supported MoPH in building an early childhood development programme.
- Supported MoPH in the adoption of the Home-Based Maternal and Child Health Book and its scale up as a national programme.
- Supported MoPH and the Health Cluster in developing national standards for the assessment, planning, implementation and M&E of emergency RMNCAH interventions targeted at IDPs, refugees and returnees.





Source: MICS-Multiple Indicator Cluster Survey, AHS-Afg. Health Survey, NRVA-National Risk and Vulnerability Assessment, AMS- Afg. Mortality Survey, A-DHS- Afghanistan Demographic and Health Survey

Programme Risks and Challenges:

- Insecurity, hard-to-reach terrains, gender inequality, cultural barriers, a lack of female staff and low quality of available services affect both access to and utilization of health care for women and children.
- Despite high (95%) knowledge of contraceptive methods (amongst married women), contraceptive prevalence is low (around 20%).
- Child marriage leading to a high adolescent fertility rate of 78 births per 1,000 women aged 15-19 years.
- High illiteracy among women (84%) leading to poor utilization of ANC, SBA and FP/BS services.
- Influx of an increasing number of Afghan refugees and returnees from Pakistan and Iran.

Way Forward:

- Support MoPH technical capacity building in performance review of SEHATMANDI, with focus on quality of RMNCAH service delivery.
- Raise funds and implement the joint WHO-MoPH MDSR and FP/BS programme proposals.
- Continue technical support for revision of national clinical guidelines, service standards and provider training packages.
- Continue to build MoPH capacity in building an early childhood development programme.
- Scale up implementation of IMNCI and BEmONC pre-service training curricula at the key national medical universities.
- Continue to build MoPH research capacity on RMNCAH, e.g. by assisting in M&E of the MCH home-based handbook scaling up.

World Health Organization Contact:
Dr Paata Chikvaidze, WHO RMNCAH Medical Officer, Phone: +93 782 200 369, Email: chikvaidzep@who.int
Dr Adela Mubasher, WHO RMNCAH Programme Officer, Phone: +93 700 281 127, Email: mubashera@who.int

[1] Pregnancy-related deaths seem to be overestimated. The AfDHS mortality data is under review by the global experts, including UN agencies, to produce adjusted estimates based on global UN model. MMR UN estimates are expected to be published by Feb. 2019.

Gender, Equity and Human Rights

(Promoting Health throughout Life)

Situation Update: The status of Afghan women remains one of the lowest in the world: According to AfDHS 2015, 52% of ever-married women have suffered from spousal violence, whether physical (46%), sexual (6%), or emotional (34%) and 53% of women have experienced physical violence after the age of 15. Further, 16%of women aged 15–49 reported that they had experienced violence during pregnancy, and 80% of ever-married women and 72% of ever-married men believed that a husband is justified in beating his wife under certain circumstances.

Health indicators for women remain poor though women and men experience different vulnerabilities and risks. Despite an increase in the number of women health workers, women face challenges in accessing services due to gender norms and poor infrastructure. Over the past decades, Afghanistan has made progress in setting up a coherent framework to eliminate gender inequality and social exclusion by establishing the Ministry of Women's Affairs (2002) and ratifying the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW, 2003). The Gender Unit within the MoPH Reproductive Health Directorate was established in 2006 and in 2013 promoted to the Gender and Human Rights Directorate.

Gender-based violence (GBV) in Afghanistan is concerning. A 2015 WHO Afghanistan baseline assessment showed major weaknesses in health service provision to survivors. Only 10% of facilities are well prepared to address GBV: only a quarter of the 280 health facilities surveyed had private examination rooms and only 2% had a protocol in place for GBV care. The assessment also showed major gaps in health care providers' knowledge and attitudes about the health consequences of GBV and the role of health care providers in helping survivors. The results also point to a need to strengthen coordination and linkages with other non-health service providers, and to properly equip and organize health facilities and address cultural and social barriers to GBV.

Achievements:

- Supported MoPH in the revision of the Gender and Human Rights Strategy (2017-2021).
- Conducted 161 five-day training workshops on GBV treatment protocol. Between 2015 and 2018, a total of 3,979 health care providers (1,590 nurses, 1,237 midwives and 1,152 doctors) were trained on the protocol. A further 565 received refresher training and 230 manager training.
- Trained 200 health care providers on GBV treatment protocol in emergency setting and 60 in gender mainstreaming.
- Equipped all 518 targeted health facilities in seven provinces with patient gowns and curtains to support privacy and confidentiality.
- Distributed 43 pre-packaged post-rape management kits to provincial and regional hospitals in seven provinces.
- Integrated the GBV treatment protocol into the syllabus of the Community Health Nursing Education Programme and Health Social Counsellor curriculum to ensure long-term sustainability of the GBV protocol project.
- Provided IEC materials on GBV and health to communities and provided guides for health care providers on GBV care at all targeted health facilities in seven provinces.

Programme Risks and Challenges:

- Pervasive gender inequality, limited availability of skilled health workers for managing GBV cases, poor attitudes among healthcare providers and communities on GBV, and women's limited and restricted access to health care.
- Weak referral system for GBV in the health, justice and protection sectors, as well as cultural barriers and stigma toward GBV survivors.
- Low political attention and commitment for enhancing gender equality and addressing gender issues in healthcare.
- Insufficient funding for gender, human rights and health issues.
- Poor coordination between ministries, departments, agencies and NGOs working on different aspects of GBV.

Way Forward:

- By 2020, over 6,500 healthcare providers will be trained on GBV treatment protocol in all 34 provinces.
- Strengthen health systems to enable them to better organize and administer GBV care, and establish a strong M&E system.
- Build capacities of health personnel on the implementation of the 2017-2021 Gender and Human Rights Strategy, gender-sensitive communication skills and overall gender mainstreaming in health programming.
- Continue to strengthen the capacity of healthcare providers on gender mainstreaming in emergency response.
- Integrate GBV treatment protocol into remaining medical student curricula.
- Distribute of job aids, training packages and GBV posters to all targeted health facilities in 14 provinces.

World Health Organization Contact:
Dr. Sharifullah Haqmal, Programme Officer (Gender and Human Rights), Phone: + 93 780 005 520 Email: haqmals@who.int

Health Systems

(Health Systems)

Situation Update:

Afghanistan's health system has been steadily progressing over the last 17 years, with increasing coverage of health services throughout the country. In 2018, a total of 3,135 health facilities were functional, which ensured access to almost 87% of the population within two hours distance. Afghanistan's National Health Policy 2015-20 has five policy areas: governance, institutional development, public health, health services and human resources. The recently developed One UN strategy focuses on Health System Strengthening among other health topics. WHO and UN agencies are helping the government to implement the National Health Policy 2015-20 and Strategy 2016-2020.

Afghanistan Health Care Facts:	
Total population (2018)	**31,575,018**
Number of physicians registered with MoPH (2016)	**2,941**
Number of nurses registered with MoPH (2016)	**5,057**
Number of midwives registered with MoPH (2016)	**2,785**
Per capita THE (2014) USD	**70.9**
Total expenditure on health as per cent of GDP (2014)	**9.5 per cent**
Out-of-pocket expenditure as per cent of total health expenditure (2014)	**72 per cent**
Government health expenditure as per cent total government expenditure (2014)	**4.3 per cent**
No. of PHC centres /10,000 population (2017)	**0.87**
No. of hospital beds / 10,000 population (2012)	**4.2**
Proportion of population having access to health services within two hours distance by any means of transport	**87**

Achievements:

- As co-chair of the Development Partners Forum, WHO provided technical support to MoPH and partners to strengthen policy dialogue, coordination and harmonization of programmes in the sector, and the mobilization of resources.
- Supported the development of a new health package for UHC.
- Assisted in the formulation of a National Health Strategy 2016-20.
- Helped the development of SEHATMANDI (2018-21).
- Supported the establishment of a Health Sector Strategic Oversight Committee, chaired by H.E Minister.
- Supported the development of a fourth round of National Health Accounts.
- Established and strengthened the first Afghan Medical Council.
- Strengthened the National Medicines and Health Regulatory Authority.
- Implemented the patient safety programme in 17 hospitals.
- Updated the National Medicine Policy and National Formulary of Medicine.
- Formulated the National CRVS strategy and facilitated development of tools for the implementation of ICD10 at hospital level.
- Established mobile health teams (MHTs) in 12 provinces to provide nomadic populations with better access to basic health services.
- Established the Public Private Partnership (PPP) model to provide basic reproductive health and immunization services in remote and insecure districts of six insecure provinces.
- Supported the establishment of a public-private partnership for upgrading 142 private health facilities in insecure areas. The health facilities provide basic maternal and child health services, including immunization.
  .
- Established a call centre

Health facility type	Number
Sub-centre	**986**
Basic Health Centre	**873**
Comprehensive Health Centre	**432**
District hospital	**84**
Provincial hospital	**27**
Regional hospital	**9**
Special hospital	**30**
Mobile clinic	**242**
Other	**452**
Total health facilities	**3,135**
Health posts	**17,297**

Programme Risks and Challenges:

- Sub-optimal utilization of services due to poverty and distance to health facilities.
- Inadequate access to priority health services due to distance, high cost, low awareness, insecurity and shortage of female health care providers.
- Reduced donor support for the health sector beyond June 2018.
- Inadequate domestic resource allocation to health.
- Low level of execution capacity particularly at the sub-national level.

Way Forward:

WHO with MoPH and key partners have identified health system development as a key priority, including support for the following: implementation of the National Health Policy and Strategy, revision of BPHS/EPHS and development of minimum package of health services for Universal Health Coverage, government leadership and regulatory role and integrated health service delivery in line with Sustainable Development Goals (SDGs) and Afghanistan National Peace and Development Framework.

Sources: HMIS 2nd Quarter 2018, AJHSR 2015, NHA Report 2016, NRVA 2012

World Health Organization Contact:
Dr. Najibullah Safi, Phone: +93 777890855, Email: safin@who.int

Hospital & Laboratory Services

(Health Systems)

Situation Update: The Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) have improved the delivery of basic health services, while less attention was paid to enhance the delivery of tertiary care over the last decade. There are 134 hospitals in Afghanistan, 26 of which are located in Kabul, among which 18 are mostly referral hospitals. The comprehensive assessments of national referral hospitals, conducted in 2012, demonstrated little improvement in the management of hospitals and the quantity and quality of health services. These 18 hospitals offer 2,669 beds with bed occupancy rate of 58 per cent and average length of stay of 9.1 days. The hospitals are run by 3,421 professional staff. MoPH and WHO have identified that strengthening laboratory services is an important tool for correct diagnosis, improvement the quality of care and medical research and surveillance.

Intensive care unit (ICU) in a pediatric ward of a Kabul hospital

Health Facilities in Afghanistan	#
National referral hospitals`	26
Regional hospitals	6
Provincial hospitals	28
District hospitals	79
No. of hospital beds/10,000 population:	4.2

Achievements:

- Expanded the patient safety programme to three regional hospitals and seven national hospitals after initial assessment on critical standards of patient safety.
- Conducted two training courses to build capacity of hospital staff on patient safety. Post-intervention assessments on patient safety critical standards in seven hospitals in Kabul indicated improvements on patient safety.
- Provided technical support for the development of a Standard Treatment Guideline for Secondary Health Care. Support includes provision of technical guidelines and supporting one technical person, who is leading the committee working on the guidelines.
- Provided technical and financial support to Patient Safety Focal Point, who has been looking after the implementation of the Patient Safety Programme in the targeted hospitals.
- Supported 25 hospital managers from MoPH hospitals to attend a TOT on hospital management for eight days, organized by WHO EMRO in Tabriz, Iran.
- Supported the development of a national strategy for laboratories.
- Strengthened the capacity of the Central Public Health Lab and regional labs through training of staff on Eliza laboratory testing, PCR, biosafety and biosecurity.

Programme Risks and Challenges:

- Insufficient quality of tertiary care and low trust in public hospitals.
- Lack of standard models for public hospitals.
- Lack of a hospital accreditation system.
- Absence of continuous medical education programmes to improve clinical care in hospitals.
- Limited number of skilled laboratory technicians, particularly at provincial and district levels.
- Lack of drug supplies and necessary medical technologies in hospitals.
- Old infrastructure in national and some regional hospitals.
- Low capacity of hospital management.
- Lack of quality standards for laboratories and low-quality lab services.
- Poor regulation of private laboratories.

Way Forward:

- Expansion of patient safety standards to six more hospitals in Kabul and other regions.
- Roll out all modules of hospital mangement training with the aim of training all hospital managers in the country.
- Initiate and promote a medical errors reporting system in hospitals.
- Implement and expand infection prevention and control in existing and new hospitals.
- Improve of biosafety and biosecurity in the labs.
- Carry out laboratory accreditation and ISO certification where possible.
- Use the WHO Laboratory Quality Stepwise Implementation Tool to upgrade the Central Public Health Lab (CPHL) and advocate for its ISO certification.
- Carry out planning and capacity building activities aimed at improving hospital quality.
- Develop National Quality Standards for labs.

World Health Organization Contact:
Dr. Najibullah Safi, Phone: +93 777890855, Email: safin@who.int

Essential Medicine and Health Technologies

(Health Systems)

Situation Update: Access to essential drugs through basic health care and secondary and tertiary health services is among the key concerns of MoPH and partners, but geographical constraints and security problems are affecting appropriate utilization and access to essential medicines. Both the quantity and quality of essential medicines are major challenges for the health system. The main sources of essential medicine are the local market, which provides medicines to private pharmacies, and BPHS and EPHS implementing NGOs. Most essential drugs are imported from neighbouring countries, sometimes illegally smuggled through Afghanistan's long and open borders. Antimicrobial resistance is a growing concern., Low-quality medicine, together with self-medication and inappropriate use are major contributing factors. Some Afghans use traditional medicine, as it is cheaper than synthetic medicine and easily accessible. In 2016, the government established the National Medicine and Health Products Regulatory Authority (NMHRA) which is responsible for the regulation of medicines, medical devices, vaccines, diagnostics and other health products. The NMHRA is working towards strengthening medicine regulation practices and quality.

Achievements:

- Continued the provision of technical support to the NMHRA to achieve targets identified during the 2017 global self-benchmarking assessment. During this assessment, the NMHRA was determined to be at maturity level one, and it was agreed that it should reach maturity level three by 2022, based on WHO recommendations.
- Provided an International Consultant to developed guidelines for the regulation of traditional and complementary medicine in Afghanistan.
- Published the Afghan National Formulary and translated it into local languages,
- Provided technical assistance for strengthening the regulatory functions of the NMHRA through training workshops on good manufacturing practices, pharmacovigilance and pricing, and through contributions to the work of relevant technical boards and committees.
- Conducted a training workshop for relevant pharmaceutical sector stakeholders on the introduction of the guidelines on traditional medicine.
- Provided regular technical support to the National Pharmacovigilance Committee in reviewing and analysing cases of adverse drug reaction in nine hospitals.
- Supported the formulation of the National Action Plan for Antimicrobial Resistance.
- Supported the annual review of the NMHRA.

Afghanistan Pharmaceutical Profile 2017	
Licensed pharmacists (all sectors) (2017)	2,407 (0.4 /10,000)
(0.96 /10,000)	600
Pharmacists and assistant pharmacists in the public sector (2017)	1,250
Pharmacists in the public sector (2017)	1,400 (0.47 /10,000)
Pharmaceutical technicians and assistants (all sectors) (2017)	7,248 (2.1 /10,000)
(1.5 /10,000)	14,000

Programme Risks and Challenges:

- Limited number of skilled pharmaceutical experts, low capacity in the quality control system.
- Low capacity in some aspects of regulatory functions such as registration and Good Manufacturing Practices inspection.
- Long and open borders with neighboring countries make it very challenging to take control of illegal medicine smuggling.
- Poor health-seeking behaviour and the high cost of healthcare in remote areas lead to self-medication.
- Inappropriate use of medicines by pharmacists and practitioners.
- Over-the-counter use of antibiotics increases the risk of antimicrobial resistance.

Way Forward:

- Continue strengthening the capacity of NMHRA to reach maturity level three.
- Provide support to upgrading the Quality Control lab.
- Support the establishment of drug quality control labs in four regions of Afghanistan.
- Support the implementation of guidelines promoting the controlled use of medicines.
- Strengthen pharmacovigilance and support its expansion to vaccination centres.

World Health Organization Contact:
Dr Safiullah Nadeeb, WHO Programme Officer, Phone: +93 781 766 650, Email: nadeebsa@who.int

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