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I. FOREWORD

The Ministry of Public Health is very pleased to present the National Priority Program (NPP), Health for All Afghans (HAA), which prioritizes practical, focused and health population approaches for the health sector in the Afghan National Development Strategy (ANDS). HAA represents a new commitment within the ANDS framework towards empowerment of Afghans and Afghan institutions for quality service delivery and protecting human rights and financial sustainability.

The HAA is likely to have a major impact on strengthening the governance capacity of the MoPH, further legitimizing the public health sector, while at the same time bringing value for money leading to satisfaction of the Afghan people as well as the international donor and development partners.

The HAA is consistent with the ten strategic directions identified in the Strategic Plan for the Ministry of Public Health 2011-2015 and its core values and principles. Like all the other 21 national priority programs of the Government the Islamic Republic of Afghanistan, the proposed program identifies clear objectives as well as components and sub components, defines the strategy to achieve the objectives/ components and contains a 3-year implementation plan with timelines, responsible deliverables, broad activities, input, process and outcome/output indicators. The detailed costing along with likely constraints to be faced and how to resolve these are part of the proposal.

This National Priority Program could not have been developed without the tremendous effort provided by many individuals (national and international), general directorates, units, directorates, departments and programs and the valued continuous assistance from our partners in health development in improving the document.

I acknowledge and appreciate the best leading of Dr. Ahmad Jan Naeem, Deputy Minister of Policy, Planning and Technical Affairs/ MoPH NPP Team Leader (Previous GD of Policy, Planning and External Relation) and outstanding coordination and facilitation of Dr. Essa Ebrahemi, ANDS Coordinator/ MoPH NPP Focal Point.
Your suggestions and recommendations have strengthened the three components of the program, enhancing equal access to quality health services for the Afghan population. May we count on your future support in a harmonized implementation of the Health for All Afghans in line with the Paris declaration on Aid Effectiveness?

Warm regards.

Suraya “Dalil” MD, MPH

Minister of Public Health
Kabul, Afghanistan

30th July 2012
II. ACKNOWLEDGEMENTS

The Health for All Afghans (HAA) document was finalized after more than a year of hard work and extensive consultations at the MoPH and with the donor and development partners. As an Afghan owned implementation plan for the Health Strategic Plan 2011–2015, the HAA will serve decision making at all levels and provide the partners in health development and opportunity to coordinate and harmonize efforts and align their support with the ANDS and national and international strategies.

The HAA was a truly collaborative and extremely participative effort, finalised under the proper guidance of HE. Minister of Public Health and NPP- 5 working group members; leading by General Director of Policy, Planning and External Relation in which all 7 General Directors and 4 directors; Monitoring and Evaluation Director, Health Economic and Financing Director, Ghazanfar Institute of Health Science Director and ANDS Coordinator were members.

We would like to thank all who contributed towards this endeavour especially Dr. Ahmad Shah Salehi-Director of Health Economic and Financing, Dr. Husnia Sadaat-Head of Health Financing, Dr. Hedayatullah Alnoor-National Expert of Curative Medicine General Directorate, Dr. Sardar Mohammad Perwiz-National Expert of Preventive Medicine General Directorate, Dr. Najiba Zia Eftali-Advisor of IQHC and RHD and Dr. Karima Mayar Amiri-Coordinator of IQHC. We would like to extend our thanks to Miss Naheed Sarabi-ANDS Director/ MoF, Mr. Kheal Afghanzai-National HRD Cluster Advisor/ MoF, Mr. Eimal Hakim-HRD Advisor/ MoF, Ms. Victoria-ANDS Senior International Consultant/ MoF, Miss Tammy-ANDS International Consultant/ MoF, Mr. Gabriel Krose-HR International Consultant/ MoPH, Miss Yanneke Roos-NPP and Gap Analysis Consultant/ MoPH and other ANDS and HRD Cluster colleagues who contributed their ideas and provided valuable inputs on Health for All Afghans. Our special thanks go to Dr. Shafiqullah Hemat-Director of Health Promotion, Dr. Sadia Fayiq Ayubi, Director of RH, Miss Salila-AMA, Dr. Bashir Ahmad Hamid-Head of Nutrition Department, Dr. Said Mohammad Karim Alawai-Healthcare Financing Senior Officer, Dr Sharifulah Haqmal-Gender and Human Rights Program Manager-WHO, Dr. Naginal Abasi-UNFPA, Dr. Abdul Basit Momand-Gender Officer-UNFPA and Dr. Hamra Khan-Head of Gender Department.
We are particularly grateful to Dr. Sanaullah Sana-M&E Consultant, Dr. Ashooquillah Sadaty- Director of Diagnostic Surgery, Dr. Ajmal Behzad-Health Financing Officer, Dr. Homa Kabairi- Director of Clinical Specialization, Mr. Razi Khan-Disability and Rehabilitation Advisor, Dr. Bashir Sanwari-Head of Mental Health and Drug Demand Reduction (DDR), Dr. Amanullah Hussaini-Director of Environmental Health and Dr. Said Habib Anwal-CBHC Coordinator for their on time responses to the individual projects development. We are particularly grateful to Dr. Jawad Mirzad- Senior Advisor to Deputy Minister of Policy, Planning and Technical Affairs on technical issues for best coordination and cooperation regarding the decision from Minister and Deputy Minister side.

We are also indebted to the many national and international advisers who supported this effort. In particular we would like to thank Dr. Zalikha Anwari-Policy, Planning and HR Advisor, Dr. Noor Mohammad Arzioi-Policy and Planning Advisor and Miss Pamila Thomson-International Advisor of Planning/ MoPH.

The Success of NPP, Health for All Afghans document belongs to all of you, who provided their valuable time and lent your expertise in making this richer. It is not perfect, but it is a good start in the right direction. We believe that by implementing this NPP, Health for All Afghans is beyond bringing changes to a community, it is a practical program to reach our main mission which is "Health for All Afghans". We would like to conclude by again expressing our gratitude to you all.

Dr. Ahmad Jan Naeem,
Deputy Minister of Policy, Planning and Technical Affairs/ MoPH NPP Team Leader
Kabul, Afghanistan
22nd July 2012

Dr. Mohammad Essa Ebrahimian,
ANDS Coordinator/ MoPH NPP Focal Point
Kabul, Afghanistan
22nd July 2012
III. EXECUTIVE SUMMARY

At the Kabul Conference (July 2010) the Government of Afghanistan presented a plan for improving development efforts through a number of National Priority Programs (NPPs) to enhance, inter alia, service delivery. The Government’s Human Resources cluster (led by the Ministry of Education) is expected to put forward five such programs, including a health sector specific program, known as Health for all Afghans (HAA). NPPs are intended to be instruments for implementing the ANDS through stronger alignment with national priorities and greater reliance on national mechanisms. Donors have requested that NPP5 becomes a comprehensive, fully cost implementation plan for the overarching Health Strategic Plan 2011-2015.

Health for All Afghans (HAA) is a holistic approach to ensure strengthening health systems, the provision of healthcare services, building and strengthening capacity and improving the overall health of Afghans in support of the Ministry of Public Health’s Strategic Plan (2011-2015) and a Population Health Promotion Approach. The aim of the HAA is to identify and address the range of constraints and gaps, and enabling factors for ensuring a healthy population. This is accomplished through three main Components that address the need to continue strengthening health systems and expand health service delivery as well as recognizing the challenge of building capacity so that the Ministry of Public Health can assume full ownership of the sector:

**Component 1:- Strengthen and Expand Existing Health Service Delivery:**
Addresses the need to provide primary, secondary and tertiary services to the population while building capacity and expanding outreach to remote parts of the country. This Component also supports the development of regulations and building an enabling environment for the private sector to meet the healthcare needs of the population while ensuring the quality and equity of care provided. This combined with a focus on improving nutritional status of the population through proactive measures such as education will provide a comprehensive approach to the delivery of health services. This Component will also support building the capacity of the national health system for disaster risk management including mitigation, prevention, preparedness and response.
The MoPH is promoting the launch and application of the H4+ partnership with UN Agencies (UNICEF, UNFPA, WHO), as well as the World Bank in order to accelerate the implementation of the maternal and newborn continuum of care, in response to the priorities recognized by the National Reproductive Health Program in Afghanistan, towards the achievement of MDGs 4 and 5.

**Component 2:– Increase and Improve HR for Health and Good Governance:**
Aims to ensure that the Government of the Islamic Republic of Afghanistan (GIRoA) builds the capacity necessary to sustain and expand health service delivery initiatives.

**Component 3:– Improve health financing:**
Improve health care financing Targets building and strengthening health finance systems to support a sustainable healthcare system in Afghanistan, and coordinating external aid sources in order to improve aid effectiveness.

The three components of the HAA will strive to ensure that 30% of staff is female (also at decision making levels) and that women and men have equal access to health services that are free of discrimination and address gender-based violence and mental health. Through these three components, the Ministry of Public Health has prioritized the areas that need to be emphasized in order to set the foundation for their Strategic Plan over the next three years and addressed the ten Strategic Direction areas identified in that plan.

An important donor to health systems strengthening is the Global Alliance for Vaccine and Immunization (GAVI), launched in early 2000. Its mission is to save children’s lives and protect people’s health through increased access to immunization. GAVI is a mix of public private partnership and an innovative financing mechanism. Its partners are mainly WHO, UNICEF, Bill and Melinda Gates foundation, WB, CSOs, Governments of both developed and developing countries, research and technical institutes and the pharmaceutical industry. Since 2007, GAVI provided support for Civil Society Organizations, Health System Strengthening, Immunization Services and New Vaccines. The proposals are submitted through the Inter Coordination Mechanism (ICC) and Consultative Group for Health and Nutrition (CGHN). Both ICC and CGHN are responsible to oversee the grants implementation. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) is another innovative partnership between governments, private sector, NGOs and international agencies.
Afghanistan received funds from the GF through the Country Coordinating Mechanism (CCM), which is responsible for overseeing program implementation. To date Afghanistan received funding from the Global Fund (GF) for HIV/AIDS, Malaria, TB and Health Systems Strengthening.

The major donors to the BPHS and EPHS in all 34 provinces are the European Union, USAID and the World Bank. In addition, MoPH is supported by USAID, EU, WB, JICA and CIDA in vertical programs and some specific areas incorporated in the NPP in the budget section under “other support”.

**Program Timeline**

The zero draft of the HAA was presented at the Kabul Conference held on 20 July 2010, and followed by the development of the Program by the MoPH and consulted with the donor community. Implementation milestones have been set for 100 days, 1 year and 3 years after the conference date.

The program timeline will run from Jan 2012 to Dec 2014 and will be followed by phase 2 (2015), phase 3 (2016-2020) and, phase 4 (2021-2025).

**Implementing and Coordinating Institutions:**

The Ministry of Public Health (MoPH) will execute the Expanding and Enhancing Health Service Delivery Program, in collaboration with all stakeholders within the Health Sector including the private sector, non-governmental organizations, and the public sector—being mostly the Ministries in the Human Resource Development Cluster (HRD).

**Institutional Partnerships: (Table 1)**

<table>
<thead>
<tr>
<th>Implementing Institution</th>
<th>Implementation Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Education (MoE)</td>
<td>Close coordination and implementation of Family health Worker Projects, which is a joint MoPH and MoE Projects (Component 1, Subcomponent 4 Deliverable 6)</td>
</tr>
<tr>
<td>Ministry of Women Affairs (MoWA)</td>
<td>Close coordination and ensure the implementation of gender issues which is in Gender and advocacy (Component 2, Subcomponent 8 Deliverable 6)</td>
</tr>
</tbody>
</table>
# Coordinating Institutions (Table 2)

<table>
<thead>
<tr>
<th>Government/Independent Agency</th>
<th>Coordinating Role</th>
</tr>
</thead>
</table>
| Center Statistics Office (CSO) | - The CSO will continue to build its capacity in order to meet the needs of data collection and data analysis.  
- The different survey reports including the National Risk and Vulnerability Assessment (NRVA) will be used  
- by government to evaluate the outcomes of development activities in the country, and prepare reports for  
- GCC, the Cabinet and the President that will be coordinated by M&E Unit of MoEc. |
| Ministry of Economy (MoEc) | - The Monitoring & Evaluation (M&E) Unit of MoEc will support the line ministries, and the IMCs in developing their capacity for better monitoring and evaluation of development projects.  
- The M&E Unit of MoEc is already building its work on the outcomes and indicators articulated in the ANDS document.  
- Their technical support will help the ministries and sectors to prepare periodic reports on progress of implementation as well as annual, bi-annual reports based on the 99 indicators set out in the ANDS document. |
| Independent Directorate of Local Governance (IDLG) | - Coordinate on capacity building programs, incorporating concepts of good governance and transparency in civic responsibility workshops  
- Coordinate on government consulting with the Afghan citizens on SD  
- Coordinate and joint monitoring from district to oversee the district level assessment of human resource and other capacity building issues. |
| Ministry of Labor, Social Affairs, Martyrs and the Disabled (MoLSAMD) | - Coordinate on vocational training capacity building programs, incorporating concepts of good governance and transparency in skills development workshops through the NSDP and Employment Services Centers  
- Coordinate on government consulting with the Afghan citizens on service delivery  
- Develop employment strategy to all line ministries for sustainable resources generation. |
| Ministry of Rural Rehabilitation and Development (MRRD) | - Coordinate on capacity building programs, incorporating concepts of good governance and transparency in NSP workshops for CDC members in hygiene and health awareness.  
- Coordinate on government consulting with the Afghan citizens on service delivery. |
| Civil Service Commission | - Coordinating with the HOC’s Asset Registration and Verification Department on sharing relevant data of targeted civil servants in the Human Resource Management Information System (HRMIS). |
| Ministry of Finance (MoF) | - The ANDS team within the MoF is coordinating the donor consultation meetings, Standing committee and JCMB for all line ministries.  
- The ANDS team is providing feedback on technical and financial issues to all NPPs.  
- The ANDS team within the MoF is coordinating and co-chairing the IMC meetings.  
- The ANDS team at the MoF, in cooperation of line ministries and agencies are responsible for the annual revision of Sector Strategies and the ANDS.  
- The ANDS team will also be supporting the IMCs in aligning their programs and projects according to the sector strategies.  
- This unit will also support the line ministries in designing the programs and projects according to the strategies adopted and results identified, taking into consideration that all sector related activities are contributing towards sector outcomes that are articulated in the ANDS sector strategies. |
<table>
<thead>
<tr>
<th>Government/Independent Agency</th>
<th>Coordinating Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>The GCC and CEAP Office</td>
<td>- The GCC and OCEAP will work closely with all IMCs, in conjunction with the MoF and MoEc, to ensure rapid resolution of any impediments that arise limiting the timely and effective implementation of the sector Strategies. They will report regularly to the president and cabinet as well as the JCMB on the progress in implementing the ANDS</td>
</tr>
<tr>
<td>Ministry of Economy (MoEc)</td>
<td>- The Monitoring &amp; Evaluation (M&amp;E) Unit of MoEc will support the line ministries, and the IMCs in developing their capacity for better monitoring and evaluation of development projects. The M&amp;E Unit of MoEc is already building its work on the outcomes and indicators articulated in the ANDS document. Their technical support will help the ministries and sectors to prepare periodic reports on progress of implementation as well as annual, bi-annual reports based on the 99 indicators set out in the ANDS document.</td>
</tr>
</tbody>
</table>
**Budget Summary**

The overall budget of Health for All Afghans (HAA) is **1,300,791,344 USD** over three years. Of this Total budget **1,045,364,071 USD** has already been secured (the Main donors are USAID, EU/EC, WB) and **255,427,273 USD** is requested.

**Table 3: Draft Budget Summary (in USD)**

<table>
<thead>
<tr>
<th>NPP-5 Components</th>
<th>1st Year</th>
<th>2nd Year</th>
<th>3rd Year</th>
<th>Total</th>
<th>Secured</th>
<th>Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component 1: To improve and expand existing health service delivery</td>
<td>250,781,717</td>
<td>424,115,696</td>
<td>400,599,450</td>
<td>1,071,351,724</td>
<td>971,066,208</td>
<td>104,430,655</td>
</tr>
<tr>
<td>Component 2: To Increase and Improve Human Resource for Health and Good Governance</td>
<td>82,628,913</td>
<td>62,556,753</td>
<td>61,777,524</td>
<td>206,963,192</td>
<td>63,219,465</td>
<td>143,743,726</td>
</tr>
<tr>
<td>Component 3: To Improve Health Financing</td>
<td>13,292,578</td>
<td>2,565,388</td>
<td>2,473,322</td>
<td>18,331,288</td>
<td>11,078,398</td>
<td>7,252,891</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>346,703,208</strong></td>
<td><strong>489,237,837</strong></td>
<td><strong>464,850,297</strong></td>
<td><strong>1,300,791,344</strong></td>
<td><strong>1,045,364,071</strong></td>
<td><strong>255,427,273</strong></td>
</tr>
</tbody>
</table>
### IV. Acronym List

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AKU</td>
<td>Aga Khan University</td>
</tr>
<tr>
<td>AMA</td>
<td>Afghan Midwives Association</td>
</tr>
<tr>
<td>ANMC</td>
<td>Afghan Midwifery and Nursing Council</td>
</tr>
<tr>
<td>ANSA</td>
<td>Afghan National Standard Authority</td>
</tr>
<tr>
<td>APHI</td>
<td>Afghan Public Health Institute</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavioral Change Communications</td>
</tr>
<tr>
<td>BFHI</td>
<td>Baby-Friendly Hospital Initiatives</td>
</tr>
<tr>
<td>BIA</td>
<td>Benefit-Incidence Analysis</td>
</tr>
<tr>
<td>BPHS</td>
<td>Basic Package of Health Services</td>
</tr>
<tr>
<td>CBR</td>
<td>Community Based Rehabilitation</td>
</tr>
<tr>
<td>CHC</td>
<td>Comprehensive Health Center</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Workers</td>
</tr>
<tr>
<td>CHS</td>
<td>Community Health Supervisor</td>
</tr>
<tr>
<td>CMAM</td>
<td>Community-Based Management of Acute Malnutrition</td>
</tr>
<tr>
<td>DEWS</td>
<td>Disease Early Warning System</td>
</tr>
<tr>
<td>DG</td>
<td>Director General</td>
</tr>
<tr>
<td>EMIS</td>
<td>Expenditure Management Information System</td>
</tr>
<tr>
<td>EPHS</td>
<td>Essential Package of Health Services</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Program on Immunization</td>
</tr>
<tr>
<td>FHW</td>
<td>Family Health Workers</td>
</tr>
<tr>
<td>FMIS</td>
<td>Financial Management Information System</td>
</tr>
<tr>
<td>GAIN</td>
<td>Global Alliance for Improving Nutrition</td>
</tr>
<tr>
<td>GAM</td>
<td>Global Acute Malnutrition</td>
</tr>
<tr>
<td>GCMU</td>
<td>General Contracts and Management Unit</td>
</tr>
<tr>
<td>GDA</td>
<td>General Directorate of Administration</td>
</tr>
<tr>
<td>GDCM</td>
<td>General Directorate of Curative Medicine</td>
</tr>
<tr>
<td>GDHR</td>
<td>General Directorate for Human Resources</td>
</tr>
<tr>
<td>GDPA</td>
<td>General Directorate of Pharmaceutical Affairs</td>
</tr>
<tr>
<td>GIHS</td>
<td>Ghazanfar Institute of Health Sciences</td>
</tr>
<tr>
<td>GIRoA</td>
<td>Government of the Islamic Republic of Afghanistan</td>
</tr>
<tr>
<td>GMP</td>
<td>Good Manufacturing Practices</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>HAA</td>
<td>Health for All Afghans</td>
</tr>
<tr>
<td>HCO</td>
<td>Health Complaints Office</td>
</tr>
<tr>
<td>HEFD</td>
<td>Health Economics and Financing Directorate</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HNSS</td>
<td>Health and Nutrition Sector Strategy</td>
</tr>
<tr>
<td>HRMIS</td>
<td>Human Resources Management Information System</td>
</tr>
<tr>
<td>HRT</td>
<td>Human Resource Taskforce</td>
</tr>
<tr>
<td>HIS</td>
<td>Health School Initiative</td>
</tr>
<tr>
<td>HSSP</td>
<td>Health Service Support Project</td>
</tr>
<tr>
<td>ICM</td>
<td>International Confederation of Midwives</td>
</tr>
<tr>
<td>ICN</td>
<td>International Confederation of Nurses</td>
</tr>
<tr>
<td>HIS</td>
<td>Institute of Health Sciences</td>
</tr>
<tr>
<td>IQHC</td>
<td>Improving Quality Health Care</td>
</tr>
<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge, Attitude and Practice</td>
</tr>
<tr>
<td>LSHTM</td>
<td>London School of Hygiene and Tropical Medicine</td>
</tr>
<tr>
<td>MAIL</td>
<td>Ministry of Agriculture, Irrigation and Livestock</td>
</tr>
<tr>
<td>MCIT</td>
<td>Ministry of Communication and Information Technology</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MoE</td>
<td>Ministry of Education</td>
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<tr>
<td>MoEc</td>
<td>Ministry of Economy</td>
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<tr>
<td>MoF</td>
<td>Ministry of Finance</td>
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<td>MoHE</td>
<td>Ministry of Higher Education</td>
</tr>
<tr>
<td>MoI</td>
<td>Ministry of Interior</td>
</tr>
<tr>
<td>MoPH</td>
<td>Ministry of Public Health</td>
</tr>
<tr>
<td>MRRD</td>
<td>Ministry of Rural Rehabilitation and Development</td>
</tr>
<tr>
<td>NDSA</td>
<td>National Disability Survey in Afghanistan</td>
</tr>
<tr>
<td>NHA</td>
<td>National Health Account</td>
</tr>
<tr>
<td>NMEAB</td>
<td>National Midwifery Education Accreditation Board</td>
</tr>
<tr>
<td>NSS</td>
<td>Nutrition Surveillance System</td>
</tr>
<tr>
<td>OPSC</td>
<td>Office of Private Sector Coordination</td>
</tr>
<tr>
<td>PETS</td>
<td>Public Expenditure Tracking Survey</td>
</tr>
<tr>
<td>PCH</td>
<td>Partnership Contract for Health Services</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>------------</td>
<td>--------------------------------------------------</td>
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<tr>
<td>PGC</td>
<td>Performance Based Grant Contract</td>
</tr>
<tr>
<td>PHO</td>
<td>Public Health Office</td>
</tr>
<tr>
<td>PLA</td>
<td>Participatory Learning and Action</td>
</tr>
<tr>
<td>PND</td>
<td>Public Nutrition Department</td>
</tr>
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<td>PNO</td>
<td>Provincial Nutrition Officer</td>
</tr>
<tr>
<td>PPA</td>
<td>Performance based Partnership Agreement</td>
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<td>PPP</td>
<td>Public-Private Partnership</td>
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<td>SFP</td>
<td>Supplementary Feeding Programs</td>
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<tr>
<td>SPS</td>
<td>Strengthening Pharmaceutical Systems</td>
</tr>
<tr>
<td>TAG</td>
<td>Technical Advisory Group</td>
</tr>
<tr>
<td>TFU</td>
<td>Therapeutic Feeding Unit</td>
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<tr>
<td>ToT</td>
<td>Training of Trainers</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Program</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
V. SITUATIONAL ANALYSIS

Thirty years of war and hardship had a devastating impact on the Health and Nutrition Sector (HNS) in Afghanistan. After 2002, the health and nutrition sector leadership, in partnership with the international community, embarked on an ambitious plan to achieve the United National Millennium Development Goals (MDG) by 2015, an agreement by all UN member states and international organizations to encourage development through the improvement of social and economic conditions.

Toward this end, the GIRoA created an interim National Health Policy (NHP) and Strategy (2004) followed by the development of the NHP 2005-2009 and the National Health Strategy (NHS) 2005-2006. These strategies were centered on the critical need to deliver health services to the population immediately. Under these strategies health services were delivered with the support and cooperation of national and international non-governmental organizations (NGOs) as the MoPH lacked of capacity to manage and provide immediate public health services to the population. The result was the successful provision of services to the population and a reduction of mortality rates.

Overall, the quality of health services has improved by 25% in the last five years. According to a Johns Hopkins University study (2009-2010), attendance and commitment of the health workforce is improving, as is the availability of health services. Access to basic healthcare has increased from 8% in 2001 to 57% today and infant mortality has been decreased from 165 deaths in 2003 to 77 death per 1000 live birth in 2010 (Afghanistan Mortality Survey - AMS). Number of health facilities with at least one female health workers has been increased from 45% (2000) to 74% in 2011 (HMIS). Number of BPHS health facilities has been increased from 1087 HFs in 2004 to 1784 HFs in 2011 (HMIS). Number of health facilities that provide IMCI services has been increased from 245 health facilities in 2005 to 1307 facilities in 2011 (HMIS). Numbers of BPHS health facilities which provide Comprehensive Emergency Obstetric Care services has been increased from 26 health facilities in 2006 to 78 health facilities in 2011 (HMIS).
Despite these improvements, a number of challenges still face the health sector in Afghanistan:

(1) **The health sector infrastructure capacity to meet rising demand is low.**

According to the Central Statistics Office, Afghanistan has an estimated population of 26.22 million (1389), growing annually at 2.3%. Consequently, the number of people using health facilities has doubled in the last two years\(^1\) while the availability of services has been unable to keep up with this growth rate. The situation will worsen unless health care services are expanded and improved upon. The Human Resources Database provides basic information designed to assist in workforce planning as well as highlighting critical shortages and imbalances in the workforce. Forecasts indicate a further 8.7% increase in services is required in the public sector, and 18.6% for staffing NGOs in order to meet minimum BPHS requirements.

Further forecasts taken from the 2010 World Bank Book on Health in Afghanistan show an estimated shortage of 39% overall. This situation is compounded by geographic imbalances with the health care workforce concentrated in cities and peri-urban areas, and a significant shortage of female staff in the rural areas. Thus, a current and projected shortage of trained staff needs to be redressed.

The Health for All Afghans is designed to address the issue of service delivery through **Component 1: Improving and expanding existing health service delivery.** This objective is designed to build upon existing programs like the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS) that focus on providing various health services to the population. These programs will be complemented by an additional focus on preventative care by MoPH, such as encouraging better nutritional habits and promoting regulations that will ensure quality medicines and goods on the market.

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\(^1\) Source – MoPH Health Workforce Observatory, Nov 2009
Another gap in service delivery is absence of services to provide assistance to the women and children - victims of gender based violence. Gender-based violence is a pervasive public health and human rights problem that has implications for almost every aspect of health policy and programming, from primary care to reproductive health programs. Not only do women experience substantial morbidity and mortality as a result of physical and sexual violence, but violence exacerbates other health conditions. Numerous studies show that in most cases survivors of GBV require multi-level assistance from health service providers.

The main role of health services in the area of gender-based violence is to identify and respond to women and girls who have already experienced violence, to mitigate the negative health consequences, and to refer GBV survivors to appropriate support services as per need. In Afghanistan healthcare sector has a huge potential of playing a leading role in GBV response due to the fact that healthcare providers interact with the largest number of women, access of women to health facility is less restricted than to other government and NGO services while healthcare providers render professional assistance on various forms of GBV (physical, psychological sexual). Strengthening health response to GBV is crucial intervention required for strengthening the institutional and managerial capacity of the service providers for addressing gender based violence, increasing understanding and improving knowledge of the GBV response actors as well as general public on violence against women and girls, national legislation and human rights instruments.

(2) The human resource capacity in the health sector workforce to meet rising demand is low.

The capacity within the public and private health care sectors is low, and unable to effectively provide a broad range of healthcare services to the general population. In addition, the MoPH’s has nascent capacity to provide managerial oversight of the healthcare system and regulation of the various structures in place. This has led to the overreliance on NGOs to provide services with little to no governance or taking on a stewardship role by the MoPH of the health sector in Afghanistan.
There is a lack of both qualified, skilled health care workers across a wide range of specialties and training programs to expand the core basic health services. Meeting these needs requires additional staff and more availability of training programs as well as improvements in performance of the major training institutes inclusive of curricula development in a range of subjects. Capacity building of health personnel should include also courses for obtaining some specific knowledge like prevention of gender based violence and related skills to provide response and care to survivors including psychosocial counseling, forensic examination and special techniques for addressing sexual violence. Given the propensity to depend on contractors, the major training institutes of the Ministry of Public Health have been under-resourced.

Consequently, training and skills development programs for both technical specialists and basic community workers are inadequate to meet the current and future demands. The HAA focus to increase the capacity and reinvigorate the Ghazanfar Institute of Health Sciences in Kabul – as detailed in Component 3.1, as well as the assessment and revision of medical specialist curricula, is aimed at increasing the numbers of skilled staff in order to expand core basic health services.

The community-based approaches identified in the HAA are also intended to increase access to basic health services and ease the burden on larger health institutes. “Managers responsible for the effective performance of the system currently lack capacity in leadership, governance, human resources, financial management and basic managerial skills. As noted in the September 2009 Expanding Health Service Delivery and Developing Institutional Capacity policy paper”:

“The MoPH needs a well coordinated and long-term commitment from international and national partners that seeks to strengthen the Ministry across its core functions. With appropriate external support, the Ministry has a unique opportunity to demonstrate how building capacity for good governance, including strong management and administrative functions, can continue to sustain improvements in health service outputs and outcomes in public and non-state sectors.”
Component 2 of the HAA is specifically designed to increase and enhance the human resources, systems and institutions of the health sector with the aim of enabling the GIRoA to sustain programs currently supported by NGOs and the donor community. Through targeted training of MoPH staff in the area of good governance, human resources, financial management and leadership the successful implementation of the HAA will set the foundation for increased capacity, in line with its Strategic Plan, enabling ownership of the health sector. The development of a Health Management Information System will further enable MoPH to monitor and assess programs, ensure quality and adjust services to meet needs based on population centers.

(3) There is a lack of professional standards and regulations of goods and services in the healthcare sector in Afghanistan.

Professional standards and regulation of goods and services to the public have yet to be fully developed. The inability of the Government to monitor the pharmaceutical and health service delivery in the private sector has resulted in the uneven quality of health services and goods to the public. The lack of a database to monitor the registration and location of doctors has led to the confluence of staff cities with varying degrees of education and certification.

This has been addressed to an extent through the new Pay and Grade program of the Civil Service Commission, which has provided some generic standards like job descriptions for the public servants, but much work has yet to be done regarding the creation of realistic performance indicators to ensure adequate health care service delivery. Component 2.6 of the HAA tackles the development of professional standards and regulation of goods and services in the healthcare sector in Afghanistan, particularly targeting cooperative governance and standard setting with the private sector.

(4) There is significant over-dependence on the NGO community for capacity development programs.

The health sector is heavily dependent on the national and international NGO community to provide capacity development programs. While necessary and sufficient for the post war period, the health sector must be able to build its civil service capacity to ensure national ownership and sustainability of the system for service delivery to the population.
The ability to address these priority areas and develop an appropriate institutional structure and corresponding facilities with qualified staff will create the backbone of the health sector.

(5) Low domestic revenue sources and uncoordinated international financial assistance and budget support.
While in developed countries health financing is provided by governments through the national budget, in developing countries, a major part of the health budget often comes from donors. In Afghanistan, international donors provide approximately 85% of funding for health care services. The issue facing the MoPH now is how to effectively raise sufficient funds for health through donor funding and domestic revenues, while improving aid effectiveness.

Component 3 of the HAA is specifically designed to address health financing by mapping costs of national health programs, identifying cost-effective methods of risk-pooling and affordable revenue generation, and coordinating external aid sources in order to improve aid effectiveness. The HAA will support the MoPH’s efforts to assess different mechanisms for risk pooling and revenue generation at the national, provincial, district, and community levels to increase domestic revenues for health.

Additionally, having the right mixture of well qualified and motivated health care providers and the appropriate information, management and systems to guide planning and strategic management will enable Afghan leaders to ensure a healthy workforce for the public and private sector, contributing to the economic growth and sustainable democratic future of the Islamic Republic of Afghanistan. The comprehensive nature of Health for All Afghans seeks to address this overarching challenge and build sufficient capacity within the health sector to provide services and sustain itself through increased human capacity.
VI. PROGRAM GOAL and OBJECTIVES/ COMPONENTS:

In accordance with the Strategic Plan for the Ministry of Public Health (2011-2015), the goal of the Health For All Afghans National Priority is to improve the health and nutritional status of the people of Afghanistan in an equitable and sustainable manner through quality health services provision, advocacy for the development of healthy environments and living conditions and the promotion of healthy lifestyles.

This Program will support this goal through a targeted approach towards improving health financing, expansion of existing health service delivery and the strengthening and expansion of human resources (with a focus on women’s capacity building), systems and institutions.

The expected results include:

- Improved and increased access to/availability of resources required to expand delivery of acceptable and affordable health services to all Afghans
- Increased capacity of the GIRoA to manage and improve the processes necessary to deliver quality and indiscriminately health services to all Afghans
- Improved health status of Afghans resulting from increased access to and expansion of health services
The program will achieve these results through the following three components:

**Component 1:** Strengthen and expand existing Health Service Delivery

**Component 2:** Increase & Improve Human Resources for Health and Good Governance

**Component 3:** Improve Health Financing

Table 4:

<table>
<thead>
<tr>
<th>Component 1: Strengthen and Expand Existing Health Service Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub-Component 1: To support the continued implementation and expansion of the Basic Package of Health Services (BPHS) for Afghanistan</strong></td>
</tr>
<tr>
<td>- Deliverable 1: Strengthen the ability of the GCMU to manage, monitor and evaluate the BPHS Program</td>
</tr>
<tr>
<td>- Deliverable 2: Increased focus on the delivery of three elements of the BPHS Program: Public Nutrition, Mental Health and Disability and Rehabilitation Services.</td>
</tr>
<tr>
<td>- Deliverable 3: To increase the coverage of health services delivery by the Ministry of Public Health and to decrease the number of referral cases from the prisons to the health facilities outside the prisons through establishment of health facilities inside the prisons</td>
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<tr>
<td>- Deliverable 4: Integration of Child survival package in the BPHS</td>
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<td>- Deliverable 5: Increase access of Nomad population to the BPHS</td>
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<tr>
<td>- Deliverable 6: To reduce the burden of communicable diseases, Polio, Measles, Maternal and Neonatal Tetanus Eradication (EPI)</td>
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<thead>
<tr>
<th>Sub-Component 2: To Implement a revised EPHS for Afghanistan</th>
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<tbody>
<tr>
<td>- Deliverable 1: Revision of the EPHS Program</td>
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<tr>
<td>- Deliverable 2: Expansion of the EPHS Program</td>
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<tr>
<td>- Deliverable 3: Integration of professional assistance and referral services for victims of GBV</td>
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<td>- Deliverable 3: Improvements of blood safety services as per WHO standards</td>
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<thead>
<tr>
<th>Sub-Component 3: To improve service at National Hospitals through staff capacity building and development of managerial and clinical standards</th>
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<tbody>
<tr>
<td>- Deliverable 1: Identify requirements for the maintenance and expansion of hospitals</td>
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<td>- Deliverable 2: The development of a Tertiary Care Package of Services</td>
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<td>- Deliverable 3: Costing of the Tertiary Care Package of Services</td>
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<table>
<thead>
<tr>
<th>Sub-Component 4: To improve the Nutritional Status of the Afghan Population</th>
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<tr>
<td>- Deliverable 1: To advocate for and increase awareness of healthy eating habits among the general population</td>
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<tr>
<td>- Deliverable 2: To reduce the prevalence of major micronutrient deficiency disorders, in particular, iron, folic acid, iodine, vitamin A and zinc</td>
</tr>
<tr>
<td>- Deliverable 3: To strengthen case management and increase access to quality therapeutic and Supplementary feeding care at the health facility and community levels.</td>
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<tr>
<td>- Deliverable 4: To ensure food safety and quality at all levels</td>
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<tr>
<td>- Deliverable 5: To monitor the nutritional situation in Afghanistan and strengthen the monitoring and evaluation of nutrition strategies and programs, in order to inform development planning and emergency responses</td>
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<tr>
<td>- Deliverable 6: To more effectively respond to emergencies through the provision of supplementation and therapeutic foods for moderate and severe acute malnutrition</td>
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<tr>
<td>- Deliverable 7: To increase the percentage of child caregivers adopting appropriate infant and young child feeding practices</td>
</tr>
<tr>
<td>- Deliverable 8: To strengthen and expand the human capacity to plan, implement, monitor and evaluate nutrition interventions to meet the current and future needs of the population</td>
</tr>
</tbody>
</table>
### Sub-Component 5: To increase equitable access to quality health services
- Deliverable 1: Policy level support established to advocate for adoption and sustainability of quality improvement initiatives
- Deliverable 2: Strengthened capacity of the Improving Quality Health Care Unit for implementation of quality-related health interventions at national and regional hospitals
- Deliverable 3: Establish & enhance coordination mechanisms for implementation of the QHC Strategy

### Sub-Component 6: To support regulation and standardization of the Private Sector to provide quality health services
- Deliverable 1: Strengthened collaboration and improved communication and understanding between public and private health sectors
- Deliverable 2: To support the development of an environment that facilitates the growth and quality of private sector contributions to the health of the Afghan population
- Deliverable 3: To build productive partnerships between the public and private sectors to achieve shared goals and promote synergies
- Deliverable 4: To enhance the MoPH’s stewardship capacity and its capacity to implement public-private partnership strategies by strengthening the Office of Private Sector Coordination
- Deliverable 5: To develop evidence of and measure private sector contributions to the health of the Afghan population

### Sub-Component 7: To create an enabling environment for the production and availability of quality pharmaceuticals
- Deliverable 1: To develop an effective and efficient Pharmaceutical Regulatory System
- Deliverable 2: Increase the capacity of the GDPA to implement the regulatory framework
- Deliverable 3: To develop effective QA systems to assure the quality of pharmaceutical products in the public and PS

### Sub-Component 8: To achieve universal access to RH and improve maternal and newborn health
- Deliverable 1: Strengthening RH Stewardship role and coordination among Stockholders to improve maternal and newborn health towards achieving MDGs 4 & 5
- Deliverable 2: To build capacity and understanding of health providers in reproductive health
- Deliverable 2: To promote and support health-related research (FP, STI, Death notification, mental health, etc) at all levels (Capacity building of MoPH, Provincial RH officers, nursing and midwifery department and AMA for RH research)

### Sub-Component 9: Maternal, Newborn and Child health (H4+)
- Deliverable 1: Support MoPH to elaborate policies and strategies for improvement of maternal and newborn health towards achieving MDGs 4 & 5
- Deliverable 2: Strengthen the implementation of quality of MNH services in the BPHS
- Deliverable 3: Improve the quality of FP and Strengthen post abortion care, including post abortion FP
- Deliverable 4: Strengthen MNH services in the EPHS and advocate for its revision accordingly
- Deliverable 5: Strengthen national capacities in addressing Obstetric Fistula
- Deliverable 6: Improve STI management, including PPTCT
- Deliverable 7: Strengthen midwifery program
- Deliverable 8: Improve the quality of the training of Ob/Gyn (Ob/Gyn residency training) and in Neonatology and encourage revision of medical education curricula & training to address MNH needs
- Deliverable 9: Elaborate and implement communication strategy for behaviour change at the community level (in line with the national Health Promotion Strategy for MNH and the CAH strategy)
- Deliverable 10: To promote and support health related research (FP, STI, Death notification, mental health, etc) at all levels. (Capacity building of MoPH, provincial RH officers, nursing and midwifery department and AMA for RH research)
- Deliverable 11: Research on new communication technology use for MNH
- Deliverable 12: Maternal and neonatal health benefit from a strong multi-sectoral approach
- Deliverable 13: WHO H4+ Operational Support Unit (OS)
### Sub-Component 10: To enhance the capacity of national health system for disaster risk management including mitigation, prevention, preparedness and response

- **Deliverable 1:** To strengthen the Ministry of Public Health (MoPH) stewardship role on EPR and DRR through development and revision of supportive policies and regulations, guidelines and standards, clarification of roles and responsibilities, fostering a mainstreaming approach
- **Deliverable 2:** Enhancing evidence based decision making through establishment of data base management for health sector EPR and detailed risk assessment at district level
- **Deliverable 3:** To ensure timely and effective response to emergencies and disasters that by-pass the local response capacity
- **Deliverable 4:** To strengthen the human capacity at all levels of health system to conduct evidence based planning, and to design, implement, monitor and evaluate disaster management interventions

### Component 2
**Increase & Improve Human Resources for Health and Good Governance**

#### Sub-Component 1: To reinvigorate health science institutes to develop, manage, and execute major health worker trainings

- **Deliverable 1:** Institutional capacity in human resources management systems is strengthened and a high Policy and Training Unit is developed
- **Deliverable 2:** Infrastructure upgraded for improved performance

#### Sub-Component 2: To improve the governance, leadership, and managerial capacity within MoPH to ensure sustainability of the system

- **Deliverable 1:** To improve efforts to decentralize human resource management services in MoPH
- **Deliverable 2:** A Human Resources Database mechanism is developed for decentralization
- **Deliverable 3:** To improve financial management in the MoPH at the provincial level
- **Deliverable 4:** To build the leadership and management capacity of health professionals and administrators developed
- **Deliverable 5:** To strengthen transparency and accountability within the national healthcare system
- **Deliverable 6:** To strengthen national capacities on Gender mainstreaming and Right based approach in Health sector

#### Sub-Component 3: To develop adequate professional standard and specialized curricula and to conduct specialized training to improve capacity for service delivery

- **Deliverable 1:** To develop a mechanism to establish standards, registration, accreditation of curricula and management of professional misconduct
- **Deliverable 2:** Medical Council established and functioning
- **Deliverable 3:** Afghan Nurses and Midwives Council established and running
- **Deliverable 4:** To increase the availability of skilled clinical resources in Afghanistan
- **Deliverable 5:** To strengthen the capacity of specialized care within the nursing and technician Workforce
- **Deliverable 6:** To develop an accredited degree program for Biomedical Engineers, Medical Technologists and Environmental Health Officers

#### Sub-Component 4: To increase the numbers and capacity of community workers and field-based professional providers

- **Deliverable 1:** To build the capacity and availability of Community Health Nurses in the Provinces
- **Deliverable 2:** To increase the number of trained midwives to ensure full coverage for all public HF
- **Deliverable 3:** To increase the number of trained Community Physical Therapist to Expand services in Mazar, Jalalabad, and Heart
- **Deliverable 4:** To build the capacity of exiting health workers trained to practice simple mental health interventions
- **Deliverable 5:** To increase the number of trained Community Health Workers to expand provincial health services
- **Deliverable 6:** Family health workers

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*National Priority Program-5 - Human Resource Development Cluster*
Sub-component 5: To support health promotion and community empowerment
- Deliverable 1: The capacity of communities to initiate and implement activities that promote their health is strengthened
- Deliverable 2: The capacity of MoPH and health sector staff to effectively promote healthy behaviors in communities
- Deliverable 3: The evidence base regarding health-related knowledge, attitudes and behaviors and effective strategies that promote support positive health behaviors/healthy lifestyles in Afghan communities are expanded
- Deliverable 4: Clear, simple and understandable health education messages are designed for communities to facilitate the integration of community health workers into pre-service and in-service education
- Deliverable 5: Monitoring and evaluation of health communication activities are supported
- Deliverable 6: Non-communicable diseases prevention and awareness (NCD-PA)

Sub-Component 6: To enhance evidence-base decision making by establishing a culture that uses data for improvement
- Deliverable 1: Relevant legislation is developed that supports improved reporting and confidentiality of essential health data
- Deliverable 2: Capacity and awareness are built in monitoring, evaluation, research and data usage for performance measurement and evidence-based policy making and planning
- Deliverable 3: To develop and information technology (IT) infrastructure within the MoPH to support the health information system (HIS)
- Deliverable 4: Strengthen governance in the health sector related to statistical information

Sub-Component 7: To advocate for and promote health environments
- Deliverable 1: To strengthen the stewardship role of MoPH in relation to environmental health by developing regulations & clarifying roles and responsibilities under the Environmental Health Program
- Deliverable 2: Build the capacity of MoPH management and staff related to environmental health to advocate for increased availability of safe drinking water in order to reduce the burden of disease from contaminated water
- Deliverable 3: To increase food safety practices to prevent food borne illnesses in food service and retail establishments
- Deliverable 4: To develop a systematic framework to lead a national process to reduce air pollution and promote clean air (in collaboration with the Environmental Protection Agency)
- Deliverable 5: To create a national multi-sectoral radiation protection forum to agree on and advocate for safe levels of radiation in the country including increasing industry and public awareness of this issue
- Deliverable 6: To create a national multi-sectoral stakeholder mechanism for the management of garbage and hazardous wastes (including solid waste and healthcare waste)
- Deliverable 7: To improve hygiene and sanitation throughout the country among the general public and health workers

Component 3
Improve Health Financing

Sub-Component 1: Capacity building of MoPH staff on health financing for effective institutional functioning and supporting health economics evidence-based policy decision-making
- Deliverable 1: Institutional capacity is developed on applied health economics, financing and resource management at the Central and provincial levels
- Deliverable 2: Costing exercises are conducted on priority MoPH strategic documents and programs
- Deliverable 3: A public expenditure tracking survey and a benefit-incidence analysis of the health sector are conducted
- Deliverable 4: Implementing and institutionalizing of NHA and EMIS in the health sector
Sub-Component 2: To improve risk-pooling and mobilize domestic resources
- Deliverable 1: Improved financial sustainability and advanced risk pooling mechanisms
- Deliverable 2: Implementing demand side and supply side financing

Sub-Component 3: To secure more external funds and improve aid effectiveness
- Deliverable 1: Introducing SWAp to the health sector, developing a MTEF, improving coordination
- Deliverable 2: Improving Inter-Sectoral Collaboration (ISC) related to ANDS/NPP and managing NPP-5
VII. STRATEGY

The strategy for the HAA is formulated through the policy and planning documents of the Ministry of Public Health (MoPH) and aligned to their Strategic Plan for the Ministry of Public Health 2011-2015. This five-year plan was created through an inclusive process within MoPH and is underpinned and guided by a Population Health Promotion Approach which focuses on identifying the broad range of factors that affect or create health and health promotion. Therefore, the Strategy represents a comprehensive approach to address the social determinants that will promote a healthier lifestyle for all Afghans, ensure adequate health service delivery, and set the foundation for the sustainability of the health sector by the Government of Afghanistan.

The MoPH Strategic Plan, in turn, was aligned with the Afghan National Development Strategy (ANDS) through the Health and Nutrition Sector Strategy (HNSS), which is woven throughout the HAA. The three-year HAA builds upon existing initiatives and prioritizes key activities to be accomplished in order to set the foundation for success of the MoPH Strategy. This alignment is accomplished through three components that, together, provide a comprehensive approach toward continued and expanded health service delivery and increased GIRoA capacity for management and direct service delivery. The HAA strives to build the necessary foundations, so that over time the MoPH possesses the same experience, skills, procedures and financial support as the contractors currently utilized to fulfill its mandate (as per - Article 20 of the Organic Law of the GIRoA). Underpinning the HAA strategy is MoPH’s Population Health Promotion Approach, which aims to improve the health of the population through a holistic approach that addresses the social determinants of health. Documented by the World Health Organization, these determinants demonstrate the factors, beyond personal behavior and access to healthcare, which have a powerful impact on the overall health of a group; this includes culture, education, physical environments and healthy child development, among other factors.
Health for All Afghans, National Priority Program-5, Strategic Approach

MoPH and GiRoA Policies and Strategies
- ANDS-2008-2013
- HNSS- 2008-2013
- BPHS-2005/ 2010
- EPHS -2005
- National HR policy
- National Hospital Sector Strategy
- National Health Policy

Strategic Plan of MoPH 2011-2015

1. Build & expand upon existing National Program to:
   - Improve tertiary health care
   - Develop Nutritional Status
   - Increase equitable access Healthcare

2. Regulate and Standardize Healthcare Services across the Public and Private Sector:
   - Quality Health Care is provided
   - Quality Assurance systems established on pharmaceuticals

3. Decrease Maternal, Newborn, and Child mortality and Morbidly:
   - Implement H4+ Action Plan with (UN cooperation )
   - EPR

Expiring the Quality and Number of Healthcare Service Providers:
1. Expanding the Quality and Number of Healthcare Service Providers:
   - Increase the size of the workforce in each major skill category and target training in order to increase and retain skilled staff
   - Enhance professional standards and accreditation of curricula
   - Capacity Building/ trainings of Health service providers

2. Institutional Development and Evidence-base Decision Making:
   - Creating HMIS and capacity building that supports the use of data to make information decisions
   - Improved management systems for effective oversight and leadership

3. Community Development & Health promotion:
   - Promote community improvement through Household education on Basic Health

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MoPH and GiRoA Policies and Strategies
- National Nursing & Midwifery Services Policy and Strategy
- National Policy for the Private Health Sector
- National Disability and Rehabilitation Strategy-2010-2014
- National Sector Revenue Generation Framework 2012
- National Medicine Policy
- National Strategy for Improving Quality in Healthcare
- Public Relation Strategy 2-11-2015
- National Gender Strategy 2011-2015

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1. Capacity Building & knowledge-base decision making:
   - Mapping costs of National Healthcare program
   - Knowledge-base decision making through PETS and BIAs

2. Identification and piloting risk pooling and revenue generation options:
   - User fees with waiver system
   - Proposed tobacco tax, vehicle tax, fuel tax. airline passenger fee

3. Using Sector Wide Approach for (SWaP) effective Aid Coordination :
   - Increased aid effectiveness through better GiRoA, DC
The three components in the HAA address the priorities within the MoPH’s five-year strategy. Component 1 seeks to build upon and expand current services and access to healthcare while also placing an emphasis on educating the population with regards to early childhood development and nutrition. Component 2 focuses on the capacity of MoPH to oversee and take ownership of the sector. Component 3 addresses Health Financing, which is an essential component of strengthening the foundation of the national health system.
VIII. RESULTS and ACTIVITIES

Expected Results:
The Health for All Afghans expects to provide a more balanced approach towards national ownership and sustainability of the Health and Nutrition Sector. The expected results therefore expand on NHSS targets to include progress in the hospital services and more importantly the measurable capacity of the civil service to deliver in terms of its mandate. As such the following, the program will aim for the following overall results:

The Indicators and targets for NPP-5:

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Value in 2008</th>
<th>Year target</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>2013</td>
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<tr>
<td>Increased access to primary health care through BPHS as measured by the Proportion of a given population that can be expected to use a specified facility, service, etc. taking into access, usually measured within 2 hours by walking distance of a HF</td>
<td>57%</td>
<td>65%</td>
</tr>
<tr>
<td>To increase coverage of the Essential Package of Health Services (EPHS) in the next 3 years through a mix of contracting in and contracting out options.</td>
<td>56%</td>
<td>66%</td>
</tr>
<tr>
<td>Reduce Maternal Mortality</td>
<td>1600/100000</td>
<td>317</td>
</tr>
<tr>
<td>Skilled Antenatal Care (at least 1 visit excluding TT)</td>
<td>32.3%</td>
<td>95%</td>
</tr>
<tr>
<td>Skilled birth attendance at deliveries</td>
<td>18.9%</td>
<td>45%</td>
</tr>
<tr>
<td>Reduce Under Five Mortality</td>
<td>161/1000</td>
<td>95/1000</td>
</tr>
<tr>
<td>Reduce Infant Mortality</td>
<td>129/1000</td>
<td>77/1000</td>
</tr>
<tr>
<td>Outpatient Visits per Capita Per year</td>
<td>1.04</td>
<td>1</td>
</tr>
<tr>
<td>Number of Health Facilities</td>
<td>1688</td>
<td>2040</td>
</tr>
<tr>
<td>Increased national immunization coverage of children aged between 12-23 months who are fully vaccinated with Penta-3 vaccines (3 doses of Penta)</td>
<td>33%</td>
<td>60%</td>
</tr>
<tr>
<td>Increased national immunization coverage with measles vaccine among children under one year of age</td>
<td>54%</td>
<td>60%</td>
</tr>
</tbody>
</table>

* In line with Afghanistan Mortality Survey 2010, Strategic Plan of MoPH-2011-2015, NRVA & AHS
Component 1: To improve & expand existing health service delivery

**Outcomes:** Increased access to basic health services and hospital services across Afghanistan; improved quality of basic health services and hospital services; improved health status of children under the age of five years old; increased capacity of the private health sector to deliver quality health services and products; improved quality and safety of pharmaceuticals

**Indicators:** 7% increase in access to BPHS services; 14% increase in coverage of EPHS services; Improved nutritional status of children under the age of two; Improved health sector response to all forms of gender-based violence; 30% improvement of staff in the hospital procurement, management, and oversight; reduction of the prevalence of acute malnutrition (to below 10%) and stunting (to below 40%) among children less than five years old; reports on the implementation of Improving Quality in Health Care (IQHC) Strategy; to ensure that all medicines available in the country, whether of domestic or foreign origin, and used for treatment purposes are effective, safe, of good quality, and affordable.

The HAA builds and expands upon to existing national programs to increase access to healthcare, improve nutritional status, and establish regulations and standards across the public and private sectors to support quality healthcare nationwide. The Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS) are longstanding and flagship programs led by the MoPH, with the support and cooperation of the international community. Together, the BPHS and the EPHS represent a number of key elements of the national healthcare system being built by the MoPH. At the planning stage, the MoPh has illustrated where essential primary care and hospital services will be provided and have explained the referral hospital system necessary to support the BPHS. This HAA strategy contains only brief summaries of BPHS and EPHS, as these programs have been fully developed, are funded and functioning. Full program documents for BPHS and EPHS are available upon request. Featuring BPHS and EPHS in the HAA three-year program demonstrates their inclusion in the overall GIRoA national healthcare program priorities.

BPHS and EPHS will be complimented by increased focus on educating the population on the nutritional standards and international lessons learned as well as ensuring improved early infant childhood development.
Sub-Component 1.1: Expansion of BPHS

To support the continued implementation and expansion of the Basic Package of Health Services (BPHS) for Afghanistan

Anticipated Results: It is expected that by the program completion:

1. Basic healthcare is firmly cemented in the provision of national healthcare services across Afghanistan.
2. Increased capacity within MoPH to manage, coordinate, monitor and evaluate the BPHS program.

The Basic Package of Health Services (BPHS) is a national-level health program led by the Ministry of Public Health (MoPH). Launched in 2002, shortly after the establishment of the Transitional Islamic State of Afghanistan, following the departure of the Taliban, this program sought to provide the immediate delivery of basic health services to the population through the creation of a standardized package of basic services. The BPHS program has succeeded in providing the health sector with uniform standards regarding preventive and curative health services. It also provided the MoPH with tools to effectively assume its stewardship role of coordinating and monitoring the implementation of these health care activities. BPHS has been the catalyst behind the establishment of strong collaboration between the MoPH and its major partners, implementing NGOs and donors. Six years of BPHS implementation have led to a significant increase in the proportion of the population with access to basic health services. BPHS is currently being implemented in districts that encompass 85% of the population. The following is a brief summary of BPHS, what it intends to achieve and the main programmatic goals and objectives. The goal in continuing to support and expand the BPHS is to provide a standardized package of basic services that forms the core of service delivery in all primary health care facilities. The HAA will continue to work within the established BPHS framework to meet specific objectives:

- The continued implementation of the standardized package of basic services that would have the greatest impact on major health problems facing the Afghan population,
- To ensure the quality of services provided;
- To include services that would be cost-effective;
To extend coverage in an equitable manner for both rural and urban populations;
To continue supporting the foundation for the national healthcare system for Afghanistan focused on community-based health care.

BPHS has seven primary elements; six involve basic services while the seventh element is necessary for all elements to succeed:

**The Seven Elements of the BPHS and their Components**

| 1. Maternal and Newborn Care   | a. Antenatal care  
b. Delivery care  
c. Postpartum care  
d. Family planning  
e. Care of the newborn |
|-------------------------------|------------------|
| 2. Child Health and Immunization | a. Expanded Program on Immunization (EPI)  
b. Integrated Management of Childhood Illness (IMCI) |
b. Assessment of malnutrition |
| 4. Communicable Disease Treatment and Control | a. Control of tuberculosis  
b. Control of malaria  
c. Prevention of HIV and AIDS |
| 5. Mental Health             | a. Mental health education and awareness  
b. Case identification, diagnosis and treatment |
| 6. Disability and Physical Rehabilitation Services | a. Disability awareness, prevention, and education  
b. Provision of physical rehabilitation services  
c. Case identification, referral and follow-up |
| 7. Regular Supply of Essential Drugs | Listing of all essential drugs needed |

Currently, three main international donors fund and support the implementation of the BPHS program: USAID, European Union and the World Bank. Between the three donors, USAID currently implements and manages the BPHS program in 11 provinces (mainly located in the East and South), the European Union covers 10 provinces and the World Bank has 11 provinces. The HAA will target key areas to increase the MoPH’s capacity and efforts to monitor and evaluate, manage and provide services under the BPHS program.
Deliverable 1.1.1: Strengthen the ability of GCMU to manage, monitor and evaluate the BPHS Program.

The General Contracts and Management Unit (GCMU) is mandated to coordinate, monitor and manage the BPHS Program, but it lacks the capacity to effectively do this. Currently, there is only one coordinating mechanism at the national level, the BPHS/EPHS Coordination Meeting, which convenes on a quarterly basis and includes all implementing partners, donors and related MoPH departments (such as Curative Medicine) in order to review the progress of BPHS and EPHS programs throughout the country.

There are smaller coordination mechanisms that are specific to the individual implementing partner, which is designed to provide a forum for sharing best practices and lessons learned. For example, the World Bank funded Performance Based Partnership Agreement (PPA) program conducts performance review workshops on a semi-annual basis and the EU-funded Performance Based Grant Contract (PGC) program conducts quarterly workshops for the same purpose.

Often, action plans are developed out of these workshops to address identified challenges or gaps. While these meetings provide a forum for the region, there are no formal mechanisms to provide linkages between regions (funded by different donors) other than the coordination meeting. Therefore, the HAA will seek to strengthen the GCMU’s coordination through training and technical assistance of GCMU staff to build its management and program oversight capacity. In addition to the crucial coordination role that the GCMU conducts, the Unit is also mandated to monitor and evaluate progress of the program. Although the BPHS program is currently being implemented by three different donors leading to separate monitoring, evaluation and reporting requirements for each implementing partner, in an effort to maintain consistency, the grants all require the compliance with the National Monitoring Checklist, and therefore, use the same methodology.

There is, however, still a need to compile this data at the national level to that efficient and accurate analysis can be conducted by the GCMU within the MoPH. The HAA will support efforts to a data management and monitoring and evaluation system that is applicable to the needs of the GCMU while working with existing and planned information systems.
Finally, in an effort to gradually transition full management and implementation of the BPHS Program to the GIRoA, the World Bank-supported Strengthening Mechanisms Program, which support’s MoPH’s efforts to build the capacity of the GCMU, is expected to expand. This program is currently being piloted in three provinces, enabling the MoPH to directly contract firms within Afghanistan (instead of relying on donor’s implementing partners) in order to implement and manage the BPHS program. As the capacity and competency of MoPH increases, additional provinces will be transferred to the direct stewardship of MoPH.

**Deliverable 1.1.2: Increased focus on the delivery of three elements of the BPHS Program: Public Nutrition, Mental Health and Disability and Physical Rehabilitation Services.**

The BPHS Program is currently built on the delivery of seven different elements as mentioned in the above table. At the outset of the program in 2002, initial emphasis on the BPHS Program was given to improving Maternal and Newborn Health, Child Health and the control of diseases. This was in part due to the alarming maternal and infant health statistics in 2002, in addition to the program’s alignment with the MGD.

As a result, implementation of the remaining elements within the BPHS program – Public Nutrition, Mental Health, Disability and Physical Rehabilitation, and Regular Supplies of Essential Drugs – has been weak and uneven throughout the country. With the current success of this program, MoPH is now seeking to expand services and provide a focus on the remaining four elements of the BPHS program.

Under the HAA, the GCMU will conduct an initial analysis of the current coverage of these elements of the BPHS program and identify any regional gaps. With the support of international or national technical assistance, the GCMU will also identify any gaps within the BPHS Program itself and develop strategic recommendations and an action plan to move forward on implementing the recommendations to ensure full country-wide coverage of all elements within the BPHS program.
Deliverable 1.1.3: To increase the coverage of health services delivery by the Ministry of Public Health and to decrease the number of referral cases from the prisons to the health facilities outside the prisons through establishment of health facilities inside the prisons.

NPP 5, Health for All Afghans (HAA) calls for “(a) holistic approach” to delivering health services for all Afghans. As Prisoners are part of Afghan community and they are temporary in Prisons. Due to limitations (no access to private sector) there is need for the provision of comprehensive health services to prisoners. Prisons are for punishment not as punishment, but the living conditions in prisons are by themselves a health hazards for the detainees by undermining the general health condition and favouring the development from small problems to serious ones.

Particular note should be given to the following:

- Adult prisoners, detainees and juveniles are highly vulnerable and marginalized populations who require special attention due to their imprisonment and inability to seek routine healthcare
- Adult women and adolescent females in custody require gender specific healthcare responses which are usually not available in these facilities
- While prison health is meant to be delivered under BPHS, all prisons are currently not receiving health services.
- The largest prisons – Pul-i-Charki (Kabul), Kandahar and Herat do not have medical services despite housing almost 40% of the total prison population
- Institutional capacity and service providers capacity on health in prisons needs to be strengthened

The delivery of adequate healthcare services for adult prisoners and juveniles requires priority and attention under the NPP 5. Absent such attention, the public health consequences of prisoners returning to the community after periods of imprisonment cannot be understated.

Increased healthcare costs to manage emergent health problems such as the spread of communicable diseases such as scabies (a common occurrence in prisons and JRCs) and the inability to enter the workforce as a result of chronic illness.
Pul-i-Charkhi (PiC) Prison:
The central prison of Kabul in Pul-i-Charkhi is the biggest prison in Afghanistan. It lies 10 km from Kabul and holds about 7000 detainees shared between seven blocks. It may hold more prisoners in the future. The health service provided in the PiC prison under the responsibility of CPD as described above reflects the general apathy and lack of interest by the MoJ for the health and welfare of detainees. There is apparently no death register in this prison, no medical files which would be expected as part of the documentation process for any detaining authority with long term sentenced detainees.

Herat Central Prison:
Herat Central Prison holds about 2600 detainees is the second biggest prison in Afghanistan. Herat Central Prison is one of the three big prisons which USAID did not provide the fund, so there are insufficient health services, and there is a need for the intervention for the solution of health problems.

Kandahar Central Prison:
Kandahar Central Prison holds more than 1000 detainees, and as well is one of the three excluded provinces from fund provision by USAID. The prisoners are in due need of health services.

Deliverable 1.1.4: Integration of Child survival package in the BPHS

Despite dramatic reduction of mortality among children, infant and under-five mortality rates are high and around 200,000 children and infants are dying each year in the country. Most of these deaths are preventable: the four highest causes of death in children and the percentage of total of under 5 child deaths in 2009 are neonatal causes (41%), pneumonia (21%), diarrhea (14%) and measles (4%). These four account for 80% of child deaths each year.
General and micro-nutrient malnutrition is an import cause of death: as many as half of child deaths would not occur if the children were not malnourished. An integrated package of Child Survival was piloted in 5 districts in 2008 and expanded to 23 districts in 2010. To date the package is integrated in the BPHS in 53 districts. The components are Growth monitoring at the community level, CIMCI, IMCI and Mother and new born care.
The HAA will contribute to avoiding preventable child deaths by ensuring that appropriate essential curative and preventive measures reach into communities and homes of the districts where the integrated child survival package is introduced in the BPHS; to improving the health and nutritional status of infants, children and adolescents by promoting healthy behaviors; and providing essential services to enable each child to avoid death and live to her or his healthy potential.

**Deliverable 1.1.5: Increase access of Nomad population to the BPHS**

6% of the Afghan population is nomad (1.5 million) all health indicators among the nomad population is the worst, compare to the other population. So, it is very important to increase the access of nomad population to the BPHS. The lowest level of welfare among all groups, are women and Kuchis. Most of Kuchi women are engaged in agriculture and postural activities. Currently, 19% of the Kuchi households have access to land. Poverty among the Kuchi population is very high (54%) comparing to other rural (36%) and urban (29%) communities. There is an apparent correlation between poverty and household size. Overall, the average size of poor households is 8.0 persons, compared to 6.9 for non-poor households. The overall indicators of education and literacy in Afghanistan reflect an education system that has performed very poorly. In the Kuchi population there is an extremely low literacy rate for both girls and boys, respectively, around 10% and 20%. The recovery of Afghanistan’s health system from a collapse in the recent decades of conflict is reflected in improving outcome indicators, child mortality rate decrease from 257 in 2003 to 191 live births in 2006 as well as infant mortality rate from 165 to 129 live births – but still the country is at the very bottom of international rankings.

Besides poor general health conditions, such as those related to nutrition, access to safe drinking water and adequate sanitation, which cause the poor performance, there are grossly inadequate availability, access and quality of health care services. Rural and Kuchi population especially women and children severely and mostly face to lack of access to the health facilities, availability of quality health care and equity.

However the national full vaccination rate was nearly triple that found in 2005 NRVA (33% versus 12%), implying a significant improvement in a short time span. Full immunization rate among Kuchi children (13%) is nearly three times less than urban population (33%). The use of contraception, especially modern contraceptives, to increase birth spacing is correspondingly low in Afghanistan.
Only 15 percent of currently married women use any modern method of family planning. Respondents from urban areas more often use contraception than those from rural areas (28 percent versus 13 percent). There is a correlation between poor household’s size (8.0) and lower use of contraception than non-poor households. Maternal mortality rate at the national level 1600/100,000 live births is high in the Kuchi communities. Only 17% of Kuchi women use antenatal care services and 8 percent of Kuchi women likely to use skilled birth attendance. Generally, there is huge challenges remain with respect to women’s mobility, participation in public life, decision making process, health and access to economic and educational opportunities.

The most urgent needs are found among rural and Kuchi population. Recently, the basic package of health services (BPHS-2010) revised and approved in which Kuchi health services has been added as a new activity. Nearly most of the challenges have been addressed in this package. Currently, BPHS is implemented in the area where 85% of the population has access to health services. The ministry of public health is committed to increase the health coverage to 90% till end of 2013.

The proposed project which will be a part of National Priority Program (NPP-5) for Afghanistan carried out for three years and specially designed to address the needs of Kuchi communities. Generally, there are several provinces where Kuchis lives and have movement from one to other including this project will provide health services through fixed Centres in 10 provinces(Nangarhar, Baghlan, kundoz, Paktia, Takhar, Laghman, Maidan Wardak, Parwan and Helmand) and establishing 20 MHTs in 20 Provinces (Parwan, Paktia, Kapisa, Khost, Kundoz, Nengarhar, Laghman, Nimroz, Takhar, Baghlan, Ghor, Heart, Kandahar, Badakhshan, Zabul, Sar-e-pul, Badghis, Bamyan, Ghazni and Kabul).

The project will be implemented by the NPP-5 health provider under the stewardship of Nomad Health Care Directorate of MOPH.

**Deliverable 1.1.6: EPI, Polio – Measles - Maternal and Neonatal Tetanus Eradication**

Immunization program in addition to the BPHS and EPHS level has a component supporting these levels. Also elimination and eradication is another program component need national level attention. Therefore the following activities need to be included in service delivery:
EPI Routine:

1. Support to cold chain facilities at national, regional, provincial and district level. Expansion of building, walk-in cold chain at national and regional level will be required. Also ice lining refrigerator at provincial level and RCW50 or solar refrigerator will be required.

2. Expansion of warehouse for dry supplies. A national warehouse in Kabul level to be able to accommodate all dry supplies is required. Also five regional cold rooms need expansion for dry supplies.

3. Cold chain is run by technicians who take care of maintenance and repair of the equipments. The number at the country is above 120 and there is no positions exist for these people. Salaries, overtime for night stay and travel allowances are required.

4. Co-financing for introduction of new vaccine pneumocal in 2013 and Rota in 2014. MoPH has committed to introduce birth dose of Hepatitis B vaccine in early 2013. Procurement cost of the vaccine will be burned by the government for 50% newborn in 2013 and gradually increased.

5. EPI activities at district level are a part of BPHS/EPHS support. But requirement for cold chain, its maintenance, supervision and monitoring are not budgeted through BPHS and EPHS.

6. Vaccines have been donated by UNICEF and or procured through UNICEF by GAVI funds. While the logistic from the port of land, clearance cost (MOPH is supposed to pay custom tax to the government) are not included in GAVI cost. Therefore additional cost needs to be reflected in the budget.

7. It is suggested that best option for district level cold chain is the solar refrigerator which accepted globally. Procurement and installation of solar refrigerator at all health facilities should be cost for year 2013 and 2014.

8. In the past many years no initial training conducted as per the requirement and many vaccinators are only trained through refresher training. Average every year 10 new vaccinators per provinces will be required. The training should be for graduate of higher education for 3-6 months. Budget need to be calculated.

9. Specific allocation should be made available to the provincial level management team to do regular supervisory and monitoring visits. In the past few years due to budget shortage these activities not implemented and it was found a major casue of decreasing immunization coverage.
Polio Eradication:
10. National immunization days have been requirement till polio eradication at the country level. Each year MOPH is supposed to conduct at least four rounds of SIAs. Vaccines, none vaccine supplies and operational cost will be required.
11. Continue AFP and measles surveillance and integrate other vaccines related disease surveillance.
12. Comprehensive social mobilization and communication budget is also required for each round of NIDs.
13. As per the global decision of Polio Eradication as public Health Emergency, Afghanistan drafted PEA for 2012-2013. Immediate funding allocation is required.
14. A specific operation introduced in 9 high risk districts for polio eradication; called polio permanent team and it is subjected to evaluation. The strategy presented to SAGE meeting and seems a successful initiative of the country. It expansion beyond 9 district to all 28 high risk district of southern region and Farah will need funding.
15. Accountability frame for evaluation of staff at each level is a well accepted tool at the country. Currently its introduction is only in 13 high districts but will need expansion to the entire country. Budget is required to have a unit within MOPH and cost for travel, transport, per diem etc required.

Measles Elimination:
16. Despite routine program through BPHS/EPHS still the coverage is low and could not take the country to the elimination level. Each three year a supplementary measles immunization will be required to maintain 90% coverage for all children subscribe for measles. Measles SIAs in 2012 and it follow up in 2015 need to be implemented. Measles vaccine, syringes, safety boxes, training, social mobilization and operation cost will be required.
17. Inclusion of rubella with measles is another requirement recommended by global strategic advisor group of expert 2011-2012. Cost of MR vaccines, non vaccines supplies and operation is required along with training and social mobilization is needed.

Maternal and Neonatal Tetanus Elimination (MNTE):
Strategy paper developed and efforts made only once in the country for elimination of Tetanus. Due to funding shortage the initiative is lagging behind. This component is missing narrative description. I think at least a short Para should be added.
Sub-Component 1.2: Implementing of revised EPHS

To implement a revised Essential Package of Health Services (EPHS) for Afghanistan

**Anticipated Results:** It is expected that by program completion:

1. The foundation within the EPHS program is established to operationalize its top three priorities
2. EPHS’ expansion plan is developed in consultations with the partners and finalized.

The Essential Package of Hospital Services (EPHS) is the MoPH’s second major national-level health program, which defines all the necessary elements of services, staff, facilities, equipment and drugs for each type of hospital in Afghanistan. The following is a brief summary of EPHS in order to provide an overview of the program, what it intends to achieve, and the main programmatic goals and objectives.

A budget summary of the current program is included, however full program documents and manuals do not appear in this summary, but are available upon request.

The Essential Package of Hospital Services (EPHS), has four purposes: (1) to identify a standardized package of hospital services at each level, (2) to provide a guide to the MOPH, private sector, NGOs and Donors on how the hospital sector should be staffed, equipped with materials and drugs to perform a defined set of services at each level of the hospital sector, (3) to promote a health referral system that integrates the Basic Package of Health Services with the hospitals and (4) to provide a basis for establishing a hospital system that provides quality hospital services through efficient management.

The top three priorities of the hospital sector are to increase access to hospital services, improve the quality of patient care, and make the operation of the hospitals more efficient. To bring about these improvements the following three priorities need to be operationalized within the next 5-10 years:

1. **Establishment of Standards:** in order to improve the clinical and managerial performance and attain an acceptable level of patient care and operations for hospitals. The establishment of such standards will permit the monitoring of hospital operations allowing hospital performance to be measured.
(2) **Establishment of Hospital Boards:** for the purpose of strengthening community involvement and creating a sense of ownership in the hospital. Community support for hospitals is often poor and are referred to as the “government’s hospital” or “NGO’s hospital”. A hospital board will provide the general direction and guidance for the management and operation of the hospital and serve as a link between the community and hospital.

(3) **Certification and Accreditation:** of Government or NGO-operated hospitals to ensure the basic standards of care are met. The HAA will be focus on establishing a foundation within the next three years to ensure the successful operationalization of these priorities.

**Deliverable 1.2.1: The Revision of the EPHS Program**

The hospital system plays a critical role in Afghanistan, enabling referrals from the community level up to the national level (Kabul-based hospitals). Hospitals within Afghanistan operate at three levels: Health Posts at the community (village) level, Basic or Comprehensive Health Centers and District Hospitals in larger communities, and Provincial or Regional Hospitals at the province level.

After establishment of the BPHS Program, the Hospital Management Task Force of MoPH developed a framework (package) for hospital services within the health system. This package identified the minimum requirements for hospital staff, equipment, supplies (including medicines) and services at the three levels of hospitals in the country. The EPHS was drafted and adopted in 2006 by MoPH. As this program is now in its sixth year of implementation, MoPH will conduct an analysis of the EPHS system to assess the quality of care, capacity of hospitals and staff as well as identify gaps in coverage.

The EPHS package was initially based on the capacity of hospitals and the health care industry seen in 2006 and since that time, the health care sector has made tremendous strides in the creation of standards, regulations and processes based on lessons learned both within Afghanistan and internationally. Therefore, in addition to assessing the current state of services in Afghanistan, this revision will adjust the EPHS program to account for changes in policy, standards, regulations and processes.
The recommendation for the revision of EPHS was made at the January 2012 Health Retreat, hosted by MoPH. Initial assessments and preparation for revision are anticipated to begin in spring 2012 and be completed by the end of the year. Based on this revision, implementation of the new package will begin in 2013.

**Deliverable 1.2.2: Expansion of the EPHS Program**

The Essential Package of Hospital Services is currently implemented by three main donors and their implementing partners: USAID, EU and the World Bank. Contracts are managed by the GCMU within MoPH, similar to that of the BPHS Program. USAID, through the Performance Based Contract for Health Services (PCH) Program, has currently implemented EPHS in 5 provinces, the EU implements through the PGC program and World Bank through PPA. Following the revision of the EPHS Program, expected by the end of 2013, the MoPH will seek to expand the services offered through the EPHS system to the remaining provinces and hospitals.

**Deliverable 1.2.3: Integration of professional assistance and referral services for victims of gender–based violence (GBV)**

Gender-based violence is a pervasive public health and human rights problem and numerous studies prove that gender-based violence has implications for almost every aspect of health policy and programming, from primary care to reproductive health programs. The consequences of gender-based violence can be fatal, such as homicide and suicide; or non-fatal, such as chronic pain syndromes, traumatic injury, or traumatic gynecologic fistula. Evidence demonstrates that maternal health problems correlate with physical and sexual violence. Violence in pregnancy may pose a threat to the life and wealth of the mother and the fetus. Physical violence during pregnancy is connected with miscarriage, late entry into prenatal care, stillbirth, premature labor and birth and low birth weight. Sexual violence is associated with a range of gynecological and reproductive health problems, including STIs, unwanted pregnancy, vaginal bleeding or infection, fibroids, chronic pelvic pain and urinary tract infections. Over a period of several generations of conflict, formal and informal social institutions in Afghanistan have both replicated and changed patterns of gender-based disadvantage and inequality.
Studies confirm that the overall level of violence against women in Afghanistan is very high-up to 87.2% and an overwhelming majority of women experience at least one form of physical, sexual or psychological violence or forced marriage, and most, 62%, experienced multiple forms of violence. (Global Rights Survey, 2008) Violence against women is more pervasive in provinces and the level of forms of violence differs from one province to another.

Numerous studies show that in most cases survivors of GBV require multi-level assistance from health service providers. The main role of health services in the area of GBV is to identify and respond to women and girls who have already experienced violence, to mitigate the negative health consequences, and to refer GBV survivors to appropriate support services as per need. The multi-sectoral approach is essential to offer comprehensive services and support to survivors of GBV.

In this regard, MOPH Assessment of Services Provided to Victims of Gender Based Violence by State and Non-state Agencies in Nangarhar, Bamyan and Kabul provinces (2011) that was implemented with technical and financial support of UNFPA’s found that healthcare facilities in rural and urban areas were often the only chance for GBV victims to seek assistance and protection outside of family circle but on the other side healthcare facilities in all examined areas presented an impasse in the referral and reporting network that connected agencies working in the field of GBV response.

In Afghanistan healthcare sector has a huge potential of playing a leading role in GBV response due to the following factors: (i) Healthcare providers interact with the largest number of women; (ii) It is easier for women to access health facility; (iii) Healthcare providers can be trained to detect various manifestations of GBV; (iv) Health facility can provide assistance to GBV victims suffering from various forms of GBV ; (v) Health system already has internal referral network with the system that can be used for referral of GBV survivors; (vi) Health facility plays a crucial role in evidence collection (forensic medicine). However the reality is that currently health facility is an impasse in referral of GBV victims.
Strengthening health response to GBV is crucial intervention required for strengthening the institutional and managerial capacity of the service providers overall, increasing understanding and improving knowledge of the GBV response actors as well as general public on violence against women and girls, national legislation and human rights instruments. While the long term ultimate goal is to contribute to creating safe and non-violent environment for women and girls of Afghanistan, its immediate objective is to establish referral path and response to cases of GBV through the health facility entry point. The necessity to integrate the Health Response to GVB is obvious and should be capitalized on existing health system while addressing current gaps. The health response model to be facilitated through the policies and procedures that generate routine practices of the institutions and incorporate as its central element the creation of multiple service hubs, facility-based coordination mechanisms capable of offering people subjected to GBV a wide range of solutions and assisting them in accessing a variety of services.

Health sector response to GBV should be integrated through the following steps:

Step I: Development of the Concept Paper on health sector response to GBV
Step II. Development of country specific model of health sector response to GBV
Step III: Capacity building of health service providers to ensure that professional multilevel assistance, safety and confidentiality standards are in place
Step IV: Piloting of the Model in selected provinces
Step V: Revision of the Model and full integration of the services into health care sector
Step VI. Monitoring and quality control assurance through continues capacity building of health professionals.
Coordination among agencies and organizations within the current draft Concept Model is facilitated through the policies and procedures that generate routine practices of the institutions. These practices include steps that secure routine coordination of efforts and information sharing among agencies engaged in GBV response. The Concept Model incorporates as its central element the creation of multiple service hubs, facility-based coordination mechanisms capable of offering people subjected to gender based violence a wide range of solutions and assisting them in accessing a variety of services.

**Deliverable 1.2.4: Improvements of blood safety services as per WHO standards**

Afghanistan National blood safety and Transfusion services [ANBSTS] is approved by HE Minister. A baseline blood banking service review was conducted by the newly formed ANBSTS [team during the early part of 2009]. This review indicated evidence of divergent and unsatisfactory service and standards practices everywhere. This evidence-based appraisal underscored the need for a standard and system to address the issue of blood safety and transfusion practice in Afghanistan.
It was clearly recognized that there is a need to produce a National Blood Safety Law and Policy which is backed by appropriate legislation and regulation and also standardize other areas within the services. The law and policy can then be supported in practice through standard operating procedures (SOP) and associated and documented service and blood safety guidelines and practices. In addition a regular checking of service activities, facilities and skills of personnel can be introduced and maintained in support of the development and maintenance of this vital National Health Service. Standard Operating Procedures have been established based on standard template by ANBSTS staff (assisted by the WHO experts) and reviewed by a special committee and other experts. Conducted Training Needs Assessment (TNA) and develop training curriculum accordingly. Trainings have been conducted in the areas of Quality Management and other Blood Bank procedures for Kabul and staffs mainly for four regions (Kandahar, Jalalabad, Mazar-e-Sharif and Herat) but still here are huge needs to train the staffs from all over the country. Public awareness activities have been carried out with the help of NGOs and other Civil servant organizations. Voluntary Blood Donation has been increased up to 50% from 20% in Kabul city; there is a tremendous achievement toward decreasing paid donors. The Blood Bank Staff has been trained on Quality management, and TTI Testing.

**Challenges:**

None availability of adequate funds for different part of this very important national program such as suitable equipments, expansion of the training program as well as providing consumables.

1. Non-availability of Negative Blood Groups Donors.

**Areas of Intervention:**

1. Nationwide Blood Safety and Transfusion Service Preamble
2. Improve and expand quality and safety of blood transfusion services on country-wide basis within the National Health Plan
3. Ensure the equitable distribution of equipment and consumables
4. Establishment of a nationwide blood transfusion service network along with sustainable financial structure for the Afghanistan National Blood Safety and Transfusion Service [ANBSTS]
5. Appropriate storage and distribution of blood and blood components.
6. Appropriate testing of blood/blood components for TTIs
7. Standardize methods of collection, transportation, processing, testing, storage and distribution of blood and blood components and derivatives which are safe for transfusion and other medical therapy.


9. Promotion of the appropriate clinical use of blood and blood components.

10. Capacity building of human resources in blood transfusion activities.

11. Collaborating with national and international partners supporting the ANBSTS.

12. Ensure universal compliance with all legislation and regulations of the National Blood Safety and Transfusion Services.

**Appropriate Use of Blood**

Prescription and administration of blood and blood products shall be under the authority of a recognized medical practitioner. ANBSTS guidelines with appropriate record keeping and hem vigilance shall be observed by all medical establishments and health personnel handling and/or administering blood and blood products. To maximize the benefits of blood therapy, ANBSTS in collaboration with medical professionals shall promote the application of national and internationally accepted principles of blood component therapy including antilogous techniques. As a general role transfusion of blood and/or its components should be limited to the situations where there are no other effective alternative interventions available. The use of alternatives to blood such as colloids, crystalloids and hematonic where appropriate shall be promoted.

Strategies for the reduction of transfusion requirements such as prevention and early diagnosis and treatment of anemia shall be promoted by the MoPH. The establishment of Hospital Transfusion Committees under the guidelines issued by the ANBSTS shall be promoted throughout the Country.

**Human Resource:**

The principle of professionalism shall be applied to all operations of ANBSTS. Conditions of service within the ANBSTS shall be determined by the MoPH and shall conform to the guidelines in the Public Service. Programs of orientation, continuous education and in-service training shall be established for all categories of staff within ANBSTS. Career structures which do not already exist in the public service shall be established to meet the peculiar needs of the ANBSTS and appropriate training programs created to produce the required cadres. ANBSTS shall encourage and cooperate with higher educational institutions in Afghanistan to establish training programs in Blood Transfusion Medicine and Science.
Sub-Component 1.3: National Hospitals

To improve service at National Hospitals through staff capacity building and development of managerial and clinical standards

Anticipated Results: It is expected that, by program completion:

1. The creation of a Secondary and Tertiary Care Package of Health Services
2. Completion of a mapping exercise that will identify gaps in the health sector regarding the creation of new hospitals and the maintenance of existing hospitals.

MoPH, with the support of development partners, has expanded access to primary health care from 9% in 2003 to around 85% in 2009. While this is a great success, little attention has been given to secondary and tertiary care. According to the Afghanistan National Hospital Survey (2004), compared to other developing countries with similar levels of income, Afghanistan has a relatively low number of hospitals and hospital beds. The ratio of one bed per 1,000 people, recommended by the World Health Organization, has not been met across the country, including Kabul.

An estimated 25% of the population lives in Kabul, but the city’s hospitals (referred to as National Hospitals) have not received adequate financial or technical support. This has contributed to public criticism that the GIRoA is unable to effectively manage institutions and provide essential services. Unfortunately, this is compounded by the fact that Nationally-run hospitals are more limited in their ability to allocate resources due to legislative constraints resulting in unevenly equipped and maintained hospital systems. In an effort to improve the quality and type of services, the three-year HAA will support the MOPH and its General Directorate of Curative Medicine (GDCM) in their efforts to develop a package of Tertiary Care services.

This will include mapping exercises to identify areas where the maintenance of existing hospitals is needed as well as to identify locations for future hospitals. The intent is to develop an action plan that will lay out the sequencing and priorities for infrastructure improvement.
Deliverable 1.3.1: Identify requirements for the maintenance and expansion of hospitals

Many of the existing hospitals in Afghanistan were built years ago and are now falling into disrepair and the medical equipment is out of date. Additionally, due to the number of donors providing support in the form of hospitals, equipment, and services, the MoPH does not have a comprehensive map of all hospital locations, types of facilities, and staffing throughout the country. While there will be a specific focus on national hospitals providing tertiary care, this mapping assessment will cover all hospitals in Kabul. Therefore, it is incumbent upon the MoPH to conduct a mapping assessment and have a clear understanding of the needs so that priority areas can be identified. The HAA will be crucial to gathering donor support and conducting this survey.

Pending the ability of MoPH to identify and hire an international technical consultant and their availability, the anticipated timeline for this survey is three months. Currently, the MoPH lacks current information on need/demand for secondary and tertiary care, in addition to data that reflects the state of its infrastructure. The HAA Afghans program will support the MoPH and the GDCM’s to conduct a comprehensive mapping exercise of the existing hospitals in Kabul, identifying the services, quality of care, equipment needs, and infrastructure of each hospital. Additionally, the GDCM will also focus on coverage of hospitals to identify the location of future buildings where coverage may be considered light or not meeting the demands of the population. This proposed mapping and comprehensive assessment of National Hospitals has been presented to the donor community but commencement has yet started due to lack of funding.

The outcome of the mapping and assessment exercise is the development of a comprehensive action plan which details and sequences priority areas of rehabilitation and building based on pre-determined qualifications and parameters set by MoPH and the GDCM.

Deliverable 1.3.2: The development of a Tertiary Care Package of Services

The BPHS and EPHS programs (described in Component 2, Subcomponents 1 and 2 respectively) are designed to identify the minimum requirements necessary to provide basic services to the population, which includes staff, equipment, and supplies. As a result of these programs, health statistics in Afghanistan have shown marked improvement over the past decade. Tertiary care, however, has lagged behind.
The hospital system in Afghanistan is designed to operate on a referral-based system. From the community level, patients are referred to district hospitals, then to regional or national medical facilities, depending on the level of medical services required. This referral system can only work effectively if the secondary and tertiary care services are able to meet demand. Therefore, the GDCM is planning to prepare a proposal for a Tertiary Care Package of Services to be piloted in 8 of the 18 national (Kabul-based) hospitals in Afghanistan. In January 2012, MoPH launched a comprehensive assessment of all hospitals in Kabul to identify the services available, staff requirements, equipment and gaps in the secondary and tertiary care provided.

In addition, the assessment is studying the feasibility of applying user fees for specific tertiary care services in order to be able to sustain maintenance and operational costs. The MoPH will work closely with the Ministry of Justice to develop a set of guidelines for the application of hospital fees to services. The assessment is expected to be completed by July 2012. Following the completion of this survey, a committee will be convened by GDCM to analyze the results of the survey and identify the different types of tertiary care services needed and create a prioritized list of requirements. In addition to the analysis of the assessment and prioritization of needs, this committee will clearly define the role and responsibilities for primary, secondary and tertiary care services in order to develop a definitive set of guidelines. While some standards have been defined through the BPHS and EPHS program, the differences between secondary and tertiary care are not as clear. This will be crucial to the creation and approval of a tertiary care package of services.

Once the assessment has been conducted and priorities and guidelines for tertiary care have been developed, the GDCM will develop a strategic plan to launch an initial pilot tertiary care program similar to BPHS and EPHS, with the support and guidance of the international community.

GDCM anticipates the development and expected completion of the program document in Dec-2012. Should the proposal for this Tertiary Care Package of Services be approved, the GDCM will conduct a second needs assessment to identify staffing and training requirements to implement this package in hospitals in Kabul.

This will identify the specific skill-sets necessary for the creation of the Tertiary Care Packages of Services and will then lead to the costing and proposal development to be presented to the donor community for support.
Deliverable 1.3.3: Costing of the Tertiary Care Package of Services.

The creation of a Tertiary Care Package of Services, as described above, will be a long, complex process involving in-depth assessments of the hospital system, infrastructure and equipment requirements as well as the identification of necessary skill sets. With the completion of the analysis prioritization of tertiary care services, the MoPH will need to identify their capacity to cultivate these services, and maintain and sustain this package. In order to identify the cost requirements of building and implementing this tertiary care package of services, renovating hospitals to handle the infrastructure and equipment requirements and operate such services, the MoPH aims to accurately cost this program down. In direct coordination with the Health Financing Unit and additional support of an international technical advisor, the MoPH will develop a costing matrix for this package. At the completion of this deliverable, the MoPH will develop a proposal and action plan to present to the international community for approval and support.
Sub-Component 1.4: Public Nutrition

To improve the Nutritional Status of the Afghan Population

Anticipated Results: It is expected that by the program completion:

1) Improvement in the nutritional status of the population through increased public awareness of appropriate nutritional practices.

2) Development of effective food safety standards and regulations.

3) Increased capacity within the GIRoA to monitor and evaluate nutritional strategies and programs in order to effectively respond to emergencies.

Studies have shown approximately 35% of deaths among children is caused by complications and disabilities resulting from improper breastfeeding practices, deficiencies in Vitamin A and Zinc and an overall lack of proper nourishment. These complications include stunting of growth, severe wasting and intrauterine growth retardation. The effects of malnourishment go beyond affecting early childhood development, often leading to permanent impairment, potentially affecting future generations. Stunted height, less mental capacity, reduced economic productivity and lower birth weights (among pregnant women), high glucose levels, high blood pressure and harmful lipid profiles are additional long-term consequences of malnourishment. Studies have shown that properly nourished children are more productive among society, earning on average 34-47% more and have 14-28% higher incomes. This computes to an approximate 2-3% loss in GDP.

According to the National Nutrition Survey 2004, Afghanistan has the worst nutrition indicators among women (of childbearing age) and children. 61% of children under the age of five suffer from stunted growth while 39.9% of children are underweight. Additionally, 18% of young children (under the age of 5) suffer from wasting and 72% of children have growth retardation.


Acute malnutrition or wasting: a loss of weight compared to children of the same height and it is measured with ‘weight-for-height’ (W/H), and/or presence of Oedema.

children suffer severe iodine deficiencies. 21% of women are also underweight, with a Body Mass Index of less than 18.5.

The severity of these statistics indicates the need for immediate and aggressive action by the GIRoA to ensure the health and safety of the population. Further, addressing and preventing malnourishment among children is a crucial development investment, as it will lead to important health, educational and economic benefits. To date, several small-scale interventions have been successfully implemented, resulting in the reduction of malnourished children. The National Nutrition Policy and Strategy (2009-2013) supports the expansion these interventions by integrating them with the current health care system and framework for service delivery. The three-year HAA supports interventions that help create the foundation necessary for the success of this National Nutrition Strategy. Through a comprehensive approach which will include interventions at the government level (through increased capacity to monitor, evaluate, plan interventions and manage cases), access to proper nutrients, education of caregivers and increased public awareness, the GIRoA will aggressively seek to improve nutrition among the population, specifically among young children.5

**Deliverable 1.4.1: To advocate for and increase awareness of healthy eating habits among the general population**

In addition to providing resources and access to higher quality foods, behavior change is necessary among the Afghan population to improve their overall nutrition status. Key to achieving this is to ensure the GIRoA provides the general population with the information necessary to make this lifestyle change and improve their nutritional habits. In order to effectively advocate for and increase awareness of healthy eating habits, the HAA seeks to incorporate ongoing activities led by the Nutrition Department of MoPH in a comprehensive approach designed to increase the knowledge of the population through strengthened coordination and targeted educational undertakings.

**Inter-Ministerial Coordination Committee to Address Nutrition:** Due to the correlation between the nutrition status of a population and its effect on the overall health, education

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5 Emphasizing the first 1000 days of life
and economic development of Afghanistan, an integrated approach is required to ensure the population has access to the information necessary to improve their nutritional habits. Therefore, MoPH is leading the development of an inter-ministerial committee to coordinate activities and oversee the drafting of a multi-sectoral plan of action designed to improve and streamline efforts among key ministries to improve the nutrition status among the population.

The inter-ministerial committee will be comprised of representatives from the Ministry of Agriculture, Irrigation and Livestock (MAIL), the Ministry of Rural Rehabilitation and Development (MRRD), Ministry of Education (MoE), Ministry of Commerce & Industry, MoF and potentially the Ministry of Women’s Affairs. The associated technical departments of these ministries are currently drafting this multi-sectoral plan of action with additional support from international consultants in the costing of activities.

It is anticipated that by March 2012, the plan will be submitted to the ministries for review, final approval is anticipated by early 2013. In addition to the oversight and implementation of the multi-sectoral action plan, the committee will also provide oversight to other related sub-committees within the Ministry of Public Health and oversee the implantation of national regulations supporting the improvement of nutrition and food fortification.

**National Education Campaign:** The second aspect of improving the nutritional status of the Afghan population is to provide information on and advocate for healthier lifestyles through the incorporation of healthy eating habits.

This education begins with integrating nutritional lessons and messages into the school system with a focus on primary aged children and secondary aged females.

Through direct coordination with the MoE and support from international donors, the MoPH has provided elementary (primary) schools with materials on healthy eating habits and proper nutrition. Over the course of the Health for All Afghans Program, this initiative will be expanded to secondary schools, with a focus on females. The Nutrition Department of MoPH is working in close coordination with the MoE to develop a comprehensive and updated curriculum for the expansion of nutritional messages and lessons throughout every class in primary schools. In secondary schools, the Nutrition Department will also work in partnership with MoED on the development of curriculum targeting females. This will include the advocacy of healthy eating habits as well as information regarding the importance of breastfeeding and maternal nutrition. Once the materials and curriculum are developed, it will be the responsibility of the MoE to
implement this plan and pilot the program in a whole school year in selected provinces and districts.

The pilot includes training of master trainers in the primary schools of Kabul province in an attempt to assess how teachers present the curriculum and if this will improve the level of knowledge of students. The nutrition topics are integrated within several subjects throughout grades 1-6 in primary schools. Additional resource materials for teachers have been developed as a guide to provide teachers with a more comprehensive understanding of the topics so that they can answer questions raised by the students. Finally, with the support of the WFP, MoPH is also incorporating key nutritional messages into adult literacy programs with the MoE. The MoPH, through the Nutrition Department, is in the process of developing a food-table indicating nutritional requirements broken down by age and gender categories based on the items available in different regions of the country. This will require a number of steps; as similar nutrition tools have been successfully utilized in India and the Nutrition Department is in discussion with an Indian Institute on the development of these guidelines. MoPH will then launch a study in 2013 on the regional requirements in Afghanistan. With the completion of the study, the MoPH will prepare the food table with supporting materials.

There will not be a formal launching of this food tables. Rather, MoPH will host a series of orientations and make the information available to other ministries, such as MAIL and MoE.

Deliverable 1.4.2: To reduce the prevalence of major micronutrient deficiency disorders in particular iron, folic acid, iodine, vitamin A and zinc

To reduce the prevalence of major micronutrient deficiency disorders, a multi-faceted approach will be used in the HAA, which will include proper coordination with policymakers, health professionals and the public.

The HAA will target activities that will help increase public awareness of the issues surrounding micronutrient deficiency disorders, and conduct trainings among health staff, specifically targeting awareness raising on the issue and support the fortification of nutrients in food. Through these activities, the MoPH will move toward achieving its goal to reduce major micronutrient deficiency disorders among the Afghan population.

There are three primary ways of reducing the prevalence of micronutrient disorders:
Food fortification, nutrient supplements and diversification of foods.

Food fortification measures are targeted towards iodized salt, flour and edible oil. While the target of food supplementation focuses on the increase use and intake of minerals and vitamins, particularly Iron, Folic acid, A and D, finally, the food diversification will focus on encouraging the population to diversify their local intake of foods. To accomplish these tasks MoPH will employ a variety of methods from conducting public messaging campaigns, providing training, and seeking legislative reform.

Public Messaging Campaigns: The MoPH currently conducts public messaging campaigns encouraging the usage of iodized salt and is planning an assessment of this campaign to determine its effectiveness; this assessment is scheduled to begin by the end of 2012. Additionally, the MoPH will seek to strengthen the on-going messaging campaign on iodized salt by revising information and methods based on lessons learned from the planned assessment. The public awareness campaign messages will focus on behavioral changes necessary at the household level to reinforce the other efforts (access to supplements and the fortification of food) to reduce the prevalence of micronutrient deficiency disorders among the population.

Training and Awareness Raising Workshops: In the past, nutritional training workshops and courses have been conducted but not in a uniform package. In an effort to correct this, the Nutrition Department is coordinating with other departments within the MoPH to develop a comprehensive Nutrition Training Package that will be launched in the beginning of 2013. This package will consist of master 21-day training (Training of Trainers – ToT) in Kabul covering a comprehensive list of issues related to BPHS, EPHS and Public Nutrition (to include food fortification, supplementation and diversification). The Kabul ToT will target approximately four master trainers per province, who will be responsible for conducting cascade training modules at health facilities and hospitals in their provinces.
It is anticipated that the first round of trainings will be completed by the end of 2013.

<table>
<thead>
<tr>
<th>Training Area</th>
<th>Training Focus</th>
<th>Target</th>
<th>Duration/ Location</th>
<th>Training Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition component of BPHS</td>
<td>• IYCF, • Management of acute malnutrition, • Micronutrients, • Growth monitoring, • Nutrition surveillance, • Planning nutrition program</td>
<td>Provincial Master Trainer</td>
<td>Kabul (21 days)</td>
<td>To develop master trainers in key topics of nutrition at the provincial level</td>
</tr>
<tr>
<td>Breastfeeding counseling</td>
<td>Breastfeeding counseling skills</td>
<td>• Midwives/ nurses at the BPHS health facilities, • CHWs and community volunteers at the community level</td>
<td>Provinces (6 days)</td>
<td>To improve knowledge and skills of mothers in appropriate feeding of infants and young children</td>
</tr>
<tr>
<td>Management of acute malnutrition</td>
<td>Diagnosis and treatment of children with severe and moderate acute malnutrition</td>
<td>• Physicians at the pediatric ward/ malnutrition, • Physicians at the BPHS health facilities doing pediatric services, • Nurses in the hospitals and health facilities</td>
<td>All provinces (6 days)</td>
<td>To diagnose and treat children with acute malnutrition</td>
</tr>
<tr>
<td>Micronutrients</td>
<td>• Micronutrients deficiency disorders prevention and treatment, • Micronutrients supplementation, • Food fortification, • Food diversification</td>
<td>Physicians and midwives at the health facilities and hospitals</td>
<td>All provinces (4 days)</td>
<td>To prevent and treat micronutrients deficiency disorders</td>
</tr>
<tr>
<td>Growth Monitoring and promotion</td>
<td>Growth monitoring, interpretation and counseling skills</td>
<td>• Pediatric nurses at the health facilities, • CHWs and Community volunteers at the community level</td>
<td>All provinces (2 days)</td>
<td>To enable personnel to use correctly the new WHO standard growth monitoring chart and provide necessary counseling to mothers</td>
</tr>
<tr>
<td>Nutrition Surveillance</td>
<td>How to collect, compile, analyze and interpret data about the outcome of nutrition programs</td>
<td>Provincial nutrition officers, Health facility staff, Other relevant staff</td>
<td>All provinces (3 days)</td>
<td>To monitor the outcome of nutrition programs</td>
</tr>
<tr>
<td>Nutrition Rapid assessment</td>
<td>SMART methodology of nutrition survey in emergencies</td>
<td>NGOs staff and nutrition focal points</td>
<td>Provinces prone to emergency (6 days)</td>
<td>To enable NGOs to monitor the nutrition status of children, especially when there is emergency situation</td>
</tr>
<tr>
<td>Titration</td>
<td>Quantifying the iodine in</td>
<td>Laboratory staff of salt</td>
<td>8 regions of</td>
<td>To enable salt</td>
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</tbody>
</table>

**National Priority Program-5 Human Resource Development Cluster**
Additionally, MoPH will continue to provide a variety of workshops and orientations to health care providers and policymakers on the role and benefits of micronutrients in nutrition.

The Nutrition Department will continue to conduct regular workshops (based on need) and events, such as a one day orientation session per month with targeted Ministries and provincial governors about Universal Salt Iodization (USI), Flour Fortification with iron and folic acid, and edible oil fortification with vitamins A and D to prevent micronutrient deficiencies. The aim of these orientation sessions is to make the key personnel in these agencies understand the role of food fortification in prevention of micronutrients deficiency as well as the consequences of micronutrients deficiency in the overall development of the country.

Health care employees directly linked to the BPHS and EPHS programs will receive additional training on micronutrients and the prevention and treatment of micronutrient deficiency disorders. The goal is to ensure that training of at least one person in each health facility throughout the country become a subject matter expert.

A comprehensive strategy and implementation plan will be created in order to strengthen food fortification, provide micronutrient supplements and diversify available food.

In close coordination with the private sector, the HAA will continue MoPH’s efforts to raise awareness and knowledge of food fortification by providing regular refresher and initial training to the owners and lab technician of iodized salt plants, technical officer of fortifying flour mills and also factories producing fortified edible oil and complementary foods.

These trainings will support efforts to produce good quality fortified products, and also distribute and procure micronutrient premix, which is used by the factories to produce fortified products. There will be a particular focus on the iodization of salt, fortification of oils with Vitamins A and D and the fortification of flour with Iron and folic acid. The availability of additional micronutrient supplements to women and children will be increased through BPHS and EPHS health facilities and mechanisms like National

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7 Potassium iodated & micronutrients powder
Immunization Days (NIDs), which are conducted for polio eradication in all parts of Afghanistan.

**Legislative Reform:** Most of the foods imported from Pakistan and other neighboring countries are not fortified with minerals and vitamins. Afghanistan lacks any mechanisms to check or enforce importations, as no legislation exists requiring this. The MoPH is currently conducting initial rounds of discussions with the Ministry of Commerce & Industry and the Afghan National Standard Agency (ANSA) to seek out collaboration on the development of appropriate legislation and standards that will mandate foods imported into Afghanistan to be fortified. This initiative is heavily supported by the Global Alliance for Improving Nutrition (GAIN) and the international donor community.

**Deliverable 1.4.3:** To strengthen case management and increase access to quality therapeutic and supplementary feeding care at the health facility and community levels

Acute malnutrition, especially among children under five years of age, is a key indicator of the overall nutrition status of the general population. While improvements have been made in preventative interventions, a number of underlying causes still lead to acute malnutrition, especially among children, including: inadequate access to food, diseases, level of education and caring practices of parents, cultural issues regarding diet, women’s status in society, and availability of basic health and social services.

The HAA supports the MoPH’s ongoing efforts to mitigate acute malnutrition through three objectives: 1 - treatment of severe acute malnutrition with medical complications, which is a medical emergency at the health facility level; 2 - treatment of severe acute malnutrition without medical complications at the community level; and 3 - supplementary feeding program to ensure complete management of acute malnutrition for long time.

The MoPH follows the international standards defined by the WHO regarding the management, treatment, and care of malnourished individuals at health facilities and communities.

The MoPH, in coordination with WHO and UNICEF, is going to revise these guidelines and protocols to adapt and tailor it more to the Afghanistan context. The revision of these guidelines and protocols are in their final stages of completion. It is anticipated that the revised guidelines and protocols will be published in the May 2012 and distributed to all
relevant health professionals and training participants by the Public Nutrition Department. The new protocols and procedures will be incorporated into the comprehensive Nutrition Training Package currently in development. This will be conducted in three phases:

Training on Updated Nutrition Training Package: The provincial master trainers will be divided in three batches of 10-12 provinces for a ToT workshop. The master trainers will then conduct cascade trainings in the provinces for all relevant health personnel and community members. To ensure the proper implementation of the revised guidelines and protocols, MoPH will monitor the BPHS and EPHS facilities. Monitoring will be conducted during the initial training of health facility staff at the provincial level and will be followed up through regular monitoring/ supervision during the implementation phase. Through strengthening coordination with BPHS and EPHS implementing partners, donors, UNICEF and the WFP, the MoPH will ensure BPHS and EPHS implementers are adequately supplied with education and training materials, fortified foods, and micronutrient supplements so that communities may be targeted for training in malnutrition procedures through a full package of Community-Based Management of Acute Malnutrition (CMAM) and Therapeutic Feeding Units (TFU).

Currently UNICEF supports the provision of therapeutic food and the World Food Program provides supplementary food for treatment centers.

**Deliverable 1.4.4: To ensure food safety and quality at all levels.**

In addition to the Public Nutrition Department, the Environmental Health Department and National Laboratory Department are involved in the food safety and food quality control activities. The Nutrition Department will strengthen coordination and technical support with these departments to ensure food is properly produced, handled, stored, and supplied to markets.

Through Coordination with and technical support to the Environmental Health Department, the public nutrition department will focus on ensuring food items available in markets are produced, stored, handled and sold safely through monitoring of direct observation at the production points and also their physical qualities (i.e. expiration date, well packed, correct labeling and other physical aspects) at the storing and selling points.
The Laboratory Department will be responsible for checking and testing food for safety and quality. This includes performing quantitative tests of fortified imported and locally produced foods.

The MoPH will link the food producers and importers to the Laboratory Department for quality check and quantifying specific micronutrients such as quantity of iodine in salt. Through the ongoing support of the Public Nutrition Department, the laboratory is well equipped with essential equipment. However, the department requires ongoing training in the proper use of the equipment, which is provided to the MoPH with the support of the international community. In addition to the inclusion of multiple departments within MoPH, the Nutrition Department will coordinate efforts with the Ministry of Commerce & Industry, the MoF and the Ministry of Interior (MoI) to ensure quality and safety of food items imported to Afghanistan from other countries through establishing and enforcing appropriate legislations and regulations.

**Awareness Raising:** The Nutrition Department will raise public awareness regarding food safety and food quality through the continuation of messaging campaigns regarding the feeding of children, hygiene and sanitation for food preparation and consumption, and consumption of iodized salt. To further this public awareness campaign, key messages will be developed and communicated to people through different channels, including mass media, health facilities and print media. The aim of this activity is to ensure consumers understand the quality and safety aspects of food items and consider it when they decide to purchase. Messaging will also include quality of food, especially when the food fortification program is launched, to inform the people about the benefits of using fortified foods. The MoPH will strengthen its coordination with the Food and Drug Quality Laboratory Department, the Environmental Health Department, and the Health Promotion Department, which is responsible for standardization of health education activities in the MoPH.

**Deliverable 1.4.5:** To monitor the nutritional situation in Afghanistan and strengthen the monitoring and evaluation of nutrition strategies and programs, in order to inform development planning and emergency responses.
The Disease Early Warning System (DEWS) is an effective mechanism used by the MoPH to alert it to any disease outbreaks in order to help prevent or mitigate epidemics.

The DEWS department in the MoPH agreed with the Public Nutrition Department (PND) to include nutrition indicators in their surveillance system and collect data, initially from the provinces at risk of drought and later on from all provinces. The quality of data collection will be monitored by the DEWS officers and Provincial Nutrition Officers and the collected data will be analyzed and interpreted by the PND staff.

In addition to the monthly data collection mechanism through DEWS, which is focused on acute malnutrition, the HAA will support PND’s efforts to collect nutrition related data from additional sources, including the health facilities and other sentinel sites that will be selected after a feasibility assessment exercise in the first half of 2012. Called the Nutrition Surveillance System (NSS), this data will include:

- The coverage of use of iodized salt at the household level
- Proportion of women received iron and folic acid supplementation
- Proportion of women received counseling on breastfeeding and complementary feeding
- Proportion of children received multiple micronutrients supplementation
- Program outcomes such as low birth weight children born in the hospitals and health facilities
- Percentage of neural tube defect among live births in the hospitals and health facilities and other outcomes.

The data collected through the NSS will allow the PND to analyze the data in order to monitor the effectiveness and outcome of the nutrition programs.

Although NSS will provide the PND with the information on the trend of outcome of nutrition programs through data collected from different sentinel sites, it cannot provide a clear picture of the nutrition status of the population. The most recent MoPH national survey that targeted data gathering on the nutritional status of the Afghan population was in 2004.

National policies and strategies to target nutrition programs in Afghanistan is based on dated information.

Therefore, the HAA will support the MoPH’s efforts to update its national nutrition data through a national nutrition survey planned for late 2012-early 2013 to update nutritional data, identify gaps in the nutrition strategy, and determine areas that require additional focus.
Deliverable 1.4.6: To more effectively respond to emergencies through the provision of supplementation and therapeutic foods for moderate and severe acute malnutrition.

The MoPH currently follows a specific criterion that triggers the launch of emergency feeding programs throughout Afghanistan. Emergency feeding programs are implemented if:

- The Global Acute Malnutrition (GAM)\(^8\) rate is greater than 10% (or GAM is >5% with aggravating factors):
  
  Severe Acute Malnutrition treatment services will be expanded if required, and targeted Supplementary Feeding Programs (SFP) will be established for the management of moderate acute malnutrition in children 6-59 months of age and pregnant and lactating women.
  
  Blanket supplementary feeding for children aged 6-24 months may also be considered on a case-by-case basis with a preventative aim.

- GAM is greater than 15% (or GAM is >10% with aggravating factors):
  
  Severe Acute Malnutrition treatment services will be expanded if required, and blanket Supplementary Feeding Programs will be established for children under 6-59 months of age and pregnant and lactating women.
  
  Nutrition counseling—including the promotion of local recipes based on locally available foods—will be an integral part of all emergency programs. Several coordinating mechanisms exist to manage the GIROA’s and international community’s response to emergencies, especially in terms of nutrition and food needs of the population:

- The HIGH LEVEL COMMITTEE FOR DISASTER MANAGEMENT led by the second vice president and the participation of the Ministers of Public Health (MoPH), Agriculture (MAIL), and Rural Rehabilitation and Development (MRRD). The aim of this mechanism is to ensure appropriate and coordinated actions are taken to respond to emergencies. The MoPH will participate actively in this mechanism and ensure that the nutrition needs and priorities of people during emergencies are considered well.

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\(^{8}\) GAM- severe and moderate acute malnutrition.
The Nutrition Cluster is a coordinating mechanism among UN agencies and humanitarian NGOs to coordinate actions at the field levels, provide evidences, conduct fund raising, and implement programs. Led by UNICEF, the Nutrition Cluster meets monthly and includes the MoPH/PND, WFP, WHO, FAO, and NGOs active in the field of nutrition. The PND’s active participation will make sure that all MoPH policies and strategies are considered in the humanitarian missions, the programs are designed according to the nutrition needs of the affected population, and different stakeholders coordinate their efforts to use the resources wisely.

The Nutrition Cluster develops appeals to different agencies at the international level in order to respond to emergencies and crises of food and nutrition and coordinates with other clusters such as the Food Security Cluster to respond to food and nutrition crises. The Public Nutrition Department oversees all activities of the Cluster closely and monitors the programs and projects implemented by its members. All Cluster members report regularly to the PND of their activities.

**Deliverable 1.4.7: To increase the percentage of child caregivers adopting appropriate infant and young child feeding practices**

The Infant and Young Child Feeding (IYCF) program, one of the priority programs of the MoPH. IYCF focuses on:

- Promoting the early initiation of breastfeeding (within one hour after birth)
- Exclusive breastfeeding for the first six months of life
- Introduction of appropriate complementary feeding at the age of six months
- Continuation of breastfeeding for two years of a child’s life
- Ensuring the implementation of national regulation on promotion and support of child feeding by breast milk.

According to the National Nutrition Survey of 2004 Afghanistan’s rate of exclusive breastfeeding is currently 25%; the goal of this Deliverable is to increase that rate to 50% or higher. The HAA recognizes that IYCF is one of MoPH’s key programs to reduce infant and child mortality and improve the health and nutrition status of Afghan population.
Therefore, continued training IYCF counselors at health facilities and communities is essential, and will increase the quality of service delivery to pregnant and lactating mothers, provide communities the tools necessary to enable a supportive environment, improve the level of knowledge of families through involvement of community leaders, religious leaders and other influential members of the community, and establish breastfeeding support groups at the village level to help lactating mothers to address problems and concerns.

Using existing resources and initiatives, the PND will use the BPHS health facilities to provide complementary feeding classes, taught by trained feeding counselors, to provide young mothers with the knowledge of how to provide their children with the best possible nutrition. These education classes will be planned at the health facility level to be delivered at least once a month for a group of 10-20 mothers.

This program will be delivered primarily through the BPHS implementing partners with technical support of the PND. Baby-Friendly Hospital Initiatives (BFHI) is another component of the IYCF for promoting the appropriate nourishment of infants and young children, particularly through breastfeeding. Currently, only Malalai, Rabia Balkhi, Khairkhana, Bamyan and Herat Hospitals are implementing BFHI. Under the HAA, the MoPH intends to extend it to 10 more hospitals in the provinces. As noted earlier in Sections 4.1 and 4.2 above and later in Component 3, change is made through family and community support and awareness. The HAA will support MoPH’s efforts to lay the foundation for encouraging behavioral changes among individual families in the proper feeding and care of infants and young children through supporting the continuation and expansion of the Behavior Change Communication Program (BCC).

The MoPH will facilitate community-based activities through support groups, initially targeting the rural population followed by the urban population. The aim is to create an enabling environment to encourage families to adopt proper nutritional habits.

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9 In many urban areas, most births occur in hospitals; therefore, the Baby Friendly Hospital Initiative is a more appropriate strategy.
Deliverable 1.4.8: To strengthen and expand the human capacity to plan, implement, monitor and evaluate nutrition interventions to meet the current and future needs of the population

The lack of specialists with varying levels of expertise in the nutrition field in Afghanistan is a primary challenge.

Currently, no university or post-graduate institute in Afghanistan provides pre-service nutrition education, preventing health professionals from gaining the required expertise to develop, lead/implement, monitor and evaluate the nutrition programs in the country. The HAA will seek to increase the number and quality of MoPH staff with the knowledge and ability to conduct in-country assessments of the nutritional status, as well as their ability to design, implement and monitor therapeutic and preventive interventions.

The PND will conduct in-service training in order to increase their knowledge of nutrition and improve their capacity to manage nutrition programs. The training manuals, guidelines and protocols have been developed based on international standard guidelines adapted to the Afghanistan context. In coordination with the MoHE, the MoPH will help the higher education institutions to develop academic programs of pre-service education in nutrition. In addition, the MoPH and the MoE are in the process of establishing educational opportunities with accredited institutions overseas for students and practitioners.10

At the sub-national level, Provincial Nutrition Officers (PNOs) will be responsible for providing training, supervising interventions, and monitoring and evaluating ongoing efforts. In order to improve their technical and managerial capacity, PNOs will participate in a 21-day ToT workshop designed by the PND to create master trainers on nutrition program management and M&E, in addition to exposing them to relevant public nutrition topics such as IYCF, management of acute malnutrition, micronutrients, growth monitoring and promotion, nutrition program surveillance and reporting, and basics of planning nutrition programs. The PNOs will conduct cascade trainings to provincial staff and lead nutrition programs in their respected provinces.

10 As an initial step the preliminary talks have been conducted with the University of Massachusetts to train some Afghan professionals in MPH in Nutrition, and discussion have been done with University of Cheragh and American University of Afghanistan to introduce some candidates so they can start a bachelor degree education in these universities after that.
Following the ToT, the MoPH's central PND staff will conduct on-site visits to monitor the implementation of cascading the training.

In addition, an annual review and planning workshop will be conducted with the PNOs to share achievements, lessons learned, and challenges. In addition, the MoPH's central PND team will share progress at the national level, including developments in the public nutrition topics and programs.

Additionally, these workshops will provide an opportunity for the PNOs to develop their leadership, management and technical capacity as well as strengthen coordination with other stakeholders, such as UN agencies and NGOs.
Sub-Component 1.5: Quality Health Care

To increase the quality of health services

**Anticipated Results:** It is expected that by the program completion:

2. Increased capacity of the Improving Quality Health Care Unit.
3. Increased coordination mechanisms for the IQHC

The Improving Quality Health Care (IQHC) Unit was established in March 2010 to lead in the promotion of high quality healthcare services. The assurance of quality services in the health industry has been a focal point of MoPH since its inception, and therefore, existing quality-control programs have been and are currently being implemented throughout the country. With the establishment of the IQHC Unit, MoPH will seek to coordinate, monitor and evaluate these programs and ensure their coherence in accordance with the broader Improving Quality in Health Care Strategy. This will elevate the improvement of quality health services to a national-level agenda and provide the IQHC with the authority to coordinate activities across MoPH and the Government of Afghanistan.

The Improving Quality in Heath Care Strategy is a five-year strategy that defines MoPH’s to improve quality in healthcare services through the standardization of improving quality methodologies. The strategy was finalized July 2011.

The IQHC Unit is responsible for coordinating efforts with MoPH departments, NGOs, and the donor community in order to streamline all quality related activities and projects at the national level.

**Deliverable 1.5.1: Policy level support established to advocate for adoption and sustainability of quality improvement initiatives**

The National Strategy for Improving Quality in Healthcare 2011-2015 (IQHC Strategy), finalized in July 2011, is an ambitious strategy that requires vast human and monetary resources, requiring policy level support. The IQHC Unit, as the lead unit responsible for the coordination and implementation of the IQHC Strategy, works directly with the General Directorate of Curative Medicine (GDCM) in order to seek support among other MoPH Departments and donors.
Since the launch of the IQHC Strategy, the IQHC Unit developed a draft implementation plan with the stakeholder support and guidance. To finalize the implementation plan, a three-day workshop in May 2012 will be convened for approximately 80-100 MoPH staff from the MoPH directorates, BPHS and EPHS implementing partners, the donor community, and private sector organizations to review and finalize the IQHC Strategy’s implementation plan. Drafts of the current implementation plan will be shared with the participants in the workshop, activities will be reviewed and roles and responsibilities discussed.

The IQHC Unit will also enforce the implementation of their strategy through the revitalization of the IQHC Task Force. Led by the Deputy Minister or Director General (DG) for Quality Medicine, this task force will be responsible for providing oversight to the IQHC strategy, and include representation from the MoPH Directorates responsible for operations and administration, BPHS and EPHS implementing partners, international organizations, and the donor community.

The IQHC Task Force will also coordinate heavily with the Public-Private-Partnerships (PPP) Unit to invite public sector associations. This task force is scheduled to begin meeting in March 2012. The IQHC Unit is developing a number of familiarization workshops to present the strategy’s objectives and implementer’s roles and responsibilities at the national-level (Kabul), pending the availability of funding resources.

In addition, IQHC Officers are currently hosting “launching ceremonies” at the regional level that presents much of the same information as in the familiarization workshops to sub-national staff. Launching ceremonies have currently been hosted in Herat, Mazar-e-Sharif, Nangahar and Kandahar. Following the initial familiarization workshops, refresher workshops will be scheduled on a bi-annual basis at both the national and sub-national level.
Deliverable 1.5.2: Strengthened capacity of the Improving Quality Health Care Unit for implementation of quality-related health interventions at national and regional levels

In order to effectively achieve the objectives and mandate of the IQHC Strategy, the HAA will support the IQHC Unit’s efforts to strengthen itself through greater human resource capacity by recruiting improving quality subject matter experts in the following areas:

IQHC Unit Director: Lead IQHC Unit staff at central and regional level and coordinate QI efforts with partners.

Maternal & Newborn Health Coordinators: Coordinate maternal & Newborn health-related issues with MOPH relevant departments and partners; provide technical support on quality to MoPH and partners on need basis; assist IQHC Unit in the implementation of IQHC strategy.

Child and Adolescent Health Coordinator: Coordinate child and adolescent health-related issues with MOPH relevant departments and partners; provide technical support on child and adolescent health-related issues to MoPH and partners on need basis; assist IQHC Unit in the implementation of IQHC strategy.

Patient Safety Focal Point: Coordinate patient safety-related issues with relevant MOPH departments and partners; provide technical support on patient safety to MoPH and partners on an as-needed basis; assist IQHC Unit in patient safety interventions.

IQHC Training Coordinators: Coordinate IQHC trainings with relevant MOPH departments and partners; assist the IQHC Unit in coordinating and implementing of quality related trainings.

Public Nutrition Coordinator: Coordinate public nutrition-related issues with relevant MOPH departments and partners; provide technical support on public nutrition to MoPH and partners on an as-needed basis; assist IQHC Unit in the implementation of IQHC Strategy.
Communicable Diseases Consultants: Coordinate on communicable diseases-related issues with relevant MOPH departments and partners; provide technical support on communicable diseases to MoPH and partners on need basis; assist IQHC Unit in the implementation of IQHC Strategy.

Mental Health and Disabilities Consultants: Coordinate on communicable diseases-related issues with relevant MOPH departments and partners; provide technical support on communicable diseases to MoPH and partners on need basis; assist IQHC Unit in the implementation of IQHC Strategy.

The additional staff will be recruited through a phased, competitive, and transparent hiring process that will take into consideration the needs of the IQHC Unit. Until this process can begin, the IQHC Unit will update and develop ToRs for each proposed position based on the job requirement and MoPH rules and regulations.
Deliverable 1.5.3: Establish and enhance coordination mechanisms for implementation of the Quality Health Care Strategy.

The successful implementation of the IQHC Strategy will require strong coordination at and between the national and sub-national level.

The IQHC Unit has developed a comprehensive mechanism to address this.

National-Level (Policy-Level): At the national-level, the National IQHC Taskforce will be revitalized with representation from multiple departments within MoPH, NGOs and the international community (WHO, UNICEF and UNFPA). The Unit will work particularly closely with other Departments within the MoPH to ensure there is shared responsibility for activity that has a direct relevance to their own agendas.

Quality Improvement Focal Points: Provincial-level Quality Improvement Focal Points will serve as a liaison between the IQHC Unit in Kabul and the provincial Quality Improvement Teams. Through the monitoring of quality improvement efforts, they will support the Public Health Department office, NGOs and other stakeholders.
Facility-Level: Quality Improvement Committees (Teams) currently exist in several hospitals in Kabul and 13 other provinces; however, coverage is uneven and the committees do not follow a standardized methodology to ensure the quality care.

The IQHC Unit is seeking to adapt, strengthen and expand these committees and is coordinating with a number of hospital directors. These Committees will be responsible for overseeing the quality of healthcare within hospitals. Sub-Committees will then be created and mandated with overseeing quality improvement activities. Examples of these sub-committees include Medical Records Sub-Committee, Maternal Death Review Committee, Adverse Events and Near-Miss reporting system that includes analysis, distilling of lesson learned dissemination of findings and action to reduce further risk. Organized into periodic meetings, these sub-committees will provide quality improvement recommendations with hospital leadership and aid in the implementation of these activities.

The IQHC Strategy is seeking to improve the quality of healthcare; the IQHC Unit is collaborating with the GCMU and HEFD to review contracts with implementing partners in order to ensure the inclusion of quality clauses, to review current contractual arrangements with implementing NGOs to establish what formal responsibilities already exist for improving quality. Furthermore, the IQHC Unit will also seek to work through donors, NGOs and implementing partners to develop curriculum and provide training to hospital facility staff.
Sub-Component 1.6: Private Sector

To support regulation and standardization of the Private Sector to provide quality health services

Anticipated Results: It is expected that by the program completion:

1. 100% complete review of private sector regulations (end 2015)
2. 2-3 hospital PPP contracts signed, which include accreditation requirement (end 2014)
3. 3 private health sector associations measurably strengthened & functioning (end 2014)

While substantial progress has been made in expanding and improving access to primary health care services in Afghanistan, less attention and resources have been focused on secondary and tertiary health care services. This is due to the high cost of service provision and the need for substantial investment and management capacity. As a result, the number of Afghans seeking treatment in hospitals in Pakistan, India, Turkey and elsewhere continues to grow; it is estimated that Afghanistan loses $80 million per year due to the lack of availability of quality hospital services in the country. Similarly, while donor construction work for approximately 15 Government hospitals has been completed or is in the process of completion, offering a capacity of approximately 2,200 beds in total, the capacity in the public sector to finance and manage the operation of additional large hospitals or medical facilities is lacking, furthering the Government’s interest in adopting a Public-Private-Partnership (PPP) model.

In response, the MoPH is actively seeking ways to leverage resources of the private sector and improve access to quality secondary and tertiary health services.

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11 Patients Acquiring Medical Treatment from India, MoPH, APHI, 20 Feb. 2011. Study found patients traveling to India from Kabul, spent at a rate of $27M/year. Patients going to India from Kandahar were not included. Similarly, patients going to Pakistan, Iran, Dubai, Turkey and other countries were not included. $80M total is an estimate, under the assumption, based on observations, that India only attracts a minority of patients seeking overseas care.
Currently, there are approximately 210 small private hospitals in Afghanistan. Private health expenditures represent between 76-83% of total national health expenditures, making the private health sector approximately five times larger than the public sector (including donor contributions to the public sector) in terms of health expenditure. Increased engagement of the private sector in the delivery of health services can help mitigate the burdens and challenges facing the public health system.

While the private sector is a critical partner for the MoPH in the delivery of health services, it also faces a number of challenges regarding the quality of healthcare services and products, in addition to the lack of trust between the public and private sectors. The lack of regulatory clarity, limited capacity of MoPH, the poor quality of private institutions, and the lack of communication has contributed to this lack of trust. Additionally, there is a larger contextual challenge posed by public health sector reliance on partner funds. In the current context, increased collaboration between the public and private health sectors is the only viable route towards increased resources and the ability to expand quality healthcare to the general population.

**National Policy for the Private Health Sector**: The HAA will support the MoPH’s efforts to seek collaboration with the private health sector through its *National Policy for the Private Health Sector*.

The Minister of Public Health approved this policy in March 2009 and its associated strategic 5-year plan in July 2011, which will build on earlier progress, under the following strategic goals:

1. To strengthen and maintain effective communication and mutual understanding and develop collaboration and coordination between the public and private sectors
2. To strengthen the policy environment, in order to facilitate the growth and quality of private sector contributions to the health of the Afghan population including the development and implementation of standards, guidelines, accreditation procedures, etc.
3. To build productive partnerships between the public and private sectors to achieve specific shared goals and benefits

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12National Health Accounts, 2011; World Health Statistics, 2007, WHO.
4. To strengthen the Office of Private Sector Coordination, thereby enhancing the MoPH’s stewardship capacity and its capacity to implement the National Policy and the Strategic Plan
5. To develop evidence of and measure private sector contributions to MoPH health programs and goals

Under the HAA, the MoPH will seek technical and financial support from its partners to ensure the plan’s successful implementation.

Given its limited capacity to enforce compliance with regulations to improve quality, the MoPH will support efforts to establish positive mechanisms that motivate private sector partners to improve the quality of their services and products. The HAA will also seek to build local private capacity for manufacturing of quality medicines and medical equipment/supplies.

In accordance with the National Policy for the Private Health Sector, the HAA will seek to improve the collaborative relationship, building and strengthening the capacity of private health sector associations to be stronger partners for the MoPH. Additionally, the MoPH will seek to establish accreditation mechanisms to raise the standards of private sector products and services for the provision of a consistent level of care and assurance of the quality of medicines and equipment.

**Deliverable 1.6.1: Strengthened collaboration and improved communication and understanding between the public and private health sectors**

With over 15,000 private sector entities in Afghanistan, the MoPH currently lacks the ability to effectively oversee the private health sector. At a World Bank meeting October 2011, the MoPH expressed strong concern over the quality and oversight of private sector entities and agreed to strengthen coordination with the private sector and to support measures that will increase accountability and quality control within the private sector. To do this, the MoPH will formalize and strengthen its coordination with key medical and health associations to empower them and set a foundation for the self-regulation of the private sector.
An increasing number of private sector associations exist. The MoPH is aiming to strengthen its relationship and coordination with these associations through their inclusion in appropriate technical working groups to address issues, which may affect the private sector; these will include:

<table>
<thead>
<tr>
<th>Type (Topic Areas)</th>
<th>Issues to Address</th>
<th>Frequency</th>
<th>Anticipated Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim Steering Committee on Hospital PPPs</td>
<td>Hospital PPPs</td>
<td>6x/year</td>
<td>2 to 3 Hospital PPPs contracts signed</td>
</tr>
<tr>
<td>National Food &amp; Drug Board</td>
<td>Pharmaceutical and food quality</td>
<td>6x – 12x/year</td>
<td>Reviewed Pharmaceutical regulations</td>
</tr>
<tr>
<td>Hospital Management Task Force</td>
<td>Quality of hospital &amp; diagnostic services</td>
<td>Quarterly</td>
<td>Accreditation body formed, working</td>
</tr>
<tr>
<td>Private Sector Regulation Working Group</td>
<td>Clarification of regulatory environment</td>
<td>TBD</td>
<td>Reviewed private sector regulations</td>
</tr>
</tbody>
</table>

MoPH will seek to utilize these working groups to review and revise existing regulations, and to develop new regulations to improve the quality of private sector services and products. The associations will serve as a direct link between the MoPH and private sector entities. The associations will help to ensure compliance by their members. To date, the Afghanistan Private Hospital Association has worked with 30 private sector hospitals to improve compliance with draft regulations.

**Deliverable 1.6.2:** To support the development of an environment that facilitates the growth and quality of private sector contributions to the health of the Afghan population.

Many of the existing regulations for the private sector are outdated. For example, one regulation dating from the 1970’s dictates the distance required between privately-owned and run pharmacies. The intent of the MoPH is to compile a set of all regulations affecting the private health sector, review them in conjunction with the main private sector associations (identified in Deliverable 6.1), repeal or revise regulations based on current standards, and identify gaps to determine where new regulations are necessary.

13 The three most prominent medical associations with which the MoPH regularly interacts are the Afghanistan Private Hospital Association, the Afghanistan National Medicines Service Association, and the Afghan Midwives Association.
The MoPH’s priority is to focus on regulations, which will increase the quality of goods and services. An action plan has been developed and was formally launched in February 2012.\(^{14}\)

The process to complete this initiative is expected to be lengthy (requiring a minimum of 5 years) and is currently in its initial stages, with the MoPH compiling the existing set of regulations.

**Coordination Mechanism:** The MoPH anticipates the need to create a subordinate office under the Office of Private Sector Coordination (OPSC), which will oversee the foregoing effort and coordinate and collaborate with the private sector on the regulatory review. The OPSC currently is staffed by three MoPH staff members, with the support of an international technical advisor provided on a short-term basis by USAID. The OPSC will add additional officersto support their efforts to lead the regulation review process. The OPSC will, however, require significant support from international technical advisors in specialized areas of regulation and legislative development.

**Accountability System:** Concurrently, the OPSC is in the process of developing an accountability system for the private sector. Through the private sector associations it will facilitate the development of self-regulation of private facilities, services and products. In addition, the MoPH wants to ensure further quality control over services through the establishment of an accreditation system and for manufacturers the attainment of Good Manufacturing Practices (GMP). Through the support of the donor community, the MoPH plans to invite an international accreditation organization to travel to Afghanistan to host an orientation workshop for the private sector healthcare industry. Invitations to accrediting organizations are expected to be issued in March 2012, including JCI Dubai, with the goal of hosting an orientation workshop in 2nd quarter 2012.

Although the accreditation organization will be an independent body, with its establishment in Afghanistan, MoPH will remain engaged through participation on the executive board.

\(^{14}\) A copy of the action plan is available from the OPSC upon request.
Deliverable 1.6.3: To build productive partnerships between the public and private sectors to achieve shared goals and promote synergies

MoPH currently has two ongoing, small-scale public-private-partnerships documented with MOUs: one for vaccinations and the other for identification of suspect cases, referral for diagnosis and treatment of tuberculosis. During 2010 and 2011 MOUs have been signed between the MoPH and 25 private hospitals in Kabul for the Expanded Program on Immunization (EPI) and between the MoPH and seven hospitals for the National TB Control Program.

The MoPH provides a vaccinator or training for hospital staff and the necessary supplies (vaccines, cold chain, etc.) to the hospital. In turn, the hospital provides a vaccination room and is responsible for ensuring the vaccination of all children who come to the hospital. The hospital reports all statistics (types of vaccines and numbers) to the MoPH through the EPI program, managed by the Curative Medicine Department. Currently, the vaccination PPP is providing approximately 10% of the total childhood vaccination requirements in Kabul Province. The MoPH is currently examining how to expand this program to other hospitals in the province.

Similar to the PPPs targeting the vaccination of children, the MoPH has a MOU with several private hospitals in Kabul who have agreed to report suspected cases of tuberculosis to the MoPH, which, in turn, provides diagnostic testing and, then, the required medicines to the hospitals for the treatment of patients. This PPP is in a pilot stage. The MoPH is in discussions with other Ministries and development partners for support in the design, negotiation and management of a number of large hospital PPPs. The donor community has funded and built approximately 15-18 new hospitals throughout the country. Three of the hospitals (totaling 950 beds) are located in Kabul, others are at the provincial and district levels. As the GiRoA cannot afford to operate these hospitals, the intent is to partner with the private sector through the creation of large PPP hospitals. The development of each of these PPPs is expected to take approximately two to three years. The MoPH is developing an action plan to conduct feasibility studies for each hospital.
Development of a Public-Private Partnership

The MoPH established an inter-ministerial Interim Steering Committee on Hospital PPPs in May 2011 with participation from the MoF, Ministry of Justice, the President’s Office, and the private sector to clearly define the expectations the MoPH will have when entering into a PPP for the operation of these hospitals and to develop an action plan. The Steering Committee has been convened four times since its establishment. In addition to identifying the roles and responsibility for these PPPs, the Steering Committee is also developing, with international technical assistance, regulations and guidelines on the proper operation of a PPP, which are to be approved by the cabinet. The Steering Committee anticipates that these regulations should be developed and submitted to the MoPH and the Ministry of Justice for final review in April 2012.

Deliverable 1.6.4: To enhance the MoPH’s stewardship capacity and its capacity to implement public-private partnership strategies by strengthening the Office of Private Sector Coordination

The OPSC currently oversees and coordinates all public-private-partnership (PPP) activities within the MoPH. This office is severely understaffed, given the planned activities, their scale, and the objectives of the office. The PPP Unit is currently part of the OPSC. The formal creation of the PPP Unit is expected to occur in or about July 2012. The new director of this unit has been recruited and two additional employees will be hired in 2012, with the intent of creating a unit staffed by six personnel. Creation of this unit is currently being funded by USAID until May 2012. The PPP Unit will be responsible for designing, procuring proposals, negotiating, and managing health sector PPPs.
To ensure the successful creation of this PPP Unit, the MoPH will need extensive support from international technical advisors in order to develop the capacity of both the OPSC and the PPP Unit. This will include a long-term (3-years) advisor for each PPP and more specialized support in areas such as equipment maintenance, and finance.\textsuperscript{15}

**Deliverable 1.6.5:** *To develop evidence of and measure private sector contributions to the health of the Afghan population.*

Currently, there are no reporting requirements on the existing PPPs through the OPSC. The reporting requirements that exist are to the individual MoPH programs that implement the PPPs, such as EPI for the reporting of the types and number of vaccines given to children. The MoPH’s intends to develop a reporting system specifically for each hospital PPP, which will be specified in the PPP contract inter-ministerial Steering Committee.

The MoPH, through the Steering Committee, is currently developing a method for accurate and consistent reporting of all PPPs. This will include the types of services provided, number of patients, and diagnosis. Specifications will be developed consistent with the information systems required to effectively manage the PPP hospitals. The MoPH is having limited successes in developing private sector participation in the Disease Early Warning System (DEWS) and aims to expand this to all private hospitals through partnership with the Afghan Private Hospital Association. An international technical advisor is scheduled to arrive in Kabul February 2012 to support the development of a system to get more private hospitals to report to the DEWS sentinel sites.

\textsuperscript{15} USAID is currently discussing these requirements with the MoPH, but funding has yet to be determined.
Sub-Component 1.7: Pharmaceutical Services

To create an enabling environment for the production and availability of quality pharmaceuticals

**Anticipated Results:** It is expected that by the program completion:

1. Increased and effective coordination between the MoPH, private sector and international community on controlled access and usage of quality pharmaceuticals
2. Strengthened procurement and quality assurance systems of imported pharmaceuticals
3. Reduction in the misuse of pharmaceuticals
4. Increased capacity within the MoPH on industry management and oversight, quality assurance, and the review and evaluation of the technical aspects of pharmaceutical products and medical devices.

The healthcare system in Afghanistan suffered tremendously during the Taliban Regime. In 2001, when the Taliban Regime fell, the GIRoA, with the direct support of NGOs and the international community, immediately focused on increasing the availability of healthcare services to the population. Utilizing a relief model of service delivery, the MoPH’s main priority was to provide medicines and access to basic services to the general population.

As the availability of services continues to increase, MoPH is shifting its delivery method to reflect a development model.

As healthcare services have increased, so have has the demand for pharmaceuticals.

In response, three main sources of pharmaceuticals exist: procurement through NGOs or the international community, private procurement through the importation from foreign countries and the black market. As a result, there has been an influx of pharmaceuticals to meet the growing demand, but the GIRoA lacks of capacity to regulate and control the quality. Therefore, a mix of quality, substandard, counterfeit and adulterated medicines are available in the market.
While a recent survey\(^{16}\) concluded that approximately 91\% of medicines in the public and private sector complied with international standards, the excessive amounts of drugs have the potential of increasing the public’s access to counterfeit and lower quality medicines, thereby creating greater risk to longer term, harmful physical medical use.

The General Directorate of Pharmaceutical Affairs (GDPA) within the MoPH is mandated to ensure the licensing and registration of pharmaceutical importers and companies as well as inspecting the quality of drugs, evaluating medicine quality documentation, increasing the rate of reporting quality issues by professionals and consumers, and enforcing established international standards on the quality of medicines. In accordance with the National Strategy on Pharmaceuticals, the HAA is designed to address the priorities within the GDPA’s five-year plan related to the procurement of, access to and usage of pharmaceuticals throughout Afghanistan.

**Challenge 1 – Lack of Effective Coordination within MoPH:** One of the key challenges related to the controlled access and usage of quality medicines is the lack of effective coordination within MoPH and the international community. Departments within MoPH are fragmented and a clear understanding of the roles and responsibilities is missing. The HAA will support the MoPH’s efforts to develop a regulatory framework that will support the standardization of the pharmaceutical sector. This coordination is crucial to the development of a clear system to establish regulations and procedures for proper distribution of medicines.

**Challenge 2 - Porous Borders and Weak Regulatory and Quality Assurance System:** The Strengthening Pharmaceutical Systems (SPS) Project is implemented by MSH and funded by USAID to provide technical support in order to improve the pharmaceutical services in Afghanistan. A 2009 assessment conducted by the GDPA regarding the procurement and distribution of pharmaceuticals in support of the SPS concluded that parallel procurement and distribution mechanisms exist. The porous borders and weak regulatory and quality assurance system in Afghanistan contribute to the manufacture and importation of ineffective, unsafe, and sub-standard or counterfeit medicines. The HAA will support the MoPH in increasing technical assistance and capacity to evaluate and test the quality of medicines, provide documentation for inspections and promote reporting mechanisms by healthcare staff and the general population.

**Challenge 3 – Misuse of Pharmaceuticals:** Compounding the procurement and distribution issues in Afghanistan is the misuse of pharmaceuticals.

The Afghanistan Medicine Use Study, conducted by GDPA in March 2009, covered 28 health facilities in five provinces. The findings from the study concluded that there is an overuse of antimicrobials in primary healthcare facilities and hospitals. This overuse of medicine borders abuse as the study showed evidence of patients suffering from conditions not requiring any antimicrobial use were prescribed medicines. The overuse of antimicrobial medicines is a result of the lack of adequate consultation between physician and patient as well as a lack of education in proper drug use and dosage. Additionally, there is currently a lack of resources on drugs and no standards for treating medicinal conditions. The HAA will support MoPH’s efforts to address these challenges through development of a regulatory framework, aligned with the National Medicine Policy, the establishment of Drugs and Therapeutic Committees at the national level and training of staff in the appropriate use and dosage of medicines. Additionally, the development of legislation, policies and procedures will assist in preventing the prevalence of low quality drugs.

**Deliverable 1.7.1: To develop an effective and efficient Pharmaceutical Regulatory System**

The MoPH established the National Medicine and Food Board in 2002, whose mandate is to coordinate between the multiple entities within the MoPH and the GIRoA responsible for ensuring the quality of medicines and food in Afghanistan.

These directorates included the GDPA and the Law and Legislation Implementation Directorate. Additionally, the Ministry of Commerce, MoF and the MoHE are also represented. In order to more effectively regulate and ensure the quality and proper use of medicines in Afghanistan, the GDPA has sought to strengthen the oversight and coordination capacity of the National Medicine and Food Board. In April 2010, the GDPA with technical support from the SPS Program an initial assessment of the regulatory components, capacities, and legislative structures related medicines and processed foods in the country. Initial findings revealed the current pharmaceutical regulatory system does not meet the country’s requirements, as there is a lack of comprehensive regulatory structures available.
The results of this assessment yielded a proposed framework for a pharmaceutical regulatory framework was identified which include the following four aspects:

1. Administrative component (Policy, legislation, regulation, Human resource, etc.)
2. Regulatory functions (Licensing of premises, practices and persons, Inspection of manufacturers and distributors, product assessment and registration, monitoring of quality of drugs, control of drug promotion and advertising, adverse drug reaction monitoring)
3. Technical elements (standards, specifications, guidelines, procedures)
4. Level of regulation (Central, provincial, district and community)

In October 2011, a revised TOR for the revised National Medicine and Food Board was approved, which identified a number of key steps that will strengthen the oversight capacity of the Board. The revised TOR includes the development and implementation of a regulatory framework to standardize all regulations and guidelines regarding the quality and proper use of pharmaceuticals. The Board began meeting under this new TOR in Feb 2012 on a monthly basis.

Additionally, the revised TOR also includes the establishment of an official secretariat, to be managed by the National Medicines and Food Board.

Under the revised TOR, the secretariat will be manned by three staff members: a medicines affairs technical advisor, a technical advisor for food and an administrative staffer.

**Deliverable 1.7.2: To increase the capacity of the GDPA to implement the Regulatory Framework.**

With the completion of the National Medicine and Food Board reorganization, the Board will begin the development of the regulatory framework. This regulatory structure is expected to include more technical capacities and resources in order to prevent the production, importation, distribution and use of low quality pharmaceuticals, herbal medicines, and medical devices (including pharmaceutical consumables and medical equipment) in the country. By developing, establishing and implementing a standard regulatory system and mechanisms the quality of pharmaceuticals and medical devices can be improved. This system will be strengthened through additional training of staff and close monitoring and evaluation.
To meet the capacity and resource requirements, the GDPA will work in close coordination with the SPS Program to hire technical consultants to consult the development process and create an incentive program that will train and entice staff to stay with GDPA. Additionally, GDPA with support of SPS have just completed an internal functional assessment of GDPA to identify capacity gaps. The analysis and final report of this assessment is expected to be available my May 2012 at which time the GDPA will host a workshop to present the findings to the MoPH staff in early June 2012, which will be followed by a larger workshop involving private sector associations, donors and implementing partners to determine the resources necessary for implementation of the regulatory framework. Focusing on existing staff in Kabul, MoPH will train 26 staff in 2012, providing them with a certification of completion in the management and oversight of the sector. Additionally, current GDPA specialist will be trained and new specialists recruited to further increase their capacity to efficiently and effectively review and evaluate the technical aspects of pharmaceutical products, medical devices and documents. The MoPH will seek training outside of Afghanistan to supplement the training received in-country through implementing partners.

<table>
<thead>
<tr>
<th>Training Area</th>
<th>Target</th>
<th>Training Outcomes</th>
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<tbody>
<tr>
<td>Pharmaceutical</td>
<td>- To conduct the GMP inspection of domestic and foreign countries</td>
<td>- Improved the registration of good quality medicines in the country.</td>
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<tr>
<td>Quality Assurance</td>
<td>companies (when their company and products are registered in the country)</td>
<td></td>
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<tr>
<td></td>
<td>- To inspect the pharmaceutical establishments in the country</td>
<td>- Improved the quality of services and medicines in public and private sectors</td>
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<tr>
<td>Regulatory Affairs</td>
<td>To develop/update the medicines legislation and regulations in</td>
<td>Updated policies, law and regulations</td>
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<td>pharmaceutical sector</td>
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<tr>
<td>Pharmaceutical</td>
<td>To establish national mechanisms for forecasting of medicines in</td>
<td>Established national mechanisms for selection, procurements, distribution and</td>
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<tr>
<td>Management</td>
<td>Afghanistan, establish and improve the rational use of medicines and</td>
<td>use of medicines in the country</td>
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<td></td>
<td>improve the procurement and distribution of medicines in the country</td>
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To sustain these activities, GDPA plans to establish a pharmaceutical management training center, located in Kabul.
This center will focus on developing a curriculum, in coordination with the MoHE for a pharmaceutical post-graduate program in Pharmaceutical Management. Additionally, the center will focus on the basic training of pharmacist and pharmacy technicians in management.

**Deliverable 1.7.3:** *To develop effective Quality Assurance (QA) systems to assure the quality of pharmaceutical products in the public and private sectors.*

To assist in the regulation of pharmaceuticals in the public and private sector, the GDPA is overseeing the development of an effective Quality Assurance System in Afghanistan that will be incorporated into the new regulatory framework. The development of this system began in 2009 and will require the direct involvement and support of a number of stakeholders, including MoPH Departments, ANSA, NGOs and the donor community. To date, the GDPA has conducted two initial assessments: a medicine sampling and testing survey (April 2011) and a medicine quality assurance survey (April 2011), and is about to launch an assessment of mini-labs around Afghanistan in late April 2012.

Following the completion of this third assessment the GDPA will establish a sub-committee of the Medicine and Food with representation from the related departments within MoPH, ANSA, WHO, and other involved stakeholders, and the donor community. This sub-committee will first establish a TOR that will provide guidelines for the development of these quality assurance systems. The GDPA anticipates completion of the quality assurance systems by the end of 2013, with implementation beginning in early 2014. The necessary step in improving the Quality Assurance systems and controls within the GIRoA is to increase the coordination and technical capacity of the GDPA. Incorporated into the Quality Assurance System, the GDPA will establish a Quality Assurance (QA) Technical Committee in Kabul and QA Provincial Agencies to implement the QA planned activities and oversee the implementation of pharmaceutical legislation and regulations in the pharmaceutical sector of the country. This will support the MoPH will seek to coordinate efforts of stakeholders in the improvement of the quality, distribution and usage of pharmaceuticals throughout the country.
Sub-Component 1.8: Universal Access to RH

To achieve universal access to RH and improve maternal and newborn health

**Anticipated Results**

- *To increase the existing coverage of Ante-Natal Care and Post Natal Care and Skilled Attendance at Birth by 10% from baseline (Baseline ANC: 60%; SBA:34%; PNC: 28% and CPR to 32%)

- *Stewardship role of MoPH in MNH enhanced with adequate focus on capacity building, research, data management, monitoring and evaluation and gender mainstreaming.*

Afghanistan has made significant progress in rebuilding its health system, despite years of continuous conflict. This evident by the fact that in 2008, the proportion of population within one hour’s walking distance from a public health facility nationally was 57.4. (NRVA 2007) The 2006 Health Survey found that the number of female staff has increased. According to the newly released State of the World’s Midwifery (SOWM) report, there were 2,331 midwives, nurse/midwives and nurses with midwifery competencies and an additional 254 auxiliary midwives and auxiliary nurse/midwives in the labor force in 2008 (UNFPA, 2011). There has been a gradual increase in the births attended by skilled birth attendants (SBAs). The 2010 National EmONC assessment shows none of the health facilities at any level achieved the goal of one skilled attendant for every 100 expected births. one assessment (Bartlett et al., 2005) estimated the lifetime risk of maternal death at one in six to one in nine, According to AMS approximately one in every fifty women will die of pregnancy related causes during life time.

The risk of maternal death was considerably lower in urban areas and increased with remoteness in rural areas. The pregnancy-related mortality ratio for Afghanistan is 327 deaths per 100,000 live births for the seven-year period before the survey. This estimate is equivalent to 3 deaths per 1,000 live births or 0.3 percent of all live births AMS. Much work remains to be done, despite significant efforts by the Reproductive Health Directorate of MoPH in the last seven years to prioritize maternal and newborn health and increase access to services.
The under-5 mortality rate for Afghanistan adjusted to take into account omission is 97 deaths per 1,000 births and the infant mortality rate is 77 deaths per 1,000 births neonatal mortality excluding the south zone 40 deaths per thousand (AMS). Total fertility rate is 5.1 and contraceptive prevalence rate is 20. 92% of all women know at least one modern method of contraception. 45% know a traditional of contraceptive method AMS. Use of family planning has increased markedly in the last seven years in Afghanistan. The National Reproductive Health Strategy, 2006-2009, has contributed in improving the health of the people of Afghanistan, especially women and children, through implementing the basic package of health services (BPHS) and the essential package of hospital services (EPHS) as the standard, agreed-upon minimum of health care to be provided at each level of the health system. BPHS and EPHS packages for health services of MoPH should be adopted in accordance to the national policy and strategy documents of Reproductive health during future revisions.

Expressing their concern about the lack of progress in achieving the MDGS, the heads of four UN health Agencies (WHO, UNFPA, UNICEF, and the World Bank) pledged to harmonize approaches towards improving Maternal and Newborn Health at country level by signing a Joint Statement for Accelerated Implementation of the Maternal and Newborn Continuum of Care (WHO et al, 2008). In 2009 USAID joined the four agencies in the H4+.

**Deliverable 1.8.1: Strengthening RH Stewardship role and coordination among Stockholders to improve maternal and newborn health towards achieving MDGs 4 & 5**

Nowadays is clear that the one of the key constraining factor to have better RH/MNCH outcomes in the country is inadequately trained health workers and shortage of competent health managers at all levels. There is also an acute lack of understanding of the direct link between lack of “hard” management skills at all levels and the poor health outcomes first of all RH outcomes as the front line health priorities for Afghanistan.

In addition there is no clear understanding that clinical and public health training and skills are not the same as and do not substitute for management competences. Extremely useful promotion of health management competences at least in three categories:

- Human resource competences
- General management skills
- Advanced or senior management competences.
General management skills are the essential tools that enable front-line supervisors to deliver the results for which they are directly accountable. It must be special training programmes for front-line RH/ MNCH managers of the middle level. Taking into account those groups is DIRECTLY responsible for practical management of planned activities – it must be LONG-TERM programme and training activity. Due to this reason, management development for health systems, particularly to the first line of supervision, must be given much higher priority and need to be arranged for the different target groups within the RH/MNCH health system. Advanced management competences are required at middle and upper positions – provincial RH/MNCH Managers, as well as the RH Directorate and RH Tack Force members from National and Provincial levels who are involved into and in charge for developing the strategies, manuals, laws and further impact assessment at high level.

RHD will Strengthen professional societies, including their provincial chapters, to safeguard the standards (AFSOG, AMA, APA), through, in particular, the organization of an annual symposium on MNH, RHD will support the strategy for Sustainable access to community based RH and referral system for isolated, unserved communities in needy and hard to reach communities. According to AMS, 2010, 34 % utilize the services of a skilled attendant at delivery (rural: 26%; urban: 71%).

Skilled birth attendance ranges from a low of 12 percent of births in the Central Highland region to a high of 58% in the Capital region. Out of all deliveries, 40% were assisted by a relative, 23% by a traditional birth attendant, 19% by a midwife, 16% by a doctor and 2% without any type of assistance at all. There is a strong relationship between a mother’s education and delivery by an SBA. Births to highly educated mothers are more than two and a half time (80%) as likely as births to uneducated mothers (30%) to receive assistance from an SBA. Similarly, assistance during delivery by an SBA varies by women’s economic status: births to women in the highest wealth quintile are much more likely to be assisted by an SBA (68%) than births to women in the lowest wealth quintile (12%). Births in the least remote households (60%) are nearly three times as likely to be delivered by an SBA as births in the most remote households (22%). As of 2012, 85% facilities have at least one female service provider. The non-availability of a female service provider at peripheral health facilities is one of the most important causes of low utilization of health facilities by women and children.
H4 plus action plan will concentrate on assessing the human resource requirements for improving equitable distribution of midwives in facilities and in remote areas. Geographic need based recruitment for pre-service training will be advocated with accelerated learning approaches in areas with lower levels of girls’ education. Partnerships will be established with AMA (Afghan Midwives Association) and AFSOG (Afghanistan Society of Gynaecology and Obstetrics) to map needs and strengthen in-service trainings and indicate measures to increase absorption and retention of trained personnel.

**Deliverable 1.8.2: To build capacity and understanding of health providers in reproductive health**

The National Reproductive Health Strategy (2006-2009) contributed to improving the health of the people of Afghanistan, especially women and children, through the implementation of the BPHS and the EPHS as the agreed-upon minimum standard of health care to be provided at each level of the health system. Although there has been some observable progress since the year 2003, the MMR and IMR data remain high among compared to neighboring countries. Much work remains to be done, despite significant efforts by the Reproductive Health Directorate of MoPH over the last seven years to prioritize maternal and newborn health and increase access to services.

To address the ongoing reproductive health (RH) issues, the HAA will support efforts to raise awareness and build capacity of trainers and community members to address RH in their communities. A list of national trainers will be prepared, indicating the reproductive health (RH) area in which the trainer is qualified. This is designed to help institutionalize training as a profession and to improve quality. Certification of trainers will be for one year, during which the newly qualified trainer will be evaluated as part of post-training follow-up activities. If the trainer is training adequately, certification will be extended.

An accreditation system for national and regional training centers for competency based training (CBT) in such fields as EmONC (emergency obstetric and newborn care) family planning, basic and advanced newborn care, fistula, breast and cervical cancer, and infertility. Training will be developed and each site and trainer will be accredited each year. This mechanism will be designed to maintain the quality of the training site and will help to identify needs at each training site.
As a means of ensuring quality basic and comprehensive obstetric and neonatal care, these training centers will train newly graduated doctors who are to be employed in provincial health services in EmONC, FP, basic and advanced newborn care, until such time that these skills are included in the undergraduate medical curriculum. For increasing the capacity of health providers, including OBGYN, midwives, nurses and male doctors, the HAA will support initial and refresher/professional development training courses to be conducted and the knowledge and skills to be updated on evidence based curricula.

Deliverable 1.8.3: To promotes and support health-related research (FP, STI, Death notification, mental health, etc) at all levels. (Capacity building of MoPH, Provincial RH officers, nursing and midwifery department and AMA for RH research)

The RH Directorate will assess and review the RH component and identify gaps which require evidence-based data to guide strategic planning. However, because of resource limitations, research priorities will be based on program needs, major health challenges, institutional capacities and capabilities, and available resources.

An important role of RHD is to advocate with partners/donors in collaboration with APHI for mobilizing financial support to conduct RH research.

Some general considerations related to RH research include the following:

1. Research should look at policy and mechanisms to increase and improve the quality of RH services, such as the mechanism for coordination and integration of RH-related activities and means of improving retention of female health care providers and improving the utilization of services.

2. Research should look into sociological aspects of RH, such as identification of unmet needs for contraception, high-risk sexual behavior, testing of the results of interventions for MNH and FP at community level.

3. The quality and output of research should be improved. The results of research should be regularly disseminated and utilized for improved programming.

4. A database for RH research will be created for knowledge management in RH sector.

The priority areas and topic that is considered for RH research; after the review of AMS findings is to understand current knowledge, attitudes and practice (KAP) of duty bearers, families and communities regarding delivery, pregnancy and its complications, and FP practices.
Sub-Component 1.9: Maternal, Newborn and Child Health Care

Acceleration of Maternal, Newborn and Child health care

Anticipated Results:

- To increase the existing coverage of Ante-Natal Care and Post Natal Care and Skilled Attendance at Birth by 10% from baseline (Baseline ANC: 60%; SBA:34%; PNC: 28%)
- To improve the utilization of family planning services and Contraceptive Prevalence Rate is increased from 22 percent to 32 percent
- To increase percent of Comprehensive EmONC facilities providing 24/7 services from 68% to at least 90%
- Government ministries, professional societies, private sector, communities and families are involved to increase the status of women and provide them with economic opportunities to address poverty, ill-health and malnutrition
- Stewardship role of MoPH in MNH enhanced with adequate focus on capacity building, research, data management, monitoring and evaluation and gender mainstreaming.

This Program, known as H4+, is a tool to support the goals of the National Reproductive Health Strategy (2011-2015), through a targeted approach towards improving health financing, expansion of existing health service delivery, strengthening of human resources, scale up of systems, and reinforcement of the existing national institutions. The ultimate goal of H4+ is to accelerate the implementation of the maternal and new-born continuum of care, in response to two main calls for action.

First, effectively address the priorities recognized by the National Reproductive Health (RH) Program in Afghanistan, towards the achievement of the MDGs 4 and 5. Second, respond to the UNSG’s Global Strategy for Women’s and Children’s Health.

At the global level, the H4+ initiative prioritizes, in the first instance, 25 of the 60 countries with a high burden of maternal mortality, for joint actions among multiple partners working together for better maternal and child health: Afghanistan remains one of the priority countries.
Deliverable 1.9.1: Support MoPH to elaborate policies and strategies for improvement of maternal and newborn health towards achieving MDGs 4 & 5

The goal of the delivery is to support National policy makers to ensure provision of quality of National strategies and policies (Reproductive Health action plan, National Gender Strategy for MoPH, 201-2015, Policy Framework to support exclusive breastfeeding, etc) that will facilitate protection of the public from unsafe practice, which will in turn contribute towards enhancement of their health status.

Deliverable 1.9.2: Strengthen the implementation of quality of MNH services in the BPHS

H4 Plan envisages improving access to MNH services in 10 most vulnerable provinces by complementing BPHS. These provinces have been rated as most vulnerable on a composite index of child labour, primary education gender parity index and net attendance rate, calorie deficiency, full immunization, skilled birth attendants, sanitation coverage and poverty level from NRVA 2007-08.

The specific activities will include close coordination with GCMU to map under-served populations and provide additional outreach services in un-served areas to increase access to essential maternal and newborn care. Support will also be provided by community based RH and referral system for isolated, un-served communities in Badakhshan, Daikondi, Bamyan, Zabul provinces by establishment of Family Health Houses.

Deliverable 1.9.3: Improve the quality of Family Planning and Strengthen post abortion care, including post abortion FP

The capacity to provide family planning services will be enhanced by enhancing the skills of service providers by revising learning resource packages, performing non scalpel vasectomy and tubal ligation. An extensive information, education and communication (IEC) campaign to stimulate demand will be conducted. Existing IEC/ BCC FP materials will be reviewed and revised and new materials developed.
The interpersonal communication skills of health workers will also be enhanced. Advocacy with religious and community leaders and other opinion makers such as mothers –in- laws is another important activity.

Monitoring and evaluation of family planning services will be strengthened by establishing a system for data collection, analysis, interpretation, feedback and data led decision making processes.

**Deliverable 1.9.4: Strengthen MNH services in the Essential Package of Hospital Services and advocate for its revision accordingly**

H4 plus action plan will focus on provision of technical assistance for improving quality of care and improving clinical reviews and data analysis to improve quality of care. The key activities include: improve management of essential and advanced newborn care in the EPHS and BPHS and establish a supportive monitoring and supervision system; support the essential and advanced neonatal care in district, provincial and regional levels; evaluation of facility based maternal and peri-natal death reviews at referral level and developing capacity for maternal and peri-natal death review within MoPH.

**Deliverable 1.9.5: Strengthen national capacities in addressing Obstetric Fistula**

H4 plan will be completely training 2 Obstetric Fistula (OF) surgery teams at Malalai Hospital and establish collaboration with the Cure Hospital in obstetric fistula treatment. Community awareness will also be increased on prevention of obstetric fistula and raising awareness about treatment services. A work plan will also be developed to advocate delaying first pregnancy until the age of at least 18 years. An operational research is also planned to provide a better understanding about the incidence and causes of iatrogenic fistula in Afghanistan.

**Deliverable 1.9.6: Improve STI management, including PPTCT**

H4 action plan envisages establishment of PPTCT centers in five regional hospitals. The plan envisages improving STI management in high risk groups and pregnant mothers.
Integrating HIV and STI prevention information, messages and means within maternal newborn, reproductive health and other services in the BPHS and supporting the integration of Adolescent Sexual Reproductive Health (ASRH) in the BPHS and EPHS to make them youth friendly are planned.

**Deliverable 1.9.7: Strengthen midwifery program**

H4 plus action plan will concentrate on advocating for the human resource requirements for improving equitable distribution of midwives in facilities and in remote areas. The major activities will include adaptation of current midwifery training standards on the basis of the Global midwifery standards (ICM-WHO); expanding mentoring system for midwives at national level; providing documents translated into local language to graduated midwives and advocating with Ministry of Higher Education for the establishment of an academic study (Bachelor of Science) for midwives. These activities will improve retention of midwives in the health system and give them incentive for career planning.

**Deliverable 1.9.8: Improve the quality of the training of Ob/Gyn (Ob/Gyn residency training) and in Neonatology and encourage revision of medical education curricula and training to address MNH needs**

The National RH Training Centre will be established under the KMU. Pool of National Trainers will be trained who will also be in charge for in-country cascade trainings. It could be great impact to sustainability of Reproductive Health Management in the country. Simultaneously, quality of pre-service training for students of medical universities must be in the frame of interest of the National Training Institutions. The Centers will be in charge for improving teaching, as well as research capacity of national health professionals.

**Deliverable 1.9.9: Elaborate and implement communication strategy for behaviour change at the community level (in line with the national Health Promotion Strategy for MNH and the CAH strategy).**

Existing community health workers (M-9856 and F-8785) and FHAG members will be trained and equipped for conducting birth preparedness planning with pregnant women and their families and improve postnatal care for mothers and new-borns.
Existing male and female CDC shuras needs to be mobilized for improving awareness on 
MNH issues and formation of community run emergency transport funds and blood donor 
groups. Ministry of Rural Rehabilitation as a part of H4 plus plan will train 12,000 CDC 
members on key maternal/new born and child health issues. Funds have already been 
secured by MRRD for the purpose.

**Deliverable 1.9.10:** *To promote and support health related research (FP, STI, Death 
notification, mental health, etc) at all levels. (Capacity building of MoPH, provincial RH 
officers, nursing and midwifery department and AMA for RH research)*

The vision of this NPP component is promotion of a nationally-directed and managed 
system for assessing, building and evaluating the capacity of researches and surveys at 
all, managers and health care providers to deliver high quality reproductive health care 
services.

It is envisaged to implement through support and establishment of independent research 
units in selected national hospitals that have good analytical and implementing capacity, 
supporting the most talented young doctors with the special grants for Master and PHD 
level.

**Deliverable 1.9.11:** *Research on new communication technology use for MNH*

Public private partnerships will be forged with Ministry of Telecommunication, mobile 
service providers and health care delivery system. The key activities will include technical 
assistance for exploring m-health solutions(using mobile phones for reaching remote 
clients); making use of Ministry of Telecom digital ID programme and CDCs to collect real-
time data; operational research on strengthening of referral systems for delivery using 
SMS technology and CDC support systems in at least 3 provinces and piloting of a call 
centre for support to CHWs on decision making on emergency referrals and management 
of an associated community –managed transport fund for emergency referrals using 
mobile banking (m-paisa) in three remote provinces; scale-up if evaluation and cost-
effective ness gives positive results.
**Deliverable 1.9.12: Maternal and neonatal health benefit from a strong multi-sectoral approach**

The H4 plus plan will organize advocacy efforts to enhance multi-sectoral support to MDG 4&5 and MoPH will coordinate the activities of relevant ministries in this regard. The existing structure of Maternal and Child Survival committee will be used for the purpose of reviewing progress at periodic intervals.

**Deliverable 1.9.13: WHO H4+ technical Operational Support Unit (TOSU)**

In February 2012 the final and costed-out version of the H4+ Plan of Action was presented to the Minister of Public Health for final endorsement and launch. During this stage, the H4+ Partners, in agreement with the National Reproductive Health Directorate, convened to the idea to establish an H4+ Technical Operational Support Unit (TOSU). The OSU would be an integrated mechanism for operational management of joint H4+ action plan. WHO was selected as the lead agency among UN partners to take the coordination role of TOSU: this, coherently with the H4+ organizational experience from other countries, where similar mechanisms of coordination are led by WHO, within the H4+. The UN partners supporting H4+ will contribute to operationalize the H4+ Plan of Action coherently to their mandate. The World Bank (WB) will support H4+ implementation for those activities to be carried out among the BPHS implementers funded by WB under the BPHS platform. However, the TOSU will act as a mechanism for promoting national ownership, strategic guidance, national capacity building, effective use financial and human resources, strengthening advocacy, knowledge sharing, monitoring and reporting.
Sub-Component 1.10: Emergency Preparedness and Responses Services

To enhance the capacity of national health system for disaster risk management including mitigation, prevention, preparedness and response

**Anticipated Results:**

- Appropriate national strategies, regulations, standards, guidelines, and policies to support to enhance the MoPH stewardship role in EPR/DRR are developed, endorsed and disseminated.

- EPR data base and detailed district level risk assessment will be conducted across the country, to identify and map the high risk areas to emergencies/disasters.

- The medicines and medical supplies necessary to respond to emergencies and disasters that bypass the local response capacities are available and prepositioned in high risk areas according with contingency plans.

- Operational costs for the establishment of emergency temporary static and mobile health services, treatment centers, and the implementation of vital public health interventions in response to emergencies and disasters are ensured.

- Training curriculum for EPR/DRR is developed and annually revised.

In Afghanistan, as it is happening worldwide, the severity of recent natural and manmade disasters- hampers the process of recovery and development thus increases poverty. Globally, there is a shift in dealing with disasters from relief and response mode to disaster risk reduction through prevention, preparedness, and mitigation approaches. After a disaster, restoring the situation alone will not be sufficient without addressing continuing vulnerabilities of communities, increasing preparedness/readiness, augmenting capacities and forewarning the communities.

The prolonged wars and conflict combined with frequent natural disasters and poor community resilience had hampered the development process and has left the majority of people of Afghanistan with numerous vulnerabilities. Even small scale events, can became disasters. So far, the response to emergencies and disasters largely depended on external support. In the view of the ongoing transitional phase, building the capacity of national health system for disaster risk management including mitigation, prevention, preparedness and response, reducing the dependence on external support is one of MoPH priorities.
Deliverable 1.10.1: To strengthen the Ministry of Public Health (MoPH) stewardship role on Emergency Preparedness and Response (EPR) and Disaster Risk Reduction (DRR) through development and revision of supportive policies and regulations, guidelines and standards, clarification of roles and responsibilities, fostering a mainstreaming approach

A detailed desk review of existing policies and strategic documents related to EPR/DRR will be done, and based on identified gaps/needs the revision and development of national policies, standards and guidelines for EPR/DRR conducted. Additionally, the MoPH strategy regarding the DRR for health sector will be developed using a mainstreaming approach across all departments and units. For each newly developed guideline, a training module and plan for capacity building and dissemination will also be developed. All the technical documents, after the endorsement by MoPH technical forums, will be printed and translated into the local languages (Dari and Poshtu) and disseminated to all provincial and district MoPH offices as well as to all relevant stakeholders.

Deliverable 1.10.2: Enhancing evidence based decision making through establishment of data base management for health sector Emergency Preparedness and Response (EPR) and detailed risk assessment at district level

During 2012/2013, a combination of quantified (scores) criteria will be compiled using data collected in the past 4 years. The criteria will include: frequency (number) and types of epidemics, EPI coverage, score for risk to natural and manmade disasters, and access to safe drinking water and basic sanitation. Wide participation and agreement with all field stakeholders will be ensured through work-shops and working groups while conducting the risk assessment and compiling the EPR data base. Technical support will be provided by WHO/EHA/ Health Cluster. The result of the risk analysis will be used for defining adapted DRR strategies in areas identified at very high and high risk to health impacts of emergencies/disasters. The data base and the risk analysis will be yearly updated with newly collected information and the lesson learned during the process. All produced maps will be printed and together with the data base information disseminated to all MOPH levels and health implementing partners.
Deliverable 1.10.3: To ensure timely and effective response to emergencies and disasters that by-pass the local response capacity

To ensure that the MoPH fulfill its role in responding to the health needs created by disasters, there will be need to ensure that adequate supplies of medicines and fund for operational costs are available with the EPR. The size and composition of the emergency and contingency stock for health sectors will be determined on the basis of the previous two years consumption, and according with the recommendations of contingency plans for floods and AWS outbreaks, drought, and winterization.

The MoPH/EPR at national and provincial levels is responsible for the development of response strategy and plans tailored to the size, severity and cause of each individual crisis/disaster. This will include ensuring immediate access to health services for affected communities through establishment of temporary health services (where the existing one collapsed or inexisten), early warning and effective surveillance for communicable diseases, reactive vaccination campaigns and special treatment centers (ex: cholera).

Deliverable 1.10.4: To strengthen the human capacity at all levels of health system to conduct evidence based planning, and to design, implement, monitor and evaluate disaster management interventions

The national training curriculum for EPR/DRR will have to be revised and adapted to the development of new national standards, manuals and guidelines, and take into account the identified present gaps. In the first year, the focus will be on the training of relevant national and provincial stakeholders on newly developed diseases specific operational guidelines for management of epidemics and water quality testing in emergency situation.

In the following two years, provincial mangers will be trained on disaster management using as facilitators the people enrolled in WHO regional training.

Relevant staff from all BPHS and EPHS implementing partners will be trained under this initiative to ensure that the capacity for quality implementation of emergency response is built within the public health system. This activity will build upon the successful previously-implemented initiative in collaboration with WHO/EHA department.
Component 2: Increase & Improve HRD for Health & Good Governance

**Outcomes:** Staff capacity in health systems management at central and provincial levels is improved; professional standards and specialized curricula yield higher quality capacity within the MoPH; increased service capacity at the central and provincial levels; improved capacity and service delivery in various community health disciplines at the central and provincial levels; better coordination of key stakeholders in their efforts to improve the Health Information System;

**Indicators:** 80% of trainees reflect minimum standards; 1,380 staff are trained in health system management; % of training participants have increased skills in health system management evidenced through grading system and improved performance evaluations; 1,940 trained staff trained using specialized curricula; increased number of community workers to 13,540; increased number of professional providers to 14,720; % increase in positive feedback in patient satisfaction surveys; % reduction in morbidity and mortality rates; 30% increase in surveillance of water (5%)/food (0%)

Human resource capacity within the national healthcare system is one of the leading factors in the viability and sustainability of any national healthcare strategy. The HAA targets developing MoPH’s human resources, systems and institutions that are necessary to deliver quality health care to the Afghan people. The HAA makes a bold statement, noting that the achievements in the health sector cannot be sustained without an accompanying plan to develop the human resources that will support both the expansion of health care coverage as well as an increase in quality.

In the current fiscal environment, successes achieved to date in the health sector will not be sustained without significant increases in the capacity of the MoPH to manage and provide an oversight role of the national health sector. Through targeted efforts aimed at developing and revising curricula and professional standards, reinvigorating health service institutes and staff, the foundation will be created to sustain service delivery.

The creation of a Health Management Information System (HMIS) will support the continued monitoring and evaluation of health programs, access and regulation of the public and private sector to ensure quality healthcare is accessible to the population.
Finally, with a focus on community development and promoting healthy environments, the health sector will target the rural population of Afghanistan and seek to improve the overall health status of the country. As outlined in the Kabul Conference, this program aims to adhere to the concept of Afghan-owned and Afghan-led programs as their strategy for Transition. To achieve this end, it intends to use the following new strategies:

*Increase the size of the workforce in each major skill category and target training in order to increase and retain skilled staff* - Analysis shows that staff numbers need to increase from the present 27,867 to 32,000 in 1392, or an estimated 11.55% increase in 1389 and 21.15% by 1392. The Capacity Building Plan of 2009 already identifies priority areas for training: midwifery, community nursing, physical therapist, psycho-social counselor, medical technology, bio-medical engineering and environmental health. Targeted training has also been identified for specialized administrative staff in the areas of: human resources, finance, procurement, logistics, law, audit and project management.

*Enhance professional standards and accreditation of curricula* - ensuring a more qualified and professional workforce. This will be done through the establishment of a Medical Council that will promote minimum standards, register faculty and students, and through provision of a forum for the development and sharing of new concepts and new approaches to advance these issues. An HR Taskforce for sector stakeholders will assist with Council development and associated curricula development for all professional groups. *Amalgamate HR databases and coordinate analysis* - by integrating training, pay, deployment and attendance data into the HR database, ensuring compatibility with the CSC HR Database, and computerization of all HR programs at all levels, including decentralization to provinces.

*Ensure tangible results are realized in the provinces* - through the emphasis on training programs for all community-based workers, implementation of programs in educational schools across the country, development of training programs in rural institutes for placement in rural areas, and through initiating decentralized hiring, finance and procurement with qualified staff.
Place particular attention to gender - by incorporating gender awareness into training program planning; coordinating with the Ministry of Women’s Affairs to enhance the quality and impact of mainstreaming training at provincial levels; increasing emphasis on recruiting female Community Health Workers (CHWs), Female nurses (Community Nursing) and other specialized fields to assist women in making decisions regarding personal and family health.

Promote Community Empowerment – through the education of families in household health practices and skills development enabling households to improve their household practices. Focusing on the community, this strategy will seek to establish self-sustainable health promotion systems through CDCs, shuras and community leaders and the reinforcement of messages and knowledge to behavioral change.
Sub-Component 2.1: Develop Institute of Health Sciences

To reinvigorate health sciences institutes to develop, manage, and execute major health worker trainings

Anticipated Results: It is anticipated that by Program completion:

1. Upgrading the institutional structure, procedure & facilities of The Ghazanfar Institute of Health Sciences and five provincial health institutes.

2. Capacity building of 160 staff from all existing Institutes will be trained Increase quality and performance through an improved IHSS infrastructure.

The Ghazanfar Institute of Health Sciences Services (IHSS), located in Kabul, coordinates activities for five Provincial Institutes of Health Sciences in Herat, Mazar Nangarhar, Kandhar, and Helmand Provinces. Additionally, nursing and midwifery IHS courses are also run in provincial sites where other community health facilities are used for the training schools. There are approximately 110 teachers, 82 administrative staff and lower-level staff at the six institutes many of which are funded through donor training programs. For years, these Institutes have been under-resourced and lack adequately skilled staff.

Donors, while supportive, have implemented ad-hoc training projects such as midwifery, orthopaedic technicians and physical therapy through contracting NGOs under the auspices of the IHSS.

The Institutes have very little funds to build their own institutions, as well as develop management and staff skills to improve curricula and run up-to-date courses. The HAA aims to address these issues through capacity building and infrastructure development.

17 There are currently 34 sites in all 34 provinces where programs are run.
Deliverable 2.1.1: Institutional capacity in human resource management systems is strengthened and a high level Policy and Training Unit is developed

To revitalize the IHSS and its Provincial satellites, an assessment of existing human resource policies, structures, systems and procedures, will be undertaken at the six institutes. The assessment will also review job descriptions for trainers and managers, the skills required for policy and training task creation, and corresponding salary levels, in addition to providing recommendations for revisions within the IHSS. These new criteria will be compared against competence levels of existing staff. Where staff members do not meet criteria due to re-graded jobs or new job descriptions, positions would be re-advertised. The assessments team will also provide recommendations on implementation strategies for a high-level Policy and Staff Training Unit, whose key functions will be to:

- Formulate policies on the training required for each category of health professional and technician as well as the level of certification through MoHE or IHSS (degree, diploma, certificate, in-service), in the various regional locations. This will include planning for categories for which no training is currently available, such as nutrition workers.

- Negotiate with MoHE to determine roles of different institutions (including the private sector) and areas for collaboration, through the newly proposed MoHE/MoPH Coordination Committee.

- Determine workforce numbers required for each category of training per location, in collaboration with General Directorate for Human Resources (GDHR) and the General Directorate for Policy and Planning Capacity Building Team.

- Develop or update curricula in all areas with identified “gaps”, in collaboration with MoHE.

- Run certificate and diploma courses (pre and in-service) for health workers at the lower level and work with the MoHE, who is responsible for administering undergraduate and postgraduate degree courses.

- Train IHSS teachers in general standards such as curriculum planning, implementation, student assessment, and teaching review.

An estimated 160 staff will be prioritized, for both the capacity-building programs (including on-site training) and the new unit, through this institutional development effort.

18 There is no official operational plan, however a program budget was undertaken a year ago, which defined the activities, their volume and costs, and materials required to undertake tasks. This serves as a de facto operational plan.
Consultants will be embedded within the Ghazanfar Institute of Health Sciences (GIHS) to manage upgrades to the facilities, structures, and systems, so that the training required can be undertaken and managed efficiently and effectively within three years. During the implementation of this project, the consultants will fill the Director and Administrator positions in each of the IHSS (with executive powers). Existing staff will shadow the consultants as they learn to take over the positions by project.

**Deliverable 2.1.2: Infrastructure upgraded for improved performance**

An assessment by the Health Service Support Project, funded by USAID in November 2010, showed that infrastructure in the IHSS is inadequate to meet needs. Specifically, it cited:
- Students who travel to Kabul for in-service courses cannot find accommodations within the CSC allowance, leading many students to turn down training. A small accommodation bloc for provincial health workers coming to centralized trainings would rectify this situation which may be developed from storage warehouses.
- The GIHS library is inadequate for students as it lacks the space, staff (affecting hours of operation) and updated materials for students. Renovation of storage garages located near the entrance and the accommodation blocks could meet this need. Additionally, the purchase of computers, updated reference books and the hiring of skill staff are also essential.
- A number of repairs are required within the main buildings of IHSS, including to generators, heaters and water heaters. Within the dormitories and classrooms, additional repairs to broken glass, furniture, walls, doors and toilets are also required. Furthermore, the procurement of an electric water pump for access to well water, new desks, chairs and storage is needed. A communication upgrades are needed, this includes new computers, software and anti-virus protection, surge protectors, printers, photocopiers and projection equipment.
- The GIHS nursery is too small; the old kitchen could be converted for this purpose.

The HAA aims to meet these rehabilitation and equipment upgrade needs where costs are relatively minimal compared to outputs.
Sub-Component 2.2: Governance, Leadership and Management Capacity

To improve the governance, leadership, and managerial capacity within MoPH to ensure the sustainability of the system

**Anticipated Results:** It is expected that by Program completion:

1. 68 MoPH staff members are trained in human resource management at central and provincial levels
2. An improved.updated HR Database is established to allow computerized HR programs to be operated by all HR Officers and current data will be transfers between provincial and central offices
3. Increased efficiency and financial governance at the provincial level through the regional management system and increased competency of provincial financial and procurement
4. 180 management and MoPH staff members are trained in management and public health leadership
5. Increased transparency and accountability through the establishment of the Development Budget Department, the Anti-Corruption Committee, and the Health Complaints Office

**Deliverable 2.2.1:** To improve efforts to decentralize human resource management services in MoPH

In order to decentralize human resource management services, the General Directorate of Human Resources (GDHR), Provincial Health Offices (PHOs), and the Central Departments must have the have the ability to function effectively.

To support this process, the GDHR must have the capacity to manage, coordinate and delegate key functions to the PHOs and Central Departments.

The GDHR is responsible for managing recruitment, providing guidance on job descriptions, workforce planning, performance management, and the formulation of labor laws. Although international assistance has been steady over the years, the GDHR capacity still lacks the requisite skilled manpower to fully implement its mandate.
Though work undertaken on planning and Pay and Grading reform has been considerable, without a significant increase in staffing capacity, funding for the implementation of institutional development, and computerized HR services through central and provincial structures, improvement will not be realized. The HAA targets this capacity gap by supporting efforts to train 68 MoPH staff from the central and provincial offices on human resource management at the central and provincial level. MoPH currently has one provincial human resource (HR) officer position, and intends to hire an additional 34 human resource assistant officers as well as 34 centralized human resource officers. These 68 (HR Officers) will be trained in recruitment, performance appraisals, HR management, civil service law and information technology to ensure that a decentralized system may function within three years.

**Deliverable 2.2.2: A Human Resources Database system is developed for decentralization**

The MoPH HR Database, established in 2005, is the only Ministry to have a database seen as a model by the Civil Service Commission (CSC); who has recently established its own HR Database. Links between the two are planned; however, considerable improvements are needed. Transparent linkages between the Provincial Public Health Directorate pay system, deployment, data and attendance data must be established in order to ensure effective decentralization of the recruitment processes to the Provincial Recruitment Committee, as is planned.

In October 2009 an assessment was conducted on the HR Database, which, among its key findings, recommended supporting workforce planning and reporting within MoPH and to automate many of the manual reporting activities currently undertaken by the deployment area. The top recommendation was to include approved MoPH post data through three options:

(a) Modifying the existing HR database to include establishment data of all approved posts within MoPH;

(b) Designing and developing a new database for post information integrated with the existing HR database; or

(c) Designing and developing a new Human Resources Management Information System (HRMIS) incorporating both employee and post information.
Under the HAA, the MoPH will determine the best option that fits its needs, resources and capacity, which will include:

- Examining the technical aspects of the current database and determine the suitability of Microsoft Access as a long-term development platform, and the capacity of the existing ICT infrastructure (e.g. server and communication hardware and desktop computers) to support the selected option.
- Identifying alternative development tools and database platforms, such as Microsoft SQL server which would support the eventual deployment of the database to the PHOs and ensure a more timely collection and management of HR data. The impact any such change may have on other core systems within MoPH such as the HMIS and Training Database must also be considered.
- Reviewing the feasibility of introducing web-based technology to allow deployment to PHOs.
- Identifying alternative methods of providing database access to PHOs such as the model used for the HMIS database.
- Integrating with computerized payroll.
- Identifying the technical resources and training required to support the application to ensure sustainability.
- Securing the availability of resources to collect and validate post data.

At the end of the three years, the HR Database will allow computerized HR programs to be operated by all HR Officers and data transfers between provincial and central offices. HR procedures will be able to operate efficiently and effectively with weekly, quarterly, and annual reports produced electronically, as required. This will result in consistent, up-to-date forms and procedures allowing for effective operation.

**Deliverable 2.2.3: To improve financial management in the MoPH at the provincial level**

The MoPH utilizes a Financial Management Information System (FMIS) and most officers have the capacity and capability to utilize a computer for their work. The MoF, World Bank and USAID have certified the financial management and procurement capacity of MoPH. However, the PHOs lack the technical and human resources to fully participate in the FMIS. Provincial Finance/Procurement Officers have limited access to computers and lack the training of the FMIS programs. Contributing to this is the low level of competency of provincial financial and procurement staff.
Since the Pay and Grading system was completed last year, many staff currently in positions do not satisfy the re-drafted selection criteria for new job descriptions, and few skilled applicants apply for the newly graded positions.

By contrast, the MoPH’s BPHS and EPHS programs in the provinces use computerized technologies through their subcontracted NGOs in the provinces. This creates disconnect between the central and provincial offices, which minimizes effective management and governance systems.

The HAA will support the MoPH’s efforts to improve human and technical resources at the provincial level through the development of a regional management and training approach to address human resource capacity needs. Currently there are 34 provincial accountants. Under the HAA, the MoPH will divide the public health system oversight into 14 regions. Regional Finance Managers will be recruited for provincial financial oversight and to build the capacity of the finance and procurement staff within their region. A series of training workshops on the proper utilization of software and the management of daily operations will be conducted by the MoF and MoPH in Kabul, in addition to: procurement and financial management laws and procedures; the roles and responsibilities of a Provincial Finance /Procurement Officers;

Training on the utilization of computerized finance/ procurement systems; the links between the General Directorate of Administration (GDA) and decentralized locations; and monitoring and reporting.

The Regional Finance Managers will be tasked to implement regional formal and on-the-job training to build the capacity of the Provincial Finance/Procurement Officers. The central GDA office will conduct periodic oversight and supervision visits of the regional and provincial operations to review compliance with training and operational standards.
Deliverable 2.2.4: To build the leadership and management capacity of health professionals and administrators

The MoPH’s Needs Assessment and Capacity Building Plan, which was finalized in February 2009, showed major gaps in healthcare management training in such areas as human resources and administration for hospitals and PHOs.

The HAA will target the gaps identified in the 2009 assessment by supporting the MoPH’s efforts to implement management and leadership training for 1000 professional health workers and healthcare administrators.

The MoPH will build upon the successful cooperative arrangement between the London School of Hygiene and Tropical Medicine (LSHTM) and the MoPH/Afghan Public Health Institute (APHI). Under this initiative, management and public health leadership trainings were provided for four years through a two-year, block release program providing a diploma upon course completion. Under the HAA Program, three new in-service, two-year diploma curricula in management and leadership training will be implemented by APHI, targeting approximately 180 MoPH staff at the central and provincial levels: hospital management (60 trainees), health service management personnel (60 trainees), and public health officers (60 trainees).

APHI will also organize short courses in the provinces for an additional 800 new graduates of Kabul Medical University in management and public health leadership.

Deliverable 2.2.5: To strengthen transparency and accountability within the national healthcare system

Since 2003, MoPH has adopted principles of modern public management to deliver more than $500 million of donor-funded primary and secondary healthcare throughout the country. Despite efficiently managing considerable development funds in the last nine years, the MoPH aims to continue strengthening its capacity in financial management. Recently the MoPH approved a financial management manual to provide guidance for all health projects in fund management.
Moreover, the MoPH established a new financial management unit, the Development Budget Department, employing experienced and skilled financial professionals. To maintain its integrity in fund management and guard against potential lapses, the MoPH is seeking to add skilled financial managers in the Development Budget Department, and to establish a managerial committee to guide risk awareness and management training and a grievance mechanism, both of which reflects the MoPH’s commitment to transparency and accountability. The recruitment of skilled financial managers and officers will be focused in the regions and provinces. Training workshops will be conducted, as reflected in Component 3.2.3 above.

In addition, three additional financial managers for the central office will be recruited, whose responsibility it will be to provide advice on further transparency and anti-corruption efforts.

MoPH recently established an Anti-Corruption Committee to support financial accountability and transparency through oversight a number of initiatives, some of which are already underway:

- Strengthening professional standards in key MoPH entities
- Dissemination of the Civil Service Commission Code of Conduct
- Establishment of a permanent MoPH transparency working group
- Training health care workers on leadership and management
- Training provincial finance officers on financial management

The committee would also assist in establishing a Health Complaints Office (HCO) as an autonomous entity serving as a free-access feedback mechanism on MoPH services. Individuals were nominated by WHO, Integrity Watch Afghanistan, and the Afghanistan Independent Human Rights Commission to serve as members of the HCO Board of Directors.

The ToR for the HCO was agreed by the MoPH Technical Advisory Group, and includes monitoring mechanisms to be implemented, and outcomes will be reviewed monthly to address high-risk areas. Although the membership was agreed a year ago, the HAA will support MoPH’s efforts to obtain a Presidential Decree (or Parliamentary approval) to officially establish the HCO, and once enacted, the HCO will begin to develop its tashkil for the HCO Secretariat.
Health for all Afghans (HAA)

**Deliverable 2.2.6: to strengthen national capacities on Gender mainstreaming and Right based approach in Health sector**

Health is an essential prerequisite for the effective participation of women and men in all areas of life. In Afghanistan, men and women face great challenges to good health. Although the situation is improved, but still there is no any system in placed to collect data from Gender based Violence survivors in a proper ways with consideration of privacy and confidentiality, due to the continuing conflict in the country, recent data, including sex-disaggregated data, that reflects the health situation in the country are scarce.

In order to ensure that women and men of all ages have equal access to opportunities for achieving their full health potential and health equity, the health sector should recognize that because of social (gender) and biological (sex) differences, women and men face different health risks, experience different responses from health systems, and their health-seeking behavior, and health outcomes differ. Gender is often misunderstood to mean women, when, in reality, gender refers to the roles and relationships of both women and men in a given cultural context. Although gender roles limit both women and men, they generally have a more repressive impact on women. In 2008, the Gender Development Index (GDI) for Afghanistan was 0.310, placing Afghani women’s status second from last in the world. While women need special attention to improve their health and economic status, programs to improve health outcomes in Afghanistan must include both women and men.

Furthermore, childhood and adolescence is a time when gender norms are passed on to the younger generation, thus ensuring equitable health care for girls and boys is important. Lack of services and existing cultural practices both play a role in perpetuating health issues that women and men face.

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19 More detail of specific gender-issues related to each health area covered in the National Gender Strategy is contained in Annex 1.
21 http://www.unifem.org/afghanistan/media/pubs/08/factsheet.html
In Afghanistan, as in many societies, women have less access to health information, care, services, and resources to protect their health. Women are disadvantaged in their ability to make informed decisions about their own health and that of their children. Current gender norms do not empower women to make such decisions. At the same time, gender norms also affect men’s health by assigning them roles that promote risk-taking behavior and cause them to neglect their health.

The overall aim of health and human rights is to enhance coherence between: Afghanistan’s international obligations and commitments; national health policy and institutional frameworks; and health sector strategies with respect to human rights and gender equality.

The Health and Human Rights strategy of MoPH is a comprehensive overarching plan to strengthen the rights based approach and ethics in health and compliments and strengthens the corresponding and relevant actions of the Afghanistan National Strategic Plan for MoPH (2-11-2015), the National Health and Nutrition Plan (2012-2020), the ANDS strategy, and the MoPH Gender Strategy (2011 – 2015).
Sub-Component 2.3: Professional Standard and Specialization

To develop adequate professional standard and specialized curricula and to conduct specialized training to improve capacity for service delivery

**Anticipated Results:** It is expected that by Program completion:

1) Legislation to officially develop a Medical Council is enacted and operationalization of the Council is launched
2) The Midwives and Nurses Act is enacted and the Afghan Midwifery and Nursing Council is launched
3) Curriculum in 13 specialized areas is developed to international standards and 383 educators in the new curricula
4) Nursing and Technician Curriculum updated and 1,257 staff trained through in-service initiatives
5) An accredited degree program for Biomedical Engineers, Medical Technologists and Environmental Health Officers is developed and 300 are trained in these specialized areas

**Deliverable 2.3.1:** To develop a mechanism to establish standards, registration, accreditation of curricula, and management of professional misconduct of physicians.

The MOPH is responsible for the registration and regulation of healthcare professionals in the private and public sectors.

In November 2009, the MoPH’s comprehensive Workforce Plan for the healthcare sector was finalized with the support and cooperation of the Chancellor of Kabul Medical University and the Director of Student Affairs.

The Workforce Plan recommended establishing a joint committee between MoPH and MoHE (the Medical Council23) to discuss curriculum content, standards, and accreditation, in addition to the establishment of new health courses and selection the criteria for students.

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23 Medical councils exist in most developed countries of the world to regulate doctors and medical standards. They are either completely independent bodies or bodies funded by the government but with autonomy to act independently, so the profession regulates itself according to international standards.
It also recommended assisting health professional groups to establish independent councils to regulate their respective professions (see Component 3.3.2 below). The Medical Council would be responsible for establishing standards, registration, accreditation of curricula, and management of professional misconduct of physicians. The establishment of the Medical Council was recently discussed in the Technical Advisory Group (TAG) of MoPH, which included the Hospital Policy Group, the Public-Private Partnership, and representatives of medical associations. The outcome of these discussions led to a draft act, which is to establish Interim Medical Council.

The Interim Medical Council was comprised of a ten-person council of medical “elders” with expertise in specific specialties such as law, curriculum, and mediation, with representatives from MoPH, MoHE, one dean from a private medical college, one dean from Kabul Medical University, one provincial medical faculty member, two representatives from the Private Hospital Association (one provincial and one central), a representative from the Union of Doctors and Medical Practitioners, one representative from the Obstetrics and Gynecology Association, one Provincial Health Director (elected at their quarterly meeting), and one BPHS NGO representative from a province. To further the efforts to officially establish the Medical Council, GDHR is working with AusAID on a planned consultation workshop to further advance the concept of the Medical Council. It is anticipated that the next steps beyond the workshop include:

- A comparative review of country strategies and mechanisms to determine the best structure for Afghanistan.
- Developing and enacting legislation to reflect the regulatory framework that will establish the authority and responsibilities of the Medical Council.
- Transfer of targeted functions and systems from MoPH to the Medical Council. This will include registration data of private doctors from the Regulation Enabling Directorate of MoPH as well as data from GDHR on publicly employed doctors.
- Accreditation and standards systems, where they exist, will be transferred from MoPH and MoHE to the Medical Council. Many systems would be re-designed.

It is envisaged that, in time, the Medical Council will be self-supporting, with a small allocation of government funds annually relating to these functions (a small increase on that which currently goes to MoPH).

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24 Work is already underway jointly by Aga Khan University and the Afghanistan Midwives Association to establish a Nursing and Midwifery Council.
Fees received from private doctor registrations by MoPH would also be transferred to the Medical Council, as well as fees for accreditation of training institutions. How much will be determined during the first year of the Council operations. The HAA will in the interim support rental accommodations, establish infrastructure, develop systems, employ and train staff, and other operational costs.

**Deliverable 2.3.2: Medical Council established and functioning**

The registration of professionals in the private and public sectors and regulation of their activities is undertaken by MoPH. In MoPH, the HR Taskforce (comprising key people from MoPH, donor groups and NGOs who are involved in HR activities in the public health sector) has been active in developing plans to advance professional standards. This is a priority in the HR Policy 2008-2013, which the Taskforce developed, and MoPH Executive Board approved. The Taskforce also organized working groups to develop and assess curricula for nurses and midwives, and then obtained Executive Board approval. However, the Taskforce has no secretariat, so its activities are stop-start due to limited resources to do the work. The Chancellor of Kabul Medical University and the Director of Student Affairs took part in a meeting on November 25th 2009, to help the MoPH finalize its first comprehensive Workforce Plan. The Plan recommends establishing a joint committee of MoPH and MoHE to discuss common issues such as curriculum content, standards, accreditation and establishment of new courses, and selection criteria for students. It also recommends assisting health professional groups to establish Professional Councils. These Councils would be responsible for establishing standards, registration, accreditation of curricula, and management of professional misconduct.

The proposed joint committee would have an overseeing role for these developments, which could culminate in an over-arching professional council. The issue of establishment of a Medical Council was discussed with the Technical Advisory Group (TAG) of MoPH, with the Hospital Policy Group, and the Public/Private Partnership, as well as with some representatives of medical associations, and was supported.

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25 Work is already underway jointly by Aga Khan University and the Afghanistan Midwives Association to establish a Nursing and Midwifery Council.
Such Councils exist in most developed countries of the world to regulate doctors and medical standards. They are either completely independent bodies or bodies funded by the government but with autonomy to act independently, so the profession regulates itself according to international standards. The discussions led to a draft act, which is available on request. It was considered that an Interim Council should be established initially that would comprise nominated Council members who are highly respected and objective. They would be medical “elders” or doctors with specific expertise in law, curricula, mediation, etc.

These could possibly be just 10 people, i.e. one representative from MoPH, one representative from MoHE, one dean from a private medical college, one dean from Kabul Medical University, one provincial medical faculty member, two representatives from the Private Hospital Association – one provincial, one central, One representative from the Union of Doctors and Medical Practitioners, one representative from the Obstetrics and Gynecology Association, one Provincial Health Director (elected at their quarterly meeting), and one BPHS NGO representative from a province.

Current functions to be transferred to the Council include 1) those from the Legislation Implementation Ensuring Department (LIED) of MoPH, which currently undertakes doctor registration and deals with matters of misconduct, and 2) standard-setting and accreditation mechanisms. MoPH and MoHE have jointly set standards for some training, accredited some training institutions and curricula, and attempted to ensure adherence to standards. However, this is not done for all courses.

A development partner (AusAID) is working with GDHR on a planned consultation workshop to further advance the concept of the Medical Council. Following the workshop, funding will be required to manage its establishment, which is expected to include:
- A twinning arrangement with another country or countries (to assist finalization decisions on its structure). Options are Syria or India; both of these have remained under the government but independent of the health ministry. Or UK or France, which are totally independent.
- Passing of legislation.
- Transfer of functions and systems. This will include doctor registration data from the Regulation Enabling Directorate of MoPH (private doctors) as well as data from GDHR on publically employed doctors.
- Accreditation and standards systems, (where they exist), will be transferred from MoPH and MoHE. Many systems would be re-designed.

The Medical Council would be independent of MoPH but still under the government as a whole. Over time, funds would be allocated directly by the Government to the Medical Council (however it should be noted that the funding has been totally inadequate). Fees received from private doctor registrations by MoPH would also be transferred to the Medical Council, as well as fees for accreditation of training institutions (as currently occurs through the Midwifery Education Board).

It is envisaged that, in time, the Medical Council could be relatively self-supporting, with a small allocation of government funds annually relating to these functions (a small increase on that which currently goes to MoPH). How much will be determined during the first year of the Council operations. The program will in the interim ensure rental accommodations, establish infrastructure, develop systems, and employ and train staff. Costs for Council meetings and travel to locations to accredit individuals and institutions will also be included.

**Deliverable 2.3.3: Afghan Midwives and Nurses Council established and functioning**

Afghanistan’s health sector is still in its evolutionary phase, creating a critical opportunity for midwives and nurses to build roots in the system. Currently midwives and nurses in Afghanistan do not have a legal regulatory body that can independently protect their profession and the safety of public. Additionally, there is a growing concern among stakeholders regarding the quality of services of midwives and nurses in the country. The best way to ensure standards of the highest quality of midwifery and nursing care would be to establish an autonomous regulatory body.

In support of the MoPH HR taskforce initiative to advance professional standards, the Afghan Midwives Association (AMA) initiated the establishment of a regulatory body for the midwifery and nursing practices in in collaboration with the MoPH and with the generous support of its development partners like USAID, UNFPA, Cord-Aid and EC.
It is expected that the MoPH will submit the drafted legislation – the Midwives and Nurses Act – to the MoJ’s Taqnin Department for legal vetting and approval, before going to the Council of Ministers and Parliament (or to the President’s office) for final endorsement in 2012. The Afghan Midwifery and Nursing Council (ANMC) will develop, improve, and maintain the quality of midwifery and nursing services delivered to individuals and communities in Afghanistan in accordance with the Government policies and guidelines of the International Confederation of Midwives (ICM) and International Confederation of Nurses (ICN). The AMNC will leverage its position to serve as a technically specialized coordinating body to effect policies and maximize the efficiency of resources flowing into the country that enable nurses and midwives to practice the highest quality of care.

The Midwives and Nurses Act outlines the composition and terms for council membership and defines the mandate of ANMC as the regulatory body of the midwifery and nursing professions in Afghanistan responsible to protect the public from unsafe practices, ensure quality of service to foster development of the profession; and confer responsibility, accountability, identity, and status of the midwives and nurses. The AMNC will be an independent body. It is anticipated that over time the AMNC will be relatively self-sustained by its fees (license renewal, verification, application for new institutions, institutional accreditation as currently occurs through the Midwifery Education Board, affiliation, member registration) and donations. However, consistent with standard practices observed internationally, the council will require a small annual allocation of government funds. The amount of government allocations will be determined during the first year of the Council operations. Additionally, consistent with standard practices observed internationally, it is expected that the Government will support the council for the first three to four years. Funding for AMNC establishment will include:

- Infrastructure and Material resource for the newly established council.
- Technical expertise to develop systems and processes to operationalize the council includes but are not limited to:
  - Five year programmatic policies and strategic plan
  - Policies for Human Resource
  - Polices for Administration
  - Polices for Finance and procurement
- Establishment of regional boards for midwifery and nursing examinations
- Establishment of comprehensive data base system and a web site for AMNC,
- Council meetings and workshops for system strengthening
Deliverable 2.3.4: To increase the availability of skilled clinical resources in Afghanistan

The unavailability of skilled clinical human resources in Afghanistan is most acute in critical care, laparoscopic surgery, cardiac surgery, nephrology, urology, pathology, radiology, neurology, rheumatology, anesthesiology, oncology, endocrinology, forensic medicine and toxicology.

According to MoPH, the private or public sectors in Afghanistan currently provide only a few of these services. This has created significant community dissatisfaction with the health sector. Moreover, the lack of quality, specialized medical services in Afghanistan causes thousands of patients to seek healthcare abroad.

To address this, the HAA will support MoPH’s efforts to improve the specialized healthcare in Afghanistan:

- **Ongoing specialized residencies for recent medical school graduates**
  Annually, GDHR coordinates residencies for approximately 200 medical graduates in 21 specialties to work as residents within MoPH hospitals for three to five years. The HAA will continue this effort, with a focus on: General Surgery, Anesthesiology, Obstetrics & Gynecology, Pediatric Medicine, General Internal Medicine, Psychiatry, Ophthalmology, Adult Orthopedics, Adult Ear Nose and Throat (ENT), Stomatology, TB, Infectious Diseases, Pediatric Surgery, Chest Internal Medicine, Chest Surgery, Brain Surgery, Pediatric Orthopedics, Pediatric ENT, Pediatric Dermatology, and Urology. In December 2009, there were 1,141 trainees undergoing training, and 346 trainers, 449 of which were located in the provinces.

- **Expanding Residency Options for Specialization**
  In 2009, Kabul Medical University, through technical assistance and support from USAID, conducted four effective curriculum development workshops covering Internal Medicine, General Surgery, Pediatrics and Psychiatry. As a result of these curriculum development workshops, MoHE aims to create a future residency programs in their two teaching hospitals in these specializations.
Upgrading curriculum in 13 specializations according to international standards

Additionally, under this initiative 13 curricula currently utilized by MoPH for medical trainings will be upgraded according to international standards.

A two-day workshop in each specialization will be conducted, targeting 283 educators. These 283 trained educators will undergo accreditation by the WHO or other international organizations to receive certification that they are competent to train medical graduates in each of these specialties.

**Deliverable 2.3.5: To strengthen the capacity of specialized care within the nursing and technician workforce**

The IHSS is currently implementing a three-year general nursing training program Kabul and eight other provinces. The IHSS created a successful framework for providing general nursing training, and the HAA will supplement this general training with specialist in-service training. The IHSS three-year general nursing training has been successful, but nursing specialists are unbalanced, with understaffing in some areas while others are overstaffed. There are currently 3,651 general nurses and nursing assistants in Afghanistan, 15% of which are female; an additional 1,185 nurses are currently receiving training through IHSS and 63 graduates receiving a Bachelor’s degree in nursing will soon enter the market. However, MoPH estimates that this is still inadequate to meet the needs of the health sector.26

The MoPH estimates that approximately 400 anaesthetic nurses are needed within the health sector, showing a severe understaffing whereas approximately 1,382 laboratory nurses are required yet there is excess in this field with 2,044 trained technicians. Additionally, the capacity of nurses and technicians is limited, in part, due to the availability of training across the country. This, in turn, poses constraints on the quality of care offered at healthcare facilities. Training should be h divided between MoHE institutions, where higher-level degrees and post-graduate degrees are provided, and IHSS where pre-service diplomas, certificates, and in-service training can be obtained.

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26 MoPH estimates approximately 5,731 nurses are needed.
Within this context, there is a great need for specialised training of nurses in intensive care as well as for other specialities linked with the medical specialization curriculum. It is essential to upgrade the skills of existing nurses and technicians while simultaneously providing new courses for community nurses and medical technologists. The HAA will aim to upgrade in-service nursing and technician curricula and training in order to provide the services required, within three years.

The HAA will implement the laboratory technician curriculum recently approved by the Executive Board and develop curricula for other courses in order to provide in-service training through hospitals. Courses will be provided utilizing similar methods used to train resident doctors (blocks of training provided equating to 1.5 days a week for 47 weeks of the year, over the course of 2 years).

Curricula development will be undertaken in the first year, and the programs will be implemented in hospitals during years two and three. An estimated 1,267 staff will be trained in nursing, laboratory x-ray technicians, and anaesthetic technicians.

**Deliverable 2.3.6: To develop an accredited degree program for Biomedical Engineers, Medical Technologists and Environmental Health Officers**

The 2009 Workforce Plan prioritizes the need for additional staff with skills in bio-medical engineering, environmental health, and medical technology.

**Biomedical Engineers:**
There is currently no biomedical engineering program in Afghanistan. Although position descriptions for biomedical engineers have been developed and are envisioned to be supported through MoPH’s pay and grade system, these positions remain unfilled due to the lack of qualified applicants. This negatively impacts the maintenance of medical equipment resulting in the need to procure international contractors for repair or requiring the equipment be shipped overseas, a costly venture.

**Medical Technologists:** Medical Technologists are specialists in technical areas such as laboratory science, radiography, blood bank, and anesthesics.
There are 1,354 lab technicians in the public sector; 1,382 are required and 75 are trained annually. While there is an excess in the public sector, these technicians are often under-skilled. In other sectors like x-ray technicians, there is a severe shortage of staff. Currently, there are 219 X-ray technicians (while an estimated 645 are required to meet demands) in the public sector. 40 new technicians are trained a year, but MoPH deems their current training inadequate.

The expected results of this initiative include:

- 100 Biomedical engineers will be trained and deployed to 16 national hospitals, 5 regional, 28 provincial, and various district hospitals. Five will be deployed to the Radiology Institute, five (5) to the central workshop and 32 to provincial workshops of MoPH with the remaining 9 being employed in the private sector.
- 100 medical technologist students will be trained over the three years. Training through IHSS would be limited to training of technology assistants when graduates start to come out of this program, and to continuing in-service training.
Sub-Component 2.4: Community Base Health Care

To increase the numbers and capacity of community workers and field-based professional providers

**Anticipated Results:** It is anticipated that by Program Completion:

1. An increase by 400 Community Health Nurses working in 25 provinces
2. 1,000 new midwives trained to expand coverage to all public health facilities
3. Number of Community Physical Therapists is expanded by 200
4. 2,660 existing health workers trained to practice simple mental health interventions
5. Community health workers are expanded by 10,000, of which 5000 are female
6. Family health awareness improved by training 14,000 teachers who will deliver lessons to 3.7m school students

**Deliverable 2.4.1: To build the capacity and availability of Community Health Nurses in the Provinces**

The number of people using health facilities in Afghanistan has generally doubled in the past two years placing tremendous stress on the number of qualified nurses needed to meet the increased demand. Simultaneously, the availability of health service facilities has also been increasing with 18 Central Hospitals, 5 Regional Hospitals, 34 Provincial Hospitals, 56 District Hospitals, 374 Comprehensive Health Centers, 26 Multi-Purpose Centers, 679 Basic Health Centers, and 120 Sub-Centers.

Nurses are needed in each of these facilities as well as community-trained nurses at other facilities providing community outreach. MoPH estimates that 692 community health nurses are needed within the BPHS to meet the needs of the health sector. These are in addition to the general nurses required in hospitals.

The program aims to train 400 community nurses in 25 provinces using a newly approved two-year program, within three years. This will supplement the new Global Fund community nursing in eight provinces (training 300 nurses), bringing the total to 700 (just over the 679 initial requirement).
The HAA will support the MoPH’s efforts to establish a Community Nursing Program with a focus on prevention, home care, health education, and community care. The focus of this program will be on enhancing decision making, critical thinking and competency-based learning of nurses through integration of theoretical knowledge in clinical practice. The target beneficiaries of this program are nurses who will operate in community settings, through the BPHS.

Several steps have already been made towards the development of Community Nursing Program. A new community nursing curricula has been developed through a subcommittee of the Human Resource Taskforce (HRT), with the help of development partners. The curriculum was approved by the Executive Board. The program will utilize the Learning Resource Package, which has just been completed and is being piloted in one province. The Community Midwifery Program will provide a framework for implementation of this program.

A summary of the course curriculum is:

- **Year 1/Semester One**: Nursing I (Anatomy & Physiology, Health Assessment, List of Common Disorders; Fundamentals of Nursing; Pharmacology; First Aid; Infection Prevention; Mathematics; Applied Sciences) and Professional Development I (English, Computer & Religion); BCC-IPC.
- **Year 1/Semester Two**: Nursing II (Fundamentals of Midwifery; Anatomy and Physiology, Health Assessment and List of Common Disorders) and Public Health Nursing I (Home Visiting, Case Load Management; Vaccination, Tropical and Communicable Diseases).
- **Year 2/Semester One**: Public Health Nursing II (Essential drugs and its pharmacology; Disaster and disability management; community mental health). Professional Development II (Self awareness: Johari window; public speaking, health care ethics).
- **Year 2/Semester 2**: Public Health Nursing III (Epidemiology, Demography, Health Systems – referrals); Leadership and Management.

A **Community Health Nurse** is an especially prepared nurse employed in a community agency to safeguard the health of persons in the community, giving care to the sick in their homes, promoting health and well-being by teaching families how to keep well, and assisting in programs for the prevention of disease.
Deliverable 2.4.2: To increase the number of trained midwives to ensure full coverage for all public health facilities

In 2003, less than 10% of health facilities had a midwife. To date, the MoPH has trained 2,200 Community Midwives throughout Afghanistan. High standards have been achieved through the establishment of a National Midwifery Education Accreditation Board (NMEAB), whose mission is to promote the quality of education in midwifery through accreditation. NMEAB created standards and criteria for the education of midwives that reflect nationally recognized core competencies and guiding principles of the midwifery profession set by the MoPH/Institutes of Health Sciences.

Midwifery schools have been established since March 2002 and have expanded throughout the country with assistance of many development partners. Hospital Midwifery schools are functioning in Kabul, Helmand, Kandahar, Herat and Nangarhar. Community Midwifery schools are functioning in Badakhshan, Jawzjan, Takhar, Paktya, Parwan, Farah, Badghis, Bamyan, Khost, Logar, Baghlan, Wardak, Samangan, Saripul, Laghman, Nangarhar, Kunduz, Ghor, Zabul, Balkh, Daykondi, Faryab, Ghazni, Kunar, Nimroz, Nooristan, Uruzgan and Helmand. Surveys have shown that the Afghan program has had a significant impact on the reproductive health of women. International data shows a direct relationship between availability of skilled birth attendants and the reduction of child/maternal mortality. Access to community midwives, particularly in remote areas, has had a considerable impact on maternal health. MoPH estimates that 3,022 additional midwives are needed by the public sector with many more needed by the private sector. Ongoing funding is required to continue the midwifery training, which currently costs $15,000 per person for the two years of training. Since nurses and midwives are often the first contact for women and children on community level, it is essential that midwives and nurses knowledge is increased in terms of prevention of gender-based violence and related skills to provide response and care to survivors of different type of domestic or other abuse.

The program aims to extend the community midwifery program, by training an additional 1000 in established provincial midwifery schools, by the end of three years. It is expected that by the completion of the program, all public health facilities in Afghanistan will have at least one midwife. Moreover, many private facilities will have midwifery services available.
Deliverable 2.4.3: To increase the number of trained Community Physical Therapists to expand services in Mazar, Jalalabad, and Herat

According to current estimates, between 747,000 – 867,100 Afghans suffer from severe disabilities. In 2005, the National Disability Survey in Afghanistan (NDSA) was conducted with support from the Central Statistics Office (CSO). The survey is recognised as the most authoritative disability study in the country. The NDSA used random samples from all provinces of Afghanistan and found 2.7% of the population had severe difficulties in everyday functioning in one or more of the following areas: physical, sensory, intellectual, psychological or social. If less severe difficulties in functioning were included, the prevalence increased to 4.8%. 35% of those surveyed suffered physical disabilities, with over 46% suffering multiple physical disabilities (29% paralyses, 12% physical deformity and 12% being amputees). The next largest group found in the NDSA study was sensory disabilities with 25.5% of respondents suffering (3.4% visual impairments, 25.2% hearing impairments, 23% speech impairments and another 15.4% with speech and hearing impairments). The primary reason for physical disabilities in Afghanistan are war injuries (32.3%), accidents (19.6%) diseases like polio (16.4%), other congenital postpartum disease (17.2%), and mistreatment or violence (3.2%).

The NDSA study found that more than half of those with disability live in Central and Western areas of Afghanistan. At the provincial level, the highest prevalence rates are observed in Samangan (4.4%), Herat (4.1%), Kabul and Ghor (both 3.9%); the highest numbers are found in Kabul and Herat whereas the highest proportions of people with disabilities are found in the Southern region of the country. This is probably due to a combination of factors including: the ongoing conflict situation, lower access to health services than anywhere else in the country, scarce or no qualified health staff, and low level of literacy and access to education, especially for girls. At present the UN is supporting disability and rehabilitation through the Mine Action Coordination Centre of Afghanistan (MACCA).
MACCA has signed a MoU with MoPH to provide technical support aimed at increasing capacity to provide disability services within BPHS and EPHS and help establish mechanisms for mainstreaming persons with disabilities into health care systems.\(^{27}\)

As about 60-80% of people with disabilities live in rural and poor peri-urban settings, a Community Based Rehabilitation (CBR) strategy remains the most viable way of outreach to people with disabilities. Currently the majority of services are provided by NGOs. They have had autonomy in determining the location, nature and standard of service. However, there have been recent efforts to integrate disability and physical rehabilitation services at the BPHS level. The majority of existing rehabilitation programs have not been integrated into the health service programmes at any level financially or administratively, rather they appeared as clear-cut vertical programmes, although located at Community Health Centres or hospital compounds.

At present there are a total of 300 Physiotherapists trained by the donor-funded Physiotherapy Institute (PTI) in Kabul with two-year IHS-recognised diplomas, to work for a population of 25 – 30 million. Of the registered physiotherapists, about 275 are presently at work in their profession (74 in the public sector). The inclusion of rehabilitation services into the BPHS and EPHS packages create the challenge of scaling up training of professional rehab staff, in particular physiotherapists. Calculations made by the Disability Task Force indicate a minimum of at least 775 physiotherapists are needed. In order to be able to recruit in districts outside of Kabul, training must be decentralised to regions. Some decentralised training was completed in Jalalabad and Mazar-e-Sharif lately with good results for regional recruitment. However, lack of qualified female staff continues to be a big challenge, in particular in districts outside the largest cities. The HAA will implement community physical therapy in provinces as designed and approved by the Physiotherapy Institute, under the auspices of Institutes of Health Sciences, so that an additional 200 skilled physical therapists are functioning by the end of the three year. Given the current levels of donor financing, the Institute can currently only accept 20 people for the bridging course (which upgrades two-year to three-year training).

\(^{27}\) Much of this plan is detailed in the Disability and Rehabilitation Strategy (2010-2014), which was drafted by the MoPH Disability Task Force, but it is not yet approved.
There is capacity for IHSS, under its auspices, to provide the following:

- Increased provision of the one year bridging course, and implement it in additional locations to the current three of Mazar, Jalalabad and Herat serving an additional 100 students;
- Implement the three-year pre-service course in six locations, thereby accommodating 100 students;
- Alternatively, in locations where there are not enough students (year 12 graduates), an alternative would be to introduce a Physiotherapy Assistant Course (which could accommodate up to 100 students a year).

This should produce an additional 100 female and 100 male community physiotherapists for health facilities throughout the country.

**Deliverable 2.4.4: To build the capacity of existing health workers trained to practice simple mental health interventions**

Since 2005, mental health has become a priority for MoPH and was officially included in the BPHS. This first inclusion mainly focused on the medical treatment of mental health problems, including awareness and case detection. Experience has shown that this medical approach was not enough to ease the mental health burden of the Afghan population. The high rate (60-80%) of symptoms of stress, depression, anxiety, fear, panic and post-traumatic stress syndrome (PTSD) have underlying psychosocial stressors or are the result of traumatic experiences which cannot be approached and healed only by medication.

Long-term consequences of PTSD symptoms cause distortions of the family system and lead to severe related physical diseases as well as an increase in domestic violence and drug addiction. Coping mechanisms of the Afghan people and families who have experienced war, as well as loss of cultural and social identity, are eroded and became dysfunctional. Physical disorders are common and often misdiagnosed as not being related to PTSD. Different programs in the country have shown that the bio-psychosocial model and care could add significantly to understand and ease the mental health burden and help people to regain their psychological and mental well-being.
Health for all Afghans (HAA)

In 2009 the BPHS was revised to cover the medical approach to mental health problems as well as integrating psychosocial care. Mental health training materials, curricula and flowcharts for the referral system were revised and newly developed according to the integrated approach by the ‘Kabul Group 08’.

After piloting the psychosocial approach during 2005-2007 with 30 Afghan female and male counselors trained and over 11,000 patients treated, a second training took place in 2009. Those counselors work now in Bamyan, Mazar and Herat, in CHCs or close to CHC Health Facilities.

An assessment confirmed that psychosocial care helps to restore social and personal functions and psychosocial well-being and mental health. Additionally, physical complaints were significantly reduced through counseling rather than through the medical treatment of those problems. This means that effective and affordable treatment options are now available and that the training of the health staff in BPHS would significantly reduce the mental health burden of Afghanistan.

The crucial point is now the training of a critical mass of qualified health workers, with the skills and capacity to be used for the treatment of mental illness and psychosocial distress. It is necessary to ensure all Afghans have access to those mental health services and can receive the same quality of treatment all over the country. At the same time supportive supervision, and monitoring and evaluation of the services should ensure the quality of the mental health services. The HAA will aim to build a pool of national trainers for psychosocial counseling as well as for the medical approach. Quality criteria have been developed and will be closely followed. Those national trainers will be managed by the Mental Health Department of the MoPH. Training manuals have already been developed, with assistance of development partners, and approved by the Ministry for all levels of staff in BPHS; there is a learning resource package (LRP) for the National Trainers for MDs and nurses. Pilots have been conducted in a few provinces. Twenty-seven (27) Psychosocial Counselors (PSC) received training by Oct 2009, and another batch has completed training since that time. In-service training has also been conducted for other health professionals in mental health. A plan has been produced to implement the PSC program on a large-scale basis. The courses will run as successfully evaluated in the pilots.
The training for master-trainers and psycho-social counselors will be three months each, for medical doctors two weeks, and one week for other health workers. It is expected that by the program’s completion, around 60 mental health master trainers, 500 medical doctors, and 2,000 other health workers at health facilities (nurses, midwives, and community health supervisors) will be trained and able to practice simple mental health interventions in health facilities.

In addition, 100 psychosocial counselors will be trained (mainly ex-nurses and teachers, as in the pilot program), if the BPHS at that time allows their employment (this is currently undecided). In all, approximately 2,660 health workers will be trained in the three years.

**Deliverable 2.4.5: To increase the number of trained Community health workers to expand provincial health services**

Due to Afghanistan’s topography, thousands of villages do not have regular access to health facilities for basic health services. Much of the country experiences severe winters that causing roads to be blocked by snow and make travel to health facilities virtually impossible for up to five months of the year. The MoPH has been struggling since 2002 with the challenge of getting basic and lifesaving health interventions to remote villages, where maternal and child mortality remains extremely high.

The decision taken by the MoPH in 2002 was to train volunteer community health workers (CHWs) who would work out of health posts located in all the larger villages. The basic idea has been to train one male and one female CHW for each health post (preferably married couples), covering approximately 100-150 households. They are trained over a six-month period, which includes two months of classroom training and four months of practical work in their villages. The main focus is to provide simple interventions that reduce maternal and child mortality and impart key messages like handwashing with soap, early and exclusive breastfeeding, immunization, and delivery by a skilled birth attendant. They also are able to treat suspected pneumonia with co-trimoxazole, diarrhea with oral rehydration and zinc, and other problems that can be life-threatening. They treat simple conditions and refer when possible the more complicated cases.

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Note that this is a change from the proposal put to the Donor Conference. Due to the uncertainty of employing new psychosocial counselors the focus is now on in-service training of existing health workers.
Since 2002 more than 22,000 CHWs have been trained and deployed to more than 11,000 health posts in all 34 provinces. Currently these CHWs see about 70% of all family planning clients in Afghanistan (they provide oral contraceptives, injectable contraception and condoms) and they also see about 40% of all sick children. The under-5 mortality rate in Afghanistan fell by 25% from 2000 to 2006, and CHWs were believed to have significantly contributed to this reduction. CHWs are trained and supervised by NGOs who are implementing the BPHS.

Each health facility has one full-time Community Health Supervisor (CHS) to supervise and support all the CHWs in that facility’s catchment area (typically about 20-30 CHWs working out of 10-15 health posts). The CHWs also help mobilize their communities to participate in outreach activities (such as immunization), identify individuals and families needing services (such as pregnant women needing pre-natal care), and report monthly to the nearest health facility.

CHWs are having an enormous impact on health in Afghanistan and it is vital that they continue to work and to expand their coverage. Female CHWs are especially vital for child spacing, child health, and the health of pregnant and post-partum women. The MoPH has a unit whose sole responsibility is to support CHWs (they are known as the Community-Based Health Care Unit) and donors, NGOs, and international agencies working in Afghanistan all have made strong commitments to support the program. The MoPH, with the support of BPHS implementing partners, conducts the training. This initiative has been successfully implemented for over five years in Afghanistan with funding from three major donor groups (World Bank, European Union and USAID). With low levels of literacy in the villages, the importance of CHWs and the education and treatment they provide cannot be overestimated. Community-Based Health Care (CBHC) is the cornerstone of successful implementation and delivery of the Basic Package of Health Services (BPHS). International experience shows that CBHC has a significant impact on child and maternal mortality through curative and preventative interventions. With all the successes of this program, many villages still lack CHWs and desperately need them. The HAA will aim to expand the Community Health Worker Training Program by 10,000 (5,000 female and 5,000 male), recommended through the evaluation of the BPHS to work in Aid Posts, by the end of the three years.
**Deliverable 2.4.6: To improve Family Health Worker (FHW) program**

The MoE is currently implementing the Health School Initiative (HSI), which involves topics similar to those found in the CHW curriculum, but in a less comprehensive manner. The HSI program, which began in 2006, has been very successful, but this is limited due to the small number of provinces and districts it has been implemented in. MoE in concert with MoPH would like to expand this program to nationwide coverage with potential to yield enormous health and economic benefits over the long term.

It will train millions of Afghan schoolchildren in all schools in the 34 provinces, combining the most successful components of the training curricula of the HSI program with that of the community health worker program and adapt them for Afghan children.

It is envisioned that when the children complete their schooling, they will have practical skills that will equip them to lead healthier lives as adults and help provide a healthier environment for their children. While still in school, they can share what they learned with their families, thereby multiplying the benefits by improving health-related knowledge and behavior of their families. Consequently, the students will be recognized for what they have learned under this program, and will be designated family health workers (FHW) to distinguish them from the community health workers that work in the community. The FHW teaching will start from grade 1, and each subsequent year, the content and detail of the curriculum will increase. Trained teachers will follow up on the students’ performance on an annual basis. By the time the students graduate, they will become certified CHWs by learning all the relevant sections of the CHW curriculum. The only difference in the FHW and the CHW training is that the children will not be trained on how to treat diseases, nor will they have drugs to use and distribute. The initial phase will involve adapting the existing curriculum and materials for teachers and students, and contracting NGO partners that have experience as BPHS providers in pilot provinces.

The actual in-service training of 2,000 teachers in pilot provinces and pilot testing in approximately 800 schools will take place during the second year. Based on an impact evaluation, in the third year, work will begin on in-service training of 14,000 teachers in 5,600 schools, altogether covering more than half of the country in this phase.
In year three, the curriculum will be included in the regular teacher training program across the country to ensure integration and continuity of the program in the education system. During this period, more than 3.7 million students will be exposed to the FHW curriculum. In the second phase, which will start in year four, the program will be rolled out in the remaining parts of the country over two–three years. A specialized institution will be hired to provide technical support to a group of experts from the MoE and MoPH on the development of the curriculum and design of the program. They will develop and field test a revised curriculum for grades 1-12 which is based on the review of the HSI and CHW curricula. The implementation of the program will be contracted out to BPHS NGOs, with the Ministry of Education and the Ministry of Health playing a stewardship role (provide oversight, direction, contract management and assuring compliance, setting standards, conducting assessments) rather than a direct implementing role.

By the end of the first phase, in three years, 16,000 teachers in 6,400 schools will receive in-service training in the new curriculum and be motivated to implement the curriculum effectively in the classroom.
Sub-Component 2.5: Health Promotion and community empowerment

To support health promotion and community empowerment

**Anticipated Results:** It is expected that by the program completion:

1) Implementation of the BCC Project in all 300 Districts of Afghanistan.
2) Completion of a framework for the adaptation of the BCC Project in Urban Environments.
3) Revitalization of the BCC project in the 365 districts covered in the initial pilots.
4) Increased capacity of the Health Promotions Unit to implement and expand initiatives.

Afghanistan ranks among the world’s countries having the poorest health statistics, with 191 out of every 1000 children under the age of 5 dying and a maternal mortality ratio at 1,600 per 100,000 live births. Due to the severity of these statistics, the Ministry of Public Health’s Strategic Plan (2011-2015) has identified the reduction of child and maternal mortality as two of its top priorities. Similarly, improving the health status of women and children in Afghanistan has also been cited as being one of the most pressing issues facing the country according to the *Afghanistan Millennium Development Goals Country Report 2005-2020*.

The reduction of maternal and child mortality will require a multi-dimensional approach involving both the GIRoA as well as internal changes within the general population. Key to the achievement of this ambitious goal is providing the general population with the knowledge and skills required to enable an attitude and lifestyle change through healthier practices. Through a comprehensive communications strategy consisting of public awareness campaigns, training and social mobilization, the Health for All Afghans program will support the Health Promotions Department of the MoPH in its efforts to empower communities with the knowledge and skills necessary for a healthier lifestyle, reducing child and maternal mortality.
Deliverable 2.5.1: The capacity of communities to initiate and implement activities that promote their health is strengthened

The Healthy Promotions Department piloted a project funded by UNICEF, known as the Participatory Learning and Action (PLA)/Behavioral Change Communications (BCC) Project from October 2007 for one year period. The aim of the project was to empower communities, giving them the knowledge and skills required to live healthier lifestyles, thereby reducing the child and maternal mortality rate. The BCC methodology relied upon a holistic communication approach utilizing multiple mediums like local media, leaders, teachers, community health workers and women’s associations to communicate messages with members of the community.

The pilot PLA/BCC project implemented a two-phased approach based upon the Precede-Proceed Planning Model:

Phase I: Beginning with data collection (demographics) of both the primary and secondary (those that will support/reinforce the intended behavior change) audiences within the community. Following data collection, a community map is created.

Phase II: The second phase of the intervention is to introduce evidence-based and culturally sensitive behavior change strategies. This is accomplished through the execution of a 3-day training workshop for 50 community members (men and women and the Family Health Action Groups (FHAs)) and the 4th day of the workshop was for formulation of village Health Committee (VHC)), who are designed to support community health workers through monthly meetings with community members to review key messages regarding the 9 behaviors. During these meetings, Information, Education and Communication (IEC) materials would also be distributed.

This pilot project targeted 9 behaviors29 and was implemented in 6 districts of 6 provinces (Kandahar, Heart, Nagarhar, Parwan, Bamyan and Balkh).

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29 The nine healthy behavior which were targeted in the pilot and second phase of the project are: (1) Parents enroll children, especially girls, in school and ensure they complete basic education. (2) Mothers initiated breast-feeding within one hours of birth, practice exclusive breastfeeding during the first six months of the baby’s life, introduce complementary breastfeeding at 6 months of the baby’s age and keep up the breastfeeding until the child 12 years of age. (3) Parents & caregivers register the birth of their child, get children fully immunized and monitor growth of children regularly. (4) Manage diarrhea with continued
In 2007, a Knowledge, Attitude and Practice (KAP) survey was conducted by the Indian Institute of Health Management and Research (IIHMR) and the Afghanistan National Public Health Institute (ANPHI) Research Directorate of the MoPH. The results reflected a significant improvement in targeted healthy behaviors.

Based on the outcome of this KAP survey, MoPH and UNICEF decided to expand and implement the BCC project to 1950 villages in 39 districts (50 villages/district/ year) of 10 provinces (Kabul, Nangarhar, Heart, Panjshir, Parwan, Balkh, Bamyan, Badghis, Hilmand, Logar) provinces by UN-Habitat, BRAC, CHA and Health Promotion department and focused on the facilitation and empowerment of communities. The expansion of this project occurred from 2010-2011; similar to the original pilot, this project showed improvements in targeted healthy behaviors but has since been discontinued to funding shortfalls.

The HAA will support the MoPH’s efforts to restart and continue the success of the PLA/BCC Project through its expansion into all 34 provinces of the country. The Health Promotion Department plans to restart this program simultaneously in all 34 provinces through the recruitment of a provincial manager who will be responsible for the implementation of the BCC/PLA project in 20% of the districts in each province the first year, then gradual expansion into additional districts each subsequent year. Subsequently, six service providers will then be recruited in each district to serve as a focal point, planner and social organizers. The criteria for the selection of districts has yet to be determined, but will be based on criteria utilized in the 2006 pilot project and may include accessibility of MoPH staff to the district, security and whether or not health staff are already located in the area.

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(5) Caregivers and children wash their hands with soap at critical times. (6) Families keep infants warm, recognize signs of ARI and seek timely referral. (7) Families recognize danger sign in pregnancy and use skilled birth attendants for delivery. (8) Families consume iodize salt in their daily diet. (9) Families habitually use sanitary toilet in their daily life.
Deliverable 2.5.2: The capacity of MoPH and health sector staff to effectively promote healthy behaviors in communities.

The GIRoA, with the support and cooperation of the international community and national non-governmental organizations, has been focused on improving the health situation since the fall of the Taliban in 2001. Incorporating both lessons learned from Afghanistan as well as other countries with regard to effective methods of health promotion and the prevention of illness, the Health Promotions Department seeks to facilitate workshops and working groups to analyze reports, promote evidence-based health promotions and services.

Key to providing promoting health living habits and providing effective services is through the increased capacity of staff to communicate with communities. In accordance with the National Health and Communications Strategy, the Health Promotions Department is seeking to train health care staff and provide them with interpersonal communication and counseling training as well as the knowledge and skills to effectively distribute and education communities in health living habits through the distribution of Information, Education and Communication (IEC) materials. Currently, the Health Promotions Department conducts training, funded through the HSSP and HSS Program, in interpersonal communications and the production, distribution and proper utilization of educational materials. Utilizing a ToT model, master trainers are expected to travel to provinces, conducting basic training and monitoring workshops. However, this is insufficient to meet the demand and the Health Promotions Department intends to expand this program.

Additionally, the Health Promotions Department increases capacity through communicating lessons learned and best practices to health care staff throughout the country through the publication and distribution of the Roghtia Magazine. This magazine is published on a quarterly basis and provides health care staff with information on treatment and control of diseases, infection and best practices among health care providers. Currently, the Health Promotions Department prints and distributes approximately 7,000 copies of the magazine each quarter and distribute to each healthcare facility throughout the country.
However, the distribution is insufficient and the department is seeking to expand production by 3,000 to ensure more copies are provided to facilities. In addition, to conduction of capacity building workshops, in order to update health personnel throughout the country, HPD is publishing Roghtia Magazine on quarterly basis, each issue consist of 40 pages, print out 7000 of each issue per quarter and distribute them throughout the country to equip and update health staff on knew knowledge and information.

There is an identified need to expand and strengthen the magazine as there is currently only one person serving as Chief Editor for Roghita; the Health Promotions Department is seeking an assistant for writing, editing and translation.

**Deliverable 2.5.3:** *The evidence base on health-related knowledge, attitudes and behaviors and effective strategies that promote and support positive health behaviors/healthy lifestyles in Afghan communities are expanded.*

The KAP surveys are utilized in order to identify the daily habits of communities, taking into consideration the local context and knowledge of inhabitants. The last KAP survey was conducted by the MoPH in March 2010 and indicated the success of the BCC Project. This format of survey is designed to target and identify the cultural norms and demographics of a specific area (i.e. local village or community) from which community interventions like BCC are tailored and developed. However, smaller-scale KAP surveys and numerous other format surveys are conducted throughout Afghanistan, such as the National Risk and Vulnerability Survey (NRVA), Afghan Mortality Survey (AMS) and others, are also conducted throughout the country by implementing partners. The Health Promotion Department has been assigned to identify all of the surveys conducted in Afghanistan in order to conduct an analysis and identify gaps in interventions specifically designed to advocate for behavior change. To coordinate this effort, the Health Promotions Department is developing a ToR for the creation of a Health Promotions Task Force (expected to be fully functional in March 2012).
Membership in this task force will include one member from each department within the MoPH, UN Agencies (WHO, UNICEF, UNFPA, etc.), NGOs who took part in the BCC/PLA Project, MoE, and Ministry of Hajj and Religious Affairs. The task force will meet on a monthly basis and its objectives will include:

1) To review and revise and implement health promotion/communication national strategies for MOPH.
2) To formulate strategic direction and synergize efforts for community involvement.
3) To review and revise communication protocols, standards, guidelines, educational materials and streamline promotion interventions within the country amongst different partners and counterparts.
4) To review and regulate KAP surveys to identify national trend of behavior changes of the community especially toward health.

The Health Promotions Department anticipates the approval of the ToR at the beginning of March.

**Deliverable 2.5.4:** Clear, simple and understandable health education messages are designed for communities to facilitate the integration of community health workers into pre-service and in-service education.

The diverse nature of Afghanistan requires a proactive approach in preventing the outbreak of illness and promoting a healthy lifestyle. The Health and Nutrition Communication Strategy of the Health Promotions Department is dependent on the tailoring of the basic public message to the individual community – taking into consideration cultural norms and demographics. However, multiple departments and units within the MoPH also have and conduct public awareness campaigns which promote healthier living. In order to avoid duplication of efforts and ensure synergy, the Health Promotions Department is seeking to develop guidelines and standardize materials utilized for public awareness campaigns and Information, Education and Communication materials.

The first step in developing these guidelines is to identify the breadth of information, materials and initiatives within the MoPH.
Through the creation of an issue-based sub-committee (answerable to the Health Promotions Task Force) who will be responsible for collecting and inventorying all messages and information on the specific issue and analyze it to determine if it is consistent with current strategies or policies and if there is a duplication of efforts.

Secondly, the sub-committee will then determine, through consensus, whether or not the materials are “simple” based on usage of language, pictures (to communicate to the illiterate in a population) and accessible. Messages will then be altered accordingly and provided to a test group in Kabul. Finally, the revised messages will be presented to the Health Promotions Task Force for approval and usage.

**Deliverable 2.5.5: Monitoring and evaluation of health communication activities are supported**

One of the key advantages to the BCC Program is its ability to tailor the messages to the account for the targeted local community. However, in order to collate all of the data from across different locations, analyze it and make broader analysis and incorporation into training, it is necessary for the development of a database.

The Health Promotions Department, in close coordination with the HMIS Department of the MoPH and HSSP/USAID, developed a database and associated protocols and procedures to efficiently and accurately collect and store data on monthly basis. The HPD hired a database officer with financial support of HSS/GAVI and technical support of HSS/USAID and HMIS department of MOPH for carrying out the data entry record keeping. With the coordination and creation of a database to efficiently store information, the Health Promotions Department is seeking to expand their capacity to effectively monitor programs and facilitate the collection of accurate data. Through coordination with the GDHR, the Heath Promotions Department is in the process of identifying human resource requirements – initial indications are that a project coordinator for activities controlled by different implementing partners, two advisors to support the development of guidelines, training manuals and creating monitoring checklists, additional staff to collect data and design new IEC materials, and trainers are required.
In addition to the creation of a database to effectively store data and the increased capacity to monitor programs, the Health Promotions Department, in coordination with the Health Promotions Task Force, will oversee an exercise to standardize current priority indicators. Currently, there are a limited number of standardized indicators used for the accurate collection of data that will effectively indicate whether or not health promotion interventions, specifically the BCC project are having an impact.

**Deliverable 2.5.6: Non-communicable diseases prevention and awareness Project for Afghanistan (NCD-PAPA)**

Prevalence of Non-Communicable Diseases (NCD) is, rising at an alarming rate; according to the Afghanistan 2010 mortality survey about 35 percent of all deaths in Afghanistan are due to non-communicable diseases, while about three in ten are due to communicable diseases and infections. Risk factors for non-communicable diseases are lack of physically activity, unhealthy diet, and tobacco. Policies and regulations for health-promotion to build an enabling environment is not in place. By this project we will raise the awareness of Afghan people regarding the risk factors of NCD in order to reduce the incidence of non-communicable diseases.
Sub-Component 2.6: Evidenced-Base Decision Making

To enhance evidence-base decision making by establishing a culture that uses data for Improvement

*Anticipated Results:* It is expected that by the program completion:

1) Legislation that addresses healthcare information security and patient confidentiality is drafted and submitted to the Ministry of Justice/Taqnin.
2) Capacity and awareness of monitoring, evaluation, research and data usage for performance measurement and evidence-based policy making and planning are built within MoPH and among implementing partners
3) Data collection and use in the healthcare sector is standardized and strengthened
4) An information technology warehouse is established that supports a centralized health data management system
5) Coordinated governance over health statistical information is established between the public and private sectors

The MoPH, in its National Health Information Systems (HMIS) Strategic Plan (2009-2013), identified the need to ensure the availability, coordination, management, distribution and use of accurate, reliable, and user-friendly health information via a number of activities. This includes the routine collection of health information through the HMIS, Surveillance, as well as program monitoring and evaluation.

The HAA intends to enhance the quality and appropriateness of data and information provided to MoPH policy makers and program/project managers to support informed and timely decision-making and policy development. It will also assist in making rational and equitable decisions on resource allocation in the health sector. This strategy increases transparency and accountability in the health sector and makes health services and their impacts more transparent to the people of Afghanistan, and other stakeholders including: the media, government, donors, service providers and technical agencies. The MoPH recently completed a significant revision of the National HMIS. The next phase of development is the effective analysis, dissemination and utilization of data and information across all tiers of the health sector, which will be supported under the Health for All Afghans Program.
An Integrated Database or Data Information System: Currently the MoPH health information system (HIS) databases are at the level that allows departments to easily search and extract data from their own databases or to do other queries using a common link. The HAA will support the MoPH’s efforts for a fully integrated and operational database that will be accessible for decision makers and program managers to support evidence based decisions.

The MoPH Executive Board determined that the MoPH HMIS Department would oversee the MoPH databases, in addition to providing technical expertise to establish standards and procedures that ensure better consultation, coordination, development and supervision of the MoPH databases. The MoPH HMIS database is the “common” database through which other departmental databases interact with the core system. The MoPH HMIS Department is to take the technical lead in facilitating database development. The establishment of a data warehouse to assist with the development of a dashboard report is one of the core activities of the MoPH HMIS Department for 2012. This is consistent with the continued development of the HIS as documented within both the HIS Strategic Plan and the more recently developed MoPH Strategic Plan. In addition, the hospital medical records system utilizes the MoPH’s HMIS data collection systems to guide management decisions and the objective of the Health for All Afghans Program over the next two years is to expand the successful piloting within three hospitals nationally.

In order to ensure the appropriate and consistent development of IT infrastructure and policies both the MoPH IT and HMIS Department will continue to work closely with the Ministry of Communication and Information Technology (MCIT). With the technical assistance and support of Aus-AID, a draft ICT Infrastructure Strategic Plan for 2012-2017 has been prepared and circulated among stakeholders for review. The ICT Strategic Plan has articulated a number of initiatives that need to be taken to extend the ICT infrastructure to the Provincial Public Health Directorates and further improve the ICT infrastructure deployed in the MoPH to improve the use of data and information, an enabling decision making environment based on trust and accountability needs to be created. Under the HAA Program, the MoPH will develop and roll out a manual across the health sector that will strengthen the ability of managers and health service providers to analyze data and information more effectively so that evidence based decisions can be made to reduce the burden of disease.
This in turn will strengthen the quality, consistency and content of reports to donors and other key stakeholders and the relationships between the GCMU and the PHOs and their directors.

**Deliverable 2.6.1: Relevant legislation is developed that supports improved reporting and confidentiality of essential health data**

Legislation and regulation are particularly significant in relation to the ability of the national HIS to draw upon data from both the private and public health services, as well as non-health sectors. Particular attention to legal and regulatory issues is needed to ensure that non-state health-care providers are integral to the national HIS, through the use of accreditation where appropriate. A legal framework can also define the ethical parameters for data collection, and information dissemination and use.

At present the MoPH has no clear plan for the capturing of health service data from the private health care sector and there is no clear direction on the monitoring of the quality of services provided by the private sector. In addition, there is no legislation to govern the collection and use of sensitive patient or client health information from either the public or private health sector or with regards to the confidentiality of health information. The 2009 HMIS Strategic Plan identified that there is little relevant legislation covering the aspects of private sector data and confidentiality and that the private sector health providers are not systematically inventoried or tracked. The HAA will support the MoPH’s efforts to govern the registration of private sector providers, to develop an inventory database of health care providers, to develop the systems and process needed to monitor and track those providers working within the private health care sector, and to develop a management information system to capture private sector financial, administrative, human resource and clinical information.

**Inventory Database of Health Care Providers:** In order to set standards and regulations on the private sector, HMIS will first attempt to “inventory” the private sector through private sector registration.
Currently, registration of private facilities is *ad hoc* and not enforced. When conducting surveys, the MoPH staff currently registers private practices through a handwritten form.\(^{30}\) HMIS is attempting to change this through giving each facility a unique ID number that is input into a computer system. The PPP Department and the Private Sector Assembly will be responsible for overseeing and enforcing registration of these facilities.

The plan for private sector registration has been drafted and is currently waiting funding. The system will be piloted in Kabul for six months then an initial analysis on the success or failure will be conducted before this is expanded to the provinces.

The HMIS Task Force – comprised of HMIS Department, M&E Directorate, UN agencies, and implementing partners – was established in January 2006 to develop data management systems, develop and conduct training modules, and further the awareness of the need to establish legislation regarding health information. The HMIS Task Force currently meets monthly, and will explore legal and regulatory options to support health care information security and patient confidentiality, and to ensure the adequate registration of private sector providers.

**Deliverable 2.6.2: Capacity and awareness are built on monitoring, evaluation, research and data usage for performance measurement and evidence-based policy making and planning**

Afghanistan lacks the capacity to effectively gather and analyze data for utilization across the health sector. Much of this is due to the recent history and conflict within Afghanistan, which has destroyed the scientific community and culture of data analysis. Furthermore, while the focus of the health sector has been on service delivery, much of the metrics gathered have been for reporting mechanisms to the international and donor community – not necessarily for the use by the MoPH. In order to ensure the highest quality of healthcare services, the MoPH, through the HMIS Unit, is supporting efforts to build the capacity to capture, store and analyze data. By increasing the capacity within MoPH and its implementing partners, the HAA will support MoPH’s efforts to:

- Strengthen the research and analytical skills of selected health professionals at the central and provincial levels to enhance the monitoring of health sector performance;

\(^{30}\) In Kabul, HMIS officers will request that private practices fill out a handwritten form for submission.
- Improve capacity of targeted MoPH staff at the central, provincial and facility levels to ensure a consistent approach to M&E and the use of health sector data and information for evidenced based decisions; and
- Improve the collection of relevant, complete, timely, and accurate data.

The HIS Strategic Plan identified that there is inadequate human resource capacity for pooling data and developing analytic reports. The HAA aims to address the capacity gaps within the public healthcare system in Afghanistan to develop implement and report rigorous and sound research.

(1) **Strengthen the research and analytical skills of selected health professionals at the central and provincial levels to enhance the monitoring of health sector performance.**

The HAA will support the MoPH’s efforts to increase the capacity of its staff through targeted on-the-job training and technical assistance. Under this Program, the HMIS Unit will coordinate and facilitate training programs to improve the analytical and research skills of key health sector staff to design, implement and report health research projects.

**On-the-Job Training**

<table>
<thead>
<tr>
<th>Training Area</th>
<th>Training Focus</th>
<th>Target</th>
<th>Duration</th>
<th>Training Outcomes</th>
</tr>
</thead>
</table>
| Analytical Skills Development        | • Reviewing and understanding data  
• Report development 
• Basic statistics  
• Basic epidemiology | Central Level  
Central Level  
80 MoPH staff  
70 HMIS + Research Departments  
150 Total training participants | Monthly  
2-3 days | • Staff able to analyze data  
• Staff able to write a brief technical |
| Research Design & Implementation     | • Qualitative research methods and tools  
• Quantitative research methods and tools  
• Data management and quality control  
• Team development and budgeting  
• Time management  
20 training participants from the HMIS, Research and M&E Departments | Annual  
2 weeks | • Stronger design application of research design  
• Staff able to ensure collection of reliable accurate and timely data |
| Basic Statistical Software and Analytical Tools | • EPii Info  
• SPSS  
• STATA  
5 HMIS Department  
5 APHI Directorate  
5 M&E Directorate | 15Total training participants | Annual  
4 weeks | • Increased understanding and usage of EPii Info, SPSS, and STATA statistical software tools |

The training and technical assistance will be externally sourced to develop the training modules, implement the training, and evaluate the effectiveness and impact of these trainings on the selected MoPH staff.
(2) Improve capacity of targeted MoPH staff at the central, provincial and facility levels to ensure a consistent approach to M&E and the use of health sector data and information for evidenced based decisions.

An evidence-based decision is an effective management tool to make well-informed decisions as opposed to relying upon intuition or political influences. In 2012, the HMIS Department developed a *Use of Information for Evidence Based Decision Making* Manual. The guide describes the steps involved in data collection, analysis, interpretation, planning, decision making, monitoring, evaluation and supervision and reporting.

The purpose of this guide is to assist all health service providers to better understand and to develop skills to be able to interpret and analyze data, results and information, identify abnormal trends and make decisions on how best to implement corrective actions to improve health outcomes.

While each Department within MoPH has staff dedicated to the monitoring and evaluation of programs and projects, there is not a consistent approach to the M&E methodology. The Health for All Afghans Program seeks to increase capacity within the health sector by rolling out the manual. To increase capacity within MoPH, the HAA will support the HMIS Department’s efforts to develop a comprehensive MoPH training program that targets key MoPH personnel at the central, provincial and health facility levels. The training program will seek to increase the capacity of MoPH staff, first through targeted training of HMIS Officers throughout the country then, utilizing a cascade model of training, this information will be passed on to other MOPH staff.

Use of Information for Evidence Based Decision making training can be divided into two levels – comprehensive training and basic. The comprehensive training is one-week in length and targets the train the trainers, while the basic training is one to two days in length and targets those who require a brief introduction to the concepts. Under the HAA, the HMIS will host two national workshops in March and April 2012 to provide comprehensive training. The national workshops will target all HMIS officers (approximately 150 people) on the proper usage of data. This will include information on conducting and analyzing surveys, different databases and other tools available.
M&E and Reporting Training of Trainers (ToT) and Cascade Training

<table>
<thead>
<tr>
<th>Training Area</th>
<th>Training Focus</th>
<th>Target</th>
<th>Duration</th>
<th>Training Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Master</td>
<td>Data Usage</td>
<td>75 HMIS Officers</td>
<td>Annual 1 week</td>
<td>• Increased proper use of data</td>
</tr>
<tr>
<td>Training</td>
<td>• Different sources and types of data</td>
<td>75 Implementing Partners, Research and M&amp;E</td>
<td></td>
<td>• Enhanced policy and decision making skills</td>
</tr>
<tr>
<td>**Training</td>
<td>• Using data for target setting, monitoring planning and budgeting</td>
<td>Departments</td>
<td></td>
<td>• Responsive program and budget development</td>
</tr>
<tr>
<td><strong>Focus</strong></td>
<td>• How to train others on using data</td>
<td>150 Total training participants</td>
<td></td>
<td>• Ability to write a brief technical report</td>
</tr>
<tr>
<td><strong>Data Usage</strong></td>
<td>• Introduction to Data Quality and how to ensure it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Data Quality</td>
<td>• Team development and budgeting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting</strong></td>
<td>• How to report data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Target</strong></td>
<td>• What to report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Frequency of reporting</strong></td>
<td>• How to report data</td>
<td></td>
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Following the two national workshops, HMIS officer will return to their provinces and be responsible for providing basic training to one to two staff members in each of their facilities. The national level workshops (ToT) and cascading model of training will go far in addressing the short-term requirements of staff.

(3) Improve the collection of relevant, complete, timely, and accurate data.

HMIS performance is defined as improved data quality and continuous use of information. The previous section focused on the use of data and information for evidenced based decision making. This component of the strategy focuses on improving the collecting, collated and reporting of data across the health sector.

Data quality is further described in four main dimensions including relevance, completeness, timeliness and accuracy. In an effort to manage the quality of healthcare services in Afghanistan, HMIS has developed a checklist of quality assurance indicators, currently based on key indicators within the BPHS system. Provincial sub-committees are responsible for overseeing and conducting this check on a monthly basis, with an annual review of the quality of the data being collected.
Provincial HMIS Officers will then provide site visits to selected facilities to confirm the quality of data being collected. All data is submitted to HMIS Headquarters in Kabul for analysis. Piloted in three provinces this year, HMIS has had an opportunity to analyze the initial tranche of data and improve the checklist.

**Training Workshops on Utilization of Data and Data Integration into Planning**

<table>
<thead>
<tr>
<th>Training Area</th>
<th>Training Focus</th>
<th>Target</th>
<th>Duration Location</th>
<th>Training Outcomes</th>
</tr>
</thead>
</table>
| HMIS revised procedures and manual | ▪ Case definitions  
▪ Reporting formats and timelines | ▪ 3 persons training team from Kabul  
▪ 20 participants per province, of which 5 from outlaying districts | Annual  
5 days / training  
34 provinces | ▪ Revised case definitions clearly understood by participants  
▪ Reporting formats and their requirements clearly understood  
▪ Reporting timeframes clearly understood |
| HMIS data base training manual and procedures | ▪ Data entry and usage  
▪ Data quality and integrity | ▪ 3 persons training team from Kabul  
▪ 20 participants per province, of which 5 from outlaying districts | Same | ▪ HMIS Officers can enter and extract data into and from the HMIS data base. |
| HMIS data quality | ▪ Data quality and integrity  
▪ Practical application exercise to conduct an assessment of 4 indicators | ▪ 3 persons training team from Kabul  
▪ 20 participants per province, of which 5 from outlaying districts | Same | Participants are able to implement and analyze the results of the data quality assessment |

**Deliverable 2.6.3:** To develop an information technology (IT) infrastructure within the MoPH to support the health information system (HIS)

The Health Information System (HIS) is supported by a number of Departments within the MoPH, including the HMIS Department, which is primarily responsible for the collection and reporting of routine information. The HMIS Department is also developing and integrating reporting systems for tuberculosis, malaria, human resources, and finance. The Afghanistan Public Health Institute (APHI) is responsible for the reporting of surveillance information and the coordination of new research. The M&E Directorate is responsible for the coordination of national complex impact surveys. These departments come under the broad umbrella of the HIS.
In an effort to standardize methods of data collection and management, it is necessary to have an efficient IT infrastructure in place. Under the HAA Program, the MoPH anticipates establishing a web-based IT data warehouse that will store all data collected. A data warehouse is a central repository for all or significant parts of data collected by a health system. Data from various applications and other sources is selectively extracted and organized on the data warehouse database for use by analytical applications and user queries.

The significant parts need to be relationally linked for easy access from a dashboard by health service providers. Using web-based technology when technically available and appropriate hastens the speed at which information can be collated and disseminated. The establishment of a data warehouse to assist with the development of a dashboard report is one of the core activities of the MoPH HMIS Department for 2012. Currently the MoPH HIS databases are at the level that allows the Executive, Director Generals and Department Managers to easily search and extract data from their own databases or to do other queries using a common link.

The servers will be housed in Kabul at an established facility either at MCIT or within the MoPH and the aim is to create an intranet site for MoPH by December 2012. An intranet site or MoPH Web Portal will be strongly integrated with MoPH databases for content availability.

The Portal will evolve and grow over-time to become the point of access for internal and external stake holders into the ministry’s various systems and service offerings.

**Cyber Security Plan:** Currently, the IT capacity varies within the both the MoPH healthcare system, with different departments utilizing different programs and differing levels of cyber-security. Each MoPH employee will have a logon with specific permissions depending on where the employee works and the level of knowledge and experience that will be necessary for him or her to access. Provincial staff will only have the ability to input data. Designated MoPH senior management in Kabul will have the highest level of access; all access will be monitored and overseen by HMIS.

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**Management Use of a Web-Based IT Data Warehouse**

The *dashboard report* is a report to senior management that provides an at-a-glance perspective on the current status of a project or program in the context of predetermined metrics. A dashboard is a visual display of the most important information needed to achieve one or more objectives.
A comprehensive Cyber Security at a minimum requires the following:

- Implement Intrusion Detection and Prevention systems at points where MoPH network is exposed to the Internet.
- Implement Workstation Endpoint Security – This will allow IT staff to ensure that individual PCs’ can be “locked down”, thereby decreasing their vulnerability.
- Commit to ongoing security training for IT staff – this will ensure that staff maintain an awareness of emerging security threats and learn to implement the strategies required to defend against those threats.
- MoPH shall filter and monitor staff’s Internet usage to ward off low productivity and the security of the network. Internet is notorious for hosting malware and many websites contain content that attracts numerous visitors and this attribute makes them the ideal medium for spreading malware

To further maintain security and consistency, MoPH created a set of protocols and recordkeeping classifications, which have been piloted in three hospitals in Kabul at the end of 2011. Following the completion of the six month pilot program, a review team will convene to analyze the results of the protocols and recordkeeping classifications to determine if the program was successful and whether or not it should be expanded to other facilities.

The information stored in computer files needs to be protected and safeguarded. Security breaches can be avoided up to the maximum possible extent by employing a two-tier strategy.

- First, is to shore up the weak links in the systems and procedures with either technology or eliminate them completely.
- Second, penalties for the various levels of security breaches need to be introduced, documented and enforced in the MoPH.

Access control implementation throughout the MoPH coupled with biometric identification of the employees can ensure physical security of the more sensitive areas. Studies show that 60% or more of "impact events" where critical missions have been compromised are associated with human activity. For this an ICT Security Section needs to be created within the Ministry, which will be responsible for the over-all ICT security of the MoPH, PPHDs, Hospitals and other health units.
**Deliverable 2.6.4:** Strengthen governance in the health sector related to statistical information

Managing results is accomplished by availability of quality information, presence of a governance structure, and accountabilities built in the system and with the target population.

The MoPH is slowly building the national health system while facing many challenges in the coordination and sharing of responsibilities and the decentralization of health system functions among the central government, NGOs and provinces in providing services and regulating quality of services.

Under Component 3, Section 6.2 above, a strategy to improve the use of information for evidence-based decisions was discussed. Identified below are two structures to facilitate better coordination between the implementing partners and the Provincial Health Officers to improve the governance of the health sector.

To strengthen the reporting of information at provincial level, the HMIS Department will work closely with the Provincial Public Health Committee. The Provincial Public Health Committee is comprised of BPHS and EPHS implementing partners, Provincial Public Health Officers, UN agencies and representatives from the provincial governor’s office, who meet on a monthly basis to discuss their achievements, challenges and raise issues through a report which is submitted to MOPH.

At present there needs to be better representation of the HMIS Officers on this committee to provide quality HMIS data so that decisions can be made to improve poor performing health programs.

The HMIS Department will also support a robust performance measurement system for Results Based Financing (RBF). The RBF initiative aims to measure the performance of healthcare workers and assess the quality of service.
Through a “treatment and control” method of providing incentives to healthcare workers and strict regulation of activities, this program aims to increase the quality of overall care. Since 2010, the RBF initiative has focused on improving the quality and quantity of health care through incentive-based financing based on pre-established measurements of results and success in service providers. The RBF initiative is currently implemented in 15 provinces.

The HAA will support efforts to study the impact of this RBF initiative by conducting a final household survey in 2013 to evaluate the impact of the RBF initiative and to improve the healthcare services.
Sub-Component 2.7: Advocate for and Promote Healthy Environment

To advocate for and promote healthy environments

**Anticipated Results:** It is expected that by the program completion:

1. Increase capacity within the Environmental Health Unit to oversee implementation of the National Environmental Health Strategy.

2. Increased coordination within the MoPH and development partners to ensure synergy of efforts.

“Creating Supportive Environments” is one of the key strategies identified at the First International Conference on Health Promotion to take action to improve population health.” The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. […]

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.” Currently, the general population has a low understanding of environmental health issues and its relationship to death and illness.

Additionally, the absence of food handling licensing, policies, standards and regulations designed to protect workers is compounded by the lack of food service outlets and contribute to environmental health issues faced in Afghanistan. At the governmental level, there are a number of other challenges including a lack of technical guidelines and financial resources, low technical and managerial capacity of staff, limited data and a lack of capacity within occupational health and strategy. These issues are further complicated by the insufficient coordination among the relevant stakeholders.

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31 Ottawa Charter for Health Promotion, 1986, pp. 2-3
MoPH, recognizing the urgent need to address environment health issues, have developed a comprehensive approach to improving the health environment of Afghanistan.

By increasing the capacity of MoPH in relation to environmental health, then targeting specific areas within the purview of the Environmental Health Directorate, such as ensuring safe drinking water, Environmental Hygiene, House and Urban Hygiene, Occupational Health and Safety (OHS), Food Safety and Radiation Protection/Safety, the HAA will support MoPH’s efforts to improve the environment in Afghanistan, ultimately reducing illness and death, specifically among infants, children and mothers.

**Deliverable 2.7.1:** *To strengthen the stewardship role of MoPH in relation to Environmental Health by developing national strategy, protocols, regulations and clarifying roles and responsibilities under the Environmental Health program.*

The Environmental Health Department within the MoPH currently is responsible for developing the national strategy, protocols, regulations and responsibilities of the program. Within MoPH, the Environmental Health Department consists of 5 department / units: Water and Sanitation WASH, Environmental Sanitation and food safety, radiation safety/protection and training/public awareness actually there are two sub-departments under Environmental Sanitation department which are Occupational Health and house and urban hygiene. Collectively, they have developed a comprehensive strategy for National Environmental Health (NEH), which is currently in its second draft form and is expected to be finalized early March 2012. The Environmental Health Department also oversees teams located in 23 provinces and the implementation of the Environmental Health Program in Afghanistan.

Although the NEH plan is entering its final stages of completion, with five sub-units under the control of the Environmental Health Unit, multiple ministries involved in improving environmental health through their own ministries and little linkages between the national and sub-national levels the role and responsibility of the MoPH's Environmental Health Unit is unclear.
The HAA will support the Environmental Health Unit in building its capacity to effectively coordinate and administer its initiative, clarifying roles and responsibilities within the MoPH. The Environmental Health Unit has established and chairs an Environmental Health Task Force at MoPH for coordination within the Government of Afghanistan and with the international community. Membership of this task force currently includes MAIL, MRRD, the Ministry of Hajj and Religious Affairs, MoED, the National Environmental Protection Agency (NEPA) and UN Agencies (WFP, etc.).

Through monthly meetings the aim is to coordinate activities, avoid duplication and identify gaps. The Task Force provides a measure of coordination but is not sufficient; the Environmental Health Unit seeking support and funding to conduct a one-month needs assessment of this sector in order to identify current projects, areas of duplication and gaps. The results of this assessment will be presented to the Task Force so that the priorities of sector can be defined and incorporated into the Operational Plan (operationalizing the NEH).

To ensure the implementation of the NEH, the Environmental Health Unit is also seeking to strengthen coordination between the national and provincial level. Currently, the Environmental Health Unit oversees 23 provincial teams; however, they are weak and unable to effectively apply regulations and implement plans due to a lack of capacity (staff, skills and equipment). The goal of the Health for All Afghans Program is to strengthen provincial capacity and have coverage in all 34 provinces. To identify the exact needs of the provinces, the Environmental Health Unit is proposing a training needs assessment be conducted (in conjunction with the sector need assessment mentioned above).

Anecdotal evidence suggests initial requirements training requirements will be in program management and additional technical capacity pertaining to environmental health issues, such as sanitation or water purity. Based on the results of this assessment, the Environmental Health Unit will then develop and action plan and request technical assistance from the donor community.
**Deliverable 2.7.2:** *Build the capacity of MoPH management and staff related to environmental health to advocate for increased availability of safe drinking water in order to reduce the burden of disease from contaminated water*

A significant contributor to the environmental health issues in Afghanistan is the lack of access to safe drinking water and public awareness of diseases stemming from contaminated water and hygiene. Through a multi-pronged approach which will include the establishment of laboratories, integration of water treatment technologies and public awareness campaigns, MoPH will seek to promote and ensure the safety of water. Key to this approach will be the capacity to run a water testing lab. Initially to be established in Kabul, this surveillance system will function through consistent testing of reference areas (sites) for water purity.

Before this surveillance system can be established and testing commenced, it will become necessary to define protocols and regulations that will guide the testing procedures; this will include clean water standards and processes for the testers. The MoPH is currently in discussion with WHO, UNICEF and MRRD to determine who will oversee this development and establishment of the surveillance system; as a result, progress on this initiative has stalled.

**Deliverable 2.7.3:** *To increase food safety practices to prevent food borne illnesses in food service and retail establishments*

The Environmental Health Directorate is responsible for developing regulations and guidelines in order to ensure food safety. These include the control procedure of oil/ghee, beverages and foods.

Additionally, the Environmental Health Directorate manages checklists for 24 skilled class workers.

The new strategy will help EHD to revise and refine the checklists as required. Through the Environmental Health Task Force, relevant stakeholders will be consulted on the food safety regulation and coordinated with other ministries. This task force is also responsible for developing a disease surveillance system related to food borne illnesses.
Additionally, the Directorate will develop and institute a system of regular, coordinated inspections of food markets, shops and restaurants.

In addition to the public awareness campaign on safe drinking water, the Environmental Health Directorate will attempt to further public awareness on safe food handling practices through the development of a health certification system for food products.

**Deliverable 2.7.4:** To develop a systematic framework to lead a national process to reduce air pollution and promote clean air (in collaboration with the Environmental Protection Agency)

The urban areas in Afghanistan, particularly in Kabul, suffer from poor air quality resulting in high rates of respiratory diseases within the population.

In order to promote and advocate for behavior change interventions within the general public the Environmental Health Directorate is developing a public awareness campaign. This campaign is designed to educate people as to what they can do to assist in reducing air pollution and provide information on the negative health effects resulting from poor air quality and will be coordinated with the Health Promotions Department.

In coordination with the Environmental Protection Agency and the Environmental Health Task Force, the Directorate will develop appropriate legislation and regulations regarding acceptable air quality levels based on health standards; this will include the identification of vehicle emissions levels, factory pollution levels and others. The Environmental Health Directorate will focus on one piece of legislation a year. An epidemiological study will also be conducted which will link air pollution exposure and the effects on human health.
Deliverable 2.7.5: To create a national multi-sectoral radiation protection forum to agree on and advocate for safe levels of radiation in the country including increasing industry and public awareness of this issue

The Atomic Energy High Commission of Afghanistan is formulating legislation and regulations that will set standards for radiation levels throughout Afghanistan. Through prime coordination via the Radiation Forum, a multi-sectoral forum with representation from relevant ministries and organizations, safe levels of radiation are agreed upon and guidelines established based on baseline data of radiation levels throughout the country. The Environmental Health Department is part of this coordination body.

Additionally, this Radiation Forum is currently developing a strategy and implementation plan that will outline a realistic monitoring and evaluation framework and communication strategy to spread public awareness on radiation levels, protection and safety. To date, the Radiation Forum is in the process of coordinating with stakeholders to identify roles and responsibilities in order to construct the strategy.

Deliverable 2.7.6: To create a national multi-stakeholder mechanism for the management of garbage and hazardous wastes (including solid waste and healthcare waste)

Key to creating a healthy environment for the population is ensuring the proper management of garbage and hazardous waste.

Through the main coordinating mechanism of the Environmental Health Task Force, the Environmental Health Directorate will develop legislation and regulations to determine proper procedures and management of solid and hazardous waste. Specific focus will be placed on the disposal and management of waste associated with the healthcare industry. In coordination with the Health Promotions Department, the Environmental Health Directorate will design a yearly public awareness campaign in order to educate the general population of the health risks associated with waste.
NEPA has worked on air quality emission standards and has widely shared these with relevant organizations to seek feedback. Once the standards have been finalized, they will become the National Emissions Standards for Air Quality Control (expected completion of this is Dec 2012) and shared with the public. This campaign will also seek the participation of communities in municipal solid waste management and encourage communities to recycle materials when possible in order to reduce overall waste. Finally, based on the Environmental Health strategy, the Environmental Health Directorate will develop tools for assessing the risks associated with hazardous waste. Data collection will also continue on the levels of solid and hazardous waste to assess management and identify future interventions.

**Deliverable 2.7.7:** To improve hygiene and sanitation throughout the country among the general public and health workers

To aid in the prevention of disease and to avoid the spread of illnesses, MoPH has placed a high priority on improving hygiene and sanitation throughout the country. This involves an aggressive public awareness campaign, coordinated with the Health Promotions Department, to encourage people to wash their hands and explain the benefits associated with proper hygiene. These public awareness campaigns are also coordinated heavily with the Department of Education in an effort integrate this message in schools. Additionally, the Environmental Health Directorate continues to develop and review hygiene and sanitation standards to utilization in the workplace. Through training workshops and health education campaigns aimed at staff in the health service industry to further ensure proper hygiene in the sector.
Component 3: To improve health financing

**Outcomes:** Budget mapping of MoPH strategy documents are finalized and revenue generation plans are developed; Reduced dependence on external aid from 75% (2009) to 65% (2013); 4% increase in GIRoA-direct contributions to the national health budget; 10% reduction in out of pocket expenditure; increased capacity among MoPH managers, national and provincial hospital managers and provincial health directors on applied health economics and financing and resource management; Cost-effectiveness, efficiency and equity studies of essential programs and interventions such as contracting modalities, results-based financing, mobile health initiative, benefit incidence analysis, public expenditure tracking survey, carried out; increased utilization of health services by introducing demand and supply side financing; improved predictability of funding streams; greater community participation in and ownership of the health system.

**Indicators:** 75% of public training institutions incorporated health economics module in their curricula; NHA, EMIS and, Program Budget are institutionalized in the health systems; revenue generation mechanisms introduced; Some type of health insurance schemes initiated based on evidence; Out-of-pocket expenditures for health decreased from 75% to 65%; Equitable access to health services improved; Per capita public health expenditures increased from 4% to 8%; Increased utilization of health services by introducing demand and supply side financing; Coordination mechanisms improved in order to increase aid effectiveness; A Medium Term Expenditure Framework (MTEF) developed; and Sector Wide Approach (SWAp) adopted.

Health financing is an essential component of strengthening the national healthcare system in Afghanistan. The National Health Care Finance Strategy (2009-2013) notes different mechanisms for risk pooling and revenue generation that will be considered at the national and at the provincial, district, and community levels to increase domestic revenues for health.

At the national level, tobacco tax, vehicle tax, airline tax, and public private partnerships are four avenues under consideration by the GIRoA to increase central government’s operating budget.
Furthermore, the HAA will target pilot programs at the provincial and district levels, such as the collection of user fees on non-essential secondary and tertiary care services, to supplement hospital’s budgets.

Finally, at the community level, the HAA will support Community Health Insurance schemes to be piloted in targeted communities across the country. As noted earlier, coordination on international donor assistance needs to be improved. The HAA will support the continued efforts of the MoPH to implement its Sector Wide Approach (SWAp) and other coordinating units. This is to ensure that the MoPH and the international community move toward a strong aid effectiveness approach in the healthcare sector.
Sub-Component 3.1: Capacity Building on Health Financing

To Capacity building of MoPH staff on health financing for effective institutional functioning and supporting health economics evidence-based policy decision-making.

**Anticipated Results:** It is expected that by the end of program completion:

1. **Capacity of the MoPH at central and provincial levels in applied Health Economics and Financing, and Resource Management is improved.**

2. **Budget mapping of MoPH strategy documents are finalized and revenue generation plans are developed.**

3. **Cost-effectiveness, efficiency and equity studies of essential programs and interventions such as contracting modalities, results-based financing, mobile health initiative, benefit incidence analysis, public expenditure tracking survey will be carried out; Results of these studies will help MoPH leadership, Ministry of Finance (MoF) and stakeholders in evidence based decision making which will lead to improved efficiency, equity, and sustainability of health programs; and cost effective quality interventions in Afghanistan.**

4. **Budget and expenditure data collection and data management are standardized and institutionalized within MoPH.**

Building capacity of MoPH in health economics, financing and resource management is critical to achieve the goals of the National Health Care Finance Strategy 2009-2013. To achieve this, the HAA will support the MoPH's efforts over the next three years to build the foundation necessary for effective financial and resource management and continued evidence-based policy decision-making.

**Deliverable 3.1.1:** Institutional capacity is developed on applied health economics, financing and resource management at the central and provincial levels.

Building institutional capacity of MoPH in health economics, financing and resource management is one of the main pillars of the Health Care Financing Strategy 2009-2013. Increased capacity will enable provincial and central level the MoPH staff with the ability to use resources more effectively through better planning, allocation, and tracking.
Greater understanding and appreciation of health economics at every level will also contribute to more effective policy and efficient use of resources.

Capacity building will be a joint effort between the MoPH with the support of international technical support. The MoPH aims to build its capacity at the central and provincial levels in applied health economics and financing through a number of interventions, including the training of staff, integration of health economics module into the curricula of the Medical University, Ghazanfar Institute of Health Science, and MoPH in-service training programs.

**Deliverable 3.1.2: Costing exercises are conducted on priority MoPH strategic documents and programs**

The MoPH selected the Basic Package of Health Services (BPHS) to begin the exercise to cost out MoPH’s programs. BPHS is a highly successful program in the MoPH with the aim to expand population access to basic health services. BPHS costing and availability of disaggregated cost information will assist decision makers at the MoPH, enabling them to use available resources efficiently. Under the HAA, the Health Economics and Financing Directorate (HEFD) team with the support of Health Systems 20/20 Project will conduct this study.

In addition to the BPHS, it is also necessary to continue costing other strategic national health documents such as MoPH Strategic Plan 2011-2015, Essential Package of Hospital Services (EPHS), National Hospitals, Communicable Diseases (Malaria Control Program, TB Control Program, and HIV/AIDS Control Program), and new health initiatives (Mobile Health, Results Based Financing, Demand Side Financing, Public Private Partnership .etc.) , so that healthcare decision makers can improve performance in facilities and the use of resources.

HEFD will cost three to four strategic documents in each year, so the three-year HAA will target 9-12 strategies, including the EPHS Program. Costing of these programs will allow proper allocation of resources to improve performance in health sector. Moreover, the costing exercise supports efforts of the MoPH to better understand the financial requirements of not only hospitals and being able to evaluate opportunities of rising revenues at hospitals.
The costing exercise across key health strategies will support informed policy decision making and improve efficiency, effectiveness, and ensure sustainability of fund to the whole sector.

**Deliverable 3.1.3:** A public expenditure tracking survey and a benefit-incidence analysis of the health sector are conducted

As an approach to address aid delivery, fiduciary and accountability concerns, the Public Expenditure Tracking Survey (PETS) is a common and internationally utilized mechanism. It is a diagnostic tool that tracks resource flows from their origin (e.g., Ministry of Finance) through the MoPH and intermediary administrative levels to the service delivery units, such as hospitals. It involves close monitoring, assessment and evaluation of the government budget process (i.e. from planning, allocations, and disbursement, to execution) to the final stage of assessing the effect and impact of a budget. Tracking financial resource flows at each level provides insight into budget planning, allocations, timeliness, leakage of resources, and how discretion is applied in resource use. The information generated by PETS can form a key part of an overall assessment of “fiduciary risk”, or the risk that resources are not used for their intended purpose and/or not properly accounted for.

The MoPH is using PETS as a means of presenting financial information that identify the gaps in the flow of funds and support the assessment of whether the current distribution of available resources are the most effective, efficient, and equitable way of achieving government policy objectives that consequently feed into reform of service delivery. However, HEFD staff lack the internal capacity to conduct PETS. In order to objectively assess the flow of public expenditures fund at health sector, the MoPH has engaged an independent evaluator as an approach to aid delivery, fiduciary and accountability concerns.

The independent evaluator also supports MoPH’s efforts to build their internal capacity to conduct, analyze and use such information to make informed, evidence-based policy decisions.
Benefit-Incidence Analysis (BIA) is another tool used to explain who is benefiting from public services and describes the welfare impact on different groups of people or individual households of government spending. It does this by combining the unit costs of providing those services with information on the use of those services. It indicates which population groups in terms of socio-economic status are benefiting from particular health services. Traditionally, BIAs has been carried out uniquely for public sector facilities, often termed a public benefit incidence analysis.

Under the HAA, the HEFD will conduct BIAs with the support and guidance of international technical assistance. In addition, a training program will be implemented to train the HEFD staff on conducting a BIA to build the internal capacity at MoPH to conduct such necessary studies.

**Deliverable 3.1.4: Implementing and institutionalizing of National Health Accounts (NHA), and Expenditure Management Information System (EMIS) in the health sector**

**National Health Accounts (NHA):** NHA is a framework for measuring total public, private, and donor national health expenditures. Additionally, it is a tool specifically utilized to assist policymakers in their efforts to understand health systems and improve system performance.

NHA information is useful in the decision making process because it provides valuable information to policymakers, such as status reports on the current use of financial resources, the monitoring of health expenditure trends, and globally accepted indicators to allow for comparison of the Afghanistan health system performance relative to that of other countries. NHA is different than PETS in that the former tracks flow of actual expenditure on health from different financing sources without looking for any leakage. However, PETS is identifying and addressing problems of bureaucratic bottlenecks, inefficiencies, and leakages.
Institutionalization of NHA will result in the activities of collecting, analyzing, and reporting total health care spending being systemized by a designated unit/department within the MoPH, and/or other related ministries within the GIRoA, following a predetermined set of standards and protocols. Institutionalizing NHA should be looked at as a GIRoA responsibility that ought to be integrated into the government routine processes with the objective of forming a core dataset for health policy development, monitoring and evaluation.

The HAA will support the MoPH’s efforts to institutionalize the NHA, establishing the NHA with a clear purpose to serve the needs of policy makers: demand and use; production, data management, and quality assurance; dissemination; translation and dissemination of data. The Steering Committee will re-examine their membership in order to strengthen partnerships and establish buy-in for the NHA.

In addition to establishing the framework to review and assess the data to make informed health policy decisions, the HAA will also support capacity building and technical assistance on the NHA, including the development of an NHA course module to be included in the curriculum of the Kabul Medical University’s public health program. The Expenditure Management Information System (EMIS) will be an essential component to support the NHA analysis, as it will centralize and standardize the health data collection and management system. Sharing of the findings from an analysis of NHA is essential to ongoing international coordination with colleagues within and beyond the region, in addition to supporting informed decision and policy making within and outside the GIRoA. Disseminating NHA findings and policy briefs at national and international meetings/conferences, organizing workshops and seminars for information sharing, and establishing MoUs with data partners will be supported within the HAA.

**Expenditure Management Information System:** The MoPH is responsible for reporting health care expenditures and producing various financial reports to MoF, Ministry of Economy (MoEc), and international donors through different formats.
To harmonize the reporting system, the MoPH conducted a financial management assessment in early 2011, which revealed that health care program implementers face difficulties in balancing financial reporting requirements, lack mechanisms to capture health facility expenditures – including expenditures for the NHA, spend too much time and direct costs on financial reporting, and report duplicate information to multiple line ministries and donors.

To overcome and resolve these problems and harmonize financial reporting, the HAA will support the development of a new database with the involvement of stakeholders. The establishment of the EMIS could alleviate financial reporting challenges by replacing manual financial reports with automated reporting features, thereby allowing MoPH to produce timely and accurate financial reports to donors. Once the EMIS is developed and launched within the MoPH, the HAA will support MoPH’s efforts to systematize the collection, reporting and analysis of health care expenditures within designated MoPH units/departments and in other Ministries within the GiRoA. Access and use will be compliant with standards and protocols to be established by MoPH.
Sub-Component 3.2: Risk-pooling

To improve risk-pooling and mobilize domestic resources

**Anticipated Results:** It is expected that by the end of program completion:

1. **10% reduction in out-of-pocket expenditures.**
2. **Reduced dependence on external aid from 75% (2009) to 65% (2013);**
3. **Some type of health insurance schemes initiated based on evidence;**
4. **Per capita public health expenditures increased from 4% to 8%**

Similar to other developing countries, Afghanistan has relied on donor support to rebuild its health care system: external funding accounts for 75% of total public expenditure in health in 2009 (NHA 2008/2009).

As Afghanistan seeks to improve risk-pooling and mobilize domestic resources for health, it is important for the MoPH to examine options for viable health financing mechanisms. These options will consist of advocating for the introduction of “sin” taxes (e.g. on cigarettes); piloting user fees and social security options (e.g. equity fund); examining pilot studies on supply-side financing and demand side financing (DSF) including the use of high technology initiatives (e.g. Mobile-Health); designing and implementing health insurance schemes; and examining health facility management and the autonomy of hospitals and other health facilities.

**Deliverable 3.2.1: Improved financial sustainability and advanced risk pooling mechanisms**

Currently, 85% of the health budget in Afghanistan is funded by donor money. Although necessary to jump-start the recovery of health system in Afghanistan after several decades of war, the GIRoA must find sustainable health financing mechanisms to increase its self-sufficiency. Therefore, it is important for the MoPH to examine possibilities for revenue generation in order to support the sector and examine the appropriate social and community conditions for introducing viable health care financing mechanisms for managing financial risk and reducing out-of-pocket payments among the population.
These options include, but are not limited to, community-based health insurance, social insurance and private market insurance. To meet health-financing objectives, the GIRoA must explore a variety of health financing/resource mobilization mechanisms. Furthermore, given the historical and cultural complexities of introducing such mechanisms in Afghanistan, the MoPH will seek the assistance of subject matter experts in other disciplines like cultural anthropology, sociology, and the legal system to explore communities that are ready for piloting and evaluating risk-pooling and insurance options. Prepayment and risk-pooling mechanisms, earmarked taxes to the health system and the institutionalization of user fees are different ways to mobilize revenue. The MoPH will prioritize these activities, as current capacity does not allow starting these three health financing schemes/resource mobilization mechanisms at the same time.

Starting assessing the feasibility of user fees together with a waiver system at secondary and tertiary care, will be a first priority, as its administrative system is easier to design and manage than risks pooling mechanisms and earmarked taxes to the health sector. Setting up user fees also implies costing of most common secondary and tertiary services, based on which prices can be fixed, which is on the agenda of the National Strategy on Health Care Financing (HCF) and Sustainability.

User fees at secondary and tertiary care facilities should be initiated after consideration of other options and should be an initial step towards other health financing mechanisms designing a revenue generation framework came at a key phase of development in the MoPH’s strategic plan; particularly as external assistance is anticipated to level off in the short-run and financing needs increase. The MoPH has drafted a health sector revenue generation framework and will be finalized by March 2012.

The objective of this paper is to outline a comprehensive, multi-year framework – both at the national and at the community level – to increase sources of domestic revenue for health. At the national level, *tobacco tax, vehicle tax, fuel tax and airline passenger fee*. In addition, the team, in collaboration with the Department of Curative Services, envisions a step-wise approach to instituting user fees at national, provincial and district hospitals. And finally, at the community level, we propose a “health for all” community campaign to encourage allocation of a proportion of Zakat to finance community health posts, mobile clinics, and community health projects.
Deliverable 3.2.2: Implementing demand side and supply side financing

To achieve health related MDGs, the MoPH is exploring alternative health financing mechanisms that increase demand for health services by providing incentives to health service providers and beneficiaries to improve the quality of services and to improve utilization rate. At present, the MoPH is implementing both schemes (demand side and supply side financing) in some provinces of the country. The MoPH anticipates expanding the schemes in a sequenced expansion to be based on best practices and lessons learned from an assessment conducted to determine program success and impact.
Sub-Component 3.3: Aid Coordination and effectiveness

To secure more external funds and improve aid effectiveness

**Anticipated Results:** It is expected that by the program completion:

1. Coordination mechanisms between the MoPH and the Donor Community are improved.
2. A Medium Term Expenditure Framework (MTEF) is developed.
3. A Sector Wide Approach (SWAp) is adopted.
4. Coordination with all stakeholders (Inter Ministerial Coordination Committee is established)

Under the perspective of national health sector stewardship and an international movement toward donor harmonization and the alignment of external inputs with the MoPH five-year Strategic Plan, the HAA will support MoPH’s efforts to explore the option of developing effective donor coordination under the mechanism of a Sector Wide Approach (SWAp) in the health sector in Afghanistan. The basis of a SWAp is an agreed working method between the Government and development partners aimed at jointly implementing consistent sector policy and strategies. A SWAp unit has already started functioning in the MoPH and the unit is providing technical and administrative support to MoPH in institutionalizing SWAp through establishing a high level SWAp steering committee. A SWAp taskforce is working currently on finalizing technical documents required for SWAp implementation (e.g. guiding principles, Code of conduct and Compact for SWAp).

It is anticipated that SWAp will enhance the ownership of the development process and the management of the assigned resources. There are several grid criteria/elements to define a SWAp on which the Afghan MoPH will look at for developing its own Health SWAp.

MoPH has established ANDS Coordination Department to facilitate and coordinate the inter-ministerial coordination and cooperation.
It will also facilitate and coordinate the national priority programs not only inside the ministry of public health (MoPH) but also in the other sectors and NPPs. ANDS Coordination Department under General Directorate of Policy, Planning and External Relation is to manage and facilitate the NPP-5, Health for All Afghans as well.

**Deliverable 3.3.1: Introducing SWAp to the health sector, developing a MTEF, improving coordination**

In order to adopt SWAp in the health sector there are a number of actions to be taken by the MoPH to fulfill the preconditions for a health SWAp. Under the HAA, the MoPH will enhance its stewardship through several key initiatives:

1. **Costing of Relevant Strategic Plans:** The MoPH will cost key strategic documents, especially the five-year MoPH strategic plan and the NPP, which will serve as single sector policy to be negotiated with external donor agencies. The costing of these two plans will take into consideration and align all of the subordinate (departmental) plans within the MoPH.

2. **Conducting Gap Analyses in MoPH:** In order to improve key functions within the MoPH, SWAp unit will continuously work on conducting gap analysis in the areas such as procurement, Financial Management, Human Resources and Monitoring and Evaluation. The SWAp unit will come up with practical recommendations to the leadership of MoPH as well as to donor communities on how to improve the areas where the gaps exist. Also analyzing existing coordination and providing recommendations (for internal and external coordination)

3. **Conducting a Mapping Exercise of Technical Assistance in the MoPH:** The unit will conduct mapping of the technical assistance in the MoPH in order to better harmonize and align the TA activities with the needs and priorities of MoPH.

4. **Gaining Agreement on Aid to the MoPH from the Donor Community:** The unit has completed the development of a guiding set of principles, Code of Conduct and drafted Memorandums of Understanding (MOU) for presentation to members of the Donor Community who are not participating in SWAp.
With the completion of the guiding set of principles and Code of Conduct, the MoPH will request donors sign the MOU and agree to comply with the Code of Conduct which is designed to strengthen Government processes for receiving of external aid.

(5) **Establishment of an Aid Coordination Unit:** An Aid Coordination Unit will be created inside the HEFD to oversee coordination efforts with the development partners and the SWAp unit will serve under the mentioned unit to improve dialogue with the donor community around milestones of the SWAp (refer to above).

Based on the outcomes of these activities, the SWAp unit, with support from and coordination with the donor community, will work on developing a Mid Term Expenditure Framework (MTEF). An Aid coordination unit will be established within the Health Economics and Financing Directorate that will serve as an entry point in the MoPH for all donors. The unit will also review and provide recommendations to the leadership of MoPH on the improvement of existing coordination mechanisms.

**Deliverable 3.3.2: Improving of Inter-Sectoral Collaboration (ISC) related to ANDS/ NPP and Facilitate and Coordinate NPP-5**

In 2010, the Afghanistan National Development Strategy (ANDS) Coordination department was established in the Ministry of Public Health to facilitate and coordinate the Inter Sectoral Collaboration (ISC) and Inter Ministerial Coordination (IMC) issues. The ANDS coordination department is also facilitating and coordinating the NPP. This department will as well facilitate and coordinate the procurement process of HAA projects, including Grant and Contract issue of projects which is going to be contracted out to NGOs to implement. This department will also facilitate the financial issue of all NPP related development projects. The ANDS Coordination Department will not only monitor the implementation of HAA projects but also as well provide technical feedback to the contracted out implementers and donor and development partners.

This department is preparing semi-annual and annual report of MoPH regarding ANDS, MDG and NPP as well continuously work on conducting gap analysis in the areas such as procurement of HAA projects, financial management, human resources, monitoring and evaluation.
This department will come up with practical and analytical recommendations to the MoPH leadership as well as to the donor and development partners on how to improve the areas where the gaps exist. Moreover, this department will conduct mapping of the technical assistance in the MoPH in order to better harmonize and align the HAA activities with the needs and priorities of the MoPH.

This department will also review and provide recommendations to the leadership of the MoPH and HRD Cluster Secretariat/ MoE as well ANDS Directorate of MoF on the improvement of existing coordination mechanisms.

The Government has introduced a number of new institutional structures to support the timely and effective implementation of the ANDS, one of highest priorities of the GiRoA and the international community. This has included the establishment of the Government Coordination Committee (GCC), the Coordination of ANDS Development & Implementation Unit in the MoF and the ANDS Monitoring and Evaluation Unit in the MoEc.

The ANDS is largely based on 17 sector strategies and six cross-cutting issues with well defined objectives and proposals for projects and programs to be implemented over the next five years (2008-2013). The volume II of ANDS, dealing Health and Nutrition, is titled as Health and Nutrition Sector Strategy (HNSS). The existing governmental institutional structure of ministries and agencies does not generally correspond closely to the coverage of specific sectors. As a result virtually all of the sector strategies including HNSS will require significant inter-ministerial cooperation and integrated action if these strategies are to be successfully implemented. As a result, the GiRoA is establishing sectoral Inter-Ministerial Committees (IMCs), each of which will be primarily responsible for the implementation of one the ANDS sector strategy and is comprised of the Ministers from relevant Ministries.

These IMCs will report to the President and the Cabinet through the GCC and their work will be supported by the ANDS directorate at MoF and MoEc.

The ANDS Coordination department of MoPH is to set a general outline of roles and responsibilities of the Health and Nutrition Sector IMCs for better clarity of coordination between government and non-governmental bodies to undertake a streamlined implementation approach toward fulfilling the ANDS and NPP targets.
IX. PROGRAM IMPLEMENTATION THREE-YEAR FRAMEWORK

BPHS and EPHS are implemented by partner organizations that have contractual agreements with the MoPH for delivering a specific package of services in a discreet geographic area. This is the model both BPHS and EPHS have used since their inception, and they will continue to be used for up to 2018.

HAA aims to support the Afghan health system to deliver its management and stewardship responsibilities at all levels by strengthening institutional development, finding new and innovative ways to meet the human resource needs of the health sector, and providing employment opportunities. See Annex for Details.
X. MONITORING and EVALUATION

The MoPH more emphases on M&E and commitment to evidence-based, participatory program planning and implementation can be seen in its extensive program of data collection, analysis, and interpretation. It has recently finalized a National Monitoring and Evaluation Strategy (NMES) to monitor and evaluate progress in implementation of the HNSS. The NMES is focused on results defined by the Afghanistan High Level Compact and MDG. The BSC measurement tool is currently used to measure 29 indicators of performance. It provides a uniform framework that looks at the principal areas of HNS performance–patients and community; staff; capacity for and of service provision; procurement; financial systems; and overall vision. The first comprehensive BSC survey was conducted in 2004, being used to set Afghan-specific benchmarks.

From 2004 to 2006, national and provincial scores have shown significant improvement. The MoPH has also invested in the development of a routine HMIS. Reporting from the provinces to the national level is required on a quarterly basis, which seemed a good compromise between the need for updated data at the national level, the burden of data collection and aggregation at the periphery. The availability of HMIS information has increased from 5% of facilities (2003) to 70% by late 2005. In addition to the BSC and the HMIS, the MoPH has also adopted other instruments and tools including Epidemiologic and demographic reports, intermittent monitoring tools and routine service statistics. All of these mechanisms are used to develop quarterly and annual M&E reports for the use of program managers and policy makers at all levels of the MoPH. They are the processes by which the policy of evidence-based decision-making is implemented. The related MoPH departments (MH, nursing and midwifery, disability, CBHC, HIS, etc) will be involved in M&E of this program along with the M&E, APHI and HR departments of the MoPH. An M&E committee will be established which will have one representatives from all of the involved departments including HRD and the APHI. This committee will review the supervision; monitoring and evaluation instruments prepared by the individual departments and will hold regular meetings to finalize indicators derived by each department for each component. For the contract out components, monitoring checklists and indicators will be prepared based on their ToRs, proposal/contract and timeliness for the planned activities by the concerned departments and will be finalized by the M&E committee using the same format. For the MoPH implemented projects, monitoring checklists will be prepared based on the action plans in the program proposal.
Each related department will monitor its related program every two months and submit a copy of the report to the M&E committee. The M&E, APHI and HRD departments will jointly monitor each component every six months. There will be midterm and final external evaluation in place to assess the gaps, success, lesson learned of all components of the project. Also the recommendation package which is provided by the final external evaluation will be used as a rich input for the other projects and programs in the future. Result dissemination seminars will be planned and leadership of MoPH will be regularly kept in the loop. Lastly, the Government of Afghanistan has implemented a new, innovative system to conduct monitoring across all National Priority Programs. The implementation plans outlined above which detail general activities to outputs, and outputs to outcomes, will be further detailed each 100 days. Progress on these plans will be reported at the Cabinet, and the SC of the JCMB, and will include a quantitative percentage of actions completed, and a qualitative narrative analysis. This will allow the government and the international community to ensure programs are fulfilling obligations, and to take corrective measures immediately if a program is off course. Further, the same system will be codified at a higher level, with a separate methodological tool, and will work with the Central Statistics Office or other bodies as required, to measure outcomes over time. These results will also be reported at appropriate intervals in the Cabinet and Standing Committees of the JCMB.

In accordance with the aforementioned system for monitoring implementation and progress of the National Priority Programs, the BPHS and EPHS programs have identified a select number of national indicators to be reported for each Standing Committee and JCMB meeting. As mentioned, the MoPH has a wealth of data that comes from its implementing partners and provincial and district hospitals on a monthly and quarterly basis. A select number of such statistics, as described in the implementation plan in Annex A, have been identified to provide an overall snapshot of the health sector in Afghanistan and are already part of consistent discussions held by MoPH with its implementing partners each quarter.
XI. Physical Infrastructure:

Ministry of Public Health of Afghanistan has established a clear mission to improve the health of people through quality health care services provision. In order to achieve this goal MoPH and donors introduced and implemented a number of different strategies, tools, methodologies and interventions aiming to improving quality of health services. Whilst much has been achieved in term of health services delivery and decrease of infant and maternal mortality till date, little attention has been paid to the physical infrastructure of health facilities. It is evident that provision of quality health care is directly linked with standardized physical infrastructure of health facilities. Though some new health facilities has been constructed in the last decade, there is need for the upgrade or possible reconstruction of facilities that are very old, and possible further expansion of facilities in terms of the growing demand from provinces for such infrastructure.

According to the Information from the HMIS, only 65% of health facilities is owned by Health authorities, whereas the remaining 35% is facilities that are in rented residential buildings. Of the facilities owned, 97% is made from concrete, whereas the remaining 3% is made from mud. (See table below)

The following table indicate that how many of HFs have permanent building, Concrete building and how many are active in temporary or rented houses in whole Afghanistan (HFs wise base on BPHS and EPHS need):

*Table: By Health facility Level wise*

<table>
<thead>
<tr>
<th>Facility type</th>
<th>Facilities with Permanent Building</th>
<th>Facilities with temporary/ rented building</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Concrete Building</td>
<td>Mud-Made Building</td>
</tr>
<tr>
<td>Basic Health Center (BHC)</td>
<td>579</td>
<td>9</td>
</tr>
<tr>
<td>Comprehensive Health Center (CHC)</td>
<td>293</td>
<td>55</td>
</tr>
<tr>
<td>District Hospital (H3)</td>
<td>56</td>
<td>0</td>
</tr>
<tr>
<td>Provincial Hospital (H2)</td>
<td>29</td>
<td>1</td>
</tr>
<tr>
<td>Regional/National hospital (H1)</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Special Hospital (SH)</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Sub Health Center</td>
<td>116</td>
<td>8</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1093</strong></td>
<td><strong>77</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The following table shows that which level of HF's in which province are active whether in permanent building, concrete building and temporary or rented houses (Provincial wise base on not only BPHS and EPHS but also some other health facilities):

*Table: By Provincial Wise*

<table>
<thead>
<tr>
<th>No</th>
<th>Province</th>
<th>Total HFs</th>
<th>Facilities with Permanent Building</th>
<th>Facility/facilities with temporary/rented building</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Concrete Building</td>
<td>Mud-Made Building</td>
</tr>
<tr>
<td>1</td>
<td>Badakhshan</td>
<td>83</td>
<td>37</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>Badghis</td>
<td>36</td>
<td>30</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Baghlan</td>
<td>55</td>
<td>39</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Balkh</td>
<td>87</td>
<td>47</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Bamyan</td>
<td>58</td>
<td>35</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>Dykundi</td>
<td>37</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>Farah</td>
<td>38</td>
<td>22</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>Faryab</td>
<td>53</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>9</td>
<td>Ghazni</td>
<td>66</td>
<td>41</td>
<td>7</td>
</tr>
<tr>
<td>10</td>
<td>Ghur</td>
<td>50</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>11</td>
<td>Helmand</td>
<td>59</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>Hirat</td>
<td>83</td>
<td>63</td>
<td>2</td>
</tr>
<tr>
<td>13</td>
<td>Jawzjan</td>
<td>33</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>14</td>
<td>Kabul</td>
<td>76</td>
<td>51</td>
<td>6</td>
</tr>
<tr>
<td>15</td>
<td>Kandahar</td>
<td>38</td>
<td>31</td>
<td>0</td>
</tr>
<tr>
<td>16</td>
<td>Kapisa</td>
<td>39</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>17</td>
<td>Khost</td>
<td>29</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>18</td>
<td>Kunar</td>
<td>38</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>19</td>
<td>Kunduz</td>
<td>61</td>
<td>41</td>
<td>0</td>
</tr>
<tr>
<td>20</td>
<td>Laghman</td>
<td>39</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>21</td>
<td>Logar</td>
<td>39</td>
<td>31</td>
<td>0</td>
</tr>
<tr>
<td>22</td>
<td>Nangarhar</td>
<td>120</td>
<td>77</td>
<td>10</td>
</tr>
<tr>
<td>23</td>
<td>Nimroz</td>
<td>22</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>24</td>
<td>Nooristan</td>
<td>24</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>25</td>
<td>Paktika</td>
<td>25</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>26</td>
<td>Paktya</td>
<td>39</td>
<td>33</td>
<td>1</td>
</tr>
<tr>
<td>27</td>
<td>Panjsher</td>
<td>18</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>28</td>
<td>Parwan</td>
<td>67</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>29</td>
<td>Samangan</td>
<td>31</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>30</td>
<td>Sar-e-Pul</td>
<td>47</td>
<td>19</td>
<td>2</td>
</tr>
<tr>
<td>31</td>
<td>Takhar</td>
<td>69</td>
<td>37</td>
<td>6</td>
</tr>
<tr>
<td>32</td>
<td>Urozgan</td>
<td>15</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>33</td>
<td>Wardak</td>
<td>49</td>
<td>40</td>
<td>2</td>
</tr>
<tr>
<td>34</td>
<td>Zabil</td>
<td>19</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>1642</td>
<td>996</td>
<td>75</td>
</tr>
</tbody>
</table>
Most of the health facilities buildings built prior to 2001, are either too old, or have undergone severe wear and tear, or have simply not been constructed with for the purpose of medical services. Some health facilities buildings, especially hospitals are not responsive to the today’s health service delivery needs and needs renovation and possible expansion in order to provide the current demand for health services.

To address the issue in the first instance, Health facilities infrastructure improvement need a comprehensive assessment (mapping) of existing physical infrastructure of health facilities this assessment that will enable MoPH to decide how many facilities needs

- New constructions
- Rehabilitation
- Renovation or
- Expansion

The study will also enable MoPH to have a clear idea about financial requirements for physical infrastructure in the coming years. It will also provide information on the health safety aspect of these facilities.

In short improving of physical infrastructure is a critical need of health service delivery and need immediate attention by MoF and donors.
# XII. IMPLEMENTATION REQUIREMENTS

## A. Planned HAA Technical Assistant requirements

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>Sub-COMPONENT</th>
<th>TECHNICAL ASSISTANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component 1: Health Service Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-Component 1.1: BPHS - Please refer to BPHS program document</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-Component 1.2: EPHS – Please refer to EPHS program document.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-Component 1.3: Institutional development at 8 of the 18 National Hospitals.</td>
<td>▪ An international TA will be hired for one year, and 16 national TA will be employed to act in Hospital Administrator and Hospital Director positions in each of the 8 hospitals.</td>
<td></td>
</tr>
<tr>
<td>Sub-Component 1.4: To improve the Nutritional Status of the Afghan Population</td>
<td>▪ An international consultant will be hired</td>
<td></td>
</tr>
<tr>
<td>Sub-Component 1.5: To increase equitable access to quality health services</td>
<td>▪ An international consultant will be hired</td>
<td></td>
</tr>
<tr>
<td>Sub-Component 1.6: To support regulation and standardization of the Private Sector to provide quality health services</td>
<td>▪ An international consultant will be hired</td>
<td></td>
</tr>
<tr>
<td>Sub-Component 1.7: To Create an enabling environment for the production and availability of quality pharmaceuticals</td>
<td>▪ An international consultant will be hired</td>
<td></td>
</tr>
</tbody>
</table>
| Sub-Component 1.8: To achieve universal access to RH and improve maternal and newborn health | ▪ Two international consultant will be contracted to develop new RH related new components guidelines and curriculum  
▪ 5 national consultants are needed to technical assist with RHD. | |
| Sub-Component 1.9: Maternal, Newborn and Child health (H4+) | ▪ An international consultant will be hired | |
| Sub-Component 1.10: To enhance the capacity of national health system for disaster risk management including mitigation, prevention, preparedness and response | ▪ An international consultant will be hired | |
| Component 2: Increase and Improve Human Resource for Health and Good Governance | | |
| Sub- Component 2.1: To reinvigorate the G-IHS in Kabul and the 5 Provincial IHS that provide the framework for developing, managing and executing major health worker trainings. | ▪ An international consultant will be contracted and embedded in GIHS, to manage the innovations. | |
| Sub- Component 2.2: To improve the governance capacity at senior and managerial levels of the general directorates of the National Health Services for improved systems and human resource management. | ▪ An international consultant will be contracted to be embedded in APHI to oversee Lead and Management development.  
▪ An international consultant will be contracted and embedded in GDHR to manage the TWG.  
▪ The international consultant will also manage the process of establishment of the H. Complaints Office. | |
### Sub-Component 2.3: To develop adequate professional standards, specialized curricula and train 1,940 specialized staff.

- An international consultant will be contracted and embedded in GDHR to manage the innovations.
- An international consultant will be contracted and embedded in GDHR to oversee the initiative, and 26 international specialists will be recruited to develop the curricula and train approximately 283 trainers. International organizations will be contracted to perform the accreditation of trainers after they have been trained in the new curricula.

### Sub-Component 2.4: To increase the numbers and capacity of 13,540 community workers and 14,720 professional providers through basic training programs in various public health disciplines

- An embedded expert to coordinate the program in GIHS, and NGOs will be contracted to run programs in provinces.
- A local expert will be contracted to oversee the initiative embedded in GIHS, and NGOs will be contracted to run trainings.

### Sub-Component 2.5: To support health promotion and community empowerment

- An international consultant will be hired

### Sub-Component 2.6: To enhance evidence-base decision making by establishing a culture that uses data for improvement

- One international epidemiologist to provide guidance for the continued development of the Health Information System
- One international legal specialist to draft legislation for health information
- One international SSQL and data warehouse specialist for the development of a dashboard with indicators using web based technology
- Three local HMIS specialists to provide the technical support and training on data use and data quality

### Sub-Objective 2.7: To advocate for and Promote healthy environments

- An international consultant will be hired

### Component 3: Improve Health Financing

#### Sub-Component 3.1: Capacity building of MoPH staff on health financing for effective institutional functioning and supporting health economics evidence-based policy decision-making.

- One international part-time consultant and one national consultant will be hired.

#### Sub-Component 3.2: To improve risk-pooling and mobilize domestic resources

- One international part-time consultant and one national consultant will be hired.

#### Sub-Component 3.3: To secure more external funds and improve aid effectiveness

- One international consultant and 36 national consultants will be hired.
### B. Planned procurement per component

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>Sub-COMPONENT</th>
<th>GOODS</th>
<th>SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Component 1.1: BPHS - Please refer to BPHS program document</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-Component 1.2: EPHS – Please refer to EPHS program document</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-Component 1.3: Institutional development at 8 of the 18 National Hospitals.</td>
<td>• Equipment, drugs and general supplies.</td>
<td>• Local experts, remuneration top-ups, training, and consultancies to develop and implement waste management and catering, and other required improvements.</td>
<td></td>
</tr>
<tr>
<td>Sub-Component 1.4: To improve the Nutritional Status of the Afghan Population</td>
<td>• Equipment and materials.</td>
<td>• Institutions sub-contracted to provide services. • Consultancy services.</td>
<td></td>
</tr>
<tr>
<td>Sub-Component 1.5: To increase equitable access to quality health services</td>
<td>• Equipment and materials.</td>
<td>• Institutions sub-contracted to provide services. • Consultancy services.</td>
<td></td>
</tr>
<tr>
<td>Sub-Component 1.6: To support regulation and standardization of the Private Sector to provide quality health services</td>
<td>• Equipment and materials.</td>
<td>• Institutions sub-contracted to provide services. • Consultancy services.</td>
<td></td>
</tr>
<tr>
<td>Sub-Component 1.7: To Create an enabling environment for the production and availability of quality pharmaceuticals</td>
<td>• Equipment and materials.</td>
<td>• Institutions sub-contracted to provide services. • Consultancy services.</td>
<td></td>
</tr>
<tr>
<td>Sub-Component 1.8: To achieve universal access to RH and improve maternal and newborn health</td>
<td>• Equipment and materials.</td>
<td>• Institutions sub-contracted to provide services. • Consultancy services.</td>
<td></td>
</tr>
<tr>
<td>Component 2: Increase and Improve Human Resource for Health and Good Governance</td>
<td>Sub- Component 2.1: To reinvigorate the G-IHS in Kabul and the 5 Provincial Institutes that provide the framework for developing, managing and executing major health worker trainings.</td>
<td>• Equipment and materials.</td>
<td>• Contracting of International Consultant for institutional development, and builder/renovator.</td>
</tr>
<tr>
<td>Sub- Component 2.2: To improve the governance capacity at senior and managerial levels of the general directorates of the National Health Services for improved systems and human resource management.</td>
<td>• Computer components for database upgrade, and computers and software for HR Officers, and other infrastructure requirement. • Equipment and infrastructure for HCO.</td>
<td>• Contracting of International HR System Expert, and two local HR system specialists. • Contracting of NGOs to run training in provinces, and an institution in Kabul. • Selection and retention of HR Officers.</td>
<td></td>
</tr>
</tbody>
</table>
### Sub-Component 2.3: To develop adequate professional standards, specialized curricula and train 1,940 specialized staff.

- Equipment and infrastructure for Medical Council.
- Workshop, Training and Accreditation materials.
- Training materials.
- Equipment for training.
- Contracting of International Expert, and four local experts (2 for secretariats) and 2 for Medical Council.
- Provision of secretariat services to undertake the activities of the Medical Council.
- Consultancy services for curriculum development, training and accreditation.
- Consultancy services for curriculum development and training.
- Institutions sub-contracted to provide services.

### Sub-Component 2.4: To increase the numbers and capacity of 13,540 community workers and 14,720 professional providers through basic training programs in various public health disciplines

- Training materials.
- Materials and equipment for new training schools.
- NGOs sub-contracted to provide services.
- NGOs sub-contracted to provide services, which includes goods (which will be small as the schools are established in each province).
- Institutions sub-contracted to provide services.

### Sub-Component 2.5: To support health promotion and community empowerment

- Equipment and materials.
- Institutions sub-contracted to provide services.
- Consultancy services.

### Sub-Component 2.6: To enhance evidence-base decision making by establishing a culture that uses data for Improvement

- Equipment and materials.
- Institutions sub-contracted to provide services.
- Consultancy services.

### Sub-Objective 2.7: To advocate for and Promote healthy environments

- Equipment and materials.
- Institutions sub-contracted to provide services.
- Consultancy services.

### Component 3: Improve Health Financing

#### Sub-Component 3.1: Capacity building of MoPH staff on health financing for effective institutional functioning and supporting health economics evidence-based policy decision-making.

- Three cars
- N/A

#### Sub-Component 3.2: To improve risk-pooling and mobilize domestic resources

- One car
- N/A

#### Sub-Component 3.3: To secure more external funds & improve aid effectiveness

- 2 cars
- Procurement of contracts and services.
XIII. CHALLENGES, CONSTRAINTS AND SOLUTIONS

The realities of Afghanistan provide many challenges and constraints for the establishment and successful implementation of an effective and efficient Afghan health system. Careful analysis of these challenges and constraints however always provide room for finding new and innovative solutions to meet the human resource needs of the health sector, and providing employment opportunities.

While the achievements of the MoPH under the BPHS framework have been significant, the future holds a number of challenges: First, further expansion of the BPHS, as measured by the percentage of the population with access to BPHS services, will become increasingly difficult. Extending access will require the MoPH to reach all remote areas in the country plus 23% of urban dwellers. For the rural population coverage, increasing levels of access will require a great amount of effort; however, the MoPH is committed to the issue of equity and will strive to increase the proportion of the population that has access to the BPHS.

The MoPH remains committed to building a sustainable nationwide health system that is appropriate for Afghanistan. However, this will prove a challenge since current services are primarily provided through funding from three major donors plus significant contributions by other donor agencies.

The MoPH remains dedicated to the principle of equity and to care being based upon need rather than ability to pay for services. This commitment is reiterated in two of the six principles stated in the MoPH's draft —National Policy on Cost-Sharing and Sustainability:

- Everyone who needs care must receive care, regardless of ability to pay
- Quality of care must be the same for paying and nonpaying patients

Insecurity is still another challenge that reduces population access to health care services. It also limits monitoring visits to the provinces where BPHS is being implemented. This may result in a compromise of the quality and possibly a lack of transparency in terms of quality service provision.

An additional challenge is to align the BPHS with the EPHS to develop a single, unified, and community-based health system with appropriate linkages for referrals throughout the system. The BPHS rests on the concept that all services in the package should be available as integrated whole, rather than piecemeal or as individual services, or only through vertical programs.
Finally, retaining the commitment to the BPHS will be a challenge. As the emergency situation that the health system faced in 2002 has diminished, increasing attention is being paid to the hospital elements of the health system. Typically, hospitals primarily benefit the urban population, yet Afghanistan’s population is over 80 percent rural. It is the BPHS that will provide the foundation for an equitable health system that can improve the health of the country’s population. The MoPH remains committed to the BPHS as the foundation for an equitable and sustainable health system.

Finally, the current form of the BPHS program does not take into account changes in wages or other costs that have occurred since the July 2010 revision. Moreover, it does not cost out the plan for expanding the program to underserved populations. This proposal does not reflect the plan by MoPH to expand the program’s services or recalibrate costs, which will occur at a later time and follow existing donor agreements and mechanisms.

Without doubt, one of the largest challenges to the HNS is that of security. In an environment where CHWs are being killed, and where M&E activities such as the BSC cannot be conducted, the delivery of HCS is certainly threatened. In the year 2006 (1385), for example, female CHWs represent staff in 30% of health facilities in insecure areas, compared with more than 50% in more stable settings. Coverage of pregnant women with two doses of tetanus toxoid, and attendance of skilled CHWs at deliveries in conflict-ridden areas are one-third and one-half respectively the proportions in secure areas. In Helmand Province, 17 clinics are closed and nine (9) clinics in Kandahar are totally dysfunctional. Security is not only a challenge to HCS delivery, but a precondition.

Investment of government-controlled funds, as discussed above, will also be a challenge. Almost 100% of the Public Health Care Services is currently being supported by external funds, as is about 40% of hospital care. The predictability of external funding cannot be ensured, and current allocations from the national budget are grossly insufficient to sustain the current rate of expansion in the sector, both in terms of geographic coverage and in terms of services being offered. Training and financial incentives, especially for female staff and in rural areas, are potential issues that will require attention.

It is difficult for people living in remote, hard-to-reach areas to access health facilities. We need to get HCSs out to these citizens of Afghanistan. So far BPHS has brought basic HCSs to the districts where 82% of the population lives.

But even in those areas a portion of the population live in relatively dispersed communities and are separated by geographic barriers from the available facilities.
It is estimated that around 35% of the population has either no access or difficulty in accessing even basic HCSs. Children remain un-immunized, there is no care for the mothers delivering their infants and emergency cases must travel long distances before finding appropriate services. The MoPH must contend with the anxieties of the members of these remote communities demanding the services promised to them. Fulfilling these promises will improve the chances for stability and development in the remote areas. At minimum, there is a need to increase the supply and mobilization of qualified HCWs, particularly female HCWs. It is assumed that the presence of a female HCW in a facility will contribute to an increase in the utilization of maternal HCSs and contribute to the goal of reducing maternal mortality.

The main constraints of the HNS sub-sector strategy are:

- Insecurity in some provinces making it difficult for program implementation, monitoring by provincial and central level, and recruitment of Provincial Public Health Officers and health facilities staff.
- Dispersed population and geographical problems; cultural barriers.
- Uncertain commitment of donors in supporting implementation, capacity building programs, logistics and functioning.
- Unwieldiness of MoPH and MoF bureaucracy and administration responsible for delays in recruitment of staff, budget disbursement and procurement of medicine and equipment.
- Law and regulation missing or not adapted to the current situation (e.g. lack of regulation for private practice).

Careful planning of activities and community involvement and visible and progress is the foundation of addressing mitigating risks and finding new and innovative ways to overcome constraints.
XIV. COSTING AND BUDGETING

The overall budget of Health for All Afghans (HAA) is **1,300,791,344 USD** over three years. Of this Total budget **1,045,364,071 USD** has already been secured (the Main donors are USAID, EU/EC, WB) and **255,427,273 USD** is requested.

XV. ANNEXES

A. *NPP-5 Health for All Afghans’ three year Implementation Plan*

B. *NPP-5 Health for All Afghans’ three year Budget*