Islamic Republic of Afghanistan
Afghanistan National Development Strategy

Health & Nutrition Sector Strategy

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Volume II
Pillar V, Health & Nutrition

Health & Nutrition Sector Strategy

Prepared & submitted by:

Ministry / Agency	Name of Minister / Director	Signature
Ministry of Public Health (MoPH)	H.E. The Minister, Dr. Said Mohammad Amin Fatimie	
Ministry of Agriculture, Irrigation and Livestock (MAIL)	H.E. The Minister, Mr.Obaidullah Ramin	

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26 Feb 2008

بسم الله الرحمن الرحيم

In the name of Allah, the Most Merciful, the Most Compassionate

Vision for Afghanistan

By the solar year 1400 (2020), Afghanistan will be:

- A stable Islamic constitutional democracy at peace with itself and its neighbors, standing with full dignity in the international family.
- A tolerant, united, and pluralist nation that honors its Islamic heritage and deep aspirations toward participation, justice, and equal rights for all.
- A society of hope and prosperity based on a strong, private sector-led market economy, social equity, and environmental sustainability.

ANDS Goals for 1387-1391 (2008-2013)

The Afghanistan National Development Strategy (ANDS) is a Millennium Development Goals (MDGs)-based plan that serves as Afghanistan's Poverty Reduction Strategy Paper (PRSP). It is underpinned by the principles, pillars and benchmarks of the Afghanistan Compact. The pillars and goals of the ANDS are:

1. Security: Achieve nationwide stabilization, strengthen law enforcement, and improve personal security for every Afghan.
2. Governance, Rule of Law and Human Rights: Strengthen democratic practice and institutions, human rights, the rule of law, delivery of public services and government accountability.
3. Economic and Social Development: Reduce poverty, ensure sustainable development through a private sector-led market economy, improve human development indicators, and make significant progress towards the Millennium Development Goals.

Foreword

For the preparation of the Afghanistan National Development Strategy

In the name of Allah, the most Merciful, the most Compassionate

Six and half years ago, the people of Afghanistan and the international community joined hands to liberate Afghanistan from the grip of international terrorism and begin the journey to rebuild a nation stunned by a long past of violence, destruction and terror. We have come a long way in this shared journey.

In just a few years, as a result of the partnership between Afghanistan and the international community, we were able to draw up a new, Constitution, embracing the values of democracy, freedom of speech and equal rights for women. Afghans voted in their first ever presidential elections and elected a new parliament. Close to five million Afghan refugees have returned home, making it one of the largest movement of people to their homeland in history.

Thousands of schools have been built; over six million boys and girls have been enrolled, the highest level ever for Afghanistan. Hundreds of health clinics have been established boosting our basic health coverage from 9 percent six years ago to over 85 percent today. Access to diagnostic and curative services has increased from almost none in 2002 to more than forty percent now. We have rehabilitated 12,200 km of roads. Our rapid economic growth, with double digit growth almost every year, has led to higher income and better living conditions for our people. With a developing network of roads and a state-of-the-art communications infrastructure, Afghanistan is better placed to serve as an economic land-bridge in our region.

These achievements would not have been possible without the unwavering support of the international community and the strong determination of the Afghan people. I hasten to point out that our achievements should not make us complacent distracting to face the enormity of the tasks that are still ahead. The threat of terrorism and the menace of narcotics are still affecting Afghanistan and the broader region and hampering our development. Our progress is still undermined by the betrayal of public trust by some functionaries of the state and uncoordinated and inefficient aid delivery mechanisms. Strengthening national and sub-national governance and rebuilding our judiciary are also among our most difficult tasks.

To meet these challenges, I am pleased to present Afghanistan's National Development Strategy (ANDS). This strategy has been completed after two years of hard work and extensive consultations around the country. As an Afghan-owned blueprint for the development of Afghanistan in all spheres of human endeavor, the ANDS will serve as our nation's Poverty Reduction Strategy Paper. I am confident that the ANDS will help us in achieving the Afghanistan Compact benchmarks and Millennium Development Goals. I also consider this document as our roadmap for the long-desired objective of Afghanization, as we transition towards less reliance on aid and an increase in self-sustaining economic growth.

I thank the international community for their invaluable support. With this Afghan-owned strategy, I ask all of our partners to fully support our national development efforts. I am strongly encouraged to see the participation of the Afghan people and appreciate the efforts of all those in the international community and Afghan society who have contributed to the development of this strategy. Finally, I thank the members of the Oversight Committee and the ANDS Secretariat for the preparation of this document.

Hamid Karzai
President of the Islamic Republic of Afghanistan

Message from the Oversight Committee

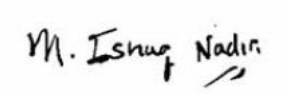
For the preparation of the Afghanistan National Development Strategy

In the name of Allah, the most Merciful, the most Compassionate

We are pleased to present the Afghanistan National Development Strategy, which reflects the commitment of the Islamic Republic of Afghanistan to poverty reduction and private sector-led economic growth for a prosperous and stable Afghanistan. The ANDS Oversight Committee (OSC) was mandated by the Government to produce a Millennium Development Goals-based national strategy that is Afghan-owned and meets the requirements for a Poverty Reduction Strategy Paper. The OSC met on a regular basis to design, discuss and oversee the development of the strategy, including the identification of the needs and grievances of the people, and the prioritization of resource allocations and actions. To embrace 'Afghanization" and ownership, the OSC facilitated inclusive and extensive consultations both at national and sub-national levels.

Sustained fiscal support and continuous evaluation and monitoring are essential now to meet the challenges ahead related to ANDS implementation. The democratic aspirations of the Afghan people are high, yet financial resources remain limited. While much has been accomplished since 2001, more remains to be done as we move from "Compact to Impact". The Afghan Government with support from the international community must act decisively, strategically, and with an absolute commitment to the ANDS goals and vision.

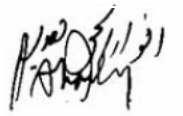
We look forward to working with our government colleagues, civil society representatives, tribal elders and religious scholars, the private sector, the international community and, most importantly, fellow Afghans to implement the ANDS, to help realize the Afghanistan Compact benchmarks and Millennium Development Goals.



Prof. Ishaq Nadiri
Senior Economic Advisor to the President
Chair, ANDS and JCMB

Ahmad Zia Masoud
First Vice-President

Dr. Rangin Dadfar Spanta
Minister of Foreign Affairs



Dr. Anwar-ul-Haq Ahady
Minister of Finance

Sarwar Danish
Minister of Justice

Dr. Amin Farhang
Minister of Commerce and Industry

Dr. Jalil Shams
Minister of Economy

Dr. Zalmay Rassoul
National Security Advisor

Haneef Atmar
Minister of Education

Acknowledgments

For the preparation of the Afghanistan National Development Strategy

In the name of Allah, the most Merciful, the most Compassionate

The Afghanistan National Development Strategy (ANDS) could not have been developed without the generous contribution of many individuals and organizations. The ANDS was finalized under the guidance of the Oversight Committee, appointed by HE President Hamid Karzai and chaired by H.E. Professor Ishaq Nadiri, Senior Economic Advisor to the President and Chair of the ANDS Oversight Committee. The committee included: H.E. Rangeen Dadfar Spanta, Minister of Foreign Affairs; Anwar-ul-Haq Ahady, Minister of Finance; H.E. Jalil Shams, Minister of Economy; H.E. Sarwar Danish, Minister of Justice; H.E. Haneef Atmar, Minister of Education; H.E. Amin Farhang, Minister of Commerce; and H.E. Zalmai Rassoul, National Security Advisor.

We would like to sincerely thank the First Vice-President and Chair of the Economic Council, H.E. Ahmad Zia Massoud. Special thanks are also due to H.E. Hedayat Amin Arsala, Senior Minister and H.E. Waheedulah Shahrani, Deputy Minister of Finance and the Ministry of Finance team. In addition, we would like to thank the Supreme Court, the National Assembly, Government Ministries and Agencies, Provincial Authorities, Afghan Embassies abroad, national Commissions, the Office of the President, Civil Society Organizations, and International Community.

All Ministers, deputy ministers and their focal points, religious leaders, tribal elders, civil society leaders, all Ambassadors and representatives of the international community in Afghanistan; and all Afghan citizens. National and international agencies participated actively in the ANDS consultations. Their contributions, comments and suggestions strengthened the sectoral strategies, ensuring their practical implementation. Thanks are also due to the Ministry of Rural Rehabilitation and Development for their significant contributions to the subnational consultations. Special thanks are further due to the President's Advisors, Daud Saba and Noorullah Delawari for their contributions, as well as Mahmoud Saikal for his inputs. We are also indebted to the Provincial Governors and their staff for their contributions, support and hospitality to the ANDS staff.

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Finally, I would like to thank all who contributed towards this endeavor in preparation of the first Afghanistan National Development Strategy, a milestone in our country's history and a national commitment towards economic growth and poverty reduction in Afghanistan.

Adib Farhadi,
Director, Afghanistan National Development Strategy, and
Joint Coordination and Monitoring Board Secretariat

The complete list of contributors to this Sector Strategy is on the next page.

The Health and Nutrition Sector Strategy was developed as a result of the commitment and efforts of members of key Afghan ministries, donors, UN, civil society, NGOs and the private sector.

The invaluable contribution of H.E. Dr.Said Mohammad Amin Fatimie , Minister of Public Health , H.E. Obaidullah Ramin, Minister of Agriculture, Irrigation and Livestock, H.E .Dr. Faizullah Kakar, Deputy Minister for Technical Affairs of Ministry of Public Health of invaluable in the development of this sector strategy.

Finally, we would like to thank everyone who assisted the ANDS Secretariat in working to develop the Health and Nutrition Sector Strategy. We look forward to the firm commitment of all our stakeholders throughout the implementation of this strategy.

Certainly, contributions to the Sector will remain key to the success of this strategy in particular, and of the ANDS in general.

Special thanks also go to the following for their valued help and support:

Dr. Aqila Noori, Advisor to Deputy Minister for Technical Affairs, Dr. Ahmad Jan , Director General Policy and Planning , Dr. Wali Ghayoor, Health System Strengthening Coordinator , Dr. Mohammad Daud Karimi ,National Consultant Policy and Planning Ministry of Public Health , Nazira Rahman Director of Home economics Department and Charlotte Dufour ,Household Food Security, Nutrition and Livelihoods Advisor FAO, Ministry of Agriculture, Irrigation and Livestock.

Map of Afghanistan

Afghanistan National Development Strategy (ANDS) Structure

SECURITY	GOVERNANCE	SOCIAL AND ECONOMIC DEVELOPMENT					
Pillar 1	**Pillar 2**	**Pillar 3**	**Pillar 4**	**Pillar 5**	**Pillar 6**	**Pillar 7**	**Pillar 8**
1 - Security	**2 - Good Governance**	**3 - Infrastructure & Natural Resources**	**4 - Education & Culture**	**5 - Health & Nutrition**	**6 - Agriculture & Rural Development**	**7 - Social Protection**	**8 - Economic Governance & Private Sector Development**
Sectors							
Security	Justice	Energy	Education	Health and Nutrition	Agriculture and Rural Development	Social Protection	Private Sector Development and Trade
	Governance, Public Administrative Reform & Human Rights	Transportation	Culture, Media and Youth			Refugees, Returnees and Internal Displaced Persons	
	Religious Affairs	Water Resource Management					
		Information and Communications Technology					
		Urban Development					
		Mining					

Cross-Cutting Issues
Capacity Building
Gender Equity
Counter Narcotics
Regional Cooperation
Anti-Corruption
Environment

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Acronyms and Abbreviations

ANC	Antenatal Care
ANDS	Afghan National Development Strategy
ARI	Acute Respiratory Infection
AHS	Afghanistan Health Survey
BCC	Behaviour Change Communication
BHC	Basic Health Centre
BPHS	Basic Package of Health Services
BSC	Balanced Scorecard
CDC	Communicable Disease Control
CGHN	Consultative Group on Health and Nutrition
CHC	Comprehensive Health Centre
CIT	Communications and Information Technology
CHW	Community Heath Worker
CMU	Contract Management Unit
CMW	Community Midwife
CSC	Civil Service Commission
DH	District Hospital
DPT	Diphtheria, Pertussis & Tetanus
DDR	Drug Demand Reduction
EC	European Commission
ENT	Ear, Nose & Throat
EPHS	Essential Package of Hospital Services
EPI	Expanded Program on Immunization
GAVI	Global Alliance for Vaccines and Immunizations
GCMU	Grants and Contracts Management Unit
GDP	Gross Domestic Product
GDPP	General Directorate of Policy & Planning
GDHR	General Directorate of Human Resources
GFATM	Global Fund for HIV/AIDS, Tuberculosis and Malaria
GIACC	General Independent Administration of Anti-Corruption and Bribery
GoA	Government of Afghanistan
GRRU	Gender and Reproductive Rights Unit
HCF	Health Care Financing
HCS	Health Care Service
HCW	Health Care Worker
HIV/AIDS	Human Immune-deficiency Virus/Acquired Immune Deficiency Syndrome
HMIR	Hospital Monthly Integrated Report
HMIS	Health Management Information System
HP	Health Post
HNS	Health and Nutrition Sector
HNSS	Health and Nutrition Sector Strategy
HR	Human Resources
HRD	Human Resources Development
HRM	Human Resources Management
HSO	Health Service Ombudsman
IAR	Independent Administrative Reform
IDD	Iodine Deficiency Disorder
IEC	Information Education and Communication
IHR	International Health Regulations
IIHMR	Indian Institute of Health Management Research
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
JHU	Johns Hopkins University
JICA	Japan International Cooperation Agency
LAB	Laboratory
LEB	Life Expectancy at Birth
MAAR	Monthly Aggregated Activity Report
MIAR	Monthly Integrated Activity Report
MDG	Millennium Development Goal
M	Million
MAIL	Ministry of Agriculture, Irrigation and Livestock
M&E	Monitoring and Evaluation
MCH	Mother and Child Health
MCN	Ministry of Counter Narcotics
MMR	Maternal Mortality Ratio
MoF	Ministry of Finance
MoHE	Ministry of Higher Education
MoPH	Ministry of Public Health
MRRD	Ministry of Rural Rehabilitation and Development
NEPA	National Environmental Protection Agency
NGO	Non-Government Organization
NHA	National Health Accounts
NHCS	National Health Care System
NHP	National Health Policy
NHS	National Health Strategy
NHSPA	National Health System Performance Assessment
NH	National Hospitals
PA	per annum
PAR	Public Administration Reform
PH	Provincial Hospital
PHCC	Provincial Health Coordination Committee
PHCS	Primary Health Care Services
PPA	Performance-Based Partnership Agreement
PPC	Performance-Based Partnership Contract
PPG	Performance-Based Partnership Grant
PPH	Provincial Public Health
PPHCC	Provincial Public Health Coordination Committee
PPSP	Policy and Planning Support Program
PRR	Priority Reform and Restructuring
QA	Quality Assurance
REACH	Rural Expansion of Afghanistan Community Based Health Care
RH	Reproductive Health
RgH	Regional Hospital
SBA	Specialized Birth Attendance
SH	Specialty Hospital
SM	Strengthening Mechanism
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
TA	Technical Assistance
TAG	Technical Advisory Group
TB	Tuberculosis
TF	Task Force
TNA	Training Needs Assessment
TWG	Transparency Working Group
U5MR	Under 5 Mortality Rate
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
UNFPA	United Nations Fund for Population
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
WB	World Bank
WG	Working Group
WHO	World Health Organization

Glossary

Balanced Scorecard (BSC)
The BSC is a sample-based health facility evaluation using selected indicators, including quality indicators, in order to establish a coherent and in-depth M&E system.

Basic Package of Health Services (BPHS)
The package provides standardized basic services with an emphasis to form the core of service delivery in all primary health care facilities.

Behavior Change Communication (BCC)
A program undertaken to make the public aware of health risks they are taking as a result of their behavior in an endeavor to convince them to change their practices.

Chronic Conditions
Health problems that persist and their prevalence is rising worldwide because of increased longevity, urbanization and unhealthy lifestyles.

Consultative Group on Health & Nutrition (CGHN)
The central platform to maximize the coordination and integration of all related activities of the HNS to promote a common approach to assessing sector problems, and provide guidance, direction and overall advisory leadership.

Cost-effective public health interventions
Interventions that can substantially reduce the burden of disease in populations, especially among the poor, and do so at a reasonable cost relative to results.

Essential Package of Health Services (EPHS)
Defines the necessary elements of service mix, staff, facilities, equipment, drugs and consumables for each type of hospital at each level to provide the missing linkage between the BPHS and hospital sector.

Health Care Financing (HCF)
The way health-related activities in a country are financed (funded). It refers to all resources used for health, their sources and the way they are used. HCF (health sector financing) is a key determinant of population health and well-being.

Health Management Information System (HMIS)
Used for collecting routine information on key BPHS; keeping the registration of facilities with unique identification numbers; and supporting data base management.

Indicators
Measures for checking progress on achieving outcomes and outputs, quantitative and/or qualitative, have a time frame, and may highlight geographical and/or target groups.

Information, Education and Communication (IEC)
The effort made in health promotion to make the public more aware of health issues that they can prevent/resolve individually and/or identify for medical assistance as required.

National Health Accounts (NHAs)
An international standard framework for reporting on country health-related expenditures, consistent with frameworks for other economic and social statistics.

National Health System Performance Assessment (NHSPA)
A system conducted in all provinces to evaluate the quality of care for outpatient services for each type of facility providing the BPHS.

Performance-Based Partnership
Contracted-out HCSs to NGOs, with funding provided by the EU, USAID or WB.

Provincial Health Coordination Committee (PHCC)
The platform to maximize the coordination and integration of all health related activities amongst the stakeholders at the provincial level with the main objective of increasing the effectiveness and efficiency of the HNS.

Public Health
The preventing of disease, prolonging life and promoting health through organized efforts of society related to populations / communities as opposed to individuals.

Quality Management (QM)
The degree of excellence of a service or a system in meeting the health needs of those most in need at the lowest cost, and within limits, directives and / or regulations.

Sector-wide approach (SWAp)
The formulation of policy and management of all agencies and organizations, both public and private, with a common strategy and mutually agreed management arrangements including the pooling of financial resources (excluded in sector-wide management).

Stewardship
The methodology of implementing the vision and direction of the NHP by exerting influence through regulation and advocacy, collecting and using information, and Contracting Out to provide HCSs to the public.

Strengthening Mechanism (SM)
Delivery improvement of HCS Provision by the MoPH, currently at district level in three provinces, and supported by the WB.

Technical Advisory Group (TAG)
The highest level technical platform to discuss issues and challenges related to the NHCS, and provide solutions to all health related activities at all levels.

Transparency Working Group (TWG)
A ministerial TF that will act as an advisory board to the leadership on accountability and integrity standards.

Executive Summary

HEALTH AND NUTRITION SECTOR STRATEGY

Afghanistan has taken a devastating toll during more than the past two decades with the human and socio-economic indicators still hovering near the bottom of international indices. Human resources (HR) in health have been decimated, leaving behind scarce qualified health professionals, who are predominantly male where it is more difficult to employ qualified female staff in districts/remote areas. Life expectancy at birth (LEB) is 47 years for Afghan men and 45 years for women, slightly more than half that of the wealthiest countries of the world.

The country suffers greatly from very high levels of Infant Mortality Rate (IMR) at 129/1000 live births, Under 5 Mortality Rate (U5MR) at 191/1000 live births and the Maternal Mortality Ratio (MMR) is estimated at 1600 for every 100,000 live births, the highest in the world except Sierra Leone. By all measures, the people of Afghanistan fare far worse, in terms of their health, than any other country of the region.

The mission of the Ministry of Public Health (MoPH) is to improve the health and nutritional status of the people of Afghanistan in an equitable and sustainable manner through quality HCSs Provision (HCSP) and the promotion of a healthy environment and living conditions along with living healthy life styles.

The goal of the Health and Nutrition Sector (HNS) is to work effectively with communities and development partners to improve the health and nutritional status of the people of Afghanistan, with a greater focus on women and children and under-served areas of the country.

In order to develop the HNS to the point that it can realize this mission and goal, the MoPH will continue to develop and implement nine broad Programs that will add strength to its ability to create a favourable policy environment and to manage and deliver a wide array of Health Care Services (HCSs) at all levels of the National Health Care System (NHCS), from the remotest rural communities through to tertiary care hospitals in the major urban areas.

However, the long process of recovery has begun and, rather than dwell on the past, it is now time to take aggressive action to address these problems in a way that can both bring about rapid and demonstrable improvement in the health status of the population and lay the groundwork for longer-term development in the HNS.

In order to achieve these objectives, and to bring order and cohesion to what had been a chaotic and non-functional HNS only a few years ago, the MoPH, in consultation with Government of Afghanistan (GoA) officials, external donors, United Nations (UN) agencies, and other stakeholders, has adopted the following eighteen strategies.

A. Reducing morbidity and mortality

- Implement the Basic Package of Health Services (BPHS)
- Implement the Essential Package of Hospital Services (EPHS)
- Improve the quality of maternal and reproductive HCSs
- Improve the quality of child health initiatives

- Strengthen the delivery of cost effective integrated Communicable Disease Control (CDC) Programs
- Establish prevention and promotion programs
- Promote greater community participation
- Improve coordination of HCSs
- Strengthen the coverage of quality support programs
- Reduce prevalence of malnutrition and increase access to micronutrients.

B. Institutional development

- Promote institutional and management development at all levels
- Strengthen health planning, monitoring and evaluation (M&E) at all levels
- Develop Health Care Financing (HCF) and national health accounts
- Strengthen HR Development (HRD), especially of female staff
- Strengthen provincial level management and coordination
- Continue to implement Priority Reform and Restructuring (PRR)
- Establish quality assurance (QA)
- Develop and enforce public and private sector regulations and laws

The MoPH recognises that long term sustainable improvements in the health status of the peoples of Afghanistan will require a long term multi-sectoral approach to addressing the causes of ill health along with improving health care and prevention interventions. There is also the recognition that the current capacity of the MoPH must be further strengthened to enable the ministry to take a lead in these public health issues.

While the MoPH has attained significant achievements in addressing key health issues across a number of priority areas, strategies are in place or are under development to expand services and interventions at a pace that does not over stretch the growing capacity of the government to organise and oversee a continually broadening of interventions and the improvement in quality in their delivery.

Highest priority, greatest impact interventions have seen the focus on primary health care services and prevention. A longer term approach will address population health issues as that capacity increases.

Recognising the above considerations, and by overcoming the many current challenges and resolving existing problems, the goal of the MoPH to achieve the following results by the year 2013 are possible:

Table 1: Desired Results for 2013

Results	2000 Baseline	Achievement by 2006	High Benchmark 2010	HNS 2013	2015 (Afghan MDGs)
"BPHS will cover at least 90% of the population by 2010"					
Increased access to Primary HCSs (PHCSs) within two hours walking distance	9% of population with nearby access to PHCSs	65% of population with nearby access to PHCSs	90% of population with nearby access to PHCSs	90% of population with nearby access to PHCSs	
"Maternal Mortality Ratio will be reduced by 15%"					

Reduction of MMR	1600 deaths per 100,000 live births		Reduction by 15% to 1360 deaths per 100,000 live births	Reduction by 21% from the baseline (1264)	Reduction by 50% from the baseline (800)
"Infant and under five mortality will be reduced by 20%"					
Reduction of U5MR	257 deaths per 1000 live births	191 deaths per 1000 live births	Reduction by 20% to 205 deaths per 1000 live births1	Reduction by 35% from the baseline (167)	Reduction by 50% from the baseline (128)
Reduction of IMR	165 deaths per 1000 live births	129 deaths per 1000 live births	Reduction by 20% to 132 deaths per 1000 births2	Reduction by 30% from the baseline (115)	Reduction by 50% from the baseline (82)
"Full immunization coverage"					
Increased national immunization coverage with three doses of Diphtheria, Pertussis & Tetanus (DPT) vaccine among children under one year of age	31%	77%	Achieve above 90% coverage	Achieve and sustain above 90% national coverage	Sustain above 90% national coverage
Increased national immunization coverage with measles vaccine among children under one year of age	35%	68%	Achieve above 90% coverage	Achieve and sustain above 90% national coverage	Sustain above 90% national coverage
Source: IMR and U5MR-2006 Afghanistan Health survey showed this target already surpassed.					

1 U5MR – 2006 Afghanistan Health survey showed this target already surpassed.

2 IMR – 2006 Afghanistan Health survey showed this target already surpassed.

In order to provide equitable HCSs of acceptable quality, the development of a sustainable and efficient NHCS is vital. Consequently, the MoPH analysed how to redress the deplorable situation that existed at the time the interim GoA was constituted. It came to the early realization that it could not simultaneously concentrate on putting its administrative and managerial houses in order and on being responsible for delivering quality HCS to the population. An early decision to take on a stewardship role allowed the MoPH to move vital reform processes forward and to infuse newly created organizational structures with a culture of "management for change".

Based on the recent proposal of Ministry of Finance (MoF) on Program Budgeting Reform, it has become clear that the earlier economic approach of the administrative budget lines was found deficient on many counts, and a programmatic approach is now preferred to address the financing and accountability issues in a more coherent and integrated manner.

Therefore, the strategies of the HNS will be discussed in terms of nine core programs (Refer Annex III) – five related to HCSP and four related to institutional development:

Health Care Services Provision Programs

1. Primary Health Care Program;
2. Hospital Care Program;
3. Disease Control Program;
4. Reproductive Health (RH) and Child Health Program;
5. Public Nutrition Program

Institutional Development Program

6. Policy and Planning Support Program;
7. HRD and Research Program;
8. Pharmaceutical Management Support Program; and
9. Administration Program.

The HCS Programs have developed specific program related national strategies to provide guidance for the provincial health offices to address priority issues in their areas.

To date, the implementation of these Programs has made a demonstrable difference. The recently conducted Afghanistan Health Survey (AHS) in 2006 (1385) shows a 25% reduction in the under five mortality rate (U5MR) over 2001 (1380) levels (from 257 to 191 deaths of children per 1000 live births) and in under one child mortality (from 165 to 129 deaths of children per 1000 live births). These estimates provide evidence that infant and child mortality has decreased in Afghanistan in recent years. Childhood vaccination coverage has also improved, especially for the most dangerous of vaccine-preventable diseases, measles. Impressive increases have also been documented for RH, with more women receiving pre-natal care, more deliveries being assisted by professional health care providers, and more families using modern contraceptive methods to determine the size of their families.

However, despite the progress that has been made to date in the HNS, many problems and challenges remain. These include: inadequate financing for many of the key Programs that should be, but are not yet, being fully implemented. Reliance on external sources of funding will be required for many years to come, but GoA prioritization of the HNS also needs to be encouraged and a higher proportion of the Gross Domestic Product (GDP) invested in HCSP to the population. Also, in order for even well-designed Programs to be implemented, health staff needs to be able to do what is being asked of them. Currently, an inadequately trained health staff at all levels, including a general lack of female health staff, poses significant problems.

Because of the dependence on Non-Government Organizations (NGOs) for the actual delivery of HCS, the potential for problems of coordination with GoA staff at peripheral levels is great. Substantial investments at the Provincial level, primarily in the form of Provincial Public Health Strategic Planning, and Budgeting and to an even greater extent at district level, need to be made to provide the MoPH with a greater capacity to oversee the implementation of its strategies and programs. A new category of management personnel, the District Health Officer, will be developed, trained, and deployed. As mentioned above, limited geographical access to HCS is a real problem in Afghanistan. Many cannot reach even the

Basic Health Centre (BHC), the most peripheral level of implementation of the BPHS. The recently approved proposal to Global Alliance for Vaccines and Immunizations (GAVI) will help greatly to expand the reach of the BPHS, but the challenges associated with doing so will have to be met.

In addition, the security situation has an important effect on the ability of the population to access available HCS. Utilization of services in more secure provinces has been shown to be more than three times greater than that in areas where conflict continues. Finally, in order to continue to be able to develop and manage appropriate health policies and programs on the basis of objective performance data, important investments will have to be made in 3the further development and maintenance of health management information systems (HMIS) and M&E mechanisms.

Finally, it needs to be mentioned that continued progress in public health and nutrition is difficult to achieve in the face of insecurity and growing violence. Ultimately, the health of the Afghan population, in addition to its continued social and economic development, will depend as much on the ability of it's and the world's diplomats and politicians to forge a lasting peace in the country and region as on the policy-makers and technicians of the MoPH.

INTRODUCTION

The Afghanistan National Development Strategy (ANDS) is a five-year Program that lays out the ways by which Afghanistan will progress toward the achievement of the Millennium Development Goals (MDGs). Based on the Afghanistan Compact 2006 (1385), the strategy is intended to chart a path of broad-based and equitable economic growth that will result in substantially lower levels of poverty and an improved political, social and economic status of the Afghan population.

The MoPH of the GoA has developed a clear statement of its mission. This is "to improve the health of the people through quality HCSP and the promotion of healthy life styles in an equitable and sustainable manner". It intends to achieve this ambitious, but appropriate, goal by implementing eight broad Programs that will strengthen its ability to create a favourable policy environment and to manage and to deliver a wide array of HCS within communities and at all levels of the NHCS, from sub-Basic and BHCs located in the most peripheral and hard-to-reach areas of the country to the tertiary care hospitals in the more populated and accessible urban areas.

Improving the health status of the population is an essential component of Afghanistan's development strategy. Poor health is a substantial drag on the ability of a country to develop economically. Although health care is free under the terms of the Constitution, the AHS suggested that substantial household expenditures are being made by families for transport to health facilities and for the purchase of drugs and other medical supplies. In some instances, in the case of serious or catastrophic illnesses, families may be forced to use an exceedingly high proportion of their disposable income in search of appropriate care. In some countries unacceptable levels of "iatrogenic poverty" people being thrown below the poverty line by HCS costs that exceed their ability to pay – have been documented and this might be the case in Afghanistan as well. In addition, work days lost to illness and a general depletion of the work force due to the kinds of diseases that are highly prevalent in Afghanistan has a measurable impact on productivity. For example, consider that in Afghanistan there are 70,000 cases of Tuberculosis (TB). If these were left untreated, with a potential result that those affected would be incapacitated for one year and therefore unable to earn even wages as low as United States Dollar (USD) 1-2 per day), the economic loss would be USD350-700 per annum (pa) per person. The total loss will be per person loss multiplied by 70,000. In general, just as ill health can be a factor in "poverty production", improved health plays an important role in poverty reduction.

The relationship between health and economics has been debated for decades at the international level. Whether poverty is a contributor to poor health and economic development is the solution, or whether poor health is a contributor to poverty and disease control a prerequisite for economic development, is not a useful argument. It has become increasingly clear, as accumulated data have been analyzed, that there is a two-way relationship between health and economic development and that each contributes to the other. Like the establishment of a secure environment, good education and the creation of economic opportunities for its population, the provision of public health interventions, health education and services is considered a core function of the State which is accountable to its population for execution. The MoPH considers that access to essential HCSs is a right of the people of the Afghanistan and it sees the fulfilment of that right as its obligation. Its strategies and programs are designed in such a way that a package of essential HCS can be made available to each and every Afghan man, woman, and child. The successful achievement of its targets and objectives will result in accelerated economic development for Afghanistan and vastly improved human development for its people. The HNS has made major measurable strides since 2003 (1382) and this document presents a blueprint for how further progress is to be achieved by the year 2013 (1392).

CHAPTER 1

BACKGROUND

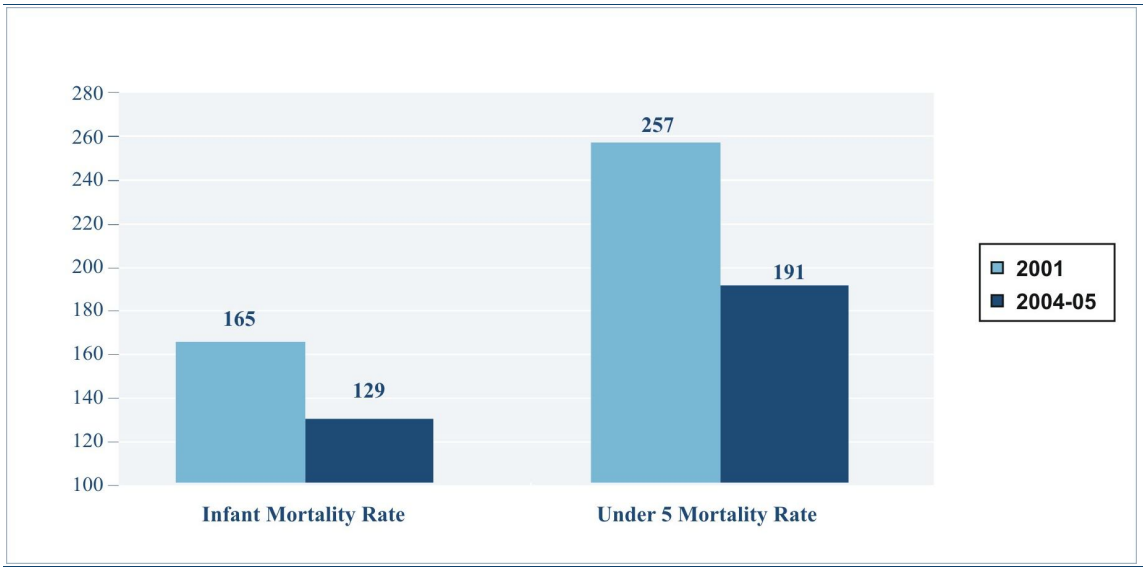
Years of conflict in Afghanistan have taken a devastating toll, as measured by dramatic drops in human, social and economic indicators. Extensive public sector inefficiencies following the long years of armed conflict have not spared the HNS.

The general health situation of the Afghan people remains overwhelmingly poor and is exacerbated by the dismally deficient determinants of health; vector caring mosquito, inadequate water supplies, poor sanitation and hygiene practices, security issues, lack of public policy on harmful goods (cigarettes, unfortified flour, non-iodized salt,), unsafe public places, uncontrolled waste disposal, air and noise pollution, unsafe drug practices, poorly designed houses, food insecurity, substance abuse and HIV potential. According to recent data, LEB at birth is a distressing 47 years for men and 45 years for women. Mortality rates for children and for women are unacceptably high – U5MR was estimated to be 257 deaths per 1,000 live births in 2000 (1379) – more than one in four children died before reaching their fifth birthday.

The MMR was estimated to be among the highest in the world - 1,600 per 100,000 live births, with estimates in some provinces ranging much higher.

However, as indicated in the figure 1.1 the AHS in 2006 (1385) shows a 25% reduction in the under five mortality rate (U5MR) over 2001 (1380) levels (from 257 to 191 deaths of children per 1000 live births) and in under one child mortality (from 165 to 129 deaths of children per 1000 live births).

Figure 1.1: Infant Mortality Rate and under 5 mortality Rate 2001 and 2004-2005



Source: MoPH

Three preventable diseases cause child mortality: acute respiratory infections (ARI), diarrhoea, and measles. Chronic malnutrition, developed at a young age, translated into extraordinarily high prevalence rates of underweight children (40%) and of stunting (54%). The country carries a high burden of communicable diseases such as TB and malaria. Human Immune-deficiency Virus/ Acquired Immune Deficiency

Syndrome (HIV/AIDS), while still at an acceptably low level, is a menacing threat, the extent of which is not yet known. In addition, as a direct consequence of the years of conflict, Afghanistan has a large number of disabled and mentally ill people for whom treatment and rehabilitation services need to be developed and for whom assistance will be required in order to re-integrate them into the daily life of the country.

After the establishment of the interim GOA, the MoPH had to assume great responsibilities with limited capacities. The long conflict resulted in few qualified health professionals, who are predominantly male where it is more difficult to employ qualified female staff in districts/remote areas. Tremendous efforts have been made to transform the MoPH into a functional institution, one capable of formulating evidence-based policies and strategies aimed at addressing the most pressing needs. Its principal purpose is to effectively and efficiently reduce the high levels of morbidity and mortality that have affected the ability of the population to develop socially and economically. At an early point during the post-conflict period, the MoPH, with its development partners, made a number of key decisions that allowed rapid progress to be made toward the adoption of HNS reforms and basic HCSP. Most importantly, the MoPH recognized the need to work within its limitations by focusing on the development of a restricted number of functions, with a singular focus on providing leadership and direction to the many different aspects of the HNS, including that of M&E of HCS delivery. A critical decision regarding the actual delivery of those services was to contract out that major responsibility to non-state providers. This strategy, while remaining somewhat controversial, has proven to be quite successful.

An interim NHP and Strategy was developed for the years 2002-2004 (1381-1383). That was followed by the development of the NHP 2005-2009 and NHS 2005-2006. The initial strategy was centred on the development and early implementation of a set of interventions to be delivered at PHCS facilities, the BPHS. The BPHS includes a defined set of cost-effective interventions aimed at addressing the principal health problems of the population, with an emphasis on the most vulnerable groups, women and children, but with provisions made for the eventual incorporation of interventions targeting other vulnerable groups as well. More recently, the EPHS has been developed in an attempt to develop a functional referral system for more severe cases of disease.

The BPHS and EPHS represent the clear and well-described content of the MoPH strategic program for service delivery. Much more work is required to develop strategies to address the many public/population health issues of the country. These points are an important part of the answer to the question, "What does the MoPH do?" The question of "How should they do it?" was the subject of a key policy decision in its early days. As mentioned above in 2003 (1382), the MoPH adopted the strategy of contracting out the delivery of basic HCS to non-state providers in order to be able to concentrate fully on its role as steward of the HNS. Under three different contracting mechanisms, under-written by the World Bank (WB), United States Agency for International Development (USAID), and the European Commission (EC), representing three different philosophical approaches to the relationship between the host country government, donor, and population, the BPHS is currently being delivered on a contractual basis with NGOs in 31 of the 34 provinces in Afghanistan. In the remaining three provinces, the MoPH is undertaking an experiment called the "Strengthening Mechanism" by which it is, essentially, contracting with its own staff, on the same terms as it contracts with NGOs under the WB mechanism.

A key strategic process that vastly enhanced the ability of the MoPH to manage many large NGO contracts was the establishment of the GCMU in 2003 (1382). Situated within the MoPH, the GCMU has expanded rapidly with the BPHS, currently managing, both technically and financially in conjunction with the MoF, about USD125m worth of grants and contracts. The success of this experience has and should convince other donors, including USAID and the EC, to channel funds through the GoA rather than developing bilateral programs with their own duplicative management systems.

One of the crucial questions to be asked at this juncture is whether to continue with the somewhat controversial policy of contracting out the delivery of HCS to NGOs or to try to return to the more traditional scheme of providing HCS through the civil service. As can be seen in the following section and throughout this document, the gains achieved by the existing mechanisms have been impressive. While there are pressures to make the HNS more "Afghan", whatever that might mean, it seems to be in the best interests of the further development of the sector and of the Afghan population to adhere to the current policy for the foreseeable future. The strengthening mechanism strategy should be carefully and objectively evaluated against comparable contracting-out outcomes (coverage, quality and cost) and, if it continues to prove to be as robust as it has been to date, utilized for further sector development beyond the next five years.

An important element of the context in which the HNS has developed to the present has been the high degree of coordination that existed among the MoPH's many partners, both external/international and internal/national. As early as 2002, the MoPH had responded to the GoA recommendation to establish an internal consultative group mechanism within the HNS for coordinating both technical efforts and the input of donors. Since then, Consultative Group for Health and Nutrition (CGHN) meetings have been held weekly. The CGHN includes donors, major NGOs, the International Security Assistance Force, UN agencies, and other line ministries, as appropriate. All relevant technical issues are presented and discussed in this forum and recommendations for action are forwarded to the Technical Advisory Group (TAG), another group of internal and external advisors that submits recommendations to the Ministry's Executive Board for endorsement.

The MoPH has also formed a number of Task Forces (TFs) and Working Groups (WGs) to address important cross-cutting issues that have not customarily received adequate attention. The formation of these groups, and the excellent record of the MoPH in following up on their recommendations, has made coordination a functional strategy within the MoPH and not just something "that has to be done". The ability of the MoPH to support its positions with hard evidence, and present that evidence to external partners in a convincing manner, has also contributed to raising the level of dialogue between the MoPH and its partners.

STRUCTURE OF THE HEALTH CARE SERVICES DELIVERY SYSTEM

The structure of the HCS system in Afghanistan is traditional. At the most peripheral level, community health workers (CHWs) who are non-health professionals with limited but highly targeted training are the initial point of contact for individuals seeking HCSs. The BHC, a formal structure maintained by the MoPH, is staffed by health professionals and provides, at a minimum, all of the services that comprise the BPHS. Comprehensive Health Centres (CHCs), the next level of the system, provides the BPHS and additional services including minor and essential surgery. The District and Provincial Hospitals offer a broader array of more sophisticated medical care and, at the pinnacle of the HCS pyramid, tertiary hospitals in the major urban areas provide the most sophisticated care available in Afghanistan's public HNS. There is a large private and traditional HCS sector in Afghanistan as well, about which relatively little is known. The MoPH is in the process of developing regulation and process to fulfil its stewardship role this aspect of the NHCS as well.

TYPES OF HEALTH FACILITIES USED BY THE NHCS:

Health Post (HP): At the community level, basic HCS will be delivered by CHWs from their own homes, which will function as community HPs. A HP, ideally staffed by one female and one male CHW, will cover a catchment area of 1,000-1,900 people, which is equivalent to 100-150 families.

Sub-Centre: Sub-centres will be established to cover a population from 2,000 to 15,000. The MOPH decision is to establish these sub-centres in the private houses and try to avoid

construction. A Sub-Centre is staffed by one male nurse and one community midwife (CMW).

Basic Health Centre (BHC): The BHC is a small facility offering the same services as a HP but with more complex outpatient care. The BHC will supervise the activities of the HPs in its catchment area. The services of the BHC will cover a population of 15,000-30,000 people, depending on the local geographic conditions and the population density. The minimal staffing requirements for a BHC are a nurse, a CMW, and two vaccinators. Depending on the scope of services provided and the workload of the BHC, up to two additional Health Care Workers (HCWs) can be added to perform well defined tasks.

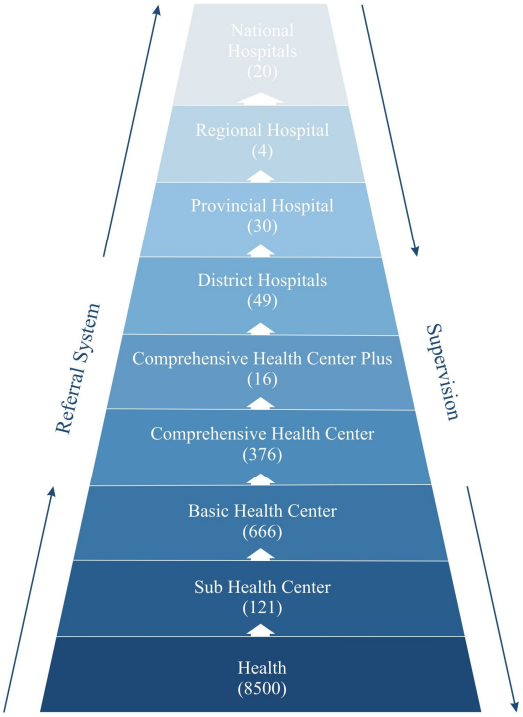
Comprehensive Health Centre (CHC): The CHC covers a larger catchments area of 30,000-100,000 people, offering a wider range of services than the BHC. The facility will have limited space for inpatient care, but will have a laboratory (lab). The staff of a CHC will also be larger than that of a BHC, including both male and female doctors, male and female nurses, midwives, and lab and pharmacy technicians.

Comprehensive Health Centre plus (CHC+): This type of health facilities aim to provide maternal health care services particularly Comprehensive Emergency obstetrics Care services. These facilities have 10 beds.

District Hospital (DH): At the district level, the DH will handle all services in the BPHS, including the most complicated cases. The hospital will be staffed with doctors including female obstetricians/gynaecologists; a surgeon, an anaesthetist and a paediatrician; midwives; lab and X-ray technicians; a pharmacist; and a dentist and dental technician. Each DH will cover an approximate population of 100,000-300,000 people in one to four districts.

Provincial Hospital (PH): The PH is the referral hospital for the Provincial Public Health (PPH) Care System. In essence, the PH is not very different from a DH: it offers the same clinical services and possibly a few additional specialties. In most cases, the PH is the last referral point for patients referred from the districts. In some instances, the PH can refer patients to higher levels of care to the regional hospital or to a specialty hospital (SH) in Kabul.

Figure 1.2: Types of Health facilities used by the NHCS:



Source: HMIS/MoPH (2007)

Regional Hospital (RgH): The RgH is primarily a referral hospital with a number of specialties for assessing, diagnosing, stabilizing and treating, or referring back to a lower level hospital. The RgH provides professional inpatient and emergency services at a higher level than is available at DHs and PHs, yet the overall objective remains the reduction of the high MMR, IMR, and U5MR, and of other diseases and conditions responsible for Afghanistan's high mortality and morbidity.

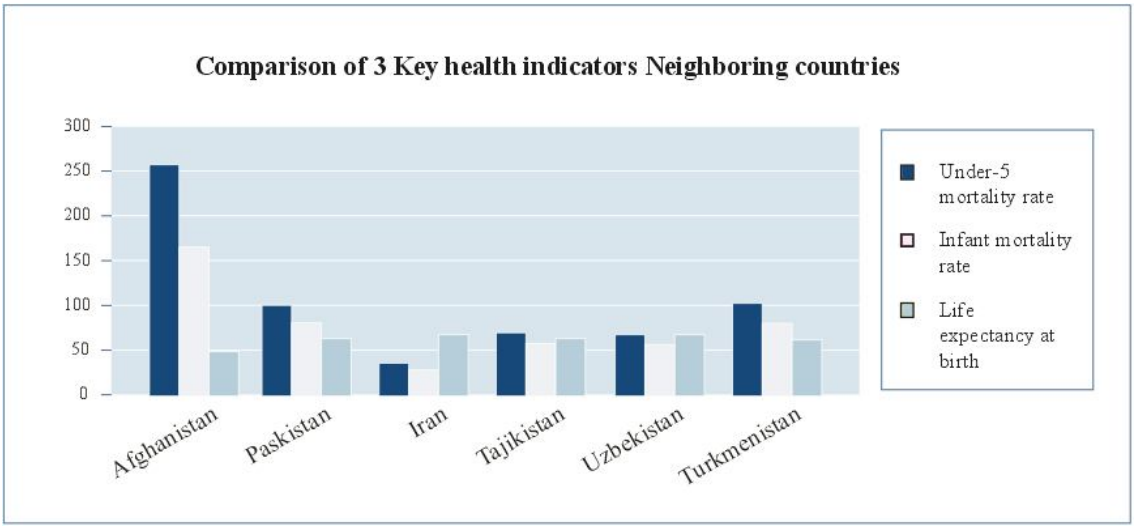
National Hospitals (NH): NHs or SHs are referral centres for tertiary medical care and are located primarily in Kabul. They provide education and training for HCWs and act as referral hospitals for the PHs and RgHs.

Comparison with Countries of the Region: It is quite difficult to compare the health parameters of Afghanistan with those of its neighbouring countries. One might think of

Pakistan and Iran as the closest neighbours, but neither has endured very recent conflict of the magnitude or duration that Afghanistan has. In particular, Iran is lauded for its longstanding commitment to the development of its HNS, while Afghanistan has a NHCS that is not yet fully functional. Afghanistan's neighbours to the north were part of the USSR and, although their NHCSs may have deteriorated some since the dissolution of the Soviet Union, they also have not suffered from the destruction and total breakdown of public administration that will continue to exercise detrimental effects in Afghanistan for some years to come.

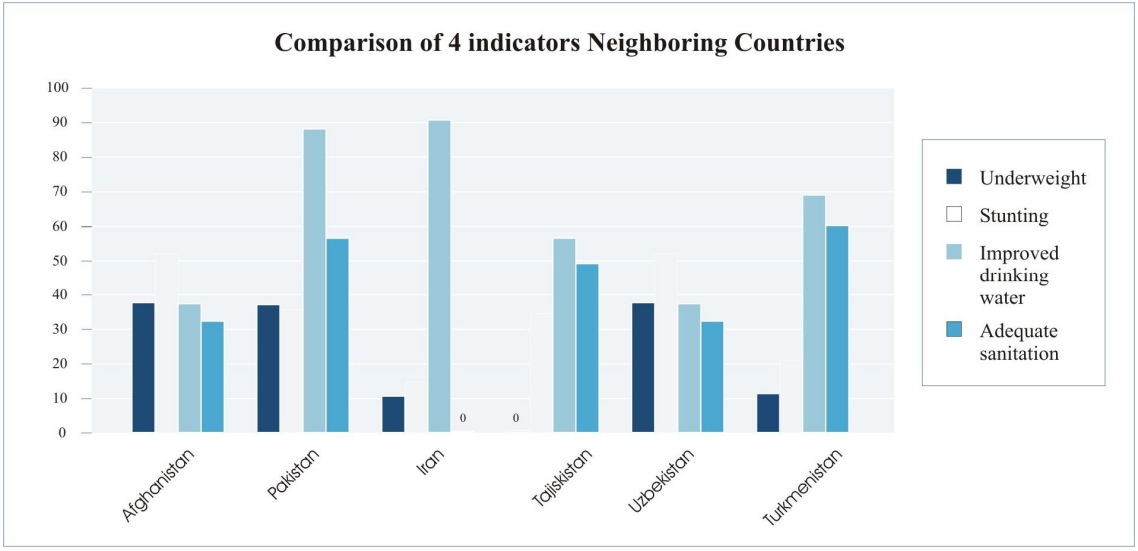
Nevertheless, it is worth presenting some of the officially recognized international data from the region. The data presented in figure 1.3 is drawn from the United Nations Children's Fund (UNICEF's) annual publication, State of the World's Children, 2007 edition (data in the document is from 2005):

Figure: 1.3 Comparison of 3 Key health indicators Neighbouring Countries



Source: UNICEF, State of World's Children (2007)

Figure: 1.4 Comparison of 4 indicators Neighbouring Countries



Source: UNICEF, State of World's Children (2007)

Afghanistan not only trails the other countries in the region by a considerable margin, but its progress stalled completely over the last fifteen years, whilst the other countries in the regions were making reasonable advances. However, over the last few years of collecting data through active methods such as health surveys and the Balanced Scorecard (BSC), it is evident that important health indicators in Afghanistan are no longer stagnant; in fact, the gains have been impressive. Refer to the AHS 2006 and Afghanistan Health Sector BSC.

BROADER ROLE OF HNS;

The broader role of the MoPH in addressing the health needs of the Afghan people has jet to be fully defined. While a large number of public and population health issues have been identified in specific program strategies, the attention to achieving immediate results remains the immediate and medium term focus until management capacity, infrastructure development and sound inter-sectoral mechanisms have been developed to enable cooperative planning, resource sharing and joint monitoring to take place. These points will be given strategic consideration as immediate term targets are achieved.

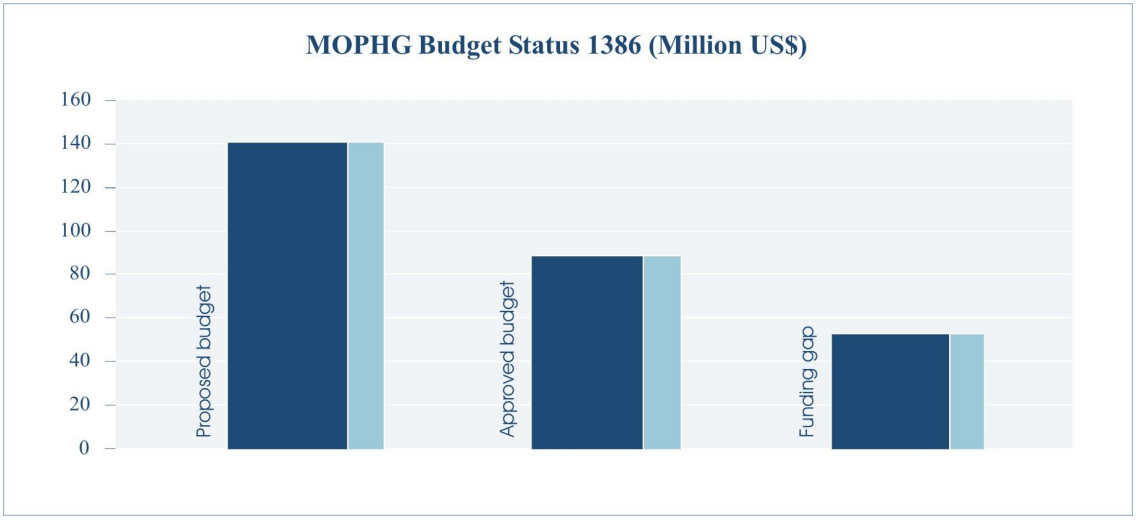
CURRENT INSTITUTIONAL, FINANCING AND MANAGEMENT SET-UP OF THE HNS;

Afghanistan's economic outlook has improved significantly since the fall of the Taliban regime in 2001 (1380). This is due to the receipt of over USD2billion in foreign assistance, combined with recovery of the agriculture sector and, to a degree, the re-establishment of a functional market economy. However, despite this progress Afghanistan remains quite poor with the path to progress likely to be arduous and prospects limited some for years to come. Afghanistan is situated in a "difficult neighbourhood", one marked by political instability and unstable international relationships. Whilst it will undoubtedly remain reliant upon international aid for the foreseeable future, there is potential for optimism when one considers that the mining sector is almost unexplored and undeveloped. However, continued insecurity within its borders and the continued existence of a "poppy culture" in large parts of the country will contribute to Afghanistan's problems until brought under better control. With its current gross GDP per capita of USD329, Afghanistan is one of the poorest countries in the world.

The HNS receives only a small portion of GoA resources, accounting for only 3% of the overall operating budget and 5% of the development budget. The discrepancy with education, the other major social sector, is particularly noteworthy, with the latter being allocated 20% and 9% of the operating and development budgets, respectively.

As shown in figure 1.5 In 2007 (1386), the MoPH had proposed 54 projects to the MoF for the Core Budget at an estimated cost of USD149.27 million (m); of these, 33 projects totalling USD92.77m (62%) were approved. As a result, the HNS is heavily dependant on its external budget, especially donor funds not channelled directly through the MoF. However, although tracking of donor resources is quite difficult, it can be estimated that about 60% of MoPH funding comes from the external budget based on MoF figures. It should be noted that Afghanistan has not yet established National Health Accounts (NHA) although it is planned for the near future. As demonstrated in the graph below, the funding gap represents 38%.

Figure1.5 on the next page: MoPHG Budget Status, 1386 (Million US$)



Source: Health Care Financing Department / MoPH (2007)

ROLE OF THE NGOS AND THE PRIVATE SECTOR WITHIN THE HNS:

After the collapse of the public health care system during the years of conflict, NGOs played a major role in the HNS by providing a range of services in accessible areas, even without having the resources, technical capacity or intention to systematically develop a coherent and externally supervised network of structured health facilities, guided by strategic guidelines for HCS delivery and linked by a referral system. The availability of donor funding at the end of the war created the opportunity to address the health situation in a systematic way through the introduction of the BPHS and EPHS schemes. The Ministry assumed a stewardship role of the HNS, creating the coherence that had been missing, and HCS delivery was contracted out to those most familiar with it, the NGOs.

The MoPH has adopted many of the principles of modern Public Management through strategies such as contracting and the promotion of competition. Using donor funds, the MoPH has contracted NGOs, both national and international, to deliver the BPHS via different mechanisms. A prominent feature of many of the contracts, one that has been championed by the WB, is performance-based incentives for performance. In Cambodia, where a similar Program was supported by the Asian Development Bank (ADB), contracting out HCS to the private sector, and specifically to NGOs, is reported to have resulted in improved HCS delivery, increased transparency in the HNS, and reduced overall HCS costs, including significantly reduced costs to the poor.

As the NHCS has developed in Afghanistan, it has become increasingly clear that the addition of a planning and policy actor, the MoPH, has had a unifying effect on HCS delivery standards. Differences in contractual arrangements with NGOs, between the three main donors, have had only a limited impact on the effectiveness and efficiency of HCS delivery. To a considerable extent, this may be due to the establishment of the Grants and Contracts Management Unit (GCMU) within the MoPH, a Unit that serves as the focal point for the three donors. The GCMU established itself as a strong steering and coordination agent for all the contracted NGOs, independent of their specific contractual arrangements. Contracting out has thus become a successful approach to HCSP, supported by a strong partnership between the Ministry, the donors and the implementers. Through NGO intervention and documentation such as surveys, assessments and the collection of baseline data, the MoPH has been able to develop a more precise overview about the epidemiological situation of the country. It might be added that the system has benefited from the fortunate but real fact that many of those who worked valiantly for NGOs during the conflict period are now working for the State. Although in many countries, the public sector and the NGOs are in a competitive situation, in

Afghanistan these contrasting cultures are well understood by all.

In addition, most NGOs have shown a remarkable commitment to implementing the new health strategies; indeed, they have participated fully in their development and provided feedback through their participation in MoPH workshops and TFs.

The contracting-out scheme has allowed for a rapid expansion of the NHCS, contracts which now cover geographical areas in which eighty-two percent (82%) of the Afghan population lives. The concept of "performance-based partnership contracts" (PPCs), measured against established benchmarks and indicators, exerts a permanent pressure on NGOs to provide services of the highest quality standards possible. Lump-sum service contracts, such as those funded by the WB contracting scheme, provide NGOs with considerable freedom to meet their targets according to the demands of the field, and bonus payments give them a further incentive to do so. USAID funded NGOs receive considerable technical assistance through Tech Serve, a follow-on to the previously funded Management Sciences for Rural Expansion of Afghanistan Community based Health Care (REACH) project. EC funded NGOs are signing grant contracts based on their own "proposals", which are then monitored against their logical framework indicators. All these NGOs are required to provide a full range of services to enable them to do so. The introduction of provincial level planning and budgeting will have a significant impact on the planning and operations of NGOs as the MOPH takes up the stewardship role even further. National program strategies will form the basis for strategic and operational plans jointly developed by all local stakeholders with common targets and indicators.

In this new role the MoPH, through the PHOs will actively participate in service and intervention monitoring to ensure that adequate medical supplies and commodities are available. In some provinces, NGOs are also contracted for the provision of the EPHS. In sum, NGOs have become an active partner of the MoPH, contributing to institutional strengthening at the central and provincial levels as much as they have to the delivery of HCS to the Afghan population.

As mentioned above, NGOs were historically accustomed to delivering HCS when and where they could. In these more stable times, assuming responsibility for all HCSP within a province is a new experience for the NGOs, and one that makes them more subject to social and political pressures than previously. It should also be noted that, as GoA contract holders, NGOs risk losing some of their ability to "represent" multi-sectoral community interests, a feature that has helped to define them in the past. Fortunately, in some ways, some more "traditional", non-contracted NGOs still exist in some provinces. Even these, to the benefit of all, are seeking to have their activities integrated into the official NHCS through information sharing and increased coordination.

After a few years of operation it has become clear that many NGOs have achieved remarkable results due to their intimate knowledge of the area in which they are working (and had been working, even during the war years), and the attention and support they have received from the new MoPH. It seems that, on the basis of this success, donors are presently willing to support the HNS for the foreseeable future. Based on this positive investment climate, the MoPH is working to help build the capacity of both new and more established indigenous NGOs in order to improve the prospects for long-term sustainability of the existing system. Whether future contracts are with NGOs that are more familiar with the regions and communities in which they are working, or whether they are NGOs that are expanding their successful work into new areas, it is clear that continued financial support and training will be required. This will be especially related to community health and outreach, in addition to quality improvement, and the MoPH remains committed to helping in all aspects.

The for-profit private sector in Afghanistan is considerably less developed than the NGO not-for-profit sector. Private pharmacies, practices (for medical, diagnostic or therapeutic services) and hospitals are relatively plentiful, which are increasingly more regulated by the MoPH. Below the level of professionally trained and recognized service providers, there is a layer of non-professionals, such as drug sellers who operate primarily in rural areas, and these are

of concern to the overall HNS. However, initiatives are underway that actively encourage the primary level of the private sector to engage in specific services listed in the BPHS.

The private sector can be seen as playing both a complimentary and, at times, a competitive role; its regulation needs to be further strengthened through current HNS policy and future unwritten legislation. The MoPH has recently decided to appoint one officer in each district who among other duties will be responsible to implement health legislations at the district level. Many valuable contributions and accomplishments of the private sector, especially in rural areas, are not accessible to the Ministry and NGOs. Consequently, they are not currently recognized in the National Health Statistics and, it is well recognized, that the data reflecting those interventions supported by the public sector do not provide a full picture of HCS delivery in Afghanistan. The addition of the district health officer is hoped to co-ordinate the private sector contributions at the village level and to provide data to MoPH on the activities of private sector at village level..

A. OUT-OF-POCKET EXPENDITURE:

Out-of-pocket spending on health is considered both significant and an issue in Afghanistan, supported by a survey conducted by the JHU/IIHMR team. It found that, within the catchment areas of health facilities, household out-of-pocket expenditure ranged as high as USD29 per capita per annum. The most commonly used source of HCS was the nearest public health clinic, as is intended. In fact, although more than 90% of those seeking care paid something, the mean expenditure was USD17.50 and the median a potentially affordable USD 4. Whether or not this amount is actually affordable to the distressingly poor rural population of Afghanistan is not clear; the survey found that for nearly 30% of visits to a health facility, the ability of a household to pay depended on borrowing or on the sale of assets or land. Although there are no clear data, there is a strong likelihood that out-of-pocket expenditure on health, especially when as high as that mentioned above, is responsible for dragging a substantial number of families who can afford to pay below the poverty line. In this sense, the high cost of HCSs may contribute more to poverty production than to poverty reduction. The MOPH has recently confirmed the commitment of the constitution to providing primary care services free of charge.

As Afghanistan rebuilds its health sector, the financing of health services and their financial sustainability in this post-conflict setting are becoming increasingly important. There are several major challenges in financing public health services in Afghanistan. Donor funds currently provide much-needed support for the delivery of basic health services, however these funds may decrease in the future and alternative sources will need to be identified. Because of this, along with the increased utilisation rates, the cost of broader coverage and higher quality care, there is the potential for increased difficultly in providing free health care for all, including to the poor and other vulnerable groups, as well as the provision of free preventive and promotive interventions. This situation makes it crucial to identify effective alternative and supplemental ways to ensure reduced reliance on donor funding of the health sector, particularly through sustainable local financing mechanisms. A second challenge is the high out-of-pocket payments for health care presently being faced by Afghans, making high quality health care either inaccessible to a large segment of the population or else leading to unaffordable health expenditures.

These and other issues motivated the MoPH to develop a pilot project to test the feasibility and utility of various modes of health financing, including user fees and community-based health funds. This project started in May 2005 and was implemented in eleven provinces. The results will provide valuable inputs on the different community financing mechanisms and will also provide lessons on how to improve the implementation of these financing mechanisms. The Mo A significant increase in population health interventions will additionally contribute to this pressure.PH aims to use these and other evidence-based results from tests of alternative health financing schemes to inform future decisions about health financing options for Afghanistan. In introducing new financing mechanisms the MoPH will follow a

step-by-step approach starting by an experimental process through which different options will be tried within Afghanistan context. This will allow the most appropriate options to be extended countrywide in the medium- and long-term.

HEALTH AND NUTRITION SECTOR DONORS

The major donors to the HNS are USAID, the WB, and the EC, figure 1.1. Donor funds are used to finance all of the major Programs of the MoPH, including the delivery of the BPHS, EPHS, Programs aimed at controlling malaria, TB, HIV/AIDS and other communicable diseases. In addition, donor funds have been applied to activities that fall under the rubric of institutional development. In all, the donors have provided financial and technical support for the renovation or construction of 763 health facilities over the past four years, without which the extension of the BPHS to at least 65% of the population would not have been possible. Most of the construction donation was made by USAID. Of these, 312 (40.9%) of health facilities have been newly built. The annual amounts of donor funding devoted to delivery of the BPHS are as follows:

Table 1.1: Health and Nutrition Sector Donors

Donor	Provinces Funded	USDm	Funds available until
EC	10	20.161	2009
USAID	13	24.100	2011
WB	11	20.825	2008
Total	**34**	**65.086**	

Source: GCMU/MoPH (2007)

An additional USD9.85m is being spent on implementation of the EPHS with the majority again provided by the donors.

As discussed in a previous section, little of the progress made to date by the MoPH and few of its successes would have been possible without the financial and technical support of external donors. For the purposes of expansion of the BPHS, the WB, USAID, and the EC have been instrumental. Each has provided substantial assistance to the MoPH albeit in different ways. The WB has provided funding directly to the GOA to establish the GCMU, and technical assistance to help it acquire the capacity to tender and manage contracts of substantial size. It provided funding to contract NGOs to deliver services under PPAs. It has also funded the BSC M&E contract discussed above. USAID initially provided funds through a US-based contractor to manage a different form of BPHS contracting program known as Performance-based Partnership Grants (PPGs). In addition, it funded a large amount of technical assistance at the central level, especially to the development of the HMIS, at provincial level to increase the managerial capacity of PPH Directors, and directly to the contracted NGOs to ensure that the quality of service delivery was acceptable. The EC has also funded NGOs to implement the BPHS in several areas, and has provided needed technical assistance to the GCMU. These donors have also funded other activities in the HNS.

Some 'vertical' Programs, such as the Expanded Program on Immunization (EPI), the National TB Program, the National Malaria Program, the National HIV/AIDS Control Program, and others, also receive funding from external donors, including the GFATM and GAVI. Other bilateral donors and the UN agencies, especially the World Health Organization (WHO), UNICEF, UNFPA and Japan International Cooperation Agency (JICA) make substantial financial and technical contributions to these areas. Finally, it should be noted that some NGOs operating within the Afghanistan HNS receive funding from sources other than the contracting schemes mentioned here.

However expedient in the short term, reliance on external funding is never an optimal strategy. The unpredictable availability of required funding, combined with frequent policy shifts of donors, has the potential to leave the HNS in a very precarious and unstable situation. With this uncertainty of

medium to long term funding, and despite planning and assurances given, MoPH still has little surety of being able to implement its plans and programs as set out in this core strategic and supporting program strategies. However, any substantial reliance on internal sources of funding at present is unrealistic, evidenced by the insufficient proportion of the operating budget currently being allocated to health. Realistically, external sources of funding will be required for many years to come. The MoPH is actively initiating systems and process that will eventually set conditions for a Sector Wide Approach to longer term funding/service partnerships with donor governments and banks. Further and continuing improvement, of the demonstrable success of the HNS to date, will provide an important incentive to the donor community to continue its substantial investment for the long-term. With this in mind, MoPH will address inefficiency fraud and corruption with vigour and commitment to make it a leading ministry in the public sector.

FUTURE CHALLENGES

The achievements have been many, but MOPH has also faced setbacks in its goal to improve health and wellbeing of the people of Afghanistan through the deliver of accessible, quality, health care services to the people of Afghanistan. Without doubt, one of the largest challenges to the HNS is that of security. In an environment where HCWs 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 HCWs 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 HCWs at deliveries in conflict-ridden areas are one-third and one-half respectively the proportions in secure areas. In Helmand Province, seventeen (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 PHCS 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 disbursed 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 difficulties in accessing even basic HCSs. Children remain un-immunized, there is no care for the mothers delivering their infants and medical 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.

There is considerable development required in the tertiary sector. While the majority of intervention to combat high levels of morbidity and mortality will take place in the primary care level, especially among women and children, an effective referral system to good quality hospitals must be established to meet the needs of those cases that require higher level treatment. The ongoing hospital assessment will assess the performance of hospitals and identify areas of priority attention.

There is a need to increase the supply and mobilisation 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.

While there have been many capacity building activities, these efforts need to be expanded to the provincial and sub-provincial levels.

There are many private health facilities that are not accountable to the MOPH. Laws need to be instituted and strengthened to regulate both public and private health sectors.

With counterfeit and ineffective drugs in the market, there is need to ensure the availability and quality of essential drugs. A national drug study recently conducted will provide us information on these issues.The public-private partnership which has characterized the delivery of HCS to date, and specifically the performance-based contracting out of service delivery to Afghan and international NGOs, has been a successful formula. Should a transition occur in the mid to long term future, it needs to be carefully planned and implemented. For the immediate future, continuing the current strategy appears to be the most appropriate.

Further challenges include increasing the capacity of the health sector to address the causes of ill-health and poor wellbeing in Afghanistan. While this is recognised in current strategies it remains a longer term objective that will require intersectoral approaches and support of cadre of health workers who can address environmental health issues, regulation compliance and strong liaison skills. The control and regulation of the private sector has yet to be addressed. Registration of facilities and practitioners, integration of their service statistics into HMIS, joint initiatives to combat priority health issues, either through regular services or in cases of public health outbreaks will be required.

More comprehensive methods of understanding and addressing demand side issues remains a key agenda item that requires attention in the decentralisation of strategic and operational planning at the provincial and services levels.

The whole aspect of providing guidance within the stewardship role of MOPH hinges on achievable, costed and budgeted program strategies forming the basis for intervention and service planning where funding, human resources, infrastructure, consumables and utilisation match the anticipated growth expected from increased services target thresholds.

And to bind all initiatives to address these existing and future challenges is the challenge to strengthen the MOPH systems and process that will enable a SWAp approach to funding/service delivery partners. This includes the realisation of the need to harmonise a broad range of processes, plans and the like between participating partners.

DEVELOPMENT PROCESS OF THE HNSS

This Sector Strategy incorporates feedback and comments from the Sub National Consultations (SNCs) and as such is a response to the people of Afghanistan's vocalized needs and development goals, both nationally and with provincial emphasis. The Sub National Consultations ensured public participation in the country's development process. Provincial representatives were invited to ask for their perception of the state of development in the HNS in their province, and were presented with HNS Strategy to get constructive local input on their content and process. With representatives from all levels of Afghan society, including 47% participation by women, the Sub National Consultations and the resulting Provincial Development Plans have contributed public support to the development of the Strategies (See Annex IV for the results of the SNCs on HNSS).

For the HNS ANDS pillar, provincial projects have been selected by the working groups during the SNCs in line with existing Ministry Strategy and planned national programmes. The Provincial Development Council's Provincial Development Plans from the previous year were used as a basis, in combination with input from local governance structures comprising Community Development Plans from Community Development Councils, and District Development Plans from District Development Assemblies (DDAs). The resulting identified potential activities were prioritised into ten project ideas per sector, per province. These have been further ranked into three tiers of descending order of urgency and impact on numbers of beneficiaries.

CHAPTER 2

OVERALL STRATEGY FOR THE HEALTH AND NUTRITION SECTOR

STRATEGIC VISION, MISSION, GOALS AND OBJECTIVES

Vision

Better physical, mental and social health for all Afghans.

Mission Statement

The mission of the HNS is to improve the health and nutritional status of the people of Afghanistan through quality HCSP[3] and the promotion of healthy life styles in an equitable and sustainable manner.

Goal

The goal of the HNS is to work effectively with communities and development partners to improve the health and nutritional status of the people of Afghanistan, with a greater focus on women and children and under-served areas of the country.

Objectives

National objectives

- To reduce maternal and newborn mortality
- To reduce under 5s mortality and improve child health
- To reduce the incidence of communicable diseases
- To reduce malnutrition
- To develop the health system

Program objectives

- Improving access, utilization, and quality of PHCSs in an equitable and sustainable manner;
- Improving access, utilization, and quality of hospital services in an equitable and sustainable manner;
- Increasing the coverage and quality of services to prevent and treat communicable diseases and malnutrition among children and adults;
- Improving access to and utilization of quality emergency and routine RH and MCH Care Services;
- Strengthening organizational development and management at central and provincial levels to ensure the effective and cost-efficient delivery of quality HCSs;
- Further developing the capacity of health personnel to manage and better deliver quality HCSs and to facilitate evidence based decision making through co-ordination of relevant and useful research;
- Harmonizing system of procurement of essential medicine for health facilities;
- Developing and maintaining equitable, affordable and sustainable quality support services, including those for LAB services, blood safety, radiology, pharmaceuticals, equipment and medical supplies.

[3] *HCSP – the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions. Dictionary of Public Health, US,*

DESIRED RESULTS BY YEAR 2013

The MoPH has modified the targets set in previous documents - Afghanistan MDGs, Afghanistan Compact 2006, and program-specific targets, for TB, EPI and Malaria, for example, in order to develop a set of "desired results" that it seeks to achieve by 2013.

The high benchmark for the HNS in the Afghan Compact had four components, which are shown in the table below beside the 2000 baseline, achievement in 2006, established 2010 target and new 2013 target. The program-specific targets (desired results) are given within each program description in sections further below.

2.1 Desired Results for 2013

Results	2000 baseline	Achievement by 2006	High Benchmark 2010	HNS 2013	2015 (Afghan MDGs)
"BPHS will cover at least 90% of the population by 2010"					
Increased access to PHCSs within two hours walking distance	9% of population with nearby access to PHCSs	65% of population with nearby access to PHCSs	90% of population with nearby access to PHCSs	90% of population with nearby access to PHCSs	
"Maternal Mortality Ratio will be reduced by 15%"					
Reduction of MMR	1600 deaths per100,000 live births		Reduction by 15% to 1360 deaths per 100,000 live births	Reduction by 21% from the baseline (1264)	Reduction by 50% from the baseline (800)
"Infant and under five mortality will be reduced by 20%"					
Reduction of U5MR	257 deaths per 1000 live births	191 deaths per 1000 live births	Reduction by 20% to 205 deaths per 1000 live births[4]	Reduction by 35% from the baseline (167)	Reduction by 50% from the baseline (128)
Reduction of IMR	165 deaths per 1000 live births	129 deaths per 1000 live births	Reduction by 20% to 132 deaths per 1000 births[5]	Reduction by 30% from the baseline (115)	Reduction by 50% from the baseline (82)
"Full immunization coverage"					
Increased national immunization coverage with three doses of DPT vaccine among children under one year of age	31%	77%	Achieve above 90% coverage	Achieve and sustain above 90% national coverage	Sustain above 90% national coverage
Increased national immunization coverage with measles vaccine among children under one year of age	35%	68%	Achieve above 90% coverage	Achieve and sustain above 90% national coverage	Sustain above 90% national coverage

4 U5MR – 2006 AHS showed this target already surpassed.

5 IMR – 2006 AHS showed this target already surpassed.

PRIORITY POLICIES

In line with the Afghanistan Compact of July 2006, the over arching strategic objective of the MoPH is to obtain nearly universal coverage of a standard BPHS through the Contracting Out initiative and the SM.

As mentioned above, in 2003 (1382), the MoPH adopted the strategy of contracting out the delivery of the BPHS to non-state providers in order to be able to concentrate fully on its role as steward of the HNS.

The BPHS is currently being delivered on a contractual basis with NGOs in 31 of the 34 provinces in Afghanistan. In the remaining three provinces, the MoPH is following a SM strategy by which it is, essentially, contracting with its own staff, on the same terms as it contracts with NGOs.

The corollary key policy and strategy is for the MoPH to maintain and strengthen its stewardship role for HNS. For that purpose, a new organizational chart of the MoPH has been defined (Refer Annex I). The number of General Directorates has decreased to correct the existing fragmentation of some departments (e.g. finances, procurement, M&E).

This allows a comprehensive approach of HCS in having BPHS, EPHS, all hospital services and the referral system, under the same Healthcare Service Provisions General Directorate. The MoPH will focus on the following main fronts:

- Leadership at all levels in policy formulations and translating these policies into concrete actions to ensure that these actions are geared towards attaining the specified goals.
- M&E of the implementation of HCSs in order to ensure quality, equity and efficiency of the health system.
- Coordinating both the multi-sectoral contribution of all national institutions involved in the HNS and the MDGs (Ministry of Defence, Ministry of Higher Education (MoHE), Ministry of Interior, MRRD, Ministry of Women Affairs, Ministry of Education and Ministry of Counter Narcotics) and the development and external assistance from a large number of health supporting agencies, to ensure aid effectiveness through upholding standards, mapping services to avoid duplication and gaps. Other coordination mechanisms will be looked at.
- Decentralisation through the delegation of responsibility and authority to PHOs for provincial level strategic planning and budgeting, improving the provincial level through activities (i.e. training, provision of equipment, performance-based bonus for the staff, networking among provincial teams).
- Developing legislations and regulations and ensuring that the health laws and regulations are adhered to both in the public and private sectors.

CHAPTER 3

HEALTH AND NUTRITION SUB-SECTOR STRATEGIES

CONTEXT

According to the NHP 2005-2009 and NHS 2005-2006, MoPH has been following eighteen (18) sub-sector strategies to achieve the general objectives of reducing morbidity and mortality and institutional development. These have been undertaken jointly or singly by different Directorates and, over the past two years, several new strategies have also been developed.

Barring unforeseen events, the continued economic and political development of Afghanistan will, and must, contribute to the creation of conditions favourable to the development of the social sectors of which health is one of the most important. Perhaps the biggest constraints to the further expansion of health and nutrition services, and the ones over which the HNS has the least control, are the availability of adequate financial resources and the growing threat to internal security. Both donors and the national-level decision-makers should give careful consideration to the needs of this sector by making a major effort to ensure its continued progress and success.

CONSTRAINTS

The main constraints of the HNS sub-sector strategy are:

1. 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.
2. Dispersed population and geographical problems; cultural barriers
3. Uncertain commitment of donors in supporting implementation, capacity building programs, logistics and functioning.
4. Unwieldiness of MoPH and MoF bureaucracy and administration responsible for delays in recruitment of staff, budget disbursement and procurement of medicine and equipment.
5. Law and regulation missing or not adapted to the current situation (e.g. lack of regulation for private practice).

PROGRAMMATIC BUDGET APPROACH

Based on the reforms proposed by the MoF on Program Budgeting Reform, the earlier economic approach of the administrative budget lines was found deficient on many counts, and a programmatic approach is now preferred to address the financing and accountability issues in a more coherent and integrated manner. Costing of the programs in the HNS has been carried out by the MoPH in collaboration with the partners for health. Although the cost is the best possible estimates which derived from the limited data available at the time of the exercise, the figures subject for refinement (See Annex IIC).Therefore, the strategies of the HNS will be discussed in terms of nine core programs (Refer Annex III) – five related to HCSP and four related to institutional development:

(A) Health Care Services Provision Programs

1. Primary Health Care Program;
2. Hospital Care Program;

3. Disease Control and Nutrition Program;
4. RH and Child Health Program;
5. Public Nutrition Program.

(B) Institutional Development Programs

1. Policy and Planning Support Program;
2. HRD and Research Program;
3. Pharmaceutical Management Support Program; and
4. Administration Program.

Strategies developed for the NHP 2005-2009 and NHS 2005-2006 have been assigned to the nine core programs, the current context and new strategic directions are discussed, and finally the 2007 objectives and desired results are mentioned.

HEALTH CARE SERVICES PROVISION PROGRAMS

1. Primary Health Care Program

Strategy 1.1 The HNS will ensure that all the principles of Primary Health Care, especially community participation, inter-sectoral collaboration, prevention, and the use of appropriate technology, will be implemented countrywide.

The BPHS has two main objectives:

- To provide a standardized package of basic services which forms the core of service delivery in all PHCS facilities; and
- To promote the redistribution of HCSs by providing equitable access, especially in underserved areas.

The main components of the BPHS are outlined in the box below:As physical rehabilitation services are almost entirely supported by NGOs in separate, vertical programs, the aim is to include services within the general EPHS and BPHS packages; as a consequence this must be included in budgets of HCS providers.

Strategy 1.2 The HNS is committed to increasing the active participation of communities in the management of their local HCSs through developing strong, active participatory links with shura (community committees) and training and supporting CHWs.

Components of the Basic Package of Health Services

- Maternal and newborn health
- -Antenatal (ANC), delivery and postpartum care; family planning; care of the newborn
- Child health and Immunization
- -EPI (routine, outreach and mobile); integrated management of childhood illness (IMCI); promotion of exclusive breast feeding for the first 6 months
- Public nutrition
- -Micronutrient supplementation; treatment of clinical malnutrition, fortified flour
- Communicable diseases
- -Control of tuberculosis, malaria, and HIV-AIDS
- Mental health
- -Community management of mental problems; health facility-based treatment of outpatients and inpatients
- Disability
- Physiotherapy integrated in PHCS; Orthopedic services expanded in hospitals
- Supply of Essential Drugs

Context: Development of a BPHS was one of the 12 priorities in the Interim Health Strategy 2002-2004, and BPHS became the official policy of the MoPH in March 2003. As a result of subsequent experience, BPHS was further revised in the latter half of 2004 and approved. Community-based HCS is an integral part of the BPHS, where around 13,000 CHWs are presently deployed in close to 5,000 villages, providing vital services to some of the most disadvantaged communities. The plan is to recruit around 25,000 CHWs to reach all corners of Afghanistan. CHWs carry out family planning, vaccination activities, refer self-reported TB patients, promote bed net use and help evaluation surveys. The objective is not only to expand access to services but to lay down a solid foundation for a sustainable NHCS.

Some of the sub-Programs in the Primary Health Care Program are: BPHS Contracting Out, Health System SM; Nomads Health Program; Provincial Coordination; and non-BPHS Clinics.

New strategic directions: From being available to 9% of the Afghan population shortly after its implementation began, the BPHS is currently being offered in districts in which 82% of the population lives. As mentioned elsewhere, due to limitations of geographical access, financial access, and insecurity, not everyone in these districts can benefit from the availability of the BPHS. It is estimated that the BPHS currently reaches about 65% of the total population, and MoPH plans to expand its reach through:

- Outreach services from the existing of BHCs, CHCs, and DHs;
- Increasing the number, utilization and quality of HPs and CHWs;
- Addition of a layer of HCS facilities, called the Basic Health Sub-Centres;
- Addition of mobile health teams to reach remote villages at least four times pa;
- District Health Officers; and
- Evaluation of SM in remote areas

Objective : Improving access, utilization, and quality of PHCSs in an equitable and sustainable manner

2. Maintenance and Extension of Hospital Care Program

Strategy 2.1 HNS will ensure the provision of a comprehensive referral network of secondary and tertiary hospitals that provide, as a minimum, the EPHS and do so within a framework of agreed, set standards to improve clinical and managerial performance.

The EPHS has three main objectives:

- To identify a standardized package of defined clinical, diagnostic and administrative services for district, provincial, regional and national hospitals.
- To provide a guide for the Ministry, NGOs and donors on how the hospital sector should be staffed, equipped and provided with drugs for the defined set of services at each level.
- To promote a health referral system that integrates the BPHS with the hospitals.

The maps below show the district population per BPHS facility in 2003 and 2006, respectively.

As seen by the changes from one map to the other, the number of BPHS facilities per population has increased substantially from 2003 to 2006. This shows the progress achieved in establishing a nationwide network of primary care facilities in Afghanistan.

Figure 3.1 District Populations per BPHS Health Facility

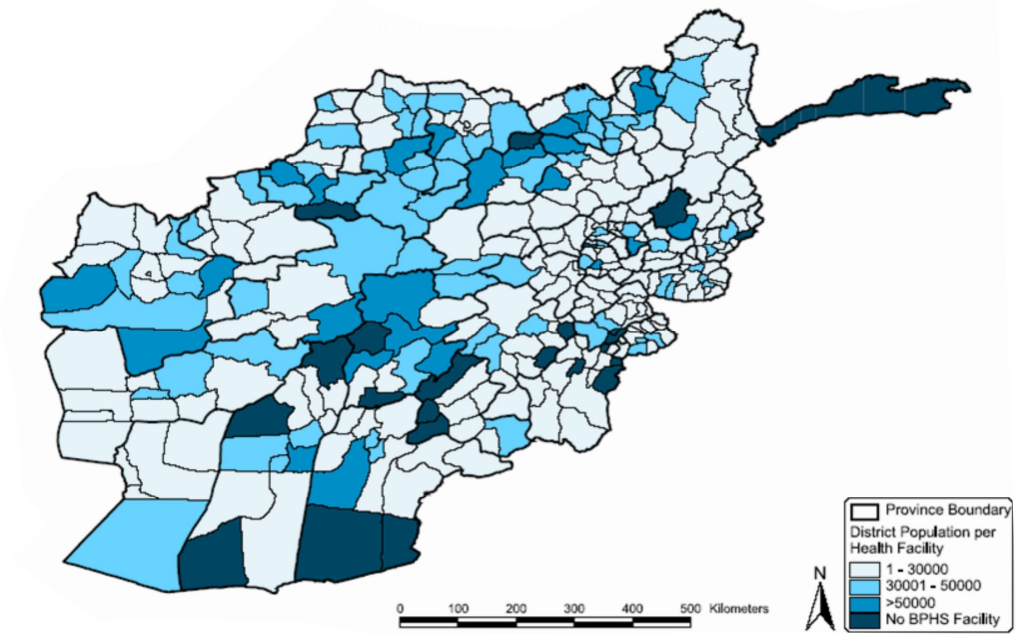
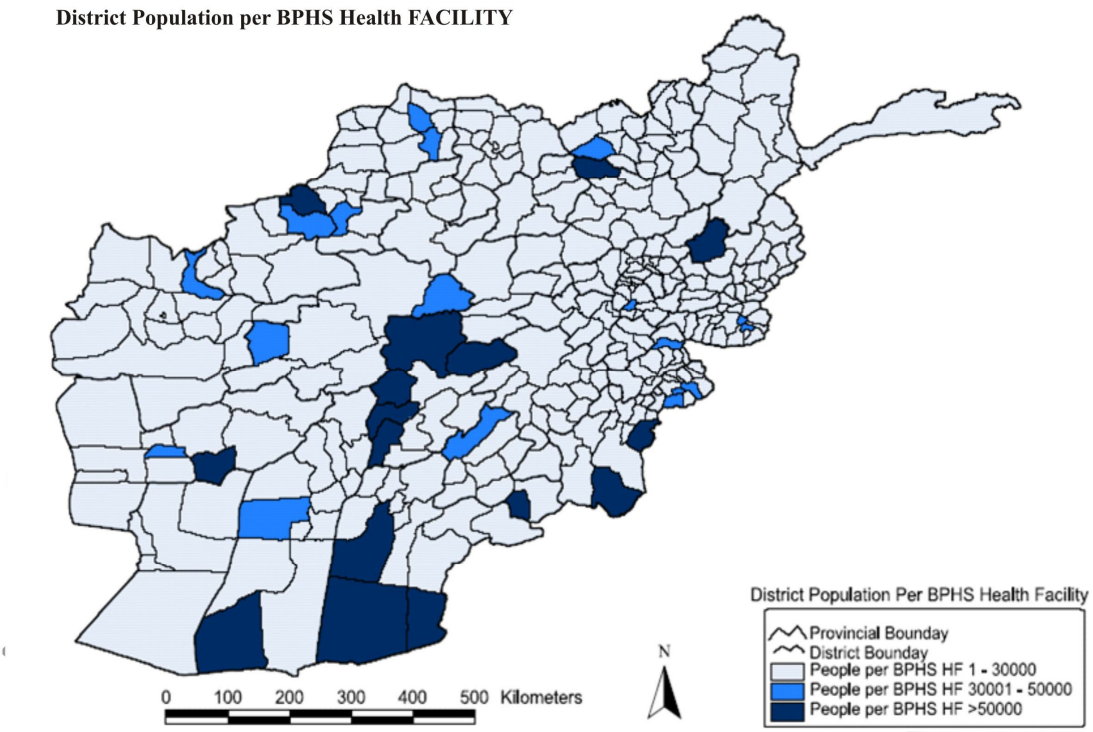


Figure.3.2: District Population per BPHS Health Facility: Source: National Health Resources Survey ,September 2002,MoPH and USAID / AHSEP, prepared by REACH



Standardized provision of services to be offered by hospitals

District Hospital: 30-75 beds

Serves a population of 100,000-300,000 in one to four districts.

Basic surgery, medicine, obstetrics and gynaecology, paediatrics, mental health, dentistry, plus support services for nutrition, pharmacy, physiotherapy, LAB, radiology, blood bank and physiotherapy clinics / outreach.

Provincial Hospital: 100-200 beds

All the above clinical and support services, plus rehabilitation services and infectious disease control

Regional Hospital: 200-400 beds

All of the above plus surgery for ENT, urology, neurology, orthopaedics, plastic surgery; medicine to include cardiovascular, endocrinology, dermatology, lung and chest, oncology and forensic medicine.

Expanded support services including full rehabilitation centres with Orthopaedic Workshop

NB: Physiotherapy clinics and outreach are / will be included in CHC, DH and PH, whilst Rehabilitation Centres, including Orthopaedic Workshops, exist at RgHs.

Context: The development of EPHS was one of the twelve priorities in the Interim Health Strategy 2002-2004. Upon its completion in February 2005, the EPHS became official policy of the MoPH.

The purpose of EPHS is to establish a mutually supportive HCS delivery system where both basic and essential services are gainfully interacting. Indeed, without having an effective secondary care and tertiary care, the benefits of the widespread PHCSs will be limited; trend of mortalities due to, for example, complicated pregnancies will not change and conditions beyond the Primary Health Care level will continue to be the leading cause of mortality.

Some of the sub-programs in the Hospital Care program are: EPHS, Blood Bank, Nursing Care, Disability and Rehabilitation; and SMs for Speciality and Training Hospitals.

New Strategic Directions: Studies elsewhere as well as current findings at the MoPH, prove that expansion of hospital services at the secondary and tertiary level care is a costly exercise. Even at the current rate, the hospital sector with curative, diagnostic and rehabilitative components consumes nearly 50% of the core budget. However, hospital sector plays a pivotal role in the overall HCSP. To reduce costs, in addition to pilot different mechanisms (e.g. user-fee, contracting out NGOs, focus on specific areas like emergency obstetric care, creation of hospital network, telemedicine), MoPH has carefully chosen the concept of strengthening existing infrastructures rather than building new facilities. Furthermore, progressive measures will be taken to address the common gaps in the hospital sector e.g. lack of standards from hospital management and for clinical care, disproportionate availability of hospital beds in the major urban areas, lack of qualified staff, of appropriate equipment which lacks maintenance, of supplies (consumables and non-consumables) and weakness of the record-keeping system. Regulations will be developed and an accreditation system will be put in place, in particular in the private sector.

Objective : Improving access, utilization, and quality of hospital services in an equitable and sustainable manner

3. Disease Control Program

Strategy 3.1 Communicable Disease: The HNS will, as a priority, better control communicable diseases, especially malaria, TB, cholera and HIV and other sexually transmitted infections (STIs), through strengthening the management of integrated, cost-effective interventions for prevention, better definition of vulnerable groups targeted, training, control and treatment. The prevention and management of outbreaks will also be strengthened further through raising public awareness and responding more rapidly through the Disease Early Warning System.

Strategy 3.2 Disease Surveillance System: The HNS is committed to developing and maintaining an effective and efficient surveillance system for certain diseases and health risks and to responding to health emergencies in a timely manner.

Strategy 3.3 Emergency Response: The HNS is committed to developing and institutionalising a Comprehensive Health Preparedness Plan at the national and provincial levels and to allocating appropriate resources in order to be able to respond to natural and man-made emergencies in an effective and timely manner. This work will be undertaken in close collaboration with other ministries.

Strategy 3.4 Health Promotion and Prevention: In collaboration with other relevant ministries, the MoPH will, as a top priority, have promotion and prevention programs that address key emerging public health problems, such as illicit drugs and their use, smoking, HIV/AIDS, blindness, and road traffic accidents. Through the development and implementation of comprehensive programs covering prevention, treatment, care and rehabilitation, the Ministry will enhance and strengthen its capacity to address chronic conditions such as cardiovascular disease, diabetes and, as control of illicit drugs is a GoA priority, especially to address the problem of substance abuse. Methods used will vary depending on the nature of the target group and the current level of awareness or knowledge about a particular issue.

Strategy 3.5 Environmental Health: In collaboration with other relevant GoA ministries and departments, the National Environmental Protection Agency (NEPA) in particular, the HNS will increase awareness and understanding of potential adverse health consequences of environmental factors, such as poor water supplies; lack of adequate

sanitation facilities; inadequate rubbish disposal and collection, particularly of plastic bags; health facility waste; poor food handling and hygiene; and high levels of air pollution. Various mechanisms will be used to raise awareness and understanding, including during Cabinet meetings and inter-ministerial meetings and through the media. The Ministry is developing an environmental health policy and strategy in co-ordination with the National Environmental Protection Department. that defines where and how it can be most effective in preventing illness due to adverse environmental factors. It will also develop and distribute guidelines on good environmental health practices. The MoPH will work together with other relevant government departments in implementing its strategies.

Strategy 3.6 Mental Health: HNS will work with the social and other sectors to develop a flexible range of integrated mental health support and care services at all levels of the health system. Particular attention will be given to post-traumatic counselling through the training of more community mental HCWs and psychologists and their placement in accessible community health facilities.

Strategy 3.7 Disability, Accidents and Injuries: HNS is committed to ensuring that the disabled and those injured through violence or accidents in traffic, at home, or at work will have access to relevant HCSs when needed. In collaboration with other relevant ministries, the HNS will develop a cross-cutting policy on disability to ensure access to economic and social development. In collaboration with the police, Ministry of Transport and other relevant ministries, the HNS will develop, implement and enforce laws and regulations to reduce the risks of accidents, especially road accidents.

Strategy 3.8 Information, Education, Communication (IEC) and Behaviour Change Communication (BCC): While BCC/IEC is a cross-cutting intervention; the HNS will initially focus on IEC/BCC issues related to the basic package of health services and to the priority promotion and prevention programs. All IEC/BCC health messages should follow the national guidelines and convey messages that do not conflict with one another.

Context: The MoPH's priorities are to better control and prevent communicable and non-communicable diseases through strengthening the management of integrated, cost-effective interventions for prevention, treatment and control, including emergency preparedness and management of outbreaks.

Some of these control sub-Programs are part of the existing BPHS/EPHS but, because of the country's international commitments and/or being recognized as public health main issues, have distinct 'vertical' administrative and managerial structures from central level to at least the provincial level. They need thus special attention and commitment. Examples include the TB Control, Malaria Control, HIV/AIDS Control, EPI, nutrition, environmental health, emergency preparedness & response, mental health and drug demand reduction, eye care; oral health and BCC, which above list is not exhaustive.

Objective : Increasing the coverage and quality of services to prevent and treat communicable diseases and malnutrition among children and adults.

4. Reproductive & Child Health Program

Strategy 4.1 Reproductive and Maternal Health: HNS is committed to ensuring that development partners deliver the different components of RH as an integrated package. In maternal health, the HNS is committed to increasing the accessibility of mothers and women of child bearing age to quality reproductive HCSs, including ANC, intrapartum care routine and emergency obstetric care and post partum care, counselling and modern family planning services, through skilled birth attendants working with community and other HCWs.

Strategy 4.2 Child and Adolescent Health: HNS is committed to significantly reducing child mortality, morbidity and disabilities and improving child growth and development by promoting exclusive breast feeding, introducing IMCI and enhancing the control of vaccine preventable diseases. Issues in adolescent health will particularly address potential public health problems posed by smoking and by communicable diseases, such as STIs and HIV/AIDS. In addition, puberty-

related issues will be raised. All these adolescent issues will mainly be addressed through school health programs, which initially will focus on raising awareness among teachers.

Context: The expansion and improvement of RH – with its main components, maternal and neonatal health (MNH), birth spacing/family planning and gender and reproductive right – services has been a major activity of the MOPH and partner agencies in its National RH Policy and Strategy for 2006-2009. This has been under the direction of the National RH Strategy (2003-2005) and the national priorities set by the MOPH. That strategy, written in late 2002, was in recognition of Afghanistan's unacceptable RH statistics mentioned in previous sections.

Priority Sub-Programs:

1. Maternal and neonatal health;
2. Birth spacing and family planning;
3. Gender and Reproductive Rights;
4. Capacity Building; and
5. Other programs, STIs, Infertility, and Non-Infectious RH problems.

New Strategic Directions: In 2006, however, the way forward is clearer. More is understood about the application of key RH interventions in Afghanistan and about what works. Greater emphasis is needed on quality and the best use of community resources and accessibility of RgH services. Accessibility is a big problem nowadays in the provision of RH services throughout the country or even worldwide, therefore HNS is following the commitment made in the World Summit 2005 by the heads of state and government which is "Achieving Universal Access to reproductive health by 2015".

Specific challenges and constraints to be addressed by the RH Program.

6. Lack of management skill at various levels of policy and service delivery; lack of coordination; lack of IEC materials in health facilities and communities; problem in family planning supply in health facilities.
7. Lack of skilled HCWs especially female HCWs; problem with having low salaries and slow governmental procedures.
8. Lack of health standards and their utilization; M&E and supervision need to be improved; quality of works need to be improved among all partners; changing attitude of the health providers.
9. Lacking evidence and mechanism for tracking maternal mortality and other impact indicators; lack of delivery registration in health facilities; HMIS to be further improved.
10. Poor referral system; need for high community awareness.

Goal of the Reproductive Health Program:

To establish and define a framework for the implementation of the National RH and MCH program and to set forth clear guidance for program implementation, in order to improve health and reduce mortality and morbidity and to achieve universal access to RH by 2015**.**

Objective : Improving access to quality emergency and routine reproductive and child HCSs**.**

Desired Results by 2013:

- Percentage of deliveries attended by Specialized Birth Attendance (SBA) will be increased to 40% by 2013.
- Percentage of women receiving ANC at least once will be increased to 50% by 2013.
- Contraceptive prevalence rate will be increased to 40% by 2013.
- MMR will be reduced by 21% by 2013.
- Total fertility rate will be reduced to 4.5 by 2013.
- Access to reproductive HCSs will be 90% of population by 2013.

Table3.4 : List of Reproductive Health Program Indicators

Process Indicators		
1. Percentage of population have access to RH services	65.0[6]	90.0
2. Number of health facilities providing basic EOC	309[7]	386
3. Number of health facilities providing Comprehensive EOC	82[8]	107
4. Percentage of health facilities with SBA	60.0[9]	90.0
5. Percentage of health facilities providing 2 modern contraceptive methods	29.0[10]	90.0
6. Percentage of caesarean section of all births	2.6[11]	5.0
Output indicators		
7. Percentage of deliveries at health facilities	14.6[12]	20.0
8. Percentage of pregnant women receiving 2TT	54.0[13]	86.0
Outcome Indicators		
10. Percentage of deliveries attended by SBA	18.9[14]	40.0
11. Percentage of women receiving ANC at least once	32.2[15]	50.0
12. Contraceptive prevalence rate	15.4[16]	40.0
Impact Indicators		
13. Maternal Mortality Ratio	1600[17]	↓ 21.0
14. Total Fertility Rate	6.60[18]	4.50

5. Public Nutrition Program

Strategy 5.1 In collaboration with development partners, the MoPH will take the lead in preventing, identifying, and reducing malnutrition by strengthening and expanding the Therapeutic Feeding Units (TFUs), uplifting knowledge and skills base of the health professionals including NGO staff at health facility and community level and disseminating messages on nutrition to mothers in particular.

Strategy 5.2 The Ministry will promote food and nutrition security for all by adopting a public nutrition approach involving multi-sectoral interventions that address the underlying causes of malnutrition, including food insecurity, poor social environment, and inadequate access to HCSs. This work will be undertaken, partly through the BPHS and a close link with food security analysis and other social development programs. Quality salt iodization, flour fortification, diarrhoeal interventions and the therapeutic feeding of hospitalized malnourished children will receive focused attention.

Strategic Directions

The HNS is committed to taking a public nutrition approach that;

- Recognizes the multi-causal nature of malnutrition: The causes of malnutrition are multi-fold and are context-specific. They can be broadly categorized into three groups including food security, social and care environment and health (access and environment). There is significant interaction and synergistic effects between the different causes. While health interventions are an important component, malnutrition cannot be effectively addressed through health interventions alone but require broad-based interventions.
- Reflects an understanding of political, economic, social and cultural factors: The categories of underlying causes, are determined in turn by economic, agricultural, and trade policies. Additionally, cultural and social norms influence people's ability to access food as well as their food consumption patterns.
- Focuses on populations not individuals: Analogous to the difference between curative and public health, public nutrition does not focus only on treatment

[6] *Health Sector Strategy 2007 (Unpublished)*
[7] *HMIS 2007*
[8] *HMIS 2007*
[9] *MICS 2003*
[10] *MICS 2003*
[11] *HMIS 2007*
[12] *AHS 2006*
[13] *EPI Database, MOPH, 2006*
[14] *AHS 2006*
[15] *AHS 2006*
[16] *AHS 2006*
[17] *Maternal Mortality Survey 2002*
[18] *Multiple Indicator Cluster Survey (MICS) 2003 and Best Estimates, UNICEF 2005*

of individuals but emphasizes an approach that addresses population needs.

- Places nutrition firmly in the public domain: Public nutrition does not belong to any single sector or expertise. Professionals from a broad range of sectors – including health professionals, agriculturists, economists, anthropologists, educators, community development workers in addition to nutritionists - need to contribute to the design and implementation of programmes in public nutrition. Public nutrition needs to be integrated into communities, legislation, the private sector and the political domain.
- Focuses on action-oriented strategies: Assessment to describe the extent and severity of the problem of malnutrition, including a description of the risks and causes, are conducted in order to inform the design or revision of interventions. This process is a dynamic one, i.e. Assessment, Action and Analysis (Triple A) concepts are applied throughout the implementation process. This assumes a dynamic process of ongoing review and analysis of process, effectiveness and impact. This understanding will determine appropriate action to be taken.
- Reflects universally accepted best practice and knowledge and reinforces learning: Programme design reflects demonstrated understanding of universally accepted best practice from scientific and non-scientific literature. A process of learning is required, which is evidence-based, involves wide dissemination of lessons learnt and demonstration of translating policies into practice.

INSTITUTIONAL DEVELOPMENT PROGRAMS:

1. Policy and Planning Support Program

Strategy 6.1 Organization and Management of the NHCS: The HNS is committed, as a top priority, to organizing and managing the national health system to reduce inequity and improve efficiency, effectiveness, quality and accountability at all levels. Decentralization and delegation will be enhanced in order to have more responsive and efficient health systems and services. Delegated powers will be used with transparency and according to norms of good governance.

Strategy 6.2 Provincial Level Strengthening: HNS is committed to strengthening the health service management capacity of the provincial level and to the decentralization of operational responsibilities and authorities to the provincial level. This will be achieved through various mechanisms, such as the implementation of PRR and of MoPH-SM; more effective functioning of PPH coordination mechanisms and donor focal points; development of PPH planning, M&E capacity; quarterly PPH Directors' meetings in Kabul, where issues such as delegation can be addressed; and the effective functioning of the relevant PPH Liaison Department at central level.

Strategy 6.3 Health Planning, Information, and M&E: The HNS is committed to enhancing evidence-based, bottom-up and participatory strategic planning in all levels of the NHCS. As a priority, emphasis will initially be given to developing annual, costed business plans in all departments; strengthening the links and communication channels between the different levels of the health systems; and ensuring that recommendations from research and practical experiences are incorporated into policy formulation and health planning.

As part of quality strategic planning, the HNS will ensure the availability, coordination, distribution and use of accurate, reliable, user-friendly health information in the design, implementation, M&E of HCSs and other related activities. Annual M&E and planning cycles will be developed at both the national and provincial level. A system will be developed to ensure that checks for the accuracy of information are in place. In addition, a particular emphasis will be placed on ensuring that reliable baseline data is obtained for various initiatives, for example, when commencing QA work. See also M&E Section at end of document.

Strategy 6.4 Health Care Financing: The HNS will coordinate closely with the MoF on the National Development Budget and on the

development of mechanisms to improve total public expenditure from internal and external resources, development of alternative HCF schemes that protect the poor and on development of a medium-term expenditure framework.

The HNS will also undertake health advocacy to increase funds and resources to the health sector; to ensure spending is in line with priorities and coordinated across sectors; to strengthen transparency in the allocation of financial resources and financial management; to strengthen coordination of different sources of funding; to monitor different mechanisms of financing the delivery of HCSs for their cost-efficiency and acceptability; and to work toward obtaining more relevant baseline information, including on household expenditure on HCSs.

Strategy 6.5 Quality Assurance: The HNS is committed to introducing a culture of quality throughout the organization, and especially in health facilities, through leadership and good examples set in day-to-day work. The Ministry will develop and utilize even more quality standards under a closer supervision. The first priority is to improve the culture in public sector facilities and in those contracted out to NGOs. Work will initially focus on improving the attitudes of staff towards patients and clients and on developing user-friendly quality management and quality clinical care tools and promoting their use. As part of improving quality of care, the Ministry will also develop a program designed to change the expectations of clients, who often believe that they need and should receive numerous different types of drugs any time they are ill. At a later stage, the Ministry will also work on quality issues with the private-for-profit sector, especially pharmacies and drug sellers.

Strategy 6.6 Public Health and Private Sector Law and Regulation: In order to safeguard the public and, in particular, to ensure quality of clinical services the HNS will focus on reviewing, developing and enforcing relevant legal and regulatory instruments (e.g. accreditation systems) that govern health and health related work. The 2004 Constitution encourages the development of the private sector. The HNS will develop constructive relationships with private and non-government health care providers and ensure adherence to laws and regulations. (Note: "Enforcing" belongs in the Administration Program, see below).

Strategy 6.7 Coordination of HCSs: The MOPH, in its role as steward of the health sector, is committed to set policies, standards and guidelines in coordination with all departments within the MOPH, all partners, implementing NGO's, and donor agencies. In line with national GoA policies, the MOPH has created the CGHN. The large CGHN, which includes representatives from other ministries, donors, the UN, and selected NGOs, meets once a month, chaired by the MOPH. A working CGHN, chaired by the Deputy Minister for Technical Affairs, meets weekly and serves as a venue in which to discuss technical and policy issues. All partners in the health sector are welcome to participate in this meeting, and key recommendations for policy formulation are referred here for review. A review of the different coordination meetings will be conducted to ensure that they are more action oriented.

In addition to the CGHN, the MOPH has established TFs around specific technical issues. Currently there are 24 TFs, which allow focused technical input on specific topics. Their objective is to provide policy and implementation guidelines, intervention strategies, or program recommendations. These recommendations are then forwarded to both the CGHN and the TAG for review prior to being forwarded to the Executive Board for approval. PPH Coordination Committees (PPHCC's) have been created within each province to coordinate the activities of all stakeholders in achieving MOPH priorities at the provincial level. In any given province, multiple partners are involved in implementing health programs, including the MOPH; hospitals; NGO's; other ministries, for example, the MRRD or Ministry of Women Affairs to ensure a multi-sectoral approach; provincial government; and the military. Under the direction of the PPH Director , the PPHCC's will play a critical role in ensuring effective implementation of HNS priority programs at all levels throughout the province.

Strategy 6.8 Coordination of Partner Organizations: The HNS is committed to

working in partnership with other stakeholders, such as NGOs; UN agencies, especially WHO, UNICEF and the UN Population Fund (UNFPA); bilateral and multilateral donors; USAID, EC; WB; ADB; and the private sector. The HNS holds effective coordination to be important and it will sustain it through both formal and informal mechanisms. The HNS will also encourage stronger donor coordination, especially when undertaking assessment and planning missions and in supporting particular health priorities, such as maternal health.

Strategy 6.9 Construction and Maintenance: The HNS will ensure that any newly constructed health facilities are well designed and resistant to potential damage from natural disasters such as earthquakes and floods, are built at an affordable cost and meet the needs of patients and staff. A maintenance program will be developed and implemented. (New Construction is the responsibility of GDPP i.e. PPSP)

Context: The Policy and Planning Support Program (PPSP) will maintain the responsibilities to support and control, through policies, laws and regulations, quality HCSP, which are accessible and sustainable at all levels of the NHCS. The program strategies include:

- Development and implementation of HNS policies;
- Coordination of donors;
- Establishment of the MoPH budget and action plans;
- Supervision of public and private HCS providers to ensure they follow governmental health rules and regulations;
- M&E of quality of HCSs; and
- Control of norms and standards with regard to health facility infrastructure.

Sub-programs: PPSP will ensure the stewardship role of the MoPH through the following main sub-Programs.

- Planning and law enforcement
- M&E and QA
- HMIS
- Contract Management Unit (CMU), coordination body for contracting out NGOs and other HCS providers
- Construction
- Health Care Financing (HCF) elaborating on ways for sustainable and accessible HCSs

New Strategic Directions: As a top priority, the HNS will focus on mobilizing the human and financial resources necessary to accelerate the implementation of the BPHS; work towards the most effective, efficient ways to ensure sustainability of services; and further develop the equitable availability of the basic package, especially for women and children.

PPSP role will be supported by TA projects: Support to Institutional Development and Health System Strengthening Projects.

Objective : Strengthening organizational development and management at central and provincial levels to ensure the effective and cost-efficient delivery of quality HCSs.

2. Human Resource Development & Research Program

Strategy 7.1 Human Resources Development: The HNS is committed as a top priority to using a comprehensive approach to HRD in addressing the issues of how to produce, deploy and retain an appropriately trained health workforce possessing the variety of skills needed to deliver affordable and equitable packages of HCSs as the basis for health care. The selection, training, deployment and retention of staff in rural areas, particularly female staff is important to the HNS.

Recognizing the detrimental effects of more than twenty years of conflict on health professional education, the HNS will assess the capacity and training needs of existing staff to raise quality performance. (Note: HR Management – HRM - including PRR recruitment will be through Administration. Please refer section below.)

Strategy 7.2 Health Research: HNS is committed to encouraging relevant, useful research that can assist evidence-based

decision making and the formulation of new policies, strategies and plans. Nationally led health systems research, conducted in collaboration with international bodies, is a priority. The research should be related to the many reforms the HNS is introducing in areas such as the institutional development of the HNS, service delivery, the financing of HCSs, the education and training of health personnel, and the development of a quality culture.

Context: The lack of qualified HCWs, inadequate staffing distribution patterns and false credentials are common. In response, the MoPH will establish a HRD and Research Program, which will deal with HRD and research with the following aims:

- Develop HR through Public Health Training sub-Program;
- Develop HR through Ghazanfar Institute of Health Sciences;
- Conduct necessary research to assess the existing health situation, health system performances and their impact through Public Health Research Sub-Program;
- Serve as a centre for QA and control for prescribed drugs, foods, safe drinking water, beverages and cosmetic materials in the country through Public Health Laboratories sub-Program; and
- Provide quality testing of specimens with public health importance for reference and referral.

New Strategic Directions: A system of HCW registration and the early maintenance of a HR database, a preliminary national testing and certification examination process (in collaboration with MoHE) to identify training needs and an upgraded pre-service curriculum for nurses and midwives, are already in place. Standards for accreditation of training institutes and programs as well as for medical doctors registration will also being put in place.

Objectives :

Further developing the capacity of health personnel to manage and better deliver quality HCSs

3. Pharmaceutical Management Support Program

Objective: To harmonize the system for procurement of essential medicines for Health Services facilities.

Strategy 8.1 Essential Medicines: HNS is committed to

1) Ensuring the accessibility, availability, safety, efficiency, effectiveness and affordability of medicines; and

2) Having a functional drug quality control lab at the central level.

Strategy 8.2 Procurement and Logistics: The HNS will establish and use standard international level procurement, stocking and logistics systems to enable international contracting, bidding, stocking and transportation.

Context: Currently the MoPH faces considerable challenge with supply and delivery of QA controlled drugs through numerous private pharmacies. QA of drugs imported and sold is not ensured, resulting in a lack of confidence by the population in the NHCS. Moreover, the country cannot rely on external supply only in the future; the re-instigation of some national production by Foreign Direct Investment (preferably with a local partner) should be considered.

New Strategic Directions: To meet these challenges and ensure regular and appropriate distribution of safe, effective, cheap, and acceptable medical drugs to the population, the program will work on effective mechanisms to:

- distribute internal productions with assurance of quality;
- import effective and QA medicine according to national and international standards;
- assess regularly drug requirement in the country, in order to avoid any shortage at health facility level; and
- Assess local use of herbal and tradition medicine and assurance of quality.

Objective :

Harmonizing system for procurement of essential medicine for BPHS facilities by the implementation of a Pharmaceuticals Management Plan.

4. Administration Program

Strategy 9.1 Support Services: HNS will aim to have equitable, affordable and sustainable quality support services, including those for LAB services, blood safety, radiology, pharmaceuticals, equipment and medical supplies. It will establish capacity for the maintenance of facilities, equipment and transport.

Strategy 9.2 Procurement and Logistics: The HNS will establish and use standard international level procurement, stocking and logistics systems to enable international contracting, bidding, stocking and transportation.

Strategy 9.3 Communications and Information Technology (CIT): The HNS is committed to establishing, maintaining and further developing an affordable, useful and functioning communications network using modern information and technology systems at both national and provincial levels. This effort should improve the decision making process.

Strategy 9.4 Continue to implement PRR: The HNS is committed to working closely with the Civil Service Commission (CSC) to implement the National PRR competitive recruitment processes for placing the most highly qualified Afghan health professionals in established HNS posts throughout all levels of the HCSs. Approximately 3,000 personnel of the 14,000 staff have already been recruited through this process with the balance expected to be completed within the next 3 years.

A Reform Institutional Management Unit (RIMU), reporting to the CSC, is being developed within the MoPH to ensure the implementation of the reform. This reform process is also designed to strengthen implementation of MOPH services by reemploying highly qualified Afghan HCWs currently working outside the government services. While HRD is the responsibility of the HRD and Research Program, HRM is the responsibility of the Administration Program.

Strategy 9.5 Enforcing Public Health and Private Sector Law and Regulation: In order to safeguard the public and, in particular, to ensure quality of clinical services the MoPH will focus on reviewing, developing and enforcing relevant legal and regulatory instruments that govern health and health related work. The 2004 Constitution encourages the development of the private sector. The Ministry will develop constructive relationships with private and non-government HCS providers and ensure adherence to laws and regulations.

Context: Currently this program faces:

- Fragmentation of procurement units;
- Fragmentation of financial units;
- Weak inter-sectoral co-ordination and communication between various units;
- Lack of maintenance of equipment and buildings;
- Lack of CIT, proper database and absence of MIS within the administration, notably for procurement, finance and stock management (data provided are incomplete and unreliable).

Strategic New Directions: This situation is negatively affecting the performance of the overall system. It is logical to merge these financial and accounting and procurement units into the MoPH, as it would result in further savings, efficiencies in procurement procedures to provide the necessary supply for health facilities to deliver HCSs and certainly assist to provide information on the actual cost of health for the country from all sources.

These improvements will require considerable training. In the short term, it is intended that existing system adherence with improvements as necessary be a priority to ensure future discipline in following procurement, finance, maintenance and logistics procedures. Moreover, the MoPH has already concentrated on the Independent Administrative Reform (IAR) CSC, to lead the implementation of a model for HRM, which could be used for

Public Administration Reform (PAR) within other ministries. This PRR process shall continue though it is yet another challenge, albeit a welcome one.

Objective :

To develop and maintain equitable, affordable and sustainable quality support services.

CHAPTER 4

CROSS-CUTTING AND OTHER SECTOR RELATED ISSUES

The MoPH has given attention to the cross-cutting issues specified by the ANDS. Whilst there is considerable room for improvement, policy statements have been formulated and in some areas significant activity has taken place.

SECTOR-RELATED ISSUES

1. Capacity Building

A report concerning capacity building was submitted by the JHU/IIHMR project in December 2006, based on the interviewing of key staff at Central and Provincial levels.

A Capacity Building WG, chaired by the Director-General of The General Directorate of HR (GDHR), and assisted by civil servants, consultants, and external advisors exists within the MoPH. It was formed to address the enormous deficiency in numbers and skills of a work force decimated by decades of conflict.

An aggressive program of training has been undertaken for MoPH staff with good results. Donors, UN Agencies, NGOs, and academic institutions alike have offered training. Some training, especially for high-level Ministry officials, has taken place abroad. Most of this training has been in various aspects of health system management.

Problems identified with capacity building activities

High level courses are often delivered in English. Most of the employees of the MoPH are not adequately proficient in English and thus cannot obtain the potential benefits of the courses. Translation, when organized, is often judged poor by participants.

Lack of coordination

The lack of coordination works in both directions. Many agencies that provide training programs do so without informing the MoPH and the selection of participants can be undertaken without MoPH approval. On the other hand, the MoPH has not provided a clear training needs assessment (TNA) to which agencies that offer training can refer when preparing their training plans.

Curriculum

Courses are often organised in a workshop format with a one-time program of a few days to a few weeks; few, if any, agencies involved in capacity building have a progressive training plan with courses structured sequentially from fundamental to more advance. Very often, the content of the courses is fully adapted to the Afghan context.

Recommendations

The aforementioned report on capacity building, which was submitted by the JHU/IIHMR project in December 2006, made the following recommendations which will be adopted:

1. The GDHR develop a systematic and routine TNA mechanism.
2. Certain core skills be acquired by all MoPH employees working at certain levels; they include English language proficiency, report writing, basic computer skills, basic management and introductory public health.
3. There is a need for sequential training programs offering different levels of training courses that are better adapted to the Afghan situation.

4. Improved coordination between MoPH and its partners in the implementation and revision of the MoPH training plan.
5. Determination of unmet training needs based on the job description of the employees. The GDHR has made great progress in providing job descriptions for all positions in the organizational chart of the Ministry. However, revisions will probably be necessary before the PRR process.
6. A cadre of Afghan trainers should be established within the MoPH in order to better implement the above recommendations.

2. Gender Equality

There is perhaps no more important determinant in regard to improving the HNS than both the health status of women and their status in society. The extent to which the interventions of the BPHS are aimed at women, and children for whom women are the primary caretakers, is ample proof of this statement.

Although deep-seated cultural customs and traditions (religious, social, etc) in Afghanistan may initially appear to be in opposition to interventions required for the improvement of women's (and children's) health, a deeper analysis will reveal that this is not the case. What is required is the adoption of goals, objectives and targets such as those outlined in this strategy focussing the attention of the HNS on the condition of women in Afghanistan. For example, MoPH's emphasis is on significantly reducing the MMR. Because this is a target that is measured, and on which the performance of the sector will be judged by internal and external observers, significant effort will be directed towards its achievement. However, regular M&E should be undertaken of the strategy that has been adopted for addressing the problem, on how the level of MMR will actually be measured, and at what intervals.

The MoPH has also placed considerable emphasis on having female health staff employed at every health facility, from a female CHW in the village to female doctors at the hospital level, with trained midwives occupying important posts in-between.

Staffing patterns are an indicator of performance in implementation of the Basic Package of Health Services and a basis for incentive awards that are part of some of Basic Package of Health Services delivery contracts.

Table 4: Percentage of Basic Package of Health Services facilities with at least one female doctor, nurse or midwife, 2004-2007

	2004	2005	2006	2007
Basic Health Centers	35.6	53.0	66.0	73.0
Comprehensive Health Centers	42.8	79.8	90.2	93.3
District Hospitals	41.2	83.7	100.0	97.9
TOTAL	38.9	64.4	76.0	81.5

On a more general note, women's health has been consistently categorized as "maternal or RH". Without denying the importance of these categories, it should be noted that women are more than mothers and bearers of children. Their general and mental health concerns have been, for the most part, neglected.

For this reason, the most important recommendation that can be made to ensure the mainstreaming of women's health within the HNS is that all data collected through the many data collection mechanisms being put in place be disaggregated by gender. This would include HMIS, routine monitoring, population-based surveys, etc. The need for gender disaggregating ranges from looking at childhood mortality rates, because girls may be subjected to considerable bias when household level decisions are made regarding whether or not HCS should be sought outside the home, to gender-specific prevalence rates of chronic communicable diseases such as TB, again because health-seeking behavioural patterns may differ considerably between the sexes. In addition, there is a need to take a special look at gender differences in the areas

of mental health, where the consequences of domestic violence may be considerably greater among women than is currently thought, and both mental and physical disability.

In fact, the MoPH should not only ensure that its data collection exercises emphasize separate analysis of data collected for men and women, but also that its Programs accurately reflect any discrepancies in access to HCS, utilization patterns, and health status that might be found. Furthermore, the MoPH should be a leader in emphasizing to other line Ministries, the need for gender disaggregating of data and for service delivery Programs to take the needs of women into account.

The MOPH had a major breakthrough in establishing Gender and Reproductive Rights Unit (GRRU) within the RH Department structure. The GRRU will continue to play a key role in addressing gender equality and equity in the national health policies and guidelines.

Key Strategic Areas:

Advancement of gender equality and equity, and the empowerment of women, should not be an isolated policy goal. Its achievement is closely related to the integration of gender perspectives into national health goals, in particular RH policies and programs such as:

1. Increase the general awareness of gender, RH and rights -

Gender, RH, Reproductive Rights concepts and approaches in health can be new to most of the HCWs in Afghanistan. It is necessary for them to understand these concepts before putting them into practice.

Training materials are already in place, which need to be officially endorsed by the MOPH. The training, which will create awareness about gender issues in the framework of RH and rights, will be incorporated into program planning and implementation at the facility level. The results of the past gender training activities show that close monitoring after the implementation of the training is critical in putting the visions into action. Detail planning for training, indicators to measure the impact, and a monitoring checklist need to be developed separately.

Coordination with the Ministry of Women's Affairs on this activity will also enhance the quality and impact of the training at provincial levels.

2. Enhance women's decision making role in relation to health seeking practices -

The evidence in Afghanistan shows that the fact that female CHWs comprise more than half of all CHWs has increased access to HCSs for rural women. The establishment of women's Community Health Committees at HP and health facility levels in some parts of Afghan communities has also facilitated more women to seek HCS. In conjunction with the MoPH's continued effort in the deployment of female CHWs and female health facility staff, and the existence of female community health committee members, empowerment of women in making decisions regarding own and their family's health need to be strengthened continuously.

Learning for Life, an integrated health and literacy program, which was implemented in twelve provinces of Afghanistan, is a good model in empowering women in providing not only literacy skills but also basic health messages, mathematics, social studies, and skills in communication, negotiation, and conflict resolution. This should eventually enable them to make decisions on healthier behaviour for their own and their family's health.

Again, this will not be an isolated strategy. In order to achieve this goal, this message and these activities must be integrated within the BCC components of the RH Strategy.

3. Involvement in activities of RH and rights

After the International Conference on Population and Development in 1994, more attention has been paid to the role of men in women's RH due to growing recognition that men's attitudes, knowledge, and behaviour can strongly influence women's health choices. This is particularly true in male dominant society such as Afghanistan.

Men, as fathers and husbands, are more intimately involved in their wife's pregnancy and childbirth than are other male family members. Besides which, they are often the decision-makers, the mahrams (spouses, close

relatives, etc) who accompany their wives to a clinic and the ones who pay for care.

As partners of women, men should be encouraged to learn birth preparedness, ANC, delivery and postnatal care. In addition, they can play a supporting role, which no one else can play. For example, they can encourage the wife to rest and help reduce her workload, encourage a nutritious diet, and follow-up on care as prescribed. Men can be positive mediators between their parents and wife since parents may put pressure on the couple to have many children soon after marriage.

3. Regional Cooperation

Afghanistan as the member state of the World Health Assembly is fully committed to the implementation of International Health Regulations 2005 (IHR 2005). Based on IHR 2005, all public health emergencies of international concern should be detected, reported to WHO and effectively responded.

Afghanistan has increasingly become a full participant in all health activities regarding the South Asia region. Its role in international organizations, including the WHO and UNICEF, has strengthened over the past few years. On an inter-country basis, its relationships in the HNS with its closest and largest neighbours, Pakistan and Iran, have been quite strong. A formal Memorandum of Understanding was signed between the three countries in 2005 calling for collaboration in the control of cholera, TB, malaria, and poliomyelitis. In February 2007, a meeting of the UN country Teams of these three countries reviewed the commitment made by all the Ministers of Health in the Kabul Declaration of April 2006. This Declaration, on Regional Collaboration in Health, was signed by seven countries with Iraq, Tajikistan, Turkey and Turkmenistan joining the three mentioned above in an agreement to collaborate on all pertinent aspects of health, and especially on the control of HIV/AIDS, avian influenza, malaria, TB, cholera, and poliomyelitis. The Kabul declaration manifested the following commitments:

- Mobilize and maintain political will at the highest level of each country;
- Harmonize health messages conveyed to the public;
- Establish uniform criteria of quality surveillance and timely exchange of essential information;
- Identify high risk and mobile populations;
- Develop and follow standardized organization and management guidelines; and
- Develop and apply evidence-based approaches.

The regional co-operation will be exercised at the following levels of the health care system:

- international level,
- regional level,
- national government level, and
- individual participant level

The vision for further collaboration between Afghanistan, Pakistan, and Iran is for a strong partnership that will:

- provide a platform for dialogue to address health issues of mutual concern, including sharing of information, technical expertise, and best practices;
- ensure joint actions for addressing critical cross-border health issues;
- enhance cross-border efforts to reduce the negative impact of insecurity on the health and well-being of the populations of each of the countries; and
- directly contribute to the achievement of MDG 8 (develop a global partnership), MDG 6 (combat HIV/AIDS, malaria and other diseases), and MDG 4 (reduce child mortality).

4. Anti-corruption

The MoPH will adhere to policies and agrees with all GoA recommendations made for addressing and limiting corruption. The existing Road map to fight corruption proposes some strategies to solidify the GoA's commitment against corruption and to clarify the institutional framework.

The achievement of having a free-access feedback mechanism on MoPH services and staff will be a decisive step. The Chair of the

Petitions and Complaints Committee, of the National Assembly of Afghanistan, is currently the closest and only example in the country similar to the traditional Ombudsmen position that directly guarantee the rights of complaint and information of citizens regarding the activities of governmental institutions. Although initially originated in Western European countries – the Swedish ombudsmen is a 200-year-old institution - ombudsmen have become in the last years a regular fixture within the Central Asian Region institutional frameworks (the first First International Conference for Central Asia Ombudsman held recently in Bishkek, Kyrgyz Republic represented a landmark in that direction).

The establishment of the Health Service Ombudsmen (HSO) unit, as a fully-autonomous entity within the MoPH, is to play a key role in improving transparency and integrity standards. The fixed-term, non-removable appointment of the HSO will follow a standard high-grade recruitment process under the supervision of the IARCSC. At the request of individuals, MoPH employees or civil society organizations, the HSO will ensure that HCS are provided with the utmost regard for equity, efficiency, professionalism and respect for human rights. Complaints or queries submitted to the HSO will be investigated independently and impartially and, when upheld, the HSO will recommend to the relevant MoPH department or unit the necessary amendment of its regulations and/or procedures. When a civil or criminal offence is detected, the HSO will inform the General Independent Administration of Anti-Corruption and Bribery (GIACC) or relevant judiciary bodies.

In a timely manner, a HSO public awareness campaign will be launched. The HSO will also publicize its commencement through the network of MoPH and HCS providers' organizations staff.

Echoing the fact that corruption cases usually tend to concentrate in those department/units (and with administrative procedures) that offer better chances of illicit personal gains, the strengthening of professional standards in key MoPH entities will ensure that existing financial management and procurement regulations are implemented. The CSC Code of Conduct, recently approved by the IARCSC, is definitely a step in the right direction to increase integrity standards among civil servants. Therefore, it will be disseminated in the MoPH as soon as the necessary administrative arrangements are completed.

Finally, to have long-term strategies in the fight against corruption (comprehensive anti-corruption plans and forum), collaboration agreements with the GIAAC, and any other governmental agency that may hold responsibilities in these areas, should be achieved.

The existence of many cross-cutting issues, in dealing with transparency and integrity issues, makes it advisable to establish a permanent MoPH Transparency WG (TWG) to gather information, share experiences and produce common analyses. The TWG will coordinate the implementation of overall governmental policies in this area throughout the MoPH. Representatives of the GIAAC and any other relevant agencies will be invited to participate as permanent TWG members. This should enable the development of a Vulnerability to Corruption Assessment to be supported.

5. Counter-Narcotics

The MoPH is the line GoA agency with primary responsibility for delivery of treatment and rehabilitation services to drug users throughout Afghanistan. The MoPH is also responsible for developing and implementing programs for drug use and HIV/AIDS prevention.

Technical monitoring of implementation of these services will be undertaken by implementing partners, usually NGOs. The Drug Demand Reduction WG (DDR WG) of the MoPH will oversee this process. In order to be able to carry out its responsibility in the monitoring process, this WG will undergo training on monitoring techniques.

Expert opinion recognizes a general increase of drug misuse and dependence in the country since 2001. Contributing demand factors include vulnerability from trauma of war and extreme poverty. A further contributing demand factor is social dislocation of Afghan refugees; historically to refugee camps in

Pakistan and Iran that were influenced by local drug consumption trends, followed by the return of drug dependent refugee populations to Afghanistan within the past three years. The demand trend is also supported by the ready supply of locally produced opium. This is especially evident in provinces of Badakshan, Nangahar, Balkh, Herat, Kandahar and Kunduz.

A National Drug Use Survey (2005) conducted by Ministry of Counter Narcotics (MCN) and United Nations Office on Drugs and Crime (UNODC) estimated a total of 920,000 users of psychotropic substances in the country, of which approximately 740,000 were males and 120,000 females. The study estimated 60,000 child drug users. Some 500,000 are estimated hashish users with another 180,000 taking prescribed drugs. Almost 150,000 of the total estimated number of drug users were opium users, with the majority of them consuming daily (86%). An estimate of 50,000 heroin users was also established. Inhaling the fumes of heated heroin (*chasing*) was the predominant method of administration, mostly taken on a daily basis (86%). Heroin use is often associated with comparatively higher risks to public health because of dependence liability and method of administration that is often by injection that facilitates transmission of blood born infections such as HIV and Hepatitis B and C. The 2005 survey identified about 15% (7,500) of all male heroin users as injectors.

The estimated level of drug use of most drug types is much higher in Central and Northern Zones than other areas of Afghanistan for both men and women. The highest level of drug use in the Central Zone is found in Kabul City and surrounding rural areas. In the Northern Zone, the highest estimated level of drug use occurs in the provinces bordering Turkmenistan and Uzbekistan. In other regional zones, drug use is more evenly distributed across provinces, with higher levels found in provinces that border Iran or Pakistan. Treatment admissions in Kabul and elsewhere generally reflect access by opium using populations, but not heroin using populations.

Afghanistan has a National Drug Control Strategy (January 2006) to ensure the achievement of the following four national priorities:

- Disrupting the drugs trade by targeting traffickers and their backers;
- Strengthening and diversifying legal rural livelihoods;
- Reducing the demand for illicit drugs and treatment of problem drug users; and
- Developing state institutions at the central and provincial level vital to the delivery of the GoA Counter Narcotics Strategy.

A Counter-Narcotics Implementation Plan also supports the strategy. The 2006 version of the plan emphasizes eight pillars including DDR, alternative livelihoods, eradication, public awareness, law enforcement, criminal justice, international and regional cooperation and institution building.

The pillar for DDR and treatment of addicts includes primary, secondary and tertiary prevention activities are delivered at centres contracted out by MoPH, which are linked with mental health and HIV programs. They are coordinated and monitored by the Demand Reduction Directorate of the MoPH

6. Environment

In collaboration with other relevant GoA ministries, departments and NEPA, the MoPH will increase awareness and understanding of potential adverse health consequences of environmental factors, such as poor water supplies; lack of adequate sanitation facilities; inadequate rubbish disposal and collection, particularly of plastic bags; health facility waste; poor food handling and hygiene; and high levels of air pollution. Various mechanisms will be used to raise awareness and understanding including during Cabinet meetings, inter-ministerial meetings and via the media. The Ministry will develop an environmental policy and strategy that defines where and how it can be most effective in preventing illness due to adverse environmental factors. It will also develop and distribute guidelines on good environmental health practices.

Environmental health, including water and sanitation, indoor and outdoor air quality and proper housing is an important and significant pillar of public health, well within the responsibilities of the MoPH. This area of

public health has not been well developed, a direct consequence of the few resources devoted to it. In order to mitigate the effects of environmental pollution, the following will be required:

- enforcement of existing laws, by-laws, and regulations;
- strengthening HR expertise in the field of environmental protection involving a number of different line ministries and civil society organizations;
- raising awareness of environmental issues with the public;
- formulating a National Environmental Action Plan for Afghanistan; and
- M&E of progress, or lack of it, toward the achievement of a clean and safe environment.

- **Disability**

Disability is another cross-cutting issue, for the health sector and across sectors. For the health sector specific challenges are:

1. Early detection of disabilities, which means more appropriate diagnostics of new born and small children with disabilities; early treatment which frequently can counteract a disabling development e.g. early treatment of club-feet and congenial hip dysplasia.

2. Access to general HCSs for people with disabilities, which means physical access to health facilities and access to health staff who know about disability and rehabilitation.

3. Access to special services, e.g. hearing aids for the hearing impaired and access to orthopaedic workshops for people with amputations.

Across sectors the general challenge is how to include people with disabilities in all kinds of development and services e.g. education and employment

- **Provincial Development Plans**

The Ministry of Public Health (MOPH) commits itself to accelerating the Afghan National Development Strategy (ANDS) development and implementation in order to achieve the national goals articulated in the ANDS. The Sub-national Consultation (SNC) process of the ANDS has been successfully involving the sub-national administration of the sector, strengthened the sense of cohesion between the central MOPH and the provincial public health departments and thus deepened the MOPH chapter of the Health and Nutrition Sector Strategy (HNSS). The MOPH sees the forthcoming challenges to materialize the SNC proposals and envisages exploring the resources in technical and financial terms for the implementation by looking into the MOPH and its partners' inputs into the HNSS.

The MOPH has adopted the evaluation criteria for the SNC proposals in such a way that focuses on equity. Equity refers to social, behavioral, economic, physical, psychological and cultural fairness and accountability responsive to those who are under-served and ill health in the society. While maximizing the number of beneficiaries, the MOPH seeks equity by looking at the scientific data on topography, depth of poverty and vulnerability of the population to be served for, health indicators of mothers and children in particular, utilization and availability of the health services in the area of concern, availability of funds and so forth. By doing so, the proposals are categorized into four;

1. the proposals that are on-going and/or to be implemented with the current funds,
2. the proposals that are included in the MOPH Construction Plan and to be implemented when fund is available,
3. the proposals that are considered in the HNSS timeframe and implemented when fund is available and
4. the proposals that have to be discussed in detail with the MOPH because they are not adhering to the evaluation criteria, colliding with the HNSS strategies and/or duplicating the efforts and inputs of the MOPH and its partners.

The MOPH acknowledges that the SNC is an opportunity for all the stakeholders in the sector to create more dialogues among ourselves and thus refine the route towards the accomplishment of the HNSS.

OTHER SECTOR-RELATED ISSUES

Policy measures to enhance the role of NGOs and the private sector in delivering HCS

The private sector in health poses a complicated set of strengths, weaknesses opportunities and threats (SWOT) to the achievement of MOPH health sector goals and national objectives. Public sector polices may be aimed at extending access to the population as well as redirecting public resources to where they will be most effective. The policies must focus on reducing demand, improving efficiency and generating increased revenues in the public sector. However, there is an expanded role for the private sector, both NGOs and for-profit, for HCSP. To this end the MOPH must ensure that attention is given in all policies to equity, access, efficiency and effectiveness. It is critical that these four elements are used by the MOPH in its stewardship role to ensure that policies related to public-private sector collaboration focus on how the public sector can partner with the private sector in order to meet national health objectives. The MOPH policies thus use its policies to improve the ability to focus resources on high-priority health activities in the public sector and to make more effective and efficient use of the resources of the private sector for meeting national health objectives.

Hence, policy decisions will have to be made as to the appropriate mix of public and private sectors. Whatever that policy, it is paramount that public and private sectors, rather than being an adversarial relationship, be one where they work together to deliver a level of quality care that is medically effective and acceptable to the patients and the population at large receiving those services.

Policies related to fiscal viability

One of the important concerns in the HNS is its fiscal viability, or sustainability. A clear HCF policy is needed to overcome resource constraints to achieve higher quality, more accessible and financially sustainable HCS. Inadequate funding and inefficient use of resources has resulted in unsatisfactory conditions in many hospitals and health centres in Afghanistan such as poorly maintained health facilities, poorly paid staff that are not motivated, broken equipment, lack of necessary medical supplies, and lack of sustainability mechanisms. Because the GoAs' resources are limited and donor resources will decrease over time, there is a need to have a strategy for greater financial sustainability. In addition to the need to generate additional resources, a greater imperative for MOPH is to make better use of existing as well as new resources; this should help achieve a sustainable health system.

A National Policy on HCF and Sustainability, developed recently by the HCF and Sustainability TF, attempted to combine the aims of resource allocation, efficient resource utilization, and the raising of additional resources to allow growth and expansion in a balanced way. It has set out seven guiding principles:

- Ensuring access to HCSs for all in an equitable manner;
- Improving quality of available HCSs;
- Sustainability of HCF mechanisms;
- Accountability and transparency;
- Efficiency; and
- Simplicity.

There are three primary sources of funding for the health sector:

1. External funding (donors),
2. Public funding (government), and
3. Private funding, of which the largest part will come from household expenditures.

At present, Afghanistan is heavily dependent upon donor funding for major health activities. A more sustainable means of financing the NHCS must be developed. However, Afghanistan's health system will be financed through a combination of various financing mechanisms rather than by a single mechanism.The guiding principles provided above will be the basis for the MOPH determining the mix and proportion in which these financing options are used for funding a NHCS that is not only sustainable, but fair and equitable.

CHAPTER 5

MONITORING AND EVALUATION

As above, and as the results achieved by the HNS to date demonstrate, the MoPH places a strong emphasis on M&E. Its commitment to evidence-based, participatory program planning and implementation can be seen in its extensive program of data collection, analysis, and interpretation. As a general internal objective, the MoPH aims to ensure the availability, coordination, distribution and use of accurate, reliable, user-friendly health information in the design, implementation, and the M&E of HCS and related activities. It intends to develop annual M&E and planning cycles at both the national and provincial levels. In addition, a particular emphasis will be placed on ensuring that reliable baseline data is obtained for its various initiatives.

MECHANISMS FOR IMPLEMENTING MONITORING AND EVALUATION OF THE HNSS

The MOPH has recently finalized a National Monitoring and Evaluation Strategy to monitor and evaluate progress in implementation of the Health and Nutrition Sector Strategy. The National Monitoring and Evaluation Strategy like the Health and Nutrition Sector Strategy, is focused on results defined by the Afghanistan High Level Compact and Millennium Development Goals.

In order to objectively assess the performance and progress of its contracted NGOs, the MoPH engaged an independent evaluator. The BSC measurement tool, consisting of about thirty indicators of performance, has been developed. The BSC 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 (1383), being used to set Afghan-specific benchmarks and guide corrective actions and NGO M&E.

The BSC provides evidence that substantial progress has been made in the first three years of BPHS implementation in Afghanistan. From 2004 to 2006, national scores for 25/29 indicators have shown improvement (16/29 improved by more than 10%) and 27/29 Provinces, for which data is available from all BSC assessments, have improved their performance. Although the BSC findings also reveal specific deficiencies, on the whole these results demonstrate that widespread improvements in HCS delivery have been achieved in Afghanistan in a short period of time.

In addition, the MoPH has invested heavily in the development of a routine HMIS. The planned rapid expansion of HCS under different grants' Programs to NGOs called for an HMIS that allowed for the M&E of the progress of BPHS implementation. Starting early in 2003, and continuing to the present, a revived HMIS TF worked in tandem with various other technical TFs to define policies and protocols for individual interventions.

Reporting from the provinces to the national level was 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. In early 2003, updated information from about 5% of facilities was readily available at the MOPH; by late 2005, 70% of all facilities targeted for early implementation (about 80% of the total) were submitting timely routine reports to the MoPH.

In addition to being used for the M&E of field-level performance of the HNS, the BSC and other sources of information are used to organize MoPH's overall activities and to modify its strategic direction as a function of the available information. Although political pressures, professional intuition, and international priorities will always be present and respected, the policy of the MoPH is to have the delivery of HCS guided by objective information, analysis and decision-making.

The MoPH has also adopted a series of instruments and tools for informing itself as to what is happening within the sector for which it is responsible. These can best be summarized as follows (also see Annex II):

1. Epidemiologic and demographic reports

- Central Statistics Office – provides population estimates at district level;
- Multiple Indicator Cluster Survey – a UNICEF developed tool that gives values of selected PHCSs and nutrition indicators at population level and is national in scope;
- Lot QA Sampling – household and community level indicator estimates of essential health (and potentially nutrition) indicators; and
- Special studies – surveys of maternal mortality, contraceptive prevalence, etc.

2. Intermittent Monitoring Tools

- Afghanistan National Health Resources Assessment – an inventory of facilities and available services;
- BSC – described more fully in Section IV, this innovative tool provides sample-based health facility M&E for a considerable number of process indicators;
- Fully Functional Service Delivery Points – routine health facility M&E; and
- HMIS – facility-based estimates for select process indicators at local levels.

3. Routine Service Statistics

- Hospital Monthly Integrated Report (HMIR) and Monthly Integrated Activity Reports (MIARs) - from RgHs, PHs, DHs, CHCs, and BHCs;
- MIARs and Monthly Aggregated Activity Report (MAAR) – from community-level HPs; and
- HR Database – from provincial and central levels of MoPH.

All of these mechanisms are used to develop monthly, 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.

SHORT AND MID-TERM DEVELOPMENT BENCHMARKS

Many of the important indicators of HNS achievement are given in section IV. In addition to those that are in full alignment with the Afghanistan MDGs and the Afghanistan Compact, others are more specific as to strategies and programs considered to be essential to the achievement of overall sector goals and objectives. In order to best inform high-level officials of the MoPH and other GoA officials regarding the evolution of the health and nutrition status of the Afghan population, and the service characteristics which can be collected at more frequent intervals, a list of relatively high-order indicators has been developed. Please refer to "Desired Results for 2013" in the previous sections.

RISK ASSESSMENT

However, no matter how successful the development of a data-based culture has been and how important it has been to the success that the HNS has had to date, longer-term success depends on factors that are not entirely within the control of either the policy-makers or the technicians of the MoPH. There will always be a major risk that the gains that have been recorded to date can be quickly undone by increasing and spreading insecurity. It has been evidenced and documented on numerous occasions in many parts of the world that public health and conflict are incompatible pursuits. The health status of the Afghan population depends, perhaps to an even greater extent than it does on those who formulate health policy and

deliver HCS, on those responsible for ensuring peace and prosperity throughout the country. In addition, to end on a more prosaic note, the continued success of the MoPH will depend on stable and progressive leadership, and crucially on the availability of sufficient resources to allow for the continued implementation of priority Programs. Donors will need to continue to fund the sector for the foreseeable future and the GoA needs to allocate an increasing proportion of available resources to those responsible for implementing the plans and strategies detailed in this document; they have been shown to have made substantial contributions to the development of Afghan society

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APPENDICES

APPENDIX I : National Action Plan

PILLAR : HEALTH AND NUTRITION
SECTOR : HEALTH AND NUTRITION

Expected Outcomes	Policy Actions or Activities	Category	Time frame	Responsible Agency
Increased quality of health care services	Develop an effective organization and management system to coordinate all services of NHCS	Institution Building	1387-1392 (2008-2013)	MoPH
	Strengthen HRD unit to oversee the HR and R&D issues, Computerize all HRM activities to strengthen Human resource management	Institution Building/ AC Cross Cutting Issues	1388-1392 (2009-2013)	MoPH
	Develop a suitable regulatory framework to encourage private sector investment	Legislation	1388-1392 (2009-2013)	MoPH
	Strengthen policy and planning support unit in the Ministry	Legislation	1387-1392 (2008-2013)	MoPH
	Effective monitoring and reporting of quality of services provided by different agencies	Institution Building	1387-1392 (2008-2013)	MoPH
	Establishment of a quality support program	Institution Building	1387-1392 (2008-2013)	MoPH
	Making service delivery performance based through incentives and contract monitoring and exploring options for implementing results based financing of health service delivery in Afghanistan.	Institution Building	1388-1392 (2009-2013)	MoPH
	To mainstream into all administrative reform programs measures required to address the systems and incentives promoting anti-corruption within the public administration system and Development Activities.	Institution Building/ Cross Cutting Issues	1387-1392 (2008-2013)	MoPH
Increased access to health care services	Implement the Primary Health Care Program	Development	1387-1392 (2008-2013)	MoPH
	Develop a comprehensive referral system integrated with BPHS to improve the service delivery level	Development	1387-1392 (2008-2013)	MoPH
	Harmonize the system of procurement and disbursement of essential medicines	Institution Building	1387-1392 (2008-2013)	MoPH
	Develop a comprehensive care system for communicable diseases like TB, HIV and malaria	Development	1387-1392 (2008-2013)	MoPH
	Establish and maintain required number of Health Facilities providing diagnostic and treatment TB services	Development	1387-1392 (2008-2013)	MoPH
	Establish number of Health Facilities providing diagnostic and treatment	Development	1387-1392 (2008-2013)	MoPH

PILLAR : HEALTH AND NUTRITION SECTOR : HEALTH AND NUTRITION				
Expected Outcomes	**Policy Actions or Activities**	**Category**	**Time frame**	**Responsible Agency**
	Malaria services			
	Establishing effective surveillance system and Volunteer Confidential Counseling and Testing Center for HIV cases in each province	Development	1387-1392 (2008-2013)	MoPH
	Awareness generation against ills of drug usage and environmental issues affecting health	Development/ CN Env. Cross Cutting Issues	1387-1392 (2008-2013)	MoPH
	Establishing centers for treatment and rehabilitation of Drugs users.	Development/ CN Cross Cutting Issues	1387-1392 (2008-2013)	MoPH
	Promotion of regional cooperation to make health facilities available to the people of Afghanistan if such facilities are not available in the country.	Development/ RC Cross Cutting Issues	1387-1392 (2008-2013)	MoPH
Effective Reproductive and Child health system	Develop an integrated reproductive and child health care system with the support of development partners	Development	1387-1392 (2008-2013)	MoPH, MoE, MoWA, MoHE
	Develop effective immunization coverage system with adequate doses of DPT vaCross Cutting Issuesne & Hepatitis, measles and polio in all provinces	Development	1387-1392 (2008-2013)	MoPH
	A Special Cell be created to take care and promote all gender issues especially health of females and mothers	Development/ Gender Cross Cutting Issues	1387-1392 (2008-2013)	MoPH

APPENDIX II: MONITORING AND EVALUATION FRAMEWORK OF SECTOR STRATEGY:

PILLAR: HEALTH SECTOR: HEALTH & NUTRITION			
Expected Outcomes	**Indicators**	**Baseline**	**Targets**
Increased quality of health care services	Number of functional public and private hospitals set up	Under Assessment	Functional regulatory framework for quality health services in place by 2013
	No. of provinces where organized structure is in place	Under Assessment	Functional organization structure for quality health services in place by 2013
	Index on the progress of putting in place quality health care services	Under Assessment	Increased quality of health care services will be available throughout Afghanistan by 2013
	Overall score on the Balanced Scorecard	TBD	TBD
Increased access to health care services	% of population within two hours walking distance from PHC services	ii) 66% - of population with nearby access to PHCs (2006)	90% of population with access to PHC services (2010)
	No. of health facilities, district, provincial and regional hospitals equipped with standard package of defined clinical and diagnostic services	Under Assessment	Comprehensive referral system integrated with BPHS & EPHS in place by 2013
	% of TB cases detected and treated	68% (2006)	Increase of 12% from the baseline
	% of Malaria cases detected and using preventive treatment	To be assessed	Reduction by 60% from baseline
Effective Reproductive and Child health system	% of children under 1 year having received measles antigen, DPT & hepatitis dosage and polio drops	77%(2006)	Achieve and sustain above 90% national coverage (2013).
	% of children under 1 year received measles antigen.	35% (2000)	Achieve above 90% coverage by 2010.
	Maternal mortality ratio	1600 deaths /100,000 live births (2000)	Reduce by 21% between 2002 and 2013
	Under 5 mortality rate in the country (%)	257 deaths/1000 live births (2000)	Reduce by 35% between 2000 and 2013
	Infant mortality rate (IMR) in the country (%)	165 deaths per 1000 live births(2000)	Reduce infant mortality rate by 30% by 2013 from the baseline of 2000

APPENDIX III: LIST OF PROJECTS (HEALTH AND NUTRITION SECTOR)

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
Program - 1: Disease Control program																
Sub program1.1.TB Control																
1	AFG/ 0746201	Tuberculosis Control Project	1386	Carry forward	0.50	0.25	0.00				0.75	0.75	0.00	JPN	External Funds	
2	AFG/ 0825601	Stop TB Action Training Course	1386	Carry forward	0.04	0.04	0.04				0.12	0.12	0.00	JPN	External Funds	
3	AFG/ 0825701	Tuberculosis Laboratory Network for DOTs Expansion	1386	Carry forward	0.04	0.04	0.04				0.12	0.12	0.00	JPN	External Funds	
4	AFG/ 0825501	Tuberculosis Control Project	1386	Carry forward	1.09	0.62	0.00				1.71	1.71	0.00	JPN	External Funds	
5	AFG/ 0828901	WHO TB Lab. Expansion	1387	Carry forward	0.50	0.00	0.00				0.50	0.50	0.00	USAID	External Funds	
6	AFG/ 0554201	Building Afghanistan's Capacity to address AIDS,TB and Malaria.	1383	Carry forward	1.035						1.03	1.03	0.00	GF	Core Funds	
	Sub Total				3.210	0.95	0.08				4.24	4.24	0.00			
Subprogram1.2.Malari Control																
Subprogram1.3.HIV/AIDS Control																
8	AFG/ 0812101	Prevention of HIV/AIDS and Human	1387	New	0.500	0.50	0.50				1.49	0.00	1.49		Core Funds	

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
		Trafficking														
9	AFG/ 0733501	HIV/Aids prevention	1386	Carry forward	3.060	0.50	12.50				16.06	3.060	13.00	AFG	Core Funds	
10	AFG/ 0766301	Harm Reduction in Balkh and Heart Provinces (HIV/AIDS CNTF)	1386	Carry forward	0.068						0.07	0.068	0.00	CNTF	Core Funds	
	Sub Total				3.628	1.00	12.99				17.62	3.128	13.00			
Sub program1.4.EPI																
11	AFG/ 0342101	National Immunization Programme.	1386	Carry forward	0.06	7.76	0.00				7.82	0.12	7.70	WHO	External Funds	
12	AFG/ 0342101	National Immunization Programme.	1382	Carry forward	3.420	9.70	0.00				13.12	5.360	7.76	GAVI	Core Fund	
	Sub Total				3.480	17.46	0.00				20.94	5.480	15.46			
Sub program1.5.Environmetnal Health																
13	AFG/ 0762301	Pilot project for improving public health state in Mazar-I-Sharif Afghanistan through introducing innovative waste management methods and capacity building for Afghan	1386	Carry forward	0.02	0.00	0.00				0.02	0.02	0.00	EC	External Funds	

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
		environmental experts														
	Sub Total				0.02	0.00	0.00				0.02	0.02	0.00			
Sub program1.6.Emerngency Prperatdness and Response																
14	AFG/ 0797301	Emergency Health Support Projects	1387	Carry forward	1.09	1.05	0.00				2.14	2.14	0.00	NLD	External Funds	
15	AFG/ 0674401	Preparedness for the Epidemics of Communicable Diseases & Disaster.	1385	Carry forward	1.036	4.60					5.64	0.500	5.14	AFG	Core Fund	
	Sub Total				2.122	5.65	0.00				7.78	2.636	5.14			
Sub Program1.7.Mental Health and Drug Demand Reduction																
16	AFG/ 0701101	Establishment of two 20 beds Rehabilitation centers for drug addicts in Balkh & Jalalabad.	1384	Carry forward	0.250						0.25	0.250	0.00	CNTF	Core Fund	
17	AFG/ 0701201	Establishment of Drug Addicts Community Based Treatment & Rehabilitation Centers, Decrease Harm & their	1384	Carry forward	0.680						0.68	0.680	0.00	CNTF	Core Fund	

List of Projects (Health and Nutrition Sector)																	
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
		Prevention in 8 Provinces of the Country.														
	Sub Total				0.930						0.93	0.930	0.00			
Program-2:Pimary Health Care Program																
Sub Program2.1. BPHS																
18	AFG/ 0687101	Expansion of Basic Package of Health Services Through New Health Cluster System in Nangarhar Province.	1386	Carry forward	0.60	0.00	0.00				0.60	0.60	0.00	EC	External Funds	
19	AFG/ 0694201	Provision of Basic Package of Health Services	1386	Carry forward	4.62	0.00	0.00				4.62	4.00	0.62	DNK	External Funds	
20	AFG/ 0714201	Basic Package for Health service delivery in two districts of Logar provinces implemented by MRCA	1386	Carry forward	0.14	0.00	0.00				0.14	0.14	0.00	EC	External Funds	
21	AFG/ 0714301	Basic Package of Health Service in Kunduz province by SCA	1386	Carry forward	0.62	0.00	0.00				0.62	0.62	0.00	EC	External Funds	

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
22	AFG/ 0774001	Demand reduction	1386	Carry forward	0.15	0.00	0.00				0.15	0.15	0.00	UK-FCO	External Funds	
23	AFG/ 0784001	Integrated community based healthcare provision: Nooristan province	1386	Carry forward	1.15	0.46	0.00				1.62	1.62	0.00	EC	External Funds	
24	AFG/ 0784101	Provision of Basic Package of Health Services (BPHS) in Zabul province	1386	Carry forward	1.00	0.38	0.00				1.38	1.38	0.00	EC	External Funds	
25	AFG/ 0784201	Provision of Basic Package of Health Services (BPHS) For Ghor Province of Afghanistan	1386	Carry forward	3.40	1.13	0.00				4.54	4.54	0.00	EC	External Funds	
26	AFG/ 0784301	Urozgan. Basic Package of Health Services	1386	Carry forward	1.09	0.43	0.00				1.52	1.52	0.00	EC	External Funds	
27	AFG/ 0784401	Provision of Basic Package of Health Services (BPHS) and Essential Package of Hospital	1386	Carry forward	2.08	0.83	0.00				2.91	2.91	0.00	EC	External Funds	

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
		Services (EPHS) in DAI KUNDI														
28	AFG/ 0784601	Basic Package of Health Services (BPHS) in Kunduz	1386	Carry forward	3.44	2.06	0.00				5.50	5.50	0.00	EC	External Funds	
29	AFG/ 0784701	Provision of Basic Package of Health Services and Essential Package of Hospital Services in Ningarhar Province	1386	Carry forward	4.33	1.73	0.00				6.06	6.06	0.00	EC	External Funds	
30	AFG/ 0784801	Provision of BPHS in Logar Province	1386	Carry forward	1.48	0.59	0.00				2.07	2.07	0.00	EC	External Funds	
31	AFG/ 0785101	Provision of BPHS and EPHS according to MOPH policy in Laghman Province	1386	Carry forward	2.37	0.95	0.00				3.32	3.32	0.00	EC	External Funds	
32	AFG/ 0786501	BPHS implementation in 3 districts of Ghore	1386	Carry forward	0.11	0.00	0.00				0.11	0.11	0.00	EC	External Funds	
33	AFG/ 0787901	Provision of BPHS and	1386	Carry forward	2.32	0.93	0.00				3.24	3.24	0.00	EC	External Funds	

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
		EPHS according to MOPH policy in Kunar														
34	AFG/ 0342601	Basic Package of Health Services (BPHS).	1382	Carry forward	20.000	9.431					29.43	18.000	11.43	WB	Core Fund	
	Sub Total				48.890	18.93	0.00				54.16	42.729	11.43			
Sub Program2.2. MPHS & Nomads Health Program																
35	AFG/ 0674201	Health Care for NOMADS.	1385	Carry forward	1.031	0.44					1.47	0.500	0.97	AFG	Core Fund	
	Sub Total				1.031	0.44					1.47	0.500	3.45			
Sub Program 2.3.Non-BPHS Clinics and Ambulance Services																
36	AFG/ 0817201	Supply of 10 Ambulances in Kabul, Kandahar, Jalalabad, Mazar-e-Sharif & Herat	1387	Carry Forward	0.24	0.00	0.00				0.24	0.24	0.00	IND	External Funds	
37	AFG/ 0543201	Prosthetic, rehabilitation Center (Swiss Funded Project)		Carry Forward	0.03	0.00	0.00				0.03	0.03	0.00	Swiss	External Funds	
38	AFG/ 0733401	Construction of BHC's & CHC's in Provinces in Southern Borders.	1386	Carry Forward	1.080						1.08	1.080	0.00	AFG	Core Fund	

List of Projects (Health and Nutrition Sector)																	
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
	Sub Total				1.350	0.00	0.00				1.35	1.350	0.00			
Sub Program 2.4.Nutrition																
Sub Program 2.5.Disability																
39	AFG/ 0715401	Technical assistant to the disabilitly Unit of the Ministry of public health	1386	Carry Forward	0.06	0.00	0.00				0.06	0.06	0	EC	External Funds	
	Sub Total				0.06	0.00	0.00				0.06	0.06	0.18			
Sub Program 2.6.Disability																
Program-3: Hospital Care Program																
Sub Program 3.1.EPHS																
40	AFG/ 0384101	Prevention of Blindness and other Eye Care	1387	Carry Forward	0.03						0.03	0.04	0.00	AUS	External Funds	
			1387	Carry Forward	0.57						0.57	0.62	-0.05	IAM	External Funds	
			1387	Carry Forward	1.19						1.19	2.13		Varius donor	External Funds	
	Sub Total				1.79						1.79	2.79	-0.05			
Sub Program 3.2. Blood Bank																
Sub Program 3.3. Nursing Care																
Sub Program 3.4. National Hospitals																
41	AFG/ 0817901	Supply of medical equipment to	1387	Carry Forward	0.50	0.00	0.00				0.50	0	0.50	IND	External Funds	

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
		Afghan national army														
42	AFG/ 0829201	Midwifery Centers & Hospitals refurbishing	1387	Carry Forward	37.00	0.00	0.00				37.00	0	37.00	USAID	External Funds	
43	AFG/ 0701301	100 Beds Hospital in Kapisa Province	1384	Carry Forward	10.000	9.43	0.00				19.43	10.000	9.43	BRU	Core Funds	
44	AFG/ 0512801	Improving Quality of Hospital Services	1383	Carry Forward	10.000	9.43	0.00				19.43	10.000	9.43	AFG	Core Funds	
														WB	Core Funds	
45	AFG/ 0735401	Construction of 100 Bed Hospital in Saripo	1386	Carry Forward	3.560						3.560	0.00	0.00	AFG	Core Funds	
46	AFG/ 0811801	Construction of One District Hospital in Baghlan Province	1386	New	1.100						3.560	2.170	1.39		Core Funds	
47	AFG/ 0812001	Construction of Faryab Provincial Hospital	1387	New	3.500	0.00	0.00				3.50	0.00	3.50		Core Funds	
	Sub Total				65.660	18.86	0.00				86.98	22.17	61.25			
Sub Program 3.5.Diagnostic Servicess																

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
Sub Program 3.6 Forensic Medicine																
Program 4.Reproductive Health & MCH program																
Sub Program 4.1. Safe Motherhoo																
48	AFG/ 0746101	Reproductive Health Project	1386	Carry forward	0.60	0.30	0.90				1.80	0.90	0.90	JPN	External Funds	
49	AFG/ 0779001	Setting up of Neo-Natal and Maternity care center	1386	Carry forward	0.50	0.50	0.00				1.00	1.00	0.00	IND	External Funds	
50	AFG/ 0822901	Reproductive Health Project	1386	Carry forward	1.44	0.54	0.56				2.54	2.54	0.00	JPN	External Funds	
51	AFG/ 0823201	Public Health Strengthen Project in Kabul (Maternal and Child Health)	1387	Carry forward	0.19	0.19	0.19				0.56	0.56	0.00	JPN	External Funds	
52	AFG/ 0823401	Maternal and Child Health for the Middle East countries	1386	Carry forward	0.06	0.06	0.00				0.12	0.12	0.00	JPN	External Funds	
53	AFG/ 0343202	Support for Reproductive Health Programmes.	1387	Carry forward	0.50	0.00	0.00				0.50	0.50	0.00	FIN	External Funds	
	Sub Total				3.29	1.58	1.64				6.52	5.62	0.89			
Sub Program 4.2.Family Planning																
Sub Program 4.3. Adolescent & Child Health																
54	AFG/ 0600201	Child Protection and	1387	Carry forward	0.40	0.00	0.00				0.40	0.40	0.00	USAID	External Funds	

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
		psychological Support for Afghan Children and Youth Program														
55	AFG/ 0823601	Seminar on how to reduce child death and international cooperation	1386	Carry forward	0.04	0.04	0.04				0.12	0.12	0.00	JPN	External Funds	
56	AFG/ 0829001	WHO Support for Polio	1387	Carry forward	1.00	0.00	0.00				1.00	1.00	0.00	USAID	External Funds	
57	AFG/ 0829101	UNICEF Support for Polio	1387	Carry forward	1.00	0.00	0.00				1.00	1.00	0.00	USAID	External Funds	
	Sub Total				2.44	0.04	0.04				2.52	2.52	0.00			
Sub Program 4.4. Gender & Reproductive Rights																
58	AFG/ 0823501	Workshop on Adolescent Sexual and Reproductive Health	1386	Carry forward	0.04	0.00	0.00				0.04	0.04	0.00	JPN	External Funds	
	Sub Total				0.04	0.00	0.00				0.04	0.04	0.00			
Program 5, Public Nutrition																
Program6. Policy & Planning Support Program																
Sub Program6.1. Policy formulation & Planning																
59	AFG/ 0746001	Adviser for Health Cooperation Planning	1386	Carry forward	0.04	0.04	0.00				0.08	0.08	0.00	JPN	External Funds	

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
60	AFG/ 0751601	NGO Service Delivery: Service Support Project (SSP)	1387	Carry forward	4.90	0.00	0.00				4.90	4.90	0.00	USAID	External Funds	
61	AFG/ 0823001	Health System Management	1386	Carry forward	0.08	0.08	0.08				0.25	0.25	0.00	JPN	External Funds	
62	AFG/ 0823901	Seminar for Health Policy Development	1386	Carry forward	0.02	0.02	0.02				0.06	0.06	0.00	JPN	External Funds	
63	AFG/ 0824001	Education cooperation planning	1386	Carry forward	0.19	0.19	0.19				0.56	0.56	0.00	JPN	External Funds	
	Sub Total				5.23	0.33	0.29				5.85	5.85	0.00			
Sub Program 6.2.Monitoring and Evaluation																
64	AFG/ 0570001	National Monitoring and Evaluation Program	1382	Carry forward	1.000						1.00	1.000	0.00	WB	Core Fund	
	Sub Total				1.000						1.00	1.000	0.00			
Sub Program 6.3. Contract Management																
65	AFG/ 0569801	Capacity Building for Grants & Contract Management Unit (GCMU)	1383	Carry forward	0.200	1.73					1.93	0.200	1.732	WB	Core Funds	
	Sub Total				0.200	1.73					1.93	0.200	1.732			
Sub Program 6.4. HMIS																

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
66	AFG/ 0788401	Establishing Disease Indexing Services in Afghanistan	1386	Carry forward	0.16	0.04	0.00				0.20	0.2	0.00	EC	External Funds	
67	AFG/ 0789201	Provision of Health information through the distribution of a magazine all over Afghanistan	1386	Carry forward	0.04	0.01	0.00				0.06	0.06	0.00	EC	External Funds	
	Sub Total				0.21	0.05	0.00				0.26	0.26	0.00			
Sub Program 6.5 HSS																
68	AFG/ 0724801	Suppor to the Afghan Public Health Sector	1386	Carry forward	16.90	0.00	0.00				16.90	16.9	0.00	EC	External Funds	
69	AFG/ 0830401	Support to Public Health Sector	1387	Carry forward	84.00	0.00	0.00				84.00	84.00	0.00	EC	External Funds	
70	AFG/ 0781601	Supporting Afghanistan Health Sector	1386	Carry forward	0.444	0.17					0.61	0.48	0.13	EC	Core Fund	
71	AFG/ 0781701	Health System Strengthening	1386	Carry forward	7.345	8.60	15.06				31.01	30.3	0.71	GAVI	Core Fund	
	Sub Total				108.689	8.77	15.06				132.52	131.68	0.84			
Sub Program 6.6. Public Relation																
Sub Program 6.7. Liaison Officer																

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
Program 7.Human Resource Development & Research																
Sub Program 7.1. Training & Development																
72	AFG/ 0825401	Medical Education Project	1386	Carry forward	0.52	0.06	0.00				0.58	0.58	0.00	JPN	External Funds	
73	AFG/ 0715201	Training of Ministry of Public Health, Kabul and privincial level Public Health Offices in Health Management System.	1386	Carry forward	0.14	0.00	0.00				0.14	0.14	-0.004314297	EC	External Funds	
74	AFG/ 0745901	Medical Education Project	1386	Carry forward	0.16	0.00	0.00				0.16	0.16	0	JPN	External Funds	
75	AFG/ 0817001	Indian Medical Missions at Kabul, Herat, Mazar-e-Sharif, Jalalabad & Kandahar	1387	Carry forward	0.20	0.00	0.00				0.20	2.00	-1.80	IND	External Funds	
76	AFG/ 0823701	Capacity Development for Public Health Leader	1386	Carry forward	0.02	0.02	0.02				0.06	0.06	0.00	JPN	External Funds	
77	AFG/ 0823801	Capacity Building for Public Health	1386	Carry forward	0.08	0.08	0.00				0.16	0.16	0.00	JPN	External Funds	
78	AFG/ 0824101	Strengthening Teacher	1386	Carry forward	1.55	1.36	0.45				3.36	3.36	0.00	JPN	External Funds	

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
		Education Program														
79	AFG/ 0635201	Institutional Support to the Ministry of Health at its Provincial Level.	1384	Carry forward	0.080						0.08	0.13	-0.05	EC	Core fund	
80	AFG/ 0733101	Technical Support to MoPH.	1386	Carry forward	0.850						0.85	0.131	0.72	CDCP	Core fund	
	Sub Total				3.591	1.46	0.47				4.52	3.847	13.89			
Sub Program7.2.Ghazanfar Institute on Health and Sciences																
Sub Program 7.3. Research & Surveillance																
81	AFG/ 0344201	Assessment and Surveillance of Nutritional Status and Treatment of Malnutrition (Severe and Moderate).	1386	Carry forward	0.01	0.00	0.00				0.01	0.01	0.00	WHO	External Funds	
82	AFG/ 0811901	Developing Oxygen Producing Factory	1387	New	0.300						0.30	0.00	0.30		Core fund	
83	AFG/ 0709901	Surveillance & Response to Avian & Pandemic Influenza by Afghan Health	1384	Carry forward	0.920	0.43					1.345	0.425	0.92	CDCP	Core fund	

List of Projects (Health and Nutrition Sector)																	
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
		Institute (API)/MoPH.														
	Sub Total				1.230	0.43	0.00				1.655	0.435	1.22			
Sub Program 7.4. Public Health Laboratories																
84	AFG/ 0674601	Expansion of DOTS & Establishment of Related Laboratory.	1387	Carry forward	0.00	0.00	0.00				0.00	0.82	-0.82	JPN	External Funds	
				Carry forward	0.41						0.41	0.82	-0.41	WHO	External Funds	
	Sub Total				0.41	0.00	0.00				0.41	1.64	-1.23			
Sub Program 7.5.Food and Drug Control																
Sub Program 7.6. Health Promotion																
85	AFG/ 0689601	REACH Social Marketing component.	1387	Carry forward	10.40	0.00	0.00				10.40	10.40	0.00	USAID	External fund	
	Sub Total					0.00	0.00				10.40	10.40	0.00			
Sub Program 7.7. Community Midwifery Training																
Sub Program 7.8. DEWS/Surveillance																
Sub Program 7.9. Avain Influeza																
86	AFG/ 0733601	Combating Influenza & preparedness for the Bird flu pandamy.	1386	Carry forward	1.359	1.12					2.481	2.022	0.459	ARTF	Core Fund	

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
	Sub Total				1.359	1.12					2.481	2.022	0.459			
Program8. Pharmaceutical Management Support Program																
Sub Program8.2:Drug Affairs																
87	AFG/ 0675301	Capacity Building of Pharmacists & their Assistants.	1384	Carry forward	0.103	0.10					0.198	0.060	0.138	AFG	Core Fund	
88	AFG/ 0675401	Developing Injecting liquid Producing Factory.	1385	Carry forward	4.500						4.500	4.500	0.000	AFG	Core Fund	
	Sub Total				4.603	0.10					4.698	4.560	0.138			
Program 9.Public Health Administration Program																
Sub Program 9.1:Personel																
89	AFG/ 0764401	Support to the Institutional Development of the Ministry of Public Health EPOS	1386	Carry forward	1.62	0.00	0.00				1.62	1.62	0.00	EC	External Funds	
90	AFG/ 0733101	Technical Support to MoPH.	1387	Carry forward	16.16	0.00	0.00				0.00	16.16	-16.16	USAID	External Funds	
91	AFG/ 0715001	National Advisor Position within the Ministry of Health GDPPH	1386	Carry forward	0.02	0.00	0.00				0.02	0.01	0.01	EC	External Funds	
92	AFG/ 0714801	Project Administrator	1386	Carry forward	0.01	0.00	0.00				0.01	0.01	0.00	EC	External Funds	

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
		Position within the ministry of Health GDPPH														
93	AFG/ 0714901	Project Manager Position within the ministry of Health GDPPH	1386	Carry forward	0.01	0.00	0.00				0.01	0.01	0.00	EC	External Funds	
94	AFG/ 0785201	EC Procurement Expert Service Contract	1386	Carry forward	0.14	0.00	0.00				0.14	0.14	0.00	EC	External Funds	
	Sub Total				17.96	0.00	0.00				1.80	17.95	-16.15			
		Sub Program 8.2: rocurement														
95	AFG/ 0763201	Second level committment Operating Costs MOPH under 4847	1386		0.03	0.03					0.03	0.03	0	EC	External Funds	
	Sub Total				0.03	0.03					0.03	0.03	0			
Sub Program 8.3: Maintenance & Central Warehouse Management																
96	AFG/ 0811701	Construction of three Provincial Health Directorate Offices	1387	New	0.300						0.300		0.300		Core fund	
	Sub Total				0.300	0.00					0.300		0.300			
	Total				**282.34**	**78.9**	**30.58**				**374.256**	**274.083**	**111.956**			

List of Projects (Health and Nutrition Sector)																
S/N	AFG Budget Ref	Programs / Project title	Project Duration		Breakdown of Requirements (US$ Millions)						Total Requirement (US$ Million)	Total Funding (US$ Million)	Gap (US$ Million)	Major Donors	External	Responsible Agency
			Start	End	1387	1388	1389	1390	1391	1392 +					Core	
					7	**4**										

APPENDIX IV: LIST OF PROVINCIAL DEVELOPMENT PROJECTS (HEALTH AND NUTRITION SECTOR)

.	Project Name	Project Location	Responsible agency	Project Duration (year)	
				Start	End
1	Construction and equipping of training centre in the public Health directorate, in the provincial centre, (1000 employees as beneficiaries).	Balkh	MoPH	1387	
2	Construction of public Health directorate and PHO members, provincial centre, (all the staff of public Health as beneficiaries).	Balkh	MoPH	1387	
3	Establishment of a quality control centre for medicine and food, in the provincial centre.	Balkh	MoPH	1389	
4	Construction of a 50 bed hospital for treatment of addicted patients, in the provincial centre.	Balkh	MoPH	1388	
5	Construction of 50 bed hospital in central Sholgara district.	Balkh	MoPH	1388	
6	Construction of Charkent district Health clinic, Charkent district.	Balkh	MoPH	1389	
7	Construction of district Health clinic building, Tash Guzar, Shor Tapa district.	Balkh	MoPH	1389	
8	Construction of Health clinic building, Diwali Maidan, Balkh district.	Balkh	MoPH	1388	
9	Construction of kuchi area Health clinic building, Sholgara district	Balkh	MoPH	1388	
10	Construction of Dalan Health clinic building, Sholgara district.	Balkh	MoPH	1388	
11	Construction of 200 bed hospital in Pul-i- Khumri (100000 as beneficiaries)	Bghlan	MoPH	1388	
12	Construction of Health clinics in Ahmadzai, Bustak, Khiderkhil, Larkhwabi, Nawaqil, Kharuti, Mangal and Tiri Mangal villages.	Bghlan	MoPH	1388	
13	Construction of Health clinic in Freng district (25000 beneficiaries).	Bghlan	MoPH	1388	
14	Rehabilitation of a proper Health clinic in Shaikh Jalal district, Baghlan-i-Markazi (8000 as beneficiaries)	Bghlan	MoPH	1387	
15	Rehabilitation of a proper Health clinic in Tangi Murch, Burka district, (15000 beneficiaries)	Bghlan	MoPH	1387	
16	Construction of a hospital in Khost district, (200000 beneficiaries).	Bghlan	MoPH	1387	
17	Rehabilitation of Health clinic in Pasha Qul, Dahana-i-Ghori district, (20000 beneficiaries)	Bghlan	MoPH	1388	
18	Rehabilitation of a proper Health clinic in Larkhwabi, Baghlan-i-Markazi district (18000 beneficiaries).	Bghlan	MoPH	1388	
19	Rehabilitatioof public Health directorate in Pul-i-Khomri, provincial centre.	Bghlan	MoPH	1388	
20	Rehabilitation) of a proper Health clinic in Dasht Gir, Baghlan-i-Markazi district (20000 beneficiaries).	Bghlan	MoPH	1389	
21	Establishment of Comprehensive Health Centre (CHC) in Jawqul village, Waras district (30,000 beneficiaries).	Bamyan	MoPH	1387	
22	Establishment of (BHC) in Sia Dara village, Yakawlang district (20,000 beneficiaries)	Bamyan	MoPH	1388	

.	Project Name	Project Location	Responsible agency	Project Duration (year)	
				Start	End
23	Establishment of Basic Health Centre (BHC) in Dasht-i-Safid village of Kahmard district (15000 beneficiaries)	Bamyan	MoPH	1387	
24	Construction of Basic Health Centre (BHC) in Warzakh of Waras district (15000 beneficiaries).	Bamyan	MoPH	1388	
25	Construction of Basic Health Centre (BHC) in Dahan Dara-i-Mazar, Sulech, and Yakawlang district (16000 beneficiaries).	Bamyan	MoPH	1388	
26	Construction of Basic Health Centre (BHC) in Khwaja Ganj, Saighan district (15000 beneficiaries)	Bamyan	MoPH	1388	
27	Provision of equipped ambulances, 7 districts.	Bamyan	MoPH	1388	
28	Construction of Comprehensive Health Centre (CHC) Sadaat ,Bamyan provincial centre, (30000 beneficiaries)	Bamyan	MoPH	1388	
29	Construction of Comprehensive Health Centre (CHC) Foladi in the centre of Bamyan province, (30000 beneficiaries)	Bamyan	MoPH	1388	
30	Construction of Basic Health Centre (BHC) in Hajar valley of Kahmard district, (12000 beneficiaries).	Bamyan	MoPH	1388	
31	Construction of 100 bed hospital in central Faizabad.	Badakhshan	MoPH	1388	
32	Construction of 50 bed hospital (300,000 beneficiaries)	Badakhshan	MoPH	1388	
33	Drinking water for the whole province	Badakhshan	MoPH	1388	
34	Construction of CHC clinic in Shaki district (18000 beneficiary)	Badakhshan	MoPH	1388	
35	Construction of clinic in Gharat district, Ashkasham (4000 beneficiaries).	Badakhshan	MoPH	1388	
36	Construction of the Clinic at Gandom Qool district, Kasham.(10000 people).	Badakhshan	MoPH	1388	
37	Construction of BHC Clinic in Yawan village Shangan district. 4000 beneficiaries 11 villages).	Badakhshan	MoPH	1388	
38	Construction of 20 bed psychiatric hospital & treatment centre for drug addicts.	Badakhshan	MoPH	1388	
39	Selection of Health Professional staff in all Health centres. (200000 beneficiaries)	Badakhshan	MoPH	1388	
40	Construction of a CHC at Kholab,(20000 beneficiaries).	Badakhshan	MoPH	1388	
41	Construction of DH hospital in centre of Meramoor district (88,400 beneficiaries).	Daikundi	MoPH	1388	
42	Construction of DH hospital in centre of Kiti province (64,900 beneficiaries).	Daikundi	MoPH	1387	
43	Construction of Health centre in Khidir district.	Daikundi	MoPH	1388	
44	Construction of Health centre (CHC) in centre of Kijran district (73800 beneficiaries).	Daikundi	MoPH	1387	
45	Construction of Health centre (CHC) in centre of Ashtarlai district (35000 beneficiaries).	Daikundi	MoPH	1388	
46	Construction of Health centre (BHC) in centre of Sharistan (21900 beneficiaries).	Daikundi	MoPH	1387	
47	Construction of Khoshak Health centre in Ashtarlai district	Daikundi	MoPH	1387	
48	Construction of Health centre in Biri Gizab district.	Daikundi	MoPH	1387	
49	Construction of Health centre in Siachoob Sangtakht district.	Daikundi	MoPH	1387	

.	Project Name	Project Location	Responsible agency	Project Duration (year)	
				Start	End
50	Construction of Health centre in Kijran district.	Daikundi	MoPH	1387	
51	Reconstruction and moderization of provincial hospital in Maimana city.	Faryab	MoPH	1387	
52	Rehabilitation of Tagab district DH hospital (Shirin Tagab district	Faryab	MoPH	1388	
53	Construction of CHC in Chil Gazi Qaisar district	Faryab	MoPH	1388	
54	Establishment of BHC in Kohistan district Dewalak village	Faryab	MoPH	1388	
55	Establishment of DH in Garziwan district Dehmeran village	Faryab	MoPH	1388	
56	Establishment of BHC for Kuchis in Almar district, Khowaja Gowhar village.	Faryab	MoPH	1388	
57	Establishment of BHC in Kohistan district Drahshman village	Faryab	MoPH	1388	
58	Construction of BHC in Almar district.	Faryab	MoPH	1387	
59	Construction of BHC building in Khancharbagh district.	Faryab	MoPH	1387	
60	Establishment of BHC in Sari Haowz	Faryab	MoPH	1387	
61	Construction of a provincial hospital (350 beds, 454000 beneficiaries).	Jawozjan	MoPH	1388	
62	Complete construction and extension of Aqcha Hospital (20 rooms, 150000 beneficiaries).	Jawozjan	MoPH	1388	
63	Construction & extension of building & surrounding wall of Darzab Hospital (20 rooms, 120,000 beneficiaries).	Jawozjan	MoPH	1387	
64	Construction of B.H.C (20 rooms with equipment for Dashte Laily Kuchis (11000 beneficiaries).	Jawozjan	MoPH	1388	
65	Expansion & reconstruction of current clinic in Qarqen (20 rooms 35000 beneficiaries).	Jawozjan	MoPH	1388	
66	Construction of B.H.C (20 rooms with equipment. Chacana Darzab district (12000 beneficiaries).	Jawozjan	MoPH	1388	
67	Construction of B.H.C in Quinly district. (10 rooms with equipment 8000 beneficiaries).	Jawozjan	MoPH	1388	
68	Costruction of Public Health directory building in Shibirghan city.	Jawozjan	MoPH	1387	
69	Cosntruction of Health centre in Mardiyan and Kohistanat Faizabad.	Jawozjan	MoPH	1387	
70	Cosntruction of Health centre new building in Jaza Aqcha.	Jawozjan	MoPH	1388	
71	Development of Charikar hospital from district to provincial level.	Parwan	MoPH	1388	
72	Building construction of Ko-i-Safi hospital in Koh-i-Safi district, the hospital will be beneficial for 27000 individuals	Parwan	MoPH	1388	
73	Rehabilitation of Worti Health Clinic Building (12500 beneficiaries)	Parwan	MoPH	1387	
74	Construction of Say Qala Health centre in Surkh Parsa district (16,000 beneficiaries).	Parwan	MoPH	1387	
75	Construction of Chinki clinic in Sayed Khil and (17,000 beneficiaries).	Parwan	MoPH	1388	
76	Construction of Bayan clinic in Charikar (152,000 beneficiaries).	Parwan	MoPH	1387	

.	Project Name	Project Location	Responsible agency	Project Duration (year)	
				Start	End
77	Construction of Kafashan clinic in Shinwari and (14,000 beneficiaries).	Parwan	MoPH	1387	
78	Construction of Bagram hospital, Bagram district.	Parwan	MoPH	1388	
79	Construction of Charikar public Health directorate, centre of the province.	Parwan	MoPH	1387	
80	Training of Health workers in all districts of the province	Parwan	MoPH	1389	
81	Establishment of provincial hospital in provincial centre (188000 beneficiaries)	Pajshir	MoPH	1388	
82	Construction of Health Directrate building in provincial centre (188000 beneficiaries).	Pajshir	MoPH	1388	
83	Establishment of Health centre in Paryan district.	Pajshir	MoPH	1388	
84	Expansion of Health centre to district hospital in centre of Paryan district (30000 beneficiaries).	Pajshir	MoPH	1387	
85	Expansion of Health centre to district hospital in centre of Dara district (48000 beneficiaries)	Pajshir	MoPH	1387	
86	Establishment of Health centre in Dara district, Tanbna village (8000 beneficiaries).	Pajshir	MoPH	1387	
87	Establishment of district hospital in Khinj district Jafarkhil village (51000 beneficiaries)	Pajshir	MoPH	1388	
88	Establishment of Health sub- centre in Shotol district Roidara village (8000 beneficiaries)	Pajshir	MoPH	1388	
89	Expansion of Basic Health Centre to Comprehensive Health Centre in Shotol district Dehkalan village (18000 beneficiaries).	Pajshir	MoPH	1388	
90	Establishment of Health sub-centre in Fawaj Ananaba (7500 beneficiaries).	Pajshir	MoPH	1388	
91	Establishment of district hospital in Ajrestan district (standard building, 30 beds 90,000 beneficiaries)	Ghazni	MoPH	1388	
92	Upgrading of Do Aba Clinic, Nawar district to district hospital (standard building, 80,000 beneficiaries).	Ghazni	MoPH	1388	
93	Upgrading of Mir Adina Clinic to district hospital, Malistan district (standard building 90,000 beneficiaries).	Ghazni	MoPH	1388	
94	Upgrading of Nawa Clinic to district hospital, Nawa district, standard building, 100,000 beneficiaries)	Ghazni	MoPH	1388	
95	Construction of BHC in central Targan area, standard building 28000 beneficiaries).	Ghazni	MoPH	1387	
96	Construction of BHC in Pati area, Gailan district (standard building, 17,000 beneficiaries).	Ghazni	MoPH	1388	
97	Construction of BHC in Deh Mard village Jaghori district (standard building, 15,000 beneficiaries)	Ghazni	MoPH	1388	
98	Construction of B.H.C in Quli Sabz area, Zana Khan district (standard building, 6000 beneficiaries)	Ghazni	MoPH	1387	
99	Establishment of obstetrics centres in central Ghazni (standard building, 1040 beneficiaries).	Ghazni	MoPH	1387	
100	Establishment of Mobile Health Care Team for kuchies in central Ghazni.	Ghazni	MoPH	1387	
101	Activating of 10 Health centres in districts	Hirat	MoPH	1387	
102	Construction of 16 clinics (centre and each district).	Hirat	MoPH	1387	
103	Equipping and activating of children's hospital in Herat City	Hirat	MoPH	1388	

.	Project Name	Project Location	Responsible agency	Project Duration (year)	
				Start	End
104	Equipping of obstetrics hospital in Herat city.	Hirat	MoPH	1388	
105	Conducting public administrative reform on APHS in Herat regional hospital.	Hirat	MoPH	1387	
106	Establishment of laboratory for food items quality control in Herat city.	Hirat	MoPH	1387	
107	Construction, equipment and activation of Herat City medical postmortem hospital and morgue.	Hirat	MoPH	1387	
108	Construction of 3 district hospitals in Ghorian, Shindan and Gozra districts.	Hirat	MoPH	1388	
109	Expansion and equipping of Herat medical university.	Hirat	MoPH	1388	
110	Equipping and set-up of all administrative affairs of public Health directorate.	Hirat	MoPH	1388	
111	Construction of comprehensive Health centre (CHC) in Khwja Bahauddin, centre of the district.	Takhar	MoPH	1388	
112	Construction of new basic Health centre (BHC) building in Shira village, Eshkamish district.	Takhar	MoPH	1388	
113	Construction of basic Health centre (BHC) in Tagab Chap, Farkhar district (21000 beneficiaries)	Takhar	MoPH	1387	
114	Construction of a clinic (BHC) in Katalut village, Darqad district (12,000 beneficiaries).	Takhar	MoPH	1388	
115	Construction of Shar Ghar Health clinic, Sar Ghar village, Rustaq district (15,000 beneficiaries).	Takhar	MoPH	1387	
116	Construction of a clinic in khuja Ghar district.	Takhar	MoPH	1387	
117	Construction of basic Health centre (BHC) Shaflesh village, Namak Aab district (20,000 beneficiaries).	Takhar	MoPH	1388	
118	Construction of a clinic in centre of the province.	Takhar	MoPH	1387	
119	Construction of a clinic in Mandara village, Chaal district (11,000 beneficiaries).	Takhar	MoPH	1388	
120	Construction of a clinic in the centre of Hazar Samoch district (15,200 beneficiaries).	Takhar	MoPH	1387	
121	Construction of a CHC in Chono for Choni village, Chak district (30000 beneficiaries).	Wardak	MoPH	1387	
122	Construction of a clinic in Mang Ali village, Jaghato District (16000 beneficiaries).	Wardak	MoPH	1387	
123	Construction of a CHC in Raqol village, Behsood district 2 (25,000 beneficiaries).	Wardak	MoPH	1387	
124	Construction of a clinic in Merck village Behsood district 2 (15000 beneficiaries).	Wardak	MoPH	1387	
125	Creation of a Health training centre in Chak district (150,000 beneficiaries)	Wardak	MoPH	1388	
126	Extension of the Medan Shar hospital (150000 beneficiaries).	Wardak	MoPH	1389	
127	Extension of the Said Abad Hospital (200,000 beneficiaries).	Wardak	MoPH	1389	
128	Construction of the Shah Qalandar clinic in Shah village, Qalandar, Chak district (15000 beneficiaries).	Wardak	MoPH	1389	
129	Creation of a Family Clinic in Meran village, Daimerdad district (15,000 beneficiaries).	Wardak	MoPH	1389	
130	Extension of the the clinics of Kohi Beroon ,Mehran, Frakhlum, Markeze Jaghato, Shaikh Abad from CHC to CHC+.(Behsood	Wardak	MoPH	1388	

.	Project Name	Project Location	Responsible agency	Project Duration (year)	
				Start	End
	districts1,2, Jaghato, Sayed Abad and Daimerdad (150,000 beneficiaries).				
131	Construction of hospital for Dowab village Hisarak district, (8 rooms for 12,000 people).	Nangarhar	MoPH	1387	
132	Construction of the hostel for the medical department (Faculty of Medicine) in Jalalabad city (30 rooms, accommodates 250).	Nangarhar	MoPH	1388	
133	Construction of clinic in Gerikhail village Pacheer wa Agam district (12 rooms, 15,000 beneficiaries).	Nangarhar	MoPH	1387	
134	Construction of a clinic at Zavi village, Kaga district, (8 rooms, for 12,000 people).	Nangarhar	MoPH	1387	
135	Extension & improvement of the central hospital of Dehbala district (15 beds,	Nangarhar	MoPH	1387	
136	Construction of a psychology hospital, in Jalalabad city (80 beds, 40,000 beneficiaries).	Nangarhar	MoPH	1389	
137	Construction of accommodation for female staff of the Kagaha district hospital.	Nangarhar	MoPH	1389	
138	Construction of accommodation for female staff in the district centre, for Ghani Khail Hospital (75 rooms).	Nangarhar	MoPH	1388	
139	Construction of a clinic for the 5th district in Jalalabad city (40,000 beneficiaries, 12 rooms).	Nangarhar	MoPH	1388	
140	Construction of a 10 bed clinic, Shaikh Misry district, Surkhrod (15,000 beneficiaries).	Nangarhar	MoPH	1389	
141	Construction of BHC in Shakhil Abad, Jani Khil (16100 beneficiaries).	Paktika	MoPH	1389	
142	Construction of CHC OR Hospital in central Park Yousuf Khil district (17500 beneficiaries)	Paktika	MoPH	1387	
143	Construction of 50 bed hospital in central Urgon (45000 beneficiaries).	Paktika	MoPH	1387	
144	Construction of CHC District Della Beneficiaries 250000 people	Paktika	MoPH	1387	
145	Construction of CHC) in central Gomal district (17809 beneficiaries).	Paktika	MoPH	1387	
146	Construction of CHC) in central Jani Khil district (20000 beneficiaries).	Paktika	MoPH	1387	
147	Construction of BHC) in central Warmami district (9500 beneficiaries).	Paktika	MoPH	1387	
148	Construction of BHC in Nakah district (32500 beneficiaries).	Paktika	MoPH	1387	
149	Establishment of CHC at Gian centre (District) Beneficiaries 28800 people.	Paktika	MoPH	1387	
150	Establishment of CHC at tarvi centre (District Beneficiaries 9500 people	Paktika	MoPH	1387	
151	Improvement of Qara Bagh hospital (20 to 50 beds,150,000 patients).(It is not included in MoPH plan, however the MoPH agrees to its extension to 30 bed hospital)	Kabul	MoPH	1388	
152	Improvement of Char Asyab hospital (20 to 50 beds 70,000 beneficiaries).(It is not included in MoPH plan and as per the policy of this Ministry does not require extension)	Kabul	MoPH	1389	
153	Improvement of Bagrami hospital from (CHC) to (+ CHC) (165,000 patients).(It is not included in MoPH plan, f MoPH agrees to promote this to CHC not to anything further)	Kabul	MoPH	1389	
154	Improvement of Estalef hospital from (CHC) to (+ CHC) (40,000 patients).	Kabul	MoPH	1389	

.	Project Name	Project Location	Responsible agency	Project Duration (year)	
				Start	End
155	mprovement of Khak Jabar hospital from (CHC) to (+ CHC) (40,000 patients)(It is not included in MoPH plan, MoPH agrees to promote this to CHC not to anything further.)	Kabul	MoPH	1389	
156	Improvement of Shakar Dara comprehensive Health clinic to hospital (20 beds, 135,000 beneficiaries). (Its not included in MoPH plan, the Ministry agrees to its extension to 10 bed CHC for the purpose of 24 hour service	Kabul	MoPH	1389	
157	Construction of Basic Health Clinic (BHC) in Farza district (40,000 beneficiaries)(Presently being constructed through Private Sectortoror and MoPH agrees to the establishment of secondary Health center)	Kabul	MoPH	1388	
158	Construction and establishment of a 50 bed hospital in Paghman district (200,000 beneficiaries)(it is not included in MoPH plan, however, MoPH agrees to the 20 bed CHC in	Kabul	MoPH	1389	
159	Creation of mobile clinics in Deh Sabz district (25,000 beneficiaries)(Establishment of Mobile Health Clinic is included in MoPH plan)	Kabul	MoPH	1388	
160	Construction of BHC in Quchi village Kalakand district (180,000)(It is not included in MoPH plan, however the MoPH agrees to the basic Health center)	Kabul	MoPH	1389	
161	Construction of basic Health centre (BHC) in Kundoz city	kundoz	MoPH	1389	
162	Rehabilitation of Shah Rawan Clinic in Dasht Archi.	kundoz	MoPH	1389	
163	Construction basic Health centre (BHC) in Qala-i-Zal district.	kundoz	MoPH	1388	
164	Establishing of medical branches Kundoz secondary school.	kundoz	MoPH	1389	
165	Construction of building for Kundoz medical institute.	kundoz	MoPH	1389	
166	Establish of 275 Health check posts in all districts of Kundoz (400000 beneficiaries).	kundoz	MoPH	1389	
167	Upgrading of all Health centres to comprehensive Health centres (CHC) 10 beds and ambulances in all districts (380000 beneficiaries).	kundoz	MoPH	1389	
168	Construction of basic Health centre (BHC) in Qasab village, Char Dara district, (5000 to 7000 beneficiaries).	kundoz	MoPH	1388	
169	Construction of Musa Zai basic Health centre, Khan Aabad district (4000 to 8000 beneficiaries).	kundoz	MoPH	1388	
170	Construction of rooms of Aaq Tapa and Char Dara clinics, Qala-i-Zal and Char Dara districts.	kundoz	MoPH	1388	
171	Establish and construction of 150 bed hospital in Aybak, centre of the province	Samangan	MoPH	1387	
172	Construction of Health clinic in Kharan OrlamishHazrat Sultan district (11520 families as beneficiaries)	Samangan	MoPH	1388	
173	Construction of Health clinic in Khuram and Sar Bagh Deh Asl,(10000 beneficiaries)	Samangan	MoPH	1389	
174	Construction of Health clinic in Dara-i-Suf Bala.	Samangan	MoPH	1388	
175	Construction of Health clinic in Roi Do Aab.	Samangan	MoPH	1388	
176	Construction of a mobile Health clinic for Kuchis (nomads) and emergency cases, in the centre of the province.	Samangan	MoPH	1388	

.	Project Name	Project Location	Responsible agency	Project Duration (year)	
				Start	End
177	Construction of basic Health clinic in Feroz Nakhjer district (3,000 beneficiaries).	Samangan	MoPH	1387	
178	Construction of a Health clinic in Tikhonak village in the centre of the province (2,500 beneficiaries	Samangan	MoPH	1388	
179	Construction of a clinic in Tuqsun, Dara-i-Suf Payen (30,000 beneficiaries).	Samangan	MoPH	1388	
180	Construction of a clinic in Shikha village in Dara-i-Suf Bala (12,620 beneficiaries).	Samangan	MoPH	1388	
181	Establishment of a nursing training centre in central Kapisa	Kapisa	MoPH	1389	
182	Construction of a research centre and medical store in central Kapisa.	Kapisa	MoPH	1389	
183	Construction of a cold room for Leishman's disease and malaria control office in the centre of Kapisa.	Kapisa	MoPH	1387	
184	Construction of Health department office in provincial	Kapisa	MoPH	1389	
185	Construction of BHC in Farkhsha Nijrab district.	Kapisa	MoPH	1389	
186	Construction of BHC in Geyawa.	Kapisa	MoPH	1389	
187	Construction of DH in Tagab	Kapisa	MoPH	1389	
188	Construction of BHC	Kapisa	MoPH	1389	
189	Construction of central stock and quality controlling system.	Kapisa	MoPH	1389	
190	Establishment of BHC in Saiad	Kapisa	MoPH	1388	
191	Purchasing of land for construction of provincial hospital in centre of Qalai e Naw (1000m3 60,000 beneficiaries)	Badghis	MoPH	1389	
192	Construction of communicable disease hospital (20 beds, 60,000 beneficiaries)	Badghis	MoPH	1389	
193	Construction of hospital building in centre of Qadis (135,000 beneficiaries).	Badghis	MoPH	1389	
194	Construction of Health medical clinic in Murghab district (one clinic)	Badghis	MoPH	1388	
195	Establishment of Health clinic in Murghab district.	Badghis	MoPH	1387	
196	Construction of Health clinic in Abkamari, Kocha and Gulkhana villages.	Badghis	MoPH	1388	
197	Construction of Health clinic in Jar Sia in Ghormach district	Badghis	MoPH	1389	
198	Construction of medical training centres	Badghis	MoPH	1389	
199	Construction of houses for living for doctors and nurses in centre of Jawod district (14 houses).	Badghis	MoPH	1389	
200	Construction of houses for living for doctors and nurses in Sang Atash district. (15 houses)	Badghis	MoPH	1389	
201	Creation of Basic Health Centres in Khaksar & Shakyar villages of Gosfandi district	Sari pul	MoPH	1388	
202	Construction of Balkhab hospital Balkhab district (80000 beneficiaries	Sari pul	MoPH	1388	
203	Rehabilitation of EPI Building in the centre of Sar-i-Pul Province	Sari pul	MoPH	1388	

.	Project Name	Project Location	Responsible agency	Project Duration (year)	
				Start	End
204	Construction of hospital in the centre of Sancharak district (25,000 beneficiaries).	Sari pul	MoPH	1388	
205	Creation of basic Health centres (BHC) in Sayad district (14,000 beneficiaries).	Sari pul	MoPH	1388	
206	Creation of a clinic for addicted patients in the centre of the province.	Sari pul	MoPH	1388	
207	Construction of a clinic in Pista lee village (12,000 beneficiaries)	Sari pul	MoPH	1389	
208	Construction of public Health directorate building in the centre of the province.	Sari pul	MoPH	1388	
209	Construction of Health clinic in Suzma Qala district and (2,500 beneficiaries).	Sari pul	MoPH	1388	
210	Development (improvement) of the Health centre in Kohestanat district (90,000 beneficiaries)	Sari pul	MoPH	1388	
211	Construction of hospital in Maiwand district -20 beds. Beneficiaries 63800	Kandahar	MoPH	1389	
212	Construction of hospital in Panjwai district - 20 beds. Beneficiaries 97950	Kandahar	MoPH	1389	
213	Rehabilitation of Spinboldak central hospital Beneficiaries 99300	Kandahar	MoPH	1387	
214	Construction of a hospital for the addicted patients in the Centre of Kanadahar,4300 beneficiaries.	Kandahar	MoPH	1387	
215	construction of CHC clinic in mirzaMoPHamad khan Qalacha centre of kandahar beneficiaries 10000	Kandahar	MoPH	1387	
216	construction of CHC clinic in mauroof District Beneficiaries 35000	Kandahar	MoPH	1387	
217	construction of CHC clinic in Dand District beneficiaries 10000	Kandahar	MoPH	1388	
218	Construction of a Kuchi hospital in centre of province. Staff of 130. 435,304 beneficiaries.	Kandahar	MoPH	1389	
219	Construction of the clinic at the pero Kalacha (40,000 beneficiaries).	Kandahar	MoPH	1387	
220	Construction of a KUBHC clinic in Arghistan district (35400 beneficiaries).	Kandahar	MoPH	1387	
221	Construction of a 50 bed hospital in Azra district, (70000 beneficiaries).	Logar	MoPH	1387	
222	Construction of a 10 room CHC hospital in Oria Khail, Kharwar district (60,000 beneficiaries).	Logar	MoPH	1387	
223	Construction of 10 room BHC hospital in central Abchakan, Pul-e Alam district (8500 beneficiaries).	Logar	MoPH	1388	
224	Construction of a 10 room CHC in Pul-e- Alam, Khoshi district (20,000 beneficiaries).	Logar	MoPH	1388	
225	Establishment of a Health training centre for midwives & nurses to help in the treatment of kuchi people. (70,000 beneficiaries).	Logar	MoPH	1388	
226	Construction of a 10 -room clinic in the refugee town.	Logar	MoPH	1388	
227	Establishment of a public Health awareness dissemination team in all districts including the provincial centre.	Logar	MoPH	1389	
228	Construction of a morgue in the provincial centre	Logar	MoPH	1389	
229	Construction of a clinic in Patkha Roghani, Baraki Barak, (15,000 beneficiaries). Since according to the Ministry policy this	Logar	MoPH	1389	

.	Project Name	Project Location	Responsible agency	Project Duration (year)	
				Start	End
	activity is being implemented in all centers therefore instead of Project 10 this was proposed				
230	Construction of an emergency department in Pul-e-Alam & all districts of this province.It is not included in MoPH plan and neither it has any funding commitment, however the PRT has promised the construction	Logar	MoPH	1387	
231	Promotion of the district clinic of Alingar to district hospital About 35 Rooms (130000 Beneficiaries).	Laghman	MoPH	1388	
232	Promotion of Alishing Clinic To District hospital About 35 Rooms Beneficiaries 130000	Laghman	MoPH	1388	
233	Construction of building for lghman Health Directorate (35 room's 150 beneficiaries).	Laghman	MoPH	1388	
234	Construction of B.H.C building in Alingar district, Gazana village (12 rooms, 25000 beneficiaries)	Laghman	MoPH	1388	
235	Establishment of Health sub centre in Qarghai district Kashmond Village, (800 beneficiaries).	Laghman	MoPH	1389	
236	Development of Qarghai clinic to district hospital (35 rooms 120000 beneficiaries	Laghman	MoPH	1389	
237	Establishment of B.H.C Alingar district, SicleVillage (12 rooms 25000 beneficiaries).	Laghman	MoPH	1389	
238	Establishment of Health sub centre Dawlat Shah district Noy village (6000 beneficiaries).	Laghman	MoPH	1388	
239	Establishment of Health sub centre Dawlat Shah district Dorgan village (5500 beneficiaries).	Laghman	MoPH	1388	
240	Construction of a 200 bed hospital in the capital	Laghman	MoPH	1388	
241	Establishment of District Hospital in Daichopan centre (20,000 beneficiaries)(Incloude the CHC in the MoPH plane)	Zabul	MoPH	1388	
242	Establishment of District Hospital in Arghandab District (20,000 beneficiaries)(Incloude the CHC in the MoPH plane)	Zabul	MoPH	1389	
243	Establishment of District Hospital in Ataghar District 25,000 beneficiaries(Incloude the CHC in the MoPH plane)	Zabul	MoPH	1389	
244	Construction of a 20 bed district hospital in refugee's Camp(100000 beneficiaries) (Incloude the CHC in the MoPH plane)	Zabul	MoPH	1388	
245	Construction of 20 bed clinicIn Shahre Safa Ghashi village (114 villages as beneficiaries).(Incloude the CHC in the MoPH)	Zabul	MoPH	1389	
246	Construction of district hospital, Shikan village Mezani district (8500 beneficiaries).	Zabul	MoPH	1388	
247	Establishment of Midwives Training centre for Kochies 2Rounds Every Round 15Days	Zabul	MoPH	1388	
248	Establishment of a CHC Clinic in Khaki Afghan district. in Akhkol Kalai 20beads Beneficiaries 45000(Incloude the CHC in the MoPH plane)	Zabul	MoPH	1388	
249	construction of CHC Clinic in Shamalzai District 20 Bead Beneficiaries 5500 (Incloude the CHC in the MoPH plane)	Zabul	MoPH	1388	
250	Construction of a 20 bed clinic ,BHC in Babu Village, Nawbahar district (26800 beneficiaries)(Incloude the CHC in the MoPH plane)	Zabul	MoPH	1389	
251	Establishment of provincial hospital in Tarainkot (880,000 beneficiaries).	Urozgan	MOPH	1388	

.	Project Name	Project Location	Responsible agency	Project Duration (year)	
				Start	End
252	Establishment of Nursing Training Courses for women (Uruzgan centre, 40 trainees)	Urozgan	MOPH	1388	
253	Establishment of Main Hospital in Khas Uruzgan, 52000 beneficiaries.	Urozgan	MOPH	1388	
254	Construction of 200 bed hospital (500,000 beneficiaries).	Urozgan	MOPH	1387	
255	Upgrading of the district clinic of Alingar to district hospital (130000 beneficiaries).	Urozgan	MOPH	1388	
256	Construction of B.H.C in Rokh Rawood district (110,000 beneficiaries).	Urozgan	MOPH	1387	
257	Construction of B.H.C in Choree district (55,000 beneficiaries).(CHC)	Urozgan	MOPH	1388	
258	Construction of C.H.C in Charcheno district (51,000 beneficiaries). (CHC)	Urozgan	MOPH	1388	
259	Construction of B.H.C in Tarinkot Mehrabad area (20,000 beneficiaries)	Urozgan	MOPH	1388	
260	Construction of B.H.C in Gizab district (36,000 beneficiaries). (BHC)	Urozgan	MOPH	1389	
261	Establishment of training centre in nursing school (Chigh Chiran.)	Ghor	MoPH	1388	
262	Construction of hospital in Toolac district (160,000 beneficiaries).	Ghor	MoPH	1388	
263	Rehabilitation of Lefra medical clinic.(Chigh Chiran) 20000 will be beneficiary.	Ghor	MoPH	1389	
264	Establishment of Health clinic in Qalimistan, Gulistan.18000 beneficiaries.	Ghor	MoPH	1389	
265	Establishment of Health clinic in Dehoor village.19000 beneficiaries.	Ghor	MoPH	1389	
266	Establishment of Health clinic in Asbarf village, Chighchiran. 18000 beneficiaries.	Ghor	MoPH	1387	
267	Establishment of Health clinic in Qalakyar Folad. 17000 beneficiaries.	Ghor	MoPH	1387	
268	Construction of Public Health Department building in centre of province.	Ghor	MoPH	1387	
269	Establishment of medical treatment centre for drug addicts in centre of province. 19000 beneficiaries.	Ghor	MoPH	1388	
270	Construction of provincial hospital incentre of province 20000 beneficiaries. One Hospital.	Ghor	MoPH	1388	
271	Provision of medical equipment for provincial hospital, for 200 beds. Beneficiaries all province inhabitants	Farah	MoPH	1389	
272	Construction & establish of blood bank for Farah provincial hospital. With related equipments, Beneficiaries all province inhabitants.	Farah	MoPH	1389	
273	Construction of cold room (for keeping the dead bodies for temporary period) at the provincial hospital. Beneficiaries all province	Farah	MoPH	1388	
274	. Construction & establishment of district hospital Bala Booluk district Shewan village (30 roomss in 10 jiribs of land 60800 beneficiaries).	Farah	MoPH	1388	
275	Construction & establishment of B.H.C in Purchaman district (8 rooms 2 jirib land) 45500 beneficiaries.	Farah	MoPH	1389	
276	Construction & establishment of B.H.C Gulistan district (8 rooms 2 jerib land 36900 beneficiaries)	Farah	MoPH	1388	

.	Project Name	Project Location	Responsible agency	Project Duration (year)	
				Start	End
277	Construction & establishment of C.H.C Delaram district (16 rooms 3 jerib land 80000 beneficiaries).	Farah	MoPH	1388	
278	Construction & establishment of C.H.C in Sheb e Koh district on 4 jerib land (16 rooms, 20000 beneficiaries).	Farah	MoPH	1388	
279	Nutrition project for children faced malnutrition in Pusht-i-koh district	Farah	MoPH	1389	
280	. Expansion of C.H.W program in Anar Dara district (40 men 40 women beneficiaries).	Farah	MoPH	1389	
281	Upgrading of Nimroz hospital from district to provincial capacity**.** Beneficiaries All Province	Nimroz	MoPH	1388	
282	Provision of ambulances, doctors and nurses for clinics in all districts.20 Ambulance with Staff	Nimroz	MoPH	1388	
283	Reqrut the Professional Nurses And Provision of Ambulances for BHC IN 4 villages Kotalak Dewalak Qala e naw ghor ghori Beneficiaries 50000	Nimroz	MoPH	1388	
284	Upgrading of BHC to CHC in Kang district.	Nimroz	MoPH	1388	
285	Construction of modern hospital in Chaharborjak district.50 beads Beneficiaries 27000	Nimroz	MoPH	1389	
286	Construction of blood bank and morgue for bodies in central Zaranj.	Nimroz	MoPH	1387	
287	Establishment of nursing training centres in all districts. And Distribution of artificial Lambs	Nimroz	MoPH	1388	
288	Establishment of Health service by BHC in centre of Chakhnsor district.	Nimroz	MoPH	1389	
289	Construction of mobile clinic in 5 districts. (5 clinics)for kochies Beneficiaries 80000	Nimroz	MoPH	1387	
290	Support for Health team in Refugee camp.one team.	Nimroz	MoPH	1387	
291	Provision of ambulance for hospital & clinics in centre & districts and two pick upVehicles for the directorate.	Noristan	MoPH	1388	
292	construction of Clinics for Katar gamber Waigal Atiten Shamder Noorgram and Pechader Villages	Noristan	MoPH	1387	
293	Construction of building for **BHC** Koraj Village Mandaul Districts	Noristan	MoPH	1387	
294	Construction district Hospital, about 30 beds in Waigal centre (beneficiaries – whole district).	Noristan	MoPH	1389	
295	Construction of district Hospital, about 30 beds in Kamdish centre.	Noristan	MoPH	1387	
296	Construction of BHC for 6 villages in Bargmatal district	Noristan	MoPH	1387	
297	Construction of clinics for various villages in Bargmatal district, in Pasha gar,((Noorgram) Kosht , Nilab (Douab).	Noristan	MoPH	1389	
298	Establishment of a clinic for the treatment of addicted patients in Burgmatal Centre.	Noristan	MoPH	1389	
299	Establishment of a clinic in Kantiwa district centre for 8 villages	Noristan	MoPH	1387	
300	Establishment of clinic / Cold Room in Paroon, centre of this province.	Noristan	MoPH	1388	
301	Establishment of a service centre for disabled at provincial level.	Hilmand	MoPH	1389	
302	Establishment of CHC, DHC,& BHC in all districts of Helmand ALL districts need all of these things?	Hilmand	MoPH	1387	

.	Project Name	Project Location	Responsible agency	Project Duration (year)	
				Start	End
303	Construction of Health sub centre in Sangin district.	Hilmand	MoPH	1387	
304	Construction of BHC in all districts	Hilmand	MoPH	1388	
305	Establishment of blood bank in Grishk district.	Hilmand	MoPH	1388	
306	Construction of DHC in Nawa district.	Hilmand	MoPH	1388	
307	Upgrading of district clinic to district hospital, Baghran district	Hilmand	MoPH	1387	
308	Construction of gynecology & obstetrics hospital in Baghran district, Karizgay village.	Hilmand	MoPH	1387	
309	Establishment of Aids Control Centre in Lash Kargah city.	Hilmand	MoPH	1387	
310	Extend to the provincial hospital and construction of borning,blood bank and nevus's hospital	Hilmand	MoPH	1388	
311	Construction of BHC Standard Dowa Manda District Beneficiaries 80000	Khost	MoPH	1389	
312	Construction of CHC Clinic in Qalandar District Beneficiaries 40000	Khost	MoPH	1389	
313	Construction of CHC in zazi maidan District Beneficiaries 100000	Khost	MoPH	1389	
314	Construction of district hospital Standard in yaqubi District Beneficiaries 80000.	Khost	MoPH	1388	
315	Contruction of obstetrics hospital in centre of khost Beneficiaries200000.	Khost	MoPH	1388	
316	Construction of district hospital Standard in Ali shir District Beneficiaries100000.	Khost	MoPH	1388	
317	Construction of BHC Clinic in masterbal Beneficiaries 50000	Khost	MoPH	1389	
318	Construction of equipped laboratory in centre of Khost city. (50000 beneficiary).(In place of this project upgrade the CHC to DH of Mosakhail 1387.)	Khost	MoPH	1388	
319	Construction of infectious hospital in centre of Khost city (80000 beneficiaries).	Khost	MoPH	1389	
320	Construction of Artopide center in the Khost capital	Khost	MoPH	1389	
321	Construction of Asad Abad hospital (for EPHS) beneficiaries, provincial level.	Kunar	MoPH	1388	
322	Construction of Naw Abad clinic (9 rooms 13,000 beneficiaries).	Kunar	MoPH	1388	
323	Construction of Qaro Clinic, Qaro village, Watapur district (9 rooms 14,000 beneficiaries).	Kunar	MoPH	1389	
324	Construction of comperhansive clinic Jame village, Chapa Dara district (16 rooms 46,000 beneficiaries).	Kunar	MoPH	1389	
325	Construction of Kurangal clinic, Manugai district village (9 room 14, 000 beneficiaries).	Kunar	MoPH	1390	
326	Construction of clinic in Lache village, Shegal district (9 room 14,000 beneficiaries). SC. And BHC are active no need more.	Kunar	MoPH	1389	
327	Construction of Clinic ,CHC in Nor gal District (9 rooms 14,000 beneficiaries).	Kunar	MoPH	1387	

.	Project Name	Project Location	Responsible agency	Project Duration (year)	
				Start	End
328	Establishment of midwifery & nursing courses in Asad Abad (20 rooms).	Kunar	MoPH	1388	
329	Construction of clinic,BHC in Saw village, Nari district (9 rooms 7000 beneficiaries).	Kunar	MoPH	1389	
330	Construction of Daracha Lam Clinic in Manugai district (9 rooms 9500 beneficiaries).Cooments : One Hospital 5o bids will Construct by the Biate Buniad NGO. At Kunar on 1387.	Kunar	MoPH	1387	
331	Extension of Sayed Karam clinic to district hospital in Sayed Karam district.	Paktia	MoPH	1389	
332	Construction of Health centre Mangyar Chamkani District (10 rooms).	Paktia	MoPH	1388	
333	Construction of Hospital for Infectious diseases in centre of Gardiz (100 beds and 60,000 beneficiaries).	Paktia	MoPH	1388	
334	Construction of a well and equipment for Metrnal Hospital in Gardez. (15, 000, 00.beneficiaries).	Paktia	MoPH	1388	
335	Construction of 30 rooms for the district Hospital in Jaji Ariob (150,000 beneficiaries).	Paktia	MoPH	1389	
336	Construction of 20 rooms in Garda Seri hospital. (25,000 beneficiaries).	Paktia	MoPH	1388	
337	Construction of BHC in Gardi Sira ,Pakhari District	Paktia	MoPH	1388	
338	Construction of a clinic in Akhund Village in Wazi Zadran (10 room's 15,000 beneficiaries).	Paktia	MoPH	1389	
339	Establishment of a hospital in bourkai / Ahmad Abad (15 rooms, 40,000 beneficiaries).	Paktia	MoPH	1389	
340	Construction of a clinic in BHC in Gad Miran ,Jani Khail (10 rooms, 35,000 beneficiaries).	Paktia	MoPH	1389	
341	Construction of comprehensive health clinic (CHC) in 2nd district (Qul-i-Aabchakan) and will be beneficial for 35000 persons.	Kabul Urbon	MoPH	1389	
342	Construction of comprehensive health clinic (CHC) in 3rd district (Jamal Mina) and will be beneficial for 30000 persons.	Kabul Urbon	MoPH	1389	
343	Construction of comprehensive health clinic (CHC) in 6th district (Qala-i-Mohd Hayat) and will be beneficial for 30000 persons.	Kabul Urbon	MoPH	1389	
344	Construction of comprehensive health clinic (CHC) in (Wazir Aabad) and will be beneficial for 35000 persons.	Kabul Urbon	MoPH	1389	
345	Construction of comprehensive health clinic (CHC) in 9th district (Bibi Mahro) and will be beneficial for 30000 persons.	Kabul Urbon	MoPH	1389	
346	Construction of comprehensive health clinic (CHC) in 15th district, and will be beneficial for 30000 persons.	Kabul Urbon	MoPH	1389	
347	Construction of comprehensive health clinic (CHC) in 16th district (Qala-i-Zaman Khan) and will be beneficial for 30000 persons.	Kabul Urbon	MoPH	1389	
348	Construction of comprehensive health clinic (CHC) in 17th district (Sar-i-Kotal) and will be beneficial for 60000 persons.	Kabul Urbon	MoPH	1389	
349	Construction of comprehensive health clinic (CHC) in 21st district (Haji Janat Gul Area) and will be beneficial for 46000 persons.	Kabul Urbon	MoPH	1389	
350	Construction of proper health clinic in 17th district (Pul-i-Charkhi) and will be beneficial for 20000 persons.	Kabul Urbon	MoPH	1389	