Islamic Republic of Afghanistan
Ministry of Public Health

National Health Strategy 2016–2020

Sustaining Progress and Building for Tomorrow and Beyond

September 2016

VISION OF THE MINISTRY OF PUBLIC HEALTH

All citizens reach their full potential in health contributing to peace, stability and sustainable development in Afghanistan.

VALUES OF THE MINISTRY OF PUBLIC HEALTH

Equity Integrity Right to Health Accountability Trust

MISSION STATEMENT, MINISTRY OF PUBLIC HEALTH

The Mission Statement of the Ministry of Public Health of the Government of the Islamic Republic of Afghanistan is to prevent ill health and achieve significant reductions in mortality in line with the national targets and sustainable development goals and to reduce impoverishment due to catastrophic health expenditure. Also to be responsive to the rights of citizens through improving access and utilization of quality, equitable, affordable health and nutrition services among all communities especially mother and children in rural areas, And through changing attitudes and practices, promoting healthy lifestyles and effectively implementing other public health interventions. All in coordination and collaboration with other stakeholders within the framework of strong leadership, sustained political will and commitment, good governance, and effective and efficient management; in its continuous pursuit to become a ministerial 'institution of excellence'.

FOREWORD

I am pleased to introduce this National Health Strategy 2016–2020 of the Islamic Republic of Afghanistan. It gives the direction and scope of work in the health sector for the next five years.

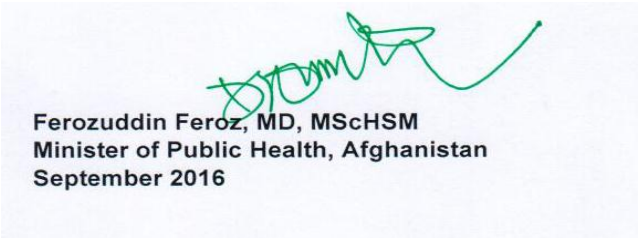
The strategy has been developed within the framework of the health sector agenda outlined in the five year strategic framework for achieving the overarching goal of self-reliance in the Afghanistan National Peace and Development Framework of the National Unity Government. It also takes account of the unfinished work of attaining some of the MDG targets under the umbrella of its successor, the SDGs.

The national health strategy also importantly builds upon the National Health Policy 2015–2020. It has taken the five policy priorities of governance, institutional development, public health, health services, and human resources for health, plus a sixth area of M&E, health information, learning, and knowledge/evidence-based practices, and turned them into strategic areas with planned results to guide implementation.

This national health strategy document helps answer the question 'how are we going to successfully achieve the national health policy and its priorities'? It outlines how all stakeholders can contribute to further improving and sustaining the health of the people of the country. It reflects strategic thinking, leadership, a wide consultative process, some evidence based decision-making, and responsible management. The strategy also helps institutionalise a culture of 'togetherness' and 'one institution' designed to work toward greater efficiency, transparency, and results. Implementation performance will be assessed regularly using the various means and results indicators outlined in this document.

The MoPH cannot succeed alone in this endeavor. We will continue to nurture our valued partnerships with all stakeholders.

Finally, I greatly appreciate and thank everyone involved for their active participation, collaboration, and valuable inputs. I would like to particularly acknowledge Dr. Ahmad Jan Naeem, Deputy Minister, Policy and Planning for leading the strategy development team, and for the support of USAID.



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September 2016

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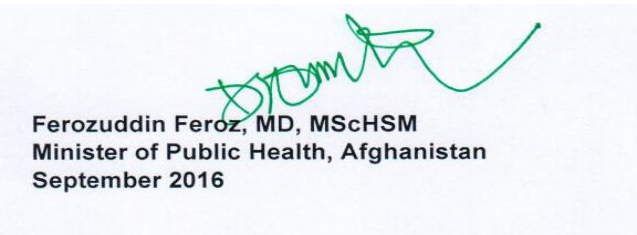
At the heart of the development were the six strategy task forces. Led by one senior adviser, Ahmad Shakir Hadad (governance), and five MoPH Director Generals, Mohammad Daud Azimi (institutional development), Najibullah Safi (public health), Mohebullah Zeer (health services), Miya Ahmad Ashraf (human resources for health), and Dr. Ataullah Saeedzai (M&E, health information, learning, and knowledge/evidence based practices). The task forces consisted members from the MoPH and its key national and international partners and stakeholders, including ANPHA, Canadian Embassy, DEWS, EPOS, EU, Health Net, JHPIEGO, MSH, The Palladium Group, UNDP, UNFPA, UNICEF, USAID, and WHO (listed alphabetically). In most cases, each task force was ably coordinated and supported by a co-chair and a facilitator - Hedayatullah Mushfiq (governance), Omarzaman Sayedi and Khwaja Mir Ahad Saeed (institutional development), Alim Atarud and Palwasha Anwari (public health), Zahidullah Rasouli and Malalah Ahmadzai (health services), Ghulam Sarwar Homayee and Mohammad Naim Abi, and Khoja Atiqullah Hasan (human resources for health), and Said Iftekhar Sadaat (M&E, learning, and knowledge/evidence based practices). Our gratitude also goes to the many provincial staff who provided valuable inputs.

The MoPH would also like to thank the members of the national strategy consultative group, which provided valuable advice and guidance at different stages. As always, our special thanks go to all health sector development partners for their direct and indirect support and participation in both the development of this document and its dissemination, sensitization, and use. We would also like to acknowledge the HSR project for providing valuable technical assistance.

Finally, we would like to extend our sincere appreciation to Tariqul Khan, an international development advisor, supported through technical assistance from USAID Afghanistan for his facilitation throughout the planning and development phases.



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EXECUTIVE SUMMARY

Context

Afghanistan and its National Unity Government is devising a new macroeconomic framework - the Afghanistan National Peace and Development Framework (ANPDF). The framework, the relevant sustainable development goals (SDGs) and the unfinished business of the millennium development goals (MDGs) have all been considered in formulating the goals, targets, and strategies of the six national health strategy strategic areas in this strategy. Other important elements influencing and providing the context for the strategy are the National Health Policy 2015–2020, macroeconomic policies and economic growth, and the socioeconomic status of the country.

Since 2002, the health sector has made sound progress in improving the health status of the population, particularly in access, coverage, and quality of health services. From a dismal 9 percent in 2002, by 2014, nearly 87 percent of the population had access to health services within a two-hour distance.[1] The downward trends in infant, under-five, and maternal mortality demonstrate good improvement in health outcomes. Trends are also upward in antenatal coverage and institutional deliveries[2].

Key overarching challenges include continuing insecurity, low levels of education and weak infrastructure i.e. roads, reliable supplies of water and power. In the health sector the policy priorities 2015-2020 reflect the most urgent challenges.

Box 1. Top policy priorities[3]

- ✓ Governance especially ensuring the **enforcement of anti-corruption measures and having mutual accountability**
- ✓ Institutional development – the **functioning of the Ministry of Health as an effective state institution, and institutional and management culture, style and practices**
- ✓ Public health especially **changing attitudes, perceptions and practices, combatting malnutrition, the prevention of non-communicable diseases, the eradication of polio, and prevention and control of other communicable diseases and controlling the quality of imported food**
- ✓ Health services especially improving **access to, and the sustainability of, quality primary health care and public health particularly for mothers, the new born, children and adolescents, as part of a direction towards universal health coverage** and **improving the quality of clinical care, and more and better quality specialist tertiary care in partnership with the private sector and controlling the quality of imported pharmaceuticals**
- ✓ Human resource management especially **merit based appointments, clarity about functions and work loads and the motivation of staff**

[1] Afghanistan Health Indicators Fact Sheet, 2014
[2] Afghanistan Demographic and Health survey 2015
[3] National Health Policy 2015-2020 Ministry of Public Health, Islamic Republic of Afghanistan The MoPH Vision, Values and Mission Statement on the second page of this document are also taken from the national health policy document

Key Strategic Areas and Results

The goal of the National Health Strategy 2016–2020 is to attain strengthened, expanded, efficient, and sustained performance by the health system. This is intended to ensure enhanced and equitable access to quality health services in an affordable manner, resulting in the improved health and nutrition status of all populations, especially women, children, and vulnerable groups - see section 3 of this document.

Following the strong commitment by the National Unity Government to gaining a high level of self-sufficiency over the course of the next decade, the MoPH will strongly emphasize gradual attainment of financial sustainability. In doing so, it will focus on two overarching issues:

1. Enhancement, expansion, and improvement through gains in efficiency
2. Resource generation/financing and effective mobilization

In general, all the planned results and associated interventions in this strategy will contribute to these issues. The strategy has 6 strategic areas. For each area, there is one overall result and some sub-results and outputs. The MoPH will ensure effective and efficient implementation of the strategic areas through the processes of change management that addresses 'how' the Ministry is working not just 'what' it is doing, mobilizing resources to support implementation, effectively engaging stakeholders, strengthening country ownership, and monitoring and evaluating results. The planned result for each strategic area is given below and more detail can be found in sections 5-10.

- ✓ **Governance**
  Enhanced, strengthened, and accountable health sector governance decisively instituted, with strong and visible leadership and evidence-based advocacy at all levels.
- ✓ **Institutional development**
  Strengthened, expanded, and sustainable health system with well-functioning institutions.
- ✓ **Public health**
  Reduced preventable death, illness, and disability through provision of cost-effective, high-impact, evidence-based public health interventions.
- ✓ **Health services**
  Improved and expanded quality health services provided in an equitable and sustainable manner across all geographic areas and population groups through more effective and efficient use of existing resources, thus achieving better value for money.
- ✓ **Human resources for health**
  Competent and motivated health workforce effectively developed, deployed, and retained in line with current and future requirements in an efficient and cost-effective manner.
- ✓ **M&E, health information, learning, and knowledge/evidence-based practices**
  Strengthened monitoring, evaluation, surveillance, health information, and an improved culture of learning and knowledge management, resulting in increased evidence-based decision making and practices at all levels of the health system.

Implementation[4]

The key cross cutting elements and guiding principles for the strategy implementation include:

- ➢ Strong and visible country ownership
- ➢ Effective strategic communication and coordination

[4] See section 11 for the full list of cross cutting elements and guiding elements

- Sustainability through health systems strengthening
- Coordinated and effective capacity building
- Greater synergies and leveraging
- Gender balance and equality approach
- Private sector engagement
- Managing for results, with mutual accountability
- Culture of data/information use and evidence-based decision making

As part of implementing this National Health Strategy 2016–2020, the MoPH will develop a prioritized national level annual action plan with targets to be reached by the end of each year. Each MoPH department and the 34 provinces will also prepare their own annual plans. See section 11.

Results based Monitoring, Evaluation, and Reporting

The efficacy of this national health strategy will be assessed regularly, using the various means and results indicators outlined in the strategy - see Section 12. The MoPH will use three interrelated M&E frameworks that will guide the monitoring, reporting, and review at these levels:

1. Sector wide strategic monitoring, review, and reporting –see annex C
2. Health impact monitoring and reporting – see annex D
3. Operational monitoring and reporting – see volume 1 to this strategy

Health Expenditure, Strategy Costing, and Health Sector Resources

The MoPH will continue to advocate in the Cabinet and with the Ministry of Finance and the donor community for mobilization of adequate funding for the effective implementation of the policy priorities in this strategy. The costing of this strategy along with available resources and associated financing gaps, will be available on the MoPH website in the next month or so.

Key risks and success factors

The effective implementation of this strategy depends on some critical success factors and faces a number of risks. These include effective government leadership, good governance, security, necessary resources, macroeconomic stability, coordination, evidence-based interventions, and stakeholder commitment and support.

1. INTRODUCTION AND CONTEXT

1.1 The National Unity Government

Since 2005 successive governments have faced a multitude of political, security, and economic issues. The National Unity Government, which came into power in 2014, is committed to addressing key national issues, including corruption, institutional reform and development, and programmatic and financial sustainability. The president and his chief executive officer (CEO) so far have taken a number of steps in an attempt to improve governance and ensure greater accountability. Now that the Bilateral Security Agreement has been signed, the prospect for international and donor assistance to the country has also improved. Commitments are already being made through both on and off-budget mechanisms.

The new leadership in the health sector clearly sees the National Unity Government as a promising opportunity for building a reformed and stronger national health system. The Minister is determined to bring about the needed changes and reforms to institute a culture of 'one institution' working toward greater efficiency, transparency, and the ultimate result – the better health of the population.

1.2 The Afghanistan National Development Strategy and Framework

The Government is devising a new macroeconomic framework along with aligned sectoral strategies. The ongoing five year strategic framework for achieving its overarching goal of self-reliance, the Afghanistan National Peace and Development Framework puts particular importance on making adequate investment to ensure a healthy and educated population.

1.3 MDGs, SDGs, and Other Global Initiatives

Several international initiatives address health and related issues directly. These include the Millennium Declaration which articulated the MDGs; and the UN Sustainable Development Summit, which issued a set of SDGs to end poverty, fight inequality and injustice, and tackle climate change by 2030. Afghanistan is a signatory to these international initiatives.

The health sector is committed to adopting and implementing SDG3, which is about improving health based on 13 specific targets[5]. In addition, the MoPH is fully committed to align, adopt, and comply with other key global initiatives such as the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030, and Family Planning 2020. Also, as one of the last two polio endemic countries, Afghanistan has set a target to achieve polio eradication within the first one to two years of strategy implementation. The results and targets set in this national health under the six strategic areas outlined earlier take into account international initiatives.

1.4 Macroeconomic Policies and Economic Growth

Although Afghanistan's economy has expanded at an average rate of more than 5 percent during the past five years, 2011–2015, poverty remains widespread and the country is still among the poorest and least developed. The annual gross domestic product growth rate has fallen sharply, from more than 14 percent in 2012 to just 1.3 percent in 2014, and an estimated 1.9 percent in 2015.[6] A nearly zero (as % of GDP) foreign direct investment in the country in recent years indicates the overall investment climate.

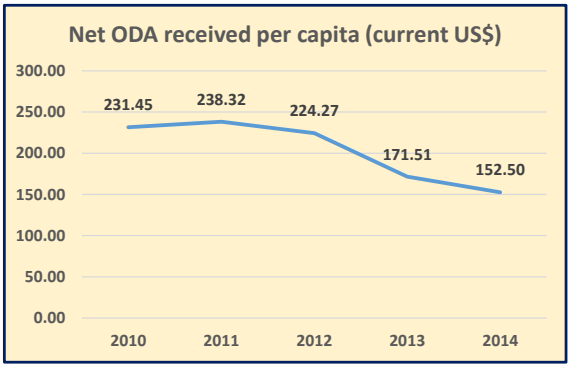
[5] See annex C of the National Health Policy 2015-2016 for extracts from the SDGs Resolution, September 2015
[6] World Bank. Global Economic Prospects

Table 1. Development Indicators, Afghanistan7

Indicator	2010	2011	2012	2013	2014
Population, total (millions)	28.0	28.8	29.7	30.7	31.6
GDP growth (annual %)	8.4	6.1	14.4	2.0	1.3
Tax revenue (% of GDP)	9.1	8.9	7.5	..	..
Net ODA received per capita (current US$)	231.45	238.32	224.27	171.51	152.50
Current account balance (% of GDP)	-10.4	-15.6	-28.0	-24.7	-20.1

Although a number of reforms have been undertaken in various sectors of the economy, Afghanistan continues to face significant institutional, political, and security challenges in furthering its transition to a modern, market based system. The economy is projected to grow at a higher rate, up to 5 percent, by 2018[8] if security and political conditions do not deteriorate, planned donor support holds firm, and the current positive trend of improved policy and governance reform continues.

Another important factor with serious consequences would be the reduction of foreign aid. In 2012, net official development assistance (ODA) was nearly 80 percent of total central government expenditure. Net ODA received as percentage of gross national income (GNI) fell from 38 percent in 2011 to 23 percent in 2014. The per capita net ODA received fell from US$238 in 2011 to US$153 in 2014[10]—a staggering 36 percent decline. This slower growth rate, coupled with the reduction of foreign aid, will hamper development seriously and affect the poverty reduction targets set in the ANPDF.



Slower growth rate will negatively affect the targets set in this strategy, highlighting their vulnerability both to economic growth and declines in foreign aid. Under this scenario, there would be an urgent and critical need to prioritize interventions, mobilize new resources through new and innovative approaches, and increase efficiency in the health sector.

1.5 Socio-Economic Status

Afghanistan is a low-income country with a fragile socio-economic status and political instability. It is a largely rural country with low literacy, insufficient infrastructure, weak public sector policies, and significant dependence on foreign aid.

Table 2. Socioeconomic Indicators, 2011–2015[9]

Per capita GDP	US$634
Per capita health spending	US$55
Population	31.6M
Rural population	74%
Adult literacy rate	32%
Gross enrollment ratio gender parity index	0.65
Female life expectancy at birth	59
Male life expectancy at birth	61

After three decades of devastating conflict, however, the country has experienced rapid improvements in its socio-economic status since the end of the Taliban era, with major improvements in income, education, infrastructure, and health (table 2). Real per

[7] The World Bank Group. World Development Indicators Database
[8] World Bank. *Global Economic Prospects*
[9] World Bank Database. Available at: http://data.worldbank.org/country/afghanistan.
[10] World Bank. *World Development Indicators Database*

capita income rose by 226 percent between 2006 and 2014. Since 2002, school enrollments have increased from 1 million to 8.7 million, including more than 3 million girls. At the same time, the number of teachers has grown from 20,000 to more than 187,000.[11] The number of schools has increased almost fivefold and the number of public sector health facilities by fourfold in just eight years. Similarly, the number of functioning health facilities has increased from 496 in 2002 to more than 2,000 in 2012, with an increased proportion of female staff.

Afghanistan has designated 2015–2024 as its 'Transformation Decade,' to be marked by the gradual hand over of program and financial responsibilities by international supporters to the Afghan government, using a self-reliance model.[12] This new paradigm has significant ramifications for the future of the health sector and health of all Afghans. Over the next five years, the MoPH is determined to build institutional, governance, and human resource capacity. All with the aim of improving public and private health services and public health towards better socio-economic and health status.

1.6 National Health Policy 2015–2020

The objective of the policy reform 2015 – 2020 is to change the culture and functioning of the MoPH and of health facilities at all levels of the health system to have a better, sustained impact on reducing preventable mortality and morbidity. Working towards achieving this objective will require increasing domestic resource allocation to health, strengthening equity, access, quality, partnerships and sustainability through the framework of sound governance, institutional development, cost-effective public health, client friendly health services, effective human resource development and inter-sectoral work at all levels of the health system. To achieve the objective and policy priorities, the policy requires that the 2016 – 2020 national health strategy focus on the five national health policy areas. These priority areas are governance, institutional development, public health, health services and human resources for health – see box 1.

1.7 National Health Strategy 2011–2015 Implementation Assessment

The 2015 Afghanistan Joint Health Sector Review and Strategic Plan Implementation Assessment report categorized the strategic plan for the MoPH 2011-2015 as a very broad level guidance document without specific strategic activities, goals with realistic targets, clear M&E frameworks, and implementation and review plans. It also identified a high level of implementation difficulties due to lack of resources and shortage of skills and capacities, limited commitment, and insufficient inter-sectoral coordination.

Based on these assessment findings, this national health strategy 2016-2020 was developed with clear and specific results and outputs with associated targets. It outlines a specific implementation plan through the translation of the strategy into national and provincial level annual action/operational plans and laying out clear implementation mechanisms and structures. In addition to having joint annual, mid and end term reviews. The strategy also lays out the M&E frameworks for national impact and output level results. To be monitored as appropriate, on a monthly, quarterly, semi-annually, annual, and multi year basis.

[11] The World Bank. 2016. "World Bank Database." Available at: http://data.worldbank.org/country/afghanistan. Various years, 2011–2015; "Afghanistan Overview." Available at: http://www.worldbank.org/en/country/afghanistan/overview.
[12] Islamic Republic of Afghanistan. November 2014. *Realizing Self-Reliance*. London Conference on Afghanistan. London.

2. OVERVIEW OF THE HEALTH SECTOR

2.1 Institutional Mandates and Core Functions

Articles 52, 53, and 54 of the Afghan Constitution[13] lay out the basic mandates and fundamental basis for health and related rights and services for the population of the country.

The MoPH is the lead state institution responsible for the health of the entire population. The mandate, functions and draft institutional chart of the Ministry can be seen at annex A. A number of other government ministries and agencies also implement activities that either directly or indirectly impact the health of the people. Development partners, non-governmental organizations (NGOs), professional associations, regulatory bodies, and the private sector are also key stakeholders in health.

2.2 Health Sector Structure and Organization

To ensure rapid expansion of basic health services for the under-served and badly affected population after the collapse of the Taliban in 2001, the MoPH developed packages of basic services — the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS). In addition, the MoPH introduced a contracting modality whereby NGOs are commissioned by the MoPH to provide the BPHS and EPHS throughout the country. This strategic choice allowed the MoPH to focus on strengthening the governance of the health sector and the institutional development of the Ministry as a state institution. The comprehensive approach was intended to lay the foundations of a health sector that had the health of the people at its core.[14]

Table 3 gives the network of facilities provides services at different levels of the health system.

Table 3. Types of Health Facilities

Service Facility Type	Number [15]
Regional and national hospital	6
Provincial hospital	28
District hospital	80
Special hospital	29
Comprehensive health center	405
Basic health center	834
Sub-health center	579
Mobile health team	147
Health post	15,175

Out of the nearly 2,300 health facilities that comprise the core of the BPHS and EPHS strategy all but the 34 hospitals in provincial capitals are BPHS facilities. Aside from the public health sector, there is a large private sector. Given the very high out-of-pocket expenditure of 74 percent, private health providers also constitute a critical mass. Nonetheless, this sector is largely unregulated and informal. Despite past efforts, there is still a long way to go before sufficient regulations are enforced and synergies between the government and private sector are secured through effective public-private partnerships.

The MoPH structure at central level currently has three deputy ministers, seven general directorates, and a number of directorates, departments, sections, and units – see the draft institutional chart at annex A. This structure is under review.

[13] Islamic Republic of Afghanistan, The Constitution of Afghanistan, (Ratified) January 26, 2004
[14] Interim Health Strategy 2002-2004: A Strategy to Lay Foundations, February 2003, Islamic Transitional Government of Afghanistan, Ministry of Health
[15] MoPH HMIS data

2.3 Decentralization

The MoPH and its stakeholders have been discussing the subject of decentralisation to the provincial health level for the last 5-7 years. A draft strategy has been under development for the past four years ago. More recently, October 2014, a paper[16] was produced that presented the results of a study that assessed the capacity of MoPH provincial public health offices to function as effective and efficient decentralized offices.

One of the main findings of the study was that stakeholders, at both central and provincial levels, highlighted the need for the health sector to be cautious about going ahead with decentralization in the absence of wider supportive government will, commitment, law and regulations. In addition, it was noted that central level cannot transfer skills and knowledge related to governance and public health if it is itself not effectively demonstrating such capacity[17].

2.4 MoPH Operating Principles

- Country owned and country led development
- Good governance including effective transparency and accountability[18]
- The right to health for all, especially women, children, and vulnerable groups
- Gender balance
- Leverage strengths through internal and external partnerships and coordination
- Effective community involvement and participation
- Cultures of evidence-based planning, decision making, results orientation and results-based management
- The promotion of 'systems thinking' at all levels
- A culture of togetherness and team and cross-functional work
- Emphasize health promotion and prevention

2.5 Key Health Sector Achievements

Since 2001, the health sector of Afghanistan, with strong support from various donors and development partners, has made remarkable progress in improving the health status of the population. This is particularly so in access, coverage, and quality of health services. These key achievements were made possible through improved and effective strategic, institutional, and operational peformance of the relatively newly rebuilt health system.

The new system has improved the health and life expectancy at birth from 42 years in 2002 to 64 years in 2012. In 2001, few Afghans had access to trained health providers. Only 9 percent of Afghans lived within a one hour walk of a health facility. By 2014, 57 percent of the population had access to a health facility less than one hour from their home, and nearly 87 percent had access to health services within a two-hour distance by any means of transportation.[19]

Actual access to basic preventive and treatment services increased from 9 percent in 2002 to 57 percent in 2012. Supported by other key additional factors, this improved access and expansion of coverage has led to some impressive results—the infant mortality ratio (IMR) has declined from 66 in 2005 to 45 deaths per 1,000 live births today; during the same period,

[16] GIA-A, 2014, Assessment of feasibility options of decentralization within the health system of Afghanistan by the Governance Institute-Afghanistan in collaboration with Management Sciences for Health, Kabul, funded by USAID

[17] Also see the MoPH Position Paper on Decentralisation in the Health Sector, April 2015

[18] See the MoPH Statement on Good Governance of the Health Sector, April 2015 and the MoPH Briefing Note on Accountability, June 2015

[19] Afghanistan Health Indicators Fact Sheet, 2014

neonatal mortality has dropped from 31 to 22 and under-five mortality from 87 to 55 per 1,000 live births, and skilled birth attendance has increased from 14 percent in 2003 to more than 40 percent today[20].

The decline in MMR also has been dramatic, falling from 1,600 to 396 per 100,000 live births[23] - see table 4. There has also been a significant increase in the coverage of key maternal and child health service indicators - antenatal coverage increased from 16 to 59 percent, the contraceptive prevalence rate rose from 10 to 23 percent, institutional deliveries from under 15 to 48 percent, and DPT3/Penta 3 coverage for children ages 0–23 months increased from 30 to 58 percent[24].

Table 4. Health Indicators, 2010–2015[21]

MMR	396/100,000[22]
IMR	45/1,000
NMR	22/1,000
Under-5 mortality rate	55/1,000
Pregnant women w/skilled antenatal care (1 visit)	59%
Births w/skilled attendant	50.5%
Breast feeding at age 2	54%
Couples using modern FP method	20%
Total fertility rate	5.3

The development and implementation of the BPHS and EPHS packages have proven to be two of the most successful and effective achievements of the key strategic plans and decisions made by the health sector and the MoPH over the last decade. Since 2003, the BPHS clearly has served as the strongest foundation for the country's primary health care system; it also has proven to be a major engine behind most of the success achieved. As a standardized package, the BPHS also has catalyzed and provided a unique platform for all stakeholders to use when focusing on a common strategy and goal, and has minimized the de facto inefficiencies and duplications throughout the health system.

The MoPH also has successfully launched other interventions to strengthen health services and public health interventions, particularly training community midwives and nurses, developing information and education materials, and strengthening health infrastructures. In addition to public sector efforts, private sector engagement in health, including of national NGOs, also has been increasing progressively. As the ANDS 2008–2013 assessment conducted in June 2014 noted, about 88 percent of the targets set were achieved during the last ANDS implementation period, making health the most successful sector in Afghanistan's development efforts.

2.6 Main Health Sector Challenges and Constraints

Afghanistan faces the serious challenges of a fragile political settlement, continued threats from insurgencies and local power holders, military stalemate, economic downturn, diminishing aid flows, widespread corruption, and regional relationships that continue to exacerbate conflict. These complex factors and associated dynamics have had significant adverse impacts on state effectiveness and all aspects of Afghanistan's development, including in the health sector.

[20] APHI and Ministry of Public Health, Afghanistan. 2010. Afghanistan Mortality Survey (AMS). Kabul. Available at: https://www.usaid.gov/sites/default/files/documents/1871/Afghanistan%20Mortality%20Survey%20Key%20Findings.pdf.
[21] Source: Afghan Demographic and Health Survey 2015
[22] APHI and Ministry of Public Health (MoPH), Afghanistan. 2010. Afghanistan Mortality Survey (AMS). Kabul. Available at: https://www.usaid.gov/sites/default/files/documents/1871/Afghanistan%20Mortality%20Survey%20Key%20Findings.pdf.
[23] Please note that the figure of 396 per 100,000 live births is disputed by a number of peopla and organsations; the MMR ratio from the 2015 DHS is currently being validated but it is likely to be in the range of 800-1,200
[24] Afghan Demographic and Health Survey 2015

One of the critical overarching challenges facing Afghanistan's health sector is the country's insecurity. It results in many parts of the country being inaccessible to health services and puts health workers at high risk of being the victims of crimes and acts of terrorism. This often makes it impossible for rural inhabitants to find health services without walking long distances. In addition, poor health sector conditions are made worse by persistent corruption. In 2015, Transparency International ranked Afghanistan 166th out of 168 on its World Corruption Perceptions Index.

Afghanistan has the highest total fertility rate in Asia, at 5.3[25]; its population is now growing by almost 1 million people annually.[26] The high rate of population growth results in increased demand for health. The combination of rapidly increasing demand for health, decreasing foreign aid, and a slowing economy represent major challenges to scaling up health services and their sustainability.

In general, Afghanistan's 'hard infrastructure', including roads and reliable supplies of water and power, is inadequate to support expanded and effective health service delivery and access. There is a nationwide shortage of qualified health workers in the public sector, particularly female medical personnel. The lack of female providers hinders the efforts of the MoPH to reduce maternal and child mortality, especially in rural areas. Besides having an unbalanced gender composition, the health workforce is also poorly distributed around the country and overly concentrated in large urban areas. Due to lack of regulations, there is also low quality production of different categories of health workers by private education institutes. Poor personnel management and operational policies and procedures result in inequitable pay scales, urban concentration of staff, favoritism, low morale, and low retention rates. The referral system is not functioning well, and district hospitals are underutilized, leading to wasteful inefficiencies in service provision while overburdening facilities at higher levels.

Programs promoting healthy lifestyles and prevention are under funded. The problem is complicated by the proportional rise in non-communicable diseases as major causes of morbidity and mortality. But there is also a serious lack of quality tertiary health services; combined with a lack of trust by citizens in the public sector health services this is resulting in significant medical tourism to countries in the region[27]. The lack of routine information readily available through functioning health management information systems negatively affects drug supply chain performance and quality control, and also adversely affects a variety of other critical MoPH functions.

Health expenditures in the country are tilted toward out-of-pocket spending by families; they account for 74 percent of all spending. The high outlays mean that low-income families are especially vulnerable to catastrophic health expenditures perpetuating the poverty cycle.

Fundamental to Afghanistan's efforts to improve health sector performance further is the urgent imperative to reduce and eventually eliminate pervasive gender inequities in the system – see section 4 for more information.

The major challenges and underlying key barriers relevant to each of the six strategic areas of the strategy can be found in sections 5 to 10 of this document.

[25] Afghanistan Demographic and Health Survey, Key Indicators 2015.
[26] World Bank. 2016. "Afghanistan Development Indicators." Washington, DC: World Bank. Available at: http://databank.worldbank.org/data/reports.aspx?source=2&country=AFG&series=&period=.
[27] See the MoPH Statement on Public Private Partnerships and Specialist Tertiary Hospitals, April 2015

3. STRATEGIC AND RESULTS FRAMEWORK

3.1 Strategic Areas and Overall Framework

This National Health Strategy 2016–2020 has been designed and formulated within the parameters of the National Health Policy 2015-2020 to effectively implement the policy priorities and statements. In February 2016, during the Ministers' Results Workshop for the development of this strategy, the five national health policy areas were adopted as the first five strategic areas of the strategy. And a sixth strategic area, focused on results based M&E, health information, learning, and knowledge/evidence-based decision making, was added. The six strategic areas and associated sub-components are:

1. **Governance:** Accountability, responsiveness, capability, transparency, anticorruption, laws and regulations, equity and a human rights approach, and aid effectiveness
2. **Institutional development:** Leadership and management in health, harassment prevention and resolution, systems strengthening, health financing and revenue generation, coordination, health planning, standards, the private sector and public-private partnerships, and the provincial level and decentralization
3. **Public health:** Health promotion, community health and empowerment, health protection, preventive health, gender and gender-based violence, reproductive, maternal, neonatal, child, and adolescent health, communicable diseases, non-communicable diseases, nutrition, disability and physical rehabilitation, accidents and injuries, drug demand reduction, mental health, environmental health, and emergency preparedness and disaster management
4. **Health services:** Quality of and access to health services and clinical care, BPHS and EPHS, tertiary hospitals, pharmaceuticals, forensic medicine, and health commodities
5. **Human resources for health:** Human resource planning, production, procurement and development, management, and finance
6. **M&E, health information, learning, and knowledge/evidence-based practices:** M&E, health system research, including operations research, a culture of information generation and dissemination, and a culture of knowledge and evidence-based decision making

Overall results framework

The overall results framework, shown in the next section, has the planned results for the next five years in each of the strategic areas.

Individual results matrices for the strategic areas and results based M&E frameworks. Based on the results and sub-results in the overall results framework, there are planned outputs. For each output, the results matrix also has parameters, such as the priority status, responsible unit(s), and collaborating partner(s).

To measure and analyze the progress and performance toward the stated goals and results there are two detailed results based M&E frameworks:

1. Results M&E framework for strategic monitoring with high level sector-wide indicators
2. Results M&E framework for operational monitoring with output level indicators

The MoPH will publish a separate document as volume 1 of this national health strategy. It will have the individual results matrices, the results based M&E frameworks and M&E frameworks

for operational monitoring with output indicators, mainly to support the development of the annual action plans.

3.2 Goal and Objectives

Goal
The goal of the National Health Strategy 2016–2020 is to attain strengthened, expanded, efficient, and sustained performance by the health system. Thus ensuring enhanced and equitable access to quality healthcare services in an affordable manner and resulting in the improved overall health and nutrition status of all populations, especially women, children, and vulnerable groups*.*

Objectives
The six objectives of the national health strategy, one for each strategic area, are:

1. Enhanced, strengthened, and accountable health sector governance is decisively instituted, with strong and visible leadership and evidence-based advocacy at all levels (governance).
2. Strengthened, expanded, and sustainable health system is in place, with well-functioning institutions (institutional development).
3. Preventable death, illness, and disability are reduced through provision of cost-effective, high-impact, evidence-based public health programs and interventions (public health).
4. Improved and expanded quality primary, secondary, and tertiary health services are achieved in an equitable and sustainable manner across all geographic areas and population groups through more effective and efficient use of existing resources, thus achieving better value for money (health services).
5. Competent and motivated health workforce is effectively developed, deployed, and retained in line with current and future requirements in an efficient and cost-effective manner (human resources for health).
6. Strengthened monitoring, evaluation, surveillance, health information, and an improved culture of learning and knowledge management are in place, resulting in increased evidence-based decision making and practices at all levels of the health system (M&E, health information, learning, and knowledge/evidence-based practices).

3.3 Overall Results Framework

Result: A strengthened, expanded, efficient, and sustained performance by the health system, thus ensuring enhanced and equitable access to quality health services in an affordable manner, and resulting in the improved health and nutrition status of all populations, especially women, children, and vulnerable groups

Result 1: Enhanced, strengthened, and accountable health sector governance decisively instituted, with strong and visible leadership and evidence-based advocacy at all levels	Result 2: Strengthened, expanded, and sustainable health system with well functioning institutions	Result 3: Reduced preventable death, illness, and disability through provision of cost-effective, high impact, evidence-based public health interventions	Result 4: Improved and expanded quality health services provided in an equitable and sustainable manner across all geographic areas and population groups through more effective and efficient use of existing resources, achieving better value for money	Result 5: Competent and motivated health workforce effectively developed, deployed, and retained in line with current and future requirements in an efficient and cost-effective manner	Result 6: Strengthened monitoring, evaluation, surveillance, health information, and an improved culture of learning and knowledge management, resulting in increased evidence-based decision making and practices at all levels of the health system
SR1.1 Appropriate laws, regulations, and procedures developed, updated, and/or amended, simplified, and effectively enforced at both the national and sub-national levels. **SR1.2** Enhanced culture of transparency and accountability among the MoPH and all of its stakeholders at all levels. **SR1.3** Increased institutional and individual capability to effectively exercise good governance practices and be responsive to the peoples' voice and health needs. **SR1.4** Improved public perception of the health sector and effective advocacy at the national and sub-national levels. **SR1.5** Increased understanding and practice of the country ownership and meaningful partnership concepts among the MoPH and all development partners and implementing partners.	**SR2.1** Strengthened national and local capacity for effective health planning, and establishment of effective linkages between plans, budget, and resource use, with meaningful participation by all stakeholders. **SR2.2** Improved health financing mechanisms and increased domestic revenue generation, and effective mobilization toward gradual sustainability and achievement of universal health coverage. **SR2.3** Enhanced and effective multilevel stakeholders' (health and non-health) dialogue, coordination, and collaboration for health system strengthening. **SR2.4** Greater private sector engagement and participation in health effectively supported, coordinated, and regulated for improved provision of quality health services and products.	**SR3.1** Reduced incidence and prevalence of acute and chronic malnutrition. **SR3.2** Improved access and utilization of reproductive, maternal, neonatal, child, and adolescent health services. **SR3.3** Reduced burden of communicable and non-communicable diseases. **SR3.4** Heightened advocacy and effective implementation of disability and physical rehabilitation services. **SR3.5** Reduced preventable disabilities due to road traffic accidents, mines, and explosive remnants of war; and occupational and domestic injuries. **SR3.6** Reduced prevalence of mental health disorders, with a particular focus on poor, under-served, disadvantaged, and vulnerable populations.	**SR4.1** Enhanced access to improved and updated quality BPHS and EPHS services. **SR4.2** Improved quality of and increased access to a wide range of tertiary services. **SR4.3** Improved pharmaceutical services management and local medical products (medicines and commodities), ensuring increased access (physical accessibility, availability, affordability, and acceptability) and rational use of medicines and health commodities.	**SR5.1** Improved human resource planning and coordination, ensuring better geographical and gender balance in health management and service provision. **SR5.2** Strengthened systems for effective human resources for health management. **SR5.3** Improved human resources for health regulation and practices through establishing regulatory frameworks and accreditation systems. **SR5.4** Health workforce capacity adequately developed based on health system needs.	**SR6.1** Strengthened, effective, and visible MoPH governance of the health information system (research, evaluation, monitoring, HMIS, surveillance, and vital statistics). **SR6.2** Operations and health systems research, monitoring, evaluation, vital statistics, HMIS, and surveillance actively supported including capacity building, and conducted, and associated findings and knowledge products effectively disseminated. **SR6.3** M&E frameworks and responsive surveillance systems developed, strengthened, and effectively used, leading to improved data collection, utilization, and dissemination at all levels. **SR6.4** Disease outbreaks and public health emergencies of international concern effectively detected, investigated, and responded to within 24–48 hours. **SR6.5** Improved culture of knowledge and evidence-based decision-making practices at all levels.

SR2.5 Strengthened overall PPP capacity, and strategic PPPs particularly focusing on secondary and tertiary care developed and fostered.
SR2.6 Strengthened pharmaceutical and other health products regulatory systems, ensuring the quality, safety, and efficacy of medicines and other associated products.
SR2.7 Strengthened financial management systems for improved program efficiency.
SR2.8 Improved procurement system and supply chain management for quality and timely health services, goods, works, and products.
SR2.9 Improved adherence to set national standards for health infrastructure, technology, and clinical care at all levels.
SR2.10 National health decentralization strategy effectively implemented.

SR3.7 Empowered communities through health knowledge, skills and attitude, actions, supportive environment, and public health policies.
SR3.8 Enhanced MoPH institutional capacity for preparedness, risk mitigation, and effective response to and management of emergencies and disasters.
SR3.9 Gender and human rights mainstreamed in all MoPH programs.
SR3.10 Reduced substance abuse.

4. KEY CROSS-CUTTING AREAS AND IMPLEMENTATION PRINCIPLES

4.1 Gender Balance

There has been a significant increase in the number of female health providers and substantial improvements in the health indicators of women and children. However, Afghanistan still stands among those countries in which health indicators for women, specifically in sexual and reproductive health, are among the lowest. Barriers to gender equity exist externally in the form of high illiteracy and cultural norms, and internally in the way public health services are structured and delivered; in addition, career opportunities for women are limited. Three types of key barriers to gender equality prevail in the health sector:

- **Physical/geographic barriers:** Lack of and limited modes of transportation for women, distance, harsh terrain, road blockage due to heavy winter and snows, and the actual cost of transportation
- **Psychosocial barriers**: Lack of women's decision-making power, including for their own health
- **Health service barriers**: Shortage of female staff, unfriendly treatment by staff, lack of separate entry gates and waiting areas for women, and limited attendance hours for public facilities

The MoPH is committed to ensure that all of its planning, budgeting, implementation, and evaluation processes at all levels are gender sensitive and adopt a rights-based approach. This strategy emphasizes improved institutional capacity for addressing gender-based violence, responding to it, and preventing it. Equitable and sustainable access to quality health services in a gender sensitive manner is a priority for the MoPH. The national health strategy strategic areas focus on the following specific strategies to overcome key barriers and achieve results relevant to quality health services for women, as well as increase demand for, access to, and satisfaction with these services:

- Integrated health services critical to the well-being of women, newborns, and children
- Gender mainstreamed in all health promotion interventions and effective health literacy messaging to women and girls
- Increased participation of women and girls in decision making and monitoring of health
- Increased male involvement in addressing gender equity and responding to the health needs of their families and communities
- Increased sensitization and engagement of men and boys in the fight against gender-based violence
- Improved education and capacity of health providers on gender issues including gender based violence
- Improved gender balance in health management and service provision

4.2 Capacity Building

There has been a mixed impact on capacity building since 2002 both nationally and within the health sector. A 2007 review of technical assistance (TA) to the country stated that 'Five years down the road and after an overall expenditure of about US$ 1.6 billion in technical assistance, both the Government and donors are concerned that less than expected is being achieved in terms of capacity building.'…..'There is a widespread dissatisfaction in Afghanistan with the high cost of technical assistance and its limited impact in terms of capacity building.'[28] Little seems to

[28] Michailof S. 2007, *Review of technical assistance and capacity building in Afghanistan.* Discussion paper for the Afghanistan Development Forum, World Bank

have changed in recent years.

In health most donor support for capacity building has been for developing the capacity of individuals and for specific technical subjects. There has been very little support for strengthening the capacity of the MoPH in governance and the functioning of the MoPH as a state institution. Based on lessons learned by the MoPH greater attention will be paid over the next five years to strengthening the capacity, the capability of the ministry as an institution[29].

Most TA in the health sector is donor driven, ad hoc and uncoordinated, and lacked a systematic approach to capacity building. Taking heed of lessons learned the approach to improving effective capacity building in this strategy include:

- Institution wide coordination of TA activities under MoPH leadership and ownership.
- Ensure that all TA support is strategically targeted and has clear institutional capacity building and knowledge transfer objectives
- Ensure that all TA is needs based and fully in line with the health policy priorities.

4.3 Country Ownership

The need for the MoPH to be in the driving seat was recognised back in 2003 and was partially reflected in the interim health strategy that very clearly stated the role of the Ministry and its' priorities.[30] The concept and practice of ownership has by the Ministry has varied in subsequent years. Afghanistan's long social and political history clearly demonstrates the great resiliency of the people, and shows that externally financed programs and initiatives simply will fail to succeed and have the intended impact without strong country ownership and buy-in, particularly if these are not domestically driven.

Effective and sustained health sector development is slow to happen while ownership is not wholly led, and achieved by the MoPH and the Afghan people. The MoPH recognizes various policy, budgetary, legal, financial, technical, and other constraints on both sides of the partnerships between the MoPH and the donors and development partners. A clear understanding and implementation of country ownership requires trust, mutual respect, compromise, and a shared long-term vision.

The issue of mutual accountability is at the front and center. The MoPH will continue to ensure meaningful participation by all stakeholders in the development, implementation, and M&E of health sector development plans, programs, and strategies. The MoPH will promote, advocate, and practice the following key elements that reflect mutual benefits and accountabilities:

- The MoPH is in the driving seat in planning, prioritizing, deciding, implementing, and managing its development agenda for the health sector.
- Any and all donor and development partner support is demand driven only; fully aligned with the national development plan, priorities, and strategies; and targeted to build and/or strengthen the Afghan health system for sustainability.
- All donor and development partners' initiatives and investments will be flexible, so as to respond to important national requests and sectoral and national priorities.

[29] Position Paper on Capacity Building April 2015 and Statement on Capacity Building, September 2015. Office of the Minister, Ministry of Public Health

[30] Interim Health Strategy 2002-2004: A Strategy to Lay Foundations. Ministry of Public Health, Islamic Transitional Government of Afghanistan, February 2003

- Strong and sufficient political commitment (both internal and external) and public support exists to implement health sector development policy and strategies.
- The MoPH holds itself accountable and takes concrete, effective, visible, and measurable actions to address issues relevant to corruption and lack of transparency, reporting all relevant information in a timely and transparent manner to all stakeholders.

4.4 Strategic Communication, Coordination, and Integration

As one of the key cross cutting elements of this national health strategy the MoPH will strive to effectively communicate and coordinate its health planning and programming at all levels with other state actors; especially other relevant government ministries and with all other internal and external stakeholders. MoPH strategic communication will focus more on delivery of policy and effective coordination rather than simply management of messages. Moreover, strategic communications will be the business not only of the highest level of the MoPH, but also of all of its constituent pillars, departments, and individuals at both the central and provincial levels, as needed.

Meaningful strategic communications also helps facilitate effective coordination. The MoPH has long recognised[31] that coordination within and among the ministry and its stakeholders takes advantage of everyone's strengths, avoids duplication, and increases the efficiency and effectiveness of resources towards achieving better value for money[32]. During the period of this strategy the MoPH will particularly strengthen coordination to help ensure the better integration of health services at the point of delivery. This will help to meet more of the health needs of individuals, as well as help ensure satisfaction with and increase demand for services.

4.5 Sustainability through Health Systems Strengthening

A key health sector challenge is to sustain the progress it has achieved in recent years and build further. To do so, resilience and long term sustainability of the health systems are critical. A principle of this national health strategy is to further promote and institute the thinking and actual practices of health systems strengthening in all aspects to work towards securing sustainability.

The focus will vary depending on specific needs, demographics, epidemiology, policies, available resources, and other structural conditions. But key health systems strengthening measures will include, but not be limited to, the following:

- Increased efforts to reduce disparities in health outcomes by strengthening the quality of health services and public health interventions, especially among under-served and marginalized groups
- Strengthened alignment of aid[33] and the need for all projects to have an exit strategy planned from inception
- Improved health financing strategies that reduce financial barriers to essential services, including increased government and/or private sector funding for health and reduced out-of-pocket payments
- Increased numbers, and the more effective deployment and functioning of, quality health service providers

[31] See for example, the Position Paper on Coordination at Annex D of the Interim Health Strategy 2002-2004: A Strategy to Lay Foundations. Ministry of Public Health, Islamic Transitional Government of Afghanistan, February 2003
[32] See the MoPH Position Paper on Coordination, original April 2015, updated June and September 2015
[33] Also see the MoPH Statement on Aid Effectiveness in the Health Sector, April 2015

- Effective and balanced capital investment and recurrent expenditure allocation and management
- Strengthened functioning of the HMIS to improve the availability of high quality information supporting effective decision making and planning
- Improved functioning of pharmaceutical management and distribution systems to ensure cost-effectiveness and quality, and reduce stock-outs of essential medicines and commodities
- Strengthened functioning of public health surveillance, M&E, human resources, procurement, financial management systems and anti-corruption measures
- Increases in community knowledge, attitudes, and practices through effective health promotion and prevention programs and initiatives

4.6 Synergies and Leveraging

One of the principles of strategy implementation is to further build effective and meaningful synergies. And to strengthen and leverage key partnerships on multiple fronts, including but not limited to relevant governmental entities, the private sector, bilateral and multilateral organizations, and other global entities/initiatives. This renewed strengthening of synergies and leveraging will help on many fronts, including building greater political momentum for sustained efforts to improve health, increasing access to resources, further mobilizing and coordinating donors' and development partners' commitments, achieving more sustainable results, and promoting greater mutual accountability among the MoPH, donors, and other stakeholders. Examples on the global side include more multilateral efforts involving the UN and others to accelerate progress toward achieving the MDGs and SDGs, closer collaboration with the Global Fund to Fight AIDS, Tuberculosis, and Malaria and with GAVI for immunization and continued commitment to the global polio eradication initiative.

4.7 Innovations

Apart from traditional approaches to providing health services, innovative approaches such as use of community health workers and midwives, community health houses, and youth-friendly health services are proving effective. However, when it comes to the innovative use of information technology, few significant achievements are evident. The health sector does not seem to be benefiting from the widespread use of mobile technology within the country. Social media increasingly will be used to reach various target groups more effectively and identify and report outbreaks. This strategy supports sending health promotion messages, maternal, newborn, and child health guidance, follow-up, and family planning related information to mothers, as well as developing smart phone applications. The strategy also promotes innovative self-learning and intradepartmental, intraregional/provincial learning mechanisms to share best practices, 'what works' and build capacity in different areas.

4.8 Use of Technology

Effective use of technology has been a challenge for the health sector. Although the availability and affordability of the latest technology has been an issue for the country, lack of qualified and skilled biomedical engineers and technicians is a critical issue. In addition, there is insufficient funding and planning available for medical equipment maintenance and management. It is a rather common occurrence that once a machine ceases to function it goes out of use. The MoPH will devise and implement a parallel and phased approach to equipment management and maintenance, focusing on the short, medium, and longer term. Through a broader consultation process with the private sector, it also will explore and support production of select medical products and commodities.

As part of this new strategy, the MoPH will introduce and scale up the use of geographic information system technology to assess the coverage and building of health facilities based on their catchment populations. Strategic and effective use of information technology to promote public health is an important aspect of this strategy.

4.9 Regional Integration and Cooperation

Due to its geostrategic location, regional integration and cooperation plays a pivotal role in the socioeconomic development of Afghanistan. The current ANDS defines regional cooperation as one of the crucial cross cutting elements of its national development for most key sectors, including health.

During the implementation of this strategy the MoPH will heighten its efforts to increase and strengthen regional cooperation as one of the critical cross cutting elements for health sector development and prosperity, based on mutual benefits. In this regard, the MoPH will:

- Continue to strengthen partnerships with regional and neighboring countries to ensure joint actions for addressing critical cross-border health issues
- Further harmonize standards and regulations across the region for quality health services
- Strengthen efforts towards the mutual recognition of professional qualifications so as to benefit from the free movement of workers in the region
- Extend the practice of having memoranda of understanding with quality hospitals in the region such as those signed with hospitals in New Delhi, India, May 2016 to protect patients and families from unfair medical tourism practices
- Harmonize regional regulations in pharmaceuticals and food safety and quality
- Timely implement international health regulations to detect, report, and respond to all public health emergencies of international concern
- Implement the Kabul Declaration on Regional Collaboration in Health
- Further intensify cross border vaccination campaigns, especially for polio
- Better integrate disease surveillance and response to prevent the spread of epidemics
- Encourage research in the health sector
- Cooperate to address health issues caused by the environment across the region

5. STRATEGIC AREA 1: GOVERNANCE

5.1 Overview

Effective health system governance is a critical element for achieving policy priorities. Good governance of the health sector is that the MoPH better functions as a capable, accountable and responsive state institution that uses its' power and authority to benefit the health of citizens[34]. Since early 2015 the MoPH, as part of state building has been reforming itself to make more effective use of government funds and development aid, ensure equity and inclusiveness, be more transparent and better enforce laws and regulations. Failure to do so will result in yet more corruption and poor quality, inequitable health services. The national health policy statement on governance can be seen in the following box.

Box 2. Governance Policy Statement[35]

It is the policy of the Ministry of Public Health to work within the framework of the political will and commitment of the Unity Government to good governance. To achieve good governance as a state institution the Ministry will ensure dynamic, committed leadership, ownership of work and of the vision and mission of the Ministry, effective oversight and influence, a culture of accountability, of being responsive to the opinions and ideas of people, and a capable institution with responsible, merit based appointees as managers and support personnel.

In the very specific context of insecurity and conflict in the country, it is also the policy of the Ministry of Public Health that within the framework of the capability, accountability and responsiveness functions of good governance, it will ensure sound mitigation, preparedness and effective, efficient response to the suffering of people as a result of insecurity and conflict. The Ministry will also continually explore innovative, alternative ways to prevent and reduce suffering linked to the fragile context.

Within the framework of the national health policy governance is the first strategic area of this new national health strategy. It encompasses the areas of accountability, responsiveness, capability, transparency, anticorruption, laws and regulations, equity, human rights approaches, and aid effectiveness. Also see the national health policy for discussion on governance[36].

5.2 Results, Outputs and Examples of Interventions

The objective of strategic area 1, governance, is to institutionalize good governance for all aspects of the health sector to effectively direct health system resources, performance, oversight, and stakeholder participation toward the overall goal of improving health and saving lives, and doing so in ways that are open, credible, transparent, accountable, equitable, and responsive to the actual needs of the population. In support of the goal of this national health strategy 2016–2020, the overall result for the governance strategic area is to achieve the following:

Result 1: Enhanced, strengthened, and accountable health sector governance decisively instituted, with strong and visible leadership and evidence-based advocacy at all levels.

In addition to the overall result there are five strategic results planned for governance. There are also planned outputs and a few examples of interventions as follows:

[34] See the MoPH Statement on Good Governance in the Health Sector, April 2015
[35] National Health Policy 2015-2016, Ministry of Public Health
[36] National Health Policy 2015-2016, Ministry of Public Health

Strategic result 1.1: Appropriate laws, regulations, and procedures developed, updated and/or amended, simplified, and effectively enforced at both national and subnational levels.

Outputs

1. A system is devised and implemented to enforce appropriate laws and regulations, and enable effective administration of health interventions by all concerned stakeholders.
2. Appropriate needs-based governing bodies are established and/or strengthened at different levels, and good governance practices are enhanced.
3. Effective regulations and standards are developed and actively enforced to optimize the safety, efficacy, quality, and affordability of medicines and health products throughout the country.
4. A forensic medicine regulatory system is established, institutionalized, and strengthened at the national and subnational levels.
5. Provincial health departments are empowered to achieve effective implementation, monitoring, and reporting on health programs, associated interventions, and population health.

Examples of interventions

1. Develop strategies and formulate comprehensive rules, regulations, laws, and codes of conduct, and ensure their fair enforcement. The MoPH will conduct evidence-based advocacy with Parliament, the Ministry of Justice, and other relevant GIRoA entities (including other line ministries) for approval of these documents.
2. Implement the newly developed anticorruption strategy and streamline associated procedures, processes, and systems to achieve good governance in tackling corruption.
3. Strengthen the rule of law by assessing the extent to which MoPH and its partners exercise power and authority in accordance with clearly written rules, regulations, and legal principles.
4. Establish a functional National Medicines and Health Products Regulatory Authority (NMHRA) for improved regulations, licensing, and inspections of medicine and other medical products.

Strategic result 1.2: Enhanced culture of transparency and accountability in the MoPH and among all of its' stakeholders at all levels.

Outputs

1. All relevant current procedures, along with associated indicators and milestones, are reviewed and revised to effectively ensure transparency and accountability in the MoPH and among all of its stakeholders at all levels.
2. Laws, regulations, and procedures are developed, mainstreamed, promoted, and enforced.
3. Complementarity and synergy are ensured among all planned (on- and off-budget) health interventions and available resources.

Examples of Interventions

1. Make all key financial, planning, management, and results reports publicly available.
2. Institutionalize a culture of integrity and openness that serves the public interest, empowers communities to demand adequate and effective services the state has committed to provide, and builds trust. Evaluate community comments and suggestions and act upon them to better serve the health needs of the public.
3. Set anticorruption measures and a shared action plan for the whole health sector in line with national anticorruption laws, focusing on prevention through increasing accountability and transparency, raising public awareness through access to information,

and strictly implementing anticorruption measures to handle any problems within the MoPH and the broader health sector.
4. Strengthen the HIS system and a web-based national data warehouse to provide quality data for the decision-making process for health programs and outcomes.

Strategic result 1.3: Increased institutional and individual capability to effectively exercise good governance practices, and be responsive to the people's voice and health needs.

Outputs

1. Enhanced institutional and individual capacity is put in place at all levels for implementation and institutionalization of good governance practices.
2. Well-capacitated individuals with appropriate skills sets are placed across the system in relevant positions to actively foster and institutionalize good governance.

Examples of interventions

1. Conduct institutional and managerial level assessments at the national and subnational levels, and develop action plans for relevant capacity building focused on the governance area.
2. Rationalize and clarify the roles and responsibilities of all associated authorities at the national and subnational levels in sound management, effective leadership, formulation and implementation of laws and regulations, and efficient use of resources - all aimed at overall good governance. The focus will be on close cordination and monitoring, especially of human resources for health.
3. Enhance MoPH managers' and leaders' capacity through institutionalization of sound management, effective leadership, including strong support for women's leadership programs, and transparent governance practices to ensure that public health interventions and health services are equitable, accessible, and meet people's needs through improved evidence-based decision making.
4. Strengthen M&E systems, as they are vital in identifying issues, turning the findings into action, modifying and removing existing barriers, and strengthening the health system.

Strategic result 1.4: Improved public perception of the health sector and effective advocacy at the national and subnational levels.

Outputs

1. Improved overall health sector perception is in place, as is increased citizens' engagement at all levels.
2. Heightened evidence-based advocacy among MoPH central leadership is used for increased resource allocation for and awareness of the health sector.
3. Effective and functional mechanisms are in in place for health complaints
4. Effective advocacy mechanisms are in place to actively address comments and respond to stakeholders' feedback and needs.

Examples of interventions

1. Develop and implement an advocacy action plan that includes multifaceted, innovative, and effective public relations activities, including through the involvement of mass media and the public.
2. Advocate on behalf of stakeholders' needs and concerns, and use resources in a way that maximizes the health and well being of the public.

Strategic result 1.5: Increased understanding and practice of the country ownership and meaningful partnership concepts among MoPH and all development and implementing partners.

Outputs

1. Increased understanding exists regarding the importance and strategies of effective country ownership practices among the Government, development partners and implementing partners leadership groups at both the national and subnational levels.
2. Health sector development is led continuously and increasingly by the MoPH
3. A well-defined and clear mechanism is devised and implemented to ensure effective and continuous strategic interaction with its partners.
4. A proactive and effective system is devised and implemented to foster new partnerships within and outside of the country.

Examples of interventions

1. Effectively further sensitize the relevant governmental national and subnational-level leadership groups on the importance of and strategies for country ownership and meaningful partnership and participation; that is, how to advocate, encourage, and allow effective broad participation by all stakeholders.
2. Establish an enabling and conducive environment for increased private sector engagement and investments, including public-private partnerships in health and related interventions.
3. Support active community participation through empowering communities to better identify their own health needs and take the initiative to solve identified health problems utilizing the community governance guideline; build capacity of the community development councils' and community health Shuras' members to strengthen the relationship between health facilities and the communities; involve the communities in planning and monitoring health services and decision-making processes; and promote women's participation in health and mobilize community resources to support health programs - all to ultimately ensure the long-term sustainability of programs.

Effective health system governance is a critical element for achieving policy priorities. Good governance of the health sector is that the MoPH better functions as a capable, accountable and responsive state institution that uses its' power and authority to benefit the health of citizens[37]. Since early 2015 the MoPH, as part of state building has been reforming itself to make more effective use of government funds and development aid, ensure equity and inclusiveness, be more transparent and better enforce laws and regulations. Failure to do so will result in yet more corruption and poor quality, inequitable health services.

[37] See the MoPH Statement on Good Governance in the Health Sector, April 2015

6. STRATEGIC AREA 2: INSTITUTIONAL DEVELOPMENT

6.1 Overview

In April 2015[38] the MoPH defined institutional development in the Ministry as a set of theories, values, strategies and techniques that aim to develop the principles and practice of managing change and improving effectiveness. Undertaken mainly through changing the capability, capacity and attitudes of staff including strategic thinking, appreciation and application of the values and working principles of the ministry and of management skills, the development of processes and systems, and having insight into and applying issues in the wider context of politics and policies to institutional challenges. All with the aim of having an effective and efficient ministry whose working culture and practices having a positive sustained impact on the health of our people. The national health policy statement on institutional development can be seen in the following box.

Box 3. Institutional Development Policy Statement[39]

The policy of the Ministry of Public Health is to ensure the ministry is a well governed, gold standard state institution whose functioning better benefits the health status of the people of Afghanistan.

The Ministry acknowledges that fundamental to having sound institutional functioning is the recognition that it is about managing change; change which itself is forever in a state of fluctuation. The priority is to address changes in transformational factors, such as mission, strategy, institutional culture and leadership and then changes in transactional factors such as structure, systems and work atmosphere.

It is the policy of the Ministry to ensure that the culture and style of management in the Ministry enables all staff to develop and implement the principles, processes, systems and practice of managing change. This is with the aim of improving effectiveness, efficiency and quality towards sustainable outcomes and impact and a better quality of life for the people of the country.

Within the framework of this policy the Ministry will place greater emphasis on evaluation. It will also ensure that health planning is based on wider governmental frameworks and/or the national development strategy. Inter-sectoral work will be an important approach with the intention of promoting health in all policies.

Institutional Development encompasses the following areas - leadership in health, health management, systems strengthening, health financing and revenue generation, coordination, health planning, monitoring and evaluation, health standards, health research, the private sector and public private partnerships, and the provincial level and decentralization.

6.2 Results, Outputs and Examples of Interventions

The objective of the institutional development strategic is to build and strengthen Afghanistan's health sector further, with a particular focus on greatly improving the performance of the MoPH, other related and relevant government entities, and key private institutions. The overall result for the institutional development area is:

Result 2: Strengthened, expanded, and sustainable health system with well functioning institutions.

[38] MoPH Statement on Institutional Development, April 2015, Ministry of Public Health
[39] See the National Health Policy 2015-2020

To achieve the objective the MoPH will build management and systems capacity for key functions such as planning, financial management and financing mechanisms, governance of the private sector, public pharmaceutical supply chain and procurement management and systems, and the establishment and enforcement of national health standards. Furthermore, working relationships will be enhanced within the MoPH and other governmental entities and donor partners to make the most efficient and effective use of available resources.

The objective of this strategic area embodies key cross-cutting themes of capacity development and sustainability. Importantly, the MoPH will strive to implement the goal of the national gender strategy, especially by incorporating a gender perspective into program work and ensuring that MoPH administrative policies and procedures are gender sensitive. To implement the strategy in this area of institutional development, the Ministry will undertake a program comprising 10 strategic results and associated outputs; also some examples of interventions for each are given as outlined below.

Strategic result 2.1: Strengthened national and local capacity for effective health planning and establishing effective linkages between plans, budget, and resource use, with meaningful participation from all stakeholders.

Outputs

1. Planning cycle is incorporated into work at all levels of the health system.
2. All off-budget health projects and development partners' work plans are fully aligned with and incorporated into a subset of the national level MoPH work plan to prevent duplication and support the work plan.
3. Evidence/results-based annual action plans are developed and costed at the central and provincial levels.
4. Increased meaningful participation of all health and non-health stakeholders is ensured in formulating policies, strategies, and plans at all levels, and effective ownership.
5. All subsector and departmental strategies are reviewed and aligned with the national health policy and this national health strategy.
6. Strengthened national and provincial level capacity is put in place for evidence-based and results oriented policy formulation and planning.

Examples of some interventions

1. Establish standard operating procedures that mandate incorporation of planning/budgeting cycles into the public health system.
2. Set up and operationalize an annual review of partner mechanisms to ensure off-budget partner program alignment with national priorities and work plans.
3. Design and implement annual national and provincial action/operational plans based on the latest evidence, costed to reflect MoPH overall policy and strategy frameworks.

Strategic result 2.2: Improved health financing mechanisms and increased domestic revenue generation and effective mobilization toward gradual sustainability and achievement of universal health coverage.

Outputs

1. Health Financing Policy 2012–2020 and Health Financing Strategy 2014–2018 are aligned with the new national health policy and national health strategy, and annual action plans are developed.
2. Increased institutional capacity at central and provincial levels is put in place to analyze economic and financial feasibility and effectiveness of all health system interventions, including resource collection, risk pooling, and service purchasing.

3. Government budget to the health sector is increased.
4. Innovative revenue generation schemes for the health sector are implemented.
5. New provider payment mechanism is implemented in national hospitals.
6. Health insurance feasibility studies are conducted; risk protection mechanism is piloted.
7. Economic evaluations and equity and efficiency analyses are conducted for important policy options, programs, and interventions.
8. The national health accounts and expenditure management information system are institutionalized, and a public expenditure tracking survey is conducted regularly.
9. All MoPH key institutional strategies and priority programs, including revised BPHS and EPHS, are effectively costed.
10. Tertiary hospitals' business plans toward self-sufficiency are developed.

Examples of some interventions

1. Develop and implement an evidence-based advocacy plan to increase the governmental budget for health.
2. Design and implement innovative revenue generation schemes.
3. Design and test new provider payment mechanisms at national hospitals.
4. Design and pilot prepayment/risk protection mechanisms to decrease out-of-pocket spending and move toward universal health coverage

Strategic result 2.3: Enhanced and effective multilevel stakeholders' (health and non-health) dialogue, coordination, and collaboration for health system strengthening.

Outputs

1. New coordination mechanisms for effective inter-sectoral dialogue and collaboration are devised and implemented.
2. Regional and cross-border coordination is strengthened.
3. National and provincial level sector coordination is improved through strengthening of all relevant bodies and mechanisms.

Examples of some interventions

1. Devise, develop consensus, establish, build capacity, and operationalize effective coordination mechanisms (forums, working groups, etc.) for improved inter-sectoral dialogue and collaboration at the central and provincial levels.
2. Devise, develop consensus, establish, and operationalize effective mechanisms for cross-border coordination on health issues.
3. Strengthen capacity at the central and provincial levels, and put in place mechanisms for follow-up and implementation of the results of the coordination committee meetings.

Strategic result 2.4: Greater private sector engagement and participation in health effectively supported, coordinated, and regulated for improved provision of quality healthcare services and products.

Outputs

1. Existing policies, laws, and regulations related to the private sector are reviewed and revised, and new ones are introduced for greater engagement and effective regulation of the private health sector.
2. The MoPH institutional structure and systems for private sector stewardship are streamlined, and technical and human resource capacity for effective regulation, coordination, advocacy support, and policy implementation is enhanced.
3. Minimum required standards are established/expanded to monitor and assess private health facilities/providers and ensure patient and provider safety; the minimum required standards are linked to private sector licensing.
4. The Government innovative incentives structures for the private health sector are designed and actively implemented to include formal recognition, financial rewards,

advocacy and coordination support for access to land and finance, tax benefits, and promotion of local pharmaceutical and other medical products production.
5. Creation and strengthening of private health sector associations is actively supported.

Examples of some interventions

1. Conduct a health private sector engagement assessment; based on the assessment, prepare a detailed, evidence-based and prioritized action plan for key activities.
2. Review and revise existing policies, laws, and regulations related to the private sector, and introduce new ones as necessary.
3. Build stewardship capacity and strengthen organizational structures for overseeing and partnering with the private sector.

Strategic result 2.5: Strengthened overall public-private-partnerships (PPPs) capacity and strategic PPPs particularly focusing on secondary and tertiary care are developed and fostered.

Outputs

1. Strengthened overall PPP capacity and strategic PPPs particularly focusing on secondary and tertiary care are developed and fostered.
2. Innovative, targeted quick wins and broader PPP models are devised and effectively operationalized for improved and expanded secondary and state-of-the art tertiary healthcare services.

Examples of some interventions

1. Devise and implement plans to strengthen capacity of the MoPH in designing, negotiating, and managing small and large scale PPPs.
2. Strengthen the legal framework for effective and supportive PPPs.
3. Prepare visible and high-impact 'quick wins' with an associated implementation strategy in a fully participatory and inclusive manner.

Strategic result 2.6: Strengthened pharmaceutical and other health products regulatory systems, ensuring the quality, safety, and efficacy of medicines and other associated products.

Outputs

1. The National Medicines and Health Products Regulatory Authority is effectively operationalized.
2. Required legislative documents and regulatory guidelines are streamlined, developed, and/or updated.
3. Strengthening and improvements to the institutional and operational capacity of the National Medicines and Health Products Regulatory Authority are made to effectively carry out all key functions.
4. A health technology assessment mechanism is put in place to rationalize selection and use of existing and new health products.
5. Post-marketing surveillance and pharmacovigilance systems are improved to ensure patient safety and marketed products' quality.
6. Quality testing capacities are improved and expanded for medicines and other health products - considering the tiered testing approaches as defined by the national medicines quality assurance policy.

Examples of some interventions

1. Support adequate funding and effective operationalization of the National Medicines and Health Products Regulatory Authority.
2. Review, revise, and streamline legislative documents and regulatory guidelines, and develop new laws, regulations, and guidelines as necessary.

3. Review and improve/reform post marketing surveillance and pharmacovigilance systems.

Strategic result 2.7: Strengthened financial management system for improved program efficiency.

Outputs

1. Standard operating procedures and manuals are developed and implemented for budget management, disbursement management, revenue management, payroll management, and accounting and financial reporting.
2. Standard budget formulation, payment, payroll, revenue, and financial reporting and tracking software/database for central, national, and provincial hospitals is installed.
3. Various public finance management processes and procedures are streamlined, and the capacity of financial management staff at the national and provincial levels is increased.
4. An effective financial management monitoring/supervision system is developed and operationalized to effectively monitor NGOs, provincial health offices, and other entities.
5. A well-prepared, accessible, and secure financial soft and hard filing system is established at the national and provincial levels.

Examples of some interventions

1. Commission, review, and approve standard operating procedures and manuals for budget management, disbursement management, revenue management, payroll management, accounting, and financial reporting.
2. Identify, test, and introduce new technology and software for budget formulation, payment, payroll, revenue, and financial reporting and tracking.
3. Undertake reviews and reforms of public finance management processes and procedures.
4. Review and design an improved financial management monitoring/supervision system to monitor NGOs and provincial health offices.

Strategic result 2.8: Improved procurement system and supply chain management for quality and timely health services, goods, works, and products.

Outputs

1. Standard operating procedures and associated manuals for an effective procurement system are developed and implemented.
2. Capacity of the procurement entity and personnel is enhanced to handle national and international procurement and contract management in a timely and efficient manner.
3. Reduced average duration is achieved for each procurement episode.
4. Streamlined processes and improved adherence to procurement law are put in place.
5. Procurement of all goods and non-consulting services is accredited by the Afghanistan National Procurement Authority

Examples of some interventions

1. Plan and mobilize support to prepare necessary standard operating procedures and associated manuals for an effective procurement system.
2. Introduce and roll out new technology and software for procurement processes and management.
3. Review, examine, and further streamline procurement processes and procedures and strengthen procurement and contracting capacity in the MoPH.

Strategic result 2.9: Improved adherence to set national standards for health infrastructure, technology, and clinical care at all levels.

Outputs

1. Adequate national standards on health infrastructure, technology, and clinical care are developed and effectively implemented and enforced.
2. Increased resources are mobilized for developing standards.
3. Increased accountability and commitment of implementers are fostered.

Examples of some interventions

1. Develop an action plan and solicit support to adequately strengthen the MoPH capacity for development, oversight, and enforcement of national standards.
2. Implement the roadmap for national health care accreditation.

Strategic result 2.10: National Health Decentralization Strategy effectively implemented.

Outputs

1. National health decentralization strategy is finalized and approved.
2. Improved technical and administrative capacity and governance of the Provincial Liaison Department and provincial health offices are put in place.
3. Implementation plans for the decentralization strategy and standard operating procedures are developed and implemented.

Examples of some interventions

1. Mobilize support and ramp up completion of the decentralization strategy, and increase advocacy for its timely approval and adaptation.
2. Develop and implement capacity development plans for the Provincial Liaison Department and provincial health offices.
3. Prepare an implementation plan and standard operating procedures for the decentralization strategy; raise awareness and sensitize people at all levels to them.

7. STRATEGIC AREA 3: PUBLIC HEALTH

7.1 Overview

The MoPH, through its new National Health Policy 2015–2020, has defined public health in the context of Afghanistan as the organization of social and political efforts to prevent ill health, and promote and protect the health of communities and groups; and to have healthy lifestyles as a result of changes in attitudes, perceptions, and practices.[40] This definition is based on the principle that to be healthy is vital to all of us all of the time, whereas quality health care is vital to all of us only at particular times in our lives. The fact is that Afghanistan needs to heighten its focus on health and health services, in which the emphasis is on promotion of good health and prevention of ill health. The national health policy statement on public health can be seen in the following box.

Box 4. Public Health Policy Statement[41]

The public health policy of the Ministry of Public Health is one that changes thinking and practice towards ensuring a health system that promotes health beyond the Ministries' responsibilities for the provision of clinical and curative services - towards a better balance between health and health services; a vision of healthy lifestyles as a result of changing attitudes, perceptions and practices.

Within the framework of this policy the Ministry of Public Health will ensure effective and efficient cost-effective public health interventions that prevent diseases and promote the health and well being of the population.

Towards this the Ministry is committed to efficiently and effectively reduce morbidities, mortalities and disabilities through a two-pronged public health approach. The first is to work on empowering individuals and communities with knowledge about what actions they can take to stay healthy and to deal with poor health.

The second concurrent approach is the provision of preventive health interventions for all Afghans especially mothers, children, and marginalized populations. The main focus will be on people dying from preventable illness, on improving nutrition and on problems such as post partum haemorrhage among women who have just delivered a baby and from communicable and non-communicable diseases. For the latter the Ministry recognises that the agendas for their prevention and control are inextricably linked. Prevention for both requires integrated multi-sectoral action addressing determinants across the life course.

Within the framework of the national health policy on public health, public health is the third strategic area of this national health strategy. It encompasses the sub-areas of health promotion, community health and empowerment, health protection, preventive health, gender and human rights, reproductive, maternal, neonatal, child, and adolescent health, communicable diseases, non-communicable diseases, nutrition, disability and physical rehabilitation, accidents and injuries, drug demand reduction, mental health, environmental health, and emergency preparedness and disaster management.

[40] Also see the MoPH Position Paper on Public Health, September 2015
[41] National Health Policy 2015-2016, Ministry of Public Health

7.2 Results, Outputs and Examples of Interventions

The public health strategic area objective is to engage effectively with the multifaceted nature of the country's public health issues, with the ultimate goal of helping to decrease disease incidence and prevalence among its population, thus leading toward healthier lives. The overall planned result for the public health strategic area is:

Result 3: Reduced preventable death, illness, and disability through provision of cost-effective, high-impact, evidence-based public health interventions.

The MoPH will attain this overall result by focusing on the critical and priority aspects of the sub-areas mentioned above. The MoPH will ensure the effective and efficient implementation of the key strategies and associated interventions in the area of public health through developing comprehensive action plans, mobilizing resources to support their implementation, engaging stakeholders more effectively, strengthening and fostering country ownership, strengthening the health system, and monitoring and evaluating results.

As demonstrated by the following strategies and key interventions, the strategic area of public health will actively employ and foster the various cross-cutting themes and principles of this national health strategy. In this regard, all programs, plans, and actions will follow the principles as described in Section 4.

Below are the 10 key strategic results under the overall result for the public health strategic area and the associated outputs for each, followed by some example of interventions:

Strategic result 3.1: Reduced incidence and prevalence of acute and chronic malnutrition.

Outputs

1. Improved nutrition status of the population is achieved, particularly infants, young children, adolescents, and women of reproductive age.
2. Strengthened in-country capacity, evidence base, and positive environment for nutrition are achieved.
3. Strengthened case management and increased access to and utilization of quality nutrition services are provided at the community level and through health facilities.
4. Increased awareness about nutrition is achieved, as is adoption of healthy food practices among the general population.

Examples of interventions

1. Build human and institutional capacity to improve planning, monitoring, supervision and evaluation of nutrition programs; build capacity of healthcare providers to provide skilled counseling and support infant and young child feeding at health service delivery points.
2. Enhance optimal dietary practices to prevent under/over-nutrition.
3. Take a multipronged approach to address micronutrients deficiency problems, with a special focus on anemia and iron deficiency anemia among women of reproductive age and children from six to 59 months of age.

Strategic result 3.2: Improved access and utilization of reproductive, maternal, neonatal, child, and adolescent health services.

Outputs

1. Strengthened informed decision making on use of family planning among women of reproductive age and their families.

2. Increased coverage and quality of preventive maternal, newborn, child, and adolescent health services.
3. Improved provision of health services for all Afghan children, with a greater focus on marginalized populations.
4. Increased awareness of and access to youth friendly services.
5. Increased public awareness of RMNCAH services.

Examples of interventions

1. Ensure that women make informed choices about their reproductive life though information and education aiming for prevention and early detection.
2. Develop and deliver appropriate evidence-based and culturally sensitive health promotion messages to address care of the newborn at the facility and community levels.
3. Provide quality newborn care services at the hospital level.
4. Develop advocacy strategies and campaigns to increase awareness of and advocacy for preventing child marriage, and delaying teenage pregnancy and birth spacing).
5. Rationalize, incentivize, and develop programs for further production, deployment, and efficient distribution of midwives and female community nurses in the country.

Strategic result 3.3: Reduced burden of communicable and non-communicable diseases.

Outputs

1. Reduced mortality and morbidity of communicable diseases, with a special focus on TB, malaria, leishmaniasis, HIV/AIDS, hepatitis, leprosy, and zoonotic diseases.
2. Increased awareness and advocacy for the prevention of non-communicable diseases as a public health policy priority.
3. Prevention/control of non-communicable diseases integrated in primary health care.
4. Sustained immunization coverage of 90 percent for all antigens at the national level and at least 80 percent in each district.
5. Polio eradication.
6. Reduced morbidity, mortality, and disability caused by occupational and environmental hazards.

Examples of interventions

1. Strengthen human and institutional capacity for the control of communicable and non-communicable disease at all service delivery levels.
2. Ensure that sufficient and potent vaccines are available in a timely manner at all levels of the health system; further strengthen the vaccine supply and cold chain and logistics management.
3. Enhance TB case finding through expanding PPM and urban directly observed treatment–short course; addressing TB/HIV, MDR-TB, and childhood TB; and addressing other vulnerable populations, such as internally displaced populations, returnees, those vulnerable to household contact, and prisoners.
4. Conduct regular screening of food industry amenities and workers to assess their standards of hygiene so as to ensure food safety.

Strategic result 3.4: Heightened advocacy for and effective implementation of disability and physical rehabilitation services.

Outputs

1. Reinforced implementation of physical rehabilitation services.
2. Improved services for people with disabilities.
3. Improved and promulgated legal framework, ensuring provision of needed health services to people with all types of disabilities.

Examples of interventions

1. Develop strategic and operational plans, standards, and guidelines for management and rehabilitation of disabilities.
2. Advocate for the rights of people with disabilities/physical impairments.
3. Initiate preventive measures to avoid preventable disabilities, especially among children.
4. Ensure disability friendly health facility environment, including but not limited to physical access.

Strategic result 3.5: Reduced preventable disabilities due to road traffic accidents, mines and other explosive remnants of war, and occupational and domestic injuries.

Outputs

1. Reductions are achieved in preventable disabilities due to road accidents, mines and explosive remnants of war, and occupational and domestic injuries.
2. A multi-sectoral coordinated approach is devised and implemented.
3. Promulgation of regulative public policy on ensuring road and mine safety issues (e.g., speed limit, helmet wearing and seat belts).
4. Improved public knowledge and awareness on all relevant safety issues are achieved.

Examples of interventions

1. Formulate and enforce regulations, and guidelines for the prevention of occupational health related outcomes and injuries.
2. Improve the knowledge, skills, and practices of health providers and communities regarding preventable injuries.
3. Work with the Ministry of Interior (Traffic Department) to identify the lead agency and leading role for guiding national road traffic safety efforts and measures.
4. Advocate for developing and promulgating regulatory public policy, strategies, and a legal framework for preventing road traffic injuries.

Strategic result 3.6: Reduced prevalence of mental health disorders, with a particular focus on poor, under-served, disadvantaged, and vulnerable populations.

Outputs

1. Evidence and rights based quality mental health services are integrated into primary, secondary, and tertiary healthcare.
2. Minimized stigma and discrimination are attached to mental health disorders.
3. Strengthened regulations, guidelines, and overall advocacy of mental health issues.

Examples of interventions

1. Develop/update mental health strategy, standards, and guidelines for all levels of the health system.
2. Improve mental health data collection, monitoring, and analysis through establishing a reliable monitoring and recording system.
3. Orient non-health gatekeepers on mental health disorders to better support affected populations in a humane manner.
4. Raise the awareness level of communities on de-stigmatization of mental health illness

Strategic result 3.7: Empowered communities through health knowledge, skills and attitudes, actions, supportive environment, and public health policies.

Outputs

1. Improved health knowledge, personal skills, and attitude of health personnel and the community.
2. Strengthened community actions.
3. Health actively incorporated into other sectors' policies.
4. Expanded coverage of community-based primary healthcare services to 90 percent in rural settings and 60 percent among poor urban and nomad populations.

5. Enhanced overall CHW capacity and sustainability.

Examples of interventions

1. Develop and effectively implement an innovative, evidence-based health promotion and prevention strategy.
2. Increase coverage of community-based health services in 'white' areas (under-served/remote) in rural and nomad settings.
3. Improve alignment, integration, coordination, and collaboration for promoting health with line ministries and other stakeholders.
4. Introduce effective and innovative mechanisms to ensure motivation and retention of CHWs and increase the number of female community health supervisors.

Strategic result 3.8: Enhanced MoPH institutional capacity for preparedness, risk mitigation, and effective responses to and management of emergencies and disasters.

Outputs

1. Strengthened institutional capacity of MoPH is achieved regarding preparedness, risk mitigation, and response to emergencies and disasters.
2. All public health emergencies of international concern are detected, reported, and responded to on a timely basis.
3. Legal frameworks for health and national multi-sectoral emergency management are developed and implemented.
4. Information management systems for risk reduction and emergency preparedness programs are developed.

Examples of interventions

1. Conduct comprehensive hazard, vulnerability, and capacity analysis mapping.
2. Develop a national health sector emergency response plan and hospital response plans, including a specific risk communication plan.
3. Strengthen laboratories' capacity to rapidly confirm any emerging infectious diseases.
4. Devise and institute rapid community feedback mechanisms to be activated in the event of a public health emergency of international concern.

Strategic result 3.9: Gender and human rights mainstreamed in all MoPH programs.

Outputs

1. Improved institutional capacity of MoPH to effectively address gender and human rights related issues, including health sector prevention and response to gender based violence.
2. Enhanced equitable, sustainable, and continuous access of women, girls, boys, and men to quality health services free of discrimination.

Examples of interventions

1. Educate health providers and managers on gender and human rights, including gender based violence, and the link between women's status in society and ill health.
2. Develop and promote communication activities for health staff to improve gender responsive health services.
3. Develop a gender and human rights accountability framework for monitoring MoPH planning and program implementation.

Strategic result 3.10: Reduced substance abuse.

Outputs

1. Increased treatment capacity and improved access to quality preventive, curative, and rehabilitative services to people who use drugs and vulnerable populations e.g. prisons, juvenile centers, returnees, internally displaced populations, and shelters, through the public and private health sectors.

2. Improved coordination of and collaboration with internal and external stakeholders for substance abuse programs.
3. Increased institutional capacity to raise and manage funds for reducing substance abuse.

Examples of interventions

1. Enhance capacities of health services and health providers to deliver quality preventive, treatment, and rehabilitation services; and prevent transmission of blood-borne and sexually transmitted infections.
2. Introduce and strengthen drug abuse awareness in the BPHS and EPHS, with a particular focus on vulnerable populations.
3. Introduce a life skills education program and a universal preventive strategy targeting all youth through school and university education programs.

8. STRATEGIC AREA 4: HEALTH SERVICES

8.1 Overview

Actual health service delivery lies at the heart of any health system. Following the guidance of the national health policy, this health services strategic area encompasses the sub-areas of quality of and access to health services and clinical care, BPHS and EPHS, tertiary hospitals, pharmaceuticals, forensic medicine, and health commodities. The national health policy statement on health services can be seen in the following box.

Box 5. Health Services Policy Statement[42]

The Patients' Charter reflects the rights based approach to health services and care. The forthcoming Citizens Charter will also reflect an aspect of equity and access to a community based health service.

The health services policy of the Ministry of Public Health is that over this policy period there will be an incremental transition from contracting-out basic health and hospital services basic services to government delivered services throughout the country.

Basic health and essential hospital services are respectively delivered through the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS). The content of both packages are evidence based cost effective interventions and are free of financial cost to all. The Ministry is committed to putting into practice the 'continuum of care' approach, both across the various levels of health service delivery and throughout the life cycle of a person. The Ministry is also committed to strengthen access in rural areas towards achieving universal health coverage.

Concurrently, it is also the health services policy of the Ministry of Public Health to reform tertiary hospital care. This is with the aim of ensuring the provision of quality, specialist care mainly through regulated public-private investment and other partnerships. Cardio-thoracic syndromes and cancer are the priority non-communicable diseases. For the latter, an essential package of affordable, cost-effective cancer implemented. The specialist care services will be provided on a fee basis. A mechanism will be developed over the next few years to enable the poor to benefit from specialist care.

The Ministry is committed to having a more responsive, well functioning referral system.

It is a policy priority of the Ministry of Health to ensure the provision of quality pharmaceuticals and other health commodities through a well regulated quality control body.

8.2 Results, Outputs and Examples of Interventions

The overall objective of this health services strategic area is to make improved and expanded health services available to all populations at the primary, secondary, and tertiary levels. In doing so, it takes into account key aspects of health services, such as quality, coverage, equity, equality, affordability, and sustainability. It also focuses on gaining efficiency regarding both current and future health services. In support of the overall goal of the national health strategy, the overall result for the health services strategic area is:

Result 4: Improved and expanded quality health services provided in an equitable and sustainable manner across all geographic areas and population groups through more effective and efficient use of existing resources, achieving better value for money.

The following are the three key strategic results under the overall result for the health services strategic area 4, the outputs for each strategic result, and some examples of interventions.

[42] National Health Policy 2015-2016, Ministry of Public Health

Strategic result 4.1: Enhanced access to improved and updated quality BPHS and EPHS services.

Outputs

1. High-impact innovative approaches to expansion of access are introduced and scaled up.
2. A standardized, fully functional referral system is in place.
3. Current and future health facilities distribution and service delivery are rationalized.
4. Cultural barriers to accessing health services are addressed through demand generation.
5. BPHS and EPHS packages are revised to improve both coverage and cost-effectiveness.

Examples of interventions

1. In close coordination with implementer NGOs and other stakeholders, and effective use of GIS technology or other appropriate means, map out the 'white' and/or under-served areas, and assess the functionality and utilization of existing health facilities to ensure sufficient and effective coverage.
2. Develop a strategy accompanied by a specific action plan, and mobilize necessary resources to effectively introduce, implement, and expand e-health, mobile health, and telemedicine services at all levels, particularly focusing on hard-to-reach areas and population segments.
3. Enhance community awareness programs and communication campaigns to improve the health seeking behaviors of the population and raise actual demand for available services.
4. Actively involve Shuras, and religious leaders in planning and implementing community awareness programs, delivering health messages, and introducing innovative initiatives, leading to building trust.

Strategic result 4.2: Improved quality and increased access to a wide range of tertiary services.

Outputs

1. The hospital transformation program is developed and implemented.
2. A tertiary health services package is developed.
3. The National Medical Council is reinforced to ensure the quality of and access to tertiary services.
4. The regulatory function of the MoPH is strengthened at both the national and provincial levels.
5. Technical and managerial capacity of staff is enhanced regarding both tertiary care services and hospital management.
6. One state-of-the art cancer hospital is established through a public-private partnership.
7. One state-of-the art cardiac hospital is established through a public-private partnership.
8. An autonomous accreditation body for healthcare accreditation is established.
9. Existing tertiary health services are upgraded to minimize unnecessary medical travel abroad.

Examples of interventions

1. Use advanced technology to ensure improved community access to available health services at each level of the health system, and required emergency ambulance services.
2. Establish an independent accreditation body for secondary and tertiary hospitals.
3. Develop and institutionalize technical, business, and management capacity building programs for both tertiary services and hospital management staff.

Strategic result 4.3: Improved pharmaceutical services management and local medical products (medicines and commodities), ensuring increased access (physical accessibility, availability, affordability, and acceptability) and rational use of medicines and health commodities.

Outputs

1. Standards treatment guidelines are developed/revised
2. Rational medicine use and antimicrobial resistance issues are improved at both the national and provincial levels.
3. Quality assurance certification is ensured for all manufacturers and importers of pharmaceutical and health commodities.
4. A cost-effective and transparent centralized procurement and distribution system is established for quality essential medicines and health products.
5. The pharmacovigilance system and regulatory and law enforcement capacity and function are strengthened.
6. Production, expansion, and diversification of select medicines and commodities are actively explored and supported.

Examples of interventions

1. Improve pharmaceutical services in the public and private sector by promoting rational medicines and health commodities use at national and provincial. levels
2. Functionalize and expand the pooled procurement and distribution mechanism on a phased-in basis in accordance with the implementation plan that will be developed.
3. Set the quality standards in pharmaceutical services through advocating and supporting the creation of Pharmacy Council, scaling up regular training programs for training institutions including universities and institutes of health sciences, networking with international/regional university schools of pharmacy and putting in place continuous professional development programs for pharmacists.

9. STRATEGIC AREA 5: HUMAN RESOURCES FOR HEALTH

9.1 Overview

The national health policy statement on human resources for health, the framework for this strategic area can be seen in the following box.

Box 6. Human Resource Policy Statement[43]

The Ministry of Public Health policy on human resources is that effective inter-ministerial, cross directorate and departmental ministry and donor and other linkages and coordination underpin human resource development. This is with the intention of ultimately ensuring that the right person is in the right place at the right time, with the right knowledge and skills to work in the right way while doing the right thing.

As part of this policy the Ministry will implement a comprehensive human resources system based on addressing all the essential elements of human resource development. These are policy, planning, production and procurement, management and financing. This will replace the previous outdated 'personnel and training' approach. It will more closely reflect the needs of the health delivery system through closer collaboration between human resources and health services and public health.

The new policy direction is towards ensuring that the workforce is 'fit for purpose'. That the Ministry can effectively, efficiently and with quality produce the appropriate quantity and skill mix of personnel sympathetic to the health and disease needs of individuals and communities throughout the country. And that it makes health personnel feel valued, motivated and that they want to stay working in the public sector.

The MoPH intends to ensure that all Afghan citizens can access a health worker who can provide quality health interventions at need. However, it is struggling to mitigate a nationwide shortage of health workers caused by out-migration, poor retention and low morale, and an unequal distribution of existing human resources (see the health workforce data in table 5). The country's current human resources for health ratio of 0.7 is still far below the WHO benchmark of 2.5 (combined doctors, nurses, and midwives per 1,000 population). Due to population growth, the ratio of professional health workers to population is expected to increase only marginally over the next five years, despite the nation's large number of pre-service educational institutions.[44]

The MoPH Tashkeel of 2015 (1394) includes 14,370 civil service positions,[45] which are funded directly by the government. Among these, 10,234 positions are technical and 4,136 are support staff. The existing core staff of the MoPH broken down by grades is shown in Table 6.

Table 6: Existing Core Staff of MoPH

Tashkeel Grades	Number of Staff	Central Level	Provincial Level
1–2	91	57	34
3–6	10,143	5,032	5,111
7–8	4,136	2,200	1,936
Total	**14,370**	**7,289**	**7,081**

[43] National Health Policy 2015-2016, Ministry of Public Health
[44] UNICEF. "Country Statistics, Afghanistan." Available at: http://www.unicef.org/infobycountry/afghanistan_statistics.html.
[45] Staff are paid from the MoPH ordinary budget.

Table 5: Health Workforce Data – MoPH, May 2016

S.N	Categories of Health workforce	Current # of Employees	Total Number Current			Gender structure		The Ratio per 10,000 population	Projected Health Workers for the Health Sector for Short, middle and Long term *(Estimated Population after 15 Years 37,660,000)						Total Projected staff			Gender structure in %	
			Civil Servants	NGOs Staff	Contracted staff	Male	Female		Short Term (2.5 Years		Intermediate Term (5 Years)		Long Term (15 Years)						
									Male	Female	Male	Female	Male	Female	Male	Female	Total	Male	Female
1	MD Doctors	5092	3306	1786	NA	3974	1118	1.82	8965	2077	10668	2475	12127	3226	31760	7778	39538	80.33	19.67
2	Nurses	5305	2360	2945	NA	4369	936	1.89	7536	1956	8989	2289	11354	3215	27879	7460	35339	78.89	21.11
3	Midwifes	3543	1224	2319	NA	0	3543	1.27	0	4687	12	5515	1052	5828	1064	16030	17094	6.22	93.78
4	Pharmacist	681	421	260	NA	562	119	0.24	1529	176	1812	208	2243	356	5584	740	6324	88.30	11.70
5	Community Midwife	2003	478	1525	NA	0	2003	0.72	0	0	0	0	0	0	0	0	0	0.00	0.00
6	Allied Health Workers	16624	7789	8835	NA	8905	7719	5.94	6712	1437	7989	1706	10222	2473	24923	5616	30539	81.61	18.39
7	Community Health Workers(CHWs)	0	0	0	NA	14447	13400	0.00	14477	13430	14508	13461	14631	13584	43616	40475	84091	51.87	48.13

Note: i) Afghanistan total population: 28,000,000 (Central Statistical Office, CSO); ii) Allied Health Workers include , Dentists, Lab. Technicians, Radiologists , Biomedical Engineers/Technicians , Orthopedics all technicians

9.2 Results, Outputs and Examples of Interventions

The goal of this human resources for health strategic area is to have the 'right' and 'ready' human resources for health to effectively support and facilitate the overall quality and coverage of priority health services essential to a healthy and productive population in Afghanistan. In support of the overall goal of this national health strategy the overall planned result is:

Result 5: Competent and motivated health workforce effectively developed, deployed, and retained in line with current and future requirements in an efficient and cost-effective manner.

The following presents the four strategic results under the overall results for this strategic area number 5 of human resources for health and the associated outputs. Some examples of interventions are also given.

Strategic result 5.1: Improved human resource planning and coordination, ensuring better geographical and gender balance in health management and services provision.

Outputs

1. A long term national health workforce plan and province specific human resource improvement action plans are developed based on current and future requirements in line with the National Health Policy 2015–2020 and National Health Strategy 2016–2020.
2. All relevant current policies and procedures are reviewed and revised to align them effectively and ensure better geographical and gender balance in health management and services provision.
3. Innovative incentive programs are devised and implemented to support effective recruitment, deployment, and retention of various cadres of health service providers in the rural, non-urban, and remote areas.
4. Key human resources for health coordination mechanisms and forums are reactivated and strengthened for improved coordination with stakeholders, including development partners and other relevant governmental entities.

Examples of interventions

1. Develop and implement an advocacy plan to revise and update current complex and stringent civil service laws (including salary scales) to effectively facilitate the recruitment

and selection, promotion, retention and succession, management of salary and benefits, and equitable deployment of different cadres of staff.
2. Coordinate and collaborate with various educational institutes to increase recruitment of female students from rural areas, and use attractive incentives to retain graduates in their home locales.
3. Coordinate with the Ministry of Higher Education for regional medical training facilities.

Strategic result 5.2: Strengthened systems for effective human resource management.

Outputs

1. MoPH current organizational structure (Tashkeel), including key functions of all directorates/departments and terms of reference for all key positions, are reviewed, rationalized, and aligned with MoPH goals and strategic objectives to avoid overlap and duplication, and improve organizational performance and efficiency.
2. Existing HRMIS is upgraded and a national health workforce observatory is established and actively operationalized for effective, evidence-based, and practical planning and decision making.
3. Reduced corruption and increased accountability are achieved through establishment and strict implementation of clear guidelines and innovative incentive mechanisms for public sector health workers to promote ethical, efficient, and quality public service in line with job requirements.
4. A one-stop client center is established to help ensure integrity and transparency in all human resource management activities and decision making.

Examples of interventions

1. Ensure that all directorates, departments, units and staff have terms of reference, with no overlap or duplication of roles and responsibilities.
2. Routinely collect, update, and audit HRH data from all relevant entities, including from public and contracted health service-providing institutions; and further support, develop, and institute an up-to-date, well capacitated, and operational HRMIS.
3. Develop and institute systematic computerized/electronic systems, including computerization of all MoPH personnel files, and link them to the HRMIS system.

Strategic result 5.3: Improved human resources for health regulation and practices through establishing regulatory frameworks and accreditation systems.

Outputs

1. Regulatory mechanisms and accreditation systems are developed and implemented for pre-service, in-service, and postgraduate programs.
2. Professional health workers' accreditation is effectively supported through establishment and strengthening of various professional health councils and umbrella organizations.
3. All testing, certification, and placement mechanisms and processes are reviewed and strengthened to improve screening of relevant cadres, including new graduates and residents.
4. An overall supportive supervision system and associated procedures and tools are developed and/or updated, and effectively implemented for postgraduate programs, PHOs, and the IHS.

Examples of interventions

1. Develop and implement guidelines and procedures for improving transparency and accountability at the national and subnational levels in all human resources for health related functions.
2. Develop accreditation standards to ensure that pre-service and in-service training curricula and relevant institutes are aligned with national strategies and needs.

3. Conduct an assessment and develop and implement an action plan to effectively develop and/or improve/update the overall supportive supervision system and associated procedures and tools.

Strategic result 5.4: Health workforce capacity adequately developed based on health system needs.

Outputs

1. Improved relevant pre-service and in-service training is instituted, as are continuous education and postgraduate programs for all categories of human resources for health.
2. Skill mix of existing staff is assessed and aligned through practical and needs based training and other capacity building initiatives at all levels.
3. 'Self-learning' and intradepartmental and intraregional/provincial learning mechanisms are devised, implemented, and supported across geographic and administrative boundaries to facilitate hands-on learning and sharing, and documenting of best practices and what works.

Examples of interventions

1. Implement a routine in-service training tracking system institutionalized within the MoPH and linked to human resources for health management information system and personnel files.
2. Strengthen the in-service training and continuous education plan and mechanisms for all categories of human resources for health at both the national and sub-national levels.
3. Support the training of trainers in the accreditation systems for training, curricula, training institutions, and development of manuals, as well as the accreditation of professional health workers within the Afghan health system.

10. STRATEGIC AREA 6: M&E, HEALTH INFORMATION, LEARNING, AND KNOWLEDGE/EVIDENCE-BASED PRACTICES

10.1 Overview

Evidence for health interventions and delivery can be obtained from formal research, analysis, and interpretation of routine program-level and service delivery data and practices. A key challenge is how to balance the need for evaluation with that for monitoring, and using the data to improve programs in real time to answer the question 'How did it work or not work'? Another challenge is how to define and measure successful and effective M&E in the context of programs focused on care delivery and health systems strengthening as well as determining major pitfalls in collecting data.

The MoPH and its partners have identified 'M&E, Health Information, Learning, and Knowledge/Evidence-based Practices' as the sixth strategic area of this national health strategy 2016–2020. It encompasses the sub-areas of M&E, surveillance of diseases, health systems research, including operational research, learning and knowledge management, a culture of information generation and dissemination, and a culture of knowledge and evidence based decision making. The following two subsections highlight the main challenges and associated underlying barriers, and key strengths and opportunities.

10.2 Results, Outputs and Examples of Interventions

The objective of this strategic area is to contribute to the improvement of the health status of the Afghan population, increased efforts and investments must be made to promote, support, and strengthen M&E, surveillance, health information, effective use of evidence, public awareness, research, learning, and sharing of best practice. The overall result will be:

Result 6: Strengthened monitoring, evaluation, surveillance, health information, and an improved culture of learning and knowledge management, resulting in increased evidence-based decision making and practices at all levels of the health system.

The following are the five strategic results under the overall results for this strategic area and the associated outputs. Some examples of interventions are also given.

Strategic result 6.1: Strengthened, effective, and visible MoPH governance of the health information system.

Outputs

1. Improved technical and strategic coordination within the MoPH General Directorate of Evaluation and Health Information System (GD-EHIS) and all other relevant internal and external stakeholders is achieved for an effective and responsive health information system management and use.
2. All relevant health data and information standards and guidelines are updated, disseminated, and effectively implemented at all levels of the health system.
3. National clinical health research guidelines are developed in collaboration with universities and research institutions.
4. National EHIS strategic plan is evaluated and revised to align with the policy priorities and this national health strategy and effectively implemented through annual action plans.

Examples of interventions

1. Establish and effectively operationalize a central level EHIS steering committee, comprising representatives from all EHIS departments and other key internal and external EHIS stakeholders..

2. Establish, provide resources, and effectively operationalize an active HIS committee for each province, comprising staff involved with HMIS, surveillance, monitoring, nutrition, reproductive health; child health officers; and representatives from other relevant stakeholders, including provincial level development partners.

Strategic result 6.2: Operations and health systems research, biomedical research, monitoring, evaluation, vital statistics, HMIS, and surveillance are actively supported, including capacity building, conducted, and associated findings and knowledge products effectively disseminated.

Outputs

1. Impact, operation, and overall health system research and evaluation capacity is strengthened.
2. Organizational and human resources capacity for effective monitoring, surveillance, and vital statistics operations is developed and/or strengthened at both central and provincial levels.
3. Surveillance system is sustained through inclusion of surveillance in provincial health structure and revision of BPHS and EPHS contracts.
4. HMIS capacity is developed at the central and provincial levels to support other programs' information systems (and improve data quality and use.
5. Improved quality of research and evaluation is achieved.
6. Established and improved collaborations are made on biomedical research.
7. Capacities are developed for biomedical research on key priority needs and biosecurity, biosafety, and bioethics.

Examples of interventions

1. Develop and employ techniques for improved data analysis, interpretation, and effective dissemination of health information for all parties, including policymakers, mid-level managers, and service providers.
2. Institute 'country-led' program evaluations of outcomes and impacts at the national and provincial levels to inform effective program design.

Strategic result 6.3: M&E frameworks and responsive surveillance systems are developed, strengthened, and effectively used, leading to improved data collection, utilization, and dissemination at all levels.

Outputs

1. Data production coverage and processes are streamlined and quality improved.
2. Adequate research support is provided for investigating performance gaps in BPHS/EPHS service delivery as identified by HMIS, M&E, and other routine reporting systems.
3. Internal and external evaluations are conducted for improved efficiency and success, and to better plan for effective programs/projects.
4. Monitoring systems and frameworks at all levels are further developed, strengthened, harmonized, and decentralized, both in the public and private health sectors.
5. The current HMIS is revised for greater efficiency and coverage, including integration of vertical programs and private sector reporting systems, and institutionalization of health administrative record systems.
6. The vital statistics system is established and operationalized for reporting births and deaths and death verification.

Examples of interventions

1. Conduct regular annual data quality verifications to improve data production and quality of HMIS at both the central and provincial levels.

2. Assess the existing M&E frameworks and tools, and use the assessment results to strengthen, harmonize, and accelerate the current effort to develop M&E plans and frameworks at all levels, both in the public and private health sectors.

Strategic result 6.4: Disease outbreaks and public health emergencies of international concern are effectively detected, investigated, and responded to within 24–48 hours.

Outputs

1. Improved communication and coordination are established for Public Health Emergencies of International Concern with WHO.
2. Improved IDSR initiatives and systems are established with expanded public and private surveillance sites and all disease surveillance components are effectively integrated.

Examples of interventions

1. Develop sufficient surveillance and response capacities, and promote rational use of resources at each level of the national health systems.
2. Decentralize and integrate the current DEWS by components.

Strategic result 6.5: Improved culture of knowledge- and evidence-based decision-making practices at all levels.

Outputs

1. Effective data and information needs are identified and corresponding utilization plans prepared for key stakeholders at all levels; appropriate analytical tools, reports, and information and knowledge management products are designed, developed, and made readily accessible; and participation of health information system representatives is ensured in relevant MoPH decision-making forums.
2. Knowledge and evidence-based decision making and innovative practices are institutionalized at all levels, and accountability is ensured through review meetings.
3. Reliable, relevant, and up-to-date public data and information access portals are in place and operational.
4. Health results conferences are effectively conducted on an annual basis.
5. Quality annual HIS institutional reports are produced in a timely manner and disseminated widely.
6. The capacity of MoPH programs is enhanced at different levels through data use sessions and visits for utilization of health information from HMIS, research, monitoring, and surveillance for planning, monitoring, and resource allocation.

Examples of interventions

1. Plan and implement program review meetings, results conferences, data use trainings, journal clubs, and so on to improve accountability and institutionalize evidence-based decision making and innovative practices at both the provincial and central levels.
2. Conduct health results conferences and produce and disseminate annual HIS reports and health indicators fact sheets to facilitate access to reliable, relevant, and up-to-date data and information.

11. IMPLEMENTATION

11.1 Implementation Arrangements

The MoPH departments at both the central and provincial levels will develop annual action for implementation of this strategy. Meanwhile, in close coordination and collaboration with all relevant central e.g., line directorates and provincial-level entities, the GD-EHIS and its departments will monitor progress and produce timely data, information, and other related reports and analytical products to keep the decision makers and all stakeholders informed about accomplishments and any challenges in achieving results, so that corrective measures can be taken as needed.

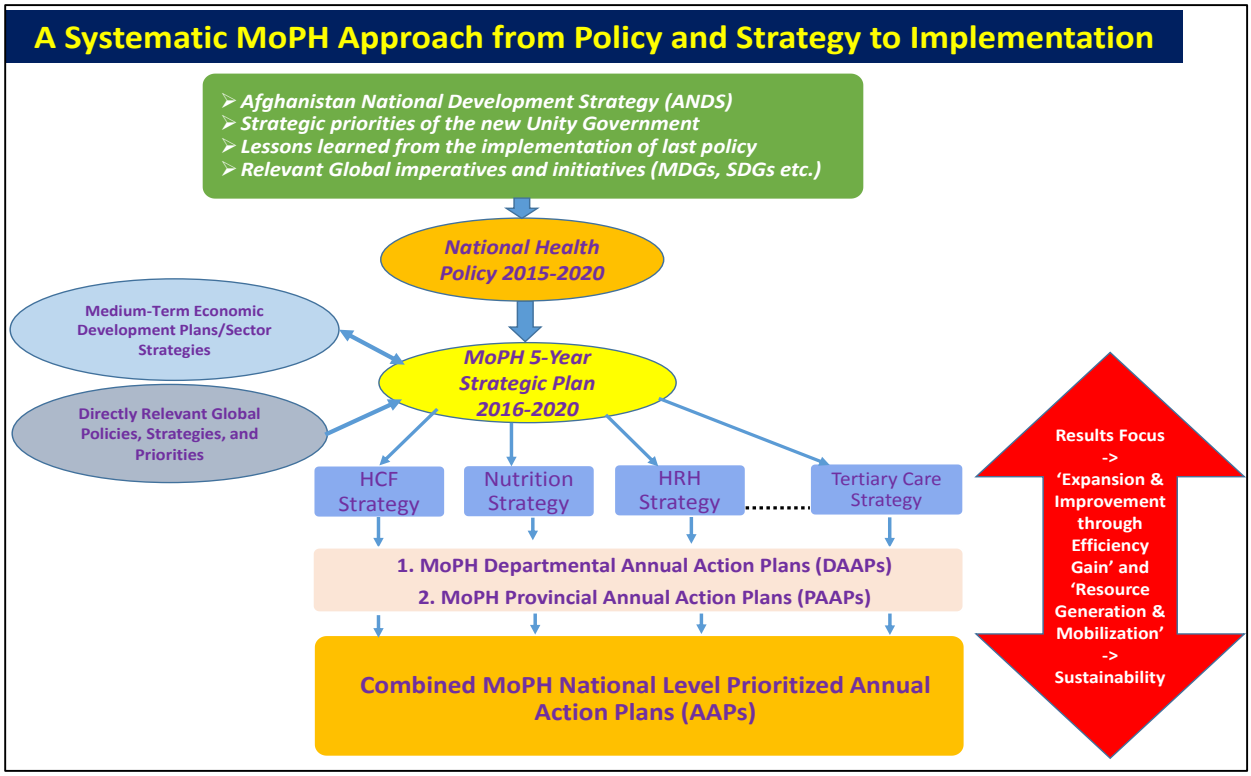
Effective implementation of the national health strategy will require active and effective multi-sectoral coordination. The MoPH will also advocate with the government and the donor community for mobilization of adequate funding for the effective implementation of the strategy. Engaging communities during implementation of the strategy is also vitally important to the MoPH.

11.2 Subsector Strategies and Annual Action Plans

Following the finalization, approval, and adaptation of this strategy, all existing MoPH subject specific strategies will be reviewed, revised, and realigned in line with the national health policy and the strategy.

As part of implementing the strategy, the MoPH will develop national annual action plans, with targets to be reached by the end of each year. The Planning Department of the MoPH will develop and share a standard template with all MoPH technical units. It also will coordinate preparation of the annual action plans in close consultation with all relevant MoPH internal and external stakeholders.

Figure 3: Systematic MoPH approach to implementation



12. RESULTS-BASED MONITORING, EVALUATION, AND REPORTING

In tracking progress toward the targeted strategic goals, results, and outcomes, the MoPH will focus on results based M&E, which emphasizes both implementation tracking and achievement of outcomes. It will involve regular collection of information on how effectively the MoPH and the sector as a whole is performing, and also demonstrate whether projects, programs, policies, strategies, and associated interventions are achieving their stated goals and desired outcomes.

12.1 Progress Monitoring and Results Report

One of the most critical aspects of the implementation of this National Health Strategy 2016–2020 will be the measurement and analysis of progress and performance toward the stated goal, objectives and results under the strategy.

The MoPH will use three interrelated M&E frameworks that will guide the monitoring, reporting, and review at these two levels:

1. Strategic monitoring, review, and reporting (sector-wide: half-yearly, mid-term, and end-term)
2. Operational monitoring and reporting (output level: monthly, quarterly, annually)
3. National development level health impact monitoring and reporting

12.2 Strategic Monitoring and Reporting: Key Sector-wide Indicators

A sector wide strategic results based M&E framework has been developed for each of the six national health strategic areas. Together these form the strategy sector-wide strategic results based M&E framework – see annex B.

A detailed operational level results based M&E framework has been developed for each of the six strategic areas. Together these form the operational-level results based M&E framework. For the 35 strategic results of the strategy, a number of indicators will be monitored at the operational level on a monthly, quarterly, and annual basis. The MoPH will publish a separate document, volume 1 of this strategy, on M&E.

12.4 National Development Level Monitoring: Health Impact Indicators[46]

As part of national health strategy implementation and monitoring the MoPH has also identified a selected set of ten health impact indicators. Along with impact indicators from all the other major sectors, these indicators underpin and help track the progress and overall development of Afghanistan. The indicators will also be part of the ANPDF's monitoring and evaluation indicators. Except for couple of exceptions, in general the following impact indicators will be measured every five years through household survey, such as the Afghan health and demographic survey.

[46] Note: for the national development health impact M&E framework see annex B

13. HEALTH EXPENDITURE, NHS COSTING, AND HEALTH SECTOR RESOURCES

Afghanistan has a higher total health expenditure as a percentage of the GDP (9.5%), than the regional average (4.2%). It is also significantly higher than any of its neighbors, such as Pakistan (3.0%), China (5.1%), and Iran (4.6%). However, this comparatively high health expenditure does not translate into a higher level of funding for the health sector, as Afghanistan's total health expenditure per capita (US$71) is only higher than that of Pakistan (US$36) and Tajikistan (US$48). Meanwhile, with only a 5 percent government contribution it is the lowest among all of the countries in the region.[47]

Although the per capita total health expenditure has increased from US$56 to US$71 in the two year period between the two rounds of national health accounts, in 2011–2012 and 2014, the share of the main sources of funding has remained fairly constant. The proportion contributed by the international community has increased slightly from 20.8% in 2011–2012 to 23% in 2014; private sources have declined in the same proportion. Overall, private out-of-pocket expenditure is still close to three-quarters of total health expenditure[48].

The costing of this national health strategy implementation currently being conducted by the MoPH with technical assistance from USAID supported HSR project experts. The final costing of the strategy along with available resources and associated financing gaps will be published as an extension to this strategy by the end of September 2016.

This section presents an estimate of possible total public resources for the health sector that may be available toward financing the implementation of the strategy. It considers past actual budgets and expenditures for the period of the last strategy 2011–2015, and prospective on- and off-budget allocations from both government and donors. To avoid double counting, the MoPH relied only on the figures provided by the donors and technical partners. In taking this approach, the MoPH used an in-house data collection tool to collect the historical budget/allocations as well as prospective allocations data up to 2020.

The MoPH could not obtain information on health program costs from a number of partners; others could not report due to their own internal policies and procedures. Thus it had to make some estimations and assumptions based on the available 2016 finances and historic budget allocations and expenditure data. For this reason, MoPH suggests that the reader to interpret the figures outlined in this section with caution. Based on the data received from both the MoPH and the relevant donors, the estimated budget section of the table below was calculated based on an assumption that there will be a 2 percent annual increment to both government and donors' allocations (closely aligned with the country's population growth rate of 2.5%).

Table 8 below shows that for the last strategy period of 2011–2015, the total on-budget allocation, including both the development and ordinary budgets, was approximately US$1.4 billion, whereas the actual expenditure or execution was just below US$1 billion, an execution rate of about 72 percent. The off-budget numbers were US$1.2 billion and US$981.4 million respectively, with an execution rate of about 81 percent.

On the other hand, the estimated total on-budget allocation (including both the development and ordinary budgets) for the new national health strategy period of 2016–2020 would be

[47] Sources: National Health Accounts 2014, WHO Statistics 2014
[48] National Health A ccounts2014

approximately US$1.9 billion—estimated as an optimistic 35.5 percent increase, with the off-budget number decreasing only negligibly. Thus, the total projected allocation to the health sector for 2016–2020 would be around US$3.1 billion, a 19 percent increase compared to the total allocation for 2011–2015.

Table 8: Summary Table for Health Sector Budget and Execution (US$)

Period			2011–2015		2016–2020
Type of Budget		**Sources**	**Budget**	**Execution**	**Estimated Budget**
On-Budget	Development Budget	SEHAT	286,900,000	221,480,000	1,025,000,000
		Government and Other Sources and Grants	812,100,003	506,043,002	541,565,072
	Ordinary Budget	Government and Other Sources and Grants	294,532,269	272,095,385	321,249,021
	Total On Budget	Including All on Budget	1,393,532,272	999,618,387	1,887,814,093
Off-Budget	Direct Donor Contributions	Donors	1,210,533,900	981,436,306	1,202,455,809
Total (On and Off Budget)			**2,604,066,172**	**1,981,054,693**	**3,090,269,902**

14. RISKS AND KEY SUCCESS FACTORS

The effective implementation of the National Health Strategy 2016–2020 depends on some critical success factors and faces a number of risks, as outlined below.

Government ownership and leadership

Strong ownership and effective leadership go hand in hand and are at the heart of a well coordinated and effective health system. Increased advocacy and political ownership, and effective joint coordination are important along with 'country ownership'.

Security

One of the critical overarching challenges facing development in Afghanistan is its continuing insecurity. This has adverse impacts on all aspects of the health system. It results in limiting both health services and access in many parts of the country.

Good governance

Public systems have been strengthened somewhat to detect irregularities, and the government has shown heightened commitment and initiative to act on corruption. However, weak governance and corruption remain critical risks for any investment, including in the health sector. Any potential mismanagement and/or misuse of funds and other resources pose a considerable threat to the overall success of the national health policy and the strategy.

Macroeconomic stability

A sound and stable macroeconomic situation in the country is absolutely vital for its' success, otherwise funding gaps will be unsustainable.

Evidence-based strategy, planning, and implementation

Use of evidence in preparation of plans and strategies seem to be problems at all levels. The available data need to be converted into meaningful information products that can support planning and decision making.

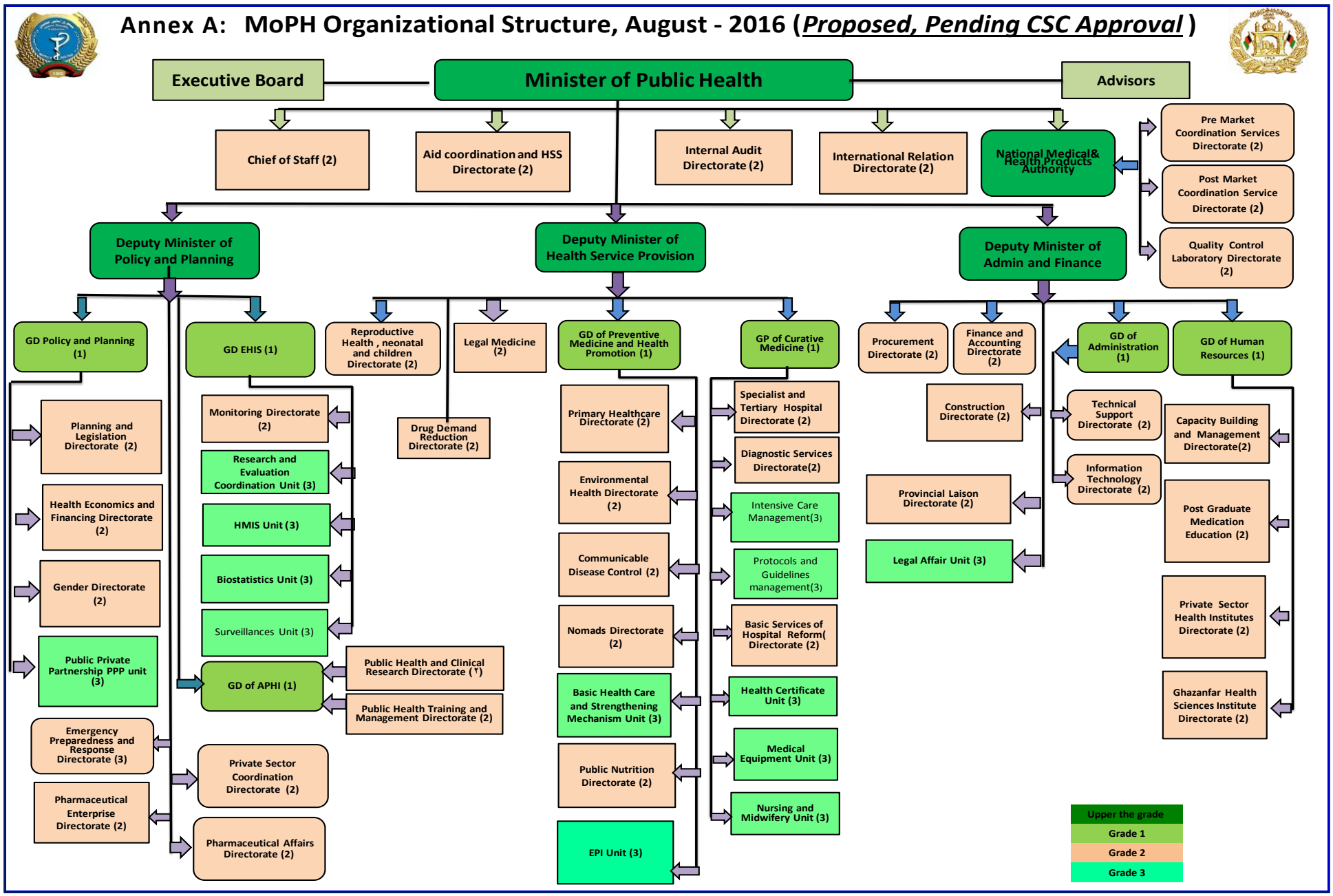
Unified stakeholders' coordination, commitment, and support

Key stakeholders appear to agree about the importance of having a more coordinated, strengthened, efficient, and integrated service mechanism across the health sector. However, the path to achieving this mechanism, along with vibrant private sector participation at times produces both winners and losers in the process. Thus, anything short of a genuine strong commitment and unified support from all stakeholders will pose a serious risk toward the successful implementation of the strategy.

Effective regional integration

ANDS defines regional cooperation as one of the crucial cross-cutting elements of its national development for most key sectors, including health. During the implementation of the national health strategy increased and strengthened regional cooperation in a systematic manner is critical for health sector development and prosperity.

Annex A: MoPH Organizational Structure, August - 2016 (*Proposed, Pending CSC Approval*)



ANNEX A continued. FUNCTIONS OF THE MoPH

Ministry of Public Health, Afghanistan

Accountable to: H.E. The President of Afghanistan and the People of Afghanistan

Mandate of the Ministry of Public Health

The Ministry of Public Health is the lead governmental institution for the health of the people of Afghanistan. Its mandate falls within the areas of leadership and governance, institutional development, policy and strategic direction, and health for all through public health interventions and health services.

Functions of the Ministry of Public Health

The work of the Ministry is undertaken within the framework of the wider political context and desired functioning of the state, and the implications for a government institution. Towards fulfillment of the mission of the Ministry of Public Health, the functions of the Ministry are:

- The policy and strategic direction of the health sector and securing the implementation and delivery of the policy priorities.
- Good governance of the health sector especially accountability, transparency and zero tolerance for corruption, and the sound, effective functioning of the Ministry of Public Health as a state institution.
- Accountability to citizens, respecting their right to health and compassionate care, and responding to their health needs with effective, evidence based interventions.
- Contributing to state legitimacy through getting results that make a difference on-the-ground and have a sustainable impact.
- Effective advocacy for inter-sectoral action for health and enacting enabling health legislation.
- Regulation of food, medicines, and medical technologies, of providers of health programmes, and for the effective management of the health sector.
- Mobilization, and efficient and equitable allocation of resources for enhancing and sustaining access to affordable, quality health services and public health for all.
- Effective aid management and coordination of all development partners and other agencies undertaking health and health related work.
- Sound human resource planning, production, procurement, management and financing.
- Continuous quality improvement of health services and public health through standard setting, monitoring compliance with standards and systematic monitoring and evaluation of health programmes.
- Transparency, accountability and efficiency in the utilization of resources and procurement and management of all health sector goods, works and services.

ANNEX B. SECTOR WIDE M&E FRAMEWORK

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework								
Strategic Area 1: Governance								
				Targets				
Sub-result(s)	**Indicator Name**	**Unit of Measure**	**Baseline**	**Mid Target**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
Strategic result 1: Appropriate laws, regulations, and procedures developed, updated and/or amended, simplified, and effectively enforced at both national and subnational levels	% of developed and updated laws, regulations, anticorruption strategy and procedures enforced	Percentage	N/A	30%	70%	Mid-end strategy/GDPP	Assessment	**Numerator:** Number of updated laws, regulations, and procedures enforced **Denominator:** Total number of updated laws, regulations, and procedures
Strategic result 2: Enhanced culture of transparency and accountability among the MoPH and all of its stakeholders at all levels								
Strategic result 3: Increased institutional and individual capability to effectively exercise good governance practices and be responsive to people's voices and health needs	Proportion of good governance practices exercised	Percentage	N/A	40%	80%	Mid-end strategy/GDPP	Evaluation	**Numerator:** Number of good governance practices exercised **Denominator:** Total number of good governance practices (accountability, setting a shared direction, stewarding of resources and engaging stakeholders)

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework								
Strategic Area 1: Governance								
				Targets				
Sub-result(s)	**Indicator Name**	**Unit of Measure**	**Baseline**	**Mid Target**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
Strategic result 4: Improved public perception of the health sector and effective advocacy at the national and subnational levels	Existence of evidence-based advocacy mechanism at community level	Number	N/A	1	1	Mid-end strategy/GDPP	Evaluation/ public perception surveys	Existence of evidence-based advocacy mechanism at community level
Strategic result 5: Increased understanding and practice of the 'country ownership' and 'meaningful partnership' concepts among MoPH and all development and implementing partners	Existence of formal consultation mechanisms at national and subnational levels	Number	N/A	1	1	Mid-end strategy/GDPP	Evaluation	Existence of formal consultation mechanisms at national and subnational levels

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework											
Strategic Area 2: Institutional Development											
				Targets							
Subresult(s)	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
Health System: Sub-results (1,3,8,9,10)											
Strengthened national and local capacity for effective health planning and establishing effective linkages between plans, budgets, and resource use, with meaningful participation from all stakeholders	Proportion of departments having unified annual plans Proportion of departments implemented their annual plans	%	0%	25%	50%	75%	100%	100%	Annual/Directorate of Planning/GDPP	MoPH annual plans records	**Numerator:** number of departments having annual plans, capturing on/off budgets without overlap and implemented **Denominator:** Total number of MoPH departments at central and provincial levels
Improved procurement system and supply chain management for quality and timely health services, goods, works, and products	Proportion of procurement episodes completed in timely manner	%	14 months	12 months	11 months	10 months	9 months	9 months	Annual/ Procurement Directorate	Review of procurement plans	**Numerator:** number of procurement episodes completed in timely manner **Nominators:** Total number of procurement episodes **Denominator:** Average duration of procurement time, as predicted in the -

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework											
Strategic Area 2: Institutional Development											
				Targets							
Subresult(s)	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
											national procurement law
Health Financing: Sub-results (2)											
Improved health financing mechanisms and increased domestic revenue generation and effective mobilization toward gradual sustainability and achievement of universal health coverage	Proportion of out-of-pocket expenditures by households	%	73%	71%		66%		60%	Biannual HEFD/GDPP	NHA	**Numerator:** Out-of-pocket expenditures by households **Denominator:** Total Health Expenditures
	Proportion of government budget allocated to health	%	4.8%	5.5%	6.5%	7.5%	8.5%	10%	Annual HEFD/GDPP/Finance Department	National Annual Budget of the GIRoA	**Numerator:** amount of allocated budget to health sector **Denominator:** Total national annual budget of the GIRoA
Private Sector: Sub-results (4)											
Greater private sector engagement and participation in health effectively supported, coordinated, and	Proportion of private health sector providers complying with minimum required	%	N/A	60%	70%	75%	78%	At least 80%	Annual/DPSC/HMIS/M&E	HMIS/MOPH Records/ MRS Database/CSO Records/ Surveys	**Numerator:** number of private health providers (hospitals, clinics, diagnostic facilities and labs) providing services according to

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework											
Strategic Area 2: Institutional Development											
				Targets							
Subresult(s)	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
regulated for improved provision of quality health services and products	standards										MRS **Denominator:** total number of private health providers (hospitals, clinics, diagnostic centers and labs)
Public Private Partnership: Sub-results (5)											
Strengthened overall PPP capacity, and strategic PPPs particularly focusing on secondary and tertiary care developed and fostered	Number of private hospitals operating through public-private partnerships (PPPs)	#	0	1	1	1	0	3	Annually/ GDCM, HEFD, DPSC	PPP unit annual report	Total number of PPP hospitals
Pharmaceuticals (Regulatory): Sub-results (6)											
Strengthened pharmaceutical and health products regulatory systems	Proportion of medicines in the market registered by NMHRA	%	TBD	-	-	5% increase from Y1	-	5% increase from Y3	Biannually/ NMHRA	NMHR post-marketing surveillance report	**Numerator:** Count number of medicines collected from market that are registered by NMHRA and meet

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework											
Strategic Area 2: Institutional Development											
				Targets							
Subresult(s)	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
ensuring the quality, safety, and efficacy of medicines and other associated products	Proportion of medicines in the market that meet pharmacopoeia quality standards										pharmacopeia quality standards **Denominator**: total number of medicines randomly collected from the market
Financial Management: Sub-results (7)											
Strengthened financial management system for improved program efficiency	Annual ordinary budget execution rate	%	99%	99%	100%	100%	100%	100%	Annually/ DBD/ Directorate of Planning/Finance Department	MoPH annual reports/MoF annual reports	**Numerator:** Amount of budget executed **Denominator:** Total annual ordinary budget
	Annual developmental budget execution rate	%	70%	85%	88%	90%	92%	95%	Annually/ DBD/Planning Directorate/Finance Department	MoPH annual reports/MoF annual reports	**Numerator:** Amount of budget executed **Denominator:** Total annual development budget

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework											
Strategic Area 3: Public Health											
				Targets							
Result	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
Reduced preventable deaths, illness, and disability through provision of cost-effective, high-impact evidence-based public health interventions	Percentage of live births attended by skilled health personnel during a specified time period	%	50	53	56	59	62	65	Annual routine facility reports, every 3-5 years from survey	Household Survey	**Numerator:** Number of births attended by skilled health personnel (doctors, nurses, or midwives) trained in providing life-saving obstetrics care, including the necessary supervision and care, made available to women during pregnancy, childbirth, and the postpartum period, to conduct delivery on their own, and care for newborns. **Denominator:** The total number of live births in the same period. **Skilled birth attendant:**
	Proportion of children under five years who are stunted	%	40	38	37	36	35	34	Every 3–5 years	Population-based household surveys, national nutritional surveillance system	**Definition:** Percentage of stunted (moderate and severe) children ages 0–59 months (moderate = height for age below -2 standard deviations from the WHO Child Growth Standards median; severe = height for age below -3 standard deviations from the WHO Child Growth Standards

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework											
Strategic Area 3: Public Health											
				Targets							
Result	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
											median. **Numerator:** Number of children ages 0–59 months who are stunted. **Denominator:** Total number of children ages 0–59 months who were measured. **Method of measurement:** Percentage of stunted (moderate and severe) children ages 0–59 months (moderate = height for age below -2 standard deviations from the WHO Child Growth Standards median; severe = height for age below -3 standard deviations from the WHO Child Growth Standards median. Children's weight and height are measured using standard equipment and methods (e.g., children younger than 24 months are measured lying down, while standing height is measured in children ages 24 months and older).

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework											
Strategic Area 3: Public Health											
				Targets							
Result	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
		Measles %	61					85	Annual tracking	Household survey	**Definition:** Percentage of the target population that has received the last recommended dose for each vaccine recommended in the national schedule, by vaccine. The national routine immunization schedule includes: Bacillus Calmette–Guerin); polio; rotavirus; diphtheria, tetanus, pertussis-Hepatitis B-hemophilic influenza type B vaccine (DTP-HepBHib); measles; rubella; tetanus toxoid; influenza; and others as determined by the national schedule. **Numerator:** The number of individuals in the target group for each vaccine that has received the last recommended dose in the series. For vaccines in the infant immunization schedule, this would be the number of children ages 12–23 months who have received the specified vaccinations before their first birthday.
	Immunization coverage rate by vaccine for each vaccine in the national schedule*	DPT3%	60					85			
		Tetanus Toxoid (TT)%	91	92	94	95	96	100			
		Polio (cases)	20	5	0	0	0	0			

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework											
Strategic Area 3: Public Health											
				Targets							
Result	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
											Denominator: total number of individuals in the target group for each vaccine. For vaccines in the infant immunization schedule, this would be the total number of infants surviving to age one. **Method of measurement:** At birth: BCG, HepB, oral polio vaccine At 6, 10, and 14 weeks: DTP-HepB-Hib, PCV, rotavirus, oral polio vaccine (with one dose of inactivated polio vaccine) At 9 months: measles At 18 months measles TT: multiple
	Percentage of children under five years of age with suspected pneumonia taken to a health facility	%	61	65	70	75	80	80	Every 3-5 years	Household surveys	**Definition:** Percentage of children under five years of age with suspected pneumonia (cough and difficult breathing NOT due to a problem in the chest, and a blocked nose) in the two weeks preceding taken to an appropriate health facility or provider. The definition of “appropriate” care provider

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework											
Strategic Area 3: Public Health											
				Targets							
Result	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
											varies between countries. **Numerator:** Number of children with suspected pneumonia in the two weeks preceding the survey taken to an appropriate health provider. **Denominator:** Number of children with suspected pneumonia in the two weeks preceding the survey. **Method of measurement:** The definition of ARI used in the DHS and MICS was chosen by group and is based on the mother's perceptions of a child with a cough, breathing faster than usual with short, quick breaths, or having difficulty breathing, excluding children who had only a blocked nose.
	Children with diarrhea receiving oral rehydration	%	TBD						Every 3-5 years	Household survey, routine facility information	**Definition:** Percentage of children under five years of age with diarrhea in the last two weeks receiving ORS (fluids made from ORS packets or

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework											
Strategic Area 3: Public Health											
				Targets							
Result	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
	solution (ORS)									systems/ HMIS	prepackaged ORS fluids) **Numerator:** Number of children under five years of age with diarrhea in the two weeks preceding the survey given fluid from ORS packets or pre-packaged ORS fluids. **Denominator:** Number of children with diarrhea in the two weeks preceding the survey. **Method of measurement:** According to the DHS, the term(s) used for diarrhea should encompass the expressions used for all forms of diarrhea, including bloody stools (consistent with dysentery), watery stools, etc. The term encompasses the mother's definition as well as locally used term(s).

National Health Strategy 2016–2020: Sector Wide Results M&E Framework											
Strategic Area 4: Health Services											
				Targets							
Sub-result(s)	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
Strategic result 4.1 Enhanced access to improved and updated quality BPHS and EPHS services	Number of new public health facilities established and upgraded	#	2406	120	120	120	120	480	Annually	HMIS	**Numerator:** New health facilities established/ upgraded **Denominator:** Total health facilities targeted
Strategic result 4.2 Improved quality and increased access to wide range (defined) of tertiary services.	Patient satisfaction index	%	73.9	2.5	2.5	2.5	2.5		Annually	BSC 2015	**Numerator:** Number of satisfied patients **Denominator:** Total number of patients interviewed

National Health Strategy 2016–2020: Sector Wide Results M&E Framework											
Strategic Area 4: Health Services											
				Targets							
Sub-result(s)	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
Strategic result 4.3 Improved pharmaceutical services management, ensuring increased access (physical accessibility, availability, affordability, and acceptability) and rational use	Proportion of the stock-out of the essential medicines specified for a health center	%	Estimated 35%	30	25	20	15	10	Annually Pharmaceutical services Directorate	Monitoring reports	**Definitions:** % of stock out of the essential medicines, which are in specified in the related health Computation: **Numerator:** Number of essential medicines stocked out in a year in the health facility for more than 3 days **Denominator:** Total number of essential medicines specified for the health facility

National Health Strategy 2016–2020: Sector Wide Results M&E Framework											
Strategic Area 4: Health Services											
				Targets							
Sub-result(s)	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
of medicines and health commodities	Proportion of rational use of antibiotics in public health centers	%	Estimated 55%	60	65	70	75	80	Annually Pharmaceutical services Directorate	Monitoring reports	**Definition:** Proportion of the rational use of antibiotics to be checked in prescriptions during monitoring visits to health centers **Numerator:** Number of prescriptions in the health center, prescribe antibiotics on rational basis during a quarter **Denominator:** Total number of prescriptions, where any antibiotic is prescribed during a quarter

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework											
Strategic Area 5: Human Resources for Health (HRH)											
Result: Competent and motivated health workforce effectively developed, deployed, and retained in line with current and future requirements in an efficient and cost-effective manner.											
				Targets							
Sub-result(s)	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
Strategic result 5.1 Improved human resource planning and coordination, ensuring better geographical and gender balance in health management and services provision	Proportion of female health workers in the health sector (both public and private)	%	30%	32%	35%	37%	40%	42	Annually/ GDHR	HRMIS Reports	**Numerator:** Proportion of female health workers in both public and private health sectors **Denominator:** Total number of health workers in both public and private health sectors *Health workers as by WHO
Strategic result 5.2 Strengthened systems for effective Human Resource for Health (HRH) management.	Proportion of health facilities with at least one female health worker	%	65	67	70	75	80	85	Annually/ GDHR/GDPP	Revised policies/ procedures	Number of revised HRH policies and practices implemented and/or adopted

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework											
Strategic Area 5: Human Resources for Health (HRH)											
Result: Competent and motivated health workforce effectively developed, deployed, and retained in line with current and future requirements in an efficient and cost-effective manner.											
				Targets							
Sub-result(s)	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
Strategic result 5.3 Improved human resources for health regulation and practices through establishing regulatory frameworks and accreditation systems	Percentage of public and private health facilities licensed	%	0	5	10	15	20	25	Annual/AfIMC	AfIMC Registration Book	**Numerator:** Number of public and private health facilities licensed[49] **Denominator:** Total number of public and private health facilities
Strategic result 5.4 Health workforce capacity adequately developed based on health system needs	Number of MoPH Tashkeel employees completing related in-service trainings	%	0%	20%	40%	60%	70%	75%	Annually/ GDHR	TMIS Reports	**Numerator:** Number of MoPH Tashkeel employees completing related in-service trainings **Denominator:** Total number of MoPH Tashkeel employees

[49]Those Health Facilities licensed Accreditation System Afghan National Medical Council.

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework											
Strategic Area 6: M&E, Learning, and Knowledge/Evidence-Based Practices Result:											
				Targets							
Sub-result(s)	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
Strategic result 6.1: Strengthened, effective, and visible MoPH stewardship role in the overall health information system **Strategic result 6.2:** Active support of operations and health system research, monitoring, evaluation, vital statistics, HMIS, and surveillance including capacity building **Strategic result 6.3:** Strengthened monitoring and evaluation frameworks and responsive surveillance systems, and effectively used leading to improved data collection, utilization, and dissemination at all	Data use index score	Score	0	50%	70%	75%	80%	80%	Annual/GD HIS	Refer to the index score table	Refer to the index score table
	Number of provinces that monitor at least 90 percent of health facilities once in a year	Number	0	10	25	28	30	30/ 34	Annual/GD HIS and Monitoring	Provincial monitoring reports	Each province will monitor 90 percent of health facilities at least once a year. **Numerator:** number of health facilities visited at least once a year **Denominator:** total number of health facilities in the province The provinces that score 90 percent or above will be counted against this indicator.
	Proportion of outbreaks responded to within 24–48 hours	Proportion	N/A	80%	85%	85%	90%	95%	Annual//GD HIS and Surveillance		**Numerator:** Number of outbreaks responded within 24–48 hours **Denominator:** Total

National Health Strategy 2016–2020: Sector-Wide Results M&E Framework											
Strategic Area 6: M&E, Learning, and Knowledge/Evidence-Based Practices Result:											
				Targets							
Sub-result(s)	**Indicator Name**	**Unit of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibility**	**Data Source**	**Indicator Definition / Calculation Methodology**
levels **Strategic result 6.4:** Effectively detected, investigated, and responded to disease outbreaks and PHEIC within 24–48 hours **Strategic result 6.5:** Improved culture of knowledge and evidence-based decision-making practices at all levels											number of outbreaks detected

ANNEX C. HEALTH IMPACT M&E FRAMEWORK

National Health Strategy 2016–2020: Health Impact M&E Framework											
No.	**Indicator Name**	**Unite of Measure**	**Baseline**	**YR1**	**YR2**	**YR3**	**YR4**	**End Target**	**Frequency/ Responsibilities**	**Data source**	**Definition**
1	Annual budget execution rate	%	73%	74%	75%	80%	85%	87%	Annually/ DBD/ Directorate of Planning/Finance Department	MoPH annual reports/MoF annual reports	Numerator: Amount of budget executed Denominator: Total annual ordinary budget
2	Total fertility rate	%	5.3	5.1	5	4.9	4.8	4.7	Every 3-5 years from survey	Household Survey	Average number of children per mother during child bearing age.
3	Maternal mortality ratio	#	TBD	TBD	TBD	TBD	TBD	TBD	Every 5-10 years from survey	Household Survey	Numerator: Number of deaths from pregnancy related- causes in time period Denominator: Number of live birth in time period
4	Access to health care within two hours	%	91%	92%	93%	94%	95%	96%	Every 3-5 years from survey	Household Survey	The walking distance to the public health facilities in hours
5	Neonatal mortality rate	#	22	21	20	19	18	17	Every 3-5 years from survey	Household Survey	Neonatal Mortality rate is the number of resident newborns in a specified geographic area dying at less than 28 days of age divided by the number of resident live births for the same geographic area, and multiplied by 1,000.
6	Infant mortality rate	#	45	43	41	39	37	35	Every 3-5 years from survey	Household Survey	Definition: Neonatal Mortality rate is the number of resident newborns in a specified geographic area dying at less than 28 days of age divided by the number of resident live births for the same geographic area, and multiplied by 1,000.

National Health Strategy 2016–2020: Health Impact M&E Framework											
7	Under five mortality rate		55	52	50	48	45	42	Every 3-5 years from survey	Household Survey	The probability of a child born in a specific year of period dying before reaching the age of 5 years, expressed per 1000 live births
8	Proportion of out-of-pocket expenditures by households	%	73%	71%		66%		60%	Biannual HEFD/GDPP	NHA	Numerator: Out-of-pocket expenditures by households Denominator: Total Health Expenditures
9	Proportion of children under five years who are stunted	%	40	38	37	36	35	34	Every 5 years	Household survey	Percentage of stunted (moderate and severe) children ages 0–59 months (moderate = height for age below -2 standard deviations from the WHO Child Growth Standards median; severe = height for age below -3 standard deviations from the WHO Child Growth Standards median.
10	Number of Doctors per 10,000 population	#	3.3	3.5	3.8	4	4.3	4.5	Annual	Human resource Information system	The existence of at least one doctor per ten thousand population

ANNEX D. STRATEGY DEVELOPMENT METHOD AND PROCESS

Under the strategic leadership and guidance of Dr. Ferozuddin Feroz, the Minister of Public Health, the National Health Strategy 2016–2020 was developed through an extensive participatory, collaborative, and transparent process involving all key internal and external stakeholders, including relevant Ministry of Public Health (MoPH) staff and departments, provincial public health directors, other governmental entities, donors and development partners, implementing partners, the private sector, civil society organizations, professional umbrella bodies, and nongovernmental organizations.

The process was owned and led by the MoPH. For overall planning, coordination, and development of the strategy, the minister appointed a national health strategy development and coordination team. The team worked under his guidance and reported progress to him on a regular basis. This team was headed by Dr. Ahmad Jan Naeem, the Deputy Minister of Policy and Planning, and comprised Dr. Daud Azimi, the Director General of the General Directorate of Policy and Planning; Dr. Sarah Safi, the Director of Planning; and Mr. Tariqul Khan, an international advisor, supported through technical assistance from USAID/Afghanistan. Dr. Sarah Safi and the Planning Directorate also played the key role of being the Strategy Secretariat.

The development process and its integrity, inclusiveness, validity, and transparency were the key focus of the leadership from the beginning. The focus was to ensure that the strategy would firstly be strategic yet practical and providing specifics; results focused; and would reflect the knowledge, experience, solutions, vision, and aspirations of those who work in the Afghan health and related sectors. Secondly, it should be comprehensive but focused. And thirdly, owned by all involved, including those entrusted to carry out its implementation.

In February 2016, with technical and logistical support from USAID Afghanistan, Minister Feroz held a Minister's Results Workshop for the National Health Strategy 2016–2020; senior MoPH officials and all major stakeholders attended it. Through discussions the participants together defined the goal and associated results of the strategy. They also agreed to follow the National Health Policy 2015–2020 to define the key strategic areas in line with the five main policy priority areas. The group also decided to add a sixth strategic area. The participants then worked in parallel in six working groups (one for each strategic area) to develop the planned result for each specific strategic area and associated sub-results. Following the working group sessions, consensus was reached on all the planned results during the plenary session. A health strategy results framework was then drafted.

The strategic areas and results framework were further revised based on feedback from the members of the National Health Strategy Consultative Group, comprising representatives from the MoPH (directors general and directors), relevant governmental line ministries, development partners, implementing partners, civil society organizations, professional umbrella bodies, and NGOs. The consultative group was kept informed of major developments; in turn, it provided valuable advice at different stages of strategy development.

The MoPH created six task forces - one for each of the strategic areas. Each task force was led by a chair, usually a MoPH director-general of a relevant general directorate; each also had a co-chair, a facilitator, and an array of members from all relevant MoPH departments and directorates, and the other stakeholders mentioned in the above paragraph. On average, each task force consisted of about 17–20 members.

Under the direction of the Strategy Development and Coordination Team, the MoPH also appointed the General Directorate of Policy and Planning (GDPP) Review Team consisting of eight members—four from within the MoPH, three from development partners and implementing partners, and the international strategic consultant. The GDPP review team members were divided into three sub-teams, each responsible for two strategic areas to work with, review, and revise the work of the two associated task forces.

In assembling the GDPP Review Team and the task forces, the MoPH leadership and the Strategy Development and Coordination Team, paid close attention to the availability of diverse expertise, with the aim of developing a comprehensive, practical, and results-oriented strategy. Each of the task forces went through the strategy results framework and provided comments and feedback. This process was particularly effective and efficient, as the chair/co-chair of each task force and other senior MoPH staff were also part of the ministers' results workshop. The ministerial workshop facilitator and the GDPP results team revised the results framework based on the feedback from the task forces.

In parallel, to effectively guide the development of the strategy, the Strategy Development and Coordination Team produced a master document a 'National Health Strategy 2016–2020 Development: Master Directional and Process Document'. This document contained a work plan (roadmap) for the development of the strategy, further defined the finalized strategic and the overall results framework, and provided clear technical definitions, detailed guidance, and templates for each of the task forces to develop the critical matrices for their strategic areas.

Each task force worked on the detailed strategic results matrix, key challenges and associated barriers, strengths and opportunities, and the two results M&E frameworks, one for sector-wide and another for operational monitoring. In doing so, the task forces built upon their knowledge of the health and related needs of the population, agreed institutional and service delivery bottlenecks, what works well and does not work well, as took into account international agreed health goals, such as the MDGs and SDGs. The master document also outlined specific guidelines for the task forces to formulate and draft the narrative sections.

With support from the Strategy Development and Coordination Team and the Strategy Secretariat, the task forces produced the four critical matrices mentioned above and the first draft of the narrative section for their individual strategic areas. The production of the matrices facilitated the drafting of the narrative section, which included the following four sub-sections: overview, key challenges and barriers, strengths and opportunities, and achieving results: strategies and key outputs.

Through coordination and facilitation by the Strategy Secretariat, the task forces and the GDPP review team went through a time-consuming process to finalize the first draft of all matrices and the follow-up narrative sections. Working closely with the Strategy Secretariat and the task forces, the General Directorate of Evaluation and Health Information System played a key role in reviewing and finalizing the M&E frameworks for all six strategic areas.

Although individual GDPP review team members initially drafted some of the sections and subsections, all other members of the team subsequently reviewed and revised them. The GDPP then circulated the first draft of the strategy to all relevant internal and external stakeholders. The Strategy Secretariat was the focal point for collecting and compiling all comments and feedback. Subsequently, the MoPH Strategy Development and Coordination Team and GDPP review team made revisions to reflect comments and prepare the next draft. This was then submitted to the Minister who in consultation with some of his senior management and a few of his advisers, and where considered important, in consultation with staff who had helped draft specific elements, produced the final draft.

ANNEX E. LIST OF ACRONYMS

ADHS	Afghanistan Demographic and Health Survey
AMS	Afghanistan Mortality Survey
ANDMA	Afghanistan National Disaster Management Authority
ANDS	Afghanistan National Development Strategy
ANDF	Afghanistan National Development Framework
ANSA	Afghanistan National Standardization Authority
APHA	Afghanistan Private Hospitals Association
BECC	BPHS and EPHS Coordinating Committee
BPHS	Basic package of health services
CBO	Community-based organization
CBRF	Capacity building for results facility
CEO	Chief Executive Officer
CSC	Civil Society Commission
CSO	Civil society organization
DDR	Drug demand reduction
DEWS	Disease early warning system
DGHR	Director General of Human Resources
DHS	Demographic and health survey
DREHC	Disasters Response Emergency Health Committee
EC	European Community
EHIS	Evaluation and health information system
EOC	Emergency operation center
EPHS	Essential package of hospital services
EPI	Expanded program on immunization
EU	European Union
GBV	Gender-based violence
GCMU	Grants and Contract Management Unit
GD-EHIS	General Directorate of Evaluation and Health Information System
GDPP	General Directorate of Policy & Planning
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GIRoA	Government of the Islamic Republic of Afghanistan
GPEI	Global polio eradication initiative
HCCA	Health Care Commission for Accreditation
HEFD	Health Economics and Financing Department
HIS	Health information system
HMIS	Health Management information system
HRH	Human resources for health
HSS	Health system strengthening
IDP	Internally displaced population
IHP+	International Health Partnership
IHS	Institute of Health Sciences
IMR	Infant mortality rate
MDG	Millennium Development Goal
M&E	Monitoring and evaluation
MMR	Maternal mortality ratio
MNCH	Maternal, newborn, and child health
MoF	Ministry of Finance
MoPH	Ministry of Public Health
NCD	Non-communicable disease
NERPH	National all-hazards emergency response plan for health
NGO	Nongovernmental organization
NHA	National health accounts
NMHRA	National Medicines and Health Products Regulatory Authority

NMR	Neonatal mortality rate
NUG	National Unity Government
OOP	Out-of-pocket
PETS	Public expenditure tracking survey
PFM	Public finance management
PHC	Primary health care
PHCC	Provincial health coordination committee
PHD	Provincial health director
PHO	Provincial health office
PLD	Provincial Liaison Department
PPHCC	Provincial public health coordination committee
PPHD	Provincial public health director
PPHO	Provincial public health office
PPP	Public-private partnership
PRSP	Poverty reduction strategy paper
RMNCAH	Reproductive, maternal, newborn, child, and adolescent health
SDG	Sustainable development goal
SEHAT	System Enhancement for Health Action in Transition
SHCC	Strategic Health Coordination Committee
SOP	Standard operating procedure
STCCC	Specialist Tertiary Care Coordination Committee
TA	Technical assistance
TB	Tuberculosis
ToRs	Terms of reference
UHC	Universal health coverage
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Emergency Fund
UNODC	United Nations Office on Drugs and Crime
WB	World Bank
WHO	World Health Organization