Islamic Republic of Afghanistan
Ministry of Public Health

National Child and Adolescent Health Strategy 2009 - 2013

July 2009

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Foreword

Since the re-birth of the Ministry of Public Health in 2002, the preservation of the life of newborns and children and improving their health have been special emphases of this Ministry. We have seen good results as both the infant mortality rate (to 129 deaths per 1000 live births) and the mortality rate of children under 5 (to 191 deaths per 1000 live births) have been reduced by nearly 25%. This translates to meaning we have reduced the annual number of infant and under 5 deaths from approximately 300,000 per year to 200,000. Despite our pride in these accomplishments, much remains to be done. The National Child and Adolescent Health Policy of May 2009 sets out a goal for MOPH of reducing infant and under 5 mortality further to less than 100,000 deaths per year by the year 2013. To ensure that we keep focused on this priority I am establishing a National Maternal & Child Health Committee to meet twice a year to review our progress and direct further action for achievement of this goal of further infant and under 5 mortality reduction by 2013.

This National Child and Adolescent Health Strategy document is the basis for providing a roadmap for how the MOPH and its partners will implement the National Child and Adolescent Health Policy for 2009 to 2013. I ask all to join with me, the staff of the Ministry of Public Health and the health workers throughout Afghanistan to recommit yourselves to this noble goal of further reducing the mortality of our newborns and children under 5. I thank the MOPH partners who also work side-by-side with us in this endeavor, donors like USAID, European Commission, the World Bank, JICA and KOICA; several UN agencies like UNICEF, WHO, and UNFPA; bilateral projects like BASICS, TechServe, and HSSP, and many NGOs. In particular I appreciate the unrelenting efforts of the Child and Adolescent Directorate, which took the lead in this effort, and the specific technical support of USAID/BASICS. Working together we will succeed in meeting these objectives by 2013.

Sincerely,

Dr. Sayed Mohammed Amin Fatimie
Minster of Public Health

List of Acronyms

ANDS	Afghanistan national development strategy
APHI	Afghan Public Health Institute
BASICS	Basic Support for Institutionalizing Child Survival (USAID)
BCC	Behavior change communication
BCG	Bacillus Calmette Guérin (anti-TB vaccine)
BEOC	Basic essential obstetric care
BEmOC	Basic emergency obstetric care
BENC	Basic essential newborn care
BHC	Basic Health Centre
BPHS	Basic Package of Health Services
CAH	Child and adolescent health
CBHC	Community based health care
CEOC	Comprehensive essential obstetric care
CEmOC	Comprehensive emergency obstetric care
CGHN	Consultative Group for Health and Nutrition
CHC	Comprehensive Health Centre
CHS	Community health supervisor
CHW	Community health worker
C-IMCI	Community-based integrated management of childhood illness
CM	Community midwife
Compri-A	Communication for Behavior Change Expanding Access to Private Sector Health Products and Service in Afghanistan (USAID)
CPR	Contraceptive prevalence rate
CRC	Convention on the Rights of the Child
DPT	Diphtheria, pertussis, tetanus vaccine
EC	European commission
EDL	Essential drugs list
EOC	Essential obstetric care
EmOC	Emergency obstetric care
ENC	Essential newborn care
EPHS	Essential Package of Hospital Service
ETAT	Emergency triage assessment and treatment
EU	European union
FAO	Food and Agricultural Organization
GAVI	Global alliance for vaccine and immunization
GF	Global fund
GMP	Growth Monitoring and Promotion
HB	Hepatitis B vaccine
HIB	Hemophilus Influenza B vaccine
HIV/AIDS	Human immunodeficiency virus/Acquired immuno-deficiency syndrome
HMIS	Health management information system
HNS	Health and nutrition sector strategy
HP	Health post
HSC	Health sub-center
HSS	Health systems strengthening
HSSP	Health Services Support Project (USAID)
IEC	Information education communication
IMCI	Integrated management of childhood illnesses
IMR	Infant mortality rate
IUD	Intra-uterine device
IYCF	Infant and Young Child Feeding
JICA	Japan international cooperation agency
KOICA	Korean international cooperation agency
LLIN	Long lasting insecticide-treated nets
M&E	Monitoring and evaluation
MCH	Maternal and child health
MDG	Millennium development goals
MICS	Multi indicator cluster survey

MMR	Maternal mortality ratio
MNH	Maternal and neonatal health
MoPH	Ministry of Public Health
NMCHC	National Maternal & Child Health Committee
NGO	Non-governmental organization
NHSPA	National health services performance assessment
NMC	National monitoring checklist
NMR	Neonatal mortality rate
NRVA	National risk and vulnerability assessment
ORS	Oral rehydration salts
OPV	Oral polio vaccine
PHC	Primary health care
PHI	Pediatric hospital improvement
PPHD	Provincial public health director
PPHO	Provincial public health office
PPHCC	Provincial public health coordination committee
QA	Quality assurance
REACH	Rural Expansion of Afghanistan's Community-Based Healthcare
RH	Reproductive health
RUTF	Ready-to-Use Therapeutic Feeding
STI	Sexually transmitted infection
TB	Tuberculosis
Tech-Serve	Technical Support to the Central and Provincial Ministry of Public Health (USAID)
TT	Tetanus toxoid
UNFPA	United Nations Population Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UXO	Unexploded ordinance
WB	The World Bank
WFP	World Food Program
WHO	World Health Organization

1. Introduction

In spite of impressive progress made in Afghanistan since 2001, the country still has the highest infant and child mortality in the Eastern Mediterranean Region[1], and it is clear that unless additional efforts are made, Afghanistan will not reach the MDG 4 goal. Part of the decline in under five mortality over the past 5 years can undoubtedly be contributed to the fact that many of the effective and affordable interventions that can diminish the infant and child mortality have been introduced and included in the BPHS. The BPHS defines children as a priority target group, and contains many of the life-saving interventions, but is less clear on how to implement the interventions. Still, every day more than 500 children under five die in Afghanistan[2] from a handful of preventable and treatable conditions, known scourges in many developing countries[3], including diarrhea, pneumonia and peri-natal events.

The strategy of the MOPH for implementing the CAH Policy is to address the most prevalent threats to the survival of Afghanistan's children using feasible and affordable approaches that can assure over time national coverage with interventions reaching into every community and home. The MOPH will address these problems as a priority, mindful of the realities of Afghanistan culture, geography, resources and human capacities. The MOPH will endeavor to assure equity and wide applicability of interventions with proven effectiveness, assuring that resources are used to reach those most in need before expanding the range of services provided to those more fortunate.

Because of the critical role of mothers, it is importantly clear that maternal care is an critical and complementary to any child and adolescent health policy – this includes not only all the health and nutrition aspects of maternal care, but also the important elements of female education, access to resources, reduction in gender violence and other concerns favoring women.

This CAH Strategy, attempts to guide the MOPH in the implementation of the critical interventions that have a major impact on mortality of mothers, infants and children receive greatest attention for the period 2009-2013. It is clear that other problems exist for children and adolescents, and the MOPH will address these after introducing but unless the most critical problems have been addressed more efficiently.

In a country where poverty, political instability and insecurity interfere with adequately strengthening the health service delivery system, community-based interventions will be promoted as a main strategy[4]. The child health policy indicates the importance of providing access to services in the community, especially where access to health facilities is difficult or impossible. Strengthening educated demand for and appropriate use of preventive and curative child health interventions will be the backbone of this strategy. The CAH strategy will pay special attention defining what the role of caretakers at home, community and Community Health Workers (CHWs) is. Health facilities provide a broader range of services and interventions for children with such standardized programs as IMCI and GMP (growth monitoring and promotion) and introduction of new vaccines as they become available. Hospitals at all levels will strengthen pediatric care through improved nursing and specialist training and particular attention to emergency and severely ill cases.

The primary focus of many of the interventions is children under five years of age, since they have the highest mortality from the cited conditions. However, many of the interventions are equally successful in treating or preventing illness in older children and adolescents. Ensuring delivery of curative and preventive services at health facilities and in the community makes these services available to children of all ages.

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[1] World Health Organization: World Health Statistics, 2008
[2] MOPH Fact Sheet, Monitoring and Evaluation Directorate, October 2007
[3] Robert Black et al.; "Where and why are 10 Million Children Dying Every Year?" The Lancet, 2003, 361: 2226-34
[4] Rudolph Knippenberg et al., "Systematic scaling up of Neonatal Care in Countries", *The Lancet* Neonatal Survival Series, No. 3 (March 2005)

The Convention on the Rights of the Child clearly indicates that its implementation necessitates not only interdepartmental collaboration within the MOPH, but also intense and focused inter-sectoral collaboration. In many instances, the primary responsibility of the cited strategic interventions does not lie with the CAH directorate. This document will help to guide the CAH Directorate in developing an implementation plan for the period 2009-2013 addressing the main essential components of an integrated package to promote the survival of infants and children.

1.1 Strategy overview

1.1.1 Goal

To reduce newborn and under five mortality and improve child and adolescent health in order to achieve MDG4.

1.1.2 Objectives

- To improve access to and utilization of a package of strategic interventions for child survival, particularly in the areas of greatest need; and
- To provide an enabling environment for child survival where political will, financial and human resources match the burden of disease.

1.1.3 Strategic approaches

- Improve efficiency and quality of service delivery
- Engage and empower families and communities
- Improve leadership and governance for child survival
- Consolidate partnerships; and
- Ensure financial support for child survival

1.2. Guiding principles

This strategy is based on the CAH Policy, which in line with the National Health Policy and National Health and Nutrition Strategy (HNS), and their proposed priority policies and objectives. It also furthers the implementation of the Convention on the Rights of the Child (CRC), which the Islamic Republic of Afghanistan ratified, in particular, but not exclusively, Article 6 on survival and development, Article 7 on access to information, and Article 24 on healthcare and health services. The strategy recognizes throughout the need for interdepartmental, interdisciplinary and inter-sectoral coordination and collaboration in order to reach its goals and objectives

Proposed intervention strategies and practices are evidence-based and integrated in the BPHS and EPHS. They will provide the best quality of care, and address the recipients' needs with respect for their culture. In line with the definition of "child" in the CRC, they ensure a continuum of care for children from pregnancy through infancy, childhood and adolescence till the age of 18, and also from the household through the primary level of care up to the higher level of services.

Interventions targeting specific age groups are represented proportionate to the burden of mortality and morbidity in the age groups, which will allow implementers to focus on those interventions that will contribute most to obtaining the HNS desired outcomes. Some age groups are well-defined, others tend to be flexible and vary in different countries and between multilateral agencies. The age groups cut-offs commonly used in this strategy are given in Annex 7.

1.3 Background

Although progress has been made towards achieving the HNS 2013 and MDG 2015 targets, Afghanistan still figures as the worst country in the Eastern Mediterranean Region for child health indicators[5]. The MOPH child health situation analysis indicates that unless additional efforts are made, Afghanistan will fall short in achieving the goals.

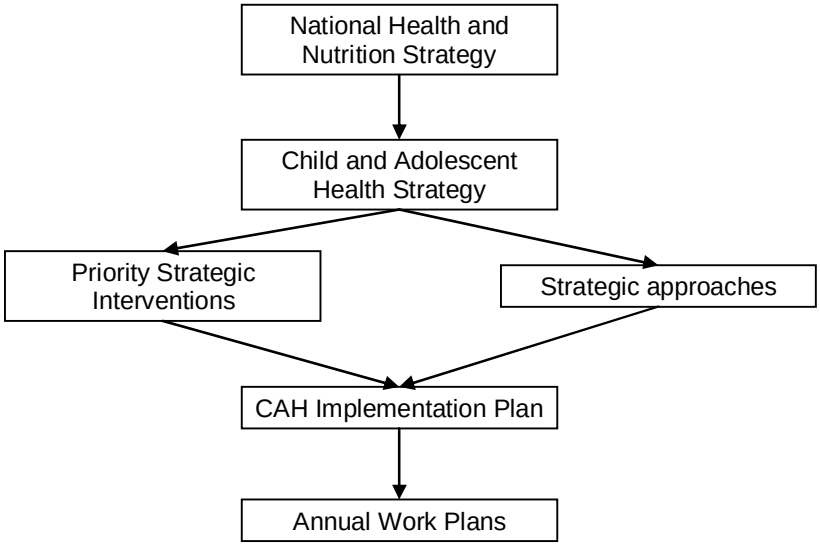
Table 1 Health and Nutrition Strategy/MDG Indicators[6]

Indicator	2000 Baseline	Achievement by 2006	High Benchmark 2010	HNS 2013	MDG 2015
Reduction of U5MR	257 deaths per 1000 live births	191 deaths per 1000 live births	Reduction by 20% to 205 deaths per 1000 live births[1]	Reduction by 35% from the baseline (167)	Reduction by 50% from the baseline (128)
Reduction of IMR	165 deaths per 1000 live births	129 deaths per 1000 live births	Reduction by 20% to 132 deaths per 1000 births[2]	Reduction by 30% from the baseline (115)	Reduction by 50% from the baseline (82)
Increased national immunization coverage among children under one year of age for					
Three doses of Diphtheria, Pertussis & Tetanus (DPT) vaccine	31%	77%	Achieve above 90% coverage	Achieve and sustain above 90% national coverage	Sustain above 90% national coverage
Measles vaccine	35%	68%	Achieve above 90% coverage	Achieve and sustain above 90% national coverage	Sustain above 90% national coverage

1.4 Strategic framework for implementation

The CAH Strategy is part of the general Health and Nutrition Strategy of the ANDS. The Strategy defines priority strategic interventions of proven effectiveness for the Identified problems and gaps and problems, as well as strategic approaches to implement these interventions. This will facilitate the drafting of a detailed implementation plan, which will allow the development of annual work plans for CAH.

[5] World Health Organization: World Health Statistics, 2008
[6] Islamic Republic of Afghanistan, Afghanistan National Development Strategy, Health and Nutrition Sector Strategy 1387-1391, Volume II, Pillar V: Health and Nutrition



2. Priority Strategic Interventions - Components of an Integrated Package

All the priority strategic interventions withheld in the strategy have been proven to be effective in developing country settings for promoting child survival through reduction of neonatal, infant and child mortality[7,8].

Table 2 Priority Strategic Interventions - an integrated package

1. Skilled or improved attendance during pregnancy, delivery and immediate post-partum
2. Neonatal care
3. Breastfeeding and complementary feeding
4. Immunization of mothers and children
5. Micronutrient supplementation
6. Integrated management of sick children
7. Use of LLINs high risk areas
8. Birth spacing

Additional interventions that strengthen the package

a. Improve water, sanitation, and environment
b. Prevention of accidental injuries
c. Promote health at schools
d. Draw attention to adolescent health considerations
e. Monitor changing priorities

2.1 Skilled or improved attendance during pregnancy, delivery and immediate post-partum

Interventions that promote infant and child survival during pregnancy include antenatal care by a skilled attendant providing:

- prevention and treatment of maternal malnourishment
- detection of maternal anemia

[7] Gary Darmstadt et Al., "Evidence-based, Cost-Effective Interventions: How Many Newborn Babies Can We Save?" *The Lancet* 2005, 365, 977-88.
[8] Gareth Jones et Al., "How many child deaths can we prevent this year?" The Lancet 2003, 362, 65-71

- prevention of maternal and neonatal tetanus (TT)
- monitoring for prevention and management of pre-eclampsia and eclampsia
- prevention and treatment of malaria, where there is high risk
- counseling for breastfeeding
- preparation of a birth plan
- detection and early referral of complications

At delivery and immediate post-partum a skilled attendant will
- ensure clean delivery
- use a delivery kit and partograph
- recognize complications and treat or refer as appropriate
- provide Vitamin A and Iron folate supplement to the mother

Identified problems and gaps:
- only about 1/3 of all pregnant women have an antenatal visit with a skilled birth attendant[9]
- uncertainty about the quality of services provided during antenatal visits[10]
- 85% of deliveries take place at home and more than 80% without a skilled birth attendant[11]

Response:
- Improve the counseling skills of the community midwives to convince mothers, families and communities to deliver at facilities with skilled birth attendants;
- Train all health workers in assisting families in preparing a feasible birth plan for a pregnant woman
- Clearly define a package of delivery care within the reach of female CHWs
- Promote clean deliveries even where no skilled birth attendants are available,
- Investigate the feasibility of providing clean birthing kits through social marketing

2.2 Care of the newborn

Evidence-based low-cost interventions that save newborn lives will be promoted regardless where the delivery takes place[12]:
- clean cord care
- newborn temperature care
- initiation of breastfeeding within one hour after delivery
- weighing of babies to assess low birth-weight
- kangaroo mother care for low birth-weight babies
- postnatal care for mother and baby

Identified problems and gaps:
- no clear strategy to provide essential newborn care in facilities without trained birth attendants, nor outside the facilities
- the MOPH Reproductive Health Strategy recommends a post natal visit at 24 hours, at one week and at six weeks after delivery. In practice, even those women who deliver in facilities with skilled birth attendants tend to leave the facility within a few hours after delivery. In many instances it is hardly possible for the facility staff to ensure post natal visits through home visits. Data from household surveys in 13 provinces indicate that less than one third of mothers get a post-natal visit[13]

[9] Afghanistan Health Survey, John Hopkins University for the MOPH, 2006
[10] Afghanistan CAH Situation Analysis, MOPH, 2008
[11] Afghanistan Health Survey, John Hopkins University for the MOPH, 2006
[12] Gary Darmstadt et Al., "Evidence-based, Cost-Effective Interventions: How Many Newborn Babies Can We Save?" *The Lancet* 2005, 365, 977-88.
[13] End of Project Household Survey, REACH, 2006

- care for the newborn is included in the CHW manual, but the module needs revision to be practical[14]
- no clear BCC strategy on newborn care exists[15]

Responses:
In addition to pursuing the ongoing training and deployment of community midwives, the MOPH will include Essential Newborn Care (ENBC) into the routine IMCI and the C-IMCI protocol, adapted from the Indian IMCNI model, thus ensuring that all health workers (re)trained in the above will be able to provide ENBC. The ENBC will be included in the CHW refresher training for Community Case Management planned for 2008-2012. Initial and refresher training in the new IMCI protocol will be organized for all staff seeing children at health facilities.

Awareness in the community, in particular of the WSG, will be raised of the need for post-natal checkups for mother and baby, the need for basic essential newborn care, and the need for Polio 0 and BCG immunization.

All health workers will take the opportunity of post-natal visits and check-ups to inform the mothers and their families of the beneficial effects of birth spacing for the mother and the newly born baby, and inform them about the adequate modern birth spacing methods.

2.3 Breastfeeding and complementary feeding

Ensuring adequate nutrition is important for children and adolescents at all ages.

2.3.1 Promotion of Breastfeeding

Exclusive breast feeding is the ideal means to feed the infant from birth to 6 months of age. Exclusive breastfeeding means that the infant takes only breast-milk, and no additional food, water, or other fluids, except prescribed medicine.

Indentified gaps:
almost all Afghan infants are breastfed at one point during the first six months of life[16], but only 40%[17] to 70%[18] of infants are exclusive breastfed during that period

Responses:
Every effort to encourage and support exclusive BF will be done by mother support groups, CHW and facility staff who will educate the mother, her husband, in-laws and other family members to the importance of exclusive BF for the first 6 months of life. Investigating common beliefs and misconceptions about exclusive breastfeeding will help develop appropriate messages.

Create an enabling environment for mothers, families and caregivers to practice exclusive breastfeeding up to six months during work. Advocate for full compliance in public and private sector with the Government Maternity Law.

Collaborate with Ministry of Trade and Commerce, and Ministry of Justice to create a National Advisory board to oversee implementation, monitoring and enforcement of the Afghanistan National Code on Marketing of Breast-milk Subtitutes.

Collaborate with the IEC and private radio and television for harmonized messages on the importance of exclusive breastfeeding and continued breastfeeding up to 24 months and beyond

[14] MOPH, Community Health Worker Training Manual, 2005
[15] Afghanistan Newborn Health Situation Analysis, 2008, Save the Children-US
[16] Afghanistan Health Survey, John Hopkins University for the MOPH, 2006
[17] End of Project Household Survey, REACH, 2006
[18] Afghanistan Health Survey, John Hopkins University for the MOPH, 2006

Collaborate with the BPHS and EPHS to promote and monitor the baby-friendly status of hospitals and facilities.

2.3.2 Promotion of timely and adequate complimentary feeding
From six months of age onwards, additional foods will be given to the child in frequent and small amounts gradually increasing variety and quantity, while breastfeeding will be continued to 2 years and beyond.

Indentified gaps:
the percentage of children of the age 6-9 months getting liquid and solid complementary food in addition to breastmilk is estimated less than 30%[19,20]
37% of children are stunted at the age of 12 months, and prevalence of underweight is highest in the age group 6-24 months[21]
growth monitoring and promotion have been limited to facility-based initiatives and not been very successful[22]

Specific dietary guidance consistent with local food availability and acceptability will be provided to health workers and CHWs in their training and supervision support:
Collaborate with the MAIL, MRRD and MOE for the broad distribution of detailed complementary feeding recipes, using locally available ingredients. Mothers and their families will get the same information and advice by staff in facilities, by CHWs, by MSG, and by other resource persons in the community (e.g. teachers, religious leaders, …)
In line with IYCF recommendations, focus will be on growth and weight gain of all children under two, in the community and at the health facilities. The MOPH will explore ways of implementing growth promotion, along with growth monitoring at the community level (see Section 9. Operations Research) using peer communication and education through family action groups.

2.3.2 Promotion healthy feeding habits in older children and adolescents

The MOPH will collaborate with the MAIL, MRRD, MOE and MOJ to:
Improve household food security specifically in relation to improving access, availability and diversity of food at the household and in communities;
Promote food diversity through skills-based nutrition education in schools and other settings where children and adolescents gather;
Ensure that foods produced in Afghanistan and imported goods are safe for the consumer through establishment and enforcement of appropriate laws and regulations in line with international standards, and education of the general public on safe and hygienic practices for purchasing, storing and handling

2.4 Micronutrient supplementation

2.4.1 Vitamin A supplementation

For reduction of child mortality, the most important micronutrient supplementation is vitamin A, administered as an oral dose of 200,000 IU every six months to children 6-59 months.

Identified problems and gap:
- Actual reported coverage varies from 44.8[23] to 79.5[24] or higher[25]

[19] MICS, 2003
[20] Afghanistan Health Survey, John Hopkins University for the MOPH, 2006
[21] National Nutrition Assessment, 2005, UNICEF and CDC
[22] MOPH: Growth Monitoring & Promotion in Afghanistan: a review of current policy and practice, 2005

- Highly dependent on polio eradication campaigns

Presently, the main distribution strategy is through polio NIDs. With the NIDs most likely phasing out in the period of this CAH strategy, alternative distribution strategies, combining CHWs, outreach activities and mobile health teams will be explored. This will also involve a IEC/BCC effort to convince all health care providers and care takers of children of the importance of vitamin A supplementation.

Iron and folic acid supplementation will be provided routinely through antenatal care, the product will be made available at all levels of the public health system, including at the health post level.

Vitamin A supplementation of the mother immediately post-natal will be encouraged.

2.4.2 Iron and folic acid supplementation

Anemia is a widespread and severe problem leading to increased risk for maternal and fetal deaths, emphasis will be placed that health facilities and CHWs will ensure that:

- folic acid and iron are supplied to each pregnant woman at ANC visits, one tablet of Ferrous Sulfate + Folic Acid daily for 90 days
- families and communities will be informed about the need for iron and folic acid supplementation for pregnant women, and

2.4.3 Iodine supplementation

The MOPH will continue working with the Ministry of Commerce and Industry, Ministry of Mines, Ministry of Agriculture Irrigation and Livestock for:

- finalization and enforcement of the legislation on salt iodization;
- working with the private sector to comply with standards of production, packaging, marketing
- promoting use of iodized salt in all food processing industries and food aid programs, including those for emergency situations
- promoting use of iodized salt at household level

2.5 Immunization of children and mothers

2.5.1 Immunization of children

In line with the national immunization program, the following immunizations will be administered to all infants:

- BCG at birth
- OPV0 at birth up to day 7
- DPT+HB + HIB1/OPV1[26] at 6 weeks
- DPT+HB + HIB2/OPV2 at 10 weeks
- DPT+HB + HIB3/OPV3 at 14 weeks
- Measles and OPV4 at nine months

Identified problems and gaps:

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[23] NRVA 2005
[24] Afghanistan Health Survey, John Hopkins University for the MOPH, 2006
[25] MICS 2003
[26] The MOPH's official schedule includes the pentavalent (DPT+HB+HIB) vaccine. If this vaccine is not available, but tetravalent (DPT+HB) or trivalent (DPT) and/or HB and/or HIB are, the available will be administered separately according to the standard schedule. In addition, Polio NIDs and SNIDs are held regularly in accordance with the Polio Eradication initiative.

- High discrepancy in coverage between antigens[27] resulting in a low percentage of fully immunized children

Particular emphasis will be put on each child completing all doses of this schedule BEFORE reaching '12' months of age. The different strategies used are fixed immunization, outreach and campaigns, in a combination best adapted to each region. CHWs, and mothers support groups where they exist, will motivate mothers and families to assure that each child is fully immunized by this age.

All health workers, CHWs and MSG members will help raise awareness of the mothers of the importance of safe keeping the immunization card and bringing it with the child for any check-up, weighing session or other contact with the health system.

In collaboration with MOE, children will be checked for immunization status at school entrance and referred for completion of the missing vaccines.

Evaluate the pilot of offering vaccination through private outlets, and scale up the intervention according to the findings.

2.5.1 Immunization of mothers

Immunization with Tetanus toxoid (TT) immunization protects mothers and their babies against tetanus, and the MOPH recommends all pregnant women to get two shots of TT during pregnancy.

Identified problems and gaps:
- 36% of women seeing a skilled attendant for ante-natal visit did not receive a TT injection.[28]
- In the present draft of the revised BPHS, CHWs are not allowed to give TT vaccine, nor provided with it[29]

Responses:
Improve TT2 coverage for pregnant women through:
- Encourage PPHDs to promote provision of TT through the most appropriate combination of fixed-point, outreach and mobile services;
- Explore the feasibility of offering TT through CHWs by using uniject (see also 9. Operations Research)

2.6 Integrated management of sick children

2.6.1 IMCI and C-IMCI

The MOPH has adopted the IMCI as integrated approach to management of sick children. It allows for assessment and treatment of the main causes of mortality: diarrhea, pneumonia, malaria and other febrile diseases, as well as malnutrition, and for prompt referral where necessary.

Pneumonia in children requires treatment with antibiotics. The standard case management of diarrhea is treated with low-osmolarity ORS and 10 days of zinc supplementation, while antibiotics are indicated for dysentery only. Malaria is treated with chloroquine and with artesunate in combination with SP when falciparum is confirmed. Severly ill children requiring more specialized care are identified and referred to hospitals.

Identified problems and gaps[30]:

[27] Afghanistan Health Survey, John Hopkins University for the MOPH, 2006
[28] AHS 2006
[29] MOPH, A Basic Package for Health Services, revised draft of March 2009

- Training of facility-based IMCI:
    - Highly centralized training strategy resulting in geographic discrepancies
    - Mostly focused on MDs, resulting in only 50% of clinical staff in BPHS facilities trained
    - Little or no increase in knowledge of health workers[31]
    - Resistance to 11 day course, judged too long by NGO partners
    - Unclear strategy to make up for attrition of trained staff
- Irregular and weak supervision
- Recording tools judged too cumbersome by implementers
- Community-based Case Management (clinical part of C-IMCI) only addressed since 2008.

Responses:
The MOPH will explore different strategies for ensure that IMCI is implemented at all facilities and by all health workers seeing sick children, and C-IMCI in all health posts:

- In collaboration with the MOHE, ensure inclusion of the IMCI approach in the pre-service training of MDs and mid-level health workers in all major training institutions;
- Decentralize the case management training of IMCI, taking advantage of the existing contracting-out mechanisms;
- Explore feasibility of implementing shorter IMCI courses, without loss of quality
- Ensuring that pre-service training of CHWs includes community-based case management of the IMCI conditions;
- Re-inforce standard case management through adequate supervision and monitoring, ensuring that Community Health Supervisors and joint BPHS monitoring teams have the capacity to assess and correct IMCI case management.

In collaboration with the General Directorate of Pharmaceutical Affairs (GDPA) the MOPH will ensure that the drugs required for standard case management are included in the Essential Drugs List (EDL) and that laws and regulations allow ORS and dispersible Zinc Sulfate tablets to be available as over-the-counter medicine. ORS and dispersible Zinc Sulfate tablets will be available at reduced cost in the private sector, and social marketing mechanisms of these products will be encouraged.

Timely and adequate care seeking at the household level is also a key requirement for ensuring the continuum of care. Mothers and other care seekers will be informed to recognize the signs that should prompt care seeking or home treatment. Working through CHWs and mother support groups will be critical for peer-to-peer knowledge transfer.

2.6.2 Hospital Care for Sick Children
A very important and often neglected link in the continuum of care for very sick children is urgent and adequate referral to and treatment at the hospital level.

Identified problems and gaps:

- Care for sick children in hospitals is not standardized and not aligned with IMCI
- Under fives make up less than 30% of all hospitalizations, but more than 60% of all hospital deaths[32], indicating two possible faults:
    - Referral is inappropriate: for the wrong indications, too late, not adhered to
    - Management of very sick children at the hospital level is inadequate

The MOPH will assess the existing obstacles to timely and adequate referral, and investigate interventions to alleviate them (see also section 9. Operations Research).

[30] A Mid-term Review of Facility-based IMCI in Afghanistan, MOPH, 2008
[31] National Health Services Performance Assessment, 2004-2007
[32] MOPH/HMIS 2008

The MOPH has adapted and translated the Pocket Book of Hospital Care for Children to serve as standard reference for child care in all hospitals in Afghanistan, which will facilitate standardizing and increasing the quality of clinical procedures for very ill children, including the development of appropriate wall charts in emergency rooms and childrens' wards. In-service training on the new standards will be organized for staff dealing with children in the hospitals.

The MOPH also started the Pediatric Hospital Improvement initiative in 6 provincial hospitals for possible expansion nationally (see also section 9. Operations Research). The MOPH will pursue the participatory Pediatric Hospital Improvement process, allowing gradual improvement of emergency and in-patient care for children in hospitals. In a first phase this will mainly involve provincial and tertiary hospitals. Later on, selected district hospitals will be included.

2.7 Use of insecticide-treated bednets.

In areas of the country where malaria is a high risk, this febrile disease, spread by mosquitoes is an important cause of infant and child deaths. In its National Malaria Strategic Plan, the MOPH promotes that in high risk areas in Afghanistan, all pregnant women and all children under 5 sleep regularly under LLINs, in order to prevent infection. The LLINs will be available at facilities, and in the community through CHWs, and also through the private sector (e.g. social marketing). In particular the plan promotes house to house distribution of the LLINs by CHWs in their catchment area, when located in high risk areas.

2.8 Avoid early pregnancies and promote of birth spacing

Closely spaced pregnancies are important precursors of maternal and child death. Birth spacing improves survival of mothers and children by enabling women to recover their own health with adequate time between pregnancies and decrease the risk of death of children not only by ensuring the survival of their mothers, but also by avoiding competition for the mother's attention and care by a new baby. The aim of birth spacing is to delay age of the mother at first pregnancy (more than 18 years of age as before this, a young woman has far higher risk of death from smaller pelvis and immature reproductive system) and to encourage good spacing between pregnancies (more than 24 months between the last birth and a new pregnancy).[33]

For spacing births the MOPH will ensure information about and availability of modern methods: condoms, oral and injectable contraceptives, and intrauterine devices. All public sector health facilities will provide these methods. In the private sector they will be available at affordable cost, e.g. through subsidies and social marketing. Every women of reproductive age will have ready access to quality birth spacing counseling, information, education, communication and services as part of BPHS at all levels of the health system, especially at the community level for people in rural and hard-to-reach areas. The MOPH will improve the knowledge of all health workers about the health benefits for mothers and their children.

A special effort will be made to increase understanding of the impact on the health of the whole family of birth spacing by the couples, through the use of community-based agents, like the family action groups, as included in the CBHC strategy.

Special approaches will be developed to promote delaying of first pregnancy, targeting not only adolescents (both girls and boys), but also decision makers in the family (mothers, fathers and

[33] 2006 Policy brief on Birth Spacing – Report from a World Health Organization Technical Consultation. WHO Department of Reproductive Health and Research and Department of Making Pregnancy Safer.

mothers in law) and community (village leaders and religious leaders) who influence the reproductive health and behavior of adolescents.

3. Actions that strengthen the package

3.1 Improve water, sanitation and environment

The MOPH will continue collaborating with other ministries for promoting access to improved water supply and sanitation with safe disposal of feces, as well as personal hygiene (hand washing with soap) to prevent transmission of diarrheal diseases. Harmonized messages will be used at all levels of the health care delivery system, in schools and mosques, and through mass media.

Breathing polluted air, both indoors and outdoors, increases the risk of respiratory diseases, both infectious and chronic respiratory diseases. In collaboration with other ministries, the MOPH will explore promotion of feasible alternatives for indoor use of solid fuel for heating and cooking. The MOPH will pursue legislation banning cigarette smoking in public places.

3.2 Prevent accidental injury

Accidental injuries are an important cause of death, especially as children begin to crawl and walk and play on their own.

Families and communities will be alerted through interpersonal communication by CHWs and facility staff, and through mass media to:

- Prevent accidents in the home by identifying where a child may fall from heights, by keeping young children away from the traditional bread oven (*tandoor*), preventing dangerous access to fires or to boiling water, …
- Prevent access to poisonous or harmful substances, including medicines
- Be aware of the danger for all children posed by vehicle traffic
- Be aware of remaining land mines and UXOs in certain areas
- Prevent accidental drowning through protection around wells and bodies of water

CHWs, other health workers and members of women support groups who routinely or occasionally visit families at home will take the opportunity to perform hazard surveillance at that level.

Schools and other public spaces used frequently by children will be subject to safety legislation and regulations, which will be developed in collaboration with other ministries (MOE, MOJ, …). In particular, traffic regulations will be aimed at protecting children, and mass media will be used to promote use of seat belts.

3.3 Health at schools

Schools are an ideal environment to teach practical health and nutrition measures to all children. CHWs and facility staff, with support of the community development committee (CDC) will improve the communication and counseling skills of the teachers to:

- Importance of personal hygiene and cleanliness among the students and the school teachers.
- To improve the awareness towards environmental health principles emphasizing protection of clean water sources and the use of safe latrines by the students and teachers.
- Encourage general healthy nutritional habits, to prevent both under-weight and over-weight, and identifying defects in nutritional status of the students, (vitamin A, iron and iodine with iodated salt)
- Injury prevention and road safety
- The need for physical exercise at school age and during adolescence

- Avoidance of smoke, both tobacco and domestic, and discourage smoking
- The illegality and dangers of drugs

The MOPH actively collaborates with the MOE and the MRRD several UN agencies (WHO, UNICEF, UNESCO, WFP) and donors (JICA, EU) on the implementation of the Healthy School Initiative, with the following specific health objectives:

- To provide basic health services to the students in their schools
- To improve the physical education regarding physical fitness of the students
- To provide mental and social care to the students
- To upgrade the health awareness and knowledge of schools staff
- To motivate the health education among students and staff in the schools

The link between healthier children and their mother's general education has been documented internationally[34]. Health workers will urge decision makers in families and communities to have girls attend at least all classes of primary school, and pursue further education as much as possible.

3.4 Adolescent Health Considerations

In collaboration with the relevant ministries, UN agencies (WHO, UNICEF, UNFPA) and donors (KOICA, EU), the MOPH will develop standard appropriate messages and communication tools to address the following topics:

- Early marriages of girls and adolescent pregnancies are common in Afghanistan which contributes to the high maternal and infant mortality rates. All levels of the health system will communicate with girls, families and communities to draw attention to the risk and convince them to postpone marriage till the age of 18;
- Promoting healthy lifestyles regarding reproductive health;
- Importance of personal hygiene and cleanliness, and the need for regular physical exercise;
- To improve the awareness towards environmental health principles emphasizing protection of clean water sources and the use of safe latrines;
- Encouraging general healthy nutritional habits, to prevent both under-weight and over-weight, and identifying defects in nutritional status of the students, (vitamin A, iron and iodine with iodated salt);
- Raise awareness in families and communities about increased risk of mental health problems during adolescence and increase counseling skills of health providers
- Raise awareness on the danger of substance abuse including tobacco and *naswar*, ……
- Work with the MOJ and other ministries to develop laws on tobacco advertising, tobacco sale, tobacco prices and smoking in public places

3.5 Changing priorities

While not included in the priorities in this strategy, several other conditions are being addressed at the moment. While they are not the immediate priorities when trying to lower neonatal and child mortality, they may become more important on the MOPH agenda when priorities shift in the future.

A protocol for TB prevention and treatment of children is being developed by the TB department. The solid implementation of DOTS will limit infection of children by adults.

[34] John Hobcraft, "Women's education, child welfare and child survival: a review of the evidence"; *Health Transition Review*: Vol. 3 No. 2, 1993

At the moment HIV/AIDS in children and mother to child transmission is not a priority problem, but the HIV/AIDS department is drafting intervention that will allow swift action when this becomes a greater issue.

All strategies are time-bound and the MOPH recognizes that the appropriateness and the priority ranking of the listed interventions will be reviewed regularly, and adapted as needed.

4. Supportive Health System Strategies

4.1 Improve efficiency and quality of care

As mentioned, focusing efforts on bringing interventions of proven effectiveness at the level where mothers and children live is a major strategy for increasing access to care for these target groups. This has implications for the organization of health services from the community level to the referral hospital level.

3.1.1 Mobilizing resources at community level
Many of the interventions are aimed at raising awareness of the mothers and families on the benefit of simple but effective measure that can be taken to prevent or more efficiently treat critical conditions interfering with the health of mothers and children. The MOPH will support a more targeted effort for mobilizing mother support groups and other community-based support mechanisms to promote birth spacing, antenatal care, safe delivery and early newborn care, postnatal care, adequate nutrition of mothers and children, prevention and management of childhood diseases. Judicious implementation will actually alleviate the BCC tasks of the CHW. The CHWs will be the link between the community-base support groups and the formal health system.

4.1.2 Support and supervision of CHWs
The support of HPs and CHWs will become the prime job of the rural health facilities, assuring that services reach the highest possible coverage and are provided regularly with high quality and accountability. A major effort is already under way to improve the quality of community-based case management by CHWs through the re-training of existing CHWs in the C-IMCI protocol. Ample attention is given in the training model to improving interpersonal communication skills.

To this end, supervision outreach activities will be a main function following clear specific guidelines and precise written reports of each visit. A monthly visit of supervisors to each HP will include a review of problems encountered and relevant plan to redress identified problems, ongoing upgrading in knowledge and skills of CHWs, re supply of commodities, review of referrals in the previous month and follow-up, review of HMIS reports and feedback on earlier reports, preparation of work plan for the coming month. In addition the supervisor will meet with the *Shura* members to obtain their impressions and provide support to the work of the CHWs. All these activities will be recorded in a short written report.

A more complete mapping of existing CHWs and health posts will be conducted to identify underserved communities and families and a strategy developed to meet the needs in these areas with an aim to reach 100% of the population over this time period. Over the next few years, the MOPH will gradually include the CHWs in the human resource database in order to facilitate tracking of coverage with community health services.

4.1.3 Sub, Basic and Comprehensive Health Centers
Regular on job training according to standard training package, timely and optimal supportive supervision will improve availability and quality of health services.

Ensuring that staff at these facilities are able to provide Basic Essential Newborn care, IMCI and the activities included in IYCF will improve the quality of child health care at the primary level. The MOPH continues to strive for having one (community) midwife as part of the staff at these facilities.

The HMIS suggests that up to 80% of facilities regularly experience a stock out of at least one essential drug. Drug use assessments at facility level suggest gross over-use and abuse of antibiotics. Ensuring availability of essential drugs for the CAH priority activities therefore requires reinforcement of adherence to standard diagnosis and treatment protocols through refresher training and supportive supervision, as well as improvement of pharmaceutical supply logistics.

Adequate referral (referring patients to higher level facilities, receiving referred patients and providing feedback on referred cases) needs improvement. The MOPH will assess obstacles to adequate referral of sick children and define interventions for improvement.

The existing routine HIS systems (HMIS, National Monitoring Checklist) and assessments NHSPA) will be closer aligned with the requirements of the IMCI follow-up visits and IYCF monitoring to increase coverage and quality of these approaches.

4.1.5 Hospital pediatric services

The CAH has started the Pediatric Hospital Improvement initiative in six hospitals, in line with the WHO global PHI initiative. Main aspects of improvement measures in this initiative are:

- the adapted and translated WHO Pocketbook of Hospital Care for Children will be made available to all hospital staff as standard reference book for all hospitals;
- presently in five provincial hospitals a participatory improvement process on hospital care for critical sick children has started, focusing on a step-wise improvement of care for children in the hospital setting in collaborative manner, based on the identification of priorities defined by the participating hospitals;
- specific training in Emergency Triage, Assessment and Treatment of sick children will be provided;
- measurement of improvement in specific areas will be done using the PHI standard assessment tool, and case-specific (under five) mortality rates will be monitored through HMIS reports and Balanced Scorecard;
- the initiative will be expanded to other provincial hospitals, based on the results in the initial five.

4.1.6 Strategic Interventions by Level of Care

This section summarizes detailed activities by level of care

Strategic intervention	**Family/ community (main actors: MSG, teachers, shura, religious, ….)**	**Health Post (CHWs)**	**Health Centre (HSC, BHC, CHC)**	**Referral Hospital (DH, PH, RH)**
	•	•	•	•
Provision of antenatal care and early detection of possible problems in delivery	• Increase awareness of the need for pregnancy registration • Increase awareness on danger signs of pregnancy • Increase awareness of women for ANC • Encourage the use of TT • Encourage that every pregnant woman receives the recommended four antenatal visits • Encourage Community Health Shura to facilitate transportation to the health center when there is an emergency related to pregnancy • Encourage the reduction of heavy physical work load of the pregnant woman	• Carefully map all pregnant women in the community. • Counseling of the pregnant woman on the importance of four ANC visits, and TT vaccination. • Counseling on important signs of pregnancy complication (bleeding, swollen feet, unremitting head ache, foul discharge, cessation of fetal movement) and arrange immediate referral to a health facility • Infection control , safe injection practices, and waste	• Confirm pregnancies with pregnancy test • Keep track of all pregnant women, promoting 4 ante-natal checkups including urine test and BP • Screening for risk pregnancies • Treatment and follow-up of pre-eclampsia • Screening, initiate treatment and referral for eclampsia • Detection and management of STIs	•Confirm pregnancies with pregnancy test •Keep track of all pregnant women, promoting 4 ante-natal checkups including urine test and BP •Screening for risk pregnancies •Treatment and follow-up of pre-eclampsia •Screening and treatment for eclampsia •Manage referred complicated cases •Detection and management of STIs
Antenatal: General nutritional status and Maternal Anemia	• Encourage and enable good maternal diet throughout pregnancy including the use of iodated salt in the home, plenty of fresh fruits, vegetables, and meat when available. • Encourage the use of targeted protein – energy supplementation for women under weight • Encourage of using iron and folic acid supplementation by all pregnant women • Encourage the use LLIN in high risk areas	• Promote good nutritional status (pre-pregnancy weight more than 41 kg) and a full nutritious diet throughout pregnancy with a minimum pregnancy weight gain of at least 5 Kgm • Provide targeted protein-energy supplementation for women falling short of these weight targets in collaboration with UNICEF, and WFP. • Provide folic acid and iron to each pregnant woman, one tablet of Ferrous Sulfate + Folic Acid daily for 90 days • Provision of LINN to all pregnant women in high risk areas. • Refer malnourished and suspected anemia cases	• Provision iron and folic acid to all pregnant women visiting health facility • Promote good nutritional status (pre-pregnancy weight more than 41 kg) and a full nutritious diet throughout pregnancy with a minimum pregnancy weight gain of at least 5 Kgm • Provide targeted protein-energy supplementation for women falling short of these weight targets in collaboration with UNICEF, and WFP. • Treatment of malnourished pregnant women • Provide folic acid and iron to each pregnant woman, one tablet of Ferrous Sulfate + Folic Acid daily for 90 days • Provision of LINN to all pregnant women in high risk areas • Treatment of anemia cases	•Treatment of severe anaemia •Promote good nutritional status (pre-pregnancy weight more than 41 kg) and a full nutritious diet throughout pregnancy with a minimum pregnancy weight gain of at least 5 Kgm •Provide targeted protein-energy supplementation for women falling short of these weight targets in collaboration with UNICEF, and WFP. •Treatment of maternal malnutrition Provide folic acid and iron to each pregnant woman, one tablet of Ferrous Sulfate + Folic Acid daily for 90 days •Provision of LINN to all pregnant women in high risk areasBlood transfusion •Treatment of anemia cases (inclusive blood transfusion if necessary

Strategic intervention	Family/ community (main actors: MSG, teachers, shura, religious, ….)	Health Post (CHWs)	Health Centre (HSC, BHC, CHC)	Referral Hospital (DH, PH, RH)
Antenatal Care: Tetanus Toxoid Injection	• Encourage the use of two TT shots during pregnancy	• Ensure that women demand TT according to schedule during routine visits and outreach • Ensure that each pregnant woman receives two TT shots during pregnancy	• Administration of TT according to schedule during at routine visits or during outreach • Administration of two TT shots during pregnancy	• Administration of TT according to schedule during at routine visits or during outreach • Administration of two TT shots during pregnancy
Antenatal Care: Promotion of birth planning and preparedness	• Encourage pregnant women, families, and communities to prepare for safe delivery and for adequate essential newborn care • Encourage pregnant women to choose a skilled provider and to use clean materials for delivery • Encourage community to arrange in advance transport to the nearest health facility with use of community participatory methods. • Raise awareness on danger signs	• Teach women/communities about danger signs for the mother and newborn. • Teach essential newborn care (warmth, early and exclusive breastfeeding, check for infection and avoiding harmful practices) to mothers: • Encourage mothers, fathers, and families to prepare for potential complications during delivery or in the newborn period, including referral. • Encourage institutional delivery by skilled provider • Assist the woman in obtaining clean delivery materials	• Assist pregnant women to prepare for safe delivery • Assist pregnant women to choose a skilled provider and to use clean materials for delivery • Assist CHWs in promoting birth planning and preparedness • Assist the woman in obtaining clean delivery materials	• Assist pregnant women, to prepare for safe delivery • Assist pregnant women to choose a skilled provider and to use clean materials for delivery • Assist CHWs in promoting birth planning and preparedness (if supervising HPs) • Assist the woman in obtaining clean delivery materials
Delivery and early neonatal care	• Awareness of clean delivery and cord care • Awareness of danger signs for mothers and newborn • Awareness of BENC and harmful practices • Encourage community to arrange in advance transport to the nearest health facility in case of problems • Promote BENC	• Provide mini delivery kit if necessary • Be present at normal delivery at home, if skilled provider not available • give 3 tablets of misoprostol after birth where the Postpartum Hemorrhage Program is implemented • Basic Essential Newborn Care: Stimulate, clean airway; clean, clamp, and cut cord; keep warm, establish early breastfeeding • Postpone bathing of baby	• BEmOC • BENC and ENC • Resuscitation of new born babies, manage and refer if needed • Treatment of low birth weight babies • Resuscitate and refer all babies born weighing less than 1.8kg • Resuscitate and refer all premature babies • Pre-referral treatment and referral of infection/septicaemia cases of neonates • Referral services for neonatal tetanus and congenital defects • Administration of OPV0 and BCG	• CEmOC including CS and blood transfusion • BENC and ENC • Resuscitation of new born babies, manage and refer if needed • Manage premature and low birth weight babies • Investigate and treat all neonatal jaundice • Management and referral services for congenital defects • Management of neonatal tetanus • Management of neonatal infections/septicemia • Administration of OPV0 and BCG
Post-natal care	• Encourage 3 post natal visits with skilled provider • Encourage early and exclusive breastfeeding • Encourage of use of Vit A • Raise awareness about the importance of essential newborn care	• Visit each newly delivered mother and baby within 48 hours. • Encourage post natal visits with skilled provider where possible • Vitamin A supplementation to mother • Promote early and exclusive breastfeeding • Counseling on birth spacing and provision	• Encourage 3 post natal visits • Reinforce exclusive breastfeeding • Screen and advise on breastfeeding problems • Vitamin A supplementation to mother • Treatment of anemia • Treatment of puerperal infection	• Encourage 3 post natal visits • Reinforce exclusive breastfeeding • Screen and advise on breastfeeding problems Vitamin A supplementation to mother • Treatment of anaemia • Treatment of puerperal infection

Strategic intervention	Family/ community (main actors: MSG, teachers, shura, religious, ….)	Health Post (CHWs)	Health Centre (HSC, BHC, CHC)	Referral Hospital (DH, PH, RH)
	• Raise awareness of postpartum nutrition • Raise awareness about the benefits for mother and baby of the use of birth spacing	of birth spacing methods, if applicable • If the child is very small, encourage the mother to wrap the child against her body between her breasts allowing suckling on demand (kangaroo care)?? • Examine the infant with special attention to the cord stump to assure there is no redness or discharge. If redness or discharge: help organize referral. • If any other suspicion of neonatal infection: help organize referral. • Examine the mother to assure: no pain in the lower abdomen on light pressure; no bloody or foul vaginal discharge, no fever. If any of these are present arrange for immediate referral. • Ensure oral polio vaccine dose and BCG vaccination to the infant in the first week of life through referral to facility or facilitation of outreach • Counseling on neonatal jaundice	• Counseling on birth spacing and provision of appropriate birth spacing methods • Detection of newborn infection/sepsis, initiate treatment and referral • Counseling on neonatal jaundice • Referral services for complications	• Counseling on birth spacing and provision of appropriate birth spacing methods • Detection and management of neonatal infections/sepsis • Counseling on neonatal jaundice • Management of complications of mother and baby
Breast feeding:	• Encourage exclusive breast feeding to feed the infant from birth to 6 months of age. Exclusive breastfeeding means that the infant takes only breast-milk, and no additional food, water, or other fluids. • Support mothers in exclusive breastfeeding • Support mothers in continued breastfeeding till 24 months and beyond	• Every effort to encourage and support exclusive BF will be done by the CHW who will educate the mother, her husband, in-laws and other family members to the importance of early and exclusive BF for the first 6 months of life. • Counsel on frequency of breastfeeding, proper positioning and attachment of the baby	• Ensure initiation of early and exclusive breast feeding from birth to 6 months of age, and encourage continued breastfeeding till 24 months and beyond • Counsel on frequency of breastfeeding, proper positioning and attachment of the baby	• Ensure initiation of early and exclusive breast feeding from birth to 6 months of age, and encourage continued breastfeeding till 24 months and beyond • Counsel on frequency of breastfeeding, proper positioning and attachment of the baby
Complimentary feeding	• Encourage the introduction of safe, timely and appropriate complementary food for young children after 6 months of age • Encourage continued breastfeeding up to 24 months and beyond • Encourage balanced diet and use of Iron/folic acid supplementation for lactating women • Motivate mothers to participate in monthly GMP and follow-up problem	• Promote and support continued breastfeeding • Promotion of safe, timely and appropriate complementary feeding for young children with behavior changes • Organize monthly growth monitoring and promotion up to 24 month, refer when necessary • Iron/folic acid supplementation for pregnant, lactating women	• Encourage the introduction of safe, timely and appropriate complementary food for young children after 6 months of age • Encourage and support continued breastfeeding up to 24 months and beyond • Provision of Iron/folic acid supplementation for pregnant, lactating women • Growth monitoring and promotion for less	• Encourage the introduction of safe, timely and appropriate complementary food for young children after 6 months of age • Encourage and support continued breastfeeding up to 24 months and beyond • Growth monitoring and promotion for less than 5 years linked with IMCI • Iron/folic acid supplementation for

Strategic intervention	Family/ community (main actors: MSG, teachers, shura, religious, ….)	Health Post (CHWs)	Health Centre (HSC, BHC, CHC)	Referral Hospital (DH, PH, RH)
	children	• Vitamin A supplementation every six months • Promotion of maternal nutritional status • Control and prevent diarrheal disease and parasitic infections (mebendazole) • Screening and referral of at risk using mid-upper-arm circumference (MUAC), or weight/height, or clinical signs of micronutrient deficiency diseases (MDDs)	then 5 years • Vitamin A supplementation every 6 months • Treatment of diarrhoea and intestinal parasites • Treatment of micronutrient deficiency diseases • Treatment of malnourished children • Referral of severely malnourished children	pregnant, lactating women • Vitamin A supplementation every 6 months • Promotion of maternal nutritional status • Treatment of diarrhoeal disease and parasitic infections • Treatment of micronutrient deficiency diseases (MDDs) • Treatment of malnourished children, including severely malnourished
Immunization	• Interpersonal and social mobilization for immunization raising awareness to have all children completely vaccinated by 12 months • Raise awareness of mothers and other caretakers of the importance of safe guarding the child's immunization card	• Support outreach immunization service • Support supplementary Immunization Activities • Report suspected EPI disease cases and suspected adverse events following immunization (AEFI), refer when necessary • Vitamin A supplementation • Particular emphasis will be made by CHWs on each child completing all doses of immunization schedule before reaching '12' months of age • Promote safe guarding of immunization card	• Promote and assist micro-planning at facility and district level • Provided fixed point and outreach immunization service according to schedule • Promote safe guarding of immunization card • Assist in supplementary immunization activities (NIDS, SNIDS, mop up …) • Disease surveillance and case reporting (DEWS) • AEFI reporting and investigation	• Promote and assist micro-planning at facility, district and provincial level • Provided fixed point and outreach immunization service according to schedule • Promote safe guarding of immunization card • Assist in supplementary immunization activities (NIDS, SNIDS, mop up …) • Disease surveillance and case reporting (DEWS) • AEFI reporting and investigation
Diarrhea	• Raise awareness on improved water, of sanitation • Encourage hygienic practices, including handwashing with soap • Encourage mothers to increase fluids offered to the child to drink at the first sign of diarrhea – this includes more frequent breastfeeding, clean water and clean traditional fluids • Encourage and support the mother to continue or increase breastfeeding and give small frequent meals for those over 6 months of age. • Encourage use of ORS and Zinc tablets	• Promote use of improved water, of sanitation, and of hygienic practices including proper hand washing • Demonstrate administration of ORS and of Zinc • Case management of diarrheal disease according to C-IMCI • If diarrhea continues beyond 3 days, referral will be made, while continuing to give ORS. • Counseling on homecare of child with diarrhea, including use of ORT and Zinc, and the need for continued breast feeding and complementary feeding	• Promote use of improved water, of sanitation, and of hygienic practices including proper hand washing • Case management of diarrhea (including bloody diarrhea, persisting diarrhea) according to IMCI • Treat dehydration, refer if necessary • Refer Diarrhea with Severe Malnutrition • Counseling on homecare of child with diarrhea, including use of ORT and Zinc, and the need for continued breast feeding and complementary feeding	• Promote use of improved water, of sanitation, and of hygienic practices including proper hand washing • Case management of diarrhea (including bloody diarrhea, persisting diarrhea) according to IMCI • Treat dehydration, refer if necessary • Treat/refer Diarrhea with Severe Malnutrition • Counseling on homecare of child with diarrhea, including use of ORT and Zinc, and the need for continued breast feeding and complementary feeding • Promote adherence to Pocket Book protocols by hospital staff
ARI and Pneumonia.	• Increased awareness to seek prompt advice from CHW or health centre for	• ARI case management as per C-IMCI, including treatment of pneumonia	• Emergency Triage, Assessment and Treatment/referral for sick children	• Emergency Triage, Assessment and Treatment for sick children

Strategic intervention	Family/ community (main actors: MSG, teachers, shura, religious, ….)	Health Post (CHWs)	Health Centre (HSC, BHC, CHC)	Referral Hospital (DH, PH, RH)
	a child with ARI • Keep child warm, keep nose free, keep feeding and give additional fluids	• Referral of children with danger signs • Clear instructions to mothers for home care • Clear instructions to mothers when to seek care outside the home	• ARI case management as per IMCI, including treatment of pneumonia • Referral of children with danger signs • Clear instructions to mothers for home care • Clear instructions to mothers when to seek care outside the home	• ARI case management as per IMCI, including treatment of severely ill children, including Oxygen • Referral of children with danger signs if needed • Clear instructions to mothers for home care • Clear instructions to mothers when to seek care outside the home • Promote adherence to Pocket Book protocols by hospital staff
Malaria	• Encourage use of LLIN in high risk areas	• Distribution of LLIN in high risk areas • Treatment of uncomplicated cases of malaria according to C-IMCI • Referral of complicated/severe cases	• Provision of LLIN in high risk areas • Treatment of uncomplicated cases of malaria according to IMCI • Referral of complicated/severe cases	• Treatment malaria cases, including severe/complicated cases according to IMCI and National Malaria Treatment Protocol • Promote adherence to Pocket Book protocols by hospital staff
Other diseases and severely ill children	• Raise awareness of danger signs • Encourage referral of severely ill children	• Classification of sick children according to C-IMCI • Treat or refer as per C-IMCI protocol	• Classification of sick children according to IMCI • Treat or refer as per IMCI protocol	• ETAT for sick children • Promote adherence to Pocket Book protocols by hospital staff
Birth Spacing	• Increase awareness on the importance of spacing their children, both for the health of the mother and for the children – those already living and those to follow. • Encourage the use of birth spacing services • Organizing depot holders(shops, pharmacies) for social marketing of contraceptives • Encouraging birth spacing after previous pregnancy of at least 24 months	• provide information to couples (both men and women) on the importance of spacing their children, both for the health of the mother and for the children – those already living and those to follow. • encourage interested couples to consult with the nearest health facility for the initial issue of appropriate spacing contraceptive methods, and will assure re supply, in the home, of condoms, pills and injectables as chosen by the couple • In the event that the couple is unable to consult with the health facility, the CHW will be trained, supplied and authorized to dispense the contraceptives even from initiation, in the village. • The CHW will be trained on key signs to recognize any complications and make timely referral of women experiencing these signs to a health facility	• provide information to couples (both men and women) on the importance of spacing their children, both for the health of the mother and for the children – those already living and those to follow. • Counsel and provide condoms, oral an injectable hormonal contraceptives and IUDs • Keep track of contraceptive users and remind couples of timely renewal • Screening for and treatment of STI • Refer complicated cases if needed • Infection control, safe injection practices, and waste	• provide information to couples (both men and women) on the importance of spacing their children, both for the health of the mother and for the children – those already living and those to follow. • Counsel and provide condoms, oral an injectable hormonal contraceptives and IUDs • Keep track of contraceptive users and remind couples of timely renewal • Screening for and treatment of STI • Management of referred and complicated cases • Infection control, safe injection practices, and waste

Strategic intervention	Family/ community (main actors: MSG, teachers, shura, religious, ….)	Health Post (CHWs)	Health Centre (HSC, BHC, CHC)	Referral Hospital (DH, PH, RH)
		• The CHW will keep careful records of all couples using contraception by method, and when supplied • The CHW will remind couples in a timely way for the need of renewing contraceptive supplies • The CHW will make timely requests for ordering necessary resupply of contraceptives.		
Accidental Injury prevention	• Increasing awareness of parents about preventing accident in the home vehicle traffic dangers and areas of land mines	• Prevent accidents in the home by identifying where a child may fall, or dangerous access to fires or to boiling water and arrange appropriate protection • Protection around wells and bodies of water will prevent drowning • Referral seriously injured and disabled	• IEC • Treatment of mild injuries • Stabilization and referral of severe injuries • Rehabilitation/referral of disabled	•Management of referred cases according to the Pocket Book •Rehabilitation/referral of disabled
Health risks of older children and adolescents	• Encourage use of improved water sources and of safe latrines by the students and teachers. • Encourage personal hygiene, including hand washing with soap • Encourage healthy nutritional habits, including micronutrient supplementation and identify defects in nutritional status of the students, including micronutrient deficiencies • Encourage avoidance of smoke, both tobacco and domestic, and discourage smoking • Increase understanding about the illegality and dangers of drugs	• Promote use of improved water sources and of safe latrines by the students and teachers. • Promote personal hygiene, including hand washing with soap • Promote healthy nutritional habits, including micronutrient supplementation and identify defects in nutritional status of the students, including micronutrient deficiencies • Avoidance of smoke, both tobacco and domestic, and discourage smoking • The illegality and dangers of drugs • Risk reduction counseling for prevention of STI and syndromic treatment of STI • Risk reduction counseling for mental health and psycho social disorders	• Promote use of improved water sources and of safe latrines by the students and teachers. • Promote personal hygiene, including hand washing with soap • Promote healthy nutritional habits, including micronutrient supplementation and identify defects in nutritional status of the students, including micronutrient deficiencies • Encourage avoidance of smoke, both tobacco and domestic, and discourage smoking • Increase understanding about the illegality and dangers of drugs • Risk reduction counseling for prevention of STI and treatment STI • Risk reduction counseling for mental health and psycho social disorders	• Promote use of improved water sources and of safe latrines by the students and teachers. • Promote personal hygiene, including hand washing with soap •Promote healthy nutritional habits, including micronutrient supplementation and identify defects in nutritional status of the students, including micronutrient deficiencies •Encourage avoidance of smoke, both tobacco and domestic, and discourage smoking •Increase understanding about the illegality and dangers of drugs •Risk reduction counseling for prevention of STI and treatment STI •Risk reduction counseling for mental health
Adolescent Health considerations	• Raise awareness on the benefits of delaying marriage and pregnancy for adolescent girls and their babies • Raise awareness about sexuality, fertility and menstrual hygiene • Raise awareness on risk behaviors like	• Promote delaying of marriage and pregnancy • Promote personal hygiene • Promote healthy lifestyles with regards to nutrition and avoidance of smoking and drugs	• Promote delaying marriage, fertility awareness, menstrual hygiene, care during pregnancy • Promote delaying of marriage and pregnancy • Promote personal hygiene	•Conduct IEC/BCC on delaying marriage, fertility awareness, menstrual hygiene, care during pregnancy •Nutrition education •Awareness on gender relations and roles •IEC/BCC to avoid harmful traditional

Strategic intervention	Family/ community (main actors: MSG, teachers, shura, religious, ….)	Health Post (CHWs)	Health Centre (HSC, BHC, CHC)	Referral Hospital (DH, PH, RH)
	smoking and illicit drug use • Raise awareness on the health benefits of education for boys and girls and their future children	• Promote school education for boys and girls • Refer pregnant adolescents to skilled providers • Refer suspected STIs	• Promote healthy lifestyles with regards to nutrition and avoidance of smoking and drugs • Counseling of newly married adolescents • Provision of condoms and information on emergency contraception • Risk reduction counseling for prevention of STI **For Girls** • Contraceptive services for delaying pregnancy • ANC for pregnant adolescents • Referrals for Ectopic pregnancies • Advise for institutional delivery for primigravidae • Services for prevention and management of nutritional anemia • Counseling on menstrual problems • Syndromic management of STIs and referral **For Boys** • Counseling and provision on birth spacing and contraception • Counseling on myths and misconceptions on sex related issues and problems • Harm reduction counseling • Syndromic management of STIs and referral services	practices and their effect • Counseling of newly married adolescents • Provision of condoms and information on Emergency contraception • Risk reduction counseling for prevention of STI **For Girls** • Contraceptive services for delaying pregnancy • ANC for pregnant adolescents • Referrals for Ectopic pregnancies • Advise for institutional delivery for primigravidae • Services for prevention and management of nutritional anemia • Counseling on menstrual problems • Lab diagnosis and management of STIs and referral if necessary **For Boys** • Counseling and provision on birth spacing and contraception • Counseling on myths and misconceptions on sex related issues and problems • Harm reduction counseling • Lab diagnosis and management of STIs
Adult health risks to children	• Raise awareness about the danger of infecting children and the need for treatment of active TB cases • Raise awareness for contact screening of infected children	• Promote case finding and referral of suspected TB cases • Follow up of short course chemotherapy, including DOTS • Surveillance of cases of interrupted treatment • Assist outreach activities regarding BCG vaccination • Active case finding in community	• Promote case finding and referral for lab diagnosis of active TB • Diagnosis and treatment (DOTS) • Contact screening and management • Referral for diagnosis if necessary	• Promote case finding and referral for lab diagnosis of active TB • Diagnosis and treatment (DOTS) • Contact screening and management • Referral for diagnosis if necessary

4.2 Human resources, training and supervision.

A special effort will be made to ensure gender balance of CHWs and CHS, in order to ensure better supervision of child health related activities of the CHWs. CHS will receive detailed guidelines and plans for supportive supervision of CHWs. CHS will be trained in the specific community-based interventions of the CHWs (as is the case for the present C-IMCI training), so they fully understand scope of activities of the CHWs.

The present very centralized IMCI training strategy does not fully profit from the possibilities offered by the contracting-out strategies of the MOPH. Future training will be fit into the contracting-out strategies of the MOPH, to ensure training capacity at least in every region, if possible in every province. This will facilitate ensuring (re)training of all primary level facility staff who see children in the updated IMCI protocol. The CAH of the MOPH will ensure that the quality of the training is retained.

The MOPH will introduce the Pocket Book of Hospital Care for Children as standard reference for care for sick children in hospitals, and will work with the MOHE to incorporate the standards in the preservice training of physicians and pediatricians. Corresponding wall charts for the management of sick children will be disseminated. The participatory improvement process of the PHI will be expanded nationally, including training in ETAT.

In collaboration with MOHE and MRRD, ensure that 2 teachers in each school are trained in the Basic Health Services package, elaborated under the HIS: first aid for accidents, administer vitamin A, recognize the IMCI diseases, promote good nutrition practices, promote hygiene and sanitation, provide information about substance abuse.

With relevant ministries, the MOPH will explore ways to improve skills of CHWs and facility-based health workers in counseling and working with peer-educators and community groups.

4.3 Engaging families and communities

Most care for childhood illness occurs at home, and most education towards healthy behaviors is done at home. To improve this care and successfully promote healthy behaviors, families often need to change behaviors, which can be done through repeatedly providing information through the available spectrum of communication channels: mass media, community and religious leaders, and health workers.

Appropriate BCC, both for the community and for the health workers, will be a cornerstone of many of the interventions. The recommended practices will be culturally relevant and practically implementable.

The many BCC materials related to the different aspects of child health need to be further harmonized, not only within the MOPH but also between different ministries, addressing the same problems at the community level, in order to set clear standardized messages for BCC.

Emphasis will be placed on creating an educated demand for services and giving the families a voice in determining the desired quality and characteristics of the services. Communities need to know what the appropriate preventive and curative care is for children and what they should expect from the health services. They will be informed about changes in the core indicators pertaining to child survival and health.

4.4 Monitoring and Evaluation of CAH strategy

Close collaboration between CAH, HMIS and M&E and QA will allow adequate monitoring and evaluation of the CAH strategy. Different interventions and activities require different approaches, which will be detailed in the implementation plan.

Population-based surveys, like MICS and NRVA will include child survival impact and outcome indicators. HMIS, NMC and NHSPA will include child survival output, process and input indicators. The data form all these will be used for analysis and planning at relevant levels, from HP to national level.

The capacity of the PPHO to use the available data sources for monitoring CAH activities and adapting the provincial plans will be improved.

Suggested key indicators that will allow to monitor success of the strategy or lack thereof are:

Intervention	Main Indicator	Additional Indicator
1. Skilled attendance during pregnancy, delivery and the immediate postpartum	1. Proportion of births assisted by skilled health personnel	Percentage of pregnant women getting ANC
2. Care of the newborn	2. Timely initiation of breastfeeding	
3. Breastfeeding and complementary feeding	3. Proportion of infants less than 6 months exclusively breastfed 4. Proportion of infants 6-9 months receiving breast milk complementary food	Underweight prevalence
4. Micronutrient supplementation	5. Proportion of children 6-59 months who received vitamin A in the past 6 months	Percentage of pregnant women receiving iron folate supplement Percentage of families using iodized salt
5. Immunization	6. Proportion of children 1 year of age that received DPT3 7. Proportion of children protected from tetanus at birth	Proportion of children 1 year old that received DPT3 and measles
6. Integrated management of sick children	8. Appropriate treatment of 0-59 months olds for : pneumonia, diarrhea, suspected malaria 9. Appropriate careseeking for 0-59 months olds for: ARI, diarrhea and fever.	
7. Use of LLIN	10. Proportion of pregnant women sleeping under LLIN in high risk areas	
8. Birth spacing	11. Contraceptive Prevalence Rate	Average birth spacing interval Percentage of deliveries with mothers under 18

For all the activities listed in the implementation plan, indicators at impact, outcome, output, process and input level, will be determined to enable the Child Survival Committee to monitor progress on a six monthly basis.

Every six months progress reports will be submitted for review by the National Maternal & Child Health Committee, which will make recommendations for corrective action, and change in priorities as appropriate.

5. Financing for child health

The necessary funding for the essential HR, infrastructure, equipment, supplies, transport and support to make full coverage with the priority interventions possible will be determined. The resources available and needed to implement the CAH strategy may differ in different parts of the country, and care will be taken to have child health adequately reflected in provincial health plans and budgets. The

MOPH will proactively disseminate the CAH strategy to PHDs and BPHS implementing NGOs, and determine the implications for the strategic plan in each province through a series of workshops, regionally and/or provincially.

Individual activities of each intervention will be carefully planned and costed out, ideally combining funding from multiple sources. A good example is the training of CHWs in the standard C-IMCI approach where GAVI funding, USAID funding and funding from WHO and UNICEF were judiciously combined into one four-year intervention.

6. Improving leadership and governance and consolidating partnerships

Success of the proposed strategy depends on strong and consistent leadership from political figures at high level, not only in the MOPH, but in different government sectors. Implementing the strategy requires close collaboration between different directorates and departments in the MOPH, and good governance of ministries and government agencies in different sectors: houses of parliament, finance, public health, education, higher education, rural rehabilitation and development, water and energy, commerce and industry, communications and information technology, justice, counternarcotics, to name some. It will also require strong partnerships with non-governmental institutions like political parties, independent media, professional organizations, religious leaders, community cooperatives and community-based organizations, civil society organizations and the commercial private sector.

6.1 National Maternal & Child Health Committee

The effective implementation of the CAH Policy and Strategy demands efficient ongoing coordination between many MOPH departments, and also with other ministries and partners. Hence the need for a structure at the highest level that oversees the implementation of the CAH Policy and Strategy. The terms of reference of the **National Maternal & Child Health Committee** (NMCHC) are given in *Annex 6*. The NMCHC will meet every six months to evaluate progress against plans, evaluate available resources dedicated to child survival, reinforce the commitment of different governmental and non-governmental actors and donors, and recommend necessary modifications of the implementation plan.

The NMCHC will also recommend timely revision of the policy and strategy based on changing child and adolescent health priorities, due to successful alleviation of the present priority problems, the increase in prevalence of presently less prominent problems, or the emergence of new conditions that affect child and adolescent health.

To enhance the needed coordination and collaboration at provincial level, an equivalent of the NMCHC at the provincial level, the **Provincial Maternal & Child Health Management Committee**, presided by the PPHD will oversee the intersectoral planning, budgeting, coordination and implementation of child survival activities in each province. Each province shall adapt the weight given to each of the identified priority interventions to match the provincial epidemiological profile, and may adapt implementation modalities to the specific needs of individual districts in the province. E.g. use of LLIN is only necessary in high-risk areas; the extent to which outreach and mobile services are used to deliver interventions will depend on the density of population and fixed service delivery points in each district.

6.2 Existing coordination mechanisms in the MOPH

The MOPH, in its role as steward of the health sector, is committed to set policies, standards and guidelines in coordination with all departments within the MOPH, all partners, implementing NGO's, and donor agencies. In line with national Government of Afghanistan policies, the MOPH has created

the **Consultative Group for Health and Nutrition** (CGHN). The large CGHN, which includes representatives from other ministries, donors, the UN, and selected NGOs, meets once a month, chaired by the MOPH.

A working CGHN, chaired by the Technical Deputy Minister , meets weekly and serves as a venue in which to discuss technical and policy issues. All partners in the health sector are welcome to participate in this meeting, and key recommendations for policy formulation are referred here for review.
In addition to the CGHN, the MOPH has established Task Forces around specific technical issues. Currently there are '24' Task Forces, which allow focused technical input on specific topics. Their objective is to provide policy and implementation guidelines, intervention strategies, or program recommendations. These recommendations are then forwarded to both the CGHN and the Technical Advisory Group for review prior to being forwarded to the Executive Board for approval.

Provincial Public Health Coordination Committees (PPHCC's) have been created within each province to help coordinate the activities of all stakeholders in achieving MOPH priorities at the provincial level. In any given province, multiple partners are involved in implementing health programs, including the MOPH; hospitals; NGO's; other ministries, for example, the MRRD or MOWA; provincial government; and the military. Under the direction of the Provincial Public Health Director (PPHD), the PPHCC's will play a critical role in ensuring effective implementation of MOPH priority programs at all levels throughout the province, and the compliance with laws and regulations pertaining to CAH.

6.3 Institutional strategies for child health

Most, if not all directorates and departments in the MOPH will contribute directly or indirectly to improving child and adolescent health. Without being exhaustive in the listing, the active collaboration of certain directorates and departments will be critical to the success of the CAH strategy.

6.3.1 Child and Adolescent Health Directorate (DCAH)

The important responsibility of the CAH under this strategy is to ensure provision of critical child health survival services throughout the country with special focus on communities and hard to reach areas. The child and adolescent health services are a complementary health priority stream to reproductive health services, therefore the DCAH will coordinates its strategies and actions with other departments such as EPI, Nutrition, Reproductive Health, and Communicable Disease Departments to facilitate quality integrated health services for pregnancy, childbirth, obstetric emergencies, newborn care, post partum care , birth spacing, control of malaria and TB, in order to avoid duplication and to meet the child and adolescent and reproductive health objectives, averting maternal and newborn mortality and morbidity. In addition the DCAH will work to contribute to the creation of an environment where children and adolescent fulfill their health needs, protection/rights and enable them to live to their full potentials.

The DCAH assists the senior level of MOPH to keep child and adolescent health activities focused on the priorities listed in the National CAH Policy 2009-2013. In particular it will perform the secretarial function for the National Maternal & Child Health Committee, composed of all child survival stakeholders (see *Annex 6*) and presided by the Deputy Minister Health Services. This committee will meet every six months to take stock of the ongoing child survival activities, overall progress and plan for future activities and additional resource allocation where necessary.

6.3.2 Reproductive Health Directorate (DRH)

The specific responsibilities of the DRH are to:

- Ensure that each reproductive aged woman has access to reproductive health services particularly at community level by monitoring, coordinating and exerting influence through stewardship, regulation and advocacy,
- Ensure the provision of evidence-based birth spacing, antenatal, natal, and postnatal care including IEC &BCC for all women through facility, outreach and community health services;
- Advocate for develop innovative strategies to increase the coverage of skilled attendance at birth
- Ensure that every district and provincial hospital can provide comprehensive emergency obstetric care in line with MOPH standards and guidelines.

6.3.3 Public Nutrition Department

The main responsibility of this department is to ensure integrated, multi-sectoral approach on nutrition surveillance, interventions, education, food security, and prevention and treatment of malnutrition and micro-nutrient deficiency through proven effective, equitable and affordable measures by formulating, coordinating, and supervising integrated national public nutrition policy, strategy, protocols.

Public nutrition forms an important component of the responsibilities of the CHW and health facility staff, specifically in the areas of:

- promotion of vitamin A supplementation for children and post-partum women
- prevention and control of diarrhoea
- promotion of early and exclusive breastfeeding and appropriate complementary feeding practices for young children
- promotion of good nutrition (including increased access to diversified foods through production and storage) for the family and particularly for women
- promotion of use of iodized salt
- referral of children at risk of malnutrition and those suffering from micronutrient deficiency diseases and severe malnutrition

6.3.4 EPI Department:
This department manages EPI and related activities in the country and ensures the implementation of nationally developed EPI policies, guidelines and standard protocols through:

- Providing leadership in the process of EPI program policy and strategy development.
- Providing leadership in formulating integrated national EPI plans and budget.
- Ensuring fair and equitable countrywide distribution of EPI services.
- Organizing the Inter Agency Immunization Coordination Committee (ICC) and follow up the decisions made.
- Providing technical guidance, logistic support and supervision to REMTs, PEMTs and their teams.
- Ensuring functioning cold-chain in all over the country.
- Identifying training needs for all categories of staff members and implement relevant training in collaboration with EPI partners.
- Responding to emergencies/outbreaks due to EPI targeted diseases in coordination with the Emergency Preparedness and Response Department and other partners.
- Collecting, compiling and timely analyzing national EPI data, and report and feedback to partners.

6.3.5 Community Based Health Care Department (CBHC)
Community-based health care is the foundation for the successful implementation of many of the proven effective health measures. It provides the context for the most comprehensive interaction

between the health system and the communities it serves. Its success depends upon community participation and a partnership between community and health staff.

- The role of CBHC is critical for the community-based interventions of the CAH Policy and Strategy will faithfully in that it oversees the widespread implementation of community-based health care interventions, monitors their overall management and their impact.
- Therefore, the CBHC will ensure regular monitoring and evaluation of the role and contribution of community-based health care in the health system, and regularly present developments and accomplishments to colleagues in the MOPH;
- The CBHC will ensure that all developments in other MOPH departmental programs that affect community-based health care are in keeping with CBHC policies and are incorporated into the CBHC program in a way consistent with the effectiveness of the whole program.
- The CBHC Department will collaborate with counterparts in other GoA Ministries to promote appropriate inter sectoral activities and support for the health and development of communities.
- The CBHC Department will promote and support the capacity of Provincial Public Health Offices to plan and implement MOPH/CBHC policies and strategies in their provinces.

6.3.6 Healthy Behavior Promotion Department

The HBPD will initially focus on IEC/BCC issues related to the basic package of health services and to the priority promotion and prevention programs. All IEC/BCC health messages will follow the national guidelines and convey messages that do not conflict with one another. Therefore, the HED will work to promote the adoption of healthy behavior and optimal use of health services and ensure that health is a valued individual and community asset through:

- Carefully overseeing the preparation of appropriate BCC materials to support and explain this Child Health Policy, especially at the community and BHC level
- Provide leadership in formulating integrated national IEC Policy , strategy , and plan
- Coordinate all IEC related activities with concerned directorates within MoH in collaboration with stakeholders.
- Supervise and monitor IEC component of health projects at central and peripheral levels.
- Facilitate the development process of health education materials.
- Standardize messages of national scale programs e.g. EPI, Nutrition, TB, Malaria, Breast Feeding, Birth spacing, and Basic Hygiene etc.
- Publish health education materials.
- Collect , compile analyze data and provide feedback
- Identify training needs and develop training plan for relevant staff at all levels with especial focus on CHWs.

6.3.7 Control of Communicable Diseases Directorate

Through the National TB Control Program (NTP) reducing the morbidity and mortality rate of tuberculosis is the prime responsibility of the TB Control department through ensuring the implementation of country wide DOTS, formulating national standard treatment guideline. Special attention will be given to community based approach by creating awareness among communities on how to prevent TB and referring suspected cases to a health facility and ensuring compliance of TB patients with the second treatment course in the community by CHWs.

Reducing the morbidity and mortality rate from malaria cases through ensuring the implementation of National Malaria Control Program, formulating standard treatment protocols with special focus on home based malaria case management and house to house distribution of LLINs by CHWs.

6.3.8 General Directorate of Policy and Planning

This general directorate will give guidance to the National Maternal & Child Health Committee on the regular progress reviews and periodical policy revisions, in order to ensure that the CAH policy and strategy stays aligned with the evolving general priorities of the MOPH.
The Planning Directorate specifically will facilitate the inclusion of CAH strategy components within the AoG program budgeting framework and the Integrated Strategic Health Planning and Budgetting process between DCAH and PPHDs.

The M&E and QA Directorate monitors and evaluates the MOPH programs and activities. It will assist the DCAH in developing and refining indicators that will facilitate monitoring progress and evaluating performance against the set targets at national, provincial and local level, and also facilitate the joint monitoring at provincial level under the authority of the PPHD.

The HMIS Unit manages all the routine statistics of the MOPH, and will assist the DCAH in determining the indicators that will be reported and used on routine basis regarding the CAH activities. HMIS will also assist in coordinating with institutions like CSO on integrating key child survival indicators in the population-based surveys like MICS and NRVA.

6.4 Cross-sectoral coordination and collaboration

The health sector alone cannot obtain significant and lasting changes in the child health status. Sectors such as Ministry of Rural Rehabilitation and Development, Ministry of Agriculture, Ministry of Education, Ministry of Women Affairs, mass media and other line ministries are clearly important. The supports of line ministries are also serve as the entry point for child survival and development. The MOPH child and Adolescent Health Department through the top/senior management will have overall leadership for child and adolescent health, but will collaborate and build strong partnership with a number of other Ministries. The MOPH in general and the CAH in particular will work closely, but not exclusively, with the Ministries listed in *Annex 1*. on all relevant activities.

6.5 International initiatives and commitments

The MOPH participates in several international initiatives that contribute to CAH, as listed in *Annex 4*.

6.6 Partnerships of MOPH

6.6.1 Donors
The MOPH Child and Adolescent Health Department will collaborate and advocate for support for child health and survival with all donors in Afghanistan with a specific focus on those supporting BPHS in which the women and child health care are the main component. Relevant areas of collaboration with each of these are specified in *Annex 2*. The main way of coordinating will be the National Maternal & Child Health Committee as specified in the TOR (see *Annex 6*)

6.6.2 Multi-lateral organizations
The MOPH Child and Adolescent Health Department will collaborate closely with, but not exclusively, with a number of United Nations (UN) agencies such as UNICEF, WHO, UNFPA, FAO and WFP. Relevant areas of collaboration with each of these are specified in *Annex 3.*

6.6.3 NGOs
The MOPH has contracted National and International NGOs to implement the BPHS and EPHS throughout the country. Child and Women health are an integral part of the BPHS and EPHS. The implantation on the ground

of this Child and Adolescent Health Policy and Strategy rest with the BPHS and EPHS NGOs. therefore, many of them have directly been involved in the process of policy and strategy development, and other national and international NGOs had opportunities to provide comments and inputs at various stages in both formal and informal meetings.

The Child and Adolescent Health Department will also closely work with NGOs to perform operations research in the field of CAH. In the past the MOPH has collaborated with CS/US to pilot community-based interventions on nutrition and community-based case management of IMCI diseases. A list of current BPHS and EPHS NGOs implementers may be obtained from the MOPH Grants and Contracts Management Unit.

6.6.4 Health Care Professional Associations and the academic community

Professional associations of physicians, nurses, midwives, and pharmacists can play important role in:

- Advocacy to increase awareness for safe motherhood and danger sign during pregnancy, and need for skilled care during entire maternity cycle for all pregnant women
- Advocacy to introduce Zinc and low osmolality (ORS) in private health sector.
- Implementation of IMCI protocol in their private practices
- Advocacy and promote health care providers regarding proper use of partograph and active management of third stage of labor.

Both the associations and the academic community can exert advocacy and leadership in the area of CAH, and help inform national strategic directions and policies, as well as research and education.

6.6.5 Other practitioners

Especially in rural areas practitioners not belonging to professional associations must be brought into the main stream if there is to be the full impact of this strategy.

The majority of pregnancies and deliveries are assisted by non-skilled attendants, who will be informed on clean delivery practices and basic essential neonatal care.

It is important to create a strategy that reaches all practitioners who the Afghan National Health Survey of 2006 have shown are consulted in over 50% of illness episodes. Major efforts from districts and health facilities are needed to approach all practitioners and inform them of the proper diagnostic and treatment procedures for the most important common ailments: diarrhea, respiratory illness and fever (malaria). For instance, helping train them in proper management of diarrhea (ORS and Zinc) and pneumonia (counting respirations and giving Cotrimoxazole).

6.6.6 Private sector

The private commercial sector will be mobilized for promotion of iodized salt, birth spacing methods, ORS and Zinc for diarrhea, and for adherence to laws and regulations regarding safety of food and medicines, limitations on commercialization of tobacco, child labor and work place safety, and environmental protection.

7. Operations research in support of child survival

In the period 2009-2013 the MOPH will take the lead in several initiatives for investigating how to improve delivery of proven effective interventions. These will include, but are not limited to:

7.1 Community treatment of severe malnutrition

The use of Ready-to-Use-Therapeutic Feeding (RUTF) as intensive therapy for severe degrees of malnutrition. Experience in other countries has shown this to be successful and much less costly than doing therapeutic feeding on an inpatient basis.

7.2 Community-based Growth Monitoring and Promotion
Given the still limited accessibility of the BPHS facilities, GMP without a strong community support and involvement will not work in Afghanistan. Successful approaches of other countries are being explored for transposing to Afghanistan, and experimented in 5 districts.

7.3 Diminish barriers to adequate referral of sick children
Referral systems and practices are ill defined in Afghanistan. The success of the BPHS – EPHS, and effective health care provision to infants and children rests with a well-functioning referral system. The barriers to adequate referral, both with providers and caretakers will be assessed, in order to indentify opportunities for improvement.

7.4 Pediatric Hospital Improvement Initiative
Linking up with the global initiative, the MOPH will explore the feasibility of a participatory approach to improve care for sick children, both emergency and inpatient, based on the best practices recommended in the WHO Pocketbook for Care of Children in Hospitals.

7.5 Uniject for TT vaccination at health posts
The MOPH will explore the feasibility of providing limited supplies of TT uniject to health posts for promoting TT immunization of pregnant women, in particular how to ensure quality of the vaccine and safe injection practices.

7.6 Mini clean delivery kits distribution
The MOPH will explore the feasibility of making mini clean delivery kits available at health posts, and in private shops through social marketing and other subsidized mechanisms.

7.7 Role of private practitioners in EPI
The MOPH will assess the role of private vaccination outlets and develop plans for the future role of private facilities and practitioners in boosting EPI coverage.

Annex 1: MOPH Collaboration with other Ministries

Ministry	Specific purpose
Ministry of Rural Rehabilitation and Development (MRRD)	• Implementation of interventions to address underlying causes, e.g. water systems and sanitation • Food aid and non-food interventions for improving food security and nutritional status
Ministry of Agriculture, Irrigation and Livestock (MAIL)	• Community-based food security interventions • Agricultural programs (livestock, production) • Food safety • Production of nutritious complementary food
Ministry of Women's Affairs	• Women, nutrition and communities • Maternal and Infant nutrition-related issues • Community-based food security interventions • Micro credit schemes for women entrepreneurs
Ministry of Commerce and Industry	• Iodized salt production • National legislation for iodized salt • Production of local nutritious complementary food • National Code for Marketing of Breast milk Substitutes • Food safety
Ministry of Education **Ministry of Higher Education**	• School curriculum development and health and nutrition education, • health education on sexuality and risks of early marriage, • prevention of Tobacco use, • prevention of accidents • dangers and avoidance of drugs • Incorporation of IMCI components in Medical Faculty Curriculum
Ministry of Justice	• National Code for Marketing of Breast milk Substitutes • Laws and regulations on tobacco • Maternity law • Traffic safety laws • Food safety laws
Ministry of Communication and Information Technology	• Health information is transferred to the community through various mass media such as newspapers, magazines, radio and television.

Annex 2: MOPH Collaboration with Donor agencies

Donor	Type of program	Coverage	Duration of Support
USAID	BPHS	13 provinces	2009-2011
USAID	EPHS	6 provinces	
USAID /BASICS	Child survival	Technical support to the central MOPH	Sep 2009
USAID / TB-CAP	TB	Technical support to the central MOPH	2010
USAID/COMPRI-A	Social marketing and private sector development support	Country wide	
USAID /Tech-Serve	Capacity building program	Central and provincial Levels	2010
USAID/HSSP	Quality improvement	13 provinces	2010
World Bank	BPHS	10 provinces/3SM	2009-2011
EC	BPHS	7 provinces	2009-2011
EC	Institutional strengthening	Central and provincial support	2009
JICA	Institutional strengthening	Central support	2009
GF	Malaria/TB/HIV-AIDs	Country wide	2009-2013
JICA	TB and reproductive health	Kabul	
GAVI/HSS	System support/C-IMCI	Country wide	2009-2011

Annex 3: MOPH Collaboration with UN agencies

UN agency	Sectors
UNICEF	• EPI (Vaccines supply) • Save Motherhood Initiative(EOC) • Birth spacing • Child protection • Child and women rights • Infant and young child feeding • Maternal nutrition • Severe malnutrition • Micronutrient fortification • IEC • Salt iodization • HIV/AIDs
WHO	• IMCI • Polio • Adolescent health • Tobacco control campaign • Maternal, infant and adolescent nutrition • IEC
UNFPA	• EOC • Birth spacing
WFP	• Food aid • Emergency Supplementary Feeding • Micronutrient fortification • Hospital food management systems
FAO	• Household food security • Food safety • Maternal nutrition • IEC

Annex 4: International initiatives and commitments

1 Afghanistan MDG goals

Afghanistan signed only up to the Millennium Declaration in 2004. Due to the long period of war the country had not only a late entrance on its way to achieving the MDG but suffers from additional problems that slow down the process of development in the health sector such as the insufficient number of qualified health staff especially females, lack of security and limited financial resources. Instead of adapting the targets the government of Afghanistan decided to extend the period of achieving the MDGs until 2020 and to use baseline data from 2000, but the Afghanistan National Development Strategy (ANDS 2008-2013) that is a MDGs-based plan serves as Afghanistan's Poverty Reduction Strategy Paper, set targets that it seeks to achieve by 2013. The targets have been listed in the CAH Policy

2. HIV

The prevalence of HIV in Afghanistan is very low and still is not posing major public health threat. The World Bank project, Afghanistan HIV and AIDS Prevention Project (AHAPP), and Global Fund project have been targeting Most at Risk Population (MARP). In addition GF round 7 projects will provide ART for those who diagnosed AIDS. The WB AHAPP will be lasted to 2010 while the Global Fund Project started in late 2008 and will be lasted for Five years. Collaboration with this department is mostly focused in promoting healthy lifestyles that prevent HIV transmission in adolescents.

3. Polio Eradication Initiative

Polio is still endemic in four countries in the world (Afghanistan, India, Pakistan and Nigeria). In 2008 Afghanistan had '32' polio conformed cases in 6 provinces mainly in southern region of the country and insecurity is mainly blame for having such cases although there is concern about highly mobile population and program management. Afghanistan planned six round of National Immunization Days (NIDs) and four rounds Sub-National Immunization Days (SNIDs) for 2009 with the financial, technical and procurement support from international community. The world is still strongly committed for polio eradication as an example in recent conference conducted in USA the Rotary International, Bill and Gate foundation, CIDA and USAID pledged millions of dollar for coming five years for Polio Eradication Initiative (PEI). CAH collaborates with the National EPI Program to promote polio eradication and strengthen routine immunization through judicious implementation of the NIDs and SNIDS.

4. Malaria

Global fund under round 8 will provide 55 million Euro over next five years to help and support the overall goal established for the recently approved National Malaria Strategic Plan 2008–2013 (NMSP) is "To contribute to the improvement of the health status in Afghanistan through reduction of morbidity and mortality associated with malaria". A limited number of carefully considered Objectives have been defined, supported by the following proposed Strategies, which all contribute to improving child survival:

- Upgrading prompt, effective treatment in endemic rural areas;
- Strengthening mechanisms for the prompt detection and control of outbreaks;
- Improving the coverage and quality of laboratory services including the introduction of RDTs in endemic rural areas;
- Introducing the wide-scale implementation of HMM through the extensive CHW network;
- Expanding the coverage and utilization of effective prevention with free distribution of LLINs;

- Increasing the awareness of the general population regarding the prompt recognition, appropriate care-seeking behaviors and effective prevention of malaria through community-level and mass media support;
- Strengthening and expanding Coordination and Partnership relationships;
- Conducting high-priority operational research activities in support of the continued implementation of evidence-based malaria control interventions.

5. TB Control Program

The Global Fund, JICA ,WHO and USAID are the donor agencies which play an important role in the TB control programme through early case detection, DOTs expansion, capacity development and promoting research. The CAH collaborates with the NTP on raising awareness of the need for early case detection to limit infection of children and of screening of contacts of infected children. Since BCG is a standard of care in Afghanistan, women with tuberculosis should breastfeed, but be diagnosed and adequately treated as early as possible, to limit infection of their children

6. GAVI

GAVI supports the introduction of new vaccines (HB and HIB) and also the implementation of C-IMCI through its Health Systems Strengthening.

Annex 5: Child age groups (0-18 years)

Clarification of child age groups as referred to in the CAH policy and CAH Strategy.

<table>
<tr><td>0-7 days</td><td>Early newborn</td><td rowspan="2">Newborn</td><td rowspan="3">Infants</td><td rowspan="4">Young Children</td><td rowspan="5">Under fives</td><td rowspan="8">Children</td></tr>
<tr><td colspan="2">0-28 days</td></tr>
<tr><td colspan="3">0-11 months</td></tr>
<tr><td colspan="4">0-23 months</td></tr>
<tr><td colspan="5">0-59 months</td></tr>
<tr><td>6-10 years</td><td colspan="5">Older chidren/school age children</td></tr>
<tr><td>11-13 years</td><td>Young adolescents</td><td colspan="4" rowspan="2">Adolescents</td></tr>
<tr><td colspan="2">11-18 years</td></tr>
</table>

Annex 6: National Maternal & Child Health Committee – Terms of Reference

Terms of Reference for
National Maternal & Child Health Committee

June 2009

Background

The Ministry of Public Health's (MOPH) National Child and Adolescent Policy 2009-2013 was recently developed and approved. This Policy provides the direction in child and adolescent health for the next four years: the focus of this policy is the reduction of mortality among infants and children under 5. As the health and survival of mothers is intimately linked to the child, it is proposed to form a National Maternal Child Health Committee (NMCHC) to ensure that this new policy for children along with existing policies for women's reproductive health, maternal health and survival are fully supported and implemented through all levels of the MOPH and partners. The NMCHC will do this by maintaining the MOPH's focus on maternal and child survival, providing oversight of various maternal and child survival efforts and promoting coordination among MOPH departments, the provincial health offices, other government ministries, MOPH partners and donors so that the Health and Nutrition Strategy goals for reducing maternal, infant and child mortality are achieved as well as the country's Millennium Development Goal-4 and 5 targets met by 2015.

Purpose

The NMCHC will provide high-level oversight, direction and advocacy for promoting implementation of maternal and child survival interventions to assure that maternal, infant and under 5 child mortality are reduced significantly in Afghanistan. The NMCHC will work closely with the MOPH Departments, NGOs, UN agencies, donors, other government ministries and the private sector to implement the National Reproductive Health Strategy and the National Child and Adolescent Health Policy in a coordinated and effective manner.

Roles and responsibilities

1. Monitor progress to implement the National Child and Adolescent Policy 2009-2013 toward achieving mortality reduction for infants and children under 5 and progress towards achieving the country's targets for Millennium Development Goal 4
2. Monitor progress to implement the National Reproductive Health Policy toward achieving mortality reduction for women and progress towards achieving the country's targets for Millennium Development Goal 5
3. Hold MOPH accountable for achieving national health objectives and targets related to reducing maternal, infant and child mortality.
4. Promote coordination of maternal and child survival activities so that targets for mortality reduction are achieved. This coordination among donors, international agencies, and NGOs will strengthen the program synergies, reinforce policies and

strategies, and to enable all organizations supporting maternal and child survival to effectively work towards the common goals for women and children.

5. Serve an advocacy function for maternal child survival by encouraging MOPH, other government ministries, MOPH partner organizations and donors to participate in accelerating the implementation of integrated and coordinated maternal and child survival strategies.
6. Oversee the establishment of Provincial Maternal and Child Survival Committees and collaborate with then and Provincial Health Directors, to ensure that maternal and child survival interventions are reflected in the development and implementation of provincial annual operational plans. Analyze annual MCH reports from each province, identifying areas of success to publicize and those with special need for reinforcement and arrange for additional resources for those lagging behind.
7. Advocate for adequate funding and human resources from all sources to promote maternal and child survival activities, including from the government, partners, international organizations, UN Agencies and donors.

Functioning of the National Maternal and Child Survival Committee:

The NMCHC will:

- Advocate for maternal and child survival at all levels of government and the private sector. NMCHC members will advocate for maternal and child survival by encouraging all relevant MOPH partner organizations to participate and accelerate the implementation of integrated and coordinated maternal and child survival strategies.
- Regularly monitor key maternal and child survival indicators derived from routine HMIS, special surveys and other information resources to identify progress and areas needing more attention to assure continued advancement towards meeting survival goals
- Issue an Annual National Maternal and Child Survival Progress Report covering key achievements in the area of maternal and child survival, citing provinces with positive progress and identifying provinces needing additional efforts and resources. The Report will cover MOPH's progress in implementation of the annual maternal and child survival workplan, major constraints and opportunities in scaling up key interventions, and issuing directives for making further progress.
- Review and approve an Annual Maternal and Child Survival Work Plan developed by the Directorates of Women's and Reproductive Health, and Child and Adolescent Health in consultation with other MOPH departments and MOPH partners and donors.
- Identify new technologies and approaches that should be incorporated into the health system that will significantly and substantially advance the goals of maternal and child survival, bringing these to the attention of the MOPH and partners for rapid implementation across the country.
- Meet at least twice a year to review progress, approve reports and make recommendations to accelerate maternal and child survival.

Membership
Chairman: His Excellency, the Minister of Public Health
Vice- Chairman: Deputy Minister of Public Health, Technical
Vice- Chairman: Deputy Minister of Public Health, Health Services Provision

- MOPH
  - Director-General for Health Services Provision
  - Director-General for Policy and Planning
  - Director, Child and Adolescent Health
  - Director RH and Safe Motherhood Initiative Program
  - Director, PHC
  - Manager, National Nutrition Program
  - Manager, IMCI Department
  - Manager, National Immunization Program

- MOPH Partner Organizations
  - WHO Representative
  - UNICEF Country Representative
  - UNFPA Country Representative
  - BASICS Country Leader
  - Representatives of NGOs working in Child Survival

- Donors
  - USAID Representative
  - World Bank Representative
  - European Commission Representative
  - JICA

- Other Government Ministries
  - Ministry of Education
  - Ministry of Rural Rehabilitation and Development
  - Ministry of Women's Affairs
  - Ministry of Agriculture
  - Ministry of Haj and Religious Affairs

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