The Afghan Ministry of Health adhered to the Integrated Management of Childhood Illnesses (IMCI) approach through a ministerial decree on the major policies to reduce infant and child mortality. The ministerial decree, taken on April 7, 2003, established the IMCI Management structure at the Central level.

Diseases such as pneumonia, diarrhea, malaria, measles, and malnutrition all prevalent in Afghanistan are major causes of mortality and morbidity in children under five years of age in the developing world.

Cost-effective approaches such as the Integrated Management of Childhood Illnesses, as developed by UNICEF and WHO, has proved its cost-effectiveness in the reduction of morbidity and mortality among children of this age group.

A full implementation of the IMCI improves the identification of illnesses in health care settings, ensures appropriate treatment of major illnesses, and rationalizes the referrals of severely sick children. The IMCI incorporates disease prevention through promotion of breast feeding, counselling on nutrition and immunization of sick children.

The major components of IMCI are improvements in (1) the skills of health staff in case management of common childhood illness (2) the health system needed to allow effective management of childhood illnesses and (3) family and community practices.

First national IMCI Case management course

Development of human resources to ensure a qualitative implementation of the IMCI was selected as a decisive component of the strategy in Afghanistan.

End of October WHO financially and technically supported an 11-day case management course for first level health facility workers.

The course conducted by a clinical instructor aided by three facilitators from Sudan, was designed for the Ministry of Health officials, program coordinators, academicians, NGOs, other partners and members of the IMCI working groups to further expose them to the IMCI approach.

The course pursued the following objectives:
- Assess and classify children under 5 years presenting fever, diarrhea, ARI, Measles and Malnutrition
- Identify serious classifications requiring referral
- Identify and treat classifications that need treatment in the facility or at home
- Counsel mother on home management and their own health
- Reassess the child on follow-up visits and provide appropriate care

Training methods used included videos, photographs, booklets, role plays, individual and group feedback, drills, discussions and hands-on clinical practice.

IMCI Orientation Workshop - 30 January 2003

Senior officials from MoH decision makers, NGOs and other partners were first introduced to the Global development of the IMCI approach during a joint WHO/MoH/UNICEF orientation workshop. Participants learned from experiences in 120 countries where the IMCI strategy is already operationally and successfully implemented.

National IMCI planning workshop...

Early April 2003, the three IMCI working groups collected information to prepare for the IMCI early implementation phase. These groups produced the Adapted Afghanistan version of training materials, mother’s card and feeding recommendations.

The group set criteria for the selection of provinces/districts, assessed health facilities and infrastructure.

Plans of action prepared by all groups of the IMCI were reviewed, compiled and endorsed by MoH and the National Plan for the early implementation phase in August 2003 at a National Planning Workshop.

Consensus Workshop

Generic materials adapted to the Afghan context were approved and endorsed by MoH at a consensus workshop conducted in August 2003 prior to the planning workshop.

Exposure of nationals to the IMCI experience in Sudan accelerated the process of adaptation and implementation.

Facilitators training course - 28 September - 2nd October 2003

Creating a pool of National Facilitators was essential to spin the IMCI approach. Prior to the first National IMCI 11-days training course the Ministry of Health and WHO organized the first training of facilitators from 28 September - 2nd October 2003, at the Indira Gandhi Institute of Child Health.

The 9 participants included senior pediatricians and medical officers from Kabul Medical Institute, MoH, Indira Gandhi Hospital, Ataturk Children Hospital, Mywand Paediatric Hospital and 3 Medical Officers (2 from Safe Children US and one freelance).

All candidates had participated in an IMCI training course in Sudan and Pakistan sponsored by WHO.

Outpatient clinical sessions were organized in Q-I-Zamankhan Health Center and OabeiMCH Clinic.

Using the guide for outpatient clinical sessions, participants were introduced to various facilitation techniques, assigned patients, conducted clinical demonstrations, practiced illing recording forms and monitored performance.

Both sick, young infants and children from 2 months to 5 years of age were consulted and their conditions demonstrated.

Major achievements 2003

- MoH adopted through a Ministerial Degree, on April 7, 2003, the IMCI strategy
- Establishment of an IMCI management structure and working group
- Nomination of a national IMCI coordinator and focal point
- Creation of the Adaptation, implementation, family and community subgroups
- Adaptation of the training materials and selection of the early implementation and development of a National Plan Fellowship to six nationals to attend an IMCI case management training in Sudan to gain experience and accelerate the process of implementation
- Training of 34 nationals in the early implementation areas
- Implementation of the IMCI three components in Kabul Wardak and Nangarhar Provinces.

Priorities for 2004

- Establish the appropriate managerial IMCI structure at provincial level in the selected provinces; expansion of the outreach level
- Promote the accurate identification of childhood illnesses in outpatient settings
- Ensure appropriate combined treatment of all major illnesses
- Ensure the necessary health facility support with the relevant supplies and equipment
- Strengthen the counseling of caretakers
- Speed up the referral of severely ill children
- Promote appropriate care seeking behaviors, improved nutrition and preventive care, and the correct implementation of prescribed care in the homesetting
- Review and expand the experience of toothprovinces.
**Maternal & Child Health**

With 45,000 women dying per day, there is evidence that women’s rights should be more centralized in Afghanistan. This country possesses one of the highest maternal mortality rates in the world (16,000 per 100,000 live births) which translates to 80% of deaths and 20% of live births.

More than 90% of deliveries occur at home. Only 5% of deliveries are attended by skilled personnel. Referral sites and hospitals are located in the remote areas where the transportation infrastructure is not developed.

The five major causes of maternal mortality include hemorrhage, sepsis, obstructed labor, hypertensive disorders of pregnancy, and abortion.

The five major causes of maternal mortality include hemorrhage, sepsis, obstructed labor, hypertensive disorders of pregnancy, and abortion.

**Establishment of a Reproductive Health task force**

In 2003 WHO provided technical and policy support to MOH through the Reproductive Health task force including establishment of norms and standards, adaptations of standards, formulation of maternal and newborn health care.

**Introduction of the Mother-Baby Package**

A tool guide for actions and interventions in the field of maternal and newborn health.

The Mother-Baby Package was introduced in Afghanistan as an important tool to guide actions and interventions in the field of maternal and newborn health.

- **Strengthening maternal and child health care services**
  - To improve and strengthen maternal and child health care services, WHO provided 180,000 kg of MCH supplies and equipment to 12 referral hospitals (provincial and district) and 40 Maternal and Child Healthcare facilities which serve around 120,000 women of child-bearing age and 180,000 underfive children in five regions of Afghanistan.

**Capacity building**

In 2003 WHO trained female doctors and midwives from five regions of Afghanistan as Master Trainers of Traditional Birth attendants. Master trainers have trained 10 trainers in their respective regions who in turn trained 100 TBAs from each region. The trained TBAs are responsible for follow-up and monitoring of the TBAs. Training materials are provided to trained TBAs and NGOs to support their TBA training programs.

**Priorities for 2004**

- Formulate national policies and strategies on integrated reproductive health care as part of a comprehensive package in the national health care system.
- Improve functional birth-spacing services.
- Improved reproductive health care, with specific focus on maternal and neonatal services.
- Implement cost-effective interventions aimed at promoting reproductive health through functional, clinical and epidemiological research.
- Improve healthy reproductive practices.
- Develop and implement plans for strengthening accessibility to and availability of quality reproductive health care.
- Develop model legislation for right-based approach to reproductive health and family planning.

**Malaria & Leishmaniasis**

A national prevalence survey in Afghanistan showed that malaria is the most common illness during the transmission season. The main vector of malaria is Anopheles stephensi, which is found in the highlands and mountains of Afghanistan.

**Technical support**

- Development and dissemination of generic guidelines for early detection, investigation and response (in local languages).
- Development and dissemination of the National Malaria Treatment Protocol (in local languages).
- Development of a Social Mobilisation/Communication for Behavioural Impact (COMBI) plan.
- Development of a National Insecticide-Treated Nets (ITNs) strategy.
- Pre-positioning of rapid malaria diagnostic test sand medications in several regions.

**Operational research**

- National prevalence survey: The study demonstrated that malaria was a common illness during the transmission season. Malaria was also common (12% of the population) in the highlands and mountains of Afghanistan.

**Priorities for 2004**

- Multi-year strategic plan
- Initiation of entomological activities
- Training programs
- Provision of anti-malarial drugs
- Scaling up of insecticide treated nets
- Health education and social mobilization
**Water & Sanitation**

- **Buckets of water on children's shanksandheads**, being trembled from one street to another is still common in Afghanistan.
- Inadequate quality of water and inappropriate sanitation account for more than 80% of diseases in developing countries. Currently, Afghanistan has the lowest water supply and sanitation coverage in the world. Only 24% of the population has access to safe drinking water, and 12% have sanitation facilities.

- The lack of proper water supply and sanitation service coverage rates in Afghanistan coupled with the hereditary conditions are attributed to an under 5-mortality rate of 25.7% and an infant mortality rate of 16.5%.

- WHO Afghanistan initiates and implements numerous activities ranging from the construction of water supplies in numerous cities (Faizabad, Jalalabad, Kunduz, Kandahar, Ghazni, etc.) to the chlorination of water sources, the purchase of pumps, pipes and fittings, and the training of staff to improve water quality and sanitation.

- Chlorination of water sources in Kabul helped control and combat cholera in the city. Latrines constructed in Kandahar, Ghazni, Kunduz, Mehterlam, and Charikar have helped control and combat cholera in the city. Latrines constructed in Kandahar, Ghazni, Kunduz, Mehterlam, and Charikar.

- **Procurement of equipments & materials**
  - All water supply projects require material, equipment, like generators, pumps, pipes, and fittings. Funding for these projects are extra budgetary sources. The Japanese donations will improve water supply and sanitation for IDPs. AGFUND’s contribution will buy water quality testing equipment.

- **Capacity building**
  - Selected Technicians from MoPH and central authority of water supply and sewerage are trained on water quality testing using water quality equipment procured and installed by WHO Afghanistan.
  - The Community Water & Sanitation unit organized 13 training courses on entrepreneurial relations between water, sanitation, and health, environmental health, water supply engineering, water quality testing, water surveillance, food safety and low-cost treatments of water-waste disposal/treatment.
  - WHO staff work from within the ministry of public health maintaining a close working relationship with the counterparts in an attempt to enhance the capacity. National authorities are being trained on how to operate and maintain projects after completion.

- 50 educators were trained to disseminate hygiene education messages to promote hygiene awareness among Kabulis. Strategies included house-to-house and school visits.

- The latest campaign was jointly launched by all stakeholders in August to chlorinate 17,500 shallow wells.

**Rehabilitation of the Kunduz Water Supply Project**

- The Kunduz water Supply Project was successfully terminated in December 2002. The project rehabilitated existing wells used as a water source for drinking water, distribution reservoirs, transmission pipes, the old water supply system of Kunduz city, existing public standposts, installed new ones, constructed a pump house and generator houses.

- WHO placed emphasis on building the capacity of primary health care doctors, nurses, clinical psychologists and Community health Workers.

- WHO helped the government formulate policies and guidelines, which acknowledged the importance of water.

- WHO provided a 3-phased treatment for drug addicts, which involves motivation, detoxification and aftercare.

- Training protocols for communitary disorders were developed for inclusion in BSP.

**Mental Health**

- **Mental health resources** and support to all the meager resources in Afghanistan.

- According to the WHO project Atlas, there are only 6 psychiatrists for a population of 25 million.

- The limited number of health facilities compounds the shortage of mental healthcare practitioners. There are only two mental health facilities with 80 psychiatry beds.

- In 2003WHO placed special emphasis on building the capacity of primary health care doctors, nurses, clinical psychologists and Community health Workers.

- WHO provided a 3-phased treatment for drug addicts, which involves motivation, detoxification, and aftercare.

- Self-help groups for drug addicts and children at the drug support program led by WHO.

- A 1997 WHO study assessed the effects of the war on Afghans. The study conducted on 300 children in Kabul showed that 40% of children lost their parents, two-thirds had seen dead bodies or spent days of bodies, 90% believed that they would die during the conflict.

- Command disorders are found in patients suffering depression, anxiety, stress, psychosis, and substance use disorders.

**Major Achievements**

- National health policies developed in which mental health was recognized as a priority.

- Basic Services Package (BSP) developed in which mental health is one of the main components.

- Treatment protocols for common mental disorders were drafted for inclusion in BSP.

**Laboratory Rehabilitation**

- When the reconstruction period of Afghanistan began, WHO implemented the rehabilitation of the Microbiology laboratory and training of its technicians as the top priority in laboratory services for communicable diseases control and epidemiological surveillance.

- Whatever Microbiology laboratory Afghanistan possessed was dismantled during the 23 years of war.

- WHO fully equipped and supplied reagents to the Microbiology Laboratory and provided in-house theoretical and practical training courses for laboratory technicians. The latter have acquired the capacity to perform microbiological confirmation of the diagnosis of many diseases including cholera, diphtheria, and typhoid.

- In 2003, WHO provided the Microbiology Laboratory with media, reagents, sera and animal blood.

**Priorities for 2004**

- Emphasis on the job training and on learning by doing individually and in groups.

- Establishment of central reagent preparation laboratories. The laboratory, quality control, and assurance system was established by establishing internal control in each laboratory.

- Molecular biological laboratory established and branch of training for laboratory technicians in Polymerase Chain Reaction.

- Quality control and assurance system implemented by establishing internal control in each laboratory.

- External quality control for reagent preparation and tests performed by Afghanistan’s Central Laboratory.
this year WHO played a key advisory role in accelerating the reform of the Information-Education-Communication (IEC) Department of the Ministry of Health. WHO collaborated with USAID and various other partners to enhance the organizational, technical and managerial capacity of the IEC department.

This exercise will empower the Ministry in the planning, design, implementation, as well as monitoring and evaluation of multi-disciplinary communication programs in Afghanistan.

Aparticipatory approach involving all stakeholders - Public, Private and NGOs. Thenational level and across all sectors - Public, Private and NGOs.

The IEC strategy was developed during a workshop with all stakeholders early in October 2003. Participants, from the public and NGO sectors, weredeliberating steps to devising a communication strategy framework, from situational analysis to monitoring and evaluation.

The strategy sets goals, objectives and designs approaches to unify the behavior change and communication efforts supporting health programs at the national level and across all sectors - Public, Private and NGOs.

A participatory approach involving all stakeholders was promoted in the development of the strategy, to ensure consensus along the process.

The endorsement and the implementation of this strategy by the Ministry of Health will constitute a paramount step in the realization of prevention objectives relating to the health priorities outlined in the National Health Policy for Afghanistan.

Major Achievements

- Sponsored and provided technical support to Ministry of Health (MOH) for the health education campaign against diarrhea in Kabul City featuring radio spots and community outreach activities.
- Continued support to the production of a radio drama with BBC, "New Home-New Life," containing health messages on various subjects.

- Worked with WFP and the MOH on the National De-worming Health Communication Campaign into change behaviors relating to the infection with worms among school children aged 6-12 years.

Priorities for 2004

- Collaborate with USAID/REACH and MOH, as well as other partners, to develop policies and work plans for the IEC directorate.
- Increase the capacity of partners and stakeholders in the public, private and NGO sectors to implement the National IEC strategy at the central and provincial levels.

- Assist in the integration of health education into primary and secondary national school curricula.
- Design and implement evidence-based integrated health communication campaigns with support from WHO programs in reaching their behavioral goals (including strategies, materials, media plans, monitoring and evaluation).

-TableName 1: Demographic, Socio-Economic, and Health Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Year</th>
<th>Value</th>
<th>Reference</th>
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<tbody>
<tr>
<td>DEMOGRAPHY</td>
<td></td>
<td></td>
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<tr>
<td>Total area (in thousand sq. km)</td>
<td>1972</td>
<td>68.6</td>
<td>Afghanistan Gazette</td>
</tr>
<tr>
<td>Population (in millions)</td>
<td>2002</td>
<td>25</td>
<td>UNDP</td>
</tr>
<tr>
<td>Population per sq. km</td>
<td>2002</td>
<td>39</td>
<td>Calculation</td>
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<tr>
<td>Population growth rate (%)</td>
<td>2002</td>
<td>3.3</td>
<td>UNDP</td>
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<tr>
<td>Urban population (25% of total) (in thousands)</td>
<td>2002</td>
<td>6,250</td>
<td>Calculation</td>
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<tr>
<td>Total fertility rate</td>
<td>1998</td>
<td>69.9</td>
<td>WHO Report, 1999</td>
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<tr>
<td>CBR ( crude birth rate per 1000 population)</td>
<td>1995</td>
<td>42</td>
<td>WHO, 1997</td>
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<tr>
<td>CDR ( crude death rate per 1000 population)</td>
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<tr>
<td>SOCIO-ECONOMIC INDICATORS</td>
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<tr>
<td>2. Adult literacy</td>
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</tr>
<tr>
<td>2.1 Adult literacy Total (%)</td>
<td>2002</td>
<td>36</td>
<td>UNDP</td>
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<tr>
<td>2.2 Adult literacy males (%)</td>
<td>2002</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>2.3 Adult literacy females (%)</td>
<td>2002</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>3. Life expectancy at birth</td>
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<tr>
<td>3.1 Life expectancy Total (ys)</td>
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<td>UNDP</td>
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<td>3.2 Life expectancy males (ys)</td>
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<td>UNDP</td>
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<td>3.3 Life expectancy females (ys)</td>
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<td>HEALTH STATUS</td>
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<td>4. Infant mortality rate (per 1000 live births)</td>
<td>2002</td>
<td>1,600</td>
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<td>5. Under 5 mortality rate (per 1,000 live births)</td>
<td>2002</td>
<td>210</td>
<td>UNDP</td>
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<td>6. Infant mortality rate (per 1,000 live births)</td>
<td>2002</td>
<td>155</td>
<td>UNDP</td>
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<td>7. Birth weight (% less than 2500 gr.)</td>
<td>2002</td>
<td>37</td>
<td>UNDP</td>
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<td>8. Acute malnutrition</td>
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<td>6.04%</td>
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<td>HEALTH SERVICES COVERAGE</td>
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<tr>
<td>1. Immunization</td>
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<td>1.2 Measles (% infants immunised)</td>
<td>2001</td>
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<tr>
<td>1.3 Polio (last visit) (infants immunised)</td>
<td>2001</td>
<td>51</td>
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<tr>
<td>1.4 BCG (% infants immunised)</td>
<td>2001</td>
<td>54</td>
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<tr>
<td>1.5 All vaccines (% infants immunised)</td>
<td>2001</td>
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<td>1.6 Tetanus (% of women in CBAs immunised with at least two doses of TT)</td>
<td>2000</td>
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<td>1.7 Total number of centres providing immunizations</td>
<td>2000</td>
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<tr>
<td>1.8 Total % receiving Vitamin A supplements</td>
<td>2000</td>
<td>95</td>
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<td>2. Primary health care services</td>
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<tr>
<td>2.2 % population covered Urban</td>
<td>1997</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2.3 % population covered Rural</td>
<td>1997</td>
<td>25</td>
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<td>3. MCH coverage by trained personnel of</td>
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<td>3.1 % of pregnant women receiving maternity care</td>
<td>1999</td>
<td>12</td>
<td>WHO, Afghanistan, 1999</td>
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<tr>
<td>3.2 % of deliveries attended by trained health personnel</td>
<td>1999</td>
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</tr>
<tr>
<td>3.3 % of deliveries attended by trained TBAs</td>
<td>1999</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>4. No. of hospitals’ beds per 100,000 population</td>
<td>2001</td>
<td>35</td>
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