

# Country Cooperation Strategy for WHO and Afghanistan 2009–2013

# Afghanistan



**World Health  
Organization**

Regional Office for the Eastern Mediterranean



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WHO and Afghanistan  
2009–2013

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## ❖ Acronyms and Abbreviations

ADB	Asian Development Bank
AHS	Afghanistan health survey
AIDS	Acquired immunodeficiency syndrome
ANDS	Afghanistan National Development Strategy (2008–2013)
ANHRA	Afghanistan national health resource assessment
ARTF	Afghan Reconstruction Trust Fund
ARDS	Afghan reconstruction and development system
ARI	Acute respiratory infection
BSC	Balanced Scorecard
BPHS	Basic Package of Health Services
CCA	Common Country Assessment
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention
CIDA	Canadian International Development Agency
CSO	Central Statistical Office
DEWS	Disease Early Warning System
EC	European Commission
EHA	Emergency Humanitarian Action
EMRO	Eastern Mediterranean Regional Office
EPHS	Essential Package of Hospital Services
GAVI	GAVI Alliance
GCMU	Grant Contract and Management Unit
GDP	Gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HEFD	Health Economics and Financing Directorate
HIV	Human immunodeficiency virus
HMIS	Health Management Information System
JICA	Japan International Cooperation Agency
JPRM	Joint Programme Review and Planning Mission
ICRC	International Committee for the Red Cross

IDB	International Development Bank
IDUs	Injecting drug users
IHR	International Health Regulations
IMCI	Integrated Management of Childhood Health
MDG	Millennium Development Goals
MICS	Multiple indicator cluster survey
MoF	Ministry of Finance
Mol	Ministry of Interior
MoPH	Ministry of Public Health
MRRD	Ministry of Rural Rehabilitation and Development
MSH	Management Sciences for Health
NIDs	National Immunization Days
NRVA	National risk and vulnerability assessment
NRVS	National risk and vulnerability survey
OIC	The Organisation of Islamic Conference
PHD	Provincial health department
PGC	Performance-based grant contract
PPA	Performance-based partnership agreement
PPG	Performance-based partnership grant
PRB	Population Reference Bureau
PRR	Priority reform and restructuring
RAMOS	Reproductive-age mortality studies
REACH	Rural expansion of Afghan community-based health care
SOWC	State of The World's Children
SWAp	Sector-wide approaches
TB	Tuberculosis
TT	Tetanus toxoid
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees

UNICEF	United Nations Children's Fund
UNIFEM	United Nations Fund for Women
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
WFP	World Food Programme



## Executive Summary

The first Country Cooperative Strategy (CCS) for Afghanistan was developed in July 2005 for the period 2005–2008. The CCS reflects WHO's medium-term vision for its cooperation in and with a particular country. In late 2008, it was felt that in view of development since then, the strategy should be revised and updated. With this in mind, a WHO Mission visited the country from 15–22 November 2008. It comprised staff from the WHO Regional Office for the Eastern Mediterranean and WHO headquarters and was led by the WHO Representative in Afghanistan. The Mission held detailed discussions with a team specially constituted by the MoPH, Afghanistan, to revise the first CCS, and were briefed by H.E. the Minister for Public Health and the Deputy Minister of Public Health for Technical Affairs on the Government's priorities and the technical support that was anticipated from WHO during the next five years. The Mission also met with WHO staff working in the country office, with representatives of some of the larger donors to the health sector in the country and nongovernmental organizations who had been contracted out to provide the Basic Package of Health Services (BPHS) in the provinces. The Mission, through one of its members, also met with the UN country team to brief them about the CCS process and outcome and its potential for shaping the health dimension of the second UN Development Assistance Framework (UNDAF) for Afghanistan that was currently being initiated in the country.

Despite the continuing conflict, threat to human security and political instability, there has been considerable progress in the country since 2002, especially in the area of political transformation to a democratically elected government. Other achievements included: enrolling nearly 6 million children in primary and secondary education (35% of whom are young girls); availability of Basic Package of Health Services (BPHS) in 85% of the country; re-establishment of core state economic and social welfare institutions; macro-economic stability and the development of commercial banking and telecommunication networks led by the private sector. However, the country continues to face several critical challenges to human development. Some of these challenges include: widespread poverty; limited fiscal resources that limit the delivery of public services; insecurity arising from the activities of extremists, terrorists and criminals; weak governance and corruption; corrosive effects of a large and growing narcotics industry and major human capacity limitations.

Afghanistan's health indicators are currently near the bottom of international indices and far worse than any other country in the Region. Life expectancy is low (47 years for males and 45 years for females), high infant, under-five and maternal mortality, respectively at 129 per 1000 live births, 191 per 1000 live births and 1600 per 100 000 live births, and an extremely high prevalence of chronic malnutrition and widespread occurrence of micro-nutrient deficiency.

There is a high burden of communicable diseases. Some of the major challenges and constraints faced by the health sector include: inadequate financing for many of the key programmes and heavy reliance on external sources of funding; insufficient and inadequately trained health workers and a lack of qualified female health workers, particularly in the rural areas; lack of access to health care due to dispersed populations; poor quality of services provided; lack of national capacities for health planning and management, especially in the areas of governance, health care financing, human resource development, for monitoring, evaluation and analysis of the health situation at central and especially so at the provincial level and lack of appreciation of the role of social determinants of health in the national context and of the need for intersectoral action for improving health outcomes.

In response to the above-mentioned developmental challenges facing the country a very positive development has been the preparation of a five-year (2008–2013) Afghanistan National Development Strategy (ANDS). It provides a roadmap for transition towards stability, self-sustaining growth and human development. It is a Millennium Development Goals (MDGs)-based plan that serves as Afghanistan's Poverty Reduction Strategy Paper (PRSP). As an integral component of this strategic plan the Ministry of Public Health (MoPH) has formulated a health and nutrition strategy that provides strategic directions for reducing morbidity and mortality and for institutional development. The preparation of these strategy documents would go a long way in ensuring that all the stakeholders in the health sector align their priorities and

programmes with those of the Government. The overarching priority of the health sector is to address priority health issues through a universal coverage of BPHS supported by a strengthened referral network that links patients with hospitals that provide the Essential Package of Hospital Services (EPHS). It appears that in the medium term the Government would like to continue the practice of contracting out the provision of BPHS to nongovernmental organizations present in Afghanistan. Recently, concerns have been raised about the quality of services provided, the costing per capita for delivering BPHS and of ensuring access to populations in security-compromised areas and in provinces that are sparsely populated or which have poor infrastructure for transport. Another concern was that due to contracting out the BPHS and EPHS to nongovernmental organizations, the provincial health authorities found themselves with a limited and ill-defined role in health care delivery at provincial and district levels, thus creating tensions.

Approximately 60% to 80% of the Afghanistan's health sector's operating budget is financed by external donors. As part of its mandate, the WHO CCS Mission undertook a review of the development cooperation and partnerships in the health sector, of aid effectiveness and coordination. A major challenge in this connection was the reduced impact of the financial and technical support given by the international community to Afghanistan's health sector due to continuous conflict in many parts of the country that hinders access. The insecurity also limits the ability of development partners and the MoPH from effective monitoring and supervision of the performance of

nongovernmental organizations in delivering the BPHS and EPHS resulting in differences in the quality of health services delivered in various districts. There was a lack of uniformity or standardization of approaches, expectations, procurement services, funding and reporting mechanisms among different donors resulting in high transaction costs on the part of the Grants Contract and Management Unit (GCMU), MoPH and the nongovernmental organizations. The various coordination mechanisms established by the Government seem to be functioning suboptimally due to lack of leadership. In spite of these challenges, the Government and international community is committed to the Afghanistan Compact that ensures continuous financial and technical support from external donors to the national development objectives, including national health objectives.

The well-defined goals, priorities and monitoring framework of the ANDS (2008–2013) and the Health and Nutrition Strategy (2008–2013) ensures that international assistance is in alignment with and contributes to these goals. However, in spite of the fact that the Government has developed an aid effectiveness strategy, in line with the Paris Declaration for Aid Effectiveness and Afghanistan's international obligations, there was a need to improve standardization of approaches, procurement services, joint programming and implementation and tools and guidelines in order to improve quality and maximize resource use, in other words harmonization is lagging.

Past and current WHO cooperation with the Government was reviewed with a view to identifying weaknesses and strengths

of the country office. WHO's role as the lead technical agency is well recognized, however, its coordination and information-sharing role needs improvement. Certain areas of technical expertise needed upgrading, such as policy formulation and strategic planning in different aspects of health systems, emergency preparedness and response to humanitarian crises, social and environmental determinants of health and in mental health. There is also a need to upgrade its leadership and coordinating role in the field of maternal and child health. It needs to play a more active role at the policy level for promoting intersectoral collaboration for improving health outcomes.

Based upon a careful analysis of the country's health and development challenges, the national and international response to these challenges and taking into account to the Organization's own priorities, strengths and strategic plans as articulated in the Eleventh General Programme of Work from 2006–2015 and in its Medium Term Strategic Plan for the period 2008–2013, the Mission identified the following strategic priorities in close consultation with national counterparts.

- ❖ Health system strengthening based on the values and principles of primary health care (main focus: human resource development, stewardship and governance; health information system and health care financing).
- ❖ Social and environmental determinants of health.
- ❖ Control of communicable and noncommunicable diseases (main focus: communicable diseases and mental health).

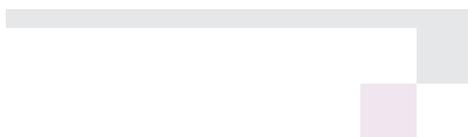
- ❖ Reproductive and child health (main focus: reproductive health and child health).
- ❖ Emergency preparedness and response (main focus: emergency preparedness and International Health Regulations (2005)).

Under each of the above strategic priorities a set of strategic approaches has been formulated.

The Mission feels confident that these priorities are aligned with the national health priorities and take into account WHO's relative advantage. It was evident from the discussions held with MoPH officials that in the period covered by the present CCS, greater emphasis will be placed on seeking

WHO support for policy formulation and strategic planning on a variety of pressing health issues. At the same time, WHO support would also be needed for generating evidence for policy formulation and planning programmes for areas that currently lack the required evidence for this purpose (e.g. noncommunicable diseases, road traffic accidents, etc.) through carefully designed surveys/research studies.

Finally, the Mission carried out an analysis of the current technical capacities of the country office to deal effectively with each of the above-mentioned strategic priorities and made recommendations about strengthening them where they were considered suboptimal.





Section

1



Introduction





## Section 1. Introduction

In order to strengthen the effectiveness of its cooperation with Member States, the World Health Organization (WHO) has institutionalized the Country Cooperation Strategy (CCS) as an integral part of its Country Focus Policy. The CCS reflects WHO's medium-term vision for its cooperation in and with a particular country. It defines a strategic framework for working with that country, highlighting what WHO will do, how it will do it and with whom. The CCS also serves as the main WHO instrument for aligning its own priorities and strategic plans with national health development plans and priorities and for harmonizing its work with other multilateral and bilateral agencies during the coming 3–5 years.

The first CCS was formulated in July 2005 for the period 2005–2008. As the country continues to face enormous health development challenges aggravated by insecurity and impending humanitarian crises, it was timely to update and revise the first CCS. With this in view, preparatory work was initiated by the WHO country office in August 2008 to review the first CCS and to revise Sections 2 and 4 of the report dealing respectively with the country's health and development challenges and national responses and past and current WHO cooperation. The MoPH (MoPH) was informed of the need to revise the first CCS and was requested to establish a working group comprising senior officers dealing with strategic planning to hold discussions with the visiting WHO CCS Mission from 15–22 November 2008.

The timing of the revision and updating of the first CCS was opportune for two main reasons. The first reason was the finalization and approval of the Afghanistan National Development Strategy (ANDS) for the period 2008–2013 in April 2008 after two years of extensive analytical work and consultations. As part of the ANDS a detailed health and nutrition strategy for the same period had been developed by the MoPH. Thus, the CCS Mission had access through the ANDS and the health and nutrition strategy to the latest information on the achievements of and challenges facing socioeconomic and health development in the country and about the national priorities and strategic plans for various sectors of the Government. The second reason was the initiation of preparations for the formulation of the second UN Development Assistance Framework (UNDAF) for Afghanistan and afforded an opportunity for the revised CCS to serve as WHO's input into the UNDAF.

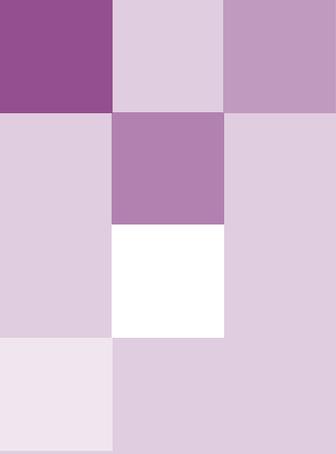
The WHO CCS Mission had frank and detailed discussions with the national counterparts and a highly informative briefing on health priorities and programmes by the H.E. Dr Amin Fatimie, Minister of Health, Government of Afghanistan and by Dr Faizullah Kakar, Deputy Minister of Public Health for Technical Affairs. Detailed discussions were also held with the WHO Representative and other professional staff working in the WHO country office, with some of the major donors to the health sector as well as with representatives of some of the nongovernmental organizations

who had been contracted out to provide the BPHS in some provinces of the country.

The Mission also had the opportunity to meet and interact with the staff of provincial health departments from all over the country who were in Kabul for a meeting with the central MoPH. One of the members of the WHO CCS Mission also attended a meeting of the UN country team in Kabul to appraise the CCS.

The CCS Mission during its work had the opportunity to use the WHO Country Cooperation Strategy e-guide, Modules 2 and 3, developed by the Department of Country Focus in WHO headquarters. The purpose of this e-guide is to increase awareness of the importance of the WHO CCS, to improve the quality of the CCS process and the document produced, and to promote the use of the CCS.





Section

# 2

Country Health and Development  
Challenges and National Response





## Section 2. Country Health and Development Challenges and National Response

### 2.1 Summary of key development and health challenges

Despite the continuing conflict, threat to human security and political instability, there has been considerable progress in the country since 2002. In addition to the political progress that has included three rounds of free and fair elections, some of the major achievements include: enrolling 6 million children in primary and secondary education (35% of whom are young girls); availability of basic package of health services in 85% of the country; the return of over five million refugees; disarmament, demobilization and reintegration of over 63 000 former combatants; re-establishment of core state economic and social welfare institutions; macro-economic stability and the development of commercial banking and telecommunication networks led by the private sector.

However, the country continues to face several critical challenges to human development, which include:

- ❖ widespread poverty;
  - ❖ limited fiscal resources that limit delivery of public services;
  - ❖ insecurity arising from the activities of extremists, terrorists and criminals;
  - ❖ weak governance and corruption;
  - ❖ poor environment for private sector investment;
  - ❖ corrosive effects of a large and growing narcotics industry;
- ❖ major human capacity limitations throughout both the public and private sector.

Afghanistan's health indicators are currently near the bottom of international indices and far worse than any other country in the Region. Life expectancy is low, infant, under-five and maternal mortality is very high and there is an extremely high prevalence of chronic malnutrition and widespread occurrence of micro-nutrient deficiency. Some of the major challenges and constraints faced by the health sector include:

- ❖ inadequate financing for many of the key programmes;
- ❖ heavy reliance on external sources of funding;
- ❖ inadequately trained health workers and lack of qualified female health workers,
- ❖ particularly in the rural areas;
- ❖ lack of access to health due to dispersed population, geographical barriers and lack of transportation infrastructure;
- ❖ poor quality of services provided;
- ❖ insecurity that makes implementation of programmes difficult;
- ❖ lack of effective financial protection mechanisms for poor households to receive required care without experiencing financial distress;
- ❖ lack of mechanisms for effective regulation of for-profit private sector clinics and pharmacies.

## 2.2 Demography and main health problems

According to data from the Central Statistic Office (CSO) Afghanistan's population is 24.5 million (CSO 2007/2008). According to available demographic data, the distribution of the population varies dramatically across the country. In 2001, the 77 districts with a population density below 20 inhabitants per km<sup>2</sup> hosted 13% of the population, scattered over 55% of the country's area. In the 120 districts with a population density below 30 per km<sup>2</sup>, representing 70% of the country's area, lived 24% of the population. 34% of the total population lived in the 71 districts with a population density of more than 100 inhabitants per km<sup>2</sup>.

Fifty two (52%) of the population is under 18 years of age with a life expectancy for females of 45 and for men 47 years. Life expectancy of men exceeds that of women, a phenomenon that is solely observed in Afghanistan and that might have its cause in an unprecedented high maternal mortality rate. With an estimated total fertility rate of 7.2 per woman and an average population growth rate of 2.0% per year, the population of Afghanistan is increasing very rapidly.<sup>1</sup>

The key problems facing Afghanistan and its health system are: (i) high levels of infant (129/1000) and under-five (199/1000) mortality rates; (ii) one of the world's highest maternal mortality ratios (1600/100 000 live births); (iii) elevated levels of malnutrition throughout the population; (iv) high incidence of communicable diseases; (v) inequitable

distribution of quality health services; and (vi) low capacity to implement effective and efficient health services at all levels of the health system (MoPH 2004).<sup>2</sup>

## 2.3 Macroeconomic, political and social context

In response to developmental challenges facing the country, a five-year national development strategy has been prepared after two years of analysis and priority-setting drawing on extensive national and subnational consultations for the period 2008–2013. It provides a roadmap for transition towards stability, self-sustaining growth and human development. It is a Millennium Development Goals (MDGs)-based plan that serves as Afghanistan's Poverty Reduction Strategy Paper (PRSP).

The pillars of the national strategy are 1) security; 2) governance, rule of law and human rights; and 3) economic and social development. Security requires achieving nationwide stabilization, strengthening law enforcement and improving personal security for every Afghan. Governance, rule of law and human rights requires strengthening democratic practice and institutions, human rights, the rule of law, delivery of public services and government accountability. Economic and social development means reducing poverty, ensuring sustainable development through a private sector-led market economy, improving human development indicators and making progress towards the targets of the MDGs.

<sup>1</sup> *Afghanistan Multiple Indicator Cluster Survey*. Kabul, UNICEF, 2003.

<sup>2</sup> *Capacity building plan for central and provincial Ministry of Public Health administration staff*. Kabul, Ministry of Public Health, May 2004.

Under these three pillars, there are several cross-cutting themes i.e. capacity-building, gender equity, counter narcotics, regional cooperation, anti-corruption and environment. Health and nutrition is one of the priorities under the pillar of economic and social development and a detailed health and nutrition strategy has been developed that is discussed later in the document.

### 2.3.1 Political and administrative structures

The structure of the Afghan Government is unitary; all political authority is vested in the Government in Kabul. The subnational administration comprises 34 provinces and 364 districts, with each province having between 3 and 27 districts. Provinces and districts are legally recognized units of subnational administration. They are not intended to be autonomous in their policy decisions, although there have been some attempts at establishing local participative bodies. The Constitution specifies that a provincial council be elected in each province, and also specifies the election of district and village councils. Each province has one provincial municipality, while most districts have one rural municipality, which are in principle a separate level of government and have limited autonomy in budget execution and in budget preparation. The Ministry of Interior controls their staffing establishment and approves their budgets.

### 2.3.2 Socioeconomic context

Partly owing to its previous poor state after years of conflict, the economy has

recorded rapid growth since 2001. The main driver of growth has been the construction sector, which has been boosted by foreign efforts to rebuild the infra-structure and the development of private housing. The country's biggest economic sector is technically illegal. Afghanistan accounted for roughly 90% of global opium production in 2007 and opium contributes to over one third of the total gross domestic product (GDP) of the country.

The GDP per capita (in purchasing power parity (PPP) terms) in Afghanistan has risen from US\$ 683 in 2002 to US\$ 964 in 2005.<sup>3</sup> Non-drug GDP has increased more than 50%, primarily reflecting the recovery of agriculture from severe drought, a revival of economic activity and the initiation of reconstruction. Afghanistan's poverty level continues to remain high (details are given later in the document). Although no specific survey has been conducted, the overall unemployment rate is estimated at 32%.<sup>4</sup> The factors identified as inhibiting employment and economic growth are: (i) weak state of national institutions; (ii) lack of support services, including key infrastructure and market access; (iii) lack of access to capital and financial services; and (iv) lack of advanced entrepreneurial skills, knowledge and technology.

The informal economy in Afghanistan continues to account for 80% to 90% of the total economy; women work primarily in this sector; sociocultural reasons and a lack of opportunity prevents them from participating in formal economic activities. The economy

<sup>3</sup> *Afghanistan human development report*. Centre for Policy and Human Development, 2007.

<sup>4</sup> IRC Labour Market Information Survey, 2003 and as quoted in Common Country Assessment for the Transitional Islamic State of Afghanistan, UN System Kabul, October 2004.

has legal and illegal components. The former is centred on agriculture, commerce, manufacturing, handicrafts and transport while the latter includes extensive opium production, along with widespread unauthorized timber harvesting and mineral extraction.

Afghanistan's social indicators rank at or near the bottom among developing countries, preventing the fulfilment of rights to health, education, food and housing. Afghanistan's health development index stands at 0.345 and places Afghanistan 174 out of 178 countries in terms of global ranking.<sup>3</sup> Since 2002, important progress has been achieved, but much remains to be done in order to reach a significantly strengthened social infrastructure, realize the rights to survival, livelihood, protection and participation and reach the targets of the MDGs.

### 2.3.3 The MDGs in Afghanistan

When the Millennium Summit was held in September 2000, Afghanistan was in the midst of a conflict. It was only in March 2004 that the Government officially endorsed the MDGs and began participating in this effort. As the country was then recovering from two decades of conflict, it was decided to modify the calendar for achieving the MDGs and to amend the benchmarks taking into account the still devastated state of the country. In other words steps were taken to 'Afghanize' the MDGs. This involved extending the time period for attaining the targets to 2020, revising the targets to make them more

relevant to Afghanistan and adding a ninth goal on enhancing security.

## 2.4 Health status of the population

The major problems facing Afghanistan and its health system are: (i) high levels of infant and under-five mortality rates; (ii) one of the world's highest maternal mortality ratios; (iii) elevated levels of malnutrition throughout the population; (iv) high incidence of communicable diseases; (v) inequitable distribution of quality health services; and (vi) low capacity to implement effective and efficient health services at all levels of the health system (MoPH, 2004).<sup>2</sup> Table 1 provides an overview of the most recent estimates of health and demographic indicators in Afghanistan.

Apart from programme-specific information, no nationwide information was currently available that could indicate the burden of disease and its trend, or morbidity and mortality patterns, such as leading causes of death. The top 10 diseases seen in the outpatient clinics in health facilities in 2007 in Afghanistan as reported by the health information systems are: acute respiratory infections; diarrhoeal diseases; urinary tract infections; trauma; psychiatric disorders; malaria; tuberculosis suspected cases; severe childhood illnesses; viral hepatitis; pertussis. The information in Table 2 can be taken as a proxy reflection of the ill-health status in Afghanistan.

**Table 1. Recent health and demographic indicators for Afghanistan**

#	Indicators	Value	Year	Source
1	Total population (million)	24.5	2007-2008	CSO
2	Settled population (million)	23	2007-2008	CSO
3	Nomadic population (million)	1.5	2007-2008	CSO
4	Women of reproductive age (15–49 years) (million)	5.64	2007-2008	CSO
5	Children under-five years of age (million)	4.9	2007-2008	CSO
6	Life expectancy at birth, females (year)	45	2003	PRB
7	Life expectancy at birth, males (year)	47	2003	PRB
8	Total fertility rate (per woman)	7.2	2008	SOWC
9	Infant mortality rate (per 1000 live births)	129	2006	AHS
10	Under-five mortality rate (per 1000 live births)	191	2006	AHS
11	Maternal mortality ratio (per 100 000 live births)	1600	2002	RAMOS
12	Contraceptive prevalence rate (%)	15.4	2006	AHS
13	Skilled antenatal care (at least one visit, excluding tetanus toxoid (TT)) (%)	32.3	2006	AHS
14	Pregnant women receiving at least two doses of TT (%)	23.8	2006	AHS
15	Skilled birth attendance (%)	18.9	2006	AHS
16	Exclusive breastfeeding (%)	83	2006	AHS
17	Underweight prevalence under five (%)	39.3	2004	NNS
18	DPT3 coverage (%)	82.9	2007	NEPI
19	Measles vaccination rate (%)	70.3	2007	NEPI
20	Fully immunized (12-23 months) (%)	27.1	2006	AHS
21	Vitamin A receipt in last 6 months (6–59 months) (%)	79.7	2006	AHS
22	Polio laboratory-confirmed cases (number)	31	2008	NEPI
23	ITN utilization rate among children under-five years of age (%)	5.7	2006	AHS
24	HIV prevalence, adult (%)	<0.1	2007	UNAIDS
25	Estimated tuberculosis prevalence (all cases per 100 000 population)	231	2008	NTP
26	TB case detection rate (%)	70	2007	NTP

#	Indicators	Value	Year	Source
27	TB (DOTS) treatment success rate (%)	89	2007	NTP
28	Hospital beds per 10 000 population	4.2	2004	NHA
29	Household access to drinking-water from pump or protected spring (%)	40.3	2006	AHS
30	Household with access to sanitary latrine (%)	75.1	2006	AHS

Sources : CSO = Central Statistical Office  
 PRB = Population Reference Bureau  
 SOWC = State of The World's Children  
 RAMOS = Reproductive-age mortality studies  
 AHS = Afghanistan health survey  
 NNS = National nutrition survey  
 NEPI = National Expanded Programme of Immunization  
 NTP = National tuberculosis programme  
 NHA = National health facility assessment  
 UNAIDS= Joint United Nations Programme on HIV/AIDS

**Table 2. The top ten diseases in Afghanistan 2007**

No	Diseases
1	Cough and cold
2	Ear, nose and throat
3	Pneumonia
4	Acute watery diarrhoea
5	Acute bloody diarrhoea
6	Diarrhoea with dehydration
7	Malaria
8	Urinary tract infections
9	Psychiatric disordersa
10	Trauma

Source: Health management information system 2007.

## 2.5 Socioeconomic and environmental determinants of health

A wide range of socioeconomic and environmental determinants influence health outcomes. What follows is a summary of the

key determinants that influence health and health equity in Afghanistan.

### 2.5.1 Poverty

Poverty in Afghanistan is complex and multidimensional due to low assets (physical, financial and human), years of insecurity

and drought, cultural traditions and poor infrastructure and public services. The Government has undertaken detailed poverty diagnostic work—to better understand the causes and effects of poverty and propose pro-poor growth strategies as parts of the national strategy. The Government's national risk and vulnerability assessment (NRVA) conducted in 2007, indicates that 42% (12 million people) of the population were living below the poverty line with incomes of about US\$ 14 per month per capita and 20% were located very close to the poverty line. Food poverty was estimated at about 45%, in other words, inability to purchase sufficient food to provide a minimum food intake of 2100 calories per day.

Within the country, significant inequality exists between the rural, Kuchi (nomadic pastoralists) and urban population. Meanwhile, gender inequality is one of the highest in the world as the vast majority of women do not participate in paid economic activity. Consumption inequality is also of great concern as the top 10% of the population's share of total consumption is 21.1% while the share of the bottom 10% is only 3.6%. Poverty is more severe in the northeast, central highlands and parts of the southeast. The rural population, who account for the majority of the poor, represent nearly 80% of the population. The main characteristic of rural poverty is high food insecurity and a lack of access to infrastructure and basic public services.

### 2.5.2 Women and gender

The status of Afghan women is one of the lowest in the world. The gender

development index (GDI) for Afghanistan at 0.310 is second lowest out of all countries. Although women and girls constitute nearly one-half of the country's population, their status remains undermined by a male-dominated society and a lack of gender sensitivity in data collection and analyses. Violence against women is one of the main security problems in Afghanistan. According to a study conducted by the United Nations Fund for Women (UNIFEM) in Afghanistan on violence against women, 30.7% of cases resulted from physical violence, 30.1% from psychological violence, 25.2% from sexual violence and 14.0% from a combination of the above, in addition to kidnapping and attempted kidnapping. The study reported that the majority of the acts of violence (82%) were committed by family members.<sup>5</sup>

In Afghanistan, despite legislation forbidding under-age marriage, 57% of girls are married before the age of 16 and 70% to 80% of women face forced marriages. According to the United Nations Population Fund (UNFPA), the mean age at marriage in Afghanistan is 17.8 years for women and 25.3 years for men. Early marriage of girls, and consequently early pregnancy and child birth, puts women at high risk of maternal mortality. The majority of rural Afghan women work at home in agriculture and livestock management but without being remunerated. Cultural constraints restrict the movement of women and limit their access to work outside their home and their access to health care. Largely as a result of two decades of war, there are nearly 1 million widows in Afghanistan with an average age of 35 years.

<sup>5</sup> <http://www.unifem.org/afghanistan/media/pubs/08/factsheet.html>, accessed 29 November 2010.

Finally, health indicators for both women and children remain excessively poor. For example, almost two-thirds of tuberculosis patients are female in Afghanistan, which is an exception. The female mortality rates reflect the dire conditions in which most of them live. Although a significant increase in the number of female health workers has potentially broadened female access to health care, it does not offset the effects of widespread violence against women in Afghanistan.

### 2.5.3 Education

Twenty-eight (28%) percent of the population (6 years and older) in the country are literate. The urban population has a literacy rate of 56%, households in the rural areas 23%; while only 6% of the Kuchi can read. Almost half of the men and more than 85% of women in Afghanistan are illiterate.<sup>1</sup> Disparities exist between provinces, reflecting the conservative, tribal societies where gender segregation is common (Kabul Province school enrolment 76%, Uruzgan Province 19%.<sup>6</sup>

The gross enrolment ratio (combined for primary, secondary and tertiary levels) has risen to 59.3% in 2005, up from 45% in 2002.<sup>7</sup> In 2005, the total number of students in primary schools (grades 1–6) was 4.25 million of whom 35.9% were girls. The total number of students enrolled in secondary and high schools was 0.63 million and 24.1% were females. Only 19% of the schools are designated as girls' school and in 29% of educational districts there are no designated

girls' school at all. At the primary level there is one girl pupil for every two boys and at secondary level one girl pupil for every three to four boys. Retention of girls is a problem in schools at all levels. Many reopened girls' schools have been destroyed by Taliban or local military fractions. Major challenges in the field of education include: poor institutional capacity to plan and manage education programmes; poor quality of education and outdated curriculum; shortage of qualified teachers, particularly women; and lack of training and shortage of spaces for learning and essential teaching–learning material.

### 2.5.4 Vulnerability

Among vulnerable groups are female-headed households, including widows, people with physical or mental disabilities, people who live in geographically isolated areas, the landless, orphans, but also children, women, nomads, the elderly, internally displaced persons and returnees. The national risk and vulnerability assessment in 2005 revealed that the highest proportion of households with low dietary diversity and poor food consumption is found in central Afghanistan and Nuristan province in the east. These areas have bad roads and difficult access to markets throughout the year. The northern parts of the country present higher dietary diversity related to higher and more diversified local production. National risk and vulnerability assessment (NRVA) 2005 data indicate that 30% of households eat, on average, below their daily requirement and population groups below minimum levels of dietary energy consumption, including

<sup>6</sup> *Common Country Assessment for the Islamic Republic of Afghanistan*. United Nations System, Kabul, October 2004.

<sup>7</sup> *Afghanistan national human development report 2004*. United Nations, 2004.

nomads (24%), rural (30%), urban (31%) and with a national figure of 30%. The identified forms of vulnerabilities found in the cities (Kabul, Jalalabad and Herat) include: income failure (people with disabilities, elderly, widowed, female-headed families), food insecurity (families with high dependency rates, less diverse income sources, women with disabilities) bad health status (working children, poor housing, people with physical disabilities, especially women, war victims), social exclusion and disempowerment.

The National Disability Survey in Afghanistan (2005) found the prevalence of disability to be 2.7% (95% CI 2.4%–3.1%). Over half of persons with disability live in the western and central regions of the country with the vast majority (69.7%) living in rural settings. The distribution of persons with disabilities has two distinct peaks, the first between 4 and 9 years (25.8%) and the second in the over-45 year age group (26.8%). The majority of persons with disability were men (58.9%).

### 2.5.5 Food security

Access to food is limited due to remoteness, bad roads and transportation, seasonal variation and low food production. Families cannot afford to purchase food as needed due to the low income and large family size. Diversity of food is very poor due to unavailability of different food items, low purchasing power and low levels of nutrition-related education. The devastation caused by the drought has left more than 5 million Afghans dependent for survival on food aid and assistance from UN and private relief organizations.

## 2.5.6 Water and sanitation

Access to safe drinking-water varies considerably throughout the country. Only 31% of households have access to safe drinking-water,<sup>8</sup> with Kuchi household having the lowest level at 16%. In some provinces such as Bamyan, Bahglan and Sar-I-Pul the figures are less than 10%.<sup>6</sup> By and large, urban households have nearly three times higher access to drinking-water (64%) as compared to rural households (26%). The Afghanistan health survey, 2006, reveals that 24.9% of households have no toilet facilities while the remaining households have access to some kind of sanitation facilities, e.g. a traditional latrine within their compounds and households. Sanitary means of excreta disposal are scarce. Sanitations systems in major cities are lacking, resulting in a high number of waterborne diseases, especially during the summer months (e.g. outbreaks of cholera). The Government has established a National Environmental Protection Agency with responsibility for developing and implementing national environmental policies and strategies.

## 2.6 Health systems and services

### 2.6.1 Priority public health problems and programmes

The following sections address the priority public health problems of maternal and child health, malnutrition, communicable and noncommunicable diseases and emergency and humanitarian crisis.

<sup>8</sup> *Afghanistan health survey*. Baltimore, John Hopkins University, 2006.

### 2.6.1.1 Maternal and child health

Poor maternal health continues to be a major challenge for the Afghan health system. Maternal mortality is estimated to be very high at 1600 per 100 000 live births, the second highest mortality rate in the world. Reproductive health services are provided as an integrated package in the BPHS and EPHS facilities. The percentage of pregnant women receiving care from skilled birth attendants has increased from 5% in 2002 to 32% in 2006 and delivery by skilled birth attendants has increased from 5% in 2002 to 19% in 2006. Thirty-two (32%) percent of women make at least one visit to a skilled provider for antenatal care, but not all receive the required antenatal services. Nine in ten rural women deliver babies at home without skilled birth assistance or proper referral services for essential and emergency obstetric care. Among the newborn infants of mothers who died, only 1 out of 4 has a chance of surviving until their first birthday. Depending on the location, between 30% and 90% of women in rural areas cannot access health care. The average Afghan woman had 7.4 children in 2004. The high fertility rate, coupled with early marriage and limited access to modern family planning methods and health facilities have a devastating toll on the health of both mothers and children. Contraceptive prevalence rate increased from 10% in 2003 to 15.4% in 2006. Educational status, wealth and geographical access play a key role in the use of health services by women. While distance is an important barrier to the use of maternal health services, many women who live close to health facilities do not receive essential services. Each provincial health directorate has a reproductive health officer whose

work is to assist, supervise and monitor the implementation of reproductive health policies at the provincial level. The shortage of skilled birth attendants, especially in rural areas, is a major constraint in delivering reproductive health services.

Though the infant mortality rate has decreased from 165 per 1000 live births in 2002 to 129 per 1000 live births, and the under-five child mortality rate from the high baseline level of 257 per 1000 live births to 191 per 1000 live births—both are among the world's highest. The major causes of morbidity and mortality among children include measles, diarrhoea, acute respiratory infection, malaria and micronutrient deficiencies, such as scurvy. The annual number of deaths from diarrhoea among children under five is estimated to be 85 000. The Integrated Management of Childhood Health strategy (IMCI) was formally endorsed by the MoPH in 2003 and by the end of 2007, 72% of primary health care facilities in all provinces had at least 60% of the providers trained in IMCI. One of the main constraints to implementation was the low rate of follow-up visits conducted after training with only 12% of providers followed up. The GAVI Alliance (GAVI) health system strengthening proposal, worth about US\$ 1 million for a period of three years (2008–2010), has been approved and funds will be used to support the child health component of training community health workers. Support for child health is also being provided by the United States Agency for International Development (USAID)/BASIC and UNICEF. The former has identified five strategic areas for support in a 18-month plan with a budget of US\$ 2 million that include child health policies and strategies, improvement of child care in community,

BPHS and EPHS levels and strengthening of health system components. UNICEF's country programme worth US\$ 18 million has been extended to 2009. Its support for child survival includes support for the immunization programme (introduction of Hib vaccine in 2009 and national immunization days (NIDs)) and nutrition (infant and young child feeding, including a pilot project on ready-to-use therapeutic foods for community management of uncomplicated severe acute malnutrition). The MoPH has constituted a working group to develop a child health situation analysis and policy.

### 2.6.1.2 Malnutrition

Fifty-four (54%) percent of Afghan preschool children are malnourished. Chronic malnutrition is widespread, between 40% and 60% of Afghan children are stunted, 39% were underweight; and 7% wasted, the latter is an indicator of acute malnutrition (Table 3). Multiple sources indicate that the introduction of timely complementary foods is low with increasing stunting rates in children between 6 and 24 months.<sup>9</sup> The prevalence of underweight among non-pregnant Afghan women 15–49 years of age was almost 20%. Factors contributing to malnutrition include: food insecurity at household and community level; the

**Table 3. Prevalence of various nutrition-related parameters by population group**

Target Group	Median urinary iodine (µg/L)	Urinary iodine deficiency (% <100 µg/L)	Received vitamin A capsule within the last 6 months (%)	Anaemia <sup>1</sup> (%)	Stunting <sup>2</sup> (%)	Underweight <sup>3</sup> (%)	Wasting <sup>4</sup> (%)
Preschool children 6–59.9 months	--	--	81.0	37.9	53.7	39.3	6.7
Children 7–11.9 years	49.0	71.9	--	--	--	--	--
Non-pregnant women 15–49.9 years	42.0	74.7	--	24.7	--	20.8	--
Men 18–60.0 years	--	--	--	7.1	--	--	--

<sup>1</sup> Anaemia defined as Hb<11.0 g/dL in children, Hb<12.0 g/dL in women, and Hb<13.0 g/dL in men (Hb adjusted for altitude, pregnancy status and cigarette smoking).

<sup>2</sup> Height-for-age Z-score <-2.

<sup>3</sup> Weight-for-age Z-score <-2 in preschool children, and BMI <18.5 in non-pregnant women.

<sup>4</sup> Weight-for-height Z-score <-2.

-- Not applicable

<sup>9</sup> *National Vitamin and Mineral Deficiency Survey, Afghanistan*. MoPH, UNICEF, CDC, 2004.

prolonged drought situation in the last few years along with the long-standing effect of war on agriculture; seasonal variation of food availability; large families with low income; low purchasing power for quality foods due to poverty; poor health nutrition education to understand the use of balanced foods; gender discrimination in relation to food consumption; improper breast and complementary feeding practices and co-existence of diseases such as diarrhoeal diseases, acute respiratory infections (ARI), malaria, worm infestation and tuberculosis.

### **2.6.1.3 Communicable diseases**

Communicable diseases are an important public health and development problem in Afghanistan. Available information indicate that, in addition to ARI and diarrhoea that affect children (as outlined above), tuberculosis, malaria and vaccine-preventable diseases such as measles and neonatal tetanus significantly contribute to the ill-health of the Afghan population. Social determinants of health such as poverty, gender, lack of health education and limited access to health services have also contributed to the high magnitude of communicable disease problems.

Tuberculosis is still highly epidemic. Afghanistan is one of the 22 high-burden countries in the world. The estimated incidence of all tuberculosis cases is about 161 per 100 000 and the mortality ratio is 32 per 100 000 population.<sup>10</sup> Almost 80% of such patients are young adults, and more importantly, about two-thirds of all patients are female. Since implementation began in 2002, Afghanistan has rapidly expanded

tuberculosis care (DOTS) greatly assisted by the expansion of the BPHS. About 500 diagnostic centres are operational and several international partners (Canadian International Development Agency (CIDA), Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Italian Corporation, Japan International Cooperation Agency (JICA), United States Agency for International Development (USAID) and the World Food Programme (WFP) have supported the expansion. Case notifications showed rapid increase: from 21 844 in 2005 to 28 689 in 2008: the case detection rate is reportedly 70%. Treatment success rates are about 90%. However, access to tuberculosis care is still limited, particularly in remote and hard-to-reach areas and the quality of tuberculosis care is not yet optimal.

Malaria is endemic in Afghanistan, particularly in 14 out of 34 provinces where 14 million people live. Returnees from neighbouring countries, internally displaced persons and nomads are also vulnerable. In 2008, a total of 4641 283 cases of malaria were reported in Afghanistan. With the assistance of partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), nongovernmental organizations and USAID, malaria care has been scaled up through expanding the network of laboratory services, introducing rapid diagnostic tests at the community level and providing free long-lasting insecticide-treated bednets (LLINs) to affected provinces. However, access to diagnostic services and the coverage of LLINs are still limited. Leishmaniasis is also endemic. Cutaneous leishmaniasis is particularly rampant in Kabul where

<sup>10</sup> *Global tuberculosis control*. Geneva, WHO, 2008.

the estimated incidence has drastically increased from 15 000 in 1995 to 70 000 at present. Afghanistan, with the assistance of partners, has expanded diagnostic and treatment services. However, despite this rapidly increasing burden, the disease is still largely neglected by the international community of donors and funding for diagnosis and treatment is limited.

HIV/AIDS epidemic is at an early stage in Afghanistan and is concentrated among high-risk groups, mainly injecting drug users (IDUs) and their partners. Reliable data on HIV prevalence in Afghanistan is sparse. To date, 478 HIV cases have been reported. However, it is estimated that there could be between 1000 and 2000 Afghans living with HIV. Afghanistan has developed a national HIV/AIDS strategic framework and has started scaling up of HIV/AIDS care, prevention and treatment to ensure universal access to health care services for most-at-risk populations and implement a multisectoral response. However, progress is often limited due to stigma, discrimination and other socioeconomic factors.

Vaccine-preventable diseases are a very important public health problem. Polio eradication is a national priority. Afghanistan is one of the remaining four polio-endemic countries in the world. Afghanistan has established well-functioning active surveillance for acute flaccid paralysis, and since 1998, successive rounds of NIDs followed by sub-NID and mop-up campaigns have been conducted. However, due to insecurity in polio-endemic areas, implementation of such activities has been seriously affected and there has been a resurgence of cases. In 2008, until mid

November, 31 cases had been reported (as opposed to 14 for the same period in 2007) largely from provinces in the south (Kandahar (12), Urzughan (5) and Helmand (7)). Afghanistan will increase the number of NIDs for nationwide and sub-NIDs for primarily affected areas.

Routine immunization (DPT3/HepB3) has reportedly shown very high coverage rates of 83% in 2007 and 85% in 2008, drastically increased from 41% in 2001. Measles vaccination coverage (routine) has also shown reportedly good coverage of 70% in 2007 and 75% in 2008. A second dose of measles vaccine was introduced as a part of routine immunization, but its coverage was only 16% in 2007 and 40% in 2008. Measles catch-up campaigns started in 2002 and were followed in 2003, 2006, 2007 and 2009. The number of reported cases of measles was reduced from 88 762 in 2001 to 2861 in 2007 and 1149 in 2008. However, there have been small outbreaks: a total of 1141 outbreak cases were reported in 2007 and 1340 cases in 2008. The cases reported during outbreaks (recorded and reported through the health management information system) are not part of the total number of reported cases through the system.

Afghanistan is one of the seven countries in WHO's Eastern Mediterranean Region that has not eliminated maternal and neonatal tetanus. A recent WHO/UNICEF mission has identified 102 districts with uncertain risk for maternal and neonatal tetanus that requires one round of TT immunization, while 101 districts were considered at high risk and required 2–3 rounds of TT immunization. The estimated burden of diseases that could be prevented by new vaccines is

high in Afghanistan: 36 000 deaths due to pneumococcus, 15 000 deaths due to Hib and 18 000 deaths due to rotavirus diarrhoea. With the assistance of GAVI, Afghanistan will introduce Hib vaccine as part of the pentavalent vaccines (DPT/HepB3/Hib) in early 2009, and is expected to introduce other new vaccines in the near future.

Outbreaks of epidemic-prone diseases continue to occur in Afghanistan. In 2008, in addition to outbreaks of pertussis and measles, an outbreak of Crimean-Congo haemorrhagic fever and multi-focus outbreaks of cholera occurred. Avian influenza has affected only poultry to date. In order to ensure early detection and response to outbreaks, Afghanistan has scaled up the Disease Early Warning System (DEWS): 129 sentinel sites in 34 provinces are functional. Afghanistan has also started full adoption of the International Health Regulations (IHR 2005), along with their preparedness for anticipated pandemic of influenza. A national focal person for IHR has been nominated. However, developing national preparedness and response is still incomplete and will remain a challenge. Laboratory support for disease surveillance is almost non-existent.

#### **2.6.1.4 Noncommunicable diseases**

Mental health remains an important problem. It is estimated that over 2 million Afghans suffer from mental health problems such as depression, schizophrenia and bipolar disorder. Due to the long period of conflict it is estimated that most Afghans suffer from levels of stress disorder. Mental diseases have not been addressed over

the last decades in Afghanistan and little is known about the disease pattern in Afghan society.

A study in 2000 compared the mental health status of women living in Taliban-controlled versus non-Taliban controlled areas. Major depression among women living in Taliban-controlled areas was recorded as 78% as against 28% among women living in non-Taliban controlled areas (Amowitz 2003). Suicidal ideation was alarmingly high—65% in Taliban-controlled area versus 18% in the control area and actual suicidal attempts 16% in the Taliban-controlled area versus 9% in the non-Taliban controlled area. There has been no demonstrable improvement in the mental health status of the population in the post-Taliban years. A nationwide survey conducted in the first year after the US-led invasion found high levels of depression symptoms (male (59.1%), female (73.4%)), anxiety symptoms (male (59.3%), female (83.5%)) and post-traumatic stress disorder (male (32.1%), female (48.3%)) and confirmed by others.<sup>11</sup> There is a clear correlation between the number of traumatic events and the likelihood of developing psychopathology.

Anecdotal evidence indicates that cardiovascular diseases and cancer are being diagnosed with increasing frequency, but reliable estimates were not available about their incidence and of the prevalence of related risk factors in the general population.

<sup>11</sup> Scholte WF et al. Mental health problems following war and repression in Easter Afghanistan. *The Journal of the American Medical Association*, 2004, 292:585-593.

### 2.6.1.5 Emergency and humanitarian crises

The humanitarian situation in Afghanistan has been deteriorating with the growing insecurity and intensification of armed conflict that has spread northwards from the south and southeast and with a dramatic rise in the prices of wheat and wheat flour, and crop failure in some regions. It is estimated that nearly 4.5 million people in both urban and rural areas face greater food insecurity. The exact quantification and geographical location of the population groups most at risk is difficult to determine. Preliminary results of nutritional data collected in 11 provinces by the MoPH indicates increases in the global acute malnutrition rate (19.7%), in severe acute malnutrition rate in children under the age of 5 years (6.7%) and in the severe malnutrition rate in 24% of lactating women and in 19% of pregnant women.

In November 2007 a workshop was held in Afghanistan to discuss how the cluster approach could support humanitarian actions in the country. A humanitarian UN Country Team (UNCT) was established at the same time under the leadership of the Deputy Representative of the UN Secretary General, the Resident Coordinator and the Humanitarian Coordinator. In early 2008, a roll-out of seven clusters was started in a staggered process. WHO leads the health cluster with UNICEF, UNFPA and national and international nongovernmental organizations as members. The MoPH is a key partner.

The existing and potential crises in the country could fall under two categories (related either to civil strife and/or due to natural disasters) that imply different

mandates and modus operandi for the health cluster. WHO country office capacity for emergency preparedness and response is rather limited to deal with the leadership role that has devolved on it and which includes functions such as coordination at the central and provincial levels, training, joint planning and resource mobilization. Additional capacities in epidemiology, information and logistics would be required to deal effectively with preparing for, and responding to, humanitarian crises.

### 2.6.2 Provision of health services and health system performance

The following sections address the provision of health services, hospital reform, governance and leadership, financing, the health workforce, health information and monitoring the performance of the health system.

#### 2.6.2.1 Provision of health services

In 2002, the MoPH decided to implement the provision of the BPHS through contracting out to nongovernmental organizations. The cost of US\$ 4–5 per capita was estimated for BPHS as the basis for contracting. The GCMU, which was established in the MoPH in March 2003, is responsible for undertaking all steps related to the contracting out process, disbursement of funds, financial monitoring of contracts and supporting the three MoPH-strengthening mechanism provinces. It is estimated that 65% of the population lives within two hours walking distance of a centre providing BPHS. The MoPH is targeting 95% coverage to be achieved by 2015, which is also the year for achievement of the MDGs.

There are three major donors supporting the contracting out of the BPHS: the World Bank (WB) in 11 provinces covered by eight nongovernmental organization contracts and three MoPH-strengthening mechanism contracts; USAID in 13 provinces based on the cluster approach; and European Commission (EC) in 10 provinces. For comparability and as a trial for future sustainability three provinces, assigned to the WB—Kapisa, Parwan and Panjsher—for implementation of the BPHS have been contracted out to the MoPH strengthening mechanisms. Staff are recruited through the MoPH priority reconstruction and reform (PRR) process, the selection is merit-based and the level of remuneration is almost three times that of the regular staff of the MoPH, but considerably less than the salaries of the staff working in the nongovernmental organization contracted out facilities.

The BPHS is offered at four standard levels within the health system.

- ❖ A health post is staffed with one female and one male community health worker covering a catchment area of 1000 to 1500 people, equivalent to 100 to 150 families.

- ❖ A basic health centre is staffed with one nurse, a midwife and vaccinators, covering a population of 15 000 to 30 000 people.
- ❖ A comprehensive health centre has more staff than a basic health centre, including both male and female doctors, male and female nurses, midwives, and laboratory and pharmacy technicians. It covers a population of 30 000 to 60 000 people.
- ❖ A district hospital (first referral hospital) serves up to four districts and a population of 100 000 to 300 000 people. It is staffed with doctors, including a female obstetrician/ gynaecologist, surgeon, anaesthetist and paediatrician, midwives, laboratory and X-ray technicians, pharmacist, and a dentist and dental technician.

Payment exemption strategies for the poor are implemented throughout the country with different mechanisms. Meanwhile, the public health interventions and clinical care (immunization, maternal delivery, antenatal care, family planning, treatment of tuberculosis and nutrition interventions) are provided free of charge to any citizen of Afghanistan. User fees are charged at most

**Table 4. Changes in the extent of access to primary health care services since 2000**

Results	2000 baseline	Achievement by 2006	High benchmark 2010	Health and Nutrition Strategy HNS 2013
Access to primary health care services within two hours walking distance	9% of population	65% of population	90% of population	90% of population

public health facilities, which is currently five Afghanis. Table 4 shows the change in extent of coverage since 2000.

The experience of contracting out of the BPHS to nongovernmental organizations has been promising in the medium term, although there have been several issues in relation to insufficient coverage, poor quality, inequity and sustainability as the funding for this initiative comes entirely from the donors. The MoPH is keen to continue the policy of contracting out over the next five years.

The CCS mission had an opportunity to meet with some of the nongovernmental organizations that had been contracted out to deliver BPHS in some provinces in the country. Some of the issues that emerged from this highly interactive meeting were as follows.

- ❖ WHO should actively engage with the nongovernmental organizations as they are the provider of the BPHS in all the provinces, except three, that are being managed by the MoPH and help build their capacities in areas such as mental health, dealing with disabilities, disease outbreaks and in responding to humanitarian crises that occur in the geographical areas where they are providing BPHS.
- ❖ WHO should be more involved in ensuring equitable access to quality health care.
- ❖ Nongovernmental organizations should be provided with health promotional and learning material produced by WHO and be invited to participate in various training activities sponsored by WHO in Afghanistan.
- ❖ In remote and poorly accessible areas, consideration should be given

to objectively assess the impact of training traditional birth attendants on reproductive health outcomes.

- ❖ The cost of providing BPHS should be recalculated.
- ❖ Clearly, there were some tensions between the nongovernmental organizations and the provincial health departments. WHO could help in improving coordination between the two through assisting the MoPH in defining clear roles and responsibilities for the provincial health departments.

### 2.6.2.2 Hospital reform

The MoPH has conducted a national hospital assessment in 2003, which helped identify the following priority needs.

- ❖ The ratio of 1 bed for 1000 was not reached in any province of Afghanistan, including Kabul, and their distribution was uneven with large parts of the population unable to access referral facilities.
- ❖ The physical infrastructure was acceptable but hospitals lacked adequate supply of water and electricity and were under-equipped with improper maintenance.
- ❖ Hospitals were under-utilized with average occupancy rates below 50%.
- ❖ Many hospitals, particularly in the large urban areas are over-staffed, lack female staff and there is lack of management and clinical skills among hospital staff.
- ❖ The availability and delivery of emergency obstetric care was particularly insufficient and the referral system was weak.

**Box 1. Strategies for improving health system performance and health outcomes****Reducing morbidity and mortality**

Implement the BPHS

Implement the EPHS

Improve the quality of maternal and reproductive health care services

Improve the quality of child health initiatives

Strengthen the delivery of cost-effective integrated communicable disease control programmes

Establish prevention and promotion programmes

Promote greater community participation

Improve coordination of health care services

Strengthen the coverage of quality support programmes

Reduce prevalence of malnutrition and increase access to micronutrients.

**Institutional development**

Promote institutional and management development at all levels

Strengthen health planning, monitoring and evaluation at all levels

Develop health care financing and national health accounts

Strengthen human resource development, especially of female staff

Strengthen provincial level management and coordination

Continue to implement priority reform and restructuring

Establish quality assurance

Develop and enforce public and private sector regulations and laws

In response, an EPHS has been prepared, which aims at standardizing hospital services. Currently, most of the secondary and tertiary hospitals are managed by the MoPH while some are supported by donors (USAID five provincial hospitals; EC four provincial or regional hospitals) or by nongovernmental organizations.

The reform process in the hospital sector was initiated with the implementation of EPHS in eight provincial hospitals, for which US\$ 10 million has been allocated by the Government to improve hospital services. The MoPH will have full ownership of this project and the proposed approach will encourage other partners in the health sector to engage in the hospital reform process.

The answer to many of the challenges for achieving better health of the Afghan people reside in improving the performance of the health system. The Health and

Nutrition Sector Strategy 2008–2013 of the MoPH provides the strategic directions for tackling these challenges. Earlier, the MoPH, in consultation with officials of the Government of Afghanistan, external donors, United Nations (UN) agencies and other stakeholders, adopted 18 strategies for reducing mortality and morbidity in the country and for institutional development in health (Box 1). This section will provide an analysis of the various health system building blocks and their contribution to improving health system performance.

**2.6.2.3 Governance and leadership**

The MoPH, with the assistance of its development partners, has made considerable progress during the last six years in assuming its legitimate role as the steward of the health system. Several policy and strategy documents have been developed with the assistance of development partners. The most recent is

the Health and Nutrition Sector Strategy for the period 2008–2013. Transforming these policies into strategic plans and implementable programmes continue to remain a challenge.

Efforts have been undertaken since 2004 to restructure the public health sector at the level of the MoPH and the provincial health directorates to confront the health challenges. A renewed effort is underway in 2008 to further reorganize the MoPH and provincial health departments so that the organizational structure is aligned to their functions, that there are clear departmental responsibilities and individual post descriptions, and that overlap among various tasks and functions is minimized. Considerable technical support shall be required in the coming years to develop the capacity of key directorates/departments, such as health policy and planning, health legislation and regulation, health human resources and health information. The health sector in Afghanistan relies heavily on financial and technical support from international development agencies, which requires good coordination. A strong international health department in the MoPH is essential to efficiently undertake this responsibility.

The overall governance function of the health system is weak and systems need to be in place to promote equity, accountability, transparency, ethics, enforcement of regulation, and informed decisions. Particular attention and institutional mechanisms are needed in the areas of:

- ❖ health regulation and enforcement
- ❖ promotion of equitable access to health services
- ❖ health workforce policy, production and management
- ❖ quality assurance in personal and population-based health services
- ❖ public health research, and
- ❖ reducing the health impact of emergencies and disasters.

#### 2.6.2.4 Financing

Data on health care financing are scarce, particularly in relation to spending by households. In the absence of a national health accounts analysis, the WHO estimates and studies carried out by donors and nongovernmental organizations indicate that the Afghan health care system is underfunded with a high level, up to 70% share of out-of-pocket spending. A survey conducted by a John Hopkins University team found that, within the catchment areas of health facilities, out-of-pocket expenditure by households was up to US\$ 29 per capita.

The financing of the health system relies mainly on contributions from donors (up to 60%, possibly more) channelled for contracting out of the BPHS to national and international nongovernmental organizations and for the MoPH strengthening mechanism and through funds to support the MoPH's regular budget. The per capita spending by the Government on health is estimated as 0.6% of GDP, which is passed on from the Ministry of Finance (MOF). In 2007, the MOF-approved projects were worth US\$ 93.0 million, which comes to less than US\$ 4.0 per capita public spending on health.

- ❖ monitoring, evaluation and analysis of the health situation
- ❖ public health surveillance
- ❖ health planning and management

Health care financing constitutes one of the major challenges facing health system rehabilitation and development, particularly as the Constitution mentions the right to 'free' health care. The concerns are the low level of health expenditure, equity in access to health services and sustainability of health care financing. The level of spending on health will remain low in the coming years unless high economic growth is expected. The financing gap should continue to be filled from donors' contribution but a scheme has to be developed in terms of gradual disengagement by donors and take over by nationals.

The Health and Nutrition Sector Strategy advocates for increased allocation to health. The spending should be: in line with priorities and coordinated across sectors; transparency strengthened in the allocation of financial resources and financial management; different sources of funding coordinated; monitoring the cost-effectiveness of different mechanisms of financing of health care monitored; and relevant baseline information obtained, including on household expenditure on health.

### **2.6.2.5 Health workforce**

Afghanistan lost many health professionals during the 20 years of civil strife and conflict. Training facilities were destroyed and degraded; ad hoc training with varying curricula, duration and teaching methodology was carried out within the country and across the borders resulting in different levels and standards of health workers. The human resource development situation in Afghanistan is complex and requires special

attention. There is a continued shortage of qualified health professionals in terms of numbers, gender, quality and distribution at all levels of the health services, especially for nurses, midwives, pharmacists and environmental hygienists. There is a continued severe shortage of female health workers in the remote areas of the country. There is maldistribution of health care providers between and within provinces, and between urban and rural areas which leaves the peripheral health facilities and remote areas understaffed. The main reasons for the maldistribution are the poor working, living and social conditions, security concerns and lack of educational facilities for children and transportation.

Since 2002, the MoPH has made major strides in building the human resources development process through establishment of the Directorate of Human Resources Development with all its important functions at the central level; development of a national policy for human resource development; rehabilitation of training institutions; updating the nursing and allied health curricula; setting admission standards; refurbishing the educational institutes; developing teachers capabilities through in-service education; developing the community midwifery programme; building the capacity of health workers; establishing a database for human resources for health; and establishing a testing and certification process to protect the health of the public.

The total health workforce in 2006 was estimated at 27 340 health personnel, about 10 500 of whom are working with contracted nongovernmental organizations. The total number of staff working at the MoPH is

estimated at 16 840. This includes 3704 physicians, 3311 nurses and midwives, 3217 allied health personnel, 1836 administrative staff and 4762 support staff. Females constitute 21% of the workforce. There are six medical schools in the country with Kabul Medical University as a main producer of physicians and dentists. There are currently 8000 medical students enrolled in the medical schools in Afghanistan. In addition, there are nine Institutes of Health Sciences that prepare nurses, midwives and allied health professionals. Currently, there are 3500 students enrolled in these institutes. The community midwifery programme started in 2002; the programme is running in 21 provinces with 640 students enrolled; 140 community midwives have graduated since the establishment of the 18-month programme. According to the MoPH's strategic plan there is a need for 7000 physicians, and 20 000 nurses, midwives and allied health personnel to implement the BPHS, EPHS and other services. A human resources database has been set up and registration of health workers has commenced, this will act as the basis for future licensure of health workers.

Concern has been expressed regarding the level of knowledge and skills of health workers trained outside the government health system. A process of testing and certification has been set up, which shows that on average 70% of nurses, midwives, laboratory technicians and pharmacy technicians fail to achieve the minimum standards and require extensive retraining and 50% of the applicants have fake certificates. Of those achieving the required standard of professional competence, most do not meet the old government requirement

of 12 years of schooling in order to be employed by the MoPH, this causes a major problem of recruiting clinically competent health workers in remote areas.

#### **2.6.2.6 Health information**

A basic health management information system (HMIS) exists, which covers almost 1450 health facilities that fall under the contracting out arrangements. Monthly reports are sent to the provinces; data are entered on customized software and forwarded to the central HMIS Directorate. The main monitoring instruments are the: 1) facility status report; 2) notifiable diseases report; 3) monthly integrated activity report; and 4) monthly aggregated activity report. There are concerns with the quality of reporting, provision of feedback and the use of information for decisions. WHO support is needed for increasing the analytical capacity at the central level and for providing hardware and supporting training at provincial levels. The disease surveillance component of the HMIS requires strengthening, with a view to eventually integrating existing vertical single disease surveillance systems. Currently, there is no programme for establishing a system of vital statistics in the country.

#### **2.6.2.7 Monitoring health system performance**

The Balanced Scorecard (BSC) has been the principle instrument for monitoring health system performance instead of the national HMIS. Its purpose is to summarize the performance of provinces in the delivery of the BPHS and to provide policy-makers, health managers and other decision-makers with evidence on areas of strength and weakness. Three rounds of BSC monitoring

of BPHS have been completed in 2004, 2005 and 2006. The comparison of results between 2004 and 2005 indicate a 12% improvement among performance-based partnership agreement (PPA) provinces.<sup>12</sup> a 10% improvement in performance-based partnership grant (PPG) areas (USAID), an 8% improvement for strengthening mechanism provinces.<sup>12</sup> and a 3.5% improvement in EC-supported provinces for the delivery of the BPHS. Other areas/facilities not covered by any of the above showed a 3% decrease in performance. The BSC is a useful tool for monitoring health facility performance, however, many of the indicators are process-oriented and do not depict service coverage or outcomes, it requires sophisticated analysis (including multivariate techniques) and the cost is high (estimated cost of data collection annually is US\$ 300 000). There is thus a concern whether it could be institutionalized as a regular activity of the MoPH. Several health and related surveys have been undertaken since 2003 that have supported evidence-based decision-making. These include the Afghanistan national health resource assessment (ANHRA); the multiple indicator cluster survey (MICS) 2003 and its re-analysis 2005; maternal mortality survey; nutrition survey; national disability survey; national hospital assessment (2006, 2007 and 2008); national risk and vulnerability assessment (NRVA); national health service performance assessment (2004–2008); and Afghanistan health survey (AHS) 2006.

The MoPH has established a Disease Early Warning Systems (DEWS) with the assistance of WHO. It has now 129 sentinel

sites across the country that provides information of epidemics and outbreaks many of which are managed at the provincial or district level. The laboratory backup for the diagnosis of epidemics needs considerable strengthening.

### 2.6.3 Challenges and priority areas for improvement

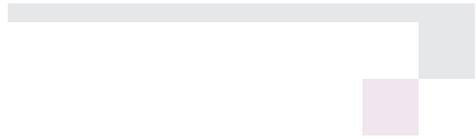
The challenges and priority areas for improvement include:

- ❖ insecurity and lack of transport infrastructure that restricts people from seeking health care, limits referrals of cases to secondary care facilities and prevents health workers from working in the security compromised and remote and inaccessible areas. This challenge is however outside the purview of the health sector.
- ❖ humanitarian crises, both man-made and natural disasters. There was limited capacity within the WHO country office and in the Government for preparedness and response to these types of disaster.
- ❖ high infant, maternal and under-five mortality rates.
- ❖ malnutrition, particularly among young children and women.
- ❖ high burden of communicable diseases and the need to stop transmission of polio virus in the country.
- ❖ lack of national capacities for health planning and management, especially in the areas of governance, health care financing, human resource development, for monitoring, evaluation

<sup>12</sup> World Bank. *Targets and Indicators for MDGs and PRSPs: what countries have chosen to monitor*. The Development Data Group, Development Economics Vice Presidency, July 2005.

and analysis of the health situation at central and especially so at the provincial level.

- ❖ lack of appreciation of the role of social determinants of health in the national context and of the need for intersectoral action for improving health outcomes.
- ❖ health regulation and enforcement.
- ❖ promotion of equitable access to health services.
- ❖ quality assurance in personal and population-based health services; public health research.
- ❖ environmental health issues, particularly scarcity of portable water, lack of sanitation facilities.







Section

# 3



**Development Cooperation and  
Partnerships:  
Technical Assistance,  
Aid Effectiveness and Coordination**



## Section 3. Development Cooperation and Partnerships: Technical Assistance, Aid Effectiveness and Coordination

The emergence of Afghanistan in 2001 as a nation state brought with it considerable challenges in rebuilding the country's physical and institutional infrastructure, as well as the human and social capital. The Afghans working relentlessly with the team of development partners have collaborated over these years to put in place some institutional frameworks that have helped to systematically guide national development, including the health sector. These include the Bonn Agreement signed in 2001; its first Constitution in 2004; the National Health Strategy 2005–2006; the National Health Policy 2005–2009 and the Afghanistan's Millennium Development Goals Report 2005, Vision 2020.

More recently and building on the success of the 2006 London Conference on Afghanistan, the Afghanistan Compact was signed by the Government and the International Community. The Compact identified three critical pillars of activity covering: security; governance, rule of law and human rights and economic and social development to which the international community committed itself to providing resources and support to realize the vision. The health and nutrition programme falls under economic and social development.

Following the development of the first national development budget in the 2002–2003 fiscal year, the ARTF was established in 2002 to create a coordinated funding mechanism for financing priority expenditure for Afghanistan's reconstruction. Three categories of expenditure were identified as

eligible through the Fund: (i) recurrent costs, including salaries and non-project technical assistance; (ii) investment activities and programmes; and (iii) salaries for returning Afghans who were living abroad. The ARTF is funded by Government revenue and external resources earmarked for special projects, it is administered by the WB with a management committee consisting of the Asian Development Bank (ADB), the United Nations Development Programme (UNDP), the International Development Bank (IDB) and the WB. Health and nutrition is one of the 15 national priority programmes funded through the ARTF.

The funding for the ARTF goes into the 'Core budget' and it is unique in supporting recurrent and operational costs which donors are normally reluctant to support. This is the case for the ARTF but also for projects outside the ARTF funded by the WB and the ADB. For Afghanistan this strategy is unique as donors are normally reluctant to fund recurrent and operational costs.

The funding requirement for health and nutrition ranged from US\$ 173 million in 2002–2003 to US\$ 320.52 million in 2003–2004 and US\$ 281.7 million in 2005–2006 fiscal year. However, the funding allocation for the last fiscal year was US\$ 115.61 million, leaving a funding gap of US\$ 166.38 million.

The overarching priority of the health sector is to address priority health issues through a universal coverage of BPMS supported by a strengthened referral

network that links patients into hospitals that provide the EPHS). The largest chunk of health budget (28%) is spent on the BPHS, followed by capacity-building of the MoPH (17%) and improving the quality of hospital services (EPHS).<sup>13</sup>

### 3.1 Key international aid and partners in health

Donor funds are used to finance all of the major programmes of the MoPH, including the delivery of the BPHS, EPHS, programmes aimed at controlling malaria, tuberculosis, HIV/AIDS and other communicable diseases. About 60% of the funding for the health and nutrition sector comes from international aid, including the salaries of high-level expert national advisers in the MoPH and for provincial health directors (ANDS 2008–2013). There are still commitments by these on continuous support from 2008–2013.

#### 3.1.1 Bilateral and multilateral partners

Although there are many donors that support the health and nutrition programme in Afghanistan, the three main donors are USAID, EC and the WB. Other notable bilateral partners include JICA, CIDA, Italian Corporation, ADB, Organization of Islamic Conference (OIC), WB funds flow to a bank account held by the Ministry of Finance (MoF) and can then requested by the MoPH. Funds for contracting from USAIDS and the EC are overseen by the donor and directly provided to the implementing agency.

USAID spent about US\$ 80 million from 2006–2008 to support the implementation of the BPHS through outsourcing of health

services to about 23 nongovernmental organizations in 13 provinces. It provides technical support to the BPHS-implementing agencies and capacity-building to MoPH and procurement services through Management Sciences for Health (MSH). It, in addition, provides institutional support to the provincial health directorate for monitoring the activities of the nongovernmental organizations funded by USAID. USAID also works through the health system strengthening project to undertake surveys and research to assess the demand accessibility of the product and use. The EC spending of about €36 million from 2007–2009 funds the BPHS in 10 provinces and the EPHS in four provinces working through 10 nongovernmental organizations and supports the salaries of provincial health directors and capacity-building of the provincial health coordination team. The WB with a lump sum grant of US\$ 98 million to the core budget from 2003–2006 supports the BPHS in 18 provinces through 11 non-governmental organizations, health infrastructural development and salaries (HEFD). CIDA supports immunization and polio eradication to the amount of US\$ 50 million through WHO (HEFD). JICA is active in the area of vaccines and the immunization programme. Saudi Arabia, Qatar, United Arab Emirates and the OIC provide support in health infrastructure development.

#### 3.1.2 The UN system in Afghanistan

Key agencies of the United Nations Systems with a presence in Afghanistan are United Nations Assistance Mission in Afghanistan (UNAMA), UNDP, UNICEF, UNFPA, Office of the United Nations High Commissioner for Refugees (UNHCR), the

<sup>13</sup> *Afghanistan's 2020 vision. Achieving the Millennium Development Goals*. Kabul, Government of Afghanistan, 2005.

World Food Programme (WFP) and WHO offers technical assistance to the Government of Afghanistan. The UNCT has developed two UNDAFs thus far. The first UNDAF (2005–2009) was found to be ambitious and had little or no impact in Afghanistan because of its very weak implementation. The second UNDAF (2010–2013), considered to be of more modest ambition, was launched in October 2009. The three areas of support are: stability/governance/human rights; food security/livelihoods and basic social services (education, health, water and sanitation). There is growing interest among the UN agencies to find out what agencies can do together using the UNDAF.

### 3.1.3 Others

#### 3.1.3.1 The GAVI Alliance

For the allocation from GAVI per year in millions of US\$, see Table 5.

#### 3.1.3.2 Global Fund for Malaria, Tuberculosis and HIV/AIDS

The MoPH is the principle recipient of two Global Fund grants for Afghanistan (Table 6).

The goal of the first grant from Round 2 is to develop the national health sector capacity for communicable disease control (with special reference to tuberculosis, malaria and HIV/AIDS) by strengthening management and administrative functions of the MoPH, together with building partnerships and developing new mechanisms for technical support and coordination. Implementation of this grant is for 18 months worth US\$ 3.1 million (from 1 December 2004 to 31 May 2006). For Round 4 the Global Fund approved (July 2005) a second grant for scaling up Afghanistan's response to tuberculosis control worth US\$ 3.4 million. The goal of this grant is to detect 70% of the expected pulmonary sputum positive cases and have a success rate of 85% in the areas covered by DOTS. Direct beneficiaries from both grants will be the people affected by AIDS, tuberculosis and malaria with limited access to health services; MoPH supervisors, BPHS health staff and community health workers; and the private sector. The total Afghan population will benefit indirectly from the improved control measures for AIDS, tuberculosis and malaria. GFATM administration is fully integrated within the GCMU.

**Table 5. GAVI allocation per year in millions (US\$) to Afghanistan**

Funding sources	Allocation per year (in millions of US\$)						
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	Year 5 of implementation	Total funds
	2007	2008	2009	2010	2011	2012	
GAVI	0.00	5.27	9.28	7.23	6.68	5.73	34.19

**Table 6. The Global Fund-approved expected and newly applied budget for Afghanistan, 2005–2010**

Rounds	Status	Budget (US\$)					
		Year 1	Year 2	Year	Year 4	Year 5	Total
R2 (integrated)	Approved (December 2004)	3 125 605 (18 months)	0	0	0	0	3 125 605
R4 (tuberculosis)	Approved (July 2005)	1 027 891	1 358 835	1 067 114	0	0	3 453 840
R5 (malaria)	Newly applied	7 825 177	9 268 157	6 895 432	4 665 645	3 577 305	32 231 719
R5 (HIV)	Newly applied	3 674 717	2 684 908	2 715 210	3 081 961	0	12 156 796
R5 (health system strengthening)	Newly applied	1 040 580	939 510	735 110	444 160	855 110	4 014 470
Grand total							54 982 430

### 3.1.4 Others

There are over 35 international and national nongovernmental organizations working actively in the Afghanistan health sector primarily implementing the BPHS under contractual services agreement from the GCMU and the donors. They are particularly useful in bringing health services to the areas where government officials and partners cannot access due to insecurity. The nongovernmental organizations and the provincial health team undertakes joint monitoring when feasible but clear definition of roles will help to ease the tension. Although the nongovernmental organizations meet monthly with the MoPH to report on their activities, there is no validation of their claims and quality of rendered service because of infrequent supervision and monitoring due to insecurity.

### 3.2 Aid effectiveness

The National Development Strategy 1387–1391 (2008–2013) is an MDG-based plan that serves as Afghanistan's PRSP. It is underpinned by the principles, pillars and benchmarks of the Afghanistan Compact and it is the overarching strategy through which the nation's three key pillars are thoroughly described with clear indicators and benchmarks. In the spirit of the Afghanistan Compact, the Government and international community commit themselves to improving the effectiveness and accountability of international assistance. Health being a social sector has a clear policy and strategy (2008–2013) which takes into account the MDGs, as well as the targets of the national strategy, thereby subsequently enjoying the assistance and the commitment to aid effectiveness of the international community.

### 3.2.1 National ownership

The Afghanistan Reconstruction Trust Fund (ARTF) helps reinforce the national budget in order to align the reconstruction programme with national objectives stated in the national strategy and gives the Government more control over the allocation of funds to development priorities. The ARTF provides a coordinated way for donors to support the Government of Afghanistan. The funds are allocated and monitored using national systems within the Ministries of Finance and Public Health.

### 3.2.2 Alignment

The ANDS (2008–2013) and the Health and Nutrition Strategy (2008–2013) have set goals and priorities with monitoring framework to ensure that international assistance contribute to these goals. Most of the assistance is given to the implementation of the BPHS and EPHS which are the stated national strategies for revamping the health sector.

### 3.2.3 Harmonization

The Government has developed an aid effectiveness strategy, in line with the Paris Declaration for Aid Effectiveness and Afghanistan's international obligations. Despite the improved alignment of partners programmes with national priorities, there is need to improve standardization of approaches, procurement services, joint programming and implementation, tools and guidelines in order to improve quality and maximize resource use.

### 3.2.4 Managing for result

The Government encourages multiyear

commitments from its international partners to support the goals of the ANDS and improve predictability of aid flows, better planning and effective management of priorities.

### 3.2.5 Mutual accountability and partnership

The ARTF represents an attempt to promote the transparency and accountability of reconstruction assistance. In addition, there are various coordination mechanisms such as the consultative group on health and nutrition, joint donor missions, technical advisory groups, etc. that meet weekly to monthly to ensure that the activities of line ministries and nongovernmental organizations related to the identified priorities in the ANDS are implemented in accordance with the targets and goals in the monitoring framework. The GCMU helps to ensure effective and transparent mechanisms to manage and oversee grant contracts. It is an important step into the direction of ownership and institutional accountability.

## 3.3 Summary of key challenges and opportunities

### 3.3.1 Challenges

The key challenges include:

- ❖ reduced impact of the financial and technical support given by the international community to Afghanistan health sector due to continuous conflict in many parts of the country which hinders access.
- ❖ insecurity which hinders development partners and the MoPH from effective monitoring and supervision of the performance of nongovernmental

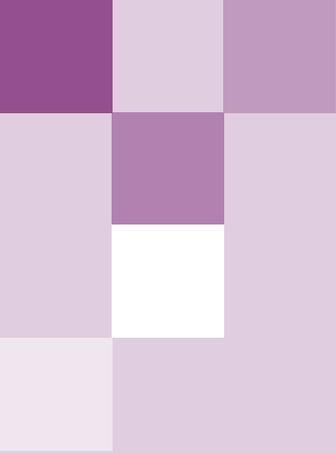
organizations in delivering the BPHS and EPHS, resulting in differences in the quality of health services delivered in various districts.

- ❖ the contracting out of the BPHS and EPHS to nongovernmental organizations that keeps the provincial health authorities off the centre stage of health care delivery at provincial and district levels in Afghanistan creating tension.
- ❖ lack of uniformity or standardization of approaches, expectations, procurement services, funding and reporting mechanisms among different donors resulting in high transaction costs on the part of the GCMU, MoPH and the nongovernmental organizations.
- ❖ maintaining a healthy balance between per capital health allocation and the expectations of the donors, MoPH and the Afghan people at the district level by the implementing nongovernmental organizations.
- ❖ weak capacity of the provincial health coordination team, particularly the health staff of many of the implementing nongovernmental organizations.
- ❖ weak harmonization in programmatic support within the UN system.
- ❖ lack of technical coordination/ leadership among donors and implementing nongovernmental organizations.
- ❖ continuous loss of trained senior health officers to the nongovernmental organization community due to better conditions of service.

### 3.3.2 Opportunities

The key opportunities include:

- ❖ the determination and resilience of the Government and the Afghan people to build a nation state.
- ❖ the commitment of the Government and international community to the Afghanistan Compact which ensures continuous financial and technical support to the national development objectives, including national health objectives.
- ❖ the existence of the various highly articulate institutional frameworks such as the ANDS (2008–2013), national health policy and overall strategy for the Health and Nutrition Sector (2008–2013), etc. that guide systematic and focused development in the health sector.
- ❖ the commitment of the Government to the principles of the Paris Declaration and establishment of various institutional mechanisms to ensure compliance, such as the ARTF, the ANDS Oversight Committee and the Joint Coordination and Monitoring Board which improves alignment of donor programmes with ANDS priorities, aid coordination and national ownership.
- ❖ the defined implementation mechanism for the BPHS and EPHS reduces duplication and confusion on the field.
- ❖ the growing interest in joint programming and implementation from the evolving UNDAF (2010–2013).



Section

# 4

Past and Current  
WHO Cooperation





## Section 4. Past and Current WHO Cooperation

### 4.1 WHO cooperation overview

#### 4.1.1 Background

The basic agreement between WHO and the Government of Afghanistan was signed in January 1959. According to this agreement, WHO shall render technical advisory assistance to the Government which shall be furnished and received in accordance with the relevant resolutions and decisions of the World Health Assembly, the Executive Board and other organs of the Organization. WHO shall consult with the Government the publication, as appropriate, of any findings and reports of experts that may prove of benefit to other countries and to the Organization. The Government will provide all personnel, materials, supplies, equipment and local expenses necessary for the technical cooperation, including counterparts to long-term staff or short-term consultants, and premises/facilities for technical activity in the Ministry.

The WHO office in Afghanistan was established with a minimal staff in the sixties in Kabul but due to the prevailing unstable situation in the country in the past, the office was moved to several locations to sustain technical support. Since 2002, the office has been operating through a well-equipped main office in Kabul and seven suboffices covering the whole regions of Afghanistan.

#### 4.1.2 Strengths and weaknesses of WHO in Afghanistan

WHO has been recognized by the Government, different partners and

nongovernmental organizations as the most competent and leading agency in the health sector. Its technical support covers all regions in Afghanistan. It owns an extensive database on health manpower, facilities and health indicators related to the country. It is playing a key role in coordinating many intercountry activities with neighbouring countries. Its capacity in resource mobilization at country level has been growing in the last few years.

Notwithstanding the above strengths, WHO in Afghanistan has several weaknesses such as the lack of critical technical expertise in some of the priority areas such as policy formulation and strategic planning in different aspects of health systems, emergency preparedness and response to humanitarian crises, social and environmental determinants of health and in mental health. There is also a need to upgrade its leadership and coordinating role in the field of maternal and child health. It needs to play a more active role at the policy level for promoting intersectoral collaboration for improving health outcomes. An analysis of the current technical capacities in the country office in relation to each of the identified strategic priorities is given in Section 6. Also, WHO is facing difficulties in the recruitment of staff and is faced with high operational costs because of the limited resources which is affecting negatively its delivery capacity, particularly at subnational level.

### 4.1.3 Major achievements

Strong alignment of strategic and operational plans with national priorities; working relationships with national authorities and different partners; and the high implementation rates of the programmes are considered among the main achievements of WHO in Afghanistan in the last few years.

### 4.1.4 Challenges

It is obvious that the challenges which are facing the country as a whole such as instability, security and violence will have their direct implication on the way that the organization is performing. In addition, it is noted that the space for humanitarian aid is narrowing. The evolving and emerging priorities, such as noncommunicable diseases and outbreaks of emerging diseases, are calling for better preparation by WHO to respond timely and effectively. The need for more capacities in advocacy and resource mobilization has been noted to be high.

### 4.1.5 Lessons learnt

Close relationships and strong partnerships facilitated WHO's work in the last few years. It helped the office to deliver more effectively. The cluster approach, although it imposes more responsibilities on the office, has enhanced the appropriate role of WHO within the UN team. The inclusion of the 10% as allocation for security and operational costs in the proposals for funding has helped a lot in improving the performance of the office.

### 4.1.6 Main areas of focus

It is envisaged that WHO collaboration will be more strategic and focused on fewer priority areas, which will be an amalgam of global and regional priorities aligned with national priorities. Increased emphasis will be given to WHO's role as a policy adviser and broker. Opportunities will be sought for increasing and strengthening partnerships with other international and national agencies, including nongovernmental organizations working in the field of health. Innovative approaches will be sought to increase the effectiveness of WHO support. Attempts will be made to ensure the utilization of the knowledge and skills present in the country for WHO's normative work.

The WHO Representative's Office through the WHO Representative and his staff has to assist national authorities in practising its role of coordination of all health-related activities in the country. This could be made through establishing strong relationships and information-sharing with all partners and stakeholders in the health sector.

WHO in Afghanistan has to make all possible efforts to be more visible in the country. It has to improve its image. A communication and advocacy strategy has to be developed for this purpose.

Considering the large number of national and international nongovernmental organizations operating in the health sector of the country, the country office needs to engage with them on a continuing basis, especially with those nongovernmental organizations that have been contracted out to provide BPHS in the provinces.

### 4.1.7 Core functions of WHO in Afghanistan

For carrying out WHO operations at the country level, four distinct functions have been identified. They include catalysing the adoption and adaptation of technical strategies, seeding large-scale implementation; supporting research and development and monitoring health sector performance; information and knowledge-sharing to provide generic policy options, standards and advocacy; providing specific policy advice and serving as a broker; influencing policy, action and spending.

### 4.1.8 Modalities of work

The above four functions will be achieved through the ordinary modalities of work that WHO is following with other Member States, such as assisting in policy advice, mobilizing different expertise, providing technical support to all health systems and programmes, improving national capacities through different means, and others. However, in Afghanistan, WHO is more prepared to adopt all necessary measures to deal with the complex emergencies that the country is facing. It will further strengthen its relationship with the MoPH, as well as other ministries and stakeholders who have a role to play in health sector.

### 4.1.9 Critical review of previous CCS, its use, input and results

Unfortunately, no systematic review of the last CCS was made as it was not planned. Apparently, it was not properly shared or disseminated. However, it was partially used as a strategic agenda for the previous operational plans in the Joint Programme

Review and Planning Mission (JPRM) 2008–2009 mainly because the two exercises had taken place back to back. As for input, it was useful to link the strategic objectives of WHO with national priorities. The CCS has captured comprehensively the most important national health indicators and country profile.

## 4.2 WHO structure and resources

The following sections outline WHO's structure and resources.

### 4.2.1 Structure and staff of the office and suboffices

The WHO country office in Afghanistan is run by a WHO representative, 20 international professional staff, and more than 332 national staff serving on different types of contracts. Approximately a quarter of the staff are in the main office in Kabul and the remaining staff are distributed all over the country in seven suboffices located in Mazar-i-Sharif, Jalalabad, Herat, Kandahar, Faizabad, Kunduz, and Gardiz. However, it is to be noted that 62 national staff members, 96 national staff have Special Service Agreement (SSA) contracts and 174 have Agreements for Performance of Work (APWs). This indicates possible difficulties of staffing in the near future. The number of female staff represents only 2.5% of the total staff (the organogram and staff are shown in Annex 1).

### 4.2.2 Support from the Regional Office and headquarters

The current support from both the Regional Office and headquarters is scored

as excellent. For emerging and unplanned activities, the two levels are making all possible efforts to provide the required support even with exceptional approvals in some cases. In the last few years, there was a very obvious growing trend to involve the country office team in so many intercountry activities organized by either the Regional Office or headquarters. The country office had been involved in several subregional activities with many of the neighbouring countries in areas such as polio, malaria, tuberculosis and HIV/AIDS.

#### 4.2.3 The biennial work plan

The financial analysis of the biennium 2006–2007 showed that the total budget which was made available for the WHO collaborative programme in Afghanistan amounted to approximately US\$ 72 million, out of which US\$ 5.3 million were from the regular budget (RB) and US\$ 66.7 million from other sources. In the current biennium, approximately US\$ 59 million have been allocated as of the end of October 2008. It is expected that other resources may increase from now until the end of the biennium in December 2009. The breakdown of the budget for the two biennia is shown in Table 7.

#### 4.2.4 Sharing and using knowledge

WHO is a knowledge-based organization and the country office can play an enhanced role in a country such as Afghanistan in sharing up-to-date knowledge related to public health and its practice and demonstrating its use at various levels in the health system of the country.

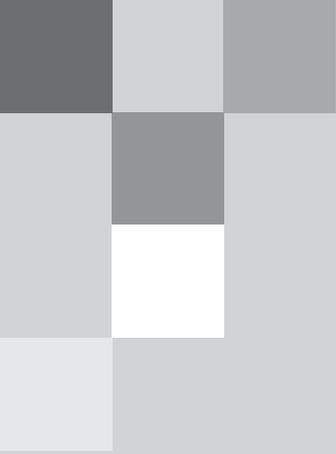
#### 4.2.5 Office infrastructure and equipment

The current main office in Kabul is located on an area of 2500 m<sup>2</sup> upon which a building of two levels has been constructed to give approximately 1820 m<sup>2</sup> office space. The office is well-equipped to meet the requirements of the work. Computer facility, networking connectivity, GSM access with both the Regional Office and headquarters, and other basic requirements have been installed. Proper filing, archiving and storage system for office assets are in place. The office is generally well-secured and represents a good working place for the staff. Some deficiencies in the security system have been already identified and forwarded to the Regional Office for action particularly the armoured vehicles which are very critical for field missions. The seven suboffices are being assessed.

**Table 7. Breakdown of budget (US\$) for 2006–2007 and 2008–2009**

2006–2007	Total	Programmes	WR country office
Total working budget (RB)	5 261 000	4 529 000	732 000
Total working budget programme	79 022 174	78 677 705	344 469
2008–2009	Total	Programmes	WR country office
Total working budget (RB)	5 495 568	4 711 568	780 000
Total working budget programme	96 866 254	96 410 942	455 312

Source: CAMS



Section

# 5



**Strategic Agenda for  
WHO Cooperation**





## Section 5. Strategic Agenda for WHO Cooperation

### 5.1 Introduction

The strategic priorities given below are based upon a careful analysis of the country's health and development challenges, the national and international response to these challenges and the gaps identified in the response to these challenges. It also takes into account to the Organization's own priorities, strengths and strategic plans as articulated in the Eleventh General Programme of Work from 2006–2015 and in its Medium Term Strategic Plan for the period 2008 to 2013. It was evident from the discussions held with MoPH officials that in the period covered by the present CCS, greater emphasis will be placed on seeking WHO support for policy formulation and strategic planning on a variety of pressing health issues. At the same time WHO support would also be needed for generating evidence for policy formulation and planning programmes for areas that currently lack the required evidence for this purpose (e.g. noncommunicable diseases, road traffic accidents, etc.) through carefully designed surveys/research studies.

The CCS Mission felt that the strategic priorities proposed below are in alignment with national priorities as set out in the National Development Strategy and with the health and nutrition component of the strategy. However, the situation regarding harmonization of priorities and programmes between the large number of donors operating and supporting the health sector in Afghanistan need further improvement.

WHO with its limited financial contribution (as compared to donors currently operating in Afghanistan) to national health development is well placed to assume a major role in coordinating the various inputs and ensuring harmonization between the agendas of various donors and nongovernmental organizations operating in the country.

WHO faces a special challenge as the lead of the health cluster to deal with the humanitarian crises facing the country.

### 5.2 Guiding principles for WHO at country level

The work of the WHO is guided by core functions, which are based on the WHO's comparative advantage. These are:

- ❖ providing leadership in matters critical to health and engaging in partnership where joint action is needed;
- ❖ shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;
- ❖ setting norms and standards and promoting and monitoring their implementation;
- ❖ articulating ethical and evidence-based policy options;
- ❖ providing technical support, catalysing change and building sustainable institutional capacity;
- ❖ monitoring the health situation and assessing health trends.

### 5.3 Mission statement of WHO in the country

The mission of WHO remains “the attainment by all peoples of the highest possible level of health” in the sense that “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” as enshrined in the WHO Constitution as one of the basic principles. The Organization aims at strengthening its technical and policy leadership in health matters, as well as its management capacity to address the needs of the country, including the Millennium Development Goals. WHO country office provides technical support to address the country’s priority health issues within the purview of WHO core functions which relate to engaging and partnerships, shaping the research agenda, setting norms and standards, articulating policy options, catalysing change and assessing health needs.

### 5.4 Strategic priorities

The strategic priorities include: health systems strengthening based on the values and principles of primary health care; social and environmental determinants of health and health equity; the control of communicable and noncommunicable diseases; reproductive and child health; and emergency preparedness and response.

#### 5.4.1 Health systems strengthening based on the values and principles of primary health care

The main focus of health systems strengthening based on the values and principles of primary health care are: human resource development; stewardship and governance; the health information system; and health care financing.

Strategic approaches include to:

- ❖ assist in the development and implementation of national human resource development policy and plan that would entail human resource development production, management, distribution, retention and accreditation.
- ❖ assist in the strengthening of stewardship and governance in health of the MoPH and the provincial health departments, in particular for overseeing, monitoring and evaluating and auditing the performance of BPHH- and EPHS-implementing partners.
- ❖ assist in the development of a well-functioning and integrated health information system that brings together all sources and provides the necessary information for informed decisions at appropriate levels.
- ❖ assist in establishing adequate and fair financing of the health system that ensures universal access to essential health care and protects households against catastrophic health expenditure.
- ❖ assist in conducting health care financing studies, including the costing of BPHS/EPHS and national health accounts.

- ❖ assist in updating and implementing a comprehensive national medicines policy.
- ❖ assist in developing coordinating mechanisms for collaboration with private and other para-state health sectors, as relevant.

The strategic approaches shall promote development of a health system that underpins the universal values of primary health care that include enhancing health equity, universal health coverage, community involvement and client centredness.

#### 5.4.2 Social and environmental determinants of health and health equity

The main focus of social and environmental determinants of health and health equity are the social determinants of health and environmental determinants of health.

Strategic approaches include to:

- ❖ provide evidence through knowledge synthesis, generation and dissemination the role of social and environmental determinants and the various pathways through which these influence health.
- ❖ advocate for health in all policies and for emphasizing the importance of social and environmental determinants of health and health equity in health policies and programmes.
- ❖ promote intersectoral action for health as a means to tackle the wider social and environmental determinants and inequities in health. Such action can be at the policy, programme and the grass-roots implementation level. The latter can benefit from the community-based initiatives experience of the Region.

- ❖ develop a health equity monitoring tool as part of the health information function that allows comparison among selected health indicators across the 34 provinces of the country.

#### 5.4.3 Control of communicable and noncommunicable diseases

Strategic approaches for the control of communicable diseases include to:

- ❖ assist the implementation of the polio eradication initiative to achieve the interruption of transmission of polio virus throughout Afghanistan.
- ❖ support the strengthening of routine immunization and national efforts for measles elimination, maternal and neonatal tetanus elimination and the introduction of new vaccines.
- ❖ support the scaling up of prevention, treatment and care for tuberculosis, malaria, leishmaniasis and HIV/AIDS.
- ❖ support the development of national capacity in preparedness and response to epidemic-prone diseases.
- ❖ assist the strengthening and integration of the different disease-specific surveillance systems.
- ❖ facilitate the collaboration with the global health initiatives on communicable diseases, such as GAVI and GFATM.

Strategic approaches in the control of noncommunicable diseases, including mental health, include to:

- ❖ assist in defining the burden of disease due to noncommunicable diseases, including mental health and road traffic accidents in Afghanistan.

- ❖ assist in finalizing the formulation of a national policy, strategies and plans for addressing needs in mental health and substance abuse and their implementation

#### 5.4.4 Reproductive and child health

Strategic approaches in addressing reproductive health include to:

- ❖ promote the Making Pregnancy Safer initiative through increasing access to, and availability of, essential obstetric care services.
- ❖ facilitate collaboration with national and international partners that address reproductive health in Afghanistan.
- ❖ assist the development and use of an advocacy and communication strategy to address social and cultural barriers against reproductive health.

Strategic approaches in addressing child health include to:

- ❖ assist in expanding the IMCI approach and in integrating it in other health-related interventions targeted at children and women of childbearing age.
- ❖ support in developing the capacity of health personnel in prevention and control of maternal and child malnutrition.

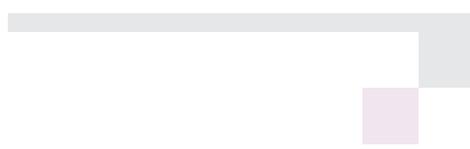
#### 5.4.5 Emergency preparedness and response

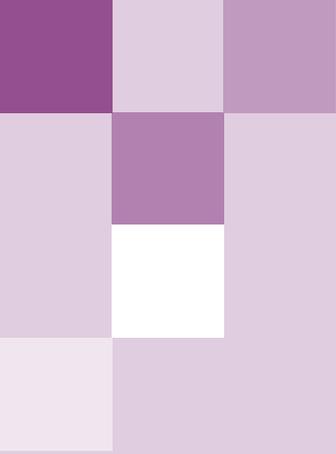
The main focus of emergency preparedness and response is emergency preparedness and the IHR (2005).

Strategic approaches in addressing emergency preparedness and response

include to:

- ❖ assist the capacity development of partners in the health cluster so that the health Cluster can prepare and respond to health needs in emergencies timely and adequately.
- ❖ assist the national capacity development for emergency preparedness and response, so that the national authorities at different levels can prepare and respond to health crises appropriately.
- ❖ support the strengthening of the disease early warning system outbreaks through improving its quality and expanding its geographical coverage.
- ❖ strengthen the humanitarian health information system by ensuring a functional communication network and data analysis capacity at national and subnational levels.
- ❖ support the national capacity development so that the government and other relevant partners would meet the required obligations under the IHR 2005 appropriately.





Section

# 6



**Implementing the Strategic Agenda:  
Implications for WHO**



## Section 6. Implementing the Strategic Agenda: Implications for WHO

### 6.1 Implications for the country office

Table 8 outlines the strategic directions, main areas, status, challenges and implications for the WHO country office in Afghanistan.

### 6.2 General implications for the country office

The following items are a list of the general implications/recommendations for the country office.

- ❖ Expand partnership development in health and leadership role of WHO under the expanding, often complicated partnerships in the country. This will be facilitated by establishing strong relationships and information sharing with all partners and stakeholders in the health sector.
- ❖ Efforts will be made to engage with nongovernmental organizations/civil society operating in Afghanistan, especially those nongovernmental organizations that have been contracted out to provide BPHS in the provinces.
- ❖ Develop a strategy for advocacy and communication and ensure greater visibility of WHO's contributions to national health development making full use of the enhanced media opportunities now available in Afghanistan.
- ❖ Improve the working environment (well-being and security of country office staff) under difficult situations.
- ❖ Identify mechanisms to ensure translation of CCS into operational plans.
- ❖ Advocate CCS to national and international partners and use it as WHO's input to shape the health dimension of the UNDAF that is currently underway.
- ❖ Consider restructuring of the organogram of the country office based on CCS and needs.
- ❖ Address the frequent absences of staff from the office due to different official reasons (rest and relaxation, in-country and international duty travels, annual leave).
- ❖ Review the role and optimal use of seven subnational WHO offices.
- ❖ Make use of the identified priority of social determinants of health as a means to promote intersectoral collaboration and assist the MoPH in developing an available and high level administrative structure for this purpose.
- ❖ The CCS Mission has highlighted the need to develop a comprehensive repository of all health-related data (including reports of studies/surveys conducted or supported by the various stake holders) in the country office. This could then be placed on the Afghanistan country office web site.

### 6.3 Implications for WHO Regional Office and headquarters

Increasingly WHO is being judged at the country level (especially in countries such as Afghanistan) by its technical expertise located in the country and by its capacity to bring in high-quality expertise often at short

notice, when such expertise is not available at the country level. Under Section 6.1 certain weaknesses have been identified in the country office to meet the needs of the strategic priorities defined in the CCS for 2008–2013. WHO Regional Office and WHO headquarters should take appropriate steps to fill these gaps soonest by fielding high-quality experts both for long-term and short-term assignments.

**Table 8. Strategic directions for the country office**

Strategic directions	Main areas	Status	Challenges	Implications
Health systems strengthening based on the values and principles of primary health care.	Human resource development, governance, health information system and health care financing.	At the time of the CCS Mission visit, the country office was in a transition period as one of the longer serving staff dealing with health systems was being reassigned.	Lack of expertise to address the health system in its entirety.	<p>Technical expertise to lead/negotiate with partners and the MoPH in health systems development is needed.</p> <p>One long-term senior expert (international staff) on health systems policy and planning is needed.</p> <p>One long-term epidemiologist for health information systems who could also provide technical assistance for emergency and humanitarian action (EHA) and strengthening national capacities to implement the IHR is needed.</p> <p>Technical support for specific areas, such as health care financing, hospital management, national medicines policy and medical equipment.</p>
Social and environmental determinants of health and health equity		A new, but a very important area that could also help in promoting intersectoral collaboration.	Limited understanding and capacity at country office (and all levels) at present.	<p>Improving the knowledge/understanding of country office staff</p> <p>The need for technical assistance (short-term) to assist the country office in working on each of the strategic approaches</p> <p>The need for technical support (national and short-term international) to expand</p> <p>Community-based initiatives to be used as an entry point for social determinants of health.</p>
Control of communicable and noncommunicable disease	Communicable diseases	Generally satisfactory, except HIV/AIDS.	Polio eradication (achieving eradication and maintaining partnerships), strengthening HIV/AIDS (strengthening capacity)	<p>Maintaining and scaling up the capacity on communicable disease.</p> <p>Utilizing the polio eradication initiative for scaling up of EPI and surveillance activities.</p> <p>Scaling up partnerships with international and national partnerships, including GAVI, GFATM and multi/bilateral donors.</p>

Strategic directions	Main areas	Status	Challenges	Implications
	Noncommunicable diseases, including mental health	limited capacity and lack of evidence	Limited capacity, in need of “focus”	Focus in areas of work (e.g. mental health, road traffic accidents and diabetes, and possibly cancer). Series of short-term consultants for: mapping (burden of noncommunicable diseases). Policy formulation; planning; training; and advocacy (resource mobilization). Partnership development for advocacy, fund raising and communication.
Reproductive and child health		Limited capacity despite the large size of problem/ demand, no strategic and comprehensive response to this priority area (fragmented efforts by partners and government, ad hoc responses, etc).	Improving capacity to regain leadership role, develop strategic response.	Given the importance of this programme area it was critical to upgrade country office capacity with a long-term senior expert (international staff) on policy and planning, supplemented with by national and short-term experts in different areas. Partnership development for strategic response to R/HC including joint planning, advocacy, resource mobilization and communication.
Emergency preparedness and response (EPR)		Limited capacity although initiatives such as the health cluster approach have started	Increasing capacity for WHO CO to show WHO’s leadership in EPR, increasing overall capacity of health cluster in health crisis	Improving health cluster capacity in health crisis through coordination, joint planning, training, communication, and joint resource mobilization Improving CO capacity with technical assistants (long and short-term and national) in different areas such as epidemiology, information, logistics, preparedness and response.





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