ANNEX A

LIST OF DOCUMENTS REVIEWED

1. IbnSina. Public Health Program for Afghanistan Annual Report 2000.

2. Global Movement for Children Afghanistan Working Group. Lost Chances.The Changing Situation of Children in Afghanistan 1990-2000. June 2001.

3. Ministry of Public Health Afghanistan. National Health Policy. Policy Statement Document Draft.

4. Ministry of Public Health, Afghanistan. Preparatory Workshop on Organizational Framework of the Afghan Ministry of Public Health. Redefining the Roles and Responsibilities of Its Departments. Final Report. Kabul, Afghanistan, 3-6 February 2002.

5. UNICEF. 2000 Afghanistan Multiple Indicator Cluster Survey {MICS2] Vol. 1. Monitoring and Evealuation Working Paper Series. UNICEF Afghanistan Country Office. Sept. 2001

6. UNFPA. Women and the Reconstruction of Afghanistan. Dec. 2001

7. UNFPA. Afghanistan Strategy Preliminary draft. Nov 2001.

8. UNICEF Afghanistan Country Office. 2001 Annual Report. Islamabad, December 2001.

9. UNICEF.1997 Afghanistan Multiple Indicator Baseline. Report to UNICEF CIET International, May 1997

10. UNICEF Regional Office for South Asia. Saving Women's Live. A Call to Rights-Based Action. 2000.

11. UNICEF ACO. Competency–Based Training Manual on Emergency Obstetric Care. Comprehensive Level. January 2002 and Checklists.

12. UNICEF Afghanistan. Strategy Paper: Safe Motherhood in Afghanistan. 18 January 2002

13. World Health Organization Afghanistan Country Office. Report on Health Planning Workshop [Kabul, 15 February – 2 March, 1998]. WHO Support Office. PO Box 1936 Islamabad Pakistan.

14. World Health Organization Regional Office for the Eastern Mediterranean. Reconstruction of the Afghanistan Health Sector: A Preliminary Assessment of Needs and Opportunities. December 2001-January 2002. Cairo, Egypt 2002

15. Dr. Suraya Dahlil. Ensuring Safe Motherhood in Afghanistan. UNICEF Afghanistan. Feb. 2002 [report presented in Bangkok].

16. World Bank. Overview of the Situation of Afghan Women.

ANNEX B

AFGHANISTAN HEALTH SITUATION[1]

The health status of Afghans ranks among the worst in the world. Specific health data (epidemiological, reproductive, environmental, etc.) for Afghanistan are fragmented and outdated. Health information about the refugee Afghan population, in combination with reports from UN agencies and UN-sponsored NGOs that were active in Afghanistan before September 2001, confirm high levels of morbidity and mortality***. Prior to the current war, life expectancy was estimated at 44 years for women and 43 years for men.*** Other major health indicators showed:

- ***Extremely poor maternal and child health***: *Maternal Mortality Rate* is estimated from 820 to 1700 per 100,000 live births (WHO, UNFPA, 2001). *Infant Mortality Rate* was 250 per 1000 births (UNFPA, 2001). *Under-5* mortality rate was estimated at 257/1000 live births in 1999 (UNICEF).
- ***Extremely poor general nutritional status:*** Forty-eight percent of children were moderately to severely underweight. Severe micronutrient deficiencies exist, especially for vitamin A and iron (1995-2000, State of the World's Children, 2001).
- ***Very low rates of immunization in children:*** Coverage for 1-year old infants was 36% for DPT and polio, and 42% for measles (UNICEF, 1999). National Immunization Days for polio have been implemented during the current conflict.
- ***Very high prevalence of infectious diseases***: ***Measles*** remains uncontrolled; an epidemic in 2000 killed nearly 1000 children. ***Malaria*** cases number 2-3 million annually (WHO/Roll Back Malaria, 2001). Meteorological forecasts predict return to normal rainfall after three years of drought; this could increase malaria risk. ***Tuberculosis*** prevalence is estimated at 555 per 100,000. HIV/AIDS is not a significant cause of morbidity now (est. prevalence = 0.01%, UNAIDS), however, there is potential for an increase in high-risk behaviors.
- ***Maternal and child health compromised by high birth rate and unmet need for family planning:*** *Total Fertility Rate* was 6.8*; Contraceptive Prevalence Rate* was 2.0% (1998, UNPOP).
- There are an estimated 210,000 ***Afghans who have been disabled by landmines.*** In the year 2000, the casualty rate was estimated at 88/month (Landmine Monitor Fact Sheet, 2001).
- ***Profound psychological impacts from chronic conflict, insecurity, and deprivation*** (WHO, 2001*).*
- ***Underlying issues:*** Strongly contributory to the poor health of families is the historically ***low status of women,*** manifested in very low educational levels (UNESCO estimated female literacy at 15% in 1995). Under Taliban rule conditions worsened still further through denial of mobility, education, access to health services, and other civil and human rights. Also affecting most of the above health problems are ***physical insecurity associated with war and conflict, widespread food insecurity, lack of potable water, and poor sanitation***.

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[1] Adapted from USAID Afghanistan Sharing Brief, 21 November 2001 Draft.

The Afghan health system was rudimentary, at best, before the current war. The following indicators describe key health sector characteristics.

- ***Health facilities are grossly inadequate in terms of number, distribution, and quality:*** 50 of 330 districts did not have a basic health center (BHC) or immunization (EPI) services. Only 11 of 31 provinces had essential obstetric care (EOC) services (reliefweb.int/2001). UNFPA recently estimated that only 1% of births were attended by a skilled health worker.
- ***Ratios of trained health workers to population are very low***. In 1997 WHO estimated that there were only 11 doctors and 18 nurses per 100,000 Afghans.
- ***Negligible investment in health data and analysis, and planning and policy infrastructure, within the health sector*** has occurred over the last decade**.** It is reasonable to assume significant variation in health problems and service availability across geographical areas and among ethnic and tribal sub-groups, but sparse data hinder accurate characterization at this time. Continuing waves of migration both within Afghanistan, and into and from refugee camps in neighboring countries, complicate assessment of health problems. Lack of hard data will mean that initial planning must be provisional and that data collection to inform planning should begin immediately.
- ***Women have experienced systematic discrimination.*** The practice of medicine by women doctors was prohibited under Taliban rule, which drastically undermined the availability of health care for women.

ANNEX C

MINISTRY OF PUBLIC HEALTH
AFGHANISTAN

NATIONAL HEALTH POLICY

POLICY STATEMENT DOCUMENT
DRAFT

Annex D

JOINT DONOR MISSION TO AFGHANISTAN ON THE HEALTH, NUTRITION, AND POPULATION SECTOR

AIDE-MEMOIRE

January 29, 2003

EXECUTIVE SUMMARY

1. A joint donor mission representing 8 different agencies visited Afghanistan in March 2002 to agree with the Government on a framework for assistance to the health, nutrition, and population (HNP) sector over the next 2.5 years, begin discussions on an investment program that could be operational in the next 3-4 months, and identify a practical, efficient, and Government-led mechanism for partner coordination.

2. **Health Situation:** The current health status of the Afghan population is very poor with an IMR of about 165/1,000 live births. Much of the burden of disease results from communicable diseases that can be easily prevented or treated. There are many non-health system factors that influence the health of Afghans including gender, security, education, transportation, and environmental issues. The health care system could potentially do a lot to improve health status, but its coverage is limited. For example, only 32% of infants are routinely immunized.

3. **Government Policies:** To address these issues the Ministry of Public Health (MOPH) has drafted an HNP sector policy that emphasizes equity and the delivery of an essential package of services as broadly as possible. The mission supports the draft policy and would like to help the MOPH turn it into effective action.

4. **Major Policy Issues:** The Government faces a series of major policy issues which center around: (i) What is the role of Government in the sector? Does it want to steer the sector or deliver services? (ii) Given its role, how large does the MOPH need to be? (iii) How will it relate to the NGO sector? How will it work with the for-profit private sector? These issues permeate the discussion below on various aspects of the health care system.

5. **Objectives, Monitoring, and Evaluation:** While the long-term objective is to reduce child and maternal mortality rates, these are not sensible indicators to use over the next 2.5 years. Instead, the Government should focus on improving output indicators directly related to its essential services package (e.g., immunization coverage, contraceptive prevalence, skilled attendance at delivery, etc.) It would be important to rapidly obtain baseline data on these from a household survey in each province, which could then be repeated in 2005.

6. **Delivering Essential Services:** The biggest and most important challenge facing the Government is how to ensure that the coverage of essential health services is expanded rapidly to cover the majority of the population (e.g. DPT3 immunization coverage is now 32%). Currently, about 84% of health facilities have NGO involvement. Thus, the Government has three options: (i) it can try to expand the MOPH and make it a major deliverer of services; (ii) NGO services can expand in a piecemeal fashion based on the increased availability of funds from donors; or (iii) the MOPH can work with NGOs on the basis of performance-based partnership agreements (PPAs).

7. **PPAs:** The PPA approach basically involves the MOPH: (i) establishing an essential service package and a series of related performance indicators; (ii) defining the geographical area covered by the PPA; (iii) carrying out a competitive bidding process among interested NGOs; (iv) signing an agreement with the winning NGO based on a fixed price; and (v) carefully monitoring the performance of the NGO and relating payment to improved service delivery.

8. **PPAs versus Other Options:** PPAs are not theory. They have been tried in at least 3 other post-conflict settings and have been shown to: (i) quickly and efficiently improve service delivery based on rigorous evaluations; (ii) they allow the Government to effectively manage and coordinate the sector; (iii) they help ensure under-served populations receive services; and (iv) they help ensure a mutually beneficial relationship between the Government and NGOs.

9. **Building Capacity in the HNP Sector:** There are many aspects of capacity building that are pressing but the mission suggested a few priorities related to delivering the essential service package. Provincial health directorates need to be strengthened by provision of communications equipment, transport, and training on supervision, health facility location, working with districts and communities. The MOPH should establish a Strategic Policy and Evaluation Unit to (i) coordinate donor resources with AACA; (ii) prepare and lobby for the annual health budget; (iii) review coverage of the essential package; (iv) establish guidelines and procedures for PPA preparation; (v) develop a unified health information system; and (vi) oversee the PPA process. MOPH should also develop a workforce strategy that prioritizes the training of community midwives. Urgent consideration needs to be given to redeploying civil servants: a 'go-slow' approach is recommended until fair recruiting policies are developed. Contractual terms for health care workers are required and a Task Force should identify future health care worker education policies. Leadership on gender issues and community mobilization should be established at national, regional, and provincial MOPH level.

10. **Physical Infrastructure:** Improving the delivery of essential services will eventually require an increased network of facilities in rural areas. It would make sense for the MOPH to undertake this construction systematically, starting in about a year and based on the lessons learned from other post-conflict settings including: (i) using standard designs; (ii) locating facilities carefully; and (iii) using experienced contractors and supervising engineers. To redress the severe urban bias and ensure there are enough funds for rural areas, no new hospital beds should be constructed in the large cities.

11. **Drugs and Equipment:** Essential drugs are often in short supply in public facilities and during the next year it would be helpful to: (i) distribute standard essential drug kits; (ii) contract out management of central procurement to a private agency; (iii) follow WHO guidelines on donated medicines and equipment; and (iv) obtain international technical assistance on drug management policy.

12. **Hospital Services:** There is a consensus that referral services are key to delivering essential health care but that many Afghans do not have access to these services. The mission proposed to the MOPH that: (i) in large catchment areas without referral services, existing facilities should be upgraded at the same time as construction of new health centers is undertaken; (ii) it carefully carry out studies on where new provincial or large district (say, > 100,000 population) hospitals should be located; and (iii) test and properly evaluate new

approaches to hospital management such as giving them autonomy, contracting in management, contracting with NGOs to run them, etc.

13. **Technical Policies and Standards:** The experience elsewhere indicates that it is critical for the MOPH to quickly establish technical policies and standards so that service providers know what to do. Defining the essential services package in operational detail is an important short-term objective, as is implementing a standard health information system for recording essential health activities.

14. **Quick Impact Projects:** The Government and the mission reached agreement on developing the details for conducting health education through women's radio listening groups and providing such groups with radios to receive broadcasts specially designed for them.

15. **Financing of the Health Sector Program:** Health expenditure varies greatly by region, with central region likely expending the highest amount. It is clear that there will be a large number of donors to the sector. This outpouring of support for the health of the Afghan people is encouraging but also could cause problems. For example, smaller donor projects will be difficult to track, and large donations for refurbishing hospitals could further worsen the dominance of health facilities toward urban centers. Preliminary estimates for the next two years of health sector financial requirements are $75 million for recurrent cost of expanded essential health services, $43 million for recurrent costs of hospitals, US$81 million for capital investment projects, and US$35 million for technical assistance, for a total of $234 million. In addition, the UN agencies working in health requested US$120 million to support health sector development in calendar 2002 under the ITAP process.

16. **Partner Coordination:** Given the need for considerable external support to the HNP sector over the next few years it is important that the MOPH take a strong leadership position coordinating assistance coming from donors. Building on existing structures it would make sense to: (i) strengthen the secretariat function within MOPH to ensure the coordination mechanisms work properly; (ii) have bi-weekly National Technical Coordination Committee meetings; and (iii) have MOPH choose an advisory committee of experts to review proposed projects and help with technical discussions. While it may be too difficult to set up joint donor financing, it would make sense for donors to have a joint program based on a few principles, including supporting MOPH articulated priorities, burden sharing of recurrent costs, and peer review of projects.

17. **Research Priorities:** The development of the HNP sector in Afghanistan is constrained by the lack of reliable data by which to conduct planning and evaluate performance. During the next 6 months research priorities include: (i) baseline household data on the output indicators; (ii) a health facility survey (planned by MSH); and (iii) a study on human resources potentially available from Afghans living abroad. In the medium-term research priorities include: (i) HIV sero-prevalence; (ii) studies on mental health; and (iii) a DHS-type survey.

18. **Next Steps:** The MOPH and the mission agreed on a series of specific next steps including finalizing the essential package of services and costing MOPH priority activities. It was also agreed that a follow-up mission would visit Afghanistan in May to finalize agreements on the HNP sector program. This aide-memoire should be circulated widely to stakeholders in Dari and English. The ongoing ITAP process needs to continue.

ANNEX E

HEALTH FACILITY CHECKLIST

Assessment of Safe Motherhood Services - Afghanistan
Facility Infrastructure Checklist

	Item	Finding
INFR1	• reception room	yes no
INFR2	• examination room	yes no
INFR3	• table and stool for obstetric examinations	yes no
INFR4	• examination light	yes no
INFR5	• wall clock with second hand (delivery room)	yes no
INFR6	• delivery room with bed and lighting	yes no
INFR7	• post-delivery room	yes no
INFR8	• electricity 24 hours/day	yes no
INFR9	• clean water supply 24 hours/day	yes no
INFR10	• toilet facilities (functioning)	yes no
INFR11	• refuse disposal (functioning)	yes no
INFR12	• laboratory facilities (functioning)	yes no
INFR13	• storage area for drugs and other supplies	yes no
INFR14	• telephone 24 hours/day	yes no
INFR 15	• other means of communication (specify)	yes no
INFR16	• ambulance 24 hours/day	yes no
INFR17	• operating room with table, lighting, trolley, suction apparatus, anaesthetic equipment	yes no
Comments:		

Location: **Facility:**

Assessment of Maternal & Newborn Health Services – Afghanistan
Consumable Supplies Checklist

	Item	Finding
CONS1 Basic Consumables		
CONS1.1	• gloves	yes no
CONS1.2	• disposable syringes and needles	yes no
CONS1.3	• gauze, dressings, adhesive tape	yes no
CONS1.4	• cord ties/clamps	yes no
CONS1.5	• IV sets	yes no
CONS1.6	• IV solutions (e.g. saline, ringers lactate)	yes no
CONS1.7	• blood transfusion sets	yes no
CONS1.8	• pregnancy test kits	yes no
CONS1.9	• HIV test kits	yes no
CONS1.10	• syphilis test kits	yes no
CONS1.11	• disinfectants and antiseptics	yes no
CONS1.12	• hand soap	yes no
CONS1.13	• nail brush or stick for cleaning nails	yes no
CONS2 Standard Forms/Records		
CONS2.1	• antenatal records	yes no
CONS2.2	• labour and delivery records	yes no
CONS2.3	• partograph forms	yes no
CONS2.4	• newborn records	yes no
CONS2.5	• family planning records	yes no
CONS2.6	• STD records	yes no
CONS2.8	• referral forms	yes no
CONS3 Educational Materials (written)		
CONS3.1	• warning signs of complications of pregnancy	yes no
CONS3.2	• antenatal nutrition	yes no
CONS3.3	• preparation for birth	yes no
CONS3.4	• breast feeding	yes no
CONS3.5	• newborn care (including NB immunization)	yes no
CONS3.6	• postnatal care	yes no
CONS3.7	• family planning	yes no
CONS3.8	• STD/HIV/AIDS	yes no
Comments:		

Location: **Facility:**

Assessment of Maternal & Newborn Health Services – Afghanistan
Equipment Checklist

	Item	Finding
EQU1 Basic Equipment		
EQU1.1	• sphygmomanometer	yes no
EQU1.2	• stethoscope	yes no
EQU1.3	• foetal stethoscope	yes no
EQU1.4	• infant scale	yes no
EQU1.5	• clinical thermometer	yes no
EQU1.6	• sterilizer	yes no
EQU1.7	• protective clothing (shoes, aprons, eye/face protection)	yes no
EQU1.8	• speculum (different sizes)	yes no
EQU1.9	• sterilizer	yes no
EQU1.10	• manual vacuum aspiration or D&C equipment	yes no
EQU1.11	• adult ventilation bag and mask	yes no
EQU2 Delivery Equipment		
EQU2.1	• scissors, suture needles, sutures	yes no
EQU2.7	• vacuum extractor	yes no
EQU2.8	• obstetric forceps	yes no
EQU3 Newborn Equipment		
EQU3.1	• cloth or towel to dry baby	yes no
EQU3.2	• blanket to wrap baby	yes no
EQU3.3	• bag and mask for newborn resuscitation	yes no
EQU3.4	• mucous extractor	yes no
Comments:		

Location: **Facility:**

Assessment of Maternal & Newborn Health Services – Afghanistan
Drug Supply Checklist

	Item	Finding
DRUG1	**Anaesthetics: general and pre-operative medication**	
DRUG1.1	• nitrous oxide/other general anaesthetic agent	yes no
DRUG1.2	• diazepam (injection)	yes no
DRUG1.3	• ketamine (injection)	yes no
DRUG2	**Anaesthetic: local**	
DRUG2.1	• lidocaine 2% and 5% (injection)	yes no
DRUG3	**Analgaesic**	
DRUG3.1	• paracetamol (oral)	yes no
DRUG3.2	• acetylsalicylic acid (oral)	yes no
DRUG3.3	• pethedine (injection)	yes no
DRUG4	**Anti-infective drugs**	
DRUG4.1	• ampicillin (oral)	yes no
DRUG4.2	• ampicillin (injection)	yes no
DRUG4.3	• benzylpenicillin (injection)	yes no
DRUG4.4	• procaine penicillin (injection)	yes no
DRUG4.5	• ceftriaxone (oral)	yes no
DRUG4.6	• ceftriaxone (injection)*	yes no
DRUG4.6	• gentamicin (injection)	yes no
DRUG4.7	• kanamycin (injection)	yes no
DRUG4.8	• sulfamethoxazole+trimethoprin (oral)	yes no
DRUG4.9	• tetracycline eye ointment <u>or</u> silver nitrate drops	yes no
DRUG4.10	• tetracycline (oral)	yes no
DRUG4.11	• erythromycin (oral)*	yes no
DRUG4.12	• doxycycline (oral)*	yes no
DRUG4.13	• sulphafurazole (oral)*	yes no
DRUG4.14	• chloramphenicol (oral)*	yes no
DRUG4.15	• metronidazole (oral)*	yes no
DRUG4.16	• ciprofloxacin (oral)*	yes no
DRUG4.17	• cefixime*	yes no
DRUG4.18	• spectinomycin (injection)*	yes no
DRUG4.19	• nystatin pessaries*	yes no
DRUG4.20	• clotrimazole pessaries*	yes no
DRUG4.21	• miconazole (vaginal)*	yes no
DRUG5	**Antianaemia drugs**	
DRUG5.1	• ferrous sulphate (oral)	yes no
DRUG5.2	• folic acid (oral)	yes no
DRUG6	**Antimalarial drugs**	
DRUG6.1	• chloroquine (oral)	yes no
DRUG6.2	• quinine (injection)	yes no
DRUG6.3	• sulfadoxide+pyrimethamine (oral)	yes no

	Item	Response
DRUG7 Antihelminthic drugs		
DRUG7.1	• mebendazole	yes no
DRUG 7 Antihypertensive drugs		
DRUG7.1	• hydralazine (injection) OR	yes no
DRUG7.2	• labetolol (injection) OR	yes no
DRUG7.3	• nifedipine (sub-lingual)	yes no
DRUG 8 Anticonvulsive drugs		
DRUG8.1	• magnesium sulphate (injection) OR	yes no
DRUG8.2	• diazepam (injection)	yes no
DRUG9 Contraceptives		
DRUG9.1	• oral contraceptives (COC and POP)	yes no
DRUG 9.2	• injectable (Depot medroxy-progesterone acetate)	yes no
DRUG 9.3	• intrauterine devices	yes no
DRUG 9.4	• condoms (male and female)	yes no
DRUG 9.5	• diaphragms	yes no
DRUG 9.6	• spermicides	yes no
DRUG 9.7	• intradermals (norplant)	yes no
DRUG 9.8	• emergency contraceptives	yes no
DRUG 10 Vaccines		
DRUG10.1	TT vaccine	yes no
DRUG10.2	BCG vaccine (for newborn)	yes no
DRUG10.3	oral polio vaccine (for newborn)	yes no
DRUG11 Oxytocics		
DRUG11.1	ergometrine injection/tablets OR	yes no
DRUG11.2	oxytocin injection	yes no
DRUG12 Vitamins		
DRUG12.1	Vitamin A	yes no
Comments:		

Location: **Facility:**