

**Report of the
Health System Review Mission-
Afghanistan**

Challenges and the Way Forward

**World Health Organization
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Health System Review in Afghanistan: Challenges and the Way Forward

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1 Introduction and Background

A World Health Organization (WHO) team composed of Dr. Belgacem Sabri, Dr. Fariba Al Darazi, Dr. Amr Mahgoub and Dr. Sameen Siddiqi from the Eastern Mediterranean Regional Office (EMRO), Dr. Jean Perrot from Headquarters and Dr. Abdi Momin Ahmed from the Country Office participated in a mission from July 9-18, 2006 to carry out an in-depth review of the health system in Afghanistan aimed at mapping the main health system functions, at identifying their strengths and weaknesses, and at suggesting strategic directions for health system strengthening.

The review exercise was preceded by an extensive analysis of important documents related to the Afghani health system including the Country Cooperation Strategy with WHO, consultancy reports and studies carried out by other partners and stakeholders in the country. The WHO team members met officials of the Ministry of Public Health (MoPH), carried out field trips and interacted with the main international and national partners working for health development in the country.

In preparation for the implementation of the joint agreement between the WHO and USAID to support MoPH in further expanding access to essential health services, the WHO team developed some proposals related to the technical and administrative components of the agreement particularly in relation to the strengthening of MoPH capabilities at various levels and for monitoring and evaluation of the planned activities.

Despite the commendable effort made by the national authorities and the support of bilateral and multilateral partners, the health system is facing critical challenges related to the political, social and economic determinants of health and the performance of the health system functions.

Years of war, political instability and lack of security have negatively impacted the economy of the country and have led to high levels of poverty, illiteracy particularly among females, environmental degradation and poor health status. The positive political developments have raised the expectations of the people for better employment, housing, education and access to quality health services.

However, the health system is facing severe under funding, a disrupted and weak health infrastructure, an inadequate and unequally distributed workforce, and weak capabilities in governance, planning and management and organization of health service delivery at the various levels. The deployment of health professionals and the provision of services remain hampered by lack of security in some areas of the country.

The prospects for health system strengthening are nevertheless promising in view of the political commitment at the highest level, the vision developed by the leadership of the MoPH, the generous contribution of the development partners, and the dedication of the national health professionals despite hardship and difficult working environment.

The national efforts to strengthen health system and to improve its performance in achieving its goal of improving health, reducing health inequalities, ensuring equity in health financing and improving population satisfaction should be supported by the international community in order to achieve the Millennium Development Goals.

The transition from rehabilitation to health system development needs important investments in health system infrastructure and personnel which can not be supported by national resources in view of the weak economic base.

Scenarios for achieving sustainable health system financing over medium and long term periods should be developed taking into consideration the evolving health and demographic status and the forecasts for national economic growth.

2 Situation Analysis

2.1 Overall Vision

The vision of the MoPH for health in Afghanistan states that in 10 years (2004-14) better health will contribute to economic and social development. Better health implies significantly reduced mortality among women, infants, and children under-five years of age; incidence of communicable diseases, especially of malaria and tuberculosis, will be at lower levels and there will be fewer epidemics; and the nutritional status of children will be much improved.

This vision will be achieved through: (i) an effective, efficient, quality, sustainable basic health services distributed equitably throughout the country, especially in the rural areas; (ii) well functioning hospitals, all of which will be able to provide comprehensive emergency obstetric care; (iii) the right mix of health workers, in the right place, in the right numbers, at the right time, with the right skills; (iv) the best use of financial and other resources, with spending in line with priorities and coordinated across sectors; (v) a Ministry of Health that is a strong steward of both the public and private health sectors, is transparent with good governance, and has evidence based policies and priorities. There will be effective and efficient health systems that will ensure a well functioning public sector institution.

The Mission of the Ministry of Public Health is commitment to ensuring the accelerated implementation of quality health care for all the people of Afghanistan, through targeting resources especially to women and children and to underserved areas of the country, and through working effectively with communities and other development partners.

2.2 Health Governance

The Ministry of Public Health (MoPH), with the assistance of its development partners, has made considerable progress during the last four years in assuming its legitimate role as the steward of the health system and in improving health governance. An Interim Health Policy was developed in 2002 followed by an interim health strategy (2002-2004) to facilitate implementation. More recently, a comprehensive national health policy (2005-09) and strategy (2005-06) has been developed to guide the overall context within which all health and health related programs should be developed and implemented. Policy documents have been developed on human resource development and community health workers. Transforming these policies into strategic plans and implementable programs continue to remain a challenge.

Efforts have been undertaken since 2004 to restructure the public health sector at the level of the MoPH (Annex 1) and the provincial health directorates (PHDs) so as to boldly confront the health challenges. A renewed effort is underway to further reorganize the MoPH and PHDs so that the organizational structure is aligned to its 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 resource,

and health information. The health sector in Afghanistan relies heavily on financial and technical support from international development agencies. There are several international donors and development agencies supporting the health sector, which requires better coordination. A strong international health department in the MoPH is essential to efficiently undertake this responsibility.

The MoPH has an explicit policy on partnership with the non-governmental organizations (NGOs) through contractual arrangements for the delivery of the basic package of health services (BPHS). For this purpose a Grants and Contracts Management Unit (GCMU) has been established in the MoPH. The GCMU, which is funded by the World Bank, has acquired rich experience in independently managing most aspects of the contracting process. For monitoring and evaluation of the delivery of BPHS the Unit relies on the technical team lead by the Johns Hopkins University (JHU) and its partner, the Indian Institute of Health Management Research (IIHMR), which is also supported by the World Bank. The institutionalization and sustainability of the work of the GCMU within the MoPH once donor support is withdrawn has to be carefully thought-out. There is some evidence that the contracting out by the MoPH directly to the NGOs has weakened the 34 Provincial Health Directorates (PHDs) in the country.

The overall governance function of the health system is weak despite formulation of national health policies and strategies (with external support), policy on involvement of non-governmental stakeholders, and the introduction of MoPH Strengthening Mechanisms (SM) to improve the efficiency of the public health sector. Systems need to be in place to promote equity, accountability, transparency, ethics, enforcement of regulation, and informed decisions. WHO is supporting a study on health governance in Afghanistan that would assist the MoPH in promoting good governance in health.

The MoPH is paying attention to some Essential Health System Functions but the approach is piecemeal. Particular attention and institutional mechanisms are needed in the areas of monitoring, evaluation and analysis of the health situation; public health surveillance; health planning and management; health regulation and enforcement; promotion of equitable access to health services; health workforce planning, production and management; quality assurance in personal and population-based health services; public health research; and reducing the health impact of emergencies and disasters.

2.3 Health Care Financing

Data on health care financing are scarce particularly in relation to spending by households and on services acquired outside government and NGO contracted facilities. However there is some evidence that the health care system of Afghanistan is clearly under funded as shown by WHO's national health accounts estimates and by some studies carried out by donors and NGOs.

It seems that the financing of the health system relies mainly on contributions from donors channeled for contracting out of the BPHS to national and international NGOs and for the MOPH strengthening mechanism and through funds to support MOH's regular budget. The per capita spending by government on health is around 0.6 % of GDP. A sizeable proportion of health care spending is borne by households as shown by some household surveys carried out as research activities.

Health care financing constitutes the major challenge facing health system rehabilitation and development particularly that the constitution mentions the right for 'free' health care. The concerns are over the low level of health expenditure, over equity in access to health services and over sustainability of health care financing.

According to World Bank projections for economic growth the GDP per capita will increase from 299 US dollars in 05-06 to 355 US dollars in 06-07, and going up to 402 US dollars in 08-09. Using the figure of 5 % of GDP spent on health to secure primary health care as recommended by WHO, the per capita spending on health will be around 15 US dollars in 2006, 18 US dollars in 2007 and about 20 US dollars in 2008. Therefore, total spending on health using 2006 figures will be $23 * 15 = 345$ millions US dollars and for 2007 (using 2% population growth, 23.5 million population * 18 = 423 million US dollars)

Using 77% coverage for a population of 23 million in 2006 and 4.5 US dollars per capita to implement BPHS, the amount is around 80 million US dollars. As government budget is 28 million US dollars, the total spending from public and NGO sources is 108 millions US dollars or 31% of total estimated spending. For 2007, adjusting for 13 % inflation and assuming zero real growth of MOPH regular budget, it will be around 32 million US dollars, total spending from government and NGO will be around 113 million US dollars which represent 27% of total spending on health leaving 73 % of expenditures to be paid by households and other UN and bilateral and multilateral donors.

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 national take over.

According to recent studies on care seeking behavior carried out by the World Bank, the publicly financed facilities (though many are managed and financed by NGOs) remain the main provider of services and 27 % of sick patients use private facilities. Such finding signals the importance of strengthening publicly financed institutions which provide more equitable access to population particularly the ones living in rural and remote areas. The recent study implemented by Johns Hopkins School of Public Health on assessing the performance of various contracted institutions to deliver BPHS, revealed that the SM contracted facilities have achieved good performance.

In terms of structure of health care financing and similar to other low-income countries of the region, the share of out of pocket spending is relatively high despite limited availability of accurate data (more than 70%). Some studies looking at the possibility of increasing financial health protection using community funds managed at the level of the health facilities do not seem to provide convincing elements of sustainability. Efforts should however be made to carry out some feasibility studies for developing community insurance schemes with active participation of local Shura people. The option of developing social health insurance for civil servants and workers in the private sector are also to be considered in the medium and long run.

Limited information is available in terms of health system efficiency but there are some good indications that the Priority Reform and Reconstruction (PRR) policy of government is contributing to selecting appropriate and motivated workforce and that some instruments used in running the various programs could lead to efficiency gains. In the SM-PRR visited site, the provincial officials have mentioned a real increase in the productivity of health professionals.

2.4 Human Resources for Health

Afghanistan lost many health professionals during the 20 years of civil strife and conflict. The 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 HRD situation in Afghanistan is complex and requires special attention.

Presently there is a 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 severe shortage of female health workers in the remote areas of the country. Evidence is accumulating that increasing the remuneration has led to increase in the number of female health workers in these areas.

The total health workforce is estimated at 27,340 health personnel and around 10,500 of whom are working with contracted NGOs. The total number of staff working at MoPH is estimated at 16,840. This includes 3,704 physicians, 3,311 nurses and midwives, 3,217 allied health personnel, 1,836 administrative staff, and 4,762 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 8,000 medical students enrolled in the medical schools in Afghanistan. In addition, there are 9 Institutes of Health Sciences that prepare nurses, midwives, and allied health professionals. Presently there are 3,500 students enrolled in these Institutes. The community midwifery programme started in 2002 and is running in 21 provinces with 640 students enrolled; 140 community midwives have graduated since establishment of the 18 months programme. According to the MOPH strategic plan there is a need for 7,000 physicians, and 20,000 nurses, midwives, and allied health personnel to implement the BPHS, EPHS, and other services. Such projected figures should be supported by evidence from research combining case studies on health needs and workload indicators.

There is maldistribution of health care providers between and within provinces, and between urban and rural areas. This 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, lack of educational facilities for children and transportation.

Since 2002, the MOPH has made major strides in building the human resources development (HRD) process through establishment of the Directorate of HRD with all its important functions at the central level; development of a national policy for HRD; 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 program; capacity building of the health workers; establishing a data base for HRH; and establishing a testing and certification process to protect the health of the public.

In addition a competitive system for implementing civil service recruitment and PRR has been established. Job descriptions of all health workers have been developed, however these need to be revised in line with the BPHS and EPHS; and staff have to be oriented to them.

A one-year public health and administration certificate program has been initiated to meet the continuing education needs of staff. Also short training courses in English, computer skills, and management are being implemented.

2.5 Provision of Health Services

The MOPH has decided to implement the provision of the basic package of health services [BPHS] and the essential package of hospital services [EPHS] through contracting out to NGOs and, in some areas through a mechanism to strengthen provincial health services authority [MoPH-SM]. The cost of \$ 4-5 per capita was estimated for the BPHS as the basis for contracting. [see Annex 2 and 3]

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 1,000 to 1,500 people, equivalent to 100 to 150 families;
- A basic health centre (BHC) is staffed with one nurse, a midwife and vaccinators, covering a population of 15,000 to 30,000 people;
- A comprehensive health centre (CHC) has more staff than a BHC, 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, DH) serves up to four districts and a population of 100,000 to 300,000 people. It is staffed with doctors, including a female obstetrician/gynecologist, surgeon, anesthetist and pediatrician; nurse; midwives; laboratory and x-ray technicians; pharmacist; and a dentist and dental technician.

For the purpose of delivering basic health services, the MoPH, with the assistance of partners, developed and setup independent mechanisms and tools:

- Developed and implemented the BPHS in 2003, revised in 2004, while the EPHS was developed in 2004. Both packages were endorsed as part of the national policy in 2005;
- Established a Grants and Contracts Management Unit (GCMU) in the MoPH in March 2003, which is funded by the World Bank. The Unit has recruited up to 20 national consultants; most of whom work with management of contracts but many are serving as advisers to various directorates of the MoPH. The scope of work of the Unit entails: undertaking all steps related to the contracting out process, disbursement of funds, financial monitoring of contracts, and supporting MoPH-SM provinces;
- Central coordination forums such as the Consultative Group for Health and Nutrition (CGHN), which includes in addition to senior MoPH staff, other line ministries, UN agencies, main donors, principal NGOs and the International Security Assistance Forces (ISAF) as members to oversee the policy and operational aspects of service provision. A technical advisory group has also been also established;
- Strengthening of health service management capacities and gradual decentralization of operational and financial responsibilities and authorities to the provincial level. A Provincial Health Coordination Committee (PHCC) has been set up, led by the Provincial Public Health Director, and 8 members involving all relevant partners in the health sector in the respective province. Its main objective is to coordinate the activities of all stakeholders in achieving the MOPH priorities, particularly the expanded delivery of the BPHS;
- Establishment of Health Services Performance Assessment Directorate with three units: HMIS, monitoring and evaluation and health system research;
- Completion of the Afghanistan national hospital survey published in August 2004. The survey was initiated by MOH in 2003 and implemented by Management

Sciences for Health Europe [MSH Europe] as a collaborative effort supported by other agencies and donors.

As of today, about 77% of the Afghan population lives in areas covered by BPHS (including the three provinces where the Ministry is the implementing body). The Ministry is targeting 95% coverage to be achieved by 2015, which is also the year for achievement of the MDGs.

Currently there are five donors supporting contracting out of BPHS: World Bank (11 provinces – 8 NGO contracts and 3 MoPH-SM), USAID (13 provinces, based on cluster approach), European Commission (10 provinces), and selected districts by Asian Development Bank and Kreditanstalt für Wiederaufbau (KfW). Various mechanisms are being used by the donors to contract NGOs. The WB has a more flexible incentive based Performance based Partnership Agreement (PPA). World Bank channels its funds through the Ministry of Finance to the Ministry of Public Health which is responsible for contracting competing NGOs. Contracts receiving World Bank funds are currently managed and overseen by the GCMU. The Asian Development Bank and USAID have outsourced this process to an international NGO, whereas the European Commission undertakes this work itself.

USAID the largest external donor, providing grant for delivery of BPHS and EPHS, and is also engaged in developing the basic infrastructure such as clinics and district hospitals. During the last two years (2002-2003) USAID has funded these projects through Afghanistan's Health Service Expansion Project and the Rural Expansion of Afghanistan's Community-based Health Care (REACH) Program. Starting from April 2006 USAID and WHO signed an agreement whereby it will support the delivery of BPHS and EPHS in thirteen USAID funded provinces in Afghanistan.

As a trial for future sustainability and for comparability and MOPH selected three provinces assigned to the World Bank - Kapisa, Parwan and Panjsher to implement BPHS. The project is supported by the Ministry of Public Health Strengthening Mechanisms (MoPH-SM). Staff is recruited through the MOPH PRR process, the selection is merit based and the level of remuneration almost three times that of the regular staff of MoPH, and considerably less than the salaries of the staff working in NGO contracted out facilities.

Payment exemption strategies for the poor are implemented throughout the country with different mechanisms. Meanwhile, the public health interventions and clinical care are provided free of charges to any citizen of Afghanistan: immunization, maternal delivery, antenatal care, family planning, treatment of TB, and nutrition interventions. User fees are charged at most public health facilities, which is currently 5 Afghanis. Exemptions are given by the local Shura-e-Sehat – the community involvement organ, which is part of the BPHS delivery initiative. The future options for financing the BPHS is being studied by MoPH through a contract with JHU and supported by the WB. Tax based, user fees and community insurance schemes are being piloted. The results of this study shall be presented in 2007.

Many provinces, including Kabul has less than 1 bed per 1,000 population. Additional efforts are being concentrated on the hospital sector in Afghanistan since this is vital for improving the health status of Afghans and complements the BPHS. Hospitals are facing major challenges in the post conflict environment. The Essential Package of Hospital Services (EPHS) has been developed to address these challenges and the national policy has been put it as the second priority.

The MoPH had developed a policy on information technology and communications, and support services including those for laboratory services, blood safety, pharmaceuticals,

equipment and medical supplies. Many of these policies have yet to be translated into programs for implementation.

The MOPH policy is addressing accessibility, availability, safety, efficiency, effectiveness and affordability of medicines; and drug quality control. The procurement and supply is completely under different providers and coupled with large drug trade through 16,000-18,000 drug stores.

2.6 Information Support

A basic health management information system exists, which covers almost 800 health facilities that fall under the contracting out arrangements. Monthly reports are sent to the provinces; data is 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. The scope of the HMIS needs to be expanded to cover the hospitals including those in the private sector. In addition, the disease surveillance component of the HMIS needs strengthening. The Health Metrics Network has approved US\$ 150,000 for strengthening HMIS in Afghanistan for which an action plan is being developed by the MoPH.

Currently, the Balanced Score Card (BSC) is the principal instrument for monitoring health system performance instead of the national HMIS. The first round of BSC monitoring of BPHS was completed in 2004 and the findings of the second round (for 2005) are being finalized. The preliminary results were shared with the MoPH and other stakeholders while the mission was on. The comparison of results between 2004 and 2005 indicate a 12 percentage point improvement among PPA provinces (World Bank), 10 percentage point improvement in PPG areas (USAID), 8 percentage point improvement for SM provinces (World Bank), and 3.5 percentage point improvement in EC supported provinces for the delivery of the BPHS. Other areas/facilities not covered by any of the above showed a 3 percentage point decrease in performance. The BSC is a useful tool for monitoring health facility performance, and may be the most effective under the current circumstances. Many of the indicators are process oriented and do not depict service coverage 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. Currently, there is no program for establishing a system of vital statistics in the country.

3 Main Challenges and Priorities

This section summarizes the main challenges and the priorities, based on the foregoing analyses that face the Afghani health system:

- **Social and economic determinants** – poverty, high illiteracy, environmental degradation represent the main challenge to ill health;
- Weak governance particularly in the areas of **policy analysis, strategic planning**, health human resource planning and long term scenarios, standard setting, health legislation and regulation, health financing and donor coordination in the General Directorate of Health Policy and Planning. Most of these functions fall under its various directorates (Annex 1). The GCMU, which is organizationally under the General Directorate functions independent of it. There is limited understanding of policy analysis tools such as the national health accounts, cost

and cost-effectiveness analysis, burden of disease analysis, and development of future scenarios for health workforce.

- There is scarce data on **health care financing** particularly in relation to spending by households and on services acquired outside government and NGO contracted facilities. The Afghani health care system is inadequately funded and there is a heavy reliance on contributions from external donors, considered to be over 95% of the total public sector spending on health. There are additional concerns about the high level of out-of-pocket spending, estimated to be over 60% of total spending, about inequity in the financing of health services, and its long term sustainability.
- The following are the major constraints related to **human resources** that contribute to weakness in the delivery of health care services in the country in terms of availability, accessibility, and quality:
 - Shortage of qualified nurses, midwives and allied health professionals;
 - Shortage of female health workers in the country, 90% of the nursing students are male;
 - Rural –urban disparity in the distribution of human resources;
 - Absence of national educational standards for all health professions;
 - Lack of health professional regulation;
 - Lack of continuing education programs for all health professionals;
 - Deficient clinical training sites both at the hospital and community level;
 - High turn over rate amongst the nursing, midwifery, and allied health teachers. The present cadre is poorly paid.

In addition, to the above constraints, lack of resources, the poor physical status of the health facilities, shortage of prepared faculty, lack of teaching-learning resources including books and references, equipment and materials, student dormitories and lack of community - based learning facilities further impedes the human resources development process in Afghanistan.

- There is also an urgent need to further develop a data base on human resources for health and integrate it within the overall health information system to ensure appropriate planning for the production of the required human resources;
 - Certification and licensure of all health personnel is another challenge that has to be addressed to ensure regulation of health human resources to protect the health of the public;
 - Ensuring the full utilization of the graduates of the newly established community midwifery program by establishing an outreach program and provision of logistic support is critical.
- The main challenges that relate to the **provision of health services** include the following:
 - The future sustainability of the health delivery system with increased expectations and demand of the communities in absence of donor funding;
 - Despite the large population coverage [77%] achieved through the contracting out process, this does not necessarily mean actual coverage of communities by services as figures on utilization are not well captured;
 - Inadequate physical infrastructure [buildings, equipment and ambulances] further reduces access to health care for communities living in rural areas of

- Afghanistan, especially for women who need emergency obstetric care and for seriously sick children;
 - Lack of experience among NGOs in managing relatively complex systems, such as: referral, supervision and supply systems;
 - Reduced managerial capacities of health system managers for effective delivery of health services at national and sub-national level;
 - Absence of accreditation initiatives, quality assurance and continuous quality improvement programs;
 - There is lack of policy on the assessment and use of appropriate technology and the need for review of the national medicines policy;
- The health (and hospital) management **information system** is not well functioning and there is lack of information on health outcomes. There are major gaps in information on the financing of the health sector, household expenditure on health, health seeking behavior of the population and on overall health status. A system of vital registration is not in place.
 - There is a need for a **long term vision** for the development of the health system and sustainability of the health services in Afghanistan. Currently, the financing of the health sector is almost entirely dependent on external funds; health workforce is inadequate, imbalanced and maldistributed with inappropriate skill mix; physical infrastructure of the health system is inadequate; and delivery of health services relies heavily on contracting out of BPHS and EPHS to NGOs. The current situation may continue in the near future, however, the MoPH has the challenge and responsibility to come up with options and strategies that would allow the health system to sustain itself and ensure essential public health functions over the longer term.

4 The Way Forward

This section proposes a set of recommendations for improving the performance of the various health system functions in the country for better health outcomes. These recommendations are for the consideration of the MoPH and all partners, WHO would continue to provide the necessary technical assistance to effect ensure their realization.

- **Health Governance and Stewardship**
 - Strengthen capacity of the General Directorate of Health Policy and Planning and its various departments in policy analysis tools such as the national health accounts, costing and cost effectiveness analysis, burden of disease assessment and health human resource projections and plans;
 - Streamline a system of strategic health planning at the central level, as well as, the development of annual provincial plans, which are aligned to the budgetary cycle of the Ministry of Planning and Finance;
 - Improve capacity of the MoPH to better coordinate among bilateral and multilateral donors and international development agencies providing support to health sector;
 - Recruit staff with background in economics and accounting in the Finance Department of the General Directorate to be able to provide a clear picture of total development and recurring annual expenditure on health, as well as to be able to undertake costing of specific health services, and work on national health accounts study;

- Align the work of the GCMU and the Department of Administration and Finance with the General Directorate of Health Policy and Planning for better coordination of activities funded through development and regular budgets of the MoPH;
 - Set up mechanisms to ensure that coordination between the central and provincial levels that incorporates human resources planning and management functions;
 - Development of a policy paper by the MoPH that provides a long-term vision (2010 and beyond) for the health sector based on an objective analysis of the current strengths and weaknesses, the major risks and assumptions, and giving future directions and various options on how health systems functions and priority health programs could be sustained and health services made more accessible, effective and of better quality in the country.
- **Health Care Financing**
 - There is a need to develop an evidence-based policy and strategy for health care financing highlighting the main principles of equity, universal coverage and fairness of financial contribution;
 - Efforts should be made to promote pre payment schemes including social, private and community health insurance to generate more resources for the health sector to supplement the government tax based system;
 - There is a need to advocate investment in health development from national sources through poverty reduction strategies and development of pro poor health systems;
 - In order to increase knowledge about health care financing, the following studies and research activities are needed:
 - national health accounts analysis;
 - costing and cost analysis studies, especially for the BPHS and EPHS;
 - feasibility studies for developing pre payment schemes, especially micro-health insurance schemes at the community level;
 - household utilization and expenditure surveys using WHO tested questionnaires;
 - analysis of equity in financing using household data;
 - development of simulation models for health system financing using the WHO-ILO simulation model
- **Human Resources for Health**
 - There is an urgent need to develop an evidence based national human resources development / work force plan and strategy based on delineation of the future scenarios taking into account the assumptions with regard to the health care delivery system, skill mix, staffing standards, and a proper mapping of existing human resources in the country, and with full participation of stakeholders such as the MOPH, MOHE, Civil Service, representatives from the community and partners;

- Establish mechanism to strengthen linkages and coordination between the Ministry of Public Health and Ministry of Higher Education to reform medical education in the country;
 - Strengthen nursing and midwifery governance at all levels of the health care delivery system;
 - Prepare a new cadre of qualified teachers in all health professions especially nursing, midwifery and allied health by establishing a national continuing education diploma program in health professions education through a twinning mechanism between the educational institutions in Afghanistan and in the Region;
 - Reviewing the present HRD policy to include the community health workers (CHW) (with special emphasis on female CHWs) as a category providing basic health services with standardized educational preparation, proper supervision, and adequate remunerations built within the health system to ensure sustainability and effectiveness;
 - Set up mechanisms to develop a national system of accreditation for all health professions education institutes in the country;
 - Strengthen the present system of testing and certification, and registration of health personnel, and build a system for licensing ;
 - Strengthen management of human resources including improving working conditions, institutionalization of performance management system, and paying special attention to the distribution and utilization of human resources to address the urban –rural disparity.
 - Prepare a core of nursing, allied health, and midwifery leaders by providing fellowships to enable these professionals to obtain their B.Sc degrees;
 - Provide technical support to establish the environmental hygienist program and update the various allied health curricula and educational programmes;
 - Continue the strategic alliances with WHO and other partners such as USAID, AKDN, IMC, BRAC, JICA, World Vision, and Ibn- Sina to strengthen health professions education in the country.
- **Provision of Health Services**
 - Review SM and national NGO led contracting out experiences and develop alternate strategies including contracting such as contracting in, internal contracting within the public sector based on the findings of the review;
 - Unification of the national monitoring and evaluation processes to be adopted by all donors funded programs for BPHS and EPHS – beside other supporting studies and external audits with full involvement of the Provincial Health Coordination Committee (PHCC);
 - Strengthening decentralization of health systems, through capacity building and technical expertise and supporting district health systems through institutionalization of the district team problem-solving approach and

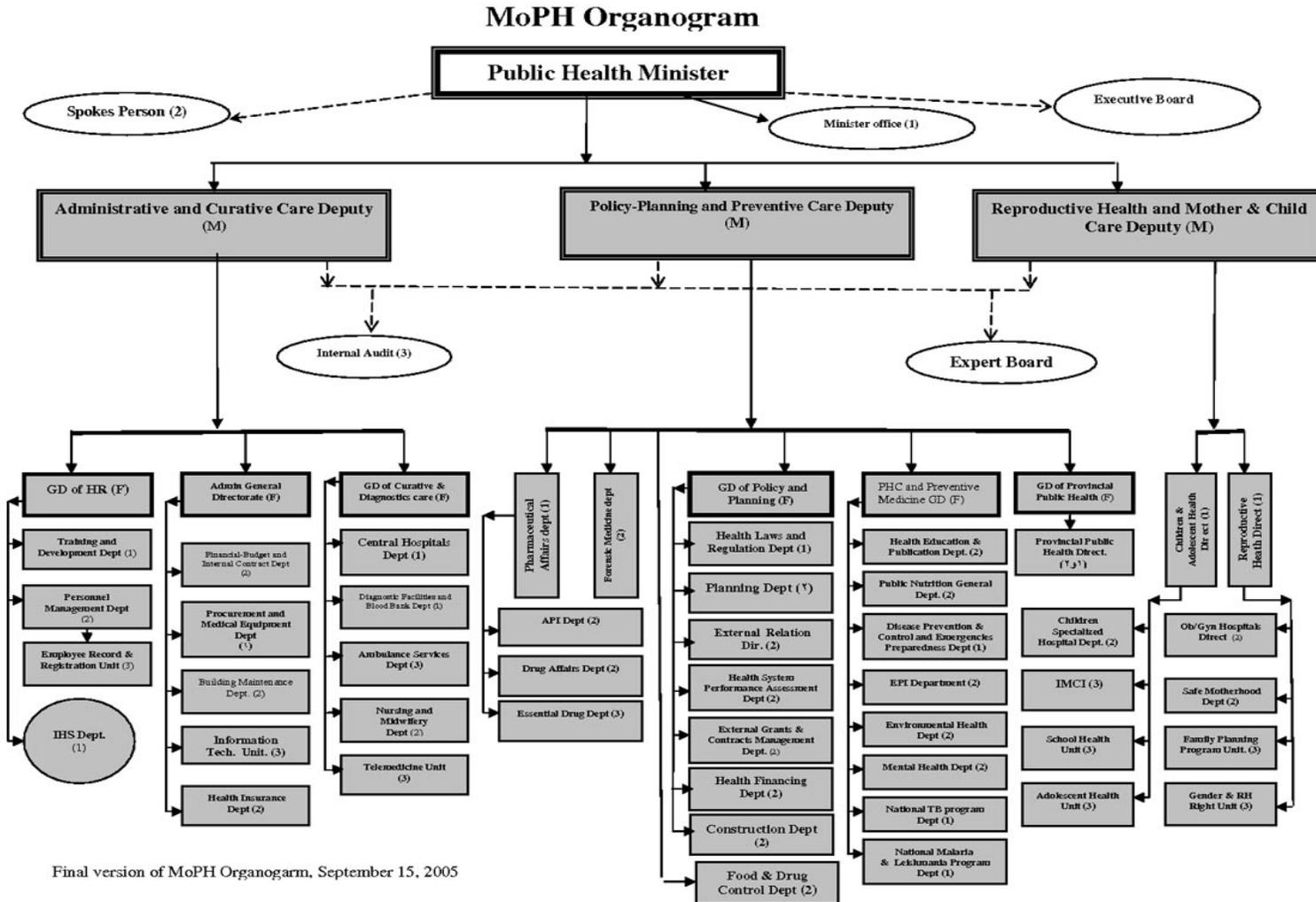
development of sustainable management capacities through national management effectiveness program;

- Improving the quality of health service delivery through continuous quality improvement program based on quality standards for individuals, departments and organizations against which performance will be measured;
- Support to accreditation of health facilities as an important approach for improving the quality of health care structures;
- Developing a mid and long term physical infrastructure plans considering the appropriate options including soft loan based implementation;
- National action plan to address organization and managerial processes necessary to improve accessibility, quality, cost, and performance of hospital services, and implement and manage a two ways referral system [the conceptual framework for hospital health services management, WHO/EMRO mission 15-27 April 2005].
- Develop capacity for technology assessment and use of appropriate technology covering areas such as safe blood transfusion, radiology and imaging, and biomedical equipment;
- Review and revise the current strategies of drug procurement and supply mechanisms including quality control measures and regulations governing drug and pharmaceutical dispensing and prescribing;
- Support the research unit in the MoPH - as the health research machinery- through technical assistance, capacity building and human capital investment.

- **Health Information System**

- Strengthen the national health management information system to cover all primary health facilities and hospitals, which should include the development of the Disease Early Warning System (DEWS), refinement of HMIS instruments, training of staff, development of database, capacity development for analysis of data and regular feedback, and increased use for informed decisions;
- Develop and submit an action plans t the Health Metrics Network in WHO for release of the allocated US\$ 150,000 in technical assistance to strengthen HMIS in Afghanistan;
- Undertake period population-based health surveys with the assistance of the Central Statistics Office that provide information, among others, on health outcomes and status, health expenditure and health seeking behaviors of communities. Initiate a program to establish a comprehensive or sample vital registration system.

Annex 1 Organizational Structure of the Ministry of Public Health



Annex 2

Components of the basic package of health services

Maternal and newborn health

- Antenatal, delivery and postpartum care; Family planning; Care of the newborn

Child health and Immunisation

- EPI (routine, outreach and mobile); Integrated management of childhood illness

Public nutrition

- Micronutrient supplementation; treatment of clinical malnutrition

Communicable diseases

- Control of tuberculosis and malaria

Mental health

- Community management of mental problems; health facility based treatment of outpatients and inpatients

Disability

- Physiotherapy integrated in PHC services; Orthopaedic services expanded in hospitals

Supply of Essential Drugs

Annex 3

Standardized provision of services to be offered by hospitals

District hospital:

- 30-75 beds, serving population of 100,000-300,000 in 1-4 districts
- Basic surgery, medicine, obstetrics and gynaecology, paediatrics, mental health, dentistry, plus support services for nutrition, pharmacy, physiotherapy, laboratory, radiotherapy and blood bank

Provincial hospital:

- 100-200 beds
- All the above clinical and support services, plus rehabilitation services and infectious disease control

Regional hospital:

- 200-400 beds
- All of the above plus surgery for ENT, urology, neurology, orthopaedics, plastic surgery; And medicine to include cardiovascular, endocrinology, dermatology, lung and chest, oncology, forensic medicine
- A greater variety and more developed support services

Annex 4

Some notes about contracting

Contracts are sometimes referred to as MOU while the latter usually indicates general agreement without necessary contractual arrangement

In the USAID managed contract, there are only 2 involved parties : NGO and WHO but the MOPH is co signatory which is not coherent: if the MOPH is not involved it can be in the form of endorsement or visa but if the MOPH is involved which is likely the case, MOPH should appear as partner

Some contracts need to be revisited and reworded in order to appear as real contracts

No performance indicators are set i.e. coverage by outpatient services, etc.. The assessment is often limited to some administrative aspects such as provision of financial accounts. There is a need to integrate result indicators.

No penalties are considered apart from the non renewal of the contract . One has to bear in mind that changing of NGO has a cost as a new unknown entity will be taken on board by the community for the delivery of services.

As contracts are often for a short period, how can the NGO has a long term vision. The NGO may be interested in providing mostly curative services at the expense of preventive and promotive ones. Also NGOs have no incentives in investing in capital development.

The technical input of WHO has been overlooked in the contract. Clear technical assistance should be provided as part of the partnership.

Local health administration should have a well defined role in such contract. If local management was not involved in the design of the contract , it should at least involved in monitoring and evaluation of the planned activities.

Scenarios should be developed on the future of NGOs and the possible hand over in terms of service delivery.

Modalities of using funds should be well defined in the contract. Flexibility should be allowed particularly for wiring between budget lines. A national strategy should be adopted in relation to incentives provided to well performing NGOs.

Contracts should be very explicit and vigilant with respect to user charges in health facilities. As prices are usually subsidized and not reflecting real costs. Systems of micro insurance could be developed in order to secure better financial risk protection.