



# Health Sector Transition Strategy

2023 - 2025



# Acknowledgements

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<sup>2</sup> WHO, UNICEF and Partners' Mission to support the development of the Afghanistan Health Sector Transition Strategy (2023-25). Mission Report and Summary of Key Health System Challenges and Future Priorities, 4-8 September 2022.

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# List of acronyms

<b>AHS</b>	Afghanistan Health Survey	<b>GFATM</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>ADB</b>	Asian Development Bank	<b>HEFD</b>	Health Economics and Financing Directorate
<b>ANC</b>	Antenatal care	<b>HMIS</b>	Health management information system
<b>ARTF</b>	Afghanistan Reconstruction Trust Fund	<b>HSTS</b>	Health sector transition strategy
<b>BPHS</b>	Basic package of health services	<b>H-STWG</b>	Health-sector technical working group
<b>BoD</b>	Burden of disease	<b>HRH</b>	Human resources for health
<b>CHW</b>	Community health workers	<b>HSS</b>	Health system strengthening
<b>DfA</b>	De facto authorities	<b>IDA</b>	International Development Association
<b>DHIS2</b>	District health information software	<b>IDS</b>	Integrated disease surveillance system
<b>EPI</b>	Essential Programme on Immunization	<b>INGOS</b>	International non-governmental organizations
<b>EU</b>	European Union	<b>IPEHS</b>	Integrated package of essential health services
<b>EPHS</b>	Essential package of hospital services	<b>JICA</b>	Japan International Cooperation Agency
<b>GFF</b>	Global Financing Facility		
<b>Gavi</b>	The Global Alliance for Vaccines and Immunisation		

<b>MoF</b>	Ministry of Finance	<b>RMNCAH</b>	Reproductive, maternal, newborn, child, and adolescent health
<b>M&amp;E</b>	Monitoring and evaluation	<b>SBA</b>	Skilled birth attendant
<b>MNDSR</b>	Maternal and newborn death surveillance and review	<b>THE</b>	Total health expenditure
<b>MoPH</b>	Ministry of Public Health	<b>UNFPA</b>	United Nations Fund for Population Activities
<b>mCPR</b>	Modern contraceptive prevalence rate	<b>UNICEF</b>	United Nations Children's Fund
<b>NHA</b>	National Health Accounts	<b>USAID</b>	United States Agency for International Development
<b>NCD</b>	Non-communicable disease	<b>UN</b>	United Nations
<b>NGO</b>	Non-governmental organization	<b>WASH</b>	Water, sanitation, and hygiene
<b>NNGO</b>	National non-governmental organization	<b>WHO</b>	World Health Organization
<b>NHP/NHS</b>	National health policy/strategy	<b>WB</b>	World Bank
<b>OOP</b>	Out of pocket		
<b>PNC</b>	Postnatal care		

# I. Executive summary

Afghanistan's health system has delivered impressive outcomes over the past 20 years and has shown remarkable resilience in the face of the recent political and economic upheaval. There are now significant opportunities to reach further into under-served parts of the country, iterate and adapt the model of care, and power another phase of improvements in the health and wellbeing of Afghans.

The security situation and the role of women in Afghan society – notably with regard to the impact of formal and informal restrictions placed on women and girls on health and nutritional outcomes – remain uncertain. Furthermore, the health care system in Afghanistan is highly dependent on external development assistance and humanitarian partners. Out-of-pocket health spending has driven most of the growth in health expenditure over the past 20 years, creating a health financing situation that is inefficient, inequitable, and risks pushing households further into poverty. The approach of the de facto authorities (DfA) to health sector financing remains unclear, and consequently, the financing outlook of services at all levels of care – tertiary in particular – is uncertain. Even more importantly, the economic crisis that was triggered by the political transition has exposed pre-existing vulnerabilities, driven nearly all Afghans into poverty, and undermined food security for most households. Additional challenges include health packages which are not fully aligned with the country's current disease burden, insufficient health care staff, inadequate health service quality, fragmentation of health monitoring systems, weak health product supply chains, low coverage among remote and rural populations ("white areas"), gender inequalities, limited integration of the private sector, and the need to clarify the overall role of the DfA vis-à-vis health and development partners.

To meet these challenges head on, it is critical for health sector partners to coalesce around a common investment strategy that aims to minimize avoidable morbidity and mortality by expanding the coverage and quality of health and nutrition services and strengthening health system resilience. This Health Sector Transitional Strategy (HSTS) proposes a set of consensus priorities for the 2023–2025 period. The priorities outlined in this strategy are deemed to be realistic for off-budget health sector partners to pursue in light of limited financial resources, and pragmatic given the current economic, political, and diplomatic situation in the country.

The HSTS is organized around four strategic directions: (i) Strengthen and expand essential service coverage/utilization and quality of care, and improve financial risk protection for the most vulnerable groups; (ii) sustain and strengthen the essential foundations of the health system that are necessary for meeting basic human health needs; (iii) strengthen capacities to prevent, detect, and respond to disease outbreaks and other health emergencies; and (iv) strengthen the harmonization and alignment of financing for national health priorities to increase the predictability, adaptability, and efficiency of funding. The plan will be supported by concerted efforts to collaborate across sectors in order to address social, environmental, and gender determinants of poor health.

The close coordination among the health, development, and humanitarian actors that are involved in Afghanistan's health sector has been critical both to health sector improvements and to the speed of the response to the crisis in 2021 and 2022. The HSTS expects to further consolidate this partnership to sustain historic gains and propel further improvements in the health and wellbeing of all Afghans.



## II. Health background

### 1. OVERALL ARCHITECTURE OF THE HEALTH SYSTEM IN AFGHANISTAN/ SITUATION ANALYSIS

#### a. Overview

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In 2002, Afghanistan began implementing a series of health reforms that resulted in steady progress over the following two decades. The advances included improved health sector governance, increased coverage of health services across the country, and, ultimately, better health outcomes for the population. Among the key contributing factors to this success were strong national stewardship, sound and stable policy frameworks, investments in primary health care by international partners, and the introduction of a basic package of health services (BPHS), in 2003, with subsequent updates in 2005 and 2010, and an essential package of hospital services (EPHS) in 2005. Investments in the sector were made primarily by the World Bank's International Development Association (IDA), international donors, United Nations (UN) agencies, and global health initiatives.

Following a health system review in 2020, Afghanistan's Ministry of Public Health (MoPH) led the development of the National Health Policy (NHP) and the National Health Strategy (NHS). Both were updated in 2021, prior to the political transition. The NHP aims to create the necessary conditions for achieving universal health coverage, focusing on (i) governance and leadership; (ii) human resources; (iii) health financing; (iv) service delivery; (v) medicines, medical products, and technologies; and (vi) health information systems. In mid-March 2022, The MoPH health ministry developed a slightly revised NHP, which has yet to be launched. Until August 2021, the MoPH had primary

responsibility for providing essential, effective, high-quality, equitable, and accessible health care services to the population of Afghanistan. Prior to the political transition, the ministry invested significantly in enhancing its governance functions through components such as strategic policy frameworks, structure, coordination, regulations, oversight, and accountability, with support from WHO and other international partners. When Afghanistan adopted the BPHS, it simultaneously introduced a contracting-out approach, which became the main service delivery model (see below). One of the reasons for choosing this model was to allow the MoPH to focus on its stewardship role and other related functions.

At the provincial level, the MoPH is represented by the provincial public health departments (PPHDs). The PPHDs are accountable to both the MoPH and the governor and have a mandate to coordinate services provided by non-governmental organizations (NGOs). Prior to August 2021, all resource allocations, with the exception of some off-budget funding, were determined at the central level. PPHDs received a line-item budget and were responsible for spending and accounting according to the set allocations. The MoPH has no management body at the district level, such as a district health office. This gap has been noted in several analyses of the health system structure.<sup>1</sup>

Given that Afghanistan has been in a state of protracted and complex emergency over the past decade, it has at times been difficult to distinguish between humanitarian and development interventions. The country's governance and coordination mechanisms were designed to respond to both humanitarian and development needs in the health sector. While both streams of governance had distinct

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<sup>1</sup> WHO. [Afghanistan: Health system](#)

coordination, resource mobilization, and planning mechanisms, there were explicit attempts to foster a more integrated approach to support the national health system. Although there was no shortage of coordination bodies, committees, and mechanisms – including at provincial level – this did not always translate to coordinated action.

After 15 August 2021, many governance functions led by the health ministry ceased, thus interrupting policy dialogue, planning, and coordination with development partners. Many MoPH departments relied on donor project financing for salaries and operating costs, and the disruptions to this funding substantially reduced the functionality of parts of the ministry. However, this was not universally the case: many MoPH staff members continued to work after the transition, and the ministry managed to maintain regulatory functions.

Against this backdrop, international health sector partners have focused on supporting the provision of basic health services and humanitarian support to the population through the health and nutrition clusters and implementation of the Humanitarian Response Plan (HRP). At the same time, partners have sought to identify alternative options for channeling funds outside the national budget. For example, the UN system developed the Transitional Engagement Framework to fill critical gaps in the funding needed to sustain basic human needs through 2022. Considering the limited engagement with the DfA, a new aid delivery coordination mechanism – the “new aid architecture” – was put in place in July 2022. Under this umbrella, the health sector thematic working group (H-STWG) brings together bilateral and multilateral donors, international financial institutions, UN agencies, and civil society organizations to provide strategic and technical guidance to partners investing in the health sector and support operational coordination for effective implementation. This strategy supports the prioritization and alignment efforts of the H-STWG.

## **b. Package of services**

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Since Afghanistan embarked on its health system reforms, from 2002 onwards, the BPHS and EPHS have been the cornerstones of the health sector. The BPHS comprises seven elements: maternal and newborn care, child health and immunization, public nutrition, communicable disease treatment and control, mental health disability prevention and treatment, physical rehabilitation services, and regular supply of essential drugs. The EPHS, on the other hand, covers specialized services for gynecology; obstetrics; neonatal care; postpartum care and complications; nutrition; orthopedics; and surgical, respiratory, and gastrointestinal care. Further, the BPHS clearly identifies what services need to be available at each level of the primary health care system – health posts, mobile health teams, health sub centers, basic health centers, comprehensive health centers, and district hospitals – as well as the norms for staffing, equipment, diagnostic services, and medications required to provide adequate services at each level.

Although the BPHS was intended to be reviewed every 3–4 years, it has not been updated since 2010, despite epidemiological changes and an evolving disease burden in the country. It is further acknowledged that the BPHS and EPHS packages have missed opportunities to support emerging high-impact interventions, and that they have been under-implemented due to fiscal constraints.

In 2019, the MoPH and its partners developed the integrated package of essential health services (IPEHS) in order to streamline, integrate, and update the BPHS and EPHS. The IPEHS is comprised of nine health service areas: (i) reproductive, maternal, and newborn health; (ii) child and adolescent health and development; (iii) infectious diseases; (iv) chronic, non-communicable diseases; (v) mental, neurological, and substance abuse disorders; (vi) emergency care; (vii) surgery; (viii) palliative care; and (ix)

rehabilitation. Of the 133 interventions identified, 92 are essential interventions that will contribute to universal health coverage (UHC). However, this package has never been implemented. Consequently, partners have recommended that a review of the packages, building on the work already done for the IPEHS, be undertaken (see SD 1.1.1). In the meantime, selected high-impact interventions<sup>2</sup> are being implemented alongside the BPHS and EPHS.

### **c. Service delivery modalities/platforms**

Prior to 2002, health care services were provided by international organizations and national NGOs, with limited central coordination. After the Afghan Republic was established, the health ministry, with support from development partners, began formally contracting international and national NGOs to provide primary and secondary health services through the BPHS and the EPHS. Over time, the development partners harmonized their approaches. In 2015, Afghanistan introduced a national contracting model in 31 of its 34 provinces, using pooled resources through the Afghanistan Reconstruction Trust Fund (ARTF). In the remaining three provinces, BPHS and EPHS services were provided by dedicated MoPH departments, which were also financed by the ARTF. Tertiary care (regional and national specialty hospitals) was funded by the MoPH together with donors and technical agencies.

A substantial amount of “off-budget support” has been and is still provided through various donors, UN agencies, and NGOs and is used to finance a range of activities. These include MoPH institution-building activities, delivery of basic health services in “white areas”, humanitarian response, mental health and disability support, polio eradication, support to family health houses, health information, and others.

Other examples of off-budget support are contributions from Gavi and the Global Fund to Fight Aids, Tuberculosis and Malaria (the Global Fund).

Following the political transition in August 2021, most development financing, including for health, was paused, thus limiting the provision of basic services. Donors and other partners managed to avert a complete collapse of the BPHS/EPHS system by channeling emergency funding through UN agencies to allow continued contracting of NGOs<sup>3</sup>.

This approach was followed by the introduction of the Health Emergency Response (HER) project, funded by the ARTF along with the Global Financing Facility (GFF) through the World Bank. Additionally, the Asian Development Bank mobilized grant financing to support the health sector in close consultation with the World Bank. UNICEF, which is the implementing agency for these projects, will continue contracting NGOs to deliver BPHS and EPHS health services under this mechanism until December 2023.

Health services in Afghanistan are provided by approximately 4,238 health facilities, including sub-health centers (SHC), basic health centers (BHC and BHC+), comprehensive health centers (CHC and CHC+), district hospitals, provincial hospitals, regional hospitals, and specialized hospitals. The specialized hospitals are only partially operational due to financial constraints (see Figure 1 for details). In addition, Afghanistan has 300 mobile health teams and 450 health facilities that do not fit the aforementioned classification, as well as over 16,000 community health posts that provide primary health care at the community level. See Figure 2 for details on the overall health delivery modalities in the country.

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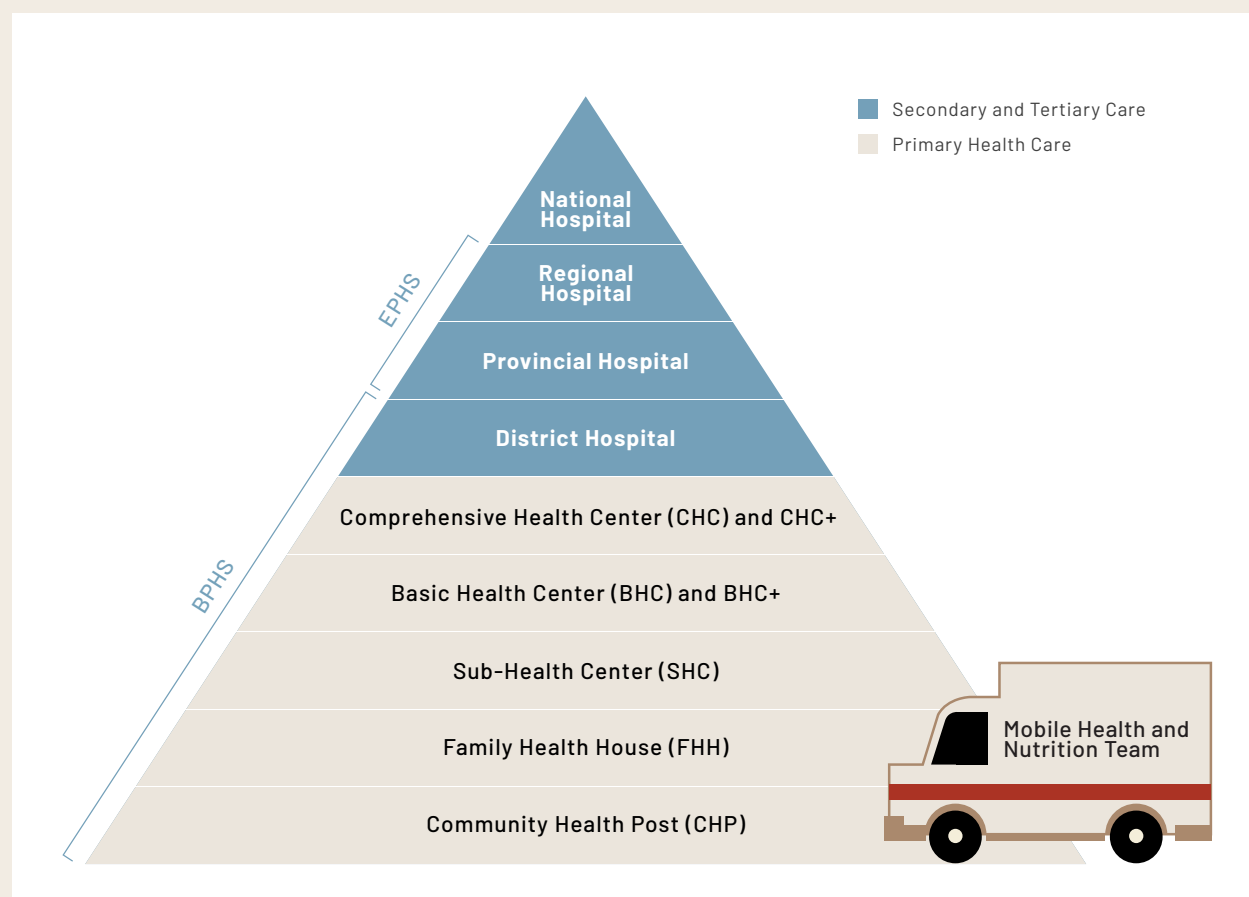
<sup>2</sup> These interventions include modern contraceptives such as sub-dermal implants and sub-cutaneous DMPA, as well as community-based use of chlorhexidine for umbilical-cord care and misoprostol for post-partum hemorrhage prevention.

<sup>3</sup> “This included mobilizing support from the Global Fund, the UN Central Emergency Response Fund (UN CERF), and a transfer-out from the Afghanistan Reconstruction Trust Fund (ARTF) to pay contract costs for service providers.”

**Figure 1. Number of health facilities by type and status (HeRAMS 2022 baseline, March 2022)**

	SH	NH	RH	PH	DH	CHC+	CHC	BHC+	BHC	SHC	MHT	FHH	FATP	Other	Total
Operational	1	3	4	15	56	35	232	16	588	725	111	42	7	10	1845
Partially Operational	12	0	8	4	29	22	127	2	233	358	50	20	0	16	881
Not Operational	1	0	0	0	0	0	0	0	2	0	1	2	0	0	6
Planned	0	0	0	0	0	0	0	0	1	20	17	0	4	0	42
Closed	0	0	0	0	0	0	0	0	0	1	0	2	0	0	3
Unknown	2	0	3	4	0	0	21	0	51	42	83	15	0	9	235
<b>Total</b>	<b>16</b>	<b>3</b>	<b>15</b>	<b>23</b>	<b>90</b>	<b>57</b>	<b>380</b>	<b>18</b>	<b>875</b>	<b>1146</b>	<b>262</b>	<b>81</b>	<b>11</b>	<b>35</b>	<b>3012</b>

**Figure 2. Structure of health service delivery platforms in Afghanistan**



Of Afghanistan's total population of 38 million, 25 million are thought to be covered by primary health services. The remaining 10 million live in so-called "white areas", with limited access to basic primary care.<sup>4</sup>

**Hospitals:** Afghanistan has a range of hospitals providing health services at different levels of complexity. Hospital placement is often related to the geopolitical division of the country or to the source of funding (see Table 1 for details). In this context, the EPHS was developed in 2005. Its purpose was to complement the BPHS by addressing the provision of secondary hospital care, primarily in district and provincial hospitals, and to assert federal stewardship over this type of care.

In Afghanistan, the lowest level of hospital complexity is the district hospital level. Progressively more comprehensive services are found in provincial hospitals, regional hospitals, and national specialty hospitals. The latter are all located in Kabul. The bulk of the district and provincial hospitals are supported by NGOs through the contracting-out mechanism, while regional and national specialty hospitals have traditionally been managed by the MoPH, funded through ordinary budget and off-budget contributions. Before the political upheaval in August 2021, there were also 59 public hospitals, mainly located in Kabul, which were supported by both the government and development partners.

A review of the efficiency of all public hospitals in the country found significant variation between them. The large Kabul tertiary-level health facilities were the least efficient, whereas the NGO-run secondary-level hospitals in the provinces were the most efficient. While much has been done at the primary and secondary health care levels to improve the efficiency and quality of services, such initiatives have largely been neglected at the tertiary level.

After August 2021, the continuity of health service delivery was disrupted at the hospital level, mainly in facilities managed by the MoPH. Hospitals that are part of the BPHS/EPHS contracting mechanism, however, continue to receive support from the international community through the HER project. Of the tertiary-level hospitals that were previously managed by the MoPH, 49 now receive support either through the International Committee of the Red Cross (ICRC) or WHO. Some facilities, however, have remained unsupported since 2021.

Additional challenges to maintaining hospital services include limited access to specialized services such as cancer diagnosis and treatment; bed shortages; lack of equipment; substandard physical infrastructure, including intensive care units and water, sanitation and hygiene (WASH) procedures; shortage of professional hospital managers; absence of a hospital accreditation program; insufficient quality and quantity of pharmaceuticals; substandard quality of care; lack of protocols; substandard referral systems; and low salaries, among others.

**Facility-based primary health care:** Primary health care (PHC) facilities comprise SHCs, BHCs and BHCs+, and CHCs and CHCs+. District hospitals also deliver some core PHC services and act as first-level referral sites for other PHC facilities. PHC facilities, as well as district hospitals, largely provide services in line with the BPHS, along with value-added services and interventions supported by vertical programs, as described above.

**Community-based services:** In light of Afghanistan's challenging geography, coupled with limitations on women's and girls' mobility, adequate availability of community-based services becomes particularly important. Community development councils and health shuras (community health committees) play important roles in mediating access to health and nutrition services and information, as well as in addressing localized environmental health issues.

<sup>4</sup> These are communities in which a health facility is not available within a one-hour walking distance.

In 2003, the Afghan government launched its Community-Based Health Care (CBHC) program as a foundational component of the BPHS. The aim of the program is to extend health services to the last mile through meaningful engagement with and enhanced participation of local communities. The CBHC program is an integral component of Afghanistan's broader PHC system as articulated in various national policies/frameworks, including the NHP and the NHS; the National Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Strategy; the National Gender Strategy; and the National Community Health Strategy. In 2019, the country launched its Community Health Roadmap, which is a key framework for implementing PHC at the community level.

In another effort to advance community health, Afghanistan has trained and supported 29,600 community health workers with support from a variety of health programs. Although implementation so far has been fragmented and uneven, the aim is to reach up to 33,000 community health workers by 2025.<sup>5</sup> Additionally, 300 mobile health teams and approximately 2,000 nutrition counselors have been deployed to bring services closer to communities that lack access to fixed sites. Currently, the CBHC program is implemented through the BPHS, and its delivery and implementation are contracted out to national and international NGOs under the same contracts as the BPHS and EPHS service delivery.

**Family health houses:** In 2009, the United Nations Population Fund (UNFPA), in collaboration with Afghanistan's health ministry, introduced the family health house (FHH) model. A community-based health facility, the FHH aims to increase access to basic reproductive, maternal, neonatal, and child health (RMNCH) services in under-served areas and to bridge the gap between a health post and a health sub-center facility. FHHs are established in areas which lie a minimum of 10 km from the nearest BPHS facility

and cover a population of 1,500–3,000 people. They offer free, round-the-clock services before, during, and after pregnancy, including provision of basic yet essential care for children under five years, as well as family planning information and tools. Furthermore, the FHH, which is staffed by a community midwife trained in the community midwifery education program, serves as a timely referral system to BPHS facilities. By 2020, 191 FHHs had been established in eight of Afghanistan's provinces, with a further 115 planned in five provinces. The FHHs are externally funded by UNFPA and receive additional support from a range of bilateral donors.

**Mobile health and nutrition teams:** As part of the effort to reach geographically isolated, remote, and otherwise vulnerable populations, BPHS providers support around 21 mobile teams offering routine health and nutrition services (MHNTs). An MHNT provides PHC services based on geographic disparities and needs for a population of 1,000–7,000 people. MHNTs are comprised of one male and one female doctor or nurse, one trained midwife, one vaccinator (preferably female), one nutrition counsellor (female), one psychosocial counsellor, and one driver. They provide the following core services: (i) maternal care (antenatal and prenatal care, including referrals); (ii) basic newborn care (newborn resuscitation, thermal care, eye and cord care, initiation of early breastfeeding, and newborn immunization/birth doses); (iii) Expanded Programme on Immunization (EPI) services; (iv) case management of acute respiratory infections, diarrhea, and measles, as well as referral of complicated cases, and TB case finding and referral; (v) nutrition (iron/folic acid supplementation for pregnant and lactating women; maternal, infant, and young child nutritional counseling; and screening and referral of acute malnutrition); and (vi) basic trauma care.

**Table 1. Overview of hospitals in Afghanistan <sup>a, b</sup>**

CATEGORY	NUMBER	NO. OF BEDS	MANAGEMENT & FUNDING MECHANISM
National specialty hospitals (NSHs) - all in Kabul	28	3,400	Mostly MoPH (ordinary budget)
Regional hospitals (RHs)	9	4,640	
Provincial hospitals (PHs)	27	3,620	Either MoPH or Sehatmandi/HER
District hospitals (DHs)	88	3,587	Mostly Sehatmandi/HER (international organizations)
<b>TOTAL</b>	<b>152</b>	<b>15,247</b>	

<sup>a</sup> Sources: WHO 2019, MoPH.

<sup>b</sup> Sources: There are various sources on the quantity of health care facilities and hospitals in Afghanistan. For this reason, some figures in this table differ from those in Figure 1.

**Private sector:** The private health care sector in Afghanistan has grown steadily during the last two decades. As of the end of 2022, 205 private hospitals and 164 private outpatient clinics were operating in the capital. In addition, the private sector serves a large proportion of the population in the five provinces that are home to major urban areas (Kabul, Herat, Mazar, Kandahar, and Nangarhar). As an example, almost half of the users of modern family planning methods receive these services or commodities from the private sector, such as private hospitals, clinics, pharmacies, and shops. Also, social marketing organizations, which tend to offer a limited selection of products and focus heavily on urban areas, provide some health commodities in the country such as contraceptives, water treatment products, and oral rehydration salts. Further, many Afghans seek private health care abroad, although data on the scope and scale of this are not currently available.

The rapid growth of the private health care sector and the lack of regulation by the authorities has meant that services are often of substandard quality. The MoPH has taken steps to address this issue by improving the regulation of the private health sector. The Private Health Centers Regulation Act, adopted in 2012, provided procedural details on licensing, fee payment, and accountability. Five years later, the MoPH ratified minimum required standards for private sector service providers, including guidelines on human resources, physical characteristics of facilities, minimal services to be provided, equipment, hygiene, and so forth. The National Health Care Accreditation Organization was formed in 2018 to strengthen the quality of both public and private health care provider organizations. Similarly, the mandatory Afghanistan Medical Council, which licenses examinations for doctors employed by public and private health providers and NGOs, has improved the regulation of human resources for health. Few private service providers, however, have proved that they can deliver high-standard health care.<sup>6</sup>

<sup>6</sup> Private Sector Assessment Report, 2018.

#### **d. Human resources for health**

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Afghanistan has one of the lowest health workforce densities in the region, as well as globally. In 2019, Afghanistan counted 2.54 physicians and 4.46 nurses and midwives per 10,000 population,<sup>7</sup> far below the minimum threshold of 44.5 doctors, nurses, and midwives per 10,000 inhabitants that is required to advance UHC. The health workforce is composed of 27 percent physicians, 28 percent nurses, 3 percent pharmacists, and 2 percent dentists and midwives, respectively. Technicians and other cadres constituted the remaining 40 percent. There are substantial imbalances in workforce density across various divides, such as gender, urban/rural, geography, and health workers cadre. At the primary care level, staffing levels as per the prescribed BPHS standards are reasonably good, except for doctors. However, the effects of the recent attrition of health workers, particularly health system advisors and managers, through emigration and internal displacement, are reportedly substantial but not well quantified. At the same time, there are reports of qualified health workers who cannot be absorbed by the health sector and are therefore not employed. This problem particularly applies to female health care staff, especially midwives. While female health workers are officially allowed to work, there are reports of barriers to attendance. Female health workers must be accompanied by a mahram, particularly if they are staying overnight to work night duty in the health facility. In many places, female and male health workers cannot work in the same areas; thus additional space is required for both care provision and breaks. Furthermore, some local authorities require a female health care provider to treat female patients. All of these requirements have infrastructure and budgetary implications that many health facilities cannot meet, and which may hinder female work attendance.

Beyond the lack of health workers, there are concerns related to the professional quality of the current workforce. Health staff in the country have received their degrees from institutes of varying quality standards with limited government regulation, while in-service training and opportunities for continuing professional education have often been scarce. In response to this challenge, the MoPH of the previous administration launched a series of initiatives to improve the quality of health care staff in both the public and private sectors, which are expected to continue going forward.

Over the years, the government has tried a number of approaches to strengthen health workforce information, for example by establishing various health workforce databases. However, most of these were linked to donor-funded projects and were not sustained when the projects ended. In 2018, a human resources management information system (HRMIS) was initiated, although it has yet to be scaled up nationally.

#### **e. Supply chain**

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Despite achievements made in medicine regulation in the past few years, with support from the newly established Afghanistan Food and Drug Authority (AFDA), both the regulation and supply of medicines and health technologies present persistent challenges. Historically, BHPS and EPHS service providers sourced most of the health supplies they needed from private distributors locally and internationally. These products were then supplemented by off-budget procurement for a sub-set of products that had special sourcing requirements, such as vaccines and TB medicines. A hybrid supply model that will support service providers with more centrally pooled procurement of pharmaceuticals is currently being implemented. This includes central sourcing of general and reproductive health medicines (including contraceptives) by UNICEF, UNFPA, and the Global Fund.



Pharmaceutical supply chain management in Afghanistan suffers from pervasive inefficiency at different levels. Frontline health workers are not trained in good quantification, procurement, storage, distribution, or dispensing practice. In the absence of a uniform logistics management information system, the majority of service providers procure medical products based on often inaccurate demand estimates, leading to poor stock management in the field.

Additional supply challenges, including a shortage of medicines from international suppliers in the market, high transportation costs for medicines and medical products, financing and banking challenges, and weak regulation that leads to importation of illegal pharmaceuticals, continue to hamper appropriate utilization of and access to essential medicines and health technologies.

#### **f. Data and health information**

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For many years, Afghanistan has had a relatively well developed and robust health management information system (HMIS). Data are primarily generated by health care workers at the community and health-facility levels. The system is paper based up to the province level, where it becomes digitized through the district health information system (DHIS2). Furthermore, various systems map health facilities and their functionality, such as the health resources and services availability monitoring system (HeRAMS). The latter plays an important role in monitoring progress in access to services and in managing the health system network.

There is some fragmentation of related information systems, as well as opportunities for better integration. In addition to the HMIS, the MoPH operates a nutrition information system that is used to identify and treat moderate and severe acute malnutrition. The data collection, processing, analysis, and dissemination functions in this system are all similar to those of the HMIS.

The MoPH also manages the National Disease Surveillance and Response (NDSR) system, which monitors 17 prioritized communicable diseases on a weekly basis. UNICEF and WHO are currently setting up a nutrition surveillance system in five provinces, which will expand over time to cover all provinces. Notably, the private sector is not fully included in any of these three systems.

Afghanistan has made use of household surveys to understand demographic changes and shifts in coverage rates for essential interventions, and to monitor health outcomes. The most recent surveys include the demographic and health survey (DHS), which was last conducted in 2016, and the AHS, which has been conducted more frequently (2012, 2015, and 2018). Afghanistan has also made use of standardized monitoring and assessment of relief and transitions (SMART) surveys at subnational level – most recently to better understand the burden of under-nutrition.

#### **g. Emergency response**

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Afghanistan faces a wide range of threats, including natural disasters (such as droughts, earthquakes, and floods), food insecurity, various disease outbreaks, internal displacement, and continuing polio cases – all compounded by socioeconomic and political instability. While armed conflict has significantly decreased since August 2021, with resulting declines in the burden of disease caused by violence, there remains a risk that this could increase again in the future. According to the 2022 HRP, more than 50 percent of the Afghan population need humanitarian assistance. Data from the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) show that natural disasters killed more than 580 people and affected some 225,000 people in 2022.

Food insecurity is another threat that has increased substantially in recent years. All 34 provinces have an integrated food security phase

classification of 3 or above (out of 5), combined with high to very high levels (above 10 percent) of global acute malnutrition. Various disease outbreaks also continue to plague the country, including COVID-19, measles, and acute watery diarrhea (AWD), along with cases of malaria and hemorrhagic fever, and cyclical peaks of acute respiratory infections – the latter mainly in under-five children. Although global wild poliovirus cases are at historically low levels (four cases in 2021), Afghanistan is one of just two countries in the world where the wild poliovirus remains endemic.

Afghanistan’s response to disease outbreaks and other health emergencies encompasses a series of information systems, such as the NDSR, and dedicated teams that are in charge of surveillance, response, and mobile services. The operations of Afghanistan’s polio surveillance system, which includes environmental surveillance, have continued uninterrupted throughout the change of government. Field surveillance teams from the NDSR program visit alert areas and investigate outbreaks and health emergencies with support from WHO’s rapid response teams. Afghanistan also recently restructured its Emergency Operations Centre for Polio Eradication to improve its performance. All of these activities are supported by mobile health and nutrition teams, which provide essential health and nutrition services in hard-to-reach areas.

Despite the presence of these mechanisms, some notable challenges to effective emergency response include: concurrent public health crises that strain response capacities; patient overcrowding in health facilities during outbreaks; lack of capacity of the NDSR; exclusion of the private sector from the health information system, the nutrition information system, and the NDSR; persistent security threats against frontline workers; and fragmentation of various emergency response plans for particular conditions and situations, such as the WASH

cluster, the AWD/cholera preparedness and response plan, the Inter-Cluster Coordination Team (ICCT) flood contingency plan, the ICCT winterization plan, and the polio response, to name a few.

### **i. Health system governance and frameworks**

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The overall role of the MoPH in the past, as well as its expected current function, is one of stewardship. This involves fostering access to and ensuring the quality of health services in the country by, for example, determining the content of health service packages; defining and implementing a human resource strategy; ensuring the implementation of and compliance with health policies and standards; managing and financially supporting tertiary health care facilities; and, together with partners, advancing coordination between the health and nutrition humanitarian response, on the one hand, and a long-term health system strengthening objective, on the other (the humanitarian-development nexus). However, it is necessary to consider the limited fiscal space of the government and partners, as well as their capacity in terms of both human resources and the health system, to ensure continued access to services and manage reforms.

### **j. Health financing**

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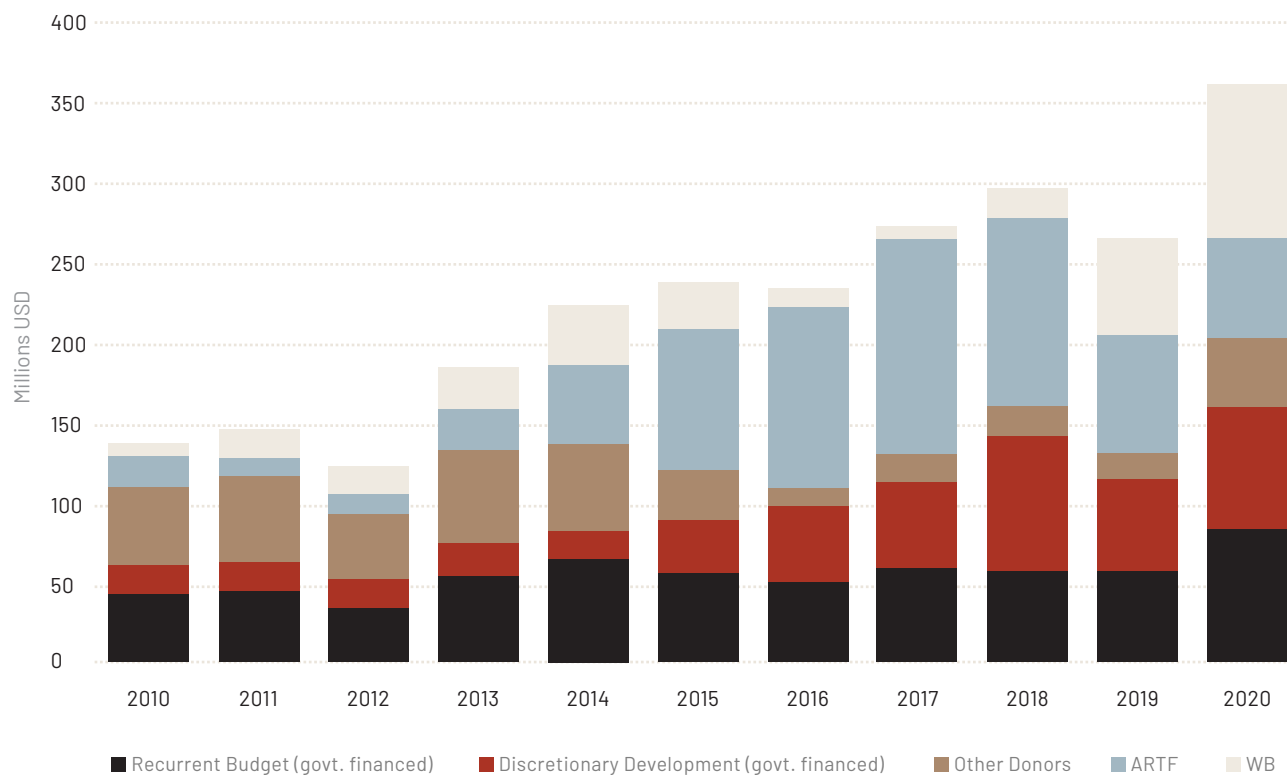
Current health expenditure (CHE) in Afghanistan has risen steadily since 2001, with most of the growth coming from out-of-pocket (OOP) spending. According to Afghanistan’s 2019 National Health Accounts (NHA) report, OOP expenditures account for 77 percent of the total health expenditure (THE), indicating a substantial financial burden on households seeking medical services. The share and level of per capita OOP in Afghanistan are significantly higher than in other South Asian and lower-income countries.

High OOP spending is attributable to various factors, including a lack of drugs in public health care facilities, where they should be freely available; demand for private services due to perceived better quality and availability of laboratory equipment and doctors; and limited scope of the BPHS/EPHS. The latter means that patients with illnesses that are not covered by the BPHS or the EPHS are forced to seek medical attention in the private sector.

As the largest component of OOP expenditures, pharmaceuticals represent the main cost barrier to Afghans' use of the EPHS. Almost 41.8 percent of OOP expenditures in public hospitals are attributed to pharmaceuticals.<sup>8</sup> Consequently, an increase in drug availability and efficient use of drugs in public hospitals have the potential to significantly reduce OOP expenditures.

Another characteristic of Afghanistan's health financing system is its high dependency on donor funds, which account for 19.6 percent of THE. Between 2014 and 2020, the share of donor-funded on-budget financing for health increased significantly through the SEHAT and Sehatmandi projects (see Figure 3). Collectively, OOP and external funding account for 97 percent of THE, while government contributions represent just 3 percent. Until August 2021, the latter covered routine expenses such as civil servant salaries and operational costs for central and provincial directorates and MoPH-managed facilities, mainly national and tertiary hospitals.

**Figure 3. On-budget health spending by source**



<sup>8</sup> Ministry of Public Health, Afghanistan, 2019.



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After August 2021, the MoPH continued to pay the salaries of civil servants working at the central ministry and provincial directorates. However, it stopped supporting national hospitals. Part of this gap was instead covered by the ICRC, WHO, and other organizations which stepped in to pay for salaries, routine hospital management, and drug costs for 49 national and specialized hospitals, as well as for some regional and provincial hospitals. At the same time, dozens of projects provide funding for individual facilities, programs, and services, allocated and executed through off-budget mechanisms.

The scope for generating more government funding through economic growth appears limited given the multifaceted crises that the Afghan economy is facing. Although the de facto government is exploring avenues to collect more domestic revenue, the outlook remains shallow due to the financial sector collapse and the fiscal and real economic shocks. A sin tax and reprioritization of the government budget could potentially be used to boost the government's contribution to health.

If current levels of financing for the health sector cannot be increased, they must at least be maintained. However, an initial resource mapping analysis indicates the risk of a diminished health budget (mainly due to reduced government contributions), along with a continued high or even increased OOP share of the THE. Since no significant progress has been made over the last two decades to shift OOP spending toward prepayment or taxation mechanisms to increase public funding, it is highly unlikely that this can be addressed in the current context. Considering Afghanistan's limited ability to generate additional domestic revenues, it is imperative for external financing to stay at the current level or be expanded. It is also necessary to increase the national budget allocation to the health sector in order to maintain primary and essential health service delivery.

#### **k. Summary of challenges and risks**

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Afghanistan faces enormous challenges in ensuring the provision of widespread, high-quality, and equitable health care, as well as other social services. Each of the previous sections has highlighted various barriers that hinder access to and utilization of health care, which are summarized below.

#### **GOVERNANCE, COORDINATION AND FINANCING**

- The relationship with the MoPH is limited, and partner approaches to engaging with the MoPH differ.
- There is a need for better understanding of the role that the DfA's MoPH will play, particularly with regard to its financial responsibilities vis-à-vis the support provided by humanitarian and development partners.
- Fiscal space is limited among all stakeholders.

- There is overall socioeconomic instability in the country.
- Despite significant partner coordination at the national level, coordination structures at the subnational (provincial) level are weak, while structures at the district level are non-existent.
- Data collection systems are fragmented, and there is a lack of capacity to analyze and use data at management and implementation levels for evidence-informed service delivery planning.

### SERVICE COVERAGE AND ACCESS

- There is a need to expand the coverage of health services in “white areas”, as well as for other vulnerable populations such as internally displaced persons, rural communities, and the urban poor.
- Human resources are inadequate, particularly with regard to female health care workers, in light of recent restrictions mandating that female patients can only be seen by female staff.
- Supply chain mechanisms are substandard.
- Quality of care is hampered by shortfalls in human resources, infrastructure, medicines, protocols and guidelines, and quality assurance mechanisms.
- There is weak regulation of and coordination with the private sector.
- There are financial barriers for patients and high levels of out-of-pocket expenditure.
- The future provision of specialized and tertiary services in hospitals is uncertain.
- It is necessary to expand the scope of

health services outside the current health packages to meet unmet needs in areas such as non-communicable diseases (NCDs) and injuries.

- Difficult terrain and insecurity hinder physical access to fixed service delivery sites, requiring improved transportation to facility-based healthcare services and/or expansion of services closer to hard-to-reach communities.
- There are gaps in the continuity of care and weak referrals pathways from the community level to facility-based primary, secondary, and tertiary care.
- The ban on female education, especially in the medical field, will result in insufficient female staff at health facilities and thus higher levels of maternal mortality.

## 2. BURDEN OF DISEASE AND DETERMINANTS OF HEALTH

### a. Health status: mortality and morbidity

Core health metrics such as maternal, newborn, and child mortality have shown steady improvements during the 2000–2020 period. Table 2 summarizes key epidemiological and health-related indicators for the country. Thanks to this progress, life expectancy at birth reached 64.8 years in 2020, up from 56 years in 2000. While these figures are in line with the average life expectancy in other low-income countries (64 years), they are lower than the average life expectancy in the South Asia region, which is 70 years.

**Table 2. Summary of key health indicators for Afghanistan (latest available data or estimate)**

HEALTH AREA	EPIDEMIOLOGICAL INDICATORS	YEAR	VALUE	SOURCE <sup>a</sup>	SERVICE-RELATED INDICATORS	YEAR	VALUE	SOURCE
<b>Reproductive, maternal, and newborn health</b>	Maternal mortality ratio	2000	1,450 x 100,000 LB	1	Women of reproductive age using modern contraceptive methods	2018	17%	2
		2017	638 x 100,000 LB	1	Pregnant women who had at least one ANC visit	2018	65%	2
	Newborn mortality rate	2000	61 x 1,000 LB	3	Pregnant women who had four or more ANC visits	2018	21%	2
		2020	35 x 1,000 LB	3	Skilled birth attendance (mostly midwives)	2018	59%	2
	Stillbirth rate	2000	36.9 x 1,000 TtB	8	Postnatal care (mothers in MoPH hospitals)	2018	44%	2
		2019	28.4 x 1,000 TtB	8	Mothers receiving two doses of TT during last pregnancy	2018	19%	2
	Total fertility rate per woman	2018	5.1 children	2	Mothers fully immunized against tetanus during last pregnancy	2018	40%	2
<b>Child health</b>	Under-five mortality rate	2000	129 x 1,000 LB	3	Children aged 12–23 months who were fully immunized	2018	50%	2
		2020	58 x 1,000 LB	3	U5C with diarrhea who were brought to see a provider	2018	60%	2
	Prevalence of diarrhea in U5C	2018	18%	2	U5C with diarrhea who received oral rehydration salts	2018	50%	2
	Prevalence of ARI in U5C	2018	11%	2	U5C with ARI who were brought to a recognized health provider	2018	68%	2
	Prevalence of febrile syndrome	2018	23%	2	U5C with ARI who received antibiotics	2018	61%	2
					Children immunized against measles	2018	64%	2
					Children immunized with DTP/penta (3)	2018	61%	2
					Children immunized with OPV (3)	2018	71%	2
<b>Adolescent health</b>	Girls 15–19 pregnant • Urban • Rural	2015	• 8% • 12%	12				
	Adolescent girls with anemia	2015	30%	12				

HEALTH AREA	EPIDEMIOLOGICAL INDICATORS	YEAR	VALUE	SOURCE <sup>a</sup>	SERVICE-RELATED INDICATORS	YEAR	VALUE	SOURCE
Nutrition	U5C suffering acute malnutrition	2021	~50% (3.2 million)	4	U5C with SAM accessing treatment (one-year period)	2021-2022	65% (650,000)	5
	U5C with SAM	2021	~17% (1 million)	4	Women receiving iron supplementation during pregnancy	2018	47%	2
	U5C with moderate stunting (<2 SD)	2018	37%	2	Postpartum women receiving vitamin A	2018	71%	2
	U5C with severe stunting (<3 SD)	2018	17%	2				
	Anemia in women of reproductive age	2015	40%	12				
Infectious diseases and outbreaks	AWD/cholera cases	2022 Sept.	184,975 cases	5				
	Measles cases	2022 Sept.	69,535 cases	5				
	COVID-19 cases	2022 cml.	199,463 cases	5				
	Malaria cases	2021 yrly.	253,000	10				
	Tuberculosis cases	2021	76,000	10				
	People living with HIV	2021	11,000	10				
	Wild polio cases	2021	4	11				
Other health performance indicators					Doctors per 10,000 pp.	2020	2.54	7
					Nurses and midwives per 10,000 pp.	2018	4.46	7
					Hospital beds x 1,000 pp.	2017	0.4	9
Other health performance indicators	See Figures 4 and 5							

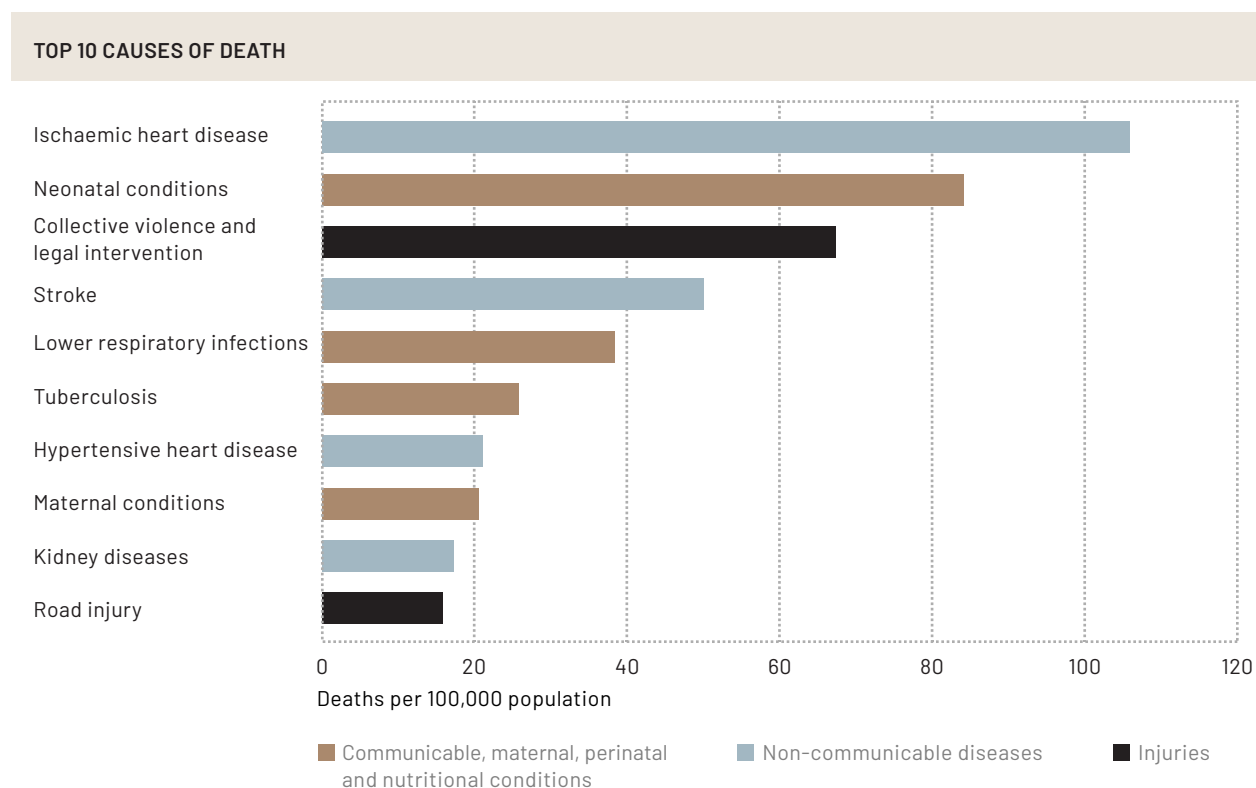
<sup>a</sup> 1) Trends in maternal mortality, 2000-2017. WHO, UNICEF, UNFPA, World Bank, and UNDP, 2019. 2) Afghanistan Health Survey 2018. Royal Tropical Institute and Ministry of Public Health Afghanistan, 2019. 3) UN Inter-agency Group for Child Mortality Estimation 2021. UNICEF, WHO, World Bank, UN, 2021. 4) Half of Afghanistan's children under five expected to suffer from acute malnutrition as hunger takes root for millions. UNICEF, October 2021. 5) Internal data from UNICEF Nutrition. 6) Outbreak Situation Report # 60, Epidemiological week 39. Afghanistan. UNICEF. 7) Global Health workforce Statistic database. WHO. 8) A neglected tragedy - The global burden of stillbirths. UNICEF, WHO, World Bank, UN, 2020. 9) Hospital beds. World Bank. 10) Global Fund internal data. 11) WHO surveillance. 12) DHS Afghanistan, 2015.

ANC: antenatal care; ARI: acute respiratory infection; AWD: acute watery diarrhea; cml: cumulative; DTP/penta 3: diphtheria, tetanus, pertussis, hepatitis B and Haemophilus influenzae type b vaccine, 3rd dose; LB: live births; No: number; OPV3: oral polio vaccine, 3rd dose; Pl: people; SAM: severe acute malnutrition; SD: standard deviations; TT: tetanus toxoid vaccine; Sept.: up to September 2022; TtB: total births; U5C: under-five children.

For some health conditions, such as NCDs and injuries, recent, nationally representative information is not available. Other service areas have been identified as problems by key informants even though there is limited availability of quantitative data. For example, Afghanistan's many years of conflict have resulted in a substantial burden of mental health issues, with high rates of post-traumatic stress disorders, depression, and anxiety, but up-to-date data on the extent of this issue are not available. Additionally, Afghanistan suffers from a drug-use problem of epidemic proportions. A nationally representative drug-use survey carried out in 2015 found that 11 percent of the population tested positive for one or more illegal drugs.<sup>9</sup>

Twenty years ago, Afghanistan's disease burden was dominated by communicable diseases and high numbers of maternal and child deaths and illnesses. This pattern has since evolved into a triple disease burden. According to the latest disease burden assessment, conducted by WHO in 2019, the main drivers of mortality are currently NCDs (particularly ischemic heart disease, stroke, hypertension, and kidney diseases); communicable and maternal conditions, such as newborn complications, respiratory infections, and tuberculosis; and injuries, including violence and road injuries (see Figure 4 for details). Alarming, malnutrition contributes to up to half of all morbidity and mortality in the country.

**Figure 4. Top-10 causes of death in Afghanistan for both sexes, all ages – 2019<sup>10</sup>**



<sup>9</sup> Colombo Plan/SGI Global. *Afghanistan National Drug Use Survey, 2015*.

<sup>10</sup> WHO. *The Global Health Observatory: Afghanistan, Mortality*. The analysis is based on the *Global Burden of Disease* developed by the IHME, community and facility-based surveys (such as DHS), information from UN partners, and HMIS/vital registration data.



## b. Health determinants and risks

Beyond the conditions identified above, it is estimated that more than 50 percent of Afghanistan's disease burden is influenced by factors that lie beyond the scope of health care, that is, by the social determinants of health and environmental conditions, such as food security, education, employment and income, safety nets, housing, access to clean water, and air quality.<sup>11,12</sup> Thus, it is fundamental for the health sector not only to strengthen activities directly related to the provision of health services, but also to develop and/or maintain a coordinated approach with other sectors. This approach will allow the sector and partners to advance policies and actions aiming to address the most pressing social needs that affect the health and wellbeing of Afghans (see section on cross-sectoral efforts).

According to the latest assessment, conducted in 2019, the Afghan population faces a triple nutritional burden, where malnutrition and micronutrient deficiencies coexist with overweight and obesity. The full scope of the nutritional burden, however, may need to be reassessed given widespread poverty and food insecurity following the 2021 political transition. Furthermore, NCD-related risk factors such as high blood pressure, hypercholesterolemia, tobacco consumption, and poor dietary habits constitute significant causes of disease in Afghanistan (see Figure 5). Although overall security has markedly improved since the political transition, there is still a risk of increasing violence from the Afghan branch of the Islamic State Khorasan and other groups. Additionally, unexploded land mines found in many parts of the country pose an ongoing threat to many communities.



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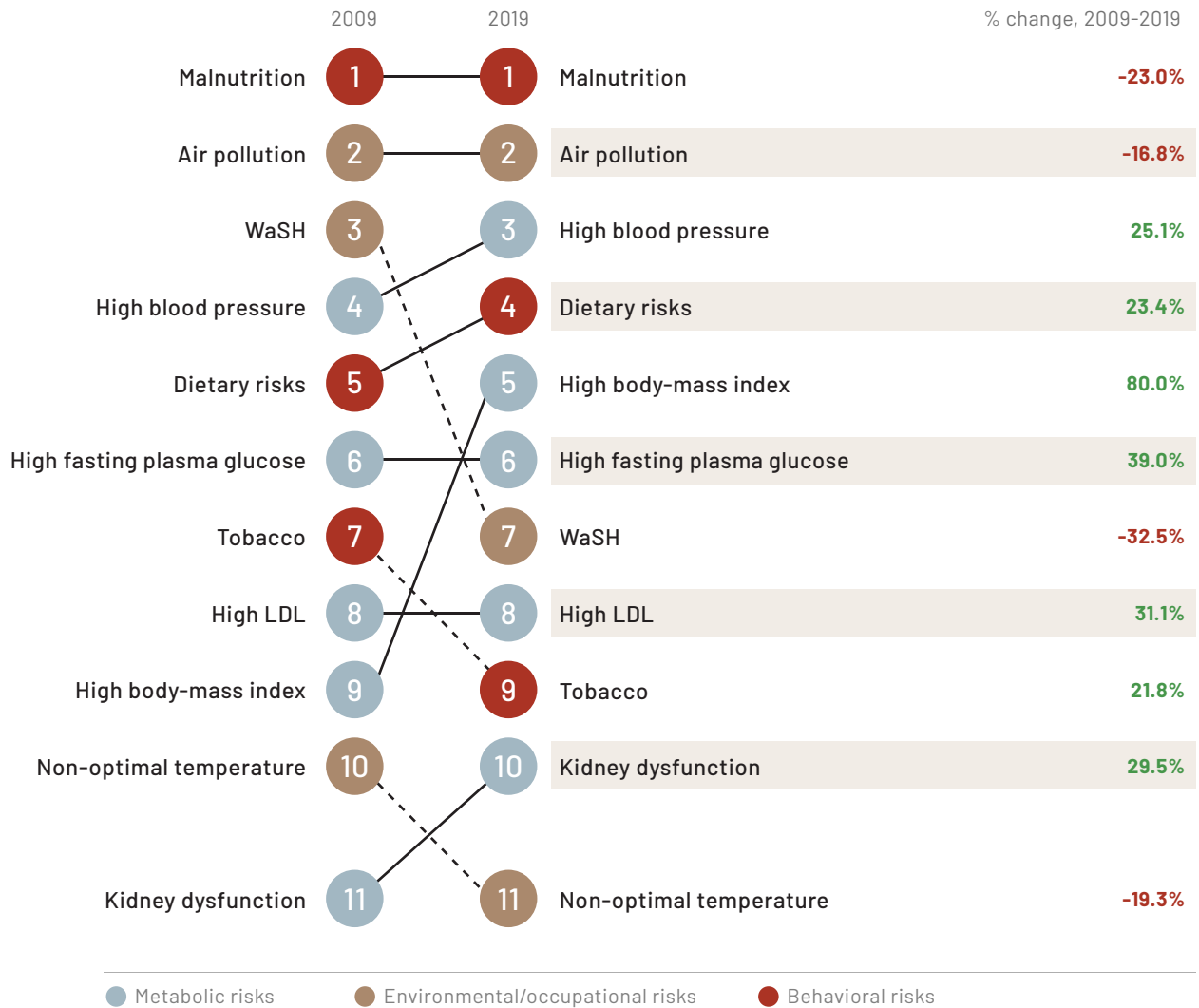
Afghanistan is prone to frequently occurring natural disasters, which often lead to substantive internal displacement and emergencies, and, in turn, trauma, disease outbreaks, food insecurity, and disruption to health services. Droughts, floods, avalanches, landslides, inadequate housing, and air pollution account for an estimated 26 percent of the total annual deaths in Afghanistan.<sup>13</sup> Finally, the growing economic hardship and high unemployment rate are all-pervasive negative health determinants, which have a direct bearing on food insecurity and financial barriers to accessing health care.

<sup>11</sup> WHO. [Social Determinants of Health](#). Accessed on November 10, 2022.

<sup>12</sup> Pruss-Ustun A., et al. "Diseases due to unhealthy environments: an updated estimate of the global burden of disease attributable to environmental determinants of health." *Journal of Public Health*, 2017

<sup>13</sup> International Federation of Red Cross and Red Cross Societies. [Afghanistan: Drought and Flash Floods Emergency Appeal n° MDRAF005](#), March 2019.

**Figure 5. Main health risk factors causing mortality and disability in Afghanistan: 2009 & 2019<sup>a, 14</sup>**



<sup>a</sup> These risk factors were calculated for the year 2019, before Afghanistan's political transition and subsequent changes to the socioeconomic context, including widespread food insecurity.

### **c. Health status of the Afghan population: thematic areas**

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#### **I. MATERNAL AND REPRODUCTIVE HEALTH**

The lifetime risk of maternal mortality in Afghanistan is significantly higher than the global average: 1 in 33 compared with 1 in 190. In 2019, pregnancy complications and related procedures were responsible for 64.2 percent of deaths among girls and women aged 15–19 and 69.9 percent among those aged 20–24. Access to sexual and reproductive health services is becoming increasingly difficult due to movement restrictions on women outside their homes, compounding risks to their health and wellbeing.

Urgent efforts are needed to address preventable causes of death among women. Immediate results are expected from tackling obstetric hemorrhage and infections, which are among the main drivers of maternal mortality. Addressing pre-existing conditions that are exacerbated by pregnancy, such as hypertensive disorders and maternal anemia, providing key services such as institutional skilled birth attendance, and increasing the use of modern contraceptive methods, will further reduce maternal mortality. Finally, improving the quality and regularity of maternal and neonatal death audits, which have traditionally been poorly performed in Afghanistan, could contribute to a better understanding of the causes behind these deaths.

The average modern contraceptive prevalence rate (mCPR) among all married women in Afghanistan is 17.4 percent. Following a modest increase in the mCPR between 2003 and 2010/11, the rate has stagnated over the past decade.<sup>15</sup> Data from the 2018 AHS suggest that the mCPR among rural residents, which reached 14.5

percent in 2018, has stagnated. The use of contraceptive methods is generally low among women below the age of 20 (10.5 percent). Afghanistan still has one of the highest rates of unmet need for family planning (25.7 percent) in the world. This issue is more notable in higher age groups, such as among women above age 40 (78.9 percent) who do not want to become pregnant, and among women in urban areas, who more often have the desire to delay or limit pregnancies (32 percent) than women in rural areas (22 percent). There is also a high discontinuation rate, with 26 percent of family planning users in Afghanistan discontinuing within 12 months of starting to use a new contraception method. Nearly 80 percent of women reported that their husbands determined their family planning use. Furthermore, close to 60 percent of contraceptive users feared side effects or bodily harm from using pills or injectables, and almost half of the women (48 percent) did not believe that family planning was necessary for birth spacing.

#### **II. NEWBORN HEALTH OUTCOMES**

Approximately 44.1 percent of all neonatal deaths in Afghanistan are due to preterm birth complications, followed by sepsis/meningitis and pneumonia (35.2 percent and 9.4 percent, respectively).<sup>16</sup>

Newborn services are provided across all levels of care in Afghanistan, from primary health care at the community level to specialized care provided by referral health facilities. However, there are critical gaps in the availability and provision of routine and essential newborn care, such as thermal protection, breastfeeding, umbilical cord management, and newborn resuscitation. For example, observations on the latter in Afghan health facilities in 2016 found serious

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<sup>15</sup> The most recent mCPR estimate is from the 2018 AHS.

<sup>16</sup> Royal Tropical Institute and Ministry of Public Health Afghanistan. *Afghanistan Health Survey 2018, 2019*.

skills gaps, with many instances of omitted or incorrectly performed steps that are essential for successful resuscitation of newborns. These challenges make the case for low-cost, high-impact interventions such as improved neonatal resuscitation and Kangaroo mother care, as well as for key strategies like skilled-birth attendance, which could lead to large gains in newborn survival.

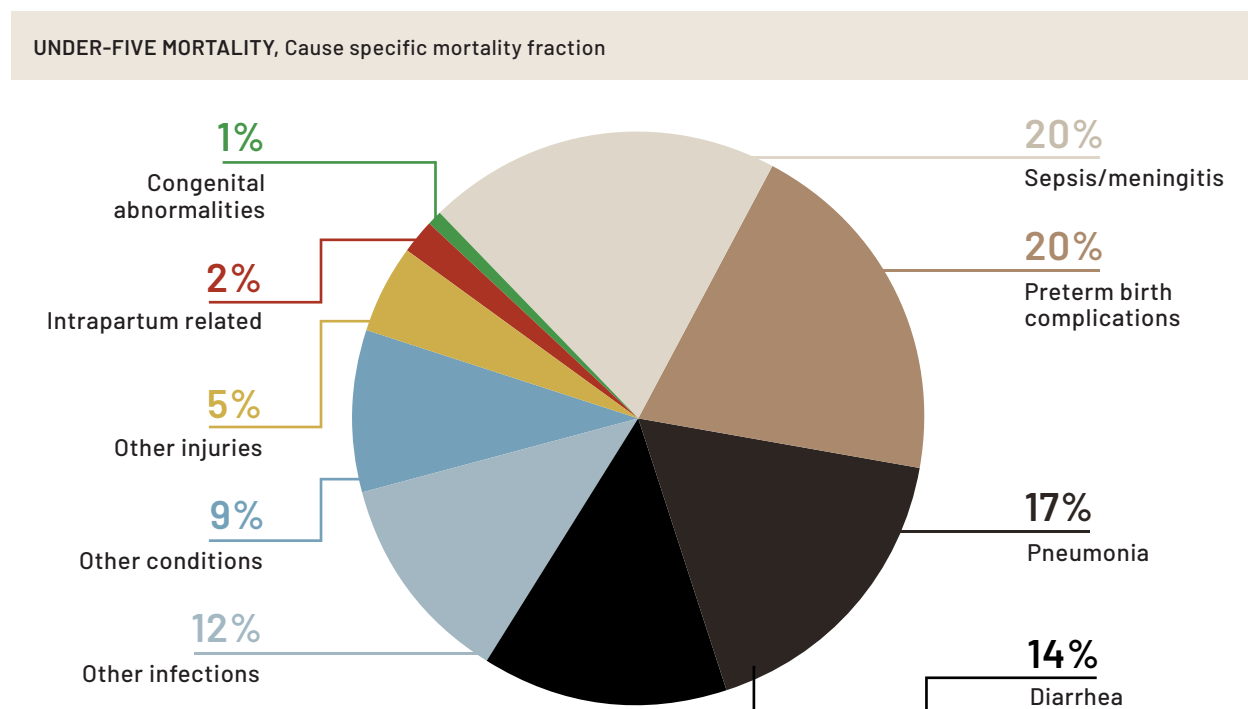
### III. CHILDREN UNDER FIVE

Although the number of under-five deaths in Afghanistan has declined over the past 20 years, the mortality rate remains high at 35 deaths per 1,000 live births. The main killers of children

under five are sepsis/ meningitis, newborn-related conditions, and pneumonia (see Figure 6). Malnutrition is estimated to be an underlying factor in up to half of all child mortality in Afghanistan.

The data on prevalence and treatment of diarrhea and acute respiratory infection (ARI) indicate that while many children are obtaining either partial or much of the correct treatment for diarrhea and ARI in health clinics and at home, there is still room for improvement in both facility- and home-based care (see Table 2).

**Figure 6.** Causes of under-five mortality, AHS 2018



#### IV. ADOLESCENT HEALTH

Afghan adolescents face a multitude of risks and health problems, including mental health issues, poor nutrition, sexual and reproductive health issues, maternal death due to teenage pregnancy, high rates of injury from violence and road traffic accidents, drowning, and drug use.

In 2015, approximately 17 percent of women aged 15–19 years were married, compared to just 3 percent of men. The average age at first marriage has been slowly increasing over the past two decades. In urban areas, 8 percent of women aged between 15 and 19 years have started childbearing, compared with approximately 12 percent of young women in rural areas. Almost 30 percent of adolescent girls are estimated to be anemic. A 2019 screening of a sample of Afghanistan’s approximately 9.2 million students found that approximately 27 percent had dental caries, 2.3 percent had refraction errors, and 0.3 percent suffered from hearing loss. There is limited access to youth-friendly reproductive and other health information and services, and the educational curriculum lacks family life education.

#### V. IMMUNIZATION

According to the 2018 AHS, the rate of full vaccination among children in Afghanistan in 2018 was 50.2 percent. Coverage of measles, the third dose of diphtheria-tetanus-pertussis vaccine or the pentavalent vaccine, and the final dose of polio vaccine stood at 64 percent, 61 percent, and 71 percent, respectively (see Table 3). Between 2017 and 2021, however, there was limited expansion in vaccination coverage.<sup>17</sup> Among rural children, immunization coverage with the third

dose of oral polio vaccine (OPV3) has shown the biggest recent increase, reaching 70 percent in 2018. However, overall immunization coverage remains low, with disparities across the country, particularly between rural and urban areas and secure and insecure zones. According to Gavi, Afghanistan was home to more than 360,000 zero-dose children in 2021.<sup>18</sup>

A continued rise in the immunization rate for OPV3 among rural children is particularly important given that Afghanistan is one of only two polio-endemic countries in the world, and that most of the remaining cases occur in rural areas. In 2020, 54 wild polio cases were identified,<sup>19</sup> a figure that declined to just 4 cases in two provinces in 2021.<sup>20</sup> Changes in the security environment have opened access to hard-to-reach communities, creating new opportunities for eradication efforts.

In terms of immunization during pregnancy and childbirth, 19.4 percent of recent mothers received two doses of tetanus toxoid-containing vaccine during their last pregnancy, and 39.6 percent reported that their most recent birth was fully protected (including immunization carried out during previous pregnancies).<sup>21</sup>

#### VI. NUTRITION

Afghanistan faces severe difficulties in meeting basic food needs. Approximately 91 percent of the population, or 36.6 million people, have an insufficient food consumption. A further 12.1 million people report challenges with accessing food markets. Although a 2019 assessment identified high body-mass index as a main health risk factor, there is a lack of recent information to assess its prevalence. One of

<sup>17</sup> WHO. [Immunization dashboard: Afghanistan](#).

<sup>18</sup> Gavi. [Country hub: Afghanistan](#). Accessed on Dec. 15, 2022.

<sup>19</sup> Global Polio Eradication Initiative. [Afghanistan polio snapshot – November 2020](#).

<sup>20</sup> Global Polio Eradication Initiative. [Afghanistan polio snapshot – May 2021](#).

<sup>21</sup> Royal Tropical Institute and Ministry of Public Health Afghanistan. [Afghanistan Health Survey 2018](#). 2019.

the latest figures, however, shows an obesity rate of around 4 percent.<sup>22</sup> It is likely that the extent of this problem has changed or decreased due to the overall socioeconomic and food crisis that Afghanistan has experienced since 2021.

Although stunting among children dropped by approximately 20 percentage points between 2004 and 2018, 36.6 percent of children under five were still stunted<sup>23</sup> in 2018, while 17.3 percent were severely stunted. To make matters worse, more recent surveys show some of the previous gains may be lost: 2022 SMART surveys found stunting rates between 34.2 percent and 55.7 percent in four provinces. In the latest SMART assessment of malnutrition, 32 of 34 provinces had emergency levels of acute malnutrition, and all 34 provinces were in crisis or worse states of food insecurity. Currently, 40 percent of all hospitalized severe to acute malnutrition cases occur among infants aged 0–6 months. This suggests poor breastfeeding practices, although current rates of practice are unknown.

Micronutrient deficiencies are another major problem in Afghanistan. Overall, anemia is rampant among women of reproductive age (40.4 percent), in adolescent girls (29.9 percent), and in children aged 6–59 months (44.9 percent). Meanwhile, iron-deficiency anemia is present in 24 percent of women aged 15–49 years, sufficiently high to be considered a public health problem.<sup>24</sup> The majority of both women of reproductive age (95.5 percent) and children aged 6–59 months (81.0 percent) are deficient in vitamin D. The AHS 2018 reported that 46.8 percent of the women in Afghanistan received iron during their latest pregnancy, whereas only 17 percent of postpartum women received vitamin A supplementation as per Afghanistan's national policy.

## VII. COMMUNICABLE DISEASE

**Malaria:** An estimated 77 percent of Afghans live in at-risk areas. There are 123 high-risk districts in the country, with the eastern part reporting the highest burden. Estimates suggest that Afghanistan has up to 253,000 cases of malaria every year.<sup>25</sup>

**Tuberculosis:** Tuberculosis (TB) remains a major public health challenge in Afghanistan. In 2021, TB caused an estimated 76,000 cases, resulting in 12,000 deaths.<sup>26</sup> The following year, 50,710 cases were detected and enrolled in treatment. In Afghanistan, 2,930 health facilities provide directly observed treatment services for TB patients.

**HIV/AIDS:** Afghanistan has a low HIV prevalence among the general population and key groups, except for people who inject drugs. The HIV prevalence among the country's close to one million drug users has reportedly been as high as 4.4 percent. In 2021, the number of people living with HIV in Afghanistan was estimated at 11,000, of which 24 percent were women and 3.4 percent children. Prevention of mother-to-child transmission centers have been established at three regional hospitals in Afghanistan.

**Other infectious diseases and outbreaks:** In the first nine months of 2022, Afghanistan reported 184,975 cases of AWD, including cholera, 69,535 clinical cases of measles, and nearly 200,000 cases of COVID-19.

<sup>22</sup> Global Nutrition Report. *Country Nutrition Profiles: Afghanistan*.

<sup>23</sup> Royal Tropical Institute and Ministry of Public Health Afghanistan. *Afghanistan Health Survey 2018*. 2019.

<sup>24</sup> Zewar, M. and Chakraborty, S. "Nutritional Emergency Among Women in Afghanistan: Anemia Prevalence and Associations with Contributing Factors in Reproductive-Aged Afghan Women." *IOMC World*, 2022.

<sup>25</sup> WHO. *World Malaria Report 2021*.

<sup>26</sup> Cousins, S. "Tuberculosis hits more men than women. But not in Afghanistan". *The New Humanitarian*, 2021.

## VIII. NCDS

Information on NCDs in Afghanistan is often limited and/or outdated. According to the latest available data from WHO, in 2015 8.4 percent of Afghans had diabetes, 14 percent were overweight, 2.4 percent were obese,<sup>27</sup> and around 3 percent of households had a family member diagnosed with cancer. In 2019, WHO reported that NCDs, including ischemic heart disease, stroke, hypertension, and kidney diseases, were the leading factors contributing to mortality in the country (see Figure 4).

Despite the importance of NCDs, data on service coverage and availability remain limited, and NCD services are not included in the current BPHS and EPHS packages. Consequently, NCD services were one of the priority areas proposed for inclusion in the updated IPEHS based on the evolving burden of disease among the population. Although partners agreed on the revised IPEHS prior to the political transition, it has yet to be officially endorsed and launched. Going forward, it is critically important to reach an improved understanding of the complex context of rural and impoverished settings that are most severely affected by Afghanistan's growing NCD burden, as well as the socioeconomic and geographic variation of the burden. Other crucial actions are to expand national service availability and increase government and off-budget financing to tackle these conditions.

## IX. MENTAL HEALTH

Afghanistan's national health strategies have all highlighted mental health as a priority public health issue. The high mental health burden largely results from long-term protracted

conflict, insecurity, violence, and economic decline. In addition to the increased prevalence of depression, anxiety, and post-traumatic stress disorder, there is a serious substance abuse problem, with injectable drug use reaching potentially epidemic proportions. The MoPH has developed several national mental health strategies, of which the most recent covers the 2019-2023 period. Mental health and psychosocial care are also included in both the BPHS and the EPHS. In recent years, a new cadre of psychosocial counselors has been formed, trained, and posted in BPHS facilities.

## X. GENDER-BASED VIOLENCE

Discrimination against women and girls, including gender-based violence, economic exclusion, and a lack of appropriate and affordable reproductive health services, is a widespread problem in Afghanistan. Unequal access to health care services between women and men largely stems from unequal influence on household decision making for health: Women's participation in household decision making in Afghanistan is estimated at just 35 percent. In addition, levels of sexual and gender-based violence are high. More than half (53 percent) of ever-married women aged 15-49 years have experienced physical violence at least once since age 15,<sup>28</sup> and 56 percent have been subjected to emotional, physical, or sexual violence from their spouse. Sixty-one percent of these women never sought help or told anyone about the violence. Furthermore, child marriage in Afghanistan persists at levels that suggest that at least one in three young girls will be married before they turn 18 - an important contributing factor to high maternal and infant mortality rates.<sup>29</sup>

<sup>27</sup> WHO. *Fact sheets: Diabetes*.

<sup>28</sup> Medica Afghanistan. *"GBV and Trauma-Sensitive Healthcare in Afghanistan. A Baseline Study"* 2016.

<sup>29</sup> MSF. *International Women's Day 2017: Safe delivery care in Afghanistan*.





### III. Goal of the HSTS

The overall goal of the HSTS is to minimize avoidable morbidity and mortality in the short to medium term (2023–2025) by expanding the coverage and quality of health and nutrition services and strengthening health system resilience. The HSTS is intended to be implemented in coordination with the transitional strategies of other priority sectors to ensure a harmonized and complementary approach.

### IV. Strategic directions

The HSTS is a strategic document that guides the health sector work of the international community in Afghanistan in the 2023–2025 period. The document does not replace the NHP or the NHS, nor is it able to address all of Afghanistan’s health needs. Rather, it puts forth areas of intervention that are appropriate for partners given the current and expected operating environment and fiscal space. The HSTS is not a fund-raising document, and it does not propose a long-term reform agenda. Instead, it serves to guide immediate health priorities and mechanisms for the purpose of developing a coordinated approach among relevant stakeholders across the humanitarian-development nexus. These collective efforts will be leveraged with the aim of sustaining and expanding access to life-saving interventions in the health sector and meeting basic human health needs.

To accomplish this objective, the HSTS proposes four strategic directions: (i) Strengthen and expand essential service coverage/utilization and quality of care and improve financial risk protection for the most vulnerable groups; 2) Sustain and strengthen essential foundations of the health system that are necessary for meeting basic human health needs; (iii) Strengthen capacities to prevent, detect, and respond to disease outbreaks and other health emergencies; and (iv) Strengthen the harmonization and alignment of financing for national health priorities to increase predictability, adaptability, and efficiency of funding.

## Strategic direction 1:

Strengthen and expand essential service coverage/utilization and quality of care and improve financial risk protection for the most vulnerable groups.

### OVERVIEW

The first strategic objective focuses on sustaining current levels of service availability, access, and delivery at primary, secondary, and tertiary levels, and on expanding access for urban and under-served populations, mainly in rural areas. These efforts will be made through a mix of supply- and demand-side approaches that aim to alleviate some of the most significant access barriers.

### EXPECTED OUTPUTS FOR STRATEGIC DIRECTION 1

#### 1.1 Expanding essential health services & utilization

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The HSTS has a strong focus on meeting basic human health needs through sustained delivery of high-quality and affordable primary and secondary health care services. This approach will reinforce the existing BPHS and EPHS with additional support for high-impact interventions in maternal, newborn, and child health and involve expanding services available at sub-health centers, including treatment of moderate and severe malnutrition.

The current mix of direct service delivery strategies, which comprises health authorities, the UN, and national and international NGOs at the primary and secondary level, will continue over the next three years, with increasing efforts to avoid duplication and improve effectiveness, efficiency, linkages, and integration. In early 2023, partners will come together to map various service delivery approaches and streamline service delivery.

The contracting-out mechanism is expected to continue at a similar scale and will involve enhanced efforts to improve the population's access to health facilities by strengthening (i) linkages with communities and community-based health and nutrition care platforms; and (ii) referral mechanisms from communities to primary care facilities, and from primary facilities to secondary, tertiary, and higher-level care. Performance payments under the contracts are expected to resume, albeit adapted to respond to contextual changes, with close attention paid to the enabling environment. Based on previous experience and evidence, performance-based payments can serve as positive incentives for service providers to expand the coverage and uptake of services. The definition of "performance" will be expanded beyond the quantity of service provision to also promote quality improvements (see section 1.3 for more details).

Operationally, efforts undertaken as part of the HSTS will aim to establish and advance a long-term strategy for expanding services into "white areas" (see 1.1.3). These efforts will focus on supply- and demand-side approaches to extending access to existing services through

outreach, mobile, and community-based services and improving transport and referral mechanisms. However, investments in the construction of new facilities is not a promoted strategy given the current operating environment.

The direct implementation of tertiary care services by health authorities and partners like ICRC is expected to end in September 2023. Nevertheless, more work is needed to understand the full scope of need at this level of care and how best to complement DfA investments. The HSTS will support a concurrent effort to revisit and update the service packages in light of epidemiological changes and current population health needs.

### **Key activities**

**1.1.1** Review the content of the BPHS and EPHS with a focus on gaining greater insight into the completeness and quality of implementation of the two current packages, and developing a strategy to improve efficiency and quality of care. This will be done by prioritizing interventions within the package that the donors and partners will commit to funding within the available fiscal space, including the essential medicines list, and implementing those at scale and with quality, as well as exploring (potential) additional capacities at the health facility level. For remaining services that donors cannot fund within the fiscal space and prioritization, TA will be provided to support improving quality and efficiency and make those services more affordable and accessible to Afghan citizens.

**1.1.2** Review the feasibility of integrating vertical responses to public health emergencies, such as COVID-19 (surveillance, vaccination, and resource leveraging) and polio, into the broader package of services as part of the service package review (see 1.1.1). This may include integration of vaccines targeting these diseases into routine immunization programming; sharing of health systems resources at the community level (see 1.1.4 and 2.1.5), including but not limited to investments in community engagement and social and behavior change communication; integration of laboratory investments and sample transportation from health facilities (see also section 3.2.1); coordination around infection prevention and control and WASH investments; updating of roles and capacities of available human resources; and shared investment in the national HMIS, including the logistics management information system (LMIS). Lessons learned from this process can inform broader resilience-building within the public health system. In this way, responses to future emergencies and outbreaks may be mounted within existing systems and structures, minimizing the creation of new vertical response mechanisms.

**1.1.3** Expand coverage of services to “white areas”. Due to the perpetually evolving dynamic of insecurity and natural hazards, which lead to frequent and shifting population displacements, there is a need to continually update analyses that define and identify “white areas”. The health cluster will review and propose a revised definition of these areas in early 2023, and subsequently lead efforts to monitor and map population movements and health system expansion, producing regularly updated mapping of “white areas”.

A variety of solutions to the challenge of expanding services to “white areas” will need to be considered and adapted based on the local context and community preference, and must consider a mix of supply- and demand-side interventions.

Supply-side approaches will aim to ensure that health and nutrition workers are available to conduct outreach, mobile, and community-based services, with a particular focus on enabling continued employment and safe mobility for female health staff. While mobile health and nutrition teams were originally intended to respond to short-term emergencies, there is now a need to consider institutionalizing them within a district-system and integrated PHC model of care, and streamlining them into the overall BPHS service management. Routine outreach services can also be expanded, building on existing mechanisms for immunization outreach services. As mentioned in sections 1.1.4 and 2.1.5 below, community health workers (CHWs) are another important mechanism for reaching remote communities and building resilience to future shocks.

Demand-side interventions, on the other hand, may involve utilizing mobile phone technology and social media, as well as telemedicine (piloting); providing cash transfers to enable travel to health facilities, especially for maternal and child health services (see section 1.2.1); establishing and improving means of transport; setting up referral and ambulance systems to bring people to health facilities; and so forth. Finally, given the need to holistically and efficiently ensure access for hard-to-reach communities to services such as health, nutrition, water and sanitation, education, and social protection, donors and partners should consider adopting an integrated multi-sectoral approach.

**1.1.4** Develop an approach to financing community-based interventions (service delivery and engagement). Programs supporting CHWs should cover all costs incurred by them during the normal course of their work. Furthermore, the community-based health care program should remunerate, motivate, and recognize CHWs for their work in a coordinated and harmonized manner, considering the 2019 CHW performance-based incentive guidelines for piloting, evaluation, modification and/or full roll-out at scale. To ensure resilience and sustainability, this process should incorporate community-based approaches and involve strengthened engagement with community groups such as community development corporations, health shuras, and family health action groups. Partners should also support improvements to the quality and oversight of CHW services by service providers (see 4.3.1). Finally, given the diversity of approaches supported by service providers and other partners, implementation research on CHW and community health strategies should be undertaken to inform future partner investments on strategies for bringing health services closer to communities. Research areas should include, but not be limited to, quality of care, motivation, and remuneration approaches.

**1.1.5** In addition to a broad prioritization of primary and secondary health care provided through the BPHS and EPH, the HSTS has a more targeted focus on the tertiary level. Support in the latter area will mainly be delivered through management and technical support, which will help to advance a few critical issues. Proposed activities include a review of hospital procedures and protocols to improve patient management and the availability of acute care, and the development of a

quality improvement program strategy for the secondary level (district to national), including a reactivation of the baby-friendly hospital initiative. During HSTS implementation, an appraisal of overall hospital needs should be undertaken to improve the understanding of the current situation and the level of DfA investment, and to inform future investments from development partners.

In light of the current authorizing environment in Afghanistan, major investments in areas such as infrastructure and advanced diagnostic equipment for government-run health care facilities, and support for strategic policy reforms (apart from what has been described above), fall outside the scope of the HSTS.

Support to select NGO- or private sector-managed tertiary facilities, particularly in high-burden urban catchments, should be considered. Such support may be in the form of health care worker salaries, medicines, and supplies, as well as limited rehabilitation investments in water and sanitation facilities and equitable spaces considering gender dynamics (such as waiting areas for women), minor maintenance and renovation, and solarization, to ensure patient and health worker safety.

## **1.2 Improve financial risk protection for the vulnerable**

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The HSTS recognizes the extreme degree of vulnerability among Afghans, as well as the historical reliance of the Afghan health sector on household OOP spending. The HSTS has identified two main approaches, listed below, to help reduce OOP expenses and catastrophic expenditures, and to address the needs of vulnerable groups in a more holistic way.

### **Key activities**

**1.2.1** Sustain and harmonize conditional and unconditional cash transfer and/or voucher programs for vulnerable populations. Cash transfers may help to offset transportation costs of reaching health services, which are some of the most important contributors to OOP payments. Another option is to provide general cash transfers to incentivize the uptake of specific targeted services, such as maternal and child health preventative services. There is an important opportunity for partners to collaborate on identifying the most vulnerable groups and to streamline administrative strategies for cash transfer delivery. Additionally, connecting cash transfer beneficiaries to complementary health and nutritional programs implemented by contracted NGOs will be critical. The health sector could partner with other sectors in delivering cash assistance to address multiple household financial vulnerabilities. Thus, efforts should be made to explore operational strategies for leveraging health sector assets to target women, children, and vulnerable households with cash assistance. Such strategies may include co-locating cash distribution with health and nutritional interventions, or using well designed cash transfers to increase the use of key preventative and promotive interventions (such as childhood immunization, or growth monitoring and promotion).

Figure 7. *Defining vulnerable groups*

## DEFINING VULNERABLE GROUPS IN THE CONTEXT OF GENERALIZED VULNERABILITY

Given the economic upheaval experienced by Afghanistan since August 2021, vulnerability is broad-based. Nevertheless, successful implementation of the HSTS will require targeted efforts to increase health service utilization and reduce financial hardship caused by OOP spending. The HSTS will therefore focus on a subset of vulnerable populations in the development of demand-side interventions and other targeted approaches. The groups that will be prioritized are:

**Zero-dose communities** | Gavi estimates from 2021 suggest that Afghanistan is home to approximately 360,000 zero-dose children. This is of concern, since communities with a high proportion of zero-dose children tend to suffer from multiple health and nutritional vulnerabilities.

**Pregnant and lactating women** | According to estimates by the UN Population Division, Afghan women and girls give birth to approximately 1.2 million babies each year. Out of these, some 40 percent – or 500,000 mothers – give birth outside of the formal health care sector, without the care of a skilled provider.

**Children experiencing acute malnutrition** | The World Food Programme (WFP) estimates that approximately 2.8 million children in Afghanistan suffer from mild acute malnutrition and 1.1 million from severe acute malnutrition, annually. Undernutrition carries the risk of death and long-term disability and causes increased morbidity, thus placing additional burdens on health and nutrition services.

**Internally displaced people** | The political crisis of August 2021 and the forced return of refugees from neighboring countries, coupled with persistent drought conditions in many parts of Afghanistan, have created a huge population of displaced people. The displacement is largely concentrated to urban areas, which are under-equipped to manage the increased need for health and nutritional services.

**Other vulnerable groups** | Other vulnerable groups that should be considered for demand-side incentives to address service access challenges include those with mental health disorders, people suffering from drug addictions, and the disabled.

**1.2.2** Improve the availability of medications and diagnostic services for the vulnerable, including those living in urban areas, to minimize their OOP payments in primary health care outlets. This will primarily be done by strengthening supply chain management practices through BPHS and EPHS contracting arrangements – for example, by increasing medicines financing and offering incentives or sanctions for stock management practices. However, the partners will also explore different innovations to see how best to leverage social marketing platforms and networks of private sector providers to meet the needs of urban populations.

### **1.3 Improve the quality of care**

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The HSTS will have a strong emphasis on improving quality of care, including the experience of care, primarily through contracted NGO service providers, at all levels of facilities and community-based services. To this end, the following priorities have been identified:

- 1.3.1** Adapt and implement existing quality improvement programs at the PHC level (community and primary facilities), for example through a review of existing standards and associated tools. Other efforts will include developing a fit-for-purpose quality monitoring tool to inform quality-based payments under BPHS and EPHS contracts.
- 1.3.2** Harmonize quality improvement approaches and indicators across service providers and health system levels. Clarity on quality standards and measurement tools will be important for service providers to effectively meet their contractual obligations, including for humanitarian programming.

**1.3.3** Strengthen managerial capacity at program, subnational, and facility levels (including in hospitals). Within the ongoing HER project (currently running through 2023), these efforts will be supported by UNICEF contract management and management accompaniment investments. However, longer-term options, such as working through health care professional associations, should also be considered. Direct collaboration with NGOs on standard-based management for first-level hospitals will be important. At present, capacity building efforts for government employees largely fall outside the scope of the HSTS. Nevertheless, changes to the partner authorizing environment during the HSTS implementation may create the space to invest in capacity strengthening for MoPH and provincial health staff.

**1.3.4** Capacity building for health care workers on infection prevention and control, and on the management of acute and emergency care at the first point of contact, will also be essential. Given the lack of investment in recent years, other health care worker capacities are also needed. However, high-priority issues will be prioritized?

**1.3.5** Some structural quality improvement investments may be made to improve the safety and efficiency of health and nutrition services. These investments may include mapping of health facility maintenance needs; small facility maintenance; provision of water and sanitation facilities, including creation of dedicated sanitation facilities for women; renovation of delivery rooms; support for waste management systems; and solarization of health facilities. Partners should also work with communities to encourage local investment in and

contribution to health facility maintenance and improvement. Such investments can be seen as a mechanism for promoting community ownership of health and nutrition services, as well as a way to ensure value for money and cost-effectiveness.

#### **1.4 Strengthen engagement with the private sector**

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The HSTS will focus efforts on enhancing the capacity of the private sector to provide the health system with high-quality medicines and health and nutrition care supplies, while exploring strategies for meeting the health and nutrition needs of the urban poor. It is important to note that private sector engagement is not fit-for-purpose in all locations and service types. The HSTS recommends this approach in limited settings, where capacity and appropriateness are considered satisfactory and where it does not introduce competition with or diversion from the public sector.

##### **Key activities**

- 1.4.1** Establish mechanisms to ensure that private-sector delivery in urban areas adheres to quality standards and programs.
- 1.4.2** Explore opportunities for engaging the private sector in urban areas. Such activities may involve contracting out select services where the private sector has a comparative advantage. They may also include limited production and distribution of pharmaceuticals and medical supplies.

- 1.4.3** Expand the services and products of social marketing organizations beyond their current focus on family planning and maternal and child health, to include hygiene and sanitation products as well as other areas. Extend the social marketing supply chain to involve midwives and female CHWs, increase the geographic availability of products and services, and expand women's access to them.

#### **1.5 Enhance community and facility-level nutrition services**

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The BPHS and EPHS already include many important nutrition-related interventions. Nevertheless, given the dramatic increase in the burden of malnutrition in the current context of economic crisis and food insecurity, utilization of treatment services for severe and moderately acute malnutrition is on the rise. Dedicated efforts are needed to shape and respond to the burden of undernutrition, while working toward improving the integration of nutrition interventions into health services at community level.

##### **Key activities**

- 1.5.1** Conduct a review of the nutrition counselors' program to better understand its operational effectiveness, while making efforts to maintain paid female nutrition counselors as part of the current packages. The review could include an assessment of the current capacity, turnover, and workload of the nutrition counselors. This information, in turn, could help determine the feasibility of expanding the scope of these services, should the package be revised (see 1.1.1).





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**1.5.2** Increase the uptake of nutrition services in communities with a high rate of severe and moderate acute malnutrition, including in urban areas, and engage with other sectors to target multi-sectoral interventions in these high-burden places. Given the national and systemic nature of food insecurity, the current growth in malnutrition treatment cannot be sustained with existing financing. Concerted

efforts should continue to engage with humanitarian, agricultural, social development, and social protection actors (including cash targeting as per section 1.2.1) to understand the distribution and drivers of malnutrition in the country. At-risk communities should be targeted using methods that involve not only treatment, but also prevention, thereby addressing the root causes of the crisis.

## Strategic direction 2:

Sustain and strengthen essential foundations of the health system that are necessary for meeting basic human health needs.

### OVERVIEW

Within strategic direction 2, the main focus will be on four health systems building blocks: health workforce, governance and coordination, health information systems, and supply chain management. Service delivery and financial risk protection are dealt with under strategic direction 1, while health financing issues are addressed as part of strategic direction 4. Some elements of the health information system that deal with disease outbreaks and other health emergencies are incorporated into strategic direction 3.

Strengthening health system foundations is primarily the mandate of national authorities and typically takes place over a timeframe of at least 5–10 years. However, some important steps can already be taken over the next 2–3 years to lay the foundation for longer-term initiatives. Partner contributions to SD2 interventions may primarily take the form of technical assistance and capacity building to (i) establish national policies and strategies and (ii) build national and local governance institutions and capacities.

### EXPECTED OUTPUTS FOR STRATEGIC DIRECTION 2

#### 2.1 Strengthen human resources for health

The HSTS will have a clear focus on improving human resources for health (HRH) management, despite limitations to direct investments in government stewardship functions, through the following proposed priorities:

#### Key activities

**2.1.1** Map all health workforce cadres, including community health workers and unabsorbed health workers, specified by gender, and conduct a needs assessment for staff. A stocktaking of all health care workers is an important starting point for workforce planning, and a unified list of health workers would allow for greater transparency in service provider payments. This is particularly the case for service providers that manage contracts with multiple donors. Should a new crisis arise that substantially disrupts service providers' ability to pay salaries, a unified list of health care workers could become an important troubleshooting tool for development partners. Since the

workforce continuously evolves in terms of numbers, capacities, and composition, it is highly recommended to assess the feasibility of institutionalizing an HMIS at the national level to ensure sustainability.

**2.1.2** Conduct a needs assessment for capacity building of the current public health workforce, especially female, at the national level, and use it to inform an in-service training plan. The plan may then be used by humanitarian and development partners for continuous professional education. While this activity builds on 2.1.1, it looks specifically at existing skills and capacity needs. The data from the needs assessment will also be useful for supporting implementation research on effective capacity building strategies, as well as for strengthening the coordination of capacity investments by partners.

**2.1.3** Support the development of a new HRH strategy, building on the previous one. Workforce planning is a multi-sectoral effort that requires collaboration across line ministries and between the public and private sectors. While this issue is critically important beyond the HSTS, development partners cannot tackle it alone. Efforts are needed to engage the health and education sectors and professional associations, with a view to increasing clarity on the health care worker pipeline and on how to meet the demand for skilled labor in the health sector. This will be particularly important for ensuring an adequate workforce of female health care workers and will include advocating for girls to return to secondary school and university. Engagement with the Ministry of Finance to clarify resource needs and availability, as well as with the civil service authority, will be critical throughout this process.

**2.1.4** Reduce barriers to increased female participation in the health workforce by supporting capacity building and retention, and by addressing context-specific mobility issues, including mahram. Each service provider will be supported to work with provincial health authorities on a context-specific plan to address barriers to female health care worker participation in health service delivery.

**2.1.5** Invest in the capacity of community health workers and nutrition councilors. Expand capacity-building programs for these groups in hard-to-reach areas with a focus on improving quality of care. Consider relevance and program design in urban under-served and nomadic communities for a harmonized community approach integrating immunization, nutrition, health promotion, support for people with disabilities, referral, and other PHC services. Review and reform incentive and motivation mechanisms for CHWs to remunerate them adequately and fairly for their work (1.1.4).

## **2.2 Support the strengthening of governance and coordination**

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There will inevitably be a degree of fragmentation between HSTS partners and national and provincial authorities. While coordination among HSTS partners is expected to become closer and more concerted compared to the recent past, coordination between the MoPH and HSTS partners will be subject to political developments. Currently, coordination primarily takes place around operational issues. However, it may expand to include contributions of HSTS partners in the form of technical assistance and capacity building within the MoPH. Considering the diverse policies of HSTS partners regarding their respective engagement with the DfA, HSTS

partners may be able to offer different types of support to the MoPH with the aim of enhancing its stewardship role and building capacity in its health system strengthening directorate. In addition, partners are encouraged to contribute to the formulation of strategic approaches and technical reforms that will ensure sustained health services to the people of Afghanistan. This includes developing an HRH strategy (see 2.1.3); revisiting and adopting the NHS, as well as a Health Financing and Private Sector Engagement Strategy; and reviewing the feasibility of adapting the service package (see section 1.1.1).

### **Key activities**

**2.2.1** Support the updating and approval of the NHP and/or the NHS, which will be led by MoPH with technical support from partners. While the HSTS provides a framework for partner investments over the next three years, there is also a need for longer-term planning around the health system, a roadmap for the use of MoPH resources to complement the HSTS, and a planning process that involves the private sector and the line ministries responsible for instituting regulations and addressing social determinants of health.

**2.2.2** Maintain health and nutrition clusters and strengthen strategic and operational coherence between humanitarian health and nutrition assistance in order to meet basic human health and nutrition needs (see also 1.5.2).

**2.2.3** Strengthen provincial/subnational governance and coordination, define an appropriate role for the PPHDs, and bring together all operational partners working in the province through an area-based health system approach.

**2.2.4** Support the MoPH's stewardship role by building capacity and engaging in coordination fora together with the ministry. While current authorizing environments limit the degree of coordination that is possible between the MoPH and development partners, it is clear that the MoPH is committed to taking a role of ownership and oversight of the health sector. The HSTS proposes important opportunities for engagement with the MoPH. However, it is also clear that the current MoPH does not have sufficient resources at the central and provincial levels to manage a complex network of health sector partners. Supporting MoPH officials with information on development partner plans and activities in the sector and bolstering efforts to integrate that information into the ministry's own planning processes are part of this effort. For example, the MoPH's ability to engage on revisions to the primary and secondary care service package will be a precondition for that process to move forward (see 1.1.1). Should authorizing environments allow, providing direct support for staff positions to manage coordination functions will also be a priority.

### **2.3 Health information systems and M&E**

HMIS, including civil registration and vital statistics (CRVS), remain key data sources for evidence-based decision making. To strengthen the access to and use of data at the national and subnational levels, the following priorities have been identified:

## Key activities

- 2.3.1** Review the existing disease surveillance system and explore opportunities for better incorporation of vertical condition-specific systems, including NCD surveillance and the private sector, into an integrated disease surveillance system.
- 2.3.2** Institutionalize the maternal and newborn death surveillance and response program, including by establishing verbal autopsy and enhancing social accountability, and scale it up at the tertiary, secondary, and primary levels.
- 2.3.3** Regularly map and monitor health facilities and their functionality.
- 2.3.4** Strengthen HMIS reporting mechanisms at the national hospitals.
- 2.3.5** Build the information management capacity of health facilities by improving registration and reporting of services delivered by all service providers (humanitarian, development, and private).
- 2.3.6** Build capacity for aggregation, analysis, and use of data at the provincial and health facility management levels.
- 2.3.7** Develop an annual monitoring plan for NGOs and other service providers, agreed upon by the MoPH and partners.
- 2.3.8** Implement the next AHS, including assessments of health seeking behaviors and demand-side barriers.

## 2.4 Supply chain management

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Access to essential medicines through primary, secondary, and tertiary health services is one of the key concerns of the MoPH and its partners. To improve the availability of medications and diagnostic services for vulnerable populations, including those in urban areas, the following priorities have been identified:

### Key activities

- 2.4.1** Perform an in-depth assessment of the current supply chain for health facilities at all levels, including national and specialized hospitals. The assessment will provide recommendations for improvements to the supply chain, gauge the appropriateness of different procurement approaches, and determine the sustainability of the supply chain in various scenarios. The assessment will also cover private distributors.
- 2.4.2** Build service-provider capacity on drug quantification and stock management at the BPHS and EPHS facility levels.
- 2.4.3** Explore opportunities for pooled or coordinated procurement, through negotiated framework agreements or long-term agreements, while implementing a hybrid approach to procurement of BPHS and EPHS services.

## Strategic direction 3:

Strengthen the capacity to prevent, detect, and respond to disease outbreaks and other health emergencies.

### OVERVIEW

The HSTS recommends a series of activities to improve Afghanistan's health system resilience, preparedness, and capacity for emergency response, including: (i) general actions to strengthen the overall health care system (described under strategic direction 2, including activity 2.3.1 on expanding and integrating disease surveillance systems), (ii) intersectoral actions (see the respective section VII), and (iii) the specific interventions listed below.

### EXPECTED OUTPUTS FOR STRATEGIC DIRECTION 3

#### 3.1 Strengthen early warning and response systems

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Early detection and response are fundamental parts of effective emergency and outbreak programming. To ensure that these crucial components are in place, the HSTS partners are encouraged to support the following activities in the next two to three years:

##### Key activities

- 3.1.1** Strengthen the early warning system for diseases based on both passive and active surveillance, including event-based surveillance.
- 3.1.2** Establish reference laboratories, especially for genetic sequencing of pathogens of concern.
- 3.1.3** Set up early control efforts through a progressive increase in the number of rapid response teams.

#### 3.2 Evolve surveillance assets to become better integrated

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Given the solid functioning of field surveillance teams that focus on polio and outbreaks of vaccine-preventable and other infectious diseases, as well as on nutrition, the following activities are recommended:

##### Key activities

- 3.2.1** Stepwise and ad-hoc integration of surveillance assets. The integration may include a plan for overlapping field surveillance guidance in areas such as polio/ acute flaccid paralysis and malnutrition surveillance. This type of coordination could be accomplished by anticipating opportunities in guideline evolution, training, and reporting schemes of field teams.
- 3.2.2** Regular, recorded coordination at the national and provincial levels under an expanded emergency operations center is advised to highlight and track progress.

Given the wide range of donors, financial commitments, and accountabilities involved in existing agreements, it will be necessary to establish guidelines for shared, mutual accountability.

### **3.3 Strengthen the integration of rapid response teams**

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To enhance the functioning of WHO's and UNICEF's rapid response teams (RRTs), the following actions/activities are suggested:

#### **Key activities**

- 3.3.1** Assure active participation of provincial health offices, as well as civil society partners, as RRT members for both training and deployments, thus helping to mainstream capacity (including gender diversity) for earlier and more comprehensive responses.
- 3.3.2** Work with other sectors, especially WASH and social and behavior change, to ensure that initial field assessments and action plans are inclusive of these contributions. As part of the enhanced coordination process, the suggested actions should be planned in advance and their progress tracked.
- 3.3.3** Leverage support for epidemic and emergency preparedness and response by the health and nutrition clusters and collaborating with and supporting (sub) national health emergency operation center capacities, where appropriate. Notably, an updated mapping of "white areas" (as proposed under 1.3.1) will help to promote more efficient deployment of mobile health and nutrition teams in support of both regular and emergency health services.

### **3.2 Expand/adapt services based on a risk-based approach with the aim of integrating emergency surveillance with regular health monitoring**

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While the leadership and ownership of Afghanistan's emergency surveillance and response processes continue to develop, a progressive, formal, and ad-hoc merger of different emergency surveillance mechanisms with regular health monitoring, as well as with emergency response, is recommended. The emergency response plan should be guided both by available data that integrate the different surveillance and health monitoring mechanisms, and by a comprehensive assessment of the multiple risks that Afghanistan faces. These activities will require additional time and energy to materialize, should they be feasible within the timeframe of the HSTS. Formally including and aligning PPHDs and CSOs into the RRTs, for example, may require evolved governance coordination and service delivery contracting. Suggested activities to achieve these goals are listed below.

#### **Key activities**

- 3.4.1** Conduct a multi-hazard risk assessment for Afghanistan, which will support tailored, context-based emergency preparedness and response mechanisms.
- 3.4.2** Develop a plan for transitioning existing surveillance mechanisms and some aspects of regular health monitoring into a unified effort.
- 3.4.3** Embark on a progressive integration of surveillance and field response for health emergencies. This integration could include a multi-agency contingency plan covering current independent preparedness and response strategies for various outbreaks and/or situations. The plan could then be implemented through different platforms, such as the PHC system, community health workers, urban nutrition mechanisms, and the like.

## Strategic direction 4:

Strengthen harmonization and alignment of financing toward national health priorities to increase predictability, adaptability, and efficiency of funding.

### OVERVIEW

Afghanistan's health sector involves multiple stakeholders, including the DfA, civil society, the private sector, and humanitarian and development partners. Given limits to the available fiscal space, it is imperative that partners work to continuously align investments and activities in order to identify all possible efficiencies. While numerous coordination mechanisms already exist, Afghanistan needs a platform for strengthening harmonization, strategic coordination, dialogue, and priority setting at the sector level – particularly among humanitarian and development partners. Below are the priority actions that have been identified for the purpose of strengthening the coordination and alignment of resources.

### EXPECTED OUTPUTS FOR STRATEGIC DIRECTION 4

#### **4.1 Support national coordination of development and humanitarian partner investments through the health sector thematic working group (H-STWG).**

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**4.1.1** Develop, and adapt as necessary, a health sector transitional strategy (HSTS). The development of the HSTS, along with the drafting of updated costing and funding requirement estimates, supports the objective of national coordination of partner investments. The estimates will be used in a prioritization exercise that aims to right-size the response of the HSTS.

**4.1.2** Establish a single monitoring and evaluation framework, including process and outcome indicators, as part of the HSTS development. This work includes a review

of and harmonization between different provincial monitoring systems for service delivery performance, as well as joint monitoring visits with the PPHDs.

**4.1.3** Set up a joint accountability mechanism, which will include regular progress reports to the H-STWG and form the basis for information sharing with the MoPH and the PPHDs.

#### **4.2 Establish resource mapping at the national and provincial levels**

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**4.2.1** At the national level, a comprehensive mapping of the sources, timing, and amount of available resources (both financial and in-kind) will be conducted, made available to the health sector, and updated on an annual basis. The mapping will cover funding from donors that support basic human health needs, such as bilateral donors, international financing institutions,



and global health initiatives like the Global Fund and Gavi, as well as humanitarian donors. Information about the latter can be obtained through OCHA's financial tracking system; however, it is important to note that not all funding is reported to it. Contributions from the MoPH, which currently funds 17 projects, should also be reflected, if feasible. This exercise will be complemented by the financial mapping conducted by the nutrition cluster.

**4.2.2** At the provincial level, resource mapping needs to contribute to operational planning. This work will require mapping of all health service delivery platforms (building on existing systems such as HeRAMS), according to ownership type and funding sources (both development and humanitarian) to support integrated service delivery. The mapping will also cover health system foundations at the provincial level supported through activities under SDs 2 and 3, such as HMIS, surveillance, epidemic preparedness and response, in-service training, and provincial health management.

### **4.3 Support for service delivery alignment at provincial level**

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#### **Aligning service delivery involves:**

**4.3.1** Retaining the approach of assigning one lead NGO in each province to channel support for service delivery and coordinate provincial partners, where possible, and putting the PPHD in charge of integrated provincial planning. This way of working is expected to reduce both fragmentation and duplication of programs by reinforcing a single provincial service delivery plan. Since contracted NGOs may have conflicts of interest, the PPHD must be supported (if feasible) in its role of overseeing all provincial planning.

**4.3.2** Developing an integrated service delivery framework and plan for all service providers in each province. The framework, which should include all health service delivery platforms and vertical programs, will be used as a basis for reducing gaps and overlaps in the network. Further, it will help to rationalize referral pathways between service delivery platforms supported by various partners and service delivery streams, as well as those supported by humanitarian assistance, and take into consideration private service providers.

**4.3.3** Finally, further investments are needed to restructure the current coordination fora at the provincial level. To this end, provincial coordination will be reviewed with the aim of creating a single mechanism for all partners. The new mechanism will need to acknowledge the governance role of the PPHD and include connections with provincial emergency operations centers and rapid response mechanisms. Smaller pooled funds may also be explored for specific purposes, such as emergency preparedness and response, and health worker training.

# V. Resource envelope, costing, and prioritization

Health sector financing is highly dependent on both international aid and OOP household spending. Over the last five years, total on-budget health expenditure in Afghanistan is estimated to have averaged US\$286 million per year, equivalent to approximately 1.5 percent of GDP.<sup>30</sup> Since 2020, an additional US\$50 million has been mobilized annually for COVID-19-related health expenditures. In addition to on-budget spending, development partners disburse some US\$160 million per year through off-budget mechanisms. However, this funding has been on a declining trend since 2018. In the 2017–2021 period, approximately 46.5 percent of the annual on-budget health spending (US\$133 million) came from domestic revenue sources. This spending predominantly focused on tertiary-level hospital services and administrative functions at the central and provincial levels of government. The remaining 53.5 percent (US\$153 million) originated from externally funded on-budget sources, including IDA and the ARTF, and was largely oriented toward supporting BPHS and EPHS service delivery at the primary and

secondary service levels of the health system.<sup>31</sup> Approximately 85 percent of all basic/essential health financing is channeled through projects such as Sehatmandi (in the 2019–2020 period), and HER (since 2021).

Prior to the political change on August 15, 2021, the health sector was jointly financed by domestically financed on-budget resources, donor-financed on-budget resources, off-budget resources, and privately financed resources, mainly in the form of OOP. With the Taliban takeover, the composition of health financing changed as the de facto government is unable to fund national hospitals through domestically financed revenue sources. ICRC is currently the only donor that provides funding to these hospitals.

Development partners and donors are active across a range of priority areas. The table below shows which donors are funding which areas in 2022 and 2023.

<sup>30</sup> World Bank. [Out-of-pocket expenditure \(percent of current health expenditure\) - Afghanistan | Data.](#)

<sup>31</sup> World Bank. [Out-of-pocket expenditure \(percent of current health expenditure\) - Afghanistan | Data.](#)

Priorities		COVID-19 vaccination	Implementation of BPHS and EPHS	Health system strengthening	Supply chain	Nutrition	Hospital
FY2022	GFF WB/ARTF	✓	✓	✓	✓	✓	
	EU	✓				✓	
	USAID	✓		✓	✓	✓	
	CANADA			✓		✓	
	GAVI	✓		✓	✓		
	BMGF		✓				
	FCDO	✓		✓	✓	✓	
	ADB	✓	✓			✓	
	GF	✓		✓		✓	
FY2023	GFF WB/ARTF	✓	✓	✓	✓	✓	
	EU	✓		✓		✓	
	USAID	✓		✓		✓	
	CANADA					✓	
	GAVI	✓		✓			
	ADB	✓	✓			✓	
	ICRC						✓

# VI. Cross-sectoral efforts to align the health strategy to other social priorities

Although various actions across different sectors may have an impact on the wellbeing of the Afghan people, this document focuses on those areas that have the biggest potential impact on health, and where there is an established government authority, mechanism, or relevant partner (UN or otherwise) in place to enable further development of some of the suggestions mentioned here. While the full implementation of some of these actions may extend beyond the 2023–2025 timeframe of the HSTS, there are short-term steps that may pave the way for more comprehensive, long-term, and sustainable social and health programming. The sectors/ areas included in this approach are food security, WASH, education, social protection, transportation, and child protection. Gender, equity, and community engagement cut across all the areas.

## 1. FOOD SECURITY

Approximately 50 percent of the population, in particular pregnant women and young children, cannot satisfy their food needs,<sup>32</sup> leading to widespread acute malnutrition (moderate and severe) and stunting. Food insecurity in the country is caused by a range of circumstances such as droughts, the COVID-19 pandemic, international conflict, inflation, and most importantly, the economic barriers created by socioeconomic instability and widespread unemployment.

Some interventions to address malnutrition have already been introduced under the current strategy. These activities could be expanded both geographically and in terms of populations covered in the short and medium term. Potential concrete actions include (i) direct provision of food, (ii) nutrition support via ready-to-use supplementary food, (iii) multi-purpose/nutrition-sensitive cash transfers (see the subsection on social protection), and (iv) school feeding programs.

## 2. WATER, SANITATION, AND HYGIENE

Access to and quality of water, sanitation, and hygiene (WASH) services in Afghanistan are among the lowest in the world. This situation, which is a consequence of decades of conflict, droughts, and lack of investment, has further worsened in the last few years due to the financial crisis and ensuing economic instability. An estimated 80 percent of the population do not have access to safe drinking water, 50 percent do not have access to basic sanitation facilities, and 35 percent of health care facilities lack access to basic WASH services.<sup>33</sup>

A range of actions launched in partnership with donors, partners and the Ministries of Rural Rehabilitation and Development, Public Health, and Education are currently taking place to address Afghanistan's WASH needs, both at the community and healthcare facility levels. These actions, which will need to be enhanced and expanded to further curb mortality and morbidity, include (i) tackling outbreaks of acute watery diarrhea by facilitating access to safe

<sup>32</sup> WFP Afghanistan. *Situation Report 19 July 2022*. OCHA services.

<sup>33</sup> UNICEF. *Afghanistan WASH on the Brink*, 2022.

drinking water and by distributing hygiene kits and WASH items; (ii) constructing emergency latrines; (iii) strengthening risk communication and community engagement to foster good WASH practices; and (iv) improving WASH services in the health care facilities that are most in need.

### 3. EDUCATION

The education sector in Afghanistan faces numerous challenges related to access and quality. Notably, women and girls have often been left out of the education system. Only 30 percent of Afghan women and 50 percent of men have ever attended school, and overall school attendance in rural areas is just 36 percent.<sup>34</sup> Out of the 3.7 million out-of-school children, 60 percent are girls.<sup>35</sup> This situation will inevitably worsen by the recent ban on girls accessing education beyond elementary school. The new law will lead to even more severe staff shortages in health care and other sectors, as the pipeline of teachers, doctors, nurses, midwives, and many other professionals will be curtailed. Women who seek health care may now only be seen by female health care staff, a restriction that hampers women's access to general and, particularly, specialized health services. Finally, there are issues related to quality in health care curricula, especially in the unregulated private sector.

The current Education Sector Transitional Framework for Afghanistan<sup>36</sup> includes various activities that aim to strengthen the education and health sectors, some of which include: (i) advocate for girls to access education beyond elementary school; (ii) provide initial vocational training to non-professional healthcare workers, such as traditional birth attendants and community health workers; (iii) provide continuous education and training to doctors, nurses, midwives, and community health

workers in the public and private sectors, with an emphasis on quality; (iv) establish or strengthen quality control mechanisms for health-related curricula, with a particular focus on programs provided by the private sector; and (v) advocate for the inclusion of certain medical specialties that are absent from the current curricula.

In the long term, there may be opportunities to establish agreements with external tertiary education institutions to train health care staff, with an emphasis on areas where health human resource supply is limited or absent (such as certain specialties), as well as to develop and enforce standards and frameworks for medical/health care education, re-licensure, use of medical equipment and technology, and health protocols, to name a few.

### 4. SOCIAL PROTECTION

Afghanistan has a fragile economy with one of the lowest GDPs per capita in the world (US\$516 per year, compared to the global average of US\$12,263).<sup>37</sup> The political turmoil in 2021 has had a vast negative impact on a country that was already highly dependent on international aid and suffered from widespread unemployment, and where two-thirds of households are unable to cover food and other basic needs.

Activities that could be implemented in the short to medium term to financially protect the population, tackle health-related economic barriers, and improve the overall health status of Afghans include (i) expanding gender-focused social safety nets in the form of multi-purpose cash transfers and other subsidy programs; (ii) establishing conditional cash transfers to incentivize demand for key health services, such as antenatal care, facility-based deliveries, immunizations, and adherence to long-term

<sup>34</sup> Royal Tropical Institute and Ministry of Public Health Afghanistan. *Afghanistan Health Survey 2018*, 2019.

<sup>35</sup> UNICEF. *Education – Afghanistan*, 2022.

<sup>36</sup> Afghanistan Education Cluster, Afghanistan Education Development Partners. *Afghanistan Education Sector Transitional Framework (ESTF)*, 2022.

<sup>37</sup> World Bank. *GDP per capita*, 2022.

treatment such as treatment for multi-drug-resistant TB; c) harmonizing different conditional and unconditional cash assistance programs, such as nutrition-sensitive, humanitarian, and multipurpose cash transfers; and (iv) looking into cross-subsidization of health services offered by the private sector.

Some of the long-term solutions include the creation of a health insurance scheme, expansion of social programs and cash transfers to the bottom socioeconomic quintile (with a gender focus), scaling up of equitable/pro-poor public-private partnerships, and a reconnection to international markets and the banking system.

## 5. TRANSPORTATION

One of the key barriers limiting the use of both health care and education services in Afghanistan is transportation, which tends to be either very expensive or unavailable. This makes it difficult for patients to reach health care facilities, which are often remote.<sup>38</sup> To make matters worse, road injuries are one of the main risk factors in the country, ranking as the 10th biggest cause of preventable mortality.<sup>39</sup>

In the short term, partners may explore community-based mechanisms and/or public-private partnerships to address unmet health care demands that are caused by transportation. An example is a partnership between USAID, Vodafone, and the Tanzanian government, whereby a free transportation service is provided by nearby taxis to pregnant women experiencing health emergencies, thus serving as a proxy for ambulances.<sup>40</sup> Many other examples exist globally of community-based taxis, public-private partnerships, and community emergency funds to support emergency referrals.

In the medium to long term, the Ministry of Transport and Civil Aviation could collaborate with partners to expand the road network, with a particular emphasis on connecting remote rural areas with urban centers. Such initiatives could help to improve access to food as well as to social and health services. In addition, advocacy efforts could be undertaken to encourage road safety policies, such as placement of speed bumps at high-risk junctions, compulsory seatbelt use in cars, and compulsory use of helmets for motorbike riders.

## 6. CHILD PROTECTION

Half of Afghanistan's population are children. Afghan children are highly vulnerable and prone to physical and mental abuse, displacement, child marriage, military recruitment, and other harmful social norms, all of which have demonstrable negative effects on children's health, nutrition, and development.<sup>41</sup> Existing programs to protect boys and girls and improve their wellbeing and health could be expanded, focusing on activities such as (i) engaging with community and religious leaders and developing risk communication and community engagement (RCCE) programs against domestic abuse and child marriage for girls, boys, and children with disabilities; (ii) advocating against military recruitment of minors; (iii) reuniting displaced, unaccompanied children with their families; and (iv) strengthening current mechanisms to promote birth registration in partnership with the Ministry of the Interior's Vital Statistics Department.

In the long term, the overall child protection system needs to be strengthened. This may be achieved, for example, through continued RCCE work with the community and engagement with the government to curb negative social norms that harm children in general, and girls in particular.

<sup>38</sup> Royal Tropical Institute and Ministry of Public Health Afghanistan. *Afghanistan Health Survey 2018*, 2019.

<sup>39</sup> WHO. *The Global Health Observatory. Afghanistan, Mortality*.

<sup>40</sup> USAID. *USAID and Vodafone foundation announce new partnership with the government of Tanzania to expand maternal health emergency transportation system*, 2022.

<sup>41</sup> UNICEF. *Child protection: Protecting Afghanistan's most vulnerable children*.

# VII. Priority implementation research and analytical needs

The GFF recommends that partners develop a dedicated strategy to expand PHC service availability in “white areas” based on updated mapping, efficiency, and sustainability considerations. Activities in this area will include:

- Developing a provincial health system with area-based referral pathways around district hospitals, which integrates all service delivery platforms and vertical health programs from all funding sources.
- Assessing the status of nutrition service delivery, including the role of nutrition counselors in expanding the services in both urban and rural areas. Analyzing the effectiveness of and potential for a scale-up of the urban and nomadic community-based health and nutrition program.
- Comparing various modalities of connecting community health workers’ motivation, remuneration, and awards with their performance.
- Mapping synergies between various community-based groups and platforms (CHWs, shuras, nutrition counselors, social behavior change mobilizers, polio volunteers, vaccinators, and so forth), and assessing their response to the needs of communities.
- Comparing the development processes and actual use of various costing exercises that have been conducted with their impact on PHC funding between 2023 and 2025, including the expected fiscal space.
- Setting up condition-specific referral protocols and defining optimal clinical pathways for high-frequency presentations.
- Producing an innovation strategy (conditional/unconditional cash transfers/ vouchers) for reducing financial barriers to access to essential health services for the most vulnerable, including those living in urban areas, in order to reduce OOP and catastrophic expenditures. Such barriers may include lack of availability or high cost of transportation to health facilities, as well as other indirect costs.
- Developing a strategy for expanding the availability of physicians at the lower levels of the health system.
- Improving health care access for female clients and retention of female staff in the current operating environment.

