Islamic Republic of Afghanistan
Ministry of Public Health
Annual Report 1387

INTRODUCTION:

Afghanistan has taken a devastating toll during the past three decades with the human and socio-economic indicators still hovering near the bottom of international indices. The country suffers greatly from very high levels of Infant Mortality Rate (IMR) at 129/1000 live births, Under 5 Mortality Rate (U5MR) at 191/1000 live births and the Maternal Mortality Ratio (MMR) is estimated at 1600 for every 100,000 live births, the highest in the world except Sierra Leone. By all measures, the people of Afghanistan fare far worse, in terms of their health, than any other country of the region. Human resources (HR) in health have been decimated, leaving behind scarce qualified health professionals, who are predominantly male where it is more difficult to employ qualified female staff in districts/remote areas. Life expectancy at birth (LEB) is 47 years for Afghan men and 45 years for women, slightly more than half that of the wealthiest countries of the world.

The mission of the Ministry of Public Health (MoPH) is to improve the health and nutritional status of the people of Afghanistan in an equitable and sustainable manner through quality HCSs Provision (HCSP) and the promotion of a healthy environment and living conditions along with living healthy life styles.

The main donors that support the health and nutrition sector are the USAID, the World Bank and the European Commission (EC). These 3 donors focus mainly on funding BPHS and EPHS. The main UN Agencies that support health sector are UNICEF, WHO, UNFPA, UNODC and UNAIDS. Also, the Global Alliance for Vaccine and Immunization (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria provide substantial assistance to the health sector. Many other health stakeholders are supporting health sectors and they are governments like, Saudi Arabia, Italy, Germany, France, Spain, Iran, Pakistan, India, United Arab Emirates, Canada, Turkey, Turkmenistan, South Korea, Japan, USA, New Zealand, Estonia and Norway.

CURRENT SCENARIO

Currently, health services are being provided as an integrated package in the BPHS and EPHS facilities, especially maternal and newborn health care and family planning services. Basic essential obstetric care services are provided at Basic Health centers (BHCs), Comprehensive Health Centers (CHCs) and District Hospitals (DHs) and comprehensive essential obstetric care at district and provincial hospitals. These services are currently being delivered in part through contracts for Non-Governmental Organizations (NGOs) overseen by the MoPH. The MoPH, in addition to providing BPHS in 3 provinces and EPHS in 20 provincial hospitals, particularly focuses on providing leadership and governance for the health sector as well as monitoring, evaluation and coordination of the delivery of BPHS by NGOs and donors inputs.

As part of the Afghanistan National Development Strategy (ANDS) the ministry has finalized the Health and Nutrition Sector Strategy (HNSS) for the year 2009-13. MoPH is the lead ministry responsible for implementation of the HNSS. The goal, as defined in HNSS, is to work effectively with communities and development partners to improve the health and nutritional status of the people of Afghanistan, with a greater focus on women and children and under-served areas of the country.

To measure the implementation of the strategy the following table shows the impact level indicators identified by the ministry and the respective targets:

Results	2000 Baseline	Achievement by 2006	High Benchmark 2010	HNS 2013	2015 (Afghan MDGs)
"BPHS will cover at least 90% of the population by 2010"					
Increased access to Primary HCSs (PHCSs) within two hours walking distance	9% of population with nearby access to PHCSs	65% of population with nearby access to PHCSs	90% of population with nearby access to PHCSs	90% of population with nearby access to PHCSs	
"Maternal Mortality Ratio will be reduced by 15%"					
Reduction of MMR	1600 deaths per 100,000 live births		Reduction by 15% to 1360 deaths per 100,000 live births	Reduction by 21% from the baseline (1264)	Reduction by 50% from the baseline (800)
"Infant and under five mortality will be reduced by 20%"					
Reduction of U5MR	257 deaths per 1000 live births	191 deaths per 1000 live births	Reduction by 20% to 205 deaths per 1000 live births1	Reduction by 35% from the baseline (167)	Reduction by 50% from the baseline (128)
Reduction of IMR	165 deaths per 1000 live births	129 deaths per 1000 live births	Reduction by 20% to 132 deaths per 1000 births2	Reduction by 30% from the baseline (115)	Reduction by 50% from the baseline (82)
"Full immunization coverage"					
Increased national immunization coverage with three doses of Diphtheria, Pertussis & Tetanus (DPT) vaccine among children under one year of age	31%	77%	Achieve above 90% coverage	Achieve and sustain above 90% national coverage	Sustain above 90% national coverage
Increased national immunization coverage with measles vaccine among children under one year of age	35%	68%	Achieve above 90% coverage	Achieve and sustain above 90% national coverage	Sustain above 90% national coverage
Source: IMR and U5MR-2006 Afghanistan Health survey showed this target already surpassed.					

OVERALL MINISTRY'S STATUS TO LINK ITS INTERVENTIONS TO THE *ANDS* RESULTS:

The Ministry of Public Health recognizes the need to strengthen the alignment of activities of the ministry to ensure national health targets are met. The MOPH has developed the Health and Nutrition Sector Strategy (HNSS) to expand on the ANDS. While the HNSS provides more detail for the general direction of MOPH, there is still the need to identify and develop specific strategies for major and priority public health concerns. These concerns are identified by more than 18 national health strategies of the ministry.

The development of these strategies, by the ministry, for the priority health concerns is the start of the process to better focus MOPH activities toward greater levels of impact and a realization of the vision and goals for the HNSS.

1 U5MR – 2006 Afghanistan Health survey showed this target already surpassed.
2 IMR – 2006 Afghanistan Health survey showed this target already surpassed

In order to align the existing and upcoming programs/projects of the ministry with the results specified in the ANDS & HNSS, the ministry has adopted an Integrated Strategic Health Planning and Budgeting (ISHPB) approach. The approach allows better organization of the strategies and supports implementation of individual components by strengthening planning and the costing/budgeting of the priority plans.

The process of implementation of the ISHPB approach

The ISHPB model utilizes existing structures and processes of the Government of Afghanistan and MOPH in conjunction with:

- providing a direction and mechanism for introducing meaningful decentralization
- linking the focus of action with the implementation of national strategies
- providing a management tool for implementation planning and monitoring
- including all budget sources – while supporting MOF Program Budgeting structure and terminology
- using GOA accounting codes (aligns with AFMIS in this respect)
- and will eventually contribute to the start of National Health Accounts development/SWAp/etc.

Progress made in implementation of the ISHPB

The ISHPB links both the central directorates with the strategic planning and implementation level of the MoPH, the Provincial Public Health Directorates, with all planned activity focused on the use of energy and resources to achieve greater impacts on the health and wellbeing of the community.

The result will be a mutually agreed and costed 5 year strategic plan. Having developed this 5 year strategic plan, further negotiation will produce an agreed and costed Annual Operational Plan (AOP). Centrally, the various contributing provincial plans will be consolidated to form a national MoPH strategic health plan and estimated budget of which AOPs will be extracted for the coming year. Implementation will commence following Government of Afghanistan (GOA) approval of the budget.

Successful introduction of the approach at the central level and across 34 provinces is a significant task. The MOPH has already commenced this initiative with the full support of the executive and other key decision makers.

THE HEALTHCARE FINANCING:

Beginning of Programme Budgeting

Program Budgeting is a central element in the drive to make the Ministry of Public Health financial management system more transparent, accountable, effective, and responsive to the real felt needs. It is a tool assuring better linkage between the MoPH strategic objectives and policy priorities, as streamlined in the ANDS & HNSS, with the annual budget prioritizing the allocation of available funds to where they are most needed as well as integrate operating and development budgets. In other words, program budgeting displays information in a way that provides clear linkages between budget resources and the policy outcomes the Government wants to achieve. It is a budget process that allocates resources to programs that have clearly specified objectives and/or results to be achieved from those resources. As well said, the MoPH priority functions are classified into main programs involving; infrastructure assessment and development, health services provision, and administrative support. Each of these programs is further broken down in terms of other minor key functions termed sub programs and activities spelt out as development projects. According to this initiative, there are clear objectives and performance indicators specified as outcome indicators at the level of programs and output indicators at the level of sub-programs. The amount devoted to the budget for the MoPH based on program budget for the year 1387 was amounting for 110 million USD which corresponds to development budget, and 27.5 million USD for the operating. Therefore, the integration of these two

budgetary pieces totaling for 137.5 million USD projects the overall program budget of the MoPH approved for the year 1387.

Programme Costing Exercise

As per the requirement and prerequisites to Paris donors' conference, the Ministry of Public Health developed a five-year strategic costing document amounting for 2.4 billion dollars to be presented at that event. This costing was developed based on program structure of this ministry in a smooth alignment with the ANDS benchmarks for the Health & Nutrition sector strategy. As per the results of this conference and the feedback provided by the Ministry of Finance (MoF), the MoPH costing document was one of the few which got finally supported towards the value it was amounted for.

Progress in the Establishment of a National Health Account

As in most low-income countries in South Asia, household out-of-pocket expenditures are by far the largest source of financing, with an estimated 70-80 per cent of a total health spending of around 45 dollars per capita. The total public financing for the health sector has increased by 54 percent between 2003 and 2008, from USD 163.6 million to 277.7 million. Public spending on health in Afghanistan remains however low, under 3 percent of GDP: 2.9 percent in 1386 (2007/2008) and 2.7 percent of 1387 (2008/2009), comparable with other low income countries in the region. The total per capita public expenditure on health has increased from 8 to 10.92 dollars between 2003 and 2008. In the absence of reliable recent census data, these data must however be taken with caution. The further establishment of National Health Accounts will assist the Government of Afghanistan to further examine the overall health financing situation in the country.

In March 2009, the Ministry of Public Health has adopted a historic step which is establishing the system of National Health Account (NHA). The Health Economics and Financing Directorate of the MoPH (under General Directorate Policy and Planning) is mandated to fully launch this initiative within a course of two years. NHA is a tool aimed primarily at policy makers to enable better-informed decisions regarding health planning, management, financing, and monitoring. NHA describes the sources, uses, and flow of funds – both by public and private entities – within the health sector.
As for now, the MoPH has hired a NHA Coordinator as well as two NHA Team Members who will design and implement the NHA. In the meantime, the Health Economics and Financing Directorate (HEFD) developed a NHA Workplan to develop NHA. Further, the HEFD organized the first NHA Steering Committee in April 2009 presenting NHA concepts to various relevant stakeholders, i.e., Central Statistic Offices, different Ministries, MoPH's Directorates and Development Partners. The NHA SC aimis at serving as a resource to the technical team (NHA Coordinator and 2 NHA Team Members under the Health Economics Unit) , particularly with respect to facilitating data collection from agencies represented in the steering committee.
The Inception Period has not been completed yet. The NHA Team will be trained in the next months. In addition to training activities, the Health Economics Unit still needs to advocate and raise awareness among the various concerned stakeholders, to facilitate data collection processes, as well as the use of the NHA Report, as a tool for better resource allocation and policy priorities.
In the coming year the NHA Technical team should focus on the following activities:

- A situation analysis (i.e., determining the flow of funds and making an inventory of the available data sources)
- Data collection process, including the assessment of current data collection, tool (e.g., NRVA, Household Survey, Grant Database Management, HMIS) and necessity of designing surveys to collect missing data, e.g., the HEF Directorate is currently trying to include Health Expenditures related questions into the UNICEF MICS Survey.
- Data Entry and Collection
- Data Analysis and NHA Report writing and submission to the NHA SC
- Dissemination of the Report
- Set up of a central repository (in the Ministry of Health) of all NHA tables, datasets, linked files, and protocols.
- Implementation of NHA Results: Implement recommendations from the Final NHA Report

- Institutionalization of NHA by closely working with the Central Statistic Office and presenting NHA Results at NHA Symposium.

A short projection of the core budget implementation "at a glance" and impediments towards expected core budget implementation in the Ministry of Public Health for the year 1387 (March 2008-March 2009)

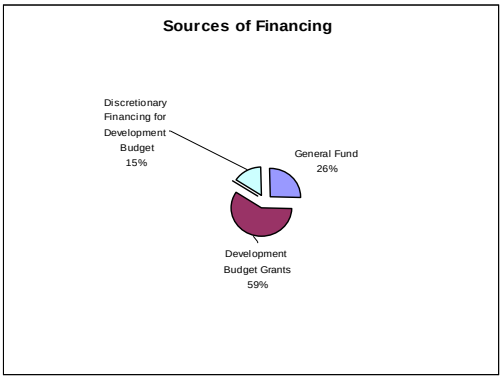
Figures in million USD

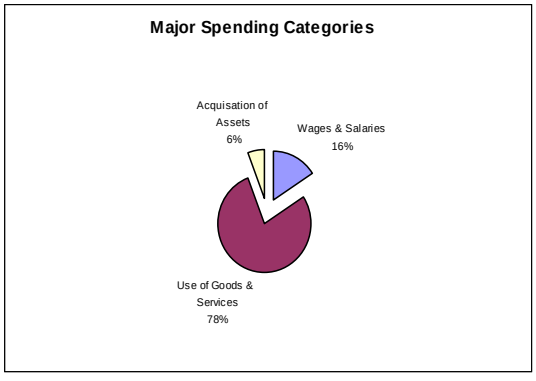
Start of the year approved budget	57, 3
Mid year approved budget	110, 57
Budget accessible	106, 5
Total allotments disbursed	75, 3
Total expenditure rate on the basis of allotments	87%
Total expenditure rate on the basis of total budget	59%
Total expenditure rate on the basis accessible budget	61%

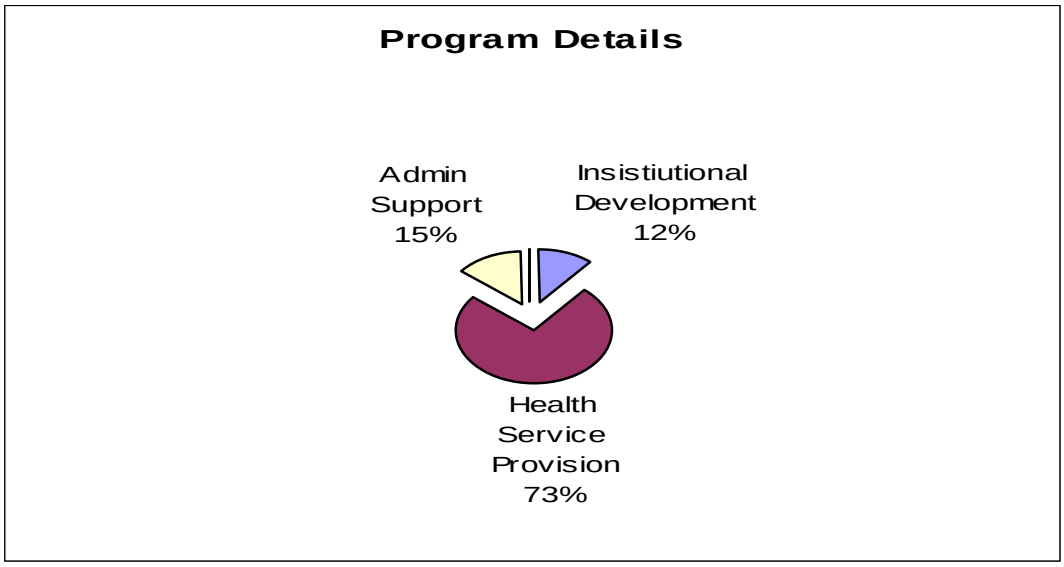
Common impediments towards expected budget implementation rate:

- A delay of nearly 4 month was caused by carry forward budget amounting 48 million dollars being transferred to the Ministry of Public Health (MoPH) account in the fourth month of the fiscal year.
- An amount of 20 million dollars under the (grant Ho43) from the World Bank had to been channeled to the MoPH account set in the Ministry of Finance (MoF) via a new account which almost took 3 months.
- Updating coding system in the Afghan Financial Management Information System (AFMIS) in the MoF posed a delay of almost one month in payments release.
- Unavailability of physical cash in HSS project of the MoPH in Da Afghanistan Bank in Kabul for a period of two months.
- Unavailability of physical cash in code 20000 of the MoF treasury for almost one month.
- Security constraints in the southern and bordering provinces to Pakistan where a number of construction projects are implemented.
- A sum of 4, 5 million USD as committed by multiple donors was not funded.
- Unavailability of money in contingency code in the MoF posed a delay of nearly one month to the normal budget implementation rate.
- An increase in the budget of already approved projects in particular construction projects of the MoPH in the budgetary mid year review session which got effective on the 9th month of fiscal year put an unnecessary load and so delayed the implementation of the project and as well budget execution furthermore.
- As per the revised procurement law of Afghanistan, a process of adaption taking place in the both MoF and the MoPH delayed the normal budget implementation process.

A break down of core budget management and execution







ACHIEVEMENTS TOWARDS THE EXPECTED OUTCOMES:

Multiple source of information has been used to analyse the progress made in the health sector of Afghanistan. Information on performance in the delivery of Basic Package of Health Services (BPHS) has been presented from the National Health Services Performance Assessment (NHSPA) conducted annually by a third party and presented in the Balanced Scorecard (BSC) framework. NHSPA is a health facility survey conducted once every year to provide information on patient, community staff perspectives, capacity for service provision, service provision, financial systems and overall vision. Information on indicators of coverage of health services have been discussed from the various household surveys conducted in the past years, namely, Multi Indicator Cluster Survey 2003 (MICS), National Risk and Vulnerability Assessment 2005 (NRVA), Afghanistan Health Survey 2006 (AHS). In addition, information from the routine reporting system has been discussed, for some indicators, to compare results and provide update information on progress.

Results are presented below, based on the outcomes defined in the HNSS.

Expected Outcome #1- Improved and equitable access provided to quality primary, secondary and tertiary health care

According to the developmental plan, BPHS has been expanded to reach 85% of the districts have been covered under contracted coverage On the other hand the Afghanistan Household Survey (AHS) conducted in 2006 shows that only 65 percentage of population has access to a primary health care facility within two hours of walking distance. To improve coverage and reducing the distance for accessing health services, sub-centers and mobile centers are identified as logical approaches and in this regard from total of 312 planned sub-centers, 291 have been established while 21 are under the process of establishment. Additionally 54 new mobile health centers have commenced services.

A number of the existing health centers have been upgraded to provide higher levels of service. Currently, in addition to more than ten thousand health posts, there are 1,688 health facilities that include sub-centers up to national hospitals.

Within the new structure of the Emergency Preparedness and Response Department, 12 additional centers, for reporting diseases and suspected prevalence of disease, have been established in the country. With establishment of these centers, the total number of Disease Early Warning System (DEWS) centers in 34 provinces of the country increased to 131 centers almost all of which were established during 1387.

The NHSPA shows that considerable progress has been achieved across all domains between 2004 and 2008. The average performance of indicators in the overall vision domain measuring pro-poor and

pro-female provision of health services has improved by 1.5 percentage points, indicating slight improvement. Average performance in the service provision domain has increased considerably in the past five years, from 41.4% to 68.2%. Indicators on provision of antenatal, delivery care and outpatient volume at BHCs showed considerable improvements, since 2004.

The capacity for service provision domain has shown the largest average increase since 2004, with a gain of 27.9 percentage points. Particularly large gains have been made in the past five years in meeting minimum staffing levels at health facilities, availability of family planning supplies, and completeness of health information system and presence of clinical guidelines, refresher training for staff, lab functionality, and presence of a TB register.

Expected Result #2: Improved Reproductive and child health care services

Reproductive and Child health care is one of the top priorities identified in the HNSS, where the maternal mortality ratio (1600/100,000 live births) is one of the highest in the world, as assessed by an independent study conducted by CDC and UNICEF in 2002. At that time, only 9% of women were assisted by a SBA, 8% of women received antenatal care, 10% of hospitals provided caesarean sections, and one third of women were vaccinated against tetanus.

In 2000, the infant mortality rate in Afghanistan was estimated to be 165 per thousand live births and the under-five mortality rate was estimated to be 257 per thousand live births. The AHS estimated the infant mortality rate in Afghanistan to be 129 per thousand live births and the under-five mortality rate to be 191 per thousand live births. These estimates provide evidence that infant and child mortality has decreased in Afghanistan in recent years.

Progress made on some of the other indicators, discussed below, show that tremendous efforts have been made in the delivery of health care and that progress has been made towards reducing maternal and child mortality.

Skilled Antenatal Care

As measured in the AHS, slightly over 32% of the respondents who were pregnant in the last 2 years saw a skilled provider, at least one time during a woman's most recent pregnancy. Seventeen percent (17%) of respondents saw a traditional birth attendant and 51% did not see anyone for their pregnancy. Thirty nine percent (39%) of respondents who lived less than 2 hours from a health facility received skilled antenatal care compared to 8% of respondents who lived more than 6 hours away from a facility. Trends in antenatal care use in rural Afghanistan show a several-fold increase from 5% in the MICS 2003 to 32% in the AHS 2006.

Skilled Birth Attendants

Use of skilled birth attendants was substantially lower than use of skilled antenatal care, but a threefold increase is observed in rural Afghanistan, from 6% in MICS 2003 to 19% in AHS 2006. Women who live less than 2 hours from a health facility were almost twice as likely to receive assistance from a skilled birth attendant compared to women who live between 2 and 3 hours from a facility (26% of respondents living within 2 hours used skilled birth attendants compared to 15% of respondents living between 2 and 3 hours from a facility).

According to the recent figures from HMIS, there is an increase of 5% in the number of Skilled Birth Attendance. 31% of the total deliveries reported on HMIS were conducted by a skilled professional in the year 1387.

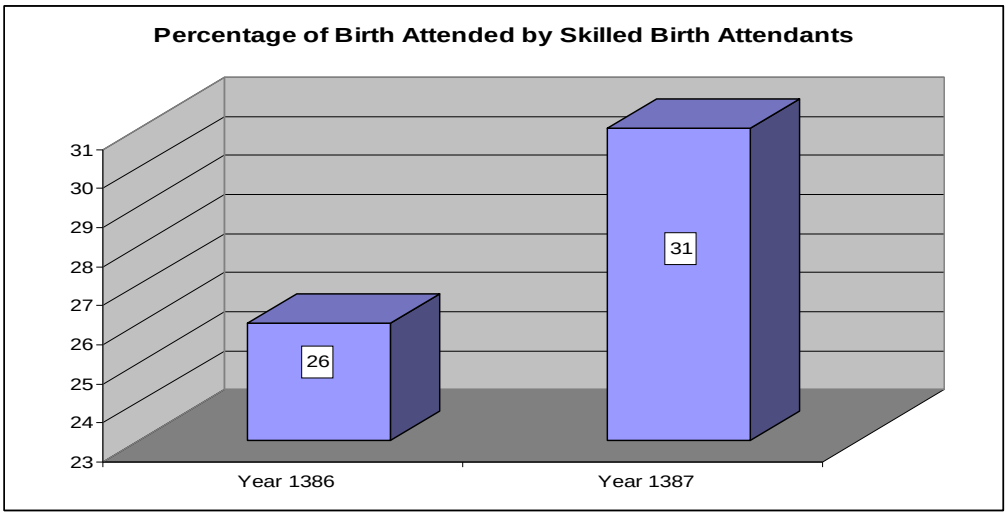


Figure 2: Percentage of Skilled Birth Attendants. Source: HMIS

Institutional Deliveries:

Overall approximately 15% of women who had delivered in the last two years had their delivery in an institution. Younger women (less than 20 years of age) were slightly more likely to deliver in an institution (19%) compared to women in other age groups (13%-14%). Thirty percent (30%) of women who had some schooling delivered in an institution compared to 14% of women who had no schooling. Twenty percent (20%) of respondents living less than 2 hours from a facility had an institutional delivery compared to less than 1% of respondents living more than 6 hours from a facility.

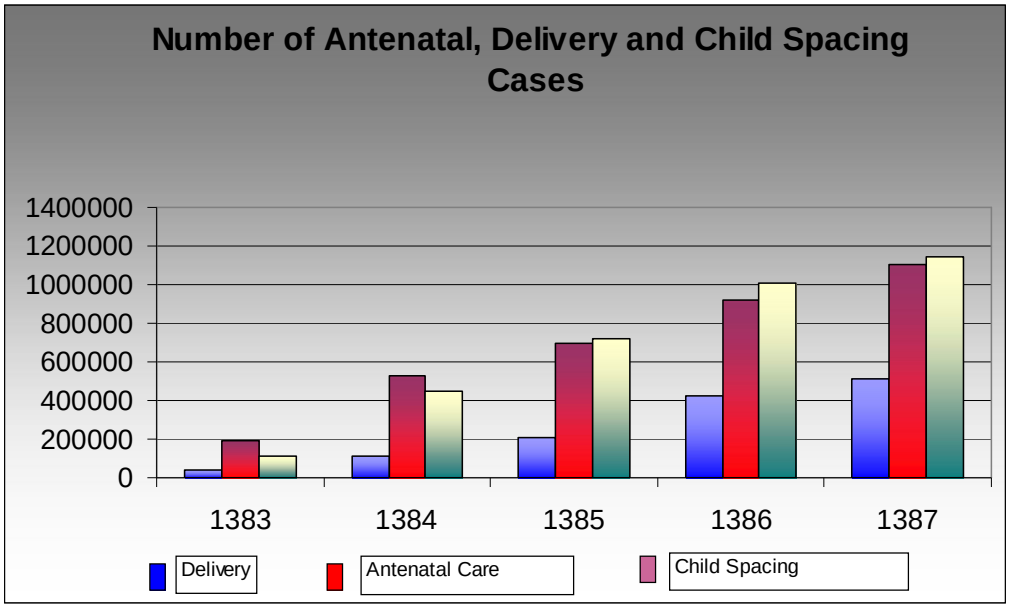


Figure 3: Number of Antenatal, Delivery and Child Spacing Cases. Source: HMIS

Contraceptive Prevalence Rate

As measured in the AHS, 33% of currently married women in the sample demonstrated knowledge of at least one modern method. Current use of at least one modern contraceptive method was 16% by currently married women. Comparisons of contraceptive prevalence in rural Afghanistan were made between estimates from the 2003 Multiple Indicator Cluster Survey (MICS 2003), the 2005 National Risk and Vulnerability Assessment (NRVA 2005) and AHS 2006. There has been a threefold increase in use of modern contraceptives in rural Afghanistan, from 5% in the MICS 2003 to 16% in the AHS 2006.

Immunization coverage

Estimates from household survey for DPT3 and measles coverage are 34.6 and 62.6 percent respectively. Caution should be used in interpreting the estimates form the household survey. DPT is only given through the routine health care system and involves 3 doses, which makes it difficult for a respondent (mother) to remember whether her child actually received all the doses in the absence of an immunization card (only 17% cards seen). In absence of a card to verify the number of doses it gets difficult for the respondent to recall the number of doses received. At the same time, measles is easier to remember as it is only 1 dose and can be given through campaigns. The estimates for measles, which follows the third dose of DPT in the EPI schedule, are higher than the DPT3 estimates.

Measles coverage is at 63%, higher than DPT3, which likely indicates some effect of measles campaigns. Full immunization is considerably lower (27% percent), being largely a function of low DPT3 coverage. Slightly over 14% of children between 12-23 months of age received none of the antigens in the Expanded Programme on Immunization.

Analysing the trends in immunization coverage show that BCG coverage increased by almost 15 percentage points from 2003 to 2006. Polio (OPV3) coverage increased from 30% to almost 70%. This large increase from 2003 to 2006 can be attributed to both the rebuilding of the health system and sustained campaigns by MOPH, WHO, UNICEF and other partners. Measles coverage was lower in 2006 compared to 2003. One of the main reasons for this decline was a nationwide measles campaign conducted before the MICS in 2003. Full immunization, while increasing over the years, is considerably lower than coverage of the individual vaccines, due to the low estimated coverage of DPT3.

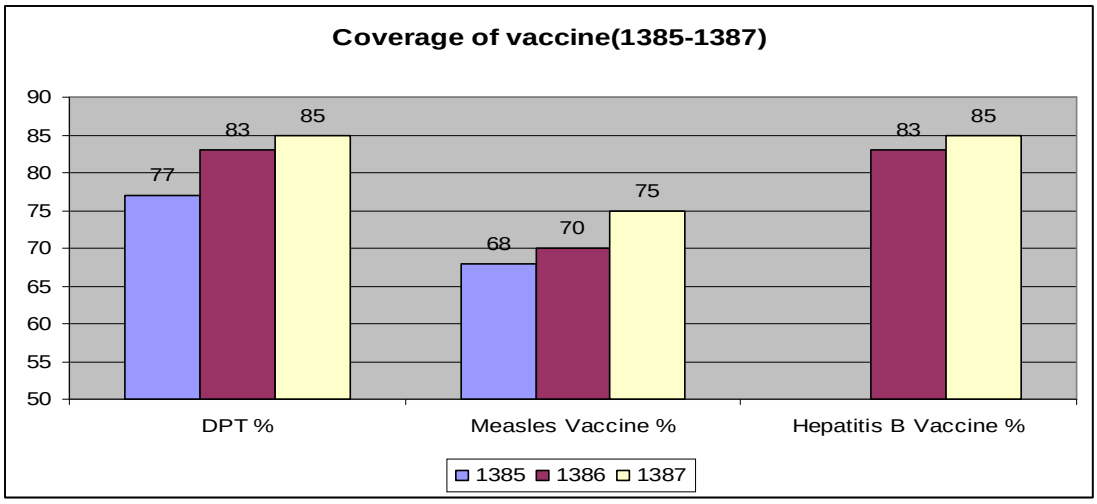


Figure 1: Vaccination coverage by year. Source: EPI report

Additionally, based on the information from routine reporting system for immunization, the coverage of measles vaccine reached 75% while that of tetanus toxoid in pregnant women attained 65% during the period. The routine coverage of DPT-Hep B3 vaccine reached to 85% in 2008. These results are a clear indication of improvement in provision of immunization across the nation.

Expected Result #3 - Spread of Communicable diseases arrested

Communicable Diseases Control

Control of Tuberculosis:

Tuberculosis case detection has increased to 73% in 2007 while the global target till end of 2010 is 70%. Case management success rate touches 90% comparing to global target for end of 2010 that is 85%. Only 537 health facilities were providing tuberculosis diagnosis and treatment services in 1383 but

by the end of 1387 this number has been increased to 1,031. As a result, mortality and morbidity due to this chronic and potentially fatal disease has decreased more than 50%.

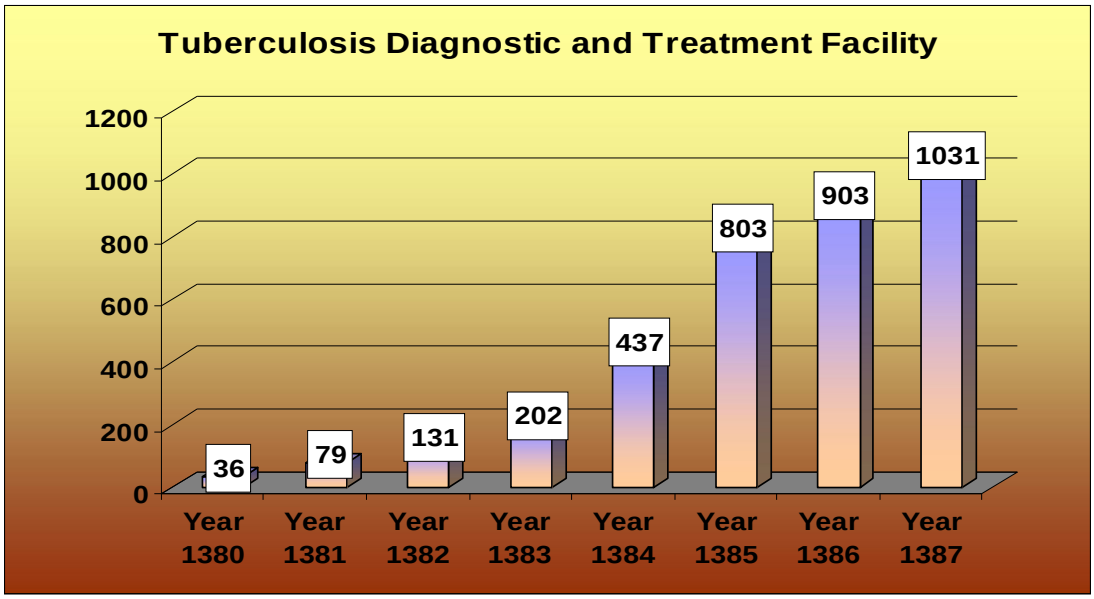


Figure 4: Number of TB diagnostic and treatment facilities

Control of Malaria:

There has been good progress for malaria control by MoPH and partners since 2007. As per the information collected from the routine reporting system at present, there are 1,180 health centers that can diagnose, treat and report malaria. This year, more than one million long term impregnated nets were distributed, which helped bringing the cases of cerebral malaria down by 86% and normal malaria cases by 79%.

Expected Result #4 - Nutritional status of people improved

Child Nutrition:

Seven new therapeutic feeding centers for severe malnutrition were inaugurated in 1387 bringing the total number of Therapeutic Feeding Centers to 44 across the nation. A total of 4,781 malnourished children are being treated in these centers. Other nutrition focused interventions include evaluating the nutritional status in the community, a total of 4,967,123 persons have been screened.

Among children 6-59 months old, 77% received Vitamin A supplementation within the last six months. Vitamin A is often given during polio campaigns with polio vaccine, so the levels of Vitamin A coverage often coincide with levels of polio vaccine coverage (70% for OPV3). Vit-A and Polio campaign not OPV3 which is routine not campaign

In the AHS, (which year) the number of children between 0-5 months of age was small (636 children), 83% were reported to have received only breast milk in the last 24 hours. There is anecdotal evidence that infants in Afghanistan are frequently given tea or maska (butter) soon after birth. The high percentage of exclusive breastfeeding belies the anecdotal evidence of supplemental liquids/solids commonly being given to infants. Some mothers may not consider tea or maska as supplemental foods, and thus may not have reported giving these items to their infants. To the extent that this occurred, the estimated proportion of children exclusively breastfed in the last 24 hours would be artificially high.

After a child turns six months, it needs additional food beyond mother's breast milk. The percentage of children 6-9 months of age that received liquid and solid food in addition to mother's breast milk in the last 24 hours (when) was approximately 28%. Given the low prevalence of complementary foods given to children 6-9 months of age, as measured in the AHS, there is some concern that infants 6 months

and older are not being appropriately fed. There is no evidence that these feeding practices differ significantly by the sex of the child.

Expected Result #5- Administrative and Finance reforms implemented to support delivery of health care services

Human Resources, Capacity Building and Counter Corruption

This year, 3,543 employees of MoPH have been recruited through competitive process. This brings the total number of PRR'ed positions to 6,021. Capacity building workshops and courses were conducted in the capital and provinces for building capacity and skills of professional and admin staff of hospitals and different agencies. As a result 7365 individuals gained required training through these courses and workshops.

As inadequate number of female personnel is a major challenge for the ministry, hundreds of female health staff including doctors, nurses, midwives and community midwives were newly trained, most of whom were hired in MoPH health system and the rest have been employed in NGOs. Additionally, 19,975 community health workers (CHWs) have been trained in 34 provinces of the country. Of these 50.8 % of them are male and the rest of 49.2 % are female CHWs. Meanwhile, 13,188 health Shuras (councils) have been established.

In regards to administrative reform program, MoPH pursues recommendations of Independent Administrative Reform and Civil Service Commission pertaining to transparency of practices. A Reform Implementation Management Unit (RIMU) was set up in 1387 (January 2009) in MoPH. RIMU so far has reviewed the policy of MoPH, structure (organogram) of MoPH, job descriptions and job classifications. Several training has been conducted for the staff of Human Resources Department of MoPH as part of capacity building.

In 1387 around 3500 medical and non-medical personnel were recruited based on merits and through transparent and competitive process.

BPHS implementers are evaluated by an impartial third party. Violation of regulation or standards is taken seriously and suspected cases of abuse are referred to the related authorities immediately.

69 financial cases were investigated in 1387, of which under the order of the Minister 11 cases were referred to the attorney general of the Islamic Republic of Afghanistan.

Through the demonstration of sound management systems and practices including expressing transparency, MoPH succeeded in attracting more than $US236 million in grants from USAID directly through the Afghan government.

Expected Result #6 - Institutional development and evidence based decision-making strengthened

Developing policies, strategies, guidelines and regulations:

Around 55 policy documents, regulation papers, strategies, bills, guidelines, and standards have been developed or revised. The national Afghan drug formula was finalized while a new list of national essential and authorized drugs was revised based on the formula.

Coordination, Communication, Health Education and Publications

A Public Relations Department has recently been established in the organizational structure of MoPH. For the purpose of coordination and establishing relations, MoPH conducts coordination meetings such as Consultative Group on Health & Nutrition (CGHN), Inter Ministerial Committee, National Technical Coordination Committee (NTCC), an Executive Board, Provincial Public Health Coordination

Committee, NGOs Coordination Groups and Technical Round Tables. The MoPH active website has an important role in this regard.

23 national and international days have been celebrated, thousands of communication brochures have been printed and distributed, a significant number of radio and TV health spots and programs have been prepared and broadcasted.

Conducting 1387 MoPH Results Conference, Strategic Health Planning Retreat Conference, and National Health Coordination Workshop are among the important activities in connection of further strengthening coordination.

Active participation of MoPH in the reporting process of Afghanistan to Human Right's Council of the United Nations in Universal Periodic Review Mechanism and active participation in preparation of Afghanistan Child Rights Report for Human Right's Council of the United Nations were other accomplishments.

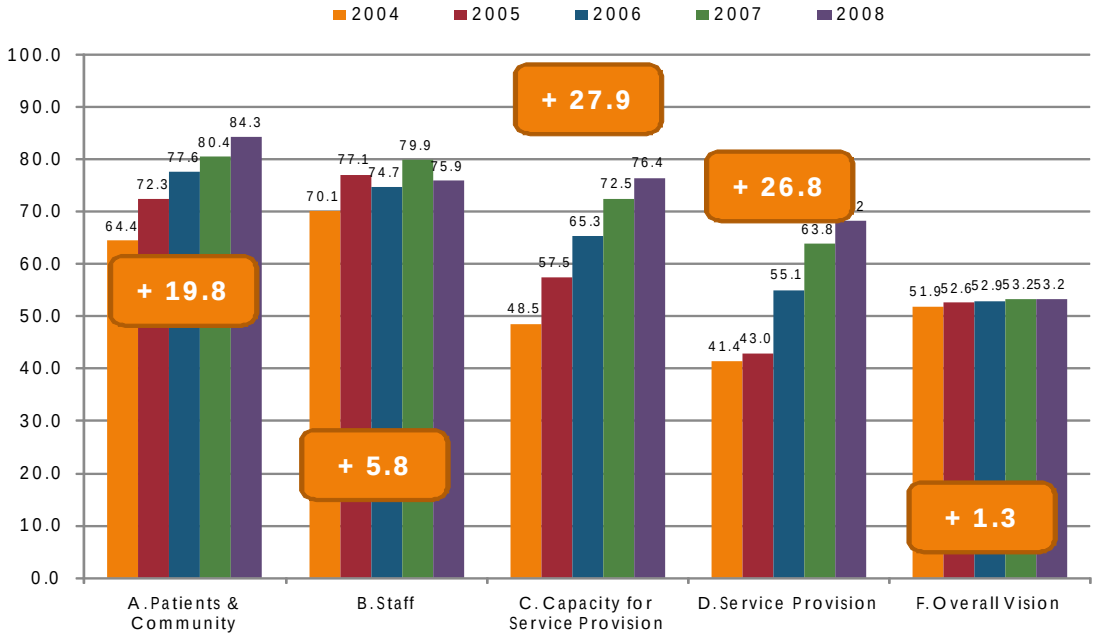


Fig 5. Overall Progress on different domains as measured in the Balanced Scorecard

BOTTLENECKS/CONSTRAINTS (TECHNICAL & POLICY LEVEL):

- Inadequate number of experts both technical and administrative at all levels including central and provincial
- Inadequate number of health workforce at health facility level, especially female personnel in remote and insecure areas
- Inadequate financial resources for funding routine projects and activities, especially in those facilities that are funded through governmental budget
- Salary discrimination and the risk of corruption
- Inadequate coordination among different sectors for the health sector
- Approval of budget based on the decision of MoF without consideration of MoPH programs and plans
- Security challenges
- Inadequate public utilities such as power, water all over the country

Recommendations/Solutions:

- Ministry budget should be allocated according to real needs and programs of MoPH.

- Better coordination among different sectors and partners to strengthen health care service delivery
- Cash payments should be transferred to the ministry according to the allocated budget on timely manner.
- Further facilitation of procurement system