PUNCTUAL POLICY ADVICE

“POSSIBILITIES FOR THE IMPROVEMENT OF REPRODUCTIVE HEALTH CARE IN AFGHANISTAN”

15 September till 15 November 2002

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DGIC
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<tbody>
<tr>
<td>AACA</td>
<td>Afghanistan Assistance Coordination Authority</td>
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<tr>
<td>ACF</td>
<td>NGO Action Contre la Faim</td>
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<td>AHDS</td>
<td>NGO Afghan Health and Development Service</td>
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<td>AIA</td>
<td>Afghanistan Interim Authority</td>
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<td>AMI</td>
<td>NGO Aide Medicale Internationale</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>ANHRA</td>
<td>Afghanistan National Health Resources Assessment</td>
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<td>AREU</td>
<td>Afghan Research and Evaluation Unit</td>
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<td>ARTF</td>
<td>Afghanistan Reconstruction Trust Fund</td>
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<tr>
<td>CDC</td>
<td>Centre for Disease Control</td>
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<tr>
<td>CHA</td>
<td>Afghan NGO Coordination of Humanitarian Assistance</td>
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<td>DFID</td>
<td>Department For International Development, United Kingdom</td>
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<td>DGIC</td>
<td>Directorate-General for International Cooperation, Belgium</td>
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<tr>
<td>EC</td>
<td>European Commission</td>
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<tr>
<td>ECHO</td>
<td>European Commission Humanitarian Office</td>
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<td>EOC</td>
<td>Emergency Obstetrical Care</td>
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<td>EU</td>
<td>European Union</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>HIS</td>
<td>Health Information System</td>
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<td>HNI</td>
<td>NGO Health Net International</td>
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<td>HOPE</td>
<td>NGO Hope Worldwide</td>
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<td>HRW</td>
<td>NGO Human Rights Watch</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development, Cairo 1994</td>
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<tr>
<td>ICPD+5</td>
<td>5-year Review and Appraisal of Implementation of the ICPD in 1999</td>
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<tr>
<td>ICRC</td>
<td>International Committee of the Red Cross</td>
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<td>ICRH</td>
<td>International Centre for Reproductive Health, University Ghent</td>
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<tr>
<td>IFRC</td>
<td>International Federation of the Red Cross and Red Crescent Societies</td>
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<tr>
<td>IMC</td>
<td>NGO International Medical Corpse</td>
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<tr>
<td>ISAF</td>
<td>International Security Assistance Force</td>
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<tr>
<td>ITAP</td>
<td>Immediate and Transitional Assistance Programme for the Afghan People</td>
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<tr>
<td>IUD</td>
<td>Intra Uterine Device</td>
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<tr>
<td>JDM</td>
<td>Joint Donor Mission</td>
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<tr>
<td>JHPIEGO</td>
<td>a non-profit organization affiliated with the John Hopkins University</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>KAP</td>
<td>Knowledge, Attitudes and Practices</td>
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<td>MCH</td>
<td>Mother and Child Health</td>
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<td>MDM</td>
<td>NGO Medecins Du Monde</td>
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<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MoPH</td>
<td>Ministry of Public Health</td>
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<td>MSH</td>
<td>NGO Management Sciences for Health</td>
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<td>MSF</td>
<td>NGO Medecins Sans Frontieres</td>
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<tr>
<td>NDF</td>
<td>National Development Framework</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organisation</td>
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<td>OPD</td>
<td>Out Patient Department</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PHR</td>
<td>NGO Physicians for Human Rights</td>
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<td>PPA</td>
<td>Performance based Partnership Agreement</td>
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<td>RAMOS</td>
<td>Reproductive Age Mortality Survey</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>RTI</td>
<td>Reproductive Tract Infections</td>
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<td>SCA</td>
<td>NGO Swedish Committee for Afghanistan</td>
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<td>SCF</td>
<td>NGO Safe the Children Fund</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>TAPA</td>
<td>Transitional Assistance Programme for Afghanistan 2003</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>UNAMA</td>
<td>United Nations Assistance Mission for Afghanistan</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNIFEM</td>
<td>United Nations Development Fund for Women</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNMAS</td>
<td>United Nations Mine Action Service</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>VLIR</td>
<td>Flemish Inter-University Board</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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EXECUTIVE SUMMARY

I. INTRODUCTION

The extremely poor reproductive health situation in Afghanistan is widely known. Mortality and morbidity rates for women and children are amongst the highest in the world. The needs regarding reproductive health care are enormous. However the improvement of reproductive health care is not an easy objective. A socially integrated and culturally well-accepted approach is essential for any initiative in the reproductive health care sector.

The Belgian cooperation committed itself to contribute to the improvement of the political, economic, social and cultural rights of Afghan women over the coming five years. In this perspective, the Belgian cooperation emitted an appeal through the VLIR (Flemish Inter-University Board) for a policy advice regarding the "Possibilities for the improvement of reproductive health care in Afghanistan". In response, a reproductive health study took place between 15 September and 15 November 2002 and has been implemented by the International Centre for Reproductive Health, Ghent University in collaboration with IbnSina, an Afghan NGO.

This document is the final and global report of this reproductive health study. Another report is available with the results of the study on Knowledge, Attitudes and Practices (KAP) regarding reproductive health, performed in October 2002 in the city of Kabul. This report is to be found in annex 4 of this document.

II. SITUATION ANALYSIS: REPRODUCTIVE HEALTH CARE IN AFGHANISTAN

The maternal death rate is estimated to be among the highest in the world, indicating that poor maternal health is a major problem in Afghanistan. The maternal mortality ratio was recently estimated at 1.600 maternal deaths per 100.000 live births (UNICEF 2002). It is estimated that every day 45 women die of pregnancy related causes in Afghanistan, resulting in over 16.000 maternal deaths every year. Afghanistan may well be the most risky place in the world for a woman to become pregnant. This high maternal mortality is related to many factors including early marriage, lack of education, lack of pertinent information on reproductive health, low-quality obstetric and gynecological care, and inadequate child spacing.

In Afghanistan, discussions about reproductive health are fairly reduced to Safe Motherhood and Family Planning issues. Reproductive health is a far larger concept and other topics deserve some attention too.

- Women do have a lot of pregnancies with little or no gap between their pregnancies (average fertility rate estimated at 6.9). The contraceptive prevalence rate is estimated at 2%. There is an unmet demand for family planning services as well as for information, education and communication regarding family planning.

- Only 30% of the primary care facilities are able to provide basic mother and child services.

- Of Afghanistan’s 32 provinces, only 11 currently have the capacity to deliver comprehensive emergency obstetrical care. Only 17 of the country’s 174 hospitals can practice caesarean sections. The number of caesarean sections is far too low. Our KAP study showed that only 1.6% of the interviewed women delivered through caesarean section. The minimal international acceptable level (according UN guidelines) sets that caesarean sections should account for 5 to 15% of all births.

- Even if there are no accurate figures available, Reproductive Tract Infections (RTIs) represent about 1.5% of all cases at out patient departments officially reported over 2001.
The level of knowledge about Reproductive Tract Infections / Sexually Transmitted Infections (RTI/STI) is extremely poor. Most of the health care providers deny the existence of HIV/AIDS in Afghanistan and are not aware of any threat of HIV/AIDS. Currently, about half of the 44 hospitals performing surgery have no means of testing blood for infectious diseases such as hepatitis or HIV.

- Harmful practices, such as honour killings and early / forced marriage are widespread. Little is known on violence against women, but it is surely an issue in Afghanistan.
- Both adolescent girls and boys have limited knowledge about puberty, their bodies, sexuality and reproductive health.
- Infertility is a serious problem since a women’s status or value to her family is often defined in terms of her fertility and particularly to her ability to bear sons.
- Induced abortion is illegal in Afghanistan. Nevertheless unconfirmed reports on induced abortion exist.
- No screening program exists for breast, uterus or other cancers. Screening programs would anyway be quite inappropriate since there is, at the moment, no health facility in Afghanistan to treat adequately reproductive tract cancers.

The bad reproductive health situation is worsened by the weak social position of the Afghan woman, limited freedom of movement for girls / women, and disrespect for human and women’s rights, among other factors.

The health care sector currently does not have sufficient capacity to cope with this dramatic reproductive health situation. The health infrastructure is in a desperate status after more than two decades of war. Only 30 - 40% of the population have access to some health service. The situation is much worse in rural areas, since the majority of the health facilities are located in urban areas. Many of the public health care facilities are, in fact, non-functional due to lack of supplies or equipment, lack of structural integrity and the absence of trained health care professionals.

Human resources are currently lacking in different ways:
- Quantity, particularly of technicians, nurses and health workers. This is especially valid in rural areas.
- Quality, because of obsolete teaching programs, poor training system and the virtual absence of in-service training
- There is a strong urban bias in the availability of health care providers, more than 50% of all doctors (2175 to 2900) being in Kabul, serving less than 12% of the population.
- Nurses, midwifes and community health workers are short in most area - more even than doctors.
- In Afghanistan reproductive health services rely almost completely on the availability of female health staff, since women can only be attended by female staff. Nevertheless female health workers are a minority. 40% of all health facilities do not have women in their staff.

The critical lack of female qualified health providers is the main limiting factor to quickly expand reproductive health services in Afghanistan, especially in rural areas.

Nevertheless the current situation of Afghan cities with many inadequately trained doctors, working in inefficient public hospitals and in private clinics – and of the rural areas with few and low qualified health staff, is likely to continue over the coming years.

The Ministry of Public Health (MoPH) only reopened in 2002. It had basically to start from scratch with little resources. Generally the MoPH is considered as weak. There are also few links between the central MoPH and the other provinces outside Kabul.

Early 2002, the Ministry of Public Health established a national health policy, which focuses on equitable access to health care, based on a Primary Health Care concept. An essential package of services has been defined to be made available throughout the public health system in the country.
The basic service package defines the essential interventions that should guarantee universal coverage through public (plus donor) funding.

In April – May 2002 an Afghanistan National Safe Motherhood Strategic Framework was developed by the MoPH and UNICEF. It focuses on 3 axes:
- To improve the coverage, utilization and quality of emergency obstetric care
- To improve the coverage of skilled attendance at birth
- To ensure effective antenatal care for all women

The national policy corresponds to the current health needs in Afghanistan and presents a valid basis for future reconstruction of the health care sector. In the same time, it outlines the general principles for international aid in the health sector.

III. RESPONSE ANALYSIS: INTERNATIONAL AID

EXTERNAL AID IN GENERAL

There are many background issues hampering the reconstruction efforts of the international community:
- Security and political stability are the cornerstones of any reconstruction process. Though immense progress has been made, Afghanistan is still far away from being a state of law and order and “peace” is a fragile word. Insecurity is still a problem in many parts of the country.
- Afghanistan is not yet a united “nation”. Most of the decisions made in Kabul by the individual ministries have little influence outside Kabul city and surroundings.
- The country’s social and economic indicators are comparable or lower than for sub-Saharan Africa. A large proportion of the population is estimated to live below the poverty threshold. The Afghan economy has been destroyed by 23 years of conflict. Afghanistan has been affected by the most severe drought of living memory during three consecutive years. Most of the Afghans depend on a “survival” economy.
- Many Afghans have unrealistic expectations towards the international community and expect the world to reconstruct the entire country.
- The end of the drought, access to water, food, employment and education are as essential for the Afghans as health.

In late 2001 and 2002, after years of abandoning, the international community has made a quite substantial contribution to the Afghan people. The architecture of the International Aid was set at several International meetings. During the Ministerial Meeting of the Afghan Steering group in Tokyo, donors promised 4,8 billion US$ over the next 3 years. Pledges for the year 2002 were 1,8 billion US$. At the Tokyo conference, Belgium pledged 30,7 million US$ for the reconstruction of Afghanistan over the coming 5 years (2002 to 2006).

Most of the funds were designated to finance life-saving humanitarian assistance in this completely destroyed country struggling to get on its own feet after more than two decades of war.

While the efforts made were considerable, we have to remark that:
- Donor- assistance is fragmented, excessively project-based and insufficiently coordinated within the Government’s budget framework.
- No distinction is being made between humanitarian assistance and reconstruction efforts.
- Despite all efforts, there was a funding shortfall over 2002.

For the next 5 years, budget estimates are even higher and a yearly increase in the funding needed for the reconstruction of Afghanistan is expected. The “real reconstruction” still has to start. Hopefully the initial commitment to reconstruct the country will be maintained.
AID IN THE HEALTH SECTOR

In the health sector, international donors assessed that a minimum of 200 million dollar donor investment in health is needed over the next two and a half years.

The overall approach is public health oriented (as opposed to a curative approach) and based on community based primary health care through partnership of MoPH and Non Governmental Organisations (NGO’s).

Within the health sector, reproductive health is considered as a priority area of intervention by the international community (donors and actors in the field). Consequently reproductive health takes an important place in the essential package of services that should be made available throughout the Afghan health care system.

The donors preferentially channel their support through direct funding of health programs implemented by many different actors:

- International and national NGOs. The number of NGOs working in the health sector is large. The medical NGOs are mainly involved in primary health care in support of the most vulnerable groups.
- UN agencies: UNFPA is the focal point for reproductive health, UNICEF for the safe motherhood initiative and WHO for health in general and technical assistance to MoPH.
- Red Cross Organisations.

The coordination between the different actors in the field and the Ministry of Public Health is quite poor and at least confusing despite a plethora of meetings, needs assessments and workshops. The links between the different levels (district, provincial, regional and national levels) are quite virtual. A stronger leading position of MoPH is needed.

There are many barriers to extend reproductive health services through international assistance. The most important are 1) the socio-economic and cultural context of Afghanistan, 2) the lack of qualified female health staff, 3) a weak leadership of the MoPH, 4) lack of efficient coordination, 5) insecurity / instable political environment and 6) lack of funding.

The health status of the Afghan population is poor and it is unlikely that this will change soon. The basic conditions for reconstruction are not yet fulfilled and the implementing capacity is not there. Even if peace and political stability are achieved, the destroyed health infrastructure and the lack of trained and technically competent health workers will hinder the reconstruction process for the years to come.

A concerted effort over a long period of time is required to improve the health status of the Afghan population in a sustainable way.

IV. REPRODUCTIVE HEALTH PRIORITIES FOR AFGHAN WOMEN

Between 15 and 31 October 2002, a KAP study was carried out in Kabul by the ICRH (Ghent University) and IbnSina. The goal was to get a better understanding of the way Afghan women perceive their reproductive health and reproductive health needs. A total of 468 Afghan women of reproductive age (15 to 49 years) have been interviewed.

Some of the main conclusions were:

- The interviewed Afghan women do marry early (in average at 17.2 years), but wanted to marry 3 years later (in average at 20.2 years).
- They deliver their first child at young age (in average at 18.8 years).
- They have many children. (For women above the age of 35 years, the mean number of previous pregnancies exceeded 7.)
- They do not space their pregnancies (average birth interval in average 2.5 years).
The use of family planning methods is quite low (23%) and there is an unmet demand for FP. Knowledge of sexual and reproductive health in general and of more particular aspects like family planning and Sexually Transmitted Infections is low. (52% of the women did not know any family planning method and only 24% of the women had knowledge of any STI).

Socio-cultural factors do play a very important role in the reproductive health priorities of Afghan women:
- The high desired family size reflects the importance and emphasis put on the reproductive role of the women in the Afghan society.
- The main determinant for the use and non-use of reproductive health services - such as emergency obstetrical care and family planning services - seems to be the schooling of the woman within the surveyed population.
- Socio-cultural factors - such as young age at marriage, lack of decision making power for women - appear to be important barriers to reproductive health. These factors are strongly linked with the traditional attitudes still prevailing in the Afghan society of today.

Note: Other potential barriers - like geographic accessibility, quality of services - have not been assessed by this KAP survey.

Therefore, we want to emphasize that reproductive health should be seen in a broader perspective than a pure medical one. Education, access to employment and women's social position are at least as important.

V. STRATEGIC PLANNING: WHAT SHOULD BE DONE?

All health indicators show the need for a rapid and sustained action in the health sector. Donors and agencies should focus on quality and quantity, as well as on a long-standing commitments and strategies. There are not such things as “quick impact” projects in the health sector in Afghanistan.

Training and capacity building are key elements for reconstruction of the Afghan health system. As general model to improve the reproductive health in Afghanistan, we propose:

A. Decrease socio-cultural barriers
This can be done through:
- Promotion of the education of girls / women
- Empowerment of the social position of women
- Community health education

Studies have shown that maternal mortality reduction is supported by gender equity in access to education, income, and decision-making in the community.

B. Increase the availability of reproductive health services
Within the broad area of reproductive health, the needs are enormous and interventions are needed in all fields. The national authorities and international community have rightly chosen to prioritise two areas of intervention:
- Safe Motherhood Initiative (including access to Emergency Obstetrical Care, EmOC)
- Family planning programs

C. Increase the quality of services
- Human capacity development: Reinforcement of MoPH as well as training of health professionals are essential. Positive discriminating actions towards women’s vocational training should be considered.
- Investment in infrastructure, equipment and supplies. The current status of most health facilities is not compatible with a minimum level of quality care. Not only capital investment but also recurrent costs need to be covered by external aid over the coming needs.
VI. HOW CAN THE BELGIAN COOPERATION CAPITALISE ITS ROLE IN THE
REPRODUCTIVE HEALTH SECTOR?

- The needs in the reproductive health care sector - like in many other sectors in Afghanistan - are huge and external funding is needed over the foreseeable future.
  
  Apart from specific reproductive health programs, reproductive health will indirectly benefit from
  - Projects that promote general education and primary schooling (especially for girls and in rural areas)
  - Projects that empower women (like income generating activities)

- Within the specifically reproductive health care oriented programs, most of the international aid is directed towards basic Mother and Child Health services, which are implemented by NGOs. This ensures RH services to be maintained at a minimum level throughout the country. These existing reproductive health programs should be maintained over the following years.

- But in addition, financial support is needed for many other meaningful projects like:
  - Family planning programs (information, education, communication and increased availability)
  - Upgrading of MCH clinics to basic EmOCs where female qualified staff is present
  - Comprehensive EmOC at provincial level. Ideally these should provide quality care and serve at the same time as practical training centres (for doctors, midwifes, auxiliary midwifes, Traditional Birth Attendants)
  - Support to MoPH (capacity building)
  - Support to formal medical and intermediate medical schools (especially midwifes)
  - In-service training and refresher courses for (female) medical staff
  - Community health programs with home-visiting component
  - Promotion of attendance of deliveries at home by qualified staff (midwifes)
  - Etc…

Reproductive health care programs can be supported through multilateral cooperation or indirectly bilateral through partnership with NGOs.

In any case, there is still a long way to go. A multi-sectoral approach and long-term commitment is needed in order to improve reproductive health in Afghanistan. Community education and primary schooling are two key elements in this process.

After more than two decades, Afghanistan finally faces a chance to get out of the dark tunnel of war and destruction. It is crucial that the Afghan men and women are not abandoned by the international community. Many years of social investment and of commitment to peace will be necessary before reproductive health will be achieved for the majority of Afghan women.
I. INTRODUCTION

A. REPRODUCTIVE HEALTH (RH)

Although the term “reproductive health” has been used before, its widespread acceptance came in 1994 with the adoption by 178 countries of the Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo. At the conference, international consensus has been reached on the definition of reproductive health:

"Reproductive Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes. RH therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

In line with the above definition of RH, RH care is defined as the constellation of methods, techniques and services that contribute to RH and well-being by preventing and solving RH problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.”

B. REPRODUCTIVE HEALTH IN AFGHANISTAN

Nearly any one is aware of the extremely bad reproductive health situation in Afghanistan. Mortality and morbidity rates for women and children are amongst the highest in the world. After years of abandoning, the international community engaged itself to assist with the reconstruction of the Afghan society over the coming 5 years. In the needs assessment of the international community, reproductive health care is considered as one of the priority areas of intervention within the health sector. The needs regarding reproductive health care are enormous. However the improvement of reproductive health care is not an easy objective in Afghanistan of today. A socially integrated and culturally well-accepted approach is essential for any initiative in the reproductive health care sector. In this perspective, we need a better understanding of the women’s position and the perspectives in the Afghan society are.

C. BACKGROUND OF THE STUDY

The Belgian cooperation committed itself to improve the political, economic, social and cultural rights of Afghan women over the coming five years. With the support of the Belgian government, two conferences have been organised in Brussels in December 2001 (Women’s Summit on 4-6 December en the UNIFEM Round Table for Afghan Women of 16-17 December). The Afghan women confirmed there the importance of the improvement of reproductive health within the health sector. Over the coming five years of Belgian support, it is a challenge to ensure a quality approach and positive impact for the Afghan women.
In order to have a better view on the Afghan reproductive health situation, the Belgian cooperation emitted an appeal through the VLIR (Flemish Inter-University Board) for a punctual policy advice regarding the "Possibilities for the improvement of reproductive health care in Afghanistan".

In this perspective, the "International Centre for Reproductive Health" of the University Ghent performed a short-term study with following main objectives:

- Analysis of the international approach regarding reproductive health in Afghanistan, with focus on the following questions:
  - What is the current international approach regarding reproductive health? How is the aid organized in the field?
  - How do Afghan women perceive reproductive health? What do Afghan women perceive as priorities?
- Establishment of a framework regarding the "Possibilities for the improvement of reproductive health care in Afghanistan", useful for Belgian actors, and eventually for a bigger group of involved actors

This document is the final and global report of this reproductive health study. Another report is available with the specific results of the KAP study regarding reproductive health, performed in October 2002 in the city of Kabul.

D. IMPLEMENTATION OF THE STUDY

The study took place between 15 September and 15 November 2002 and has been implemented by ICRH in collaboration with IbnSina.

The "International Centre for Reproductive Health (ICRH)", established in 1994 within the medical faculty of the University Ghent, is a Belgian university group focusing on the improvement of reproductive health care through operational research, training and adapted interventions.

IbnSina is an Afghan NGO, established in 1996 and operational in the public health sector in 13 provinces in Afghanistan.

E. METHODOLOGY

Different means have been used to reach the study objectives.

Background information has been collected through Internet search, literature review and through networking with and reports of other agencies.

In collaboration with IbnSina – an Afghan NGO - a one month field study in Afghanistan has been done, during which following was achieved:

- A KAP study in the city of Kabul:
  - A total of 468 Afghan women of reproductive age (15 to 49 years) have been interviewed on their Knowledge, Attitudes and Practices regarding reproductive health
  - Interviews with key people: representatives of UN agencies, donor community, Afghan and international NGOs, Ministry of Public Health, Afghan health workers....

A summery of the most relevant findings is presented in this report.
II. SITUATION ANALYSIS: REPRODUCTIVE HEALTH CARE IN AFGHANISTAN

A. NATIONAL POLICIES

1. NATIONAL HEALTH POLICY

The Afghan Ministry of Public Health, responsible for the reconstruction of the health sector, established early 2002 a national health policy, which focuses on equitable access to health care, based on a Primary Health Care concept.

This includes basic health facilities providing essential health services to the entire population and an appropriate and accessible referral system dealing with emergency and obstetrics care.

In the National Policy document, reproductive health is listed among the health sector priorities to save and improve lives, and the national reproductive health policy is very much focused on safe motherhood, including the mother/baby package, as shown in annex 7 of the National Health Policy (2002):

7. REPRODUCTIVE HEALTH

The overall policy is to increase availability of and equitable access to reproductive health services with special emphasis on essential obstetric care; to improve use and quality of reproductive health services and to improve knowledge and decision making in the community.

The safe motherhood services package includes:
Community education, antenatal care, counselling and promotion of maternal nutrition, skilled assistance during childbirth, family planning counselling, information and services, reproductive health education and services for adolescents.
Care for obstetric complications, including emergencies, postpartum care, management of abortion complications, and post abortion care.

The principal policy guidelines with related mechanisms include the following:

Policy area 1:
The Ministry of Public health will work in collaboration with partners to ensure total coverage of effective integrated safe motherhood services and essential obstetric care throughout the health system.

Mechanisms
1. Providing adequate care as close as possible to where women live. Services should include clean deliveries by health workers who have been trained in midwifery; prompt recognition of complications and appropriate referral; and treatment of a woman who is experiencing complications until she can be transferred safely to a higher level of care.
2. Support the national MCH task force and follow-up the decisions taken.
3. Addressing gender inequalities and discrimination that prevent women from obtaining appropriate care and contribute to their ill health and death.
4. Monitor the coverage and use of maternal health services and maternal mortality trends and use the findings to strengthen future activities and improve the quality of care.
5. Strengthening supervision, monitoring and evaluation as part of the process to assess the quality of care.
Policy area 2:
Develop functional referral systems, including a reliable means for communication and system of transport, to ensure that women with complications are taken promptly to health care facilities capable of providing appropriate care.

Mechanisms
1. Mapping the coverage of first referral facilities and institutionalising responsibility for back-up support, supervision and referral for designated geographic areas.
2. The development of referral facilities that have the managerial and technical capacity to respond immediately to emergencies, provide essential obstetric care to women with complications, have sufficient supplies of essential drugs, equipment and safe blood, and apply universal precautions to prevent the transmission of infection.
3. The identification of necessary community-based programs to support the early recognition and transportation of women with complications to health care facilities capable of providing care.

Policy area 3:
The Ministry of Public Health will ensure that a health worker with midwifery skills is present at every birth.

Mechanisms
1. A sufficient number of health workers to be trained, provided with essential supplies and equipment and are accessible to poor and rural communities.
2. Expanding the role of midwives through training with community level development, with responsibility delegated for the management of obstetric complications.
3. Continue to organize various training courses in collaboration with partners.

Policy area 4:
Promote community mobilisation to help women understand and articulate their health needs, and obtain services without delay. Addressing gender inequalities and discrimination that prevent women from obtaining appropriate care and contribute to their ill health and death.

Mechanisms
1. The identification of necessary community-based programs to support the early recognition and transportation of women with complications to health care facilities capable of providing care.
2. Strengthening partnerships around the issue of safe motherhood to review priorities, assist the MOPH in targeting existing resources and mobilizing additional resources.
3. Educating women and their families about the risk of complications faced by all women, and about actions they should take if and when a problem arises.

Policy area 5:
The Ministry of Public health will ensure that women and men have access to family planning information and services and incorporate and integrate the family planning services into the national health care system.

Mechanisms
1. Improve access to safe, effective, affordable and acceptable methods of family planning of their choice.
2. Couples will be provided with good quality, client-oriented information and services, a wide choice of modern birth spacing methods, confidential counselling that is responsive to and respectful of clients’ needs.
3. The service providers will be trained in technically accurate and culturally appropriate counselling techniques.
4. The support of community and religious leaders will be sought.
5. Information, education and communication campaign emphasizing child spacing, safe motherhood and women’s health will be carried out.
This central MoPH approach has been and is still encouraged by all stakeholders and international donors.

A joint donors mission representing 8 different agencies \(^1\) conducted a ten-day assessment of the health situation in Afghanistan in March 2002 to agree with the Government on a framework for assistance to the health, nutrition and population sector over the next 2.5 years. According to the mission members, the most important health challenge facing the Afghan government is to ensure access to basic health services for the majority of the Afghan population.

An Advisory Committee to the MoPH has been formed to define the essential package of services to be made available throughout the public health system in Afghanistan. The Committee consisted of the MoPH, the three UN agencies involved in health (WHO, UNICEF, UNFPA) and Management Sciences for Health (MSH), a NGO providing technical assistance to the MoPH.

In summary, the proposed Basic Package of Health Services contains the following components:

- **Maternal and newborn health**
  - Antenatal care
  - Delivery care
  - Postpartum care
  - Family planning
  - Care of the newborn

- **Child health and immunization**
  - Expanded Programme on Immunization (EPI) services (routine and outreach)
  - Integrated Management of Childhood Illnesses (IMCI)

- **Public Nutrition**
  - Micronutrient supplementation
  - Treatment of clinical malnutrition

- **Communicable diseases**
  - Control of tuberculosis
  - Control of malaria

- **Mental health**
  - Community management of mental health problems
  - Health facility-based treatment of outpatients and inpatients

- **Disability**
  - Physiotherapy integrated in the Public Health Care (PHC) services
  - Orthopaedic services expanded to hospital level

- **Supply of essential drugs**

The basic service package defines which interventions are essential to be provided through public (plus donor) funding. It does not include all necessary health interventions, but the ones considered as essential for the country at the moment. Theoretically all interventions listed should be provided at health centre level, with easy and rapid possibility of referral to a higher level. However, the reality is different.

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\(^1\) The Joint Donor Mission was composed of teams from the World Bank, European Community, USAID, WHO, UNICEF, UNFPA, the Asian Development Bank and Britain's Department of International Development.
2. **SAFE MOTHERHOOD STRATEGIC FRAMEWORK**

An Afghanistan National Safe motherhood Strategic Framework has been developed by the MoPH and UNICEF in April – May 2002. It focuses on 3 axes:
- Improve the coverage, utilization and quality of emergency obstetric care
- Improve the coverage of skilled attendance at birth
- Ensure effective antenatal care for all women

It also sets a list of short-term, medium-term (18 months to 3 years) and Long-term (3 to 10 years) objectives:

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The Afghanistan National Safe Motherhood Strategic Framework  
Ministry of Public Health  

This strategic framework was developed in order to allow the achievement of the vision for Safe Motherhood in Afghanistan, developed at the Safe Motherhood strategic visioning and planning workshop, April-May, 2002. It focuses on three axes:

a. **Improve the coverage, utilization and quality of emergency obstetric care:**
   - Ensure that every provincial hospital can provide comprehensive emergency obstetric care according to agreed standards.
   - Ensure that every district hospital or primary health centre can provide basis EmOC according to agreed standards.
   - Develop creative and sustainable ways for women living in the remotest areas to have access to the health facilities as described above.

b. **Improve the coverage of skilled attendance at birth:**
   - Train a sufficient number of midwives and auxiliary midwives, so that every woman can have a skilled attendant at delivery, and ensure their availability at the community level.

c. **Ensure effective antenatal care for all women:**
   - Implement evidence-based antenatal care through routine basic health services and community services, focusing on: prevention and control of anaemia, prevention of malaria, specific nutrition interventions where necessary, infection prevention/clean delivery, and birth preparedness. Birth preparedness includes providing mothers and their families with the appropriate information to recognize the symptoms of complications and to know when, how and where they should seek care, provision for transportation and financial resources to seek care.

The three strategic axes will be implemented in a way which ensures links with the family planning services, so that women have access to a continuum of care allowing them to avert maternal death.

As the health sector is not the unique actor to develop interventions for reducing maternal mortality, inputs from other sectors other than health will make important contributions to this strategy.

**Objective setting**

1. **Short-term Objectives (18 months):**
   - The MoPH owns the safe motherhood initiative and works closely with the donors and the implementing partners.
   - Set rights-and gender-based policy framework for Safe Motherhood.
   - Set evidence-based standards for clinical care (antenatal care and EmOC), for training programs and for blood banks. MoPH and partners will work to ensure that standards are set and maintained also for related services that are critical to safe motherhood, i.e.
laboratories and pharmacies.
- Begin implementation of the strategy by developing 4 centres of excellence:
  - Facility renovation
  - Input with supplies and equipment according to the agreed standards
  - Training of trainers in EmOC, infection prevention and management
  - Development of related services
- Pre-service training for midwives, auxiliary midwives and physicians:
  - Curriculum development, consistent with agreed standards and job descriptions;
  - Upgrade of clinical training facilities.
- Develop communication plans for safe motherhood and innovative programs for reaching the hard-to-reach.
- Provide direct support to maternal health service delivery and start expansion beyond the centres of excellence, based on existing capacity and opportunities. The support will consist of provision of supplies, equipment and training of service providers. Given the current option for service delivery through performance-based partnership agreements (PPAs) in the next two years, priority will be given to ensure full support to the service providers to meet the requirements of the agreements and provide the full package of maternal health services according to the agreed standards.
- Clarify roles and responsibilities of the community health workers and the TBAs.

2. Medium-term Goals (18 months to 3 years):
- Continue expansion beyond the centres of excellence to existing hospitals in every provincial capital (provide training, supplies, renovation) and continue to enhance existing district hospitals and PHCCs; provide training, supplies and renovations, in order to meet standard UN indicators for availability and use of EmOC services.
- Expand communications strategies to beneficiaries in more remote areas.
- Encourage and support implementing partners to develop community-based solutions to affordable and safe transport to E3mOC providers.
- Continue training midwives, auxiliary midwives and obstetricians.
- Continue providing support to service delivery in the frame of the reconstruction of the health system.

3. Long-term Goals (3 to 10 years):
- With the MoPH and donors, plan siting and construction of new facilities in areas with insufficient coverage.
- Expand developed strategies for reaching the hard-to-reach.
- Include safe motherhood information in school curricula for health education.
- Continue training midwives and women obstetricians.
- Continue providing support to service delivery in the frame of the reconstruction of the health system.
3. COMMENTS

a. To put this national health policy into practice, a complete reorganisation of the Afghan health care system is needed
   - Redirection of the (material and human) resources from Central to peripheral level
   - Redirection of the (material and human) resources from hospitals to basic health facilities
   - Restructuration and reinforcement of the MoPH at all levels
   - Reorientation of medical educational / training system,…
   - Reorganisation of the referral system, etc …

b. There is a big gap between an ambitious model likely to have an impact on public health and the current reality. Due to socio-economic and political factors, the re-organisation of the health system is not really taking place. E.g. Hospitals in Kabul remain currently as they were: under-equipped, inefficient, and over-staffed. In order achieve the above set goals a strong commitment and persistency of the national authorities as well as a long term investment and commitment of the international community is needed.

c. There is not always a general consensus on what “essential” services should be offered at which level. A “draft document for discussion: a basic package of health services for Afghanistan” states the level of care, interventions, necessary resources including staff and essential drugs needed at the 3 different health levels (community level, health centre level and rural / provincial hospital). But on the time of our field visit, no general consensus was agreed on the draft document. Several people from MoPH as well as from non governmental organizations disagreed with the idea of community distribution of drugs - like “oral contraceptives”, anti-tuberculosis drugs, antibiotic and anti-malaria treatment - by Community Health Workers. Main fear is the lack of competence of CHW and TBAs, potential delay in referral and potential misuse / selling of the drugs.

d. The implementation of the national policy is undermined by the current lack of female qualified staff in rural areas, as well as by the strong decentralisation of Afghanistan. The lack of security and political stability is a serious constraint to extend health services in many regions.

e. One can wonder to which extent the national policy is really a well integrated Afghan policy rather than a donor driven one. The documents have been written with the input and according to the views of the main international actors. These views are not necessarily shared by the national staff. The dominating view among Afghans is still very much oriented towards (high tech) curative services. Of concern is the fact that the documents (on national policy, essential package of services, safe motherhood initiative...) are largely circulated among international actors, while only a very small minority of the Afghans are aware of these documents. They are generally written in English and thus poorly understood. Neither are they distributed to the local levels.

f. Even if it is a priority to extend basic health care services in Afghanistan, investments at the referral level are also needed. A basic health care system can only be fully effective if it is supported by community participation and a high-quality referral system.

But despite its shortcomings, the national policy corresponds to the current health needs in Afghanistan and presents a valid basis for future reconstruction of the health care sector. In the same time it outlines the general principles for the international aid in the health sector.
B. HEALTH SYSTEM’S CAPACITY

The health care sector currently does not have sufficient capacity to cope with the dramatic reproductive health situation in Afghanistan. Problems include lack of infrastructure and trained staff as well as weakness at the level of the Ministry of Public Health (MoPH).

1. MINISTRY OF PUBLIC HEALTH (MoPH)

Since the civil war started in 1989, there hasn’t been one single ministry of public health. Every different political / military fraction appointed its own MoPH. Persons were nominated at these MoPH rather for political reasons than because of competence or experience. The MoPH has always been more an administrative unit than a ministry with the necessary capacity for planning and policymaking.

With the interim government, for the first time in years a central MOPH has been installed early 2002. Very renewing is the fact that a woman has taken up the position of Minister of Health. Yet the new Ministry inherited important problems of the past, which are not easy to overcome in a short term:

a. The Ministry still has the old administrative structure of the soviet period.
   There are two main units within the Ministry, a technical as well as an administrative/financial one. The administrative unit is responsible for human resource planning, law and legislation, budget amongst other. Under the technical deputy minister, there are several departments like Primary Health Care, Curative department, Pharmacy, Mother and Child Health, International relations, Information, Education and Communication (IEC), etc...

   All these entities are vertically organized and in charge of separate health structures:
   - The MCH director is in charge of the MCH clinics (30 in Kabul).
   - The Primary Health Care department is in charge of the comprehensive health centres (C1) and basic health centres (C2).
   - The Curative department runs the hospitals and polyclinics.

   This organization does not contribute to the set-up of a coherent and efficient health system. One of the major problems is the lack of relation between the hospitals and the basic health facilities, resulting in a non functioning referral system.

   Moreover, a number of health structures belong to other ministries, like the Ministry of Rural Development and the Ministry of Defence. All these ministries and separate departments try to attract international aid and to allocate the available resources in their facilities. International aid in the field of health needs to be coordinated with and approved by the department of International Relations (director Dr. Abdullah Fahim).

b. The concept of reproductive health as an integrated part of primary health care services is not existing:
   It is only recently that reproductive health is included in the priority areas of intervention within the national policy of MoPH, largely because of the interest and pressure of the international community. But this certainly does not mean that all MoPH staff consider RH as the most important area of intervention. The Afghans are used to a male dominated society, with little attention for women and their health status.

   Reproductive health is simplified to Mother and Child Health and MCH clinics. It is not seen as a responsibility of all health care providers nor as a service that needs to be available in all health facilities. The change of government has not induced any changes in this attitude.

c. Poor capacity of the Ministry of Public Health.
   The Ministry of Public Health reopened in 2002 and had basically to start from scratch with very limited resources. Most people nominated at the MoPH are poorly trained for their job and lack a
public health view. Inheritants of the soviet system, many have a curative approach to health care. Due to the war, staff has not had the opportunity to be trained in management, public health and computer skills, nor to get familiar with the evolution of medicine over the past two decades. The majority does not speak English either, difficulting access to international training and literature. Because of the low numerations, it is extremely difficult to attract highly qualified or well trained staff for key positions.

Whereas nominations seem political, ethnical and gender-wise correct at the top, this is not the case at the bottom. The Minister is a woman. But directors of the health departments and their staff are generally male. The Tajik are predominantly present in the current ministerial positions.

d. Lack of connection with the provinces
A frequently heard comment is that the Ministry of Public Health is working as MoPH for Kabul province (and provinces around) with little or no connection to the other provinces and rural areas. During the long years of war, people got used to operate in a decentralised system without supervision of the central government. Despite the huge progress made over 2002, we cannot speak yet from a unified country. In the provinces the governors and local commanders retain the real political power.

2. Health Infrastructure
The health care system is organised as a pyramid and has five levels: village level (village health workers and TBAs, basic health post), district level (basic health centre or district hospital (10 to 20 beds)), provincial level, regional level and finally central level.  

Basic health facilities
Basic health facilities are divided into 3 different categories:

- C1: Comprehensive Health Centre, offering curative and some preventive services. Usually a male doctor and nurses are present. Some preventive services (like antenatal care and family planning) are only offered when a midwife is available.
- C2: Basic Health Centre, offering curative care. Usually only mid-level staff present (nurses).
- MCH: Mother and Child Health Clinic, offering curative and preventive care for women and children up to 12 years. Usually a male doctor (for paediatric OPD and director of clinic) as well as a female doctor (for women’s OPD) and a midwife are present. The clinics are under the authority of the MCH department, which is different from the PHC department, responsible for the C1 and C2 clinics.

This existing division is out-dated and inappropriate since Mother and Child Health should be seen as a general and integrated service, to be provided at all primary health facilities, instead as separate itentity.

According to WHO data and to the Afghanistan National Health Resources Assessment, following data reflect the desperate status of the Afghan primary health care health system:

- Only 30 - 40 % of the population have access to some health service, most of them being residents of urban areas (70% for people living in urban areas and 38% in rural areas)
- Of the 698 facilities said to exist, 131 were found to be inactive or destroyed.
- The average population of a primary health care facility is = 27,800 persons. But there are huge imbalances in how these facilities are distributed throughout the country. For example, the densely populated district of Ghazni, has a ratio of 273,000 persons per health facility.
- Thirty-nine of the 320 districts do not have a single health facility.
- Less than half of all health facilities have access to safe water.
- Less than one fourth have a vehicle that could allow transportation of a patient.

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2 Afghanistan is administratively subdivided in 7 regions, (23 to) 32 provinces and about 329 districts (see maps introduction).
The WHO produced an Infrastructure and Health Atlas of Afghanistan in February 2001. The map shows that basic health centres are concentrated in and around Kabul and in the eastern region. Although these are the areas of highest population density in Afghanistan, the ratio of basic health centres to population ranges from 1 per 40,000 in the central and eastern regions to 1 per 200,000 in the south. After the comprehensive, active national survey of all health facilities and associated resources (ANHRA), maps were extended and updated in November 2002.

Figure 1

**District Population Per Health Facility**

According to WHO preliminary needs assessment of the Afghanistan health sector, there are:

- 17 national hospitals in Kabul
- 9 regional hospitals
- 34 provincial hospitals
- 41 district hospitals

Most are in a state of disrepair and are not functioning with the level of quality, efficiency and effectiveness required. As an example, only 17 of the country’s 174 hospitals (little less than 10%) can practice caesarean deliveries.

General statistics like utilisation figures for hospitals are not available. But for the few hospitals for which the number of admissions is known, bed occupancy rates are known to be low.

The hospitals are operating quite independently one from another and resources are directly managed by the central administration of MoPH. Little or no connection exists with the primary health care sector.

There is still staggering inequity in distribution of health facilities and human resources between rural and urban areas. Of the 8,333 beds in the whole of Afghanistan, 50% are located in the central region, of which 90% are in Kabul city alone. Hospitals serve approximately only one quarter of the entire population.

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Maps can be found at AIMS website: [http://www.aims.org.pk/](http://www.aims.org.pk/)

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ICRH 2002

“Possibilities for the improvement of Reproductive Health Care in Afghanistan”

Punctual Policy Advice
A recent study of the hospital system in Kabul by French experts recorded 23 hospitals and 3,344 in-patient beds in Kabul city (2,794 under MoPH responsibility). Kabul’s hospitals have greatly deteriorated. Their current status is incompatible with decent health care either for out-patients or in-patients. A total of 4,600 hospital staff has been noted with roughly one nurse per doctor. Kabul’s hospital system is absorbing a far too great proportion of the resources available. It is ponderous and inefficient and disproportionately large.

The experts recommend an urgent rehabilitation and reorganisation reducing the number of hospitals in Kabul and upgrading them to high-quality referral hospitals of excellence (renovated technical facilities, properly managed and trained staff, strengthened management). They also recommended to reduce the number of hospital beds and the number of medical staff (especially doctors) in the hospitals and to reorient the other, smaller hospitals to primary health care activities.

There are few public laboratories and the quality and quantity of laboratory tests they can perform is usually very limited. Equipment is generally limited to a microscope, with no reagents. Biochemical analysis is out of question. Very few laboratories are able to perform bacteriologic examinations.

**Private sector**

The private health sector has increased in size, scope and importance during the long years of war. Health personnel are state-employed, but in the absence of a government regulatory mechanisms and inability of the health sector to pay a decent salary, almost every health worker has a small private clinic or laboratory. Prices are quite high but people who can afford often prefer the private sector because of perceived better quality of care (better equipped), availability of medicines and less waiting queues.

A growing number of pharmacies, especially in major cities, is observed. Only in Kabul there are about 3000 pharmacies reported. This system dispenses most of the drugs. Medicines (even potentially addictive drugs) are sold without regulations. Many people do seek directly health care (medicines) in those pharmacies instead of passing through a consultation by a health professional. A number of private clinics offer specialized services as lab diagnosis, x-ray, ultrasound, surgery and even Ct-scan. In Kabul, there are 2 or 3 small private clinics doing deliveries including caesareans.

Again the private sector is most developed in urban areas. There is a strong link between the public hospital and private cabinets (doctors referring patients to the private sector).

**Equipment and supplies**

Many of the public health care facilities are, in fact, non-functional due to lack of supplies or equipment, lack of structural integrity (windows, doors, electricity, or water) and the absence of trained health care professionals. Even in Kabul, the French expert mission found that every MoPH hospital was under-equipped to a degree incompatible with medical hospital practice. Operating tables are outdated, there is no monitoring equipment, no examination or therapeutic materials. This inadequacy in the public sector contrasts with a fairly well structured supply in the private sector for e.g. standard laboratory examinations, x-ray equipment...

Drugs are obtained from abroad by private traders or humanitarian agencies. The quality of available drugs is questionable as quality control is not performed and storage problems exist. Irrational drug use is widespread. MOPH is supplying health structures with no or a very limited amount of drugs. If a health structure is not supported by an external agency, people have in general to go to the private pharmacies or bazaars to buy their medicines.

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4 In May 2002, a French expert mission, with the support of the French Embassy, took place for a study of the “Health Care and Hospital Referral System in Kabul”.

*ICRH 2002*  
“Possibilities for the improvement of Reproductive Health Care in Afghanistan”  
Punctual Policy Advice
3. **Human Capacity**

According to the standards laid down in the 2002 – 2006 master plan, for a population of 25 million, staff requirements are:

- 5,826 doctors
- 6,442 senior technicians
- 13,222 technician / nurses
- 37,500 community health workers

Estimates of total human resources inside Afghanistan indicate that there are about 17,600 health care providers, comprised of 3,906 doctors, 2,564 mid-level professionals, 4,993 nurses and technicians, and 6,123 community health workers and birth attendants. Yet the exact figures are unknown and the MoPH needs urgently to regulate and certificate all medical health professionals. Organisations will have to accept the authority of the MoPH in this process.

Human resources are currently lacking in two ways:

- Quantity, particularly of technicians, nurses and health workers. This is especially valid in rural areas.
- Quality, because of obsolete teaching programs, poor training systems and the virtual absence of in-service training

**There is a strong urban bias in the availability of health care providers.**

More than 50% of all doctors (2175 to 2900) work in Kabul and serve less than 12% of the population. Globally 94% of the physicians are in urban areas, reaching only 18% of the population. **Whereas there are enough doctors in urban areas**, there is a big need in rural areas. In some cities as Kabul, one could say that there are even too many doctors. Most of them are absorbed in large and inefficient hospitals, and do operate simultaneously private practices.

But more even than doctors, what the country needs is nurses, midwives and community health workers.

There is a big shortage of midwives. In 1998, 654 midwives were working for the Ministry of Public Health and non-governmental organizations in Afghanistan.

Doctors and nurses are badly trained since civil war started more than two decades ago. Many professors fled the country and there were almost no practical training opportunities in quality hospitals. Medical and paramedical teaching under taliban regime has been theological and dogmatic. Doubts have arisen as to the competence implied by professional diplomas granted during that period.

In Afghanistan reproductive health services rely heavily on the availability of female health staff, since women can only be attended by female staff. Yet in most health facilities, female staff is absent. **40% of all health facilities do not have a single woman in their staff.** Those who are present generally lack clinical and management skills and have not received a proper comprehensive in-service training over several years. **The critical lack of female qualified health providers is the main limiting factor to expand reproductive health services quickly in Afghanistan, especially in rural areas.**

**Training of health professionals**

**Training of doctors**

For historical reasons, there are 6 faculties of medicine in Afghanistan – called “medical schools”: Kabul, Herat, Jalalabad, Mazar-I-shariff, Kapisa and Kandahar. They fall currently under the responsibility of the Ministry of Higher Education. They are reportedly overcrowded and under resourced since many years.
Only doctors graduating in Kabul receive an international diploma and can start a specialization. At the moment there are about 3,000 medical students at the Kabul university, of whom 25% are female (mostly concentrated in the first two years). Little less than 400 doctors are expected to graduate this year in Kabul. For the whole of Afghanistan, this figure might be around 800. This means that the number of required doctors will soon be met. There will be even an “overproduction” of doctors, which is worrisome. It endangers the long-term sustainability of the health sector. And because the majority of them stay in Kabul or in the other main cities, the urban bias will be only reinforced and the over-staffing of hospitals continue. There is a need to motivate doctors to go to rural areas and some measures might be introduced such as an obligatory stay for newly graduated doctors during some years in rural areas. It is still the question whether these measures will be very effective.

Most of the doctors want to specialize in surgery. Female doctors often choose gynaecology / obstetrics. The obstetric department has been closed under the taliban regime even if doctors continued graduating. In 2002, the department reopened and is lead now by two female inexperienced gynaecologists. Only the two MoPH maternities of Kabul – Malalai and Rabi Balkhi- are providing spaces for specialization for obstetricians / gynaecologists. Only a limited number of specialists can be trained in these hospitals each year (30 specialists finish this year).

Medical doctors are poorly trained in reproductive health and public health matters. Antenatal care, family planning and other preventive services are not approached. The in-service training of general practitioners is very limited as well (e.g. only 10 days practical training in obstetrics / gynaecology in the medical curriculum). Professors would benefit from refresher courses in RH and public health inputs.

**Training of nurses and midwives**

There are about 8 training centres for nurses and midwives in Afghanistan, called IMS (Intermediate Medical Schools): Kabul, Kandahar, Jalalabad, Mazar, Herat, Kunduz, Helmand and Farah.

In the Kabul IMS, the midwife school –after being closed during 5 years under the taliban regime- has reopened. Currently 150 female students are being trained (100 in the first and 50 students in second and third year each).

350 students are currently studying nursing. Only 30 (less than 10%) of them are female. This percentage is expected to increase over the coming years.

The IMS schools are badly equipped. Students receive quite inadequate theoretical training and almost no practical, in-service training. Curricula are out-dated and the curriculum of midwife needs to be revised urgently.

Midwifes are not allowed to perform some basic obstetrical procedures – like the manual removal of a placenta- or to give injections. They are only officially authorized and trained to assist completely normal (not primipara) deliveries. Even if this is also a common strategy in industrialized countries, in the context of Afghanistan it is completely inadequate.

Of concern is that the responsibles of the IMS are not convinced that the curriculum needs to be changed. (Since 20 years it has been like this and it is still the best…) Only the Agha Khan Institute has been accepted to give technical advice so far.

**Training of other health staff: auxiliary nurses, community health workers and TBAs**

There is no official training foreseen for auxiliary nurses, auxiliary midwives nor for community health workers. Training of auxiliary midwives, TBAs, community health workers… depends completely on international and national agencies.
Most of the medical NGOs have TBA training programs. Many are training community health workers too. Health Net International started training of 20 auxiliary midwives in Jalalabad, Ghani Khel and Mehtar Alam. This pilot program has been retaken by UNICEF. Women from the communities are selected and receive at least one year appropriate theoretical and practical training in order to become midwives in their villages of origin. Despite its value, the training is not yet officially recognised by the appropriate ministries.

**In-service trainings and refresher courses by NGOs**

The other major source of training has been the practical training provided by NGOs. This has been essential during the years of war, because NGOs were the only ones able to provide practical training. Many agencies have organised training courses for doctors, nurses and auxiliary health staff. Usually these courses were only open to the health staff working within the health structures supported by those agencies. The adequacy and the content of the different trainings varies substantially.

**Perspectives for the future**

The current urban bias, the male dominance as well as the relative over “supply” of doctors is very likely to continue:

a. More physicians are currently being trained than nurses. The number of midwives in training limited. (Auxiliary midwives are even in much lower number).

b. Almost all students starting and graduating from the medical and intermediate medical schools live in urban areas. The vast majority plans to stay in the cities, to work in the MoPH hospital and/or private cabinet. Rural areas will remain understaffed.

c. Doctors and nurses are unwilling to work outside the main urban areas, because of
   - Insufficient degree of security and stability.
   - Lack of infrastructure, like schools for their children, electricity, water,…
   - Doctors do perceive basic health facilities as “second rang”. Curative work in the hospital (especially surgery) is associated with a much higher professional status.
   - More private practice opportunities in urban than in rural areas.
   - MoPH cannot attract staff in the remote provinces at the salary levels currently proposed.

d. Though intermediate and medical schools are again accessible for women, most students are male. From all medical students in Kabul, only 25% are female.

e. The position of women, even for professionals, will continue to hamper efforts to extend reproductive health care programs in rural areas over the coming years. There are few educated women in rural areas. In some districts, all women are illiterate. Women are traditionally not supposed to learn or earn money. Her task is to raise children. Even highly educated women (like doctors, obstetricians) need permission of their husband or male family member regarding whether and where they can work. Women are not allowed to move freely. They need to be accompanied at any time by a “Mahram”, male family member(s). This complicates work in rural areas, especially outreach activities.

f. Even if the MoPH officially encourages health professionals to work in the provinces and rural areas, more and more staff is allocated to MoPH hospitals in urban areas. In general the hospitals are over-staffed.

g. There is a certain reluctance to recognize officially courses and titles like auxiliary midwives, to change curricula of nurses and midwives, to apply positive discriminating measures for female medical and paramedical students…

h. The new government is under big socio-political pressure to recognize and re-employ:
   - All health staff already employed before by MoPH under the previous regimes
Doctors and students trained in neighbouring countries (Pakistan (Peshawar university)) and now returning, mainly to Kabul city

Health professionals trained by NGOs...

Former doctors and nurses, exiled for years abroad, now returning to their country

Doctors who were unemployed under Taliban regime (like female doctors)

For many health staff – like for the staff in the other ministries- it would seem unacceptable and lead to general protest if health professionals would loose a job which they were able to keep under previous regimes now at a moment that more “international money” is available.

e.g. There have been manifestations late 2002 in Kabul city by Afghan students coming from Peshawar university and who were encountering problems to be reintegrated in the university of Kabul.

Therefore the situation of Afghan cities with a surplus of poorly trained doctors, working in inefficient MoPH hospitals and in private clinics – and of the rural areas with few and lowly qualified health staff, is very likely to remain over the coming years.

4. Financial aspects

It is almost impossible to estimate the total budget spent on health care in Afghanistan. The MoPH has no formal budget, whereas external resources are fragmented into uncountable projects.

The global State budget for the 2002 was planned to be about 460 billion US $, of which 83 billion would come from internal revenues. The rest would be provided by promised international aid. Within this budget, about 28 billion US $ (or 6 %) was due to be spent on health, mainly for salaries.

Grosso modo one could say that most hospitals are financed by the state through salaries and by direct user payments, whereas Primary Health Care services largely depend on external funding for their functioning. Investment is totally shouldered by donors.

Despite bad remuneration conditions, doctors and nurses prefer to work within MoPH structures because of:

- Easy working conditions
- Job security and guaranteed salaries after retirement

The average salary for a doctor at Ministry of Public Health is about 25 to maximum 40 US $ per month. A qualified nurse earns nearly the same amount.

The salaries are not uniform throughout the country. In some regions (e.g. western and northern regions), the salaries of state employees are apparently paid by the local commanders / governors instead of by the central authorities.

Only through paying much higher salaries or incentives (varying between 140 and 650 US$) and offering decent working and living conditions, agencies succeed to attract some doctors and nurses in rural basic health facilities.

Most resources are centralised in Kabul. Kabul’s hospitals concentrate probably between 50% and 70% of the total resources of the Afghanistan’s health system.

Health care is officially free of charge – as a constitutional principle. In public clinics and hospitals, patients officially do not pay. Nevertheless, in practice, patients are charged for every single service. Charges are quite unpredictable and arbitrary, and end up relatively expensive. Especially hospital care becomes unaffordable for many people. (All services, whether for treatment, accommodation, entrance, cleaning, examinations etc have to be paid for). Consumables and products, as well as medicines have to be bought by the family in private pharmacies.

In the private sector, substantial fees for services exist. Prices are quite fixed and known by the people, but the majority of the people do not have the means to access the private system. In health facilities supported by agencies, usually a fixed and low standard fee is asked for all services including medical treatment. In general, there is a need to put in place control systems, as well as financial compensations for the staff.
5. **The Health Information System**

A standardised data collection format exists for gathering information at health centre level. The format has been developed by NGOs under UN coordination (WHO) and the National Health Information System was launched in early 2000. Several reproductive health parameters are included in the data collection format. Most of the NGOs are using the standardised forms.

756 basic health facilities were included in the Afghanistan HIS (Health Information System) database managed by WHO during 2001. The data collection was far irregular though and largely incomplete. During 2001, reports from about 16% of all health centres were received monthly and computed. The reliability of the collected data is highly questionable. Data were gathered through the 7 WHO regional sub offices. At the end of 2002, a shift of the data collection system and integration of HIS into MoPH was taking place.

This system could be a valid instrument for global monitoring purposes. But because of fragmentary, unreliable data and late transmission and computing, the system looses a lot of its pertinence.

Only data of the national HIS (managed by WHO) for the year 2001 could be obtained at the moment of the visit.

*Table 1. Data related to RH as reflected in the national HIS system 2001*

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total OPD visits</td>
<td>1,270,590</td>
</tr>
<tr>
<td>Reproductive Tract Infections / STI</td>
<td>19,405</td>
</tr>
<tr>
<td>Hypertensive disorder during pregnancy</td>
<td>1,387</td>
</tr>
<tr>
<td>Abortions</td>
<td>2,726</td>
</tr>
<tr>
<td>Haemorrhage, antepartum</td>
<td>1,783</td>
</tr>
<tr>
<td>Haemorrhage, postpartum</td>
<td>2,461</td>
</tr>
<tr>
<td>Puerperal / postpartum sepsis</td>
<td>2,485</td>
</tr>
<tr>
<td>Deliveries at clinic, normal, vertex</td>
<td>2,060 (80% of reported deliveries)</td>
</tr>
<tr>
<td>Assisted deliveries at clinic</td>
<td>520 (20% of reported deliveries)</td>
</tr>
<tr>
<td>Neonates delivered &lt; 2500 gr</td>
<td>269 (13.6% of live births)</td>
</tr>
<tr>
<td>Neonates delivered &gt; 2500 gr</td>
<td>1,716 (86.4% of live births)</td>
</tr>
<tr>
<td>Stillbirths</td>
<td>119 (60 per 1000 live births)</td>
</tr>
<tr>
<td>Neonatal deaths</td>
<td>151 (76 per 1000 live births)</td>
</tr>
<tr>
<td>Maternal deaths</td>
<td>512 (quid?)</td>
</tr>
<tr>
<td>New antenatal visits</td>
<td>26,084</td>
</tr>
<tr>
<td>Second antenatal visits</td>
<td>10,446</td>
</tr>
<tr>
<td>Other antenatal visits</td>
<td>6,236</td>
</tr>
<tr>
<td>Postpartum visits</td>
<td>5,422</td>
</tr>
<tr>
<td>Obstetric referrals</td>
<td>908</td>
</tr>
</tbody>
</table>
C. REPRODUCTIVE HEALTH CARE INDICATORS

The International Conference on Population and Development (ICPD) endorsed a number of goals and targets in the broad area of sexual and reproductive health. In 1996, the World Health Organization (WHO) took the lead in the selection of 15 global indicators as well as two complementary indicators for monitoring the set reproductive health targets.

Table 2 presents the existing data for these reproductive health indicators for Afghanistan as well as the estimates for other countries. Few statistics are available for Afghanistan. The ones that are available are not 100% accurate and/or often out of date. But partial as they are, the existing figures reflect a disastrous reproductive health situation.

### Table 2. Reproductive Health Indicators

<table>
<thead>
<tr>
<th>Source</th>
<th>Date</th>
<th>Afghaniston denominator</th>
<th>Other Country estimates</th>
<th>Source</th>
<th>Date</th>
<th>Afghaniston denominator</th>
<th>Other Country estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total fertility rate</td>
<td>WHO / UNICEF 1998</td>
<td>6.9 per woman</td>
<td>1.5 - 1.6, 2.9 - 3.2, 5.2</td>
<td>Contraceptive prevalence</td>
<td>UN Pop Division 1973</td>
<td>2%</td>
<td>75%, 55%, &lt; 23%</td>
</tr>
<tr>
<td>Maternal mortality ratio</td>
<td>WHO / UNICEF 2002</td>
<td>1600 per 100,000 live births</td>
<td>21, 440, 1000</td>
<td>Maternal mortality ratio</td>
<td>UNICEF 1973</td>
<td>2%</td>
<td>75%, 55%, &lt; 23%</td>
</tr>
<tr>
<td>Antenatal care coverage</td>
<td>WHO / UNICEF 1996</td>
<td>8 to 15%</td>
<td>99%, 54%, 26-30%</td>
<td>Antenatal care coverage</td>
<td>WHO / UNICEF 1996</td>
<td>8 to 15%</td>
<td>99%, 54%, 26-30%</td>
</tr>
<tr>
<td>Births attended by skilled healthcare personnel</td>
<td>WHO / UNICEF 1996</td>
<td>8 to 15%</td>
<td>99%, 54%, 26-30%</td>
<td>Births attended by skilled healthcare personnel</td>
<td>WHO / UNICEF 1996</td>
<td>8 to 15%</td>
<td>99%, 54%, 26-30%</td>
</tr>
<tr>
<td>Availability of basic essential obstetric care</td>
<td>N.A.</td>
<td>per 500,000 population</td>
<td>N.A.</td>
<td>Availability of basic essential obstetric care</td>
<td>N.A.</td>
<td>per 500,000 population</td>
<td>N.A.</td>
</tr>
<tr>
<td>Perinatal mortality rate</td>
<td>WHO / UNICEF 1995</td>
<td>120 per 1000 total births</td>
<td>8 – 11, &gt; 30 (57)</td>
<td>Perinatal mortality rate</td>
<td>WHO / UNICEF 1995</td>
<td>120 per 1000 total births</td>
<td>8 – 11, &gt; 30 (57)</td>
</tr>
<tr>
<td>Low birth weight prevalence</td>
<td>WHO / UNICEF 1991</td>
<td>20%</td>
<td>6%, 18%, 22%</td>
<td>Low birth weight prevalence</td>
<td>WHO / UNICEF 1991</td>
<td>20%</td>
<td>6%, 18%, 22%</td>
</tr>
<tr>
<td>Prevalence of infertility in women</td>
<td>N.A.</td>
<td>% of women 15 - 49 years</td>
<td>N.A.</td>
<td>Prevalence of infertility in women</td>
<td>N.A.</td>
<td>% of women 15 - 49 years</td>
<td>N.A.</td>
</tr>
<tr>
<td>Prevalence of anaemia in women</td>
<td>N.A.</td>
<td>% of women 15 - 49 years</td>
<td>N.A.</td>
<td>Prevalence of anaemia in women</td>
<td>N.A.</td>
<td>% of women 15 - 49 years</td>
<td>N.A.</td>
</tr>
<tr>
<td>% of obstetric and gynaecological admissions owing to abortion</td>
<td>N.A.</td>
<td>% of all obstet. / gynec. admissions</td>
<td>N.A.</td>
<td>% of obstetric and gynaecological admissions owing to abortion</td>
<td>N.A.</td>
<td>% of all obstet. / gynec. admissions</td>
<td>N.A.</td>
</tr>
<tr>
<td>Reported prevalence of women with Female Genital Mutilation</td>
<td>N.A.</td>
<td>% of all respondents</td>
<td>N.A.</td>
<td>Reported prevalence of women with Female Genital Mutilation</td>
<td>N.A.</td>
<td>% of all respondents</td>
<td>N.A.</td>
</tr>
</tbody>
</table>
Perhaps the most known and cited reproductive health indicator is the Maternal Mortality ratio.

Mid 2002, UNICEF in collaboration with CDC conducted a reproductive age mortality survey (RAMOS) in four Afghan provinces, with the aim to document maternal mortality statistics, to identify causes of maternal death and potential barriers to care. The study found an average of 1,600 maternal deaths per 100,000 live births (with a 95% confidence interval [CI] 1100 – 2000). Almost half of the deaths of women aged 15 to 49 years resulted from pregnancy or childbirth. 87% of these deaths were considered preventable. The situation in rural areas was far worse than in urbanised areas. The most frequent cause of maternal death was haemorrhage, followed by obstructed labour. In another study in the province of Herat, Physicians for Human Rights did estimate the maternal mortality ratio through the indirect sisterhood method at 593 deaths/100,000 live births ([95% CI] 557 to 630).

In our KAP study, the maternal mortality rate among the surveyed population was - roughly estimated through the indirect sisterhood method - 1756/100,000 women of reproductive age ([95% CI] 840 to 3496)).

Whatever the exact figure is, the maternal death rate is estimated to be among the highest in the world and shows that poor maternal health is a serious problem in Afghanistan. It is estimated that every day 45 women die of pregnancy related causes in Afghanistan, resulting in over 16,000 maternal deaths every year. An Afghan woman has a risk of about 1 on 10 to die from pregnancy or childbirth during her lifetime. Afghanistan may well be the most risky place in the world for a woman to become pregnant.

For comparison, in Belgium the maternal death rate is 200 times smaller than in Afghanistan and less than 10 maternal deaths are usually registered over an entire year.
D. REPRODUCTIVE HEALTH CARE

In Afghanistan, discussions around Reproductive Health are fairly reduced to Safe Motherhood and Family Planning issues. Reproductive Health is a far larger concept though and therefore some other topics are discussed here as well.

1. FAMILY PLANNING

Women do have many pregnancies with little or no gap between their pregnancies. (average fertility rate estimated at 6.9)
There is a reasonable awareness among health service providers to offer Family Planning. Yet family planning methods are often not available in the existing health care facilities.

According the 2002 Afghanistan National Health Resources Assessment study, 578 basic health facilities out of more than 800 existing facilities, claimed to offer birth spacing and 447 or about maximum 50% of all basic health facilities are really offering at least one type of method. Big differences between the provinces were reported (availability varying from less than 30% to more than 90%).

Knowing that about 65% of the population has no access to basic health facilities, the real availability of family planning services is low, which explains partially the low contraceptive prevalence figures - estimated at 2% - for Afghanistan.

The Multiple Indicator Cluster Survey of 2000 (MICS) learnt that 5.3% of married women interviewed in east Afghanistan used a modern (1.2%) or natural (3.6%) family planning method. The UNICEF maternal mortality survey showed that 4% had used family planning at some time. Pills and injectable hormones are the most common used modern contraceptive methods, followed by IUD (when available) and condoms.

Most of the women using a modern family planning method are of relatively “older” age (25 years and more) and do use contraception because they consider having “enough” children (usually 7 or more) rather than for birth spacing.

Nevertheless studies pointed out that, even if a group of women / men will never use family planning for socio-cultural reasons, there is a large number of women and men who are favourably disposed to the idea of spacing children. The level of knowledge about contraceptive methods is low though and incomplete among both men and women. Women and men need to receive more accurate information about contraceptive methods, especially those methods that are most readily accessible (e.g. pills, injections and condoms).

The conclusion is that there is an unmet demand for family planning services as well as for information, education and communication regarding family planning.

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5 A nationwide assessment of the Afghanistan National Health Resources (ANHRA) was commissioned by the Afghan government and conducted in 2002 (July to October) by MSH (Management Sciences for Health) together with the Japanese NGO HANDS as well as other NGOs, with support of the European Union, the UN Fund for Population (UNFPA), and the American and Japanese Development Agencies. An inventory of all basic health facilities in Afghanistan as well as of the services offered was done.

6 UNICEF conducted in 2000 in Afghanistan - like in other countries of the world - a Multiple Indicator Cluster Survey in order to assess the situation of children and women at the end of the decade for monitoring progress towards goals established at previous World Summits. Due to the socio-political context, only 22 clusters (located in Eastern, Central and South-Eastern regions) out of the 97 could be surveyed.

7 Mid 2002, UNICEF in collaboration with CDC conducted a reproductive age mortality survey (RAMOS) in four Afghan provinces, with the aim to document maternal mortality statistics, to identify causes of maternal death and potential barriers to care.
2. **Basic Mother and Child Health Services**

According WHO preliminary needs assessment of December 2001 – January 2002, only 35% of all districts have any maternal and child health services.

From the Afghanistan National Health Resources Assessment (ANHRA) we learn that the provision of mother and child health services is still problematic with only 30% of the primary care facilities able to provide basic mother and child services.

The availability and quality of MCH services vary considerably between the different geographical areas.

**Antenatal care**

According ANHRA, about 50% of all basic health facilities provide antenatal consultations and dispose of appropriate equipment (foetoscope, stethoscope and sphygmomanometer).

Not all women do seek antenatal care though, even if the service is available in the health facility. The UNICEF / CDC Maternal Mortality study 2002 pointed out that only 9% of the women accessed ANC in any of their previous pregnancies and 12% in the most recent pregnancy. Only 11% had ever received a tetanus vaccine. According to the Multiple Indicator Cluster Survey of 2000 (MICS) 37% of the interviewed women received antenatal care from a skilled attendant during last year pregnancy and 56% of the women were protected against neonatal tetanus.

Some clinics register very few ANC, primarily because little is offered of any benefit. Other clinics serve many patients per day. The use of antenatal care services seems to be encouraged by the payment of financial and non-financial incentives to the staff, the availability of drugs and supplies on site, presence of feeding programs... (conditions fulfilled usually in clinics supported by agencies).

One of the focus areas of the antenatal care should be the prevention and control of anaemia. According MISP 2000, 89% of the non-pregnant and 71.4% of the pregnant women were anaemic (Tallquist scale). IbnSina conducted a survey in the areas they are providing health services and found 61% from the pregnant and 75% from the lactating women to be anaemic. This underlines the importance of micronutrient supplementation (iron folate) during pregnancy.

**Clean and Safe deliveries**

More than 90% of the deliveries occur at home, in both rural and urban areas and less than 15% of the deliveries are attended by trained health personnel.

According to the Afghanistan National Health Resource Assessment, about 30% of the basic health facilities do (home) deliveries, and have some equipment as well as a female health worker to do it. Female relatives assist most of the deliveries. Usually the older “experienced” - which means that the woman delivered herself a certain number of children - women of the family (e.g. mother-in-law) do attend during birth giving of their younger family members (table 3).

<table>
<thead>
<tr>
<th>Table 3 Number of skilled birth attendants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled attendant</td>
</tr>
<tr>
<td>Maternal Mortality survey 2002</td>
</tr>
<tr>
<td>MISP 2000</td>
</tr>
</tbody>
</table>

The role of Traditional Birth Attendants seems rather limited, but great variations do exist between the different regions. In several communities (like some Hazara communities) TBAs are well respected and do play an important role in child delivery. In other regions - e.g. in large parts of Paktya and Paktika province (traditional Pashtun culture) - their role seems to be very limited and only when nobody “experienced” can be found in the family, assistance from someone outside of the family will be looked for.

Most of the deliveries do not happen in clean circumstances.
Thanks to the TBA training programs of different agencies, there is a growing awareness about e.g. washing hands before delivery and the use of a clean razor blade for cutting the umbilical cord. This does not mean however that deliveries happen in clean and safe circumstances.

* A midwife told us the story of a TBA explaining she was always cutting the umbilical cord with a single-use clean razor blade… after putting the umbilical cord on her (dirty) shoe.

Malpractices during childbirth seem to occur as well. Manual pressure to expel child and afterbirth (placenta) was reported to be quite often used by untrained birth attendants.

**Postnatal care**

Though a lot of medical NGO offer postnatal care services in the basic health facilities they support, the coverage is very low. From the Afghanistan National Health Information System only 5,422 postpartum visits were reported over 2001 which represents only about one fifth of all new antenatal care visits (26,084 new ANC reported).

This can be explained by the fact that according the Afghan traditions - women are supposed to stay at home with their baby during 40 days after delivery. Therefore projects aiming at improving postnatal care should focus on postnatal services at home.

Even when the woman delivers in a hospital, she usually stays few hours after delivery. It is very important though to stay at least 24 hours after delivery since most of the postpartum complications occur 24 hours after birth. Many maternal and neonatal deaths could be prevented that way.

**Other MCH services**

Other services often exist which contribute to maternal and newborn health, like supplementary and therapeutic feeding programs. Many clinics supported by NGOs offer these programs. Ideally these should be combined by health education activities and Iron folate supplementation to pregnant women, since they attract more pregnant women than the antenatal care consultations.

**3. EMERGENCY OBSTETRICAL CARE (EMOC)**

In 1997, UNICEF, WHO and UNFPA published guidelines that stated that for every population of 500,000 there should be at least four basic EmOC facilities and one comprehensive EmOC facility.

Minimal acceptable levels of care also require that 15% of all births in the population take place in the hospital and 100% of women with obstetric complications are treated in EmOC facilities.

Afghanistan does not meet these standards at all:

- Of Afghanistan's 32 provinces, only 11 currently have the capacity to deliver comprehensive emergency obstetrical care. Only 17 of the country's 174 hospitals can practice Caesarean deliveries. The number of basic EmOCs could not be documented but is estimated to be very low. Note that even in Kabul city, there are no real public basic EmOCs at the moment.

- Even where basic emergency obstetric services exist, the number of institutional deliveries is low. Less than 10% of the women give birth in a health facility. The women who are delivering in the health facilities are usually inhabitants from the town the health facility is located in.

- Another important observation is that the number of caesarean sections is very low. The caesarean section rate is an internationally recognised obstetric service indicator. The minimal international acceptable level (according to UN guidelines) sets that caesarean sections should account for 5 to 15% of all births.

  The rate found during the KAP survey - done in Kabul city - is far below this figure. The KAP study showed that only 1.6% of the interviewed women delivered through caesarean section.

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8 A basic essential obstetric care facility is one that can provide parenteral antibiotics, oxytocic drugs, anticonvulsants for pre-eclampsia, manual removal of placenta, removal of retained products via manual vacuum aspiration, and available assisted vaginal delivery. A comprehensive EmOC facility must be able to administer all of the basic services and perform surgery (i.e., caesarean section) and blood transfusions.
The caesarean section rate at some comprehensive EmOCs (cfr. Table 4) is also far beyond this level. This low percentage is a reflection of poor access to comprehensive Emergency Obstetrical Care facilities, even in Kabul city.

**Table 4. Figures collected from some (large) comprehensive emergency obstetrical units:**

<table>
<thead>
<tr>
<th>Province</th>
<th>Hospital</th>
<th>Total nb of deliveries</th>
<th>Normal deliveries</th>
<th>Caesarean sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kabul city</td>
<td>Malalai</td>
<td>2174 / month</td>
<td>89 %</td>
<td>3.3 %</td>
</tr>
<tr>
<td>Logar</td>
<td>Rabi Balkhi</td>
<td>About 1200 / month</td>
<td>About 90%</td>
<td>About 5%</td>
</tr>
<tr>
<td></td>
<td>Baraki</td>
<td>279 / year</td>
<td>79 %</td>
<td>2.2 %</td>
</tr>
<tr>
<td>Lagman</td>
<td>Mehterlam</td>
<td>1508 / year</td>
<td>84 %</td>
<td>2.7 %</td>
</tr>
</tbody>
</table>

In a general population, about 15% of all pregnant women are expected to have major complications during labour and delivery. Around 90% of the caesarean sections are estimated to be missed.

### 4. REPRODUCTIVE TRACT INFECTIONS (RTIs)

Very few figures are available on the prevalence of Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs).

From WHO database, we learn that – for the year 2001 – RTIs represented 1.5% of all officially reported cases at out patient departments (19,405 cases on 1,270,590 registered OPD visits). 91% of all RTI were reported in women aged 15 years and older; 4.7% in men aged 15 years and older and 4.0% in girls and boys younger than 15 years old.

Reports from medical NGOs were more or less coherent with the above mentioned figures. (e.g. MSF B registered 8,087 consultations for RTIs or 2% out of a total of 392,653 consultations from January till August 2002).

Among women, the most common RTI reported were pelvic inflammatory disease (PID) and vaginitis. Whereas PID is usually a consequence of a STI, the main causes of vaginitis are not sexually transmitted.

Among men, gonorrhoea and sometimes syphilis were the most mentioned RTIs by the medical staff.

There are few laboratories and even where existing (in cities) little tests can be performed. Especially for serologic testing, the possibilities are extremely limited. Nowhere in the country adequate individual HIV testing can be done. HIV testing for screening purposes can be done in some hospitals but is not systematically performed before blood transfusion.

Serologic screening for syphilis is not performed during pregnancy because the lab facilities are non-existent.

The level of knowledge about RTI/STI is also extremely poor. Health care providers as well as the general population often attribute them to poor hygiene, instead of sexual activity. In a society where women are often victimised and risk death penalty for extra-marital sexual relations, this reasoning is understandable. Most of the health care providers deny the existence of HIV/AIDS in Afghanistan and are not aware yet of any threat of HIV/AIDS. It would be foolish though for Afghans to pretend there is no risk of AIDS in their country, since other sexually transmitted infections occur in the country.

A scientific survey on the prevalence of HIV in the country has not been performed. There are known factors for potential spread of HIV: high levels of poverty, prostitution, large-scale movements of populations, unsafe blood transfusions, intravenous drug users and multi-partner homosexuality. But cultural taboos within the Afghan society make it difficult to discuss risk behaviours, etc…

The issue needs to be handled with extreme care. Sexual contact is not a subject in the Afghan society. Exclusion and penalisation of HIV positives – especially women – needs to be seriously feared.

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Even if reproductive tract infections are not a priority at the moment, actions need to be taken to reduce transmission. Blood transfusion should be a major concern, not only for the spread of HIV, but also of hepatitis. Currently, about half of the 44 hospitals performing surgery have no means of testing blood for infectious diseases such as hepatitis or HIV.

Effective treatment of RTIs needs to be enhanced as well. Few health care providers are familiar with the syndromic approach treatment guidelines recommended by WHO. The necessary drugs are usually not available.

Besides this, there is a need for an effective educational program. (E.g. condom as family planning method aiming dual protection). The input of Afghan officials (health and other authorities) is needed to design such program, in order not to be offensive to Afghans – especially to the many conservative men in Afghanistan who still find it offensive for a woman to be seen in public without being covered by a burqa.

5. GENDER AND SEXUAL VIOLENCE

Women in Afghanistan, as in many parts of the world, have few rights relating to their sexuality and role in the family.

Gender and sexual violence is still a taboo and ignored problem in the Afghan society. Few reports exist on sexual violence against women, and reported violence is mainly linked to war events. Early 2002 there have been reports on rapes by militia against displaced women in camps in the north. Sexual violations against pashtun women in the northern region have also been reported. Sexual abuse of young boys has been described too.

Intra-domestic violence

On intra-domestic (sexual) violence (worldwide the most common form of violence against women), almost nothing is known. The interpretation of the role and rights of women is completely different in the Afghan society compared to western societies. It makes them extremely vulnerable to violence. Most of the Afghan women consider it as their duty to have sex with their husband, even if they do not want to. Beating of a woman when she disobeys her husband is commonly accepted. It is also described that women who do not bear children or sons are beaten.

Harmful practices, such as honour killings and early / forced marriage are widespread. Domestic violence often causes girls to run away, and in Afghanistan this can trigger "honour killings" by male relatives eager to wipe out a perceived disgrace to the family.

Early marriage

In 1980 - 85 the mean age of marriage was estimated by UN at only 18 years. The age gap between mean age of marriage for men and women was 7 years. In the Physicians for Human Rights study, the mean age of marriage among respondents was as low as 15 years (range 5-39). According to UNICEF 54% of the girls marry at young age (under the age of 18) in Afghanistan. Together with Bangladesh and the Democratic Republic of Congo, Afghanistan figures among the worst countries regarding early marriage. In the northern region, there have been reports of girls being sold into marriage at younger age because of the financial crisis due to the recent drought.

Early marriage is related to poverty, traditional patterns linked with fear for premarital loose of virginity and social pressure. According to Unicef, early marriage constitutes a violation of a girl's human rights, primarily because it can deprive her of the right to give full and free consent to marry. Pregnancy-related deaths are the
leading cause of mortality for girls aged 15 to 19 worldwide, and early marriage is associated with an increased risk of becoming a victim of domestic violence.

In our KAP survey, the mean age of marriage was 17.2 years, though the interviewed women considered the “best age” for marriage to be 20.2 years, thus 3 years later.

**Arranged marriages, bride price or dowry system**

Marriages are often arranged between parents of girls and boys long before the children reach puberty. Often girls are married out to cousins or other related family members. Girls are seldom consulted regarding the selection of a husband. The married woman lives with her husband’s extended family. It is customary for the groom’s family to pay money for the girl’s family in exchange for a bride. The amount of money is determined during negotiations between the two families. The bride price varies widely between the different regions. High bride prices are asked in rural areas for skilled carpet weavers since they generate family income. They are also reported to marry lately.

**6. ADOLESCENT REPRODUCTIVE HEALTH**

Both girls and boys have limited knowledge about puberty, their bodies, sexuality and reproductive health. A real understanding about reproduction and conception is lacking at adolescent age – the age they usually get married. Mothers and fathers are not the primary source of information. Especially for girls, there is a deep sense of shame and embarrassment associated with talking about any topic related to the body. No educational program for Afghan adolescents exists at the moment.

**7. INFERTILITY**

Fertility is extremely important for an Afghan woman, her main role being reproductive. Women and girls commonly start child bearing within the first year of marriage. Usually the woman is blamed when a couple remains unfertile. Infertility is a serious problem since the women’s status or value to her family is often defined in terms of fertility and particularly to her ability to bear sons. Husbands generally take second wives. “Infertile” women are often physically abused or suffer the humiliation of being returned to the home of their parents. No figures exist on the infertility rate, but infertility is an important for medical consultations. More early and adequate treatment of reproductive tract infections could reduce the burden of this socially marginalizing disease.

**8. PREVENTION OF UNSAFE ABORTIONS AND MANAGEMENT OF ABORTIONS**

Induced abortion is illegal in Afghanistan and not performed in the official health circuit. Spontaneous abortions are common. In most facilities having emergency obstetric care services, dilatation and curettage can be performed. The most common indications for curettage are incomplete abortions, retentio placentae, abnormal bleeding and infertility examination. There are not many EOCs though. Facilities capable of managing (incomplete) abortions correctly do certainly constitute a big gap. Health care providers sometimes see complications of unsafe abortions – like sepsis -, but no accurate figures exist. Many presume that majority of the women suffering complications of unsafe abortions do not reach the health facilities in time and / or not managed correctly. Unconfirmed reports on induced abortion exist. Women told us that generally older women in the community carry out the inductions, using wooden sticks or physical pressure. Injections (prostaglandines?) seem to be used as well. Private practitioners also engage in pregnancy interruptions. Their clients are mainly unmarried singles or mothers with a high number of children.

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10 Save the Children USA conducted a May 1997 a PRA (Participatory Rapid Appraisal) to determine knowledge, attitudes and practices of Afghan refugees regarding reproductive health issues.
9. PREVENTION AND TREATMENT OF GYNAECOLOGICAL CANCERS

Diagnosis, treatment and education for breast cancer and other malignancies of the reproductive tract do not exist in Afghanistan.

No screening program exists for breast, uterus or other cancers. Screening programs would anyway be inappropriate since early treatment is not available. (Only surgery available, but no possibilities for chemotherapy or radiotherapy.)

Even if this belongs to tertiary health care level and not to the immediate priorities, the availability of some tertiary health care services is justified at national level (Kabul) and reflection is needed now at central level which tertiary health care services should be available in the future and at which level.

Other Reproductive health issues like information, education and care of post menopausal age and old age, are not on Afghanistan's agenda of today and tomorrow.
E. GENDER AND HUMAN RIGHTS

It is well recognised that the rights of women are under-represented in Afghanistan. The weak social position of the Afghan woman has a negative influence on her health condition.

The low social status of the Afghan woman is not entirely a phenomenon introduced by the Taliban. For women in rural areas, life was always tough and dominated by men. In cities women had more access to education and were allowed to work, to travel and to have an income. These rights were abolished with the arrival of the Taliban, which changed the women’s position in the urban settings. The Taliban put additional restrictions to women in public life, limiting their role to procreation.

Different attitudes towards women survive today. There has been an increasing acceptance of women in education and employment, especially in urban areas. Yet, for many others, “women’s rights” recall bitter memories of Soviet attempts to undermine traditional values. Such ideas are still considered as corrupting, western and non-Islamic for the majority of the Afghan population. The mujahideen, present in all political parties, retain a strong commitment to the preservation of their honour – maintained, among other things, by the seclusion of women (purdah). With the recent political developments, a new era for recognition of women’s rights might start. The designation of 2 positions in the recently chosen transitional government to women is a good example of this. Since the end of the Taliban regime, women enjoy more freedom of movement. Schools for girls reopened this year.

Changing government will be insufficient if the local communities and women themselves are not involved and interested in the process. Still in the rural areas the traditional feudal system, which considers women as the property of men, is remaining. The conservative traditional attitude towards the status of the women is still predominating. Women do remain prisoners at home. For the western world, the wearing of the “Burqa” is one of the most visible expressions of the repression of the women. Till today the Burqa is omnipresent in Afghanistan and even in Kabul city, worn by most women. It will undoubtedly take years before women’s rights will be recognised as such and have a real place in the Afghan society.

1. INTERNATIONAL HUMAN RIGHT TREATIES:

Afghanistan has ratified only two of the international conventions:

- Convention Against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment (CAT): signed on 04/02/85, Entry into force since 26/06/87
- Convention on the Rights of the Child (CRC): signed on 27/09/90, Entry into force since 27/04/94

Afghanistan has signed on 14/08/80, but has not ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). This Convention is the international human rights instrument, which specifically addresses women’s rights, adopted by the General Assembly in 1979 and legally binding the 168 States parties. The Convention requires States to embody the principle of gender equality in their laws and policies; to adopt legislative and other measures – including sanctions – prohibiting discrimination, and to establish legal protection for women through tribunals or other public institution.

Other international treaties have not been signed yet, amongst other:

- The International Covenant on Civil and political Rights (CCPR),
- The International Convention to the Elimination of All Forms of Racial Discrimination (CERD),
- The International Covenant on Economic, Social and Cultural Rights (CESCR)
2. CONSTITUTION AND JUDICIAL FRAMEWORK

According to the Bonn agreements, a Constitutional Loya Jirga had to be convened within eighteen months of the establishment of the Transitional Authority, in order to adopt a new constitution for Afghanistan.

To prepare the proposed Constitution, a Constitutional Commission has been established in October 2002. In the meantime the Constitutional framework as defined in the Bonn agreements is used:

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<th>Constitutional framework as defined in the Bonn agreements</th>
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1) The following legal framework shall be applicable on an interim basis until the adoption of the new Constitution referred to above:
   i) The Constitution of 1964, a/ to the extent that its provisions are not inconsistent with those contained in this agreement, and b/ with the exception of those provisions relating to the monarchy and to the executive and legislative bodies provided in the Constitution; and
   ii) existing laws and regulations, to the extent that they are not inconsistent with this agreement or with international legal obligations to which Afghanistan is a party, or with those applicable provisions contained in the Constitution of 1964, provided that the Interim Authority shall have the power to repeal or amend those laws and regulations.

2) The judicial power of Afghanistan shall be independent and shall be vested in a Supreme Court of Afghanistan, and such other courts as may be established by the Interim Administration. The Interim Administration shall establish, with the assistance of the United Nations, a Judicial Commission to rebuild the domestic justice system in accordance with Islamic principles, international standards, the rule of law and Afghan legal traditions.

With no functioning nationwide judicial system, many municipal and provincial authorities in Afghanistan rely on some interpretation of Islamic law and traditional tribal codes of justice. The Bonn Agreement of December 2001 called for the establishment of a Judicial Commission to rebuild the domestic justice system in accordance with Islamic principles, international standards, the rule of law, and Afghan legal traditions. However, by year's end, there was no independent judiciary.

In January 2002, the Afghan Interim Authority appointed the influential Pashtun Islamic scholar Fazal Hadi Shinwari, the former administrator of a religious seminary in Pakistan, as the new Chief Justice of the Supreme Court of Afghanistan. Chief Justice Shinwari has been quoted in press reports remarking that justice in post-Taliban Afghanistan will continue to be dispensed according to Islamic law or sharia.

"The Taliban are gone, but sharia, or the code of Islamic law, is here to stay, says Fazel Hadi Shinwari. That means that in new Afghanistan, adulterers can still face death by stoning, homosexuals can be punished by being hurled from a high place and thieves can be sentenced to having a hand lopped off."

In September, President Karzai confirmed that sharia is the law of the land during a Questions & Answers at the Council on Foreign Relations. He tried to assure that amputation punishments, at least, would not be applied: “There are strict, strict rules of earning that kind of punishment. Very strict rules... So I assure it will not happen.” But what if the new court were to dispense with the “strict rules” - as the old Taliban court did?

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11 From Associated Press - January 30, 2002
3. Human Rights

The Bonn agreement foresees in the set-up of an independent Human Rights Commission.

Human Rights framework defined in the Bonn agreements

1) The Interim Administration shall, with the assistance of the United Nations, establish an independent Human Rights Commission, whose responsibilities will include human rights monitoring, investigation of violations of human rights, and development of domestic human rights institutions. The Interim Administration may, with the assistance of the United Nations, also establish any other commissions to review matters not covered in this agreement.

2) The Interim Authority and the Emergency Loya Jirga shall act in accordance with basic principles and provisions contained in international instruments on human rights and international humanitarian law to which Afghanistan is a party.

On the 6th of June 2002, Hamid Karzai signed into law the Decree on the Establishment of the Independent Afghan Human Rights Commission. Dr. Simi Samar, former minister of Women’s Affairs has been appointed as the head of the Afghan Human Rights Commission.

The reality is different. Several reports mention violation of human rights in the country.

Recents reports of Human Rights Watch revealed that violations of women’s and girls’ rights occur still on large scale in Afghanistan.

Women do not have the right to contest male family members’ decisions about whom they will marry, whether they can attend school or work... Women are marginalized politically, economically and socially.

“The common perception outside Afghanistan is that when the U.S.-led forces overthrew the Taliban, women and girls were liberated. The truth is somewhat different. Despite improvements in access to education and an end to the Taliban’s ban on working outside the home, an array of Taliban-era restrictions on women remains in place. One of the worst places is the western province of Herat, ruled by local warlord Ismail Khan.”

“Even in Kabul, many Afghan women still face constant threats to their personal security from other civilians or armed men belonging to various political factions. Outside Kabul, the situation is one of acute general lawlessness and insecurity, as there is no ISAF presence and rival warlords control security conditions. In these areas, more than in Kabul, Afghan women continue to face serious threats to their physical safety, which denies them the opportunity to exercise their basic human rights and to participate fully in the rebuilding of their country.

The danger of physical assault is evident throughout northern Afghanistan, where ethnic Pashtuns have been specifically targeted for violence and harassment, including sexual violence. During February and March 2002, Human Rights Watch documented cases of sexual violence against Pashtun women perpetrated by the three main ethnically based parties and their militias in the north.”

UN and NGO officials reported that restrictions on women and girls are again increasing all over Afghanistan.

In Kabul, a Vice and Virtue squad (renamed “Islamic Teaching”) is operating again. This recalls better memories of the notorious “religious police” under the Taliban regime.

Under the Ministry of Religious Affairs, a religious police was established counting 200 to 300 staff, including 50 to 90 women. They are harassing women in Kabul’s streets and girls’ schools...
for “un-Islamic behaviour”, such as wearing makeup, and - in some instances - follow them home to castigate their parents or spouses.

Schools for girls have been attacked or set on fire in several provinces (Kandahar, Sar-e-Pol, Zabul, Logar, Wardak, ...). Local forces have done little to prevent these attacks.

In some areas playing music at weddings and dancing is still dangerous. Musicians have been beaten in several places.
Commanders have pressured women not to work in some provinces.

During the Loya Jirga process local commanders threatened women candidates. Dr Sima Samar had been marginalized during and after the loya jirga by intimidation and death threats

Shortly after Afghanistan’s cabinet was announced in June, new chief justice Fazul Hadi Shinwari denounced the newly appointed women’s affairs minister, Sima Samar, for speaking “against the Islamic nation of Afghanistan.” Samar was formally charged with “blasphemy,” which can carry the death penalty. Her crime? Dr. Samar had allegedly told a magazine in Canada that she did not believe in sharia, or Islamic law. Fearing for her life, Samar ultimately declined her office, even though, under intense U.S. pressure, the charges were dropped.

Several women feel threatened and do not dear to move in public because of fear for forced marriages, sexual harassment, ...

The Independent Afghan Human Right Commission, which is mandated to monitor human rights conditions and investigate abuses, is not receiving sufficient political and moral support though to effectively investigate or monitor human rights conditions. The commission is also suffering from serious staffing problems.

Human Rights Watch has criticized the United States, other nations involved in Afghanistan and the UN mission for not making human rights a high enough priority in the country.

The replacement of Dr. Simi Samar as Minister of Women’s Affairs by the more moderate Habiba Sorabi, is perceived as a step downwards by the feminist activists.

There is an extreme shortage of qualified judges in Afghanistan. There are currently no functioning law schools in Afghanistan; a faculty of law was established at Kabul University in 1938, but the university - closed at one point under the Taliban regime - is currently in disarray and the status of the law program is unclear.

The importance of the sharia is discussed in following opinion article 12:

“The stoning to death of women found guilty of adultery under the Taliban (and, more recently, in Africa) has prompted outraged editorials in the West. But the more fundamental problem of extreme sharia—that its all-powerful judicial apparatus precludes democracy and sharply reduces human freedom across the board—has been all but overlooked. When asked about the development of penal sharia in Afghanistan, a senior State Department official told me recently that State was concerned about Karzai’s security, not about sharia. They fail to realize that in a hard-line sharia state, with 7th-century laws and punishments, the supreme court is not merely another branch of government: It’s where the real power resides. … No president or parliament can override their decisions, no politician or journalist can criticize them; to do so would be blasphemy …”

12 Opinion article available at
http://www.freedomhouse.org/religion/country/afghanistan/Sharia%20in%20Kabul.htm
F. BARRIERS TO REPRODUCTIVE HEALTH CARE

Dr. Oliver Brasseur, UNFPA Representative for Afghanistan noted that Afghanistan's high maternal mortality is related to many factors including early marriage, lack of education, lack of pertinent information on reproductive health, low-quality obstetric and gynaecological care, and inadequate child spacing.

UNICEF identifies 3 barriers to health care in general and to emergency obstetric care in particular:

- socio-cultural: Not knowing there is a problem or deciding to seek care
- geographic: Not being able to reach health care
- health care: Not receiving adequate treatment at the health care facilities

1. SOCIO-CULTURAL BARRIERS:

The traditional low status of women, their reproductive role and early marriages

Early marriage and pressure to have a large family contributes to high maternal mortality.

In the Afghan society men are the decision makers regarding family matters. Women stay normally at home and do rarely participate in public life. Lack of decision-making power limits the reproductive choices a woman has and results in many pregnancies with short birth intervals. The Afghan women’s role is principally reproductive, and most importantly giving birth to sons.

This has a lot to do with the traditional way in which the afghan society is built. In rural areas the feudal system is remaining. Only about 5% of the population are landowner from whom the other families lease land. A complicated system of indebting exists. The family clan is very important and consists of the parents, their sons and grandsons who stay traditionally within the family compound and defend the interests of the family. Many sons mean many defenders and many working hands. Girls are married out (usually arranged marriages) into a new family against a bride price. The preservation of honour of women is very important. Partially this happens through exclusion of women from social life, the so-called “purdah”.

“Reproductive shame” of women

Vaginal bleeding is associated with “impurity”, which inhibits women from prayers and should at all prices be hidden, above all from males. Some women will prefer to die at home than to seek help when they are bleeding. From interviews with women and female health professionals in e.g. Paktya province, we also learnt that being pregnant is a shame for a woman. Afghan women will therefore not inform their environment on her pregnancy.

Delivery is a shame as well, as it is associated with vaginal bleeding and sexual relations. This “shame” is the main reason - according the interviewed midwives - why women do not frequent maternity wards for delivery. Women feel ashamed to discuss pregnancy related matters with men and therefore do not tell when something is wrong, especially not when they are bleeding. Some health professionals recommended to separate the maternity ward from the hospital and to install it on rather invisible place, hidden behind trees. So that people would not see which men are bringing their daughters to the maternity. Even if this is not a universal truth - Paktya is known as one of the most conservative, traditional regions- the traditional way “blood” is perceived might be an important factor in the “non” health care seeking behaviour in case of severe bleeding before or after delivery. The recent UNICEF mortality study identified post-partum haemorrhage as the most important cause of maternal death (40%).

Limited freedom of movement for women

They have to ask permission to a male relative (husband or their brother) to leave the house. Several health workers reported that women are still not allowed to leave their homes to visit the health
centres. This seems especially true in rural areas and in more conservative regions (like Kandahar, Paktya and Paktika,).
Woman can neither move alone. They always need to be accompanied by male family member(s) (the so-called "Mahram"). Since the woman has the care of the children, a hospitalisation means often an expensive and cumbersome adventure with the move of the whole family (husband, brother-in-law, sister-in-law, children...) to the town or city.

The over-all low education level of women
Most of the women are illiterate. The adult literacy rate for women aged more than 15 years is estimated at only 16% (10 to 21 %).

2. GEOGRAPHIC BARRIERS

The natural geographic features of Afghanistan
Afghanistan is a beautiful but rude country, consisting of rugged mountains and plains in the north and south-west (deserts). It has very limited natural water resources and desertification is going on. The northern region is divided from the southern by high mountains (the Hindu Kush mountains), with peaks reaching 7,485 m. The climate is harsh with cold winters and hot summers (arid to semi-arid). Several provinces are inaccessible during winter due to snowfall and muddy roads.

Lack of roads and transport means
The roads have suffered during the long years of war. Only a few roads are still usable for cars (four wheel drive). Another obstacle to transport is the presence of landmines and unexploded missiles. In urban areas taxis ensure transport but these are quite expensive (especially during the nights). In rural areas the main used transport means are donkeys.

Lack of security
Banditism and interfactional fighting are still part of daily life in Afghanistan. Especially during the night, travelling is considered dangerous. This is an additional factor limiting the freedom of movement of people, especially of women.

Lack of health facilities
In urban areas, there is a minimum Mother and Child Health (MCH) care, but in remote areas where health structures are often non-existing, the health situation of women and children is dramatic. Hospitals are only existing in bigger towns and do offer few health services. The referral system between the different levels within the health care system is not functioning.

3. HEALTH CARE RELATED BARRIERS

These barriers have extensively been discussed in the previous chapters. They include:
- Low capacity of MoPH
- Poor training of health staff
- Lack of female health professionals, especially in rural areas
- Lack of health facilities in rural areas

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- Lack of material and financial resources (for infrastructure, equipment, medical supplies, staff remuneration amongst other)
- Ineffective health information system
- High cost of service delivery, especially at referral level
- Overall low quality of service delivery
- Focus on curative services
- Lack of a good functioning referral system
III. RESPONSE ANALYSIS: INTERNATIONAL AID

A. ISSUES CONCERNING THE RECONSTRUCTION OF AFGHANISTAN

1. INSTABLE POLITICAL ENVIRONMENT

Security and political stability are the cornerstones of any reconstruction process. But despite general optimism, the political situation in Afghanistan remains volatile. Though immense progress has been made, Afghanistan is still far away from being a state of law and order and “peace” remains a fragile word. Inter factional tensions and fighting, crime, banditism as well as human right violations are part of daily life. Warlords and commanders with armed militia set the rules outside Kabul. For many Afghans, the overthrowing of the Taliban regime is more perceived as a shift of power towards the northern alliance instead of the start of an era of peace and security.

Though political stability is a known imperative for reconstruction, donors tend to reason in an opposite way and believe that peace and political stability can be achieved through reconstruction of the country. They focus on development programs and quick impact projects. This reconstruction process is seriously hampered by insecurity, especially outside of Kabul. Repeated calls from the Afghan government, the UN mission and several NGOs to expand the International Security Assistance Force (ISAF) outside of Kabul, have so far been disregarded.

2. LACK OF NATIONAL AUTHORITY

It is important to realize that Afghanistan is not a united “nation”. Over the past 25 years, regional leaders have taken advantage of the political vacuum at national level, and strengthened their own power:

- Ismail Khan rules the western provinces.
- Northern provinces are under the control of general Dostom.
- In each province, the governor and local commanders are the real strong people. On local level, the religious leaders or “mullahs” are the most influential.

As a result, most of the decisions made in Kabul by the individual ministries have little influence in the regions. The strengthening and capacity building of the central level, to become a real authority, is an urgent need. The international community should provide the necessary technical, material and political support to reinforce this process. Instead, some donors cling to old habits by negotiating separately with individual power holders across the country whereby the authority of the central level is denied.

3. POOR SOCIO-ECONOMIC SITUATION

Afghanistan is one of the poorest countries in the world. The country’s social and economic indicators are comparable or lower than the indicators for sub-Saharan Africa. (Life expectancy is only lower in 7 other countries and only 3 countries have higher child mortality rates). A large proportion of the population is estimated to live below the poverty threshold.

The Afghan economy has been destroyed by the 23 years of conflict. Most of the Afghans depend on a “survival” economy. Land mines, destruction of bridges, tunnels and roads and the recourse to camels and donkeys for local transport, have reduced the economy to a slow, low level and mostly local affair. Communication is almost non-existent. Irrigation channels suffered from 20 years of war, access to the fields is often impossible due to land mines and war activity. Industry hardly exists.
The main economic activity consists of agriculture. This economy has been disrupted by the war and a devastating drought, which affects the country since three years. Due to the war, the people have little reserves and their income has been reduced significantly by the repeated loss of harvests. People are widely believed to have exhausted their coping mechanisms. UNICEF estimates that 50% of the children are malnourished.

Many families did not find other alternatives than leaving their villages and moving towards bigger centres in order to survive. The wealthier went to Iran, Pakistan, or further away, the poorest could probably not even afford to leave their place, while the majority of the displaced went to the suburbs of the bigger cities, in the hope to survive on humanitarian aid, begging or to find cheap work. Most of the displaced have sold everything and are basically relying on external support. UNHCR calculates the number of displaced people living around the larger urban centres at more than one million. More than 250,000 have been resettled during 2002. During the same year, another 1.8 million Afghans returned from abroad. Most of them settled down in and around urban areas. Cities like Kabul are growing rapidly and a large proportion of the population is unemployed.

The “reconstruction of Afghanistan”, as discussed during international conferences in Bonn and Tokyo, should go hand-in-hand with humanitarian assistance to improve the critical situation of these people. Basic security is a further precondition for the implementation of longer-term development programs. Whereas reconstruction programs and humanitarian assistance do have an independent approach, coordination mechanisms are essential if impact is to be reached. There is still a long way to go in this field.

4. THE HIGH AFGHAN EXPECTATIONS

Many Afghans have unrealistic expectations regarding international aid and expect the world to reconstruct their entire country. These false expectations have been fuelled by the unrealistic political speeches and public relations talks of many countries. Also the memory of the invasion by the Russians - who built biggest part of the infrastructure of Afghanistan – might play a role.

The priority interventions of the international community do not necessarily correspond to the expectations of Afghan people. An example is the international interest to improve the status of women, which is not seen as a priority by many Afghans. Direct needs as access to water, food, employment and education are perceived by the population as more urgent to resolve. Many people feel abandoned and disillusioned with the United States, the United Nations and the international community in general. This could lead to increasing security incidents with international staff in the future.
B. INTERNATIONAL AID

1. THE RECONSTRUCTION PROCESS OF AFGHANISTAN

The Architecture of the International Aid was set at several international meetings.

a) November 2001
   - Afghanistan Steering Group meeting in Washington DC
     - Steering group was established. The steering group includes more than 60 countries with the objective to assist and coordinate reconstruction efforts for Afghanistan. 5 building blocks were identified: 1) national army – US (DOD/CENTCOM) lead, 2) national police – German lead, 3) judicial training – Italian / European Commission lead, 4) counter-narcotics – UK lead, 5) demobilization – UN lead.
     - Needs Assessment was commissioned

b) December 2001
   - On the 5th of December 2001, a U.N. sponsored Afghan peace conference in Bonn approved a broad agreement for the establishment of a 6-month interim authority (Afghan Interim Administration) to govern the country.
   - Two meetings were held in Brussels:
     - "Afghan Women’s Summit for Democracy"
     - UNIFEM Roundtable on Building Women’s Leadership in Afghanistan
   - Steering Group Meeting in Brussels:
     - Establishment of an implementation group
     - Progress on Needs Assessment was reviewed
   - The European Commission and the Belgian presidency co-hosted a Conference of the Steering Group for Assistance in the Reconstruction of Afghanistan to discuss a common and coordinated approach to the international contribution to the reconstruction of Afghanistan. In particular, agreement was reached that the international community will contribute reconstruction assistance within a single needs assessment framework, on options for financing mechanisms (including a Trust Fund), and on the role and membership of an Implementation Group to coordinate on the ground, including with the Afghan Interim Authority.

c) January 2002
   - The joint team comprising experts from the World Bank, the United Nations Development Programme (UNDP) and the Asian Development Bank (ADB) have completed their preliminary needs assessment for the reconstruction (that is excluding humanitarian aid) of Afghanistan; these organisations now work on the "base case" assumption that US $ 9 - 12 billion will be necessary for the next five years.
   - Ministerial Meeting of the Afghanistan Steering Group, in Tokyo
     - Donors promised 4,8 billion $ over the next 3 years (30 months)
     - Pledges for the year 2002 were 1,8 billion US$
   - Presentation of the Immediate and Transitional Assistance Programme for the Afghan People 2002 (ITAP) by the United Nations. Parallel with the Tokyo Conference, the UN presented the ITAP consolidated appeal of UN agencies and several NGOs in order to respond to the urgent humanitarian, recovery and reconstruction needs. In 2002, agencies participating in ITAP were planning to implement programmes with a total value of 1,7 billion US$ (85% by UN agencies, 15% by NGOs). At this moment, 600 million were available, and thus 1,1 billion US $ was needed to fully fund the planned programmes.

d) March 2002
   - Establishment of the United Nations Assistance Mission in Afghanistan (UNAMA)) for 12 months was adopted by the UN security council, in order to ensure implementation of the Bonn agreement. UNAMA has 2 main focuses and mandates:
     - Political affairs (promotion of national reconciliation)
     - Relief, recovery and reconstruction (manage, plan and conduct all UN activities).
April 2002
  o Implementation Group Meeting in Kabul, co-chaired by the Afghanistan Interim Authority and the World Bank
    o Shift of focus to Afghanistan and its government
    o The Donors endorsed the Government's National Development Framework (NDF). This NDF established 12 main programme areas through which assistance priorities are defined and operationalised. Under the NDF, the 12 programme areas are clustered into 3 pillars:
      o Pillar I: Humanitarian and human social capital - 45% of total expenditure
      o Pillar II: Physical reconstruction and Natural Resources - 35%  
      o Pillar III: Private sector development; Rule of Law/Security - 20%.
    o ITAP projects and projects requirements have been formally inserted into these pillars. In each programme area, programme groups have been formed to bring all actors together. Each programme group is guided by a lead ministry, and technically supported by a Programme Secretariat, normally a United Nations (UN) agency, multi-lateral institution or a Non-Governmental Organisation appointed to support and help manage the Programme Group. The Programme secretariat is asked to assist the government in developing strong operational coordination mechanisms, to provide technical support in drawing up the National development budget, and to channel resources to national capacity building. The process will culminate in a national development plan. A National Development Budget (NDB), finalised by October 2002, serves as the financial planning mechanism for the NDF. It covers assistance funding channelled through ITAP, the Trust Funds, bilaterally and from private sources.

May 2002
  o Establishment of the Afghanistan Reconstruction Trust Fund (ARTF). The ARTF was jointly prepared by UNDP, World Bank, ADB and IsDB and established in May 2002. It succeeds the UNDP Trust Fund, which provided short-term emergency funding for salaries of civil servants. ARTF aims to meet serious shortfalls for salaries of civil servants. It is a coordinated financing mechanism to enable AIA to fund budget and priority sector and investment projects and programs. The ARTF assists the AIA to fund both physical reconstruction projects and running expenses such as salaries for civil servants including health workers, teachers and police. ARTF activities include 3 categories of eligible expenditures:
    o Government recurrent costs (salaries, Operations &Maintenance, other recurrent expenditures)
    o Programs, investments and quick impact projects: finance pre-feasibility studies and activities in agriculture, infrastructure, micro-finance and the social sectors, as well as re-integration of combatants into society and programs to facilitate the return of private business. Through this component, approved proposals for specific NGO programs can be financed, with the NGO’s concerned acting as executing entities.
    o Afghan expatriates and training (salaries, travel and allowances)
  o Apart from ARTF two other Trust Funds exist:
    o LOFTA = Law and Order Trust Fund for Afghanistan. Administered by UNDP, LOFTA has been established to receive funds for police related expenditures (including salaries not eligible from the ARTF).
    o Military Trust Fund. UNAMA administers this trust Fund for paying salaries and benefits to the Afghan National Army.

March and July 2002
  o Joint Donor Mission representing 8 different agencies visited Afghanistan in March and again in July, in order to agree with the Government on a framework for assistance to the health, nutrition, and population (HNP) sector over the next 2,5 years.

December 2002
  o Annual meeting of the Afghanistan Support Group (ASG) in Oslo. This meeting was held on 17-18 December 2002, under the chairmanship of Norway. The meeting was attended by representatives of the Afghanistan Transitional Administration (ATA), Afghanistan's
neighbouring states and other interested states, the UN and UNAMA, a number of UN organizations, intergovernmental and non-governmental organizations. The focus of the meeting was on the short and longer term needs in Afghanistan that require the support of the international community. The meeting also took stock of the results so far of the ITAP. The Transitional Assistance Program for Afghanistan 2003 was presented, and the future organization of international support efforts was discussed. The overriding issue in the discussions was the urgent necessity of promoting lasting peace, security and democratic values in the whole of Afghanistan. Stocktaking showed that most of the pledges for 2002 made at the Tokyo Conference last January have been disbursed. There was no doubt among the participants that this had contributed substantially to positive developments in Afghanistan. However, there was also agreement that Afghanistan’s needs substantially exceeded the resources made available.

2. Financial Requirements

According to the preliminary needs assessment of UNDP, Worldbank, Asian Development Bank (January 2002), donor funding requirements were estimated for each sector. The low, base and high case scenarios reflect different assumptions about absorptive capacity, investment priorities and rates of economic growth.

As shown in table 5, the total base financing requirements from the sectoral analysis amounted to 1.7 million US$ in the first year, 4.9 million US$ over 2.5 years, 10.2 billion over 5 years and 14.6 billion over 10 years.

<table>
<thead>
<tr>
<th></th>
<th>1 Year</th>
<th>2.5 Years</th>
<th>5 Years</th>
<th>10 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base case</strong></td>
<td>1.700</td>
<td>4.900</td>
<td>10.200</td>
<td>14.600</td>
</tr>
<tr>
<td><strong>Low case</strong></td>
<td>1.400</td>
<td>4.200</td>
<td>8.300</td>
<td>11.400</td>
</tr>
<tr>
<td><strong>High case</strong></td>
<td>2.100</td>
<td>6.500</td>
<td>12.200</td>
<td>18.100</td>
</tr>
</tbody>
</table>

Financial requirement for Health

a. According to the preliminary needs assessment of UNDP, Worldbank, Asian Development Bank (January 2002), the Base case capital investment and technical assistance needed for the health sector was estimated at 50 million US$ for the first year, **210 million over 2.5 years**, 380 million US$ over 5 years and 640 million over the next 10 years.

b. According to WHO, an average annual expenditure of 221,776,000 US$ is to be expected (table 6).

<table>
<thead>
<tr>
<th></th>
<th>1st to 10th year</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capital costs</strong></td>
<td>164,600,000</td>
<td>551,895,000</td>
</tr>
<tr>
<td><strong>Recurrent costs</strong></td>
<td>290,730,000</td>
<td>1,665,865,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>455,330,002</strong></td>
<td><strong>2,217,760,000</strong></td>
</tr>
</tbody>
</table>

Table 6: Preliminary costing for the health sector according to WHO preliminary needs assessment (December – January 2002).

c. In February 2002 an update of the financial requirements of ITAP, based on the actual activities to be undertaken in 2002 and for which an agency was ready to assume immediate implementation responsibility, has been done. In the reviewed ITAP, **136 million US$** for the health sector have been required.

d. Joint donor mission (March 2002)
A joint donors mission has concluded after a ten-day assessment of the health situation in Afghanistan that a **200 million dollar** donor investment in health **over the next two and a half years** is needed.

e. The **National Development Budget** (NDP, established in October 2002) for solar years 1381 – 1382 (corresponding with the years 2002 – 2003) provides an outline of ongoing and proposed investments needed around the 12 program areas presented within the National Development Framework. The NDP was developed by the different line ministries assisted by their program secretariats and hereafter reviewed by the Ministries of Finance, Reconstruction and Planning assisted by UN agencies and international donor community. For the Health and Nutrition program area, the budget scheduled for solar year 1381 (2001) was 63.8 million US$ and for solar year 1382 (2003) **226.1 million US$**. Within the 226.1 million US$ scheduled for the health and nutrition program 2003, following budgets are foreseen (table 7):

**Table 7. Budget lines of the Health Nutrition Programme 2003**

<table>
<thead>
<tr>
<th>Total Operating and recurrent costs: 172.5 million US$, including</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Basic Package of services: 100 million</td>
</tr>
<tr>
<td>o Reproductive Health – Family Planning: 2.7 million</td>
</tr>
<tr>
<td>o Safe Motherhood: 15.4 million</td>
</tr>
<tr>
<td>o Referrals (from clinics): 17.5 million</td>
</tr>
<tr>
<td>o Medical equipment – supplies: 9.9 million</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Capital or One Time Costs: 53.6 million US$, including</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Rehabilitation / expansion: 25 million</td>
</tr>
<tr>
<td>o Medical equipment hospitals: 16.4 million</td>
</tr>
<tr>
<td>o Medical equipment clinics: 10 million</td>
</tr>
</tbody>
</table>

f. Transitional Assistance Programme for Afghanistan (TAPA) is the new consolidated inter-agency appeal from **January 2003 to March 2004** of mainly UN agencies as well as of some NGOs. Total requirements are estimated at 815,313,404 US$. For the Health and Nutrition sector, **77,265,974 US$** are requested.

### 3. COMMITTED AND DISBURSED INTERNATIONAL FUNDING OVER 2002

Through the Donor Assistance Database (DAD)\(^\text{13}\), the information resumed in table 8,9,10,11 and in figure 1 was obtained:

**Table 8 Donor contributions by ITAP and non ITAP projects:**

<table>
<thead>
<tr>
<th></th>
<th>Total requested</th>
<th>Donor committed</th>
<th>Donor disbursed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ITAP project</strong></td>
<td>1,604,220</td>
<td>837,394,412</td>
<td>829,592,028</td>
</tr>
<tr>
<td><strong>Non ITAP project</strong></td>
<td></td>
<td>1,530,668,371</td>
<td>1,142,253,778</td>
</tr>
<tr>
<td><strong>TAPA project</strong></td>
<td>815,313,404</td>
<td>67,942,371</td>
<td>10,638,197</td>
</tr>
<tr>
<td><strong>TOTAL projects</strong></td>
<td><strong>4,337,683,147</strong></td>
<td><strong>2,436,005,154</strong></td>
<td><strong>1,982,484,003</strong></td>
</tr>
</tbody>
</table>

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\(^\text{13}\) Accessed through the internet at [http://aacadad.undp.org](http://aacadad.undp.org) (username UNDPguest, password database)
Table 9 Donor contributions per sector:

<table>
<thead>
<tr>
<th>Sector</th>
<th>Total requested</th>
<th>Total committed</th>
<th>Unmet amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Refugee and IDP Return</td>
<td>$748,500,272</td>
<td>$274,046,855</td>
<td>$474,453,416</td>
</tr>
<tr>
<td>1.2 Education &amp; Vocational Training</td>
<td>$227,332,431</td>
<td>$104,639,935</td>
<td>$122,692,496</td>
</tr>
<tr>
<td>1.3 Health &amp; Nutrition</td>
<td>$428,156,053</td>
<td>$247,748,968</td>
<td>$180,407,085</td>
</tr>
<tr>
<td>1.4 Livelihoods &amp; Social Protection</td>
<td>$1,133,656,832</td>
<td>$652,613,452</td>
<td>$481,043,377</td>
</tr>
<tr>
<td>1.5 Cultural Heritage, Media &amp; Sport</td>
<td>$47,429,047</td>
<td>$11,536,196</td>
<td>$35,892,851</td>
</tr>
<tr>
<td>2.1 Transport</td>
<td>$136,257,178</td>
<td>$60,700,675</td>
<td>$75,556,503</td>
</tr>
<tr>
<td>2.2 Energy, mining, &amp; telecom</td>
<td>$26,880,600</td>
<td>$11,700,000</td>
<td>$15,180,600</td>
</tr>
<tr>
<td>2.3 Natural Resource Management</td>
<td>$344,088,084</td>
<td>$166,090,595</td>
<td>$177,997,490</td>
</tr>
<tr>
<td>2.4 Urban Management</td>
<td>$107,446,155</td>
<td>$42,514,855</td>
<td>$64,931,300</td>
</tr>
<tr>
<td>4.1 Public Administration</td>
<td>$124,837,278</td>
<td>$67,640,570</td>
<td>$57,196,708</td>
</tr>
<tr>
<td>4.2 Security &amp; Rule of Law</td>
<td>$299,016,129</td>
<td>$146,661,912</td>
<td>$152,354,217</td>
</tr>
<tr>
<td>6. Unclassified</td>
<td>$513,206,824</td>
<td>$495,639,824</td>
<td>$17,567,000</td>
</tr>
<tr>
<td>7. Outside of Budget</td>
<td>$200,876,264</td>
<td>$154,471,319</td>
<td>$46,404,946</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$4,337,683,147</td>
<td>$2,436,005,156</td>
<td>$1,901,677,989</td>
</tr>
</tbody>
</table>

Figure 1 Contributions (committed and disbursed) over 2002 by donor (group)

Table 10. Donor contributions to the health sector:

<table>
<thead>
<tr>
<th>Sector</th>
<th>Total requested</th>
<th>Total committed</th>
<th>Unmet amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Policy &amp; Planning</td>
<td>$1,973,508</td>
<td>$0</td>
<td>$1,973,508</td>
</tr>
<tr>
<td>Health Management System Dev</td>
<td>$13,489,350</td>
<td>$8,147,000</td>
<td>$5,342,350</td>
</tr>
<tr>
<td>Basic Health Services</td>
<td>$192,677,367</td>
<td>$120,612,095</td>
<td>$72,065,272</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>$56,756,698</td>
<td>$54,069,332</td>
<td>$2,687,366</td>
</tr>
<tr>
<td>Disease Prevention &amp; Control</td>
<td>$129,206,045</td>
<td>$51,895,312</td>
<td>$77,310,733</td>
</tr>
<tr>
<td>Unspecified: Health &amp; Nutrition</td>
<td>$34,053,084</td>
<td>$13,025,228</td>
<td>$21,027,856</td>
</tr>
</tbody>
</table>
### Table 11. Contributions to the Afghanistan reconstruction Trust Fund as of 20 December 2002

<table>
<thead>
<tr>
<th>Donor</th>
<th>Million US $ pledged</th>
<th>Donor</th>
<th>Million US $ pledged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bahrain</td>
<td>0.5</td>
<td>Japan</td>
<td>5</td>
</tr>
<tr>
<td>Canada</td>
<td>11,936</td>
<td>Korea</td>
<td>1</td>
</tr>
<tr>
<td>Portugal</td>
<td>0.75</td>
<td>Kuwait</td>
<td>15</td>
</tr>
<tr>
<td>Denmark</td>
<td>5</td>
<td>Luxembourg</td>
<td>1</td>
</tr>
<tr>
<td>European Commission</td>
<td>29,288</td>
<td>The Netherlands</td>
<td>33,666</td>
</tr>
<tr>
<td>Finland</td>
<td>2,576</td>
<td>Norway</td>
<td>1,847</td>
</tr>
<tr>
<td>Germany</td>
<td>9,762</td>
<td>Saudi Arabia</td>
<td>5</td>
</tr>
<tr>
<td>India</td>
<td>0.2</td>
<td>Switzerland</td>
<td>0.661</td>
</tr>
<tr>
<td>Ireland</td>
<td>1</td>
<td>Turkey</td>
<td>0.5</td>
</tr>
<tr>
<td>Iran</td>
<td>1</td>
<td>Sweden</td>
<td>3,237</td>
</tr>
<tr>
<td>Italy</td>
<td>17</td>
<td>UK – DFID (to 2006)</td>
<td>150,332</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>329,255 million US$</strong></td>
<td>United States</td>
<td>5 (+33)</td>
</tr>
</tbody>
</table>

### Critical Note

The “War against Terror” in Afghanistan is estimated to have cost at least 15 billion US $ (about 1.5 billion US $ per month) or thus 8 times more than the international reconstruction budget so far.

### 4. The Contribution from The European Union and other EU Member States:

At the Tokyo conference, the EU Member States and the European Commission made a combined pledge of about 600 million Euro (including 200 million Euro from the European Commission) for the year 2002. 352 million Euros since September 2001 has been spent on humanitarian assistance. The amounts pledged so far for 2002 to 2006 are close to 2.3 billion Euros (2.1 billion US$).

The European Union has a long record of supporting for health care in Afghanistan. Between 1993 and 2001, the European Commission Humanitarian Office (ECHO) spent €178 million on humanitarian aid in the country of which around a quarter was spent directly on health. In addition, the “Aid to Uprooted People programme” provided almost € 200 million from 1992 - 2000, including the provision of basic healthcare. Much of this health spending has been focused on primary emergency health care intervention. Internally displaced people, refugees and the provision of emergency health care near the frontlines and most badly war affected areas were the main targets.

In 2002, ECHO allocated 10 million Euros to health care activities. In addition, around a third of the €22 million allocation for “Aid to Uprooted People”, was devoted to primary health care and the fight against diseases such as malaria. The European Commission’s budget for health was 12 million Euros over 2002 (approved under the second Reconstruction Programme). In total 236 health clinics have been financed over 2002. The focus are integrated primary health care programs in underserved areas (like Uruzgan, Zabul, Badaghshan and Paktika, through direct funding of international and national NGOs, being Action Contre la Faim (ACF), Aide Médicale Internationale (AMI), Health Net International (HNI), Médecins du Monde (MDM), Médecins Sans Frontières (MSF), Medair, Coordination of Humanitarian Assistance (CHA), IbnSina, Swedisch Committee for Afghanistan (SCA), Afghan Health and Development Services (AHDS), amongst others.

Health will remain a priority for assistance in 2003 (European Commission budget: 10 million Euro) and 2004 (EC budget: 15 million Euro) helping the Government to deliver a basic healthcare package through NGOs, especially focusing on mother and child healthcare. The European Commission foresees also 1 million Euros for capacity building of the Ministry of Public Health on regional level and in rural areas.
EU member states

In total 249 million Euros have been spent over 2001 after September 11, and 109 million over the year 2002 by the European Union Member States. Most was spent on humanitarian assistance (food, education, health, IDPs) through funding of UN agencies, NGOs and Red Cross organisations. Regarding the reconstruction efforts, most of the member states seem to have chosen a priority area for intervention, e.g.

- Germany: training of police, electricity in Kabul,…
- Italy: legislation
- UK: crop cultivation and drug abuse

The health sector has generally not been identified by the member states as a major investment area. This does not mean though that no health projects are financed. E.g. Germany invested for about 2 million Euros in the health sector. The French cooperation invested as well about 1.6 million Euros in health projects over 2002 (e.g. Kabul medical University, laboratory and blood bank Kabul).

5. THE BELGIAN CONTRIBUTION

The official Belgian aid is restricted to 25 countries maximum, 5 sectors (health, education, agriculture and food security, basic infrastructure and society building) and 3 transsectoral themes (equal rights, environment, social economy).

The Directorate-General for International Cooperation (DGIC) estimates the total official Belgian aid for the year 2001, as follows:

- directly bilateral: 138 million Euro
- indirectly bilateral (NGO’s, Vlir, CIUF, …): 205 million
- multilateral: 70 million
- multilateral “core”: 129 million
- TOTAL: about 542 million Euro

At the Tokyo conference in January 2002, Belgium has promised 30,7 million US$ for the reconstruction of Afghanistan over the coming 5 years (2002 to 2006). Belgium expressed its special commitment to the democratisation process as well as to the improvement of the position of the Afghan women.

Since September 2001, the total Belgian contribution exceeded 11 million Euros:

- On the 9th November 2001, 5 million Euro was liberated by ministerial decision for humanitarian aid in Afghanistan (food aid, health care, education and assistance to refugees)
- Another 4,8 million has been allocated for 2002 in the field of food security and rehabilitation through non-governmental and international organisations.
  - 1,8 million for food aid assistance
  - 2 for humanitarian relief (particularly rehabilitation actions)
  - Another 1 million from the “prevention of conflicts and peace construction” budget of the Ministry of Foreign Affairs, which has been divided as follows:
    - To UNDP trust fund (Un Afghan Interim Authority Fund) with soft earmarking for the Ministry of Women’s Affairs: 500.000 Euro
    - For UNMAS demining program in Afghanistan: 225.000 Euro
    - For UNIFEM program in Afghanistan: 500.000 Euro
- In March 2002, another 1,2 million Euro was liberated by ministerial decision for assistance to the victims of the earthquake in northern Afghanistan.
Table 12. Belgian contribution to Afghanistan September 2001 – December 2002

<table>
<thead>
<tr>
<th>Implementing agency</th>
<th>Amount</th>
<th>Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(approved in 2001)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICRC</td>
<td>1,239,468</td>
<td>Hospital care</td>
</tr>
<tr>
<td>IOM</td>
<td>743,681</td>
<td>Assistance to IDP</td>
</tr>
<tr>
<td>UNICEF</td>
<td>763,514</td>
<td>Education</td>
</tr>
<tr>
<td>UNICEF</td>
<td>485,870</td>
<td>School sanitation</td>
</tr>
<tr>
<td>UNICEF</td>
<td>485,870</td>
<td>Safe Motherhood Programme</td>
</tr>
<tr>
<td>MSF</td>
<td>229,549</td>
<td>Nutrition</td>
</tr>
<tr>
<td>WFP</td>
<td>1,305,000</td>
<td>Food aid</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5,252,952</td>
<td></td>
</tr>
<tr>
<td>Approved projects in 2002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FAO</td>
<td>575,000</td>
<td>Seeds and tools</td>
</tr>
<tr>
<td>WFP</td>
<td>1,000,000</td>
<td>Food aid</td>
</tr>
<tr>
<td>MSF</td>
<td>379,728</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Handicap International</td>
<td>362,615</td>
<td>UXO clearance</td>
</tr>
<tr>
<td>UNHCR</td>
<td>1,001,000</td>
<td>Support to returnees</td>
</tr>
<tr>
<td>WHO</td>
<td>521,500</td>
<td>Obstetric care</td>
</tr>
<tr>
<td>Caritas</td>
<td>660,000</td>
<td>Assistance to IDPs</td>
</tr>
<tr>
<td>UNMAS</td>
<td>225,000</td>
<td>Coordination demining</td>
</tr>
<tr>
<td>UNDP Trust fund</td>
<td>500,000</td>
<td>Earmarking Ministry of women’s affairs</td>
</tr>
<tr>
<td>UNIFEM</td>
<td>500,000</td>
<td>Support Ministry of Women’s Affairs</td>
</tr>
<tr>
<td>OXFAM</td>
<td>500,000</td>
<td>Agricultural rehabilitation</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6,474,843</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL 2002 11,727,795 Euro

*Data from the Belgian International Development Cooperation as of March 2003

Gender perspective has been integrated in the Belgian assistance to the reconstruction of Afghanistan:
- Two meetings were held in Brussels in December 2001
  - “Afghan Women’s Summit for Democracy”
    No financial contribution was made by Belgium.
  - UNIFEM Roundtable on Building Women’s Leadership in Afghanistan
    A contribution of 200,000 Euro for the UNIFEM workshop was made.
- Invitation of the Afghan Minister of Women’s Affairs by the Ministry of Employment
- The organisation of a workshop of Belgian and Afghan experts regarding “equal opportunities policy” is planned for 2003. The objective is to define a 2 years agenda, in which the 2 key elements will be: 1) institutional strengthening of the Afghan Ministry of Women’s affairs, including of the regional centres, and 2) the support to the Afghan civil society active on the field of women’s rights
- 200,000 Euro from the “prevention budget” of the Ministry of Foreign Affairs, attributed to the Ministry of Employment (Ms Onkelinckx) will be spent on 4 projects related to women’s health, training of female professors, education of girls and professional training of women refugees in Iran.

6. COMMENTS

Afghanistan was said to be a kind of test case for a renewed approach towards international cooperation by the donor community who tried to integrate lessons learnt from the past. Key elements in this approach are ‘partnership’, ‘ownership’, ‘coordination of the efforts’ etc… In the reconstruction programs the individual organisations and donors (small and big) would try to fit in a process of reconstruction lead by the Afghan Interim Authority and the Afghan population, with the support of the international community who would present itself as one common “block” for funding, means, procedures, studies, research etc …
The reality is somehow different:

- Though the **partnership and ownership of the AIA** are stressed in all meetings and documents, everybody refrains from channelling funds directly through the AIA. This undermines the credibility of Afghan’s ownership. Donors –whether bilateral, multilateral, governmental or non-governmental- insist on controlling resource allocation and refuse to cooperate in shared funding for basic recovery. This compromises the physical tasks of reconstruction as well as the political prerequisites for recovery.

- One can wonder to **which extent the international community is a community**. It includes multilateral and bilateral donors, UN agencies and the large and diverse group of national and international NGOs. All of these have different priorities, views and approaches. Different and multiple needs assessments have been performed.

- There are **many different actors** involved in the over-all aid coordination.
  - The Afghanistan Interim Authority (AIA).
  - Afghanistan Steering group: US, Japan, European Union, … Established to enhance overall international political support for the reconstruction effort and help provide strategic guidance.
  - Implementation group, co-chaired by the AIA and WorldBank. Established to coordinate reconstruction efforts.
  - UNAMA, lead by Brahimi; coordinates the UN agencies
  - Afghanistan Support Group: UNDP, World Bank, Asian Development Bank, the Islamic Development Bank (IsDB)
  - Bilateral donors
  
  Each of this donor (groups) has its own strategy. This leads to a lack of transparency, confusion and over-all coordination problems.

- The objective of **ITAP** was to build a coherent vision for assistance in Afghanistan in 2002. Many agencies criticised the ITAP process, since it did fail in its attempt to come to an integrated and coordinated programming.
  - It did not create an overview on who is doing what where
  - It neither did generate much funding, especially not for NGOs. Therefore, most of the NGOs did not submit projects to the new TAPA.

- More than **half of the funding** has been **channelled directly** by bilateral donors to **individual projects and organizations**, instead of through common appeals. This contributed to the lack of overview and undermined the partnership with the Afghan Interim Government. It generated tensions between the government and the international community.

- Donor **pledges** made in Tokyo were **slow to be translated into commitments**.

- The **committed and disbursed funding did not meet the requirements**. Government recurrent budget remains seriously under-funded.

- A **distinction** should be made between **humanitarian assistance and reconstruction** efforts. A considerable part of the funding at the end of 2001 and 2002 went to humanitarian assistance. The Afghan Government was left in the wrong belief that all money pledged at Tokyo would be physically available for the reconstruction plans. In order to avoid misperceptions and simplify coordination procedures, humanitarian assistance budgets should be clearly separated from reconstruction aid. While humanitarian assistance can and should be independent, reconstruction efforts should be lead by the Afghan authorities.
After years of abandoning, the international community has made over the end of 2001 and 2002 a substantial contribution to the Afghan people. Much of the funds were needed to finance life-saving humanitarian assistance in this completely destroyed country struggling to get on its own feet again after more than two decades of war. While the efforts made were considerable, we have to remark that:

- Donor-assistance is fragmented, excessively project-based and insufficiently coordinated within the Government’s budget framework.
- No distinction is being made between humanitarian assistance and reconstruction efforts
- Despite all efforts, there was a funding shortfall over 2002.

For the next 5 years, budget estimates are far higher even and an increase of funding is needed each year for the reconstruction of Afghanistan. The “real work” has still to start.

Now that Afghanistan is not longer on the news’ headlines, one can only hope that the international community will stick to its initial commitment to reconstruct the country.
C. THE INTERNATIONAL APPROACH ON HEALTH AND REPRODUCTIVE HEALTH

1. PRIMARY HEALTH CARE

The overall approach is very public health model oriented (as opposed to a curative approach) based on community based primary health care through partnership of MoPH and NGO’s

A Joint Donor Mission (JDM) \(^{14}\) to Afghanistan on the Health, Nutrition and Population Sector (HNP) took place in March 2002. The objective was to agree with the Government on a framework for assistance to the HNP sector over the next 2.5 years. The JDM was repeated in July 2002.

The draft Aide-Memoire of the Joint Donor Mission strongly urged:

- The redistribution of health services to provide equitable access in underserved areas
- The development of a standardised package of basic health services that would form the core of health care delivery in all primary health care facilities
- The development of a set of measurable indicators that would allow for the regular monitoring of progress toward clearly defined health sector objectives

One of the earliest steps recommended by the Joint donor mission was the definition of the essential package of services to be made available throughout the public health system in Afghanistan. This essential package (see above) has been defined with the assistance of an Advisory Committee (UNFPA, UNICEF, WHO and MSH) and can be seen as the basic policy line of the future primary health care system.

The JDM recognized the limitations of the MoPH to deliver health services to its entire population. Therefore it recommended a strong partnership between the MoPH and the private sector. The main axe of this partnership would be performance-based partnership agreements (PPAs) under which the government would contract the private sector (local and/or international NGOs and/or other private sector entities) for the delivery of specified health services to the population. MoPH would be involved in policy making, monitoring and supervision, but to a much lesser extent in service delivery.

Especially the World Bank has been pushing to introduce this “PPA” concept in Afghanistan, which would have been previously (more or less) successfully implemented in Cambodia and Haiti. The main objective of the PPAs is to increase the provision of the essential package of health services in currently underserved provinces. These provinces were identified as Bamyan, Nuristan, Badakhshan, Uruzgan, Kapisa, Paktiya, Ghor, Badghis, Nimroz and Zabul.

There have been a lot of controversial discussions around the so-called PPA or “Performance Based Partnership agreements”. The MoPH expressed several concerns, supported by most of the agencies, and has proposed a number of modifications.

- The planned starting date of 2003 seems too early. Start with pilot testing of the concept in some areas.
- Limit contracts to districts or a cluster of districts instead of province level, and to specific services at specific facilities.
- Limit contracts to 1 year instead of 3 years

These concerns are legitimate, since:

- The MoPH does not have the capacity to develop and manage large contracts. Substantial technical assistance will undoubtedly be required before the required skills will be available.

\(^{14}\) The JDM was led by the World Bank and the World Health Organization (WHO). Members of the team included representatives from Department for International Development (DFID), the European Union (EU), the United States Agency for International Development (USAID), the Asian Development Bank (ADB), UNICEF and UNFPA.
The role of the MoPH as responsible for the health system needs to be safeguarded. It is not up to agencies / donors to define how the health system will be organised. The most important observation from the NGOs is that, like the government, they neither have the capacity to provide even basic services across the levels of the health system on a provincial basis.

But finally it is quite unsure whether the issue of PPAs will soon or ever see the light. The WorldBank offered part of the necessary funds to implement the PPAs as a grant, something the MoPH did not approve so far. Other donors (like the European Union) will neither join the PPAs, but rather focus on the implementation of the essential service package in underserved areas.

2. Reproductive Health

Within the health sector, RH is considered as a priority area of intervention by the international community, including donors and actors in the field. Consequently reproductive health takes an important place in the defined essential package of services that should be made available throughout the Afghan health care system. This includes:

- Antenatal care
- Delivery care
- Postpartum care
- Family planning
- Care of the newborn

Reproductive health is fairly limited to Mother and Child Health and Family Planning services. Other Reproductive Health issues - like adolescent reproductive health, sexually transmitted infections, and gender violence- are currently not approached and neglected. This reduction of the RH concept makes sense in the perspective of the need for prioritisation and the sensitivity of some RH issues within the Afghan society. Nevertheless, in the mid- to long-term, RH has to be approached in its entirety through integrated and adapted interventions.

3. The Safe Motherhood Initiative

In May UNICEF, with the assistance of JHPIEGO, conducted an assessment of the resources needed to implement the SMI in Afghanistan. The team recommended that a strong and immediate emphasis be placed on the training of intermediate and lower-level health workers, that technical and financial support be given to NGOs working on the SMI and that the MoPH capacity in the area of the maternal and newborn health be strengthened. The principal objective of the SMI in Afghanistan should be to increase the proportion of births attended by skilled health personnel.

Based on these and other findings, an Afghanistan National Safe motherhood Strategic Framework has been developed by UNICEF and MoPH in April – May 2002, as presented before.

At the time of our visit, workshops were organised around this theoretical framework. Implementation still had to start.
4. COMMENTS

There is an important gap between the international approach on health and RH and the implementation in the field. This is due to a number of reasons:

- To introduce and adapt the international approach on health and international health, there have been a multitude of workshops organised inside and outside the country. Many experts (from countries all over the world) have come and gone. A plethora of strategic frameworks, recommendations and plans of action have been written. The impact in the field is still minimal. One of the main reasons is the lack of ownership by the Afghan authorities and communities. The MoPH and the NGOs are not always involved in the decision making. Moreover, many plans are not followed by the necessary (financial and other) resources to implement them and to translate them into interventions in the field.

- Despite or maybe due to the poor organisation of a multitude of coordination meetings and task forces, the communication between the different actors (donors, multilateral agencies, MoPH, NGOs) is weak. There is an overall feeling that transparency is lacking regarding who what doing where. On important issues, no consensus has been reached amongst these actors. Examples are the (non) pertinence of TBA workers and the role of Community Health Workers.

- The international recommendations are poorly integrated at service level. This is partially due to the (unrecognised) lack of authority of the MoPH. Decisions taken at the central level might have little or no impact outside Kabul. Agencies and donors are writing policies, strategies and frameworks, involving the MoPH only at the very end in order to get official approval. These “official” MoPH policies and strategies circulate mainly in international hands. Few are translated in Afghan languages (Dari, Pashtun), few are understood, few are available and even less are considered as real national policy papers by the Afghan health staff.

- The focus on primary health care does not mean that this is the only sector for which international support is needed. A basic health care system can only be fully effective if it is supported by community participation and a high-quality referral system. This requires a reorganisation and an investment in the global health care system, from community-based programs till the upgrading of some hospitals in Afghanistan.

But one should recognize that in the last year major achievements have been made:

- The political commitment of the Afghan authorities and the international community, which is a major achievement.
- The development of the national health policy, the definition of an essential package of health services and the establishment of a national safe motherhood strategic framework. These documents should be seen as a general guiding strategy for the international assistance in the health sector over the first next years.
- The relevance of the chosen strategy (community based primary health care), which corresponds to the current most pressing needs of the Afghan citizens.
- Merely thanks to the commitment of the international community, RH has been taken up into the national health policy as a priority.

Time has come now to translate the commitment in more financial and other resources and to invest in the concrete realization of the principles outlined on paper with the aim to achieve the main goal of “health for all”.
D. THE ANSWER OF THE CIVIL SOCIETY

During the long years of war, a number of medical NGOs ensured autonomously a minimum of health care throughout the country. The number of NGOs exploded since the events on September 11th. Whereas during the war there were 20 to 30 NGOs effective on the ground, Kabul has now about 250 NGOs. The number of projects did not increase accordingly, since many of the new NGOs have various small and sometimes unclear projects.

The number of NGOs working in the health sector is large, the scope of their work varies considerable and, for the most part, they are delivering services in discrete project areas. The medical NGOs are mainly involved in primary health care in support of the most vulnerable groups. A number of international and national medical NGOs developed considerable technical and implementing capacity over the past years like IbnSina, AHDS and CHA. They might still benefit from training in specific aspects as evaluation of programs and gender sensitivity.

It is estimated that more than 80% of functional health facilities have some form of NGO involvement. NGOs ensure usually the accessibility and quality of services of the basic health facilities they support. They provide essential drugs, medical materials and rehabilitation of the health facilities. The NGOs improve the motivation, stability and quality of the staff with initial and in-service training, incentives to salaries and auditing and control mechanisms. While some are working through MoPH, many have bypassed the government structures and are operating independently, with permission of the (local) government.

Although a number of NGOs are attempting to address the needs of particularly underserved areas in the central and southern parts of the country, the overall distribution of NGO activities is uneven, with a concentration in the urban areas and areas near the Pakistani border.

1. COMMON REPRODUCTIVE HEALTH SERVICES OFFERED BY NGOs

Primary health care services

Most NGOs are providing integrated Primary Health Care services, meaning that - among other services - a reproductive health component is included in the package of services offered at the clinics. The availability of basic Mother and Child Health services depends on the presence of female qualified staff.

When a midwife is present, preventive reproductive health services at basic health facilities generally include:
- Antenatal consultations: supplementation with Iron Folate, screening of at risk pregnancies, …
- Family planning: In general pills, injectable hormones, condoms and sometimes IUDs
- Immunization against tetanus
- Postnatal care
- Health education

Only when a female doctor is available in the clinic specific curative services for women (as gynaecologic consultations) are offered at the clinic, as male doctors are not allowed to examine female patients.

In some MCH clinics, normal deliveries are attended during working hours. Some female health staff assist deliveries at home.

Data of the clinics are generally collected according the existing standardised national Health Information System format, and transmitted to the MoPH and or the WHO.
Emergency Obstetrical Care

The upgrading of MCH clinics to basic EmOC Units is often scheduled or being implemented by several NGOs. Some NGOs (like AMI) support EmOC in rural hospitals, and a few have invested in maternities (e.g. Gardez, Ghazni) in larger hospitals. The obstetric departments of the larger provincial and regional hospitals are usually considered as too complex to work in, very money absorbing and to be managed by the MoPH.

Training

Most NGOs list in-service training and courses among their activities. MCH is usually included. However the content and adequacy of the different courses do vary greatly. Only few NGOs (IMC, IbnSina) give some support to the formal Intermediate Medical Schools (for training of nurses and midwives).

Other reproductive health services

Other reproductive health topics (like adolescent health and violence against women) are so far ignored by most NGOs.

Table 13. RH activities of a selected number of major NGOs working in the health sector, which we had the chance to interview

<table>
<thead>
<tr>
<th>Number supported</th>
<th>MCH</th>
<th>C1</th>
<th>C2</th>
<th>Mob</th>
<th>Hospitals</th>
<th>EOC</th>
<th>Training</th>
<th>Other RH activity</th>
<th>Provinces</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACF</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td></td>
<td>Support central lab</td>
<td>Kabul</td>
</tr>
<tr>
<td>AMI</td>
<td>18</td>
<td>1 referral and 2 district</td>
<td>3 comprehensive EOC</td>
<td>yes</td>
<td></td>
<td>Support central lab</td>
<td>Kabul</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AHDS</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>8 delivery rooms</td>
<td>yes</td>
<td></td>
<td></td>
<td>Kabul</td>
</tr>
<tr>
<td>CHA</td>
<td>24</td>
<td>1 (Farah province)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 (Herat, Farah, Ghor, Faryab, Kabul)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOPE</td>
<td>5</td>
<td>Planned (2 basic EOCs)</td>
<td>yes</td>
<td>Basic EOC training</td>
<td></td>
<td></td>
<td>3 (Kabul, Paktya, Ghazni)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IbnSina</td>
<td>30</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>2 (Gardez and Ghazni province)</td>
<td>2 comprehensive EOCs (maternities)</td>
<td>yes</td>
<td>Training, delivery kits</td>
<td>13 provinces</td>
</tr>
<tr>
<td>IMC</td>
<td>40</td>
<td>2</td>
<td></td>
<td></td>
<td>1 basic and 1 comprehensive EOC</td>
<td>Yes</td>
<td>Community education</td>
<td>9 provinces</td>
<td></td>
</tr>
<tr>
<td>HNI</td>
<td>13</td>
<td>3</td>
<td>2</td>
<td></td>
<td>3 (2 rural and 1 provincial)</td>
<td>yes</td>
<td>Auxiliary midwife training, Delivery kits</td>
<td>1 province (Nagargar)</td>
<td></td>
</tr>
<tr>
<td>MDM</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td></td>
<td>1 provincial (Ghor)</td>
<td>EOC training and awareness</td>
<td>3 (Kabul, Herat, Ghor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSF B</td>
<td>20</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>yes</td>
<td></td>
<td>5 (northern Afghanistan)</td>
<td></td>
</tr>
<tr>
<td>MSF F</td>
<td>3</td>
<td></td>
<td></td>
<td>2 provincial (Bamyan and Ghazni)</td>
<td>1 comprehensive EOC (surgery ICU), 1 basic</td>
<td>3 (Kabul, Bamyan, Ghazni)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCA</td>
<td>45</td>
<td>64</td>
<td>103</td>
<td></td>
<td>4 basic EOC of which 2 can do caesarean</td>
<td>yes</td>
<td>Several trainings</td>
<td>18 provinces</td>
<td></td>
</tr>
<tr>
<td>Terre des Hommes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Home visiting program ANC and postnatal</td>
<td>2 (Kabul, Kandahar)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C1 = Comprehensive Health Centre (always medical doctor present, curative and preventive services)
C2 = Basic Health Centre (not always MD present; mostly only curative care)
MCH = Mother and Child clinic: for women and children up to 12 years (female doctor present and full range of RH services)
Mob. = Mobile clinics
EOC = Essential Obstetrical Care
2. **IMPLEMENTING CAPACITY**

Most of the NGOs are effective, follow the national policy guidelines and are heavily involved in the provinces and rural areas.

A number of NGOs – usually smaller ones and / or those with political or religious aspirations - lack a vision and recur to short-term strategies. They tend to disappear rapidly, when institutional funding becomes a problem.

In general, the NGOs had more means over 2002 than during previous years. Therefore many extended their health activities. Funding opportunities were and are especially directed towards basic health services in underserved rural areas. Most NGOs reported to have reached by now the limit of their capacity and want to focus more on quality improvement in the area's they are currently working in. The main limiting factor to expand furthermore reproductive health services is the lack of qualified female staff in the rural areas. A consequence of the expansion of health services in rural areas was the competition between agencies to attract –especially female- staff. Only by paying high salaries (from 140 to 650 US$) and offering accommodation, employment for the husband, transport fees and other incentives, agencies were able to employ qualified female medical staff in rural health facilities. But even than, a lot of vacancies are still open.

*We visited a newly rehabilitated and fully equipped health centre with a basic obstetrical unit, at 1 hour drive outside Kabul city. Although the working conditions are fair, the agency has not been able to contract a female doctor to run the maternity.*
E. Multilateral Agencies Actively Involved in RH

3 UN agencies are running RH programmes in Afghanistan: UNFPA, UNICEF and the WHO.

1. UNFPA

UNFPA is the focal point for reproductive health in Afghanistan.
The operations of UNFPA in Afghanistan concern 3 different fields of action
- Reproductive Health
- Population Statistics / census
- Women’s programs

Reproductive health
Regarding the reproductive health component, following projects are being implemented:

1. Emergency Obstetrical services in Kabul:
   Basic equipment and supplies have been delivered to two maternity hospitals in Kabul (Malalai hospital and Rabi Balkhi). The main investment is oriented to the major reconstruction of the Xharkhanar hospital (52 beds) in northern area of Kabul, with the objective to open 40 maternity beds (instead of the 6 existing now). While the reconstruction works go on, support is given to a temporary field hospital “Danish emergency mobile hospital”.

2. Support agencies to build a Reproductive Health component to the Primary Health Care program: 3 agencies are benefiting this support : AMI, SCA and IbnSina

3. Family Planning: UNFPA tries to identify among the NGO community, FP service providers and identifies needs for equipment and FP supplies. 30 tons of RH and FP materials have been distributed to 11 NGOs.

4. Capacity building of MoPH: More precisely to the Mother and Child department in charge of RH. A Reproductive Health communication centre (with database and internet-access) has been established within the building of the MoPH.

5. Coordination: on a monthly basis, UNFPA and MoPH organize RH coordination meetings.

Population and census
The activities regarding population statistics and census are related to election procedures. UNFPA ensures that women are included.

Women’s programs
Regarding the Women’s programs, UNFPA gives support to

1. The Ministry of Women’s Affairs: UNFPA wants to work with the women’s centres and add a RH component. Issues as overlapping/ duplication and lack of female staff of course need to be considered in this regard. Therefore, the RH component of the women’s centres will be more directed to counselling, guidance and referral.

2. The recently established Human Rights Commission: UNFPA will support the setting-up and capacity building of a Women’s Rights unit.

3. Women’s education through AIL (Afghan Institute of Learning), which was giving education to women, mainly to refugees in Pakistan, but more and more expanding activities in Afghanistan

4. Support to IPPF: rebuilding of the “Afghan Family Guidance Association”

5. The national health resources assessment: Funding was provided to the Japanese NGO HANDS in order to focus on data gathering around RH

Funding
According the DAD database, UNFPA received in 2002 about 8.100.000 $ (with Luxembourg 4,5 million and Italy 2,4 million as biggest donors).

- ITAP project: Rehabilitation of Maternal wards/ Hospitals/ Clinics / RH Planned Centres: 4.500.000 US$ received from the 4.500.000 US$ requested
ITAP project: Capacity building in Delivering Reproductive health services: 2,400,000 US$ from the 2,400,000 US$ requested

ITAP project: Support to ongoing MCH and RH services in Afghanistan: 500,000 US$ from the 800,000 US$ requested

ITAP project: Support to Vulnerable Groups of Women: 715,000 US$ from the 1,141,999 US$ requested

Note: In July 2002 the US state department has cut 34 million US$, previously approved by the congress. They also blocked UNFPA funding for 2003. This decision affected reproductive health programs in 160 countries, from which Afghanistan is one (about 600,000 US$ pulled from the UNFPA Afghanistan budget).

Foreseen budget for 2003:
In the new TAPA 2003, following projects were so far submitted:
  - TAPA project: Support for Family Planning and Reproductive Health: 2,074,950 US$ requested
  - TAPA project: Safer motherhood for Afghan women in Western, Southern and Northern region: 5,375,000 US$ requested
  - TAPA project: Afghanistan census – Phase1: 670,000 received from 7,015,000 US$ requested

2. UNICEF

UNICEF is implementing activities in the area of education, child’s health, vaccination, mine awareness, safe motherhood and sanitation…

The Safe Motherhood Initiative

Unicef, as leading agency in the Safe Motherhood Initiative, gave assistance to the development of the national strategic framework for the reduction of maternal mortality in Afghanistan (cfr. Supra).

It focuses on 3 major strategies:
- Improve the coverage, utilisation and the quality of Emergency Obstetric Care services, ensuring life-saving interventions for women who develop complications of pregnancy and childbirth.
- Increase the number of skilled attendants at birth, able to provide services to women in the communities.
- Improve the antenatal care services and the delivery of effective interventions (i.e. anaemia prevention, malaria prevention and treatment, nutrition) at the community level.

Projects implemented over 2002:
1. Needs assessment: Safe Motherhood Needs Assessment (human resources needs) and RAMOS (Reproductive Age Mortality study)
2. A reproductive age mortality survey has been conducted nationwide (in collaboration with CDC) to document MMR, causes of maternal death and potential barriers to care.
3. Improvement of skilled staff at birth attendance:
   A pilot project of HNI (Health Net International) was taken over by Unicef. In this project 20 auxiliary midwives are trained in Jalalabad, Ghani Khel and Mehtar Alam.
   In Kabul, 20 midwives (3rd year) were trained.
4. Support to MCH activities and Emergency Obstetric Care services through NGOs
5. Foundation of the Afghan Society of Obstetrician and Gynaecologists
6. Malalai Hospital, the largest maternity hospital in Kabul (15,000 deliveries every year) has been refurbished, water and sanitation facilities upgraded, equipped, supplied in drugs. The hospital will be the first “Centre of Excellence” for competency-based training in Emergency Obstetric Care.
Funding

For all UNICEF projects, 146,199,269 US$ were disbursed from the 162,258,540 US$ requested. For RH activities: ITAP Promotion of Safe Motherhood in Afghanistan: 1,492,653 US$ received from the 8,760,000 US$ requested. To these funds, 1,7 million US$ emergency funds from UNICEF were added.

Funding needed in 2003:

- TAPA Project: Safer Motherhood for Afghan women in Western, Southern and Northern Region: 5,375,000 US$ requested
- TAPA Project: Transfusion Services in Afghanistan: 2,263,100 US$ requested

3. WHO

The World Health Organization is implementing overall health activities.

RH related activities

Regarding reproductive health, following activities have been deployed over 2002:

1. Setting up of a maternal death reporting system in 3 hospitals in eastern and 3 hospitals in central region
2. Translation of the WHO publication “Management of Complications in Pregnancy and Childbirth” (printing of the translated material is underway)
3. Training of TBA master trainers in 4 regions
4. Provision of essential obstetric care supplies and equipment to 7 hospitals and 10 basic health centres in south eastern region, together with UNICEF
5. Technical assistance to MoPH in drafting the National Policy for Reproductive Health and support to the MCH task force
6. Work group HIV/AIDS is looking into the issue of blood safety
7. WHO / MoPH Workshop “Introduction of Mother-Baby Package”
8. Support to MCH project of Afghan Solidarite
9. Support to NGOs in TBA training programs
10. Support to the Intermediate Medical Schools, that are training midwives, with teaching learning materials and curriculum development

Funding

In 2002, globally 23,624,923 US$ of the 26,404,353 US$ requested were disbursed to WHO.

For RH activities:

- ITAP Making Motherhood Safer in Afghanistan: 390,000 US$ from the 3,264,800 US$ requested
- ITAP Integrated Primary Health Care Programme: 3,694,678 US$ received from the 5,522,600 US$ requested

Funding needed in 2003:

- TAPA project: Towards Making pregnancy Safer in Central, Eastern and South Eastern regions of Afghanistan: 760,020 US$ requested
- TAPA project: Transfusion services in Afghanistan: 2,263,100 US$ requested
- TAPA project: Safer Motherhood for Afghan women in the Western, Southern and Northern region: 5,375,000 US$ requested

4. OTHER ACTORS: RED CROSS ORGANISATIONS

Only the reproductive health care related activities of ICRC and IFRC are briefly mentioned in here. Besides these activities these organisations have a wide range of other program activities.
The International Committee of Red Cross (ICRC)
The ICRC is not targeting on reproductive health, but more on the referral level with specific attention for (war) surgery. Through their support to the surgical and other wards of several hospitals (6 rural and 7 regional hospitals), women in need of e.g. caesarean section do benefit from quality comprehensive emergency obstetrical care.

The International Federation of Red Cross and Red Crescent Societies (IFRC)
The IFRC is active in the field of reproductive health, especially through its integrated primary health care program (network of 48 Afghan Red Crescent Society Clinics in 5 regions, including MCH activities), health education program and training of Traditional Birth Attendants.

5. Comments

- In theory UNFPA is the focal point for reproductive health, UNICEF for the Safe Motherhood Initiative and WHO for technical assistance to the MoPH. In reality, their activities overlap and all 3 agencies have submitted Safe Motherhood proposals to TAPA 2003.

- The approach between the different agencies is not always 100% coherent, which is confusing for the field implementers. E.g. UNICEF does not support training of TBAs but rather of mid-level female staff. WHO though trained TBAs and TBA trainers over the year 2002.

- The UN are to a large extent relying on the same limited implementing capacity – mainly of international and national NGOs – as do the international donors, for the implementation of their projects.

- From the 3 UN agencies, UNFPA did implement the most concrete actions in the field of reproductive health.
F. COORDINATION BETWEEN NATIONAL, INTERNATIONAL AGENCIES, CIVIL SOCIETY AND THE MoPH

1. OVER-ALL COORDINATION

Complaints on the lack of a clear picture of “who is doing what” are widespread. Basically no one is able to provide an overall picture of the coordination structures, as expressed by an aid worker:

“What we are still missing is a Coordinating Agency to coordinate all coordinating agencies.”

A large number of coordinating structures do indeed exist:

UNAMA
All UN agencies were folded into an integrated UNAMA structure, led by SRSG Brahimi. UNAMA absorbed all coordination activities carried out before by UNOCHA and is in charge of all humanitarian and development activities from the UN and deals with civil and political affairs.

Afghanistan Assistance Coordination Authority (AACA)
Is an agency of the Transitional Government of Afghanistan in order to promote an Afghan-led vision for reconstruction and development, and accountable and efficient mechanisms for the implementation of aid. AACA produced the national development framework.

Afghan Ministries
The different Afghan ministries operate as quite independent and separate entities. The Ministries of Planning, Reconstruction and of Finance are reviewing all budgets of the individual ministries and developed – together with the international donor assistance community - the National Development Budget for solar year 1381 and 1382 (2002 and 2003).

Programme Groups and Secretariats
Under the National Development Framework, 12 programme areas have been defined and clustered into 3 pillars. In each programme area, programme groups have been formed to bring all actors together. Each programme group is guided by a lead ministry, and technically supported by a Programme Secretariat, normally a United Nations (UN) agency, multi-lateral institution or a Non-Governmental Organisation appointed to support and help manage the Programme Group.

Afghanistan Support Group: UNDP, World Bank, ADB, IsDB
They are operating quite independently from the UN structure. Teams of the WorldBank have been organising independent assessment missions and meetings with ministries, UN agencies and NGOs. Many individual bilateral donors have been doing this as well.

NGO coordination structures
Besides the official coordination, there are NGO coordination structures that have been in existence for more than a decade and bring together the large majority of the NGO community:

- ACBAR (Agency Coordinating Body for Afghan Relief) is the largest NGO platform composed of both national and international NGOs. Regularly sectoral coordination meetings are organised by ACBAR.
- ANCBA (the Afghan NGOs Coordination Bureau’s), consisting only of Afghan NGOs
- Two other bodies exist: SWABAC for NGOs working in Beluchistan and ICC for Islamic NGOs.
2. **COORDINATION OF THE HEALTH SECTOR IN GENERAL**

The prevailing feeling among the different stakeholders is that national and peripheral efforts to coordinate activities only have limited success. This is hardly surprising, given the overcrowding of agencies, the difficult communications, the unclear mandate of many actors, the quick turnover of managers, the under resourcing of health authorities.

On national level, coordination is “ensured” by different mechanisms:

- **The program secretariat**
  A new body “program secretariat” has been established within the Ministry of Health. This will be the policy making body and set the agenda’s to technical task forces. UNICEF, WHO and UNFPA as well as 4 NGOs are part of this advisory body of MoPH.

- **The National Health Coordination Committee (NTCC)**
  The NTCC is the over-all coordinating body and has been established to provide a forum for discussion and information sharing. It groups all agencies working in the health sector and donors. All other coordination bodies should be accountable to it. General panel meetings are convened bi-weekly.

- **The Coordination Task Force**
  The Task Force is composed of the MoPH, UN agencies, ICRC, donors, 12 national and international NGOs. It has an operational mandate, including information sharing and analysis, as well as advising partners on priorities and resource allocation. It has increasingly become a forum to discuss general policy issues. The sector of health and nutrition has been divided into task forces representing sub-sectors. Eleven task forces have been identified, each with a team leader.

- **Technical Advisory Committee**
  The Technical Advisory Committee (WHO, UNICEF, UNFPA and MSH) can be considered as the policy and planning cell of the Programme Secretariat.

- **Others**
  - ACBAR organises regularly health coordination meetings. ...
  - On regional levels, regional health coordination committees as well as different other interagency coordination mechanisms seem to exist. These have usually very few links with what is happening on national level, nor with the provinces and districts. The perception of the efficacy of these differs quite greatly from region to region.
  - On provincial level, coordination between agencies seems mostly absent. Agencies do usually consult though the provincial health authorities for the implementation of their respective health programs. Often this type of field coordination concerns authorization and administrative issues and MoPH is seldom really involved in planning and policy issues.

3. **COORDINATION OF RH ACTIVITIES**

There are a number of specific meetings that are regularly organized at national level.

**Reproductive Health Coordination Meetings**
They are organized by UNFPA and MoPH every month, in Kabul. The meeting we assisted was more a technical information sharing meeting than a coordination meeting (presentation on HIV/AIDS by WHO, presentation of the Danish Emergency Mobile Hospital…).
Safe Motherhood Unit meetings
Organized by UNICEF / MoPH, every 3 months

MCH task force meetings
Organized every week. The role and responsibility of the task force had not been clearly set, and therefore the task force is not really functioning.

4. COMMENTS

In the report on 5 AACA-UNAMA-Donor joint field missions\textsuperscript{15} regarding local coordination and capacity building, 5 conclusions were made:

- Assistance agencies (both international and Afghan) are most often “doing their own thing” with very little advance consultation with local authorities or even with each other
- Local authorities - lacking tools and in some cases qualified personnel – are currently not in a position to lead project planning and implementation
- Trust / confidence among the various stakeholders needs to be built from a very low starting point
- Local authorities feel isolated from Kabul and generally the information flow between Kabul and provinces needs improvement
- There are uneven relations between regional; and provincial centres on one hand and districts or local communities on the other

The plethora of coordination bodies, meetings and committees leads to chaotic and inadequate communication and information. In the field, people are not aware of national strategies. At national level, the realities of the field are unknown. Nobody has a real overview of what is happening. On important issues – like a uniform salary scale for health staff – no consensus could be reached among the agencies.

This can only be improved through a stronger leading role of the MoPH and improved communications between national, regional and provincial levels. This will need improved transport and communication means, but in the first place a more open attitude towards communication and information sharing.

\textsuperscript{15} The Afghan Assistance Coordination Authority (AACA), the United Nations Assistance Mission (UNAMA) and key interested donor / diplomatic missions did a series of joint field missions between 7 May and 11 July in order to improve communication between Kabul and the other parts of Afghanistan.
G. CONCLUSIONS

The health status of the Afghan population is poor and improvement will require a long-term and sustained support. The basic conditions for reconstruction are not yet fulfilled and the lack of implementing capacity is a major issue.

Even if peace and political stability were achieved, the destruction of the health infrastructure of the country and the failure to develop an adequate cadre of technically competent health workers will be an obstacle for the years to come.

Specific barriers to extend RH services through international assistance include:

- The overall situation in Afghanistan, after years of war, repression and poverty. The poor educational level of the people and the lack of infrastructure result in poor implementation capacity. The health system is destroyed and fragmented. Socio-cultural barriers are omnipresent.

- The lack of trained personnel and of qualified female health staff in particular, is a major issue, and this is especially the case in rural areas. Interventions cannot be implemented because the necessary female staff cannot be found.

- The lack of authority, the poor organisation and the lack of capacity of the MoPH hampers decision-making and implementation.

- Poor coordination between the different stakeholders, including the donors and the implementing agencies, results in duplication of efforts and inefficiency.

- Because of the unstable political environment and the lack of security, interventions in critical areas are nearly impossible.

- Pledged donor funds are often not materialized, hampering implementation.

A concerted effort over a long period of time is required to improve health and reduce morbidity and mortality in Afghanistan\(^\text{16}\). The International Community has to enhance its support to a long-standing peace process in the country. Commitments have to be fulfilled. Capacity building of the MoPH, of health staff and education of the population are urgently needed. Special attention should be given to training of female staff and education of girls and women. The efficiency of the interventions will be improved by better coordination amongst the different actors.

\(^{16}\) Based on a study of the Afghanistan Research and Evaluation Unit (AREU): “The Public Health System in Afghanistan” May-June 2002
IV. REPRODUCTIVE HEALTH PRIORITIES FOR AFGHAN WOMEN

The poor reproductive health situation has been extensively described in some studies, like the Multiple Indicator Cluster Survey (MICS 2000) and the more recent Reproductive Age Mortality Study (RAMOS 2002) carried out by UNICEF.

Several needs assessments have been carried out by international agencies and donors, which pointed out the lack of qualified female health staff and the lack of services (availability, accessibility and quality) as major barriers to reproductive health.

But besides this, consideration has to be given to the question: “What do the Afghan women want?” In order to generate answers to this question, we decided to carry out a KAP study (Knowledge, Attitudes and Practices) focusing on women’s RH needs.

Between 15 and 31 October 2002, the KAP study was carried out in Kabul city together with IbnSina, a medical Afghan NGO and counterpart in the study. A total of 468 Afghan women of reproductive age (15 to 49 years) were interviewed. They have been selected through systematic sampling of adult women attending four different health clinics in Kabul city (2 general outpatient clinics and 2 MCH clinics).

The major conclusions are listed hereby. For the full report, we refer to the final report, which is annexed (annex 4): “KAP survey regarding reproductive health; Kabul, 15 to 31 October 2002”.

Knowledge

- The literacy rate is low: 62% of the interviewed women were illiterate.
- General sexual education of the women is mostly ignored: only 16% had had any sexual education by the age of 15.
- Knowledge on family planning methods is unsatisfactory: 52% did not know about any method. There is an unmet demand for FP because of this lack of knowledge.
- Knowledge on sexually transmitted infections is equally poor: only 24% of the women had knowledge of any STI. HIV is the most commonly known STI. Many misconceptions exist regarding ways of transmission and prevention. As knowledge on STI is low, and the problem is denied, STI could become an increased health problem in the near future.
- Health professionals do play an important role in reproductive health education, often more than the girls’ own relatives.

Attitudes

- The traditional pattern is dominant in which the reproductive role of the woman is the most essential one.
- Women have other perceptions and interpretations of gender issues and violence than women in western countries. Their weak social position is perceived as natural.
- Before seeking health care, most women (93% of the women interviewed) do need authorization from their husband or from a male relative.
- Good health is largely associated with access to drugs and not with a status of physical, mental and social well being.
- Women consider fulfilment of basic needs more important than access to health care facilities for improving their health status.
- Women want many children, especially boys. But they would prefer to get married at more advanced age (in average around the age of 20.2 years).
- Antenatal care services are commonly well accepted.
- Most women prefer institutional delivery and assistance by qualified health staff at birth. About one quarter of the women prefer home delivery and assistance by a female relative.
- The main reason for delivering in a health facility is the woman’s own preference for institutional delivery. The presence of emergency symptoms – like haemorrhage, pre-
eclampsia, obstructed labour- does not influence significantly the place where women deliver. This can partially explain the low caesarean section rate.

- Few women want to limit their reproductivity. Generally women consider the use of family planning at more advanced age when family size is completed. Besides IUD, oral contraception and injectable hormones, condoms are quite well accepted as family planning method.

### Practices

- Afghan women do marry early: the average age of marriage is 17.2 years.
- They deliver their first child at young age, in average at 18.8 years.
- They have many children. For women above the age of 35 years, the mean number of previous pregnancies exceeded 7.
- They do not space their pregnancies. The Average birth interval was 2.5 years.
- The use of family planning methods is quite low: 23% of the interviewed women.
- The main determinant factor for the use of reproductive health services as well as for other RH parameters is the educational level of the woman.

The study pointed out that socio-cultural factors do play a very important role in the reproductive health priorities of Afghan women:

- The high desired family size reflects the importance and emphasis put on the reproductive role of the women in the Afghan society.
- The main determinant for the use and non-use of reproductive health services - such as emergency obstetrical care and family planning services - is the educational level of the woman.
- Socio-cultural factors - such as young age at marriage, lack of decision-making power for women - appear to be the important barriers to reproductive health. These factors are strongly linked with the traditional attitudes still prevailing in the Afghan society of today. (Note: Other potential barriers - like geographic accessibility, quality of services - have not been assessed by this KAP survey).

We want to emphasize that reproductive health should be seen in a broader perspective than a medical one. Education, access to employment and women’s social position are at least as important.

Major findings of this KAP study are summarized in table 14.
Table 14. Summary of the major findings of the KAP survey.

<table>
<thead>
<tr>
<th>Identified situation</th>
<th>What interviewed women want</th>
<th>Action suggested</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women do perceive their health as “between good and bad” and not different now from 1 year earlier (end of taliban regime)</td>
<td>Women associate health with fulfilment of basic needs + medicines (very curative approach)</td>
<td>Ensure fulfilment of basic needs Do not deliver preventive care without ensuring curative services</td>
</tr>
<tr>
<td><strong>Schooling</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only 36% ever went to a formal school. Women who attended school had significantly better reproductive health indicators</td>
<td>98% of all women think all girls should learn to read and to write and to attend school till the age of 19.5 years.</td>
<td>Community education Investment in primary schooling and promotion of education for girls</td>
</tr>
<tr>
<td><strong>Sexual education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only 16% of woman at age of 15 years were sexually informed</td>
<td>Before marriage, sexual issues cannot be approached. Health care providers can play an important role.</td>
<td>Health education for adolescents Stimulation of education from mother to daughters</td>
</tr>
<tr>
<td><strong>Early marriage</strong></td>
<td>16% married at age 14 or younger. Mean age of marriage was 17 years.</td>
<td>Women want to marry in average 2.8 years later than they do now (at 20 years old).</td>
</tr>
<tr>
<td><strong>Teenage pregnancy</strong></td>
<td>67% of (ever) married women delivered their first child when between 13 and 19 years old. Majority pregnant within one year after marriage.</td>
<td>After marriage, women want ASAP (many) children</td>
</tr>
<tr>
<td><strong>Multiparity</strong></td>
<td>60 to 80% of women above 30 years had been pregnant 6 times or more</td>
<td>Women want to have a lot of children (in average 5.6).</td>
</tr>
<tr>
<td><strong>Birth spacing</strong></td>
<td>Mean interval between two deliveries is estimated at 2.5 years. The younger the woman, the shorter the interval.</td>
<td>Women do not use family planning for birth spacing, even if they say so.</td>
</tr>
<tr>
<td>Identified situation</td>
<td>What interviewed women want</td>
<td>Action suggested</td>
</tr>
<tr>
<td>----------------------</td>
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</tr>
<tr>
<td><strong>Antenatal care</strong></td>
<td>Antenatal care and vaccinations are very well accepted / wanted</td>
<td>Offer ANC services in all PHC services. Use ANC for health education on FP, birth spacing and danger signs.</td>
</tr>
<tr>
<td>Good coverage found in Kabul for first ANC visit (79%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clean and safe delivery</strong></td>
<td>More women want to deliver in health facility (72%)</td>
<td>Increase capacity of obstetrical care services.</td>
</tr>
<tr>
<td>41% delivered in health facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency obstetrical care</strong></td>
<td>Many women attend ANC. More institutional deliveries among women who attend ANC.</td>
<td>Community education. Education of women on danger signs “get help immediately” during ANC.</td>
</tr>
<tr>
<td>No significant association found between risk signs and institutional delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled birth attendance</strong></td>
<td>70% of women who delivered at home prefer unskilled assistance (59% female relative). TBAs are not often used. Midwives (20%) and gynaecologist (10%) are accepted though</td>
<td>Training of midwives. Promote home delivery by skilled midwife. Equip midwives for house deliveries. Train TBAs only in communities where they do play a significant role (local inquiry needed!).</td>
</tr>
<tr>
<td>74% of home deliveries occur without skilled professional.</td>
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</tr>
<tr>
<td><strong>Family planning knowledge</strong></td>
<td>39% of the women with knowledge on FP were currently using any method and 82% said to be willing to use modern contraception in the future</td>
<td>Information on FP methods to all women, as part of antenatal / PHC services. Target women at home too. Ensure availability of 4 methods at all health facilities.</td>
</tr>
<tr>
<td>40% do not know of any family planning method (higher % in teenagers) 35.5% of (ever) married women know 3 different methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family planning use</strong></td>
<td>40% of the women did not want more children than they currently had 87% of all women thinks a woman should be able to decide on her number of children</td>
<td>Increase knowledge and availability of FP methods.</td>
</tr>
<tr>
<td>22.9 % of currently married women were using any FP method</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STI</strong></td>
<td>Not perceived as priority. Condom accepted as family planning method.</td>
<td>Promotion of condom (as FP method). Promotion and distribution through Community Health Workers?</td>
</tr>
<tr>
<td>Poor knowledge on STI, transmission and prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Weak social position perceived as normal. Traditional patterns prevail</td>
<td>Avoid pushing too much human rights. Use the Quran to explain women’s rights and promote education of women.</td>
</tr>
<tr>
<td>Role of women is mainly reproductive (giving birth to boys perceived as most important)</td>
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<td></td>
</tr>
</tbody>
</table>
V. STRATEGIC PLANNING: WHAT SHOULD BE DONE?

All health indicators underline the need for a rapid and sustained action in the health sector. Actions in other fields - like access to water, access to food and to education - are just as important for the improvement of health in Afghanistan. Also security and political stability are prime imperatives for any reconstruction plan.

The planning of “what should be done in order to improve reproductive health in Afghanistan” will be approached in here according the 3 barriers to health care identified by UNICEF:

a) Socio-cultural: Not knowing there is a problem or deciding to seek care
b) Geographic: Not being able to reach health care
c) Health care: Not receiving adequate treatment at the health care facilities

A. DECREASE SOCIO-CULTURAL BARRIERS

Reproductive Health should be seen from a broader perspective than only from a health care provider point of view. Equally important is to know, to understand and to give an answer to what Afghan women and men really want, taking into account the socio-cultural environment.

Even if it is very important and crucial to increase the quantity as well as the quality of reproductive health services, we suggest to invest in three other major fields of action for improving reproductive health in Afghanistan:

- Promotion of the education of girls / women
- Empowerment of women
- Community Health Education

These have a direct and indirect impact on RH, as shown by other studies. Maternal mortality reduction is supported by gender equity in access to education, income, and decision-making in the community.

1. PROMOTION OF THE EDUCATION OF GIRLS / WOMEN

The KAP study underscores the role of education for girls and women. RH indicators are consistently worse for illiterate women than for literate ones. Educated women marry at older age, have fewer pregnancies, do use family planning methods more often and deliver more frequently with skilled birth attendants.

The importance of schooling of girls and women is widely recognised:

“The evidence is clear that the total benefits to education multiply when schools open their doors to girls and women. In addition to being more productive in market work, educated women have smaller families, fewer of their children die in infancy and the children who survive are healthier and better educated. Educated women are also better equipped to enter the paid labor force, which is critical to the survival of the many female-headed households in developing countries. It is not surprising then, that nations with higher levels of female school enrolment in the past, today show higher levels of economic productivity, lower fertility, lower infant and maternal mortality, and longer life expectancy than countries that have not achieved as high enrolment levels for girls. As an economic investment, increased outlays directed at educating girls may well yield the highest return of all investments available in developing countries considering both private...”
benefits and returns to other family members. As a rough approximation, wages increase by more than 10-20 percent for each additional year of schooling.

Educated women also choose to have fewer children. Econometric studies within individual countries looking at the effects of education on fertility find that an extra year of female schooling reduces female fertility by 5-10 percent.”

Therefore, access to primary schooling for every girl in Afghanistan is and should be a priority. Vocational training for girls / women is important too, because it increases even more women’s opportunities for a paid job and stable family income. Not only her own reproductive health but as well the health of her entire family will benefit from this. In Afghanistan, training of female health workers is crucial for women’s and children’s health because women can only be examined by female health staff.

2. EMPOWERMENT OF WOMEN

The positive impact of gender promotion on maternal mortality, but also the relation between gender equity and poverty reduction and the socio-cultural development of the entire society has been largely documented. Therefore, improving the status of women is a crucial issue in Afghanistan.

One should be careful with the direct promotion of women’s rights however. The women’s interpretation of their role and rights are different in Afghanistan than in western societies. Promotion of these rights can be seen as western, non- Muslim and might thus be completely unsuccessful. (E.g. Even among educated women living in Kabul, with access to health care, the idea that a man can beat his wife if she disobeys, is widely accepted and women can only seek health care after male permission).

The best way to achieve empowerment is probably through promotion of education for women, linked with better access to employment. The importance of literacy is recognized by the Afghan women since schooling of women is something all interviewed women desired.

The rights of women can be explained through the perspective of Islam. The difference between what is “being a good Muslim” and between what is a strictly traditional interpretation of the women’s role should be explained to the women. (E.g. the Quran does teach “No bad behaviour against women is allowed”; “The best of you are the ones who have the best relation with their wives”, “Women and men should learn till their grave.”)

3. COMMUNITY HEALTH EDUCATION

Not only women but also the whole society – especially the elderly, religious and other leaders - should be involved in health education programs. Some do consider male involvement even more important than education of women since men are the decision makers in the Afghan families.

Some specific elements to consider in reproductive health education:
- Sexual education is quasi absent. At the usual age of marriage, most of the girls do not know anything about reproduction. Health education should be targeting adolescent women. These are not well represented among the population attending PHC facilities. Therefore we recommend separating health education programs from the health infrastructures and actively

17 From “HRO Dissemination Notes: The Benefits of Education for Women” Human Resources Development and Operations Policy; Number 2, March 8, 1993
targeting female adolescents where they are. These might be in their household, in school, out-of-school.

- Early marriage is a phenomenon that is embedded in Afghan society. Yet, most women are in favour of marriage at later age. **Community education on the risks of early pregnancy** could be attempted. Important too is that the basic family needs are fulfilled in order to avoid very early marriage for dowry.

- The reproductive role is the most important role for women. This is a characteristic of many traditional societies. Specific interventions to decrease fertility rates might not be successful in the short-term. However, the risks of multiple pregnancies in a short period of time can be explained and the **promotion of family planning methods to space pregnancies** is important. It might have a substantial impact on maternal mortality.

- Even if not a health priority at this moment, STI are likely to become an important health problem because of the denial and the lack of knowledge. **Promotion of condoms as a family planning and birth spacing method** could reach a dual objective.

- **Health education programs** should be carefully implemented. Important as they are, women do not perceive them as a priority. When a woman attends a health facility, she mainly expects curative care. Therefore **preventive services** should be delivered together with **curative care**.
B. INCREASE THE AVAILABILITY OF REPRODUCTIVE HEALTH SERVICES

Within the broad area of reproductive health, the needs are enormous and interventions are needed in all fields. The national authorities and international community have rightly chosen to prioritise two areas of intervention at the moment:

- Safe motherhood
- Family Planning

The approach chosen is a community based primary health care approach.

In order to achieve a reduction of the maternal mortality, expansion of reproductive health services is needed at all 3 health care levels:

a) community level
b) basic health centre
c) hospitals

A primary health care system is only fully effective when a functioning referral level and links with the community exist. A cluster approach with investment in all levels will therefore be the most efficient. One can inform mothers and their families appropriately on danger signs of pregnancy and childbirth meaning “get help immediately”. Yet, when it takes more than two days travelling by donkey to reach a badly equipped health facility, ... not many maternal lives will be saved. The other way around - a well-equipped hospital but without female patients presenting danger signs of pregnancy and childbirth -, is not relevant neither.

Other external factors having a beneficial impact on the accessibility of health care services - like roads, transport means, economic development- are not discussed in here.

1. SAFE MOTHERHOOD INITIATIVE:

Three Main Axes have been identified to “make motherhood safe” in Afghanistan (see above: National Safe Motherhood Strategic Framework).

- Ensure effective antenatal care for all women
- Improve the coverage of skilled attendance at birth
- Improve the coverage, utilization and quality of emergency obstetric care

Ensure effective antenatal care for all women

Evidence-based antenatal care should be implemented through basic health facilities and community services. Standards for antenatal care need to be defined and respected.

The first priority would be to ensure ANC at all existing basic health facilities, and provide them with the needed training and supplies. Currently, less than half of the basic health facilities offer antenatal care services. This is automatically linked with the availability of female health staff.

Where no health facility exists, community health workers and / or Traditional Birth Attendants can – through home visiting – ensure some antenatal care activities, as:

- Birth preparedness: Providing mothers and their families with the appropriate information to recognize the symptoms of complications and to know when, how and where they should seek care.
- Prevention and control of anaemia though supplementation with iron folate.
- Promotion of clean delivery
More advantage could be taken from the existing supplementary feeding programs for pregnant and lactating women—since these are widespread and attract numerous women—through combination with ANC activities like birth preparedness, supplementation with micronutrients, hygiene education.

Improve the coverage of skilled attendance at birth

Studies have shown that a higher percent of skilled attendance at birth can effectively reduce maternal mortality\(^{18}\). Currently, less than 10\% of all births in Afghanistan are attended by skilled health personnel\(^{19}\). A sufficient number of midwives and auxiliary midwives have to be trained and their availability at community level should be ensured.

Meanwhile, some progress could be made by encouraging present female health professionals to assist deliveries at home. This requires: Identification of midwives, training, supervision and staff motivation and supply with the appropriate materials.

Improve the coverage, utilization and quality of emergency obstetric care

There is clearly a need for expansion of obstetrical services. The target of four basic emergency obstetric care facilities and one comprehensive EOC for each 500,000 inhabitants is far from reached. Of Afghanistan’s 32 provinces, only 11 currently have the capacity to deliver comprehensive emergency obstetrical care. Even in Kabul city, there are at the moment only 2 public maternities, whereas the population is estimated at more than 2 million people. These are over-loaded resulting in poor quality of service delivery.

Interventions needed

1. Every provincial hospital should be able to provide comprehensive EmOC according to international standards. This requires:
   - Rehabilitation of the hospitals
   - Input with supplies and equipment according the agreed international standards

   Special attention should be given to:
   - Infection prevention and management
   - Safe blood transfusion (anonymous testing for HIV, hepatitis)
   - Training of health care providers in EOC
   - Improved staff management and staff remuneration

   Because of the acute shortage of well trained female health staff, upgraded provincial hospitals should be ideally used at the same time as training sites for midwives, auxiliary midwives and female medical doctors.

2. Upgrading of MCH clinics / district hospitals to basic EOC.

3. Development of an adequate and sustainable referral system between community level, basic EOC and comprehensive EOC (ambulances, community car services, ...)

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\(^{18}\) Source: UNICEF and UNFPA

\(^{19}\) Skilled health personnel refers to doctors (specialist or non-specialist), and/or persons with midwifery skills who can manage normal deliveries and diagnose or refer obstetric complications. Both trained and untrained traditional birth attendants are excluded.
2. **FAMILY PLANNING**

Family planning could in a first period be a relatively “easy” way to reduce maternal mortality since no highly qualified staff or health infrastructure is needed to implement FP programs.

Studies have shown that spacing births has a powerful impact on chances of survival for both mothers and their children. Over the past two decades, surveys have shown that children born within 2 years of the previous birth are twice as likely to die by the age of one, than children born in an interval of two to four years.

Additionally, family planning can prevent many if not most deaths from unsafe abortion and help to prevent the growing epidemic of HIV/AIDS and other sexually transmitted infections.

Family planning is highly cost-effective. According the World Bank, family planning is one of the best ways to improve maternal and child health at an annual cost of only 1 to 2 US$ for each person per year.

Even if there are barriers to the use of FP - mainly linked with the reproductive role of the women- FP as “birth spacing method” is generally accepted. There is certainly an unmet demand for FP. Women and men need to receive more accurate information about contraceptive methods, especially those methods that are most readily accessible (pills, injections and condoms).

Especially **promotion of condoms** as a family planning and birth spacing method should be considered because a dual objective can be reached: FP and decreased transmission of STI.

FP services should be targeted at both men and women, since men are often the decision makers in child bearing.

**Interventions needed**

1. Community sensibilisation and education
2. Making FP available at all primary health facilities (including male OPD)
3. Making FP available at community level through CHW and/or TBA (condoms, pills)

The input of Afghan officials (health authorities, political and religious leaders) is needed to design an effective family planning program, in order not to be offensive to the many conservative people in the country.

Some neighbouring Islamic countries – like Iran - have very effective FP programs. It could be interesting to send Afghan policy makers to Iran for exchanging ideas and practical experiences, because of some similarities of the context.

3. **OTHER REPRODUCTIVE HEALTH ISSUES**

The above-mentioned interventions can be considered as key interventions in the field of RH services. Besides these, the international community should at any moment try to enable a more favourable environment to

- promote sexual health and rights
- combat gender violence and promote women’s rights

These topics should always be approached carefully and with respect for the religious and social sensitivities of the country.
C. INCREASE THE QUALITY OF SERVICES

1. HUMAN CAPACITY DEVELOPMENT

Reinforcement of MoPH

The approach of the international community is not always coherent: a highly performing MoPH is expected, but there is little readiness to invest in improving working conditions and remuneration of the MoPH staff. There is a sharp contrast between the working conditions of the deputy ministers, who are still working with pencils and paper, and the international experts carrying laptops and giving PowerPoint presentations, moving in their white land cruisers and working in newly renovated and fully equipped offices.

More attention is needed to equip the provincial, regional and national ministries with a minimum of decent administrative furniture as well as communication and transport means.

There is an urgent need for capacity building of the Ministry of Public Health at all levels, in order to enable them to take a leading position. Besides technical knowledge, also communication, administration and management skills need to be strengthened.

This can be achieved through:

Technical assistance by international experts

Many international experts have visited Afghanistan over the past year. UN agencies, the World Bank, donor agencies, NGOs and research institutions sent their respective experts to carry out needs assessments, workshops and trainings, in a quite uncoordinated way. Though reports with very valid recommendations have been written, the impact of all these at national level must be put into perspective.

However, technical assistance can made more efficient through:

- Longer term commitment and contracts.
- Selection of international experts with previous work experience in Islamic countries and preferably, familiar with the local languages. Experts from neighbouring Muslim countries could be involved.
- Work in a framework agreed on by the MoPH with clear terms of reference and within a well defined department and largely recognised organisation.
- Systematic translation and printing into the Afghan languages (dari and pashtun) and circulation of these documents among the concerned actors as wide as possible.

Training of Afghan health officials

While it has not been possible over the past years due to the war, workshops should be preferably organised in-country. Workshops organised abroad have limited impact because policymakers are not involved. A careful selection should be made of who should attend these workshops. Many workshops and meetings target the same population. In Kabul, professional “workshoppers” exist who make a decent life hopping from one workshop to another.

More efforts should be made to organise workshops at field level and to invite really the people who are immediately involved.

Besides workshops, punctual training opportunities should be offered. Staff working at MoPH should at maximum benefit from the many trainings organised by the different organisations all over Afghanistan. This includes training on technical medical topics, on communication, management, languages, computer knowledge, human and women’s rights. Selected MoPH responsibles should be offered the possibility to attend training courses abroad, especially public health courses.
Working visits of some Afghan health authorities to effective RH programs implemented in countries with comparable socio-cultural contexts (e.g. FP program in Iran), could be useful to get Afghan policy makers familiar with alternative ways of organisation.

Attraction of highly qualified staff into MoPH

Some highly qualified Afghan medical staff are residing abroad. Their return to Afghanistan and integration in MoPH and/or medical educational institutions, on voluntary basis, could be highly beneficial to improve the internal capacity of the MoPH. The donor community should encourage this.

Many medical health professionals developed a considerable capacity (e.g. in managing health programs) through their working experience with international and national agencies. They are not keen to be employed by the MoPH, as this would mean a considerable loss in salary. The situation could be partially solved if agencies would second Afghan management staff directly to the MoPH. A common inter-agency standard scale for salaries and incentives for Afghan medical staff, more in accordance with the national MoPH salaries, would be a good initiative too.

Logically these are critical controversial issues and plenty of good-will of the organisations, Afghan staff as well as of the international donors will be required for any progress in this field.

Training of health professionals

Regulation of the status of health staff

Many health staff was trained outside the official educational system (by agencies) or abroad. Other staff has received more theological than practical training over the past years (under taliban regime). For many of them, their official professional status remains unclear. Inventarisation and certification of all the existing health professionals is therefore a difficult but important task for the MoPH. Organisations will need to accept and respect the authority of the MoPH in this process.

Training of doctors, nurses and midwives

The official medical institutions have heavily suffered in quantity and quality (brain drain) during the past two decades of war. Under taliban regime, most of the courses were closed for girls/women. Practical trainings in qualified hospitals were reduced to almost zero.

During the long years of war, agencies have been the main source of practice oriented trainings. Besides in-service training, many medical organizations have organized training sessions for the local health staff on various health topics. Despite their value, these trainings have a number of limitations:

- They are usually restrained to the health staff directly supported by the agency
- They are not officially recognized
- They are not standardized nor uniform and do not respond to punctual needs as observed by the International health staff

In-service training of health staff and refresher courses will undoubtedly continue to play an important role and need to be maintained in the foreseeable future. Virtually all medical people graduated during the last twenty years need to upgrade their skills in many fields. Standardisation of training manuals is required to guarantee quality and to avoid duplication. There is an urgent need for more practical training (e.g. in emergency obstetrical care, general hygienic measures…)

International investment in the formal education system is needed too. Reproductive health is approached in a conservative and old-fashioned way in the current curricula of midwives and doctors. Technical assistance to adapt curricula is needed, both in the medical schools as in the intermediate medical schools. This can be done by hiring qualified Afghan health professionals who received their training abroad or by contracting native language speaking professors from e.g. Iran and Pakistan. For this, full integration of the external professors in the national education system by the Afghan authorities (Ministry of Higher Education and Health) as well as long term commitment of the donor to the experts (decent salary for at least 10 years) will be needed.
(Female) Afghan professors should also be sent to public health and reproductive health courses abroad. The number of eligible candidates is certainly limited. Follow-up and financial support will be needed afterwards.

**Positive discrimination towards women**

An important fact to consider is that access to health for women depends completely on the availability of female medical staff. Women can only be attended by women in Afghanistan. Currently women are the minority within the medical staff as well as within the (intermediate) medical schools. Therefore positive discriminative actions should be put in place to attract more girls / women in vocational trainings such as medical doctor, nurse and midwife.

**Health care providers in rural areas**

As mentioned above, lack of skilled female staff is the most serious constraint to expand reproductive health services in rural areas. Short-term solutions for this do not exist. Yet, action should be taken to change this picture:

**Attract qualified staff from urban areas to work in rural communities**

This is currently the most exploited option. Agencies need to offer high salaries, accommodation for female staff and her family, employment for her husband and other benefits, before vacancies can be filled. Probably this option reached the limit. Positions in rural health facilities are not being filled by new qualified female staff, but by kidnapping female staff from other agencies by offering better working conditions. It does neither provide a long term solution to the problem.

**Get more girls / women from rural communities to start studies at the (intermediate) medical schools.**

Positive discriminative actions for girls from rural areas could be helpful. An important constraint is that is difficult to find eligible candidates for such trainings. In many districts it is impossible to find even one literate girl / woman. Other obstacles are the limited freedom of movement for girls, young age of marriage and delivery, as well as other socio-cultural factors. Promotion of primary schooling for girls in rural areas is therefore a first priority. But it will take at least a generation before the inferior educational position of women can be improved.

**Train community health care workers, TBAs and auxiliary midwives**

This is probably the most suitable option at the moment. But, while this might be the only option in rural communities, the role of TBAs might not be over-emphasised.

Currently, this role varies from region to region. In some communities TBA are non-existent. In others – like in some Hazara communities in the central region- TBA are omni present and well respected. Proper investigation of the role and impact of TBAs in the different societies is needed first. Training should focus on those TBAs who perform many deliveries, in order to be cost effective. It is quite useless to train older women who perform few deliveries. TBA training programs need to be followed up by regular supervision and refresher courses.

Meanwhile, many TBAs are being trained by several agencies. Training schedules vary from a few days to several weeks. A proper inventarisation would be appropriate before training more TBAs. Operational research is needed to define a national policy and a uniform curriculum towards TBAs.

A worthy alternative to TBA training is the more comprehensive and extensive practical training of TBAs in rural communities to “auxiliary or village midwives”. This initiative is still on a small scale (HNI / UNICEF pilot project) and the training is not yet officially recognised.

Besides TBAs, training of CHW needs to be emphasized. CHW could be effectively involved in

- Promotion of birth spacing; distribution of some contraceptives (condoms, pills).
- Promotion of delivery with skilled attendance.
o Nutrition during pregnancy and breastfeeding.
o Sensibilisation of families and education on danger signs for delivery.
o Promotion of antenatal care services; distribution of iron folate to pregnant women, etc

Important factors to consider are that
o You need male CHW to reach men and female CHW to reach the female population.
o Education of men is as least important than educating women on reproductive health, since men are the decision makers regarding family matters. Key people within the communities – like religious leaders (mullahs) and elderly should also be involved.
o Even if linked to and supervised by the health centres, the CHW should bring education messages to the households in order to reach women and girls

2. INVESTMENT IN INFRASTRUCTURE, EQUIPMENT AND SUPPLIES

The Afghan health sector is almost entirely depending on external aid. In the current socio-economic context, the capacity of the Afghan communities to invest in health, are minimal. In order to guarantee access to health care, only small “symbolic” user’s fees can be asked - which can help to cover running costs of the health facilities to a certain extent.

Over the coming years, financial resources are needed from the international community in order to cover:

Investment needs
Most of the hospitals are in a state of despair. Their current status does not allow quality services. Many basic health facilities do not have the necessary basic equipment, water is lacking in more than half of them and sanitary conditions are often awful.

An important capital investment is needed over the coming years for:
- Medical equipment, according to agreed international standards
- Rehabilitation (reconstruction) of basic health facilities
- Rehabilitation of hospitals
- Water and sanitation
- Electricity (generator) for surgical wards
- Transport and communication

Renovation and eventually reconstruction of health facilities should be very carefully planned. Not only the potentially covered population should be taken into account, but the availability of health staff as well. Even if necessary, it would be useless to build maternities all over the country, as no female staff is available to provide the services. It is more advisable to start with upgrading of the existing facilities to functioning levels, where staff is present and where most needed.

Recurrent needs
Over the coming years, recurrent costs need to be covered by external budgets.
Funding is needed for:
- Supply of drugs
- Supply of medical materials
- Financial support for salaries of all staff working in the health sector
- Running costs of the health facilities
Needs in rural versus urban areas

The international community tends to fund preferentially primary health care projects of agencies in rural areas. Expansion of health care services to rural and undeserved areas is certainly a priority. But the attitude of all money to the rural and no penny to the urban areas is not entirely justified.

Support of urban health services is needed as well:
- Most returnees, returning from Pakistan and Iran do settle down in urban areas, because they are used to urban life style (About 75% of the 600,000 people who returned from Pakistan settled down in Kabul). This urban influx should not be stimulated and people need be encouraged to return to their home villages. Nevertheless a vast part of the newly urbanized population will remain in the cities and need access to medical services. This continuous influx of people in the Afghan cities can put serious constraints on the already limited capacity of the health care system. Even if there are too many hospitals and hospitalisation beds in Kabul city, there are only 3 public maternities in Kabul city (which are currently over-loaded).
- Even if more doctors and specialists are present in urban areas, the quality of services is poor. External support (training, incentives, equipment and drugs) is needed for upgrading an essential number of basic health facilities and hospitals.
- A well equipped and running peripheral primary health care network looses a lot of its pertinence if on central level no second line services can be offered.
- Low investment in urban areas will lead to increasing tensions between the Afghan health authorities and the international community. The general population expects the international community to invest in urban medical care.
D. CONCLUSIONS

Interventions at different levels are needed and donors and agencies should both focus on quality and of quantity, as well as on long standing commitment and strategies. There are not such things as “quick impact” projects in the reproductive health sector in Afghanistan.

Training and capacity building are key elements for the reconstruction of the Afghan health system. This starts with primary schooling for girls, followed by vocational training and access to employment for women as well as training of female health workers. Improving the status of women is crucial, but might be difficult to reach in short-term. Innovative approaches, with respect for the religious and social context are needed. The perspective of Islam, more than a constraint, should be used to explain the empower women and improve her position.

Increased availability, accessibility and improved quality of services are important. Investments in RH programmes should prioritise FP services and support the Safe Motherhood Initiative. Extension of ANC services is needed, presence of skilled birth attendants, EmOc and availability of FP services offering condoms amongst other methods.

Capacity building of the MoPH is essential. Training should be done as much as possible in-country, in order to involve policy makers. Trained Afghans living abroad as well as experts from the neighbouring countries should be involved in these trainings. A number of professionals could also benefit from public health courses abroad.

Training of field staff, including practical training and refresher courses is also necessary. Because of the current lack of female staff, women and girls should be prioritised for training opportunities.

Besides training, investments are needed in rehabilitation of clinics, including equipment and coverage of recurrent costs. The need might be the highest in rural areas, but upgrading urban clinics, especially maternity wards, should not be neglected. As expansion of services to rural areas is highly jeopardized by the lack of female staff, alternative ways of service delivery in rural areas should be sought. TBAs and CHW can play an important role in making primary health care available for a large part of the rural population.
VI. HOW CAN THE BELGIAN COOPERATION CAPITALIZE ITS ROLE IN THE RH SECTOR?

The needs of the reproductive health care sector - like in many other sectors in Afghanistan - are huge and external funding will remain important during the following years.

A. PRIORITY INTERVENTIONS NEEDING SUPPORT

1. EDUCATION

This should focus on primary schooling, especially for girls and in rural areas. Vocational training for women and training of female health staff is also necessary.

2. ACTIVITIES THAT EMPOWER WOMEN

Community education is important, but also income generating projects in order to improve the status of women.

3. REPRODUCTIVE HEALTH CARE ORIENTED PROGRAMS.

Most of the current investment in the health sector is used for basic Mother and Child Health services, through financing programs of agencies. This ensured RH services to be maintained at a minimum level throughout the country. Essential is that these existing reproductive health programs can at least be maintained over the following ten years.

But in addition, financial support is needed for many other RH projects. Any funding of the following projects can be considered as meaningful:

- Capacity building of MoPH
  The importance and mechanisms for capacity building of the MoPH have been extensively explained in the previous chapter.

- Training of female health staff
  - Support to formal medical and intermediate medical schools (especially midwives)
  - In-service training and refresher courses for female medical staff

- Strengthening of RH services
  - Family planning programs (information, education, communication and increase availability)
  - Increase coverage of “evidence based” antenatal care activities
  - Upgrading of MCH clinics to basic EOCs - where female qualified staff is present
  - Ensure comprehensive EOC at provincial level. Ideally these should provide quality care and serve at the same time as practical training centres (for doctors, midwives, auxiliary midwives and TBAs)
  - Promotion of attendance of home deliveries by qualified staff (midwives)

- Community health programs
  - Training of Community Health Workers
Home-visiting RH programs

NB: The opening / construction of more MCH clinics is with the current limited (female) human capacity is not realistic in many regions over the first years. Though certainly more facilities are needed in some districts, it is better to focus on the improvement / expansion of RH services in existing health facilities as well as on community health programs and the development of an adequate referral system.
B. PROPOSED MECHANISMS FOR BELGIAN AID SUPPORT

1. **DIRECTLY BILATERAL SUPPORT**

Since the law of May 1999, the Belgian assistance has been limited to maximum 25 partner countries or regions, which have been defined by a royal decree. Afghanistan does not belong to the 25 priority countries for Belgian bilateral cooperation. Hence no opportunities exist for direct bilateral cooperation.

2. **MULTILATERAL COOPERATION : THROUGH RECOGNISED INTERNATIONAL ORGANISATIONS**

**Trust funds**
Through contribution to the ARTF trust fund (see page 49), the central authorities in Kabul can be supported. This fund provides support for the payment of salaries of MoPH staff. However, the visibility is rather low. Contributions to ARTF should be accompanied by a reorganisation of the administration and capacity building, in order to be more fruitful.

**UN agencies**
Within the large variety of UN programs, the most relevant could be supported. These include:
- Support to family planning services through UNFPA.
- Support to provincial emergency obstetrical care services and establishment of practical training centres through UNICEF.

**Red Cross Organisations**
Support to the reproductive health programs of the Red Cross Organisations could also be an option.

3. **INDIRECTLY BILATERAL: THROUGH PARTNERSHIP WITH REGOGNISED BELGIAN NGOs**

NGOs are the main providers of basic mother and child services. They are in the best position to maintain and eventually extend these services to other (less served) areas.

The choice is limited though since there are few Belgian NGOs operating in Afghanistan: MSF Belgium, Handicap International, Solidarite... Only MSF has RH activities, as an integrated part of their primary health care project. They are implementing their projects in northern Afghanistan, a poorly covered region. Other Belgian NGOs could be encouraged to be involved in RH activities.

4. **PARTNERSHIP WITH OTHER INTERNATIONAL NGOs: THROUGH HUMANITARIAN AID**

Through humanitarian aid, other international NGOs could be supported. Unfortunately, only short-term rehabilitation and emergency projects can be financed through this mechanism.

**International NGOs**

**Aide Médicale Internationale**
This NGO is currently supporting basic health facilities as well as 3 comprehensive EOCs.

**Terre des Hommes**
They have a small RH program, based on home-visiting MCH activities, in Kabul and Kandahar.
Médecins du Monde
They have a MCH program in 3 provinces and face currently difficulties in finding financial support to upgrade MCH clinics to basic EOCs in Kabul. This is urgently needed as the existing maternity hospitals in Kabul city are over-crowded.

Health Net International
They have an integrated approach and support the health care system in one province (Nangarhar). It would be interesting to export this to other more underserved provinces.

Several other international NGOs (like SCA, MSF-I, IMC…) have valuable RH programs. A number of NGOs in neighbouring countries (e.g. Heed Bangladesh) are also increasingly involved in health and RH projects in Afghanistan. They have a longstanding experience of working at grass-root level in difficult circumstances and could be interesting partners.

5. SUPPORT TO AFGHAN NGOs: THROUGH UN OR BELGIAN NGOs?

There are some very valuable Afghan medical NGOs. They are usually better integrated than the international agencies since they have a better understanding of the context. Nevertheless they need to care not getting over-stretched, as they are asked by almost everyone to act as implementing agency: by international donors, UN agencies and even international NGOs. IbnSina is the largest and the best known medical agency. Others are AHDS and CHA.

The Belgian cooperation is not in a position to provide direct funding to national NGOs, but earmarking UN funds for Afghan NGO specific programs or funding Afghan NGO projects included in TAPA, can be considered. Financing of Afghan NGOs through Belgian recognised NGOs, could be an option too.

6. CAPACITY BUILDING: THROUGH SPECIAL PROGRAMS

Following options could be explored:
- Support the return of qualified medical Afghan staff, through long-term contracts in Afghanistan
- Identify some key (female) Afghan staff for public and/or reproductive health courses in Belgium (e.g. Antwerp, Brussels)
- Scholarships for Afghan students to study abroad, preferably in a neighbouring country (e.g. Iran, Pakistan…)

Note: The medical advisors of the European Union and of the French Cooperation, based in Kabul, could be helpful contacts to facilitate this process.

7. TECHNICAL ASSISTANCE: THROUGH BELGIAN EXPERTS AND UNIVERSITIES

The Belgian Cooperation can play a role in punctual monitoring and evaluation, in RH training programs and operational research. Belgian experts from universities or private companies can be hired for this purpose. Expert missions should fit in a framework agreed on by the MoPH and coordinated with UN agencies (UNFPA, UNICEF or WHO). Partnership with Afghan institutions or NGOs is recommended for efficient field missions.

Belgian experts can also play a role in the provision of technical assistance (TA) to local and international NGOs for an efficient design and implementation of quality RH programs. TA can be provided for general administrative and managerial issues. Specific TA can also be warranted to ensure that interventions are gender-sensitive. TA can be helpful to design the framework of RH projects and to monitor progress and outcomes. This can be realized through a partnership between NGOs and universities.
C. CONCLUSIONS

After more than two decades, Afghanistan finally gets a chance to get out of the dark tunnel of war and destruction. It is now crucial for Afghan men and women not to be abandoned by the international community.

At the Tokyo conference, the Belgian Government pledged 30.7 million Euro aid to Afghanistan for the period 2002 to 2006. These funds should be unconditionally spent inside Afghanistan. A Belgian contribution to reproductive health is undoubtedly valuable and can be done in various ways: through support of international and national NGOs, through support to UN agencies or through the input of Belgian experts. Whatever the intervention, the gender-sensitive should be taken into account and a gender perspective has to be integrated in all assistance programs. Extension of the Belgian assistance beyond this initial period of five years is recommended.

The funding of the health sector - like for many other sectors in Afghanistan – is currently insufficient. Moreover, an increase in expenditure is to be expected as a result of expansion of service delivery. Within the health sector, RH is a priority area for intervention. A multi-sectoral approach and long-term commitment is needed in order to improve RH and care. Despite major interventions, it will take many years of social investment and of commitment to peace before reproductive health can be achieved for the majority of the Afghan women and men.

In the short term, RH care can be improved through support to specific RH programs. Belgian aid could be channelled through UN agencies as UNFPA to support the MoPH at central level. Field interventions could be supported by indirectly bilateral aid through NGOs. Technical assistance can be useful to guarantee the quality of the interventions.

Whereas community education and primary schooling for girls will probably not have an effect on RH in the very short-term, they are essential to improve the social status of women. Investments in these areas are encouraged.
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For ICRH
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VIII. BACKGROUND DOCUMENTS

Assessment Reports

- Reports on the EC Rapid Reaction Mechanism Assessment Missions: Urban Recovery, Gender guidelines, Food security, Governance, Education; April 2002
- Report of the “Reproductive Health Survey April 20th to May 17th 2000”; conducted by IbnSina and funded by UNFPA

Health Care in Afghanistan

- Ministry of Public Health Afghanistan “Policy statement Document: National Health Policy” Final Draft
- Second draft “A basic Package of Health Services for Afghanistan” May 2002
- UNICEF joint press release “Afghanistan is among worst places on globe for women's health, say UNICEF and CDC” http://www.unicef.org/newsline/02pr59afghanmm.htm
- Report “Afghanistan Health Sector Profile: A contribution to the debate on health sector recovery - Incomplete draft” by Enrico Pavignani and Sandro Colombo; August 2002
USAID / WHO “Aid Agencies Outline Health Care Reconstruction Plan for Afghanistan: Two-thirds of Afghans have no health care access”; 5 April 2002
http://usinfo.state.gov/topical/pol/terror/02040508.htm

Press release WHO/14 “Agencies seek major investment in Afghan health sector” 4 March 2002


Human Rights – Gender:

http://www.unhchr.ch/html/menu2/7/a/mafg.htm

United Nations Human Rights Documents: Treaty body database:
http://www.unhchr.ch/tbs/doc.nsf/

Jurist: The Legal Education Network; World law section: Afghanistan
http://jurist.law.pitt.edu/world/afghanistan.htm

The Bonn agreement: “Agreement on provisional arrangements in Afghanistan pending the re-establishment of permanent government institutions”
http://www.uno.de/frieden/afghanistan/talks/agreement.htm

Reports from Human Rights Watch:
“Women in Post-Taliban Afghanistan”, May 2002
http://hrw.org/backgrounder/wrd/afghan-women-2k2.htm
“We want to live as humans: Repression of Women and Girls in Western Afghanistan”, December 2002
http://www.hrw.org/reports/world/afghanistan-pubs.php


“Taking stock: Afghan women and girls six months on”

United Nations issues wall chart on marriage patterns 2000

Opinion article regarding sharia:
http://www.freedomhouse.org/religion/country/afghanistan/Sharia%20in%20Kabul.htm

International approach

http://www.undp.org/afghanistan/needsreports/needsreport2.html
Reconstruction of Afghanistan: A World Bank perspective; presentation for OECD Development Assistance Committee, May 2 2002


Steering Group Meeting in Brussels: http://europa.eu.int/comm/external_relations/afghanistan/intro/pr21_12_01.htm


Afghanistan Research and Evaluation Unit (AREU):”The A to Z Guide to Afghanistan Assistance”; http://www.areu.org.pk/a_to_z/terms/itap.html


Forced Migration Review: “September 11th: has anything changed?”, published by the Refugees Studies Centre in association with the Norwegian Refugee Council / Global IDP project; June 2002, nb.13

Official website of the Afghan Assistance Coordination Authority (AACA): http://www.afghanaca.com/

Belgian aid

Website of the Belgian Cooperation (DGIC): http://www.dgic.be

Brussels Action Plan “Afghan Women’s participation in the reconstruction of Afghanistan”: Unifem roundtable Brussels, 10 – 11 December 2001

Afghan Women’s Summit for Democracy “The Brussels Proclamation”, 4-5 December 2001, Brussels

Rapport de mission en Afghanistan de Marion Van Offelen (25/6 au 5/7/2002) “Mise en œuvre d’une perspective de genre (égalité homes/femmes) dans l’appui de la Coopération internationale a la reconstruction de l’Afghanistan”

Transcription of the “Intervention of the Belgian delegation at the Tokyo International Conference on Afghanistan”, Tokyo, 21 January 2002

Funding

“Interim Humanitarian Analysis: ITAP review”; 29 May 2002
“Immediate and Transitional Assistance Programme for the Afghan People 2002: Updated financial requirements”, February 2002
“ITAP update and summary of progress by National Development Budget Programme Area, 13 Oct 2002”
http://www.reliefweb.int/w/rwb/nsf/vID/

UNAMA (UN Assistance Mission in Afghanistan): “Afghanistan, ITAP and beyond: update of urgent humanitarian and recovery needs”, 10 July 2002


Afghanistan Reconstruction Trust Fund Contributions: http://www.worldbank.org/artf

Website of the Afghanistan Information Management Service: Projects included in ITAP http://www.hic.org.pk/


Reproductive health general background information


WHO report “A framework to assist countries in the development and strengthening of national and district health plans and programmes in reproductive health; a report based on the meeting of Regional Advisers in Reproductive Health” August 2000

WHO publication “The Minimum Initial Service Package for reproductive health in crisis situations”
WHO publication “Mother-baby package: implementing safe motherhood in countries”
WHO publication “Safe Motherhood needs assessment”
WHO publication “Reproductive Health Indicators for global monitoring: Report of the second interagency meeting 2001”
WHO publication “The Sisterhood method for estimating maternal mortality”
http://www.who.int/reproductive-health/publications/

UNFPA “Background Information on the Key International Agreements (ICPD)”
http://www.unfpa.org/mothers/concensus.htm


HRO Dissemination Notes: The Benefits of Education for Women” Human Resources Development and Operations Policy; Number 2, March 8, 1993
IX. ANNEXES

ANNEX A: DEFINITIONS REPRODUCTIVE HEALTH INDICATORS

ANNEX B: SOME BASIC FACTS ON AFGHANISTAN

ANNEX C: MAP OF AFGHANISTAN

ANNEX D: RESULTS OF THE KAP STUDY
### A. Definitions of RH Indicators

<table>
<thead>
<tr>
<th>Definitions</th>
<th>International goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total fertility rate</strong></td>
<td>Total number of children a woman would have by the end of her reproductive period if she experienced the currently prevailing age-specific fertility rates throughout her childbearing life.</td>
</tr>
<tr>
<td><strong>Contraceptive prevalence</strong></td>
<td>Percentage of women of reproductive age* who are using (or whose partner is using) a contraceptive method** at a particular point in time.</td>
</tr>
<tr>
<td><strong>Maternal mortality ratio</strong></td>
<td>The number of maternal deaths per 100,000 live births.</td>
</tr>
<tr>
<td><strong>Antenatal care coverage</strong></td>
<td>Percentage of women attended, at least once during pregnancy, by skilled health personnel*** (excluding trained or untrained traditional birth attendants) for reasons related to pregnancy.</td>
</tr>
<tr>
<td><strong>Births attended by skilled health personnel</strong></td>
<td>Percentage of births attended by skilled health personnel*** (excluding trained or untrained traditional birth attendants).</td>
</tr>
<tr>
<td><strong>Availability of basic essential obstetric care</strong></td>
<td>Number of facilities with functioning basic essential obstetric care**** per 500,000 population.</td>
</tr>
<tr>
<td><strong>Availability of comprehensive essential obstetric care</strong></td>
<td>Number of facilities with functioning comprehensive essential obstetric care***** per 500,000 population.</td>
</tr>
<tr>
<td><strong>Perinatal mortality rate</strong></td>
<td>Number of perinatal deaths****** per 1000 total births.</td>
</tr>
<tr>
<td><strong>Low birth weight prevalence</strong></td>
<td>Percentage of live births that weigh less than 2500 g.</td>
</tr>
<tr>
<td><strong>Positive syphilis serology prevalence in pregnant women</strong></td>
<td>Percentage of pregnant women (15 - 24 years) attending antenatal clinics, whose blood has been screened for syphilis, with positive serology for syphilis.</td>
</tr>
<tr>
<td><strong>Prevalence of anaemia in women</strong></td>
<td>Percentage of women of reproductive age (15 - 49 years) screened for haemoglobin levels with levels below 110 g/l for pregnant women and below 120 g/l for non-pregnant women.</td>
</tr>
<tr>
<td><strong>% of obstetric and gynaecological admissions owing to abortion</strong></td>
<td>Percentage of all cases admitted to service delivery points providing in-patient obstetric and gynaecological services, which are due to abortion (spontaneous+induced, but excluding planned termination).</td>
</tr>
</tbody>
</table>
### Definitions

<table>
<thead>
<tr>
<th>Definitions</th>
<th>International goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reported prevalence of women with Female Genital Mutilation</strong></td>
<td>Percentage of women interviewed in a community survey, reporting to have undergone Female Genital Mutilation.</td>
</tr>
<tr>
<td><strong>Prevalence of infertility in women</strong></td>
<td>Percentage of women of reproductive age (15-49 years) at risk of pregnancy (not pregnant, sexually active, non-contracepting and non-lactating) who report trying for a pregnancy for two years or more.</td>
</tr>
<tr>
<td><strong>Reported incidence of urethritis in men</strong></td>
<td>Percentage of men (15 - 49 years) interviewed in a community survey, reporting at least one episode of urethritis over the last 12 months.</td>
</tr>
<tr>
<td><strong>HIV prevalence in pregnant women</strong></td>
<td>Percentage of pregnant women (15 - 24 years) attending antenatal clinics, whose blood has been screened for HIV and who are sero-positive for HIV.</td>
</tr>
<tr>
<td><strong>Knowledge of HIV-related prevention practices</strong></td>
<td>The percentage of all respondents who correctly identify all three major ways of preventing the sexual transmission of HIV and who reject three major misconceptions about HIV transmission or prevention.</td>
</tr>
</tbody>
</table>

### Other definitions used:

- **Reproductive age:** Women of reproductive age refers to all women aged 15 - 49, who are at risk of pregnancy i.e. sexually active women who are not infecund, pregnant or amenorrhoeic.

- **Contraceptive methods:** Includes female and male sterilisation, injectable and oral hormones, intrauterine devices, diaphragms, spermicides and condoms, natural family planning and lactational amenorrhoea.

- **Skilled health personnel:** Refers to doctor (specialist or non-specialist), and/or persons with midwifery skills who can manage normal deliveries and diagnose or refer obstetric complications. Both trained and untrained traditional birth attendants are excluded.

- **Basic essential obstetric care:** Should include the capabilities for administration of parenteral antibiotics, oxytocics and sedatives for eclampsia; the manual removal of placenta and retained products; assisted vaginal delivery with forceps or vacuum extractor.

- **Comprehensive essential obstetric care:** Should include basic essential obstetric care plus surgery, anaesthesia and safe blood transfusion.

- **Perinatal deaths:** Deaths occurring during late pregnancy (at 22 completed weeks gestation and over), during childbirth and up to seven completed days of life.

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"Possibilities for the improvement of Reproductive Health Care in Afghanistan"

*Punctual Policy Advice*
B. Some Basic Facts on Afghanistan

1. Human Development Indicators
   - Infant mortality rate: 154 - 165/ 1000 live births
   - Under 5 mortality rate : 257 / 1000 live births
   - Life expectancy at birth : 46.6 years (47.3 years for males, 45.9 years for females)
   - Literacy rate (ages 15+, males, 1995): 46 - 51 %
   - Literacy rate (ages 15+, females, 1995): 15 - 21 %
   - Access to basic care: 29 – 35 %
   - Access to safe water: 6 - 13 %

2. Geographic Information
   - Capital : Kabul
   - Surface : 647.500 square km
   - Administrative division : Depending on the source : 29 - 32 provinces and 329 - 456 districts
   - Three main geographical areas : the northern plateau (the main agricultural area), the south-west plateau (desert and semi desert) and the central highlands
   - Climate: arid to semi-arid; cold winters and hot summers
   - Geopolitical importance because of its situation in Central Asia, in between former communism (ex-USSR : Uzbekistan, Tajikistan, Turkmenistan ), Islam (Shiites in Iran, Sunnite in Pakistan ) and more western influence sphere
   - Elevation extremes: 258 m (Amu Darya) – 7485 m (Nowshak)
   - Natural hazards: earthquakes (Hindu Kush region), drought, flooding

3. Demographic and Socio Cultural Information
   - Population : 27.8 million (mid 2002 estimation)
     NB: Refugee population outside Afghanistan estimated at still more than 3 million (mainly in Pakistan and to a minor degree in Iran). Internally displaced population inside Afghanistan estimated now at about 800.000.
     NB: Population in Kabul estimated at more than 2 million inhabitants.
   - Crude Birth rate : 41.0 births /1000 persons / year
   - Crude Death rate : 17.4 deaths / 1000 persons / year
   - Annual population growth rate: 3.43 %
   - Projected Population 2025: 45.9 million
   - Population under 15 : 43 %
   - Population density: 42 persons per square km
   - 78 % of the population is living in the rural areas ; the differences (economic activities, level of poverty, lifestyle and tradition) between the cities and the countryside are enormous
   - Ethnic division :
     - Pashtun : pashtun speaking, about 44%, predominate in the south and west
     - Tajiks : farsi speaking, about 25%, in the north east
     - Uzbek : uzbek speaking, about 8 % in the central north
     - Turkmen : turkmen speaking, about 5%, in the north
     - Hazara : farsi speaking, about 10%, in the centre
     - Minorities: Baluchis in the south west and Nuristans near the Chitral border
     - Kuchi nomads (about 8%)

Religion: Islam (most are Sunni Moslems (84%) and less Shiite Moslems (15%))
The many cultural and ethnic groups in the country have long histories of trade and conflict. In fact, the tribal, ethnic and commercial rivalries have always dominated daily life. Islam was and is the major binding force of all groups in Afghanistan. The Russian occupation has only strengthened the importance of religion as the "counter-weight" against foreign influence.
Afghanistan has always been at cross roads for trade and travel over land routes and (important) migration is thus not exclusively a recent and/or war related phenomenon – although it has of course been exacerbated by the conflicts.

4. Economic information

Afghanistan is an extremely poor, landlocked country. The vast majority of the people are living from subsistence agriculture: farming (mainly wheat and to a lesser degree rice) and livestock.

- Due to a lack of available estimate of income per capita, Afghanistan has not appeared in UNDP’s Human Development Index since 1996. It then ranked as number 169 of a total of 174 countries.
- GDP: estimated at 2.1 billion $ (2000 est.)
- GDP per capita: estimated at 800 $ (2000 est.)
- Population below poverty line: N.A.
- Natural resources include: gas, petroleum, coal, copper, talc, sulphur, lead, zinc, iron, salt and (semi)precious stones.
- Note: Afghanistan has become the largest producer of illicit opiate products.

5. Political profile

History
The country has been at war since 1973 and is totally disrupted and to a very large degree destroyed
Chronological overview of key dates:

- 1933-1973: monarchy (king Zahir Shah)
- 1973: king Zahir Shah ousted by military coup by his cousin, Mohammed Daoud
- 1978: president Daoud killed in a Marxist coup; Taraki elected president; Islamic groups start armed protest against communism
- 1979: Taraki killed; the Russians invade the country
- 1980: UN calls for withdrawal of troops; mujahideen rebels get arms from Pakistan, United States, Saudi Arabia, Egypt, China and others
- 1987: Najibullah (People’s Democratic Party of Afghanistan) becomes president
- 1989: withdrawal of the Russians; very soon the civil war breaks out
- 1992: Najibullah overthrown; president Rabbani emerges but continues fighting
- 1994-1995: start of the Taleban movement under leader mullah Mohammed Omar
- 1995: fall of Herat to the Taleban
- 1996: taking of Kabul and Jalalabad by the Taleban
- Made-up under Rabbani of the “Northern Alliance” coalition by 3 partners: the Tadjiks with Masood, the Uzbeks with Dostom and the Hazara with Abdul Karim Khalily. The only thing that binds this alliance is the common enemy
- 1997-2000: Taleban take control over 90% of the country: fall of Mazar-i-Sharif in 1998, fall of Taloquan in 2000. Only the north east part of the country (Badakhshan province, tajiks mainly) remains under control of the fraction of former president Rabbani, headed by its military commander Masood.
- 1999-2001: UN sanction against the Taleban for failing to surrender Bin Laden
- September 2001:
  - Masood fatally wounded in assassination attempt and some days later: the 11 September attack on WTC and Pentagon

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3 weeks later, an international coalition clearly led by Washington and London, launches a military operation against the Taleban and the Al Qaeda network.

**Situation since September 2001**

In November, US coalition bombing and Northern Alliance troops withdrew the Taleban from the main cities. On 7 December the last Taleban stronghold, Kandahar was taken. Main leaders Mullah Omar and Osama Bin Laden still go missing.

An international conference in Bonn organised by the UN resulted on 5 December 2001 in the agreement on a multi-ethnic transitional government, headed by Pashtun chairman Hamid Karzai (inauguration on 22 December). The interim authority ruled for 6 months while a 21 member special independent commission called a traditional assembly “Loya Jirga”, presided by the king Zahir Shah. Also the 4 fractions agreed upon on a multinational force (ISAF) securing Kabul and surrounding area.

The Loya Jirga took place in June 2002 and a transitional government was elected to lead the country during the next 18 months. Hamid Karzai was re-elected as President and announced his new cabinet. Many key ministries (foreign affairs and defence) are in the hands of the Northern Alliance.

Despite the many progress, peace is still fragile and Afghanistan cannot be considered yet as a united state of law and order. Insecurity remains an issue in many areas of the country. The central government has little control over Northern Afghanistan (region of general Dostom) and governor Ismail Khan is the strong man in the west.
D. RESULTS OF THE KAP STUDY

This document is annexed as a separate report.