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**UNITED NATIONS HUMANITARIAN AND ECONOMIC ASSISTANCE  
PROGRAMMES RELATING TO AFGHANISTAN**

**PROPOSED WHO PROGRAMME  
AND BUDGET FOR 1991**



Geneva, 13 December 1990

# AFGHANISTAN



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## I. INTRODUCTION

Under its Emergency Relief Operations, the World Health Organization provides member states with the technical and financial cooperation required to begin the rehabilitation of its health services in cases where these have been severely affected by disasters or war situations.

WHO has had a continuous involvement in Afghanistan throughout the last twelve years, although its work in the country has varied considerably in nature and in magnitude as the situation evolved.

In 1989-1990, the emphasis of WHO's cooperation has been on the strengthening of the health care infrastructure through the rehabilitation of health care facilities and manpower development.

As of end of December 1990, seven projects and activities with a total value of US\$ 1.365 Million have been completed, and 30 projects with an additional value of US\$ 8.183 Million are under implementation. Four projects with a total value of US\$ 1.457 Million are under donor clearance against received contributions (for details on the majority of these projects see also interim progress report to the Government of Japan, October 1990).

At all stages of project development, close operational links were maintained with the Office of the Coordinator for United Nations Humanitarian and Economic Assistance Programmes relating to Afghanistan (UNOCA) and with all United Nations agencies operating in sectors related to health.

In cooperation with all Afghan parties concerned, WHO aims towards an integrated health system approach. This approach focusses on the rehabilitation and reconstruction of health care facilities, and aims at the development of a national health plan which recognizes Primary Health Care as the utmost priority with a strong emphasis on rural areas.

The immediate task is the formulation of a five-year Master Plan for the Health Sector of Afghanistan which is being consolidated by both sides, with WHO facilitating the exchange of views on technical health issues. The document which will result from this process will be a core element towards unified planning and the overcoming of segregated and uncoordinated resource allocation for the health sector.

The present programme and budget should therefore be regarded as an interim process which will bridge between the initial rehabilitation phase and the implementation of the five-year Master Plan for the Health Sector. The priorities highlighted in this 1991 programme budget are in line with the main direction of the draft Master Plan available to date.

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## II. DIRECTIONS FOR 1991

Initially, WHO like most of the UN specialized agencies, concentrated its efforts in the development of individual projects. This was necessitated by the emergency relief framework with the persistence of armed conflict and the inaccessibility of certain regions. A series of projects, often targeted onto specific communities, institutions or health care facilities were undertaken both cross-border and in government controlled areas.

As these projects proceeded, the need for linking the numerous facilities which were being rehabilitated by various non-governmental and UN agencies became evident. In parallel, the chance to use them as stepping stones for primary health care development also became more visible.

WHO initiated the first elements of overall planning by developing a "Health Information System" for Afghanistan and "Standardization and Training" for health manpower development. Both of these priority activities assisted in needs assessment and monitoring thus allowing the programme to integrate emergency action and medium/long term development.

1991 will be a critical year of consolidation for the WHO Afghanistan Programme. It will be used to consolidate the elements of WHO's 1989/1990 programme with a view towards developing a comprehensive health system. This process will focus on priority health issues and defined geographic areas. WHO will aim at achieving four specific goals:

- o A continued increase in population coverage within Afghanistan;
  - o A focus on priority health issues;
  - o An acceleration of repatriation through the creation and/or strengthening of the Afghan health infrastructure network
  - o A reinforcement of repatriation through the enhancement of self-reliance and sustainability of health sector activities.
- o A continued increase in population coverage within Afghanistan
- will be achieved through the usage of all possible channels of service delivery. These will include cross-border and cross-line work as well as operations out of the capital Kabul. The creation or expansion of certain mobile schemes will be promoted to allow for the initiation of essential health services.

The initiation of outreach services from fixed facilities within Afghanistan will be encouraged. The curative and preventive work of such health facilities will allow for an increased population coverage once improved linkage mechanisms and existing health workers can be incorporated into the outreach system.

WHO's aim is to enhance a delivery of preventive and curative health services and training at the utmost proximity to the community in need.

o A focus on primary health issues

will encompass action in ten priority areas which are described in detail under section III.1: Disease Prevention and Control.

These areas include: Mother and Child Health (MCH), Expanded Programme of Immunization (EPI), Control of Diarrhoeal Diseases (CDD), Acute Respiratory Infections (ARI), Disabilities, Tuberculosis, Malaria, Trachoma, Leprosy, and Basic Medical Care - Essential Drug Production and Supply.

Specific attention will be given to maternal and child health with utmost priority on mortality reduction.

o An acceleration of repatriation through the creation and/or strengthening of the Afghan health infrastructure network

involves a strengthening of links between facilities of existing health care providers. Thus a strengthening of referral systems and other components of the curative system are conceived as a basis upon which preventive health services can be built and implemented. In turn, this will enhance the quality of the medical care provided to resident Afghan population inside Afghanistan and, at the same time, promote the acceleration of repatriation.

o A reinforcement of repatriation through the enhancement of self-reliance and sustainability of health sector activities

In keeping with organizational philosophy, WHO will continue to execute its programme through trained Afghan staff. Afghanization implies that Afghan nationals not only are the recipients of assistance but that they are the ones who design and manage their own health system. This increases the longterm sustainability of health systems, thus creating favourable grounds for repatriation and population reinsertion. WHO continues to support Afghan counterparts in project planning and monitoring in order to enhance the self-reliance and long-term sustainability of the system.

It is important to create points of contact between the rural and the urban services, initially at the technical level whereby the tasks stated above may begin to be discussed between each side and finally options for operational networks can be considered.

Through the use of coordination meetings sponsored by WHO, UN sister agencies, and nongovernmental organizations, regional approaches for health care programmes will be further developed. This also means to use the information available regarding urban and rural Afghanistan, and to plan for inputs within an area in terms of how they represent the optimal use of existing resources, and to what extent they impact positively on creating an efficient health care network. Cooperative or consortium approaches among implementing partners (both national and international), will be strongly encouraged.

WHO has clearly implemented the majority of its programmes inside Afghanistan in keeping with the mandate for assistance within the country. Therefore, projects in neighbouring countries are limited to training of health staff who will immediately return to their home areas within Afghanistan.

WHO will continue to cooperate with UNHCR, UNICEF and UNDP in order to create conditions conducive to refugee return. It is believed that the availability of adequate health services will encourage Afghan resident population to remain in Afghanistan as well as refugees to return to the country. Health has indeed been named as one of the priority sectors which will encourage Afghan families towards repatriation.

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### III. PRIMARY HEALTH CARE

The health services in the rural areas of Afghanistan have been implemented by numerous agencies over the last ten years. These projects have been initiated in the context of armed conflict. Therefore, the focus was towards the provision of emergency medical aid through the placement of ancillary medical workers within often isolated health posts. The positive result has been the emergence of health facilities/services in even very remote rural areas. In urban centers on the other hand, secondary and tertiary care facilities remained unlinked with the rural health system.

Within the rural areas some of the health workers trained were left in deeply isolated health posts with little supervision, very limited access, if any, to first and second referral centres, or connection with other health workers in their same area. Therefore, the task at this time confronting WHO in collaboration with the implementing partners, is the move towards a functioning primary health care system within the context of Afghanistan. This calls for a networking and linking of programmes and projects currently in existence within rural Afghanistan, regardless of their source of funding.

Attention also needs to be given to the standardization of criteria for service delivery and human resources development in the health sector. This includes definition of terms, agreement on human resources development needs, training curricula and certification schemes, establishment of norms for essential drugs and equipment, and protocols of treatment for different layers within the referral system.

The focus for all these activities will be via regional approaches whereby functional geographical, political, and ethnic catchment areas are defined and linked.

The establishment of active supervision, assessment, and monitoring mechanisms on-site within the regions of Afghanistan is crucial for the integration of many aspects of primary health care.

The creation or expansion of certain mobile services will be promoted to allow for the initiation of essential health services. Included within this would be for example on-site refresher training for health workers, vaccination campaigns, MCH services, and ophthalmological services.

The development of community education materials and health worker re-training materials will focus on motivating both the providers and the recipients of the health services towards the missing components of PHC such as clean water, nutrition, and sanitation.

Much work has begun in these areas both on the part of WHO and the NGO's. WHO, in cooperation with NGOs will now have to refine priorities for action and to use types of existing facilities the most effective and economic way. 1991 will be a year of consolidation.

Within Primary Health Care, WHO has summarized its priorities and organized its programme under three sections below:

- Disease Prevention and Control
- Strengthening of Health Systems and
- Coordination, Monitoring and Evaluation.

These sections contain the entirety of WHO's resource allocation planning for the 1991 Afghanistan Programme, and describe inputs in more detail.

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## 1. Disease Prevention and Control

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Prewar and current information indicate that some ten health problem areas deserve priority attention. In consultation with UNICEF and implementing partners, WHO reviewed areas of disease prevention and control in Islamabad in November 1990. Based on the strong interest of Afghan and international NGOs as well as from the UN system in coordinated approaches and guidance from WHO, it was decided that follow-up consultations were needed. These are scheduled for mid December 1990. It is expected that not only the mapping of disease prevalence will be agreed, but that common strategies for priority health areas of Afghanistan will emerge.

Planned WHO allocation  
under section III, 1 : US\$ 4,800,000 (see breakdown below).

## 1.1 Mother and Child Health (MCH)

Afghanistan has one of the highest maternal, infant and child mortality rates in the world, although there is no recent aggregated data due to the armed conflict since 1979. According to the 1975 National Demographic survey of Afghanistan, maternal mortality was approximately 640/100,000 births. The infant mortality rate has been estimated to be 185/1000 live births, and child mortality 329/1000 live births.

There are many factors related to the war situation which have probably caused these rates to increase and all numbers would be understated due to significant reporting problems.

Before 1979, women and children in rural Afghanistan shared a disproportionately large burden of illness and death; more than 50% of all deaths occurred among those under age five, and women aged 30-40 years had rates of reported illness almost twice as great as men of the same age.

The major causes of mortality in these cases could be avoided with the improvement in preventive health measures and the establishment of proper and accessible health services.

The reconstruction of Afghanistan will require a healthy youth and yet, children today are severely affected by poor health, malnutrition and resulting stunted growth.

The goal of maternal and child health care is to reduce maternal, infant, and child mortality and morbidity and to promote a good nutritional and health status for Afghan women and children. The immediate priority is to reduce mortality due to preventable causes. The prevention of morbidity and disability ranks second.

It is because of the enormous need for improved Maternal and Child Health that WHO has listed this activity area as top priority for 1991 and the years to come.

The objective to be achieved cannot be quantified in terms of percentage reductions, as there is no baseline data available at present. Attention will be given to establishing and monitoring a data base which expands the existing WHO Health Information Systems (see below) by the inclusion of MCH indicators. In the medium long term, this will allow for evaluating the efficiency and effectiveness of MCH interventions.

In the short term, WHO will look toward improving the existing health services within Afghanistan such that the services provided encourage culturally acceptable and technically sound MCH interventions.

WHO is in the process of developing a framework for mapping regions or subregions in regard to the different levels of community interest, MCH resources, and interest in the topic. This mapping will help in future planning in order to appropriately reach promising areas with a tailored MCH intervention.

In the area of MCH, WHO will promote safer motherhood through the training/retraining of Traditional Birth Attendants, the strengthening of the referral system and the education of women of reproductive age. It will specifically improve the surveillance and control of such nutritional disorders as Iodine and Iron deficiencies among pregnant women, and Vitamin A and D deficiency in infants. It will use MCH as an opportunity to promote and implement such other life saving interventions as immunization, and the prevention and treatment of diarrhoea and acute respiratory infections (see below). In areas where there is a demand for birth spacing, WHO will respond favourably with careful attention given to the local cultural and religious context.

As Traditional Birth Attendants schemes have been developed in Afghanistan before the war with some documented success, WHO will endeavour to learn from this past experience in designing and implementing community based MCH activities. As an immediate priority the skills of a large number of existing male health workers will be upgraded to include MCH components.

Support will also be provided continuously to WHO implementing partners with ongoing MCH programmes.

Planned allocation by WHO: US\$ 500,000.

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## 1.2 Expanded Programme of Immunization (EPI)

Of the six diseases commonly preventable through immunization, two have been noted as major contributors to early childhood mortality. These are measles and tetanus, particularly neonatal tetanus. One has been reported as widely spread: poliomyelitis. Cases of diphtheria and whooping cough have been seen both in rural and urban areas. Tuberculosis is common, both among children and adults. The existing disease surveillance system still falls short of providing baseline epidemiological data but the many accounts provided by health workers working in Afghanistan leave no doubt that:

- a) diseases preventable by immunization are frequent and severe; and
- b) immunization activities are in great demand and are feasible even in remote areas as demonstrated by AVICEN, a leading NGO in this area.

At present, immunization programmes in the capital and in rural Afghanistan are in a process of consolidation. While efforts were scattered over the years, thus producing diversification of approaches, current programming aims at the introduction of standards suitable to and agreeable by all sides. Non-governmental and governmental approaches need to be harmonized for the sake of the best and most sound EPI delivery to urban, and most critical, rural areas.

A coherent national framework with agreed national goals and protocols on the one hand, and regionalization and decentralization of

operational activities on the other, will have to be carefully balanced.

Past experience gained by NGOs in rural areas, and by governmental facilities elsewhere, have demonstrated that immunization activities are confronted with key operational problems: the irregular availability of vaccines, cold chain failure, the lack of continuity in immunization efforts in certain population groups, the uncertainty as to whether reusable (sterilizable) injection equipment should be used instead of disposable (non-reusable) ones.

In addition, there is a need to adjust immunization strategies and schedule to local logistics imperatives and epidemiological factors. One should question periodically the expected effectiveness of immunization in relation to evolving opportunities and constraints. There is a need, for example, to assess the feasibility to tag on to ongoing immunization activities other life saving interventions that are part of primary health care.

These issues are complex and their solution should be based on the large body of expertise which has been built over the years within and outside Afghanistan. To this end, a first consultation of UN agencies and NGOs on priority health issues was held in Islamabad in November 1990, followed by a workshop specifically centered on the Expanded Programme on Immunization in December 1990. These are the first steps towards what should become a close and regular consultation process among partners involved in this critical health activity.

WHO will function as a facilitator for programmes of non-governmental organizations, and discussions on the expansion of and improvements in the currently existing EPI programme efforts. It will also cooperate closely with UNICEF in planning, strategy development, and quality control. WHO will play a direct role in monitoring and evaluation, and, to this end, include EPI into the scope of its Health Information System project (HIS) referenced below. (see para 3.3)

WHO will implement EPI activities in selected project areas as an integral part of primary health care.

In the area of training, WHO will play a key role in the design of training curricula, the training of trainers and the production/review of locally adapted training materials.

Planned WHO allocation: US\$ 500,000.

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### 1.3 Control of Diarrhoeal Diseases (CDD)

Diarrhoeal diseases are common in Afghanistan, and particularly seriously affect the age group below five years. Limited personal hygiene and unfamiliarity with concepts like oral rehydration in the

family context pose barriers to a reduction of diarrhoeal diseases mortality countrywide.

As the ultimate priority of the set of primary health care elements described here is to reduce mortality, the treatment of acute, watery diarrhoea, particularly in children, is the key.

Based on many accounts, the low level of education of mothers and the unavailability of basic ingredients point to the necessity to promote the use of ORS packets and not home-made solutions.

There is a considerable awareness already among the Afghan population of the usefulness of ORS and the demand is never fully satisfied. Health workers have been trained on oral rehydration therapy. There is a need to strengthen the distribution of, and storage mechanisms for ORS and to monitor its use while efforts should continue to educate mothers on its use and health workers on complementary approaches in case management.

In relation to morbidity prevention, immediate efforts should be placed on educating mothers about diarrhoea prevention and treatment, including personal, home and food hygiene, and nutrition. At present, the scope for improving water and sanitation through the promotion of proper water distribution points and latrines seems limited. It should, however, form part of health care activities in rural areas where and when community demand and willingness to act are present. This may be proposed as an area of emphasis from 1992 onwards.

It will be recalled that dysentery, particularly amoebic dysentery is reported to be a highly prevalent disease in Afghanistan. Palliative treatment through the provision of essential drugs is included under the following section on treatment of common illnesses.

CDD and Maternal and Child Health (MCH) promotion will be integral parts of combined programmes in many instances.

In relation to the control of diarrhoeal diseases, WHO's specific tasks will be to improve surveillance systems through training and expansion of its Health Information System (HIS). It will continue to train trainers in the key aspects of diarrhoeal disease prevention and treatment. It will continue to disseminate information, education and such instruments as periodically updated treatment charts. It will assist NGOs in the design of monitoring and evaluation systems. It will create and operate warning systems for the possible occurrence of cholera-like outbreaks. It will incorporate ORT in the field projects it executes and will provide all participating groups with access to ORS quality control schemes.

Planned WHO allocation: US\$ 200,000.

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#### 1.4 Acute Respiratory Infections (ARI)

Acute respiratory tract infection is reported to be the leading cause of childhood mortality in Afghanistan, as in other developing countries in the world. Major objectives of WHO's programme are to prevent acute lower respiratory tract infection, to reduce mortality from pneumonia and to reduce severity and complications from acute upper respiratory tract infections. The strategy for achieving these objectives are proper case management including reduction of improper use of drugs, and immunization against measles and pertussis.

Proper case management at the primary level can be ensured through the retraining of midlevel and basic health workers who, particularly in rural areas, are the main providers of basic health care in Afghanistan.

Such retraining should focus on proper diagnosis of pneumonia, on case management including antibiotic therapy, prevention of dehydration and nutrition, advice to mothers and referral of severe cases. Initial retraining in Paktika province in 1990 has produced encouraging results.

In 1991, WHO therefore aims at the update and dissemination of diagnosis and treatment guidelines, on the training of trainers, and on the strengthening of case management capability at the first and second referral levels. It will also procure antibiotics for such facilities and monitor their use and their impact.

Planned WHO allocation: US\$ 100,000.

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#### 1.5 Disabilities

War related injuries continue to affect civilian population even where fighting has ceased as millions of undetected mines are scattered throughout the country.

Afghanistan is predominantly rural and lacks adequately functioning referral structures. For the performance of amputations this means that at times, mid-level health workers with three to six months of medical training perform amputations at the community level. Treatment facilities in Pakistan border provinces for example, rarely receive cases from inside Afghanistan with less than two week old stumps. Differences in technology and price between the main providers of services for movement impaired patients stimulate some patients to search for the most affordable and cosmetic solution by commuting over long distances, cross-line within zones of conflict, and even cross-border into neighboring countries.

The main providers of services are ICRC in Kabul and Peshawar, the Wasir Akbar orthopaedic workshop in Kabul, the workshops of the Sandy Gall Afghanistan Appeal in Hayatabad and in Takhar province, the

workshops of the Kuwaiti Red Crescent in Peshawar, the Handicap International workshops in Quetta, Zindajan (Herat province), Dara (Helmand province), Spendai (Ghazni province), and soon GTZ in Peshawar.

In 1989 and 1990, WHO was the first UN specialized agency to become actively involved in post-war support to orthopaedic workshops in response to the enormous demand for prosthetic and orthotic services in Afghanistan.

To date, WHO directly supports the Wasir Akbar workshop, the Sandy Gall workshops, and the above cited Handicap International workshops. There remains, however, a complete absence of Afghan NGOs in this field of service provision.

In 1991, WHO intends to serve as a source of technical advice and support agency with regard to the selected strategies and activities. WHO is in the unique position to actively support the reconciliation of standards as applied by the different service providers, and to help in establishing an ongoing dialogue with a view towards an increased use of locally produced components and maximum uniformity of services available to patients at the initial and maintenance stage of service provision.

In the area of manpower development, it will promote the training of trainers inside Afghanistan and it will create a limited number of fellowships for training abroad (e.g. in Vietnam).

WHO will also establish links with GTZ in order to explore possibilities for the training of workshop technicians in 18 month courses. It will translate training manuals into Dari and Pashtu and WHO will work towards a uniform certification of Afghan trainees after the successful completion of training courses.

WHO will intensify cooperation with ICRC in order to promote in-country training for workshop technicians. It will support local level Afghan NGOs and initiatives caring for the disabled. It will also supply and equip technicians who support Afghan counterparts and it will assist in monitoring progress.

Finally, WHO will determine the scope of possible interventions like physiotherapy instead of GAIT training and conduct studies and assessment surveys in this regard.

In 1991, WHO plans for the continuation of this scheme and its extension into areas of prevention and early detection of disabilities.

Planned WHO allocation: US\$ 750,000.

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## 1.6 Tuberculosis (TB)

A survey on tuberculosis conducted in 1982 showed that the standardized infection rate in Afghanistan stood at 45% (47.5% in rural and 41.6% in urban areas). More than 5% of the children in the age group 0 - 4 years were infected. Thirty five percent of the total population was infected by the age of 30. Twenty percent of the population in age groups above 15 years of age had symptoms suggesting pulmonary tuberculosis. Among these 5 per 1,000 had bacteriologically confirmed pulmonary tuberculosis. In absolute terms, there could be 75,000 to 100,000 infection cases in the country at any given point in time. It can be further estimated that there could be as many as 20,000 new infections per year.

Thus, tuberculosis is a severe problem in Afghanistan. Preventive measures include immunization with BCG, which is already part of the immunization programme and the improvement of the social and health environment.

In 1991, however, priority will be given to the treatment of known tuberculosis patients with an association of carefully selected and monitored antibiotics. The follow up of patients under treatment will be most critical as it will both impact on the further spread of the disease and reduce the risk of resistance against anti-tuberculosis drugs.

In this context, WHO will continue to improve the quality of diagnostic methods through the further training of microscopists. WHO will also train health workers in case management, follow up and referral, with an adequate outreach into communities, and it will reinforce immunization activities with the aim of vaccinating infants with BCG and the earliest possible age, whenever possible at birth.

Planned WHO allocation: US\$ 200,000.

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## 1.7. Malaria

Malaria control was one of the most successfully handled health problems before the war. Systematic investigation of malaria problems started in the 1950's when it became clear that almost all inhabited and cultivated areas up to 2,000 meters altitude were infected.

Two types of malaria are widespread in Afghanistan. These are Plasmodium vivax and Plasmodium falciparum. Some 17 types of anopheles mosquitos are responsible for the transmission of the disease with A.Superpectus and A.Staphense being the most common ones.

By 1980, plasmodium falciparum was eradicated while plasmodium vivax was moderated and limited to certain foci. In 1988, however, as a result of interrupted control mechanisms, the limited surveillance system available in Afghanistan recorded some 400,000 cases. The

actual figure is likely to be higher.

Malaria has therefore again developed into one of the major health problems of Afghanistan. There are all reasons to believe that this involves high morbidity and mortality.

A WHO malaria mission in November 1990 recommended to reduce the dangerous and costly overuse of chloroquine injections and to produce and distribute widely health posters which show the correct dosages of chloroquine.

The mission also recommended that the population should be alerted to the dangerous side effects of Fansidar with the aim of limiting the use of this second-line drug to the microscopical verification of chloroquine treatment failure. This should be combined with the training of Afghan doctors in the assessment of the rate of chloroquine treatment failures.

Provisions should be made for the availability of an emergency stock of Fansidar in case of emergencies caused by chloroquine-resistance of *P. falciparum*.

Training of health workers, health education and the further extension and improvement of the Afghan laboratory network are methods of choice to achieve these goals. These efforts should then be linked with other health priorities like MCH, the training of laboratory technicians, refresher courses, drug quality control and with the collection of parasitological data.

The usage of pyrethroid-impregnated bed-nets on a trial basis will be tested for acceptance in Kunar province at the start of the transmission season 1991.

Planned WHO allocation: US\$ 200,000.

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#### 1.8 Trachoma

Trachoma is the most readily preventable cause of blindness. It generally co-exists with other preventable diseases in low-income rural communities. Trachoma is an infectious eye disease which causes inflammation and scarring of the conjunctiva, the inner lining of the eyelid, thus leading to blindness. A loss of vision occurs because of scarring of the normally transparent cornea.

Where the environment favours the multiplication of eye seeking flies, trachoma infections and other ocular pathogens interact to enhance the risk of damaging the eyesight. Transmission of the disease is by direct or indirect contact with infected surfaces like hands, clothing, towels, etc.

Children are the reservoir of trachomatous infection, as they are commonly and heavily infected. Compared to men, women tend to have

more severe trachoma probably because they are repeatedly reinfected by their children. Unavailability of adequate housing, safe water for household use, and inadequate waste disposal are other important risk factors.

In general, family and personal hygiene play an important role, and health education thus is an important tool for alerting the Afghan population to the risk of trachoma. In particular, the practice of keeping children's faces clean can be easily encouraged by health education. Handwashing is another simple preventive measure.

Where schools or madrasas are available, a small-scale trachoma prevention and control programme can be introduced in 1991, to spread the knowledge about the connection between hygiene and trachoma and thus to encourage personal hygiene. Health workers will provide ointments to households, madrasas and schools, treat children, and instruct mothers and older children on how to treat young children.

Antibiotic treatment will use topical tetracycline for large scale treatment of trachoma. This chemotherapy will reduce the reservoir of chlamydia in the population and it will be followed by intermittent family based self-treatment. In the long run most of the antibiotic treatment will be carried out at the family level and it is assumed that a better understanding of the disease and of preventive and curative measures will emerge.

During 1991, WHO will make attempts to collect epidemiological and behavioural information to guide a further expansion and refinement of the programme in the years to come. While it is recognized that trachoma prevention and control will not have any significant impact on mortality, this health problem has been included in the list of priorities because it causes disability and due to the relative low cost and easiness of control mechanisms.

Planned WHO allocation: US\$ 50,000.

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## 1.9 Leprosy

The magnitude of the leprosy problem in Afghanistan is not clearly known. A survey conducted about 30 years ago estimated the prevalence to be one per thousand. For Hazarajat, however, the prevalence is estimated to be higher.

Leprosy is greatly feared in Afghanistan with many misconceptions and myths prevalent within the community. Afghan patients tend to hide themselves in fear of the rejection and stigma that is attached to their disease. This in turn leads to late treatment and untreated cases, thus enforcing stigmatization at the family level and by the community.

Access to leprosy patients for all these reasons requires great care and a community based approach. Organizations with experiences in

leprosy prevention, treatment, and control such as the German nongovernmental organization LEPCO and the German Initiative Overseas (GIAO) will be encouraged to share their experience with newly emerging agencies in order to create a uniform approach to leprosy control with the main aim of longterm sustainability.

In 1991, WHO will focus on support to existing schemes and will advocate the principles of community based prevention and rehabilitation. In this context, priority will be given to regionally limited interventions like for example in the Hazarajat and other neglected areas as well as Kabul. Through health education, affected population groups will be sensitized to the importance of sanitation, hygiene, nutrition, and the problems of misuse of medicines.

Actual case finding and treatment will be supported, and support to the training of leprosy workers will be provided. First priority will be given to the creation and maintenance of those outreach systems with the highest possible ability to follow up patients during a full course treatment.

Planned WHO allocation: US\$ 300,000.

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#### 1.10. Basic Medical Care - Essential Drug Production and Supply

##### Basic Medical Care

Basic and midlevel health workers are the main providers of basic medical care in Afghanistan. In rural Afghanistan, they are the ones seeing patients day to day for common health problems like headaches, high fever, acute abdominal pain, sudden loose motions, common cold, tooth ache, earache, burns, injuries, unconsciousness, coma and various other problems.

Further qualifying the service delivery at this level means to strengthen the ability of health workers to take the right decision at the right moment and to use referral mechanisms adequately.

Basic medical care is provided by a wide variety of health professionals ranging from physicians with formal training in one of the Afghan medical schools, over midlevel health workers (nurses, health assistants) to health workers who have received three to six months basic training before returning to rural areas.

It is clear that the capacity to provide certain types of care, to perform certain medical or surgical acts, or to prescribe certain drugs will be a function of their training level and the availability of supplies.

In 1991, WHO will therefore support the design and promotion of a skills and knowledge review system for the different levels of health

workers. This activity aims at determining the skills and knowledge profile which health workers should have acquired in connection with a defined function and then to link this with the selection of drugs and equipment which these health workers can safely and efficiently use. This process directed by WHO and implemented in collaboration with numerous agencies has been very successful during 1990 and will continue as a priority during 1991.

Planned WHO allocation for this sub-section: US\$ 500,000.

#### Essential Drug Production and Supply

The stimulation of a local production of essential drugs, oxygen, and intravenous fluids has already attracted donor support in the previous year. Based on a request for the provision of production and maintenance related equipment by a Kabul based institute, WHO was able to procure initial quantities of machinery. Together with machinery yet to be procured, this machinery will permit increased local production of safe drugs. A better and more constant supply of Afghan hospitals, clinics, health posts and the public is expected in turn. Disease prevention and control schemes will therefore profit from this undertaking.

The Avicenna Institute in Kabul is WHO's local partner in this programme and WHO will continue support to this scheme in 1991. The SCA measures referenced above and the Kabul based strengthening of essential drug production will be complementary in extending the population coverage of the WHO programme. They will also reassure Afghan population towards repatriation.

The availability of essential drug kits in emergency and post-emergency situations is critical for a functioning health system. Basic and supplementary kits are needed to guarantee the functioning of health facilities up to the required standard where no other supply system is available. They are also required for emergency assistance.

WHO will therefore seek continued support for the provision of medical kits. WHO specifications for such kits have been approved and are tailored to the specific demand profile of Afghanistan.

Planned WHO allocation for this sub-section: US\$ 1,500,000.

Planned WHO allocation for the two sub-sections above: US\$ 2,000,000.

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## 2. Strengthening Health Systems

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The strengthening of health systems in Afghanistan comprises Afghan health manpower development, training standardization, the rehabilitation of health structures, and the provision of WHO field support.

Planned WHO overall allocation under priority III.2: US\$ 4,800,000 (see breakdown below).

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### 2.1. Afghan Human Resources Development for the Health Sector

WHO's priority for 1991 is to address the training and retraining of Afghan health personnel with a view towards a continuation of repatriation and improved support to the resident population of Afghanistan.

In 1991, WHO will therefore endeavour to conduct the majority of its training programme within Afghanistan. Training courses will be held in the newly rehabilitated health care facilities which are supported by WHO at present and will be assisted in those Afghan health care facilities which welcome health manpower development.

During scheduled and structured supervisory visits to health care facilities, trainers will apply a "one-to-one" training approach which has the merit of occurring within the trainee's environment, without pulling her/him out of a duty station for extended periods of time. This training will be based on checklists of skills that specific categories of health workers are expected to acquire. This will include the group training of health workers from the same catchment area with the aim of maximizing the trainer's time and assist in forming health system networks within regions.

Meanwhile, courses outside Afghanistan will continue with WHO focussing on training of trainers.

In 1991, WHO will give priority to refresher training particularly for male midlevel health workers. Initial training will be offered to female midlevel and basic health workers and to male trainees from areas where existing health services can be shown to need strengthening with human resources. Additional areas of training will include field microscopist in the context of disease control, dental technicians, X-ray technicians and other ancillary personnel in the context of the expansion of PHC programmes for 1991.

Planned WHO allocation: US\$ 900,000.

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## 2.2. Training Standardization

The disintegration of Afghan health services in the context of war and civil strife has resulted in the initiation of at least three different approaches to health manpower development and training in the country. These are namely, the approach of cross-border programmes from Pakistan, the restricted but continuing system of health care and training provided by the Kabul government, and refugee training programmes from Iran and Pakistan.

Over the last 17 months the WHO health data base project has played a prominent role in UN projections and situation analyses in the field of health, particularly health manpower assessment.

The WHO Health Information System project (HIS - see 4.2.1) has developed standards for the classification of health facilities in Afghanistan and provides information on e.g. the frequency of clinics and hospitals per province, mobile health services, the level, specialization, and number of health workers per province and serves as a data bank in many instances.

WHO undertook an initial assessment of human resources availability in the health sector. Based on HIS data, WHO arrived at the conclusion that significant problems existed with regard to a future nation-wide system for human resources development in the health sector.

The result shown was that large numbers of Afghan health workers have been trained for rural Afghanistan to levels which are not standardized. The management and ongoing support of this manpower pool is beyond the capacity of any future government.

WHO, under its 1991 programme, will therefore concentrate on uniform training approaches with the final aim of an integrated system. The goal towards integration and absorption during repatriation will be assisted by continuation of the activities related to standardization of the minimum skills requirements to be achieved before certification takes place.

The strategy towards this goal has included the development of skills checklists. These have been developed and agreed upon with local community collaboration for different levels of paid health workers within Afghanistan and match the essential drug lists recommended. The critical next step involves widening the collaboration to include training programs from all sides within this consensus and expanding into other types of necessary health workers. The development of new standardized skills check lists will apply to vaccinators (in cooperation with UNICEF), nurses, certain types of technicians, and other health professions as appropriate.

In this context, WHO will have an active role to play in the certification of health personnel after the successful completion of training courses that follow standards which comply with WHO recommendations.

A third element of WHO involvement will be the continuation of Afghan physician refresher training. This training is built on a program

initiated during 1990 which was designed to reach physicians in a "top down approach" for integration of PHC and health systems development. Expansion, utilization, and distribution of the materials created during 1990 will be carried out to support the physicians within their working environment as part of on-site training and supervision described in section 2.1.

WHO will expand its input into the production of training materials and guidelines in Dari and Pashtu. It will take advantage of existing printing workshops like the WHO/UNDP supported Health Learning Material Centre located in Kabul and workshops with cross-border supply capacity.

Community education for health which utilizes uniform health messages is another WHO support to the rural Afghan population. Presentation of important or "prime" messages in the form of posters and flipcharts has been pursued by WHO and UNICEF in joint collaboration resulting in the distribution of these materials within all 29 provinces of rural Afghanistan. In 1991, WHO intends to expand the topics in keeping with the priority health problems and target activities.

Planned WHO allocation: US\$ 600,000.

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### 2.3 Rehabilitation of Health Structures

In 1990, WHO along with other agencies supported the partial rebuilding of selected health facilities. Priority was given to traditionally undersupplied areas, areas of massive destruction of health infrastructure, and areas of possible refugee return.

The major part of WHO construction measures is still under completion. These relate to the partial repair, equipment, overhauling, or rebuilding of smaller and medium size health facilities including health posts, clinics, and three hospitals.

In 1991, local communities will therefore be in the situation of profiting from the usability of a limited number of new and repaired facilities. Provision will be made by WHO to make these facilities operational. This comprises local staffing, and staff training as well as the provision of materials and equipment and, where needed, drug supplies for an initial period. The concept of using WHO rehabilitated health facilities as a focal point for training of Afghan health manpower will be introduced.

While the initial effort was on emergency assistance, WHO will now more and more assess and evaluate the opportunities for a reopening of existing facilities. This particularly relates to non-war affected pre-war buildings which were previously financed under bilateral assistance schemes. It is believed that at least some of these buildings can be made operational again, and that they could in fact serve as focal points for Afghan health manpower development and

clinical medicine in combination with outreach programmes. This would prepare the ground for bilateral donors and their future reinvolvement in schemes previously financed by them.

WHO will refrain, however, from financing large hospital constructions. Where minor repair is needed and a facility can be made operational without major capital investment, WHO will try to assist. WHO will also assist its present partners by advocating the best possible use of facilities and by making provisions for staff training and equipment and supply related requests.

Planned WHO allocation: US\$ 2,600,000.

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#### 2.4. WHO Personnel in Afghanistan

In 1991, WHO will continue cross-border assistance for Afghanistan. The activities in this programme will include an increase in on-site presence within certain regions of Afghanistan. WHO will establish area coordination teams within selected regions capable of overseeing ongoing or planned field programmes related to priority goals. Planned locations under this category include Arghandab in Kandahar, and Urgun in Paktika. These locations will be supported by the WHO area coordination office in Quetta, under the field coordination office with staff posted to Peshawar and to Quetta.

On-site presence will also be established in the northern and western part of Afghanistan in areas that require in-country monitoring of WHO programmes. Planned locations under this category include the area coordination offices in Herat/Zindajan in Herat province, Faizabad in Badakshan province and Masar-i-Sharif in Balkh province. The coordination of in-country monitoring activities will be based in Kabul under the overall supervision of the WHO Representative with a view towards inter-agency coordination.

Beyond the scope of budget allocation presented below, local backup for WHO operations in Afghanistan continues to be provided by the WR offices in Pakistan and Iran.

WHO regional backup continues to be provided by EMRO, the WHO Regional Office in Alexandria. Programme planning and coordination and resource mobilization and monitoring remain with the Relief Programme, Emergency Relief Operations (REL/ERO) at WHO Headquarters in Geneva.

Finally, field duty stations will profit from the continued services of United Nations Volunteers under a special arrangement with UNOCA/UNDP. These services are provided to WHO free of charge.

Planned WHO allocation: US\$ 700,000.

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### 3. Coordination, Monitoring and Evaluation

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WHO considers that, in 1991, it will have a significant role to play with regard to the coordination, monitoring and evaluation of health programmes in Afghanistan.

Planned WHO allocation under priority III,3: US\$ 1,200,000.

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#### 3.1 Coordination

It is the mandate of the World Health Organization to act as the leading UN specialized agency in health matters and to coordinate sectoral multilateral assistance in the health sector.

In exercising this role, WHO will not only coordinate its activities with UN sister agencies and the Office of the Coordinator but also perform a series of other coordination functions.

The promotion of interagency-coordination necessitates an active information exchange on health related issues between WHO and other UN agencies, NGO, and Inter-governmental Organizations. WHO will continue to expand its Health Information System in order to establish better means of information sharing and exchange of relevant health sector information and programme planning information.

WHO will promote the continued refinement of strategy development and planning for the health sector of Afghanistan through periodic meetings of those involved in service delivery. It will coordinate the finalization of the Health Master Plan for Afghanistan and its adoption by all parties.

It will promote and support consistent standards of care and manpower development in governmental and other areas and it will facilitate the coordination and linkage of health facilities in a coherent system of support and monitoring.

WHO will field regular site visits by WHO staff and consultants for planning, monitoring, and evaluation purposes.

The concepts of partnership and sharing of responsibility are the underlying philosophy guiding WHO's coordination function.

In this regard, WHO will make a specific effort to work closely with Afghan groups and NGOs and it will encourage coordinated supportive supervision by Afghan health personnel on-site.

Headquarters related costs are included in the allocation under this heading. Costs projected to incur at other levels of the Organization are budgeted under 2.4 above.

Planned WHO allocation: US\$ 400,000.

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### 3.2 Monitoring, and Evaluation of Health Programmes

Monitoring, supervision, and evaluation are integral parts of programme planning, implementation, and review.

Agency monitoring may not only provide planning data for the direct implementation of projects and programmes of an individual agency, but may serve as a source of information for other agencies working in the same area or in a similar health specialization. It may alert these to areas of possible improvements and strengthen inter-agency cooperation.

There are already inter-agency health monitoring missions as well as joint planning exercises that lead to the representation of one agency by another in field visits to areas of concern. Both NGOs and UN agencies which work in the field of health have expressed their hope that more joint monitoring missions will be undertaken in the future, and that these will help to set standards.

Common monitoring and evaluation standards are needed and recommendations also include the definition of protocols. WHO has been approached by agencies in the field of health with the request to follow up these issues and to provide technical cooperation. A particular concern of agencies working in isolated areas of Afghanistan is that the information flow in monitoring and reporting terms is one way and that lessons learned are rarely communicated back to the originators and the field agency personnel, thus preventing them to learn from experience.

In 1991, WHO will therefore not only monitor and evaluate its own programme activities but, within the scope of its ability, assist other programmes in evaluating their programmes and projects upon request.

WHO will develop monitoring and evaluation frameworks and specialized expertise in these fields and it will report to donors on progress, status and evaluation findings.

Planned WHO allocation: US\$ 200,000.

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### 3.3 WHO Health Information System (HIS)

WHO started its Health Information System project (HIS) in July 1989. HIS rapidly developed into a powerful planning and monitoring instrument for WHO's Afghanistan programme but also for other agency planning. It is considered a key element for future national health planning.

In 1991, the objectives of the WHO Health Information System project are maintenance and expansion of the health resource database.

As for expansion, mapping for the better presentation of material and regional planning purposes will be undertaken together with a coordination and standardization of terms, definitions, and design of health resources within Afghanistan.

The monitoring of health resources within Afghanistan by WHO staff as well as a coordination of monitoring and evaluation missions within Afghanistan via other implementing agencies will be equally pursued.

WHO will act a major repository for health information for the sake of a adequate coordination of data entry with NGO and UN agencies.

An initiation of health surveillance tracking for selected areas within Afghanistan and surveys within Afghanistan will be established with regard to the coverage and access to health facilities.

WHO will continue to train Afghan nationals in related issues of Health Information System and Management Information Systems (MIS). It will also design mechanisms for an improved information flow back to the field level.

A new element for reaching the above goals will be the creation of a community advisory board. This board will address some of the main objectives listed above and it will be comprised of local agency representatives with expertise in the field of health.

WHO will introduce, as another new element, the mapping of health manpower availability and the prevalence of diseases such as TB, ARI, diarrhoeal diseases and EPI target diseases, etc as well as immunization or other specific services coverage.

WHO will build on its achievements in categorizing and recording operational health facilities countrywide; a task that demands constant updating of information. Field monitoring reports from WHO, other specialized UN agencies and non-governmental organizations are the major source of information for this task.

Planned WHO allocation: US\$ 600,000.

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IV. WHO AFGHANISTAN PROGRAMME BUDGET FOR 1991  
(all amounts in US\$)

<u>Priority area as per text</u>	<u>Programme Priority</u>	<u>Budget allocation</u>	
		<u>Sub-total</u>	<u>Total</u>
III.	Primary Health Care		
1.	Disease Prevention and Control		4,800,000
1.1	Mother and Child Health (MCH)	500,000	
1.2	Expanded Programme of Immunization (EPI)	500,000	
1.3	Control of Diarrhoeal Diseases (CDD)	200,000	
1.4	Acute Respiratory Infections (ARI)	100,000	
1.5	Disabilities	750,000	
1.6	Tuberculosis (TB)	200,000	
1.7	Malaria	200,000	
1.8	Trachoma	50,000	
1.9	Leprosy	300,000	
1.10	Basic Medical Care - Essential Drug Production and Supply	2,000,000	
2.	Strengthening Health Systems		4,800,000
2.1	Afghan Human Resources Development	900,000	
2.2	Training Standardization	600,000	
2.3	Rehabilitation of Health Structures	2,600,000	
2.4	WHO Personnel in Afghanistan	700,000	
3.	Coordination, Monitoring and Evaluation		1,200,000
3.1	Coordination	400,000	
3.2	Monitoring and Evaluation of Health Programmes	200,000	
3.3	WHO Health Information System (HIS)	600,000	
	Total WHO Afghanistan Programme 1991:		10,800,000
	plus WHO Agency support costs (13%) :		1,404,000
	Grand total in US\$ :		<u>12,204,000</u>