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Eastern Mediterranean Regional Office (EMRO)**

**Division of Health System and Services Development (DHS),
Health Policy and Planning Unit,**



**Health Systems Profile
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CONTENTS

FOREWORD	4
1 EXECUTIVE SUMMARY	6
2 SOCIO ECONOMIC GEOPOLITICAL MAPPING	10
2.1 Socio-cultural Factors	10
2.2 Economy	10
2.3 Geography and Climate	11
2.4 Political/ Administrative Structure	12
3 HEALTH STATUS AND DEMOGRAPHICS	14
3.1 Health Status Indicators	14
3.2 Demography	15
4 HEALTH SYSTEM ORGANIZATION	17
4.1 Brief History of the Health Care System	17
4.2 Public Health Care System	17
4.3 Private Health Care System	18
4.4 Overall Health Care System	19
5 GOVERNANCE/OVERSIGHT	20
5.1 Process of Policy, Planning and management	20
5.2 Decentralization: Key characteristics of principal types	21
5.3 Health Information Systems	22
5.4 Health Systems Research	23
6 HEALTH CARE FINANCE AND EXPENDITURE	25
6.1 Health Expenditure Data and Trends	25
6.2 Tax-based Financing	27
6.3 Insurance	28
6.4 Out-of-Pocket Payments	29
6.5 External Sources of Finance	29
6.6 Provider Payment Mechanisms	30
7 HUMAN RESOURCES	32
7.1 Human resources availability and creation	32
7.2 Human resources policy and reforms over last 10 years	33
7.3 Planned reforms	33
8 HEALTH SERVICE DELIVERY	34
8.1 Service Delivery Data for Health services	34
8.2 Package of Services for Health Care	36
8.3 Primary Health Care	36
8.4 Non personal Services: Preventive/Promotive Care	38
8.5 Secondary/Tertiary Care	40
8.6 Long-Term Care	42
8.7 Pharmaceuticals	42
8.8 Technology	43
9 HEALTH SYSTEM REFORMS	45
9.1 Summary of Recent and planned reforms	45
10 REFERENCES	46
10.1 Source Documents	46
11 ANNEXES	47
11.1 Summary of Annexes	47

List of Tables

Table 2-1 Socio-cultural indicators	10
Table 2-2 Economic Indicators.....	10
Table 2-3 Major Imports and Exports.....	11
Table 3-1 Indicators of Health status	14
Table 3-2 Indicators of Health status by Gender and by urban rural.....	14
Table 3-3 Top 10 causes of Mortality/Morbidity.....	15
Table 3-4 Demographic indicators.....	15
Table 3-5 Demographic indicators by Gender and Urban rural	16
Table 6-1 Health Expenditure	25
Table 6-2 Sources of finance, by percent.....	25
Table 6-3 Health Expenditures by Category	26
Table 6-4 Tax revenue projections for Afghanistan	27
Table 6-5 Population coverage by source	28
Table 7-1 Health care personnel	32
Table 7-2 Human Resource Training Institutions for Health	32
Table 8-1 Service Delivery Data and Trends	34
Table 8-2 Inpatient use and performance.....	40

FOREWORD

Health systems are undergoing rapid change and the requirements for conforming to the new challenges of changing demographics, disease patterns, emerging and re emerging diseases coupled with rising costs of health care delivery have forced a comprehensive review of health systems and their functioning. As the countries examine their health systems in greater depth to adjust to new demands, the number and complexities of problems identified increases. Some health systems fail to provide the essential services and some are creaking under the strain of inefficient provision of services. A number of issues including governance in health, financing of health care, human resource imbalances, access and quality of health services, along with the impacts of reforms in other areas of the economies significantly affect the ability of health systems to deliver.

Decision-makers at all levels need to appraise the variation in health system performance, identify factors that influence it and articulate policies that will achieve better results in a variety of settings. Meaningful, comparable information on health system performance, and on key factors that explain performance variation, can strengthen the scientific foundations of health policy at national, regional and international levels. Comparison of performance across countries and over time can provide important insights into policies that improve performance and those that do not.

The WHO regional office for Eastern Mediterranean has taken an initiative to develop a Regional Health Systems Observatory, whose main purpose is to contribute to the improvement of health system performance and outcomes in the countries of the EM region, in terms of better health, fair financing and responsiveness of health systems. This will be achieved through the following closely inter-related functions: (i) *Descriptive function* that provides for an easily accessible database, that is constantly updated; (ii) *Analytical function* that draws lessons from success and failures and that can assist policy makers in the formulation of strategies; (iii) *Prescriptive function* that brings forward recommendations to policy makers; (iv) *Monitoring function* that focuses on aspects that can be improved; and (v) *Capacity building function* that aims to develop partnerships and share knowledge across the region.

One of the principal instruments for achieving the above objective is the development of health system profile of each of the member states. The EMRO Health Systems Profiles are country-based reports that provide a description and analysis of the health system and of reform initiatives in the respective countries. The profiles seek to provide comparative information to support policy-makers and analysts in the development of health systems in EMR. The profiles can be used to learn about various approaches to the organization, financing and delivery of health services; describe the process, content, and implementation of health care reform programs; highlight challenges and areas that require more in-depth analysis; and provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries. These profiles have been produced by country public health experts in collaboration with the Division of Health Systems & Services Development, WHO, EMRO based on standardized templates, comprehensive guidelines and a glossary of terms developed to help compile the profiles.

A real challenge in the development of these health system profiles has been the wide variation in the availability of data on all aspects of health systems. The profiles are based on the most authentic sources of information available, which have been cited for ease of reference. For maintaining consistency and comparability in the sources of

information, efforts have been made to use as a first source, the information published and available from a national source such as Ministries of Health, Finance, Labor, Welfare; National Statistics Organizations or reports of national surveys. In case information is not available from these sources then unpublished information from official sources or information published in unofficial sources are used. As a last resort, country-specific information published by international agencies and research papers published in international and local journals are used. Since health systems are dynamic and ever changing, any additional information is welcome, which after proper verification, can be put up on the website of the Regional Observatory as this is an ongoing initiative and these profiles will be updated on regular intervals. The profiles along with summaries, template, guidelines and glossary of terms are available on the EMRO HSO website at www.who.int.healthobservatory

It is hoped the member states, international agencies, academia and other stakeholders would use the information available in these profiles and actively participate to make this initiative a success. I would like to acknowledge the efforts undertaken by the Division of Health Systems and Services Development to help countries of the region in better analyzing health system performance and in improving it.

Regional Director
Eastern Mediterranean Region
World Health Organization

1 EXECUTIVE SUMMARY

Afghanistan suffered from very high mortality and morbidity even before the Soviet invasion of 1979. The under-five mortality rate in 1960, estimated at 360 per 1,000 live births, was 30% higher than the average of the least developed countries at the time. Twenty-five years of war meant that little progress was made in improving health service delivery and the coming of the Taliban worsened an already difficult health situation. Girls and women had very limited access to services since most women health workers were not allowed to work. From 1990 to 2002 the under-five mortality rate hardly changed and Afghanistan is today where most developing countries were 40 years ago.

Current Health Status: While on-going efforts are contributing to some progress in improving health status, the overall situation remains grim. The under-five mortality rate is now 172 and the infant mortality rate is 115. These indicators have significantly decreased but still the highest in Asia and very high compared to other developing countries. The maternal mortality ratio, estimated at 1,600 per 100,000 live births is also very high and reflects the low status of women, poor infrastructure, and a barely functioning curative health care system. The rate of chronic malnutrition (moderate and severe stunting) remains around 50% reflecting a combination of poor caring practices, micronutrient deficiency, and chronic food insecurity. Most of the burden of disease results from infectious causes, particularly among children where diarrhea, acute respiratory infections, and vaccine preventable illnesses account for 60% of deaths. Among adults, tuberculosis accounts for an estimated 15,000 deaths per year with 70% of detected cases being among women.

Comment [Dw1]: Indicators should be consistent with I-ANDS (see PP 106) and National Health policy (see PP 7)

Most of the Afghan population does not have access to the basic services that could make a large difference to their health. For example, routine immunization coverage (DPT3) is estimated to be only 54% and 66% in 2003 and 2004 respectively and even this may overstate the reality. Forty percent of existing health facilities does not have female staff, which means that women are very unlikely to access those facilities. More than 80% of existing services are provided by Non Governmental Organizations (NGOs).

Accomplishments: Through successful mass vaccination, the Ministry of Public Health and its partners have been able to reduce the number of confirmed polio cases in 2003 to 7 and in 2004 to 4 in the whole country, a remarkable improvement from the situation in 1997 in which polio caused more disability than land mine injuries. A measles mortality reduction campaign reached more than 90% of children 6 months to 12 years of age resulting in saving of an estimated 30,000 lives. In addition to leading these activities, the Ministry of Public Health has taken on a stewardship role in the sector and has developed and communicated a coherent National Policy for 2005-2009 and Strategy for 2005-2006, helping to ensure that disparate partners focus on national strategic priorities such as delivering basic health services to the majority of Afghans who live in rural areas, with focus on Essential Package of Hospital Services.

Key Health Sector Issues: Within the sector, the most important constraint to improving health status is lack of access to basic health services in much of the country. Even simple and effective interventions, such as routine immunization, are only slowly becoming available. The major constraints to improving service delivery are: (i) inadequate number of female health staff in rural areas; (ii) shortage of skilled health staff in rural areas generally; (iii) lack of managerial capacity particularly at provincial level; and (iv) managerial and organizational structures that do not provide incentives or accountability for results.

Cross-Cutting Issues: There are many important cross-cutting issues that impede improvements in health status including: (i) lack of physical security and respect of human rights; (ii) low status of women; (iii) lack of physical infrastructure including rural roads, electricity, improved water supplies, and sanitation systems; (iv) low levels of education, particularly female education; and (v) narcotics and their pervasive effect on health.

In order to tackle the Afghans health issues and problems, MOPH decided to develop national health policy (2005-2009) and strategy (2005-2006) within the framework of the Constitution of Afghanistan 2004, the Public Investment Program 2004 and the National Development Framework 2002. The 2004 Public Investment Program reinforces the focus on the three pillars outlined in the National Development Framework, namely development of human capital, physical infrastructure and good governance. Health falls within the human capital pillar. A key priority in The Public Investment Program is the need to expand the delivery, coverage and quality of both basic health services and hospital services. In addition, many other cost effective interventions need further development.

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

Values and principles embody the essential ideals of the Ministry of Public Health and offer a moral and ethical code that guides decision making to achieve success. Values are also useful in communicating the reasoning behind decision-making. The following values are believed in by the Ministry of Public Health, all of which are equally important:

- Right to a healthy life
- Compassion
- Honesty and Competence
- Equity
- Pro-rural

The above values are incorporated into the following seven working principles, which are moral rules or strong beliefs intended to guide the every day work of the entire Ministry. Each of the following principles is equally important and they are not presented in any priority ranking:

1. Treating all people with dignity, honesty and respect and considering healthy life as a basic right of every individual.
2. Making evidence based decisions.
3. Ensuring equitable access to, and provision of, quality, basic, essential health services.
4. Being honest, transparent and accountable.
5. Improving the effectiveness, efficiency and affordability.
6. Giving priority to groups in greatest need especially women, children, the disabled and those stricken with poverty.
7. Promoting healthy lifestyles and discouraging practices proven to be harmful

Key Priorities: The Government has committed itself to ensuring that the BPHS (a package of services covering maternal and newborn health, child health and

Comment [Dw2]: The key priorities are now falls under four programs (I- ANDS)1: Implementation of BPHS,2: Implementation EPHS,3: Control of communicable-, non communicable disease and 4; Human resources development

immunization, public nutrition, and communicable disease control) and Essential Package of Hospital Services are delivered to all Afghans, regardless of where they live, their ethnicity, or gender, in the next 5 years.

The approach has been the key priority in the sector, is agreed to by almost all stakeholders, and continues to be compelling. The Government will continue to pursue this over-arching goal as its first priority, as a means to provide a peace dividend to Afghans, and achieve the Millennium Development Goals (MDGs).

The following two MDGs will be aimed at: Target 5; reduce by two thirds, between 1990 and 2015, the under-five mortality rate and target 6; reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

Comment [Dw3]: The MDGs can be translated for relevance of I-ANDS

While implicit in ensuring the delivery of the BPHS, the Government is committed to reducing inequity in the availability and utilization of health services and will continue to track this by gender, locale, and socio-economic status. Once the current content of the BPHS and EPHS have been successfully delivered to all Afghans, the Government intends to broaden the scope of the BPHS to include additional services such as mental health, community care for the disabled, and prevention of HIV/AIDS. This will likely be implemented in 5 years but could begin earlier if rapid progress on BPHS delivery is achieved.

Comment [Dw4]: These three programs are already added into BPHS but are in the early stages of implementation and still there is need for financial support of these programs

Special Programs: Ensuring the nation-wide delivery of the BPHS and EPHS will take at least 5 years, and in the mean time the Government will continue to strengthen the vertical programs and campaigns that ensure blanket coverage of simple but effective interventions such as salt iodination, polio, measles, and tetanus immunization, and vitamin A distribution.

Human Resource Development: The Government will ensure that every health facility in the country has sufficient female staff and that all staff is properly trained and independently certified to have the skills and knowledge required to deliver high quality health services.

Improve Quality of Hospital Services while Maintaining Centrality of BPHS: Without compromising the delivery of the BPHS, the Government intends in 5 years to considerably strengthen the quality of hospital services with priority being given to services such as emergency obstetrical care and trauma management.

Administrative Reform & Capacity Building: The Government is committed to rigorously testing and evaluating managerial and organizational reforms to improve health service delivery. These reforms will address issues of accountability and incentives for results. Driven by what works rather than ideology, the Government will find productive means to work with the private and NGO sectors. The capacity of Afghans to manage health services will be substantially strengthened with the aim, in 5 years and certainly with the hope of replacing all expatriates with properly trained Afghans.

Role of Government: In order to achieve the goals listed above the Government has decided to keep for itself the following roles: (i) financing; (ii) monitoring and evaluation; (iii) coordination of donor inputs; (iv) strategic planning; (v) setting technical standards; (vi) regulation of the for-profit private sector; and (vii) coordination and regulation of the NGO sector.

Delivery of Public Health Services: The government has not yet decided on whether it wants to take on responsibility for delivering public health services itself or contract with NGOs to do. The decision on this will be made based on rigorous evaluation of

current contracts, grants, and Ministry of Public Health (MOPH) strengthening mechanism.

1. **Accountability, Monitoring and Evaluation:** The MOPH intends to hold itself and its partners accountable for achieving the goals and targets it has established. This will be done through appropriate household and health facility surveys carried out with 3rd party assistance.

2. **Financial Flows Through Government:** The Government is working towards having most external funding for public health services flow through the Government budgeting system (pooled funding), and expects to make considerable progress on this in the next 5 years. MOPH is in the process of piloting health care financing different options in order to ascertain the most applicable and feasible option for making the health sector financially sustainable.

3. **Structure of MOH and Staffing:** With the exception of females, the MOPH will not recruit additional health care providers over the next five years and expects to have many of its staff working with NGOs. The MOPH will expend considerable effort to strengthen the Provincial Health Offices using the Government's Priority Reform and Restructuring (PRR) process.

Comment [Dw5]: Can be reflected: contracting has been largely accepted for short term, for long term it is to be decided

Comment [Dw6]: Any meaning for numbering?

2 SOCIO ECONOMIC GEOPOLITICAL MAPPING

2.1 Socio-cultural Factors

The main socio cultural factors that affect the health system in Afghanistan are female restriction in movement, unwillingness to accept health services from male care provider and superstitious and misbelieves. Unwillingness to send girls to school and unawareness regarding the importance of education and appropriate and timely health services resulted to poor health status.

Table 2-1 Socio-cultural indicators

Indicators	1990	1995	2000	2002	2003
Human Development Index:	-	-	-	-	(Rank 169 out of 171)
Literacy Total:	-	16%	36%	-	28.7%
Female Literacy:	12%	5%	21%	-	14%
Women % of Workforce	34%	34.8	35.5	35.8%	-
Primary School enrollment	27%	25%	36%	-	54.4%
Primary education, pupils (% female)	-	14%	14%	14%	-
Urban Population (%)	18%	20%	-	23%	25%

Sources: Multiple Indicator Cluster Survey 2003,
The state of the world children 2004 by UNICEF,
Demographic and Health Indicators for Countries of the Eastern Mediterranean 2004,

2.2 Economy

Key economic trends, policies and reforms

Afghanistan economy has been devastated and distorted by more than two decades of protracted war and conflict capped by a severe nationwide drought in 1999-2001, but has bounced back in the last three years. The strong economic recovery is attributable to the end of drought and major conflict and initiation of reconstruction, and has been supported by sound, conservative government macroeconomic policies, a highly successful currency reform, and structural reforms most notably in trade and the financial sector. Official GDP (non opium), starting from a very low base, has grown dramatically by 29% in 2002 and by 16% in 2003. Two thirds of this growth came from agriculture due to better precipitation and better availability of seeds and fertilizers and hopefully will be escalated further in 2005. From macroeconomic policies point of view another important cornerstone for the economic recovery has been macroeconomic stability, a remarkable achievement by the government after more than a decade of high inflation. A currency reform was completed successfully between October 2002 and January 2003. Since then monetary policy has sought to keep inflation under control (it was 10.5% in the year ending March 2004), and smooth volatility in the exchange rate.

Strong fiscal discipline underpins macroeconomic stability. Under the no-overdraft policy, the government has been refraining from printing currency to finance its deficit.

Table 2-2 Economic Indicators

Indicators	1990	1995	2000	2002
GNI per Capita (Atlas method) current US\$	-	-	-	250
GNI per capita (PPP) Current International	-	-	-	-
GDP per Capita: (constant 1995 US\$)	-	-	-	-
GDP per Capita annual growth %	0.1	-	-	-
Unemployment % (estimates)	3%	-	-	-

Sources: The state of the world children 2004 by UNICEF, Demographic and Health Indicators for Countries of the Eastern Mediterranean 2004

Table 2-3 Major Imports and Exports

Major Exports:	Fresh fruit, dried fruit, Medicine botanies, spices, seeds, skin, sausages, carpets, and wool.
Major Imports	Machinery and equipment, petroleum, oil, metals, chemical materials, construction materials, paper, clothing materials, food, cigarettes and drinks, fabrics, clothing and footwear, household needs and medicine.

Sources: Afghanistan Statistical Yearbook 2003

2.3 Geography and Climate

Map of Afghanistan



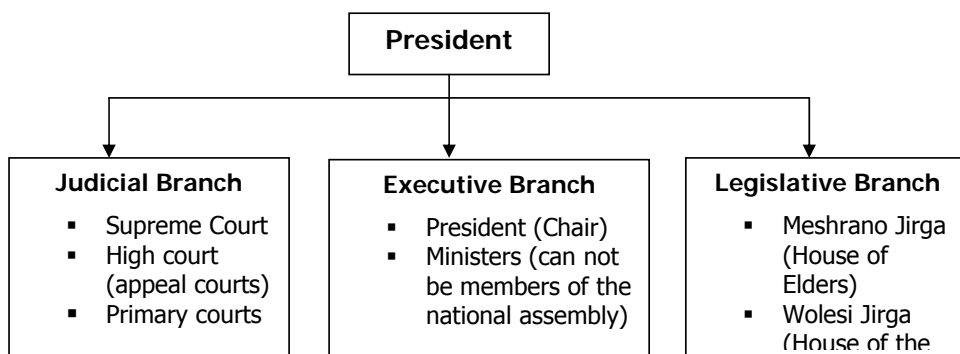
Afghanistan is a land locked country with dry climate. The mountainous terrain of Afghanistan has made it difficult to deliver health services throughout the country. Severe nationwide drought during 1999 -2001 has further deteriorated the health status

of Afghans. But fortunately heavy precipitation during the recent years especially in the current year (2005) has revitalized the hope of Afghans to overcome the consequences of the severe drought. But due to heavy snowfall as soon as the temperature gets increased and snow melted there is possibility of severe and devastated flood in the flood prone areas. MOPH is proactive in this area and propositioned adequate drug and supply in stock and has made comprehensive plan in cooperation of all line ministries and all stakeholder to react in a timely fashion.

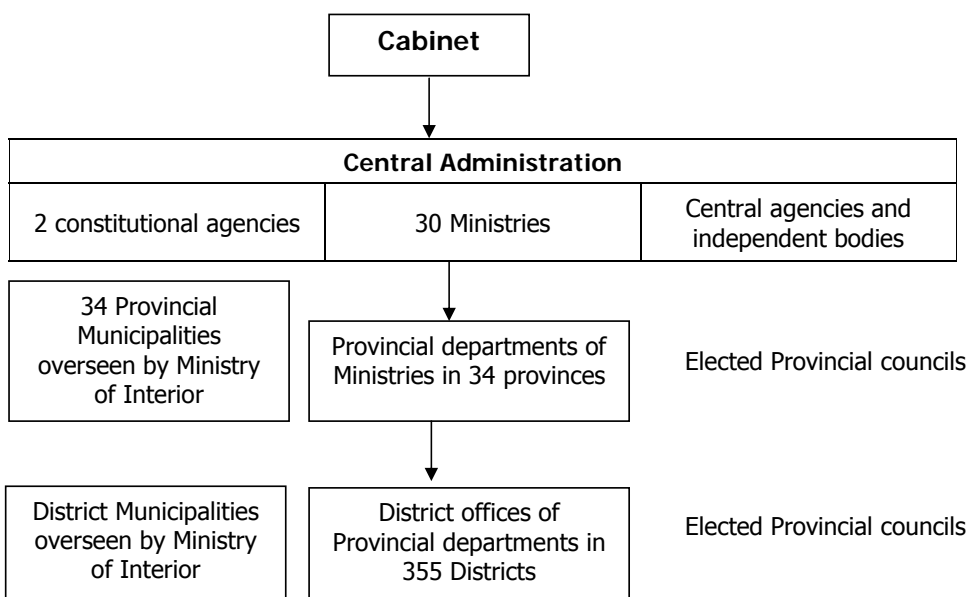
2.4 Political/ Administrative Structure

Basic political /administrative structure

Structure of Administration:



Structure of the Government:



In year 2002 after the establishment of the transitional Islamic state of Afghanistan, the government decided to develop 13 main development programs within the national development framework. Health and Nutrition program is one the mentioned programs.

Key political events/reforms

- Establishment of the transitional Islamic state of Afghanistan
- National Development Framework
- Development of the Afghan constitution
- Conducting election
- Establishment of the Islamic Republic of Afghanistan.
- |

Comment [Dw7]: Can be Added"
Development of interim ANDS together with Afghan Compact (London Conference) also establishment of Parliament can be mentioned

3 HEALTH STATUS AND DEMOGRAPHICS

3.1 Health Status Indicators

Afghanistan is one of the countries with the poorest health indicators. It is lacking some major and important health indicators especially in the field of reproductive health and health care financing. Afghanistan is ranked fourth by having the highest under five-mortality rate in the world. The highest maternal mortality ratio belongs to our country, which is 1600 per 100000 live births. With keeping in mind the human development index, Afghanistan ranked 169 out of 171.

Table 3-1 Indicators of Health status

Indicators	1995	2000	2002	2003	2004
Life Expectancy at Birth:	38 (70)	44.7	42.6	44.5	-
HALE:	-	-	35.5	-	-
Infant Mortality Rate:	-	165 (97)	165	115	-
Probability of dying before 5th birthday/1000	260(90)	250 (97)	257	172	-
Maternal Mortality Ratio:	-	1900 adjusted	1600	1600	-
Percent Normal birth weight babies:	80% (93)	-	-	-	-
Prevalence of stunting:	52%	52%	52%	-	54%
Prevalence of wasting:	25%	25%	25%	-	7%

Sources: MICS 2003,
World Health Report 2003,
The state of the world children 2004 by UNICEF,
Maternal Mortality Survey in Afghanistan by UNICEF November 2002,

Table 3-2 Indicators of Health status by Gender and by urban rural

Indicators	Urban	Rural	Male	Female
Life Expectancy at Birth:	-	-	41.9	43.4
HALE:	-	-	35.3	35.8
Infant Mortality Rate:	97	121	-	-
Probability of dying before 5th birthday/1000:	142	183	258	256
Maternal Mortality Rate:	-	-	-	-
Percent Normal birth weight babies:	-	-	-	-
Prevalence of stunting/wasting:	-	-	-	-

Sources: MICS 2003
World Health Report 2003

Table 3-3 Top 10 causes of Mortality/Morbidity

Rank	Mortality	Morbidity
1.	-	Cough and Cold
2.	-	ENT
3.	-	Acute Watery Diarrhea without dehydration
4.	-	Urinary Tract Infections
5.	-	Pneumonia
6.	-	Acute Bloody Diarrhea
7.	-	Malaria
8.	-	Trauma
9.	-	Diarrhea with dehydration
10.	-	TB suspected Case

Sources: Morbidity (BPHS report by MOPH, HMIS April to December 2004)
MOPH HMIS is reporting only neonatal and maternal mortality.

3.2 Demography

57% of the population in Afghanistan is below 18 years of age. There are more men than women. The average household size is seven, with children under 18 accounting for 4 out of 7 people in the household. The population of Afghanistan is increasing rapidly. The total fertility rate is estimated as 6.3 per woman. The overall population growth rate over the last 24 year of conflict is estimated as 2.5 percent per year. The limited access to health facilities means that many women are repeatedly exposed to the risk of disease, disability and health during pregnancy, labor, birth and post natal recovery. Maternal mortality is assumed to be one of the highest in the world. 3.3 percent of households are headed by a female, indicating the male member might be dead or displaced. Under five mortality is estimated at 172 and infant mortality at 115 per 1000 live births. This is one of the highest in the world.

Table 3-4 Demographic indicators

Indicator	1990	1995	2000	2003
Crude Birth Rate:	-	48	48	48
Crude Death Rate:	-	28	-	17.2
Population Growth Rate:	4.2 (95)	2.5 (96)	4.2	3.8%
Dependency Ratio:	88% (95)		92%	86%
% Population <15 years	-	45.5 (96)	43.7	-
Total Fertility Rate:	7 (95)	-	-	6.23

Sources: The state of the world children 2004 by UNICEF
Demographic and Health Indicators for Countries of the Eastern Mediterranean 2004

Table 3-5 Demographic indicators by Gender and Urban rural

	Urban	Rural	Male	Female
Crude Birth Rate:	-	-	-	-
Crude Death Rate:	-	-	-	-
Population Growth Rate:	-	-	-	-
Dependency Ratio:	-	-	-	-
% Population <15 years	-	-	-	-
Total Fertility Rate:	6	6.38		

Source: MICS 2003

4 HEALTH SYSTEM ORGANIZATION

4.1 Brief History of the Health Care System

Outline of the evolution of the Health Care System

Before the communist regime in Afghanistan the health system was both curative and preventive oriented but during communist regime it was focused more on curative services. Eventually during Taliban regime the health system collapsed and all infrastructures annihilated. Brain drain of professionals was one the main problems. The health system was in the emergency phase on that time. After the collapse of the Taliban regime the health system passed the emergency and conflict period and now is in the post conflict and developmental phase. For the first three years of the transitional Islamic state of Afghanistan, the health system was more preventive focused and more emphasis was placed on delivery of Basic Package of Health Services. Fortunately after the setting up of the Islamic Republic of Afghanistan, MOPH has put more attention to the implementation of both Basic Package of Health Services and Essential Package of Hospital Services. It means the government again insist on both curative and preventive aspects of health care.

4.2 Public Health Care System

Organizational structure of public system

(Diagram) Refer to Annex I

Key organizational changes over last 5 years and consequences

Five years ago, when Taliban was in power there was no specific public health policy and strategy by the government in health sector. Lack of health infrastructure was visible throughout the country and female health workers were inadequate and even the existing female workers were not allowed to work in health facilities and take part in the health events and training programs. The health services were more curative oriented and 80% of health services were delivered by NGOs.

After the fall of Taliban and establishment of the transitional Islamic state of Afghanistan, the government decided to bring reforms in all sectors. In order to improve health service delivery MOPH was resolute to bring changes in the structure of public health system by introducing new policies, strategies. One of the main policies developed was the Basic Package of Health Services. Later due to the new set up of the health system and given the fact that more than 80% of services were provided by Non Governmental Organizations (NGOs), and according to a report, the Cambodian experience suggests that the service delivery outcomes associated with contracting-out were superior, the Ministry of public health decided to sub contract NGOs in delivering health services and retained responsibilities for planning, organizing, training, supervision, monitoring, evaluation, designing policies, strategies and financing. As phase out strategy and taking over from NGOs after the completion of the contract period, Ministry of public health decided to be ready for this strategy and to strengthen its own capacity. Therefore MOPH decided to run health facilities in three provinces (Parwan,

Panjshir and Kapisa) in order to strengthen the MOPH staff capacity (MOPH Strengthening Mechanism) and to be ready to take over from NGOs. As consequences of the all above-mentioned changes in the health system, Ministry of public health succeeded to extend the coverage of the Basic Package of Health Services to 77% by February 2005 throughout the country with more focus on the remote and far-flung areas. The coverage of EPI significantly increased and many baseline studies were conducted at the national and provincial levels to have a clear picture of the existing health situation in the country for evidence based decision-making.

Planned organizational reforms in the public system

The Independent Administrative Reform & Civil Service Commission, in consultation with the Ministerial Advisory Committee on Public Administration Reform, may also require Ministries/government agencies carrying out critical functions to apply for Priority Reform and Restructuring.

The Independent Administrative Reform & Civil Service Commission, on the advice of the Ministerial Advisory Committee on Public Administration Reform, may, in collaboration with relevant Ministries as appropriate, initiate Priority Reform & Restructuring of certain common functions across all Ministries/agencies. Up to date Ministry of public health has established its provincial health liaison office and policy and planning general directorate. The process is followed by the Ministry very seriously and hopefully in the near future all departments will come under this process. The new organogram of the MOPH has been developed and the MOPH will move forward toward its goal by putting the mentioned organogram in function.

4.3 Private Health Care System

Modern, for-profit

The for-profit private health care system is available in the form of hospitals, clinics and diagnostic centers in the country. But unfortunately there is no policy and laws available for the private health sector. There is no accurate data available regarding how large this system is in Afghanistan. The government has been pursuing pro-private sector policies in recognition that a sound investment climate is essential for private sector development. The legal framework for the private sector will be critical.

Modern, not-for-profit

Ministry of public health sub contracted health service delivery to Non Governmental Organizations and retained responsibilities for financing, planning, regulating, monitoring, supervision, evaluation and monitoring.

Traditional

Traditional healers, Hakims, mullahs provide some sort of health services in community.

Key changes in private sector organization

The key changes in private sector are the sub contracting of health service delivery that is considered the first step toward privatization.

Public/private interactions (Institutional),

Contracting out and contracting in strategy of the Ministry of public is an example of the public/private interactions.

Public/private interactions (Individual),

There is linkage between public and private health sector in terms of establishing referral system between the sectors individually but unfortunately there is no reliable and accurate data.

Any planned changes to private sector organization

Government is supporting the idea of privatization in health sector. Despite above mentioned role of NGOs in health service delivery the government is going to hand over responsibility of running some hospitals to private sector. New financial sector legislation such as central bank law and banking law was adopted in the summer 2003 to grant the central bank independence and establish a modern framework for the banking system that could play an important role in promoting private sector and would provide opportunity to bring significant changes in the private sector organization.

4.4 Overall Health Care System**Organization of health care structures**

(Diagram) See Annex I

In the Ministry of public health under the leadership of minister there are three deputy ministers named Policy/planning and preventive deputy minister, reproductive health and mother and child health care deputy minister and administrative and curative health care deputy minister who are mainly involved in policy development and are considered as political positions that are affected by political changes in the government. Below the line of responsibility of the deputies there is position of secretary general who is directly reporting to minister and is overseeing all activities of the underlying directorates. The secretary general's position will not be affected by the political changes of the government. Secretary General will be responsible for the implementation of the overall policies of the Ministry.

5 GOVERNANCE/OVERSIGHT

5.1 Process of Policy, Planning and management

National health policy, and trends in stated priorities

In February 2002 within the context of the Transitional Islamic State of Afghanistan the Ministry of Public Health developed a comprehensive interim health policy. Then in August 2002 to help close the gap between health policy and implementation, an interim health strategy for 2002-2004 was developed. This was finalized in February 2003. This interim strategy focused on laying the foundations for equitable, accessible, quality health care through strategic planning, management and actions that made the best use of limited resources. It set priorities and also stated what should be achieved by end 2004.

To a great extent the foundations for recovery were gradually put in place. So, by mid 2004 it was generally agreed that the Ministry needed to focus more on accelerating the implementation of health care services, especially in underserved rural areas. The process involved in developing both the new national policy and strategy started in July 2004 and was coordinated by the Ministry's Policy and Planning Directorate.

Comment [Dw8]: I-ANDS can be mentioned here as well

This national health policy is a guide to the overall context within which all health and health related work for accelerating implementation should be developed and implemented over the next five years, 2005-2009. The choice of a time frame of five years for this new national policy reflects the more stable and wider context within which the Ministry of Public Health is now functioning. As a health policy should not go into detail, a new national health strategy has also been produced which is further described below and towards the end of this document. The policy and strategy have been agreed with the following three important factors in mind:

- The formation of a new government following agreement on the new Afghan Constitution in 2004
- The 2004 Public Investment Program
- To ensure a close link existed between the development of the new health national policy and strategy and that of the next National Budget

The new national health policy 2005-2009 gives the:

- Mission Statement, Values and Working Principles of the Ministry of Public Health
- National Health Policy goal, objectives, priorities and outcomes
- Policy statements on each of the 18 policy priorities

A new organizational chart for the Ministry at central level has also been produced (see Annex I). This reflects both the new policy context and also recent guidelines on the organization of each Ministry in government from the Independent Administrative Reform and Civil Service Commission (IAR-CSC).

The new national health strategy gives the direction and scope of work for two years, 2005-2006 within the framework of the national health policy. The strategy helps answer the question 'how are we going to successfully achieve the policy?'

The new national health strategy states the:

- National health strategy objective and 5 planned outputs
- Critical success factors, conditions, risks and assumptions
- 18 strategies, based on the 18 priorities given in the national health policy, which give both 'what' is going to be done and 'through' what mechanism each of the strategies will mainly be implemented
- Outputs to be achieved for each strategy with appropriate indicators of achievement to facilitate for example, review and/or a midterm evaluation
- Strategic actions to help implement the strategies
- Priorities among the 18 strategies for resource allocation
- Allocation of responsibility for each strategy within the Ministry

During the period 2005-2009 there will be two national health strategies, one for 2005-6 and one for 2007-9. This is because considerable uncertainty exists around future funding for the health sector, including implementation through contracting out primary and hospital services to non-government organizations. The current donor agreements for support end in 2006 and there may need to be different ways of working from 2007 onwards. In addition, in the rapidly changing post conflict environment in Afghanistan a period of five years is too long a time frame for only one strategy.

Comment [Dw9]: Current donor Agreements are changed : The WB will support till March 2008 , The USAID for five year from March 2006 onward, EC looks that is willing to provide funds for its currently supporting provinces

Formal policy and planning structures, and scope of responsibilities

The policy for 2005-2009 and strategy 2005-2006 was developed based on the 18 national health needs and priority areas. MOPH has developed short and midterm working plan, which will be pursued by a long-term plan of action. MOPH is in the stage of developing Term of Reference for the whole structure. Some have already been developed and some are in the process.

Key legal and other regulatory instruments and bodies: operation and any recent changes

There is a directorate within the structure of MOPH that is regulating laws in the health system. This directorate is called laws and regulation directorate.

5.2 Decentralization: Key characteristics of principal types

One of the decentralization processes that have been put in practice is decentralized provincial planning.

Within the MOH:

There is only decentralized planning process at provincial level.

State or local governments

There are many plans for the decentralized activities in various field of health services delivery but the only one, which is decentralized planning, has materialized in some provinces.

Greater public hospital autonomy

There is no autonomy in the public hospitals running by the government.

Private Service providers, through contracts

Contracting out and contracting in are the main type of contract that is signed by MOPH with NGOs.

Main problems and benefits to date: commentary

Contracting with NGOs for delivering health services is one of the decentralized processes in the health system. The main problems in this approach are: 1) there will be a very challenging phasing out strategy for the government to take over from NGOs. 2) Monitoring and evaluation of the programs that are running by different NGO will be full of problems.

At the time being since MOPH doesn't have the capacity to run all type of health facilities therefore using the capacity of NGOs with adequate human resources would be one of the advantages for the health system.

Integration of Services

MOPH is trying to integrate all the vertical programs into the Basic Package of Health Services as much as possible. The integration will be successful when the primary health care is quite improved and developed. Based on the mentioned fact MOPH decided to keep the vertical program as it is at both provincial and central levels and to integrate it at district level.

5.3 Health Information Systems

Organization, reporting relationships, timeliness

- National level (central MOPH, HMIS Unit): facility codes and database, service statistic, training in database and grant management database. Data is used for analysis and calculation of national indicators and feedback to provinces.
- Provincial level: Data storage: status of facility, staff information and service statistic and training. All collected data are computerized, analyzed and feedbacks are given to facility and are used in provincial annual planning.

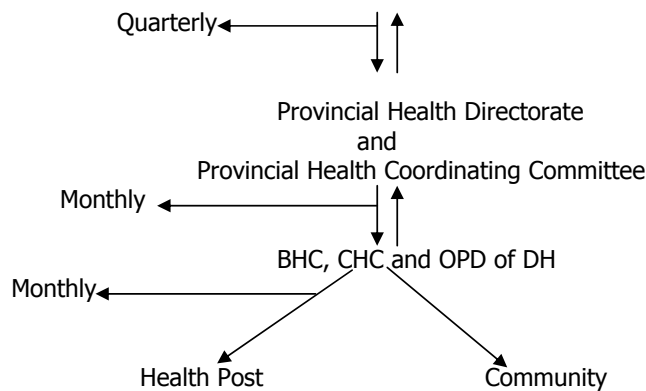
Data availability and access

Data is aggregated quarterly. The routine reports are coming from almost 75% of the country where covered by Basic Package of Health Services (BPHS).

Sources of information,

Routine reporting system from Basic Health Centers (BHC), Comprehensive Health Centers (CHC) and OPD of District Hospitals (DH) is shown in diagram below.

Data Flow Diagram



5.4 Health Systems Research

- To collect essential data through surveys and surveillance on major public health problems for which no or little data exists. Areas of interest include but are not confined to: landmine and other war-related injuries, nutrition including macro and micronutrient deficiencies, maternal morbidity and mortality, and vaccine-preventable diseases.
- To assist in training and capacity building of MoPH and national NGO staff in public health, surveillance and operational research.
- To support as required and by invitation the ongoing surveillance system for AFP, measles and tetanus and communicable disease outbreak response.
- To conduct high quality research on areas identified by the MoPH, UN agencies and the NGOs.
- To review all kind of studies/researches through Ethics Review Board and Technical Advisory Board

Comment [EM10]: •after gaining required experience in terms of capacity building.

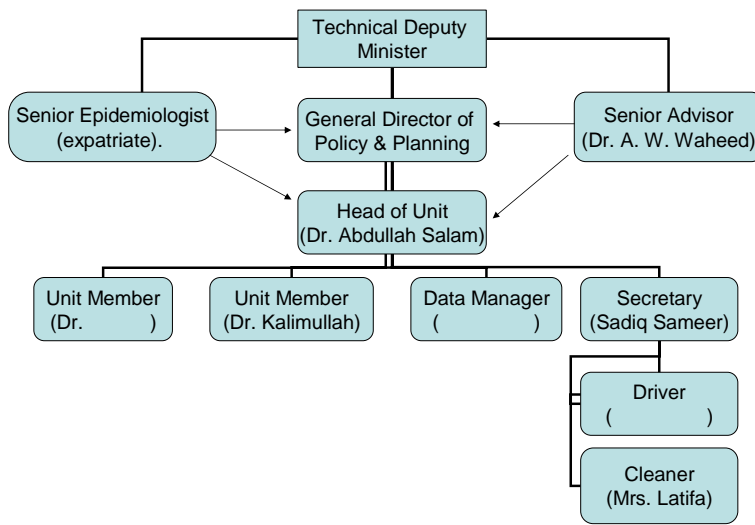
Comment [EM11]: and formulation of TOR for ERB and codes of conduct and guidelines for the health related studies.
 ▪ To facilitate research in biomedical field on priority public health problems and vital issues needed for decision makers.
 ▪ To develop special study database containing research protocols plus results of all studies so far taken place in Afghanistan and is kept on updating.

Structure of Public Health / Research Department

- Head of the department
- National Public Health / Research Adviser

Public health and research unit is accountable to the Director General policy and planning MOPH. One of the main responsibilities of this unit is to move forward the activities of the Ethical Review Board. The main purpose of this board is to make sure each of the proposed interventions is safe and have benefit for Afghanistan. It will ascertain the potential risk of the various studies. And will ensure that the standardized procedures are followed and qualified people are involved in the studies.

Organogram for PH/Research Unit



6 HEALTH CARE FINANCE AND EXPENDITURE

6.1 Health Expenditure Data and Trends

Table 6-1 Health Expenditure

Indicators	1990	1995	2000	2002
Total health expenditure/capita, USD	-	-	9	4.5 (03)
Total health expenditure as % of GDP	-	5.5 (99)	5	3.2%
Investment Expenditure on Health	-	-	-	-
Public sector % of total health expenditure	-	-	-	-

Sources: MICS 2003

World Health Report 2003

The state of the world children 2004 by UNICEF

Costing of Basic Package of Health Services by Ministry of Public Health 2003

Table 6-2 Sources of finance, by percent

Source	1990	1995	2000	2002
General Government (GG expenditure on health as % of total expenditure on health)	52.8	53.1	53.8	52.6
Central	-	-	-	-
State/Provincial	-	-	-	-
Local	-	-	-	-
Social Security	0	0	0	0
Private (private expenditure on health as % of total expenditure on health)	47.2	46.9	46.2	47.4
Private Social Insurance	0	0	0	0
Other Private Insurance	0	0	0	0
Out of Pocket	100	100	100	100
Non profit Institutions	0	0	0	0
Private firms and corporations	0	0	0	0
External sources	3.7	4.4	14.8	11.2

Sources: World Health Report 2003

Trends in financing sources

Based on the data from MOPH operation budget 2002 the source of health financing are government health expenditure in million USD \$18, from donors, UN and NGOs is \$126 and from user fees is \$17 million. Therefore we can say 78%, 11% and 11% are coming from donors, UN, NGOs, government and user fees respectively.

Health expenditures by category

Table 6-3 Health Expenditures by Category

Health expenditure	1990	2003	2004	2005
Total public health expenditure requirements in million USD:	-	173	320	282
% Capital expenditure	-	-	-	-
% by type of service				
Curative Care	-	-	-	-
Rehabilitative Care	-	-	-	-
Preventive Care	-	-	-	-
Primary/MCH	-	-	-	-
Family Planning	-	-	-	-
Administration	-	-	-	-
% by item				
Staff costs	-	-	-	-
Drugs and supplies	-	-	-	-
Other	-	-	-	-

Sources: Afghanistan National Development Budget

Trends in health expenditures by category

The overall health expenditure requirements for 2005 fall in to five categories as follows: Basic Package of Health Services, Essential Package of Health Services, Special Health Programs, Capacity Building of Human Resources, and Administrative Reform and Management. Out of total 292 million USD for the expenditures requirements 161.27, 17.70, 16.82, 14.46, and 71.73 million are allocated for the above-mentioned categories respectively.

It should be noted that the breakdown of Development Budget into capital and recurrent expenditures for 2003, 2004 and 2005 is given in below:

Development Budget	2003	2004	2005
Total Capital	12%	15%	13%
Total Recurrent	88%	85%	87%

6.2 Tax-based Financing

The revenue to the health sector that could potentially be generated from increased government tax collection efforts over the 8 years has been modeled in table below. However, it is unlikely that the increased tax revenue collection will translate into additional resources to the health sector because the tax revenue is likely to replace current donor assistance to the Ministry of Finance via the ARTF (Afghanistan Reconstruction Trust Fund).

Table 6-4 Tax revenue projections for Afghanistan

	1381	1382	1383	1384	1385	1386	1387	1388	1389	1390
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
GDP average annual growth rate (%)	15%	12%	10%	9%	8%	8%	7%	7%	7%	7%
GDP annual total (\$ million)	5,000	5,750	6,440	7,084	7,722	8,339	9,006	9,637	10,311	11,033
Population annual growth rate (%)	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%
Population (million)	25.0	25.9	26.8	27.7	28.7	29.7	30.7	31.8	32.9	34.1
Per capita GDP (\$)	200	222	240	256	269	281	293	303	313	324
Tax Revenue as % of GDP	0%	0%	4%	4%	10%	10%	10%	10%	10%	10%
Tax Revenue	-	-	258	283	772	834	901	964	1,031	1,103
Health share of Govt Budget	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%
Projected additional Health exp. (\$ million)	-	-	18	20	54	58	63	67	72	77
Projected additional Health exp. (\$ p.c.)	-	-	0.7	0.7	1.9	2.0	2.1	2.1	2.2	2.3

Levels of contribution, trends, population coverage, entitlement

The projected one is displayed in above table.

Key issues and concerns

Since for the coming 5-year there will be continued and considerable donor reliance hence the taxation and user fees could be an important source of funding but it requires peace, stability, political commitment and good governance.

Planned changes

Refer to the above table.

6.3 Insurance

Table 6-5 Population coverage by source

Source of Coverage	1990	1995	2000	2002
Social Insurance	-	-	-	-
Other Private Insurance	-	-	-	-
Out of Pocket	-	-	-	-
Private firms and corporations	-	-	-	-
Government	-	-	-	-
Uninsured/Uncovered	-	-	-	-

Trends in insurance coverage

More than twenty years ago a system of civil servant health insurance existed. Currently there exists a Civil Service Health Insurance Unit in the MOPH. It appears that there are moves toward the re-introduction of the civil servant health insurance. During the 1980s health insurance contributions were set at 2 percent of wage, but the system was abandoned because of erosion of wage levels. The system operated in three provinces only – the reason for this sub-set of provinces is not clear.

In Afghanistan the targeted population is proposed to be civil servants. The administrative complexities, historic experience and local realities suggest that only urban civil servants are likely to be enrolled. The benefit incidence analyses in most developing countries suggest that the upper 2 income quintiles receive a disproportionate benefit from government health expenditures. Given that health insurance coverage is usually accompanied by increased healthcare demand, there may be even greater skewing of the benefit incidence after the introduction of civil servant health insurance in Afghanistan.

Social insurance programs: trends, eligibility, benefits, contributions

It is widely recognized in the health economics literature that the introduction of health insurance is accompanied by increased demand for healthcare. Two key information asymmetry problems associated with the introduction of a third party payer system are: moral hazard and adverse selection. Moral hazard arises because the users of the services do not face the full costs of their healthcare consumption. Adverse selection arises because the consumers of healthcare know more about their own medical risk and choose to enroll in health insurance accordingly. This complicates risk pooling because low-risk individuals are less likely to seek insurance than high-risk individuals. In social health insurance the adverse selection problem is addressed through compulsory membership among the eligible group (e.g., civil servants). The moral hazard problem is usually addressed by introducing some form of out-of-pocket cost sharing to avoid frivolous use of health services, and to curb demand for expensive healthcare. The moral hazard problem is a challenge facing health insurance systems worldwide, and is a key driver of escalation medical inflation.

Private insurance programs: trends, eligibility, benefits, contributions

There has never been private insurance program in Afghanistan.

6.4 Out-of-Pocket Payments

Although government health services are officially free of charge as mentioned in Afghanistan constitution, informal fees are paid for MOPH health services. In the MOPH there appears to be considerable discussion about the potential for user fees as a source of increased revenue for the sector. NGOs, who provide healthcare to the largest share of the population, have been charging user fees for years. It is estimated that user fees currently contribute about one tenth of total health spending in Afghanistan. Recently MOPH in cooperation of partners developed formal cost sharing and user fee policy which has not been approved by the Afghan Cabinet yet. The advantage of developing a user fee policy is that it may provide a framework that will guide user fee collection in this sector.

(Direct Payments) Public sector formal user fees: scope, scale, issues and concerns

In the public sector still the policy of free services is effective based on the decisions endorsed in the Afghanistan constitution.

(Direct Payments) Private sector user fees: scope, scale, type of provider involved, issues and concerns

The new setup of the MOPH after the collapse of Taliban has predominantly sub contracted NGOs for service delivery and retained responsibilities for planning, regulating, training, monitoring, supervision, financing and evaluation. As far as we know the majorities of the NGOs have their own user fee and cost-sharing scheme, which are not unified, throughout the country. The unification of this system is still pending to the government approval of the MOPH cost sharing and health care financing policies.

Public sector informal payments: scope, scale, issues and concerns

As far as we know in Afghanistan as aftermath of almost 25 years of strife and conflict and deterioration of all health infrastructure the informal payment like under table payment in the public health sector has been escalated and has become as a normal practice at both central and peripheral hospitals and health facilities.

Cost Sharing

MOPH in cooperation of partners developed formal cost sharing and user fee policy, which has not been approved by the Afghan Cabinet yet.

6.5 External Sources of Finance

Total public health expenditure accounts for approximately 3.2 percent of GDP in Afghanistan. Donors, NGOs and UN agencies account for eighty percent of spending in the public health sector. One tenth (11 percent) of public health spending comes from the government of Afghanistan financed mainly from the Afghanistan Reconstruction Trust Fund (ARTF). In 2002 per capita health spending was estimated at \$6.5 per capita, of which \$5.1 per capita came from donors, UN agencies or NGOs. Households account for \$0.7 per capita through user fees. In 2003 MOPH operation budget was financed from the ARTF and covers almost exclusively staff salaries. Donors and UN agencies via the development budget finance non-salary recurrent cost and capital costs. According

to budget projections, per capita spending will increase at an average annual rate of about 18 percent from \$7.6 in 2003 to \$10.3 in 2005. About ninety percent of the development budget finances recurrent expenditures. Recent expenditure is further divided into expenditure on services delivery and non-service delivery (expenditure on policy formulation, systems building and institutional strengthening). Seventy percent of the development budget finances actual service delivery.

6.6 Provider Payment Mechanisms

In Afghanistan there has been considerable discussion about performance-based partnership agreements (PPAs). Given the nature of the health system it is not easy to see how service delivery can be expanded at a significant pace without contracts with NGOs, given the NGOs currently provide health services to just under two thirds of the population. It is however critical that these contractual arrangements be structured such that the outcome brings the health system closer to achieving better cohesion, rather than perpetuating the fragmentation that characterizes the system. Furthermore, the recent experiences with similar forms of contracting have clearly identified key shortcomings of the approach that need to be addressed proactively. Following terms address a few key issues that fundamentally relate to sustainability, cost and cohesion.

- **Cost:** According to report, the Cambodian experience suggests that the service delivery outcomes associated with contracting-out were superior. It is also important to note that these were the most costly of the contract arrangements – \$4.50 per capita recurrent costs under the contracting-out model and \$0.50 under contracting-in model. A decision has to be made which level is financially sustainable in Afghanistan in the long run.
- **Salary Expenditure in the Health Sector:** A cost-related concern is that the expenditure on salaries in the health sector may be distorted by the contracting process. Recurrent expenditure on contracts will disguise salary expenditure. This is already a concern, but if NGOs are financed from public sources (e.g., the World Bank credit) then the balance between salary and other recurrent inputs need to be monitored.
- **Cohesion in the system:** In both forms of contracting (contracting-in and contracting-out) it was not clear what the role of the provincial health authority was in Cambodia. In Afghanistan this may be of particular importance possible sensitivities between Kabul and some of the provinces. This concern has to be addressed, for example, by involving the PHD in a substantive manner, and explicitly stating what the reporting requirements are (e.g., management responsibility, channels of reporting etc.). A further issue that arose in the contracting-in model was that the role of the director of the health facility was unclear given that performance was managed and rewarded by the NGO management.
- **Equity impact:** The Cambodian experience indicated increased utilization of health services. It is not clear among whom the utilization increased. For example, it is possible that utilization may have increased substantially among the upper three income quintiles whereas utilization may have decreased among the poorest income quintiles. This may be a distinct possibility in districts where no exemption policies were introduced.
- **Service delivery in an entire province by an NGO:** Concern has been expressed about what happens after the conclusion of the PPA contract, especially given that

service delivery in the entire province will be affected, and possibly interrupted. This concern does not necessarily imply that province-wide contracts should be avoided, but that they are structured in a way that the likelihood of management of some facilities by the MOPH is enhanced.

Hospital payment: methods and any recent changes; consequences and current key issues/concerns

The contracting out mechanism is going on in the district hospitals by NGOs. But there is no exact payment mechanism in the other levels of public hospitals.

Payment to health care personnel: methods and recent changes; consequences and current issues/concerns

Since delivery of the Basic Package of Health services has been contracted out with NGOs therefore the health care personnel at this level is in the payroll of NGOs.

7 HUMAN RESOURCES

7.1 Human resources availability and creation

Table 7-1 Health care personnel

Personnel per 100,000 population	1999	2001	2003	2004
Physicians	-	19	11	13
Dentists	-	3		1.5
Pharmacists	2.5	-	-	2
Nurses/Midwives	-	22	-	15
Paramedical staff (vaccinators, Sanitarian, Radiology Technician, and Lab technician)	-	-	-	11
Midwives	-	-	-	-
Community Health Workers	-	-	-	18.4
Others (Admin Technician, Support staff)	-	-	-	29

Source: HR Human Resource Development Directorate Database, Ministry of Public Health 2004
Demographic and Health Indicators for Countries of the Eastern Mediterranean 2004
MOPH HMIS Database 2005

Trends in skill mix, turnover and distribution and key current human resource issues and concerns

Due to big difference between the salary scale of government and NGOs hence the level of staff turn over has been escalated and has become a great issue for the Ministry. Hopefully the process of Priority Reform and Restructuring would overcome this issue as soon as the system gets implemented in all MOPH concerned departments.

Table 7-2 Human Resource Training Institutions for Health

Type of Institution	Current		Planned		
	Number of Institutions	Capacity	Number of Institutions	Capacity	Target Year
Medical Schools	8	800	-	-	-
Postgraduate training Institutions	-	-	-	-	-
Schools of Dentistry	1	30	-	-	-
Schools of Pharmacy	1	100	-	-	-
Nursing Schools	8	600	-	-	-
Midwifery Schools	8	150	-	-	-
Paramedical Training Institutes	4	400	-	-	-
Schools of Public Health	-	-	-	-	-

Capacity is the annual number of graduates from these institutions.

Sources: Human Resource Development Directorate Database, Ministry of Public Health 2004
Medical schools in each province

Accreditation, Registration Mechanisms for HR Institutions

The HRD directorate of the MOPH has been established in 2004. This department has set up testing and certification board for midlevel health workers who have graduated from outside of the MOPH training centers and institutes.

7.2 Human resources policy and reforms over last 10 years

In 2003 HRD directorate of MOPH and partners (donors, UN agencies, national and international NGOs, embassies and line ministries), based on the recommendations of a national workshop, held on January 2003, developed a national HRD policy. Now HRD department in cooperation of concerned partners is going to revise the policy based on the current needs. In 2004 the new structure of HRD directorate was developed along with the job description of all 22 central level staffs.

7.3 Planned reforms

- To develop job description for all MOPH employees
- To revise HRD policy and strategy
- To implement Priority Reform and Restructuring (PRR)
- To train and develop MOPH staff capacity
- To implement public health administrative capacity building plan
- To develop capacity building for clinical skills
- To make questions bank
- To certify health workers

8 HEALTH SERVICE DELIVERY

8.1 Service Delivery Data for Health services

Table 8-1 Service Delivery Data and Trends

TOTAL (percentages)	2000	2002	2003	2004
Population with access to health services	35% (97)	-	-	77% (05)
Married women (15-49) using contraceptives	5%	5%	10.3%	21.9%
Pregnant women attended by trained personnel	37%	7%	16.1%	-
Deliveries attended by trained personnel	12%	12%	14.3%	-
Infants attended by trained personnel	-	-	-	-
Infants immunized with BCG	48%	59%	56%	56%
Infants immunized with DPT3	32%	47%	54%	66%
Infants immunized with Hepatitis B3	-	-	-	-
Infants fully immunized (measles)	37%	44%	50%	60%
Population with access to safe drinking water	13%	-	40.2%	-
Population with adequate excreta disposal facilities	12% (98)	-	-	-

Sources: MICS 2003

National EPI Coverage Ministry of Public Health
The state of the world children 2004, UNICEF

URBAN (percentages)	2003
Population with access to health services	-
Married women (15-49) using contraceptives	21%
Pregnant women attended by trained personnel	38.3%
Deliveries attended by trained personnel	34.8%
Infants attended by trained personnel	-
Infants immunized with BCG	-
Infants immunized with DPT3	-
Infants immunized with Hepatitis B3	-
Infants fully immunized (measles)	-
Population with access to safe drinking water	61%

Population with adequate excreta disposal facilities	-
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Sources: MICS 2003

RURAL (percentages)	2003
Population with access to health services	-
Married women (15-49) using contraceptives	6.1%
Pregnant women attended by trained personnel	8%
Deliveries attended by trained personnel	6.9%
Infants attended by trained personnel	-
Infants immunized with BCG	-
Infants immunized with DPT3	-
Infants immunized with Hepatitis B3	-
Infants fully immunized (measles)	-
Population with access to safe drinking water	31.2%
Population with adequate excreta disposal facilities	-

Sources: MICS 2003

Access and coverage

Access to primary care:

The majority of the Afghan population does not have access to a health facility and thus to the basic services that could make a large difference to their health. The reasons for this situation are complex, and include inadequate number of female health staff in rural areas; shortage of skilled health staff in rural areas generally; lack of managerial capacity particularly at provincial level; and, managerial and organizational structures that do not provide incentives or accountability for results. Of the 912 facilities listed as active in Afghanistan National Health Resource Assessment conducted on 2002, not all offer all services that are included in the BPHS or are all personnel assigned to the facility working. One third (95 districts) of all districts are currently above the 1 facility to 30,000 population norm proposed by the MoH as a short-term goal. Moreover, the distribution of health facilities is not at all geographically balanced, and there is significant variation in the number of population served by one facility between provinces as well as districts within provinces. In addition, successful implementation of the BPHS requires essential medical and technical equipment and specific supplies, as well as electricity and access to safe drinking water.

Access to secondary care:

Since the Essential Package of Hospital Services has been budgeted and implementation has not yet been started therefore the coverage for the secondary and tertiary health care is still not known.

8.2 Package of Services for Health Care

MOPH developed separate packages for health service delivery at primary, secondary and tertiary levels. Basic Package of Health Services (BPHS) for primary health care and Essential Package of Health Services for secondary and tertiary health care.

8.3 Primary Health Care

Infrastructure for Primary Health Care

Health services in Afghanistan operate at three levels. At the community or village level there are health posts (HP) and community health workers (CHWs). In larger villages or communities of a district are Basic Health Centers (BHC), Comprehensive Health Centers (CHC), and District Hospitals. The third levels are the provincial and regional hospitals. In urban areas, for the time being and due to a general lack of facilities offering basic curative and preventive services, urban clinics, hospitals and specialty hospitals provide the services that in rural areas are provided by the HPs, BHCs and CHCs.

BPHS addresses the main primary health priorities such as Maternal and Newborn Health, Child Health and Immunization, Public Nutrition, Communicable Diseases control, Mental Health, Disability and Supply of Essential Drugs. There is standardized system of names for health facilities like Health Post, Basic Health Center, Comprehensive Health Center and District Hospital.

Public/private, modern/traditional balance of provision

Public-private ownership mix;

Currently the private sector (NGOs) is running health services at the primary level and the public health sector (MOPH) is overseeing NGOs activities and playing main role in monitoring, evaluation, financing and capacity building.

Public Sector:

The public health sector (MOPH) described as given above.

Primary care delivery settings and principal providers of services; new models of provision over last 10 years

There is standardized system of names for health facilities in primary care delivery settings such as Health Post, Basic Health Center, Comprehensive Health Center and District Hospital. The providers are NGOs. At the initial stage in the last 10 years the PHC model was used and recently in the last three years the Basic Package of Health Services has come into being.

Public sector: Package of Services at PHC facilities

BPHS is the package of services at primary health level. BPHS addresses the main primary health priorities such as Maternal and Newborn Health, Child Health and Immunization, Public Nutrition, Communicable Diseases control, Mental Health, Disability and Supply of Essential Drugs. Treatment of chronic conditions is ignored in the document.

Private sector: range of services, trends

The part of the economy of a country that is not under the direct control of the government is called private sector. There are a number of different players in the private sector in many countries. These can be summarized as: private-for-profit, private not-for-profit, and informal sector. Health policy and strategy need to cover the private provision of services and private financing, as well as state funding and activities, in other words be sector wide. Only in this way can health systems as a whole be orientated towards achieving goals, outcomes and outputs that really do make a difference, for the better, to the health of the population in the country. Good stewardship helps ensure such an approach.

Many years of conflicts and civil strife resulted to limited public health service delivery system. It subsequently moved the health service delivery trends toward privatization and many primary, secondary and tertiary health facilities have been established in center of cities. But nationally there is no accurate data available.

Referral systems and their performance

First referral hospital is available for almost 77% of population. Afghanistan is lacking secondary and tertiary levels hospital. The majority of complicated cases that need specialized treatment are being referred to Kabul.

Utilization: patterns and trends

No specific data.

Current issues/concerns with primary care services

MOPH new national policy (2005-2009) and strategy (2005-2006) focuses on accelerating the implementation of essential, basic services at all levels of the health sector. To successfully do this, both new and existing challenges have to be dealt with. Rigorous, focused health policy and planning has to be performed in the following three areas:

- Implementing health services
- Reducing morbidity and mortality
- Institutional development.

In addition, there are also three different situations requiring particular strategic approaches for people living in areas which are:

- Not currently covered by any health services
- Underserved districts with poor access to health services
- Suffering from the emergency withdrawal or collapse of contracted out services.

The Ministry of Public Health faces many challenges in ensuring the most efficient mechanisms for delivery of health services. The Ministry will retain responsibility for managing and delivering services in a few provinces through the so-called Ministry of Public Health Strengthening Mechanism (MoPH-SM). However, health services in many other provinces and districts have been contracted out to NGOs.

In the near future it is highly likely that the Ministry will need to accept more direct responsibility for health services as about 23% of the population now live in areas that are either underserved or not served at all. However, only about 77% of the population

lives in areas covered by basic health services, with many of these services presently contracted out to NGOs. In the longer term the Ministry will also need to take into account the following possibilities:

- Reductions in external donor funds for contracting NGOs
- Increasing demands on central government funds
- Return of many hospitals to direct Ministry control
- Rising expectations in the population for access, quality and range of services
- More services provided by private medical services in the main urban centers.

Planned reforms to delivery of primary care services

Priority Reform and Restructuring at both central and provincial levels.

8.4 Non personal Services: Preventive/Promotive Care

Availability and accessibility:

Preventive care is part of the BPHS. The BPHS delivery is expanded to almost 77% of the population.

Affordability:

As stated in the Afghanistan constitution all health services are free. Although there is cost sharing policy running by NGOs but the cost are pretty affordable by the targeted community.

Acceptability:

Fortunately all available health services are socially, economically, religiously and culturally acceptable for the majority of the population.

Organization of preventive care services for individuals

Following departments come under the organization structure of PHC and Preventive medicine general directorate, in MOPH: health education and publication, public nutrition, disease prevention and control and emergency preparedness, EPI, Environmental health, mental health, national TB Program, and national malaria and leishmaniasis program.

Comment [EM12]: HIV/AIDS project is also operating under department of preventive medicine and CBHC department demand drug reduction

Environmental health

MOPH has an environmental health department in its structure with the main purpose to reduce the burden of disease associated with unsafe water supply, inadequate sanitation and hygiene, occupational hazards, and ill (polluted) environment in the workplace and at home amongst the vulnerable groups. The term of reference for the department is given in below:

1. Provide leadership in the process of EH program policy and strategy development.
2. Provide leadership in formulating national EH plans, standards, protocols and program budget.

3. Coordinate all EH related activities with concerned directorates within MoH in collaboration with stakeholders.
4. Ensure environmental health impact assessment of the developmental projects.
5. Conduct environmental audits of existing projects.
6. Prepare the plan for conduction of quality environmental inspection (sanitary inspection of hotels and food production places, industrial plants, commercial places, agribusiness etc.).
7. Prepare the plan for conducting training of the staff.
8. Supervise and monitor environmental health related issues at central and provincial levels.
9. Collect , compile, analyze data and provide feedback
10. Preparing and designing environmental health related projects, and sharing it with other relevant directorates and agencies.

This department is responsible and accountable to the PHC and Preventive Medicine director general. The sub units are: Occupational health, Public health lab, Environmental health management and Pollution prevention and control.

Health education/promotion, and key current themes

Department of health education and publication aims to promote the adoption of healthy behavior and optimal use of health services and ensure that health is a valued individual and community asset. The main scope of work of this department is to:

- Provide leadership in the process of IEC program policy and strategy development.
- Provide leadership in formulating integrated national IEC plans and program budget.
- Coordinate all IEC related activities with concerned directorates within MoH in collaboration with stakeholders.
- Supervise and monitor IEC component of health projects at central and peripheral levels.
- Facilitate the development process of health education materials.
- Standardize messages of national scale programs e.g. EPI, Nutrition, TB, Malaria, Breast Feeding, Basic Hygiene etc.
- Publish health education materials.
- Collect, compile analyze data and provide feedback
- Supervise the printing press.
- Identify training needs and develop training plan for relevant staff at all levels.

This department is accountable and reporting to the Director General of PHC and Preventive medicine.

Changes in delivery approaches over last 10 years

During the last 10 years, initially, NGOs and Government were offering preventive and promotive health care separately without following the unified policy and strategies. But in the recent three years NGOs are implementing and MOPH is playing the role of stewardship.

Current key issues and concerns

MOPH will put more emphasis on developing a comprehensive Information Education and Communication policy and strategy. Other concern will be to establish a well coordination mechanism with all stakeholders and try to standardized health education messages and incorporate in to the BPHS at all levels and finally try to identify training needs for relevant staff at all levels.

Planned changes

- Overall reform and restructuring
- Integration of vertical programs in to the BPHS
- Widening the strengthening mechanism to be able to take over from NGOs
- Rolling out the pilot health care financing options such as user fee, community health fund and health insurance schemes
- Strengthening of community based health care.

8.5 Secondary/Tertiary Care

Table 8-2 Inpatient use and performance

	1990	1995	2001	2002	2004
Hospital Beds/1,000	-	-	0.39	0.16	0.42
Admissions/100	-	-	-	-	-
Average LOS (days)	-	-	-	-	-
Occupancy Rate (%)	-	-	-	-	-

Sources: Demographic and Health Indicators for Countries of the Eastern Mediterranean 2004
Afghanistan National Hospital Survey October-November 2003,

Public/private distribution of hospital beds

Public hospitals beds per 1000 population is figured out in the table 8-2. No figures are available for the private distribution of hospital beds.

Key issues and concerns in Secondary/Tertiary care

The Ministry of Public Health (MOPH) of Afghanistan determined the priority health services which would address the most immediate needs of the population. That culminated in the release of "A Basic Package of Health Services for Afghanistan" in March 2003. This package included the most needed services at the health post and health center level of the health system.

After establishment of the Basic Package of Health Services (BPHS), the Hospital Management Task Force of MOPH felt the need for development of a framework for the hospital element of the health system. The Basic Package made clear the need for a primary care based health system, which requires having a functioning hospitals system in order to have an appropriate referral system where all health conditions may be treated. Health services in Afghanistan operate at three levels. At the community or village level there are health posts (HP) and community health workers (CHWs). In larger villages or communities of a district are Basic Health Centers (BHC),

Comprehensive Health Centers (CHC), and District Hospitals. The third levels are the provincial and regional hospitals. In urban areas, for the time being and due to a general lack of facilities offering basic curative and preventive services, urban clinics, hospitals and specialty hospitals provide the services that in rural areas are provided by the HPs, BHCs and CHCs.

Hospitals are a critical element of the Afghan health system because they are part of the referral system which is required if there is to be a reduction in high maternal and early childhood mortality rates. In addition, hospitals utilize many of the most skilled health workers and the financial resources used by the health system. Hence, it is important that these scarce resources used by hospitals be used in an effective and efficient manner. This requires the dramatic improvement in the management of hospitals so they function better as part of the health system as well as ensuring that their resources are used more effectively. These needs for improvement are at all hospital levels—district, provincial and regional hospitals as well as the tertiary and specialty hospitals in Kabul.

As a consequence, the Hospital Management Task Force began working on a national policy on hospitals. A policy was needed in order to define the role of the hospital in the Afghan health system. First however, the key problems facing the Afghan hospital system had to be identified. The Hospital Management Task Force determined that the key issues facing hospitals could be summarized by five key problems and the resultant consequence:

1. Problem: Misdistribution of hospitals and hospital beds throughout the country
Consequences: Lack of equitable access to hospital cares throughout the country—people in urban areas have access but semi-urban and rural populations have limited access. For example Kabul has 1.28 beds per 1000 people while in provinces they have only 20% of the beds/pop that Kabul has (0.22 beds per 1000 population)
2. Problem: Lack of standards for clinical patient care
Consequences: Poor quality of care,
3. Problem: Lack of hospital management skills for operation of hospitals
Consequences: Inefficiently run hospitals, poorly managed staff, lack of supplies, unusable equipment due to lack of maintenance
4. Problem: Hospital system is fragmented and uncoordinated, hospitals are not integrated into the health system
Consequences: Referral system does not work—people from rural areas and basic health centers not referred to hospitals for problems, such as problem pregnancies. So there is a lack of support for Basic Package of Health Services based system for secondary and tertiary services. The roles of hospitals in a BPHS-based health system have not been spelled out.
5. Problem: Financial resources for hospitals and sustainability
Consequences: Virtually all hospitals in Afghanistan lack adequate financial resources. There is a need to develop a user fee system to help finance hospitals while ensuring there are exemption mechanisms for the poor so they continue to have access to care.
6. Problem: Lack of qualified personnel, especially female, in remote areas.

Consequences: difficulties to guarantee 24-hour coverage, problems with quality of care provided to female patients.

As a result of the Hospital Management Task Force's review of the situation, a national policy was adopted in February 2004 by the MOPH that had been drafted by the Hospital Management Task Force. This policy provided the rational, structure and guidelines needed to complete the definition of a health system that was appropriate for Afghanistan by clearly (1) identifying the needs of the hospital sector, (2) establishing 10 key policies relative to hospitals, (3) setting forward 31 standards for hospital in 6 major areas (responsibilities to the community, patient care, leadership and management, human resource management, management systems, and hospital environment), (4) identifying the levels of hospitals in the system and (5) the need for rationalizing hospitals. This is the framework by which work in the hospital sector is moving forward.

The hospital sector did not receive significant attention for donors, probably because of its perceived recurrent cost.

Reforms introduced over last 10 years, and effects

Hospital policy and Essential Package of Hospital Services have been developed in the recent three years. Priority Reform and Restructuring (PRR) is in the process of implementation.

Planned reforms

Implementation of the new EPHS through PRR.

8.6 Long-Term Care

8.7 Pharmaceuticals

Essential drugs list: by level of care

National essential drug list is included at national level of essential drug and regional level but in Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) the drug list is available at health post, Basic Health Center, Comprehensive Health Center, District Hospital, Provincial Hospital and National Hospital.

Manufacture of Medicines and Vaccines

Very limited items of drugs are produced locally but mainly good quality manufacturer of medicines and vaccines are not available.

Regulatory Authority: Systems for Registration, Licensing, Surveillance, quality control, pricing

Regulatory authority according to the newly developed drug law and regulation is responsibility of the pharmaceutical affairs department of Ministry of Public Health.

Systems for procurement, supply, distribution

Presently main supply, procurement and distribution of medicines are run by private sector but for public sector (MOPH and Health facilities) donors provide essential drugs.

Reforms over the last 10 years

- Revision, updating and development of drug law
- Develop national medicine policy, pharmacies law, manufacturing regulation, traditional medicine, price control and advertising regulation.

Current issues and concerns

Afghanistan is in the phase of implementation of the new organogram, laws and regulations.

Planned reforms

Implementation of the new policy and strategy with the recent MOPH organogram could be considered as planned reforms.

8.8 Technology

Generally MOPH is trying to bring new technology in the health system either in preventive side or curative side. One of the example is the setting up of the information technology unit in the MOPH structure with main responsibilities to ascertain the needs, organizing the meeting of those needs and maintaining all information technology equipment and systems so that the MOPH is able to maintain necessary communication linkages with all offices and provinces. This unit is striving to:

- Ensure well operating information system in the MOH.
- Establish IT system in the provinces and ensure proper communication network.
- Liaise with the Supply and Logistic Directorate for ordering of IT and communications equipment
- Ensure the development of the necessary systems to maintain an IT system in the MOH and provinces
- Maintaining all IT equipment, Internet and radio systems.
- Conduct IT training for MoH staff at all levels.
- Provide regular reports.

MOPH is willing to bring new technology especially in the secondary and tertiary health care system by establishing diagnostic health centers in long run. MOPH has put the telemedicine unit in its new structure with emphasis to seek health care from distant that is a cost effective approach for improving health status in Afghanistan.

Trends in supply, and distribution of essential equipment

For provision of supply and equipment, MOPH has contracted with the main agencies like Japan International Cooperation System (JICS) and the World Bank.

Effectiveness of controls on new technology

There is no figure available to indicate its effectiveness. Since government is in the establishment phase rather than in the implementation phase to measure effectiveness.

Reforms in the last 10 years, and results

The new health system and reform in the last three years is worth mentioning. The results are awaited for the third part evaluation of the programs.

Current issues and concerns

Since we are facing gaps in BPHS delivery as well as in EPHS implementation therefore bringing in new technology is in the second tier and the main concern is the high cost implication.

Planned reforms

Implementation of the current reforms for bringing main changes in the health sector is challenging for MOPH.

9 HEALTH SYSTEM REFORMS

9.1 Summary of Recent and planned reforms

MOPH is in the process of health system reform by bringing changes in the main control knobs such as Financing, Payment, Organization, Regulation and Behavior. For instance PRR, developing new policy and strategies, EPHS, BPMS, piloting new financing options, new MOPH structure are the main reform procedures developed and are in the process of implementation.

Determinants and Objectives

The reform in the government is required to document evidence to demonstrate the followings: Relevant government priorities as expressed in the National Development framework have been fully considered and taken into account, the MOPH has reviewed to determine the nature of its activities such as Policy formulation, regulation, Coordination, supervision and performance monitoring, full consideration has been given to shedding activities and responsibilities that can reasonably be abolished, rationalize activities, reducing the volume or complexity of activities, retained functions are those essential to Ensure public safety and comply with national or international law.

Chronology and main features of key reforms

Afghanistan health sector has been confronting various reforms by different political parties that were in power for different duration. From 1978 onward, first the communist regime has brought reform in the health system, which has been followed by the Mujahedin, Taliban, Transitional Islamic government of Afghanistan and Islamic republic of Afghanistan.

The nature of the health system during communist regime was most curative oriented, as well as during Taliban and Mujahedin, but fortunately recently the health system is changing its nature to both curative and preventive.

Process of implementation: approaches, issues, concerns

For the implementation of the reforms the national health policy and strategy outlined the main priority policy and strategy and set specific goals and targets. And verifiable indicators were defined for measuring the process of implementation.

Progress with implementation

The new structure of the MOPH is in the process of implementation of its first six month plan of action.

Process of monitoring and evaluation of reforms

The MOPH intends to hold itself and its partners accountable for achieving the goals and targets it has established. This will be done through appropriate household and health facility surveys carried out with 3rd party assistance.

Results/effects

The results will be provided by the third party evaluation in future.

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10.1 Source Documents

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11 ANNEXES

11.1 Summary of Annexes

- Annex I (MOPH Organogram 2005)
- Annex II (BPHS Coverage by Donors, 2003 through February 2005)

GD of Provincial
Public Health (F)

Provincial Public
Health Direct.
(2,1)

Children
Specialized
Hospital Dir. (2)

IMCI Dept (2)

School Health
Unit (3)

Children &
Adolescent Health

Ob/G
P

Safe

Fam
Prog