THE AFGHANISTAN CASE STUDY

Working Paper of the collaborative NATO-Harvard project:

TOWARDS A COMPREHENSIVE RESPONSE TO HEALTH SYSTEM STRENGTHENING IN CRISIS-AFFECTED FRAGILE STATES

NATO JOINT ANALYSIS AND LESSONS LEARNED CENTRE
THE AFGHANISTAN CASE STUDY

Working Paper of the collaborative NATO-Harvard project:
Towards a Comprehensive Response to
Health System Strengthening in Crisis-affected Fragile States

This project was conducted jointly by researchers from Harvard University School – Department of Global Health and Social Medicine and analysts from NATO’s Joint Analysis and Lessons Learned Centre under the sponsorship of NATO’s Allied Command Transformation. Additional funding for this case study was provided by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.

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FOREWORD

A joint study team from NATO's Joint Analysis and Lessons Learned Centre, Harvard Medical School, and the Harvard Humanitarian Initiative was engaged in an ongoing study project to infer elements of a strategic framework for health system strengthening in crisis-affected fragile states. The joint study team has adopted a multi-case study approach, and it is with great pleasure that we release this working paper documenting the findings from the subject of this case study: Afghanistan, since the international military intervention in 2001.

The paper addresses four key themes: the impact of the conflict; the security community's participation in health system recovery and reconstruction; the coordination mechanisms that facilitated or directed the security community's involvement; and the information generating and sharing mechanisms that allowed the security community to best participate in health system strengthening. Investigations into these four themes were focused through the use of the narratives given in the Annexes to this paper.

The outcome of this case study is a number of key takeaways and food for thought which highlight the possible involvement of the security community in health system strengthening in crisis-affected fragile states.

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Effective comprehensive response to health system strengthening in a crisis-affected fragile state demands coherent action by all participating actors. Coordinating the desired outcomes and the required actions of the humanitarian, development and security communities presents a particularly complex challenge.

A joint team from NATO’s Joint Analysis and Lessons Learned Centre and the Harvard Medical School is engaged in a project with the overarching aim of inferring elements of a strategic framework for health system strengthening in crisis-affected fragile states: one which focuses on the optimal use of all global contributions. The team decided to use four case studies of international interventions in crisis-affected fragile states as the primary foci for their research.

As a record of the second case study, this working paper documents the results from investigation in Afghanistan, a country that is experiencing the cumulative effects of over three decades of war and instability. Since 2001, the international community has contributed billions of dollars and much human effort towards stabilizing and rebuilding Afghanistan, including the health system. The NATO-led International Security Assistance Force (ISAF) has supported the government of Afghanistan in multiple ways in their attempt to re-establish viable health systems in both the military and civilian sectors.

Four key issues were investigated during this study: the impact of the crisis on the Afghan health system; the security community’s participation in health system recovery and reconstruction; the coordination mechanisms that facilitated or directed the security community’s involvement; and the information generating and sharing mechanisms that allowed the security community to best participate in health system strengthening.

Investigations were further focussed through the use of three narratives, which are given in the Annexes to this report.

FINDINGS

In Afghanistan, the security community has not been able to establish a consistently secure environment throughout the whole country to date and therefore development has suffered in insecure areas. Because health is seen as a key component of development—and improved health is expected to contribute to stability—the security community supported and invested in health development programmes. However Afghanistan provides scant evidence to show that health system strengthening improves stability or supports counterinsurgency efforts. Sustained insecurity and violence continue to have a major impact on the provision health care. These ongoing concerns force humanitarian, security, and development actors to share the same operating space, creating a wide range of issues in terms of coordination: between relief and development, civil and military, public and private, donors and service providers. This includes the fields of responsibility becoming blurred and creates the potential for the perceived impartiality of civilian actors to be eroded.

The Afghanistan case reveals that humanitarians are often uncomfortable with the involvement of the security community in the health sphere and as a result there are limitations on the extent to which the security community can involve itself in health and development efforts.

IDEAS TO TAKE FORWARD

Three takeaways have been identified for consideration by global crisis responders in developing future frameworks for strengthening health systems in fragile states:
a. In a crisis situation, the security community can be an appropriate contributor to strengthen some elements of the health system.

- ISAF has put a great deal of effort into developing an Afghan National Security Forces (ANSF) health care delivery system capable of providing acceptable field-level combat casualty care, restorative surgery, rehabilitation, and long-term care for ANSF personnel.

b. Afghanistan provides no proof that the success of direct medical engagements led by security actors contributes to a wider strategy to win hearts and minds. However there have been some notable successes in which medical programmes have been aligned with operational objectives and have promoted the credibility and capacity of the host nation.

- Direct health interventions by military, such as Medical Civic Action Programmes were eventually recognized to be counter-productive because they undermined the confidence of the people in the capabilities of local government and the Ministry of public Health and so hindered the development of capacity in the Afghan public health system.

- The main strategy shifted to supporting governance, which is seen as a key factor to change population perceptions and a facilitator to the stabilization process. Good governance can contribute to improved security and is a pre-requisite for health system strengthening, through high visibility actions, synchronizing efforts with the other actors, and better aligning with the priorities of the host nation.

c. Coordination and mutual understanding among the key actors from the humanitarian, development and security communities are indeed essential to ensuring coherent responses.

- The polio eradication campaign in Afghanistan shows how, by adopting a passive support approach, the security community can align their activities with humanitarian and development actors so as to avoid conflict where (and while) immunization campaigns are active. ISAF adopted a new approach to support the humanitarian and development community actors, by enforcing and promoting the necessary neutrality, and by desisting from any involvement in or use of the campaign for other purposes.

- With Afghanistan’s health system 90% dependent on foreign aid, it seems wasteful that the different health systems (Afghan National Army, Afghan National Police, and civilian) are not better coordinated so as to avoid overlap, competition and waste.

**FOOD FOR THOUGHT**

Humanitarian, development, and security communities operating in the same space often hold different views about local needs and their respective roles in dealing with them. Overlap between civilian and military efforts, especially with such a large numbers of players, has created many challenges in Afghanistan, as the host nation has limited ability to ameliorate tension, confusion and complications between the conflicting agendas of donors, troop contributing nations and NGOs working in the same space. To improve the value of future investments in health system strengthening, the security community should focus heavily on coordination efforts from the beginning, as well as on impact evaluation and monitoring. This would create viable foundations for a system that would continue to benefit the country long after the international investors leave, as well as allowing the security community to iteratively adjust its interventions and resource investment decisions and change paths as needed to respond to the complexity of the situation.
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INTRODUCTION

1. This report is the second in a series of four case studies being undertaken by a joint study team from NATO's Joint Analysis and Lessons Learned Centre (JALLC) and the Harvard Medical School that will contribute to an overarching report. The scope of the overarching report is to examine the relationship between health system strengthening in crisis-affected fragile states and the activities of the security community, particularly through the employment of their military assets in those states. The corresponding overarching report will seek to infer elements of a strategic framework for health system strengthening in crisis-affected fragile states. The intended audiences for the project's products are policy and decision-makers in the humanitarian, development and security communities who are interested in achieving a comprehensive response to health system strengthening in crisis-affected fragile states.

2. Afghanistan was chosen for a case study because it was seen to meet the three criteria the team established for cases that would most likely yield the insight needed to inform the overall project: 1) A fragile state whose health system was threatened by a series of human security crises. 2) Implementation of a crisis response directed towards health system strengthening. 3) Presence of a multinational military force with a stabilization mandate.

3. A great deal of literature has been produced examining the Afghanistan conflict and the international response to it, much of which has served as source material for this case study. It is not the intention of this report to duplicate that literature or to serve as a historical record of events in Afghanistan. For that reason, this case study’s findings are based on a carefully selected set of narratives that the team believes best illustrate the lessons from Afghanistan that will be most useful in addressing the project’s aim. The narratives used to reach the case findings are presented immediately following this report.

METHODOLOGY

4. The research was carried out from July 2012 to May 2013. The joint civilian-military study team from Harvard and NATO progressed through four phases of data collection and iterative analysis: background research, background interviews, field-based data collection—mainly through the presence of a JALLC Permanent Representative in the headquarters of the International Security Assistance Force (ISAF)—and data analysis and report writing. The study team achieved access to both the military and civilian actors and perspectives. The fundamental unit of analysis in this project is the health system in the fragile state, in this case the Afghan health system.

5. The team used the WHO Health System "Building Block" Framework as a guide for considering how the security community may have impacted aspects of Afghanistan's health system. The framework, shown in Figure 1, describes health systems as consisting of six building blocks: service delivery, health workforce, information, medical products, vaccines & technologies, financing and leadership/ governance. These building blocks contribute to improved health of the population, improved responsiveness to the population’s health needs, increased social and financial risk protection, and improved efficiency.
Seven questions for this case were also formulated to guide the research within the context of the chosen health system framework and with the final project aim in mind. These questions were grouped as follows:

a. How did the crisis impact the Afghan health system? How has this situation changed since the fall of the Taliban?

b. How did the security community participate in health system recovery and reconstruction? How were the Afghan National Security Forces (ANSF) health systems developed? What unintended consequences has this had?

c. What were the coordination mechanisms, both formal and informal, that facilitated or directed the security community’s involvement?

d. What were the information generating and sharing mechanisms that allowed the security community to best participate in health system strengthening?

Phase one: Background Research
7. The study team conducted a comprehensive review of scholarly articles, written interviews, after action reviews, lectures, websites, relevant NATO and US doctrines, and newspaper and magazine reports about the international response in Afghanistan. Particular focus was given to where military assets made direct contributions in health sector response and reconstruction, and how these assets coordinated with other responders during participation. This phase took place from July 2012 to September 2012.

Phase two: Background Interviews
8. The study team held discussions with key personnel who were knowledgeable about Afghanistan’s health sector, governance, and history. Based on information from these background interviews, the study team generated a data collection plan that included specific questions and an initial list of stakeholders to be interviewed. To encourage participants to share their candid views and protect them from political or social liability, we agreed comments would not be attributed nor would we disclose the identity of the participants or the specific organization for which they worked. This phase took place from September 2012 to October 2012.

Phase three: Field-Based Data Collection
9. Due to security reasons, the joint study team was not able to travel to Afghanistan. However two JALLC team members had recent ISAF experience and the team used the JALLC Permanent Representative in HQ ISAF in Kabul to establish contact with major
stakeholders who were identified during initial interviews. The JALLC Permanent Representative was then able to conduct a series of interviews on behalf of the team. Until early April 2013 the team attended meetings, organized interviews and conference calls with officials known to have been involved in the international efforts in Afghanistan, including key representatives from the Afghan public and private health sectors, NGOs, donor agencies, national development agencies, UN agencies including the UN Assistance Mission in Afghanistan (UNAMA), military response organizations and foreign diplomatic representation.

10. The interviews were semi-structured; having a framework of themes to be explored, but allowing new ideas to be brought up during the interview as a result of what the interviewee said. The common framework of themes included:

   a. the participant’s role and involvement in health system protection or recovery in Afghanistan;
   b. the participant’s understanding of the major challenges faced in addressing Afghans’ health needs;
   c. the participant’s perspective on the security community’s impact on health system protection and recovery;
   d. the information and coordination mechanisms the participant used to interact with the global response and/or security community;
   e. the participant’s perceptions of what went well and what could have been improved in terms of recovering and strengthening the health system in the aftermath of the 11 September 2001 attacks in the United States and resulting operations in Afghanistan.

11. Interview notes were compiled into interview transcripts which were then reviewed by the study team, which then extracted the salient issues and recurrent themes. This phase concluded in early May 2013.

Phase four: Data Analysis and Report Writing

12. The data collected in the previous phases was reviewed and further investigated through targeted research—including additional interviews—which refined and deepened the team’s understanding of the salient findings. With this deeper understanding, the team identified the key themes and issues and selected the major stories to develop into narratives that would best illustrate these themes. Narratives were built around instances of when the security community impacted one or more aspects of Afghanistan’s health system.

13. A draft report was written and circulated for comments and feedback to informal advisors familiar with health system strengthening issues, military policy, and civilian military interactions. Based on the feedback the final draft of the case study report was prepared. Final review and editing of this report took place in September 2013.

LIMITATIONS

14. A twelve-month exploratory study possesses inherent limitations for a context as complex as Afghanistan, not least owing to the length of the crisis and the number of actors involved. The time elapsed since the events occurred may have shaped participants' recollections and influenced their judgments of what events were important and which stakeholders they now consider influential.

15. The security challenges in Afghanistan and the time-limited nature of the study prevented the research from continuing until all possible leads had been followed and forced the team to focus their research on the most accessible parts of the story. They confronted constant trade-offs between exploring specific issues in depth and capturing the breadth of issues relevant to the security community’s involvement in the health sector. The study team discussed these trades-offs and decisions systematically and at length during both the data collection and the production of this report. They attempted to strike a balance, with the
issues presented in this report representing those most salient and notable to developing elements of a strategic framework for health system strengthening in crisis affected fragile states.

16. The findings and conclusions put forth in this study should be viewed as key takeaways in support of the final report.
AFGHANISTAN – A BRIEF HISTORY

17. Afghanistan is a landlocked central Asian country of more than 30 million people. It comprises 34 provinces with approximately 400 districts and almost 80% of the population lives in rural areas¹.

18. Starting with a coup in 1973, a communist counter-coup in 1978 and subsequent Soviet invasion in 1979, four decades of successive wars have killed over one million Afghans². Insurgents, funded in part by the western world, continued to resist the Communist regime and when the Soviets withdrew their support to the regime in the 1990s, a civil war erupted which did not end even when the fundamentalist Taliban took control of the capital, Kabul, in 1996 and established the Islamic Emirate of Afghanistan.

19. Although the Taliban takeover provided a degree of political stability, the main focus of their government was on implementing an ultra-conservative interpretation of Islamic law. There was little effort spent on developing modern state functions and the country remained divided along regional and ethnic lines, with tribal and ethnic identities continuing to conflict with the central state.

20. The attention of the world was drawn to the Islamic Emirate of Afghanistan following the attacks on the World Trade Centre on 11 September 2001: the Taliban were accused of providing sanctuary to those responsible for the attacks—Osama Bin Laden and al-Qaeda. Operation ENDURING FREEDOM (OEF) began on 07 October 2001, with the armed forces of the United States, the United Kingdom and Australia entering Afghanistan in concert with the Afghan United Front (aka the Northern Alliance). The stated aims were to capture Osama Bin Laden and other high-ranking al Qaeda members, to destroy al Qaeda, and to remove the Taliban regime which supported and gave safe harbour to al Qaeda.*

21. On 12 November 2001 Taliban forces fled Kabul and by mid-December 2001 Kandahar—the last Taliban-controlled city—had fallen, and the majority of the Taliban fighters had disbanded. Members of the Taliban leadership and al-Qaeda personnel, including Osama Bin Laden, fled into the federally-administered tribal areas of northern Pakistan and the Afghan Interim Administration (AIA) was established at the Bonn Agreement in December 2001. This was succeeded by the Afghan Transitional Administration (ATA) from July 2002 until December 2004 when the first Government of the Islamic Republic of Afghanistan (GIRoA) was elected.

22. ISAF was also envisaged by the Bonn Agreement—and subsequently ratified by UN Security Council Resolution 1386—as a security mission to allow for the establishment of the ATA in the Kabul area and to provide training for the ANSF. In 2003, NATO assumed command of ISAF and by 2006 the ISAF mission was broadened to cover the whole of Afghanistan. The mission has continued to develop over the next decade into the counter-insurgency campaign with which we are now familiar. International military forces remained in Afghanistan to provide security and stability, to combat residual Taliban and Al Qaida elements and to support the development of ANSF: all to ensure that Afghanistan did not

¹ UN Security Council Resolution 1378 of 14 November 2001, included "Condemning the Taliban for allowing Afghanistan to be used as a base for the export of terrorism by the al-Qaeda network and other terrorist groups and for providing safe haven to Osama bin Laden, al-Qaeda and others associated with them, and in this context supporting the efforts of the Afghan people to replace the Taliban regime".
return to being an ungoverned space within which terrorist training and preparation could flourish.

A CRISIS-AFFECTED FRAGILE STATE

23. Afghanistan is experiencing the devastating cumulative effects of over three decades of war and instability. The Afghan political and security environments are fragile: the ostensible end to each successive conflict did not bring an end to high levels of violence and instability. Links between central, provincial, district and village governance in Afghanistan are either non-existent or very weak. Alleged fraud and widespread corruption have also undermined international confidence in the GIRoA and led to the suspension of funding to some reconstruction and development projects. The country is expected to have little economic generation capacity by 2014 and it is anticipated to revert to low-income-country status in the coming years.

24. According to the UN High Commissioner for Refugees (UNHCR), Afghanistan had the largest annual number of refugees leaving the country of any nation from 1980 to 2001. More than 5.7 million refugees have returned to Afghanistan since 2002, increasing the population by 25%. More than 40% of returnees had not reintegrated into their home communities by 2011, making for a large population of internally displaced persons.

25. In 2013 Afghanistan ranked 175th out of 186 countries on the Human Development Index. 36% of Afghan households are unable to obtain the means to satisfy their basic subsistence needs and the UNDP new multidimensional poverty index (based on health, education and standard of living) suggests that 84% of Afghan households should be considered poor. This takes into account that, despite improvements, only 42% of the rural population has access to an improved water source and only 37% of the population has access to improved sanitation facilities, at the current rate of progress, Afghanistan will not meet the Millennium Development Goal for water until 2042, 22 years after the target. In addition, the educational dimension includes an illiteracy rate of approximately 78% for women and 48% for men.

26. The ubiquitous presence of explosive devices and weapons also continues to make social and economic reconstruction in Afghanistan very difficult. In 2003, after many years of conflict, Afghanistan had over 10 million landmines and other unexploded ordnance. Between 1989 and the end of 2012, over 20,000 minefields were cleared, however 4,500 minefields remained, some in areas that posed a direct threat to the population.

THE HEALTH SYSTEM

27. Prior to 2002, Afghanistan’s health system mirrored the rest of the government: dysfunctional, poor, with little outreach to rural areas. The Afghan Ministry of Health’s budget was $1 per capita in 2002 and there was one public health centre for every 40,000 citizens in the central and eastern regions; and only 1 per 200,000 citizens in the south. In addition, only 9% of the population had access to an improved water source and only 37% of the population had access to improved sanitation facilities, at the current rate of progress, Afghanistan will not meet the Millennium Development Goal for water until 2042, 22 years after the target. Immunization coverage against childhood diseases hovered around a mere 20%.

28. The country’s healthcare system was dominated by NGOs; approximately 20 different organizations delivered fragmented, project based, care in a largely unregulated fashion. While little complete and high quality health data existed, the studies that were done showed health outcomes in Afghanistan to be among the worst in the world.

29. Today, NGOs still play an important role in the Afghan health system, receiving money from the Afghan Ministry of Public Health (MOPH) to ensure that a Basic Package of Health System (BPHS) reaches as much of Afghanistan as possible. Health services have also
been (separately) developed to serve the needs of the Afghan National Army and Afghan National Police, while trainers continue the arduous task of running 7-year courses to produce enough Afghan doctors to man these three health systems from the local workforce.

**Contributions of Global Actors**

30. The United Nations has been present in Afghanistan for some 40 years: there are currently 28 UN agencies, funds and programmes operating in the country under the umbrella of UNAMA. The World Bank, US Agency for International Development (USAID) and the EU are the major contributors to the health sector, along with the Asian Development Bank (ADB) in the field of health and UNICEF addressing immunization and safe motherhood. The WHO provides technical support to various national programmes that include polio, tuberculosis and malaria, but lacks the expertise to address the Afghan health system in its entirety.18

31. More than 3,000 local organizations are engaged in various forms of development assistance, and 190 NGOs are now registered with the Afghanistan NGO Coordinating Bureau.19 The NGOs cannot be seen as a homogenous group, however, and differ in how much they are willing to cooperate with the security community: some NGOs argue for broadening humanitarian mandates to include developmental and peace-building elements, but others are anxious to keep relief activities disconnected from the security community and nation-building activities, believing that if they are seen as impartial, neutral and independent they can operate without harassment from insurgents.

32. Before 2001, one factor that united NGOs working in Afghanistan was a strong sense of independence developed in the absence of government or a strong UN presence.20 In 1988 the Agency Coordination Body for Afghanistan (ACBAR) was formed and played a key coordinating role in setting policy and standards. Its creation was a response to a growing demand from many aid agencies and international donors for a coordinated approach to humanitarian assistance in Afghanistan. Other NGO coordination bodies proliferated as well. Many NGOs and some international NGOs were members of more than one such coordination body.

**Transition from Relief to Development Efforts**

33. UNAMA was created in 2002 to support the AIA and its successors in coordinating international civilian efforts and laying the foundation for peace, and ACBAR moved from coordination to advocacy on issues including government relations, legal analysis, civil-military relations and aid effectiveness. UNAMA brought the UN’s relief and development activities into a political framework, but did not gain the expected legitimacy across the entire country.21

34. The formation of an internationally-recognized Afghan transitional administration and the 2002 Afghan National Development Framework led to donors redirecting funding towards official government channels, becoming less supportive of NGOs. At the same time, large institutional actors such as the EU, World Bank, USAID and the UN operational agencies established offices in Kabul to focus on development.

35. The transition from humanitarian relief to a development approach impacted almost all NGOs, regardless of their original missions. Afghan authorities created the Afghan

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18 Coordinating agencies include: South-Western Afghanistan and Baluchistan Agency for Coordination, Afghan NGOs Coordination Bureau – (formed in 1991), the Islamic Coordination Council (established in 1986) and the NGO Coordination Body (established in 1995). In addition to that a variety of network organizations were also formed over the years: the Afghan Women’s Network (formed in 1996), the Afghan Civil Society Forum (2001). Outside Afghanistan there were also coordination initiatives such as the British Agencies Afghanistan Group, the European NGOs Network for Afghanistan and the US-based Afghanistan Reconstruction Working Group
Assistance Coordination Authority in 2002 to oversee international aid, and the responsibility for NGO coordination was handed to the Ministry of Planning in 2004–2005. ACBAR was invited to represent NGOs in meetings to develop the Afghan National Development Strategy (ANDS) in 2005, but its involvement was complicated due to the sheer number of actors that it would have to represent.

36. NGOs have continued to play an important role in the civilian public health sector. Over the last decade capacity development has been limited: “most assistance has been delivered off budget and Afghanistan continues to rely very heavily on outside staff to run the government and deliver services”. 22

**Summary:**

- After more than three decades of conflict Afghanistan is one of the poorest and least developed countries in the world before the crisis.
- Violence has undermined efforts to strengthen state functions and Afghan governance structures are fragile, from national to local levels.
- The Afghan health system was largely inoperable before the establishment of GIRoA and has a long way to go to.
- The country has one of the highest external assistance dependency ratios in the world.
- The lines between the humanitarian and development initiatives have been blurred and coordinating efforts among actors has proved challenging, even before military involvement.
Activity to bolster the health system began after the fall of the Taliban government in Kabul in November 2001 and the Bonn Agreement the following month. Over the last decade the global community and the MOPH have made major strides in building the health system. As Dr. Suraya Dalil, acting Afghan Minister of Health in 2011, explained:

“During a time of continued violence and pessimism about Afghanistan’s future in some quarters, tens of thousands of men, women and children who would not have survived continued Taliban rule are alive today because of the partnership between the Afghan people, health care providers and the international community.”

The Crisis’s Impact on the Afghan Health System

How does the crisis impact the Afghan health system?

38. Afghanistan had been in turmoil for a long time before western forces entered the country under the banner of OEF. Whatever civilian health system had been in place prior to the first crisis in 1973 was long gone, rent and broken by years of fighting. What passed for health services in 2001 were provided by at least 20 different NGOs under the nominal coordination of ACBAR.

39. Sustained insecurity and violence continue to have a major impact on the provision of health care. The consequences of many years of insecurity for health are great, and existing assessments of these consequences may even under-estimate the impact. Armed conflict and other violent situations in Afghanistan endanger health workers, exposed to threats, harassment and attacks. Health centres and health care workers can be targeted and centres closed due to violence, depriving the population of access to basic health services. As the International Committee of the Red Cross (ICRC) states: “Dozens of health workers have been abducted, sometimes for ransom payments and other time for their skills, for treating wounded fighters who fear arrest if seeking treatment in a government clinic.” Since 2001, over 350 incidents against health workers were reported, making Afghanistan the most dangerous place for humanitarians.

40. As a result of threats resulting from the security situation, healthcare facilities were less able to provide their services. In addition to loss of resources, staffs are often too frightened to return to work and the communities are too scared to come to the clinic. Sick or wounded Afghans going to military health facilities or receiving assistance from groups believed to be affiliated with NATO risk retaliation from anti-government elements.

How has the situation changed since the fall of the Taliban?

41. The process for allocating international aid and development has been complex and challenging in Afghanistan. Initially aid went to post-conflict reconstruction and the international community helped with ratification of the new Afghan constitution. After more than a decade of state-building efforts and financial support by the international community, the Afghan state apparatus is still far from being able to operate independently.

* “Anti-government elements” is a UNAMA term which encompasses all individuals and groups involved in armed conflict with or armed opposition against the Government of Afghanistan and/or international military forces. They include those who identify as “Taliban” as well as individuals and non-State organized armed groups taking a direct part in hostilities and assuming a variety of labels. From an ISAF perspective, this would include Insurgents, Suspected Insurgents/Armed Individuals, Foreign Fighters, Terrorists, and Criminals.
Donor funding was funnelled through the MOPH to contracted NGOs who were selected through a competitive bidding process. NGOs had to provide the basic package of health services—high-impact, low-cost interventions, including child and maternal health. These NGOs were perceived as neutral and better positioned than government institutions to expand health services to different parts of the country (including unsecure areas). The involvement of NGOs emphasized transparency and accountability and enabled the MOPH to assume a role of guiding, governing, and coordinating health sector activities.

Progress has clearly been made towards better public health:

a. Since 2002, Afghanistan has received a total of 14 grants from the Global Fund to Fight Aids, Tuberculosis and Malaria, 9 of which remain in progress, and over US$140 million has been approved.\(^{28}\) As an example of the trials and tribulations experienced by a specific health programme, Narrative C gives details of the progress of the Global Polio Eradication Initiative in Afghanistan.

b. By 2007, infant and under-five mortality rates had declined by 22% and 26% respectively from the 2002 estimates\(^{29}\). However communicable diseases such as Tuberculosis and malaria still claim many lives, particularly in rural Afghanistan.

c. By 2009, around 85% of the population lived within two hours walk of a centre capable of providing the BPHS.\(^{30}\)

In 2012, aid dependency, around 50%, was extremely high relative to virtually all comparator countries\(^ {31}\) and at the July 2012 Tokyo Conference, the international community pledged to provide up to a further US$16 billion in development assistance until 2015 and maintain support until 2017.\(^ {32}\) While International funds have increased since 2001 there is concern that aid will start to decrease as the transition removes much of the international military presence that remains on the ground, supporting security and stability efforts. A high aid dependency and the risk of that aid being reduced has led to fears for the future:

“The transition through, and then beyond, 2014—with expected reductions in aid and international military expenditure—might challenge progress already made.”\(^ {33}\)

Table 1 summarizes health system progress based on the components of the WHO health system framework.

<table>
<thead>
<tr>
<th>WHO Framework Component</th>
<th>Before October 2001</th>
<th>After October 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Delivery (Infrastructure)</td>
<td>Emergency relief, Limited access to health services, Dilapidated health infrastructure, Inequitable distribution of health services, No clinical patient care and hospital management standards.</td>
<td>Public health system reconstruction and development, emphasizing coverage and quality of primary health-care services; development of the BPHS in 2003. Emphasis on community-based interventions and access to health services in remote areas. Development of the Essential Package for Hospital Services (EPHS) in 2005 as a set of standards and processes for hospitals, including a referral system linking primary health-care facilities with hospitals. Increase in health care utilization, especially in urban areas. Improved access for women and increase in attended deliveries.</td>
</tr>
<tr>
<td>Health Workforce (Human Resources)</td>
<td>Exodus of health workers, Lack of trained personnel (physicians, nurses,</td>
<td>Increased number of midwives. Aggressive donor funding to recruit and retain health workers.</td>
</tr>
</tbody>
</table>
midwives).

<table>
<thead>
<tr>
<th>Information (Systems)</th>
<th>Health information systems limited.</th>
<th>Responsive Health Management Information System (HMIS). Health statistics based on imperfect reporting mechanisms that have yet to fully mature.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Products, Vaccines &amp; Technologies (Supplies)</td>
<td>Lack of supplies and pharmaceuticals.</td>
<td>Regular provision of quality drugs. Drug availability index rose from 65% to 85% between 2004 and 2008.</td>
</tr>
<tr>
<td>Financing</td>
<td>Limited resources.</td>
<td>Afghanistan remains heavily dependent on external assistance. Ban on user fees at BPHS facilities.</td>
</tr>
<tr>
<td>Leadership (/Governance)</td>
<td>No national healthcare strategy. Limited hospital management skills.</td>
<td>MOPH’s stewardship role for health: various coordination mechanisms at central, provincial and community levels. Weak governance function: limited ability to set priorities due to external financial dependency.</td>
</tr>
</tbody>
</table>

**THE SECURITY COMMUNITY AND THE HEALTH SYSTEM**

46. This subject has been divided into three questions, primarily describing the interactions between the Security Community and the civilian health system, then expanding on the development of the ANSF Health System and the unintended consequences of the Security Community’s actions.

47. ISAF has supported health for all in Afghanistan in multiple ways in both the military and civilian sectors. Narrative A discusses counter-insurgency Strategy and gives details on the effect of military forces on the health sector and Narrative B discusses the development of the ANSF health systems as a separate entity to the public health system. These narratives will be referenced within this section, as they provide more detail on the areas that we will discuss.

**How did the Security Community participate in health system recovery and reconstruction?**

48. The primary mechanism of military involvement is through Provincial Reconstruction (PRT) Teams, civil-military institutions led by individual Troop Contributing Nations (TCN), designed to enhance interagency cooperation, improve stability and build capacity by working closely with local officials. They are able to penetrate the most unstable and insecure areas because of their military component and are able to stabilize these areas because of the capabilities brought by their diplomacy, defence and development components. Despite the criticism of PRTs’ short-term outlook at the expense of long-term development, PRTs have achieved notable development successes, for example, doubling the number of health centres in Helmand Province by 2009. The stabilization and reconstruction efforts through the PRT concept and lessons identified in Afghanistan by NATO and ISAF are developed further in Narrative A.

49. Another means of supporting health reconstruction efforts comes in the form of human resource capacity development. In Kabul, ISAF and civilian personnel work to improve the quality and accountability of both the undergraduate medical curriculum and the system of graduate medical education at the Kabul Medical University. The efficient functioning of this institute is critical to enabling an autonomous Afghan medical system as it provides the majority of trained Afghan clinicians.

50. The security community also contributed to efforts to improve health system governance at local and national levels. In particular, ISAF and US Forces – Afghanistan
(USFOR-A) strongly advocated establishing medical professional regulations and bodies, as well as supporting the MOPH’s strategy of BPHS implementation. ISAF training programmes in support of the civilian sector used MOPH-approved standards and curricula and focused on training the Afghan trainers. Its civilian physician assistant and nurse training programmes were geared towards increasing the number of these medical professionals who take postings in rural areas.

51. Overall contributions had an impact on many of the WHO Health System Building Blocks as shown in the following figure:

![Figure 2: Impact of the security community on the WHO Health System Building Blocks](image-url)

How were the ANSF Health Systems developed?

52. One of the mission goals of achieving security and stability in Afghanistan was to develop an indigenous military and policing capability able to confront the Anti-Government Forces. The high level of casualties of the ANSF required a robust medical system which was then developed by foreign security actors. Creating such a system also entails human capacity building via mentoring and training.

53. ISAF also supported the Afghan National Police (ANP) in restoring its facilities, many of which were destroyed during the civil war: for instance the ANP polyclinic and a nearly completed 200-bed hospital in the Afhsar area of Kabul were heavily damaged and looted in 1993. The first fully operational ANP hospital since 1991 opened in November 2007 and was the only ANP inpatient facility in the nation.

54. The manpower and funding dedicated by the security community to building the ANSF health system were significant; however, there was no reliable accounting of the amount of

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† The ANP, Afghan Border Police and Afghan National Civil Order Police fall under the Ministry of Interior (MOI) healthcare system. Within the MOI, the Office of the Surgeon General is responsible for the health and welfare of all ANP members and all medical facilities.

† Informants reported that the US spent US$153 million on medical supplies and medicines from 2007–2010 with over US$42 million in pharmaceuticals delivered in 2010 alone; not including the building and equipping of four 50-bed hospitals, three hospital expansions and medical barracks, numerous troop medical clinics, years of funding 65–85% of all of the Afghan military medical personnel salaries and 100% of their incentive bonuses. Also, Japan provided US$23 million for
money spent on the entire Afghan military medical system prior to 2007. This lack of a unified budget reveals that ISAF actors were still uncoordinated in their capacity building, despite having a clear overall goal.

55. There were a number of challenges to the successful implementation of the ANSF health system in the areas of Governance, Financing, Supply Chain, Health Workforce, Infrastructure and Health Services. These topics are developed in depth in Narrative B.

What unintended consequences did this have?

56. While the well-known capacity of the military to provide timely and effective support in emergency situations has made a clear impact on the health of Afghans in the affected areas, efforts have also been criticized, for example by Leonard Rubenstein, a Senior Scholar at the Center for Human Rights and Public Health at the Johns Hopkins Bloomberg School of Public Health:

“The military’s civilian health initiatives, largely disconnected from the MOPH, are short term, ad hoc, and unsustainable, and to date have lacked a consistent rationale strategy, and have not been subject to evaluation”.

57. On 28 July 2010, ISAF released its “Guidance on Military Engagement in Health Sector Reconstruction and Development”. The document reflected on the unintended consequences of ISAF’s involvement in the health sector as well as a decade’s worth of its experiences in the reconstruction and development of the Afghan health system. It included reflections on the initial failures with direct patient care by ISAF medical personnel, such as the Medical Civic Action Programmes (MEDCAP) considered detrimental to long-term health outcomes, and subsequent success with strategies based upon counterinsurgency principles, as discussed in Narrative A.

58. Sustained efforts have made significant progress in improving this situation, culminating with the ISAF Standard Operating Procedure (SOP) HQ-01154 which requires military personnel engaging with International Organizations and NGOs to be sensitive to their neutrality and avoid conducting “humanitarian assistance” unless responding to a humanitarian crisis declared by GIRoA or UNAMA. The implementation of this SOP marked a significant achievement in eliciting from NATO/ISAF a recognition that, in a context of conflict such as Afghanistan, their direct involvement in humanitarian matters can do more harm than good.

59. In 2011, under a new Operation Plan (OPLAN), ISAF began to focus on transitioning towards its end-state, which depends among other things, on an Afghan government capable of sustaining medical operations. ISAF’s engagement strategy reflected the important lessons drawn over the previous decade and their initiatives (plans, programmes, and operations), capabilities (knowledge and training), and resources (material, facilities and services) were all focused on support for the Afghan MOPH’s development efforts. Indirectly it recognized that in the past ISAF did not invest sufficiently in monitoring supplies or addressing corruption, which was rampant in a society lacking rule of law.

COORDINATION MECHANISMS FOR THE SECURITY COMMUNITY

What were coordination mechanisms, both formal and informal, that facilitated or directed the security community’s involvement?

60. There is a strong need to align international support with local needs. Donors and supporting agencies have a tendency to want to create tangible results that can benefit them and that are easily visible. As the British Ambassador to Afghanistan explained about how drugs for the Afghan National Army (ANA) in 2010 alone and built a 150 bed hospital for the Afghan Police from 2009-2011.
the United Kingdom’s assets were allocated: “We focused on the physical and visible rather than the human capital which would manage the country in the longer term.”

61. Even early on it was realized that coordination, and communication, between actors in all sectors was important but in practices these proved difficult to achieve. In November 2001, WHO prepared an assessment of health needs and a 30-day operational plan focusing primarily on medical supplies and medical staff for UN Office for the Coordination of Humanitarian Affairs (OCHA). At a Ministerial Meeting in Tokyo in 2002, a Steering Committee of donor governments requested the Asian Development Bank, the UNDP and the World Bank to urgently conduct a preliminary needs assessment for consideration. However, there was limited participation by aid agencies and limited engagement with the Transitional Government of Afghanistan. Despite these limitations, the assessment was used to create the National Development Framework released by the Afghan Government in 2002.

62. A separate National Planning Workshop—also held in 2002—outlined the health needs in Afghanistan. The fledgling Afghan MOPH made an urgent appeal for assistance in mapping out the available health resources in the country. The list of facilities compiled from this was the most comprehensive listing of health facilities available in 2002.

63. While the security community was introducing the Provincial Reconstruction Team approach—beginning in 2003—to bring civilian and military development activities closer together, ACBAR was adopting a strong position against military involvement in development work. It wasn’t until 2008 that OCHA created a protocol for NGO-military interactions in Afghanistan, to establish principles and practices for constructive civilian-military relations in aid of better coordination.

64. From 2006/7, a model of PRTs increasingly focused on governance-related initiatives has been widely adopted, albeit with the inevitable variations due to local security circumstances. Lessons identified by the NATO Senior Civilian Representative (SCR) mid-2010 highlighted the need for unity of command within the ISAF, unity of purpose and effort in support of building partnerships, and harmonizing actions and “burden sharing” in the international community:

“Recommendations for civil and military cooperation boiled down to one important issue: good work relations between the two components. These, and a mutual respect and understanding of what expertise both bring, were of critical importance for the PRT to be successful and efficient. Other points often made included a joint understanding and analysis of the conflict and consequently shared objectives; combined planning (of both military and civilian activities), combined implementation, monitoring and evaluation of projects and activities; regular (or daily) meetings to exchange views and share information; joint visits where possible with shared interlocutors and joint pre-deployment trainings or regular exchanges between ministries at home.”

65. Despite the ongoing conflict, violence and instability, the MOPH has made progress in the gathering of health information. The country has developed a strong and responsive HMIS, which has clearly grown in its effectiveness: 90% of the facilities were regularly reporting their data in 2011, compared to 32% in 2004.

66. A Balanced Scorecard was used as a tool both to monitor and evaluate service delivery and to help the Ministry assess its progress in realizing its core goals of quality,

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1 Balanced Scorecard is a management methodology described in Brandon 2010.
access and equity. It includes 29 indicators, divided in six domains (patients and community perspective, staff perspective, capacity for service provision, service provision, financial systems, and overall vision for the health sector), that are measured by an independent third party annually, security permitting.  

However, the Afghan authorities do not have information on how about one third of all assistance since 2001 was spent: some US$5 billion. Without such information, the MOPH cannot generate a comprehensive, accountable health picture: feeding the perception of an ineffective government, unable to competently disburse international aid and address the needs of the citizens.  

Summary:

- After a decade of efforts by the international community, Afghanistan remains socially, economically, politically and physically insecure.
- Disputes, corruption and abusive public officials, the absence of accountable government and rule of law—represent a major cause of unrest among Afghans.
- Beyond its role in security, ISAF has supported health in Afghanistan by building a medical system for the ANSF, providing direct care to civilians, and rebuilding infrastructure:
- The international security community has helped build the ANSF Health System to prepare the ANSF for a 2014 security transition.
- However there are limits to the extent that the security community can involve itself in health and development efforts and humanitarians are often uncomfortable with the involvement of the security community in the health sphere.
- Closer collaboration among actors in all sectors is necessary for effective, appropriate health care interventions.
FOOD FOR THOUGHT – A DISCUSSION OF OUR KEY TAKEAWAYS

68. In the last decade, the international community has contributed billions of dollars and much human effort towards stabilizing and rebuilding Afghanistan. Nonetheless, the country remains fragile, insecure, and faces critical humanitarian issues. The continual severe security concerns force humanitarian, security, and development actors to share the same operating space, creating a wide-range of issues in terms of coordination between relief and development, civil and military, public and private, donors and service providers including a perceived blurring of fields of responsibility and potential erosion of impartiality of civilian actors.

69. Security is a pre-requisite for successful development efforts and, in turn, development is necessary for long-term stability. In Afghanistan it has not been possible to date to establish a consistently secure environment throughout the whole country. In highly insecure areas, the security community engaged progressively in development efforts to support the security mandate as this was perceived to be an enabler for stabilization. Because health is seen as a key component of development—and improved health is expected to contribute to stability—the security community supported and invested in health development programmes. However Afghanistan provides scant evidence to show that health system strengthening improves stability or supports counterinsurgency efforts.

A Host Nation Security Medical Capability

70. A major effort of ISAF has been the creation of an ANSF capable of providing security and conducting combat operations, which will inevitably lead to casualties in the face of the continuing security situation. Effective ANSF operations depend on an ANSF health care delivery system that provides acceptable field-level combat casualty care, restorative surgery, rehabilitation, and long-term care for ANSF personnel.

71. The new ANSF medical capability is designed to serve ANSF members and their relatives but is having an unintentional impact on the development of the broader public health system because this prominent security health system is competing with the public health systems both for funds and for the services of Afghan health professionals—a competition it is currently winning. Some Afghans are also turning to the military health system rather than the public. Based on proximity, security or other concerns they approach military facilities asking for aid, leaving that facility the choice between treating them and undermining the civilian system or turning them away and alienating a portion of the local population.

72. With Afghanistan’s health system 90% dependent on foreign aid, it seems wasteful that the different health systems (ANA, ANP, and civilian) are not better coordinated so as to avoid overlap, competition and waste. An extreme solution would be to merge the three systems (or even the two ANSF health systems); however attempts to merge them have failed due in part to weak Afghan governmental support.

Supporting Governance Efforts in the Health Sector

73. Initially security actors were conducting direct health campaigns (such as MEDCAPs) in the Afghan population. These were eventually recognized to be counter-productive because they hindered the development of capacity in the Afghan public health system; the public system went unneeded and underused. In addition, direct health intervention by military did not promote complete confidence on the part of the Afghan people in local
government or the MOPH, and hence it is debatable whether these interventions have done more harm or good.

74. Such direct medical engagements—part of a wider military strategy to “win the hearts and minds”—were therefore discouraged within ISAF in 2010, though they still continue at the tactical level. The main strategy shifted to supporting governance, which is seen as a key factor to change population perceptions and a facilitator to the stabilization process. Military support to governance efforts represents a pursuit of Counter-Insurgency (COIN) objectives through contribution to the health sector: involving high visibility actions, synchronization of efforts with the other actors and better aligning of development with the host nation priorities. The areas of overlap between counter-insurgency and health system strengthening efforts could be better exploited to achieve significant gains and therefore improve stability.

Coordinating Health Initiatives between International Actors

75. The example of the polio eradication campaign shows how the security community and humanitarian and development actors could align their activities so as to avoid conflict occurring where immunization campaigns are active. ISAF adopted a new approach to support the humanitarian and development community actors in a passive way, by enforcing/promoting the necessary neutrality and by desisting from any involvement in or use of the campaign for other purposes.

76. Here, the aim of civil-military coordination was to improve the coverage of the campaign in remote/insecure areas and increase the humanitarian space/access on these days. The contribution of ISAF to this concept is perceived as a best practice by the Global Polio Eradication Initiative (GPEI), as it recognizes the importance of such campaigns, the neutrality of actors and the need to maintain interaction mechanisms to reach vulnerable/at risk populations.

CONCLUSION – ELEMENTS FOR FUTURE HEALTH STRENGTHENING FRAMEWORKS

77. The commonly understood model for a crisis intervention is that, at the start of hostilities, military forces often engage in direct provision of civilian care in the absence of other actors. As security is restored, civilian government and NGOs gradually assume the lead and as stability is further restored; reconstruction and development of the civilian health sector become the focus of NGOs, who also have the task of capacity building. When security is fully restored, the military can disengage: ideally the conditions in theatre dictate this military response, not the time elapsed.

78. However, in the case of Afghanistan, security has not been established evenly throughout the country and so the process has been far from smoothly linear—engagement has not always depended on need. Any future health strengthening frameworks must be able to represent and adapt to a fluctuating and uneven level of security within the host nation.

79. Humanitarian, development, and security communities operating in the same space often hold different views about local needs and their respective roles in dealing with them. Overlap between civilian and military efforts, especially with such a large numbers of players, has created many challenges in Afghanistan, where the host nation has limited ability to ameliorate tension, confusion and complications between the conflicting agendas of donors, TCNs and NGOs working within the same space.

80. Given that security conditions were not uniformly maintained, prolonged security community engagements interfered with MOPH and NGO planning, and vice versa, causing strategies to change midcourse. This suggests that better coordination is required to avoid these conflicts and inefficiencies and that future health strengthening frameworks should be
built to consider coordination issues. This implies a clear impact evaluation and monitoring capability (as discussed in the Narrative B).
THE NARRATIVES
1. Health intervention has been used in Afghanistan as both a means in the counter-insurgency strategy and also as part of the process of stabilization and infrastructure development. Military-led health operations and development projects have had a major impact on basic health and life expectancy. However, the utility of health operations in achieving counter-insurgency aims is not yet fully proven and their real effect in terms of stabilization has remained unclear.

2. In executing a counter-insurgency strategy, the security community seeks, among other things, to provide a safe and secure environment, improve governance and provide direct medical care when the situation dictates. In general terms achievement of these aims could be expected to yield positive results in health system strengthening.

3. Victory in a counter-insurgency campaign is about creating a space in which a peaceful political process can take place: winning the “hearts and minds” of a people. The phrase hearts and minds is much used but not well understood. The US Department of the Army offers the following description of what it should mean:

   “Hearts’ means persuading people that their best interests are served by COIN success. ‘Minds’ means convincing them that the force can protect them and that resistance is pointless. Note that neither concerns whether people like soldiers and Marines. Calculated self-interest, not emotion, is what counts.”

4. Commanders may have one or more motives for conducting medical operations. These may include the desire to do good deeds, to influence local civilians, to gain an advantage over the insurgents, to gather intelligence or to generate positive content for media articles or Information Operations. However, random acts of kindness towards the population create no sustainable gain, are not synchronized with other actors, and are not nested within strategic plans. To succeed in counter-insurgency, foreign military and host nation forces must lead the population to respect and rely upon the host nation government. Health system strengthening could be a viable way of contributing to this goal.

5. Under the Geneva Convention and its protocols, it is incumbent on military medical practitioners to treat civilians who are injured as a result of conflict. But some analysts argued that such treatment should not form part of a wider military strategy to win hearts and minds. It was argued that by conducting a MEDCAP or Village Medical Outreach Programmes (VMOP) the military provider introduced an unsustainable free-at-the-point-of-use health care system; that MEDCAPs and VMOPs were detrimental to long term health outcomes because they undermined local civilian providers.

6. In July 2010, ISAF released its Guidance on Military Medical Engagement in Health Sector Reconstruction and Development. The document stated that the direct provision of health care by military personnel to Afghan citizens was generally detrimental to the long-term development of Afghan health system and therefore asserted that in the long run MEDCAPs may do more harm than good.

7. The ISAF Guidance was reinforced by Commander ISAF (COMISAF) in November 2010, in a letter to NATO/ISAF Commanders in which he stated that “the negative aspects
of MEDCAPs can outweigh any limited or short term positive effects they produce”. The Medical Seminar (MEDSEM) was developed to address the shortcomings of the traditional MEDCAP by adding education to the venue, thereby promoting self-reliance and improving sustainability of medical interventions. The MEDSEM sought to provide the security bubble in which local Afghan health care providers could train volunteer Afghan civilians in simple public health messages for the benefit of their community. This approach aims to empower local healthcare providers, build local confidence in civilian health providers, and reinforce the MOPH as the primary provider of healthcare. Furthermore, MEDSEMs have been seen to forge relationships and promote interoperability through collaboration between local medical providers, governmental leaders, host nation forces and US Special Operations Forces.64

8. In 2010 in southern Afghanistan, 2nd Battalion, 1st Special Forces Group (Airborne) employed the MEDSEM concept as a way to connect local populations to their government and to the health officials responsible for their care while simultaneously addressing the health needs of the population. In this example, medical operations were seen as successful because they were aligned with operational objectives and with the desired end state in a counter-insurgency environment. MEDSEMs were completely led by national officials and facilitated by coalition forces. They were designed to promote interoperability between local Afghan leaders, Afghan medical officials and Afghan security forces. The key to their success was a prolonged period of area preparation and relationship building which occurred over 30–60 days. The actual execution of the seminar took about three to four days. MEDSEMs connected local doctors, nurses, midwives and recently trained villagers with the intent of increasing the perception by villagers that local MOPH officials and medical personnel are responsible for their health.65

9. The 2nd Battalion, 1st Special Forces Group (Airborne) also managed to develop relevant measures of performance and effectiveness aligned with their objectives and then, significantly, was able to track the effects that their MEDSEMs were having over time. Effectiveness indicators were tracked across seven different lines of operation: capacity to govern, security, access, interoperability, focused engagement, medical and information operations. Improvements were noted through the attendance level at district shuras. Furthermore, Improvised Explosive Devices reporting by local nationals increased, white space around the district increased, and tribal leaders expressed multiple requests for additional medical engagements.

**Health Initiatives as part of Counter-Insurgency Strategy**

10. In 2009, the US Government decided to link military and development goals in Afghanistan through a counter-insurgency strategy which sought to mesh development and security objectives through activities that would enhance the legitimacy of the Afghan government in the eyes of its people. However, in the field of health, there were considerable tensions between counter-insurgency and development strategies.66 The US Government’s guiding principle of “Afghanization” (meaning Afghan-led development) was meant to ensure that Afghans led, not followed, in their path to a secure and economically viable country. This approach also aimed to fight a pervasive public perception that US assistance was not benefitting ordinary Afghans.

11. Under COIN, the watchwords for winning the trust of the population are “shape, clear, hold, and build”.67 However, some have suggested that too much emphasis was probably put on the “build”, producing highly visible symbols of improvement without involving the Afghans in a sustainability strategy.68 This overemphasis can be detrimental to COIN goals and to health system strengthening by undermining confidence in the government and reducing long-term capability.
SUCCESSES AND FAILURES

12. The overall goal of the COIN strategy was to develop confidence and support for the GIRoA within the Afghan population through improved health care. There are examples where medical operations have, through improved health care, successfully supported a COIN strategy by developing confidence and support for the GIRoA within the Afghan population. However there is a danger of the Afghan people becoming dependent on the military-provided health care and a constant battle for perception in which military medical efforts struggle to be recognised.

Capacity Building

13. NATO Allied Command Operations Directive 83-2 defines MEDCAPs as a commander’s tool to win heart and minds. As such, MEDCAPs have been used for purposes beyond just serving purely local health needs. However, ISAF Regional Command South reviewed their MEDCAPs activities and concluded that MEDCAPs were neither providing lasting health care benefits to the local population, nor supporting the MOPH in creating a sustainable health care system.

14. The 82nd Airborne Division, during its 2007 deployment Afghanistan as Combined Joint Task Force (CJTF)-82 was probably the first conventional unit to wage a comprehensive and successful counterinsurgency campaign within its area of operations. During previous tours in 2002 and 2004, the division had earned a reputation as “door kickers”, focused on killing insurgents. But over the course of a 15-month tour beginning in January 2007, the task force focused on reconstruction and development projects throughout Regional Command East. One of their key lessons was that security improvements occur when the population sees growth in governmental capacity and tangible development efforts: “improved governance leads to good security”, as Lt. Colonel Michael Tarpey, US Army, puts it. It is also a key factor in health system strengthening; hence there is a logical contribution the security community can provide through pursuing COIN governance aims. In this example, the CJTF-82 surgeon’s section developed a health sector strategy which was in complete alignment with the Afghan MOPH’s own strategy involving the implementation of the BPHS.

15. LTC Tarpey also identified that a best practice was to “Facilitate and Empower” locals and local health systems rather than have foreign troops “Perform and Do” medical relief through activities like medical engagements, training events and meeting community leaders in support of MOPH strategy. His ideas were based on the example of CJTF-82 units becoming involved in training programmes for midwives as well as developing responsive medical logistics, disease surveillance and outbreak response systems.

16. Throughout all of CJTF-82’s written documents and actions, the Afghan MOPH was given the forward-face in directing health care efforts in Afghanistan, reinforcing the MOPH’s role in providing healthcare, rather than supplanting it with a military alternative. This engagement turned short-term relief tasks into long-term capacity building, which can outlast the transition and withdrawal of international military personnel.

Provincial Reconstruction Teams

17. Looking to longer-term stabilization and development, “NATO’s contribution to the comprehensive approach in Afghanistan is made concrete by the PRT”, even if they only account for a small part of the total international reconstruction and development effort. Each PRT has three core tasks: to support the extension of the authority of the Afghan central government; to support reform of the security sector; and to facilitate development and reconstruction. For the PRTs, development is a means of turning Afghans away from insurgency and thereby creating a stable environment in which the Afghan government can exert its authority.
18. By 2010, there were 27 ISAF PRTs in Afghanistan, including 12 belonging to the United States. Although PRTs in Afghanistan initially faced criticism for their focus on short-term unsustainable construction projects, over time most critics acknowledged that PRTs moved towards support for more long-term capacity building efforts. The 2009 ISAF PRT handbook reflects this with its focus on the four enduring principles which underpinned all of its operations in reconstruction and development—Afghan-owned, ISAF enabled, wholly collaborative and sustainable—before undertaking any health-related infrastructure projects, such as construction or renovation of health facilities, ISAF reaffirmed these principles in its guidance.

19. The NATO SCR’s office worked to capture lessons from the PRTs concept in Afghanistan after president Karzai and NATO Secretary General emphasized, in December 2009, the need to strengthen coordination of PRTs efforts and to support Afghan development priorities.

20. PRTs have done a difficult job in a complex environment, often learning through experience. Mistakes have been made over the years and good intentions have had unintended consequences. The North Atlantic Council endorsed a number of lessons identified in the years since the implementation of the first PRTs in Afghanistan, including the need to:

a. Invest in supporting Afghan inspired, Afghan-led and Afghan-owned programmes. This may take more time, but will allow the PRT to enhance governance efforts, particularly in building local Host Nation (HN) capacity and strengthening the relationships between district, provincial and central government.

b. Allocate local communities and districts greater roles in PRT leadership and in setting the conditions for a phased transition of responsibilities. This will help align activities with HN priorities.

c. Promote HN ownership and leadership of PRT efforts. It is important to make all necessary efforts to avoid PRTs being perceived by the HN as parallel structures.

d. Harmonize PRT activities with the humanitarian community by leaving the ownership of relief operations in the hands of UN agencies and the Afghan authorities. PRTs have recognized the need to only engage in humanitarian support activities when requested to by the host nation or the UN Humanitarian coordinator.

e. Reinforce visibility of overall PRT efforts: implementation of a mechanism to better synchronize and harmonize the delivery of common strategic effects by PRTs.

21. As PRTs were a temporary solution, the Afghan government is stepping to the fore to takeover PRT projects and activities. The Independent Directorate of Local Governance was tasked in July 2012 to work to recommend a mechanism for PRT activities to be replaced with governmental organizations. It engaged with PRT nations and the government will have to prioritize which projects it will take over as it can’t absorb all the costs. “It is an Afghan led process which should contribute to an increased Afghan ownership and responsibility of PRT activities.”

Dependency

22. When military medical aid is provided to the civilian populace to a better quality than the local health system, there is a risk that locals will become dependent on that military aid as a first resort, rather than last. Throughout 2009–10 the dependency on free services at the Ataturk Military Hospital in Camp Dogan was identified as a concern by ISAF medical staff and health sector development organizations such as USAID, WHO and EU. Local Afghan health providers around the hospital left the area and Turkish officers at ISAF confirmed that the hospital would not continue operations once the mission ended. The net effect was reduction in the local civilian health system and reduced confidence in the
remaining providers because they could not provide the quality and variety of service that the Ataturk Military Hospital was capable of.

23. The risk of increased dependency on military medical services is illustrated in initiatives such as the one launched by South Korea at Bagram Air Base. From February 2002 to June 2007, the South Korean military hospital staff treated about 204,000 Afghans, with an average of about 4,000 patients per month. “The Korean medics also conduct public health education and humanitarian relief activities for the local people”. These efforts, intended as “making contributions for the establishment of peace” in Afghanistan, addressed the needs but not necessarily in a longer-term perspective, which may raise concern in terms of sustainability.81

Perception

24. Despite the considerable work that has been done, including the expansion of basic social services, major investments in infrastructure or communication networks, changing the mind-set of the population appears to be difficult. Improving the Health system and successfully implementing development projects may have little effect on stabilization if the Afghan population does not know about the improvements or if we fail to build on the successful outcomes.

25. In fact, negative perceptions persist that: little has been done, that the wrong things have been done, that what was done is of poor quality, that the benefits of aid are spread inequitably and that much money is lost through corruption and waste. Afghan perceptions of aid and aid actors are negative and some international analysts consider that, instead of contributing to stability, in many cases aid is contributing to conflict and instability and ultimately there is little evidence that aid projects are winning hearts and minds.82

26. Repeated public opinion surveys conducted in Afghanistan by the Asia Foundation have pointed out that, over the past six years, security has remained the main problem in Afghanistan.83 The Afghans constantly prioritize medical services lower than security, employment and economic. Therefore, the successful provision of health services cannot be considered as a major predictor of long-term success of GIRoA and providing security will likely remain the most important government concern and activity.

DISCUSSION

27. Long-term stabilization is a strategic level issue achieved through a coordinated international community response to achieve sustainable development that involves the development and security communities working alongside GIRoA. Sustainable developments cannot be achieved without enhancing governance efforts. Even if difficult, lessons identified highlighted that efforts in building local capacity and strengthening the relationships between district, provincial and central government are paramount and imply that focus is also needed in the reinforcement of intellectual capacities and mechanisms.

28. Good governance is a key factor to change the population perception and therefore a facilitator to the stabilization process. It can contribute to improve security and is a pre-requisite for health system strengthening. There is therefore a logical contribution the security community can provide in the health sector, through pursuing COIN objectives. That implies a higher visibility of actions, synchronizing efforts with the other actors, and better aligning with the host nation priorities.

29. There have been some notable successes in which medical programmes have been aligned with clear operational objectives and have managed to successfully promote the capacity of the host nation government, leading to greater self-sufficiency, improved governance and measurable counter-insurgency effects.

30. Medical engagements that advance and empower the HN health care system over the long term can contribute to the success in COIN operations, as the engagement and consent
of Afghans in said health system is a mark of success. However, there is little evidence to show that health system strengthening significantly improves stability. On the other hand, however, health actions can have a negative effect if they are poorly implemented, do not give the host nation government the lead or are unsustainable by that government.

31. PRTs providing secure areas in insecure Afghan provinces gave humanitarian and development actors a space to operate in relative safety. However, PRTs have in the past tended to focus on short term projects in an attempt to achieve the maximum perceived impact in the shortest time, often driven by National agendas. This lesson has been learned in Afghanistan, clearly indicating the requirement to change the focus to long-term sustainable programmes in which developed capacity and self-reliance were key factors in those operations which were regarded as successful.
NARRATIVE B:
THE ANSF HEALTH SYSTEM

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1. Until the new Afghan constitution was in place (2004) and the PRT expansion process was finalized, the security community supported the ANSF health efforts primarily by rehabilitating infrastructure, without much coordination. In 2005, ISAF began investing directly in the reconstruction of the Afghan military health system to enable the ANSF to provide the highest standards of care for its combat personnel, initially by addressing the shortcomings caused by past decline. \(^8^4\) Since then, considerable resources have been devoted to this objective and responsibility is currently being transferred to the Afghan authorities as part of the ISAF transition.

2. This narrative provides an overview of the strategy employed in directly investing in the health sector and discusses: 1) the implications of this experience for health system strengthening and 2) the implications for the civilian health sector in Afghanistan and 3) the challenges encountered.

AFGHAN MILITARY HEALTH SYSTEM OVERVIEW

3. According to the NATO website, ISAF’s objective in Afghanistan is, broadly speaking, to enable the Afghan government to provide effective security across the country in order to ensure Afghanistan can never again become a haven for terrorists. \(^8^5\) ISAF and its TCNs have supported the development of the ANSF in order to hand over security responsibilities to the Afghans as soon as possible. Due to the number of ANSF casualties*, a critical component of supporting the ANSF therefore involves supporting the ANSF medical capability: a strong Afghan military health system would enable the indigenous forces to be independent and effective.

4. The ANSF health system had developed substantially during the Russian-backed regimes in the 1970s, in which many health units and hospitals, including the Daoud Khan Hospital in Kabul, were built, primarily near population centres. This system was in place when OEF began in late 2001. As ANA troops were deployed further from population centres, the utility of the former military health system became limited and the ANSF facilities needed to be strategically relocated along with the troops. The security community’s financial assistance was to be based upon what it could secure from international donor nations and ISAF would work to help transform the supply chain to reduce waste and stock outs and improve efficiency.

5. The new ANSF health system was set up to serve approximately one million beneficiaries, including the ANA, ANP and their families. ANSF primarily provided tertiary care built around the so-called “Warrior Care” model that focuses on medical and surgical capabilities, including field-level combat casualty care, evacuation of casualties, restorative surgery, rehabilitation and long-term care for disabled ANSF personnel. This was in contrast to the civilian health care system, which concentrated on providing a basic package of health services, instead of managing public clinics and hospitals directly, and focused on obstetrics and pediatrics.

6. Building up human resource capacity was also important for strengthening the ANSF health system and a number of newly constructed health training programs were created to

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* Around 790 battlefield and 14,500 non-battlefield casualties between March 2009 and March 2010
contribute to this. Financial incentives were also added for trainees to enter into military contracts.

IMPLEMENTATION AND CHALLENGES

Governance
7. The military health system was divided in two almost isolated arms: the ANA under the MOD and the ANP under the Ministry of the Interior (MOI). The two arms had different donors, different funding mechanisms, separate management, and separate health workforces with little crossover. Having multiple governing bodies created conflicting leadership. One ISAF interviewee stated that “It is very hard for them to talk with each other. Nobody oversees both of them. It is very hard for them to give out common policies and guidelines”. A US Department of Defence (DoD) report highlighted that there was also “confusion among the ANSF medical leadership as to the policy and strategy on integrating ANA and ANP functions into a common ANSF medical corps, or even whether this was a desirable goal”.86

8. There was fragmentation of the security community’s efforts as well. HQ ISAF has focused on ministerial and donor engagements. NATO Training Mission – Afghanistan (NTM-A) has focused on Above Corps/Zone development and education and training. And ISAF Joint Command has focused on efforts directed toward Corps/Zone and below units. Informants recognized that these efforts have not been systematically coordinated.

9. Mutualisation and monitoring of efforts improved significantly since the publication of a strategic plan for an ANSF Transitional Objective for Health in November 2011, which has served as both a planning tool for the US DoD and a mentoring tool for ANA leaders. Today, there are a multitude of high-level forums where the coordination of ANSF health care development is discussed, such as the Weekly Key Leader Engagements, Monthly Principals’ Group, and Quarterly General Officers’ Steering Committee meetings. In addition, HQ ISAF contributes to optimizing inter-ministerial coordination.87

Financing
10. Challenges with governance impacted financial oversight and value of the system. Payments to the ANA and ANP for services were organized around a historical budget, with each facility receiving a set annual budget regardless of fluctuations in patient load or acuity.

11. Funding for the ANSF health system has been difficult to track because the accountability systems were weak, if not altogether non-existent. No one was responsible for tracking or monitoring the funding across the various entry points of the system to the point where it was spent. Funding from both coalitions (OEF, ISAF) and non-troop contributing nations—including India, United Arab Emirates, Japan and others—was often not well documented. For example, “During 2005–2009 there was US$5 million given directly to the surgeon general of the ANA and much not accounted for,” one interviewee said, who further noted that the US Government provided over US$150 million in medical supplies to the ANA in one year, which would be adequate for three years’ worth of supplies for a similar US naval facility.

12. The lack of accountability and financial oversight also allowed for corruption, which took many forms in Afghanistan. Corruption underlay mechanisms for contracting maintenance services, hiring medical and paramedical staff, and monitoring and managing funds. In some cases, more money was allocated for projects than was needed, often due to overbidding. One officer involved in reconstruction stated that “Projects were sold repeatedly (by local contractors) to (other) contractors because of the high (usually 50–60%) profit margin. The last contractor holding the workload would fail to pay the workers, which could cause unrest in the communities.”88 In addition, Afghans were not breaking any US law or
treaty by stealing money and resources that originated with the US taxpayers since they pilfered it after it had entered the Afghan government.89

13. The short-term postings of NATO and US officers as well as the limits on their authority also contributed to the depth and nuances of corruption in the system. Problems and concerns were identified by ISAF, but the means to address corruption were limited. In fact the country’s principal anticorruption institutions have minimal political support.90 91

Supply Chain
14. The separate ANA and ANP supply chains had national, regional, and local warehouses that used a push system (i.e. distributed supplies regularly based on a schedule rather than on demand or need). ISAF is working to help transform the system into a pull system based on needs to prevent waste, stock outs, and to improve efficiency. Such a system will require accurate and reliable data, which relies on supply depots providing the necessary data to supply chain managers and administrators. Additional training was required to implement the new process and obtain buy-in at all levels of the system.

Health Workforce
15. One of the largest obstacles to the development of the ANSF health-care sector had been the lack of trained health care personnel, especially female personnel, in the country. In 2010, only 37–39% of physician positions were filled. As of early January 2013 the country-wide average had increased to around 70%, however such gains were not universal: the Kandahar Regional Military Hospital still had only 57% of the required number of physicians and 51% of the required physician’s assistants.92

16. The shortage of health care personnel stems in part from the fragmented nature of the medical education system and reflects challenges similar to those seen in other aspects of the system. The three ministries involved in medical education—the Ministry of Higher Education, which assumed leadership of medical schools from the MOPH in 2009, the MOPH, which oversees hospital training and residencies, and the MOD, which has its own training programmes—each use different criteria and curricula. As one informant explained about MOD students, "medical training … became a personal patronage system, and these residents were never tested by the MOPH and never even got a certificate." The fractured nature of the education systems impacts the quality of training, placement of staff, and overall management of human resources.

17. The security community helped launch a number of health training programs to build up military human resource capacity for health. For example: the Allied Health Professionals Institute accepts both ANA and ANP personnel. In 2007, it began training nurses, radiology technicians, laboratory technicians and diagnostic ultrasound technicians. Starting in 2009, the Afghan Forces Academy of Medical Science began a seven-year physician training program and an 18-month programme for physician assistants.93 To draw students to the military, prior to or during any year of their medical education they can choose to join the ANA and receive a monthly stipend, in return for a lengthy commitment to the ANA after graduation.

18. ISAF also implemented a medical mentor mission training program to strengthen existing human resource capacity in the fall of 2009.94 The programme included initial orientation for ISAF medical mentors upon arrival in-country; a 150-page mentor training handbook; an action plan for each mentor team; and continuous monitoring and support for mentor teams throughout their tours. The US Medical Training Advisory Group had about 155 medical mentors from logistics to surgical specialists throughout Afghanistan working with both ANA and ANP personnel. Mentor teams met three to five times per week to work toward predetermined milestones.

19. The impact of such investments in human resources is hard to gauge given problems with personnel management: a source in theatre stated that Afghan physicians’
performance—whether military or other—is not monitored. Many US and NATO medical mentoring teams were not fully staffed, particularly those assigned to work with the ANP, and many mentors were inadequately trained to work as mentors in a foreign country, through an interpreter, in a very different culture. Moreover, despite efforts, it was not possible to optimize human resources and get the right trained persons where needed. Restrictive personnel practices for US Navy and US Air Force medical personnel assigned to the Combined Security Transition Command – Afghanistan (CSTC-A) hindered the ability to relocate them to meet changing needs of ANSF troops. Absorbing and utilizing personnel trained by the CSTC-A was also hard. One ISAF interviewee explained that, “of the 21 students we had trained to be the highest level nurse they had in the country, over two-thirds were sent back to their units to be cooks, Emergency Medical Technicians, combat medics or drivers for commanders”.

Infrastructure

20. As of February 2013, the National Military Hospital in Kabul had a 400–600 bed capability and the five regional military hospitals have a 50–100 bed capacity. In addition, the ANA also has 32 clinics (10–20 beds), 56 health centres (5–10 beds) and 1200 ambulances. The ANP health system has one hospital in the capital and several smaller clinics in the provinces but has not been bolstered the same way the ANA system has. The ANP hospital, as of February 2013, still relied on coalition assistance.

21. The challenges posed by infrastructure investment also highlight the lack of coordination and governance between agencies and actors working to implement the ANSF health care system. NATO troops began reconstructing the ANSF health infrastructure around 2006, abandoning most of the old health facilities including all those in provinces where they lacked control after the fall of the Taliban government. The plan had been to spread hospitals evenly throughout the country, however the high value—and low availability—of usable land led to new hospitals being placed on ANA compound bases, primarily in remote areas where there was little threat of attack. Other than the two facilities in Kabul, the military hospitals were thus constructed so far from the population centres that it was challenging for the dependents of military personnel to reach them.

22. There was a perception among some that the security community built so quickly and so much that it came to create more infrastructure than it could keep up or use. One interviewee stated, “they had no way to continue maintenance, no way to train personnel to use the technologies [or space]... That was the negative of trying to over-develop the military system”. In addition, given the lack of a national utility infrastructure, the cost of running the generators, water tanks and other facilities that hospitals rely upon may also become prohibitively expensive.

Health Services

23. While the security community began supporting the ANSF health system to maintain a healthy fighting force, it was unclear what ANSF health system impact truly has been. Measures of effectiveness of the health system have historically been basic, limited to percentages of required staffs that were in place and trained, buildings constructed and renovated, and equipment purchased.

24. ISAF interviewees reported that Afghans believe the highest quality of health care in the country to be available at the Daoud National Military Hospital, the “crown jewel” of the ANA medical system. This hospital, funded and supervised by US personnel, was staffed by Afghan doctors and nurses with mentorship from US military doctors. Despite the strong reputation, however, “rampant corruption, physical abuse and failed leadership” at the hospital was brought to light when ISAF commanders reported to the US Government Inspector General’s office. There were reports of patient deaths due to starvation, administration of counterfeit drugs and extreme negligence in medical care. While there were other examples of unacceptable conditions identified by some NGOs in civilian
hospitals, it was particularly surprising that this was happening in Daoud National Military Hospital—given its strong reputation—and that there was not sufficient monitoring.

25. ANSF hospital standards were completed in the fall of 2011. Though the ANSF Healthcare System Development Support Plan suggests that to be sustainable, the standard of care of the ANSF medical system must be less developed than that of the international military forces home nations, such standards have made an impact as validation teams, first deployed in 2012, complete inspections. However, inspections remain quite intermittent, and there are gaps in the inspection system timetables.

26. Under the new mission support plan that was hammered out in November 2011, there were to be reconstruction and development milestones and a very closely monitored end-state progression with penalties for failure to reach milestones. The progress was carefully evaluated every two weeks, leading to major changes in tasks and priorities. This assessment process was adopted by other CSTC-A sections working with the ANA. ISAF also plans to assess the capability indicators for 50–90 days after the transition ends. On 25 April 2012, 51 of the milestones had commenced and 67% of those were either completed or on track to complete on time; 29% were delayed or subject to challenges, and 4% had been dismissed as no longer relevant.

THE RELATIONSHIP BETWEEN ANSF AND CIVILIAN HEALTH SECTORS

27. The direct impact of the development of the military health sector on the civilian health sector is difficult to discern because of how independently the two operated and the vast difference in their size and scope. The very notion that there are two separate health care systems operating in the same—resource-limited—setting raises the question of whether the two systems should work more closely.

Governance and Financing

28. The Security Council of Government, under the leadership of the president, aims to ensure that ministries work together when emergencies occur. At the national level, there are systems in place and meetings that occur between the MOPH, MOD and MOI leadership, which could support coordination. In addition, the Inter-Ministerial Health Committee and common medical boards work to exchange experiences and capacities among sectors. Despite these mechanisms for coordination, the collaboration and joint efforts are minimal between the ANSF and civilian health sectors and the mechanisms seem ineffective.

Supply Chain

29. The ANSF and civilian health sectors use completely separate supply chain and procurement systems, whereas the MOPH hospitals rely on contracted NGOs, which procure independently, to provide supplies at their facilities. There is no clear visibility of supply chains or stores between the two health sectors.

Health Workforce

30. The ANSF and civilian health sectors have competing demands for limited human resources. Most physicians working in the civilian sector make a good living by also running private clinics and having trained in the civilian sector, they are comfortable there. Military physicians have a higher base salary but are limited to working only eight hours per day in the military facilities, and therefore earn less overall, as well as being required to respond to casualties and live near military facilities in the provinces. Many enjoy their work in the

* The salary for a commissioned officer, the position a graduating medical student assumes, including their bonuses for being a physician, is approximately equal to $7800 a year, which is a pretty good salary in Afghanistan.
ANSF facilities because they are better equipped and funded than the NGO-run clinics the MOPH finances. In 2012, the ANA recruited 18 physicians and 43 physician’s assistants from the civil sector. However, militarily trained physicians were not accredited to work in the civilian sector.

**Infrastructure**

31. Strengthening the ANSF military system did not entail strengthening or investing directly in MOPH infrastructure. PRT investments in civilian health infrastructure are discussed in Narrative A (Counter-Insurgency Strategy). The network of fixed hospitals required to support security forces could support the indigenous civilian population, however, this would require closer coordination between civilian and military health agencies.

**Health Services**

32. ANSF facilities were absorbing part of the caseload that other health systems, including the MOPH, would have otherwise borne. The heavy investment in the military sector created a quality gap between the military and civilian sectors. The civilian sector had a limited per capita budget and relatively small support from the international community compared to the military sector.

33. In some places, the population was suspicious of military facilities and stopped seeking care there, mainly for security reasons and pressure from anti-government elements. In others, military facilities provided additional access to health care. Military facilities were not built based on the civilian need, the location of existing MOPH facilities, or in consultation with other health partners or the local governments.

**DISCUSSION**

**Challenges of Combining the Military and Civilian Health Systems**

34. Given the scope of services necessary for the ANSF—from emergency evacuation and casualty care to primary care for the troops—the military health system would benefit from being integrated into an Afghan civil-military-police health care system, in which civilian clinical services, medical education, and medical logistics would be available to support the ANSF.  

35. However, some have argued that the ANSF and civilian health systems are not sufficiently parallel, based on differences between the two sectors' target populations, missions and capabilities:

   a. The MOPH is the steward of the public health system: delivering the BPHS, through contracted NGOs, that is focused on primary care, with some secondary care but with minimal tertiary care (such as EPHS) and no publicly funded intensive care unit.
   
   b. The military system is focused on care at the point of injury and focusses almost entirely on tertiary care. The centralized system is hospital-based and developed in large part based on donor support and troop location.

36. ISAF has assumed the duty of encouraging the ANA, ANP and MOPH to collaborate: “We are looking forward to create something like an inter-ministerial advisory group or steering committee” an ISAF informant explained. ISAF would invite the three to monthly meetings and is working to eliminate suspicions and build the confidence and the trust the ministries have in each other. ISAF representatives have noted that while “everyone wants to keep [the funding] they already have in their hands”, the Afghan Ministry of Defence (MOD) supports the idea of working together to maximize the potential of each entity given the limited resources in the country.
Lessons for Health System Strengthening in Fragile States

37. There are several clear lessons that are highlighted by the experience of the security community in health system strengthening in Afghanistan:

a. First, governance is a critical piece of any health system. Issues of governance in Afghanistan impacted all aspects of the ANSF health system, reaching far beyond rule-making and leadership.

b. Second, efforts both on the ground and at a national or international level must be coordinated. In Afghanistan, there were overlapping projects, multiple funding streams, and uncoordinated efforts that allowed for—and may have even promoted—waste and corruption. Coordinating the inputs to the system, and the donors, is important to ensure that the inputs achieve maximum value and are used effectively; we cannot expect coordination to occur spontaneously. Resources may need to be allocated to coordination to ensure it is not burdensome to, or overlooked by, an already understaffed workforce. Coordination among those on the ground, in country, could be aided by procurement and budgeting plans. Clear plans and well-managed budgets are needed to assure accountability, insure against stock outs or pilferage, to monitor impact, and to learn from the experience about how to improve on efforts.

c. Third, transferring knowledge is hard and takes more than people who have the knowledge and who are willing to share it. Mentors must be properly prepared to teach in the conditions in which they will be working and understand how best to do so. It is important to have a mechanism to continuously monitor and evaluate activities on the ground and have the flexibility to adjust to respond to the complexities that mechanism reveals.

38. Despite these lessons, there are also limitations to what we can learn from the experiences in Afghanistan at this point in time. Given the limited outcome data and the ongoing questions about sustainability, the outcomes of over a decade worth of intensive investments are hard to assess. Hospitals have a strong reputation despite rampant corruption; but whether the ANSF is meeting its goal of losing fewer soldiers is not clear because of lack of outcome data. In addition, much remains to be seen about the long term impact that investments in the ANSF health system will have on the Afghan health systems.

39. The security community was not clear when it began assisting in Afghanistan that it would be engaged for so long and did not begin to think about transitioning out and creating a sustainable system until long after it began its work. In the future, the security community should consider questions of sustainability when initiating an operation and look to manage quick impact projects, even in cases where there is limited time to spend available funds.

Looking Ahead

40. This narrative suggests that to improve the value of future investments in health system strengthening, missions should focus heavily on coordination efforts, as well as impact evaluation and monitoring.

41. Coordination is important both within the governance of a system as well as between systems: coordinating better with the civilian sector from the beginning could have allowed the systems to grow in parallel, fill unique niches for one another and create the foundation for a system that would continue to benefit the country long after the international investors leave.

42. Finally; progress and impact should be monitored and evaluated regularly and from the beginning. This will allow the security community to iteratively adjust its interventions and resource investment decisions and change paths as needed to ensure that its ultimate goals are met: that the health of the troops and security of the nation are truly improved.
1. Afghanistan is one of few countries where the Polio virus remains endemic. The GPEI began in Afghanistan in 1988 and has faced a multitude of challenges, including a unique interplay of socio-cultural, political and security issues. This narrative presents an opportunity to understand the ways insecurity impacted the polio eradication campaign’s strategies in Afghanistan and suggests lessons as to how security actors can best support this and similar global health initiatives in the midst of armed conflict.

**POLIO**

2. The Polio virus is transmitted from person to person via the oral-oral or faecal-oral routes. Humans are the only known reservoir and while people of all ages can contract polio, the majority of cases occur in children and adolescents. People infected with polio, whether or not they have symptoms, excrete the virus in their stool for four to six weeks after contracting the virus. Once a person contracts polio, she develops lifelong immunity to the serotype of the virus—I, II or III—that infected her but is still susceptible to the other serotypes.

3. More than 90% of polio infections are asymptomatic; 4–8% lead to flu-like symptoms lasting 2–10 days; and 1–2% lead to a non-lethal aseptic meningitis. Less than 1% of all cases result in paralytic polio, including paralysis of one or two limbs, quadriplegia, and respiratory muscle paralysis. 2–5 % of paralytic polio cases in children and 15% to 30% of adult cases result in death. Polio may be suspected based on a constellation of symptoms, but diagnosis is confirmed by identifying poliovirus in a stool sample or throat culture or by detecting antibody levels in the blood.

4. Two different vaccines are used to immunize people against polio: an Inactivated Polio Vaccine (IPV) and an Orally-Administered Polio Vaccine (OPV). IPV is a chemical mixture of killed virus. OPV contains live virus that has been attenuated or weakened. OPV induces a more robust immune response than IPV, and confers life-long immunity to all serotypes and prevents immunized individuals from becoming carriers of the virus. It is shed in stool, and by faecal-oral spread it can confer some immunity on close contacts of immunized individuals. There is a slight risk that the attenuated virus will revert to its more virulent wild-type strain and, in rare cases, cause vaccine-associated paralysis.

5. OPV, which is administered in liquid form, can be delivered by untrained volunteers. It is very sensitive to heat exposure and loses potency after 24 to 48 hours of exposure to 90- to 100-degree Fahrenheit. A person is considered fully immunized to polio if he or she has received at least three doses of either IPV or OPV or four doses of some combination of the two.

**THE GLOBAL POLIO ERADICATION CAMPAIGN**

6. In 1988 Rotary International, WHO, The US Center for Disease Control (CDC), and UNICEF formed the GPEI to attempt to eradicate polio from the world by 2000. GPEI is the...
single largest, internationally-coordinated public health project in the world, leveraging more than 200 countries and 20 million volunteers to immunize 2.5 billion children.  

7. When GPEI was launched, polio was endemic in more than 125 countries, paralyzing more than 1,000 children daily and killing some, all despite the availability of a vaccine.  Incredible progress in eliminating the disease was made, especially in countries with relatively stable political situations and well-functioning health systems, until the first decade of 2000s. Today, polio remains endemic only in Nigeria, Pakistan and Afghanistan. In 2012–13, the World Health Assembly called for a comprehensive polio endgame strategy.  

8. Failure to eradicate polio in the three remaining countries will mean up to 200,000 new cases per year.  Having spent US$9 billion since 1988, thousands of man-hours and even lives on the campaign, failure may also mar attempts at future global collective health campaigns. If successful, however, estimates show that the GPEI and vaccinations against the disease will have saved up to US$50 billion for the period 1988 through 2035 as a result of prevented polio treatment costs and gained productivity.  In some places in Afghanistan the campaign has also strengthened health delivery systems and provided other health interventions.  

9. Afghanistan is one of the countries that will make or break the successful outcome of the entire global polio eradication effort. The GPEI campaign has overcome conflict, civil strife, political instability, financing challenges, delivery hurdles and geographical barriers to reach the most remote parts of the planet.  

THE GLOBAL POLIO ERADICATION CAMPAIGN IN AFGHANISTAN  

10. Afghanistan has been attempting to address polio for many decades. The Ministry of Public Health’s 1978 “Expanded Program of Immunisation (EPI)” was restructured as part of the effort to strengthen health services in 1994. A series of polio eradication campaigns called National Immunization Days were implemented, and the following year EPI began to be managed regionally. But owing to the ongoing conflict and turmoil, polio vaccination activities nearly ceased in mid-1997 in northern Afghanistan, likely facilitating the large polio outbreak that occurred in Kunduz province in 1999.  

11. After the fall of the Taliban in 2001, the Afghan government formally partnered with the GPEI. A complex multi-layered administrative structure was put in place to oversee the Polio campaign in Afghanistan. The health ministry was in charge, and the basic strategy was four fold: clinics provide vaccines, Supplemental Immunization Activities (SIA) included National and Subnational Immunization Days (NID and SNID, respectively), surveillance to monitor disease incidence, and mop-up campaigns when outbreaks did occur. The scope and scale has been impressive: the six NIDs in 2009 reached almost 7.5 million children; there were four NIDs, eight SNIDs, and two rounds of mop-up in 2010, four NIDs and four SNIDs annually in 2011 and 2012 as well as two mop ups in 2012. Almost 800 district coordinators were overseeing 4,098 clusters who oversaw 45,000 volunteers. Roughly 1,600 monitors were tracking implementation and progress.  

12. Despite the progress, one of the big challenges the Polio campaign faced was insecurity. In 2010 polio immunization was not conducted in several districts of the Helmand Province due "to the ongoing conflict there," a provincial health department director said. Coverage in the southern region and Farah province was sub-optimal: over 60% of 'clusters' (sub-district units) achieved less than 90% coverage during each SIA. About 80–90% of all confirmed cases between 2006 and 2009 have been in the Southern region, and 75% of these were detected in just 10 insecure districts.  

13. But another analysis showed that 80% of children identified by vaccinators as missed during a campaign were from areas where there was not severe conflict and insecurity. Children were often missed due the child being absent when the team showed up (40–50%)
or being newborn and therefore not shown to strangers (20–30%) and so while rates of outright refusal were rare (2–3%), there is a concern that silent refusals may underlie the major statistical groups. In all, the tripling of reported polio cases in 2011 represented a severe setback for the campaign and consequently, in 2012, Polio was declared an emergency in Afghanistan.

14. In late 2012, the GPEI also initiated Permanent Polio Groups, static groups dedicated to working in specific areas that they know well. These type of groups had been initiated along the border with Pakistan previously (in 2009, there were 14 gates) and were newly set up as mop-up teams. In addition to these Permanent Polio Groups, transit vaccination teams were deployed to target displaced populations in the southern and eastern regions facing conflict. The new cases also prompted immediate case response campaigns in December 2012 and January 2013 by the MOPH, UNICEF and WHO.

FACTORS IMPACTING THE POLIO ERADICATION PERFORMANCE

15. The Polio Eradication Initiative (PEI) in Afghanistan has faced service delivery and Afghan cultural challenges in working towards eradicating the disease. Insecurity has intensified each challenge.

Service Delivery

16. The service delivery challenges in Afghanistan are impacted by many of the same factors influencing the overall health system. Though polio immunizations are considered part of the EPI, which is included in the BPHS that NGOs are contracted to provide, and though children are supposed to receive a routine polio immunization at birth, provision of EPI is not monitored; the balanced scorecard used to assess NGO performance does not include EPI as a quality indicator. And, the same challenges that the country sees in implementing the BPHS—the low quality of care and services—carry over to polio.

17. In addition, as found in an independent report on barriers to interrupting polio transmission in Afghanistan, NGOs interpret the mandate “to support” polio eradication activities, including NIDs and SNIDs, at their own discretion and interpret their roles therein differently. The report continues that NGOs often find NIDs and SNIDs distracting from routine responsibilities and are often unclear about whether nurses, community health workers, or volunteers should be the ones supporting the immunization days. For these reasons, many NGOs are not motivated to engage with the PEI, are passive, and the campaign often must take place outside the normal health care service delivery infrastructure. In addition, there is minimal private practitioner involvement, and the role of donor initiatives is confusing to some involved in the campaign due to lack of coordination. Management issues, particularly in the transmission zone, have repeatedly been highlighted as a significant cause of the continued failure to interrupt polio transmission in Afghanistan.

Cultural Challenges

18. The cultural challenges related to the polio eradication initiative in Afghanistan involve issues of gender, trust, and communication. Campaigns must be tailored not only to the country at large, but to local villages, as culture and norms vary vastly, even between neighbouring communities. Communities in the south, for example, tend to be more conservative. There women cannot leave the house without a maharam—a male family member whom they cannot marry—to accompany them. In those conditions, women often lack the opportunity to take their children to clinic for routine immunizations. Further, cultural attitudes throughout the country also may prevent mothers from having contact with male vaccinators. This is a reason why female vaccinators are more easily accepted into the household and are more successful in vaccinating children. However female staff and volunteers are very difficult to recruit. While some of these issues have been resolved by hiring volunteers as young as 14, this presents another set of issues related to training, responsibility, capacity building, and trust. Campaigns also must rely on communication with
men as the local intermediaries to enable access to women who are often home with children during the immunization campaigns,

19. In addition, mass vaccination campaigns have historically been targets of suspicion based on mistrust of the west and western medicine, the fact that they target the healthy, and misinformation about harmful effects of the vaccine. Given the low prevalence of polio and other high priority issues such as security, gaining local buy-in has required considerable efforts.

**Insecurity**

20. The 2009 report on the barriers to interrupting transmission in Afghanistan states, “Insecurity poses the most significant non-health sector barrier to achieving high polio vaccination coverage throughout the country.” The Polio campaign has become a target of insurgent activity in Afghanistan and Pakistan, especially since the US Central Intelligence Agency carried out a fake hepatitis B vaccination campaign in an attempt confirm the location of Osama Bin Laden. Insecurity in the region undermines efforts as it impacts the Polio response teams’ physical security, access to the population, and access of the population to health care. It leads also to a politicization of the campaign.

**Polio Campaign Health Workforce**

21. Health workers have been the explicit targets of the Taliban, according to some news sources, even though Mullah Muhammad Omar, spiritual head of the Afghan Taliban, signed a letter of protection for vaccination teams in 2007. It is not clear who has been behind all the incidents with health workers, but they are numerous: in 2008, in the rural district of Zhari in Kandahar, 10 vaccinators were kidnapped and eventually released (though the abductors retained their vaccines). In 2010, the public health director and Governor of Kunduz province were murdered in separate incidences. As a result, international UN staff were no longer allowed to stay in Kunduz, and the WHO polio officer was redeployed to Badakhshan province. In addition, there is restricted staff movement in other provinces. There was a direct threat of attack on UN compounds in Gardez and Kandahar provinces, which led to the evacuation of medical officers.

22. In January 2012 another health worker was kidnapped in Zhari in Kandahar and polio immunization workers were abducted in December 2012 for three days by insurgents. In December 2012, a young female polio volunteer was shot dead, allegedly by non-Taliban gunmen. In March 2013, reports suggested the Taliban halted an annual polio vaccination campaign in a remote part of Afghanistan close to the border with Pakistan. This activity raised concerns that opposition to the campaign could be spilling across from insurgent groups in neighbouring Pakistan.

23. Health workers are therefore quite aware they can be targets. Insurgents have targeted them and their health facilities, and ISAF forces have hit facilities and personnel with bombs or sniper fire by mistake. As one aid worker said, “humanitarians are supposed to do humanitarian work, but there are also pockets and areas that are very, very dangerous. We are not armed, we are not protected either, and as humanitarians nor do we want to be, or to be seen walking around in flak jackets. We need to make sure that we are seen as civilians, that we are able to make that distinction.” The entire health workforce in conflict-affected provinces/districts therefore works with fear and trepidation.

**Access to Populations and to Health Care**

24. Beyond direct threats or attacks on health workers, general insecurity and fighting impedes the polio campaign. Fighting on the shared border with insecure areas of Pakistan, where access to vaccination and disease surveillance may be quite limited, poses a major threat of importation of polio virus into eastern and southern provinces of Afghanistan. Fighting and insecurity has been a major factor causing under-five children in these districts to miss out on polio immunization.
Politization of the Campaign

25. The disease and the campaign can be very politically charged for both the Taliban and GIRQoA. The exact roles and aims of the Taliban and other anti-government elements in actively promoting and damaging the campaign directly are unclear but their messaging on these contradictory approaches appears to be for political gain. The Taliban have claimed to have never prevented medical workers from reaching children in their strongholds. “We have never attacked medical teams, as long as they coordinate with us when they enter areas under our control,” the Taliban’s southern Afghanistan spokesman, Qari Yousef Ahmad, said. But a newspaper reported, “There is one group that doesn’t care to see polio stop stealing and crippling young lives. It’s the Taliban. In a part of the world constituting polio’s last stronghold, the greatest foe is not new outbreaks or vaccine shortages. Its grizzly militants with room on their agenda for one more bone to add to the anatomy of their death cult ideology.”132 President Hamid Karzai said, “Those who stand in the way of vaccination are the true enemies of our children’s future.” He then called on “the armed opposition to allow the vaccination teams to help save children against the lifetime paralysis,”133 to which the Taliban reacted indignantly. “It is not for Karzai to ask us to attack or not to attack someone,” said Mr. Ahmad.

26. There has been highly visible political leadership on the side of the polio eradication initiative. The President, Minister of Health, and governors of provinces have each led NIDs and sub-NIDs. At various points in Afghanistan’s history, political support was very important for the campaign and produced good results. In fact, political will and leadership are considered essential components of successful health campaigns. However, much of the leaders’ desire to promote their involvement with the campaign stems from the need to be seen as credible leaders who care for the Afghan people. “He [Karzai] is hoping to win hearts—hearts and mind,” one interviewee said. “He wants to be seen as a provider for the nation. Everything is a re-election ploy, a way to be seen in a positive light.”

27. Political leadership that has made the PEI into a partisan issue has not proved helpful to the health sector in Afghanistan recently. Naqibullah Faieq, who leads the health committee in the Afghan Parliament recently tried to temper this political activism and said, “This health issue is non-political, non-military.” He added, “We want both the government and the Taliban to not use the issue of vaccination in their speeches.”134 An August 2009 evaluation of the program suggested, “Now is the time to promote the neutrality of the programme, and to distance it from any political, institutional, organizational, and military links. The health system has to adapt and take risks in developing different ways to achieve eradication such as building local trust, developing negotiating skills and reducing fear.”135

THE SECURITY COMMUNITY’S ROLE IN AFGHANISTAN’S PEI

28. The security community has addressed some of the challenges insecurity has posed to the campaign by: 1) sharing information 2) participating in days of tranquillity 2) receiving education and 4) remaining sensitive to issues of branding and reputation. These interrelated approaches to easing the burden of insecurity on the campaign, all of which involve coordination, together have made an impact on the ability to vaccinate children and reduce the threat of polio for the world.

Information Sharing and Coordination

29. When campaign aid workers realized that they would need ceasefires—termed “Days of Tranquility”—in the period 2008–2009 to be successful in their campaigns, the heads of several agencies, including the WHO, UNICEF, and Canadian International Development Agency (CIDA), as well as representatives of the MOPH met with ISAF representative in Kandahar Province. “We explained that we need to make sure that Days of Tranquility are being observed because our guys are being stopped,” a CIDA representative explained.
30. The PEI shared the NID and SNID schedule for the year online so all levels of command could coordinate and avoid miscommunications about Days of Tranquillity timing. Prior to each NID or SNID, in fact, HQ ISAF published a Fragmentary Order to ensure that ISAF personnel:
   a. “Do not offer direct support, intervene, or interfere with immunisation teams
   b. “Distance themselves from the program
   c. “Are aware of, and appreciate, the importance of the program.”

31. This “passive” support from ISAF was important in preparing for the Days of Tranquillity and supporting the WHO and MOPH to achieve their goal to have a polio-free Afghanistan.

Days of Tranquillity
32. Though humanitarian ceasefires have been called for in Afghanistan as part of vaccination efforts since the late 1980s, they have not always been respected. Prior to the security community engaging in the PEI campaign, PEI volunteers would report to WHO and UNICEF that they had been stopped and, often, that they had their vaccines confiscated or destroyed—they didn’t know what to do.

33. The security community’s cooperation with the Days of Tranquillity was helpful. Aware of the three days that vaccinators would be in the field for each immunization campaign, the security community and anti-government elements would facilitate safe passage for the vaccinators. The security community regularly participated in SIA planning and review meetings as well.

34. Sometimes, however, orders didn’t get handed all the way down to the bottom and communication mechanisms were flawed, so there would still be people patrolling in certain areas. This was true for both the Taliban and the ANSF; sometimes even the ANA would get different orders from the ANP, and vaccination would still be interfered with.

Collaboration
35. Senior commanders were briefed on the importance of the PEI in June 2009, and local ISAF commanders coordinated and exchanged information on operations with UNAMA and local NGOs. There has been extensive engagement between the UN partners, the WHO and NATO. Other organizations that have played an active role in SIAs include the ICRC and UNAMA. Both agencies have been able to communicate with anti-government elements in some areas to promote community mobilization in insecure areas.

36. Frequent turnover among military staff can make it harder for the humanitarian community to establish strong working relationships and coordination mechanisms, but the often cited hurdle can be overcome if both parties are determined to make such relationships work.

37. Humanitarian actors must be willing to accept the military’s help as well. As one interviewee reported, “I have been at meetings with UN OCHA and the donors—and you can see daggers. There is so much tension. Half the room is in uniform, saying what can we do to help, and the other half are just saying: Don’t. And a very small minority saying, this is not a solution.” There must be a broad recognition that the military can and wants to contribute positively in areas beyond security, accompanied by a willingness of all parties use what resources are available when appropriate.

Branding and Reputation Building
38. There was agreement at the high command level that ISAF personnel should not directly provide vaccination services. As one humanitarian stakeholder said, “I remember seeing pictures of soldiers giving out polio vaccine, and our faces turning white because it’s so hard for us to remain neutral. We have to ensure that there are no emblems on vaccines,
nothing that shows we are part of the conflict.” As one aid worker explained, “Afghans don’t trust the military. They see it as an extension of the government, in which they don’t have much confidence anyway.”

39. ISAF clearly demarcated its activities from those of UN and humanitarian organizations. ISAF agreed not to use any white vehicles, which were associated with the UN and humanitarians. This helped the humanitarian groups improve their relationships with the community. “Perception is very important in Afghanistan,” one informant explained.

40. Ensuring all people or vehicles that enter a community are properly marked will allow people to better understand who is coming and going and to trust their intentions. And, should any incidents occur or vaccinators be stopped, it will be possible to identify who stopped them.

41. Experiences in Afghanistan have shown that constructive dialogue, listening and responding to community needs, priorities and cultural values and the development of trust play a key role in fostering community support and acceptance of external engagement in insecure areas.

**DISCUSSION**

**Past Practices**

42. Actors on both sides of the conflict—GIRoA supported by international military forces; and anti-government elements—have, in the past, attempted to use the polio eradication campaign as a heart and mind exercise in support of their own political agendas and purposes. In addition, interviewees with high-level civilians in Afghanistan left the distinct impression that the engagement of military actors in polio eradication efforts in security-compromised areas until mid-2009, as part of a military strategy, has been problematic. With this use of the campaign for purposes other than health, many humanitarian and development actors, involved in the same campaign, had a very legitimate concern for their necessary independence and neutrality. The physical safety of these actors was compromised and the effectiveness of the polio eradication campaign thereby endangered.

**Lessons Learned**

43. Consequently ISAF adopted a new approach to support the humanitarian and development community actors in a passive way, by enforcing/promoting the necessary neutrality and by desisting from any involvement in or use of the campaign for other purposes. The concept of days of tranquility was introduced to implement temporary ceasefires to facilitate the immunization campaign. The aim was to improve the coverage of the campaign in remote/insecure areas and increase the humanitarian space/access on these days. The contribution of ISAF to this concept is perceived as a best practice as it recognizes the importance of such campaigns, the neutrality of actors and the need to maintain interaction mechanisms to reach vulnerable/at risk populations.

44. Noteworthy therefore from this example of the polio eradication campaign is that the security community and humanitarian and development actors could align their activities so as not to interact in an insecure area. The security community provided passive rather than direct support to solve the “security problem” thanks to open lines of communication and good working relationships between the players. This lesson can certainly be transposed to other situations with other threats to health. It also shows that the security community learned that it was important not to be an obstacle to maximizing the chance of a health campaign success.

**Other Obstacles**

45. Beyond security issues, many major issues endangering Afghanistan’s polio eradication program in the longer term revolve around cultural factors. Community
knowledge of the nature and value of polio immunization could be inadequate leading to an ownership problem with insufficient acknowledgement of the need to participate in the campaign. Inadequate performance of routine immunization conducted via the BPHS, difficult access to remote areas, and operational weaknesses (e.g., development of a strategy to reach the last child, difficulty in recruiting and training female vaccinators, monitoring capabilities) were also barriers to success.

**Looking Ahead**

46. Afghanistan has demonstrated that in such a complex situation the security community should **have a proactive interest** in maintaining situational awareness (case epidemiology, monitoring the developments in the campaign) and in preparing/updating plans of how to most effectively support the actors in charge, without endangering them or their impartiality. At the same time, the security community should **adopt a passive engagement approach**. This should not be interpreted as indifference on the part of the security community to a health campaign—on the contrary, it is a sign of recognition by the community of how they can best ensure maximum overall effect from differing communities engaged in the same geographical area.
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# Annex A

## Glossary of Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACBAR</td>
<td>Agency Coordinating Body for Afghan Relief</td>
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<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>AIA</td>
<td>Afghan Interim Administration</td>
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<tr>
<td>AIAF</td>
<td>Afghan Interim Authority Fund</td>
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<tr>
<td>ANA</td>
<td>Afghan National Army</td>
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<td>ANDS</td>
<td>Afghan National Development Strategy</td>
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<td>ANP</td>
<td>Afghan National Police</td>
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<td>ANSF</td>
<td>Afghan National Security Forces</td>
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<tr>
<td>ARTF</td>
<td>Afghan Reconstruction Trust Fund</td>
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<td>ATA</td>
<td>Afghan Transitional Administration</td>
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<td>BPHS</td>
<td>Basic Package of Health System</td>
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<td>CDC</td>
<td>(US) Centre for Disease Control</td>
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<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<tr>
<td>CJTF</td>
<td>Coalition Joint Task Force</td>
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<tr>
<td>CNTF</td>
<td>Counter Narcotics Trust Fund</td>
</tr>
<tr>
<td>COIN</td>
<td>Counter-Insurgency</td>
</tr>
<tr>
<td>COMISAF</td>
<td>Commander ISAF</td>
</tr>
<tr>
<td>CSTC-A</td>
<td>Combined Security Transition Command – Afghanistan</td>
</tr>
<tr>
<td>DoD</td>
<td>(US) Department of Defence</td>
</tr>
<tr>
<td>EPHS</td>
<td>Essential Package of Hospital Services</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Program of Immunization</td>
</tr>
<tr>
<td>GIRoA</td>
<td>Government of the Islamic Republic of Afghanistan</td>
</tr>
<tr>
<td>GPEI</td>
<td>Global Polio Eradication Initiative</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HN</td>
<td>Host Nation</td>
</tr>
<tr>
<td>ICRC</td>
<td>International Committee of the Red Cross</td>
</tr>
<tr>
<td>IPV</td>
<td>Inactivated Polio Vaccine</td>
</tr>
<tr>
<td>ISAF</td>
<td>International Security Assistance Force</td>
</tr>
<tr>
<td>JALLC</td>
<td>Joint Analysis and Lessons Learned Centre</td>
</tr>
<tr>
<td>JCMB</td>
<td>Joint Coordination and Monitoring Board</td>
</tr>
<tr>
<td>LOFTA</td>
<td>Law and Order Trust Fund for Afghanistan</td>
</tr>
<tr>
<td>MEDCAP</td>
<td>Medical Civic Action Programme</td>
</tr>
<tr>
<td>MEDSEM</td>
<td>Medical Seminar</td>
</tr>
<tr>
<td>MMF</td>
<td>Multinational Military Forces</td>
</tr>
<tr>
<td>MOD</td>
<td>Ministry of Defence</td>
</tr>
<tr>
<td>MOI</td>
<td>Ministry of the Interior</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
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</tr>
<tr>
<td>MOPH</td>
<td>(Afghan) Ministry of Public Health</td>
</tr>
<tr>
<td>NID</td>
<td>National Immunization Day</td>
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<tr>
<td>NTM-A</td>
<td>NATO Training Mission – Afghanistan</td>
</tr>
<tr>
<td>OCHA</td>
<td>Office for the Coordination of Humanitarian Affairs</td>
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<tr>
<td>OEF</td>
<td>Operation ENDURING FREEDOM</td>
</tr>
<tr>
<td>OPLAN</td>
<td>Operations Plan</td>
</tr>
<tr>
<td>OPV</td>
<td>Orally-administered Polio Vaccine</td>
</tr>
<tr>
<td>PEI</td>
<td>Polio Eradication Initiative</td>
</tr>
<tr>
<td>PRT</td>
<td>Provincial Reconstruction Teams</td>
</tr>
<tr>
<td>SCR</td>
<td>Senior Civilian Representative</td>
</tr>
<tr>
<td>SIA</td>
<td>Supplementary Immunization Activities</td>
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<tr>
<td>SNID</td>
<td>Sub-National Immunization Day</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
</tr>
<tr>
<td>TCN</td>
<td>Troop Contributing Nation</td>
</tr>
<tr>
<td>UNAMA</td>
<td>UN Assistance Mission in Afghanistan</td>
</tr>
<tr>
<td>UNHCR</td>
<td>UN High Commissioner for Refugees</td>
</tr>
<tr>
<td>USAID</td>
<td>US Agency for International Development</td>
</tr>
<tr>
<td>USFOR-A</td>
<td>US Forces – Afghanistan</td>
</tr>
<tr>
<td>VMOP</td>
<td>Village Medical Outreach Programme</td>
</tr>
</tbody>
</table>
The complexity of the Afghanistan case study made it necessary to emphasize chronological milestones to highlight the commitment of the international community after decades of war and instability and the evolution of the health system in this context.

The purpose of the following non-exhaustive three Tables is to facilitate the understanding of dedicated international conferences and the process of reconstruction of Afghanistan (politically, economically and in terms of security), to point out the key steps of the Multinational Military Force (MMF) response and to highlight the evolution of the health care system during the last decades of turmoil.

The tables were built-up via compilation of various sources: UN, NATO, European Commission\(^ {10} \), Steering Committee\(^ {11} \), Afghan Ministry of Finance, US Congress, USAID, ISAF, World Bank, WHO, UNHCR, USIP, BBC News\(^ {12} \), CFC\(^ {13} \) and Wikipedia.

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### KEY INTERNATIONAL AID AND DONOR STEPS FOR AFGHANISTAN

<table>
<thead>
<tr>
<th>Events</th>
<th>Outcome</th>
<th>Connected processes and Food for thought</th>
<th>Phases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonn Conference</td>
<td>UN Talks on Afghanistan. The Bonn agreement, endorsed by UNSCR 1383 (6 Dec. 2011), defined the direction for Afghanistan in the post 9/11 era. It set out a framework and timetable for the establishment of a constitution and democratic institutions in Afghanistan. Intended to “end the tragic conflict in Afghanistan and promote national reconciliation, lasting peace, stability and respect for human rights”.</td>
<td>The World Bank in coordination with the Afghan government wrote the Preliminary Need assessment in preparation of the Tokyo reconstruction conference. The estimated requirements were of US$4.89 billion per 2.5 years for Afghanistan and the initial donors pledges were US$4.5 billion per 2.5 years. As a comparison, for Iraq the estimated requirements were 7 times more important (US$36 billion) at the Madrid donor conference held in Oct. 2003 and the initial donors pledges were 8 times more important (US$33 billion).(^ {14} )</td>
<td>From comprehensive destruction to initial phase of reconstruction.</td>
</tr>
</tbody>
</table>

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\(^ {10} \) “Thematic evaluation of the European Commission support to the Health sector”; Final report volume IId, August 2012.


\(^ {13} \) Civil-Military Fusion Centre (CFC); Afghanistan Agreements – A Collection of Official Texts from 2001 to 2011; [http://reliefweb.int/sites/reliefweb.int/files/resources/CFC_Afghanistan_Agreements_June2012.pdf](http://reliefweb.int/sites/reliefweb.int/files/resources/CFC_Afghanistan_Agreements_June2012.pdf); Last accessed 04 April 2013.

<table>
<thead>
<tr>
<th>Event</th>
<th>Key Points</th>
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</table>
| Afghanistan Reconstruction Steering Group Conference Brussels, 20–21 Dec. 2001 | Lack of a clear long-term plan for the implementation of assistance. Weak financial engagement of participants.  
  Call for an extraordinary coordination effort by donor community.  
  The AIA was inaugurated on 22 December 2001.  
  “Success will not simply be determined by how much money we throw at the problem. The building of a new Afghanistan needs to take place in an atmosphere of peace, stability and security” … “We should keep the regional dimension of this vision in mind” (Rt Hon. Chris Patten)  
  International donors meeting Tokyo, 21–22 Jan. 2002 | First major international conference on development and aid in Afghanistan. The Afghan government requested US$10 billion and received less than half of that in pledges (US$4.5 billion).  
  The Afghan Interim Authority Fund (AIAF) was created for donor contributions for the next six months.  
  UNAMA was established in March 2002 as a political and "integrated" mission, directed and supported by the UN Department of Peacekeeping Operations, to help implement the Bonn Agreement.  
  Diversion of the international community attention in May 2003 with the US-coalition led operations in Iraq: it had an effect on troop contribution, assistance and progressively in the insurgent techniques, tactics and procedures (bombings and Improvised Explosive Devices).  
  In July 2002 the Afghan Reconstruction Trust Fund (ARTF) replaced the AIAF mechanism.  
  UNDP established the Law and Order Trust Fund for Afghanistan (LOFTA) in 2002 with a primary focus on financing ANP recurrent budget and financing ANP infrastructure projects.  
  Optimism and light footprint |  
| Berlin Conference 31 March–01 April 2004 | The focus was on reconstruction efforts of Afghanistan.  
  Ratification of the new Afghan Constitution by the Loya Jirga.  
  NATO to the rescue. Extension of the  

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15 Former European Commissioner for External Relations, speech 01/643, 20 Dec. 2001

16 The ARTF is managed by the Asian Development Bank, the World Bank, the Islamic Development Bank and the United Nations Development Programme (UNDP). It became the largest contributor to the GIROA budget for both operating and development costs and provided a way to coordinate donor funding with priorities of the Afghan government. Donations to the fund cannot be earmarked for a particular project, but donors can identify a preference (though non-binding) of a component or sector for which their ARTF funding should be used. This helps ensure that the Afghan government is able to direct funds toward projects that it identifies as priorities during the reconstruction process.
<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Istanbul Summit (NATO) 28–29 June 2004</td>
<td>NATO Heads of State and Government expanded the Alliance’s presence in Afghanistan.</td>
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<tr>
<td>Karzai won the 9 Oct. 2004 presidential election. Election for National Assembly on 18 Sept. 2005. The Counter Narcotics Trust Fund (CNTF) was created and administered by UNDP in 2005 to assist the GIRoA.</td>
<td></td>
</tr>
<tr>
<td>Rising insecurity 2005-2009</td>
<td></td>
</tr>
<tr>
<td>London Conference 31 Jan.–01 Feb. 2006</td>
<td>The GIRoA and the International Community signed the Afghan Compact that outlined the principles of their cooperation over the next 5 years and donors pledged US$10.5 billion. The Compact identified three critical and interdependent areas or pillars of activity: 1. Security; 2. Governance, Rule of Law and Human Rights; and 3. Economic and Social Development. It recognised that “security remains a fundamental prerequisite for achieving stability and development in Afghanistan. It states that security cannot be provided by military means alone, but requires “good governance, justice and rule of law, reinforced by reconstruction and development”.</td>
</tr>
<tr>
<td>Served as a basis for next stage of reconstruction, which is to rely more strongly on the country’s own institutions. The Joint Coordination and Monitoring Board (JCMB) was set up to oversee the implementation of the Afghan Compact and to ensure greater coherence of the efforts by the GIRoA and the international community.</td>
<td></td>
</tr>
<tr>
<td>Rome Conference 02–03 July 2007</td>
<td>Focus on the rule of law and judiciary reforms in Afghanistan. Little money was raised for state development projects (US$40 million). The ANDS is issued in April 2008. It envisioned that most of the</td>
</tr>
</tbody>
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17 The ANDS strategic objectives include achieving the following Afghanistan Compact and the UN Millennium Development Goals (MDGs): by end-2010 the BPHS is due to be extended to cover at least 90% of the population; maternal mortality is due to be reduced by 15%; and full immunization coverage for infants under-5 for vaccine-preventable diseases is due to be achieved and their mortality rates reduced by 20%; to reduce by 50%, between 2003 and 2015, the under-five mortality rate, and
| Paris Conference 12 June 2008 | The GIRoA and the international community reiterated their partnership with guidance from the Compact and the Afghan government’s assigned leadership role in the implementation plan outlined in the ANDS. The conferees affirmed the expanded role of UNAMA in all aspects of coordination. Key priorities identified included in particular: strengthening democracy and governance; investing in infrastructure and the private sector; improving aid effectiveness and reducing corruption; improving counter-narcotics measures; ensuring the needs of all Afghans would be addressed through government services; and greater civil society participation. Total pledge to support the ANDS reached more than US$21 billion in additional funds for Afghanistan reconstruction. Donor countries and organizations also agreed to deliver these funds in a more coordinated manner than in previous years to prevent waste and duplication of efforts. The United States pledged US$10.2 billion over 2 years, thus funding more than one-fifth of the US$50 billion required to implement the ANDS.  

The JCMB expanded its focus from merely monitoring the implementation of the Afghanistan Compact to include the provision of strategic and policy guidance on the prioritized implementation of the ANDS. UNSCR 1806 (20 March 2008) expanded the mandate of UNAMA and announced the “strengthening of cooperation with ISAF at all levels and throughout the country”, in order “to improve civil-military coordination, to facilitate the timely exchange of information and to ensure coherence between activities of national and international security forces and of civilian actors in support of Afghan-led development and stabilization process, including through engagement with provincial reconstruction teams and engagement with non-governmental organizations”. Closure of the CNTF in Dec 2008 and extended through 2009. | Building security as an exit strategy |

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Building security as an exit strategy

further reduce it to one third of the 2003 level by 2020; to reduce the maternal mortality rate by 50%, between 2002 and 201, and further reduce by an additional 25% of the 2002 level by 2020; and reverse the spread of HIV/AIDS by 2020; and to halt and begin to reverse the incidence of malaria and other major diseases by 2020.

The Hague Conference  
31 March 2009

Representatives to the “International Conference on Afghanistan: A comprehensive Strategy in a Regional Context”, made a commitment to further efforts in the country, pledging a stronger military offensive against the Taliban insurgency, to invest in civil reconstruction, to tackle the drug trade and to stabilize neighbouring Pakistan.

The conference reinforced the central role outlined for UNAMA as coordinator of international action and assistance. The participants urged also UNAMA “to expand its presence into as many provinces as possible”.19

By 2009, Afghanistan was the leading global recipient of official development assistance for the second consecutive year.20

UNSCR 1868 (23 March 2009) incorporates UNAMA’s increased scope, which includes leading international civilian efforts to support the Afghan government, increasing cooperation with the ISAF, and developing greater political outreach with Afghan leaders.

President Obama’s comprehensive, new strategy for Afghanistan and Pakistan released on 27 March 2009.

Parliamentary elections in Aug. 2009 with controversial results that damaged the legitimacy of Karzai government.

“The influx of assistance is hoped to continue. However, the Government of Afghanistan is concerned that the levels of assistance spent outside the government system remain large because it limits government ownership. Development aid is only effective when there is close consultation between donors and the recipient government, and there is a strong focus on strengthening development capacity of the government to build its internal institutional capacity to manage and implement its development.”21

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London Conference  
28 January 2010

Representatives agreed to develop a plan for phased transition to Afghanistan security lead province by province to begin by late 2010/early 2011.

The Afghan Finance minister complained that 80% of development funds for Afghanistan were distributed without any GIRoA control. The conference agreed that

Increased MMF efforts to support training of Afghan forces. Afghan government plans to convene a Grand Peace Jirga before the Kabul Conference.

UNSCR 1917 (22 March 2010) focus on promoting international support for the GIRoA’s development and governance priorities, increasing cooperation with international security forces,

Towards transition of security responsibility and peace negotiation with armed opponents.

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within the next 2 years, the GIRoA had to get control over half of the total funds spent in its country, depending on Kabul’s own progress in improving its performance, in particular in the fight against corruption.

<p>| Kabul Conference 20 July 2010 | The GIRoA put forward an Afghan-led plan for improving development, governance and security. The “Kabul process” is viewed by experts as a potentially important link in the transition to full Afghanistan leadership. Support for sustained capacity building at the national and sub-national levels was emphasized. | Peace Jirga in Kabul (June 2010) and establishment of Afghan High Peace Council. Donors agreed to extend the ARTF until 2020: it reflects an on-going commitment by donors to utilize the ARTF mechanism and it is an acknowledgement of the development challenges that remain in Afghanistan. LOFTA ended on 31 August 2010. |
| Lisbon Summit (NATO) 20 November 2010 | Participants endorsed a framework under which full security responsibilities would be handed over to Afghan forces by 2014. The process defines the implementation of the transition province-by-province with a simultaneous drawdown of international combat forces. UNAMA will support the civilian side of this transition, particularly in areas of governance and development. | 20 Sept. 2011: assassination of former president Rabbani, head of the Afghan High Peace Council. Start of the security transition process. |
| Istanbul Conference 2 November 2011 | The conference focused in particular on regional economic cooperation: Turkey as a mediator between Pakistan and Afghanistan, with the participation of 14 countries from the region. | Establishing a roadmap leading to 2014 and to define a vision beyond 2014 transition |
| Bonn Conference 5 December 2011 | The GIRoA and the international community mutually renewed their long-term commitments in the areas of governance, security, peace process, economic and social development, and regional cooperation. (Pakistan did not attend the Bonn conference) | The international community agreed on a target of 157,000 ANP by Oct. 2013 as part of the 352,000 strong ANSF. Dec-Jan 2012: president Karzai was angered by US and Qatari efforts to kick-start the peace process without consulting his government fully. Mid-March 2012: preliminary peace talks between Taliban |</p>
<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
<th>References</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Chicago Summit        | ISAF’s mission to be concluded by the end of 2014. But members confirm that thereafter close partnership will continue beyond the end of the transition period, “to safeguard and build on the substantial progress and shared achievement”. They reaffirmed their strong commitment to support the training, equipping, financing and capability development of the ANSF beyond the end of the transition period in 2014.  
| Tokyo Conference      | To ensure continuity and progress, the GIRoA and the international community decided to establish a follow-up mechanism to review their mutual long-term commitments and to verify the fulfilment of these commitments based on the notion of mutual accountability. Under the Kabul process framework, participants decided that follow-up meetings will take place at the ministerial level every 2 years, in between years at the senior official levels, and at more regular intervals under the Afghan-UN led JCMB.  
Established a renewed stronger foundation for partnership to support sustainable growth and development of Afghanistan through the Transformation Decade (2015-2024).  
“Certainty and sustained partnership with Afghanistan is what is required now, ensuring that the Afghan people have the confidence to focus on building a better future” (Ján Kubiš, Head of UNAMA, Security Council 6896th meeting, Dec. 2012) | [22](NATO, Secretary General’s Annual Report 2012, “Defence matters”, 31 January 2013, http://www.nato.int/cps/en/natolive/opinions_94220.htm?utm_medium=email&utm_campaign=SG+Report+2012+-+SECOND+email&utm_content=SG+Report+2012+-+SECOND+email+CID_844ca1aa033b7373b5d8f5d5b7fc433f&utm_source=Email%20marketing%20software&utm_term=website, accessed 31 Jan 2013.) | |
| 2013                  | Donors have pledged a total of US$62 billion in aid for reconstruction of Afghanistan in the period 2002-2013.  

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## KEY MMF COMMITMENT STEPS IN AFGHANISTAN

<table>
<thead>
<tr>
<th>Dates</th>
<th>Key steps</th>
<th>Food for thought</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Creation of ISAF and UNAMA</strong></td>
<td></td>
<td></td>
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<tr>
<td>Dec. 2001</td>
<td>ISAF was created in accordance with the Bonn Conference in December 2001. The concept of a UN-mandated international force to assist the newly established Afghan Transitional Authority was also launched at this occasion to create a secure environment in and around Kabul and support the reconstruction of Afghanistan (UNSCR 1386, adopted on 20 December 2001). Afghan opposition leaders attending the conference began the process of reconstructing their country by setting up a new government structure, the Afghan Transitional Authority.</td>
<td>These agreements paved the way for the creation of a three-way partnership between the Afghan Transitional Authority, the UNAMA and ISAF.</td>
</tr>
<tr>
<td>28 March 2002</td>
<td>UNSCR 1401 established UNAMA, at the request of the Afghan Transitional Authority to assist it and the people of Afghanistan in laying the foundations for sustainable peace and development.</td>
<td>In Mid-2002, Pentagon officials who long opposed expanding the international security force in Afghanistan consider that enlarging it and placing its troops outside Kabul may help secure and rebuild the country, still wracked by banditry, warlords and renegade Taliban fighters. The change in the Pentagon’s thinking is an important precondition for other nations to contribute troops for a peacekeeping effort. But officials recognize that it might take months and finding nations to contribute the forces would not be easy.(^{24})</td>
</tr>
<tr>
<td><strong>NATO increased role</strong></td>
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<tr>
<td>11 Aug 2003</td>
<td>The Alliance assumed leadership of the ISAF operation. NATO became responsible for the command, coordination and planning of the force, including the provision of a force commander and headquarters on the ground in Afghanistan.</td>
<td>ISAF’s mandate was initially limited to providing security in and around Kabul.</td>
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<tr>
<td><strong>ISAF expansion and extension of the provincial Reconstruction Team (PRT) concept</strong></td>
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<tr>
<td>October 2003</td>
<td>UNSCR 1510 paved the way for an expansion of ISAF’s mission across the country.</td>
<td>The expansion was developed in four stages(^{25}) implemented progressively between late 2003 and late 2006.</td>
</tr>
<tr>
<td>Dec 2003</td>
<td>The North Atlantic Council authorized the Supreme Allied Commander to initiate the expansion of ISAF by taking over command of the German-led PRT in Kunduz. The other eight PRTs operating in Afghanistan in 2003 remained under the command of OEF, the continuing US-led military operation in Afghanistan</td>
<td>First stage: expansion to the North (Dec. 2003 – Oct. 2004)</td>
</tr>
<tr>
<td>28 June</td>
<td>During Istanbul Summit, NATO</td>
<td>On 31 Dec. 2003, the military component of the Kunduz PRT was placed under ISAF command as a pilot project and first step in the expansion of the mission - The process was completed on 1st Oct. 2004 and at that stage, ISAF was able to influence security in country’s nine Northern provinces.</td>
</tr>
</tbody>
</table>


\(^{25}\) [http://www.isaf.nato.int/history.html](http://www.isaf.nato.int/history.html), accessed 06 August 2012.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Notes</th>
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<tbody>
<tr>
<td>2004</td>
<td>announced that it would establish new PRTs in northern Afghanistan, in Mazar-e-Sharif, Meymana, Feyzabad and Baghlan.</td>
<td>Second stage: expansion to the West (May- Sep. 2005) At the end of that process, the command led a total of nine PRTs in the north and the west, providing security assistance in 50% of Afghanistan’s territory. The Alliance continued to make preparations to further expand to the Afghan south.</td>
</tr>
<tr>
<td>10 Feb. 2005</td>
<td>NATO announced that ISAF would expand into the west of Afghanistan.</td>
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<tr>
<td>31 May 2005</td>
<td>ISAF took command of two additional PRTs in the provinces of Herat and Farah and of a forward support base in Herat.</td>
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<tr>
<td>Sep. 2005</td>
<td>ISAF completed its westward expansion when two further ISAF-led PRTs became operational, one in Chaghcharan, capital of Ghor province, and one in Qala-e-Naw, capital of Baghdis province. The Alliance also temporarily deployed 2,000 additional troops to support the provincial and parliamentary elections.</td>
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<tr>
<td>8 Dec. 2005</td>
<td>The NATO Foreign Ministers gathered in Brussels endorsed a plan that paved the way for an expanded ISAF role and presence in Afghanistan.</td>
<td>Third stage: expansion to the South (July 2006). The expanded ISAF led a total of 13 PRTs in the north, west and south covering some three-quarters of Afghanistan’s territory. The number of ISAF forces in the country also increased significantly, from about 10,000 prior to the expansion to about 20,000 after.</td>
</tr>
<tr>
<td>31 July 2006</td>
<td>ISAF assumed command of the southern region of Afghanistan from US-led Coalition forces, expanding its area of operations to cover an additional six provinces (Day Kundi, Helmand, Kandahar, Nimroz, Uruzgan and Zabul) and taking command of four additional PRTs.</td>
<td></td>
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<tr>
<td>5 Oct. 2006</td>
<td>ISAF took command of the MMF in eastern Afghanistan from the US-led Coalition.</td>
<td>Fourth stage: expansion to the East (Oct. 2006). In addition to expanding the Alliance’s area of operations, the revised operational plan also paved the way for a greater ISAF role in the country. This includes the deployment of ISAF Operational Mentor and Liaison Teams (OMLTs) to ANA units at various levels of command.</td>
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**Increased NATO contributions**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Sep. 2008</td>
<td>US president George Bush sent an extra 4,500 US troops to Afghanistan, in a move he describes as a “quiet surge”.</td>
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<tr>
<td>Feb 2009</td>
<td>NATO countries pledged to increase military and other commitments in Afghanistan after US announced dispatch of 17,000 extra troops.</td>
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<tr>
<td>March 2009</td>
<td>US president Obama unveiled a new strategy for Afghanistan and Pakistan.</td>
<td>An extra 4,000 US personnel will train and bolster the Afghan army and police and there will be support for civilian development.</td>
</tr>
<tr>
<td>21 Nov. 2009</td>
<td>NATO’s NTM-A was established bringing together NATO and national training efforts under one umbrella.</td>
<td></td>
</tr>
<tr>
<td>Dec. 2009</td>
<td>US president Obama decided to boost US</td>
<td>As of May 2012, 38 nations were contributing to NTM-A.</td>
</tr>
</tbody>
</table>

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26 Final communiqué of the Ministerial meeting of the North Atlantic Council, Brussels, 8 December 2005, [http://www.nato.int/docu/pr/2005/p05-158e.htm](http://www.nato.int/docu/pr/2005/p05-158e.htm).
troops number in Afghanistan by 30,000, bringing total to 100,000. It works in close partnership with the Afghan MOD and MOI, as well as in collaboration with the European Police Mission in Afghanistan and the European Gendarmerie Force. Training and mentoring of ANSF is carried out by NATO's Military Advisory Teams and Police Advisory Teams. Additional ISAF advisors teams are provided to the Afghan Operation Coordination Centres, which support the ANSF commanders in coordinating the employment of forces in their areas.

| Towards withdrawal | May 2012 | NATO Summit in Chicago endorses the plan to withdraw foreign combat troops by the end of 2014. | The sustainment of ANSF post-2014 remains the responsibility of the GIRoA and the International Community as a whole |
### Key Events and Implications for the Health Sector

<table>
<thead>
<tr>
<th>Dates</th>
<th>Event</th>
<th>Health-related context</th>
</tr>
</thead>
<tbody>
<tr>
<td>1933</td>
<td>Zahir Shah becomes King and Afghanistan remains a monarchy for the next four decades.</td>
<td>Health care was mostly provided by the government, and was largely absent, or at abysmal levels, in rural areas. In urban areas, the health system was relatively well developed and dominated by hospitals and a large number of health workers. The services were curative-orientated and only 1 to 4 % of the national budget was allocated to the health system. Starting from this weak foundation, the public health system further deteriorated in the years of war that followed. Although Afghanistan remained calm and stable in the 1960s-1970s, the health status of the people, especially women and children, was significantly lower when compared to other countries in the region.</td>
</tr>
<tr>
<td>1973</td>
<td>Mohammed Daud seizes power in a coup and declares a Republic</td>
<td>Beginning of serious dilapidation of most health care that used to be available. The country missed out on the 1978 Alma Ata declaration inspired primary health care movement in bringing primary care services to more peripheral, mostly rural population</td>
</tr>
<tr>
<td>1978</td>
<td>Mohammed Daud is overthrown and killed in a coup. Start of armed revolt.</td>
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<tr>
<td>Dec. 1979 to 1988</td>
<td>Soviet forces invade Afghanistan and prop up communist government. Anti-regime resistance intensifies with various mujahidin groups which formed an alliance in 1985. Najibullah is appointed in 1986 as head of Soviet-backed regime</td>
<td>In the mid-1980s, half of Afghan population estimated to be displaced by war, with many fleeing to neighbouring Iran or Pakistan. NGOs emerged providing health care services for Afghan refugees, and starting cross-border operations in Afghanistan and gradually expanded their activities by establishing health facilities in rural areas. The health system was made more centralized under the control of local Mujahidin commanders.</td>
</tr>
<tr>
<td>1989</td>
<td>Last Soviet troops leave but civil war continues as mujahidin push to overthrow Najibullah.</td>
<td>The outbreak of civil war and the lack of a centralized government resulted in a fragmented health care system.</td>
</tr>
<tr>
<td>1992-1996</td>
<td>Najibullah’s government is toppled, but a devastating civil war follows.</td>
<td></td>
</tr>
<tr>
<td>1996-2001</td>
<td>Taliban seize control of Kabul.</td>
<td>This situation continued with the emergence of the Taliban. During this period, women’s access to health services became even worse. Despite the restrictions placed by the Taliban, private non-for-profit sector was prominent and when the Taliban regime fell, NGOs provided 80% of health services in the country. The virtual lack of any central health policy making and war-induced increased poverty resulted in Afghanistan having one of the poorest arrays of health indicators in the world by 2001. The target of the UN Millennium Development Goals 27 is for most of the goals to be achieved by 2015; due to years of conflict, in Afghanistan this is extended to 2020.</td>
</tr>
</tbody>
</table>

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27 The UN MDGs were developed and agreed upon by 2000 by 189 countries of the UN. The goals, targets and indicators of the MDGs are the internationally recognized standard to address unacceptable inequalities between rich and poor countries.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 2001</td>
<td><strong>09 Sept.</strong> – Assassination of Ahmad Shah Massoud, leader of the main opposition to the Taliban – the Northern Alliance. On the 11th Sept, terrorist attacks against the United States. UNSCR 1368 (12 Sept.) expresses the readiness of the security council to take all necessary steps to respond to the terrorist attacks and to combat all forms of terrorism. UNSCR 1373 (28 Sept.) reaffirms the need to combat by all means threats to international peace and security caused by terrorist acts.</td>
</tr>
<tr>
<td>Oct. 2001</td>
<td>US-led military operation is launched on the Taliban stations. Anti-Taliban Northern Alliance forces enter Kabul shortly after. After years of Taliban rule, Afghanistan’s health infrastructure was demolished. Insecurity and a lack of health care providers (especially female), were major challenges to health care delivery, particularly in the South and along border regions. On 15 Nov. 2001, WHO prepared for OCHA an assessment on health needs and a 30-day operational plan focusing primarily on medical supplies and medical staff.⑧</td>
</tr>
<tr>
<td>Nov. 2001</td>
<td>UNSCR 1378 recognizes the urgency of the situation in Afghanistan, particularly in Kabul, and supported efforts to combat terrorism. It calls on member states to provide support towards the establishment of the transitional administration and government, humanitarian assistance and long-term assistance with regard to social and economic reconstruction and the rehabilitation of the country.</td>
</tr>
<tr>
<td>Dec. 2001</td>
<td>Bonn agreement for interim government (5 Dec.). Hamid Karzai is sworn in as head of an interim power-sharing government. UNSCR 1386 (20 Dec.) authorizes the establishment of ISAF to assist the Afghan government “in the maintenance of security in Kabul and its surrounding areas, so that the Afghan Interim Authority as well as the personnel of the United Nation can operate in a secure environment”. Beginning of the rehabilitation process of the Afghan health system.</td>
</tr>
</tbody>
</table>

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⑨ The Afghan Ministry of Health (MoH) became the Ministry of Public Health (MOPH) in early 2005.
Tokyo. Deployment of the first contingents of NATO-led ISAF. Start of a protracted fight against the Taliban. Creation of PRTs. the health system and in 2003 introduced the BPHS for use nationwide.

<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td>2004</td>
<td>Loya Jirga adopts new constitution which provides strong presidency. Hamid Karzai won the Oct-Nov presidential elections.</td>
</tr>
<tr>
<td>Sept. 2005</td>
<td>First Parliamentary elections in more than 30 years.</td>
</tr>
<tr>
<td>Oct. 2006</td>
<td>NATO assumes responsibility for security across the whole of Afghanistan</td>
</tr>
<tr>
<td>Aug. 2008</td>
<td>Lead security responsibility for Kabul city transferred to Afghan forces.</td>
</tr>
<tr>
<td>Aug to Oct. 2009</td>
<td>Presidential and provincial elections are marred by widespread Taliban attacks, patch turnout and claims of serious fraud. Mr. Karzai is declared winner, after second-placed opponent Abdullah Abdullah pulls out before the second round.</td>
</tr>
<tr>
<td>Dec. 2009</td>
<td>US president Obama decides to boost US troops number in Afghanistan by 30,000, bringing total to 100,000.</td>
</tr>
<tr>
<td>Sep. 2010</td>
<td>Parliamentary polls marred by Taliban violence widespread fraud and a long delay in announcing results.</td>
</tr>
<tr>
<td>Nov. 2010</td>
<td>NATO Summit in Lisbon agrees plan to hand control of security to Afghan forces by end of 2014.</td>
</tr>
<tr>
<td>22 March 2011</td>
<td>President Karzai announces the first set of Afghan provinces and districts to start the transition process.</td>
</tr>
<tr>
<td>17 July 2011</td>
<td>First transition ceremony takes place in Bamyan province.</td>
</tr>
</tbody>
</table>

30 The Afghan National Development Strategy ensures Afghanistan is on the path to reach the MDGs, which are focused on improving the lives of the citizens of Afghanistan. It contains four pillars through which GIRoA focuses its priorities: security, governance, rule of law and human rights, and economics and social development.

31 The HNSS aims to improve the health and nutritional status of the people in Afghanistan in an equitable and sustainable manner through quality Health Care Services provision and the promotion of healthy life styles. To this end the MOPH, in consultation with major donors, UN agencies and other stakeholders adopted 19 strategies aimed at 3 distinct categories: implementing health services, reducing morbidity and mortality and promoting institutional development.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>27 Nov. 2011</td>
<td>President Karzai announces the second set of Afghan provinces, districts and cities to start the transition process.</td>
<td>Achievements in Afghanistan’s health sector over the past decade are encouraging even if health conditions for many Afghans remain dire. More than 5.5 million Afghan refugees have returned to Afghanistan from Iran and Pakistan from 2002. From Jan. to June 2012, improvised explosive devices caused 33% of civilian deaths and injuries among Afghan casualties (1,145 killed / 1,954 wounded).</td>
</tr>
<tr>
<td>Early 2012</td>
<td>In Jan. Taliban agree to open office in Dubai as a move towards peace talks with the US and the Afghan government.</td>
<td></td>
</tr>
<tr>
<td>May 2012</td>
<td>NATO Summit in Chicago endorses the plan to withdraw foreign combat troops by the end of 2014. President Karzai announces the third tranche of Transition</td>
<td></td>
</tr>
<tr>
<td>31 Dec. 2012</td>
<td>President Karzai announces the fourth set of Afghan provinces, districts and cities to start the transition process.</td>
<td></td>
</tr>
</tbody>
</table>

**Way ahead**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>Next presidential election. Completion of security hand-over between ISAF and ANSF.</td>
<td>Completion of the development of the ANSF medical system in support of Afghan security forces operations.</td>
</tr>
<tr>
<td>2015</td>
<td>Next parliamentary elections.</td>
<td>A decade of efforts (“Transformation Decade”) will be necessary towards an autonomous and sustainable Afghan Health system.</td>
</tr>
</tbody>
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