For a healthy society

AHDS Strategic Plan 2019-2023
# Table of Contents

Abbreviations ........................................................................................................ 4  
Chapter 1 ............................................................................................................... 6  
Introduction ........................................................................................................... 6  
  Purpose of this Strategic Plan ........................................................................... 6  
  Process ............................................................................................................... 6  
Chapter 2 ............................................................................................................. 7  
AHDS’ Theory of Change .................................................................................... 7  
Chapter 3 ............................................................................................................. 8  
AHDS in brief ........................................................................................................ 8  
Chapter 4 ............................................................................................................. 10  
Context ................................................................................................................ 10  
  Internal Environment ....................................................................................... 13  
Chapter 5 ............................................................................................................. 14  
AHDS’ Vision and Mission .................................................................................. 14  
  Motto: ............................................................................................................. 14  
  Goal: ................................................................................................................. 14  
  Vision: .............................................................................................................. 14  
  Mission: ........................................................................................................... 14  
  Values: .............................................................................................................. 14  
  Priority interventions ....................................................................................... 14  
Chapter 6 ............................................................................................................. 15  
Organizational Development ............................................................................. 15  
  Objectives of Organizational Development .................................................. 15  
  Outcomes ......................................................................................................... 15  
  Indicators for measuring organizational success ............................................ 15  
  Organizational development (OD) interventions: ......................................... 16  
  Restructuring: .................................................................................................. 17  
Chapter 7 ............................................................................................................. 19  
The Programs ...................................................................................................... 19  
  Strategic Objectives ......................................................................................... 20  
  Geographic Expansion ...................................................................................... 20  
  Healthcare ......................................................................................................... 21  
  Strategic Objective .......................................................................................... 21  
  Outcome .......................................................................................................... 21  
  Indicators for measuring program success .................................................... 21  
  Strategic Interventions .................................................................................... 21  
  Achieving the strategic objective .................................................................. 21  
  Nutrition ........................................................................................................... 23  
  Strategic Objective .......................................................................................... 23  
  Outcomes ......................................................................................................... 23  
  Indicators for measuring program success .................................................... 23  
  Strategic Interventions .................................................................................... 23  
  Achieving the strategic objective .................................................................. 23
Education .................................................................................................................. 24
Strategic Objective .................................................................................................. 24
Outcome .................................................................................................................... 25
Indicators for measuring program success ............................................................. 25
Strategic Interventions ............................................................................................ 25
Achieving the strategic objective ........................................................................... 25
Environment ............................................................................................................ 26
Strategic Objective .................................................................................................. 26
Outcome .................................................................................................................... 27
Indicators for measuring program success ............................................................. 27
Strategic Interventions ............................................................................................ 27
Achieving the strategic objective ........................................................................... 27
Community Development ....................................................................................... 28
Strategic Objective .................................................................................................. 28
Outcome .................................................................................................................... 28
Indicators for measuring program success ............................................................. 29
Strategic Interventions ............................................................................................ 29
Achieving the strategic objective ........................................................................... 29
Chapter 8 .................................................................................................................. 32
Monitoring and Evaluation of the Programs .......................................................... 32
Chapter 9 .................................................................................................................. 35
Funding and donors .................................................................................................. 35
Chapter 10 ................................................................................................................. 36
Monitoring and evaluation of the Strategic Plan ...................................................... 36
Chapter 11 ................................................................................................................. 37
Sustainable Development Goals Targets and Indicators ......................................... 37
Goal 2 ....................................................................................................................... 37
Goal 3 ....................................................................................................................... 38
Goal 4 ....................................................................................................................... 39
Goal 5 ....................................................................................................................... 40
Goal 6 ....................................................................................................................... 41
Goal 8 ....................................................................................................................... 41
Goal 13 ..................................................................................................................... 41
Goal 15 ..................................................................................................................... 41
Goal 16 ..................................................................................................................... 42
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACBAR</td>
<td>Agency Coordinating Body for Afghan Relief</td>
</tr>
<tr>
<td>AHDS</td>
<td>Afghan Health and Development Services</td>
</tr>
<tr>
<td>AHO</td>
<td>Alliance of Health Organizations</td>
</tr>
<tr>
<td>AHS</td>
<td>Afghanistan Health Survey</td>
</tr>
<tr>
<td>AICS</td>
<td>Afghanistan Institute for Civil Society</td>
</tr>
<tr>
<td>AMNEAB</td>
<td>Afghanistan Midwifery and Nursing Education Accreditation Board</td>
</tr>
<tr>
<td>ANCB</td>
<td>Afghan NGO Coordination Accreditation Bureau</td>
</tr>
<tr>
<td>AMS</td>
<td>Afghanistan Mortality Survey</td>
</tr>
<tr>
<td>ARTF</td>
<td>Afghanistan Reconstruction Trust Fund</td>
</tr>
<tr>
<td>BPHS</td>
<td>Basic Package of Health Services</td>
</tr>
<tr>
<td>CBHC</td>
<td>Community Based Healthcare</td>
</tr>
<tr>
<td>CCAP</td>
<td>Citizens’ Charter Afghanistan Project</td>
</tr>
<tr>
<td>CCNPP</td>
<td>Citizens’ Charter National Priority Program</td>
</tr>
<tr>
<td>CDC</td>
<td>Community Development Council</td>
</tr>
<tr>
<td>CFHE</td>
<td>Child Focused Health Education</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>CHNE</td>
<td>Community Health Nursing Education</td>
</tr>
<tr>
<td>CME</td>
<td>Community Midwife Education</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuous Professional Development</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organizations</td>
</tr>
<tr>
<td>E. Coli</td>
<td>Escherichia coli</td>
</tr>
<tr>
<td>EPHS</td>
<td>Essential Package of Hospital Services</td>
</tr>
<tr>
<td>ETS</td>
<td>Effective Teaching Skills</td>
</tr>
<tr>
<td>FATP</td>
<td>First Aid Trauma Points</td>
</tr>
<tr>
<td>FP</td>
<td>Facilitation Partner</td>
</tr>
<tr>
<td>GCMU</td>
<td>Grant and Contract Management Unit</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GHG</td>
<td>Greenhouse Gases</td>
</tr>
<tr>
<td>HAFOcc</td>
<td>Humanitarian Assistance and Facilitating Organization</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HRD</td>
<td>Human Resource Development</td>
</tr>
<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
</tr>
<tr>
<td>HRM</td>
<td>Human Resource Management</td>
</tr>
<tr>
<td>IDA</td>
<td>International Development Association</td>
</tr>
<tr>
<td>IDP</td>
<td>Internally Displaced People</td>
</tr>
<tr>
<td>IMAM</td>
<td>Integrated Management of Acute Malnutrition</td>
</tr>
<tr>
<td>KIHS</td>
<td>Kandahar Institute of Health Science</td>
</tr>
<tr>
<td>LHL</td>
<td>Learning for Healthy Life</td>
</tr>
<tr>
<td>LMG</td>
<td>Leadership, Management &amp; Governance</td>
</tr>
<tr>
<td>MAM</td>
<td>Moderate Acute Malnutrition</td>
</tr>
<tr>
<td>M&amp;ET</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MDF</td>
<td>A Global Training and Consultancy Agency</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MHT</td>
<td>Mobile Health Teams</td>
</tr>
<tr>
<td>MIS</td>
<td>Management Information System</td>
</tr>
<tr>
<td>MoEc</td>
<td>Ministry of Economic Affairs</td>
</tr>
<tr>
<td>MoPH</td>
<td>Ministry of Public Health</td>
</tr>
<tr>
<td>MRRD</td>
<td>Ministry of Rural Rehabilitation and Development</td>
</tr>
<tr>
<td>NEAP</td>
<td>National Emergency Action Plan</td>
</tr>
<tr>
<td>NCDs</td>
<td>Non-Communicable Diseases</td>
</tr>
<tr>
<td>NERS</td>
<td>Nutrition Education Rehabilitation Sessions</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NNS</td>
<td>National Nutrition Survey</td>
</tr>
<tr>
<td>OCHA</td>
<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
</tr>
<tr>
<td>OD</td>
<td>Organizational Development</td>
</tr>
<tr>
<td>OTP</td>
<td>Out-Patient Treatment Points</td>
</tr>
<tr>
<td>PCM</td>
<td>Project Cycle Management</td>
</tr>
<tr>
<td>PEI</td>
<td>Polio Eradication Initiative</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>PHP</td>
<td>Private Healthcare Provider</td>
</tr>
<tr>
<td>RFP</td>
<td>Request for Proposal</td>
</tr>
<tr>
<td>RMNCAH</td>
<td>Reproductive, Maternal, Neonatal, Child, and Adolescent Health</td>
</tr>
<tr>
<td>SAM</td>
<td>Severe Acute Malnutrition</td>
</tr>
<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
</tr>
<tr>
<td>SFP</td>
<td>Supplementary Feeding Programs</td>
</tr>
<tr>
<td>SHN</td>
<td>School Health and Nutrition</td>
</tr>
<tr>
<td>SIG</td>
<td>Social Inclusion Grants</td>
</tr>
<tr>
<td>SO</td>
<td>Social Organizers</td>
</tr>
<tr>
<td>TCU</td>
<td>Trauma Care Units</td>
</tr>
<tr>
<td>TNA</td>
<td>Training Needs Assessment</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAMA</td>
<td>United Nations Assistance Mission for Afghanistan</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Fund for Children</td>
</tr>
<tr>
<td>US</td>
<td>United States</td>
</tr>
<tr>
<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
</tr>
<tr>
<td>WCLRF</td>
<td>Women and Children Legal Research Foundation</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Program</td>
</tr>
<tr>
<td>WHS</td>
<td>World Humanitarian Summit</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WPV-1</td>
<td>Wild Polio Virus (type 1)</td>
</tr>
<tr>
<td>ZIHE</td>
<td>Zawul Institute of Higher Education</td>
</tr>
</tbody>
</table>
Chapter 1

Introduction

Purpose of this Strategic Plan

1. The strategic plan provides clarity, direction, and focus for the organization. The primary purpose of strategic planning is to connect the organization’s mission and vision by addressing these three questions:
   a. What is our purpose? (Mission)
   b. What do we want to achieve? (Vision)
   c. How are we going to get there? (Plan)

2. The strategic plan drives organizational alignment. A strategic plan is a document to keep everyone on track.

3. The strategic plan communicates our message.

Process

The current strategic plan (2014-2018) is going to end by 31 Dec 2018. The issue was discussed in the AHDS’ Board of Directors meeting on 2 April 2018. The management team was assigned to assess the progress of the strategic plan, monitor new opportunities and challenges and update or adjust our strategic plan accordingly for the coming five years.

The current strategic plan was developed based on our 23 years’ experience of working with the Afghan society in various social and political circumstances. The organizational memory and staff experience from the lessons learned were pooled together in the process of AHDS assessment. The organizational assessment, facilitated by MDF, sought to elucidate the strengths, weaknesses, and challenges that AHDS faces as a member of the Afghan civil society.

The strategic plan (2019-2023) was drafted by the Management Committee of AHDS in consultation with partners, beneficiaries, staff and literature review. In this participatory process AHDS’ vision, mission, core values and strategic directions were thoroughly reviewed and necessary changes were brought in according to the current situation in the country.

We would like to express our gratitude and appreciation to the board members and all the staff in the frontlines that make our services possible by their tireless dedication and hard work.
Chapter 2

AHDS’ Theory of Change

Good health is essential to sustained economic and social development and poverty reduction. Access to needed health services is crucial for maintaining and improving health. At the same time, people need to be protected from being pushed into poverty because of the cost of health care. Universal health coverage is defined as ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user the financial hardship. Sustainable development is defined as “development that meets the needs of the present without compromising the ability of future generations to meet their own needs”.

AHDS’ theory of change describes how to ensure universal health coverage and the right to the highest attainable level of health. It can be achieved through promotion of healthy lifestyle, provision of primary healthcare and addressing the root causes of environmental and social threats to health. AHDS’ theory of change stresses the need to improve its ability to identify and respond to such moments. AHDS play its role by advocacy, technical assistance, and provision of development and emergency relief programs. AHDS can convene like-minded organizations such as civil society organizations (CSO), private sector, government and the international community.

A major part of our success is due to the acceptance we have gained from the local communities and the cooperation they continue to provide. That transcends the financial assistance coming from the international community, and stresses the importance of communities assuming the kind of practical, on-the-ground responsibility for the continuously improving health, disaster management and sustainable development.

Typically, changes in knowledge alone are not likely to generate measurable changes in behavior. Despite the fact, the more members of our community understand a problem the greater the momentum to solve it and the more likely that we will support changes. AHDS ensures that program objectives and outcome measures include both knowledge and behavioral components.

AHDS advances diversity, equity, and inclusion throughout its internal culture and programs. AHDS focuses on the people with special needs, internally displaced people (IDP), returnees and other marginalized and disadvantaged groups especially those with disabilities. AHDS recognizes the importance of gender equality; therefore, is committed to mainstreaming gender measures (gender-sensitive language, gender-specific data collection and analysis, equal access to and utilization of services, equal involvement in decision making and equal treatment integrated into steering processes).

---

1 WHO
2 World Commission on Environment and Development, 1987
3 City of Vienna; the five principles of gender mainstreaming
Chapter 3

AHDS in brief

Afghan Health and Development Services (AHDS) is a non-for-profit, non-governmental and non-political organization founded by Afghans on April 7th, 1990. AHDS is registered in Afghanistan as a national NGO (registration # 5 dated 25/8/2005) and in the USA as a tax-exempt 501(c)(3) organization. AHDS is also an active member of Afghan NGOs Coordination Bureau (ANCB), Agency Coordinating Body for Afghan Relief (ACBAR) and Alliance of Health Organizations (AHO). AHDS is one of the first signatories of the Codes of Conduct for NGOs engaged in humanitarian action, reconstruction and development in Afghanistan.

The main governance of AHDS lies with the Board of Directors. The board members have diverse professional expertise; health, education, agriculture, rehabilitation, community mobilization, entrepreneurship, governance, women empowerment, private sector, relief and developmental programs.

AHDS’ Board of Directors:

1. Eng. Sayed Jawed, Director of HAFOcc, Chairperson of the Board
2. Mr. Zabihullah Ehsan, Director of Tak-Dana, Treasurer of the Board
3. Mrs. Freshta Karimi, Director of DQG
4. Mrs. Zarqa Yaftali, Director of WCLRFB
5. Mr. Abdul Samad Stanekzai, Community Leader, member of the High Council for Peace.
6. Mr. Sayed Fazlullah Waheedi, Chairman of ANCB
7. Dr Najibullah Mojaddedi, Team Leader, National Polio Eradication
8. Dr Hamidullah Saljuqi, Academic Vice Chancellor of ZIHE
9. Mr. Aziz R. Qarghah, AHDS President
10. Dr Mohammad Fareed Asmand, AHDS Executive Director, Secretary of the Board

Honorary member:

1. Dr Sayed Mohammad Amin Fatemie, Public Health Expert

AHDS has been enabled to serve millions of people, by tireless efforts of the staff and vigorous help of the supporters. Through continuous support from our donors and technical support of partners; Ministry of Public Health (MoPH), Ministry of Economic, Ministry of Rural Rehabilitation and Development (MRRD), local authorities, and the community leaders, AHDS has been able to take firm strides in the areas of health and education development and services in Afghanistan. AHDS understands that Afghanistan has unique challenges and difficulties that require innovation and out of the box thinking.

AHDS is dedicated towards and has supported organizational development, capacity building and system promotion related to health and educational services at the national level. Activities of AHDS are well coordinated with national and local government authorities, community elders, and other stakeholders. Throughout the years, AHDS has had continuous presence and active participation in the task forces and workshops lead by the local and international agencies related to capacity building, providing health services and improving education quality and
accessibility. The secret of our success is related to our ability to reach peoples, gain their support and corporations and involve them in our efforts. Without critical support and collaboration from these communities, AHDS’ success would not be possible. Our experiences are indicative that by directly engaging and involving communities in our efforts and making them aware of their rights and responsibilities, we can ensure sustainable development.

In 2018, AHDS provides healthcare, immunization, nutrition, education, emergency and community development in Kandahar, Kunar, Uruzgan and Zabul provinces according to the national policies and standards. The projects include, but not limited to, BPHS, EPHS, SFP, CME, CHNE, Emergency Healthcare, support to Polio Eradication, Birth Center, Institute of Health Sciences, and Citizen’s Charter.

We feel that sustainable development is possible only through persistence and continued perseverance in the face of difficulties. The national NGOs, more importantly the communities, have to take personal ownership and responsibility to see our country through this difficult yet promising time.

A major part of our success is due to the acceptance we have gained from the local communities and the cooperation they continue to provide. Without the critical support and collaboration of these communities AHDS’ success would not be possible. It is this idea that transcends the financial assistance coming from the international community, and stresses the importance of communities assuming the kind of practical, on-the-ground responsibility for the continuing improved health of this and future generations. Without a sense of personal responsibility in the local communities to complement the broader social responsibility of the international community, the sustainability of reconstruction efforts such as ours will be at great risk. There is no doubt that Afghanistan is not ready to be free of international assistance. But without local Afghans accepting personal responsibility for the on-going health of the members in their community, it will be impossible for the country to prosper.

AHDS gained the art and science of how to work in difficult area in terms of geographical, traditionally conservativeness and most insecure by insurgencies. Insurgency does not only cause security risk, but simultaneously deteriorate availability of qualified staff, proper living conditions and attractiveness for professional staff from other places; while traditional conservativeness adds on to those challenges.
Chapter 4

Context

The security situation has worsened in Afghanistan. In 2016 and 2017, more than 1.1 million Afghans were internally displaced due to conflict. From January – June 2018, the United Nations Assistance Mission for Afghanistan (UNAMA) recorded 1,692 civilian casualties – more than at any comparable time over the last 10 years since records have been kept. At the same time, 2016 and 2017 witnessed the return of almost 1.7 million documented and undocumented Afghan refugees, primarily from Pakistan and Iran. Internal displacement and large-scale return within a difficult economic and security context poses risks to welfare, not only for the displaced, but also for host communities and the population at large, putting pressure on service delivery systems and increasing competition for already scarce public services and economic opportunities.

Growth is expected to slow to 2.4 percent in 2018, in the context of election-related uncertainties and weak business confidence. Growth is expected to accelerate gradually to around 3 percent by 2020 as confidence recovers. In the context of gradually declining aid, the current account surplus is expected to narrow to 0.2 percent of GDP in 2018 before moving into a slight deficit from 2019 (1.2 percent of GDP). Afghanistan has experienced a slight recovery in growth since 2015, with growth accelerating to 2.3 percent in 2016 and reaching 2.7 percent in 2017. Growth in 2017 was driven mostly by the services sector, which expanded by 2.5 percent in the context of recovering confidence and investment. The agricultural sector grew by 3.8 percent, with strong growth in fruit and vegetables offsetting declining wheat production in the context of ongoing drought impacting the northern and eastern areas of the country.

A disruptive election period could have major negative impacts on revenues, investment, and growth over 2018, 2019, and beyond. On the other hand, progress with a negotiated peace settlement with the Taliban could have a major positive impact on investment confidence, potentially spurring accelerated growth and improved government revenues. Over the medium term, and in the context of expected declines in aid, economic development progress will depend on mobilizing the sectors with greatest capacity to support increased growth, job creation, exports, and government revenues.4

The Afghanistan health system has made considerable progress over the period of 2003-2016. The Afghanistan Health Survey (AHS -2015) found the infant mortality rate of 63 per 1,000 live births and the under-five mortality rate of 77 per 1,000 live births. The maternal mortality ratio is 327 deaths per 100,000 live births (AMS 2010). About 60% of the population has access to health services, defined as being within one hour’s walking distance. The number of functional health facilities was 2725 in 2017 and the proportion of health facilities with skilled female health worker was 95.2% (MoPH-HMIS department). The number of CHWs has been increased to 29596 in 2017 (MoPH-CBHC department). Afghanistan has high levels of child malnutrition, 9.5% children under-five suffer from acute malnutrition and about 40.9% suffer from chronic malnutrition, i.e. stunting (National Nutrition Survey 2013).5

---

4 World Bank, Country Context, Oct 07, 2018
5 MoPH, GCMU, Sehatmandi RFP, July 2018
Afghanistan is one of only three countries in the world with ongoing wild poliovirus transmission, alongside Nigeria and Pakistan. While we are in the middle of the endgame strategy to end polio, wild polio virus cases are still occurring in the border area between Afghanistan and Pakistan. The total number of wild poliovirus type-1 (WPV1) cases in 2018 was 21 in Afghanistan.\(^6\) Afghanistan Ministry of Public Health in consultation with its partners has developed a National Emergency Action Plan (NEAP) to gear up the efforts with more aggressive, innovative and measurable approaches. This has been a milestone activity in Afghanistan for Polio Eradication Initiative (PEI) which has started in 1994. Hence, the PEI has become not only a health priority but also a national emergency program.\(^7\)

Unfortunately, drought and warming of air temperatures have reduced the size of the glaciers in Afghanistan. The reduction and loss of Afghanistan’s glaciers, drought, war related damage to the irrigation systems it does have, poor management, waste, pollution, and the fact that over 80% of Afghans are engaged in agriculture and livestock-raising, makes the country extremely susceptible to water shortages. Nationwide, the majority of Afghan households do not have access to safe drinking water. Because of unsafe sanitary facilities, water contamination is a major issue in Afghanistan. Many water sources are contaminated with harmful bacteria such as E. Coli which sickens and kills many people, especially children and the elderly. Valuable water resources are polluted as a result of the disposal of industrial and domestic liquid wastes. Due to cost and pretty much little other alternatives, Afghans are forced to burn wood in order to keep warm and to cook their food. This, along with the fact that a large number of vehicles (many old and poorly maintained) in Afghanistan run on poor quality fuels, air pollution has become a problem in Afghanistan’s major urban areas – like in the city of Kabul where it is clearly visible.

In fact, a recent study revealed that 60% of Kabul’s residents are exposed to increased levels of harmful toxins such as nitrous oxides, and sulfur dioxide.\(^8\)

Winter in Afghanistan has an impact on the crop production and drinking water availability throughout the year. The last winter season (2017-2018) was the fifth consecutive year in which the main planting season (October to February) has been compromised, with below average snowfall and a precipitation deficit of 70% prevailing in most of the country. The lack of water from the meltdown has negatively impacted irrigated agriculture lands – the vast majority of agricultural land in Afghanistan. In addition, the lack of ground water is causing water points to dry up and therefore become inaccessible to communities. The limited water availability has also negatively influenced pastureland and impacted the ability of farmers to feed livestock. Consequently, producers’ long-term livelihood prospects have become affected as their herd size has been reduced, resulting in a lower income which in turn impacts their food security. The potential consequences of severe food insecurity and limited water availability will affect the most vulnerable people across Afghanistan, particularly children under 5 who may experience deterioration in their nutritional status due to poor access to potable water and typical seasonal spikes in diarrheal diseases.\(^9\)

A broad understanding of health as defined by the WHO Constitution of 1946 is “a state of complete physical, mental and social well-being and not merely the absence of disease or

---

\(^6\) Rotary International; Weekly Polio Update
\(^7\) http://moph.gov.af/en/page/polio-eradication/polio-background-information
\(^8\) Afghanistan online, environment
\(^9\) Contingency Plan: Inter-Cluster Drought Response, OCHA 26 April 2018
infirmity”. Inherent in this understanding is that population health is influenced by the broader cultural, economic, political and social environment into which people are born, grow, live, work and age. This recognizes the growing complexity of public health, going beyond traditional boundaries and the direct control of the health sector. It also takes public health back to important historical lessons which show how sectors other than health contributed to lowering child mortality and increasing overall life expectancy. What is new is the emphasis on a much more clearly articulated contribution of how a healthy population contributes to the goals of other sectors’ and to societal goals overall. Health is an important input for the economy, productivity, socioeconomic development and wellbeing. This makes health a shared goal across different sectors of government and of stakeholders beyond government including the private sector and civil society.

The SDGs adopted by world leaders in September 2015, built upon the lessons learned from the MDGs and called for an integrated approach to “just, rights-based, equitable and inclusive” action to address today’s challenges and promote growth, social development and environmental protection for all. While SDG-3 aims to “ensure healthy lives and promote wellbeing for all at all ages”, core health targets are also embedded in other goals. More broadly, health is influenced by and contributes to all other goals and targets as well. These positive and negative links between health and other social, economic, cultural and political factors operate both at the individual and the societal level. They lie at the heart of health inequities – the unfair and avoidable differences in health status seen within and between countries. This places equity at the center, with particular focus on disadvantaged groups that are typically excluded from social benefits such as a good education, health care and economic participation while facing higher burdens of disease and disability. The social determinants of health interact with each other, leading to compounded inequities for marginalized population groups.

There has been increasing acknowledgement and efforts to strategically align social and environmental determinants of health. This organizational shift has been coupled with new concrete activities and projects aimed at streamlining social and environmental determinants in technical work, including in housing, water and sanitation and air quality as priority areas considering the gender, equity and rights.¹

The commitment to moving from delivering aid to ending need was the main outcome of the World Humanitarian Summit, with the Sustainable Development Goals and 2030 Agenda upheld as a common framework for results. This approach involves a wide variety of actors, working based on their comparative advantages and over multiple years, to reduce need, vulnerability and risk and increase peace and resilience. This way of working is known as the Humanitarian-Development-Peace Nexus. In many of the protracted crisis and conflict settings around the world, NGOs, governments, donors, the UN and other partners are considering what this approach means in practice.

After more than 30 years of conflict and displacement, it is clear that Afghanistan needs a new way forward for peace and sustainable development. As such, NGOs are committed to working

collectively with each other and their partners towards realizing the Humanitarian-Development-Peace Nexus in Afghanistan. Dialogue on this topic, between NGOs and with their partners, has highlighted both opportunities and challenges in this approach. Most importantly, it is clear that any such approach should be developed specifically for Afghanistan, drawing on international best practice but informed by the experiences of the individuals and organizations who best understand this complex, challenging environment. These approaches are not new ways of working to operational NGOs in Afghanistan. However, there is recognition that NGOs need to be able to work better with each other and with other actors.

**Internal Environment**

**Relevance**: the objectives of AHDS intervention are consistent with beneficiaries’ requirement, Afghanistan needs, global priorities (SDGs), national strategies and partners (like UN agencies, MoPH and MRRD) and donors’ policies in the country.

**Efficiency**: AHDS is used to economical management of the resources to achieve the intended results. Comparing to the other national and international NGOs, AHDS utilizes minimum number of capable staff and least operational cost to make maximum outputs perfectly. More than 75% of the funds are budgeted for services provided to the communities.

**Effectiveness**: all the projects are in line with AHDS strategic plan. In each project, the activities pursue the set objectives and predicted results. The donors also had performance based contracts; which ensured achievement of the objectives and targets for any development and humanitarian intervention.

**Impact**: generally, the health and nutrition status of Afghanistan had tangible improvement in the last five years. Number of professional health staff increased. Demand for the preventive healthcare and education is enhanced among the communities. Communities are alliterated about their rights and deserved social services. AHDS has not done an impact survey in its target areas, but its project had obviously contributed to the national achievements.

**Sustainability**: AHDS organizational capacity is developed; it’s constitution, the terms of reference for the board of directors and management committee were revised. A set of necessary policies and procedures were developed. Operation manual containing five chapters (program, human resources, logistic, finance and monitoring & evaluation) was developed and implemented in practice. AHDS gained good reputation among the government, non-governmental, UN and donor agencies for its result oriented work, transparency and accountability. Financially, AHDS survival rate is three years without external support.

Ability to absorb new funds depends on the highly competitive market prevailed in the country which relies on relations as well as least costs that negatively affect the beneficiaries. AHDS will try to keep contact with the donors who are more concerned about the people than their own benefits.

---

1 Realizing the Humanitarian-Development-Peace Nexus in Afghanistan, ACBAR and ICVA, 2018.
Chapter 5

AHDS’ Vision and Mission

*Motto:*
For a healthy society.

*Goal:*
Saving lives and improving living quality by provision of humanitarian assistance and development programs.

*Vision:*
A healthy Afghan society that is socially and economically empowered!

*Mission:*
We contribute to the Sustainable Development Goals (SDGs) by addressing healthcare and social & environmental determinants of health, considering the triple nexus (humanitarian, development and peace).

*Values:*
The Codes of Conduct for NGOs engaged in humanitarian action, reconstruction and development in Afghanistan, recommends the following principle values:

1. Humanitarian principles (Humanity, Impartiality, Neutrality and Independence)
2. Do no harm
3. Accountability
4. Transparency
5. Autonomy (independence)
6. Equal opportunity (no discrimination)

*Priority interventions*
To achieve its mission, AHDS has decided to intervene in the following priority areas, along with its organizational development, during coming five years:

1. Healthcare
2. Nutrition
3. Education
4. Environment
5. Community development
Chapter 6
Organizational Development

Goal: build the organizational capacity to cope with the new challenges and efficiently achieves its strategies.

Objectives of Organizational Development

1. Improvement in the performance of the organization.
2. Improvement in the ability of the organization to adapt to its environment.
3. Improvement in inter-personal and inter-group behavior to secure team work.

Outcomes

The purpose of OD is to enable an organization to better respond and adapt to market changes and technological advances.

A. Continuous Improvement: the OD process creates a continuous cycle of improvement whereby strategies are planned, implemented, evaluated, improved and monitored.
B. Increased Communication: one of the key advantages to OD is increased communication, feedback and interaction within the organization. The improved communication aligns all employees to shared goals and values to bring about desired changes.
C. Employee Development: OD focuses on enhancing employee skills to meet evolving market requirements through a program of learning, training, skills/competency enhancement and work process improvements.
D. Service Enhancement: a major benefit of OD is innovation, which leads to service enhancement.
E. Increased Fund: through raised innovation and productivity, efficiency and donor satisfaction are increased.

Indicators for measuring organizational success

AHDS measures its performance in terms of effectiveness and efficiency. Effectiveness refers to the extent to which the organization is achieving the outcome. Efficiency refers to the ratio of relevant outputs to relevant inputs and can include costs and steps in a process or time. AHDS will be audited to earn ISO9001 and Afghanistan Institute for Civil Society (AICS) certifications. Furthermore, the indicators will be:

A:

1. Has a clearly stated vision, purpose and strategic plan that define the outcomes sought for sustainable success
2. Has a system of policies, processes, controls, risk management and relationships to meet its legal, financial and ethical obligations
3. Controls process quality by monitoring variation in performance, checking results, determining causes and making corrections

B:

1. Has a clear approach for collecting information and reporting back to the stakeholders including the beneficiaries, focusing on key needs, collaborations, and expectations.
2. Has data and information procedure to ensure a continuous focus on improving the data available and underpin decision-making.
3. Reports complaints to the board, management committee or senior executives, informing them of the response, including service changes.

C:
1. Has a culture that encourages staff to share ideas and explore approaches that can lead to better outcomes.
2. Maintains its capacity to resource improvement projects through ongoing professional development, giving staff the skills they need.
3. Staff fully understand and adhere to policies and procedures

D:
1. Responds to changing community needs, within contractual obligations and service or funding agreements.
2. Builds relationships with organizations to promote its services, improve delivery and connect with prospective communities.
3. Applies structured approaches to promote creativity, adopt innovative ideas (both internal and external), and achieve breakthrough performance.

E:
1. Increases the efficiency and effectiveness of its processes.
2. Allocates accountability for executing and communicating the plans, and uses team and individual measures to track achievement.
3. Continually compares itself with similar organizations and independent information to understand how it can improve or adapt its performance and outcomes.

**Organizational development (OD) interventions:**

1. Problem identification—Diagnosis: OD program starts with the identification of the problem in the organization. Correct diagnosis of the problem will provide its causes and determine the future action needed.

2. Planning Strategy for Change: OD attempts to transform diagnosis of the problem into a proper action plan involving the overall goals for change, determination of basic approach for attaining these goals and the sequence of detailed scheme for implementing the approach.

3. Implementing the Change: the interventions contribute to align AHDS with its environment. Strategic interventions help AHDS to gain a better understanding of its current status and environment, that allow it to better target strategies for competing or collaborating with other organizations. OD interventions are initiated at the top and require employee participation and commitment. Individual process interventions aim at improving organizational performance by developing specific skills of individuals. Team development and group processes interventions aim at improving different aspects of group performance, such as goal setting, development of interpersonal relations among team members, role clarification and analysis, decision making, problem solving, and communities of practice, among other. The objective is to improve the coordination efforts of members, which will result in increasing the team’s performance. The team building interventions relies on improving interdependency of team members. The underlying premise is that the aggregated value of the team is much greater than any individual.
4. Evaluation: OD is a long-term process, so there is a great need for careful monitoring to get process feedback whether the OD program is going on well after its implementation or not. This will help in making suitable modifications, if necessary. For evaluation of OD program, the use of critic sessions, appraisal of change efforts and comparison of pre- and post-training behavioral patterns are quite effective.

**Restructuring:**

The organogram of AHDS (structure) was changed according to the recommendation of the External Auditor “AHDS should establish an internal control department which should work independently and report to the Board of directors. As part of the formation of an internal control department it is important that a suitably experienced professional is employed to perform the function”. The aim was to renew the structure that ensures separation of functions and more efficient lines of hierarchy.

The highest governing body of AHDS is the Board of Directors. The US based liaison office is important from the viewpoint of fundraising, led by the President. AHDS is represented on the country level, by fully *de jure* and fully *de facto* leadership the Executive Director. The executive director is assisted by the Management Committee which consists of the heads of departments and AHDS representatives from the field.
A major challenge ahead is to ensure flexibility of the structure, which means that it should have the ability to expand and shrink easily whenever the situation requires it. The clarity of functional boundaries between departments, efficiency of structure, headquarters and provincial alignment, reporting lines and vertical and horizontal balance are the elements considered in the AHDS future institutional structure.

The Program Department is involved in needs assessments, program development, project implementation, quality improvement, partnership with the stakeholders, coordination, monitoring, reporting and research. An expert can be hired as service contractor for proposal writing on ad-hoc basis.

The Admin and Finance Department manages general services for the organization and its programs. Its main functions are office management, human resource, procurement and supply, inventory, information and communication, publicity, financial management, security and risk management.

Provincial Offices are established in the provinces, where AHDS has projects. The Provincial Managers has dual responsibility to the Program Department in terms of program development and the Admin and Finance Department in terms of office management.

Internal Audit/Control is part of AHDS’ governance framework and is a service unit established to provide an independent appraisal, advisory and assurance functions for the Board of Directors and Management Committee thereby assisting AHDS in achieving its mission. The purpose of the audit is to examine how AHDS complies with government regulations, quality standards, internal policies and procedures, and its contractual obligations. Its functions include examining, evaluating and monitoring the adequacy and effectiveness of operational and internal controls established to ensure that AHDS’ activities and operations mitigate risk and secure propriety, economy, efficiency and effectiveness in all areas. The Internal Audit ensures transparency and accountability; also leads to improvement in the effectiveness and efficiency of the system. The Internal Audit/Control function will be provided by an external accounting firm and/or qualified individuals with demonstrated expertise in the field of internal audit/control. The Board of Directors assigns impartial auditor to prepare a yearly plan, purpose, and scope of the audit. The in-charge of the internal audit/control service will be referred to as Internal Audit/Control Officer.
Chapter 7

The Programs

Goal: the goal of AHDS programs is improved health through promotion of healthy lifestyle, provision of primary healthcare and addressing the root causes of environmental and social threats to health.

Determinants of Health

A healthy lifestyle is physical, mental, emotional and spiritual well-being. Living a healthy lifestyle is a key component to disease prevention, wellness, and longevity.

Evidences indicate that clinical care accounts for only 20% of health outcomes, while socioeconomic, behavioral, and environmental factors determine the remaining 80%. Social determinants of health refer to characteristics of the social environment that contribute to an individual’s health. These characteristics include economic, political, and legal structures, as well as social norms that determine how a society is organized and, by extension, the degree to which communities can access the resources necessary for health. The types of environmental influence that populations suffer are broadly related to their socio-economic development. Recent estimates of the global burdens of disease from environmental factors shows that the greatest burdens relate to unsafe drinking water, poor sanitation & hygiene, and to pollution of
the indoor and outdoor air. Burdens relating to climate change, which currently are modest, are expected to increase substantially over time.

AHDS services will contribute to the following sustainable development goals (SDGs):

1. Goal 3: Good health and well-being for people; ensure healthy lives and promote well-being for all at all ages.
2. Goal 2: Zero hunger; end hunger, achieve food security and improved nutrition, and promote sustainable agriculture.
4. Goal 5: Gender equality; achieve gender equality and empower all women and girls.
5. Goal 6: Clean water and sanitation; ensure availability and sustainable management of water and sanitation for all.
6. Goal 8: Decent work and economic growth; promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.
7. Goal 13: Climate action; take urgent action to combat climate change and its impacts
8. Goal 15: Life on land; protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss.
9. Goal 16: Peace, justice and strong institutions; promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.

**Strategic Objectives**

1. Healthcare: increased access focusing on emergency services, health promotion and prevention.
3. Education: empowered youths for provision of equitable services and economic growth.
5. Community development: enabled people to interact and work toward common goals.

**Geographic Expansion**

AHDS have projects in Kandahar, Kunar, Uruzgan and Zabul provinces (2018). AHDS is willing to work in any province in order to serve various ethnic groups in different parts of the country. The program scaling up and geographic expansion depend on the available resources and capacities of potential partners.
**Healthcare**

**Strategic Objective**
Increased access focusing on emergency services, health promotion and prevention.
Healthcare programs contribute to SDG-3 (good health and wellbeing), SDG-4 (clean water and sanitation), SDG-5 (gender equality) and SDG-8 (decent work and economic growth).

**Outcome**
Reduced preventable death, illness, and disability through provision of cost-effective public health interventions.

**Indicators for measuring program success**
1. Improved access to reproductive, maternal, neonatal, child, and adolescent health (RMNCAH) services.
2. Reduced burden of communicable and non-communicable diseases (NCDs).
3. Reduced preventable disabilities due to road traffic accidents, war wounds, and occupational injuries.

**Strategic Interventions**
1. Provide quality healthcare that is appropriate, responsive, acceptable, coordinated, and equitable to the target population.
2. Assess individual and community needs, assets and capacity for health education
3. Promote positive health behavior, immunization, nutrition habits and healthy lifestyle in the communities.
4. Conduct and incorporate research findings into practice settings.
5. Communicate and advocate for health and health education.

**Achieving the strategic objective**
The principles of the Primary Health Care (PHC) approach are as relevant today as they were nearly 30 years ago. PHC provides guide not just for the organization of healthcare systems, but also for how healthcare systems should act as an engine for promoting health and development more generally, and as an instrument for promoting equity and empowering the poor. The ‘Primary Health Care’ stresses a comprehensive approach to health by emphasizing ‘upstream interventions’ aimed at promoting and protecting health such as improving household food security, promoting women’s literacy and increasing access to clean water. PHC promotes a multi-sectoral approach to health. It emphasizes equity; aim to correct the neglect of rural populations as well as socially and economically marginalized groups. PHC also incorporates the involvement and empowerment of communities.

Operational research is required in health systems management, planning and problem-solving activities. There is also a need to invest more in the development of health information and disease surveillance, and the capacity and time for staff to conduct their own researches.
The spectrum of appropriate community involvement includes community mobilization to assert rights, challenge policies and present alternatives, monitoring of services, involvement in planning and decision-making, and involvement in the implementation of programs and services.

Healthcare systems can disseminate information about local health services and the rights of service users, as well as publicize disparities in key indicators such as maternal mortality and immunization coverage to encourage a social commitment towards reducing inequity.

The performance of public sector health workers is affected by many factors and calls for a concerted, coordinated program of health worker support and development. The problems of demoralization and demotivation are more complex and require a multi-dimensional program involving:

1. A living wage to behave ethically and function effectively.
2. The right number and mix of types of health personnel.
3. Adequate supplies of essential equipment, consumables and medicines to enable health workers to exercise their skills.
4. Systematic quality improvement programs, including the training of staff in health service quality, interpersonal relations and responsiveness of care.
5. Support for health workers, especially those who work in isolated and difficult circumstances.
6. A participatory style of health service management.
7. An incentive structure of professional rewards for good performance.¹

AHDS has been one of the pioneers for Basic package of health services (BPHS) and Essential package of hospital services (EPHS) in the country. Furthermore, the health services are provided through establishing birth centers, mobile health teams (MHT), first aid trauma points (FATP), trauma care units (TCU) and partnership with the private health service providers (PHP).

Vaccination is one of the efficient and cost-effective interventions to reduce mortality and morbidity among children under-5 years of age. Polio Eradication Initiative (PEI), a global-scale public health intervention, made significant progress by sparing millions of children from lifelong paralysis. AHDS is committed to support the PEI that would lead to success of the national implementation of actions.

AHDS carefully assesses the various dimensions of barriers to healthcare access including geographical access, availability, affordability & acceptability with due consideration for specific vulnerable groups. The experience of AHDS has clearly demonstrated the importance of extensive collaboration and cooperation with the local population, health service providers and relevant government authorities.

The quality of health services will be attained through the application of a range of Quality methodologies. The staff will be mentored and supported to assess their capabilities with respect to their duties and identify areas where capacity building would be of value. Technical backstop ping will be of particular benefit in building the capacity of management and health staff and their performances. Staff attaining target standards and engaging positively with capacity

¹ Global Health Watch; B1 | Health care systems and approaches to health care
building measures, will be eligible for incentives, either monetary, offered certificates or options for professional training.

A sustainable needs-based procurement and supply management methodology will cover adequate shelf life, supply remote areas, deal with wintery environment etc. De-centralized procurement will promote timely supply. Consumption rate plus buffer stock will be calculated for winterization supplies.

**Nutrition**

**Strategic Objective**

Improved nutrition status of the children and pregnant and lactating women.

Nutrition programs contribute to SDG-2 (zero hunger), SDG-3 (good health and wellbeing), SDG-15 (life on land) and SDG-4 (quality education).

**Outcomes**

1. Increased access to nutrition services and products.
2. Improved nutrition behaviors and practices of public.

**Indicators for measuring program success**

1. Reduced incidence and prevalence of acute malnutrition.
2. Improved quality of nutrition services.
3. Improved knowledge of caretakers and community influencers on optimal nutrition behaviors.

**Strategic Interventions**

1. Provide integrated management of acute malnutrition (IMAM) services.
2. Provide supplementary feeding programs (SFP) for emergency situations.
3. Enable the population to adopt healthy dietary practices, access nutritious foods and benefit from quality preventive and therapeutic nutrition services.
4. Train farmers and livestock owners to adopt new technologies to improve their food security and nutrition.
5. Promote value chain of agriculture products as a main demand in the markets.

**Achieving the strategic objective**

The good nutrition in the first 1,000 days between pregnancy and a child's second birthday, the critical "window of opportunity", builds a strong immune system and ensures healthy physical and intellectual development.

AHDS aims to scale-up, high impact, cost effective nutrition interventions to reduce undernutrition. These interventions include vitamin and mineral supplementation, deworming, the promotion of breastfeeding and complementary feeding, and the treatment of severe acute malnutrition, amongst others. AHDS assists in building the skills of health services providers in delivering services to children and women. In addition, AHDS helps families learn essential
skills and basic knowledge in the nutritional care of young children. This includes best practices in breastfeeding and complementary feeding, the promotion of iodized salt consumption, and health-seeking behavior. We concentrate our efforts on the most vulnerable, targeting young children, pregnant women, breastfeeding mothers and people living with disabling illnesses.

In emergencies, AHDS works to ensure that vulnerable children under five, pregnant women, and nursing mothers have access to supplementary food to meet their nutritional needs and prevent them from becoming undernourished.

AHDS implements integrated management of acute malnutrition (IMAM) as main approach. The nutrition program managed at community level through application of Nutrition Education Rehabilitation Sessions (NERS) focusing on coverage and access, sensitization and community awareness, screening and community-based growth monitoring and counselling. Health education sessions are conducted for the mothers. Severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) cases are referred to out-patient treatment points (OTP) and supplementary feeding program (SFP).

Food security and livelihoods programs tackle the root causes of malnutrition by addressing the challenges of low production and poverty. Livelihood outcomes go beyond food and income security, to also include quality of life. Responding to the community needs, the program will bolster agricultural productions, livestock and promote value chain to enhance access to sustainable sources of food and income.

AHDS programs aim to improve household food availability by increasing staple food and livestock production, nurturing home gardening, improving storage facilities and investing in local food and market systems. The focus is on strengthening families’ ability to produce more nutritious food and market the excess for a regular income. AHDS organizes producer groups, works towards improved market information and provides training on processing and value chain development. Income generating activities provide new skills, services and opportunities, thereby stimulate the local economy.

AHDS approaches include climate-smart agriculture practices, integrating agriculture with nutrition and exchange of knowledge. Sustainable livelihoods program support community strength and resiliency, food security, and help to ensure access to health services and education. Interventions will be selected based on analysis of the livelihoods of targeted beneficiaries. Community-building activities are important to support where beneficiaries are encouraged to work together to gain an advantage in relation to sale of goods and purchase of inputs, or to be trained as a group to further build skills.

### Education

#### Strategic Objective

Empowered youths for provision of equitable services and economic growth.

Education programs contribute to SDG-4 (quality education), SDG-5 (gender equality), SDG-8 (decent work and economic growth) and SDG-3 (good health and wellbeing).
**Outcome**
Competent gender balanced workforce developed and deployed.

**Indicators for measuring program success**
1. Improved relevance of the curriculum to the social and economic needs of learners.
2. Accredited learning centers that satisfy standards.
3. Number of qualified/credentialed graduates produced.

**Strategic Interventions**
1. Raise professional human resource in health and education sectors to provide equitable services for the deprived communities.
2. Provide technical and vocational skills training for community members, especially women.
3. Develop human resources for health (HRH) capacity adequately based on health system needs.

**Achieving the strategic objective**
AHDS provides higher education opportunity for the adolescence girls and boys to address shortage of professionals in health sector. Adolescence is a significant transition period and a unique window of opportunity to shape the healthy and successful development of future generations. Addressing the diverse needs of youth and adolescents is critical to end poverty and promote equality. Higher education skills help youth find a lucrative career while teaching how to deal with a variety of other real-life situations. The ability to solve problems and the ability to communicate with the people are even important. They learn how to approach in different ways and be open to alternate solutions. It enables them to develop critical thinking skills. Collaboration is often an essential aspect of any type of work environment. Learning how to collaborate with other students helps to learn how to interact better in a group. When the people earn a higher degree, they will be better off and can invest their money to stimulate the local economy. They will have enough time to allocate for volunteer work and help the community in which they live.

By creating an enabling and equitable environment where young people can exercise their skills, knowledge and leadership, they are able to step into new roles and lead the change themselves. AHDS implements gender-synchronized approaches that address the barriers in front of girls as well as working with boys and men to remove such barriers.

Health systems can only function with health workers; improving health service coverage and realizing the right to the enjoyment of the highest attainable standards of health depend on their availability, accessibility, acceptability and quality. Mere availability of health workers is not sufficient: only when they are equitably distributed and accessible by the population, when they possess the required competency, and are motivated and empowered to deliver quality care. The health workforce has a vital role in building the resilience of communities and health systems to respond to disasters caused by natural or man-made hazards, as well as related environmental,
technological and biological hazards and risks. The health workforce will be critical to achieve health and wider development objectives in the next decades.\(^1\)

AHDS education centers adapt their institutional set-up and modalities of instruction to respond to transformative educational needs and are aligned with accreditation systems. AHDS approaches for pre-service, in-service, and continuous professional development (CPD) trainings to increase the number and skills mix of mid-level and community level human resources for health (HRH).

Vocational training, also known as technical and vocational education and training (TVET) is used to prepare for a certain trade or craft. It allows students to get ready for specific careers; focus on providing students with hands-on instructions. Considering the access and acceptability, AHDS provide vocational training in the community college or at trade schools for adults.

AHDS has experience of managing the Kandahar Institute of Health Sciences (KIHS) having midwifery, nursing, laboratory technician and pharmacy technician schools. In addition, has number of Community Midwifery Education (CME) and Community Health Nursing Education (CHNE) courses. All of the mentioned programs were accredited by the Afghanistan Midwifery and Nursing Education Accreditation Board (AMNEAB).

School health and nutrition (SHN) with child focused health education (CFHE) and learning for healthy life (LHL) programs are innovative approaches taken by AHDS to strengthen health status with particular impact on mothers and children. They empower the mothers and school age children taking better care of themselves and their families.

Furthermore, AHDS conduct Certificate programs typically consist of a short series of job-specific courses. They are tailor made initial and refresher courses for the teachers and health staff based of their training needs assessment (TNA). They include but not limited to communication skills, training methodology, effective teaching skills (ETS), management information system (MIS), report writing, supervision, monitoring and evaluation (M&E), project cycle management (PCM), human resource management (HRM), community health worker (CHW), leadership, management and governance (LMG) and health-specific topics.

Building capacity is not a short-term undertaking. Periodic assessments help guide the process since the environmental conditions and expectations change. Mid-course corrections are likely as new conditions unfold and new needs arise. The process of ongoing feedback and adjustment can both strengthen capacities of AHDS and the beneficiaries.

\section*{Environment}

\subsection*{Strategic Objective}

Protected human health and the environment.

Environment programs contribute to SDG-15 (life on land), SDG-6 (clean water and sanitation), SDG-13 (climate action) and SDG-3 (good health and wellbeing).

---

\(^1\) The Global Strategy on Human Resources for Health: Workforce 2030
Outcome
Water, air and land protected from harmful pollution.

Indicators for measuring program success
1. Improved air quality.
2. Increased access to safe drinking water.

Strategic Interventions
1. Integrate energy efficiency and environmental considerations into our work practices.
2. Educate and empower individuals, communities, and partners in decision making through public access to environmental information and data.
3. Focus on increasing community capacity to establish and implement environmental programs.
4. Provide water, sanitation and hygiene (WASH) in emergency situations.
5. Advocate to ensure the availability of safe drinking water, safe sanitation, and a hygiene infrastructure at all healthcare facilities.

Achieving the strategic objective
The aim of environmental programs of AHDS is protection of environment, the health and well-being of people. By encouraging pollution prevention, AHDS increases opportunities for people to look after their own neighborhoods and environments. It includes educate and encourage behavioral change to minimize the amount of waste generated, promote safe water and sanitation, change social norms around littering and illegal dumping, stimulate investment in waste recycling infrastructure, promote the use of safer chemicals and pesticides, increase the energy efficiency of buildings, promote use of renewable energy and increase in planting operations.

To maintain a healthy lifestyle, AHDS will educate the communities about the environment in order to create a sense of consciousness and participation, and to help them acquire knowledge of ecological principles aimed at ensuring a balance between the health of the individual, society, and the environment. AHDS raise public awareness on environmental issues, impacts of climate change, greenhouse gases (GHG), mitigation and adaption approaches.

Human fecal material and urine are major sources of environmental pollution in Afghanistan. It is also a source of disease organisms. When discarded into the environment as a waste material, it creates pollution and threatens public health. By composting, its pollution and health threats can be eliminated and valuable soil nutrients for plant growth can be produced.

AHDS strives to improve the quality of living environment through encouraging active planting, proper maintenance and preservation of trees together with other vegetation. Planting trees is one of the easiest and most sustainable ways to positively affect the environment. Planting trees benefits local environments tremendously by providing habitat for native and endangered birds.
and wildlife, removing carbon dioxide from the atmosphere, helping to combat climate change and preventing soil erosion.

WASH is the collective term for Water, Sanitation and Hygiene. Due to their interdependent nature, these three core issues are grouped together to represent a growing sector; each is dependent on the presence of the other. Without toilets, water sources become contaminated; without clean water, basic hygiene practices are not possible. AHDS want to ensure access to safe water and the quality of the water. An important work for sanitation is to end the practice of “open defecation,” and facilitate community-led initiatives to build, maintain and use basic toilets. The hygiene part aims at nurturing good hygiene practices, especially handwashing with soap; this act is essential to prevent disease and the health of children. AHDS takes part in the campaigns on improving air quality to protect human health. Short-lived climate pollutants, such as black carbon and methane, are major contributors to climate change and air pollution. Vehicle emissions are the main source of outdoor air pollution due to poor fuel quality and weak vehicle regulations. Reducing short-lived climate pollutants can decrease disease, increase food security, improve diets and increase physical activity.

AHDS advocates with the ministry of public health (MoPH) and other stakeholders to adopt a strategy for involvement of the health sector in the safe management of pesticides and industrial chemicals. It should include the whole spectrum of health services from research, surveillance and monitoring and risk assessment to prevention, emergency preparedness and response and treatment of poisonings. Raising the awareness of the public is an important activity about drinking-water safety, food safety, product safety, occupational safety and protection of public health.

AHDS raise awareness and lobby for the sustainable energy. Renewable energy and energy efficiency are the "twin pillars" of sustainable energy. Both resources must be developed in order to stabilize and reduce carbon dioxide emissions. Efficiency slows down energy demand so that rising clean energy supplies can make deep cuts in fossil fuel use. Green energy means electricity and gas made from renewable sources; green electricity made from the wind, the sun and the sea, and green gas made from organic material.

**Community Development**

**Strategic Objective**

Enabled people to interact and work toward common goals.

Environment programs contribute to SDG-16 (peace, justice and strong institutions), SDG-5 (gender equality), SDG-6 (clean water and sanitation), and SDG-15 (life on land).

**Outcome**

Community-wide capacity for organizing residents, organizations and other stakeholders in developing initiative plans and advocating for community change.

---

1 UNICEF
4
2 UN environment
5
Indicators for measuring program success

1. Empowered communities to claim their rights and access to the economic opportunity.
2. Strengthened structure, systems and processes of the local bodies to be inclusive, accountable and transparent.
3. Improved service delivery for poor and excluded people.

Strategic Interventions

1. Support the target communities to work for enhancing their social capitals and economic growth.
2. Support the women to have equal power in decision making, to shape their lives and contribute to their communities.
3. Build advocacy capacity in the target communities to raise their voice for positive changes in the policies and attain their rights regarding health, nutrition, education, social justice and livelihood.
4. Cultivate culture of tolerance, mediation, communication/negotiation, and peaceful dispute resolution based on Islamic and traditional values in the target communities.
5. Facilitate income generation of the community members and access to efficient markets.

Achieving the strategic objective

Sustainable development is defined as “development that meets the needs of the present without compromising the ability of future generations to meet their own needs”\(^1\). It applies to a wide range of social and economic concerns, such as poverty, education, healthcare, or cultural enrichment.

AHDS aims at community empowerment to enhance economic and social services and community benefits from upgraded community infrastructures and productive assets operated mainly by communities. AHDS will provide appropriate technical assistance and support from the start based upon prior experience with successful collaborations that mobilized residents. The emphasis will be on democratic selection of office bearers, participation of households in community institutions, inclusion of poor households and addressing women’s issues.

Without the critical support and collaboration of these communities AHDS’ success would not be possible. It is this idea that transcends the financial assistance coming from the international community, and urges the importance of communities assuming the kind of practical, on-the-ground responsibility for the continuing improved health of this and future generations. Without a sense of personal responsibility in the local communities to complement the broader social responsibility of the international community, the sustainability of reconstruction efforts such as ours will be at great risk. Our experiences are indicative that by directly engaging and involving communities in the programs and making them aware of their rights and responsibilities, we can ensure sustainable development.

Circles of Sustainability provides practical tools for creating sustainable cities and communities. The circular figure is divided into four domains: ecology, economics, politics and culture. Each

---

\(^1\) World Commission on Environment and Development, 1987
of these domains is divided in seven subdomains. Assessment is conducted on a nine-point scale; ranges from ‘critical sustainability’, the first step, to ‘vibrant sustainability’, the ninth step.\(^1\)

The target people are consulted for their needs and what is going to be planned during the rapid needs assessments. Community committees (Shura) is established for each service delivery point; or linkage established with the community development council (CDC) if exist. At the beginning of any project, each service delivery point presents the types and extension of services can be provided for the people. The Shura members are oriented on how to cooperate with the service delivery point; rapid assessment, proposing solution, drafting initial plan, negotiation with authorities, community monitoring, early reporting of the concerned cases, follow up of the defaulters and oversight.

\(^1\) http://www.circlesofsustainability.org/
AHDS is involved in the Citizens’ Charter National Priority Program (CCNPP) as facilitation partner (FP). The Ministry of Rural Rehabilitation and Development, Afghanistan (MRRD) leads Citizen’s Charter National Priority Program/ Citizens’ Charter Afghanistan Project (CCNPP/CCAP) is funded by the World Bank (WB/IDA).

The objective of CCNPP is to improve the delivery of core infrastructure and social services to participating communities through strengthened Community Development Councils (CDCs). The program is a whole-of-government effort to end fragmentation, bring people together to collectively address their development needs and contribute towards unity. The Charter is a commitment to provide every village and urban communities in Afghanistan with basic services, based on community prioritization.

The AHDS is mainly responsible for community mobilization for Citizens’ Charter, facilitation of CDCs, its sub-committees and participatory community monitoring team establishment, clustering the CDCs, basic community profiles, socio-economic grouping, participatory methodologies to address key issues within the communities, women’s empowerment, inclusion of the vulnerable groups, community development plans, capacity building of CDCs and sub-committees, support CDC, Cluster CDC and sub-committees, facilitate community-led total sanitation and build capacity of a cadre of future social organizers (SO) from among emerging leaders in the communities and MRRD staff. Facilitation of Social Inclusion Grants (SIG) as a pilot aims to support the CDCs to identify the vulnerable and help the very poor socio-economic households.

AHDS can support the poor and marginalized communities to improve their livelihood and economy mainly through vocational and skills trainings, and employment opportunities. Furthermore, AHDS supports and strengthens communities to get prepared against disasters and for preservation of environment. Community sub-committees are organized, trained and supported to reduce risks from and manage disasters.
Chapter 8

Monitoring and Evaluation of the Programs

AHDS chooses a systematic approach of integrated interventions. Integrated interventions are fundamentally people centered and seek to improve the effectiveness and efficiency of providing a continuum of care to improve the health and well-being of the beneficiaries. The traditional M&E process is a series of important decision points: identify the problem, plan the response to the problem, monitor implementation of the response, collect and analyze data to revise the response as needed and assess the effectiveness of the response. The M&E process is iterative, where information gained in the latter steps can be used to go back and improve program responses in earlier steps. The frameworks are also useful to help identify information needs and gaps and to plan to fill those gaps.

The following 6-step systematic approach to the M&E of integration presents best practices. The steps in the approach are:

1. **Begin with the end in mind; define the public health problem**
   Understanding the main causes of deaths and diseases in a population and how those vary by sub-populations or geography is a fundamental first step to defining response. Determining the programmatic response, however, requires a systematic examination of the full range of health concerns and recognition of which services could work together to mutually address the specific public health priorities, targets and goals.

2. **Identify common primary points of contact for care**
   Based on the findings from step one, project managers need to identify point(s) of contact where additional care are needed to ensure that health needs are comprehensively addressed by a
specific activity or set of activities. Provision of some interventions may be limited in availability to certain levels of care and types of providers; priorities for where/what services should be integrated, have to be determined. Research and evaluation can help understand the optimal intervention packages and mechanisms of delivery. Case studies can be useful to document how AHDS and others coordinate care and what changes are necessary.

3. **Define and test interventions for integrated service delivery packages**

As additional interventions necessary to meet clients’ comprehensive care needs are identified and integrated by care entry point, and evidence is generated about the most effective set of integrated interventions, as well as on the most successful techniques for implementing these interventions, then standardized interventions packages and guidance can be developed at the national level. The defined intervention package will also help identify and standardize critical indicators that should be measured for monitoring.

4. **Create a theory-driven logic model**

Once the vision for what priority needs will be addressed (end in mind) through integration and how this vision will be addressed (package of services delivered at specific points of contact), the next step in the process is to create a logic model (also known as a program impact pathway). A logic model clearly defines the mechanisms for integration and implementation and visually links inputs and processes with expected outputs, outcomes, and impacts. Lack of program impact is often attributed to either a failure to fully implement the intervention or a failure by intended recipients to fully utilize all elements of the intervention. Therefore, it is important to ensure that the logic model states explicitly the program theory; in other words, that it spells out the underlying assumptions about what changes the intervention is intended affect.

5. **Improve the health information system**

The implementation depends on the functionality and skilled interlinking of all health system elements. Successful M&E require particularly strong health information systems. Health information systems are the sources of data for indicators to measure inputs, processes, outputs, and outcomes defined from logic models. That information comes from censuses, birth and death monitoring, disease and behavioral surveillance, surveys, service data, mapping services, financial sources, modeling, and health research.

When developing monitoring and evaluation plans for integrated programs, new indicators will be needed to get some outcome indicators, such as proportions of clients receiving integrated services, met needs, service quality, and referrals and counter referrals. Caution is urged with new indicators as there is already a proliferation of indicators posing huge burdens on front line providers and yielding low quality and incomplete information. Clearly defined logic models will help prioritize key indicators.

6. **Use data in decision making**

From the outset, stakeholders need to make a specific link between data collection and national strategic plans, operational plans, and program plans. Making that link requires explicit attention to determinations about what data are needed for program decision making; in other words, who are the different stakeholders and what information do they need to have in order to make timely
and informed decisions which will improve programs? These questions are especially critical for the M&E of integrated service delivery programming due to the relative scantiness of the existing evidence base for decision-making. Data collected as part of a quality M&E effort around integrated programs will allow the data collection to adequately inform program decision making; to provide information for the refinement of the logic model’s inputs, processes, and indicators for integration; and to help build up the evidence base for integration efforts.¹

¹ BMC Health Services Research, published online 2013 May 6, A systematic approach to the planning, implementation, monitoring, and evaluation of integrated health services, Heidi W Reynolds and Elizabeth G Sutherland.
Chapter 9

Funding and donors

AHDS has made concerted effort and has succeeded at acquiring broad based support from several donors. AHDS’ main financial contributors have been the international donors, Afghanistan reconstruction trust fund (ARTF), UN agencies, international NGOs and private supporters. AHDS’ strength is its trust built among the donors by proving its performance, transparency and accountability.

With the emergence of a market economy in the country and the promotion of the private sector, mostly in competition with NGOs, political and economic changes in donor countries can make AHDS vulnerable too, as the access to traditional easy money has come to an end and the era of hard money and tough competition has arrived. Difficulty arises from trying to match AHDS programs with different donors having different interests, requirements and funding patterns. However, these difficulties are not specific to AHDS but common to nearly all NGOs in Afghanistan.

AHDS’ practices developing a comprehensive financial plan on yearly basis for identifying funding sources, (savings, reserves, recycled surpluses, external support etc.).

It is evident that there are three distinct types of funding:

- The standard national packages of services, to be managed and operated under a national uniform program management system. These are supported by the foreign offices of the developed countries or the multilateral organizations such as the World Bank.
- The second important source of funding is the private charities/foundations/international organizations that are more privately handled and have a better focus on equipping local NGOs not just financially but also technically.
- The non-conventional resources include the micro-enterprises, microfinance and micro-insurance.

AHDS is diversifying its funding sources to reduce single donor dependency and will increase fundraising to private and local donors to cover the strategic gap in program activities and provide capacity building for staff and organizational development. AHDS will also use its fund pool to generate income towards its strategic goals. AHDS will make partnership with NGOs, educational institutions and for profit sector for efficient utilization of the resources and maximizing outcomes for the beneficiaries.
Chapter 10
Monitoring and evaluation of the Strategic Plan

Monitoring is a continuous management function that tracks the actual performance or situation against what was planned or expected according to pre-determined standards, while evaluation generally involves collecting and analyzing data on program processes and results and recommending corrective measures. Organizational learning is important for increasing organizational effectiveness, developing organizational capacity and make best use of limited resources. It also strengthens partnerships that are built on transparent decision making, mutual respect and positive experiences of cooperation. Organizational learning improves use of information from monitoring and evaluation for future planning and creates a healthy organization (which is more effective and adaptable, and where people want to stay longer and contribute more).

M&E system will be established as an integrated part of this strategic plan. The core purpose of the strategic plan’s M&E system is to provide the information needed for understanding the progress against the strategic plan, and to involve AHDS’ stakeholders with its staff in the process improvement. The system will provide regular reports on strategic plan progress to the different level of staff and stakeholders in a format appropriate for their need.

A team assigned by the Board of Directors (one from Board Members and two from the Management Committee to develop the strategic plan’s M&E system and monitor the progress of the strategic plan throughout its implementation. The M&E team will be responsible for formulating annual work-plan and M&E system for the strategic plan and necessary resources required for systematizing information on strategic plan progress to guaranteed timely decision-making by management. The M&E team should ensure timely provision of information for management decisions. The M&E team should ensure that the collection, processing and analyzing of information on strategic plan progress are available to management. The team will undertake valuable activities on progress. The team will present the summary of key success and problems, lessons learned, ideas for changing the strategic plan activities or even strategies. The team monitor circumstances during the year that may rise to strategies needing to be adjusted from time to time and situations may arise for which contingency plans need to be developed quickly.
Chapter 11

Sustainable Development Goals Targets and Indicators

By this strategic plan, AHDS will contribute to the following SDG targets and indicators:

**Goal 2.** End hunger, achieve food security and improved nutrition and promote sustainable agriculture.

<table>
<thead>
<tr>
<th>Goals and targets (from the 2030 Agenda for Sustainable Development)</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| 2.1 By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round | 2.1.1 Prevalence of undernourishment  
2.1.2 Prevalence of moderate or severe food insecurity in the population, based on the Food Insecurity Experience Scale (FIES) |
| 2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons | 2.2.1 Prevalence of stunting (height for age < -2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age  
2.2.2 Prevalence of malnutrition (weight for height > +2 or < -2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)  
2.2.3 Prevalence of anemia in women aged 15 to 49 years, by pregnancy status (percentage) |
| 2.3 By 2030, double the agricultural productivity and incomes of small-scale food producers, in particular women, indigenous peoples, family farmers, pastoralists and fishers, including through secure and equal access to land, other productive resources and inputs, knowledge, financial services, markets and opportunities for value addition and non-farm employment | 2.3.1 Volume of production per labor unit by classes of farming/pastoral/forestry enterprise size  
2.3.2 Average income of small-scale food producers, by sex and indigenous status |
| 2.4 By 2030, ensure sustainable food production systems and implement resilient agricultural practices that increase productivity and production, that help maintain ecosystems, that strengthen capacity for adaptation to climate change, extreme weather, drought, flooding and other disasters and that progressively improve land and soil quality | 2.4.1 Proportion of agricultural area under productive and sustainable agriculture |
**Goal 3.** Ensure healthy lives and promote well-being for all at all ages.

| 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births | 3.1.1 Maternal mortality ratio  
3.1.2 Proportion of births attended by skilled health personnel |
|---|---|
| 3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births | 3.2.1 Under-5 mortality rate  
3.2.2 Neonatal mortality rate |
| 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases | 3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations  
3.3.2 Tuberculosis incidence per 100,000 population  
3.3.3 Malaria incidence per 1,000 population  
3.3.4 Hepatitis B incidence per 100,000 population  
3.3.5 Number of people requiring interventions against neglected tropical diseases |
| 3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being | 3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease  
3.4.2 Suicide mortality rate |
| 3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol | 3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders |
| 3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents | 3.6.1 Death rate due to road traffic injuries |
| 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs | 3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods  
3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group |
| 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all | 3.8.1 Coverage of essential health services  
3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income |
### AHDS’ Strategic Plan 2019-2023

<table>
<thead>
<tr>
<th>Goal</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.9</td>
<td>By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination</td>
</tr>
<tr>
<td>3.9.1</td>
<td>Mortality rate attributed to household and ambient air pollution</td>
</tr>
<tr>
<td>3.9.2</td>
<td>Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)</td>
</tr>
<tr>
<td>3.9.3</td>
<td>Mortality rate attributed to unintentional poisoning</td>
</tr>
<tr>
<td>3.a</td>
<td>Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate</td>
</tr>
<tr>
<td>3.a.1</td>
<td>Age-standardized prevalence of current tobacco use among persons aged 15 years and older</td>
</tr>
<tr>
<td>3.b</td>
<td>Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all</td>
</tr>
<tr>
<td>3.b.1</td>
<td>Proportion of the target population covered by all vaccines included in their national program</td>
</tr>
<tr>
<td>3.b.2</td>
<td>Total net official development assistance to medical research and basic health sectors</td>
</tr>
<tr>
<td>3.b.3</td>
<td>Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis</td>
</tr>
<tr>
<td>3.c</td>
<td>Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States</td>
</tr>
<tr>
<td>3.c.1</td>
<td>Health worker density and distribution</td>
</tr>
<tr>
<td>3.d</td>
<td>Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks</td>
</tr>
<tr>
<td>3.d.1</td>
<td>International Health Regulations (IHR) capacity and health emergency preparedness</td>
</tr>
<tr>
<td>3.d.2</td>
<td>Reduce the percentage of bloodstream infections due to selected antimicrobial-resistant organisms</td>
</tr>
</tbody>
</table>

### Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2</td>
<td>By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education</td>
</tr>
<tr>
<td>4.2.1</td>
<td>Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Participation rate in organized learning (one year before the official primary entry age), by sex</td>
</tr>
<tr>
<td>4.3</td>
<td>By 2030, ensure equal access for all women</td>
</tr>
<tr>
<td>4.3.1</td>
<td>Participation rate of youth and adults in</td>
</tr>
</tbody>
</table>
and men to affordable and quality technical, vocational and tertiary education, including university

formal and non-formal education and training in the previous 12 months, by sex

4.4 By 2030, substantially increase the number of youth and adults who have relevant skills, including technical and vocational skills, for employment, decent jobs and entrepreneurship

4.4.1 Proportion of youth and adults with information and communications technology (ICT) skills, by type of skill

4.6 By 2030, ensure that all youth and a substantial proportion of adults, both men and women, achieve literacy and numeracy

4.6.1 Proportion of population in a given age group achieving at least a fixed level of proficiency in functional (a) literacy and (b) numeracy skills, by sex

**Goal 5.** Achieve gender equality and empower all women and girls.

5.1 End all forms of discrimination against all women and girls everywhere

5.1.1 Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex

5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age

5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence

5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

5.3.1 Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18

5.4 Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate

5.4.1 Proportion of time spent on unpaid domestic and care work, by sex, age and location

5.5 Ensure women’s full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life

5.5.1 Proportion of seats held by women in (a) national parliaments and (b) local governments

5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their

5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care

5.6.2 Number of countries with laws and
| review conferences | regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education |

**Goal 6.** Ensure availability and sustainable management of water and sanitation for all.  

| 6.1 By 2030, achieve universal and equitable access to safe and affordable drinking water for all | 6.1.1 Proportion of population using safely managed drinking water services |
| 6.2 By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations | 6.2.1 Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water |
| 6.3 By 2030, improve water quality by reducing pollution, eliminating dumping and minimizing release of hazardous chemicals and materials, halving the proportion of untreated wastewater and substantially increasing recycling and safe reuse globally | 6.3.1 Proportion of domestic and industrial wastewater flows safely treated  
6.3.2 Proportion of bodies of water with good ambient water quality |
| 6.4 By 2030, substantially increase water-use efficiency across all sectors and ensure sustainable withdrawals and supply of freshwater to address water scarcity and substantially reduce the number of people suffering from water scarcity | 6.4.1 Change in water-use efficiency over time  
6.4.2 Level of water stress: freshwater withdrawal as a proportion of available freshwater resources |

**Goal 8.** Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.  

| 8.6 By 2020, substantially reduce the proportion of youth not in employment, education or training | 8.6.1 Proportion of youth (aged 15–24 years) not in education, employment or training |

**Goal 13.** Take urgent action to combat climate change and its impacts.  

| 13.3 Improve education, awareness-raising and human and institutional capacity on climate change mitigation, adaptation, impact reduction and early warning | 13.3.1 Extent to which (i) global citizenship education and (ii) education for sustainable development are mainstreamed in (a) national education policies; (b) curricula; (c) teacher education; and (d) student assessment |

**Goal 15.** Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss.
### Goal 15.2
**By 2020, promote the implementation of sustainable management of all types of forests, halt deforestation, restore degraded forests and substantially increase afforestation and reforestation globally**

| Goal 15.2.1 Progress towards sustainable forest management |

### Goal 15.3
**By 2030, combat desertification, restore degraded land and soil, including land affected by desertification, drought and floods, and strive to achieve a land degradation-neutral world**

| Goal 15.3.1 Proportion of land that is degraded over total land area |

---

### Goal 16
**Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.**

<table>
<thead>
<tr>
<th>Goal 16.1 Significantly reduce all forms of violence and related death rates everywhere</th>
<th>Goal 16.1.3 Proportion of population subjected to (a) physical violence, (b) psychological violence and (c) sexual violence in the previous 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children</td>
<td>Goal 16.2.1 Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month</td>
</tr>
<tr>
<td></td>
<td>Goal 16.2.2 Number of victims of human trafficking per 100,000 populations, by sex, age and form of exploitation</td>
</tr>
<tr>
<td></td>
<td>Goal 16.2.3 Proportion of young women and men aged 18–29 years who experienced sexual violence by age 18</td>
</tr>
<tr>
<td>Goal 16.6 Develop effective, accountable and transparent institutions at all levels</td>
<td>Goal 16.6.1 Primary government expenditures as a proportion of original approved budget, by sector (or by budget codes or similar)</td>
</tr>
<tr>
<td></td>
<td>Goal 16.6.2 Proportion of population satisfied with their last experience of public services</td>
</tr>
<tr>
<td>Goal 16.7 Ensure responsive, inclusive, participatory and representative decision-making at all levels</td>
<td>Goal 16.7.1 Proportions of positions in national and local institutions, including (a) the legislatures; (b) the public service; and (c) the judiciary, compared to national distributions, by sex, age, persons with disabilities and population groups</td>
</tr>
<tr>
<td></td>
<td>Goal 16.7.2 Proportion of population who believe decision-making is inclusive and responsive, by sex, age, disability and population group</td>
</tr>
<tr>
<td>Goal 16.9 By 2030, provide legal identity for all, including birth registration</td>
<td>Goal 16.9.1 Proportion of children under 5 years of age whose births have been registered with a civil authority, by age</td>
</tr>
</tbody>
</table>