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Mapping of physical rehabilitation services in Afghanistan – 2018

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FOREWORD

Afghanistan is one those countries where the crises due to protracted conflict are still ongoing. This indeed puts Afghanistan among the most vulnerable countries in growing rate of disabilities. The global figure shows that around 15% of any community are persons with disabilities, out of this, 19% are women with disabilities (WHO & World Bank, 2011). Social and economic status of persons with disabilities is lower than of average population, 80% of persons with disabilities live in the poorest countries, and 2/3 belong to the poorest population group (WHO & World Bank, 2011). Disease and congenital abnormality is counted as the second major cause of disability. According to the new data from Afghanistan Living Condition Survey (ALCS) 2016 to 2017, disability prevalence rate is 3.2%.[1].

The National Strategy for Disability and Rehabilitation (2016 -2020) shows a crucial commitment of MoPH and has expanded its role through scaling up the DRD to Disability Rehabilitation Program (DRP). Disability indicators have recently been introduced to HMIS and this will contribute to the systematic collection of data on disability.

As the unstable security and political situation continue, it is mandatory for all Disability Stakeholders to continue to coordinate their efforts together for improved and increased services for the most vulnerable people.

This Mapping of the Physical Rehabilitation Services provides relevant and clear information on the current status of the sector with regard to human resources and service provision. It also highlights the need to ensure quality rehabilitation service provision through development of human resources for Health facilities (Physiotherapists, Prosthetics and Orthotics technicians for example) and the great importance of the recognition of Prosthetics and Orthotics technician position into Afghanistan Health structure.

This report also provides a guidance and recommendations to stakeholders, including donors; these recommendations can support the planning and re-organizing of financial commitments toward disability and physical rehabilitation services.

Handicap International and all the stakeholders involved in this mapping are committed to support the Disability sector in Afghanistan, improve the quality of physical rehabilitation service delivery and thus the life of thousands of Afghans.

Handicap International Afghanistan Team

[1] http://cso.gov.af/Content/files/Surveys/ALCS/Final%20English%20ALCS%20Highlight(1).pdf

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Afghanistan suffers from shortage of reliable data about physical rehabilitation services for persons with disabilities and other vulnerable groups. The only available data was the assessment done by Handicap international and later on in 2013 the survey conducted to update the data and figure related to disability and physical rehabilitation.

MoLSAMD has been very interested to conduct a holistic survey throughout the country in 2017 to find out the clearer situation of disability and physical rehabilitation services. In early 2018 Asia foundation announced a call for proposal to launch countrywide survey, financed by USAID and can be done in collaboration of Central Statistical Office (SCO).

Following the National Strategy for Disability and Rehabilitation which was put in practice in 2017, the most important element was to revitalize the existed gaps in terms of shortage of data and information about the level of physical rehabilitation services in the country.

Handicap international with support of AFD fund and with close collaboration of relevant departments of MoPH (DRD, GCMU, GDPP, GDHR, and HMIS) and other stakeholders such as AAPT/ANSOP, partner organizations including SCA, NAC and KOO etc. launched the current mapping and by 2nd January 2018 the initial results were shared with the stakeholders and last November 2018 the figures were updated. This mapping was led by an assigned expert and supported with DRP and by using of WHO questioners to address the following key issues in physical rehabilitation:

- Leadership and governance
- Allocated financial resources
- Human resources
- Service delivery
- Assistive devices
- Infrastructure and medications
- Information and research
- Emergency preparedness

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Acronyms

ACBAR	Agency Coordinating Body for Afghan Relief and Development
AABRAR	Afghan Amputee Bicyclists for Rehabilitation and Recreation
AAPT	Afghanistan Association of Physical Therapists
ANSOP	Afghan National Society of Orthotic and Prosthetic
BPHS	Basic Package of Health Services
CBR	Community Based Rehabilitation
CHW	Community Health Worker
CRPD	Convention on the Rights of Persons with Disabilities
DAO	Development and Ability Organization
DSCG	Disability Stakeholders Coordination Group
DPOs	Disabled Peoples' Organizations
DRD	Disability Rehabilitation Department
DRP	Disability and Rehabilitation Program
EPHS	Essential Package of Hospital Services
GCMU	Grant Contract Management Unit
GIHS	Ghazanfar Institute of Health Sciences
HMIS	Health Information Management System
IAM	International Assistance Mission
IHS	Institute of Health Sciences
INGO	International Non-Governmental Organization
HI	Handicap International
ICRC	International Committee of the Red Cross
ILO	International Labor Organization
ISPO	International Society for Prosthetics and Orthotics
KOO	Kabul Orthopedic Organization
MBT	Mine Ban Treaty
MDG	Millennium Development Goals
MoLSAMD	Ministry of Labor and Social Affairs, Martyrs and Disabled
MoPH	Ministry of Public Health
NDTF	National Disability Task Force
NGO	Non-Governmental Organization
NAC	Norwegian Afghanistan Committee
PT	Physiotherapy
PH	Provincial Hospital
RH	Regional Hospital
SCA	Swedish Committee for Afghanistan
SEHAT	System Enhancement for Health Action in Transition Program
UNDP	United Nations Development Programme
UHC	Universal Health Coverage
UNMACCA	United Nation Mine Action Coordination Centre of Afghanistan
USAID	United States Agency for International Development

Executive Summary

The World Health Organization (WHO) highlights that there are unmet and ever increasing needs for rehabilitation in the world and especially in low and middle-income countries[1]. The availability of accessible and affordable rehabilitation is necessary for many persons with health conditions to remain as independent as possible, to participate in education, to be economically productive, and to have a fulfilling and meaningful lives. The magnitude and scope of unmet rehabilitation needs signals an urgent need for concerted and coordinated global action by all stakeholders.

Handicap International (HI) produced a mapping report on physical rehabilitation in Afghanistan in 2013[2]. The aim of this mapping report was to improve the availability of information on physical rehabilitation sector and to have an overview of the needs in physical rehabilitation. This was based on the process of collecting and gathering information and data through a consultation mechanism with key actors linked to the Ministry of Public Health (MoPH), Ministry of Labor, Social Affairs, Martyrs, Disabled (MoLSAMD) and other key disability stakeholders such as professional associations, training centers, Disabled People's Organizations (DPOs) and Non-Governmental Organizations (NGOs). This mapping report aims to update the 2013 mapping. Following the same consultation mechanism, the process took place from December 2017 to mid-April 2018, with an update of the figures in November 2018.

The World Health Organization (WHO) Rehabilitation Capacity Assessment Tool has been used, as requested by MoPH and with the consent of WHO. Indeed, in the most developing countries, one of the gaps in the field of physical rehabilitation is the lack of evidence to support advocacy actions based on comprehensive analysis and documentation of the situation. To this end, the purpose is to provide an up-to-date situation analysis of the physical rehabilitation sector in Afghanistan, focusing on:

- Leadership and governance
- Allocated financial resources
- Human resources
- Service delivery
- Assistive devices
- Infrastructure and medications
- Information and research
- Emergency preparedness

First, the report intends to highlight the steps and actions already undertaken in the rehabilitation sector. Secondly, it aims to identify the gaps and provide recommendations and guidance to the various stakeholders involved in rehabilitation service enhancement in the country: the concerned ministries (MoPH, MoLSAMD), civil servants and private practitioners, donors and national / international NGOs involved in rehabilitation projects implementation.

A review and follow-up of the 2013 recommendations is included in the end of the report. It includes a presentation of the actions undertaken so far and the valid recommendations to this day.

[1] http://www.who.int/disabilities/care/rehab-2030/en/

[2] See annex 1.2

The recommendations were based on four broad areas:

- Accessibility
- Availability
- Accountability
- Quality of services

Third, a new set of recommendations is also presented to address the gaps and improve the physical rehabilitation services, which are essential for many persons with disabilities or with temporary impairment for their active participation in their personal, professional, school, family, community and social life.

MAIN FINDINGS	
1	Disability and physical rehabilitation are highlighted in the National Health Policy 2015-2020. MoPH developed a **National Strategic Plan for Disability Prevention and Physical Rehabilitation** 2017 – 2020. Disability Rehabilitation Department (DRD) of MoPH is going through restructuring, the new name is **Disability and Rehabilitation Program** (DRP). The terms of reference for the **disability and rehabilitation task force** chaired by DRP was revised in 2017.
2	MoLSAMD is currently working on the National Disability Strategy with the disability stakeholders, after which, the Afghan National Disability Action Plan (last one expired in 2011) and policy will be developed.
3	MoPH and MoLSAMD has formal coordination system **through DSCG and inter-ministerial coordination meeting.**
4	There is **no fixed percentage** in the annual health budget allocated to disability and physical rehabilitation at MoPH. The approved budget dedicated to disability and rehabilitation for 2018 is one third of what was requested.
5	The Planning and Policy Directorate of MoPH, in collaboration with the London School of Hygiene and Tropical Medicine, has just started a research about the state of health and disease based on country evidence**. Based on such evidence, the BPHS and EPHS policies will be revised by the end 2018.** The current policies are the BPHS of 2010 and the EPHS policies of 2005. **Prosthetic and Orthotic services/Technical Orthopedic Services are not part of it.**
6	The guidelines on physical rehabilitation services for BPHS and EPHS implementers have been revised and approved in 2015, mentioning the number of Health facilities and needed human resources to provide rehabilitation services.
7	The **SEHATMANDI program** (System Enhancement for Health Action in Transition) will start from July 2018 to the end of June 2021.
8	The only official data and statistics about persons with disabilities in Afghanistan is the **"National Disability Survey in Afghanistan"** which was carried out in 2005 by Handicap International in close link with MoLSAMD.

	According to this survey, the prevalence of persons with **severe / very severe** disability was estimated at **10.8%** of the whole Afghan population[1]. According to the new data from Afghanistan Living Condition Survey of 2016-2018, disability prevalence rate is 3.2%.[2].
9	The prevalence of **lower limb amputation** is the highest, followed by cerebral palsy, clubfoot, spinal cord injury and road traffic accident.
10	The **2015 Afghanistan Demographic and Health** survey highlights major issues impeding the access to rehabilitation / health service: ➢ Financial constraint is the main barrier for households. ➢ 5% of women make decisions alone about their own health care. ➢ 80% of women and 72% of men believed that violence against women is justified in certain circumstances (particularly going out without telling her husband).
11	**There are 14 active physiotherapy training** centers, out of these **7 are run through TIQRA project** (Kabul, Kapisa, Kandahar, Herat, Balkh, Takhar and Nangrahar), **2 are run by government** (Kabul PTI, IHS Nangrahar),and **5 private institutes** (Hayat Institute in Balkh, Atefi Institute in Heart, Razi institute, Inaam Institute and Aryana Institute in Kabul. **There are 3 prosthetic and orthotic training centers,** one in Heart, one in Takhar province and **one is run by ICRC in Kabul.** For both professions, a 3yr Diploma and a national curriculum is used. The Afghan curriculum for physiotherapy was revised in 2015. **315 PTs** (60 will be graduated from PTI and 18 from Nangrahar IHS and 237 from 7 centres of TIQRA Project from 2018 to 2020. **93 Physiotherapists (PT) will graduate** from 5 private institutes from 2018 to 2020 and it is not clear whether they will fulfill the required criteria for accreditation. **There are 4 Category 1 P&Os** with Bachelor Degree in prosthetics and orthotics and recognized by Ministry of Higher Education, but they are not working in service delivery structures. **10 P&O Category 1**[3] upgraded in 2018 for the first time in Afghanistan by support of ICRC. 58 P&O Category 2[4] will graduate **(39 from 2 P&O centres run by HI and SCA) and 19 by ADPO/ICRC)** in 2019. **7 P&O Category II have** already graduated from Kabul Orthopedic centre.
12	At primary health care level, **CHWs** are responsible for awareness raising on disability, identification of persons with disabilities and referral to Health facilities. However, mental health and disability topics are not included in their training manual. After their deployment, DRP conducts **some trainings but not systematic and especially not in the hard to reach areas.** **Community Based Rehabilitation (CBR) activities are implemented in 12 out of 34 provinces by SCA, in 50 districts**; but the scope and coverage of other CBR activities were not well documented. In the mapping 2013, CBR activities were said to be implemented in 16 out of 34 provinces, in 80 out of 364 districts. There is no recognized training curriculum, **no clear coordination mechanism**, centralized monitoring and evaluation among Government and non-government actors. **CBR is led by MoLSAMD.**

[1] The WHO estimation for 2011 is that 15% of the world's population lives with some form of disability.
[2] http://cso.gov.af/Content/files/Surveys/ALCS/Final%20English%20ALCS%20Highlight(1).pdf
[3] Category 1 personnel are educated and trained in all areas of prosthetics and orthotics practice and related réhabilitation issues
[4] Category 2 personnel are educated and trained in only the major areas of prosthetics and orthotics which are commonly needed.

	Physiotherapy at CHC level for assessment of physical needs and advice through outreach visits from DHs is subject to staff availability, according to the BPHS policy, so this is probably rare due to the shortage of physiotherapists at the DH level. Physiotherapy services are available in 22 out of 34 provinces (21 in the mapping 2013).
13	At the secondary and tertiary health care levels in 34 provinces, **8 Regional Hospitals (RH)** and **28 Provincial Hospitals (PH)** are active but only **15 PHs have PT Units**. Out of 407 districts of the country, only **86 DHs are functional** and of these, **38 DHs have active** PT units. Among **8 Regional hospitals, 4 RH have active PT units.** **Currently more than 50 %** of the persons delivering PT services in these Health facilities do not have a PT Diploma and 21 PT units only have at least one PT with a recognized Diploma. The ongoing training under TIQRA will partially address this issue if the PTs will be deployed. At the time of survey, **65% of the professionals** delivering physiotherapy services are male, which constitutes a main barrier for women to access physiotherapy services. This gap is also noted in the current MoPH Health Strategy, emphasizing that it one of the barriers faced by women in accessing services due to shortage of female health staff[1] Out of 86 functional DHs, 48 DHs do not have functional PT unit, out of 28 active PHs, 13 PHs do not have a functional PT unit and out of 8 functional RHs, 4 RHs don't have functional PT units in the country. Currently, there are 28 vacant PT positions in 38 functional DHs with active PT units, 32 vacant PT positions in 15 functional PHs with active PT units and 22 vacant PT positions in 4 functional RHs with active PT units. Furthermore, the number of vacant PT positions in 48 DHs, 13 PHs and 4 RHs with non-functional PT units is 96, 52 and 32 respectively. The total number of needed PTs is these functional Health facilities with non PT units is **180.** The number of needed Physiotherapists in Health facilities (15 DHs, 6 PHs) expected to be established in coming 3 years (2019- 2021) is **54.** Total needed PTs for all functional and nonfunctional PT Units in Health facilities (DHs, PHs and RHs) and expected new Health facilities to be established (15 DHs, 6 PHs) and PRC is **443.** According to the data collected from ongoing training centre, there will be **315 graduate PT** professionals until end of 2020. This brings the total number of needed PTs to 128 after 2020. See Annex 1 for details about current employed PTs.
14	**According to the Physical Rehabilitation Strategic Plan, 23 PRCs operate** in 16 provinces. Out of 23 PRC, 20 are run by I/NGOs and 3 are run by MoPH. This is 4 more compared with the mapping 2013. Most of the health care staff delivering physiotherapy services in the PRCs have a Diploma, contrary of the situation in DHs, PHs and RH under MoPH. This could be explained by the difference of salary between NGOs and the government. The PRCs are also more balanced between the male and female PTs, hence facilitating the access of rehabilitation services for women and girls. **83% of Category I / Technical Orthopedists and Category II PO Orthopedic technicians are men**. This is a factor clearly impeding the access of women to quality P&O services. According to the EPHS guidelines, 4 new provinces should have P&O workshop under the management of MoPH. AABRAR (a local organization) runs a P&O centre in Farah. There is a plan to have 2 P&O workshops, one in Baghlan and another in Bamyan in 2019; related to the ongoing P&O project funded by EU, which will end in July 2019. There is also a plan to open Ghor PRC

[1] Ministry of Health National Health Strategy 2016-2020, p. 15

	under MoPH, but it is not clear when this will happen, it depends on availability of funds and human resources. **The staff needed for PRCs is as follows:** ➢ **71 PTs are needed for PRC** ➢ **202 P&Os** are needed, representing **84 Category I, 44 Category II and 28 Category III and 60 technician assistants.** 10 CAT I have already graduated, 4 CAT I exist in the country, 7 unemployed from KOO is available and 58 CAT II will graduate in 2019 from ADPO and P&O project supported by EU.
15	**As per information from PRC run by I/NGOs and DRP, 71 PTs positions are vacant** in PRCs of the country. In addition 372PT are required in functional DHs, PHs and RHs. Approximately, 315 PTs with a 3yr Diploma will graduate in coming 3 years, which gives a deficit of **128 PTs.**
16	There is a **consistent increase** of the annual production of assistive products in 2017 compared with the previous years. The creation of 4 more additional PRCs since 2013 is an explanatory factor. However, **only 0.15 %** of the population benefits from P&O services because they are insufficient, considering the statement of WHO and ISPO in 2013 that 0.5% of the population was in need. Most of the assistive products are delivered for free by national and international organizations according to the needs. Public Hospital can provide them free of charge with a prescription and if the product is available. Each organization uses its own quality regulations and procedures for provision of assistive devices.
17	**Some essential categories of rehabilitation professionals do not exist** in the rehabilitation facilities such as **occupational therapist**, **speech therapist** and **orthoptist** due to the lack of educational institutions in these fields.
18	**Physical rehabilitation has been included in the humanitarian response plan 2018-2021** for the first time. The health cluster is willing to address the health emergency needs of crisis affected population. **80 districts**[1] in conflict affected areas without trauma care have been identified. Of the 1.5 million people in need affected by conflict, natural disaster and displacement, **69,000 people** will require urgent life-saving trauma care. An estimated **45% of them will eventually require interventions (physical rehabilitation, psychosocial support etc.)** which are not available or inaccessible in many conflict affected regions. **Rehabilitation emergency preparedness** in case of natural disasters or mass casualties due to the conflict **does not exist** in the country.
19	DRP has recently developed **service quality assurance monitoring standards** for the physical rehabilitation services. Accreditation process is not yet in place for the PRCs.Currently, the international and national NGOs use their own monitoring process and are evaluated by donors.
20	There is **no formal evaluation mechanism** in place to monitor the users' satisfaction. International and national NGOs have their own process. However, MoPH has M&E checklist for the services, which are accredited on quarterly bases.

[1]https://www.unocha.org/sites/unocha/files/dms/afg_2018humanitarian_response_plan0.pdf P 32-33.

21	The disability and rehabilitation indicators have been included in the National Health Information system, the data is collected by DRP, compiled and submitted to policy and planning directorate for future planning. Indicators concerning the sector of physical rehabilitation, whether in terms of services, quality of services, human resources or beneficiaries' ratio are not yet fully incorporated into the HMIS. The definition of disability indicators was finalized through the national disability and rehabilitation task force and DRP, but they **focus only on persons with disabilities and not on all persons receiving rehabilitation services**. A database has been recently developed to improve the reporting system and services delivery.
23	There is no research in the field of physical rehabilitation in Afghanistan.

Main Recommendations	
1	A **Physical Rehabilitation Department** may be set up in each Provincial Public Health Directorate to ensure the data collection, identify the needs in terms of complementary structures and adequate availability of rehabilitation human resources. They should also support the monitoring and evaluation of the services. The terms of reference for the disability and rehabilitation task force chaired by DRP should go with a clear action plan with dedicated funds.
2	The **National Disability Strategy** is to be finalized and the Afghan National Disability Action Plan and policy are to be developed by MoLSAMD with the support of the stakeholders. After the approval of the revision of the **Law on the "Rights and Benefits of Disabled Persons"** in line with the CRPD and awareness on it to be delivered to all ministries, military groups and communities.
3	The **coordination mechanisms** shall be improved and the sharing of roles and responsibilities refined between MoPH, MoLSAMD and other concerned ministries as well as with the international and national NGOs and DPOs.
4	**Advocacy** for more investment in disability and physical rehabilitation field needs to be reinforced towards the government, namely in areas such as relevant financial, human, technical resources, including monitoring and for the evaluation process of the services. **A percentage of the annual health budget** to be allocated for disability and physical rehabilitation at MoPH each year. The discussion to set the most relevant rate should involve different stakeholders (national authorities, Health facility workers, NGOs / INGOs, Civil Society Organizations working in the field of rehabilitation / disabilities).
5	Advocacy towards the government and the donors needs to continue to follow / endorse the **Charter on Inclusion of persons with disabilities in Humanitarian Action**, to contribute to achieve the **Sustainable development goals** (SDGs 3-4-5-9-10-11-16 and 17). **Donors** need to be sensitized to allocate a part of their funds to activities linked to addressing the needs of people with disabilities. The capacity of DPOs should be strengthened to take part in policy making and advocacy towards realization of rights of people with disabilities, including right to health and rehabilitation.
6	**P&O should be included in the EPHS policy revision** and approved by the government.

7	The implementation of the **guidelines on Physical Rehabilitation** services by BPHS and EPHS implementers can be facilitated through the extension of awareness / sensitization and trainings on disability and physical rehabilitation.
8	An updated Disability Survey could be conducted using the **Washington Group Questionnaire**[1]. This would support the specialized services' needs assessment to be developed and the development of specific subjects in the health/rehabilitation professional's curricula (i.e. awareness training for the CHWs, CBRWs, the communities on certain impairments etc.).
9	**Awareness raising at community level** on disability, benefits of physical rehabilitation and the importance of early detection/ early intervention and secondary prevention could be extended and developed.
10	**More physiotherapists and prosthetic and orthotic technicians** should be trained, especially the female physiotherapists to work in the Health facilities under MoPH and P&O Category I and category II to work in the PRCs. Gender balance of future trainees should be set as a top priority to allow the access of women and girls to rehabilitation services. A **coordinated human resource capacity development plan** needs to be defined / implemented by the relevant line ministries, PPHD, GIHS/IHS, the Disability Task Force, professional associations and donors and a budget dedicated for this purpose in order to ensure sustainability It is recommended to **strengthen the capacity of AAPT and ANSOP** to better promote the professions and ensure continuous training for the practitioners. A B**achelor in Physiotherapy and in Prosthetic and Orthotic** is essential to be set up, taking into consideration the harmonization of the level of training. The core curriculum of the common subjects needs to be the same as for the PT 3yr Diploma.
11	The trainings of social workers should be harmonized to ensure a better quality of services. Disability and physical rehabilitation needs to be better included into **the medical curriculum**, with a **clinical placement in PRCs** and any other relevant service provider centers to efficiently prepare the future practitioners. Modules on **prevention of disability, early identification and referral mechanisms** should be included in the curriculum for midwives and nurses. **Explore the setting up of training of other essential cadres of rehabilitation** such as occupational therapists, speech therapists to ensure comprehensive rehabilitation services. **It is essential to hire Psychologists in PRCs** or to have them available as needed in order to answer any identified mental health and psychological support needs.
12	Identification of persons with disabilities and referral to Health facilities, disability and rehabilitation at primary health care level should **be included into CHWs training manual**. They also need to be better supervised, monitored and evaluated.

[1] The Washington Group is a United Nations Statistics Commission City Group formed of representatives of national statistical offices working on developing methods to better improve statistics on persons with disabilities globally, with input from various international agencies and experts. These include UN agencies, bilateral aid agencies, NGOs, Disabled People Organizations, and researchers. Currently membership in the WG includes over 135 countries and several international organizations and Disabled People Organizations.

	Developing a training curriculum for CBRWs is essential, using the WHO CBR guidelines as well as coordination mechanism, centralized monitoring and evaluation procedures for all stakeholders (governmental and non-governmental). Some CHCs can provide physiotherapy services where the coverage of District Hospitals (DHs) is making it impossible for people to reach these services.
13	BPHS and EPHS policies need to be better implemented within the district and provincial hospitals, including physical rehabilitation services. **48 PT units should be set up** in functional DHs, 13 PT units in functional PHs and 4 PT units in functional RHs without PT Units. 15 New PT units are expected to be functional in 15 new DHs due to upgrading of CHC+ or newly established DHs in coming 3 years. 6 New PT units are expected to be functionalized in 6 new PHs due to upgrading of DHs or newly established PHs in coming 3 years
14	According to the EPHS guidelines, it is recommended to set up **3 more provincial PRCs in Afghanistan**. This is also in line with the recommendation from WHO and ISPO in 2013 which states 0.5% of the population is in need of P&O services. EPHS policy should be revised including P&O services, which **need to be included in the MoPH 'Tashkeel'.** A plan with an allocated budget should be developed to forecast the takeover of some PRCs and set up the remaining ones. A **harmonization of procedures and processes** in the NGOs / INGOs managed PRCs (staff recruitment and job descriptions, salary scales, monitoring and evaluation tools, quality standards, as well as logistical processes, purchase procedures and types of material)to be established to facilitate the handover of PRCs to the government.
15	The implementation of the **physical rehabilitation activities of the humanitarian response plan 2018-2021** should be done to address emergency situations. These activities shall be implemented through direct support to the existing health institutions, the establishment of new facilities, community initiatives or deployment of mobile health teams when necessary. In collaboration with the **National Disaster Management Unit** (Independent Governmental Organization), MoPH and the Afghan Red Crescent Society should consider the preparation and training of qualified rehabilitation professionals to react quickly and adequately in the areas at high risk of sudden onset disaster with mobile rehabilitation emergency response teams in case of natural disasters or mass casualties due to the conflict. Stocks of assistive devices that may be requested in case of sudden conflicts / clashes should be established.
16	To better ensure the **quality and performance of physical rehabilitation service** monitoring, MoPH should: ➢ Develop an accreditation process for the PRCs. ➢ Develop policies for the process. ➢ Organize regular monitoring and supervision visits to the rehabilitation facilities. ➢ Include NGO capacity building plan with budget, material and technical support. The capacity building plan should be coordinated with the capacity building department of MoPH. ➢ Recruit professional trainer to train the rehabilitation providers on the newly developed quality assurance monitoring standards.

17	Advocacy towards Ministry of Urban Development and Housing Directorate to strictly follow the **Accessibility Guideline** in construction works for all sectors: ➢ Public services and particularly MoPH / health structures ➢ Private companies
18	A formal **evaluation mechanism** to measure users' satisfaction needs to be developed.
19	Harmonize and expand the **data set of impairments' prevalence** required by the HMIS procedure manual on physical rehabilitation/disability. Incorporation of indicators concerning the disability and physical rehabilitation sector (services, quality of services, human resources and beneficiaries' ratio) in the HMIS needs to be considered. It should also include persons without disabilities, but in need of rehabilitation services. Include disability and physical rehabilitation in the HMIS Health facilities profile update and reports is a prerequisite to get more updated data on service provision at the field level.
20	A centralized system to assess **the needs and demands** and developing **territorial maps of services** needs to be set up.
21	**Research about disability and physical rehabilitation** in Afghanistan to be developed to have a global picture of the management of certain impairments with a high prevalence such as cerebral palsy, spinal cord injury and stroke in the country. The objective would be to harmonize the practices in the country to provide better quality services. Improve the **technological watch** and have an overview of good practices at an international level will update the rehabilitation staff's knowledge (new techniques of rehabilitation, evolution in the management of certain pathologies).

BACKGROUND: Extract of the WHO Rehabilitation capacity assessment tool

The WHO Rehabilitation capacity assessment tool enables the national authorities to capture the status of rehabilitation capacity in their country. Rehabilitation is defined as "*a set of measures that assist individuals who experience, or are likely to experience disability, to achieve and maintain optimal functioning in interaction with their environments*".[1] Rehabilitation includes multiple disciplines that address different aspects of functioning (mobility, communication and activities of daily living). It assists and supports people who experience difficulties with functioning in their lives.

The demand for rehabilitation services is expected to increase in the coming years as population's age will grow, causing an increase in the numbers of people living with the consequences of non-communicable disease and injury[2]. However, in many parts of the world, rehabilitation systems and services do not have the capacity to meet the needs among the population[3].

Universal Health Coverage (UHC) emerged in response to a growing awareness of the worldwide problems of low access to health services, low quality of care and high levels of financial risk. According to WHO, it aims at ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services. In September 2017 the new WHO Director General stated "*UHC is our top priority at WHO*" [4]. The world has agreed on UHC; it is Sustainable Development Goal 3.8.

Conducting a rehabilitation sector capacity assessment is the **first step to understand the systems and resources** supporting the provision of rehabilitation services and guiding further action towards their development. This assessment may be used as a component of a more comprehensive rehabilitation situation assessment. It considers the sectors' performance, the historic and current drivers of rehabilitation, provides valuable data to inform governments and support decision making and planning.

[1]World Health Organization / World Bank. *World report on disability*. 2011, Geneva, Switzerland: WHO Press
[2]World Health Organization, *World Health Statistics 2016. Monitoring Health for the SDGs*. 2016, Geneva, Switzerland: WHO Press
[3]Department for International Development, *Disability, poverty and development*. 2000: London, United Kingdom.
[4]Tedros Adhanom Ghebreyeus. All roads lead to universal health coverage. The Lancet Global Health, Vol 5, September 2017.

PURPOSE AND SCOPE

The objectives of conducting a rehabilitation capacity assessment are the following[1]:

- To establish the national or sub-national rehabilitation capacity across the health system building blocks.
- To provide governments with comparable data regarding the status of the rehabilitation sector's capacity in the areas assessed.
- To identify specific needs relating to the capacity of rehabilitation policy, financing, service delivery, human resources, assistive technology and emergency preparedness.
- To help identify opportunities for sustainable rehabilitation services and human resources development.

This assessment was conducted **in close coordination with the Disability Rehabilitation Programme (DRP)** of MoPH, to collect and analyze relevant and up-to-date data in order highlight the strengths and areas which need improvement within the physical rehabilitation sector in Afghanistan. This will support the implementation of the national strategic plan for disability prevention and physical rehabilitation.

[1] Extract of the WHO Rehabilitation capacity assessment tool

1. METHODOLOGY

1.1. Desk Review

A desk review was conducted, mainly focused on health, rehabilitation and disability. Meetings with the key stakeholders involved in the field of the physical rehabilitation in Afghanistan were held. For this purpose, the WHO Rehabilitation capacity assessment tool was used as guidance in order to:

- Understand the governance system for physical rehabilitation in Afghanistan
- Collect accurate data
- Gather recommendations from key stakeholders

A participatory workshop took place to present the results and formulate recommendations.

1.2. Data collection & research tools

The WHO Rehabilitation capacity assessment tool questionnaire addresses the core elements of rehabilitation:

- Leadership and governance
- Funding for rehabilitation
- Human Resources engaged in the physical rehabilitation sector
- Physical rehabilitation services in Afghanistan
- Assistive products
- Equipment and medicines
- Available information and research
- Emergency preparedness for physical rehabilitation

It focuses on identifying rehabilitation capacity, it does not gather detailed information regarding the performance of rehabilitation systems and services and factors affecting its development, and neither does it address drug-related or correctional rehabilitation.

Three other tools were created and adjusted to the interlocutors to collect more specific data on:

1.2.1. Questionnaire on physical rehabilitation services including:

- Types of services and location
- Human resources (qualifications, gender and age of staff, equipment of facilities)
- Patient deliverables

The questionnaire was distributed to HMIS and GCMU of MoPH, as well as to local and international NGOs after a preliminary meeting.

1.2.2. Physiotherapist (PT), prosthetic and orthotic (PO) training centers

- Number of newly graduated professionals from 2016 to 2020
- Gender disaggregation

- Details of the Diploma they obtained

This tool was distributed to the Afghanistan Association for Physical Therapy (AAPT) and the various PT and P&O training centers of the country. AAPT provided the data concerning the private PT institutes and the Institute of Health Sciences (IHS) of Nangrahar.

1.2.3. "Prevalence data collection tool[1]"

This tool was designed to measure the prevalence of diseases treated in different services. It was given for dissemination to HMIS, GCMU and NGOs/ INGOs managing PRC.

The following stakeholders replied and have sent filled questionnaires:

- **8 NGOs and INGOs service providers of about 20 PRCs**
- **3 PO training centers**
- **9 PT training centers**

1.3. The meetings with stakeholders

During the whole process, 33 meetings were held with various stakeholders:

1.3.1. Ministry of Public Health:

- The Disability and Rehabilitation Programme
- The General Directorate of Health Policy & Planning
- The Grant & Service Contract Management Unit
- The Health Management Information System

Various topics were tackled with MoPH interlocutors touching on PT and P&O services, assistive products/devices, number and types of beneficiaries etc.

1.3.2. Institutional and stakeholders:

- MoLSAMD
- Disabled People Organizations (DPOs)
- National Professional organizations: AAPT and ANSOP
- Institutions providing physical rehabilitation trainings
- National service providers
- International Organizations
- ACBAR (platform of national and international associations committed to persons with disabilities and for physical rehabilitation)

[1] See annex 9.2

1.3.3. Rehabilitation facilities visited:

Number of facilities	Type of facility	Managed by	Location
7 physiotherapists units and physical rehabilitation centers	Community Health Center (CHC)	MoPH	Kabul and Herat
	District Hospital (DH)	Bakhtar Development Network (BDN)	
	Regional Hospital (RH)	International Committee of the Red Cross (ICRC)	
	Physical Rehabilitation Center (PRC)	Kabul Orthopedic Organization (KOO)	
4 training centers	Physiotherapy, Prosthetics and Orthotics	Ghazanfar Institute of Health Sciences (GIHS) Private sector HI	Kabul and Herat

1.4. The workshop with stakeholders

On the 2nd of January 2018, a workshop which brought together stakeholders of physical rehabilitation sector in Afghanistan took place. The aim was to present the methodological approach and the findings of the assessment. A roundtable was also organized to share perceptions and information about the main changes which have taken place linked to the recommendations which were made in previous mapping report of 2013 mapping. The results of this workgroup are presented with the recommendations.

1.5. Challenges

Different challenges set some limitations for the assessment. The duration of 1.5 months was a constraint; there was a large number of stakeholders, time needed to locate and understand data and the implications etc. The security situation in Afghanistan also prevented some field visits. Although various measures were put in place to address these challenges, this may have had an effect on the outcome of the mapping; some information may be missing or unavailable. Despite this, the information gathered is considered to give **a rather accurate macro-level understanding** of the physical rehabilitation sector in the country.

2. THE CONTEXT OF AFGHANISTAN

Afghanistan is a country located in South Asia. It is bordered by Pakistan, Iran, Turkmenistan, Uzbekistan, Tajikistan and China.

According to 2016 World Bank data, the **population is estimated at 34.66 million**. The urban population represents 27.6% of the total population in 2017[1] and the life expectancy at birth is 63 years.

The majority of the population works in agriculture, followed by services and minority in various industries. In the "*Afghanistan Demographic and Health"* Survey done in 2015, the main population data were as following:

- 12% of women and 91% of men appear to be employed.
- The estimation of literacy rate is 15% for women and 49% for men.
- The school attendance ratio dropped from 60% in primary school to 38% in secondary school. Boys were much more likely to attend both primary and secondary school than girls.

According to the Afghanistan Health Survey which was carried out 2015, most households own transportation means, such as a bicycle (26.7%), motorcycle (31.4%) or car (12.7%). Cell phone ownership is almost universal.

Before 2014[2], the economy had sustained nearly a decade of strong growth, largely due to international assistance. However, since 2014, the economy slowed down in large part because of the withdrawal of nearly 100,000 foreign troops and the decrease in funding by institutional donors. Despite improvements in life expectancy, health, income and literacy since 2001, Afghanistan remains extremely poor, landlocked and highly dependent on foreign aid.

Much of the population continues to suffer from shortages of housing, clean water, electricity, medical care and jobs. Corruption, chronic insecurity, weak governance, lack of infrastructure and human resources pose challenges for the future economic growth. Afghanistan's living standards are among the lowest in the world.

The international community remains committed to Afghanistan's development, pledging over $83 billion at ten donors' conferences between 2003 and 2016. In October 2016, the donors at the Brussels conference pledged an additional $3.8 billion in development aid annually from 2017 to 2020.

2.1. Overview of Afghanistan Health Care System

Many international and national NGOs were providing health services during the years of war and conflict. In 2003, a major reform took place in order to fight the disastrous health situation in Afghanistan; MoPH with bilateral donors defined the **Basic Package of Health Service (BPHS)** program. The goal was to provide more equitable access to basic health care for the most vulnerable people as well as those living in rural and remote areas. Through this mechanism, MoPH intended to build its capacity of stewardship and ensure coordination of services, reduce overlaps and provide more equitable provision of services. It was also designed to allow more stable and long-term funding from the three key donors, United States Agency for International Development (USAID), the European Commission (EU) and the World Bank (WB).

[1] https://www.cia.gov/library/publications/the-world-factbook/geos/af.html
[2] ditto

Later on in 2005, the MoPH developed the **Essential Package of Hospital Services (EPHS)**, which defined the role and services of the hospital sector, specifically for the district, provincial and regional hospitals and aimed to reduce high maternal and childhood mortality rates.

The delivery of BPHS and EPHS (in part) has been funded by the three main donors (the WB, EU and USAID) and implemented either by Consultants (through contracting-out approach) or by MoPH Strengthening Mechanism since 2003.

In general, MoPH is overseeing and monitoring/supervising the implementation of BPHS and EPHS through its central departments and provincial offices. In particular, the Grant and Services Contract Management Unit (GCMU) of MoPH is carrying out procurement of consultancy services, contract management, financial management, coordination and continuous tracking of contract compliance of BPHS and EPHS implementation.

Key figures

As per the National Health Accounts (NHA) of 2014:

- **72% of the health expenditures in Afghanistan rely on out-of-pocket (OOP) spending.**
- **23% relies on external aid.**
- **5% depends on the financing of the central government.**

2.1.1. Review of the period 2003-2013

For a decade, the EU, USAID and the WB have been supporting the health service delivery in Afghanistan, each targeting a specific set of provinces. WB provided funding for 11 provinces till the end of September 2013. Similarly, EU provided financial support in 10 provinces and USAID covered the remaining 13 provinces.

Central functions were also supported by these three development partners in a complementary manner. Under this arrangement, the WB supported a Service Procurement and Contract Management Department (SPCMD/ GCMU), the third party monitoring and results based financing for improved service delivery.

Besides funding the BPHS and EPHS, the EU and the USAID also financially supported SPCMD and capacity building activities both for MOPH and NGOs. The bilateral EU support for the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS) programs ended on December 30th, 2013.

2.1.2. System Enhancement for Health Action in Transition (SEHAT) Program for Afghanistan, 2014 - June 2018

Following this, all three major donors directed their intervention to a joint effort under **SEHAT project** and extended the support for the health sector through the Afghanistan Reconstruction Trust Fund (ARTF) which is administered by the World Bank. External donors fund more than 85% of the project.

The SEHAT goal is to extend the scope, quality and coverage of health services provided for the population, particularly for the poor in the project areas. It likely aims at strengthening the national health system and the capacity of MoPH at central and provincial levels, so it can effectively perform its stewardship functions in the sector.

SEHAT has three components:

- Component 1: Sustaining and improving BPHS and EPHS services
- Component 2: Building the stewardship capacity of MoPH and system development
- Component 3: Strengthening program management

The project supports BPHS implementation in 31 provinces (out of thirty four provinces) and EPHS implementation in 15 provinces through contracting out and contracting in arrangements both in rural and urban areas in 31 provinces.

The current SEHAT will end in June 2018 and will be continued through the **SEHAT MANDI**.

2.1.3. The Strengthening Mechanism

In 3 provinces (Kapisa, Panjshir and Parwan), MoPH is contracting managers to help strengthening service delivery in line with the BPHS and EPHS policies, using MoPH staff. This specific mechanism is called Strengthening Mechanism (MoPH-SM). It includes the competitive recruitment of managers, the provision of funding level similar to the NGOs one and the use of the same M&E mechanism.

2.1.4. SEHAT MANDI, July 2018 - end of June 2021

To continue the work undertaken with SEHAT, SEHAT MANDI will develop **3 components**:

- Component 1: Improving Service Delivery
- Component 2: Strengthening the Health System and its Performance
- Component 3: Strengthening demand and community accountability for key health services

GCMU launched a call for proposals in January 2018 following the new WB procurement regulations which concerns the selection criteria of the implementers, the procurement and funding rules and procedures.

There will be for 1 contract:

- 1 consultant or
- 1 lead consultant + one joint venture or sub-consultancy for 20% /or a consortium

The Quality and Cost Base Selection (QCBS) establishes the criteria for selection of the implementers with the following attribution of scores:

- 80% mark for the technical quality and methodological approach of the implementer to reach the communities
- 20% mark for the cost estimated by the implementer.

The selected implementers will receive:

- 80% of the financing after their quarterly report
- And the remaining 20% after an evaluation by a third party firm hired by MoPH. The functionality status of Health facilities in terms of their capacity to provide health services according to BPHS/EPHS policies will be assessed, and the HMIS reports submitted by consultants to the HMIS department of MOPH will be verified.

This will be done at two stages:

- Assessment of consistency through comparing consultant's reported figures in HMIS to MOPH with key outputs data recorded in the Health facility register;

- Visits of a random sample of households listed in Health facility's register for verification of services received by the clients.

Moreover, the Third Party will measure the consultants' performance in delivering of BPHS / EPHS through the **Health facility annual assessment**.

The selected consultant should implement all BPHS and EPHS components in accordance with MoPH National Health Strategy 2016-2020. MOPH has selected 11 provinces[1] where implementation of both BPHS and EPHS packages will be combined through a single contract for each province. In the 12 remaining provinces[2], only BPHS will be implemented by consultants.

2.1.5. Organization of the BPHS and EPHS system

The first BPHS policy had been developed in 2003. It was complemented with the EPHS in 2005. A full review of the BPHS was undertaken in 2010. This revised version identified new priority areas in **mental health, disability and nutrition** and new types of Health facilities (Health Sub-center and Mobile Health Teams) to increase the accessibility to health care for the people living in remote areas. Furthermore, health care to underserved population such as nomadic breeders and detainees were also added in the revised BPHS.

A revision of EPHS was been done in 2013, but was not validated by MoPH. The Plan and Policy Directorate of MoPH, in collaboration with the London School of Hygiene and Tropical Medicine, has just started a research about the state of health and disease based on country evidence. Its objectives are to investigate the opportunities towards Universal Health Coverage (UHC) in Afghanistan and to help further address equity and quality.

Based on such evidence the BPHS and EPHS will be revised by the end of 2018. The policies in use are the BPHS of 2010 and the EPHS policies of 2005. Prosthetic and Orthotic services are not part of it.

The BPHS objectives are:

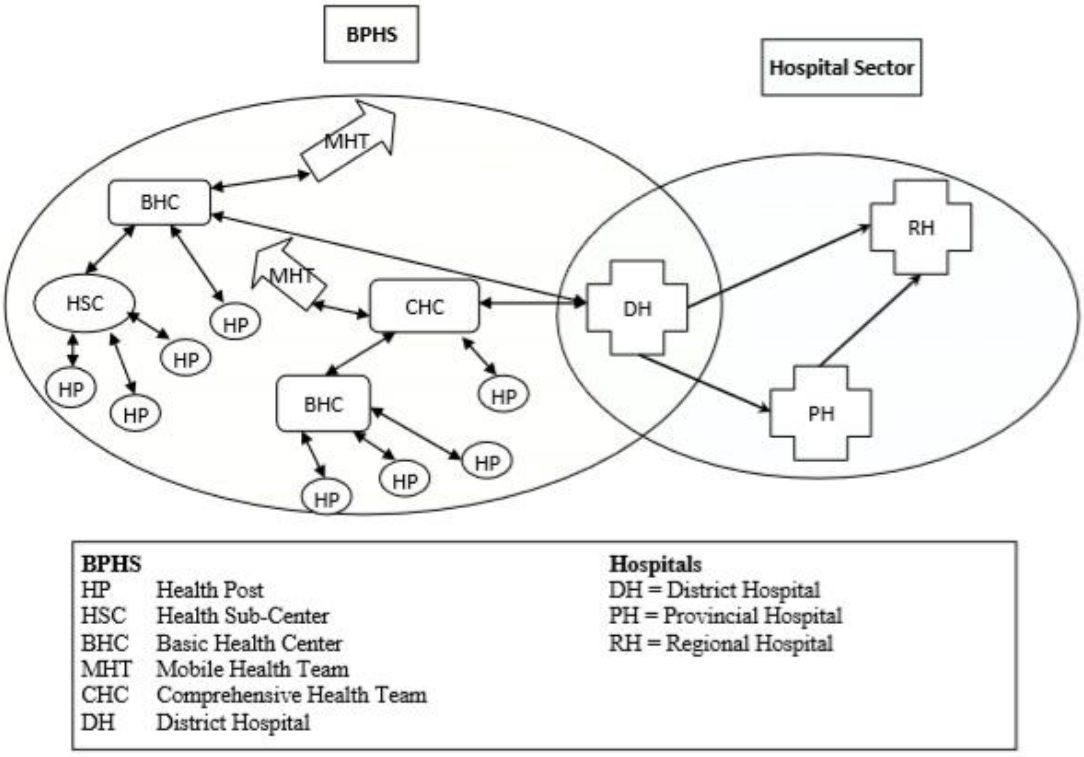
- To improve both the **access to and the quality** of the basic health services to all Afghans
- To provide a guide on which services need to be available at **each level of the primary health care system** and list of the staff, equipment, diagnostic services and medication required to provide those services at each level

The EPHS purposes are:

- To identify a **standardized package** of hospital services at each level of hospital
- To provide a guide for the MOPH, private sector, NGOs and donors on **what services should be provided** at each type of hospital and how each level should be staffed, equipped and medications required
- To promote a **health referral system** that integrates the BPHS with hospitals

The organizations and logical links between both services are summarized in the figure hereunder.

[1] Faryab, Wardak, Kunar, Farah, Daikundi, Laghman, Paktia, Logar, Paktika, Urozgan, and Badghis
[2] Baghlan, Balkh, Takhar, Bamyan, Kandahar, Ghor, Kabul, Kunduz, Nuristan, Jawzjan, Samangan, and Zabul



*extract of the BPHS policies of 2010

2.1.6. Rehabilitation sector in BPHS / EPHS structure (adapted from BPHS policy)

i. At the Primary level of care services

Health Posts (HPs) at village level:

- Operating from community health workers own house
- Covering between 1,000 – 1,500 inhabitants.
- Community Health Workers (CHWs) are responsible for treating patients with minor illnesses and mental health issues, for awareness raising on disability and mental health and for identification of persons with disabilities and mental conditions.

Health Sub-centers (HSCs):

- At village level, covering between 3,000 – 7,000 inhabitants.
- Bridges HPs and Basic Health Centers (BHCs).

Basic Health Centers (BHCs):

- At a larger village level, covering 15,000 – 30,000 inhabitants
- Identification, referral, follow-up care for mental health patients and persons with disabilities, including awareness raising.
- Hospital physiotherapist should visit BHC on an outreach basis from the district level.

Mobile Health Teams (MHTs):

- They are an extension of the BHC services.
- The services they provide are in most cases the ones recommended for a BHC

Comprehensive Health Centers (CHCs)

- Smaller towns, covering 30,000 – 60,000 inhabitants.
- Persons with disabilities and persons requiring physiotherapy services can be screened, given advice and referred to appropriate services.
- Physiotherapists visit CHC on an outreach basis from DH.

ii. At the Second level of care services

District Hospitals (DHs):

- Covering 100,000 – 300,000 inhabitants.
- It should provide outpatient and inpatient care for mental health patients and rehabilitation for persons who need physiotherapy with referrals for more specialized treatment when needed.
- Minimum requirement of the policy is to have 2 physiotherapists (1 male, 1 female).

iii. At the Tertiary level of care services

Provincial Hospital:

- Serves one province and provides additional services to the district hospital or when no district hospital is available, provincial hospitals fill that function.
- It can refer to the regional hospital or a specialized hospital in Kabul. 4 physiotherapists should work (2 males and 2 females).

Regional Hospital:

- Serves several provinces and have number of specializations.
- RH provides professional inpatient and emergency services at a higher level than the DH and PH. 8 physiotherapists should work (4 males and 4 females).

Specialty Hospital and National Hospital:

- Mainly located in Kabul.
- Provides more complex services than the regional hospitals.
- They do not have physiotherapy or prosthetics and orthotics services.

Physical rehabilitation services:

- As in table blow

Table 2.13. Physical Rehabilitation (including Persons with Disabilities) Services						
Interventions and Services Provided	**Health Facility Level**					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**District Hospital**
Information, education, communication[1]	Yes	Yes	Yes	Yes	Yes	Yes
Identification of people with disabilities and referral to nearest services for physical rehabilitation	Yes	Yes	Yes	Yes	Yes	Yes
Early identification and referral to physical rehabilitation services at DH level for children with physical, sensory and intellectual impairments.	Yes	Yes	Yes	Yes	Yes	Yes refer on as needed
Assess and treat persons with musculoskeletal conditions such as: developmental dysplasia of the hip, clubfoot, low back pain; neurological conditions such as cerebral palsy and sequels of poliomyelitis and traumatic injuries from burns, accidents, explosive devices, war	No	No	No	No	No[2]	Yes
Provision of crutches, walking aids at CHC and DH[3]. Physical rehabilitation staff at DH can measure for wheelchairs and assistive devices for children with cerebral palsy and refer to Orthopedic Workshops centers for prostheses, orthoses, assistive devices, special seating, wheelchairs and management of club foot and DDH	Refer to nearest rehabilitation centre (RC)	Refer to nearest RC	Refer to nearest RC	Refer to nearest RC	Refer to nearest RC	Yes

1. Awareness and information package available with Disability and Rehabilitation Department of MoPH.
2. Physical rehabilitation staff can assess physical needs and advice on outreach visits from DH to CHCs subject to staff availability
3. Wooden auxiliary crutches and walking sticks can be made locally for low cost as an income generation project for persons with disability or low income families or purchased. Measurement of correct height can be easily taught to staff in CHC.

Note: Disability services will be implemented gradually

Table 1: Disabilities and physical rehabilitation in BPHS. Extract from BPHS 2010

2.2. Rehabilitation needs

The need for physical rehabilitation services in Afghanistan is not defined according to the type of impairments, the geographical distribution of impairments or the age of the population that might benefit from them. Currently, there is limited data available about the prevalence of disabling diseases and/or trauma.

The only official data and statistics about persons with disabilities in Afghanistan is enclosed in the **"National Disability Survey in Afghanistan"** done in 2005 by Handicap International in close link with MoLSAMD. It concluded that the prevalence of persons with severe disability was 2.7% of the total population.

This prevalence rate of severe disability was the lower estimation, and these results should be interpreted cautiously. Depending on which threshold is chosen to identify person with disabilities, the results might change. In fact, if the threshold to define disability is based on the health set of questions, then the prevalence of persons with very severe or severe disability was at **10.8% of the whole Afghan population**.

If we compare these results with the 2011 WHO World report on disability, about 15% of the world's population lived with some form of disability. It is known that the global estimation for disability is on the rise due to population ageing and the rapid spread of chronic diseases, as well as improvements in the methodologies used to measure disability. So the threshold leading to the 10.8% said above in the NDSA seems more realistic than the one leading to the estimation of 2.7%.

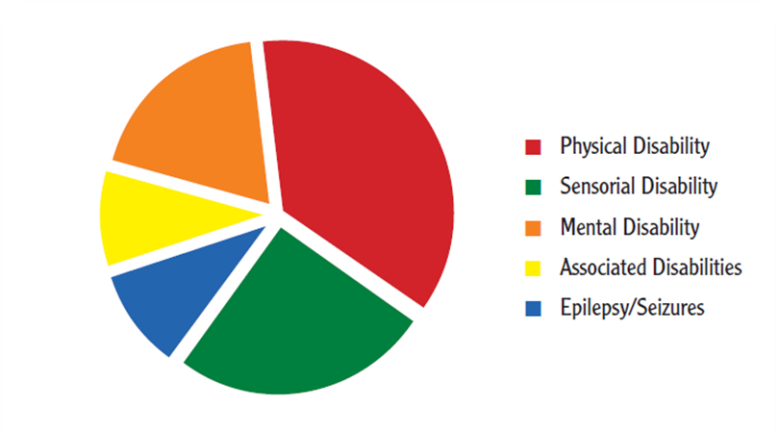


Figure 1: Overall typology of disabilities - NDSA 2005

Physical Disability	36.5%	Multiple physical disability	46%
		Paralyses	29%
		Physical deformity	12%
		Lack of limb	12%
Sensorial disability	25.5%	Visual impairment	32.4%
		Hearing impairment	25.2%
		Speech impairment	23%
		Speech and hearing impairment	15.4%

Table 2: details of physical and sensorial disabilities - NDSA 2005

Within the major causes identified by the respondents of the 2005 NDSA, the main cause was disability caused in birth or acquired during the first years of life, which represented 26.4% of the total causes identified. The war related disabilities were also identified as another major cause. This information seems still valid if we compare with the data available, collected through HI, SCA and ICRC: the prevalence of lower limb amputation is the most common, followed by cerebral palsy, clubfoot, spinal cord injury and road traffic accident (see annex 2.1, 2.2 and 2.3).

These impairments are only a handful of impairments that people can have and where physical rehabilitation plays an important role for restoring functions and removing barriers which support the access to education, employment and facilitate social inclusion. A lack of appropriate health care for persons with lower limb amputation, including physical rehabilitation, can result in further complications and worse health outcomes. The majority of children with cerebral palsy and persons with a spinal cord injury would need continuous physical rehabilitation services, including technical aids and specifically orthotic appliances for maintaining or improving their functional capacities.

In Afghanistan, national disease prevalence and disability disaggregated data in general statistics of the health and social sectors is not available. So there is a need for more complete studies and data to have a better assessment of the needs for physical rehabilitation.

According to the "*Afghanistan Health survey"* (AHS) done in 2015, out of the 17,921 persons who reported illness in the two weeks prior to the survey, **81.7% were reported to have sought treatment outside of the home**. This represents a good level of access to services by households in Afghanistan. People expressed to trust more and be more satisfied with the quality of care of private hospitals/clinics, with no major differences by demographic groups.

Individuals stated that they would preferentially go to private clinics or hospitals (49.8%), MoPH clinics (25.4%), and government hospital (11.5%).

The three primary reasons reported by the persons for not going to Health facility were:

- Perceptions that the illness would go away by itself (53.3%)
- Cost of the services as a barrier (24.1%)
- Difficulty to access the facility (18.3%)

Indeed, of those who reported being hospitalized in the last 12 months prior to the survey, 48.4% reported some form of financing distress and 12.3% reported some form of severe financing distress. Financing distress is defined as households spending over and above their regular savings and budget on health care (borrowing money, selling or mortgaging possessions and land). Only households who sold assets (and not those who borrowed money) are considered in severe financing distress. The average amount spent for hospitalization was 8,593.3 Afghanis.

Drugs, supplies and food are some of the leading forms of expenditures for persons receiving outpatient or inpatient care. Specifically, drugs and supplies represented the highest cost for those who required treatment at a Health facility (659.4 Afghanis) and those who were hospitalized (4,753.4 Afghanis).

Accessibility and transportation issue is another main barrier. In 2006, 35.5% required less than an hour to reach the nearest Health facility, where in 2015, 54.6% could reach their Health facility of choice in under 30 minutes. Those seeking care in 2006 travelled predominantly by foot (75.1%), whereas in 2015 it was 30.5%. At the time of the 2006 survey, Afghanistan's population was 76.8% rural compared with 73.0% in 2015. Customs and beliefs discouraging the public from accessing health care would also be mitigated.

The 2015 *Afghanistan Demographic and Health survey* highlights the fact that **only 5% of women reported to make decisions** alone about their own health care. 44% reported that their husbands make the decisions for them. It was also shown that 80% of women and 72% of men believed that a husband is justified in beating his wife in at least 1 of 5 specified circumstances, particularly if she goes out without telling her husband.

If we look generally at the accessibility to health services, the geographical accessibility have been improved in 9 years.

Consequently, there is major need to look for solutions to address the financial issue for the household to access health services, as well as empowering women to improve their access to health services.

A new program called SEHAT (System Enhancement for Health Action in Transition) MANDI will start July 2018 - end of June 2021.

The Plan and Policy Directorate of MoPH, in collaboration with the London School of Hygiene and Tropical Medicine, has planned a research about the state of health and disease based on country evidence. Based on such evidence the BPHS and EPHS policies will be revised by end 2018. Actually the guidelines applied remains: the BPHS of 2010 and the EPHS policies of 2005. Prosthetic and Orthotic technicians are not part of it.

According to the data collected from HI, SCA and ICRC, among the patients received into their rehabilitation facilities the prevalence of lower limb amputation is the most common, followed by cerebral palsy, clubfoot, spinal cord injury and road traffic accident.

The only official data and statistics about persons with disabilities in Afghanistan is enclosed in the "*National Disability Survey in Afghanistan*" done in 2005 by Handicap International in close link with MoLSAMD. According to it, the prevalence of persons with very severe or severe disability was at 10.8% of the whole Afghan population (≠ WHO 2011, 15% of the world's population live with some form of disability).

The 2015 Afghanistan Demographic and Health Survey highlights the importance of financial resources for the household to access health services.

3. REHABILITATION CAPACITY ASSESSMENT: LEADERSHIP, GOVERNANCE AND FUNDING

3.1. Governance and leadership

3.1.1. The Ministry of Public Health

The Ministry of Public Health is in charge of the Physical Rehabilitation sector in Afghanistan. At MoPH, the **Disability Rehabilitation Program (DRP)** has the role to ensure coherence between the specific needs identified and the development of services, as well as to coordinate the activities in the sector. DRP works closely with different MoPH structures:

- The Health Management Information System
- The Directorate of Human Resources
- The Department of General Health Policy and Planning

The aim is to ensure that persons with disabilities and rehabilitation needs are taken into account in the health system. The department has moved forward considerably in defining policies and plans for physical rehabilitation, developed manuals and guidelines as well as awareness material. However, the **indicators concerning the sector of physical rehabilitation**, whether in terms of services, quality of services, human resources or beneficiaries' ratio are not yet fully incorporated into the HMIS, which is not facilitating the tasks of DRD. According to the department heads, there is a need to have more technical advice and human resources. A restructuring of DRD is ongoing; its new name is National Disability Rehabilitation Program (DRP). The definition of disability indicators was finalized through the national disability and rehabilitation task force and a database has been recently developed to improve the reporting system and services delivery.

The DRP also leads the **National Disability and Physical Rehabilitation Task Force**. GCMU and all the implementers, NGOs and INGOs working on the physical rehabilitation sector, are involved in this working group. Since 2010, the working group has developed guidelines and standards, policy documents and strategy and proposed some changes to be implemented in order to better take into account the health and rehabilitation needs of people with disabilities in a more systematic way. The task force has Terms of Reference (ToR) which was revised in 2017, but a plan of action is not defined. Meetings are held every one or two months.

3.1.2. The Ministry of Labor, Social Affairs, Martyrs and Disabled

The MoLSAMD is divided into **4 departments**:

- The Deputy Ministry of Labour
- The Deputy Ministry of Social Affairs
- The Deputy Ministry of Martyrs and Disabled
- The Deputy Ministry of Administration and Finance

MoLSAMD is undergoing restructuring and a new body by the name of National Support Authority for the persons with disabilities and Heirs of Martyrs has been created.

Vocational training activities at the National Disability Institute are implemented under the leadership of the Deputy Minister for Labor. Trainings take place either at the Afghan and Korean Vocational training

center in Kabul or in other vocational training centers in other provinces. The Martyrs and Disabled Deputy Ministry is currently working on the **National Disability Strategy** with the disability stakeholders.

When finalized, work will focus on the **Afghan National Disability Action Plan** (last one expired in 2011) and policy. The Deputy Minister has a global budget for war victims. According to the Law on Rights and Benefits of Disabled Persons, an allowance to the war victims (article 7) is provided to those who have been confirmed disabled by the *Disability Confirmation Health Commission*, depending on their level of disability (article 2). See hereunder the article 8:

- Persons coming under Article 7 of this law who have been confirmed with total disability shall be eligible to receive salaries as set forth below:
    - Military personnel and employees of governmental and mixed agencies are eligible to receive 35% of their latest salary along with other addendum without taking into account their duty period.
    - Persons not coming under the grading system or who did not have fixed salary or didn't have salary at all are eligible to receive 30% salary of grade 8, step 1 of the Civil Servants Law.
- Persons who have been confirmed with partial disability by Disability Confirmation Health Commission are eligible to receive half of the salary mentioned in paragraph 1 of this Article.
- In case the pension of persons coming under paragraph 2 of this Article is more than half of the salary of persons mentioned in paragraph 1 of this Article, they can ask for their pension.

Persons with disabilities not caused by war, such as persons with congenital disability or disability due to diseases have been left out from this benefit.

Apart from this, individuals with disabilities get benefit for the primary and higher education (article 19); the state should ensure recruitment of at least 3 % of eligible individuals with disabilities in the ministries and other government agencies (article 22). Lastly, they get benefits on allocation of Land for House and Dwelling Apartments (article 24).

MoLSAMD is the chair of the **Internal Ministry Meetings** which are held every three months with representatives of all ministries, to coordinate disability issues. Unfortunately, MoPH and MoLSAMD do not have a formal coordination system.

MoLSAMD is also leading a **Disability Stakeholders Coordination Group** (DSCG) since 2002. The DSCG is composed of all organizations working in the field of disability, including DPOs, National and International NGOs, representatives from the Ministry of Education (MoE) and the MoPH.

3.2. Disability and rehabilitation policies, legal documents

Afghanistan ratified the following international treaties / conventions:

- Mine Ban treaty (MBT) in 2003. The article 6 International cooperation and assistance (…) mentions that "*Each State Party in a position to do so shall provide assistance for the care and rehabilitation, and social and economic reintegration, of mine victims*".
- International Labor Organization (ILO) C159 Vocational Rehabilitation and Employment (Disabled Persons) Convention in 2010.
- Convention on Cluster Munitions (CCM) in 2011. The article 5 mentions that "*Each State Party (…) shall (…) adequately provide age- and gender-sensitive assistance, including medical care,*

rehabilitation and psychological support, as well as provide for their social and economic inclusion. Each State Party shall make every effort to collect reliable relevant data with respect to cluster munitions victims".

- **United Nations Convention on the Rights of Persons with Disabilities** (UNCRPD) was signed and ratified in 2012.

Afghanistan has not endorsed the Charter on Inclusion of Persons with Disabilities in Humanitarian Action[1] which was endorsed at the World Humanitarian Summit (23 and 24 May 2016, Istanbul) by over 70 stakeholders from States, UN agencies, the international civil society community and global, regional and national organizations of persons with disabilities. By endorsing this Charter, States, UN agencies, organizations commit to render humanitarian action inclusive of persons with disabilities, by lifting barriers persons with disabilities are facing in accessing relief, protection and recovery support and ensuring their participation in the development, planning and implementation of humanitarian programs.

The government of Afghanistan has developed policy documents and strategies related to health, disability and physical rehabilitation:

- Afghanistan Constitution - 2004. Article 52 "*The state shall provide free preventative healthcare and treatment of diseases as well as medical facilities to all citizens*" and article 53 "*The state shall adopt necessary measures to regulate medical services as well as financial aid to survivors of martyrs (...), and for reintegration of the disabled and handicapped and their active participation in society. The state (...) shall render necessary aid to the (...) disabled and handicapped*".
- Law on the rights and benefits of People with disabilities in 2010: some articles were revised in line with the CRPD, it has been submitted to the Ministry of Justice, pending approval.
- Afghanistan is a party to the Asian and Pacific Decade of Persons with Disabilities 2013-2022, during which the Incheon Strategy to "Make the Right Real" for Persons with Disabilities in Asia and the Pacific is implementing actions and monitoring the advancement of the disability-inclusive development goals. The full and effective implementation of the Incheon Strategy is critical in achieving the 2030 Agenda for Sustainable Development and its Sustainable Development Goals and set forward a path for building inclusive societies that leave no one behind.
- National Health Policy 2015-2020: Disability and physical rehabilitation are highlighted, mentioning that MoPH will put disability as a priority in the health system of the Country.

Since the establishment of DRP in MoPH, a number of strategic documents, guidelines and manuals have been developed:

- Guidelines on Physical Rehabilitation Services 1393-1395 (2014-2016): Basic Package of Health Services Implementers. This was revised and approved in 2015.
- Guidelines on Physical Rehabilitation Services 1394-1396 (2015-2017). Essential Package of Hospitals Services Implementers, it was revised and approved in 2015.

These two guidelines for physical rehabilitation services are to support BPHS and EPHS implementation of physical rehabilitation services.

- Disability prevention and physical rehabilitation resource training manual for the health staff (revised at the end of 2017). DRP with the support of a GIZ consultant planned to organize trainings of the health staff in the remaining provinces on disability, rehabilitation, and referral, during the coming months.

[1] http://humanitariandisabilitycharter.org/

- Physical Rehabilitation Directory 2011. It was revised in 2014 according to DRP.
- MoPH - National Strategic Plan for Disability Prevention and Physical Rehabilitation 2017 – 2020, hereunder detailed.

3.3. The National Strategic Plan for Disability Prevention and Physical Rehabilitation 2017-2020

This plan was developed through a consultative process of DRP, an external expert supported by EPOS Health Management, the Community Health Department of MoPH and the stakeholders of the sector. This was supported by the Technical Cooperation Programme, founded by EU and the Afghan Civilian Assistance Program (ACAP III) of the United Nations Mine Action Services (UNMAS) funded by USAID.

The Afghanistan National Strategic Plan provides strategic directions in line with the national health policy and strategy, the National Disability Law, the UNCRPD, and the recommendation of WHO Global Action Plan on Disability (2014-2020) to ensure equal access of person with disabilities to health and physical rehabilitation services.

The objectives can be split into 4 main parts:

3.3.1. Leadership and governance

- To reinforce the stewardship of MoPH, particularly the Disability and Physical Rehabilitation Department, through better governance and effective coordination and monitoring of the disability and rehabilitation sector.
- To improve disability and rehabilitation data collection and analysis.
- To improve communication and information within MoPH, towards BPHS and EPHS implementers, donor community and civil society organizations.
- To reinforce the implementation of the BPHS and EPHS physical rehabilitation services guidelines and increase the number and coverage of rehabilitation services.
- To develop a five years plan to upgrade the Kabul Rehabilitation Hospital to a national referral center for physical rehabilitation services.
- To develop and promote accessibility standards at all MoPH institutions and Health facilities.
- To increase knowledge amongst health workers, including midwives and CBR workers on early identification and referral of persons with disabilities, especially children with disabilities.

3.3.2. Human resources development and national training capacities

- To increase the number of professionally trained practitioners in disability and rehabilitation and promote their integration in BPHS and EPHS. Furthermore, enhance national education institutions capable of providing training programs of good quality.
- To develop a long term plan for the training, recruitment and retention of physical rehabilitation professionals in BPHS and EPHS according to the needs and an equal geographical distribution.

3.3.3. Health promotion and preventable disabilities

- To improve the access for persons with disabilities, particularly women and girls, to health promotion and prevention and strengthen knowledge on preventable disabilities in BPHS and EPHS.
- To increase the knowledge around preventable disabilities among BPHS and EPHS implementers, including training of Community Health Workers, CBR workers, midwives, nurses and doctors.

3.3.4. Advocacy and awareness on the rights of person with disabilities and physical rehabilitation

- Raising awareness on the rights of persons with disabilities among BPHS and EPHS health staff in coordination with Disabled People's Organizations.

3.4. Funding opportunities in rehabilitation sector

There is not a fixed percentage of the health budget allocated for disability and physical rehabilitation at MoPH each year.

The financing for rehabilitation is allocated from the development budget. In the national budget for fiscal year 1397-2018[1], the approved budget for Health is around 160,767,000 USD (11,097,047,862 AFN), and only 200,000 USD (13,668,000 AFN) has been allocated to Disability and Rehabilitation, even though MoPH has requested 685,000 USD. This will be enough only for salaries till end of September 2018, according to MoPH.

The development budget for the SEHAT is corresponding at around 86,631,000 USD (5,979,750,000 AFN).

In 2017, the budget for Health was around 178,000,000 USD (12,305,035,482 AFN), slightly more than this year, and the budget for Disability and Rehabilitation was around 442,000 USD (30,500,812 AFN) [2], more than the double compared with 2018.

MoPH developed the National Strategic Plan for Disability Prevention and Physical Rehabilitation 2017 – 2020.

DRP and the National Disability and Rehabilitation Task Force defined disability indicators, but they focus only on persons with disabilities and not on all persons receiving rehabilitation services. DRP has recently developed a database to improve the reporting system and services delivery.

The terms of reference of the Disability and Rehabilitation Task Force chaired by DRP was revised in 2017, but is not going according to planned action.

MoLSAMD is going through restructuring, the approval of the president is remaining.

MoLSAMD is currently working on the National Disability Strategy with the disability stakeholders, then they will work on the Afghan National Disability Action Plan (last one expired in 2011) and policy.

MoPH and MoLSAMD does not have a formal coordination system.

There is no fixed percentage in the annual health budget allocated for disability and physical rehabilitation at MoPH. The approved budget for disability and rehabilitation for 2018 is one third of what is requested by MoPH.

[1] Ministry of Finance, National Budget Fiscal year 1397 (approved) Final.
[2] http://MoPH.gov.af/en/page/approved-budgets

4. REHABILITATION CAPACITY ASSESSMENT: HUMAN RESOURCES

Currently, the human resources involved in the physical rehabilitation sector in Afghanistan are physiotherapists, prosthetic and orthotics technicians, psychosocial counsellors, community health workers and community based rehabilitation (CBR) workers. This section covers the training available in the country, the number of students already trained, as well as those currently trained and who will be trained in the next years. Ideally, there are other professional groups that should be involved in physical rehabilitation, such as physical medicine and rehabilitation doctors, occupational therapists and speech therapists. In Afghanistan though, these professional groups are yet to be developed.

4.1. Physiotherapists

In Afghanistan, there is no professional registration of physiotherapists at national level yet.

According to the National Professional Association called Afghan Association of Physiotherapy (AAPT), 630 physiotherapists have been trained in Afghanistan till the end of 2017, mostly in Kabul, but it is difficult to follow their career path. AAPT estimates that 10% of them have emigrated. Indeed, retention of these professionals is difficult due to low wages: 7000 Afghanis per month (100 USD) in MoPH government hospitals.

The first physiotherapy training in the country was set-up in partnership with MoPH in 1984 by support of the International Assistance Mission (IAM). In this period of time, this was 2yr training. The Physical Therapy Institute (PTI) is now a department in the Ghazanfar Institute of Health Science (GIHS) and has operated a 3yr Diploma course since 2008. Several other physiotherapy trainings have been organized by NGOs or private institutes, delivering a two- then 3yr Diploma. Some short physiotherapy training courses have been also organized by NGOs, delivering a physiotherapy assistant certificate (PTA).

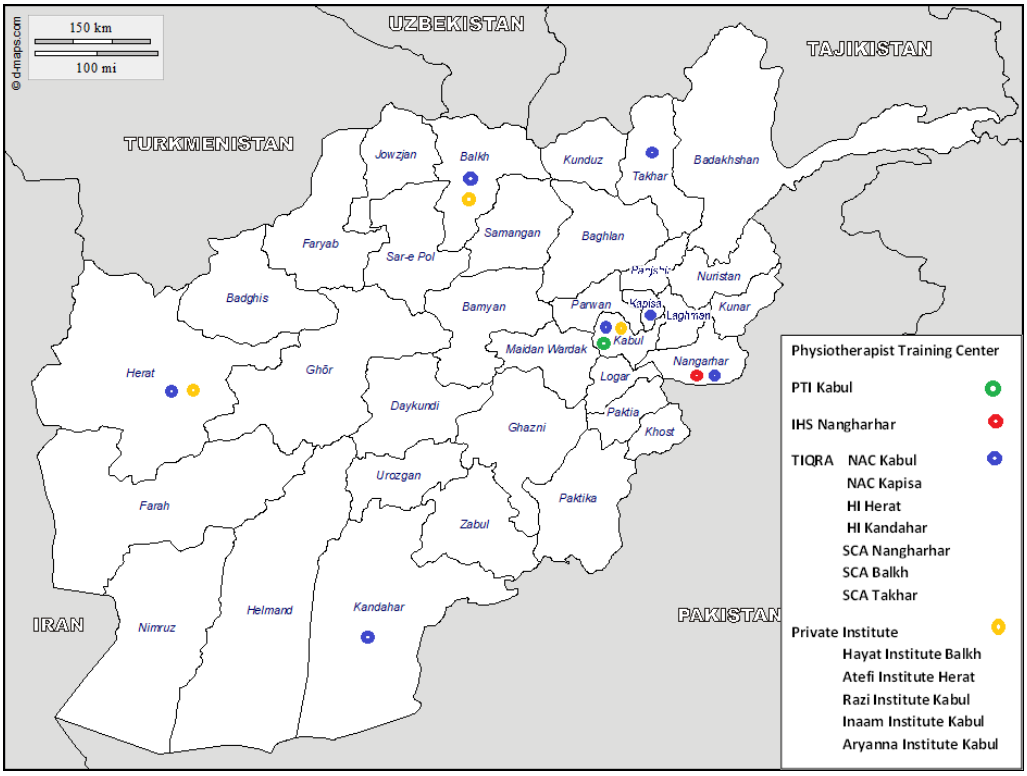
Several upgrading courses have been organized: the first one upgraded 17 physiotherapists in 2008, the second one upgraded 105 physiotherapists in 2011 and the third upgrading course allowed 32 physiotherapists to be upgraded from 2yr Diploma to 3yr Diploma in 2016. A total of 154 physiotherapists have been upgraded in the past. In March 2018, AAPT started another upgrading course for 35 physiotherapists supported financially by INGOs.

The national physiotherapy curriculum was revised in 2015.

Currently, there are 14 physiotherapy training centers in 7 provinces which are Kabul, Kapisa, Balkh, Takhar, Nangarhar, Kandahar, and Herat:

- 1 Physical Therapy Institute of Kabul (PTI/GIHS) graduates 20 students each year
- 1 Institute of Health Sciences Nangarhar offering physiotherapy training, for males, but it is not consistently admitting students.
- 5 private institutes

Additionally, under the scope of the TIQRA project "Towards Improvement of Quality Rehabilitation in Afghanistan", funded by EU, a consortium led by Handicap International with SCA and NAC runs 7 PT training centers. The objectives are to train professionals in the rehabilitation sector, male and female, across the country in various provinces and from different districts in order to improve the quality and the access to rehabilitation services to the Afghan population, including more women and girls, through the employment of skilled human resources in those underserved areas.



Map 1: Mapping of the Physiotherapy training centers in Afghanistan in 2018

According to the data collected from HI, NAC, SCA, Ghazi private institute and AAPT presented in the tables below:

567 physiotherapists (including 250 from private institute) will be have graduated between 2016 and 2020.

It is planned that the 237 physiotherapy students enrolled in the TIQRA project will graduate in 2019, 127 are males and 110 are females. The gender details of the other training centers could not be verified during the time of the survey.

Physiotherapy gradueted in 2016	Number
Physiotherapists already graduated in 2016 Atefi Institute HERAT	18
Physiotherapist already graduated in 2016 Razi Institute KABUL	39
Physiotherapist already graduated in 2016 PTI Kabul KABUL	20
	77

Table 3: Number of PT graduated in 2016 by training center in Afghanistan. Annex 3.1

In 2nd year TIQRA Project SCA NANGARHAR	31			31	
In 2nd year TIQRA Project SCA BALKH	39			39	
In 2nd year TIQRA Project SCA TAKHAR	28			28	
In 2nd year TIQRA Project HI HERAT	40			40	
In 2nd year TIQRA Project HI KANDAHAR	35			35	
In 2nd year TIQRA Project NAC KAPISA	27			27	
In 2nd year TIQRA Project NAC KABUL	37			37	
In 2nd year Aryana Shifa Institute KABUL	17		17		
In 2nd year Atefi Institute HERAT	21		21		
In 2nd year PTI KABUL	20		20		
In 3rd year Razi Institute KABUL	26		26		
In 3rd year Atefi Institute HERAT	20	20			
In 3rd year Inaam Institute KABUL	12	12			
In 3rd year IHS Jalalabad NANGARHAR	30	30			
In 3rd year PTI KABUL	20	20			
Total		**82**	**84**	**286**	**38**
		490			
Subtotal of graduate from private schools	125	32	64	29	
	157		93		
Graduates in 2018 to 2020	408				
Graduates without private 2018 to 2020	315				

Table 4: Number of PT graduates in 2017 and who will graduate in the 3 coming years from various training center in Afghanistan.

	Male	Female	TOTAL
SCA Nangarhar	13	18	31
SCA Balkh	21	18	39
SCA Takhar	14	14	28
HI Kandahar	20	20	40
HI Heart	18	17	35
NAC Kapisa	16	11	27
NAC Kabul	25	12	37
TIQRA students	**127**	**110**	**237**

Table 5: Number of students to be graduated in 2019 - TIQRA training centers.

4.2. Prosthetic and Orthotic[1]

In Afghanistan, there is no professional registration at the national level.

According to the Afghanistan National Society for Orthotics and Prosthetics (ANSOP), Kabul Orthopedic Organization (KOO) and ICRC, 144 P&O technicians or assistants have been trained in the past. Some others have been trained on the job by a few organizations before the creation of the first P&O training centers.

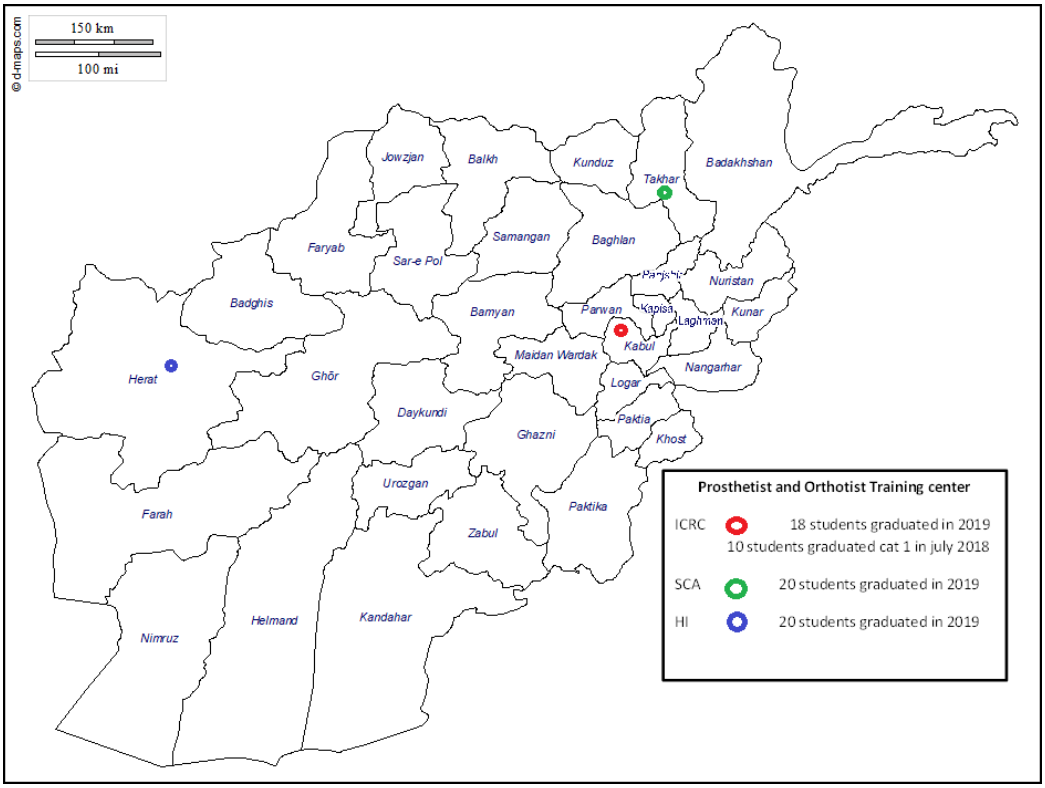
The Afghan National Diploma in Prosthetics and Orthotics (ADPO) Category 2 opened in April 2008. This is a 3yr Diploma, run by ICRC, recognized by the International Society for Orthotic and Prosthetic (ISPO). Before the ADPO, from 2003 to 2008, ICRC ran several upgrading courses, endorsed by MOPH-GIHS, and Kabul Orthopedic Organization (KOO) ran some short courses in Kabul city.

Currently, 3 Prosthetic and Orthotic training centers in Afghanistan, in Kabul supported by ICRC. The others are in Takhar and Herat supported by consortium funded by EU, led by Handicap International with SCA and using the ADPO curriculum. The students are expected to graduate in July 2019. The objectives are to train P&O professionals in the rehabilitation sector, including women, across the country in various provinces and from different districts, to improve the quality and the access to rehabilitation services for the Afghan population (including more women and girls) through the employment of skilled human resources in these districts.

A blended learning upgrade Bachelor Degree for P&O is currently running with the support of ICRC and Human Study, a German based Non-Profit Organization.

- 58 students will have graduated Category 2 in 2019.
- 10 students will have graduated Category 1 in July 2018.

[1] Ministry of Public Health, Guidelines on Physical Rehabilitation Services 1394-1396. Essential Package of Hospitals Services Implementers. Revised 2015. p 30-31 :
• Category. I: Prosthetist/Orthotist (Orthopedic Technologist). This category of P&Os carries out the patient assessment, device prescription and manufacture and supervises the Category.II technicians.
• Cat. II Prosthetist/Orthotist (Orthopedic Technologist) P&Os carry out the patient assessment, device prescription and manufacture and supervise the Cat. III technicians. Category. II P&Os provide all services that would be done by CAT. I P&Os.
• Category. III: The Afghan Cat. III is a P&O who attended on the job training and short trainings only. They have long experience and because of the limited number of Cat... II P&Os in the country, they are often called to carry out the work of A Cat. II P&O (and even Category I). They do not have P&O Diplomas. Unlike the ISPO Categorization, they do work directly with the patients but under strict supervision of Cat... II qualified P&Os.
• Bench Workers or Technical Assistants: staffs assisting the Cat. II P&Os in the manufacture of the devices or manufacture other mobility devices. They do not perform any direct work with the patients. They are equivalent to the Cat. III of ISPO.
Nowadays, the international nomenclature had changed, ISPO and WHO distinguish only clinicians and non-clinicians.



Map 2: Mapping of the Prosthetic and Orthotic training centers in Afghanistan in 2018

	Number		Total
	Male	Female	
Number of Prosthetic and Orthotic Technicians already graduated with Category 2 Certificate by ICRC	26	13	39
Number of Prosthetics and Orthotics Technicians already graduated Category 2 by KOO in 2016	12	5	17
Total CATEGORY 2	**38**	**18**	**56**
Number of graduates with MOPH Diploma 14th class through the 1yr upgrading course by ICRC	60	11	71
Total 14th grade	**60**	**11**	**71**
Number of Technician Assistant trained for 2 years by KOO, graduated in 2010	6	0	6
Number of Technician Assistants trained 1.5 years by KOO, graduated in 2014	3	2	5
Number of Technician Assistant trained 1 year by KOO, graduated in 2005	0	6	6
Total Tech assistant	**9**	**8**	**17**
Total Prosthetic and Orthotic Technicians or Assistants trained in the past	**107**	**37**	**144**

Table 6: Number of P&O graduates from various training centres in the past.

	Number		Total	Year of graduation
	Male	Female		
Prosthetic and Orthotic Technicians who will graduate with Category 1 qualification	8	2	10	2018
P&O Category 1 are already existing in country	4		4	
Total CATEGORY 1	**12**	**2**	**14**	2018
Prosthetic and Orthotic students in 2nd year HI/SCA	23	17	40	2019
Prosthetic and Orthotic students in 2nd year ICRC	10	8	18	2019
Total CATEGORY 2	**33**	**25**	**58**	2019
Total Prosthetic and Orthotic technicians who will be trained in the 2 coming years	**45**	**27**	**72**	

Table 7: Prosthetic and Orthotic technicians CAT.1 and CAT.2 who will graduate by 2020

4.3. Other professionals involved in Physical Rehabilitation Sector

4.3.1. Mental health and psychosocial (MHPSS) professionals

MoPH has a department for Mental Health. The 5 centers run by MoPH in Kabul, Herat, Kunduz, Nangarhar, and Balkh in Afghanistan propose a 3yr course for doctors to become psychiatrists. This course started in 2003. Each center has one batch of 6 to 10 trainees. These professionals can either work in the national health system, private sectors or NGOs.

There are two universities which provide General Psychology and Counseling Psychology Bachelor programs in Kabul under Ministry of Higher Education; Kabul Education University and Kabul University.

i. Kabul Education University

- General psychology curriculum was set-up in 2010 and **graduates 45 to 50 psychologists annually.**
- Counselling Psychology was started in 2014 and graduated a first batch of **45 counselors in 2018**.

In Kabul University;

- General Psychology has been established in 1964. **38 students graduated in 2017**.
- Counselling Psychology has been established in 2012. **35 students graduated in 2016 and 38 students in 2017**. Graduated students work: in addiction treatment hospitals; as teachers in primary schools; as a psychologist in mental health hospitals. **Most of them are working in positions which are not relevant to their training as psychologists.**

ii. Kabul University

A **social work department** at Kabul University had about 40 graduates in 2018.

Under Ministry of Higher Education, Mazar-e-Sharif and Bamyan Universities have general Psychology Bachelors. Herat University has both General Psychology and Counseling Psychology Bachelor's Degree training.

iii. Other stakeholders

IPSO (International Psychosocial Organization) in Kabul organizes a number of trainings:

- A 1yr psychosocial training, including 3 month intensive in class and 9 month of practical work. Since 2007, **700 psychosocial counselors** have been trained.
- A 2-week course on basic counselling for midwives and nurses working in primary health care. So far **800 midwives** have been trained.
- A 2-weeks course on Gender Based Violence (GBV)-PSC for Family protection centers (FPC) and so far 500 midlevel and doctors have been following the course implemented by NGOs in Kabul and provinces.

Some NGOs propose an emergency counseling package, consisting of 3-day training for mid-level health workers. So far, staff from 15 emergency-prone provinces have been trained (no precise figure available).

The government and some NGOs also provide Psychological First Aid (PFA) training since 2017. So far hundreds of community gatekeepers have been trained in 15 provinces at risk of emergencies. Premiere Urgency - Aide Medical International (PU-AMI) is doing internal and external capacity building for the staff in the Field in PFA.

Regarding the services, other organizations are currently working in the psychological sector:

- Health Net TPO Afghanistan
- PARSA
- Tabish
- UNICEF
- WAR CHILD United Kingdom
- Medica Afghanistan
- HI

The **MHPSS working group** is currently working on a mapping of the MHPSS services delivered from the different NGOs in Afghanistan.

4.3.2. Community Health Workers (CHW).

The CHWs are the first level of health workers within the Health Care System. They are part of the BPHS policies. CHWs promote a healthy community through healthy behaviors and environment. They are responsible for treating patients with minor illnesses and mental health issues, raising awareness on disability and mental health, identifying persons with disabilities and mental conditions. They also refer patients to the Health facilities when needed.

CHW candidates are identified by the community and go through a six months training provided by MoPH or BPHS implementers, on the basis of a national curriculum. Disability and rehabilitation is not included in the training manual, but DRP has conducted some training at provincial level.

The CHWs should be regularly supervised by the Community Health Supervisor (CHS) from the nearest Health facility.

4.3.3. Community Based Rehabilitation (CBR)

CBR was introduced in the 1970s in Afghanistan as a strategy to prevent disabilities and transfer knowledge and skills about disability and rehabilitation to persons with disabilities, their caregivers and within the communities.

CBR thus focuses on persons with disabilities and is articulated around the involvement and combined effort of different groups of actors: families, communities, DPOs and health and social services provided by governmental or non-governmental actors. The objective to "*promote the rights of persons with disabilities to live as equal citizens within the community, to enjoy health and wellbeing, to participate fully in educational, social, cultural, religious, economic and political activities*" (ILO, UNESCO and WHO, 2004).

International NGOs such as SCA, HI, SERVE Afghanistan, national NGOs, and the cooperation of the United Nations have been active in the country. Some of them have used the WHO CBR guidelines to deliver the trainings.

According to the report of the 5th South Asian Regional Community Based Rehabilitation Conference held in 2010, CBR programs were active in more than 90 districts in 19 provinces through the efforts of national and international NGOs in Afghanistan. The report pointed out that more than **500 professional** received training in this field.

At present, SCA is among the more active in CBR field, with around 200 CBR staff trained including CBR workers, supervisor and trainers among **50 districts in 12 provinces**. The national CBR network created in 2006 is not active anymore whereas the South Asia CBR network is active and Afghanistan joined in 2006.

4.3.4. Medical doctors specialized in physical rehabilitation or physiatrist

In Afghanistan there is no specific specialization in physical medicine and rehabilitation.

Handicap International is currently advocating towards the Ministry of High Education (MoHE) to include a rehabilitation module in the medical curriculum, including a clinical placement for the students within the national PRCs. Normally paramedical profession consisting of Physiotherapists, Prosthetic and Orthotic Technicians, Occupational Therapist and Speech Therapist work as part of a multidisciplinary team under the leadership of a rehabilitation doctor.

4.3.5. Occupational therapist, speech therapist

There is no official training for occupational therapy or speech therapy in Afghanistan. The physiotherapists have some short sessions on these topics during their studies, to be able to provide some advices and interventions.

4.3.6. Orthoptist

There is no initial training for orthoptist in the country.

CHWs do not have disability and rehabilitation included into their training manual. DRP has conducted some trainings in some provinces. These topics should be included into their training as they are responsible for identification, awareness and referral of persons with disabilities.

Regarding the CBRWs, a recognized training curriculum should be developed using the WHO CBR guidelines.

14 physiotherapy training centers and 3 prosthetic and orthotic training centers are present in the country, which represent a consistent increase compared with the 2013 mapping where only 1 training center for physiotherapy and 1 for prosthetic and orthotic technicians were recorded[1].

The Mental Health sector is growing with some university trainings and shorter ones, but psychologists need to be hired in PRCs, so that people experiencing post-traumatic stress can have access to psychotherapy sessions to cope with their stress and improve their quality of life.

In addition, trainings are still missing for some rehabilitation professions as physiatrist, occupational therapist, speech therapist and orthoptist. These professions are needed to provide comprehensive rehabilitation services for the Afghan population.

[1] Important to note 7 of these PT training centres are operated by a consortium of NGOs and there is no clarity about their sustainability since they are currently on a project bases, relying in donor funds.

5. REHABILITATION CAPACITY ASSESSMENT: SERVICE PROVISION

5.1. Physical Rehabilitation at primary health care level

CHWs are responsible for awareness raising on disability, identification of persons with disabilities and referral to Health facilities, but they are not trained on these topics. The number of CHWs and their activities are requested by HMIS but the data does not show figure in the HMIS Health facility (Health facilities) profile update or HMIS report.

CBR activities are implemented in **12 out of 34 provinces by SCA (see below),** with around 200 trained CBR staff including CBR workers, supervisor and trainers among **50 districts.** The scope and coverage of other CBR activities was not well documented. There is no clear coordination mechanism, centralized monitoring and evaluation among Government and non-government actors.

A few stakeholders are providing outreach activities as **physiotherapy, plus or minus prosthetic and orthotic services through mobile teams**

Organization	Activities	Provinces of work
SCA	Community based Physiotherapy services projects through home base therapy Patients requiring Prosthetic or Orthotic services are referred to the relevant Physical Rehabilitation Centers Provision of assistive devices	12 provinces: Nangrahar, Kunar, Laghman, Ghazni , Wardak, Baghlan, Kunduz, Taloqan, Badakshan, Balkh, Samangan, Jawzjan
HI	Physiotherapy and psychosocial services through Mobile Team interventions Provision of assistive devices and NFI kits Referral to provincial / regional structures for complex cases	2 provinces: Kunduz, Kandahar (temporary project)
DAO	Community-based rehabilitation services through mobile teams	3 provinces: Urozgan, Zabul Daykundi
AABRAR	Community-based rehabilitation services through mobile teams	4 provinces: Khost, Ghazni, Paktia,Paktika
KOO	Community-based rehabilitation services through mobile teams	Parwan, Panjshir, Kapisa

Table 8: Organizations providing community-based rehabilitation services

In total, **physiotherapy services are available in 22 provinces out of 34**. However, all districts are not necessarily covered and the level of service is also hampered by the financial capacities of the stakeholders and the security issues. The basic physical rehabilitation is seldom available at community level and the most of people have to travel to the nearest District or Provincial Hospitals to access physiotherapy.

At primary health care level, CHWs are responsible for awareness raising on disability, identification of persons with disabilities and referral to Health facilities, but some of them did not receive a training to enable them to fulfill these tasks.

CBR activities are implemented in 50 districts out of 409 districts by SCA (SCA CBR program was only in 12 provinces), but the scope and coverage of other CBR activities in the country were not documented well. In the mapping 2013, CBR activities were said to be implemented in 16 out of 34 provinces, in 80 out of 364 districts. There is no clear coordination mechanism, centralized monitoring and evaluation among Government and Non-Government Actors.

Physiotherapy at CHC level for assessment of physical needs and advice through outreach visits from DHs is subject to staff availability. According to the BPHS policy, so this is probably very rare due to the shortage of physiotherapists at the DH level as it will be explained after.

Physiotherapy services are available in 22 out of 34 provinces (21 in the mapping 2013), without detail on the number of districts covered, through fluctuating home-based rehabilitation services and mobile team, provided by a few number of organizations.

5.2. Physical therapy at secondary and tertiary health care level

5.2.1. Health facilities in Afghanistan

According to the Health Management Information System, there is a total of 14,806 Health posts and 2,792 Health facilities around the country[1] :

- 749 Sub Health centers
- 878 BHCs
- 170 mobile teams
- 419 CHCs
- 86 DHs
- 28 PHs
- 8 RHs
- 30 SHs
- 429 others[2]

[1] Health facilities Profile update - 3rd quarter of 2017
[2] See detailed list in annexes

Type of Health facility (HF)	Number of Active Health facilities	Expected number of Health facilities in the country	Gaps in Health facilities countrywide
District Hospital (DH)	86	15	15
Provincial Hospital (PH)	28	6	6
Regional Hospital (RH)	8	Not defined	NA
Total	**122**	**21**	**21**

Table 9: Gaps in Health facilities in Afghanistan

15 DHs (out of 407 districts) and 6 PHs (out of 34 provinces) are expected to be established in the country, which represent a considerable gap for the population to access health services including physiotherapy.

5.3. Physiotherapy Units

The figures hereunder were shared by the MoPH.

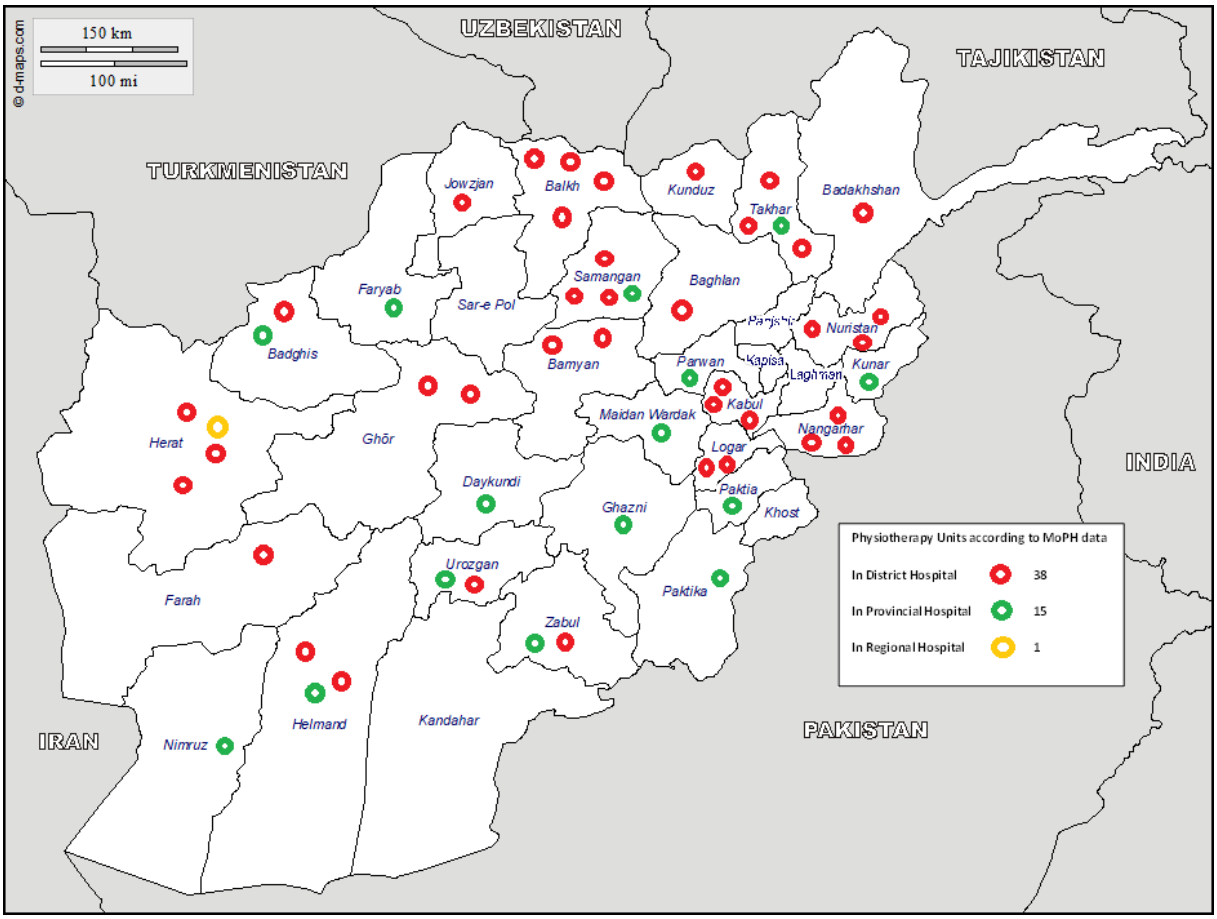
5.3.1. Facilities

According to the data shared by DRP and GCMU, 57 physiotherapy units are functional in the country:

Type of Health facility	Number of Health facilities with PT services	Number of Health facilities with No PT services	Expected number of PT units in Health facilities in the country
District Hospitals	38	48	15
Provincial Hospitals	15	13	6
Regional Hospitals	4	4	NA
Total	**57**	**55**	**21**

Table 10: Number of active and non active4 PT units in Afghanistan's Health facilities

Knowing that the country has 407 districts and 34 provinces, the physiotherapy unit gap is quite important in DHs and PHs.



Map 3: Location of the operational Physiotherapy units

5.3.2. Physiotherapists

The following section will present figures considering two types of situation: active and inactive (non-functioning) Health facilities. Due to many factors such as economy, lack of human resources, security etc, the Health facilities forecasted in the health policies and strategic plans are not all functional. For this reason, the analysis will be divided in two parts, the compilation of the figures being done at the end.

According to the BPHS and EPHS policies and guidelines, every Health facility must be staffed with the following numbers of rehabilitations practitioners:

- 2 PTs in District Hospitals
- 4 PTs in Provincial Hospitals
- 8 PTs in Regional Hospitals

i. Functional Health facilities

There are currently **57 active Health facilities** (38 DHs, 15 PHs and 4 RHs), where a total number of **87 practitioners** provide rehabilitation services:

Number of functional DHs, PHs, RHs in the country, out of this 65 48 DHs, 13 PHs and 4 RHs do not have active PT unit (number of units which should provide PT services in the country).	122
Number of PT positions in the 57 functional DHs, PHs, RHs in the country (2 per DH, 4 per PH, 8 per RH)	168
Number of personnel delivering PT services in the 57 functional units (DH,PH and RH) are 87, and only 31 are professional PTs. The remaining 56 are not trained PT professionals.	87
Number of vacant PT positions in the operational Health facilities in the country	**81**

Table 11: Number of vacant PT positions in the operational Health facilities

137 PT positions are vacant in the operational Health facilities which highlights some of the barriers faced by the Afghan population to access physiotherapy services during hospitalization or as outpatient.

Moreover, as noted above, about 50 % of the persons charged with delivering PT services have not undergone proper training. Only 31 persons with a Diploma of Physiotherapy are currently hired and 13 physiotherapist assistants are working in the physiotherapy services of the country.

Number of PT units in operational 38 DHs, 15 PHs and 4 RHs in the country	168
Number of filled PT positions in active DHs, PHs, RHs in the country by non PT professional	56
Number of persons with a recognized Diploma of Physiotherapy	31
Number of PTs with a Diploma needed in active Health facilities	**137**

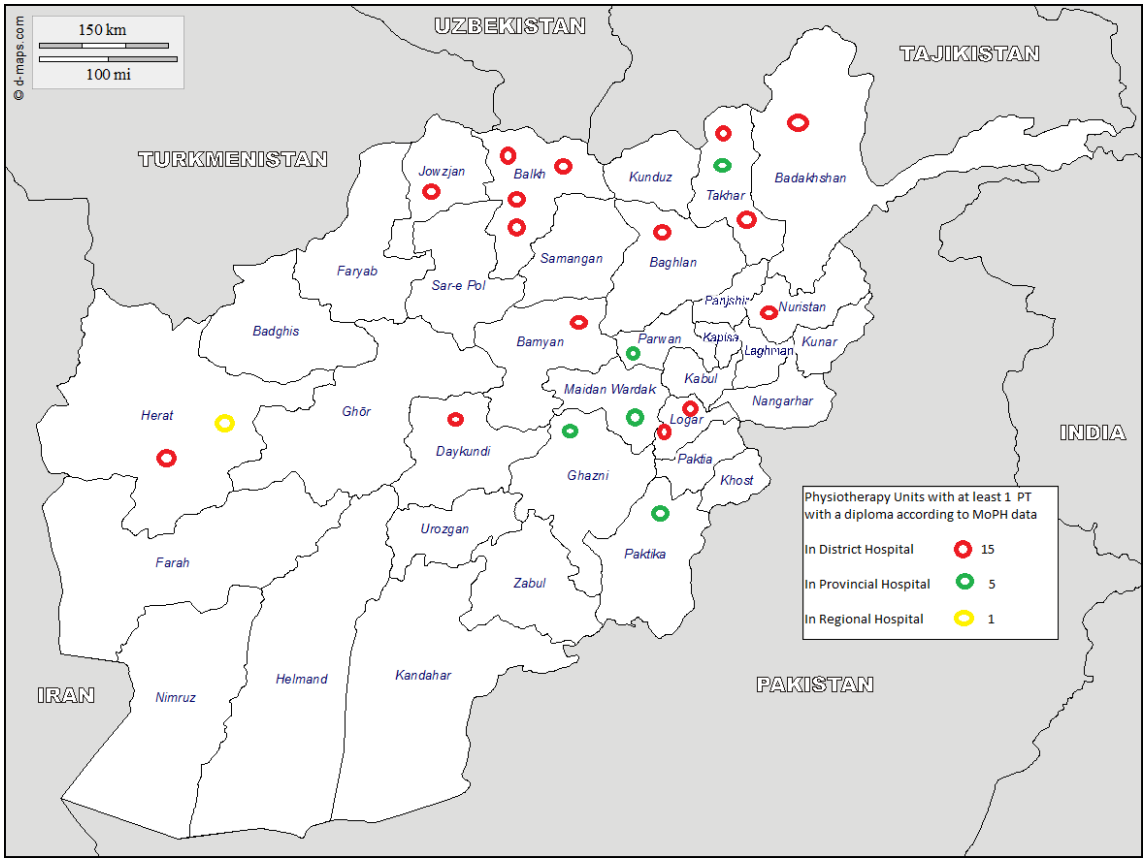
Table 12: number of practitioners with a PT degree needed in the operational Health facilities

Furthermore, most of these 87 practitioners (professional and nonprofessionals) are men (71%), making access for to rehabilitation services women and girls more difficult due to cultural barriers.

	TOTAL	Male	% Male	Female	% Female
Number of persons delivering PT services	**87**	62	71%	25	29%

Table 13: Physical rehabilitation practitioners - Gender breakdown

31 physiotherapists with a 2 or 3 year Diploma currently work in the active Health facilities, which shows a big shortfall in staffing in the Health facilities. The map below show the location of PT units with at least 1 graduated PT.



Map 4: Location of PT units with at least one graduated PT

The map clearly shows the gap in PT staffing at national level in operational Health facilities. The exact number of PTs needed in operational Health facilities is shown in the table below.

	Male	% Male	Female	% Female	Total
Total number of graduated PT positions	158	50.1%	157	49.9%	**315**
Total number of PTs already working in HF	20	65	11	35	**31**
Total Number of PT positions needed in active HF	69	50.1%	68	49.9%	**137**
Total number of PTs needed for HF without active PT unit and expected PT units to be established	218	50%	218	50%	**234**
Number of PTs with a Diploma needed in the Health facilities	154	48.5%	163	51.5%	**371**

Table 14: number of graduated PTs needed in operational Health facilities - gender breakdown

Furthermore, 65% of the professional practitioners delivering physiotherapy services are men, which also represent an issue for women and girls to access quality physiotherapy services.

ii. Non-operational Health facilities

The analysis of the needed PT practitioners can also be refined with the number of vacant PT positions in non-operational Health facilities[1]. As a reminder, according to BPHS / EPHS policies, every DH and PH should be staffed with respectively 2 (1 woman, 1 man) and 4 (2 women, 2 men) physiotherapists.

DHs expected to be established in coming 2019 to 2021	15
Number of vacant PT positions in non-operational DHs (1 man, 1 woman)	30
PHs expected to be established in 2019 to 2021	6
Number of vacant PT positions in non-operational PHs (2 men, 2 women)	24
TOTAL	**54**

Table 15: number of vacant PT positions in the non-operational DHs and PHs

54 PT positions can thus be considered as vacant in expected Health facilities of the country according to the BPHS, EPHS policies.

iii. Total in all operational and non-operational Health facilities

	Male	% Male	Female	% Female	Total
Number of vacant PT positions in the operational Health facilities	154	48.5	163	51.5	**137**
Number of vacant PT positions in the non-operational Health facilities	27	50	27	50	**234**
TOTAL	**181**	**48.7**	**190**	**51.3**	**371**

Table 16: Number of needed PT practitioners regarding the gaps in operational and non-operational HF

When considering both operational and non-operational HF countrywide, there are totally **371 vacant PT positions countrywide.** This shows a significant gap in human resources in the country.

Key facts and figures

At the secondary and tertiary health care levels, only 54 PT units are active in operational Health facilities.

At DH level, there are 38 PT units. It shows a decrease compared with the 2013 mapping, where 44 units were listed.

65% of the persons delivering PT services do not have a PT Diploma

Only 21 PT[2] units have at least one PT with a proper Diploma.

65% the professionals delivering physiotherapy services are male, which represent a barrier for women to access physiotherapy services.

48 DHs and 13 PHs don't have functional PT services and 15 DHs and 6 PHs are expected to be established in the country.

[1] These are Health facilities which are expected to be established from 2019-2021
[2] From PT database provided by DRP

In total, there is a HR gap of 371 physiotherapists in the country in the active and non-functional DHs, PHs and RHs in the country.

5.4. Physical Rehabilitation Centers in Afghanistan

5.4.1. Facilities

There are **23 Physical Rehabilitation Centers** (PRCs) identified countrywide in **16 of the 34 provinces**. All of them include physiotherapy and prosthetic and orthotic services according to the data provided by the 8 PRC implementers[1]. Of these 2 PRCs managed by the MoPH are in Kabul and Khost, but there was no data available on the number of human resources during the time of the survey. ECHO has generously supported Kandahar PRC financially through HI since March 2015, with co-funding from AFD and Swiss-Solidarity during 2015-2017. Kandahar PRC is currently under an integration process into the MoPH structure, in a jointly defined 5 year plan up to end of 2021.

The establishment of Physical Rehabilitation Centres is hampered by the large financial investment needed to establish and supply equipment and raw materials to operate a prosthetic and orthotic workshop, as well as a shortage of trained technical staff. However, 4 key provinces have been identified to establish rehabilitation facilities: Bamyan, Farah, Ghor and Baghlan/Samangan. The prioritization was based on population cluster, under coverage of service and strategic location. These 4 PRCs are mentioned in the physical rehabilitation guidelines for EPHS (these were developed under the leadership of DRP and the National Disability Task Force for rehabilitation) to facilitate access.

According to the EPHS Guidelines for Physical rehabilitation services, there should be:

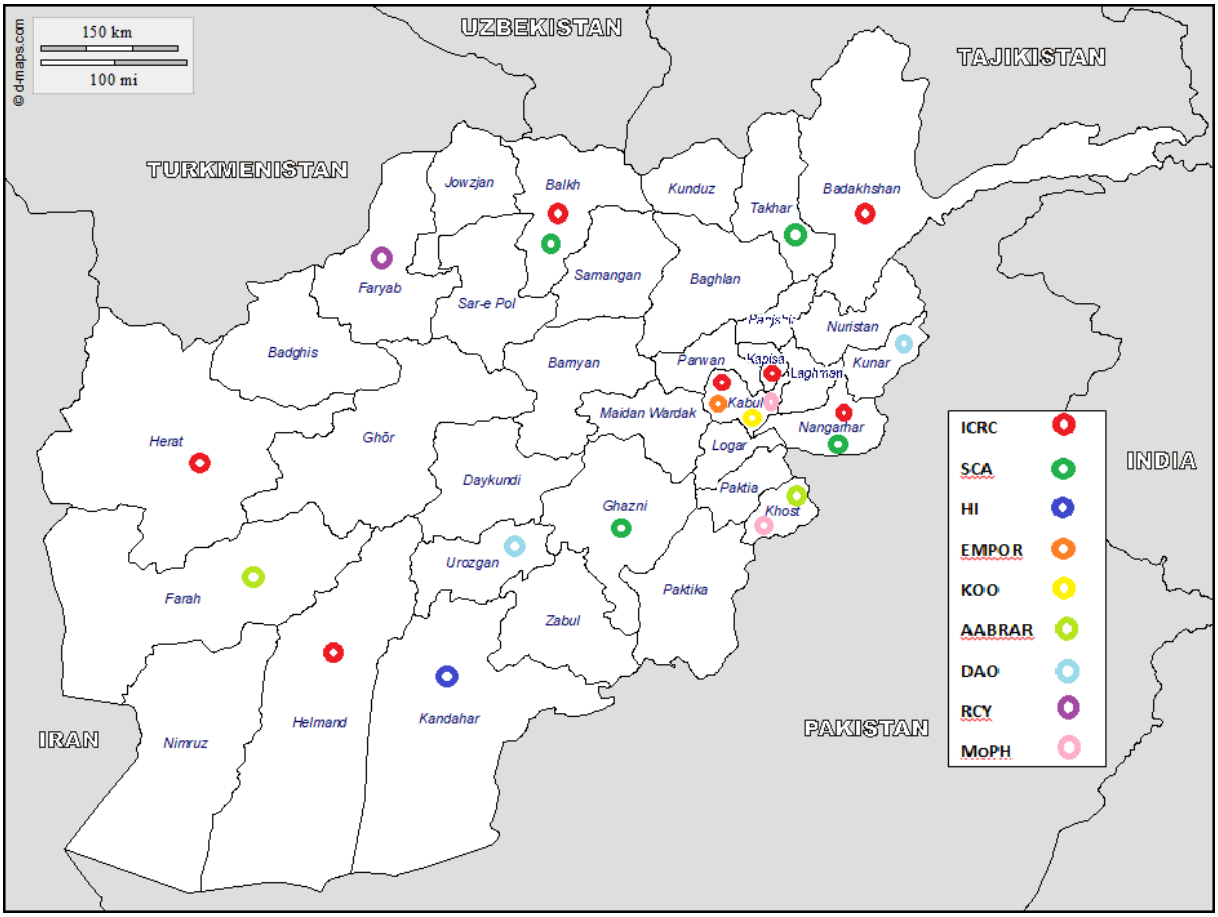
- 1 national PRC, currently run by ICRC in Kabul
- 1 Regional PRCs linked to each regional hospital
- 1 Provincial PRC linked to each Provincial Hospital

At Regional level	Number of operational RHs	8
	Number of operational RHs with a PRC	4
	Number of regional PRCs to be established	**0**
At Provincial level	Number of operational PHs	28
	Number of operational PHs with a PRC	20
	Number of provincial PRCs to be established in operational PH (figure from strategic plan of DRP)	**3**
TOTAL Current functional PRC		**23**

Table 17: Gap in PRC facilities linked to operational regional and provincial hospitals

3 PRCs shall then be established at regional and provincial level, according to the EPHS guidelines.

[1] ICRC, SCA, EMPOR, KOO, AABRAR, DAO, RCY and HI – December 2017



Map 5: Location of the 21 PRC countrywide

As for the number of vacant PT positions, the number of non-operational Provincial Hospitals, which should also include a PRC, has also to be taken into account to get a clear picture of the number of PRCs needed:

Provincial Hospitals	Number of non-operational PH	6
	TOTAL	**6**

Table 18: number of non-established PRCs which should be linked to operational and non-operational Health facilities

Key facts

The number of PRCs to be established in operational Health facilities is 3.

The total number of PRCs after establishment of 3 new PRCs in the country will be 26 PRC by 2021.

5.4.2. Physiotherapists

Note: the following figure excludes the MoPH PRC of Kabul and Kandahar, due to data unavailability.

Regarding the human resources for physical rehabilitation in the PRCs, the figures are a more positive than the other aforementioned Health facilities (DH, PH and RH). There are currently **189 physiotherapy practitioners** in all the PRCs. The table below shows the breakdown per type of Diploma and gender:

	Number of men	% of men	Number of women	% of women	Total number
Number of practitioners with 2- or 3yr Diploma	107	61.5%	67	38.5%	174
Number of practitioners with 1yr Diploma	0	0%	7	100%	7
Number of practitioners without Diploma	3	37.5%	5	62.5%	8
TOTAL	**110**	**58%**	**79**	**42%**	**189**

Table 19: Number of practitioners in the PRCs (excluding MoPH PRCs) - breakdown per diploma and gender

Most of the personnel delivering physiotherapy services in the PRCs in country have a Diploma and there is greater gender balance than in other Health facilities. The fact that PRCs are located in major cities, where it is less sensitive for women to work, might be an explanation. It is a factor which facilitates the access to rehabilitation services for women and girls.

According to EPHS guideline, every RH (17 practitioners) and PH (7 practitioners) should also include one PRC within its facility. To better analyze the number of vacant PT positions, the number of positions in the non-operational PRCs shall also be taken into account. The table below shows the details of the vacant PT positions in non-operational Health facilities.

At Provincial level	Number of expected PRCs to be established	3
	Number of vacant PT positions in non-operational provincial PRCs	**21**
TOTAL		**21**

Table 20: Total number of vacant positions in operational HF with non-operational PRCs

Number of needed Physiotherapists in PRCs

PRCs	Available PT in PRCs	Total PTs who should be employed in operational PRCS	Total PT shortfall
PRCs (20 supported by I / NGOs) **PTs (1 N PRC, 4 R PRC, 14 P PRC)**	183	199	16
PTs needed in 3 PRC which are planned to be established in coming in coming 3 years		21	21
Kabul Rehabilitation Hospital + National Disability Institute and Khost Orthopedic (Category III)	6	40	34
Sub Total of PT in RPC	**189**	**260**	**71**

71 PT practitioners will be thus be needed in the operational and expected PRCs to be established PRCs as recommended in the EPHS guidelines.

As a consequence, the total number of vacant PT positions in PRCs is presented in the table below.

Country level	Number of vacant PT positions in functional and PRCs which are expected to be established	71
TOTAL		**71**

Table 21: Total number of vacant PT positions in PRCs countrywide

5.4.3. Prosthetic and orthotic (P&O) technicians

According to BPHS/EPHS standards, the number of P&O practitioners in each PRC should be different regarding the type of facility. The table below shows the number of P&Os needed depending on the type of facility.

Category of P&O worker needed in each PRC	Provincial level	Regional level
Category I	2	6
Category II	4	10
Category III	3	8
Technicians / Assistants	2	3
TOTAL	**11**	**27**

Table 23: Total number of vacant P&O positions in each PRC according to EPHS guideline

At the time of the survey, 82 P&O Category I and II, with a large majority of men (83%). The breakdown is available in the table below.

As for the PT section, the figure below only take into account the 20 PRCs supported by I/NGOs.

	Number of men	% of men	Number of women	% of women	Total number
Number of P&Os CAT I	1	100	0	0	**1**
Number of P&Os CAT II	67	82.7	15	17.3	**82**
Number of P&Os CAT III and number of P&Os with on-the job training	43	63%	25	37%	**68**
TOTAL	**111**	**74%**	**40**	**26%**	**151**

Table 24: Total PO practitioners in 19 PRCs of the country.

Only P&Os Category II as clinicians can have physical contact with the patients. The fact that 83% of P&Os Category II are mostly men is a main barrier for the women and girls to access P&O services.

Type of rehabilitation facilities	Number of available P&O professionals	Total Vacant P&O positions	Number of P&Os who will graduate	Gap of P&O profession

PRCs (20 supported by I / NGOs) - CAT I (1 National PRCs, 4 Regional PRCs, 15 Provincial PRCs)	0	64	10	54
Number of CAT I certified by MoHE	0		4 (Not employed in PRC)	
3 P&O Workshops (Kabul Rehabilitation Hospital + National Disability Institute and Khost Orthopedic Workshop (National PRC and 2 Provincial PRC) CAT I	0	14		14
CAT I needed in 3 PRC which are planned to be established in coming 3 yrs (Bamyan, Baghlan and Ghor)	0	6		6
Sub-total of CAT I		**84**	**4**	**70**
CAT II				
PRCs (20 supported by I / NGOs) – CAT II (1 National PRC, 4 Regional PRCs, 15 Provincial PRCs)	82	114		32
CAT II needed in 3 PRCs which are planned to be established in coming 3 years	0	12		12
CAT II to be graduated from ADPO and P&O (Consortium) and KOO unemployed by 2019			65 (7 already + 58 will graduate)	0
Subtotal CAT II	**82**	**126**	**65**	**44**
Subtotal of CAT I	**82**	**84+126=210**	**70-21=49**	**49 are needed**
PRCs (20 supported by I/NGOs) CAT III (1 National PRC, 4 Regional PRCs, 15 Provincial PRCs)	68	89	0	21
CAT III needed in 3 PRCs which are planned to be established in coming 3 years	0	9	0	9

Kabul Rehabilitation Hospital + National Disability Institute and Khost Orthopedic (CAT III)	20	18		
Subtotal CAT III and on the job training	**88**	**116**		**30**
TOTAL CAT I, CAT II and CAT III	**170**	**326**	**10 CAT I & 65 CAT II**	**144**

Table 25: Number of P&O vacant positions in operational HF with non-operational PRC

The estimated number of vacant P&O positions in the country is then 77, all categories of workers combined. The breakdown per category is presented hereunder:

P&O category	Number
CAT I vacant positions	70
CAT II vacant positions	44
CAT III vacant positions	28
Technician Assistants vacant positions	60
TOTAL	**202**

Table 22: Total number of vacant positions in operational and expected to established PRCs

In total, 137 P&O positions are needed for the PRCs which are operational and those that planned to be operational in future.

Most of the PRC practitioners delivering physiotherapy services have a formal qualification, this is not the case in the other Health facilities under the MoPH (Regional, Provincial, District hospitals). There is also a difference between the salaries of the PTs in INGO supported PRCs and the Health facilities operated by MoPH. The gender balance is also more respected in these PRCs, facilitating the access of women and girls to rehabilitation services.

No PRC has physical rehabilitation doctors, occupational therapist, speech therapist, psychologist or audiologist. Not having physical rehabilitation doctor in PRC is a serious problem because specialized doctors should assess the heath conditions of the patients entering to receive treatment, to prescribe the relevant services accordingly and ensure the follow-up with the team. This **multidisciplinary approach** is a prerequisite to guarantee the **quality of the treatment** and ensure coordinated health care pathways addressing the needs of each patient.

Physical rehabilitation doctors are also responsible to discharge the patients ensuring they have all the information they need, for example, with exercises or advices to complement the treatment.

In 2013, the ISPO and WHO guidelines on service coverage for prosthetics and orthotics suggested that Afghanistan needed at least one orthopedic workshop in each province. Four new provinces have been identified to establish orthopedic centers during a five years period in Bamyan (2014), Ghôr (2016), Farah (2018) and Baghlan/Samangan (2018). However, no PRCs has been set up up to date, despite the fact that they are still considered as priorities in EPHS guidelines.

Key facts

23 PRCs are operational in 16 provinces out of 34. This number shows an increase compared to 2013 (17 PRCs in 13 provinces).

The prosthetic and orthotic technicians Category I and II are largely men (83%), which represents a barrier for women to access quality PO services.

194 persons are currently working as social workers in 11 PRCs with a variety of training backgrounds.

According to the EPHS guidelines, there should be 3 more provincial PRCs in the country.

In these 23 PRCs operational and 3 to be built / made operational PRCs in the future, 71 Physiotherapists, 70 P&O Category I, 44 Category II, 28 Category III and 60 Technician Assistants will be needed.

5.4.4. Other physical rehabilitation services in Afghanistan

Some **private physiotherapy clinics and prosthetic and orthotic services** exist in the country, but they could not be investigated during the time of the survey.

The MoPH manages the **Rehabilitation Hospital** in Kabul. According to Dr Siddiqi, the Health Director of this structure, 1 PT (2yr Diploma), 2 PTs (1yr Certificate) and 17 Prosthetic and Orthotic Technicians trained on-the-job currently work in this facility.

Due to ongoing construction work, physiotherapy services are provided but the P&O services are restricted. According to the National Strategic Plan for Disability Prevention and Physical Rehabilitation 2017-2020, MoPH is planning to upgrade this facility to a national referral center for physical rehabilitation services.

MoLSAMD supports the **National Disability Institute** in Kabul, which provides physiotherapy, prosthetic and orthotic services. The structure employs 2 Physiotherapists (2yr Diploma) and 3 P&O Technicians who received a 4 months training in India are also working in this institute. There is a need for coordination between MoLSAMD and MoPH in order to ensure quality and efficiency of the facility. The institute additionally organizes 6 months vocational trainings. The following topics are proposed:

- Tailoring
- Production of cushions
- Learning computer
- Mobile repairing
- Electricity

Lastly, the Institute is planning to develop a research and **knowledge management department**.

The construction of a **National Disability Center** in Kabul is also under discussion. Three different donors have accepted to fund it. The purpose of this center is to propose four types of services: (i) Rehabilitation, (ii) Education / Resource Center, (iii) Income Generating Activities (IGA)/ vocational training and (iv) Shelter.

5.4.5. Final estimation of the PT and P&O human resources available in the country and needed at primary, secondary and tertiary health care levels, and highlighted with the international standards

i. Physiotherapists

Based on the data collected during the survey, the total estimated number of physiotherapy practitioners in the different rehabilitation facilities is presented below.

Type of rehabilitation facilities	Number of practitioners
Health facilities (Regional, Provincial and District hospitals)	31
PRCs (20, supported by I / NGOs)	183
Kabul Rehabilitation Hospital + National Disability Institute	6
TOTAL	**210**

Table 23: Total number of PT working in Health facilities excluding the 2 MoPH PRCs

210 PTs with 3 or 2 years Diploma are providing PT services in the country, which is underestimated because this does not take into consideration the PTs of the private sector, as well as the ones working in the 2 governmental PRCs (data not available at the time of the survey).

The total number of physiotherapists needed in the different rehabilitation facilities can also be estimated. 2 data sets have to be taken into account:

- Vacant positions in operational and non-operational DHs, PHs and RHs
- Vacant positions in non-operational provincial and regional PRCs

The future graduated professionals (in the different training centers) are also considered to mitigate the final figure:

	Total number
Number of vacant PT positions in DHs, PHs, RHs	371
Number of vacant PT positions in 20 I/NGO supported PRCs	71
TOTAL	**442**
Number of future PT graduated 2017-2020	315
Total number of vacant PT positions	**127**

Table 24: Total number of needed PT practitioners in the rehabilitation facilities in coming years

Considering that 490 physiotherapists (including 250 private graduates) would be graduated from 2017 till 2020 (with at least 110 women from the TIQRA project, no data on gender were received from the other training centers), there is still a **need of 127 physiotherapists to be trained after 2020**.

Mitigation of the final figure
This estimation does not consider the physiotherapist retirement age, as no data could be collected on this topic at MoPH level.
It neither takes into account the fact that the future graduated PT practitioners could not be willing to work in the Health facilities of the country: the low-level of salaries in MoPH Health facilities, the

geographical origin of the graduated people (not necessarily from the province where needs are the most important) are some of the factors to be considered to mitigate the figures.

There is no international standard on the ratio of PT needed per 10,000 inhabitants, because it depends on the country and the working roles and job designs of the staff within that health workforce. However, the **physiotherapy workforce data**[1] states that the ratio of PTs per 10,000 population is between 5-10 in high income countries, between 0.5-2 per 10,000 for the middle income and remains under this ratio in low and low income countries.

The estimated total population in Afghanistan is 34.66 million people (Central Statistics Office). Based on this figure and the ratio calculated by the PT workforce data, a further estimation of the PT needs in the country can be done.

	Ratio Per 10,000 inhabitants	For 34.66 millions
Number of PTs available in the country in DHs, PHs, RH, PRCs	**0.06**	210
Estimation of the total number of PTs needed in the country	0.5-2	1733-6932
Final estimation of the number of PTs lacking in the country	/	**1523-6722**

Table 25: Estimation of the number of PT needed in the country regarding the PT workforce data ratio

The current ratio of the PTs in Afghanistan is **0.06 per 10 000 inhabitants** which is a dramatically low figure, compared with the middle **income countries which is 0.5-2/10,000 inhabitants.** Taking into account the ratio for middle income countries, there should be approximately 1,523 and 6,722 PTs.

Even if the objective would not be to match this ratio of middle income countries, it highlights the fact that there is still a great need in trained physiotherapists. It also underlines the importance for the training centers to be supported in the coming years to fill the gap.

Lastly, it is a strong argument to continue the **advocacy** work for both MoPH and donors **to better address the needs of a population affected by decades of armed-clashes and conflicts**.

ii. Prosthetic and Orthotic professionals

Based on data collected during the survey, the total estimated number of PO practitioners in the different rehabilitation facilities is presented below.

Type of rehabilitation facilities	Number

[1] http://iris.wpro.who.int/bitstream/handle/10665.1/13808/9789290618331-eng.pdf?ua=1.p 29

Total of Category I and II in PRCs (20 supported by I/NGOs)	82
Kabul Rehabilitation Hospital + National Disability Institute	0
Unemployed practitioners trained by KOO	7
Category 1 employed in non PRC structure	4
CAT I upgraded through ICRC	10
Subtotal Category I and II	**103**
PRCs (20 supported by I / NGOs)	68
Kabul Rehabilitation Hospital + National Disability Institute	20
Subtotal Category III and On the job training	**88**
TOTAL	**181**

Table 26: Total estimated number of PO practitioners in Afghanistan

The figure of 181 is estimation only including civil service, as it does not take into consideration:

- The P&Os of the private sector
- The 2 governmental PRCs (data not available during the time of the survey).

The total number of prosthetic and orthotic professionals needed in the operational provincial and regional PRCs can also be estimated and linked up with the number of the future graduated professionals in the coming years.

	Total number
Number of vacant P&O Category I positions	84 (+)
Number of P&O Category I to be graduated in 2018	10 (-)
Number of PO Category I employed by non PRCs structure	4
Subtotal I	**70**
Number of vacant P&O Category II positions	44 (+)
Number of P&O Category II to be graduated in 2019	58 (-)
Number of unemployed P&Os	7 (-)
Subtotal II	**21-**
Number of vacant Category III P&Os and Technician Assistants	28
Number of future P&O Category III and Technician Assistants trained in the coming years	0 (-)
Subtotal III	**28**
TOTAL Needs in Category I,II, and III	**77**

Table 27: Total number of PO practitioners needed in operational PRCs

Considering that 10 P&O Category I were graduated in 2018 (8 men and 2 women), 58 P&O Category II will graduate in 2019 (with 33 men and 25 women from the P&O project) and the 7 P&O Category II unemployed trained by KOO, there is still a **need of 77 P&O practitioners**. As for the PT, this estimation does not consider the P&Os' retirement age.

According to the international standards for P&O[1], the ratio for P&O clinicians is between 5 and 10 per million population, and the need for P&O non clinicians (equivalent at Category III, on the job is between 10 and 20 per 1 million population. In high-income countries, the number of clinicians is usually higher at 15-20 per million inhabitants or more in some countries.

	For 34.66 millions	Ratio Per 1 million population
Number of P&Os Catergory I and II available in the country	89	**2.5**
Estimation of the total number of P&Os Category I and II needed in the country	173 - 346	5-10
Final estimation of the number of POs Category. I and II lacking in the country	**84-257**	**/**
Number of P&Os Category III and on the job trained available in the country	88	**2.5**
Estimation of the total number of P&Os Category III and technician assistants needed in the country	346 - 693	10-20
Final estimation of the number of P&Os Category III and Technician Assistants lacking in the country	**258-605**	/

Table 28: Estimation of the P&O practitioners needed according to international standards

The current ratio of P&O Category I and II (clinicians) in Afghanistan is **2.5 per million inhabitants**, and the one for P&O Category III and Technician Assistants (non-clinicians) is 2.5 per million population, putting the emphasis on the gaps.

Taking into account the standards, an estimation of the gaps trained P&Os Category I and II in the country is between 84-257 practitioners. The estimated gap in P&Os (Category III and technician assistants) is 258-605 practitioners, which is higher than the estimation done above of 178 needed Category III and Technician Assistants. Even if the objective would not be to match the international standards, this highlights the fact that there is still a considerable need of P&Os professionals in the country.

One of the main issues in this regard is the question of the employment of P&O graduates because P&O positions are not part of the EPHS policies yet, making their absorption into the health sector difficult. For instance, 7 P&O graduates who were trained by KOO in 2016 remain unemployed. The first step should be to **integrate P&O into the EPHS policies** before launching other batches of P&O students and create other PRCs.

[1] World Health Organization. (2017). Standards for Prosthetics and Orthotics. Part 2: Implementation manual. Geneva: WHO Press. p 57

Key figures
The ratio of one physiotherapist in Afghanistan is 0.06/10,000 inhabitants, which is very low compared with the middle income countries with 0.5-2/10,000 inhabitants.
71[1] PT positions are vacant in operational and non-operation PT units (DHs, PHs, RHs and PRCs) of the country.
The ratio of P&O Category I and II is 2.5 per million inhabitants, which is 50% of the lower threshold of the international standards.
The ratio of P&O Category III and on the job trained is 2.5 per million inhabitants, which is 25% of the lower threshold of the international standards.
70 P&O Category I, 44 P&O Category II and 28[2] P&O Category III and 60 Technician Assistants positions are vacant in the PRCs.

5.5. Assistive and mobility devices

The following are some examples of assistive products/devices are available on the local market:

- Manual wheelchairs
- Rollators and walking frames
- Crutches
- Adapted chairs for activities of daily living such bathing/shower/toileting needs
- Lower and upper limb prosthetics and orthotics
- Pressure relieving cushions
- Communication boards / books / cards and continence products.

Most of them are delivered free of charge by national and international organizations according to the needs. Public hospitals can provide them free of charge with a prescription and if the product is available. Some I/NGOs provide assistive devices to MoPH hospitals, for instance, HI PRC Kandahar provides crutches to Mirwais Regional Hospital on monthly basis.

Each organization uses its own quality regulations and procedures for provision of assistive devices: assessment and prescription, production, fitting/customization, training, follow-up and maintenance by skilled personnel.

The Jaipur Foot, an Indian NGO organized a distribution of free ready-made prosthetic limbs in two centers under MoLSAMD few times in the National Disability Institute and Darulaman Center. ICRC and Organizations of persons with disabilities highlighted the poor quality of these products which were just distributed **without adaptation** to individual needs.

Type of service	Total number of Devices produced in 2017	Total number of beneficiaries in 2017

[1] This figure has been calculated on the basis of the estimated needs regarding EPHS / BPHS guidelines. The number of students currently in PT training has been considered and their number deducted from the first needs estimation to reach this figure.
[2] ditto

Prosthesis	7,589	6,528
Orthosis	28,850	21,655
Technical Aids	28,121	26,631
Wheelchair / Tricycle	2,260	2,260
Subtotal - produced devices	**66,820**	**57,074**
Repaired devices	31,274	27,358
TOTAL	**98,094**	**84,432**

Table 29: produced and repaired assistive / mobility devices and beneficiaries

84,432 persons benefited from manufactured or repaired devices in 2017, which is lower than the number of products produced or repairs. The discrepancy can be explained by the fact that patients can benefit from two different items/devices. However, they are not included in the above figures that only take into account beneficiaries of PRCs.

Type of service	Number of beneficiaries / Male	Number of beneficiaries / Female	Total number of beneficiaries in 2017
Produced devices	42,620	14,454	57,074
Repaired devices	21,579	5,779	27,358
TOTAL	**64,199**	**20,233**	**84,432**

Table 30: Number of beneficiaries of assistive/mobility devices - Gender breakdown

75% of the beneficiaries provided with assistive devices are male (42,620 out of 57,074 patients). 2 main factors can explain the figure:

- A majority of war wounded persons are male, which is an element that cannot be controlled.
- 83 % of Prosthetic and Orthotic Technicians are male, which also impedes the access to the service for female patients. This component can be improved through the promotion of female candidates to P&O trainings.

Type of service	2013	2014	2015	2016	2017
Prosthetics	6,121	6,576	9,321	No data	7,589
Orthotics	21,728	23,437	17,946		28,850
Technical Aids	22,280	22,761	25,318		28,121
Wheelchairs	1,741	2,068	1,765		2,260
Subtotal produced devices	**51,870**	**54,842**	**54,350**		**66,820**
Repaired devices	21,373	21,737	11,018		31,274
Total	**73,243**	**76,579**	**65,368**	**0**	**98,094**

Table 31: Annual production of prosthetics, orthotics and mobility aid devices in Physical Rehabilitation Centers 2013-2017[1]

There is a consistent increase of the annual production of assistive products in 2017 compared with previous years, which can be explained by the fact that 4 PRCs have been built in the last 4 years.

[1] National strategic plan for disability prevention and physical rehabilitation 2017-2020 p 24 – see also annex 6

Type of service	Beneficiaries in 2017
Prosthesis	6,528
Orthosis	21,655
Orthopedic appliances repaired	27,358
Total	**55,541**

Table 32: number of beneficiaries of assistive devices

If we look at the P&O services in 2017, 55,541 patients benefited from prosthetic, orthotics and repairs.

	Population of the country	Beneficiaries of PO services
Number of persons	34,660,000	55,541
Percentage	100	0.16

Table 33: Percentage of the population benefiting prosthesis and orthosis - 2017

0.16% of the population benefited from P&O services in 2017 whereas in 2013, WHO and International Society for Prosthetics and Orthotics (ISPO) estimate that at any given time, 0.5**%** of a population are in need of a prosthetic and Orthotic devices[1]. Only a third of the estimated needs can then be considered as covered, emphasizing the needs expressed above to increase the number of PRCs.

5.6. Rehabilitation Infrastructure and medications

There was limited time to collect data on equipment for rehabilitation. However, few PT units in Kabul showed equipment were either non-functional or in poor state (wear and tear). The PRCs which were visited had equipment and machinery of better quality.

Access to rehabilitation equipment and consumables seems inadequate in both community and hospital settings. However, due to limited time, it was not possible to get detailed information.

5.7. Rehabilitation information and research

5.7.1. Health Information System

The Health Management Information System (HMIS) of MoPH is the national system to record the information on health.

According to the HMIS procedure manual, the following data is about disability and rehabilitation which needs to be to be recorded by the Health facilities:

- In the **Hospital Status Report** by semester[2], the number of psychiatrists, physiotherapists, community health supervisors and community health workers are required by gender. Services provided as surgery for closed fractures and dislocations, acute osteomyelitis, rheumatoid arthritis, amputation and burns are recorded. Mental health services for common or severe disorders, as well as IEC activities for mental health are also part of the reporting.
- In the **Hospital Monthly Inpatient Report**[3], the number of patients getting surgical interventions for orthopedic/trauma are recorded by gender and classified by age (under/above 5 years old). Priority health problems/disease as weapon wounds, road traffic accident, occupational injuries,

[1] http://apps.who.int/iris/bitstream/handle/10665/43127/9241592672.pdf?sequence=1
[2] Page 102 of the procedure manual
[3] Page 94

burns, fractures, dislocations, cerebrovascular accidents, ischemic-heart diseases, other cardio vascular, other neurological, common or severe mental problems, respiratory tract infections, other respiratory conditions and musculoskeletal disorders are recorded in the same way.

- In the **Facility Status Report** [1]by semester, used for the Health facilities under DH, the number of community health supervisors and community health workers are recorded, as well as the services provided for mental health such as awareness raising, case detection or treatment and follow-up; and for disability services awareness raising, case detection and referral.
- The **Monthly Integrated Activity Report**[2] records the patients with pneumonia, acute flaccid paralysis, mental disorders, trauma, musculoskeletal. They are recorded by gender, age and if referred in or out.

Moreover, at the Health facility level, other information are recorded such as the number of patients receiving physiotherapy sessions, including gender and age information, as well as the type and cause of their impairment, the number of physiotherapy sessions per period of time, but they are not forwarded to higher level.

At province level, the Provincial Public Health Directorates (PPHD) are structured as following:

- Mother and Child Department
- Communicable Disease Department

These departments collect data in each province and report to HMIS for compilation and analysis. However, PPHDs do not have physical rehabilitation department. As a consequence, there is no data collection / communication to HMIS at this level.

It has to be noted that DRP, along with the Rehabilitation Task Force, developed disability indicators to be integrated into HMIS in July 2016. However, this integration is still pending.

The data required by the HMIS procedure manual on physical rehabilitation/disability are not homogeneous among all types of facilities:

- Disability services (awareness raising, detection and referral) are mentioned only for the Health facilities under DH, not above.

- The terminology, the diseases/impairments recorded are not the same which complicates a possible analysis process.

In addition, some impairments as cerebral palsy, Parkinson's disease, multiple sclerosis, spinal cord injury, spina bifida, club foot and chronic obstructive pulmonary disease could be interesting to be recorded to better assess the rehabilitation needs in the country.

In terms of data on the services requested by HMIS: physiotherapy sessions are not recorded. The information is collected at the facility level, but not forwarded to PPHDs due to lack of human resources, a specific department to analyze the results and forward them to HMIS. DRP is willing to integrate disability indicators into HMIS, but they focus only on persons with disabilities and not on all persons receiving rehabilitation services.

Finally, there is no details related to physical rehabilitation services in the HMIS 3rd quarter Health facilities Profile update, or 2015, 2016, first quarter 2017 reports. So the data received are not analyzed

[1] Page 83
[2] Page 76

in the reports, priorities are focused on infrastructures, maternal and child health, communicable diseases and nutrition.

5.7.2. Research

There is no research about physical rehabilitation in Afghanistan according to GIHS and DRP.

MoLSAMD is willing to develop a department for research in the National Disability Institute, but since its inauguration in 2014, this department is still not functioning.

Research about disability and physical rehabilitation in Afghanistan may be developed to have a global picture of the management of certain impairments with a high prevalence such as cerebral palsy, spinal cord injury, stroke, with the objective to harmonize the practices in the country and to provide better quality services.

Research on what is done in the other countries would also allow to keep the knowledge of the human resources up to date on the new techniques of rehabilitation, on the evolution of the management of certain pathologies.

5.8. Rehabilitation Emergency Preparedness

According to WHO, in the past five years the level of conflict increased, contributing to a 20% increase of trauma cases in 2016 compare to 2015. Some stakeholders have established First Aid Trauma Posts (FATP) in different Health facilities, for example Medical Refresher Courses for Afghans (MRCA) in Paktia and Farah to treat trauma cases and war wounded patients. The organization called Emergency has also FATPs in different areas. Usually they refer the patients to the DHs, PHs, RHs or physical rehabilitation centers to get physiotherapy, prosthetic and orthotic services.

Nowadays, mobile rehabilitation emergency preparedness in case of natural disasters or mass casualties due to the conflict does not exist in the country.

It has to be noted that **physical rehabilitation has been included into the humanitarian response plan 2018-2021[1] for the first time.** The health cluster is willing to address the health emergency needs of the targeted population, through ensuring access to emergency trauma care, rehabilitation and psychosocial support for shock affected people among 80 districts identified as conflict affected areas with limited or no access to healthcare. The health cluster partners will establish trauma services including:

- Immediate life-saving First Aid care
- Surgery
- Post trauma rehabilitation including physiotherapy, prosthesis and psychological first aid services

These activities will be implemented through:

- Direct support to the existing health institutions
- Establishment of new facilities
- Community initiatives
- Deployment of mobile health teams when necessary

[1] UNOCHA. (December 2017). Humanitarian response plan. January 2018 - December 2021. P 32-33.

"*Health cluster partners will attempt to fill gaps left by other humanitarian stakeholders particularly in the field of rehabilitation, physiotherapy and prosthesis care (...).*

The overall number of people in most critical need is determined at **1.5 million people affected by conflict, natural disasters, and displacement** *(...) with limited or no access to healthcare. The urgency of service delivery across geographic locations is identified as high and very high. Southern, south-eastern and northeastern regions of the country have been identified as the highest priority. Provinces with the highest need are identified as Balkh, Badghis, Herat, Kandahar, Kunduz, Nangrahar, Urozgan and Zabul. Of the 1.5 million people in need,* **69,000 people** *will require urgent life-saving trauma care.*

30% of those needing trauma care will be women and 15 percent will be children and adolescents. Many of these will eventually require ***disability aftercare which is unavailable or inaccessible in many conflict affected regions****. It is estimated that this could be as high as* ***45 percent***".

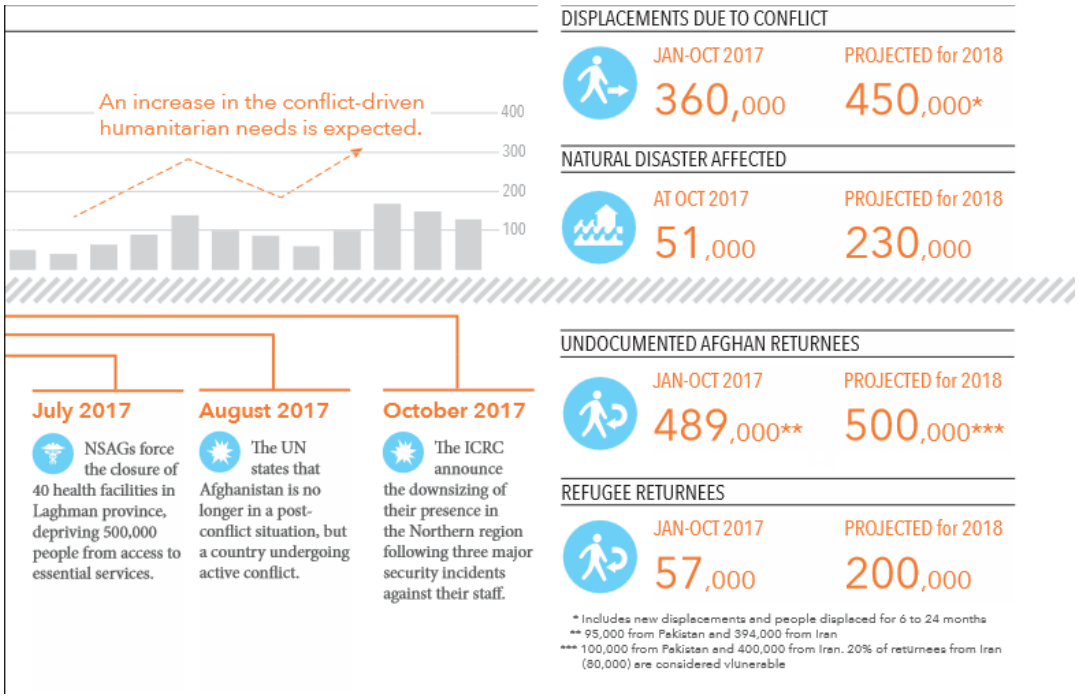


Figure 2: Extract from the Humanitarian Response Plan 2018-2021

In line with this, the Health Cluster with MOPH/DRP decided to improve the physiotherapy and rehabilitation response in case of emergencies. WHO launched a call for proposal to be submitted for the beginning of April 2018, to provide a refresher training for physiotherapists, prosthetic an orthotic technicians from DHs, PHs, RHs as well as from the Physical Rehabilitation Centers to improve the services for the war wounded patients and to train CHWs on how to do awareness raising at the community level on giving priority to persons with disabilities during emergencies. Priority provinces have been listed as follows based on high risk and feasibility of the program: Urozgan, Kandahar, Kunar, Nangrahar, Badakshan, Khost, Paktia, Kunduz and Ghazni.

On the other hand, Handicap International is starting a project in April in Kunduz and Kandahar, provinces with acute needs due to new shocks or returnees' movement. Through a mobile and flexible response, HI will target the most vulnerable persons among the returnees, internal displaced persons and host communities at risk of exclusion (including People with Special Needs (PwSN), persons with disabilities (PwDs), people with injuries, people experimenting psychosocial distress and/or mental health problems), who are often invisible to mainstream relief organizations due to the specificity of their needs. Mobile

teams will identify specific vulnerabilities and provide targeted assistance to these vulnerable groups through the provision of rehabilitation, psychosocial and mine risk education services with a complementary support to the Emergency Response Mechanism (ERM) actors. The action will reduce vulnerability and mitigate the impact of the conflict by facilitating access to lifesaving services, improving functional capacities and independence, strengthening positive coping mechanisms, promoting wellbeing, mitigating psychological distress and improving the dignity of the targeted beneficiaries.

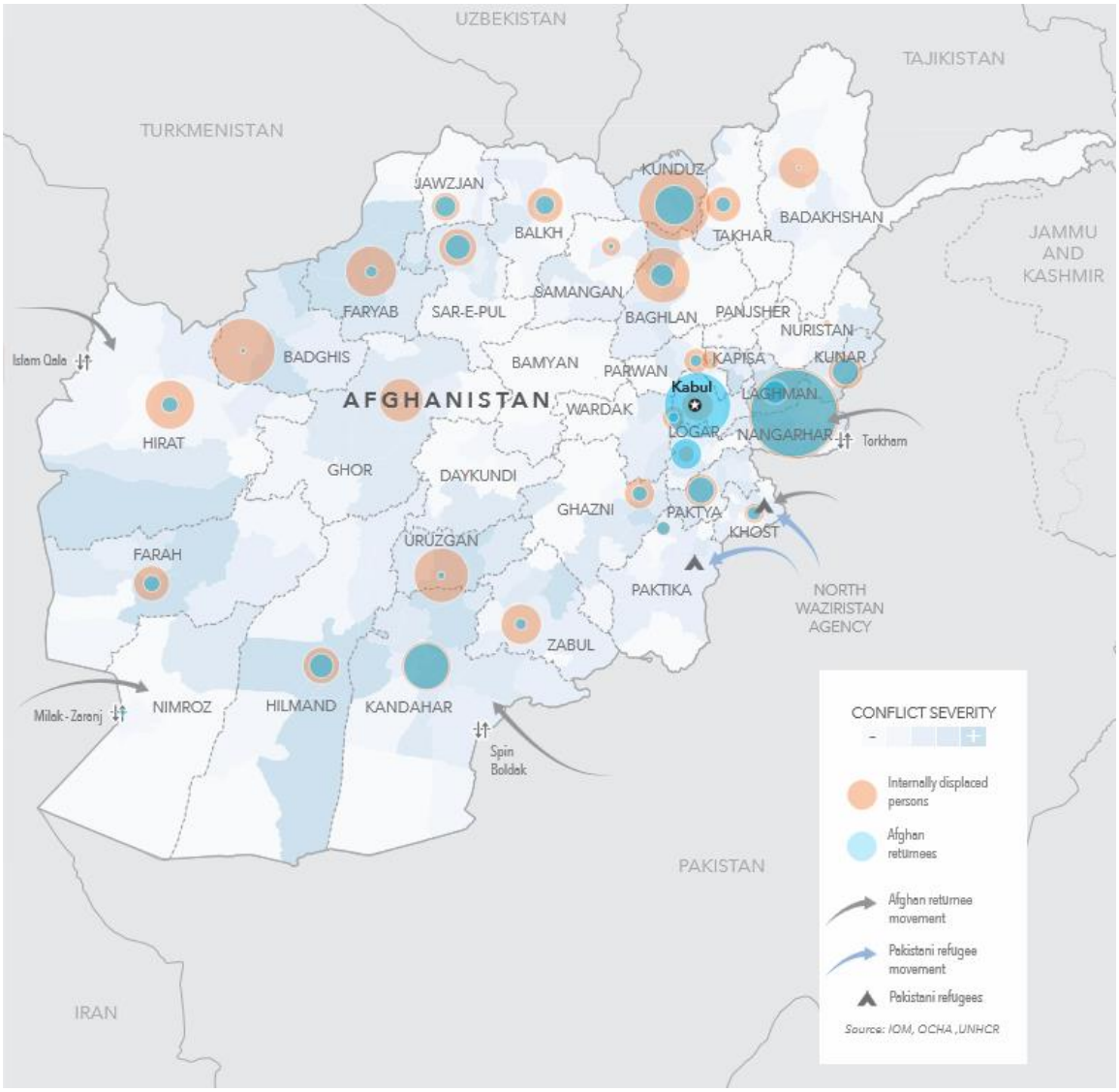
Physical rehabilitation has been included into the humanitarian response plan 2018-2021 for the first time. The health cluster is willing to address the health emergency needs of the targeted population through ensuring access to emergency trauma care, rehabilitation and psychosocial support for shock affected people.

80 districts in conflict affected areas without trauma care have been identified. Of the 1.5 million people in need affected by conflict, natural disaster and displacement, 69,000 people will require urgent life-saving trauma care and an estimation of 45% of them will eventually require disability aftercare which is unavailable or inaccessible in many conflict affected regions.

In line with this, WHO launched a call for proposal to improve the identification of persons with disabilities by CHWs, the referral, and follow up after returning from Health facilities; and to improve the quality of physiotherapy services for war wounded patients in certain provinces which are more at risk of conflict.

Moreover, Handicap International is starting a project of mobile teams in Kunduz and Kandahar to answer to the rehabilitation needs of the IDPs, returnees from Pakistan and host communities.

Currently mobile rehabilitation emergency preparedness in case of natural disasters or mass casualties due to the conflict does not exist in the country.



Map 6: Localization of the conflicts and people's displacements (IDPs, returnees, refugees). Humanitarian Response plan 2018-2021 - p.2

6. Recommendations

6.1. Recommendations in the 2013 Mapping

During the workshop, after the presentation of the results of the physical rehabilitation assessment, a working group session was organized, including all attending stakeholders.

The participants were dispatched randomly into 4 groups to work together on the 2013 mapping recommendations. Each group had to work on a specific thematic:

- Quality
- Accessibility
- Accountability
- Availability

These are criteria for ensuring an equal access to physical rehabilitation services for Persons with disabilities, and others in need for such services in Afghanistan.

Each group was asked if the recommendations made in the 2013 physical rehabilitation mapping were still relevant, if any progress had been made, giving concrete examples. The groups also worked on suggestions for new recommendations and the outcomes of each group were presented in plenary.

Although some improvements have been made, it appears that the vast majority of the recommendations from 2013 are still valid. The results of the workshop are presented hereunder.

6.1.1. Availability

Availability refers to having functioning and sufficient physical rehabilitation services in a balanced and equitable geographical distribution. Services should also strive to answer to the diversity of needs for services, i.e. age, gender, type of impairment etc. There must also be a long-term strategy of ensuring sustainability of services, financial as well as in terms of quality, including staff availability and adequate competence.

	Steps already implemented or ongoing development in line with the recommendations of the 2013 mapping
A2	EPHS guidelines have been approved. The TIQRA and P&O projects run by HI,SCA,NAC Consortium plan to train 700 staff of BPHS/EPHS implementers (including doctors, nurses) on identification, referral of persons in need of physical rehabilitation and how to work in interdisciplinary approach. 340 BPHS/EPHS managers will also be trained on how to manage rehabilitation services in Health facilities, to prepare the integration of the newly graduated students in the provinces.
A3-A4	The concept of TIQRA is developed to increase the geographical coverage of rehabilitation services and increase the number female PTs. Physical rehabilitation messages have been distributed for the promotion of the physical rehabilitation services and its benefits in the country and to present the project to the community and for the parents to allow their daughters to study.

A5	The indicators on disability have been developed by DRP and the disability and rehabilitation task force.
	Recommendations of the 2013 Mapping still valid
A1	Implement projects aimed at reaching full implementation of the BPHS and EPHS policies and guidelines to include physical rehabilitation in all DHs, with coverage of all provinces. This can be achieved through strong collaboration between MoPH, BPHS and EPHS Implementers and international and national NGOs working in physical rehabilitation sector.
A2	Put into practice the guidelines on physical rehabilitation in BPHS and EPHS and continue training the key stakeholders on disability and physical rehabilitation : ➢ BPHS implementers, general medical doctors and nurses And set priority in training for : ➢ Community Health Workers and CBR workers
A3	Develop a coordinated human resource capacity development plan among the relevant line ministries, the Disability Task Force, professional associations, donors and provincial health authorities. Current capacities are not adequate to train the necessary physiotherapists and P&O technicians. Assessment of possibilities to conduct training in other provinces should be studied, with the objective of recruiting personnel from more rural districts. This can ensure a better geographical coverage of rehabilitation professionals and willingness to work outside of main cities.
A4	Encourage and facilitate female students to apply for both physiotherapy and P&O training. It is equally important to ensure that they pursue their first employment, in particular through the provision of a positive environment for retention in the health care workforce. This is a general challenge in the health sector, hence the MoPH needs to include rehabilitation professionals in the overall human resource strategy ensuring that women are both being trained and employed as health professionals. This also means identifying and addressing the barriers to access professional training (stringent exams system, cultural attitudes etc.)
A5	Finalize the inclusion of the indicators on physical rehabilitation and disability in the Health Management and Information System. This will open up more opportunities to advocate for increased and better services, as the gaps will be more visible when measured. The ways should be explored to add financial resources for this aspect.
A6	A CBR training curriculum should be developed and coordination should be strengthened among government and non-government actors within health, education, employment and social affairs. A centralized monitoring and evaluation mechanisms for CBR programs should be developed under the competent authority.

6.1.2. Accessibility

Accessibility implies that services can be reached and used by the person who needs them. It has 4 overlapping dimensions: non-discrimination, physical accessibility, economical accessibility (affordability), and information accessibility.

	Steps already implemented or ongoing development in line with the recommendations of the 2013 mapping
B1	➢ Training package developed for BPHS/EPHS health staff by DRP and the disability and rehabilitation task force. ➢ Some health staff already trained in 20 provinces ➢ Training will be continued by DRP ➢ Training included in TIQRA and P&O projects (see above)
B2	➢ CBR manual translated to Dari and Pashto. ➢ National strategic plan for disability prevention and physical rehabilitation 2017-2020 developed by MoPH. ➢ BPHS/EPHS guidelines.
B3	➢ The DAO Gadoon Magazine published with disability and victim assistance related articles with the support of HI. ➢ Number of DPOs increased ➢ Advocacy efforts/capacities of 20 DPOs strengthened through Victim Assistance project run by HI, and this support will continue. ➢ Celebration of National and International disability events/PT days.
	Recommendations of the 2013 Mapping still valid
B1	Continue to roll out the awareness raising training to BPHS and EPHS on physical rehabilitation through Training of Trainers approach, in coordination and with support of the international and national NGOs involved in the sector.
B2	Develop a better understanding of the needs for physical rehabilitation in order to find out how the needs at community level in rural areas can best be addressed. What is the capacity of the CBR programs to be more involved, which physical rehabilitation needs can be answered through trained CBR workers?
B3	Increase the awareness of local communities and groups of persons with disabilities about the benefits that physical rehabilitation can bring and importance of early identification as well as secondary prevention. It is important though that such awareness comes parallel to increasing the access to services in areas that are not yet covered.

6.1.3. Accountability

Accountability concerns both the transparency and efficiency of the regulatory framework implemented from authority level, as well as accountability from service providers themselves. It refers not only to financial management of services but also to the overall organization of the service: clear manuals of policies and procedures, internal regulations, and a qualitative and transparent staff management system and the active involvement of users in both treatment and service delivery. Key words are: person-centered, user involvement, community partnership, continuity of service and result-outcome oriented.

	Steps already implemented or ongoing development in line with the recommendations of the 2013 mapping
C1	The revision of the Law on the Rights and Benefits of Disabled Persons in line with the CRPD has been done with the Disability Stakeholders Coordination Group chaired by MoLSAMD. The law has been submitted at the Ministry of Justice, pending approval. Then awareness should be delivered in all ministries, military groups and communities.
C3	Through their advocacy activities, the TIQRA and P&O projects are working with AAPT and ANSOP to improve the recognition of the rehabilitation professionals. As part of these activities, AAPT is also supported financially to run the upgraded course for the PT 2yr Diploma to 3yr Diploma this year.
C4	Advocacy efforts/capacities of 20 DPOs strengthened through Victim Assistance project run by HI, this project is continuing at the time of this report.
C6	The Disability and Rehabilitation Task Force chaired by DRP is still active. Quality assurance monitoring standards for PRCs and physiotherapy services have been newly developed by DRP.
	Recommendations of the 2013 Mapping still valid
C1	Follow the approval process of the revision of the Law on the Rights and Benefits of Disabled Persons in line with the CRPD.
C2	Conduct an assessment of current physical rehabilitation provision, including orthopedic centers. To facilitate a progressive handover to the MoPH, it is important to understand which procedures in terms of staff recruitment, salary scales, monitoring and evaluation tools, quality standards, as well as logistical processes, and types of materials are used. A harmonization of procedures and processes will facilitate a smooth handover.
C3	Strengthen the capacity of the two professional associations of physiotherapy and P&O technicians. They need to develop skills in policy making and advocacy, as well as having a stronger capacity to promote Continuous Professional Education in collaboration with training institutes.
C4	Strengthen the capacity of DPOs to taking part in policy making and advocacy in the field of physical rehabilitation and disability rights.
C5	CBR programs should enhance their support for self-help groups or interest groups to strengthen the voice of persons with disabilities at community level. This requires a long term planning knowing that current capacities are weak. CBR programs need to be strengthen and monitored by the government.
C6	Improve the coordination and sharing of roles and responsibilities between I/NGOs, MoPH and MoLSAMD. MoPH should take the lead to identify the needs for the Afghan population and the priorities and give its agreement for NGOs activities to avoid duplication. The PRCs and physiotherapy service providers should apply the newly developed quality assurance monitoring standards and report to DRP. Accountability in terms of technical and financial resources is crucial for a long-term hand over strategy.

6.1.4. Quality

	Steps already implemented or ongoing development in line with the recommendations of the 2013 mapping
D1	The indicators on disability have been developed by DRP and the Disability and Rehabilitation Task Force.
D2	The Disability and Rehabilitation Task Force chaired by DRP is still active and needs to continue its activities.
D3	DRP had recently developed a database to improve the reporting system and services delivery. DRP has recently developed quality assurance monitoring standards.
D5	Upgrading course to train P&O Category I has started in 2018.
D6	TIQRA and P&O projects ongoing.
D7	DRP has recently developed quality assurance monitoring standards including the monitoring of the staff.
	Recommendations of the 2013 Mapping still valid
D1	Finalize the inclusion of indicators on physical rehabilitation and disability in the Health Management and Information System so that performance can be measured and monitored.
D2	Continue and improve the coordination between the international and national NGOs providing physical rehabilitation services, the EPHS/BPHS implementers and the MoPH through greater follow-up and leadership of DRP within the Task Force group and greater coordination among concerned Ministries.
D3	DRP to continue the work started with the Health Management Information System, build their capacity to monitor and evaluate the rehabilitation sector.
D4	To continue to take over the role and responsibility of monitoring quality and performance of physical rehabilitation service provision, MoPH should : ➢ Develop policy for the evaluation process. ➢ Organize regular monitoring and supervision visits of the rehabilitation facilities. ➢ Include NGO capacity building plan with budget, materials and technical support. The capacity building plan should be coordinated with the capacity building department of MOPH. ➢ Recruit professional trainer to train the rehabilitation providers on the newly developed quality assurance standards.
D5	Curricula of physical rehabilitation professionals needs to reflect the functions required in the BPHS and EPHS guidelines on physical rehabilitation.
D6	Elaborate a consistent human resource plan and budget, for training of physical rehabilitation professionals in accordance with estimation of needs. Such plan has to be linked to service needs and supported by budget and future retention policy as well as salary payment planning.
D7	There is a need to strengthen internal capacities of professional associations to support the professionals to match the quality standards of practice for each designated field.

	New recommendations from the workshop
1	Advocacy towards MoPH to make physical rehabilitation and disability a top priority with relevant financial, human, technical resources, including the monitoring and evaluation process of the services.
2	Advocacy towards the donors to allocate more resources to improve the physical rehabilitation services in Afghanistan, and to strictly implement their global policy in terms of percentage for disability.
3	Service barriers should be considered in the service provision.
4	Advocacy with Ministry of Urban Development and Housing Directorate of construction of MoPH and private sector to strictly follow the accessibility guideline.
5	BPHS policy should include physical rehabilitation into CHCs where the DHs with broad area of coverage makes it difficult for people to reach these services.
6	Develop a smooth process for handover and integration of PRCs into the Health System.

6.2. Additional Recommendations

The recommendations presented here are the results of this mapping, based on the data that was available at the time of the assessment. They also reflect the need to give greater importance to rehabilitation.

6.2.1. Governance and data collection

	Additional recommendations
1	A Physical Rehabilitation Programme should consider to be decentralized in each Provincial Public Health Directorate, to ensure the collection of data in each Health facility, identify the needs in order to ensure planning for services (availability of rehabilitation in Health facilities and human resources) and support the monitoring and evaluation of the services.
2	An action plan for Disability and Rehabilitation Task Force which is chaired by DRP should be developed in order to operationalize the its Terms of Reference.
3	The National Disability Strategy to be finalized and the Afghan National Disability Action Plan and Policy are to be developed by MoLSAMD with the support of the stakeholders.
4	Advocacy towards the government to secure a minimum percentage of the annual health budget allocation for disability and physical rehabilitation at MoPH each year.
5	Advocacy towards the government and the donors to follow/endorse the Charter on Inclusion of persons with disabilities in Humanitarian Action and work together to achieve the Sustainable Development Goals (SDGs 3-4-5-9-10-11-16 and 17).
6	P&O should be included into the EPHS policy revision and be approved by the government.
7	An updated survey on the statistics about persons with disabilities in Afghanistan, using the Washington Group Questionnaire*, should be done. This can support the needs assessment of the specialized services to be developed, specific subjects to be taught in initial or

	continuous training for the health/rehabilitation professionals; awareness training for the CHWs, CBRWs, the communities on certain impairments, etc. **The Washington Group is a United Nations Statistics Commission City Group formed of representatives of national statistical offices working on developing methods to better improve statistics on persons with disabilities globally, with input from various international agencies and experts. These include UN agencies, bilateral aid agencies, NGOs, Disabled People Organizations, and researchers. Currently membership in the WG includes over 135 countries and several international organizations and Disabled People Organizations.*
8	A formal evaluation mechanism to monitor the physical rehabilitation services users' satisfaction should be developed.
9	Homogenize and add certain data regarding the prevalence of impairments required by the HMIS procedure manual on physical rehabilitation/disability among all type of facilities. It is recommended to include indicators in the HMIS concerning all the people who access physical rehabilitation regardless of the type of impairments. It is also suggested to include disability and physical rehabilitation in the HMIS Health facilities profile update, and reports.
10	A centralized system to assess the needs and demands and developing territorial maps of services should be set up.

6.2.2. Human resources development and national training capacities

	Additional recommendations
1	In order for the CHWs to ensure the awareness raising on disability, identification of persons with disabilities and referral to Health facilities, the following topics should be included into their training manual : ➢ Comprehension of national and international policies, legal documents for the rights of persons with disabilities ➢ How to reinforce the understanding and acceptance of disability by the person affected and his/her family, community ➢ Prevention of disability, identification and referral mechanisms.
2	Modules on prevention of disability, early identification, referral mechanisms should be included in the midwives and nurses curriculum.
3	To ensure sustainability, the establishment or continuation of physiotherapy training centers should be done with provincial Institute of Health Sciences (IHS) according to their availability and identified needs.
4	Before considering the establishment or continuation of P&O training centers, EPHS policy should be revised and approved including P&O services and P&O should be included into the MoPH human resources 'Tashkil', to ensure that new graduates would be employed after graduation.
5	A harmonization of the trainings for social work could be done, to ensure better quality of these services.

	Disability and physical rehabilitation should well elaborated in the medical curriculum, with a clinical placement in PRCs to ensure that graduates have a good understanding of physical and functional rehabilitation. Some training for physiatrist (specialized doctors in physical rehabilitation), occupational therapist, speech therapist and orthoptist should be set up in the country to ensure comprehensive rehabilitation services for the Afghan population.

6.2.3. Increasing access to physical rehabilitation services in BPHS and EPHS

	Additional recommendations
1	Awareness on disability, benefits of physical rehabilitation and importance of early identification, as well as the secondary prevention to be continued among the communities.
2	To improve the supervision of the CHWs, they should be better supervised, monitored and evaluated.
3	To improve the access to rehabilitation services, 369 PT units should be set up in active or lacking DHs; 19 PT units in active or lacking PHs, as well as 7 PT units in the active RHs of the country, according to the BPHS/EPHS policies and guidelines.
4	According to the EPHS guidelines which are yet to be approved, it is recommended to set up 18 more provincial PRCs and 8 more regional PRCs in the country. This is also in line with the recommendation from WHO and ISPO in 2013 which highlights that 0.5% of the population is in need of PO services, while in 2017 only 0.15% benefited from these services. P&O should be included into the MoPH 'Tashkil'. Knowing the cost to develop such PRC, the 4 PRCs planned by MoPH till the end of the year should be set up. A plan with dedicated budget should be developed to forecast the handover of PRCs from INGOs to government and to set up the remaining ones.
5	Develop an accreditation process could be developed for the PRCs

6.2.4. Rehabilitation research

	Additional recommendations
1	Research about disability and physical rehabilitation in Afghanistan should be developed to have a global picture of the management of certain impairments with a high prevalence such as cerebral palsy, spinal cord injury and stroke. The objective would be to harmonize the practices in the country for the provision of better quality services. Research on what is done in the other countries would also allow to keep the knowledge of the human resources up to date on the new techniques of rehabilitation, on the evolution of the management of certain pathologies.

6.2.5. Emergency preparedness

	Additional recommendations
1	The implementation of the physical rehabilitation activities of the humanitarian response plan 2018-2021 should be done to answer to the emergency situations among persons affected by conflict, natural disaster and displacement.
2	In collaboration with the National Disaster Management Unit (Independent Governmental Organization), MoPH and the Afghan Red Crescent Society could consider the preparation and training of qualified rehabilitation professionals to react quickly and adequately in areas at high risk of sudden onset disaster, with mobile rehabilitation emergency response teams in case of natural disasters or mass casualties due to the conflict.
3	Consider identifying the stocks of assistive products that may be required for disaster preparedness.

Illustration Table

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