

SOAG Annex 1

Amplified Description

I. Introduction.

This annex describes the activities to be undertaken and the results to be achieved with the funds obligated under this Agreement. Nothing in this Annex 1 shall be construed as amending any of the definitions or terms of the Agreement.

II. Background.

A. Health Sector - Current Situation

Health conditions in Afghanistan are among the worst in the world. The highest rates of death and disability are among infants, children and mothers during childbirth. There has been little change in the high maternal mortality rates (1,600 per 100,000 births), infant mortality rates (115 per 1,000 births) and child mortality rates (172 per 1,000 live births). High levels of chronic and seasonal malnutrition and infectious diseases contribute significantly to these levels of morbidity and mortality.

While there has been some progress in certain areas, maternal health remains among the highest risk areas, as a result of cultural practices and lack of health systems capacity. Overall, the number of women who receive antenatal care and gave birth in a well-equipped facility in the presence of a trained attendant is still low. In 2003, 16% of pregnant women received at least one antenatal care visit from a doctor, nurse or midwife. Similarly, 88% of the births in Afghanistan were at home, with 85% attended by an unskilled birth attendant. The lack of trained female health workers has been cited as the major barrier to reducing the maternal mortality rate, as well as other reproductive health issues. At 6.8 children, the total fertility rate in Afghanistan is one of the highest in the world. Knowledge and utilization of modern methods of contraception remains low. According to the Multiple Indicator Cluster Survey conducted by UNICEF in 2003, only 29% of ever-married women under the age of 50 are aware of a method to delay pregnancy, and only 10% of this group is currently using a method of contraception.

The incidence of infectious diseases continues to be a major problem in Afghanistan. Diarrheal diseases, immunizable diseases, malaria and leishmaniasis affect millions, and tuberculosis continues to be a serious threat in Afghanistan as evidenced by an estimated annual incidence of 71 thousand active cases, of which approximately 68% are in people age 15 to 44. Of great concern is that 75% of the positive sputum smear cases of tuberculosis in Afghanistan are in women. The annual death toll related to TB is estimated to be 20 thousand. Crowded and confined living conditions and lack of access to health facilities, especially for women, for consistent drug therapy are critical barriers to controlling tuberculosis in Afghanistan.

Like most post-conflict countries, there is a high incidence of vaccine-preventable diseases. Notwithstanding the tremendous strides made by the Ministry of Public Health since the fall of the Taliban to make immunization services available to high risk

populations, Afghanistan is one of five countries in the world that has not eradicated the wild polio virus; seven polio cases were reported in calendar year 2003 and so far three cases in 2004. Diphtheria, pertussis and tetanus (DPT3) coverage is 54%. Measles accounts for about 35 thousand deaths of children under the age of five per year. Twenty-six percent (26%) of the neonatal deaths are due to tetanus; about 10 thousand cases are reported annually.

Health systems, particularly the physical infrastructure, institutional capacity and human resources, have been crippled by the years of destructive warfare. One significant consequence of 23 years of conflict and civil strife that has affected all sectors of society including health, is the drain, or out migration, of trained and qualified medical personnel. Many qualified staff either left the country or were they themselves victims of war. In addition to the loss of competent medical staff, the disruption and low quality of medical, nursing and midwifery education programs further exacerbated the human capacity crisis in the health sector, which has limited access to effective health services. According to the Afghanistan National Health Resources Assessment (December 2002), the number of physicians per 1,000 people is 0.1 as compared to 1.0 for all developing countries. Counting all categories of skilled health workers per, Afghanistan has 0.3 health workers per 1,000 people, with a range of health worker to population in the rural areas from 0.8 in Balkh to 0.1 in Uruzgan.

Of particular concern in Afghanistan, which has a cultural prohibition of women receiving health care from male service providers, is the lack of female health workers. Again according to the Afghanistan National Health Resources Assessment there were 605 female physicians, 90 female specialist physicians, 467 midwives and 566 female nurses in Afghanistan. The overall male/female ratio among health providers is 3 to 1. However, further provincial analysis indicates a more extreme imbalance. Nuristan Province, at the time this assessment was conducted, had one female worker for population of 110,700; making the ratio 43 to 1. Herat Province has a more favorable male/female ratio of 2 to 1.

1. Government Efforts

Despite some daunting challenges, the Ministry of Public Health (MOPH) has made significant improvements in the health sector since 2001. Admittedly some of these advancements have not at this time led directly to a reduction of the three major health indicators, maternal, infant and under five mortality. Nevertheless, evidence suggests that if the MOPH continues to build internal management systems, improve the quality and access to basic services and preventive health practices to those who need them most, these indicators will improve. For example, in 2002, 11 million children between the age six months and twelve years were immunized against measles; and 5 million between the ages nine and 59 months in 2003. Thus far, polio eradication campaigns have reached more than 6 million children under the age of five, as a result, the number of wild polio virus cases has decreased from 27 in 2000 to seven in 2003. There have been three reported cases of polio since the end of 2003. This epidemiological trend may indicate that Afghanistan is in the final and most critical stage of stopping the wild polio virus, which is a major step towards making Afghanistan polio-free. National Tetanus Toxoid immunization efforts have reached approximately 3,200,000 women of child-bearing age, with approximately 64% of the target population vaccinated with two doses.

The goal of the National Health and Public Investment Programme submitted to the Ministry of Finance by the Ministry of Public Health in January 2004 is to reduce the high level of mortality and morbidity, especially among women and children, through the development of equitable, effective and efficient health services that address priority health and nutrition problems through developing the human capacity to deliver the necessary services.

The mission of the Ministry of Public Health is to lay the foundations for equitable health care for the people of Afghanistan, especially women and children, through *building the capacity to define the context, direction and scope of work for all stakeholders*; to develop and implement strategic plans and coordinate health sector actions which act in ways that make the best use of limited resources, exerting influence through stewardship, regulation and advocacy; and, to collect and use information for evidenced-based decision making.

The Minister of Public Health has two deputy ministers, one covering technical areas and one for administration. There are four director generals: Policy and Planning, Health Care and Promotion, Provincial Liaison, and Management and Administration. All but the Director General for Management and Administration reports directly to the Technical Deputy Minister. Major decisions are deliberated through the Ministry of Health Executive Board.

The main functions of the Ministry of Public Health are to set over-arching health policies and to coordinate sector-wide health activities in Afghanistan at all levels of the health system. The MOPH has established the Consultative Group for Health and Nutrition (CGHN) to *coordinate activities of implementers, donors and policy makers*. Issues decided at the CGHN are forwarded to the MOPH Executive Board for final approval. The MOPH Executive Board is chaired by the Minister of Public Health and is comprised of the two deputy ministers and four director generals. Executive Board decisions are communicated to stakeholders and partners through the National Technical Coordination Committee (NTCC).

To ensure effective coordination between the national and sub-national levels, the MOPH created the Grants and Contracts Management Unit (GCMU), which is supervised by the Director General for Policy and Planning. The GCMU has four functions:

- Assist in the expansion of the delivery of the Basic Package of Health Services (BPHS);
- Strengthen the MOPH's stewardship role in the health sector so it can ensure that MOPH priorities and policies are implemented;
- Integrate donor, multilateral and NGO efforts into the health system, and
- Develop the capacity of the MOPH to work effectively with stakeholders in establishing and effective and efficient public private mix.

To further coordinate with provincial units, the Provincial Health Liaison Offices (PHLO) work with the Provincial Health Coordination Committees (PHCC) in the 32 provinces. The Provincial Health Director chairs the PHCC meeting, and it is attended by NGOs and other line ministries.

The Ministry of Public Health in the Health and Nutrition Public Investment Program (SY 1383-1385¹) has identified six priorities that need to be addressed to improve the overall health of the Afghan population. They are:

- To reduce the high levels of infant and child mortality rates by decreasing the incidence of vaccine preventable diseases, diarrhea and acute respiratory infection (ARI);
- To decrease the maternal mortality rate (1600/100,000 live births);
- To address the high levels of malnutrition and micronutrient deficiency disorders;
- To combat the high incidence of communicable diseases, especially tuberculosis, malaria, leishmaniasis and STDs, and to maintain the very low incidence of HIV/AIDS;
- To improve the inequitable distribution of quality health services; and
- To develop human capital to implement effective and efficient health services at all levels of the health system.

From the Ministry of Public Health's perspective, as well as that of donors and stakeholders working in the health field, the predominate constraint to addressing these issues is a critical lack of access to basic health services throughout much of the country; especially in the rural areas. The government has committed itself to improving the number and quality of health facilities and to ensuring that the Basic Package of Health Services (BPHS)² is delivered to all Afghans regardless of where they live, their gender or ethnicity in the next three to seven years.

The government and its international partners recognize that in order to achieve its objectives, a series of policies and systemic improvements need to occur within the Ministry of Public Health that support a stronger human resource and health care financing system, including the costing of the Basic Package of Health Services. In the midst of a decentralizing health system, the MOPH will define the roles and responsibilities of the central and provincial health authorities.

The MOPH has played a critical role in coordinating activities among the UN agencies, NGOs and other donors working in health. This includes but is not exclusive to directing the construction of new health facilities, primarily in rural areas, although an increased focus on urban center is predicted once rural populations are positioned for significant improvements in access and quality services. Similarly, while the BPHS focus remains at the forefront, the MOPH is coordinating policies and activities that will define and enhance the role of tertiary hospitals in Afghanistan.

¹ Afghan year 1383 goes from 20 March 2003 to 21 March 2004

² The Basic Package of Health Services (BPHS) is a service delivery framework that includes Maternal and Newborn Health, Child Health & Immunizations, Public Nutrition, Communicable Diseases, Mental Health and Disability. At this time, Mental Health and Disability have yet to be integrated into services.

2. External Support

In addition to USAID, there major international donors supporting the Ministry of Public Health in Afghanistan are the European Commission, the World Bank and the Japanese International Cooperation Agency (JICA). Both the European Commission (EC) and the World Bank support the delivery of the BPHS. The European Commission currently provides 36.5 million euros through grants to NGOs for BPHS services to 4.6 million people in nine provinces. World Bank NGO grantees provide these services in eight provinces; they also provide support to the MOPH to implement the BPHS in three provinces. Both donors also provide management technical assistance to both the central and provincial levels of the MOPH. JICA provides support to Kabul University Medical School, as well as the National Tuberculosis Institute. The World Bank's investment in health in Afghanistan from September 2003 to September 2006 is estimated to be \$59.6 million. Key areas for the World Bank are providing the BPHS, as well as providing furniture for newly constructed clinics and technical assistance to the central MOPH.

3. Summary of binding constraints in the Health Sector

The principal constraint in the health sector can be generally categorized as a lack of human and institutional capacity, whether it is the quantity, skill level or type of worker, or where they are placed. Simply put, there is not an ample pool of health workers, especially but not limited to those who provide direct client care. Generally speaking, only about 50% of the people have access to a place where they can get quality BPHS services. The main barrier to achieve more expansive coverage is the lack of appropriately qualified and supervised health care providers.

There are several sub-issues within the broader human capacity crisis, apart from not having enough trained health workers to meet the needs of the population, especially female workers in the rural areas. The institutions that train health workers, and the systems that support their work after they graduate have deteriorated over the past 23 years. Also of priority importance are community participation, the quality of service facilities, institutional support services (particularly communications, IT and logistics) and supervision to achieve quality assurance and timely monitoring and evaluation of individual and system performance.

Afghanistan has difficulty recruiting, training and deploying a sufficient number of health workers to areas where the need is greatest—the rural areas. Most doctors, especially females, remain in the urban centers, while the need is greatest in rural areas, leaving many rural communities underserved. Evidence abounds that this unbalanced sex distribution of health care personnel affects access to services for women, who are in greatest need of basic services.

The shortage of trained personnel is a "supply" issue. Pre-service education institutions—nursing and midwifery schools in particular—are having difficulty attracting a sufficient pool of qualified candidates. Many applicants who present for admission to midwifery and nursing schools do not possess the requisite academic credentials or levels of literacy to gain admission and complete the course of study. The lack of qualified candidates is directly related to long periods of interruption of the primary and secondary education systems the low female literacy rates and the current poor access to basic education for women.

Afghanistan also lacks a strong pre-service education system. The Institute of Health Sciences (IHS) is responsible for training all health workers in Afghanistan with the exception of Community Health Workers (CHWs) and physicians. The lack of physical infrastructure at the IHS, such as female dormitories and well-equipped laboratories and classrooms, have negated the ability of the IHS to produce the quality and the quantity of midwives, nurses, and laboratory technicians needed to meet the needs of the health system. In addition to these infrastructural issues, the teachers and instructors at the IHS have suffered from an inability to keep their knowledge and skills current.

Added to issues confronting the IHS in the pre-service education arena, Afghanistan has no capacity to conduct in-service training for those workers who are currently in the system. At this time, the in-service training is by NGOs who are contacted on behalf of the MOPH for a defined length of time to train a specified number and cadre of workers. While these efforts have served a short-term need, this model is not developing a training competency within the MOPH or another Grantee institution.

There has been considerable work done on human resource systems in Afghanistan, but the systems, especially at the provincial level, are still evolving. Few health workers have job descriptions or criteria for performance that reflect their current work responsibilities. Tied to the lack of job descriptions is the absence of systems that support an objective performance appraisal process focused on improving personnel performance. The absence of written job responsibilities and clear policies for performance appraisal are likely to adversely affect female workers in particular, who may already be disadvantaged by culturally defined power dynamics with male supervisors.

Currently, performance appraisals are either non-existent, used as a "rubber stamp," or are used punitively and not always tied to work performance. This leads to supervision approaches and systems which do not support or contribute to improved performance. Resource shortages often prevent supervision from taking place on a regular and periodic basis. The limited technical knowledge and skills of supervisors often limit their capacity to move beyond punitive approach to work with staff to define "lessons learned" best practices and evidenced-based adjustments to work plans to achieve improved performance.

Afghanistan is in the process of decentralizing its health system, giving more power and authority to provincial health units. While the provincial authorities have more responsibilities for coordinating the implementation activities in their provinces, the central MOPH maintains a policy-making and coordinating role. Both levels of the MOPH are acting in a new capacity, and these new roles will require some technical support to function effectively over time.

The MOPH cannot make evidenced-based decisions because there is a scarcity of reliable data: epidemiological, operations research and policy for the entire country. The Multiple Indicator Cluster Survey (MICS) provides national information on the incidence and prevalence of diarrhea, infectious disease, acute respiratory infection, pregnancy and reproductive health statistics. However, MICS does not provide information on health seeking behavior, provider and community attitudes. Not only do

these data not exist, there is no capacity in the Afghanistan to carry out this type of research.

Despite an intense effort to revive the health infrastructure in Afghanistan, a significant proportion of the population still does not have immediate access to a health facility. Right now, approximately 50% of the population is more than a four-hour walk from a basic or comprehensive health facility, district hospital or a provincial hospital.

As Afghanistan rebuilds, the Ministry of Public Health is introducing the BPHS, which has more of a preventive orientation than currently existed in the past. The transition from curative to preventive has not taken place in the health system, or with the clients. There is little or no health or client education, what is done is done in groups and is fairly doctrinaire based on the approach that the provider or health worker knows best. There is a lack of Information, Education and Communication and Behavior Change Communication (IEC/BCC) materials, or the capacity to develop them in a timely manner.

As the BPHS package is currently reaching about 50% of the country, systems that monitor the quality of the services need to be established. In addition, systems need to be in place to track the performance of the health system.

B. Education Sector - Current Situation

In 2002, at the invitation of UNESCO, a high level Committee, comprising prominent Afghan experts, convened to draft the educational policies and proposals for the new Constitution. The recommendations of the Commission included the right to free education for all citizens regardless of gender, ethnicity, religion and language, the need for geographically-balanced development of education, policy on educational governance, teacher training, national infrastructure for educational planning, non-formal education and distance learning. Subsequently, the transitional government's National Development Framework of April 2002 highlighted provision of education, with special emphasis on quality education, teacher training, and vocational education, as one of its priority programs.

To achieve this vision, the Afghan government has identified three strategic areas for intervention: (a) Expand access and raise the quality of primary and secondary education country-wide; (b) Build a higher education system that responds to Afghanistan's reconstruction needs, creates new professional and income opportunities for Afghans, and meets international standards; (c) Expand citizens access to vocational and informal education, which is closely connected to the demands for skills in the economy, with special focus on improving livelihood opportunities for vulnerable populations like widows and the disabled, returning refugees and internally displaced persons, demobilized soldiers and unemployed youth.

1. Basic (primary and secondary) education

Since the fall of the Taliban large numbers of students, many returning from outside Afghanistan, have enrolled in school. The rate of enrollment in primary education has doubled, with an estimated 4.8 million children in primary and secondary, more than at any time in Afghanistan's history. Gender disparities have been halved. According to a

UNICEF, the number of teachers in 2002 was 70,000 and today, according to the MOE, it has grown 50% to 105,000.

However, despite this progress, there are enormous challenges in the face of 25 years of war and upheaval:

- Only half of all children age seven through thirteen are currently enrolled in school, with girls representing only 34% of enrollments.
- Less than half of first grade enrolled children complete fifth grade, for girls, only one in four starting first completes fifth grade. Children do not enroll or stay in school for many reasons – economic constraints, family obligations, cultural practices, poor quality teaching, but the single most important factor in why children do not enroll, especially girls, is the school is too distant, or not available at all.
- Eighty percent of school facilities have been damaged or destroyed and the MOE projects the need for an additional 3,413 schools to be constructed or rehabilitated over the next several years.
- The MOE estimates a shortage of 40,000 teachers.
- An estimated 1.7 million over aged young people, many out of school, need to be reached with non-formal accelerated learning programs.
- All indicators of teaching quality are low: less than half of teachers are high school graduates; teachers use rote learning methods and lack knowledge of the subject they are teaching.

a. *Government efforts*

The government of Afghanistan is a signatory to the 1948 Declaration of Human Rights and its Covenants and other conventions of the United Nations and is committed to the goals of Education for All (EFA). In line with the EFA principles articulated at the Jomtien Conference in 1990 followed by the Dakar Framework of Action, the government's vision is to ensure that all children complete compulsory education (grades 1-9).

There are two Ministries responsible for the education sector: Ministry of Education (MOE) and the Ministry of Higher Education (MOHE). The MOE is responsible for primary, secondary, vocational and technical education and literacy while the MOHE covers higher education.

The central MOE is organized into 22 departments and these are grouped into five categories: (i) Coordination and control; (ii) Planning, International Relations and Construction (iii) Management structures: Personnel and Administration (iv) Subsectoral structures comprising several specialized directorates such as that of primary education, secondary education, professional and vocational education, literacy, health, Islamic education, and sciences education (v) Pedagogic Structures: teacher training, translation and compilation (curriculum and textbooks), printing and publication, and distance education.

Each of the 32 provinces has an education office that is responsible for implementing the national policies and administering finances allocated by the central government. The provincial education departments (PED) are

accountable to the Provincial Governor and the Ministry of Education at the center. In addition to the PEDs, there are 535 District Education Departments (DED).

The overall organizational model of the MOE is a centralized one, with most decision-making authority resting at the center. In order to encourage innovation and sustainability, there is a need to delegate decision-making and spending power at the provincial, district and local government level. There is also a need for rationalization of the role of the Ministry from that of a service provider to that of policy-maker, regulating and monitoring service delivery.

There are no accurate records available of the actual number of staff working in the provincial offices, districts, and schools. Estimates vary from source to source, making the process of planning human and financial resources difficult. Lack of reliable data, capacity constraints, lack of clear cut roles and responsibilities of the different departments, inadequate coordination among them, compound the problems. The absorptive capacity of the Ministry is limited. Per a UNICEF report, in 2003, out of the \$250 million education budget the MOE formulated, donors committed only \$66.1 million and MOE was able to disburse only \$19.2 million.

Despite the above challenges, the MOE has achieved considerable success in restarting the education system and increasing enrollments. This is owing to the high level of motivation and commitment of the MOE, the exceptional leadership in some key departments of the Ministry, and the openness/receptivity to working with international consultants in order to build capacity. Also, the Ministry has undertaken some encouraging steps such as initiating a revision of its staffing structure and introducing personnel and administrative reforms, and establishing a donor coordination mechanism to coordinate the Teacher Education Program (TEP).

b. External support

The government has almost no budget of its own to carry out its educational activities and is almost entirely dependent on donors who contribute substantially to the education sector. Among the principal bilateral donors and international organizations providing significant support for education are the World Bank, USAID, UNICEF, DANIDA, JICA, GTZ and the Asian Development Bank.

International NGOs such as Save the Children, CARE, Catholic Relief Services, International Rescue Committee, and Aga Khan Development Network, complement the efforts of donors by providing educational opportunities for hard-to-reach children and non-literate adults through community schools, residential schooling for orphans, and skills training.

However, despite significant donor funding in most priority areas such as construction and rehabilitation of school buildings, textbook printing and distribution, curriculum development, institutional capacity building, there is a funding gap between the national budget and available funding.

The World Bank works directly with the government of Afghanistan. All their education funding to the government is currently in the form of grants and has three broad components: (i) school grants for quality enhancement and infrastructure development. This component is concentrated in five provinces: Bamiyan, Logar, Parwan, Kapisa, and Badakshan (ii) capacity building/human resources development – this includes teacher training, training of school principals and capacity building of DEDs and PEDs; and (iii) policy development and monitoring and evaluation. The Bank will be assisting the Ministry with school mapping and planning for the Education Management Information System (EMIS). The Bank also supported preparation of *Securing Afghanistan's Future*, which provides a detailed analysis of education sector needs and priorities. The World Bank representative is a founding member of the Teacher Education Program (TEP), a group of donors working with the MOE Teacher Training Department to develop policies, a strategic plan and a framework for coordinating teacher training programs in Afghanistan.

While UNICEF's efforts have largely focused on teacher training, they have also assisted the MOE in the distribution of school supplies and textbooks to all schools throughout the country; distribution of 1000 tents to accommodate the influx of girls in schools; and identifying schools in need of repair, locating sites for new schools; producing standardized specifications for construction of schools. Another of UNICEF's important contributions has been in formulating a framework for the development of a modern curriculum. Textbooks for some of the primary grades are being developed with technical assistance from the Teachers College Columbia University. UNICEF has conducted short-term refresher training for an estimated 50,000 teachers in language arts, pedagogy, and land mine awareness. They have also developed training manuals for future training programs for teachers. UNICEF is an active member of the Teacher Education Program (TEP).

The United Nations High Commission on Refugees (UNHCR) undertook a survey of the physical infrastructure of schools. This report was used as a basis for the construction and rehabilitation of schools in the country, to which USAID has made a major contribution.

DANIDA has identified five priority areas for support to primary education in Afghanistan. These are: curriculum development; teacher training and development; educational materials development (including textbook development and printing); physical infrastructure; and aid management and planning and management capacity development. Danish funding will include technical assistance, as needed in areas such as syllabus development, teacher education and development and management. DANIDA is also active with TEP.

JICA has supported the reconstruction efforts of Afghanistan by providing assistance to the ongoing efforts of the UNICEF and UNESCO and also by implementing projects through their own contractors. JICA has repaired existing women's schools, and built new ones as part of a wider effort at improving the status of women; funded UNESCO for training Afghan teachers in Pakistan and developing literacy and extracurricular education in Afghanistan; contributed to UNICEF's Back-to-School Campaign; placed Education Advisors in the MOE and

in the Literacy Department; and promoted youth friendship programs. JICA is represented on TEP as well.

In addition, there are small-scale teacher training initiatives being implemented and managed by NGOs. For example, Bangladesh Rural Advancement Committee (BRAC) has been training teachers in the Kapisa and Parwan Provinces while CARE International and Save the Children are training teachers in the Logar and Bamian Provinces, and Aga Khan Development Network (AKDN) in Baghlan and Badakhshan. ISCECO (Islamic Countries) is training teachers who teach Islamic studies and Arabic in various provinces.

2. Vocational Education

With a devastated economy and extremely under-resourced government staff, Afghanistan is in desperate need of skilled workers—ranging from laborers with basic industrial skills to professional leadership. USAID's program analyses and the Mission's efforts to date indicate, the need for trained workers in construction, manufacturing, commerce, justice, health, agriculture as well as in the operations and maintenance of power, water, transportation, and communications infrastructure. Yet there is no Afghan system and very little donor structure in place to train people in the skills needed in these sectors. As a consequence, external development agencies are either employing foreigners, even for the most basic tasks of road building, while unskilled Afghan people sit idle, or they are hiring Afghan workers who produce sub-standard results.

While the general need for skilled workers is widely recognized, there is no good information about the demand for specific skills. Nor are there standards or certification programs that allow employers to judge the competence of potential recruits. Government efforts.

One of the government's 12 National Priority Programs is the National Skills Development and Market Linkages Program (NSD&MLP). The emphasis in this program is clearly on the more fundamental, basic skills, at least in the short and intermediate terms. The immediate strategy of the program aims to provide skills training to the defined vulnerable groups. The NSD&MLP lays out a comprehensive plan in the four traditionally defined sectors (agriculture, industry, commerce, and service), plus smaller programs in "Second Chance Livelihood Skills Development," infrastructure development, and labor market surveys.

The stated aims are to provide skills development in the immediate term for the worst affected groups in the community, to provide skilled workers for those sectors currently facing a worker shortage in the intermediate term, and to provide quality training in the long term to meet the needs of a modern market economy.

The government has designated several groups as being particularly vulnerable as the nation emerges from decades of conflict. Estimates of the numbers of persons in each of these categories are so varied as to be useless, but there can be no doubt that the numbers are large. As an example, the number of demobilized soldiers was originally projected to be approximately 60,000. Similarly, the numbers of widows and war-affected children are in the tens of thousands. The defined vulnerable groups include:

- Demobilized soldiers and child-soldiers.
- War affected children.
- Street and working children
- Internally displaced persons.
- People with disabilities.
- Unemployed persons
- Single-headed households (primarily widows)
- Returning refugees.

The immediate goal involves the expenditure of approximately \$5 million over the next three years to provide short-term skills training that will lead to employment of 10,000 citizens.

The Ministry of Labour and Social Affairs, which is responsible for this program, has limited capacity. The ministry's activities in this arena have been assisted by an informal group of international advisors. Without this help, or some analog, the Ministry is ill-equipped to run a \$20 million National Priority Program (NPP).

The Ministry of Education's Department of Vocational Education runs the formal vocational training school system, which is more or less defunct. It has operated approximately 40 technical schools, but most of these are now in serious disrepair. However, with good management, this nationwide system could be resuscitated and would then contribute significantly to the training and the development of skilled individuals. The Ministry of Justice runs (at least) one Vocational Training Center for "delinquent children" in its care. Regrettably, there are no standards and no certification process.

Information from the Ministry of Finance (as of December 7, 2004) indicates that government requires approximately \$6.5 million for vocational training programs within the education NPP. This does not include vocational skills training taking place within other sectors.

a. *External support*

European and other bilateral agencies are providing some support to the government in rebuilding vocational education programs. Many NGOs are working effectively in this arena. Activities are not coordinated, although the IRC has made an effort at getting together an inventory. JICA has made a serious commitment, and GTZ, IOM, CONTRACK International, and other organizations are doing excellent work, particularly in the construction sector. There are a few domestic or Afghan-American groups that are also effective, one of the best being Afghans 4 Tomorrow. University of Nebraska/Omaha and Purdue University were previously involved in USAID supported vocational education but are no longer active.

The Ministry of Finance source (www.af/MOF/budget; no date) shows that in 2004 donors funded approximately \$5.5 million in vocational training projects.

3. Higher education

There has been considerable progress in the past three years. Many buildings at Kabul University have been renovated. New emphasis has been placed on the teaching of English. There is a growing appreciation of the need for libraries and librarians. Student enrollment has grown, especially female enrollment, which in 2003 was about 20% of the total higher education student population and nearly half of the student population in the Pedagogical Institutes and the University of Education. There is a strategic plan for higher education. But there remain very serious issues:

- Only 6% of the faculty in the 16 institutions have a PhD (or equivalent) degree. At Kabul University and Kabul Polytechnic Institute the situation is better (10% and 33%, respectively); at all other institutions, the situation is very poor (2%).
- Only 12% of the faculty is female.
- There are currently no private institutes of higher education.
- Many of the buildings in the universities are in very dilapidated condition. At Kabul University the most serious infrastructure problems are at the School of Chemistry, the Faculty of Science, and the Old Medical School. Some provincial institutions have virtually no physical infrastructure of their own (e.g., Takhar, Balkh).
- Sanitation at most institutions is in a deplorable state. Kitchens at most institutions are run down, ill equipped and unsanitary. There is almost no functioning scientific equipment.
- Libraries are poorly stocked, and many of the resources are in English or Russian, neither of which can be read by a majority of students.

a. Government efforts

The Ministry of Higher Education has adopted a Strategic Action Plan that calls for the introduction of private higher education in Afghanistan; the designation of five specified regional institutions to attain "university status" in the American/western sense, with concomitant strengthening of those institutions; the enhancement of the four "national" universities in Kabul; and the development of branch campuses and community colleges in the provinces.

The Ministry of Higher Education runs the sixteen universities and institutions of higher education. The Ministry has now also taken on two teaching hospitals in Kabul, with some responsibility for a third. The Ministry is strongly supportive of the soon-to-be established American University of Afghanistan, and has provided the land for this institution.

The recurrent budget for FY 1382 was 330,543,000 AF (approximately \$7 million), which is 5.5% of the total education budget or 1.3% of the total government budget. Slightly more than half of this higher education budget was for personnel. The budget for the sixteen institutions was approximately 205 million AF (approximately \$4.2 million). With a total enrollment of slightly more than 31,000 students, this equates to a per student expenditure of about \$135.

b. *External support*

UNESCO provided leadership for the Strategic Action Plan, with funding from Germany and the Nordic countries. Japan is committed to supporting the proposed Ali-Abad teaching hospital. Both Germany and Japan have funded significant reconstruction at Kabul University and elsewhere. The Government of Italy has committed \$1 million for the Legal Training Center, and INL has offered to provide furnishings. The UN is funding the building of the law library.

4. Literacy

Afghanistan has one of the highest rates of non-literacy in the world. In rural areas, where three-fourths of all Afghans live, 90% of the women and 63% of the men are not literate, and in many villages 95 to 100% of the women cannot read or write. Countrywide, 70% of rural and 47% of urban heads of households are not literate. Even in Kabul, among 18 to 25 year-olds, 51% of young women and 31% of young men are not literate, and the rate worsens dramatically in each older age group.

a. *Government efforts*

Securing Afghanistan's Future: Accomplishments and the Strategic Path Forward targets an increase in the adult literacy rate from 36% to 56% between 2004 and 2015, which meets the Millennium Development Goal³ but it does not outline any government strategy to achieve that.

Within the Ministry of Education, the Department of Functional Literacy and Non-formal Education has staff at the central Ministry and provincial department levels. However, capacities are extremely low, lack of background or training in literacy, and low government salaries that do not attract competent staff.

The MOE runs literacy schools and courses primarily in urban centers. 2003 data show 10,864 courses with 249,571 students and 6,843 teachers, with the large majority of teachers and students being male. The program includes both basic literacy and higher-level courses with a science, history, math curriculum similar to the MOE, with 60% of courses covering vocational skills such as tailoring. Students who complete the course can enter government secondary or vocational schools; most choose the latter. The curriculum is comprised of primers published many years ago, using an alphabet-led approach, that is considered by internationals and experienced Afghans as extremely poor pedagogically.

b. *External support*

UNICEF and UNESCO have developed a women's literacy text but have no funds to print the books. UNICEF's and UNESCO's new literacy texts are

³ (reference, if not discussed earlier)

more linked to life skills than the old national curriculum, and depend more upon active learning. Both organizations have worked closely with the Literacy Department to co-develop these materials and therefore to get buy-in and designation of their materials as a national literacy curriculum or approved materials under the MOE. JICA is funding a Japan/UNESCO effort to replicate a community learning centers model developed elsewhere by UNESCO. A few of these have been built in Kabul/Kabul province but with no funding for programs as yet. The Literacy Department seems to endorse these as the future direction. IRC, CARE, GTZ, AIL and others have had or are carrying out literacy efforts, some as stand alone, others in conjunction with other activities; Relief International states it has trained 7,000 women in functional literacy. Many individuals and small groups offer literacy classes throughout the country, most without adequate training; many provide services for a small fee and some are funded by donors.

5. Summary of binding constraints in the Education Sector

In every sub-sector of education—basic education, higher education, vocational skills training and literacy for out-of-school youth and adults—the constraints to progress are similar: pay for teachers, shortage of teachers, poorly trained teachers, poor teaching materials, lack of instructional materials/equipment and lack of facilities. The *binding constraints*—those that must be reduced if more students are to receive a quality education—are the dire lack of competent teachers/trainers and classrooms, schools and other instructional settings that provide a suitable learning environment.

III. Funding.

Financial Plan. The financial plan for the Program is set forth in the attached tables. Changes may be made to the financial plan by representatives of the Parties without formal amendment to the Agreement, if such changes do not cause (1) USAID's contribution to exceed the amount specified in Section 3.1 of the Agreement, or (2) the Grantee's contribution to be less than the amount specified in Section 3.2 of the Agreement.

IV. Results To Be Achieved/Results Framework.

A. Health Sector Result

The Objective of a better educated and healthier population is supported by the Result which is increased access of women and children under the age of five to quality basic health services, especially in the rural and underserved areas.

The Result is supported by four sub-Results or Intermediate Results, described below:

1. Expanded access to quality BPHS services

In addition to supporting the provision of basic services at the basic and comprehensive Health Center (CHC) levels, USAID will support the provision of the Essential Package of Hospital Services (EPHS). In coordination with communities and the MOPH, USAID will build and rehabilitate clinics, hospitals and other health facilities improving BPHS and EPHS implementation. This package will be implemented in district and provincial hospitals.

USAID will help the ministry provide pre-service education and in-service training. A more intense and consistent effort is needed to train health workers in both pre and in-service. The current efforts are not sufficient in scope to meet the needs of the population. Currently, only 50% of the population has access to BPHS services.

2. Improved capacity of individuals, families and communities to protect their health

To complement all of the work that is being done to train providers, strengthen health systems and increase access to services, USAID will also support activities that improve the capacity of individuals and communities to become active consumers of health services and make informed decisions about their health. This will be accomplished by developing and disseminating health messages and creating linkages between communities and service points.

3. Strengthened government health systems

The program will improve the capacity of the Ministry of Public Health to do health research. Begin and build the capacity to do health research that will eventually lead to an increased volume of reliable data and evidence-based decision making. It will also support the development of a quality assurance system. Steps need to be taken to encourage the development of a low-tech quality assurance system to monitor at the quality care being given at the community level.

4. Improved capacity of the private sector to provide health products and services

Previously social marketing was included in the expanding access to quality services result. Evidence suggests that approximately 80% of health services, although generally low quality and unregulated, in Afghanistan are provided by the private sector. While it is difficult to predict, experts speculate that even when public facilities improve and attract more users, the private sector will continue to be the main provider of care for the majority of the population. Because so many people in Afghanistan rely on private doctors, midwives and pharmacists to provide services as well as health products, USAID feels additional investment is essential. This Intermediate Result seeks to develop the private sector by expanding the range of products and services provided by the private sector while at the same time improving the quality of the services they offer.

B. Education Sector Result

The Objective of a better educated and healthier population is supported by the Result which is increased access of children, youth and adults to quality teaching and suitable learning environments.

The Result is supported by Intermediate Results in three sectors described below: basic (primary and secondary) education, literacy and occupational skills training, and higher education. Each of the Intermediate Results is supported by sub-results.

1. Basic (primary and secondary) education

Development hypotheses. Afghan students need to acquire knowledge and skills that prepare them for leading meaningful and productive lives. The critical inputs into an education system that provides these skills and knowledge are qualified teachers and a suitable learning environment. Teachers must not only know their subject matter; they must also be able to help students acquire new skills and knowledge and to think critically and creatively about information presented. Students must also have access to a safe and healthy learning environment.

(a) Intermediate result 1: Primary and secondary students with knowledge and skills to better prepare them for productive lives. It has three sub-Intermediate Results.

(i) Sub-result 1.1. Teachers who know their subject well and use learner-centered methods to teach it.

In cooperation with the MOE and implementing partners, USAID will improve teachers' subject knowledge and teaching skills through a comprehensive in-service teacher training program that uses a multiple strategies. Short, needs-based, practical courses may be developed and targeted to basic education teachers nationwide with a special effort to include MOE, community-based schools and early childhood development initiatives, which may include madrassas, in underserved areas. The approach will entail school-based, provincial, distance, and face-to-face training. Over time and with proper follow-up this will lead to a measurable improvement in teacher performance.

(ii) Sub-result 1.2. A sustainable MOE system supports continuous teacher development.

Through training and technical assistance, USAID will ensure that the MOE develops the institutional capacity to provide quality training and support to in-service teachers. USAID assistance will include development of teacher standards; training packages for teachers, inspectors, and headmasters; linkages between parents/community groups and schools; cadres of master trainers, teacher trainers and training managers; teacher networks, a training monitoring and evaluation system; and a EMIS to track and report on training. Throughout the 5 years of the basic education strategy USAID will work closely with the

MOE and implementing partners to increasingly take over, manage, and fund a national in-service teacher training and support system.

Sub-result 1.3. More schools providing a safe and healthy learning environment.

USAID will also focus on ensuring greater access to a suitable learning environment by working in partnership with communities, implementing partners, and the MOE to build and rehabilitate schools, again with an emphasis on primary level early childhood development and underserved areas.

2. Higher education

Development Hypothesis. The Agreement is designed to assist the Afghan nation in the development of human capital and emerging leadership. A key constraint to this development is the poor quality of tertiary education, including professional education and training. Good-quality education, in turn, hinges more than any other factor on the competence of teachers. In conjunction with the Ministry of Higher Education, and using an integrated approach that takes into account the efforts of other donors and organizations, USAID will focus on the enhancement of selected existing departments/faculties and the introduction of private higher education.

(a) Intermediate Result 2: Higher-level students with knowledge and skills that prepare them for productive lives. It has two sub-Intermediate Results.

(i) Sub-result 2.1. Upgraded standards, teaching, facilities and equipment in teacher-education institutions and selected faculties

USAID will focus first on teacher-education institutions as they prepare the teachers of tomorrow and thus help strengthen I.R 1. Within the confines of available resources, USAID will also select other departments/faculties for assistance based on the following criteria: government development priorities, USAID objectives, opportunities, unmet needs, and cost-impact trade-offs, and donor complementarity.

(ii) Sub-result 2.2. Private, American-style higher education

The development of an American University of Afghanistan will provide the benefits of an American-style university education to the next generation of Afghanistan's leaders. Since existing Afghan universities do not provide appropriate training in management and other business-related subjects, public administration, or in programs designed to cultivate women's leadership, these are the areas that will form the initial focus of AUAF. The building of an American University here will give Afghanistan the opportunity to become an educational and cultural center for all of central Asia and will ensure that the leadership of this country has an American-style education with democratic values.

3. Literacy and occupational skills training

Development hypotheses. There is a huge gap between Afghanistan's literacy and occupational needs for its recovery and long-term development and the pool of skills currently available. Efforts to fill this gap are being carried out by the government and several donors in the formal and non-formal sector. At the community level, non-literacy rates vary according to region and gender but average between 70 – 90%, with the highest rates in rural areas and among women. Adults and young people who lack literacy have less opportunity to improve or develop new occupational skills. Separate from literacy, adults lacking basic occupational skills either perform at a sub-standard level or lose out on jobs openings to more qualified foreign workers.

To develop literacy and occupational skills on a wide scale, USAID will pursue two approaches. The first is to model, then expand, literacy and productive skills development through the extensive network of the elected Community Development Councils of the National Solidarity Program (NSP). The Councils will mobilize community resources and provide support, especially for participation of women and girls. The Councils will help facilitate a program of literacy linked with economic skills and assets development.

USAID will also strengthen the capacity of the Ministry of Rural Rehabilitation and Development (MRRD) to ensure continued support of community-based literacy and occupational skills training programs.

A second approach will address the market's need for skilled workers including on USAID and other donor-funded projects. It will focus on strengthening private sector capacity to provide quality integrated vocational and literacy training. Through an umbrella mechanism, USAID will award grants/contracts to training providers for job-training required by USAID projects. Recognizing the weaknesses in this sector, USAID will also offer training and TA to ensure a pool of qualified and competitive training providers.

(a) Intermediate Result 3: Out-of-school adults and youth with literacy and occupational skills.

(i) Sub-result 3.1. Develop community-based literacy, numeracy and life skills training, particularly for women and girls.

USAID will work through communities and locally elected Community Development Councils of the National Solidarity Program to implement literacy linked with economic skills and strengthened participatory governance based upon prioritized needs of local communities.

(ii) Sub-result 3.2. Strengthen MRRD capacity to support community-based programs for literacy, numeracy, and enterprise skill training.

To build long-term sustainability, USAID will provide training and technical assistance to the Ministry of Rural Rehabilitation and Development to effectively plan, manage, and evaluate community-based programs

(iii) Sub-result 3.3. Develop a Center for National Literacy.

The Center will produce appropriate pedagogy and materials adaptable to various skills needs, and provide training for quality literacy, numeracy and life skills linked with productive skills development. The Center will provide these as a resource for all relevant Mission sectors to meet their objectives for literacy and productive skills development, and for the Ministry of Education and organizations of civil society to offer quality literacy training. The Center will also develop an innovative program for training of literacy trainers and literacy teachers with a stepped certification process that creates and supports a vocational career path for adults and young people, particularly women and older girls.

(b) Intermediate Result 4: A private-sector market for vocational training.*(i) Sub-result 4.1. A framework for a system of vocational standards and qualifications.*

In order to provide larger numbers of learners with timely acquisition of vocational skills, Afghanistan will need a system for vocational standards and qualifications. The system will eventually be able to articulate course objectives with corresponding job qualifications and certify learners' fulfilment of course requirements. The first stage of the system is a framework that complements the primary-secondary curriculum for all students.

(ii) Sub-result 4.2. Model private training organizations.

Because it has few models of private vocational training organizations, Afghanistan will benefit from a few successful organizations that serve as models for others. The training organizations will offer modularized courses, so that learners can acquire specific skills within a short period of time and move directly into an entry-level job or advance to a higher-level of certification. Short, modularized courses allow more learners to access the system, because each training centre can accommodate more students in a given period of time.

V. General Indicators

Through USAID's support to the Ministry of Public Health (MOPH) it is anticipated that by 2010 that there will be 14 fully functioning Provincial Hospitals that have been newly constructed, or renovated and equipped. In addition, these hospitals will have a full compliment of trained staff with adequate supplies to deliver the Essential Package of Hospital Services (EPHS). Below the hospital level USAID inputs will allow 100% of the population in 14 provinces to have access to the Basic Package of Health Services (BPHS) that are provided by a compliment provider in a new or refurbished facility that has the required compliment of drugs. Between services provided in hospitals, comprehensive and basic centers approximately 11,992,716 people will have