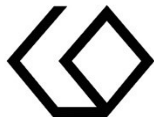

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Master: Health Education

Master's Thesis

Theme:

„Health and Health Promotion in Developing Countries: A Case study of Community-Based Health Promotion Approaches in Afghanistan "

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Note: This text corresponds almost completely to the master thesis, only a few changes in formatting and grammar were made for this online publication.

Abstract

Community-based health promotion approaches have proven to be very appealing and effective in rural and under-resourced countries such as Afghanistan. Surprisingly, however, empirical evidence and practical recommendations are lacking for Afghanistan, a country with some of the worst health indicators worldwide (e.g., maternal mortality rate). The purpose of this mixed-method exploratory case study was to identify community-based approaches to health promotion in Afghanistan and the factors that lead organizations and activities to succeed and sustain despite challenging circumstances. The author conducted extensive secondary research, a scoping review, 28 semi-structured oral qualitative interviews with people working in health projects in Afghanistan, and obtained 22 written responses to a qualitative questionnaire sent to NGOs working in the health sector in Afghanistan as well. After transcribing and analyzing the content, she was able to exhaustively explore the topic by integrating and triangulating multiple perspectives.

First, she presented the findings regarding the prerequisites for and determinants of health in Afghanistan by contrasting qualitative and quantitative data. This comprehensive overview illustrated not only the poor conditions and numerous challenges but also the diversity within the country. Second, she described the findings on the Afghan health system, structured along the components of the WHO Health System Framework. This allows for comprehending the well-planned strategies and comparing them to the actual situation. Third, she identified most (NGO-supported) healthcare providers and conducted a gap analysis of existing activities in 13 areas of health. Fourth, the qualitative findings provided insights into the concept of health, common health practices, community-based healthcare approaches, and success factors for working in Afghanistan. Overall, there are various health activities and approaches to health promotion in Afghanistan. The most successful approaches were those that work in the community, with trained female health workers who are trustworthy, committed, and paid, and who provide curative as well as preventive and promotive services. For working successfully in the Afghan setting, trust, collaboration with leaders, community participation, and training are highly recommended. Nonetheless, all activities took place in a context characterized by insecurity, corruption, poverty, low level of education, and cultural constraints.

The author proposed the concept of “health care plus and beyond” as an approach applicable to all providers. This concept includes taking care of the immediate health need of

the person and, at the same time, empowering them to improve their health. In conclusion, there is a great need for health promotion and health education in Afghanistan, which is worth exploring further. This study could not provide a complete picture, but it does provide a very good first-hand understanding of the numerous influencing factors and facets of community-based health promotion, thus providing numerous starting points for further research and practice.

Acronyms

BHC	Basic Health Center
BPHS	Basic Packages of Health Services
CBHC	Community-based Health Care
CBPH	Community-based Health Promotion
CDC	Community Development Committee
CHC	Comprehensive Health Center
CHN(E)	Community Health Nurses Education
CHW	Community Health Worker
CM(E)	Community Midwife Education
CSO	Central Statistic Office
DP	Disease Prevention
EPHS	Essential Packages of Hospital Services
FHAG	Family Health Action Group
HE	Health Education
HP	Health Promotion
HW	Health Worker
MoPH	Ministry of Public Health
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Acknowledgment

I would like to thank everyone who contributed to this study. It has been a fascinating journey to get to know different people and approaches that attempt to sport people in Afghanistan.

It was my great privilege to be in touch with so many great people who are very committed and passionate about working in Afghanistan. I am often very impressed by your strength, joy, and support. Thank you so much!

It was a great honor to learn from you and to be inspired by you. I wish you all the best in your further work.

Freiburg, 25.01.2017

SECTION I: INTRODUCTION, THEORETICAL BACKGROUND, AND METHODOLOGY

1 Introduction

"God bless you with good health" or "Good health" is one of the most common wishes worldwide and indicates the relevance of health in people's lives. Health is one of the world's most valuable "goods" and resources. It is empirically proven that there are multiple strong correlations between health and - on the individual's level - the quality of life, wellness, education, and income – but also nationwide with development. Some researchers argue that health is the key to development (UNFPA 2013). The empirically proven fact that richer and more educated people are also healthier can be seen within a group of individuals, a nation, and worldwide. A review of the current health status around the world shows an enormous gap and inequity between the health status and the burden of diseases in the richest countries compared to low-income countries (Houweling et al. 2007). An individual's health behavior cannot simply explain this huge gap. It is strongly influenced by social, economic, and environmental factors (WHO 2008, 1986). Many studies provide scientific evidence that context plays a major role in a person's positive or ill health. In formerly called *developing countries*, most of these relevant circumstances are manifested inadequately, such as a low level of education or a shortage and lack of sanitation facilities, quantity and quality of nutrition, and the provision of health services. All these factors are responsible for a high prevalence of environmental-prone and preventative diseases in these countries (WHO n.d.b). Some countries are even worse off due to additional state fragility, physical geography, recurrent natural and human-made disasters, insecurity, and war. One of these, in multiple ways, affected countries is Afghanistan. It "*is experiencing the devastating cumulative effects of over three decades of war and instability*," states Harvard University (2013). Also, Afghanistan faces numerous environmental health challenges, such as unsafe drinking water, inadequate sanitation facilities, and drainage and water supply. Furthermore, improper solid and hazardous waste management or even chemical contamination, poor air quality, and unhygienic food handling (WHO 2016d). Furthermore, Afghanistan suffers from inadequate state capacity, insecurity, a high rate of illiteracy and unemployment, (multidimensional) poverty, drug problems, trafficking, malnutrition, cultural constraints, and a high rate of inequality (CMI 2005). All these factors strongly impact the physical, mental and psychological health of Afghans (WHO 2008, 2016d, 2010c; MoPH 2015c).

Afghanistan was chosen for this master's thesis for multiple reasons. The first one is (a) health situation related: Afghanistan demonstrates the unneglectable impacts of determinants of health and the remarkable improvements in its health status within the last 15 years within a post-war conflict-affected country. The second one concerns (b) its geopolitical significance. Afghanistan evoked the international interest of more than 50 countries that contributed intensively to the reconstruction but are now reducing their involvement in the transition period. The third reason is (c) the current overall deteriorating situation. It is intensified by massive migration movements and the withdrawal of international support. Therefore, there is an urgent need for more well-developed, effective, sustainable health activities to sustain and maintain the recent gains in the health sector. The fourth reason is based on (d) a general lack of research in the Afghan health sector, particularly best practice examples in health promotion. The last reason is (e) personal interest. The researcher was part of a research group at the University of Education in Freiburg, Germany, which explores support strategies for education and health promotion in Afghanistan.

Three major shortcomings in health services become evident not only from an academic point of view but are also underpinned by the experience of practitioners. These are the 'three wrongs' in health services: wrong gender, wrong skills, and wrong location (Loevensohn in WoodrowWilsonCenter 2006). In addition, there is a very thin base of scientific publications focusing on health promotion activities in Afghanistan. Some practitioners state the importance of establishing the medical service first and focusing on health promotion. Others – particularly those who embrace a public health perspective – emphasize the need to address health determinants and enhance health education and health promotion. Practitioners reinforce their point of view by providing common examples and referring to regional myths, superstitious beliefs, and common health practices in Afghanistan, which should be addressed by health promotion. One of the numerous examples is the practice of mothers placing their newborn babies in cow dung to keep them warm, despite the fact that the child has already become sick in this highly infectious environment earlier. Common beliefs are that "breastfeeding your baby in the first two days is harmful," that "only drinking liquids after an operation will strengthen your body," and that "a good doctor is only the one who prescribes several drugs" (conversation with Afghan doctors, 27.9.2016). Other critical points are some practices of traditional healers which often lead to a late referral to a clinic when the disease is severe or even chronic. Neither the living conditions, myths, nor common health practices are sufficiently addressed within the current healthcare services (Newbrander et al. 2014b). Due to these environmental issues and the numerous empirically investigated barriers to health care for a large proportion of the population, the MoPH states, "what Afghanistan needs more of is health" (MoPH 2015c, p.19). Irrespective of the chronological order and priority of healthcare services and health promotion, it is empirically proven throughout the literature on the health situation in developing countries that both are essential and not replaceable. Exploring

Afghanistan without considering the challenging conditions would lead to wrong interpretations and conclusions. AREU deplores this and calls it the 'conflict-blindness' of literature on service delivery (AREU 2016). Studying the manifestation of the prerequisites and determinants of health in Afghanistan intensively and analyzing the developments in the last 15 years, the author summarized her observations as follows. Because of the various challenging conditions in Afghanistan, all health promotion activities are prone to collapse at the end of the project phase (as has been demonstrated by many NGOs lately). However, despite this reoccurring pattern, some NGOs and approaches show surprising resilience and sustainability even within these challenging circumstances. The author was inspired by the researcher Antonovsky who asked: "Why, when people are exposed to the same stress which causes some to become ill, do some remain healthy?" (Antonovsky 1984). Similar to Antonovsky's salutogenic perspective, the author was curious to identify existing approaches among NGOs and explore why they are sustainable and what can be learned from them. Therefore, this thesis aims to conduct a systematic and explorative inquiry into good practices in Afghanistan's community-based health promotion approaches. This is in line with one of Afghans' MoPH formulated aims: Expanding the evidence basis "regarding health-related knowledge, attitudes and behaviors and effective strategies that promote support positive health behaviors/healthy lifestyles in Afghan communities" and "to advocate for and promote healthy environments" (MoPH 2012c). With the following research questions, the author wishes to close the research gap concerning the lack of systematically explored health promotion approaches in Afghanistan to provide empirical evidence for Afghanistan and different developing countries.

- What types of community-based health promotion approaches exist in Afghanistan?
- What are the reasons behind their resilience and success despite the challenging circumstances?
- What practical recommendations can be given for evidence-based health promotion in Afghanistan?

To shed light on these topics, an explorative mixed-method case study approach with methodological triangulation is used. Throughout this thesis, the author intends to provide evidence-based, accurate, timely, and action-oriented information on health promotion in Afghanistan. She strives to find best practice examples and assess health promotion approaches critically. However, this study cannot address all health-related issues exhaustively in Afghanistan but aims to provide first ideas on health promotion and a deeper understanding of the various dimensions relevant to it.

This thesis is structured into three main sections and ten chapters. The first section is divided into three parts, the introduction, the theoretical background, and the methodological approaches. In the second section, the five leading questions are covered starting in chapter four with a general

presentation of the health status, the prerequisites, and determinants of health, as well as an overview of diseases. Chapter five gives an overview of the health system using the WHO health system framework. Chapter six presents the findings of the systematic exploration of health service providers and the results of a gap analysis of health activities. Chapter seven covers the concept of health, typical health-seeking behaviors, and common health practices. The last chapter in the results section presents the findings of the health promotion approaches, gaps, good practice criteria, and recommendations. Each chapter of these five-part studies ends with a summary, a short discussion, and a conclusion. The final chapters, nine and ten, focus on a critical discussion of the study design and the hypothesis, draw conclusions, and make suggestions for further research and action by politicians and practitioners.[1]

[1] A further initial remark. The author's intention was to provide an easy understandable, comprehensive report on her research. Therefore, she refrained from the German rule for scientific writing. This is to write complex, very elaborated sentences by using a waste variety of words. Instead, she applied the common role for English writing with the highest goal of readability.

2 Theoretical Background

The purpose of this chapter is, first, to establish a common understanding of the relevant terms by defining them. Then, it reviews empirical work on health education in developing countries and Afghanistan. Next, it introduces relevant theories and closes with formulating the research questions.

2.1 Definitions of Key Terms

2.1.1 Health, Health Promotion, and Related Terms

For this thesis, general terms such as health and health promotion need to be defined to distinguish them from related words such as health education, disease prevention, and public health. Additionally, the conditions in which people live, the prerequisites for and determinants of health, community, and setting are specified based on the WHO glossary (Nutbeam 1998).

Following the WHO's constitution in 1948, **health is:**

"*A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities"* (WHO 1986 cited in Nutbeam 1998, p. 1). One recommended strategy to improve health **is health education**, which "*comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health"* (Nutbeam 1998, p.4). In accordance with this definition, "health education" is in this master's thesis always referred to as some form of teaching focusing on individuals and their health behavior. In contrast, health promotion is a broader concept that integrates learning opportunities for people to improve their healthy lifestyle but extends its scope to a new dimension to address holistically environmental conditions as well. ***"Health promotion*** *represents a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals but also action directed towards changing social, environmental, and economic conditions so as to alleviate their impact on public and personal health.* ***Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health****." (Nutbeam 1998, p. 1)*

In the Ottawa Charta, the WHO identified five approaches to health promotion: (1) Building Public Policy, (2) Reorienting Health Services, (3) Strengthening Community Action, (4) Developing Personal Skills, (5) Creating Supportive Environments. (WHO 1986) As research on publications about health in Afghanistan shows, several publications can be found on the first two strategies (WHO 2010c; Salama and Alwan 2016; Dalil et al. 2014). In summary, this thesis wishes to have a fresh look at health promotion by emphasizing the last three approaches in the communities, respectively rural communities.

In health promotion, a community is usually referred to as *"A specific group of people, often living in a defined geographical area, who share a common culture, values, and norms, are arranged in a social structure according to relationships which the community has developed over a period. Members of a community gain their personal and social identity by sharing common beliefs, values, and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them." (Nutbeam 1998, p.5)*

Within the last few years, practitioners and researchers in health promotion univocally said that a good knowledge of the individual's concepts of health and common health practices is essential and has theoretical and practical implications for all people working in the health sector. Several studies and multifaceted experiences of health workers have shown that the individual's **concept of health** and illness influences their health attitudes, behavior, and thoughts about health and sickness (Boruchovitch and Mednick 2002).

Disease prevention is one additional concept often mixed up with health promotion**.** They are defined as "specific, population-based and individual-based interventions for primary and secondary (early detection) prevention, aiming to minimize the burden of diseases and associated risk factors." (WHO n.d.c)

2.1.2 Prerequisites and Determinants of Health

To better understand the situation in which health is gained and protected, the WHO has pointed out that it is not necessarily or exclusively the individual's behavior, but the contextual factors determine health. These influencing factors are called the prerequisites for and determinants of health. Prerequisites are, following the WHO definition, "fundamental conditions and resources for health" (WHO 1986), whereas the determinants of health are defined as "the range of personal, social, economic and environmental factors which determine the health status of individuals or populations." (Nutbeam 1998, p.6). The following table (Table 1) provides an overview of the main indicators commonly referred to as each dimension. Economic factors are not listed again because they are already integrated into the prerequisites.

TABLE 1: PREREQUISITES AND DETERMINANTS

Prerequisites	Environmental Determinants	Social Determinants	Personal Determinants
• peace, • shelter, • education, • food, • income, • a stable eco-system, • sustainable resources, • social justice • (is) equity	• Transport, • Food and Agriculture, • Housing, • Waste, • Energy, • Industry, • Urbanization, • Water, • Radiation, • Nutrition	• social gradient, • stress, • early life, • social exclusion, • work, • unemployment, • social support, • addiction, • food, • transportation	= the person's individual characteristics and behaviors • Gender • Genetic • Risk & protection factors • Concept of health • Lifestyle and coping strategies • Healthcare-seeking behavior
(WHO 1986)	(WHO 2016c)	(WHO 2003)	(WHO 2016c)

The WHO repeatedly demonstrated the vital role of environmental factors. For example, in 2012, the WHO stated that 12.6 million deaths globally were attributable to the environment. This has been 23% of all deaths. If one removed the environmental risks, 26% of all deaths of children <5 could be prevented. (WHO 2016a). The impact of these environmental factors on ill health and death is shown in Table 2.

TABLE 2: ENVIRONMENTAL RISK AND RELATED DISEASES (WHO 2016A)

RISK FACTORS	Related Disease	Estimations of deaths globally from the most significant environmental-related causes or conditions annually (WHO n.d.b)
Outdoor air pollution	respiratory infections, selected cardiopulmonary diseases, lung cancer	Urban air pollution: 800,000
Indoor air pollution from solid fuel use	COPD, lower respiratory infections, lung cancer	Esti. 1.6 million people
Lead	mild mental retardation, cardiovascular diseases	230,000 (97% in the developing world)
Water, sanitation, and hygiene	diarrhea diseases, trachoma, schistosomiasis, ascariasis, trichiniasis, hookworm disease	Est. 1.7 Mio people
Climate change	diarrhea diseases, malaria, selected unintentional injuries, protein-energy malnutrition	Malaria: 1.2 Mio people (mostly children); further climate change: 150,000
Selected occupational factors		
Injuries	unintentional injuries	Road traffic: 1.2 Mio (90% in low and middle-income countries9
Noise	hearing loss	
Carcinogens	Cancer	
Airborne particulates	asthma, COPD (chronic obstructive pulmonary disease)	
Ergonomic stressors	low back pain	
		Unintentionally poisoning 355,000 (2/3 in developing countries)

Most of the deaths reported in Table 2 occur in low-income and least-developed countries, plus all other countries that have formerly been classified as *developing countries*. Furthermore, infectious diseases are far more widespread than in higher-income countries. This indicates the need for a multi-sectoral approach to improve health, e.g., by working together in the water, sanitation, and hygiene (WASH) sector, in agriculture and nutrition, and in environmental health, such as waste management (BROWN et al. 1992). Apart from a poor manifestation of the prerequisites for and determinants of health, the following repeatedly identified issues play a crucial role in developing countries: Medical expenses, indirect costs of transportation and time of being away, the stigma associated with the illness and/or the treatment, communication breakdown between providers and patients, limited health literacy, presence of too few health workers, problems in drug procurement (Weaver et al. 2015).

2.2 Review in Developing Countries[2] and the Role of Community-based Health Promotion

Reviews on evidence-based health promotion or health education in a developing country can barely be found (McMichael et al. 2005). There is only one review on RCTs that summarized that there is (a) a lack of available scientific papers, (b) the reporting of these papers is poor, and (c) identified four best practice criteria. These are: "using a few messages, of proven benefit, repeatedly, and in many forms" (Loevinsohn 1990). In 1987, Elder reviewed and discussed the application of behavior modification (primarily operational conditioning) to health promotion in developing the world (Elder 1987). Even though there are studies on the proven benefit of health education in developing countries, there are several reasons why health education can fail. Hubley identified the following four overlapping categories: (a) failures in the planning process to apply epidemiological and behavioral sciences to the selection of appropriate objectives; (b) communication failure in reaching the intended audience and promoting understanding ad acceptance of messages; (c) failures in the organization of health education services and the weak status of the specialist health educator; and (d) failure in the evaluation process and the dissemination of research into decision making (Hubley 1988). Therefore, in 1986 the WHO also recommended: "*Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems."* (WHO 1986) [3] Later Glanz et al. summed up their study on health education

[2] There is an important linguistic debate going on concerning the proper wording, the prejudices, and underlying presumptions of using the word '**developing countries**'. This study echoes the elaborations by Hubley 1988. The author dissociates herself from any colonialist, premodern connotation that might resonate with this term. The author decided to use this wording for two reasons (a) because there is a bundle of major diseases and factors that are common and predominant in so called developing countries and one can benefit from studying their experiences and (2) she could link her study to the huge body on research literature concerning health in developing countries.

[3] A widely used tool for health promotion and health education in low-income countries are the materials of Hesperian "where there is no doctor" Werner.

approaches with the following suggestion for effective programs. The good practice examples are: (1) a good program-to-audience match; (2) accessible and practical information; (3) active learning and involvement; and (4) skill building, practice, and reinforcement." (Glanz et al. 2008, p. 516). All these statements resonate with the call for the need to take into consideration that one approach will not fit all.

2.3 Evidence-based Health Promotion, Scientific Theories, and Models

The combination of the best scientific evidence with expertise on individual needs is echoed in the growing worldwide trend towards evidence-based decision-making and intervention. "*Evidence-based health promotion is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individuals, communities, and populations. The practice of EBPH means integrating local expertise with best available external evidence yielded by systematic research*" (Rada et al. 1999). This has to be contrasted with evidence reviews which are "defined as those using formalized methods to collect, prioritize, and weigh the findings of intervention research" (Glanz et al. 2008, p.17). Two common approaches in health promotion are to use theoretical frameworks or models. The former can guide "the pursuit of successful efforts; the maximize flexibility and help to apply abstract concepts of theory in ways that are most useful in diverse work settings and situations." (Glanz et al. 2008, p. 516) Additionally, the knowledge of theory and a comprehensive planning system can also help. Before analyzing health promotion approaches in Afghanistan, the author introduces common analytical frameworks for health promotion and points to several theoretical models that can be used as a reflection framework later.

2.3.1 Analytical Framework

A variety of different frameworks were developed for health promotion. They help to systemize, describe, and analyze existing health promotion approaches. Five of the most commonly used are briefly introduced here. The first was introduced in 1985 by Tannahill. He showed that health education, health protection, and prevention are different facets of health promotion. The three facets overlap (Tannehill 2008). Another model was introduced by Beattie's who differentiates health promotion approaches along the dimensions: individual vs. collective and authoritative as well as negotiated. So, he defined four manifestations of health promotion along these dimensions. Such as health persuasion, legislative action, personal counseling, and community development (Beattie 1991). A third strategy to differentiate the health promotion approaches is suggested by Naidoo and Wills, who refer to health promotion as either medical, education, behavior change, empowerment, or social change (Naidoo and Wills 2016). A fourth often used health

promotion model is the rainbow model by Dahlgren and Whitehead. This model places the individual in the center and has layer by layer the different influencing factors on health, such as immediately the individual lifestyle factors, then the social and community networks, followed by living and working conditions as well as the overall socioeconomic, cultural and environmental conditions (Dahlgren and Whitehead 1991). The European Health Promotion Monitoring System (EUHPID) is a comprehensive analytical framework.

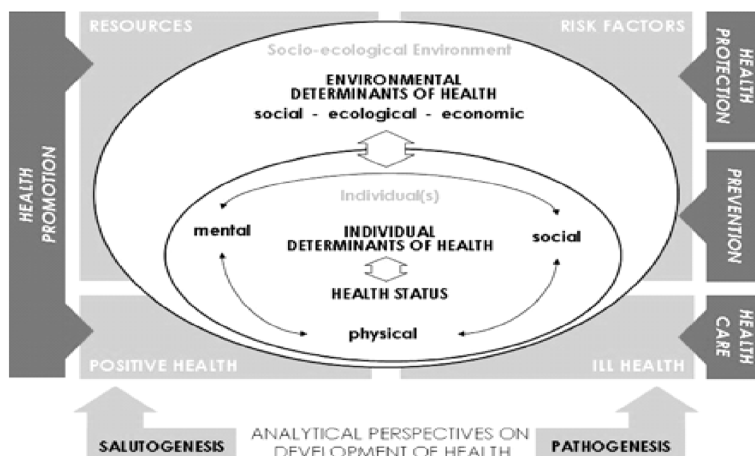

FIGURE 1: EUHPID-MODEL

The EU initiated 2004 the development of this framework for the European countries by consulting several experts from the health sector and improving the preceding model of the European Community Health Indicators (ECHI) framework (Figure 1). In this thesis, the author presents the generalized version, which the main authors suggested in 2006. The model differentiates between two levels: the individual level, which has a closer look at the individual determinants of health and the health status in the three aspects social, physical, and mental. Additionally, on the socioeconomic level, it addresses the environmental determinants of health, such as social, ecological, and economical. Furthermore, one benefit of this model is that it distinguishes between two main analytical perspectives. The salutogenic perspective focuses on positive health, the resources and finds its expression in health promotion. The second perspective is the traditional pathogenic perspective, focusing on ill health and risk factors influencing health protection, prevention, and health care. Strengths of this model are its transparency, easy understandability, integration and clear distinction between the most important concepts defined above, and integration of the underlying perspectives in medical and health science. (Bauer et al. 2006) Whereas this model is static and can help classify different approaches, it cannot explain nor predict dynamical changes and interlinkages of factors.

2.3.2 Health Promotion Theoretical Models, concepts, and instruments

When describing, explaining, and even predicting health behavior and health promotion on a micro-level, researchers and practitioners have developed various theoretical models, as presented

below. Furthermore, there is a wide range of instruments[4] for measuring health. The benefit of health promotion theories can be seen in their utilization as a toolbox, a foundation, a road map, a guide, and a compass (Mitic et al. 2012, 19). Glanz et al. structure the different approaches into three main categories – individual, interpersonal, and group (Glanz et al. 2008). Whereas the first models try to define very clearly certain aspects that explain a person's behavior, for the latter, a very precise description becomes vague (see references[5]

- The widely applied models of individual health behavior are the (1) Health Belief Model (HBM), (b) Trans-Theoretical Model (TTM) and Stages of Change, (c) Theory of Reasoned Action (TRA) and Theory of Planned Behavior, (e) Rational Model, (f) Extended Parallel Model, (g) integrated behavioral model, (h) Health Action Process Approach and the (i) Salutogenic model
- Models of interpersonal behavior are: (a) Social Cognitive Theory and social learning theory, (b) Social Networks and social support, (c) stress, coping, and health behavior, (d) Patient-Provider Interaction, (e) Health promotion model (Pender 2011)
- The community and group models of health behavior change include: (a) improving health through community organization and community building, (b) Diffusion Theory/ Diffusions of Innovations, and (c) (socio-)ecological approaches as well as (d) communication theory.

All these theoretical models point to the huge determinant/influence of the concept of health and health-seeking behavior. They all indicate that only targeting the information side is not enough.

Despite this impressive body of health promotion theories and models, most of them are conceptualized in Western countries. Research has argued for the need to consider possible shortfalls/traps by applying western-derived theories, models, concepts, and evidence from developing countries. Hubley identifies several features which distinguish "developing countries from western industrialized countries and assess their implications for health education practice." He stresses the following areas which are not applicable: "the health education roles of different cadres of field workers; the social science theories underlying health education; the selection of communication media and methodology for health education research" (Hubley 1988). Instead of inventing a new model or applying one of these western-derived theories to create a new program – and so be most likely to fall into the same trap as many others, the author decided to explore the existing health promotion approaches. This list of theories was given as an overview of the many available models, and it will serve as a foundation for comparing the findings with the existing theories in the west.

[4] Some instruments that can be used to measure health (a) Health Risk Appraisal, (b) Health Enrollment Assessment Review, (c) Health Promoting Lifestyle Profile, (d) behavioral Risk Factor Surveillance System, (e) Medical Outcomes Study, (f) Wellness Evaluation Battery, (g) Data Envelopment Analysis (Galloway 2003).

[5] Pender 2011; Glanz et al. 2008; Galloway 2003

2.3.3 Good Practice Criteria

Instead of applying certain models and theories exclusively, a growing body of public health and health promotion researchers and practitioners prefer to assess public health interventions by a certain set of criteria. These criteria are often derived from expert consultations using the Delphi method or systematic reviews. These ‘good practice’ criteria can either be the four core components of (1) the efficacy of interventions, (2) the level of existing human resources, (3) the infrastructure, and (4) the level of community support (McDonnell et al. 2007). This can also be the eight criteria for selecting best practices (Ng and Colombani 2015)[6]. Apart from these criteria for assessment, practitioners often define a set of good practice criteria for developing their interventions. The assumption is that the intervention is more likely to be successful by applying these criteria than without considering these criteria. Several lists of criteria are often used as guidelines: e.g., quality criteria for preventative measures[7] (Goldapp et al. 2011), the twelve best-practice criteria[8] (gesundheitliche Chancengleichheit 2016), the Paris Declaration on Aid Effectiveness (OECD 2009b),[9] the logical framework with its five components of relevance, effectiveness, efficiency, impact, sustainability (OECD 2009a), or the guiding principles for health promotion initiatives provided by the WHO: empowering, participatory, holistic, intersectoral, equitable, sustainable, and multi-strategy (Rootman et al. 2001)The use of good practice criteria in health promotion is demonstrated, e.g., by (Mielck et al. 2016). All of these lists of criteria were derived in countries untouched by conflict or war. Hence, the author assumes that other criteria might be more relevant for countries in a crisis. Moreover, she echoes Eggerman and Panter-Brick, who analyzed resilience in Afghanistan and detected very specific Afghan cultural values. They concluded that ethnographic work is highly relevant to identify “what matters most in formulating social and public health policies to promote a hopeful future” (Eggerman and Panter-Brick 2010). In light of all that, the author refrained from applying these criteria but aimed at developing an Afghan-specific one.

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[6] These are relevance, community participation, stakeholder collaboration, ethical soundness, replicability, effectiveness, efficiency and sustainability (Ng and Colombani 2015

[7] including concept quality, structure quality, process quality and outcome quality (method, author, target group, costs, expenditure of time)

[8] Or the best-practice criteria for health promotion activities: (1) conception, self-perception, (2) target group, (3) innovation and sustainability, (4) multiplicator concept, (5) low barrier approach, (6) participation, (7) empowerment, (8) setting approach, (9) integrated working-concept, cooperation, (10), quality management and development, (11) documentation and evaluation, (12) cost-effectiveness-relationship 1. Konzeption, Selbstverständnis 2. Zielgruppe, 3. Innovation und Nachhaltigkeit 4. Multiplikatorenkonzept, 5. Niedrigschwellige Arbeitsweise 6. Partizipation, 7. Empowerment, 8. Settingansatz, 9. Integriertes Handlungskonzept/Vernetzung 10. Qualitätsmanagement/Qualitätsentwicklung 11. Dokumentation und Evaluation, 12. Kosten-Nutzen-Relation (gesundheitliche Chancengleichheit 2016)

[9] Another list that have been applied by the former Afghan minister of public health are the Paris declaration of „aid effectiveness“ „ownership, alignment, harmonization, managing for results and mutual accountability“ (Dalil et al. 2014)

2.4 Review on Health Promotion in Afghanistan.

To identify scientific evidence of community-based health promotion activities in Afghanistan, an exhaustive systematic search of scientific studies on five databases was conducted (see methodology in chapter 3)[10]. Overall, many studies on health in Afghanistan, in particular on the health situation of soldiers, could be identified.[11] Narrowing down the research strategy to “Afghanistan” and “health promotion” in the abstract and title or to “Afghanistan” and “Health Education,” 10, respectively, 15 articles were identified as relevant and fit the inclusion criteria after excluding military studies. The addition of the search term “community (-) based” excluded all results except one result. The analysis of the identified papers can be summed up in four points: (a) Most of the papers refer to BPHS, CHW, and Community Midwives. (b) The majority of the studies were conducted in urban areas and did not represent rural (insecure) areas. (c) The understanding of health promotion and education is often very narrow to ‘transferring information.’ (d) Almost no empirical evidence on the effectiveness is available based on this research strategy. Based on these few scientific findings, the conclusion is adequate that health promotion does almost not exist in Afghanistan. This is consistent with Waldman’s findings in 2002, who stated that prevention “is rarely practiced” (AREU 2002). This finding echoes the common statements in conversations with actors working in health in Afghanistan, who point out that there exists almost no healthcare system in rural areas and only occasionally, some health messages are spread in the health facilities (Schefter 2002). Several studies (Sato 2007; Mashal et al. 2007; Mashal et al. 2008; Newbrander et al. 2014b) showed the importance of understanding the sociocultural and religious context to introduce effective behavior change programs. A study by Newbrander et al. on barriers to care-seeking concludes that targeted and more effective behavior-change communication programs are needed (Newbrander et al. 2014a). An analysis of the WHO documents concerning its strategy on Afghanistan brings interesting insights. Their primary focus is, on the macro level, on strengthening the MoPH leadership, developing strategies and regulations, and monitoring. However, neither in their current Afghanistan strategy nor the country cooperation they stress the importance of “health promotion,” “health education,” “health literacy,” and “community-based interventions[12] it appears that “enabling” is highly related to enabling MoPH and less on communities (WHO 2010c, 2010b). So, it is impossible to learn about community-based

[10] One study on an Afghan Health Education Project Lipson et al. 1995 could be found but was not included in this study because the research focused on studies since 2001.

[11] To underpin the statement above, the search on PubMed in October 2016 is prescribed: The results for ‘health’ in general in Afghanistan were (N= 1564, of which 730 are not related to military people in Afghanistan), and some studies are about disease in Afghanistan (N=383 respectively N=227). 75 studies focus on the health system. 21 studies deal with ‘health education’ in Afghanistan and 14 with ‘health promotion’. On the contrary, only 43 (respectively 27) studies are community-based and combining “community-based” “health promotion” approaches in Afghanistan there are only 2 results – Haver role of CHW to provide maternal and child primary health service and Mawyeh improving nutrition through growth monitoring.

[12] Only one information could be found in the paper which is one recommendation. If this is put in place could neither be confirmed nor denied „nongovernmental organizations should be provided with health promotional and learning material produced by WHO and be invited to participate in various training activities sponsored by WHO in Afghanistan“ (WHO 2010, p. 35).

health promotion activities by analyzing WHO papers. Some information can be found on the national level. The health promotion department of the MoPH defines several areas for health promotion and publishes some material. However, no study on health promotion could be found neither on the homepage of the Health Promotion Department (MoPH HPD o.d.) nor the MoPH resource bank (MoPH o.d.). In accordance with the MoPH interest, it might be very beneficial to expand its empirical evidence on health promotion activities (MoPH 2012c). In summary, very little is known about health promotion approaches based on scientific evidence and policy papers. However, it is of political and practical relevance to explore community-based health promotion

2.5 Problem Formulation – Community-based Health Promotion Approaches in Afghanistan

Not only the lack of research on health promotion in Afghanistan is the main reason health promotion should be investigated. The following reasons further stress the importance of expanding health promotion activities in Afghanistan: (a) The rate of preventable infectious disease in Afghanistan is high and needs to be addressed holistically. (b) The prerequisites and determinants of health have an enormous impact on the health status but are often neglected, as the CPHD pointed out to them as “the forgotten front. (CPHD 2011) (c) It is empirically proven that health promotion in developing countries is a cheap, effective way to improve the health status of people in rural areas (Kumar and Preetha 2012). (d) There is lots of scientific evidence that shows that spreading information is not sufficient to change behavior (Waldman and Hanif 2002). (e) Health knowledge is extremely low in Afghanistan (Schefter 2002). (f) Afghans need to be able to control the determinants of their health, particularly because they can rarely rely on the flawed health system, and the geographical and political situation calls for it (AREU 2016). Given that, it is indicated to strengthen health promotion in Afghanistan further. In contrast to health education, health promotion is highly interactive, strives for changes in the lifestyle of the individual and the community, and enables people to create a supportive, healthy environment. The importance of considering the environmental factors is stressed by Naim et al. study on the decrease in maternal mortality in Afghanistan who concluded that the following areas need to be addressed: infrastructure issues (accessibility) and sociocultural factors (including husbands and mothers-in-law in health education) (Naim et al. 2015).

Asking practitioners about health education and health promotion in Afghanistan, two reactions are common. Either they say nothing is available, or they refer to the most common health activities on the community level, the Basic Packages of Health Services (BPHS). The BPHS is a nationwide project to enhance mother and child health primarily. It does not address healthy environmental aspects explicitly. Also, there are several 1 to 3-year health promotion projects by various healthcare providers, which rarely have an impact beyond the project phase. There have

been numerous "quick impact, quick collapse projects" (MSF 2014). However, surprisingly, some projects showed remarkable resilience, e.g., the Chak-e-Wardak hospital or the community midwifery program. So, this thesis aims to provide an answer to the following research question. What types of community-based health promotion approaches exist in Afghanistan, what are the reasons behind their resilience and success despite the challenging circumstances, and what practical, empirical recommendations can be given for evidence-based community-based health promotion approaches? It is only possible to give an empirical sound answer if health is regarded in all its complexity and as a phenomenon influenced by many aspects. Consequently, a holistic multi-perspective, mixed-method case study is considered the best method to conduct an evidence-based assessment of health promotion approaches in Afghanistan. The author assumes that knowledge of the following five areas is required to provide an empirical sound answer to the research questions. From the macro to the micro perspective, the following five areas will be covered. First, (a) the variety of prerequisites and determinants which impact health and health status. Then (b) the existing health system, Next (c) the healthcare provider and available activities. Followed by (d) the concept of health as well as common health practices and myths, and (e) concluding with best practices in community-based health promotion (CBHP) activities. Figure 2 integrates the different assumptions.

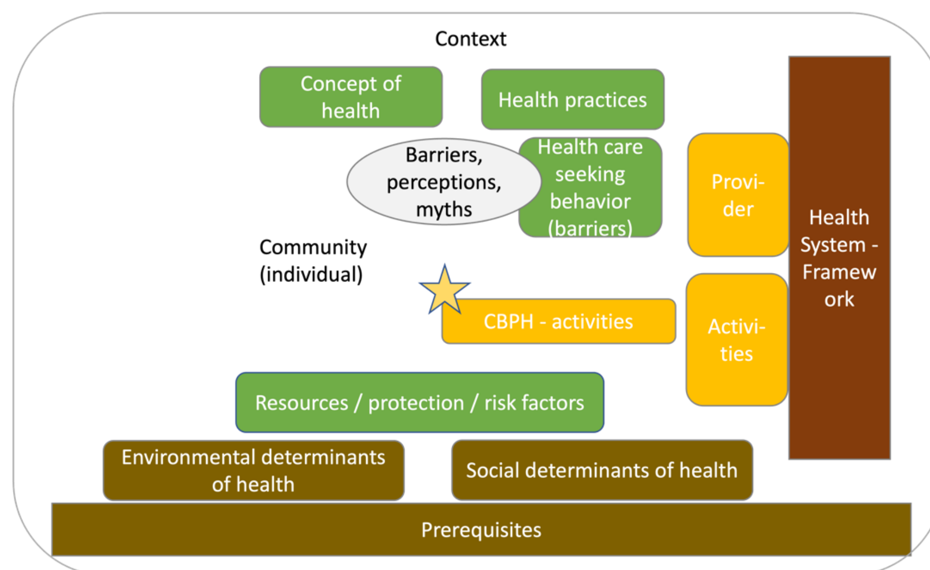

FIGURE 2: MODEL FOR EXPLORING HEALTH IN AFGHANISTAN (OWN PRESENTATION)

As it shows, the prerequisites for health are the basis. Build on that the environmental, as well as social determinants, influence health. Part of the context is the health system as well as the individual providers who carry out a set of health activities. However, tangible and intangible things influence how individuals seek health care. These are barriers, the concept of health, common health practices, risks, and protective factors. Many health workers in Afghanistan point out that the obstacles are the largest concern for not seeking health care. Hence, it is indicated to bring

health services as close as possible to the individual (shown as 'CBPH). Not all health promotion approaches might be similarly effective; therefore, good practices in community-based health promotion should be explored. Consequently, it is assumed that the following definition is adequate for CBHP.

The two underlying assumptions of this study are that "A promising community-based health promotion approach is evidence-based and covers the right topics, provides the right messages with the right methods at the right place at the right time to the right people and includes the right changes in environmental determinants by the right people. Furthermore, it addresses concepts of health and health-seeking behavior, is linked or integrated into the health system, and addresses and improves the determinants of and prerequisites for health." Second, Health promotion approaches are more likely to be effective and sustainable if the NGOs - the main health care providers in Afghanistan - work properly. Therefore, good practice in health promotion is strongly correlated with good practice in NGO work.

3 Methodology

This chapter gives an overview of the methodological approaches used for this instrumental, collective, multi-site case study and explains the data collection, management, and analysis of the five sub-studies (Creshwell 1998). As expressed above, due to the lack of available data and the holistic nature of the question, a comprehensive approach, including several perspectives, was adopted. Moreover, by applying methodological and information triangulation, the researcher attempts to overcome the limitations and blindness of a single-method approach. Furthermore, triangulation helps provide an in-depth description, specify the understanding, and enhance the trustworthiness and credibility of the data analysis (Miles et al. 2014). The Standards for Reporting Qualitative Research were applied to report the findings (O'Brien et al. 2014). Table 3 presents the five dimensions and the specific research questions, the source of empirical data, and the rationale.

TABLE 3: RESEARCH QUESTIONS

Dimensions	Research questions	Data	Rationale
Health situation and conditions	1.1. What does the Afghan context look like? 1.2. How are the prerequisites and environmental and social determinants of health manifested? 1.3. What is the current health status of people in Afghanistan, and which studies are available concerning the various health topics?	Databases, surveys, studies,	Available data on Afghanistan are of poor quality. Contrasting data from different sources might help to come as close to reality as possible.
Health system	2. How is the health system set up? - applying the WHO framework	Policy papers, studies, reports, information gathered at attended conferences	providing data, structured in categories, internationally comparable
Providers and activities	3.1. Who is active in health promotion and health-related activities? 3.2. Mapping: What types of activities exist in which sector? 3.3. Is this sufficient? Are there any gaps?	Systematic explorative study, scope analysis; website analysis, email correspondence	Compilation of providers from main homepages → not to lose smaller initiatives
Concept of health	4.2. What are common health practices and health-seeking behaviors? 4.1. What is the concept of health? 4.3. What barriers, perceptions, and myths predominate? 4.4. What are resources, protection, and risk factors?	Semi-structured interviews and questionnaires	Operational knowledge can only be gathered through direct contact
Community-based health promotion approaches	5.1. What (community-based) health promotion activities exist? What are their strengths and weaknesses?	website and annual report analysis, interviews, and	Operational knowledge

	5.2. Which factors are contributors to success? 5.3. What are recommendations for good health promotion activities —> good practice criteria	additional gray literature

Describing the health situation in another country can be a huge and even borderless task because there are uncountable aspects that relate to health. The author sought to apply existing frameworks and lists of categories of the WHO and the Afghan MoPH to make the study feasible, to break down the complexity of the context of health, and to make findings suitable for international comparison. In addition, she used an open approach and developed categories inductively to explore the activities, the concepts of health, and the health promotion approaches and to structure the recommendations.

The researcher gathered the data for this study through systematic and free internet searches, formal semi-structured Skype interviews, correspondence by email with different key persons, and additionally received reports and policy papers from various key agencies. Furthermore, she attended two conferences on Afghanistan and informal group discussions and led numerous casual conversations with Afghans and people working in Afghanistan. The first-hand information helped her to define areas of importance and to relativize some findings.

Next, the author describes in detail the procedure of the three main approaches: desk research, provider identification, and semi-structured interviews and specifies the sampling strategy, data collection, data management, and data analysis.

3.1 Desk Research

The initial research showed that there is no comprehensive overview of Afghanistan's health situation, which integrates the health status, the health system, the determinants, and, in particular, the health promotion activities. Usually, information about the health system is mostly given by individual providers based on their experiences. However, to be able to assess good practices in health promotion in Afghanistan, a good understanding of these factors is irreplaceable. Therefore, the purpose of the desk research was to gather sufficient data on the health system and relevant factors to provide a thick and as precise as possible description of the prerequisites, determinants, health status, and health system. The quality of data on Afghanistan is mostly poor and unsatisfactory (Broughton et al. 2013)(see chapter 4.). Therefore, the author sought to contrast existing data from the CSO with data from the WHO, CIA World Factbook, World Bank, and additional empirical evidence to try to describe the situation as correctly and closest to reality as possible.

Sampling: The author conducted a systematic literature search to identify all studies and surveys on health promotion in Afghanistan. She included all types of studies: meta-analyses, reviews, randomized control trials, cohort studies, case-control studies, qualitative studies, and surveys.

Inclusion criteria were: English language, focusing on Afghans in Afghanistan, published since 2001. Exclusion criteria were studies on non-Afghan soldiers based in Afghanistan. Furthermore, she also integrated data from the Afghan Central Statistical Office, WHO, World Bank, CIA, UN, and others. To capture further opinions, the researcher extended her research and integrated newspaper articles, annual reports, and views of experts, e.g., the Afghan Analyst Network.

Data collection: The author searched the following databases initially for primary studies about health promotion in Afghanistan in the year (2001-2016): The Cochrane Central Register of Controlled Trials (CENTRAL), Ovid, PUBMED, and Google Scholar. She also searched further relevant websites on Afghanistan, such as Samuel Hall, Afghan MoPH, WHO, Afghanistan Research and Evaluation Unit (AREU), refworld, reliefweb, humanitarian response, diva-portal.org, popeline. Search terms were "Afghanistan" and terms associated with "health" and "health promotion" (= health education, health protection, prevention, primary health care) and "community-based" and "developing countries." (See overview attached[i]). The electronic search produced a total of records (titles and abstracts). She then screened all articles and retrieved full copies of all the reports deemed eligible for closer inspection. Finally, she expanded the research to a free internet research using the Google search engine for websites of organizations providing health care services in Afghanistan.

Data processing: The author all identified articles to a literature management software, Citavi, and categorized them by the five domains as well as subcategories, e.g., prerequisites for health, health system, diseases, and the concept of health. She shared this data collection with other researchers conducting studies in the field of Afghanistan.

Data analysis: The purpose of the desk research was to provide a thick description of the situation in the health sector in Afghanistan with a focus on health promotion. To cover most of the important factors, the author followed the WHO's categories to describe the prerequisites and determinants of health (WHO 2016c, 1986). Additionally, the author developed a logical framework for systematizing the overview of common diseases and the empirical data inductively. She analyzed the health system using the WHO framework (WHO 2015c). To describe the health situation comprehensively, she contrasted the newest available data for each topic and, if possible, she also tried to point out the changes over time (by presenting data from different years). Furthermore, the interviews indicated that qualitative measures would usefully supplement and extend the quantitative analysis of the health system. So, she combined qualitative and quantitative so that quantitative data could specify the qualitative data and qualitative statements would relativize the epidemiological data. Rada suggests this combination for any evidence-based study (Rada et al. 1999).

3.2 Scoping Review of Providers and Activities

The purpose of the scoping review was threefold: first, to find all providers[13] that offer some health-related activities in Afghanistan and to develop a typology; second, to identify activities in the health sector and present them collectively; and third, to analyze the activities and to define gaps. The author followed the outline of Arksey and O'Malley (Arksey and O'Malley 2005).

Sampling: All organizations with some health-related activities were interesting for this study. These activities could have been (a) directly health-related activities, such as doctors working in a hospital. Next, (b) activities were closely related to health, such as installing a sanitation system in a community or working in agriculture. Alternatively, it could have been (c) activities that are indirectly related, such as activities in education or livelihood. The author limited her research to organizations with an English (or German) website. The limitation was deemed eligible because most of the funding for the health sector comes from foreign countries, and all providers who wish to apply for it have to write their proposals in English and communicate with them in English. Therefore, the author assumed that by using the English language, she could identify most of the largest (healthcare) providers. Hence, the overview of the providers as well as of the activities might be representative.

Data collection: For the reason that NGOs provide most of the health services in all districts in Afghanistan; the appropriate way to identify the providers was to use existing lists for NGOs.

Before data collection, the author developed a framework for categorizing the providers. Then, data was collected following the process:

(1) Identifying publicly accessible lists of organizations (primarily NGOs, namely the list of the Ministry of Economics, BAAG, Humanitarian Response, ACBAAR)

(2) Combining all NGOs in an Excel file

Including organizations identified post-hoc, e.g., organizations she had identified via reference lists, recommended by other organizations, or found using a Google search of the internet.

(3) Deleting doublets

(4) Searching and screening homepages

a. Excluding organizations with no homepage or homepages not available in English

b. Excluding all organizations without contact details, which only had a not-updated Facebook profile or which she regarded irrelevant based on the activities.

c. Extracting relevant data from the website by using a data-charting form and transferring it to an excel file

(5) Analyzing data (see below)

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[13] She intended that her findings represent a vast group of organizations in (international and national, several countries and exclusively Afghanistan, experiences for longer than 2 years, preferably with available annual reports).

a. Identifying areas of action and categorizing them based on how directly they impact health

b. Clustering all activities per sector and along subcategories to provide an overview of the breadth of activities

c. Analyzing the data thematically and presenting aggregated data.

d. Identifying gaps (=if the reality does not meet the required standard)

In addition to the provider and activity analysis based on website analysis, the organizations were contacted to gather further information[14]. The author sent a short questionnaire to the organizations twice at the end of September and the beginning of November. She sent it to those organizations that have not been invited for an interview in order to broaden their perspective on health. The questionnaire included further questions concerning organization, activities, success factors, recommendations, and success stories (see the attached questionnaire).

TABLE 4: STRUCTURE OF NGOS

A1	A2	B1	B2	B3	B4	C1	C2a	C2b	C2c	C3a	C3b	D1	D2
Abbreviation	Name	Source	Contact detail	web site	Last update	Relevance to health	Activity in health sector	health-related activity	Additional sector	HP, DP, HE	Community-based	Sent	participated
		MoEco, AC-BAAR, Humanitarian Response, ANCB, BAAG, UNDOC, add		(Direct, indirect, not found)	(Preferable 2016)	direct, close, indirect unclear	Health facility, BPHS, health education	Nutrition & food security, agriculture, WASH, infrastructure, women empowerment	Law, adminis tration			Yes/ no, not deliverable	Interview, questionnaire, not possible but publications, not possible, no response

Note: HP= Health Promotion, DP = Disease Prevention, HE = Health Education

In addition, she prepared a thick, qualitative description of health-related activities in Afghanistan. As can be seen in the outline (Table 4), she analyzed the data collectively. Next, she performed a gap analysis to identify areas needing further activities and concept development. Furthermore, she analyzed the following: availability of policy and strategy papers, community-based approaches, health promotion, health education, or disease prevention activities. Finally, she tried to give an overall estimation of the sufficiency of (conceptual) available activities. However, she could not identify the actual sufficiency regarding coverage of all provinces and access for all people.

3.3 Semi-structured Key Informant Interviews

The purpose of the semi-structured key informant interviews was: (a) to determine and to deepen the understanding of good practice in community-based health promotion approaches; (b) to

[14] Initial idea: focusing on 48 org in health cluster. But early the researcher realized that by doing so many important additional organizations – e.g., focusing on one disease - would be left out. Therefore, the author decided to contact the 48 organization and ask for a Skype interview and extend to integrate other initiatives by sending them a questionnaire concerning their health-related work.

explore the success factors of organizations working in health; (c) to shed light on common health practices and perceptions of health; and (d) to get a better picture of needs and recommendations for action in Afghanistan.

Sampling strategy: To gather data in Afghanistan is very challenging. Furthermore, in observations and many conversations with people working in Afghanistan, it became evident that many organizations in Afghanistan are very busy, so any additional task – such as conducting an interview - must be of outstanding relevance. Otherwise, they will not participate in it. Therefore, the author refrained from a cluster sample or applying the snowball principle and decided to use a convenience sample. She contacted all providers of the health cluster (Humanitarian Response 2016) and added some further organizations that have reported many activities in health in Afghanistan. She informed them about the study and asked for their voluntary participation in the study. Because there is no instrument to calculate or estimate the response rate of NGOs working in war and conflict-affected countries, she could not assess whether the numbers are sufficient. To have a maximum variation, she intended to identify possible concepts and existing activities until the theoretical saturation of health promotion approaches is achieved. The attempt was to include an exhaustive representation with a maximum variation of different organizations and approaches. The sample should have had the following characteristics: wide range of providers, national/international, experiences (duration, sectors), urban/rural, size, a variety of addressed topics, mix of communities, and professional background. Moreover, it should represent different health promotion approaches: including home-based, community-based, and health facility-based interventions.

Development of the questionnaire: She developed the questions for semi-structured interviews around the key topics of interest for this study: activities, the concept of health, contributing factors to success, recommendations, suggestions for the future, and further comments. (See attachment [ii]). After an initial pilot interview, she adapted some questions. At the beginning of the interview, she asked the respondents to briefly introduce the organization, his/her position, and the organization's mission or objectives. This introduction served two functions (a) as an icebreaker and (b) to provide further information concerning experiences and the scope of activities. Then, the author encouraged the interviewees to describe the health-related activities of the organization. She flexibly added questions concerning target groups, methods, and locations to deepen her understanding of health promotion. Next, she raised some questions concerning the perception of health and existing beliefs because several studies have shown that these greatly impact health in Afghanistan (Newbrander et al. 2014b). Moreover, she asked the interviewee to elaborate on the contributing factors to success, point out some challenges, and explain how they have overcome some difficulties. By this, the author hoped to identify all contributing factors and successful coping mechanisms. Then, she invited the interviewee to provide some recommendations for health promotion and suggest further activities that might help restore, maintain, and promote

health. The last two questions served to identify ideas that can help conceptualize promising health promotion approaches but could not be realized yet, as well as to provide the interviewees the opportunities to further point to the main important issues related to health. Lastly, the author concluded by asking the respondents, if they want to add any further relevant information that helps to understand the (health) situation in Afghanistan (see the questionnaire attached[iii]).

Data collection: After an initial email contact, she arranged a Skype meeting. Due to internet connectivity problems, two interviews were conducted via Viber. At the beginning of the interview, the interviewer briefly introduced the study and collected oral informed consent. Then, she asked the questions and adapted them flexibly. She recorded the interviews and saved the data on a secured hardware. The author conducted the interviews during September and November and another one in December 2016 (see overview attached). She used a brief interview protocol to capture the initial impressions of the interview. Some respondents provided additional papers and studies which she gathered and organized using Citavi.

Data processing: The data was copied and saved on a secured hardware. The author transcribed almost all interviews completely; for some, she only focused on the most relevant passages. She applied the following transcription rules of simple transcription inspired by Dressing et al. (2015) (Table 5).

TABLE 5: RULES FOR TRANSCRIPTION

I:	interviewer
R:	respondent
Bold	(emphasis/stresses)
(…):	breaks
]:	comments
/:	breaking voice or unfinished sentence
(incp.):	incomprehensible

Data analysis: For a rough categorization, she developed a deductive categorization system based on the research questions (see Figure 3 left). For an in-depth content analysis of the research questions, she extracted sub-categorizations inductively from the material (see Figure 3 right). In the study, she revised the subcategories to best represent the respondents' perspectives (Mayring 2000). She used the qualitative data analysis computer software MAXQDA (Version) to analyze the data. The category system can be found in the annex.[iv]

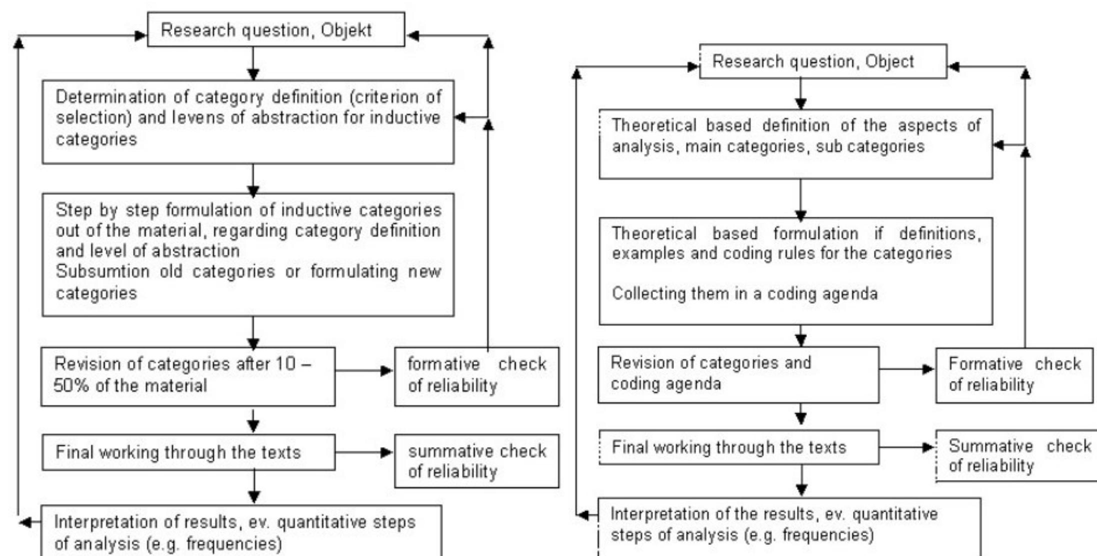

FIGURE 3: STEP MODEL OF INDUCTIVE (LEFT) AND DEDUCTIVE (RIGHT) CATEGORY DEVELOPMENT (MAYRING 2000)

The author strived to generate meaning from the data material by applying a set of different strategies: such as noting patterns and themes, seeing plausibility, clustering, making metaphors, counting, making contrasts/comparison, and partitioning variables. Moreover, she also used the methods of subsuming particulars into the general, factoring, noting the relationship between variables, finding intervening variables, building a logical chain of evidence, and making conceptual and theoretical coherence (Miles and Huberman 1994).

Ethical consideration: The author did not seek ethical acceptance from the government of Afghanistan for several reasons, mainly the short timeframe, the explorative character of this study, and because this study caused neither physical nor psychological harm. The author gathered oral consent. She conducted the analysis anonymously. For each organization, she gave a letter, followed by a number. In case more than one organization's representative participated, she added a letter, e.g., I14a, I14b. Generally, ‘A’ represented answers to the questionnaire. ‘G’ German organizations and ‘I’ health care provider in Afghanistan.

3.4 Role of Researcher, Data Quality, and Limitations

In the following passage, several aspects are presented that might substantially impact the study. Overall, the following three themes have been regarded as the most important aspects (a) the researcher’s characteristics, (b) the data quality, and (c) the heterogeneity in Afghanistan.

(a) Researcher characteristics: The researcher was quite motivated to understand the situation. She holds a BA in educational science and received training in research in her works as a student and graduate student researcher. Throughout her master’s studies, she focused on health promotion in low-income countries and did a research internship in Southeast Asia. Unfortunately, she

could not visit Afghanistan for security reasons, but she had an idea of the area during her time in Iran. To enhance her knowledge of Afghanistan, she attended several conferences on Afghanistan, read books, and tried to talk with many Afghans about health, particularly Afghans who came as refugees to Germany. To verify her interpretations, she discussed her findings with many Afghans. She needed to limit her study to English and German data because she did not speak Dari or Pashtu. She did not receive any funding for this study. There is no conflict of interest.

(b) The quality & validity of data on Afghanistan varies not only between types of papers: from strategy papers of low evidence concerning implementation, expert consultations, surveys, case-control studies, and randomized-controlled-trial to peer-reviewed systematic reviews. In the course of the study, it became apparent that even data from the same provider (the MoPH, WHO, and others.) varied widely. Another main distortion of data – reporting bias - is the purpose for which several papers were written, such as the policy statements by the MoPH and evaluations by the donor. Moreover, the reports by NGOs might also be biased and do not always portray the real situation but are intentionally prepared (seldom very critical towards their own role). Independent, external evaluation is almost missing in health in Afghanistan. Barely available are studies that include a wide range of perspectives from all around Afghanistan and where data was not primarily gathered in main cities. Very often, the credibility of data from Afghanistan is often challenged as being "too good to be true" (Michael et al. 2013); data are difficult to locate, to verify and are often contradictory (e.g., Broughton et al. 2013). The author used two strategies to check and improve the quality: (a) contrasting data and second (b) strictly adhering to standards of quantitative and qualitative research. Whereas the quality of quantitative research can be evaluated by applying the criteria of objectivity, reliability, and validity, which are followed in the CONSORT and PRISMA Statement, these criteria lack applicability to qualitative, explorative research because of other ways of data quality and verification. In this study, the author followed the recommendations of SRQR (Standards for Reporting Qualitative Research) (O'Brien et al. 2014). Throughout the study, she strived to achieve plausibility and accuracy and, in addition, the following seven quality criteria for qualitative health care research (Cohen and Crabtree 2008). She used the following approaches (Table 6).

TABLE 6: QUALITY CRITERIA AND APPROACH

Quality criteria	Approach
(1) carrying out ethical research	Causing no harm, voluntary participation
(2) the importance of the research	In-depth research and focusing on the research gap, which does not exist yet and will be useful for further extend on health promotion
(3) the clarity and coherence of the research report	A detailed description of the process (also attached)
(4) the use of appropriate and rigorous methods	Quantitative for static statistics and qualitative for connections/interlinkages

(5) the importance of reflexivity or attending to researcher bias	Intensive reflection in chapter 9, summary at the end of each chapter, and critically reflecting on limitations of the results
(6) the importance of establishing validity or credibility	By contrasting data, proving data with anchors, and applying the 13 strategies below.
(7) the importance of verification or reliability	member checking, peer review, debriefing, and external audits to achieve reliability

In order to double-check her data, she applied the following methods: checking for representativeness, checking for researcher effects, triangulation, weighting the evidence, checking the meaning of outliers, using extreme cases, following up surprises, looking for negative evidence, making if-then tests, ruling out spurious relations, replicating a finding, checking out rival explanation, getting feedback from participants (Miles et al. 2014).

(c) The last biggest challenge arises from Afghanistan's large heterogeneity and variance. Some people draw a line between 'Kabul' and 'the rest,' whereas others refrain completely from talking about 'Afghanistan' and only speaking about a specifically defined area. The heterogeneity can be seen in (MoPH HMIS Department). Whether one divides Afghanistan into two or multiple regions, it points to the need to assess the given context individually. Similarly, some difficulties occurred due to a different understanding of "health promotion." The term health promotion can either be defined as very narrow, 'improving the health of the individual,' or very broad and inclusive (e.g., see discussion on ResearchGate (Whitehead 2017)).

3.5 Sample Description of the Qualitative Research

In this paragraph, the sample is described, and an estimation of its representative nature is given. The following table (Table 7) shows the three sample strategies, the number of organizations contacted, the type of data gathered, the number of respondents, anonymization code, and the length. Attached is a detailed list of the organizations as well as the date, length, and a brief characterization of each organization[v].

TABLE 7: SAMPLE INTERVIEWS AND QUESTIONNAIRE

German orgs/ initiative	UN OCHA + additional	health (or health-related) organization
google-search	humanitarian response - "health cluster" + relevant promising	HR, BAAG, ACBAR, AREU, MoE,
N=212 health related = 56; 15, in health	N=48 (in total N=51 contacted) (3 excluded - not available or double)	N=505 (including 48 OCHA); N = 258 contacted
interview (semi-structured)	interview (semi-structured)	questionnaires (per email)
N= 7: G1-G7	N= 21: I1-I17, 2 organization 2x, 1 3x	N=22: A1-A22
Length: 29:06 min	Length: 46:33	1 to 4 pages

The responding organizations represent a great variation: from large donors (N=1+3) and concept developer (N=1) to small initiatives focusing on a clinic in a village (N=2). From international generalizer (N=3), Afghan generalizers (N=2), over BPHS implementer plus (N=9) to specialize in certain areas of health (N=11) as well as 'targetizer' focusing on a certain group of people (N=5). From constructor N=1; and developer (N=1) to capacity-builder (N=3). From educational story developer (N=1) to agriculture (N=2). Furthermore, the medical side (in clinics) and the protective side of health are targeted, e.g., through peer groups. Organizations that concentrate on one community and organizations that work all across Afghanistan. Interviewees were seven international and 15 were Afghan or people with Afghan background (see Table 8). They have been young (in their 30s and older than 65). People who work and live in Afghanistan and people who work from outside. The professions vary largely but with the main focus on people of a medical background (doctors, psychologists). Most of the interviewees have graduated from university. Not included are the MoPH and NGOs without an English-speaking person.

TABLE 8: OVERVIEW OF SAMPLE CRITERIA AND REPRESENTATION

Indicator	Manifestation	
Organization	Local (n=10+6+10)	International (n=7+1+12)
Nationality (interview partner)	Afghan (+ A background): (n=15+5)	International: (n=8)
Location	Only Kabul	Country side and Kabul
Scope of services	Wide (more than 5)	Narrow (<5)
Gender	Men (N=21)	Women (n=7 (3+4)

Even though it was a convenient sampling, the NGOs present a vast range of providers and types. Furthermore, in the last interviews, the author did not come across further new approaches, and also the success factors and recommendations varied only slightly. Hence, she assumed that her sample fulfills the criteria of maximum variation as well as theoretical saturation.

SECTION II: RESULTS

In the next five chapters, the results of this study are presented and discussed in each domain. Starting with the context, followed by the health system, the results of the scoping review on providers and activities, the concept of health, and finally, health promotion. At the end of each chapter, the author gives a conclusion. Each conclusion follows the same structure: it starts out with a summary, an assessment of the findings by referring to other related studies, a reflection on the importance of these findings for health promotion and raises open questions.

4 Context: Afghanistan – and the health situation

As mentioned above, finding reliable data on Afghanistan is challenging, so the author attempted to come closer to reality by contrasting the newest data available. Primarily, she derived data from the CSO, MoPH, WHO, CIA World Factbook, the World Bank, and UNDP. However, she also used the following Afghan-specific surveys listed (Table 9), which serve as the basis for setting the scene in the next passages.

TABLE 9: NEWEST SURVEYS IN AFGHANISTAN

TITLE	YEAR	LINK
Afghanistan National Health Resources Assessment	2002	(MOH 2002)
Afghanistan National Nutrition Survey	2004	(MoPH et al. 2004)
National Risk and Vulnerability Assessment 2007/2008. Afghanistan Living Condition Survey	2008	(EU 2008)
Malaria Indicators Survey	2009	(WHO et al. 2009)
Afghanistan Health Survey	2006	(John Hopkins University and IIHMR)
Afghanistan Human Development Report 2015	2015	(UNDP o.J.)
Afghanistan Human Development Report 2011. The Forgotten Front. Water Security and the Crisis in Sanitation	2011	(CPHD 2011)
Afghanistan Multiple Indicator Cluster Survey	2011	(CSO and UNICEF 2012)
National Nutrition Survey Afghanistan	2013	(MoPH and UNICEF 2013)
Afghanistan Drug Report	2013	(Ministry of Counter Narcotics 2013)
Afghanistan Demographic and Health Survey	2015	(Central Statistic Organization 2015)
Afghanistan National Health Accounts with Subaccounts for reproductive health	2012	(Ahmed 2013)
Afghan Futures: A National Public Opinion Survey	2015	(ACSOR et al. 2015)
Afghan Futures Wave 6Topline Data		(ASCOR)
Health and Nutrition Survey	2015	(Aga Khan Foundation 2015)
A benefit incidence Analysis of the Afghanistan Health State	2013	(MoPH 2013a)
National Risk and Vulnerability Assessment 2011-2012. Afghanistan Living Condition Survey	2012	(Central Statistic Organization 2014)
Afghanistan Mortality Survey	2010	(MoPH et al. 2011)
Children and Women in Afghanistan. A situation analysis	2014	(UNICEF 2014)
Afghanistan in 2015: A Survey of the Afghan People	2015	(The Asia Foundation 2015)
Common Country Assessment for the Islamic Republic of Afghanistan	2014	(United Nations Country Team 2014)
Eastern Mediterranean Region Framework for health information systems	2015	(WHO 2015c)
National Disability Survey in Afghanistan	2005	(Handicap International 2006)

4.1 Afghanistan – Introduction and Main Health Indicators

Afghanistan is a landlocked country located in South Asia and Central Asia, bordering Iran, Pakistan, China, Tajikistan, Uzbekistan, and Turkmenistan, with a size of 652,230 km^2. Its physical geography is very diverse regarding altitude (7,234 m), with its lowest 258 m to its highest point Noshaq 7,492 m and regarding climate, arid to semiarid and vegetation (CIA 2016).

TABLE 10: (SELECTED) KEY EVENTS IN AFGHAN HISTORY

KEY EVENTS IN AFGHAN HISTORY (UN o.d.; Schetter 2010).)
1919: Emir Amanullah Khan declares independence from British influence
1964: Introduction of constitution monarchy (political upheaval)
1979: Soviet invasion (Mujahedeen uprising, civil war)
1989: Soviet troop leave; Mujahedeen strives to overthrow Najibullah (1992) civil war
1996: Taliban first control Kabul and expand their influence

On August 19, 1919, Afghanistan became independent of UK control (Table 10). After ten years of Soviet reign, followed by the Mujahedin and the Taliban, the Taliban regime was defeated in 2001. (Further information on Afghanistan's history can be found in (Schetter 2010; Rashid 2010). The presidential Islamic Republic of Afghanistan signed its last constitution in 2004. As a whole, Afghanistan is divided into 34 provinces with 368 districts (CIA 2016). Researchers and politicians describe it as a least developed, low-income country and as a fragile and conflict-affected state (UN 2015; Newbrander 2007; Witter et al. 2015; Miyake et al. 2016; Haar and Rubenstein 2012). Several calculations estimate Afghanistan's population between 28.5 (WHO 2015a) and 33.3 Million inhabitants (CIA 2016) with different ethnic groups such as the main four Pashtun, Tajik, Hazara, Uzbek, and several others. The two official languages are Dari (spoken by 50%) and Pashto (35%), followed by other officially recognized languages in certain areas, e.g., Turkic languages (Uzbek and Turkmen) (CIA 2016). Three main groups can additionally be distinguished (a) the urban population (6,698,100), rural population (20,403,300) and the nomadic population (1,500). In General, the tribal structure is critical for structuring social life (Miakhel o.d.).

Table 11 summarizes some additional basic facts concerning Afghanistan in aggregated numbers. The year and source of the data are indicated for each piece of information.

TABLE 11: GENERAL FACTS ON AFGHANISTAN

Basic Facts	Empirical evidence
Population	21.6 million (2001) →28.5 million[(a)]; 29.5 million[(c)] or estim. 33,3 million[(b)] (plus 1.5 million nomads, 1 million internally displaced people 805.4[(d)], prox. 3 million in Pakistan/Iran (OCHA 2016)
Population growth rate	2%[(a),] 2.03% [(c 2012)], 2.22% (WB 2011), 33rd-highest in the world[(b)] 60,500 p.a. [(e)]
Average age	18.6 (WHO 2015), 17[(d)], 15 (Akseer et al. 2016b)
Net official development assistance received per capita	172 US Dollar (Akseer et al. 2016b) 130.6 (MoPH); total 3,734,340,000 $ (aid disbursed, 0.019 US $ billion from loan disbursed)
Gross National Income (GNI)*	GNI: $ 1,885[(d)] 672 (LDC: 1,436; DC: 6,798) UN 2015; GDP: $ 1,900[(b), 1.5]% growth rate[(b)]
Human development index (HDI)	0.465 (171 out of 188) [(d)]
Human Asset Index (HAI)*	43.1 (LDC: 51.5; DC: 75.2) (UN 2015)
Economic Vulnerability Index (EVI)*	35.1 (LDC: 41.4; DC: 35.1) (UN 2015)
UN categorization	Low human development[(d)] Least developed country (see GNI, HDI, HAI)
Failed state rank	Rank 8 out of 178 “high alert”; 107.9 of 120.0 points (FFP 2016)
Corruption perception index	11, Scale: 0-100; at the bottom: Rank 166 of 168;(Transparency International e. 2016)

Note: (a) = WHO 2016, (b) = CIA 2016, (c) = CSO 2016, (d) = UNDP 2015, (e) WHO 2016b, (f) MoPH 2016, (g) = World Bank 2016

This overview above illustrates that Afghanistan ranks poorly compared to many other countries in relevant indicators; it is extremely burdened with many challenges that assume that the conditions for health and health status are poor. To capture the wide range of activities affecting health, several approaches can be utilized, such as the Dahlgren-Whitehead rainbow (Dahlgren and Whitehead 1991) or the EUHPID model (Bauer et al. 2006), or the differentiations between prerequisites and determinants of health (WHO 2016c, 1986). This thesis uses the last because it clearly distinguishes several contextual factors. The next tables (Table 12 and Table 13) present the findings of this study, categorized by the introduced subcategories of prerequisites and determinants of health. The manifestation of each subcategory is specified by using qualitative findings from the interviews as well as supported by quantitative empirical data (if available). Rada et al. highly recommended the combination of qualitative and quantitative evidence for any evidence-based health promotion (Rada et al. 1999).

4.2 Prerequisites and Determinants of Health

TABLE 12: PREREQUISITES FOR HEALTH

Prerequisites for health		
Indicator	**Comments by interviewees**	**Empirical data**
Peace	• Long-standing war, War (destruction) (N=5) • Insecurity (increase in last six years) (N=23) • interference by power holder (N=4) • fragile political settlement; lack of good government; lack of continuation in structure	• Chronic, armed conflict, war, and conflict-prone country (see UN-OCHA of 9/2016 overview attached, Human rights watch 2016; 17,273 people died in battle-related deaths[(g)] • 31 of 34 provinces reported some forced displacement
Shelter (housing)	• IDP camps in "extreme worse situation," no shelter (I14b, 41), not enough: 100,000 return, a drastic increase in rents • Ten people per household	• % of urban population living in slums: 86.6 (NRVA 2011) • % of households living in overcrowded dwellings: 37.0 (NRVA 2011) • Wall material: prepared mud 42.4; stone with mud 27.0 (AKDN 2011) • Lead (indoor and outdoor pollution): no information
Education	• Very low literacy, lack of education • the high rate of illiteracy • poor level of health literacy • lack of sanitation facilities —> menstruating girls stay home	• Low level of literacy (38.2 5, M= 52%, F=24.2%) [(b)]31,7%[(d)] • Youth literacy rate: 47.0 (NRVA 2011); 31.0[(e)] • Expected years of schooling F=7.2, M=11.3[(d)] mean years of schooling: 3.9[(d),] 3.2[(b)] • Primary school enrolment (57%[(a)]) and completion rate: 30.7 (MICS 2011) • P with at least some secondary education: F=5.9%, M=29.8%[(d)]
Food (security) and agriculture (P, ED, SD)	• high level of malnourishment • lack of fruit, vegetable • <4 years too short projects to have an impact • introducing new crops (soybean) is hard work	• 1/3 food insecure (long winter, short growing season, short harvest season due to early snowfall, '?' WFP (2016) • 14% borderline food insecure; poor growing conditions, • Caloric deficit: 30.1% (NRVA 2011), 173 kilocalories p.P p.d. (g) • 0/1 meat intake per week 42.1/32.2; 0/1 fruits and vegetables per week: 46.7/14.0 (AKNS 2015) • Agricultural land 58.1%[(b)]
Income	• Poverty(14b), highly in debt, corruption • (multiple) poverty	• 39.1%[(c)] 35.8%[(d)] below national poverty line, international 35.8% [(a] • Multidimensional poverty Index: 0.293[(d)]; approx. 49.9% (= 17.1 million) in and 16.0% nearby[(d)] • According to the Ministry of Finance, almost 100% of its development and 45% of its operating budgets are externally financed. (MEC 2016) • Child labor 10.3%[(d1)] 25.3% [(a)]
Stable eco-system	• natural challenges (long, cold winter)	• 105 disasters in 2015, prone to earthquakes, flooding, drought, landslides, and avalanches (OCHA-humanitarian response) • "Harsh winters, deadly avalanches, earthquakes, landslides, droughts and floods leave nearly half of Afghanistan's districts hazard-prone." (Irin News 2013) • Climate change
Sust. resources	• Lack and withdrawal of financial investment	•

Social justice	• Corruption, violence (14b); depending on local and trad. institution	• High corruption (MEC 2016), bride, nepotism, weak execution of law
Equity	• Gender-based violence (I14) • Differences between regions, ethnic groups; lack of access (women/rural) • lack of TV, radio, or magazine in the remote area • local differences (e.g., students with epilepsy in Herat)	• Gender equity index: 0.673 rank 152 of 155[(d)] • GINI coefficients: 27.8 (UNDP 2016) • Forced marriages (estimated 70-80%), 57% are younger than 15 (Boslaugh 2013) • Marriage before age 15/18: 15.2/46.3 (MicS 2011)

Legend: (a) = WHO 2016, (b) = CIA 2016, (c) = CSO 2016, (d) = UNDP 2015, (e) WHO 2016b, (f) MoPH 2016, (g) = World Bank 2016

Overall, the prerequisites, which are the foundation for health (WHO 1986), are very inadequate manifested (see Table 12). In particular, insecurity, corruption, and low level of education were repeatedly named as the most pressing challenges. But not only challenges with respect to prerequisites of health are reported, but also the Afghan MoPH acknowledges the impact of environmental determinants of health. It said, (MoPH 2015c). A first glimps of how this is manifested is shown in the Table 13.

TABLE 13: ENVIRONMENTAL DETERMINANTS OF HEALTH

4.2.1	4.2.2	Environmental Determinants
Trans-portation (ED, SD)	• Many obstacles, roadblocks, checkpoint damaged routes, impassable; *poor infrastructure • free moving limited due to the armed forces	• 29.800 of 42.150 km unpaved [(b)] • 80.0% of households living in communities with a distance to the nearest drivable road of 2 or fewer kilometers (NRVA 2007) • Car/truck: 3.9%; motorcycle /scooter (15.7%); bicycle: 7.3% (AKNS 2015)
Waste	(No mentioning by interview partners)	• Waste management/ burning of waste (AAN)→ air pollution; • improper solid and hazardous waste management(MoPH 2014a)
Energy	• lack of a reliable power source	• Electrification: 43% (urban areas 83%; rural areas 32%) [(b)] • use of early fuel: 84.2 (MICS 2011); 79.9 (NRAV 2011) • cooking in the house: 77.3% (AKNS) • Delay in obtaining an electrical connection: 111,3 days[(g)]
Indus-try	(No mentioning by interview partners)	• 5.7% of the labor force[(b)]mainly small-scale productions
Urbani-zation	• Scattered population	• 26,7%[(b)]; Kabul (4.6 million[(b)]) Herat, Mazar-e-Sharif, Jalalabad, • Urbanization: the annual rate of change is 3.96%[(b)]
Water	• Lack of access to safe drinking water i.p., in IDP camps and rural areas (I14b, 45); lack of safe and clean water. —> high prevalence of waterborne diseases	• 32.6 /32% use improved sanitation facilities, • 54.5 /55% use improved drinking water sources (AKNS 2015/[(e)]), Water pollution in River Kabul (Ahmad et al. 2015); “Water security and the crisis in sanitation” (CPHD 2011)
Radia-tion	• Not specified	• No data

Housing and food	(No mentioning by interview partners)	• See prerequisites for health

Note: (a) = WHO 2016, (b) = CIA 2016, (c) = CSO 2016, (d) = UNDP 2015, (e) WHO 2016b, (f) MoPH 2016, (g) = World Bank 2016, n.i. no information

Most interviewees reported that water and nutrition are the environmental determinants of health that strongly impact health. Besides, a majority referred to the difficulties in transportation as one of the main barriers to extending health care to all Afghans. Interestingly, no interviewee talked about the industry's negative impact on health. One explanation might be that only 5.7 % of all Afghans work in industry and that other topic has a far higher impact on health. Moreover, having any work is valued much higher than being negatively affected by the work: One interviewee expressed: *"no health is not a priority if a work is dangerous for our life and health still, we have worked because we have to earn"* (I8, 51).

In the next table (Table 14), the social determinants of health are presented. The factor "food" and "transport" were already discussed.

TABLE 14: SOCIAL DETERMINANTS OF HEALTH

Social determinants of health		
Social gradient	• Based on education, rural/urban, gender, age	• N.i.
Stress	• Recurrent traumatizing events, permanent stressors; due to war • psychosocial problems	• Recurrent traumatizing events
Early life	• no breastfeeding in the first two days • lack of micronutrients	• Low birth weight 20→ 6%[(a)] • Exclusive breastfeeding <6% 58.4%[(a)]
Social exclusion	• Discrimination: drug users or people with a certain disease	• rural population, IDP, orphans, widows, nomads, drug addicts…
Work	• migration: brain drain	• 55.3% participate in labor force (81.6% m, 28.3% f) • 78.6% work in agriculture[(b)]
Unemployment	• lack of employment	• 35% [(b 2008 est.)] 40% (estimated 2016) (UNDP) • Est: 43.4% (M: 72.8%, F: 13.7%) [(g)]
Social support	• Strong family support but the fragmentation of families	• n.f.
Addiction	• high rate (due to "joblessness."	• Drug: approx. 3 million; smoking: 8.6%[(c)]; alcohol: 0.7 l/p.c./p.a.[(a)]

Legend: (a) = WHO 2016, (b) = CIA 2016, (c) = CSO 2016, (d) = UNDP 2015, (e) WHO 2016b, (f) MoPH 2016, (g) = World Bank 2016

Many interviewees reported that the ongoing war increases stress and has a negative impact on health (I2, 12). Despite the various challenges concerning social determinants of health, they also emphasized the positive impact on health, for example, the strong family ties or the likeliness of women to easily share their thoughts and feelings (I14, I16).

Statements regarding the **individual determinants** of health cannot be given based on aggregated qualitative data. The manifestations of these determinants must be defined for each individual, such as genetics, individual risk and protection factors, knowledge about health, the concept of

health, lifestyle, and healthcare-seeking behavior. Some ideas of their manifestation were explored in the qualitative interviews and presented in Chapters 7 and 8.

4.3 Health Status and Current Studies

The WHO distinguishes two main domains in health status: (a) life expectancy and mortality and (b) morbidity (see Table 15). The following chart illustrates the life expectancy and mortality of 2001 and 2016, highlights the change in increase or reduction, and contrasts it with the average in South Asia and other conflict-affected countries (World Bank 2016).

TABLE 15: AFGHAN HEALTH INDICATORS

General health indicators	2001	Last	Change	Contrast to South Asia/Conflict(World Bank 2016)
Life expectancy at birth	44.2[a]	51.3[b], 60.5[e] (45 MoPH 2016) third last in the world (rank 222 of 224) [b] Healthy life expectancy 46.7 (2000) →52.3[e1]	16.3 years +	
Maternal mortality	1,700/100,000[a]	372/100 000 (AMS 2010); 396[e] or 400[d]/100.000	76.5% red (400)	182/481
Neonatal mortality	60/1,000[a 2006]	36/1,000[e 2014]	40.0% red.	29.9/28.5
Infant mortality rate	165/1,000[a]	66/1,000[e]	60.0% red.	41.9/55.4
>5 mortality rate	250/1,000[a]	91/1.000[e]	63.6% red	52.5/77.6
fertility rate, the birth rate	*6.9/1,000[a]*	5.3[e] (u: 4.8; r: 5.4) Adolescent birth rate: 90[a] or 86.8/1000[d] or 51.9/1000[e]	23.2% red	2.6 vs.4.4 21.2 vs. 33.6 32.8 vs. 83.9
Morality rate by main cause of death (age-standardized) (per 100,000)	(missing)	- Communicable diseases: 363[e] - non-communicable diseases: 846[e] - injuries: 169[e] - cardiovascular. dis, cancer, diabetes, or chronic respiratory disease: 31[e] - road traffic injuries: Reported: 4.6[e], Estim: 15.5[e]		24.7/22.7 16.1/25.4

Legend: (a) = WHO 2016, (b) = CIA 2016, (c) = CSO 2016, (d) = UNDP 2015, (e) WHO 2016b, (f) MoPH 2016, (g) = World Bank 2016

Maternal mortality was staggering in 2001 but decreased by three-fourths in the last 15 years. Overall, as the numbers demonstrate, the mortality rates have significantly decreased. A drastic improvement in these relevant health indicators can be interpreted as a success of the developed interventions (Dalil et al. 2014). However, compared to the average in South Asia as well as in conflict countries, Afghanistan clearly still lags behind. Nevertheless, these data need to be interpreted thoughtfully because there are huge regional differences. For

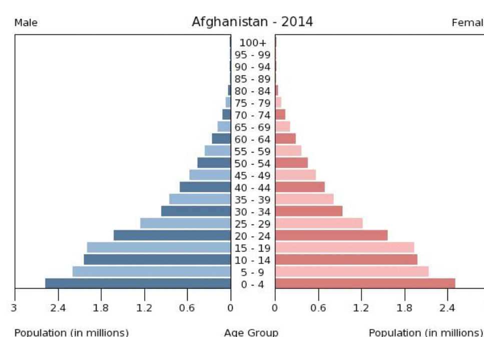

FIGURE 4: AFGHANISTAN'S POPULATION PYRAMID (2014)

example, the maternal mortality in Ragh was 6507, whereas it was 418 per 100 000 (Bartlett et al. 5), see also (Carvalho et al. 2013; Boslaugh 2013).

Figure 4 displays the population pyramid in Afghanistan and visibly shows the large groups of people under the age of 20.

TABLE 16: DISEASES AND STUDIES

Disease/Indicator	Quantitative indicators	Study Materials and recommendations
Infectious and parasite diseases		
(1) cough & cold	• 4,176,191 cases (20.3%); children below 5: 28% of all under DEWS[f]	(Csetal.Ä)
(2) Diarrhea	• Acute diarrheal disease (+ with dehydration): 11.13% of all under DEWS[f] • Acute watery/bloody diarrhea: 2.1 million (8.25/2.15%); children <5: 15.39/3.27%[f]	(Opryszko et al. 2010)
(3) Pneumonia	• 746,479 (3.63%); children <5: 7.43% of all under DEWS[f] • Care seeking for suspected pneumonia 63.9% (MICS 2011)	
Malaria[1]	• Total number of reported malaria: 364 243 (2001) → 290,079 (2014) [a] / 350044[e] • Percentage of suspected malaria with diagnostic test: 73%[e] • Incidence of confirmed malaria 3.5/1000 (2014) [a] (13,000/100,000 (2003) → 330/100,000 (2015 CSO)) • Total number: 106,386[c] • incidences of confirmed malaria cases per 1000 = 4.2[e] • Sleeping under ITN the previous night 30.6[a 2004], 18.2[e]	(Rowland et al. 2002; Adimi et al. 2010; MoPH 2008)
HIV[1]	• Newly reported 165 (2014), estimated: 999 [a 2014] (48 (2006) →1856 (2015 CSO) • Antiretroviral therapy among patients living with HIV: 3.8[a], 5.3%[e] • Higher, underreported because of widespread social stigma, accepting attitude low: 16.0 (MICS 2011) • (low) comprehensive knowledge about HIV prevention: 1.5 (micS 2011) • HIV-Test: IDU: 22.5%; Sex workers: 5.9%; MSM: 17.4%[a]	(Ruisenor-Escudero et al. 2014; Todd et al. 2015)
Poliomyelitis[2]	• 25 cases [a 2010], 14 [a 2013], 28 [a 2014], 20 [a 2015]	(MoPH 2015d; CDC 2012; Nordland; Norris et al. 2016; Abimbola et al. 2013)
Typhoid Fever	• 0.40% (N=81,716) of all cases under DEWS[f]	
Hepatitis	• 0.7% general population, 32.6% of injected drug users • 0.05% (N=10,896) of all cases under DEWS[f]	(Chemaitelly et al. 2015)
Measles[1]	• Incidences (per 1,000,000): 4.55 (2008) →20.8 (2014) [a] • 0.06% (N=12,390) of all cases under DEWS[f] • responsible for 46.2% (N=200) of all outbreaks in 2015[f]	
Leishmaniasis[2]	• 30,319 (2007); anthroponotic cutaneous 32,364 (2012), zoonotic c. 1530 (2012), zoonotic visceral 24 (2012)[a]	(Stewart and Brieger; Reithinger et al. 2010; Reyburn et al. 2003; Monge-Maillo and Lopez-Velez 2013)
Tuberculosis[1]	• Notification: 103 per 100.000[e] (20/100,000 (2003) → 340/100,000 (2015 CSO) • Treatment success: 92% (2013) → 88% (2014) [a]	(Delawer et al. 2013; Ahmadzai et al. 2008)
Tetanus	• 148 cases DEWS[f] • Neonatal tetanus protection: 40.8 (MICS 2011)	
Leprosy	• Leprosy 2008: 24 cases (WHO 2010e)	
Congo virus	• Crimean-Congo hemorrhagic fever (CCHF) 8 died(Sahil 2016)	(Sahil 2016)
Further infections and diseases	• Meningitis: 0.05 (N=9,704) of all cases under DEWS[f] • Gulran diseases • Thalassemia	(Akbarian et al. 2015)
Immunization coverage	• Polio: 48.0ß	(Hemat et al. 2009; WHO and UNICEF 2015; WHO | World Health Organization)

	• Measles: 55.5 (MICS 2011), 90%(e) E.g., Measles 46% (2001) → 88% (2014) (a) (2) • Tuberculosis: 64.2 (MICS 2011) • DTP3: 45% (2001) → 95% (2014)(a)	
Life-skills factors/lifestyle factors and non-communicable diseases		
Prevalence of Tobacco Use(2)	• 13-15 years: 7.6 (2010 in Kabul)(a) 8.6%(e); 35.2 (WHO FCTC 2016) • Tobacco Free Initiative **(2)**	(Mohmand 2011; Heydari et al. 2012),
Drugs	• 1 in 9(Iraj n.d.) • (Approximately 3 million drug addicts) cf. Mop 2016 (UNODC et al. 2009)	(AREU 2006; Cottler et al. 2014)
Diabetes	• (No data)(a) 8.4% (m: 8.0; f: 8.8) (WHO DIABETES "16), 8.8%(g)	(Singh et al. 2015)
Malnutrition (A et al. 2016) (2)	• Stunting (moderate and severe): 51.6 (MICS 2011)/children <5: 40.9(e) • Wasting (moderate and severe): 13.9 / 9.5%(e) • Micronutrients deficiency: Anemia among women: 40.4(e) • Vitamin D deficiency 95.5% (NNSV 2013)	(Ahmed et al. 2014; Assefa et al. 2001; Levitt et al. 2010; Flores-Martinez et al. 2016)
Overweight obesity	• Overweight/obese children <5: 5.4/2%(e) • Overweight/obese adults (18+ years) 16.2/2.9(e) in Jalalabad prevalence: 27.4	(Saeed 2015; Ng et al. 2014)
Diarrhea-Treat	• Oral rehydration therapy 70% (e) with continued feeding: 47.5 (MICS 2011)	(Aluisio et al. 2015)
Further risk factors	• Raised blood glucose (18+ years): 9.6%(e) • Raised blood pressure (18+ years): 21.7%(e) • low physical activity (daily < 11 min): (no data)(e) • low intake of fresh fruits and vegetables (%):(-)(e)	
(WHO 2010e) Alcohol con-sumption	• 0.7 liter per capita annual average (2008-2010) (WHO 2010d) • Total Ban	
Cancer(1)	• 115.2/100,000 incidence all types(e)	
Maternal and child health		
Maternal and child mortality	• Antenatal care coverage: 1 or 4: 47.9, respectively. 14.6 (MIC 2011) respective. 60.0/16.4(e) • Institutional deliveries 32.9 (MICS 2011); 35.8 (NRVA 2011) • Skilled births attendance 15% (2002) → 40% (2014)(a)	(Adegboye and Danelle 2014)(Ahmadi et al. 2015; N et al. 1969)(Cs et al. 2008; Kim et al. 2012; Rahmani and Brekke 2013)
Ante- and Ne-onatal health	• Prematurity 12%; early childbearing 25.6 (MICS 2011) • Low birth weight: 6%(e) • Neonatal sepsis: 4%	(Kandasamy et al. 1969)
Breastfeed	• Early initiation: 53.6% • Predominant under 6 months: 69.2% (MICS 2011) 58.4%(e) • Age-appropriate: 36.7% (MICS 2011)	
Reproductive Health(2) Family Plan-ning	• Demand for family planning satisfied with modern methods 51.8%(e) • Contraceptive prevalence: (no data)	(Conde-Agudelo et al. 2007; Sato 2007; Tawfik et al. 2014; Am Rahmani et al. 2013; Todd et al. 2008)
Obstetric fis-tula	• 4 of 1000 (UNFPA 2011)	(Cs et al. 2008; Kim et al. 2012; Rahmani and Brekke 2013; UNFPA 2011)
Disability (people with)	•	(Bertani et al. 2015; Handicap International 2006; Trani et al.; François et al. 1998; Trani et al. 2016)
injuries	• 15.5/100,000 mortality rate from traffic injuries estimated(e) • In 2015/16: 2,927 recorded accidents (most of them either by car or motorcycle) (government: ‚at a glance ‘); self-immolation (amnesty international)	(Saeed et al. 2016)
Mental health		-
mental health	• Women/men • Service coverage for severe mental disorders: (no data)(a) • YLD Depression "highest" in Afghanistan (Ferrari et al. 2013)	(Amowitz et al. 2003; Miller et al. 2006; Miller et al. 2008; Dastagir Sayed 2011)
Additional risk factors/stress-ors	• Traumatizing experiences (no data)	(Miller et al. 2008; Miller and Ras-mussen 2010)

Note: (a) = WHO 2016, (b) = CIA 2016, (c) = CSO 2016, (d) = UNDP 2015, (e) WHO 2016b, (f) MoPH 2016, (g) = World Bank 2016

In this table (Table 16), the prevalence and related health measurements of the health status were presented in four categories: infectious and parasite diseases (which are very common in Afghanistan), lifestyle factors, maternal and child health, and mental health. This table also demonstrates that finding data on communicable diseases is easy, but data on lifestyle factors or non-communicable diseases are rarely available. Generally, the prevalence of communicable diseases is high (if compared to other countries in South Asia). People in Afghanistan are still affected by diseases that have been almost eradicated worldwide, such as polio, leprosy, and leishmaniasis. The numbers of malnutrition are extremely high; not only the stunting and wasting rate is high, but there is also a remarkable increase in obesity within the last few years. Furthermore, the care for pregnant mothers is very low; despite the increase, many births are still unattended by skilled health workers. Only about half of the population report that their demand for modern family planning methods is satisfied. Also, there is a rising need for more treatment (and prevention) of the rising number of people addicted to drugs, as well as to find ways to provide appropriate care for the high number of mentally ill or mentally burdened people.

4.3.1 Specific Themes/Groups

Using aggregated data to describe Afghanistan cannot give a precise picture of the situation of individuals or a specific group of people or a region. One interviewee put it there is not “one Afghanistan” there are at least “two Afghanistans,” which are Kabul and the other areas (A2, G7, 14). Also, another said that Herat is a “really special” city, with more educated people and influenced by Iran (I1, 35). Besides the geographical location and the level of education, further distinct lines for differentiation can be drawn, such as ethnicity (I10, 12) and the level of vulnerability (I1, 19). The purpose of this master’s thesis was not to investigate one person with a case study or the whole public health system with nationwide surveys and longitudinal studies, even though this would be promising for future research. The purpose was to give sufficient general information on the contextual factors but also specific enough in order to be able to assess health promotion approaches. In a country without general available social and health insurance and poor living conditions, the health status of the most vulnerable is even more affected by environmental determinants, and their coping/resilience is extremely low (WHO 2016a). Therefore, they can be considered highly at risk of suffering from a majority of diseases (I1). The interviewees described several particular groups at risk, such as children (I11), mothers, youth, young women (I2), widows (I3), elderly people (HelpAge International), and poor people (I1). But they also name a large number of migrating people such as internally displaced people (I14), refugees (I4, 26), undocumented Afghans, returnees, in prison, nomads, further those living in rural/urban/urban slums, groups of people that are discriminated, e.g., Hazara, drug-addicts, trafficking…) The

interviewees recommended that these groups have their specific risk profile health difficulties that need to be studied separately and addressed specifically (I3, I4).

4.4 Conclusion: Overview of the Health Situation in Afghanistan

The purpose of this chapter was to provide an in-depth understanding of the context of health in Afghanistan by describing the prerequisites, the determinants of health, the health indicator as well as the manifestation of diseases. Good knowledge of the context allows for defining the most influential factors on health, the most important health issues, the expected challenges, and available resources, as well as the assessment of the appropriateness of health promotion approaches. By using a mixed-method approach, the author sought to compensate for the shortcomings of one individual method and the poor quality of many data. Furthermore, she contrasted qualitative data from interviews with quantitative data on the prerequisites for and the determinants of health to refine the qualitative findings and relativize the quantitative epidemiological findings. To better understand the health status of Afghanistan, she has presented the main health indicators as well as referred to existing studies on these health issues in Afghanistan. The data used was (a) findings from the semi-structured qualitative interviews (N=28) and questionnaires (N=22), (b) databases of the UN, WHO, World Bank, and CIA World Factbook, as well as (c) research articles.

In summary, the general context of health in Afghanistan is extremely challenging and has an almost exclusively negative impact on health. Overall, the prerequisites for health are poorly manifested, as shown in the 28 interviews and supported by quantitative data. The five top challenges are insecurity, corruption, poverty, low level of education, and cultural barriers. Also, the following determinants of health lack good housing conditions, access to improved water sources and sanitation facilities, and a variety and sufficiency of nutrition.

The health indicators can be summarized in the four statements: (i) There is a high prevalence of preventable diseases; and a significantly higher rate of maternal and child mortality and of polio, leprosy, or leishmaniasis when compared with other conflict-affected countries or countries in South Asia. (ii) Since 2001, there have been remarkable improvements in many health indicators, e.g., life expectancy and reduction in neonatal mortality rate. (iii) New challenges for the health sector arise from increased non-communicable diseases and substance abuse. (iv) There is little scientific research available on health promotion, and most of the studies focus on maternal and child health and communicable diseases and were conducted in cities.

Even though the longitudinal comparison of health indicators in Afghanistan within the last 15 years shows remarkable improvements (Ahmadi et al. 2015; Akseer et al. 2016b), the remaining needs are still very high. Moreover, the demand for health services has intensified due to fast population growth due to the high birth rate and the influx of Afghans returning from Pakistan in

2016 (ACF and OCHA 2016; OCHA 2016). Comparing the identified findings with other research on community health in Afghanistan, it becomes apparent that the five top challenges largely overlap with the four most crucial areas for the future of the community midwifery education program. These are funding uncertainty, insecurity, corruption, and the lack of regulation (Speakman et al. 2014). In their country cooperation strategy, the WHO hinted at the environmental determinants but did not specifically investigate the prerequisites or the social determinants (WHO 2010c). However, in 2008, the WHO analyzed social determinants in countries of conflict and concluded that the major three are (i) the loss of human rights. The (ii) breaches of medical neutrality require national and international action and the involvement of NGOs. Moreover, lastly, (iii) stress, distress, and disease (WHO 2008). These positions were also expressed in the interviews, yet, overall, the participants referred to the identified five prerequisites and elaborated on their impact on all areas of life.

The quantitative, aggregated data presented here can give a first idea of a country's general situation. It can help prioritize action areas and contrast them with other countries' situations or further relevant sectors. However, it cannot reveal the large variations within the diverse 'Afghan' population and countrywide. The qualitative data and the studies show significant differences in geographical location, socio-demographic and economic status, literacy, and gender (Naim et al. 2015). These researchers stressed even more the vulnerable and inadequate situation in which many Afghans in remote areas live. For example, Ahmed et al. demonstrated how these challenges intensify the impact on the health of mothers and children[15] (Ahmed et al. 2004). The challenges within the context do not only impact the health of any individual Afghan but also shape the working environment for the NGOs and form barriers to health care. One further interesting observation needs to be mentioned, which applies to all other studies: the limitation of data. Data was either (a) not available, for example, can nothing be said about lead and pollution, (b) old, (c) not representative because it was a small group, often in urban areas, (d) or of questionable reliability. This is shown by the fact that the data on the same issue varies not only between providers but also from the same provider (See also OCHA 2016)

IMPLICATION: The poor manifestation of the prerequisites, determinants, and health indicators specifies a significant need for health promotion and disease prevention. Because of the considerable heterogeneity, the specific manifestation of the prerequisites for and determinants of health must be thoroughly assessed, and the program must be adapted according to the identified needs

[15] Household health indicators indicate serious maternal and child health concerns in these two districts. Of particular concern is the poor immunization coverage, lack of reproductive health service, and the prevalence of common childhood illness in these populations. The feeding practices for children and the anemia among mothers also raised concerns. Poor environmental health contributes substantially to childhood illness. Without special emphasis, efforts to rebuild the health sector are likely to reach the household level only late in the process. An aggressive program to integrate community development and promotion of sound health practices is needed to i OCHA 2016mprove the health of the Afghanistan people. (Ahmed et al. 2004

of the target group and the contextual condition. However, the various challenges could limit the scope of action despite the need.

Based on these findings, some critical questions are worthy of further discussion.

- With a long-term perspective in mind, one can ask: Which prerequisite for or determinant of health has the highest impact on health? How can this factor be improved, and would it be more effective to invest all resources primarily on this factor instead of simultaneously focusing on many other areas?
- From a humanitarian point of view, one should consider the question: What are the most pressing needs in health, and what are the most effective and cost-effective strategies to reduce these urgent needs?
- From a needs-based versus asset-based perspective, it is worth reflecting on the question: Should one primarily focus on reducing the immediate needs, or should one strengthen the existing resources to help to cope with the situation?
- From the perspective of a health promotion program 'conceptualizer,' one should reflect on the question: Is it possible and adequate to develop a general health promotion program adequate in a country with such huge diversity?

5 Afghanistan’s Health System

In the next chapter, the author provides an overview of the existing health system focusing on health promotion. A health system consists “*of all organizations, people, and actions whose primary intent is to promote, restore and maintain health*” (WHO 2000). The overview is based on MoPH documents the MoPH (policy, strategy papers, and surveys), the WHO cooperation paper (WHO 2010), further scientific studies as well as publications of health care providers. For structuring purposes, the author did not repeat Boslaugh’s description of ten categories in “health care systems around the world” (Boslaugh 2013) but explored and summarized the Afghan health system based on the WHO Health System Framework (see Figure 5). This is an internationally used, standardized analyzing tool, which makes it possible to compare the Afghan health system with other countries (WHO 2016b). The WHO Health Systems Framework includes six system building blocks that lead – by taking into consideration access, coverage, quality, and safety – to the four defined goals: improved health, responsiveness, financial risk protection, and improved efficiency. The chart below shows the framework and a brief summary of the following chapter. Each building block is discussed by (a) giving the definition, (b) demonstrating the commonly used indicators, (c) describing the situation with quantitative data, and further specifying it by (d) presenting qualitative data.

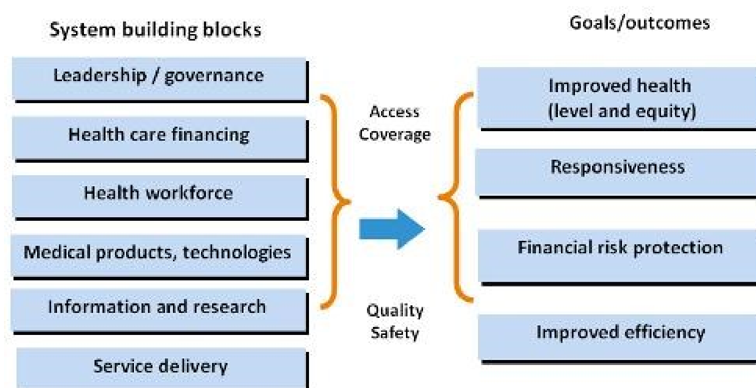

FIGURE 5: WHO HEALTH SYSTEM FRAMEWORK (WHO 2016B)

5.1 Development of the Health System at a Glance

Before analyzing the health system, the author gives a brief outline of the development of the health sector since 2001. An in-depth study on the historical development of Afghanistan or its health care system is beyond the scope of this thesis but can be read in (Waldman et al. 2006; AREU 2002; Newbrander 2007; Hartman and Newbrander 2006). During the warlike confrontation since 1979 under the Sowjets, since 1989 under the Mujahedeen, as well as till 2001 under the Taliban, vast areas of the health system were destroyed. In addition, the health of Afghans was negatively impacted by violence, poverty, food insecurity, population displacements, and even the breakdown of family units (WHO 2008; UN o.d.). Almost no data on the health status and the health system were available in 2001, so rapid baseline studies and an assessment of Afghan health resources were conducted. They revealed a ‘catastrophic” situation in 2002 and painted a very grim image of the health system. There were a lack and shortage of everything,

such as finances, health facilities, health workforce, equipment, capacity, and policy-making structure. Also, the health status was disastrous (MOH 2002; Waters 2007). Furthermore, the determinants of health, e.g., poverty and education, were very low. "We are looking at one of the worst humanitarian crises in the world," stated UN Representative Letizia Rossano (Ahmad 2001). Within the first years after the expulsion of the Taliban, there was an enormous influx of new organizations, embassies, and security forces to support Afghanistan in the reconstruction process. The emergence of (local) organizations in the health sector was comparable to "mush-room-style progress in health sector" (World Bank 2015). To channel the initially uncoordinated attempts to (re-)build the health system by various organizations, a joint donor mission under the leadership of the MoPH, World Bank, USAID, EC, and NGOs developed common strategies. Based on a self-defined set of prioritized needs, they developed the Basic Package of Primary Health Services (BPHS) in 2002/2003 and the Essential Packages of Hospital Services (EPHS). The aim of BPHS is to provide basic healthcare services to all people in all areas. Also, the EPHS provide secondary diagnostic and treatment services. In both BPHS and EPHS strategies, a stand-ard package of treatments, structures, and resources on each health system level was defined. Due to a shortage of all resources, the MoPH could not provide these services by itself. Therefore, a three-player structure was introduced. The MoPH has the coordinating role and contracts out the services of BPHS and EPHS to NGOs. The three largest donors, World Bank, USAID, and European Commission, cooperate with NGOs either directly or through the MoPH with several types of contracting in and contracting out mechanisms (Newbrander 2008; Hamilton et al. 2016). Several large programs integrate these strategies, such as REACH (Management Sciences for Health) and SHARP (2009-2013). In 2012, the MoPH and the international community developed one shared strategy, System Enhancing for Health Actions in Transition (SEHAT), to coordinate the three main donors in the transition period. The two most important components of this strategy are (1) provision and implementation of basic health and essential hospital services both in rural and urban areas to improve access to and quality of health service and (2) strengthening of Ministry of Public Health stewardship functions and build system both at the central and provincial level (MoPH 2016c; EU 2015). Generally, the implementation of the BPHS and EPHS did not happen smoothly but repeatedly faced the challenges of recurrent crises and violent confrontation, insufficient resources with high-level of poverty, and low education (Hamann 2005; WHO 2002; Waldman and Hanif 2002). See also the initial National Development Frame-work (AACA 2002; RAND 2006; Michael et al. 2013; Acerra et al. 2009).

5.2 Leadership and Governance

> "**Leadership and governance** involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, attention to system-design, and accountability." (WHO 2016b)

6. Leadership and Governance
Review of national health policies in respective domains (such as essential medicines and pharmaceuticals, TB, malaria, HIV/AIDS, maternal health, child health/immunization)
Policy Index (including ten areas, not calculated)

Afghanistan's health system is led by one of the 25 ministries, the Ministry of Public Health (MoPH). It is represented by provincial departments in all 34 provinces and 398 districts with offices (Ahmadi et al. 2015). Its legal basis is Article Fifty-Two of the Constitution of Afghanistan from 2004:

"The state shall provide free preventative healthcare and treatment of diseases as well as medical facilities to all citizens in accordance with the provisions the law. Establishment and expansion of private medical services, as well as health centers, shall be encouraged and protected by the state in accordance with the provisions of the law. The state shall adopt necessary measures to foster healthy physical education and development of the national as well as local sports." (AREU 2015)

Article 53 further defines the necessity that aid should be guaranteed specifically to the most vulnerable people (AREU 2015). The MoPH defined the mission as: *"To improve the health and nutritional status of the people of Afghanistan through quality health care services provision and the promotion of healthy lifestyles in an equitable and sustainable manner." (MoPH 2012c).* Currently, its five main areas of operation are (1) Governance, (2) Institutional Development, (3) Public Health, (4) Health Services, and (5) Human Resources (MoPH 2015c). The MoPH strives to operate based on the following working principles right to health, especially for women, children, and other vulnerable groups; gender balance; quality; transparency; sustainability; responsibility; results-oriented culture; teamwork, cross-functional and sectoral working; evidence-based decision-making, and lifelong learning (MoPH 2015c).

The five types of main actors in the health sector are MoPH, donors, NGOs[16], and traditional and private healthcare providers (Hamilton et al. 2016). Since 2002, four people have held the position of Minister of Public Health: Sohaila Siddiqi (2002-2004), Mohammad Amin Fatemi (2004-2010), Dr. Suraya Dalil (2010-2015), and Dr. Ferozudin Feroz (MoPH o.d.) since 2015. The Afghanistan National Public Health Institute is the academic and intellectual body of MoPH with its five sub-departments: the community-based healthcare department with the Public Health Research Department, Central Public Health Lap Dept., Surveillance/DEWS & All Dept., Public Health & Management Training Dept, and the Health Promotion Department. The Health promotion department's Term of Reference defines its priority as 'healthy behavior promotion' and not promoting a healthy environment (ANPHI; MoPH; ANPHI; ANPHI; AMPHI; ANPHI). Within the last 15 years, the MoPH has developed many laws, regulations, policies, strategies, and statements concerning health to regulate the centralized health delivery system in close cooperation with international consultants. The following table (Table 17) presents the newest, most relevant,

[16] In 2015, there were "1,947 NGOs registered with the Ministry of Economy. Of those, 273 are foreign NGOs and 1,674 are domestic" (it could not be defined how many NGOs work in health sector (see overview providers in chapter §) WADSAMhttp://wadsam.com/afghan-business-news/afghan-government-to-supervise-ngos-to-ensure-transparency-232/

and online accessible publications pertinent to this research on CBHP: A more exhaustive overview is attached.

TABLE 17: CURRENT HEALTH POLICIES AND STRATEGIES

PROGRAM	YEARS	WEB LINKS
MoPH Strategic Plan	2011-2015	(MoPH 2011b)
National Priority Program – Health for All Afghans		(MoPH 2012c)
National Health Policy	2015	(MoPH 2015c)
System Enhancing for Health Actions in Transition (SEHAT) Program	2016	(MoPH 2016c)
Community-Based Health Care Strategy	2015-2020	(MoPH 2015a)
Policy of and National Reproductive Health Strategy* 2012-2016	2012-2016	(MoPH o.J.)
National Communication Strategy for Nutrition 2013-2016	2013-2016	
National Mental Health Strategy	2009-2014	(MoPH 2009b)
National Strategy on Human Resource for Health (HRH). Capacity Building with a focus on In-service Training	2014-2018	(MoPH 2014c)
Afghan National Drug Action Plan 2015-2019	2015	(MoCN 2015)
Comprehensive Health Care Waste Management Plan (HCWMP) for the (SEHAT) project	2014	(MoPH 2014a)
Term of Reference of Health Promotion Dept.		(MoPH)

The most important strategies for CBHP in Afghanistan are, apart from the BPHS, the EPHS and the CBHC (see Chapter 5.2), the *Health for all Afghans,* and the National Health Policy."

The core values of the MoPH are (a) the right to health, (b) partnership and collaboration, (c) community participation and involvement, (d) evidence-based decision-making, (e) results-oriented culture, (f) quality, (g) transparency, (h) sustainability, (is) dignity and respect, (j) equity. (MoPH 2012c). In its national priority program **"Health for all Afghans**, "it defines three main components**:** (1) to improve & expand existing health service delivery; (2) to increase and improve HRD for Health & Good Governance; (3) to improve health finances. Component 2 is important for this study because it addresses evidence-based community-based health promotion. The Sub-components 2.5-2.7 and their deliverables are presented in the next table (Table 18) (MoPH 2012c).

TABLE 18: OVERVIEW CBHP RELATED SUP-COMPONENTS OF MOPH (2012)

Sub-component 5: To support health promotion and community empowerment	**Sub-Component 6: To enhance evidence-based decision-making by establishing a culture that uses data for improvement**	**Sub-Component 7: To advocate for and promote health environments**
1: The capacity of communities to initiate and implement activities that promote their health is strengthened, _2: The capacity of MoPH and health sector staff to effectively promote healthy behaviors in communities _3: The evidence bases regarding health-related knowledge, attitudes and behaviors and effective strategies that promote and support positive health behaviors/healthy lifestyles in Afghan communities are expanded	1: Relevant legislation is developed that supports improved reporting and confidentiality of essential health data _2: Capacity and awareness are built-in monitoring, evaluation, research and data usage for performance measurement and evidence-based policy-making and planning	1: To strengthen the stewardship role of MoPH in relation to environmental health by developing regulations & clarifying roles and responsibilities under the Environmental Health Program _2: Build the capacity of MoPH management and staff related to environmental health to advocate for increased availability of safe drinking water in order to reduce the burden of disease from contaminated water _3: To increase food safety practices to prevent food-borne illnesses in food service and retail establishments _4: To develop a systematic framework to lead a national process to reduce air pollution and promote

_4: Clear, simple and understandable health education messages are designed for communities to facilitate the integration of community health workers into pre-service and in-service education _5: Monitoring and evaluation of health communication activities are supported _6: Non-communicable diseases prevention and awareness (NCD-PA)	_3: To develop an information technology (IT) infrastructure within the MoPH to support the health information system (HIS) _4: Strengthen governance in the health sector related to statistical information	clean air (in collaboration with the Environmental Protection Agency) 5: To create a national multi-sectoral radiation protection forum to agree on and advocate for safe levels of radiation in the country, including increasing industry and public awareness of this issue _6: To create a national multi-sectoral stakeholder mechanism for the management of garbage and hazardous wastes (including solid waste and healthcare waste) 7: To improve hygiene and sanitation throughout the country among the general public and health workers

The new **National Health Policy 2015-2020** envisions that "All citizens reach their full potential in health contributing to peace, stability and sustainability development in Afghanistan" (MoPH 2015c). This is further specified in a very holistic mission:

> "The Mission of the Ministry of Public Health of the Government of the Islamic Republic of Afghanistan is to prevent ill health and achieve significant reductions in mortality in line with national targets and sustainable development goals and to reduce impoverishment due to catastrophic health expenditure. Also, to be responsive to the rights of all citizens through improving access and utilization of quality, equitable, affordable health, and nutrition services among all communities especially mothers and children in rural areas and through changing attitudes and practices, promoting healthy life-styles and effectively implementing other public health interventions. All in coordination and collaboration with other stakeholders within the framework of strong leadership, sustained political will and commitment, good governance, and effective and efficient management; in its continuous pursuit to become a ministerial 'institution of excellence'." (MoPH 2015f)

In this policy, in the section Public Health, the MoPH recommends various interventions to prevent communicable and non-communicable diseases and to address lifestyle and environmental factors on the individual (behavior change) and national level through control of imported food. They demonstrate their commitment through several statements for related areas, such as the community health and empowerment statement, health protection, and preventive health policy statement. (MoPH 2015c)

In the qualitative interviews and questionnaires, the following themes emerged repeatedly. First of all, the respondents acknowledged the important role the MoPH has (I4, 36) and supported the idea of coordination and regulation through the MoPH. However, despite this, they named some challenges: *"but it could have been far positive. The two, three things it avoided in a precise, very effective, and positive role is on the corruption issue. The other is the low technical expertise, the (…) and the third you can also add the equipment or the resources for the financial resource*" (I4, 36). The following topics were repeatedly named (a) it has low technical expertise (I5); (b) it is weak in executing the strategies and in regulating and maintaining (e.g., A15, I2, I4), (c) it cannot cover the whole country (I5), (d) not all papers are translated from English into Pashtu or Dari (I1), (e) there is poor coordination among the several providers (A19, I1).

5.3 Service Delivery – Facilities and Main Services

"Good **health services** are those which effectively deliver, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources." (WHO 2016b)

1. Health Service Delivery (2001 → 2014 =/= suggested)
District and national databases of health facilities. Special efforts — notably facility censuses — are often required to obtain the number of private facilities, especially if no registration system is enforced; Population-based surveys; Health facility assessments
- Number and distribution of health facilities per 10 000 population: 0.4 - Number and distribution of inpatient beds per 10 000 population (3.9 → 5.0) (=/=10) - Number of outpatient department visits per 10 000 populations per year - General service readiness score for health facilities (n.i.) - Proportion of health facilities offering specific services (n.i.) - Number and distribution of health facilities offering specific services per 10 000 population (MoPH HMIS Department) - Specific-services readiness score for health facilities (n.i.)

5.3.1 Facilities

The MoPH and the international community have designed a hierarchical system of referral and supervision. In the BPHS and EPHS, each of the seven levels is clearly defined regarding staffing, catchment area service delivery, and equipment (cf. Figure 6). From the national, regional, provincial, and district hospitals to comprehensive and basic health centers to health posts (see Figure 6). Currently, the number of primary health facilities is 0.4 per 10 000, which is the third lowest in the EMRO region. The annual number of outpatient department visits per capita is 1.9, which is low compared to the 4.6 in Pakistan (WHO EMRO). Table 19 gives an overview of the types of facilities[17][18], the absolute number of facilities, and the development since 2002, 2009[19], and 2016.

FIGURE 6: HEALTH SYSTEM HIERARCHY (MOPH 2010A)

[17] There is one important comment that one needs to make. This is that not all facilities exist or operate. Some are written on paper but there are empirically based concerns on the validity of this data and additionally there are some facilities – such as the Chinese hospital – that was built but it does not operate at the moment. One can conclude that the existing data should be used cautiously, there are some facilities that do not exist or operate but it is hard to quantify.

[18] The diversity in the types of hospitals can be exemplified with the following four hospitals: such as for a selected group of people theDawood National Military Hospital oversight 2012, for specific diseases the Noor Eye Hospital in Kabul (cf. IAM), for specific target groups the French Medical Infant and Child Hospital, or for specific areas Chak-e-Wardak Schefter 2002(presented at conferences).

[19] 2009 was chosen because many interviewees described that till 2009 it was an improvement and since 2009 there is a deterioration in the security situation which has an impact on all projects.

TABLE 19: FACILITY TYPE (CHRONOLOGICAL DEVELOPMENT)

FACILITY TYPE	2002	2009	2009	2016/ week 24
Polyclinic			n.i.	1
Regional / National Hospital	21	6&26	5/n.i.	+
Provincial Hospital	41	28	30	34
District Hospital	114	75	61	80
Comprehensive health center (CHC)	(n.i.)	392/442	372	
Basic Health Centre (BCH)	353	822/928	780	+ CHC 1239
Sub-Centre	224	526/423	342	
Other specialized centers (TB, malaria, EPI, etc.)	85 +2 +2+70	n.i.	22/87	29
Private Hospital				293
mobile health Team	22	103	55	
Total	912	2221	1754	1676
	(MOH 2002)	(MoPH 2014/ CSO 2015)	(Lodin 2009)	MoPH 2016

This overview shows three remarkable phenomena: first, the undeniably remarkable increase in health facilities between 2002 and 2009. Second, it might reflect a decrease since 2009. Third, it gives hints to the questionability of the reliability of the data, as demonstrated in the year 2009 when the MoPH, CSO, and Lodgin's data differed sharply. This table does not reveal the great inequity in the distribution of health facilities with a concentration in the major cities, particularly Kabul (MoPH HMIS Department; Dittmann 2014; Akseer et al. 2016a). In 2008, the MoPH declared that 85% of all districts in Afghanistan have access to BPHS (Frost et al. 2016). In 2010, more than 60% of all Afghans lived more than 1 hour's walking distance away from a healthcare facility (World Bank Group 2010). In 2016, there were still almost 3 Mio people (approx. 10%) who lived further away than 2 hours' walking distance from the next facility (WHO 2010b). The permanent health facilities are supported by various mobile health teams/mobile health clinics covering remote and white areas. In addition to the public facilities, innumerable private health care providers emerged rapidly in the last years.

5.3.2 MAIN NATIONWIDE APPROACH SEHAT: BPHS AND EPHS

1. Maternal and Newborn Care	a. Antenatal care b. Delivery care c. Postpartum care d. Family planning e. Care of the newborn
2. Child Health and Immunization	a. Expanded Program on Immunization (EPI) b. Integrated Management of Childhood Illness (IMCI)
3. Public Nutrition	a. Prevention of malnutrition b. Assessment of malnutrition

4. Communicable Disease Treatment and Control	a. Control of tuberculosis b. Control of malaria c. Prevention of HIV and AIDS
5. Mental Health	a. Mental health education and awareness b. Case identification, diagnosis, and treatment
6. Disability and Physical Rehabilitation Services	a. Disability awareness, prevention, and education b. Provision of physical rehabilitation services c. Case identification, referral, and follow-up
7. Regular Supply of Essential Drugs	Listing of all essential drugs needed

TABLE 20: CONTENT OF BPHS

Two main nationwide approaches, the Basic Packages of Health Services (BPHS) (Table 20) and the Essential Packages of Hospital services (EPHS), define the structure of the health services. The 34 provinces are divided between the three main donors. Overall, the WB is responsible for 11 provinces under MoPH strengthening mechanisms, including three. USAID is responsible for 13 and the European Commission for ten provinces (WHO 2010b). Under the new strategy "System Enhancing for Health Action in Transition Program (SEHAT)," the three donors mainstreamed their budget in 2014 (MoPH 2016c). The current implementer of BPHS and their distribution can be found on the website "humanitarian response." (UN OCHA 2016a)

The structure is as follows:

- Each health post should be staffed with two community health workers (male and female) covering an area of 1,000 to 1,500 people.
- The basic health center's personnel are one nurse, one midwife, and trained people to administer vaccination with a catchment area of 15,000 to 30,000 people.
- The comprehensive health center has physicians (male and female), nurses, midwives, as well as lab and pharmacy technicians and should serve 30,000 to 60,000 people.
- Lastly, in a district hospital, specialized physicians (e.g., female obstetrics and gynecology specialist), midwives, technicians, and even a dentist should cover the catchment area of 100,000 to 300,000 people (MoPH 2010a).

5.3.2 Community-based Health Care

In addition to the BPHS and EPHS, a thoroughly developed **Community Based Health Care** strategy was implemented in rural areas to strengthen local disease prevention and health activities. The objectives of its revision in 2015 are expanding the CBHC, improving quality, empowering communities to identify health needs and take action, and enhancing governance (MoPH 2015a). For sustainability of the health service, the MoPH suggests establishing Health Shuras on several levels of the health system, starting at the provincial level as Provincial Public Health Coordination Committee (PPHCC) and going down to the Community development council Shura (the Facility Shura-e-Sehle). They receive support from Community Health Supervisors who are also responsible for Community Health Workers (female and male). The CHW trains the family health action groups (a group of women) on health issues. Then these women share the messages with their neighbors. The Facility Shura-e-Sehle cooperates with the community development council, community health post Shura-e-Sehle and the DHCC. Each role and responsibility are clearly defined in the strategy paper (MoPH 2009a, 2010b).

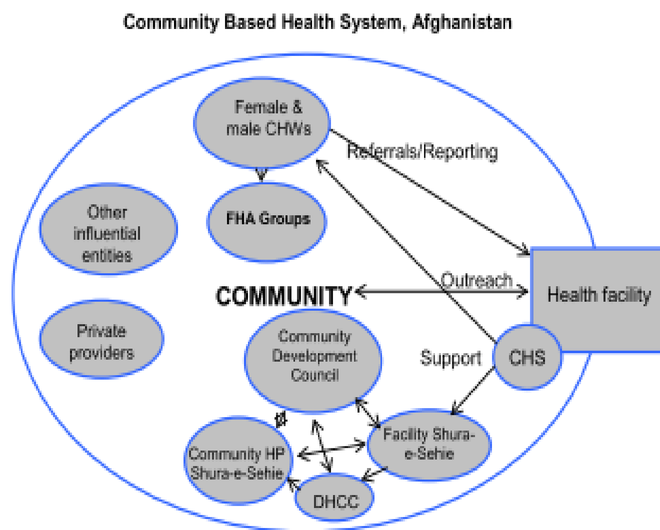

FIGURE 7: HEALTH ACTORS ON THE COMMUNITY LEVEL

In the point of view of the interviewees, the BPHS and CBHC were highly valued: "*Now we are mainly focused on these BPHS, which is very valuable, we are focusing on target groups, very primary health services, of course, they are very valuable but not enough." (I6, 47)* Reports and qualitative interviews revealed manifold shortcomings concerning health facilities and the provision of services. First of all, they pointed out the concentration of health facilities in the cities (A2), the shortage in a rural area as well as an increase in the closing of health centers[20] in the countryside due to insecurity (I13, I4) and even attacks on them (I9). Next, the respondents stressed that initially, the focus was on rapid expansion and less on quality (I1, 27). Furthermore, curative services are mainly provided and less promotive services (I9, 39). One respondent stated that the conditions are often poor, not reliable, and the standard is not met (A19). Furthermore, private health care providers are highly frequented because public health providers have limited opening hours of about 2-3 hours per day, and, commonly, doctors refer the patient to their private clinic in the afternoon. Besides, the service provision varies widely, e.g., one interviewee reported

[20] "" if you say it was at the number 5 percent then it reaches to the peak in 2007 and 2008 and after it is reduced, reduced and right now it is basically approach to very, very low level it means like 10 to 15." (I15b)

that immunization was everywhere in Balkh (I11, 24), whereas others stressed the difficulties in accessing areas. Even though the BPHS includes preventive and promotive services, the interviewees said that preventative services are rarely provided. One interview explained that the availability of a clinic does not mean better access to health care, as stated in the CMI report. Singh's assessment of the suboptimal provision in the public health system (2015). Besides, Newbrander Edward and Hansen have conducted several studies on the BPHS (Newbrander et al. 2014a), the role of a balance score card for quality assurance (Hansen et al. 2008a), the CBHC, the role of CHW (Najafizada et al. 2014; Newbrander 2008) and the quality of the services (Edward et al. 2012; Edward et al. 2009).[21] Figure 7 summarizes the different actors involved in providing health services and care at the community level.

5.4 Medical Products and Technology

"A well-functioning health system ensures equitable access to **essential medical products, vaccines** and **technologies** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use." (WHO 2016b)

4. Essential Medicines
National (or sub-national when necessary) surveys of medicine price and availability conducted using a standard methodology developed by WHO and Health Action International.
- Average availability of 14 selected essential medicines in public and private health facilities; (-)[a] - + Median consumer price ratio of 14 selected essential medicines in public and private health (-)[a] - Density per million populations of 6 selected medical devices in public and private health facilities - (a) computed tomography units: 0.2 (2014)[a] - (b) radiotherapy units: (-)[a] - (c) magnetic Resonance Imaging: 0.1 (2014) [a] - (d) Mammographs: 0.0 (2013) [a] - (e) Digital Subtraction Angiography units: (-)[a] - (f) Lithotripters: (-) [a]

In accordance with MoPH's BPHS strategy, every health facility should always have the needed essential medicine in stock and the required non-medical supplies; as defined in the BPHS and EPHS guidelines, all children should be vaccinated (MoPH 2010a). The discussion on medicine is mostly concentered on two most important aspects: supply/availability and quality. The availability in cities is higher than in rural and remote areas. A total number of **pharmacies** (11,971) exist, of which a small number (N = 169; 1.4%) are owned by the government (CSO 2016b). A total of 1,838 **laboratories** exist in Afghanistan of which 421.8% (769) are public (CSO 2016b). Even though this is the defined requirement, many health facilities are understaffed, lack

[21] For further details on the role, effectiveness and. of community health workers, see the Cochrane reviews: cf. Perry et al. 2014; Perry H and Crigler L, editors. 2014; Standing and Chowdhury 2008; Haver et al. 2015; Bhattacharyya et al. 2001; Ahmadi et al. 2015

electricity, water, or waste management, are short in supply of drugs (stock out), and have insufficient emergency obstetric care (Boslaugh 2013).

Whereas at the beginning of the 21-century, medicines were imported from outside Afghanistan, e.g., Iran, Pakistan, or China, more and more medicines are produced in Afghanistan and sold through pharmacies and even street sellers. Nevertheless, many practitioners report that the medicine is expired or lacking (imported vaccine). So there is a significant need to guarantee the drug quality and the medication supply chain, e.g., for medications and vaccinations that need to be stored (WHO 2010c; Schefter 2002; Mahr 2014). Depending on the special unit, various **equipment, and medical technology** are needed in addition to the requirements of EPHS and BHPH for this level of health facility. e.g., for Optical and Pharmaceutical Department produces glasses and medicine needed. Furthermore, having a basement full of expensive equipment does not mean that this is used, as it is repeatedly said (MSF 2014). Contraceptives are sparsely available and unacceptable (cf. the report by Rasooly et al. (2015)).

The interviewees reported that within the last 15 years, the availability of medicine in Afghanistan has increased (A2, 28; A15), but it is still of poor quality (A15). The regulation is fragmented, and the quality of control institutions should be improved (A15). Furthermore, importing medicine of good quality is not always easy, as well as buying medicine from an independent pharmacist as well (I7b). The shortage and stock out of medicine are even higher in rural areas (G3, I15) due to insecurity (I4, I9). Due to various circumstances and the low technical expertise of the staff (I4, 26), it is recommended to use locally available resources and 'simple,' not high-technology equipment (I8, 68).

5.5 Health Workforce

"A well-performing **health workforce** is one which works in responsive, fair, and efficient ways to achieve the best health outcomes possible, given available resources and circumstances. I.e. there are sufficient numbers and a mix of staff, fairly distributed; they are competent, responsive and productive" (WHO 2016b).

2. Health Workforce
Routine administrative records are periodically validated and adjusted against data from the national population census or facility-based assessments. •Routine administrative records from individual training institutions. In some cases, data may be validated against registries of professional regulatory bodies where certification or licensure is required for practice.
- Number of health workers per 10 000 population (n.i.) - Distribution of health workers by occupation/specialization, region, workplace, and sex (n.i.) - Annual number of health professions educational institutions graduates per 100 000 population, by level and field of education (n.i.) - (Calculation of these data was not possible because the correct numbers were missing)

The regulation for Afghanistan's health workforce is cemented in the strategy paper: health workforce 2012-2016 and their framework conditions (MoPH 2011a). The distribution of health workers on each level was described above (MoPH 2005a). Generally, there is an increase in medical professionals in absolute numbers. Little data is available on the distribution between urban and remote/rural, but it is widely known that the rural areas are disproportionally underequipped (MoPH HMIS Department).

In 2015/2016, 9808 doctors worked in Afghanistan, of which 18.5% (N=1821) were women. Additionally, 16.853 health associate professionals supported the health sector, of which 35.8% were women (N=6029) (CSO 2016)[22]. The government announced that there are about 20 000 community health workers. Approximately 38% of all health workers are employed by NGOs (CSO 2016b). The following table (Table 21) summarizes the progress made from 2001 to 2016[23]. It shows that the Afghan health force per 1000 is far from reaching the recommended 2.3/1000 threshold (WHO n.d.a).

TABLE 21: HEALTH WORKERS

category number of x per 1000	2001 in x per 1000[(a)]	2009	WHO (2014)[(a)]	WHO rec.	2016	Registered recent graduates per 100 000
hospital beds	0.39[(a),] 0.5 (CSO 2003)	0.5 (CSO 2009)	0.5 beds/1.000		n beds: 6.029 (13.6% increase)	
physicians	0.19[(a)]	GP 0.15; SP 0.07	0,27/1.000	2.3		(-)[(e)]
nurses and midwives	0.22[(a)]	0.14 + 0.08 (register.)	0.32/ 1.000	2.3 +2.3		(-)[(e)]
dentists	0.3[(a)]		0.1/10,000;	n.i.	reduction	(-)[(e)]
pharmacists	0.25[(a)]	pharma: 0.02; pharma technicians 0.03	0.3 /10,000	n.i.		(-)[(e)]

Additionally, there are many trained vaccinators, managers, and administrative staff. It is estimated that 7,000 additional physicians, 20,000 nurses, and other health professionals are missing (Boslaugh 2013). Currently, there are about 3,699 students in medical sciences institutions (CSO 2016b). Overall, there are six medical universities and nine institutes of health sciences (Boslaugh 2013). The MoPH has established schools for medical personnel on intermediate levels (training nurses, midwives, dentists, technicians in the lab, x-ray, pharmacists, and a course in public health) called the intermediate Medical Education Institute (IMEI). Additionally, they established CME centers in each provincial city to train CHN and CM. A variety of teaching material for CHW, FHAG, CME, and others, is available on the MoPH website (MoPH 2014b; Herberg 2005; IFRC 2013; MoPH o.d.). In addition to the medical school, the MoPH paid more attention to

[22] In its publication 'Afghanistan at a glance' the government announces having 15,822 health associated professionals and 8681 doctors. (At a glance

[23] Information of 2009 based on National Strategy for Improving Quality in Health Care

capacity building, stressed the importance of mentoring and coaching on the on-the-job of individuals, and strives to improve the rationalization, coordination, and holding of workshops and seminars in-country (MoPH 2015b).

In the interviews, the respondents further presented valuable insights into the health system. One explained that only the best students in the exam are admitted to medical school. (I4, 16). There is also a Public Health department at a medical school in Kabul (I12,81). Besides these public schools, there are also some private colleges (A18f) and training courses for special health professionals such as Ophthalmic Technicians at Noor eye-hospital Kabul (I1) and psychosocial counselors, orthopedic technicians, physiotherapists (A15,5) at the physiotherapists' Institute in Kabul and Mazar-e-Sharif (I1). Despite the unneglectable improvement in the training of health care professionals, there are still some difficulties, e.g., the poor quality of medical education (G6, A14, A20) or teaching material (see medical books by Yahya Wardak of Afghanic e.V.). Furthermore, the low literacy of many health workers (HW), particularly the CHW, requires appropriate teaching material. Besides, there are numerous vacant positions of qualified medical professionals and associates.[24] Concerning the health force, the themes that emerged in the interviews correspond to the quantitative findings and Mayhew's analysis (2015). This is the general shortage, lack of female staff, poor quality and concentration in the city, staff turnover, poor regulation, and salary concerns. In contrast, one interviewee emphasized that almost all facilities are fully staffed (in Bamiyan) (I6), and most report an overall lack of health workers (A15, A19, I15, I6, I9). Next, they stressed the lack of female workers (A15, I13) which demonstrates a huge barrier for women to seek care at the health center (I5, I13). Some NGOs try to fill this gap by offering additional training (I7a), e.g., on obstetric care or midwife assistants (A22). One interviewee elaborated on the concentration of health workers in the cities, who estimated that about 60 to 70% of graduates from Afghan medical school stay in Kabul, 20 to 30% in the larger cities, and only a small number works in the other areas (I4, 12). From their point of view, HWs are unwilling to work in rural areas (A19, I6), where they are sometimes threatened (A15). Some NGOs tried to increase attractiveness with incentives (A18, 22). The interviewee reported that often there is a huge staff turnover, and it also happens that an NGO, which was newly assigned to provide BPHS in a certain area, fires all old staff. This requires more training, for which often no further finances are available (I2). Lastly, they state there is a lack of execution of rewarding and punishment of health workers' conduct and service provision (I8, 68), e.g., through result-based financing as well as a need for more regulation concerning who is allowed to work as a 'medical doctor' (I6, I7c). Furthermore, salary in public facilities is low compared to salary in private facilities or NGOs. Mayhew additionally identified that many empirical findings hint at the challenges due to

[24] See the many vacant positions at RELIEFWEB, repeatedly updated.

high training costs, recurrent staff turnover, poor implementation quality, training content, and use of job aids and assessment lists (Mayhew et al. 2015).

5.6 Health Information

"A well-functioning **health information system** is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance, and health status." (WHO 2016b)

3. Health Information
Health information system performance index
Review of national health information systems (Birth registration coverage: 37%[(d)] n.r.f.[(a)] Death registration coverage: n.r.f. [(a)]

There is no data available for death registration. Also, the birth registration rate of 37 % is very low compared to other Middle Eastern countries, e.g., Pakistan.

5.7 Research Institutions

The MoPH combines five institutions under its Evaluation& Health Information System General Directorate: Monitoring Directorate, Research & Evaluation Coordination Directorate, HMIS Department, Surveillance Department, and Biostatistics Department. Furthermore, other organizations play additional important roles, such as the Central Statistic Organization, Management Sciences for Health, Afghanistan Research and Evaluation Unit (AREU), Silk Route Training and Research Organization, Health Protection and Research Organization (HPRO), Afghan Analysts Network, CPAU, ACBAR. Despite this, there are numerous investigators of various backgrounds (government, NGO, international organization, and external researchers, e.g., of WHO, WB, ACF, MSF, MEC, Samuel Hall, JHPIEGO, SIGAR, Asia Foundation, Relief web, Refworld[vi]. Evidence-based decision-making is increasingly acknowledged and supported by the MoPH (MoPH 2012c). Nevertheless, there is still a need for improvement and capacity building (WoodrowWilsonCenter 2016; WHO 2015b)[vii].

5.8 Monitoring, Evaluation, and Quality Management

The central Statistic Organization, the donors who set indicators, and the NGOs in their projects are the main providers of monitoring, evaluation, and quality management. In order to monitor and increase the capacity, several Monitoring and Health Information System Tools[25] were

[25] Health Management Information System; Balanced Score card; National Monitoring Checklist. Diseases Early Warning System; Human Resources Database; CHW-HR Database; Training Database; Afghanistan Tuberculosis Information System (ATBIS); LQAS

established nationwide (MoPH 2012b). The most common monitoring tool is the Balance Score Card (BSC). It is an instrument to measure the health system performance on a (bi-)yearly basis in six domains: patient perspectives, staff perspectives, capacity for service provision, service provision or technical quality, financial systems, and overall vision for the health sector (Edward et al. 2011; Eldridge and Palmer 2009; Edward et al. 2015; AREU 2008). Furthermore, there are the Disease Early Warning System (DEWS) to monitor the outbreak of diseases (MoPH 2016b), the weekly surveillance updates, e.g., for polio, vaccination surveillance (MoPH 2016a); urban dots (Ikram et al. 2014; Dott et al. 2005). Two further tools are the community-based Growth monitoring (Mayhew et al. 2014) to improve nutrition in Afghanistan; and the fully functional service delivery point, which is a tool to encourage behavior change in medical staff (USAID 2006).

Furthermore, there are several coordinating bodies, such as UN-OCHA (OCHA 2016) with its Health Cluster (Humanitarian Response(Humanitarian Response Plan).

In the qualitative interviews, the respondents referred to the use of the balanced scorecard as the principal nationwide evaluation tool (I8, 28). Besides, they point out that there is a very low level of health information (I17) and a huge lack of monitoring (I14a, I2) as well as supervision (I9, 4). As the reasons for low monitoring, they primarily name the insecurity (I13, I9) and that it is hard to find people again for follow-up (I2).

5.9 Health Care Financing / Expenditure

"A good **health financing system** raises adequate funds for health, in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them." (WHO 2016b)

5. Health Financing
National Health Accounts (NHA); Household expenditure and utilization surveys
- Total expenditure on health: $ 1,500,975,945 (2011)(MoPH 2013b) - General government expenditure on health as a proportion of general government expenditure (GGHE/GGE): 1.6 (2001); 7.1 (2014) [(a)] 12.0% [(e)] - The ratio of household out-of-pocket payments for health to total expenditure on health: 73.8 *(2014)* [(a)]

Within the last years, the total expenditure on health per capita has risen from $ 3 (2001) to $ 55 (2014), respectively $ 57 (e). The level of out-of-pocket expenditure has also increased since 2004 from 48.1% (2004) and is estimated at 73.8% (2014) (a) or 63.9% (e). In 2015, the MoPH estimated that approximately 36.5% of the Afghan population could get into a catastrophic crisis (MoPH 2015c; Singh et al. 2015). This is in sharp contrast to Article 52 of the Afghan

Database; Essential Drug List/License Drugs List; Health Related Studies/Special Studies Database; Grant Database; Standard Based Management & Recognition; Fully Function Service Delivery Point (FFSDP); Partnership Defined Quality; Healthcare Improvement (HCI); Afghanistan Health Survey; National Risk and Vulnerability Survey; Afghanistan Multi Indicator Cluster Survey (AMICS); Central Statistic Organization Population Estimation

constitution, which states that basic health care should be free. Furthermore, there is no health insurance yet, but it is set as a target (WHO 2010c; Ahmed 2013).26 There is almost no information available on the costs of a health visit. In 2008, Newbrander et al. assessed the cost of health services in Afghanistan. The annual cost per capita was 3.78 with a large range (1.60-10.55) and the annual drug cost per visit was 0.3 (range: 0.14-0.54) (Newbrander 2008). Not only the cost of treatment but also the "hidden cost" of non-medical spending must be integrated into the calculation of medical expenditure (Mashal et al. 2016). In 2011/12, the total health expenditure was $ 1,500,975,945, of which the central government revenue accounted for ca. 5.6%, external aid ca. 20.8%, and private household expenditure = out-of-pocket expenditures for ca. 73.6%. Large inconsistency exists toward the percent of expenditure on health: Some declare 8.2% of GDP in 2014, but it is 1.12% (Afs. 3,037 Mio) based on a calculation on the CSO report[27]. This is very low in contrast to the military expenditure of 28.09% of GDP in 2016 (CSO 2016a). The Afghan health system and the MoPH depend heavily on donor funding, and there is no tax base for revenue generation. The MoPH's limited capacity in budget execution is about 60%. (MoPH 2013b). According to the Ministry of Finance, almost 100% of its development and 45% of its operating budgets are externally financed. The main donors are the World Bank, USAID, and EC. Overall in 2015, USAID disbursed 1107.0; Denmark 534.9; Germany 364.3; the EU 339.3; World Bank 253.028 . However, not all money is disbursed; there is a large funding gap (CSO 2016a). In order to enhance quality, foster partnership, and increase transparency, some finance transfer mechanisms were installed, for example, the performance-based paying mechanism (Dale et al. 2016; Eichler and Levine 2009; Jean-Pierre; Eldridge and Palmer 2009). Besides, the partnership contract for health service programs (Office of Inspector General 2011), mobile banking (MoPH 2012a), and other programs targeting, in particular, the poor (Alonge et al. 2015). The need for finding new sustainable health financing schemes is echoed everywhere, and approaches are discussed, such as tobacco tax, vehicle tax, fuel tax, user fees, and health insurance (MoPH 2015c, 2014d).

The interviewees explained that the high expenditures (G3, I5, I14, I15) are the highest barriers to seeking care and the reason for delaying seeking care. Some organizations provide some free services, but other organizations require some financial contribution (I7a). They point out the low financial resources of the MoPH (I4), the high external dependency (A15), and the impact of the

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[26] It is very difficult to find and to verify current information, some people trace back the information on health insurances to the public health law passed in 1985 and an ordinance of 1987, only some employed personnel have a lump sum payment as a work injury benefit (Boslaugh 2013).

[27] Generally, in 2015/2016, the Afghan Government declares its total budget of 271,011,300,000 Afs. of which are 3,037,900,000 Afs in the health budget (1.12%). Compared to previous years, there was an increase from 3 294,000,000 to 3,726,600,000 of 13% between 2013/14 and 2014/15 followed by a decrease of 18.5% 2014/2015 to 2015/16. The percent of national budget that was spend on health decreased from 2% in 2013/2014 to 1.3% to 2014/2015 to 1.1% in 2015/2016 (CSO).

[28] Other main donors are DFATD, ECHO, GAVI Alliance, Global Action, JICA, GFAMT, UNFPA, WHO, UNICEF, CIDA, SIDA, MSF; MHS, MSI and many more. There are two types of budgeting "on budget or core budget" which is allocated trough the MoPH to providers and "off budget" directly transferred to the MoPH. (2012).

decreasing financial support (I5). Even though the MoPH has tried to increase its influence on channeling the financial flow lately, it is largely dependent on external donors. One interviewee stated: *"more than 80% or 90% of the MoPH is being funded by the international community and the donor community. So it is their help and their support and their mechanism, so using funds and the organization of the budget and the mechanism and the scenario they apply for it is really important because the ministry will do at the end of the day do what they the international community or the donor community will want." (I4, 36).* Little is known about the donors and the amount of money spent on health promotion/disease prevention. Certain vaccines are provided for free, e.g., financed by GAVI and UNICEF, but not all (see interviews below).

Generally, it can be said that health care is not free and becoming sick is a financial threat due to large out-of-pocket expenditures. The MoPH is highly dependent on external aid and is poor in execution. There is an urgent need for new strategies for financing health because of the announced reduction.

5.10 Further Qualitative Assessments of the Health System

The six building blocks do not cover all the relevant information for a thick description of the Afghan health system, such as cultural barriers to health, the interaction between the health care providers, and further qualitative studies. To be able to analyze the Afghan health promotion approaches realistically, the author gives insights into four more topics. These topics dominate the public debate on the health sector in Afghanistan (WoodrowWilsonCenter 2016), such as (a) the improvements in the health sector, (b) challenges in and barriers to health care, (c) the role of external donors, and (d) recent development. The next paragraphs highlight some key findings and will provide references for additional research.

5.10.1 Improvements in the Health Sector

The reporting about the changes within the last 15 years in the Afghan health system is often selective storytelling (MSF 2014). However, it is neither appropriate to tell only the narrative of success nor the narrative of horrific failure. To strive for a brief, realistic presentation of the health system, a contrasting of both narratives is useful. It points out the dualism, such as success and failure, and improvements and remaining challenges (for example, in Adegboye and Danelle 2014).

Several studies portray the remarkable improvements in the health sector in Afghanistan, such as Dalil et al. (2014), who show the improvements in health indicators, expansion of access to health services, and the increase in the range of services (Dalil et al. 2014). These findings agree with the review of Kruk et al. of primary healthcare systems in low- and middle-income countries (Kruk et al. 2010). Furthermore, Newbrander repeatedly showed the important role of the Basic

Packages of Health Services for the health system due to its increase in access to primary health care, esp. for women, in attended births, in the supply of essential medicines and information system (Newbrander et al. 2014a). This positive perspective is also echoed by several others who point out that the success is based on the involvement and support of the Ministry of Public Health, international and local NGOs, international donors, and the REACH team (Management Sciences for Health; Anwari et al. 2015; Michael et al. 2013). Shehata (2012) concluded in her study on health systems: *"In some ways, it is easier to impact health systems in post-conflict countries because often you are designing the system from scratch without having to navigate the existing system and its bureaucracy."* (Shehata 2012) The interviewees themselves also stress a series of improvements such as (a) more available (A6, 36), (b) an increase in own capacity (I6, 39) but also in the knowledge of health *"Afghans today know that handwashing is important"* (A2, 28). One interviewee summarized the changes as follows: *"if you say it (the health system) was at the number 5 percent then it reaches to the peak in 2007 and 2008, and after it is reduced, reduced and right now it basically approaches to very, very low level it means like 10 to 15."* (I15b, 13)

5.10.2 Barriers to Health Care

Despite these remarkable improvements, many "health outcomes remain inadequate," and many health concerns are not targeted sufficiently. Part of the explanation is that climate, culture, and security, limit the implementation of the strategies and the performance of the health care service (e.g., ACF, 2016 MSF 2014, Shadow report). In 2014, MSF identified barriers to access to healthcare in a representative study. These are (a) war and insecurity, (b) long distance, (c) high cost, (d) gaps in the health system, and (e) lack of respect for medical facilities and health workers (Medicines sans frontiers 2014). Another explanation for the still high maternal mortality rate is the "lack of trained, motivated and accountable staff" (UNICEF 2014). Several studies point out that the assumption that 'having a basic health center nearby means having better access to health care' is incorrect. The CMI report identified the following factors that further limit access: "Cultural factors, gender roles, lack of education, seasonal variations, poverty and lack of transportation" (CMI 2005). These barriers lead to delayed health care seeking, so many diseases are already very severe and cannot be treated in basic health centers anymore. The following table presents a comprehensive overview of identified barriers to health care interventions along the supply and demand sides and four dimensions of access. The original framework was developed by Gawhari (2014), who combined the models of Peters et al. (2008) and Ensor and Cooper (2004). Table 22 displays challenges that repeatedly occurred in the last 15 years. The italic words are further responses by the interviewees of this qualitative study.

TABLE 22: BARRIERS TO HEALTH SERVICES

	Supply-side barriers	Demand-side barriers
Geographical accessibility**	- security conditions (A15) service location *(transportation staff, equipment, medication) (I13, I14b, G44)*	- security condition (A15) - service location (A15), *scattered population (I6, 11)* *absence/*means of transport
Availability	- drugs and other consumables (I4, 36) - availability of staff (A15) - the motivation of staff - waiting time (A18) - referral system (A14) - *female staff* —> shame (A15)* - *electricity* (I10, 14)* - *suitable hospital conditions** - *unused high-tech medical equipment*(I8)*	- information on health care services/providers
Affordability	- costs and prices of services, including informal payments - private-public dual practices (I7c) corruption (A15)	- opportunity costs - household resources and willingness to pay - cash flow within society indirect costs to the household (transport, *lost wages*)
Acceptability	- staff interpersonal skills, including trust - *discrimination*	- education - lack of health awareness - the mismatch between households' expectations and health services provision - low self-esteem and little assertiveness - stigma - the community beliefs and cultural preferences: *what constitutes safe practice*; resistance/acceptance by mother- and father-in-law (I11)* *teenagers cannot go out (I3, 9)*

A further in-depth assessment of strengths and weaknesses, opportunities and threats, as well as recommendations and options, can be found by WHO and others (WHO 2015b; Ahmadi et al. 2015).

5.10.2.1 Structural criticism role of donors and NGOs

Discussing the health sector without addressing further structural issues and the role of the donors, and the difficulties for the NGOs would not paint an accurate picture. Analyzing international relations and the (hidden) agendas of the donors and NGOs is beyond the scope of this thesis. The author only wishes to point out some of the major conflicts: (a) the redistribution of finances and its focus on state building and development work rather than meeting the humanitarian needs and the inflexibility to respond to reappearing emergencies (see a thorough analysis by (ACF 2016) or the support of unsustainable and unused projects (OECD n.d.); (b) the linkage of humanitarian aid with military assistance, (c) the tension and poor coordination among government and health care providers (G1, I4, I6) which leads to redundancy (Boslaugh 2013). (d) Besides the difficulties related to contracting: the NGOs recommended it should include a long-term vision and sustainability (I1, 35), some sort of standardization (I2, 49), and also build the capacity of local NGOs (I6, 29). Furthermore, the NGOs complain about the lack of respect for medical facilities and

health workers and misuse them as targets. (e) Generally, the increased difficulty in monitoring projects on the ground due to increased insecurity was named. This also resulted in an increasing reluctance by the international provider to continue financial support. Even though the contracting out of service to NGOs is regarded as a success, the role of NGOs and the long-term sustainability of a health system that strongly depends on NGOs is highly questionable (IRIN 2009).

5.10.2.2 Overall perspective on the health system's main challenges for health promotion

Speaking about 'the health system in Afghanistan' and possible approaches to health promotion is barely possible, as the response of one interviewee clearly demonstrated: *"there is not any system (…) how can we promote (health)"* (I7c, 8). Others argued that there is no system because the government can neither control nor implement it (I7c, 10). Despite these structural challenges, the interviewees pointed out, "*in war (…) there is no prosperity to anyone, its completely damaged and devastation to everyone on different scales*" (I4, 18), and so the "basic survival" is a core concern (A16, 59). Another respondent stressed, "*saving lives in Afghanistan depends on having health workers in the field and sufficient medical supplies, as well as food, shelter, and security"* (A6, 70). Furthermore, they criticized that, in their perspective, so far, little emphasis has been placed on developing the institutions and regulation systems of the MoPH. They were concerned with the situation in the Afghan health system as well as the whole nation; for example, the inadequate treatment and resources in the health system (I4, 26), the poor health indicators (A6, 32), the critical delay to seeking health care (I8, 64), and recurrent traumatized experiences (I2, 11). Nationwide problems are the deterioration of security (A15, 21) and the violence escalating humanitarian needs (UNOCHA 2016b). Taking together the following five top challenges that arose from the interviews. Even though education and cultural constraints appear to be less important than insecurity or corruption, the interviewees repeatedly referred to the significant role of cultural constraints concerning health care and the need for more education and capacity on all levels of society. Figure 8 summarizes the top challenges named by the respondents.

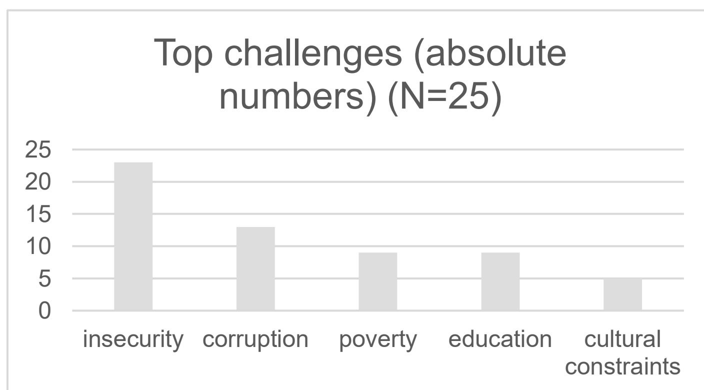

FIGURE 8: MOST CHALLENGES NAMED

5.10.3 Current and Future Perspective

All these challenges would be worth further exploration, but to describe the current state of Afghan's Healthcare system, the author gives an account of the three major current changes and

their direct impact on the health work. These three dominating these are increasing insecurity, corruption, donor withdrawal, and migration processes.

As these statements show, there was a significant improvement in the (re)construction of a functional health system within the first years till 2008/09; the reported increasing insecurity slowed the process down and had a deteriorating impact on the health system (UNICEF, UNAMA, UN HR 2016). The wide-known reported attack on the MSF hospital on October 3rd, 2015, is only one of many events demonstrating the increasingly threatening situation for health workers but also for the withdrawal of NGO and donor support (MSF 2016). The decrease in financial assistance will have drastic consequences on the health system because it is highly dependent on external support. The overview of the aid worker security database shows a drastic increase in attacks in Afghanistan in the last years (1 or 2 between 1997 and 2001 to its peak of 81 in 2013 and a slight decrease to 27 in 2015. All in all, with a number of 481 attacks, Afghanistan had 23.8% of all reported incidents (Safeguarding Health in Conflict Coalition 2016; The Aid Worker Security Database 2016). The merge of military and humanitarian strategies has several consequences, such as (a) an increase in attacks on healthcare providers (Carta and Bhugra 2015), (b) the destabilization of the system, (c) the limited access to rural areas for health care providers, e.g., due to checkpoints (Graham-Harrison). UNAMA assessed the far-reaching effects of attacks. UNAMA also points out the immediate as well as the long-term effects, such as the (a) loss or lack of access to health facilities, (b) flight or health workers, (c) people deprived of health care, (d) increased mortality or morbidity risk (UNICEF, UNAMA, UN HR 2016; Islamic Relief). The withdrawal of the military and financial aid will further lay a high burden on the Afghan health system, and it is very unlikely that Afghanistan can afford to uphold the current standard.[29]

The second recurrent theme is corruption, a key obstacle to development and better health care. In 2015 the Minister of PH gave an order to the **Independent Joint Anti-Corruption Monitoring and Evaluation Committee (MEC)** to analyze the vulnerability to corruption in Afghanistan. A thorough analysis showed that corruption is found at all levels of the health system. And in all areas, such as (a) Monitoring and Evaluation, (b) Transparency, Governance, and Accountability, (c) Policies, (d) Contracts, (e) Embezzlement (f) Nepotism / Abuse of Power, (g) Quality Assurance / Quality Control, (h) Human Rights and Discrimination, (is) Extortion, (j) Fraud / Falsification / Fakes / Forgery, (k) Conflicts of Interest, (l) Briber. 126 recommendations were given to reduce corruption within the Afghan system (MEC 2016). The minister of public health pointed

[29] With the announced withdrawal of many international donors, Afghanistan has not only to bare the existing public expenditures of 5.6 percent of the budget but also the international 20.8 (NHA) 2013) Due to the many other sectors in need it is unlikely that Afghanistan can pay for the 26.4% (see Ahmed 2015 see also (QARANI/KANJI IN 2015)) prognosis about future development let assume that there will be even a greater need then today of spending money in security (in 2012 40% and health 4%), expecting that there will be a continuous reduction of spending on health and therefore a higher out of pocket expenditure and a further exclusion of the most vulnerable/poor. see The World Bank 2012

out that they are willing to work for it, but their scope of action is also strongly influenced by the context it operates (WoodrowWilsonCenter 2016)

The last nationwide challenge is the massive migration movement, such as the emigration to other countries, e.g., European countries, and the large influx of Afghan refugees returning from Pakistan. The rapid assessment of the Health Cluster at the end of 2016 showed that the health facilities are "desperately overstretched" (OCHA 2016). For further investigation on the current situation (cf. A Good Diagnosis for Afghanistan: Strengthening the Health Sector), (Global), Health in Afghanistan: Hope and future (Lancet 2011)

5.11 Conclusion

The aim of this chapter was to analyze the Afghan health system systematically by using the WHO health system framework with its building block leadership, policies, and strategies, health facilities, health care professionals, equipment, financial structures, and information. It is extremely difficult to gather representative data on the health system and validate it. Therefore, again, a mixed-method approach was used. The following data was integrated: (a) publications by the MoPH, (b) quantitative data by the WHO, and (c) research papers. This was contrasted with (c) news articles and press releases, (d) gray literature, and (f) findings in the qualitative interviews. Despite the approach of triangulating data (policy and strategy papers, research articles, news, and expert comments) as well as triangulating perspectives (MoPH, researchers, practitioners), it was barely possible to describe the system precisely in all its heterogeneity and variety. So, the author's main focus was to present most of the relevant details of the health system that are relevant to health promotion.

In 2001, Afghanistan's entire health system was severely damaged and almost completely destroyed in all its six building blocks. To provide access to basic health services, the MoPH and the international community have developed several strategies, principally the BPHS, the EPHS, and the CBHC. Overall, (1) The Ministry of Public Health and its Health Promotion Department are responsible for the health sector in Afghanistan. Supported by the international community, the governance and leadership have developed many promising policy and strategy papers on almost all areas of health, e.g., the 'Health for all Afghans' and the 'National Health Policy.' The qualitative data indicates that the MoPH is inadequate for executing the laws and strategies or regulating the health system, particularly in rural, remote, and conflict-affected areas where facilities are closed down. Inequity in health care services is a major problem in Afghanistan. (2) Even though Article 52 of the constitution defines that health services should be free, the out-of-pocket expenditure and hidden costs are remarkably high, and there is no health insurance yet. Some health promotion activities are included in the BPHS, but the execution of BPHS shows that therapeutic services are more prominent and prioritized. Any other promotion and prevention services

must be funded externally. (3) The overall workforce increased within the last years, but there is still a significant need, particularly for female, skilled HW in rural areas. The interviewees explain that there are some additionally trained health workers, but they state it is insufficient to cover all the needs. Furthermore, the service of some CHWs is questionable because not all CHWs receive additional refresher training or any incentives. (4) Despite the increasing availability of medicine in Afghanistan, there are remaining challenges: inadequate quality, shortage in remote areas, and the lack of proper regulation. Sufficient and advanced medical equipment (technology, diagnostic, as well as monitoring systems) can primarily be found in urban areas. Vaccines are externally funded and available. Furthermore, contraceptives are rarely available and not widely accepted by the community. (5) There is a growing number of institutions for information and research, e.g., the ANIP. There are more broadly used evaluation and monitoring tools, such as the balanced scorecard or the disease early warning system, DEWS. However, registration and surveillance remain challenging. Government, NGOs, and external investigators research, monitor, and report. (6) The health services did not only increase the number of health facilities but also brought a set of basic packages of health services to many areas in Afghanistan. Even though BPHS includes preventative, primary health care, and therapeutic services, most interviewees stressed that preventive services are seldom provided. Despite the remarkable improvements, numerous tangible and intangible barriers to health care remain. Besides some criticism of the role of donors and NGOs, the chapter closed by pointing to the three current dominating challenges in the health sector: the increase in insecurity in the country, the corruption, and the migration processes.

Generally, the development in the health sector is widely regarded as remarkable or "too good to be true," in particular, given the many difficulties in building a resilient health system in a fragile context (Salama and Alwan 2016). The improvements in the health system are interpreted as indicators of the success of the BPHS program, but practitioners further stress that "there is still a lot to be achieved" (MSF 2014). The findings presented here go beyond the presentation of Boslaugh and the paper of Qarani and Kanji (2015). They are consistent with the WHO findings in their cooperation strategy (WHO 2010c). Nevertheless, this presentation is unique in its attempt to describe health promotion within the framework.

In general, the following difficulties have an enormous impact on all curative and promotive activities in the health sector. On the community level, the main challenges concern the work of the CHW (incentives, training, supervision) also the lack of qualified female workers in rural areas. Furthermore, there are administrative difficulties (late provision of the salary, e.g., six months too late (I2, 27), and obstacles due to security, quality, cultural barriers, lack of resources (facilities, equipment, finances, medical staff), lack of capability for providing health care; lack of protection of professional titles. These findings are loudly echoed by many health care providers ((MMRCA). Analyzing all these difficulties, Acerra concluded: *"The long-term goal of quality*

healthcare for all Afghan citizens will only be met by a combination of specific goal-oriented projects, foreign aid, domestic responsibility, and time." (Acerra et al. 2009)

One major criticism needs to be made. The indicators of the WHO Health System Framework barely capture the scope of health promotion, even though they help to set the scene. Therefore, there should be a revision and adaptation of the framework to reorient health services (one main strategy of health promotion). Suggested indicators are (a) The existence of an institution (health promotion department). (b) The nationally available services – CBHC – specify which promotive and preventive areas should be covered. (c) Besides, there should be transparency concerning the resources allocated to health promotion and – if possible – the commitment to dedicate a certain percentage of the health budget to health promotion. (d) The framework should integrate the number of specially trained health promoters and the number of schools for it. Also, it should define the proportion of the curricula of medical education dedicated to health promotion. (e) A set of equipment should be defined, such as vaccine availability, contraceptives, equipment for safer use, micronutrient supplements, health education material, and guidelines for improving healthy environments. (f) The number of research institutions and established structures for sharing best practices. Furthermore, it should provide information on specific programs which integrate health promotion in all areas of life, e.g., school, workplace, and place of worship. Last, it should strongly emphasize salutogenic and life skills, and new ways should be identified to strengthen the focus on resources and to enable them. It might be useful to extend the health system indicators by those to enhance awareness of health promotion. Unfortunately, the WHO – which advocates a holistic understanding of health worldwide – shows a strong medical orientation in executing its mandate.

To sum up, disease prevention and health education are part of the strategy of the BPHS and CBHC in Afghanistan, but little can be said about the actual performance of health promotion based on the presented data. Considering the current developments of insecurity, corruption, and migration, one can assume that health promotion in insecure settings is perceived less as a need and is likely to disappear even more from public attention due to its high dependency on external funding.

Open questions for further research:

- From the perspective of a conceptualizer of health promotion strategies who wishes to establish health promotion more widely: How can health promotion be measured in a health system framework? Some suggestions have been provided above.
- From the perspective of a politician/donor: How can the limited budget be allocated to have the largest increase? As the interviewees said, the BPHS has been a good start but should be revised and expanded.
- From the perspective of a health worker coordinator: How can a good allocation of resources take place?

- From the standpoint of a salutogenesis supporter: How can the three perspectives be brought together: to provide the needed basic treatments, focus on preventing diseases as well as strengthening and enabling the individual?

6 Scoping Review of Provider and Activities

The following chapter gives an overview of the health promotion and preventative approaches of the last 16 years in Afghanistan. Even though it demonstrates a vast range of providers and activities, this overview has some limitations. It is based on (a) findings of a systematic identification and analysis of registered NGOs, an exhaustive website analysis, and key informant interviews but cannot represent the unregistered NGOs or private providers. Next, (b) studies on effectiveness or evaluations are barely available; it is impossible to give valid statements on the scope of the activities in terms of regional coverage as well as beneficiaries. (c) It is unclear if all of the approaches still exist. (d) There are many reasons for ending the commitment (see the book by Karla Schefter). Hence, this overview cannot serve as an all-inclusive description of current health approaches but as an overview to be used as a point of reference.

The following Prisma Flow Chart (Figure 9) summarizes the number of identified NGOs, the exclusion criteria, and the number of organizations the author has contacted[30].

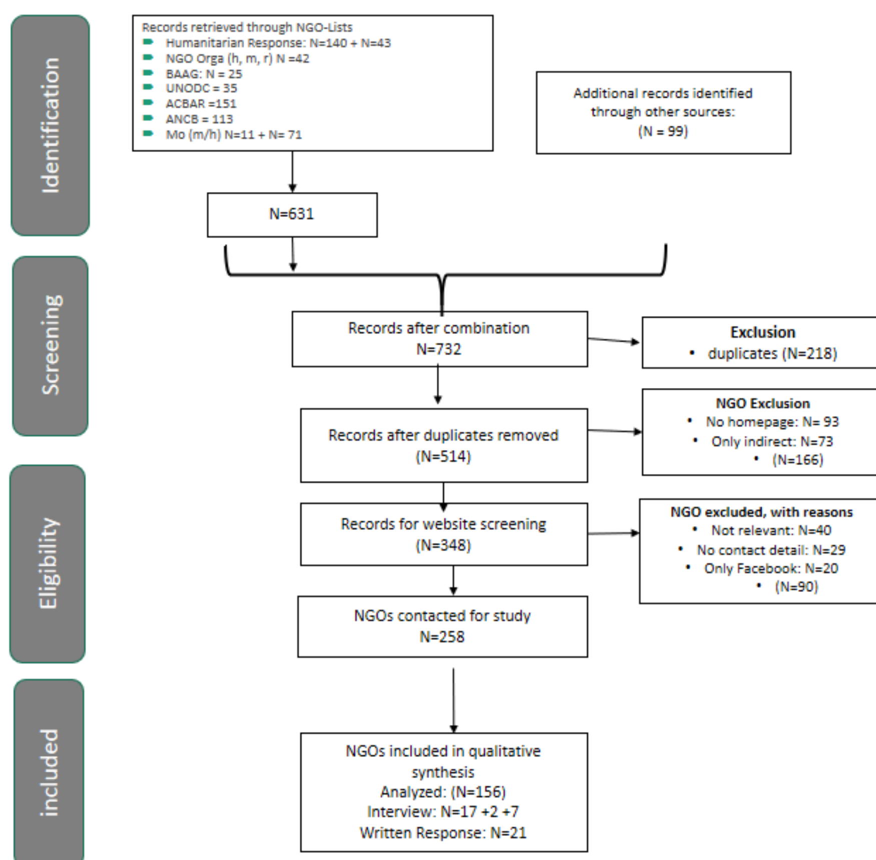

FIGURE 9: PRISMA FLOWCHART OF NGOS[viii]

[30] It is difficult to estimate the real number of NGOs working in Afghanistan. Even though the Ministry of Economics registered in 2015 a specific number of NGOs, conversations and research show there are many more. This study focused on organizations working in health an health-related sectors therefore the number of all the NGOs we are interested in is bigger than registered number of 'health NGO'. Nevertheless, due to the purposeful selection of these organizations might provide a good picture of the situation.

6.1 Provider

Not only does the overview of available permanent health care providers in Afghanistan (see humanitarian found) reveal an uneven distribution, but also the MoPH points out the inequity in health care provision. Furthermore, by analyzing the locations of the activities, it becomes apparent that there is an urban and regional dominance of some topics (e.g., HIV in the northwest). A detailed presentation of the uneven distribution of health facilities and health status in the provinces can be found here (MoPH HMIS Department) (see Figure 10).

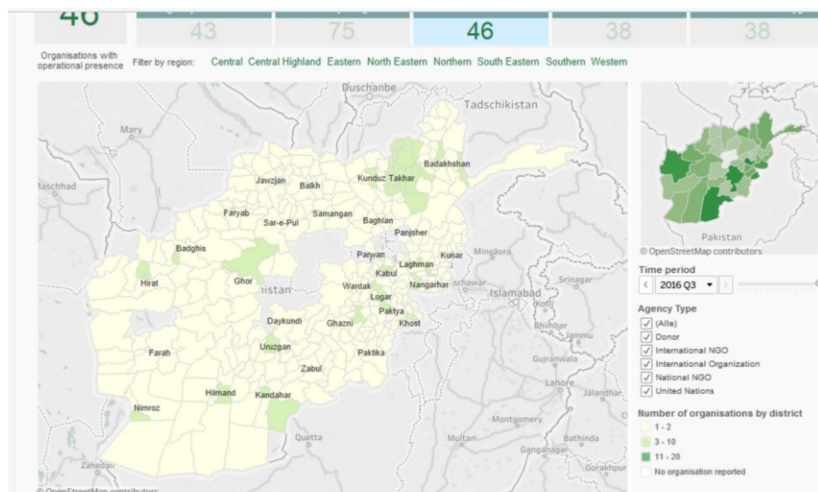

FIGURE 10: PERMANENT CAPACITY OF HEALTH CLUSTER (UN OCHA 2016A)

Data was collected by website research. The providers were classified in the categories "health," "close" to health and "indirect" or "unclear" impact on health. Though this helped to estimate the size of providers for these services in Afghanistan, two problems made this classification difficult (a) most organization work in several sectors (e.g., disaster response, WASH, agriculture), and (b) many websites were not updated in the last year, so their existence cannot be confirmed. One strategy for credibility was that the author only included NGOs with a web presence and provided contact details on their website. Second, she did not categorize the organizations based on their mission but the reported projects. Third, if an organization had projects in several areas, she checked for the most health-related activity and the dominance of this activity in the organization to classify it. Organizations with a health facility and the main focus on health were classified as "health." If the activities directly impact health, such as agriculture nutrition and WASH, it was defined as close to health. Other activities that indirectly impact health (by addressing the prerequisites of health) are categorized as indirect. However, there is considerable overlap in these areas, so the lines are sometimes blurry. The following tables (Table 23) present the result of the classified area as well as typical activities. It also shows the distribution of the sectors asked, some NGOs as examples for each category and typical activities and the response to the questionnaire/interview.

TABLE 23: SAMPLE SCOPING REVIEW

	German NGOs	For inter-view (health)	Health [31]	close	Indirect/unclear	total
contacted	N=15	N=51	N= 87	N=42	57/21	15+258
Not deliver.		N = 8	N = 8	N=5	N=4/N =2	
		ARCS, AADA	GAIN, ADVS	HIHAO, DACAAR	VARA, DDG	
	Clinics, hospitals, orphan-ages	BPHS, EPHS, CM, CHN, CHW, disability, HIV	Health ed-ucation, food distri-bution	Agriculture, nutrition, WASH	Research, educa-tion, law, liveli-hood, etc.	

If one only integrates organizations with a permanent facility, then the 46 NGOs of the health cluster are the most relevant. But as the data show, far more organizations provide essential health activities than these 46 NGOs. 138 organizations fall into this category, based on the website analysis. When analyzing the provider from a holistic understanding of health, at least 42 additional providers whose activities directly impact health should be considered important. In addition, more than 57 other organizations addressed the determinants and prerequisites for health and have an indirect impact on health, and their activities also need to be integrated. The numbers of 42 NGOs and 57 others are much too small compared with the total of 1994 NGOs registered by the MoE. Nevertheless, the findings below provide an idea of a broad range of activities and how these might impact health. However, the common response to the questionnaire was that these organizations do not perceive themselves as *health* organizations and use other characteristics to describe them. Based on the self-description of the respondents of the questionnaires and interviews, the typology below was developed (Table 24). To verify the quality, she checked for representativity. This typology can help identify specific challenges, recommendations, and action areas for each type of health service provider.

TABLE 24: TYPES OF HEALTH SERVICE PROVIDERS

	Characteristics	**Exam-ple**
Donor	Providing money, supporting (local) actors, influence setting requirements, standards, and reporting. A specific subgroup of these is the "equipper," who collect supply, e.g., crutches	WB, A15,
Conceptual-izer	Their main responsibility is to develop a new program and implement it.	A2
Generalist	Provide many activities in various sectors can be Afghan or international organization	
BPHS imple-menter	Main responsibility is to implement BPHS; they are externally financed	

[31] Contacted were additional 15 'close health' 11 not found 4 'big players: OCHA; JHIPEGO, UNODC, CDD← perceived as being more active on an overall level and not in close contact with the communities. Therefore, these organizations have not been contacted individually

Specializer	They focus on one specific area of health, e.g., 'mental health,' 'neurology' "dental care," reproductive health, transfer for surgery in another country	
Localizer	Their main characteristic is their focus on working in one place; they often provide several services at one location, e.g., a local clinic plus an education center	A1
"Targetizer"	Their main focus is on specific target groups, e.g., women, orphans,	
Capacity builder	Their main focus is to train medical people professionals, e.g., doctors or	A6
Environmen-talist	Target environmental determinants "reconstruction, "agriculture," "development of books of value"	

The following overview is limited in its representation of health activities because it does not include the vast group of private and traditional providers. It focuses on NGOs and additional health providers identified in the internet research.

6.2 Sector - Mapping

The providers' websites were intensively studied, the programs and activities extracted, categorized, and structured (see overview[ix]), and a gap analysis was conducted. In this study, a gap exists if the reality does not meet the minimum desirable standard. A gap can occur in an area of importance defined by the responsible health institution, the MoPH[32].

The MoPH health promotion department has identified 13 categories of importance (MoPH HPD o.d.). Gaps can be analyzed on several levels, as a summary for each sector and subcategory concerning the target area and the type of intervention. The following screenshot (Figure 11) gives an insight into the 400+ identified activities. Figure 12 gives an overview of the structuring of the programs along the most common categories inductivley derived from the material

[32] The interviewees often referred to the role of the government in defining key principles. NGOs and health care providers can contribute to decision making and priority setting through working closely with the MoPH and integrating piloted best practice examples into the governments standard package of services. (I4, 36)

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General description of activities in Afghanistan, category, and parts	provider	nation	Facil	com	school	urban	media	HP, HE, DP	Treat	
0.7. construction of CME school (I15) - construction of Health (I8) and education facilities (IOM); - Afshar hospital (AMOR) - health sub centre, also healthcare (subcenter) in white areas; #integrated health post (MoPH Arwal) - Hospital (I5, I7) (ca. 100 deliveries per day/26,000 in 2013) (G5) - clinics (G1, G4) - extend clinic in the border regions for refugees (I15b) for treatment and awareness raising about health care services in Afghanistan - (clinic with treatment for widows and orphans of the program A22, 18)	A22		X							
0.8. general: life skills: Learning for Healthy Living project (SCA 2015); LCEP - vocational training, health education and literacy (childrenincrisis) - life skill training for rural women (AADO) - Life-skill education (Echavez et al. 2014) - health and literacy courses (SHAO) - Women's right to Life and Health Project (UNICEF) - mother's dinners (save the children) - income generating - some health messages integrated in education and vocational training (A22) - basic courses (literacy, numeracy, life skills hygiene) (A8, 37) - General awareness raising (legal rights and access to health services) (HAWCA)	A8			X						
0.9. additional cultural sensitive programme (I8, 10) - training cultural field workers who set up cultural container (I2, 4) - blood donation - MoPH: printing leaflets for raising awareness on blood donation - various strategies (SHOA)				X						
1. Maternal and child health	I10, I5, I12	X	x							
1.1. BPHS*; ANC, DC, PNC, FP, CotN	A15	x	x							
1.2. Maternal and perinatal surveillance system (BABIES); - birth registration mapping (ACTD)			X							
- family health book (JVC) —> identifying frequent patient and visiting their home to promote health habits										
general "mother and child programmes"/	I5									
1.3. provision of health services to lactating and pregnant women (A18) • provision of maternal and child health instructions • promoting hygiene, improving knowledge and teaching about first aid (A12) 1.3.1. integrated maternal and child health nutrition project (IMCHN); • integrated child survival package;			x	x						
specific program • Opportunity for mother and infant development = OMID (CARE 2011); CDD cf. Coleman Maternal Health in Afghanistan 2011 • Better health for Afghan mothers and children (2008-2014) (I15)			x							
• BLiSS – Birth and Life Saving skills; (A12) • home based lifesaving skills (I15) • door to door visits (also including counselling) (I14b) • timed and targeted counselling (I15)	A12			x						
1.4. support groups: (A14) 1.4.1. women • expected mothers workshop (AIL) • Breastfeeding Support Groups (CAF); • safe motherhood group • social support (A14) 1.4.2. men support group				x						

Wiederhergestellt

FIGURE 11: CATEGORIZATION ACTIVITIES AFGHANISTAN

Outline
X.: category
X.1. nationwide
X.1.1. policies, strategies, and laws,
X.1.2. programs
X.1.3. research, surveys…
X. 2.1. Capacity building (staff)
X.2.2. program,
X.3. Community-based programs,
X.4.1. Health promotion,
X.4.2. Tele and mobile health,
X.5. Supply and Equipment
X.6. specific diseases.
X.7. Construction
X.8. /X.9. Additional

FIGURE 12: SUBDIMENSIONS FOR CATEGORIZATION

6.3 Sector – Gap Analysis

Each sector was analyzed separately, and estimation was given concerning the sufficiency of the available activities and programs. The estimation is based on the deeper analysis of four sub-dimensions and the overall impression gained through conversations with local actors. The four subdimensions of interest for CBHP are (a) availability of policy or strategy and general programs, (b) community-based health promotion activity, (b) types of activities: primary treatment, or also education, or even health promotion, (d) and a brief general summary of the main activities in this sector. The next table (Table 25) presents a summary of the results and compares the sectors. In the second column, an aggregated estimation of the sufficiency of activities available relating to the conceptual ideas and not the sufficiency in coverage is given.

TABLE 25: CATEGORIZATION AND GAP ANALYSIS HEALTH SECTOR

Sector	Evaluation	Government guidelines?	Main provider	Community	HP, HE, DP	Approaches
General		BPHS, Policy on Community Based Health Workers, CME/CHNE				BPHS, EPHS, strategies, world X-day, capacity building
(1) Maternal and child health	*High priority	Also, National Policy for Nursing and Midwifery	several	Home-based life-saving skills; timed and targeted counseling	Yes	Many approaches on many levels, application of multiple methods, BCC multiplier, gender-sensitive; BPHS*; ANC, DC, PNC, FP, CotN
(2) Child Health	*IMCI, vaccination	National Child and Adolescent Health Strategy (2009) Vaccines and immunization Products Regulation		vaccination, school health, hygiene, dental, education, mind & mental awareness, first aid	yes	Priority in immunization, some school-based approaches (in cities), BASIC, EDC, IMCI,
(3) Public Nutrition	*Several	Several (see attached); Nutrition Law (u.d.), Regulation for Iodizing Salt in Food 2011		food demonstration, the introduction of food variety, school feeding, food fortification	some	Primarily emergency supply and treatment, almost no prevention → nutrition cluster, prevention and assessment, nutrition during lifetime (MoE), Infant and Young children feeding
(4) Sanitation and Hygiene	Several	Indirect: national policy for healthy school initiative	UNICEF,	school based, CLTS	Yes	Cb ODF, CLTS, hygiene education, WASH, committees, Low standard in the hospital →water cluster?
(5) Non-communicable disease	Barely	Non-Communicable Diseases Strategy	?	(One sports activity)	No	!
(6) Disability, injury prevention	*Several	Strategy for Disability and Rehabilitation	IAM, HI	some to reduce stigma	increasing	Treatment and rehabilitation in the city
(7) Population Growth	Some	Policy and reproductive health strategy	MSI	Population growth monitoring, mullah birth spacing	Some	Family planning is a sensitive topic
(8) Environmental Health	(-)	Environmental Health and Protection of Living Environment Regulation	?	(-) village cleaning campaign, lead, a bio-sand filter	Barely	!
(9) Communicable Diseases	*Malaria, TB, Polio, HIV	Several: National Infection Prevention Program; also, HIV …	Various UNICEF,	LLIN	Yes	Many activities addressing HIV,
(10) Mental Health	*Increasing	National Mental Health Strategy	HealthNet TPO, IPSO, IAM	Limited; social support groups, awareness raising, focusing	increasing	differences: D, A, PTBS vs. Epilepsy
(11) Occupational Health	(-)	(Not found)	?	-	no	(-) only some small initiatives
(12) Substance Abuse	Drug some, missing	Tobacco Control Legislation (2014); Afghanistan	WVI	-	no	Some focus more on drug users

		Counter Narcotic Law 2010,				
(13) Pharmaceutical Affairs	Some	Pharmacy Regulation 2006; Medicals drug law (2006);	HPIC	-	no	High demand, call for good quality
Disaster Response	Several	(Not found)	ARCS	(In case of emergency)	no	In acute phases but apart from vaccination, almost no DP, HP, or HE

Note: An Asterix in column 2 indicates that this area is included in the BPHS. The colors used in this description do not represent the appropriate nationwide coverage but merely refer to the estimated amount of existing and comprehensive programs and activities in this sector. They cannot give an answer concerning coverage, beneficiaries, effectiveness, scope, or quality. The color red represents areas in which there is a substantial need to develop further activities and programs. The color orange symbolizes that some activities are available, but they are not sufficient. The color green illustrates that various activities are available, so there is less the need for further development of programs but for rolling them out nationwide.

In total, more than 400 different programs and activities were identified (see the table attached). Besides the 'general sector,' six sectors had substantially more available activities than others. These sectors correspond to the prioritized sectors of the MoPH in the BPHS, such as mother and newborn health, child health, nutrition, WASH, communicable diseases, and mental health. The available activities and types vary widely across sectors according to what is required. For example, most of the activities in the communicable disease sector address the surveillance of and prevention of diseases through early detection and vaccination, etc. In contrast, the priority in mental health is given to training mental health professionals, reducing stigma, and strengthening psychoeducation and psychosocial support groups. Considerable gaps occurred in the occupational and also environmental sectors as well as the pharmaceutical sector. Whereas there are almost no activities in the first two, the activities in the pharmaceutical sector are almost exclusively on the conceptual level: developing strategy papers. Little is known about the execution of these activities.

The national-level analysis showed that, overall, the government had developed national policy papers for all of these priorities except for occupational health. Many of these papers deal with maternal health and pharmaceutical affairs, indicating that the MoPH regards them as one of the most relevant action areas.

On the community level, most activities are related to mother and child health, nutrition, and washing. Some prevention activities for communicable diseases include the handing out long-lasting insecticide nets or polio vaccination. Some community-based activities address mental health and disability, such as working with social support groups or having large campaigns to address the stigma of disability. The usual form of community-based activities is to raise awareness, have a demonstration session, or work with small groups. The activities in WASH are highly concerned with providing hygiene education (and sometimes also installing sanitation facilities) and how to treat diarrhea. In contrast, most activities in nutrition are about reducing malnutrition, often through supplementary targets feeding programs and (for a few years) also providing

micronutrients to mothers, etc. one attempt that has scientifically been proven as successful is the use of pictorial community-based growth monitoring and promotion program (Mayhew et al. 2014)

The analysis of the health promotion activities showed that it is not easy to separate health education, health promotion, and disease prevention based on the available data. In order to estimate the availability of activities, the author sought any kind of promotive or preventive intervention. Health promotion activities directly addressing the environmental factor are very scarce; only some activities were identified in WASH and rarely in the nutrition sector, e.g., kitchen garden. An ordinary form of health education is an awareness campaign via media or health facilities. In addition, they play a vital role in spreading health messages within the school, during literacy courses or vocational training. Also, many NGOs provide specific programs for women not only related to birth but also concerning some literacy and life skills activities. A vast range of programs for women groups was identified, which cover not only pregnancy and birth-related issues such as the birth life-saving skills (BLISS (operation mercy) but also integrate some literacy and life skills activities, for example, the cultural and social support groups (I16).

Some observations were surprising and unique to Afghanistan:

(a) There is a large need for disaster response activities, which is not explicitly included in the BPHS, (b) Many activities aim to prevent communicable diseases, for example, to eradicate polio. Yet, most activities address HIV, even though the rate is exceptionally low (c) The activities in substance abuse are small in number and target almost exclusively drug addiction with a focus on treatment and rehabilitation. Only one organization refers to raising awareness of the risk of smoking, alcohol, and other drugs. (d) Lastly, it is crucial to prevent early marriage and address the issue of self-immolation, e.g., by having a burns department at the health facility.

Here, the scoping review mainly focuses on health-related activities that can impact the community level. It is worth performing further analysis to identify gaps, for example, in regard to the geographical coverage[33], target groups, socio-economic distribution, gender segregation, the extent of the activities, the quality of the performance of the health workforce, or the funding of these activities.

6.4 Conclusion – Gap Analysis

The purpose of the scoping review was (a) to identify providers of health interventions and existing health activities in Afghanistan, (b) to systematize them, and (c) to give a cautious estimation of the sufficiency of the number of available activities. Instead of using free internet research

[33] The overview of humanitarian response provides already an idea for many white areas that are not covered with a permanent basic health facility nor with other services. Little is known about them.

exclusively, the author identified the organizations systematically based on publicly available lists of NGOs. The selected lists were double-checked with communication partners and verified. A total of 732 organizations were identified. After excluding duplicates (N=218), NGOs without an internet website (N=166), or lack of contact details, relevance, or sufficient information (N=90), a total of 258 organizations were integrated into the website analysis of providers and activities. Organizations were categorized based on the immediacy of the impact of their activities on health. The activities were clustered along the 13 sectors for health promotion (described by the MoPH) and subdivided into seven dimensions.

Based on the systematic identification and website analysis, at least 138 organizations work directly in the health sector. Further, 42 organizations perform activities that immediately impact health, such as nutrition or WASH. Other 57+21 organizations indirectly collaborate in areas that impact health by addressing the prerequisites for health, such as education, legal aid, and livelihood.

The main results of the scope analysis of the providers are (i) heterogeneity in terms of provider, services, the range of topics, locations, and target groups. (ii) Many more organizations work in the health sector than only the 46 + members of the UNOCHA health cluster. (iii) Nine main types of providers could be distinctly identified: (a) the donor, (b) the conceptualizer, (c) the generalist, (d) the BPHS implementer, (d) the "specializer", (f) the localizer, (g) the "targetizer", (h) the capacity-builder, and (i) the "sectoralizer".

Overall, manifold activities are available in all 13 sectors. The foremost program nationwide is the BPHS and all its activities. Most programs or activities available could be identified in the sectors of maternal and child as well as communicable diseases. Gaps, such as areas in which the reality does not meet the required standard, were identified for pharmaceutical affairs, non-communicable diseases, and environmental and occupational health. Based on the MoPH website research, national policies and strategies are available for all 13 areas except occupational health. Community-based health promotion activities occur almost exclusively in the BPHS sectors. Many projects are available that target women specifically; however, little is known about these projects' content, length, or outcome. Regarding the type of health activity, disease treatment activities, and some sort of disease prevention dominate; little is known about rehabilitation. Health promotion is mostly reduced to spreading messages for the purpose of enhancing a healthy lifestyle. There are only a few activities that also address the determinants of health. Feinstein also found the dominance and prioritizing of curative over preventive interventions in the BPHS, who stressed it as "a near-universal phenomenon" (Feinstein International Center 2011, p.53).

Until now, there has been no publicly available overview of health activities in Afghanistan. Therefore, these findings cannot be validated compared with other surveys on activities in Afghanistan. Even though it identified the NGOs systematically and included further NGOs, which

were found based on a free search, this overview cannot rule out all limitations: For example, many unregistered NGOs have likely been missed out. Next, difficulties arise in verifying the continued existence of the activities or the outcome because many NGOs (particularly Afghan NGOs) did not present an annual report on their website, which would have helped double-check their report's accuracy. Furthermore, subdividing the programs was difficult because the information was often lacking, in particular, concerning the location (urban/city) and the type of health activity (promotion, prevention, treatment, rehabilitation). Notwithstanding these challenges, this overview provides a good start for continuing to structure and work on this.

Three implications can be derived:

First, the health situation in Afghanistan has changed tremendously in the last 15 years. Despite the decrease in mother and child mortality, which still remains high, there is a significant increase in non-communicable diseases. The Afghan health system, for the future, needs to adapt to these new challenges by not trading off the remaining needs in mother and child health, nutrition, and WASH. So, there must be not only an expansion of treatment of NCD but also a revision of health promotion activities and a new focus on non-communicable diseases as well as environmental and occupational health. The revision is even more necessary and appropriate because these diseases correlate to individual lifestyles.

Second, many promising activities have been developed and implemented, but it appears that a considerable number of them did not continue after the end of the project phase. Not only did the project end, but also the lessons learned, and the recommendations could not be passed on to others. It would be worth having a database of all existing activities and lessons learned from Afghanistan to improve and implement worthwhile projects on a larger scale. The question must be asked if this strategy can be realized in a setting in which NGOs have to compete for funding from the main donors. It is assumed that the way the NGO-donor system works might be less enabling and more inhibiting for this.

Third, the overview shows that many activities have been developed in almost all health sectors since 2002. In some sectors, the activities are even redundant. These findings contradict the recommendation of the World Bank, which says: *"In health, lagging programs (including family planning, nutrition, and immunization) will need to be prioritized, and government stewardship will need to be strengthened"* (The World Bank 2016). By exclusively looking at concepts and activities, the author can state that they are sufficient for many sectors, and there is no need for developing other concepts and projects in these sectors. But as already said, this overview cannot present the availability for all people in all areas. Knowing the various projects, an interviewee said:

"Well, what I suggest is before moving forward with any health promotion activities, data needs to be gathered, and through using different models we have studied at our schools, health behavior models that have and theories that we have, we also have to find out: where can we intervene

in order to have an impact? Mostly health promotion activities have not been based on scientific data. It is - you know- people believe that health education can convey and is a health promotion idea, yes there are but does not address drastic the main reason why people are not practicing certain healthy behavior" I12, 59). Some thoughts on important aspects of this are explored in the following chapters.

Based on this analysis, the following questions could be further explored:

- How can the execution of the available strategy papers be strengthened? Could these strategies be integrated into medical education and into the everyday work of health workers?
- Some methodological questions need to be asked: How could a representative and validated overview of health activities be developed? And for what could it be used?
- From the perspective of practitioners, it is interesting: How could this overview be used to identify further activities which enrich their own work? How could sharing best practices be realized in a country of constant change?

7 Concept of Health

The next chapter presents findings relating to health practices, the concept of health, rumors, misconceptions about health, resources, and risk factors. The chapter starts with the observation, followed by definitions of health, then presents common explanations, and closes with identifying inhibiting and enabling factors.

7.1 Health Practice and Health-Seeking Behavior[34]

To assess whether and how health was perceived, the interviewees were asked to give examples of common health behavior, a description of the concept of health, and rumors about health practices. The interviewees defined a common way of seeking care and named five groups of Afghan people who are consulted for health care (see I14b, 56). This is illustrated in the chart below (Figure 13) and also specified in Figure 14. Almost all interviewees stated that Afghans first consider themselves healthy as long as they do not perceive any physical symptoms (A18, 52) (see 7.2.). Initially, if they have some signs of a disease, the people ignore it (I15b, 10). However, if the disease becomes more severe, they seek advice from their family members. In the family, the moral power holder, the mother-in-law (I10, 30), often decides whom they ask for health based on a set of questions (I6, 16). So, Afghans either seek advice from their neighbors (or elders) and treat themselves with homemade remedies (cf. I15b, 10). Alternatively, Afghans go to a traditional birth attendant (I14b, 56), a traditional healer (A18, 45), or the mullahs (I15b, 10). In many areas, people only visit the health facility if the disease is very severe or chronic (I11, 35) and/or if health care at a health center is accessible, affordable, available, and acceptable (I13, 21). The interviewees pointed to various barriers to seeking care at the health facility, such as lack of trust, poverty, or cultural constraints (see Chapter 5.8). Figure 13 below lists the identified ways of seeking care, and the chart illustrates the known decision-making processes. The author developed this chart and verified it with the feedback of interview partners. Moreover, Figure 14 lists the people consulted for health advice (=experts) and the various health issues that people approach each person about.

[34] Pattern see also: “The most common coping mechanisms listed by the respondents included reading the Quran (37 percent), praying (28 percent) and talking to family members (9 percent)”. *(Scholte et al, 2004).*

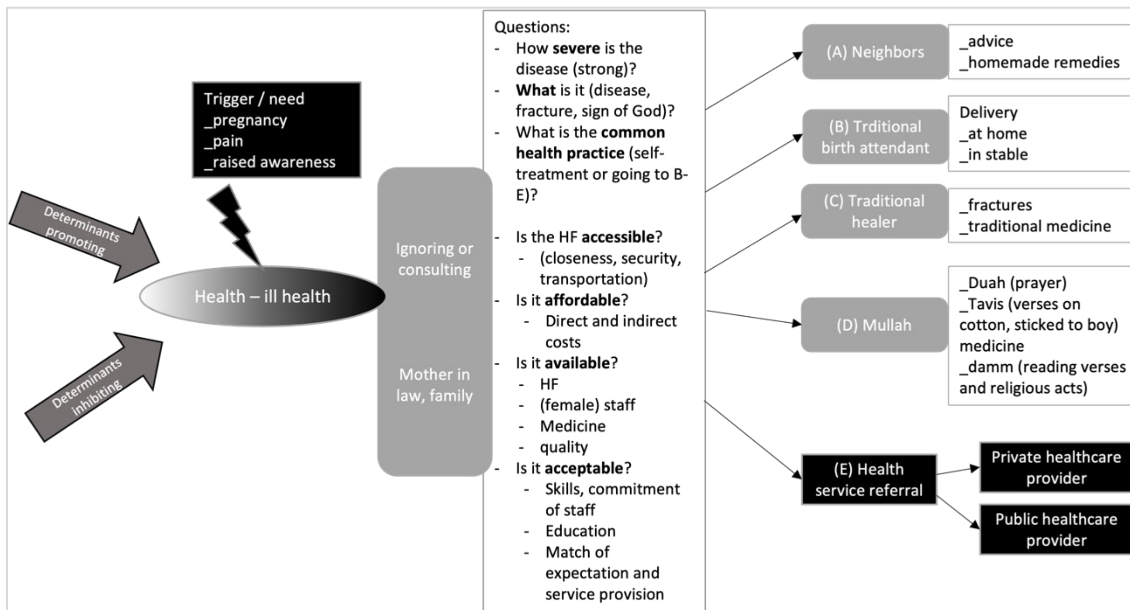

FIGURE 13: PATHWAY OF DECISION-MAKING AND INFLUENCING FACTORS

Family Neighbors						(elders)	Mullahs				Trad. Healer	Doctors					
		I7c		I7c	I7c	I7c	4	I10, 51	I10		I10	2	I1	I7c	I7c	I2	
Ignoring	Mother (in law)	Homemade remedies	chains	Lack of awareness	Do not believe in modern medicine	Advice on health behavior	Duah	Damm	Tavis	Some do not advise going to HF	Fracture	Delayed care seeking	medicine	Trust in doctor' cure everything.'	No knowledge of specialists	Keeping secrets	Delivery

FIGURE 14: PEOPLE CONSULTED FOR VARIOUS HEALTH CONCERNS

Generally, trust (I8, 61) and awareness of available, accessible services (I9, 39) are key components for seeking care at the health facility. One person vividly explained that the number of people seeking health care at the facility had drastically risen after a media campaign. In this campaign, the health facility, all working staff, and available services were shown, and the local mullah encouraged the people to seek care there (I9, 41). This example demonstrates that seeking care at the facility is highly dependent on knowledge, availability, trust, and support by key opinion leaders.

The interviewees stated that a common belief is that mental health comes from God (I10, 53). These beliefs make some people assume that doctors cannot do anything about it (I1, 8). The respondents' reported that some people link health to "intangible things like spirits, souls, demons, genie, and beliefs that with prayer we can cure some diseases" (A18, 89f.). Hence, it is quite common to address the local mullah. There are three treatments that the mullah usually performs (i) The most common form is to treat diseases with prayers (Duah), e.g., in the case of epilepsy.

(2) He also reads some verses and practices rites (Damm). (3) Or he writes Koranic verses on a piece of paper or fabric and ties it to the body of the sick. (I10, 51) *"you will improve with it if God wants, if God do (sic!) not want, you will die*" (I10, 51).

One very common health practice is that people expect to receive several drugs from the doctor. This *"over-medicalization"* (I1, 57) is regarded with skepticism and even as a harmful practice because the medicine might have spill-over effects and can even trigger mental disease (I1, 57). Overall, the interviewees reported that within the last years, they recognized a significant improvement in hygiene practices and health care seeking (e.g., I9, 13; I12, 53).

7.2 Concept(s) of Health and Sickness

To understand why people search for support from one or more of these people, knowledge of the fundamental understanding of the health and sickness of local Afghans is useful. A variety of aspects were expressed regarding the concept of health, such as (a) the dimensions included, (b) the manifestation of the dimensions, (c) the explanation, and (d) measurements. The answers also indicate three main distinctions, reveal some surprises, and vary in the prevalence of diseases. Overall, the interviewees used three dimensions that differentiated their answers: urban/rural, an education level (A15, 16), and medical/non-medical staff (I13, 19).

First of all, it became apparent that many Afghans, in particular, illiterate people in rural areas, have a contrasting understanding of health as the absence of disease: *"if you have fever, (...) body ache, or a headache,"* you are sick *(I10, 49) "Otherwise they think they are healthy."* (I8, 57). In contrast, several medical health professionals referred to the holistic WHO definition of health with the specific addition of not having an economic problem. Based on this definition, they state: *"Afghanistan people are not healthy"* (I7c, 3).

Generally, four dimensions emerged from the interviews concerning the concept of sickness and health. These are the physical, psychological, social, and economic dimensions, plus some additions (see Figure 15).

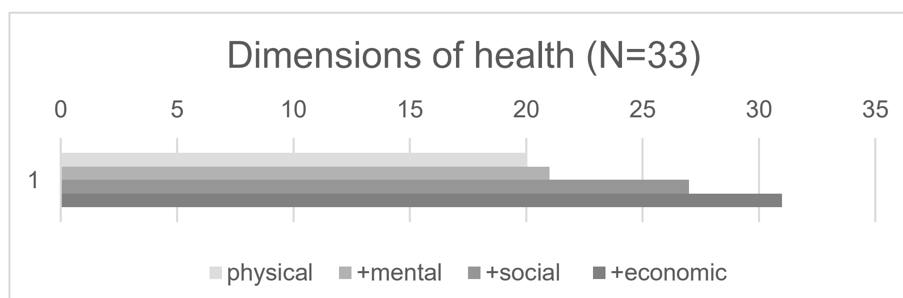

FIGURE 15: OCCURRENCE OF THE DIFFERENT DIMENSIONS OF HEALTH IN PEOPLE'S NOTION OF HEALTH

Most interviewees refer either to the first dimension or successively add further dimensions, one after the other. Twenty respondents name the first dimension: 'physical: the absence of disease"

(I13, 19) (mentioned by 20 respondents). One interview states health is physical and psychological (I4, 18) (N=1). Many others refer to three dimensions "complex status as physical, mental, social well-being" (I13, 19). One person exemplifies that people feel sick if they are limited in doing their daily work and cannot contribute to social life (e.g., G3, 35; I12, 34) (N=6). Some others talk about the fullness of the definition that additionally integrates an economic dimension (I7c,3) (N=4). One interviewee even expanded it, included coping with the challenges, and stated: *"to survive war, famine, and social disruption*" (A18, 57) (N=1). The majority of the respondents (N=20) said that people describe their sickness/health by referring to immediately recognizable symptoms. In contrast, silent symptoms of non-communicable diseases remain unrecognized for a long time until an incident happens (I8, 57). So that people are more aware of their own health status, some medical doctors suggest they should undergo a regular medical check-up to identify these silent symptoms (see A15, 16).

The interviewees did not only use different dimensions to talk about health. They even pointed to various manifestations of the dimensions. For example, the physical status was described in two ways a more pathogenic way, such as having no severe pain/symptoms (A9, 25), and a more salutogenic way by focusing on functionality: being able to function in life ("able to eat, drink, walk, think, work (A18, 52). Besides, there is a wide range of patterns of explanation. Some people explain that sickness is not only caused by viruses, infections, or lifestyle; it can also be due to Allah or spirits (G6, A18, 89; A4, 36). Moreover, war can also, directly and indirectly, impact their health (I2). Even only to hear negative or positive news can strongly impact their feeling of sickness and health. One interviewee reports: *"So, they feel sick when they hear bad news such as killings, suicides, destructions, and they feel healthy when they hear good news such as peace, stability, and economic development in Afghanistan"* (A19,61). This phenomenon was also confirmed by I4, who specified that it could occur even when there are no blood ties between the hearer of the news and the person directly affected by it (I4, 18).

To answer this question, a person suggested this could be measured by using standard instruments such as quality of life and functionality. However, she noted that this might be insufficient because her observations show that the contentment of the family and security plays an important role in defining if one is content/satisfied or not (I2, 17).

Some phenomena surprised the interviewees. Even with a mental disease: *"they function most of the time remarkably well"* (I1, 12). In contrast to internationally used classifications of diseases, the interviewees stated that Afghans do not interpret some diseases, and physical states as illness or sickness, for example, depression (I1, 17). Furthermore, some diseases come along with stigma whereas others do not (e.g., anxiety, depression, or post-traumatic stress disorder (I1, 14), whereas others are highly stigmatized (epilepsy and bipolar disease) because people expect that "you are possessed" (I10, 53), or it is explained by religious phenomenon (I1, 14). Many interviewees refer

to the lack of proper awareness of sickness: *"we have kind of a lot of people who think they are sick, but actually they are not sick, and also we have a lot of people they are sick, but they think: No, I am healthy*" I8, 61. A fourth difficulty is that – from the perceptive of doctors – patients often lack the ability to describe what they have physically but also mentally. (I7c)

In the following table, the four dimensions and their exhibition are illustrated. The author refrains from the dialectic understanding of sick or healthy and refers to the continuum between ill health and positive health. This indicates that it is not about "either-or" but about having fewer portions of ill health and more positive health. In summary, the interviewee said that health is linked to daily functionality[35], as well as to wealth, job opportunities, good friends, and partners as well as education.

Figure 16 shows the description used for explaining positive health (top) and ill health (bottom).

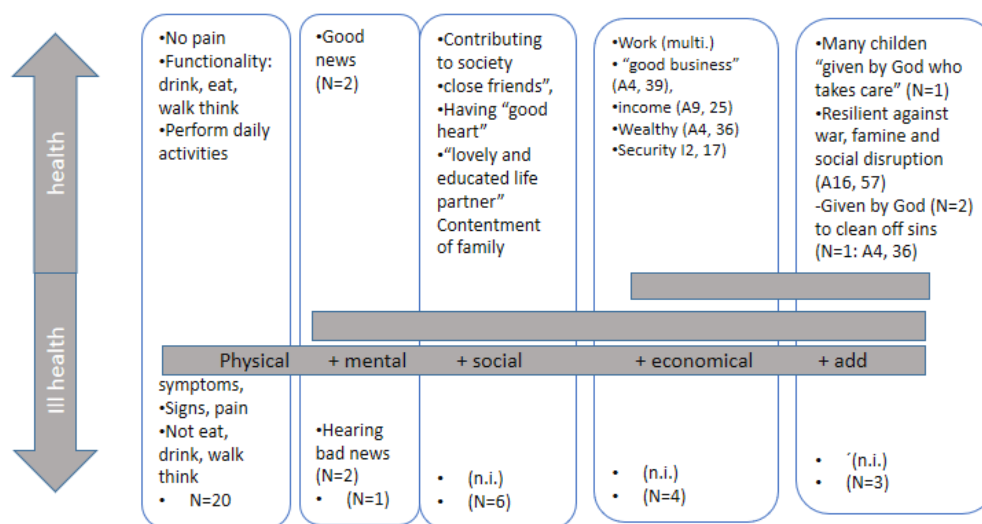

FIGURE 16: DIFFERENT WIDELY SPREAD NOTIONS OF HEALTH

7.3 Rumors and Misconceptions

Turning to the empirical evidence on health behavior, several health practices and interpretations of certain diseases were identified. Table 26 presents these practices and a cautious estimation of how common they are. This estimation is based on the number of people referring to it and the feedback selected from some interviewees for cross-checking.

[35] A sick child also requires the support and care of other people who then are also not able to accomplish their everyday work ("double burden" (G3, 37)

TABLE 26: RUMORS AND MISCONCEPTIONS IN HEALTH BEHAVIOR

Behavior	Identified practice	Perception	Risk	Estimation
Delivery	Stable	Will be safe	Tetanus, Infectious diseases (I9, 29)	Rare
	Cutting novel with an agricultural tool	Long life	Tetanus (I9, 29)	Rare
	At home, not in a facility	"Should be" (I12)		common
	Pre-eclampsia	It is a kind of 'jinn' (I10, 49)		Rare
Pre-eclampsia	Put them in a dark room and only give them water and bread			Rare
New-born child	Red lipstick on the umbilicus	Red lips look beautiful (I10, 49)	?	Rare
	Black mascara	Look handsome (I10, 49)	?	Rare
	In cow dung	Keep warm (I7a)	Infectious diseases	Rare
Breast-feeding	Not in the first two days	"harmful" (I9, 35)	harming	Very common
	Give oil to a newborn child (I7c)		harming	Rare
Surgery	Belief: only eating water, tea, and bread;	Other things are "harmful" (I7c)	Not recovering properly	Common
Fracture	Seeking care from a traditional healer			Common
Mental disease	Epilepsy	"Sign of God" (I10, 53; I1)	Not seeking care	Common
	Mental disorder	Caused by a 'jinn' (I9, 62)	Not seeking care at HF	Rare/com
General	Pain	Given by God to clean off sins should be appreciated	Not seeking care	common
Family planning	Not practiced	"It is haram" (I7c)	Large families, poor health of women	Very common
Good doctor	Patients expecting to receive several medical drugs	A good doctor is one that prescribes many medicines (I1)	Negative side-effects, the interaction of drugs	common
	Mother is not allowed to go out of the house or receive visits by relatives or neighbors in the first 40 days	"They bring problems with themselves"		
Hepatitis	Just give water and bread and hang a white onion on their neck (I10f)			
CVA	Patients go to a shrine (I10f)			
Arthralgia	Put a hot knife on the painful joint to make scare for the treatment of a.(I10f)			

Most of these health practices have been observed in rural areas. However, the practice of seeking care from a traditional healer in case of a fracture and addressing the mullah for Damm and Tavis is common nationwide.

There is one health theme that was identified as highly needed and highly controversial at the same time. This is family planning. One interviewee reported that they could freely talk about family planning in the cities. However, in remote areas, they have to cooperate with mullahs, who

are often reluctant or even opposed to family planning. It occurs that their teaching conflict with the application of new family planning methods. A common strategy is to introduce birth spacing based on Islamic teaching.

7.4 Resource, Protection, and Risk Factors

In addition to these rumors and misconceptions, several recurrent factors that protect or threaten health were named in the interviews and questionnaires. Five categories emerged from the interviews: factors on the national level related to city/housing, the community, lifestyle, and the individual, which can be protective in the respondents' opinion (cf. Table 27). One person lists many factors on the national and housing level such as: *"Culture of citizenship education, Preventable by vaccination, Reduction of old vehicles in city, Preparation of sanitation water, Keeping the environment clean, Prevention of high population in the city, Prevention using coal to heat the house, strictly (sic!) control of imported food and drugs."* (A7, 38 pp.). These reported environmental factors are very general and applicable to all countries worldwide. However, interviewees recurrently point out a specific and unique character trait that protects, strengthens, and helps them to stay healthy *"Afghan culture for centuries has a strong thread of resilience, self-reliance, and pride that can be foundational in rebuilding social cohesion."* (A16, 59)

TABLE 27: RESOURCES

Nation Level	City/Housing	In Community	Lifestyle	Individual
Education (N=4): a "Culture of citizenship education" (A7, 38) also, hygiene education, literacy	Clean environment, e.g., city (N=2) _ Reduction of old vehicles in the city _Prevention of high population in the city	knowledge about healthy lifestyle: having a 'source of information' which helps "to guide communities for good health" (A18, 56),	Nutrition (N=5) _good quality, healthy, sufficient food intake _kitchen farming -	self-reliance, pride (N=2), resilient, creativity, will survive, "zest of life" (G3, 31), very strong The God-given gift "Saber" = "patience" (A19, 64) Smart, diligent, skillful
Environment, healthy _fresh air _no contaminated water	housing _Prevention of using coal to heat the house (A7, 44)	Social support (N=3) family & relationships, strong family ties, do not abandon their mentally ill	Exercise	Conviction that a very committed person can bring about change
Control of imported food and drugs	WASH (N=4) _access to potable water & sanitation facility	Awareness of music and culture as a spiritual support	Daily structure, e.g., basic education courses for drop-out students	Guidance from Quran, "Feqa," prophet Mohammad (N=2)
media _increasing awareness of health and hygiene	Health services _available & accessible _consoler	people with a good heart who show sympathy and provide knowledge (A4, 39)	Use of protection devices such as masks or their hands to avoid pollution	Identifying individual resources (I2, 19)
Safety		People are always willing to work, to help, and to find a way to continue (G2)	Being able to take care of themselves (I2, 19)	Educated

Preventable by vaccination (A7, 38)		Life goes on despite insecurity (N=2)	Being able to communicate (I2, 19)

Three additional observations are remarkable. First, the *"Afghan great culture as a spiritual support/ resource during calamity and joy*" (A19, 64) helps them live their life even in the face of insecurity. One Afghan living outside of Afghanistan mentioned that the people are friendly, tell jokes, are continuously busy on the street, and attend weddings despite the lack of security (G6, 23, I14). Second, the major role of 'saber' (A19, 64) is a kind of character trait that helps them to stay patient and somehow resilient and live even in the face of many difficulties. Third, one interviewee suggests using it as a resource "*I think, Afghani people are nice people, in general, they respect they respect the program, they respect you know each other there is a kind of a lot of welcoming kind of attitude, I think what we need to do is we need to catalyze that kind of strength in the community into the creation of more awareness especially focusing on the preventive diseases, preventable diseases, creating awareness,"* (I11, 55). Despite this psychological resilience, a non-Afghan elaborated on the physical strength and stated that they "are kind of actually immune" (I11, 35).

However, despite this strength and resilience, people point to changes within the last few years. They witness a decrease in hope and negative but a decrease in pessimism and lack of hope (G3, 11). Besides these resources and protective factors, one interviewee also pointed out **risk factors** and stressors that contribute negatively to health (see determinants of health Chapter 1 and barriers Chapter 5.8.). These potential risk factors and stressors: are war, family conflicts, domestic violence, poverty, insecurity, and traumatizing experiences (I2, 11). To strengthen people to cope with the situation, one person elaborated on the need for rebuilding relationships and good communication (I2, 11). Even though the health sector can contribute to improving health, several interviewees claimed this is not enough. One person explained: *"the health sector have (sic!) to work with economy, agriculture, education, and other sectors because poverty, insecurity, low awareness of communities are the reasons behind the diseases" (A18, 69).*

7.5 Conclusion – the Concept of Health

This qualitative study aimed to gain a deeper understanding of the concept of health, rumors about health, and common health practices in Afghanistan. This is needed because several studies and practitioners' observations have shown that these issues largely define if and when people seek care and how they accept health promotion messages. So, knowledge of these can give valuable insights for conceptualizing health promotion approaches promising for effectively addressing the need, changing harmful practices, and improving healthy behavior. The qualitative data was collected through 28 semi-structured interviews and in 22 written questionnaires that were

returned. The category system was developed inductively. To ensure greater data verification, interviewees were invited to provide feedback on the available data and the mechanism identified.

In Afghanistan, the common health-seeking behaviors and health practices initially seek advice from the family or another trustworthy person, such as neighbors, the traditional birth attendant, the traditional healer, or the mullah. If the disease is very severe and/or the health service is accessible, available, affordable, and acceptable, people go to health facilities. The concept of health varies widely and depends on the level of education, the village's remoteness, the level of medical training, and the disease. The answers demonstrate the diversity of dimensions of the concept of health and explanations. It starts from a medical and spiritual component and shows that the perception over a large distance can even impact health. As seen in the findings, physical symptoms are primarily used as an explanation for being sick which resonates with the medical, pathogenic, dialectic understanding of health as the absence of disease. However, health professionals often broaden the concept and include psychological, social, and economic dimensions as well as the ability to cope with war. In this study, a unique collection of rumors and misconceptions could be identified, which are more likely to occur in remote areas. Repeatedly, changes in mental state are interpreted as being influenced by spirits. Various rumors exist concerning births and operations. Lastly, resource, protective, and risk factors were assessed. In addition to general protection factors in the environment, the unique, strong, resilient, and committed character of the Afghan people, as well as the robust and supportive social bonds, have been identified by the interviewees, which have the potential to counteract the many challenges and stress factors.

Information on health behavior and concepts of health are very scarce in Afghanistan. In 2014, Newbrander et al. conducted a study on barriers to appropriate care (Newbrander et a. 2014) and identified shame, women's inability to seek care without a male relative, and seeking care from mullahs as the main sociocultural barriers. Furthermore, in the manual for CHW, USAID presented five misconceptions and encouraged the health educator to address them. These are apart from the (a) lack of breastfeeding after birth, they inform (b) that some people think that children's immunizations make some of them sick, (c) in case of diarrhea to give children liquids increases diarrhea, (d) oral contraceptive pills cause cancer, and (e) injectable contraceptive depot-medroxyprogesterone acetate is perceived as a tool to dominate Afghans (USAID 2008). One interviewee whose organization does much research pointed out that the concept of health and health practices (more than primarily observing the barriers to seeking health care at the health facility) "requires some studies" (I12, 41). These topics can barely be assessed with quantitative research. Asked for qualitative or even ethnographic research, he said that little is done because it is hard to get funding for it. The study of Newbrander can be an example of good qualitative research in this area and can be used as a best practice example even in difficult areas.

The following implications for health promotion approaches can be drawn on the basis of these findings. (a) It is strongly recommended that health advisors are integrated into any community-based health promotion approaches because they largely act as enablers or inhibitors for certain suggested, evidence-based health behavior. As the examples, such as concerning family planning, show, little can be achieved if the health messages contradict their attitude and advice. (b) It is recommended to find effective ways to work not only with the mullahs and traditional birth attendants but also with traditional healers, for which almost no data and no cooperation strategy were found. (c) Because all people interpret physical symptoms as signs of sickness, health promotion should focus on raising awareness of the signs and even silent symptoms. (d) Concerning the increase in non-communicable diseases, it is even more necessary to emphasize the focus on this. (e) The collected rumors and misconceptions might be confusing and even perceived as irrational, but it is highly recommended that ways be found to overcome harmful approaches. As many interviewees who work with female groups suggest, it is very beneficial to learn to identify these factors and to address these them in order to reduce the harmful impact of risk factors (economic, environmental, war-related) as well as to accentuate those resources and protective factors that have the potential to improve health outcomes, e.g., social support and the strong character of Afghans. Others, such as Edward, also identified this strong, resilient Afghan character. He said: "The health workforce in Afghanistan faces some daunting challenges in the backdrop of worsening security conditions and yet continues to provide care, illustrating remarkable resilience, dedication, and commitment." (Edward et al. 2012a, 2012b). Furthermore, for a promising health promotion approach it might be worth integrating the "six fundamental cultural values – faith (imam), family unity and harmony ('wahdat' and 'ittifaq'), service ('khidmat'), perseverance and effort ('koshesh'), morals ('akhlaq'), and respectability and honor ('izzat') – that underpin the sense of resilience in Afghan culture." (Fernando and Ferrari 2013). These values strongly correspond to the resources identified by Anonovsky (Bengel et al. 1986), such as the studies on health in conflict times (Eggerman and Panter-Brick 2010; Fernando and Ferrari 2013; Ghosh et al. 2004).

This demonstrates that health education and health promotion activities should be aware of these findings to successfully address existing myths, barriers, and harmful health practices. It is highly recommended to conduct studies and include other perspectives of other stakeholders (not exclusively NGOs).

Throughout the work on this chapter, the following questions can be discussed further:

- From a medical anthropologist's perspective, one can ask: What are other health concepts, and how do they shape health-seeking practices?
- Regarding the health system, it is important to discuss the following: What role can, and should traditional healers and mullahs play in the health system?

- For developers of health promotion approaches, the question should be posed: What are further culturally appropriate and effective ways to overcome barriers related to these perceptions?

8 Health Promotion Approaches

The next chapter sheds light on the variety of health promotion activities in Afghanistan, focusing mainly on community-based health promotion approaches. The findings are based on the qualitative interviews and the responses to the questionnaire. Initially, two contrasting examples of ordinary sceneries in Afghanistan are given. Then an overview of the major health promotion approaches is presented. Next, the strengths and limitations of the approaches are briefly summarized on five levels: national, health facility, community, school level, and through media. The last part of this chapter presents the recommendations provided by the interview partners for overcoming barriers, good practice examples for working, suggestions for health education and health promotion, and recommendations for the future.

8.1 A Contrastive Description

Following Miles's suggestion for presenting the complexity and variety of qualitative data, the author reconstructed based on the data (Miles et al. 2014).

An exhaustive description of poor health care/worst-case scenario
XY is a small village deep in a beautiful mountainous area. The community has no health facility, and for a long time, no mobile health team accessed the village via the unpaved road. The people live in very poor environmental conditions, have no sanitation facilities, poor water quality, and no variety of nutrition, and the maternal and child mortality rate is very high. There are only an old traditional birth attendant and a traditional healer. Due to conflict and natural hazards in the area, several people left the area. The migration of people led to a fragmentation of families and a lack of social cohesion or support groups. The literacy rate is very low, and most of the time, there is no electricity and no access to media. Just recently, the level of insecurity increased again. Mullah is reluctant to family planning, no permission for NGOs to work there, The next health facility is more than a 5-hour walking distance away. People, e.g., pregnant women, have to walk all the way or ride on a donkey. On their way, they cross several checkpoints. However, even though there is a health facility, there is no female staff, a shortage of medicine, a lack of quality of care, a lack of commitment, and no health education is provided. So, people are very reluctant to go there. (Reconstructed from: I10, 45; A22, 25)
An exhaustive description of best-case scenario/community
In a perfect scenario, the community health worker collaborates closely with the community health shura (and the CDC) as well as the community midwife and the nearby health facility. All of them provide health promotion. The CHW trains FHAG, who then spread the message to their designated neighbors. The CC is eager to support the HF and works to improve its inhabitants' living situation. Everyday health awareness messages are spread through the radio and video. Apart from the behavior changes and the improvements in the environment, the CDC plans to cultivate new nutrition sources, such as soybeans, and improve the school's sanitation situation. The nearby clinic is well equipped, following the BPHS standards. The women travel there with their 'mahram,' and they can rest in a female waiting room; they receive interactive health education using many methods about seasonal disease and prevention. The health workers are qualified and committed and work to improve not only the acute health status but also the patient's health literacy. (I7b)

The respondents repeatedly used the following six dimensions within the interviews to talk and differentiate between the contexts in which people live. These are (a) availability of appropriate health services, (b) local health knowledge and competencies (I10, 35), (c) cultural beliefs (I8, 61), (d) manifestation of the determinants of and the prerequisites for health (A6, 90) as well as (e) having some level of health education (I12, 59) and, in particular, (f) security (A9, 35).

The next section presents a cautious evaluation of the identified community-based health promotion approaches. Asked about community-based health promotion activities, most respondents elaborated on the CBHC and the BPHS (see description in Chapter 5) and pointed to the IEC material provided by the MoPH (A18, 38). Two definite opinions could be distinguished concerning the community-based health care program: the supporter and critics. The supporters emphasize the strengths: it is a good idea, *"works with people, and strengthens and empowers themselves,"* they can take care of their health, and the people become self-sufficient/-dependent (I6, 29). It is effective, sustainable in the context. The others do not criticize the conceptual idea but point out the poor execution due to various difficulties, e.g., insecurity and geographical difficulties.

The table below summarizes the results obtained from the analysis of the health promotion approaches. It gives a brief characterization, a description of the tasks (and covered topics), an estimation of the level of activation of the community, and the estimated impact. This overview takes more into account the conceptual and theoretical ideas behind the approaches than their practical performance. A contrasting elaboration gives an estimation of the real applicability of these approaches on the strengths and limitations of these approaches (cf. Table 28).

TABLE 28: OVERVIEW COMMUNITY-BASED HEALTH PROMOTION APPROACHES AND THEIR ESTIMATED IMPACT

Actors	Characteristic of provider	HE/HP Tasks	Level of interaction	Estimated Impact Additional references
Medical doctors	• 7 years in a government medical university, • + recently, some private medical schools with low quality	• During the consultation (I13, 27) • various: e.g., disease, nutrition	Heterogeneous (often low)	Potential but seldom used
Nurse/midwife at a health facility	• years after graduation refresher courses (I15b, 5) (some receive additional training, e.g., on mental health)	• Daily in the waiting room (or tent), general information for all relatives, following a schedule by the MoPH, • (b) individually according to the expressed and identified needs, e.g., food supplementation	Informative, less interactive	Potential reaching
CHW	• 9-week training in 3 phases • refresher training (2x) yearly based, and quarterly meeting • Cooperate with HF and CHC, supervised; mostly illiterate, male, and female relatives, learning with audible, visible approaches	• Using material by MoPH, IEC, BCC; health education/promotion, referral, treatment of minor illness, reporting • various topics defined by MoPH (e.g., Vaccination, hygiene, MNCH, Family planning, nutrition, mental health, HIV, WASH,	Pictorial, informative BCC	Sometimes successful
Community midwife/ community health nurse	• Available in 32 (or 34?) of 34 provinces • village chooses eligible girls (e.g., married 18-45) • who attend a 2-year training, free = all expenses covered, signs contract to serve the community, employed & paid	• Suggested to use tablets (I15b • provide several health education sessions • (Also, the main gain: increase access to health services for women in remote areas) • various	Various	Successful
specially trained midwives	• 6 months of training,	• some additional (?) education: counseling points in their village, first aid, advice on hygiene, illness, family planning		successful
CM in IDP	• Door-to-door, respond to individual needs (I14) • Midwives live in the same community (I14b, 26)	• + home-based services and education, Women from other tents join	Highly interactive, also identifying	Very successful

	• + close cooperation with others (e.g., social workers or health facilities)	• + awareness raising sessions at designated places in the camps (suggested by the camp representative) (daily in camps) • + is contacted by phone • + giving out iron (micronutrient) • various health and hygiene related but also options to address additional difficulties (in social life), theater to enact delivery; various material on health and hygiene	barriers, a variety of methods	
Health Shuras	• 10-15 men (sometimes mixed gender), primarily influential people (I13, 28) also including mullahs (I8, 47) • The link between community and HCS	• Supervision and transfer messages, community awareness activity (I13, 28), supporting water supply (I11, 38), health education and promotion • Also: protection of HF, decisions on reconstruction • _ Solve problems inside, e.g., on sanitation	Less interactive? Inform, report	Essential for security and environmental
Mullah (gatekeeper)	• Part of Shura, e.g., trained on Mental Health • (Also, religious leader's wives as trainers for mothers-in-law)	• Convey messages, e.g., on birth spacing or mental health: focus on behavior and attitude change • Cooperate (MoPH + M. of religious affairs) in developing a book on health behavior in Islamic teaching (I12, 35)	Inform, moral power	Important, successful
Mullah (tradition)	• Some (il)literate men in the village	• Provides spiritual treatment (Duah, Tavis, Damm) • topics: n.i.	less interactive	?
Family health action group	• 10-12-15 women (I13, 28) (I14b, 34), selected in the presence of the community leader and CHW (I14b, 32) • Approx. 6,500 groups *(Arwal 2015b)*	• Receives training on defined health promotion and disease prevention activities. Each woman shares it with her neighbors (10-15 families), (I12) hygiene but also whom to call, when and where to go (I14a) also referring for vaccination and ANC and PNC • various see manual of MoPH	Very interactive	successful
Further trained volunteers	• Trained by NGO,	• linked with HF, refer patient (I5, 20), health promotion and hygiene education (I5, 7) • topics: n.i.	n.i.	Some success
Peer to peer	• Drug users, women, students	• support group, FHAG, school-based • various depends	interactive	Very successful for the group
Mobile health teams	• 1 MD, 1 midwife, 1 nurse, 1 dispenser • Raising demand through getting them familiar with and increasing awareness of services → stimulating them to go to health facilities (I13, 25)	• Two types (a) belonging to a fixed health facility, doing regular outreaches to the communities, (b) covering "white" unserved areas, also for IDP, nomads, in areas of man-made and natural disasters • Various, providing examination, health care services, health education, mainly vaccination (for 'herd immunization')	?	Very useful overcomes barriers
Psychosocial support group	• Trained volunteers (=facilitators), often former participants, training once a week	• Gathering once a week, sharing stories, raising awareness • On health, social support, human and legal rights	interactive	Very successful
Cultural container	• Peer group for youth:	• Psychosocial, culture-dialogue based. Resource identification and strengthening (I2, 19) • Themes: Culture, tradition, music, values	Highly interactive	Successful
General education	• Heterogeneous, through the trainer, teachers, or even trained students	• health and hygiene lessons are part of the curricula	interactive	Very promising
Helplines	• e.g., in online platform	• Via cell phone, computer access at the center • Psychosocial support, reporting abuse, seeking help in case of danger, being exploited	interactive	useful
School-based	• Heterogeneous, student ambassadors, trained teachers	• WASH • distributing meals (or bread) • e.g., mental health, hygiene, mind awareness • train students as "positive agent of change"	e.g., competition: highly interactive;	Very promising

TTC (timed and targeted counseling)	• Special training, focusing on the whole family, 3 layers approach (household, community change, and advocacy change process)	• Spreading messages on 7/11 essential components on mother and child health at home at the right time; the detailed description in the household handbook; including negative and positive stories • Addressing knowledge, behavior, and attitude level of all members of the family (+key decision-maker)	Extremely high, also emotions	Very successful if adopted
Media	• MoPH produces clips for national media, TV, and radio, and material for health education sessions in hospitals • billboards (I1) • educational handouts for patients used in training (A2, 8) • Leaflets adapted to literacy level	• e.g., enhancing acceptance of local health facilities by roundtable on TV showing the facility, inviting the mullah to join • awareness raising, e.g., on mental health (I1, 8) • Mental health (knowledge, attitude, practice), informing about symptoms of diseases, birth spacing (I3)	Informative, passive listeners but also highly interactive (calling in)	useful
Mhealth	• Tablet (I15b), phone, computer… • landlines	• Various uses: e.g., mobile phone services for monitoring, reminding, diagnostic support, having landlines to be contacted	highly	promising

As seen in this table, there is a huge variety of health promoters, their received training, the tasks, their topics, and the activation level of the approaches. Each group aims to achieve different things, e.g., often the doctors are sought for health treatment, the midwife for delivery, the psychosocial support groups for having fellowship, the helplines for psychological relief, or the media for raising awareness. Therefore, the approaches cannot be compared simply by one dimension. In the interviews, several dimensions emerged, which are regarded as necessary for distinguishing and evaluating community-based health promotion. First of all, the medical expertise (regarding training and refresher training (I10, 29), the sustainability (of the health skills in the community (I6, 29), activities on the awareness raising interventions (A2, 28), prevention (I5, 13), treatment (I15b, 10), follow-up (I6, 33) and addressing environmental changes (A7, 47) as well as target, scope, and depth of the provided health promotion activity. In the following table, the estimation of the manifestation of the primary approaches is given from "not existing" to "very high."

TABLE 29: HOW DOES HEALTH COME INTO THE COMMUNITY AND STAYS THERE?

	Expertise	Sustain.	Awareness	Prevent	Treat	Follow-up	Environmental Change	Target	Scope of topics	Depth
BHC	2	2	1	2	2	0	0	Patients/ caregiver	wide	Ps. Deep
Mobile health	2	0	2	2	2	0	0	All	wide	Less dep
CHN/CM	2	2	2	1	1	2	1	com	Basics	Middle
CHW	2	2	2	1	1	0	0	com	Basics	Middle
Shura	0	2	1	0	0	0	2	?	Limited	Low
FHAG	0	2	2	0	0	1	0	Neighbor	Basics	Deep
Mullahs (gatekeeper)	1	2	2	0	0	0	0	Community	Depends	Low
Mullah (traditional. Practice)	1	2	?	?	1	?	?	community	?	?
Patients	0	1	1	0	0	0	0	Patients	Some	Low
School HP	1	1	2	1	1	0	1	students	? some	Middle
Traditional Healer	?	2	?	?	?	?	?	all	?	?
Media	2	1	2	1	0	0	0	all	wide	Less deep

Notes: 0 = perceived as not existing, 1 = perceived as some, 2 = perceived as high

As seen in the overview, none of the approaches scores high in all dimensions. The participants very much recommended the approach of Community health nurses and community midwives,

but CM is limited in addressing environmental determinants. The manifestation of the dimensions concerning the work of the traditional healers and the traditional practice of the mullahs could not be estimated based on the available data.

Before having a closer look at the specific performance of the approaches, some general remarks need to be mentioned. First of all, the interviewees stated that having some awareness raising is better than having no health promotion at all. However, some approaches are more promising for being effective (I15a). Second, the respondents said that the role of the MoPH in health education is very important because each organization disseminating messages needs the approval of the MoPH (I4, 36). Third, most identified challenges do not lie within the process of sharing health messages. The weaknesses are structural, such as geographical barriers, staff shortages, or a lack of time to provide sufficient explanations (I6, 29). Many interviews explain that female staff does not want to work in rural areas because there are 'less facility (sic!) for life', no good education for their children, and no security (comment I10). Also, there is a high staff turnover in management and a lower level of HF (I2, 43). Moreover, that training is short-term, some employees go for master's program in Public Health in other countries, but the courses are of low quality, as one respondent said (comment I10).

Next, the five levels further discuss the different health promotion approaches. The (a) nationwide program/campaigns, (b) facility based, (c) community-based and (d) school and (e) media. Capacity building is regarded as a transvertical topic that is discussed at each level.

Several interviewees point out that, in their understanding, health promotion is highly associated with primary health care and with well-qualified staff. One doctor elaborates on the effect of improving medical doctors' skills to identify diseases and advise clients so that their children lead a healthier life (G6, 14).

8.1.1 Nationwide – MoPH Strategy

Awareness-Raising at national day and nationwide campaigns

The MoPH has developed several materials for health education and awareness through media or in the health facilities, e.g., IEC (see elaboration below). A specific emphasis is on organizing nationwide immunization campaigns, e.g., against polio (I13, 28). Besides, the MoPH enhances awareness of certain health topics by holding several national or world days such as World AIDS day, 'no tobacco day,' CHW, the international day to end obstetric fistula, global handwashing day, and World Cancer Day (2013).[36]

[36] Additional newly studies health Integrated health posts, and Friday Cleaning Campaign Arwal 2016

8.1.2 Facility-Based Strategies

Even though the BPHS includes some promotive and preventive activities[37], curative treatment and deliveries are the primary health services provided at the health centers, as the interviewees said. *"I still think they are very much focused on the clinical side rather than the awareness side of health."* (I1, 27) The reduction of health promotion to disease prevention or some sort of health information sharing emerged very often in the interviews (I12, 71). Generally, two groups of health professionals play a major role in sharing health messages: the nurses and the doctors. The interviewees with a permanent clinic stated that a skilled nurse provides health education in the health facilities daily in the morning (I13, 27). The primary focus is on spreading health messages. The MoPH has prepared visual materials for it and also an annual schedule that includes seasonal diseases (I5, 9). These health education sessions address the caregiver and the waiting patients. Some facilities have TVs and spread further messages on health, e.g., the clips produced by the MoPH (I7a, 35). Additionally, doctors provide counseling and share health messages during the visits (I7a, 35). In some facilities, the doctor refers patients to nurses if he has identified a need for health education, such as how to clean the nails (I9, 39). Asked to estimate the level of interaction, most say the nurses share the lessons, and sometimes they ask questions (I7c, 70). The availability of doctors who can explain health issues and of health education sessions is still not frequently found in all the facilities (A2, 32). In response to the question on success stories, they said that patients appreciated sharing health messages in an understandable way and even invited others to join the lesson (A2, 33). A strength of this approach is that they reach a large group of people who are aware of some psychological strain (so they might be more open to listening), and not only the patient but also the caregiver and family can be reached with the messages. A doctor as an educator can be very influential if he is regarded as an expert not only in diagnosing diseases and prescribing medicine but also in advising disease. One respondent mentions that they raise awareness of proper techniques, e.g., hygiene, with the aim in mind that patients will also be aware of improper techniques in other facilities (A2, 6).

One main limitation of this approach is that it only reaches those who actually come to the facility. However, as the various barriers show, the patients often do not seek healthcare at the facility due to several obstacles. One reason is that public health services are often only available for a few hours in the morning, e.g., 2-3 hours. Commonly, doctors refer clients to their private clinic in which they work in the afternoon. Interviewees also reported that in some private clinics, the doctors prescribe medicine and charge high fees for certain diagnoses that are not needed (I7b). Some doctors complain that even if they share health messages and give advice on appropriate behavior, the patients often do not follow the advice but seek advice from a mullah. A further

[37] (BASICS) Schedule for IMCI Short Course (MoPH o.J.b), (Mayhew et al. 2015) basics, (BASICS; MoPH 2009d)

difficulty is the doctor-client-communication because either the doctor does not explain properly (A2, 7) or the patients do not know the words to describe their disease or understand the physician (A6, 60). Several statements suggest that explanations and advice are seldom given by all doctors (I13, 27). Even though the nurses provide health education, one interviewee said it is primarily on information sharing and less on behavior change and does not address the environment (I12, 71).

8.1.3 Community-Based Health Promotion

On the community level, the approaches can roughly be clustered into three categories such as in (a) health staff, (b) committees, and (c) further approaches.

Mobile health teams

Mobile health teams are also known as mobile health units or mobile clinics. Two types can be distinguished: The first one belongs to a permanent health facility and performs regular outreaches into its catchment area. The second one travels to areas with no health facilities, such as remote locations, disaster-affected areas, and IDP camps (I13, 25). Their principal activity is to provide basic health care and vaccination for herd immunization. They also often distribute food, sanitation, and emergency kits and sometimes provide health education. One NGO works deliberately with them to specifically work with their target groups: orphans and widows (I4). During the mobile health team visit, they screen orphans/widows in one organization and provide health education (which is announced through local people, e.g., elders, to come to a certain place at a certain time) (I4, 28). The largest strength is that they reach under-/unserved populations in areas where it is impossible to establish a clinic for a small, scattered population (I15b, 8). One interviewee commented that the mobile health team's visit also enhanced the awareness and demand for services available at the hospital (I13, 27). Based on the data, no further specification on health education can be given.

Community health workers[38]

CHWs have an essential role within the CBHC strategy of the MoPH. The involvement of CHW in the health programs varies widely: one large NGO trains its own community health volunteers (I5, 7+20), some NGOs work with the existing CHW (I8, 37), another NGO extends the training of the CHW to fit their requirements (I3, 24).

The common strategy to elect CHW is that a female and male CHW are nominated by the community based on a specific set of criteria (e.g., the woman should be able to move freely in the

[38] For further research see: USAID 2008; MoPH 2005b; Dr. Suraya Dalil, Conley; Haver et al. 2015; Najafizada et al. 2014

valley) (I8, 18). One interviewee explains that the community's solution is often to anoint a couple or two close relatives as CHW. After the election, they get an initial training of three phases, each lasting three weeks, interspersed with practical experiences. A challenge for the training is that they are mostly illiterate. To make learning and acquiring the skills easier, the CHWs receive a *"training package that is supported with learning aid that is audible visible, so it is easy to help illiterate people to get the knowledge and skills."* After the nine weeks of interval training, they are bestowed with a set of materials (medicine as well as teaching materials) to work in their villages. Two CHWs work in one health post and serve about 100-150 families. Also, they provide health education in the houses for each gender separately (I8,18). Some mention they receive supervision. There is inconsistency concerning their work, the effectiveness, and also the refresher training. Some interviewees report that they attend two refresher training per year (comment I10), while other interviewees criticize that they have neither refresher training nor supervision (I7c, 137). The presence of the CHWs in the community is regarded as a strength because they can advise, refer, follow up and report (I3; I7c, 36)). Nevertheless, several weaknesses are mentioned: First, they are not paid and receive only some incentives (I3, 12). One interviewee stated they do not accept responsibility because of the lack of salary (I7c). Second, they have a massive workload (I8, 43), and third, they often lack experience (I8, 18). One person elaborates on the difficulty CHW faces when they try to share family planning methods in communities where the local leaders are opposed (I7c, 33).

Community midwives and community health nurses

The nationwide community midwife and community health nurses' education was introduced in 2004. It does address the three most important wrongs such as gender, skill, and location. The interviewees, who work with it, highlighted that this strategy is a very successful one because it is not only increasing access, but also women empowerment. The community midwife is a role model and an "*agent for change." (I13, 23)* One interviewee said, "*when you train a girl from a remote community and send her back in the role of midwife, it is that kind of community leader in that village it is it promotes the education of girls; it encourages parents to lead their girls to be enrolled in schools because they see the importance of education."* He further adds that she is consulted for many problems, increases awareness, advocates, and refers to the facilities (I13, 21). Yet, some limitations remain because some midwives are jobless, and having only one midwife means that no one can replace her if she is on delivery leave (comment I10)

One organization trains its own midwives for 6-months, who then open counseling points in their village and share knowledge on first aid, hygiene, illnesses, and family planning. They report that they are sought in case of burns, pregnancy-related problems, dysentery, smaller injuries, bleeding, measuring blood pressure, and advice to go to the hospital (A14, 29 f.).

Other special types of community midwives work in camps for internally displaced people. These CMs receive special training from the NGO. In the morning, they are at the health facility for an hour, and afterward, they provide health education and health services in the camps and even in the women's houses. Several strengths of this door-to-door service were identified: First, they have direct access to women, adapting messages based on the individual expressed and observed needs. Second, they can address environmental factors as well. Third, they target settlements outside the scope of government. Fourth, they build trust and provide social support. Fifth, all women can also attend from the neighboring tents/houses. Sixth, they are closely linked with other service providers and can sort out cases before referring them to the clinic. They use various educational and visual materials on hygiene and health; they even have a small theater to enact a birth from hand washing, cleaning towels, and cutting the cord (I14a, 11). (I14). No information on the limitation of this approach was given. Even the Afghan midwife association has consulted them as 'good practice.' (I14a and I14b)

Family Health House

Several NGOs announced that in the future, they want to focus on family health houses, a UNFDP initiative. A Family Health House is a small facility in remote areas where pregnant women receive some essential core services (I6, 29). The MoPH assigns the location for each FHH. Community midwives who received the 2-year training are deployed there. Their main tasks are to "provide antenatal, postnatal services, delivery services, newborn care services, family planning." One NGO advocates for integrating immunization into their work scope (I15b, 5).

CHC – Shura: Health Shuras are a group of 10-15 men who serve as a link between the community and the health center. Their role and influence are contrary to those discussed in the interviews. Some respondents recommend them (I13, 28). others point out the weaknesses. A key strength is that they can be very influential, *"know each other very well, share concerns/challenges freely and take timely and immediate action"* (A19, 57). Other organizations mention that they are unpaid and influential people do not want to be part of it. Therefore, the Shura members are jobless and less effective (I7c, 137). A further challenge is that women are (often) not included, so the concerns of women can only be integrated by gathering the ideas at a women's meeting, and the female CHW reports to the male CHW or the health facility to the CHC (I18, 22). Nothing is said about their role as health educators. However, their prominent role is supporting them to create a healthy environment and protect the health facility, as has been repeatedly reported.

Family Health Action Group

An FHAG is a group of 10 to 15 illiterate women selected by the community. They receive training on health-related issues from the CHW (or trained community health nurses), and afterward, they spread it to 10-15 families in their neighborhood. Furthermore, they will refer women for vaccination and antenatal and postnatal care (I14b, 34). A strength of this multiplier approach is that multipliers reach many people in the community, disseminate health messages, teach about symptoms, promote vaccination, and suggest referrals. Besides, they are a sustainable group that can constantly build their capacity (I14a, 47). Even though they received the correct messages, one organization doubted that they could disseminate the correct messages based on the standards provided by MoPH (I15b). In order to overcome this potential difficulty, organizations discuss the applicability of using mobile devices, such as a tablet, as a job aid for the FHAG (I15b, 5).

Further key person: Malik, mullah, traditional healer:

Apart from these health workers and designated groups, many organizations train influential people (mullahs, teachers, police officers, governmental workers) on behavior and attitude change and address the barriers to accessing help for mental health (I1, 8).

Mullahs and traditional healers are the key opinion makers and are therefore influential. An interviewee reported that the mullah is part of the shura and is often the only literate person in the community (I8, 47). The strength of cooperating with the mullah is that he is regarded as a locally available, trustworthy person who teaches children, preaches in Friday Mosque, and is even approachable by women (I8, 47). One of the main weaknesses is additionally linked to his influential role. It happens that they are sometimes opposed to family planning and are even resistant and do not advise people to go to the HF because of beliefs that people will change their minds and stop being Muslims (I10, 45). Besides their role in spreading health messages, mullahs also often practice traditional healing methods such as Duah, Damm, and Tavis (I10, 51). The interviewees refer that they *"believe healing and death come from God and happens in accordance to [sic!] his will."* No information is reported about the active involvement of the community in health education, but due to its influence, he has an ambiguous role. He can be a great supporter as well as "resistant" (I10, 45) to the spread of health messages, for example, on family planning.

Further health educator

Additionally, the concept of peer-to-peer is often applied. The common understanding of this approach is that a person who was affected by something (it can be a former drug user, a woman who recovered from domestic violence, or a student in school) will be trained to work with people who experience the same as him (A11, 29; A11, 55; I9, 39). The organizations using it stated that this strategy is very successful. A trustworthy person, who can understand the situation and

overcome it, a model for behavior, knows their life reality and is listened to (I9, 19). One interviewee commented that a shortcoming is that they lack refresher training and follow-up. (I10)

A particular form of peer support is **psychosocial support groups**. Their strength is that in these groups, they are establishing trust, learning to share, being aware of their needs, expressing concerns, addressing sensitive issues indirectly, linking with other services (I16)

Another form is the cultural container: a peer group for youth in which they meet and work on culture, tradition, music, and values. A strength of this approach is that it enables people to start thinking and talking about their cultural roots and that they get access to psychological topics through cultural dialogues. (I2, 4) (The last three approaches are reported as happening in the cities and might need to be adapted to rural conditions.)

Furthermore, some community-based activities are used nationwide and address the determinants of health, e.g., "also 'locally run community workshops" about health and hygiene (A22, 25).

School-based health promotion

The main topics covered in school-based health promotion are WASH (I15), nutrition (nutrition education and nutrition program, (e.g., Mail/FAO), oral health (A2), deworming interventions (I15), mine awareness (Christine Knudsen (4.3) 2013)) but also training as health "ambassadors for change and awareness" implemented by UNFPA (cf. Samuel Hall). For children also exist the Youth Health Line by the MoPH and the "Youth Information Centre" and "Youth Information and Contact Centers" YICC with its focus on reproductive health (Samuel Hall). One initiative focuses on restoring pride and cultural awareness (hoopoe books (1,730,000 Dari-Pashto bilingual books, 115,000 teacher's guides, 65,000 audio version) (A16, 38), and cultural container (I2). The scope of these interventions remains unclear. Some are one-time training sessions; others integrate the construction of a sanitation system with hygiene education. An NGO presented a comprehensive program integrating many stakeholders, awareness-raising, training sessions, establishing hygiene committees, and even making a 3-month plan (A11). There are several strengths to school-based HP (a) building capabilities and resilience in the next generation (I2), (b) girls can stay in school even after their first menstruation, (c) supervision of health practice in school, (d) dissemination of health /hygiene messages to families, (e) addressing hardware and software. But still, as weaknesses, the interviewees point out that still, often infrastructure at schools for toilets is weak, there is no availability of water in school; girls during menstruation have difficulties with washing. Even though school-based interventions could successfully be implemented in some areas, they can be a failure in others – as the healthy school initiative showed

Health and hygiene educations are not only part of the school curricula; they are also often part of other training such as vocational training or literacy courses. One strength is that people are approached where they are. Little can be said about further strengths and limitations of these

programs because they often vary widely in length, depth, broadness, and expertise of the trainer and the strategies used.

Media & mhealth

Two other approaches specifically address the need for transgressing the geographical barriers. These are using media and mhealth. The interviewees report there are several types of media used, such as (a) IEC material, (b) magazines, (c) helplines, and (d) several mhealth tools.

The MoPH has developed a series of IEC materials that are widely used for health education sessions in health facilities but also in communities. "*The pictorial leaflet is managed by our health educators in rural areas, which they go picture by picture and explain if you have so many children, what would be the impact. Now, if you would like to continue to switch to birth spacing, what would be the impact? So, they change each picture and give a story*" (I3, 22). Furthermore, the posters are also hung in health facilities and near highly frequented places such as mosques (I13, 28). They spread the most important messages, e.g., on vaccination, nutrition, referring, and tuberculosis. No information on strengths and weaknesses was given in the interviews, so there can be neither an estimation of the scope, the coverage, nor the effectiveness.

Some organizations regularly publish magazines, e.g., on mental health (I1)[39].

A new way of providing psychological support and counseling is the **helplines or online counseling portals**. One interviewee stated that calling a helpline is not stigmatizing compared to going to a clinic for psychological care (I2, 25). Furthermore, another stated that sensitive topics could be reported and addressed (A8, 32). Nothing is known about how frequently it is used, what topics are covered, and how accessible and well-accepted it is for people from rural areas.

The applicability of electronic devices is widely discussed (I13, 28). As the main strength, one interviewee elaborated and said they "help as a job aid for the s family health action groups and also for the community midwife, during the household visit if they face any challenges, problem, they also use this tablet during their home visit for dissemination for the health message in terms of ANC, delivery complication, newborn complication and the others to the household. So, this is our five-year project" (15b, 5) So generally, they emphasize the strengths of reaching remote areas, easier reporting, guarantees the quality of health messages; (a) learning resource for CHW, (b) emergency referral, (c) reporting (I15b). The main weaknesses are the cost and availability of

[39] During the scope analysis further magazines have been identified which provide health messages on a monthly, or bimonthly basis. First of all, the magazine of MoPH: the "Ghazanfar Medical Journal (GMJ)", then the "roghtia" series of the MoPH, the magazine of the Afghan Institute for Learning: Gadoon a bimonthly magazine of DAO, addressing issues of people with disabilities or. Furthermore, there are additional associations that addresses issues of other groups of people (causalities of mine explosions).

electricity (power). One respondent elaborated on their program, which is 6 (downloadable) radio programs of the stories for local Afghan radio (A16)[40].

Some **further activities**

Besides the approaches above, the interviewees pointed out other approaches which are minor in scope. Seen as presented here, such as (1) working with drug users (1,700,000 injected drug users, raising numbers) also addressing stigma against them (as being criminals) (I9, 17), (2) special programs for prisoners (I9, 17), (3) burn centers for people with self-immolation (I11, 47), (4) emergency relief for recently internally displaced people as well as (I15b, 5), (5) comprehensive women educational approach (I7b), (6) working with the most vulnerable, those living in the Marstoon (social welfare center) or orphans (I4, 28), (7) working with special communities such as HIV positive people or MSM -men who have sex with men (I15, 5).

To conclude, several good practice examples for the village level were identified; there is a series of examples of good practice, such as a trained and committed health shura working together with highly qualified, committed, and respected community midwives and community health workers. The health shura not only holds ownership and responsibility for the health facility but also undergoes monitoring and surveillance of the villages, strives to implement environmental changes (such as the construction of latrines), and the mullah and elders raise awareness on diseases, stigma, and prevention activities and the CM facilitates family health action groups whose participants then share the information. Furthermore, sensitive topics such as family planning can best be addressed by training mullahs and religious leaders' wives who spread the message to the whole community. In particular, religious leaders' wives have been identified as successful in convincing mothers-in-law, who are the family's moral power holders.

[40] Further applications of mhealth or technology for health education are: Interactive electronic health education tool Kim et al. 2008; a talkative book by GlaxoSmithKline http://www.acbar.org/upload/1476354903247.pdf; Knowledge on Parenting and Improving the Learning Space through Technological Advances in Afghanistan Qayumi et al. 2014; Arian Tele heal see http://www.ariantele-heal.com/wp-content/uploads/2016/08/RCR_Newsletter_118-13.pdf and HOSA ansatz von mhealth

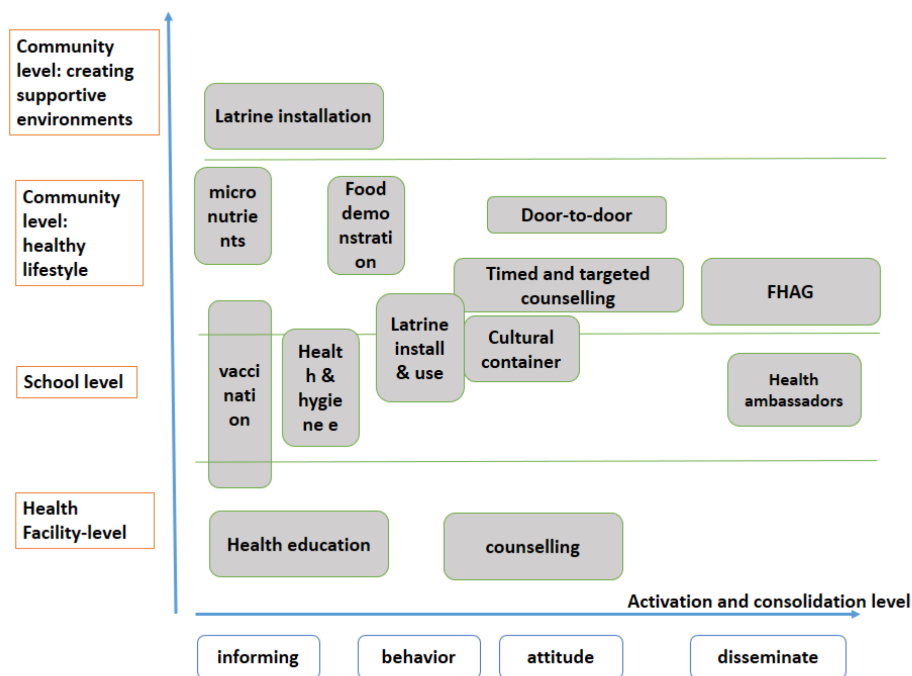

FIGURE 17: VISUAL SUMMARY OF COMMUNITY-BASED HEALTH APPROACHES

Figure 17 combines the approaches and clusters them alongside the activation level.

8.2 Recommendations: Success Factors and Good Practice Criteria

Health promotion in Afghanistan cannot be analyzed separately from many contextual factors, and any evaluation must consider these factors. Collecting operational knowledge is very limited if one only analyzes websites. Therefore, asking the health care provider was the best approach. The interviewees reported challenges as well as recommendations. Five main levels emerged from the interviews: (a) nation level, (b) health sector, (c) community, (d) project, (e) program.

As pointed out in the introduction, health promotion is highly impacted by the work of NGOs. Therefore, the next chapter sheds light on health promotion by initially starting with presenting encountered barriers and good practices in overcoming them, narrowing down to good practice criteria for NGOs, and focusing on good practices in health education. The last section will broaden the perspective again to further recommendations.

Even though this variety of approaches could be identified, all interview partners stressed the challenging circumstances they work in, which largely contribute to how projects are put in place. The overall challenges, as already pointed out in Chapter 5, emerge from insecurity, corruption, shortage of (female) skilled staff in rural areas, poverty, the multitude of needs that should be addressed, cultural and traditional values, and the low education level. They dealt out criticism concerning the international community, e.g., that they have not fulfilled what they had promised

(I4, 22). Next, they named mistrust towards foreigners and the negative impact of the 'aid industry' (G3, 53). One interviewee explained that a large donor had organized gender-based violence training in Afghanistan and paid the participants $ 100 as an incentive (I1, 31). Furthermore, they add structural issues such as short periods of programs (I15b, 5), administrative difficulties, e.g., lack of coordination in reporting requirements (I4, 36) and late provision of funding (I2, 27), and difficulties applying for passports (G3, 25), the difficulty to keep staff and a high staff turnover (I2, 43), challenges to monitor (barely possible) (I10, 15), poor effect after the end of the project and many parallel services (I8, 28), lack of coordination and lack of standardized training (I2, 49).

Univocally, the interviewees pointed out programs that did not continue in the last years (see overview attached)[x]. Only in light of these obstacles can the good practice criteria be assessed realistically. The difficulties arose in 7 areas. First, projects could not be continued due to financial reasons, e.g., the burn unit in Herat despite its success (I11, 47), (2) projects could not be continued because of corruption, unexpected requirements for paying taxes (G1, 13), or miss-match of expectation between project initiator and community (G1, 13), (3) The purpose of the project was not regarded as interesting or needed (disaster prevention project) (A21), (4) The size of the project was too large to focus, so it was not continued (I1, 6) (5) The project touched a sensitive topic (health training for 15-18-year-old girls (A11), (6) The location was not possible such as working outside of Kabul was not feasible (G2), (7) Furthermore, the establishing of a maternity service in the village because of the lack of technical skills, and shortage of qualified doctors there. (8) Intersectoral projects can barely be established because other sectors are less involved. (A1, 26). One other interviewee explained that one comprehensive program for health, peace, human rights, and literacy could not be extended due to financial reasons, the need for well-trained female health professionals, and the means for transportation to these villages (I7b).

However, despite the many challenges, a good number of health activities still exist. Several good practice criteria emerged from the analysis, which can be roughly categorized into five areas – structured similarly to a sand glass from broader too narrow good practice and extending to recommendations (a) in good practice for addressing barriers, (b) in good practice for NGOs, (c) good practice for health education and health promotion, (e) further recommendations.

8.2.3 Good Practice in Addressing Barriers

Facing difficulties is very common for almost all interviewees. Only one respondent stressed that they never had difficulties, which might be due to the famous person, his willingness, and the great need for the project. In contrast, most interviewees report some difficulties they face(d), and they give examples of how they could overcome these barriers. The statement of one of the interviewees showed the importance of addressing the target group, at the right time, at the right place, with the right message:

"So, men are one of the big barriers in the access to information, so we are targeting these religious leaders when they are very young. So, they know about sexual and reproductive health and how to provide birth spaces. So, the languages are different, even the language we choose to communicating (sic!) with this audience. "(I3, 9).

Table 30 summarizes the observations/problems and the lessons learned reported by the interview partners.

TABLE 30: LESSONS LEARNED IN OVERCOMING BARRIERS

Observation / Problem	Solution
People hesitate to go to the health facility because of a lack of knowledge (a) about available services, (b) the health care provider (including females), (c) low acceptance	Promotion video introducing the services, showing the facility and all staff and the mullah who encourage the people to go there (I7c, 26) or mobile health team introduces it
HFs are closed, difficulties establishing health facilities of water supply, lack of security,	Cooperation with local power holder, ownership by the community (A9, 35; G1, A2, 38, A4, A6 A7, I10, I11)
Interference by armed forces/politicians	Emphasizing the NGO's non-political involvement and the provision of health for all Afghans (A7, 50)
Lack of permanent health knowledge in the villages	CHW, CHN, CM, Multiplicators, FHAG, Peer to peer (I8, 12)
The gap between information on and access to health service	Mobile clinic for men in mosques (I3,14), schools, mobile clinic
people's culture and tradition (gender interaction)	Female worker (as field officer) A4, 47;
Young women cannot decide for themselves; their mother-in-law has "moral power"	Addressing mothers-in-law through mullahs or wives of mullahs (I3)
women cannot leave the house	kindergarten (A8), other house in IDP camp (I14b)
Men are uninformed about birth spacing	Training religious leaders and spreading birth spacing messages in accordance with Quran at Friday Mosque (I11, 55)
Lack of referral/ follow-up	FHAG distribute 'sheets' for health service in hospital (I4, 22)
Lack of sanitation facilities in school, girls drop out of school	Installing toilets and wash facilities (A11, 21)
Poor educational skills/level of knowledge	tailor-made programs (A14, 22), technical devices for learning and spreading the message
lack of health workers in rural areas	prior to training, signing an agreement that they will stay in the rural area for some time (A14, 27)
lack of familiarity with certain nutrition	working bottom up and top down (on cultivation and consumption) (A5, 64 f.)
lack of health facilities everywhere	establishing family health houses
Lack of effectivity of single-sector approach	Multisector approach, e.g., nutrition

The main reported obstacles were (a) related to education: lack of knowledge in the community about the disease, prevention, e.g., where and when to go and what services are available, of health skills as well as poor quality of health care providers. (b) Difficulties opening a health facility, e.g., due to security, (c) culture and tradition (e.g.). So, the main best practice criteria to overcome these obstacles were buying in of local leaders, bringing basic health services as close as possible to people, raising awareness, and working with female health workers

8.2.4 Good Practice Criteria for Working as an NGO

Next, the NGOs[41] were invited to define criteria that helped them succeed.[42]Four main domains emerged from the data: these are (a) specification of the Afghan context, (b) NGO characteristics, (c) NGO working features, and (d) participation in the community[43]. The answers were categorized for quantitative presentation – see Table 31.

TABLE 31: GOOD PRACTICE CRITERIA FOR WORKING WITH NGOS

	Category		Subcategory	NGO	relevant
A	Afghan general	A1a	Culture _understanding of culture and languages	6	++
		A1b	_ respecting traditional society	2	+
		A1c	_respecting sensitive topics	5	++
		A2a	Ministries _working with	8	+
		A2b	_implementing activity in MoPH policy/strategy	2	++
		A3	_needed intervention	0	++
		A4a	Approach _ intersectoral	8	+
		A4b	improving both hard- and software	7	+
B	Characteristics NGO	B1	Trust	18	++
		B2	transparency, accountability,	6	+
		B3	humanitarian principles (e.g., impartiality)	9	++
		B4	commitment by all	11	++
		B5	local-based (available) - staff - local NGO or partner	5 6	++
C	community	C1	support by key leaders	14	++
		C2	participation of community	17	++
		C3	local committees take ownership	10	++
		C4	good cooperation	6	++
		C5	addressing key decision-makers	3	+
		C6	local (f) health professionals	4	+
D	NGO working feature	D1	adapting interventions	3	++
		D2	good quality in management	8	+
		D3	good quality of services	7	+
		D4	training & supervision	11	++
		D5	MEAL monitoring, evaluation, appraisal, learning	9	++
		D6	flexibility	5	+
		D7	linkage to other services	2	+

[41] cf. ACBAR good practice: (a) willingness to change, (b) geographical access and past experiences in implementation, (c) culturally appropriate, (d) focussing on service delivery and strategy and not only on getting money, (e) preparing turn-over

[42] Whereas many NGOs – in particular, those answering the questionnaire – point out to a variety of success factors, many interviewees reported some (internal) challenges as well. One said "we cannot blame that we are successful. But we are a bit better than others (I9).

[43] "People to work with (a) contact with different people like community, like government, like provincial council, like parliament members, like different religious, like Sunni, Shia, different tribes, like Pashto, Tadzhiks, Uzbeks, Hazara, Turkmen, Kurdistani, Baluchi, different areas around more then 32 tribes. the different ethnics and different gender like male, female, young old, literate, illiterate, rich poor, disable, mental persons, anti-government opposition because in some area as I mentioned to you I am working in NGO and I'm not in the governmental body, like NGO is non-political, non-armed activity". (I10, 12)

The following story demonstrates all the 'good practice criteria' very vividly:

"I went to (province), of course, I talked with the governor then with the women affairs director, then the directorate of education, director of higher education, then it went to (name) (...) a remote district and I went there a local fire club (incomp.) like our people because I am (ethnic group), and I know the (language) very good and when I went there to (name) clinic there were many patients yeah and during my visit from that clinic all patients I collected them, is told them: my name is (name) I am a non-political person, I am not in the favor of anybody, I am a doctor, just I want good health for you. Good house for you. Good hygiene for you and tomorrow your religious leader, your influential people, some elderly women, please talk to them and come here. And I will be here available for you, and I want to talk about some important issues of health with you. Then I went tomorrow again to (name) district and in (name) district the people tomorrow came from different villages, and they were very surprised: 'oh, a person come [sic!] from Kabul, and he is director of an NGO, and she come with a new message' and tomorrow I went there, and I told them we want to make a school community midwifery, health nursing education program. We need girls and women their age from 18 to 45 years. We prefer marriage women because they will be for a long time here, one, the second thing they should know some literacy, if they lack literacy we will hire a teacher for them to improve their literacy and after literacy we also will learn about them, we will teach computer, and some English to know the name of the medicine because all medicine are in English medicine and when they graduate from nursing they will come back to this clinic because in this clinic there is no female nurse, and your wife your mothers your sisters, your daughters will come to this female nurse and now your women not come to clinic due to culture barrier because all staff are male and they will check your children, they will do vaccination for TB, they will also do PNC and delivery and we will good room for you that room will be safe for women, according to your culture and after graduation we will, we will give to these girls the student for sageny(sic!) 1000 afghani per month one also the hostel the clothes the food and also provide bedside training, a hospital to learn the practical work there, and we will also bring mullah for them, and we will make for them mosques and also for them holy Quran to read every day, and also we will teach them Islamic manner how can a human being have manner with their neighbours with their mothers, their fathers, their brothers, sisters, and how can we make our society and please introduce volunteer 24 person for us but from this district there are four clinics in this district in our plan, so please introduce 4 or 5 students from district. The same I went to (name) district and also, I went (names,) and I collected the community and talked with them, and I passed more than three weeks among the community. When I did not face anything, they brought me delicious food and local fruits, and they expected to go to me, and finally, we made the community nursing school. "(I10, 35)

In summary, for the informants of this study, the four main good practices criteria are (a) trust, (b) the participation of the community, (c) the support of the key leaders as well as (d) training and supervision have been regarded as the main working features, alongside with the other identified criteria. None of these criteria could be eliminated nor integrated into the other factors without losing their significant meaning.

Despite the expressed need for **monitoring,** many respondents pointed out its various difficulties (I2, 23). Working with rather than the opposing group is even more essential when it comes to certain topics (e.g., concerning family planning with religious leaders (I12, 35)).

Apart from the given example of good practice in NGO work, the respondents reported various **success stories,** which provided additional empirical insights into what is regarded as successful health interventions and how it is manifested (see success stories attached). (a) reaching a large group of girls and women by setting up an awareness-raising session in learning centers (e.g., schools or US-LINCOLN Learning Center) (e.g., A19). (b) Good quality attracts: An organization reported that a woman at the dentist was excited about the treatment and brought all her children. (c) the right method leads to acceptance of the message by opinion leaders. An organization reported using traditional tales to spread the message that elders highly accept and recognize (A16). (d) Being part of the health committee increases competencies. A girl was part of the health

committee, and she could see the improvements in hard and software (e) villagers who started to talk about the improvement the consumption of soybeans had on their health (A5, 101).

8.2.5 Good Practice in Health Education

So far, this report has given examples of people involved in health education and some fair idea of what this looks like. Most websites do not describe in detail how health education and promotion are performed specifically. Therefore, this question was covered in the interviews. The interviewees' comments showed that there is a large variety concerning topics, places, methods, targeted groups, trainers, training of the trainers, and monitoring (see Table 32 below). For a comprehensive assessment, each strategy deserves to be studied individually, which is beyond the scope of this master thesis. In order to exemplify the wide range of approaches, two of them are described in detail below. The two examples have been chosen because they differ highly in various dimensions. The first one is health education in the waiting room of health facilities, and the second is "timed and targeted counseling" developed by world vision international, which is also acknowledged by the WHO as a 'best practice example' (I15, 13) for mother and child health. By contrasting these two approaches, the universal strengths and limitations of most health promotion approaches can be demonstrated.

Timed and targeted counseling:
A trained health worker visits the mother and her family in their home in a series of 11 visits which are properly scheduled around the birth. The CHW started out to visit the mother in the first third of the pregnancy. During her visit, the CHW does not only talk with the pregnant women but involves the whole family, in particular, the key decision makers such as the mother-in-law and the husband. In the beginning of the visit, the CHW presents a negative 'problem story' of a family. Often the husband and wife are angry /imposed about the behavior demonstrated in the story. The CHW asks several questions to the family members about what they see, what has happened and why did it happen. While engaging in the dialogue, the family members can easily identify problematic health behavior as well as causes of health problems. Then the CHW presents a 'positive story' which provides solutions for the health problem. Next, they start to talk about the positive behavior, and they identify together what they already put in practice and what is unknown. They think about which new behaviors they can practice and what might be barriers for the implementation. the CHW writes down their decision on behavior change in a Household Handbook to follow up at the next time., the CHW visits the family at home regularly during pregnancy and within the first 1000 days and introduces step by step 7-11 components, 7 components for the mother and 11 related components for the child at the proper time when they need it.

Health education in the waiting room
Every day in the morning, a nurse provides some health messages in the waiting room to the patients and their accompanying relatives. She uses the pictorial IEC material, developed by the MoPH. In the session, she covers general important topics such as hygiene or prevention of communicable diseases. The MoPH has prepared an annual schedule that takes into consideration seasonal diseases. Usually, the nurse holds high the visual material or points at posters at the wall. She the uses a frontal, directive teaching strategy and she spreads verbally the messages on disease and healthy behavior. Sometimes she also asks questions to the participants. (

Through the presentation of these two methods,[44] the following dimensions for comparison become apparent: general vs. specific topics, targeting individual or family, '°come' or 'go' service, one-time education vs. series, spreading information vs. addressing knowledge, behavior, and attitude; passive vs. highly interactive; sharing cognitive information or life-touching stories; ignoring or addressing inhibiting factors through behavior change counseling; focusing only on behavior or also on the environment, pathogenic or salutogenic approach; familiarity and trust towards the health worker or not. In addition, further important differentiating lines are generally untrained or trained people.

Table 32 compiles the recommended health education strategies. Overall, guidelines for the best evidence-based health education varied between urban and rural. Generally, it is indicated to share simple messages based on Islamic teaching, supported by pictures and stories. It should be spread and supported by trusted people, e.g., mullahs, and by trained women. The health educators should receive continuous on-the-job training people should be encouraged to disseminate the message mouth-to-mouth, a proper segmentation and profound analysis should be conducted not only by the non-Afghan workers but also by the Afghan NGO staff who works in the city and develops programs for rural areas (I3). Furthermore, they stressed if it is used, it should be very simple and not complicated (I8, 68).

TABLE 32: GENERAL SUGGESTIONS FOR HEALTH EDUCATION

SUMMARY ON SUGGESTIONS FOR HEALTH EDUCATION IN AFGHANISTAN
Location: nation, media, city, facility, community, mosque, school, home
Target group: • proper segmentation (I3, 9) nation, community, homogenous group (e.g., women), school, family, individual • addressing and integrating "key opinion leaders: Malik, mullah, CDC • addressing 'moral power' holders, e.g., mother-in-law & key decision maker
Provider • Health educator: Trusted, qualified, experienced, committed, ready to provide (good quality) • mullahs, religious leader's wives (I1, I3 • "Knowledge ambassadors," e.g., students, women (FHAG), peers • committees
Awareness raising • National TV, radio, charts, panels, and social media (I13) • health education sessions – in HF and all educational facilities • disseminating the message in the mosques on Friday • mobilizing people (e.g., to monitor growth)

[44] The representative stressed several strengths of this program, which was acknowledged by the WHO as one of the most comprehensive, integral approaches for mother and child health (BPHS). This approach is currently used by about 1 million CHW worldwide. In Afghanistan, 2386 CHWs are specially trained on ttC. Its strengths are that (a) it addresses the whole family in particular the decision maker (b) it includes behavior change counselling (c) it is provided at the right time and (d) and is target in terms of right time (during and up to 2 years after birth), towards the right people and at the right place. Delivering this service at home makes it possible to identify unhealthy issues in the family and the family's environment). It refrains from dividing the care for mother, newborn, and child in the first two years to several people, which often leaves a gap of care. The storytelling approach enables the family to easily understand causes and effects of behavior. It integrates behavior change counseling which addresses not only classical health behavior such as breastfeeding, but it also aims at stimulating the parents to engage positively with the child, promote language and communicate and play. The interviewee stressed that ttC should be embedded in wider health promotion approaches such as the work with community health committees on the community level and the 'citizen voice and action' at the advocacy level. TT"C "we take it to the people who need it at the time that they need to hear it" (I15a.)

Method
• material: text, visual, auditive, video, theatre • suggested lots of pictures and understandable language (A6) • MoPH material (I14b) • flipchart (I14b) • multi-method, critical, innovative, fun, creative methods, & • stories and examples (I14b) • repetition (A6) • high activation level preferred (e.g., student contest) • starting very simply: simple material (hand soap) (A2) • local drama • mouth-to-mouth dissemination
tailor-made messages - knowledge level • adapted to target group: knowledge, cultural and religious background (e.g., wording) • in accordance with Islam: developed in cooperation (religious consortium) • activation dimension: only information (knowledge), or behavior, attitude, or desire for environmental change • topics: (see above) • sensitive topics: avoiding or addressing sensitive problems indirectly • timeframe: single vs. consecutive (timed and targeted counseling"; immediate or long-term change • goal: (a) designating, (b) building resilience in young people, (c) empowerment
Follow-up and monitoring • monitoring: e.g., through a committee/health shura • creating a plan for follow-up (A11, 29) • looking at achievements, e.g., KAP-analysis (I3) • using a riffle system: women of religious leaders give welfare cards to their clients, and clients bring them to HF (I3)

The main topics that should be covered, as requested by the interviewees, are first of all maternal and child health (A7), then WASH (I14b), mental health (A7), nutrition (I14b), school health, comprehensive HIV programs, installing burn centers, strengthening curative, tertiary, diagnosis and surgical capacity (needed to the rise in injuries), but also livelihood (I14b). The interviewees said that it is important to know when and where to go at a minimum because this basic knowledge is often lacking (I1, 31). Concerning the stated priority of many organizations: maternal and child health, organizations prioritize three approaches: (a) establish more family health houses, (b) increase access to midwives and number of deliveries in HF, (c) and enhance home-based life-saving skills as well as an early referral. Conducting a profound analysis of the target group is important not only for international workers but also for the NGO staff that works in urban areas and tries to develop a program for the rural area (I3).

The importance of being cautious when dealing with sensitive issues was repeatedly stressed. An organization working in counseling reported three main observations, (a) that patients do not reveal their secrets, (b) that the issues lay within the family context, and (c) that sensitive issues cannot be addressed directly.

So they recommended cautious handling of sensitive matters such as taboos, secrets, and family planning and suggested that if people want to keep secrets, their privacy in counseling sessions: (a) pointing indirectly to the problem, (b) assure and request cooperation, (A10,10), (b) referral (A10, 10), systemic approach, family counseling (A10,10). In a group session, they also suggest

not approaching sensitive topics directly but arranging the sessions in such a way that sensitive topics can emerge from questions and be addressed separately (A11, 53). Generally, other NGOs that work in mental health stress that there is a need for capacity enhancement in the area of working on understanding and communicating own situation and building relationships, working on identification of problems and resources (I2, 11), resource orientation (I2, 11).

TABLE 33: SPECIFIC IDEAS FOR TRAINING AND LEARNING

CONCRETE IDEAS FOR TRAINING AND LEARNING
Training (of health promoters) • training influential people (teachers, mullahs, master police trainers) • continuous (in-service) training of staff, also by volunteers from around the world, and monitoring if messages are spread continuously **Further types of learning opportunities** • exchange and "advocate for good practice." • a participatory approach to finding & evaluate ways for disease prevention • plan-do-act-check (integrating new sciences) • exposure trips (e.g., cleanness of cities) • reading studies and internalizing theories
Model learning • positive deviant session (I15b) • female health champions, e.g., religious leader's wives, sisters, mothers • staff model behavior (holistic healthy lifestyle promotion approach) **Target** • addressing three layers (household, community, nation) (I15a) • capacity building of communities (A18) • classroom health education approach (A18) • BCC participatory learning and action & change of behavior • interpersonal communication and counseling **General characteristic** • evidence-based approach (A18), I12 • integrated, intersectoral approach (both hard and software)

Even though ttC is acknowledged worldwide as a best practice approach to mother and child health, there are at least three main challenges for the timed and targeted counseling in place. If compared to other approaches in Afghanistan (I7b), the following three challenges might be the most relevant: (a) It requires a trained (female) health worker. (b) These persons need to be paid over an extended period of 2 years. (c) Many rural areas are not accessible. Because of these reasons, a comprehensive health, peace, empowerment, and literacy program could not be continued (I7b).

Asked about health promotion approaches, they primarily focus on spreading health messages so that individual health behavior can be enhanced. Concerning health promotion activities with a focus on **environmental determinants**[45], most of the interviewees refer to activity in the WASH sector, such as constructing wells and latrines in the villages; some other organizations also hint

[45] Some health-related activities that target the determinants of health are e.g., the cash-for-work project (medair), several nutrition projects (e.g., sida and ACF), addressing food security through employing people in road building projects, establishing demonstration plots for showcasing how to cultivate certain plants (relief. medair)

at training farmers to enhance their crops, e.g., introducing soybeans (A5), raising poultry (I15), having kitchen garden (I15b) and also increasingly creating supportive social environment, e.g., in mental health. One organization described its comprehensive health promotion approach, which integrates. Collective sanitation analysis, sudden behavior change, making village OPD free (A6), targeting not individuals but communities' open free villages' (A6). In the BPHS is suggested to have some food demonstration nutrition courses (MoPH 2012) with cascade training (p. 57), but an analysis of the last reports shows that it is seldom implemented. Generally, constructing a health facility or having a community midwife is already referred to as important environmental changes. Some interviewees explained that some of these projects could not be continued, mainly due to a lack of funding. Others also referred to some problems with the government. Moreover, another described that the intervention was unsuitable (such as poultry raising. He said the community used the poultry immediately and did not wait for the next chicken (I15).

8.2.6 Recommendations and Suggestions for the Future

The NGOs were invited to share their recommendations and suggestions for health promotion and general for the future of health in Afghanistan. A large variety of recommendations were given in five areas. The recommendations concerning the community, the project as well as the program were presented in the previous paragraph. The following section focuses[46] on the recommendations for the national level as well as the health sector. One statement presents the broad range of requirements and the micro and macro level interlinkage: "*we should sleep 4 hours and work 20 hours to move from this disaster. If we work hard and study a lot and be honest and remove obstacles, then we will succeed, and besides the support of foreigners, we can do something for our country for ourselves"* (I17, 50). Apart from the repetition of the identified success factors such as commitment, hard work, trust, and education, this statement also sheds light on macro-level factors, e.g., the need for external support. Another person emphasized four main themes and said our *"future depends on peace, education, good health facility, support by international community"* (I10, 53), and he concluded that if the international community withdraws their support, everything will collapse. In Figure 18, recommendations are provided have been given for the national level as well as for the health sector.

[46]A methodological remark needs to be made. The questions concerning recommendations and suggestions were primarily directed towards (a) the working feature of health care providers as well as (b) establishing health generally. The interviewees gave a wide range of answers, some very specifically concerning the health sector but often also referring to very general themes concerning Afghanistan which does largely influence the health activities (therefore the number of references might be smaller than if the interview partner were asked directly about the impact of this topic.

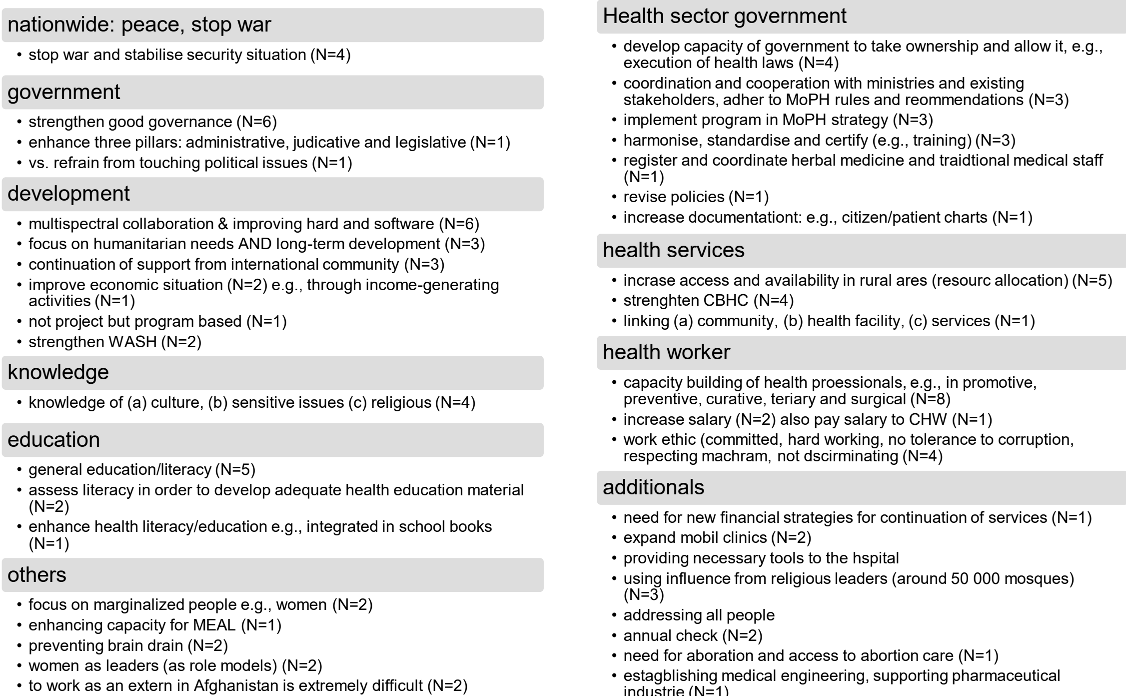

FIGURE 18: RECOMMENDATIONS ON THE NATIONAL AND HEALTH SECTOR LEVEL

This figure (Figure 18) highlights the most common recommendations for both levels. First of all, the interviewees expressed the need to stabilize the country by stopping the war, establishing good governance, and focusing on multisector development. Furthermore, the interviewees stressed the need for education on all levels: such as enhancing basic education, medical education, nationwide health education, and general capacity building. The overall need for more female health workers in rural areas and the priority of maternal and child health was also elaborated on. One other recurrent theme was the allocation of resources, e.g., they suggest that starting with 2002, the sources should have been distributed differently more into humanitarian work (G3); one requests: investing in. injustice, humanity, progress, or development than in military interventions (G4).

In regard to the best strategy to enhance the health status in Afghanistan, five distinct and sometimes even conflicting discourses emerged in the interview. Some suggested (a) enhancing general health literacy/education, (b) improvement of the quality of medical education, (c) through an expansion of health service coverage (I11), (d) a strengthening of the health system, or (e) improving the determinants of health.

a) The 'advocates for general health education' suggested that awareness should be raised through TV programs (A2), specific health education sessions in schools starting in madrassas, and primary school (A13, A2) going up to tertiary level but also in vocational

training. Others also recommended, e.g., having prevention campaigns in the communities (A18, I10, I11). Moreover, they stressed the need for more "evidence-based health promotion" (I12, 59).

b) The improvement of the quality of medical education: it was suggested to improve knowledge of learning techniques; improve medical education, also an extension of knowledge of services. (All areas for promotive to rehabilitative and also surgical were recommended) (A2, G6).
c) The expansion of health service coverage should be realized by more community midwives and community health nurses, additional mobile clinics, and by finding new solutions for supporting health workers who want to work in rural areas.
d) A variety of ideas to strengthen the system (see, in particular, to address corruption and to further financing schemes.
e) Lastly, it is about establishing healthy environments. A general health NGO suggests that the challenges should be solved more comprehensively and broadly (A19).

All these sectors are worth further exploring.

8.3 Conclusion Health Promotion Approaches and Recommendations

This chapter presented the findings of the qualitative interviews and questionnaires on health promotion activities in Afghanistan on five levels, as well as recommendations for action. (is) The main health promotion activities on the national level are BPHS, CBHC, the world X-days, and campaigns. (ii) At the facility level, there is health education in the waiting areas and by means of individual counseling. (iii) In the communities, there are four distinct types of health promotion approaches, either through trained local people, e.g., CHW, CM, and CHN; or through committees, e.g., community health Shuras, family health action groups, and community development committees; or by spreading messages through mullahs, patients returning to the community, specially trained volunteers, religious leaders' wives, and peers; or through mobile health teams. (iv) Furthermore, there are various education sessions at the school level. (v) Besides the MoPH IEC material, media are often used to raise awareness, e.g., the clips produced by the MoPH or low-budget production for TV by several providers. Also, electronic devices are used, e.g., the helpline for counseling or tablets and mobile phones for training, diagnosing, and monitoring. Each approach has its strengths and limitations. The most critical dimensions were local availability, (refresher) training courses, salary, and female workers. Of all approaches, the community midwife approach scored highest in the ranking of community-based health promotion. The respondents provided recommendations for NGOs' success factors, health education/promotion, health system, and national level. Twenty-six success factors were identified: trust,

participation, support from religious leaders, and training were the most important. The best practice in health education is to have tailor-made programs and generally to use simple, pictorial, timed, target methods, be supported by religious leaders, address the immediate needs (maternal and child health, water, nutrition, communicable disease, and nutrition), and train people to share the health message with their peers. Last, a variety of recommendations were given to improve the health system as well as work on the national level, which cluster around improving capacity, regulation, intersectoral approaches, and the allocation of finances to remote areas.

In the next four paragraphs, the results are contrasted with the findings of other studies. First, the recommended strategies are in accordance with the results of Newbrander and colleagues, who studied barriers to care and suggested using: "religious leaders, trained health workers, family health action groups and radio to disseminate these messages" (Newbrander 2014). The call for integrating mullahs in promoting behavioral change is also advised by Sato, based on his explorative study on the socio-cultural and religious context of communities (Sato 2007). The remarkable success of the community midwifery program is repeatedly reported. Overall, country-wide programs such as the BPHS, CM, and CHW appear more promising and sustainable than small individual projects (see Newbrander 2014). The key success factors of these strategies are (a) commitment by the government, (b) external financial support, and (c) the contracting out to humanitarian NGOs, ownership, alignment, harmonization, managing for results and mutual accountability" (Dalil et al. 2014). Dalil points out. However, as the Healthy School Initiative has shown, goodwill on the national level is not sufficient for success. In light of this, a good program needs a supportive environment, trustworthy providers, committed staff, and participation and ownership of local people. This combination is not only necessary for individual health but also for all projects/programs etc. (see also recommendations by the WHO (World Bank Group 2010; Edward et al. 2015a; WHO; WHO). The identified good practice criteria for working successfully for health in Afghanistan resonate with the core values of the MoPH. By comparing the identified best practices criteria with the proposed framework for selecting best practices in public health. It can be seen that the (1) relevance of the context, as well as the processual dimensions such as (2) engaging the community (community participation), (3) involving the right stakeholders, (4) ethical soundness, and (5) replicability are in accordance with the findings. However, despite the own estimation of the interviewees, little can be said if the approach's outcome is (6) effective, (7) efficient, and (8) sustainable (Ng and Colombani 2015). However, the proposed framework fails to emphasize the two most relevant success factors: "trust" and "relationship." Gilson thoroughly discussed the role of trust in the health system (Gilson 2003). The importance of community participation for sustainability is not only indispensable in the protection of the health facility but also highly recommended for the selection of health workers. Mansoor et al. showed that the employment rate in high-risk rural areas is much higher if the community selects health workers than with any other selection strategies (Wood et al. 2013; Tuhkanen et al. 2008). Besides, the

relevance of gender-sensitive health promotion can never be estimated too little (see (WHO 2013).

Regarding the recommendation for health education, they do not match the "using a few messages, of proving benefit, repeatedly, and in many forms," as Loevensohn identified in his review of RCTs location (Loevensohn in WoodrowWilsonCenter 2006). It becomes apparent that the answers given by the interviewees focused more °on what to do and less on what makes the strategies (most) effective. Specific recommendations of best practices for health promotion in Afghanistan can be found by Sakkena Yaccoobi, the director of the Afghan Learning Institute. First of all, she suggests that her staff incorporate them. Nevertheless, overall, a high level of activation and involvement of the target group is the key to all good practice examples for health promotion and should be favored instead of merely spreading health information.

Overall, health promotion in Afghanistan is mostly understood in its narrow meaning as health education. Reflecting on the available activities, it still appears that most of them focus on the treatment of health promotion as understood in Tannahill's model. He defined health promotion as the combination of prevention, health protection, and health education. Almost no activity focuses additionally on addressing changes in the environment and the strengthening of resources.

To bring these findings further, the following questions should be assessed. From an NGO's point of view? What is the best strategy to improve health in the community rapidly and sustainably? How is it possible to implement/live up to the best practice examples in a fast-changing environment? From a sociologist's point of view: What might be the impact of community midwives on the role of women in the future? From a health system adviser's point of view: How can these valuable health promotion activities be further sustained and strengthened even when there is a decrease in donor funding? From a human rights health activist's point of view: How can the inequity in health service provision be reduced?

SECTION III: ASSERTIONS AND CONCLUSION

9 Critical Assessment of the Study Design and Hypotheses

So far, this paper has focused on comprehensively describing and evaluating the context of Afghanistan's health and health promotion approaches. Each of the five result sections closed with a summary, contrasting the findings with other related studies, reflecting on the importance of these findings for health promotion, and posing open questions. In the next section, the author seeks to assess the study design and the hypothesis critically and sums up the results. Then she reflects on the findings from different perspectives and compares them to theories, models, and frameworks to point to further research needs and draw implications and recommendations.

9.1 Critical Assessment of the Study Design

Before the author sets out to give an overarching answer to the research questions, she critically evaluates the study design by reflecting on the seven criteria for qualitative studies in health care (Cohen and Crabtree 2008).

To carry out ethical research, the author applied the four following criteria. (a) Participation was voluntary. (b) Participants were fully informed about the purpose of this study. The author comprehensively explained the purpose and process in an email to the participants. (c) The author obtained informed consent orally at the beginning of the interviews or in written form at the end of the questionnaire. (d) To guarantee that no person was harmed by participating in the study, she interviewed via Skype or Viber and took place at the participant's house or office. So additional disadvantages such as time and cost of transportation were eliminated. No sensitive psychological information was gathered, and the people endorsed no pressure.

The following criteria defined the importance of the research: (1) To guarantee that there was no other study done on the same topic yet, the author conducted exhaustive research on scientific databanks and free internet research. The research could not find one single article on this subject. (2) Furthermore, the topic should be relevant for practitioners, politicians, and researchers and should advance the current knowledge base. Not only the MoPH but also the participating interviewees expressed their interest in further evidence-based information on health promotion. And even one respondent mentioned that they usually do not participate in scientific research but made an exception due to the relevance of the topic (email correspondence with A8).

The author strived for clarity and coherence in the research report, for example, by providing sufficient information on the study design. Besides, each of the five result sections followed the

same structure: (a) Introduction, explaining the relevance and rationale and the structure of the chapter. (b) followed by a stringent presentation of the results, and (c) concluded each section with a short abstract, a comparison of the findings with other studies, implications for health promotion, and open questions. Furthermore, she presented the reference for each piece of data and sought to make the relationship between data and interpretation understandable.

Because of the lack of research papers on (community-based) health promotion approaches in Afghanistan and the rapidly changing situation in Afghanistan, a mixed-method approach was identified as the most appropriate strategy to address the research questions. She integrated a triangulation of methods (desk research, scoping analysis, a short questionnaire, semi-structured interviews) and triangulation of data (research papers, epidemiological, quantitative data, qualitative data gathered through interviews, and gray literature of policy and strategy papers). However, the scope of the study is limited to German or English. Unfortunately, the author could not conduct interviews with patients, community health workers, community health Shuras, or mullahs because of the unstable safety condition in many rural areas, the language barrier in Dari or Pashtu, and the short timeframe. Nonetheless, interviewing NGO representatives and contrasting the findings with other data appeared to be an acceptable way to explore health promotion in Afghanistan. Being aware that many organizations in Afghanistan are short in staff, very busy, and not all have English-speaking staff, she expected that the response rate might be low. Therefore, she decided to contact a broad range of organizations. The limitation in resources was often expressed by NGOs who apologized for not being able to participate (e.g., MSF, ACF, CARE). Nevertheless, she was surprised by the tremendous response, particularly to her request for an interview. The variety of responding organizations has fit the predefined sample criteria of a maximum variation of NGOs. Hence, the sample appears to be a good representation of active and committed NGOs. However, it remains a self-selected sample. The generalization of the results is restricted because no perspective of 'not active' or 'poorly active' NGOs nor of further stakeholders (MoPH, NGO staff, further health workers, and beneficiaries) are included.

The researcher emphasized reflecting on her preconceptions, motivations, and her way of seeing and interpreting data and their impact on the data quality. Primarily, she used three main strategies: (a) reflecting on the assumptions of each sub-study and raising critical questions at the end of each chapter. (b) By reflecting on the application of the methods (this section) and (c) by trying to roll out social desirability, detection as well as reporting bias. However, detection bias plays a vital role because the researchers sought to identify health-related NGOs based on a holistic notion of health. Applying a comprehensive notion of health impacted the selection and categorization of the NGOs and their activities. Therefore, many activities were declared part of health promotion even when not defined as such by the NGOs. For example, many NGOs working in WASH announced, 'we are not a health NGO.' She wanted to rule out the detection bias in qualitative interviews by searching for negative examples. Furthermore, she reflected on normative

assumptions that might contradict her own assumptions and the perceptions found in the data (see the next chapter). To assess the reporting bias and identify the impact of social desirability, the author searched for positive representation of their organizations and, in particular, self-criticism. It turned out that some NGOs ranked high, others very low in self-criticism. Some only presented the strategy and the challenges on a national level and not on their NGO level. Generally, self-criticism and data sufficiency were higher in the interviews than in the short questionnaire. But throughout the health and agriculture organizations (N=12), who responded via questionnaire, provided very exhaustive and constructive criticism and recommendations. Therefore, the credibility of health-related activities is regarded as higher. But still, it could not be ruled out that NGOs reported significantly more positive results, so significant distortions remain. An additional source of reporting bias occurred because many of the questions raised were formulated positively, focusing on strengths and success factors. This was done to refrain from repeating the challenges but point to the factors that make NGOs resilient in this challenging environment. By using a mixed-method approach and by checking the data with others as well as asking for feedback from the NGOs, she tried to decrease these distortions. Another important influencing factor is the performance of and perspectives on the researcher: Which is hard to estimate. During the interviews, the researcher encouraged the respondents to report freely and asked further questions to illuminate, in particular, the existing health promotion activities. Depending on the interview partner, his/her specific role and professional background, and the perception of the interviewer - as one who has exhaustive knowledge of the setting or is simply exploring it - the responses varied. Some interviewees generally described the system in Afghanistan, whereas others gave precise answers to the health educator's conceptual ideas and explicit performance.

Validity was sought by producing a rich and meaningful account of the multiple perspectives and realities studied. The author intended to include sufficient quotes to present the situation in detail but not to overload the report with real-life statements, which would limit its readability. She applied several strategies to enhance credibility, such as checking for representativeness, researcher effects, or the meaning of outliers, triangulation, weighting evidence, using extreme cases, following up surprises, looking for negative evidence, making if-then tests, ruling out spurious relations, replicating a finding, checking out rival explanations, getting feedback from participants (Miles et al. 2014).

In addition, to enhance verification, she sought feedback from participants as well as readers to confirm or modify the patterns identified, the analysis, and the interpretations.

In the next sections, the application of the three most important research strategies was critically reflected, and limitations were described.

The collection of data on Afghanistan has several difficulties. The initial research on scientific databases did not provide the researcher with the required and sufficient data. Therefore, she

expanded her research to other pages, such as the MoPH website, the data basis of the UN, WHO, CIA, and free online search using the Google search engine. However, verifying data quality, objectivity, validity, reliability, and representativity is even harder. To reduce the bias, she tried to compare several databases and highlight congruencies and incongruences. This method still cannot rule out some distortion within gray literature. Generally, applying the different frameworks turned out to be a useful and pragmatic strategy for structuring vast amounts of data and making a comparison with data from other countries possible. Categorizing the data along the sub-dimensions of prerequisites, determinants, and health indicators also helped to define the most pressing needs. Presenting qualitative data with quantitative data turned out to be useful in refining qualitative data and relativizing quantitative data. The combination of empirical research with quantitative data on health status provides a useful start for further in-depth studies on health in Afghanistan. However, some factors limit the data. First, the individual selection of subcategories for each prerequisite based on the qualitative information and quantitative data enhance the representativity for Afghanistan but limits it to a direct comparison to other countries. Second, these frameworks, in particular, the framework for the health system and its indicators, do not specifically focus on health promotion approaches in particular, nor do they distinguish between urban and non-urban areas.

To identify the NGOs, the author verified the lists for the compilation of NGOs were verified with partners in email contact from Afghanistan concerning their all-inclusiveness. On the one hand, this strategy was useful in identifying a significant number of Afghan NGOs, but on the other hand, it did not include the private health providers, nor did it cover all the NGOs in Afghanistan which are not registered with the Ministry. So, she extended her research to free internet research and added further relevant actors in Afghanistan that she found out about in this way. The response rate to the additional short questionnaire was very low. The main reasons can be equivalent to those of health organizations (a) shortage in staff, (b) no English-speaking person, (c) do not consider themselves as a health organization, and (b) assuming their participation would be of no value. Anyhow, some organizations used the tool to share their experiences. Furthermore, answering the questions per email seemed to be more attractive for some organizations, in particular, because it was distributed in English. Categorizing activities under certain domains might be an arbitrary approach inductively developed. But for pragmatic reasons, it helped to structure and therefore appeared to be the best solution. The aggregated overview has several limitations. It can present a huge variety of health activities clustered accordingly to the primary domain of actions defined by the MoPH. But it cannot quantify the approaches, give information on their geographical distribution, or if they still exist. The initial plan to try to describe most of the approaches existing in 2016 could not be followed through based on a website search because many organizations (in particular Afghan organizations) do not publish their annual reports on their websites, and the description of the projects are often not up to date.

The semi-structured interviews with the NGOs provided unique and rich sources of information. Despite their shortage of time, the interviewees seemed to enjoy talking about their activities and the lessons learned: "thank you."… The researcher sought the ask questions that stimulated narrative, which appeared to be well accepted. Some questions were easier to be answered than others; for example, the question concerning the activities in contrast to the concept of health and health-related behaviors for this study, it was useful and less time-consuming to ask for their experiences than to do an ethnographic study (even though this might be helpful to gain more insights). A limitation could be the self-selection of the interviewees. Most of them expressed that they were very interested in the theme and eager to share their experiences. The respondents' motivation might have led to an over-emphasis on health promotion and education's importance. Concerning the responses to the questionnaire, 12 of the 22 organizations provided exhaustive information on all questions. These organizations were all the 'health' NGOs and large donor and environmental organizations; the other ten did not answer all questions or used the platform to promote their organization (by only describing the concept and less the real implementation). The answers varied widely, from very specific practical suggestions to ideas that appeared to be unrealistic. Unlike the interviews, no further questions for clarification could be asked.

Despite the strive for high quality, some further difficulties should be pointed out. (a) A further source of difficulties was that English is not the researcher's mother tongue, and German and English scientific writing varies widely in the way of structuring. (b) Initially, she did not expect to find so much material and receive so much feedback. That is why she broadened her scope. But then finally, with the many data, it was a challenge to present an overview that is general enough and highlights the most significant findings precisely. (c) Even though the researcher tried to achieve validity through comparison, providing references for all data, and using several strategies to analyze the data thoroughly, this could make up for the poor quality of external data.

8.1.2. Critical assessment of the hypothesis

Before answering the research question, it is necessary to reflect on the hypotheses of this study. The hypotheses were (1) Health promotion approaches are more likely to be effective and sustainable if the NGOs - the leading health care providers in Afghanistan - work appropriately. (2) A promising health promotion approach is evidence-based and covers the right topics, provides the right messages, with the right methods, at the right time, at the right place, to the right people, by the right person. It addresses concepts of health and health-seeking behavior, is linked, or integrated into the health system, addresses the determinants and prerequisites of health, and strives to improve them.

Some remarks can be given concerning the second assumption. This study did not assess the effectiveness and sustainability of the NGOs with rigorous methods but based its judgment on the NGOs' self-reports. Hence, it might be distorted. Furthermore, this study integrates almost

exclusively the self-selected, good-working NGOs perspective. Based on the observations that many NGOs do not continue, the identified NGOs already fulfilled the criterion of a sustainable organization. To specify 'good practice in Afghanistan,' the author has asked the NGOs to define factors that made them successful. The identified criteria can be used now in the next step to be validated as the main success factors for NGOs in Afghanistan. The list of good practices which the NGOs identified defines not only the NGO's work characteristics but also specifies a required character trait of the NGO and the way of interacting with the local communities and other stakeholders. These specified criteria can account for an appropriate way of working that contributes to being effective and sustainable.

In the following paragraph, the coherence of the second hypothesis is discussed by exploring the relevance of each component regarding the local needs and challenges and reflecting on confirming and disconfirming empirical qualitative data.

The first component of the hypothesis was that promising health promotion approaches should be **evidence-based**. Only two interviewees referred specifically to the need for evidence-based health interventions. The unanimous view of the respondents is that the interventions should be adapted to the local needs, which is one of the four components of the definition. Many also support the idea of integrating local expertise. However, the use of "evidence yielded by systematic research" was only suggested by one organization and the need to "use conscientious, explicit and judicious the current best evidence." However, one person explained that for the conceptual development of the BPHS, the joint mission integrated the best evidence available, which was gained through systematic research and discussions. The call for evidence-based health promotion conflicts with the requirement for daily flexible adaptation of the approaches. The NGOs described that - even though they prefer to plan long-term - the conditions in Afghanistan do not allow them to follow the plan through but require constant modification. Furthermore, little data exist on best practices of health promotion in conflict and war-affected countries or in Afghanistan, as the findings of the systematic research on health promotion in Afghanistan showed. So, the results of a systematic search can barely contribute to developing evidence-based health promotion approaches. Hence, the use of empirical evidence is only echoed by some providers, but the holistic definition with its four components cannot be applied holistically due to a lack of data and the need to adapt flexibly to the everyday challenges of a war conflict-affected country, such as Afghanistan. The lack of and difficulties around evidence-based decision-making was also systematic reviews in developing countries was similarly described by McMichael et al. (2005).

The next component can be summarized by consciously planned health education. The study presented a variety of types of health education all around Afghanistan, and it becomes apparent that health education is an important add-on to medical care but not always a primary issue. By applying the rigorous term of 'right' people, methods, etc., only a few approaches meet this standard.

One was introduced on the conceptual level, which is timed and targeted counseling; another one is the door-to-door approach by the midwives working in the internally displaced camps. The interviewees explained that striving to identify the 'right' topics and 'right interventions' was one aim during the development of the BPHS. Even though this strategy integrates some promotive and preventive interventions, little is known about their implementation and effectiveness. This is because most evaluation focuses primarily on structural aspects, such as the number of participants and not the noticeable improvements in health behavior. One interviewee state that health education is mainly about "spreading information" (I12, 71) and less about changing target behavior and attitude. Since there is little health knowledge in Afghanistan in general, each and every attempt to increase knowledge and skills on health is regarded as useful, such as hygiene education or training on safe delivery. One interviewee states, "*I think the first thing is, we should aware them, but awareness, as you know, need health education, awareness needs supervisors to conduct a different meeting with all levels of community and also through media through newspaper (incomp.)*" (I10, 14). In summary, even though it is undeniable that having any health education is better than having none, this study could identify several approaches that go beyond spreading information and are more promising by including behavioral and emotional/attitudinal components.

(b) The concept of health, health practices, and health-seeking behavior play a key role in deciding where to go for healthcare. The interviewees reported various traditional health practices and suggested: *"considering the cultural and traditional barriers"* (I13, 21) in health education. They recommended cooperating with mullahs to spread messages on health. One success story demonstrated that the community started seeking care at the health facility after launching an awareness-raising campaign. In this campaign, a TV spot showed the available services and staff at the health center as well as a roundtable, in which the mullah encouraged the people to seek health care there. Yet, an interview recommended being careful with addressing these practices: *"another thing for my recommendation to change some behavior of the community, not touch the culturally sensitive issues, but some behaviors which are not acceptable and which is not for the benefit of the community which should focus on these things and we should change the behavior of the community"* (I9, 31) To conclude, the findings provided a differentiated picture of the intangible issues of health and the need and strategies for addressing them. Overall knowledge about and trust in services, support by the mullah, and the availability of female health workers turned out to be key strategies repeatedly to change harmful health behavior.

(c) Linked or integrated into a health facility. Most health education and health promotion are provided through the health system (I12, 69). The majority of interviewed NGOs use the health education materials of the MoPH, for example, the material for the CHW, IEC for the health education in the waiting room, and TV and radio spots for mass media. Some interviewees recommended developing further materials for areas that are not yet tested, piloting them in a small

group, and then integrating them into the MoPH material. Apart from the 'health NGOs,' some health education is also provided by other NGOs, for example, those working in WASH or education. If these providers also use the MoPH material for their health and hygiene training or cooperate with the MoPH cannot be answered based on this data. However, it is unlikely that health promotion activities can happen separately from the health system because all respondents stressed the importance of working with the responsible ministry (I18, 5; I13, 21).

(d) The determinants of health are crucial in the opinion of many respondents. They explained that these determinants can positively impact health, e.g., through family support, but can also negatively influence health. Even though most of the named health activities are therapeutic, preventative interventions, or health education, a few projects directly focus on the determinants of health, for example, mental health, WASH, nutrition, and the livelihood sector (I14b). One of these programs was the healthy school initiative, which was successful in Herat but less in other provinces (I1, 11). One statement indicates that being able to care about avoiding the negative impact of an action on health is a privilege: *"no health is not a priority if a work is dangerous for our life and health still, we have work because we have to earn*." (I8, 51).

Furthermore, they define several factors which profoundly influence that healthcare is sought at the hospital, such as transportation, the economic ability of the family (I13, 21), natural hazards, human-made challenges, and obstacles (I6, 25) which cannot be addressed on the individual level. One person emphasized, *"you know that health is not something you can do regardless of all the other sectors. Warfare, security, education, economics, culture, religion, lots of other things are affecting people, so, with only short-term intervention for sure, you cannot bring changes, for there are no changes in all the other sectors"*. In summary, determinants of health are highly important in the respondents' view as important factors causing health but also as the factors limiting health care. Several interviewees emphasized the importance of determinants, but even more than the **prerequisites** for health have a large - if not *the* largest- impact on health.

The following two statements integrate the most common answers of the interviewees: *"Afghanistan is full of problem, and one cause is illiteracy, the second is war, the third is insecurity situation, the fourth is cultural barriers, less awareness"* (I10, 43). Moreover, the second described: *"I am not going into individual challenges like how would you feel if you are not allowed to help someone in need. I am just referring to the big issues, which is the corruption, which is the security, which is the IDPs or the internally displaced people, which is the refugees which is the vast requirement and demand on the ground, and which is, of course, the limited resources or the funds you have been receiving after 2010*" (I4, 26). Asked for specific health recommendations, a third respondent mentioned: *"The above are the main challenges faced in the health sector, and they are beyond the control of the individual entity, and they should be addressed and solved at a more comprehensive and broader level."* (A19, 83) In summary, many people agree that it is

necessary to address the determinant and prerequisites for health, but they also acknowledge that due to several social and political circumstances (such as different local leaders and poor cooperation between the ministries), it is barely possible.

The importance of the community and community-based approaches as the key to improvements in health was stressed several times. The interviewees often expressed that the community's major role is to care for and protect their health facility. Furthermore, the community is important not only because of the cultural barriers or social support they provide, but NGOs also suggest strengthening the interventions that can be performed at the community level for which it is not necessary to seek a doctor. For example, one 'mental health' NGO trains people to listen non-judgmentally (I1, 57). The change in focus was also expressed by one interviewee, who reported that the concept of *"government is responsible for the health, education and other development activities of the communities"* has been changed to the concept of "*everyone is responsible*" to actively participate in the development efforts of the communities (A3, 28). In particular, concerning long-term sustainability, the community approach is regarded as key and superior to any other external approach: *"I think sustainable health can anchor when we bring health policies or drive health policies into action by the villagers and enable the villagers to have information and to deliver services. Because any outside intervention to a village will be donor-dependent or highly external dependent, so we need to establish a health unit within the community to stay longer and beyond financial funding from a donor."* (I3, 40).

Salaman and Alwan pointed out the need for addressing the context to enhance health in their analysis of health systems in fragile states: *"In particular, the need to take context as the starting point; to focus on state building as the central objective; to promote non-discrimination; to align goals against local priorities; and to act fast, but to stay engaged long enough to give success a chance, seem highly relevant"* (Salama and Alwan 2016). But the health status is not only impacted by the prerequisites for health, but the health status also impacts the prerequisites. One interviewee referred to the intertwined circles of George Marshall: The Cycle of Goodness, - "*you cannot have stability without economic activity, you cannot have economic activity without health. You cannot have public health without security and economic growth (WoodrowWilsonCenter 2016).*

All in all, the reflections on the hypotheses have demonstrated their applicability to Afghanistan. For health promotion approaches in Afghanistan, the following points are regarded as highly important: health education, addressing wrong beliefs, integrating health promotion into the health system, and addressing determinants and requisites. So, this holistic approach turned out to be the supported and required strategy, in theory, and even calls for further evidence-basis. But the reality is different; even though there are various suggestions for increasing the effectiveness of health education activities and addressing harmful beliefs, the determinants and prerequisites have a much larger impact on health, but it is barely possible to attack them currently with the

given conditions on the ground (of high insecurity and lack of good governance). It also shows that community-based activities are key to any successful and sustainable health promotion approach. Overall, the basis of evidence for health promotion in war and conflict-affected countries is primarily defined by experts and local needs and by (the lacking) systematic scientific data.

9.2 Critical and Cautious Assessment of the Results

The following section draws together the findings of this study, presents models for implementation, and points out the need for further research.

By discussing health promotion approaches, at least two dimensions have to be distinguished from each other. The first dimension is "general" vs. "specific." The second dimension is a "conceptual" idea vs. "practical" implementation. Every opposing aspect of each dimension has its strengths and limitations. By assessing health promotion approaches, the author could either try to provide a general overview (see Chapter 6.2) or specify one of one or more approaches (see Chapter 8). When looking at the first dimension, the central debate arises from the question of "generalizations versus precision." Whereas the general level is of primary relevance for the decision-making on the national level, e.g., by the MoPH or donors, knowledge on the specific level is needed for implementers. On the second dimension, the debate is on scientific soundness versus practical applicability. On the conceptual level, it is about terminology, the best conceptual models, and theories, about the best available practice for developing promising, evidence-based health promotion strategies (see Chapter 2). However, on the practical level, it is less about theory and more about reacting flexibly to immediate needs and adapting the program to the changing determinants. In this study, the author has tried to integrate both the need for an overview and the relevance of in-depth research, as well as the need for good theory and a variety of practical implications. In the next section, she will discuss her findings from six viewpoints intricately linked to these dimensions.

First, she presents the reflections and implications for the practical work. (a) The practical level points out the needs, good practices, and recommendations of what to do and what not to do on several levels, starting with a general point and going to a more specific level. Then she presents (d) the conceptual level, which is concerned with how to develop an evidence-based health promotion approach. (c) On the terminological level, she raises the question of what health and health promotion are. (d) The theoretical level considers what appropriate models and frameworks are. (e) On the normative level, she discusses the question of what should be done. And finally, she closes with (f) the scientific level and reflects on the role of research in health and how to assess health promotion approaches in conflict and times of war.

After an initial remark, each level is discussed on the next pages.

During the work on this thesis, it became apparent that Afghanistan cannot be clearly described in one picture. The best characterization is "diversity": Afghanistan is diverse and heterogeneous regarding physical geography, ethnic groups, cultures, languages, educational level, and urban and rural living standards. Therefore, the author refrains from talking about 'one Afghanistan' but suggests properly segmenting each area. The findings in this thesis can serve as starting points to identify relevant areas and references.

(a) Practical Level

Afghanistan is multi-diverse and multi-complex. Therefore, one general recommendation for improving health cannot be given, and it is more appropriate to structure and cluster the various recommendations for action on each level. In the next table (Table 34), the author focuses on the five top challenges and seven higher-importance levels. Each (health promotion) project in Afghanistan might be limited in its effectiveness and sustainability if it fails to address the five top challenges: insecurity, corruption, poverty, low level of education[47], and cultural barriers.

TABLE 34: ASSESSMENT OF THE CHALLENGES AND RECOMMENDATIONS ON 7 LEVELS

ACTOR	MAIN CHALLENGES	RECOMMENDATIONS
International community (e.g., donor, conceptualizer)	- withdrawal	- Making MoPH responsible for it - a clear divide between humanitarian and military aid - support establishing of peace and stabilizing the situation - focus on long-term sustainability
Nation (conceptualizer	- insecurity - Corruption - Poverty - Low level of education - (migration) - culture	
MoPH	- weak in execution and regulation, maintaining and continuation (i) - corruption © - dependent on foreign aid - low technical expertise	strengthen, transparency and work through it, Enforcing law and regulations - (! Reduce corruption) - Enhancing capacity (coverage, quality) - Assuming continuation - capacity building in leadership: LMG – project
Health sector	- Low capacity and quality - Low execution - Shortage and concentration - No budget - Cultural constraints	—> extend training
NGOs (Generalizer, BPHS-Implementer, Capacity Builder, Targetizer, Specializer)	- Limited due to requirements (and strongly influenced by political changes) - Projects based - Possibility to focus on capacity - Cooperation (is) - Working features - character	A single-time capacity training is not enough → people profited from continuation; Adhere to humanitarian principles - Focus on training/enabling - Enforcing impact on determinants of health in each proposal - Assuming the continuation of a program - transparency
Health staff	- no staff - not transparent/committed - not paid	- Committed © - Trained € - Understanding as (health promoter including cultural barriers) - Paid (p)

[47] Insecurity, corruption, funding uncertainty and lack of regulation was also identified as the most crucial areas for the future of community midwife education (Speakman 2014)

	- not skilled, low level of literacy - only male	Protected (is)
Community	- insecurity - low level of education - geographical barriers - low income - (Many children) - Cultural barriers	raising general education; higher transparency (on all levels), e.g., communities can hold the NGOs accountable. Specific health education sessions

Even though there is a need to decrease poverty and corruption on all levels, the study shows that the effectiveness of these singular approaches is highly dependent on acceptance and supported by the next higher levels. Overall, all people involved should be strongly committed, and it is recommended to use an intersectoral approach. Available policy papers and even signing sustainable development goals could be the first step. But only the future will show if they are also respected and executed by all. Dr. Feroz expressed the high dependency on the further levels as the response to the corruption report in the health sector. He emphasized that all the attempts to reduce health sector corruption are stimulated or inhibited by the context in which it operates (WoodrowWilsonCenter 2016).

The evidence thus far supports the idea that health promotion should and can help further decrease health problems in Afghanistan. But to realize them, one needs to consider the statement of a representative of a large donor: *"Programs promoting healthy lifestyles and prevention are underfunded, thus not realizing their potential for raising the country's health status."* (A15, 26)

(b) Conceptual Level

Coming back to the research question and the initial assumption, it is tempting to present one specific health promotion approach that fits all. But based on the diversity of Afghanistan and the need to integrate the key success factors' trust' and 'participation of the community,' the author cannot suggest one single approach. There is, however, another answer than simply stating that everything "must be adapted individually." The following table includes the strategies which have been proven to be useful in the Afghan context. By properly analyzing the specific target group and their living context, these approaches are very likely to be promising. Furthermore, this table can enrich existing health education and health promotion approaches by going one step further to enhance the program's effectiveness. The following overview (Table 35) presents ideas for highly recommendable, used but less optimal, and not recommendable approaches.

TABLE 35: RECOMMENDATIONS FOR HEALTH PROMOTION

Domain	Examples	Specification
Right topic	(Suggested by MoPH and revised); see BPHS, FHAG, CHW _But need for revision and prioritizing Enhances competencies, enables and	Reproductive health, menstruation

Right message	Wording adapting wording FP: birth spacing Knowledge, attitude, practice, Inhibiting and enabling factors, Also, focus on stigma	→Family planning
Right method	Multimethod, visual, Multiplier Bad and good story stigma	Only information; Written material or (electronic devices in some areas)
Right time	Boys in school for family planning Children in School Pregnant women Season specific	
Right place	Men in mosque Children in school Women at home	Patients and caregivers at the HF
Right people	Mothers-in-law, mullahs, elders, husband Also, female leader	Only women, only the patient
Right environmental changes	WASH, enhancing nutrition variety, safe birth	
Right revealer	CHN, CM, peer, mullah	CHW (controversial)
Addressing previous habits	TTC, door-to-door	Mullahs (maybe media) (Not addressing at el)

A realistic health promotion approach in Afghanistan tries to adhere to the following guidelines (a) addresses and cooperates with the opinion leader and key decision maker, (b) is simple on all levels: simple message, simple material, less complicated technology (3) addresses the most basic needs (e.g., knowledge about hygiene, pregnancy issues and when and where to go, e.g., CBHC (4) works with groups and trains multipliers (5) is resource-oriented (strong character of Afghans, 'sabr,' commitment, enhances social support), (6) has a high level of activation with the aim to enable not just to inform but to enable (6) works with (local) women, (7) strives for a multisector approach to address the environmental determinants, (8) goes one step at a time but always one step further (9) is adapted to the local needs. Furthermore, an ideal health promotion approach also integrates health in all areas and sensitizes medical professionals on how to address common harmful health behaviors. When contrasting this with the WHO-evaluated best practice model, the TTC model shows many areas can be improved.

The study showed that the determinants of health have the most important impact on health and should be changed. However, this case study shows that this is rarely possible, so the roots of the problem remain the same. Despite these limitations, health promotion can still be improved with the purpose that people are more strong, more enabled, and more empowered to cope with challenging circumstances. So, in the context of Afghanistan, developing an evidence-based best practice health promotion approach is always a tradeoff between a 'best case' and a 'realistic case'

scenario. In view of all the challenges and the variety in Afghanistan, the author suggests applying the model "health care plus and beyond."

A further remark needs to be made concerning health education. It is worth considering how people learn and acquire new skills for successful health promotion approaches. The success stories and recommendations presented in this thesis reveal that Afghans' behavior is strongly shaped by the advice of mullahs and mothers-in-law and the consequences of not following their advice ('conditional learning'). Another identified way of learning is 'observational learning,' the second type of behavioristic learning theory. People observe how others behave, listen to their stories in social support groups, and follow their examples. The interviewees rarely reported cognitive and constructivist learning processes. Hence, health education should consider refraining from spreading messages or behavior change counseling but should concentrate on modeling behavior and working with and through opinion leaders. However, further research is needed that specifically increases the understanding of learning processes in Afghanistan.

(c) Terminological Level

The empirical data on the concept of health revealed that there is an explicit miss-match between the definition of health in purely physical terms and the immense impact of social circumstances on health. Overall, the individual's mental health appeared to be less important than the social impact on health. Therefore, it is indicated to identify the causes of diseases not exclusively within the individual but also in the social and environmental determinants and consequently to seek treatment and healing within this group (and not individually). The unique strength of Afghans' sabr', patience, commitment, social support, and ease of relating to others could be further strengthened to uphold against the various strains of life (see also Eggerman and Panter-Brick 2010).

Throughout the study, there was a large variety of understanding of health promotion. Mostly, people referred to it as health education and disease prevention. Health promotion, with its focus on enabling people to take control over the determinants of health, is seldom realized. Reducing health promotion to health education can have drastic consequences if it leads to the assumption that spreading health messages is sufficient for enhancing health. The difficulties in defining and distinguishing health promotion from other concepts such as health literacy etc., theoretically, and practically is not only a problem of practitioners. Also, famous professors in health promotion still strive for proper definitions of these terms for academic and practical use (see discussion on research gate.)

(d) Theoretical Level

Generally, the knowledge of health promotion models and health behavior models is a sophisticated tool to plan, implement and assess health promotion activities around the world. Therefore, the identified results were analyzed and compared with widely used models and theories. By contrasting the findings with available health promotion models, it became obvious that Tannahill's model comes closest to the identified concept of health promotion in the study. The various approaches could be further differentiated by using Beattie's model. However, both models lack to integrate the relevant determinants and prerequisites for health. Naidoo's differentiation between the five domains is also common but does not comprehensively integrate the determinants and prerequisites. The rainbow model might be suitable to show important determinants of health, but it does not further differentiate between salutogenic and pathogenic approaches, which are highly relevant in Afghanistan. Hence, the comprehensive EUHPID model might be most suitable. However, the author still explicitly argues for extending it and integrating health beliefs/rumors and traditional practices. An integration of the findings into a comprehensive model with an example of war and conflict-affected developing countries can be found (Figure 19).

As introduced in Chapter 2, there are three categories of health behavior models: individual, interpersonal, and community-based approaches. The study demonstrated that health and the decision for adequate health behavior are less a choice of the individual but more of the group the person belongs to. So, the individual models are less suitable for the Afghan context. Furthermore, the findings show that, in particular, in rural areas with a low level of education, cognitive approaches seem to be less important. The advice of others, e.g., the mullah and modeled behavior – as used in the social learning theory appear to be more appropriate. Therefore, a promising approach must address the social setting to be successful. Next to the social learning theory, the community health promotion approaches are worth further investigating. The idea used in this thesis corresponds more with the ecological theory than with the diffusion theory. However, all these approaches should thoroughly address the contextual factors.

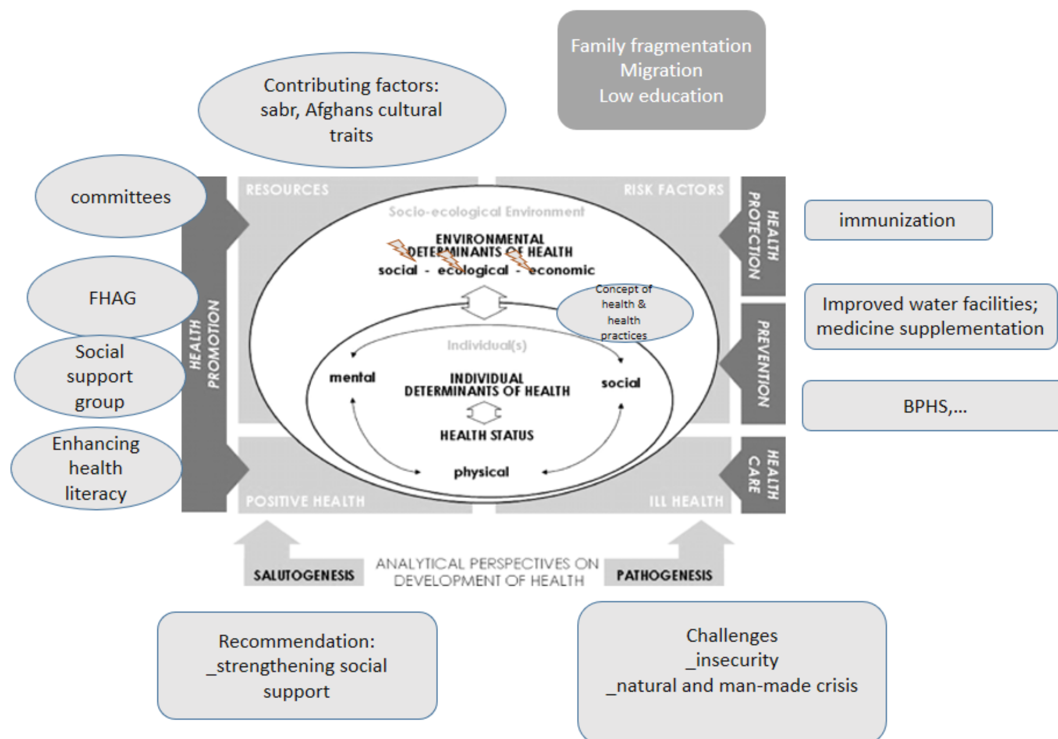

FIGURE 19: DRAFT OF A COMPREHENSIVE MODEL FOR CBHP IN CRISIS-AFFECTED COUNTRIES

(b) Normative Level

The discussions on health promotion are highly normative; see the statements made in the Ottawa Charter. To raise awareness and critically reflect on the norms and assumptions of the profession (health promotion), the author contrasts different opinions concerning health in war and crises that arose in the interviews. First, there is the 'need-based' statement that health promotion is not needed in a conflict-affected country because it is urgently necessary to provide basic health care for all Afghans before even thinking about health promotion (I7c, 8). Second, there is the question concerning relevance and effectiveness. Respondent says health promotion is unlikely to be effective because the Afghans are concerned with how to survive and not with how to live in a 'healthy way.' (A21, 7) Third, there is the 'provision' statement that, particularly when access to a health facility is not guaranteed, the need for the individual to stay healthy is even higher than in a society where health care is easily available. Therefore, enabling people to establish healthy environments is even more needed. Fourth, there is the 'human rights' statement, which argues that everybody has the right to health, not only to shelter. Fifth, it needs to be discussed "what is a life worth" and "what is a healthy life worth in times of war (I11, 39). Sixth, the question concerning the intertwining of military, political vs. humanitarian work and the consequences that arise with it. Seven, it is worth discussing the question of what services can be provided in Afghanistan and not raise awareness and demands on services that are out of reach (I1, 29). These are, for example, if one cooperates with warlords or the Taliban. The author argued primarily from a human right, needs, and effectiveness perspective in this paper. However, the study has

shown it requires a new way of thinking about health promotion in Afghanistan. Health promotion aims to enable people to take responsibility for their health and control health determinants. This is, for example, reflected in the vision of one interviewed NGO, "self-reliant, aware, and healthy families" (A18, 13).

Despite its purpose of enabling all people (in particular, the most vulnerable), the health promotion dilemma observed worldwide exists in Afghanistan. The dilemma is that most health promotion activities are developed for and asked for by those groups that are already healthier and not for the most vulnerable, which are often focused on the more literate urban people but miss out on the illiterate women in the remote areas (I1, 10). If the declared goal is to reduce health inequity, then, in particular, this group needs to be focused on. So, it is recommended to "tackle social, economic and institutional factors that result in unequal access and multiple deprivations.",

Due to the situation in Afghanistan, health promotion is strongly linked to health facilities. Furthermore, without question, the people's immediate needs for curative services should be addressed. However, the study showed that a focus on health education and addressing the determinants of health is highly needed. To improve the focus on health promotion, it is worth considering the concept of "health care plus and beyond." A realistic and promising health promotion approach in Afghanistan does tackle the pressing need for health care by providing health services. However, this approach always integrates some sort of interactive health education and even strives to improve the determinants of health as well. Besides, this approach should also integrate the main success factors: trust, participation, cooperation, commitment, training, and transparency.

(e) Scientific Level

This study could not assess the performance and effectiveness of several approaches in Afghanistan because it has more of a general look at the health situation and health promotion in Afghanistan and provides insights into the conceptual ideas behind health approaches as well as recommendations that come along with them. However, it can identify important areas for further research. Throughout the study, manifold questions concerning health in Afghanistan emerged, but the author wanted to focus on a holistic understanding of health promotion.

- By being aware of the recent increase in non-communicable diseases, it is worth finding strategies on how the health services and health promotion activity can be reoriented to not only focus on the prevention of non-communicable diseases but also to meet the need for change in healthy lifestyles.
- Besides, it would be interesting to study common learning theories in Afghanistan and how to support health workers to become good health promoters.
- Furthermore, the study has shown that the current strategy of awareness raising is not enough to change behavior and address the determinants of health. As interviewees suggest, enhancing

health education and literacy might be worth it. The issue of health literacy is intriguing and could be usefully explored in future research[48].

- The strengths and limitations of integrating mullahs in health promotion and the role of Islamic teaching in health promotion should be investigated further.
- Besides, it is worth assessing strategies for how the good practice criteria can be upheld and even strengthened further.
- In addition, it is difficult to provide strong empirical evidence that health promotion activities have an impact on increasing the overall health status. So it is worth considering how assessing a complex phenomenon such as health promotion can be best studied (Whitehead 2017). In Afghanistan's context, several studies revealed that the participation of local people also in data collection is very useful and provides further in-depth information (Lapping et al. 2002; Newbrander et al. 2014b)
- As the study has shown, there is almost no data on evidence-based decision-making. It is worth discussing the importance of evidence-based decision-making in crisis- and war-affected countries and the options for providing a basis for practical implications.

9.2.1 Conclusion of Discussion

This chapter aimed to critically assess the study design and the hypothesis, bring together the results, and draw implications. Despite the strive for representability, these findings are limited to the perspective of (good) working NGOs in Afghanistan. The discussion and reflection on the findings show that Afghanistan does not lack general ideas for health promotion. However, it lacks the financial support, the time, the regulation of execution, the medical ethic code, and the acceptance that health centers/staff are non-political actors and should be supported. The findings and implications were discussed on the practical, conceptual, terminological, theoretical, normative, and scientific levels. A new strategy for health promotion was introduced: "health care plus and beyond" and the imperative for cooperation and commitment.

[48] To develop a nationwide health education program: It might be useful that all each organization working in a specific field of health identifies the 5-10 main cultural barriers and ideas on how they could overcome it. They could - similar to Newbrander - identify several strategies for mother and childcare.

10 Final Conclusion

The purpose of this master's thesis was to explore health and health promotion with its main focus on providing evidence-based, good practice examples for community-based health promotion (CBHP) approaches in Afghanistan as an example for developing countries. Using an explorative mixed-method case study was the appropriate research method for describing and evaluating the status of health promotion in Afghanistan (Rada et al. 1999). The thesis integrated the four perspectives of Rada's evidence-based health promotion definition: (a) the adaptation to local needs through a thick description compiled from epidemiological, qualitative data, and grey literature. (b) The application of best evidence through the systematic identification of activities and crosschecking them from practitioners. (c) The integration of local expertise through semi-structured interviews and questionnaires, and (d) the systematic research of current scientific evidence on CBPH in Aghanistan (Rada et al. 1999). In five steps, the author narrowed her focus to CBHP. Starting with the contextual factors: the prerequisites for and determinants of health as well as the current health situation in Afghanistan. Followed by a description of the Afghan health system, the identification of health care providers and activities, the exploration of the concept of health and health practices, and finally a description and evaluation of common CBPH approaches and recommendations for the work in health promotion in Afghanistan. Before this master's thesis, no systematic identification of health activities or holistic analysis of health promotion approaches was available. Despite the attempt to include as many activities as possible, this master's thesis cannot claim to paint a complete picture of all health-related activities in Afghanistan. The main limitations are the lack of, or often the poor quality of data, the enormous complexity of Afghanistan, and the restricted resources of the researcher. Overall, insecurity, corruption, poverty, low education, and cultural barriers are the top five challenges that strongly impact any health-related activity. These factors are also the main reasons why people cannot rely on health facilities but need to take care of their health status themselves. Additionally, most Afghans live in environments that negatively influence their health, such as having no access to safe water and poor nutrition. Some social determinants, such as the family's social support, were recognized as both a resource and a stress factor. Several harmful health practices and misconceptions were identified that were explained to occur due to the lack of access to health care and, in particular, low health literacy. Most respondents stated that many Afghans lack basic health and hygiene knowledge and do not know when and where to seek healthcare. In view of all this, there is a great need to enable people to control the determinants of health and improve their health. The study explored various promising health promotion approaches and specific health education strategies. Besides this, the study focused on the contextual factors for health promotion and

identified reasons for NGOs to show resilience despite all these challenges. The study concluded that now is not the time to develop evermore new programs concerning the same health topic but to apply the lessons learned from best practices and continue supporting successful CBHP approaches. Since, first, the situation in Afghanistan is changing rapidly; second, there are such immense needs for health care and third, the low capacity of health educators, the author advocates the concept of 'health care plus and beyond.' Based on the findings of this thesis, promising health promotion approaches should care for the immediate health needs and, in addition, provide activating health education and move beyond the individual's health behavior to address the environmental and social determinants of health.

Overall, this master's thesis can be beneficial for researchers, politicians, and practitioners. First, for researchers, it offers an overview of existing studies on health and identifies needs for further research. Second, for politicians, it provides empirical evidence for decision-making. Third, it also allows practitioners to gain further insights into good health promotion approaches and gives tips for the practitioner on how to improve their health promotion activities.

Concerning the great need for health knowledge and skills, she highly suggests that health education should be brought further. It would be worth further investigating a holistic health promotion approach that might be developed that integrates the strategy "health care plus and beyond" and adheres to the 'good practice' standards in Afghanistan. These are trusted, participation, buying in local power holders, and training. The best practice in community-based is having community midwives in the community, who are committed, qualified, trusted, paid, linked with other services, and function as health enablers. Besides, training religious leaders and their wives to address the key decision-makers in the families. With all the richness of the insights it presents, this study can serve as a starting point for more promising community-based healthcare approaches.

Even though the challenges are great, and Afghanistan is currently at a tipping point, the author wishes to conclude with two statements that demonstrate resilience and hope despite the odds:

"Corruption is also a disease, and we will cure this disease as well." (I7a, 61). As well as *"the conditions here on the ground are difficult, but they are not impossible, they are not impossible, there is always a will, there is always an optimism and Afghans are optimistic that they can cope up and that they can live through this difficult phase." (*I4, 42).

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i Overview research

Data base	Results "Afghanistan"	+ "Health"	"Health Promotion"	„Health Education"
Cochrane Library	3	52	1	4 (without =1)
Ovid	1528	444 (without 'mili' =171)	15 (4 relevant)	236
PUBMED	4353	1564 (without = 730)	15 (without = 4 relevant)	14 (since 2001, 8 relevant)
ScienceDirect (since 2001)	1207	303	4 (without = 1)	27 (without = 22)
Google scholar (since 2001 in title)	70,900 21,100	755 (without = 582) (t=427)/ 603	0	7
			10 relevant	*15 relevant*
Samuel Hall	Many external reports	6		
AREU	230	8	4 (but not relevant)	8 (2 relevant)
Refworld (UNHCR)	7062 (18 research papers,	31 (100 in text)	0	0
Reliefweb (UN OCHA)	39,046	4,794 (3,214 – 1937 press release)	0	0
Humanitarian response (UN OCHA)	3065 (mainly meeting minutes; 33 statistics)	316 (Health Cluster)	2 (1 relevant)	8 (1 relevant)
Diva portal	547	31	0	0
Eldis	605	38 (HIV: 8), (nutrition: 3)	8	8
Popline (K4Health)	281	44	3	42 (20 since 2001)
MoPH	930	930	1	
WHO EMRO emro.who.int	443	425	175/67	320 / 74

The search was conducted in August and October 2016. An overview on interesting qualitative and quantitative data can be found on the digital device in the appendix.

ii Questionnaire for semi-structured interview

	Name: interviewer's notes: Organization Day: Time:
Issue to learn about	Question(s)
Introduction, ice-breaker	1. in the beginning I would like to ask you to provide a brief description of you, your organization and its objectives (objectives, sectors
Activities	2.1 I got interested in your organization because of …. Please can you present what kind of activities related to health your organization does?

_types	2.1.1 What aspects are covered in your programme? Which diseases? Do they also address risk and protection factors?
_scope	2.2. You have named several aspects, that serve to restore health. Does your organization also provide activities that attempt to prevent diseases and to promote health?
Specification	3. Can you please describe a little bit more about your health promotion activity (target group, provider, topics, methods to deliver, evaluation)
Concept of health & health practices	4. Taking into consideration your experiences in Afghanistan, what do you think what Afghans have in mind, if they talk about diseases and sickness? what do Afghans say when they are ill?
Success factors	5. What would you say what have been success factors, factors that contributed to achieve your goals/to realizing your project? Have you faced any challenges? How did you solve them? - Did you also have to end projects? What was the reason for that?
Challenges and coping mechanism	5. Have you faced any challenges? How did you solve them? - Did you also have to end projects? What was the reason for that
Recommendation	6. Can you give some **recommendations** for people who are interested to work in health promotion in Afghanistan? What do you suggest them to do and what do you suggest them not to do?
Future perspective	7. Looking ahead, what do you suggest what kind of activities and approaches should be realized in order to strengthen, sustain and restore health?.
(Optional)	Optional: Analyzing the health situation in Afghanistan there are several stakeholders that play a key role. In the next section I would like to ask you about your opinion on the role of the MoPH, WHO, NGOs and private health provider as well as on the BPHS and application of technical media. - What is the role of the Ministry of Public Health? - What's the role of the WHO? - What do you think about the BPHS? - What do you think about the application of media and technical devices for health promotion?
	Looking ahead, what do you suggestion what kind of activities and approaches should be realized in order to strengthen, sustain and restore health?

iv *List of Codes*

Liste der Codes

Code	#
0_introduction of the interviewees	7
further comments_often related to challenges	39
1_Vision/Mission	17
2_Activities Health related	81
specific health education/promotion	82
(IV) school	15
(V) media	4
(III) community-(health)-based	47
(II) facility-based	12
(I) nation-wide	24
3_Activities_non-health related	20
4_concept of health	43
Barriers, perception, myths	0
concept of health	0
health practice	25
protection/ressources/stressor	19
5_contributing factors	53
Afghan General	2
working features	1
characteristic NGO	1
community	0
6_challenges	65
Additional	0
sensitive topics and health practices	1
NGO-international work related	1
health system	0
social	1
prerequisites	2
environmental	0
7_recommendations	49
8_suggestions for future	32
9_success story	21
Sets	0

0 0 0 0 Einfache Coding-Suche

v Overview participants

(removed to guarantee anonymity)

vi Questionnaire organizations

“Stefanie Harsch
Research Group Afghanistan
University of Education in Freiburg, Kunzenweg 21, 79117 Freiburg, Germany

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****

Questionnaire:

1. ORGANISATION
In the beginning I would like to ask you to introduce your organization and to present its objectives.
1.1. What’s the name of your organization?

1.2. What are the objectives or mission of your work?

1.3. Where do you work?

1.4. In which areas do you work in?
(health, agriculture, WASH, emergency relief, …

2. ACTIVITIES
2.1. Please can you describe what kind of activities related to health or activities that help to create a healthy environment your organization does?

2.1 What aspects are covered in your program? Which diseases? Do you also address risk and protection factors? If yes, please describe how.

2.2. Do you also do some activities to prevent disease or to promote health or educate about health? If yes, how?

2.3. Can you please describe in detail how you work in and with communities? You can also tell us one of your SUCCESS-STORIES.

3. UNDERSTANDING OF HEALTH
3.1. Taking into consideration your experiences in Afghanistan, what do you think what Afghans have in mind, if they talk about diseases and sickness? when do Afghans think they are sick, ill and when do they think they are healthy?

3.2. Is there something that helps them to stay healthy?
What helps them to stay healthy? Do they have some resources that help them to stay healthy? What kind of resources has the community to support each other?

4. LESSONS LEARNED - SUCCESS FACTORS AND CHALLENGES
4.1. What would you say what have been contributing factors that helped you to achieve your goals/to realize your project and to be successful?

4.2. What are challenges that you have faced in your health-related work in Afghanistan or that you currently face?
How do you address these challenges? How do you solve the problems?

5. RECOMMENDATIONS
Can you give some recommendations for people who are interested to work in health promotion in Afghanistan? What do you suggest them to do and what do you suggest them not to do?

6. FUTURE
Looking ahead, what do you suggest what kind of activities and approaches should be realized in order to strengthen, sustain, and restore health?

7. FURTHER COMMENTS
In your opinion is there anything else people should know about health in Afghanistan?

8. ONE SUCCESS STORY
Can you provide us with a success story of one of your health promotion approaches/health-related activities? This will help to get a better understanding of your great work.

****

Additional questions concerning the use of these information.
I agree, that the information I've provided can be used - anonymously - for the Master's thesis.
- No
- Yes

Do you agree that we share your success story with other organizations?
- No
- Yes

Would you like to be put in touch with other organizations that work in the same province or on the same topic.
- No
- Yes
****

Congratulation, thank you very much for taking part in this study!
Your contribution is of great value. We appreciate it a lot.

vii Overview of Organizations

Several organizations	
Afghanistan National Public Health Institute	Trains health professionals
MSH	Msh.org
Central Statistic Office	
AREU – Afghanistan Research and Evaluation Unit	(Waldman et al. 2006)
jhpiego	(jhpiego)
Samuel Hall	
Central & South Asia Archives	(Samuel Hall)
reliefweb	(reliefweb)
Silk Route Training and Research Organization	(Silk Route Training and Research Organization)
general	
The Asian Foundation	
The Asian Development Bank	
Central Statistics Office	
World Bank	

Health Protection and Research Organization	Hpro.org.af

viii **_Overview of findings_**

Website N=88	only indirect N=73	Not N=93	Total = 254
N= 7 database		N=21 ANCB	
N= 20 not relevant N=6+7 +16 not found N=4 +3 asked N=6 ANCB not relevant N=20 only Facebook ANCB	N=19 ANCB N=54	N=72 (also under construction)	

ix **_Overview of Activities, structured_**

General description of activities in Afghanistan, category, and parts	provider	Na.	Facil	com	school	urban
0. General programs	health related (I8) PLA (A3)					
0.1.1. Basic Package of Health Services-BPHS-SEHAT - Essential Packages of Hospital Services (EPHS) (A15, A18) - innovations in BPHS project - complementary programs in addition to BPHS (I13)	A1, A7, I9, I6, A18, BARAN, I13, i12A15, A6, I7, A1	X	X			
0.1.2. *government support (A3)* - *LMG Leadership, Management and Governance Project* - *HSSP (Health Service Support Project)* - Health Sector resilience (strategy (Karimi and Kabul/DOC) - Organizational and Human Resource Capacity Strengthening - Public Private Partnership; (policy for private health care provider) (CAF) - partnership contracts for Health service (AHDS) - Civil Society Organizations Support Partnership with For-Profit Private Health Service Providers (ACTD) - Result Based Financing (RBF) (Jul 2015 – June 2018) (A18)		x	x			
0.1.3. Registration, Surveys, studies, research (A15) o registration of all midwives also used for refresher training (I15b, 5) o monitoring, screening, DOTs (A18), o Screening beneficiaries, treatment phase, referral mechanism (I4) o referral sheets (for diagnosed beneficiaries to another health facility) (I4) o community resource mapping and mobilization RMM (Health net TPO) o Monitoring and taking responsibility for e.g., sanitation situation (by CDC) (A6) o community based register (I15) o e.g., National Mental Health Survey; cost of BPHS, assessment of referral system o operational research (I12) o ethnography study on injected Drug users (I15b), exploring service delivery for men sex men (I15b)		x	X	x		
0.2. General capacity building (A7) - Capacity development project (CDP) (CAF) - medical storage (HPIC)	also, OHPM	x	X			
0.2.1. medical doctors (G6, I1) - improving education: medical books (Afghanic e.V.) - capacity building of medical doctors (medica mondiale: doctors of hope) - training medical staff (medicalteams) - fistula procedure (CURE, Fistula Foundation); Cleft palate surgical training (CURE) - training in neonatal care (I11) - support institute of health sciences (I12)	I12, Ibnisina	x	X			
0.2.2. CME/CHNE (nationwide programmes) - Community Midwifery Education Program (CME) - Community Health Nurses Education Program (CHNE) initial training and follow up/refresher training: improving how patients are perceived & their follow–up care - Midwife assistant (A22)	I15, I12, BARAN, BDN, G5 with cap anamour, MMRC, I8, A14, I10, I13	x	x	X		
0.3. Community Based Health care (CBHC) project - Community-based health and first aid (IFRC - comprehensive community health intervention (I5) - community-based workshops on health and hygiene A22, A6, I12 - community health workshops (when requested and resources allow (A22) - community mobilization pilot project (CAF)				X		
0.3.3. community capacity building: - family health house (AADA) - health committees (JVC) & community health council (ACTD) - Community development Councils (CDC) - family health action groups (FHAG) (I14b)	CHW training A12, A18			X		
0.3.3. Trainings: CHW, training health workers, and providing technical, methodological and financial support.	MTI, A6		x	x		

- CHP (community health promoter) (BRAC) - hygiene promoter (A6) - volunteers: I5						
0.4. tele/mobile - mobile health (m-health) initiative - mobile health technology for three purposes, to be learning the resource package for the community health workers, to use for emergency referral, and for the reporting purpose (I15b, 5) - TELE - health information centre - health care telephone helpline 199 - HIV prevention: eMOCHA(R)--based mobile health application (JHCfCGHE) - connecting health care facilities (ROSHAN) - ipso-e-care (connecting clients with counsellors) I2, 4) - for health education at family health house community midwives (I15b, 5)	(I15)		x	X		
0.4. mobile health teams: (2 types) (I13, 27) - regularly outreach, (ii) in response/prevent the emergency cases (CAF, NCA); to support un-served/ conflict areas (CAF), for conflict-affected people and IDP (WHO), IDP in slums (SHRDO) - temporary static health clinics (WHO/PU-AMI) - Healthcare & Establishment of HSC for White Areas & IDPs (AHDS) - also integrated management of severe acute malnutrition (I15b) - 0.5.2. Mobile Cinema Outreach Programs (ASMO)	A7, I5, I15b			X		
0.5. Supply, Equipment • distribution of medicine to home - of vitamin A, multivitamins and deworming tablets (A22) - primary laboratory (malaria, sugar, cholesterol, triglyceride and microscope tests) (A19) - distribution: Basic Health Kit (AVDA, WHO) - providing aid materials… (G3)			X	x		
0.4.2. media - IEC material - BCC material (A18) - AIL videos - speaking out about women's violence (BRD) - drama "Realize your Rights" (BRD) - TV & radio program focussing on knowledge, attitude and practice change, interactive (I1) - health education via radio (tearfund) - challen TV (I9) - radio broadcast 16 hours of health messages ACTED (also radio awareness raising: AKF - awareness raising for soybean (A5) - books: "good books" (operation mercy) - magazine (DAO)		x	x	x		
0.7.1. general: providing health education and hygiene promotion 0.7.2. Health Promotion/Education Strategies - COMPRI-A Communication for Behavioural Change (BCC) (2008-2013) (A3); (USAID 2010, USAID and Nayib 2010) - participatory learning and action methods (PLA) 0.7.3. comprehensive community health interventions (safe drinking water, latrines) (I5) 0.7.4. campaign: World physical therapy day; gulran diseases (Move 2008); global hand washing day (A4); global pneumonia day (WHO), CHW Day (HSS 2015), world mental health day (I1) (Rand 2006)	A7, I5, IFCR, I12	X	x	X		
0.7. construction of CME school (I15) - construction of Health (I8) and education facilities (IOM). - Afshar hospital (AMOR) - health sub centre, also healthcare (subcenter) in white areas; integrated health post (MoPH Arwal) - Hospital (I5, I7) (ca. 100 deliveries per day/26,000 in 2013) (G5) - clinics (G1, G4) - extend clinic in the border regions for refugees (I15b) for treatment and awareness raising about health care services in Afghanistan - (Clinic with treatment for widows and orphans of the program A22, 18)	A22		X			
0.8. general: life skills: Learning for Healthy Living project (SCA 2015); LCEP - vocational training, health education and literacy (childrenincrisis) - life skill training for rural women (AADO) - Life-skill education (Echavez et al. 2014) - health and literacy courses (SHAO) - Women's right to Life and Health Project (UNICEF) - mother's dinners (save the children) - income generating - some health messages integrated in education and vocational training (A22) - basic courses (literacy, numeracy, life skills hygiene) (A8, 37) - General awareness raising (legal rights and access to health services) (HAWCA)	A8			X		
0.9. additional cultural sensitive programme (I8, 10) - training cultural field workers who set up cultural container (I2, 4) - blood donation - MoPH: printing leaflets for raising awareness on blood donation - various strategies (SHOA)				X		
1. Maternal and child health	I10, I5, I12	X	x			
1.1. BPHS*; e.g., ANC, DC, PNC, FP, CotN	A15	x	x			
1.1.3. Maternal and perinatal surveillance system (BABIES) - birth registration mapping (ACTD)			X			
- family health book (JVC) —> identifying frequent patient and visiting their home to promote health habits						
general "mother and child programmes'/	I5					

1.1.2. provision of health services to lactating and pregnant women (A18) ▪ provision of maternal and child health instructions ▪ promoting hygiene, improving knowledge and teaching about first aid (A12) 1.3.1. integrated maternal and child health nutrition project (IMCHN) ▪ integrated child survival package;			x	x		
specific program ▪ Opportunity for mother and infant development = OMID (CARE 2011); CDD cf. Coleman Maternal Health in Afghanistan 2011 ▪ Better health for Afghan mothers and children (2008-2014) (I15)			x			
▪ BLiSS – Birth and Life Saving skills; (A12) ▪ home based lifesaving skills (I15) ▪ door to door visits (also including counselling) (I14b) ▪ timed and targeted counselling (I15)	A12			x		
1.1. support groups: (A14) 1.1.2. women ▪ expectant mothers workshop (AIL) ▪ Breastfeeding Support Groups (CAF); ▪ safe motherhood group ▪ social support (A14) 1.1.3. men support group				x		
1.5.1. infrastructure ▪ Maternal waiting room (UNICEF 2013) I11, 16) ▪ Comprehensive RH/EMOC (emergency operation centre) (CAF) ▪ Aino Birth Centre (AHDS/WHO) ▪ maternal and neonatal care unit (in Herat G5) I11 ▪ EmOC (Emergency Obstetric Care) Centers in the provin, (UNICEF cf. CMI-Report 2005)	UNICEF		x			
1.5.2. equipment - Embrace Nest (a form of incubator) (HEEDA) - Maternal delivery kits (medical teams international) - Preparation of Sputum collection box; Construction of incinerator for Diakundi 1.6.2. material: pictorial: menstrual hygiene; chlorhexidine radio spot, MNCH (MoPH)			x			
1.8. additional 1.8.1. funding programs to help women and children to get access to medical treatments in clinics - funding program for treatment for obstetric fistula patients (CURE, Women's hope international) 1.8. 2.. transportation: - donkey saddle (HealthProm) - also providing transportation in case of emergency (I14b, 30) 1.8.3. gender based (IMC), (I14; I1; Healthnet TPO) ▪ Gender-based violence: 'one step assistance centre' ▪ "women's shelter" (I2) - training on gender (I14b, 32)	A12					
1. Child health						
1.1 BPHS*; training of CHW on special topics); EPI; IMCI; - CHW education (pneumonia, diarrhoea, fever) - BASIC (Basic Support for Institutionalizing Child Survival); Child Survival (I15) Carvalho 2013) - EDC - Early Childhood Development Programme) - infant, child and adolescent health including IMCI (MoPH 2009a/BASICS)			x			
1.1.1. Immunization/ vaccination; vaccination campaign (e.g., NCA) Expanded program on immunization (EPI) (often main focus on children under 5 and women	A19, I10, 14, I11, A15					
1.2. Community Integrated Management of Childhood Illness (C-IMCI) (MoPH/BASICS) - child well-being committees (CBWCs) - child focused health education (CFHE) (ANCC)			X			
- early literacy to promote health and well-being (A16) - Mercy Little Caliph (preschool education, immunization, daily meal supplements at clinic) (Mercy Malaysia) - "children's house" - child friendly spaces for conflict displaced IDP (against violence, neglect, exploitation, abuse)			X	x		
1.2. School: Food security and nutrition program (ICT), • 1.5.1 healthy school initiative (UNICEF) (Abolfotouh 2006), • School in a box (A11, 22) • Learning for Healthy Life (LHL) (Cordaid); Health in School (HIS-Initiative) • training school health promoter (NAC) • 1.5.2. School sanitation and hygiene (UNICEF), A11, A4 • promotion physical activity in schools, school sanitation and hygiene (UNICEF/SHAO); (WHO 2007) • 1.5.3. School Health & Nutrition (Cordaid 2015), • healthy eating promotion campaign (I15b) nutrition program (MAIL founded by FAO) • School health nutrition: School Meal; food for learning • 1.5.4. Mental health awareness through trained teachers (I1, 8) • Mental health prevention (I1, 19) • 1.5.5. Dental assistance classes (A2) • Who "oral health" campaign 2013 in Kabul (EMRO) • 1.5.6. Mine Awareness, (Knudsen 2013 - the challenge of mine awareness education for children • 1.5.7. First Aid Training in Schools (JVC)	I8				x	
1.3. Equipment: education and health kits (ANCC)					X	
1.4. "Ambassadors for change and awareness" (Samuel Hall) - "Youth Information Centre" and "Youth Information and Contact Centres YICC)"				x	x	

- Young children: peer-to-peer support techniques to empower young people through condom education, interpersonal communication and motivational talks encourage the clients to visit the MHCs for further medical advice and check-up (HIV/AIDS, STI education and prevention, and sexuality). (YHDO) (also I5) - Youth help line (AFGA), child health line (A8) (topic: seeking advice, counsel, reporting cases of abuse, referral to relevant service provider, free of cost) (A8, 33) /AFGA)						
1.5. Additional: Surgery: special screening, transfer to Germany and treatment phase (approx. 50-100 students) (G3) - surgery for children with heart disease (I5) - Health Journal activity: writing essays on health-related topics (JVC) - circumcision ceremony (TIKa) - sport: football, cricket (Afghan Youth Cricket Support Organisation)	G3					
3. Public Nutrition	I8, I12, I16					
3.1. Policy Papers: BPHS*: prevention and assessment, nutrition during lifetime (MoE) - Infant and Young children feeding (IYCF) (CAF), A18						
3.1.1. 1000 Days Nutrition campaign project (CAF) o Food security and nutrition program (ICT) (I8) I15 - Baby Friendly Village Initiative, nutrition focused project (I15b) Supplementation: Therapeutic Supplementary Feeding Program (TSFP); (A19, I9) - expanded nutrition programme (Medair) - Targeted Supplementary Feeding Program (ACTD)						
3.1.2. Survey KAP; Baseline nutrition survey - Baseline Nutrition Survey (SMART methodology) (ORDC/AHDS) - Rapid nutrition assessment (I15b) - Survey: community-based growth and monitoring programme (Mayhew 2014)		X				
1. Fortification MoPH2010)	(MoPH2010)					
3.2. teaching nutrition; (capacity building of the implementer and health workers (I15b), preservice training-diploma in nutrition) (A15) - Teaching safe application of pesticides, herbicides (A13) - intensive nutrition programme in clinic on food preparation, nutrition, cooking instructions			X			
3.3. Community based management of Acute Malnutrition: CMAM (CAF; AHDS) - Integrated Management of Acute Malnutrition (IMAM) - child integrated management of acute malnutrition CIMA (I15b) - Out-patient therapeutic programme (OTP) (ACF) - food demonstration in village (I15b,5) - training on adequate food storage (A11) - PDR sessions (women's group with focus on providing treatment for malnutrition (15b,5				x		
3.4. Micronutrient campaign (CAF) - distribution for children 6-24 months (I15) - pregnant & lactating women (supplement iron folic, zinc, Vitamin A & C) Iron Folic Acid (IFA) use among pregnant women (CAF) - weekly iron folate supplement program (Flores-Martinez et al. 2016, USAID) - zinc MoPH 2008b, I15 - Enhancing Community Access & Utilization of Zink and ORS (USAID, ACTD) - ORS (USAID 2016a) - Vitamin A and multivitamins (A22) - multi nutrient powder (GAIN)	MI, MTI, A15		X			
3.5. infrastructure: availability of therapeutic feeding unit (TFU) (ACF) 3.5.2. Ready-to-use therapeutic food (RUTF) (ACF/mercy Malaysia - BP-5 high -energy biscuits for pregnant, lactating women and malnourished children (A6) 3.5.3. MoPH material on nutrition			X			
1. environment: Soymilk factory (A5) cultivating and introduction of soybean as a natural rich protein source for defeating malnutrition	A5	X				
3.6. dental clinic (shelter now); (DV) dental: dental care; clinic in Kabul, shipping container with dental supplies; plan: school for dental laboratory technicians mobile dentist, visiting clinics regularly & providing dental health education in schools (G1, 37)	A19, A2	X				
3.7. food for work WFP mixed food basket food assistance programme (ANCC) 3.7.1. Soymilk factory (A5) ▪ cultivating and introduction of soybean as a natural rich protein source for defeating malnutrition - Soybean to combat malnutrition (A5) - Train farmers, women through TOT, opinion leaders, CHW on soybean (A5) 3.7.2. poultry-keeping A6 (chicken-hatching machine not sustainable: I15b) - chicken egg distribution (I15b) 3.7.2. strengthen interlinkage between agriculture high schools and local communities (A13) (A15) 3.7.4. environment: kitchen garden or small green house (I15) (A6) - School garden (MAIL, GAIN) 3.7.5. Fortification MoPH2010)						
4. Sanitation and Hygiene: -Exposure, - burden of disease, - hand washing with soap						
4.1. MoPH material on hygiene, diarrhoea, safe water - MoPH on hygiene, diarrhoea, safe water						
4.1.2. Afghan Sustainable Water Supply and sanitation Project (SWSS) (CAF, OHPM; I11 - Participatory hygiene and sanitation (PHAST) - Hygiene: Health and Hygiene Promotion Project (HHPP) - integrated Public Hygiene and Water Sanitation project (A6)						

4.1.3. WASH need assessment (environmental factors and waterborne disease) (A6) • KAP Survey on Water sanitation and Supply project; formative research on communication mechanism (UNICEF) • Formative Research on Communication Mechanisms Related to Water, Sanitation and Hygiene under funds from UNICEF (Jun 2012 – Mar 2014) (ACTD) • monitoring and improving sanitation situation by Shura leaders (A6) • train how to supervise appropriate hygiene practices in school (A11) • test water quality (A11)						
4.3.1. training women as village hygiene promoter (FutureGeneration) - Students as knowledge ambassadors (A11) (A6) - water committees/ hygiene committee (if possible mixed gender) (HAPA, A6) 4.3.2. Health and Hygiene promotion/hygiene education (I5) (A9, IFRC) ▪ community water, health and hygiene education course (A6, 44) - Hygiene education at schools (part of education) (A11) ▪ education program including some hygiene education 4.3.3. community led total sanitation (CLTS) A6 ("focuses on collective sanitation analysis, sudden behaviour change, and making the village ODF" (A6, 49) A9 (Siegler et al 2015) - clean village project (MMCR) - community-well rehabilitation project (A12) - building latrines, kitchen, washrooms				X		
4.5. construction of (drinking) water(storage) tanks - water filters - Water supply project, (e.g., shallow well, deep well, water net supply A7) Peshawar-Kai, ANCC - canal cleaning 4.5.2. Kit: Basic hygiene supply kit	(TF)			X		
4.3.4. equipping schools with WASH (A11, !4, I11 - using UNICEF WASH program adapted for school setting, 3 days (A11) - creating a 3 months' action plan of intervention for school (A11) - hygiene groups in school (A11, 25) disseminate information and coaching appropriate behaviour - menstrual hygiene (HDP - MoPH); gender-sensitive school approach (A11, 26)	A11, UNICE_F				x	
4.9. general: water treatment unit for flood-prone province (delivers drinking water) (WHO) - focussing on empowerment of vulnerable communities (A6, 45) - Friday Cleaning Campaign (MoPH Arwal)						
5. Non-communicable diseases: - cancer; - cardiovascular diseases, - chronic respiratory diseases			X			
5.6.1. cancer (ASAC) (Faqeerzai 2016)			X			
5.6.1. medical check-up (Mahobas' promise)			X			
5.6.2. diabetes ambulance (HDAA 2011)			X			
5.6.3. comprehensive heart disease project (children with heart defect —> surgical care)			X			
5.6.4. Awareness on physical exercise - Support of physical activity even for girls (I11, 16)	A19		X			
6. Disability, injury prevention						
6.1. BPHS*: awareness, prevention and education; provision of rehab. Services, identification, referral, follow-up						
6.1.3. survey to identify barriers to free access for people with disabilities in Kabul (DAO)						
6.1.1. promoting recognition and inclusion of rehabilitation in MoPH policies (HI)						
6.4. Social Promotion in Afghanistan, People with Disability Program (CAF) addressing social norms/behaviour AOAD; disability awareness (SGAA), speaking out for rights of PWD						
6.3. community-based rehabilitation of PWD (UMCOR/IAM)						
6.2. o empower people with disabilities (ALSO, AOAD), employment opportunities, support programs for pwd to find a job o rights and disability awareness training; Leadership and Management trainings (DAO o workshops for landmine survivors (DAO) o workshops: physiotherapy, orthopaedic, component (SGAA) A15 o assisting people with disabilities (A4)				X		
6.5.1. addressing infrastructure (accessibility, building ramps AOAD), - rehabilitation centre (HI, DAO 6.4.2. resources for people with disability, victim assistance (HI) orthopaedic: provide orthopaedic device (SCA) donations from other countries e.g., wheelchairs, walking support devices, prosthesis, medicine, glasses, clothes, blankets, splint, (G3, 17)	G			X		
6.6. media: production of Dictionaries on National Disability Terminology (DAO); production of 'Gadoon' bi-monthly magazine (DAO) - production of TV and radio programs (DAO), domestic violence: video Healthnet TPO						
6.8. blindness: identify blind women; work with local Afghani hospitals and clinics to o Fund publishing of Braille textbooks; provide crucial medical treatment and psychosocial services; - deliver educational supplies for blind students; Train teachers at blind schools (ABWC) - - eye: university eye hospital; school screening project; general eye-screening 6.8.2. bicycle training program (AABRAR); Disabled Cyclist Messenger service (AABRAR); afghan cricketers with disability (ADVS 2014) 6.8.3. Rehabilitation of Hansen's disease patients, sandal distribution (Peshawar Kai)						

6.8.4. provides children with literacy recreational activities with different physical games to keep them busy mentally (Aschiana)						
7. Population Growth						
7.3. Accelerated Contraceptive Use Project (ACU) (MSH)				X		
7.4.1 prevention of immature marriage - forced and/or early marriage: video clip	A7				X	
7.3.1. family planning (CAF/MSI) (A19, (Huber et al. 2010), I7, A15 - Reproductive Health (ACTD)					X	
7.4. adolescent sexual and reproductive health (ASRH) (WRDOAW) - Youth Advocacy, policy and RH information and service project (AADA) - Comprehensive Sexuality Education (AFGA) (I3) - providing sexual productive health education (in schools and madrassas) (I3, 7)					X	
7.5. Minimum Initial Service Package for reproductive health in crises (MISP) (WRDOAW) - increase access to contraception (I3)				X		
7.4. Family Health Worker Project (OHPM)				X		
8. Environmental Health: - climate change; - household air pollution, -lead, (-occupational risk factors), -outdoor air pollution, -second hand smoke, - UV radiation, (-WASH)						
8.3. environmental burden of disease. DALYs/1,000 cap: 255; Deaths:176 800; 33% of total burden — mainly: respiratory infection, diarrhoea, asthma (WHO, Genf 2009)						
8.1.3. assessment of needs in the villages				X		
8.8. self-immolation (AIL), I9 - creating awareness - burn centre in Herat (I9)					X	
8.4. in city: such as waste removal from city streets, road gravelling, ditch cleaning, park rehabilitation) (CARE)					X	
8.4. waste collection and hygiene composting (HIA 2008)					X	
8.5. bio-sand filter (tearfund)				x		
- lead (operation mercy)				X		
8.3. addressing environmental hygiene and sanitation (A4)						
- providing a green, recreational area						
9. Communicable Diseases						
9.1. BPHS*, TB control, malaria control, HIV/AIDS prevention Day campaign, immunization, deworming campaign	A18, for IDP: A6					
9.1.3. DEWS surveillance system; campaigns about malaria, tuberculosis, Polio, HIV, surveillance: communicable disease control and DEWS-Surveillance, general screening living areas for mosquitos						
9.4.2 pictorial books: diarrhoea, cholera, ARI, pneumonia, infection prevention: video: radio spot: pneumonia, infection prevention, cholera, measles (all in Dari and Pashtu)	MoPH					
9.4.1. Health education and promotion based on the MoPH guidelines and other international organisations	A18					
9.8. Targeted approaches: IDU, prisoners				X		
9.5.1. Tuberculosis: Community Based identification of TB cases, referral…) CBDOTs (A18); TB control Program (Global Fund, MMCR, ACTD) - TB Challenge (BDN) - TB CARE (CHA) - TB CAP (Tuberculosis Control Assistance Program), anti-TB service A6(ORCD); billboard installation, media/radio spot regarding TB	A7			X		
9.5.2. Polio: national polio eradication; _polio eradication initiative, _3P Polio Peace Partnership	(Shaikh et al. 2003, WHO 2013)					
9.5.3. malaria (MMCR, Healthnet TPO): - Community based Management of Malaria project (CAF), - Malaria Roll Back Program (CAF); - distribution of Long-Lasting Insecticidal Nets (LLIN); Bed net protection (MMCR) - setting up malaria Lab facility and hiring lab-technician; Malaria Control (Training and Capacity Building) (ACTD),	(Human rights watch, Kolaczinski et al. 2004 & 2005, J et al. 2004), A15			xx		
9.5.4. HIV: _capacity building of civil society to provide HIV prevention and sexual health related services; _HIV drop in centre; national aids control program (HACCA 2013); _safe national blood supply via the Afghanistan National Blood Safety and Transfusion Service (ANBSTS), _mobile blood collection, Laboratory, surveillance (CDC); _targeted intervention among IDU; _harm reduction for female prisoners (SAF), community-based and Night Shelter Service (SAF), prevention of parent-to-child transmission in hospital (UNICEF), Peer Education Program (PEP) and outreach Services, _youth program at schools (I5),_harm reduction program (including training and provision of harm reduction kits (I9, 17), testing (I9), _working on discrimination (I9, 19), _treatment and also anti-retroviral therapy (I9, 19), comprehensive therapy (I9, 19) _suggestion of successive reduction (stop drug using going to smoking to oral substitution therapy - reintegrating in society finding work (I9, 19) _service through peer workers (recovered addict) at hotspots (I9, 19 HIV/AIDS strengthening provincial HIV Program (I9) focussing on truck drivers in a clinic installed inside the truck driver terminal at the Afghan Iranian, Afghan-Turkmen border (I15b): awareness raising, testing, treatment, counselling daily shelter for IDU (I15b)	A19, A7, I9, I15 (IMF 2008, MoPH 2007, HACCA 2013)		x	X	X	

detoxification centre (closed) (I15b) female sex workers, very sensitive topic (I15b) prior STD/HIV (AIDS service for detainees and prisoners (I15b) MoPH_Program: National HIV & AIDS Control program: 10 voluntary Counselling and Testing centre, 15 Drop-In-Centres, 2 ART Centres						
9.5.5. Zoonotic diseases (RI)						
9.5.6. Deworming campaign/ provision of medicine (A22), UNICEF						
10. Mental Health	Healthnet TPO, IPSO, IAM, Wassa, A15					
10.4. BPHS* education and awareness; case identification, diagnosis and treatment						
10.1.3. research in clinical mental health (I1) - some pre-post evaluation (I2; I1)						
10.2. Training of healthcare professionals: MH training centre: Herat and Mazar (IAM) also I2, A15 - training influential people as trainers (teachers, mullahs, police workers, government workers) (I1) - training in psychological first aid for medical staff (Pu-ami) - develop manual for psychosocial counsellors (I2) - (psychosocial) training of teachers (Omidian) - training for CHW I2	I1					
10.5. clinic (I2)						
10.5. Psychosocial counselling (Johanniter) Medica Afghanistan - preventive psychoeducation (I2)						
10.4.2. Psychosocial support - for EDP (ACTD) - general social support (I14b) - online psycho-social counselling service (I2)						
10.3. community mental health project in Herat (IAM) - community counselling service						
1.1.1. translation material/guidelines - counselling centre, (I2) - mental health support of orphanages, mental health training material/workshop (APMO) - validate all material by government (I1)						
10.4.1. awareness raising - focus on rights and stigma associated (I1, 15) - mental health literacy and awareness raising advocacy project (—> addressing barriers on the community level) (I1, 8) - advocate for mental health (I1) - (re)activate mental health focal points, some closed due to political issues (I1)	A19					
10.8. integrating children with epilepsy in mainstream school (I1) - Healing Classroom Approach (A10)	I1					
10.6. mental health magazine (I1) - material for teachers to teach to students (I1) - Billboards in the city with simple messages (I1)	I1					
10.8. o visiting certain locations o trauma sensitive approach						
11. Occupational Health: -Airborne particulates, -carcinogens, - ergonomic stressors, - noise, - risk factors for injuries						
11.2. provision of health cover, on-site healthcare (Afghan Action)						
- free meal for staff (Afghan Action)						
- working with local employers and establishing workplace safety standards, - training employers (A8, 34 f.)						
11.3. physiotherapy: physiotherapy clinics (AABRAR) also (SCA, HI)						
12. Substance Abuse						
12.2. treatment and rehabilitation Programme (ACTD) - drug treatment (WADAN) - harm for reduction for injected drug users (Todd et al. 2015) (I9)						
12.4. "instruction" on "avoiding tobacco, snuff, hashish and heroin"	A19					
13. Pharmaceutical Affairs						
1.1. severalstrategy by MoPH 13.1.2. Development of Standard Operating Procedures (SOPs) (HPIC)						
13.2.1. pharmaceutical supply chain: - support of central polyclinic in Kabul, (OR - shipping medicine and providing drug supply for the clinics - emergency health service clinic 13.2.2. Capacity building and access to medicine projects (CBAM) (HPIC) - capacity building for workers in pharmaceutical area (e.g., Central Medical Stores);						
14. Disaster Response	A7					
14.1.2. General disaster response (G3) - Healthcare for Returnees and IDPs (AHDS)						

- Emergency Assistance to Disaster and Conflict Victims (SCI/ECHO); Emergency Mobile Health Services (ACTD), ambulance (A1) (I15b) - Improve Access to Emergency Health Services in High-Risk Province (AHDS) - surgical centres for war victim (several locations) (Emergency) - Winter emergency aid						
14.2. Community Based Integrated Disaster Risk Reduction Program (CBDRRP) (ACTD, OHPM, IMC)				X		
14.2.1. training on mass casualty management simulation (WHO); training on emergency preparedness and response (WHO) - first aid training (also for delivery complications) (A12)						
14.5. Physical infrastructure and equipment 14.5.1. trauma centre, first aid trauma posts (A1) - microscopic diagnostic facilities in high-risk areas /ACTD) 14.5.2. material o distribution of Basic InterEmergency Health Kits (IEHK) (WHO) - Distribution of further items e.g., food, blankets for refugees… (I4, 24)						
14. Special group						
○ prison clinics (SCA/ACTD						
○ health for Nomadic Population						
○ Externally Displaced Population (ACTD)						
○ IDP: Healthcare for Internally Displaced People (IDP) (I14						
○ orphans (screening, treating, referral)	I4, 22					
○ support of people living in marasstron	G3, 19					
○						

x ***Reasons for work that work that was unsuccessful***

What could not be done	
Establishing maternity service in village	Requires technical skills, qualified doctors → created awareness campaign television
Continuation of burn unit 3 years in Herat (self-immolation) (11, 47)	Lack of financial support
Working outside of Kabul (G2	
Intersectoral collaboration	Very less involvement of other sectors (A1, 26)
Health training for girls (15-18 years) in public is too sensitive	Organizing program → topics emerged from questions. Choosing school to discuss cultural taboos (A11
disaster prevention (deteriorating security situation)	could not continue, low interest in disaster prevention —> they were interested in participating in economic life, survival of family, livelihood security, urbanisation … (A21)
continuation of a clinic	corruption, sudden need for paying taxes for the last 10 years (G1, 13)
continuation of a project	Afghans worked differently than the Afghan/German project donor expect (G1, 13)
having large project (component of training health professionals in mental health)	too large to focus, did not work out, not continuation after end of funding cycle