



**Islamic Republic of Afghanistan**



# **Strategy for Disability and Rehabilitation**

**4 Year Strategy  
1391 - 1394**

**A strategy for the  
inclusion and  
improvement of  
Disability and  
Rehabilitation  
Services within the  
Ministry of Public  
Health.**

**Ministry of Public Health  
Disability and Rehabilitation Department**

## **Appreciation**

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- MoPH Disability and Rehabilitation Department
- Disability Task Force NGO and DPO Members
- UN Afghanistan Disability Support Programme

## Foreword

The wars in Afghanistan have resulted in many victims, people in need facing physical, social, economic and psychological problems that involve their families and the whole of Afghan society. During these years of war, Afghanistan has experienced a breakdown of medical and social infrastructures leaving many ill or disabled due to lack of prevention and treatment facilities. The National Disability Survey of Afghanistan estimates that at least 2.7% of the population (approximately 750,000 people) is severely disabled. This number is large and exemplifies a critical need for physical and social rehabilitation programmes throughout Afghanistan.

Disability is complex issue in any country as the needs of persons with disability span a wide range of services and opportunities that are often interlinked. In Afghanistan the complexity is increased by the lack of institutional expertise, trained field practitioners, skilled teachers, informed society and physical barriers. The remoteness in some areas and the funding to implement national programmes often prevents people with disabilities from receiving the services they need to survive and integrate into society.

The Ministry of Public Health will implement this disability and physical rehabilitation policy within its mainstreamed health services and support the provision of specialized as well as referral services through the basic package of health services providers. Crucial to this is the training of disability professionals such as physiotherapists and orthopedic technicians to provide accessible services throughout the country. Currently the number of physiotherapists trained each year does not meet the national demand.

Training medical staff and community workers will help facilitate the inclusion of persons with disability in health services as well as raise awareness with regards to rights and social standing of persons with disabilities.

The ministry has selected priorities for this strategy that will not only address specific disability related issues but which are meant to also build necessary skills and mechanism in support of all MoPH responsibilities in this sector.

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## Acronyms

AABRAR	Afghan Amputee Bicyclists for Rehabilitation and Recreation
AAPT	Afghanistan Association of Physical Therapists
ADSP	Afghanistan Disability Support Programme
AIHRC	Afghanistan Independent Human Rights Commission
ANAB	Afghanistan National Association for the Blind
ANAD	Afghanistan National Association for the Deaf
ANDAP	Afghanistan National Disability Action Programme
ANDS	Afghanistan National Development Strategy
BPHS	Basic Package of Health Services
CBR	Community Based Rehabilitation
CBRC	Community Based Health Care
CDAP	Comprehensive Disabled Afghans' Programme
CHC	Comprehensive Health Centre
CHW	Community Health Worker
CRPD	Convention of Rights of Persons with Disabilities
CRDC	Community Rehabilitation and Development Centres
CSO	Central Statistics Office
DDH	Developmental Dysplasia of the Hip
DPO	Disabled Persons Organization
DRD	Disability and Rehabilitation Department
DRPS	Disability and Rehabilitation Policy and Strategy
DTF	Disability Task Force
DU	Disability Unit
EPHS	Essential Package of Hospital Services
EU	European Union
GCMU	Grant Contracts Management Unit
GIHS	Gazanfar Institute of Health Sciences
HI	Handicap International
HNSS	Health and Nutrition Sector Strategy
IAM	International Assistance Mission
ICRC	International Committee of the Red Cross
ISPO	International Society for Prosthetists and Orthotists
MACCA	Mine Action Coordination Centre of Afghanistan
MBT	Mine Ban Treaty
MDG	Millennium Development Goals
MOE	Ministry of Education
MOLSAMD	Ministry of Labour and Social Affairs, Martyrs and Disabled
MOPH	Ministry of Public Health
NDSA	National Disability Survey in Afghanistan
NGO	Non Government Organization
NPAD	National Programme for Action on Disability
PHC	Primary Health Care
PTI	Physical Therapy Institute
SCA	Swedish Committee for Afghanistan
SERVE	Serving Emergency and Vocational Enterprise
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Council for Asia and the Pacific
UNFPA	United Nations Population Fund
WB	World Bank
WCPT	World Confederation of Physical Therapists

## Background

In Afghanistan, 60-80% of people with disabilities live in rural and poor peri-urban settings. These areas are in most cases under resourced providing limited services and programmes for persons with disabilities. The majority of services for people with disabilities are provided by international and national non-government organizations (NGO) that are donor sustained and somewhat independent of Government oversight due to the lack of infrastructure, human resources and funding within the Ministry of Public Health systems as well as other key ministries responsible for employment and education.

## Analysis of Disability in Afghanistan

### Definitions

Disability is the outcome of the *interaction* between a person with an impairment (which can be acquired or congenital), the environment (for example architectural barriers) and cultural attitudes (prejudice).<sup>1</sup> Disability is a state that may be modified, by reducing impairment, changing attitudes or adapting the environment.

Disability summarizes a great number of different functional limitations occurring in any population in any country of the world. People may be disabled by muscular, intellectual or sensory impairment, medical conditions or mental illness. Such impairments may be permanent or transitory in nature and reduce independence in daily activities or participation in social life.

Rehabilitation means to bring back something to an earlier level of structure or function that is better than the present level. Physical rehabilitation in this context refers to the process aimed at enabling persons with functional limitations because of physical impairment, to reach a level of optimal function. Rehabilitation may include measures to provide and/or restore physical functions, or compensate for the loss or absence of a function or for a functional limitation. The rehabilitation process does not involve emergency or initial medical care.

### Prevalence and incidence of disability<sup>2</sup>

The National Disability Survey in Afghanistan (NDSA)<sup>3</sup> is recognized as the most authoritative disability study in the country<sup>4</sup>. The NDSA used random samples from all provinces of Afghanistan<sup>5</sup> and gives the following definition of prevalence of disability:

*“The prevalence of disability is the proportion of persons in the overall population that is considered to be disabled”.*

The NDSA also emphasizes that the prevalence rate changes and is closely linked to a number of factors:

- Definition of disability and the choice to include or exclude certain forms of difficulties
- Level of awareness (of disability) that exists within a given cultural or social context

<sup>1</sup> International Classification of Functions - ICF, WHO, 2004.

<sup>2</sup> Information from “Disability Awareness and Physical Rehabilitation Manual for the Health Sector” Disability and Rehabilitation department, MOPH, 2007

<sup>3</sup> The National Disability Survey in Afghanistan (NDSA) implemented by Handicap International (HI) in 2005 with support from the Ministry of Labour, Social Affairs, Martyrs and Disability, the MoPH and the Central Statistics Office (CSO).

<sup>4</sup> Confirmed in official conference by CSO and Handicap International, Oct 2009

<sup>5</sup> The National Disability Survey in Afghanistan - NDSA 2006. Implemented by Handicap International 2005

- Beliefs and expectations of what these rates should be within a given context
- Underestimation of certain kinds of disability that may be hidden within a given culture (this is frequently the case with mental disabilities in Afghanistan)

The NDSA is based on an assessment describing severe disability as difficulty in everyday functions of at least one category including motor, sensory, intellectual, psychological and social functions.

Function in this sense means to:

- take care of oneself on a day to day basis
- contribute to tasks within the household (and / or breadwinning outside)
- move around and contribute to tasks outside the house
- communicate with other members of family and community
- interact and have social relations with people
- intellectual and memory abilities
- have coherent individual behavior

Good functioning also means the absence of:

- depressive symptoms, signs of psychological trauma and other psychological problems
- fits, seizures or other signs of epilepsy<sup>6</sup>

A 2.7% prevalence rate of people with a severe difficulty in at least one of these dimensions was assessed among the population surveyed. If less severe difficulties in functioning were included, the prevalence increases to 4.8 %. This means there are between 747,000 – 867,100 Afghans with severe disabilities<sup>7</sup>.

## Categories of disabilities

The NDSA defined five types of disability: physical, sensory, mental<sup>8</sup>, multiple and epilepsy/seizures. The two main types were identified as motor at approximately 37% and sensory at 26% of people with disabilities.

<b>Physical disability</b>	<b>37%</b>	Multiple physical disabilities	46%
		Paralyses	29%
		Physical deformity	12%
		Lack of one limb	12%
<b>Sensory disability</b>	<b>26%</b>	Visual impairment	32%
		Hearing impairment	25%
		Speech impairment	23%
		Speech and hearing impairment	15%

## Main causes of disability

The NDSA found that disability from birth<sup>9</sup> or acquired during the first year of life by disease or illness was reported in 26.4% of the total identified cases and is the main cause of all disability in Afghanistan. War related disabilities are the cause of almost 17% of all

<sup>6</sup> Chapter 1 of the Psychosocial Rehabilitation Resource Book, MOPH 2007

<sup>7</sup> A population estimate of 29.9 million according to UNFPA's State of World Population Report September 2005.

<sup>8</sup> Mental disability in this respect means learning impairment, not mental health problems.

<sup>9</sup> Including congenital factors

disabilities. The NDSA also found that the prevalence of mental health problems in the population with disabilities is significantly higher than in the population at large.

The NDSA also found local variations in the prevalence of disability. More than half of people with disabilities live in Central and Western regions of the country. At the provincial level the highest prevalence rates are observed in Samangan (4.4%), Herat (4.1%), Kabul (3.9%) and Ghor (3.9%). Additionally, the Southern area of the country, with lower population density was found to have a relatively higher proportion of persons with disability. This is probably due to a combination of factors such as the ongoing conflict, lower access to health services than elsewhere in the country, scarce or no qualified health staff, and the lowest levels of literacy and access to education in the country, especially for girls.

## Temporary Disabling Conditions

A substantial number of people seek physiotherapy for conditions defined as temporary disabling conditions. This is illustrated in the 2009 DRD statistic report<sup>10</sup> below:

Physiotherapy consolidated statistics report: January – June 2009			
Category of People Served	Achieved		
	Male	Female	Total achieved
Persons with disabilities treated	35974	15592	51566
Non-disabled persons treated	10923	8983	19906
Persons with disabilities referred to specialized services	4028	2361	6389
Non-disabled persons referred to specialized services <sup>11</sup>	2048	2447	4495

It is interesting to note that more than half of the females treated are defined as non-disabled and that the total number of females treated is less than half the total number of males treated. This table does not show statistics for home based support and other services from community based programmes.

Some service providers report that almost all children and young persons under 20 who receive physical rehabilitation have disabilities, while a majority of adults receiving treatment are non-disabled with temporary disabling conditions.

<sup>10</sup> Consolidated Statistics, Physical Rehabilitation services: DRD, MOPH October 2009

<sup>11</sup> Non- disabled defined as temporary disabled e.g. low back pain, fracture of limb.



## **Problems and Constraints**

### **Coordination and Technical Capacity**

In the absence of strong central and provincial Ministry of Public Health control, the service providing NGOs and ICRC have had autonomy in terms of location, nature, and standard of service. Responsible agencies have made commendable efforts over the past years, during conflict and with changing authorities, to coordinate and collaborate with each other as well as with the MoPH towards achieving coherence in approach and equitable provision of care for persons with disabilities and for those with more temporary problems.

The reality remains that services are not equitably distributed across the country for complex reasons such as security, lack of proper needs assessment, and lack of coordinated referral systems. The result is that some persons in need of rehabilitation cannot access services, are not well informed about what services are available, lack appropriate care and are often obliged to make long journeys to receive help.

The majority of rehabilitation programmes are not integrated into the health service programmes at any level financially or administratively. Additionally, there is limited reporting by agencies on home based or CBR activities that provide physical rehabilitation services to persons with disabilities. Thus the success of such activities has limited impact on the best practice of new MoPH DRD initiatives and methodologies.

### **Quality Management**

At present there is no unified national supervision by the MoPH, on job or supplementary training or quality assurance systems for the oversight of care and rehabilitation services for persons with disabilities. Operational procedures for orthopedic and physiotherapy exist but are not standard among all implementing agencies and are not mandated by the MoPH. Standards of physical therapy practice are defined and monitored by NGOs that give such services, in collaboration with Afghan Association of Physical Therapists (AAPT). Orthopedic technicians work according to the standards of the International Society of Prosthetists and Orthotists, (ISPO). Recognition and certification of service staff are be critical for the management of standards and quality in the sector.

### **Prevention of Disability**

Limited prevention activities are implemented by the MoPH to mitigate preventable disabilities. Cerebral Palsy has been identified as one of the major types of disability among children and although there are numerous causes, better maternal health and obstetric practices can decrease the incidence. Additionally, there are few accident and injury prevention programmes including fire, vehicle, bicycle and pedestrian safety.

Afghanistan's efforts in the prevention of polio has almost eliminated the new cases of this disease, however many children with post polio conditions will require rehabilitation, as well as other conditions resulting from poor nutrition, maternal health care and lack of management in infancy. Primary and secondary prevention actions are limited and require greater emphasis.

- Primary prevention actions are aimed at preventing the occurrence of motor, intellectual, psychiatric or sensory impairment.
- Secondary prevention actions are aimed at preventing impairment from causing a permanent functional limitation or disability<sup>12</sup>.

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<sup>12</sup> Definitions from "Guidelines on physical rehabilitation services for BPHS implementers" MOPH 2007

## **Physiotherapy and orthopedic services**

The demand for physical therapy and orthopedic services prompted the MoPH to ensure the inclusion of rehabilitation services into the BPHS and EPHS packages. The greatest challenge is the scaling up of training for professional rehabilitation staff, in particular physiotherapists. The Disability Task Force recommends a minimum of 775<sup>13</sup> physiotherapists be trained, but this is a minimum figure and will not provide maximum service implementation.

Scaling up training requires the decentralization of activities that ensure recruitment of persons from districts without rehabilitation services promoting the expansion of these services. This is included in the latest Human Resource proposals from MOPH<sup>14</sup>. Additionally, increasing the number of qualified female staff to provide physical rehabilitation services in particular in districts outside the largest cities will be paramount for equitable service provision.

## **Psychosocial Supports**

Persons with disability often experience a variety of mental health problems due to reasons such as isolation and pain. Persons with disability often have little social support to connect them with social and peer groups, employment opportunities and education. Links to MoPH Mental Health services as well as Ministries of Labor, Social Affairs, Martyrs and Disabled and Education programmes are not well established. The creation of stronger referral mechanisms and support programmes are required.

## **Financial**

The total aid budget and finance by program for disability, mental health and drug reduction is only 1% each of the total MoPH allocation for health services as noted in the EC's Health Care Financing Study<sup>15</sup>. See Annex C for the cost estimates for funding requirements of this strategy.

## **Strategy Contribution**

If financed fully and implemented the strategy will ensure:

- Increased coordination, monitoring and reporting and quality management of rehabilitation services
- Increased understanding of the needs and realities of persons with disabilities throughout the MoPH to ensure disability is included in all policy, planning and implementation activities.
- Improved and expanded physical rehabilitation services particularly in underserved areas.
- Policies to guide and enhance provision of rehabilitation and care for persons with spinal cord injury and children with severe disabilities
- Long-term MoPH plan developed to ensure government oversight of rehabilitation services and standards of implementation.
- Prevention materials and actions implemented and mechanisms of tracking impact emplaced.

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<sup>13</sup> Physical therapy figures from the survey Physical Therapy in Afghanistan, UNDP 2006. Here was added projected numbers for CHCs, which were not accepted in the 2009 version of BPHS Guidelines.

<sup>14</sup> Proposed in "Consolidated Activity Proposals for MOPH, Programme in Human Resource Cluster" 11 August 2010.

<sup>15</sup> See figures page 41 and 42, EC's Health Care Financing Study (Op.cit.)

## **Conclusion**

This National Disability and Rehabilitation strategy for improving disability and rehabilitation services seeks to contribute to the MoPH's mission, health-related Millennium Development Goals, (MDGs) and the goals within the Mine Ban Treaty and Convention of the Rights of Persons with Disabilities (CRPD) and other national and international treaties and obligations. It will embrace and build upon different quality approaches and methodologies that have had proven success in improving the health and quality of life of persons with disability and those with temporary disabling conditions in Afghanistan and other countries. In addition the strategy intends to raise better awareness for the prevention of disabilities, and improve coordination and quality management initiatives at the central and provincial levels of the MoPH.

## **MoPH Vision for Disability and Rehabilitation**

It is the vision of MOPH to promote a barrier free society for all underpinned by the principles of participation, integration and equalization of opportunities as defined by the United Nations Convention on the Rights of Persons with Disability (CRPD) and the general health vision expressed in the HNSS goal.

*To work effectively with communities and development partners to improve the health and nutritional status of the people of Afghanistan, with a greater focus on women and children and underserved areas of the country.*

This strategy provides a set of priorities, goals and objectives that fit within the MoPH Policy Framework and will provide support for the fulfillment of MoPH vision.

## **MoPH Policy Statement**

*To improve the health and nutritional status of the people of Afghanistan through quality health care services provision and the promotion of healthy life styles in an equitable and sustainable manner.*

## **National Disability and Rehabilitation Vision**

*Persons with disabilities and others in need of assistance will have access to quality physical rehabilitation services enabling them to become positive contributors to and beneficiaries of social, health, education and employment opportunities.*

## **National Disability and Rehabilitation Mission**

*To ensure physical rehabilitation services are fully integrated or specifically provided for within mainstream services of health care and persons with disability have full access to these services in both rural and urban settings.*

## **National Disability and Rehabilitation Strategic Goal**

*To restore maximum physical, mental and social functional ability for persons with disabilities, including landmine survivors, as well as for persons with temporary impairments and prevent disability where possible, especially in children.*

## **National Disability and Rehabilitation Strategic Objectives**

The strategic priorities of the MoPH will reinforce and enhance all service provision for persons with permanent and temporary disability and will inspire the fulfillment of the following objectives:

1. To increase the capacity of the Disability and Rehabilitation Department for coordination, monitoring and reporting on Ministry and NGO implemented rehabilitation services including community based rehabilitation
2. To develop a long-term MoPH plan for the oversight and integration of rehabilitation services within the BPHS and EPHS including budgeting, referral systems, standards of care, service implementation and quality management.
3. To improve Physical Therapy and Orthopedic Services through increased numbers of professionally trained practitioners at the provincial and community level
4. To improve the psychological and social inclusion of persons with disabilities through cross sector links and referrals.
5. To enhance provision of early treatment of children with severe disabilities and care for persons with spinal cord injury and through research, strengthening of rehabilitation services, coordination among key ministries, the development of care policies and guidelines for both medical and non-medical practitioners
6. To increase prevention measures that target avoidable disabilities due to accident and preventable diseases.

## **Purpose Statement**

This strategy will contribute to the health and well-being of persons with temporary and permanent disability by increasing and enhancing the provision of rehabilitation services throughout the country. The strategy will guide actions that will promote MoPH standards and quality management of service provision as well as the coordination of services by NGO implementers and the BPHS and EPHS providers.

## **Target priorities for specific interventions:**

- The early detection, treatment and physical rehabilitation of children with disabilities or early impairments which cause severe forms of disability.
- The treatment and physical rehabilitation of persons with all types physical, sensory and intellectual disabilities including war and landmine victims.
- The training of health care professionals in the areas of disability awareness, prevention, and physical and psychosocial rehabilitation.

## Institutional Approaches

The DRD will promote a twin track approach to disability and rehabilitation support:

- Mainstreaming to ensure access to general health services at all levels for people with disability and others with temporary disabling conditions
- Support and develop specific services both centre based and at community levels for those in need.

To achieve sustainable outcomes, a focus on building strong foundations for the implementation of services, coordination between BPHS, EPHS and Rehabilitation service providers and NGOs and the related quality management mechanisms must be put in place within the MoPH DRD.

## Strategy Components

### Component 1: Coordination

To increase the capacity of the Disability and Rehabilitation Department for coordination, monitoring and reporting on NGO implemented rehabilitation services including community based rehabilitation activities.

Strategic Approaches:

1.1	Complete planned recruitment of permanent MOPH DRD staff with technical competence in physical rehabilitation
1.2	Convene regular meetings of the DRD Disability Taskforce which include the participation of all relevant physical rehabilitation providers at the national and regional levels.
1.3	Ensure involvement of people with disabilities and other patient organizations in the work of the DRD.
1.4	Information and reporting mechanisms on disability and physical rehabilitation sector established for regular reporting on ANDS, ANDAP, and MoPH DRD strategy
1.5	Establish monitoring mechanisms for physiotherapy and orthopedic professions in practice with HR policy and the National Health Workforce Plan
1.6	Participate in and support regional and international networks of rehabilitation expertise establishing regular exchanges for technical and professional advice and association.
1.7	DRD to support MoLSAMD in the development of comprehensive and standardized curriculum for CBR workers, community volunteers, community Shura and self help groups in the areas of rehabilitation.
1.8	Support the Mental Health Department in the development, implementation and coordination of psychosocial rehabilitation activities associated with physical rehabilitation activities for people with permanent disabilities.
1.9	Health service providers, education and employment sector actors are provided a directory of all physical rehabilitation services in Afghanistan

### Component 2: Technical Capacity

To develop a long-term MoPH plan for the oversight and integration of rehabilitation services within the BPHS and EPHS and the development of specific priority projects including budgeting, referral systems, standards of care and service implementation and quality management.

Strategic Approaches:

2.1	Develop guidelines, budgets and costing of the inclusion of physical rehabilitation services to be integrated in BPHS and EPHS.
2.2	Establish formal recognition procedures and standards for professions of physiotherapists and orthopedic technicians
2.3	Establish unified national supervision and monitoring mechanisms for physical rehabilitation services.
2.4	Establish a long-term plan for the gradual integration and eventual hand over of rehabilitation services to BPHS and EPHS facilities.

### **Component 3: Physiotherapy and orthopedic services**

To improve Physical Therapy and Orthopedic Services through increased professionally trained practitioners at the provincial and community level.

Strategic Approaches:

<b>3.1 Train BPHS providers in disability awareness, physical rehabilitation.</b>
<b>3.2 Physical Rehabilitation Guidelines revised according to 2009- BPHS Package</b>
<b>3.3 Disability related topics integrated into the curriculum of health staff training, in particular, nurses, doctors, Community Health Workers and health administrators</b>

### **Component 4: Provision of care**

To enhance early treatment of children with severe disabilities and provision of care for persons with spinal cord injury through research, strengthening of rehabilitation services, coordination of services among key ministries and the development of care policies and guidelines for both medical and non-medical practitioners.

Strategic Approaches:

<b>4.1 Ensure early interventions and coordination of rehabilitation and other services for children with severe disabilities</b>
<b>4.2 Ensure coordination of services for persons with spinal cord injury from emergency care to outpatient physical rehabilitation</b>
<b>4.3 Establish national centres for research and evidence based improvement of physical rehabilitation services</b>

### **Component 5: Psychosocial Supports**

To improve the psychological and social inclusion of persons with disabilities through cross sector linkages and referrals.

Strategic Approaches:

<b>5.1 Develop linkages and provide technical supports to Department of Mental Health programmes and new initiatives to ensure persons with disability are provided psychological supports.</b>
<b>5.2 Develop linkages and provide technical supports to the Ministry of Labor, Social Affairs, Martyrs and Disability ensuring persons with disability are provided referrals to social services.</b>

### **Component 6: Prevention**

To increase prevention measures that target avoidable disabilities due to accident and preventable diseases.

**Strategic Approaches**

<b>6.1 Decrease the number of avoidable disabilities in three priority areas of accident and disease prevention</b>
<b>6.2 Support the establishment of injury/disability reporting mechanism</b>
<b>6.3 Establish long-term disability prevention programme</b>

## **Institutional Framework**

### **National Disability and Rehabilitation Guiding principles:**

- To encourage people with disabilities and their families to play an active role in the development of services.
- To recognize, respect and promote the rights of people with disabilities
- To respect and build understanding of diversity
- To take into account issues of gender and disability to ensure non-discriminatory practices.
- To promote linkages between civil society, government, education, private sector and religious institutions and organizations to promote effective inclusion of people with disabilities.
- To understand that change to current practices and the developing of new capacities will take time.
- To recognize the number of organizations already working in the sector and the value of their expertise

### **Trained Community Rehabilitation Professionals and Volunteers**

There are a wide range of both volunteers and trained CBR staff that provide grassroots level social mobilization and disability awareness activities through Community Based Rehabilitation (CBR) programmes<sup>16</sup>. CBR workers and volunteers support individuals with disabilities and their families as well as provide advocacy in local government and elsewhere. Some of their advocacy task is quite similar to that of Community Health Workers (CHW) trained for the Community Based Health Care programme.

In Afghanistan CBR programmes have been implemented by NGOs for more than 15 years<sup>17</sup>. CBR is implemented in 16 out of 34 provinces (80 out of 364 districts). CBR field workers and volunteers survey villages to register new persons with disabilities in need of rehabilitation and support.

### **Trained Rehabilitation Professionals**

The key groups responsible for delivery of physical rehabilitation services are physiotherapists and orthopedic technicians and assistants to the professionals. At present there are a total of 316 Physiotherapists trained in the 2-3-year IHS recognized diploma. Of these about 285 are presently at work in their profession. There are 16 three years graduate physiotherapists in the Country. Some 2 year physiotherapists have undergone training to upgrade to the 3 year diploma, IHS recognized and MoPH preferred level of training.

Training for physiotherapists is provided almost exclusively by the Physiotherapy Institute (PTI) operating under the MoPH Institute of Health Sciences (IHS) has a national two year curriculum which was recently expanded to an IHS recognized three year training programme for Physiotherapists.

Approximately 65 orthopedic technicians trained by the NGOs or the ICRC for IHS 2-year diplomas or 3 year equivalent diplomas from either Pakistan or Iran work according to International Society for Prosthetists and Orthotists (ISPO) standards. MoPH recognition or

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<sup>16</sup> CBR was developed by World Health Organization (WHO) as a strategy of rehabilitation within the community so that people with disability and others should have easy access to services at a low cost. Recently the WHO launched new CBR guidelines that will assist countries in implementing stronger and more coordinated national programmes.

<sup>17</sup> Up until 2004 the Comprehensive Disabled Afghans' Programme (CDAP) a CBR style programme was implemented by UNOPS.

certification of this training is required. The total number of technical staff at orthopedic workshops throughout the country is 289 male and 51 female, consisting of orthopedic technicians, leather workers, carpenters and welding technicians at the 16 orthopedic workshops in 12 Provinces. At present this number is sufficient, but since large areas of the country are not covered, there is needed more staff for a more equal distribution of services.

## Facilities and services

Facilities and services are organized by various service providing NGOs who operate clinic based services as well as outreach services to patients in their homes providing basic treatment as well as advice to family members on how to train and support a disabled family member in particular children.

### Current physiotherapy service coverage at provincial and district level<sup>18</sup>

Province	No of dist.	Province	No of dist.	Province	No of dist.
1. Kabul	14	9. Faryab	2	17. Nooristan	2
2. Wardak	5	10. Bhaghlan	2	18. Ghazni	3
3. Logar	3	11. Kunduz	3	19. Gardez	1
4. Parwan	1	12. Takhar	5	20. Khost	1
5. Kapisa	1	13. Badakhshan	2	21. Kandahar	1
6. Mazar	5	14. Jalalabad	*13	22. Herat	8
7. Samangan	1	15. Kunar	1		
8. Jowzjan	3	16. Laghman	*4	* including districts with only outreach services	
<b>TOTAL Provinces: 22</b>		<b>TOTAL Districts: 81</b>			

### Current orthopedic services in provinces by implementing organization<sup>19</sup>

Province	MOPH	ICRC	SCA	HI	IAM	KOO	Total
Kabul	1	1				1	3
Heart		1					1
Khost	1*						
Kandahar				1			1
Balkh		1	1				2
Nangarhar		1	1				2
Takhar			1				1
Kapisa		1					1
Badakhshan		1					1
Ghazni			1				1
Faryab					1		1
Helmand		1					1
Total	2	7	4	1	1	1	15

\*Khost orthopedic workshop is in the process to become operative

Orthopedic centres are generally well equipped and staffed providing physiotherapy departments for women and men and the workshops produce a wide range of walking aids such as prostheses, orthoses, and special equipment for children with disabilities. Training for families in the utilization of these devices is given. Additionally, wheelchairs are produced and repaired at most centres.

Disability is also included in the Health and Nutrition Sector Strategy (HNSS) as one of the cross cutting issues specified within the ANDS. The HNSS set out the following objectives:

- Early detection of disabilities: appropriately diagnostics of new born and small children with disabilities; early treatment to counteract disabling developments such as club-feet and Developmental Dysplasia of the Hip (DDH).
- Barrier free access to general health care services for people with disabilities and access to health staff that is knowledgeable about disability and rehabilitation.

<sup>18</sup> Statistics from DRD, MOPH based on information from service providers

<sup>19</sup> From Guidelines on physical rehabilitation services for EPHS providers, MOPH 2011



- Barrier free access to special services such as audiology and orthopedic services.

Health services are outlined in Guidelines for the Basic Package of Health Services (BPHS)<sup>20</sup> and for the Essential Package of Hospital Services (EPHS)<sup>21</sup>. Physical rehabilitation services are included in the BPHS at the Comprehensive Health Centre (CHC) and District Hospital levels. However, no funds or staffing was allocated.

EPHS covers provincial, regional, national and specialized services. Within the EPHS, rehabilitation centres including orthopedic workshops are planned at provincial, regional and national levels as well as specialized services and departments for burn and spinal cord injuries. Funding and staff capacities are required to secure rehabilitation services that the EPHS and BPHS levels.

Services will be gradually implemented over the next three years at District Hospital level. This gradual implementation is viewed as more realistic due to the shortage of adequately trained rehabilitation staff, in particular physiotherapists, as well as significant lack of funding. The roll out of physiotherapy services to CHCs will follow.

## **Partnerships within the MoPH**

### *Mental Health and Drug Demand Reduction Department (MH/DDRD)*

The MH/DDRD cooperates on the development and future delivery of psychosocial rehabilitation supports for persons with disability.

### *Grant Contracts and Management Unit (GCMU)*

The GCMU promotes and plans for the financial and managerial integration of rehabilitation services and disability information and advocacy. The GCMU also provides monitoring of the steps required for rehabilitation services to be fully integrated and eventually implemented by the BPHS and EPHS providers.

### *Monitoring and Evaluation Department (M&ED)*

The M&ED assists with the development of monitoring and evaluation systems and routines in accordance with general MOPH regulations

### *Human Resources Department (HRD)*

The HRD ensures MOPH recognition of the rehabilitation professions and monitors the inclusion of rehabilitation professions into the MOPH tashkeel.

### *Policy and Planning Directorate (PPD)*

The PPD supports strategy development ensuring that the National Disability and Rehabilitation Strategy is accordance to MOPH requirements. The PPD also ensures that disability and rehabilitation services remain areas of priority within key MOPH policy and strategy developments

### *Community Based Healthcare Department (CBHC)*

CBHC is responsible for Community Health Workers who in turn provide basic healthcare services and work with the community to improve and encourage healthy life styles of people.

### *Ghazanfar Institute of Health Sciences (GIHS)*

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<sup>20</sup> A Basic Package of Health Services for Afghanistan. MOPH 2009/1388 (Third revised edition)

<sup>21</sup> Essential Package of Hospital Services. MOPH 2005

GIHS is responsible for the curriculum development and providing the quality assurance of the training of rehabilitation professionals. Regional Institutes of Health Sciences are responsible for regional training of rehabilitation professionals.

## **Ministry Partnerships**

The Ministry of Labor, Social Affairs, Martyrs and Disability (MoLSAMD) has the overall responsibility for ensuring disability services are provided by and integrated into Government policies, planning and implementation strategies. As the MoLSAMD does not have specific expertise and mandate in all areas of disability, it relies on the MoPH to provide technical inputs for rehabilitation, orthopedic, and psychological services for persons with disabilities. When required the MoLSAMD will ask MoPH to report on disability progress for the overall status of disability as well as any international treaty obligations. The MoPH is represented at the highest levels at the Interministerial Task Force on Disability chaired by the MoLSAMD and at the technical levels, the Heads of the DRD and MH/DDRD represent the Ministry.

## **Technical Partnerships**

### **European Union**

The EU is committed to supporting technical assistance to the MoPH and will play a specific and targeted role in the overall assistance to the disability sector in the country. It will support disability-related policy development aimed at strengthening the operational strategies to facilitate the implementation of disability services within the BPHS and EPHS. EU's technical assistance will support the capacity of development of the DRD staff and closely collaborate with national counterparts.

### **United Nations Afghanistan Disability Support Programme**

The United Nations Afghanistan Disability Support Programme (ADSP) is a multi-year programme implemented in cooperation with and in support of the Ministries of Labour, Social Affairs, Martyrs and Disability, Education and Public Health for the implementation of the Afghanistan National Disability Action Plan objectives towards achieving the goals of the ANDS. The ADSP will assist the MoPH in their goals of increased capacity and the development of required structures that coordinate and mainstream disability efforts that increase access and implementation of disability services throughout Afghanistan. In partnership with the MOPH, the ADSP will provide technical and financial support to the Disability & Rehabilitation and Mental Health & Drug Demand Reduction Departments that will include disability awareness, expansion of services through professional training, education, social services, and psychosocial supports.

## **Mechanisms for Coordination**

### **Disability and Rehabilitation Department**

The Disability and Rehabilitation Department (DRD) was formally established by the MoPH in 2009 after being upgraded from a Disability Unit established in 2006. The DRD aims to strengthen rehabilitation service development and coordination. DRD is tasked to ensure disability services are integrated fully into the Basic Package of Health Services and Essential Package of Hospital Services, create mechanisms for mainstreaming persons with disabilities into health care systems, and provide the standards, quality assurance and monitoring for disability services. Additionally, the DRD raises awareness with regards to disability and disability prevention. The DRD is supported in the strategy by the United Nations Afghanistan Disability Support Programme (ADSP), EU MoPH stewardship development programme, donors and non-government organizations that provide the largest majority of disability related services throughout the country.

### **Disability Task Force**

The DRD leads a Disability Task Force (DTF) of persons with technical and managerial expertise in physical and community based rehabilitation, as well as representatives from BPHS and EPHS implementing agencies and other departments of the MOPH. When required the DTF forms work groups to tackle specific technical tasks such as the production of manuals and guidelines for rehabilitation services, staffing recommendations, costing exercises, and general resource materials. This task force is centric for NGO coordination, monitoring and reporting in the rehabilitation sector, as well as for exchange of information between rehabilitation service providers.

**Action Plans:** See Annex B

### **Advocacy and Support**

Afghanistan promotes the inclusion of persons with disability in all sectors of society and is a signatory to the Declaration on the Full Participation and Equality of People with Disabilities in the Asia Pacific Region. Additionally, Afghanistan is a signatory to the Biwako Millennium Framework<sup>22</sup> for Action towards an Inclusive, Barrier Free and Rights Based Society for Persons with Disability (2002). It has ratified the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction (2003), and is a signature to the Convention on Cluster Munitions Ban Treaty (2008) both having strong support obligations for people with disabilities. Although Afghanistan is a signature of the UN Convention on the Rights of Persons with Disabilities<sup>23</sup> (CRPD) has not yet ratified this treaty however the CRPD is providing guidance to the disability sector.

The Afghanistan Constitution of 2004 as well as a specific Disability Law for Afghanistan was approved by the President and Parliament in 2010 emphasizes human rights for persons with disabilities, the right to access and fully participate in development and the services of all sectors of the community. The national goals of development with and for people with disabilities are expressed in the Afghanistan National Development Strategy (ANDS), the Afghanistan National Disability Action Plan (ANDAP)<sup>24</sup> and obligations to the Mine Ban Treaty (MBT).

### **Information Dissemination:**

Disability and rehabilitation information is the responsibility of the Disability and Rehabilitation Department within the MoPH. The DRD will collect data on disability and rehabilitation services on a quarterly basis from and in consultation with service providing organizations. The use of this information will inform the MoPH on gaps in services, quality of services and the number of people served. The information will also be used to report on the progresses of this strategy as well as the ANDS, ANDAP, Mine Ban Treaty, and MDGs.

**Resources Required:** See Annex C – Cost Estimates

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<sup>22</sup> Biwako Millennium Framework, UNESCAP (2002)

<sup>23</sup> The United Nations Convention on the Rights of Persons with Disabilities was signed in 2006 and 142 other countries have signed the convention and 66 countries have ratified.

<sup>24</sup> Facilitated and edited by Mine Action Coordination Centre for Afghanistan (MACCA) May 2008

## Monitoring and Evaluation:

MoPH M&E Policy stresses the importance and responsibility of stewardship for the oversight of public health initiatives. M&E should rely on sets of evidence-based initiatives. Monitoring objectives will:

- Monitor and evaluate health services and their impact
- Provide the best available information on priority indicators
- Provide relevant, high quality data and information on health system performance
- Coordinate the design and use of monitoring and evaluation plans and systems at the MoPH. (Integration of System)

The DRD will monitor progress of the indicators outlined below. The M&E Directorate will periodically evaluate the effectiveness of the actions through analysis of reports and the development of a mid-term evaluation of the DRD.

## Monitoring Indicators

To achieve the strategic objectives following indicators were set:

1. To increase the capacity of the Disability and Rehabilitation Department for coordination, monitoring and reporting on Ministry and NGO implemented rehabilitation services including community based rehabilitation.
  - Coordination meetings held monthly
  - Monitoring tools developed and used
  - Monitoring reports submitted
  - Quarterly and annual reports submitted
2. To develop a long-term MoPH plan for the oversight and integration of rehabilitation services within the BPHS and EPHS including budgeting, referral systems, standards of care, service implementation and quality management.
  - BPHS and EPHS budgets are developed and made available to MoPH planning department
  - Standards of care developed and approved
  - Referral systems for rehabilitation in place and documented
  - BPHS and EPHS providers are providing rehabilitation services
    - Number of agencies implementing
    - Number of people provided services
    - Types of services provided
  - Number of monitoring missions
  - Monitoring findings reported and circulated
3. To improve Physical Therapy and Orthopedic Services through increased numbers of professionally trained practitioners at the provincial and community level
  - Number of new physiotherapist trained and working
  - Number of new orthopedic technicians trained and working
  - Number of Physiotherapists working with the BPHS in a District Hospital levels
  - Number of health staff receiving disability and physical rehabilitation awareness training
4. To improve the psychological and social inclusion of persons with disabilities through cross sector links and referrals.

- Numbers of people with permanent or temporary impairment provided physiotherapy or orthopedic services.
  - Number of District Hospitals with physiotherapy centres or providing physiotherapy services
  - Number of Provincial and regional Hospital with physiotherapy and Orthopedic technology Providing services
  - Number of referral cases from Health Center to physiotherapy and Orthopedic workshops
  - Number of new health facilities recognize the needs of accessibility in the building
  - Number of new orthopedic centers established
  - Number of new disability specific project developed and funded
5. To enhance provision of early treatment of children with severe disabilities and care for persons with spinal cord injury and through research, strengthening of rehabilitation services, coordination among key ministries, the development of care policies and guidelines for both medical and non-medical practitioners
- Research projects developed and implemented
  - Coordination meetings held regularly and minutes produced and circulated
  - Numbers of children with disabilities and persons with spinal cord injury provided services
  - Types of services provided
  - Linkages between ministries established particularly for education and social supports.
  - Care policies developed and approved
  - Care guidelines developed and approved
6. To increase prevention measures that target avoidable disabilities due to accident and preventable diseases.
- Avoidable disabilities identified for prevention activities
  - Develop and implement a Public Health & Safety programme through schools, clinics, BPHS, EPHS, and Ministry of information and culture activities

## **Strategy Review**

This strategy will be reviewed on an annual basis through the monitoring of progress and identifying weaknesses and gaps. The MoPH under the guidance of the Policy and Planning Directorate will provide for an independent mid-term review.

## **Contact Details:**

Ministry of Public Health-Afghanistan  
General Directorate for Preventative Medicine and Primary Healthcare  
Disability and Physical rehabilitation department

**Annexes:**

**A: Reports, guidelines, manuals and training programmes**

**B: Action Plan 1390-1393**

**C: Cost Estimates**

## **Annex A**

### **Reports, guidelines, manuals and training programmes developed and supported by the Disability and Rehabilitation Department**

1. Report from first national conference on Community Based Rehabilitation 13-14 November 2006. MOPH, UNDP, SCA, HI, SERVE 2006
2. Guidelines on physical rehabilitation services for BPHS implementers. MOPH 2007
3. Disability awareness and physical rehabilitation manual for the health sector. MOPH 2007
4. Psychosocial rehabilitation resource book. MOPH 2007
5. Afghanistan National Disability Action Plan. Government of Afghanistan 2008
6. Mine Ban Treaty obligations – 2<sup>nd</sup> Review Conference Outcome: Cartagena Action Plan for Victim Assistance 2010-2015.
7. Psychosocial rehabilitation training manual. MOPH 2008
8. Training guide on disability awareness and physical rehabilitation for BPHS and EPHS providers. MOPH 2008
9. Guidelines on physical rehabilitation services for EPHS implementers. MOPH (To be finalized in 2011)
10. Report from the fifth South Asian regional conference for CBR (the first in Afghanistan) 28 – 30 March 2010