

Afghanistan and the Millennium Development Goals 2005
 Report of the Technical Working Group 3, Sub-group A: Child mortality

Objectives:

The Technical Working Group discussed the following Goal, Target and Indicators. The purpose of the discussion was to assess the validity or relevance of the goal and targets for Afghanistan, whether they need to be revised to take account of the Afghan context, and to discuss the available data against each indicator.

Goal #4	Reduce child mortality
Target #5	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.
Indicator #13	Under-five mortality rate
Indicator #14	Infant mortality rate
Indicator #15	Proportion of 1-year-old children immunised against measles.

Data:

Indicators #13 and #14

The primary data collected by the MICS survey in 2003 has an urban bias. It shows unexpectedly large regional variations, which have been linked to the difficulties researchers experienced in gaining access to women during the survey. There is no other empirical data on which we can rely. However, UNICEF have produced three scenarios which are a useful guide to the issue.

Optimistic scenario

In the 1980s, a Growth monitoring, Oral re-hydration, Breast feeding & Immunisation initiative (GOBI) may have contributed to a decline in infant mortality until 1990. This is followed by a period of stagnation through to 1997 [as confirmed by the 1997 MICS data], which can probably be contributed to ongoing fighting, and a decline after 1997, which is further accelerated after 2001. The latter can be explained by improvements in vaccinations, diarrhoea treatment, and improved micronutrients content in the diet. Although education levels did not improve until 2001, many refugees returned with skills

This scenario puts the U5MR at 200 and the IMR 125 in 2003.

Pessimistic scenario

According to this scenario, there was virtually no progress from the time of the Soviet invasion, and this implies a constant U5MR of 257 per 1000. However, considering the major impact which measles vaccinations alone account for, this scenario is considered as too pessimistic.

Median scenario

This scenario also accepts the 1997 MICS results, but suggests that as a consequence of drought and war, the infant and under-five mortality rates showed an increase from 1997 – 2001. This trend is demonstrated by the 2003 MICS and suggests that the mortality rates for 2001 would have been very close to those of 1990.

2001: U5MR is 250 and the IMR is 150.
 2003: U5MR is 230 and the IMR is 140
 2005: U5MR is 210 and the IMR is 130.

Indicator #15

According to data from the MICS 2003 survey, 75% of 1-year-old children (12-24 months) were immunised against measles. The values are similar for boys and girls.

Summary of Discussion:

Infant and Under-five mortality

- Participants were reminded that the Technical Working Group had been established to develop a consensus on the national baseline, and appropriate national targets, against which progress will be measured in future. There was support for the setting of sufficiently ambitious targets, which can be used to energise those involved in the health sector, and assist in the mobilisation of resources.
- It was suggested that in the absence of reliable data, the median scenario estimates for 2003 might be adopted as the baseline for the under-five and infant mortality rates for the MDG report. There was support for comparing the estimates derived from the median scenario with other countries with similar socio-economic status, to verify the appropriateness, and to compare what has been achieved in similar countries over a ten-year period to assess the appropriateness of any targets set.
- A consensus emerged that the global target to reduce the under-five mortality ratio by two-thirds by 2015 is too ambitious for Afghanistan, given the complexity of the factors which determine the under-five mortality ratio and the fact that Afghanistan has adopted a 2003 baseline, rather than a 1990 baseline. However, it was noted that a significant level of resources is already being used to target this issue, and there are grounds to be optimistic about what can be achieved in the years to come.
- The Technical Working Group discussed two proposals: (i) to aim for a 50% reduction by 2015, and 2/3 reduction by 2020, or (ii) to aim for a 1/3 reduction by 2015, and 2/3 reduction by 2020. The former implies that the reduction will be steeper in the first ten years, and then begin to tail off. The latter suggests that there will be a steady reduction in the mortality rates between 2005 and 2020. On reflection, the group concluded that the first scenario was most likely, reflecting on the high concentration of resources currently available for child health and the fact that progress is likely to slow down, once some of the simpler interventions have been made such as immunisation and the introduction of exclusive breast-feeding of infants. However, social and cultural factors can take much longer to overcome.
- Both the Ministry of Public Health and the World Health Organization underscored the importance of incorporating whatever targets are agreed for the MDG report into the national policies and programmes of the Government.
- It was suggested that Afghanistan aim to achieve a 50% reduction of the under-five mortality rate by 2015, and a 2/3 reduction by 2020.

Measles vaccination:

- Participants noted that the rate of immunisation is already relatively high. In 2004, the coverage was around 60% of one-year-olds and this is set to increase to approximately 70% in 2005. However, it was noted that this has been achieved through emergency immunisation campaigns, which are very difficult to sustain over long periods of time. It is important to set a target, which reflects what can be realistically achieved through routine health care systems.

- A target of 90% of one-year-olds immunised against measles by 2015 was suggested. It was noted that this is an ambitious target, particularly to maintain over several years in a growing population. Such a target assumes that health facilities and trained staff are accessible in each district.

Agreements:

Goal #4	Reduce child mortality	Baseline adopted	Numerical target:
Target #5	Reduce by 50%, between 2003 and 2015, the under-five mortality rate, and further reduce the U5MR to 1/3 of the 2003 U5MR by 2020		
Indicator #13	Under-five mortality rate	230/1,000 live births (2003)	115/1,000 live births by 2015 77/1,000 live births by 2020
Indicator #14	Infant mortality rate	140/1,000 live births (2003)	70/1,000 live births by 2015 47/1,000 live births by 2020
Indicator #15	Proportion of 1-year-old children immunised against measles	60% (2004)	90% by 2015

Afghanistan and the Millennium Development Goals 2005
Report of the Technical Working Group 3, Sub-group B: Maternal Health

Objectives:

The Technical Working Group discussed the following Goal, Target and Indicators. The purpose of the discussion was to assess the validity or relevance of the goal and targets for Afghanistan, whether they need to be revised to take account of the Afghan context, and to discuss the available data against each indicator.

Goal #5	Improve maternal health
Target #6	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
Indicator #16	Maternal mortality ratio
Indicator #17	Proportion of births attended by skilled health personnel

Data:

The 2005 Report of the State of the World's Children gives a modelled estimate of 1900 maternal deaths per 100,000 live births. The most recent empirically based study was undertaken by the Centres for Disease Control (CDC) and UNICEF in 2002 in 4 districts of 4 different provinces. These districts were chosen to represent the diverse nature of Afghanistan – one urban, one rural/peri-urban, one rural and one isolated rural site were selected. This study found that in one district (the remote rural district of Ragh in Badakhshan) the maternal mortality ratio was 6507 deaths per 100,000 live births. This is the highest recorded ratio in the world. The CDC study then attempted to generate a national estimate using similarity of population estimate, i.e. those four figures were assigned to provinces with similar environments. UNICEF have published the findings using a conservative estimate of 1600 (excluding the Badakhshan data) and 2200 (including Badakhshan). Despite its shortcomings, it is the most rigorous study.

Summary of discussion

Maternal Mortality Ratio

- UNICEF briefed participants on the definition of maternal mortality, which is, for their purposes, the deaths of women due to complications of pregnancy and delivery, or due to interventions used in treatment during pregnancy and delivery.
- There was considerable discussion about the pros and cons of including the Badakhshan data in the national estimate. Concerns were raised that if this data was excluded, leading to the adoption of a baseline from the lower range (i.e. 1600), the target subsequently adopted might be unrealistically high if the higher estimate of 2200 turns out to be more representative.
- It was noted that there are other areas, which show high incidence of poverty and food insecurity such as Ghor, and which are equally isolated as Badakhshan, which suggests that they might also suffer with similarly high maternal mortality ratios. Other data, such as the fact that Afghanistan is the only country where male life expectancy exceeds women's seems to support a high Maternal Mortality Ratio.
- It was suggested that adopting the range 1600 – 2200 as the baseline, and a range for the target might be the best way to overcome the data constraints. However, this was ultimately rejected in favour of a single figure baseline and target.

- The Working Group argued that the Maternal Mortality Ratio was likely to decline more slowly than the U5MR and the IMR, since the changes required are likely to take a long time to effect.

Proportion of births attended by skilled health personnel

- WHO informed the group that the UN agencies have set themselves a target of 30% of births attended by skilled health personnel by 2008. It was noted that this target correlates with Pakistan, where currently 33% of births are attended.
- UNICEF explained that 65% of the maternal deaths reported in the CDC study occurred during childbirth itself, and suggested that the target for skilled birth attendance should be closely linked to the target just agreed for the Maternal Mortality Ratio. A rough calculation showed that if 300 midwives qualify each year (the current graduation rate), it would take approximately ten years for 50% of all births to be attended by a midwife. UNICEF agreed to work with the drafting team to finesse this calculation in coming days.
- Using this estimate, the Working Group concluded that a target of 50% of all births attended by skilled personnel by 2015 was an appropriate target.

Agreement:

Goal #5	Improve maternal health	Baseline adopted	Numerical target:
Target #6	Reduce by 50%, between 2002 and 2015, the maternal mortality ratio, and further reduce the MMR to 25% of the 2003 MMR by 2020		
Indicator #16	Maternal mortality ratio	1,600/100,000 live births (2002)	800/100,000 live births in 2015 400/100,000 live births in 2020
Indicator #17	Proportion of births attended by skilled health personnel	14.3% (2003)	50% by 2015 75% by 2020

Afghanistan and the Millennium Development Goals 2005
Report of the Technical Working Group 3, Sub-group C: HIV/AIDS, Malaria and other diseases

Objectives:

The Technical Working Group discussed the following Goals, Targets and Indicators. The purpose of the discussion was to assess the validity or relevance of the goal and targets for Afghanistan, whether they need to be revised to take account of the Afghan context, and to discuss the available data against each indicator.

Goal #6	<i>Combat HIV/AIDS, Malaria and other diseases</i>
Target #7	Have halted by 2015, and begun to reverse, the spread of HIV/AIDS
Indicator #18	HIV prevalence among 15-24 year-old pregnant women
Indicator #19	Condom use rate of the contraceptive prevalence rate
Indicator #19 (a)	Condom use at last high-risk sex
Indicator #19 (b)	Percentage of population aged 15-24 with comprehensive correct knowledge of HIV/AIDS
Indicator #19 (c)	Contraceptive prevalence rate
Indicator #20	Ratio of school attendance by orphans to school attendance of non-orphans aged 10-14 years
Target #8	Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases
Indicator #21	Prevalence and death rates associated with malaria
Indicator #22	Proportion of population malaria risk areas using effective malaria prevention and treatment measures
Indicator #23	Prevalence and death rates associated with tuberculosis
Indicator #24	Proportion of TB cases detected and cured under DOTS (Directly Observed Treatment Short Course)

Data:

Indicator #18

No data.

Indicators #19, #19a, #19b and #19c

Data for indicator 19 is from the MICS survey 2003. The rate is 0.45% at national level (0.4% in rural areas and 1.3% in urban areas). Indicators 19a and 19b: No data (19b will be collected by the NRVA 2005 from the heads of households, but not for the specific age group). 19c: MICS 2003 has data for married women <50 years of age not using contraceptives. The proportion is 90% at the national level (94% for rural areas, 79% for urban areas).

Indicator #20

The UNICEF-UNAIDS-WHO definition of this indicator explains that it looks at the school attendance rate of orphans (without parents) aged 10-14 as % of non-orphans attendance rate, in countries where HIV/AIDS is 1%+. This is not the case in Afghanistan, which makes the indicator's relevance for the country questionable. Available data suggests an interesting picture: a child is least likely to go to school if its father is dead, a little more likely if its mother is dead, and likely to attend school just as children with both parents if both parents are dead (ratio of 1.026).

Indicator #21

In 2004, there were 261,456 confirmed cases of malaria (2002: 626,839; 2003: 585,602). Many cases, however, are not captured through the official reporting mechanisms, such as private doctors, nurses and traditional healers. One study from Shiwar district in Nangarhar shows that approximately 80% of all malaria cases are treated by the private medical sector.

The malarial death rates for 2002 is 3,1%, for 2003 2.7% and for 2004 1.1%. These are low rates compared with humid tropical Africa. But they are very likely to capture only some of the caseload, however, because deaths from malaria are very difficult to determine.

Indicator #22

The malaria high-risk population in Afghanistan is estimated at \approx 11.6 million. Some 700,000 bed nets were distributed in the country over last 8 years, which covers approximately 18% of the high-risk population (2004), assuming that one bed net benefits three people. The calculation is complicated by the fact that most of the nets distributed were conventional nets, which need annual re-treating. There is overall poor compliance with re-treating. A smaller number of nets were long lasting (\approx 5 years).

Indicator #23

The total caseload of active cases stands at 333/100,000 population per year. The TB burden is enormous and Afghanistan is one of the 22 high TB-burdened countries in the world. The annual incidence is 76,000 cases, and there are 23,000 deaths from TB every year.

Indicator #24

18,402 TB patients were identified through DOTS in 2004 and 85% of them successfully treated. The proportion of new TB cases detected and cured under DOTS is estimated at 21% in 2004.

Summary of discussion

Target 7

- There was a lively discussion among Technical Working Group members if HIV/AIDS was a relevant issue for Afghanistan due to the suspected low prevalence. It was agreed eventually that it is timely for preventive measures to be taken, since while the country has a low prevalence, it is a country at high-risk of uncontrolled spread. The group suggested expanding the age group that MDG indicators look at for Afghanistan to 15-49, in order to capture the full reproductive age group, as well as the ultra-mobile who are especially at risk of bringing HIV/AIDS into the country.
- The group looked at setting a target for HIV/AIDS prevalence. The baseline in Afghanistan is not known. UNAIDS, based on a modelled estimate, sets the HIV/AIDS rate to 0.01% of the population in 2000. The University of Minnesota is currently working on a large-scale mathematical model to estimate HIV and then suggest prevention methods. It was suggested to try to look at the research team's plans for empirical data collection and maybe suggest changes to them, which will suit the purposes of the MDG indicators. Among the suggestions was to keep a target of HIV/AIDS prevalence of less or equal than 0.1% of the population by 2015, which would be roughly 30,000 people, with population growth factored in. Another proposal was to choose 0.5% as target, given that the baseline is unknown, and that there is a very long latency period, which makes that the cases registered in 2015 will be the result of infection from years before. Other group members argued that no target should be set when there is so little known of the current situation and the transmission mechanisms. Finally, the group agreed to set the target that prevalence should not be more than 0.5% of the sexually active population aged 15-49. The national prevalence will be estimated from the prevalence among the cohort of blood donors whose samples were screened.

- Comprehensive and correct knowledge is critical for prevention of an HIV/AIDS spread. It was recognised that it is a challenge to maintain high levels of awareness once they are reached. This has slipped in Europe for example and is now manifested in higher risk behaviour and higher prevalence rates. The group therefore agreed that by 2015, at least 50% of population aged 15-49 have a correct and comprehensive knowledge of HIV/AIDS.
- The Technical Working Group agreed to delete Indicator 20 on the grounds that Afghanistan is a low-prevalence country, and 19(a) because it is very difficult to gather data and monitor the indicator.
- Recognising from experience in other countries that it tends to be high-risk segments of the population (e.g. IV drug users) who donate blood for cash, the Technical Working Group added an indicator on blood screening. Afghanistan should achieve 100% screening of blood for HIV/AIDS and STDs by 2015.
- Two more indicators were added. By agreement of the Technical Working Group, (a) 50% of the need for family planning of women is met by 2015 (data will come from future MICS surveys; it was suggested to also measure this by household to show a potential discrepancy); and (b) 60% of known IV drug users will be under anti-drug treatment by 2015.

Target 8

- Afghanistan has seen a reduction in reported malaria cases between 2002 and 2004, which is likely influenced by several factors, such as Plasmodium Vivax not having developed resistances yet, expansion of treatment availability, better coverage with bed nets, and the length of winter in the north that leads to a shorter malaria season. The apparent drop, however, is to a large extent explained by the fact that 2003 laboratory figures consisted of all suspected cases, whereas 2004 figures include only confirmed cases. Drought has had a big impact but this year was very wet, so we can expect higher prevalence in 2005.
- The Technical Working Group agreed that 60% of the malaria at-risk population with bed nets in 2010 (this is the herd immunity threshold). 1.2 million bed nets will be needed to achieve this. The proportion should rise to 80% by 2015.
- The TB infection rate is likely to be much lower than expected. The upcoming study on HIV/AIDS of the Global Fund will look at this. It was agreed not to focus on the TB death rate, but to set the target that by 2015, the DOTS (Directly Observed Treatment – Short Course) detection rate to DOTS coverage will be 70%. Also, by 2015, 85% of detected TB cases will be successfully treated under DOTS. The indicator will be monitored through the Health Information Management System and the Global Fund survey.

Agreement:

Goal #6	Combat HIV/AIDS, Malaria and other diseases	Baseline adopted	Numerical target
Target #7	Have halted by 2015, and begun to reverse, the spread of HIV/AIDS		< 0.5% of population aged 15-49 are HIV positive by 2015
Indicator #18	HIV prevalence among all blood donors		
Indicator #19	Condom use rate of the contraceptive prevalence rate		
Indicator #19(a)	Condom use at last high-risk sex	<u>Indicator deleted</u>	

Indicator #19(b)	Percentage of population aged 15-49 with comprehensive correct knowledge of HIV/AIDS		>= 50% of population aged 15-49 have a correct and comprehensive knowledge of HIV/AIDS by 2015
Indicator #19(c)	Contraceptive prevalence rate	10% of married women < age 50	
Indicator #20	<i>Ratio of school attendance by orphans to school attendance of non-orphans aged 10-14 years</i>	<u>Indicator deleted</u>	
ADDED Indicator under Target #7	Proportion of blood samples screened for HIV/AIDS and STDs		100% of blood is screened for HIV/AIDS and STDs by 2015
ADDED Indicator under Target #7	Proportion of women's need for family planning met		50% of the need for family planning of women is met by 2015
ADDED Indicator under Target #7	Proportion of IV drug users treated for their addiction		60% of known IV drug users will be under treatment by 2015
Target #8	Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases		
Indicator #21	Prevalence and death rates associated with malaria		
Indicator #22	Proportion of population malaria risk areas using effective malaria prevention and treatment measures	≈ 18% of population in high-risk areas use bed nets (2004)	60% by 2010 80% by 2015
Indicator #23	Prevalence and death rates associated with tuberculosis		
Indicator #24	Proportion of TB cases detected and cured under DOTS (Directly Observed Treatment Short Course)		70% of TB will be detected and 85% treated successfully under DOTS by 2015