مؤسسه خدمات صحی و انکشافی افغان

AHDS

Afghan Health & Development Services

AHDS' Theory of Change

Our ambition for 2030

for a healthy society

Table of Contents

Abbreviations

AAP	Accountability to Affected People
ACBAR	Agency Coordinating Body for Afghan Relief
AHDS	Afghan Health and Development Services
AHF	Afghanistan Humanitarian Fund
AHO	Alliance of Health Organizations
AIDS	Acquired Immune Deficiency Syndrome
AMNEAB	Afghanistan Midwifery and Nursing Education Accreditation Board
ANC	Antenatal Care
ANCB	Afghan NGO Coordination Bureau
AMS	Afghanistan Mortality Survey
API	Annual Parasite Incidence
BPHS	Basic Package of Health Services
CCHF	Crimean-Congo Hemorrhagic Fever
CCNPP	Citizens' Charter National Priority Program
CDC	Community Development Council
CDC	Control of Communicable Diseases
CFHE	Child Focused Health Education
CHW	Community Health Worker
CHNE	Community Health Nursing Education
CME	Community Midwife Education
CNBP	Community Based Nutrition Program
COVID-19	Coronavirus disease of 2019
CPD	Continuous Professional Development
CSO	Civil Society Organizations
DQG	De Qanoon Ghoshtonkay (Legal Aid Organization)
DRR	Disaster Risk Reduction
EPHS	Essential Package of Hospital Services
EPI	Expanded Program of Immunization
ETS	Effective Teaching Skills
FATP	First Aid Trauma Points
GBV	Gender-Based Violence
GHG	Greenhouse Gases
GRM	Grievance Redress Mechanism
HAFOcc	Humanitarian Assistance and Facilitating Organization Construction Company
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HRM	Human Resource Management
IDA	International Development Association
IDP	Internally Displaced People
IMAM	Integrated Management of Acute Malnutrition
IASC	Inter-Agency Standing Committee
IPC	Infection Prevention and Control
KIHS	Kandahar Institute of Health Science
LHL	Learning for Healthy Life
LMG	Leadership, Management & Governance
MAIL	Ministry of Agriculture, Irrigation and Livestock
MAM	Moderate Acute Malnutrition
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MEAL	Monitoring, Evaluation, Accountability and Learning
MHNT	Mobile Health and Nutrition Team
MHPSS	Mental Health and Psychosocial Support
MICS	Multiple Indicator Cluster Survey
MoEc	Ministry of Economic
MoPH	Ministry of Public Health
MRRD	Ministry of Rural Rehabilitation and Development
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organization
NSIA	National Statistics and Information Authority
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
ODA	Official Development Assistance
PCM	Project Cycle Management

PEI	Polio Eradication Initiative
PHC	Primary Health Care
PHP	Private Healthcare Provider
PLHIV	People Living With HIV/AIDS
PLW	Pregnant and Lactating Women
PSEA	Preventing Sexual Exploitation and Abuse
RBM	Result Based Management
RMNCAH	Reproductive, Maternal, Neonatal, Child, and Adolescent Health
RUW	Rational Use of Water Sources
SAM	Severe Acute Malnutrition
SDGs	Sustainable Development Goals
SFP	Supplementary Feeding Programs
SHN	School Health and Nutrition
SO	Social Organizers
STI	Sexually-Transmitted Infections
TB	Tuberculosis
TCU	Trauma Care Units
TNA	Training Needs Assessment
ToC	Theory of Change
TPR	Test Positivity Rate
UN	United Nations
UNAIDS	United Nations for AIDS
UNICEF	United Nations Fund for Children
WASH	Water, Sanitation and Hygiene
WB	World Bank
WCLRF	Women and Children Legal Research Foundation
WHO	World Health Organization
WPV-1	Wild Polio Virus (type 1)

Preface

Purpose of this document

The strategic plan provides clarity, direction, and focus for an organization. The primary purpose of strategic planning is to connect the organization's mission and vision. The strategic plan drives organizational alignment, keeps everyone on track and communicates our message.

Theories of change grew out of evaluation planning techniques, such as logic models. They were originally used by community development charities. Today, more and more charities are using theories of change, and more and more funders are asking to see them.

A theory of change is an excellent basis for a strategic plan because it works methodically through the path from the need we are trying to address to the change we want to achieve. A theory of change (TOC) describes the logical sequence of steps expected to lead to a desired outcome or impact. It is a way of thinking about and planning for change. It helps organizations clarify their goals and strategies, identify the resources and interventions needed to achieve them, and measure progress over time. Theory of change is often shown in a diagram, allowing us to see the causal links between all the steps.

Process

The period of existing strategic plan (2019-2023) will end by 31 Dec 2023. Therefore, the management team assessed the progress of the strategic plan, monitored new opportunities and challenges and propose an updated strategy with TOC for the coming years to the AHDS' Board of Directors.

The strategic plan (2019-2023) was drafted by the Management Committee of AHDS in consultation with partners, beneficiaries, staff and literature review. In this participatory process AHDS' vision, mission, core values and strategic directions were thoroughly reviewed and drastic changes were brought according to the potentials and needs of the country.

AHDS had monitored its activities progress towards the strategic plan in annual reviews. AHDS projects in each year, capability to attract donors and absorb funds, and most important the result of services for the people were analyzed.

AHDS' governance believes that in spite of radical political changes in the country, the health sector still relies on interventions of the civil society organizations. No tangible change is seen in health indicators and access to the services. Therefore, the vision and mission of AHDS remain as before. The goals, outcomes, indicators and interventions were somehow revised according to our projects implemented, lessons learned from the past five years' experience and opportunities in front.

The 17 Sustainable Development Goals (SDGs) are heart of the 2030 Agenda for Sustainable Development, adopted by all United Nations Member States. Based on that we also forecast our TOC for 2030 as well. The TOC is dynamic; it is not a written-on stone document, changes will be brought time to time as required.

Acknowledgement

We would like to express our gratitude and appreciation to the board members, the management team and all the staff in the frontlines that make our services possible by their tireless dedication and hard work.

Validation

This document was approved by AHDS' Board of Directors on 2 November 2023.

AHDS' Theory of Change; Our ambition for 2030

Good health is essential to sustained economic and social development and poverty reduction. Access to needed health services is crucial for maintaining and improving health. At the same time, people need to be protected from being pushed into poverty because of the cost of health care. Universal health coverage is defined as ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user the financial hardship.[1] Sustainable development is defined as "development that meets the needs of the present without compromising the ability of future generations to meet their own needs"[2].

AHDS' theory of change describes how to ensure universal health coverage and the right to the highest attainable level of health in Afghanistan. It can be achieved through promotion of healthy lifestyle, provision of healthcare services and addressing the root causes of environmental and social threats to health. AHDS' theory of change stresses the need to improve its ability to identify and respond to such moments. AHDS play its role by advocacy, technical assistance, and provision of development and emergency relief programs. Behavior change will be at the center of AHDS efforts; typically, changes in knowledge alone is easy but takes time to be internalized and generate measurable changes in behavior.

Healthcare is one of the basic social services required for people, it is the first-line intervention during emergencies, healthy people can play better role in development and economy, mental health is most important precondition for tolerance and peace building. Therefore, each health project will contribute in a way to humanitarian-development-peace nexus in the country.

AHDS advances diversity, equity, and inclusion throughout its internal culture and programs. AHDS serves the general population with special focus on the people with special needs like women and children, marginalized and disadvantaged groups including those with disabilities. AHDS is committed to mainstreaming gender measures (gender-sensitive language, gender-specific data collection and analysis, equal access to and utilization of services, equal involvement in decision making and equal treatment integrated into steering processes[3]).

AHDS is committed to accountability to affected people (AAP) as defined by IASC: to use power responsibly by taking account of, giving account to, and being held to account by the people humanitarian organizations seek to assist.[4]

A major part of our success is due to the acceptance we have gained from the local communities and the cooperation they continue to provide. That transcends the financial assistance coming from the international community, and stresses the importance of communities assuming the kind of practical, on-the-ground responsibility for the continuously improving health, disaster management and sustainable development.

Although AHDS primary target is SDG-3 (good health and wellbeing), it will contribute to SDG-2 (zero hunger), SDG-5 (gender equality), SDG-6 (clean water and sanitation), SDG-8 (decent work), SDG-16 (peace, justice and strong institutions) and SDG-17 (partnership for the goals).

[1] WHO

[2] World Commission on Environment and Development, 1987

[3] City of Vienna; the five principles of gender mainstreaming

[4] Accountability to Affected People (AAP) guide for integrating AAP activities into programming, November 2021 revision

AHDS' Theory of Change, Our ambition for 2030	Achieve universal health coverage (UHC) and the highest attainable standard of healthcare; through promotion of healthy lifestyle, provision of healthcare services and addressing the root causes of environmental and social threats to health.			
	Improved health status of the people.			**Impact**
	Healthcare: reduced preventable death, illness, and disability through provision of cost-effective public health interventions.	**Nutrition**: reduced incidence and prevalence of malnutrition among children, and pregnant and lactating women.	**Environment**: protected human health and the environment (water, air and land) from harmful pollution.	**Community development**: enabled people to interact and work toward common goals.	**Outcomes**
	1. Improved access to healthcare especially reproductive, maternal, neonatal, child, and adolescent health (RMNCAH) services. 2. Reduced burden of communicable and non-communicable diseases. 3. Reduced preventable disabilities due to road traffic accidents, war wounds, and occupational injuries.	1. Improved quality of nutrition services in the health facilities. 2. Improved knowledge of caretakers and community influencers on optimal nutrition behaviors. 3. Improved food security of vulnerable people during disasters.	1. Decreased air pollution by promoting green energy. 2. Increased access to safe drinking water. 3. Clean communities: protected water sources, sanitation, waste management and safety of the chemicals used.	1. Programs, projects and policies are adapted to the needs, priorities, values and cultures of local populations. 2. Community diversity is reflected in participatory processes without discrimination. 3. Communities have mechanisms to register concerns and provide continuous feedback.	**Outputs**
	1. Provide quality healthcare that is appropriate, responsive, acceptable, coordinated, and equitable. 2. Promote health literacy to improve personal and community health by changing personal lifestyles and living conditions. 3. Preparedness and public health response to disease outbreaks, natural disasters and other emergencies. 4. Develop human resources for health (HRH) based on health system needs. 5. Conduct operational research; incorporate findings into practice settings and disseminated to stakeholders.	1. Provide management of acute malnutrition. 2. Provide supplementary feeding programs (SFP) for emergency situations. 3. Promote community-based nutrition program (CBNP) approach.	1. Integrate energy efficiency and environmental considerations into our work practices. 2. Provide water, sanitation and hygiene (WASH) services in emergency situations. 3. Educate communities in rational use of water (RUW) and analysis of environmental data. 4. Raise community capacity to establish and implement environmental programs. 5. Advocate for availability of WASH facilities at each healthcare center, school and highway.	1. Build capacity of community-organizations in needs assessment, developing initiative plans and advocating for community change. 2. Support the communities to raise their voice for positive changes and attain their rights. 3. Ensure access for all people particularly children, women, persons with disabilities and other vulnerable populations.	**Interventions**
	Attract diverse funding sources to reduce single donor dependency, fundraising for programs, capacity building of the organization and staff, and partnership for results.				**Inputs**
	1. International and domestic investments remain committed to support achievement of SDGs targets. 2. Political will supports the activities of non-governmental organizations (NGO) in the country. 3. Capacity buildings leads to improved performance.				**Assumptions**

AHDS introduction

Motto

For a healthy society.

Goal

Saving lives and improving living quality by provision of humanitarian assistance and development programs.

Vision

A healthy Afghan society that is socially and economically empowered!

Mission

We contribute to the Sustainable Development Goals (SDGs) by addressing healthcare and social & environmental determinants of health, considering the triple nexus (humanitarian, development and peace).

Values

The Codes of Conduct for NGOs engaged in humanitarian action, reconstruction and development in Afghanistan, recommends the following principal values:

1. Humanitarian principles (Humanity, Impartiality, Neutrality and Independence)
2. Do no harm
3. Accountability
4. Transparency
5. Autonomy (independence)
6. Equal opportunity (no discrimination)

Governance

The main governance of AHDS lies with the Board of Directors, which consists of 5 to 9 members. Except for the director of AHDS, all the remaining members of the Board of Directors are volunteer outsiders. Headed by a Chairperson elected for three years term, the Board is primarily responsible for employment of the executive director, amendments in the constitution, and approval of policies, strategies, annual budgets, annual audited financial statements and reports, and last the dissolution of the organization as and when needed. The board members have diverse professional expertise; health, education, agriculture, rehabilitation, community mobilization, entrepreneurship, governance, women empowerment, private sector, relief and developmental programs.

The founders of AHDS (founders' committee) headed by Mr. Aziz R. Qarghah has no legal responsibilities and is formed to give advices and recommendations to AHDS' board and management committee.

Brief history

Afghan Health and Development Services (AHDS) is a non-for-profit, non-governmental and non-political organization founded by Afghans on April 7th, 1990. AHDS is registered in Afghanistan as a national NGO (registration #219 on 18/11/1999 renewed as #5 dated 25/8/2005). AHDS is also an active member of Afghan NGOs Coordination Bureau (ANCB), Agency Coordinating Body for Afghan Relief (ACBAR) and Alliance of Health Organizations (AHO). AHDS is one of the first signatories of the Codes of Conduct for NGOs engaged in humanitarian action, reconstruction and development in Afghanistan.

AHDS has been able to take firm strides in the areas of development and humanitarian services with continuous support from the donors and support of partners; UN agencies, sister NGOs, Ministry of Public Health (MoPH), Ministry of Economic (MoEc), Ministry of Rural Rehabilitation and Development (MRRD), Ministry of Agriculture, Irrigation and Livestock (MAIL), local authorities and the community leaders.

AHDS is dedicated towards and has supported organizational development, capacity building and system promotion related to health and health related services at the national level. Activities of AHDS are well coordinated with national and local government authorities, community elders, and other stakeholders. Throughout the years,

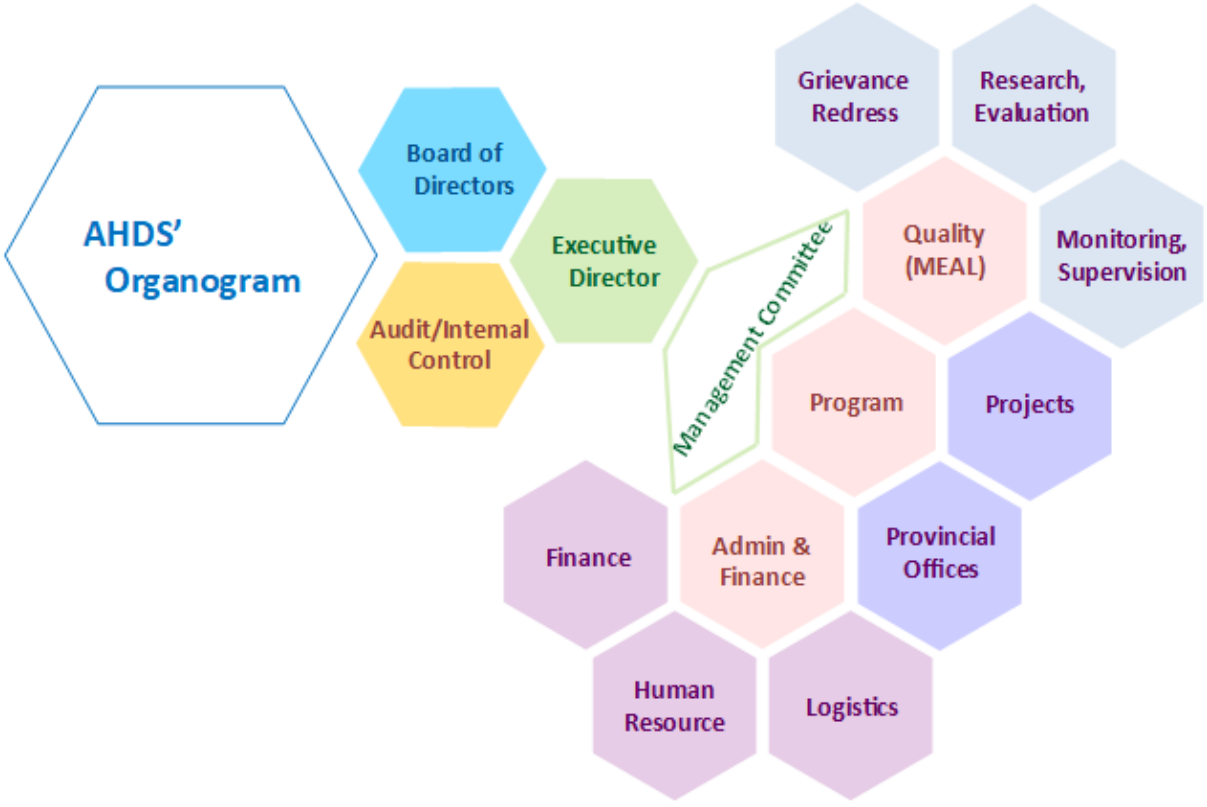
AHDS has had continuous presence and active participation in the task forces and workshops lead by the local and international agencies related to capacity building, providing health services and improving education quality and accessibility.

AHDS has been enabled to serve millions of people, by tireless efforts of the staff and vigorous help of the supporters. AHDS has implemented more than 150 projects in Daykundi, Helmand, Kabul, Kandahar, Kapisa, Kunar, Logar, Nangarhar, Nimroze, Uruzgan, Wardak and Zabul provinces. AHDS has implemented humanitarian and development projects including healthcare with focus on women and children, immunization, nutrition, community development, education, emergency relief, water and sanitation, agriculture and livestock and the Citizens' Charter.

The healthcare and health related projects include, but not limited to, primary health care (PHC), basic package of health services (BPHS), essential package of hospital services (EPHS), reproductive, maternal, newborn, child, adolescent health (RMNCAH), expanded program on immunization (EPI), integrated management of acute malnutrition (IMAM), polio eradication, control of noncommunicable and communicable diseases (Tuberculosis, Malaria and HIV), supplementary feeding program (SFP), institute of health sciences (IHS), community midwifery education (CME), community health nurse education (CHNE), school health and nutrition (SHN), protection of gender based violence survivors (GBV), management of sexually transmitted infections (STI), water-sanitation and hygiene (WASH), emergency healthcare, first aid trauma point (FATP), mobile health and nutrition teams (MHNT), mental health and psychosocial support (MHPSS), and COVID-19 response.

The secret of our success is related to our ability to reach peoples, gain their support and corporations and involve them in our efforts. Without critical support and collaboration from these communities, AHDS' success would not be possible. Our experiences are indicative that by directly engaging and involving communities in our efforts and making them aware of their rights and responsibilities, we can ensure sustainable development.

Structure



Context

Situation analysis

The collapse of the previous government resulted in a suspension of direct international development assistance, which previously accounted for 75% of public expenditure, including the maintenance of the public health system. In the absence of development activity, the Afghan people are experiencing a backwards slide evidenced by the surge of humanitarian needs across the country.

In 2023, a staggering 28.3 million people (two thirds of Afghanistan's population) need urgent humanitarian assistance in order to survive as the country enters its third consecutive year of drought-like conditions and the second year of crippling economic decline, while still reeling from the effects of 40 years of conflict and recurrent natural disasters.

While in previous years, humanitarian needs have been largely driven by conflict, the key drivers of humanitarian need in 2023 are multidimensional: drought, climate change and the economic crisis. Nevertheless, conflict, natural disasters, the lingering effects of war, and recent large-scale conflict displacement continue to prevent people from building resilience and moving towards recovery and solutions.

High levels of unemployment and sustained inflation of key commodity prices have caused the average household's debt to increase, challenging people's coping mechanisms and thwarting the already fragile economy's ability to adapt to shocks. Within this reality, 17 million people face acute hunger in 2023, including 6 million people at emergency levels of food insecurity, one step away from famine.

As for health, more than 17.6 million people (53% children) require humanitarian health assistance in 2023, with five million living in urban areas and 12.6 million in rural areas. Accordingly, four million children and women face acute malnutrition. There have been major barriers to access to healthcare services in rural areas while, at the same time, increased displacement and migration to cities have overburdened the existing health services.

The other main driver of humanitarian need is the traditional gender norms and patriarchal culture which have long reinforced discrimination against women and girls in Afghanistan, increasing their vulnerability and decreasing their capacity to recover from shocks, and leaving them disproportionately affected during crises.

Substantial investments in water infrastructure, sustainable agriculture, alternative livelihoods, gender policy reform and macroeconomic stabilization are urgently needed, along with the stabilization of services supporting basic human needs – especially health care and social services – to reduce dependence on humanitarian actors to provide emergency care and transition to longer-term support.[5]

The Afghanistan Multiple Indicator Cluster Survey (MICS) was carried out in 2022-2023 by UNICEF in collaboration with National Statistics and Information Authority (NSIA), as part of the Global MICS Program. The following figures are taken from that report.

Mortality rates: neonatal mortality rate 24 per 1,000 live births, infant mortality rate of 46 and the under-five mortality rate of 55.

Maternal and newborn: total fertility rate 5.4, first antenatal care 76.4%, four ANC 33.4%, institutional delivery 66.3%, cesarean section 5.7%, postnatal care with two days of birth 36.3%, early newborn care 34.2%

Child nutrition: breastfeeding within first hour of birth 47.7%, children under five stunted 44.7%, overweight 4.5%, wasted 3.7% including severe malnutrition 1.2%.

Immunization: basic immunization 36.6% and full immunization 16.2%. The Ministry of Public Health of Afghanistan recommends all infants and young children to be vaccinated against tuberculosis, polio, hepatitis B, diphtheria, tetanus,

[5] Excerpts from, Humanitarian Needs Overview, Afghanistan, January 2023, consolidated by OCHA

pertussis, hemophilus influenzae type B, pneumococcal disease, rotavirus, and measles. Basic immunization refers to children age 12-23 months vaccinated against tuberculosis, polio, diphtheria, tetanus, pertussis and measles. Full immunization refers to children age 24-35 months who have received all the vaccines scheduled to be given in the two first years of life, according to the national vaccination schedule.

Child health: birth registration 47.8%, care seeking for diarrhea 40.1%, for fever 49% and for signs of acute respiratory infection 45.3%.

Water and Sanitation: access to basic drinking water 68.8%, basic sanitation 44.5% and basic hygiene 58.3%.[6]

In 2020, maternal mortality ratio for Afghanistan was 620 deaths per 100,000 live births. According to government data, there were 3,472 active healthcare facilities in the country up to the third quarter of 2022. These included 725 hospitals (207 public and 518 private); the healthcare facilities had a total of 15,318 beds. According to WHO 2021 data, for every 10,000 people in Afghanistan, there were only 2.8 doctors, nurses, and midwives. A severe shortage is defined as 23 doctors, nurses, and midwives per 10,000 people. [7]

Afghanistan is affected by ongoing endemic wild poliovirus transmission. The Global Polio Eradication Initiative is focusing on reaching every last child in Afghanistan with vaccines, strengthening surveillance and maintaining political commitment, financial resources and technical support at all levels. There have been six wild poliovirus type 1 (WPV1) cases reported this year all from Nangarhar Province (4 Sept 2023).[8]

Afghanistan is suffering from the double burden of communicable and non-communicable diseases. Outbreaks of many communicable diseases such as acute watery diarrhea, measles, dengue fever, pertussis, and Crimean–Congo hemorrhagic fever in addition to COVID-19 have worsened the situation. Non-communicable diseases (NCDs) account for almost 50% of mortality in the country with a transition towards a heavier burden by 2030. A national assessment on the provision and use of essential health services in 2022 showed that NCDs were the most disrupted services and an unmet need of the Afghan population during the COVID-19 pandemic.[9]

Tuberculosis (TB) is considered as a serious public health challenge in the country. With the recent changes in the country coupled with the COVID-19 imposed restrictions in Afghanistan, the TB incidence rate has jumped to 193/100,000 population from previously 189/100,000.

The malaria incidence rates vary by location. Nationally, 27% of the Afghan population lives in areas at high risk for malaria. Areas at high risk are defined as provinces and districts with annual parasite incidence (API) rate per 1000 persons at risk of 1 or above and test positivity rate (TPR) at 9% and above. Half (50%) of the population lives in areas at medium risk.

It is estimated that total number of PLHIV is 12,000 (UNAIDS, 2020). By end of December 2020, there were 3169 (26%) new HIV diagnosis reported since the start of the epidemic.[10]

Nationwide, the majority of Afghan households do not have access to safe drinking water. Because of unsafe sanitary facilities, water contamination is a major issue in Afghanistan. Valuable water resources are polluted as a result of the disposal of industrial and domestic liquid wastes. Due to cost and pretty much little other alternatives, Afghans are forced to burn wood in order to keep warm and to cook their food. This, along with the fact that a large number of vehicles (many old and poorly maintained) in Afghanistan run-on poor-quality fuels, air pollution has become a problem in Afghanistan's major urban areas. [11]

[6] The Afghanistan Multiple Indicator Cluster Survey (MICS) 2022-2023

[7] https://iwpr.net/global-voices/afghanistans-healthcare-crisis

[8] https://polioeradication.org/polio-today/

[9] Non-communicable diseases in Afghanistan: a silent tsunami https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)01071-1/fulltext

[10] UNDP- Background and Context: Afghanistan HIV/AIDS, TB, and Malaria

[11] Afghanistan online, environment

Drought has severe impact on the crop production and drinking water availability throughout the year. The lack of water from the meltdown has negatively impacted irrigated agriculture lands – the vast majority of agricultural land in Afghanistan. In addition, the lack of ground water is causing water points to dry up and therefore become inaccessible to communities. The limited water availability has also negatively influenced pastureland and impacted the ability of farmers to feed livestock. Consequently, producers' long-term livelihood prospects have become affected as their herd size has been reduced, resulting in a lower income which in turn impacts their food security. The potential consequences of severe food insecurity and limited water availability will affect the most vulnerable people across Afghanistan, particularly children under 5 who may experience deterioration in their nutritional status due to poor access to potable water and typical seasonal spikes in diarrheal diseases. [12]

Sustainable Development Goals

The Sustainable Development Goals (SDGs) adopted by world leaders in September 2015, built upon the lessons learned from the MDGs and called for an integrated approach to "just, rights-based, equitable and inclusive" action to address today's challenges and promote growth, social development and environmental protection for all.

A broad understanding of health as defined by the WHO Constitution of 1946 is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The declaration of Astana recognizes three key components of primary healthcare (PHC), represented in the figure on the right: a) primary care and essential public health functions as the core of integrated health services, b) multisectoral policies and action and c) empowered people and communities.

Inherent in this understanding is that population health is influenced by the broader cultural, economic, political and social environment into which people are born, grow, live, work and age. This recognizes the growing complexity of public health, going beyond traditional boundaries and the direct control of the health sector. It also takes public health back to important historical lessons which show how sectors other than health contributed to lowering child mortality and increasing overall life expectancy. What is new is the emphasis on a much more clearly articulated contribution of how a healthy population contributes to the goals of other sectors' and to societal goals overall. Health is an important input for the economy, productivity, socioeconomic development and wellbeing. This makes health a shared goal across different sectors of government and of stakeholders beyond government including the private sector and civil society.

While SDG-3 aims to "ensure healthy lives and promote wellbeing for all at all ages", core health targets are also embedded in other goals. More broadly, health is influenced by and contributes to all other goals and targets as well. These positive and negative links between health and other social, economic, cultural and political factors operate both at the individual and the societal level. They lie at the heart of health inequities – the unfair and avoidable differences in health status seen within and between countries. This places equity at the center, with particular focus on disadvantaged groups that are typically excluded from social benefits such as a good education, healthcare and economic participation while facing higher burdens of disease and disability. The social determinants of health interact with each other, leading to compounded inequities for marginalized population groups.

There has been increasing acknowledgement and efforts to strategically align social and environmental determinants of health. This organizational shift has been coupled with new concrete activities and projects aimed at streamlining social and environmental determinants in technical work, including in housing, water and sanitation and air quality as priority areas considering the gender, equity and rights.[13]

[12] Contingency Plan: Inter-Cluster Drought Response, OCHA 26 April 2018

[13] Global action on the social determinants of health to address health equity, supplement to the official progress

The commitment to moving from delivering aid to ending need was the main outcome of the World Humanitarian Summit, with the SDGs and 2030 Agenda upheld as a common framework for results. This approach involves a wide variety of actors, working based on their comparative advantages and over multiple years, to reduce need, vulnerability and risk and increase peace and resilience. This way of working is known as the Humanitarian-Development-Peace Nexus. In many of the protracted crisis and conflict settings around the world, NGOs, governments, donors, the UN and other partners are considering what this approach means in practice. As such, NGOs are committed to working collectively with each other and their partners towards realizing the Humanitarian-Development-Peace Nexus in Afghanistan. These approaches are not new ways of working to operational NGOs in Afghanistan. However, there is recognition that NGOs need to be able to work better with each other and with other actors.[14]

Internal Environment

Relevance: the objectives of AHDS intervention are consistent with beneficiaries' requirement, Afghanistan needs, global priorities (SDGs), national strategies, UN agencies and donors' policies in the country.

Efficiency: AHDS is used to economical management of the resources to achieve the intended results. Comparing to the other national and international NGOs, AHDS utilizes minimum number of competent staff and least operational cost to make maximum outputs perfectly. More than 75% of the funds are budgeted for services provided to the communities.

Effectiveness: all the projects are in line with AHDS' theory of change and strategies. In each project, the activities pursue the set objectives and predicted results. The donors also had performance-based contracts; which ensured achievement of the objectives and targets for any development and humanitarian intervention.

Impact: generally, the national surveys show tangible improvement in health status of Afghanistan had in the last decade. Number of health facilities and professional health staff increased. Demand for the preventive healthcare and education is enhanced among the communities. Communities are alliterated about their rights and deserved social services. An impact survey cannot be done for beneficiaries of AHDS projects, as join efforts of multiple stakeholders had affected them, but for sure our efforts contributed to the national achievements.

Sustainability: AHDS organizational capacity is developed; it's constitution, the terms of reference for the board of directors and management committee were revised. A set of necessary policies and procedures were developed. Operation manual containing program, human resources, logistic, finance, administration and monitoring, evaluation, accountability and learning was developed and implemented in practice. AHDS gained good reputation among the government, non-governmental, UN and donor agencies for its result-oriented work, transparency and accountability. Financially, AHDS survival rate is three years without external support.

Ability to absorb new funds depends on the highly competitive market prevailed in the country which relies on relations as well as least costs biddings that negatively affect the beneficiaries. AHDS will try to establish partnership with the donors who are concerned about the people and result based management of the programs.

report on WHA65 submitted to the Sixty-Eighth World Health Assembly, Geneva, May 2015. Government of South Australia & World Health Organization. Progressing the Sustainable Development Goals through Health in All Policies: Case studies from around the world. Adelaide: Government of South Australia; 2017.

[14] Realizing the Humanitarian-Development-Peace Nexus in Afghanistan, ACBAR and ICVA, 2018.

Impact of the Programs

The goal of AHDS programs is improved health status of the people; through promotion of healthy lifestyle, provision of healthcare services and addressing the root causes of environmental and social threats to health.

Universal health coverage (UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care. WHO Constitution envisages the highest attainable standard of health as a fundamental right of every human being.

A healthy lifestyle is physical, mental, emotional and spiritual well-being. Living a healthy lifestyle is a key component to disease prevention, wellness, and longevity.

Evidences indicate that clinical care accounts for only 20% of health outcomes, while socioeconomic, behavioral, and environmental factors determine the remaining 80%. Social determinants of health refer to characteristics of the social environment that contribute to an individual's health. These characteristics include economic, political, and legal structures, as well as social norms that determine how a society is organized and, by extension, the degree to which communities can access the resources necessary for health. The types of environmental influence that populations suffer are broadly related to their socio-economic development. Recent estimates of the global burdens of disease from environmental factors shows that the greatest burdens relate to unsafe drinking water, poor sanitation & hygiene, and to pollution of the indoor and outdoor air. Burdens relating to climate change, which currently are modest, are expected to increase substantially over time.

AHDS programs will contribute to the following sustainable development goals (SDGs):

1. Goal 3: Good health and well-being for people; ensure healthy lives and promote well-being for all at all ages.
2. Goal 2: Zero hunger; end hunger, achieve food security and improved nutrition, and promote sustainable agriculture.
3. Goal 5: Achieve gender equality and empower all women and girls.
4. Goal 6: Clean water and sanitation; ensure availability and sustainable management of water and sanitation for all.
5. Goal 8: Decent work and economic growth; promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.
6. Goal 16: Peace, justice and strong institutions; promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.
7. Goal 17: Partnership for goals; strengthen the means of implementation and revitalize the global partnership for sustainable development.

Healthcare, Change Strategies

The principles of the Primary Health Care (PHC) approach are as relevant today as they were nearly 35 years ago. PHC provides guide not just for the organization of healthcare systems, but also for how healthcare systems should act as an engine for promoting health and development more generally, and as an instrument for promoting equity and empowering the poor. The 'Primary Health Care' stresses a comprehensive approach to health by emphasizing 'upstream interventions' aimed at promoting and protecting health such as improving household food security, promoting women's literacy and increasing access to clean water. PHC promotes a multi-sectoral approach to health. It emphasizes equity; aim to correct the neglect of rural populations as well as socially and economically marginalized groups. PHC also incorporates the involvement and empowerment of communities.

AHDS carefully assesses the various dimensions of barriers to healthcare access including geographical access, availability, affordability & acceptability with due consideration for specific vulnerable groups. The experience of AHDS has clearly demonstrated the importance of extensive collaboration and cooperation with the local population, health service providers and relevant government authorities.

The spectrum of appropriate community involvement includes community mobilization to assert rights, challenge policies and present alternatives, monitoring of services, involvement in planning and decision-making, and involvement in the implementation of programs and services.

The performance of public sector health workers is affected by many factors and calls for a concerted, coordinated program of health worker support and development. The problems of demoralization and demotivation are more complex and require a multi-dimensional program involving:

1. A living wage to behave ethically and function effectively.
2. The right number and mix of types of health personnel.
3. Adequate supplies of essential equipment, consumables and medicines to enable health workers to exercise their skills.
4. Systematic quality improvement programs, including the training of staff in health service quality, interpersonal relations and responsiveness of care.
5. Support for health workers, especially those who work in isolated and difficult circumstances.
6. A participatory style of health service management.
7. An incentive structure of professional rewards for good performance.[15]

AHDS has been one of the pioneers for Basic package of health services (BPHS) and Essential package of hospital services (EPHS) in the country. Furthermore, the health services are provided through establishing birth centers, mobile health teams (MHT), first aid trauma points (FATP), trauma care units (TCU) and partnership with the private health service providers (PHP).

Vaccination is one of the efficient and cost-effective interventions to reduce mortality and morbidity among children under-5 years of age. Polio Eradication Initiative (PEI), a global-scale public health intervention, made significant progress by sparing millions of children from lifelong paralysis. AHDS is committed to support the PEI that would lead to success of the national implementation of actions.

Health promotion is the process of enabling people to increase control over, and to improve their health. Health promotion helps reduce excess mortality, address the leading risk factors and underlying determinants of health, and strengthen sustainable health systems. It places health at the center of the broad development agenda. It moves beyond a focus on individual behavior towards a wide range of social and environmental

[15] Global Health Watch; B1 | Health care systems and approaches to health care

interventions. As a core function of public health, health promotion supports governments, communities and individuals to cope with and address health challenges. This is accomplished by building healthy public policies, creating supportive environments, and strengthening community action and personal skills.

Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions.

The priority area are measures to eliminate air, water and soil pollution; early child development; protecting women and girls from harassment and gender-based violence; immunization; clean water, sanitation, waste management and vector control; stop stigmatization against people living with disabilities, TB or HIV; physical activity; affordable healthy food and safe water; smoke free environments; and better mental health.[16]

A sustainable needs-based procurement and supply management methodology will cover adequate shelf life, supply remote areas, deal with wintery environment etc. De-centralized procurement will promote timely supply. Consumption rate plus buffer stock will be calculated for winterization supplies.

Emergency and disaster reduction in health includes prevention, mitigation, preparedness, early response and rehabilitation.

Preparedness and public health response to disease outbreaks, natural disasters and other emergencies need the following action areas:

1. Improving human capital to provide integrated services. Prioritized integrated set interventions at critical phases are immunization, nutrition, physical activity, mental health, contraception, leading disease burden, injuries, health literacy, assistive technologies and community engagement.
2. Accelerating action on preventing noncommunicable diseases (NCD) and promoting mental health; with equitable access to effective treatment for cardiovascular diseases, cancer, diabetes, chronic respiratory diseases and mental health conditions.
3. Accelerating elimination and eradication of high impact communicable diseases (CDC); including polio, HIV/AIDS, tuberculosis, malaria, hemorrhagic fever (CCHF), viral hepatitis, sexually-transmitted infections (STI).
4. Tackling antimicrobial resistance; including increasing awareness, infection prevention and control (IPC) and optimizing the use of antimicrobial medicines.
5. Addressing health effects of escalating climate and pollution-related risks.[17]

Health systems can only function with health workers; improving health service coverage and realizing the right to the enjoyment of the highest attainable standards of health depend on their availability, accessibility, acceptability and quality. Mere availability of health workers is not sufficient: only when they are equitably distributed and accessible by the population, when they possess the required competency, and are motivated and empowered to deliver quality care. The health workforce has a vital role in building the resilience of communities and health systems to respond to disasters caused by natural or man-made hazards, as well as related environmental, technological and biological hazards and risks. The health workforce will be critical to achieve health and wider development objectives in the next decades.[18]

AHDS provides higher education opportunity for the adolescence girls and boys to address shortage of professionals in health sector. AHDS implements gender-synchronized approaches that address the barriers in front of girls as well as working with boys and men to remove such barriers.

AHDS education centers adapt their institutional set-up and modalities of instruction to respond to transformative educational needs and are aligned

[16] WHO, Shanghai Declaration on promoting health

[17] WHO, Thirteenth General Programme of Work 2019-2023

[18] The Global Strategy on Human Resources for Health: Workforce 2030

with accreditation systems. AHDS approaches for pre-service, in-service, and continuous professional development (CPD) trainings to increase the number and skills mix of mid-level and community level human resources for health (HRH).

AHDS has experience of managing the Kandahar Institute of Health Sciences (KIHS) having midwifery, nursing, laboratory technician and pharmacy technician schools. In addition, has number of Community Midwifery Education (CME) and Community Health Nursing Education (CHNE) courses. All of the mentioned programs were accredited by the Afghanistan Midwifery and Nursing Education Accreditation Board (AMNEAB).

School health and nutrition (SHN) with child focused health education (CFHE) and learning for healthy life (LHL) programs are innovative approaches taken by AHDS to strengthen health status with particular impact on mothers and children. They empower the mothers and school age children taking better care of themselves and their families.

Furthermore, AHDS conduct Certificate programs typically consist of a short series of job-specific courses. They are tailor made initial and refresher courses for the teachers and health staff based of their training needs assessment (TNA). They include but not limited to communication skills, training methodology, effective teaching skills (ETS), management information system (MIS), report writing, supervision, monitoring and evaluation (M&E), project cycle management (PCM), human resource management (HRM), community health worker (CHW), leadership, management and governance (LMG) and health-specific topics.

Building capacity is not a short-term undertaking. Periodic assessments help guide the process since the environmental conditions and expectations change. Mid-course corrections are likely as new conditions unfold and new needs arise. The process of ongoing feedback and adjustment can both strengthen capacities of AHDS and the beneficiaries.

The quality of health services will be attained through the application of a range of quality methodologies. The staff will be mentored and supported to assess their capabilities with respect to their duties and identify areas where capacity building would be of value. Technical backstop ping will be of particular benefit in building the capacity of management and health staff and their performances. Staff attaining target standards and engaging positively with capacity building measures, will be eligible for incentives, either monetary, offered certificates or options for professional trainings.

Operational research is required in health systems management, planning and problem-solving activities. There is also a need to invest more in the development of health information and disease surveillance, and the capacity and time for staff to conduct their own researches.

Healthcare systems can disseminate information about local health services and the rights of service users, as well as publicize disparities in key indicators such as maternal mortality and immunization coverage to encourage a social commitment towards reducing inequity.

The followings are high-priority health challenges. They address determinants of health that promote quality of life, healthy behaviors, and healthy development across all life stages to improve health at the national and community levels.

1. Access to health services.
2. Maternal, newborn, child and adolescence health.
3. Reproductive and sexual health.
4. Mental health including substance abuse.
5. Nutrition, physical activity, and obesity.
6. Clinical preventive services.
7. Disability.
8. Environmental quality.
9. Oral health.

Nutrition, Change Strategies

The good nutrition in the first 1,000 days between pregnancy and a child's second birthday, the critical "window of opportunity", builds a strong immune system and ensures healthy physical and intellectual development. Therefore, careful attention to the nutrition of under two years age as well as pregnant and lactating women is required.

AHDS aims to scale-up, high impact, cost effective nutrition interventions to reduce undernutrition. These interventions include micronutrients (vitamins and minerals) supplementation, deworming, the promotion of breastfeeding and complementary feeding, and the treatment of severe acute malnutrition, amongst others. AHDS assists in building the skills of health services providers in delivering services to children and women. In addition, AHDS helps families learn essential skills and basic knowledge in the nutritional care of young children. This includes best practices in breastfeeding and complementary feeding, the promotion of iodized salt consumption, and health-seeking behavior. We concentrate our efforts on the most vulnerable, targeting young children, pregnant women, breastfeeding mothers and people living with disabling illnesses.

In emergencies, AHDS works to ensure that vulnerable children under five, pregnant women, and nursing mothers have access to supplementary food to meet their nutritional needs and prevent them from becoming undernourished.

The National Guideline for Integrated Management of Acute Malnutrition (IMAM) was developed as a tool to assist health workers in the assessment and appropriate management with services and/or counselling for the treatment both Moderate Acute Malnutrition (MAM) and Severe Acute Malnutrition (SAM). IMAM main components are a) Inpatient therapeutic care (ITC); b) Outpatient therapeutic care (OTC); c) Supplementary feeding program (SFP) and d) Community linkage. AHDS has implemented IMAM as main approach. It may need some modification since CBNP approach is introduced.

The Afghanistan Community Based Nutrition Program (CBNP) aims at promoting optimal growth and development of children through community-based activities linked to social and behavior change to improve parents' and care givers' knowledge and practices on nutrition and caring practices. It also aims at strengthening the capacity and motivation of parents, families and communities to adopt appropriate and healthy practices that will result in improved nutritional status of young children. The CBNP approach will draw on local community participation as well as available local resources and will be responsive to local needs and sensitivities.

The CBNP was designed and introduced in 2018 to improve access to essential nutrition services and to improve child feeding practices and diets. It builds on existing community-based healthcare platforms in Afghanistan to deliver nutrition services at community level, as an adjunct to health facility services. The approach has a particular focus on children under two years old, their mothers and fathers, and other male community members who are the main decision-makers at household level.

The CBNP delivers a number of focused interventions for improving young children's diets and feeding practices.

1. Seasonal food calendar tool is used to explore and map the available foods during different seasons of the year. It is used to encourage consumption of these locally available foods based on availability across the seasons.
2. Village nutrition action plans focus on improving the nutrition status of families; particularly those with children under two years of age.
3. Food demonstration sessions teach families with children under two years old about the preparation of complementary foods by using different available food groups.

The decision to implement a Supplementary Feeding Program (SFP) is usually based on raised prevalence of acute malnutrition among children

under five and the presence of aggravating factors such as poor food security in the general population, disease epidemic and raised mortality.

Supplementary feeding implemented in an emergency context is known as an SFP. Its purpose is to treat moderate acute malnutrition (MAM) in children 6-59 months and other vulnerable groups, such as malnourished pregnant women and lactating women (PLW) with infants under 6 months of age. Children under 6 months are never admitted to SFPs. However, the mother receives counselling on adequate breastfeeding and, if malnourished, will be admitted to the SFP herself. If the infant shows signs of severe acute malnutrition, the infant will then be referred to inpatient care for specialized care. There are two types of supplementary feeding interventions in emergencies: Blanket supplementary feeding: a supplementary ration is provided for everyone in an identified vulnerable group for a defined period. This might be all children under 3 or 5 years old and/or all pregnant and lactating women, regardless of their nutritional status. Blanket feeding is used when the prevalence of acute malnutrition is high, numbers of vulnerable people are very large and general food distributions are inadequate. It can also be used during certain peak seasons or shocks. Targeted supplementary feeding: a supplementary ration is targeted to individuals with MAM in specific vulnerable groups. The vulnerable groups usually include children age 6 to 59 months and malnourished pregnant women and lactating women with infants under 6 months of age. Groups also might include individuals with special needs such as people living with HIV (PLHIV), people with tuberculosis (TB) and the elderly. Specific anthropometric criteria for entry and discharge are usually used.

The following indicators are crucial to achieve optimal nutritional status for Afghans:

1. Increase exclusive breastfeeding rate.
2. Reduce stunting rate among under-five children.
3. Reduce childhood wasting including Severe Acute Malnutrition (SAM).
4. Reduce micronutrient deficiencies; specially anemia in adolescent girls, and pregnant and lactating women.
5. Reduce prevalence of diet-related non-communicable diseases.
6. Achieve universal access of all school children in the pre and basic school classes to school-based feeding programs
7. Arrest the emerging increase in obesity prevalence in adolescents and adults
8. Increase households with relevant nutrition knowledge and practice that improve their nutritional status.
9. Mainstream nutrition objectives into social protection and safety programs.

Environment, Change Strategies

Environmental Health defined by WHO is "the aspects of human health, including quality of life, that are determined by physical, chemical, biological, social and psychosocial factors in the environment". Clean air, stable climate, adequate water, sanitation and hygiene, safe use of chemicals, protection from radiation, healthy and safe workplaces, sound agricultural practices, health-supportive cities and built environments, and a preserved nature are all prerequisites for good health.

The aim of environmental programs of AHDS is protection of environment, the health and well-being of people.

To maintain a healthy lifestyle, AHDS will educate the communities about the environment in order to create a sense of consciousness and participation, and to help them acquire knowledge of ecological principles aimed at ensuring a balance between the health of the individual, society, and the environment. AHDS raise public awareness on environmental issues, rational use of water sources (RUW), impacts of climate change, greenhouse gases (GHG), mitigation and adaption approaches.

By encouraging pollution prevention, AHDS increases opportunities for people to look after their own neighborhoods and environments. It includes educate situation analysis and encourage behavioral change to minimize the amount of waste generated, promote safe water and sanitation, change social norms around littering and illegal dumping, stimulate investment in waste recycling infrastructure, promote the use of safer chemicals and pesticides, increase the energy efficiency of buildings, promote use of renewable energy and increase in planting operations.

WASH is the collective term for Water, Sanitation and Hygiene. Due to their interdependent nature, these three core issues are grouped together to represent a growing sector; each is dependent on the presence of the other. Without toilets, water sources become contaminated; without clean water, basic hygiene practices are not possible. AHDS will provide WASH services in emergencies and advocate with stakeholders to provide WASH facilities at public places at least in each health center and each school.

Human fecal material and urine are major sources of environmental pollution in Afghanistan. It is also a source of disease organisms. When discarded into the environment as a waste material, it creates pollution and threatens public health. By composting, its pollution and health threats can be eliminated and valuable soil nutrients for plant growth can be produced.

An important work for sanitation is to end the practice of "open defecation," and facilitate community-led initiatives to build, maintain and use basic toilets. The hygiene part aims at nurturing good hygiene practices, especially handwashing with soap; this act is essential to prevent disease and the health of children. [19]

AHDS takes part in the campaigns on improving air quality to protect human health. Short-lived climate pollutants, such as black carbon and methane, are major contributors to climate change and air pollution. Vehicle emissions are the main source of outdoor air pollution due to poor fuel quality and weak vehicle regulations.

AHDS advocates with the ministry of public health (MoPH) and other stakeholders to adopt a strategy for involvement of the health sector in the safe management of pesticides and industrial chemicals. It should include the whole spectrum of health services from research, surveillance and monitoring and risk assessment to prevention, emergency preparedness and response and treatment of poisonings. Raising the awareness of the public is an important activity about drinking-water safety, food safety, product safety, occupational safety and protection of public health.

AHDS raise awareness and lobby for the sustainable energy. Renewable energy and energy efficiency are the "twin pillars" of sustainable

[19] UNICEF

energy. Both resources must be developed in order to stabilize and reduce carbon dioxide emissions. Efficiency slows down energy demand so that rising clean energy supplies can make deep cuts in fossil fuel use. Green energy means electricity and gas made from renewable sources; green electricity made from the wind, the sun and the sea, and green gas made from organic material.

AHDS will try its best to have green energy, ensure waste reduction and use recycling items as much as possible in its offices and other facilities.

Environmental health indicators help identify potential risks to human health, including emerging risks. They are based on known or plausible cause-and-effect relationships between the environment and health.

WHO recommend the following core set of environmental health indicators:

1. Air Quality (consumption of leaded gasoline, fuel for heating and cooking, emissions of air pollutants)
2. Housing (living floor area per person)
3. Traffic (injury and mortality rate)
4. Noise (population annoyed by certain sources of noise, sleep disturbance)
5. Waste (hazardous waste generated and imported, area of contaminated land)
6. Radiation (cumulative radiation dose, ultraviolet light index)
7. Water and Sanitation (adequate amount of safe drinking water, water treatment, access to adequate excreta disposal, diarrhea, outbreaks of waterborne diseases)
8. Food Safety (hazardous chemicals monitored in food)
9. Chemicals (sites containing large amounts of chemicals, emergencies)
10. Workplace (occupational diseases, occupational injuries and fatality rate)
11. Vector control (mortality due to vector-borne diseases).

Community Development, Change Strategies

Community self-help initiatives involves community members mobilizing themselves to identify and prioritize their needs and communally plan for satisfying those identified needs. Implement projects that benefit all community members concerned by the project.

AHDS aims at community empowerment to enhance economic and social services and community benefits from upgraded community infrastructures and productive assets operated mainly by communities. AHDS will provide appropriate technical assistance and support from the start based upon prior experience with successful collaborations that mobilized residents. The emphasis will be on democratic selection of office bearers, participation of households in community institutions, inclusion of poor and marginalized households and addressing women's issues.

Without a sense of personal responsibility in the local communities to complement the broader social responsibility of the international community, the sustainability of and development efforts such as ours will be at great risk. Our experiences are indicative that by directly engaging and involving communities in the programs and making them aware of their rights and responsibilities, we can ensure success of the projects and sustainable development at the communities.

The target people are consulted for their needs and what is going to be planned during the rapid needs assessments. Community committees (Shura) is established for each service delivery point; or linkage established with the community development council (CDC) if exist. At the beginning of any project, each service delivery point presents the types and extension of services can be provided for the people. The Shura members are oriented on how to cooperate with the service delivery point; rapid assessment, proposing solution, drafting initial plan, negotiation with authorities, community monitoring, early reporting of the concerned cases, grievance redress, follow up of the defaulters and oversight.

AHDS was involved in the Citizens' Charter National Priority Program (CCNPP) as facilitation partner (FP). AHDS was mainly responsible for community mobilization for Citizens' Charter, facilitation of CDCs, its sub-committees and participatory community monitoring team establishment, clustering the CDCs, basic community profiles, socio-economic grouping, participatory methodologies to address key issues within the communities, women's empowerment, inclusion of the vulnerable groups, community development plans, capacity building of CDCs and sub-committees, support CDC, Cluster CDC and sub-committees, facilitate community-led total sanitation and build capacity of a cadre of future social organizers (SO) from among emerging leaders in the communities and MRRD staff.

AHDS can support the poor and marginalized communities to become active members of the community. Furthermore, AHDS supports and strengthens communities to get prepared against disasters and for preservation of environment. Community sub-committees are organized, trained and supported to reduce risks from and manage disasters.

AHDS will ensure access to all people particularly children, women, persons with disabilities and other vulnerable populations. That would be through analysis of the barrier, negotiations, awareness about humanitarian principles, sensitization the actors, teaching codes of ethics, cultivating culture of tolerance, advocacy and peacebuilding efforts.

Peacebuilding with focus at the community and societal levels strengthens relationships and creates conditions for peaceful coexistence and positive social change. Preventing or ending direct violence requires people to talk to one another, build relationships and come to agreements about how to resolve conflicts without fighting, address underlying inequalities, improve justice and assist each other.

AHDS measures a person's experience of sense of community based on three individual factors: a) feeling of belonging to the local area; b) whether they feel people from different backgrounds get on

well together in the area; and c) whether people in the area treat each other with respect and consideration.

The role of community engagement is to empower communities, community leaders and community organizations to play a role in improving the equity and impact of the government, development, and humanitarian initiatives that affect them. The minimum quality standards provide guidance and support in achieving the following aims:

1. Communities are meaningful stakeholders in two-way, transparent and open flows of information. Mechanisms are in place to sustain two-way communication.
2. Communities know and claim their rights. They have meaningful ownership and leadership roles in the deliberations, decision-making, design, implementation and measurement of actions that affect them.
3. Community diversity is reflected in participatory processes without discrimination, including gender, ability, age, faith, race, ability and ethnicity.
4. Community-based power inequalities are addressed, not reinforced, through community engagement actions.
5. Communities have mechanisms to register concerns and provide continuous feedback on the quality, availability, accessibility and acceptability of services. This feedback is listened to, and appropriate responses are taken.
6. Programs, projects and policies are adapted to and aligned with the needs, priorities, values and cultures of local populations.
7. Programs, projects and policies are adapted to and aligned with the needs, priorities and policies of national, subnational and local governments.
8. The quality of research, evaluation and monitoring of community engagement is tied to community structures, processes and ownership, so that communities have influence over research documenting the issues that impact them.[20]

Community engagement and Accountability to Affected Populations (AAP) are interconnected. Community engagement is two-way communication between the organization/project staff and beneficiaries. AAP is an active commitment to use power responsibly by:

1. Taking account of: giving communities influence over decision making in a way that accounts for their diversity, and allows the views of the most at-risk to be equally considered.
2. Giving account to: transparency and effectively sharing information with communities.
3. Being held to account by the people: giving the communities to assess and, if appropriate, sanction our actions.[21]

Community diversity is reflected in participatory processes without discrimination, including gender, ability, age, faith, race, ability and ethnicity.

[20] UNICEF; Minimum Quality Standards and Indicators for Community Engagement

[21] The Afghanistan Humanitarian Fund (AHF), Accountability to Affected People (AAP) guide for integrating AAP activities into programming, Nov 2021 revision.

Cross-cutting Program Areas

Disability

AHDS recognizes that people with disabilities are among the most excluded and invisible members of every society. They face widespread discrimination, stigma and inaccessible environments that exclude them from a range of critical services and opportunities while exposing them to risks and vulnerabilities, which are exacerbated in humanitarian crises and fragile contexts.

AHDS will work across all goal areas to mainstream strengthened programming on disability rights. AHDS adopt approaches to ensure that disables can access inclusive and barrier-free services and support; including primary health care, nutrition, accessible WASH facilities and participate in their societies on a full and equal basis with others.

Gender mainstreaming

The realization of human rights and the achievement of SDGs requires the achievement of gender equality and empowerment of women and girls. AHDS strives to expand its efforts to integrate gender across all its programming and systems. As a core principle, gender equality requires investment in sex-disaggregated data and gender analysis in all contexts; adoption of inclusive, diverse and family-friendly workplace practices.

AHDS will focus on gender equity by expanding access to female providers, promoting equitable access to services, providing gender awareness trainings to the staff, and raising awareness of communities, families and caregivers about gender equity in services and outcomes.

A reasonable ratio of experienced and qualified female staff will be maintained through practical approaches and targeted measures:

Establish responsive gender committee to monitor and evaluate women's workplace conditions, identify recruitment blockages and institute measures to increase female recruitment by:

1. Provide elevated allowances for female staff.
2. Conduct gender awareness training sessions for all staff – male and female.
3. Provide suitable privacy for female staff.
4. Support couple recruitment.
5. Mobilize local communities to support female health staff.

Environmental and Social Safety

Humanitarian and development programs must be designed and implemented to do-no-harm, prevent conflict and build resilience. Environmental and social safeguards are key to ensuring that AHDS programs are smart. AHDS considers that its programs, operations, and supply chain need to work together for an effective climate response, and is incorporating climate action into organizational improvement efforts. Climate action, sustainable energy practices, environmental sustainability and disaster risk reduction (DRR) are all critical components of resilience. AHDS commitment to mainstream social and environmental sustainability aims at:

1. Strengthen the quality of programming by ensuring a principled approach
2. Avoid adverse impacts to people and the environment
3. Minimize, mitigate, and manage adverse impacts where avoidance is not possible

Staff will be employed at equal opportunity without discrimination. The staff, local authorities and community committees will be oriented on humanitarian principles, all AHDS policies, professional ethics, project goal and expected results. The staff will be oriented and held accountable for Preventing Sexual Exploitation and Abuse (PSEA) policy and Child Protection policy. The triage training will emphasize on prioritization of the most vulnerable people like disabled, women and children. Community awareness will be conducted to the people to become aware of risk factors and seek gender-

based violence (GBV) prevention measures, referral and psychosocial counselling to GBV survivors.

AHDS will ensure that appropriate measures are in place for waste management and infection prevention and control (IPC). AHDS will improve environmental health related factors such as water, food, and diagnostic radiation safety within the health facilities.

Grievance redress mechanism (GRM) will be established to ensure quality services are provided to the people with full respect to their dignity.

Peacebuilding

Building resilience is a key part of systems strengthening work and risk-informed programming, which considers a range of risks, such as those stemming from climate change and natural disasters, public health threats, violence and conflicts. It is also a core concept in enhancing coherence and collaboration among humanitarian, development and peacebuilding programming.

AHDS programs will be informed by a robust conflict and risk analysis, in order to avoid doing harm or exacerbating conflict and violence factors. It will focus on delivering and managing social services in equitable, inclusive and accountable ways; promote the participation of communities, build trust and collaboration within and between communities and strengthen state-society relations and strengthen individual coping mechanisms and capacities to deal with causes and effects of conflict and sustaining peace.

Community engagement and AAP

Community engagement and Accountability to Affected Populations (AAP) are interconnected. Community engagement is two-way communication between the organization/project staff and beneficiaries. AAP is an active commitment to use power responsibly by taking account of, giving account to and being held to account by the people. Being held to account includes PSEA. (Read page 22 for details).

AHDS focuses on interventions that build local ownership and the capacities of affected people, strengthen systems, and contribute to social cohesion so as to enhance prevention and preparedness for future potential crisis, while improving long-term outcomes. AHDS will intensify family and community engagement to address demand-side barriers to access including social and gender norms and support for the meaningful participation of communities.

AHDS conducts community mobilization meetings to analyze the data, design the interventions and maximize access and acceptance. The members of Shura (community representatives) will be oriented on how to cooperate with AHDS teams and monitor the services. The members of Shura will be responsible to ensure access, security of the staff, help in community mapping and planning, facilitate activities, prompt informing about any casualty and outbreak, complain redress and share concerns of the people with AHDS.

The Shura will support participation of women, people with disabilities, elderly people, and marginalized groups to ensure that different groups are involved in identifying solutions and making the response relevant and durable which increases participation and empowers beneficiaries.

Operational Research

AHDS will invest in operational research, building evidence base on the effectiveness of programs, in both humanitarian and development settings. Furthermore, it builds responsive and accessible feedback mechanisms to inform interventions and track changes in priority results, including social and behavior change results.

AHDS will promote the culture of evidence generation through investments in data collection, assessments, analysis, and research and evaluation activities for each project. AHDS will focus on:

1. Strengthening its capacities to generate and utilize data.
2. Strengthening information management capacities in emergency response.
3. Disseminating data and evidence through knowledge management platforms.

4. Applying and sharing it to support policies, planning, partnerships, resource mobilization, decision-making and program delivery.

Advocacy and communications

AHDS will step up its strategic engagement to influence policy and financial decisions that can unlock progress, guided by data-driven, evidence-based, insight-led advocacy strategies at the provincial, regional and national levels. It will use advocacy strategies that are agile and integrated, mobilizing the organization's many advocacy assets behind a shared goal. Where there is a clear value add for public communication or public mobilization to support these strategies, multichannel communication plans will be used to achieve measurable positive change.

Key approaches will include:

1. Sophisticated influencing strategies to secure political commitment.
2. Empowering the communities with the information, skills and capacities to lead change.
3. Strategic use of evidence to make a compelling case for increased investment to pivot results.
4. Audience insights, online and offline media.
5. Strategic partnerships with those who have influence over decision-makers, to transition gamechangers to scale.

Inputs

The emergence of a market economy in the country and political and economic changes in donor countries make AHDS vulnerable, as the access to traditional easy money has come to an end and the era of hard money and tough competition has arrived. Difficulty arises from trying to match AHDS programs with different donors having different interests.

It is evident that there are three distinct types of funding:

1. The national packages of services, to be managed and operated under a national uniform program management system. These are supported by the foreign offices of the developed countries or the multilateral organizations such as Afghanistan Humanitarian Fund (AHF) and World Bank programs.
2. The private charities, foundations and international organizations that are more privately handled and have a better focus on equipping local NGOs not just financially but also technically.
3. The partnership with UN agencies and international NGOs that promote localization through partnership with national NGOs.

AHDS tries to diversify its funding sources to reduce single donor dependency and will increase fundraising to private and local donors to cover the strategic gap in program activities and organizational development. AHDS will make partnership with likeminded UN agencies and NGOs, for efficient utilization of the resources and maximizing outcomes for the beneficiaries.

AHDS will continuously invest in to become a more agile, values-based, effective and efficient organization that can effectively respond to change and uncertainty. AHDS should work on the following five enablers: [22]

1. Accelerated resource mobilization: maximizing flexible and predictable income for AHDS programs, to enable faster, more effective and at scale delivery of results for beneficiaries.
2. Agile and responsive business model: simplifying and automating processes and recalibrating functions to ensure that the AHDS operating model can adapt more nimbly to changing and increasingly complex operating contexts while maximizing results for beneficiaries through improved program quality, accelerated delivery and greater efficiency.
3. Decentralized and empowered internal governance and oversight: strengthening the accountability of individual staff members to deliver results for beneficiaries, with oversight and decision-making following the principle of subsidiarity (issues should be dealt with at the most immediate or local level) and informed by a common set of principles, including protection from sexual exploitation and abuse, ethical standards, transparency and environmental sustainability.
4. Dynamic and inclusive people and culture: ensuring that the entire AHDS workforce is skilled, motivated, agile and empowered to perform at its best for the beneficiaries, in a culture that is based on the core values of care, respect, integrity, trust and accountability, with zero tolerance for any form of misconduct.
5. Strategic internal communication and staff engagement: fostering inclusive, transparent, constructive and authentic exchanges between staff at all levels, for enhanced awareness, agile collaboration and connectedness.

[22] Adapted from: Theory of Change, UNICEF Strategic Plan, 2022–2025

Assumptions

Investments on SDGs

International and domestic investments remain committed to support achievement of SDGs targets.

Developing countries are grappling with an unprecedented rise in external debt levels following the COVID-19 pandemic, compounded by challenges such as record inflation, escalating interest rates, competing priorities and constrained fiscal capacity, underscoring the urgent need for debt relief and financial assistance. While official development assistance (ODA) flows continue to reach record peaks, the increase in 2022 is primarily attributed to spending on refugees in donor countries and aid to Ukraine.[23]

Supports to NGO

World politics and international development have undergone a radical transformation mostly because of increasing globalization. A unique characteristic of this transformation is the increasing number and type of stakeholders organized into interest groups or nongovernmental organizations (NGOs). Their influence on public policy at local, national, and global levels and in nearly every aspect of policy-making and international relations has made them dominant actors in the development arena.

In this global association revolution, NGOs have gained prominent positions in negotiations, especially in advocacy activities for human rights, peace, and the environment. They have also played leading roles in delivering disaster relief, humanitarian aid, and development assistance. While they are known for questioning the effectiveness, accountability, and legitimacy of governments and the private sector alike, many NGOs have also been questioned on their own effectiveness, accountability, and legitimacy.

Conventional wisdom suggests that the negative perceptions of the NGO sector will force it to take notice of the accountability and transparency gaps that have often characterized their operations and that this will open the doors for a comprehensive shift toward more transparent and accountable decision-making and policy development processes.[24]

Capacity building

Capacity building is referred as the development of knowledge, attitude, and skills of the workforce for enhancing the abilities to achieve the short-term and long-term goals on organizational as well as personal levels. According to this, capacity building broadly covers the inabilities of all employees and develops the desirable skills and attitude, which enable them to accomplish suitable tasks efficiently. Capacity building has a positive impact on the employees' performance along with external factors significantly examined. In general, capacity building improves effectiveness at the organizational level. The managers are involved in designing the different training programs for enhancing employees' learning, aptitudes, and capacities for the accomplishment of organizational goals. These efforts not only enhance the employees' performance but also develops a better organizational image. The manager support involves the provision of favorable and reasonable conditions of employment, while capacity building deals with providing sustainable opportunities to employees, keeping in view their natural talents. So, the capacity building can enhance the socioeconomic benefits for the employees.[25]

[23] The Sustainable Development Goals Report 2023

[24] Tortajada: NGOs and Influence on Public Policy

[25] Impact of Capacity Building and Managerial Support on Employees' Performance

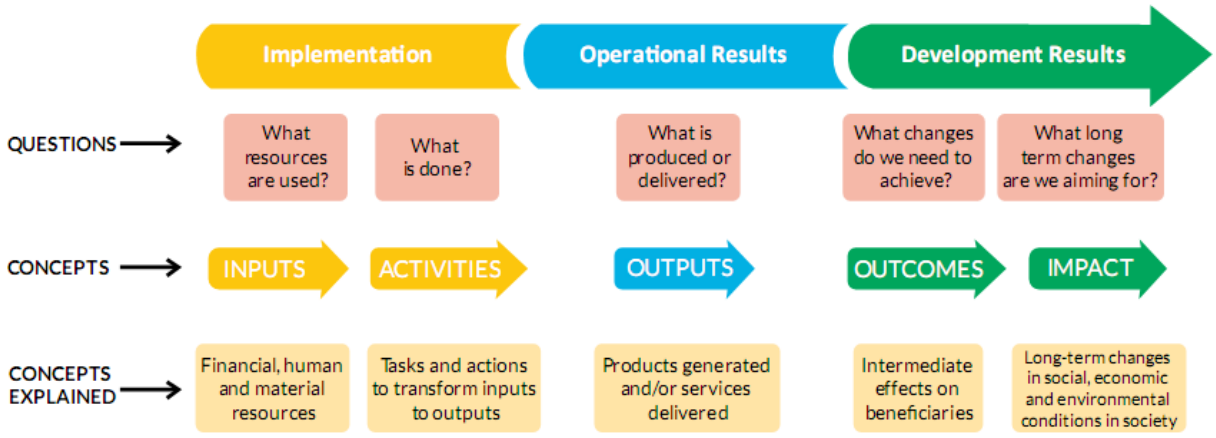
Monitoring, Evaluation, Accountability and Learning (MEAL)

AHDS initiated results-based management (RBM) systems to improve the organization's effectiveness and accountability.

Results-Based Management (RBM) aims at improving management effectiveness and accountability by defining realistic expected results, monitoring progress toward the achievement of expected results, integrating lessons learned into management decisions and reporting on performance.

The key elements of RBM are:

1. Focusing the dialogue on results at all phases of the development process.
2. Aligning programing, monitoring and evaluation with the results.
3. Keeping measurement and reporting simple.
4. Managing for, not by results.
5. Using results information for learning and decision making.



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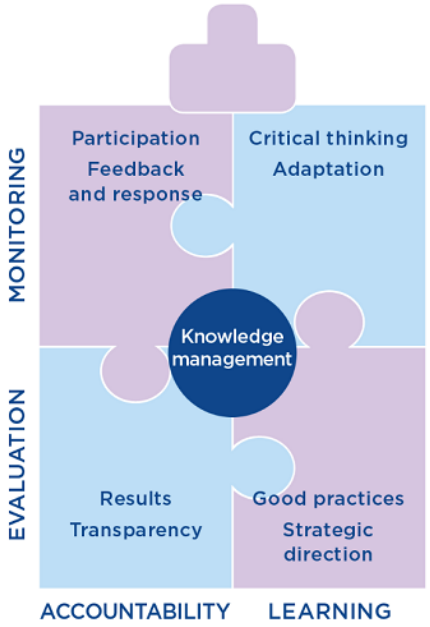
MEAL involves tracking the progress of programs, making adjustments and assessing the outcomes. Equally challenging is the use of this information to foster change within the organization or even the system as a whole. While collecting and analyzing monitoring and evaluation information is critically important, a MEAL system is only effective when project teams use data to demonstrate and improve the effectiveness, efficiency and, ultimately, the outcomes and impact of their projects. In short, monitoring and evaluation data should always be used to inform management decisions, which, in turn, promote accountability and learning.[27]



[26] UN-Habitat: Results-Based Management Handbook, applying RBM concepts and tools for a better urban future, 2017

[27] https://www.crs.org/sites/default/files/tools-research/propack-i_0.pdf

Monitoring is continual and systematic collection of data to provide information about project progress.

Evaluation is user-focused, systematic assessment of the design, implementation and results of an ongoing or completed project.

Accountability is commitment to balance and respond to the needs of all stakeholders (including project participants, communities, donors, partners and the organization itself) in the activities of a project. Projects embrace accountability by promoting: a) Transparent communications with all stakeholders; b) Alignment with standards in compliance with agreed donor requirements; c) Responsiveness that can voice feedback, ideas, suggestions and complaints; d) Participation of stakeholders.

Learning is a culture and processes in place that enable intentional reflection. The aim of learning is to make smarter decisions. Learning requires that you engage different stakeholders in thoughtful discussion of what is working and what is not working, in the efforts to achieve the stated objectives.

Organizational learning is important for increasing organizational effectiveness, developing organizational capacity and make best use of limited resources. It also strengthens partnerships that are built on transparent decision making, mutual respect and positive experiences of cooperation. Organizational learning improves use of information from monitoring and evaluation for future planning and creates a healthy organization (which is more effective and adaptable, and where people want to stay longer and contribute more).

MEAL activities are organized into five phases: Phase-1, Designing logic models (theory of change, results framework and logical framework); Phase-2, Planning MEAL activities; Phase-3, Collecting MEAL data; Phase-4, Analyzing MEAL data and Phase-5, Using MEAL data.[28]

MEAL system will be established as an integrated part of all programs. AHDS will keep its ToC under strict observation as well. The TOC is a dynamic document, means that it should be regularly reviewed and corrected/updated as required. While the Board of Directors and the Management Committee are primary responsible, any views and comments from staff of AHDS and other stakeholders will be welcomed.

A committee of three (one from the Board of Directors and two from the Management Committee) will be assigned for formulating annual work-plan and necessary resources required for systematizing information on progress to guaranteed timely decision- making. The team should ensure that the collection, processing and analyzing of information progress are available to governance. The team will undertake valuable activities on progress. The team monitor circumstances during the year that may rise to strategies needing to be adjusted from time to time and situations may arise for which contingency plans need to be developed quickly. The team should ensure timely provision of information for changes and management decisions. The team will present the summary of key success and problems, lessons learned, ideas for changing in Board Meetings.

[28] A Guide to the MEAL Dpro; Version 1.0, April 2019

Sustainable Development Goals Targets and Indicators

AHDS will contribute to the following SDG targets and indicators from the 2030 Agenda for Sustainable Development.

Goal 3. Ensure healthy lives and promote well-being for all at all ages.

Goals and targets	Indicators
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1 Maternal mortality ratio 3.1.2 Proportion of births attended by skilled health personnel
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	3.2.1 Under-5 mortality rate 3.2.2 Neonatal mortality rate
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations 3.3.2 Tuberculosis incidence per 100,000 population 3.3.3 Malaria incidence per 1,000 population 3.3.4 Hepatitis B incidence per 100,000 population 3.3.5 Number of people requiring interventions against neglected tropical diseases
3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease 3.4.2 Suicide mortality rate
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1 Coverage of treatment interventions (Pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders
3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents	3.6.1 Death rate due to road traffic injuries
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs	3.7.1 Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods

Goals and targets	Indicators
	3.7.2 Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	3.8.1 Coverage of essential health services 3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.9.1 Mortality rate attributed to household and ambient air pollution 3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services) 3.9.3 Mortality rate attributed to unintentional poisoning
3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older
3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all	3.b.1 Proportion of the target population covered by all vaccines included in their national program 3.b.2 Total net official development assistance to medical research and basic health sectors 3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis
3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States	3.c.1 Health worker density and distribution
3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness

Goals and targets	Indicators
	3.d.2 Reduce the percentage of bloodstream infections due to selected antimicrobial-resistant organisms

Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture.

Goals and targets	Indicators
2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons	2.2.1 Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age 2.2.2 Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight) 2.2.3 Prevalence of anemia in women aged 15 to 49 years, by pregnancy status (percentage)

Goal 5. Achieve gender equality and empower all women and girls.

Goals and targets	Indicators
5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation	5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age 5.2.2 Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences	5.6.1 Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care 5.6.2 Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education

Goal 6. Ensure availability and sustainable management of water and sanitation for all.

Goals and targets	Indicators
6.1 By 2030, achieve universal and equitable access to safe and affordable drinking water for all	6.1.1 Proportion of population using safely managed drinking water services
6.2 By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations	6.2.1 Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water
6.3 By 2030, improve water quality by reducing pollution, eliminating dumping and minimizing release of hazardous chemicals and materials, halving the proportion of untreated wastewater and substantially increasing recycling and safe reuse globally	6.3.1 Proportion of domestic and industrial wastewater flows safely treated 6.3.2 Proportion of bodies of water with good ambient water quality
6.4 By 2030, substantially increase water-use efficiency across all sectors and ensure sustainable withdrawals and supply of freshwater to address water scarcity and substantially reduce the number of people suffering from water scarcity	6.4.1 Change in water-use efficiency over time 6.4.2 Level of water stress: freshwater withdrawal as a proportion of available freshwater resources

Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.

Goals and targets	Indicators
8.5 By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value	8.5.1 Average hourly earnings of employees, by sex, age, occupation and persons with disabilities 8.5.2 Unemployment rate, by sex, age and persons with disabilities

Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.

Goals and targets	Indicators
16.1 Significantly reduce all forms of violence and related death rates everywhere	16.1.3 Proportion of population subjected to (a) physical violence, (b) psychological violence and (c) sexual violence in the previous 12 months
16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children	16.2.1 Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month

	16.2.2 Number of victims of human trafficking per 100,000 populations, by sex, age and form of exploitation 16.2.3 Proportion of young women and men aged 18–29 years who experienced sexual violence by age 18
16.7 Ensure responsive, inclusive, participatory and representative decision-making at all levels	16.7.2 Proportion of population who believe decision-making is inclusive and responsive, by sex, age, disability and population group
16.9 By 2030, provide legal identity for all, including birth registration	16.9.1 Proportion of children under 5 years of age whose births have been registered with a civil authority, by age

Goal 17. Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development.

Goals and targets	Indicators
17.17 Encourage and promote effective public, public-private and civil society partnerships, building on the experience and resourcing strategies of partnerships	17.17.1 Amount in US$ committed to public-private partnerships for infrastructure

AHDS' theory of change describes how to ensure universal health coverage and the right to the highest attainable level of health in Afghanistan. It can be achieved through promotion of healthy lifestyle, provision of primary healthcare and addressing the root causes of environmental and social threats to health. AHDS' theory of change stresses the need to improve its ability to identify and respond to such moments. AHDS play its role by advocacy, technical assistance, and provision of development and emergency relief programs. AHDS can convene like-minded organizations such as civil society organizations (CSO), private sector, government and the international community.