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# EVALUATION OF THE PERFORMANCE-BASED PARTNERSHIP GRANTS PROJECT IN AFGHANISTAN

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## ACRONYMS

AADA	Agency for Assistance and Development of Afghanistan
ADRA	Adventist Development and Relief Agency, Afghanistan
AHDS	Afghan Health and Development Services
AHS	Afghanistan Household Survey
AHSBS	Afghanistan Health Sector Balanced Scorecard
AKDN	Aga Khan Foundation
ANC	Antenatal care
ARI	Acute respiratory infection
BDF	Bakhtar Development Foundation
BHC	Basic health centers
BPHS	Basic Package of Health Services
CAF	Care of Afghan Families
CHA	Coordination of Humanitarian Assistance
CHC	Comprehensive health centers
CHW	Community health worker
CHS	Community health supervisor
CPR	Contraceptive prevalence rate
DD	Diarrhoeal disease
DH	District hospitals
EPHS	Essential Package of Health Services
EPI	Expanded program of immunization
FP	Family planning
GCMU	Grants and Contracts Management Unit in MOPH
GH Tech	Global Health Technical Assistance Project
HF	Health facility
HMIS	Health management information system
HSSP	Health Services Support Project
IMC	International Medical Corps – UK
IMR	Infant mortality rate
IPC/C	Interpersonal communication and counseling
MOPH	Ministry of Public Health
MOVE	MOVE Welfare Organization
NAC	Norwegian Afghanistan Committee
ORT	Oral rehydration therapy
PH	Provincial hospital
PNC	Postnatal care
PPG	Performance-based Partnership Grants project
QA	Quality assurance
RFA	Request for Application
SCUS	Save the Children, USA
SDF	Sanayee Development Foundation
STEP	STEP Health and Development Organization
TA	Technical assistance
TB	Tuberculosis
USAID	U.S. Agency for International Development
WHO	World Health Organization



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## **EXECUTIVE SUMMARY**

The Performance-based Partnership Grants (PPG) project is the core service delivery component of USAID's current health program in Afghanistan. USAID funds the PPG project through an agreement signed with the World Health Organization (WHO) in April 2006. WHO has in turn entered into 21 sub-grant agreements with nongovernmental organizations (NGOs) to deliver the Basic Package of Health Services (BPHS) in 13 provinces and five agreements for delivery of the Essential Package of Hospital Services (EPHS) in five provincial hospitals. The project started in July 2006, was scheduled to end in April 2008, and is now being extended to December 2008.

USAID commissioned the Global Health Technical Assistance (GH Tech) project to evaluate the PPG project. A GH Tech consultant spent two weeks in-country February 16–28, 2008. The findings from this evaluation will be incorporated into the design of a new PPG project starting in March 2008; the new project is due to be launched in January 2009.

## **CONCLUSIONS FROM THE EVALUATION**

The overwhelming conclusion is that the PPG project has performed extremely well. Since the project covers roughly 40 percent of the country (parallel projects funded largely by the World Bank and the European Commission cover the rest), it is fair to attribute a significant part of the national improvement in health outcomes in recent years to PPG's successful work:

- The Afghanistan National Household Survey in 2006 shows that contraceptive prevalence and skilled attendance at birth both tripled between 2003 and 2006; take-up of antenatal care rose by six-fold; under-5 and infant mortality rates dropped by a quarter. However, the Expanded Program of Immunization (EPI) coverage remains disappointing at 27 percent.
- The Afghanistan Health Sector Balanced Scorecard, which has been conducted annually since 2004, reviewed health performance against 29 indicators in 2007. Mean scores for all 29 indicators have risen substantially, from 53 percent achievement of targets in 2004 to 70 percent in 2007. Performance in the PPG provinces is closely aligned with the national figures. However, the amount of time spent with new patients, the quality of counseling, and the degree to which tuberculosis (TB) has been integrated into the BPHS are consistent weak points.

Evidence of the project's performance from PPG-specific data sources is also quite positive. A 2007 household survey of PPG provinces alone shows that performance improved on 9 of 10 outcome indicators in the first 15 months of the project. Where direct comparisons with the national household survey are possible, PPG performance is generally above the national average. The main exception is exclusive breastfeeding, where measured performance is slightly below baseline. Moreover, care-seeking behavior for the main killers of children under 5—acute respiratory infection (ARI) and diarrhoeal disease—has shown little improvement.

PPG-specific BPHS data extracted from the national Health Management Information System (HMIS) shows that PPG client volumes grew on average by over 15 percent annually in the first two years, although there are signs that the rate of growth is slowing as fewer new facilities come

on stream. Volume growth at the community level has been especially strong but growth for both ARI and TB has been relatively disappointing.

The Ministry of Public Health (MOPH) monitors PPG performance monthly and quarterly through its Grants and Contracts Management Unit (GCMU). Performance is much affected by security and terrain issues, but even in the most challenging locations none of the sub-grantee NGOs shows abnormally poor performance. The three BPHS clusters performing best in the first three quarters of 2007 are managed by Afghan NGOs that are relatively new to the project; they are clearly trying harder and seem to have above average management skills.

Analysis of findings from recent BPHS field monitoring visits by GCMU and WHO staff shows that more attention to TB case detection and infection prevention practices would be justified. Consultation with the NGO sub-grantees on their own perception of the project's performance confirms both of these as areas of weakness.

It is more difficult to judge the success of the EPHS rollout in the provincial hospitals. EPHS is newer than BPHS (launched only in 2005) and these sub-grants have been consistently operated on a rolling six-month basis. As a result, it is difficult to see any long-term trend because the baseline and targets keep changing. It does seem that the number of active beds and staff are roughly on target, but inpatient admissions, the number of C-sections performed, and compliance with national hospital quality standards are generally below target.

Five main lessons can be learned from this evaluation:

- The quality of an NGO's management and leadership is the main determinant of performance. Good leaders can even overcome the challenges presented by lack of security or difficult terrain.
- The Afghan market is culturally very resistant to deliveries outside the home. Despite a large increase in the supply of clinical delivery services, 85 percent of women still deliver at home. The drop-out rate between antenatal care (ANC) and delivery is also very high.
- TB, a classic vertical program, is difficult to integrate into a standard package of services. It still has not fully entered the mindset of service providers.
- Consistent community outreach and tight community linkages seem to have a favorable impact on outcomes. (This consensus view is, however, difficult to prove quantitatively.)
- A package-based approach is totally appropriate for Afghanistan but may not work fast enough to prevent avoidable maternal and child deaths.

## IMPLICATIONS FOR THE NEW PROGRAM

Eight issues arise from the evaluation that could help shape any new PPG program:

- **Supplementing the BPHS/EPHS rollout with two highly focused initiatives to reduce maternal and child deaths:** A package-based approach makes eminently good sense but we recommend that more be done in parallel to tackle the extremely high mortality rates in Afghanistan. The child health initiative should probably be demand-driven and focus on ARI and EPI. The maternal initiative would focus on identifying and handling complicated deliveries and should probably be driven at the community level.

- **Doing more to increase community preparedness, particularly for complicated deliveries:** We recommend a concerted effort to identify potentially complicated deliveries, linking the mother to a trained provider (preferably at a clinical facility although possibly having the provider come to the client's home for the delivery); planning and paying for transport (either for the mother or the midwife); lining up a blood donor in case of need, etc. Much of the raw material for a prepared village of this sort already exists in the tools and resources of the Health Services Support Project (HSSP).
- **Improving the balance of effort going into EPHS:** The newer EPHS has not yet matured to the same extent as the BPHS; it needs attention over the next few years to bring it to the current level of performance of BPHS. It is recommended that EPHS awards be competitively bid through a separate Request for Application (RFA) for the new program and that every effort be made to build a group of NGOs that specialize in hospital work, which requires different skills and deeper experience than the BPHS.
- **Integrating TB more fully into the BPHS:** Given the low visibility accorded to TB, we recommend that all service providers be refreshed in case detection skills and how to make TB referrals. Thought also needs to be given to how to make sputum testing more accessible. We suggest either selective provision of TB microscopy at basic health centers (BHCs) or investment in teaching the skills necessary to take sputum samples and prepare slides at selected BHCs.
- **Strengthening interpersonal communication and counseling skills:** These are still weak, and more training is recommended for community and health facility providers. Failure to spend sufficient time with new clients may be attributable to a lack of counseling awareness, although it could also be a result of bottlenecks in client flows. We recommend operations research into the entire topic of front-line customer service, from reception to triage to privacy. This could help to focus training on areas of real need.
- **Achieving a better balance between supply of and demand for services:** Most attention to date has gone to the supply side, which is logical and necessary. Now that the physical system is largely in place, however, a better balance between supply and demand will be needed, and we recommend that resources for demand generation be increased. The prime candidate interventions are antenatal care (partly as a route into attended deliveries), ARI, and EPI. Generating demand through community health workers, health facilities, and mass media and close attention to quality of services as the prime generator of long-term demand will both be needed in a concerted effort to maintain the growth momentum built up in the last few years.
- **Giving NGOs a budget for cascading training provided through HSSP:** We recommend that HSSP continue as the lead training provider, quality controller, curriculum developer, and master trainer, but that NGOs be given a budget for cascading the value of HSSP's training more directly to NGO staff. HSSP might assist NGOs in cascading competency-based training.
- **Improving the referral success rate:** Referrals in Afghanistan face major logistical barriers and the basic referral processes (slips, feedback, follow-up, etc.) could also be

improved. The task is so huge that we propose starting in the new program with just the priority maternal and child health interventions.

In addition to these eight action areas, we recommend a review of the BPHS and EPHS indicators for the next program. The current BPHS list is very long, and the indicators for both BPHS and EPHS are not well-aligned with objectives assigned to sub-grantees. Since both GCMU and Tech-Serve staff monitor EPHS performance, we propose that they interact more to ensure better awareness of each other's work and findings. Finally, there seems to be uncertainty about targets for cost recovery in hospitals: policy in this area needs to be clarified if this is to remain a functional indicator.

## I. BACKGROUND

USAID has done a great deal to help improve Afghanistan's public health outputs and outcomes over the last six years. During that time health service in the country has improved considerably:

- The BPHS, launched in 2003 and revised in 2005, has now been rolled out nationwide in active facilities in the lower four tiers of the health service delivery system—9,780 health posts (HPs), 680 basic health centers (BHCs), 381 comprehensive health centers (CHCs), and 57 district hospitals (DHs).
- In 2005 the EPHS was introduced in DHs plus the five regional and 30 provincial hospitals and is now being rolled out nationwide.
- Operation of some provincial hospitals and all health facilities in the lower four tiers has been contracted out to NGOs, who are funded mainly by USAID (13 provinces), the World Bank (10), and the European Commission (10).
- Large numbers of service providers have been given in-service and refresher training to enable them to deliver better-quality BPHS and EPHS. This is especially true at the community level; about 19,000 volunteer community health workers (CHWs) have now been trained and put in place.
- A comprehensive HMIS has been installed and is now yielding large volumes of monthly data that allow managers to track performance.

With this huge national increase in service coverage, infant and under-5 mortality rates are estimated to have dropped by a quarter since 2000, contraceptive prevalence and the rate of skilled attendance at births have tripled, and percentage take-up of ANC has risen six-fold.

In June 2006 USAID's previous flagship project in Afghanistan—Rural Expansion of Afghanistan's Community-based Health Care (REACH)—ended and was replaced by a variety of projects, of which the main service delivery component is the PPG project. PPG is contracted through WHO for funding purposes and in April 2006 USAID and WHO signed a \$55 million grant agreement for a period of two years. Simultaneously, WHO finalized sub-grant agreements with NGOs covering 21 geographical clusters in 13 provinces for delivery of the BPHS and another five sub-grant agreements for rollout of the EPHS in five provincial hospitals (see Table 1). The sub-grants are now being extended through December 2008.

In January 2008, USAID commissioned this end-of-project PPG evaluation through the GH Tech project. A consultant spent two weeks in-country February 16–28, 2008 (see Appendix A for the consultant's scope of work and Appendix B for the list of persons contacted). In March 2008, design begins for a new PPG project, which is planned to commence on January 1, 2009; the evaluation findings will be incorporated into the design. To improve alignment with the aid effectiveness principles of the Paris Declaration, USAID plans to fund the new project for NGO implementers directly through the Afghanistan MOPH—how to do that is now being explored.



**Table 1: PPG Provinces and NGO Partners**

<b>MOU #</b>	<b>Province</b>	<b>NGO</b>	<b>Service Focus</b>
1	Badakhshan, cluster 1	Medair	BPHS
2	Badakhshan, cluster 2	Merlin	BPHS
3	Badakhshan, cluster 3	Aga Khan Foundation (AKDN)	BPHS
4	Badakhshan, cluster 4	AKDN	BPHS
5	Baghlan	Bakhtar Development Foundation (BDF)	BPHS
6	Bamyan, cluster 1	Agency for Assistance and Development of Afghanistan (AADA)	BPHS
7	Bamyan, cluster 2	Adventist Development and Relief Agency, Afghanistan (ADRA)	BPHS
8	Faryab, cluster 1	AADA	BPHS
9	Faryab, cluster 2	Save the Children, USA (SCUS)	BPHS
10	Ghazni, cluster 1	BDF	BPHS
11	Ghazni, cluster 2	Sanayee Development Foundation (SDF)	BPHS
12	Ghazni, cluster 3	Norwegian Afghanistan Committee (NAC)	BPHS
13	Herat, cluster 1	Coordination of Humanitarian Assistance (CHA)	BPHS
14	Herat, cluster 2	MOVE Welfare Organization (MOVE)	BPHS
15	Jawzjan	STEP Health and Development Organization (STEP)	BPHS
16	Kabul	STEP	BPHS
17	Kandahar	Afghan Health and Development Services (AHDS)	BPHS
18	Khost	International Medical Corps – UK (IMC)	BPHS
19	Paktya	Ibn Sina Public Health Program for Afghanistan (Ibn Sina)	BPHS
20	Paktika	IMC	BPHS
21	Takhar	Care of Afghan Families (CAF)	BPHS
23	Badakhshan	CAF	EPHS
24	Ghazni	BDF	EPHS
25	Khost	IMC	EPHS
26	Paktya	Ibn Sina	EPHS
27	Paktika	IMC	EPHS



## II. PLANNED CONTRIBUTIONS FROM PPG PARTNERS

Although the MOPH/USAID/WHO/NGO relationships principally define what the PPG project is expected to achieve, both the HSSP and the Tech-Serve project have been given integral support roles.

### THE USAID-WHO GRANT AGREEMENT

USAID's agreement with WHO took effect on April 24, 2006, for a period of two years. WHO was selected to make the sub-grants to NGOs partly in response to USAID's decision to break up REACH into smaller, more manageable projects and partly to address MOPH concerns that USAID move toward direct government funding for its health activities. While WHO is fully responsible to USAID for project performance, it was made clear in the agreement that throughout WHO would also work closely with the MOPH. For instance, the agreement specifically charged the MOPH GCMU with issuing RFAs to NGOs and convening a Technical Review Committee (whose membership included both USAID and WHO) to assess applications.

WHO initially made sub-grant awards for BPHS services for one year. In 2007 these were extended by one year and have now been extended again for eight months, to December 2008. Since many of the EPHS sub-grants under REACH were still in place when the main agreement was signed, WHO initially provided six months of bridge funding for the provincial hospitals (PHs) listed in Table 1. This funding has undergone continuous six-month extensions since then because USAID was unable to commit funds for a longer period. It is anticipated that the five PHs will now be funded, like their BPHS counterparts, through December 2008.

The main objective assigned to WHO under the agreement is to use the grant procedures established by the REACH project to "further expand the scope, scale, and quality" of BPHS and EPHS delivery, in accordance with the "procedures, methodologies, standards, and criteria set by the MOPH" for the two programs. Normal USAID reporting rules were in the agreement but the list of indicators to be tracked and the targets attached to them were to be developed later and were not attached to the main agreement.

In addition to this main objective, WHO was given objectives with respect to infectious diseases (particularly avian influenza) in such areas as disease early warning systems and vector control. Since this evaluation focuses on BPHS/EPHS, performance in these areas has not been investigated. The agreement also lists objectives to which the sub-awardees are expected to contribute in such areas as reinforcing MOPH and provincial health departments, service quality, and informed decision-making. These aspects are described below under the contributions of HSSP and Tech-Serve.

### WHO-NGO SUB-GRANT AGREEMENTS

#### *BPHS Objectives*

The WHO sub-grant agreements with NGOs list four BPHS objectives:

- Improve the quality and utilization of health services.

- Increase the number of trained, supplied, and supervised clinical staff and CHWs, especially women.
- Expand and enhance service coverage for women of reproductive age and children under five.
- Develop health service delivery systems at the community level, including community outreach and appropriate referral centers.

Approximately two months into the agreement period a list of 46 BPHS indicators – 27 at the output level and 19 at the outcome level—was finalized between the MOPH, NGOs, USAID, and WHO (see Appendix C for the list).

There seem to be two issues associated with the list:

1. It is very long. None of the cross-cluster analyses reviewed actually reported on all the output indicators. This constant selection of certain indicators to study suggests that most analyses cannot cope with 27 variables; it also conveys an incoherent picture of PPG progress when different sub-sets of indicators are routinely selected for analysis. Even the PPG’s own household surveys only cover 10 of the 19 outcome indicators.
2. Second, the alignment of the list with the sub-grantees’ objectives is not perfect:
  - There are in fact roughly eight separate objectives listed in the sub-agreements:
    - service quality
    - service utilization
    - number of staff
    - staff training
    - staff supervision
    - supplies (drugs, commodities, consumables, equipment, etc)
    - service coverage
    - delivery systems at the community level
  - The output indicators are divided into four groups:
    - expanding service delivery systems
    - improving quality of services
    - implementation and management
    - other (sustainability and coordination)

*Service quality* is well-covered by the indicators, although it might be useful to add an indicator on client satisfaction to capture the client perspective on quality—usually quite different from the service provider’s. *Service utilization* is not covered but is now readily available from the parallel HMIS: so long as utilization data from the HMIS are routinely added to any analysis of NGO/cluster performance, the picture will be complete. *Staff supervision* is covered only with respect to supervision of CHWs. Supportive supervision of clinical staff, both within fixed sites and outside them, would be a useful addition—especially because it will be an increasingly important source of information for improving training and knowledge in future. The other objectives are well-covered.

## *EPHS Objectives*

The objectives assigned to sub-grantees by the EPHS agreements are to

- Implement the EPHS in the hospitals.
- Improve service quality.
- Correct any operational weaknesses using the standards-based management approach.
- Increase the capacity of provincial health departments, NGOs, and NGO partners.

The fourth objective overlaps with those of both HSSP and Tech-Serve. Since the NGO sub-grantees are working alongside Tech-Serve in building provincial health department capacity, there is no risk of duplication. It is less clear how the WHO agreement will directly increase NGO capacity, although there will be plenty of indirect capacity-building through the experience of implementing sub-grant activities.

The list of agreed EPHS indicators (also in Appendix C) is shorter (13) and therefore more manageable, but again two issues arise:

1. Alignment of objectives with indicators could be improved: five of the 13 indicators address hospital utilization, which is not an explicit objective of the sub-grants. Service quality and standards-based management are well-covered. Tech-Serve provides technical assistance on management to all PHs in the PPG provinces using the National Hospital Standards (indicator 13 in the EPHS list): there appears to be limited interaction between that work and GCMU's EPHS monitoring—this could be improved.
2. Two of the indicators do not seem to be routinely monitored in GCMU's work: cost of medications (#4) and cost recovery (#12). There are no firm targets for either of these, which suggests there is a lack of policy direction to guide standards and targets. Policy on drug expenditure and cost recovery at hospitals probably needs to be clarified before these indicators can be worth detailed monitoring.

## **HSSP'S ROLE IN THE PPG PROJECT**

The HSSP project has a strong role to play in supporting the PPG's NGO sub-grantees in seven main areas:

- Development of quality assurance (QA) and supervision systems: National QA standards for 13 components of the BPHS have been developed and baseline assessments against those standards are complete for four provinces.
- NGO capacity-building: Clinical and management training, development of model health facilities (HFs) through application of the QA system, and development of job aids.
- Midwifery and safe motherhood: Pre-service midwifery education, accreditation of pre-service education facilities and a post-partum hemorrhage demonstration project.
- Provision of in-service reproductive health training: Essential and emergency obstetric care and family planning (FP).
- Capacity-building for both NGOs and provincial health departments in behavior change communication techniques.

- Technical assistance with community mobilization: Baseline assessment of community mobilization activities in all 13 PPG provinces, improving dialogue between HF-based service providers and the communities they serve, and plans for mobilizing religious leaders around health issues.
- Building gender sensitivity into quality standards, including gender awareness training for NGO staff.

HSSP is also active in many other areas where PPG NGOs are not the direct beneficiaries, such as support to the Afghanistan Midwives Association and capacity-building for the MOPH's Information, Education, and Communication Department.

Training in a variety of forms constitutes the single largest component of direct HSSP support to the PPG project: although sub-grantee NGOs have their own budgets for training CHWs and community health supervisors (CHSs), all other training is to be handled through HSSP. This has proved somewhat controversial, because NGOs are more used to handling much of their training needs directly, and they find the supply of training through HSSP to be limited. More importantly, they report difficulty in cascading internally the value of the training they do receive through HSSP because they have no budget for this. HSSP for its part insists that training be justified by real gaps in service provider knowledge and that NGOs may need to become more creative in transferring knowledge and learning among their staff; it should not just be a budget issue. We explore this issue in detail in Chapter IV, but our basic conclusion is that HSSP should its firm grip on the supply and quality of training for PPG NGOs, but that in the future NGOs should receive a budgetary allowance for cascading training.

## **TECH-SERVE'S ROLE IN THE PPG PROJECT**

The Tech-Serve project focuses on capacity-building within the MOPH centrally and among the provincial health departments in all 13 PPG provinces. It therefore has fewer areas of direct overlap with PPG NGOs than does HSSP. However, it does have a very direct impact on the success of the PPG project in two specific areas:

1. As part of its capacity-building work at MOPH, Tech-Serve provides the entire staff for the PPG section of the GCMU. This means that Tech-Serve is central to MOPH day-to-day monitoring of the PPG project and conducting periodic analyses and assessments of project performance.
2. Provision of USAID-funded pharmaceuticals: Tech-Serve distributed over \$5.5 million of essential drugs, contraceptives, and TB medications in the first 15 months of the PPG project. It helps MOPH assess demand for pharmaceuticals and accepts delivery in its store when the pharmaceuticals arrive in-country. NGO sub-grantees then collect their supplies from Tech-Serve warehouse and are responsible for distribution to HFs. Tech-Serve also takes a wider view of the whole logistical system, training pharmacy managers in provincial health departments and now working on both national logistics guidelines and development of standard treatment guidelines to rationalize drug use.

As reported in Chapter III, there are occasional shortages or stock-outs of items reported through routine monitoring of HFs, but in general the PPG pharmaceutical supply system is working extremely well.

### III. PROGRAM PERFORMANCE TO DATE

#### PPG'S CONTRIBUTION TO NATIONAL PERFORMANCE

Two recent national surveys have produced data on overall health performance in Afghanistan. Since PPG is funding delivery in 13 of the country's 34 provinces (about 38 percent of national coverage), it can take its share of credit for the improving health indicators.

#### Afghanistan Household Survey (AHS), 2006

This survey was conducted by Johns Hopkins University and the Indian Institute of Health Management Research for the MOPH; the field work was conducted September–December 2006. It covered rural households only and focused on maternal and child health indicators, but it also addressed care-seeking behavior, health expenditures, and perceptions of health service. Table 2 shows the results that have most relevance for the PPG project.

**Table 2: Selected Results from the AHS 2006**

<b>Indicator</b>	<b>Estimate</b>	<b>Comment/Trend</b>
CPR	16%	Up from estimated 5% in 2003
Knowledge of at least 1 modern FP method	33%	Modern and traditional: 37%
At least 1 ANC visit to skilled provider	32%	Up from estimated 5% in 2003
Skilled attendance at birth	19%	Up from estimated 6% in 2003
Institutional delivery	15%	Includes both public and private
Full immunization	27%	Big dropout DPT1 > DPT3
Vitamin A supplementation	77%	Benefit from polio campaigns/NIDs
Exclusive breastfeeding	83%	Surveyors suspect this is too high
Infant mortality per 1,000 live births	129	Down from estimated 165 in 2000
Under-5 mortality per 1,000 live births	191	Down from estimated 257 in 2000
First visit for an illness to public sector	44%	Private sector: 55%
Second visit for an illness to public sector	27%	Private sector: 50%

These results are highly encouraging. Many of the main health indicators are up by a factor of three to six times since the BPHS was launched. They confirm the wisdom of a package-based approach and the diligence with which it has been pursued. This all reflects very well on the PPG project. We understand that the National EPI Program reports different numbers for EPI coverage but have not been able to explore those differences. The main dampener in the list is high utilization of the private sector—a preference that increases after the first visit for an illness. Because anecdotal evidence suggests that generally service quality is very poor in the private sector, its apparent 50–55 percent market share may be attributable to location and therefore easier access, or to clients' emerging appreciation of the value of quality.

It is also true, of course, that while tremendous progress has been made, many indicators are very low by world standards. The under-5 mortality rate, for instance, still translates into 220,000 deaths annually. The only major indicator not covered is maternal mortality: a separate study of this is anticipated in early 2009. In the meantime, the 2002 estimate of 1,600 deaths per 100,000 live births is the only measure available, although there is an informal consensus that the current rate is probably down to about 1,200 based on much higher ANC coverage, improved attendance at birth, and the slightly higher number of institutional deliveries.

### **Afghanistan Health Sector Balanced Scorecard (AHSBS), 2007**

This survey has been conducted annually since 2004, also by Johns Hopkins University and the Indian Institute of Health Management Research. A balanced scorecard deliberately casts its net wide, looking at all aspects of care and delivery; the AHSBS uses 29 indicators spread across six domains. Table 3 shows the mean scores each year across the 29 indicators.

**Table 3: Mean Scores for Indicators 1-29, AHSBS 2007**

	National	PPG Provinces*	Other Provinces**
2004	53.2%	53.0%	53.3%
2005	59.0%	57.9%	59.9%
2006	65.4%	62.0%	68.1%
2007	70.2%	69.2%	71.0%

\*excluding Kandahar

\*\*excluding Helmand

Progress has again been good, both nationally and in the PPG provinces. Mean scores (measuring performance against a set standard for each indicator) have risen from the low 50s to about 70 percent over four years. As with the AHS results, this reflects well on PPG's efforts, although the increase in performance in PPG provinces seems to have been slightly below the national average for the four years. This gap is not significant, especially given the number of indicators involved in the averaging process; the results for year-end 2006 might have been more worrying had the gap not narrowed significantly in 2007. The differences between the two sets of provinces are thought to be largely attributable to the number of insecure areas in each set: the PPG provinces contain slightly more insecure areas where good performance is more difficult to achieve.

Analysis of the AHSBS results by indicator contains more important lessons for PPG. Four indicators consistently score worst each year (they were still below 55 percent achievement in 2007) even though improvement within each has been varied over the four years:

- Time spent with clients (18.4% in 2007): This measures the number of new clients with whom the service provider is able to spend the recommended minimum of nine minutes. This is consistently by far the lowest indicator in the AHSBS; it has not improved since 2004. We conclude that the problem is probably caused by bottlenecks during the peak period from 9am to noon, rather than by an overall lack of supply capacity. If this conclusion is true, then better reception and triage may well help to spread client flow. It is also possible that service providers are simply not yet thinking laterally and taking the time to ask questions to identify missed opportunities. This whole topic needs study.
- Counseling (48.7%): This measures completion of the steps needed to convey appropriate information to clients. So far less than half the steps are being taken, although progress in 2007 has been significant. This could again mean that either service providers are too busy to give proper counseling or they are not yet thinking actively about missed opportunities. It implies the need for more effort on interpersonal communication/ counseling (IPC/C) training or changes in reception/triage processes to ensure that clients are properly counseled at the start of a client visit.
- Tuberculosis (53.7%): This measures the number of health facilities with a TB register. Such a low percentage suggests that TB is not getting the attention it needs, given that it probably ranks among the top five killers in Afghanistan. There is a clear need for better availability of TB services at all levels.
- Infrastructure (54.6%): This measures the proportion of health facilities that comply with BPHS/EPHS infrastructure standards (size and layout). The challenge stems from the speed with which the more than 1,200 BPHS/EPHS facilities have been commissioned over the last five years: the resulting stock includes some facilities which are below standard (e.g., very old or in private premises with inflexible layouts). PPG can do little about this, because USAID's budget now only extends to minor repairs and maintenance of up to \$1,000.

## **PPG-SPECIFIC PERFORMANCE IN DELIVERING THE BPHS**

It is clear that PPG has contributed to a remarkable improvement in health outcomes at the national level. This section assesses PPG's actual performance in its assigned provinces. To do so, we accessed six data sources.

### **PPG Household Survey, 2007**

This survey was conducted in 2007 using lot quality assurance sampling; the results became available in February 2008. The survey covered 10 of the 19 BPHS outcome indicators (see Table 4).

**Table 4: Results from the PPG Household Survey, 2007**

Indicator	PPG 2007		AHS 2006
	Baseline (%)	Survey (%)	Survey (%)
CPR	24	30	16
Knowledge of 2 modern FP methods	47	56	33*
Skilled attendance at delivery	18	21	19
DPT3 coverage	30	34	35
Vitamin A coverage	67	71	77
Exclusive breastfeeding for six months	37	34	83
One or more ANC visits	32	41	32
One or more PNC visits	23	31	-
TT2 coverage	32	41	-
Seek qualified help with ARI and DD	38	39	-

\*1 method

The baseline data are taken from the REACH project in late 2005; the AHS 2006 national data from Table 2 are included for comparison. Again, the implications for PPG are very good:

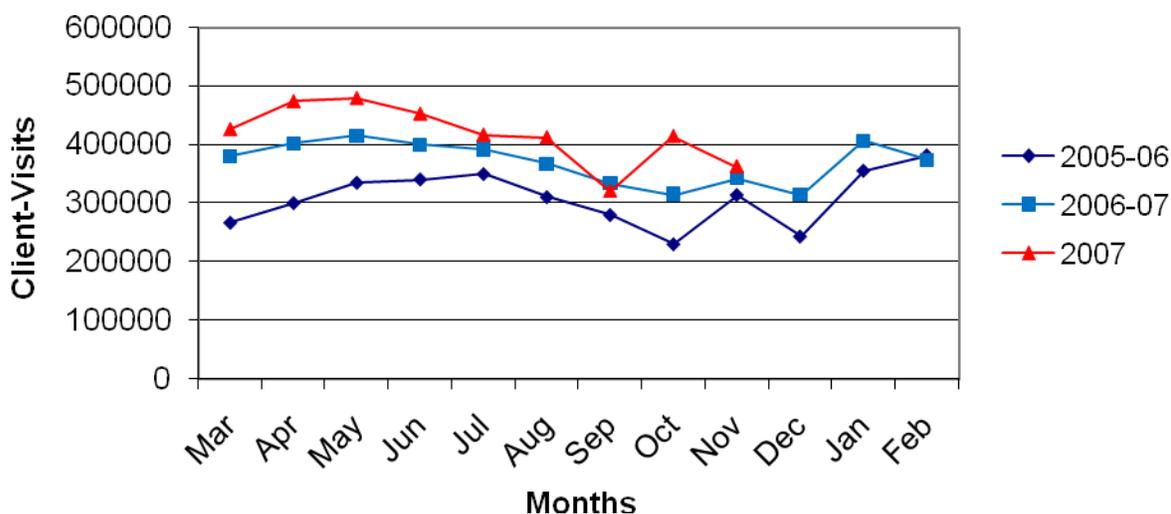
- All indicators but one show improvement over the baseline. FP knowledge, ANC and postnatal care (PNC) visits, and tetanus toxoid injections have all achieved an almost 10 percentage point increase in two years.
- The improvement in ARI and diarrhoeal disease (DD) results is disappointing, however, especially since together they are suspected of accounting for over half of under-5 deaths.
- Skilled attendance at delivery is still an intractable problem linked directly to a continuing cultural preference to deliver at home.
- The slight decline in exclusive breastfeeding is also disappointing. (Unlike the AHS, the PPG survey looks at breastfeeding from a care-seeking perspective, so it is not possible to compare the two surveys directly.)
- Where comparisons are possible between PPG and national results, PPG comes out at or above the national average. Its performance in FP is especially good: contraceptive prevalence is almost double the national figure; even the baseline in 2005 was above the 2006 national figure 2006. This may reflect PPG's commitment to community-level activities.

The areas of less than average performance represent opportunities for a change of emphasis during the rest of the current project and certainly in the project commencing January 2009.

## Implications from HMIS Data

The HMIS is now generating regular monthly and quarterly performance data for the entire service delivery system. An analysis of just the PPG facilities shows continuing fast growth (see Figure 1).

**Figure 1: Total PPG Client-Visits March 2005–November 2007**



**Table 5: PPG Volume Growth by Selected Intervention, June 2005–June 2007**

Intervention	June 2007	Avg. Annual Growth (%)
Total BPHS client-visits	453,254	15.4
Total FP visits at HFs	26,045	57.3
Total FP contacts at HPs	60,471	71.9
Total ANC 1 <sup>st</sup> visits	22,890	38.0
Total PNC 1 <sup>st</sup> visits	10,351	69.6
Total deliveries	5,529	50.8
Total ARI visits	61,394	4.0
Total TB cases completed	345	7.1
Total family visits by CHWs	286,057	72.1

Total client visits have grown at about 15 percent annually over the last two years. Community-level visits—FP visits at HPs and family visits made by CHWs—have grown fastest (both over 70 percent annually). Other interventions that are central to maternal and child health have also shown impressive growth, although ARI client visits are disappointing. Combining the low growth for ARI visits with only slow improvement in care-seeking behavior for ARI (see Table

5) suggests that a substantial effort is now needed to generate awareness of ARI services. TB cases are also very few and show low growth, which confirms evidence from many other sources that the TB program is not yet functioning smoothly.

In Figure 1, although growth has averaged 15 percent annually for two years, it is clear that growth is slowing. The line for 2007 touches that for 2006-07 in two or three of the 12 months. This is to be expected: increases in supply can only have a short-term effect; long-term growth has to come from growth in demand. There is a need for more attention to generating demand.

### **GCMU Tracking of PPG Performance against Targets**

GCMU is charged with routine monitoring of sub-grantee performance on behalf of the MOPH, USAID, and WHO. It does this monthly and quarterly through both quantitative data from NGOs and the HMIS and qualitative reports of monitoring visits to health facilities and NGO offices. It produces regular performance summaries and ad hoc reports. We have examined the regular quarterly performance summary for third quarter 2007, which consolidates all three quarters to date in 2007 and examines performance both by NGO/cluster and by indicator (see Table 6).

**Table 6: PPG BPHS Performance Analysis, January–September 2007**

<b>Analysis by MOU/Cluster/NGO</b>			
<b>MOU #</b>	<b>Province</b>	<b>NGO</b>	<b>Combined Score</b>
14	Herat	MOVE	400
15	Jawzjan	STEP	396
21	Takhar	CAF	387
13	Herat	CHA	367
16	Kabul	STEP	366
11	Ghazni	SDF	361
01	Badakhshan	Medair	360
08	Faryab	AADA	354
06	Bamyan	AADA	350
03	Badakhshan	AKDN	349
18	Khost	IMC	334
05	Baghlan	BDF	328
09	Faryab	SCUS	327
02	Badakhshan	Merlin	324
10	Ghazni	BDF	324
07	Bamyan	ADRA	318
12	Ghazni	NAC	318
19	Paktya	IbnSina	307
20	Paktika	IMC	289
17	Kandahar	AHDS	240

### Analysis by Indicator

<b>Subset of Indicators Agreed with NGOs</b>	<b>Score*</b>
# facilities now providing services through PPG	4.8
# health posts now providing services through PPG	4.4
# HFs reporting use of health education messages	5.0
# CHWs completed 3 <sup>rd</sup> phase of training	3.8
# active CHWs	4.0
% of active HFs correctly staffed to BPHS standard	2.3
# CHWs dropped out of program	4.7
# active HPs properly stocked with essential drugs	2.9
# active HFs making obstetric referrals	2.9
% of HMIS forms correctly submitted by HFs/HPs	4.9
<b>Service Delivery Evaluation Analysis</b>	
Achievement of target # active HPs	4.7
% BHCs/CHCs with at least one female provider	3.4
Achievement of BHC/CHC female complement	2.8
% HPs actively linked to an HF	3.9
% HFs with stock-outs of essential drugs	4.7
Monthly client flow above average at HFs	3.8
% HPs with >50 client contacts per month	4.6
% achievement of DPT3 targets	4.1
% achievement of target deliveries	3.1
% achievement of TB case detection targets	3.2
<b>Grant Administration Evaluation Analysis</b>	
Timeliness of technical reports from NGOs	3.8
Quality of technical reports from NGOs	3.4
Timeliness of financial reports from NGOs	5.0
Quality of financial reports from NGOs	3.0
NGO collaboration with all stakeholders	3.4
NGO communication/responsiveness to PPG	3.0

\*5 is top/best score

The upper half of Table 6 deals with NGOs and their geographical territories. The first message appears to be that it is difficult to extract high-scoring performance from geographical territories that are highly insecure (e.g., Paktya, Paktika, or Kandahar) or have difficult terrain (e.g., the southern parts of Bamyan). GCMU is quick to observe that performance in these areas should not be considered weak in any sense of the word: the NGOs working in these areas are thought of as the “champions”—both for taking on a difficult challenge and for producing results that are in fact so good.

The second message is that NGOs working in marginal areas (e.g., with some insecurity or unpredictable security records) can overcome these handicaps with strong NGO leadership. For instance, one of the clusters in Ghazni (considered a relatively insecure area) was among the most improved performers in 2007, a fact confirmed by the PPG household survey.

The third observation is that three provinces show particularly high performance—Herat, Jawzjan, and Takhar—and it happens that all three are assigned to Afghan NGOs. These areas are neither insecure nor with particularly challenging terrain, so they have a natural performance advantage. However, they are little different in these respects from the 10 or so clusters ranked below them and yet they still stand out. GCMU staff suggests that there may be several factors contributing to this result, three NGO-specific and two or three province-specific:

- New NGOs try harder. All three—MOVE, STEP, and CAF—are relatively new to BPHS service delivery. Their good performance challenges the supposition that it is risky to experiment with new partners.
- All three have good local PPG project managers. This confirms experience in other countries that the main differentiating factor between service delivery NGOs is the quality of their management.
- As new NGOs, they may have been able to take the pick of the recent best available staff, while others have tended loyally to bring their staff forward from past contracts.
- All three provinces are characterized by:
  - Provincial Health Offices that are particularly strong
  - a solid community outreach track record, providing a good base to build on
  - probably above average wealth, and therefore higher than average educational attainment and health-seeking behaviors and fewer risk factors

The main finding here that can help to steer selection of NGO partners for the new program commencing in January 2009 is the emphasis on project management skills: USAID may even wish to consider making the NGO cluster managers “key personnel.”

### **GCMU/WHO Tracking of Qualitative Performance**

Both GCMU and WHO staff summarize the results of monitoring visits they make with qualitative reports in a standard format that has a summary of strengths and weaknesses and recommendations for follow-up actions. We examined the most recent monitoring report for each cluster in 2007 and extracted weaknesses listed to get a sense of the frequency of the challenges the facilities still face. Though the results may not be statistically accurate, they can be considered indicative. The top five issues that come up repeatedly are:

- Incomplete staffing, especially few female staff: This is a national and intractable problem, alleviated somewhat by success in recruiting over 9,000 female CHWs over the last five years. Hopefully, the current effort to recruit a community midwife cadre to place within BHCs will also make a major contribution.
- Nonstandard buildings and layouts: This issue was already highlighted in the AHSBS results. The lack of oral rehydration therapy (ORT) corners seems to be mentioned often, but this may be one qualitative impression that is inaccurate: there are apparently data on this that can be checked.
- Incomplete/inaccurate HMIS form-filling: It is not surprising that it is taking time for staff to become familiar with the relatively new and demanding paperwork. But despite any teething problems, the quality of the HMIS data is now generally accepted as sufficient for management purposes.
- Poor infection prevention practices: This seems to manifest itself throughout the clinics, even in supposedly sterile areas, and is generally attributed to a continuing lack of service provider knowledge about the subject.
- Little attention to TB: This again repeats an AHSBS finding. Monitors find that few cases are being detected and few providers exhibit good knowledge of the symptoms or appropriate referral practices.

The last three of these are within the manageable interest of PPG to fix, although we doubt the HMIS form-filling issue requires much attention.

### **NGO Self-assessment of Performance**

We had two opportunities to interact with NGOs in a group, at a routine briefing about extension of the project through December 2008 and at a quarterly meeting of all BPHS NGOs (PPG plus those funded through the European Commission, the World Bank, and others). Many subjects were addressed in these meetings and we were not able to attend the entire quarterly meeting; however, the following six NGO observations, around which there seemed to be a fair degree of consensus, are probably of most relevance here:

- Training budgets are inadequate. NGO budgets include amounts for training only CHWs and CHSs (stationed at BHCs). Other training is done through the HSSP project. As reported in Chapter II, the NGOs feel strongly that the volume of training available through HSSP is insufficient for their purposes; and they need a budget to cascade the HSSP training they do receive. This topic is both complicated and sensitive: we return to it in Chapter IV.
- Demand for services is now lagging behind supply. We agree: key indicators in several areas—especially EPI coverage, uptake of ARI and DD services, and attended deliveries—are showing little improvement despite a huge increase in supply. Demand now needs to be stimulated. The HMIS data seem to confirm this.
- The TB program is still weak, especially at the community level, and it is still not comprehended by most service providers. This confirms what we have learned from many sources: the AHSBS, the HMIS, and the qualitative findings from GCMU and WHO monitoring.

- More behavior change communication aimed at service providers is needed. The priorities appear to be assuring better privacy; handling client relationships in a more welcoming and friendly manner; and becoming aware of correct infection prevention practices. (The last came up previously in terms of GCMU/WHO monitoring.)
- The community health system needs to be more robust. With many CHWs and CHSs now in place, and with the linkage between the CHW and the BHC now well-formed, there is a need to embed CHWs more deeply into the communities they serve. They currently risk becoming overloaded and unfocused: the burden of alerting, notifying, and organizing a response to community health issues should be shared more widely.
- Referrals should be approached more systematically. Most quantitative data suggest that few referrals are occurring at any level. We conclude that a more systematic approach—e.g., portable documentation in appropriate detail, feedback loops, follow-up processes—might well improve the rate of referrals. However, the overwhelming issue is still access.

### **Evidence from the Field**

We only had time to make one one-day trip, so these findings are purely impressionistic. Three facilities—DH, CHC, and BHC—were visited in the Shamali area north of Kabul. All were extremely busy that day. The first and overwhelming impression was how much more confident, well-informed, and assertive the service providers are today than they were during the consultant’s last field work in Afghanistan in late 2004. Clearly, the system is rapidly maturing—a tribute to intensive efforts and training in the last three years.

Another very positive finding is the existence of loyal repeat clients—a good sign in any business. We found two ANC clients who had delivered their first child at the CHC and were preparing to deliver their second there as well. Interestingly, however, the midwives and clinic managers in all three locations estimated that the dropout rate between ANC and delivery is still very high (50% at the DH and about 80% at the BHC) despite the trust and rapport that is created during the ANC relationship. This confirms the cultural bias in favor of delivery at home, but it also suggests that promoting ANC is probably the single most effective way of encouraging delivery at clinics, since even at the BHC 20 percent of those who took ANC deliver at the clinic. The national average is just 15 percent delivery outside the home.

The field trip tended to confirm other findings:

- The CHC premises (a very old government building inherited by the PPG program) were clearly too small and the layout was inappropriate. This reflects the AHSBS concern with infrastructure and the qualitative monitoring finding that some facilities are still ill-suited to their function.
- Privacy and client flow management were clearly huge challenges at the DH especially, confirming the NGO suggestion that behavior change among service providers is needed to address these two issues.
- Infection prevention was questionable in some of the sterile areas in these facilities, e.g., fabric curtains can harbor dust, and metal cabinets in a delivery room are difficult to keep sterile regardless of their contents.

## PPG-SPECIFIC PERFORMANCE IN DELIVERING THE EPHS

In contrast to the BPHS, PPG’s EPHS-related activities in the five PHs seem to receive less analytical attention. While the five clusters are monitored just as often as the BPHS sites, GCMU makes fewer summaries and cross-comparisons. The main reason for this seems to be the rolling six-month term of the five sub-grant agreements. Although this stems from USAID not being able originally to commit funds for a longer period, it has now become entrenched. The result is that there is little long-term thinking about PH progress.

Another problem caused by the six-month terms is that baseline and target data have to be updated almost continuously—the baseline for a new agreement is the outcome of the previous six-month agreement—and new targets have to be agreed for each indicator as well. This makes monitoring more laborious. For instance, for the current agreements to April 2008, it is not clear that targets had been agreed when fourth quarter 2007 performance data was collected. Division of responsibility for monitoring and technical assistance (TA) also does not help: Tech-Serve provides TA on national hospital standards (indicator #13 in Appendix C) for all 13 PPG provinces; GCMU is looking at all 13 indicators but for only five PHs.

It is therefore not surprising that PH performance seems relatively inconsistent, and it is difficult to draw firm conclusions about areas of strength and weakness (see Table 7).

**Table 7: EPHS Performance by Indicator, July-September 2007 Quarter**

Indicator	(Percent of Target)				
	Badakhshan	Ghazni	Khost	Paktya	Paktika
OPD consultations % target	30%	86%	52%	na	63%
Active beds % target	95%	100%	100%	100%	66%
% EPHS std staffing achieved	na	100%	94%	95%	95%
Cost of medications consumed	na	na	na	na	na
Average length of stay (days)	24%	111%	75%	80%	133%
Bed occupancy rate	7%	87%	106%	136%	152%
Inpatient admissions % target	37%	48%	45%	62%	86%
Inpatient deaths % target	30%	183%	159%	108%	74%
Inbound referrals % target	117%	140%	17%	95%	104%
C-sections performed % target	76%	40%	75%	68%	42%
Cumulative board meetings % target	33%	50%	50%	67%	50%
Cost recovery	na	na	168%	na	na
National hospital standards met	76%	73%	88%	88%	78%

It seems fairly safe to conclude that the number of active beds and completeness of staffing are roughly on target, and that inpatient admissions, number of C-sections performed, and compliance with national hospital quality standards are generally below target. Other indicators seem too variable to judge performance yet, and (see Chapter II), two indicators seem not to be tracked regularly (cost of medications and cost recovery).

## CONCLUSIONS AND LESSONS LEARNED

The main conclusion from this evaluation is that the PPG program is achieving all of its objectives, usually with plenty of room to spare. Use of BPHS services has grown dramatically; the number of trained staff is still not perfect with respect to female staff, but most sites are staffed adequately to provide basic services; and community-level delivery systems have been greatly expanded, with utilization of community-level services among the fastest growth areas. Quality of services can still vary (e.g., time spent with clients, counseling skills, adequacy of physical infrastructure, infection prevention). Service coverage remains difficult to measure: the number of facilities in a district per capita suggests good coverage, but physical access problems may still undermine adequate coverage.

USAID and MOPH can feel relatively secure in rolling the PPG program forward in January 2009 with only relatively modest changes of emphasis (see Chapter IV). Seven subsidiary conclusions that we draw from the evaluation of PPG performance to date are:

- Excellent progress is being made across a wide front, both within and beyond the PPG provinces. Most of the main outcome and output indicators have shown significant improvement; PPG's almost 40 percent share of service delivery means that it has made a substantial contribution. Regardless of the program's immediate objectives, the desired health outcomes are being achieved.
- Where comparisons are possible between PPG and non-PPG areas, the data generally show PPG performance to be above average, reinforcing its claim to be a solid contributor to national health.
- The program does not seem to contain any major links that need fixing: while sub-grantee performance varies, none is clearly under-performing; while some indicators show less improvement than others, none is performing disastrously.
- Tech-Serve's supporting role with respect to drug procurement is working well: stock-outs are generally not a problem.
- HSSP's role in providing training to NGO sub-grantees is slightly more controversial but any problem can be resolved relatively easily within any new program (see Chapter IV).
- Attention and measured progress for the BPHS have been generally higher than for EPHS: this needs rebalancing.
- The country and therefore the PPG program still face major health challenges, which may help to shape changes of emphasis; the main challenges seem to be:
  - continuing high mortality rates, especially child/infant and probably maternal
  - resistance to delivery at fixed sites and low access to skilled attendance at home undermining reductions in maternal mortality
  - contraceptive prevalence rate (CPR) slow to improve nationally
  - EPI coverage too low (just 27% nationally)
  - TB not yet adequately integrated into the BPHS.

These conclusions in turn guide us to five lessons learned from the program to date:

- NGO performance is directly affected by the characteristics of the area to which they are assigned. It is difficult to extract comparatively good performance in insecure or difficult terrain areas; however, in marginal areas, an NGO with good management and leadership can overcome security or terrain issues to achieve strong performance. Generally, then, the quality of an NGO's management and leadership determines its performance if there are no overwhelming security or terrain issues.
- The Afghan market is culturally very resistant to deliveries outside the home. Given the strength of this resistance, it might be better to acquiesce and try to find ways of getting skilled providers for home deliveries. Meanwhile, the way to 'sell' clinical deliveries is through promotion of ANC services; the chances of a woman choosing to deliver at a fixed site with assistance from her ANC midwife increases as trust and rapport build.
- As the classical vertical program, TB is very difficult to integrate into a package-driven system. A lot of extra effort will be needed here because TB is probably among the top five killers in Afghanistan (estimated annual deaths of over 20,000).
- High community-level activity and strong linkage of fixed sites to the community seem to improve health outcomes. This is difficult to prove quantitatively, in the context of this study but PPG's above-average commitment to community-level effort must account at least in part for the above-average outcomes it is achieving. As an example, higher CPRs in the PPG provinces seem to be linked to a high number of FP contacts at the community level.
- The package-based approach (BPHS and EPHS) makes eminently good sense for Afghanistan given its history. It is working and should be reinforced. However, a package-based approach may not be sufficiently rapid or focused to prevent avoidable maternal and child deaths in the short term.



## IV. IMPLICATIONS FOR THE NEXT PROGRAM

### ISSUES ARISING FROM THE EVALUATION

We identify eight issues arising from the evaluation findings that may have a bearing on design of the next PPG program.

#### **Package Rollout or Focused Response**

Does the PPG program need supplementing with modest but highly focused efforts on safe motherhood and child survival? While rollout of the BPHS and the EPHS must continue to take priority, the package-based approach may not be the fastest route to reducing maternal and child deaths. The packages are clearly making a very large contribution to reducing both, but it will be a large *relative* improvement over time. The *absolute* number of deaths is still unacceptably high. Worryingly, some of the individual child health outputs like DPT3 and ARI clinic-visit growth are not very robust, suggesting that room for further relative improvement in child and infant mortality over time is limited.

A detailed study of maternal and child death by cause would be very helpful, but the safe motherhood initiative would probably best focus on the first two of the three delays: seeking help for pregnancy-related complications, and reaching a health facility or skilled provider. In a country like Afghanistan, improvements in these two delays are most likely to come through efforts in the community and are therefore tied to a more robust community-level system of preparedness (see below). The child survival initiative should best focus on the relatively poor ARI statistics—raising care-giver awareness of danger signs and improving care-seeking behavior—and broadening EPI coverage.

We understand that USAID has now made a buy-in to the BASICS project. This may be the appropriate vehicle for the work on ARI and EPI that is urgently needed to help reduce under-5 deaths. HSSP may well be the right vehicle for the safe motherhood work, since it is already active in many areas touching on maternal mortality (e.g., its post-partum hemorrhage project and work with village women’s action groups).

#### **Raising Community Preparedness**

Almost 10,000 villages are covered by the 19,000 CHWs now at work. The CHWs are now also better anchored to a BHC through creation of the CHS cadre, which gives them better direction and support. However, there is still widespread concern that the CHWs are overburdened, and therefore unfocused, and that there is still room for them to be better prepared for health events or emergencies, especially complicated pregnancies. Global experience suggests that 15 percent of pregnancies present life-threatening complications; the proportion may be higher in Afghanistan, where fertility rates are higher than average and nutrition is generally poorer.

To make a significant impact on maternal mortality, ANC counseling needs to be used to identify potential problem deliveries. Then there needs to be an organized system for preparing for the delivery, e.g., deciding where the delivery will occur, how the client is to be transported to a health facility when the time comes or how the midwife is to reach the client’s home, who will

pay for the transport, what arrangements can be made for blood transfusion in case of hemorrhage, etc. To achieve full preparedness, the CHW, village religious and political leaders, the community or BHC midwife, possibly the local pharmacy owner, friends, neighbors, etc., all need to be part of the process. Pooled community funding may also be needed to eliminate any economic constraint on accessing the right care.

Some of the pieces of such a ‘prepared village’ model already exist, e.g., the CHW and the health *shura* in many locations, but there is consensus that more could be done on preparedness. HSSP has been working with village women’s action groups to harness friends and neighbors into a more organized community response. There are also some international models for mobilizing communities for preparedness around maternal health issues, such as Indonesia’s *Desa SiAGA*.

### **More attention to EPHS**

The new program needs to ensure that more attention is given to the EPHS. One way of doing this would be to ensure that NGOs who work with PHs are dedicated to hospital work, so that they can build specialization in an area where EPHS skill sets are different from those the BPHS requires. This seems even more important given that it is relatively unusual to see NGOs acting as contractors in institutions as complex as a PH. At present, all five EPHS clusters are assigned to NGOs who do BPHS work in the same province (see Table 1). We found no evidence that sub-grantees lack competence with respect to the PHs, but we do suspect that EPHS sites are not as well monitored as BPHS sites, making it more difficult to evaluate their true performance.

On the other hand, we acknowledge clear advantages to having one NGO handling both BPHS and EPHS in the same province:

- Economies of scale would be diminished if two NGOs were working alongside each other in one location.
- Referrals, which are difficult enough to generate in Afghanistan, are facilitated if the same NGO is managing both the source and destination sites.
- It could be easier for the PH to act as a training site for staff from BPHS facilities if both facilities are under the same management.

The two arguments are finely balanced but we conclude that today specialization may be the greater need, at least until the EPHS has matured and reached the same level of consistent performance across multiple sites that characterizes the BPHS.

### **Better Absorption of TB into the BPHS**

It is fairly clear from a variety of sources that TB is not yet fully integrated into BPHS services. Few cases are detected; referrals are therefore also low, as is the number of clients successfully ending treatment. Service providers at all levels from CHWs upward need to be reminded of the need for case detection and also need refresher training in recognizing symptoms and how to refer suspected cases.

Referrals are probably the weakest link in the curative chain because microscopy labs are not available below the CHC level. Making a successful referral from a community-level site to a

CHC is a stretch. One solution would be to attach microscopy labs to selected BHCs in areas where TB prevalence is thought to be higher than average. There was just such a proposal in the recent past: the Global Fund would have financed 30 new labs, but the operating cost for lab technicians and consumables was felt to be too high. Maybe this proposal could be revisited as the evidence of TB underperformance builds. Alternatively, it may be possible to take sputum samples at the BHC level and prepare slides for transmission to the nearest CHC-based lab. If this were again done selectively, the extra workload at the chosen BHCs could be contained—but for successful analysis there must be a reasonable chance of being able to reliably transport the slides without fear of water or dust contamination within two to three days.

### **Counseling Time and Skills**

Although counseling has apparently improved significantly over the last four years, it still ranks as one of the lowest-performing BPHS indicators. It may well also be linked to the real difficulty that service providers seem to have in spending the minimum amount of time with new clients. More attention to IPC/C skills is indicated. It is also possible that bottlenecks are a problem in some facilities, and that providers genuinely have insufficient time to spend with clients. Some operations research into this issue would be sensible. It certainly seems that the whole issue of front-line client service—greeting and welcoming, checking-in and extracting client histories, counseling and triaging with adequate privacy, and managing client flow through the facility—deserves attention.

### **Balancing Supply and Demand**

The huge expansion of supply as new facilities have been added and staffed over the last three to four years is reflected in the growth rate of client volumes. However, that growth is now slowing as the system approaches its planned size. Furthermore, take-up of selected interventions is too low for there to be much improvement in outcomes yet, e.g., in both ARI and EPI coverage as they affect child mortality. Growth in the next few years must come from increasing demand. Demand creation can be split conceptually into three stages: creating awareness of the simple existence of services, regardless of their quality yet; improving client understanding of health risks and appropriate ways to seek care, so they are stimulated to seek the services they now know exist; and providing continuing quality at the HFs that keeps clients coming back.

Considerable progress is being made on the first two stages as supply is rolled out, though now much more effort will be needed at the community-level through CHWs, at the facility-level through better IPC/C and wider use of mass media, and at the provincial and national levels. It is less clear that sufficient progress is being made on the third stage: convincing clients of HF service quality. The AHS shows that clients tend to think of the private sector first and the public sector only second: it is possible that this is quality-related, although there is no evidence that the private sector has a good quality image. AHSBS reports that both patient satisfaction and client perceptions of quality were high but static for three years and then fell in 2007. Time spent with clients and quality of counseling are consistently the two lowest-scoring individual indicators. HF infection prevention practices are continuously mentioned as weaknesses. Clearly further progress is needed on quality and it would be disastrous to promote HFs as high quality if the client perception is realistically different.

All demand-side work needs to be highly focused on such areas as ANC, ARI, and EPI. The objective at this stage is not capacity utilization but rather better outcomes in child and maternal mortality and more intensive CHW demand-side efforts at the community level.

### **Budget for Training**

The current NGO sub-grant budgets cover training for CHWs and CHSs only. This was done to ensure that the volume and quality of training is carefully controlled, but the NGOs feel that the volume is now too low and they need additional budget, if only to allow them to cascade the value of training they receive through the HSSP project. On the one hand, we support the idea of controlling the volume of training, because NGO-based service delivery programs all too often spend undue amounts and effort on training. We also support the idea of a more subtle approach to training over the long term, e.g., less movement of staff to attend large classes and more focus on coaching through a well-defined system of supportive supervision. However, at this stage in Afghanistan's development, we feel it may be premature to switch to a more ambitious and subtle approach, if only because supportive supervision has to be a major challenge in a rural country with limited infrastructure.

HSSP rigorously tests the need for training. We would expect this to continue in any future program. Since HSSP continues through 2010, it will overlap with at least two years of any new PPG program and should continue to be the quality controller, curriculum developer, and master trainer. However, we do think that the NGOs are unnecessarily constrained in rolling out the value of that training if they have no budget to bring staff together for this purpose from time to time. Tacking training onto the end of meetings called for other purposes can only achieve so much, so we suggest this practice be changed in the new program. With adequate budget NGOs can readily cascade the routine training they receive from HSSP. However, because competency-based training with a significant practical component and the need for (say) anatomic models may be beyond many NGOs, HSSP may need to provide assistance to cascading in such areas.

### **Strengthening Referrals**

A sub-theme in all of the above is the fact that the referral system is generally not working well. It is rarely mentioned as a major issue but, as with the shortage of female staff, is often called an inevitable problem in a country like Afghanistan, characterized by long distances to potential referral HFs, poor roads, limited availability of transport, economic barriers to accessing transport, and hostile winter weather.

The theory and structure of a referral system are spelled out within the BPHS by the detailed list of services available at each tier; the linkage between the public health and hospital systems is through the DH, with the point of referral usually a PH. But our impression is that referral *processes* are still weak: certainty over the appropriate destination, routine provision of referral slips, adequate detail on referral slips, feedback from the destination to the referral point of origin, post-referral follow-up plans, etc. Adding this to the logistics challenges means that there is a huge organizational task to be undertaken here.

We are so mindful of the logistics problems in particular that we are not sure of the likely payback from a major investment in this area at this stage of Afghanistan's development. It may make more sense to pick off the referral aspects of improving priority maternal and child

interventions, let them define practical models for referral, and only later explore how to standardize an approach to referrals within BPHS and between BPHS and EPHS sites. If more balanced attention is to be given to the EPHS, practical ways of ensuring a higher successful referral completion rate between BPHS and EPHS could be one useful aspect of better balance.

## **SUMMARY OF RECOMMENDATIONS**

We have 13 main recommendations for changes of emphasis in the next PPG program. Wholesale changes of direction are not required, given the obvious success of the program to date. These suggestions are drawn from the findings ; they all apply to the next PPG program commencing in January 2009, but some might also be piloted or the subject of experiments in the remaining nine months of the current program.

1. Review both BPHS and EPHS indicators for completeness, length, measurability, and alignment with objectives stated in sub-agreements or future RFAs. Try to considerably shorten the BPHS list. As part of the indicator review, consider adding measures of client satisfaction and supportive supervision carried out at both BPHS and EPHS sites.
2. Increase interaction between GCMU EPHS monitoring and Tech-Serve TA on national hospital standards compliance in PHs. Each can learn from the other.
3. Clarify policy on cost recovery in hospitals if this is to remain a functional EPHS indicator.
4. Conduct research into client flow management, reception and counseling practices, and triaging to better understand why it appears that not enough time is spent with new clients and why many counseling steps are still not being followed.
5. Provide training on front-line customer service to health facility staff, especially to improve client-friendliness and privacy. Anecdotal evidence from the field suggests that such training is almost certainly needed. The research suggested in (4) may find that the need is even greater.
6. Supplement the BPHS/EPHS rollout with emergency action to reduce maternal and child mortality. BASICS could be the vehicle for the child health activity, which needs to give priority to ARI and EPI and which could be rolled into the expansion of demand generation suggested below. HSSP could well be the vehicle for maternal health, which needs to give priority to identifying and preparing for complicated deliveries; this could be rolled into the prepared village concept suggested next.
7. Build on the activities of CHWs and health *shuras* to develop a stronger level of preparedness at the village level for handling complicated pregnancies. This could involve a wider circle of political and religious leaders, midwives, CHWs, women's groups, pharmacy owners, friends, and neighbors in identifying problem pregnancies early and then planning collectively how to handle the delivery, how to obtain and pay for transport, how to source blood if needed, etc.
8. Issue separate RFAs for BPHS and EPHS sites in the new PPG program. While this will be a competitive bid process, try to ensure that NGO hospital management experience is

weighted heavily in the selection process so that a core of specialist sub-grantees with solid hospital management experience is built over time.

9. Provide refresher training and behavior change communication to health facility staff on TB case detection and referral. Try to ensure that the need to better integrate TB into the BPHS package is a regular message at NGO meetings.
10. Explore the feasibility of introducing TB microscopy at selected BHCs or of taking sputum samples and preparing slides at selected BHCs.
11. Increase the attention and budget dedicated to demand generation under the new PPG program. This should include activity at community and facility levels and through provincial and national mass media.
12. Continue HSSP's role as lead training provider, quality controller, curriculum developer, and master trainer but also provide additional budget to allow sub-grantees under the new program to more readily cascade internally the value of HSSP's work. Explore whether HSSP should also assist NGOs with cascading training that is competency-based.
13. Explore how to improve referral rates both within BPHS sites and between BPHS and EPHS sites. This should be done initially for a limited list of interventions, with a focus on practical ways of overcoming the real logistics barriers Afghanistan raises and on codifying and enforcing referral processes more rigorously.

## **APPENDICES**

**A. SCOPE OF WORK**

**B. PERSONS CONTACTED**

**C. BPHS and EPHS INDICATORS**

**D. REFERENCES**



## **A. SCOPE OF WORK**

### **Background**

As a result of prolonged civil war, health conditions in Afghanistan were among the worst in the world at the time of the fall of the Taliban. The highest rates of death and disability were among infants, children, and mothers during childbirth. A multiple indicator cluster survey (MICS) carried out in 2003 found skilled birth attendance and prenatal care coverage of 5% and vaccination coverage (DTP3) was 19.5%. The infant mortality rate (IMR) in 2001 was estimated at 165 per 1,000 live births and the under-5 mortality rate at 257 per 1,000 live births.

Despite some daunting challenges, the Ministry of Health set out to rebuild the health sector by focusing government efforts on stewardship of the health sector, developing a basic package of health services (BPHS) to be delivered through a nationwide network of primary care facilities, and rapidly expanding health services in rural areas to reach the target populations of poor women and children. This strategy, along with strong donor support, has contributed to significant improvements in the health sector. A nationwide survey conducted in late 2006 by Johns Hopkins University found that the IMR was 129 per 1,000 live births and the under-5 mortality rate was 191 per 1,000 live births, representing a 22% and 26% decline, respectively, from the last year of the Taliban regime. Similarly, prenatal care coverage has increased to 32% and DTP3 coverage has increased to 35%. The quality of care in publicly financed facilities increased by about 22% from 2004 to 2006 based on independent health facility assessments. Administrative data indicate that the number of functioning primary health care facilities has increased from 498 in 2001 to 936 now (a 89% increase) and the proportion of facilities with skilled female health workers increased from 25% in 2002 to 82% in 2007.

USAID currently supports BPHS by providing technical assistance through TechServe and HSSP and funding NGO service providers through a grant with WHO that ends in December 2008. To build on successes and expand quality cost-effective clinical services activities, USAID/Afghanistan envisions a new five-year agreement to continue support of direct service provision.

### **Scope of Work and Deliverables**

The consultant will evaluate USAID's support for BPHS implementation by examining the performance of NGO service providers and underlying ingredients for success. The evaluation will draw lessons learned in implementing BPHS at scale and identify challenges and gaps and appropriate means to deliver these services. The consultant's findings and recommendations will shape future agreements for clinical service provision and inform USAID's continued support for BPHS implementation.

USAID/Afghanistan will provide access to the WHO, TechServe, and HSSP agreements, related files, associated individuals, documents, and all other products mentioned to the consultant upon award. The consultant's point of contact will be Randolph Augustin, a USAID/Afghanistan Health Officer.

In addition to using the agreement-related materials mentioned above, the consultant shall:

- Build on GoIRA and USAID strategies and policies to inform the direction and aspects of the clinical services program in the evolving Afghan context, including:
  - reinforcing referral systems between the different levels of care,
  - decentralization of health services management,
  - development of a network of care in each province, and
  - building capacity and long term sustainability of service delivery.
- Synthesize results from various evaluations and assessments conducted by MSH, JHU, the World Bank, and the MoPH Grants and Contracts Management Unit (GCMU). These include the household survey in USAID-supported provinces, the national Afghanistan Household Survey, the balanced score card, and GCMU monitoring reports.
- Review WHO, HSSP, and TechServe annual reports, work plans, and trip reports.
- Conduct key informant interviews with USAID/Afghanistan and USG partners (DOD and PRT staff); GoIRA representatives from GCMU, Afghanistan Public Health Institute, Policy and Planning

Directorate, Curative and Diagnostic Care Unit, Preventive Medicine Unit, Child and Adolescent Health Directorate, Reproductive Health Directorate, Provincial Public Health Directorate; WHO sub-grantees, HSSP, and TechServe project staff; informants in other partner institutions (Global Fund, World Bank, EC), and other NGO implementing partners to:

- Determine what has facilitated some NGOs' abilities to successfully implement key health strategies and achieve results; and what have been obstacles or factors that have distracted efforts.
- Determine the optimal operational structures and processes for success.
- Identify key changes in the implementation and policy environment that will have operational implications for the new NGO grants.

The consultant shall prepare and deliver to the activity manager:

- A note detailing the evaluation methodology, including instruments and analytical methodology, within one week of the award of the contract.
- A draft report within 3 weeks of the contract.
- A final report that incorporates the comments from USAID, World Bank, and other stakeholders by the 4<sup>th</sup> week of the contract.

### **Method of Payment**

The contractor will submit an invoice for each deliverable in the amounts not to exceed the allocable cost. Payment will be in accordance with the Prompt Payment Act.

### **Period of Performance**

This 4-week assignment can begin as early as February 4 but no later than February 17, 2008.

### **Place of Performance**

The place of performance will be:

USAID/Afghanistan

Kabul, Afghanistan

### **SELECTION CRITERIA**

To address and carry out effectively the range of duties and responsibilities described above, the incumbent should possess the following:

- A. Technical field-based experience in program design, implementation, and monitoring in two or more of the following priority areas: Reproductive Health and Maternal and Child Health in clinical settings as well as community-based settings, integrated health systems, or quality assurance and continuous quality improvement systems. (35%)
- B. Extensive USAID program design and writing RFA(s)/RFP(s) for USAID procurements in health. (25%)
- C. Prior experience with USAID's Managing for Results policies, procedures, and directives that guide strategy development, project/activity development, approval and implementation processes, results review, budgeting process, and performance monitoring. (10%)
- D. Equivalent of a Masters degree in public health or a related degree and at least ten years USAID relevant experience, preferably designing/implementing activities in a decentralized health care system with limited financial and human resources. (10%)
- E. Demonstrated excellent oral and written communications and interpersonal skills. Ability to successfully work in professional settings with senior officials of USAID, partner organizations, host governments, and other USAID customers. Fluent English speaking, reading, and writing proficiency within the USAID context. (20%)

## **B. PERSONS CONTACTED**

### **AFGHANISTAN**

#### **U.S. Agency for International Development**

Mark White, Director, Office of Social Sector Development (OSSD)

Michele Russell, Deputy General Development Officer, OSSD

Randolph Augustin, Health, Population, Nutrition Officer, OSSD

Faiz Mohammad, Health Specialist, OSSD

Mary Hanchett, Health Adviser, OSSD

Kassahun Abate Belay, Health Adviser, OSSD

Mohammad Shapor Ikram, Health Program Management Specialist, OSSD

#### **Ministry of Public Health**

Faizullah Kakar, Deputy Minister for Technical Affairs

Ahmad Jan, Acting Director General, Policy and Planning

Md Daim Kakar, Director General, Preventive Medicine and Primary Health Care

Mohibollah Nejat, Director General, Curative and Diagnostic Care

Ali Alawi, Director, Child and Adolescent Health

Ashraf Mashkoo, Head, Health Management Information System Department

Hamid Ebadi, Director, Reproductive Health

Saleh Rahmani, Head, IMCI Department

Hizbullah Kazim, Team Leader, Global Fund Program, Grants and Contracts Management Unit

#### **Adventist Development and Relief Agency (ADRA)**

Vinod Nelson, Country Director

Rebecca de Graaf, PPG Project Manager

#### **European Commission**

Elisabeth Rousset, Deputy Head of Operations Section

Sarah Bernhardt, Task Manager, Health and Disability Sector

#### **Health Services Support Project/JHPIEGO**

Hannah Gibson, Chief of Party

Denise Byrd, NGO Capacity Building Manager

**Japan International Cooperation Agency**

Kota Omiya, Assistant Resident Representative

Norio Kasahara, Health Cooperation Planning Officer

**Save the Children, USA**

Aftab Tariq, Deputy Country Director

**STEP Health and Development Organization**

Maroof Behzad , PPG Project Manager

Homayun Kakar, Director, Qarabagh District Hospital, Kabul Province

Nasir Sadat, Doctor-in-charge, Kalakhan CHC, Kabul Province

Dr. Haidar, Doctor-in-charge, Gulzar BHC, Kabul Province

**Tech-Serve Project/Management Sciences for Health**

Mubarak Shah Mubarak, Chief of Party

Omid Ameli, HMIS and M&E Adviser

Bradley Dollis, GCMU Adviser

Daud Azimi, M&E Consultant

Jawid Omar, Grants Consultant, GCMU

Massoud Mehrzad, Grants Consultant, GCMU

Stephen Morgan, Finance and Operations Manager

Dad Md Shinwary, Provincial Support Manager

Md Essa Tawfik, Grants Consultant, GCMU

**World Bank**

Gh Sarwar Hemati, Deputy Director GCMU and PPA Program Coordinator

**World Health Organization**

Pir Mohammad Paya, National Grant Consultant, PPG Program

## C. PPG/BPHS Indicators – Outputs

Facility = First Referral Hospital, CHC, or BHC; it **does not** include health posts.

No.	INDICATORS	DATA SOURCES AND <i>Required Deliverables</i>
<b>EXPANDING SERVICE DELIVERY SYSTEMS</b>		
1	# of facilities (First Referral Hospital, CHC, BHC) providing services through PPG program	<p>In order to be counted, the facility must be registered with the MOPH through the HMIS Department and have an ID code.</p> <p><b>Data Source:</b> <i>Facility Status Report (FSR)</i> of BHC or CHC; <i>Hospital Status Report (HSR)</i> for DH and PH. Registration requires one FSR/HSR to be sent with the registration form. Once registered, an FSR/HSR is filled out every quarter.</p> <p><b>Note:</b> This indicator <b>does not</b> include health posts.</p>
2	# of active health posts providing services through PPG program	<p>In order to be counted, a health post must have at least one active CHW. An active CHW is a person who has completed at least the first phase of his/her training and is actively delivering services in the community.</p> <p><b>Data Source:</b> <i>Facility Status Report (FSR)</i> Section D9.2 and <i>Hospital Status Report (HSR)</i> Section E10.2</p>
3	Population in PPG project districts	<b>Data Source:</b> Total CSO population 2005/2006 in covered PPG districts
4	Population with immediate access to Basic Health Services	<p>This indicator shows the proportion of population with immediate access to basic health care through either health posts or BPHS health facilities.</p> <p><b>Data Source:</b> <i>Catchment Area Annual Census (CAAC)</i> gives population served by health posts and facilities. Alternative data sources can be HHS household listings or CSO pre-census data. If you use an alternative data source, state name and date of the source in the comments.</p> <p><b>Note:</b> if you plan to take over facilities from another agency, list the population covered by these facilities as well and mention in comments that this refers to the activity of another agency.</p>

No.	INDICATORS	DATA SOURCES AND <i>Required Deliverables</i>
5	# and % of active health facilities reporting use of health promotion messages related to Child Health, Birth Preparedness, Family Planning, Nutrition, Safe Injections	<p>A facility is counted if it delivers messages for all 5 components.</p> <p><b>Data Source:</b> <i>Facility Status Report (FSR)</i> Section D8 and <i>Hospital Status Report (HSR)</i> Section E9 indicates whether the facility claims to do this.</p> <p>The Cumulative Percentage is the cumulative total for this indicator divided by the cumulative total active facilities at the end of this reporting period.</p>
6	# (Male/Female) CHWs started CHW training (first phase) this reporting period	<p>CHWs who started the training according to the MOPH standard curriculum</p> <p><b>Data Source:</b> Training participants list</p>
7	# (Male/Female) CHWs successfully completed training (third phase) this reporting period	<p><b>Data Source:</b> <i>Facility Status Report (FSR)</i> Section B2.1 and <i>Hospital Status Report (HSR)</i> Section B6.44.</p> <p>Take the the number of CHWs cumulatively (ever) trained as of this reporting period minus the number of CHWs cumulatively (ever) trained in the previous reporting period.</p>
8	Total number of active CHWs (Male/Female) at the end of this reporting period	<p>An active CHW is a person who has completed at least the first phase of his/her training and is actively delivering services in the community.</p> <p><b>Data Source:</b> <i>Facility Status Report (FSR)</i> Section B2.2 and <i>Hospital Status Report (HSR)</i> Section B6.45.</p>
<b>IMPROVING QUALITY OF SERVICES</b>		
9	# and % of active facilities (First Referral Hospital, CHC, BHC) properly staffed as required by the BPHS	<p>A facility is properly staffed if it has staff at least equal to BPHS recommendations.</p> <p><b>Data Source:</b> <i>Facility Status Report (FSR)</i> Section B and <i>Hospital Status Report (HSR)</i> Section B give # of each type of staff for each facility.</p> <p><i>Cumulative percentage:</i></p> <p style="padding-left: 40px;"><i>Numerator:</i> cumulative total for this indicator</p> <p style="padding-left: 40px;"><i>Denominator:</i> cumulative total active facilities at the end of this reporting period</p> <p><b>Note:</b> Numerator <b>does not</b> include health posts.</p>
10	# of properly staffed health posts	<p><b>Data Source:</b> Health post listing with list of CHWs.</p> <p>Number of health posts with two CHWs, of which at least one is a female.</p>

No.	INDICATORS	DATA SOURCES AND <i>Required Deliverables</i>
11	# and % of active facilities (First Referral Hospital, CHC, BHC) properly equipped as required by the BPHS	Compare the list of “usable” equipment with the BPHS—a facility is properly equipped if it has functional equipment at least equal to BPHS requirements. <b>Data Source:</b> <i>Facility Status Report (FSR)</i> Section C and <i>Hospital Status Report (HSR)</i> Section D.
12	% of CHWs who dropped out during this reporting period.	<b>Data Source:</b> CHW listings, <i>Facility Status Report (FSR)</i> Section B2.2, and <i>Hospital Status Report (HSR)</i> Section B6.44 <i>Numerator:</i> number of active CHWs at the end of the last reporting period that ceased activity for whatever reason during this reporting period <i>Denominator:</i> ‘cumulative this quarter’ of Indicator 8 Note: This indicator does not cumulate over time.
13	% of active health posts properly stocked with essential drugs during this reporting period	Indicates number of health posts properly supplied. <b>Data Source:</b> <i>Monthly Aggregated Activity Report of the Health Post (MAAR)</i> Section F1. <i>Numerator:</i> the lowest number filled in for one of the listed drugs <i>Denominator:</i> total number of facilities that reported on drugs during the last month of the reporting period (the number is listed in the heading of section F1 of the <b>Monthly Aggregated Activity Report of the Health Post [MAAR]</b> ). Note: This indicator does not cumulate over time.
14	# (male/female) CHWs who received refresher training during this reporting period	CHWs who received a formal and planned refresher course during this reporting period. <b>Data Source:</b> <i>Facility Status Report (FSR)</i> Section B2.2 and <i>Hospital Status Report (HSR)</i> Section B6.45. Note: This indicator does not cumulate over time.
15	# and % of active CHWs supervised during this reporting period	<b>Data Source:</b> <i>Monthly Integrated Activity Report of the Health Facility (MIAR)</i> Section H2. <i>For percentage:</i> <i>Numerator</i> from <b>Monthly Integrated Activity Report of the Health Facility (MIAR)</b> section H2 <i>Denominator:</i> <i>Facility Status Report (FSR)</i> Section B2 (Total Active) Note: This indicator does not cumulate over time.

No.	INDICATORS	DATA SOURCES AND <i>Required Deliverables</i>
16	# and % of Health Workers in active facilities (BHC, CHC, First Referral Hospital) who received refresher courses during this reporting period	<p><b>Data Source:</b> <i>Facility Status Report (FSR)</i> Section B1 and <i>Hospital Status Report (HSR)</i> Sections B1 to B4.</p> <p><i>For percentage:</i></p> <p style="padding-left: 40px;"><i>Numerator:</i> field "refresh"</p> <p style="padding-left: 40px;"><i>Denominator:</i> add "male" and "female"</p> <p>Note: This indicator does not cumulate over time.</p>
17	# and % of active facilities implementing referral systems for obstetric care during this reporting period	<p>At least one patient referred in for obstetric care during reporting period.</p> <p><b>Data Source:</b> <i>Monthly Integrated Activity Report of the Health Facility (MIAR)</i> Section C3.</p> <p><i>For percentage:</i></p> <p style="padding-left: 40px;"><i>Numerator:</i> number of facilities that had at least one patient referred in for any of the obstetric care categories during this reporting period</p> <p style="padding-left: 40px;"><i>Denominator:</i> total number of active facilities (number of FSR received)</p> <p>Note: This indicator does not cumulate over time.</p>
18	# and % of active facilities using appropriate waste disposal	<p>Number of facilities that have either "incinerator" or "burn &amp; bury."</p> <p><b>Data Source:</b> <i>Facility Status Report (FSR)</i> Section A21 and <i>Hospital Status Report (HSR)</i> Section A20b.</p> <p><i>For cumulative percentage:</i></p> <p style="padding-left: 40px;"><i>Numerator:</i> cumulative total</p> <p style="padding-left: 40px;"><i>Denominator:</i> total number of active facilities in the reporting period</p>

No.	INDICATORS	DATA SOURCES AND <i>Required Deliverables</i>
19	# and % of facilities receiving OPD patients referred into facility during this reporting period	<p>This indicator reflects the functioning of the referral system. It indicates referrals served at the health facility (referred in).</p> <p><b>Data Source: Monthly Integrated Activity Report of the Health Facility (MIAR)</b> Section A1.</p> <p>Number of facilities with at least one patient referred into the facility for obstetric care during this reporting period.</p> <p><i>For the percentage:</i></p> <p style="padding-left: 40px;"><i>Numerator:</i> number of facilities with “referred in” cases</p> <p style="padding-left: 40px;"><i>Denominator:</i> total number of active facilities</p> <p><b>Notes:</b> Number of facilities <b>does not</b> include health posts.</p> <p style="padding-left: 40px;">This indicator does not cumulate over time.</p>
<b>IMPLEMENTATION &amp; MANAGEMENT</b>		
20	# of active personnel with a registration card	<b>Data source:</b> HR module of the MOPH: active personnel registered with the MOPH.
21	Inventory report of existing and purchased equipment submitted semi-annually and at end of project to PHO & GCMU	<b>Data source:</b> Inventory reports of existing and purchased equipment submitted to GCMU & PHO every six months and at the end of the project.
22	Average # and % of HMIS/MIAR forms submitted per active facility	<p><b>Data Source:</b> Number of <b>Monthly Integrated Activity Reports of the Health Facility (MIARs)</b> received during the reporting period.</p> <p><i>For percentage:</i></p> <p style="padding-left: 40px;"><i>Numerator:</i> total number of <b>MIAR</b> forms received during the last month of the reporting period</p> <p style="padding-left: 40px;"><i>Denominator:</i> total number of active facilities</p> <p>Note: This indicator does not cumulate over time.</p>
23	Training work plan evaluated and updated this period	Copy of revised training plan

No.	INDICATORS	DATA SOURCES AND <i>Required Deliverables</i>
24	# and % of monthly HMIS reports of active facilities which include information on re-attendance for FP services	<p>This indicator assesses the quality of data in HMIS reports from the health facilities.</p> <p><b>Data Source: Monthly Integrated Activity Report of the Health Facility (MIAR)</b> Section C1 – number of MIAR reports indicating re-attendance for any FP service during this reporting period.</p> <p><i>For the percentage:</i></p> <p style="padding-left: 40px;"><i>Numerator:</i> number of MIAR reports with re-attendance data</p> <p style="padding-left: 40px;"><i>Denominator:</i> total number of MIAR reports for this reporting period</p> <p>Note: This indicator does not cumulate over time.</p>
<b>OTHER INDICATORS (SUSTAINABILITY AND COORDINATION)</b>		
25	# of Memorandums of Understanding signed with local district or village health council (s), including listing of community contributions	<p>MOUs signed between the NGOs and local health committees, governmental agencies, and other public health partners.</p> <p>Note: Copy of agreement in Dari/Pashtu or English should be submitted.</p>
26	Average # of community health committee meetings attended per active health post this reporting period	<p>This indicator assesses the activity of the local health committees at the level of health posts.</p> <p><b>Data Source: Monthly Activity Report of the Health Post (MAR)</b> Section G.</p> <p><i>For calculating the average,</i></p> <p style="padding-left: 40px;"><i>Numerator</i> : total number of meetings with community health committees</p> <p style="padding-left: 40px;"><i>Denominator:</i> total number of active health posts in this reporting period multiplied by 3</p>
27	Estimated financial community contribution to the project	Listing of contributions and estimated value

PPG/BPHS - Outcome Indicators		Definition	Source & Frequency
1. Reproductive Health	A. CPR (%)	Proportion of currently married, not pregnant women who are using (or partner is using) a modern contraceptive method	Household Survey; baseline & PY2
	B. # new FP clients served at the health facilities per yr		HMIS (2); Quarterly
	C. % women of reproductive age able to identify at least two methods	Proportion of currently married, not pregnant women who can name at least two modern contraceptive methods	Household Survey; baseline & PY2
2. Mothers' Health	A. % deliveries attended by skilled professionals	Proportion of mothers having a living child under 1 year old whose latest delivery was attended by a doctor, nurse, or trained midwife	Household Survey; baseline & PY2
	B. # deliveries performed at the BPHS/EPHS health facilities		HMIS; Quarterly
	C. % of pregnancies receiving at least 1 ANC	Proportion of mothers having a living child under 1 year old who received at least one antenatal care visit by a doctor, nurse, or trained midwife during their latest pregnancy	Household Survey; baseline & PY2
	D. # new ANC visits by BPHS/EPHS health facilities		HMIS; Quarterly
	E. % of deliveries received at least 1 PNC	Proportion of mothers having a living child under 1 year old whose latest delivery was followed by a visit to a doctor, nurse, or trained midwife	Household Survey; baseline & PY2
	F. # new PNC visits by BPHS/EPHS health facilities		HMIS; Quarterly
	G. % of pregnancies received at least 2 TT	Proportion of mothers having a living child under 1 year old who received at least two doses of tetanus toxoid during their latest pregnancy	Household Survey; baseline & PY2
	H. # pregnancies received TT2+ in BPHS/EPHS health facilities		HMIS; Quarterly

3. Child Health	A. % of children 1-2 year received DPT3	Proportion of children between 1 and 2 years old who received at least three doses of DPT vaccine	Household Survey; baseline & PY2
	B. # under 1 children received DPT3 in BPHS/EPHS health facilities		HMIS; Quarterly
	C. % of children 1-2 year received Vitamin A during the past 6 months	Proportion of children between 1 and 2 years old who received Vitamin A drops during the previous six months	Household Survey; baseline & PY2
	D. % of under-1 children exclusively breast-fed during the first 6 months	Proportion of children under 1 year old who were exclusively breastfed for the first six months of their lives	Household Survey; baseline & PY2
	E. % of children 1-2 whose parents showed appropriate care-seeking behavior	Proportion of children under 2 years old with an episode of either diarrhea, ARI, or fever during the past two weeks whose mothers reported appropriate care-seeking practices	Household Survey; baseline & PY2
	F. # new under-5 morbidity visits		HMIS; Quarterly
4. TB	A. # new pulmonary TB cases detected in BPHS/EPHS health facilities		HMIS; Quarterly
5. Health Posts	A. # families visited by HPs		HMIS; Quarterly

## PPG/EPHS INDICATORS

1. Number of OPD consultations
2. Number of active beds
  - Percentage of technical staff positions filled, according to EPHS minimum staff requirements
  - Cost of medications consumed (cumulative, life of project)
  - Average length of in-patient stay
  - Hospital bed occupancy rate
  - Number of inpatient admissions (by major groups, diagnosis, age, and gender) and discharges (cumulative, life of project)
  - Number of hospital inpatient deaths (cumulative, life of project)
  - Number of inpatient referrals (cumulative, life of project)
  - Number of caesarean sections performed (cumulative, life of project)
  - Number of community board meetings conducted
  - Percentage of funds obtained from cost recovery (cumulative, life of project)
  - Percentage of National Hospital Standards met



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