

## **Trip Report, June 30 – August 30, 2005: Development of REACH Project Activities in Health Reform, Health Financing and Hospital Management**

---

William Newbrander

August 30, 2005

This report was made possible through support provided by the US Agency for International Development, under the terms of Contract Number EEE-C-00-03-00021-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the US Agency for International Development.

---

Rural Expansion of Afghanistan's Community-Based Healthcare (REACH)  
Management Sciences for Health  
784 Memorial Drive  
Cambridge, MA 02139  
Telephone: (617) 250-9500  
[www.msh.org](http://www.msh.org)

**Rural Expansion of Afghanistan’s Community-Based Healthcare (REACH)  
Program  
Trip Report**

**William Newbrander  
30 June 2005—30 August 2005**

**Background:** Part of the REACH strategy is to increase the capacity of the Ministry of Public Health to develop policies and plans as well as mechanisms for financing and managing the health system.

**Purpose of Trip:** The purpose of the visit was to further develop the REACH activities in the areas of health reform, health financing, and hospital management for the three-year REACH program.

**Activities:**

**1. If requested, conduct an arrival briefing for USAID/Kabul:** A briefing was not requested.

**2. Continue serving on the MOPH Technical Advisory Group (TAG) and Consultative Group for Health and Nutrition (CGHN) in order to facilitate development of strategic policies, strategies and guidelines for MOPH. Dr. Newbrander has assisted the TAG, CGHN and Deputy Minister with development of written policies once consensus has been reached within the MOPH :** *Completed:* Attended the meetings and made verbal and written contributions to the issues being discussed, including the use of misoprostol for prevention of postpartum hemorrhage mortality, issues of acute gastroenteritis, TB board and national TB program, IEC support, and the MOPH salary policy.

**3. Assist the Ministry of Public Health with the planning for the mid-year evaluation of the 1384 National Development Budget (March 2005 to March 2006) as a follow-up to Dr Newbrander’s work with the MOPH in development of the NDB. This will involve coordination with the Ministry of Finance:** *Completed:* Initially work was done on the National Development Strategy (NDS). Dr. Mubarak and this advisor worked with MOPH senior management in developing the written input from the health sector for the NDS, which was submitted in July. (See [Annex 1](#) for a copy of the submitted NDS document.) The NDS complements the NDB. In consultation with the Director of Health Financing, a workplan was developed for the process and timeline for the mid-term evaluation of the 1384 National Development Budget (NDB) Public Investment Program for Health and Nutrition (see [Annex 2](#)), to begin in October 2005. The mid-term evaluation will mark the start of preparation of the MOPH 1385 NDB.

**4. In consultation with the MOPH, (1) develop a plan for translating the final version of the Essential Package of Hospital Services into Dari and Pushtu, (2) assist the MOPH in developing presentations to PPHOs and others on the detailed elements of the EPHS to ensure it is widely known and understood, and (3) coordinate its dissemination to provinces and NGOs:** *Completed:* The final EPHS, dated July 2005, was completed during this visit; a cover design for EPHS was developed and approved by MOPH and USAID (see [Annex 3](#)). The EPHS is now being printed in English, and a review of the Dari translation has been completed. Translation into Pushtu is underway. The MOPH is planning to “launch” the EPHS in October or November through a news conference to be held by the Minister and the Director-General of

Curative Care and Diagnostics. A plan has been developed for the dissemination of the EPHS documents as soon as the printing of the document in three languages has been completed.

**5. In consultation with the MOPH, develop a plan for the final editing of the English version of the revised and approved Basic Package of Health Services (BPHS) and oversee its production:** *Completed:* The BPHS revision has been completed. An extraordinary amount of time was required to write the document, organize the tables, verify consistency among the tables and actual MOPH policies, and ensure a reader-friendly format. The final version will be ready by September for translation into Dari and Pushtu.

**6. Assist the MOPH Health Financing and Sustainability Task Force in planning for the evaluation of the pilot testing of user fees and community health financing pilot schemes which will start in July.:** *Completed:* Provided advice on the development of health financing pilot studies being conducted by Johns Hopkins University (JHU) to test free services, user fees and community health financing. Met with the JHU staff and the MOPH health financing staff. Reviewed the information submitted by NGOs and helped developed a set of indicators (see [Annexes 4 & 5](#)). Attended a two-day workshop for implementers of pilot projects in four provinces (Parwan, Panjshir, Wardak and Kapisa) to discuss the issues faced and to develop common solutions (see [Annex 6](#)).

**7. Technically support the REACH initiative in hospital management improvement in the further development of strategies related to training, mentoring and networking of hospital managers so as to further strengthen REACH support for better hospital management in four provinces.:** *Completed:* Held a July 24-27 workshop for staff of the four provincial hospitals receiving REACH technical support (Khost, Ghazni, Paktia, and Paktika) to develop pediatric standards for the hospitals. The workshops proved very successful, with solid participation by the provincial hospital pediatricians. The five sets of pediatric standards developed at the workshop (see [Annexes 7, 8, 9, 10 & 11](#)) were considered outstanding, and the MOPH has requested that these standards be sent to all provincial hospitals. Standards were also developed by this author for Hospital Pharmacies (see [Annex 12](#)) with input from the AQS pharmacy section; Ms. Joyce Smith developed the Performance Standards for Human Resources Management in Hospitals (see [Annex 13](#)).

**8. Work with the MOPH Hospital Management Task Force to develop a consensus on the structure for a Hospital Standards Manual for Afghanistan that addresses clinical and management standards.:** *Completed:* The revised Terms of Reference for the Hospital Management Task Force (HMTF) were completed (see [Annex 14](#)). A work plan was developed for the HMTF ([Annex 15](#)), as well as a time line for completion of the tasks (see [Annex 16](#)). The author of this report will be the lead person for REACH in developing the hospital standards.

**9. Oversee the process for hospital management in four provinces ( Ghazni, Paktya, Paktika and Khost) and develop recommendation for follow-up after the period of this RFCC:** *Completed:* Organized provincial hospital visits (Sharan 31 July –12 August), Gardez (14-18 August), Ghazni 21-29 August) and Khost (4-9 September) by Dr Shinwary to develop action plans for surgery, anesthesia and hospital community boards. Also undertook the second assessment of emergency obstetric center standards (EOC).

**10. Respond to priority ad hoc requests by the MOPH Deputy Ministers, Director-Generals, and senior management of MOPH, as has been done in the past.:** *Completed:* At MOPH request, I assisted with the following tasks: **(1)** In coordination with the London School of Hygiene and Tropical Medicine, developed plan with EC for training young MOPH

professionals. This plan was largely a component of the REACH proposal for a MOPH Institute of Management, which was not included in the 2004 workplan **(2)** Assisted the MOPH Executive Board on the issue of cost-sharing and in initiating legislation at the Ministry of Justice on a law authorizing user fees. An opinion had been received from the Ministry of Justice that fees are not forbidden if there is a law authorizing them. **(3)** Met with Dr Faizal Rabbani, the new advisor to the Minister for Private Sector Health Matters, on private sector hospitals in Afghanistan. Will continue to assist in developing actionable items for Dr. Rabbani's office and assisting the advisor in reconstituting the MOPH Public Private Taskforce. **(4)** As a member of the organizing committee, participated in the development and planning of a regional conference of health ministers from surrounding countries, scheduled for 2006. **(5)** Assisted in organizing an August 10 meeting at the MOPH on pharmaceuticals. **(6)** At the Minister's request, assisted MOPH in development of proposals for additional activities and resources required by the Afghan health sector to be presented during a visit to the US in August.

**11. Conduct an exit briefing with USAID/Kabul within two days of departure** *Not requested.*

**12 Submit a trip report, not to exceed 2 pages, within 2 weeks of completion of assignment.** *Completed and hereby submitted..*

A list of annexes is on the next page.

**List of Annexes**

- Annex 1: MOPH National Development Strategy Submission July 2005
- Annex 2: Mid-term Review of 1384 National Development Budget for Health and Nutrition.
- Annex 3: Essential Package of Hospital Services for Afghanistan, 2005 Final
- Annex 4: Monitoring and supervision plan for Health Financing Pilots
- Annex 5: Indicators for Health Financing Pilots July 2005
- Annex 6: Workshop Agenda and materials for Health Financing Pilots August, 2005
- Annex 7: Performance Standards for Hospitals: Pediatrics, Acute Respiratory Distress in child 2 months to 5 years
- Annex 8: Performance Standards for Hospitals: Pediatrics, Diarrhea/Dehydration–Afghanistan
- Annex 9: Performance Standards for Hospitals: Pediatrics, Acute Febrile Illness in a child over 2 months of age to 5 years
- Annex 10: Performance Standards for Hospitals: Pediatrics, Malnutrition—Severe for 0 to 5 years
- Annex 11: Performance Standards for Hospitals: Pediatrics, Institutional Standards for Pediatrics Department and Ward
- Annex 12: Performance Standards for Hospitals: Hospital Pharmacy – Afghanistan
- Annex 13: Performance Standards for Human Resources Management in Hospitals–Afghanistan
- Annex 14: Hospital Management. Task Force Terms of Reference Revised August 2005
- Annex 15: Hospital Management. Task Force Total Work Plan 1384 Final
- Annex 16: Hospital Management. Task Force Work Plan Time Line

**Annex 1**

**MOPH National Development Strategy Submission July 2005**

**Section 1**

Ministry of Public Health policies, strategies, national programs and current funding levels

Documents provided:

1. National Health Policy 2005-2009 and National Health Strategy 2005-2006, Ministry of Public Health, Islamic Republic Of Afghanistan, April 2005.
2. Health and Nutrition Public Investment Programme, National Development Budget 1384-1387, Ministry of Public Health, Islamic Republic Of Afghanistan, 1384
3. Operational Budget for 1384, Ministry of Public Health, Islamic Republic Of Afghanistan, 1384.

## **Section 2**

Summary of problems to be addressed by the Ministry of Public Health and its linkages to poverty reduction and economic growth.

- Problems addressed by MOPH:

The key problems facing Afghanistan and its health system are

- (1) high levels of infant (140/1000) and under five (230/1000) mortality rates;
- (2) one of the world's highest maternal mortality ratio (1600/100,000 live births);
- (3) elevated levels of malnutrition throughout the population;
- (4) high incidence of communicable diseases;
- (5) inequitable distribution of quality health services; and
- (6) low capacity to implement effective and efficient health services at all levels of the health system.

- Linkages to poverty reduction and economic growth.

Three major causes of families becoming poor or remaining poor are ill-health, malnutrition and high fertility. The 6 problems listed above are being addressed by the MOPH. All of those interventions by MOPH to address the problems have a positive impact on the poor and are supportive of economic growth. International evidence indicates that increased utilization of a basic package of cost-effective health services will significantly improve the health status and general welfare of the poor. The MOPH addresses these issues of the poor having increased use of health services by emphasizing the extension of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS).

Because the burden of disease falls most heavily on the poor who are predominantly in the rural areas, the MOPH has extended the percentage of the population with access to the BPHS from 5% to 77%. The extension of the BPHS to many parts of the country addresses the issues of infant, child and maternal mortality, and malnutrition as well as equity in distribution of health services. Thus the above problem of equity in the distribution of quality health services has been addressed by the MOPH through the BPHS and EPHS. The goal is to extend BPHS to 100% of the population in five years.

Reduced mortality of children and mothers through the extension of the BPHS and EPHS will help families to be healthier. A greater number of healthy days increases the productivity of family members in household tasks or wage earning livelihoods. Healthier families means a healthier population which means a gain of resources for the families because they will be more productive economically.

Treatment of diseases will also increase productivity, especially of the poor who are disproportionately affected by high morbidity rates. For instance, with 70,000 cases of tuberculosis, if untreated so that those affected are incapacitated for one year and are not productive, there will be a loss in earned wages potential as well as household activities not being accomplished for those poor families. If the wage earner were earning \$1-\$2 per day, that would come to a loss of \$350-\$700 per year for the families of those TB patients.

With greater access to reproductive health services through BPHS there is not only the lowering of maternal mortality rates but a lowering of fertility rates, as well. These will have a positive impact on the poor by having families that are complete—fewer mothers, who are the care givers and nurturers for the children, are dying. Other diseases are treated more appropriately or prevented because community members, especially mothers, learn more about safe life and health practices. This means people are more involved in their own health as they learn how to better protect themselves and their families from diseases.

Construction of health facilities for BPHS and EPHS have also helped the poor by providing for families financially because the labor and materials for the construction come from communities where the health centers are built. Hiring of local labor and purchase of supplies locally for expansion of health services provides wages and earnings to community members which is fed back into the economic life of the community.

The extension of the BPHS requires additional health workers too. This will also provide an economic infusion. This provides jobs and economic opportunity which will help some of the poor. The attached annex indicates the number of health workers required for the population. For instance, a population of 23 million will require 46,000 CHWs, 18,000 health service providers and 7,200 support staff just for provision of BPHS. The EPHS will provide economic benefits to other families.

Finally, as the problem of low capacity to implement effective and efficient health services at all levels of the health system is being addressed, it helps the poor too. Increasing capacity by training for health workers and Ministry staff results in the skills of those individuals being enhanced. These better trained workers will have better job opportunities in the future, which is a benefit to the economy. Further, there will be increased income from the jobs of those working in the health sector. Some of the poor will be these health workers, such as trained community health workers (CHWs).

### Section 3

Summary of monitoring indicators used by the Ministry of Public Health.

The Ministry of Public Health policies and strategies are dedicated to the reduction of disease and improvement of the health of the Afghan people. Through the implementation of the Basic Package of Health Services (BPHS) and the newly developed Essential Package of Hospital Services (EPHS), the MOPH will be working towards the delivery of health services to the population at large.

While an overall monitoring and evaluation system for the programs of the MOPH is currently being developed, there exist programmatic indicators for the BPHS. The indicators are complimentary to the Millennium Development Goals. The following is the summary of the indicators for the key problem areas of the MOPH.

#### **Infant and Under Five Mortality**

- Infant mortality rate which is estimated to be 140/1,000 live births (2003)
- Proportion of Under-1 year olds who receive Measles vaccinations
- Under-five mortality rate
- Proportion of children 12 to 23 months who have received DPT3.

#### **Maternal and Neonatal Mortality**

- Maternal Mortality Ratio
- Proportion of births attended by skilled birth attendants
- Percentage of all pregnant women receiving at least one antenatal care visit
- Proportion of pregnant women who received at least two TT vaccination
- Proportion of deaths among all cases with major obstetric complications
- Total Fertility Rate
- Neonatal mortality rate

#### **Nutrition**

- Prevalence of malnutrition (wasting, stunting and underweight)
- Percentage of children aged 0–6 months who are exclusively breastfed during the last 24 hours
- Percentage of children aged 6–24 months who received breast milk and appropriate complementary foods during the last 24 hours
- Proportion of children 6 to 59 months that have received vitamin A supplement within last 6 months
- Proportion of households using iodized salt

#### **Communicable Diseases (Malaria, Tuberculosis, HIV/AIDS)**

##### *HIV/AIDS*

- HIV prevalence among all blood donors
- Condom use rate of the contraceptive prevalence rate
- Percentage of population aged 15-49 with comprehensive correct knowledge of HIV/AIDS
- Contraceptive prevalence rate
- Proportion of blood samples screened for HIV/AIDS and STDs
- Proportion of women's need for family planning met

- Proportion of IV drug users being treated for their addiction

#### *Malaria*

- Prevalence and death rates associated with malaria
- Proportion of population malaria risk areas using effective malaria prevention and treatment measures
- Percentage of children age 0–23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night
- Proportion of (malaria) epidemics detected within 2 weeks of onset and control measures launched within 1 week of detection

#### *Tuberculosis*

- Prevalence and death rates associated with tuberculosis and finally
- Proportion of TB cases detected and cured under DOTS (Directly Observed Treatment Short Course)
- Rate of new smear-positive cases that are detected in a given period of time
- Proportion of health facilities with DOTS services
- Proportion of adults knowing key signs and symptoms of TB
- Percentage of patients that started treatment, completed treatment and were cured

#### **Mental Health and Disabilities**

The national policy and strategy for mental health and disabilities are currently being developed. Indicators will be written once these important documents are finalized.

- From BPHS
  - The proportion of all people with symptoms of mental illness who requested treatment

#### **Inadequate Distribution of Health Services**

##### *Equity of Health Services*

- Proportion of population within 10 kms (or 2 hours walking) of facilities offering BPHS by component
- Outpatient Visit Concentration Index from National Balanced Scorecard
  - This indicator is a measure of equity (by wealth status) of utilization of the assessed BPHS facilities. Concentration indices range from -1 to +1, with zero indicating perfect equality. Negative numbers between -1 and 0 indicate inequality in favor of the poor, while positive numbers between 0 and +1 indicate inequality in favor of wealthier groups. The outpatient visit concentration index measures how equitable utilization of assessed BPHS facilities is; zero indicates equal utilization by all wealth groups; negative numbers indicate higher rates of utilization by poorer groups, while positive numbers indicate higher rates of utilization by wealthier groups. For the purposes of this indicator, a negative number is considered more favorable

##### *Health Services Function Indicators*

- Percentage of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday
- Proportion of facilities with recommended equipment and supplies
- Proportion of facilities with recommended staffing
- Proportion of vaccinators who follow safe injection practices

- Proportion of appropriate essential drugs that are available in the various levels of care
- Percentage of health facilities with no stock outs of essential drugs continuously for one week during the last 3 months
- Proportion of facilities using HMIS forms

**Low Capacity of MOPH for Implementation**

- Proportion of health workers in each cadre that have been certified based on basic competencies
- Proportion of health workers that have received refresher training in the past year
- Proportion of all facilities that receive at least one supervisory visit every three months
- Proportion of patients receiving care included in BPHS according to protocols
- Proportion of facilities with trained health worker by BPHS components
- Proportion of health facilities that have a copy of the most recently published STG

## **Section 4**

Summary of MOPH's strategic priorities for 2005-2009.

### **1. Implementing health services**

- 1.1. Implement the basic package of health services
- 1.2. Implement the essential package of hospital services
- 1.3. Establish prevention and promotion programs
- 1.4. Promote greater community participation
- 1.5. Improve coordination of health services
- 1.6. Strengthen the coverage of quality support programs
- 1.7. Promoting mental health and improving management of mental health disorders

### **2. Reducing morbidity and mortality**

- 2.1. Improve the quality of maternal and reproductive health care
- 2.2. Improve the quality of child health initiatives
- 2.3. Strengthen the delivery of cost effective integrated communicable
- 2.4. disease control programs
- 2.5. Reduce prevalence of malnutrition, increasing access to iodized salt and micronutrients, and increase exclusive breast feeding

### **3. Institutional development**

- 3.1. Promote institutional and management development
- 3.2. Strengthen human resources development, especially of female staff
- 3.3. Strengthen health planning, monitoring and evaluation
- 3.4. Develop health financing and national health accounts
- 3.5. Strengthen provincial level management and coordination
- 3.6. Continue to implement PRR
- 3.7. Establish quality assurance
- 3.8. Develop and enforce public and private sector regulations and laws

## **Section 5**

Focal point for Ministry of Public Health to the National Development Strategy Process:

Dr. Diem, Director-General, Policy and Planning, Ministry of Public Health, phone 079-036-799.

**Annex 2**

**Mid-Term Evaluation of the 1384 National Development Budget for  
Health and Nutrition**

**Workplan**

No.	Activity	Completion date
1	Prepare parameters for mid-term review (e.g. what will be reviewed and what will not—for instance, review of large donors but not necessarily of smaller donors inputs as it may not be cost-effective for the time required)	October 1
2	Gather data on expenditure by donor funded projects	October 8
3	Compile data and draft narrative	October 22
4	Review data with Executive board and Director-Generals— Make presentation to MOPH officials discuss priorities for 1385	October 29
5	Draft outline for 1385 NDB	November 5
6	Decisions by Executive Board n 1385 NDB priorities	November 12
7	Discussions with donors on plans for 1385	November 19
8	Finalize priorities and draft budgets and narrative (project documents)	November 20 –January 14
9	Review by Executive Board	January 21
10	Revisions ordered by Executive Board	January 28
11	Submission of 1385 Budget documents to Ministry of Finance	February 4
12		

Prepared: 31 July 2005

**Annex 3 - Essential Package of Hospital Services for Afghanistan, 2005**  
**(see following pages)**

# The Essential Package of Hospital Services for Afghanistan



Ministry of Public Health  
Great Massoud Road  
Kabul  
Afghanistan



This publication was prepared by the Ministry of Public Health with technical and financial assistance from the United States Agency for International Development under the Rural Expansion of Afghanistan's Community-based Health Care (REACH) Program, Contract Number EEE-C-00-03-00015-00.



Islamic Republic  
of Afghanistan  
Ministry of Public Health

2005/1384



Islamic Republic of Afghanistan  
Ministry of Public Health

---

**The Essential Package of  
Hospital Services  
for Afghanistan**

July 2005  
Saratan 1384

## Table of Contents

<b>Abbreviations .....</b>	<b>iv</b>
<b>Foreword.....</b>	<b>v</b>
<b>Acknowledgments .....</b>	<b>vi</b>
<b>1. The Hospital Sector in the Afghan Health System .....</b>	<b>1</b>
1.1 Background: The Afghan Health System and Issues Facing Hospitals .....	1
1.2 Purpose.....	2
1.3 Levels of Hospitals.....	3
1.4 The Relationship between the BPHS and the EPHS.....	3
1.5 The Role of Hospitals in the Health System .....	5
1.6 Organization of Hospitals .....	9
1.7 The Future of Hospitals in Afghanistan .....	10
<b>2. Services Provided by Different Levels of the Hospital Sector .....</b>	<b>14</b>
<b>3. Diagnostic Services Provided by Different Levels of the Hospital Sector .....</b>	<b>21</b>
<b>4. Staffing of Hospitals by Type of Hospital.....</b>	<b>23</b>
<b>5. Equipment for Hospitals by Type of Hospital .....</b>	<b>25</b>
<b>6. Essential Drugs for Hospitals by Type of Hospital.....</b>	<b>32</b>

### Annexes

A. Hospital Policy for Afghanistan's Health System .....	43
B. Staffing Assumptions for Advised Staffing Patterns .....	51

### List of Figures

Figure 1. Link between the BPHS and Hospital Sector .....	4
Figure 2. Entry and Flow of Patients at the District Hospital.....	5
Figure 3. Organizational Structure of Hospitals.....	10

### List of Tables

Table 1. Summary of Services at a District Hospital .....	6
Table 2. Summary of Services at a Provincial Hospital .....	8
Table 3. Summary of Services at a Regional Hospital.....	9
Table 4. Standards for Hospitals .....	12
Table 5. Accreditation: Dimensions of Quality of Care.....	14
Table 6. Diagnosis and Treatment of Common Conditions, by Type of Hospital .....	15
Table 7. Diagnostic Services, by Type of Hospital .....	21
Table 8. Staffing of District, Provincial, and Regional Hospitals .....	24
Table 9. Equipment and Supplies List, by Type of Hospital.....	26
Table 10. Essential Drugs for Hospitals, by Type of Hospital .....	33

## Abbreviations

ANC	antenatal care
BHC	basic health center
BPHS	Basic Package of Health Services
CHC	comprehensive health center
CHW	community health worker
DH	district hospital
DOTS	Directly Observed Therapy, Short Course
DPT	diphtheria pertussis tetanus
EC	European Commission
ECG	electrocardiogram
ENT	ear-nose-throat
EPHS	Essential Package of Hospital Services
EPI	Expanded Program on Immunization
HMIS	health management information system
HP	health post
ICRC	International Committee of the Red Cross
IMR	infant mortality rate
IP	inpatient
MMR	maternal mortality ratio
MOPH	Ministry of Public Health
MSH	Management Sciences for Health
NEDL	national essential drug list
NGO	nongovernmental organization
OPD	outpatient department
OT	operating theater
PH	provincial hospital
PHC	primary health care
RH	regional hospital
STD	sexually transmitted disease
U5M	under-five mortality
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization



## Islamic Republic of Afghanistan Ministry of Public Health

---

### Foreword

The Ministry of Public Health is pleased to present the Essential Package of Hospital Services (EPHS). This document represents a key element in the development of the Afghan health system. The EPHS establishes what each type of hospital in the Afghan health system (district, provincial, and regional) should provide in terms of the services offered at each level and the resultant staff, equipment, diagnostic services, and medications required to provide those hospital services. This, in essence, establishes the standards for the hospitals of our country. The EPHS will help us develop the clinical and administrative standards by which our hospitals should operate and thereby improve quality. The ultimate purpose for the development of the EPHS has been to improve the quality of hospital services provided to the population of Afghanistan.

The EPHS is not a stand-alone document but clearly complements the Basic Package of Health Services (BPHS). These two documents, the BPHS and the EPHS, define the key elements of the health system Afghanistan's Ministry of Public Health is building. They illustrate where basic primary care and hospital services are provided and the referral hospital system necessary to support the BPHS. Figure 1 in this document illustrates the role the district hospitals play as the link between the BPHS and the hospital sector. Afghanistan is building a health system based on basic health services that address our major health problems and supported by our hospital system, as represented in the EPHS.

I would like to express my appreciation to Dr. Shakohmand and the members of the Hospital Management Task Force for development of the EPHS. The MOPH is also grateful to the many other Ministry, NGO, and international staff who made comments on earlier drafts and participated in the development of this document. We are especially grateful to USAID, which, through Management Sciences for Health, has provided funds and technical experts for the development as well as the publication and distribution of the EPHS.

Let us all use this opportunity to recommit ourselves to the ongoing development of the health system of Afghanistan for the benefit of our noble and deserving people.

A handwritten signature in black ink, appearing to read 'Sayed Mohammad Amin Fatimie'.

Dr. Sayed Mohammad Amin Fatimie  
Minister of Public Health  
Kabul, Afghanistan  
March 2005

## **Acknowledgments**

The development of the Essential Package of Hospital Services was completed by the MOPH Hospital Management Task Force. The members of the task force during the time of its development in 2004 were:

### ***Ministry of Public Health Task Force Members***

Dr. Ahmad Shah Shakohmand, Director-General and Task Force Chairman  
Dr. Abdul Hakim Aziz  
Dr. Gyuri Fritsche  
Dr. Ghulam Sarwar Hemati  
Dr. Abdul Rab Kohistani, Wazir Akbar Khan Hospital  
Dr. Abdul Basir Mansoor  
Dr. Nasrin Oryakhil, Rabia Balkhi Hospital  
Dr. Rohullah Rasekh, Indira Ghandi Children's Hospital  
Dr. Fahima Sekandari, Malalai Hospital

### ***MOPH Partner Organization Task Force Members***

Ms. Palina Asgeirsdottir, ICRC  
Dr. Maurice Coenegrachts, EC  
Dr. Abdullah Fahim, UNICEF  
Dr. Abu Hashish, WHO  
Mr. Craig Hostetler, US Government/Health and Human Services/LTS  
Ms. Florence Morestin, Embassy of the Republic of France  
Dr. William Newbrander, USAID/MSH  
Dr. Moh'd Khakirah Rashidi, USAID/MSH  
Dr. Katja Schemionek, EC

## **1. The Hospital Sector in the Afghan Health System**

### **1.1 Background: The Afghan Health System and Issues Facing Hospitals**

In March 2003, the Ministry of Public Health (MOPH) of Afghanistan released the Basic Package of Health Services (BPHS), the culmination of a process that determined priority health services to address the population's most immediate needs. This package included the most needed services at the health post and health center levels of the health system.

After establishment of the BPHS, the MOPH's Hospital Management Task Force saw the need to develop a framework for the hospital element of the health system. The Basic Package made clear the need for a primary-care-based health system, which requires functioning hospitals in order to have an appropriate referral system where all health conditions may be treated. Health services in Afghanistan operate at three levels: health posts (HP) and community health workers (CHWs) provide service at the community or village level; basic health centers (BHCs), comprehensive health centers (CHCs), and district hospitals operate in the larger villages or communities of a district, provincial and regional hospitals comprise the third level. In urban areas, due to a lack of facilities offering basic curative and preventive services, urban clinics, hospitals, and specialty hospitals provide the services that HPs, BHCs and CHCs provide in rural areas.

Hospitals play a critical role in the Afghan health sector: they are part of the referral system, which aims to reduce high maternal and early childhood mortality rates. In addition, hospitals utilize many of the most skilled health workers and much of the financial resources available in the health system. Hospital management must dramatically improve to ensure that these scarce resources are used in an effective and efficient manner and to enable hospitals to function more effectively as part of the health system. Serious need for improvement exists at all hospital levels—district, provincial and regional hospitals—as well as at Kabul's tertiary and specialty hospitals.

Before it could begin to develop a national policy on hospitals that would define the role of the hospital in the Afghan health system, the Hospital Management Task Force needed to identify the key problems facing the hospital system. The Hospital Management Task Force determined that the key issues facing hospitals could be summarized by six problems and the resulting consequences:

1. **Problem:** Poor distribution of hospitals and hospital beds throughout the country  
**Consequences:** Lack of equitable access to hospital care throughout the country: people in urban areas have access, but semiurban and rural populations have only limited access. Kabul has 1.28 beds per 1000 people, while provinces have only 20% of that amount (0.22 beds per 1000 population).
2. **Problem:** Lack of standards for clinical patient care  
**Consequences:** Poor quality of care
3. **Problem:** Lack of management skills for operation of hospitals  
**Consequences:** Inefficiently run hospitals, poorly managed staff, lack of supplies, and unusable equipment due to lack of maintenance
4. **Problem:** A fragmented and uncoordinated hospital system that is not integrated into the health system

**Consequences:** A referral system that does not work—people from rural areas and basic health centers are not referred to hospitals for problems such as problem pregnancies. Support for a BPHS-based system for secondary and tertiary services is lacking; the roles of hospitals in a BPHS-based health system have not been spelled out.

5. **Problem:** Limited financial resources for hospitals, and sustainability  
**Consequences:** Virtually all hospitals in Afghanistan lack adequate financial resources. A user fee system must be developed to help finance hospitals while at the same time ensuring that exemption mechanisms allow the poor continued access to care.
6. **Problem:** Lack of qualified personnel, especially female, in remote areas  
**Consequences:** Difficulty in guaranteeing 24-hour coverage, problems with quality of care provided to female patients.

Having reviewed the situation, the Hospital Management Task Force drafted a national policy, the Hospital Policy for Afghanistan's Health System, which was adopted in February 2004 by the MOPH Executive Board (Annex A). This policy provided the rationale, structure, and guidelines needed to complete the definition of a health system appropriate for Afghanistan by

- identifying the needs of the hospital sector;
- establishing 10 key policies related to hospitals;
- setting 31 standards for hospitals in six major areas (responsibilities to the community, patient care, leadership and management, human resource management, management systems, and hospital environment);
- identifying the levels of hospitals in the system and the need for rationalizing the distribution of hospital facilities and beds.

## 1.2 Purpose

The Essential Package of Hospital Services (EPHS) has three purposes: (1) to identify a standardized package of hospital services at each level of hospital, (2) to provide a guide for the MOPH, private sector, nongovernmental organizations (NGOs), and donors on how the hospital sector should be staffed, equipped, and provided materials and drugs, and (3) to promote a health referral system that integrates the BPHS with hospitals. The EPHS defines, for the first time, all the necessary elements of services, staff, facilities, equipment, and drugs for each type of hospital in Afghanistan. The EPHS identifies, with tables, the following elements for each level of hospital so that the inputs or resources needed at each level may be easily compared:

- diagnostic and treatment services for various conditions (Section 2)
- diagnostic tests (Section 3)
- staffing (Section 4)
- equipment and supplies (Section 5)
- essential drugs (Section 6)

Annex A provides the national hospital policy, and Annex B describes the assumptions behind the staffing calculations.

### **1.3 Levels of Hospitals**

Hospitals play a critical role in the Afghan health sector: they are part of the referral system, which aims to reduce high maternal and early childhood mortality rates. Hospitals are classified into three groups according to size of the referral population, number of beds, workload, and complexity of patient services offered:

- district hospitals (part of the BPHS)
- provincial hospitals
- regional hospitals

Another group of hospitals, specialty hospitals, are referral centers for tertiary medical care and are located primarily in Kabul. They provide education and training for health workers and act as referral hospitals for the provincial and regional hospitals. A separate category of specialty hospitals was not created for the EPHS because each of these hospitals is unique, and it would be difficult in this document to characterize in one group the unique services, staffing, equipment, and drugs required at each of these hospitals.

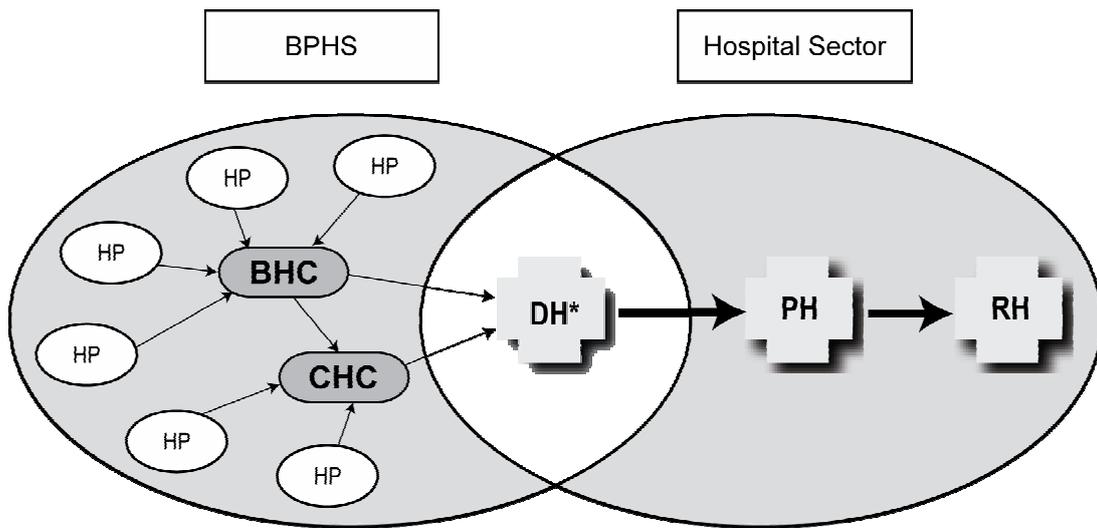
Four core clinical functions will exist in each of the three levels of hospitals: medicine, surgery, pediatrics, and obstetrics and gynecology. Mental health and dental health are predominantly provided as outpatient services at various levels. Mental health services, for instance, are provided as an outpatient service at the district and provincial hospitals, while such services are provided on an inpatient basis at the regional level, if required.

District hospitals (and where there are no district hospitals, provincial hospitals) support the primary health services of the BPHS. District hospitals are typically staffed by junior general medical officers. As compared to district hospitals, provincial hospitals provide more sophisticated services for diagnosing and treating various conditions and support the use of some specialist doctors. Regional hospitals are tertiary hospitals that, in addition to the above, provide more advanced specialized care. Research, as well as training of medical officers, midwives, and nurses, will be practiced at all three levels of hospitals.

### **1.4 The Relationship between the BPHS and the EPHS**

Hospitals provide increasingly sophisticated services in support of referrals from the primary health care system. The health post, basic health center, and comprehensive health center offer basic curative and preventive services. The level of sophistication increases moving from district to urban hospitals. The district hospital (or provincial hospital, where there is no district hospital) is the link between the BPHS and the hospital referral system, as illustrated in Figure 1.

**Figure 1. Link between the BPHS and Hospital Sector**

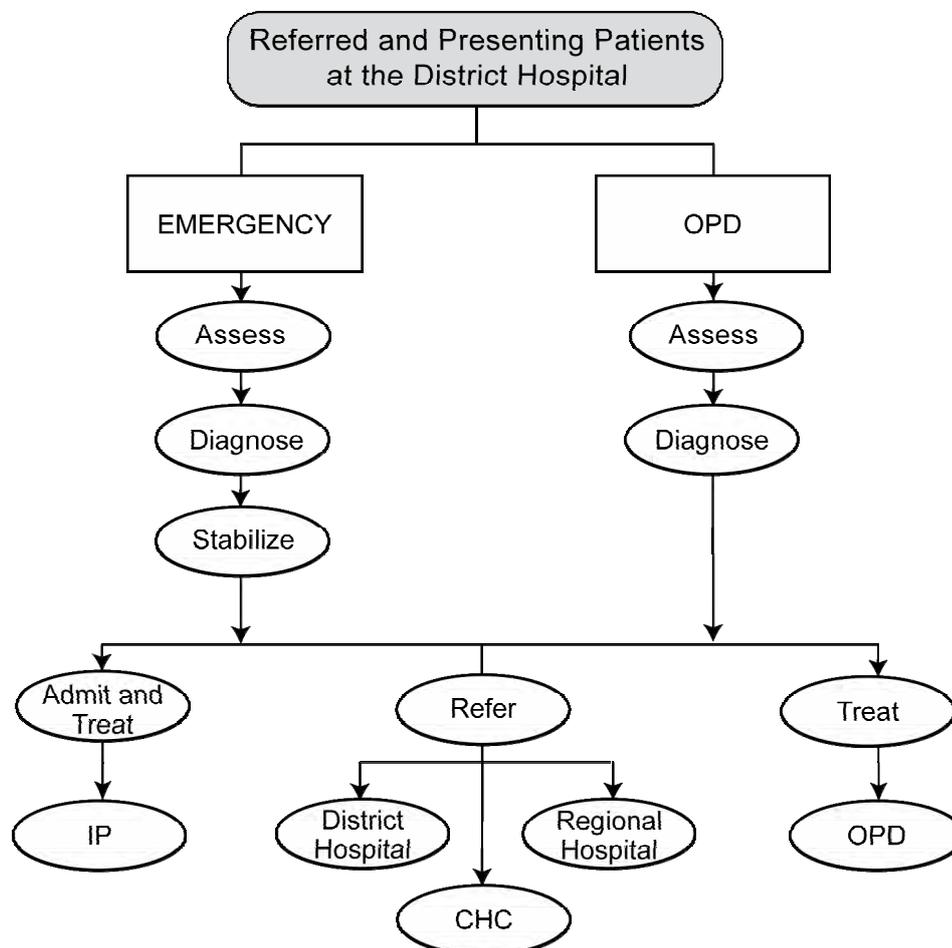


\* Where there is no district hospital, the provincial hospital provides services to fill this role.

<p><b>BPHS</b></p> <p>HP = health post          BHC = basic health center          CHC = comprehensive health center</p>	<p><b>Hospitals</b></p> <p>DH = district hospital          PH = provincial hospital          RH = regional hospital</p>
--	---

The district hospital is the entry point to the hospital system, as shown in Figure 2. The flow would be similar for the provincial and regional hospitals in accepting patients from the lower-level health facilities and hospitals.

**Figure 2. Entry and Flow of Patients at the District Hospital**



### 1.5 The Role of Hospitals in the Health System

Each level of hospital plays a role in providing a continuum of care from the health post to regional and specialty hospitals. This section defines the purpose and role of each level of hospital and summarizes its services.

#### District Hospitals

##### Purpose:

The district hospital (DH) brings professional inpatient and emergency services closer to the population in rural areas. Its role in supplementing the health centers aims at reducing the maternal mortality ratio (MMR), infant mortality rate (IMR), and under-5 mortality (U5M). The DH is mainly an emergency hospital where patients are assessed, diagnosed, stabilized, and either treated or referred back to a lower level or referred to a higher level of health facility. Provision of 24-hour comprehensive emergency obstetric care service is a crucial aspect of a DH. As illustrated in Figure 2, there are two entry points to the DH: the outpatient department (OPD) and emergency department.

**Role:**

- The DH is an important part of the referral system. It is the first point of entry for referrals from the comprehensive health center and for self-referrals in case of an emergency.
- The DH is part of the BPHS. It functions as a triage station where patients are assessed, diagnosed, stabilized and treated, and referred, if needed, to a higher hospital level.
- The DH OPD functions as the entry point to the health system where no BHCs or CHCs are available.
- The health system promotes a two-way referral system in which patients who no longer need DH care are referred back to the health centers.
- The DH is not to be the primary place for emergency surgery.
- The DH plays a role in building the capacity of health workers, providing health education, collecting health management information system (HMIS) data, and participating actively in improving the health of the population. This role includes health education, immunization campaigns, information sharing with partners, responsiveness to the changing needs of the community, and appropriate use of materials and equipment.

**Summary of services:**

A DH should provide the following clinical, diagnostic, and administrative services. See Section 2 for a more detailed listing of conditions diagnosed and treated at the district hospital.

**Table 1. Summary of Services at a District Hospital**

<b>Clinical and diagnostic services</b>	<ul style="list-style-type: none"> <li>• Inpatient services (24-hour)                         <ul style="list-style-type: none"> <li>- general surgical services (operating theater, anesthesia, recovery room services, and sterilization services)</li> <li>- general obstetric and gynecology services</li> <li>- general pediatric services (including therapeutic feeding services)</li> <li>- general medical services</li> </ul> </li> <li>• Emergency department open and staffed 24 hours</li> <li>• Outpatient services (including vaccinations, mental health, and dental services)</li> <li>• Hospital pharmacy</li> <li>• Physiotherapy services</li> <li>• Basic laboratory and blood transfusion (no blood bank) services</li> <li>• Basic x-ray and ultrasound services</li> </ul>
<b>Administrative and support services</b>	<ul style="list-style-type: none"> <li>• Management and administration team                         <ul style="list-style-type: none"> <li>- finance and accounting</li> <li>- procurement and medical stores</li> <li>- human resources</li> <li>- supervision of all support services and buildings</li> <li>- security</li> </ul> </li> <li>• Central sterile supply</li> <li>• Medical records and HMIS statistics</li> <li>• Kitchen</li> <li>• Laundry and tailor</li> </ul>

	<ul style="list-style-type: none"> <li>• Waste management and cleaning services</li> <li>• Maintenance services and workshop</li> <li>• Vehicles: transportation for emergencies and transferring patients</li> </ul>
--	---

## Provincial Hospitals

### Purpose:

The provincial hospital (PH) is the referral hospital for the provincial health system. In essence, the PH is not very different from a district hospital: it offers the same clinical services and possibly a few additional specialities (see Section 4 for staffing). In most cases, the PH is the last referral point for patients referred from the districts. In some instances, the PH can refer patients to higher levels of care—to the regional hospital or to a specialty hospital in Kabul. The PH brings professional inpatient and emergency services closer to the population in rural areas. In their supplementary role to the basic and comprehensive health centres and the district hospital, PH aim to reduce the maternal mortality ratio, infant mortality rate, under-five mortality rate, and other diseases and conditions responsible for the high mortality and morbidity in Afghanistan.

### Role:

- The PH is an important part of the referral system: it is the first point of entry for referrals from the district hospital or comprehensive health center, and for self-referrals for emergencies.
- The PH is supplementary to the BPHS and functions as a triage station where patients are assessed, diagnosed, stabilized, and treated, or referred to a regional hospital.
- The health system promotes a two-way referral system in which patients who no longer need PH care are referred back to the health centers (similar to the referral patterns shown in Figure 2).
- The PH outpatient department functions as the entry point to the health system when no BHCs or CHCs are available.
- Because a PH is primarily an emergency hospital, it does not perform complicated elective surgery (see Section 2).
- The PH's role includes training health professionals, collecting HMIS health information, and actively participating in improving the health of the population through community outreach, health education, immunization campaigns, information sharing with partners, responsiveness to the changing needs of its community and province, and appropriate and efficient use of staff, buildings, equipment, and materials.

### Summary of services:

A PH should offer the clinical, diagnostic, and administrative services described in Table 2. (See Section 2 for a more detailed listing of conditions diagnosed and treated at the PH.)

**Table 2. Summary of Services at a Provincial Hospital**

<p><b>Clinical and diagnostic services</b></p>	<ul style="list-style-type: none"> <li>• Inpatient services                             <ul style="list-style-type: none"> <li>– general surgical services (operating theater, anesthesia, recovery room services, and sterilization services)</li> <li>– general obstetric and gynecology services</li> <li>– general pediatric services (including therapeutic feeding)</li> <li>– general medical services</li> </ul> </li> <li>• Emergency department open and staffed 24 hours</li> <li>• Outpatient services (including vaccinations, basic ear-nose-throat, mental health, eye care, and dental services)</li> <li>• Hospital pharmacy</li> <li>• Physiotherapy services</li> <li>• Basic laboratory, blood transfusion services, and blood bank</li> <li>• Basic x-ray and ultrasound services</li> </ul>
<p><b>Administrative and support services</b></p>	<ul style="list-style-type: none"> <li>• Management and administration team                             <ul style="list-style-type: none"> <li>– finance and accounting</li> <li>– procurement and medical stores</li> <li>– human resources</li> <li>– supervision of all support services and buildings</li> <li>– security</li> </ul> </li> <li>• Central sterile supply</li> <li>• Medical records and HMIS statistics</li> <li>• Kitchen</li> <li>• Laundry and tailor</li> <li>• Waste management and cleaning services</li> <li>• Maintenance services and workshop</li> <li>• Vehicles: transportation for emergencies and transferring patients</li> <li>• Mortuary</li> </ul>

**Regional hospitals**

**Purpose:**

The regional hospital (RH) is primarily a referral hospital with a number of specialities for assessing, diagnosing, stabilizing and treating, or referring back to a lower-level hospital. The RH provides professional inpatient and emergency services at a higher level than is available at district or provincial hospitals, yet the overall objective remains reduction of the high maternal mortality ratio, infant mortality rate, and under-five mortality rate, and of other diseases and conditions responsible for Afghanistan’s high mortality and morbidity.

**Role:**

- The RH is an important part of the referral system, having many of the specialists that are not present at other levels of the hospital system.
- The RH has a significant role to play in training health professionals, collecting HMIS and medical research information, and conducting medical and health system research.

**Summary of services:**

A RH should have the clinical, diagnostic, and administrative services outlined in Table 3. (See Section 4 for a more detailed listing of specialist staff and Section 2 for the range of conditions diagnosed and treated at the provincial hospital.)

**Table 3. Summary of Services at a Regional Hospital**

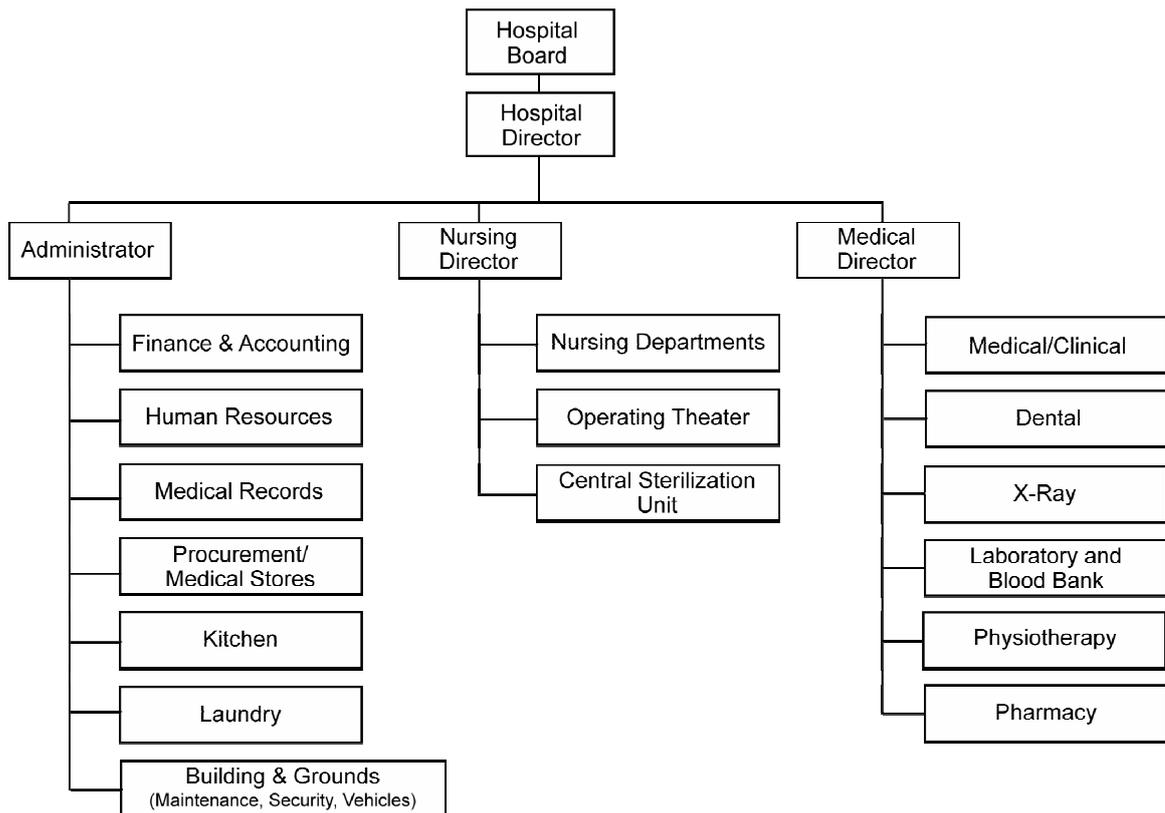
<p><b>Clinical and diagnostic services</b></p>	<ul style="list-style-type: none"> <li>• Inpatient services                             <ul style="list-style-type: none"> <li>- general and specialized surgical services (operating theater, anesthesia, recovery room services, and sterilization services)</li> <li>- obstetric and gynecology services</li> <li>- pediatric services (including therapeutic feeding center)</li> <li>- general and specialized medical services</li> <li>- ophthalmology and ENT services</li> <li>- mental health and psychiatric services</li> <li>- dental services</li> <li>- forensic medicine</li> </ul> </li> <li>• Emergency department open and staffed 24 hours</li> <li>• Outpatient services</li> <li>• Hospital pharmacy</li> <li>• Physiotherapy services</li> <li>• Laboratory, blood transfusion services and blood bank</li> <li>• X-ray and ultrasound services</li> <li>• Endoscopy services</li> <li>• CT scan (Kabul only at tertiary hospital level)</li> </ul>
<p><b>Administrative and support services</b></p>	<ul style="list-style-type: none"> <li>• Management and administration team                             <ul style="list-style-type: none"> <li>- finance and accounting</li> <li>- procurement and medical stores</li> <li>- human resources</li> <li>- supervision of all support services and buildings</li> <li>- security</li> </ul> </li> <li>• Central sterile supply</li> <li>• Medical records and HMIS statistics</li> <li>• Kitchen</li> <li>• Laundry and tailor</li> <li>• Waste management and cleaning services</li> <li>• Maintenance services and workshop</li> <li>• Vehicles: transportation for emergencies and transferring patients</li> <li>• Mortuary</li> </ul>

**1.6 Organization of Hospitals**

The way in which the general administration of hospitals in Afghanistan should be organized is illustrated in Figure 3, “Organizational Structure of Hospitals.” Figure 3 shows the staff positions, the relationship among the various hospital departments, and the necessary reporting relationships. As noted in the following section, hospital boards will be introduced to make sure that hospitals are overseen by community members who can identify the true needs of the community and ensure the accountability of the hospital administration.

While the Hospital Director is responsible for the hospital’s operation and the day-to-day management of the facility and its services, the Director is also expected to develop a management team of key staff. Team members should meet on a weekly basis to discuss and resolve the hospital’s major plans, problems, and budgets. By promoting participatory management and teamwork, the Hospital Director will be able to improve the quality of care, performance, operation, and management of the hospital.

**Figure 3. Organizational Structure of Hospitals**



**1.7 The Future of Hospitals in Afghanistan**

The top three priorities of the hospital sector in the coming years are to increase access to hospital services, improve the quality of patient care, and to increase the efficiency of hospital operation. Bringing about these improvements will require several initiatives. The following three initiatives can be expected to be operational within the next five to 10 years.

First, **standards must be established.** Hospitals require standards for both clinical and administrative operations in order to improve clinical and managerial performance and to attain an acceptable level of patient care and hospital operation. Standards establish what is expected of hospitals and their staff at all levels of operation; standards permit the monitoring of operations and the measurement of performance. The national hospital policy (Annex A) outlines the six areas for which basic standards need to be developed. The standards for each of these areas are also presented in Table 4. Specific elements of each standard must be developed and specified in greater detail by the Ministry of Public Health.

Second, to strengthen community involvement and support, **hospital boards must be established.** Community support for hospitals is often poor; communities using a hospital tend to regard it as the “government’s hospital” or the “NGO’s hospital” rather than “their” hospital. A hospital board will provide general direction and guidance for the management and operation of the hospital, as well as serving as a link between the community and hospital. Hospital community boards will be made up of volunteers with diverse skills and experiences who will be responsible for the long-term viability of the hospital and ensure that it meets the real and felt needs of the community. Their responsibilities will include:

- ensuring that high quality services are provided;
- maintaining community and government relations and generating community support for the hospital;
- serving as the policy and strategy-setting body of the hospital;
- supporting the leadership of the hospital;
- providing financial oversight;
- helping develop the hospital’s strategic plan.

Third, as the number of hospitals operated by government, NGOs and private entities increases, **hospital certification or accreditation will be needed** to ensure that all hospitals provide a basic standard of care. Accreditation is the process of assessing health institutions against a commonly accepted set of standards in order to ensure and improve the quality of health services. The goal of accreditation is to ensure that providers, both the hospital as an institution and its physicians and nurses, provide high-quality care to patients. Table 5 lists the elements of quality of care that would be considered in an accreditation process.

**Table 4. Standards for Hospitals**

<b>Responsibilities to the Community</b>	<ul style="list-style-type: none"> <li>• The hospital is responsive to the community’s (health) needs.</li> <li>• Hospital services are accessible to the community.</li> <li>• The hospital has a proper disaster preparedness plan to properly respond in the event of natural or manmade disasters.</li> </ul>
<b>Patient Care</b>	<ul style="list-style-type: none"> <li>• Patients are treated with dignity and have a right to be treated in a respectful manner.</li> <li>• Quality of clinical care to the patient is high and appropriate for Afghanistan, including the proper staffing, equipment, and supplies.</li> <li>• Quality of care is monitored and measured by agreed-upon indicators (e.g., wound infections, length of hospital stay, operations per patient, mortality rates, etc.).</li> <li>• Women and children receive the basic package of health services at hospitals, including immunization, outpatient care for conditions such as pneumonia and diarrhea, and appropriate assistance at the time of delivery.</li> <li>• Hospitals are “mother and baby friendly” and encourage “rooming-in” and immediate, exclusive breastfeeding.</li> <li>• Care delivery is monitored by the hospital’s health care team to ensure that care meets the needs of patients and to assist in the improvement of care.</li> <li>• Medical records are maintained for each patient and are kept confidential and secure.</li> </ul>
<b>Leadership and Management</b>	<ul style="list-style-type: none"> <li>• The hospital is effectively and efficiently governed, organized, supervised, and managed to ensure the highest quality of care possible for patients.</li> <li>• To ensure the responsiveness of hospitals to the community, a hospital board of directors or board of management is established at each hospital to govern and oversee operation and management of the hospital.</li> </ul>
<b>Human Resource Management</b>	<ul style="list-style-type: none"> <li>• Staff planning ensures a properly trained hospital staff and the appropriate number of staff.</li> <li>• Staff are appointed through a recruitment, selection, and appointment procedure that is consistent with the MOPH human resources policy.</li> <li>• In performing their duties, staff adhere to high ethical standards and a code of conduct.</li> <li>• A comprehensive program of staff development and in-service training meets individual and hospital needs.</li> <li>• Effective workplace relations are developed through use of teams.</li> </ul>

<b>Management Systems</b>	<ul style="list-style-type: none"> <li>• Financial management policies and procedures are developed and adhered to in order to ensure accountability of the hospital's finances from all sources.</li> <li>• Management information systems meet the hospital's internal and external needs.</li> <li>• Patient care, management of services, education, and research are facilitated by the timely collection and analysis of data.</li> <li>• Information technology enhances the hospital's ability to gather, store, and analyze information and to communicate.</li> <li>• Appropriate logistics and purchasing systems are maintained to ensure clinicians have the proper equipment, supplies, and pharmaceuticals to provide patient care.</li> <li>• Buildings and grounds are maintained to ensure a safe patient care and work environment for patients, staff, and visitors.</li> </ul>
<b>Hospital Environment</b>	<ul style="list-style-type: none"> <li>• Infection is effectively controlled throughout the hospital.</li> <li>• The physical environment of the hospital and its equipment are properly maintained to ensure patient and staff safety.</li> <li>• The hospital is accessible to all patients, including those with physical disabilities.</li> <li>• Buildings, grounds, plant, and equipment are regularly maintained to ensure a safe environment for all persons in the hospital.</li> <li>• Waste from the hospital is handled, contained, and disposed of safely and efficiently.</li> <li>• Occupational health measures are adopted to ensure the safety of staff, especially those dealing with direct patient care.</li> <li>• Clean water of sufficient quantity and quality is available for patients and staff and for proper hospital functioning.</li> <li>• Toilets in the hospital are kept clean for use by patients, staff, and visitors.</li> </ul>

Source: Ministry of Health, Hospital Policy for Afghanistan's Health System, February 2004.

**Table 5. Accreditation: Dimensions of Quality of Care**

<b>Technical aspects of quality</b>	<ul style="list-style-type: none"> <li>• Accuracy of diagnosis</li> <li>• Efficacy of treatment (appropriateness of treatment)</li> <li>• Excellence according to professional standards</li> <li>• Necessity of care</li> <li>• Appropriateness</li> <li>• Continuity of care</li> <li>• Consistency</li> </ul>
<b>Interpersonal aspects of quality</b>	<ul style="list-style-type: none"> <li>• Patient satisfaction <ul style="list-style-type: none"> <li>– Time spent with provider</li> <li>– Attitudes of provider and treatment by staff</li> </ul> </li> <li>• Community satisfaction</li> <li>• Amenities</li> </ul>
<b>Social aspects of quality</b>	<ul style="list-style-type: none"> <li>• Efficiency</li> <li>• Accessibility</li> </ul>

Source: W. Newbrander, MSH, "Report on Accreditation of Providers for the National Health Insurance Fund," Ministry of Health, United Republic of Tanzania, July 1999.

## 2. Services Provided by Different Levels of the Hospital Sector

The services provided by hospitals encompass diagnosis and treatment based upon the diagnosis. The services provided by each level of hospital are identified in Table 6, "Diagnosis and Treatment of Common Conditions, by Hospital Level." To define the services provided at each hospital level, Table 6 categorizes the major physiological conditions treated. Within each category are listed the more specific conditions that may present and the hospital level at which those conditions would be treated.

Particular hospital levels are not suited to treat all conditions, but in an emergency situation, the clinicians' only option may be to treat the patient as best they can. For instance, it would be best to use a defibrillator to deal with a cardiac arrest. Table 6 shows that cardiac arrest is primarily dealt with at the regional hospital level since that is the only level where a defibrillator, electrocardiogram machine, advanced cardiologic drugs, and cardiologist are available. However, if a patient at a district hospital has a cardiac arrest, referral is out of the question. In such a case, even though a defibrillator is not available, the district hospital clinical staff will make every attempt to resuscitate the patient as best it can using available staff, equipment, and drugs. Table 6 notes such circumstances in italics.

**Table 6. Diagnosis and Treatment of Common Conditions, by Type of Hospital**

Diagnosis and Treatment of Common Conditions		Type of Hospital		
		District Hospital	Provincial Hospital	Regional Hospital
<b>1. ACUTE TRAUMA &amp; SELECTED EMERGENCIES</b>				
1.1	Anaphylaxis	X	X	X
1.2	Cardiac arrest (simple ABC resuscitation done at all levels, but defibrillator only available at RH)			X
1.3	Abdominal trauma	X	X	X
1.4	Bites and rabies	X	X	X
1.5	Burns	X	X	X
1.6	Natural disasters	X	X	X
1.7	Head injury	X	X	X
1.8	Multiple injury to patient	X	X	X
1.9	Pneumothorax and hemothorax	X	X	X
1.10	Poisoning	X	X	X
1.11	Shock	X	X	X
1.12	Tracheotomy (done at all levels in cases of emergency)	X	X	X
1.13.	Fluid and electrolyte balance		X	X
<b>2. AIDS/HIV AND SEXUALLY TRANSMITTED DISEASES</b>		<b>DH</b>	<b>PH</b>	<b>RH</b>
<b>AIDS Prevention and Management</b>				
2.1	Universal precaution measures	X	X	X
2.2	Needle-stick injury	X	X	X
2.3	Mother-to-child transmission of HIV			X
2.4	HIV screening by rapid test	X	X	X
2.5	Confirmation of HIV infection (by two different Elisa tests)	X	X	X
2.6	Stages and diagnosis of AIDS			X
2.7	Information, education, and communication	X	X	X
2.8	Voluntary counseling and testing			X
<b>Sexually Transmitted Diseases (STDs)</b>				
2.9	Gonorrhea and urethral discharge	X	X	X
2.10	Genital discharge in the female	X	X	X
2.11	Dysuria in the female	X	X	X
2.12	Pelvic inflammatory disease	X	X	X
2.13	Genital ulcer disease	X	X	X
2.14	Buboes or swollen inguinal glands	X	X	X
2.15	Venereal warts (genital)	X	X	X
<b>3. CARDIOVASCULAR CONDITIONS</b>		<b>DH</b>	<b>PH</b>	<b>RH</b>
3.1	Congenital heart disease			X
3.2	Deep-vein thrombosis	X	X	X
3.3	Heart failure			X
3.4	Hypertension	X	X	X
3.5	Pulmonary edema	X	X	X
3.6	Ischemic heart disease (symptomatic treatment only; refer to tertiary Kabul level if possible)	X	X	X
3.7	Rheumatic heart disease	X	X	X
<b>4. CENTRAL NERVOUS SYSTEM</b>		<b>DH</b>	<b>PH</b>	<b>RH</b>
4.1	Cerebral palsy			X
4.2	Seizure disorders	X	X	X

5. DENTAL AND ORAL CONDITIONS		DH	PH	RH
5.1	Abscess, periapical	X	X	X
5.2	Acute necrotizing ulcerative gingivitis	X	X	X
5.3	Alveolitis (dry socket)		X	X
5.4	Cellulitis (oral)	X	X	X
5.5	Gingivitis	X	X	X
5.6	Neoplasms, salivary gland, and hereditary/developmental disorders (refer to Kabul hospital)	—	—	—
5.7	Pericoronitis	X	X	X
5.8	Periodontitis	X	X	X
5.9	Pulpitis	X	X	X
5.10	Temporomandibular joint disorders (refer to Kabul if necessary)			X
5.11	Trauma (jaw trauma: refer to Regional or Kabul tertiary hospital level if necessary)		X	X

6. EARS, NOSE, THROAT CONDITIONS		DH	PH	RH
6.1	Acute otitis media	X	X	X
6.2	Otitis externa	X	X	X
6.3	Chronic otitis media (CSOM)			X
6.4	Epistaxis	X	X	X
6.5	Foreign bodies in the ears	X	X	X
6.6	Foreign bodies in the nose	X	X	X
6.7	Mastoiditis			X
6.8	Wax on ear	X	X	X

7. ENDOCRINE SYSTEM		DH	PH	RH
7.1	Diabetes mellitus		X	X
7.2	Thyroid diseases (for simple goiter; otherwise refer to Kabul hospital)	X	X	X

8. EYE CONDITIONS		DH	PH	RH
8.1	Common eye conditions (for most conditions a generalist may treat at all levels, but for trachoma and cataracts and other complicated conditions, ophthalmologist at RH required)	X	X	X
8.2	Eye injuries (many conditions can be treated at all levels; for those that cannot, refer to ophthalmologist at RH required)	X	X	X

9. FAMILY PLANNING		DH	PH	RH
9.1	Hormonal contraceptives	X	X	X
9.2	Intrauterine contraceptive devices (IUCDs)	X	X	X
9.3	Barrier methods	X	X	X
9.4	Surgical contraception	X	X	X
9.5	Periodic abstinence (natural family planning)	X	X	X

10. GASTROINTESTINAL CONDITIONS		DH	PH	RH
10.1	Amoebiasis	X	X	X
10.2	Diarrheal diseases	X	X	X
10.3	Gastritis	X	X	X
10.4	Peptic ulcer disease	X	X	X
10.5	Upper GI tract bleeding (at all levels patient is stabilized with IVs and anti-peptic drugs, but further diagnosis and treatment requires referral for use of endoscope at RH level)			X
10.6	Worms	X	X	X

11. GYNECOLOGY		DH	PH	RH
11.1	Uterus fibromyoma		X	X
11.2	Infertility (only basic treatment offered, advanced tests not available at any of the hospital levels)	X	X	X
11.3	Pelvic masses		X	X
11.4	Menstrual disturbances	X	X	X
11.5	Neoplasms (refer to Kabul hospital)	—	—	—
11.6	Vaginitis (vaginal discharge)	X	X	X
11.7	Pelvic inflammatory disease (PID)	X	X	X
11.8	Abscesses		X	X
11.9	Prolapse and transvaginal operations			X
11.10	Fistulae			X
11.11	Sexual assault	X	X	X

12. IMMUNIZATION		DH	PH	RH
12.1	Vaccination schedule	X	X	X
12.2	Dosage and administration	X	X	X

13. INFECTIOUS (SELECTED) & RELATED CONDITIONS		DH	PH	RH
13.1	Acute rheumatic fever (ARF)	X	X	X
13.2	Bacterial infections	X	X	X
13.3	Leishmaniasis	X	X	X
13.4	Malaria	X	X	X
13.5	Measles	X	X	X
13.6	Meningitis	X	X	X
13.7	Poliomyelitis	X	X	X
13.8	Tetanus	X	X	X
13.9	Tuberculosis	X	X	X
13.10	Typhoid fever	X	X	X
13.11	Rabies (rather than refer with inherent dangers of transporting publicly, patients treated and isolated with arrier nursing at all hospital levels)	X	X	X
13.12	Viral hemorrhagic fevers	X	X	X

14. MENTAL ILLNESS <i>(as a psychiatrist is only available at regional hospital level, common psychiatric condittons such as acute psychosis, depression, sleep disorders and suicide attempts will have to be treated at all hospital levels)</i>		DH	PH	RH
14.1	Acute confusion (Acute psychosis)	X	X	X
14.2	Anxiety and stress-related disorders			X
14.3	Childhood psychiatric disorder			X
14.4	Conversion disorders			X
14.5	Depression	X	X	X
14.6	Mania			X
14.7	Schizophrenia			X
14.8	Suicidal ideation	X	X	X
14.9	Substance abuse and dependency			X
14.10	Post-traumatic stress syndrome and trauma-related problems	X	X	X

15. MUSCULOSKELETAL CONDITIONS		DH	PH	RH
15.1	Arthralgia, nonspecific	X	X	X
15.2	Gout			X
15.3	Osteoarthritis	X	X	X
15.4	Osteomyelitis		X	X
15.5	Rheumatoid arthritis		X	X
15.6	Septic arthritis			X

16. NEONATAL CARE & CONDITIONS		DH	PH	RH
16.1	Neonatal asphyxia and resuscitation	X	X	X
16.2	Care of the normal newborn	X	X	X
16.3	Birth injuries		X	X
16.4	Congenital anomalies (simple conditions, such as sixth finger, may be treated at lower levels)			X
16.5	Infants of diabetic mothers		X	X
16.6	Jaundice (complicated cases to be referred to higher levels)	X	X	X
16.7	Preterm infant (major difficulty is lack of power supply for operating incubators, if none then refer)		X	X
16.9	Apnoeic attacks			X
16.10	Respiratory distress		X	X

17. NEOPLASMS		DH	PH	RH
17.1	Neoplasms in childhood	—	—	—
17.2	Adult neoplasms (refer to Kabul hospital)	—	—	—

<b>18. NUTRITIONAL &amp; HEMATOLOGIC CONDITIONS</b>			
18.1	Anemia	X	X X
18.2	Blood transfusion	X	X X
18.3	Failure to thrive	X	X X
18.4	Growth monitoring and nutrition	X	X X
18.5	Malnutrition—severe or moderate, acute/chronic	X	X X
18.6	Malnutrition—micronutrient deficiency diseases (Vitamin A, anemia, iodine, Vitamin C) deficiencies)	X	X X
18.7	Thalassemia (refer to Kabul)	—	— —

<b>19. OBSTETRICS</b>		<b>DH</b>	<b>PH</b>	<b>RH</b>
<b>Antenatal Care and Complications</b> (at present, many conditions will have to be treated at the hospital level where they present due to lack of or poor transportation for referring patients)				
19.1	Antenatal care	X	X X	X
19.2	High-risk pregnancy	X	X X	X
19.3	Anemia in pregnancy	X	X X	X
19.4	Antepartum hemorrhage (APH)	X	X X	X
19.5	Cardiac disease in pregnancy		X X	X
19.6	Diabetes in pregnancy		X X	X
19.7	Drugs in pregnancy	X	X X	X
19.8	Malaria in pregnancy	X	X X	X
19.9	Multiple pregnancy	X	X X	X
19.10	Pre-eclampsia	X	X X	X
19.11	Eclampsia	X	X X	X
19.12	Rhesus (Rh) incompatibility		X X	X
19.13	Urinary tract infection in pregnancy	X	X X	X
19.14	Ectopic pregnancy	X	X X	X
<b>Intrapartum Care and Complications</b>				
19.15	Normal labor and delivery (including assessment of low-birthweight infants)	X	X X	X
19.16	Complicated labor and delivery (including CS and uterus rupture)	X	X X	X
<b>Postpartum Care and Complications</b>				
19.17	Postnatal care	X	X X	X
19.18	Complications of puerperium	X	X X	X
19.19	Postpartum hemorrhage (PPH)	X	X X	X
19.20	Puerperal infections	X	X X	X
19.21	Breast conditions	X	X X	X
19.22	Deep vein thrombosis (DVT)	X	X X	X
19.23	Puerperal psychosis (rare condition—it is difficult to refer such patients so basic treatment would have to be done at all levels)	X	X X	X
19.24	Abortion (due to medical indication: a special committee is necessary)			X
19.25	Incomplete abortion (and complications of abortion)	X	X X	X
19.26	Destructive operations		X X	X

20. ORTHOPEDICS		DH	PH	RH
<b>Orthopedic Trauma Cases</b>				
20.1	Closed fracture and dislocation of all of minor joints and bones	X	X	X
20.2	Supracondylar displaced fractures	X	X	X
20.3	Old condylar and epicondylar fractures (complicated cases)	FA	X	X
20.4	Volkman's ischemia and compartment syndrome	FA	X	X
20.5	V.I.C.			X
20.6	Soft tissue injuries and crush injuries	X	X	X
20.7	Spinal vertebrae fracture and trauma	FA	X	X
20.8	Pelvic fracture without complication	FA	X	X
20.9	Pelvic fracture with complication	FA	X	X
20.10	Hip joint dislocation	FA	X	X
20.11	Femur neck fracture			X
20.12	Femur fracture			X
20.13	Knee joint dislocation		X	X
20.14	Knee joint inner lesion			X
20.15	Tibia and fibula closed fracture	FA	X	X
20.16	Tibia open fractures			X
20.17	Ankle joint dislocation and fractures			X
20.18	Ankle bones open fractures			X
20.19	Tarsal bones fractures and dislocations		X	X
20.20	Tarso-metatarsal joint dislocation		X	X
20.21	Skin graft and tendon injuries		X	X
<b>Orthopedic Procedures</b>				
20.22	Acute osteomyelitis	FA	X	X
20.23	Chronic osteomyelitis			X
20.24	Pyogenic septic arthritis		X	X
20.25	Tuberculosis of bones and joints		X	X
20.26	Gout arthritis		X	X
20.27	Rheumatoid arthritis	X	X	X
20.28	Congenital bone diseases		X	X
20.29	Osteogenesis imperfecta			X
20.30	Bone tumors (benign and malignant)			X
20.31	Pott's disease			X
20.32	CDH, DDH			X
20.33	Bone cyst		X	X
20.34	Carpal tunnel lesion			X
20.35	Hand flexors and extensors injuries		X	X
20.36	Amputation (open amputation)	X	X	X
20.37	Scoliosis			X
20.38	Menopausal osteoporosis	X	X	X
20.39	Genu valgum and Genu varum			X
<b>Note: FA = First Aid</b>				

21. RESPIRATORY SYSTEM		DH	PH	RH
<b>Acute Upper Respiratory Tract Infections</b>				
21.1	Common cold (Acute Rhinitis, Coryza)	X	X	X
21.2	Pharyngotonsillitis, tonsillitis	X	X	X
21.3	Sore throat	X	X	X
21.4	Sinusitis	X	X	X
<b>Lower Respiratory Tract Conditions</b>				
21.5	Approach to cough or difficult breathing in children	X	X	X
22.6	Pneumonia—Infant age less than 2 months	X	X	X
21.6	Pneumonia—Child age 2 months–5 years	X	X	X
22.7	Pneumonia—Adults	X	X	X
21.7	Acute epiglottitis	X	X	X
22.8	Croup	X	X	X
21.8	Acute bronchitis—Bronchitis (Tracheobronchitis)	X	X	X
22.9	Wheezing & Asthma—Child under 5 years	X	X	X
21.9	Bronchial asthma—Adults	X	X	X
21.10	Chronic obstructive pulmonary disease	X	X	X

22. SIGNS AND SYMPTOMS		DH	PH	RH
22.1	Coma	X	X	X
22.2	Fever	X	X	X
22.3	Fever of unknown origin	X	X	X
22.4	Hepatosplenomegaly	X	X	X
22.5	Jaundice	X	X	X
22.6	Lymphadenopathy		X	X

23. SKIN DISEASES		DH	PH	RH
23.1	Atopic eczema	X	X	X
23.2	Impetigo	X	X	X
23.3	Ringworm (Tinea)	X	X	X
23.4	Scabies	X	X	X
23.5	Herpes zoster	X	X	X

24. SURGICAL CARE AND CONDITIONS		DH	PH	RH
24.1	Acute abdomen and traumatic abdomen. (Stabilize and refer. If a competent surgeon and anesthetic service and appropriate equipment are available, then laparotomy can be performed at DH.)		X	X
24.2	Thyroidectomy (Refer to center)	—	—	—
24.3	Mastectomy (Refer to center)	—	—	—
24.4	Chest conditions (Chest tube at all levels)			X
24.5	Hiatus hernia (Refer to center)	—	—	—
24.6	Esophageal operations (Refer to center)	—	—	—
24.7	Biliary tract and liver operations			X
24.8	Pancreas operations (Refer to center)	—	—	—
24.9	Colon operations			X
24.10	Proctological operations (perianal abscess at DH)		X	X
24.11	Hernioraphy (simple at DH)		X	X
24.12	Rectal prolapse, Crohn's disease, all malignancies (Refer complicated cases to center)			X
24.13	Superficial abscesses, cysts, and tumors (Refer to center if suspected malignancy)	X	X	X
24.14	Cavity abscesses			X
24.15	Cystostomy	X	X	X
24.16	Kidney stones and nephrectomy			X
24.17	Prostatectomy			X
24.18	Pyeloplasty (Refer to center)	—	—	—
24.19	Circumcision	X	X	X
24.20	Burns (pending distribution [%] and dept [°])	X	X	X
24.21	Vascular and neurosurgery (Refer to center—life-saving procedures can be done by competent surgeons at PH and RH level)	—	—	—

25. URINARY TRACT AND RENAL CONDITIONS		DH	PH	RH
25.1	Urinary tract infections	X	X	X
25.2	Renal disease signs and symptoms	X	X	X
25.3	Acute glomerulonephritis	X	X	X
25.4	Acute renal failure	X	X	X
25.5	Chronic renal failure (only treatable at RH level if services are upgraded there)			X
25.6	Hypokalemia		X	X
25.7	Nephrotic syndrome		X	X

### 3. Diagnostic Services Provided by Different Levels of the Hospital Sector

Laboratory and imaging departments support clinicians in their diagnoses of patient conditions. Radiology, laboratory, and other diagnostic services that should be provided by each type of hospital in the health system are identified in Table 7, “Diagnostic Services, by Type of Hospital.”

**Table 7. Diagnostic Services, by Type of Hospital**

Diagnostic Tests Performed		Type of Hospital		
		District Hospital	Provincial Hospital	Regional Hospital
<b>1. LABORATORY SERVICES</b>				
<b>HEMATOLOGY</b>				
1.1	Hemoglobin	X	X	X
1.2	Hematocrite	X	X	X
1.3	Bleeding time and coagulation time test	X	X	X
1.4	Prothrombine time		X	X
1.5	White blood count (WBC and differential) manual	X	X	X
1.6	WBC automated			X
1.7	Erythrocyte sedimentation rate (ESR)	X	X	X
1.8	Plateletes and reticulocyte		X	X
1.9	Malaria parasite smear (MPS)	X	X	X
1.10	Histopathology (on Kabul level only in one institute)	-	-	-
<b>BIOCHEMISTRY</b>				
1.11	Blood sugar, glycometer	X	X	X
1.12	Blood sugar advanced automated			X
1.13	Electrolytes (Na+, K+, Ca++)			X
1.14	Liver function tests (LFT) and liver enzymatic test		X	X
1.15	Kidney function tests			X
<b>SEROLOGY</b>				
1.16	Creactive protein		X	X
1.17	Toxoplasmosis (Kabul tertiary hospital level only)			X
1.18	Anti-Streptolysine-O (ASLO)		X	X
1.19	Rubeola AG			X
1.20	Typhoid AG (Widal)		X	X
1.21	CD 4 cell count			X
1.22	Brucellosis		X	X
<b>CULTURE</b>				
1.22	Culture and sensitivity testing			X
<b>GRAM STAIN</b>				
1.23	Body fluids	X	X	X

		DH	PH	RH
<b>URINE TEST</b>				
1.24	Macroscopic	X	X	X
1.25	Chemical	X	X	X
1.26	Microscopic	X	X	X
1.27	Pregnancy test	X	X	X
<b>STOOL TESTS</b>				
1.28	Macroscopic	X	X	X
1.29	Microscopic	X	X	X
<b>SPUTUM TESTS</b>				
1.30	Acid fast bacil (AFB) Ziehl-Nielson	X	X	X
<b>BLOOD TRANSFUSION AND BLOOD BANK SERVICES</b>				
1.31	Blood grouping (Beth Vincent/Simonin)	X	X	X
1.32	Cross matching	X	X	X
1.33	HIV antibody (I and II) testing	X	X	X
1.34	Hepatitis B surface antigene	X	X	X
1.35	Hepatitis C virus	X	X	X
1.36	VDRL testing (syphylis)	X	X	X
<b>2. IMAGING SERVICES</b>				
<b>X-RAY</b>				
2.1	Chest	X	X	X
2.2	Abdomen	X	X	X
2.3	Skeletal	X	X	X
2.4	IVP (KUB)			X
2.5	Hystero salpyngography			X
2.6	Barium enema and barium meal			X
<b>ULTRASOUND</b>				
2.7	Ultrasound (simple portable at DH/PH, doppler at RH)	X	X	X
<b>3. ELECTROCARDIOGRAPHY (ECG)</b>				
<b>4. ELECTROENCEPHALOGRAPHY (EEG)</b>				
<b>5. ELECTROMYOGRAPHY (only in Kabul)</b>				
<b>6. ENDOSCOPY</b>				

#### **4. Staffing of Hospitals by Type of Hospital**

A hospital's most critical resources are its human resources. Because human resources for health are scarce in Afghanistan, the critical skills needed must be identified, based on the conditions that a hospital is expected to treat. However, while identifying the skills the staff for each type of hospital must possess, the Hospital Management Task Force found it impossible to specify the number of staff needed because (1) within each type of hospital the number of staff will vary according to the number of beds and services provided, and (2) a large difference exists between the number of staff required to operate a hospital and the number of staff that would be ideal. To address this quandary, Table 8, "Staffing of District, Provincial, and Regional Hospitals," provides staffing figures within the following guidelines:

1. Since for each type of hospital the number of beds may vary, the midpoint in the range of number of beds was chosen to determine staffing. For instance, district hospitals may have from 25 to 75 beds. The staffing for district hospitals in Table 8 therefore reflects staffing for a 50-bed hospital—the midpoint. While the range in the number of beds is specified for each level of hospital, the allocation of those beds to various clinical services is not specified (e.g., the number of surgical beds, the number of pediatric beds, etc.). Instead, the hospital director is expected to allocate beds to clinical services according to the needs of the community and situation. For instance, in the event of an earthquake, many hospital beds should be shifted to serve as surgical beds for the duration of the emergency.
2. Two staffing levels are given for each type of hospital—"minimum staffing" and "advised staffing." Minimum staffing reflects the minimum number of staff required for a hospital of that type, size, and number of beds to operate in a responsible manner. The number given as minimum staff may not be the desired or ideal number, but it is the number of staff required for the hospital truly to function as expected. The second staffing figure reflects the "best case" or ideal number of staff. Providing the necessary training institutions, the proper training programs, and an intake of qualified candidates adequate to reach such staffing levels will require a great deal of effort. Thus the number in the "advised staff" column for each type of hospital may be considered the number of staff Afghanistan aspires to in the medium term—five to 10 years. (See Annex B for the assumptions underlying the advised staffing patterns.)

**Table 8. Staffing of District, Provincial, and Regional Hospitals****Minimum and advised staffing levels for hospital with midpoint number of beds in each hospital category**

Position	District Hospital (25–75 beds)		Provincial Hospital (75–250 beds)		Regional Hospital (300–450 beds)	
	Staffing for 50 Beds		Staffing for 150 beds		Staffing for 350 Beds	
	Minimum Staffing	Advised Staffing	Minimum Staffing	Advised Staffing	Minimum Staffing	Advised Staffing
<b>1. MANAGEMENT</b>						
Hospital Director	1	1	1	1	1	1
Medical Director (duties performed by the hospital director at district and provincial hospitals)	—	—	—	1	1	1
Nursing Director/Chief Nurse	1	1	1	1	1	1
Administrator	1	1	1	1	1	1
Subtotal	3	3	3	4	4	4
<b>2. PHYSICIANS</b>						
Surgeons (For regional hospital includes all other specialty surgeons)	2	2	2	5	4	8
Ophthalmologist	—	—	—	—	1	3
ENT	—	—	—	—	1	3
Anesthesiologist doctor (includes reanimation)	—	1	1	2	2	4
Obstetrician and Gynecologist	1	2	2	4	4	6
Pediatrician	1	1	2	2	4	4
Medical specialists (internal medicine, psychiatry, dermatology, and cardiology)	—	1	2	3	4	5
General practitioners (nonspecialized— <i>malaige</i> )	3	3	7	13	14	28
Radiologist (medical imaging including X-ray and ultrasound)	—	—	—	1	1	2
Dentist	—	—	1	1	1	3
Subtotal	7	10	17	31	36	66
<b>3. NURSES/MIDWIVES</b>						
Operating theater and sterilization	2	3	5	6	10	12
Midwives	3	4	8	9	12	15
Ward nurses	8	8	12	24	28	58
Anesthetic nurses	2	2	2	3	4	5
ER (emergency room) and OPD (outpatient department) nurses	2	2	4	7	8	12
Subtotal	17	19	31	49	62	102
<b>4. TECHNICAL STAFF</b>						
Psychologist	—	1	—	2	1	4
Physiotherapist	1	1	1	4	2	6
Pharmacist	1	2	2	2	2	3
X-Ray technician	1	2	2	2	2	4
Laboratory technician	2	2	4	3	4	5
Blood-bank technician	—	2	—	2	—	3
Dental technician	1	1	1	2	3	4
Vaccinator	2	2	2	2	2	2
Nutritionist/Cook	—	1	—	2	—	3
Technical assistants (x-ray, lab, pharmacy, physiotherapy)	—	—	2	3	4	5
Subtotal	8	14	14	24	20	39
<b>5. SUPPORT STAFF</b>						
Administration (procurement, accounting, human resources, medical records, clerks)	2	2	3	4	6	8
Storekeeper	—	1	1	2	2	3
Maintenance	1	2	2	4	4	6
Cleaners, waste management, and grounds (gardeners)	5	8	16	20	20	34
Laundry	2	2	2	4	4	8
Cook	2	2	4	4	4	5
Drivers	1	1	2	2	3	4
Guards (and porters)	4	5	5	10	8	15
Tailor	—	—	—	2	—	4
Mullah	—	—	—	1	—	1
Subtotal	17	23	35	53	51	88
<b>TOTAL STAFF</b>						
Administration	3	3	3	4	4	4
Physicians	7	10	17	31	36	66
Nursing/Midwives	17	19	31	49	62	102
Technical	8	14	14	24	20	39
Support	17	23	35	53	51	88
<b>TOTAL</b>	<b>52</b>	<b>69</b>	<b>100</b>	<b>161</b>	<b>173</b>	<b>299</b>

## **5. Equipment for Hospitals by Type of Hospital**

If doctors and nurses lack the equipment necessary to provide patient care, their knowledge and skills are wasted. If quality of care is to improve, the basic equipment necessary for each level of hospital—district, provincial, and regional—must be clearly identified. Table 9, “Equipment and Supplies List, by Type of Hospital,” lists the equipment and supplies needed by each level of hospital. When specialized equipment is required, such as ultrasound machines, maintenance and operational training plans should be included.

Great care was taken in selecting appropriate technology equipment for all levels of hospitals. Choices have been informed by (1) grassroots-level experience in Afghanistan, (2) the necessity to offer appropriate technology to help lower maternal, neonatal, infant, and child mortality, (3) cost-effectiveness considerations, and (4) recurrent cost considerations.

For instance, appropriate technology neonatal incubators, such as the Van Hemel Neonatal Incubator,<sup>1</sup> have been added at all three hospital levels. However, at the DH level (and quite frequently, at the PH level as well), such an incubator can be used for only short periods of time due to the absence of 24-hour electricity. Caring for a premature neonate at delivery or following a caesarean section may require other methods, such as kangaroo care.<sup>2</sup>

Ultrasonography was considered important at all levels, although the exact type of ultrasound machine would differ at each hospital level: portable ultrasounds for DH and PH levels and a larger machine, perhaps with echo Doppler functions, for the RH level. Oxygen concentrators were deemed indispensable for all three levels of hospitals. However, ventilators and anaesthetic machines, for use during operations, will be available only at the RH level: at the DH and PH levels, local, spinal, and ketamine anesthesia will be practiced.

---

<sup>1</sup> The Van Hemel Neonatal Incubator costs about US\$385 and is easy to maintain. <http://www.clinicalresearch.nl/incubator/INFO.HTM> (accessed 9 Sept. 04).

<sup>2</sup> <http://www.prematurity.org/baby/kangaroo.html> (accessed 9 Sept. 04).

**Table 9. Equipment and Supplies List, by Type of Hospital**

<b>Equipment and Supplies</b>				<i>District Hospital</i>	<i>Provincial Hospital</i>	<i>Regional Hospital</i>
<b>1. NONMEDICAL EQUIPMENT</b>						
<b>1.1 Administration</b>				<b>DH</b>	<b>PH</b>	<b>RH</b>
Office furniture				X	X	X
Office equipment				X	X	X
Computer				X	X	X
Stationary				X	X	X
<b>1.2 Communications</b>				<b>DH</b>	<b>PH</b>	<b>RH</b>
Radios				X	X	X
Telephone (type depends on level)				X	X	X
<b>1.3 Medical maintenance and power</b>				<b>DH</b>	<b>PH</b>	<b>RH</b>
Generator (including backup for OT, lab/blood bank, and maternity)				X	X	X
Solar				X	X	X
Emergency lights (back-up lighting in key areas)				X	X	X
Voltage stabilizer for all electronic equipment				X	X	X
Tools and spare parts				X	X	X
Fuel and oil				X	X	X
<b>1.4 Water Supply (24/7)</b>				<b>DH</b>	<b>PH</b>	<b>RH</b>
Water source for safe drinking water at 100 liters per patient per day				X	X	X
Water pump				X	X	X
Storage reservoir, holding tank				X	X	X
Water purification chemicals/filters				X	X	X
Utility sinks with taps				X	X	X
Hand washing sinks with taps				X	X	X
Surgical scrub sinks in operating theater				X	X	X
<b>1.5 Waste Disposal</b>				<b>DH</b>	<b>PH</b>	<b>RH</b>
Incinerator/burial pit				X	X	X
Septic tanks				X	X	X
Drainage systems				X	X	X
Sanitation facilities for patients and families				X	X	X
Sharps containers (in all locations where sharps are used)				X	X	X
Rubbish bins (in all rooms)				X	X	X
<b>1.6 Safety and Security</b>				<b>DH</b>	<b>PH</b>	<b>RH</b>
Fire extinguishers				X	X	X
Water hoses and buckets				X	X	X
Spotlights				X	X	X
<b>1.7 Vehicles</b>				<b>DH</b>	<b>PH</b>	<b>RH</b>
Vehicle, 4-wheel drive				1	1	2
Ambulance, 4-wheel drive				1	2	4
Fuel and oil				X	X	X

<b>1.8 Medical stores</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Refrigerators	X	X	X
Cool boxes	X	X	
Vaccine carriers	X	X	
Shelves	X	X	X
Padlocks	X	X	X

<b>1.9 Kitchen</b>			
Ovens	X	X	X
Cooking stove	X	X	X
Cooking pots and utensils	X	X	X
Dishes, cups, cutlery	X	X	X
Dishwashing machine			X
Refrigerators	X	X	X
Shelves	X	X	X

<b>1.10 Laundry</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Washing equipment	X	X	X
Washing machine		X	X
Basins	X	X	X
Irons	X	X	X
Water heater (electrical/diesel/wood)	X	X	X
Wash detergent/powder	X	X	X
Sewing/repair kits	X	X	X

<b>1.11 Housekeeping</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Mops	X	X	X
Brushes	X	X	X
Brooms	X	X	X
Soap and disinfectant	X	X	X
Buckets	X	X	X

<b>1.12 Mortuary</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Mortuary fridge		X	X

<b>2. MEDICAL EQUIPMENT</b>			
<b>2.1 Basic Equipment Sets for Medical and Nursing Examinations</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Sphygmomanometer	X	X	X
Stethoscope	X	X	X
Vision chart	X	X	X
Thermometer	X	X	X
Dressing (Lister) scissors	X	X	X
Torch/flashlight	X	X	X
Adult scale	X	X	X
Pediatric and infant scales	X	X	X
Height measuring scale (and height board for infants and young children)	X	X	X
Fetal stethoscope Pinard (specifically for OB/GYN)	X	X	X
Ophthalmoscope and otoscope set (specifically for ER)	X	X	X
Reflex hammer (specifically for ER)	X	X	X
Tourniquet	X	X	X
Hand washing facilities (container or running water)	X	X	X
Sharps container (in all rooms)	X	X	X
Wall clock	X	X	X

<b>2.2 Emergency equipment</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Basic examination set (see 2.1) plus ophthalmoscope and otoscope set and reflex hammer	X	X	X
Defibrillator			X
Electrocardiography (ECG)		X	X
Examination lamp	X	X	X
Patient separators/dividers	X	X	X
Suction machine (foot/pedal operated)	X	X	X
Fetal stethoscope (Pinard)	X	X	X
Oxygen (concentrator)	X	X	X
Oxygen cylinder (various sizes)	X	X	X
Ambu bag, masks, guedel (oropharyngeal airway, adult and child)	X	X	X
Drip (IV) stands	X	X	X
Kramer splints, different sizes	X	X	X
Suture set	X	X	X
Wound dressing set	X	X	X
Bowls and bassins	X	X	X
Examination trolleys, stretchers, and wheelchairs	X	X	X
Dressings trolley	X	X	X
Bed pan	X	X	X

<b>2.3 Operating Theater/Room</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Operating table with accessories (lithotomy poles—stirrups & arm rests)	2	2	4
Instrument sets for each operating table, consisting of			
- wound set	5	10	15
- minor set	1	2	4
- laparotomy set	2	4	6
- caesarian section set/hysterectomy set	2	4	6
- gynecology set	1	2	4
- obstructed labor set	1	1	1
- episiotomy set	1	2	3
- suture set	5	7	10
- amputation set	1	1	2
- arm and leg pneumatic tourniquet			X
- diathermy set		X	X
Suction machine (foot/pedal operated) one per OR table	X	X	X
Bucket for decontamination, one for each table	X	X	X
Heating and cooling equipment	X	X	X

<b>2.4 Anesthesia</b>			
Basic examination equipment (see 2.1)	X	X	X
Oxygen (concentrator)—if oxygen, then oxygen saturation monitor advisable	X	X	X
Ventilator machine		X	X
Anesthetic machine		X	X
Laryngoscope set (handle and different size blades, spare bulbs)	X	X	X
Magill forceps	X	X	X
Nontoothed artery forceps	X	X	X
Endotracheal introducer (malleable)	X	X	X
Ambu bag, masks (0–5), guedel (oropharyngeal airway), adult and child	X	X	X
Suction machine (foot operated)	X	X	X
Refrigerator, lockable	X	X	X
Pedal waste bin	X	X	X

<b>2.5 Sterilization equipment</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Autoclave (approximately 60–70 L per OT/OR table), electric or gas heated team/pressure autoclaves	X	X	X
Each autoclave (high pressure steam sterilizer) with:			
- autoclave carts	X	X	X
- metal instruments trays (rigid containers/perforated trays or pans)	X	X	X
- metal wire baskets	X	X	X
- cloth/linen for surgical wraps (woven textiles)	X	X	X
- dry steriliser Poupinel (electric)		X	X
- metal instrument containers with lid for dry sterilizer		X	X
- sterilization drums and boxes	X	X	X
Indicators for both steam and dry heat (consumables):			
- indicator tape	X	X	X
- chemical indicators (time/temperature/pressure and time/temperature)	X	X	X
- biological indicators	X	X	X
High-level disinfection:			
- boilers for boiling items (electric) or pots with lids	X	X	X
- electric/gas/kerosene stoves	X	X	X
- plastic containers with lids for chemical HLD and rinsing (endoscopes)			X
- tables for instrument preparation and for wrapping (dedicated)	X	X	X
- shelves/cabinets for with doors for storage	X	X	X

<b>2.6 Obstetrics and Gynecology</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
OB/GYN examination table	X	X	X
Basic examination equipment (see 2.1)	X	X	X
Doppler (small, portable, battery operated)	X	X	X
Fetal heart monitoring machine			X
Dilatation and curettage set	X	X	X
Delivery table	X	X	X
Dressing trolley	X	X	X
Examination lamp	X	X	X
Bed pan	X	X	X
Manual vacuum aspirator (for D&C)	X	X	X
Vacuum extractor (for childbirth)	X	X	X
Infant mucus aspiration pear	X	X	X
Infant cot	X	X	X
Infant warmer	X	X	X
Incubator, neonatal, Van Hemel	X	X	X
Nebulizer	X	X	X
Infant emergency resuscitation equipment	X	X	X
Speculum (all sizes)-retractor vaginal	X	X	X
Intravenous (IV) poles	X	X	X
Scale, infant, with tray	X	X	X
Apron and boots (and masks and caps)	X	X	X

<b>2.7 Medical</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Electrocardiogram (ECG) machine		X	X
Basic examination equipment (see 2.1)	X	X	X
Examination table	X	X	X
Examination lamp	X	X	X
Medicine storage cabinets or cupboards	X	X	X
Table and chairs	X	X	X

<b>2.8 Pediatrics</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Infant scale	X	X	X
Photo therapy equipment			X
Circumference measurement tape	X	X	X
Height measurement board /mat for infants and young children	X	X	X
Children height measurement board	X	X	X
Growth monitoring charts	X	X	X

<b>2.9 Specialist (ENT, Ophthalmology, etc.)</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Highly specialised equipment			X
Bronchoscopes and endoscopes			X
ENT mirror or lamp	X	X	X
Nasal speculum	X	X	X
Ear speculum	X	X	X
Dental specialized equipment		X	X

<b>2.10 Nursing wards</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Ventilators/AC/Bukharies (where appropriate)	X	X	X
Basic examination equipment (see 2.1)	X	X	X
Beds with mattresses and pillows, and bedside tables	X	X	X
Stretchers on wheels	X	X	X
Intravenous (IV) stands	X	X	X
Medicine storage cabinets or cupboards	X	X	X
Dressing trolleys	X	X	X
Bedpans and urinals	X	X	X
Pedal waste bin	X	X	X
Patient and bed linen	X	X	X

<b>2.11 Outpatient Department (OPD)</b>			
Basic examination equipment (see 2.1)	X	X	X
Examination table	X	X	X
X-ray viewer	X	X	X
Examination lamp	X	X	X
Scales, infant and adult	X	X	X
Medicine storage cabinets or cupboards	X	X	X
Pedal wastebin	X	X	X
Table and chairs	X	X	X

<b>2.12 Orthopedics and Physiotherapy (equipment only if physiotherapist present)</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Brown frame with pulleys and weights	X	X	X
Weights for traction	X	X	X
Thomas splint		X	X
Blocks for elevating beds	X	X	X
Pillows (various sizes and shapes)	X	X	X
Bed frames for traction		X	X
Walking frames	X	X	X
Treatment bench	X	X	X
Measuring tape and goniometer	X	X	X
Pulley system	X	X	X
Floor mattress	X	X	X
Weights: 0.25–5kg	X	X	X
Dumb-bells: ½–5kg	X	X	X
Walking bars	X	X	X
Steps	X	X	X
Crutches	X	X	X
Wheelchairs	X	X	X

<b>2.13 X-Ray/Radiology</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
X-ray machine (fixed and/or mobile)	X	X	X
X-ray developing machine (manual) and darkroom equipment	X	X	X
X-ray protection material (e.g., lead aprons and protective walls)	X	X	X
X-ray wall viewer	X	X	X
Ultrasound machine (small, portable with voltage stabilizer at DH and RH level)	X	X	X
Voltage stabilizer for x-ray machine	X	X	X

<b>2.14 Laboratory</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Microscope (electric where electricity through grid available)	X	X	X
Distiller machine	X	X	X
Hemoglobinometer (Sali method at DH and PH and Haemacue and RH)	X	X	X
Hematocry + D290t (HCT) centrifuge (electric)	X	X	X
Centrifuge (hand and electric)	X	X	X
Glucometer		X	X
Glycostrips	X		
Urine strips	X	X	X
Pregnancy test	X	X	X
Water bath	X	X	X
Counting chamber	X	X	X
ESR rack, (automated) pipette and tube	X	X	X
Spirit lamp	X	X	X
Timer/stop watch	X	X	X
Slide rack	X	X	X
Measuring jug and cylinders	X	X	X
Fridge (absorption type)	X	X	X
Rotator for syphilis test	X	X	X
Sterilizer (dry heat)	X	X	X
Balance	X	X	X
Spectrophotometer (colorimeter on PH level)			X

<b>2.15 Blood Bank/Transfusion Service</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Examination table	X	X	X
Blood donor beds		X	X
Refrigerator		X	X
Deep fridge			X
Water bath		X	X
Autoclave		X	X
Automated pipette, adjustable (10–100 micro liter)	X	X	X
Stethoscope		X	X
Sphygmomanometer		X	X
Adult scale	X	X	X
Crystallizing dish	X	X	X
Cool box	X	X	X
Lens mirror	X	X	X
Shaking machine (vs 1–2 kg scale for manual stirring of blood bag)	X	X	X
Transfusion bags	X	X	X
Cross match test	X	X	X
HIV tests	X	X	X
Hepatitis B and C tests	X	X	X
VDRL test	X	X	X

<b>2.16 Infection Prevention</b>	<b>DH</b>	<b>PH</b>	<b>RH</b>
Buckets for general waste, one for each treatment area	X	X	X
Buckets for contaminated waste, one for each treatment area and one for each bed in DR	X	X	X
Buckets for decontaming instruments, one for each treatment area, OT table, and delivery bed	X	X	X
Sharps containers	X	X	X
Impermeable aprons	X	X	X
Utility gloves (for housekeeping staff)	X	X	X
Eye protection or face shield	X	X	X

## 6. Essential Drugs for Hospitals by Type of Hospital

Drugs are necessary for treating most patients in hospitals, and they can be very expensive. It is important that hospitals have the necessary drugs, but only those absolutely necessary for the types of conditions diagnosed and treated at that level of hospital. In 2003 the MOPH defined the National Essential Drug List (NEDL) for Afghanistan. Table 10, “Essential Drugs for Hospitals, by Type of Hospital” is a subset of the complete NEDL. Each hospital must adhere to this list and not add to its formulary expensive and “exotic” drugs that benefit very few patients. Table 10 identifies the basic drugs needed by each level of hospital based upon the conditions diagnosed and treated at that level (see Table 6).

Table 10. Essential Drugs for Hospitals, by Type of Hospital

Drug	Dosage			
		District Hospital	Provincial Hospital	Regional Hospital
		DH	PH	RH
<b>1. Anesthetics and Oxygen</b>				
<b>1.1 General Anesthetics and Oxygen</b>				
	Halothane			X
	Ketamine	X	X	X
	Sodium thiopental			X
	Oxygen	X	X	X
<b>1.2 Local Anesthetics</b>				
	Lidocaine	X	X	X
	Lidocaine	X	X	X
	Lidocaine + Adrenaline	X	X	X
	Lidocaine	X	X	X
	Bupivacain (not in EDL but critical for hospitals)	X	X	X
<b>2. Analgesics, Antipyretics, Nonsteroidal Anti-inflammatory Drugs (NSAID) Medicines Used to Treat Gout</b>				
<b>2.1 Nonopioid Analgesics / Antipyretics / NSAID</b>				
	Acetaminophen	X	X	X
	Acetaminophen (Paracetamol)	X	X	X
	Acetyl Salicylic Acid	X	X	X
	Ibuprofen	X	X	X
<b>2.2 Opioid Analgesics</b>				
	Morphine	X	X	X
	Pethidine	X	X	X
	Pethidine		X	X
<b>2.3 Medicines Used to Treat Gout</b>				
	Allopurinol			X
	Colchicine			X
<b>3. Anticonvulsant /Anti-epileptics</b>				
	Carbamazepin			X
	Diazepam	X	X	X
	Ethosuxamid			X
	Magnesium Sulphate	X	X	X
	Phenobarbital	X	X	X
	Phenobarbital (sodium salt)	X	X	X
	(Complementary)			
	Valproic acid			X
<b>4. Antidotes and Other Substances Used in Poisonings</b>				
<b>4.1 Nonspecific Antidotes</b>				
	Activated Charcoal	X	X	X
<b>4.2 Specific Antidotes</b>				
	Acetyl Cystein			X
	Atropine Sulphate	X	X	X
	BAL (Dimercaprol)			X
	Deferoxamine			X
	Diphenhydramine	X	X	X
	Methylen Blue (Methylthionium)			X
	Naloxone	X	X	X
	Calcium gluconate	X	X	X
	Protamine Sulphate		X	X
	(Complementary)			
	Flumazenil	X	X	X

5. Antihistamines			DH	PH	RH
<b>5.1 H1 Receptor Antagonists</b>					
Chlorpheniramine Maleate	tablet 4mg, injection 10mg/1ml		X	X	X
Promethazine	tablet 25mg, injection 25mg/ml				X
Promethazine Hydrochloride	syrup 5mg/5ml				X
<b>5.2 H2 Receptor Antagonists</b>					
Ranitidine	tablet 150 mg, 300mg, injection 50mg/2ml ampoule		X	X	X
6. Anti-infective Medicines			DH	PH	RH
<b>6.1 Anthelmintics</b>					
<b>6.1.1 Intestinal Anthelmintics</b>					
Mebendazole	chewable tablet 100mg		X	X	X
<b>(Complementary)</b>					
Albendazol	chewable tablet, 200mg, 400mg		X	X	X
<b>6.1.2 Antifilarials</b>					
Diethylcarbamazine	tablet 50mg, 100mg (dihydrogen citrate)		X	X	X
<b>6.2 Antibacterials</b>					
<b>6.2.1 Beta Lactam Medicine</b>					
Amoxicillin	tablet 500mg and 250mg (anhydrous)		X	X	X
Amoxicillin	powder for oral suspension, 125mg (anhydrous)/5ml, 250 mg/5m		X	X	X
Amoxicillin	syrup		X	X	X
Ampicillin	powder for injection 1g and 500mg (as sodium salt) in vial		X	X	X
Benzathine Benzyl	powder for injection, 1,2 million IU & 2.4 million IU in 5ml vial		X	X	X
Benzyl Penicillin G (Crystal)	powder for injection 1 million IU and 5 million IU (sodium or potassium salt) in vial		X	X	X
Cloxacillin	vial 500mg for injection		X	X	X
Cloxacillin	capsule/tablet 500mg, 250mg (as sodium salt)		X	X	X
Phenoxy Methyl Penicillin	tablet 250mg, 500mg (as potassium salt)		X	X	X
Procaine Penicillin	powder for injection, 2 million IU and 4 00 000 IU in vial		X	X	X
<b>(Complementary)</b>					
Amoxicillin + Clavulanic Acid (restricted indication)	tablet 500mg + 125 mg				X
Amoxicillin + Clavulanic Acid (restricted indication)	for oral suspension 125mg, 31.25mg/5ml				X
Ceftriaxone (restricted indication)	vial 1 gram, 500mg			X	X
<b>6.2.2 Other Antibacterial</b>					
Chloramphenicol	capsule 250mg		X	X	X
Chloramphenicol	oral suspension 125mg (as palmitate)/5ml		X	X	X
Chloramphenicol	powder for injection 1 gram and 500 mg (sodium succinate) in vial		X	X	X
Doxycycline	capsule/tablet 100mg (hydrochloride)		X	X	X
Erythromycin	tablet 400mg/200mg (ethyl succinate)		X	X	X
Gentamicine	injection 20mg, 40mg, 80mg (as sulfate)/ml in 2ml vial		X	X	X
<b>(Complementary)</b>					
Ciprofloxacin (restricted indication)	tablet 500 mg 250mg (as hydrochloride)			X	X
Ciprofloxacin (restricted indication)	injection 2mg/ml, 50ml bottle			X	X
<b>6.2.3 Antileprosy medicines (in speciality facilities only)</b>					
Clofazimine	capsule 50mg, 100mg		--	--	--
Dapsone	tablet 25mg, 50mg, 100mg		--	--	--
Rifampicin	capsule or tablet 150mg, 300mg		--	--	--

<b>6.2.4 Antituberculosis medicines</b>					
Ethambutol	tablet 400mg		X	X	X
INH	tablet 100mg, 300mg		X	X	X
Pyrazinamid	tablet 500mg		X	X	X
Rifampicin	capsule or tablet 150mg, 300 mg		X	X	X
Rifampicin	syrup 100mg/5ml				X
Streptomycin	powder for injection 1g (as sulfate) in vial		X	X	X
<b>(Complementary)</b>					
Thiacetazon +Isoniazid	tablet 50mg + 100mg & 150mg + 300mg				X
<b>6.3 Antifungal medicines</b>					
Benzoic acid+ Salicylic	cream or ointment 6% + 3%		X	X	X
Griseofulvin	capsule or tablet 125mg, 250mg			X	X
Ketoconazol	tablet 200 mg, topical cream 2%		X	X	X
Nystatin	tablet 100 000 IU, 500 000 IU		X	X	X
Nystatin	vaginal tablet 100 000 IU		X	X	X
<b>6.4 Antiviral Medicine</b>					
Aciclovir	ophthalmic ointment 3%			X	X
<b>6.5 Antiprotozoal medicines</b>					
<b>6.5.1 Anti-amoebic and Antigiardiasis medicines</b>					
Metronidazol	tablet 250mg, 400mg		X	X	X
Metronidazol	injection 500mg in 100ml vial		X	X	X
Metronidazol	oral suspension, 200mg (as benzoate)/5ml				X
<b>6.5.2 Antileishmaniasis</b>					
Meglumine Antimonate	injection, 30%, equivalent to approx. 8.1% antimony in 5ml ampoule		X	X	X
Stibogluconate Sodium	injection 100mg/ml ampoule		X	X	X
<b>6.5.3 Antimalarial</b>					
Chloroquine	tablet, base 150mg (as phosphate or sulfate)		X	X	X
Chloroquine	syrup, base 50mg (as phosphate or sulfate) /5ml		X	X	X
Pyrimethamin + Sulfadoxine (Fansidar)	tablet 25mg + 500mg		X	X	X
Quinine	tablet 300mg (as bisulfate or sulfate)		X	X	X
Quinine	injection, 300mg (as dihydrochloride)/ml in 2ml ampoule		X	X	X
<b>(Complementary)</b>					
Artesunate	tablet 50 mg (Note: Provided only in malarial endemic areas)		X	X	X
Artemether	80mg/ml 2ml Ampule (for IM only)		X	X	X
<b>6.6 Sulfonamide/Related</b>					
Co-Trimoxazole (Sulfamethoxazole+Trimethoprim)	suspension 200mg + 40mg/5ml		X	X	X
Co-Trimoxazole (Sulfamethoxazole+Trimethoprim)	tablet 100mg + 20mg & 400mg + 80mg		X	X	X
<b>6.7 Urinary and Intestinal Antiseptics</b>					
Nalidixic Acid	tablet 250mg 500mg, 250mg/5ml Syrup				X
Nitrofurantoin	tablet 100mg		X	X	X
Furazolidon	tablet 100mg, Syrup 125mg/5ml				X
<b>7. Antimigraine Medicines</b>			<b>DH</b>	<b>PH</b>	<b>RH</b>
Acetyl Salicylic Acid	tablet, 300mg 500mg		X	X	X
Acetaminophen	tablet 325mg		X	X	X
Ergotamine	tablet 1mg (tartrate)				X
Propranolol	tablet 20mg 40mg (hydrochloride)		X	X	X

8. Antiparkinsonism Medicines			DH	PH	RH
Biperidin	tablet 2mg (hydrochloride)				X
Biperidin	injection, 5mg (lactate) in 1ml ampoule				X
Levodopa + Carbidopa	tablet 100mg + 10mg				X
Levodopa + Carbidopa	250mg + 25mg				X
Trihexylphenidyl	tablet 2 mg				X
9. Medicines Affecting the Autonomic System			DH	PH	RH
9.1 Parasympatomimetics					
Pilocarpine	solution (eye drop), 2%, 4% (Hydrochloride or Nitrate)				X
9.2 Parasympatholytics					
Atropine	solution (eye drop) 0,1%, 0,5%, 1% (sulfate),				X
Atropine	tablet 1mg (sulfate), injection 1mg (sulfate) in 1-ml ampoule	X	X		X
Hyoscine-N-butyl bromide	tablet 10mg, injection 20mg/ml	X	X		X
9.3 Sympathomimetics					
Adrenaline	injection 1mg (as hydrochloride or hydrogen tartrate) in 1-ml ampoule	X	X		X
Salbutamol	tablet 2mg, 4mg (as sulfate)	X	X		X
Salbutamol	inhalation (aerosol), 100 microgram (as sulfate) per dose		X		X
Salbutamol	respirator solution for use in nebulizers 5mg (as sulfate)/ml	X	X		X
Dopamine Hydrochloride	injection, 40 mg/ml, 5ml ampoule				X
9.4 Sympatholytics					
Methylidopa	tablet 250mg	X	X		X
Atenolol	tablet 50mg, 100mg				X
Propranolol	tablet 10mg, 40mg	X	X		X
Timolol	solution (eye drop), 0.25%, 0.5% (as maleate)				X
9.5 Muscle Relaxants (Peripherally acting) and Cholinesterase inhibitors					
Alcuronium	injection, 5 mg/ml in 2ml ampoule				X
Suxamethonium (Succinyl Choline)	injection, 50mg (chloride)/ml in 2ml ampoule	X	X		X
9.6 Autonomic Agents, Other					
Bromocriptine	tablet 2.5 mg (as mesilate)				X
10. Medicines Affecting the Blood			DH	PH	RH
10.1 Drugs Used in Anemia					
Ferrous Sulphate	tablet, equivalent to 60 mg iron, oral solution	X	X		X
Folic Acid	tablet, 1mg and 5 mg/tablet	X	X		X
Ferrous Sulphat+Folic Acid (Nutritional Supplement for use during pregnancy)	tablet, equivalent to 60 mg iron + 400 microgram folic acid	X	X		X
Hydroxocobalamine	injection, 1mg in 1-ml ampoule		X		X
(Complementary)					
Iron Dextran	injection equivalent to 50mg iron/ml in 2-ml ampoule				X
10.2 Drugs Affecting Coagulation					
Vit.K (Phytomenadione)	injection 10mg/ml ampoule, tablet, 10mg	X	X		X
Sodium Heparine	injection 1000 IU/ml, 5 ml and 5000 IU/ml, 1 ml		X		X
Enoxaprin (low molecular weight Heparine) restricted indication only for DVT	sc injection	X	X		X
11. Blood Products and Plasma Substitutes			DH	PH	RH
Dextran 70	Injectable solution 6%				X

12. Cardiovascular Medications			DH	PH	RH
<b>12.1 Anti-anginal Medicines</b>					
Atenolol	tablet, 50mg, 100mg				X
Glyceryl Trinitrate	tablet, (sublingual), 0.5 mg				X
Isosorbide Dinitrate	tablet, (sublingual), 5mg, 10 mg	X	X		X
Verapamil	tablet, 40 mg, 80 mg (hydrochloride)				X
<b>12.2 Anti-arrhythmic Drugs</b>					
Atenolol	tablet 50mg, 100 mg				X
Digoxin	tablet 0.25 mg, injection 0.5 mg/2ml	X	X		X
Lidocaine	injection, 20 mg (hydrochloride)/ml in 5ml ampoule				X
Procainamide	injection 1000 mg /10 ml, cap/tab 250mg				X
Verapamil	tab 40mg, 80 mg, injection,				X
Verapamil	2.5mg (hydrochloride)/ml in 2ml ampoule				X
<b>12.3 Anti-hypertensive Agents</b>					
Atenolol	tab 50mg, 100mg				X
Captopril	tablet 25mg				X
Hydralazine	tablet 25mg, 50 mg (hydrochloride), powder				X
Hydralazine	for injection, 20mg (hydrochloride) in ampoule	X	X		X
Methyl dopa	tablet 250 mg	X	X		X
Nifedipine	capsule/tablet 10mg	X	X		X
<b>12.4 Cardiotonics</b>					
Digoxin	tablet 0.25mg, injection 0.5 mg/2ml	X	X		X
<b>12.5 Platelet Aggregation Inhibitors</b>					
Acetyl Salicylic Acid	tablet 100mg	X	X		X
<b>13. Dermatological Medicines (topical)</b>			DH	PH	RH
<b>13.1 Anti-infective, Topical</b>					
Methyl Rosanilinium Chloride (Gentian Violet)	aqueous solution, 0.5%, 1%	X	X		X
Neomycin+Bacitracine	ointment, 5mg neomycin sulfate + 500 IU bacitracin zinc/G	X	X		X
Silver Sulfadiazine	cream 1%, in 500-gram container	X	X		X
<b>13.2 Antifungal, Topical</b>					
Benzoic Acid + Salicylic Acid	ointment or cream 6% + 3%	X	X		X
Nystatine	ointment 100 000 U/gram, vaginal tablet	X	X		X
Nystatine	100,000 U, drop 100 000 U/ml, coated tablet 500,000 U	X	X		X
Tolnaftate	topical cream 1%, topical solution 1%				X
<b>13.3 Anti-inflammatory and Antipruritics, Topical</b>					
Calamine-lotion	lotion	X	X		X
Hydrocortisone	ointment or cream, 1% (acetate)				X
<b>13.4 Anti-infective/Anti-inflammatory Combination, Topical</b>					
Betamethasone-N	topical cream/ointment Betamethason (as Valerate) 0.1%+ Neomycin Sulfate 0.5%	X	X		X
<b>13.5 Sun Protectants/Screen</b>					
Zinc Oxide	topical ointment 20%, powder	X	X		X
<b>13.6 Keratolytics/Caustics</b>					
Benzoyl Peroxide	lotion or cream, 5%				X
Coal Tar	solution, 5%				X
Fluorouracil	ointment, 5%				X
Resorcinol-S	topical cream Resorcinol 2% + sulphur 8%				X
Salicylic Acid	solution, 5%	X	X		X
<b>13.7 Scabicides/Pediculocides</b>					
Lindane	lotion 1%	X	X		X
<b>13.8 Local Anesthetics, Topical</b>					
Lidocaine	gel 2%, 4%	X	X		X

14. Diagnostic Agents		DH	PH	RH
<b>14.1 Radio Contrast Media</b>				
Barium Sulfate	aqueous suspension			X
Meglumine Compound 76%	injection 20 ml, 100ml (Meglumine diatrizoate 66% + sodium diatrizoate 10%)			X
Meglumine Compound 76%	oral solution (Meglumine diatrizoate 66% + sodium diatrizoate 10%)			X
15. Disinfectants and Antiseptics		DH	PH	RH
Methanol	solution, 70% (denatured)	X	X	X
Chlorhexidine	solution, 5% (digluconate) for dilution	X	X	X
Chlorine releasing comp.	powder for solution, 1 gram per liter	X	X	X
Hydrogenperoxid	solution 6% (= approx. 20 volume)	X	X	X
Iodine Polyvidone	solution, 10%	X	X	X
Gentian Violet	aqueous solution 0, 5%, 1%	X	X	X
Potassium Permanganate	aqueous solution, 1:10 000	X	X	X
16. Diuretics		DH	PH	RH
Furosemide	tablet 40 mg,	X	X	X
Furosemide	injection, 10 mg/ml in 2-ml ampoule	X	X	X
Hydrochlorothiazid	tablet 25 mg 50mg	X	X	X
Mannitol	injectable solution, 10%, 20%			X
Spironolactone	tablet 25 mg			X
17. Gastrointestinal Medicines		DH	PH	RH
<b>17.1 Antacids</b>				
Aluminum hydroxide + Magnesium Hydroxide	chewable tablet aluminum hydroxide 200mg + magnesium hydroxide 200mg	X	X	X
<b>17.2 Laxatives</b>				
Bisacodyl	tablet 5mg	X	X	X
<b>17.3 Drugs Used in Peptic Ulcer</b>				
Histamine H2 Receptor Antagonist Ranitidine	tablet 150 mg, 300mg, injection 50mg/2ml	X	X	X
<b>(Complementary)</b>				
Omeprazol	capsule 20mg		X	X
<b>17.4 Anti-emetics</b>				
Metoclopramid	tablet 10mg (hydrochloride),	X	X	X
Metoclopramid	injection 5mg (hydrochloride)/ml in 2-ml ampoule	X	X	X
<b>17.5 Antimuscarinics/Antispasmodic</b>				
Atropine	injection 1 mg (sulfate) in 1-ml ampoule	X	X	X
Hyoscine –N- Butyl Bromide	tablet, 10 mg,	X	X	X
Hyoscine –N- Butyl Bromide	injection 4 mg/ml in 5-ml ampoule	X	X	X
<b>17.6 Antihemorrhoid Drugs</b>				
Anti-Inflammatory Astringent/Local Anesthetic Drugs	ointment or suppository	X	X	X
<b>17.7 Oral Rehydration Salts (ORS)</b>				
Oral Rehydration Salt	powder, 27,9 g/l	X	X	X
(for Glucose Electrolyte solution)	sodium chloride (3.5 G/L), trisodium citrate dihydrate (2.9 G/L), potassium chloride (1.5 G/L), glucose (20 G/L); trisodium citrate			

<b>18. Hormones, Other Endocrine Medicines, and Contraceptives</b>			<b>DH</b>	<b>PH</b>	<b>RH</b>
<b>18.1. Adrenal Hormones and Synthetic Substitute</b>					
	Hydrocortisone	powder for injection	X	X	X
	Prednisolone	tablet 5mg	X	X	X
<b>18.3. Contraceptives</b>					
<b>Hormonal Contraceptives</b>					
	Ethinylestradiol + Levonorgestrol	tablet 30 microgram + 150 microgram	X	X	X
	Ethinylestradiol + Levonorgestrol	tablet 50 microgram + 250 microgram			X
	Ethinylestradiol + Norethisterone	tablet 35 microgram + 1.0mg			X
	<b>(Complementary)</b>				
	Medroxy Progesterone	depot injection, 150mg/ml in 1-ml vial	X	X	X
		50mg/ml in 3ml vial			
<b>18.4 Intrauterine Devices</b>					
	Copper-containing device		X	X	X
<b>18.5 Barrier Methods</b>					
	Condoms with or without spermicide (Nonoxinol)		X	X	X
<b>18.6 Estrogens</b>					
	Ethinylestradiol	tablet 10 microgram, 50 microgram			X
<b>18.7 Progestines</b>					
<b>18.8 Ovulation Inducers</b>					
	Clomiphene (Clomifen)	tablet 50 mg (Citrate)			X
<b>18.9 Insulin and Other Antidiabetic Agents</b>					
	Glibenclamide	tablet 5mg		X	X
	Insulin injection (soluble)	injection, 40 IU/ml in 10ml vial			X
	Insulin injection (soluble)	100 IU/ml in 10ml vial		X	X
	Intermediate-acting insulin	injection, 40 IU/ml in 10-ml vial			X
	Intermediate-acting insulin	100 IU/ml in 10ml vial (as compound insulin zinc suspension or isophane insulin)		X	X
	Metformine	tablet, 500mg (hydrochloride)		X	X
<b>18.9.1 Thyroid Hormones and Antithyroid Medicines</b>					
	Levothyroxine	tablet, 50 microgram, 100 microgram (sodium salt)			X
	Potassium Iodide	tablet, 60mg			X
	Carbimazole	tablet, 5mg			X
<b>19. Immunologicals</b>			<b>DH</b>	<b>PH</b>	<b>RH</b>
<b>19.1 Diagnostic agents</b>					
	Tuberculin, Purified Protein Derivative (PPD)	injection	X	X	X
<b>19.2 Sera and Immunoglobulins</b>					
	Anti-D immunoglobulin (human)	injection, 250 microgram in single-dose vial		X	X
	Antitetanus Immunoglobulin (human)	injection, 500 IU, 1500U, 3 000U ampoule	X	X	X
	Pertussis Antitoxin				X
	Diphtheria Antitoxin	injection, 10 000 IU, 20 000 IU in vial		X	X
	Rabies Immunoglobulin	injection, 150 IU/ml in vial		X	X
<b>19.3 Vaccines</b>					
	BCG		X	X	X
	DPT		X	X	X
	Hepatitis-B		X	X	X
	Measles		X	X	X
	Poliomyelitis		X	X	X
	Tetanus		X	X	X

19.4 For Specific Group of Individuals					
Mumps vaccine			X	X	X
Rabies vaccine (inactivated: prepared in cell culture)			X	X	X
Rubella vaccine					X
20. Ophthalmological Preparations and Drugs Used in ENT			DH	PH	RH
20.1 Antiglaucoma and Miotics					
Acetazolamid	tablet, 250mg				X
Pilocarpine	solution (eye drop), 2%, 4% (hydrochloride or nitrate)				X
Timolol	solution (eye drop), 0.25%, 0.5% (as maleate)				X
20.2 Anti-infective, Topical:					
Aciclovir (Acyclovir)	ophthalmic ointment 3%		X	X	X
Chloramphenicol	solution (eye drop) 0.5%		X	X	X
Gentamicine	solution (eye drop) 0.3 % (as sulfate)				X
Sulfacetamide	solution (eye drop) 10%, 20%				X
Silver Nitrate	solution (eye drop) 1%				X
Tetracycline	eye ointment, 1% (hydrochloride)		X	X	X
20.3 Anti-inflammatory Topical Agents					
Prednisolone	solution (eye drop), 0.5%				X
20.4 Local Anesthetics					
Tetracaine	solution (eye drop), 0.5% ( hydrochloride)		X	X	X
20.5. Mydriatics					
Atropine	solution (eye drop), 0.1%, 0.5%, 1% ( Sulfate)				X
Tropicamide	solution (eye drop) 0.5%, 1%				X
20.6 Drugs Used in E.N.T					
20.6.1 Decongestant					
Naphazoline	solution (nasal drop) 0.05%		X	X	X
20.6.2 Removal of Ear Wax					
Glycerin Boric	solution 5%				X
21. Oxytocics and Antioxytocics			DH	PH	RH
21.1 Oxytocics					
Ergometrine	tablet 200 microgram (hydrogen maleate),		X	X	X
Ergometrine	injection 200 microgram (hydrogen maleate)		X	X	X
Oxytocin	injection, 10 IU in 1ml ampoule		X	X	X
21.2 Antioxytocics					
Salbutamol	tablet 4mg (as sulfate)		X	X	X
Salbutamol	injection, 50 microgram (as sulfate)/ml in 5ml ampoule		X	X	X
22. Psychotherapeutic Medicines			DH	PH	RH
22.1 Medicines Used in Psychotic Disorders					
Chlorpromazine	tablet 100mg (hydrochloride),				X
Chlorpromazine	syrup 25mg (hydrochloride)/5ml				X
Chlorpromazine	injection 25 mg (hydrochloride)/ml in 2ml ampoule				X
Haloperidol	tablet 2mg, 5mg, injection 5mg /1ml ampoule		X	X	X
22.2 Medicines Used in Depressive Disorders					
Amitriptyline	tablet, 25 mg (hydrochloride)				X
Fluoxetine	capsule, 20mg		X	X	X
22.3 Medicines Used in Generalized Anxiety and Sleep disorders					
Diazepam	tablet 2mg, 5mg, 10mg; injection 5mg/ml in 2ml ampoule		X	X	X
Alparazolam	tablet 0.5mg			X	X
22.4 Medicines Used in Vertigo					
Dimenhydrinate	tablet 50mg				X

23. Medicines Acting on the Respiratory Tract		DH	PH	RH
<b>23.1 Anti-asthmatic Medicines</b>				
Aminophylline	injection, 25mg/ml in 10-ml ampoule	X	X	X
Aminophylline	tablet 100mg	X	X	X
Beclometasone	inhalation (aerosol), 50 microgram, 250 microgram (dipropionate) per dose			X
Epinephrine (Adrenaline)	injection 1mg (as hydrochloride or hydrogen tartrate) in 1ml ampoule	X	X	X
Salbutamol	tablet 2mg, 4mg (as sulfate)	X	X	X
Salbutamol	inhalation (aerosol), 100 microgram (as sulfate) per dose			X
Salbutamol	syrup, 2mg (as sulfate)/5ml			X
Salbutamol	injection, 50 microgram (as sulfate)/ml in 5ml ampoule			X
Salbutamol	respirator solution for use in nebulizers, 5mg (as sulfate)/ml	X	X	X

24. Solutions Correcting Water, Electrolyte, and Acid-base Disturbances		DH	PH	RH
<b>24.1 Oral</b>				
Oral Rehydration Salts (for glucose-electrolyte solution)	for composition see section 18. 7	X	X	X
Potassium Chloride	Powder for solution			X
<b>24.2 Parenteral</b>				
Glucose	injectable solution, 5% isotonic, 10%, 50% hypertonic	X	X	X
Glucose with Sodium Chloride	injectable solution, 4% glucose, 0.18% sodium chloride (equivalent to Na+30mmol/l Cl-30mmol/l)		X	X
Potassium Chloride	11.2 % solution in 20ml ampoule, (equivalent to K+1.5mmol/ml, cl-1.5mmol/ml)			X
Sodium Chloride	injectable solution, 0.9% isotonic (equivalent to Na+154 mmol/l, Cl-154 mmol/l)	X	X	X
Sodium Hydrogen Carbonate	injectable solution 1.4% isotonic (equivalent to Na+167mmol/l, HCO3-167 mmol/l)			X
Sodium Hydrogen Carbonate	8.4% solution in 10ml ampoule (equivalent to Na+ 1000 mmol/l, HCO3-1000 mmol/l)			X
Compound Solution of Sodium Lactate (Ringer lactate)	injectable solution	X	X	X
<b>24.3 Miscellaneous</b>				
Water for injection	5ml, 10ml ampoule	X	X	X

25. Vitamins and Minerals		DH	PH	RH
Iodine	iodized oil, 1ml (480mg iodine)			X
Iodine	0.5 ml (240 mg iodine) in ampoule (oral or injectable)			X
Iodine	0.57 ml (308 mg iodine) in dispenser bottle			X
Iodine	capsule, 200 mg			X
Multimicronutrients	capsule	X	X	X
Pyridoxine	tablets 25 and 40 mg, injection (dosage)	X	X	X
Cholecalciferol	ampoule 600,000 IU/ml	X	X	X
Phytomenadione (Vitamin K)	injection, 10mg/ml ampoule	X	X	X
Phytomenadione (Vitamin K)	tablet, 10mg			X
Retinol	sugarcoated tablet, 10 000 IU (as palmitate) (5.5mg)	X	X	X
Retinol	capsule 200 000 IU (as palmitate) (110mg)	X	X	X
Retinol	oral oily solution, 100 000 IU/ml in multidose dispenser (as palmitate)			X
Retinol	injection, 100 000 IU (as palmitate) (55mg) in 2ml ampoule			X

**Annex A. Hospital Policy for Afghanistan's Health System**



**Islamic Transitional Government  
of Afghanistan  
Ministry of Health**

**Policy Statement**

**Hospital Policy for  
Afghanistan's Health System**

**February 2004**

## **Ministry of Health Policy Statement**

### **Hospital Policy for Afghanistan's Health System**

Approved by the MOH Executive Board, February 2004

The Basic Package of Health Services (BPHS) is being expanded throughout Afghanistan. The BPHS is an important element in the redevelopment of the health system because it deals with the priority health problems of the country. Hospitals have an important role in this PHC-focused strategy because district, provincial, and regional hospitals are required to form an integrated referral system providing a range of needed services: from health promotion to disease prevention to basic treatment to disability care to specialized inpatient care. This policy establishes the guidelines for the redevelopment of hospitals as a key element of the Afghan health system.

#### **Issues: The Need for a Hospital Policy**

The major problems facing Afghanistan's hospitals which must be addressed to ensure that hospitals are part of an integrated health system and providing quality patient care are:

- *The lack of standards for clinical patient care and management of hospitals.* The consequence is poor quality of care for patients.
- *The lack of equitable access to hospital services throughout the country.* People in many parts of the country have no access to a hospital and its services, while other areas, such as Kabul, have a disproportionate number of hospital beds relative to the population. The problem of the skewing of hospital beds and services toward certain areas is often compounded by donors.
- *The concentration of financial resources and health workers at hospitals.* The result is the potential for hospitals to be allocated a disproportionate share of new health workers and financial resources which will reduce the ability of the health system to address basic health problems.
- *The lack of hospital management skills for the operation of hospitals.* As a result, the hospitals are inefficient.
- *The lack of necessary staff, equipment, supplies and pharmaceuticals in many hospitals.* The result is the hospital is often ineffective in the treatment it provides.
- *The referral system does not work.* The hospital system is fragmented and uncoordinated.

As a consequence, there is a need to address the role of hospitals in the health system, the organization and management of hospitals, standards for hospitals and the financial and human resources allocated to hospitals so the Afghan health system is properly planned to address the health problems of the country for the long-term. That is the purpose of this policy.

## **MOH Hospital Policies**

The hospitals of Afghanistan will provide a comprehensive referral network of secondary and tertiary health facilities. The policies guiding the hospital sector are:

1. Hospitals, as part of a unified national health system, will provide necessary curative and emergency services, which complement the Basic Package of Health Services, that includes disability care, offered at basic and comprehensive health centers.
2. Hospitals must be rationally distributed so their services are accessible on an equitable basis for the entire population.
3. The MOH will carefully plan the number of hospitals, their location, hospital beds, and types of hospital beds to ensure that the resources committed to hospitals result in the maximum impact on the population's health status. Because Afghanistan does not have unlimited resources to finance hospitals, so health planning, resource allocation and financial management of hospitals will be undertaken by MOH for the entire hospital sector as a means for maximizing the impact and effectiveness of hospitals on the country's health status.
4. Provision of hospital care must be based on need for hospital care and not on ability to pay.
5. Hospitals must be managed in an efficient manner that adheres to basic clinical and managerial standards that ensure the provision of quality care to all patients, including patients with disabilities.
6. The proportion of the government's annual operational budget for hospitals will not exceed 40% of the total health budget.
7. To ensure budgetary accountability and transparency, the MOPH will develop the appropriate financial systems and develop proper mechanisms, such as empowering financial management of hospitals to their board of directors.
8. Equitable cost-sharing strategies which are appropriate for Afghanistan, will be developed to help make the operation of hospitals more financially sustainable.
9. Hospitals also have a role within the health system to provide supervision of lower level health facilities, a place for professional training of physicians, nurses, midwives, and other health providers as well as supporting necessary national medical and health systems research.
10. Private hospitals are permitted and are part of the health system and must comply with all standards for providing good quality care, be accredited and adhere to all MOH policies.

## **Standards for Hospitals**

Standards are required to improve the clinical and managerial performance to attain an acceptable level of operations for hospitals. Standards establish what is expected of hospitals and their staff at all levels of operation. It is the establishment of such reasonable standards which permits the monitoring of hospital operations against which hospital performance can be measured. This is required to improve the standard of care and management of hospitals in Afghanistan. The following provide the framework of the basic standards. Specific details, elements and components of each standard must be developed and specified in greater detail by the MOH. The following provides a structure and direction for development of detailed standards for hospitals, which will be used for accreditation, ultimately.

**1. Responsibilities to the Community**

- 1.1. The hospital is responsive to the community's needs
- 1.2. Hospital services will be accessible to the community.
- 1.3. Hospitals will have a proper disaster preparedness plan so it can properly respond in the event of natural or man-made disasters.

**2. Patient Care**

- 2.1. Patients will be treated with dignity and have a right to be treated in a respectful manner.
- 2.2. Quality of clinical care to the patient that the hospital serves is high and appropriate for Afghanistan, including the proper staffing, equipment and supplies.
- 2.3. Quality of care will be monitored and measured by agreed indicators (e.g. wound infections, length of hospital stay, operations per patient, mortality rates etc).
- 2.4. Women and children will receive the basic package of health services at hospitals, including immunization, outpatient care for conditions, such as pneumonia and diarrhea, as well as appropriate assistance at the time of delivery.
- 2.5. Hospitals will be "mother and baby friendly" and encourage "rooming-in" and immediate, exclusive breast feeding.
- 2.6. Care delivery is monitored by the hospital's health care team to ensure that care meets the needs of patients and to assist in the improvement of care.
- 2.7. Medical records are maintained for each patient and are kept confidential and secure.

**3. Leadership and Management**

- 3.1. The hospital is effectively and efficiently governed, organized, supervised and managed to ensure the highest quality of care possible for patients.
- 3.2. To ensure the responsiveness of hospitals to the community, a hospital board of directors or board of management will be established at each hospital to govern and oversee the proper operation and management of the hospital.

**4. Human Resource Management**

- 4.1. Staff planning ensures a properly trained hospital staff and the appropriate number of staff.
- 4.2. Staff are appointed through a recruitment, selection and appointment procedure that is consistent with the MOH human resources policy.
- 4.3. In performing their duties, staff adhere to high ethical standards and a code of conduct.
- 4.4. A comprehensive program of staff development and in-service training meets individual and hospital needs.
- 4.5. Effective workplace relations are developed through use of teams

**5. Management Systems**

- 5.1. Financial management policies and procedures are developed and adhered to in order to ensure accountability of the hospital's finances from all sources.
- 5.2. Management information systems meet the hospital's internal and external needs
- 5.3. Patient care, management of services, education and research are facilitated by the timely collection and analysis of data

- 5.4. Information technology enhances the hospital's ability to gather, store and analyze information and to communicate.
- 5.5. Appropriate logistics and purchasing systems are maintained to ensure clinicians have the proper equipment, supplies and pharmaceuticals to provide patient care.
- 5.6. Buildings and grounds are maintained to ensure a safe patient care and work environment for patients, staff and visitors.

## **6. Hospital Environment**

- 6.1. Infection is effectively controlled throughout the hospital
- 6.2. The physical environment of the hospital and its equipment are properly maintained to ensure patient and staff safety and that there are no physical barriers for those with disabilities.
- 6.3. The hospital is accessible to all patients with including those with physical disabilities.
- 6.4. Buildings, grounds, plant and equipment are regularly maintained to ensure a safe environment for all persons in the hospital.
- 6.5. Waste from the hospital is handled, contained and disposed of safely and efficiently
- 6.6. Occupational health measures are adopted to ensure the safety of staff, especially those dealing with direct patient care.
- 6.7. Clean water of sufficient quantity and quality is available for patients and staff and for proper hospital functioning.
- 6.8. Toilets in the hospital are kept clean for use by patients, staff, and visitors.

## **Levels of Hospitals**

There are three levels of hospitals: district (as a part of the BPHS), provincial, and regional, including specialized hospitals. Differentiation of hospital levels is based on the patient services offered. Five core clinical functions will exist in each level of hospital: medicine, surgery, pediatrics, obstetrics and gynecology, and mental health. An escalating level of sophistication will exist from district to urban hospitals. The health post, basic health center and comprehensive health center will offer basic curative and preventative services.

Hospitals in conjunction with the Provincial Coordination Committees (PCC) will ensure the enforcement of a well-functioning referral system. A two-way referral mechanism will be established maintaining a functional link between hospitals and primary health care facilities. First line referrals will stem from health centers to district hospital outpatient departments from where consultation will define whether patients need to be further referred to higher levels or treated at that level. Similarly patients are referred back to primary health care facilities for follow-up. The following general specification of services for various hospital levels will be supplemented by the Basic Package of Hospital Services, to be developed by MOH, will identify, in detail, the clinical services provided at each level, the equipment and supplies required, and the minimum staffing required.

## **District Hospital**

Each district hospital will have from 30 to 75 beds and serve a population of 100,000 to 300,000, covering from one to four districts. The basic services offered at a district hospital are:

- surgery
- medicine
- pediatrics
- obstetrics and gynecology
- mental health (outpatient)
- dental services

The district hospital will also have nutrition, physical therapy, laboratory, radiology, blood transfusion, and pharmacy services.

### **Provincial Hospital**

A provincial hospital serves a province and will have from 100 to 200 beds. In addition to the services offered at a district hospital, the provincial hospital has:

- physical therapy and rehabilitation services;
- nutrition services;
- infectious disease medicine.

### **Regional Hospital**

A regional hospital serves several provinces and will have from 200 to 400 beds. In addition to the services offered at a provincial hospital, the regional hospital has:

- surgery with ENT, urology, neurosurgery, orthopedics, plastic surgery, and physiotherapy;
- medicine with cardiovascular, pulmonary, endocrinology, and dermatology;
- forensic medicine.

Diagnostic services include:

- **laboratory:** hematology, parasitology, bacteriology, virology, allergy and immunology, biochemistry, toxicology, cytology, and pathology;
- **blood bank/transfusion services:** Provides for the taking, preserving, and distributing blood to patients and the diagnosis of blood related diseases (hemophilia, thalassemia, leukemia, and viral diseases—hepatitis, HIV/AIDS);
- **imaging:** routine and specialized radiography, ultrasonography.

### **Rationalization of Hospital Services**

There will be rationalization of services, such as polyclinics, where specialized diagnostic and curative services are provided on an outpatient basis. These facilities will be linked to regional and specialized hospitals for referral of complicated cases requiring inpatient care in order to reduce the burden on these hospitals and to give quality services at an outpatient level. They will not have beds as this duplicates what exists in hospitals and is expensive for the health system.

While there may be a need for some additional specialized diagnostic services for the country, these services are too expensive and for too few patients to be available at every regional hospitals. Further rationalization of services will occur at the urban level where specialized clinical and diagnostic services and equipment will be centralized. These include: pathology and forensic medicine, histology, bio-technical support, centralized statistics center, and research. Equipment and services such as CT-scan and radiotherapy will be

located at only one hospital in the country to provide the services for the entire the country rather than being provided at each regional hospital.

Specialized hospitals will be combined into regional hospitals with multiple specialties, as much as possible. As current specialized hospitals are rehabilitated and new facilities planned, the MOH will seek to combine them with other major hospitals in order to rationalize the number and type of hospitals. The current specialized hospitals include eye, mental health, disabilities, tuberculosis, chest, oncology, orthopedic and prosthesis, maternity, pediatrics, and emergency hospitals.

## Annex B. Staffing Assumptions for Advised Staffing Patterns

The assumptions related to the advised staffing patterns for the hospitals are:

- Related to the % of beds per service based on (1) Mirwais Kandahar, (2) JPHH-1 Jalalabad, and (3) Ghazni hospitals, however modified: surgery to 40% (58%; 57%; 37%); medical to 25% (24%; 28%; 37%) and OB/GYN increased to 20% (5%; 5%; 9%) and pediatrics to 15% (10%; 8%; 15%).
- Staffing doctors: 1:5 (total medical doctors versus total hospital beds: Regional Hospital Afghan standard)
- Staffing nurses 1:5 (with one head nurse/midwife in each ward/department)
- Staffing midwives 1:4
- Staffing psychiatry nurses/psychologists/anesthesiologists: estimate, unexplored area in Afghanistan
- Staffing operating theater 1 table: 2 nurses (OT tables 50 beds = 1 then 1 for every 100 beds)
- Staffing sterilization 1: table (OT tables 50 beds = 1 then 1 for every 100 beds)
- Staffing anesthesia 1: table + 1 night (OT tables 50 beds = 1 then 1 for every 100 beds)
- Staffing for outpatient department (morning shift only):
  - 50 beds: 1
  - 100 beds: 1
  - 150 beds: 2
  - 200 beds: 2
  - 250 beds: 3
  - 300 beds: 4
  - 350 beds: 4
  - 400 beds: 4
- Staffing for emergency room (shifts: morning + night + sleep)
  - 50 beds: 1 + 0 + 0
  - 100 beds: 1 + 1 + 1
  - 150 beds: 2 + 1 + 1
  - 200 beds: 3 + 2 + 2
  - 250 beds: 3 + 2 + 2
  - 300 beds: 4 + 2 + 2
  - 350 beds: 4 + 2 + 2
  - 400 beds: 5 + 3 + 3
- Staffing laboratory and blood bank are based on recommendations of lab and BB experts.
- Staffing X-ray technicians are per X-ray machine covering 24 hrs (not per bed). If mobile machines are used or fluoroscope in the OT, an increase can be considered.
- Staffing physiotherapists covering both OPD and IPD is an estimate based on ICRC experience in Afghanistan.
- Staffing dental technicians and vaccinators are estimates.
- Staffing technical assistants: important for physiotherapy, X-ray, sterilization/OT and pharmacy: preferable to using cleaners

- Staffing pharmacist: estimate based on ICRC experience in Afghanistan
- Staffing administration: estimate
- Staffing storekeeper: estimate
- Staffing maintenance: at minimum, a plumber and an electrician are needed. When hospitals become bigger, other professions may be needed (e.g., a welder and a carpenter). In addition, the plumber and the electrician may need to be available 24 hours a day.
- Staffing kitchen: both cooks and helpers are included in this estimate
- Staffing laundry: depends on if laundry machines are used or hand washing is practiced, whether staff uniforms are washed, etc.
- Staffing drivers: estimate
- Staffing guards: outside guards 24 hours and inside (ward) guards
- Staffing cleaners: includes administration (1), wards (1–2 per ward), corridors (1:50 beds), OT (1: table), and waste management
- Staffing porters for emergency room and OT during day time and 1 per night (> 100 beds): added to guards

**Annex 4****Monitoring and Supervision Plan for Health Financing Pilots**

The Health Financing Pilots are being implemented in 11 provinces and cover 61 pilot facilities. The pilot project has four main objectives – (1) Raise revenue of the health sector; (2) Improve the quality of health services; (3) Ensure financial protection and access to services, particularly to the poor; (4) Develop and enhance community ownership of health services. The distribution of these pilot facilities by treatment group and facility type is shown below.

	User Fee	CHF	Free Service	Control	TOTAL
District Hospital	7	0	0	0	7
CHC	15	4	7	7	33
BHC	8	6	3	4	21
TOTAL	30	10	10	11	61

**A. Monitoring and supervision plan.**

Monitoring indicators – For the user fee, CHF and free service health financing pilots a set of monitoring indicators have been developed with attempt to link the project objectives with (a) Input / Process, (b) Output, (c) Outcome and (d) Impact indicators. These indicators are presented in the Excel file “monitoring\_indic”. Information on Input/Process and Output indicators will be collected monthly and entered into a database using Microsoft Access. Data sources for these indicators is detailed in section B below and will come from (a) pilot tools; (b) HMIS and (c) from the pilot facilities.

Supervision plan – To supervise implementation of the health financing pilots the following plan will be followed :

- 1) Post training follow-up (June and July 2005) - Training will be completed by June 16, 2005. From this date through July 2005 progress in appointing pilot functionaries (lead coordinator, user fee/CHF/free service advisor ) and initial implementation progress will be monitored. No field visits are planned for this period unless necessary to facilitate project implementation.
- 2) Initial review of progress (August 2005) – Approximately two months after completion of training, in August 2005, a review of progress will be held in the three regional training venues (Kabul, Mazar-i-Sharif and Herat). The purpose of the review will be to get project functionaries (lead coordinator, user fee/CHF/free service advisor ) involved in implementing the pilot (CHF, user fee, free service) to meet together and discuss difficulties they are facing in implementation and try to find solutions to these problems. Each review session will last one and a half day. The first half of day 1 will be dedicated to presentations from each province (approximately 40 minutes each) of implementation progress, problems faced and lessons learned. This will be followed by a brief discussion. The second half of day 1 will consist of a problem solving workshop. Participants will be divided into groups according to type of pilot facility where they will identify problems faced in implementing their specific pilots and propose solutions. The first half of day 2 will be dedicated to making presentations of problems and solutions by pilot type. The identified solutions will then be implemented.

3) Field visits (October to December 2005) - The period between October through December 2005 will be used to conduct field visits to various project facilities to assess implementation progress. Implementation progress will also be assessed by analyzing monitoring indicators. Field visit reports will be generated.

4) Mid-term evaluation (February/March 2006) – A mid-term evaluation will be undertaken in January/February 2006 to assess project progress. This will involve a compilation of field visit reports and analysis of monitoring data. Another possibility is to have progress review sessions in Kabul and/or the regional training venues along the lines of the initial review of progress held in August 2005.

5) Field visits (March to May 2006) - The period between March through May 2006 will be used to conduct field visits to various project facilities to assess implementation progress. Implementation progress will also be assessed by analyzing monitoring indicators. Field visit reports will be generated.

6) Final evaluation (June 2006) – The final evaluation of the health financing pilots will be held in June 2006.

**B. Health financing tools to be collected regularly for monitoring pilots.**

1) Regular monitoring reports from pilot facilities.

Community Health Fund Pilot

Importance	Tool	Indicators	Reporting frequency
High	CHF monitoring and Supervision check-list (Tool #25)	General check list of actions completed	Monthly (< 6 month) 1/3 (6+ moths)
Med	Rational prescription monitoring (Tool #26)	- # drugs per prescription - # prescription with >1 anti-biotic, injection	1/3 month
High	Finance and utilization report (Tool #22)	- CHF income, expenditure - OPD visits(exempt/non-exempt service visits; members/non-members; curative care visits). - IPD visits (total visits, member/non-member  Note : no info on new visits, length of hospital stay.	monthly
High	End-of –year statement of income and expenditure (Tool # 23)	Annual Income, expenditure	yearly
High	Regular membership report (Tool 13)	# new, total members; # hh paying full/reduced/no premium; # hh enrolled in each catchment village.	Monthly (< 6 month) 1/3 (6+ moths)

User Fee Pilot

Importance	Tool	Indicators	Reporting frequency
High	Regular financing and administrative report (Tool # 16)	- User fee income, expenditure - OPD visits(exempt/non-exempt service visits; members/non-members; curative care visits). - IPD visits (total visits, member/non-member  Note : no info on new visits, length of hospital stay.	Monthly (< 6 month) 1/3 (6+ moths)
High	End-of –year statement of income and expenditure (Tool # 17)	Annual Income, expenditure	yearly
High	Monitoring and Supervision check-list (Tool #20)	General check list of actions completed	Monthly
Med	Rational prescription monitoring (Tool #21)	- # drugs per prescription - # prescription with >1 anti-biotic, injection	1/3 month

Free Service Pilot

Importance	Tool	Indicators	Reporting frequency
High	Free service monitoring and supervision check-list	General check list of actions completed	Monthly
Med	Rational prescription monitoring	- # drugs per prescription - # prescription with >1 anti-biotic, injection	1/3 month

2) HMIS data from Ministry of Public Health / Pilot facilities.

3) Additional monitoring tools developed after review of progress. These tools will contain select Input/Process and Output indicators detailed in the monitoring plan which are not available from the above two sources.

**Annex 5 - Indicators for Health Financing Pilots, July 2005**  
**(see following pages)**

User Fee Monitoring Indicators

PROJECT OBJECTIVE	INPUT/PROCESS	OUTPUT	OUTCOME	IMPACT
1 Improve quality	Total number of sanctioned doctor posts (Source: Facility)	Total number of OPD visits in past month (Source: Tool 16)	Levels and change in quality of care indicators from endline survey	Health indicators in catchment area
	Total number of doctors present for 20 days or more during past month (Source: Facility)	Total number of OPD visits for preventive care in past month (Source: Tool 16)		
	Total number of sanctioned nurse posts (Source: Facility)	Total number of OPD visits for curative care in past month (Source Tool 16)	- direct observation of provider at facility	
	Total number of nurses present for 20 days or more during past month (Source: Facility)	Total number of new OPD visits in past month (Source: HMIS/Facility)	- facility audit	
	Any stockout of essential drugs during the past month (Yes/No) (Source: HMIS)	Total number of new OPD visits for preventive care in past month (Source: HMIS/Facility)	Health care utilization rate in catchment area:	
	All essential equipment available at facility during the past month(Yes/No) (Source: Facility)	Total number of new OPD visits for curative care in past month (Source: HMIS/Facility)	- immunization rates in children	
	All essential equipment in working condition at facility during the past month(Yes/No) (Source: Facility)		- % seeking treatment at health facility when sick	
	Any stockout of essential medical supplies during the past month (Y/N) (Source: Facility)	Total number of inpatient admissions in past month (Source:Tool 16)		
	Refresher trainings for doctors conducted during the past month (Y/N) (Source: Facility)	Total number of inpatient days ( occupied bed days) in past month (Source: Facility)	Bed occupancy rate	
	Refresher trainings for nurses conducted during the past month (Y/N) (Source: Facility)			
		Average number of drugs per prescription (Source:Tool 21)		
	Total number of inpatient beds available (Source: Facility)	Percentage of prescriptions with >1 anti-biotic (Source:Tool 21)		
	Total number of supervision visits to facility in past month (Source: Facility)	Percentage of prescriptions with >1 injections (Source:Tool 21)		
	Total expenditure on doctor salary in past month (Afs) (Source: Facility)	Number of referrals in (Source: HMIS/Facility)		
	Total expenditure on nursing staff salary in past month (Afs) (Source: Facility)	Number of referrals out (Source: HMIS)		
	Total expenditure on other staff salary in past month (Afs) (Source: Facility)			
	Total expenditures on medical supplies in past month (Afs) (Source: Facility)			
	Total expenditures on drugs in past month (Afs) (Source: Facility)			
	Total expenditures on purchase of equipment in past month (Afs) (Source: Facility)			
	Total expenditures on repair of equipment in past month (Afs) (Source: Facility)			
	Total expenditures on repair/maintenance of building in past month (Afs) (Source: Facility)			
	Total expenditure on vehicle purchases in past month (Afs) (Source: Facility)			
	Total expenditure on vehicle maintenance (petrol, oil, lubricants) in past month (Afs) (Source: Facility)			
Total expenditure on electricity, water, rent in past month (Afs) (Source: Facility)				
Total other expenditures on health facility in past month (Afs) (Source: Facility)				

User Fee Monitoring Indicators

Project Objective	INPUT/PROCESS	OUTPUT	OUTCOME	IMPACT
Increase revenue 2 for health care	<p>User fee charged for OPD consultation(Afs) (Source: Facility)</p> <p>User fee charged for OPD medications (Afs) (Source:Facility)</p> <p>User fee charged for IPD admissions (Afs) (Source: Facility)</p> <p>User fee charged for IPD medications (Afs) (Source: Facility)</p> <p>User fee fund balance at start of previous month (Afs) (Source: Tool 16)</p> <p>Total revenue generated from user fees in previous month(Afs) (Source: Tool 16)</p> <ul style="list-style-type: none"> <li>- user fee revenue from service fees (Afs) (Source: Tool 16)</li> <li>- user fee revenue from medication fees (Afs) (Source: Tool 16)</li> <li>- user fee revenue from other fees (Afs) (Source: Tool 16)</li> </ul> <p>Total expenditure from user fee fund in previous month (Afs) (Source: Tool 16)</p> <ul style="list-style-type: none"> <li>- expenditure on facility building maintainence in past month (Afs) (Source: Facility)</li> <li>- expenditure on medicines and medical supplies in past month (Afs) (Source: Facility)</li> <li>- expenditures on repair/purchase of medical equipment in past month (Afs) (Source: Facility)</li> <li>- expenditures on other facility related items in past month (Afs) (Source: Facility)</li> <li>- expenditures on facility staff in past month (Afs) (Source: Facility)</li> <li>- expenditures on community in past month (Afs) (Source: Facility)</li> <li>expenditures on user fee fund administration in past month (Afs) (Source: Tool 16)</li> </ul>	<p>Total number of OPD preventive care visits by exempt patients (Source: Tool 16)</p> <p>Total number of OPD preventive care visits by non-exempt patients (Source: Tool 16)</p> <p>Total number of OPD curative care visits by exempt patients (Source: Tool 16)</p> <p>Total number of OPD curative care visits for non-exempt patients (Source: Tool 16)</p> <p>Total number of new OPD preventive care visits by exempt patients (Source: Facility)</p> <p>Total number of new OPD preventive care visits by non-exempt patients (Source: Facility)</p> <p>Total number of new OPD curative care visits by exempt patients (Source: Facility)</p> <p>Total number of new OPD curative care visits for non-exempt patients (Source: Facility)</p> <p>Total number of inpatient visits by exempt patients in past month (Source: Tool 16)</p> <p>Total number of inpatient visits by non-exempt patients in past month (Source: Tool 16)</p>	<p>Annual revenue generated at facility due do user fees</p> <p>Share of user fees in facility operating costs</p> <p>Bed occupancy rate for non-exempt patients</p> <p>Bed occupancy rate for non-exempt patients</p>	<p>Health sector revenue in district/province</p>



CHF Monitoring Indicators

PROJECT OBJECTIVE	INPUT/PROCESS	OUTPUT	OUTCOME	IMPACT
CHF Pilot				
1 Improve quality	<p>Total number of sanctioned doctor posts (Source: Facility)</p> <p>Total number of doctors present for 20 days or more during past month (Source: Facility)</p> <p>Total number of sanctioned nurse posts (Source: Facility)</p> <p>Total number of nurses present for 20 days or more during past month (Source: Facility)</p> <p>Any stockout of drugs during the past month (Yes/No) (Source: HMIS)</p> <p>All essential equipment available at facility during the past month(Yes/No) (Source: Facility)</p> <p>All essential equipment in working condition at facility during the past month(Yes/No) (Source: Facility)</p> <p>Any stockout of essential medical supplies during the past month (Y/N) (Source: Facility)</p> <p>Refresher trainings for doctors conducted during the past month (Y/N) (Source: Facility)</p> <p>Refresher trainings for nurses conducted during the past month (Y/N) (Source: Facility)</p> <p>Total number of inpatient beds available (Source: Facility)</p> <p>Total number of supervision visits to facility in past month (Source: Facility)</p> <p>Total expenditure on doctor salary in past month (Afs) (Source: Facility)</p> <p>Total expenditure on nursing staff salary in past month (Afs) (Source: Facility)</p> <p>Total expenditure on other staff salary in past month (Afs) (Source: Facility)</p> <p>Total expenditures on medical supplies in past month (Afs) (Source: Facility)</p> <p>Total expenditures on drugs in past month (Afs) (Source: Facility)</p> <p>Total expenditures on purchase of equipment in past month (Afs) (Source: Facility)</p> <p>Total expenditures on repair of equipment in past month (Afs) (Source: Facility)</p> <p>Total expenditures on repair/maintenance of building in past month (Afs) (Source: Facility)</p> <p>Total expenditure on vehicle purchases in past month (Afs) (Source: Facility)</p> <p>Total expenditure on vehicle maintenance (petrol, oil, lubricants) in past month (Afs) (Source: Facility)</p> <p>Total expenditure on electricity, water, rent in past month (Afs) (Source: Facility)</p> <p>Total other expenditures on health facility in past month (Afs) (Source: Facility)</p>	<p>Total number of OPD visits in past month (Source: Tool 22)</p> <p>Total number of OPD visits for preventive care in past month (Source: Tool 22)</p> <p>Total number of OPD visits for curative care in past month (Source Tool 22)</p> <p>Total number of new OPD visits in past month (Source: HMIS/Facility)</p> <p>Total number of new OPD visits for preventive care in past month (Source: HMIS/Facility)</p> <p>Total number of new OPD visits for curative care in past month (Source: HMIS/Facility)</p> <p>Total number of inpatient admissions in past month (Source: Tool 22)</p> <p>Total number of inpatient days ( occupied bed days) in past month (Source: Facility)</p> <p>Average number of drugs per prescription (Source: Tool 26)</p> <p>Percentage of prescriptions with &gt;1 anti-biotic (Source: Tool 26)</p> <p>Percentage of prescriptions with &gt;1 injections (Source:Tool 26)</p> <p>Number of referrals in (Source: HMIS/Facility)</p> <p>Number of referrals out (Source: HMIS)</p>	<p>Levels and change in quality of care indicators from endline survey</p> <p>- patient satisfaction at facility</p> <p>- direct observation of provider at facility</p> <p>- facility audit</p> <p>Health care utilization rate in catchment area:</p> <p>- immunization rates in children</p> <p>- % seeking treatment at health facility when sick</p> <p>Bed occupancy rate</p>	<p>Health indicators in catchment area</p>

CHF Monitoring Indicators

Project Objective	INPUT/PROCESS	OUTPUT	OUTCOME	IMPACT	
Increase revenue for 2 health care	Total number of OPD preventive/promotive care visits by CHF members in past month (Source: Tool 22)	Annual revenue generated at facility due do user fees	Health sector revenue in district/province		
	Total number of OPD preventive/promotive care visits by non- CHF members in past month (Source: Tool 22)	Share of CHF revenues in facility operating costs			
	Number of supervision visits made to facility by CHF pilot monitor in past month (Source: Facility)	Total number of OPD curative care visits by CHF members in past month (Source: Tool 22)	Total number of OPD curative care visits by non-CHF members in past month (Source: Tool 22)	Bed occupancy rate for CHF members	Bed occupancy rate for non-CHF members
	User fee charged for OPD consultation by non-CHF members(Afs) (Source: Facility)	Total number of new OPD preventive/promotive care visits by CHF members in past month (Source: Facility)			
	User fee charged for OPD medications by non-CHF members (Afs) (Source: Facility)	Total number of new OPD preventive/promotive care visits by non- CHF members in past month (Source: Facility)			
	User fee charged for IPD admissions by non-CHF members (Afs) (Source: Facility)	Total number of new OPD curative care visits by CHF members in past month (Source: Facility)			
	User fee charged for IPD medications by non-CHF members (Afs) (Source: Facility)	Total number of new OPD curative care visits by non-CHF members in past month (Source: Facility)			
	CHF premium levels for very poor households (Afs) (Source: Facility)	Total number of inpatient visits by CHF members in past month (Source: Tool 22)	Total number of inpatient visits by non-CHF members in past month (Source: Tool 22)		
	CHF premium levels for poor households with 1-5 members (Afs) (Source: Facility)	Total number of inpatient days ( occupied bed days) by CHF members in past month (Source: Facility)	Total number of inpatient days ( occupied bed days) by non-CHF members in past month (Source: Facility)		
	CHF premium levels for poor households with 5-10 members (Afs) (Source: Facility)				
	CHF premium levels for poor households with 11+ members (Afs) (Source: Facility)				
	CHF premium levels for less poor households with 1-5 members (Afs) (Source: Facility)				
	CHF premium levels for less poor households with 5-10 members (Afs) (Source: Facility)				
	CHF premium levels for less poor households with 11+ members (Afs) (Source: Facility)				
	Total revenue generated from user fees from non-CHF members in previous month(Afs) (Source: Tool 22)				
Total revenue generated from copayment from CHF members in previous month(Afs) (Source: Tool 22)					
Total revenue generated from CHF membership premiums in previous month (Afs) (Source: Tool 22)					
Total expenditure from CHF fund in previous month (Afs) (Source: Tool 22)					
- Total expenditure on facility building maintainence in past month (Afs) (Source: Facility)					
- Total expenditure on medicines and medical supplies in past month (Afs) (Source: Facility)					
- Total expenditures on repair/purchase of medical equipment in past month (Afs) (Source: Facility)					
- Total expenditures on facility staff in past month (Afs) (Source: Facility)					
- Total expenditures on other facility related items in past month (Afs) (Source: Facility)					
- Total expenditures on community in past month (Afs) (Source: Tool 22)					
- Total expenditures on CHF fund administration in past month (Afs) (Source: Tool 22)					

CHF Monitoring Indicators

Project Objective	INPUT/PROCESS	OUTPUT	OUTCOME	IMPACT
Increase access to health services	Total number of households in catchment area (Source: Tool 13)	Number of OPD visits by full premium paying CHF member patients in past month (Source: Tool 11)	Health care utilization rates by poor in catchment area - immunization rates in children from poor / female headed households - % seeking treatment at health facility when sick among individuals from poor/female headed households	Health indicators of poor and very poor households
	Total number of new CHF member households enrolled in last month (Source: Tool 13)	Number of OPD visits by partial premium paying CHF member patients in past month (Source: Tool 11)		
	Total number of enrolled households paying full premium (Type 1) in past month (Source: Tool 13)	Number of OPD visits by premium exempt CHF member patients in past month (Source: Tool 11)	Bed occupancy rate of premium exempt CHF member patients Bed occupancy rate of partial premium paying CHF member patients Bed occupancy rate of full premium paying CHF member patients	
	Total number of enrolled households paying partial premium (Type 2) in past month (Source: Tool 13)	Number of new OPD visits by full premium paying CHF member patients in past month (Source: Tool 11)		
	Total number of enrolled households exempt from payment (Type 3) in past month (Source: Tool 13)	Number of new OPD visits by partial premium paying CHF member patients in past month (Source: Tool 11)		
		Number of new OPD visits by premium exempt CHF member patients in past month (Source: Tool 11)		
		Total number of inpatient visits by full premium paying CHF member patients in past month (Source : Facility)		
		Total number of inpatient visits by partial premium paying CHF member patients in past month (Source: Facility)		
		Total number of inpatient visits by premium exempt CHF member patients in past month (Source: Facility)		
		Total number of inpatient days ( occupied bed days) by full premium paying CHF member' patients in past month (Source: Facility)		
		Total number of inpatient days ( occupied bed days) by partial premium paying CHF patients in past month (Source: Facility)		
		Total number of inpatient days ( occupied bed days) by premium exempt CHF patients in past month (Source: Facility)		
Enhance community ownership of health services	CHF committee formed (Y/N) (Source: Facility)	Number of CHF committee meetings held in past month (Source: Facility)	-	-
	Number of communities/villages in catchment area (Source: Facility)	Number of communities/villages where mobilization has taken place in past month (Source: Facility)		
	Community mobilizers identified and functioning (Y/N) (Source: Facility)			



Control Monitoring Indicators

PROJECT OBJECTIVE	INPUT/PROCESS	OUTPUT	OUTCOME	IMPACT
1 Improve quality	Total number of sanctioned doctor posts (Source: Facility)	Total number of OPD visits in past month (Source: HMIS/Facility)	Levels and change in quality of care indicators from endline survey	Health indicators in catchment area
	Total number of doctors present for 20 days or more during past month (Source: Facility)	Total number of OPD visits for preventive care in past month (Source: Facility)	- patient satisfaction at facility	
	Total number of sanctioned nurse posts (Source: Facility)	Total number of OPD visits for curative care in past month (Source: Facility)	- direct observation of provider at facility	
	Total number of nurses present for 20 days or more during past month (Source: Facility)	Total number of new OPD visits in past month (Source: HMIS/Facility)	- facility audit	
	Any stockout of drugs during the past month (Yes/No) (Source: HMIS)	Total number of new OPD visits for preventive care in past month (Source: HMIS/Facility)	Health care utilization rate in catchment area:	
	All essential equipment available at facility during the past month(Yes/No) (Source: Facility)	Total number of new OPD visits for curative care in past month (Source: HMIS/Facility)	- immunization rates in children	
	All essential equipment in working condition at facility during the past month(Yes/No) (Source: Facility)	Total number of inpatient admissions in past month (Source: Facility)	- % seeking treatment at health facility when sick	
	Any stockout of essential medical supplies during the past month (Y/N) (Source: Facility)	Total number of inpatient days ( occupied bed days) in past month (Source: Facility)	Bed occupancy rate	
	Refresher trainings for doctors conducted during the past month (Y/N) (Source: Facility)	Number of referrals in (Source: HMIS/Facility)		
	Refresher trainings for nurses conducted during the past month (Y/N) (Source: Facility)	Number of referrals out (Source: HMIS)		
	Total number of inpatient beds available (Source: Facility)			
	Total number of supervision visits to facility in past month (Source: Facility)			
	Total expenditure on doctor salary in past month (Afs) (Source: Facility)			
	Total expenditure on nursing staff salary in past month (Afs) (Source: Facility)			
	Total expenditure on other staff salary in past month (Afs) (Source: Facility)			
	Total expenditures on medical supplies in past month (Afs) (Source: Facility)			
	Total expenditures on drugs in past month (Afs) (Source: Facility)			
	Total expenditures on purchase of equipment in past month (Afs) (Source: Facility)			
	Total expenditures on repair of equipment in past month (Afs) (Source: Facility)			
	Total expenditures on repair/maintenance of building in past month (Afs) (Source: Facility)			
	Total expenditure on vehicle purchases in past month (Afs) (Source: Facility)			
	Total expenditure on vehicle maintenance (petrol, oil, lubricants) in past month (Afs) (Source: Facility)			
	Total expenditure on electricity, water, rent in past month (Afs) (Source: Facility)			
	Total other expenditures on health facility in past month (Afs) (Source: Facility)			

**Annex 6**

**Workshop Agenda and Materials for Health Financing Pilots, August 2005**

Contents:

1. Agenda for review workshop (Kabul, Mazar and Herat)
2. Implementation Progress Report guidelines
3. Review workshop Presentation 1 guidelines
4. Review workshop working group guidelines
5. Review workshop Presentation 2 guidelines
6. Procedure for conducting working groups

**For information please contact :**

Dr. Ahmad Jan ([ahmadjn@hotmail.com](mailto:ahmadjn@hotmail.com); Ph : 070207826)

Krishna D. Rao ([krao@jhsph.edu](mailto:krao@jhsph.edu) ; Ph: 079886569)

Dr. Sahibullah ([smohammadalam@yahoo.com](mailto:smohammadalam@yahoo.com); Ph: 070217492)

## Agenda/Planning of Review Workshop on Health Financing Pilots

### Kabul Region: Day 1

Time/Day	Day 1, (Sunday, August 14)	Time/Day	Day 1, (Sunday, August 14)
08:00-09:00	<b>Welcome &amp; introduction to review workshop</b> - Introduction of participants - Explanation of workshop objectives - Explanation of workshop time line and activities. <i>By - Dr. Ahmad Jan, Krishna &amp; Sahibullah</i>	01:00-03:00	<b>Working groups by pilot type</b> (Tea will be served and took during working groups) <ul style="list-style-type: none"> <li>• User fee</li> <li>• CHF</li> <li>• Free Services</li> </ul> <i>By - All participants</i>
09:00-09:30	<b>Presentation I of Parwan:</b> <ul style="list-style-type: none"> <li>• Progress(main achievements) by pilot type</li> <li>• Tasks remaining to be completed</li> <li>• Problems faced by pilot type</li> <li>• General perceptions of the pilots</li> </ul> <i>By - Lead Coordinator + Team</i>	03:00-03:10	<b>Brief presentation of User fee working group findings</b> <ul style="list-style-type: none"> <li>• Problems identified</li> <li>• Solution suggested</li> </ul> <i>By - User fee working group members</i>
09:30-10:00	<b>Presentation I of Panjshir:</b> <ul style="list-style-type: none"> <li>• Progress(main achievements) by pilot type</li> <li>• Tasks remaining to be completed</li> <li>• Problems faced by pilot type</li> <li>• General perceptions of the pilots</li> </ul> <i>By - Lead Coordinator + Team</i>	03:10-03:30	<b>Presentation II of Kapisa - User Fee group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - User fee members + Lead Coordinator</i>
10:00-10:30	<b>Tea break</b>	03:30-03:50	<b>Presentation II of Wardak - User Fee group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - User fee members + Lead Coordinator</i>
10:30-11:00	<b>Presentation I of Wardak:</b> <ul style="list-style-type: none"> <li>• Progress(main achievements) by pilot type</li> <li>• Tasks remaining to be completed</li> <li>• Problems faced by pilot type</li> <li>• General perceptions of the pilots</li> </ul> <i>By - Lead Coordinator + Team</i>	03:50-04:10	<b>Presentation II of Parwan - User Fee group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - User fee members + Lead Coordinator</i>
11:00-11:30	<b>Presentation I of Kapisa:</b> <ul style="list-style-type: none"> <li>• Progress(main achievements) by pilot type</li> <li>• Tasks remaining to be completed</li> <li>• Problems faced by pilot type</li> <li>• General perceptions of the pilots</li> </ul> <i>By - Lead Coordinator + Team</i>	04:10-04:30	<b>Presentation II of Panjshir - User Fee group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - User fee members + Lead Coordinator</i>
11:30-11:45	<b>Explanation/guidelines for working groups</b> <i>By - Krishna &amp; Sahibullah</i>	04:30-04:40	<b>Closing remarks for the day</b>
11:45-01:00	<b>Lunch &amp; Pray</b>		<i>By - Krishna &amp; Sahibullah</i>

**Kabul Region: Day 2**

<b>Time/Day</b>	<b>Day 2, (Monday, August 15)</b>	<b>Time/Day</b>	<b>Day 2, Monday, August 15)</b>
08:00-08:30	<b>Opening remarks</b> - Review of the first day - Explanation of workshop time line and activities for day 2. <i>By - Krishna &amp; Sahibullah</i>	09:30-10:00	<b>Presentation III of Wardak CHF group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - CHF Advisor + Lead coordinator</i>
08:30-09:00	<b>Presentation III of Kapisa - Free services group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - Free services members + Lead Coordinator</i>	10:00-10:30	<b>Tea break</b>
09:00-09:10	<b>Brief presentation of CHF working group findings</b> <ul style="list-style-type: none"> <li>• Problems identified</li> <li>• Solution suggested</li> </ul> <i>By - CHF working group members</i>	10:30-11:30	<b>Presentation of Monitoring indicators</b>  <i>By- Dr. Ahmad Jan, Krishna &amp; Sahibullah</i>
09:10-09:30	<b>Presentation III of Parwan - CHF group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul>	11:30-12:00	<b>Wrap-up of workshop</b> <ul style="list-style-type: none"> <li>• Discussion</li> <li>• Conclusion</li> </ul> <i>By - Dr. Ahmad Jan, Krishna &amp; Sahibullah</i>
	<i>By - CHF Advisor + Lead coordinator</i>	12:00-01:00	<b>Lunch &amp; Pray</b>  <i>End</i>

## Agenda/Planning of Review Workshop on Health Financing Pilots

### Mazar Region: Day 1

Time/Day	Day 1, (Wednesday, August 17)	Time/Day	Day 1, (Wednesday, August 17)
08:00-09:00	<b>Welcome &amp; introduction to review workshop</b> - Introduction of participants - Explanation of workshop objectives - Explanation of workshop time line and activities. <i>By - Krishna &amp; Sahibullah</i>	01:00-03:00	<b>Working groups by pilot type</b> (Tea will be served and took during working groups) <ul style="list-style-type: none"> <li>• User fee</li> <li>• CHF</li> <li>• Free Services</li> </ul> <i>By - All participants</i>
09:00-09:30	<b>Presentation I of Balkh-BDF:</b> <ul style="list-style-type: none"> <li>• Progress(main achievements) by pilot type</li> <li>• Tasks remaining to be completed</li> <li>• Problems faced by pilot type</li> <li>• General perceptions of the pilots</li> </ul> <i>By - Lead Coordinator + Team</i>	03:00-03:10	<b>Brief presentation of User fee working group findings</b> <ul style="list-style-type: none"> <li>• Problems identified</li> <li>• Solution suggested</li> </ul> <i>By - User fee working group members</i>
09:30-10:00	<b>Presentation I of Sari-pol:</b> <ul style="list-style-type: none"> <li>• Progress(main achievements) by pilot type</li> <li>• Tasks remaining to be completed</li> <li>• Problems faced by pilot type</li> <li>• General perceptions of the pilots</li> </ul> <i>By - Lead Coordinator + Team</i>	03:10-03:30	<b>Presentation II of Balkh-BRAC - User Fee group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - User fee members + Lead Coordinator</i>
10:00-10:30	<b>Tea break</b>	03:30-03:50	<b>Presentation II of Samangan - User Fee group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - User fee members + Lead Coordinator</i>
10:30-11:00	<b>Presentation I of Samangan:</b> <ul style="list-style-type: none"> <li>• Progress(main achievements) by pilot type</li> <li>• Tasks remaining to be completed</li> <li>• Problems faced by pilot type</li> <li>• General perceptions of the pilots</li> </ul> <i>By - Lead Coordinator + Team</i>	03:50-04:10	<b>Presentation II of Saripol - User Fee group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - User fee members + Lead Coordinator</i>
11:00-11:30	<b>Presentation I of Balkh-BRAC:</b> <ul style="list-style-type: none"> <li>• Progress(main achievements) by pilot type</li> <li>• Tasks remaining to be completed</li> <li>• Problems faced by pilot type</li> <li>• General perceptions of the pilots</li> </ul> <i>By - Lead Coordinator + Team</i>	04:10-04:30	<b>Presentation II of Balkh-BDF - User Fee group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - User fee members + Lead Coordinator</i>
11:30-11:45	<b>Explanation/guidelines for working groups</b> <i>By - Krishna &amp; Sahibullah</i>	04:30-04:40	<b>Closing remarks for the day</b>
11:45-01:00	<b>Lunch &amp; Pray</b>		<i>By - Krishna &amp; Sahibullah</i>

**Mazar Region: Day 2**

<b>Time/Day</b>	<b>Day 2, (Thursday, August 18)</b>	<b>Time/Day</b>	<b>Day 2, (Thursday, August 18)</b>
08:00-08:30	<b>Opening remarks</b> - Review of the first day - Explanation of workshop time line and activities for day 2. <i>By - Krishna &amp; Sahibullah</i>	09:20-10:00	<b>Presentation III of Saripol CHF group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - CHF Advisor + Lead coordinator</i>
08:30-08:50	<b>Presentation III of Samangan - Free services group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - Free services members + Lead Coordinator</i>	10:00-10:30	<b>Tea break</b>
08:50-09:10	<b>Presentation III of Balkh-BRAC - Free services group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - Free services members + Lead Coordinator</i>	10:30-11:30	<b>Presentation of Monitoring indicators</b>  <i>By- Dr. Ahmad Jan, Krishna &amp; Sahibullah</i>
09:10-09:20	<b>Brief presentation of CHF working group findings</b> <ul style="list-style-type: none"> <li>• Problems identified</li> <li>• Solution suggested</li> </ul> <i>By - CHF working group members</i>	11:30-12:00	<b>Wrap-up of workshop</b> <ul style="list-style-type: none"> <li>• Discussion</li> <li>• Conclusion</li> </ul> <i>By - Krishna &amp; Sahibullah</i>
		12:00-01:00	<b>Lunch &amp; Pray</b>  <i>End</i>

## Agenda/Planning of Review Workshop on Health Financing Pilots

### Herat Region: Day 1

Time/Day	Day 1, (Monday, August 22)	Time/Day	Day 1(Monday, August 22)
08:00-09:00	<b>Welcome &amp; introduction to review workshop</b> - Introduction of participants - Explanation of workshop objectives - Explanation of workshop time line and activities. <i>By - Krishna &amp; Sahibullah</i>	01:00-03:00	<b>Working groups by pilot type</b> (Tea will be served and took during working groups) <ul style="list-style-type: none"> <li>• User fee</li> <li>• CHF</li> <li>• Free Services</li> </ul> <i>By - All participants</i>
09:00-09:30	<b>Presentation I of Farah:</b> <ul style="list-style-type: none"> <li>• Progress(main achievements) by pilot type</li> <li>• Tasks remaining to be completed</li> <li>• Problems faced by pilot type</li> <li>• General perceptions of the pilots</li> </ul> <i>By - Lead Coordinator + Team</i>	03:00-03:10	<b>Brief presentation of User fee working group findings</b> <ul style="list-style-type: none"> <li>• Problems identified</li> <li>• Solution suggested</li> </ul> <i>By - User fee working group members</i>
09:30-10:00	<b>Presentation I of Helmand:</b> <ul style="list-style-type: none"> <li>• Progress(main achievements) by pilot type</li> <li>• Tasks remaining to be completed</li> <li>• Problems faced by pilot type</li> <li>• General perceptions of the pilots</li> </ul> <i>By - Lead Coordinator + Team</i>	03:10-03:30	<b>Presentation II of Nimruz - User Fee group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - User fee members + Lead Coordinator</i>
10:00-10:30	<b>Tea break</b>	03:30-03:50	<b>Presentation II of Badghis - User Fee group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - User fee members + Lead Coordinator</i>
10:30-11:00	<b>Presentation I of Badghis:</b> <ul style="list-style-type: none"> <li>• Progress(main achievements) by pilot type</li> <li>• Tasks remaining to be completed</li> <li>• Problems faced by pilot type</li> <li>• General perceptions of the pilots</li> </ul> <i>By - Lead Coordinator + Team</i>	03:50-04:10	<b>Presentation II of Helmand - User Fee group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - User fee members + Lead Coordinator</i>
11:00-11:30	<b>Presentation I of Nimruz:</b> <ul style="list-style-type: none"> <li>• Progress(main achievements) by pilot type</li> <li>• Tasks remaining to be completed</li> <li>• Problems faced by pilot type</li> <li>• General perceptions of the pilots</li> </ul> <i>By - Lead Coordinator + Team</i>	04:10-04:30	<b>Presentation II of Farah - User Fee group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - User fee members + Lead Coordinator</i>
11:30-11:45	<b>Explanation/guidelines for working groups</b> <i>By - Krishna &amp; Sahibullah</i>	04:30-04:40	<b>Closing remarks for the day</b>
11:45-01:00	<b>Lunch &amp; Pray</b>		<i>By - Krishna &amp; Sahibullah</i>

**Herat Region: Day 2**

<b>Time/Day</b>	<b>Day 2, (Tuesday, August 23)</b>	<b>Time/Day</b>	<b>Day 2, (Tuesday, August 23)</b>
08:00-08:30	<b>Opening remarks</b> - Review of the first day - Explanation of workshop time line and activities for day 2. <i>By - Krishna &amp; Sahibullah</i>	09:40-10:00	<b>Presentation III of Nimruz CHF group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - CHF Advisor + Lead coordinator</i>
08:30-08:50	<b>Presentation III of Farah - Free services group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - Free services members + Lead Coordinator</i>	10:00-10:30	<b>Tea break</b>
08:50-09:10	<b>Presentation III of Badghis - Free services group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - Free services members + Lead Coordinator</i>	10:30-11:30	<b>Presentation of Monitoring indicators</b>  <i>By- Dr. Ahmad Jan, Krishna &amp; Sahibullah</i>
09:10-09:20	<b>Brief presentation of CHF working group findings</b> <ul style="list-style-type: none"> <li>• Problems identified</li> <li>• Solution suggested</li> </ul> <i>By - CHF working group members</i>	11:30-12:00	<b>Wrap-up of workshop</b> <ul style="list-style-type: none"> <li>• Discussion</li> <li>• Conclusion</li> </ul> <i>By - Krishna &amp; Sahibullah</i>
09:20-09:40	<b>Presentation III of Helmand - CHF group:</b> <ul style="list-style-type: none"> <li>• Problems identified from Presentation 1</li> <li>• Adaptation of working group solutions to identified problems</li> </ul> <i>By - CHF Advisor + Lead coordinator</i>	12:00-01:00	<b>Lunch &amp; Pray</b>  <i>End</i>

### **Implementation Progress Report Guidelines**

Aim: The aim of the Implementation Report is to gauge progresses and achievement till date, what activities remain to be completed and when it will be done, what problems are being experienced and general observations about each pilot. All type of pilots being implementing in the province will be included. The report is to be prepared by each PPA NGO/ MOPH-SM province in advance and will form the basis of Presentation 1 to be made by each province during the workshop.

Length of report: The report should be a minimum of six to eight pages long in total. Since two types of interventions are being implemented in each province, Four pages should be devoted to each pilot. For example, a province implementing user fee and CHF will devote four pages to user fees and four pages to the CHF pilot. For free services, one or two pages will be adequate. Additional pages could be added for title pages etc. Reports should be single spaced.

Structure of report: Each province is implementing two interventions and so they should report on each of the two pilots being implemented. The report for each pilot being implemented in the province should have the following structure. –

Section 1 – Progress made in implementing pilots (minimum 1 1/2 page).

Section 2 – Implementation activities remaining to be completed (minimum 1/2 page).

Section 3 – Problems faced during implementation (minimum 1 page).

Section 4 – General perceptions about the health financing pilots (minimum 1 page).

The contents for each of the above sections are described next.

### Structure of report for User Fee pilots

Section 1: Progress made (minimum 1 1/2 page) - In this section of the report, progress made in implementing the user fee pilots in the province till date will be described. As a minimum, the topics listed below should be included. Other topics can also be added.

- (a) Project officials: designated officers at each pilot facility, lead coordinator identified.
- (b) Training status: Dates started / completed; number trained, time taken.
- (c) Printing of tools: When printed; adequate for how many months.
- (d) Household enumeration: Total number of villages in catchment area of each facility; in how many villages was enumeration done; how many households enumerated; who did the enumeration.
- (e) User fee committee – Has committee been established; what is its composition; how many members.
- (f) Fee setting: Level of fee in each facility for OPD, IPD (if available); % of drug cost charged for each type of service; was fee levels set in consultation with community/villagers opinions; other issues (specify).
- (g) Community mobilization: Has community mobilization been done; who conducted it; in how many villages it was conducted.
- (h) Exemptions: How many households were identified as very poor/ female headed and its breakdown by each village; have households applied for exemptions in facility and community; who decided about exemptions.
- (i) Monitoring & Supervision: Who does routine monitoring to each facility?, How many monitoring visits made for each facility?, was the monitoring checklist used.
- (j) Management of funds: Amount collected till date from user fee. Where are these funds being kept. What are they being spent on?

Section 2: Tasks remaining to be completed (minimum 1/2 page) - In this section please provide a listing of tasks remaining to be completed for implementing the pilot design. As a minimum, the topics listed in Section 1 should be used as a guide for identifying incomplete activities. Other activities can be added.

Section 3: Implementation problems (minimum 1 page) - This is an important section of the presentation. As a minimum, for each topic listed in Section 1, please describe problems being faced, if any. In addition, each province should comment on any problems they are having with the user fee design or specific user fee tools. Other topics can be added.

Section 4: General perceptions about user fee pilot (minimum 1 page) – In this section please describe their general observations about implementing the user fee pilots. The following structure should be followed:

- (a) Community perceptions about user fee pilot.
- (b) Facility staff perceptions about user fee pilot.
- (c) Government/ political perceptions about user fee pilot.
- (d) Perceptions about implementation of user fee pilot.

### **Structure of report for Community Health Fund (CHF) pilots**

Section 1: Progress made (minimum 1 ½ page) - In this section of the report, progress made in implementing the CHF pilots in the province till date will be described. As a minimum, the topics listed below should be included. Other topics can also be added.

- (a) Initial analysis: Is it done?, What are the main findings
- (b) Project officials: designated officers at each pilot facility, CHF advisor, lead coordinator identified.
- (c) Training status: Dates started / completed; number trained, time taken.
- (d) Printing of tools: When printed.
- (e) Household enumeration: Total number of villages in catchment area of each facility; in how many villages was enumeration done; how many households enumerated; who did the enumeration.
- (f) Premium setting: What is the level of premium in each facility; what is the level of fee for non CHF members for OPD, IPD (If exist), others (specify); % of drug cost charged for each type of service, were premium levels set with consultation with community/villagers opinions.
- (g) Formation of CHF committee: When established; how many member; were key members identified/elected, who are the key people (from community or facility or NGO/SM?); how many meetings took place till date?, Are minutes of the minutes taken.
- (h) Community mobilization: Has community mobilization been done; who conducted it; in how many villages it was conducted; mobilization experience in 1<sup>st</sup> stage, 2<sup>nd</sup> stage (intensive mobilization).
- (i) Exemptions: How many households were identified as very poor/ female headed and its breakdown by each village; have households applied for exemptions in facility and community; who decided about exemptions.
- (j) Management of funds: Amount collected till date from premiums, copayments. Where are these funds being kept. What are they being spent on?
- (k). Monitoring & Supervision: Who does routine monitoring to each facility?, How many monitoring visits made for each facility?, was the monitoring checklist used.  
on ?

Section 2: Tasks remaining to be completed (minimum 1/2 page) - In this section please provide a listing of tasks remaining to be completed for implementing the pilot design. As a minimum, the topics listed in Section 1 should be used as a guide for identifying incomplete activities. Other activities can be added.

Section 3: Implementation problems (minimum 1 page): This is an important section of the presentation. As a minimum, for each topic listed in Section 1, please describe problems being faced, if any. In addition, each province should comment on any problems they are having with the CHF design or specific CHF tools.

Section 4: General perceptions about the CHF pilot (1 page) – In this section please describe general observations about implementing the CHF pilots. The following structure should be followed :

- (a) Community perceptions about CHF pilot.
- (b) Facility staff perceptions about CHF pilot.
- (c) Government/ political perceptions about CHF pilot.
- (d) Perceptions about implementation of CHF pilot.

### **Structure of report for Free Services pilots**

Section 1: Progress made - In this section of the report, progress made in implementing the free service pilots in the province till date will be described. As a minimum, the topics given below should be included. Other topics can also be added.

- (a) Training status: Dates started / completed; number trained, time taken.
- (b) Printing of tools: When printed.
- (c) Community mobilization: Has community been informed about change in fee for service, if any.
- (d) User fee: If user fee was being charged, has it been discontinued; when ?
- (e) Contributory funds: Has there been any contribution to budget of health facility over and above the normal budget.
- (d). Monitoring & Supervision: Who does routine monitoring to each facility?, How many monitoring visits made for each facility?, was the monitoring checklist used.  
on ?

Section 2: Tasks remaining to be completed - In this section please provide a listing of tasks remaining to be completed for implementing the pilot design. As a minimum, the topics listed in Section 1 should be used as a guide for identifying incomplete activities. Other activities can be added.

Section 3: Implementation problems: This is an important section of the presentation. As a minimum, for each topic listed in Section 1, please describe problems being faced, if any. In addition, each province should comment on any problems they are having with specific user fee tools.

Section 4: General perceptions about free services pilot – In this section please provide general observations about implementing the free service pilots. The structure below should be followed :

- (a) Community perceptions about free service pilot.
- (b) Facility staff perceptions about free service pilot.
- (c) Government/ political perceptions about free service pilot.
- (d) Perceptions about implementation of free service pilot.

### **Review Workshop Presentation 1 Guidelines**

Aim of the presentation: Based on the Implementation Progress Report each PPA NGO/MOPH-SM province will prepare a presentation to be made during the workshop. All type of pilots being implementing in the province will be included.

Presentation by: Lead coordinator or other team member. English Power point presentation, to be prepared by team in advance and explanation in Dari. As a guideline, the whole team should be involved in preparing and making the presentation.

Time given: 30 minutes (18 slides)

Structure of presentation: Each province is implementing two interventions and so they will make separate presentations on each of the two pilots being implemented. The presentation for each pilot being implemented in the province should follow the following structure. –

Section 1 – Progress made in implementing pilots (4 slides).

Section 2 – Implementation activities which remain to be completed (1 slides).

Section 3 – Problems faced during implementation (3 slides)

Section 4 – General perceptions about the health financing pilots (1 slides).

Since each province is implementing two interventions, the total number of slides will be 18 ( 9 for each pilot being implemented). Extra slides can be added for title pages etc. During the presentation each province will present on each intervention sequentially. For example, a province implementing user fees and CHF will first present on user fees and then on CHF.

The details of what each section of the presentation should contain are described next.

### **Structure of presentation 1 for User Fee pilots**

Section 1: Progress made (4 slides) - In this section of the presentation, progress made in implementing the user fee pilots in the province till date will be described. The contents for this section will be taken from Section 1 of the user fee report.

Section 2: Tasks remaining to be completed (1 slide) - In this section please provide a listing of tasks remaining to be completed for implementing the pilot design. The contents for this section will be taken from Section 2 of the user fee report.

Section 3: Implementation problems (3 slides): This is an important section of the presentation. In this section each province should present a listing of problems they are facing during implementation. The contents for this section will be taken from Section 3 of the user fee report.

Section 4: General perceptions about user fee pilot (1 slide) – In this section the provinces will provide their general observations about implementing the user fee pilots. The contents for this section will be taken from Section 4 of the user fee report.

**Structure of presentation 1 for Community Health Fund (CHF) pilots**

Section 1: Progress made (4 slides) - In this section of the presentation, progress made in implementing the CHF pilots in the province till date will be described. The contents for this section will be taken from Section 1 of the CHF report.

Section 2: Tasks remaining to be completed (1 slide) - In this section please provide a listing of tasks remaining to be completed for implementing the pilot design. The contents for this section will be taken from Section 2 of the CHF report.

Section 3: Implementation problems (3 slides): This is an important section of the presentation. In this section each province should present a listing of problems they are facing during implementation. The contents for this section will be taken from Section 3 of the CHF report.

Section 4: General perceptions about the CHF pilot (1 slide) – In this section the provinces will provide their general observations about implementing the CHF pilots. The contents for this section will be taken from Section 4 of the CHF report.

### **Structure of presentation 1 for Free Services pilots**

Section 1: Progress made (1 slide) - In this section of the presentation, progress made in implementing the free service pilots in the province till date will be described. The contents for this section will be taken from Section 1 of the Free Services report.

Section 2: Tasks remaining to be completed (1 slide) - In this section please provide a listing of tasks remaining to be completed for implementing the pilot design. The contents for this section will be taken from Section 2 of the Free Services report.

Section 3: Implementation problems (3 slides): This is an important section of the presentation. In this section each province should present a listing of problems they are facing during implementation. The contents for this section will be taken from Section 3 of the Free Services report.

Section 4: General perceptions about free services pilot (1 slide) – In this section the provinces will provide their general observations about implementing the user fee pilots. The contents for this section will be taken from Section 4 of the Free Services report.

### **Review Workshop Working Group Guidelines**

Aim of the working groups: To identify solutions to the problems faced during implementation of the health financing pilots. At the end of the working group session, each group will make a presentation about its findings.

Organization/composition: As applicable, there will be three main working groups

- Group 1: User fee intervention
- Group 2: CHF intervention
- Group 3: Free services intervention

Participants:

- Group 1 - All designated/responsible persons of health facilities implementing User fee pilot.
- Group 2 - All designated/responsible persons of health facilities implementing CHF, including CHF advisors.
- Group 3 - All designated/responsible persons of health facilities implementing Free services.
- The lead coordinators (if they are other than above) would be divided among the 3 groups

Time given: two hours.

Tools provided: Flipcharts, markers, laptop for Power Point presentation.... (as well facilitation)

Working group procedure: Each working group will participate in an adaptation of a commonly used group problem solving technique known as the Nominal Group Technique (NGT), which will be explained to participants. The steps to be followed are detailed in the document “Procedure for conducting working group”. In brief, each group will take the problems identified in Presentation 1 and try to find solutions to them as a group using the NGT.

At the end of this exercise, one person from each group will present the findings/noted points.

### **Review Workshop Presentation 2 Guidelines**

Aim of the presentation: Each province will present on (a) when incomplete activities, if any, will be completed, and (b) how the solutions identified in the working groups will be adapted to the problems listed in presentation 1.

Team presentation : A representative from each pilot team will make the presentation. The presentation can be made in Dari or in English. The presentation can be made on a flipchart (explanation in Dari) or on Power Point.

Time given: 20 minutes

Structure of presentation :For each type of pilot being implemented in the province, the following topics should be covered:

- Incomplete tasks: Tasks which remain to be completed from Presentation 1 and when they will be completed.
- Implementation problems and solutions: Listing of problems from Presentation 1 and how solutions from working group will be used to overcome these problems.

### **Procedure for conducting working group**

Aim: The aim of the working group is to identify a set of solutions to each of the implementation problems highlighted in the presentations made by each province. By pooling together experience and knowledge across provinces it is hoped that a richer and practical solutions will be arrived at.

Procedure: There will be one working group for each type of pilot – user fee, community health fund, and free services. Each group will then work through the steps of an adaptation of the Nominal Group Technique, a well known group problem solving tool. The following steps are to be followed for each working group:

#### Preliminary requirements:

- 1) Identification of a group moderator.
- 2) Moderator should have a listing of problems identified in the presentations made by provinces. Duplication of listed problems should be avoided.
- 3) Each group member given a pad and pen.

#### Steps:

- 1) The moderator will read out the first problem on the list and write it on the top of the flip chart sheet. The problem should be written as a brief statement. Moderator to make sure that everyone in the group can read and understands the problem listed.
- 2) Each group member will write down a various solution to the listed problem on a piece of paper. They are given 10 minutes to do this.
- 3) The moderator then asks each member of the group to give one solution each. After clarifying each response, the moderator will write the proposed solution on a flip chart for all to see. Each written solution will be identified by a unique number (e.g. 1, 2, 3,...) The moderator will ensure that all duplicate/similar solutions are eliminated.
- 4) The above steps will be repeated till no new solutions are forth coming.
- 5) After no more new ideas/solutions are forthcoming, the group will discuss each idea listed. All members should be encouraged to participate.
- 6) After all listed ideas/solutions have been discussed, each group member will then rank each of the solutions in terms of what they think is most feasible/best according to them. This is done on a piece of paper and handed to the moderator.
- 7) The moderator then puts these rankings against each of the listed solutions.
- 8) The moderator then adds the score given to each solution. The lowest scoring solution is given a rank of 1, the second lowest is given a rank of 2 and so forth.
- 9) The moderator and one group member from each province then writes down the solutions in ascending order of rank. These will be presented at the end of the working group session. Either flip charts or Power Point presentation can be used.
- 10) End of working group !!



PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	<ul style="list-style-type: none"> <li>• Start oxygen therapy (100% oxygen at 2-5L/min) if one of the following is present:                             <ul style="list-style-type: none"> <li>➤ Significant tachypnea                                     <ul style="list-style-type: none"> <li>○ If less than 1 yr RR &gt; 70</li> <li>○ If older than 1 yr RR &gt; 50</li> </ul> </li> <li>➤ severe indrawing/retractions</li> <li>➤ grunting</li> <li>➤ head bobbing</li> <li>➤ cyanosis</li> </ul> </li> <li>• Starts B agonist therapy via inhalation with spacer or nebulizer if physical exam shows severe decreased air entry or wheezing</li> <li>• Asks for history of choking and records:                             <ul style="list-style-type: none"> <li>➤ if positive initiates treatment –Heimlich maneuver</li> <li>➤ If convulsing Diazepam given IV or rectally or paraldehyde</li> </ul> </li> <li>• If secretions suction the airway if no evidence of epiglottitis</li> </ul>	<p>_____</p>	
<p>3. The provider obtains pertinent history and records if not severe distress or once above treatment initiated</p>	<p>Verify whether: History to include all of the following:</p> <ul style="list-style-type: none"> <li>• Length of illness</li> <li>• Paroxysms</li> <li>• Vomiting</li> <li>• Cyanosis</li> <li>• Feeding ability</li> <li>• Presence of fever</li> <li>• Activity level</li> <li>• Sick contacts</li> <li>• History of convulsions</li> <li>• Medications given</li> <li>• Allergies</li> <li>• History of similar episodes/ Potential TB</li> </ul>	<p>_____</p>	



PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	<ul style="list-style-type: none"> <li>➤ tenderness</li> <li>➤ distension</li> <li>➤ masses</li> <li>• lymphadenopathy</li> <li>• Extremities-                             <ul style="list-style-type: none"> <li>➤ capillary refill</li> <li>➤ cyanosis</li> <li>➤ pallor</li> </ul> </li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
5. Provider records degree of dehydration	Verify whether patient classified: <ul style="list-style-type: none"> <li>• mild</li> <li>• moderate</li> <li>• severe</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p>	
6. Provider initiates and documents laboratory and x-ray findings as indicated:	Verify the existence of: <ul style="list-style-type: none"> <li>• Oxygen saturation</li> <li>• CBC</li> <li>• Chest x-ray.</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p>	
7. Provider records patient diagnosis, decision to admit or discharge and documents treatment plan:	If diagnosis is moderate/severe pneumonia, verify the existence of: <ul style="list-style-type: none"> <li>• Admit to inpatient service</li> <li>• Appropriate antibiotics are initiated- PCN/Gent or Ceftriaxone 50 mg/kg/day or chloramphenicol 25mg/kg every 8 hr</li> <li>• Oxygen started as above criteria</li> <li>• Rehydration based on level of dehydration</li> <li>• Intravenous catheter started as needed for fluids or medication administration</li> <li>• Vitamin A given if not received in the last 6 months                             <ul style="list-style-type: none"> <li>○ 100,000 U if 6 months to 1 year</li> <li>○ 200,000 U if over 1 year</li> </ul> </li> <li>• If febrile paracetamol given 15mg/kg per dose</li> </ul> If Asthma exacerbation:	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	





PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	as needed • Discharge summary/referral slip given to patient	_____ _____	

<b>TOTAL STANDARDS:</b>	<b>9</b>
<b>TOTAL STANDARDS OBSERVED:</b>	
<b>TOTAL STANDARDS MET:</b>	



PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	<p>Assessment of Dehydration:</p> <p><b>Moderate Dehydration</b></p> <ul style="list-style-type: none"> <li>➤ General: irritable/restless</li> <li>➤ Drinking: eagerly</li> <li>➤ Eyes/fontanelle: sunken</li> <li>➤ Mouth: dry</li> <li>➤ Skin: goes back slowly</li> <li>➤ Pulse: fast</li> </ul> <p><b>Severe Dehydration</b></p> <ul style="list-style-type: none"> <li>➤ General: lethargic/ comatose</li> <li>➤ Drinking: unable to drink</li> <li>➤ Eyes/fontanelle: very sunken</li> <li>➤ Mouth: very dry</li> <li>➤ Skin: goes back very slowly                             <ul style="list-style-type: none"> <li>➤ Pulse: fast, weak or absent</li> </ul> </li> </ul>	<p>_____</p> <p>_____</p>	



PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	<p>10cc/kg/hr for next 4 hrs or more if still dehydrated</p> <p>If the patient is assessed as malnourished, dehydrated but with weak pulse-in shock:</p> <ul style="list-style-type: none"> <li>• IV fluids initiated LR 5% dextrose or 1/2NS 5% dextrose at 15cc/kg x 1 over 1 hour and may repeat if improves (pulse and general condition). When able to swallow change to ORS</li> <li>• After 2 boluses of IV Fluids and no improvement consider sepsis and transfuse 10cc/kg of blood or hemacell if available</li> <li>• Blood sugar checked and give glucose 10% 5cc/kg bolus</li> </ul> <p>If the patient was assessed as severely dehydrated but no malnutrition</p> <ul style="list-style-type: none"> <li>• Vital signs and mental status and skin tenting evaluated every 30 minutes- if continued poor pulse then rate of IV fluids increased or if infusion as above finished it is repeated at severe dehydration levels</li> </ul> <p>-if improving, able to take po's after initial rehydration as above but some signs of dehydration ORS continued at moderate dehydration levels- 75cc/ kg over 4 more hours. Vital signs can then be checked hourly</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>3. The provider monitors patient and adjusts management as required</p>	<p>Verify whether:</p> <ul style="list-style-type: none"> <li>• Once child has no signs of dehydration and is drinking well manage per guidelines above</li> </ul>	<p>_____</p>	
<p>4. Provider takes and documents history and physical:</p>	<p>Verify whether the provider includes in history:</p> <ul style="list-style-type: none"> <li>• Length of diarrhea</li> <li>• Frequency of diarrhea</li> <li>• Consistency of diarrhea\</li> <li>• Presence of blood/mucus</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p>	



PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	breastfeeding If non bacterial diarrhea rehydration, zinc and vitamin A given as above <ul style="list-style-type: none"> <li>• Continue breastfeeding and feeding .</li> </ul>	_____ _____	
5. If diarrhea reported to be chronic > 14 days considers other causes of diarrhea	Verify whether stool exam ordered <ul style="list-style-type: none"> <li>• Treatment initiated according to results:</li> <li>• Giardia metronidazole 5mg/kg for 5 days</li> <li>• Entameoba histolytica trophozoites seen 10mg/kg for 5 days of metronidazole</li> <li>• Multivitamins started</li> <li>• Zinc started at 10-20 mg/kg/day for 10 days</li> <li>• Vitamin A as above guidelines</li> <li>• If diarrhea continues despite treatment consider other causes such as TB</li> </ul>	_____ _____ _____ _____ _____ _____	
6. Provider arranges and documents follow-up plan for the patient after discharge:	Verify the existence of: <ul style="list-style-type: none"> <li>• Medications provided for treatment completion</li> <li>• Parental education documented for concerning signs and symptoms</li> <li>• Return visit or home visit by CHW arranged as needed</li> <li>• Discharge summary/referral slip given to patient.</li> </ul>	_____ _____ _____ _____	

<b>TOTAL STANDARDS:</b>	<b>6</b>
<b>TOTAL STANDARDS OBSERVED:</b>	
<b>TOTAL STANDARDS MET:</b>	





PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	Suspect meningitis/sepsis <ul style="list-style-type: none"> <li>• Irritability</li> <li>• Meningeal signs</li> <li>• Bulging fontanelle</li> <li>• Shock</li> <li>• Petichiae or purpura:</li> </ul>	_____ _____ _____ _____ _____	
4. Provider makes diagnosis and treatment initiated:	Verify whether treatment initiated based upon diagnosis:  If <b>sepsis or meningitis</b> highly suspected based on History and Physical antibiotics initiated immediately even if before lab tests done <ul style="list-style-type: none"> <li>• Appropriate antibiotics include: ampicillin 200 mg/kg/day divided q 6 hours /gentamicin 7.5mg/kg/24hrs or ceftriaxone 75-100mg/kg/24hrs or chloramphenicol 100mg/kg/day divided q 6 hours</li> <li>• Dehydration/shock treated as per dehydration protocol</li> <li>• If meningitis suspected the patient is isolated for 24 hours and as appropriate prophylaxis given to family and health care worker contacts</li> <li>• Complications treated as per protocol</li> </ul> If <b>Malaria</b> diagnosed: <ul style="list-style-type: none"> <li>• treatment initiated based on national guidelines for severe complicated malaria-quinine sulphate 20 mg/kg IV first does then 10mg/kg every 8 hrs for 7 days</li> <li>• Dehydration treated as per dehydration protocol</li> <li>• Complications treated as per protocol included</li> </ul>	_____ _____  _____  _____  _____  _____  _____	

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	<p>here</p> <p>If <b>Measles</b> diagnosed</p> <ul style="list-style-type: none"> <li>• Vitamin A given if not received in the last 6 months:               <ul style="list-style-type: none"> <li>➢ &lt;6 mo 50,000 Units</li> <li>➢ 6 mo to 11 mo 100,000 Units</li> <li>➢ &gt;12 months 200,000 units</li> </ul> </li> <li>• Dose repeated on day 2</li> <li>• Antibiotics given if secondary infection only</li> <li>• Nutritional status monitored by checking</li> <li>• Weights/Height</li> <li>• NG feeds if patient refuses to eat</li> <li>• MVI given daily</li> <li>• Dehydration treated as per protocol</li> </ul> <p>If <b>Typhoid</b> diagnosed antibiotics started</p> <ul style="list-style-type: none"> <li>• Chloramphenicol 75-100 mg/kg/day divided 3 doses or ceftriaxone 50 mg/kg/24 hours.</li> </ul>	<p>_____</p>	
<p>5. Provider provides supportive treatment of all cases of fever</p>	<p>Verify whether stool exam ordered</p> <p>Fever treated with paracetamol 15 mg/kg/dose</p> <p>IV fluids:</p> <ul style="list-style-type: none"> <li>• Malaria suspected/confirmed use D5W with Quinine of 20 mg/kg 1<sup>st</sup> dose then 10 mg/kg on subsequent doses at maintenance rate for 4 hours then D10W at maintenance rate until the next dose of quinine</li> <li>• Sepsis without shock or Typhoid maintenance IV FLUIDS initiated 2 parts D5W to 1 part NS</li> <li>• Meningitis without shock- IV FLUIDS initiated at ½ to 2/3 maintenance rate of 2 parts D5W to 1 part NS</li> <li>• Septic Shock- Give 20cc/kg boluses of NS or</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Maintenance Fluids</p> <p>1<sup>st</sup> 10 kg 100cc/kg/24 hours</p> <p>2<sup>nd</sup> 10 kg 50cc/kg/24 hours</p> <p>3rd 10 kg and up 20 cc/kg/24 hours</p> <p>up to 40 kg then use adult maintenance rates</p>





PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	<p><b>IV Fluids</b> as above</p> <p>If no clinical improvement in 48 hours:</p> <ul style="list-style-type: none"> <li>• Reconsider diagnosis</li> <li>• Consider change or additional antibiotics</li> <li>• Consider further diagnostic studies</li> <li>• Consider referral to regional or specialty hospital or if unable electronic consultation with specialist</li> </ul> <p>If clinical Improvement: Continue therapy and change to oral antibiotics when all three of the following occur:</p> <ul style="list-style-type: none"> <li>• clinical improvement documented,</li> <li>• fever gone for 24 hrs</li> <li>• child able to take orally.</li> </ul>	<p>_____</p>	
<p>8. Provider arranges and documents follow-up plan for the patient after discharge</p>	<p>Length of antibiotic treatment is dependent on the diagnosis: Meningitis- 10-14 days Typhoid- 10-14 days Malaria- change to oral quinine 10mg/kg divided TID for completion of 7 days or artimiseate 4mg/kg/day for three days and fansidar single dose or UTI- 10- 14 days</p> <ul style="list-style-type: none"> <li>• Medications provided for treatment completion</li> <li>• Parental education documented for concerning signs and symptoms</li> <li>• Return visit or home visit by CHW arranged as needed</li> <li>• Discharge summary/referral slip given to patient</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

<b>TOTAL STANDARDS:</b>	<b>8</b>
<b>TOTAL STANDARDS OBSERVED:</b>	
<b>TOTAL STANDARDS MET:</b>	



PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	<p>to 5 years or weight and height and plot of weight for height on growth chart</p> <ul style="list-style-type: none"> <li>• HEENT (Head, eyes, ears, nose throat)</li> <li>• Presence of edema</li> <li>• Skin rashes, tenting and color</li> <li>• Lungs</li> <li>• Heart</li> <li>• Abdomen</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>2. Provider makes the diagnosis of severe malnutrition</p>	<p>Verify that definition of severe malnutrition is followed:</p> <ul style="list-style-type: none"> <li>• 6 months to 5 years- If &lt; 70% weight for height and or edema, or mid upper arm circumference &lt; 11 cm</li> <li>• &lt;6 months – weight for height &lt; 70%</li> </ul>	<p>_____</p> <p>_____</p>	
<p>3. Provider initiates treatment immediately for complications and documents</p>	<p>Verify whether the following assessment is made:</p> <p><b>If lethargic, and or hypothermia (temp &lt; 35.5 rectally or 36.5 auxiliary) or hypoglycemia</b>  dextrose checked if &lt; 3 mmol/ l or 45 mg/dl child given 50 cc 10% dextrose or sucrose orally or NGT  Frequent feeds started every 30 min for 2 hrs then every 2 hours  If temperature &lt; 35.5 C rectally child warmed by bundling, or placed under warmer, near a heater or kangaroo position if infant  Temp rechecked every hour until &gt;36.5 C rectally</p> <p><b>If signs of dehydration</b>  See dehydration protocol for malnourished children  Vital signs reassessed half hourly for two hours and then every 2 hours until improvement in pulse/ respiratory rate/mental status  Initiate refeeding as below</p> <p><b>Infection-</b> if localizing signs, lethargic, hypoglycemic or hypothermic as above start</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	







PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	<ul style="list-style-type: none"> <li>• Pneumonia not improving on antibiotics</li> <li>• Or other evidence suggestive of TB</li> </ul>	<p>_____</p> <p>_____</p>	
7. Provider prepares for discharge:	<p>Once 80 % weight for height for minimum of 1 week, no edema for 15 days and good clinical condition the patient may be discharged if</p> <ul style="list-style-type: none"> <li>• Parental education documented on diet and activity</li> <li>• Parental education documented for concerning signs and symptoms</li> <li>• Return visit or home visit by CHW arranged</li> <li>• Discharge summary/referral slip given to patient</li> </ul> <p>The child is taking a diet that can be replicated at home</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

<b>TOTAL STANDARDS:</b>	<b>7</b>
<b>TOTAL STANDARDS OBSERVED:</b>	
<b>TOTAL STANDARDS MET:</b>	

Annex 11

**Performance Standards for Hospitals: Pediatrics, Institutional Standards for Pediatrics Department and Ward**

Identification of health facility (name and place): \_\_\_\_\_

Date of visit: \_\_\_\_\_

Individual responsible for visit: \_\_\_\_\_

**Area: Hospital Pediatrics, Institutional Standards for Pediatrics Department and Ward**

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
1. The facility is prepared for receiving and treating outpatient, acute and emergency pediatric patients 24 hours per day.	Verify that the following facilities and environment for pediatric patients are observed: <ul style="list-style-type: none"> <li>• Dedicated area for pediatrics with appropriate ventilation, heating and light</li> <li>• Examination rooms with privacy for physicians seeing patients in the emergency area</li> <li>• A clean waiting area with benches or seats for patients and family</li> <li>• A clean procedure room or area is available</li> <li>• An ICU is available at provincial and regional hospitals</li> <li>• There are clean patient wards for inpatient pediatric patients</li> <li>• A room for the on-duty physician is clean and maintained</li> <li>• There is a nurses station in the pediatric ward</li> <li>• There are toilets for patients and staff in the pediatric areas</li> </ul>	_____ _____ _____ _____ _____ _____ _____ _____ _____	
2. Appropriate staffing for treating	Verify that the following staffing patterns are		





PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	<ul style="list-style-type: none"> <li>• Medications immediately available 24 hours.                             <ul style="list-style-type: none"> <li>➤ B-agonist</li> <li>➤ Antibiotics as listed in pediatric treatment standards</li> <li>➤ Prednisone or dexamethasone or both</li> <li>➤ Furosemide</li> </ul> </li> <li>• Face masks or nasal canola's of appropriate sizes</li> <li>• Bumpers</li> <li>• Appropriate patient charts, forms and registers</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

<b>TOTAL STANDARDS:</b>	<b>4</b>
<b>TOTAL STANDARDS OBSERVED:</b>	
<b>TOTAL STANDARDS MET:</b>	

**Annex 12**

**Performance Standards for Hospitals: Hospital Pharmacy – Afghanistan**

Identification of health facility (name and place): \_\_\_\_\_

Date of visit: \_\_\_\_\_

Individual responsible for visit: \_\_\_\_\_

**Area: Hospital Pharmacy**

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
<b>Ordering of drugs and supplies</b>			
<p>1. The drugs and supplies needed are ordered in a timely manner and are based on usage and expected needs of patients.</p>	<p>Verify the existence of</p> <ul style="list-style-type: none"> <li>• Date of drug delivery for each item</li> <li>• Frequency of distribution of drug orders</li> <li>• Calculation and use of lead time in ordering and receipt of drug shipments to determine when drugs are to be ordered</li> <li>• Calculation of Average Monthly Consumption (AMC)</li> <li>• Take into consideration stock out periods when calculating the AMC</li> <li>• Calculate the Maximum Stock by multiplying the AMC by the Maximum Stock Factor</li> <li>• The Maximum Stock has been calculated for each item in the store</li> <li>• The Maximum Stock is recorded on each item's stock card</li> <li>• Place your order when the stock balance is less than the Maximum Stock</li> <li>• When order, use the Quantity to Order formula</li> <li>• All orders are placed in writing using the prescribed forms</li> <li>• All information on the requisition is complete,</li> </ul>	<p>_____</p>	

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	accurate and written clearly	_____	
<b>Pharmacy Environment</b>			
2. Is there adequate and proper space and storage area for the pharmacy?	Verify the existence of: <ul style="list-style-type: none"> <li>• Is the area appear clean and tidy?</li> <li>• The refrigerator is in working condition.</li> <li>• Is the refrigerator clean and tidy?</li> <li>• A temperature record is available and up-to-date</li> <li>• There are no nonmedical items found in the refrigerator (e.g no staff food)?</li> <li>• Are there any spillages in the pharmacy that are left unattended?</li> <li>• Are stock containers in the proper place?</li> <li>• Do stock containers have correct and adequate labeling?</li> <li>• Are prepackaged medicines clearly labeled?</li> <li>• Are sufficient counting aids and surfaces available?</li> <li>•</li> <li>•</li> </ul>	_____ _____ _____ _____ _____ _____ _____ _____ _____	
<b>Pharmacy Store and Storage Conditions</b>			
3. The pharmacy has a separate store area that is adequate and properly maintained	Verify the existence of: <ul style="list-style-type: none"> <li>• Is there a separate store for storage?</li> <li>• Drugs are not dispensed to patients from the store</li> <li>• Is the room large enough store to keep all supplies?</li> <li>• The door to the store has two locks and each lock has a separate key</li> <li>• The store is kept locked at all times when not in use</li> <li>• There are no cracks, holes or sign of water damage in the store</li> <li>• There is a ceiling in the store which is in good condition</li> </ul>	_____ _____ _____ _____ _____ _____	

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	<ul style="list-style-type: none"> <li>• Air moves freely in the store; fans and screens are in good condition</li> <li>• The windows have curtains and are secured with grills</li> <li>• The store is free of pests (i.e. cockroaches, rats, mice): there are no sign of infestations</li> <li>• The store is tidy: shelves are dusted, the floor is swept, and walls are clean</li> <li>• Supplies are stored neatly on shelves or in boxes</li> <li>• Shelves and boxes are raised off the floor, on pallets or on boards and bricks.</li> <li>• Narcotics and psychotropic drugs are in a separate double-locked storage space.</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<b>Storage Procedures</b>			
<p>4. Are the storage procedures for the pharmacy adequate and properly followed?</p>	<p>Verify whether:</p> <ul style="list-style-type: none"> <li>• Supplies are classified on the shelves: by therapeutic class.</li> <li>• Tablets and other dry medicines (e.g. ORS) are stored in airtight containers.</li> <li>• Liquids, ointments and injectables are stored on the middle shelves.</li> <li>• Supplies, like surgical items, condoms and bandages are stored on the bottom shelves.</li> <li>• Temperature-sensitive items are stored in a refrigerator.</li> <li>• Supplies are arranged on the shelves in alphabetical order by generic name.</li> <li>• Items are grouped in amounts that are easy to count.</li> <li>• There are no expired drugs in the store.</li> <li>• Drugs with shorter expiry dates are placed in front of those with later expiry dates.</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	<ul style="list-style-type: none"> <li>• Supplies with no expiry or manufacture date are stored in the order received (FEFO).</li> <li>• There are no damaged containers or packages on the shelves.</li> <li>• There are no overstocked or obsolete items on the shelves.</li> <li>• The disposal of drugs is recorded and includes the date, time witness and reason(s).</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<b>Receiving supplies</b>			
<p>5. Are proper procedures followed for receiving supplies?</p>	<p>Verify whether the TOR includes:</p> <ul style="list-style-type: none"> <li>• Deliveries are received by a health worker watching the delivery.</li> <li>• The condition of the boxes at time of delivery are checked by a health worker.</li> <li>• Deliveries are acknowledged and dated on the prescribed forms.</li> <li>• The delivery person signs the form before he leaves the facility/ warehouse</li> <li>• The supplies received match the items listed on the delivery form.</li> <li>• The expiry dates of all items are checked before final acceptance.</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>6. If deterioration of drugs received is suspected, is proper and prompt action taken?</p>	<p>Verify whether:</p> <ul style="list-style-type: none"> <li>• There is inspection to determine if there is deterioration of drugs (e.g. unusual odors of tablets and capsules, damaged tablets or capsules, injectables with small particles that reflect light,</li> <li>• All discrepancies are documented: unacceptable expired drugs or drugs of poor quality are identified.</li> <li>• As soon as the supplies are stored, all receipts are recorded on the stock cards.</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p>	

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
<b>Stock card usage for inventory control</b>			
7. Stock cards are used to control inventory and are used continually.	Verify the existence of stock cards and their proper usage: <ul style="list-style-type: none"> <li>• There is a stock card for each item in the store.</li> <li>• All information on the stock card is up-to date and accurate.</li> <li>• The stock card is kept on the same shelf as the item.</li> <li>• Information is recorded on the stock card at the time of movement of the drug or item.</li> <li>• There is an accurate running tally kept in the balance column.</li> <li>• A physical count is made at regular intervals, such as once a month.</li> </ul>	_____ _____ _____ _____ _____ _____	
<b>Dispensing drugs</b>			
8. There is an appropriate system for dispensing drugs to patients---inpatient and outpatient:	Determine in the pharmacy whether: <ul style="list-style-type: none"> <li>• There is a responsible pharmaceutical professional or technician on duty?</li> <li>• All medicines dispensed are checked by a second staff member before issue?</li> <li>• What proportion of prescriptions are cross-checked for the patient's name at point of receipt?</li> <li>• Are dispensing containers cleaned before use?</li> <li>• There are records delivery of drugs to the patient</li> <li>• There are records of unsatisfied demands</li> <li>• Does the pharmacist explain to the patients the dosage, side effects, adverse reactions in the patient language?</li> <li>• Is dosage of drug written on medicine envelopes?</li> <li>• Has the pharmacist or dispenser confirmed that the patient knows how to take the drug appropriately?</li> </ul>	_____ _____ _____ _____ _____ _____ _____	

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	<ul style="list-style-type: none"> <li>Are patients able to repeat and remember vital instructions?</li> </ul>	<p>_____</p> <p>_____</p>	

<b>TOTAL STANDARDS:</b>	<b>8</b>
<b>TOTAL STANDARDS OBSERVED:</b>	
<b>TOTAL STANDARDS MET:</b>	

Annex 13

**Performance Standards for Human Resources Management in Hospitals– Afghanistan**

Identification of health facility (name and place): \_\_\_\_\_

Date of visit: \_\_\_\_\_

Individual responsible for visit: \_\_\_\_\_

**Area: Human Resources Management**

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
<b>Staffing</b>			
1. The roles, functions and hierarchy of each employee is clearly defined	<ul style="list-style-type: none"> <li>• Verify that the staffing patterns for the hospital organizational structure and the levels of each post are clearly indicated</li> </ul>	<p>_____</p> <p>_____</p>	
2. Each health worker is fully aware of his/her job description	<p>Verify whether:</p> <ul style="list-style-type: none"> <li>• Each health worker has received a copy of his/her job description</li> <li>• The job description is compatible with the job the health worker is doing</li> <li>• The job description clearly shows the main functions, level of responsibility</li> <li>• Each health worker meets the requirements in terms of qualifications for the job based on the job description</li> </ul>	<p>_____</p>	
3. The performance of each member of staff is evaluated annually	<p>Verify whether:</p> <ul style="list-style-type: none"> <li>○ An staff appraisal process is implemented annually</li> <li>○ Results are communicated to hospital Board , PHD and MoPH GD of HR (if government hospital</li> <li>○ Salary increments are based on results of performance appraisal</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p>	

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
<b>Ensuring 24 our coverage</b>			
4. Is there appropriate 24 hour coverage by staff in the hospital	Verify whether <ul style="list-style-type: none"> <li>• Each department in the hospital has developed weekly/ monthly staff rosters (staffing plans) to ensure appropriate staffing levels for each shift</li> <li>• Staffing for each shift is appropriate to ensure adequate work coverage on each of the shifts based on work load</li> <li>• There is an appropriate plan for the hospital to mobilize staff who are not on duty in the event of having to deal with a major emergency</li> </ul>		
<b>Strengthening Capacity of staff</b>			
5. Are there appropriate plans for strengthening the capacity of managerial, clinical and support staff of the hospital	Verify whether: <ul style="list-style-type: none"> <li>○ All management and supervisory staff have had appropriate training</li> <li>• Head of each section has identified the training needs of the different categories of staff in their section to ensure strengthening of staff performance within the section</li> <li>• All training attended by staff is relevant to the work they undertake</li> <li>• Details of all formalized training, including details of staff trained, HR ID nos and results of training are notified to Provincial HR Officer for inclusion in the HR Database</li> </ul>		
<b>Personnel Procedures</b>			
6. All health workers are registered with the MoPH General directorate of Human Resources	Verify that: <ul style="list-style-type: none"> <li>• All health workers have completed the MoPH HR Database form</li> <li>• Qualifications of employees are verified with</li> </ul>		

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y, N or NA	COMMENTS
	General Directorate of HR for authenticity and to identify who wequires testing and certification <ul style="list-style-type: none"> <li>• Staff have been issued with their national HR ID Card which includes their national HR ID Number and photograph</li> <li>• Staff movements and all types of leave are notified on a regular basis to the PH HR Officer for sharing with the PHD and general Directorate of HR</li> </ul>		
7. Is there a process for implementing staff disciplinary measures	Verify that: <ul style="list-style-type: none"> <li>○ There are clear disciplinary procedures</li> <li>○ How the disciplinary process is implemented</li> </ul>	_____ _____ _____	
8. Is there a process for monitoring staff attendance	Verify that: <ul style="list-style-type: none"> <li>○ The is a process for monitoring staff attendance and hours worked</li> </ul>	_____	

<b>TOTAL STANDARDS:</b>	<b>8</b>
<b>TOTAL STANDARDS OBSERVED:</b>	
<b>TOTAL STANDARDS MET:</b>	

## Annex 14

### Hospital Management Task Force Terms of Reference

Ministry of Public Health

*Reviewed and endorsed by MOPH Technical Advisory Group—4 August 2005*

#### **Purpose:**

The Hospital Management Task Force is the focal point within the Ministry of Public Health for all technical and managerial issues related to the hospitals of Afghanistan.

#### **Goal:**

To ensure the implementation of the Essential Package of Hospital Services into a fully integrated health care system with the Basic Package of Health Services

#### **Authority:**

The Hospital Management Task Force shall have the authority to review all issues related to the hospitals of Afghanistan and to make technical recommendations to His Excellency the Minister of Public Health, the MOPH Executive Board and to the MOPH Technical Advisory Group.

#### **Composition:**

The Hospital Management Task Force core group shall be composed of no more than 20 members selected from the Ministry of Public Health, donors, UN agencies, International Organizations (IOs) and Non-Governmental Organizations (NGOs). One additional member shall represent the teaching hospitals within the Ministry of Higher Education. The Director General for Curative and Diagnostic Care, the HMTF chair, shall recommend the names of individuals for 1-year task force terms. The MOPH Executive Board shall review all nominations and make the final membership selections. Members may serve more than one term.

The HMTF may select experts from various clinical, administrative and organizational disciplines to serve as Facultative HMTF associate members. Facultative members will be invited to attend meetings and participate in work groups addressing their areas of expertise.

#### **Responsibilities:**

- Policy
  - Review existing MOPH hospital guidelines and policies
  - Compose new or revised draft policies
  - Recommend new policies to MOPH leadership
  - Develop strategies for hospital policy implementation
- Implementation and Integration of the EPHS
  - Design programs for implementation of the EPHS
  - Encourage additional funding from donors for EPHS implementation
  - Devise plans for patient referral systems among all levels of the Afghan health care system, i.e. from the health posts all of the way to the country's tertiary care hospitals
- Capacity Building/Training
  - Determine the needs for capacity building within all areas of the hospitals of Afghanistan
  - Coordinate with the Health Resources Department in the formulation of a national capacity building plan for hospital staff
  - Identify sources of support for capacity building

- Coordinate all hospital training programs
- Quality Standards
  - Review currently existing hospital standards for Afghanistan
  - Develop a comprehensive set of quality standards for hospitals of Afghanistan
  - Identify sources of new standards or organizations capable of creating needed standards
  - Ensure ongoing evaluation of compliance with MOPH standards
- Monitoring and Supervision
  - Review existing hospital performance monitoring tools
  - Coordinate with appropriate MOPH departments to develop a comprehensive plan for monitoring of the hospitals of Afghanistan
  - Provide feedback on the results of hospital monitoring, with recommendations for corrective actions when needed.
- Assessment, Evaluation and Accreditation
  - Provide oversight of all hospital assessments in Afghanistan
  - Review results of all assessments
  - Determine the need for any additional assessments
  - Develop a national accreditation system for hospitals
- Liaison
  - Coordinate with other Ministries, IOs, NGOs, donors and other organizations dealing with hospital issues
  - Communicate with MOPH departments, the Consultative Group for Health and Nutrition and other entities regarding hospital policies and regulations
- Rationalization
  - Establish principles for equitable distribution of hospital services in Afghanistan
  - Review proposed expansion of facilities, beds or services in all hospitals in Afghanistan and make technical recommendations to MOPH leadership
- Private Hospitals
  - Provide technical expertise and recommendations to MOPH leadership regarding all aspects of private sector hospitals in Afghanistan

**Work Plan:**

The Hospital Management Task Force shall prepare an annual work plan and time line that will include the priority issues to be acted upon during that year.

**Annexes 15 & 16**

**Hospital Management Task Force  
ANNUAL WORK PLAN – NDB 1384  
Draft 3- August 14**

	<b>Task</b>	<b>Lead Person/ Organization</b>	<b>Due Date</b>	<b>Status</b>
84-1	Hospital Visits Plan	Dr Basir, Dr Zurmati		
84-2	Hospital Managers Capacity Building Plan / Training plan	Dr Hemati, Emilie		
84-3	Clinical Standards Development / Management Standards	Bill Newbrander, Dr Nafisa		
84-4	Rationalization Plan	Craig, Emilie		
84-5	User Fees Assessment	Bill Newbrander, Dr Basir		
84-6	Private Hospital Oversight Plan	Dr Zurmati, Dr Dowglass		
84-7	Hospital Guidelines and Policy Review / Hospital Policy revisions	Dr Nafisa, Dr Naja		
84-8	EPHS Implementation Project Inauguration	Dr Katja, Dr Basir		
84-9	EPHS-IP Donors Plan	Katja, Dr Basir		
84-10	Patient Referral Plan	Dr Dowglass, Dr Hemati		
84-11	Monitoring / Supervision Plan	Dr Basir		
84-12	Assessment / Evaluation Plan / Accreditation / Compliance Plan	Emilie, Craig		
84-13	HMIS	Dr Rashidi, Dr Basir		
84-14	Medical record development plan / standardization	Philippa, Bill Newbrander		

Hospital Management Task Force  
Work Plan Time Line  
2005-2006  
1384

No.	Task	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
84-1	Hospital Visits Plan	1. Gather informations 2. Discussion with relevant dptmts	3. Drafting comprehensive plan 4. Visiting hospitals								
84-2	Capacity Building Plan		1. Detemine skills needed for hospital staff 2. Gather informations about hospital training programs			3. Develop NCBP for hospital staff		4. Introduce NCBP to NGOs and IOs			
84-3	Standards Development	1. Gather existing standards	1. Gather existing standards 2. Review established standards	2. Review established standards 3. Develop a complete list of standards to be developed	4. Develop a initial draft of "National Standards for Afghanistan's Hospitals" 5. Pilot : introduce standards to 5 provincial hospitals	5. Pilot : introduce standards to 5 provincial hospitals 6. Have standards reviewed	5. Pilot : introduce standards to 5 provincial hospitals 6. Have standards reviewed	6. Have standards reviewed	7. Revise standards	8. Introduce standards to hospitals - workshop	
84-4	Rationalization Plan	1. Conduct inventory of beds and services currently available	2. Determine acceptable levels of bed-to-population ratios	3. Identify service voids in hospitals	4. Establish a "Needs Assessment" application / approval process	5. Elaborate a map of the distribution of the hospitals					
84-5	User fees			1. Gather informations on hospital currently charging fees for services		2. Develop national guidelines for equitable cost sharing and necessary forms and training material	3. Have a national workshop on cost sharing				
84-6	Private hospitals	1. Desktop review of all capacity docs	2. Desktop review of all capacity and establishment	3. Database development	4. Database inputs	5. Mapping exercise	6. Review work to date with MoPH dptmts	7. Sample assessment of 5 locations K&R	8. Recommendations re assessment made to ???		

Hospital Management Task Force  
 Work Plan Time Line  
 2005-2006  
 1384

		to date	info available								
84-7	Hospital Policies Review				1. Gather existing guidelines and policy documents	2. Review documents	3. Revise documents if needed 4. Workshop to introduce changes	5. Disseminate final revised policies			
84-8	EPHS Implementation Project	1. Contact MinFin and collect relevant informations on procedures 2. Share informations with relevant MoPH staff and PHD team 3. Formulate the ToR for all consultants	4. Identify potential candidates for the project and conduct a selection process		5. Contact HRD and IARCSC on up-date about required PRR process						
84-9	EPHS Donors Plan	1. Inform potential donors/partners about the current problems in the hospital sector 2. Disseminate findings from the NHA and other surveys	3. Analyze the current funding statuts in the hospital sector	4. Involve relevant partners in the preparation of the mid-term review	5. Add informations on funding the hospital sector to the existing grant data base	6. Formulate a fund raising strategy					
84-10	Patient Referral System		1. Structured interviews with clinical and admin staff on current practice of referral		2. Examination of best practice in referral including literature review	3. Critical analysis of EPHS and BPHS in the context of referral recommendations included to date	4. Develop algorithm and test	5. Revise	6. Develop implementation plan	7. Training and dissemination	8. Audit and report

Hospital Management Task Force  
Work Plan Time Line  
2005-2006  
1384

84-11	Monitoring / Supervision Plan		1. Gather informations	3. Make visit plan							
	Assessment / Accreditation	1. Gather existing assessment / evaluation procedures	2. Review results of assessments / evaluations			3. Develop a draft for assessment / evaluation official procedures		4. Develop a draft for a national accreditation system		5. Introduce the procedures to 5 provincial hospitals	6. Revise the procedures
84-13	HMIS	1. Regular attendance in HMIS taskforce		2. Organize an introduction workshop		3. Facilitate smooth implementation of HMIS in all hospitals					
84-14	Medical Record Development	1. Gather existing medical records		2. Prioritise which records should be developed	3. Develop a format for these first documents	4. Hold a workshop in Kabul for hospital staff to comment on these standardized medical record		5. Introduce these records into a select group of hospitals			