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**The Fully Functional Service Delivery Point
in Afghanistan: Results of Two
Improvement Cycles during One Year
(Third External Evaluation)**

April 2006

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LIST OF ACRONYMS / ABBREVIATIONS

AED	Academy for Education and Development
AQS	Access to Quality Services
BHC	Basic Health Center
BPHS	Basic Package of Health Services
CAAC	Catchments Area Annual Census
CBHC	Community Based Health Care
CHC	Comprehensive Health Center
CHW	Community Health Worker
DH	District Hospital
EPI	Expanded Program on Immunization
FFSDP	Fully Functional Service Delivery Point
HF	Health Facility
HMIS	Health Management Information System
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illness
MAAR	Monthly Aggregated Activity Report
MIAR	Monthly Integrated Activity Report
MOPH	Ministry of Public Health
MSH	Management Sciences for Health
NGO	Non-governmental Organization
PPHCC	Provincial Public Health Coordination Committees
PPHO	Provincial Public Health Office
PSS	Provincial Support and Strengthening
REACH	Rural Expansion of Afghanistan Community-based Health Care
TA	Technical Assistance
TAI	Technical Assistance, Inc.
TB	Tuberculosis
T&E	Training and Education
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Executive Summary

In February 2005, REACH introduced the Fully Functional Service Delivery Point (FFSDP) methodology (tool) in 14 REACH-supported provinces of Afghanistan. This tool is designed to encourage behavior change on the part of medical staff at the health facility level, who are generally very clinically and curatively oriented and thus give little attention to management and preventive health practices that can help to improve service delivery. FFSDP introduces a set of standards which help clinic staff systematically focus on expanding Basic Package of Health Services (BPHS) coverage to target groups in the health facility's catchment area and raising the quality of basic health services.

The present report is based on the results of the FFSDP third external evaluation conducted in February 2006 in 76 (36%) health facilities in 6 provinces¹ of the 213 health facilities which were evaluated with a baseline. The baseline results² showed that basic management support systems were non-existent or if they existed were not used properly by the staff. It also showed that NGO management was extremely centralized. The most striking finding was that no links existed between the health facility and the communities it served.

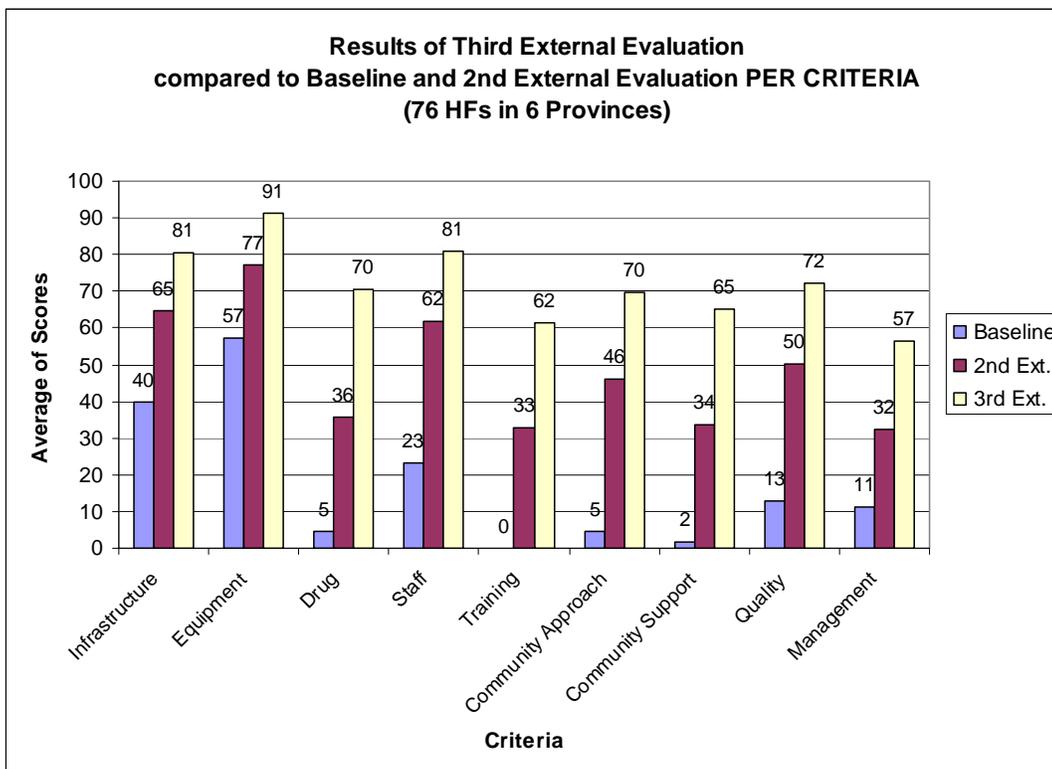
Six months later, the second external evaluation results in 199 health facilities³ showed that with a critical mass of Community Health Workers (CHW) trained and posted, the health facility system was in the process of partnering with the communities through *Shura-e-Sihies* (Community Health Committees). Also, health facility staff started to work on monitoring patient satisfaction and they started to get the basic management systems in place at the health facility level through slow decentralization by the NGO and empowering the health facility staff.

The general results of the third external evaluation compared to the results of the baseline and the second external evaluations conducted in the same health facilities one year and less than six months earlier, respectively, show continuous and important improvements as shown in the figure which follows. Out of the 76 BPHS health facilities evaluated in the third round, 42 are Basic Health Centers (BHC), 32 are Comprehensive Health Centers (CHC), and 2 are District Hospitals (DH).

¹ Kabul, Herat, Takhar, Faryab, Ghazni, and Bamyan

² Report October 2005: "The Fully Functional Service Delivery Point in Afghanistan: A Baseline Evaluation"

³ Report December 2005: "The Fully Functional Service Delivery Point in Afghanistan: First six-month improvement cycle"



Conclusions and Recommendations from the Third External Evaluation

The following general conclusions can be drawn from this third and final round of external evaluation to take place under the REACH program. It is hoped that this successful supervision methodology will be sustained in the next phase of NGO funding for BPHS implementation.

- A critical mass of trained and supplied CHWs is needed to build an effective health team within the catchment area of each health facility.
- In one year and with continuous technical support, the health facility staff is changing its attitude from an almost exclusively clinically-oriented approach to a more community-based preventive care approach. Among various technical assistance (TA) activities, the baseline household survey conducted in the catchment areas and the data-use training at the health facility level were particularly important in this transformation.
- The continuous but slow improvement in filling female positions in facilities argues for the continuation, and possibly an acceleration, of the Community Midwifery training program and the Learning for Life literacy program.
- Also related to gender, the *Shura-e-Sihies'* related to 56% of the health facilities evaluated have at least one-third or more female members. Compared to the results of previous evaluations, this greater involvement of women is an important achievement; however it still needs to be sustained and gradually increased by the implementing NGO grantees.

The following recommendations require attention in follow-on activities after the REACH contract ends.

- A routine supervision system needs to continue in order to sustain the remarkable improvements seen at the third external evaluation
- Targeted support and TA is required to help the facility staff to meet the unmet standards.
- The Health Management Information System (HMIS) Task Force and the Monitoring and Evaluation Advisory Board of the MOPH should finalize, as soon as possible, the development of a national individual patient record card and guidelines for use to facilitate the delivery of integrated health care at the health facility level.
- Analysis of preventable deaths occurring at health facilities and, particularly, at the community level is part of the process of strengthening the awareness of CHWs and community members about the priority health problems and should be promoted
- Regular and transparent flow of financial information between the NGO headquarters and the health facility staff is an important step in building a sound health care financing system at this level.
- As MOPH is starting its phased implementation of FFSDP methodology in non-REACH provinces, it is recommended that the tool be not revised for the time being and new standards be not introduced.
- Furthermore, it is recommended that the provincial implementation framework be continued in the 14 REACH-supported provinces and be replicated in all non-REACH-supported provinces as it has proven to be an effective approach.
- Throughout the process of future FFSDP implementation, the MOPH national FFSDP task force and the Provincial Public Health Offices should undertake the stewardship of the FFSDP in their monitoring and evaluation role.

Phased National Expansion of FFSDP by the Ministry of Public Health

The MOPH has started the implementation of national expansion of FFSDP in 4 provinces – Parwan, Maidan Wardak, Saripul, and Laghman. To this end, several activities have been undertaken:

- Training of 24 MOPH master trainers in the FFSDP approach by a team from REACH
- Training of 111 FFSDP facilitators in the 4 provinces by MOPH trainers
- Creation of a National FFSDP Task force at the MOPH
- Transfer of the FFSDP database to the central MOPH and training in its use for staff in the MOPH and in the 4 provincial PPHOs by REACH team.

Background

The Rural Expansion of Afghanistan’s Community-based Healthcare (REACH) Program was launched May 16, 2003, by Management Sciences for Health (MSH) under contract to the United States Agency for International Development (USAID). The program was designed to address the health of women of reproductive age and children under age five. The REACH strategic objective is to increase the use of basic health services by these two target groups.

Five REACH technical units—Access to Quality Services (AQS), Ministry of Public Health (MOPH) Capacity Building, Provincial Support and Strengthening (PSS), Social Marketing (SM), and Training and Education (T&E)—conduct activities designed to foster REACH’s strategic objective by achieving three intermediate results: (1) expanded access to quality Basic Package of Health Services (BPHS), (2) improved capacity of individuals, families, and communities to protect their health, and (3) strengthened health systems at the national and provincial levels. Through its grants program, REACH supports 19 nongovernmental organizations (NGO) to provide services according to the BPHS in 14 provinces throughout Afghanistan.

REACH introduced the Fully Functional Service Delivery Point (FFSDP) methodology (tool) in Afghanistan to encourage behavior change on the part of health facility medical staff who are generally clinically and curatively oriented and thus give little attention to management tools and preventive practices that can help to improve service delivery. FFSDP introduces a set of standards which help clinic staff systematically focus on expanding BPHS coverage to target groups in the health facility’s catchment area and raising the quality of basic health services. The FFSDP is implemented in six-month improvement cycles and builds on regular encounters among facility staff, the director of the facility, the NGO supervisors, and REACH technical staff during which the needed changes are reiterated and further progress can be planned.

Between February 2005 and October 2005, a baseline evaluation using the FFSDP tool was conducted in 213 (97%) of the 220 health facilities started up and managed by the NGOs which received grants during Rounds 1 and 2 of the REACH grant-making process. These NGOs work in all 14 REACH-supported provinces. A second external evaluation was conducted between August and December 2005 and results from 199 health facilities managed by Rounds 1 and 2 NGO grantees were presented. In the same time, the results of the third external evaluation in 9 health facilities which participated in the FFSDP “Demonstration Project” were also presented.⁴

Introduction

The present report is based on the results of the FFSDP third external evaluation conducted in February 2006, almost one year after the baseline evaluation was conducted allowing for almost two full six-month improvement cycles. The results are based on this external evaluation conducted in 6 REACH-supported provinces in 76

⁴ Refer to December 2005 Report: “The Fully Functional Service Delivery Point: Results of First Six Month Improvement Cycle”

(36%) health facilities out of the 213 evaluated in the baseline. Due to the pending close-out of the REACH project, time and winter conditions did not allow the performance of the third evaluation in all the 213 health facilities. Of the 76 BPHS health facilities evaluated, 42 are Basic Health Centers (BHCs), 32 are Comprehensive Health Centers (CHCs) and 2 are District Hospitals (DH).

This report also presents the results of the fourth external evaluation conducted in the same period (February 2006) in the 9 health facilities which were involved in the “Demonstration Project” launched in June 2004.

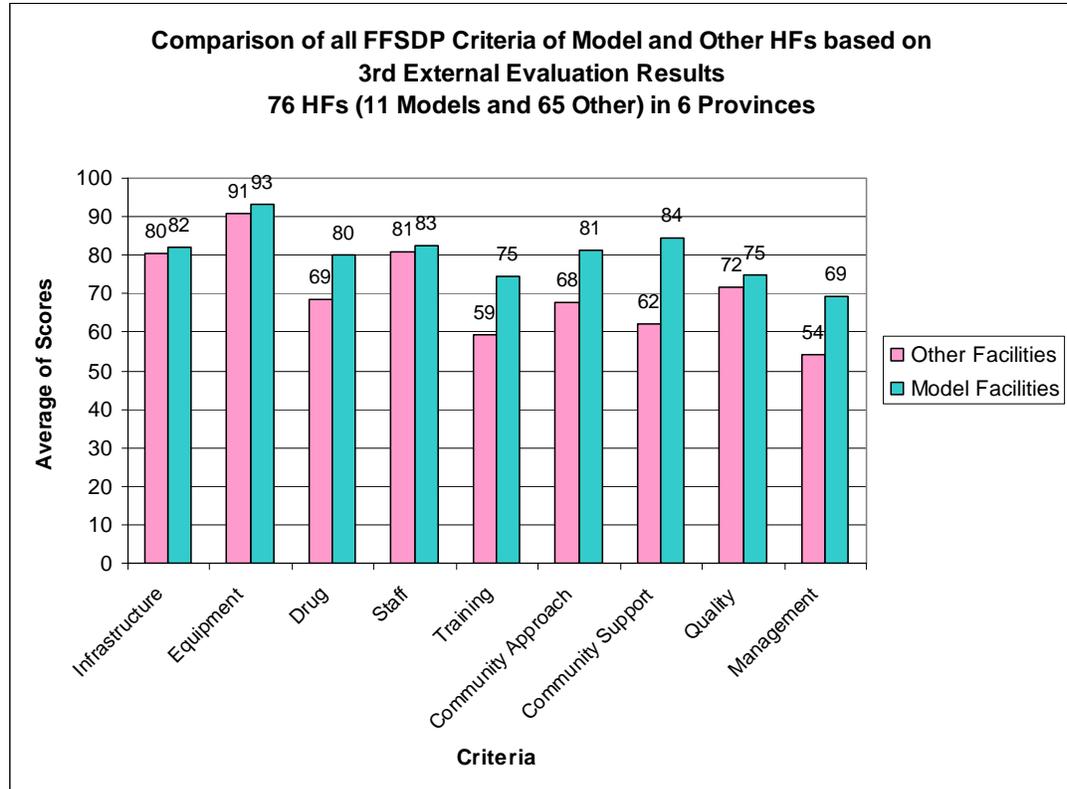
The FFSDP Provincial Implementation Framework

Based on the positive impact of FFSDP implementation in the health facilities, the provincial implementation framework continued with success during the second improvement cycle as follows:

1. Following the external baseline assessment, REACH performed two additional **external evaluations** at the end of each improvement cycle. Between external evaluations, the NGOs are advised to perform two formal **internal evaluations** (self-assessment). Also, during these interim periods, the NGOs conduct ongoing supervision through making visits to assist the clinic staff in introducing necessary changes and to monitor progress.
2. Following each external evaluation, the staff of each NGO health facility develops a **workplan** for the next six months improvement cycle. The workplan specifies the concrete corrective actions identified as necessary during the previous external evaluation; it also names the person(s) responsible for taking the corrective action, for example, clinic staff, NGO manager, and/or REACH staff.
3. A **Provincial FFSDP Support Committee**, comprised of the NGOs implementing the FFSDP in their health facilities, staff of the Provincial Public Health Office (PPHO), and REACH field office staff, oversees and coordinates the FFSDP implementation in each province. These provincial FFSDP Support Committees have been established in each REACH-supported province and are meeting each month.
4. In the 6 provinces evaluated during the Third External Evaluation, **11 Model FFSDP Health Facilities** have received more intensive (weekly or bi-weekly) technical assistance (TA) to accelerate implementation of FFSDP standards and to strengthen the ability of the NGO supervisors to replicate the TA to the health facility staff. At the same time, a replication strategy for the other health facilities in the province is developed to allow them to benefit from the example of the model health facilities.

Figure 1 shows an accelerated improvement in each criterion in the 11 Model Health Facilities compared to the results of the third evaluation in the other 65 health facilities

Figure 1

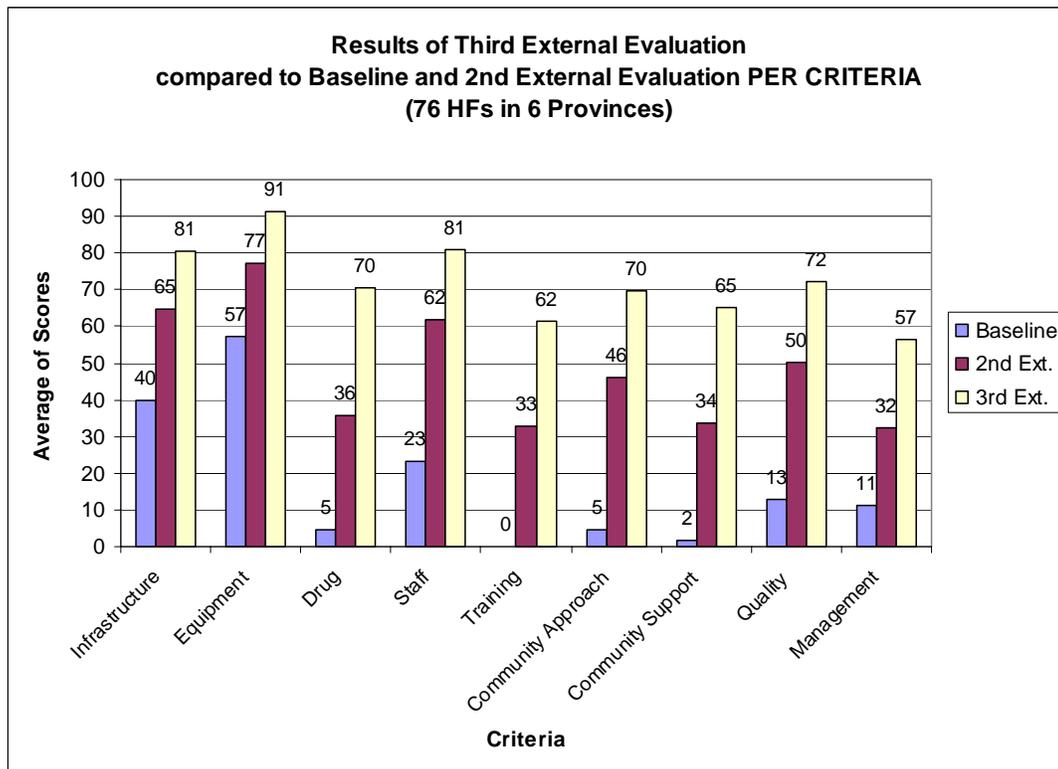


5. Through regular joint monitoring visits, the **Provincial Public Health Coordination Committee (PPHCC) members monitor the quality** of improvements in the health facilities using a monitoring checklist that includes the key standards of the FFSDP tool. During the first year of implementing the FFSDP methodology, the PPHCC members, including the PPHO staff, improved their knowledge and understanding of the use of the FFSDP methodology and also improved their ability to monitor the quality of services provided by the NGO grantees at the BPHS health facility level.

General Findings of the Third External Evaluation⁵

General results of the third external evaluation are shown Figure 2. These results are for 76 health facilities in the 6 provinces evaluated by criteria compared to the results of the baseline and second external evaluations conducted in the same health facilities almost one year and six months earlier, respectively. Each criterion includes several standards which are evaluated. The results presented in Figure 2 are aggregates of these standards for each criterion.

Figure 2



Compared to the results of the baseline evaluation, the improvements for each criterion differ on average from 34 to 65 additional aggregated score (out of a total of 100 per criterion). In a period of less than one year, the scores which have increased the most significantly are in the following criteria, Drug Management (+65), Community Approach (+65), and Community Support (+ 63).

Improvement in essential supplies and basic drug management system

While none of the evaluated health facilities were using a stock control card system at the time of the baseline evaluation, 96% of the health facilities are using it and 84% are filling it in correctly in these facilities in the third evaluation. Importantly, 66% of the health facilities are also now keeping records of the “out of stock days” for each

⁵ See comprehensive “**Results of third evaluation for selected standards**” in Annex 1

item and 63% are now ordering essential disposal supplies and drugs based on their stock surveillance data. In 39% of the health facilities, this basic drug management system has already shown some impact as the frequency of the “out of stock days” has decreased over the last 3 months.

Improvement in Community approach

The health facility staff has shown considerable improvement in understanding that without identifying the target groups of the BPHS in their catchment area it is difficult to reach them and plan a strategy for promoting the utilization of the services at the health facility and/or at the health post level. Now, 87% of the health facilities have drawn a catchment area map which shows the various geographical sections covered by the CHWs and those primarily covered by the health facility. With the use of the community mapping tool by the CHWs, the number of each target group is known for each CHW's geographical section in 53% of the health facilities. In 90% of the health facilities data of MIAR and MAAR (national Health Management Information System-HMIS) reports are aggregated and allow the health team of the catchment area (health facility and CHW health posts) to know the total number of monthly visits for each service. Improvements are also seen in the availability and appropriate use of IEC material in 78% of the facilities.

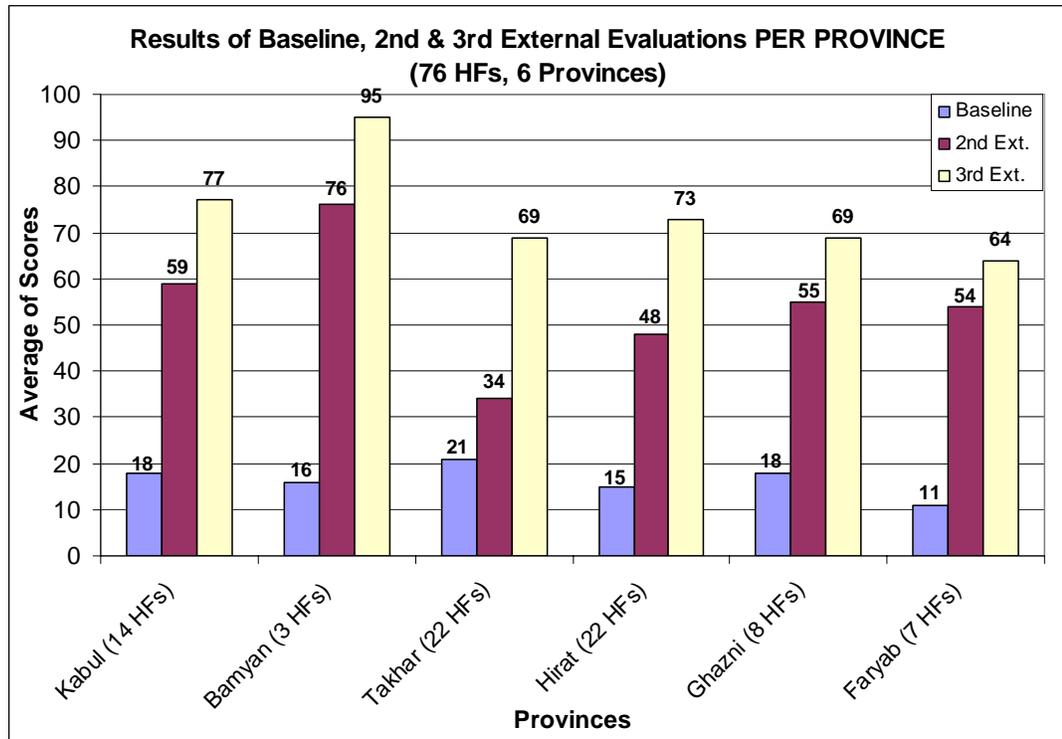
Improvement in Community Support

A remarkable effort has been undertaken by the health facility staff to establish a formal *Shura-e-Sihie* or health committee. Now, 94% of the health facilities have an official *Shura-e-Sihie* and 88% of these committees submit regular monthly meeting minutes. Also, 56% of the *Shura-e-Sihies'* membership is comprised of one-third or more female members. Compared to the results of the second evaluation, the number of health committees with this level of involvement of women has more than doubled. The *Shura-e-Sehie* of 65% of the health facilities have developed an annual action plan which reflects the BPHS priorities and in 32% of the sites evaluated there is already physical evidence or proof of solutions to problems identified in the annual action plan. Forty-eight percent of the health facilities have experienced at least one “Open Door Event” organized by the *Shura-e-Sehie* members allowing the population to visit the health facility, to learn about the various services offered, and to meet with the health facility staff.

Through monthly meetings with the surrounding CHWs, in 78% of the evaluated health facilities the staff is aware of the services rendered at the health posts and 47% of the Community Health Supervisors are taking actions in those monthly meeting to improve the performance of the CHWs.

Figure 3 shows the comparative results by province between the baseline, second and third external evaluations for all criteria demonstrating a sustained supervision system and continuous improvements within the 6 provinces. The duration of the last improvement cycle for the six provinces evaluated was 5 months on average.

Figure 3



Behavior change of the health facility staff

As we have observed throughout the one year process of implementing the quality standards, sustained support is required before the changes can be integrated into the day-to-day routine. Regular supervision visits and regular FFSDP self-assessments every two-three months are vitally important for sustainable changes.

Two other impressive changes related to behavioral change among the staff are observed in the results of the third evaluation. First, while there was no system one year ago in the health facilities to monitor the satisfaction of the clients, now 88% of the health facilities evaluated are monitoring the patient satisfaction and the data on satisfaction are analyzed in 75% of the health facilities. Conclusions of the analysis are made available to all the health facility staff in 63% of the facilities and, finally, actions are taken to improve the service provision based on the patients' remarks in 54% of the health facilities.

A second significant change is that health facility staff has learned how to use the data which are available in the health facility and in the health posts of their catchment area. They have also learned how to calculate the number of the BPHS target groups living in the catchment area. As a result, 71% of the health facilities evaluated are now able to calculate the annual and monthly goals for each BPHS service and are able to draw coverage monitoring graphs for each service in 42% of the health facilities. These are remarkable achievements which still need to be sustained. However they show a change in the understanding of the role of the health facility staff by the staff themselves; they are no longer purely clinically-oriented but they have become more oriented to the application of a public-health approach.

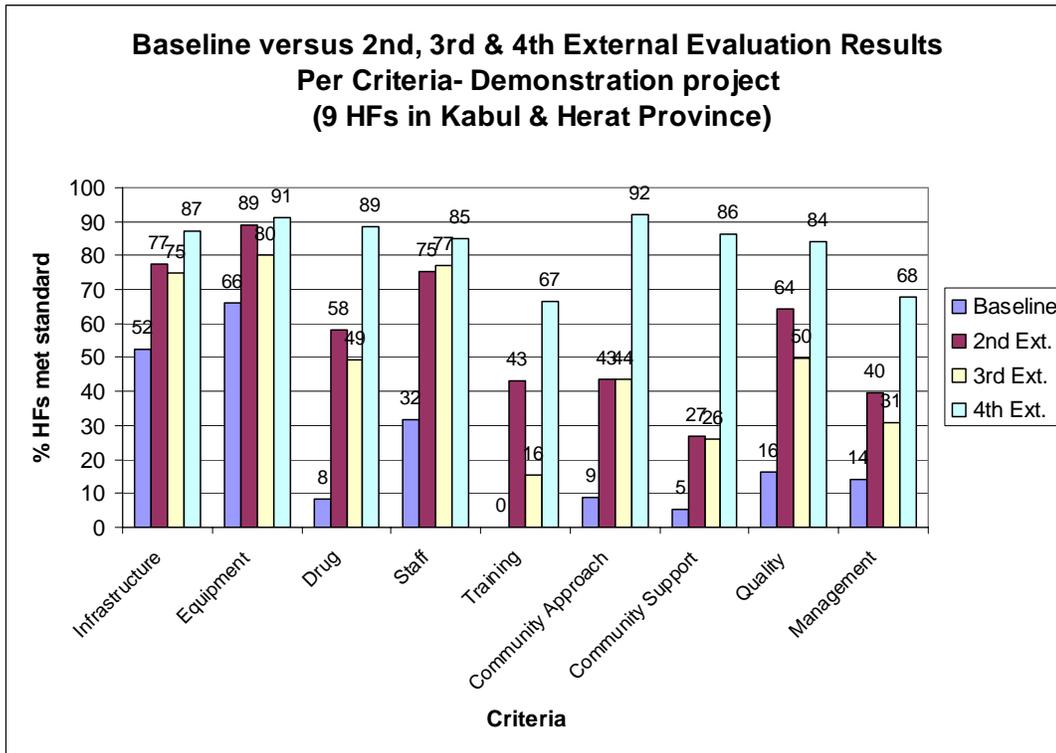
The following standards remain weak and need for further improvement

- Standards related to proper staffing required by the BPHS. Only 37% of the health facilities evaluated have all of the staff required by the BPHS policy of MOPH. Having the appropriate number of staff depends mainly of availability of female staff to achieve this standard.
- Standards related to the analysis of the preventable deaths occurring at the health facility level and at the community level. About one-fifth (21%) of the health facilities evaluated have started this important activity.
- Standards related to the use of an individual patient card system and to optimizing each patient visit. One-fifth (21%) of the health facilities have introduced an individual patient card system and only 12% have put in place an integrated care approach to optimize each patient visit.
- Standard related to the exchange of information between NGO headquarters and health facility staff about the annual budget allocated to the health facility. Only 22 % of the health facilities evaluated have been provided with this information.

Demonstration Project: Results of the Fourth Evaluation of 9 Health facilities

After three improvement cycles (one and half years) the 9 health facilities which participated in the demonstration project have sustained the improvements of many standards. Figure 4 shows the overall results in 9 health facilities for each criterion

Figure 4



As can be seen in Figure 4, the results of the third evaluation showed a general decreased due to some neglect in the supervision system of those 9 health facilities. This neglect was explained by the fact that these NGOs were busy introducing the FFSDP standards in all their other facilities. However, the results of the fourth evaluation demonstrate that the NGOs involved have acknowledged that supervision system must be continuous. Presently 46 standards out of a total of 103 are fully met in these nine health facilities and 29 other standards are fully met in four-fifths of the facilities. Only two standards have not been met by any of the 9 health facilities: these are the standards related to a) the use of an individual patient card system and b) the optimization of each patient visit through an integrated care approach.

General Conclusions

NGO and MOPH clinical and managerial staff received the FFSDP methodology with enthusiasm. They see the FFSDP as a useful guide that helps them put together the pieces of the service delivery puzzle and introduce basic management systems wherever they are lacking. Most standards get a full positive score when forms and procedures are in place *and* used and when activities are planned *and* performed as planned.

The following general conclusions can be drawn from this third and final round of external evaluation to take place under the REACH program. It is hoped that this successful supervision methodology will be sustained in the next phase of NGO funding for BPHS implementation.

- A critical mass of trained and supplied CHWs is needed to build an effective health team within the catchment area of each health facility.
- In one year and with continuous technical support, the health facility staff is changing its attitude from an almost exclusively clinically-oriented approach to a more community-based preventive care approach. Among various technical assistance (TA) activities, the baseline household survey conducted in the catchment areas and the data-use training at the health facility level were particularly important in this transformation.
- The continuous but slow improvement in filling female positions in facilities argues for the continuation, and possibly an acceleration, of the Community Midwifery training program and the Learning for Life literacy program.
- Also related to gender, the *Shura-e-Sihies'* related to 56% of the health facilities evaluated have at least one-third or more female members. Compared to the results of previous evaluations, this greater involvement of women is an important achievement; however it still needs to be sustained and gradually increased by the implementing NGO grantees.
- Changing the behavior of facility staff takes time. Behavior change requires sustained support before the changes can be integrated into day-to-day practice.

Specific Recommendations

The following recommendations require attention in follow-on activities after the REACH contract ends.

- A routine supervision system needs to continue in order to sustain the remarkable improvements seen at the third external evaluation
- Targeted support and TA is required to help the facility staff to meet the unmet standards.
- The Health Management Information System (HMIS) Task Force and the Monitoring and Evaluation Advisory Board of the MOPH should finalize, as soon as possible, the development of a national individual patient record card and guidelines for use to facilitate the delivery of integrated health care at the health facility level.
- Analysis of preventable deaths occurring at health facilities and, particularly, at the community level is part of the process of strengthening the awareness of CHWs and community members about the priority health problems and should be promoted.
- Regular and transparent flow of financial information between the NGO headquarters and the health facility staff is an important step in building a sound health care financing system at this level.
- As MOPH is starting its phased implementation of FFSDP methodology in non-REACH provinces, it is recommended that the tool be not revised for the time being and new standards be not introduced.
- As the REACH project is coming to a close, it is recommended that the provincial FFSDP committee continues to provide the technical support to the NGO implementers and to the PPHO staff, particularly in preparing summary reports of the results to inform the Provincial Public Health Coordination Committee (PPHCC) members of progress made.

- Furthermore, it is recommended that the provincial implementation framework be continued in the 14 REACH-supported provinces and be replicated in all non-REACH-supported provinces as it has proven to be an effective approach.
- Throughout the process of future FFSDP implementation, the MOPH national FFSDP task force and the Provincial Public Health Offices should undertake the stewardship of the FFSDP in their monitoring and evaluation role.

Future Directions

By the end of February 2006, a total of 308 persons had been trained by REACH as facilitators to introduce FFSDP standards of quality in health facilities. Of these, 197 are REACH-supported NGO staff, 55 are MOPH staff (33 from central level and 22 from provincial level), 40 are REACH program staff, and 16 are non-REACH NGO staff.

Based on the evidence of the positive impact of the use of the FFSDP methodology at the field and provincial level, the MOPH received positive recommendations from its Monitoring and Evaluation Advisory Group and its Technical Advisory Group (TAG) to expand the FFSDP. Therefore, a decision was made in June 9th, 2005 to expand the introduction of the FFSDP methodology to non-REACH supported provinces in a phased manner.

REACH supported this expansion initiative by training MOPH Master Trainers, providing the FFSDP manual for further dissemination, and transferring the FFSDP database to the MOPH central and provincial levels. In March 2006, MOPH master trainers trained 115 additional facilitators in the four non-REACH provinces selected for expansion of FFSDP. During the same month, a National FFSDP Task Force was created at the MOPH led by the General Directorate of Provincial Public Health. Also involved are the General Directorate of Policy and Planning (Health System Performance Assessment Directorate), the General Directorate of Primary Health Care and Preventive Medicine, the Grant and Contract Management Unit, other donors and several NGOs.

Annex 1

Results of the Third External Evaluation for Selected Standards

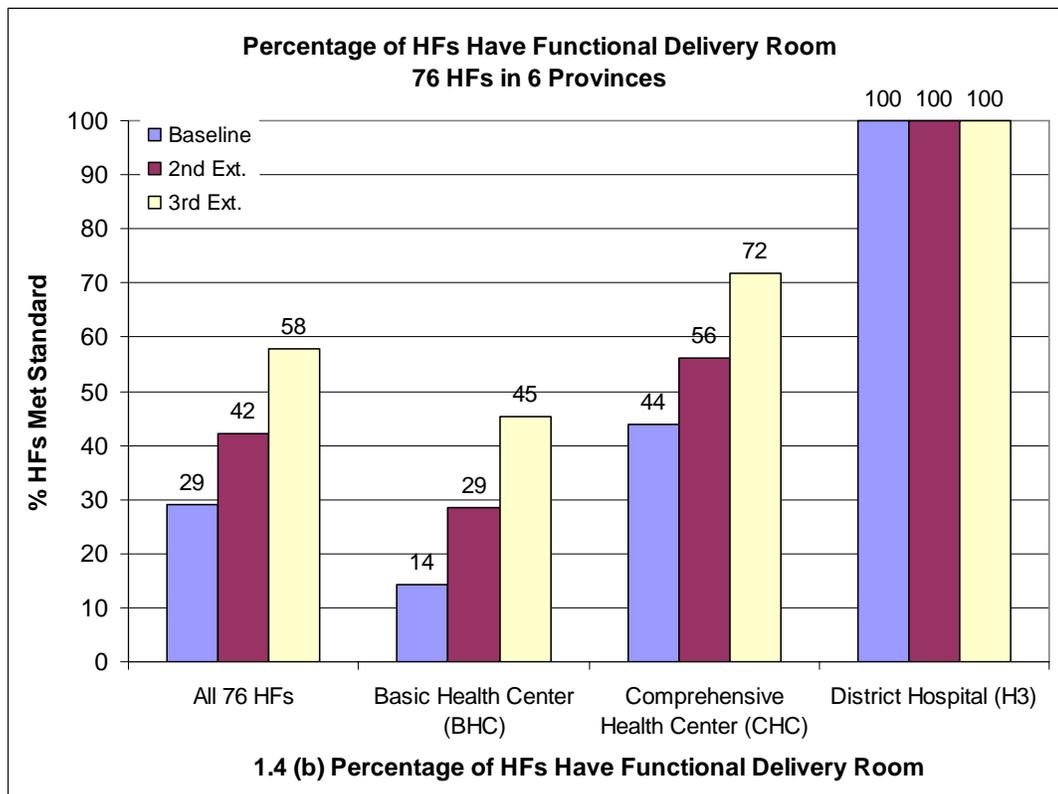
The analysis of specific data in the 76 health facilities evaluated which included 42 Basic Health Centers, 32 Comprehensive Health Centers, and 2 First Referral Hospitals (also called “District Hospitals H3”) is presented in this annex.

Throughout the annex, the figures contain reference numbers, e.g. 1.4 (b) in Figure 1, which refer to the numbering of the standards list in the FFSDP tool.

1. Infrastructure

The two following figures show the results of some selected standards related to Infrastructure:

Annex Figure 1



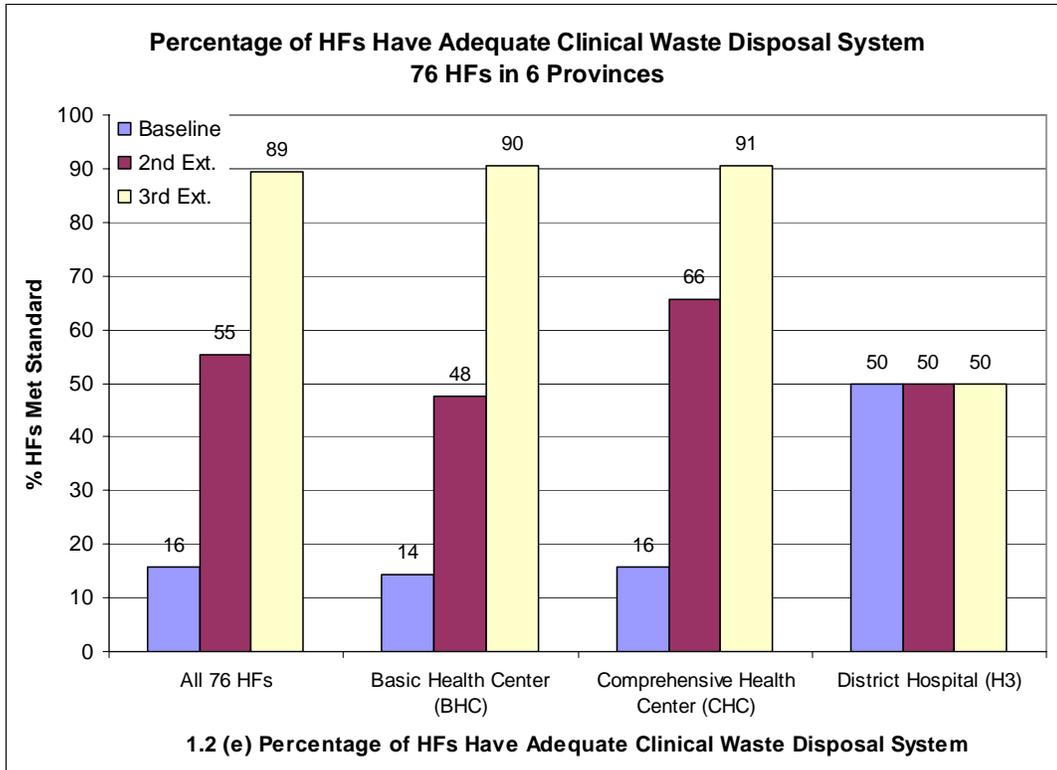
Health Facilities with a Functional Delivery Room (Annex Figure 1). Out of 76 health facilities, 58% have an appropriate delivery room with minimum requirements defined as: “bed –ideally a delivery bed, closed container of clean water with a bowl and soap for washing hands and a cleanable floor with a channel or drain. The room

should be private with a lockable door and screenable windows. (Note: an area partitioned by a curtain only is not acceptable).”

Of the 42 Basic Health Centers evaluated 45% have a functional delivery room. Of the 32 CHCs evaluated 72% have a functional delivery room as well as 100 % of the 2 District Hospitals.

Health facilities having an adequate clinical waste disposal system (Annex Figure 2). The NGO grantees have greatly improved the clinical waste disposal system in their health facilities. One of the two district hospitals had the adequate material but the staff were not yet using it properly

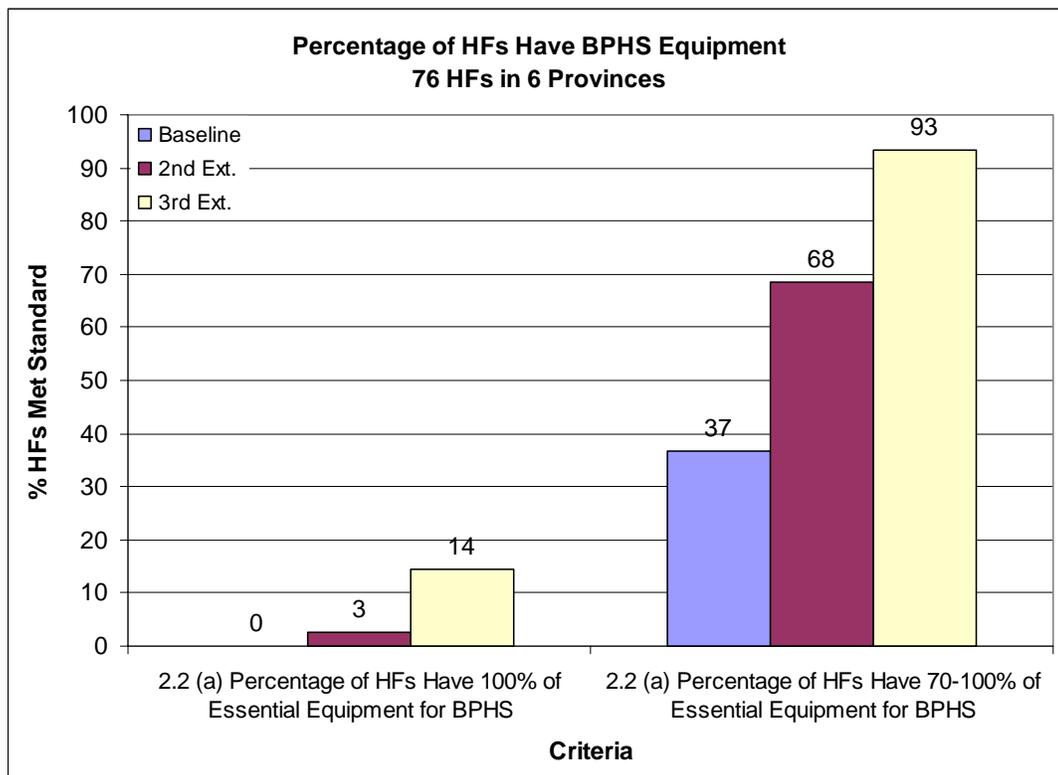
Annex Figure 2



2. Equipment

In general all standards of this criterion have improved. In particular a regularly updated inventory system of furniture, stationary and equipment in each room of the health facility is in place and used by the staff in 93% of the health facilities evaluated. Such a system allows for well-informed decisions to replace, repair or purchase as necessary.

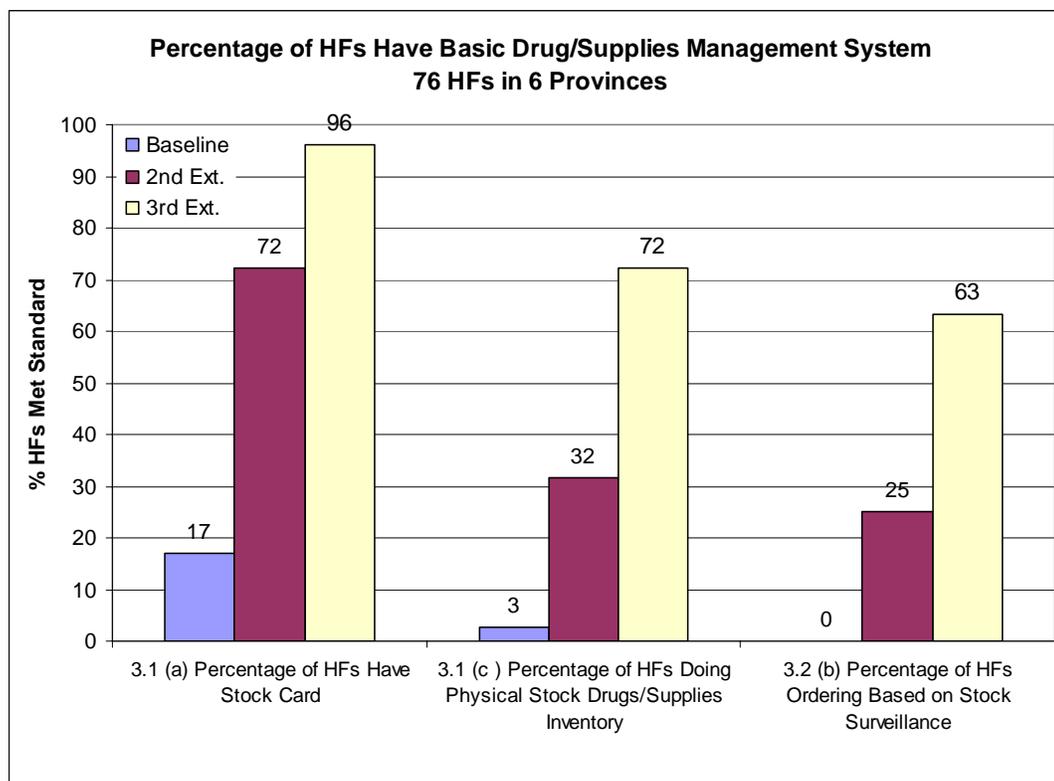
Annex Figure 3



Availability of adequate equipment (Annex Figure 3). Out of 76 health facilities evaluated, only 14% have a complete set of equipment as required by the BPHS. However, a clear improvement occurred in 93% health facilities in which between 70 and 100% of the required equipment is available (this is the case in 93% of the BHCs, 94% of the CHCs and 100% of the DHs).

3. Drug/Supply Management

Annex Figure 4



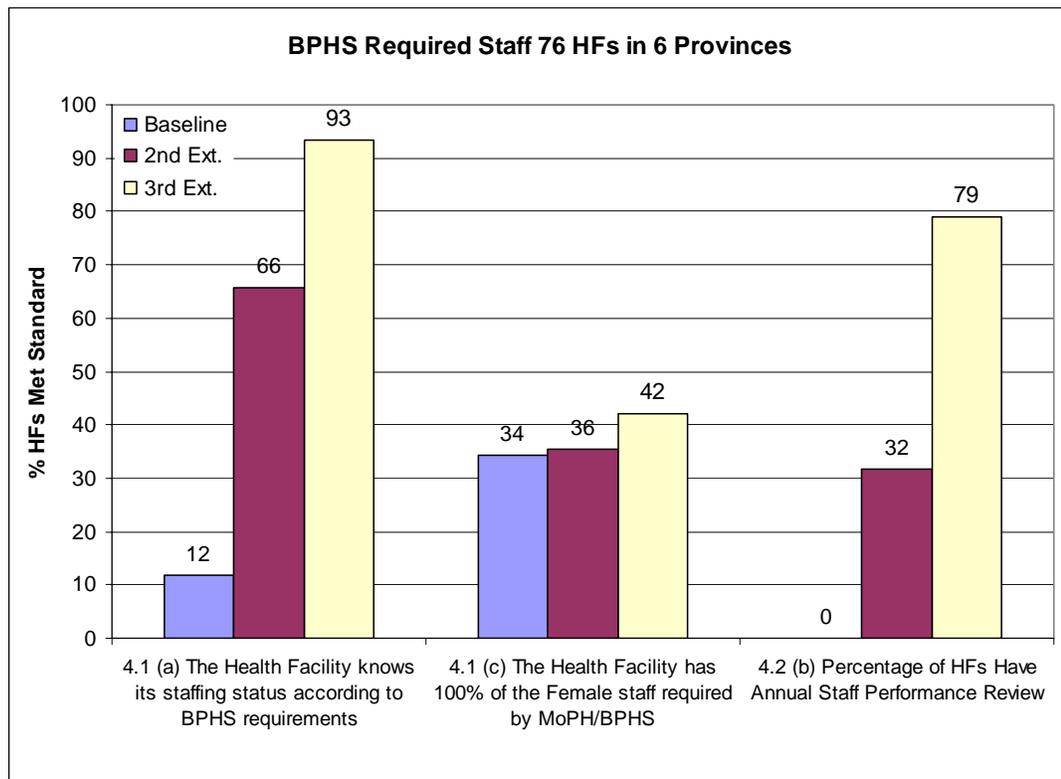
Availability of a basic supply/drug management system (Annex Figure 4). The stock control card system has been adopted by almost (96%) all of the pharmacists or in-charges of the health facilities evaluated. The supply/drug management system put in place has been strengthened since the second evaluation but still needs to be sustained: the physical stock inventory and ordering based on stock surveillance system are part of the basic drug/supply management system in 72% of and 63% of the health facilities, respectively.

4. Staff

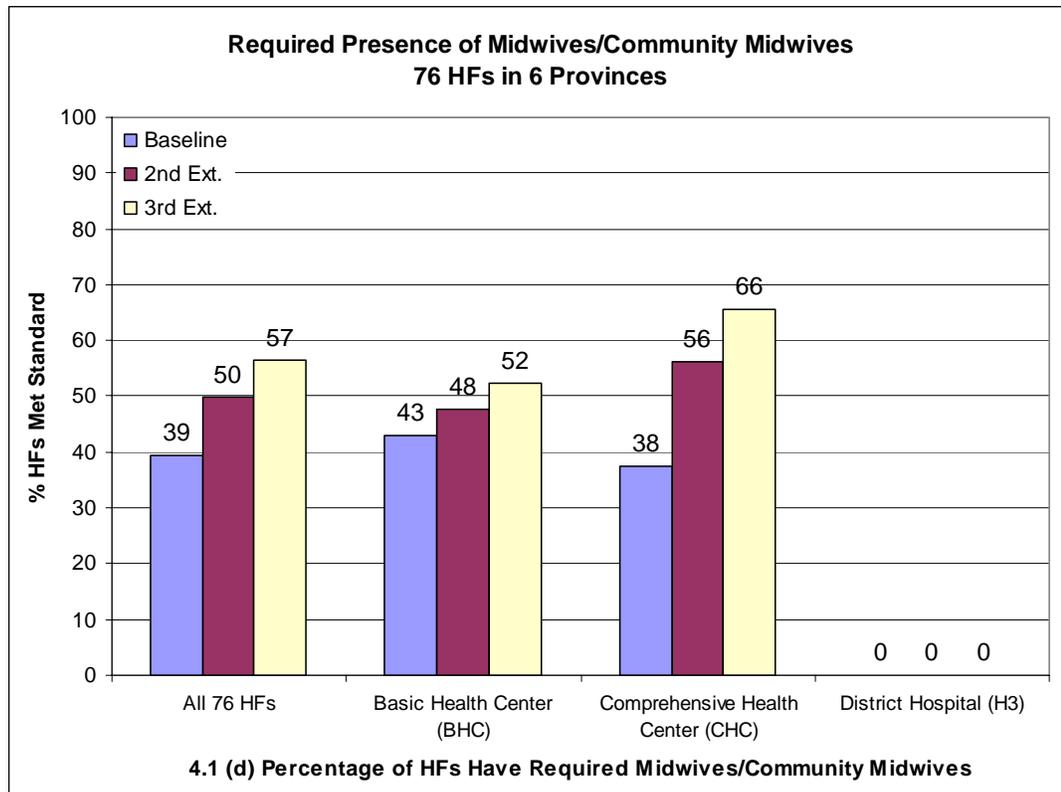
Adequate staffing (Annex Figure 5). Among the 76 health facilities, staff in 93% know the staffing requirements of the MOPH for their type of health facility and they know their own staffing status and 42% of the health facilities have the required female staffing. The latter finding represents a continuous but limited improvement compared to the baseline results; BHCs have improved from 43% in the baseline to 52% in the third evaluation, the CHCs have improved from 25% to 31 % and neither of the district hospitals have improved nor do they have the required female staff.

The process of conducting an annual performance review of the health facility staff has significantly improved since the second external evaluation: now it is conducted in 79% of the health facilities.

Annex Figure 5



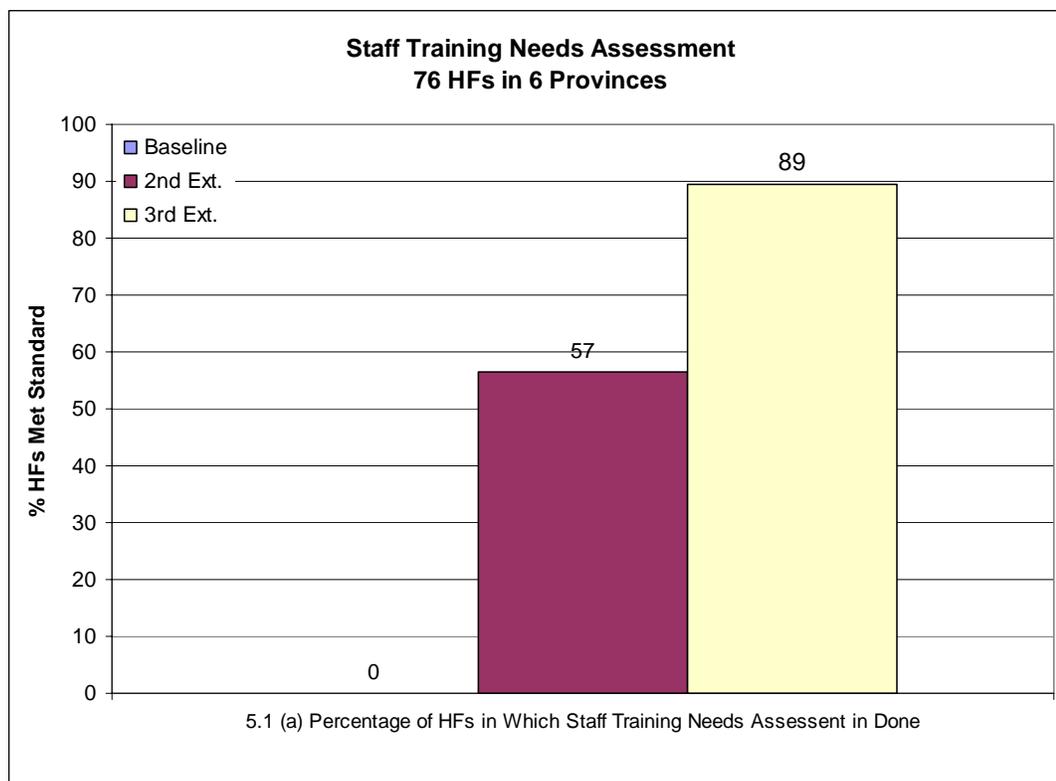
Annex Figure 6



Availability of required midwives/community midwives (Annex Figure 6). While only 42% of the health facilities have the full required female staff (see Annex Figure 5), 57% have the required number of midwives/community midwives (52% of the BHCs, 66% of the CHCs, and neither of the District Hospitals are fully staffed with the required midwives/community midwives). This finding supports the need for continuation, and possibly an increase, of the community midwifery training program and the health literacy training program (Learning for Life) that prepares women to enter health professions.

5. Training

Annex Figure 7



Availability of staff training needs assessment report (Annex Figure 7). Out of the 76 health facilities evaluated, 89% keep a copy of the staff training needs assessment report. However, improvements in staff training must be sustained as only 45 % of the health facilities have fulfilled their annual planned training activities.

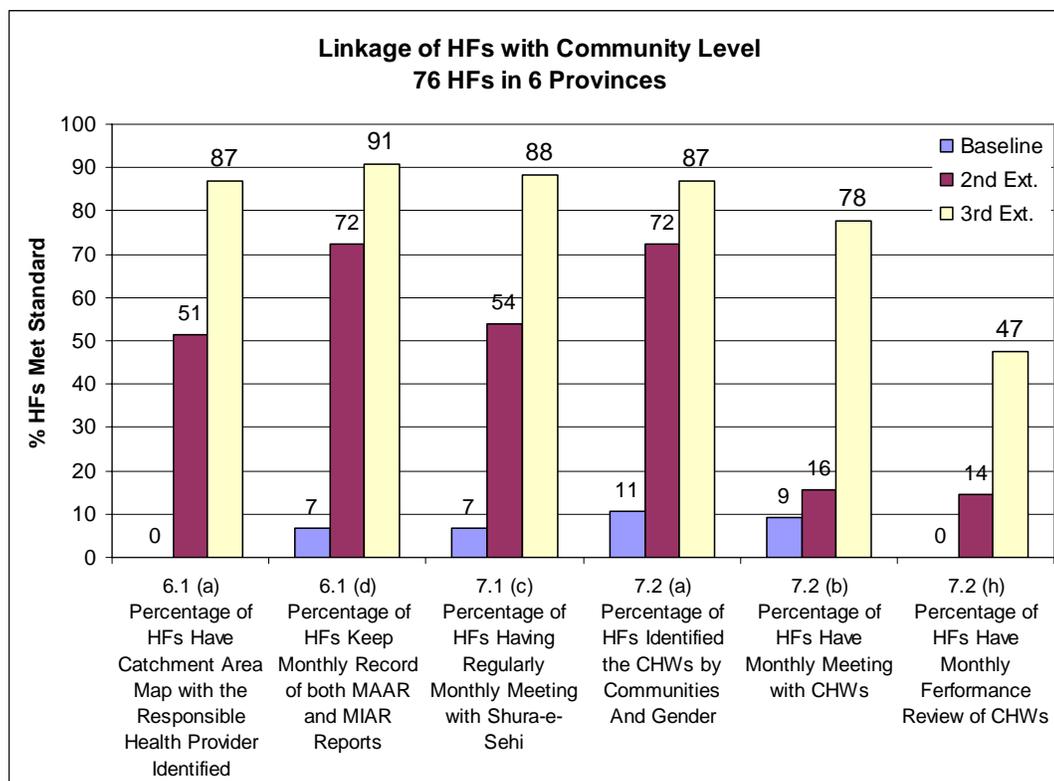
6. Community Approach and Community Support

Community Approach and Community Support (Annex Figure 8). These two components have greatly improved during the second improvement cycle.

Catchment area map and required HMIS reports available at the health facility. Identifying the various geographic sections of the HF catchment area with the health provider responsible for the delivery of services is carried out in 87% of the health facilities evaluated. Likewise, management of the HMIS reports from the health facility and from the surrounding CHWs (MIAR and MAAR forms) occurs in 91% of the health facilities. The use of the data has also improved in 53% of the health facilities evaluated where health facility staff know the number of target groups for each geographic section of the catchment area. The additional data-use training

provided by REACH in the first quarter of 2006 at the health facility level in all provinces played a critical role in this improvement.

Annex Figure 8



Regular and formal meetings with the *Shura-e-Sehie* (Community Health Committee). Ninety-four percent of the health facilities are formally partnering with a *Shura-e-Sihi* and 88% have monthly meetings that are formalized with written minutes. The representation of women has improved considerably: the membership of 56% of the *Shura-e-Sihies* is comprised of one-third or more females compared with 25% of the health facilities at the second evaluation six months earlier. This important effort on the part of the NGOs needs to be continued.

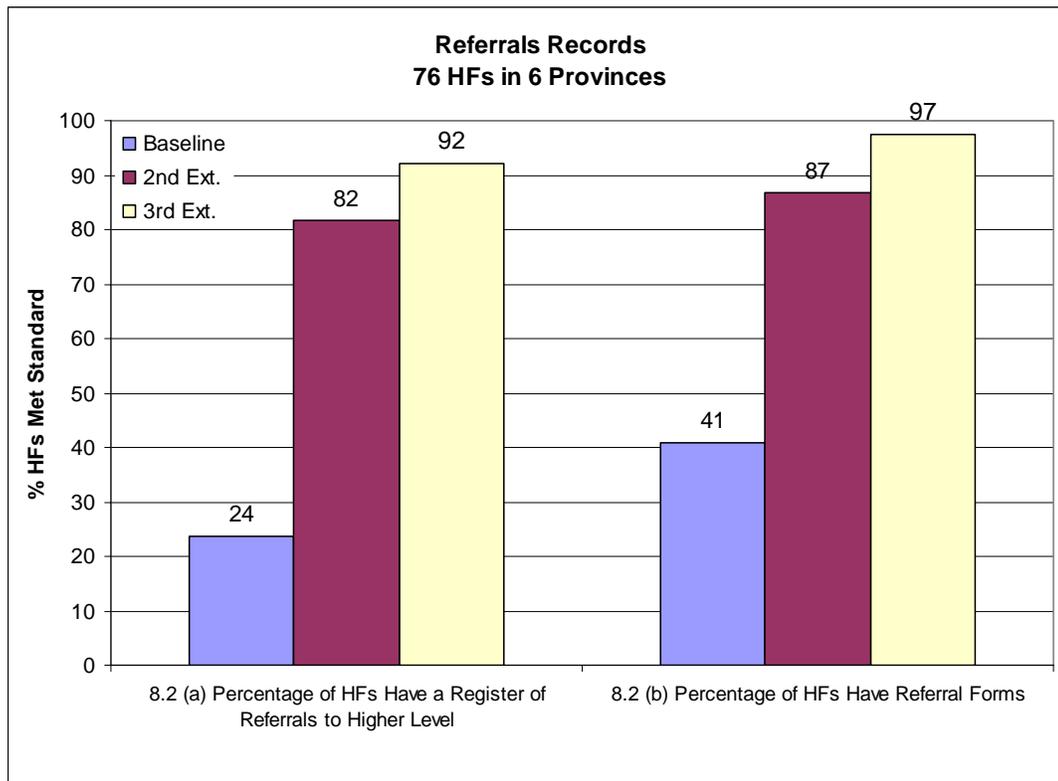
Identification of CHWs by community and gender. Eighty-seven percent of health facilities can identify the affiliated CHWs within their catchment area by community and gender.

Monthly meeting at the health facility with the CHWs. While 87% of the health facilities have identified their surrounding CHWs, 78% of them are now meeting the CHWs on a monthly basis and exchange health information and plan together the health activities for the next month. This is a remarkable improvement greatly facilitated by the presence of the Community Health Supervisors as per the revised BPHS policy of MOPH.

The Health facility is taking action to improve the performance of those CHWs who are not performing in providing the BPHS. The second external evaluation found that only 14% of the health facilities were taking this responsibility. As expected with the deployment of trained Community Health Supervisors during recent months, this activity is taking place now in 47% of the health facilities evaluated.

7. Quality and Management

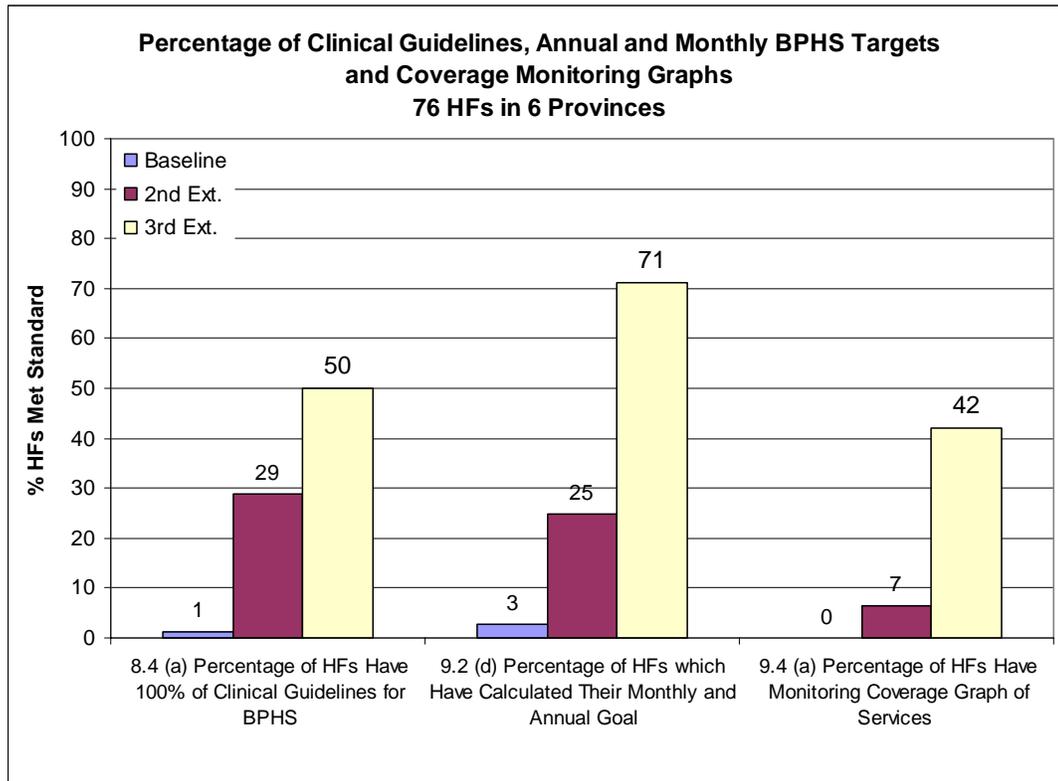
Annex Figure 9



Quality and Management indicators (Annex Figure 9)

Referrals of patients to a higher level. Of the 76 health facilities evaluated, 92% had a referral register in place at the time of the third external evaluation and 97% of the health facilities have proper referral forms.

Annex Figure 10



Availability of clinical guidelines for the major areas of BPHS health services. Of the 76 health facilities, 50% have now a complete set of the clinical guidelines related to BPHS. To meet this standard, the following technical guidelines are required:

1. Maternal & Newborn Health
 - Antenatal care
 - Delivery care
 - Postpartum care
 - Family Planning
 - Care of the newborn
2. Child Health & Immunization
 - EPI services (schedule of EPI for Afghanistan)
 - Integrated Management of Childhood Illnesses (IMCI) guidelines
3. Public Nutrition
4. Communicable Diseases
 - Treatment of TB
 - Treatment of malaria
5. Essential Drugs (A list of essential drugs for the type of facility and guidelines for their use should be available to staff).

For this standard, the FFSDP scoring system allows for separate scoring for each of the five areas of BPHS (20 points for each area), for a total of 100 points. This flexibility in scoring allows calculation of the average number of points for the availability of guidelines in all the health facilities. This average score for all the 76

health facilities is 85 out of 100 points, which is a great improvement compared to the baseline average score (18 points) and the second external evaluation average score (59 points).

Annual and monthly goals for health care delivery have been calculated.

As a result of the data-use training provided to the health facility staff by REACH, a remarkable improvement (71% of the health facilities compared to the 25% of health facilities in the second external evaluation) has occurred in the calculation of the annual and monthly goals for each service at the health facility level.

Coverage Monitoring is up to date for the last month for the following services:

Of the 76 health facilities, 42% are now able to draw a monitoring coverage graph for each of the following BPHS services:

- Antenatal Care
- Postnatal Care
- Tetanus immunization of pregnant women
- Institutional Delivery
- Family Planning
- DTP3
- BCG

For this standard also, the FFSDP scoring system allows for separate scoring for each of the seven services (5 points for each service coverage monitoring graph) for a total score of 35. This flexibility in scoring allows calculation of the average number of points for the availability of coverage monitoring graphs in all the health facilities. This average score for all the 76 health facilities is 22 out of 35, indicating that the health facility staff moving toward fully meeting this standard.