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Rural Expansion of Afghanistan's Community-based Healthcare Program's Learning Center Initiative

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Acronyms

BCC	Behavior Change Communication
BHC	Basic Health Center
BPHS	Basic Package of Health Services
CAAC	Catchment Area Annual Census
CAF	Care for Afghan Families
CHC	Comprehensive Health Center
CHS	Community Health Supervisor
CHW	Community Health Worker
CM	Community Map/Mapping
DH	District Hospital
FFSDP	Fully Functional Service Delivery Point
HF	Health Facility
HMIS	Health Management Information System
IEC	Information, Education and Communication
IMC	International Medical Corps
LC	Learning Center
MAR	Monthly Activity Report
MIAR	Monthly Integrated Activity Report
MOPH	Ministry of Public Health
MSH	Management Sciences for Health
MSL	Minimum Stock Level
NGO	Non-governmental Organization
REACH	Rural Expansion of Afghanistan's Community Based Healthcare Program
STEP	STEP Health and Development Organization
TA	Technical Assistance

Executive Summary

Over the last three years, the Rural Expansion of Afghanistan's Community-based Healthcare (REACH) Program has not only provided funding for non-governmental organization (NGO) grantees but it also provided them with regular technical assistance (TA) from different REACH departments. During the later half of the project, REACH technical staff came to realize that the knowledge and skills provided through REACH TA, largely to staff at the central level of the NGOs, had not effectively been transferred to the health facility (HF) level.

The REACH response was to develop a Learning Center (LC) initiative which involved a series of six bi-weekly visits, each two to three hours long, by technical staff from all REACH departments. Carried out over a three-month period, these visits provided intensive, integrated and structured TA directly to trainers and supervisors based at four selected HFs in Kabul province.

The objectives of the LC initiative were to improve the quality and effectiveness of care at REACH HFs and in their catchment areas; to provide regular, focused TA visits from REACH technical teams paired with NGO supervisors who were taught to mentor HF staff in improving quality of services; and to enable HF staff to learn new skills.

The following particular fields were the focus for the LC initiative technical assistance:

- understanding and using patient data to understand the health status of the population in the HF catchment area and the use of clinic services. This TA was provided by the REACH Health Management Information System (HMIS) section;
- community leadership by male and female health councils (*shura-e-sahie*) in the villages served by the clinic provided by the Community-based Health Care (CBHC) section;
- performance of the clinic's Community Health Workers (CHW) and their use of tools such as community maps and pictorial registers provided by the Community Mobilization (CM) section;
- management and operation of the clinic pharmacy provided by the Drug Management Unit (DMU), and
- health education provided to clinic patients and visitors provided by the Information, Education and Communication (IEC) section.

As a result of the LC Initiative, the four selected REACH NGO grantees have made notable progress in addressing the gaps found in meeting REACH's Fully Functional Service Delivery Point (FFSDP)[1] quality standards.

For instance, after training in data use the staff of each LC facility was able to calculate target population groups for their catchment areas. Based on this information, they are now able to establish and monitor monthly and annual targets and find ways to achieve their targets. They can also monitor and evaluate their performance, plot monitoring graphs and look for opportunities and find appropriate solutions to improve target achievement. The NGO supervisors and the midwives, vaccinators, and doctors at the

[1] The Fully Functional Service Delivery Point (FFSDP) is a standards-based quality improvement tool used in Afghanistan's BPHS (Basic Package of Health Services) health facilities –Basic Health Centers, Comprehensive health Centers and District Hospitals. This tool has 9 criteria and 103 standards.

HFs know their key indicators and how to calculate progress against these indicators, and they can calculate properly the annual and monthly targets to improve family planning and immunization coverage.

In another example, following LC initiatives provided by REACH's Community Mobilization team, the *shura* members understood the importance of community participation, community mobilization, BPHS priorities, decision making and how to develop an action plan. This has enhanced their ownership of promoting health care at the community level and enhanced their support for the local HFs. All members have increased their commitment to reducing the maternal and child mortality rates.

After REACH TA, one of the HFs held an Open Door Event[2] for the first time to address the challenge of a low number of deliveries in the HF. Each HF Community Health Supervisor (CHS) and the Community Health Worker (CHW) trainers were assisted to supervise the CHWs and coordinate their activities closely with the activities of the health facility and of other relevant local programs. Special emphasis was given to improvements in the development and proper use of CHW community maps. Also, CHWs and the HF staff received coaching on the guidelines and proper use of various REACH information, education and communication and behavior change communication (IEC/BCC) materials.

The LC Initiative also oriented pharmacists to the importance of keeping and correctly filling out stock control cards on the supply of each essential disposable item and each essential drug in the HF. They were taught to conduct physical stock inventory at least every two months, and also were enabled to regularly record "out of stock days" for each item. They are now capable of calculating the Minimum Stock Level (MSL) to trigger ordering essential disposable supplies and essential drugs based on their stock surveillance data. Pharmacists also learned to take timely and proper action to reduce the number of "out of stock days."

The NGO supervisors assured REACH technical staff that they are able to continue the process in the follow-on projects without external assistance from REACH. Each of the four NGOs made a LC replication plan so that the staff of the remaining HF will be enabled to learn new skills from their NGO supervisors and from their peers at the HFs that participated in the Learning Center initiative.

[2] The *shura-e-sehie* is advised and mentored to hold an "Open Door Event" at the Health Facility for the public every 6 months. They are encouraged to choose a special day when a number of rural people come to the area of the health facility such as a market day. At the "Open Door" event, both women and men can visit the HF and be reassured that they will receive good services from appropriate health staff (for example female health staff will see women, privacy of the examination room etc.)

Background & Introduction

Concept:

Afghanistan's Basic Package of Health Services (BPHS) includes the primary health care services that the Ministry of Public Health (MOPH) believes will have the greatest impact on the country's major health problems. REACH not only awarded USAID-funded grants to selected Afghan and international NGOs to deliver the BPHS and train health workers, but the project also assisted its NGO grantees technically by building their capacity to deliver and expand quality health services and helping them to develop the technical, managerial and leadership skills for implementing the BPHS in 14 priority provinces.

Continuous and intensive TA was planned and provided to the NGO grantees by REACH. In the early stages of the project, the direct recipients of most of REACH's TA were NGO staff located at the NGO headquarters, training centers, or provincial offices. All along REACH assumed that those individuals receiving the TA would replicate it among the HF staff in order to empower them to deliver quality services to the population. As time passed, several departments of REACH raised the concern that the TA was not always replicated as anticipated thus delaying the expected improvements in service delivery and its potential impact on the health of the population.

Accordingly, REACH decided to take a different approach to TA. Intensive, integrated, structured and targeted TA was to be provided through a Learning Center approach.

Objectives of the LC initiative

- Improving the quality and effectiveness of care at the health facility and in its catchments areas.
- Providing regular focused technical assistance visits by REACH technical teams working with NGO supervisors to provide targeted TA along with a learning process to mentor the HF staff to improve quality of care
- Enabling the HF staff to learn new skills from their NGO supervisors and from their peers in other HFs

Methodology

Identification and selection of Health Facilities to become Learning Centers

One health facility (Basic Health Center-BHC, Comprehensive Health Center-CHC; or District Hospital-DH) was selected from each grantee NGO working in Kabul Province (STEP, BRAC, International Medical Corps-IMC, Care for Afghan Families-CAF) using the following criteria:

- The HF should be accessible in all seasons (as this work was to be done over the winter months)
- The surrounding catchment area should have trained and active Community Health Workers (CHW) serving supportive communities

Also implementation of the Catchment Area Annual Census (CAAC) was a preference for selecting a HF to be a LC. Ideally, the HF manager should have received training in the FFSDP and the HF should be implementing an improvement cycle of FFSDP.

Composition of the TA team

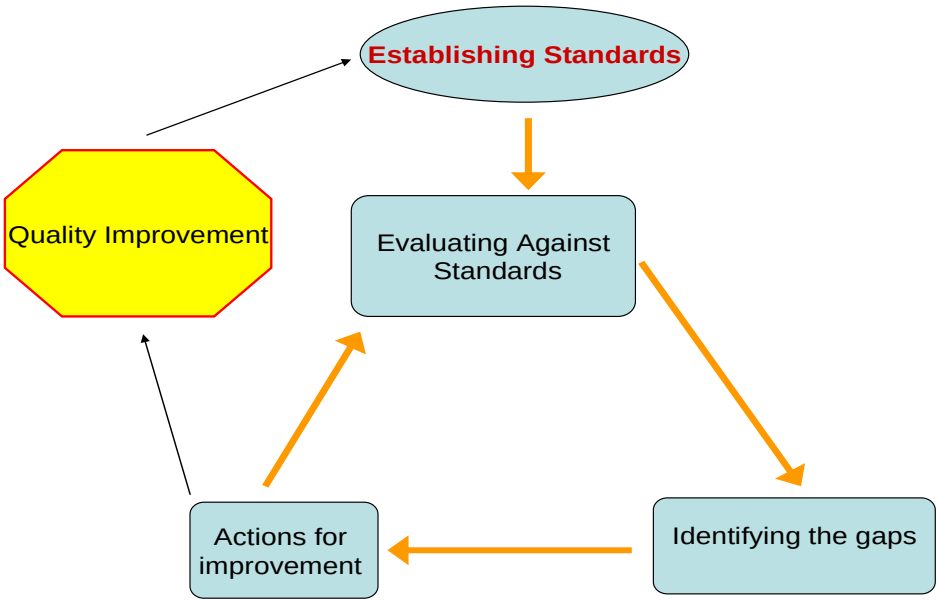
One technical staff member from the Provincial Support and Strengthening unit of REACH was assigned to each of the four selected NGOs to serve as lead focal person responsible for coordination between the NGO supervisors and technical staff from other units of REACH. Focal persons were selected from various REACH technical units to provide technical inputs for this effort. One technical staff member from the REACH Kabul/Ghazni Field Office was appointed to provide facilitation and support for each TA visit. Finally, one NGO supervisor was selected for each LC and assigned by his or her respective NGO head office to replicate the LC concept to all of that NGO's remaining HFs.

Strategic Plan

In discussion with the NGO Head Offices (HO), four HFs in Kabaul Province were selected as LCs. The REACH LC technical team reviewed the HFs' relevant documents: baseline FFSDP assessment, monitoring reports, Face to Face TA meeting reports, HMIS and Qualitative Reports of FFSDP. Following this desk review, focal persons from various sections of REACH made an initial assessment visit using the FFSDP tool to identify gaps in selected HF staff skills and knowledge. Action plans were developed based on the feedback from the initial assessment visits. Focus of the TA was given to drug management, the Health Information Management Information System, community-based health care, and information/education/communication (IEC). The duration of the work plan was from mid-November to mid-February 2006; biweekly half-day visits in the afternoons for each LC. According to the action plan, regular biweekly visits started in the 2nd to 3rd week of November. At the end of each visit the date for next visit was being decided and scheduled. Therefore a total of six bi-weekly integrated TA visits were conducted by REACH TA team members for each LC. After the last REACH TA visit, the supervisor, trainer and HMIS officer of the NGO developed their replication plans for the continuity of this process.

The following diagram illustrates the LC approach to providing TA to ensure quality improvement.

The usage of Standards for Quality Improvement



Achievements: Findings/progress at the Four Learning Centers

The following sections are organized around the challenges identified (shaded boxes) and TA provided by REACH to staff of the Learning Centers.

Health Management Information System (HMIS) Technical Assistance

Improper filling out of HMIS forms (Pictorial tally sheet, MAR, MAAR, MIAR)

The HFs had problems in properly filing out the Pictoral Tally sheet, so REACH HMIS representative presented many cases and scenarios in showing staff how to do it. CHSs, supervisors and HMIS- officers were assisted in accurately reporting each case in the pictorial tally sheet. There were many problems in properly ticking the stock out section of the MAR, MAAR, and MIAR, especially regarding the concept of ZERO/NUMBER in the MAAR for stock outs; this was explained. In addition, staff were oriented in tallying the number of families visited by CHWs and on the importance of using HF referral slips. Staff were also motivated to properly file the various HMIS monthly reports and separately file these different forms in a folder.

As needed, the BHC in-charge was shown how to keep MAR and MAAR forms in a separate file. Staff were shown how to use separators to divide MIAR, FSR reports for each quarter inside one folder. At the DH, HF staff were told to keep all the old registers and CHW pictorial referral slips in a specific cupboard in the administration office. Their pictorial Tally sheet was also updated.

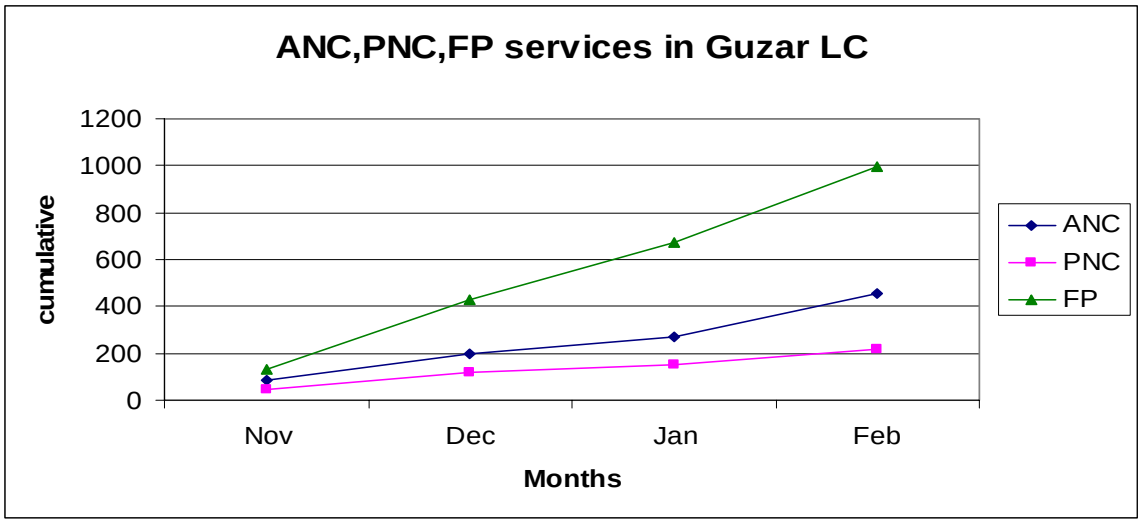
HF staff's lack of knowledge about the defining their catchment population and target group, and establishing the baseline and targets for each indicator

All four HFs' staff needed some orientation and training in data use to address identified gaps. The REACH senior HMIS officer coordinated with the HF staff and the NGO HMIS officers in conducting the training, which enabled the HF in-charges to draw their catchment area map, calculate the HF catchment area population, monitor and evaluate HF performance; plot a monitoring graph; and interpret the graphs to identify problems and opportunities and find appropriate solutions.

Midwives, vaccinators and the female doctors have no knowledge about key indicators, calculation of BPHS indicators, and proper calculation of annual and monthly targets to improve the coverage of family planning and immunization

Key health indicators were listed and HF staff were assisted in calculating each indicator and also shown how to set a target for each BPHS indicator. They were trained to make monitoring graphs for family planning and immunization to measure progress. In Guzar, Central Statistical Office and CAAC data were compared, showing a big difference in the number of pregnant women. So the staff were told about the accuracy and importance of CAAC data.

Note: The following graph shows the ante-natal care (ANC), post-natal care (PNC) and family planning (FP) achievements in Guzar LC over the 3 months of TA.

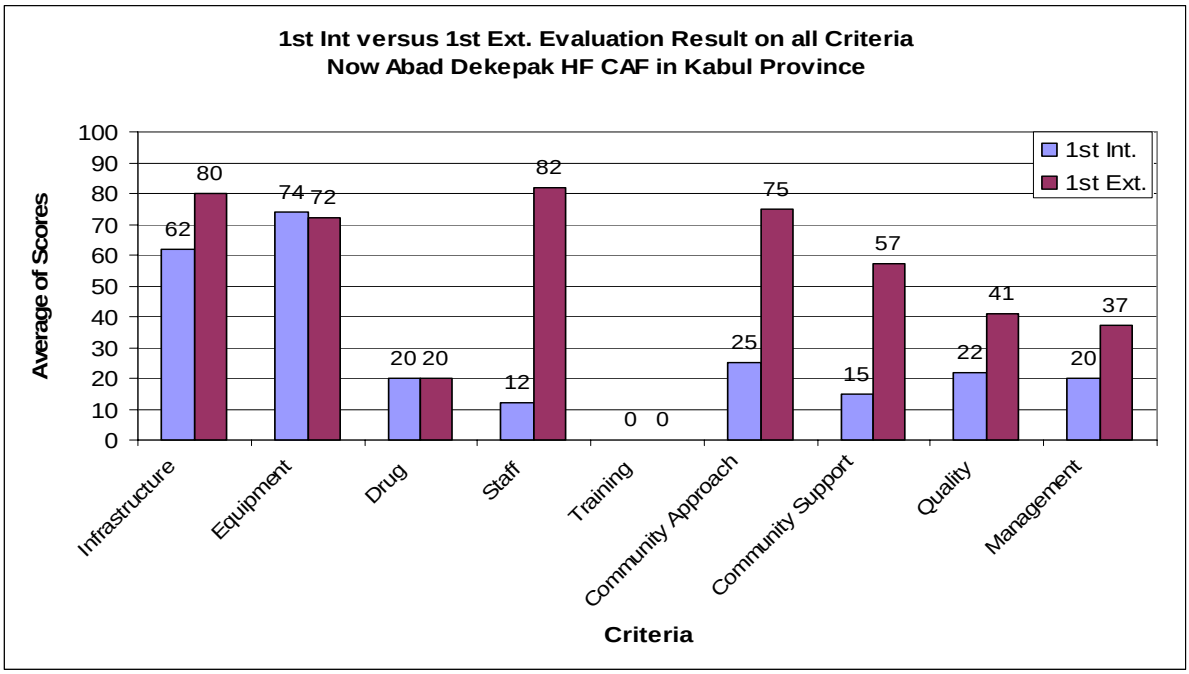


Community-based Health Care Technical Assistance

Improperly organized *shura-e-sehie* meetings and failure to keep records/minutes

The head of each HF along with the HF staff were assisted in learning how to record meetings of the local health committees and the need to supply a specific subject, the names of the participants and a proper agenda as well as in how to file the *shura-e-sehi* (health committee) meeting minutes and follow up the *shura's* decisions. In addition, HF staff were oriented in their responsibility to be supportive and to facilitate well conducted *shura* meetings. They were also coached to understand that all *shura* members should have ownership in the *shura* activities and that when any decision is made, the *shura* will be responsible for fulfilling future actions. They were also instructed in how to encourage and motivate female *shura* members, who are very effective in providing information on safe health for mothers and their children. They were also assisted in how to strengthen the coordination of male and female *shuras*.

Note: The bar chart below shows the FFSDP quality improvement cycle in one learning center by comparing the first internal assessment in August 2005 and the first external assessment on 6th March 2006, immediately following the LC intervention.



To promote family planning services, CHWs need to know more about making the community aware of these services

The TA team visited the representative of a district hospital *shurai-e-sehi* and explained the importance of community awareness about all methods of FP. Based on FFSDP support documents, they agreed upon the efficiency of conducting open door events or HF open houses for this purpose. In addition, to respond to many of their questions about FP, they were referred to several specific REACH NGO Newsletters (Numbers 16, 23, 25, and 27) containing information on the myths and realities of birth spacing. HF staff and CHWs were requested to let REACH know of any false stories and perceptions they heard about FP so that REACH can address them in the coming newsletters. All NGO supervisors were requested to share each edition of the REACH NGO newsletter with the HF staff.

Lack of a proper catchment area map and a need to properly collect and integrate health post (HP) data collected by CHWs, to better understand HMIS reporting, to better supervise CHWs and HPs and better understand the importance of establishing a good linkage and effective communication between the CHWs, communities and the HF staff

During the TA visits to the LCs, typical catchment area maps were properly drawn and explained to the HF staff who were also briefed on target groups and told how to correctly use the community map (CM) to identifying them. Three health interventions of particular focus on the community map were explained in detail: children's immunization, maternal health (ANC/PNC) and family planning, with the main emphasis on children under two years of age and women of reproductive age (WRA). The concept of "eligible

couple" (EC) was defined and explained to Community Health Supervisors (CHS) and CHWs. Confusion about the colors to be used in the map to signal the use of particular family planning methods was clarified by explaining that pills, condom, injectables, IUDs and pregnant women should be circled with yellow, green, brown, blue and red colors, respectively.

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CHSs and some CHWs were also provided TA on correctly compiling MAR/MAAR forms for the HMIS, conducting effective health education sessions and conducting coordinated planned activities to promote immunization and FP. CHSs were assisted in checking the quality of community health information. HF staff were briefed on setting up a regular linkage with their CHWs to improve their performance and coverage. In the BHC, the CHW trainer was also assisted on how to supervise Health Posts and CHWs in effectively using a checklist. REACH representatives oriented the CHW trainer in how to conduct supportive supervision as needed.

Lack of effective communication between the CHS, HF staff, NGO supervisor, the CHW, and *shuras* in order to increase demand for and utilization of BPHS priorities, especially FP and Immunization. Also, the *shuras* did not have action plans and they needed improved organizational skills and a better understanding of how to promote health services in the community.

At the Paghman CHC, REACH Community Mobilization unit TA staff successfully brainstormed with the *shura* members, CHWs, and the HF staff on the following issues:

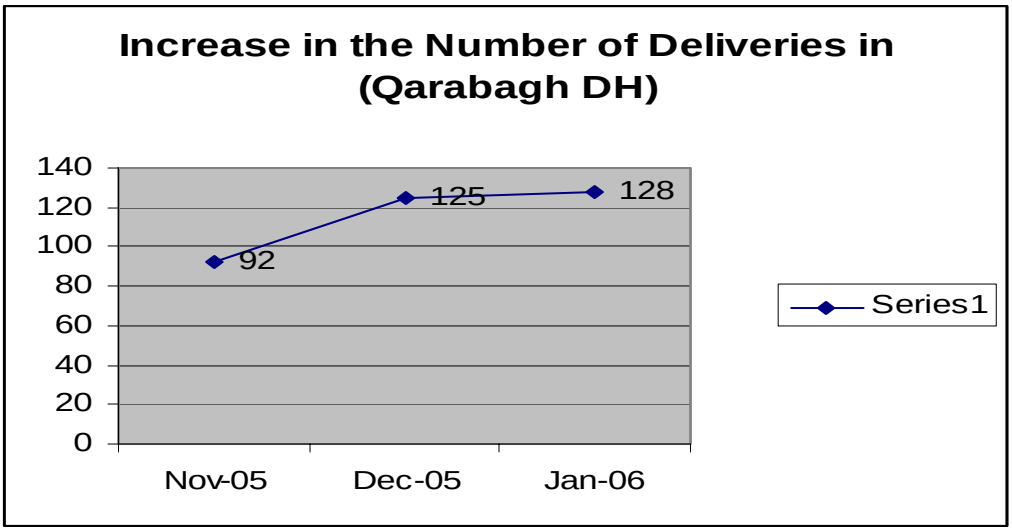
- What is the CM and how can it be used to improve health care?
- Who are the target groups on the CM?
- What are the BPHS priorities on the CM?
- How can we update our CM?

This brainstorming method was very effective and was used for all the remaining LC staff by the NGO supervisors. Now they well understand the criteria for selecting *shura* members, the ownership of the *shura*, and the secretariat role played by HF managers. HF staff were also assisted in learning how to develop an annual action plan for both facility/community *shuras*. The importance of the CM to the HF staff, the *shura-i-sehi* and the clients during health education sessions was explained. HF staff also understood that they should inform their communities that CHWs are a strong bridge between the people and the HFs. All these directions were given in detail to the HF staff.

The present *shura-e-sehi* members were oriented about effectively organizing and conducting meetings and, along with CHSs and CHWs, were provided proper TA about conducting mass mobilization activities reflecting BPHS priorities (FP and immunization). *Shura* members were briefed about community participation, community mobilization. the importance of the *shura-e-sehie* in promoting BPHS priorities, monthly meetings, decisions, and action plans. They were assisted in conducting open door events, meeting with elders about sanitation, clean water and removing the garbage, and conducting health education sessions about FP, immunization, and ANC for their community through mullahs and teachers in order to mobilize all HF BPHS target groups.

At the Qarabagh District Hospital, a REACH representative explained the importance of the annual work plan for *shura-e sehie* and was requested to help in developing an annual plan.

Note: The graph below shows the increase in the number of deliveries in Qarabagh DH over the period of the LC initiative



Drug Management Technical Assistance

Problems in understanding and recording "out-of-stock days"; lack of understanding of the stock surveillance and control system; and drug stock cards showed no evidence of inventories having been conducted

After observing drug management in the four LCs—in the stock rooms and dispensaries—the pharmacists were assisted and oriented in Drug Management in both dosage and alphabetic forms. Both the First In, First Out (FIFO) and First Expired, First Out (FEFO) systems were explained to the pharmacists. The pharmacists were not only assisted in keeping all the stock cards in one folder but were also trained in properly filling out the stock cards and shown that each row of the stock card should be used for only one movement in drug supply/consumption. For instance, in one LC (Qarabagh DH) practice enabled the pharmacists to understand the basic definition of each heading used on the stock control card (item name ,item code, shelf number, unit item, expiry date, date issued, date received, order date, stock balance). The use of the Remarks column was emphasized for recording any required explanation.

Using many examples from the FFSDP tool, the TA team showed the pharmacists how to properly record daily drug consumption on the stock control card and oriented them in conducting both random monthly inventory and quarterly physical inventory. The labels of all medicine bottles were also checked and help given if needed.

Understanding and knowing how to make orders or requisitions for essential drugs and disposable supplies based on the stock surveillance data

In all the LCs the above issues were explained and exercises in calculating minimum stock level (MSL) were practiced. At the Paghman CHC, the importance of having a buffer stock to respond to emergencies, such as an outbreak, winterization, or an emergency at a HF at another location, was explained. Buffer stock differs by 10-25% according to the geographic area and the winter season. All LCs were oriented to avoid any probable stock-out days.

One of the pharmacists (Dehkepak CHC) was receiving the medicine on a monthly kit basis and so was not making requests based on counting his MSL (minimum stock level). Because the main office was not using the MSL concept in accepting his requests, the supervisor was oriented and encouraged to follow the issue up with the main office. Although making requisitions based on MSL was understood, the main office still prefers to provide a kit-based supply. This should be further discussed with the NGO head office.

Information, Education and Communication (IEC) Technical Assistance

Lack of skills to conduct effective health education sessions with appropriate target groups

To ensure more effective health education sessions, the REACH IEC focal point provided refresher training for most of the CHWs and the LC staff on the following topics:

- The definition of IEC/Behavior Change Communication (BCC)
- IEC/BCC materials made available by REACH
- Distribution plan (selected target groups) and guidelines for use of IEC/BCC materials
- Conducting an effective health education session

The staff were oriented in the different types of REACH IEC/BCC materials and their proper use: Cloth flipcharts are to be used by CHWs during large gatherings to disseminate information and improve the awareness of the population; flipcharts are to be used by CHWs during home visits and by Health Providers during counseling to discuss thoroughly the problems and barriers preventing the population from adopting the suggested behaviors; the large posters are to be displayed in health centers and public places as a reminder of the key messages; and, finally, the small posters are to be displayed in homes and the community to ensure the presence of key messages in the daily lives of the population and to reinforce the messages given by health workers, which helps them adopt the suggested behavior.

They were also updated about the distribution of each type of IEC/BCC material, as listed below:

- Cloth flip chart and flip card: one for each HP and HF

- Large posters distributed according to the population and HF type: 1 per 500 persons, 2 per BHC, 3 per CHC, and 5 per district hospital
- Small posters: one to every 5 families.

They were also briefed in selecting the target groups for IEC/BCC efforts (considering their knowledge level, age, gender and the community need). To conduct effective health education sessions, they were also assisted in 1) developing a lesson plan, including an introduction, motivation, development of the main topic, evaluation and summary, 2) showing respect for the culture, 3) practicing time management, 4) how to do practical work, and 5) developing good interpersonal communication skills between the educator and participans and good communication methods.

Management and Quality TA

Not properly making and following up on the leadership development program (LDP) challenge model by service delivery point (HF, CHW and *shura* members)

A joint team comprised of the Kabul Provincial Public Health Director (PPHD), the REACH PSS Program Manager, REACH LDP focal person and other REACH colleagues visited Qarabagh DH to find out about the hospital's follow up of their leadership development training During that visit, hospital staff and *shura* members were updated about the LDP (as below) and were asked about their progress in this regard:

- LDP is a new approach to identify problems, accept them as challenges, and find the ways and methods to solve them.
- It is really important to have community support to successfully implement the program; without community support it would be difficult to achieve our measurable objectives, especially utilization of local resources.
- Examples of challenges in Egypt, similar to those in Afghanistan, and their solutions were used. Emphasis was placed on having a strong team committed to working together.

The DH LDP focal point was motivated and some suggestions were made on using community mobilization to better achieve their established FP targets.

The very low numbers of deliveries in Dehkepak CHC was a particular challenge. Staff were assisted in establishing a shared vision and in determining measurable results for the HF. The team identified the root causes and prioritized their actions. In the action plan, indicators were set for measuring the progress toward their objectives on a monthly basis. *Shura-e-sehie* members were assisted to convene open door events for the first time at the HF to motivate people to use clinic services included safer deliveries.

Guzar BHC had already made a FP challenge model, which was reviewed in order to determine staff knowledge and understanding. During the visit, the midwife had a very clear understanding of the challenge model and was able to share it with the female *shura* members. They were taught how to give directions to all those who are involved in FP coverage. Now all are more determined to achieve their objectives. At the January joint male/female shura meeting, the HF in-charge and the midwife shared the challenge

model for community mobilization to increase community awareness about the benefits of FP.

Lack of skills to analyze the findings following patient satisfaction assessment interviews or discussions; assisting the HF to maintain a proper register book for all the patients referred to a higher level of facility

The NGO and HF staff were assisted and motivated to regularly update and conduct exit interviews with their clients, according to FFSDP, in order to determine the level of the patient satisfaction with quality service delivery. These interviews are done either with individual clients or in focus groups of several clients. LC staff were shown how to analyze the data collected from these interviews and prepare documents for display or circulation to all staff so that they are aware of the results and relevant solutions can be found to client dissatisfaction.

At one LC, records of patients referred to higher level facilities did not exist. During the LC TA staff were coached about the importance of having both a referrals register and records for all deaths occurring in the HF. The monthly mortality analysis was explained so they can act to address preventable deaths at the HF and community level.

Lack of CHW MONTHLY PERFORMANCE REVIEW sheet in the CHC to verify that actions are being taken to increase the proportion of CHW's taking part in different activities (immunization; FP; referrals to the HF for ANC, deliveries and PNC; and transport for clients)

The CHW, CHS and HF in-charges were oriented to the concept of CBHC, community participation and the importance of a useful linkage between HF and HP for better community-based health care services. They were also assisted through question and answer sessions and discussion on how to draw community maps including identifying target groups and using the proper signs and symbols for BPHS activities to show different health activities and household visits.

The in-charges of the HFs were motivated to make and regularly update the CHW situation sheet (CHW performance review) per their communities and specifically to identify those CHWs who are not properly submitting reports for the HMIS or are not properly promoting health activities in the community, especially immunization, good infant feeding practices, FP, ANC, and emergency transport in their communities. In-charges and CHSs were also oriented about how to take further steps to improve the performance of those CHWs who are not performing the above activities.

Not reviewing the maternal and early neonatal death analysis (from MAR) with the CHWs in monthly meetings; addressing the need for availability of all clinical guidelines for each area of the BPHS according to the relevant FFSDP criteria (8-4a)

It was explained that all known maternal and early neonatal deaths in the community reported by CHW's in the MAR forms (HMIS) should be analyzed and reviewed at the monthly meetings with CHWs in order to identify preventable causes of death. Relevant health facility staff were assisted in undertaking these reviews. They were also assisted

to understand the proper actions to to be taken to address the causes of preventable deaths at the health facility and in the community.

Conclusions

The REACH LC Initiative was planned to achieve visible and sustainable improvements at the targeted health facilities. It was also designed and expected to establish these health facilities as Learning Centers whose staff would be capable of replicating the technical assistance they received and providing it to the staff of other clinics.

As models of successful performance, the Learning Center HFs and their staff as well as their associated *shuras* and CHWs will prove valuable resources for NGOs, enabling continued and sustained capacity building at other health facilities throughout the country into the future.

Leadership development training of the HF staff and the supervisors of the HF took place at the same time that the technical team visits were taking place, adding to a shared vision among all the staff and instilling a changed perspective of themselves: from service providers to leaders.

On March 7, 2006, at the end of the LC initiative, four Learning Center staff along with their NGO supervisors gave a one-hour presentation for all REACH technical staff. They stated clearly that even if they do not receive additional and similar integrated and structured TA from REACH, the various members of their HF staff are now able to do peer mentoring staffs for the remaining HFs in Kabul and then nationally.

Recommendations from NGOs regarding the Learning Center Initiative

- If the Learning Center idea had been used at the beginning of the project, BPHS of the required quality would have been more effectively implemented.
- Providing TA to a model HF staff so they can mentor peers at similar HFs is an effective way to improve service delivery.
- All the NGO supervisors appreciated this kind of TA and are happy to expand it to all REACH and non-REACH supported HFs and to implement it in all HFs.
- Some of the REACH focal points need to strengthen their facilitation skills in providing proper TA.

> "Continuation of the REACH grant is essential for implementing our replication plan in 13 HFs of Kabul as well as at the national level"
>
> CAF representative who participated in LC Initiative

Appendices

1. Baseline Qualitative Report: Analysis of Findings
2. Work plan for each Learning center.
3. LC mile stones
4. A sample of LDP (challenge model used in LC)
5. LC progress sheet

Annex 1: Baseline Qualitative Report: Analysis of Findings

The Fully functional Service Delivery Point (FFSDP) is a standards-based quality improvement tool being used in Afghanistan at the health facility level. This tool has 9 criteria and 103 standards. An "Evaluating guideline" and "Supportive guidelines" are provided as part of the FFSDP package to provide guidance in implementing quality improvement cycles. During the initial LC assessment visits, this tool was used to identify the following gaps in skills and knowledge at each LC. To address the gaps, the REACH LC team made 3-month action plans for each LC.

Gaps Identified in Skills and Knowledge of Learning Center Staff			
Health Management Information System	**Communiy-based Health Care**	**Drug Management**	**Information, Education and Communication**
• The HF staff do not know the population of their catchment area and its definition; they also lack knowledge about the baseline and targets established for each indicator • Nurses, midwives and vaccinators have not had any HMIS training • HF staff need data use training and instruction on calculation of annual and monthly targets for each indicator. • Midwives, vaccinators and the female/male doctors have no knowledge about key indicators • Not all health workers know how to calculate BPHS indicators • HF staff does not know how to share information appropriately among themselves and with the CHWs and the Shura-e-Sihies • Limited knowledge and understanding of the HF staff to generate monitoring graphs for each BPHS service; graphs	• A regular supervision system and consistent support to all HPs are not in place • Lack of organizational skills. Better orientation and understanding of the health services for the community and the shuras is needed. • Poor involvement of the community and the Shuras • At the Qarabagh DH open door events only government officials and Maliks have visited the facility; the community has not been informed or asked to take part. • The Dehkepak CHC has only a male Shura for the HF. None of the health facility-based Shuras have an action plan to implement in order to remain a functional shura. The Shura members need to develop a sense of ownership of the health activities based on identified needs and priorities.	• The pharmacist has a problem filling out the stock cards. All the medicine in the pharmacy had stock cards but there were some problems in filing of boxes and binders. • Needs a better understanding of the stock control card and ordering system. • Problems on recording out-of-stock days, especially in reporting them on the stock control cards. • Problem in using the Minimum Stock Level. • Quarterly inventory has not been done properly. • Some medicine bottles did not have labels; the pharmacist requires some briefing about proper labeling. • The monthly physical inventory in the pharmacy and the	• CHW trainers, CHSs and the HF staff have very little knowledge on the proper use and distribution of IEC materials • Lack of knowledge and information on the availability of IEC usage guidelines • Lack of skills to conduct effective HE sessions with appropriate target groups • In the next visit, we will get more details from the CHW trainer and the CHS about their challenges in the field and will find better solutions. • No system is in place at the health facility to assess patient satisfaction with the service provided to the community. • No activities have been undertaken to improve services based on patient satisfaction data.

have been prepared, but staff cannot interpret them properly; furthermore, the graphs are not up to date and have been prepared quarterly rather than monthly. • No knowledge of CAAC and how to conduct it • Not able to create a proper HMIS filing system • No proper catchment area map	• No exchange of basic health information or basic community health data by the CHWs. • Lack of skills by CHWs to perform co-coordinated planned activities with the communities and HFs. • CHWs are not providing injectable contraceptives and need some refresher training to start this activity. • Community Leadership needs: Reorganization of Community Health Shuras; Monthly meetings; Development and implementation of annual and monthly action plans; outcomes of these action plans and oversight of the implementation of action plans and CHW performance; and use of community maps for improving Health Status.	reporting of stock outs in the stock cards has not been done regularly. More orientation is needed. • The drugs (ED) were mixed with the commodities and other materials; proper separation of the ED (Essential Drugs) from other types of drugs, commodities, etc. is needed.	• There is no Register book or file at the health facility in which all referrals of patients to a higher level of facility is recorded. • There is no record (book or file) of all deaths that occur at the health facility

Annex 2: An Example of a LC Workplan for TA in HMIS

(Similar work plans were made for each TA area--CBHC, IEC, Drug Management, and Management and Quality)

Work Plan for the Techncial Team Support (HMIS)

Date: 20/11/05 **Technical staff : Dr Roshan**
HF : Dehkepak **ID : 156**
Supported by: CAF
TA recipients : HF incharge, Nurses, Midwifes, CHS and CHWs
(CAF Supervisor and HMIS officer)

Objective: To enable the HF staff to have the a proper understanding from HMIS forms and set up their HMIS filling system; know their annual and monthly targets, catchment population, and key indicators; develop monitoring graphs; and share the information with other departments

		V1	V2	V3	V4	V5	V6	
Defined Gaps / Skills	**Tasks for Technical Support**							**Remarks**
HMIS filing system is not properly in place	Ability to fill out and to maintain a proper HMIS filing system							
The HF staff do not have knowledge about their catchment area population and its definition; there is lack of knowledge about the baseline and targets established for each indicator	Basic understanding and knowledge and use of HMIS and BHHS.							
Nurses, midwifes and the vaccinators did not have any HMIS training	Understand and know the BPHS indicators and target groups							

MW, vaccinators and the female doctor has no knowledge about key indicators and about the calculation of BPHS indicators	To orient these staff about the importance of the use of HMIS data, especially for monitoring and planning in FP, immunization, ANC and PNC.							
HF staff do not know how to share information appropriately among themselves and with the CHWs and the *shuras*	Develop an ability to define and calculate target groups within each catchment area and an understanding about the source and how to use relevant and appropriate population figures (CAAC/BHHS/CSO for the HF staff and CM for the CHWs)							
Limited knowledge of the HF staff about how to generate, interpret, and use up-to-date monthly monitoring graphs for each BPHS service,	Know how to develop a catchments area map with the target groups and with the name of each health provider							
No knowledge of CAAC and how to conduct it	Orientation and information on different HMIS materials.							
Little understanding and ability to calculate annual and monthly targets to improve the coverage of family planning and immunization	Obtain and use the results of the BHHS and the targets already fixed for each indicator							
HF staff have very little or no knowledge of the catchment area of the HF/HP	Understand and know how to collect information correctly from the HF and from the CHWs activities.							
Lack of ability to develop a catchment area map	Understand the appropriate data use for decision-making.							
Staff do not know how to use the data, check the quality of the data and to share the information	knowledge and ability to set annual and monthly targets							

Data use training is needed for the HF staff including the calculation of annual and monthly target for each indicator.	Develop skills to generate coverage monitoring graphs for each BPHS service, particularly on FP, EPI, ANC, PNc and deliveries							
	Ability to analyze the coverage and monitoring graph among the HF staff and the CHWs							
	Staff understand and know how to keep a record of monthly clinic attendance for each BPHS service, the BPHS indicators and target groups							
	Ability to compile MAR, MIAR data at the HF level and to check the quality of the data							
	Ability to share the HF information among HF staff, clients and communities (CHW and *shura-e-sehie)*							
	Understand and know how to control the quality of the data							

Annex 3: Milestones for TA in Drug Management
(There are similar milestones for IEC and HMIS)

Overall indicators:

1. HF correctly records 100% of the stock out days for essential drugs and supplies in MIAR and MAAR REPORTS
2. HF reduces by 50 % the stockout days for essential drugs and supplies of the HF and surrounding CHWs
3. HF and surrounding CHWs have no stock outs of their BPHS contraceptive methods

Objectives	Expected staff competency and skills	Expected results / Milestones	Recipient staff
1. To have a surveillance system that provides a continuously updated inventory of disposable supplies and essential drugs	1(a). Knows how to establish and use a system of stock control cards 1 (b). Understand and knows how to conduct a physical stock inventory	1. There is a continuously updated inventory of all essential disposable supplies and essential drugs	1. The pharmacist and/or the HF in-charge
2. To have an ordering system that allows effective planning and appropriate orderingof essential disposable supplies and essential drugs based on surveillance system	2(a) The staff knows how to keep records of the “out of stock days” on the stock control cards and on HMIS reports to 2(b) Able to calculate and the " minimum stock level” (based on the " Average Monthly Usage” and “lead time”) 2.(c) Able to appropriately use and order drugs correctly	2. A continuous adequate supply of essential disposable supplies and essential drugs	2. The pharmacist (and/or the HF in-charge)

Explanation of the methodology :

It will be helpful for the Drug Management TA team to have a copy of the FFSDP Support document on Criterion 3 : essential supplies and equipments and the BPHS Table 8.1.4 : Family Planning and table 8.2.1 EPI services.

The session should start with asking the pharmacist how he is managing the stock and ordering system for the drugs and supplies. Please let him understand that we are there to help him acquire the skills to properly manage the stock control system so that he himself understands and knows how to do it step by step and so he will be able to show others how to do it properly.

If the staff knows and understands the system let him show you how he has established it. It is good for the pharmacist to start from the very beginning. Properly and correctly filling the stock card from the item name down to the unit item. Then go through the stock card for each received and issued column and work together with the staff to see whether its been correctly filled in. Remember the expiry date is to be noted and if there is a manufactured date instead of an expiry date, ask how that is understood. If not understood, please explain about the shelf life of a drug. Please work through for a couple of cards until you are confident that staff really understand and knows how to to properly and correctly filled in the stock card.

The next step would be, to let the pharmacist do the physical stock inventory. The NGO supervisor must be able to observe and guide how the inventory should be properly done. Please observe the pharmacist in doing an inventory for 5 items of the drugs (preferably, select family planning and immunization).

It would be a motivation for the staff : If you can put up on the wall the skills that the pharmacist has learned or a list or set of skills that he needs to know and beside it a tick or a note saying ' I know how to do ----- ' etc.

Annex 4: A sample of the LEADERSHIP AND MANAGEMENT Program Rollout Plan for one LC.

Mission
The provision of quality health service delivery to all the people living in our catchment area, within the 4th districts of Dehkepak CHC.

One of the **Challenges** in Dehkepak CHC is:
Low number of deliveries in the clinic compared with the number of pregnant women in the catchemnt area.

Current situation:
We cover a population of 65,360, which include 2,287 pregnant women. Now the number of assisted deliveries is 1-2 per month done by clinic staff.

Measurable result:
We want to increase the number of deliveries at the clinic to 4-6 deliveries per month by the end of March 2005.
Root causes determination by **5 "why**s" and Fishbone system,

1. The delivery room is not acceptable with regard to the privacy for women, because the male clients pass this area as well. ------ a need for a standard delivery room----- the clinic building is not standard----- as this is a living building----we do not have funds for the building.
2. The families do not refer ------ they do not have confidence over the delivery room exclusiveness-----they are not aware of the service delivery of the clinic------ the awareness level is very low in the community ------- the health education of CHWs is weak ----- patient referral by CHWs is very low ----refresher/initial training for the CHWs is very poor.
3. Clinic is inactive at night ------ why the clinic is inactive for night time ------- why the contract with the staff/clinic is only for day work ----- why REACH can not afford night activities at the clinic ------ Due to the government current policy.

Prioritized activities:

1. Orienting all women coming for any purpose (ANC/treatment) to the clinic to visit the *Delivery Room* and see it with their own eyes.
2. Orienting *shura-e-sehie* members (facility/community) to encourage safe deliveries by female staff in the clinic.
3. Conducting an open door event by the *shura-e-sehie*, focusing on the existence of a safe delivery room with female staff.

4. Meeting with all the CHWs to foster ensuring/educating their community about the existence of delivery room with the female staff in the CHC.
5. Conducting Training (refresher/initial) for the CHW to calculate their target group in their catchment area, especially to know and follow those women, who are pregnant and try to refer them to the HF for delivery.

Leadership Development Program
Province: Kabul, district 4
Clinic: Dehkepak, CHC **Code**: 156 **Date:** 23 Dec 2005

Challenge	Current situation (baseline data)	Measurable result
Very low number of Deliveries in the CHC	Only 1-2 deliveries per month	Increasing it to 4-6 by end of March 2006

Root Causes	Priority actions
• The delivery room is not acceptable with regard to the privacy for women, because the male clients pass through this common area . • Lack of an existing standard delivery room, because the clinic building is actually a living building • Lack of budget allocation for a standard CHC building construction. • Clinic is closed at night, because the contract with the clinic/staff is only for day work • REACH can not afford night activities of the clinic, due to the government current restriction in policy for CHCs. • The families do not want to use the delivery room, as they do not have confidence over the delivery room exclusiveness from males passers by. • The community is not aware about this facility and the existence of delivery room in the clinic • The health education of CHWs is weak and the referral of pregnant women to CHC is very low by CHWs • Poor system of refresher/initial training for the CHWs of the CHC.	• Orienting all the women coming to the CHC for any purpose (ANC/treatment) should see the *Delivery Room* with their own eyes. • Orienting the facility and community level *shura-e-sehie* members to be sure for the safe deliveries by female staff in the clinic. • Conducting open door event by the *shura-e-sehie*, focusing on the existence of a safe delivery room with female staff. • Meeting and informing all the CHWs to ensure/educate their community about the existence of delivery room in the CHC with the female staff. • Conducting refresher and initial training for the CHWs in how to calculate the target group in their catchment area, especially to know and follow those women who are pregnant and try to refer them to the HF for delivery.

Work Plan: for Dehkepak CHC to increase the number of deliveries in the HF
HF/Code: 156 4th District of Kabul
Measurable result: until the end of March we want to increase deliveries in the clinic to 4-6 per month

Activities	Responsible person	Resources (Human, financial, material)	Time duration			
			December	January	February	March
• Orienting all the women coming to the clinic for any purpose; they should see the *Delivery Room* by their own eyes.	Head of the CHC/female staff		X	X	X	X
• Orienting *shura-e-sehie* members at facility/community levels understand the availability of safe deliveries by female staff in the clinic.	CHS/Head of the CHC		X		X	
• Conducting open door event by the *shura-e-sehie*, focusing on the existence of a safe delivery room with female staff.	HF Shura-e-Sehi/in charge of CHC			X		
• Meeting and informing all the CHWs to ensure and educate their community about the existence of a delivery room in the CHC with the female staff.	CHS/CHW trainer		X	X	X	
• Conducting Training (refresher/initial) for the CHWs in how to calculate the target group in their catchment area, especially to know and follow those women who are pregnant and try to refer them to the HF for delivery.	CHW trainer/CHS	Support for Training by CAF.		X	X	

The following indicators will be followed and reported monthly to REACH/CAF focal points.

- # of women visiting the delivery room of the HF.
- # of *shura-e-sahie* members meeting with the people about safe delivery room in the HF.
- # of CHWs receiving refresher training.
- # of women receiving health education (focus on referring pregnant women to the CHC) after CHWs are oriented.

Annex 5: LC Progress Sheet: Updated after each TA visit

Progress in HMIS knowledge, skills and competency

Done	
under process	
Already known	

HMIS	BRAC	STEP	CAF	IMC
Skills and Knowledge attained	**Third visit**	**Second visit**	**Third visit**	**third visit**
The HF staff and supervisor know how to develop a catchment area map	Done	Done	Done	Done
The HF staff and supervisor know how to calculate the BPHS target groups within the HF catchment area using either the BHHS, CSO or CAAC	**Fourth visit**	**Fourth visit**	**Third visit**	**third visit**
	Done	Done	Done	Done
The HF staff and supervsior knows how to use data to calculate annual and monthly goals for BPHS services	**Fourth visit**	**Fourth visit**		**third visit**
	Done	Done		Done
The HF staff and supervsior knows how to use fill in, analyze and use a monitoring coverage graph for FP and Immunization services	**Fourth visit**	**Fourth visit**		
	Done	Done		

Progress in Drug Management Knowledge, Skills and Competency

DM	BRAC	STEP	CAF	IMC
Skills and Knowledge attained The Pharmacist (and / or the HF in charge) is able to establish and use a system of stock control cards	**Second visit** Done	**Already known** Initial visit	**First visit** Done	**Second visit** Done
The Pharmacist (and / or the HF in charge) is able to conduct a physical stock inventory properly and regularly	**Second visit** Done	**Already known** **Initial visit**		**Second visit** Done
The Pharmacist (and / or the HF in charge) knows how to keep record of the out of stock days on the stock control cards and HMIS reports	**Fourth visit** Done	**Already known** **Initial visit**	**First visit** Done	**Fourth visit** Done
The Pharmacist (and / or the HF in charge) is able to calculate the minimum stock level (based on average monthly usage and lead time) and to correctly conduct an ordering system	**Third visit** Done	**Fifth visit**	**First visit** Done	**Fourth visit** Done

Progress in IEC Knowledge, Skills and Competency

IEC	BRAC	STEP	CAF	IMC
	Second visit	**Fifth visit**	**Second visit**	**Second visit**
Skills and Knowledge attained HF staff is able to understand and know how to conduct HE sessions using IEC materials	Done		Done	Done
The HF staff is able to use the appropriate IEC materials and methods to guide people towards safe and healthy practices		**Fifth visit**		**Second visit** Done
The HF staff and CHWs is able to recognize, understand and develop effective communication and linkages to optimize client visits		**Fifth visit**		**Fourth visit** Done

Progress in CBHC Knowledge, Skills and Competency

CBHC	BRAC	STEP	CAF	IMC
The CHS/CHWs are able to conduct community mapping correctly and identify BPHS target groups	**Second visit** Done	**Second visit** Done	**Third visit** Done	
The CHS and in-charge are able to set up a regular monthly meeting with CHWs and *shura-e-sehie*			**Third visit** Done	**Second visit** Done
The *shura-e-sihies* understand fully the priorities of BPHS and know their role in the CBHC approach			**Third visit** Done	
The *shura* members know how to plan for conducting mass mobilization activities reflecting BPHS priorities			**Third visit** Done	