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The Fully Functional Service Delivery Point in Afghanistan: Results of First Six-Month Improvement Cycle

January 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 | Cachment 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 Communications |
| 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

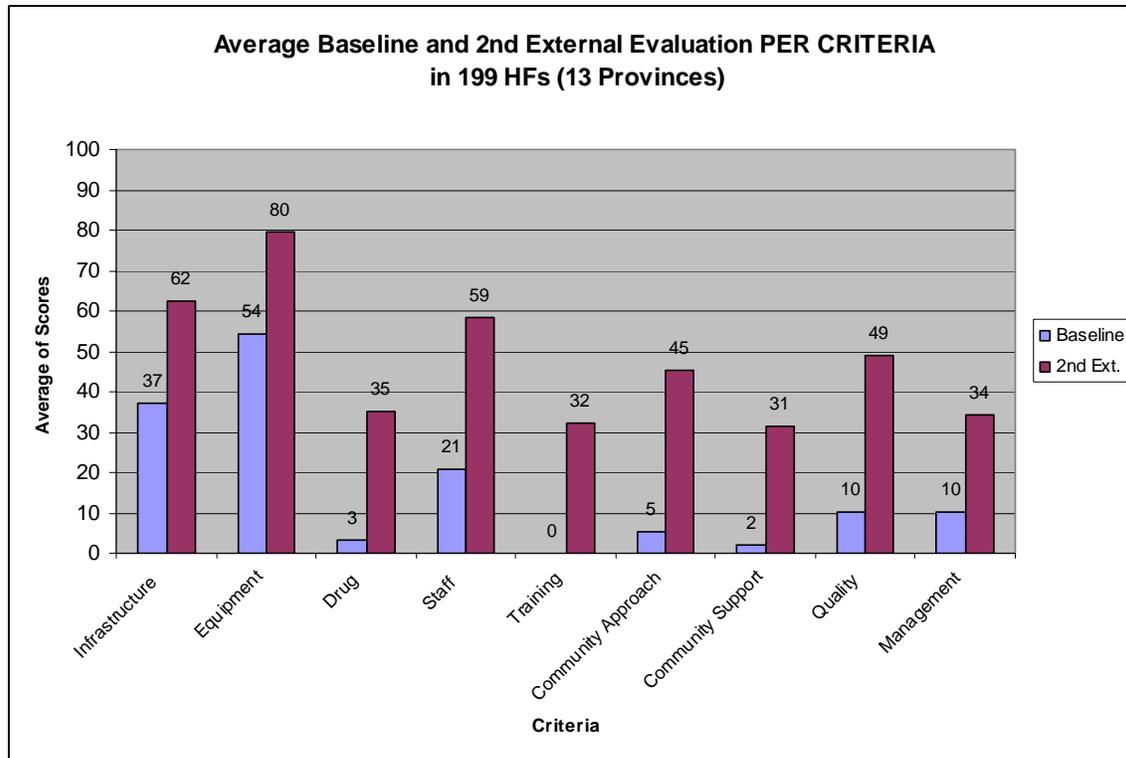
In February 2005, REACH introduced the Fully Functional Service Delivery Point (FFSDP) methodology (tool) in 14 REACH-supported provinces of Afghanistan. This tool is designed to encourage behavior change on the part of medical staff at the clinic level, who are very clinically and curatively oriented 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 second external evaluation conducted between August and December 2005, six-months after the baseline evaluation, allowing for a full six-months improvement cycle. The second external evaluation was conducted in 13 REACH-supported provinces in 199 health facilities out of the 213 evaluated with a baseline¹. Of these 199 BPHS health facilities, 107 are Basic Health Centers (BHC), 82 are Comprehensive Health Centers (CHC) and 10 are District Hospitals (DH).

The FFSDP implementation framework, containing several mechanisms to manage the FFSDP process in each province involved the NGO headquarters, supervisors, health facility staff, REACH Field Office staff, PPHOs and PPHCC members.

The general results of the second external evaluation compared to the results of the baseline conducted in the same health facilities six months earlier show important improvements as shown in the figure which follows.

¹ Baseline evaluations of 7 health facilities in Ghor province were conducted in October 2005, therefore the second external evaluation has not yet been conducted. A second external evaluation could not be conducted in 7 other facilities (3 due to security in Ghazni and Paktika, 3 due to weather in Badakhshan, and 1 due to the late relocation of one facility in Faryab)



Several recommendations and conclusions are drawn from the analysis of the first 6 month improvement cycle:

- 1) Despite the many improvements seen at the end of the first FFSDP cycle, there is still ample space for enhanced quality and sustained behavior change. Also the MOPH has demonstrated interest in implementing the FFSDP methodology in non-REACH supported provinces. For these two reasons, it is recommended not to revise the tool to add more sophisticated standards of quality for the time being.
- 2) The results of the second external evaluation confirmed the insufficient replication at the health facility level of the technical assistance (TA) provided by REACH to managers and supervisors of the NGOs. The experience shows that it is important to guide the managers and supervisors on how to deliver the appropriate on-the-job-training to the health facility staff, particularly in data use.
- 3) The Health Management Information System (HMIS) Task Force and the Monitoring and Evaluation Advisory Board of the MOPH should develop a national individual patient record card and guidelines for use to facilitate the delivery of integrated health care at the health facility level to reduce the number of missed opportunities to integrate services during a client visit. Only 5% of the 199 health facilities have a systematic integrated health care delivery system in place.

The NGO partners have proven through the FFSDP that they are committed to and capable of improving the quality of their services. Although many challenges remain in delivering quality services, the results of the second external evaluation show a slow but continuous improvement in deployment of community midwives, particularly at the BHC sites. This finding argues for the continuation, and maybe an acceleration, of the community midwives training program. The increase from 0% in the baseline to 27% of the *Shura-e-Sihies'*, which have of one-third or more female members supports the REACH strategy of promoting more female participation in these oversight bodies.

In order to continue quality improvements, the NGO grantees need to strengthen a regular and effective supervision system in the health facilities and for CHWs. Using the same FFSDP tool, the Provincial MOPH authorities and the stakeholders of the PPHCC are enabled to play their role of monitoring the quality of the services at the provincial level.

The fact that the greatest improvements registered by this FFSDP experience are related to the implementation of an effective Community-Based Health Care approach is extremely promising. With the creation of an increased demand for services from the population, the health service delivery system in Afghanistan may well become fully integrated in the civil society.

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) to address the health of women of reproductive age and of 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 programs – Access to Quality Services (AQS), Ministry of Public Health (MOPH) Capacity Building, Provincial Support and Strengthening (PSS), Social Marketing (SMR) and Training and Education (T&E) – conduct activities designed to foster the 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, provincial, and district levels. Through its grants program, REACH supports 19 nongovernmental organizations (NGO) to provide the BPHS in 14 provinces throughout Afghanistan.

REACH has introduced the Fully Functional Service Delivery Point (FFSDP) methodology (tool) in Afghanistan to encourage behavior change on the part of medical staff at the clinic level, who are very 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 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.

NGO and MOPH clinical and managerial staff has 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.

Changing the behavior of facility staff takes time. Behavior change requires sustained support before the changes can be integrated into day-to-day practice. 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 FFSDP baseline evaluation was conducted in 213 BPHS Health facilities out of the 220 BPHS Health facilities run by Round 1 and 2 grantees in the 14 REACH-supported provinces².

² Refer to October 2005 Report: "The Fully Functional Service Delivery Point: A Baseline Evaluation"

By the end of December 2005 a total of 257 persons have been trained as facilitators to introduce FFSDP standards of quality in the health facilities. Of these, 194 are NGO staff, 12 are central level Ministry of Public Health (MOPH) staff, 20 provincial level MOPH staff and 31 are REACH program staff.

Introduction

The present report is based on the results of the FFSDP second external evaluation conducted between August and December 2005, six-months after the baseline evaluation was conducted allowing for a full six-months improvement cycle. The results are based on the second external evaluation conducted in 13 provinces in 199 health facilities out of the 213 evaluated with a baseline³.

Of these 199 BPHS health facilities 107 are Basic Health Centers (BHCs), 82 are Comprehensive Health Centers (CHCs) and 10 are District Hospitals (DH).

Performance of the Implementation Framework

During this first six-month performance cycle, an implementation framework containing several mechanisms to manage the FFSDP process has been functioning:

1. REACH has performed two **external evaluations**, the baseline evaluation and a second evaluation at the end of the cycle. Between these two external evaluations, the NGOs are advised to perform two formal **internal evaluations** (self-assessment) also during this period the NGOs conduct ongoing supervision, making visits to assist the clinic staff in introducing necessary changes and to monitor progress. Ten NGOs in 4 provinces performed the 2 formal internal evaluations. Nine NGO grantees in 6 provinces performed only one formal internal evaluation. Four NGOs in 3 provinces performed none.
2. Following each external evaluation, each NGO develops a **workplan** for the next six months improvement cycle. The workplan specifies the concrete corrective actions identified as necessary during the last external evaluation; it also names the person(s) responsible for taking the corrective action (clinic staff, NGO manager, and REACH staff). All NGO grantees developed a 6-month workplan based on the findings of the baseline evaluation
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. The field staff also prepares summary reports of the results to inform the Provincial Public Health Coordination

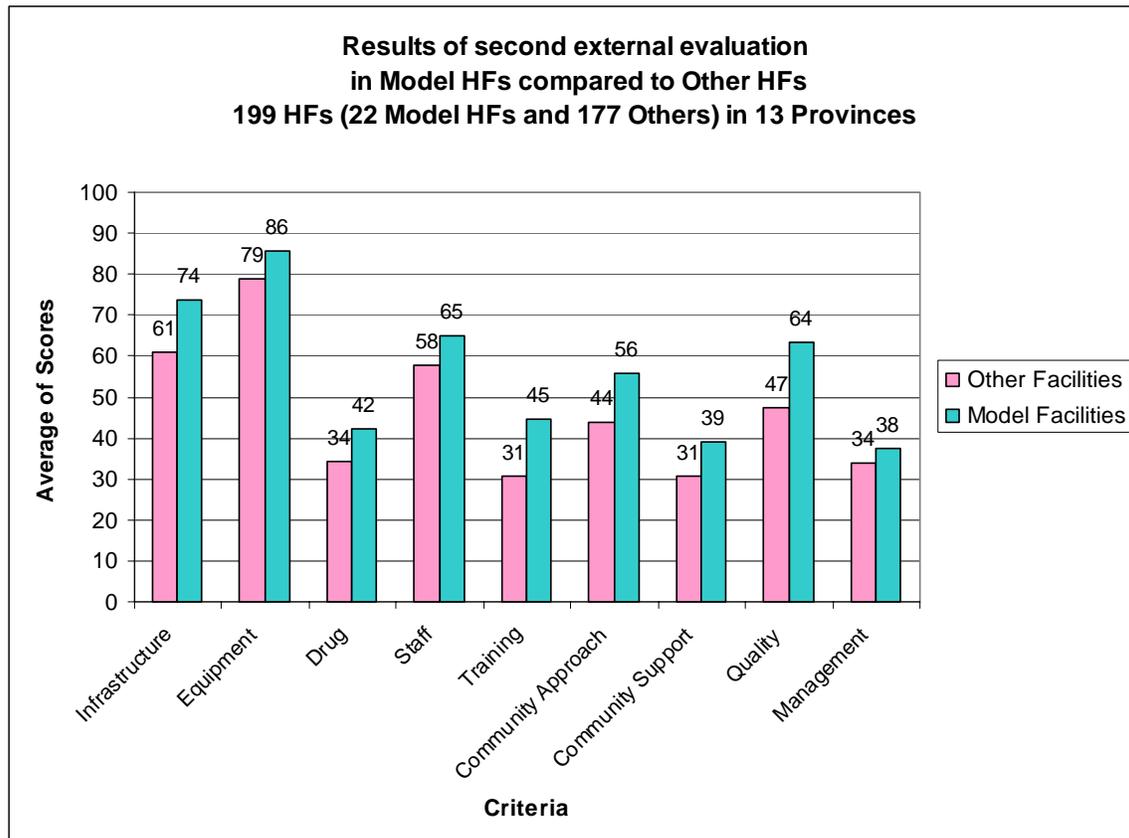
³ Baseline evaluation of 7 health facilities in Ghor province was conducted in October 2005, therefore the second external evaluation has not yet been conducted. Second external evaluation could not be conducted in 7 other facilities (3 due to security in Ghazni and Paktika, 3 due to weather in Badakhshan and 1 due to late relocation in Faryab)

Committee (PPHCC) members of progress made. These provincial FFSDP Support Committees have been established in each REACH-supported province and are meeting each month. The PPHCC members are regularly informed of the progresses made in the facilities.

4. In the 13 provinces, **22 Model FFSDP Health Facilities** are provided more intensive (weekly or bi-weekly) technical assistance (TA) to accelerate the 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.

The **Figure 1** shows an accelerated improvement in each criteria in the 22 Model Health Facilities compared to the results of the second evaluation in the other 177 health facilities

Figure 1



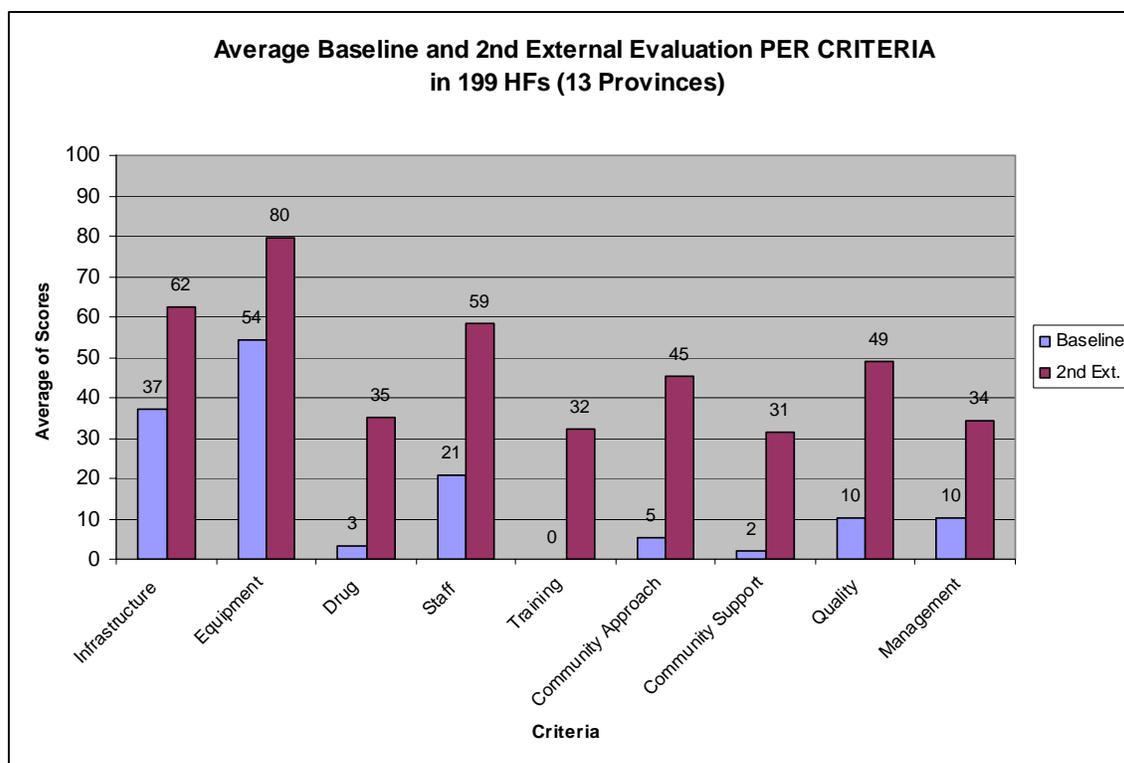
5. Through regular joint monitoring visits, the **PPHCC members monitor the quality** of improvements in the health facilities using a monitoring checklist that includes the key standards of the FFSDP tool. During the first 6-month improvement cycle, the PPHCC members including the PPHO members

improved their knowledge and understanding of the use of the FFSDP methodology, and improved their ability of monitoring the quality of services provided by the NGO grantees at the BPHS health facility level.

General comments on the results of the second external evaluation⁴

General results of the second external evaluation are shown Figure 2. These results are for 199 HF's (in 13 provinces) **by criteria** compared to the results of the baseline conducted in the same health facilities six months earlier.

Figure 2



Obviously during the six-month period the health facility staff with the support of their supervisors and headquarters have greatly improved the quality of their service delivery points. The overall trend of the improvements still follows the overall trend seen in the baseline: the standards based on availability of resources (infrastructure, equipment and staff) are less of a problem than the standards based on availability of management support systems.

However, the improvements of the health facilities in establishing closer links with the Community Health Workers (CHW) and the target group population within the facility's catchment area are quite remarkable (criteria "Community Approach" and

⁴ Results of the second external evaluation for selected standards are in Annex 1

“Quality”). It reflects primarily the great effort performed by the NGOs in training a critical mass of CHWs in all provinces. There were about 2000 CHWs at the beginning of the baseline evaluation process and there were almost 5000 CHWs trained and posted at the end of the second external evaluation process and a more systematic way for involving the Community Health Committees (now 61% of the 199 health facilities have a regular monthly meeting with the *Shura-e-Sihie*).

Compared to the baseline evaluation results, the improvement for each criterion differs on average from 24 to 40 additional aggregated scores. Besides the performance of the health facility staff in introducing quality standards, these improvements reflect the results of the new policy of MOPH in appointing a Community Health Supervisor (CHS) based at the health facility and reflect also the results of focused TA provided by REACH, particularly in:

- providing IEC material and specific guidelines for use
- providing community mapping and community leadership training to NGOs
- developing training material and providing training to Community Health Supervisors
- providing refresher training to doctors, nurses and public-health training to new medical graduates
- training midwives and community midwives
- training health facility staff in the use of HMIS and, more recently in data-use
- promoting the ability of the PPHOs and PPHCCs in monitoring the services in the province and in use of HMIS data.

This list is not exhaustive.

The criteria which improved the most (40 points) during the 6 months improvement cycle is the criterion related to the “Community Approach”. In this criterion, a) the health facility staff is seeking to identify the various health providers and their communities within the catchment area and to identify the BPHS target groups of population and b) the health team, including the CHWs, are promoting IEC activities and the organization by the *Shura-e-Sihies* (Community Health Committees) of mass mobilization to promote the BPHS priorities. This is the most striking and certainly the most promising finding of the results of the second FFSDP external evaluation. Indeed in the previous report on the results of the FFSDP baseline evaluation we wrote that “one of the most striking findings is the lack of linkages of the health facility’s activities with the community. The concept of Community-Based Health Care (CBHC) is somewhat understood intellectually (or “culturally”) by the facility staff but is not applied in a formal and effective way”. The progressive implementation of FFSDP standards serves as a guide to the health facility staff and CHWs for applying formally and effectively the various means provided to the health facility staff. Some examples, among others, include the impressive improvement in the availability of the IEC material related to the BPHS priorities in 80% of the health facilities, and their visibility and proper use in 60% of the health facilities. The role and support of the *Shura-e-Sihies* for organizing mass mobilization to promote BPHS is still weak (17% of the health facilities) but the expansion of the Community Leadership training to all NGOs during this first improvement cycle may result in

higher visible improvements of the mobilization of the *Shura-e-Sihies* in the near future. In December 2005, an assessment which focused on the community leadership was conducted and showed that in some areas the *Shura-e-Sihies* are meeting every month at the mosque.

The second most improved criteria (39 additional points) is the criteria related to “quality”. In this criteria, a) the health facility staff is monitoring and analyzing the patient satisfaction, b) the staff is ensuring adequate information is provided for any referrals, c) the staff is recording and analyzing the preventable deaths, and d) the health facility staff has the clinical guidelines related to the BPHS at their disposal. For the first time (compared to the baseline), 48% of the health facilities have introduced a system for monitoring the satisfaction of the clients from which results are analyzed in 24% of these health facilities and shared with the rest of the facility staff and used for action in 16% of the health facilities. Also 84 % of the health facilities evaluated have introduced a record system of deaths which occurred at the health facility, but only 12% of those are analyzing the maternal and neo-natal deaths which occurred in the communities served by the CHWs within the catchment area. Proper referral forms and referral registers are now present in 84% of the health facilities.

The third most improved criteria (38 additional points) is the criteria related to staffing of the health facility according to the BPHS requirements. In that criteria the staff a) are aware of and fully meeting the MOPH staffing requirement by number and type of professionals, b) are evaluated according to their performance, c) have their certification documents available, and d) maintain a proper daily record of their presence and activity. Even though progress in fully staffing the health facility remains a challenge, particularly with female staff⁵, proper job description for each staff and its certification documents are now available at the health facility site (respectively in 90% and 36% of the health facilities), as well as a proper daily record-keeping of the presence and activities of the staff (in 86% of the health facilities).

Figure 3 shows the comparative **results by province** between the baseline and second external evaluation for all criteria. The duration of the improvement cycle for all provinces was 6 months except for Badakhshan which experienced a lower level of improvement as its cycle lasted only three and a half months.

⁵ See also results of selected standards in Annex 1, section 4 on “Staff”

Figure 3

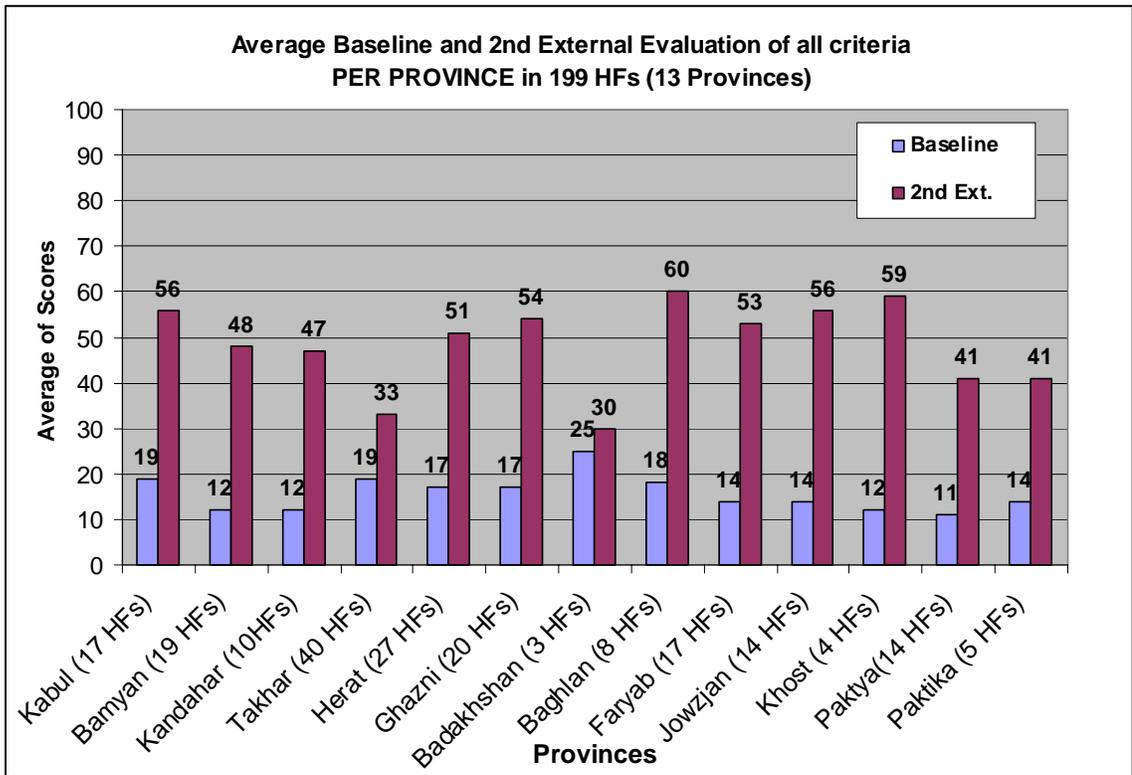


Figure 4 points out several factors which may have affected the overall results in a province, for instance the number of health facilities and the number of NGO grantees evaluated.

Figure 4

| Province | Average score improved at second evaluation | No. HFs evaluated | No. NGO grantees | Average Health Posts Per HF | First NGO Internal Assessment conducted | Second NGO Internal Assessment conducted |
|------------|---|-------------------|------------------|-----------------------------|---|--|
| Kabul | 37 | 17 | 4 | 13 | + | + |
| Bamyan | 36 | 19 | 2 | 15 | + | No |
| Kandahar | 35 | 10 | 1 | 7 | + | No |
| Takhar | 14 | 40 | 2 | 8 | + | No |
| Herat | 34 | 28 | 4 | 17 | + | + |
| Ghazni | 37 | 20 | 2 | 11 | + | + |
| Badakhshan | 5 | 3 | 2 | 8 | No | No |
| Baghlan | 42 | 8 | 1 | 17 | + | No |
| Faryab | 39 | 17 | 2 | 8 | + | + |
| Jawzjan | 42 | 14 | 2 | 12 | + | No |
| Khost | 47 | 4 | 1 | 12 | + | No |
| Paktia | 30 | 14 | 1 | 10 | No | No |
| Paktika | 27 | 5 | 1 | 7 | No | No |

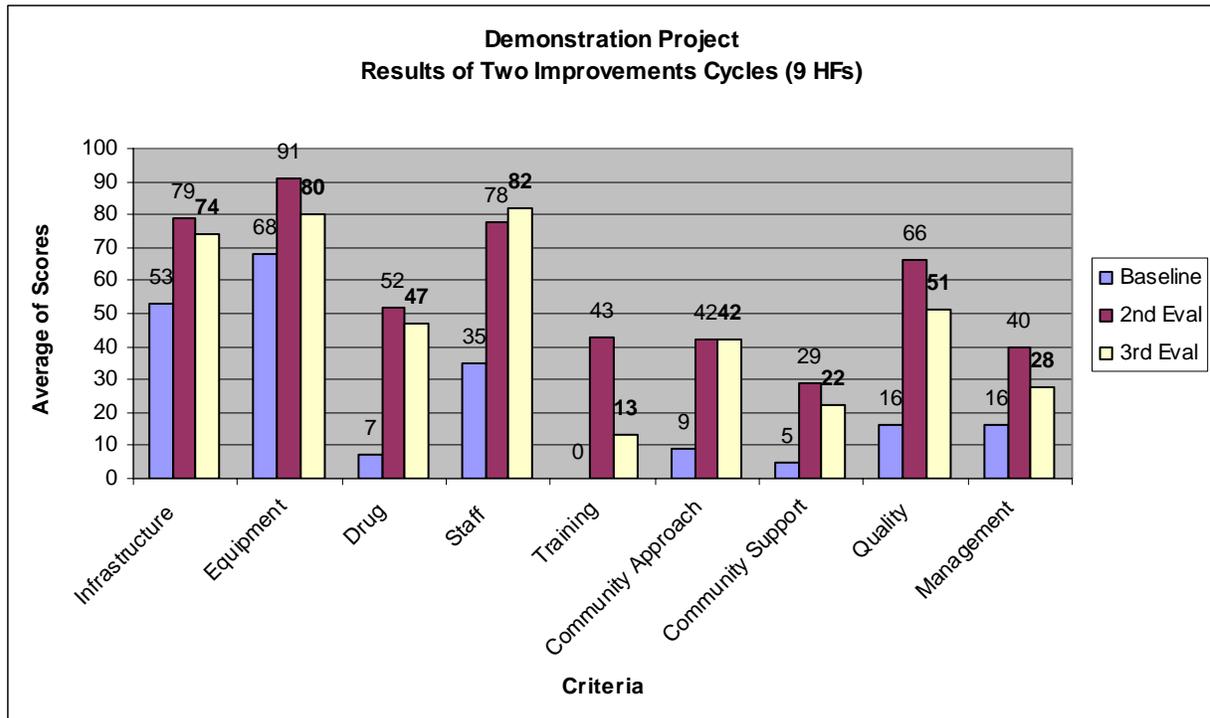
The average score improvement of all criteria between the results of the baseline evaluation and the results of the second external evaluation of the 13 provinces is 33. The provinces which did not attain this average improvement (shaded rows in figure 4) have in common a combination of similarities:

- a) A low ratio of average number of health posts per health facility
- b) NGO grantees have a weak supervision system which did not allow for one or two self-assessments of the health facilities as recommended during the 6 months improvement cycle. One of the reasons for the weak supervision system is high turn-over of the supervisors trained in the use of the FFSDP tool in several NGOs. Where this occurred, a second session of FFSDP training had to be conducted for the newly hired supervisors which delayed the implementation of the FFSDP by those new supervisors.

Behavior change of the health facility staff requires sustained support before the changes can be integrated into the day-to-day routine. Regular supervision visits and regular FFSDP self-assessment every two-three months are vitally important for sustainable changes. To this end it is interesting to note in Figure 5 the comparative results of the third external evaluation conducted in the 9 health facilities of the Demonstration Project which started in June 2004, approximately six-months before the scaling-up implementation of FFSDP in the 199 health facilities. Those 9 health

facilities have experienced **two** improvement cycles. The results of the third evaluation shows a decrease of improvement of quality in most criteria, except in two criteria (“Staff” and “Community Approach”)

Figure 5



Two main reasons may explain those results:

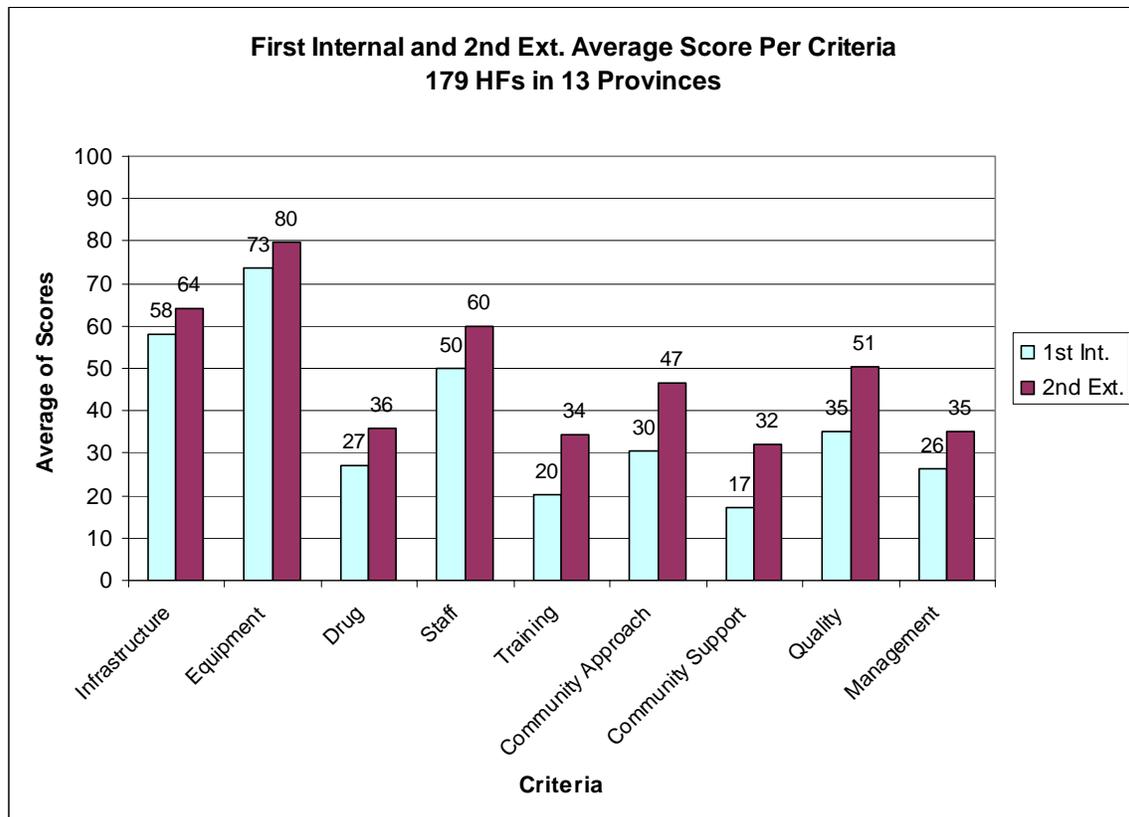
- a) Right after the second external evaluation was conducted in those 9 health facilities, the 3 NGOs participating in the Demonstration Project reduced their support to those health facilities as they were scaling up the implementation of FFSDP in all their other health facilities.
- b) There has been a drastic turn-over of all the supervisors and many female clinical staff in one of the three NGOs.

However the main reasons are mostly related to the weakness of the supervision system. Even though the sample of health facilities is small to come up with general conclusions, it may be wise to emphasize that in order to see progressive and sustained improvements in the next improvement cycles, the NGOs need to ensure a regular supervision system.

Good understanding of the scoring system and the value of the quality standards by the NGO FFSDP facilitators. The NGO FFSDP facilitators who have been formally

trained in the use of the FFSDP tool have demonstrated a good understanding of the value of the standards (particularly those related to the need for behavior changes) and in the scoring system. **Figure 6** compares the results of their first internal assessment with the results of the external evaluation conducted by the REACH FFSDP facilitators four months later. Indeed there is a potential tendency for “over” scoring the standards when their value is misinterpreted by the new FFSDP facilitators (often the supervisors); it seems that this risk has been effectively addressed in the design of the FFSDP training of NGO facilitators.

Figure 6



Some recommendations

- 1) Despite the many improvements seen at the end of the first improvement cycle, there is still ample space for improvement in many standards of quality and sustained behavior change. In addition, the MOPH has demonstrated interest in implementing the FFSDP methodology in non-REACH supported provinces. For these two reasons, it is recommended not to revise the tool and not to add more sophisticated standards of quality for the time being.
- 2) The results of the second external evaluation have once more highlighted the insufficient replication of the TA provided by REACH to managers and supervisors of the NGOs at the health facility level in some specific areas. In particular it was expected that the results of the household survey and results of the Catchment Area Annual Census (CAAC) would be shared with the health facility staff to help them in identifying the BPHS target groups in their catchment area and to fix and monitor annual targets for each BPHS service. Even though there has been some improvement in 26% of the health facilities evaluated⁶, REACH has taken two important steps to facilitate and accelerate this process:

- a) Designed and conducted a data-use training for the HMIS staff AND health facility staff of the NGO grantees.

- b) Implemented the “Learning Center” concept in several health facilities where NGO managers and supervisors learn how to deliver the appropriate on-the job-training to the health facility staff and how to replicate this experience in other health facilities.

With this additional support it is hoped that more important improvements in the standards related to data-use will be seen at the time of the third external evaluation.

- 3) 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. This would help in reducing the significant number of missed opportunities to integrate services during a client visit, particularly in immunization and family planning services. (only 5% of the 199 health facilities have a systematic integrated health care delivery system in place)

⁶ Refer to the Annex 1 “Results of the Second External Evaluation for Selected Standards”, standard 9.2 (d)

Conclusions

The NGO partners have proven in this second external evaluation exercise that they are committed to and capable of improving the quality of their services. Although, many challenges remain in delivering quality services, particularly adequate numbers of female staff and balanced female representation in the *Shura-e-Sihies*, the results of the second external evaluation show a slow but continuous improvement in staffing community midwives, particularly at the BHC sites. This finding supports a need for the continuation – and maybe acceleration- of the community midwives training program. These results also show an increase from 0% in the baseline to 27% of the *Shura-e-Sihies*' membership which is comprised of one-third or more female members supporting REACH's strategy of promoting more female members in these oversight bodies.

In order to continue quality improvements, the NGOs grantees need to strengthen a regular and effective supervision system in the health facilities and for CHWs. Using the same FFSDP tool, the Provincial MOPH authorities and the stakeholders of the PPHCC are able to play their role of monitoring the quality of the services at the provincial level.

The fact that the greatest improvements are related to the implementation of an effective Community-Based Health Care approach is extremely promising. With the creation of demand for services from the population, the health service delivery system in Afghanistan may well become integrated in the civil society.

Annex 1

Results of the Second External Evaluation for Selected Standards

The analysis of specific data, in 199 health facilities evaluated, including:

- 107 Basic Health Centers
- 82 Comprehensive Health Centers
- 10 First Referral Hospitals (also called “District Hospitals H3”)

is presented in this annex.

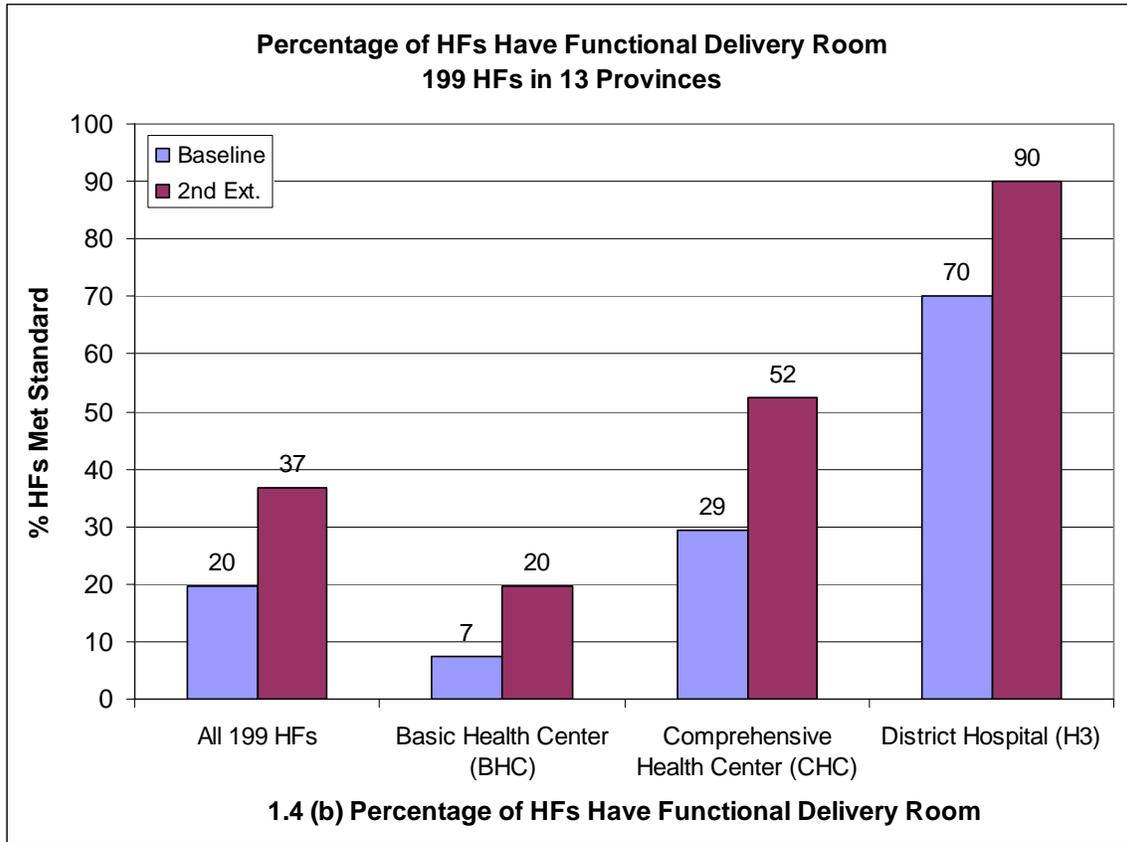
Throughout this Annex, the figures contain reference numbers, e.g. 1.4 (b) in Figure 1, which refer to the standards list numbering of the FFSDP tool.

1. Infrastructure

In general, all standards of this criterion have improved. In particular 79 % of the 199 health facilities have developed a corrective and preventive maintenance plan for the building(s) and the material and financial needs for the maintenance are identified at the health facility level in 50% of the health facilities evaluated.

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

Annex Figure 1

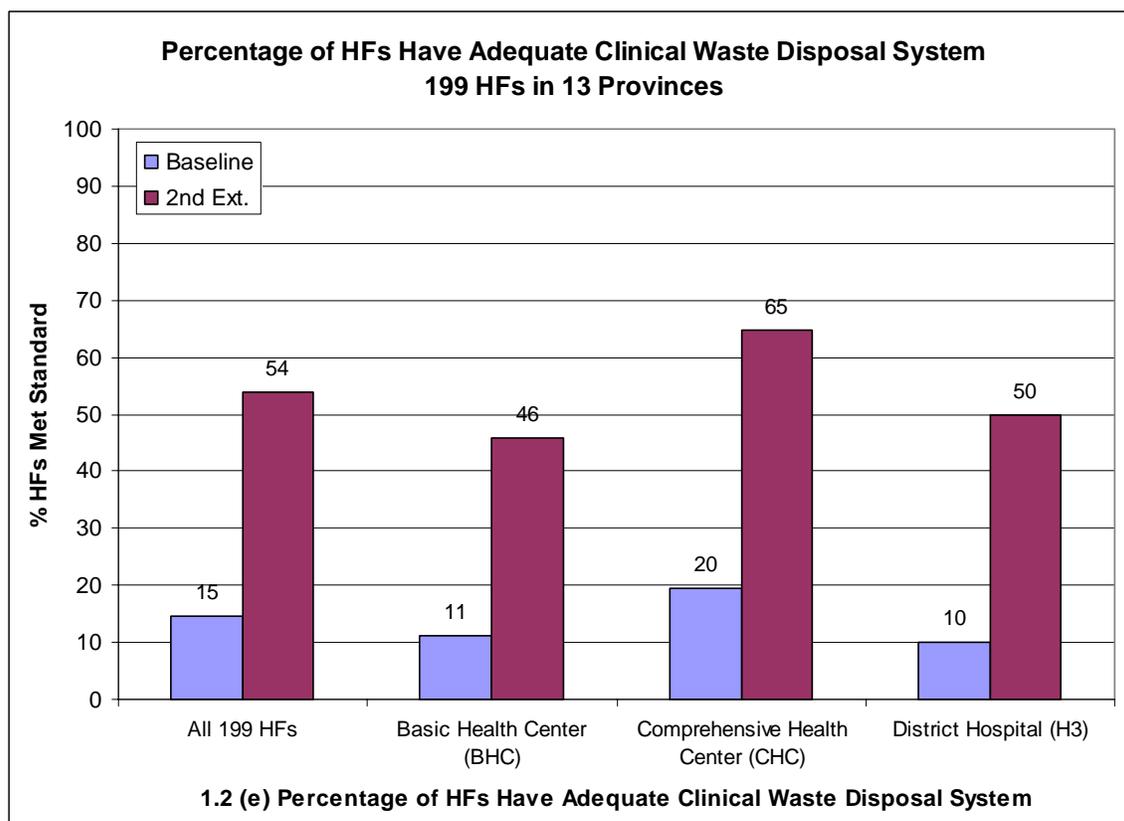


Percentage of health facilities having a functional delivery room (Annex Figure 1)

Out of 199 health facilities, 37% 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 screen able windows. (Note: an area partitioned by a curtain only is not acceptable.)”.

Of the 107 Basic Health Centers evaluated 20% have a functional delivery room. Of the 82 CHCs evaluated 52% have a functional delivery room as well as 90 % of the 10 District Hospitals.

Annex Figure 2



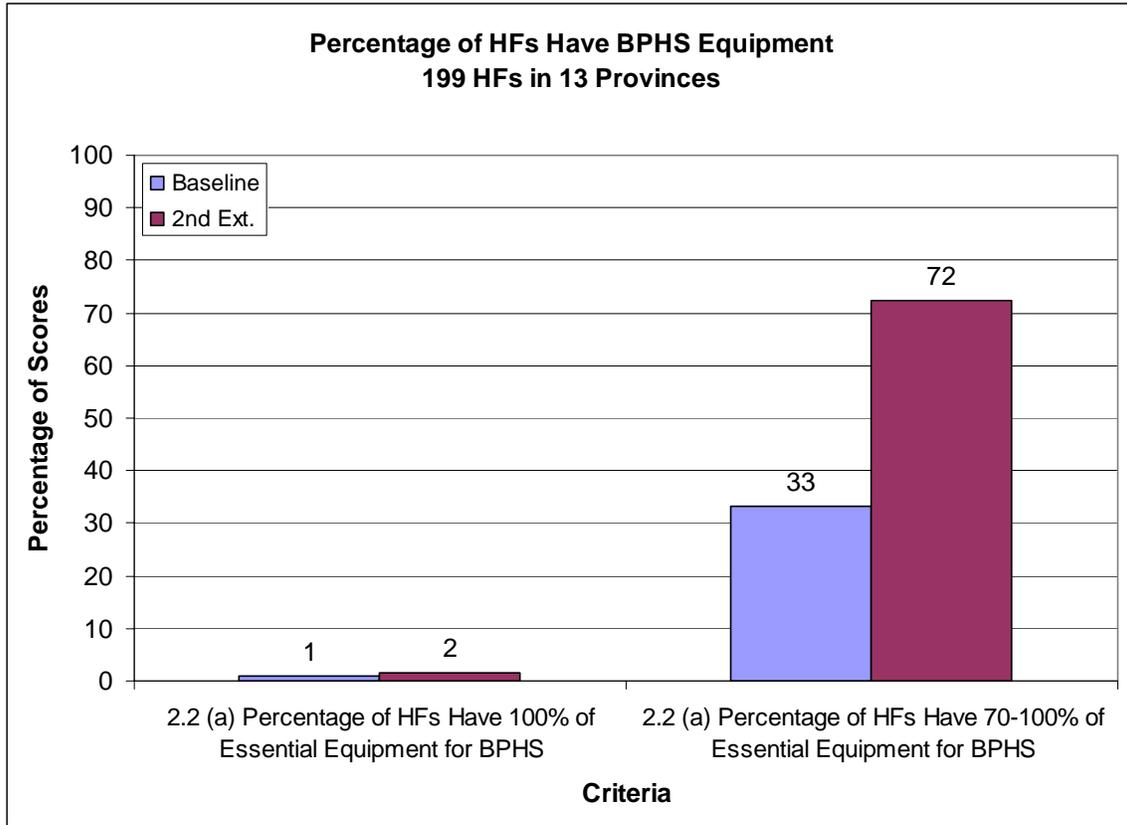
Percentage of health facilities having an adequate clinical waste disposal system

The NGO grantees have demonstrated a great interest in improving the clinical waste disposal system in their health facilities. However there is still space for improvements and one could hope that at least the remaining 5 district hospitals will complete the necessary improvements in the quality of the clinical waste disposal system at the end of the second improvement cycle (third external evaluation). Since the FFSDP baseline evaluation, the MOPH General Directorate of Curative and Diagnostic Services has finalized the “Procedures Manual for Infection Prevention and Control in Hospitals and Health Centers” including the waste management. This manual should be distributed to the health facility staff by the NGO grantees.

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 80% of the health facilities evaluated. Such a system would allow for well-informed decisions to replace, repair or purchase as necessary.

Annex Figure 3

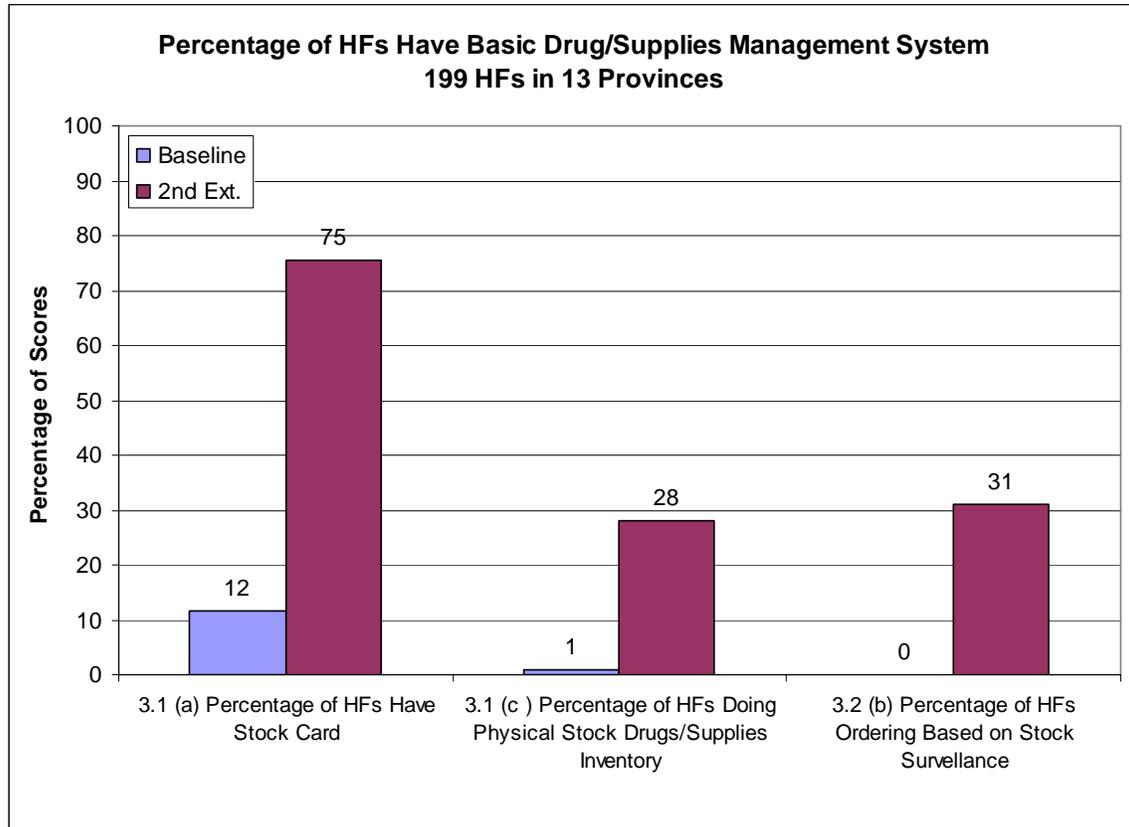


Availability of adequate equipment (Annex Figure 3)

Only two percent of the 199 health facilities evaluated have a complete set of equipment as required by the BPHS. However, a clear improvement occurred in 72% health facilities in which between 70 and 100% of the required equipment is available (this is the case in 62% of the BHCs, 83% of the CHCs and 100% of the DHs).

3. Drug/Supply Management

Annex Figure 4

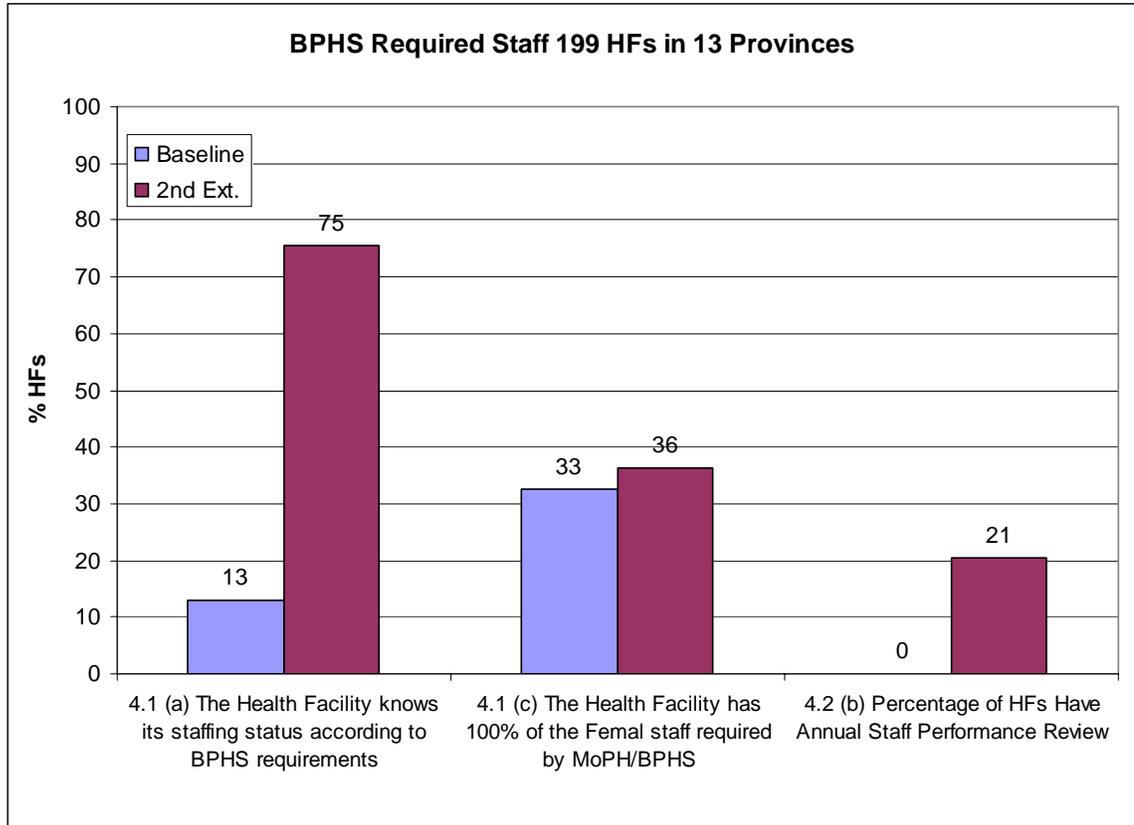


Availability of a basic drug supply management system (Annex Figure 4)

The stock control card system has been adopted by most (75%) of the pharmacists or in-charges of the health facilities and its availability reflects a clear improvement. However, this change is not yet sustained as the physical stock inventory and ordering based on stock surveillance are part of the basic drug/supply management system in only 28% of and 31% of the health facilities, respectively. The procedures and good practices in a basic drug/supply management system require more attention by the supervisors and/or the drug management staff of the NGO working closely with the pharmacists.

4. Staff

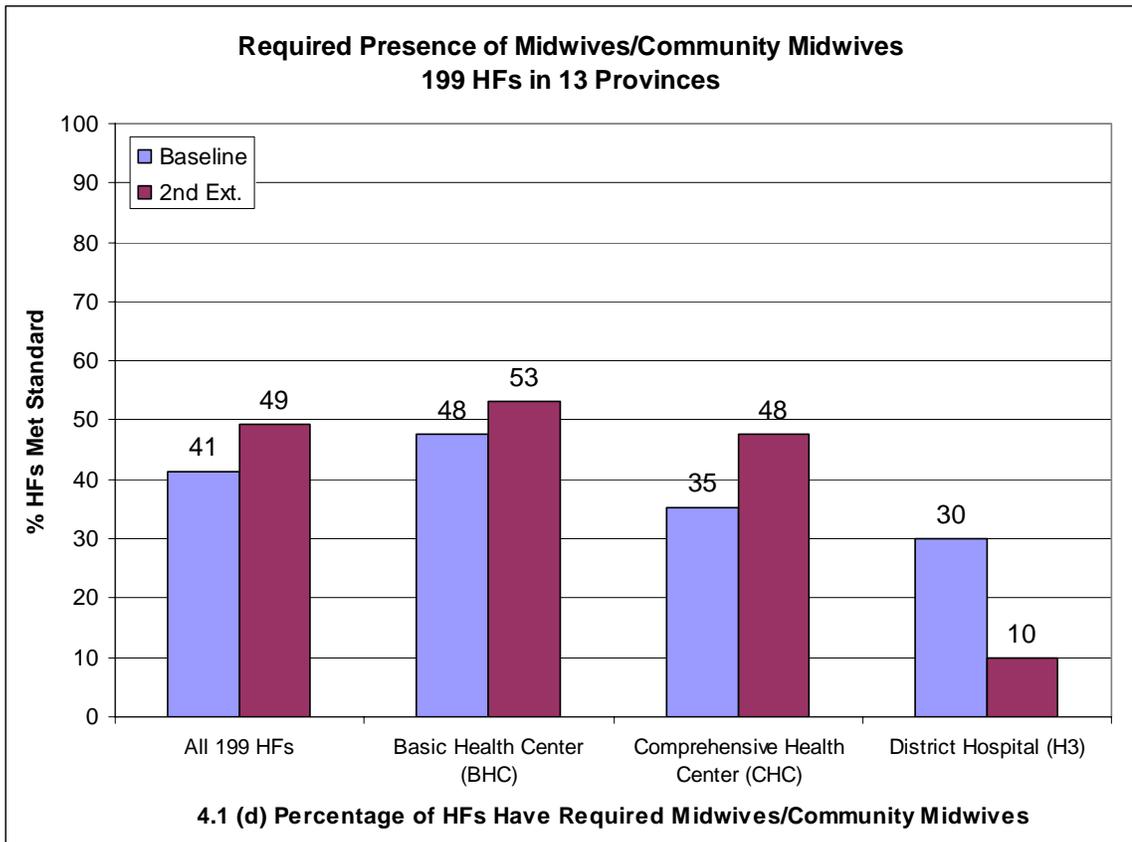
Annex Figure 5



Adequate staffing (Annex Figure 5). Out of the 199 health facilities, 75% health facility staff know the staffing requirements of the MOPH for their type of health facility and they know their own staffing status. More than one-third (36%) of the health facilities have the required female staffing: this is a slow improvement compared to the baseline results (the BHCs have improved from 48% in the baseline to 53% in the second evaluation, the CHCs have not improved and have the required female staffing in only 17% of participating CHCs. The district hospitals have improved from 0% in the baseline to 10% in the second external evaluation).

The process of conducting an annual performance review of the health facility staff has been introduced in 21% of the health facilities, which is a considerable improvement as none of the facilities had undertaken performance reviews at the baseline.

Annex Figure 6

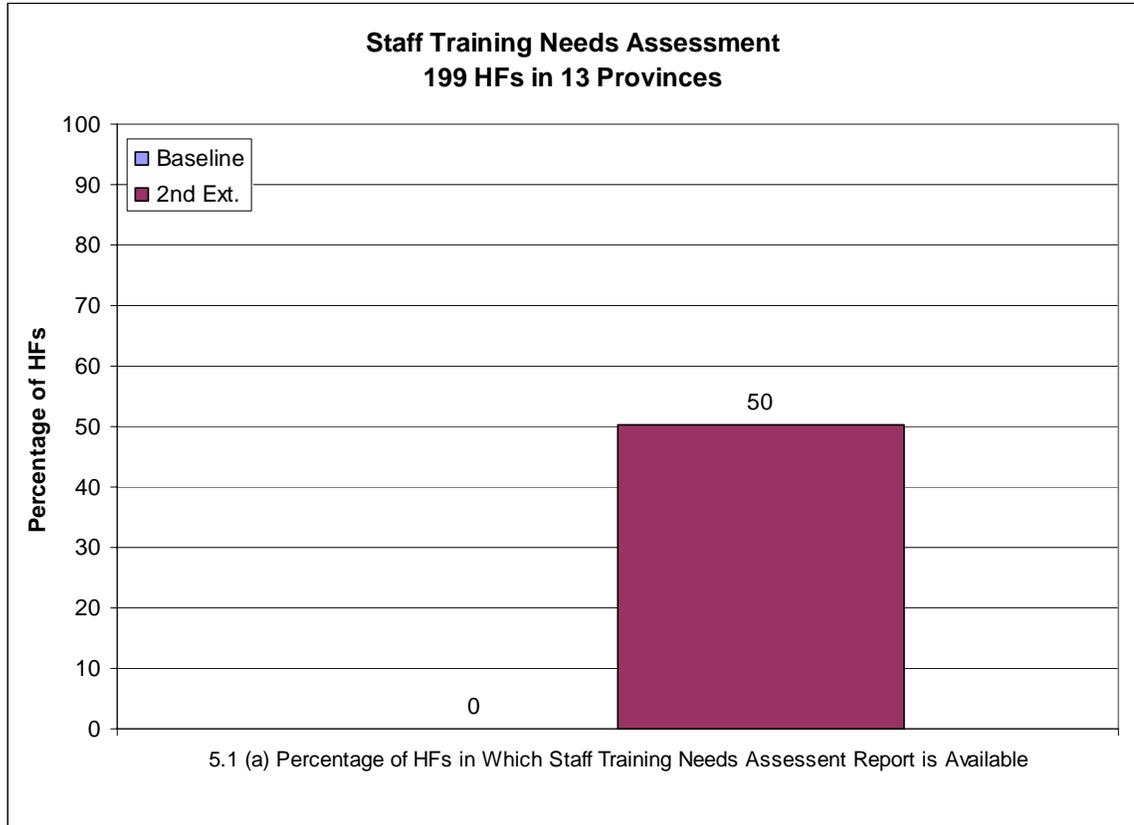


Availability of required midwives/community midwives (Annex Figure 6).

While 36% of the health facilities have the full required female staff (see Annex Figure 5), Annex Figure 6 shows that 49% have the required number of midwives /community midwives. Since the baseline there has been a continuous (but slow) improvement in staffing of BHCs and CHCs with newly graduated midwives and/or community midwives. This advocates for the continuation (and increase?) of the community midwives training and literacy training program for women (“Learning for Life” training). Surprisingly there has been a decrease in the required midwives serving in the district hospitals.

5. Training

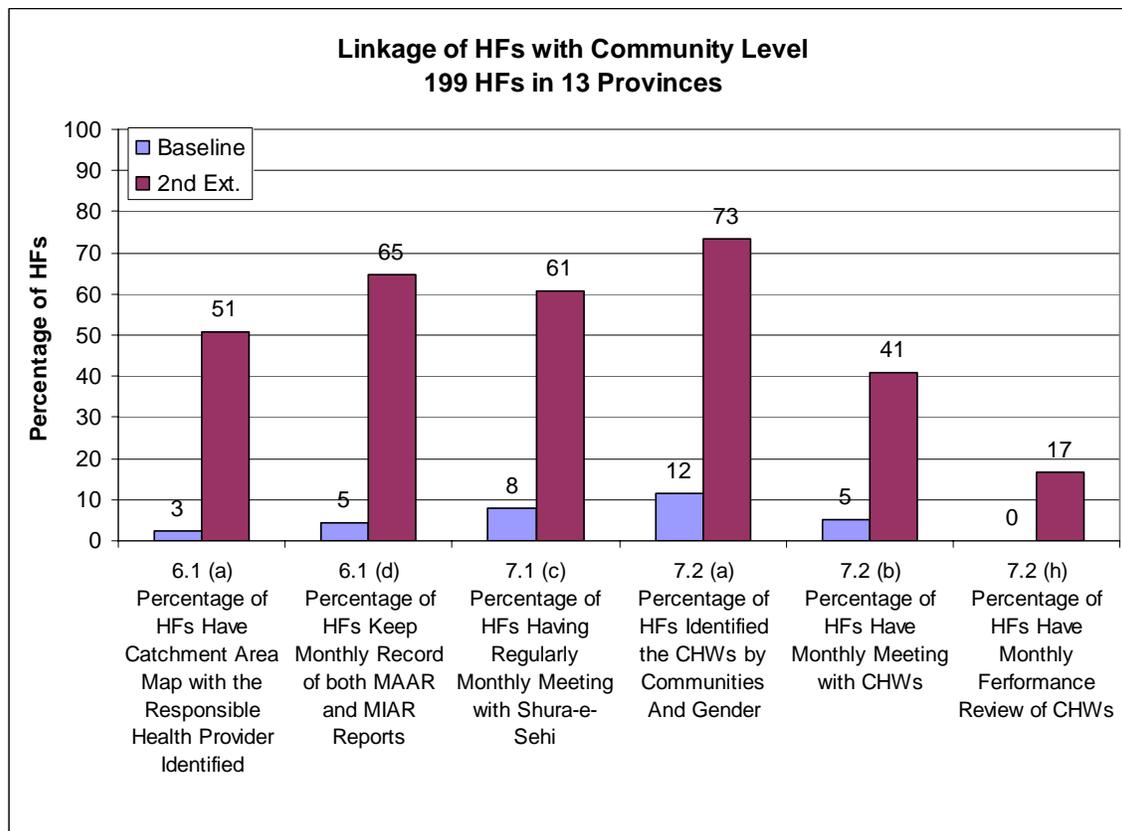
Annex Figure 7



Availability of staff training needs assessment report (Annex Figure 7). Since the introduction of FFSDP, 50% of the health facilities evaluated keep a copy of the staff training need assessment report. However, the improvements have to be sustained as only 22 % of the health facilities have fulfilled their annual planned training activities.

6. Community Approach and Community Support

Annex Figure 8



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

Catchment area map and required HMIS reports available at the health facility. Identifying the various geographical sections of the HF catchment area with the health provider responsible for the delivery of services has improved in 51% of health facilities. The same applies for the management of the HMIS reports from the health facility and from the surrounding CHWs (in 65% of the health facilities). However, the use of these data is still weak and needs further technical support. For example, the identification of the BPHS target groups in the catchment area is correctly done only in 20% of the health facilities evaluated.

Regular and formal meetings with the *Shura-e-Sehi* (Community Health Committee). While 73% of the health facilities are formally partnering with a *Shura-e-Sihie*, only 61% of have monthly meetings that are formalized with written minutes. Only 27% of the *Shura-e-Sihies'* membership is comprised of one-third or more female members. An important effort on the part of the NGOs is needed here to get a good representation of the BPHS target groups in the *Shura-e-Sihies*.

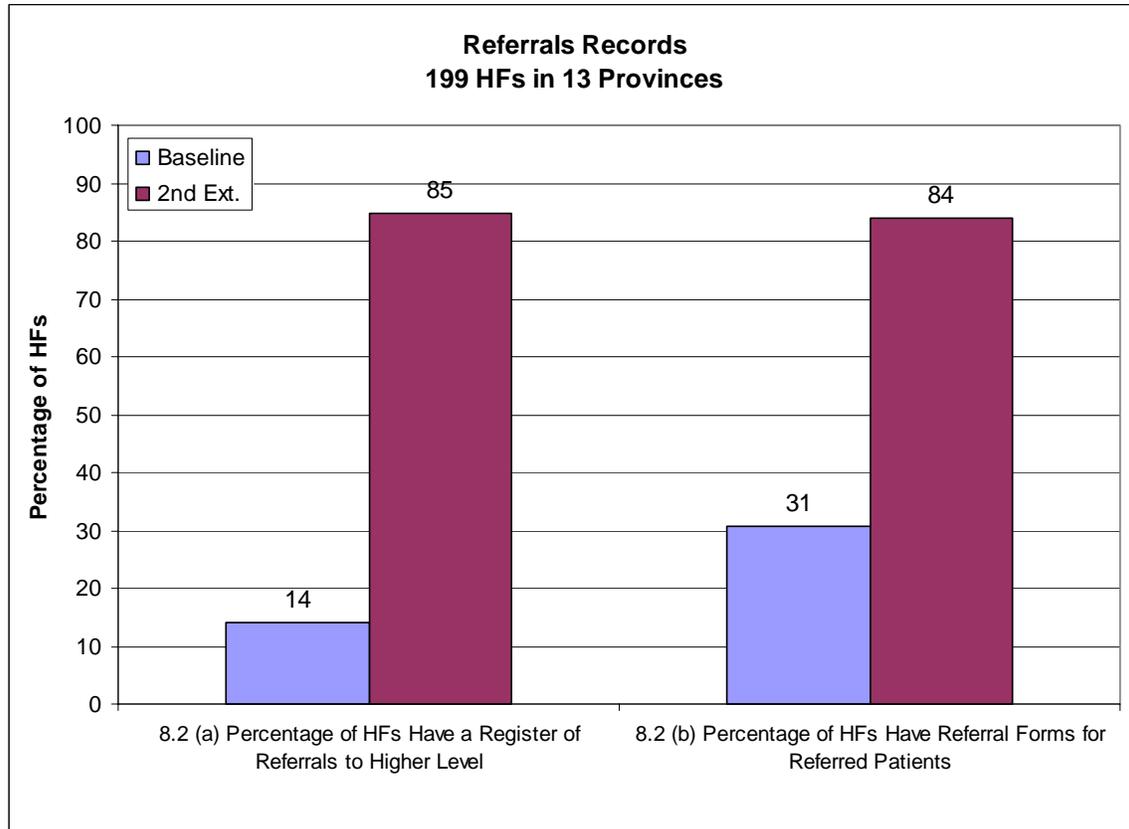
Identification of CHWs by community and gender. Nearly three-fourths (73%) of health facilities can identify their affiliated Community Health Workers by communities and gender within their catchment area.

Monthly meeting at the health facility with the CHWs. While 73% of the health facilities have identified their surrounding CHWs, only 41% of them are meeting the CHWs on a monthly basis and exchange health information and plan together the health activities for the next month. It is hoped that the training of the Community Health Supervisors which was held during this first improvement cycle will result in more regular meetings with the CHWs.

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 17% of the health facilities are taking this responsibility. Now that the Community Health Supervisors have been posted and trained it is hoped that the health facilities are going to serve as a base for helping CHWs improve their clinical knowledge and also plan activities (particularly IEC and referral) in accordance with the activities of the health facility and the *Shura-e-Sihie*.

7. Quality and Management

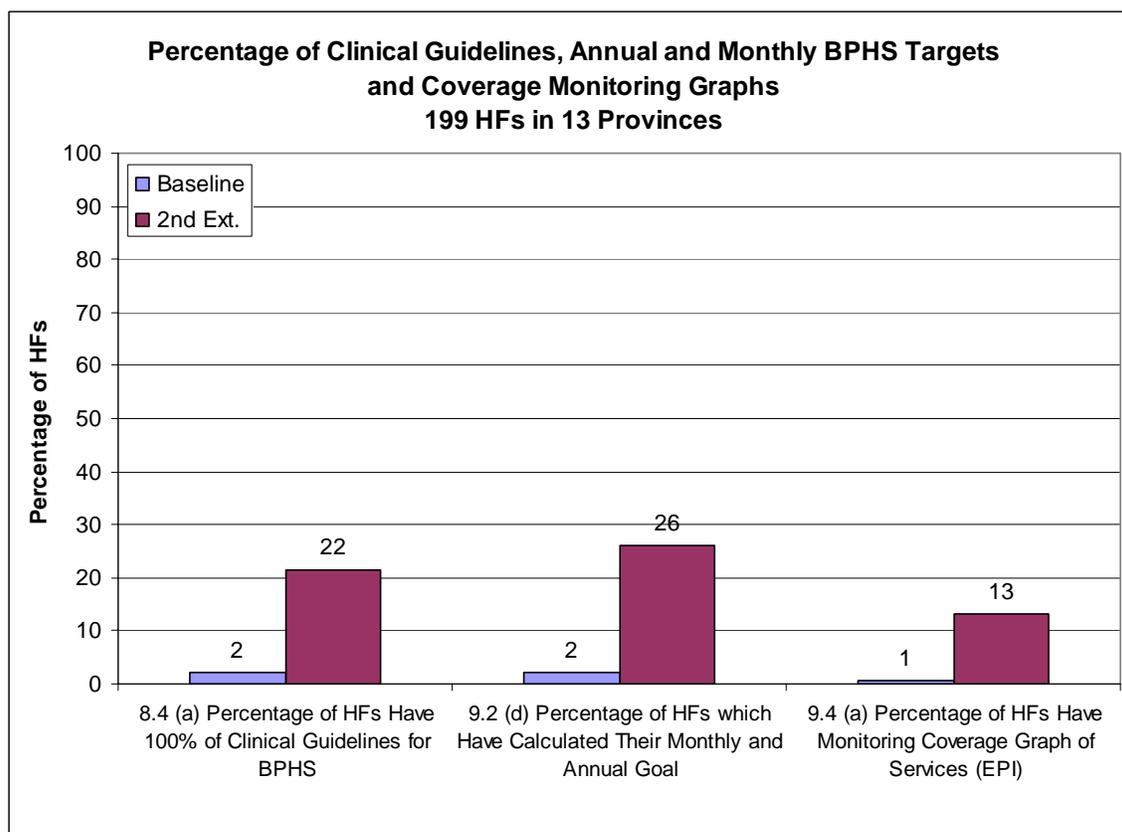
Annex Figure 9



Quality and Management indicators (Annex Figure 9)

Referrals of patients to a higher level. Of the health facilities evaluated 85% had a referral register in place at the time of the second external evaluation and 84% 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 199 health facilities, 22% have now a complete set of the clinical guidelines related to BPHS. To meet this standard, the following 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 is 59 out of 100 points, which is a great improvement compared to the baseline average score (which was 18).

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

A slow but steady improvement (26% of the health facilities) has occurred in the calculation of the annual and monthly goals for each service at the health facility level although all NGO grantees have performed a baseline household survey. With the new data-use training provided to the health facility staff it is expected that this standard will improve substantially in the near future.

Coverage Monitoring is up to date for the last month for the following services: Of the 199 health facilities, 13% have drawn a monitoring coverage graph for each of the following BPHS service

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

Annex 2

Photographic Evidence of Change resulting from FFSDP

Moqoor CHC, Ghazni Province

Criterion 1: Infrastructure

Criterion 1.4 (b) Functional Building-Delivery room

"A suitable designated room and equipment for deliveries"



Baseline FFSDP evaluation: Delivery room condition



2nd FFSDP External Evaluation: Delivery room condition after 6 months

Jaghashiow BHC, Nawar District, Ghazni Province

Criterion 1: Infrastructure

Criterion 1.2 (b) Safe Drinking Water

"...water from a safe source such as a well, or spring, or boiled or chlorinated water which is stored in a covered container."



Baseline FFSDP Evaluation: Health facility water source



2nd FFSDP External Evaluation: Health facility water source after 6 months

Paghman CHC, Kabul Province
Criterion 1: Infrastructure
Criterion 1.2 (e) Adequate disposal of clinical waste
"Clinical waste should be kept separately in the health facility...it should be incinerated without delay"



Baseline FFSDP Evaluation: Clinical waste disposal



2nd FFSDP External Evaluation: Clinical waste disposal after 6 months

Unjalad CHC, Faryab Province
Criterion 3: Essential Supplies and Drugs
Criterion 3.1 (a-c) Stock control, inventory & pharmacy management



Baseline FFSDP evaluation: Pharmacy, stock and drug supplies



2nd FFSDP External Evaluation: Pharmacy, stock and drug supplies after 6 months