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USAID/AFGHANISTAN COMBINED HEALTH PROJECTS EVALUATION: BASICS, TECH-SERVE, AND HSSP

ASSESSING USAID'S HEALTH PRIORITIES: CAPACITY
BUILDING, TRAINING, QUALITY ASSURANCE, AND
COMMUNITY-BASED HEALTH CARE

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This publication was produced for review by the United States Agency for International Development. It was prepared by Carina Stover, Leslie B. Curtin, Barbara Spaid, Connie Carrino, and Terrence Tiffany through the Global Health Technical Assistance Project.

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Despite the team's best efforts to get accurate information from the literature and through interviews, factual errors may persist in the report. These must be considered the responsibility of the principal authors, who attempted as best they could to grasp a highly complex environment and large portfolio in a short period of time.

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ACRONYMS

ACCESS	Access to Clinical and Community Maternal, Neonatal, and Women’s Health Services
AFSOG	Afghan Society of Obstetricians and Gynecologists
AMA	Afghan Midwives Association
AMNC	Afghan Midwifery and Nursing Council
AMNEAB	Afghanistan Midwifery and Nursing Education and Accreditation Board
ANC	Antenatal care
ANDS	Afghanistan National Development Strategy
AO	Assistance objective
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behavior change communication
BEMNC	Basic emergency maternal and newborn care
BEmOC	Basic emergency obstetric care
BEOC	Basic essential obstetric care
BHC	Basic Health Center
BPHS	Basic Package of Health Services
BPHS-SM	Basic Package of Health Services – Strengthening Mechanism
CA	Cooperating agency
CAH	Child and adolescent health
CB	Capacity building
CBHC	Community-based health care
CHC	Community health center
CHN	Community health nurse
CHNE	Community health nurse education
CHS	Community health supervisor
CHW	Community health worker
C-IMCI	Community-based integrated management of childhood illness
CME	Community Midwifery Education Program
COMPRI-A	Communications for Behavior Change Expanding Access to Private Sector Health Products and Services for Afghanistan
CPR	Contraceptive prevalence rate
CQAC	Central Quality Assurance Committee
DH	District hospital
DMPA	Depo-Provera

DMU	Drug Management Unit
EC	European Commission
EMNC	Essential maternal and newborn care
EOP	End-of-project
EPHS	Essential Package of Hospital Services
ETAT	Emergency triage assessment and treatment
ETS	Effective teaching skills
EU	European Union
FHA	Family Health Action
FHAG	Family Health Action Group
FP	Family planning
GCMU	Grants and Contract Management Unit
GDP	Gross domestic product
GH Tech	Global Health Technical Assistance Project
GIHS	Ghazanfar Institute of Health Sciences
GIRoA	Government of the Islamic Republic of Afghanistan
GMP	Growth monitoring and promotion
HCI	Health care improvement
HIS	Health information system
HMIS	Health management information system
HNSS	National Health and Nutrition Sector Strategy
HPD	Health Promotion Department
HR	Human resources
HSSP	Health Systems Support Project
IARCSC	Civil Service Commission
ICSP	Integrated Child Survival Package
IEC	Information, education, communication
HIS	Institute of Health Sciences
IMCI	Integrated management of childhood illnesses
IPCC	Interpersonal communication and counseling
IQHC	Improving quality of health care
IR	Intermediate result
IRB	Institutional Review Board
IYCF	Infant and young child feeding
Jhpiego	Johns Hopkins Program for Int'l Ed. in Gynecology and Obstetrics

LAM	Lactation Amenorrhea Method
LDP	Leadership Development Program
LMS	Leadership, Management, and Sustainability
LOP	Life of project
LQAS	Lot Quality Assurance Survey
LRP	Learning resource package
MCH	Maternal and child health
M&E	Management and evaluation
MIS	Management information system
MoPH	Ministry of Public Health
MSH	Management Sciences for Health
NBC	Newborn care
NGO	Non-governmental organization
NMC	National Monitoring Checklist
NMCHC	National Maternal Child Health Committee
NMCSC	National Maternal and Child Survival Committee
NRHS	National Reproductive Health Strategy
OIG	Office of Inspector General
PC	Provincial coordinator
PCH	Partnership Contracts for Health
PDQ	Partnership defined quality
PENTA-3	Vaccine to prevent diphtheria, pertussis, tetanus, polio and hepatitis-B
PHA	Provincial health advisor
PHI	Public Health Institute
PHO	Provincial Health Office
PMCHC	Provincial Maternal Child Health Committee
PMP	Performance management plan
PNC	Postnatal care
PPFP	Post-partum family planning
PPH	Post-partum hemorrhage
PPHC	Provincial public health coordinator
PPHO	Provincial public health official
PPIUCD	Post-partum intra-uterine contraceptive device
PRT	Provincial Reconstruction Team
PTFU	Post-training follow-up

QA	Quality assurance
QAP	Quality assurance process
QIC	Quality improvement collaboration
RDU	Rational drug use
REACH	Rural Expansion of Afghanistan’s Community-Based Health Care
RH	Reproductive health
SBM-R	Standards-based management and recognition
SM	Strengthening mechanism
SMS	Sustainable Management Systems (project)
SOW	Scope of work
TT	Tetanus toxoid
Tech-Serve	Technical Support to the Central and Provincial Ministry of Public Health
TFR	Total fertility rate
TL	Team leader
UN	United Nations
UNFPA	United Nations Fund for Population Activities
USAID	U.S. Agency for International Development
USG	United States Government
VT	Virtual team
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

This report consists of an evaluation of progress toward achieving results by three USAID/Afghanistan-funded health projects: Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve), Health Services Support Project (HSSP), and Basic Support for Institutionalizing Child Survival (BASICS). Project results are assessed in terms of their impact on four areas of health program development considered critical by USAID/Afghanistan: 1) capacity building; 2) training; 3) quality assurance; and 4) community-based health care.

The purpose of this report is to assess the extent to which the aforementioned health projects met their stated goals and intended results within each of the four priority areas, while identifying the facilitating and impeding factors influencing the achievement of those results.

The objective is to provide USAID with a credible basis for making informed decisions on whether and in what manner existing health project activities in these four priority areas should be continued, expanded, or reduced in any future assistance to meet critical health needs in Afghanistan's changing health and development assistance environment.

The evaluation team originally comprised two international health consultants from the GH Tech Project. Representatives of USAID and the Ministry of Public Health (MoPH) provided logistical support. Because of the unexpected early departure from Afghanistan of one of the international health consultants, and given the limited participation of USAID and MoPH team members, a "virtual team" was assembled consisting of four experienced former USAID health officers (two with recent on-the-ground experience in Afghanistan) to support the team leader in Afghanistan in completing the evaluation. Documents reviews, field visits, and key informant interviews were conducted to inform the evaluation team's writing of this report.

OVERVIEW OF THE HEALTH SECTOR IN AFGHANISTAN

The development challenges in Afghanistan are both formidable and unique. A mountainous country about twice the size of Arizona, much of the country faces harsh winters and hot dry summers. Rugged terrain and poorly developed roads and infrastructure make access to health centers problematic for most of the rural population. About three-fourths of Afghanistan's population of around 28 million live in rural areas, with about 80% of households employed in agriculture, including illegal opium production, which accounts for an estimated one-third of gross domestic product (GDP).¹ The Pashtun, Tajik, and Hazara are the dominant ethno-linguistic groups and rivalry within and among these groups complicate nation building. Afghanistan is a poor country with a per capita income of less than \$400. About one-third of the population lives in absolute poverty.

By almost any measure, the health status of the Afghan people is very low. Life expectancy is a mere 43 years.² About one in eight women dies from causes related to pregnancy and childbirth and nearly 20% of children die before reaching their 5th birthday. Maternal, infant, and under-5 child mortality rates are among the highest in the world. Chronic and seasonal malnutrition is widespread, with stunting reported for nearly 60% of children.³ Poor nutrition also contributes to high infection rates for diarrhea and respiratory illnesses. Fertility is very high⁴ and contraceptive

¹ The World Factbook, CIA 2010.

² WHO Report on Afghanistan 2011.

³ WHO Report on Afghanistan 2011.

⁴ Total Fertility Rate of 6.5 – UNICEF Afghanistan Health Statistics 2009.

use is low, especially in rural areas. Although, according to the MoPH, the contraceptive prevalence rate (CPR) has increased from as low as 15% in 2006 to about 43% currently, progress has stalled and has even regressed recently in some areas due to a lack of sustained program emphasis.

USAID HEALTH INVESTMENT IN AFGHANISTAN

Following the fall of the Taliban government in 2001, USAID became an important partner with Afghanistan to improve the health of its population. USAID assistance in the health sector falls under Assistance Objective (AO) 2 of the USAID Afghanistan Country Plan, which has four intermediate results (IRs):

IR 1: Effective utilization of the Basic Package of Health Services (BPHS) and other client-oriented health services increased

IR 2: Healthy behaviors adopted by the population

IR 3: Strengthened capacity of the Government of the Islamic Republic of Afghanistan (GIRoA) to deliver quality health services

IR 4: Strengthened private sector health services and products

In support of this AO, USAID provides on-budget assistance to the MoPH to fund its Partnership Contracts for Health (PCH) program, which supports 14 national and international NGOs in carrying out BPHS and Essential Package of Hospital Services (EPHS) activities in 481 clinics and seven provincial hospitals in 13 provinces. In addition, USAID funds a variety of cooperating agencies (CAs) which provide supporting technical assistance to the MoPH, NGOs, and other related organizations (off-budget support). In addition to PCH, the key USAID/Afghanistan projects working in support of this AO are Tech-Serve, HSSP, BASICS, and COMPRI-A (a social marketing program that is not included in the scope of this evaluation).

An important consideration for future USAID project development is how to comply with the policy of shifting more financing from off- to on-budget support while still providing the Afghanistan health sector with the external (off-budget) technical support it will continue to need to improve and expand the quality, scope, efficiency, effectiveness, and sustainability of public health services.

HIGHLIGHTS FROM THE THREE USAID/AFGHANISTAN HEALTH PROJECTS

The Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve) project is an associate award under the Leadership, Management and Sustainability (LMS) Leader with Associates Award. At the time this report was written, the project was scheduled to close out in December 2011. The objective of Tech-Serve is to improve the capacity of the MoPH to plan, manage, supervise, monitor, and assess barriers to access to quality BPHS and EPHS services, particularly for those at the highest health risk. Since its inception in 2006, Tech-Serve has played a leading role in helping strengthen the capacity of the MoPH at all levels to plan, manage, supervise, deliver (directly and through NGOs and other intermediaries), monitor, and evaluate health services. Tech-Serve is working in seven strategic program areas: central and provincial capacity building, health economics and financing, scaling up family planning, drug management, technical support for EPHS implementation, strengthening monitoring and evaluation (M&E), and management information systems (MIS). Tech-Serve has helped the MoPH develop national policies, tools, systems, guidelines, and practices important to the effective implementation of BPHS, along with training to improve the managerial capacity of key staff. At

the provincial level (IR 2), Tech-Serve has improved the leadership and management capability of key provincial staff through intensive training and technical assistance.

The Health Service Support Project (HSSP) is an associate award under the Access to Clinical and Community Maternal, Neonatal, and Women's Health Services (ACCESS) Leader with Associates Award. The associate award was signed on July 1, 2006, and was scheduled to end on November 30, 2011, although an 11-month cost extension has been approved and is currently under way. The objective of HSSP is to improve the quality of services provided to women of reproductive age. HSSP is expected to achieve results in five areas:

- IR 1: Strengthening and developing systems that support service delivery quality
- IR 2: Increasing the number and performance of BPHS providers, especially women, in rural and underserved areas
- IR 3: Improving the capacity and willingness of communities, families, and individuals to make informed decisions about their health and support and sustain health-seeking behavior
- IR 4: Integrate gender awareness and practices into health services
- IR 5: Strengthen southern and southeastern health systems through quick impact activities (Helmand, Kunar, Nangarhar, Laghman, and Farah)

HSSP has concentrated its efforts in the area of quality assurance (QA). A total of 606 health facilities and health posts have been enrolled in the QA process by having at least the baseline assessment conducted. In addition, QA field guides, briefers, and other tools were designed and deployed. The project has supported a national midwifery education system to improve competency and ensure ongoing quality education along with efforts to improve the capabilities and performance of practicing midwives at the community level, resulting in an increase in births attended by skilled attendants in project areas. The project has also worked to increase the use of exclusive breastfeeding as well as expanding knowledge and use of modern contraception. While family planning knowledge and use have increased over the life of the project, both have decreased over the last year, possibly due to insecurity and disruption of health services delivery in some areas. HSSP integrated gender into QA standards, designed gender modules for incorporation into MoPH gender training programs, and conducted research to identify gender barriers to health care.

The Basic Support for Institutionalizing Child Survival (BASICS) project is a task order under an indefinite quantity contract (IQC); dates of implementation are March 2008 – September 30, 2011. The objective of BASICS was to improve the national/provincial capacity to implement state-of-the-art child health policies and programs and strengthen the child health components of the BPHS and the EPHS. BASICS was expected to achieve results in five areas:

- Revising and developing child survival and health-focused policies and strategies
- Improving child health care at the community level
- Improving child health care at the BPHS facility level
- Improving child health care at the EPHS hospital level
- Strengthening cross-cutting health system components to improve child health care

BASICS aimed to address gaps in policy, improve child health, and promote institutionalization of child survival in Afghanistan. As a result of BASICS efforts, four national foundational policies and strategies in support of child health were developed and adopted by the MoPH, including revised child and adolescent health (CAH); public nutrition; infant and young child feeding (IYCF); and diarrhea case management. In addition, BASICS developed a number of child survival training materials and job aids that were adopted by the MoPH, including integrated management of childhood illnesses (IMCI) improvements (e.g., updated protocols; development

of seven-day, modular, and community-based courses along with integration of essential maternal and newborn care) as well as courses to improve growth monitoring and community health worker (CHW) behavior change and communications skills. BASICS further contributed to improvements in child health at the community level through the introduction of proven child survival interventions, particularly the Integrated Child Survival Package (ICSP) in 28 districts.

CROSS-CUTTING CHALLENGES AND RECOMMENDATIONS

1. The four priority areas given focus in this report will require continued support from USAID. Managing USAID support to the health sector and coordinating these efforts with other U.S. Government entities and other governments has been a huge, if not impossible challenge, for USAID. With upcoming changes in the development budget and U.S. Government priorities for Afghanistan, the evaluation team concluded that future off-budget support should be consolidated and managed by as few entities as possible to simplify management and monitoring of USAID's contribution. An example of this as a recommendation is found in the last recommendation in this report, under the priority area of the Community-Based Health Care (CBHC) program.
 - Consolidate USAID off-budget support to strengthen coordination and integration of services
2. Considerable assistance was provided to directorates and units in the MoPH to improve their operational and administrative structures and mechanisms and day-to-day management. However, low salaries and high vacancy rates compromised the ministry's capacity to provide high-quality health services to adequate numbers of the population. Furthermore, within the projects and NGOs there seemed to be differences in what was expected in terms of salaries and other benefits, differences that have also led to high job turn over and vacancies. Concerted assistance in human resource planning is needed to include recruitment and benefit plans that raise the stature of what are likely to remain low paying positions.
 - Standardize and publicize widely, all policies regarding salary, MI&E (meals, incidentals and emergencies), and other job benefits.
3. There is evidence that NGOs do not always receive incremental funding on time. USAID needs to review its financial system to ensure that NGOs receive incremental funding on schedule. This may require changes in funding tranches to addresses MoPH slowdowns in monitoring and disbursement.
 - Improve the efficiency of provision of funding from USAID to the NGOs
4. Monitoring and information visits are not always coordinated and it appears that too many units within the central Ministry of Public Health are collecting and independently managing and reporting health management and information Systems (HMIS) and M&E information. Projects need to review the number of reporting and M&E contacts they and ministry counterparts have with NGOs with a view to using NGO time more efficiently
 - Strengthen coordination and integration of collection and management of information at the central and provincial levels

RECOMMENDATIONS FROM THE ASSESSMENT OF THE FOUR PRIORITY AREAS

I. CAPACITY BUILDING

- a. Strengthening the MoPH as a steward of the health sector

- USAID should continue to monitoring, and if necessary support, the Ministry of Public Health’s use of the National Maternal Child Health Committee and the Provincial Maternal Child Health Committee.
 - Facilitating communication across directorates in areas of importance to the BPHS and EPHS should continue and be expanded. Mentoring new Ministry of Public Health leaders and offices, involving some more than others, is also important for developing a team of stewards that can work together productively and efficiently.
 - It is too early to transfer the Leadership Management Program (LDP) to a government agency. LDP should be continued, expanded to new districts, and periodically updated.
- b. Improve and help sustain key operations of the MoPH
- In the near term, the Ministry of Public Health’s Human Resources Directorate needs concerted assistance in human resource planning to include recruitment and benefit plans that raise the stature of what are likely to remain low-paying positions.
 - Once transfer of Tech-Serve consultants to the MoPH is completed, it will be important to monitor MoPH’s progress on routine actions, such as NGO contract management. The turnover rates of these personnel should also be monitored and assistance provided to fill identified gaps.
 - Improve supply chain management for the BPHS and EPHS programs to ensure timely delivery of drugs and avoid expirations.
 - For the long term, develop plan to transfer supply chain management to an Afghan institution (public or private).
 - USAID should support the development of Internet connectivity among relevant monitors and implementers for BPHS and EPHS in USAID-assisted provinces. The system itself could be funded on-budget, with additional technical assistance provided, as needed.
- c. Improved capacity of government officials and NGOs at the provincial level
- The provincial health advisor and provincial coordinator positions should be combined, either into a two-person team that covers the present job descriptions or, preferably, into a single, senior advisor in each province who addresses key government and NGO needs.
 - Ensure that NGOs receive incremental funding on time. This may require changes in funding tranches to address MoPH slowdowns in monitoring and disbursement.
 - Quality assurance tracking should continue to be established and, as USAID implementation priorities change, those priorities should be tracked in NGO proposal, monitoring, and evaluation processes.
 - Future off-budget technical support should be provided to help the MoPH and NGOs develop a unified, simplified system to monitor M&E and HMIS reporting, and decrease the number of contacts and MoPH counterparts involved, until such time as the NGOs or MoPH can take over this function efficiently and effectively.

II. TRAINING

- a. Institutional development for pre and in-service training
- USAID should provide financial and technical resources to the Ghazanfar Institute of Health Services (GIHS) to implement the recommendations that resulted from the GIHS capacity assessment.

- USAID lacks a comparative advantage in assessing or strengthening mental health services. It would be more efficient to shift this assistance to another U.S. Government agency or another international donor.
 - Future efforts to strengthen national organizations and professional medical organizations would benefit from a more coherent and strategic approach addressing the types and numbers of institutions to be developed.
 - An institutional strengthening strategy should be developed that defines the priority areas for assistance for each organization; provides a cost-benefit analysis; and includes annual performance monitoring and evaluation plans.
- b. Training – clinical, non-clinical and community-based programs and approaches
- Consideration should be given to consolidating in-service training into one project.
 - A competency-based training methodology should be used for all future in-service training.
 - Future assistance (and HSSP until the end of project) should continue to assist the MoPH in nationalizing post-training follow up systems. Oversight mechanisms should ensure that training follow up assessments occur every three months.
 - Assistance to BPHS implementers should be targeted to participating providers based on the needs they identify and the action plans they develop during the learning transfer visit process to model clinics.
 - The midwifery training program should be continued and expanded so that the MoPH can reach its Millennium Development Goals. The United Nations Population Fund estimated that Afghanistan still needs roughly 7,400 additional midwives to attain 95% skilled birth attendance by 2015.⁵
 - The Grants and Contracts Management Unit within the MoPH (GCMU) should contract an organization with the technical capacity to provide oversight as well as direct monitoring of midwifery training. In the longer term, capacity must be built within the MoPH or the GIHS to provide this oversight.
 - USAID should review indicators for family planning. Since creating targets for the number of family planning users cannot be included, other indicators should be added to PCH grants (e.g., the number of women counseled in family planning) to provide motivation for health providers and monitoring on family planning knowledge. It is necessary to devise mechanisms to motivate and reward the provision of high-quality family planning services.

Community health nursing education (CHNE) curricula and material development should be given a high priority. Technical oversight of the CHNE program will likely be required through off-budget support. Continued strengthening of Afghanistan Midwifery and Nursing Education and Accreditation Board (AMNEAB) to perform its oversight role will be important.

- All IMCI training should be consistent with the MoPH policy of using the condensed seven-day IMCI course.
 - Performance monitoring indicators should disaggregate and report on the subject of training courses conducted and identify the training conducted for providers in each level of the health system.
- c. Use of innovative technologies for training

⁵ Coleman, Isobel, and Gayle Tzemach Lemmon. “Maternal Health in Afghanistan: Improving Health and Strengthening Society.” Washington, D.C.: The Council on Foreign Relations. September 2011, p.11.

- The team recommends phased expansion and an analysis of training costs.

III. QUALITY ASSURANCE

- a. Development of national standards, care protocols, and a national strategy for quality assurance
 - Continued technical and budget support over a three-to five-year period should be provided to the new Improving Quality of Health Care (IQHC) Unit to build its capacity and mandate to coordinate and oversee the QA work of the MoPH's technical departments, particularly in carrying out continuous review and revision of health care standards and care protocols as needed.
- b. Implementation of QA processes, methodologies, and initiatives
 - Where multiple USAID projects introduce QA models and interventions in the same areas, efforts should be made to ensure that various approaches and efforts are coordinated and do not duplicate effort and confuse the MoPH, NGOs, and facility staff, thereby losing the opportunity for commitment to QA efforts and potentially affecting improved health outcomes.
- c. Monitoring and measuring QA performance against national standards and USAID-approved project monitoring plans (PMPs)
 - Future projects should be accountable for measuring and monitoring improved quality of care achieved by the project. Data collection on improved quality of care and analysis of the effectiveness of QA components (such as quality assurance process, or QAP, LDP, emergency triage assessment and treatment [ETAT], and Public Health Institute [PHI]) should be carried out regularly to better link activity costs to quality of care outcomes/impact.
 - Given the commitment of the new Integrated Quality Health Care Unit to improved measurement of the impact of adherence to quality standards, future health projects should also focus on improved coordination with and between the monitoring and evaluation and health management information systems divisions, particularly with regard to measuring improvement in the quality of health care.
 - Future USAID projects should develop and report regularly to USAID against PMPs that identify and track fewer but better indicators that focus on improved quality of care as well as health outcomes and impact, rather than processes and numbers trained. For measuring quality assurance achievements, indicators could focus on composite QA scores at the facility level as well as several specific performance measures.
 - USAID should encourage new projects to incorporate into their PMPs some of the new HMIS indicators that BASICS and earlier projects assisted the MoPH in developing to measure and report progress against improved quality of health care delivery and health outcomes, as well as improved facility quality assurance performance.
- d. Sustainability of QA processes, commitment, and ownership of QA processes/tools

Future projects should support the new IQHC Unit in growing into a larger role to provide national coordination of QA. This would require a considerable increase in capacity building and technical support. Consideration should be given to establishing a QA training capability within the IQHC Unit to ensure that new staff are continuously trained in the various QA processes and can serve as national trainers along with NGO trainers. Future projects should avoid reinventing the wheel and introducing new QA processes and should assist the MoPH as necessary in streamlining and choosing a single QA process for future implementation.

IV. COMMUNITY-BASED HEALTH CARE

- a. Foundations established for community-based health care
 - Additional mechanisms should be developed to compensate, motivate, recognize, and reward the achievement of CHSs and CHWs.
 - Additional technical assistance should be provided to assist the CBHC department in developing milestones and annual operational plans for 2012 and 2013.
 - There will be a continuing need to support the development of CBHC among marginalized and hard-to-reach populations, including the urban poor and nomadic communities.
- b. Assessment of community-based interventions and approaches
 - Further investigation and strengthening of the post-partum family planning (PPFP) monitoring system is necessary.
 - Indicators for monitoring PPFP should be specifically included in the performance monitoring plan of any future project.
 - A program impact assessment of the PPFP model in the next year is necessary to determine the causes for these declines and to inform future implementation.
 - The Post-Partum Demonstration Program is currently scaling up and should be continued, particularly to support the registration of misoprostal in Afghanistan.
 - The CBHC program will require continued support from USAID. The team concluded that the focus should be on expanding the post-partum family planning program, expanding the prevention of post-partum hemorrhage, and expanding IMCI interventions. However, it would be most effective and efficient to consolidate MoPH capacity-building efforts and community-based service delivery for maternal health, family planning, and child survival in one project (perhaps implemented by a consortium). Attention should be given to supervision throughout the entire system to ensure that the quality of service and information provided by CHSs, CHWs, health *shuras*, and family health action groups (FHAGs) is consistent.

I. INTRODUCTION

This report consists of an evaluation of progress toward achieving results by three USAID/Afghanistan-funded projects: Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve), Health Services Support Project (HSSP), and Basic Support for Institutionalizing Child Survival (BASICS). Project results are assessed in terms of their impact on four areas of health program development considered critical by USAID/Afghanistan: 1) capacity building; 2) training; 3) quality assurance; and 4) community-based health care.

The four priority areas of capacity building (CB), training, quality assurance (QA), and community-based health care (CBHC or CBI) were selected because together they comprise the key elements of a sustainable health care delivery system. The delivery of timely, effective, and sustainable basic health services at the community level requires skilled managers and supervisors to plan, organize, direct, and monitor those services. Moreover, to meet the health needs of recipients, systems must be in place (e.g., quality assurance process [QAP] and in-service training) to ensure that services are of acceptable quality. Each of the three projects, to a greater or lesser degree, focuses on these key areas. Although there is some overlap between the capacity building and in-service training areas with regard to managerial and supervisory skills training, in-service training is treated as a separate priority area in this assessment to capture the broader scope it encompasses (e.g., technical and clinical skills training), which goes well beyond managerial and supervisory training for capacity building. The body of the report consists of a brief review of the health situation in Afghanistan and USAID's response, including an overview of each project. This is followed by an in-depth assessment of the approaches, findings, achievements, and challenges associated with each of the priority areas.

OBJECTIVES AND PURPOSE OF THE REPORT

The purpose of this report is to assess the extent to which the aforementioned health projects met their stated goals and intended results within each of the four priority areas, while identifying both the facilitating and impeding factors influencing the achievement of those results.

The objective is to provide USAID with a credible basis for making informed decisions on whether and in what manner existing health project activities in these four priority areas should be continued, expanded, or reduced in any future assistance to meet critical health needs in Afghanistan's changing health environment.

METHODOLOGY

Team Composition

The evaluation team originally anticipated assembling a full team of international health experts but due to the increased security threats in Afghanistan at the time of the evaluation and other factors, ultimately only two international health consultants were willing to sign on from the GH Tech Project. Representatives of USAID and the Ministry of Public Health (MoPH) provided logistical support. Then, because of the unexpected early departure from Afghanistan of one of the international health consultants and the limited participation of USAID and MoPH team members, a "virtual team" was assembled consisting of four experienced former USAID health officers (two with recent on-the-ground experience in Afghanistan) to support the team leader in Afghanistan in completing the evaluation. Having a virtual team helped compensate for the shortage of team members in-country. As the team leader recorded and emailed her interviews to the virtual team and held regular Skype-assisted discussions with individuals and as a team,

the virtual team was able to acquire a considerable amount of information apart from home-based literature reviews. It was, however, an added burden of time and responsibility on the team leader, who had to attend all meetings, manage logistics, keep all interested parties informed, and keep abreast of the outputs of the other virtual team members.

Basic Approach

The following is the sequence of key steps followed in conducting the evaluation. In addition, attachments to this report include the scope of work (SOW) (Annex A), and work plan (Annex B).

- Background literature review
- Team meeting and planning in Kabul
- Addition of virtual team (followed by continuous electronic consultation and collaboration on report preparation between the team leader in Afghanistan and the virtual team members (VT) members throughout the evaluation)
- Meetings with the USAID/Afghanistan project management team
- Interviews with non-governmental organizations (NGOs), MoPH, and other key informants
- Field visits to project sites (Bamyan, Badakhshan, and Kabul province)
- Report analysis and writing
- Report presentation to USAID
- Finalization of report

Field Visits/Key Informant Interviews:

The team leader conducted briefings and detailed interviews with the directors and staff of the Tech-Serve, HSSP and BASICS projects and key MoPH officials in Kabul, including directors and key personnel from the departments of health management information system (HMIS), monitoring and evaluation (M&E) human resources (HR), reproductive health (RH), policy planning, the Improved Quality of Healthcare (IQHC) Unit, and others. She also carried out field visits in Kabul, Badakhshan, and Bamyan provinces to observe project activities at various sites and conducted interviews with the Government of the Islamic Republic of Afghanistan (GIROA), MoPH, NGO, project, and local representatives. Key issues regarding project performance were also addressed to projects and implementing NGOs through the use of a “survey monkey” instrument and direct emails.

Document Review/Data Analysis:

An extensive literature review was conducted prior to and throughout the course of the assessment. Key documents included a variety of background reports on the health situation in Afghanistan; documents from the MoPH, including relevant health policies, studies and reports, and selective USAID documents, including the 2011-2015 PMP and USAID briefings on health activities. The most extensive body of documents reviewed were those generated by Tech-Serve, HSSP, and BASICS in the form of project proposals and cooperative agreements, along with numerous annual, semi-annual, and quarterly progress reports. A list of the references used is found in Annex C.

OVERVIEW OF HEALTH SITUATION AND USAID RESPONSE

Country Context

The development challenges in Afghanistan are both formidable and unique. A mountainous country about twice the size of Arizona, much of the country faces harsh winters and hot dry

summers. Rugged terrain and poorly developed roads and infrastructure make access to health centers problematic for most of the rural population. About three-fourths of Afghanistan's population of around 28 million live in rural areas, with about 80% of households employed in agriculture, including illegal opium production, which accounts for an estimated one-third of gross domestic product (GDP).⁶ The Pashtun, Tajik, and Hazara are the dominant ethno-linguistic groups; rivalry within and among these groups means that more formative research is needed to understand different cultural attitudes and norms so that they can be used to develop health education material tailored to different ethno-linguistic groups to improve health care-seeking behaviors and achieve better health outcomes.

Afghanistan is a poor country with a per capita income less than \$400. About one-third of the population lives in absolute poverty.⁷ As would be expected under such conditions, most of the population lacks adequate basic services. According to the 2008 Afghanistan National Household Survey, only 20% of households had access to electricity. The large majority of Afghans live in substandard housing that poses physically and environmentally unhealthy conditions. Only about 13% of Afghans have access to safe drinking water and just 12% have access to adequate sanitation.⁸

Another major development challenge is Afghanistan's low literacy rate, especially among women. According to the Afghanistan Ministry of Education, the literacy rate is only about 39% for men and 12% for women. WHO reports literacy as low as 2% among rural women.⁹ Again, according to the Ministry of Education, as of 2008, only about 17% of persons over 25 years attended any type of formal education, although school attendance has improved in recent years. In addition, there are significant socio-cultural impediments preventing women in Afghanistan from fully utilizing health services, which helps explain why even when health facilities are nearby, only an estimated one-third of pregnant women use skilled birth attendants.¹⁰ Even though access to health facilities has improved in rural areas, women must usually be accompanied by a male member of the household, which often results in lower utilization due to cost and inconvenience. Finally, the growing insurgency in Afghanistan, which often targets government programs, including health services, is a serious obstacle to the provision of health care to the rural population in many parts of the country.

CRITICAL HEALTH CHALLENGES

By almost any measure, the health status of the Afghan people is exceedingly low. Life expectancy is a mere 43 years.¹¹ About one in eight women dies from causes related to pregnancy and childbirth, and nearly 20% of children die before reaching their 5th birthday. Maternal, infant, and under-5 child mortality rates are among the highest in the world. Chronic and seasonal malnutrition is widespread, with stunting reported for nearly 60% of children.¹² Poor nutrition also contributes to high infection rates for diarrhea and respiratory illnesses. Fertility is extremely high¹³ and contraceptive use is low, especially in rural areas. Although, according to the MoPH, the contraceptive prevalence rate (CPR) has increased from as low as 15% in 2006 to about 43% currently, progress has stalled and has even regressed recently in some areas due to a lack of sustained program emphasis.

⁶ The World Factbook, CIA 2010.

⁷ The World Factbook, CIA 2010.

⁸ UNICEF Report on Afghanistan 2008.

⁹ WHO International Disasters Report 2011.

¹⁰ Dr. Abdul Saljugi. Dialogue-4Health 2011.

¹¹ WHO Report on Afghanistan 2011.

¹² WHO Report on Afghanistan 2011.

¹³ TFR 6.5 – UNICEF Afghanistan Health Statistics 2009.

Despite these grim statistics, significant improvements have been made in recent years. For example, according to World Bank reports, infant mortality declined from 129/1000 to 111/1,000 and under 5 child mortality dropped from 191/1,000 to 161/1,000 in just two years from 2006 to 2008.¹⁴ Significant gains have also been reported in immunization rates, which increased from a low 19% in 2002 to over 80% of children immunized against most childhood diseases in 2009.¹⁵ These figures on immunization rates are somewhat at odds with lower figures on gains reported by the World Bank (increase in child immunization from 12% in 2005 to 33% in 2008). Nonetheless, by any measure, substantial progress has been made in this area. While still very poor, nutritional status is improving and, as noted above, while still low, contraceptive use overall has increased substantially in recent years. While these gains are encouraging, the health of women and children in Afghanistan clearly remains substandard and must remain a major focus of any future national development effort.

The GIRoA has recognized the importance of improving the health of its population and has made the delivery of basic health services a priority, especially for women and children. The National Health and Nutrition Sector Strategy (HNSS) 2008-2013 and the MoPH Strategic Plan give substance to this priority with specific plans and strategies for health improvement. The main vehicles for health services delivery are the Basic Package of Health Services (BPHS), which was developed in 2002, and the more recent Essential Package of Hospital Services (EPHS). The BPHS is widely viewed as the principal reason for the MoPH's success since 2002 in improving health status in Afghanistan. The BPHS approach commits the major donors and stakeholders to a common approach to delivery of high-impact primary health care interventions, including vaccination, nutrition interventions, communicable disease control, integrated management of childhood illness (IMCI), maternal care, family planning, and basic curative services, along with mental health and disability. Health services are delivered through NGOs under contract with the MoPH, which also provides supervisory oversight. Though coverage remains low, it has increased in recent years and the MoPH reports that currently over 60% of the rural population reside within an hour's travel of a health facility and up to 90% within two hours' travel.

The MoPH is heavily reliant on external assistance. Over 85% of its budget is funded by international donors, most notably USAID, the World Bank (WB), the European Union (EU), and United Nations (UN) agencies. With respect to BPHS coverage, USAID funds activities in 13 provinces, while the World Bank is responsible for 10 provinces and the European Commission (EC) 7 provinces. The World Bank also supports BPHS in three provinces under a BPHS-Strengthening Mechanism (BPHS-SM) program whereby MoPH staff are directly involved in health service delivery under conditions and salary scales followed by NGO contractors. Contracting arrangements vary, with USAID and the World Bank providing funds directly to the MoPH for on-budget support for NGO contracts, whereas contacts with NGOs working in EC provinces are managed through the EC office in Afghanistan.

USAID HEALTH INVESTMENT IN AFGHANISTAN

Following the fall of the Taliban government in 2001, USAID became an important partner with Afghanistan in improving the health of its population. Based on these critical challenges, consultants from a USAID cooperating agency, Management Sciences for Health (MSH), helped the MoPH develop the BPHS in 2002; MSH has since supported its implementation through the REACH and Tech-Serve projects. USAID assistance in the health sector falls under Assistance Objective (AO) 2 of the USAID Afghanistan Country Plan, which has four intermediate results (IRs):

¹⁴ World Bank Report on Afghanistan 2009.

¹⁵ UNICEF Afghanistan Health Statistics, 2009.

IR 1: Effective utilization of BPHS and other client-oriented health services increased

IR 2: Healthy behaviors adopted by the population

IR 3: Strengthened capacity of the GIRoA to deliver quality health services

IR 4: Strengthened private sector health services and products

In support of this AO, USAID is providing on-budget assistance to the MoPH to fund its Partnership Contracts for Health (PCH) program, which supports 14 national and international NGOs in carrying out BPHS and EPHS activities in approximately 531 clinics and 7 provincial hospitals in 13 provinces. In addition, USAID funds a variety of cooperating agencies (CAs) which provide supporting technical assistance to the MoPH, NGOs, and other related organizations (off-budget support). In addition to PCH, the key USAID/Afghanistan projects working in support of this AO are Tech-Serve, HSSP, BASICS, and COMPRI-A (a social marketing program that is not included in the scope of this evaluation).

The USAID/Afghanistan Performance Management Plan 2011-2015 (PMP) is USAID's principal tool for monitoring and evaluating achievement of its assistance programs in meeting the plan's stated objectives and results. A major thrust of the plan is to align at least 80% of U.S. Government development assistance programs in financing National Priority Programs of the Afghanistan National Development Strategy (ANDS) and to channel at least 50% of assistance funds for these programs through the GIRoA core budget (on-budget support) by 2012. The plan places priority on strengthening governance through "reform-oriented service delivery ministries" and channels funding directly to those ministries that have been certified to receive U.S. funding (e.g., MoPH). Although future funding levels are uncertain, the PMP assumes that adequate resources will be available to achieve the plan's stated objectives and targets.

An important consideration for future USAID project development is how to comply with the policy of shifting more financing from off to on-budget support while still providing the Afghanistan health sector with the external (off-budget) technical support it will continue to need to improve and expand the quality, scope, efficiency, effectiveness, and sustainability of public health services. USAID health projects are in the process of implementing the policy of shifting to on-budget funding through actions such as transferring staff positions (e.g., Tech-Serve provincial health advisors) to the MoPH. How far in and in what areas this process can productively precede will heavily depend on institutional factors such as the high staff turnover and vacancy rates that currently prevail at the MoPH. This situation diminishes the ministry's capacity to effectively carry out its responsibilities in the absence of continuing external technical support.

USAID/AFGHANISTAN PROJECT OVERVIEWS

Tech-Serve

Technical Support to the Central and Provincial Ministry of Public Health Project (Tech-Serve)	
Project Objective:	To improve the capacity of the MoPH to plan, manage, supervise, monitor, and assess barriers to access to quality BPHS and EPHS services, particularly for those at the highest health risk.
Project LOP:	July 2006 – September 2011 (extension in process)

The Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve) project is an Associate Award under the LMS Leader with Associates Award. The project was

scheduled to close out on August 31, 2012, following a recently granted extension. The objective of Tech-Serve is to improve the capacity of the MoPH to plan, manage, supervise, monitor, and assess barriers to access to quality BPHS and EPHS services, particularly for those at highest health risk.

Tech-Serve is expected to achieve results in three areas:

IR 1: Improved capacity of the central MoPH to support the delivery of BPHS and EPHS services, primarily through NGO service providers

IR 2: Improved capacity of the 13 provincial health officers (PHO) of the MoPH to support the delivery of BPHS and EPHS services

IR 3: Improved management and leadership capacity of the MoPH

Overview of the Target Audience and Activities:

Since its inception in 2006, Tech-Serve has played a leading role in helping strengthen the capacity of the MoPH at all levels to plan, manage, supervise, deliver (directly and through NGO and other intermediaries), monitor, and evaluate health services. This is achieved through the provision of technical assistance, training, mentoring, and direct interventions in seven key strategic areas. These efforts have contributed to significant improvements as measured by key intermediate indicators such as prenatal visits, immunization rates, births delivered by skilled attendants, contraceptive prevalence, and provision of essential drugs and contraceptives; these improvements are leading to enhanced health outcomes (e.g., reduction of maternal, infant, and child mortality).

Tech-Serve works in seven strategic program areas: central and provincial capacity building, health economics and financing, scaling up family planning, drug management, technical support for EPHS implementation and strengthening M&E and management information systems (MIS). It has developed indicators to measure progress in each area. Despite serious challenges to project implementation, including security concerns and MoPH staffing problems, Tech-Serve is meeting most of its results indicators. With respect to IR 1 (improved capacity at the MoPH central level) Tech-Serve has helped the MoPH develop national policies, tools, systems, guidelines, and practices to support effective BPHS implementation, along with training to improve the managerial capacity of key staff. With Tech-Serve's assistance, the Grants and Contract Management Unit (GCMU) has assumed responsibility for health services funding and NGO contract management. Migration of Tech-Serve staff to the MoPH is under way. At the provincial level (IR 2), Tech-Serve has improved the leadership and management capability of key provincial staff through intensive training and technical assistance. This has resulted in improved resource mobilization; improved monitoring, supervision and reporting among NGO implementers; improved use of MIS data; improved operational planning and improved coordination with other partners and stakeholders. Under IR 3 achievements include strengthening the Drug Management Unit (DMU) of the MoPH to better monitor and control the supply and distribution of essential drugs and contraceptives; training and information, education, and communication (IEC) programs at the community level to improve acceptance and use of family planning; improved hospital management in such areas as budgeting, development of clinical protocols, and training to improve clinical case management; and better use of health information, including support for development of the MoPH health information system (HIS) Strategic Plan in 2009.

HSSP

The Health Service Support Project (HSSP)	
Project Objective:	The objective of HSSP is to improve the quality of services provided to women of reproductive age.
Project LOP:	July 2006 to October 2012 (following a recently granted extension)

The Health Service Support project is an associate award under the Access to Clinical and Community Maternal, Neonatal, and Women's Health Services (ACCESS) Leader with Associates Award. The associate award was signed on July 1, 2006, and, following a recently approved extension, is now scheduled to end on October 31, 2012. The objective of HSSP is to improve the quality of services provided to women of reproductive age.

HSSP is expected to achieve results in five areas:

- IR 1: Strengthening and developing systems that support service delivery quality
- IR 2: Increasing the number and performance of BPHS providers, especially women, in rural and underserved areas
- IR 3: Improving the capacity and willingness of communities, families, and individuals to make informed decisions about their health and support and sustain health-seeking behavior
- IR 4: Integrate gender awareness and practices into health services
- IR 5: Strengthen southern and southeastern health systems through quick-impact activities (Helmand, Kunar, Nangarhar, Laghman, and Farah)

To achieve these results, HSSP provides technical assistance to NGOs contracted to deliver health services through the USAID-funded MoPH PCH project.

Overview of the Target Audience and Activities:

HSSP appears to have achieved measureable results in the five areas for which it is responsible. With respect to IR 1, the project has concentrated its efforts in the area of QA. It has introduced QAP in over 900 health facilities and health posts, and conducted training for hundreds of users. In addition, HSSP has designed and deployed QA field guides, briefers, and other tools. To support IR 2, the project has concentrated on improving midwife performance. The project has supported a national midwifery education system to improve competency and ensure ongoing quality education and conducted efforts to improve the capabilities and performance of practicing midwives at the community level. These efforts have resulted in an increase in births attended by skilled attendants in project areas. In IR 3, the project has worked intensively with the MoPH's Health Promotion Department (HPD) to improve its technical and management capacity, particularly with respect to IEC. The project has also worked to increase the use of exclusive breastfeeding as well as to expand knowledge and use of modern contraception. While family planning knowledge and use have increased over the life of the project, both have decreased over the last year, possibly due to insecurity and health service delivery disruptions in some areas. The project has also designed materials and conducted training in the area of mental health. With respect to gender (IR 4), HSSP has integrated gender into QA standards, designed gender modules for incorporation into MoPH gender training programs, and conducted research to identify gender barriers to health care. Project activities were expanded to designated quick-impact provinces (IR 5).

BASICS

Basic Support for Institutionalizing Child Survival (BASICS)	
Project Objective:	The objective of BASICS was to improve national/provincial capacity to implement state-of-the-art child health policies and programs and strengthen the child health components of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital (EPHS).
Project LOP:	March 2008 to September 30, 2011

The Basic Support for Institutionalizing Child Survival project is a task order under an indefinite quantity contract (IQC); dates of implementation were March 2008 to September 30, 2011. The objective of BASICS was to improve national/provincial capacity to implement state-of-the-art child health policies and programs and strengthen the child health components of the BPHS and EPHS.

BASICS was expected to achieve results in five areas:

- Revising and developing child survival and health-focused policies and strategies
- Improving child health care at the community level
- Improving child health care at the BPHS facility level
- Improving child health care at the EPHS hospital level
- Strengthening cross-cutting health system components to improve child health care

Overview of the Target Audience and Activities:

BASICS aimed to address gaps in policy, improve child health, and promote institutionalization of child survival in Afghanistan. The project appears to have been successful in meeting most of its intended results and indicators. As a result of BASICS' efforts, four national foundational policies and strategies in support of child health were developed and adopted by the MoPH for revised child and adolescent health (CAH); public nutrition; infant and young child feeding (IYCF); and diarrhea case management. In addition, BASICS developed a number of child survival training materials and job aids that were adopted by the MoPH and that incorporated IMCI improvements (e.g., updated protocols; development of seven-day, modular, and community-based courses; and integration of essential maternal and newborn care) as well as courses to improve growth monitoring and community health worker (CHW) skills in behavior change and communications. BASICS further contributed to improvements in child health at the community level through the introduction of proven child survival interventions, particularly the Integrated Child Survival Package (ICSP) in 28 districts, with plans to scale up ICSP to 54 districts in 2011. BASICS also contributed to improvements in child health care at the hospital level through the Pediatric Hospital Initiative (PHI) under which very sick children are immediately assessed, triaged, and treated. Finally, BASICS promoted institutionalization of child survival at the policy and program level through initiatives such as the creation of national and provincial maternal and child health committees, the integration of ICSP into routine BPHS PCH and the adoption by the MoPH of the revised IMCI short (seven-day) course. An additional important outcome and contribution of the project to sustainability was the transfer of all BASICS child survival activities to the MoPH Child and Adolescent Health Department.

PRIORITY AREA ASSESSMENTS

USAID/Afghanistan is preparing for a transition to providing more financial resources directly to the MoPH in what is called "on-budget," while only supporting "off-budget" activities that require external management and inputs from outside the MoPH. After extensive discussions, it

was determined that rather than evaluating the entirety of the three projects, this evaluation would focus on the four priority areas supported within the current projects that require additional off-budget investment in the future to complement MoPH on-budget supported programs. These priority areas are capacity building, training, quality assurance, and community-based health care. It should be noted that, while training is often considered as a subset of capacity building, in this case it was decided to give training equal attention due to the high importance of, and great need for, quality training in Afghanistan.

Capacity Building

Introduction

Capacity building through the Tech-Serve, HSSP, and BASICS projects focused on three inter-related areas: 1) strengthening MoPH as the steward of the health sector; 2) improving and sustaining key operations (HMIS, medicine/supplies/equipments, workforce, finance) of the ministry and provincial directorate; and 3) improving the capacity of government officials and NGOs at the provincial level. Tech-Serve's scope was primarily dedicated to leadership and operational capacity building at both the national and provincial levels, while HSSP and BASICS encompassed policy development and system strengthening within their technical mandates. It should be noted that the service delivery function is discussed separately in this report in the subsection on in-service training and quality assurance.

Unlike operations research, drug distribution, or general service delivery – all three of which lend themselves to monthly work plans – CB is an ongoing process that requires repeated reassessment and realignment. The scopes of work for the projects (particularly Tech-Serve) as well as the PMPs provide overall direction for what needs to be done. Building the capacity of senior leaders at the central or district level, many of whom are political appointees, requires clear objectives. The PMP provides objectives, including where CB will be carried out and which units in the ministry will be assisted. Specific staff positions to receive attention are singled out in the case of some sub IRs. From there, the process needs to be flexible. One director may require a team-building session with staff, while another may need to learn how to network within the ministry; similar personalized attention is necessary at the district level. In addition, the leadership and management qualities that are being transferred need to be continually re-explained in different contexts as the central and district staff address new and more complex challenges.

Assistance highlights include 11 new national policies and strategies, including the National Health Policy for 2011-2015 and policies and strategies for QA, HMIS, CAH, nutrition, infant feeding, and diarrhea case management. In May 2010, the high-level National Maternal Child Health Committee (NMCHC) was established, with assistance from BASICS, to ensure policy dissemination and review. Nine MoPH units received leadership, management, and logistical assistance from Tech-Serve, including the GCMU and the CBHC Directorate, both of which are nearing graduation from support for staffing, as well as the Human Resources Directorate, DMU, and Health Management Information Unit.

At the provincial and district level, Tech-Serve's Leadership Development Program (LDP) was initiated in 140 health facilities, and an estimated 1,800 government, NGO, and community representatives have been trained through the program. Tech-Serve provided provincial health advisors (PHAs) and HSSP provided provincial coordinators (PCs) in 13 provinces to support different aspects of the BPHS and EPHS. Tech-Serve established the Provincial Health Learning Center in Herat as a Center of Excellence to serve as a model for BPHS management and implementation. BASICS helped develop provincial maternal child health committees as extensions of the NMCHC; meanwhile, HSSP supported critical organizational capacity building for two national organizations and two medical professional NGO associations.

Table I. Summary Tech-Serve, BASICS, and HSSP Capacity-building Accomplishments

Tech-Serve	<p>Assisted in the management, drafting, and development of major national policies and strategies</p> <p>Mentored and coached ministry leadership and major directorates and units</p> <p>Developed and fielded the Leadership Development Program</p> <p>Established the Provincial Health Learning Center in Herat</p> <p>Developed several national units to manage key operations such as HR, NGO contracts, drugs, and M&E</p> <p>Fielded provincial health advisors</p>
BASICS	<p>Participated in policy and strategy development and in the dissemination of policy elements</p> <p>Supported development of the National Maternal Child Health Committee and provisional committees</p> <p>Provided technical assistance to complete cost studies</p>
HSSP	<p>Incorporated project technical guidance, e.g., QA, into policies and strategies</p> <p>Provided organizational assistance to several health associations related to BPHS, including the Afghan Midwives Association</p> <p>Fielded provincial coordinators</p>

Annex D provides a list of Tech-Serve and BASICS indicators for capacity building.

Strengthening the MoPH as Steward of the Health Sector

USAID projects are influential, and are clearly appreciated and respected by the MoPH for their assistance with policy and strategy development. The projects hosted consensus-building sessions, provided expert consultants and project personnel to work with drafting teams, and prepared policies for dissemination. At times the projects have worked together at different stages to support a particular policy. For example, when the Child and Adolescent Health Policy and Strategy was being revised, BASICS supported consensus-building sessions, Tech-Serve assisted with drafting, and BASICS disseminated the strategy to the PCH NGOs. Similar situations arose with the Infant and Young Child Feeding Policy and Strategy and the National Policy for Community-based Health Care. Coordination among the projects proceeded well on these efforts and helped move the policy development process forward. Most important, the ministry demonstrated ownership of the process, as well as ownership of the actual policies and strategies.

Aside from policy and strategy development, BASICS staff and consultants helped build consensus for development of the National Maternal Child Health Committee. This effort, which was headed by the minister with participation from key international health organizations, MoPH, and the donor community, had the mandate to review policies and progress in strategy implementation. Bi-annual meetings began in May 2010 and provincial-level committees were formed. Minutes of the meetings indicate that the committee is a comprehensive mechanism to disseminate policies, strategies, and study findings to a wide range of health leaders and practitioners in the public and private sector.¹⁶ All NGO representatives surveyed noted that their staff had attended either a national- or provincial-level committee meeting.

¹⁶ MoPH/CAH, September 2011.

Recommendation: USAID should continue to monitor, and if necessary support, the MoPH's use of the National Maternal Child Health Committee and Provincial Maternal Child Health Committee.

Understanding the costs of providing services is important for the MoPH as it takes on more of a stewardship and normative role in the health sector. BASICS helped the MoPH determine what health money was being spent on and where the funding gaps lie. The information has been – and will continue to be, the team was told – reviewed by the NMCHC. While the team heard that delivery costs were higher than originally estimated, the improvement in health status and coverage discussed above demonstrates that the MoPH and donors can have greater confidence that their investments are resulting in significant accomplishments. This will allow program managers to better plan their strategies in the future.

Tech-Serve provided the MoPH with comprehensive capacity-building assistance focused on five key areas: 1) hands-on assistance in organizational change; 2) workforce development; 3) resource allocation; 4) partnerships; and 5) leadership.¹⁷ The project did so using technical assistance, training, observation visits, and, at first, embedded advisors. The embedded advisors started to be co-opted by the MoPH for routine work, moving Tech-Serve to the use of consultants for these tasks by the project's second half.¹⁸ Tech-Serve reports show that a small number of consultants with topic expertise were routinely used when needed.

Tech-Serve PMP results indicate that the MoPH is, in fact, becoming the steward of the health sector. This is indicated by the following facts:

- Seven MoPH management units use LDP techniques for achieving results (IR 3.b. target was five units).
- This year MoPH provided feedback to 100% of provincial public health directorates with requests (IR 2.j.).
- A policy to regulate private hospitals and diagnostic centers was developed and shared with the private sector (IR I.j).

Interviews with MoPH officials revealed that they appreciated that Tech-Serve encouraged ministry staff to follow a learning-by-doing approach to capacity building. This approach is in contrast to other donors whose consultants often tended to undertake tasks themselves, resulting in limited skills transfer.

An impediment to MoPH's becoming a recognized steward of the health sector is its own internal compartmentalization. Interviews and review of policy documents demonstrate a high level of compartmentalization among units within the MoPH. This has led to a lack of coordination both in Kabul and between Kabul and the field.

Both Tech-Serve and BASICS have been aware of the problem from the beginning of the projects and have attempted to address the issue in their programming. BASICS support for the NMCHC resulted in an on-going forum for communication among MoPH directorates and units, and an opportunity for MoPH leaders to encourage coordination, communication, and streamlining. Some Tech-Serve successes in addressing compartmentalization include the following:

- The General Directorate for Curative Services streamlined procurement within the directorate.
- A MoPH health retreat was held to improve mechanisms for enhanced donor coordination.

¹⁷ Tech-Serve response to team questions, October 2011.

¹⁸ Dugue and Loganathan, 2009, p. 29.

- CBHC works with reproductive health, child health, and other relevant units.
- The CHW is not being fielded as a stand-alone program.

Recommendation: Facilitating communication across directorates in areas of importance to the BPHS and EPHS should continue and be expanded. Mentoring new MoPH leaders and offices, some more than others, is also important for developing a team of stewards that can work together efficiently and productively.

Leadership development. A centerpiece tool of capacity assistance is Tech-Serve’s Leadership Management Program, a multistaged approach to developing leadership and management skills that provides for both self-monitoring and independent monitoring. An estimated 1,800 provincial public health officials (PPHOs) and NGO and hospital staff have received LDP training and all USAID provinces have been monitored to determine if the skills are being used. LDP skills range from building teams, to developing community consensus, to mobilizing resources. The facilitators for LDP include a wide range of topic experts and representatives from ministry units. When Tech-Serve began building the capacity of hospitals, LDP facilitators included representatives familiar with Tech-Serve assistance to set up drug and therapeutic committees, as well as facilitators with experience in budgeting and working with the Ministry of Finance.

In tracking the progress of LDP via the PMP, all four indicators under Tech-Serve’s IR 3 “improve management and leadership capacity” were met or exceeded. The evaluation team found support for the program among PPHOs, and Tech-Serve reports that, for IR 2.h., 90 health facilities in USAID and non-USAID funded provinces are applying the Leadership Development tool. The notion of transferring the PDP program to a ministry entity has been discussed for some time. Tech-Serve’s mid-term evaluation recommended transfer of LDP elements to an Afghan institution, naming the Afghan Institute of Public Health¹⁹ as the likely candidate. More recently, MoPH’s HR Directorate is being considered as a candidate for taking on LDP, with a long-term view of offering the program to other ministries.²⁰

LDP is a program that requires state-of-the-art international management and leadership participation and fine-tuning. Usually one would transfer responsibility for such a program to another entity that was already implementing a similar program and needed minor oversight during the transfer. Given this reality, the evaluation team is hesitant to endorse a rapid move to transfer LDP at this time. It is important that the program continue to project gravitas and dynamism with the individuals and teams served.

Recommendation: It is too early to transfer the LDP to a government agency. LDP should be continued, expanded to new districts, and periodically updated.

Improve and help sustain key operations of the MoPH

Tech-Serve provided considerable assistance to directorates and units in MoPH to improve their operational and administrative structures and mechanisms and day-to-day management. The content of this assistance has ranged from individual leadership training, to advising units on strategy implementation and tool development, to providing offices with equipment and space for work and holding meetings. HSSP provided similar organizational development support to a number of national and non-governmental medical associations.

Key operations that currently exert an impact on BPHS and EPHS implementation relate to management of human resources, contracts, drugs and medicines, and information.

¹⁹ Dugue and Loganathan, p. 10.

²⁰ Tech-Serve responses to questions, October 2011.

Human resource management. The National Health Strategy for 2011-2015 is transparent on the subject of the low salary scales that exist within the MoPH and the high vacancy rates, which range from 19-34%.²¹ A majority of vacancies are in positions needed to effectively implement the BPHS and EPHS, and include female doctors, midwives, nurses, and technicians. Turnover rates of up to 50% have been reported; recruiting women professionals, especially when the women need to travel to the field, is difficult. At the provincial level, medical personnel in NGOs are paid on MoPH salary scales, yet other NGO personnel have much higher salaries. At the national level, consultant salaries are significantly higher than regular ministries salaries.

Tech-Serve helped the HR directorate standardize position descriptions, qualifications, and reporting and is helping link HR information with financial information (e.g., salaries.) It also advises specific ministry units (e.g., the GCMU) on their own HR procedures. Tech-Serve's sub IR I.I "the number of health workers nationally registered with MoPH with updated data in the HR Directorate database" was exceeded by 38%, with 34,600 existing health workers registered. Concurrently, the Civil Service Commission (IARCSC) plans to launch its own system for all ministries; while this national process is not proceeding as scheduled, the MoPH HR Directorate has worked well with IARCSC in the past²² and maintains communication on national HR issues.

Recommendation: In the near term, the Ministry of Public Health's Human Resources Directorate needs concerted assistance in human resource planning, including recruitment and benefit plans, to raise the stature of what are likely to remain low-paying positions.

Contract management. The GCMU could prove to be a REACH²³ and Tech-Serve success story, as well as an important sustainability achievement for USAID. GCMU manages procurement, grants management, and financial and program reporting for the PCH program, which supports NGOs in USAID-funded provinces. This procurement unit works in parallel with other procurement in MoPH. The grants themselves are supported on-budget, offering a significant sustainability achievement and savings on overhead for USAID.

As the GCMU becomes independent from project support and oversight, it is worth tracking how the unit works with grantees. NGOs surveyed appreciated GCMU's capacity to fund and monitor its programs, and appreciated the fact that they got feedback on their reporting. GCMU is viewed as the appropriate vehicle for contract management over the medium term, and remains a testament to taking the long view when building capacity. Some problems with purchasing equipment, receiving budget tranches, and micromanaging by GCMU were noted, but in general progress has been good.

At issue now is the transfer of approximately 20 Tech-Serve consultants in GCMU to MoPH consultant positions. In terms of evaluating whether GCMU is organizationally ready for the transfer, it is worth noting that Tech-Serve still remains involved in amending contracts with service providers²⁴ and has identified that additional finance and HR assistance will be needed after the transfer.²⁵ It will be important to check in on routine activities after the transfer. The current state of play is as follows:²⁶

- The acting minister of public health and USAID are expected to approve MoPH's contract template for the consultants by December 2011.

²¹ IRoA/MoPH, Strategic Plan 2011-2015, p. 26.

²² Schemionek et al. reports that the HR Directorate and IARCSC worked together between 2002 and 2005 to develop the current structure.

²³ Rural Expansion of Afghanistan's Community-based Health Care.

²⁴ USAID/Tech-Serve, PY5 Semi-annual Report, October 10-March 11, p. 16.

²⁵ USAID/Tech-Serve, PY5 Semi-annual Report, October 10-March 11, p. 20.

²⁶ Tech-Serve responses to questions, October 2011.

- Tech-Serve has hired two HR consultants to negotiate with the PCH consultants, who are prepared to enter into negotiations once the template is approved.

Staff turnover has presented challenges when moving local advisors from one USAID project to another in the past in Afghanistan. Transfer of personnel from a project to the ministry may face similar challenges and will require post-transfer monitoring.

Recommendation: Once transfer of Tech-Serve consultants to the MoPH is completed, it will be important to monitor MoPH's progress on routine actions, such as NGO contract management. The turnover rates of these personnel should also be monitored and assistance provided to fill gaps.

Drug management. Under the REACH project, MSH delivered and monitored essential drugs provided to PCH NGO sites. In the first years of the follow-on project, Tech-Serve built capacity within the ministry's DMU and transferred the monitoring role to the unit. Like GCMU, the DMU remains a parallel unit within the ministry. In FY 2009, the DMU monitored 21 NGO stocks and 102 health facilities. Reporting for April through June of 2011 indicates that the DMU is capable of monitoring NGO sites, with modest oversight by Tech-Serve PHAs. DMU reports include data on the number of drugs used by NGOs compared with the NGOs' monthly projections; the reports monitor the delivery of drugs against requests made by the NGOs.²⁷ This system is more reality-based than GCMU's method of tabulating drug needs up-front on the basis of NGO proposals.

Tech-Serve continues to provide essential drugs, contraceptives and, on request, equipment. Five Tech-Serve sub IRs – IR 1.e to 1.i – under IR 1 “improved capacity of the central MoPH to support the delivery of BPHS and EPHS services, primarily through NGO service providers” relate directly to drug distribution. All sub-IRs appear to have been adequately met. Tech-Serve also assessed pharmaceutical supply and management, provided 500 NGO facilities with equipment, and initiated work on rational drug use to support maternal and child health (MCH). At the same time, reporting from the DMU and the field notes cases of drugs being slow to arrive and drug stocks expiring. These problems, which include lags in getting drugs into the country, are not unusual for poor or conflict-ridden countries. However, it does mean that concerted attention needs to be paid to improving current supply chain management. In the future, it will be important to determine whether and how to invest in building and transferring supply chain management capabilities to the MoPH or an Afghan entity. USAID is now using the MSH Sustainable Management Systems (SMS) project to expand on Tech-Serve activities in rational pharmaceutical management and drug management. That project could be better used to access MSH expertise in supply chain management.

Recommendation: Improve supply chain management for the BPHS and EPHS programs to ensure timely delivery of drugs and avoid expirations.

Recommendation: For the long term, develop a plan to transfer supply chain management to an Afghan institution (public or private).

Information management. While all three projects worked with the HMIS Unit in MoPH to ensure quality indicators were available for the BPHS and EPHS, Tech-Serve's objective was to advise on the development of the unit itself and implementation of its work plan. Tech-Serve's 2006 mid-term evaluation team noted that “completeness and adequacy of HMIS reporting increased in three years corresponding to the Tech-Serve project.”²⁸ In recent years USAID-funded provinces consistently provide indicator reporting and other types of information reporting, such as the preparation of minutes on Provincial Maternal Child Health Committee

²⁷ Tech-Serve, June 2011.

²⁸ Dugue and Loganathan, p. 26.

(PMCHC) meetings, better than other provinces.²⁹ Over the last year Tech-Serve helped revise HMIS Unit forms to highlight organizational, process, technical, and behavioral determinants. Its coaching also resulted in MoPH's leading a household survey and a data analysis workshop for the Lot Quality Assurance Survey (LQAS). Tech-Serve exceeded its IR I.n. indicator of training 40 Provincial and Central staff on the LQAS tool by 20%, training more staff than targeted in the sub-IR. This IR, established to measure the number of people trained, provides an indication of this training's impact.

Interviews and reporting statistics indicate that reporting from the PCH NGO sites is good. There is interest in both Kabul and the field in the Internet and achieving Internet connectivity; this can be achieved via a number of innovative means, including cell phones and satellite devices that can make use of self-generated electrical sources, if necessary. The belief is that standardized electronic connectivity would increase the efficiency of reporting, improve the use of reported information, and better disseminate information to various audiences, including providers who need this information to improve service delivery.

Recommendation: USAID should support the development of Internet connectivity among relevant monitors and implementers for BPHS and EPHS in USAID-assisted provinces. The system itself could be funded on-budget, with additional technical assistance provided, as needed.

Improved Capacity of Government Officials and NGOs at the Provincial Level

Capacity building at the provincial level has focused on three areas: first, building the leadership and management skills of individual health providers within the government and NGOs; second, developing and strengthening health teams and their systems; and third, encouraging coordination with MoPH units. Evaluation team members asked Tech-Serve staff what PHOs were doing differently today than four years ago. Project staff cited the following, backed up by evidence from individual provinces:

- Discussing and analyzing health status, risks, and remedies
- Reviewing NGO quarterly reports and providing actionable feedback
- Updating provincial health profiles; improving the quality of provincial public health coordinators (PPHCs)
- Raising resources from provincial reconstruction teams (PRTs) and other donors
- Developing services in such areas as environmental health and health emergency management
- Improving capabilities in identifying areas of provinces that are underserved³⁰

Related to LDP, Tech-Serve established the Provincial Health Learning Center in Herat as a center for excellence where provincial and district teams come to learn together and understand what their counterparts in other districts do. This center combines LDP and service delivery capacity building in an environment familiar to participants. While Herat is more accessible than many provinces outside of Kabul, Afghanistan's conflict, rough terrain, and weak travel infrastructure will remain challenges for the center's operations in the near future. Nevertheless, testimonials from participants are positive and a strong model has been developed that can serve as an effective way to strengthen service delivery programs.

²⁹ Tech-Serve responses to questions, October 2011.

³⁰ Tech-Serve responses to questions, October 2011.

Advisors. Tech-Serve and HSSP have on-the-ground advisors at the provincial level to provide technical assistance, facilitation, coaching, liaison with ministry units, and gap assistance for provincial health officials and NGO providers. Annex E provides side-by-side job descriptions for the two positions, showing similarities in qualifications and distinctions in responsibilities and scope. As evident in both job descriptions, much of the advisors' time is spent representing, acting for, and reporting to either HSSP or Tech-Serve. HSSP PCs tend to focus on the technical work of the BPHS implementing NGOs. A PC may, for example, provide QA post-training follow-up to a health facility. Tech-Serve PHAs assist PPHOs in performing their core functions and tasks; given the current turnover of personnel, this appears to be a recurrent need. A PHA may coach a PPHO in reviewing NGO performance or secure training in pharmacy management for a district. PHAs and PCs have participated in joint monitoring with PHO teams. The evaluation team's discussions in the field and with the projects indicate that the two advisors have a good working relationship.

The advisors themselves are busy and continually juggle stakeholders in Kabul, staff at their project headquarters, and provincial counterparts. Nevertheless, combining the PC and PHA positions into one advisor position is tenable and advisable, considering the plethora of actors working with provincial offices, the PCH NGOs, and health facilities. The question is how to configure the position. From what the evaluation team learned in the field, there too much work for one person, which suggests the possibility of a two-person advisory team with a single scope. Alternatively, at this juncture in the program, it may be useful to have a single, senior adviser. The scope of the advisor could be to pull back from day-to-day assistance and focus on helping provincial leaders and NGOs address key issues.

Recommendation: The PHA and PC positions should be combined, either into a two-person team that covers the current job descriptions under a single scope or, preferably, into a single, senior advisor in each province who addresses key government and NGO needs.

PHC/NGOs. NGOs contracted by the MoPH form the hub of service delivery in the provinces. Some are experienced, others less so. Most are Afghan. Except for the MoPH medical staff noted above, NGO salaries are much higher than MoPH employees. Field visits and surveying of PCH/NGOs in the last month indicates they are confident about what they do, know what assistance they need from projects such as Tech-Serve, HSSP, and BASICS, and tend to see themselves as more experienced than ministry counterparts, such as those in the CBHC Directorate. Nevertheless, they want BPHS to work, and rely on the government and the projects for critical needs such as budget, drugs and contraceptives, and information infrastructure. There was considerable anecdotal evidence in the field that the monitoring and inputs provided by the PHAs and PCs have increased communications between the MoPH, NGOs, and the facilities, leading to better outcomes in service delivery. However, the evaluation team did not find any source of measured impact that this and other technical assistance provided.

For incremental funding of the NGOs, the MoPH procedure is to monitor NGO progress semi-annually as a prerequisite to contract extensions. The MoPH reports having visited 11 of 13 NGOs at least once over the last year. However Tech-Serve reports that the ministry's visits are less regular. In the June 2011 Ernst & Young audit of 10 NGOs, auditors noted that some NGOs said there were cases of MoPH funds' not arriving on time.³¹ Attention to incremental funding is important and, as recommended above, close monitoring of the transition of consultants from Tech-Serve to MoPH is necessary to ensure that funding gaps do not increase.

Recommendation: Ensure that NGOs receive incremental funding on time. This may require changes in funding tranches to address MoPH slowdowns in monitoring and disbursement.

³¹ Ernst & Young, p. 12.

NGOs are evaluated on a quarterly basis on administration, service delivery, and coverage of all the NGO's health facilities by the organization's Project Data Sheet. Tech-Serve has found that joint monitoring by Kabul-based and local MoPH officials, using the National Monitoring Checklist (NMC) has helped both the PCH and the NGOs identify programming gaps. Specific to hospitals, the EPHS monitoring checklist covering management, infrastructure, supplies, staff, and service delivery has uncovered important improvements. From April 2010 to July 2011 the provinces of Ghanzi, Paktia, Badakhshan, Khost, and Paktika showed increased scores in all five areas monitored.³² Tech-Serve and the evaluation team see this tracking as useful for meeting stated objectives. HSSP would like to see more QA work tracked in the NGO proposal and monitoring and evaluation processes to build commitment and better integrate QA into the health system.³³ In short, HSSP would like better tracking of QA, and that process has started. Both projects see a positive correlation between tracking and implementation.

Recommendation: QA tracking should continue to be established and, as USAID implementation priorities change, those priorities should be tracked in NGO proposal, monitoring and evaluation processes.

Despite improvements, weak coordination at the central level affects information management. Monitoring visits are not always coordinated, and it appears that too many people provide assistance with program reporting and M&E. When three NGOs were asked who provided them with assistance on program reporting data, all three said MoPH/HMIS, MoPH/M&E, and Tech-Serve. Two of the three also reported assistance from their own headquarters office, HSSP, BASICS, and another donor. Rationalization of the number of entities working with NGOs, even when for different purposes, is necessary. It was noted that in non-Tech-Serve provinces, M&E was in need of more improvement than in the ones Tech-Serve supports.

Like their MoPH colleagues, NGOs would like to have Internet-based systems. As one NGO put it, "If we establish a networking communication with HFs through Internet facilities [it] would help the HMIS system in the country to use more reliable data." He went on to note that the system needed to be simple. An investment in connectivity would improve the processing and use of information and, once in place, could help open coordination channels among key offices within the ministry.

Recommendation: Future off-budget technical support should be provided to help the MoPH and NGOs develop a unified, simplified system to monitor M&E and HMIS reporting, and decrease the number of contacts and MoPH counterparts involved, until such time the NGOs or MoPH are able to take over this function efficiently and effectively.

³² Tech-Serve response to questions, October 2011.

³³ HSSP response to questions, October 2011.

II. TRAINING

INTRODUCTION

Afghanistan faces a serious shortage of trained health care providers, especially females, to deliver critical maternal and child health services. To address this need, HSSP, BASICS, and Tech-Serve contributed to the rebuilding of human resources for health in Afghanistan by providing pre-service and in-service clinical and non-clinical training for doctors, nurses, midwives, and NGO staff. While Tech-Serve lacked a specific mandate for in-service clinical training, it did strengthen the capacity of central- and provincial-level health providers among MoPH and NGO staff. Tech-Serve's capacity-building efforts included training in leadership, management, planning, monitoring, and evaluation; these efforts are described in this report in the section on capacity building. BASICS provided training to improve QA as part of its pediatric hospital Initiative, as described in the section of this report on quality assurance. HSSP, Tech-Serve, and BASICS supported training for community health supervisors and community health workers to strengthen community-based maternal and child health programs, efforts discussed in the section on community-based health care.

This section focuses on pre-service and in-service training conducted by HSSP in family planning, reproductive health, newborn health, and maternal health. Specific education and training programs and approaches and innovative technologies used for training are addressed, along with findings and conclusions for education and training institutional development. The section is divided into three parts: a) institutional development for pre- and in-service training; b) in-service training and clinical, non-clinical, and community-based programs and approaches; and c) use of innovative technologies for training.

INSTITUTIONAL DEVELOPMENT FOR PRE- AND IN-SERVICE TRAINING

National Level

Development of foundational policies. HSSP and BASICS provided support to the MoPH to develop five foundational, evidence-based policies and strategies to improve reproductive health and child survival in Afghanistan:

- National Reproductive Health Strategy 2011-2015 (HSSP)
- National Child and Adolescent Health Policy 2009-2013 (BASICS)
- National Public Nutrition Policy and Strategy 2009-2013 (BASICS)
- Infant and Young Child Feeding Policy and Strategy 2009-2013 (BASICS)
- National Action Plan of Improved Diarrheal Case Management (BASICS)

The development and implementation of these policies and strategies required HSSP and BASICS to assess the capacity of the respective MoPH departments with which they worked and to assist the MoPH in developing action plans to address gaps and challenges facing the departments. The strategies also defined the needs for human resource management and pre- and in-service training for various levels of the health system.

Ghazanfar Institute of Health Sciences (GIHS), Kabul. GIHS in Kabul and its eight satellite campuses are responsible for training mid-level health workers for the entire country, including midwives, nurses, and allied health professionals. There are nine institutes of health sciences (HIS), including the GIHS in Kabul. GIHS serves as the policy-making center and coordinating

body for the satellite IHS campuses and is the largest pre-service academic institute of the MoPH.

HSSP identified systemic weaknesses within GIHS that impede its ability to meet the training needs of the country's health system. HSSP has supported and strengthened the institutional and human capacity of GIHS by providing an international technical advisor and an administrative officer to GIHS in FY 2010. HSSP also conducted a comprehensive capacity assessment of GIHS in FY 2011 on 12 capacity-related topics to identify strengths and weaknesses. HSSP found that the MoPH's financial and technical resources are insufficient to implement the recommendations that resulted from the GIHS capacity assessment.

Afghanistan Midwifery and Nursing Education and Accreditation Board (AMNEAB).

AMNEAB is the national regulatory authority for the establishment and maintenance of high-quality midwifery educational institutes in Afghanistan. Pre-service education accreditation standards are used by the ANMEAB to evaluate Community Midwifery Education (CME) implementers and ensure the quality of midwifery education programs.

The midwifery standards have been used effectively in the accreditation process since 2003. HSSP served as Secretariat of the AMNEAB up until the end of FY 2010, at which time the AMNEAB office was shifted to the Ghazanfar Institute for Health Sciences in Kabul. In FY 2011, HSSP supported the AMNEAB in renovating and furnishing an office, conducting 12 assessments, and accrediting seven additional midwifery schools. The HSSP project supported the ANMEAB in reinforcing regulation and strengthening the supervisory system so midwives can perform effectively after their deployment to the health facility. As a result of HSSP support, the ANMEAB has accredited all 27 midwifery education programs in the country.

Afghan Midwifery and Nursing Council (AMNC). HSSP supported ANMEAB and the Afghan Midwives Association (AMA) in beginning the establishment of the AMNC. It is presumed that such a council could serve as an autonomous regulatory authority to implement legislation once it is developed. A consortium of partners, including an HSSP grant to AMA, United Nations Population Fund, and others, would support the establishment of a fully functioning AMNC.

Mental Health Department of MoPH. HSSP collaborated with the Mental Health Department of MoPH in establishing a mental health service training program for the country. The project supported the Mental Health Department in identifying and selecting 30 mental health trainers from five main regions and developed a post training follow-up tool. This training had not been completed as of October 2011 but is on track for completion next quarter.

Maternal and child health survival committees. BASICS helped MoPH institutionalize child survival by establishing national maternal and child survival committees. These committees meet twice a year.

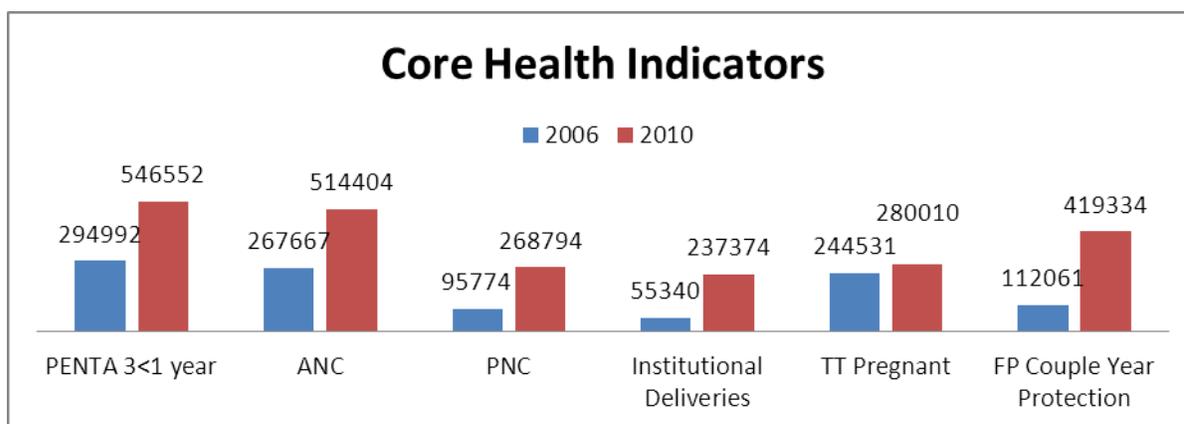
Provincial Level

Regional training sites. HSSP and BASICS conducted clinical training sessions and provided technical assistance to regional training sites. For example, as part of the National Reproductive Health Strategy (NRHS), HSSP provided technical assistance and clinical training in newborn care (NBC) to the three regional NBC training sites in Herat, Balkh, and Kabul provinces.

Effective Teaching Skills (ETS). In response to USAID/Afghanistan's concerns about the quality of replicable trainings at the provincial level, HSSP designed and added ETS courses and trained 50 NGO trainers and capacity-building officers from 17 provinces in ETS. Provincial coordinators who received training improved their monitoring of the training replication process. Provincial coordinators attended replication trainings, assisted when needed, and reported back to HSSP on training organization and quality.

Support to provincial leadership development. BASICS helped the MoPH initiate and establish MCH committees in five provinces. MCH committees, now functional, are improving coordination at the provincial level. Tech-Serve supported MoPH in designing and conducting an assessment of the health system at the provincial level by developing a system to measure improvement in health through six core indicators of progress. Provincial public health office representatives calculated and analyzed the six core health indicators through quarterly reviews. The six indicators are: PENTA-3; antenatal care; postnatal care; deliveries; tetanus toxoid 2; and family planning couple years of protection.³⁴

Figure 1: Core Health Indicators 2006-2010



Source: Tech-Serve data provided to team, November 1, 2011.

Professional Medical Non-governmental Organizations

Afghan Midwives Association. HSSP has supported the AMA since its establishment in 2005. In the early years, HSSP provided the AMA with technical and advocacy support. As the AMA's capacity in those areas grew, HSSP later provided technical assistance to strengthen AMA's organizational capacity in an effort to promote longer-term sustainability. HSSP has supported the development of a board of directors for the organization, and assistance for AMA to conduct its first board meeting. The HSSP project has supported AMA in developing a governance structure, conducting an AMA partners' meeting, and leading coordination efforts with partners to advance the establishment of the ANMC. AMA is currently managing funds to implement three projects.

Afghan Society of Obstetricians and Gynecologists (AFSOG). HSSP has provided financial and technical support for AFSOG to hold four congresses.

Conclusions and Recommendations: Institutional Development of Pre- and In-service Training

GIHS. GIHS has systemic weaknesses that impede its ability to meet the training needs of the health system. It will continue to require significant technical assistance and support to carry out its role of formulating relevant policies and curricula for the eight satellite IHSs.

Recommendation: USAID should provide financial and technical resources to GIHS to implement the recommendations that resulted from the GIHS capacity assessment.

³⁴ PENTA-3 is a combination of five vaccines to protect against preventable diseases: diphtheria, pertussis, tetanus, polio, and hepatitis-B.

Mental health. USAID projects have provided limited assistance to the MoPH Mental Health Department and the activities have not yet been completed. It does not appear to be part of a larger strategy for mental health. The team concluded, while there may be enormous needs for mental health services in Afghanistan, to achieve significant impact, USAID assistance would require a multiyear strategy with substantial funding and technical assistance.

Recommendation: USAID lacks a comparative advantage in assessing or strengthening mental health services. It would be more efficient to shift this assistance to another U.S. Government agency or another international donor.

Institutional development. HSSP supported organizational development of national institutions and professional medical NGOs. These institutions and associations play a useful role in regulating the health sector and building the clinical skills of health providers. Medical associations also have a useful role to play in insecure or conflict-affected environments, as they can assist in providing health service delivery personnel when the MoPH or implementing NGOs face staffing shortages in specific provinces.

Mental health. The team also recognized the value that the professional associations can provide in fostering the exchange of knowledge and skills, even between countries. The AMA study tour where midwives participated in Safe Motherhood training in Egypt was a good example of South-to-South cooperation that enabled midwives from both countries to share best practices and lessons learned. At the same time, the approach to institutional development was fragmented, despite the large amount of technical assistance provided for workshops.

Recommendation: Future efforts to strengthen national and professional medical organizations would benefit from a more coherent and strategic approach to addressing the types and numbers of institutions to be developed.

Recommendation: An institutional strengthening strategy should be developed that defines the priorities areas for assistance for each organization; provides a cost-benefit analysis; and includes annual performance monitoring and evaluation plans.

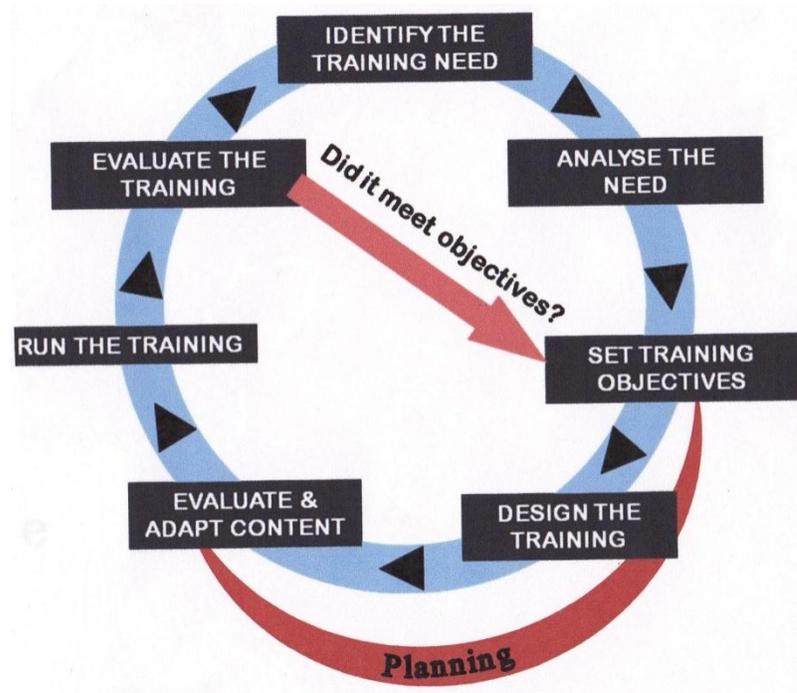
IN-SERVICE TRAINING AND CLINICAL, NON-CLINICAL, AND COMMUNITY-BASED PROGRAMS AND APPROACHES

HSSP had a well-defined objective for training, expressed in a specific IR to address the critical need for trained female health care providers: “Increased number and performance of BPHS providers, especially women in rural and underserved areas.” Data provided by HSSP indicate that the project has either achieved its training objectives, or is well on the way to achieving its training targets before the project’s end. HSSP monitored and measured performance against this IR through several indicators. A complete table of indicators measuring training outputs is provided in Annex F.

Competency-based training. HSSP was the technical lead and principal support mechanism for in-service, competency-based training for family planning, reproductive health, and maternal/newborn health. HSSP provided training and training materials to NGOs working under the PCH and BPHS and EPHS health facility staff on the following subjects: basic emergency obstetric care (BEmOC); IMCI; advanced newborn care; essential newborn care; and basic essential obstetric care (BEOC). In addition to clinical training, HSSP also provided non-clinical competency-based training on a wide range of topics, including gender awareness, partnership defined quality (PDQ), interpersonal communication and counseling (IPCC), laboratory skills, blood transfusions and blood banking, rational drug use (RDU), and ETS.

HSSP's approach to in-service training was systematic and involved a training cycle model. (See Figure 2.) The cycle includes pre-training, during-training, and post-training phases. The outcome of each stage provides the inputs for the next stage; the omission of any stage undermines the validity of the process. The training process requires the measurement of pre-test scores and post-test scores of trainees to evaluate training effectiveness.

Figure 2: HSSP In-service Training Approach



HSSP reported that, as of March 2011, the project had supported clinical and non-clinical training for nearly 1,600 health facility providers.

In terms of the cumulative numbers of people trained, from July 2006 to August 2011, HSSP funded over 546 trainings with over 12,809 beneficiaries³⁵ (see Figure 3).

³⁵ HSSP. Data in PowerPoint briefing provided to team, September 2011, p. 58.

Figure 3: HSSP Training Achievements 2006-2011



Source: HSSP Data in PowerPoint briefing provided to team September 2011, page 58.

HSSP also supported the development of the post-training follow-up (PTFU) system to ensure sustained performance improvements among trainees. The project assisted the MoPH in reviewing post-training follow-up tools and conducting PTFU in five areas of five training: IMCI, emergency obstetric and neonatal care, NBC, family planning and interpersonal counseling. HSSP and MoPH were still assessing the lessons learned from that effort at the time of the writing of this report. The lessons will be used to improve the system so that it can be nationalized and institutionalized within the MoPH and in the NGOs.

HSSP promoted a learning transfer training methodology to improve service delivery quality and sustainability. The project facilitated the visit of health providers to nine model health facilities. Demonstrations at the facilities modeled best practices and lessons learned on delivering quality health services and improving coordination and communication among health facility staff and health *shuras* in the community. Participants developed action plans to be rolled out in their health facilities; they reported that the experience provided them with important tools for improving the quality of services they provide.

Community Midwifery Education (CME) Program. The HSSP midwifery education strategy included the following elements: i) supporting midwifery schools; ii) developing the CME curriculum and learning resource package (LRP); iii) strengthening faculty; iv) training community midwives and hospital midwives; v) strengthening the GIHS; vi) strengthening supportive supervision; and vii) evaluating the national midwifery education program.

As of March 2011, HSSP had provided 16 grants to subrecipients across 13 provinces for pre-service training of community and hospital midwives.³⁶ HSSP provided technical support to the grantees to ensure that high-quality midwifery education would be conducted according to national standards.

HSSP also revised the CME curriculum to include new content area in response to competency gaps and the actual jobs being performed by midwives, and, as a result, recommended extension in the duration of CME training from 18 to 24 months. MoPH approved the extension in the

³⁶ USAID and HSSP. Semi-Annual Report. October 1, 2010 – March 31, 2011. Annex 9, p. 117.

duration of CME training. HSSP has worked to update and revise the CME LRP accordingly. A list of the Community Midwifery Education Learning Resource Package modules, and the status of their completion, is provided in Annex G.

A total of 942 hospital and community midwives graduated from HSSP-supported programs from HHSP's inception through March 2011.³⁷ (See Table 2.) The number of midwives trained represents 89% of the adjusted end-of-project target (1,059 midwives), and accounts for 40% of the national midwifery workforce (2,367 midwives) trained since 2003.³⁸ These absolute numbers may not seem significant, but considering that Afghanistan had fewer than 500 midwives in 2002, these achievements are noteworthy.

Table 2. HSSP: Midwifery Training Achievements

Indicator	Adjusted Target 2011	Cumulative Result (2009-March 2011)
Number of community midwives trained by HSSP-supported community midwifery schools	630	504
Number of hospital midwives trained by HSSP-supported Institute of Health Sciences	429	438
Percent of HSSP-supported community midwifery school graduates deployed to health facilities	98%	72%

Source: HSSP Semi-Annual Report, October 1, 2010-March 2011, Annex 2, PMP, p. 98.

As of March 2011, 401 students were enrolled in HSSP-supported CME programs. The project reported a 72% deployment rate for midwives.³⁹ While this result is on track, there were reported obstacles that interfered with graduates' successful deployment to health facilities. Among the obstacles cited were worsening security in project-supported areas, and graduates' not being selected from areas where there are vacancies in facilities. This was attributed to low literacy rates among women, which prevented them from meeting selection criteria for enrollment; this will need to be addressed with intermediate methods such as the use of pictorial lesson books, etc. The project noted the importance of community involvement and coordination among implementing NGOs, provincial health director offices, the health *shura*, and community elders in the selection, deployment, and security of midwives assigned to communities.

HSSP provided financial and contractual oversight of the 16 grants; these functions were to be transferred to the GCMU for on-budget support in September 2011. HSSP reported that it has provided orientation to GCMU members and that it will continue to discuss and report on the transition. While GCMU has the capacity to manage the grants, HSSP reported that it lacks the capacity to provide technical oversight of the CME programs.

The Evaluation of the Pre-service Midwifery Education Program in Afghanistan (March 2011) revealed that community and hospital midwives are having a substantial, significant impact on

³⁷ HSSP Semi-Annual Report, October 1, 2010 – March 2011, Annex 2, PMP, p. 98.

³⁸ According to the Evaluation of the Pre-Service Midwifery Program, 2,367 midwives had graduated as of November 2010.

³⁹ Deployment rate is defined as: number of graduates who are assigned to a health facility/# of graduates.

maternal health utilization and skilled birth attendance rates. Antenatal care rates increased significantly from 2003 to 2008, on average by 30% in provinces with midwifery schools.⁴⁰

Family planning service training within BPHS. One of HSSP's major objectives has been to strengthen family planning services within the BPHS by funding, planning, managing, and conducting in-service training for family planning. The project has helped build the skills of health providers through the provision of competency-based training in counseling, DMPA injection, post-partum intra-uterine contraceptive device (PPIUCD) insertion, and condom and pill demonstration.

Post-test training results reported for various family planning training sessions in FY 2010 ranged from 81% to 96%, indicating that the trainees were competent. HSSP's assistance to the MoPH for family planning has consisted of: i) preparation of training of trainers courses (such trainers are often referred to as master trainers); ii) translation of LRPs; iii) donation of training models and instruments; iv) identification of national master trainers; and v) preparation of site readiness assessments to strengthen clinical training sites.

A promising indicator that family planning services were strengthened and scaled up around the country is an observed increase in the CPR, which increased from 24.7% at project baseline (2006) to approximately 43% in 2009.⁴¹ Another promising indicator is the number of new cases of family planning visits reported in HMIS for health facilities covered by PCH and quick impact provinces; the figure was 363,873 for the period July 2009 to December 2010. This represents 94% of the adjusted target for 2011.⁴²

The team noted a troubling finding related to the status of family planning. Health providers' motivation to provide family planning has apparently been declining.⁴³ Under USAID-supported PCH programs, implementers cannot have any family planning targets, in accordance with U.S. policy Tiarht restrictions. Thus, family planning providers believe that they receive insufficient recognition for their efforts to increase utilization of family planning.

Community Health Nurse Education (CHNE) Program. The Community Health Nurse program is a top priority of the MoPH. A community health nurse is a first-level health care provider who has successfully completed the two years of a community health nurse (CHN) education program and is qualified and licensed to practice as a CHN in health facilities and in the community. HSSP has assisted the MoPH in the development of this program since 2009. Reported progress included approval by MoPH for CHN education program policy, preparation of LRP curricula and standards, and faculty development. The evaluation of the Pre-Service Midwifery Education Program supported the need for this cadre of health provider to reduce the overall shortage of nurses. This cadre also provides nursing and other services that are outside of reproductive health. Since midwives are often called upon to provide services outside of reproductive health, the presence of more CHNs would enable midwives to focus on their primary role as skilled birth attendants.

As of end FY2010, 150 students from four provinces had been trained. An additional 150 students from another four provinces are scheduled to be trained by the end of the project.

The CHNE Learning Resource Package and faculty development training package are still in the process of being completed. Semester I, which included seven modules, was completed June

⁴⁰ USAID and HSSP. Semi-Annual Report. October 1, 2010 – March 31, 2011. p. 16

⁴¹ Data source for CPR: Performance Based Partnership Grants Household Survey, as noted in HSSP Annual Report for FY 2010, p. 39.

⁴² USAID and HSSP. Semi-Annual Report. October 1, 2010 – March 31, 2011. Annex 2, p. 97.

⁴³ Interview with MoPH Director for Reproductive Health.

2010. Semester 2 included nine modules and was completed July 2011. At the time of writing, HSSP reported that Semester 3 would be completed by the end of December 2011.

HSSP reported that ANMEAB instructed one CHNE school to stop implementation since faculty had not been trained and they were not using approved standards. This is a good example of the accreditation and regulation oversight role that ANMEAB is playing. It also underscores the need to complete the LRP and faculty development plan.

Training in hospitals. Tech-Serve provided technical support to the MoPH to develop hospital-related policies, strategies, and standards to be applied to all reformed hospitals across Afghanistan. Tech-Serve also assisted with EPHS implementation at five PCH-supported provincial hospitals in Ghazni, Paktia, Paktika, Khost, Farah, and Badakhshan. Tech-Serve conducted training-of-trainer courses for selected staff and organized intensive hands-on clinical training for provincial hospital staff from 12 USAID-supported provinces and 5 quick impact provinces. Clinical training that Tech-Serve provided was conducted at Cure Hospital in Kabul and focused on obstetrics and gynecology, internal medicine, and pediatric surgery. A five-member outreach team conducted follow-up monitoring visits to assess the work of the trainees and provided input into action plans so that NGOs could address gaps and challenges. In addition, Tech-Serve provided trainers and training materials to the 11-day training course on IMCI for 10 hospital interns (seventh year medical students) from the Faculty of Medicine at Kabul University.

IMCI. BASICS served as the technical lead and principal support mechanism for infant and child health care. As such, the project provided training and training materials for BPHS facility providers, with a focus on IMCI. One of the most significant achievements under BASICS was a study conducted to evaluate the effectiveness of an alternative approach to the IMCI training for facility-based health workers. Based on a review of the IMCI program in 2008, BASICS supported the MoPH in improving the IMCI training curriculum by updating it to include zinc and the newborn period, as well as antibiotic updates, and to shorten the curriculum from 11 days to 7 days to facilitate course completion by more rural and remote health workers. A monitoring and supervision system was also developed to promote the practice of skills acquired during the training. Results of the study clearly showed that health workers trained in the 7-day IMCI course provided at least the same level of quality care case management as the health workers trained via the 11-day course.⁴⁴ In 2011, the MoPH adopted the policy that all future training for health workers on IMCI will be done with the seven-day course, which will result in more sick children being seen at health facilities and will lower costs.

Conclusions and Recommendations for Specific Training Programs

Achievement of training objectives. HSSP has increased the number and performance of BPHS providers, especially women in rural and underserved areas. The project is well on its way to achieving or exceeded its training targets.

HSSP, BASICS, and to a lesser degree, Tech-Serve, all conducted in-service training. HSSP conducted the majority of in-service training to improve reproductive health and maternal health service delivery. BASICS conducted in-service training to improve child survival. Tech-Serve conducted limited in-service training for hospital providers.

Recommendation: Consideration should be given to consolidating future support to in-service training into one project.

⁴⁴ USAID and BASICS. "An Evaluation of Quality of Care of Sick Children Provided by Physicians, Nurses, and Midwives in Afghanistan: Comparison of Health Workers Trained in a Condensed 7-Day IMCI Course to Health Workers Trained in the Standard 11-Day IMCI Course." Publication prepared under Contract #GHA-I-00-04-00002-00, Task Order 10.

Competency-based training and post training follow-up. Competency-based training methodology provides an effective way to measure the effectiveness of the training. It is not clear, however, whether all projects used the competency-based training methodology for clinical and non-clinical training.

Recommendation: Competency-based training methodology should be used for all future in-service training.

The post-training follow-up systems that HSSP has developed are working in the field and constitute an important part of the supervision and monitoring process.

Recommendation: Future assistance (and HSSP until the end of project) should continue to assist the MoPH in nationalizing post-training follow-up systems. Oversight mechanisms should ensure that training follow-up assessments occur every three months.

The HSSP learning transfer visits to model health facilities appeared to benefit both the providers and visitors, serving as a good example of Afghans' leading and learning from each other.

Recommendation: Assistance to BPHS implementers should be targeted to participating providers based on the needs they identified and the action plans they developed during the learning transfer visit process to model clinics.

Community midwifery education. HSSP has made a major contribution to the national midwifery workforce by supporting the training of 942 hospital and community midwives. Community and hospital midwives are having a substantial, significant impact on maternal health utilization and skilled birth attendance rates.

Recommendation: The midwifery training program should be continued and expanded so that the MoPH can reach its Millennium Development Goals. The United Nations Population Fund estimated that Afghanistan still needs roughly 7,400 additional midwives to attain 95% skilled birth attendance by 2015.⁴⁵

MoPH GCMU unit currently lacks the capacity to provide technical oversight of the CME programs. GCMU will need strong support to oversee and monitor the performance of the CME grantees in recruitment and selection of students, quality of education in clinical training sites, and supportive supervision. While the AMNEAB monitors and regulates the quality of the education programs, a technical entity will be required to provide direct support and to ensure programs are meeting the technical terms of their contracts with GCMU.

Recommendation: The Grants and Contracts Management Unit within the MoPH (GCMU) should contract an organization that has the technical capacity to provide oversight as well as direct monitoring of midwifery training. In the longer term, capacity must be built within the MoPH or GIHS to provide this oversight.

A valuable lesson learned was that community involvement and coordination among implementing NGOs, provincial health director offices, the health *shura*, and community elders is important in the selection, deployment, and security of midwives who are recent graduates and assigned to communities.

Family planning training. Evidence from competency-based in-service training for family planning indicates that family planning providers are being trained successfully. Family planning services were being delivered successfully, as demonstrated by reported increases in CPR and in

⁴⁵ Coleman, Isobel, and Gayle Tzemach Lemmon. "Maternal Health in Afghanistan: Improving Health and Strengthening Society." Washington, D.C.: The Council on Foreign Relations. September 2011, p.11.

the number of visits for family planning at health facilities and health posts from 2006-2009. Disturbingly, there are reports that the lack of family planning utilization targets, per U.S. policy, serve as a de-motivation force for providers.

Recommendation: USAID should review indicators for family planning. Since creating targets for the number of family planning users cannot be included, other indicators should be added to PCH grants (e.g., the number of women counseled in family planning) to provide motivation for health providers and monitoring on family planning knowledge. It is necessary to devise mechanisms to motivate and reward the provision of high-quality family planning services.

CHNE. HSSP and MoPH have not yet completed the LRPs for the Community Health Nurse Education Program. At least one school had to be instructed to stop teaching since it was not performing according to standards.

Recommendation: CHNE curricula and material development should be given a high priority. Technical oversight of the CHNE program will likely be required through off-budget support. Continued strengthening of AMNEAB to perform its oversight role will be important.

IMCI. Health workers trained in the 7-day IMCI course that BASIC developed provided at least the same level of quality care case management as the health workers trained via the 11-day course.

Recommendation: All IMCI training should be consistent with the MoPH policy to use the condensed seven-day IMCI course.

IMCI is not being offered during pre-service training for medical students. While the Tech-Serve training may have been beneficial, this struck the team as an example of an activity that may not be sustained. The team could not determine whether the MoPH is planning to institutionalize IMCI in pre-service medical training, or whether USAID would support this.

Training for hospital providers. The team could not assess the extent to which the projects trained hospital-based providers in the EPHS. The team also could not assess the extent to which in-service training in emergency obstetric care was for hospital providers versus other health facility providers.

Recommendation: Performance monitoring indicators should disaggregate and report on the subject of training courses conducted and identify the training conducted for providers in each level of the health system.

USE OF INNOVATIVE TECHNOLOGIES FOR TRAINING

SMS messages. HSSP piloted the use of mobile short message service text messages as a follow-up to training participants to remind them to implement the new skills that they received during training. Among the sample of 40 respondents, 80% were satisfied with the text messages and appreciated the initiative.

Electronic learning modules. HSSP developed the technical content for electronic learning modules (e-training) for family planning counseling, active management of the third stage of labor, and newborn care in midwifery education programs.

Telemedicine assessment. The MoPH reported that it would like to establish an electronic health system (e-health system) in Afghanistan. MoPH asked Tech-Serve to further explore this area and identify the needs of the Afghan health system within the framework of its current priorities. An assessment team traveled to Afghanistan in March 2011. Results are expected to be reported before the end of project.

Conclusions and Recommendations for Innovative Training Technologies

HSSP's experience with short message texting to provide key training messages as a post-training follow-up showed that this is a feasible mechanism for calling training participants to action.

Recommendation: The team recommends phased expansion and an analysis of costs of innovative training technologies.

Use of e-learning appears to hold promise for Afghanistan. Any clear recommendation for expansion and future investment, however, requires additional information. The team could not ascertain whether HSSP has systematically evaluated the effectiveness of the e-learning modules as a training tool for family planning and midwifery education, and there was no evidence that cost-benefit analyses had been done to justify introducing these innovative technologies in Afghanistan.

Results of the telemedicine assessment conducted by Tech-Serve were not available at the time of writing, so the team could not determine whether future investments should be made.

III. QUALITY ASSURANCE

Tech-Serve, HSSP, and BASICS supported the MoPH in improving the quality of health care. This focus has been articulated to varying degrees in their project objectives, expected results, activities implemented, and indicators measured. HSSP's first expected results area is "Strengthening and developing systems that support service delivery quality." Three of five of the BASICS Project's original intended results are to "Improve child health care at the community, BPHS facility and EPHS hospital levels." Tech-Serve's results focus on "Improved management and leadership capacity of the MoPH and 13 PPHOs to improve health outcomes."

Improving and maintaining the quality of health care depends on i) the development and use of standards for care and treatment; ii) implementation of QA processes and methodologies, including community/client involvement; iii) measurement and monitoring of quality of care; and iv) commitment to continuous improvement for sustainable QA. Each of these four areas is treated separately below, along with a discussion of achievements under each of the three projects against QA-focused project monitoring plan indicators. The other three focus areas of this evaluation – in-service training, capacity building and community involvement – are all necessary for and lend synergy to improving quality of health care and QA.

These areas are addressed as separate focus areas elsewhere in this report. They will only be mentioned here insofar as they provide synergy to improved QA.

DEVELOPMENT OF NATIONAL STANDARDS, CARE PROTOCOLS, AND A NATIONAL STRATEGY FOR QA

Standards of care represent the basic building blocks for all QA efforts. They establish and define the targets for quality of health care. They serve as job aids for providers, informing them of what needs to be done and how. They serve as monitoring and assessment tools for supervisors. The national QA strategy serves as a critically important blueprint for implementing standards of care.

HSSP facilitated the establishment of the Central Quality Assurance Committee (CQAC) that worked with various technical working groups under MoPH leadership to develop evidence-based QA standards for 21 areas. Fourteen of these national standards are already in use in support of the BPHS. These are the following: family planning, antenatal care (ANC), normal labor management, management of delivery complications, postpartum, care of the sick newborn, IMCI, EPI, tuberculosis, infection prevention, health facility management, drug supply management, behavioral change communication, and gender. Standards for an additional seven areas were recently field-tested and finalized and include nutrition, malaria, C-section, blood transfusion, mental health, basic first aid, and trauma. Pictorial standards were printed and provided to health posts, reinforcing the usefulness of standards as job aids for CHWs. These standards have provided a strong foundation for QA work at BPHS facilities in the 13 USAID-assisted provinces of Afghanistan. Standards are being used in the development of in-service training for both clinical and non-clinical training, as well as in implementation of QA initiatives and assessment of provider and health facility performance.

Under Tech-Serve, over 600 national hospital standards were developed with the MoPH in an effort to improve the quality of care in hospitals. These cover governance, clinical care, nursing services, ancillary support services, hospital administration, and management. The standards define a minimum expected level of performance required of all hospitals. Tech-Serve is also supporting the MoPH in developing a hospital accreditation system to ensure that all hospitals, public and private, provide a basic standard of clinical, nursing and ancillary services, as well as

adopt standard management and administration procedures. In addition, clinical case management protocols were developed for the top 10 diseases in PCH hospitals. Tech-Serve also collaborated with HSSP and BASICS in adapting technical guidelines for improving the quality of care for severely sick children.

The BASICS project worked with the MoPH to review and revise outdated protocols for managing childhood illnesses, and also worked to develop a national action plan for improving diarrhea case management by introducing zinc and low osmolarity ORS into diarrhea treatment. BASICS also supported the MoPH in organizing the Pediatric Hospital Initiative to oversee improved quality of emergency care for children at the hospital level by ensuring that very sick children are immediately assessed, triaged, and treated.

While the primary responsibility of assisting the MoPH in establishing a new MoPH unit for improving the quality of health care fell under the mandate of the HCI project, all three projects collaborated and assisted with this process and then supported the new unit's efforts in developing the National Strategy for Improving Quality in Health Care for 2011-2015. The establishment of this new unit and the development of the QA strategy, along with the standards and care protocols developed by HSSP, Tech-Serve, and BASICS over the past three to six years, provide a substantial foundation for the MoPH's QA efforts.

Stakeholder feedback indicates that the participatory approach taken for setting standards worked well in the Afghanistan context and fostered ownership and capacity within the MoPH. It is generally felt that standards and protocols developed under these three projects are being used effectively by providers and are helpful in identifying weaknesses and addressing necessary actions required to improve care.

Recommendation: Continued technical and budget support over a three to five year period should be provided to the new IQHC unit to build its capacity and mandate to coordinate and oversee the QA work of the MoPH's technical departments, particularly in carrying out continuous review and revision of health care standards and care protocols as needed.

Implementation of QA Processes, Methodologies, and Initiatives

The QAP was developed by JHPIEGO (an affiliate of Johns Hopkins University) and implemented under HSSP with the MoPH and NGOs to i) define quality through standards; ii) implement standards; iii) measure progress; and iv) recognize and reward achievements against those standards. QAP is a simple but comprehensive process consisting of two components: standards-based management and recognition (SBM-R) and PDQ. QAP has been introduced (baseline initiated) into 450 health posts in 13 provinces and 496 health facilities, including basic health centers, comprehensive health centers, and district hospitals in 21 provinces (including 5 quick impact provinces). A total of 111 health facilities (including BHCs, CHCs, and DHs) have completed the cycle of four QAP assessments (baseline, first and second internal, and second external). A benchmarking system has also been developed and implemented to identify and recognize over 46 high-performing health facilities.

Among DHs that have completed the entire QAP process, the average QA score rose from 30% at baseline to 90% after the second external assessment, according to data in the QAP data base. The QA score includes all 13 areas covered by the BPHS standards. Data also shows that CHCs that have completed all four assessments show similar improvement in all 13 QA score areas. Regrettably, there is no facility-based data on improved health outcomes to track and support conclusions on the effectiveness of QAP in improving quality of health care and health outcomes. Several stakeholders mentioned positive changes in quality of care following the roll-out of QAP. Challenges faced at the facility level include the need for constant staff retraining in QAP due to high staff turnover, low salaries, and insufficient equipment.

The PDQ component of the QA process implemented by HSSP and the MoPH utilizes community mobilization for improved quality of health care and improved access to care. Following discussions with the community health *shura*, health facility providers, and CHWs, issues impeding access to quality health care were identified and action plans agreed upon to address gaps in facility/community level health care. As one stakeholder noted, PDQ as a QA tool is especially appropriate for Afghanistan, a country where community councils are involved in all development sectors, including health. Most stakeholders felt that PDQ had improved involvement of the communities as well as increased their contribution to identifying problems and their sense of ownership for improving health care. Several cited the fact that health facilities functioned better following the initiation of PDQ. Data from NGO QAP databases for 20 facilities in seven provinces show considerable improvement in QA scores after PDQ implementation. Improved scores were seen more commonly in the areas of delivery, growth monitoring, antenatal care, postnatal care, TT2+, DPT3+, and tuberculosis case detection. Stakeholder feedback and data from the QAP database confirm that quality of care and health outcomes have improved as a result of community involvement in the PDQ process.⁴⁶

MSH's support to the MoPH under Tech-Serve has focused largely on improving capacity at the national and provincial levels to manage the delivery of BPHS and EPHS services for improved health outcomes. Facility management is one of the 13 emphasis areas in the BPHS and is included as an indicator of quality health care in such national assessment tools as the Balanced Scorecard and National Monitoring Checklist. Through the Leadership Development Program, Tech-Serve has worked with the MoPH to improve leadership and management practices at all levels so that health challenges can be identified and addressed for improved quality of service delivery. As a result of the LDP initiative:

- Thirty-six LDP model health facilities have been established in 13 provinces
- LDP activities were undertaken in 140 health facilities
- Over 100 local LDP facilitators from the MoPH, NGOs, and AMA were trained
- More than 1,800 health professionals from all levels participated in the LDP
- Regular and effective monitoring of health services and health outcomes has improved
- Facility management and clinical case management capacity of five EPHS implementing hospitals was improved

Stakeholders confirmed that as a result of LDP, the quality of health services had improved, but few were able to provide examples. One of the few examples mentioned was the improvement in infection prevention practices in the delivery section. Tech-Serve's work with enhanced community-based networking, including reactivating community *shuras* and family health action groups, also resulted in stronger community-based health programs that focused on improving quality of care. Stakeholders interviewed stated that many earlier problems at the health facilities are being solved by the staff with the support of the community. The result is that health facilities are more user-friendly and the quality of health services has improved.

The BASICS Project was not intended to introduce and implement QA processes, but rather to identify a few interventions that would improve quality of on-going child survival activities. Many of these interventions are discussed in other sections of this report, but two are particularly noteworthy for establishing systems that have already, or have the potential to, improve the quality of child health care. These are the Pediatric Hospital Initiative and the Integrated Child Survival Package.

⁴⁶ Obtained from NGO responses to the Survey Monkey Questionnaire.

BASICS in collaboration with the MoPH successfully introduced the ICSP to improve prevention and treatment of child illness at the community level into five demonstration districts. The ICSP combines several key child survival interventions activities, including i) community-based child growth monitoring and promotion (GMP); ii) community IMCI, especially treatment for diarrhea, pneumonia, and immunizations to prevent measles and other childhood diseases; and iii) essential maternal and newborn care (EMNC) and counseling of behavior communication change messages to mothers and community members. Based on successful improvements in health outcomes and improved quality of care, the MoPH then successfully expanded the program into a total of 28 districts and is currently in the process of extending this program to a further 26 districts. The involvement of the community turned out to not only be acceptable in the Afghanistan context but the improved collaboration among the women, the family health action groups (FHAGs), and the CHWs resulted in improved outcomes in child health, as documented in a 2011 evaluation of this activity.

Both BASICS and Tech-Serve have supported the MoPH in introducing the Pediatric Hospital Initiative into seven provincial and regional hospitals in Nangarhar, Patktya, Herat, Bamyan, Takhar, Balk and Kunduz as well as into three national tertiary pediatric hospitals: Indira Gandhi, Attaturk, and Maiwand. The aim of PHI is to:

- Improve the quality of care for hospitalized children with serious infections and severe malnutrition through the application of evidence-based standards
- Improve recognition and management of emergency conditions in children under 5
- Decrease hospital death rates of children under 5 years as well as hospital case fatality rates in common conditions

In support of PHI, BASICS established a functional triage system at provincial hospitals in Takhar and Bamyan, training staff in emergency triage assessment and treatment (ETAT). ETAT trainers have become national ETAT facilitators, conducting ETAT training for staff in six additional provincial hospitals. While data on deaths of children within 24 hours of admission to hospitals is a standard indicator of how well the ETAT system is working, this data is not yet available. Feedback from staff during monitoring visits at facilities indicates satisfaction with the system for improving rapid identification of the very sick children for priority attention and care.

Numerous QA approaches and initiatives were carried out under the three projects and improved QA practices and systems. The projects frequently collaborated or coordinated in development of standards or protocols. However, based on stakeholder feedback, it would appear that these projects worked more with the MoPH and less with each other. Several stakeholders remarked that MSH and JHPIEGO did not work hard enough to integrate and coordinate their efforts in the same areas of QA. Others complained that there were too many approaches to QA being used without sufficient coordination. In addition to the QA efforts under these three projects, the Health Care Improvement (HCI) Project is implementing the quality improvement collaboration (QIC) approach in many of the same facilities and provinces. Stakeholders at the national and provincial levels felt that multiple QA approaches were confusing, duplicative in effort, and overly time consuming for staff.

Recommendation: Where multiple USAID projects introduce QA models and interventions in the same areas, efforts should be made to ensure that various approaches and efforts are coordinated and do not duplicate efforts, thereby confusing the MoPH, the NGOs, and facility staff, losing the opportunity to gain commitment for QA efforts, and potentially affecting health outcomes.

Monitoring and Measuring QA Performance against National Standards and USAID-approved PMPs

Implicit in any QA process or methodology is the need to monitor improvements in the quality of health care against minimum standards for quality health care. This includes both routine supervision and monitoring of performance as well as collection of data that is appropriate and useful for decision making by health facility staff, health managers, and national health authorities. The Balanced Scorecard was developed in 2004 by the World Bank and adopted by the MoPH as its primary measurement tool for summarizing performance and quality of care at primary health facilities in each province. Data is collected annually from households, client-provider interaction observations, and provider interviews. Twenty-six indicators cover patient satisfaction and community involvement, staff satisfaction, capacity for services provision, quality of service provision, and equity of health care. While this national monitoring tool provides a broader, nationwide look at QA by province, the PMP offers a closer look at the effectiveness of each individual project in reaching agreed-upon targets and is USAID's most important project-level monitoring tool.

With HSSP assistance, QA committees were established in all provinces where QAP was initiated to oversee monitoring and evaluation of quality of health care. Scores from internal and external assessments provided information on what is working and where gaps exist, enabling information to be fed into action plans. The steady improvement in QA scores among those facilities that went through the entire QA process support the fact that the QAP system is working. However, stakeholder feedback indicates that much of the data collected was not being fed into the decision-making process to the extent it should have been, primarily due to a lack of coordination between HMIS and M&E and between M&E and the technical implementing departments.

HSSP has maintained and reports to USAID on a quarterly basis against a PMP that measures results against five IRs. The first IR measures "Strengthened and developed systems that support service delivery quality" against six indicators that measure processes completed or numbers trained (Annex H, QA Indicators). Accomplishments against these six targets are on track, with three targets already exceeded. These accomplishments confirm that QAP has been initiated in more facilities than originally targeted, that only two out of a targeted three NGO Task Force meetings were held during the second quarter of FY 2011 and that more facility staff were trained than originally targeted. However, the PMP indicators fail to measure and track how many QAP facilities have actually improved the quality of their services and in which areas. While the QAP system could have allowed for facility-level tracking of either a composite score or specific QA outcomes against specific performance areas or elements, it has simply not been systematically collecting and reporting into the PMP indicators.

Tech-Serve worked with provincial MoPH teams to carry out regular monitoring visits for improved service delivery. These visits focused on compliance with standards such as infection prevention, and identification of gaps in quality service provision. The project also developed and helped the MoPH maintain various national databases, including the National Monitoring Checklist. Six core indicators (defined in this report in Section II. Training) were developed with the MoPH to serve as proxy measures for assessing progress in improving health standards and the quality of care. Tech-Serve has completed and maintained a USAID PMP with indicators focused on capacity building. Five of these indicators are particularly focused on quality of care, and can be found in Annex H. Accomplishment against these five indicators is mixed. Two have exceeded the life of project (LOP) targets; one is still well short of the target, with only two reporting quarters remaining, and two of the indicators show no data.

There is a consensus among stakeholders that the various community-based activities in GMP, community-based IMCI, and BEMN as well as ETAT and the Pediatric Hospital Initiative supported through BASICS improved the quality of health services and health outcomes for children. Looking at five QA indicators in the 2011 BASICS PMP (Annex H: QA Indicators), two have been met, two have not been met, and there is no data available yet for the fifth indicator. The 2011 PMP, however, does include several very good indicators for improved health outcomes and quality of care, for example:

- Age-specific death rate within 24 hours of admission in two provincial hospitals
- % of children participating in C-GMP with adequate weight gain
- % of mothers starting breastfeeding within one hour of birth
- % of facilities without zinc and ORS stock-outs

In addition, BASICS carried out several end-of-project (EOP) assessments, studies and surveys of specific interventions such as the EOP evaluation of the ICSP demonstration project. This latter assessment showed improvement between the control area and the project area in i) overall healthcare seeking behavior; ii) treatment of illnesses; and iii) the percentage of children 0-23 months who had attended a weighing session within the previous two months.

BASICS contributed significantly to the national effort to monitor and measure quality of care by ensuring that the HMIS indicator table contained appropriate and key child health and nutrition indicators reflecting the latest treatment and case management protocols. Many of these revised indicators are included in the new BASICS PMP and will make use of national data from the HMIS. BASICS also contributed to the review and revision of data collection tools to ensure that the data needed for the revised HMIS indicator table would be captured. This included assistance in developing the new Child Health Scorecard that is still under review as a potential monitoring and assessment tool. Assuming that data for these new HMIS indicators are actually collected and used, this will be a significant accomplishment toward improved measuring and monitoring of the quality of child health care nationwide.

Most of these QA initiatives were implemented along with competency-based training, periodic follow-up of trainees, capacity development training, supportive supervision, and community involvement for improved synergy among QA activities. While it is likely that all of the various QA processes and initiatives implemented under HSSP, Tech-Serve, and BASICS contributed to improving the quality of health care, there is insufficient data to fully support this. Much of the data collected for the PMPs focus on processes completed and numbers trained rather than improvements in quality of care as a result of QA activities carried out. Stakeholder comments, as well as the September 2011 Office of the Inspector General (OIG) Audit, point out certain “quality deficiencies” at facilities visited, including gaps in facility management, staffing, and drug supplies and management. The PMPs do not track QA scores or achievements at the individual facility level, although the QAP is flexible enough to allow QAP assessment results to be broken down by performance area or technical element to inform the MoPH and NGOs for monitoring purposes. Failure to identify more outcome and impact indicators for quality of care and to monitor them over the LOP through the PMPs means that USAID cannot track actual improvements in the quality of health care provided by the projects or adequately determine which QA initiatives work more effectively than others. While USAID assisted the MoPH in developing a cutting-edge national balanced scorecard to track quality of care nationally, PMPs do not incorporate QA indicators by facility or QA element to monitor and track QA outcomes under individual projects.

Recommendation: Future projects should be accountable for measuring and monitoring improved quality of care achieved by the project. Data collection on improved quality of care

and analysis of the effectiveness of QA components (such as QAP, LDP, ETAT, and PHI) should be carried out regularly to better link activity costs to quality of care outcomes/impact.

Recommendation: Given the commitment of the new Integrated Quality Health Care Unit to improved measurement of the impact of adherence to quality standards, future health projects should also focus on improved coordination with and between the M&E and HMIS divisions, particularly with regard to measuring improvement in quality of health care.

Recommendation: Future USAID projects should develop and report regularly to USAID against PMPs that identify and track fewer and better indicators that focus on improved quality of care as well as health outcomes and impact, rather than processes and numbers trained. For measuring QA achievements, indicators could focus on composite QA scores at the facility level as well as on several specific performance measures.

Recommendation: USAID should encourage new projects to incorporate into their PMPs some of the new HMIS indicators that BASICS and earlier projects assisted the MoPH in developing to measure and report progress against improved quality of health care delivery and health outcomes, as well as improved facility QA performance.

Assuming that data for these new HMIS indicators are actually collected and used, this will be a significant accomplishment toward improved measuring and monitoring of the quality of child health care nationwide.

Sustainability of QA Processes, Commitment, and Ownership of QA Processes and Tools

HSSP's QAP model emphasizes the concept of "continuous improvement," using tools such as self-assessment. It is not clear that the MoPH has sufficient training capacity to implement continuous training of new staff in QAP and other QA methodologies, given the high rate of staff turnover. Numerous stakeholders including the new IQHC Unit within the MoPH have praised the QAP tools developed under HSSP for their ease in identifying gaps and solutions, measuring progress, and continuously improving the quality of care within individual facilities.

Tech-Serve assisted the MoPH in developing a work plan for continued post-project capacity building. It is unclear, however, if sufficient training capacity for QA and ability to support the HMIS has been sufficiently developed within the MoPH. Networking among PPH teams has also been promoted by Tech-Serve as a means of sustaining commitment to QA and other focus areas under LDP.

BASICS has already transferred all child survival activities to the MoPH's CAH Department. Capacity development and incorporation of key indicators for quality child survival interventions into MoPH reporting and evaluation systems were undertaken specifically to ensure that quality of child health care would continue. The project also assisted in establishing the National Maternal and Child Survival Committee (NMCSA) to coordinate child survival efforts countrywide.

All three projects assisted the MoPH in establishing and building the capacity of the IQHC Unit and in developing the National Strategy for Improving the Quality of Healthcare, 2011-2015. Both the establishment of the IQHC Unit and the development of a national QA strategy suggest strong commitment on the part of the MoPH to maintaining a focus on QA in health care. The IQHC Unit is relatively new, but the leadership is energized and committed to leading QA efforts in health care. With numerous QA initiatives in place, the new strategy should serve to guide future expansion of MoPH's stewardship over QA in health care.

The fact that the importance of improving the quality of care has been emphasized in key health care strategies indicates interest and commitment on the part of the MoPH for continuing QA efforts. The MoPH's Strategic Plan for 2011-2015 includes quality as one of 10 core values and principles: "We believe that quality in health programs and services means responding to client needs and developing and providing health programs and services that are appropriate, affordable, available, timely, safe and consistent, effective and efficient, and continuously improving." The focus of Strategic Direction #3 in the same strategy is to "increase equitable access to quality health services." The National CAH Strategy for 2009-2013 also includes a section on improving efficiency and quality of care. It is encouraging to hear the unit's mantra and see it written on the wall of the IQHC Unit: "Quality is Everyone's Business." While the IQHC acknowledges that continuous monitoring, assessment, and recognition is challenging, it appears to be committed to the goal of "continuous improvement of quality in health care." However, the unit will need considerably more support from top leadership and donors to effectively address this challenge.

All three projects took positive steps to build capacity and instill ownership of QA in the various units and departments of the MoPH at the national and provincial levels, from the development of standards to competency-based clinical training, development and roll-out of QA processes, development of monitoring, and assessment capability. Stakeholder feedback was mixed regarding the commitment and ownership of the MoPH to implement internal QA systems. One stakeholder noted the perception that ensuring quality of care is expensive. The MoPH will have to make decisions over the next five years regarding QA systems. However, the three projects succeeded in putting into place the elements necessary for the establishment of a strong QA system.

Recommendation: Future projects should support the new IQHC Unit in growing into a larger role of national coordination of QA. This would require a considerable increase in capacity building and technical support. Consideration should be given to establishing a QA training capability within the IQHC Unit to ensure that new staff are continuously trained in the various QA processes and can serve as national trainers along with NGO trainers. Future projects should avoid "reinventing the wheel" and introducing new QA processes, and should assist the MoPH as necessary in streamlining and choosing a single QA process for future implementation.

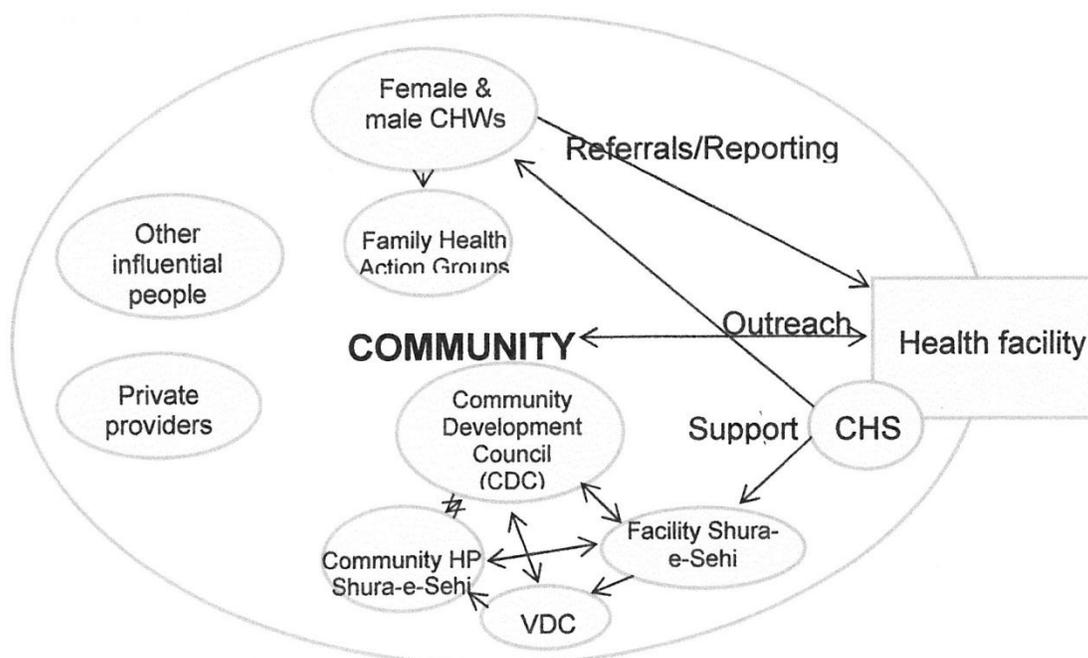
IV. COMMUNITY- BASED HEALTH CARE

INTRODUCTION

One objective in the National Health Policy is “to increase the active participation of communities in the management of their local health care services through developing strong active participatory links with health *shura* (community committees) and training and supporting community health workers.”⁴⁷ In Afghanistan, CBHC is the foundation for successful implementation of the BPHS package. Success of the BPHS depends upon community participation through partnerships between community and government health staff.

The components of the CBHC system in Afghanistan are shown in Figure 4.

Figure 4: Afghanistan CBHC System Components



Source: Islamic Republic of Afghanistan, Ministry of Public Health. Community-Based Health Care Policy and Strategy 2009-2013. December 2009, p. 5.

This figure emphasizes the dynamic nature of the system between health facilities and various community entities, including *shuras*, CHW, and FHAG. A summary overview of the CBHC system is in Annex I. This CBHC section will be divided into three parts – institutional development for implementing and sustaining CBI, progress and impact of CBI, and recommendations.

Thousands of villages in Afghanistan do not have regular access to health facilities for basic health services. The MoPH made a decision in 2002 to train volunteer CHWs to work out of health posts to provide basic health education and simple medical treatment to villagers in order to reduce maternal and child mortality. In 2004, when implementation of BPHS started, there were about 2,500 CHWs, most of whom were men. By the end of 2008, there were almost

⁴⁷ National Health Policy, page 2, as discussed in the Community-Based Health Care Policy and Strategy 2009-2013. *Shura* are local governing bodies or community committees.

20,000 CHWs, 49% of whom were women, trained and deployed in over 10,000 health posts in all 34 provinces.⁴⁸

The three projects included in this evaluation worked to strengthen the basic components of the Afghan CBHC system by working (a) to improve partnership between the community and the health facility staff; (b) improve the skills and knowledge of community-based providers, particularly women, so they provide good quality care; and (c) foster the promotion of healthy practices and life styles. Each project worked to strengthen the foundation for community-based health care by building capacity within the MoPH and by increasing the involvement of religious leaders. Each project also implemented community-based programs for maternal and child health. Those efforts are described in this section of the report.

While Tech-Serve did not have a specific IR related to CBHC, it nevertheless adopted a two-pronged approach to supporting the delivery of community-based services. First, it provided a significant amount of support for strengthening the CBHC Department within the MoPH. Second, it strengthened the CBHC network by training CHWs and activating FHAGs to support the CHWs.

The HSSP project objectives related to CBHC were articulated in two separate, but related, IRs. HSSP worked to achieve an “Increased number and performance of BPHS providers, especially women in rural and underserved areas.” (IR 2) HSSP also worked to achieve “Improved capacity and willingness of communities, families, and individuals to make informed decisions about their health seeking behavior.” (IR 3) This report reviews HSSP’s achievements across those two results areas by focusing on HSSP’s efforts to strengthen the capacity of the Health Promotion Unit in MoPH to foster behavior change within communities. The report also assesses HSSP’s efforts to improve and expand community-based post-partum family planning and to develop a community-based program to prevent post-partum hemorrhage during home deliveries.

The BASICS project articulated a specific objective to: “Improve child health care at the community level” through implementation of the ICSP.

FOUNDATIONS ESTABLISHED FOR COMMUNITY-BASED HEALTH CARE

Community-Based Health Care Department, MoPH. The MoPH plays a stewardship role in ensuring that the CBHC program is being implemented according to MoPH values, priorities, policies, and guidelines. Since 2006, Tech-Serve provided significant financial, technical, and leadership development support to the CBHC Department so that it could fulfill its stewardship role. Tech-Serve supported MoPH at the central level in producing a number of strategic documents: the National Community-Based Health Care Policy and Strategy; the CBHC sub-strategies for poor urban and nomad populations; the National CBHC Monitoring Checklist, and the national package on best practices for CBHC. These strategic documents provided guidelines to help partners follow standard principles and priorities in the implementation of CBHC programs.

Tech-Serve financed a strong technical assistance consultant team in the CBHC that helped strengthen coordination between different departments within the MoPH and the provincial health office teams to implement CBHC programs at central, provincial, and community levels. The assistance led to expansion of CBHC interventions by: i) supporting new mobile teams in areas not covered by community health workers; ii) developing a strategy for recruiting female community health supervisors; and iii) recruiting and training over 3,000 CHWs. The CBHC

⁴⁸ Islamic Republic of Afghanistan, Ministry of Public Health. Community-Based Health Care Policy and Strategy 2009-2013. December 2009. P. 5.

also developed a database for CHW registration and improved the indicators used to monitor and measure CHW performance. The CBHC performance measurement framework formed the basis of the MoPH's strategic planning for community-based health care. In its final year, Tech-Serve is planning for the transition of a dozen technical consultants to the CBHC as part of the on-budget support strategy to enhance the CBHC stewardship role.

Tech-Serve and HSSP supported the CBHC team in completing a study tour of community-based health care programs to identify best practices in Indonesia and Bangladesh in FY 2010. As a result, the CBHC developed guidelines to pilot these practices in selected districts to integrate these activities into the CBHC national package.

The HSSP and Tech-Serve projects also provided technical and financial support to national community health worker conferences to recognize and reward CHW performance. While this is an important effort, it may not be sufficient to compensate volunteer CHWs for the important work they do within the community. The issue of inadequate CHW recognition and reward came up repeatedly during interviews with MoPH, NGOs, and communities, leading the team to conclude that this issue warrants further attention.

According to the Tech-Serve and HSSP technical teams, the CBHC Department is capable of integrating the CBHC strategy into the BPHS package that will be implemented by NGOs at the community level. However, these teams also pointed out that the National CBHC Policy and Strategy lacks a clear annual implementation plan. To address this gap, additional technical assistance from HSSP or Tech-Serve to the CBHC department to develop milestones and annual operational plans for 2012 and 2013 would be helpful. It would be important to ensure the participation of stakeholders in the process of development and finalization of the implementation plans.

Health Promotion Department, MoPH. Another key MoPH department involved in promoting community and family participation is the HPD. The HSSP project has provided significant financial and technical support to build the capacity of the HPD to foster the promotion of healthy practices and life styles. Key achievements of HSSP's support to HPD include: i) development and approval of the National Health and Nutrition Communication Strategy 2008-2013; ii) development of behavior change communication (BBC) and IEC materials; iii) development of BCC LRPs and training for regional officers; iv) inventory and database of BCC and IEC materials and job aids; and v) development of a national clearing house and repository for BCC and IEC materials and job aids.

As a result of HSSP support, the HPD has the capacity to: i) develop operational plans for the implementation of national BCC strategies; ii) train officials from provincial health departments to implement, monitor, and evaluate BCC strategies; and iii) manage a national clearing house repository of BCC materials produced in all sectors. Perhaps most noteworthy is that the HPD can now respond to donor funding requests and develop proposals. HSSP reported that this resulted in a 400% increase in funding for IEC activities.⁴⁹

Child and Adolescent Health Department, MoPH. The MoPH CAH Department has, as one of its mandates to improve child health care at the community level. The BASICS project assisted the CAH Department in developing several foundational policies to help reduce infant and child mortality. BASICS assisted the CAH Department in developing the following strategies: i) the National Child and Adolescent Health Policy 2009-2013; ii) the National Public Nutrition Policy and Strategy 2009-2013; iii) the Infant and Young Child Feeding Policy and Strategy 2009-2013, and iv) the National Action Plan for Improved Diarrheal Case Management. All of these policies

⁴⁹ USAID – HSSP. Annual Progress Report FY 2010, October 1, 2009 – September 30, 2010, and HSSP project brief September 2011.

contained guidelines to implement evidence-based interventions to improve infant and child health. As a result of BASICS support, the CAH Department was able to manage and evaluate the implementation of the Integrated Child Survival Package, including the community-based efforts of the ICSP.

Involvement of opinion leaders. Both Tech-Serve and HSSP worked to improve the involvement of religious leaders in family planning and reproductive health activities. Both projects worked in collaboration with MoPH, USAID, and BPHS implementing NGOs to develop a training manual focused on reproductive health and family planning to enable religious leaders to provide accurate information to the community. The “Islam and Family Planning Booklet” has been approved by the *shura-e-ulama* religious scholars. This booklet provides an interpretation of family planning in the local context of Islamic law regarding fertility and reproductive health.

Conclusions and Recommendations: Foundations Established for Community-based Health Care

MoPH is committed to facilitating the improved quality of community-based services. This is contributing to better perception by the Afghan people of their government’s positive role in improving their health. The MoPH’s commitment is also contributing to the sustainable delivery of services at the community level.

Tech-Serve provided a conceptual framework and future direction for the management of an effective CBHC program to ensure that the program is institutionally, socially, and financially sustainable.

A good initial effort has been made to gain the endorsement and involve religious leaders in reproductive health and family planning.

A continuing challenge is the issue of motivation, recognition, and reward for CHSs and CHWs. The recent decision by MoPH to pay for the CHW’s monthly transport to the health facility should help. The National CHW Recognition Day also helps.

Recommendation: Additional mechanisms should be developed to compensate, motivate, recognize, and reward the achievement of CHS and CHW.

Tech-Serve, HSSP, and BASICS capacity-building efforts enhanced MoPH’s role in providing leadership in the implementation of community-based interventions. The team received reports, however, that the CBHC department lacks a clear implementation plan for the National CBHC Policy and Strategy.

Recommendation: Additional technical assistance should be provided to assist the CBHC department in developing milestones and annual operational plans for 2012 and 2013.

The National CBHC strategy for urban poor populations and nomadic communities had just been completed at the time of writing. The strategy has not yet been implemented.

Recommendation: There will be a continuing need to support the development of CBHC among marginalized and hard-to-reach populations, including the urban poor and nomadic communities.

ASSESSMENT OF COMMUNITY-BASED INTERVENTIONS AND APPROACHES

Post-partum family planning. HSSP and Tech-Serve provided significant support for the MoPH to bring health services closer to the community by introducing a community-based post-partum

family planning (PPFP) program in 2008. The program was designed to train and empower CHWs to: i) address misconceptions about family planning; ii) promote the Lactation Amenorrhea Method (LAM); iii) provide the first injection of depo-provera (DMPA) contraceptive; and iv) provide counseling on other family planning methods for breastfeeding women. The community-based PPFP program was first implemented in 13 USAID-supported provinces. The MoPH approved the expansion of the program to 21 non-USAID provinces and the program is in the process of scaling up to all 34 provinces.

HSSP and Tech-Serve employed a four-pronged approach to expanding community-based PPFP: a) advocacy to create an enabling environment for PPFP services; b) capacity building to equip health workers with knowledge and skills to deliver the intervention package; c) supportive supervision; and d) monitoring. HSSP provided technical direction to the MoPH on PPFP program development and implementation, particularly with regard to strengthening the capacity of MoPH and the implementing NGOs to provide post-partum family planning services. Tech-Serve also provided technical direction to the MoPH on PPFP program development and implementation, particularly with regard to monitoring and evaluation.

Tech-Serve assisted the CBHC Department in designing a monitoring system so the CBHC and NGO implementers could monitor and report on the activities of FHAGs, who were involved in the post-partum family planning program. The monitoring system includes 19 indicators across a range of training, knowledge, counseling, and supervision issues.

Since responsibility for program interventions were shared between HSSP and Tech-Serve, the achievements for the PPFP program are hard to attribute between the two projects or to disaggregate which ones were more effective than others. In fact, in some cases, when asked who provided the assistance, the beneficiary was unsure. The team did not find any contradiction in approach between the projects but it did make assessing project inputs more difficult. Achievements that HSSP reported for the PPFP program included: i) reactivation of community committees *shura* for this purpose; ii) distribution of IEC materials; iii) training of FHAGs; and iv) in-service training completed for 54% of CHWs and 84% of CHSs.⁵⁰ Tech-Serve reported that it trained 10,000 CHWs and 458 CHSs.⁵¹ Tech-Serve also reported, “Community health supervisors are providing support to volunteer CHWs in i) mobilizing and motivating their communities in support of family planning; ii) providing counseling about birth spacing; iii) addressing misconceptions; iv) promoting family planning messages consistent with the Holy Quran; v) administering the first doses of injectable contraceptives; and vi) using community mapping as an effective tool for identifying the women in their community who would benefit from family planning services.”⁵²

When asked about the number of women the program reached, HSSP reported that, “according to MoPH population-based estimates, there are 522,000 pregnant women from 188 districts in the 13 USAID-assisted provinces. We assume that all of these women have received family planning and PPFP counseling and services from CHWs. Additionally, according to HMIS data, health posts have delivered family planning services 894,348 times during 2010.”⁵³ It is difficult to assess the actual situation without further investigation and more integrated reporting systems.

⁵⁰ HSSP, PowerPoint briefing provided to team, dated September 2011, p. 66.

⁵¹ Tech-Serve PowerPoint briefing provided to team, dated 9/21/2011, p. 14.

⁵² Tech-Serve Annual Progress Report FY 2010 October 1, 2009 – September 30, 2010, p. 25.

⁵³ HSSP, email communication with evaluation team, 11/1/11.

Tech-Serve reported evidence from Badakhshan Province in FY 2010 indicating significant improvement in the CBHC indicators that were measured between the first and second monitoring visits by the CBHC monitoring team.⁵⁴ Evidence from additional monitoring visits in 2011 to Herat, Kabul, Laghman, Logar, Ghazni, Paktya, and Takhar also reported “remarkable improvement in quality of work.”⁵⁵ These promising results were corroborated in data charts that the CBHC provided to the external evaluation team, “CBHC and PFP Post Training and Monitoring Progress.” The data indicated significant improvement between the first and second monitoring visits by the CBHC team. Data reported through NGO quarterly visits also indicated improvement across the range of indicators. But data for some of the indicators reported by the NGOs differed so significantly from the data reported by the CBHC monitoring visits that further investigation of the PFP monitoring system is warranted.

The PFP program in the 13 USAID provinces has shown some encouraging achievements, particularly in terms of training, knowledge, counseling, and supervision. But there has been no study to measure the impact of the community-based PFP intervention package on contraceptive knowledge, utilization, and practices in Afghanistan.⁵⁶ So far, the program has demonstrated that trained CHWs can deliver family planning even in conservative, rural communities in Afghanistan. HSSP and Tech-Serve utilize data from the National PCH Household Survey that is conducted by NGOs every year in Afghanistan. Under the PCH contract, renewal is based on the performance results based on an annual survey using LQAS. The specific indicators for measuring program outcomes are: (a) percentage of children under 6 months who were exclusively breastfed; (b) contraceptive prevalence rate; and (c) knowledge of modern methods of contraceptives among women of reproductive age. According to PCH household survey data that is available in public domain but not formally disseminated, the percent of children under 6 months who were exclusively breastfed increased from 38.6% in 2009 to 42.8% in 2010.⁵⁷

Many challenges remain, however. According to unpublished data recently released to the evaluation team, knowledge on the number of modern contraceptive methods has decreased since the PCH Household Survey in 2009, from 71.4% to 62.7%. The CPR also decreased from 40.3% in 2009 to 38% in 2010.⁵⁸ It was impossible in the time provided for the evaluation team to provide definitive reasons for the decreases in knowledge and utilization of contraceptives. HSSP staff offered several possible explanations: a) increase in the number of security incidents between 2009 and 2011; b) health facility staff turnover; c) possible disruption to supervision and monitoring during the transition between the Partnership Grants and the Partnership Contracts for Health Services; d) difficulty in monitoring PFP activities in the 21 non-USAID provinces because there is no provincial coordinator; and e) U.S. policy regarding prohibition on setting family planning targets, which serves as a de-motivating factor for CHWs to provide family planning. Furthermore, several partners stated that it is still early to measure impact of the PFP community-based model. The team concluded that a program impact assessment of the PFP model in the next year would be necessary to determine the causes of these declines and inform future implementation.

⁵⁴ Tech-Serve. Annual Progress Report FY 2010 October 1, 2009 – September 30, 2010, p. 20.

⁵⁵ Tech-Serve. Semi-Annual Report October 1, 2010 – March 31, 2011, p. 20.

⁵⁶ The package utilized in Afghanistan was adapted from a Bangladesh model under MCHIP, known as the Healthy Fertility Study.

⁵⁷ HSSP PowerPoint briefing to evaluation team; data based on unpublished results from the PCH HH survey for 2010, September 2011.

⁵⁸ HSSP PowerPoint briefing to evaluation team; data based on unpublished results from the PCH HH survey for 2010, September 2011.

Prevention of post-partum hemorrhage (PPH) at home births. HSSP is working with the MoPH to implement and expand a program to prevent post-partum hemorrhage during home births. The objective is to train CHWs to educate families about pregnancy risks, and how to mitigate them, and to provide a drug, misoprostol, to women and their families. The efficacy of misoprostol in saving women's lives by preventing or stopping post-partum hemorrhage has been clearly demonstrated.⁵⁹ Community-based birth preparedness, complication readiness counseling, and distribution of misoprostol by CHWs are important ways to reduce the number of maternal deaths due to post-partum hemorrhage in Afghanistan, where more than two out of three births (67%) take place at home.⁶⁰

The HSSP demonstration project is not assessing the incidence of PPH, but rather assessing that the quality of the community-based intervention can be maintained during scale up. HSSP worked to: i) inform national decision-makers, ii) supported the translation and printing of counseling material; iii) trained 468 CHWs and 67 CHW trainers and supervisors; iii) established a distribution and monitoring system; iv) trained 73 skilled birth attendants on active management of third stage labor; and v) hired provincial and district health supervisors. By September 2011, about 7,417 pregnant women had been registered for the program in 20 districts in five provinces, including Kabul, Bamyan, Badakshan, Jawzjan and Faryab.⁶¹

A significant impediment to the implementation of the PPH program was the length of time required by the MoPH Institutional Review Board (IRB) to approve the study. There are no written or approved IRB guidelines or process. Additional capacity building to MoPH on the IRB process would help all USAID-supported operations research efforts.

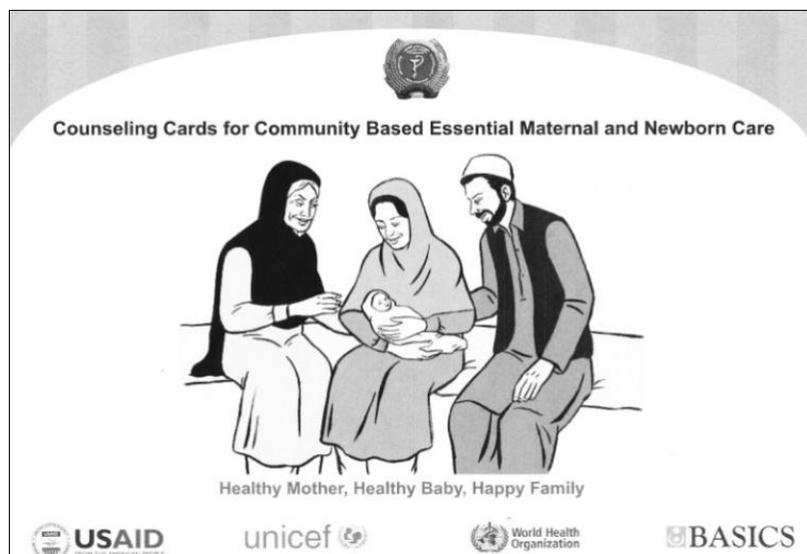
Integrated Child Survival Package. BASICS supported the MoPH in planning and implementing its key child survival strategy, ICSP. The program was piloted in five districts and later expanded to 23 districts. BASICS advocated the use of child survival indicators in the HMIS reporting system. In an effort to improve child survival at the community level, BASICS pioneered, promoted and institutionalized community-based nutrition monitoring in Afghanistan, particularly through the establishment and use of FHAGs. BASICS contributed to the development of pictorial job aids for illiterate mothers and CHWs. The team observed these job aids being used in virtually every facility and community visited. As a result of improved community participation in growth monitoring, thousands of children received better food and nutrition and showed marked weight gain in the districts where the program was implemented. In addition to infant and child growth monitoring, BASICS conducted formative research on care-seeking behavior of families for maternal health and newborn care services.

⁵⁹ Several published medical studies demonstrated the efficacy of misoprostol in preventing PPH when oxytocin was unavailable.

⁶⁰ Afghanistan Mortality Survey 2010, November 2011.

⁶¹ HSSP PowerPoint briefing to evaluation team on the PPH program, September 2011.

Figure 5: ICSP Job Aid for Maternal Health and Newborn Care



Source: BASICS

Community Mobilization Approaches

Over the last four years, HSSP, BASICS, and Tech-Serve piloted, tested, and implemented a number of community mobilization approaches for BPHS implementers. These included Partnership Defined Quality (PDQ) approach, FHAGs, and a Community Mobilization pilot project in two districts of Nangarhar and Takhar Provinces.

PDQ approach. In some cases, community mobilization activities were begun with the express purpose of linking those activities with the quality assurance approach that was rolled out in 18 provinces, known as Partnership Defined Quality. The PDQ process was designed to involve the community in improving the accessibility and quality of services at the health facility. PDQ is discussed more fully in the Quality Assurance section of this report.

FHAGs. HSSP and BASICS also provided support to MoPH in establishing another community support mechanism, known as family health action groups. FHAG are an element of the MoPH CBHC national program, according to the revised BPHS 2010. The intention of the FHA groups was to: i) promote healthier homes and lifestyles; ii) increase the use of health services provided by the CHW or the facility; and iii) build a strong information and referral system within the community to serve as a community support mechanism for female CHWs. BASICS pioneered the community-based IMCI by establishing FHAGs to improve the care and feeding of sick infants and children. HSSP developed training materials for FHAG, including: a) National FHAG Facilitator's Training Manual; b) FHAG Pictorial Guide for Illiterates; and c) FHAG National Monitoring Checklist. In addition, HSSP conducted training for CHW trainers and CHWs so they could train FHAGs on basic health issues, including family planning, early neonatal and under 5 child feeding, hygiene and sanitation, and communicable diseases.

By July 2011, 63 active FHAGs (685 women) had been established in seven districts in nine provinces: Kabul, Bamyan, Badakshan, Khost, Herat, Jawzjan, Takhar, Nangarhar, and Paktya.⁶² The team observed FHAGs in Kabul, Bamyan, and Badakshan provinces and found that they were successfully fulfilling their missions and were welcomed by the community.

⁶² HSSP PowerPoint briefing to evaluation team on the PPH program. Briefing was dated September 2011.

Community Mobilization Pilot Project. HSSP is also implementing the Community Mobilization Pilot project in two facilities in Nangarhar and Takhar provinces (representing Dari and Pashtu ethnic areas) to improve health promotion activities in those communities. The objectives of the pilot project were to: i) strengthen the leadership role of health *shura*; and ii) empower community members in decision-making and implementation of health interventions. The health *shura* play an important role in referring clients to the health facility for services and transferring key health messages from the facility to the community. The project is expected to obtain four results, including: a) improved capacity of NGO and health facility staff to mobilize and empower community members to solve their health problems; b) formed or re-organized health facility and health post *shuras* to have a wider representation among marginalized communities; c) improved capacity of health facility and health post *shuras* to take a leadership role in community health; and d) strengthened linkages between health facility, health post *shuras*, and communities. The community mobilization efforts had shown some initial promising results, but it is too early to evaluate the effectiveness of this program.

There may have been merit in developing, testing, and expanding numerous community-mobilization approaches by the three projects over the past several years. But it was not efficient. For example, there were examples where PDQ worked well in involving health *shuras* and community health supervisors. But PDQ has not worked with FHAGs because those were limited to specific districts. The evaluation team concluded that the next phase of program design would benefit from a strategy to consolidate and harmonize these approaches.

Conclusions: Assessment of Community-based Interventions and Approaches

Post-partum family planning. Implementing partners reported that trained community health supervisors were able to: i) support the community-based distribution of family planning methods, including CHWs giving the first doses of DMPA; ii) conduct effective supervision and use community maps; iii) analyze HMIS data; and iv) increase community participation through community leadership and awareness initiatives.

Data on post-training monitoring for post-partum family planning are confusing. Results from many of the 19 indicators that PCH NGOs monitored differed significantly from data reported by the CBHC monitoring unit for those same indicators.

Recommendation: Further investigation and strengthening of the PFP monitoring system is necessary.

There were no specific indicators for monitoring the post-partum family planning program that could be attributed to any particular HSSP or Tech-Serve effort.

Recommendation: Indicators for monitoring PFP should be specifically included in the PMP of any future project.

The Post-partum Family Planning Program in the 13 USAID provinces showed some encouraging achievements in terms of community health workers trained to provide the LAM method and community acceptance. However, there has been no study to measure the impact of the community-based PFP intervention package on contraceptive knowledge, utilization, and practices in Afghanistan. Data from the 2009 PCH household survey data indicate that knowledge of two modern methods of family planning has declined and that contraceptive use has also declined.

Recommendation: A program impact assessment of the PFP model in the next year is necessary to determine the causes for these declines and to inform future implementation.

PPH Demonstration Program. The Prevention of Post-Partum Hemorrhage Program has demonstrated the safety, acceptability, feasibility, and program effectiveness of misoprostal in preventing post-partum hemorrhage during home births. However, a significant impediment to the implementation of the PPH program was the length of time required by the MoPH's IRB to approve the study. Scale-up is affected by non-registration of misoprostal in Afghanistan and no policy is devised yet.

Recommendation: The Post-Partum Demonstration Program is currently scaling up and should be continued, particularly in support of the registration of misoprostal in Afghanistan.

BASICS. Timely access to critical primary health services was provided through BASICS efforts to strengthen CHWs to diagnose and treat childhood diseases, particularly diarrhea, nutrition, and ARI at the community level. Findings suggest that FHAGs were successfully fulfilling their missions to improve infant and child health.

BASIC's development of pictorial aids for illiterate CHWs and mothers were particularly effective in monitoring the growth and weight gain of sick children. HSSP also developed effective BCC and IEC materials on maternal health and newborn care. The team observed that IEC and BCC materials and job aids were supplied to those health facilities and CHWs surveyed, and that the facility providers and CHWs were using them correctly.

CBHC program coordination. All three projects used an effective synergistic approach to strengthening community-based health care by working at different levels of the health system simultaneously – providing national advocacy and policy development together with strengthening linkages between the health facilities and the communities. National-level CBHC advocacy efforts helped strengthen coordination among MOPH departments and with PHO teams, and helped engage support for the CBHC program at central, provincial, and community levels. However, several partners mentioned that lack of coordination is a continuing challenge that will require attention in the years ahead.

The team concluded that there was significant technical overlap and duplication among projects in the implementation of CBHC programs:

- HSSP and Tech-Serve – post-partum family planning
- HSSP and BASICS: maternal health and newborn care, and family health action groups
- HSSP and HCI – quality assurance efforts through PDQ process.

The team reviewed a variety of community mobilization approaches, including PDQ; FHAGs; and a pilot community mobilization program. Each of these uses various elements of the CBHC system, and each appears to be operating in different areas of the country. While there may have been merit in developing, testing, and expanding numerous community-mobilization approaches by the three projects over the past several years, the evaluation team concluded that the various approaches were not necessarily complementing each other. For example, there were examples where PDQ worked well in involving health *shuras* and community health supervisors. But, PDQ has not worked with FHAGs because those were limited to specific districts.

Recommendation: The CBHC program will require continued support from USAID. The team concluded that the focus should be on expanding the post-partum family planning program, expanding the prevention of post-partum hemorrhage, and expanding IMCI interventions. Attention should be given to supervision throughout the entire system to ensure the quality of service and information provided by CHSs, CHWs, health *shuras*, and FHAGs is consistent.

BASICS in collaboration with the MoPH successfully introduced the ICSP to improve prevention and treatment of child illness at the community level into five demonstration districts. The ICSP

combines several key child survival interventions activities including i) community-based child growth monitoring and promotion; ii) community IMCI, especially treatment for diarrhea, pneumonia, and immunizations to prevent measles and other childhood diseases; and iii) EMNC and counseling of BCC messages to mothers and community members. Based on successful improvements in health outcomes and improved quality of care, the MoPH then successfully expanded the program into a total of 28 districts and is currently in the process of extending this program to a further 26 districts. The involvement of the community turned out to not only be acceptable in the Afghanistan context but the improved collaboration among the women, the FHAGs and the CHWs resulted in improved outcomes in child health, as documented in a 2011 evaluation of this activity.

Both BASICS and Tech-Serve have supported the MoPH in introducing the Pediatric Hospital Initiative into seven provincial and regional hospitals in Nangarhar, Patktya, Herat, Bamyan, Takhar, Balk and Kunduz, as well as into three national tertiary pediatric hospitals: Indira Gandhi, Attaturk, and Maiwand. The aim of PHI is to:

- Improve the quality of care for hospitalized children with serious infections and severe malnutrition through the application of evidence-based standards
- Improve recognition and management of emergency conditions in children under 5
- Decrease hospital death rates of children under 5 years as well as hospital case fatality rates in common conditions

In support of PHI, BASICS established a functional triage system at provincial hospitals in Takhar and Bamyan, training staff in ETAT. ETAT trainers have become national ETAT facilitators, conducting ETAT training for staff in six additional provincial hospitals. While data on deaths of children within 24 hours of admission to hospitals is a standard indicator of how well the ETAT system is working, this data is not yet available. Feedback from staff during monitoring visits at facilities indicates satisfaction with the system for improving rapid identification of very sick children for priority attention and care.

ANNEX A: GLOBAL HEALTH TECHNICAL ASSISTANCE PROJECT SCOPE OF WORK

GH Tech

Contract No. GHS-I-00-05-00005-00

SCOPE OF WORK

(09-24-11)

I. TITLE

Activity: USAID/Afghanistan: End-of-project assessment of progress towards achieving results in four priority areas through project implementation by the Basic Support for Institutionalizing Child Survival (BASICS), Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve) and Health Services Support (HSSP) Projects.

Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

II. PERFORMANCE PERIOD

USAID/Afghanistan anticipates that the period of performance of this assessment will be approximately eight weeks. This will include preparation days, in-country work, report writing and finalization. The period of performance should begin no later than o/a September 12, 2011 (with arrival in-country o/a September 17).

III. FUNDING SOURCE

USAID/Afghanistan will fund this assessment

IV. OBJECTIVES AND PURPOSE OF THE ASSIGNMENT

To conduct end-of-project assessment of progress towards achieving results in priority areas by the projects noted above in order to:

- Evaluate the contributions of the projects to program level objectives in four priority areas:
 - Provincial Capacity Development
 - Community-based interventions and Service Delivery
 - Quality Assurance
 - In-service Training.
- The contributions of these projects to these Mission priorities will be assessed based on their effectiveness (according to each project's mandate/SOW) in 1) assisting GIRoA to develop and operationalize sound and relevant policies; 2) building capacity at all levels in management and service delivery; and 3) ensuring that measures are taken to enhance sustainability of programs at all levels;
- Document lessons learned for the future, including constraints and challenges encountered by the projects in implementing activities (security, staffing, lack of stability in USAID staff, etc.); and

- Make recommendations for informing and improving future projects, including what should be continued, discontinued, and/or scaled-up, as well as what needs further institutionalization.

V. BACKGROUND

The Projects

The **Basic Support for Institutionalizing Child Survival (BASICS)** project is a Task Order under an Indefinite Quantity Contract (IQC); dates of implementation are March 2008 – September 30, 2011. The objective of BASICS is to improve the national/provincial capacity to implement state-of-the-art child health policies and programs and strengthen the child health components of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital (EPHS).

BASICS is expected to achieve results in five areas:

- Revising and developing child survival and health-focused policies and strategies
- Improving child health care at the community level
- Improving child health care at the BPHS facility level
- Improving child health care at the EPHS hospital level
- Strengthening cross-cutting health system components to improve child health care

The USAID-funded **Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve)** project is currently being implemented by Management Sciences for Health (MSH). The cooperative agreement was signed on June 29, 2006, and is currently scheduled to end on September 30, 2011. Prior to the award of this agreement, USAID/Afghanistan supported the development of the health sector under the REACH project.

The Tech-Serve project is an Associate Award under the Leadership, Management and Sustainability (LMS) Leader with Associates Award, which closed out in December 2010. The objective of Tech-Serve is to improve the capacity of the Ministry of Public Health (MoPH) to plan, manage, supervise, monitor, and assessment the scales of access to quality Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) service, particularly those of highest health risk.

Tech-Serve is expected to achieve results in three areas:

1. Improved capacity of the central MoPH to support the delivery of BPHS and EPHS services, primarily through nongovernmental organization (NGO) service providers;
2. Improved capacity of the 13 Provincial Health Offices (PHO) of the MoPH to support the delivery of BPHS and EPHS services; and
3. Developed planning, management, supervision, monitoring and assessment, and leadership capacity of the MoPH.

The **Health Service Support (HSSP)** project is an associate award under the Access to Clinical and Community Maternal, Neonatal, and Women's Health Services (ACCESS) Leader with Associates Award, which closed out on March 31, 2010. The associate award was signed on July 1, 2006, and is currently scheduled to end on November 30, 2011. The objective of HSSP is to improve the quality of services provided to women of reproductive age

HSSP is expected to achieve results in five areas:

- Strengthening and developing systems that support service delivery quality,
- Increasing the number and performance of BPHS providers, especially women, in rural and underserved areas,
- Improving the capacity and willingness of communities, families, and individuals to make informed decisions about their health and support and sustain health-seeking behavior,
- Integrate gender awareness and practices into health services, and
- Strengthen Southern and Southeastern health systems through quick impact activities (Helmand, Kunar, Nangarhar, Laghman, and Farah)

In order to achieve these results, HSSP provides technical assistance to NGOs contracted to deliver health services through the USAID-funded MoPH Partnership Contracts for Health (PCH) project.

The Priorities Areas

- Provincial Capacity Development
- Community-based Interventions and Service Delivery
- Quality Assurance
- In-service Training

VI. SCOPE OF WORK

The evaluators shall assess the approaches, results, and challenges of the projects to determine whether their implementation successfully contributed to overall USAID program objectives. The following are suggested areas to be considered during this assessment and illustrative assessment questions. These questions are illustrative and final questions will be developed by the assessment team in collaboration with USAID/Afghanistan.

A. Priority-Specific Questions

- a. Provincial Capacity Development
- b. Community-based Interventions and Service Delivery
- c. Quality assurance
- d. In-service Training

B. Project Level Questions (these will need to be folded into the above questions as appropriate once the Mission has decided where the priority questions within the priority areas are.

- I. Determine whether the projects achieved intended goals and results for the four priority areas given the individual program designs and operating assumptions.
 - a. To what extent did the projects meet their goals and achieve specific objectives by target?
 - b. Identify the facilitating and impeding factors influencing the achievement of intended results.
 - c. To what extent are the projects' achievements sustainable from financial, institutional and programmatic perspectives?
 - d. How effective were the projects in monitoring and documenting compliance with U.S. family planning policy and statutory regulations (including concepts of free and

informed choice, no targets, etc.) and in educating partners/NGOs/MOPH about family planning compliance?

2. Assess the effectiveness of key technical components and approaches of the projects in the priority areas.
 - e. Assess the appropriateness and soundness of the main technical activities in which the projects are engaged in the four priority areas. Are they aligned with sector strategies and GIRoA priorities? According to key stakeholders, are the projects' technical activities appropriate and of high quality?
 - f. To what extent have staff and senior management practiced learned skills/standards related to planning, management, training, supervision, information system and service delivery, etc.?
 - g. Did the (relevant) projects sufficiently invest in interventions to generate effective demand for health services, complementing supply-side investments? Are community outreach and mobilization activities and behavior change communication strategies technically sound and appropriate for the target populations? Were community outreach/mobilization activities timely, and effective in reaching target audiences and in improving health-seeking behaviors? How effectively are the USAID-supported community-based interventions integrated into the BPHS, and which of these community approaches can or should be scaled up nationally?
 - h. Assess the projects' coordination and possible overlap/duplication with other projects. For example, how effective has the partnership between the projects, USAID and other USAID implementers been in moving key technical interventions forward? Specifically, how effective has the following work been:
 - Tech-Serve and HSSP with post-partum family planning and religious leaders,
 - BASICS and Tech-Serve in hospitals (the Pediatric Hospital Initiative), and
 - The use of four different quality approaches: Leadership Development Program (Tech-Serve), Quality Assurance (HSSP), Health Improvement Collaboratives (URC), and Partner-defined Quality (HSSP).⁶³
 - i. To what extent did HSSP's training of trainers and supportive supervision models improve the quality of care that skilled health providers provide?
 - j. What is the level of gender integration⁶⁴ in the management and delivery of health services? To what extent did gender integration increase women's access to health services and information about healthy behaviors?
3. Document Lessons Learned and Best Practices and provide management/administrative and technical recommendations for future projects.
 - k. Based on current experience and lessons learned, what are the essential activities that should be continued or expanded upon in any new or follow-on USAID health projects?
 - l. What kinds of activities should not be continued?
4. BASICS-specific questions
 - m. To what extent has BASICS institutionalized the child health components of the BPHS?

⁶³ This assignment will not evaluate the URC Health Improvement Collaboratives per se; only assess the utility and effectiveness of implementing multiple approaches to improved quality, of which collaboratives are just one.

⁶⁴ Gender integration using USAID framework would mean identifying, addressing gender inequalities during project design, implementation, monitoring, and evaluation. Thus, an index score could be created on how many of these steps were accomplished and with what frequency.

- n. Assess the effectiveness of BASICS' efforts at strengthening cross-cutting health system components (e.g., BCC, immunization) to improve child health outcomes.
 - o. What is the level of Community Health Workers' knowledge and skill relative to growth monitoring promotion, C-IMCI, community newborn care, and BCC?
 - p. To what extent do BASICS target districts have better child service coverage and outcomes than non-BASICS districts relative to immunization coverage, malnutrition and care-seeking behavior?
 - q. To what extent was case fatality in health facilities reduced due to BASICS application of the Pediatric Hospital Initiative?
5. HSSP-specific questions
- r. To what extent did the Quality Assurance methodology produce the desired impact?
 - s. Assess the extent to which HSSP has institutionalized the Quality Assurance methodology in the facilities where the methodology has been introduced.
 - t. To what extent have QA activities been made a part of NGO service delivery, monitoring/supervision/self-assessment, workplan and performance appraisal, and have an assigned budget?
 - u. Assess the extent to which HSSP has built the capacity of the Midwives and Nurses Accreditation Board and the Afghan Midwives Association are autonomous organizations.
 - v. To what extent have NGOs' institutional capacities (technical, administrative, planning, management, training, supervision, information systems/monitoring and assessment, continuous improvement in quality of care and finance, etc.) improved to implement the BPHS?
 - w. Assess the effectiveness of the HSSP Provincial Coordinators in building the capacity of the implementing NGOs to conduct in-service trainings and institutionalize QA. If effective, to what extent would capacity building suffer if this position was combined with the Tech-Serve Provincial Health Advisor and Hospital Advisor into one position in the future? Compare the relative contributions of Provincial Coordinators in HSSP provinces to those non-USAID funded provinces that do not utilize such coordinators.
 - x. How effective were HSSP's efforts in building the long-term capacity of the MoPH at the central level, particularly the Health promotion Department, Reproductive Health Directorate, and GIHS?
6. Tech-Serve-specific questions
- y. Assess the validity of Tech-Serve's approach of employing "mobile advisors" who reside primarily within Tech-Serve, but make frequent trips to the MoPH to provide technical assistance. In particular, assess the MoPH's opinion of these advisors and how well this technique worked or did not work in facilitating Tech-Serve's goals and relationship-building.
 - z. Assess whether the technical assistance advisors funded by Tech-Serve for the MOPH -- especially those devoted to monitoring and assessment -- should have been transferred over to MOPH staff sooner than now being required by the on-budget effort.
 - aa. Assess the effectiveness of the Tech-Serve Provincial Health Advisors and Hospital Advisors in building capacity at the provincial level. Compare the relative contributions of PHAs and HAs in Tech-Serve provinces to those non-USAID funded provinces that do not utilize such advisors.

- bb. Were the pharmaceuticals supplied by Tech-Serve to health facilities provided in a timely manner? Was planning appropriate given the context, e.g., taking into consideration winter months when supplies cannot be delivered?

VII. METHODOLOGY

Methodology, techniques and or/procedures anticipated/suggested starting from the Team Planning Meeting (TPM) to the acceptance of the final report. The final methodology will be developed by the team in collaboration with USAID during the TPM. The health team proposes that the assessment team design a methodology that employs mixed methods using both existing literature and interviews to collect information..

The Assessment Team should consider a range of possible methods and approaches for collecting and analyzing the information required.. Data collection methodologies will be discussed with, and approved by, USAID at the start of the assessment.

The Assessment Team should use facilitative methods and activities that will enhance collaboration and dialogue among counterparts, particularly the MOPH and project partners. The Assessment Team will work in collaboration with the USAID Health Team, which will assist in organizing meetings.

The Assessment Team will propose and organize the assessment process in collaboration with the Health Team. The assessment design and work plan will be presented to Health team members for comments after the Team Planning Meeting. The AOTR and Chief of Party from each project will arrange for an initial introductory meeting with appropriate stakeholders at the outset of the process. A general list of relevant stakeholders and key partners will be provided to the Assessment Team by each AOTR at the time of arrival, but the Assessment Team will be responsible for expanding this list as appropriate, and arranging the meetings and appointments so as to develop a comprehensive understanding of the program and services offered through each of the projects.

The final methodology and work plan will be developed as a product of the Team Planning Meeting (TPM) and shared with the USAID Health Team prior to application.

Document Review/Data Analysis:

- USAID/Afghanistan will provide the Assessment Team with key project-related documents (see Annex I) prior to the start of the in-country work. Team members will review these documents in preparation for the initial Team Planning Meeting.

Prior to conducting field work, the Assessment Team will review existing literature and data, including program strategies; quarterly reports; work plans; monitoring plans and reporting indicators/data; success stories; the agreement and relevant modifications; internal project financial records and reports, as well as external audit reports; and any other reports and documents reflecting the projects' work in Afghanistan.

Team Planning Meeting

- A two-day Team Planning Meeting (TPM) will be held in Kabul before the assessment begins. This meeting will allow USAID to present the team with the purpose, expectations, and agenda of the assignment. In addition, the team will begin to:
 - Clarify team members' roles and responsibilities, including how to divide work between the three projects and/or the four priorities areas;
 - Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;

- Review and develop final assessment questions;
- Review and finalize the assignment timeline and share with USAID;
- Develop data collection methods, instruments, tools and guidelines;
- Review and clarify any logistical and administrative procedures for the assignment;
- Develop a preliminary draft outline of the team's report.

A final outline of team member roles and responsibilities will be available when the virtual team members are established and assessed for their skills and availability.

Field Visits/Key Informant Interviews:

- USAID currently implements project activities in 13 provinces, 5-7 quick impact provinces, and at the national level. After initial briefings by each project on project design, strategies, models, activities, and results, the Assessment Team will arrange to visit sites selected in consultation with the AOTRs and the respective project personnel. Preliminary plans include visits to three provinces (the exact sites will be selected prior to the Team Planning Meeting). The Team will rent vehicles for travel within Kabul (final arrangements will be communicated to the Team before arrival) and Implementing Partners will provide transportation while in provinces. USAID will book Team travel to/from provinces on Embassy Air and ensure that logistics and other travel arrangements are in place prior to in-country travel. The Team will visit project sites in the following provinces: Herat, Bamiyan, Badakhshan, and Kabul. Logistics remain to be finalized but some mechanism will be chosen to assist the Team with logistics.
- The Assessment Team may be accompanied by a staff member from USAID/Afghanistan as appropriate to facilitate meetings and field visits. The site visits will involve interviews (or Focus Group Discussions, as appropriate) with select provincial- and district-level MoPH staff, Provincial Health Advisors/Coordinators, Hospital Advisors, facility staff, clients, and community members.
- The Assessment Team will also conduct interviews with central-level MoPH staff, including GCMU, donor/UN organizations, SPS, and any other key stakeholders identified during the TPM.

Internal USAID/Afghanistan meetings will include, at a minimum:

- **Initial organizational/introductory meeting** at which the Assessment Team will present an outline and explanation of the design of the assessment (refer to the TPM noted above);
- Additional **consultation meetings** with USAID staff, as needed, to fully explain the project;
- A **mid-assessment meeting** with USAID, following the field visits, to outline progress and implementation problems (a/o 12 October);
- At the conclusion of the field visits there will be **debriefing meetings** with both USAID/Afghanistan and partners. The purpose of these meetings will be to share findings and get final inputs before preparing the reports.
- Preliminary draft assessment report review discussion during the final week; and
- **Final Assessment debrief** - summary of the data, draft recommendations and draft report.

VIII. DELIVERABLES

The team will be responsible for producing the following final deliverables:

Work Plan: During the Team Planning Meeting, the Team will prepare a work plan which will include the methodologies to be used in the assessment as well as the final list of assessment questions to be answered. The work plan will be submitted to the Health Team for approval no later than the sixth day of work.

Methodology Plan: A written methodology plan (assessment design/operational work plan) will be prepared during the Team Planning Meeting and discussed with USAID prior to implementation.

Discussion of Preliminary Draft Assessment Report: The Team will submit a rough draft of the report to the USAID Health Team (o/a 26 Oct), which will then provide preliminary comments prior to final Mission debriefing. This will facilitate preparation of a more final draft report that will be left with the Mission upon the Assessment Team's departure.

Debriefing with USAID: The Team will present the major findings of the assessment to USAID/Afghanistan through a PowerPoint presentation after submission of the draft report and before the Team's departure from country. The debrief will include a discussion of achievements and issues, as well as any recommendations the Team has for possible future projects. The Team will consider USAID comments and revise the draft report accordingly, and as appropriate.

Debriefing with Partners: The Team will present the major findings of the assessment to USAID partners (as appropriate and as defined by USAID) through a PowerPoint presentation prior to the Team's departure from country. The debriefing will include a discussion of achievements and activities only, with no recommendations for possible future project approaches, results, or activities. The Team will consider partner comments and revise the draft report accordingly, and as appropriate.

Draft Assessment Report: A draft report of the findings and recommendations should be submitted to the USAID Health Team prior to the Team Leader's departure from Afghanistan. The written report should clearly describe findings, conclusions and recommendations. USAID will provide comments on the draft report within two weeks of submission (o/a 14 November).

Final Report: The Team will submit a final report that incorporates the team responses to Mission comments and suggestions no later than ten days after USAID/Afghanistan provides written comments on the Team's draft assessment report (see above). This report should not exceed 45 pages in length (not including appendices, lists of contacts, etc.). The format (see below) will include an executive summary, table of contents, methodology, findings, and recommendations. The report will be submitted in English, electronically. All procurement sensitive information will be removed from the report and compiled into an Internal USAID Memo for dissemination within USAID only.

A public version of this report, excluding any potentially procurement-sensitive information, will be submitted (also electronically and in English) for dissemination among implementing partners and stakeholders. Once the mission has approved the final version of the report, this report will be edited/formatted and made 508 compliant by GH Tech and will take approximately 30 days. The report will be prepared for release as a public document on the USAID Development Experience Clearinghouse (DEC) (<http://dec.usaid.gov>) and the GH Tech project web site (www.ghtechproject.com).

Proposed Final Report format:

Executive Summary

The Executive Summary will state the development objectives of the program/project evaluated; purpose of the assessment; methodology; findings; conclusions, lessons learned and future design implications.

Table of Contents

Introduction

The context of what is evaluated, including the relevant history, demography, socioeconomic, and basic political considerations.

Body of the Paper

1. The purpose of the assessment. Brief description of the program.
2. Evidence, findings and analysis of the assessment questions.
3. Conclusions drawn from the analysis of findings, stated succinctly.
4. Recommendations.

Appendices shall include:

1. Assessment scope of work
2. List of documents consulted
3. List of individuals and agencies contacted
4. Technical topics, including study methodology if necessary
5. Schedule of activities in an Excel format.
6. Assessment Team composition

Once USAID/Afghanistan has approved the final version of the report, GH Tech will have the document professionally edited and formatted and will provide the final report to USAID/Afghanistan for distribution. GH Tech will require approximately 30 business days to edit and format and print the final document. This final revised version of the report can be used as a working document while final report editing/formatting is in process.

IX. RELATIONSHIPS AND RESPONSIBILITIES

Client Roles and Responsibilities:

Before In-Country Work

1. Consultant Conflict of Interest. To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors or NGOs evaluated/assessed and information regarding their affiliates.
2. Documents. Identify and prioritize background materials for the consultants and provide them, preferably in electronic form.
3. Local Consultants. Assist with identification of potential local consultants and provide contact information.
4. Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs. Missions can protect scarce budgets by using their in-country knowledge to suggest the travel calendar (i.e. number of in-country travel days required to reach each destination, and number of days allocated to interviews at each site).

5. Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and identify a person to assist with logistics (i.e., visa letters of invitation etc.)
6. USAID-Supplied Participants. If relevant, provide guidance regarding participation in the assignment by Mission and USAID/W staff (i.e., who will participate, how long, source of funding for their participation).

During In-Country Work

1. Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Mission Point of Contact person(s) and provide technical leadership and direction for the team's work.
2. Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
3. Meeting Arrangements. While local consultants typically will arrange meetings for contacts outside the Mission, client will support local consultant(s) in coordinating meetings with stakeholders.
4. Formal and Official Meetings. Assist the team in arranging key appointments with national and local government officials and accompany the team on these introductory interviews (especially important in high-level meetings).
5. Other Meetings. If appropriate, assist in identifying and helping to set up meetings with local professionals relevant to the assignment.
6. Facilitate Contacts with Partners. Introduce the team to project partners, local government officials and other stakeholders, and where applicable and appropriate, prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After In-Country Work

1. Timely Reviews. Provide timely review of draft/final reports and approval of the deliverables.

X. MISSION AND/OR WASHINGTON CONTACT PERSONS

The Assessment Team will work under the direction and guidance of the USAID/Afghanistan Monitoring and Evaluation Advisor and the Health Officer and in collaboration with the OSSD Health Team.

XI. COST ESTIMATE

[To be added later by GH Tech.]

XII. REFERENCES

[To be added later by USAID/Afghanistan.]

XIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT

The assessment team will consist of 5-6 local and international consultants. International team members should have 10+ years of health systems development expertise in low-income countries with USAID and/or other donors, and include specialists with a mix of one or more of the following areas of expertise: family planning/reproductive health, maternal/child health, capacity building, systems strengthening and behavior change communication/ community mobilization. The team should also include 1-2 local consultants who have a good understanding of the Afghan public health system, NGOs, and USAID/donor programs if possible, and who can act as translators. At least one member should also have expertise in monitoring and evaluation.

The in-country team will be supplemented with 3-4 virtual team members who will review interview and focus group findings, assist in extracting data from reports, assist in analyzing data and in writing the draft report.

The Team Leader should have at least 10 years senior-level experience working in health systems programs in a developing country. S/he should have extensive experience in conducting qualitative evaluations/assessments, as well as excellent oral and written skills. S/he should have experience managing large and diverse teams, and be able to bring together a large and complex variety of information, opinions, and data into a representative and comprehensive final report. This specialist should have wide experience in implementation of USAID-funded MCH/FP/RH programs. S/he should also have a good understanding of project administration, financing, and management.

The Team Leader will take specific responsibility for assessing and analyzing the project's progress towards qualitative and to a certain extent quantitative targets, factors for such performance, benefits/impact of the strategies, and compare with other possible options. S/he will provide leadership for the team, finalize the assessment design, coordinate activities, arrange meetings with the assistance of USAID, consolidate individual input from team members, and coordinate the process of assembling the final findings and recommendations. S/he will also lead the preparation and presentation of the key assessment findings and recommendations to the USAID/Afghanistan Health Team and key partners if desired.

Team members will be required to travel to project sites throughout Afghanistan to obtain an understanding of the program's field activities and therefore should be capable of traveling to rural and/or rugged areas.

USAID/Afghanistan anticipates that the period of performance of this assessment will be approximately eight weeks. This will include preparation days, in-country work in Kabul and the provinces, and report writing and finalization. The assessment should begin no later than September 12, 2011. A six-day work week is authorized for this activity, while working in-country.

An Illustrative Table of Level of Effort (LOE)

Activity	Team Member(s)	Total Team Days	Period of Performance
Mission sends background documents to GH Tech and Team Members	USAID		Sept 5
Review of Documents	GH Tech Team	5	Sept 9 – 14
Travel to Country		2	Sept 16 – 17
TPM in Country ⁶⁵		3	Sept 18, 19, 24
Meetings and Interviews with Key Stakeholders		6	Sept 20 – 27
Fieldwork		18	Sept 28 – Oct 18
Information Analysis and Synthesis		5	Oct 19 – 24
Drafting Report		5	Oct 25 – 30
Oral Debriefing of Mission staff. Team submits full draft to Mission and GH Tech		1	Oct 31

⁶⁵ Includes any necessary introductory meetings with USAID

Activity	Team Member(s)	Total Team Days	Period of Performance
Stakeholders Presentation		1	Nov 1
Team Departs Country		2	Nov 1 – 2
Mission and GH Tech send technical feedback/comments on draft to Team Leader	USAID & GH Tech	0	Nov 2 – 10
Draft revised by Team	GH Tech Team	5/2	Nov 14 – 18
GH Tech edits and finalizes report	GH Tech		
GH Tech submits final report to Mission	GH Tech		
Missions approves report	USAID		
GH Tech closes out the activity	GH Tech		
Total LOE*		52/49 days	
*Note LOE will be adjusted with the selection of the virtual team members.			

XIII. LOGISTICS

GH Tech will hire a security and logistics firm to provide support to the team for work and travel in and around Kabul. In conjunction with this, GH Tech will look to USAID implementing partners for supplemental security and logistics support when the team travels to the provinces. We will also expect to rely on USAID/Afghanistan and the US Embassy for up to date security information throughout this assignment.

ANNEX B: USAID/AFGHANISTAN ASSESSMENT OF BASICS, TECH-SERVE AND HSSP WORK PLAN

27 SEPTEMBER 2011

Introduction GH Tech is pleased to submit this preliminary work plan as Deliverable #1. The Work Plan has been broken down the following items.

- A. Proposed methodology for the assessment
- B. Key assessment questions
- C. Assessment timeline/calendar
- D. Responsibilities of each team member
- E. List of proposed organizations/individuals for Kabul and field-based interviews and suggested site visits
- F. Outline of the final report

We hope that this meets your expectations and look forward to any comments or suggestions for modifications.

A. PROPOSED METHODOLOGY

A range of methods and approaches will be used to collect and analyze information relevant to the assessment objectives and questions outlined in the Scope of Work for the USAID/Afghanistan Projects (BASICS, HSSP and Tech-Serve) and for the four priority areas (Provincial capacity building, Community-based interventions and service delivery, Quality Assurance, and In-service Training). A team of experienced consultants will work together to conduct the assessment (o/a two international consultants, two members of the MoPH, two members of USAID, and o/a three international consultants serving in a virtual capacity).

A combination of the following methods will be used:

1. **Review of documents:** Documents relevant to the Afghanistan projects (BASICS, Tech-Serve and HSSP) and the four priority areas have been identified and assembled for review and analysis. These include project documents (e.g., initial technical proposal and extension proposal, work plans, semi-annual reports, monitoring and assessment strategy and assessments, mid-term assessment reports, etc.), USAID reports, documents from the Government of Afghanistan (e.g., national strategy, national action plans), documents from External Donor Organizations including the World Bank and the EU, among others. A complete list of documents consulted will be included as an annex in the final report.
2. **Team Planning Meeting:** This meeting will allow USAID/Afghanistan to present the team with the revised purpose, expectations, and agenda of the assignment. In addition the team will:
 - Clarify team members' (including virtual members) roles and responsibilities
 - Review and develop final assessment questions
 - Review and finalize the assignment timeline and share with USAID
 - Develop data collection methods, instruments, tools and guidelines
 - Review and clarify any logistical and administrative procedures for the assignment

- Develop a preliminary draft outline of the team’s report and
 - Assign drafting responsibilities (including virtual team members) for the final report.
3. **Interview guides:** Draft interview guides that address the main results areas listed in the SOW have been prepared and will be used for conducting structured open-ended interviews with key informants related to the 3 projects and for the four priority area. Categories of people to be interviewed include the following:
- USAID staff
 - Project staff
 - Project partners: see attached table of proposed interviews associated with each project.
 - Key partners at each level of Implementation from national MoPH counterparts through provincial level officials, NGO partners, facility based implementers (management and clinical staff) and clients (including potential clients as possible).
4. **Internal USAID/Afghanistan meetings.** Will include as at a minimum:
- Initial organizational/introductory meeting at which the Assessment Team will present an outline and explanation of the design of the assessment
 - Mid- Assessment briefing
 - Final assessment debrief/summary of the data, draft recommendations and report.
5. **Site visits:** Three provinces will be visited: Kabul, Bamyán, and Badakhshan. Meetings will be held with provincial MoPH officials, NGOs, client managers and service providers, clients and potential clients.
6. **Data Analysis:** Data collected by the assessment team through the above-described methods (in addition to observations and informal discussions) will be reviewed, analyzed and consolidated and used as the basis for formulating the assessment findings and recommendations.

B. KEY INTERVIEW QUESTIONS

The overall **objectives as stated in the SOW** are as follows:

To conduct end-of-project assessment of progress towards achieving results in priority areas by the projects noted above in order to:

- Evaluate the contributions of the projects to program level objectives in four priority areas:
 - Central and Provincial Capacity Development
 - Community-based interventions and Service Delivery
 - Quality Assurance
 - In-service Training.
- The contributions of these projects to these Mission priorities will be assessed based on their effectiveness (according to each project’s mandate/SOW) in 1) assisting GIRoA to develop and operationalize sound and relevant policies; 2) building capacity at all levels in management and service delivery; and 3) ensuring that measures are taken to enhance sustainability of programs at all levels;
- Document lessons learned for the future, including constraints and challenges encountered by the projects in implementing activities (security, staffing, lack of stability in USAID staff, etc.); and
- Make recommendations for informing and improving future projects, including what should be continued, discontinued, and/or scaled-up, as well as what needs further

institutionalization. Based on this understanding of assessment objectives, the team will develop a detailed question set, identified data sources needed to answer each question, and determined which team member will take responsibility for analysis of the question. Interview guides and site visit guides will be developed based on this detailed question set.

The detailed questions aim to answer these major assessment questions:

1. Determine whether the projects achieved intended goals and results for the four priority areas given the individual program designs and operating assumptions.
 - To what extent did the projects meet their goals and achieve specific objectives by target?
 - Identify the facilitating and impeding factors influencing the achievement of intended results.
2. Document Lessons Learned and Best Practices and provide management/administrative and technical recommendations for future projects.
 - Based on current experience and lessons learned, what are the essential activities that should be continued or expanded upon in any new or follow-on USAID health projects?
 - What kinds of activities should not be continued?
3. Specific Questions about each Priority Area
 - Central and Provincial Capacity Development
 1. Was evidence available to show that projects developed a capacity building implementation plan after need assessment and monitored capacity improvement? If not, how projects target audience determined and which capacities were developed and monitored?
 2. List three things which you learned from PHA/PC?
 3. List three things which you do not like PHA/PC to repeat?
 4. List three things which you can do without assistance from PHA/PC?
 5. List three reasons for continuing the assistance from PHA/PC in future?
 6. In your opinion, what are the advantages and disadvantages of combing PHA and PC position?
 7. In your opinion, which capacity building areas need strengthening in future provincial capacity, GCMU, HMIS, DMU, etc?
 - Community-based interventions and Service Delivery
 1. Which of the CBIs have been made part of the revised BPHS?
 2. Do you have scale-up plan for revised BPHS for whole country? What is the contribution of different donors?
 3. Does the CBI implementation plan have required benchmarks (e.g. integrated into MoPH standardized CHW training, stipulated in PCH contract, captured in HMIS reporting) for ensuring implementation?
 4. In your opinion, which capacities your department has to scale-up the CBI and for which capacities you need technical assistance?
 5. At the facility/community level, which CBI you like most and for what reasons?
 6. Which CBI you can implement without outside assistance?
 7. To what extent the Ministry has prioritized and integrated various CBI in community based health system?

- Quality Assurance
 1. At provincial/NGO – Do you have a plan to implement QAP after close-out of the project? If not, what are those reasons to inhibit you doing that?
 2. Ministry level - What are comparative advantage and disadvantages of QAP, PDQ, and LDP? Describe the critical steps and benchmarks for institutionalizing this quality intervention for relevant Ministry and NGO officials? Which one of the training has been institutionalized? If not, why not?
 3. Facility level - List three things which improved after introduction QAP beside improvement in practice of standards?
 4. Have you received training both in QAP and PDQ? If yes, list three things which are common in QAP and PDQ and three things which are different between the two?
 5. Have you received training in LDP? List three things you learned and practiced and three things you did not like about LDP?
 6. List three things which improved after training on LDP?
- In-service Training
 1. Which in-service trainings have produced the most benefits? Is it based on documentation/research or personal opinions?
 2. Were there records available that follow-up was made to document practice of learned skills? Was there evidence available of supervisor feedback via records or interviews at the facility level?
 3. Which in-service training need to be continued in future?
 4. Can you describe the steps involved in the training needs assessment? How do you ensure that the health workers are receiving training based on gaps in clinical, interpersonal, or management skills? How do you track the trainings individual health workers receive in the province?
 5. How do you select the master trainers and ensure their retention? Do master trainings work full time as a trainer or do they have other responsibilities?
 6. Do the master trainers have a training plan for the year? How do you track the performance of the master trainers? Once master trainers complete their courses, do they have obligations to complete training plan and follow up student assessment and supportive supervision?
 7. Is the Gender Based Violence (GBV) culturally appropriate and are they able to identify GBV survivors and provide appropriate counseling? After receiving the training, how much support do the health workers receive in practice their newly learned skills and knowledge?

C. ASSESSMENT TIMELINE/CALENDAR (PROVIDES DATES FOR ALL KEY ACTIVITIES)

Dates	Task
11-15 September	Document review and initial planning and preparation (out of country for international consultants) Teleconference with team members and USAID to touch base on overall planning
16/17 September	Travel to Afghanistan (Domingo, Stover). Security briefing with AKE security team

Dates	Task
18/19/24 September	Team planning meeting in Kabul Inception briefing with USAID, team presents TPM deliverables to USAID/Afghanistan, Selection of partners, government officials for interview,
20/21/22 September	Preliminary meetings with Project teams for overall briefings and discussion (entire Team)
25 September	Discuss draft revised SOW and workplan with USAID. Expat team members get briefing from RSO. (Stover)
26/27 September	SOW and workplan revision and agreement.
28 September – 3 October	Bamyan-based stakeholders interviews (see list). VTM complete document review and begin outlining priority areas.
4-6 October	Kabul province-based stakeholder interviews (see list). Extra security assistance will be provided the team via AKE
8-11 October	Badakhshan-based stakeholders interviews (see list) Extra security assistance will be provided the team via AKE
12 October	Mid-Assessment review with USAID. (Assessment Team)
13-18 October	Interviews and discussions with key project and MoPH partners in Kabul
19-24 October	Data consolidation, compilation, field notes preparation. Data/information analysis and identification of preliminary findings and recommendations
25-30 October	Report writing (In-country and virtual team)
31 October	Debrief USAID
1 November	Debrief Partners
2-3 November	Travel home (Stover)
2-10 November	USAID reviews draft report and provides comments
14-18 November	Final drafting of report based on USAID inputs (Stover and virtual team)
18 November	Submission of draft report to USAID/Afghanistan and GH Tech
21 November	GH Tech finalizes the report for submission to USAID (30 days)

ANNEX C: REFERENCES

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ANNEX D: CAPACITY BUILDING INDICATORS FOR HSSP, TECH-SERVE, AND BASICS

Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve)		
Indicator	TARGET Project Year 2011 (September)	PY5 through Q4
IR #1: Improved Capacity of the Central MoPH		
I.a. MOPH GCMU remains certified as determined by USAID reviews	GCMU reports	HEFD reports separately
I.b. The average number of days for processing GCMU payments to NGOs	GCMU reports	HEFD reports separately
I.c. Improve the average PPG/PCH Quarterly Performance Evaluation scores.	GCMU reports	HEFD reports separately
I.d. Improve average quarterly PPG/PCH Monitoring Single Score.	GCMU reports	HEFD reports separately
I.e. Weighted average % of inventory variation for NGO warehouses.	8%	14.5% ⁶⁶
I.f. Average % of records matching physical stock for NGO warehouses	56%	45.9%
I.g. Average % of tracer stock on the day of visit for NGO warehouses.	88%	89.78% (from PY5 Q3)
I.h. Average % of time out of stock for NGO warehouses.	9%	4.17% (from PY5 Q3)
I.i. Develop policy and regulations for private hospitals and diagnostic centers	Introduce through proper channels at the HF level	Completed 2010
I.j. No. of MOPH policies(child and adolescent health, CDD, user fee, national salary) developed through a coordination mechanisms in the MOPH	4 implemented	16 policies, strategies and other document processed ⁶⁷
I.k. No. of health workers nationally registered with MOPH with updated data in the HRD data base (cumulative)	25,000	32,000
I.l. % of BPHS facilities nationally submitting HMIS reports	>90%	91%

⁶⁶ Number of facilities increased from 465 to 478.

⁶⁷ 1. Public Relation Strategy, 2. National Hospital Policy, 3. National Hospital Strategy, 4. National Policy on Blood Safety and Transfusion 5. Pollution Control and Management Policy, 6. Gender National Policy and Strategy, 7. Disability and Rehabilitation National Strategy, 8. Quality Improvement Healthcare National Strategy, 9. Nursing and Midwifery National Policy and Strategy, 10. Reproductive Health Strategic Plan, 11. Occupational Safety Health Policy, pending, 12. National Strategy for Community-based Management of Malaria, 13. MOPH 5 Year Strategic Plan and Its Operational Plan for 1390 (approved by the Executive Board), 14. MOPH and Parliament Affairs Strategic Paper, submitted to MOPH leadership, 15. Environmental Health Strategy, and 16. Assessment Protocol on the Overall Residency Program and Residency Faculty of MOPH Report.

Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve)		
Indicator	TARGET Project Year 2011 (September)	PY5 through Q4
1.m. No. of EPHS facilities (district and provincial hospitals) in PPG/PCH provinces submitting EPHS HMIS reports	25	32
IR #2: Improved Capacity of PPHOs of the MoPH		
2.a. Number of Provincial Health Teams with a functioning PPHCC team reporting improved collaboration and communication on at least one new priority issue each year	13	13
2.c. No. of PPG provinces implementing an updated provincial plan	13 (adjusted)	13 + 4Q1
2.e. No. of PPHOs who actively collect and use national BPHS monitoring Checklist data	13	17
2.f. No. of PPHOs with a functioning HMIS provincial hub (No. of PPHOs capable of managing HMIS information flow in their provinces)	13	11
2.g. No. of PPHOs renovated to improve working environment for PPHDs and provincial health teams	Already completed	Already completed
2.h. No. of health facilities in USAID or non-USAID provinces applying Leadership Development tool to improve health results	174	152
2.j. Percent of required PHCC reports submitted by USAID supported PPHOs, and the percentage of those PPHOs with requests, receive MOPH feedback.	100% filled 65% w/ feedback	100% PHHCCs conducted at USAID supported provinces and report made to PLD. Analysis made and feedback provided to the concerned DGS and PHDs.
2.k. No of USAID supported PPHDs who review the NGO quarterly reports and provide technical inputs on their performance.	13	13 + 4 PPHDs reviewed the NGO quarterly reports and provided feedback on their performance through Central MoPH.
IR #3: Improved Management and Leadership Capacity of 13 PPHOs		
3.a. No. of Joint Monitoring Visits by PPHOs to BPHS and EPHS health facilities (cumulative life of project)	700	1056
3.b. Number of central MOPH management units using LDP techniques for achieving results	5	7
3.c. Number of PPHOs and the number of Provincial NGO management units using LDP techniques for achieving results	13	13 + 4Q1

Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve)		
Indicator	TARGET Project Year 2011 (September)	PY5 through Q4
3.d. Number of provincial NGO management units using LDP techniques for achieving results	13	13 + 4Q1
Basic Support for Institutionalizing Child Survival (BASICS)		
Indicator	2011 Target	Current Status
IR 1: Improved Oversight and Coordination of Child Survival Activities by National and Provincial Child Survival Committees		
1.1 # of NMCSC meetings held	3	3
1.2 # of PMCSC meetings held	10	9

ANNEX E: JOB DESCRIPTIONS OF PHAS AND PCS

Tech Serve Provincial Health Advisor (PHA) ⁶⁸	HSSP Provincial Coordinator (PC) ⁶⁹
<p>QUALIFICATIONS:</p> <p>Be an Afghan national and preferably a resident of the province.</p> <p>Hold a Medical degree. Master’s degree in public health and/or hospital management will be an advantage</p> <p>Five to six years experience working with public sector institutions and NGOs at various levels in the health sector in Afghanistan.</p> <p>Professionals with residence and cultural familiarity from the community and Farah province are preferred</p> <p>Knowledge and experience with management and community-based health care programs</p> <p>Fluency or near-fluency in Pashto and/or Dari</p> <p>Ability to speak and write coherently and effectively in English</p> <p>Basic computer ability, including competence in word processing and spreadsheets; prefer knowledge of MS Office suite.</p> <p>Ability to travel to districts and rural areas on a regular basis as well as to other provinces.</p>	<p>REQUIRED QUALIFICATIONS</p> <p>Graduate degree in medicine</p> <p>Three or more years of experience in program health implementation</p> <p>Preferable experience working with international donor agencies</p> <p>Strong skills in program monitoring, supervision and evaluation</p> <p>Comprehensive understanding of Afghanistan health priorities and players</p> <p>Excellent verbal, written and presentation skills</p> <p>Results oriented person and able to make decisions with low direct supervision</p> <p>Experience working with Microsoft Office software applications (Excel, Word, Outlook Explorer, Power Point</p> <p>KNOWLEDGE:</p> <p>Knowledge of the BPHS policy of the Ministry of Public Health</p> <p>Knowledge of quality assurance methodologies</p> <p>Knowledge of USAID report requirements (a plus).</p> <p>Understanding of performance improvement and training techniques</p> <p>ABILITIES/SKILLS:</p> <p>Ability to work in a complex environment with multiple tasks, short deadlines and intense pressure to perform</p> <p>Demonstrated skills in program implementation</p> <p>Ability to negotiate and solve conflicts</p> <p>Ability to identify solutions for complex problems</p> <p>Strong ability to adapt a very demanding, challenging and changing situations</p> <p>Strong skills in facilitation, team building and coordination</p> <p>Ability to manage and facilitate trainings.</p>

⁶⁸ Integrated Job Description for PHA (HA finalized), Tech-Serve

⁶⁹ Key elements of Jpiego job description for Provincial Coordinator.

Tech Serve Provincial Health Advisor (PHA) ⁶⁸	HSSP Provincial Coordinator (PC) ⁶⁹
	<p>Experience in public speaking and professional presentations.</p> <p>Preferred Qualification: Fluency in English, Dari and Pashto</p>
<p>OVERALL RESPONSIBILITIES:</p> <p>The Provincial Health Advisor will help to ensure the delivery of technical, managerial, leadership development assistance to the Provincial Hospital, and the PPHO, contribute to designing and implementing Tech-Serve strategies for capacity building of the PPHO and PH; and, encourage the flow of strategic, Policy, and operational information amongst the BPHS and EPHS providers, PPHO, NGOs, MoPH, Tech-Serve & other partners. S/he will have to work within a complex environment of the PPHO and PH interacting with a number of stakeholders including donors, NGOs & the private sector.</p> <p>SPECIFIC RESPONSIBILITIES</p> <p>Be located in the Provincial Public Health Office and responsible for focusing on the Provincial Public Health Office and Provincial Hospital and their directors to provide technical as well as general management coaching and advice.</p> <p>Work with the PPHO and Provincial Hospital staff to identify low and high performing tasks and to develop the sharing (networking) and improvement plans.</p> <p>Carry out specific training, support, and other capacity building activities for the PPHO and the Provincial Hospital staff in planning, leadership & management, human resources, supervision & monitoring, HMIS, and other technical areas (in collaboration with appropriate Tech-Serve departments). Also, facilitate the implementation of Standard Based Management in the Provincial Hospital.</p> <p>Coach the PPHO and PH staff to develop provincial monthly, quarterly and annual action plans and review progress regularly.</p> <p>Actively participate in the joint monitoring/supervision of the PHCC members from the health facilities and the PH and provide TA to the use of information obtained through monitoring.</p> <p>Help to liaise among NGOs, PPHOs, PHCCs, and Tech-Serve Kabul in matters of policy and implementation of health care, including location of health facilities.</p> <p>Provide technical assistance to support the Provincial Health Coordination Committee Meetings, Hospital management and Hospital community board meetings in performing basic functions e.g. planning, reporting,</p>	<p>SUMMARY SCOPE OF WORK:</p> <p>The Provincial Coordinator (PC) will work under the direct supervision of the senior provincial coordinator in close coordination and communication with the NGO implementers of the Basic Package of health Services (BPHS) assigned to his/her province. This position will have also a very close communication with the Provincial Health Directors and technical staff of the Provincial Health Office (PHO). One of the main responsibilities of this position will be to coordinate the implementation process of interventions selected as a result of the Quality Assurance baseline assessments that will be conducted in his/her province. It will provide also follow up and facilitation to the different request coming from the province under his/her responsibility.</p> <p>RESPONSIBILITIES</p> <p>Leadership:</p> <p>Provide leadership and mentoring to the NGO/BPHS provincial staff that will be involved in the implementation of interventions after the Quality Assurance baseline assessments have been conducted</p> <p>Represent the HSSP project at provincial level to participate in Provincial Health Coordination Committee meetings</p> <p>Represent the HSSP project in joint monitoring visits</p> <p>Represent HSSP in monitoring and evaluation meetings, conferences and presentations at MOPH, with NGOs, USAID and with other stakeholders.</p> <p>Advocate on behalf of HSSP with partners and stakeholders</p> <p>Management:</p> <p>In collaboration with HSSP technical staff, ensure necessary program planning, development and implementation at provincial level function smoothly and efficiently</p> <p>Actively participate in the annual project work planning</p>

Tech Serve Provincial Health Advisor (PHA) ⁶⁸	HSSP Provincial Coordinator (PC) ⁶⁹
<p>monitoring and evaluation, and proposal writing/review. Advocate for external support as needed by the hospitals, both within MSH and at the MOPH through Provincial Hospital Management Task Force.</p> <p>Coordinate with the Tech-Serve Program Manager for Health System Strengthening (Provincial) for the support of Kabul-based Tech-Serve technical staff through regular visits, proper communication between the provincial and central levels of MoPH, and obtaining necessary technical inputs or to meet specific provincial needs.</p> <p>Coordinate with Tech-Serve and MOPH to obtain technical materials (i.e., reports, tools, policy guidelines) for use by PPHO and NGO staff.</p> <p>Facilitate the work of other Tech-Serve departments, including in the areas of management support, pharmaceutical management and management training.</p> <p>Provide regular and special reports on the progress of activities and on the general situation in the relevant provinces. Provide information to Tech-Serve Kabul on local needs, including program and technical needs, administrative and management problems, and political situation, which affects the development of the health system.</p> <p>The PHA responsibilities will evolve over time as the scope and activities in the field expand.</p>	<p>Work collaboratively with BPHS/NGO implementers to ensure that HSSP resources for program implementation are available</p> <p>Participate in and lead the QA process at provincial level</p> <p>Provide advice to the MOPH and HSSP on development of new performance data collection systems or enhancement of existing systems</p> <p>Support the conduction of identified workshops and trainings at the provincial level based on HSSP work plan and NGO training cascading plan.</p> <p>Support the NGOs to appropriate select staff for trainings based on HSSP selection criteria and training need assessment and follow up on all three phases of training (pre, during and post trainings)</p> <p>Provide technical assistance on development of cascading training plan and assure from availability of NGO training budget.</p> <p>Mentor and supervise replication of NGO training course</p> <p>Support NGOs to facilitate transfer of learning and knowledge management at provincial level.</p> <p>Provide support to the NGOs to organize a training unit in every targeted province for the QA process</p> <p>Support and follow up of quality assurance (QA) process in the province and provide mentoring to health facility (HF) staff to conduct internal assessment</p> <p>Participate in joint external evaluations of HF</p> <p>Analyze the QA data and provide feedback to the HF staff and BPHS/NGO implementers</p> <p>Support the HF staff and NGOs to follow up the intervention to reduce identified gaps</p> <p>Support NGOs to facilitate on the job training at the HFs</p> <p>Provide management and leadership advice to the project managers of the implementer NGOs</p> <p>Lead the development of HSSP provincial progress reports for USAID and MOPH</p> <p>If requested, provide input to the development of project communication material such as briefer, stories, press releases etc</p> <p>Comply with JHPIEGO operational policies and regulations</p>

Tech Serve Provincial Health Advisor (PHA) ⁶⁸	HSSP Provincial Coordinator (PC) ⁶⁹
	<p>Knowledge management/knowledge sharing:</p> <p>Identify and inform his/her supervisor, technical director, managers and advisors of successes, challenges and lessons learned.</p> <p>Ensure sharing of information and knowledge and that flow of information with other partners inside the HSSP in Afghanistan and with ACCESS global award in other countries and headquarters</p> <p>Communication and coordination:</p> <p>Establish a dynamic and fluent channel of communication between NGO BPHS implementers and the PHO</p> <p>Identify challenges in the coordination with partners at provincial level and identify proactively appropriate solutions</p> <p>Regularly attend PHCC meetings and provide recommendations when necessary</p> <p>Coordinate and collaborate activities with PPHD</p> <p>Conduct and facilitate monthly NGO-HSSP technical taskforce meeting at provincial level</p> <p>Report to the HSSP Senior PC and NGO capacity building unit the activities conducted</p>

ANNEX F: TRAINING INDICATORS FOR HSSP, TECH-SERVE AND BASICS

Health Services Support Project (HSSP)		
Indicator	Adjusted Target 2011	Current Status (as of March 2011)
IR #1: Strengthened and Developed systems that support service delivery quality		
1.6. Number of health staff trained in clinical and non-clinical trainings.	1,448	1,581
IR #2: Increased Number and Performance of BPHS providers, especially women in rural and underserved areas		
2.1. Number of community midwives trained by HSSP-supported Community Midwifery Schools.	630	504
2.2. Number of hospital midwives trained by HSSP supported Institute of Health Sciences.	429	438
2.3. Percent of HSSP-supported Community Midwifery School graduates deployed to health facilities.	98%	72%
2.4. Percent of HSSP-supported midwifery schools that are accredited. (13 schools not counting Paktika - in process of being accredited.)	100%	100%
2.6. [sic] No. of strategic documents (LRPs, Standards, Strategies, Policies, Guidelines).	6	2
2.7. Train national trainers on mental health in five selected provinces.	30	To be conducted next quarter
2.8. Technical support to AMA to be registered as an Afghan NGO.	AMA registered as Afghan NGO	Delayed. AMA is researching options.
2.9. Provide grant to AMA to establish midwife-led private birthing center.	2	Removed from workplan with USAID approval.
2.10. Minimal management capacity established for AMA.	7 positions	positions

Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve)		
Indicator	Target September 2011	Current Status (as of June 2011)
IR #2: Improved capacity of PPHOs of the MoPH to:		
2.b. No. of PHO staff who received appropriate in-service training.	100	452
Basic Support for Institutionalizing Child Survival (BASICS)		
Indicator	Adjusted Target	Current Status
No PMP indicators available		

ANNEX G: COMMUNITY MIDWIFERY EDUCATION LEARNING RESOURCE PACKAGE MODULES

Module	Status	Date Completed	Estimated date of completion
Module 3: Health Care in Afghanistan	Complete	September 2011	
Module 4: Interpersonal Communication Counseling & Behavior Change Communication	Complete	September 2011	
Module 14: Pharmacology	Complete	September 2011	
Module 29: STIs and HIV/AIDS	In process		December 2011
Module 30: Mental Health	In process		December 2011
Module 32: Supervision and Partnership	In process		December 2011
Module 35: Basic epidemiology & surveillance	In process		December 2011

ANNEX H: QUALITY ASSURANCE (QA) INDICATORS FOR HSSP, TECH-SERVE, AND BASICS

Health Services Support Project (HSSP)		
Indicator	Adjusted Target 2011	Current Status (as of March 2011)
IR #1: Strengthened and Developed systems that support service delivery quality		
1.1 Number of Health Facilities (BHB, CHC, DH and health posts) enrolled in QA Process by having at least the baseline external assessment	380	606
1.2 Number of participating facilities with completed baseline internal(s) -- external assessment	139	111
1.3 Percent of QA participating facilities that have conducted their scheduled QA external assessments	100%	57% 79 of 139
1.4 Percent of HFs trained in PDQ that have conducted at least one PDQ process involving the related health <i>shura</i>	100%	100% (135/139)
1.5 Number of NGO task force meetings held per quarter	3	2
1.6 Number of staff trained in clinical and non-clinical trainings	1448	1581
Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve)		
Indicator	FY 2011 Target	Current Status (as of September 2011)
IR #2: Improved capacity of PPHOs of the MoPH to improve health outcomes		
2.d Change over time in the composite percentage in compliance with hospital standards for 5 USAID-supported provincial hospitals	80%	75%
2.h Number of health facilities in USAID or non-USAID provinces applying LDP tools to improve health results	174	139
IR #3: Improved management and leadership capacity of 13 PPHOs to improve health outcomes		
3.a Number of Joint Monitoring Visits by PPHOs to BPHS and EPHS health facilities (cumulative LOP)	700	813
Basic Support for Institutionalizing Child Survival (BASICS)		
Indicator	2011 Target	Current Status
IR 2: Improved community-based ICSP in 28 districts		
% of mothers in demonstration districts starting breastfeeding within one hour of birth	75%	66%

Health Services Support Project (HSSP)		
Indicator	Adjusted Target 2011	Current Status (as of March 2011)
% of sick children under 5 in demonstration districts receiving appropriate home care for ARI, diarrhea or fever	50%	38%
% of children participating in C-GMP with adequate weight gain	80%	80.7%
% of children participating in C-GMP without adequate weight gain for 2 consecutive months	<5%	3%
IR5: Improved hospital care for sick children (PHI, inclusive ETAT)		
Age-specific death rate within 24 hours of admission in 2 provincial hospitals	20% reduced	No data yet

November 9, 2011

ANNEX I: OVERVIEW OF THE CBHC SYSTEM IN AFGHANISTAN⁷⁰

“Community-Based Health Care is the foundation for the successful implementation of the BPHS implementation package. BPHS provides the context for a comprehensive interaction between the health system and the communities it serves. Its success depends upon community participation and a partnership between community and health staff. The implementation of CBHC recognizes first that families and communities are responsible for their own health. Religion and cultural norms and beliefs play an important part in health practices, and families are making decisions to maintain health or care for illness every day. In addition, community members understand and have better information on local needs, priorities, and dynamics. The partnership of health services with communities, therefore, has two aspects:

1. To persuade families and communities to make appropriate use of scientific health services, and to change certain behaviors and social norms to more healthy ones; and
2. To accept the guidance and collaboration of communities in the implementation of health programs and the acceptable provision of health care and encourage them to identify and solve their own problems.

Components of the dynamic CBHC system include the following:

- Health Facility: provides case management, midwifery services, and preventive services that are not available in the health post. At the end of 2008, there were 1,546 health facilities. 50% of the population is within 10 km of these facilities, however ANC is used by only 32% of pregnant women. Only 16% deliver with a skilled attendant at a health facility. Many facilities provide outreach services, especially EPI, where the proportion of children immunized is 70%.
- Facility *shura*: local governing body, usually town elders, that works with facility staff to assure the relevance of services to community needs, quality of care and patient satisfaction. At present, 1,701 facilities (90%) have *shura*.
- Community Health Workers. CHWs are community volunteers. A health post has one male and one female CHW to serve a population of 100-150 households (about 700-1300 population). CHWs are trained to provide high impact primary care in rural communities and to refer severely sick patients and those needing preventive services or delivery care. They also promote health behaviors and lifestyles in the community. CHWs provide monthly reports to the HIMS system; reporting rate is 98%.
 - Number of CHWs: in 2004, there were about 2,500 CHWs, most of whom were men. By the end of 2008, there were almost 20,000 CHWs, 49% of whom were women. Together they provide services at 10,075 posts in all parts of the country.
 - Over the past two years, the numbers seen at the health posts have increased by 50%. Unlike at health facilities, there is no decline in visits during the winter months. 40-45% of childhood illnesses are managed by CHWs and 66% of visits for birth spacing methods are to CHWs.

⁷⁰ This information summarized directly from the IRoA, Ministry of Public Health, Community-Based Health Care Policy and Strategy 2009-2013, pp. 1-8. The Tech-Serve project provided technical assistance to MoPH in developing this strategy.

Referrals to health facilities of severely sick children and pregnant women have all increased steadily. However, only 32% of pregnant women attend the clinic for even one antenatal care visit and only 16% of women deliver at a health facility. These low utilization rates largely represent the combined effects of distance, climate, culture and security problems. CHWs provide iron and folic acid tablets to pregnant women and education on healthy pregnancy, birth preparedness, and safe home delivery. They can also distribute clean delivery kits and train families to use misoprostol to prevent postpartum hemorrhage. There is a good potential for CHWs to provide significant antenatal care and birth preparedness if some of the activities were appropriately programmed during pregnancy.”

ANNEX J: COMMUNITY-BASED INTERVENTIONS FOR SERVICE DELIVERY: INDICATORS FOR HSSP, TECH-SERVE AND BASICS

Health Services Support Project (HSSP)		
Indicator	Adjusted Target 2011	Current Status (reported in Semi-annual Report Oct 2010 - March 2011)
IR#3: Improved Capacity and Willingness of Communities, Families, and Individuals to make Informed Decisions about their Health Seeking Behavior.”		
3.1. Percent of QA participating facilities achieving 80% of the PDQ standards (BCC area) and follow up external assessments.	66%	62%
3.2. Percent of women of reproductive age who know two danger signs of pregnancy.	NA	49% (unpublished results from PCH HH survey 2010 reported to team Nov. 2011)
3.3. Percent of women of reproductive age who know two modern family planning methods.	66%	71.4% (PCH HH survey 2009) 62.7% (unpublished results from PCH HH survey 2010 reported to team Sept. 2011)
3.4 Percent of children under 6 months who were exclusively breastfed.	58%	39% (per HH survey 2009)
3.5. Percent of children under one year who were immediately breastfed after delivery.	73%	51% (unpublished results from PCH HH survey 2010 reported to team Nov. 2011)
3.6. Number of community leaders trained in health related issues at provincial, district and village level.	526	478
I.R. #4. Integrate Gender Awareness and practice into BPHS service delivery		
4.4. FHAG groups holding regular monthly meetings.	90%	100%
Source: HSSP PMP tables, AR FY 2010 and Semi-annual Report Q2, FY 2010, and others as cited.		

Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve)		
Indicator	Target September 2011	Current Status (as of June 2011)
I.R. #1. Improved Capacity of the central MoPH to support the delivery of BPHS and EPHS services, primarily through NGO service providers.		
I.l. Number of CHW nationally registered with MoPH with updated data in the HRD database.	25,000	34,600
I.m. Percent of CHWs in USAID grant NGOs who are working with community based maps	2%	375 health facilities have reported CAAC.
I.r. Increase Couple Years of Protection through contraceptives distributed by Tech-Serve	345,000 (9 months)	214,516 (Jan-June 2011)
I.s. Increase Contraceptive Prevalence Rate in USAID-supported provinces.	Baseline 28% (HSSP) 30.3% (Tech-Serve) Target: 38%	40.3% (PCH HH survey 2009 disseminated in Feb 2010) 38% (unpublished results from PCH HH survey 2010; provided to team by HSSP, Sept 2011).
Sources: TechServe PMP PY4 Oct 2010; and Tech-serve PMP Annex 4, Update on Provincial Indicators PY 5, Q2, and other sources as cited.		
Basic Support for Institutionalizing Child Survival (BASICS)		
Indicator	Adjusted Target	Current Status
Primary Strategy 2: Improve Child Health Care at the Community Level		
No PMP indicators available		

ANNEX K: AFGHANISTAN NGO QUESTIONNAIRE – SURVEY MONKEY

Dear PCH implementers,

It was a pleasure to meet some of you and your staff this past month as we were collecting information for the Combined Health Projects Evaluation of BASICS, HSSP and Tech-Serve.

This evaluation will highlight Capacity Building, Quality Assurance, Community-based Interventions for Service Delivery, and In-Service Training. Your experience in these areas is very important for this evaluation. May I ask you to answer the following 25 questions by the end of the day on Thursday, October 27, 2011. The survey should take about 15 to 20 minutes.

Your responses will be kept confidential. Thank you very much for your timely attention. The Evaluation Team

1. Organization name _____
2. Position of person answering survey _____
3. What do you see as the strengths and weaknesses of the GCMU model of using NGOs as implementing entities for the Ministry of Public Health?
4. Do you envision that this structure will need to continue into the next
 - a. 2
 - b. 5
 - c. 10
 - d. more years
5. Over these next years, what changes, if any, do you see needing to be made?
6. Has your organization received assistance in reporting program data over the last year from any of the following organizations? Check as many as relevant.
 - e. Your organization's headquarters
 - f. MoPH HMIS
 - g. MoPH M&E
 - h. Tech-Serve
 - i. HSSP
 - j. BASICS
 - k. Other donors
 - l. Other NGOs
 - m. Other, please specify _____
 - n. No assistance receive
7. Do you have recommendations for improving reporting and utilization of program data?
8. Has your organization received assistance in the management of essential drugs and contraceptives over the last year from any of these organizations? Check as many as relevant.
 - o. Your headquarters office
 - p. MoPH
 - q. Provincial Government

- r. Tech-Serve, MSH
 - s. HSSP
 - t. BASICS
 - u. USAID Washington
 - v. Other donors
 - w. Other, please specify _____
 - x. No assistance received
9. How would you improve drug management for your program? _____
 10. Have you or anyone in your organization attended a meeting of the National Maternal and Child Health Committee or a Provincial Maternal and Child Health Committee?
 - y. Yes
 - z. No
 - aa. Don't know
 11. Have you or anyone from your organization participated in an event at the Provincial Health Learning Center in Herat?
 - bb. Yes
 - cc. No
 - dd. Don't know
 12. How has the Leadership Development Program (LDP) program been applied to your organization? _____
 13. Has the Leadership Development Program (LDP) influenced the quality of health services?
 - ee. Yes
 - ff. No
 14. If so, provide examples. _____
 15. Please describe your successes and challenges in implementing the Quality Assurance Program (QAP)?
 16. In particular, please describe your experience with Partnership Defined Quality (PDQ) interventions?
 17. Do you plan to continue QAP/PDQ interventions after 2012? Explain.
 18. Which Community-Based Interventions (CBIs) has your organization implemented?
 19. Which CBIs have provided the most benefit? Explain
 20. Which CBIs have been made part of the revised BPHS?
 21. Do you think the CBHC unit in MoPH has the capacity to scale up the community-based services? Explain.
 22. Does your organization have the capacity to scale up community-based services? Explain.
 23. Which in-service training has produced the most benefits for your organizations? Explain.
 24. What are the "best practices" for in-service training that you would like to see continued or expanded?
 25. Do you have any additional comments that you would like make, please provide them below.

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