

**Final Report of BPHS implantation in
Nilli, Khedir, Shahrestan, Ashtarlay, Ulqan and Gitti Districts of
Daikundi Province
August 2006 – April 2007
Funded by European Commission (EC)**



IPD of one of the CHCs

Bakhtar Development Foundation (BDF)
Recently renamed to Bakhtar Development Network (BDN)
(125-683/EC contract)

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Summary of the report

Daikundi being a very isolated province with high maternal and child mortality rates (national wise), with no specific health care intervention, needed immediate interventions and improvement of health care services. Initially 9 HFs (including 6 BHCs and 3 CHCs) were covered by ACF in Daikundi. Upon approval of this contract in August, BDN officially took over the 9 health facilities. The activities of BDN started with rationalizing the HFs and provision of quality and standard health service to the communities according to the BPHS standards and structure.

Key accomplishments of the project

Service establishment and coordination with PPHO and communities

- Offering Basic Package of Health Services (BPHS) through 20 Health Posts (HPs), 9 Basic Health Centers (BHCs), 3 Comprehensive Health Centers [plus] (CHC+s) with active support from 27 Local Health Committees (LHCs).
- 20 female/20 male CHWs trained in the catchments areas of 1 CHC and 3 BHC
- Coordination with PPHO and other stakeholders were further strengthened through PPHCC and other similar mechanisms.
- Assist Daikundi Provincial Public Health Director in establishing PPHCC for the first time in the province
- MoUs signed and annual work plan drafted with all local health committees (LHCs)
- BDN in collaboration with the Provincial public health office developed the EPI Micro plan at provincial level
- CBHC network was established and strengthened through regular meetings of LHC and HF staff and their involvement in the implementation of the project.
- LHC members, Governor, District authorities, PPHD and HFs staff were oriented on User fee system and BDF community development strategy.

HF staff recruitment and training

- Stable human resource framework was established by recruiting qualified technical and administrative staff based in Daikundi Sub Office
- Developed IPD patient files for three CHCs (Nili, Khedir and Ulqan) and the services were offered as per the requirement of CHC+ in all these three CHCs
- Emergency Preparedness and Response Committee established at provincial and HF level.
- 100% Diagnostic DOTs centers established and five nurses were trained on DOTs conducted by NTP in Kabul
- Three Lab Technicians got initial DOTs training.
- More than 12 health workers from all health facilities received IMCI training
- Medicines, stationary, Lab reagent, food supply and winter heating materials were prepared and were supplied to all HFs till end of March 2007.
- All HFs pharmacy stocks and sub office were arranged based on Managing Drug Supply and Rational Use of Drugs Guidelines.
- Proper waste management system established in all HFs
- Installing afghan telecom in all three CHCs for smooth communication

MCH

- 100% of health facilities staffed with at least one female health staff

- Delivery rooms in all HFs were made functional and proper Infection Prevention System maintained in all supported HFs
- All HFs received medical supplies and equipments related to MCH activities
- Recruitment of two female medical doctors in HFs for the first time in the history of province and even when it was part of Bamyan and Urozgan
- Separation of Delivery rooms from MCH rooms in all HFs.
- Female staff of the health facilities received refresher training on family planning and reproductive health

HMIS

- HMIS committee established at provincial level and prepared the joint supervision action plan as part of its scope of work.
- HMIS system absolutely implemented in all HFs and all relevant HMIS data was collected and submitted on monthly basis

Coordination with local stakeholders

- MoU and proposal drafted for opening of TFU in three CHCs (Nili ,Ulqan and khedir) with UNICEF and WFP
- MoU was made with World Food Programme representative for distribution of food to TB patients. The food was received for TB patients.
- MoU and proposal drafted and submitted to UNICEF for opening of EmOC services in three CHCs.

All HF staff were offered supportive supervision using the Comprehensive Supervisory Checklists. In addition, the HFs incharge and staff were trained in self-assessment and monitoring to monitor their own activities when roads are blocked and they can not be accessed during winter.



A notice of very difficult conditions of Daikundi during winter

Accomplishments of the proposed activities

2. PROJECT MANAGEMENT AND ADMINISTRATION:

(i) Project Management

BDN carried out its interventions through constant involvement in PPHO activities. Working in close collaboration with PPHO was one of the guiding principles of our efforts for the implementation of the project. The management staff of BDN and PPHO had been working as one team, planning together, sharing information and consulting each other on relevant decisions.

BDN overcame to maintain a Provincial Management office in Daikundi. The project is managed by a qualified Project Manager who is based in Daikundi and leads the programme activities in the site. In addition, this office consists of competent technical, managerial, and admin/finance personnel who oversee and manage programme at provincial level.

During the short life of this contract, BDN ensured effective and efficient provision of opportunities for creation of strong middle management layers to maintain a continually renewing resource base, for higher management levels, of experienced managers. Team leaders and other technical staff are reporting to Project Manager. Our main office team including Programme Manager/Consultant and technical and managerial staff based in Kabul oversaw the overall activities of the project and have had frequent visits to the field.

(ii) Human Resource Management

BDN did its best in filling the positions required for proper implementation and management of the project. Our technical staff consisting of health supervisors, pharmacy officer, EPI officer and CHW trainers, created a great team in field.

Health services are offered through health facilities that are staffed with experienced personnel who were recruited based on their capacity and competency. The salaries of the office staff is based on BDN HR policy, where as the salaries of the HF staff is made inline with the MoPH National Salary Policy (NSP) guideline. Throughout the 8-month contract BDN overcame to recruit experienced male and female doctors to the HFs. Most importantly, BDN recruited 3 female health providers (Female MD and Midwives) and placed them in the remotest health facilities in the province. Recently two Tajik midwives were recruited on local scale, and were placed in the HFs of Daikundi.

As BDN started implementation of BPHS in August 2006, the staffing structures in the existing health facilities were assessed and adjusted according to the revised BPHS guidelines to the extent possible. BDN staffed the HFs properly and according to the guideline.

3. COMMUNITY BASED ACTIVITIES

Implementation of health services through involvement of the communities is another guiding principle of the BDN's programme approach. All the activities shape through involvement of communities, discussions with the community members and giving the feeling of ownership in its practical manner.

Throughout the programme period, BDN successfully approached the communities in the catchment areas of the established health facilities. The Local Health Community (LHC) boards were established, where BDN discussed the type of services that will be delivered

through the HFs. During the reporting period we established 21 Local Health Committees (LHCs) at village and health post level. Our further plans included establishment of LHCs at health facility level as well as district levels.

Upon agreement of the LHC members and with their direct involvement BDN identified competent candidates to be trained as CHWs. As a result, 20 HPs were established and fully functional by the end of the reporting period. A systematic referral chain was established between the CHWs and HFs.

To maximize the utilization of the HPs services, BDN attained the following measures:

- Conducting and facilitating exposure visits of LHCs to encourage their participation in health facility activities
- Involvement of male and female CHWs in provision of health services
- Promotion of community trust in CHWs by discussion of HFs staff with the patients
- Discussions with religious leaders and elders and their orientation on women rights, harmful cultural taboos and practices to women health (especially early girl marriage and inadequate birth spacing practices).
- Availing proper and sufficient amount of medical supply – appropriate to the level of knowledge of CHWs at the HPs.

As mentioned above – giving the feeling of ownership to the communities significantly contributed to attain our objectives. The LHCs were highly involved in implementation of the project and played a great role in its achievements. Their contribution could be summarised as bellow

- Identified and introduced CHWs for training
- Supervised CHWs and outreach BPHS health facilities in non-technical issues
- Provided material and non-material compensation for CHW services
- Regularly participated in mass health education campaigns
- Promoted the role of LHCs and integrated other development efforts as part of their work
- Provided buildings for HFs, venue for CHW trainings and security for health workers

4. RATIONALIZING THE BPHS & INTEGRATING ITS COMPONENTS:

Nine health facilities that were handed over to BDN were providing various health services. However, neither these services nor the staffing pattern of the health facilities matched the current MOPH policy on health service provision. Therefore, the initial step was to rationalise the BPHS in all the health families.

BDN revised the existing service provision pattern of the health facilities to fit MoPH guidelines. Mental health, disability and HIV/AIDs were also integrated in service provision.

With continuation of the bridge fund BDN will continue offering BPHS in a higher standard with a wide range of services through 3 CHC, 6 BHCs and 20 Health Posts. BDN has established 20 health posts in locations where considered to be highly accessible by majority of the population in an area.

The following table shows the established and functioning health facilities and health posts that BDN supported during the last months. The quality of services provided through these HFs will be further enhanced during the bridging and the period afterwards.

District Name	Population		Currently available structures		
	NID	CSO	CHC	BHC	HP
Nili	42,700	34,700	1	0	2
Ashterlei	40,500	40,500	0	1	2
Khadeer	49,000	39,700	1	1	3
Sharestan	70,000	56,600	1	1	6
Miramoor	69,000	53,300	0	2	5
Gitti	40,000	28,500	0	1	2
	311,200	253,300	3	6	20

BDN delivered health services according to the Afghanistan Basic Package of Health Services (BPHS), through a three-tiered service delivery infrastructure ranging from CBHC delivered by CHWs, and facility based outpatient care at BHC, OPD and IPD services at CHC level, having referral linkages with higher tier facilities at hospital level.

To enhance service utilization and maximize access to service delivery, BDN strictly considered the following aspects as major intervention elements:

- *Filling female positions at BPHS facilities with female health providers:* as a result all HFs are staffed with at least one female health provider. One female MD and two midwives were recruited from Tajikistan at local salary scale and were placed in the HFs
- *Provision of quality medical services and drugs through the HFs:* essential drugs in accordance to the MOPH standards were purchased and provided to each HF prior to the closure of the roads and heavy snowfalls. Managing Drug Supply training was provided to all pharmacy in-charges.
- *Create and maintain a gender and cultural sensitive environment in BPHS facilities:* having placed a female health provider at health facility, consideration of separate waiting rooms for male and female were the major points in observing the above mentioned issue by BDN. Besides, a female CHW trainer was recruited and provided training to the female CHWs.

To ensure appropriate health services delivery mechanism – BDN identified and addressed the following priority areas:

(i) Establishing Referral System:

During the reporting period, BDN established a community supported referral system linking the communities to the HF services that are the most appropriate. Even though during the winter season accessing the villages and transportation was a big problem overall Daikundi province – the HMIS data shows 1304 referrals over 8 month period (an approximate of 163 per month); this could be indicative of a very strong referral system in Daikundi province

All the CHWs were trained in the system, and provided with referral formats (pictorial for illiterate CHWs). The CHWs as well as LHCs participate in increasing community awareness on availability, operational hours and location of referral sites.

The current system works as a chain where the CHW is responsible for referring cases beyond their capability to their respective health facility, using a referral sheet. HF staff register the patient and report the referrals received. All the system is monitored closely by CHW trainers

and supervisors. In case of more advanced service requirement the BHCs refer the patients to the nearest CHC, as per registered hierarchy, which in its turn refers to hospitals if needed.

In the locations where there no transport is available communities were mobilized to cope with the challenges – so a proper practical system for providing local transportation for the referral of severe cases is developed. At the facility level for poor patients HF in charge provides the transport cost from clinic cash box officially and informs LHC about this issue. Upon approval of LHC one copy of the travel cost is sent to sub office another is kept at the facility level.

Taking into consideration the fact that Daikundi is a province with very difficult accessibility and even in some areas lacking very simple road structures, where the only means of transportation is donkey/mules, BDN tried to avail ambulance services at each CHC level. Currently, one of the CHCs has ambulance facility. Procurement of two ambulances for the other two CHCs is in progress.

In the first month when, BDN took over the health facilities from ACF, the available cost recovery from all the HFs was collected and transferred to a separate bank account under the name of Daikundi. BDN project manager discussed the issue of purchasing ambulances for the other two CHCs from this amount – which was much appreciated by the communities. At the mean time BDN is awaiting opening of the roads – so that community representatives could come to Kabul – in order to participate in the purchase and transportation of the vehicles to Daikundi province.

(ii) Provision of EmOC services:

In the second quarter of the project, BDN approached UNICEF for support to provision of EmOC service; the MoU has been drafted and is going to be signed. BDN promoted the EmOC services at CHC level enabling and the CHCs were upgraded as CHC+, to make sure that all the CHCs in the cluster provide quality EmOC services. During the reporting period a total of 253 EmOC cases were handled at 8 HFs.



BDN overcame to manage the service delivery in this regard by implementing the following interventions:

- Filled midwives' positions with competent staff and ensured housing for them through LHCs
- Provided equipment, supplies, furniture and having functioning delivery rooms in all HFs
- Stimulated demands for MCH services in the community through CBHC networks
- Ensured night duty coverage for services especially for deliveries by skilled providers
- Mobilized communities to utilize services of the health facilities especially for the delivery

(iii) Control of Communicable Diseases:

BDN contributed a great deal in promotion of community healthy practices and reinforcing preventive measures by conducting mass health awareness campaigns with participation of BPHS facilities, communities, other stakeholders. During the 8-month of project period, BDN ensured capacity building for PPHO staff by provision of on-job training on communicable diseases at the provincial level. This was done to ensure that DOTs activity was overseen and used by the Daikundi PPHO.

In order to conform to BPHS services, BDN established TB diagnostic centres at every CHC level, and treatment centres at every BHC level and HP levels. The BHC staff and CHWs have partially received training on overseeing the treatment of patients. BDN will continue providing training and overseeing the treatment of TB patients during the bridge project. The CHWs played a key role in identification of TB cases by referring the suspected TB cases for laboratory testing and confirmation.

Due to limitation of accessibility during winter less than expected number of TB cases were identified. During the project period, 506 TB cases were suspected, 263 were tested, 9 was reported positive. By to-date the 4 positive pulmonary cases are under treatment.

BDN has introduced IMCI in practice of health providers through offering training and on-going supervision to them. Moreover, BDN will continue paying attention to enhancing TB case finding, appropriate case management following DOTS and prevention of disease resistant cases. Raising awareness and Voluntary Confidential Counselling and Testing (VCCT) on HIV/AIDs as well as prevention and treatment of malaria will continue to be other priorities in this regard during the bridging period.

(iv) Improve Infection Prevention:

Infection Prevention remained a high priority for Daikundi project as it is for its other projects. BDN conducted training for all Health Facility staff and volunteers on infection prevention and control while ensuring the compliance. During the bridge funding, BDN will ensure that the practices are being successfully implemented by the HF staff. Moreover, In the light of the policies of MoPH, BDN has developed infection prevention guidelines which are already used in trainings in Dai Kondi province.

BDN has been maintaining a functional waste-disposal system for infectious materials involving incineration and then burial at all HFs. BDN has provided each Health Facility station with sharps container for safely storing of used syringes until they can be collected and disposed of in the sharps pit. BDN will continue overseeing this practice and promoting IP at the HFs.

(iv) Integrated outreach service delivery:

During the reporting period, the coverage of health services was broadened by establishment of mobile clinics. Seven mobile clinics were established during the months of January and February 2007, that were staffed by one MD and one nurse.. The establishment of these clinics was substantially as an immediate response to the recent outbreaks of seasonal diseases in the area. As a result of these mobile clinics 1645 patients were examined and treated as outpatient, out of which around 50 patients were admitted as IPD. A complete report of the outbreak response is presented in the attachments.

Additionally, the 3 existing CHCs were upgraded to CHC+ level, and beside that sub-centers (staffed with a midwife and a nurse) established in the areas that the communities are most marginalised.

During the reporting period EPI micro plan was developed with PPHO. EPI mobile teams were established, that conducted outreach visits and covered the areas which did not have fixed EPI centres. Throughout the project 3141 children and 3514 women received DPTH3 and TT2+ vaccines.

(v) Integration of BPHS components

BDN established the Nutrition committee in January 2007 at provincial level. The committee in its initial stages introduced and test a new strategy on identification of malnourished children. To detect the malnourished cases, we developed and provided the new registration books. All children under five who visited the HF were regularly monitored for their growth and received the growth monitoring card (chart). If the children needed vaccination, they were directly referred to vaccination room; otherwise received consultation by MD.

5. PROMOTING THE QUALITY OF HEALTH CARE:

Monitoring and Supervision

Project Manager monitored the project activities on day to day basis. Due to the heavy winter and blocked roads by snowfall, it was very difficult to have frequent visits to the HFs, however, in order to ensure the progress THURAYA communication was used to follow up and verify the situation in the programme area. Furthermore, the health facility in-charges were trained on self assessment of their health facilities and supervisory tools were provided to them before the start of winter.

Prior to closure of the roads necessary MOPH guidelines and literature was supplied to every HF. Besides, the staff were trained in HMIS. During the reporting period every HF has reported the progress of their activities using HMIS formats.

BDN had planned to conduct a household survey in March 2007, but due to blockage of the roads and lack of accessibility to all the districts – this activity was postponed for the bridge period.

BDN made all efforts to involve PPHO in every step of project activities. PPHCC Joint monitoring visits under leadership of PPHO regularly carried out to see the progress made, identify gaps and provide guidance and support. The findings and the results were fed back in to the provincial strategic workshops to improve the service delivery and quality of services. This intervention will continue during the bridge funding period.

iii. Supplies and essential drugs

BDN procured quality drugs/supplies from reliable companies and supplied the essential drugs based on BPHS drug list for each level of facilities during the first 3 months of the project. Taking into consideration the blockage of the roads the supply was done up-to end of March 2007. The essential drugs were provided based on the local needs, morbidity of the catchments area to include ample supply of some drugs used for seasonal problems including malaria and least supply of those drugs not commonly required. Estimation of the drug needed was done based on:

- Number and type of active BPHS facilities

- The population size under coverage of BPHS facilities
- Common illnesses (Morbidity rate) in the target communities and seasonal diseases trend
- Past consumption and projection of case increase/decrease for the coming request period

BDN ensured the appropriate drug supply to CHWs by undertaking the following actions:

- Provision of training to CHSs on Managing Drug Supply (MDS) who then provided on-the-job training and support to CHWs on maintaining their drugs properly
- Supply of CHW kits was done in the beginning of the reporting period to the Daikundi field office – from where then the kits were distributed to the CHWs prior to blockage of roads by snowfalls and according to their level of utilisation.

6. CAPACITY BUILDING:

a. Training of project staff employees

Since BDN was awarded the contract, BDN performed an initial technical competency assessment/review to identify the strengths, weaknesses and the gaps in the professional skills of the project management and Health Facility staff. As the result of this review, the gaps and weaknesses were addressed by developing and implementing an extensive staff capacity building.

To strengthen the managerial oversight of the project in Daikundi, Bakhtar Development Network will sponsor a management staff for an international short course on PHC, health system management and leadership in Pakistan. The project has conducted project management, monitoring, HMIS, data use, Rational Use of Drugs (RUD), BPHS, CBHC and community leadership for project management team and HF staff including selected topics for LHC members

b. Training Provincial Public Health Office staff:

Throughout the project period, BDN invited the relevant PPHO staff in trainings on Health Management, Finance Management, supervisory skills training, monitoring and evaluation training courses organized for the project managerial staff. It was done to make sure that at the end of the project they will have enough managerial capacity to successfully coordinate, plan, supervise, monitor and evaluate the project. BDN assisted HMIS unit of PPHO in data collection, analysis, provision of feedback and reporting to MOPH. This will ensure uninterrupted provision of health services beyond the term of the project. In addition BDN will increasingly develop the capacity of provincial public health office staff through inviting them in the BDN quarterly management workshops held in Kabul.

C. OVERALL PROJECT INPUTS AND OUTPUTS:

(i). Inputs:

Following inputs were provided to the project:

- A strong and competent management team
- Refresher trainings to health facility staff
- Trainings on health system management, leadership and community participation.
- Drugs, consumable supplies and all necessary equipment to the project
- Necessary guidelines of MOPH, Quality Assurance tools and other brochures for ensuring the quality of care

- Transportation facility to management staff to supervise and supply the health facility on a regular basis
- Technical backstopping and support to the Project Management Team.
- Analysis of HMIS data and provision of feedback and orientation on a regular basis
- Supportive supervisions by Head Office
- Assistance of the project management team in preparing the action plans for carrying out the activities smoothly
- Databases and other tools for calculating the costs for services
- Providing the Financial Databases for accounting the project

(2) Outputs

Output activity

- 3 CHCs, 6 BHCs and 20 HPs rationalized, and all CHCs upgraded to CHC+ and maintained fully functional
- DOTs centres established in 3CHC+.
- 3 BHCs are functioning as TB treatment centers
- 501 suspected TB cases were tested out of which 9 reported positive. The detection rate is lower than anticipated due to the fact that project duration was very short. During the winter season majority of the villages in the coverage area of the HFs are blocked with winter snow falls.
- Currently the 23 TB patients that reported positive are under treatment (4 of them having pulmonary positive cases and 19 with extra TB) until end of May 2007
- 36 CHWs (more than proposed) consisting of 20 male and 16 female, are active and all of them will have completed standard basic initial and refresher training
- A formal and effective referral system among HPs, BHCs, CHCs and the first referral hospital is established
- 27 LHCs of both male and female are established and the network of BPHS is supported
- All vertical programmes of EPI, control of Malaria, TB, HIV/AIDS, SMI, IMCI, Mental health and disabilities are consolidated into the BPHS HFs
- Appropriate waste management and Infection prevention facilities are in place in all HFs and standard IEC/BCC materials on key areas are distributed and used
- Two cluster cold rooms and pharmacy warehouse established
- User fee system is introduced in all HFs and the initial steps were achieved – during the life of project 6172 USD was collected
- In excess of 64991 outpatients have been consulted (about 902 patients per month per HF/month). In addition to this 1710 inpatients admitted at the 3 CHCs.
- More than 4002 CBA women (15-49 y) (or partner) have used a contraceptive method,

- The proportion of deliveries performed by skilled birth attendant at BPHS HFs is more than 7%.
- 47% of all children (0-23 months) are fully immunized (DPTH3)
- 65% of all children (0-23 months) will have received Vitamin A supplement
- *90% children will have exclusively breastfed within the children group younger than 6 months (this indicator will be possible to measure by household survey)*
- A proportion of 37% of pregnant women will had at least one ANC visit, and this percentage is increasing ultimately each quarter
- About 66% of women of CBA have receiving TT injections
- *80 % mothers will report appropriate behaviour for treating a sick child within the group of all women that had given birth during last year. (this indicator will be possible to measure by household survey)*
- 4 doctors received training on DOTS and other allied refresher
- 3 doctors, 10 nurses and one midwife from the BPHS facilities received training on IMCI.
- 2 Female doctors and 12 midwives received on the job training on EmOC
- All the project staff received on the job training on HMIS and data use during the project period
- 3 Lab technicians trained in TB sputum exam
- 29 MoUs signed with LHCs and communities to have clear support and contribution of community into the BPHS programme
- 1 provincial annual health planning workshops facilitated by PPHO, supported by BDN
- HMIS feedbacks were sent to the project on quarterly basis
- 29 Local Health Committees will receive CBHC orientation training
- PPHO staff received orientation on CBHC
- 100 % of health facilities have female professional health provider