

**ANNUAL  
PROJECT REPORT**

**Quality Reproductive Health Project  
(Funded by UNFPA)**

**Daikundi Province  
January 2008 – January 2009**

**Bakhtar Development  
Network (BDN)**

*29 January 2009*



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## **SUMMARY**

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The overall *goal* of the project was to train female health providers in EmOC and strengthen the linkage between the CHWs and the health facilities in referring EmOC patients.

Following *activities* took place which contributed to the achievement of the above stated goal:

1. Provision and strengthening outreach activities for SRH services including demand creation activities to increase utilization, with focus on MMR reduction by strengthening CHW and SBA activities and linkage with health institutions
2. Strengthening partnership and coordination with the respective communities for effective service utilization
3. Up gradation of infrastructure, strengthening of skill human resources for EmOC
4. Provision of Emergency Obstetric Care through comprehensive and basic EmOC centers
5. Strengthening referral system for RH services (access and utilization)
6. Building capacity of service providers from village to provincial level and to strengthen the referral linkage
7. Maintaining on time and regular supervision and monitoring of the program activities

## **KEY ACCOMPLISHMENTS OF THE PROJECT**

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### 1. Provision of EmOC services

- EmOC services were provided during the year through a total of 6 HFs
- Coordination with PPHO and other stakeholders were strengthened through PPHCC meetings and other similar mechanisms.
- Stable human resource framework was established by recruiting qualified technical and administrative staff for the HFs as well as for the Daikundi Sub Office.
- Delivery rooms in all HFs were made functional and proper Infection Prevention System maintained in all supported HFs
- In 6 HFs (Nilli PH, Eskan DH, Ashterlie, Miramoor, Sange takht, Kejran) EmOC services were strengthened. These HFs were staffed with female doctors, midwives, and surgeons through other sources but were equipped according to the national standards through UNFPA funding
- All HFs received medical supplies and equipments related to MCH activities on regular basis.
- Delivery rooms were separated from the MCH rooms in all HFs in order to facilitate privacy and build trust within the communities.
- One mobile health team was activated and provided services to villages located out the catchment areas of the HFs.

### 2. Personnel Knowledge and skills up-gradation:

- 12 Female staff of the health facilities received refresher training on family planning and reproductive health
- ANC and PID standard training conducted to 4 midwives at the Nilli hospital
- One midwife received training in Health Planning and Budgeting

- 14 personnel of Nilli hospital received English language and commuter classes for a period of 3 months
- 20 midwives were identified and trained in Basic EmOC in Malalay Hosptial in Kabul
- 2 midwives received family planning training in Malalay hospital, Kabul

### 3. Provision of drugs and other equipment to the HFs

- 2 delivery tables, one anesthesia machine were provided to Ashterlai EmOC ward
- Necessary equipments for upgrading the EmOC ward of Eskan DH were provided and the said health facility was fully upgraded into DH level
- A mobile health unit (MHU) established, staffed and equipped with necessary medicines and other required equipment/ items
- 1PH, 1 DH, 4 CHC+, and one CHC were provided with necessary equipments such as delivery tables and other required consumables
- 7 HFs were equipped with generators and heating facilities

### 4. Increased Community Awareness

- Regular monthly meetings maintained with 12 Community Development Committees
- Community Mobilisation training conducted to 4 CHS and 4 CHWs
- 25 LHC members received training on RH and EmOC
- 50 identified CHWs were selected to maintain regular contact with EmOC staff of clinics

### 5. Referral System Strengthened

- Referral system was established and promoted amongst 14 BHCs, 4 CHCs, 3 CHC+ and 5 sub centers, and district and provincial hospitals. This was done by strengthening the linkages between CHWs and health facilities by frequent supervision, holding meetings, etc.
- Re-imburement payment was introduced at all health facilities so that the families who bring their patients for seeking obstetric services can get their incurred expenses.
- The issue of establishing community supported referral system was extensively discussed in the monthly meetings of community health committees to have them ready for establishing a sustainable locally supported referral system.

### 6. Monitoring and supervision

- 100 CHWs and the technical staff of the 6 EmOC facilities were supervised regularly
- All HF staff were offered supportive supervision using the Comprehensive Supervisory Checklists, as well as EmOC guidelines. In addition, the HFs managers 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.

## **ACCOMPLISHMENTS OF THE PROPOSED ACTIVITIES**

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### **1. Provision of EMOC Services**

BDN carried out its interventions through constant involvement of PPHO in the 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.

The EMOC services were provided through total of 7 HFs (Nili PH, Eskan DH, 4 CHC+, 1 CHC, and a mobile health team. Through UNFPA fund BDN recruited one project coordinator and a driver for the mobile health team.

BDN ensured that all CHCs as well as the hospitals provide quality EmOC services during the project. The HMIS collected information shows that more than nine thousand EmOC cases were registered at HFs covered by this project in Daikundi. These encompass 491 C-Sections, 1481 deliveries, 5,725 ANC and 1,831 PNCs.

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

### **2. Skill building**

During the contract BDN was able to train 193 persons (including 45 clinical personnel and 148 community members) in different aspects and provide refresher trainings to other 12. The trainings were arranged for health personnel as well as CHWs and LHC members.

The list below provides the figures of those clinical staff trained during the contract:

- ANC and PID standard training conducted to 4 midwives at the Nilli hospital
- One midwife received training in Health Planning and Budgeting
- 14 personnel of Nilli hospital received English language and commuter classes for a period of three months
- 20 midwives were identified and trained in Basic EmOC in Malalay Hospital in Kabul
- 2 midwives received family planning training in Malalay hospital, Kabul
- 4 CHS and 4 CHWs received training on community mobilization
- 12 Female staff of the health facilities received refresher training on family planning and reproductive health

### **3. Establishing Referral System:**

During the contract 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 6167 referrals over one year period (an approximate of 513 per month); this could be indicative of a very strong referral system in Daikundi province

Moreover each of the HFs delivering EMOC services have been having obstetric referrals in each quarter of the year. A total of 41 obstetric referrals took place during the year in 6 supported EmOC HFs.

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.

A total of 100 female CHWs were trained on danger signs of pregnancy and birth preparedness plan and time for referral and the procedure of referral. BDN oriented the managers of 23 HFs on the topics such as reimbursement of complicated delivery patients transport costs and incentives to CHWs for obstetric referral cases. To those pregnant women who were living in a long distance from the EmOC centers and were not able to reach the HFs at the time of delivery, clean delivery kits were provided in advance. However, in order to increase the demand and interest of the women in delivering at the HFs BDN prepared and distributed baby kits for those who delivered at the HF.

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 through other resources to facilitate the success of the UNFPA supported activities

#### 4. Integrated Mobile Health Unit

During the contract period, the coverage of health services was broadened by establishment of a mobile clinic. This clinic was staffed with a nurse and a midwife and was provided with a vehicle which facilitated on time routine visits to the areas that were located out of coverage of the HFs. This mobile health unit was activated in July 2008. As a result of the mobile clinic 5540 patients were examined and treated which consisted of 55% female over 5 and 14% children under age of 5.

It shall be mentioned that the mobile health team visited the villages on routine and regular basis, however, due to the fact that the population of the province is very scattered, the periods of the visits were longer than what was anticipated. It is suggested that in case of the following similar projects at least two mobile health units shall be considered for Daikundi province.

#### 5. 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 during the winter season, 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 EmOC guidelines and literature was supplied to every HF. Besides, the staff were trained and supervised in regard to provision of EmOC services and

reporting their activities through HMIS. During the contract every HF has reported the progress of their activities using HMIS formats.

## **OVERALL PROJECT INPUTS AND OUTPUTS AS PER SET WORKPLAN:**

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### **1. Inputs**

Following inputs were provided to the project:

- A strong and competent management team
- Refresher trainings to health facility staff
- Establishment of mobile health team and recruitment of competent staff into the team
- Recruitment of female health providers to the HFs
- Trainings on health system management, leadership and community participation.
- Training on referral, birth preparedness plan,
- Vehicle for mobile clinic, some drugs, consumable supplies and all necessary equipment to the project
- Necessary guidelines
- 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:**

- The EmOC wards of 1 DH, 1PH, 4 CHC+, 1 CHC maintained fully functional and ensured provision of EmOC services
- 119 female CHWs received training on birth preparedness and on time referral of patient to the HFs from 5 target CHCs (Khedir CHC, Sange takht CHC, Ulqan CHC, Eskan DH, and Nilli PH)
- 23 HF managers ensured reimbursement of transportation costs to those patients that were referred to HF for complicated delivery
- 5,540 patients treated by the mobile health team
- 5,725 pregnant women received ANC service
- 1,831 women received PNC service
- 1,481 births were delivered at the health facilities
- 36 cesarean cases performed
- More than 6270 CBA women (15-49 y) (or partner) used a contraceptive method,
- A formal and effective referral system among HPs, CHCs and hospitals is established
- 12 CDCs of both male and female are established and the network of BPHS is supported
- Regular monthly meetings maintained with 12 CDCs
- 25 LHC members received training on RU and EmOC

- 20 Midwives received formal training of 21 day on EmOC
- Community Mobilisation training conducted to 4 CHS and 4 CHWs

### **COMMENTS ON ACCOMPLISHMENTS AND CONSTRAINTS :**

As per the plan, BDN was able to go beyond of the target in training of CHWs on birth planning and birth preparedness. As per set workplan BDN was responsible to train 100 CHWs, whereas BDN trained 147 CHWs.

Because of the lack of budget for rehabilitation of EmOC wards, we were not able to carry out some basic activities such as in Eskan where community was able to construct 7 rooms as in - contribution to this project. BDN with the support of UNFA was expected to provide support in terms of trainings, windows, gates, etc. but due to the shortage of budget we were not able to do so.

#### **Major Constraints:**

During implementing UNFPA supported activities in Daikundi province, BDN experience a number of constraints as well opportunities / facilitating factors. BDN did its best to use the available opportunities to overcome the constraints to a higher extent. It is described as follow:

- **Geographical barriers:** Difficult geography and climate related problems had a remarkable effect on halting the outreach and mobile health activities
- **Shortage of qualified staff:** Shortage of local qualified staff has been another great challenge.
- **Dispersed Population:** As Daikundi is a mountainous province and people are living dispersedly in this province, only one mobile health unit cannot meet the needs of the communities because majority of the villages are located in very remote areas and do not have access to existing service for which one mobile health unit is not sufficient.
- Mobile health team activity started in mid 2008 as before August the available funds did not allow establishing mobile health unit activity in the province

The Opportunities / Facilitating Factors during the project implementation are described below:

- Security; fortunately in all areas of operations fair security enabled in achieving the targets to a greater extent. The people were able to move for accessing health services. Likewise, it was not a concern for deploying qualified staff from other provinces. Although, the insecurity in three districts of Daikundi, Kejran, Gezab and Gitti had its own role in limiting this facilitating factor.
- Community participation –During the project implementation community was found highly committed for supporting their own health program. Donating buildings as in – kind contribution can indicate that how community was willing to actively participate for the success of the program

### **COMMENTS ON MANAGEMENT AND USE OF FINANCIAL RESOURCES:**

### 1. Expenditures vs. estimated budget

Considering the scarcity of the allocated funds, it is evident that the project expenditures seem to be higher than the original estimates. Incompletion of some activities as detailed above can indicate that how greater investment is required in the province. As Daikundi is a very remote and newly established province, therefore, more investments are required to achieve the desired results. Furthermore, considering the needs of the population, the expectations are very high at different levels which need to be met because health is the only sector which is having a dominant existence in the province and the attention of the people is highly focused on it. On the other side, private health sector is not in a position to fill any gap in the health service delivery as it does in many other provinces.

### 2. Appropriateness and timeliness of the technical support

As Daikundi is located very remotely, it is quite a natural phenomena that a sufficient and timely technical support cannot be provided. Due to bad roads and limited transportation facilities to the province, the number of supervisory visits from Kabul by and BDN and UNFPA were not enough. Furthermore, the notices given for attending workshops / meetings to be held in UNFPA or MOPH were too short for Daikundi which did not allow us to invite the nominees from Daikundi on a timely manner.

### 3. Effectiveness of the execution modality selected for the project.

This project started in a location that was not covered by health services for a long period of time. The provision of health services and BPHS, focusing primarily on mother and child health newly started in Daikundi in 2006. Due to remoteness of the area as well as cultural believes and low level of awareness on reproductive health lesser number of women were visiting the HFs.

With up-gradation of knowledge of the female health providers on EmOC within the established HFs BDN ensured provision of quality EmOC services. Once the quality standards ensured, at the same time communities' awareness on reproductive health was also up-graded through constant monthly meetings. The third factor contributing to the success of the project was creation of the link between the communities and HFs through CHWs.

The analysis of the figures show that all three components together have shown significant improvement in the utilisation of health services by women. Bellow please find the table comparing services being provided in 2007, where BPHS was provided however, without particular focus on EmOC, with services of 2008 where BPHS and EPHS are focused on EmOC.

Indicators	Target Population	2007		2008	
		Coverage by %	Coverage by #	Coverage by %	Coverage by #
ANC	12873	38%	4957	45%	5725
Delivery	11194	9%	986	13%	1481
PNC	11194	3%	329	16%	1831
Family Planning(HF)	48974	14%	6695	13%	6275
Cesarean Section			40		491

**COMMENT ON HOW THE COMPONENT PROJECT HAS CONTRIBUTED TO THE ADVANCEMENT OF GENDER EQUITY, EQUALITY AND WOMEN'S EMPOWERMENT.**

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The whole focus of the project was on improving gender equality, such as provision of access to quality health services, empowering women through provision of trainings and maintaining contact with CDCs so that the communities are not causing barriers to women in achieving clinical services.

This project addressed the following issues in particular:

1. Contributed to advancement of gender equity,
2. Contributed to empowerment through conducting birth planning and birth preparedness plan training
3. Enhanced women's decisions making role in relation to seeking health practices

**Summary of the findings of research, monitoring and evaluation activities undertaken. Indicate how the outcome of these activities has been or will be followed up or used.**

During the life of the project supervision, monitoring and evaluation activities have been undertaken on routine and regular basis. The visits were conducted by the project coordinator as well as the project manager and head office staff. The weaknesses found during the visits were fed back to the project in order to improve the quality of health care and service provision.

The supervision and monitoring of all facilities were conducted on regular, systematic and objective oriented manner. To make the supervision and monitoring system sustainable the health facility managers were trained in supervision, monitoring and evaluation of the activities to support other staff to maintain high quality of standards.

**List of Attachments:**

1. Updated work plan for reporting year
2. updated project budget with estimated expenditures for reporting year
3. Personnel
4. Non – expendable equipment