BAKHTAR DEVELPMENT NETWORK

IMPLEMENTATION OF BASIC PACKAGE OF HEALTH SERVICES IN GHAZNI PROVINCE

Covered by World Bank Fund

(Waghaz, Rashidan, Khogiany Districts)

END OF PROJECT REPORT

(July 2006 – June 2008)

BAKHTAR DEVELOPMENT NETWORK (BDN)

in partnership with

SOLIDARITY FOR AFGHAN FAMILIES (SAF)

October, 2008

EXECUTIVE SUMMARY:

Waghaz, Rashidan and Khogiany districts of Ghazni province had been considered a very isolated area with high maternal and child mortality rate, due to lack of proper interventions from the organisations involved in provision of health services in the area.

Considering the needs of the communities a PPA project was launched in June 2006 to cover the white areas left out from any health service delivery. This project encompasses service delivery through 3 CHCs, 60 health posts and health networks; and was implemented by BDN[1] in partnership with SAF. Upon approval of this contract in June, BDN officially took over the 3 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 MOPH guidelines.

KEY ACCOMPLISHMENTS OF THE PROJECT

Service establishment and coordination with PPHO and communities:

- Offering Basic Package of Health Services (BPHS) through 60 Health Posts (HPs), 3 Comprehensive Health Centers with active support from 60 Local Health Committees (LHCs).
- 30 female/60 male CHWs trained in the catchments areas of 3 CHC.
- Coordination with PPHO and other stakeholders were further strengthened through PPHCC and other similar mechanisms.
- 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.
- The referral system was established and strengthened through provision of ambulance services in all 3 CHCs
- A user-fee system was set up in the 3 HFs. LHC members, District authorities, PPHD and HFs staffs were oriented on User Fee system and BDN community development strategy.

HF staff recruitment and training:

- Stable human resource framework was established by recruiting qualified technical and administrative staff based in the Sub Office and HFs.
- Each HF was staffed with one female MD and 2 midwifes (except for Khogiany which had one female MD and one midwife)
- Developed IPD patient files for three CHCs (Waghaz, Khogiany and Rashidan) 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 3 nurses were trained on DOTs conducted by Global Fund
- Three Lab Technicians got initial DOTs training.
- Three medical doctors and three nurses from all health facilities received IMCI training.

[1] BDF (the implementing NGO) was re-registered under the name of BDN with the Ministry of Finance in 2007

- Medicines, stationary, Lab reagent, food supply and winter heating materials were prepared and were supplied to all HFs during the two winter seasons within the life of the project.
- 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 mobile telephones in all three CHCs for smooth communication

MCH
- 100% of health facilities staffed with female MD and midwives (or at least with one female health provider)
- 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 3 female medical doctors in HFs for the first time.
- 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
- BDN assisted in establishment of HMIS committee 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.
- During the life of the project 4 HMIS workshops took place (organized by BDN).

Coordination with local stakeholders:
BDN and SAF participated at different stages of the coordination meetings with the local stake holders. As the result of the coordination additional projects were initiated within the province; such as provision of support by PRT and construction of new buildings, establishment of sub-center and mobile services within the province, extending the services to new villages which themselves put in requests to MOPH.

All HFs staffs were offered supportive supervision using the Comprehensive Supervisory Checklists. In addition, the HFs in charge and staffs 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

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 is implementing both, PPA and PPG projects in Ghazni province, and thus maintains one sub office through which activities are being coordinated and managed. The project is managed by a

qualified Project Manager and Deputy PM who are based in Ghazni and lead the program activities in the site. In addition, this office consists of competent technical, managerial, and admin/finance personnel who oversee and manage program at provincial level.

During the 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 Program Director, Managing Director, Planning and Monitoring Director 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 in partnership with SAF did its best in filling the positions required for proper implementation and management of the project as per agreed contract. Our technical staff consisting of Project manager, Deputy project manager, Deputy manager admin/finance, MCH officer, HMIS officer, EPI Assistant, Pharmacy Officer, Training officer and CHW trainers as well as health supervisor 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 Operational Manual, where as the salaries of the HF staff is made inline with the MoPH National Salary Policy (NSP) guideline. Throughout the two year contract BDN overcame to recruit experienced male and female doctors to the HFs. Most importantly, BDN recruited 3 female doctors and five midwifes and placed them in the remotest health facilities in the province.

As BDN started implementation of BPHS in June 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 program 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 program 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 60 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, 60 HPs were established and made functional. 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:

The 3 health facilities handed over to BDN in 2006 were not supported by any organization. Therefore, the prevailing health service delivery system was not according to MOPH guidelines and policies. Neither the services nor the staffing pattern of the health facilities matched the MOPH policy on health service provision. Therefore, the initial step was to rationalize the BPHS in all the health facilities.

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.

The table bellow shows the population vs the available structures of health service delivery within the districts.

District Name	Population	Currently available structures			
	CSO	CHC	HP	M CHW	F CHW
Waghaz	35022	1	21	21	11
Rashidan	16253	1	21	21	10
Khogiany	18350	1	18	18	8
Total	***69625***	***3***	***60***	***60***	***29***

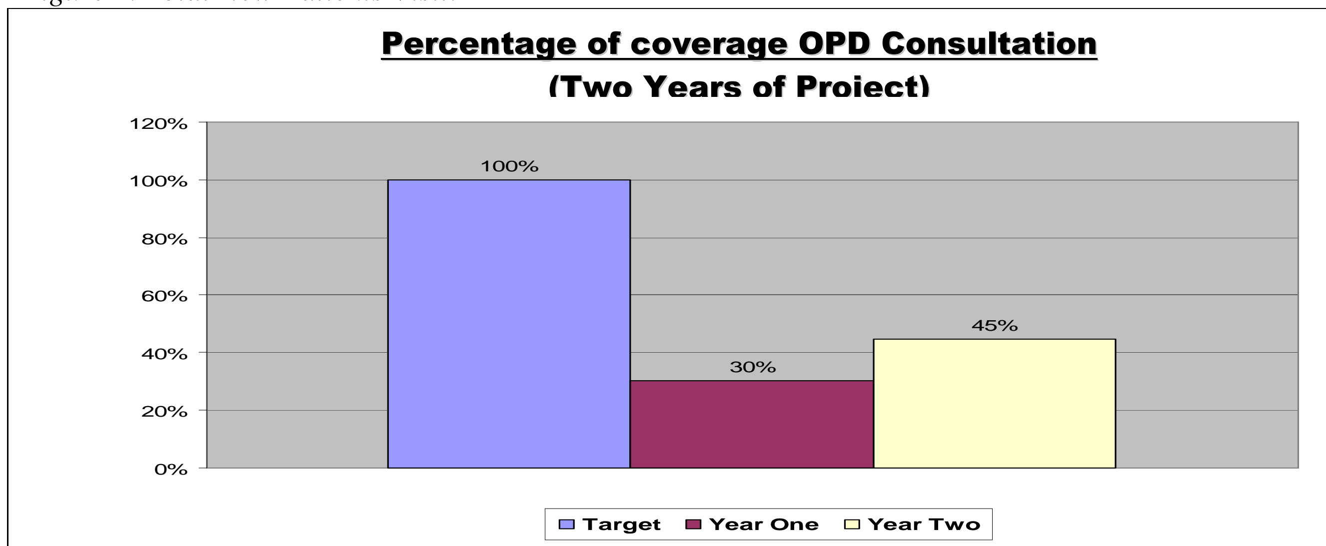
As per the set guidelines of MOPH the health services were delivered through a three-tiered service delivery infrastructure ranging from CBHC being delivered by CHWs, to inpatient and outpatient services being provided by the CHCs, which in their turn are linked to the provincial hospital which is supported by BDN through MOPH/USAID fund.

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 midwifes were recruited and 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.

Figure 1 shows percentage of utilization growth during the two years of the project implementation. As the project area was considered to be an area without any health services prior to the start of this project (or white area), the utilization rate is satisfactory considering the initiation of the project as well as security situation.

Figure 1. Total New Patients Visit:



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

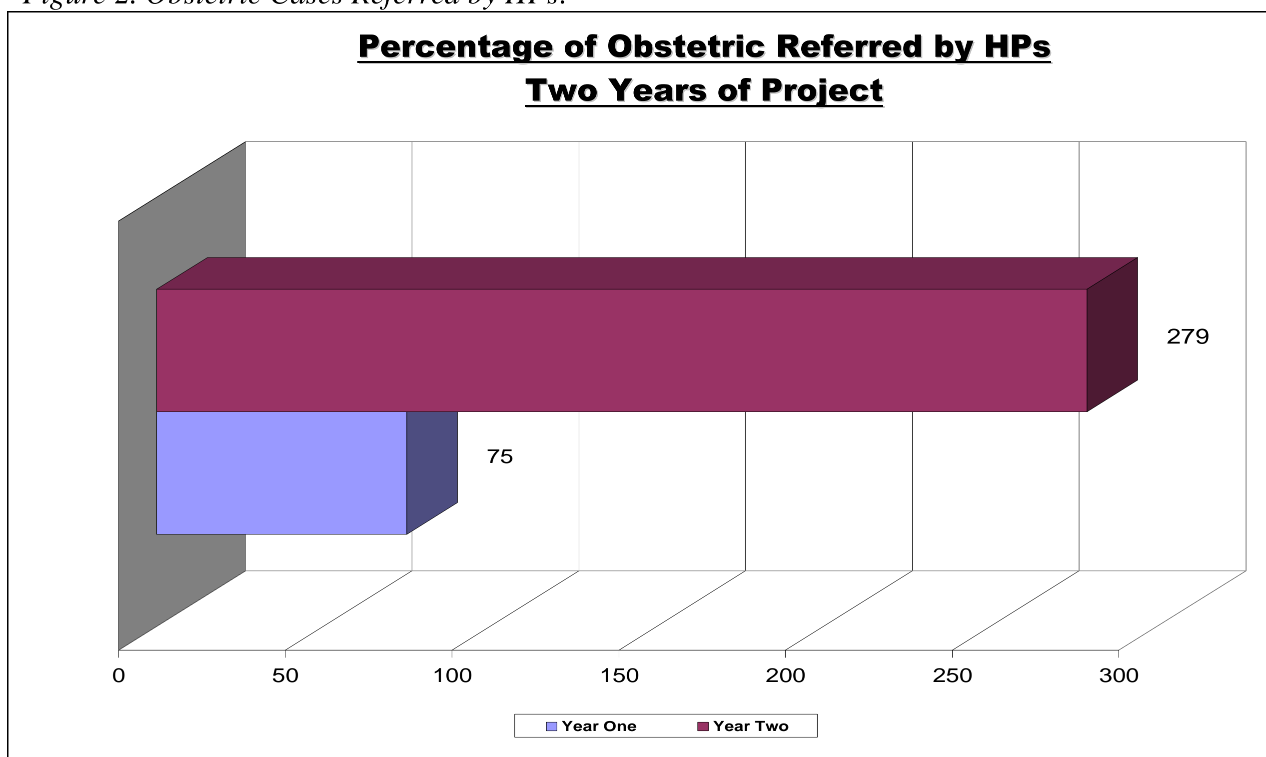
(i) Establishing Referral System:

During the reporting period, the NGOs 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 province – the HMIS data shows significant change since the start of the project: 160 referrals over the first year of the project and 883 referrals over the second year of the project. In the first year the average number of referral was 13 cases per month, where as in the second year it is 74 cases per month. This could be

indicative of a very strong referral system is set up during the life of the project in the 3 districts of Ghazni.

The chart bellow displays the difference in the referral system in the first and the second year of the project. However, it should be stated that not all referral cases were able to reach HFs, which is a matter of cultural behavior, security, difficult or not proper access roads and facilities.

Figure 2. Obstetric Cases Referred by HPs:



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 staffs register the patient and report the referrals received. All the system is monitored closely by CHW trainers and CHSs. In case of more advanced service requirement the CHCs refer the patients to the central hospital, as per registered hierarchy. The referral system was strengthened by provision of ambulances to each HF.

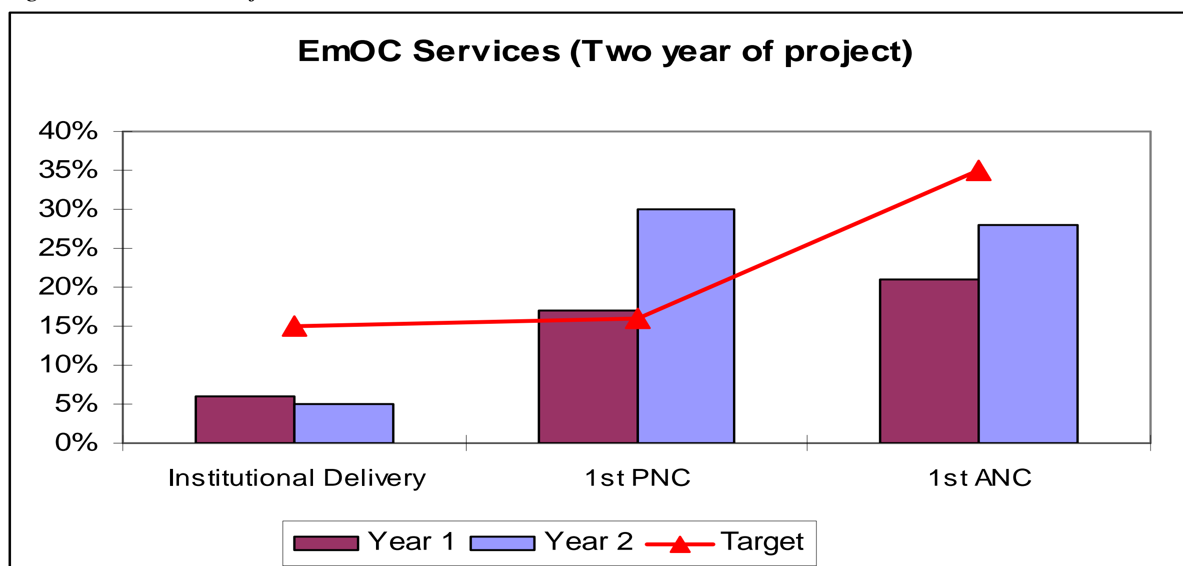
Understanding the issue of difficult accessibility from the villages to the HFs and the fact that most of the referred cases do not visit the HFs, BDN tried to seek another approach. In the locations where there no transport is available communities were mobilized to cope with the challenges – so a practical system for providing local transportation for the referral of severe cases was developed in cooperation with the LHCs. At the facility level for poor patients HF in charge provides the transport cost from health facility user fee cash 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. Since the user fee system was banned in April 2008 this system was also stopped.

(ii) Provision of EmOC services:
During the life of the project the basic EmOC services were provided through the 3 CHCs in the districts. These services covered institutional deliveries including normal and assisted deliveries, Cesarean Section and management of Obstetric Major Complications. The midwives and the female MDs were approached by the MCH officer of the province and were provided on the job training in different sectors of the EmOC services. BDN promoted the EmOC services at CHC level enabling and ensuring cluster wide provision of quality EmOC services. During the reporting period a total of 441EmOC cases were handled at 3 HFs.

The chart bellow depicts the three main services under this component being delivered to the communities. Achievements on the institutional deliveries show that the set target was not achieved. This indicator has direct relation to the security in the area as well as accessibility from the furthest villages, as well as cultural taboos. BDN has worked much to increase awareness among the communities as well as placing 24 hour services in the site. The PNC visits have been over the target, where as the ANC visit still has not reached its target, however both indicators have an elevating deed.

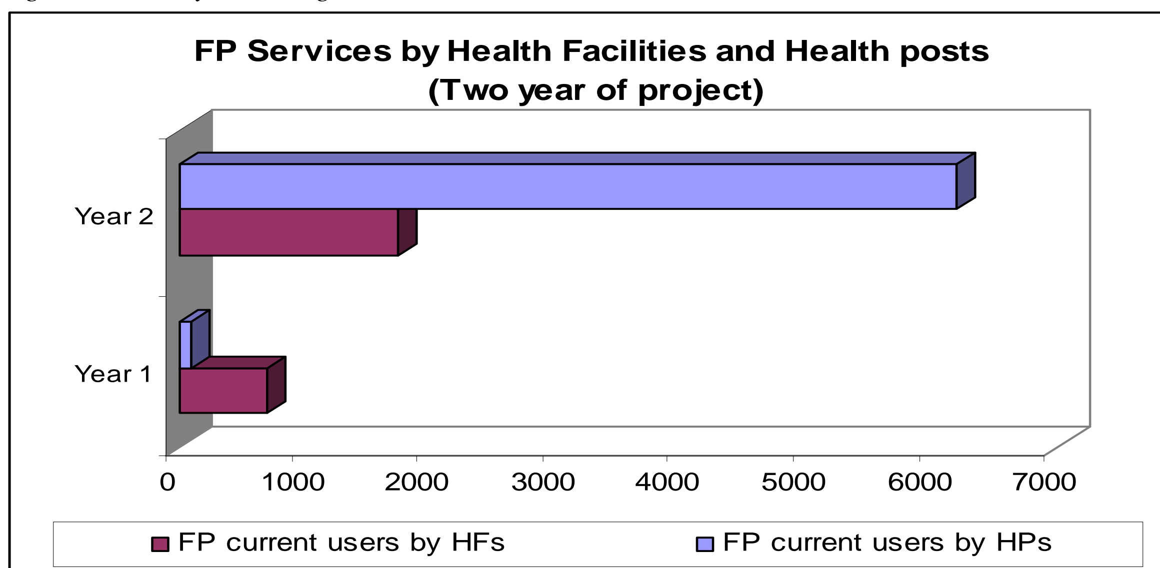
Figure 3. EmOC major services



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

- Filled midwifes' 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

Figure 4. Family Planning services



Family planning being one of the major contributors to reduction of maternal mortality rate has shown a great improvement in the area. The difference in the services and their acceptance by the communities - from the start till the end of the project - are depicted in the chart above (figure 4)

(iii) Control of Communicable Diseases:

BDN in cooperation with SAF 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, and other stakeholders. During the two year we ensured capacity building for PPHO staff by provision of on-job training on communicable diseases at the provincial level.

In order to conform to BPHS services, BDN established TB diagnostic and treatment centers at every CHC level, as there were no BHCs in between the CHC and HP services. The HPs also served as referral and treatment centers.

The CHWs have partially received training on overseeing the treatment of patients. The CHWs played a key role in identification of TB cases by referring the suspected TB cases for laboratory testing and confirmation.

During the project period, 24 TB positive cases were identified within the 3 CHCs. However, the HMIS data shows 27 TB cases started treatment and 36 cases of smear negative being discharged. This variation of the figures indicates that some TB patients have been verified in other HFs (perhaps in other districts/provinces, prior or during the project implementation), however, as they were the original residents of the 3 covered districts (Khogiany, Waghaz and Rashidan) they had returned to their region after case definition was done, but were treated within the available services of the 3 HFs. After their treatment was completed and final sputum was collected and analyzed, they were reported as cases that have completed treatment

BDN has introduced IMCI in practice of health providers through offering training and on-going supervision to them.

(iv) Improve Infection Prevention:

Infection Prevention remained a high priority for the three districts covered by the project. BDN conducted training for all Health Facility staff and volunteers on infection prevention and control while ensuring the compliance. Both partners have ensured that the practices were 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 within the 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.

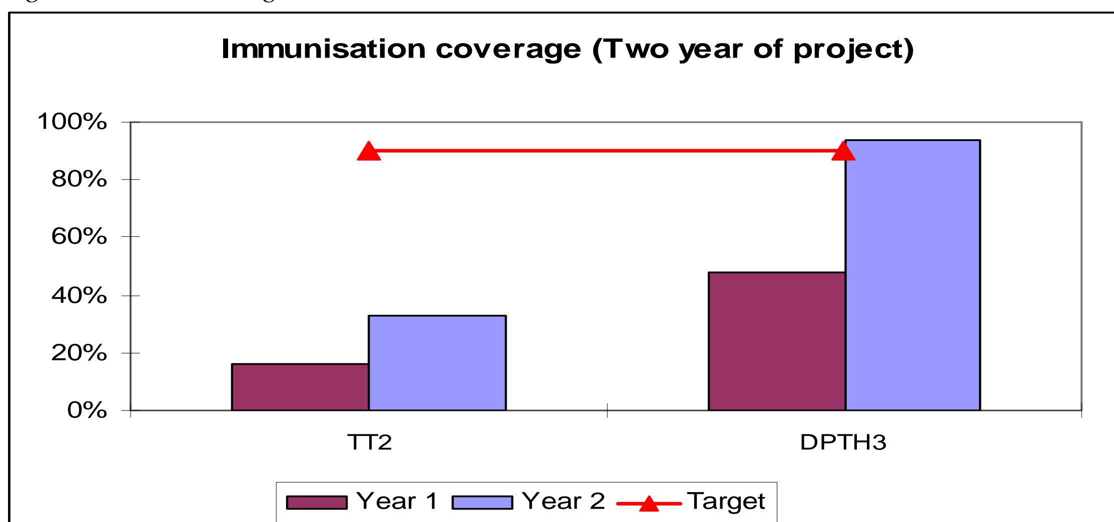
(iv) Integrated outreach service delivery:

During the reporting period, the coverage of health services was broadened by establishment of mobile clinics. Seven mobile clinics were established during the first winter and the second winter seasons, that were staffed by one MD, one nurse, one vaccinator and one CHS. 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 2120 patients were examined and treated as outpatient, out of which around 18 patients were admitted as IPD.

Additionally one sub-center (staffed with a vaccinator and a nurse) established in the area that the communities are most marginalized.

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 2682 children and 843 women received DPTH3 and TT2+ vaccines.

Figure 6. EPI coverage



(v) Integration of BPHS components
BDN established the Nutrition committee in July 2006 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 program 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 staffs were trained in HMIS. During the reporting period every HF has reported the progress of their activities using HMIS formats.

BDN in collaboration with SAF 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.

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 before the approaching of the winter season. Taking into consideration the blockage of the roads the supply was done up-to end of March in the both years. 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 as soon as the CHWs finished their initial training process. After then the quarterly supplies were provided to the CHWs, where as in case of winter seasons – same as for the HFs – their supplies ere provided for two quarters ahead.

6. CAPACITY BUILDING:

a. Training of project staff employees

Since BDN and SAF were 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.

BDN implemented internal training processes through in-door workshops and gatherings. The project staffs were given opportunity to travel to other provinces, see and share experiences with other colleagues from other provinces. Quarterly workshops held at the main office facilitated quarterly reviews of the achievements and stimulation of actions towards achieving targets.

During the last two quarters of the project monthly detailed HF wise review sessions were held with the project staff – that directly pointed each target and achievement against each indicator.

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.

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 maintained fully functional • DOTs centres established in 3CHCs • 24 suspected TB cases were identified positive. • By the end of the project 36 TB positive cases treated and discharged after becoming smear negative • 89 CHWs consisting of 60 male and 29 female, are active and all of them have completed training and refresher training • A formal and effective referral system among HPs, CHCs and the first referral hospital was established and strengthened by including ambulance services in the area • 60 LHCs 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 • Pharmacy warehouse established • User fee system is introduced in all HFs– during the life of project 4656 USD was collected, before the userfee system was banned in April 2008. • In excess of 55519 outpatients have been consulted (about 805 patients per HF/month). • More than 2440 CBA women (15-49 y) (or partner) have received contraceptive method from CHCs while a total of 6276 women received their methods from the relevant HPs. • A total of 375 normal and assisted deliveries were attended at the 3 CHCs, where as 66 major /and other complications were handled. • 82% (4244) of all children (0-11 months) are fully immunized (DPTH3) • A proportion of 32% (1784)of pregnant women had at least one ANC visit, and this percentage is increasing ultimately with each quarter • About 27% (1797) of women of CBA have receiving TT2+ injections. • 3 doctors, 3 Lab technicians and 3 nurses received training on DOTS. • 3 doctors, 2 nurses and one midwife from the BPHS facilities received training on IMCI. • 3 Female doctors and 5 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. • 60 MoUs signed with LHCs and communities to have clear support and contribution of community into the BPHS program. • 1 provincial annual health planning workshops facilitated by PPHO, supported by BDN • HMIS feedbacks were sent to the project on quarterly basis, and 4 HMIS workshops were conducted. • 60 Local Health Committees received CBHC orientation training. • PPHO staff received orientation on CBHC. • 100 % of health facilities have female professional health provider.