

Islamic Republic of Afghanistan
Ministry of Public Health
Performance-Based Partnership Grant

HHS LQAS Final Report

Reporting period: Mizan, Aqrab, Qaus (7-9, 1386)
Province: Ghazni
Districts: Nawur, Ajrestan, , Khwaja Omari, Bahrami Shahid (Jaghatu)
Lead PPG NGO: Bakhtar Development Network (BDN)
Sub-grantee: Asian Development Corporation (ADC)

Contact Details:

Address of Lead PPG NGO: Kart-e Parwan, Baharistan
Kabul Afghanistan

Phone: 070 262461

Email: bakhtardf@yahoo.com
zshafiq.bdf@gmail.com

Signature/ Name and Title: Zohra Shafiq, PMEU Director, BDN

Date received by the GCMU:	
Submitted by:	
Submitted to:	
Name/Signature/Designation:	

Submission of required reports: (Please put tick mark if submitted)

TYPE OF REPORT	Hard copy	Soft copy (on CD)
HHS LQAS Final Report		
Report of the 5% re-survey		
Excel Sheet of SA level priority setting		
Result of surveyors reliability testing		

Executive Summary:

BDN is a developmental organization that was founded in 2001 by Afghans. BDN has been implementing Basic Package of Health Services (BPHS) in 4 provinces of Baghlan, Balkh, Daikundi and Ghazni, dealing with a total number of 34 districts, covering 1840593 Afghans through a total of 1 Provincial Hospital, 3 district hospitals, 34 CHCs, 55 BHCs, 25 sub health centers and 1500 HPs.

During the last two years, BDN has been implementing a total of 7 health projects in the country, out of which 2 PPG health projects are located in Ghazni province: EPHS in Ghazni city and BPHS in Nawur, Ajrestan, Khwaja Omari and Bahrami Shahid (Jaghatu) districts of Ghazni province at health facility and community level. The project aims to improve the health of women of reproductive age and children under five through providing BPHS through 14 health facilities and a number of CHWs associated with these HFs. A major focus of this project is to support existing services as well as build the capacity of communities to run the community-based health care programs in the long term. It is a USAID funded project.

Three rounds of HHS had been accomplished before conducting the current round of HHS in October 2007.

In March 2004, a baseline survey was conducted by RCA in Khwaja Omari and by BDN in Nawur and Ajrestan to collect data on three major issues on which the program mainly focuses: it was a) Child health, b) Safe motherhood, and c) Reproductive health. Data was analyzed to highlight the prevailed health status and identify the high priority areas of the population in the covered areas. Based on the results the targets were identified and set.

A mid-term evaluation was conducted in 2005 focusing only on a few of the selected 10 indicators.

In March 2006 end of project evaluation was conducted, the results of which are used as the baseline for the current survey.

Background:

Catchment population, figures of the major target groups in the CA:

BDN's PPG projects covers four districts of Nawur, Ajrestan, Khwaja Omari, Bahrami Shahid (Jaghatu) as well as Ghazni city with a total population of 289100 according to CSO in 1384. Adding the Afghanistan's growth rate (2.4%) to the figure, we can estimate that the current population of the area is 303143.

Calculation of Target groups:

- Children U1: Population X 0.048 X 0.9175= 13338
- Pregnant Women: Population X 0.048 X 1.15= 16733
- Women of CBA: Population X 0.21= 63660

Summary of Baseline Survey findings, SAs with a baseline high priority status

Comparison of the EOP 2006 with the baseline 2004 showed improvement in all categories of indicators with the highest in child health and lowest in the safe motherhood.

All indicators had been improving remarkably except ANC coverage which had a slight elevation in Nawur and Ajirestan districts, but had been worsening in Bahrami Shahid district.

ANC, exclusive breastfeeding, PNC, and knowledge of two modern contraceptive methods were found as the high priority indicators.

Center of Nawur, Khwaja Omari, Sard Koh, Jerghai-Batoor and Barakat were identified as the SAs with the significant improvement, Qala Naw and Sheghna of Nawur with little improvement, Tormai and Deh Dawlat with no improvement and Ajirestan as the SA with worsened state.

Safe Motherhood recognized as the high priority field while Reproductive Health as the low priority.

Qala Naw, Barakat, Ajirestan and Sheghna of Nawur were distinguished as the high priority SAs.

Summary of the specific interventions by the NGO to improve indicators in those SAs

Interventions at community level:

- A total number of 138 Local Health Committees (LHCs) were established through communities out of which 126 are male and 12 are female.
- In cooperation and coordination with the LHCs 340 CHWs were selected.
- 340 CHWs (170 Male and 170 female) were trained using the standard MoPH curriculum.
- LHCs provided non-technical supervision to the CHWs.
- Regular meetings have been conducted between CHWs, LHCs and HF's staff and refresher trainings organized for them in order to strengthen the link between CHWs and HF with more focus on EPI and MCH referral and IEC activities.
- Community resources were mobilized and donations made to the project by community
- Initial and re-supply kits were provided to all the trained CHWs.
- Refresher training was provided to all CHWs.
- A referral system was worked out and established between the trained CHWs with the existing referral health facilities.
- Supervision and follow-up of 170 Health Posts (HPs) was conducted on monthly where as re-supply was done on quarterly basis.

Interventions at HF levels:

- The locations for HFs were identified, the structures were renovated and community contribution was sought.
- Basic package of health services were provided through 14 HFs (5 CHC and 9 BHCs)
- 14 HFs were staffed according to the BPHS guideline
- The HFs were supported, operated and equipped with the necessary tools.
- More refresher training provided for the HF's in charges on HMIS, community leadership for LHC members and other required trainings.
- Antenatal, delivery and post-natal care, neonatal care, curative services, family planning, nutrition and vaccination services were provided at the HFs.
- Essential drugs were provided to the health facilities, based on the BPHS Essential Drug List and communities' need.
- Effective referral system was established at provincial level.
- IEC materials were provided to all HFs.
- EPI fixed and outreach services were provided and the EPI defaulters were traced by CHWs.
- Efforts made to strengthening the referral system between the community and HF from one side and among the HFs themselves from the other side through:
 - Providing the ambulance for the CHCs
 - Improving the reporting system
 - More frequent supervisions of the HPs by CHSs.

Implementation of the survey:

Preparations (updating the sampling protocols, surveyor training and reliability testing)

In the HHS LQAS workshop conducted on Sep 04 2007 by Tech-Serve all 10 previously selected SAs were kept the same. It is noteworthy to mention that two SAs of Barakat and Ajirestan were included in Watch List due to lack of security until the security condition allows implementation of the survey there.

The lists of villages used at the previous round of HHS were sent to the projects, updated and entered in the HHS LQAS database within the second and third week of September. At the same time the random sampling was done and the sampling protocols were sent to GCMU for approval by the end of 3rd week of September.

At the end of September we received the approval of sampling protocols and the permission of conducting the survey. The below is the list of SAs with their location and number of HHs:

Supervisory Area Name	Locations covered	Number of households in supervisory area HHS LQAS 2007	District name
SA1: Bahrami A	Qala Naw	530	Khwaja Omari
SA2: Bahrami B	Khuja Omari	472	Khwaja Omari
SA3: Bahrami C	Tormai	587	Khwaja Omari
SA4: Bahrami D	Deh Dawlat	736	Khwaja Omari
SA5: Bahrami E	Barakat	406	Khwaja Omari
SA6: Nawur A	Nawur Center	4438	Nawur
SA7: Nawur B	Shagna Nawur	1417	Nawur
SA8: Nawur C	Sard Koh	5396	Nawur
SA9: Nawur D	Jerghai-Batoor	4441	Nawur
SA10: Ajirestan	Ajirestan	5865	Ajirestan

The team that consisted of 14 CHSs, 4 CHW trainers, 2 CHWs, 1 cluster manager, 1 CBHC officer, 1 MCH officer and the HMIS officer were trained for the implementation of the survey for three days. Training was conducted by BDN's focal point of HHS in Ghazni. After the reliability testing was performed the team headed to the field. The result of reliability testing is attached.

Data collection process:

The trained staff was divided into 3 teams. Each team consisted of 3 fixed members and one changeable CHS. One female surveyor, one male surveyor, the related CHS and one supervisor were gathered in each one team. The HMIS officer as well as the project managers contributed to the supervision of the survey. The data collection from 8 SAs completed within 4 weeks including the EID's holidays starting from Oct 6th and ending on Nov 7th.

Re-survey report:

In addition to BDN's survey team Dr. Ajab Khan Hamidi, Ghazni Provincial HMIS Officer, and Dr. Mashouq, the Ghazni Provincial Health Advisor took part in the HH resurvey process which took place from Dec 2 to 6, 2007. All SAs were accepted by the team. The resurvey reports are attached.

Data entry, data editing:

The survey data was completely entered in the HHS database in BDN's project office by the HMIS officer and then the database along with the questionnaires were transferred to BDN's main office. All the questionnaires were cross-checked with the database by BDN's HMIS/PME Dep. in main office.

Limitations of the survey

Lack of security in two SAs of Barakat and Ajirestan prevented us from conducting the survey there. Therefore the result represents the coverage of indicators in 8 SAs out of 10. In addition remoteness of some selected villages and terrible conditions of the roads complicated the process of data collection.

Main Findings:

Group indicators in categories:

Ten indicators classified in 3 categories were measured through the survey.

The first category is Reproductive Health which includes two indicators of contraceptive prevalence rate and knowledge of two modern contraceptive methods.

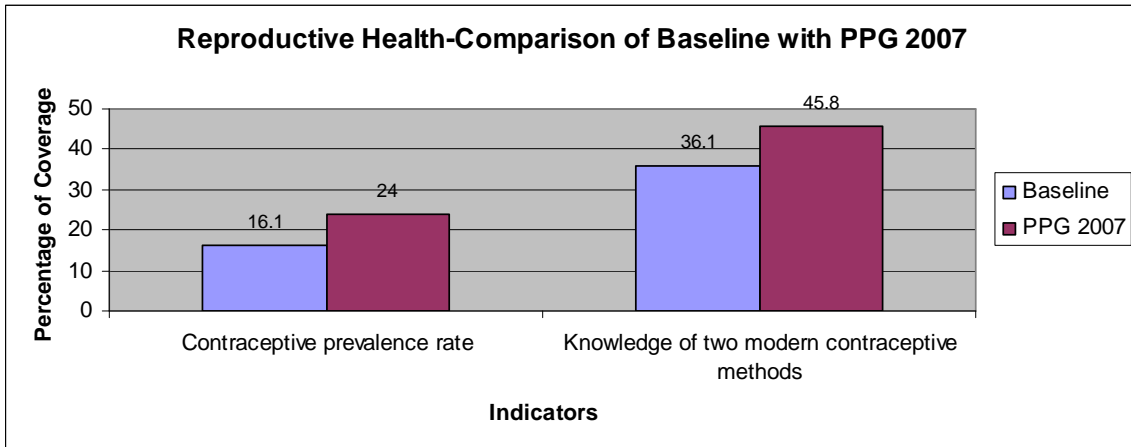
Four indicators constitute Safe Motherhood category: a) births attended by a skilled attendant, b) mothers receiving PNC after delivery, c) mothers attending one ANC visit, and d) mother receiving TT injections.

In the category of child health four indicators are assessed including: a) children 1-2 fully immunized (DPT3), b) children 1-2 received Vitamin A therapy, c) children exclusively breastfed during first 6 months, and d) mothers with appropriate care-seeking behavior.

Comparison of baseline and PPG HHS findings:

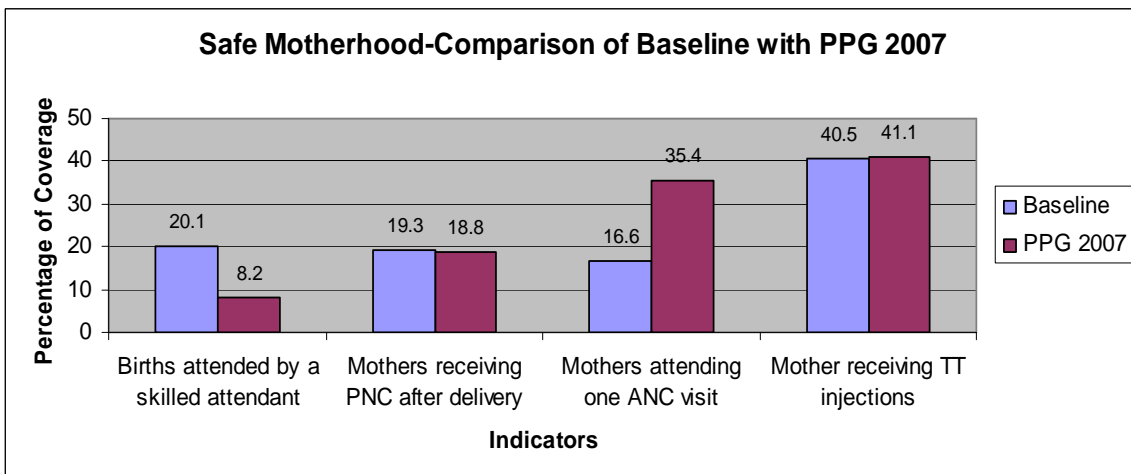
Both indicators of reproductive health show an increase in the coverage compared to the baseline.

- An increase of 7.9% can be observed in the coverage of CPR that is more than the confidence interval. Therefore the improvement is statistically considered significant.
- The coverage of knowledge of two modern contraceptive methods has increased by 9.7% that is significant from the statistics point of view as it is again larger than the Confidence Interval.



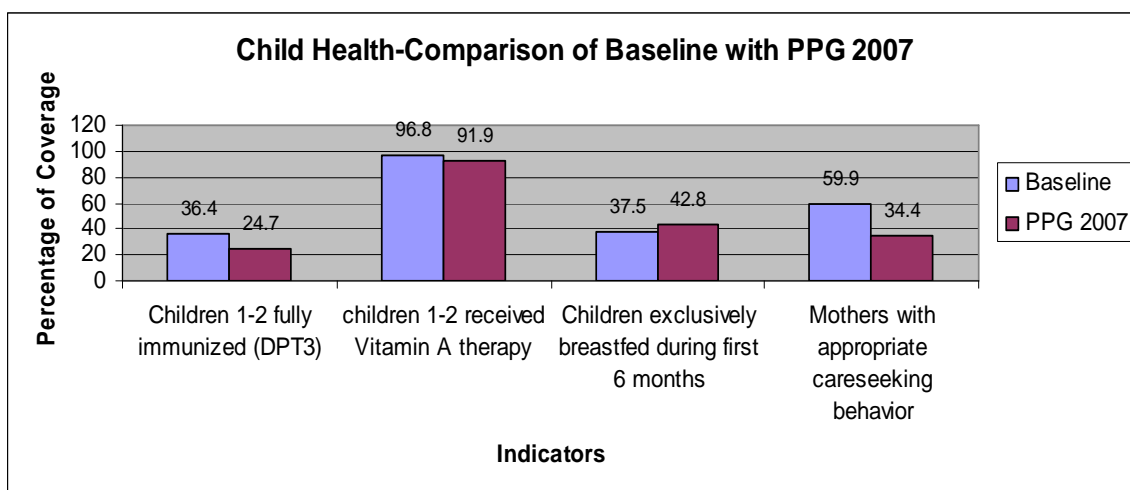
In general the status of safe motherhood has improved. Raises are observed in 2 indicators while the other two show declines.

- The main raise is observed in the coverage of ANC by 18.8% in comparison with the baseline that is statistically significant.
- There is a slight improvement of TT immunization coverage of mothers by 0.6%.
- Unlike the above-mentioned indicators, a decline of 11.9% is seen in the coverage of delivery attended by skilled birth attendants, which can not be regarded considerable.
- The coverage of PNC has decreased by 0.5% that is not bigger than the confidence interval. The change, thus, is considered insignificant.



No obvious improvement can generally be distinguished in child health.

- The only progress is attributed to the coverage of exclusive breastfeeding which shows a trivial rise of 5.3% compared to the confidence interval of 9.7%.
- The coverage of both DPT3 and Vit A supplementation diminished by 11.7% and 4.9% respectively. The fall in coverage of Vit A supplementation is not valuable from the statistic point of view but as the reduction in DPT3 coverage is more than the confidence interval, is judged important.
- The result reveals that the percentage of mothers who report a proper care-seeking behavior while their child is sick has decreased outstandingly by 25.5%.



Comparison of the PPG values for indicators with the targets:

Indicators	PPG 2007	CI	Best Scenario	Target
Contraceptive prevalence rate	24	7.6	31.6	25
Knowledge of two modern contraceptive methods	45.8	8.3	54.1	60
Births attended by a skilled attendant	8.2	4.4	12.6	35
Mothers receiving PNC after delivery	18.8	7.8	26.6	30
Mothers attending one ANC visit	35.4	9.6	45	40
Mother receiving TT injections	41.1	9.8	50.9	55
Children 1-2 fully immunized (DPT3)	24.7	8.0	32.7	55
children 1-2 received Vitamin A therapy	91.9	6.0	97.9	99
Children exclusively breastfed during first 6 months	42.8	9.7	52.5	55
Mothers with appropriate care-seeking behavior	34.4	9.2	43.6	70

Green: Target might be achieved.

Yellow: Target not achieved but close to the target.

Red: Target not achieved and far from target.

Conclusions and Recommendations:

SAs with the greatest improvements:

1. Sard Koh SA in Nawur district
2. Qala Naw and Tormai SAs in Khwaja Omari district

SAs with the little or no improvements:

1. Khwaja Omari SA in Khwaja Omari district (Little improvement)
2. Deh Dawlat SA in Khwaja Omari district. (Little improvement)
3. Jerghai-Batoor SA in Nawur (No improvement)
4. Sheghna of Nawur and Center of Nawur SAs in Nawur district (Worsened)

In short, all assessed SAs of Khwaja Omari district with no exception have improved, but in Nawur the progress can only be seen in Sard Koh SA.

All SAs of Nawur district have been identified as high priority areas.

Indicators with greatest improvements: (More than CI)

- Mothers attending one ANC visit: by + 18.8 %
- Knowledge of two modern contraceptive methods: by + 9.7%
- Contraceptive prevalence rate: by +7.9%

Indicators with little improvements: (Equal or Less than CI)

- Children exclusively breastfed during first 6 months: by +5.3%
- Mother receiving TT injections: by + 0.6%

Indicators with no improvements:

- Mothers receiving PNC after delivery: by – 0.5% (Less than CI, not significant)
- Children 1-2 received Vitamin A therapy: by – 4.9% (Less than CI, not significant)
- Children 1-2 fully immunized (DPT3): by -11.7% (More than CI, significant)
- Births attended by a skilled attendant: by -11.9% (More than CI, significant)
- Mothers with appropriate care-seeking behavior: by -25.5% (More than CI, significant)

The following reasons could explain low or lack of improvement in the above-mentioned indicators:

1. The security condition has been deteriorating since last year so as health workers have received several threats from Taliban and once two health workers and their driver were kidnapped by them. Although they were returned after interfering of the elderly, their vehicles were not given back. Insecurity must have affected the access of people, particularly mothers and children, to the health providers and vice versa.
2. In addition, last year, Ghazni experienced one of its most terrible winter which lasted for 8 months and caused road blockage and inaccessibility to health services.
3. Lack of security and hard living condition contributed to the decreased staff's interest to resuming their jobs and frequent turn over of female staff in particular.

Suggested future interventions:

The following interventions are proposed, some of which have already been initiated:

- Strengthening link between CHWs and HF by conducting regular meetings and refresher trainings with more focus on EPI and MCH referral and IEC activities.
- Strengthening EPI outreach services and defaulter tracing system.
- HP target setting especially for EPI and obstetric case referral.
- Providing incentive to CHWs for each delivery referred to HF
- Initiating night duty in BHCs
- HFs to be completely staffed with female health workers and preventing from frequent turn over of staff.
- Establishing some sub health centers in very remote and scattered areas.
- Identifying local and capable candidates for community midwifery education to prevent recurrent turn over of female staff.

How useful did you find the LQAS methodology for evaluation of your work CA?

The evaluation done with this methodology cleared us in which areas and for which indicators we have achieved major success and improvements. Although we realized that the areas where need to be focused more.

What implementation problems did you encounter?

Apart from lack of security in Barakat and Ajirestan SAs which stopped us from conducting the survey there, we have faced no specific problem in implementation of the methodology. It was as quite simple as possible and neither took long time nor needed huge logistic and administrative support.

Description of a simple timeline for dissemination of household survey down and upwards:

The final report of the HHS will be submitted to GCMU by Jan 20, 2008.

The result will be shared with HMIS, EPI, MCH officers as well as cluster managers through conducting Quarterly HMIS Workshop at BDN's main office on Feb 11-12.

The NGO's HMIS officer will transfer the result to Provincial HMIS Taskforce in a meeting that will be held on Feb 13.

The result will be disseminated to the project and program managers in Monthly Technical and Management Meeting at BDN's main office on Feb 13.

During PPHCC Meeting on Feb 19, the BDN's provincial project manager will present the survey outcomes to the PHD and other stakeholders.

In the Monthly Review Meeting at BDN's provincial office that is going to be held on Feb 23, the HMIS officer will share the results with the head of HFs.

Appendices

- HHS Database
- Excel Sheet of SA level priority setting
- Result of surveyors reliability testing
- Report of the 5% re-survey