MID TERM EVALUATION REPORT
IBNSINA

November 1998
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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACBAR</td>
<td>Agency Coordinating Body for Afghan Relief</td>
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<td>ACF</td>
<td>Action Contre la Faim</td>
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<tr>
<td>ANCB</td>
<td>Afghan NGO Coordinating Body</td>
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<tr>
<td>AVICEN</td>
<td>Afghanistan Vaccination Immunization Center</td>
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<tr>
<td>BBC</td>
<td>British Broadcasting Corporation</td>
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<tr>
<td>BHW</td>
<td>Basic Health Worker</td>
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<tr>
<td>CBHC</td>
<td>Community Based Health Care</td>
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<td>CHS</td>
<td>Community Health Supervisor</td>
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<tr>
<td>COC</td>
<td>Combined Oral Contraceptive</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme for Immunization</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>HABITAT(UNCHS)</td>
<td>United Nations Center for Human Settlement</td>
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<td>HC</td>
<td>Health Committee</td>
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<td>HIP3</td>
<td>Health Information Programme 3</td>
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<tr>
<td>HIS</td>
<td>Health Information System</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>IFRC</td>
<td>International Federation of the Red Cross societies</td>
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<tr>
<td>KAP</td>
<td>Knowledge, Attitude, Practice</td>
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<td>MO</td>
<td>Main Office</td>
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<td>MCH</td>
<td>Mother and Child Health</td>
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<td>MEMISA</td>
<td>Health for All in the Third World</td>
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<td>MFA</td>
<td>Ministry of Foreign Affairs</td>
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<td>MLHW</td>
<td>Mid Level Health Worker</td>
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<td>MoPH</td>
<td>Ministry of Public Health</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
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<tr>
<td>NOVIB</td>
<td>Netherlands Organization for International Development Cooperation</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>REMT</td>
<td>Regional EPI Management Team</td>
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<tr>
<td>SWOT</td>
<td>Strengths, Weaknesses, Opportunities, Threats</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>TCC</td>
<td>Technical Coordinating Committee</td>
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<tr>
<td>TOF</td>
<td>Training of Facilitators</td>
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<td>TOT</td>
<td>Training of Trainers</td>
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<tr>
<td>UNICEF</td>
<td>United Nations International Children’s Emergency Fund</td>
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<td>VHV</td>
<td>Village Health Volunteer</td>
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<tr>
<td>VOA</td>
<td>Voice Of America</td>
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<tr>
<td>VSF</td>
<td>Vaccine Storage Facility</td>
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<td>WHO</td>
<td>World Health Authority</td>
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SUMMARY

IbnSina has been involved with the provision of Primary Health Care since 1995 and was originally a section of AVICEN. It became independent of AVICEN in November 1996. This young NGO is committed to the formation of an excellent transparent Afghan NGO, working for the improvement of the health of the Afghan people.

Its current programme dating from December 1997 to May 1999 is financed by the European Union, MEMISA and NOVIB. It works in four regions: South Western or Kandahar; Eastern or Nangarhar, South Eastern or Ghazni and Central or Bamyan. The provision of primary health care is effected in the lines with the “The Project Framework for Minimum Primary Health Care in Afghanistan”. IbnSina runs eighteen MCH clinics, one maternity home, and twenty one other clinics. There is a strong emphasis on the MCH component of the programme, and where possible an MCH clinic is the desired health system unit. It is also involved in the provision of EPI services in thirty three districts (in health facilities or otherwise).

This mid term evaluation was planned for August 1998 but was delayed due to political crises i.e. the missile strike on Afghanistan. It has been conducted at short notice to allow for its use for the planning of the next programme. The evaluation comprised of a short preparation phase, a field trip to Nangarhar, a participatory workshop, a field trip to Ghazni and report writing. Consultants from MEMISA and SCA were used.

The evaluation and the report looked at the strengths, weaknesses, opportunities and threats for each programme activity, each aspect of the PHC programme that IbnSina has sought to incorporate, and the organization and its policy/strategy.

The organization is well motivated, the structure is clear and well understood. The Main Office comprising the Technical department, the Operational department and the Financial department and headed by the Director General, is the central management of the programme. The field work is managed from Regional offices, headed by Regional Directors and assisted by PHC trainers/supervisors and female supervisors assisting them in programme management and improvement.

IbnSina aims to deliver low cost sustainable health care of good quality and contribute to organizational, local, and national capacity building. It has kept its programme at a reasonable cost levels with the use of appropriate technology and deployment of Afghan staff while maintaining quality through training and supervision and motivation of staff. Personnel are recruited after careful selection procedures. The programme planning, budgeting and work plans are clearly laid out and objectives and indicators are SMART. Audits carried out by a donor and an external consultant produced favourable reports with some recommendations that will be implemented.

The programme activities are: Health education, Water and Sanitation, Nutrition and Growth monitoring, Curative services (OPD and Obstetrics and gynaecology), EPI, pilot activities for Community participation, and the Health Information System. Some of the programme activities need strengthening e.g. the purpose and correct use of growth monitoring and water and sanitation. The EPI programme has suffered from several constraints, many of which have been outside IbnSina’s control.
It is well represented at both at Regional levels and in Peshawar/Islamabad. It is a member of ACBAR, ANCB, TCC and the APB. Coordination and cooperation is sought at Regional and Main Office levels. The common programming and other donor emphasis at present is for coordinated planning between organizations. This will need to be considered seriously, though it presents difficulties, since organizations have their own mandates and funding and programme cycles.

There are various constraints/weaknesses which have been identified during the course of the evaluation and recommendations to address these have been formulated. The report presents the recommendations along with a discussion of the strengths, weaknesses, opportunities and threats of each PHC activity, aspect, and the organization. All the recommendations are collectively presented in the summary of recommendations.

IbnSina has made an excellent recovery from the circumstances surrounding AVICEN’s collapse. It has done this through judicious down sizing, employment of qualified personnel, suitable training, supervision and monitoring, regular supplies of drugs and equipment, motivation of staff by timely salary provision and training, financial transparency and accountability, and development of its own programme capacity e.g. the HIS.
INTRODUCTION

IbnSina is a relatively new Afghan Non Governmental Organization created by AVICEN as that part of it which would be the provider of Primary Health Care. This move was made in response to the coordinated European support (MEMISA/European Union/NOVIB) programme which took up the responsibility of providing PHC in four regions of Afghanistan. In November 1996, IbnSina became independent of AVICEN. Since then, it has continued in the pursuit of its twin goals of good quality PHC provision and the formation of a high caliber, accountable Afghan NGO, working in the service of Afghanistan. It has been jointly financed by the EU, MEMISA and NOVIB; the EPI component has been financed by UNICEF.

IbnSina is working in 4 Regions (West-Central, South-East, South-West and Central), 12 provinces (Nangarhar, Parwan, Wardak, Paktia, Bamyan, Baghlam, Ghore, Ghazni, Paktika, Kandahar, Helmand and Zabul) and providing EPI services in 33 districts. There is also a liaison office in Kabul. At its inception, a decision was made to build upon the skills and knowledge gained by AVICEN with women and children and to make this its area of emphasis. The programme has made the opening of Mother and Child Health (MCH) clinics its special cause.

During the period of IbnSina’s operation, Afghanistan has continued in a state of civil conflict, remaining a complex emergency as it has done for the past several years. The Ghazni, Kandahar and Nangarhar regions of IbnSina’s programme have been in the Taliban controlled area of the country. Bamyan has, till recently, been in the hands of the opposition forces but is now in the control of the Taliban. Neither side has achieved full world recognition. The erosion of all service/support sectors continues along with the loss of trained or skilled man power.

The mid-term evaluation of IbnSina’s programme was initially scheduled to take place in August 1998. This was not possible since the missile strike by the USA in Khost and Jalalabad resulted in a climate of insecurity and uncertainty, rendering it difficult for foreigners to journey into the country.

Objectives of Evaluation

**General Objectives**

1. To study to what extent IbnSina has developed an appropriate PHC programme for the people of Afghanistan since November 1996, but with special emphasis on the period 1st December 1997 till October 1998 (midterm evaluation of the 18 months project period starting on 1.12.97)

2. To review IbnSina’s EPI activities as part of PHC, in relation to national and UNICEF policies, in order to define the role of IbnSina in future EPI activities.

3. To advise on the basis of such a study, while assessing the capacity of the organization in terms of management and PHC views, on the formation of a realistic plan for the future (1999-2000)
The specific objectives and the planned methodology can be seen in Annex 1 which is the Terms of Reference (ToR).

**Methodology**

**Evaluation Team**

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Asia Desk Officer, MEMISA  
Dr. Peter Kok  
Asia Medical Adviser, MEMISA  
Dr. Inger A v Rosen  
Health Adviser, Swedish Committee for Afghanistan

The planning and organization of the evaluation was carried out by Dr. Loan Liem, former Technical Manager, IbnSina. The ToR were drawn up by MEMISA and with further input from Dr. Loan and IbnSina.

The evaluation comprised **five broad stages**:

1. Finalisation of evaluation plan and timetable and recruitment of in country consultant. Compilation of project documents and orientation with the programme through interviews with project staff. Questionnaires were designed and sent to Regional staff (Dr. Liem and Dr. Panna)

2. Field trip to Jalalabad area (Dr. Panna)

3. Participatory evaluation of programme through a SWOT workshop and project staff interviews, meetings with donor and other organizations (Project HQ staff and Regional and some field staff along with all external consultants).

   The workshop examined through group work and plenary sessions the Strengths, Weaknesses, Opportunities and Threats of the PHC activities viz: Health Education, Water and Sanitation, Nutrition/Growth Monitoring, General OPD curative care, Obstetric/Gynaecological care, Community Based Care and the Health Information System. Similarly the organization was discussed at field, regional and main office level. In addition to the activity content, the following aspects of each were discussed using the same SWOT format: community participation, gender, coordination/cooperation, capacity building, cost effectiveness and sustainability.

4. Field trip to Ghazni (Dr. Inger, Dr. Panna)

5. Report writing

The field trip to Nangarhar consisted of visits to two MCH clinics, Bagrami and Khiwa, interviews with Regional and clinic staff; interviews with patients, interviews with Health Committees and interviews with other organizations including MoPH and the UN.

In Ghazni, MCH clinics at Khwaja Umari, Qarabagh and Ghazni city were visited as was the Maternity Home in Ghazni city. Interviews with Regional staff, clinic staff, Health Committees, patients and representatives of the MoPH and other organizations were conducted. The VSF and 1 fixed center and 1 EPI post in Paktika were visited.
Interviews with staff at the Kabul liaison office were also carried out. Due to time spent on resolving problems resulting from MFA and MoPH regulations/requirements the visit to the MCH clinic in Maidan Shahr had to be canceled.

The objectives of the interviews with staff were to elucidate:

1. their roles in the programme, their qualifications, any training received and further training needs
2. their views as to strengths, weaknesses and future development of IbnSina
3. their understanding of PHC

Interviews with patients (mostly female patients were interviewed) were conducted in order to:

1. obtain their view and understanding of IbnSina’s work (clinic work)
2. get a picture of why they use the clinic and where they came from
3. obtain an impression of their understanding/retention of the promotive and preventive messages that IbnSina seeks to impart to the community

Health Committees were met to obtain:

1. their understanding of the role of the HC and the manner of their initiation
2. their view of IbnSina’s programme

Representatives of other organizations were met in order to seek:

1. their views (if any) of IbnSina’s strengths and weaknesses
2. their views as to the cooperation, collaboration and coordination between the various agencies and between their organization and IbnSina

The choice of organizations was made in consultation with the concerned Regional Director, Dr. Ahmad Jaan and Dr. Liem. Advise was sought as to which organizations had any inter-action with IbnSina.

Dr. Ahmad Jaan, the Technical Manager, and the various Regional Directors served as translators and facilitators for the field trips.

Constraints

As mentioned before, the evaluation could not be carried out in August as field trips would not have been possible and it was necessary to hold it in good time for the evaluation findings to be useful for the planning of the next two years’ programme. Thus, the evaluation was organized at fairly short notice. This resulted in some constraints which were:

- The evaluators did not have sufficient time to go through all the project documents thoroughly
- there was some difficulty in recruiting in-country evaluators, both due to time and a limited budget, (restricting consultant fees), for what was perceived as a difficult country
- the timing of the workshop was changed due to the schedule of some key staff and this resulted in some lack of organization
all regions could not be visited due to the limited time available
the questionnaires that were sent to the field could not involve responses from all field and region staff
it was not possible to organize the attendance of more field staff at the workshop at such short notice
The operations and finance department were not fully involved in the workshop nor fully interviewed

Language was a problem for the evaluators during the field trips. Translation by Dr. Ahmad Jaan, though done highly professionally, may have resulted in some bias in the interviews.

The Finance department, operations department, the HIS section and the EPI section were requested to write a short account of their departments, activities and strengths and weaknesses. These have been incorporated in the evaluation report.

_Evaluation Report_

The evaluation report examines the programme activities as listed in the questionnaires, the various aspects of IbnSina’s PHC programme, and the organization itself. Each activity and aspect of the PHC programme and the organization have been examined in the following headings:

- the objectives and activities as set out in the project proposal
- achievements reported in the six monthly report and the fact sheets
- indicators/targets as set out in the proposal, for the period of the proposal
- strengths and weaknesses
- recommendations for each in the short (till end May 1999) and long term (next programme)
II. PROGRAMME ACTIVITIES

II.1. PREVENTIVE AND PROMOTIVE ACTIVITIES

The programme activities can be divide in to those that are preventive and promotive and those that are curative. The preventive and promotive activities are:

1. Health education
2. Water and sanitation
3. Nutrition and Growth monitoring
4. EPI
5. Exploratory activities for community based work

Health Education

Background

Since the beginning of this present programme, health education has been a part of the PHC package that is delivered from the clinics run by IbnSina. A trainer, with previous experience in health education programmes in Afghanistan, was recruited to train a cadre of female health educators for all MCH clinics. A training programme was instituted and clinics asked to set out their own schedules for various health issues. A set of flip charts and teaching aids are supplied to each clinic. Health education is also stated to be an integral part of the immunization services. Food demonstrations are used to augment the health education delivery.

Objective

Continuation and improvement of the current promotive and preventive health service.

Activities:

1. Providing health education combined with vaccination services, both in fixed centers and during outreach activities in the villages.
2. Providing health education sessions in the health facilities and in the nearby villages.
3. Providing health education on child nutrition by teaching and demonstrating to the mothers how to make energy rich food from local available food items.
4. Training health educators and supplying them with sufficient/adequate material to conduct HE sessions in the facilities.
5. Set up demonstration gardens and nutrition demonstration corners in the facilities. Improve sanitation at facilities in order to match theory and practice.
A health education schedule is decided upon through discussions between the Supervisor and the clinic staff. One session is conducted in the first part of the morning and if there are many patients afterwards, a further session is held in the latter part of the morning. The EPI teams have been taught to teach during or before a vaccination session. The food demonstrations are generally held at the point of weighing the children. The food prepared is from locally available foods such as lentils, rice, wheat etc. and a folder of recipes is available at the clinic. A schedule of foods to be demonstrated is also drawn up.

The training manager is directly involved with the main office support of the health education.

**Indicators/targets**

1. In 80% of all the clinics (M1/C1, C2/M2) health education sessions are conducted on (at least) a weekly basis

2. In all M1 clinics food demonstrations will take place at least on a weekly basis

3. 15 health educators will be trained and provided with books, cards and adequate teaching aids

4. At least 10 demonstration gardens at facilities will be initiated. 20 facilities will be provided with a pit latrine and 7 facilities with a water well.

**Reported Achievements**

It should be noted that that the programme has a further six months to completion and the targets have been set for the whole period.

1a. Experienced health educator hired in February 1998

1b. 80% of all clinics hold health education sessions at least once a week

1c. A total of 5635 health education sessions (i.e. group sessions only) have been conducted till September 1998 with a total of 112,216 participants

2. Food demonstration are held at least on a weekly basis in:
   - All M1 clinics in Nangarhar province
   - 5 out of 7 M1 clinics in Ghazni
   - 1 out of 2 M1 clinic in Kandahar
   - 2 out of 4 M1 clinics in Bamyan

3. 15 health educators in the four regions have been trained by the Health Education Supervisor. 28 other personnel have received some training in this field. The Supervisor visits each of these clinics to provide on the job training for 2 - 3 days each as formal group training of women by male staff is restricted.
4a. 2 demonstration gardens have been set up; 1 in Bamyan as part of a co-operation with HABITAT’s larger agricultural programme; and 1 in Nangarhar.

4b. 2 pit latrines and 2 wells have been constructed.

**Strengths**

- The targets that have been set have been achieved to a large extent, the period between November 1998 and May 1999 remaining to complete the targets.
- There has been a strategy for the achievement of this activity and this has been put in place. A health education supervisor has been employed, a plan and curriculum designed for training, lesson plans and a topic schedule is present at each clinic.
- The health educators are all women.
- On the job training and refresher training is planned for and in execution.
- The kitchen gardens in Bamyan and Nangarhar have been set in place with community participation in terms of the land donated, labour etc.
- Anecdotal impressions of improvement in personal hygiene, use of weaning foods at the appropriate time, fewer cases of severe dehydration at the clinic and an increase in the numbers of vaccinated children.
- An attempt was made to elicit if health messages were remembered through interviews with patients and health committees; Many of the female patients did remember important messages e.g. about vaccination, weaning. As the health committees comprise only men and the beneficiaries of the MCH clinics are mostly women (some clinics do see male patients if there is no other facility), the HC was not an important source of verification of this. However, one member of the HC (a mullah), was able to list the subjects and the contents of those sessions that his wife had attended.

**Constraints/weaknesses**

- No impact indicators have been developed.
- Training of female educators presents difficulties in the present socio-political climate.
- I supervisor is unable to supervise, support and provide training for this activity adequately over all four regions.
- Health educators have to conduct the sessions, weigh the children, register patients and hold the food demonstrations; in busy clinics this could be an overload.
- Health education is still clinic based and the impact in the community is questionable.
- The construction of wells and pit latrines has had poor organizational commitment but has also been slightly hampered by the fact that some of the clinics are located in private houses.
- Patients felt that the nutritional messages involved the use of foods that were expensive and not easily affordable.
- Many of the educators observed, used none of the teaching aids.

**Opportunities**

- Expand health education to schools.
- Increase community participation in the planning, implementation and evaluation of this component.
- If funds are found to employ female health educators in C1/C2 clinics.
to develop commitment to the construction of wells and latrines and the concept of setting a good example of good health practices

To involve other NGOs in the construction of wells and latrines

**Threats**

- Some other NGOs with engineering capacity have quoted very high prices for latrine and well construction

**Recommendations**

**Short term (till June 1999)**

1. Involve through training the PHC trainers and female supervisors in the supervision and support of the health educators

2. To complete the construction of those wells and latrines that are deemed possible. It was felt that it would be possible to construct 11 of the 20 latrines planned and 9 wells, though only 7 had been planned and budgeted.

3. To continue with the existing kitchen garden support but explore the need in areas where people have their own gardens and do grow vegetables etc.

4. If funds are available to recruit female health educators for C1/C2 clinics

**Long term (next programme)**

1. Develop impact indicators

2. Explore the possibility of health education in schools and in the community

3. Develop organizational commitment to the use of good sanitation and water

4. Involve other NGOs in the construction of wells and latrines after appropriate discussions of cost of the same.

**Water and Sanitation**

**Background**

Water and sanitation work/construction is part of the programme plan only as the development of model wells and toilets in the clinics, in order to reinforce the health messages through example. The health
education component does contain water and sanitation messages. The organization does not have the capacity to embark on a community watsan programme.

**Objective**

Continuation and improvement of the current promotive and preventive health service.

**Activities**

1. Providing health education sessions in the health facilities and in the nearby villages.
2. Improve sanitation at (health) facilities in order to match theory and practice.

**Indicators/Targets**

1. Twenty facilities will be provided with a pit latrine and 7 facilities with a water well.

**Achievements reported**

1. 2 pit latrines and 2 wells have been constructed.

**Strengths, Constraints and Opportunities**

These have been discussed in the section on health education as these were planned as a part of that objective.

**Other weaknesses**

- Latrines in the regional office of Ghazni are short drop latrines and the effluent flows out on to the streets. The emptying of this type of latrine is carried out traditionally by a person/s who carries out the raw sewage for use as compost. Whether this sewage is treated or composted before use on fields is open to question. These present a hazard to both the public and to the person handling raw sewage. The continued use of these latrines also indicates very little personal change on the part of the staff.

**Threats**

- Some other NGOs with engineering capacity have quoted very high prices for latrine and well construction

**Recommendations**

**Short term**

1. To complete the construction of those wells and latrines that are deemed possible. It was felt that it would be possible to construct 11 of the 20 latrines planned and 9 wells, though only 7 had been
planned. Completion of the planned 7 latrines by May 99 should be the objective with the remaining 2 carried on to the next programme.

2. To construct model latrines in the Ghazni regional office
3. To ensure that all project offices and clinics have safe drinking water and sanitary facilities.
4. Consideration of the which type of latrine would be sustainable, and which if any other NGO would be involved in their construction

*Long term*

1. Develop organizational commitment to the use of good sanitation and water
2. Explore the possibility of other NGOs being involved in the construction of wells and latrines
3. Personal change in the staff should be part of the training intention.

*Nutrition/Growth monitoring*

*Background*

This activity is carried out in the MCH clinics. They are supplied with Salter scales and growth charts. All clinics are also provided with mid upper arm circumference tapes (MUAC). Both parameters are age dependent. The health educator normally has the responsibility of carrying out this activity.

While this has been regarded as a promotive and preventive activity for this evaluation, in the project proposal it falls under the objective of providing curative care.

*Objective*

Provision of curative care and other services through existing health facilities with emphasis on mothers and children.

*Activities*

Growth monitoring and screening for malnutrition. Children are weighed on Salter scales and their weight for age is plotted on growth charts. The MUAC tapes are rarely used; the MCH clinic in Ghazni city used it to check the nutritional status if it was felt clinically that the growth chart entry was likely to be false (error in eliciting age).

*Indicators/targets*

None have been developed but some such as the demonstration gardens are included in the health education indicators.
Achievements reported

This activity is not reported in the six monthly reports or the fact sheets developed by IbnSina. Information regarding the numbers of malnourished children is collected and forwarded to the regional and main offices.

Strengths

- Information obtained from screening that indicated a rise in the numbers of malnourished children seen at the clinic, has been used in Nangarhar to obtain food material from WFP in order to carry out a distribution of food to families with malnourished children.
- Equipment to carry out this activity is present
- Regular training is carried in some regions to facilitate growth monitoring
- Co-operation with other agencies (ACF, HABITAT) to obtain training for IbnSina staff and also to participate in an agricultural programme to provide health education

Weaknesses/constraints

- Not all children are weighed in some clinics; only the thin or malnourished children are selected for weighing.
- The birth month of the child is entered as the Roman calendar month but the mothers state the month in the Afghan calendar. The calendars are situated at a different location in the clinic than at the place of weighing.
- No targets have been set
- It would seem that the purpose for which growth monitoring is used in the programme is for the treatment of individual children who show growth faltering or are malnourished, and the use of growth monitoring as a promotive/preventive tool has not been considered
- No guidelines for the medical treatment of malnourished children have been developed
- IbnSina, at the present, is clinic based and lacks the capacity to carry out follow up of children in the community where holistic treatment of the malnourished/distressed family might be possible
- The training/understanding of the use of growth charts is weak in Ghazni
- Other experiences of growth monitoring in other parts of the world have found it to be not cost effective
- The purpose of the MUAC tapes is not clear.

Opportunities

- Develop/define strategy for which growth monitoring is used. Define the clear use of the tools involved. (charts, MUAC tapes)
- Coordination with other organizations for any responses to an increase in malnutrition in the community as perceived by an increase in the percentages of children attending the clinic who are malnourished
• Rapid screening e.g. screening by arm circumference or weight for height to assess the problem in the community before responding with a supplementation programme
• Training to ensure correct use of tool
• Development of targets
• Examine the benefit of this activity

Recommendations

Short term

1. Training to ensure good use of growth monitoring; use of the Afghan calendar months on the growth charts
2. Explore ways in which this could be expanded into the community and mothers could be involved with the weighing of their children
3. Develop targets and indicators

Long term

1. Define the purpose for which growth monitoring is used; preventive and promotive or curative
2. Assess the benefit or otherwise of this activity in light of the world experience

Expanded Programme for Immunization (EPI)

Background

55 teams providing EPI services are fielded by IbnSina in different regions. There are 6 EPI supervisors, one Provincial Field trainer (Paktika) and 110 vaccinators. IbnSina maintains two VSFs (Bamyan and Paktika). One cold chain manger and three cold chain technicians are working in these two VSFs. The manner in which the EPI services operate is a rather mixed one. There are districts where IbnSina runs the health facility but the MoPH or other organizations run the EPI services and vice versa. In Paktika and Bamyan, IbnSina provides EPI services but there are no health facilities. Some of the vaccinators in Bamyan have received some basic health training to enable them to provide some health services; but this has not been very successful.

Objectives:
1. To provide vaccination for six immunizable target diseases for children under two years old, with special emphasis on children under one years old.

2. To provide TT vaccine for women in child bearing age (15-45 years old).

3. To provide supplementary Vitamin A for children from six months to two years old.

**Activities:**

The main activities of EPI section of IbnSina are supervision, training, logistics and maintenance of the cold chain, review of the EPI program, social mobilization, routine immunization services for target groups (children and women), EPI coverage analysis and reporting, coordination & cooperation, and implementation of NIDs and acceleration campaigns.

1. **Supervision:**

IbnSina Main office supervises the VSFs and EPI teams in all regions at least once. Supervisors use a standard checklist for supervision. In Kandahar Region and Paktika, EPI teams was supervised at least 4 times, and in Ghazni and Bamyan two times by EPI supervisors and the Provincial Field trainer.

2. **Cold chain and logistics:**

Kandahar and Ghazni supervisors receive vaccines and supplies from the Regional cold room(REMT) and distribute these to IbnSina EPI teams on a quarterly basis.

However, the blockade of the Hazara area in Ghazni by the Taliban forces and UNICEF’s delay in releasing the budget resulted in a delay of the supply of IbnSina EPI teams. The majority of the teams were supplied twice.

The Paktika VSF receives vaccines and supplies form UNICEF, Kabul.

In Bamyan, due to the political situation (blockade of roads to supply Hazara area), the supply to the VSF was limited. The majority of the teams were supplied once only.

3. **Training:**

IbnSina provides TOT and refresher training for supervisors, basic training and refresher training for vaccinators. From December, 1997 till October, 1998 four EPI training courses were conducted by IbnSina. One refresher and TOT training course for EPI supervisors held in Ghazni and 5 supervisors were trained. One initial training course for vaccinators was held in Bamyan and 8 vaccinators were trained. and two refresher training courses for vaccinators was conducted in Bamyan and Kandahar for 20 vaccinators.

In order to integrate EPI/PHC, 5 MLHWs attended vaccination courses.

4. **Social mobilization:**

Social mobilization is done through mullahs, teachers and health workers. There is one contact person for each outreach site, who informs the people before and on the day of a vaccination session. IbnSina has
requested VOA (Voice of America) and BBC (British Broadcasting Corporation) to publicize the EPI program, especially through dramas. The response to this request has been positive.

5. Service delivery:

EPI teams in different regions use both fixed and outreach strategies (outreach is defined as a 1 hour radius around the center). Each team is expected to work 8 days in the fixed center and 16 days per month on the outreach program, according to UNICEF policy. Due to the geography of Paktika province, where the population distribution is scattered and distances are large, a mobile program was agreed upon with UNICEF and started in June 1998. EPI teams also carry out local acceleration campaigns (they visit the same villages for three consecutive months).

Since the number of clinics where a fixed center might be established is limited, most of the teams house the EPI equipment in their homes, and work in outreach or mobile modes.

Vaccinators are also meant to carry out some health education to mobilize the people.

IbnSina Main Office staff take an active part in the Technical Coordination Committee (TCC) meetings and have contributed to the improvement of the EPI program implementation in Afghanistan.

6. National Immunization Days (NID) and acceleration campaigns:

IbnSina took active part in the NIDs, during which polio vaccines for children and tetanus toxoid for women are delivered, in three regions (Kandahar, Bamyan and Ghazni) in May and June 1998. Two rounds were conducted. IbnSina was involved in planning, training, implementation and monitoring of NIDs. The EPI Officer and EPI Field Officer took part in planning, training, implementation and monitoring of NIDs in Paktika and Ghazni.

During the negotiated cease fire period for the NIDs, IbnSina sent a number of gas cylinders to Bamyan. During this same period vaccines and other supplies (drugs) were sent to Bamyan and the Hazara area of Ghazni province.

7. Administration and reporting:

During a vaccination session, the team registers the children and women who are vaccinated. Vaccination cards are given to children and women. Tally sheets are used during the session. At the end of the month a monthly report is prepared. Monthly reports are collected by the supervisor during supervision or supply. The reports are corrected by supervisors and copies sent to the PEMT, UNICEF or WHO sub-offices and IbnSina Main Office. A copy of the report remains in the regional office. The EPI coverage report is prepared on a quarterly basis by the regions and sent to IbnSina Main Office. These reports are checked in the Main Office by EPI section and are given to HIS department to compile and analyze. The quarterly coverage report for Paktika is prepared in IbnSina Main Office and is sent to the UNICEF office in Peshawar/Islamabad.

Supervision checklists are filled by supervisors and sent to the Main Office. The Main office then gives feedback regarding these to the supervisors. Supervision, supply and review reports are prepared by
provincial field trainer and supervisors and submitted to the Main Office. The EPI officer prepares an EPI activity report on a monthly basis and submits this to the Technical Manager.

The EPI department has developed a supervision checklist and job descriptions for the EPI staff (Provincial Field Trainer, Supervisors, Vaccinator, Cold chain manager, cold chain technician).

**Indicators/Targets**

1. The EPI coverage for 1997, 1998 (fully immunized under 1) should be 80% in those districts where 2 teams are allocated (UNICEF target)

2. In the VSFs run by IbnSina no break in the cold chain should occur.

3. All vaccination teams will be supervised at least every three months, except for Bamyan/Panjab teams in winter

4. During the contract period, at least 60 vaccinators of different regions will receive a refresher course.

**Achievements reported**

1. No reporting has yet been done on the numbers of fully immunized under ones

2. No break in the cold chain has taken place in any of the VSFs run by IbnSina.

3. Vaccination teams have been supervised every two months in all regions except for Bamyan due to insecurity.

4. 14 vaccinators have had refresher training; 19 vaccinators have had initial training and 5 Supervisors have had refresher training.

**Strengths**

- The training for the EPI cadres is regular and the training courses well formulated
- The supervisors are motivated
- IbnSina was able to respond to a reported outbreak of measles in a district of Paktika where it is not working, by sending in a team of vaccinators to immunize the children

**Weaknesses/constraints:**

1. **General**
   - Logistical problems in Bamyan and Paktika (Mountainous areas). Roads are blocked during the winter in Bamyan and Paktika.
   - The clinic staff especially the women have no interest or notion of EPI coverage
   - The reporting is done according to the UNICEF protocols and reflects provincial coverage rather than by district. This is not representative of the organization’s work (under reporting)

2. **Related to UNICEF**
UNICEF has delayed signing EPI contracts and releasing funds, which has badly affected the program, since moneys cannot be spent if there is no guarantee of funding from UNICEF. IbnSina does not have own funding for EPI.

UNICEF sub-offices have not released funds in advance and have asked for the signatures of vaccinators in advance and expenses documents to be signed and counter signed by PEMT and WHO before releasing fund. (Ghazni and Kandahar)

WHO sub-office, Bamyan do not release funds in advance.

Supply and supervision is delayed because of the delay in the release of funds.

Incentives for vaccinators are paid late because of the delay in the release of funds. This de-motivates the vaccinators and affects the program, contributing to the decrease in coverage.

The number of teams are insufficient in Paktika (one team per district). 8 out of 18 districts have EPI teams. The districts are vast and the terrain is mountainous. The population is scattered. There are limited health facilities. The level of education of the people is very low, making it difficult to recruit vaccinators according to the formulated criteria.

Incentives for vaccinators were initially low when UNICEF took over as compared to the salaries paid them previously. It de-motivated the vaccinators and affected the program badly. It has now been raised.

There are no bicycles or transportation costs for most of the vaccinators

There are no motorcycles for supervisors

Lack of coordination between UNICEF and WHO sub-office Bamyan, causes delay in delivering the funds for EPI program. Lack of capacity of WHO sub-office Bamyan to develop proposals and manage finance.

Refusal to negotiate funds in Peshawar has contributed greatly to the work load of the Regional Directors.

UNICEF has not provided initial training for vaccinators as planned

The EPI car allocated for supervision and supply to the Ghazni REMT, is reportedly used for other non EPI purposes by the REMT/MoPH director

**Recommendations:**

**Short term**

1. Negotiations with UNICEF for prompt signing of contracts and release of funds in Peshawar/Islamabad and not in the regions.

2. Negotiations with UNICEF to provide motorcycles for supervisors and bicycles for vaccinators and transportation costs for the outreach programme.

3. Negotiate with UNICEF for the use of the mobile strategy where it is felt needed as in Paktika and Bamyan.

4. Rationalization of EPI work to be carried out by organizations in those districts where they have health facilities as decided in a recent TCC meeting but for IbnSina to continue its work in those areas where there is no other organization till such time as one is ready to continue.

5. More social mobilization to increase client uptake.

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6. Involve the clinic staff in the discussion of coverage and vaccination uptake.

**Long term**

1. Find a donor who could provide a buffer/bridging fund to cover costs such as transport for supply/supervision/mobile and salaries.

2. To report coverage in such a manner as to reflect the actual coverage in those districts where IbnSina is working.

3. To explore the possibility of sources of more accurate population figures such as other organizations and the vaccinators and community.

4. To use information such as coverage and or cost efficiency, to lobby for the strategy that IbnSina sees as optimal.

5. Increase the number of teams in difficult areas such as Paktika.

6. Train female vaccinators in each MCH clinic in order to reduce missed opportunities.

7. Provide EPI training courses to all regional staff.

**Pilot Community Based Activities**

**Background**

Community based activities were included in the project proposal and after intensive discussions at main office and regional levels, a decision was made to have initial experimental/pilot activities in Ghazni and Bamyan.

The expressed view of those HCs met and patients interviewed indicate that their perception of the clinic is that of an institution providing curative care, supplying quality drugs at reasonable costs and would like the range of services offered to be upgraded to offer more secondary care. One person did talk of the vaccination services as important preventive care. There are requests for IDA drugs (not Pakistani), clinics to be open for longer hours and the costs to remain reasonable.

**Objectives**

1. To facilitate positive changes in the knowledge, attitude and habits of the community about health so that through prevention there will be a reduction in morbidity and mortality.

2. To be able to access information directly from the communities.

**Activities**
1. A qualified and experienced community health programme supervisor was hired in February.

2. Health Committee formation - at first the situation in Ghazni or Bamyan was not stable and Health Committees were formed in Nangarhar. Health Committees (HC) have subsequently been formed in Ghazni. The HC comprises representatives of the community, authorities and the health facility. The clinic doctor along with the Regional Director contacted the authorities to discuss this strategy. They then met with key people in the community (as identified by people at the Friday mosque worship). Meetings were also held at the mosques with those who had attended. The HC was then formed. A chairman and a deputy chairman were identified by the HC.

3. The HCs were asked to identify candidates for training as Community Health Supervisors (CHS) and 2 were chosen according to formulated criteria. The CHSs will be paid workers attached to the clinics and will act as liaison persons with the community and also be the supervisors and trainers for the Village Health Volunteers (VHV).

The curricula for both cadres has been adapted from the one in use by SCA. The CHSs have received an 11 week training and have been through their qualification ceremonies.

4. Once the CHSs have been trained, they will identify VHVs along with the community and these will be trained for 2 hours per day over 10 weeks.

5. The program will be evaluated 9 months after inception.

Indicators/targets

1. To establish 11 Health Committees.
2. To train 10 CHSs.
3. To train 50 VHVs.

Achievements reported

1. 6 HCs have been formed in Nangarhar and 5 in Ghazni.
2. 10 CHSs have been trained.

Strengths

- A Community Health Supervisor has been recruited who is dedicated to this task.
- Curricula for training of cadres are in place.
- The training of the CHS was observed and was seen to be participatory
- There is a women’s’ committee in Bamyan that has been active and co-operative in mobilization for immunization

Weaknesses/constraints
• The organization has little experience of community based work at senior and middle management level
• The community is perceived at present solely as being the key players and therefore, social mobilization is on a very narrow level and more in a top down basis
• The cadre of VHYs are meant to work completely voluntarily; the world experience of the long term sustainability of this has not been good
• It is difficult, in the present political climate, to involve women in the planning for communities. This is also true of the socio-cultural norms in parts of Afghanistan but is exacerbated by the Taliban rules
• HC in Qarabagh had no clear concept of their role
• No indicators or targets have been developed to evaluate the programme. The objective to effect positive change in the KAP of the communities in health is more a goal than an objective

Recommendations:

Short term

1. Develop indicators and targets for evaluation of the programme

Long term

1. Recruit a person with community experience to guide the programme. Develop this skill within the organization through courses and study visits to projects in Pakistan or Afghanistan that do CBHC

2. Since the community based work is still experimental and a lot of it is process oriented, budgeting for this will require formulation for flexibility.

3. Define goals and objectives of community based work based on learning experience in the present programme.

4. Coordination with other organizations as to their experiences (also for the short term).

II.2. CURATIVE ACTIVITIES

General Out patients' Department (OPD)

Background

IbnSina inherited 88 health facilities from AVICEN which had been established according to the criteria defined in Project Framework for "Minimum Primary health Care Needs for Afghanistan". In the first quarter of 1997, an evaluation of these facilities showed that some, including many of the C3 facilities, in the South Western Region, were not functioning and 48 facilities were closed down.

Curative care via the general OPD is provided through the following types of facilities:
M1 1 female and 1 male doctor (also clinic head) plus health educator, pharmacist/dispenser, laboratory technician, vaccinator(s) and support staff. Many of the staff are women.

These provide care to women and children in the main but in areas where there are no facilities for men, a system where men are seen separately is worked out.

C1 1 male doctor and other male workers as above (no female health worker)

M2/C2 These have two medical staff (nurse and/or Mid Level Health Worker, MLHW) and support staff. Vaccinators may be present. All M2 clinics will have a female MD doctor and female nurse if possible (often the nurse is male).

C3 These have only one medical worker, the Basic Health Worker (BHW). The BHWs are chosen by the community and trained for 3 months. He operates from his house and also in the majority of cases is a vaccinator. In fact, many vaccinators have been given this training, rather than the other way around.

As far as possible, the staff are recruited locally. The lady doctors provide obstetric and gynaecological care including family planning and the male doctor, in addition to being clinic head, provides curative care to the women, children and the men.

Patients are registered, receive health education and the children are weighed. They are then seen by the doctors and sent for vaccination if need be. If they have come only for the vaccinations they go there directly after HE and weighing. They then go to the pharmacist or drug dispenser where they pay for the consultation and 30% of the cost of the drugs, according to the price list. A second session of health education may be held depending on the case load.

The clinics are meant to operate from 8:00 am to 1:00 p.m. The times will vary a bit with clinics starting later in the winter as patients arrive later. The clinics have operated for a half day under past governments. This policy allowed staff to work for the MoPH which could not pay good salaries in the mornings and to earn well through their private practices, in the evenings.

Objectives

Provision of curative care and other services through existing health facilities with emphasis on mothers and children.

Activities

1. Provision of paediatric services.

2. Treatment of common diseases through the general OPD and referring complicated cases for proper management to other appropriate health facilities.

3. Provision of routine laboratory services in M1/C1 type of facilities.
4. Provision of essential drugs according to a standard list.

5. Preparation of monthly reports on attendance, disease patterns, income and drug use.

6. Promotion of adequate referral procedures for complicated cases.

**Indicators/targets**

1. The minimum daily attendance in the OPD/MCH services in C1M1/C2M2/C3 will be 30/15/8 patients on an average.

2. At least 75% of the attendances are women and children under 5 years.

3. 90% of the drugs will arrive in time at the health facilities according to the timetable.

**Achievements reported**

1. 41 health facilities are operative in the four regions:
   - Ghazni: 7 M1 clinics, 1 Maternity Home
   - Kandahar: 2 M1, 2 C1, 8 C2 clinics
   - Nangarhar: 5 M1, 1 M2 clinics
   - Bamiyan: 4 M1, 1 C1, 3 C2, 7 C3 clinics

2. The average daily attendance in C1M1/C2M2 clinics is 33/20 respectively.

3. Paediatric services are offered in C1/M1 clinics by the male doctor largely, and in M2/C2 clinics by the nurse/MLHW. Growth monitoring is part of this service (has been discussed previously).

4. Common diseases are treated in the clinics and complicated cases are referred to appropriate centres where available. On the job training and refresher courses have been held to improve diagnosis and prescriptions. A green book (patient register) analysis has been done for some areas to further examine this issue.

5. 79% of the patients seen were women and children below 5 years.

6. Laboratory services are available in 8 M1 clinics.

7. A standard list of drugs has been drawn up and the supply has been regular and on time.

**Strengths**

- The staffing pattern largely matches the work load, except in the newer clinics and a few others where the staff/patient ratio seems high. Some of the busier clinics do complain about the work load versus the multitude of tasks that need to be done, e.g. the health educator in Bagrami.
The clinics are well organized, clean and tidy. Disposal of sharps, dressings etc. seems to be adequate.

A list of essential drugs has been drawn up and drugs are supplied regularly and on time.

The Regional Director in Nangarhar along with the PHC trainer had introduced a system of daily drug stock taking.

The drug stocks where checked have matched the expected amounts (spot checks).

The staff felt they had adequate support from the Regional office and the Main office.

In the clinics visited, the registers were used.

All clinics had area information and work plans on the notice boards.

The clinics had scheduled weekly meetings for discussion of some topic.

Clinic buildings visited were located in either Government buildings or were built or donated by the community.

95% of M1/C1 clinics have laboratory services and these provide quick service.

**Weaknesses/constraints**

- The clinic heads had some idea of the catchment area population and villages in the area, but the female staff especially did not know this information. All clinic staff were not aware of coverage rates either for curative care or EPI.
- The buildings are not purpose built and therefore, issues such as patient flow, waiting area space and space for health education can be problems. Where buildings are the private buildings of a member of the community, alterations are difficult and also lead to demands from the MoPH to relocate in a government building, so that it could be rehabilitated.
- Self evaluation of clinics has not been considered.
- There is still some misuse of drugs (wrong and over prescription)
- The referral system is weak; patients not referred, poor feedback from centres referred to, follow up of patients not possible
- Coordination and collaboration are not fully explored.
- The microscopes are monocular and of poor quality.

**Recommendations**

**Short term**

1. Involvement of all the staff in discussions of coverage for EPI and curative care.

2. Staffing levels to remain the same, except for the busy clinics where the health educator also has to register, weigh children, hold nutrition demonstrations and do the dressings and injections; others, such as the female vaccinators, could be asked to assist with dressings.

3. Patient flow and waiting areas need to be considered and solutions found for individual clinics. At one of the clinics, shade was provided in the summer through the HC who provided the clinic with tarpaulin.
4. A new clinic to be established in Nangarhar if feasible.

Long term

1. Construction of appropriate spaces for the clinic buildings

2. Development of self evaluation methods for the clinics.

3. Development of clinics as providing some referral care (to discuss to what level practicable/possible).

4. Development of clinic view of their role in the community; training of both male and female staff in PHC perspectives.

5. Coordinate with other organizations regarding treatment of patients diagnosed as having TB

6. Development of referral system

7. Purchase of better quality microscopes

8. The numbers of new clinics to be opened should be limited to 3 in Ghazni, 4 in Nangarhar, 1 in Bamiyan and 2 in Kandahar. 2 clinics to be upgraded in Bamiyan and Kandahar respectively.

Obstetric and Gynaecological Care

The female doctors in the MCH clinics provide Obs/gynae care to the female patients. This is both culturally appropriate and in keeping with the Taliban strictures. Recruiting of female doctors is especially problematic if there are none available in the area. Usually a couple has to be found in order for her to be able to move to the area; it would be very difficult for a single female to live alone.

As part of this service, female doctors provide antenatal and postnatal care, curative care for obs/gynae problems and general problems and family planning advice. Some clinics also have equipment for normal deliveries, and dilatation and curettage and do offer this service.

Some clinics in Nangarhar and Ghazni also provide some support to trained TBAs. The TBAs are trained to do health education in some key topics regarding pregnancy, child birth, child rearing and vaccination. They are also taught to perform clean normal deliveries.

The family planning materials at the moment is limited to condoms and the combined oral contraceptive pill (COC).

The maternity home in Ghazni is a new venture undertaken on the basis of a request from the MoPH and the coordinating body of Ghazni. It has 10 beds and a delivery room. At the moment it is not functioning for 24 hours. Normal deliveries and dilatation and curettages have been performed there. Those
requiring Caesarian sections are sent to the surgical ward. The female Afghan doctors are not allowed to perform Caesarians as the operating theater does not have female staff.

**Objectives**

1. To provide curative services and other services through existing facilities with emphasis on mothers and children

2. To recruit two female MD supervisors in order to strengthen the MCH part in areas where activities are needed.

3. To assess the possibility of giving practical training in gynaecology and obstetric cases for female health workers by supporting a referral emergency obstetric and gynaecology hospital.

**Activities**

1. Providing antenatal and postnatal care and delivery services.

2. Treatment of common diseases and referring the complicated cases for proper management to other appropriate health facilities.

3. Training of female supervisors.

4. Supply of appropriate equipment

5. Supply of essential drugs (discussed under curative care).

6. Motivation of women for their own and their children’s immunization.

**Targets and indicators**

1. At least 75% of the attendances are women and children under 5 years.

2. At least one female supervisor will have been recruited during the first phase of programme.

3. Before the end of phase 1, an assessment of the expansion of the MCH structure has taken place and a decision has been taken as to the most needed activities.

**Achievements reported**

1. 88% of attendances are women and children under 5 years.

2. Two female MD Supervisors have been recruited in Nangarhar and Ghazni respectively.

3. 19 of the 41 facilities are MCH clinics; the maternity home in Ghazni brings the number of facilities geared to the special reproductive problems of women, up to 20.
**Strengths**

- The emphasis on MCH clinics where needed and feasible, has been seen as one of IbnSina's strengths by the HCs, IbnSina staff and other organizations.
- The Maternity home in Ghazni and the women’s’ hospital in Nangarhar are accepted by authorities as places where training of women can legitimately occur. Refresher courses have been held.
- The recruitment of female supervisors with experience in obstetric and gynaecological experience facilitates the training of clinic doctors.
- Equipment and drugs are supplied on time and in sufficient quantities.
- Antenatal care and postnatal care are offered.

**Weaknesses/constraints**

- Practical obs/gynae training for the clinic doctors still remains a problem. The hospital in Nangarhar is a possibility
- The female doctors are not involved in the PHC training. They also do not generally treat the children who are treated by the male doctor.
- The family planning materials are limited. Broadening of the range should be explored with consideration of skills
- The TBAs who are supplied by the clinics have been trained under either a HealthNet initiative or WHO programme and their support and supervision have not been thought of.
- The maternity home at the moment is not productive, admitting only 30 patients a month, most of which are for D&C after incomplete abortions. Few deliveries are conducted. The staff do not cover a 24 hour shift and quote the authorities as being the obstacle. The authorities now permit this, indeed are pressurizing IbnSina to arrange 24 hour cover. The problem lies else where.
- No proper feedback after referrals.

**Recommendations**

**Short term**

1. Female doctors should be included in refresher courses that cover general medical topics and PHC as well as the male doctors.

2. Female doctors should treat children as well and be trained to do so.

3. Attempts to have the Maternity Home functioning over 24 hours should be made.

**Long term**

1. TBA training should be undertaken where possible but only after consideration of the entire process.

2. The range of family planning materials should be reviewed

3. Practical training of doctors in Peshawar or Nangarhar should be explored.
II.3. HEALTH INFORMATION SYSTEM

The Health Information System (HIS) has been developed over the past four years. The forms, registers, reporting forms and supervision checklists have been designed by IbnSina for clinic use. The EPI information is recorded and reported using the system designed by UNICEF. The information is collected via the monthly reporting forms. One copy of the forms is sent to the Main Office. Both the Main Office and the Regional HIS analysts in Ghazni, Bamyan and Kandahar enter the data into the computer system.

An analyst was employed for Nangarhar but his services had to be terminated. At present it is considered to be close enough for the Main Office to provide rapid feedback after analysis, and therefore it has the responsibility for data entry and analysis for Nangarhar.

The software used is designed for ease and simplicity of use for both entry and analysis, and has been designed using EPI 6 as the basic template. It is called the Health Information Programme 3 (HIP3).

The forms used are:
- Patient register
- Family card
- Family Patient card
- OPD Register
- MCH Register
- Antenatal and postnatal cards
- Growth charts
- Nutrition tally sheet and monthly report form
- OPD tally sheet & monthly disease form
- HE tally sheet and monthly form
- MCH tally sheet and monthly form
- Laboratory register
- Laboratory monthly report form
- Drug dispensing register
- Drugs monthly report form
- Dressing room/injections register
- Monthly supervisory checklist (for the Regional offices)
- Monthly HIS summary report

Objective

To strengthen the HIS and make a step towards developing a Health Management Information System.

Activities

1. To recruit a HIS analyst for the Main Office and for the South West Region.

2. To supervise all regional HIS analysts by the Main Office.
3. To conduct health related surveys for improvement of the management of the programme.

**Indicators/targets**

1. All regions will at least be visited once by the HIS analyst from the Main Office.
2. 1 formal training for HIS analysts will take place.
3. At least 3 different kinds of surveys will be conducted during the programme period.

**Achievements reported**

1. HIS analysts for Kandahar, Ghazni and Bamyan have been recruited and are in place after training at the Main Office.
2. A search for a surveyor has been ongoing but unsuccessful so far.
3. A HIS summary sheet has been developed in order to facilitate the analysis and use of clinic data at regional level.
4. Nangarhar has been visited by the Main Office HIS officer 3 times and Ghazni and Kandahar have been visited once. The visit to Bamyan had to be canceled due to political insecurity.
5. A formal 22 day course was conducted internally for the regional HIS officers.
6. The Regional Directors and other staff from the regions took part in a 2 ½ day training session on HIS as part of a management course.

**Strengths**

1. The system has been designed and is in use after training of staff.
2. The clinic staff find no difficulty in the use of the various forms.
3. The placing of regional analysts makes feedback quicker.
4. The system has been adopted by the International Federation of the Red Cross Societies; SCA is also interested. This will make inter organizational comparison of data easier.
5. The software for data entry and analysis is user friendly.
6. IbnSina will join a task force by UNICEF/WHO to further explore the possibilities of developing a national HIS for Afghanistan.

**Weaknesses/constraints**

1. The referral system needs further development.
2. The software is DOS based and many organizations use Microsoft Excel for data entry in the field. This might prove a stumbling block to universal adoption.

3. The lack of a surveyor/survey skills hampers the undertaking of special studies etc.

4. The difficulty of recruiting a surveyor weakens IbnSina’s ability to do special studies.

5. WHO has advised MoPH of a HIS system that is ill considered. It might create some difficulties for the consideration of HIP3 as a nation wide programme. In Nangarhar, IbnSina is required to use both MoPH forms as well as its own and submit these to MoPH. This increases the work load pointlessly, since no further use of this data is made.

6. Lack of organizational epidemiological skills and non-availability of courses in the region to date.

7. The computers in the field are slow and old; they are not standardized.

8. The information available is not optimally utilized.

9. The HIS officer feels that his job description and role do not allow for quick decisions and actions taken upon identification of problems that are highlighted by HIS.

10. The step from HIS to HMIS is not clearly envisioned.

Recommendations

Short term

1. Training for epidemiological skills for HIS officer.

2. Completion of referral system.

3. Recruitment of surveyor.

Long term

1. Standardization of hardware.

2. Lobbying for national HIS system.

3. Exploration of ways and means in which the organization can fully utilize the information used.

4. Discuss and define what is meant by HMIS.

III. PRIMARY HEALTH CARE STRATEGY
IbnSina was formed as an organization whose specialty would be to deliver PHC to the people of Afghanistan, concentrating on the lower level of the pyramid. Various aspects were considered vital to the way in which its strategy would assist in the building of a sound health system in Afghanistan.

Community Participation

At present, IbnSina when establishing a new clinic, asks that it be located if possible in a government building. If not, the community is approached to donate a building or build one. This has been successful. Some rehabilitation is carried out by IbnSina if needed.

Community participation is also sought in the demonstration gardens. The community is asked to donate land and labour. There have been successes only in two sites.

Health Committees have been set up through which community participation and IbnSina’s participation in the community is sought to be increased.

Strengths

- Some community participation is ongoing and contributes to the sustainability of the programme. It also creates a certain feeling of ownership.
- The establishment of HCs can increase dialogue with the communities

Weaknesses

- Key players rather than communities are approached in the setting up of HCs.
- Understanding of what the IbnSina seeks as community participation is not uniform.
- Communities are not involved in the planning, implementation and evaluation of the project.

Recommendations

Short term

1. To develop guidelines of what is sought in terms for community participation; the following were seen as guidelines for new clinic choices:
   - The community must make a written request for a clinic that is signed by the shuras, elders and also the authorities
   - IbnSina will also assess the needs and feasibility of setting up a clinic.
   - the building should ideally be a government one. If not, IbnSina should ask the community for a three room structure.
   - If the structure needs rehabilitation, the community should be approached for 100% of the costs or materials. If this is not possible, a minimum of 50% of the costs/materials should be asked for.
   - If a building is to be constructed, land should be provided by the authorities or the community.
   - The maintenance of the building will be IbnSina’s responsibility

These guidelines should be developed in the short term but be included in the next programme.
Long term

1. Community participation at the present is considered as the donation of materials or land to the health structure. It should also include ways in which the community participates in the planning, implementation and evaluation of health work. This concept needs to be broadened.

2. Further recommendations have been made in the section on the pilot community based projects.

Gender

Traditionally, the gender roles in Afghanistan dictate that women play an important role in the domestic sphere with the men making important decisions. Men are the bread winners. The social spheres are distinctly separate and women socialize generally within the family circle. Before the Jihad, education and work opportunities were altering this situation in the big cities. Under the mujahid the situation reverted to the previous norms. With the Taliban, restrictive rules governing the operation of women outside the home have emerged. This makes it difficult for women to work. The health sector is comparatively liberal but movement of women without a male family member is not permitted. The rules vary in areas and regions.

Gender issues in Afghanistan, seemingly, are mostly about the provision of opportunities for women. However, men are also deprived by circumstance, if not by law, of economic, educational and developmental opportunities. Working with women without the sanction of their men and the community would be a self defeating exercise.

Beneficiaries

The programme lays an emphasis on health care for women and children. 88% of clinic attendances are of women and children. As far as community participation in programme planning etc. is concerned, the current political climate and socio-cultural norms make it difficult to include women in joint meetings. However, there was an existing women’s’ shura in Bamyan that has co-operated in vaccination work.

Men are usually not seen at MCH clinics but in areas where there is no other health facility, IbnSina makes a special effort to provide care for men; after the women are seen, or with separate entrances etc. in order to comply with Taliban restrictions.

Staff

59 of 215 staff are female. Most of these are field staff since many of the clinics are MCH units. There are two supervisors who are part of the middle management. The Technical Manager since 1995 has been and expat female. She will be replaced by a female expat in the post of Technical Advisor. MEMISA had been unable to recruit a female for the post and upon suggestion that a male be considered, IbnSina had insisted that this post be strictly for a female. There is one Afghan female staff at the Main Office who is not part of the management. A previous attempt was made to include a
woman at middle management at Main Office level. Her role had not been sufficiently developed and resulted in her working only for 50% of the time, and her services were terminated.

It would be difficult to employ women in roles where they might need to liaise with authorities or with the HCs. The arrangement of travel for Afghan women inside Afghanistan can be very complicated as it involves a chaperone and considerations of appropriate seating space etc.

The fact that women are not represented equally in senior and middle management raises two issues
• the perspective of the programme may be biased towards a male one.
• The fact that women are not allowed in to the Regional offices means that they are not included in the discussions regarding work.

The female staff of the clinics had little idea of the catchment area, coverages etc.; indicating an exclusion from the management perspective of health.

**Recommendations**

*Short term*

1. Female staff should be included in PHC management training/discussions.

2. The organization should consider ways of including the female supervisors in the discussion and thinking processes e.g.
   - regular study sessions in Peshawar
   - exercises such as green book analysis and obs/gynae registers in the maternity home in Ghazni or the home of the supervisor in Nangarhar.

*Long term*

1. Explore ways of including women at community level

2. Actively look for female staff at middle and senior management levels should there be real and full roles for them

**Coordination and cooperation**

All regions have coordinating bodies which comprise the MoPH and representatives from the UN and NGO organizations working in the area. In Peshawar, IbnSina is a member of ACBAR (Agency Coordinating Body for Afghan Relief); ANCB (Afghan NGO Coordinating Body); the TCC (Technical Coordination Committee). IbnSina is also a member of the Afghanistan Programming Board for Common Programming which will have responsibility to recommend programme priorities. Membership to the APB was done through a rigorous selection process by peer NGO representatives.

**Strengths**
• IbnSina is well represented at regional level and in Peshawar/Islamabad in the various fora.
• Should another NGO operate a clinic in an area, IbnSina by policy, will not start one in the area; avoiding duplication and a wasteful use of resources.
• Collaboration in some projects such as the kitchen garden as part of the larger agricultural project with Solidarite and HABITAT in Bamyan as part of a joint planning and implementation
• In other regions, TBA training and a food supplementation programme in coordination with and funded by UN agencies
• MoPH and other organizations expressed satisfaction with IbnSina’s co-operation and co-ordination with them.

Weaknesses/constraints

• TBA training undertaken in the name of coordination but without consideration of follow up or support
• There is little sharing of experiences or knowledge of other work at field and regional levels

Recommendations

Short term

1. Active sharing of other experiences at the field and regional levels.

2. Not to undertake programmes that are not well considered but may be part of another organizations planning.

3. Contact with other organizations to exchange experiences and maybe to cooperate in future activities.

Long term

1. Explore ways in which IbnSina might be able to work with organizations that have skills in fields that IbnSina does not e.g. construction, agriculture and watsan.

Capacity Building

IbnSina seeks to provide regular training, according to needs, to all its staff. A training schedule has been drawn up. Plans have been made for supervision and evaluation. It plans to use the courses and resources of regional organizations. It in turn, has opened its own training courses to other organizations.

Most of the field training has been done according to schedule. Some of the senior managers have been unable to attend planned courses because the course have been either canceled or staff have not been able to take time off. The Director General was denied a visa to a country where a study visit had been arranged (general problem for Afghan nationals).
The following training needs have been requested by the staff themselves:

<table>
<thead>
<tr>
<th>Position</th>
<th>Training Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director General</td>
<td>Health Planning and Management</td>
</tr>
<tr>
<td>Senior Technical staff</td>
<td>Management, report writing, MCH, TOT/TOF</td>
</tr>
<tr>
<td>HIS officer</td>
<td>Epidemiology</td>
</tr>
<tr>
<td>Finance/operations</td>
<td>Finance and Management</td>
</tr>
<tr>
<td>Regional staff</td>
<td>PHC management, computer, English</td>
</tr>
<tr>
<td>Field staff</td>
<td>Technical training (especially practical)</td>
</tr>
</tbody>
</table>

The following skills gaps are present at the Main office/organization:

- Community based health care
- MCH
- Report writing and proposal writing (to a degree). This gap is problem in the second tier of management; the first tier having the capacity to undertake this task.

**Recommendations**

**Short term**

1. Senior staff for the course run by the Aga Khan Foundation, Karachi for epidemiology, community based work and PHC management

2. 4 senior staff and 1 regional staff for courses at the Pakistan Institute of Management.

3. To use the skills of the MEMISA finance officer for help with financial and budgetary issues.

4. Search for possible courses for the DG in the UK, Holland, USA. Length of course will be an issue, 3 months being the maximum time he could be away.

5. Recruit deputy technical manager.

6. Use of local organizations such as the Pakistan Family Planning association, Pakistan Red Crescent for training of female staff.

7. Training input from MEMISA for planning and management for Main Office and Regional staff.

**Long term**

1. Replacement for the Financial coordinator, if needed.

2. Back up staff for key positions if needed.

3. Health planning and management courses for senior and middle management.

4. Explore ways in which IbnSina can contribute to national capacity building.
Cost effectiveness

IbnSina attempts to keep costs down in various ways in order to be more cost effective. It uses largely Afghan staff, procures drugs locally and maintaining low cost facilities. The costs per patient has been calculated to be a little over $2.00 if all costs are accounted for.

However, measures of cost effectively are complex and no measure of this is available. Cost and effectiveness have been addressed by the following:

- **Choice of technology:** The medical technology is low cost and effective. The computer hardware is relatively low tech but needs standardization. The lack of communications systems hampers communications between the Main Office and the Regions and reduces efficiency and effectiveness.

- **An essential drugs list is drawn up**

- **Work is ongoing with diagnosis and prescription patterns**

- **Staff are selected according to set criteria, tested and interviewed. The staffing pattern seems appropriate. However, there is lack of coverage at community level and the appropriate cadre of worker is yet to be developed. Experience has not been good with the Basic Health Worker category which are all service based workers.**

- **Health facilities at the district level treat for common diseases. They do not provide adequate coverage. The logistical problems in Afghanistan make them difficult to access for those people who live further away**

**Recommendations**

**Short Term**

1. Explore ways to increase the collaboration with other organizations e.g. SCA

**Long term**

1. Plan for communications equipment in the next programme.

2. Explore ways to improve coverage and access.

3. Train staff especially at field level
Sustainability

IbnSina works towards sustainability by the following:

1. Using largely Afghan staff
2. Cost recovery on drugs.
3. Capacity building of staff.
4. Working where possible within national and international guidelines.
5. It aims to contribute, if possible, to national capacity building.
6. Pilot community based activities to explore ways in which it can enter capacity building at a community level.

Recommendations

Long term

1. The donors would like to see the cost recovery on drugs go up from 30%. As this will affect affordability and consequently, equity, a price rise for drugs should be thought of with the following in mind: policies of other organizations, time period and community opinions.

2. The development of IbnSina’s role in the provision of training at community level, inter organizationally and nationally.

IV. IBNSINA, THE ORGANISATION

IV.1. Organogram

The organization comprises:

1. The Board of Trustees
2. The Main Office (Main Office)
3. Regional offices
4. Clinics, C3 facilities, EPI teams

The organogram can be seen as Annex 3.
The board is responsible for the policy, ensuring fiscal transparency and accountability to its donors, appointing the Director General and electing new members.

The Director General has ultimate executive authority and responsibility for the organization’s work and is accountable to the board. He is assisted in his work by the Assistant to the Director and a Secretary.

The management team is the body where all the branches of the organization discuss and decide upon operational, strategic, financial and technical issues with the DG having the last word.

The Regional offices are responsible for the implementation of the programme in the field and the Regional Directors are the line managers, assisted by the Main Office staff. They are assisted by the supervisory staff in the management, training, and supervision of the clinic staff.

At clinic level, the male doctor is the clinic head and is meant to be responsible for clinic administration and organization and liaison with the HCs and the community.

IV.2. Operational Management

The Operations Department has 2 key staff and 3 junior staff. The Assistant Operations Manager is responsible for the greater part of the operations work in the field. The roles of the junior staff are not formally described.

The operations department is responsible for the following functions:

1. Participation in the Management Team.
   The relevant operational issues, problem are raised for discussion and decision

   2a. Office administration for Main office and supervision of office administration for Regions
   - rental and maintenance of premises
   - office equipment and stationery
   - management of office staff
   - general official correspondence

   2b. Inventories of Main Office and regional offices

2. Personnel Management

   2a. Personnel files and staff list (updated monthly)

   2b. Recruitment of personnel as described in the rules and regulations as outlined below.
   - Job announcement for a vacant position.
   - Short list of suitable candidates and fixing the date of interviews.
   - Interview with members of the Management Team.
   - Approval of Director General for appointment.
   - Job description along with related documents.
In the Regions, the procedure is as below:
• Job announcement
• Interview through Regional Director, one Technical officer and Administrator.
• A letter of request for the appointment is set to the MO.
• This is further processed through the Operations Department.

2c. Termination of personnel as per rules and regulations, procedures as below.
• One month notice for poor achievements.
• One month’s salary for immediate termination.

3. Logistics.

3a. Vehicle management
• Vehicle maintenance and purchase for Main Office and major repairs for Regional vehicles
• Registration and renewal of registration of cars

3b. Purchasing

3b. Supplies of drugs and equipment to Afghanistan (using SCA permits as IbnSina is not registered in Pakistan). Organization of transport of cash to the field.

3c. Responsible for organization of IbnSina staff missions to Afghanistan, by road and air (ICRC)

4. Representation with Pakistan and Afghan authorities in Pakistan and Regions especially Kabul
• Afghan Consulate (visas etc.)
• Afghan Foreign Ministry
• Afghan Ministry of Planning
• Commissionerate for Afghan Affairs
• Pakistan Interior Ministry

4. Security
• Security of Main and Regional offices.
• Security of staff members on their missions to Afghanistan, especially of expatriates.

5. Communications
• Establishment and managing communications with Regional offices.

Previously, regular contacts with Kandahar, Ghazni, Bamyan were conducted through radio call sets, using AVICEN’S radio permits. The Pakistan Government asks for registration with the Taliban authorities before registration with Pakistan can be obtained; this is necessary for obtaining radio permits allowing radios to be installed and used in Pakistan.

Direct communications between Main Office and the Regions are at present limited to:
• Through telephones with Nangarhar, Kandahar and Kabul (has to be done via the telephone office and is time consuming)
With Ghazni, through SCA’s radio set and email system
With Kandahar, through UNICEF sub office’s fax system
With Bamyan, through the radio sets of HABITAT and Solidarite.
Sending messengers to and from the regions

IbnSina inherited radio sets from AVICEN and bought a set from DHSA. Nangarhar and Kandahar have radio sets but these have only recently been permitted to be used by the Taliban. The radio set in Bamyan has been stolen and this issue is being investigated.

Strengths

- The department feels that the work is well within its capacity and capability
- Salaries, drugs and equipment are supplied regularly and according to schedule

Weaknesses/Constraints

- Blockade of the roads to Hazarajat caused a delay in transportation for 4 to 5 months. This affected work in Bamyan Region seriously.
- Lack of regular communication system. Radio call sets are military equipment, whose use needs Afghanistan and Pakistan permission. Radio transmission can be interfered with or stopped by both governments.
- Lack of central administration in Afghanistan. This causes many delays in programme implementation. Also, in case a problem requires the intercession of authorities, matters have to be sorted through personal influence rather than proper channels.
- No registration with governments of Afghanistan and Pakistan. Registration with the Afghan (Taliban) authorities is under process. Registration will facilitate some affairs. IbnSina has been waiting to proceed through ACBAR to allow for a coordinated NGO response.
- The vehicles at the Main Office are old and require a lot of maintenance. In addition to this, one more vehicle than there are at present would be optimal
- Task delegation and departmental structure may need to be examined.
- Complaints about general employment conditions e.g. pensions

IV.3 Financial Management

Finance Department consists of six team members:

<table>
<thead>
<tr>
<th>POSITION</th>
<th>MAIN TASKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Finance Coordinator</td>
<td>(Budgets and proposals and liaison with the donors)</td>
</tr>
<tr>
<td>2. Finance Manager</td>
<td>(Financial reporting and looking after the finance department)</td>
</tr>
<tr>
<td>3. Assistant Finance Manager</td>
<td>(Assisting Finance manager and data entry for Main office)</td>
</tr>
<tr>
<td>4. Senior Accountant</td>
<td>(Data checking and entering for regional offices)</td>
</tr>
<tr>
<td>5. Accountant</td>
<td>(Classification of all expenses according to the account chart)</td>
</tr>
<tr>
<td>6. Cashier</td>
<td>(Dealing with the cash)</td>
</tr>
</tbody>
</table>

Every member of the team has his own job description according to which routine work is carried out. Financial Procedures have been classified in two sections i.e. Main Office and Regional Offices. The Main Office procedures are described as major activities in the Finance Department e.g. receipts of funds, payment of expenses, recording of financial data and financial reporting.
The Finance Coordinator has left the organization and the Finance Manager will take on his duties.

MAIN OFFICE FINANCE

1. RECEIPTS OF FUNDS
A quarterly request for the funds is submitted to the donors according to the budget. Funds are transferred to our bank account on request. These funds are accounted for in the books on receipt of credit advice from the bank and an acknowledgment is sent to the donor for receipts of funds.

2. PAYMENTS
Money for the office running is withdrawn from the bank on a weekly basis. A plan is prepared for money requirements for the office and is withdrawn from the bank. Procedures for the major types of payments are briefly described:

Salaries
Salaries are paid according to a monthly payroll which is checked and revised every month. The payroll is approved by the Director General and is checked by the Finance Manager. After the salaries are paid, a formal payment voucher is prepared and filed for data entry.

Advances
Advances against salary are restricted to the extent of one month’s salary while advances for purchases and missions are paid after estimation of the costs involve thereof. An advance of Rs. 2,000/- is given to the procurement in-charge who makes routine purchases as per departmental requisitions; he settles his advance on a daily basis.

Purchases
Purchases are initiated by the operation department. The operation department receives a request from the concerned department and makes a plan for purchases. If the cost of items is equal to or more than Rs. 5,000/-, then quotations are obtained from the market. The proposal for purchases along with the quotations is submitted to the Director General for approval. After approval, the item is purchased and the bill is submitted to finance department from where payment is made after a formal voucher form is prepared.

Mission costs
Missions going inside Afghanistan for different tasks incur expenses during their mission. These mission costs are paid after they submit a report of their activity and expenses. This mission report is checked and verified by departmental heads. Usually an advance for the mission is extended to the mission in-charge before the mission and this advance is settled after the completion of the mission.

Other expenses
All other expenses such as fuel, stationery, postage, utilities etc. are routed through the operations department and paid by the procurement in-charge.

Approving authorities for bills and expenses are:

Bills for up to Rs. 1,000/- can be approved by Finance Manager or Operation Manager.
Bills for up to Rs.5,000/- can be approved by Finance Coordinator. Bills for more than Rs.5,000/- are approved by Director General.

3. RECORDING
After all payments are made, all vouchers are entered in the cash book by the cashier and filed. The vouchers are then classified according to account and budget lines. These classified vouchers are then re-entered on the computer records, using the PAM (Project Accounts Management) software. PAM is a multi-currency, multi-donor and multi-project system. The package enables the classification of expenses in three modes viz. account heads, donors and projects.

4. REPORTING
For reporting purpose, the computer records are used as the main source of information. These reports are adapted to the donor’s requirement and added with necessary narrative information and submitted to the donor.

5. FILING
After the data are entered in the PAM, the voucher files are arranged in a current record shelf. All the finance record is maintained in chronological order. Main office monthly files are subdivided for the separate currencies. Different currencies have different serials for identification purpose.

REGIONAL FINANCE
Regional finance is the second section of financial activity. There is a cashier in each region who takes care of the region’s finance. He makes vouchers for all receipts and payments of the region. The vouchers are entered in the cash book which is maintained at each region. At the month end, all the vouchers are sent to the Main Office. The vouchers from the region are checked and classified in the Main Office and finally entered on to the computer files. The regional vouchers are separately filed in chronological order.

Strengths
- The finance department has made every attempt to ensure financial accountability and transparency. Vouchers are scrutinized at Regional and Main office levels and purchasing undertaken after appropriate checks. External audits have been conducted recently by both donors and a specialist firm; these have been largely favorable with some recommendations which are to be implemented.
- Salaries are paid on time.
- Reports are drawn up and submitted according to schedule.

Weaknesses
- The Regional Directors have responsibility for approval of Regional payments and purchases; they need some procedural and financial orientation before they assume their posts.
- The Regional cashiers need regular training so that their submission of vouchers and reporting is uniform and of the required standard

Recommendations

Short Term
1. The Regional Directors should have financial and procedural orientation before they take up posts.

2. The Regional cashiers should have regular training in accounts preparation.

3. Back stopping for financial manager from MEMISA.

IV.4 Supervision and Monitoring

At the Main Office, each Department plans and is responsible for the supervision of its department activities in the Main Office, Regional offices and at clinic level. The regional offices in turn plan the clinic supervision schedule according to their manpower capacity and the differing logistical situations. The schedule for supervision and monitoring has been drawn up and has been submitted in the work plan for programme implementation.

At Regional level, the female supervisors and the male PHC supervisor/trainer and the EPI supervisors have direct responsibility for field supervision.

Strengths

- Supervision and monitoring is a planned activity and a work plan for it has been drawn up.
- The supervisory visits have largely taken place according to schedule
- Supervision and monitoring have resulted in corrective action

The monitoring of drug use is an ongoing and important issue as drugs constitute 20% of the budget. Drugs are procured in Pakistan with strict attention to quality and shelf life. They are then forwarded to the Regions who are responsible for their distribution and supervision.

Weaknesses/constraints

- The female supervisors are sometimes limited in their activities because of the Taliban rules. They need to be accompanied by their husbands who may not be free to accompany them at all times.
- The supervision and monitoring of drugs is important and the Main Office pharmacist is stretched too thin trying to improve the use of drugs

Recommendations

Short Term

1. One other person be recruited to strengthen the supervision and monitoring of drugs

Appropriateness of the Organization

The organization is well structured and reporting lines and responsibility are clearly delineated and understood for the most part. The post of Finance coordinator falls vacant and it remains to be seen whether this post needs to be filled or not.
Technically, IbnSina has the capacity to implement the programme. The gaps in its capacity have been mentioned before:

- MCH and community based work skills
- Report writing and proposal writing skills at the second tier of management (as felt by staff)

However, the organization has a sound grasp of the programme formulation process.

Financially, the organization is committed to accountability and transparency and has put in place the necessary systems. It has the capacity to develop budgets along with the technical department.

IbnSina endeavors to keep its programme low cost and cost effective. The technology is low cost and appropriate to skill levels, the staff are mostly Afghan, there is an emphasis on capacity building through training, supervision and support and facilities are located in government or community buildings.

The Director General is committed to the organization and its work. The staff are equally committed to the concept of an Afghan organization in the service of Afghans, to the concept of PHC and to excellence.

It has made remarkable progress and achieved recognition for this after the demise of AVICEN, whose history impacted on the credibility of IbnSina.

Recommendations for change within the organization have been made under various sections, viz: capacity building, financial management and supervision and monitoring.

V. FUTURE STRATEGIES

V.1. Future Policy of IbnSina

The goals, policy and strategy of IbnSina have been outlined in the constitution of the organization. The goals are:

- improvement of the health status of the population of Afghanistan by contributing to the rehabilitation and reconstruction of the health system
- facilitation of the repatriation of refugees by its contribution in the reconstruction and rehabilitation of the health system in Afghanistan
- provision of health care to the Afghan refugee population in Pakistan

The policy and strategy are to:
• select interventions which are:
  1. sustainable in the future
  2. affordable by the Afghan people
  3. accessible and acceptable to the people
  4. cost effective in order that it may be taken over by the MoPH in the future

• work without any political, religious and ethnic considerations
• work in close cooperation with the national/regional authorities in Afghanistan
• be a non-profit organization working solely in the provision of health care, rehabilitation of the health system and relief activities. Any income shall be used for these activities.
• seek for and stimulate community participation/involvement where possible
• work in close cooperation with international aid organizations and (inter)national NGOs working in the field of public health
• work both in relief and development activities

Handing over to the MoPH has consequences for issues such as salaries to clinic staff, approval by MoPH of staff and enrollment of staff on MoPH pay rolls etc. The board needs to consider the horizon at which it is looking for IbnSina to continue working as an NGO.

It also needs to enter a strategic discussion of how it can help safeguard IbnSina’s needs based work as against work that is too donor driven.

Recommendations

Short and long term

1. The board should enter a discussion of the present policy and strategy and review in light of the 2 years of experience IbnSina has garnered and lessons learned.

V.2. (Common ) Programming for next programme

The donor community for Afghanistan sees that funding will be for a planned response to a integrated district/province development. Given that IbnSina’s capacity is in the provision of health care, during the planning process, thought needs to be given to whether and how it can approach other organizations in its area to work together in a complementary fashion.

This is easier said than done, since organizations have different mandates, vision of appropriate methods and costs and different funding and programme cycles.

Given the current donor climate, this issue should be considered seriously but the essential drive should be IbnSina’s own vision.
V.3. Funding opportunities

The board should actively seek to widen its funding base, in the interests of the sustainability of the organization and the programme.

Certain sections of the programme, as in the EPI section and the community based projects could be funded through other donors.

Multi donor funding will place a huge reporting burden on IbnSina and this should be part of the equation when funding is considered.

VI. SUMMARY OF RECOMMENDATIONS

Programme Activities

Health Education

Short term (till June 1999)

1. Involve through training the PHC trainers and female supervisors in the supervision and support of the health educators

2. To complete the construction of those wells and latrines that are deemed possible. It was felt that it would be possible to construct 11 of the 20 latrines planned and 9 wells, though only 7 had been planned and budgeted.

3. To continue with the existing kitchen garden support but explore the need in areas where people have their own gardens and do grow vegetables etc.

4. If funds are available to recruit female health educators for C1/C2 clinics
Long term (next programme)

1. Develop impact indicators
2. Explore the possibility of health education in schools and in the community
3. Develop organizational commitment to the use of good sanitation and water
4. Involve other NGOs in the construction of wells and latrines after appropriate discussions of cost of the same.

Water and Sanitation

Short term

1. To complete the construction of those wells and latrines that are deemed possible. It was felt that it would be possible to construct 11 of the 20 latrines planned and 9 wells, though only 7 had been planned. Completion of the planned 7 latrines by May 99 should be the objective with the remaining 2 carried on to the next programme.
2. To construct model latrines in the Ghazni regional office
3. To ensure that all project offices and clinics have safe drinking water and sanitary facilities.
4. Consideration of which type of latrine would be sustainable, and which if any other NGO would be involved in their construction

Long term

1. Develop organizational commitment to the use of good sanitation and water
2. Explore the possibility of other NGOs being involved in the construction of wells and latrines
3. Personal change in the staff should be part of the training intention.

Nutrition/Growth Monitoring

Short term

1. Training to ensure good use of growth monitoring; use of the Afghan calendar months on the growth charts
2. Explore ways in which this could be expanded into the community and mothers could be involved with the weighing of their children
3. Develop targets and indicators

Long term

1. Define the purpose for which growth monitoring is used; preventive and promotive or curative
2. Assess the benefit or otherwise of this activity in light of the world experience
**EPI**

**Short term**

1. Negotiations with UNICEF for prompt signing of contracts and release of funds in Peshawar/Islamabad and not in the regions.
2. Negotiations with UNICEF to provide motorcycles for supervisors and bicycles for vaccinators and transportation costs for the outreach programme.
3. Negotiate with UNICEF for the use of the mobile strategy where it is felt needed as in Paktika and Bamiyan.
4. Rationalization of EPI work to be carried out by organizations in those districts where they have health facilities as decided in a recent TCC meeting but for IbnSina to continue its work in those areas where there is no other organization till such time as one is ready to continue.
5. More social mobilization to increase client uptake.
6. Involve the clinic staff in the discussion of coverage and vaccination uptake.

**Long term**

1. Find a donor who could provide a buffer/bridging fund to cover costs such as transport for supply/supervision/mobile and salaries.
2. To report coverage in such a manner as to reflect the actual coverage in those districts where IbnSina is working.
3. To explore the possibility of sources of more accurate population figures such as other organizations and the vaccinators and community.
4. To use information such as coverage and or cost efficiency, to lobby for the strategy that IbnSina sees as optimal.
5. Increase the number of teams in difficult areas such as Paktika.
6. Train female vaccinators in each MCH clinic in order to reduce missed opportunities.
7. Provide EPI training courses to all regional staff.

**Pilot Community Based Projects**

**Short term**

1. Develop indicators and targets for evaluation of the programme

**Long term**

1. Recruit a person with community experience to guide the programme. Develop this skill within the organization through courses and study visits to projects in Pakistan or Afghanistan that do CBHC.
2. Since the community based work is still experimental and a lot of it is process oriented, budgeting for this will require formulation for flexibility.
3. Define goals and objectives of community based work based on learning experience in the present programme.
4. Coordination with other organizations as to their experiences (also for the short term).

**General OPD Services**

**Short term**

1. Involvement of all the staff in discussions of coverage for EPI and curative care.
2. Staffing levels to remain the same, except for the busy clinics where the health educator also has to register, weigh children, hold nutrition demonstrations and do the dressings and injections; others, such as the female vaccinators, could be asked to assist with dressings.
3. Patient flow and waiting areas need to be considered and solutions found for individual clinics. At one of the clinics, shade was provided in the summer through the HC who provided the clinic with tarpaulin.

**Long term**

1. Construction of appropriate spaces for the clinic buildings
2. Development of self evaluation methods for the clinics.
3. Development of clinics as providing some referral care (to discuss to what level practicable/possible).
4. Development of clinic view of their role in the community; training of both male and female staff in PHC perspectives.
5. Coordinate with other organizations regarding treatment of patients diagnosed as having TB
6. Development of referral system
7. Purchase of better quality microscopes

**Obstetric and Gynaecological Services**

**Short term**

1. Female doctors should be included in refresher courses that cover general medical topics and PHC as well as the male doctors.
2. Female doctors should treat children as well and be trained to do so.
3. Attempts to have the Maternity Home functioning over 24 hours should be made.

**Long term**

1. TBA training should be undertaken where possible but only after consideration of the entire process.
2. The range of family planning materials should be reviewed
3. Practical training of doctors in Peshawar or Nangarhar should be explored.

**HIS**

**Short term**

1. Training for epidemiological skills for HIS officer.
2. Completion of referral system.
3. Recruitment of surveyor.

Long term

1. Standardization of hardware.
2. Lobbying for national HIS system.
3. Exploration of ways and means in which the organization can fully utilize the information used.
4. Discuss and define what is meant by HMIS.

Aspects of the PHC Programme

Community Participation

Short term

1. To develop guidelines of what is sought in terms for community participation; the following were seen as guidelines for new clinic choices:
   - The community must make a written request for a clinic that is signed by the shuras, elders and also the authorities
   - IbnSina will also assess the needs and feasibility of setting up a clinic.
   - The building should ideally be a government one. If not, IbnSina should ask the community for a three room structure.
   - If the structure needs rehabilitation, the community should be approached for 100% of the costs or materials. If this is not possible, a minimum of 50% of the costs/materials should be asked for.
   - If a building is to be constructed, land should be provided by the authorities or the community.
   - The maintenance of the building will be IbnSina’s responsibility

These guidelines should be developed in the short term but be included in the next programme.

Long term

1. Community participation at the present is considered as the donation of materials or land to the health structure. It should also include ways in which the community participates in the planning, implementation and evaluation of health work. This concept needs to be broadened.
2. Further recommendations have been made in the section on the pilot community based projects.

Gender

Short term

1. Female staff should be included in PHC management training/discussions.
2. The organization should consider ways of including the female supervisors in the discussion and thinking processes e.g.
   - regular study sessions in Peshawar
   - exercises such as green book analysis and obs/gynae registers in the maternity home in Ghazni or the home of the supervisor in Nangarhar.
Long term

1. Explore ways of including women at community level
2. Actively look for female staff at middle and senior management levels should there be real and full roles for them

Coordination and Cooperation

Short term

1. Active sharing of other experiences at the field and regional levels.
2. Not to undertake programmes that are not well considered but may be part of another organizations planning.
3. Contact with other organizations to exchange experiences and maybe to cooperate in future activities.

Long term

1. Explore ways in which IbnSina might be able to work with organizations that have skills in fields that IbnSina does not e.g. construction, agriculture and watsan.

Capacity Building

Short term

1. Senior staff for the course run by the Aga Khan Foundation, Karachi for epidemiology, community based work and PHC management
2. 4 senior staff and 1 regional staff for courses at the Pakistan Institute of Management.
3. To use the skills of the MEMISA finance officer for help with financial and budgetary issues.
4. Search for possible courses for the DG in the UK, India, Holland, USA. Length of course will be an issue, 3 months being the maximum time he could be away.
5. Recruit deputy technical manager.
6. Use of local organizations such as the Pakistan Family Planning association, Pakistan Red Crescent for training of female staff.
7. Training input from MEMISA for planning and management for Main Office and Regional staff.

Long term

1. Replacement for the Financial coordinator, if needed (see under financial management)
2. Back up staff for key positions if needed.
3. Health planning and management courses for senior and middle management.
4. Explore ways in which IbnSina can contribute to national capacity building.

Cost Effectiveness

Short Term
1. Explore ways to increase the collaboration with other organizations e.g. SCA

Long term
1. Plan for communications equipment in the next programme.
2. Explore ways to improve coverage and access.
3. Train staff especially at field level

Sustainability

Long term
1. The donors would like to see the cost recovery on drugs go up from 30%. As this will affect affordability and consequently, equity, a price rise for drugs should be thought of with the following in mind: policies of other organizations, time period and community opinions.
2. The development of IbnSina’s role in the provision of training at community level, inter-organizationally and nationally.

The Organization

Financial Management
1. The Regional Directors should have financial and procedural orientation before they take up posts.
2. The Regional cashiers should have regular training in accounts preparation.
3. Back stopping for financial manager from MEMISA.

Supervision and monitoring
Short Term
1. One other person be recruited to strengthen the supervision and monitoring of drugs

Future Policy of IbnSina

Short and long term
1. The board should enter a discussion of the present policy and strategy and review in light of the 2 years of experience IbnSina has garnered and lessons learned.
2. During the planning process, thought needs to be given to whether and how it can approach other organizations in its area to work together in a complementary fashion.
3. The board should actively seek to widen its funding base, in the interests of the sustainability of the organization and the programme.

Certain sections of the programme, as in the EPI section and the community based projects could be funded through other donors.

Multi donor funding will place a huge reporting burden on IbnSina and this should be part of the equation when funding is considered.
Annex 1

TOR for the evaluation of and the planning for the Afghan PHC programme of IbnSina.

Introduction.
IbnSina is a relatively new Afghan non-governmental organisation arising from the co-ordinated European (Memisa/European Union/NOVIB) support programme which has taken up the responsibility of providing primary health care to the Afghan people in 4 Regions of the country. The organisation has done this through a network of small health facilities co-ordinated and supervised by regional centres under the administration and technical support of the head office at Peshawar, Pakistan. Since more than 10 years the organisation (formerly operating under the name of AVICEN) programme has provided extensive EPI services in the country, but following the changing policy of UNICEF, the present EPI services are limited to 3 of the regions.

Memisa defines PHC as a comprehensive health approach linking the community and its health problems with an appropriate and responsive health services infrastructure. In the process, it aims at involving the community to identify, plan and contribute to the aim of curing and preventing diseases and to promote better health as a contribution to development.

Consultants: Panna Erasmus, medical officer, Public Health.
Partner: IbnSina, Dr. Riaz Malik, Memisa.
Period: 1 November till 1 December 1998.

Evaluation.

General Objectives.

To study to what extent the IbnSina has developed an appropriate PHC Programme for the underdeveloped people in Afghanistan since November 1996, but with special emphasis on the period 1 December 1997 till October 1998 (midterm evaluation of the 18 months project period starting on 1-12-97).

To review IbnSina’s EPI activities as part of PHC in relation to National and UNICEF policies in order to define the role of IbnSina in future EPI activities.

To advise on the basis of such a study, while assessing the capacity of the organisation in terms of management and Primary Health Care views, on the formulation of a realistic plan for the future (1999-2001).

Specific Objectives

A. Health care interventions.

1. Assess the achievements and constraints of the health interventions in the 4 regions at HF level. Which elements if PHC are implemented by IbnSina and to what extent.

2. To what extent the principles of PHC have been considered and realised and how could they improve in the future?

* Universal accessibility and coverage in relation to need.
  How did the organisation select the sites of the clinics / programme?
  Is there a monitoring system to access the accessibility / need for the programme?

* Focus on prevention.
  Does the key and field staff sees health mainly as the absence of disease or in a broader sense?

* Intersectoral action for health.
  Is IbnSina co-ordinating its activities with other sectors?
  Are the field activities interrelated with other sectors contributing to better health?

* Appropriate technology.
  How does IbnSina consider this principle at field level?
  Assess the level of skills of the health personnel and the training needs.
Assess the equipment and supplies.
Assess the infrastructure of the health units and indicate the needs.

* Cost-effectiveness
  How does IbnSina apply this principle at different levels?

* Sustainability.
  What actions have been taken place to improve the sustainability of the programme.

3. Assess the different functions of the regional offices in relation to the field activities: (technical, administrative and financial procedures.)

B. Community Participation.

1. What initiatives have been taken by IbnSina and the community and to what extent is the community actively involved in IbnSina’s health care programme (planning, executing, evaluation)? Assess the roles of men and women.

2. How is the target population defined and who are actually reached (and who are not).

3. What local contribution, also monetary, is the programme expecting from the community or users of the health service?

4. How is the level and skill of project staff dealing with community health care activity? How are the trainings for community members performed (type, level, method), and is it geared towards local settings and problems.

5. How could IbnSina’s strengthen its community participation approach?

C. The organisation.

1. Assess the structure and the organogram of the organisation. (Horizontal, vertical, cost effective?). Assess the functioning of the management team (critical mass, gender). Suggestions for improvement of the organisation for the future?

2. Assess the strengths and weaknesses of the organisation in view of the set objectives and activities.

3. Assess the personnel strength and indicate personnel needs, the need for specific competence and assess the training needs.

4. Assess the appropriateness of the Health Information System by area, province, region and the whole programme. How does it relates to the actual health care activities?

5. Assess the role in planning and evaluation of the HIS system.

6. Assess the administrative and financial procedures and its management. How are finances controlled in the main office and the region. Is external auditing performed?

7. Assess the composition (diversity, critical mass) and guidance of the board of trustees and its supportive and controlling role.

8. How are the geographical areas of the programme prioritised and on what criteria (PHC) activities have been selected? Assess the ‘EPI areas separately.


10. To what extent could IbnSina play an active role in emergency assistance?
11. Should IbnSina start a programme in Pakistan for Afghan refugees.

12. What other desirable roles could IbnSina play in view of development of the poor in Afghanistan?

D. Health Infrastructure and communications.

1. What other (main) health care providing groups are available (government, local and international providers) and assess the interaction and co-ordination with them at field, regional and national level.

2. What donors are assisting IbnSina and how is the communication. Assess the working relation with UNICEF and its impact on the activities. How could this communication be improved in view of IbnSina’s development towards independence from Memisa?

E. Gender

1. Assess the presence and role of female keystaff at all levels.

2. Is the female targetgroup sufficiently reached according to their needs. How could it be improved?

F. Formulation of a 3 years programme.

1. Indicate the priority activities at the level of the community, the HSFs, and the regions.

2. Indicate the geographical priority areas (including urban vs rural, Afghanistan vs Pakistan) in view of accessibility, local needs and logistics.

3. Indicate other community activities to be undertaken to increase the capacity of the local population and especially the women in attaining better health and living standards.
Minutes of the Mid Term Evaluation Workshop.

Venue: Peshawar
Day one: 09/11/1998
Secretary: Dr. Nabi

Dr. Anwar welcomed and thanked the participants for their participation and requested active participation in the workshop. The workshop was opened by recitation of verses from holy Quran by Eng. Khair Mohammad from IbnSina main office.

Dr. Anwar gave a brief presentation of IbnSina program and added that MEMISA as the main donor has contributed for the sustainability of the program. He thanked MEMISA for their assistance in providing IbnSina with the two expatriate staffs to facilitate the financial and technical aspect of the program.

At the beginning when IbnSina became an independent Afghan Organization it was a challenging difficult time for all IbnSina programs. As an Afghan NGO IbnSina proved that Afghans can implement programs very well if they wish and if they heartily and honestly work. There was a sort of feeling among donors that Afghan NGO’s are not doing well but IbnSina prove that if the people are doing honestly and interestingly they can offer better job with less funds in comparison with the other organizations.

In order to improve the implementation of the program, a team of evaluators will conduct an evaluation on program activities with participation of IbnSina members. He hoped for productive discussions to formulate the future 3 years program for IbnSina.

The objectives of conducting this workshop was highlighted by Dr. Anwar as:

General objectives of the evaluation program was mentioned as to know about the extend of IbnSina development since the commencing of activities as an independent Afghan NGO.

This evaluation is a mid term evaluation for the 18 months of IbnSina program (Dec 1997- June 1999).

Dr. Peter. Kok, medical advisor of the Asia Desk in MEMISA, thanked the participant for their participation in the evaluation. He added that MEMISA is a 75 years old organisation and IbnSina is a young organisation of more than 750 days (around 2 years). He added that MEMISA is having a policy to improve the programs with counterparts. ‘We are here to learn from you how to better improve and implement programs. Having difficult times together, MEMISA is very proud to be associated with IbnSina’. MEMISA’s policy is the PHC policy which is not focusing only on curative aspects of the programs but also on the promotive and preventive part. It is not only aiming at providing curative measures and distribute drugs.

Introduction: All the participant were introduced.

Expectations from the workshop by the evaluation team:

Jolande explained about the aims for this workshop as follows:

A: What are main health problems
B: What are the contributing factors
C: How IbnSina program address the main health problems through its activities, which are
   - Preventive and promotive activities (EPI, health education, nutrition/growth monitoring and water and Sanitation (WES))
   - Curative activities (Gynecology/Obs and general OPD services)
D: Evaluation of the program implementation:
   It includes the strengths, weaknesses, opportunities and threats (SWOT).
E: Inputs for formulation of the future 3 years program.

Exercise: The group had to identifying the main health problems and its contributing factors

The main problems were identified and among them the following 4 main problems were discussed in 4 regional working groups:
1. Gyno/Obs problems
2. Malaria
3. Respiratory diseases
4. Diarrhoeal disease and wrong treatment

After the discussion within the groups, each team presented the problem analysis as follows:

Group 1, Nangarhar region (Gyn/Obs problems):
The following diseases were described:
Infectious diseases (PID): Salpingitis, cervicitis and Trichomoniasis.
Abortions: Incomplete abortions and threatened abortions.
Hemorrhage.

Contributing factor for the above problems were identified as:
- Lack of personal hygiene
- No knowledge on the importance of receiving health services in health facilities
- Wrong habits
- Multiparity
- Incomplete and wrong treatment
- Not acceptance the family planning
- Difficult transportation

Group 2, Kandahar region (Malaria):
Causes:
- Presence of the Anophil mosquitoes
- Presence of the parasites

Underlying factors:
- Lack of preventive measures
- Chloroquine resistant of malarial cases: Wrong usage of the drugs, using the drugs without medical advise and wrong diagnosis.
- Lack of access to health services
- Lack of environmental sanitation
- Lack of impregnated bed nets
- Lack of health facilities.
- Difficulty in transportation

Group 3, Ghazni Region (Respiratory diseases):
It was divided in upper and lower respiratory infectious diseases.
The disease were classified as acute and chronic infections.

For acute infections the following underlying factors were identified:
- Lack of education
- EPI related diseases (Measles and TB)
- TB
- Over crowding
- Poverty
- Low immunity

Underlying factors for chronic infections:
- Chronic respiratory diseases
- Chronic usage of tobacco

Group 4, Bamyan Region, (Diarrhoeal diseases and wrong treatment):
Underlying causes:
Lack of safe and clean drinking water
using drinking water from the river and unprotected springs
Lack of fuel and wood for boiling water
Wrong habits (late weaning and stopping breast feeding during disease)
Lack of sanitation
Lack of immunization
Wrong treatment: More than 70% of Diarrhoeal cases are caused by viruses and they are treated by antibiotics and for a long time. Most cases of Diarrhoeal diseases can be treated by ORS.

After the presentation Jolande presented the following topic: How could we link IbnSina programs to address the main health problems through its activities?

As an example, if we talk about Diarrhoeal diseases, IbnSina program can address the following underlying factors:
- Lack of measles vaccine which is a contributory factor to the Diarrhoeal diseases, could be linked and addressed by the EPI activities of IbnSina.
- Lack of water which is a contributory factor to the Diarrhoeal diseases, could be linked and addressed by the WES activities of IbnSina.
- Lack of hygiene which is a contributory factor to the Diarrhoeal diseases, could be linked and addressed by the health education program of IbnSina.
- Malnutrition which is a contributory factor to the Diarrhoeal diseases, could be linked and addressed by the nutritional and growth monitoring program of IbnSina.
- Wrong treatment which is a contributory factor to the Diarrhoeal diseases, could be linked and addressed by the curative activities of IbnSina.

IbnSina activities consist of:
- Preventive and promotive activities (EPI, H. Education, Nutrition/growth monitoring and WES)
- Curative activities (Gynecology/Obs and general OPD services)

In general the IbnSina program aims to reduce the morbidity and mortality rates of the target population but the impact could not be measured due to unavailability of base line data & statistics. To measure the impact will require costly and time consuming surveys, but we will have to look for some indicators to measure the impact of our programs.

Definition of terms, community participation/cost effectiveness by Dr. Peter Kok:

Community participation:
There are different health organizations (WHO, UNICEF, IbnSina etc.) that provide health services. Each organization has its own time frame for the implementation of their health projects. We should find out that what the community want to have from health organizations. Community has to organize themselves to recognize the problems. Request from health personnel to solve the problems. Looking from the community point of view to health services. (Usually they ask for curative services). If a community is well organized, a program might be introduced.. We can assist the community to determine the problems of the society.

Conditions to start a community based program:
Using of appropriate material acceptable to the community based on their traditions and culture. Prior to offer services, we should know our community. Selection of proper approaches. Consider cost effectiveness of the program. Use simple tools which can be acceptable to the community. Use resources which are in accordance with community development. Choice of the training should be at the level that is understandable for the community, easily readable and to consider the literacy status of the community. Long term commitment should be considered. For example not to select too many villages where you can not follow up the activities but to select as minimum villages as possible to conduct a better follow up and program implementation.

Objectives:
Training of community health staff:
In this regard we should first train ourselves to know the community. As an example not only discuss with the leaders in the community. The leaders are not the actual community.
It is good to have the ideas of the leaders and mullahs. As the program is for the community, therefore we should have the views and ideas of the real community. Health committees which consist of some officials are not representing the community. A group of community can survey the village to find out the problems.

A group should be established for training of trainers. Volunteers are not true volunteers but they are paid health workers of the organization. Select the real volunteers. Community group formation process will have their own objectives, treasurer and monitors. Technical assistance could be offered by the organization. The community group formation from different communities set up associations by which they evaluate the needs and plan their activities. They reach a stage where they can ask for funds from donors directly.

**Cost effectiveness:**

What do we get for one dollar? What you get, is it useful for you?

Cost effectiveness - reaching a result which solve a health problem.

The following are the important factors:

- choice of technology - low cost and appropriate.
- choice of drugs - there is essential drug list for particular country and for particular program.
- drug therapy with right drugs
- choice of staff
- choice of health facilities for treating diseases
- organizing the organization
- Reduce the costs and to maintain the quality of the services.

Presentation of examples of cost effective activities of IbnSina regional teams (from the questionnaire):

**Bamyan:**
Supervision and supply of PHC and EPI were rendered at the same time which saves time and money.
Use of local transportation which is cheaper than using office car.
In time provision of supplies.

**Nangarhar:**
Limited staff with high output.

**Kandahar:**
Health education which costs less (it was commented that the effect of the activity (impact) should be high before you can stated that HE is cost-effective.)

**Ghazni:**
Food demonstration (Again it was commented that an activity itself is not cost-effective if you did not measure the effect).

Cost per attendance at health facility level (without office costs) in IbnSina was discussed and according to Dr. Loan's presentation:

<table>
<thead>
<tr>
<th>Province</th>
<th>Attendance Cost/$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghazni</td>
<td>0.87</td>
</tr>
<tr>
<td>Bamyan</td>
<td>0.62</td>
</tr>
<tr>
<td>Kandahar</td>
<td>0.44</td>
</tr>
<tr>
<td>Nangarhar</td>
<td>0.51</td>
</tr>
</tbody>
</table>

It was commented that Nangarhar, which is having the same kind of facilities as Ghazni (M1’s) is far cheaper. That Kandahar might be cheaper due to the number of C2 facilities which are cheaper to run (lower salaries) and have good attendance (it was calculated that C2’s attendance cost is 0.36 U.S. Dollar). The cost per attendance including the Regional costs (running Regional offices, drug
transport, supervision and training) became 1.00 U.S. Dollar. And including Main Office Costs (running Main Office and training courses key staff, evaluation etc) the amount became double (2 U.S. $)

What are your main PHC activities in the region at present? Feedback from questionnaire:
+++ = much, + = little 0 = not present

<table>
<thead>
<tr>
<th>The main PHC activities</th>
<th>Jelalabad</th>
<th>Ghazni</th>
<th>Kandahar</th>
<th>Bamyan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treating patients</td>
<td>++ (9645)</td>
<td>++ (6792)</td>
<td>++ (5398)</td>
<td>++ (2347*)</td>
</tr>
<tr>
<td>Gyno/Obs</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Growth monitoring &amp; nutrition</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>EPI</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Health Education</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>WES</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* Bamyan 6 month reports, other regions 9 months reports

EPI program activities of 10 months of 1999:

- TT 3: 6481
- BCG: 9425
- DPT3: 3822
- Measles: 6448

It was commented by Loan that all regions mentioned that they do a lot of curative activities and EPI. But what is the opinion of the community? Are they satisfied with the services provided. Does IbnSina provide enough vaccination to the target population? The regions think that they do much EPI activities, still the coverage is very low.

It response to the above remarks it was mentioned that IbnSina is still doing better than other organizations involved in EPI implementation.

The SWOT analysis was explained, and one out of the 6 main PHC activities was done in a plenary session.

Water and Sanitation

Weaknesses:
- No capacity for Wat/San work
- Lack of knowledge technology
- Of 7 targeted wells only 2 well in Helmand and 1 in Nangarhar built.

Strengths:
- (Ghazni) Health committees asked for chlorination of wells which was provided by WHO to IbnSina and used.
- Created community awareness on water and sanitation in relation to disease
- Ghazni, IbnSina has good knowledge of community. Supported a well building activity through community health supervisor
- Asked other organizations to talk on activities (Habitat) Bamyan, ICRC (Ghazni)
- Was included in budget and follow-up
- Model well in clinic example
- Included in check-list of HIS

Opportunity:
- Awareness, creation of water related diseases H. Education
- Coordination with other organizations
- Technical training
- Train expertise in WES
- All people want water near their houses next program, it should be with H.E
- Community involvement in program
Threats:
- Other NGOs charge very high price for making pit latrines or water wells.
- Introduction new system of water creates conflicts?

Planned to achieve in 18 months: Pit latrine = 20
Well = 7

<table>
<thead>
<tr>
<th>Already Achieved</th>
<th>Planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pit latrine</td>
<td>Well</td>
</tr>
<tr>
<td>Bamiyan</td>
<td>1</td>
</tr>
<tr>
<td>Kandahar</td>
<td>2</td>
</tr>
<tr>
<td>Ghazni</td>
<td>1</td>
</tr>
<tr>
<td>Jalalabad</td>
<td>2</td>
</tr>
</tbody>
</table>

SWOT for Water and Sanitation:

<table>
<thead>
<tr>
<th>Strength</th>
<th>Weakness</th>
<th>Opportunity</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Planning</td>
<td>Of 7 targeted wells, 2 in Helmand and 1 in Nangarhar were dug</td>
<td>- Realistic plan</td>
<td>- Other NGOs give very high price</td>
</tr>
<tr>
<td></td>
<td>- Of 20 pit latrines 2 were built</td>
<td></td>
<td>- Introduction new system of water creates conflicts</td>
</tr>
<tr>
<td>- Chlorinating of wells in Ghazni</td>
<td></td>
<td></td>
<td>- Clinics in private houses</td>
</tr>
<tr>
<td>- Community awareness on water born diseases</td>
<td></td>
<td>- Technical training</td>
<td></td>
</tr>
<tr>
<td>- Co-ordination with other organizations</td>
<td>- Lack of knowledge about technology</td>
<td>- Organizational awareness of WES especially pit latrines</td>
<td></td>
</tr>
<tr>
<td>- Model well in clinics was planned</td>
<td>- No capacity for Wat/San work</td>
<td>- Community involvement in program</td>
<td></td>
</tr>
<tr>
<td>- Follow up was done by supervision check list</td>
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<td></td>
</tr>
</tbody>
</table>

Tuesday 10th November 98

Group 1: Growth Monitoring & Nutrition Facilitator Dr. Panna
Group 2: Health Education Facilitator Dr. Jolanda.
Group 3: Gyn/Obs. Problems Facilitator Dr. Inger.
Group 4: OPD Facilitator Dr. Peter.
**Group 1- Presented by Dr. Sharif Eastern R.D.**

Activity: Nutrition, Kitchen Gardening.

**Strengths:**

Supplementary Feeding Center in Shiwa MCH clinic. It was not in the plan but the community encouraged us to propose to WFP and then the community assisted us in distribution of the food to the right people.

Involvement of the female in the program (the program was designed for 160 Malnourished children and 250 lactating mothers.)

Extra activity (the output was US$ 32000 for 160 Malnourished children and 200 lactating mothers, within two months we replaced 105 extra children in the program.)

Regular training regarding Growth and Nutrition.

**Weakness:**

- No Specific target.

**Coordination:** UNICEF, WHO, WFP.

**Opportunity:**

80% of the people from the catchment area’s of the facilities should receive Health Education messages.

Set Target.

Training.

**Threat:** Not

**Sustainability:**

Kitchen Gardening - the community has provided land and laborers and cultivated the ground.

Regular Training regarding Growth and Nutrition. It is also the strength of the program.

2- **Growth Monitoring:**

**Strength:**

- Training on Growth and Monitoring.
- Registered malnourished cases.
- Use of tally sheets and other forms for each defined activity.
- Use of growth charts for every child.

**Weakness:**

- Growth charts were not understood by mid level staff in Ghazni region. Less training of Growth Monitoring in Ghazni.
- No target for growth monitoring.
Fact sheets which were developing for each 6 months basis, did not get feedback. Kandahar, Ghazni and Banyan are seem to be weak in growth monitoring (Dr Panna).

Opportunity:
Training.
Filling Growth Charts for every child.

Threat: NOT.

Out Put :
Good growth monitoring activities because of the presence of MCH clinics in Eastern region.
Food demonstration program/ basis on two time per week.
Supplementary feeding center in Shiwa.
In Kandahar and Banyan the number of MCH clinics are limited.

Cooperation coordination:
Mr. Sarwar from Banyan- Food demonstration program were proceeded by our clinics with assistance of WFP despite the blockage of the roads. SCF trained our staff and assisted us in growth monitoring.
Supplementary feeding center is established in coordination with WFP and supported by community's leaders and representatives.

Out Put:
Good Growth Monitoring activities because of the presence of MCH clinics in Eastern Region.
Food demonstration program/ basis on two time per week. Supplementary Feeding Center in Shewa. In Kandahar and Banyan the number of MCH clinics are limited.
There were lots of discussions on different activities proceeding by participants.

Group 2 - Health Education: Facilitating by Dr. Jolanda.

Health Education in 4 regions:
In each M1 clinic is one H.Educator, so for Jalalabad there are 5 M1 and 5 H.Educators.
Kandahar 2 M1 and two H. Educators.
Ghazni 4 M1 and 4 H. Educators.
Banyan 4 M1 and 4 H. E.
H. Educators responsibilities:
• To convey health messages to the people.
Weighing the children in the clinic.
Nutrition demonstration,
2 sessions up to the end of work time.

In C2 clinics H. Education training has being proceeded during MLHWs PHC training course in Kandahar.
It was 2 hours per day and lasted 10 days. On job training for Grishk M1 clinic.
Methodology:
Different methodologies like discussion, Q&A, Demonstration, Role plays are observing during training. Using different teaching material. Dr. Shafiqa from Ghazni mentioned that they gave special Health messages for pregnant women coming with edema or hypertension.

Strength:
Kitchen garden in Banyan and Shamsapure of Nangarhar.
Daily H.E activities.
Existing plan, curriculum, lesson plan and topics present.
On job training and refresher training.

Weak point:
10 kitchen garden were planned and still only two ones are established.
Regarding the impact of the program of H.E, Dr. Zohra from Charbagh facility said: When she was working with AMI they did not had H.E program so they were facing to very problems regarding getting their health messages by the patients, but when came to IbnSina Since there was H.E program, I felt the impact of the program because people were so motivated and wised.
The people of different areas where we have facilities did not use weaning for breast feed babies, after H.E programs now they are using weaning food for their babies.
The number of Severe dehydration are limited in our catchment area in contrast with other areas. More people bring their children for vaccination.

Opportunity:
Expand H.E program to the schools and far communities. Specific meetings in H.E programs regarding sharing teaching material with WHO,SERVE, DAACAR, SCA and others. There is the needs of community participation in planning, implementation and evaluation of the program.
Dr. Anwar: to involve female much more, we should add one female H.E in each C1 or C2 clinics. If fund Found.

Threat:
Male H.E conducting H.E to women, effect?
Difficult to organize meeting with female due to restriction on women.
Use of pictures make problems( Policy ). Restriction on working of women in clinics.

Gender:
Lots of female are working as H.Educators as well as male.

Group 3-

Gyn/Obs . Presented by Dr. Inger.

The activities:
Ante Natal Care: Regular services;
  MD issues visit cards- after visiting vaccinator, who also check the immunization of the children.
  Cards kept by ante natal Nurse.
Individual consultations: Blood Pressure, Lab( Hb, Urine, no smear.)

Group sessions for H.E: Breast feeding- nutrition- child spacing, family planning- personal hygiene, EPI, traditional believes.

Tracing risk pregnancies:
need for home visits - train nurse to do this - large catchment area, should be maximum?

Delivery Services:
• Carried out 8 - 13 daily in remote areas.

Maternity home ( in Ghazni city- 10 beds.) where also deliv. are carried out.

Collaboration with MOPH, NGOs in the region.

Planned to be 24 hr service but now 8-16 hr. Women not allowed to work night duty.

Post Natal Care:
regular services: BP, post natal cards.

Family planning:
• pills.

Gyn/Obs problems:
individual consultation- some times partner treatment

Essential drugs:
Enough and regularly supplied drugs.


Referrals:
- formatted referral cards.
  ■ Ghazni : Maternity home ( since 3 months). Hospital in city.
  ■ Kandahar: -
  ■ Bamyam: 1 Hospital.
  ■ Nangarhar: 4 Hospital( 3 in Jalalabad and 1 in Laghman).

Skills of personnel:
Number of trained health personnel( Gyn/Obs).

■ Up grading: according to a regional (IbnSina) plan- on job training in regular evaluation/ supervision .
■ Of Nurses: nutrition, anemia, family planning.
■ Of MD : Gyn/Obs problems.
■ H. Education issues: Nutrition, Breast feeding.

Child Health Care:
On job training + Refresher courses.

Teaching aids:
Flip charts : should also include weaning, normal delivery.
Technical books for Training Center.
Audio Visual.
Dai (TBAs)
- In coordination with WHO: Initial 20 days training in the district.
- Need for refresher training.

Community Participation:
- Site selection for establishment of facilities.
- Cost sharing of services and drugs.
- Acceptance of the program.

Sustainability:
- Media.
- Establishment of H. Committees.
- Locally accepted staff.

Coordination & Cooperation:
- Regional Coordination Bureau.
- Establishment of Maternity Home.
- Referrals.
- Shared delivery cost.

Gender:
- 1 Male MD, 1 Female MD / clinic.
- Locally based and accepted female personnel.

Cost Effectiveness:
- Right level of Technology.
- Separate localities (include delivery rooms).
- Sustainability: problem with clinics in private houses.

Capacity Building:
- Skilled staff.
- No general guideline.

HIS:
- Well functioning feedback system.

Group 4: OPD and Curative Services:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Strength</th>
<th>Weakness</th>
<th>Opportunity</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of</td>
<td>Redistribution of</td>
<td>Less amounts in some busy facilities.</td>
<td>Different type of</td>
<td>Transport problems in banyan( blockade-</td>
</tr>
<tr>
<td>essential drugs</td>
<td>drugs</td>
<td>Some miss use of</td>
<td>kits e.g. C2 A &amp; C2B kits.</td>
<td>winter, fighting),</td>
</tr>
<tr>
<td>Treatment of</td>
<td>Training (regular)</td>
<td></td>
<td>Training.</td>
<td>Patients not</td>
</tr>
<tr>
<td>Treatment of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Pediatric services.</td>
<td>Skilled personnel. Easy accessibility Immunization/growth monitoring/food demonstration.</td>
<td>Lack of exact population of the catchment area.</td>
<td>Training. Catchment area survey</td>
<td></td>
</tr>
<tr>
<td>Laboratory.</td>
<td>Training - Initial-Refresher. Quick services. In more than 95% of M1 C1 clinics.</td>
<td>Equipment/mono-ocular microscope-Low quality microscopes.</td>
<td>Increase services to all M1/C1 even C2.</td>
<td></td>
</tr>
</tbody>
</table>

|--------|----------------|--------------|--------|----------|-----------|----------------|------|--------|

Second day's sessions finished at 17:30.
Minutes of day 3.
Secretary : Dr. Nabi

After summarizing day 2, Dr. Anwar mentioned about today's program as:

I: Evaluation of the organisation.
   It will include:
   ■ The office structure and organogram
   ■ Links between main office, regional offices and the field (health facilities)

3 groups will work as a team:
Group 1. main office
Group 2. regions
Group 3, field

II : Sustainability of the program
III: Scope of activities
IV: Planning
V : Coordination and cooperation

Dr. Loan briefed the participants about the answers to the questionnaires from regional offices.
(See separate file)

Group representation:

Presentation by the Field group:

Dr. Samehuddin presented his group as under:

Organogram of the clinics:

Clinic doctor who heads the clinic and the other staff are included as below:
- Female doctor
- Lab. Technician
- Pharmacist
- Health educator/registrar
- Receptionist
- Vaccinator
- 2-5 support staff

Their are good links in between:
A good link has been established in between the clinic responsible, regional director, and main office.
In the clinic level also a good link is existed in between the head of the clinic and the staff of the clinic.

Organizational Structure:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Strength</th>
<th>Weakness/ constraint</th>
<th>Opportunity</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication/lines of command</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervision</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job description/understanding of job</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selection (test, interview)</td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td></td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
</tbody>
</table>
**Procedure:**

<table>
<thead>
<tr>
<th>Planning (clinic, regional minimal input)</th>
<th>+</th>
<th></th>
<th>+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial (different in regions)</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Capacity building</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Co-ordination/collaboration</td>
<td>+</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Aspect</th>
<th>S</th>
<th>W</th>
<th>O</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost effectiveness</td>
<td>? Lab. Fee to be increased</td>
<td>Sustainability</td>
<td>community based work to investigate</td>
<td>other clinics give free drugs in same area and charge more fees and no charge for pregnant women Poverty, war and lack of stable government</td>
</tr>
<tr>
<td>Sustainability</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>

**Strengths:**

Staff selection: (male or female):
Selection of new staff is based on:
- Staff introduced by the community
- Identification of staff by regional office
- Introduction of the candidates to regional office
- Group interview for selection of candidates
- Interview group consists of the representative from the IbnSina as well as from MoPH.
- In case the candidate is presently employed by another organization the recruitment is based on the agreement of the relevant organization.
- Involvement of women in the program
- The head of clinical is responsible for the clinic and reports to regional office.
- Activities of the clinical staff is supervised by clinic responsible.
- Good planning
- Holding conferences in the clinics and learning from each other

**Weaknesses:**

- There are different salary scales for the same position in different regions.
- No self evaluation
- Shortage of training material
- Very weak co-ordination with other organizations at district level
- Financial procedures are not clear.

It was commented by main office that 10% of the income from the clinics (cost recovery fund) could be used for the running cost of the clinics apart from the budgeted running cost. But according to the regional directors, this policy was not known in all the regions. For example: Kandahar spends a fixed amount of AFs 70,000 for C2 and AFs 200,000 for C1 clinic.

**Opportunity:**

- Hire more female qualified staff
- Uniform salaries for the same position in different regions but, difficult area will get incentives.
- To perform self evaluation
- Increase lab. Fees
- Standardize financial procedures for all the regions.

**Threats:**

- EU request for increasing cost recovery.
- Other clinics gave free medicine
- Poverty, war and lack of stable government

Peter Kok;
Who are the community?
The community are the villagers but not the leaders.
To see the possibilities for more women to start the community approach.
The doctors should have home visits to discuss with the community and find the problems.

Sustainability: Who should run the clinic in long term?
Answers: NGO with the support of community, increasing income generation activities and ask other organizations to cooperate in this regard.

Main office group:

The organization presented its organogram.

Strengths:
The organogram was designed by founders of IbnSina and approved by Board of trustees.
There is a management team: in absence of D.G one of management team member will act.
There is an assistant to D.G
Co-operation and co-ordination with other organizations

Opportunities:
- Planning of realistic work plan
- Cooperation with other in communication (radio, E-mail Swedish Committee for Afghanistan, SCA)
- Training to be planned in co-ordination with SCA
- Joint supervision with SCA
- Training of HIS and finance staff
- Prior to visit of regions, minutes of their last meeting should be asked for
- Since the posts are very specialized there should be a back-up for key staff.

Organization Structure Main Office:

<table>
<thead>
<tr>
<th>Aspects</th>
<th>Strengths</th>
<th>Weakness</th>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organogram</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management team</td>
<td>+</td>
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<tr>
<td>Assistant to director general</td>
<td>+</td>
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<tr>
<td>Staff:</td>
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<td></td>
</tr>
<tr>
<td>- Specialized</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>- Multifunction</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Backup</td>
<td>+ less</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Planning/Budget</td>
<td>+ donor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human resource development:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Supervision</td>
<td>+</td>
<td></td>
<td>regional demand to be increased</td>
<td></td>
</tr>
<tr>
<td>- Planning</td>
<td>+</td>
<td></td>
<td>can not materialize</td>
<td>realistic plans</td>
</tr>
<tr>
<td>- Funding</td>
<td>+</td>
<td></td>
<td>didn’t materialize</td>
<td></td>
</tr>
<tr>
<td>- On-job training</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Consultant</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordination</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Gender</td>
<td>+</td>
<td></td>
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</tr>
</tbody>
</table>
Strategy:
- Specialized or multi functional staff
- Need for back-up for key staff in main office

Training:

Strengths:
- Dream planning
- Training consultant
- Training each other in main office
- Training planned in the Pakistan Institute of Management.
- Training in region
- Training of D.G
- Dr. Panna will train the staff
- On-job training

Weakness:
- Training of staff in foreign countries can’t materialize
- Train of D.G can not materialize
- Female staff are less in main office

Constraints:
- Costly as they can not work multipurposely and outside office.
- Travelling to the fields

It was discussed why, in spite of so many visits why some regions asking more supervision from main office side (see answers from field questionnaires):
- Show off of their activities
- to solve problems

Opportunities:
- Training by other organizations
- Explore gender aspect
- Multi functional staff is required
- Back up for key staff

Threats:
- Low staff in main office

Weakness:
- Cancellation of consultant

Regional Groups (regional Office Group)

Strengths:
1- IbnSina is a strong organization, the staff and people respect it
2- It has a good relation and cooperation with, NGOs, M.P.O.H., UN for example: IbnSina is working as leading agency : (Elected by coordination bodies. Banyan also active member of REMT and PEMT and Coordination.
3- Staff are familiar with aims and objective of P.H.C

Threats:
- Delay in release of E.P.I fund from Unicef in Banyan and Ghazni.

Community participation:

Strengths:
IbnSina has active community support: Example Building facilities, cost sharing assistance for transportation.

Weaknesses:
- The community is not taking action for solving their own problems.
- Community organization are still weak.

Opportunity: Strengthening community organization

Threats: Difficult to gather the people.

Sustainability:

Strengths:
- Well trained Afghan staff
- Well organized good communication some cost sharing 30%.

Weakness:
- People selected by leader not by community
- Depending on forgoing support

Opportunities:
- Increase cost sharing, income generation project.
- Making union to contribute
- Health insurance to be designed.
- CHW could train (villagers)
- In eastern region women are allowed to participate in income generating project
- Ladies should be trained organized women groups in the village

Threats:
- Lack of cooperation of the Government.
- Lack of Fund, poverty, war

- Relation with main office:
- No problem
- Regional office staff are satisfied with main office works
- Sufficient feedback to Regional office
- Regional office take active part in planning

Threats:
In Bamyan some transportation problems

- Skills:
- Regional office staff has been trained sufficiently.
- Unskill staff terminated.
- All regions are satisfied regarding training.

- Organogram:
- Well organogram
- Some staff based in one region, work for other region also.
- Regional director and supervisor take part in training as trainers.

Opportunities:
- Field staff to know program target
- Salary standardize
- How to evaluate our selves
- Financial procedure to be standardize
Future of IbnSina Program:

Dr. Loan summarized the opportunities which came up from workshop (and grouped them in 5 groups):

**Community Based Activities**
- H.E. in School to be improved.
- H.E in far community to be improved.
- Create awareness of water born diseases.
- Home visits for antenatal care
- Community awareness on food demonstration.
- Community contribution in every where
- To educate people on proper usage of the essential drugs.
- Community participation especially in WES and Health Education.
- Educate people on TB

To involve female in community based program in Health committees

**Programme Based activities.**
- Increase lab services
- Rehabilitation of equipment Bamiyan
- Improve feedback from referral
- Involve regions in Planning
- Improve financial procedures
- Increase EPI outreach
- Approach other donors for gaps
- Closure of poor clinics
- Use mass media

**Coordination / Collaboration**
- Improve the coordination with other agencies.
- The agencies should coordinate within the community.
- Coordination on WES
- More intersectoral collaboration
- Intersectoral collaboration on Growth monitoring / Nutrition
- Coordination of H.E.

**New activities for the proposal / policy**
- Set Target on cost effectiveness or unit cost
- Set Target for activities
- Survey on catchment area to know about the number of population
- Establishing Feeding Center (Jalalabad)
- Identify the catchment area
- Increase cost sharing
- Standardize salaries
- Increase salaries field staff
- Increase Lab. Services
- Expansion of MCH activities
- Set program targets
- Upgrading facilities
- Female health committees to be established
- Expand the Health Committees of the pilot project to other regions

**Training**
- Training on misuse of drug
- Training in WES
- Job training growth monitoring
- Training on H.E.
- More updated technical books
Increase duration for EPI course, H.E, On-job training  
Backup for key staff  
Training center in Kabul

There was a question about setting targets for cost effectiveness:  
She gave the example that the cost per attendance (as was presented before) could be an indicator to measure cost effectiveness.

**The following suggestions for improvement came up from questionnaires**

Ghazni,  
-More training in supervision  
-Training using the maternity room (Technical topics and management of deliveries including anesthesia and premeditation).  
-Improved WES  
-More teaching (Medical Book) books and updated book.  
-Use mass media for maternity home in order to increase the accessibility.  
-Training key staff in Pakistan and outside Pakistan.  
-Involve women directly in the program.  
-Increase salaries of some field staff positions.  
-Expansion to more region and provinces particularly with MCH activities.

**The following comments came up from Ghazni & Bamyan**

-More TBA to be trained  
-We will have better accessibility if we involve more female staff

Bamyan  
-Maternity Home to be established in Bamiyan Region.  
-Improve the quality of the kitchen garden and increase number.  
-Health Committees to be established  
-Upgrade the facilities  
-Training center to be established

Kandahar.  
-Close poor performance clinics  
-Improve the EPI activities to increase the accessibility for women.

**NANGARHAR**

-Start incoming generation Activity  
-Start school H.E. program  
-H.E outside clinics

-Improve Teaching aids  
-More cooperation in building infrastructure  
-Home visit by MLHW and Midwife for antenatal care  
-Training or PHC + Management  
-Pit latrine for villages.  
- Increase female staff

Dr. Loan expressed that according to the outcome of the workshop there are some new activities that have to be discussed with IbnSina’s Board of trustees and Management team.  
She added that we have to prioritize activities what is realistic.
Dr. Anwar requested Dr. Loan to summarize the yesterday's detail

Dr. Loan explained that:
Yesterday we were looking at IbnSina organization in 3 groups including regional office/main office and clinic level. Following points were found:
1. Clinics near to region were present in the workshop so may be the reason of good impression of regional office.
2. Far facilities were not present so we do not know of there impression of regional office.
3. Regions are also satisfied from main office.
4. Structure is good no main changes suggested.
5. Discussion was on key staff to go for training to be more qualify.
6. It is felt that back up for key staff is needed.
7. Standardization of salary specially of personnel of clinics.
8. Increase in salary scale.
9. Procedure on communication: Main office sends every thing is present in paper and clear to main office, how the region take this information there is a problem and were taken by different regions in different ways.
10. Field group was not informed / or not aware of office procedure or changes and target for there activities.

Later in the afternoon suggestions will be taken for future programming:
1. A lot of activity can be improved such as training and cooperation. No major changes suggested in these programs but an improvement is felt.
2. Community based activities: A lot were suggested/ some limited weakness are pointed out / organization can do it or not.
3. Suggestion on new activities/ but looking on these suggestions some are already in plan.
4. New activities which are not in plan / can be included in future plan/ If included why and how to be done, what are objectives for that/ will be discussed to include or not in the afternoon.
5. Do we have capacity to do/ man power is there/ is there capacity/ indicators to measure it/ Is there skill to do survey and to know the target is achieved or not.
6. Should we grow new projects or become stable on present activities/ to think of future is it possible to get fund or not/ donor may ask for new activities community to take more/ donor may say we will contribute less and the community will be asked to take more part and more contribution/ role of community to be more emphasized.

Today group work:
2 groups
1. Community Based Health Project Group
2. EPI group. 2 EPI Staff present today will be of help in this group work

The time for this group work is 1 hour and after that there will be discussion.

Dr. Panna explanation on Community Based Health project
Go for back few days we talked in detail on problems and activities of IbnSina, Strength, weaknesses opportunities and threats were discussed.
Two activities are in program and not discussed during last few days and will be discussed today and those are EPI and Community based health project.

EPI GROUP
Discuss activities
  Strength, weak, opportunity, threats
Why and how
1. Provide health education combined with vaccination services in fix centers and during outreach activities in the villages.

2. Cold chain
   - Provision of technical assistance for program management and logistic from main office
   - Maintaining cold chain equipment
   - Running of region and provincial vaccine storage facilities (VSF)
   - Technical support by the regional office for VSF

3. Providing vaccine to EPI teams

4. Data collection and reporting and feed back (HIS) to UNICEF / region/ main office quarterly

5. Feed back to EPI teams and supervision

6. Participation in NIDS/ and other campaigns

7. Training of vaccinators and supervisors

Community Based Health Project
Discuss activities
   Strength, weak, opportunity, threats
   Why and how
1. Assess feasibility of starting a community based health project in Bamyan and Ghazni region.
2. Design two community based community projects according to feasibility and need (how it was done)
3. To start implementation of 2 pilot projects
4. To evaluate the pilot project after 9 months of start of project

Group 1
Community based health project
Dr Shareef
Dr Saboor
Dr Shafeeqa
Dr Zohra
Dr Anwarulhaq
Dr Qudsia
Dr Samaiudin
Mr Mukhtar
Mr Mohibullah
Dr Rukhsana

Group 2
EPI GROUP
Dr Ahmad Jan
Dr Khaja Ahmad
Dr Ekramuffin
Dr Nabi
Mr Srarwar
Dr A. Majed
Dr Iqbla
Mr Said Nadir
Mr Moqeen

There was no facilitator/ but EPI team can request Dr. Panna and community team can ask Yolende for any assistance needed.
In the last 18 years the activities were run in cities by government and in the villages by opposition (Mujahideen). In 1994 regionalisation and establishment of Provisional management team (PMT) and Regional Management Team (RMT) was done. EPI fund and expenditure was accepted by UNICEF. Under new scale by UNICEF incentives were very low for vaccinators as compared to already existing one. So most of vaccinators left the job. Specially those vaccinators funded by AVICEN, had to leave due to low incentive. IbnSina then trained new staff funded of UNICEF during that period. As the new staff had been still paid very low, it was difficult to find the people according to the required criteria.

Curriculum developed by UNICEF for EPI trainer had been for only few days and not quite enough for teaching in all aspects. IbnSina after independence tried its best to improve EPI activities. In the year 1997 the EPI program run by IbnSina in 4 regions Kandahar, Kabul, Ghazni and Banyan. In the beginning of 1998 MoPH requested IbnSina to take Wardak and Parwan EPI Teams. In the year 1998 IbnSina work in three regions, Kandahar, Ghazni and Banyan. Includes 8 provinces/ 33 district/55 EPI teams/ 110 vaccinators and 6 regional supervisors. IbnSina is involved in program implementation, supervision, training, logistic (supply), etc. Two VSF one in Banyan and one in Paktika is run by IbnSina. VSF in Ghazni was handed over to govt. one VSF closed in Punjab districts, Banyan as it was considered to be not needed. We have 4 cold chain technician. IbnSina has hired a qualified field trainer in Paktika since June, 1998.

1. Provide health education combined with vaccination services in fix centers and during outreach activities in the villages.
   a. Strength
      HE is done in fix and outreach
      HE schedule is present and during vaccination provided
   Curriculum is present

Weaknesses
Curriculum time is not enough to discuss with vaccinators on HE
Low salary so it is taught to be an extra job by vaccinators.

Opportunity
Increase the time period for curriculum
Include vaccinator's in HE training program
Through community health supervisors, volunteers etc.
To approach other donors to fill the gaps

Threats
Low salary
EPI Policy dictated by others

2. Cold chain
11.Provision of technical assistance for program management and logistic from main office
22.Maintaining cold chain equipment
33.Running of region and provincial vaccine storage facilities (VSF)
44.Technical support by the regional office for VSF

Str changed forms, so different forms received from field, vaccinators cannot fill it as it is difficult, no training for filling new forms.

Opportunity
11. coordination with UNICEF
22. survey is needed for exact pop. coverage
33,None
44.None
Threats
11. Budget is delayed by UNICEF
22. None
33. None
44. None

Bamyan VSF according to some reports is being looted or destroyed in recent fighting.

3. Providing vaccine to EPI teams
4. Data collection and reporting and feedback (HIS) to UNICEF / region/ main office quarterly

Strength
- HIS Officers in regions and main office
- On time collection and transportation
- Computer program
- Quarterly reports

Weaknesses
- Too frequent changes in reports by UNICEF
- Not availability of forms on time, so different forms
- Too complicated forms to be filled by vaccinators
- Incomplete filling of forms

Opportunity
- Simple forms

Threats
5. Feedback to EPI teams and supervision

Strength
- Supervisors are trained, and other organization are also helped.
- As vaccinators are situated in facilities, supervised with PHC combined
- Every two months supervision planned
- Regular supervision done

Weaknesses
- Delay in funding for supervision in some places

Opportunity
- Hand over those EPI teams in the district where IbnSina has no PHC activity
- Keeping those facilities where IbnSina has PHC program
- Fund EPI program from other donors

d. Threats
- Delay in funding

6. Participation in NIDS/ and other campaigns

Strength
- Implementation, training, technical support

Weaknesses

Opportunity

Threats
- No Plan by UNICEF for his NIDS
- No planning on NID to consider the constraints

Training of vaccinators and supervisors

Strength
- IbnSina had and had planned for supervisors training, to initial vaccinators in Bamyan, and other refresher courses in different regions
Weaknesses

Opportunity
Training for female MCH can be trained in vaccination program.

d. Threats
Problem of delay in release of funds

Community Based Health Project:
PRESENTED BY Mr. Mukhtar

Program started in March, 1998. Planned initially to be implemented in Bamyan and Ghazni, the situation was not favorable at that time for above regions and initially started in Jalalabad with establishment of Health Committees. first the district authorities were contacted and after their permission with elders, influenced people, Mulhas and teachers discussion took place. It was suggested to have health committee meeting on monthly basis, but due to work and others works to do by people it was decided to held meeting randomly according to the needs whenever felt. Example of their effectiveness is that in Khewa this health committee helped IbnSina in identifying the malnourished and pregnant women in need of food, so food by WFP can be provided to them.

Discuss activities
Strength, weak, opportunity, threats

Why and how
Assess feasibility of starting a community based health project in Bamyan and Ghazni region.
(SURVEY)

Strength
Establishment of this Health committees
Community Health Supervisors training.

Planned training in Bamyan, but due to political and military situation in Bamyan not started. It was started in Ghazni.

Ghazni Health Committees are established, same procedure as Nangarhar region applied. Contact with District administrators and authorities was done to be in touch and inform them about our objectives. Health committees were established in Kakrak, Qarabagh, Moqor and Khuja Omeri:

Health committees were asked to identify few people, then by Mr Mukhtar and Dr Hidayatullah some of them selected and training started in regional office. Ten CHS are under process of training. From each district two person for this program is selected. A mid training test was taken and results were very good.

It is planned to start village health volunteers training afterward by these CHS, so we can penetrate inside the community.

Weaknesses
Female Health Committee not established.
In Shamshapor clinic where Female Health Committee but we have not contacted them.

Opportunity
to establish female health committee
same in other regions
Female Community Health Supervisors

Threats
no threat, except in political situation or military situation

Design two community based community projects according to feasibility and need (how it was done)
3. To start implementation of 2 pilot projects
4. To evaluate the pilot project after 9 months of start of project

As the presentation was not according to the questions prepared by evaluating team some analysis were not specific.

Here are some other points which were discussed:
Community participation is that these people are from community, and still weakness is that they have not gone to houses or contact of common or ordinary people is not done and also other NGOs are not well contacted. Although some contact on material is a positive point. Effectiveness and sustainability we will be able to say in future after evaluation.

Dr. Ahmad Jan
we after long discussion decided to find a qualifies person first and as Jalalabad was near and access able, so started in this region, we assessed Bamiyan and due to situation and fighting we could not start. Ghazni was chosen to begin with.

Dr. Yolande raised some question which are mentioned below:
With whom discussion were done on establishment of Health Committees, were women involved?
As it is seen no women were involved only elders, mullahs, teacher and others mentioned earlier were involved. One of CHS sayed in Ghazni we can introduce female CHW as for example close relatives.

what discussion were done with the people?
According to the area and people discussions were done and also responsibility of CHW was discussed to as far as for example to teach people about the common diseases, route of transmission and prevention.

Do you have check list to evaluate the work of CHS?
No there is no check list but can be done to ask from people. Some questions to be asked is in plan from CHS.

what did you tell on role of CHW?
It is explained to them that the thing you do others cannot do it, example prevention measures, health education and first aid dressing, ORS and WSS.

Difference between CHW and BHW?
Dr. Anwar explained this point and also give general information on IbnSina Community based program. He said we had little experience in community based program. After some looking we finally were able to find an experienced person Mr. Mukhtar. He was involved in Afghan Refugee camps in Pakistan, to work in community we should train CHS and these CHS can select CHW and area of work to be selected. CHS will be attached to the IbnSina clinic and will report to clinics on regular basis. The reporting time table and frequency is under discussion. It is clear many things are still under discussion and to be finalized. Mr. Mukhtar to go and met people and establish Health Committee in Nangarhar. The problem that women are not involved and to see how much it is possible, can be discussed in future. In 5 district of Ghazni and 4 districts of Nangarhar and Laghman province the program started.

How many villages are involved in one Health Committee?
8-12 members from each district are selected. For example Mqor district has 100 villages and so 15 people were selected.

Is it specified that one VHW will cover how many villages?
we started the project and we had not enough practical experience. So this not estimated yet.

Did you or IbnSina did any research on other organization?
Other organization had CHWs and these volunteer were paid. In Bamyan no program like this is existing. The opportunity is to see what other people are doing, such in Pakistan, or other organizations. Other organization were not successful. Volunteers should not be paid and should be discussed for a long time so a real volunteers. No first aid or any other supply to be given.

CHW Report to CHS and CHS to clinic

Since when has started its work, it is 6 months. any feedback or evaluation or effectiveness is observed?
In Charbagh transportation of patients to referral centers in emergency cases. This health committee and identifies people with a car and schedule was made in case of need to be used.

Format for health committee is not available and its function is not fixed. If check list is made and a formal report is asked so money can be asked by CHW.

If there is no check list then how can we evaluate it. Is there in Jalalabad any report, nothing in paper yet. Dr. Panna and had Dr. Ahmad Jan saw minutes of meeting. So check list for evaluation can be made.

First objective of establishment of these health committees were to go out of clinics and talk with community. so in future we can go to community and evaluate the clinic by them. Women to approach and make women health committee is very difficult one. But we have to explore and find the possibilities.

CHS curriculum was developed and training material were prepared and conduced in Ghazni and the process is going on in Ghazni. After training of CHSs they will go to community and to find CHW which will be really volunteer and no payment to be given. It is the challenging part and a lot is to work on.

Dr. Peter is saying that it is HC is not a village health committee and it is clinic health committee. CHS name is not correct and to supervise is not the duty or the actual objective of this type of programs and the name should be community health motivators CHM. So supervision is not proper name.

Dr. Loan/ Yolende

Present program of IbnSina, 6 activities are done, we talked on strength weakness, opportunity and also threats.

We had looked for future opportunities in each field. We will look in opportunity and we will look for the reason, justification. First we look for short term priorities, for examples kitchen garden, before June how far we can carry this program. Some training can be carried out till June. Long term mean for new programs that is after June 1999. We will have opportunity for 7 activities mentioned bellow. Some opportunities are new one.

Opportunities to put together we can give priority and changes to these new activities. Why it is important and why, how, where to be done. We have to look in IbnSina if it is able to do or not, may be the structure has to be changed. We will do in three phase.

First we will look on new opportunities at present activitie

**Water and sanitation**

Opportunity at present.

Building of remaining planned latrine and water pit

It will be done

- 3 latrines and 2 well Banyan
- 3 latrines and 3 wells Kandahar (achieved 2 wells)
- 2 latrines and 1 well Ghazni
- 1 latrines and 2 wells Nangarhar

<table>
<thead>
<tr>
<th>Latrines</th>
<th>Wells</th>
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<td>9</td>
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There will be done by community participation, it will be done by community and will be cheap and on time ready.
Training on water and sanitation to be done, staff to be trained

More inter-sector cooperation for experts

Community participation

Create awareness of community
In curriculum of health education there are three topics water related diseases, cleaning of water, water itself. Under sanitation topic on toilet.

Well will be in front of the houses. Latrines are at the house of some body, but still that will be for a house if clinic removed. To consider these the problem of private house.

Long term

Water and sanitation
Latrine/sanitation to be included for demonstration purposes not preferred not in private houses.
Other org. can do it and w don't have experts so not to be involved extensively
Maintenance can be done through income generation/ or budget
Experts from other org.

Health Education
Improve teaching aids
Vaccinators he training
Daia trainers are trained about the clean delivery, pregnancy related health education.

Health Education
Health education outside/ Health education in far community;
Some people are not coming to clinic so they can be approached
Improve teaching aids
Proposed on extra person to work as heath community/ daia supervisor

Community awareness on diseases and medicines (on long term) and also use of drug training (long term)
catchment area in cooperation with others
coordination with other org. and format
he from clinic for referral
Coordination on drug from other org. On some drugs as TB.
Laboratory for C2 clinics (in long term)
HIS, EPIDEMIOLOGY COURSES FOR MAIN AND REGION

MCH
Training TBAs
In present program was not planned by IbnSina, but conducted with cooperation of other organizations.
In future it is needed or not
Dr Shareef says that there is a need for training of TBAs.
So some say we have to go for refresher course
We have capacity
Is it beneficial? Yes it is beneficial or not
Follow up is needed
INCLUDE IN FUTURE PROGRAM FOR REFRESHER AND INITIAL

Home visits
TBAs can do
Establish female health committee
not possible at present
Special gynae and obs teaching aids (present program)
Maternity home for Bamyan (in future plan/first to evaluate the need)

Construction of special facilities for health care/new clinics for IbnSina
Problem for children and women of space for deliveries, examination.
House owner refuses for extension of his/her house provision
Sustainability of these facilities made at home after closure of program
**New construction/repair with the help of community financially and manpower at government places. In next program and will be reconsidered.
Develop of the program for family planning (pills, condom, IUC) in future plan:
Free of charges medication
IUD should be introduced, staff is trained and can apply it.
Pills with no side effect for pregnancy (to discuss of essential drugs list for this purpose)

Nutrition and growth monitoring
Set target for growth monitoring: (In long term ILT)
Nutrition program in long term(ILT)
Kitchen garden is needed for Bamyan but for other regions not clear as for example vegetable is already cultivated in there. Seed also should be provided. Kitchen garden is used for food demonstration and also for income generation by solidarate.
Short term not possible kitchen garden to achieve the target, but after the winter if solidarate provide cooperation we will keep or continue it. Until June it will be kept. In Bamyan we can assist it.
PCH Concept is that if only focus is clinic to reach to malnutrition we will never reach to objective. Dr Panna says that IbnSina has a program, EPI, oars, food demonstration. IbnSina should go to program of supplementary nutrition program.
On job training for growth monitoring
Use information growth monitoring for interest, collaboration.
AGREE TO CONTINUE FOOD DEMONSTRATION PROGRAM.
Malnutrition I usually due to some family problem that is called family distress syndrome and the main problem is family to be solved.
not acceptable as explained the feeding problem has to be solved

Minutes Day five 12.11.98

Dr. Panna stated that we had discussed a series of activities yesterday, with the purpose of future short and long term plans. Five activities had been discussed yesterday, the two remaining will be discussed today. We should prioritise.

Considerations such as future expansion, for example will have both pros and cons. It could be be dangerous because though the quantity of output will be increased, there might be a loss of quality. On the other hand growing bigger needs more funds and good reasons need to be given to donors in this respect. IbnSina has got a good reputation now and it is important not to jeopardise this by increasing the activities.

Community Based Health Care

The next topic for discussion was the experimental community based projects. The question raised was whether IbnSina felt this was the right approach and what it meant in practical terms. The consensus was that this was the right approach and the following should be part of the way in which all decisions about which areas to work in should be made:

Community Contribution should be sought everywhere.
We insisted on Community contribution and it is correct. It is in our plan. Is it the policy of IbnSina or is it just an unplanned method of work of the organization to look for community contribution.

Dr. Anwar asked what is the understanding of Community contribution? Providing building for facilities. Payment of fees and charges of drugs and finding staff are all various types of community contribution. Do you think that IbnSina should work for an area whose people does not like to contribute? IbnSina should work or not? Community contribution is released through demand of community. Starting new activity is one point and strengthening and extending the present activity in other. We should not work in an area where people do not contribute.

Dr. Panna said that for example, NAC policy is that they build a school whenever there is a need and a formal application is made which is signed by the shura and elders and the people are ready to contribute materials such as sand, gravel, stone etc. Should IbnSina design a policy to follow its routine program based on it? Should IbnSina ask for some type of contract between organization and community.

Criteria for community participation:

The following were agreed upon as the ingredients for an understanding with the communities:

- Request from community. Community must request IbnSina presence.
- Written request. From elders, shoras, and authority confirmation.
- Assessment by IbnSina. To assess the need. Will check if other organizations are working in the area.
- The building should be selected from government belongings or from Public buildings.
- If this not available, IbnSina should ask for three rooms from the community.

In both cases, if either the building needs rehabilitation or the three rooms clinic needs to be upgraded, what should be the policy of IbnSina?

Sarwar requested 50% from Community. Said Nadir mentioned community contribution of people in Kamard district.

Dr. Anwar stated that our policy in rehabilitation would be 100% from community. If they are not able to a such an extend 50% community contribution is required.

Maintenance of facilities' buildings will be the responsibility of IbnSina.

These would be policy of IbnSina after May 1999 whenever IbnSina decide to establish new facility. To explore the help of other NGOs for construction. The land will be provided by government or community.

Establishment of Health Committees and the formation of female Health Committees.

IbnSina will not be in position to talk with every one in the community. We will contact with the elders.

Do you think IbnSina should have Health Committees in all facilities catchment areas in Kandahar and Ghazni, asked Dr. Panna.

In future Health Committee should be there or not? And why?

Before establishing a clinic should there be a Health committee.

Panna asked the staff of Nangarhar and Ghazni about any change or improvement after Health Committees have been established?

Sharif reply was positive and he stated that before establishing Health committee they had had problem and they do not have them now.

Female Health Committees

From the floor it was suggested that men can represent the women in a committee. The women present were asked if they thought that they could be represented fully by men. The female staff did not agree. Women and children have made majority of a society, Dr. Shafiqa stated. So there should be a female HC.

There is no problem from Taliban side. The problem is from the community for Female Health Committee.
Solution:
IbnSina has only one experience in Bamyan. Women cannot perform anything their men disagree with or that has not been discussed with them. So IbnSina policy will be to explore the possibility in future.

The point was raised that a suggestion from the group working on community work had been that an assessment of community needs can be done through Health committees (Mullah). It was asked whether it is possible to make an exact survey, to map the village, its size, its population. Said Nadir mentioned the example case of survey in vaccination activities.

Dr. Panna said that Dr. Peter Kok had suggested that methods such as PRA or RRA could be used for this.

Dr. Karim - IDD in Shiwa

Train more CHW?
Mukhtar.
1. In the current program we should implement the current plan and in next program we will plan other CHW training.
2. It was proposed to add one female staff for Health Education and Nursing skills in Nangarhar and Ghazni. The budget will be reallocated.

Cost recovery and sustainability
Increase of cost sharing explain the possibility in the next program.
Income Generating activities had been suggested by the group as a possible way of making the programme sustainable.

The capacity of IbnSina should be considered. The general thought was that we will not able to do it.

Coordination and collaboration with other agencies working in the same areas was a strong recommendation from the group that worked on this issue. The question was as to how this could be practically done and to what extent. There was general agreement that this was needed and that donors were asking for more co-ordinated planning.

Dr. Panna. Can you affect other agencies to change their policies.
Dr. Nabi - Every NGO has its own policy. We should talk with them to design a joint plan.
Dr. Anwar - At district level meeting with other agencies should be conducted
District Coordination meetings should be conducted. Where does IbnSina want to serve?
To prevent duplication. For example in Nawor we discussed with SCA and after that SCA upgraded their C2 to C1 and IbnSina closed up its C1 clinic and shifted it to other place.

Where should we work? This raised the discussion of whether IbnSina should expand its programme
To extend to more regions?
Upgrading the clinics?
It was agreed that in the present program up to May we do not have the plan to expand the program.

This was followed by suggestions from the regions:
Dr. Khuja felt that it was justified to upgrade C2 clinics to C1 or M1.
They could establish M1 clinic in Nowzad. They plan to upgrade 5 C2 to C1 or M1
1 in Nad Ali
1 in Karz
1 in Nawa.
Sangeen (new facility) Helmand within the current programme Nad Ali M1 and Karz (C1).
Mr. Sarwar: To upgrade Waras and Panjab in future. (F. Dr. Karim)

Dr. Sahrif: Stated that around 6 months before there was a survey for EC in Jalalabad. There is a need for a new facility in Kama district which has a population of 80000 people.
He feels a need for 4 extra clinic in Khas Konar, Laghman........
Dr. Hedayatullah: Serious need of clinic to be established in Paktika. This was recommended by representatives and elders of province in Last Feburary. This of course is a request after May. Staff can be found from locality.

Panna. The question is now Budget. IbnSina works and it should work well. IbnSina is not working in clinics only. The organization is working in HE, CHS. More clinics need more staff, more administration more capacity and more supervision.

Sharif states that he can manage with the help of the PHC trainer to continue with the current level of supervision and support even if the number of facilities were to increase.

No upgrade of Karz clinic

Ok for one new MCH clinic in Nangarhar.

Should we work within present four region or deduct one of them and concentrate in three others or add one more beside the present Regions. There seemed to be consensus to continue working in the present areas.

Sharif. To streathen the present Region and facilities.

Hedayatullah: Expansion to more province but not exceed to other regions.

Khuja : We have our activity in 3 province and he prefers to keep within the same.

Hedayat : Bamyan has been considered as Central Region. It is better to bring the center in Kabul in order to cover northern part of Kabul as well.

Sarwar: Kabul will have the difficulty to cover remote area. He opposed to get expanded.

Summary: No expansion. Only new clinics or upgrading present facilities.

We should have a limit for 3 years.

Hedayatullah : 3 clinics in Ghazni

Shaif : 1 up to June and 4 more after that.

Sarwar : 2 Upgrading and 1 new one.

Khuja : 2 Up grade, 2 New more

EPI

The following points were discussed:

More courses for vaccinators.

Vaccinator can join Health Education course whenever there is a course. A vaccination course will be in Ghazni in December 1998.

Do we extend duration of the course of vaccinators?

UNICEF policies affected IbnSina's activities.

Coverage and accurate reporting or representative reporting of the same showing actual achievements in districts where IbnSina works rather than province wide reporting which will decrease the coverage.

There are short comings in IbnSina's work and these need to be addressed, all problems were not caused by UNICEF.

Solutions:

1. Other organization or donor have to be asked to support IbnSina in EPI. The gap should be identified. We can approach other donors to fill the gap that is identified.

   In every MCH clinic we can appoint one female vaccinator so that horizontal vaccination is not interrupted by the outreach/mobile work.

2. To coordinate with UNICEF for tool kit for the Bamiyan VSF.

   Rehabilitation of Bamyan should be done through UNICEF and Novib. It is possible to do it till March.

   Population survey in catchment area is to be put within 3 years program.

   Said Nadir : It can be done not so perfect but a high percentage as per his experience in vaccination activity.

   In population survey UNHCR has to be contacted because of Refugees returning stated Dr. Nabi.

   Dr. Panna. It will be better to explore for population in catchment area than to do survey.
3. Hand over EPI to MOPH in Ghazni and hand over EPI partially in Bamyan should MoPH request this.

IbnSina will continue present EPI activity there is a strong request to hand over EPI to MOPH and unless there is changes in policy. Similar decision has been made between Dr. Iqbal and representative of UNICEF in Ghazni that all Health activities are to be going on in districts where IbnSina is working.

The possibility to train one female vaccinator.

4. Regional female Supervisor should be trained in vaccination. Then she will train the female vaccinator.

The program should be implemented before May 1999.

5. All Regional key staff should be involved in EPI and require training for the same as this is an important issue and is a complicated and specialist programme

In future 3 years the same should be continued.

Personnel

1. There was suggested to hire a female MCH incharge in the Main office. But the problem of the Taliban regulations will continue making it difficult for female Afghan staff to travel without a maharram. Explore the possibility actively but hire only if there is a real role for her.

2. Standardization of salaries:

IbnSina has solved the problem in its next program. All salaries of the staff has been standardized. Financial procedures differ in clinics and Regions. Should clarified the issue.

Cost sharing - 30 % cost recovery.


It is an already going activity. (Dr. Ahmad jan)

4. Back up for key staff.

Assistant Technical Assistant

We will explore the possibility and asking the donor (Dr. Anwar)

Other Strategies:

1. Training center for Bamyan and Mass media.

In the next future program to explore the possibility of Training center in Kabul or Jalalabad or Mazari Sharif for training of PHC and community based prorgms.

It need a separate budget.

2. IbnSina should get involved in a programme for refugees in Pakistan (Dr. Anwar).

From different aspects it will be considered in future program should a proposal or approach be made to IbnSina.

End of Program

Dr. Panna

It was hard work of every one. It was fruitful and useful. The concerned report of the workshop will be sent to each participant. It was a mid term evaluation. Thank you for your participation.

Dr. Anwar

Thanks for your participation. It was fantastic to see field staff in the Main office.
List of Participants

1. Ms. Jolande Dekker Memisa
2. Dr. Peter Kok Memisa
3. Dr. Panna Memisa
4. Dr. Loan Memisa
5. Dr. Inger SCA
6. Dr. Anwar Director General
7. Dr. Ahmad Jan Technical Manager
8. Dr. Majid HIS Officer
9. Dr. Iqbal EPI Officer
10. Dr. Karim Training Coordinator
11. Mr. Muqeem Pharmacist
12. Mr. Tariq Financial Manager
13. Mr. Stan Klinkenberg Financial Coordinator
15. Captain Fazal Liaison Officer
16. Eng. Ikramuddin Operations Manager
17. Dr. Khwaja Regional Director, Kandahar
18. Dr. Hedayat Regional Director, Ghazni
19. Dr. Shafiqa Female Supervisor, Ghazni
20. Mr. Mukhtar Community Health Supervisor
21. Mr. Mohibullah Health Education Supervisor
22. Dr. Kutsia Head, MCH clinic, Ghazni city
23. Mr. Sarwar HIS analyst, Bamyan
24. Dr. Sharief Regional Director, Nangarhar
25. Dr. Rokhshana Female Supervisor, Nangarhar
26. Mirwais MLWH, Surkhrud clinic, Nangarhar
27. Dr. Saboor Head Khwaja clinic, Nangarhar
28. Dr. Samiuddin Head Chorbagh clinic, Nangarhar
29. Dr. Zohra Female doctor, Chorbagh clinic, Nangarhar