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**Support to the Health Sector in Helmand Province,  
Afghanistan**

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## ACRONYMS

ANDS	Afghanistan National Development Strategy
ARTF	Afghanistan Reconstruction Trust Fund
BPHS	Basic package of health services
BSC	Balanced scorecard
CIMIC	Civil Military Cooperation
CMMH	UK Civil-Military Mission to Helmand
DFID	Department for International Development UK
DH	Department of Health UK
EPHS	Essential package of hospital services
FCO	Foreign and Commonwealth Office UK
GIRoA	Government of the Islamic Republic of Afghanistan
HMG	Her Majesty's Government UK
IDLG	Independent Directorate of Local Government
ISAF	International Security Assistance Force
MRRD	Ministry of Rural Rehabilitation and Development
MoPH	Ministry of Public Health
NHS	National Health Service UK
PAR	Public Administration Reform
PRT	Provincial Reconstruction Team
SAF	Stabilisation Aid Fund
Wat/San	Water and sanitation

## EXECUTIVE SUMMARY

The main aim of this consultancy was to develop options for increased Department for International Development (DFID) support or stabilisation aid funds (SAF) that will help improve health outcomes in Helmand province, Afghanistan<sup>1</sup>. A country where health is consistently ranked among the top 5 priorities of the general public and the Ministry of Public Health (MoPH) has achieved some notable successes in getting health services out to the people<sup>2</sup>.

The overall conclusion from this scoping study is that DFID development funds would have the most impact on improving health outcomes. While insecurity is hampering health service delivery in some places in the province some of the time, there is a sound health development framework in place. What is needed is to support equitable, quality service delivery and systems development, and at the same time incrementally work on building state capacity and governance. Raising state visibility and legitimacy in the health sector is currently not advisable, except at provincial hospital/directorate level. At district level and below the public sector health services have been contracted out to an NGO, which is working to the principles of neutrality and impartiality. However by positioning itself in relation to the state through having a contract with government to deliver health services, some members of the general public in the province do not see it as being impartial. There have been 12 conflict related deaths among the staff of the NGO since 2006.

Some possibilities have been identified for SAF funding but for the most part there are few interventions that could have an 'immediate stabilisation impact' which is a SAF requirement. Such interventions, which are essentially quick impact projects (QIPs), have mainly been useful in the health sector immediate post-conflict to fill gaps by providing packages of basic drugs, vaccination, training programmes and the re-building or renovating of health facilities.

There are 6 key messages in this report. The first is that the country is now at a critical period. In areas where progress has been made such as health, this is now slowing or has stalled. This is particularly the case in Helmand Province in those places where there are high levels of insecurity. Security is fundamental to improving health. But there is also an intuitive recognition of the stabilising effect of providing services and meeting people's needs, security and health are mutually reinforcing. By having a purposeful drive to engendering trust with local communities, building on things that work in health service delivery, taking risks about innovative approaches to improve equity, access and quality, strengthening governance in health and communicating the results the provincial health directorate can be helped to make a sound contribution to better health and to a more stable political context. For the most part all this needs a participatory development approach, a mix of health services and systems development for which DFID can add value.

The second key message is that another important way forward in health and other sectors is to focus more on the 'how' of capacity development rather than so much on the 'what' in Helmand. There are a number of people who can expound on what the problems are and what needs to change. But few suggest pragmatic, relevant and useful ways on how to go about managing change. Crucial are the attitudes and approaches by the provincial reconstruction team (PRT), civil military cooperation (CIMIC) and others working towards stabilisation. There is capacity among Afghans the challenge is to recognise it and build upon it. Developing the capacity to working

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<sup>1</sup> See - Terms of reference: Support to the health sector in Helmand, October 2008, DFID

<sup>2</sup> WB 2005. Chapter 2, Health sector. Afghanistan public expenditure review. World Bank, Kabul

better with community shura is particularly important, only they can provide the humanitarian space needed for health service delivery in insecure areas in Helmand.

A third message is that apart from insurgencies, what is currently jeopardising efforts to deliver client-friendly health services in some areas in the province is the presence of ISAF troops in or near a health facility, and where ISAF provides static or mobile health care for the people of Helmand. Some in ISAF think that providing medical care 'will win the hearts and minds of the locals'. But, by association, it is putting the lives of communities and NGO personnel at serious risk, an issue first recognised in 2004 – see annex A<sup>3</sup>. There is no one easy answer as on rare occasions the medical care may be justified. But it is hoped that standard operating procedures that address this issue, being produced by the ISAF Regional Command South Headquarters Kandahar December 2008, will be adhered to by all ISAF troops.

The fourth message is that sound information is scarce, but currently it is likely that because of the insecurity deaths and illnesses are more of a problem in Helmand than national averages suggest. In a country with some of the highest mortality and morbidity rates in the world (see table 1) health service coverage is thought to be very low in at least 50 percent of districts in the province and almost non-existent among those who, for security reasons, are hard to reach (see table 1 for estimates of coverage of important public health interventions.) Members of the community are key to getting service delivery done, especially in times of insecurity. There is a well founded belief among many in the province that all factions, whether political or tribal, do not want to see their women and children die. Somehow trust has to be established on all sides and health services made accessible and available.

**Table 1. Differences in health status, Helmand province and national averages<sup>4</sup>**

Subject	Helmand province	National average
Maternal mortality ratio	4,503/100,000 live births <sup>^</sup>	1,600/100,000 live births+
ARI	12 /1000	6.7/1000
Diarrhoeal disease	15.3/ 1000	2.6/1000
Contraceptive prevalence rate	1.8%	15.4%
Antenatal care	5.6%	30.3%
Skill attendance at birth	1.5%	18.9%
OPV	16%	69.7%
DPT3	3.9%	34.6%
TB case detection rate	11.6%	36.4%

Basic health service delivery will be in jeopardy next year as the World Bank, which currently funds implementation of the basic package of health services (BPHS) in

<sup>3</sup> MoH. 2004. Ministry of Health statement on security and access to health care. Ministry of Health, Kabul

<sup>4</sup> \*See annex B for sources of information. <sup>^</sup>Analysis of limited data 2007; +UNICEF 2003

Helmand, will have insufficient funds. Implementation of the BPHS is the priority for the MoPH as reflected in the Health and Nutrition Sector Strategy 2008-2013<sup>5</sup>. The MoPH has expressed the wish for DFID to take over the full cost of funding the BPHS next year. World Bank is in accordance with this. Its' overall funding for Afghanistan will be reduced as the Bank will receive less IDA money next year. The value added of support in the health sector in Helmand from Her Majesty's Government (HMG) would be its comparative advantage of being able to provide a comprehensive package of support for health services and systems and their governance. In addition HMG can access Helmand better than most other donors and organisations – see sections 2, 4 and 7 of this report and also annexes B, C and D.

The current mechanism for delivery of the BPHS is that of contracting out to an NGO with the provincial hospital run by the MoPH. To help improve equity and access, specifically targeting those who for security reasons are hard to reach, some initiatives have been identified. These include the need to strengthen the relationship with community shura to help assure the safety of health personnel when delivering the BPHS, innovations such as training all doctors in the province to be able to perform an emergency caesarian section, increasing the number of evidence based interventions in the BPHS for which a financial incentive can be paid and increasing staff morale through better support, supervision and continuing education. These initiatives (called "add-ons") mostly require a medium term commitment, but some work that only requires short term funding would also be useful – see option 5. Also see Box 1 for a summary of the initiatives, Box 2 for some of the security related challenges they address and sections 3 and 6.

**Box 1. Approaches to achieve equity in health service delivery and improve morale of health staff in Helmand**

- Integrating vertical polio and other EPI campaigns with the delivery of other essential BPHS evidence based interventions
- Emergency caesarian section training for all doctors in the province
- Payment for transport scheme to prevent catastrophic out-of-pocket expenditure among the poor and continuation of the conditional cash transfer scheme
- Public-private partnership for M&E of basic health service delivery and for quality of provincial hospital care
- Incentives by results
- Continuing education
- Supervision and support by central level Ministry of Public Health to the provincial health directorate and by the latter to districts

Effectively and efficiently functioning hospitals providing quality care are also important. Currently in Helmand, apart from the provincial hospital there is just one district hospital, the other two have been destroyed. A missing factor is support to implement the essential package of hospital services (EPHS). Initially, this is especially so in the case of Bost provincial hospital. Camp Bastion is looking to withdraw from providing emergency care for Afghans. One of the key reasons is that once admitted they tend to have to stay longer than ISAF or other eligible internationals because of problems surrounding discharge including transport and ongoing care. A military hospital such as at Bastion has to be able to rapidly evacuate casualties in order to be able to deal with sudden increases in admissions. This means Bost hospital and its neighbour the Italian emergency hospital will need to be able to receive and care for such patients. A public private partnership between

<sup>5</sup> ANDS 2007 Health and Nutrition Sector Strategy 2008 – 2013. Afghan National Development Strategy  
DFID Health Resource Centre



the two hospitals to improve quality such as in nursing care is a way forward. Additionally, the UK National Health Service is prepared to provide continuing education focused on quality improvements and hospital management advice. Also see section 5 and annex H.

The 5<sup>th</sup> message is that making better use of, or building upon, existing DFID initiatives in other sectors e.g. infrastructure, advisory, sub-national reform and oversight of service delivery could be useful, but not in isolation of addressing the top priority: implementation of health service delivery and the systems crucial for achieving good results. If there is a gap in financing health services next year then only building upon existing DFID initiatives would at best be tinkering at the edges and at worst, ignoring what is really needed: quality health services and public health management. Not addressing this need in Helmand in a country with some of the worst death and illness rates in the world, especially among women and children, will be a real missed opportunity. If there is no need for HMG financial support for the implementation of the BPHS next year then there will still be a need to strengthen the quality of hospital services and indeed, building upon current DFID work on sub-national reform within the framework of governance would be useful in the health sector Helmand and at national level – see option 4.

**Box 2. Key constraints to health in Helmand**

Extremely difficult to ensure equitable, quality health services throughout the province because:

- Twelve of the 440 health workers (2.7%) employed by Ibn Sina, the NGO contracted to deliver the BPHS in Helmand were killed during insurgencies and/or by targeting between 2006 and the middle of 2008
- Achieving adequate coverage of public health interventions such as vaccination campaigns is very problematic as health personnel face acute danger when travelling in some areas
- There is insufficient negotiation with, and support from, community shura to assure safety
- The routine provision of key evidence based public health interventions is not possible as some health facilities have either been destroyed or are in difficult to access places
- The presence of ISAF troops in or near a health facility and the provision of mobile or static health care by ISAF jeopardises security of both community and staff
- Inadequate numbers of doctors who can do an emergency caesarian section and nurses who can give the necessary anaesthetic
- Some facilities are not adequately staffed, if at all, due to high levels of fear among staff, low levels of motivation and high turnover
- Unable to obtain and distribute adequate medical supplies
- Some hospital services are not functioning for lack of financial and other resources
- It is almost impossible to travel around to do any outreach, supervision or monitoring of quality
- Poor people cannot financially afford to travel to the nearest functioning health facility
- In addition to cultural reasons, male heads of households are even less likely to allow females in the family to travel to a health facility for safety fears
- The provincial health system not functioning effectively due to poor support from, lack of decentralisation by, the MoPH at central level; allocated recurrent budget the same every year despite requests by province for changes; undermining of the provincial health office by the office of the governor; and a disempowered provincial health director as no budget or authority re. the oversight, monitoring and supervision of all stakeholders in the health sector

The 6<sup>th</sup> final key message is about what is not needed. For the foreseeable future there should hardly be any more health facilities built, inappropriate medical equipment and supplies must not be allowed to be donated / provided and projects or ad hoc activities that do not fall within the framework of Afghan government policies, guidelines and systems must not be allowed to happen. There should be no link between HMG and/or the UK general public or 'white elephants' e.g. UK funds used to build inappropriate facilities or buildings standing empty because of lack of staff or funds used for interventions parallel to current government policy and NGO initiatives in Helmand.

**Supporting the health sector in times of insecurity** In Helmand HMG has a very real opportunity to have a comprehensive approach to making health services and systems work effectively in times of insecurity through providing multi faceted development orientated support. A healthier society could make better use of the livelihoods, infrastructure, and private sector initiatives and contribute to economic, social and governance development. Much of the support in health needs to be targeted to address equity, to better enable effective, efficient and quality health services to be delivered to those hard to reach in the province. In this way the support would also contribute to stabilisation. If there is no equity, if people feel they are being neglected and if there are poor quality services, then discontent can lead to de-stabilisation. Helping improve the delivery of the BPHS which are free services would also help reduce the estimated national average of US\$45 per capita per annum household out-of-pocket expenditure<sup>6</sup>. This in turn would help reduce resentment and so contribute to stabilisation. These and other contributors to stabilisation can be seen in Box 3.

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<sup>6</sup> MoPH/EC. 2008. Health Financing Review. Ministry of Public Health, Kabul

### **Box 3. Stabilisation and health in Helmand province**

- Trust has to be (re) established with members of the community, with all factions whether political or tribal, to enable health service delivery. Individuals and communities do not want to see their women and children die
- Targeting much of the support in health to address equity, to better enable effective, efficient and quality health services to be delivered to those hard to reach in the province to address social inequalities would help reduce feelings of neglect among communities
- Enabling all doctors in the province to be able to perform an emergency caesarian section will help reduce the high levels of maternal mortality and so help increase confidence in public sector services. Husbands will often allow a male doctor to do an emergency caesarian operation as they do not want their wife to die, even in conservative Helmand
- Helping improve the delivery of the BPHS which are free services to help reduce the estimated national average of US\$45 per capita per annum household out-of-pocket expenditure would help reduce resentment in households
- The condition of health services is generally in the top three publicly voiced concerns in Afghanistan with perception heavily influenced by hospital services so help improve state legitimacy through improving the quality of the provincial hospital services
- Develop and communicate radio messages that raise awareness about successes and ongoing work in the health sector and about key health issues as a first step towards forging a state-society compact
- Improve provincial governance and state visibility and legitimacy in health through helping the PHD have better oversight of the public and private health sector with increased authority and a budget
- Improve motivation to deliver health services and develop health systems through better supervision, monitoring and support being provided by the provincial health directorate on a regular basis to districts and also by central level MoPH to the provincial health directorate
- Better health would enable women in particular to contribute to economic, social and political development
- HMG has value added in governance and systems development and by renewing its support in health including at national policy level could directly help the stabilisation effort in health

Any potential support requires willingness by HMG to: bear the increased costs of reaching those hard to reach because of insecurity, allow for innovation, flexibility and rapid decision making in Afghanistan and in Helmand in particular and make greater allowances for the use of qualitative rather than quantitative indicators for success given the challenges of obtaining sound information.

The areas of support, both medium and short term, identified in this report are a response to expressed need and provincial aspirations, they build upon lessons learnt in service delivery in times of conflict, would contribute to strengthening state building and stabilisation, are harmonised with other stakeholders and are consistent with national policies and guidelines. At present, because of the high levels of insecurity in Helmand, there is no one thing, no “big bang” that could immediately make a difference to strengthening health service delivery or to enhancing state legitimacy or visibility in health. For the most part, peace is the key pre-requisite to better health. However, there are incremental steps that can be taken towards such objectives. Potential areas of support by HMG can be seen in Box 4.

Currently, for security reasons, there are relatively few donors in health in the province. The key stakeholders are the Helmand Provincial Health Directorate/Ministry of Public Health, the World Bank through the local NGO Ibn Sinh for delivering basic health services, the Italian emergency hospital, WHO and UNICEF and the PRT with funds from the Estonian government - see Annex C. WHO is predominately supporting polio campaigns and UNICEF both the prevention of polio and other vaccine preventable communicable diseases. The PRT has mainly focussed on infrastructure work. Any DFID/SAF resources would complement, not overlap or duplicate other initiatives and would build upon general rather than any specific initiative in the health sector.

**Box 4. Framework of possible HMG support in health in Helmand**

1. Targeting those who, for security reasons, are hard to reach in the province
2. Enhancing the delivery of basic health services
3. Strengthening the delivery of essential hospital services
4. Raising the morale of health personnel
5. Strengthening governance in the health sector

**Possible HMG support - success factors**

Early, rapid decision by HMG especially about funding for BPHS, or not

The proposed support builds upon expressed needs at provincial level and a firm conviction that the add-ons to the BPHS and EPHS can help make a difference and the actions must be supported to achieve planned results

Both the medium and short term support is all interlinked, falls within government policies and would be implemented within the overall health system, not parallel to it

Taking risks about initiative and innovations to strengthen health service delivery in times of insecurity - see Box 1.

**Anticipated results** will need to be agreed with the provincial health directorate once there is a decision on the level and type of support. If for example the focus of support is on health service delivery with governance and systems strengthening then, security permitting:

Coverage of basic health services will increase from an estimated 10-15% to at least 70%

Quality of service delivery indicators will improve from the 2004 baseline – see Annex B and no less than 10 of the indicators will be below the national median average

Emergency caesarian sections will be being performed in at least 4 districts

Supervision, monitoring and support being provided by the provincial health directorate on a regular basis to districts from the current zero level

Bost hospital will improve as per the logical framework at Annex H

Provincial health directorate has oversight of the public and private health sector with increased authority and a budget

Other overall anticipated results from financial investment by HMG include:

Improved provincial state visibility and legitimacy in health

Better health enabling women in particular to contribute to economic, social and political development

Contribution to the national achievement of the health MDGs and the ANDS targets

In its use of the Stabilisation Aid Fund (SAF) monies the focus of the PRT in Helmand is doing things that will have an “immediate stabilisation impact”. Currently, no Helmand specific criteria exist to help clarify what this means but generally stabilisation usually requires a focus on the legitimacy and capability of the state, and tangible benefits to the population to underpin confidence in the state and the political process<sup>7</sup>. There is an intuitive recognition of the stabilising effect of meeting people’s needs through providing health services. For the most part in Helmand this means providing support within the framework of health development rather than only having funds available for ‘quick wins’ or quick impact projects. For life to become ‘normalised’ in insecure areas it will take the building of trust with local communities to ensure the humanitarian space to permit regular provision of quality health services.

**Overall monitoring and evaluation** of any HMG support could be undertaken in conjunction with intermittent policy, institutional development mentoring visits by a national level DFID health adviser or TA equivalent. For example, brief quarterly monitoring reports, an annual review and a final completion report. If only limited short term support is provided then the anticipated results could be set by, and the monitoring of any such support could be undertaken by, the PRT health adviser.

**Risks** include:

Increases in insecurity in Helmand may mean that a few investments, such as in infrastructure, are worthless as buildings are again destroyed

Planned results are achieved to a limited extent because security, transport, communications and poor morale continue to hamper implementation

Lack of political will and institutional commitment at both the national level and in Helmand to improve governance and service delivery in the health sector

Inadequate, inefficient coordination of HMG inputs

### **If there is no HMG support for health**

Nationally Afghanistan has some of the worst health indicators in the world. Accurate data is impossible to obtain in Helmand but it is likely that given the high levels of insecurity some key indicators such as maternal mortality rate and the death rates for children under five years of age are even higher than the national estimates. This

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<sup>7</sup> Stabilisation Unit 2008 Stabilisation Issues Note: Quick Impact Projects. Stabilisation Unit, HMG, London

scenario will continue. In addition, there will be some very real missed opportunities – see option 6 below.

### **Aid instruments**

The forthcoming new window for health in the ARTF (due February 2009) could be used for options 1, 2, and most of option 3. For the latter the only exception might be the need for a separate contract for any NHS support. To ensure any funds are used for Helmand health DFID could state its wish for the preferenced funding modality (under which donors prefer to fund specific projects in specific ANDS sectors) as opposed to the non-preferenced modality (where donors give funds the use of which will be decided by the ARTF Management Committee)

Earmarked budget support through the Ministry of Finance is another possibility for options 1, 2 and most of option 3. In terms of aid effectiveness it would be preferable for any DFID funding (as opposed to SAF) to be in the form of budgetary support and therefore be direct to national government level as opposed to project support to Helmand. There would be lower transaction costs, it would avoid duplications of activities by different donors in the same sector, ensure programmes are aligned with government's priorities, increase ownership by government and build mutual accountability and management for results. DFID gave a small amount of budgetary support to the MoPH through the Ministry of Finance in 2003 to help develop decision making and the development of the administrative systems necessary for transparency and efficiency

Option 4 could be financed through (i) an amendment to the existing DFID support for governance or (ii) be at no direct cost if the advice is provided by a DFID health adviser for Afghanistan or (iii) TA be contracted as part of new support.

The SAF monies available for the PRT Helmand could be used for any, all, the content of option 5.

### **What is not wanted in the health sector in Helmand province through HMG advocacy and support as a result of this scoping and analysis?**

ISAF troops in or near health facilities or providing static or mobile health services for communities that do not follow the forthcoming ISAF standing operating procedures

Any health facilities built other than those mentioned in this document – see Option 5, number 5(e)

Contracted out construction without having consulted the provincial health directorate in the design and specification and which is not well supervised

The use of inappropriate technology especially at community level e.g. flush latrines for schools and health facilities and the building of latrines too close to water supplies

Donations of inappropriate medical equipment and/or pharmaceutical products

Any new/different support not mentioned in this document that is not first discussed and agreed with DFID Kabul and the MoPH in Kabul and Helmand

Uncoordinated TA

TA that is not sensitive to the culture and that does not recognise that some capacity does exist in Helmand province, the challenge is the approach taken to build upon this

Health coordination meetings parallel to the Provincial Health Coordination Committee that request the attendance of members of the committee

Any move to advocate for a greater humanitarian approach to health service delivery which bypasses government and other systems, structures and processes in place

## **COSTED OPTIONS**

Options 1-5 in Box 5 are all linked to existing government of Afghanistan programmes and initiatives. This approach would contribute, sometimes directly and in some cases indirectly, to state building, legitimacy and visibility in the health sector. In addition, the HMG value added is significant in option 1 as it has the comparative advantage of comprehensively working effectively on health service delivery, governance, institutional and systems strengthening and short term issues. Options 2 and 3 also address health service delivery with the wider governance, systems framework but in a more limited way. Option 4 is if HMG support is not needed for health service delivery, sub-national governance strengthening will still be needed. The content of option 5 has been designed to ensure that it is not a wish list or a list of quick wins that has no or little relationship with ongoing, important work in the health sector.

The options have additionally been framed within a resource availability perspective – also see Box 5. Option 1 is ‘high scenario’. It would be feasible if there were the HMG will to provide sufficient funds. In a ‘medium scenario’ of more limited availability of funds either options 2 and/or 3 could be considered. Options 4 and 5 are ‘low scenario’. Ideally, option 5 would be added on to support for any one of options 1-4. The time frame of 4 years is used for options 1, 2 and 3 as this is the timing used by government for each round of the BPHS contracts.

Different decision makers will read the following options coming from different perspectives. Therefore the options have been written in such a way as to offer a range of approaches and a menu that can be chosen from. All can be taken forward none are mutually exclusive, although it will be obvious that if for example option 1 is chosen then all the others are not needed. At the moment of writing it is clear that option 1 and if not, then option 2 is the most appropriate for taking forward. But this is a complex, continually changing context and should assured funding be found for the BPHS by the time a decision is made then choices will have to be made between the remaining other options. If there is only SAF funding available then there should be joint PRT/provincial health directorate decision making as to which of the interventions in option 5 are priority for funding.

The options are all for implementation across the province. There has to be equity in delivery. Additionally, difficulties surrounding making useful field visits etc did not allow for a valid conclusion to be arrived at about limiting activities to key districts.



**Box 5. Options for HMG support in health in Helmand**

**'High scenario'**

1. Comprehensive medium term approach: BPHS + add-ons, EPHS + add-ons, provincial health governance strengthening, national level policy, governance, institutional and systems development for 4 years

**'Medium scenario'**

2. Focus on support for BPHS + 2 specific add-ons for 4 years  
and/or
3. Focus on EPHS + 2 specific add-ons for 4 years

**'Low scenario'**

4. Strengthen sub-national health governance
5. Provide short term inputs

**Final option**

6. Do nothing

**Option 1. HMG supports the state to take a medium term health sector approach in Helmand through supporting the full costs of implementing the BPHS and the EPHS, both with their add-ons and governance and institutional development in the provincial health directorate complemented at national level by health policy support plus some short term inputs.** This option proposes investing about £ 15,009,000 over 4 years. This level of aid is seen as meeting some priorities of the Afghan government and in doing so enabling HMG to: directly support more equitable, quality health service delivery that is responsive to the security context; and help: strengthen governance in the provincial health office; improve central and provincial communications and support in the health sector; and support policy making at central level. The full content of this option is summarised in table 2.

It is likely that there will be a gap in the financing of the BPHS next year. The current funder of the BPHS in Helmand is the World Bank. It has only US\$ 30 million over 3 years from IDA for financing the BPHS in the 11 provinces it currently covers. It needs a total of US\$ 25 million for the 11 provinces for just one year. It is imperative that the BPHS be fully funded and so this is the preferred option if there is a gap in financing and if option 1 is rejected. Crucially there would also be the need for some add-ons for basic service delivery and support for strengthening the health system and its governance at both the provincial and national levels in order to have a sustained impact. By taking over the full costs of the BPHS and also supporting the EPHS there will be more opportunities for HMG to influence stakeholders in the health sector at the national level. There are so few major donors prepared to work in Helmand, and because of the World Bank's forthcoming funding gap for the BPHS, it does mean that HMG support would be addressing health in Helmand almost alone. But this is no different to World Bank, EC and USAID support for the EPHS and BPHS in other provinces.

**Option 2. HMG provide the full costs for the BPHS in Helmand plus 2 specific add-ons, addressing constraints and PHD and national level policy, governance support for 4 years. Full cost of BPHS = £9.3m; add-ons = £1m; PHD and national policy support = £750,000. Total cost of £10.4m**

This option would require a lower level of resources than option 1 and would have as its focus the key intervention of enabling the equitable delivery of quality, efficient health services. It is imperative that the BPHS be fully funded and so this is the preferred option if there is a gap in financing and if option 1 is rejected. Crucially there would also be the need for some add-ons for basic service delivery and support

for strengthening the health system and its governance at both the provincial and national levels in order to have a sustained impact.

**Option 3. HMG strategy is focussed on support for the planning for, and the implementation of, the EPHS with 3 specific add-ons, a public-private partnership between the provincial hospital and the NGO emergency hospital, TA from the NHS, and PHD and national level policy, governance support for 4 years. EPHS cost = £2m; public-private hospital partnership = £100,000; NHS TA = £350,000; PHD and national policy support = £750,000. Total cost of £3.200,000**

Given the very high levels of maternal and child mortality it is crucial to have efficient, quality, user-friendly hospital services especially for obstetric and neonatal care. In addition, quality of care needs to be strengthened if some Afghan war wounded are to be cared for in the provincial hospital instead of at Camp Bastion. Bost Hospital, in the provincial capital Lashkar Gah is the key referral hospital in the province. It has not received any support, financial, technical or management to help it improve its functioning. Implementation of the EPHS would start in Bost Hospital and then rollout to district hospitals. The public-private hospital partnership would be between Bost hospital and its next door neighbour, the Italian emergency hospital with the latter initially providing continuing education to improve the quality of nursing. The TA from the NHS would initially focus on helping improve the quality of obstetric/gynaecology, neonatal and paediatric services and also address hospital management. Support for the implementation of the EPHS would be strengthened by simultaneous work on the health system and governance development at both the provincial and national levels.

**Option 4. HMG builds upon existing DFID support to Afghanistan in governance by helping strengthen sub-national health governance in Helmand through short term advisory visits at both provincial and national level at a cost of £150,000 over 2 years**

If there is no need next year for support for implementation of the BPHS there will still be a need to help strengthen the health system and its governance at the provincial level in Helmand. To be effective such support should also be combined with national level policy and governance development in the MoPH. Only recently has the MoPH seriously started to consider effective and efficient decentralisation. There is only very limited TA at central level to help the MoPH move ahead and none at provincial level. HMG could contribute much to the process of decentralisation and its governance by taking Helmand province as an example of a mix of bottom-up and top-down approaches to improving sub-national governance.

**Option 5. HMG provides short term inputs for health through SAF funding**

The total cost of this option proposes a spend of about £1.380,000 for Helmand Province as either the only support in the immediate future to the health sector until more funds are available or is in addition to options 1-4. All the following interventions have been identified as falling within the framework of health development work. They may be short term but they are not ad hoc or included based upon individual whims. Number 5(c) could have a fairly immediate impact and also contribute to the relevant MDG. The total cost for this option could be reduced to £980,000 by removing proposed support at the national level for 2 of the 4 mechanisms under 5(g).

**5a) Building trust** - no direct cost to HMG only PRT time. Facilitate the provincial health directorate, Ibn Sina, WHO and UNICEF to learn lessons from MRRD in

Lashkar Gah about getting support from municipal authorities and village shura/community development committees to enable personnel to work safely when delivering polio campaigns and other aspects of the BPHS.

**5b) Allaying fear** - at an estimated cost to HMG of £70,000 supply 2 (armoured)<sup>8</sup> vehicles initially to facilitate polio campaigns to reach the estimated 90,000 difficult to access children in the 3 districts of Sangin, Nad Ali and Musa Qa'leh and at the same time deliver other essential evidence based public health interventions in the BPHS. The vehicles must only be provided if, when, 4a above is also addressed. To ensure a coordinated, integrated approach to the vertical delivery of essential interventions in the future and to facilitate supervision, the vehicles should be donated to the office of the provincial health director who should oversee the approach.

**5c) Reducing maternal mortality** - at an estimated cost of to HMG of £100,000 facilitate the training of all doctors in the province (as opposed to surgeons) initially in year one, in Gereskh, Gamsir and Musa Qa'la to be able to do caesarian sections train of at least 2 nurses in each location to give an anaesthetic and provide the equipment necessary to do an emergency caesarian section. The training could take place in Bost hospital, Lashkar Gah. The costs include (a) travel for 1-2 trainers from Kabul and their accommodation allowance and fee; (b) travel costs within Helmand for trainees; and (c) equipment costs.

**5d) Raising morale** - at an estimated cost of to HMG of £20,000 PRT provide some relevant textbooks/CD Roms for use at provincial and district level and fund a local institution such as the Afghan Governance Institute to help develop a continuing education programme for PHD staff and its implementation, initially combined with a short course in Lashkar Gah on health planning and management at provincial level.

**5e) Infrastructure** - at an estimated total cost of to HMG of £600,000 support infrastructure work following MoPH guidelines by the PRT- in Lashkar Gah construct and equip a: 1) 60 bedded hostel for midwifery and nursing students; and 2) provincial health directorate office; and 3) in Marjah construct and equip a community health centre.

**5f) Water and sanitation** - a spend of about £100,000 over 2 years in Helmand Province through MRRD (50 wells = \$75,000; 100 latrines = \$11,000; plus some CHCs may need a piped water supply).

Water supplies and sanitation facilities for 20 schools and 27 health facilities would be a fundamental public health measure to reduce the levels of diseases transmitted through poor water supplies and lack of sanitation facilities. MRRD could implement this but any new support should be dependent on the results of the mid term review of the current DFID support for community water and sanitation supplies in Helmand that is being implemented by MRRD. There may well be important lessons to be learnt about MRRD's experience. Stories abound in the province about poor quality, inappropriate, newly constructed facilities, as because of security problems the supervision of the companies contracted to do the work is particularly difficult.

**5g) Raising awareness about health** – at a total cost of £425,000 over at least 2 years through 4 different mechanisms: (i) PRT to help the provincial health

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<sup>8</sup> There is some debate as to whether the provision of such vehicles, or indeed any new shiny vehicle, is wise as they may be targeted for possession by the Taliban – last minute consultation should take place again before purchase. Any consultation must bear in mind that the provision of such vehicles is primarily to help allay the fears, improve the morale of health workers. An expensive way forward maybe, but the concerns of health workers should not be under-estimated in times of insecurity. Twelve Ibn Sina health workers have been killed since 2006 due to insecurity.

directorates develop a communications strategy and enhance its capacity in the development and communication of radio messages that sensitively - in such a way as to not put the NGO delivering basic health services at risk - raise awareness about successes and ongoing work in the health sector and about key health issues as a first step towards forging a state-society compact at no cost through the PRT and the forthcoming radio station Hawad, funded by FCO/SAF; (ii) Educate teachers in Helmand to give health education in, and providing first aid kits for, schools; and training school teachers to work as trainers on drug demand reduction education in schools as part of a healthy lifestyles approach at a cost of £25,000 through the PRT and provincial health directorate; (iii) Build upon the experience and credibility of BBC Trust. All health messages are relevant nationwide, none are very specific to Helmand province. BBC Trust is thinking about newly addressing TB and maybe drug demand reduction, both of which are major problems in Helmand where the BBC is listened to. Drug demand reduction is particularly relevant and would be a good complementary move to any HMG support for the drug demand reduction centre in Lashkar Gah (see 5h below). Being such a specialised subject it would need some good field research before transmission, as was necessary for the current programme on HIV. The research has been allowed for in the first year costs at a total cost of £250,000 (1<sup>st</sup> year costs = £200,000); and (iv) Help the MoPH at national level develop a communications strategy to inform the general public about its successes, to publicise its achievements at a cost of £150,000

**5h) Drug demand reduction** – at an estimated cost of £100,000 per annum for at least 2 years, through the NGO WADAN. Evidence is beginning to suggest that if opium drug use were routinely recorded as part of the national health management information system it would probably rank among the top 10 health and disease problems in Helmand. It is important to work on drug demand reduction while trying to also change the livelihoods of poppy growers. One way is through a health lifestyles messages approach, section 5g above and the other is to help reduce or stop opium addiction. The running costs for the only facility working on the treatment of drug addiction, the NGO WADAN need to be supported with some TA to advise on care, treatment and follow-up and for management advice on ways for the clinic to move towards self-financing.

#### **Option 6. Do nothing**

There will be some very real missed opportunities if HMG does nothing in the health sector in Helmand. Such missed opportunities include not:

Building on the fact that health is a priority for the general public

Doing something much needed that will have a positive impact on the seriously high levels of mortality and morbidity in the province

Improving access to free basic health care and helping the poor avert being driven into even deeper poverty through catastrophic out-of-pocket expenditure

Working with a line ministry that is a 'winner', the MoPH is one of the better functioning ministries and influencing national level policy and governance

Helping a willing, able and keen provincial health office take steps to develop sub-national state building in the health sector in Helmand

**Table 2. Content of option 1**

Area of support	Cost	Time frame	Detail
<b>1) BPHS</b>	a) £9.3 m (\$14m*)	4 years	
a) Full cost of BPHS			
c) Addressing constraints	£ 1m	4 years	(1) payment for transport scheme; (2) extending the CHW incentives by results; (3) incentives by results for outreach work (4) higher level of salary supplementation for specific health personnel; (5) payment by results for private practitioners at district level
d) Community level wat/san	£100,00	4 years	27 health facilities and 20 schools each with one well and 3 latrines or some CHCs with piped water supply
e) Health messages	- PHD communications = no cost	- 2 years	-PRT time and through radio Hawad
	MoPH communications =	- 2 years	Development and implementation of communications strategy
	£150,000		
	- BBC Trust = £350,000		-£ 200,000 for first year then £ 50,000 pa
	- training teachers as trainers in health education in schools= £25,000	- 4 years	- training costs, first aid kits all schools, health education materials
		- 2 years	
	Total = £525,000		
f) Drug demand reduction	£1m	4 years	Running costs of the centre run in Lashkar Gah by WADAN plus TA
<b>2) EPHS</b>	£ 2m (\$3.5m*)	4 years	
Full cost			
Public-private hospital partnership	£100,000	4 years	Continuing education with exchange of staff to particularly improve the quality of nursing in Bost hospital especially for the war wounded
Incentives by results	£250,000	4 years	

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NHS TA	£350,000	18 months	TA and educational materials – see annex I
<b>3) PHD support</b>	£250,000	4 years	
<b>4) National level policy support</b>	£500,000	4 years	DFID adviser time or TA
<b>5) Short term support</b>	£704,000	2008/2009	See option 5 (costs for numbers 5(f), (g) and (h) already included in this table)
<b>Total</b>	<b>£15,009,000</b>		

\*Exchange rate of US\$1.5 = £1

## 1 PREAMBLE

### 1.1 Introduction

Afghanistan is at a critical period. In areas where progress has been made, such as health, this is now slowing or has stalled. This is particularly the case in Helmand Province which has seriously high levels of insecurity. This is negatively impacting on efficient health service delivery to the extent that some crucial evidence based interventions are not now able to be delivered throughout the province e.g. polio vaccination and caesarian sections. The UK is playing a leading role in Helmand to try and turn around the security situation and re-new state building. One way to contribute to the latter is for HMG to renew its support in health. DFID played a key role in health policy, strategy, systems and institutional development with top/senior management in the MoPH 2002 – 2004.

In its terms of reference this DFID commissioned consultancy had the following objective<sup>9</sup>:

‘To work with the Provincial Health Department in Helmand province, Afghanistan, and the UK Civil-Military Mission to Helmand (CMMH) to develop options / programme proposals for increased DFID support or Stabilisation Aid Fund financing for the provision of health facilities and allied services. The goal of this initiative is to improve health outcomes in Helmand’.

Five outputs were anticipated all of which are covered in this report:

An assessment of health statistics and donor mapping

Needs assessment for the effective delivery of EPHS / BPHS

Needs assessment of public health awareness initiatives

Needs assessment of water and sanitation programmes

Based on the above assessments an options/programme proposal document for DFID/SAF funding

### 1.2 Methodology

Two external consultants, one national and one international, both of whom are public health specialists, undertook this consultancy. Between them they decided who would take the lead on which output. Time was spent in Kabul before, in between and after 2 visits to Helmand province. During the first week of the consultancy, the consultants were accompanied by an official from the UK Department of Health (DH) who was assessing what the National Health Service (NHS) might do within the framework of possible HMG support in the health sector. The DH official wrote a separate report in consultation with the consultants which can be obtained from the DH.

In addition the consultants:

Read all relevant literature (see footnotes)

Reviewed and amended the MoPH mapping of health stakeholders in Helmand (annex C)

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<sup>9</sup> See - Terms of reference: Support to the health sector in Helmand, October 2008, DFID

Undertook 2 SWOTs of health in Helmand (annex D)

Gave a presentation in DFID Kabul mid way through the work (annex E)

Drafted a summary of health infrastructure works in Helmand (annex F)

Developed, with DH official, a framework of possible support by the NHS (annex H)

Attended a 3 day MoPH strategic planning retreat (Annex I)

Interviewed key stakeholders in Kabul and in Helmand both talked with stakeholders and visited facilities (annex J)

Our conclusions about possible HMG support are sound based as they are on the in-depth knowledge of one of the consultants, a former Afghan Deputy Minister of Public Health, 2002 – 2004 and the experience of the second consultant in development, humanitarian, conflict and post conflicts environments around the world since 1972 which includes short term work in Afghanistan between 2004 and 2007. However, the following factors played a constraining role in our ability to come to such conclusions. The factors, all related to the insecure environment, were around the inability in Helmand to:

Get out to community level to sit down and talk with communities about their concerns, needs and priorities

Talk with a variety of health personnel at district level and below about their fears, successes and constraints

Visit health facilities and assess water and sanitation supplies in schools and health facilities outside the capital Lashkar Gah

Have the number of desired visits to, and length of time for discussions with, key stakeholders in Lashkar Gah

### 1.3 Insecurity and health systems and service delivery

International experience shows that political conditions have a profound effect on health. For example, there is a high correlation between levels of insecurity and levels of mortality and morbidity among civilian populations. Civilians mostly, but not always, suffer from the indirect consequences of conflict e.g. lack of access to health services<sup>10</sup>. For the most part peace is the key pre-requisite to better health. However, if health service delivery is well focussed on priority evidence based interventions within the framework of government health policy then it is possible to both prevent some morbidity and mortality. In children under five years of age this is mainly related to the prevention of infectious diseases and undernutrition. Among pregnant women the key interventions are a safe delivery with a midwife in attendance and the availability of a functioning 24 hour emergency caesarian section service. If such health service delivery is to work well, the health system and its governance must be effective.

Quality health services and effective aid instruments and channels that support basic social services for the poor are needed. Sustainable systems can be developed

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<sup>10</sup> For a recent epidemiological analysis of the indirect impact of violence on mortality see G Coghlan et al (2006) Mortality in the Democratic Republic of the Congo: A nationwide survey. The Lancet vol 367: 44-51



within difficult environments. A starting point would be for all assistance to work from the principle that local capacity does exist, whether within communities, civil society, local or national government. Sustainability can be fostered by ensuring much greater involvement of these different levels in planning, delivering and monitoring services<sup>11</sup>.

The human cost of not engaging in health with countries in conflict is high. Health is often a priority among populations in such a context. In Iraq, there is evidence that poor health conditions especially poor sanitation, contributed to anti-Americanism and support for the insurgency<sup>12</sup>.

There is some thinking that security and development are mutually reinforcing and that service delivery can promote sustainable peace<sup>13</sup>. A study has shown that to maximise the capacity of services to do this it is important to undertake a strategic analysis, have an integrated approach and place service delivery within the wider context of reconstruction and people rebuilding their livelihoods. The study also highlighted the need for donors to support equitable distribution of and access to resources in order to address social inequalities, which may be an obstacle to peace<sup>14</sup>. Issues for maximising the capacity of service delivery to promote sustainable peace have been learnt from international experience and addressed. Such issues include:

Involving village/community development committees as a means of improving health service delivery

Providing the means for, and supporting equitable and accessible health care

Having a strategic analysis and an integrated approach to any support

Taking incremental steps towards helping establish state legitimacy and visibility in health

Helping harness non-state stakeholders within the government's policy and strategic framework

Building capacity through quality, coordinated TA

Finally, the verdict is out on the usefulness of quick impact projects (QIPs) in the health sector in times of conflict and in peacekeeping, for humanitarian and post conflict settings. There are more questions than answers. What is the scope for the military in health care that does not replicate the work of NGOs and others? There are tensions around the delivery of QIPs how should their purpose be made more explicit and transparent? In a context of humanitarian crises and political conflict, such as in parts of Iraq and Afghanistan, assistance should be provided impartially according to need, doesn't using QIPs by the military or PRT change the intervention? What is good practice in QIPs in health and how is it best implemented?

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<sup>11</sup> Carlson, C. et al (2005). Improving the delivery of health and education services in difficult environments: lessons from case studies. Department for International Development Health Systems Resource Centre

<sup>12</sup> Seth G. Jones et al (2006) Securing health lessons from nation-building missions, RAND Centre for Domestic and International Health Security

<sup>13</sup> See for example The Tswalu Protocol, January 2008. [www.thebrenthurstfoundation.org](http://www.thebrenthurstfoundation.org)

<sup>14</sup> Vaux, T.; Visman, E (2005) Service delivery by donors can help prevent conflict - or make it worse. UK Department for International Development

Some QIPs have been shown to be useful some of the time in some places. It is very much down to the prevailing context. In the early days of peacekeeping in Sierra Leone and Liberia for example, they were useful to fill gaps. More recently in northern Afghanistan feedback from communities to one NGO is that they do not meet community's needs<sup>15</sup>. Generally, current thinking is that the types of projects that are appropriate in health are small in number.

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<sup>15</sup> PSLG (2008) Delivering health care in insecure environments: roles, capacities and consequences. Proceedings of the Peace and Security Liaison Group Round Table meeting, 24 June 2008 at the Royal Society

## 2 THE HEALTH INFORMATION SYSTEM AND STAKEHOLDER MAPPING IN HELMAND PROVINCE

### 2.1 Valid, quality health statistics and other information: a challenge in Helmand

Afghanistan has some of the worst health indicators in the world, especially maternal and child mortality and morbidity. While the first casualty in war is information, there is plenty of misinformation, disinformation and biased information; international evidence does show that the higher the levels of insecurity, the higher the number of deaths and illnesses and the lower the coverage rates of public health preventive interventions.

In the highly insecure context in Helmand province it is not surprising that there is inadequate monitoring and supervision resulting in poor quality information, poor communications, and poor data base management. This is resulting since 2005 in incomplete, biased health information. The reliability of data from Helmand is therefore questionable but the data in table 3 seems to support indications that health status is worse in Helmand than that indicated by national level data. In addition in 2004, which was the last time there was reliable data from Helmand on the quality of basic health services, a number of the indicators were worse than the national average, a situation that can only have gone downhill – see annex B.

**Table 3. Differences in health status, Helmand province and national averages\***

Subject	Helmand province	National average
Maternal mortality ratio	4,503/100,000 live births	1,600/100,000 live births
Diarrheal disease	15.3/ 1,000	2.6/1,000
ARI	12/1,000	6.7/1,000
Antenatal care	5.6	30.3
Skilled attendance at birth	1.5	18.9
BCG	52.4	70.2
OPV	16	69.7
DPT3	3.9	34.6
TB case detection rate	11.6	36.4

\*See annex B for sources of information

The Afghan Central Statistical Office (CSO) gives the total population in Helmand province as 900,000<sup>16</sup>. The UN works on a figure of 1.4million. Interestingly, the contracts for the contracting out of health services are based on the CSO figure, yet the supplies and coverage for the EPI programme is based on the UN data. There are 13 districts in the province, the most populous being Nadali, Lashkar Gah, and Nah-i-Sarag with 16.3%, 14%, and 11.6% respectively<sup>17</sup>.

<sup>16</sup> CSO 2002. Population data in Afghanistan. Central Statistical Office, Kabul

<sup>17</sup> CSO. 2005. A Socio-Economic and Demographic Profile, Helmand. Central Statistics Office, Afghanistan

When looking at the patchy health management information system (HMIS) findings for Helmand province in 2007, one gets the impression that no caesarian sections were performed at all. This is because the HMIS does not include provincial hospital data. The Bost provincial hospital did indeed undertake such operations last year. However, it does highlight the dire situation of no caesarians having been done at district level. If the maternal mortality ratio is to fall, this needs to be urgently remedied. Another challenge is that Helmand is one of the two provinces in the country where polio cases have been reported. There have been four confirmed polio cases to date in 2008. These cases were in 3 districts where a pool of 90,000 children under-five years of age has remained unvaccinated. Data from post national immunization days (NIDs) reveals that coverage was less than 50% in the southern districts<sup>18</sup>. The districts with the lowest immunization coverage and highest drop out rate from vaccination are Nadali, Sangin and Musa Qala.

### **Health facilities**

In 2002/3 a health facilities mapping exercise was undertaken by the MoPH<sup>19</sup>. This provides a good baseline for monitoring which facilities currently exist and which do not. Both Ibn Sina and the PRT obtain information about health facilities when they travel out to district level and below. Ibn Sina then updates its list and the PRT regularly produces maps showing the location and type of facility. Of the 47 health facilities on the MoH's list in 2002, 42 were functioning in the province in 2003<sup>20</sup> and in 2008 only 31<sup>21</sup>. Seven of the 42 functioning facilities have been destroyed during upsurges in fighting, 3 community health centres (CHCs) and 4 basic health facilities (BHCs). In 2 of the locations where such facilities have been destroyed, houses have been rented and converted into health centres. This is seen as a good alternative to re-building while insecurity remains an issue. In 5 other locations where BHCs have been destroyed health workers work from home. Of the remaining facilities some are occupied by military forces and some are standing empty for lack of staff.

Some new facilities have been built. For example in 2004 an Italian NGO built a hospital in Lashkar Gah to care for the war wounded, see section 2.2. In addition, 350 health posts and 8 sub-centres have been constructed with the objective of making health services more accessible to communities – see table 4. It is not clear how many of these are actually functioning.

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<sup>18</sup> UNICEF 2007 Report of EPI Mid year review workshop. UNICEF. Kabul

<sup>19</sup> MoH/MSH 2003 Health facilities mapping in Afghanistan. Ministry of Health with Management Sciences for Health

<sup>20</sup> MoH/MSH 2003 Health facilities mapping in Afghanistan. Ministry of Health with Management Sciences for Health

<sup>21</sup> Ibn Sina 2008 Update of health facilities, August 2008

**Table 4. Type and number of health facilities in Helmand province<sup>22</sup>**

Type of facility	2002	2008	Comment
Provincial hospital	1	1	Not implementing EPHS
District hospital	3	1	Functioning in Gereshk
Emergency hospital	0	1	Opened 2004 in Lashkar Gah for war wounded
Comprehensive health centre	15	9	None currently provide comprehensive emergency obstetric care as per MoPH guidelines
Basic health centre	28	20	Buildings for 5 of BHCs do not exist, health workers work from home
Sub-centre	0	8	2 more planned
Health post	0	350	No-one knows what is happening at this level and supplies thought to be inadequate and infrequent

### ***Health personnel***

Human resources are always even more of a challenge in times of insecurity or conflict than in 'normal' times. For very understandable reasons usually safety, health workers in Helmand have migrated into towns or the capital city. Or in some locations if they stay, have stopped working for Ibn Sina/MoPH and gone into private practice in order not to be associated with the authorities. So, for example at the moment there is only one surgeon at district level which means 1 surgeon for an estimated population of about 500,000. While in Lashkar Gah it is not known how many private practitioners there are but some are surgeons with their own private hospitals. And in the public sector Bost hospital has 55 doctors including 4 female obstetricians for a 150 bedded facility.

Since 2002 it has been MoPH policy to both train more basic level health workers including CHWs and community midwives and train more females as health providers. Ibn Sinh has trained over 600 CHWs since 2004 and, with the MoPH has established a midwifery school in Lashkar Gah. The first intake is currently in training. Eighteen of the possible 25 places were taken and the students undergo 18 month training.

### ***Health financing***

No sound data on health financing in Helmand is available. At a national level, according to a recent health financing review, the total public financing for the health sector has increased by 54 percent between 2003 and 2008, from US\$ 163.6 million to US\$277.7. The external assistance has increased from US\$ 94.4 million in 2003 to

<sup>22</sup> Ibn Sina 2008 List of health facilities, August 2008

US\$ 223.6 million in 2008. However, the public spending on health remains low, under 3 percent of GDP at 2.9 percent for 2007/2008 and 2.7 percent for 2008/2009. A disturbing finding is that household out-of-pocket expenditure is by far the largest source of financing. An estimated 80 percent of the total health spend is around US\$45 per capita per annum<sup>23</sup>.

The review also highlights that the largest share of external funding is for health services delivery (48%), procurement of medical supplies is 16 per cent, TA for capacity building 14 per cent and training only 6 per cent. The focus of the spend on health services is consistent with the Afghan National Development Strategy (ANDS)<sup>24</sup>. More than 45 per cent of the money spent on procurement is for vaccines. A recent annual results conference concluded that given the high spend on vaccines efforts must go into improving the efficiency and effectiveness of immunisation programmes<sup>25</sup>.

## 2.2 Who is doing what and where in health?

Currently, for security reasons, there are relatively few donors stakeholders in health in the province. The main ones are the MoPH represented in the province by the provincial health directorate (PHD), the World Bank through the local NGO Ibn Sinh for delivering the BPHS, the Italian emergency hospital, WADAN an Afghan NGO working with drug addicts and WHO and UNICEF – also see annex C. The annual plan of the PHD and the contract for the delivery of the BPHS have set targets but because of the security situation, not since 2004 has it been possible to collect information on whether the targets are being met. The main functions and work of stakeholders in the health sector in Helmand are:

### **MoPH/PHD**

As the owner of the health sector the MoPH has the key functions of leadership, policy and strategy formulation, monitoring and coordination, and setting standards among other health institutions and organisations in the country. At provincial level the main functions of the PHD can be summarised as:

Assessment of needs

Setting and review of progress towards achieving targets

Annual planning and evaluation cycles

Supervision and monitoring of all health service delivery

Coordination of all stakeholders in the health sector

The functioning of the referral system

The PHD also has the responsibility of providing hospital services in the provincial capital. Bost Hospital, which has an approximate capacity of 150 beds for in-patients is expected to provide secondary level health services in surgery, internal medicine, obstetric, eye care and paediatrics as a minimum. It has 4 female obstetricians and there is a section of the hospital which has a separate entrance for females. The

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<sup>23</sup> MoPH/EC. 2008. Health Financing Review. Ministry of Public Health, Kabul

<sup>24</sup> ANDS 2007 Health and Nutrition Sector Strategy 1387 – 1391 (2007/08 – 2012/13: Volume 11, Pillar V, Health and Nutrition. Afghanistan National Development Strategy, Islamic Republic of Afghanistan

<sup>25</sup> MoPH 2008 Summary of 2<sup>nd</sup> Annual Results Conference, 29-30 November 2008. Ministry of Public Health, Kabul

recurrent costs are being born by MoPH. Occasionally, the PRT provides ad hoc financial and logistical support to the hospital.

### ***Italian Emergency Hospital***

This hospital was established in 2004 for the care of the war wounded, which as at November 2008 comprised 65-70% of patients. The only other patients admitted are those with an open fracture as a result of a road traffic accident and children under the age of 14 who have an accident related injury. There are 75 beds and all the staff are Afghan with the exception of the chief surgeon and an administrator who are both Italian. Emphasis is given by the permanent Italian and other visiting international staff to teaching and building local capacity. The financial resources of the hospital are donations from the Italian public. The hospital is sited adjacent to Bost hospital and there is a good referral system between the 2 facilities. It is expected that in not too distant future the hospital will be handed over to the MoPH, who would be expected to cover the recurrent costs.

***Ibn-Sina*** is an Afghan NGO. It has been providing primary health services in the province since 1998. The organization received a contract in 2003, which was renewed in 2005, to provide the BPHS throughout the province. The MoPH/World Bank awarded the contract to Ibn-Sina by within the framework of the contracting-out mechanism. Beyond March 2009 there is no funding commitment.

Ibn Sina has the responsibility of providing the primary and secondary health services in 56 health facilities, which includes 3 district hospitals, 15 comprehensive health centres (CHCs), 28 basic health centres (BHCs), and 10 sub-centres. But due to security problems and the unavailability of female staff particularly in obstetrics and gynaecology, 2 district hospitals are not functioning. Only 1 district hospital at Gereshk has recently been opened.

Approximately 10 health centres, a mix of CHCs and BHCs, have been destroyed during surges in conflict. Ibn-Sina also has a training centre for community midwives in Lashkar Gah that currently has 24 students. The students graduate after one year of training. Ibn-Sina also has the responsibility of acting as the secretariat for the Provincial Health Coordination Committee.

***The Afghan Red Crescent Society*** has a comprehensive health centre in Lashkar Gah that provides primary health services. A number of its volunteers cooperate in the polio eradication campaigns. Two were killed September 2008 during a campaign.

***WADAN*** is an Afghan NGO that is active in the field of drug demand reduction. It has rented a house in Lashkar Gah that functions as a health centre with 20 beds for the physical and psychological treatment of drug addicts. An increasing number of addicts are referring themselves for treatment; in 2005 a survey by UNODC estimated that nationally 3.8% of population was addicted to opium. Currently WADAN has 1,500 drug users, 300 of them females, on their waiting list. Because of the increased demand the health centre now has insufficient room for in-patient care and so some of the patients, particularly the women, are treated at home. The relapse rate among these patients is high. Funding for the centre is provided exclusively by the British Foreign Office/Embassy Kabul and will be exhausted at the end of this year. Further committed funding does not exist.

***UNICEF*** does not have a field office in Helmand province and so their personnel travel there from Kandahar for the purpose of monitoring and evaluating. In 2004 UNICEF committed itself to ensuring that each provincial capital in the country has a functioning emergency obstetric care centre. But such support has not yet

materialised in Lashkar Gah. UNICEF cooperates with the PHD in the provision of vaccines and cold chain equipment. UNICEF also provides assistance in the provision of potable water for local schools. In addition, it actively assists the PHD in with polio eradication initiatives.

**WHO** does not have an office in Helmand province. From its office in Kandahar province, WHO provides technical assistance for the polio eradication campaign.

**GAVI**, the Global Alliance for Vaccine Initiative has granted about \$ 34 million for the period of 2008-2010, with possible extension to 2012 to support the MoPH to improve access to services including immunisation through support to sub-centres and mobile health teams, improvement in monitoring, public health management, communication and utilization of health services. Currently, GAVI is specifically supporting the Helmand PHD for the early warning disease system, prevention of HIV infection, and the prevention and control of bird flu with salary and other costs but the people and their posts are vertical to that of the PHD team. In addition, GAVI has also committed to provide the salary for district health officers in Helmand province, they have are not yet been appointed.

**Development Alternatives International** is an American based organization that is working in the field of institutional development in Helmand province. It has appointed one consultant to the provincial health directorate to build the capacity of administration staff in the areas of database development, report writing and monitoring. This contract is only for one year.

**PRT**, the provincial reconstruction team has particularly focussed on the building of health facilities in the province and infrastructure improvements/renovations in Bost hospital. Much of all this work has been undertaken with Estonian government money which also funds the PRT health advisory post.

**ISAF** provides some emergency care for Afghans at the PRT Lashkar Gah, in Camp Bastion and occasionally in forward operating bases. It also undertakes medical civic action projects (MEDCAPS) which is essentially raising awareness about health facilities in any particular geographical area with the provision of medical care either through static clinics or mobile services. There has also been some mentoring on medical issues among the Afghan military, especially when ISAF is embedded with them.

Camp Bastion is looking to withdraw from providing emergency care for Afghans. One of the key reasons is that once admitted they tend to have to stay longer than ISAF or other eligible internationals because of problems surrounding discharge including transport and the need for ongoing, often quite intensive care. A military hospital such as at Bastion has to be able to rapidly evacuate casualties in order to be able to deal with sudden increases in admissions. The evacuation process for ISAF forces is very swift for example, transfer can occur in under 24 hours from point of wounding, to Bastion and on to a hospital in England. ISAF is therefore looking for ways in which capacity at Bost hospital can be strengthened. To address this an official public-private partnership could be established between Bost hospital and the Italian emergency hospital next door, with the latter providing time to upgrade the quality of care in Bost, especially nursing care and war surgery. This would not conflict with, indeed would be complementary to, any potential input by the NHS – see section 5 of this document and annex H.



### 2.3 Coordination Mechanisms

#### ***Provincial Health Coordination Committee***

The provincial health coordination committee (PHCC) is a forum in which all involved stakeholders in health and health related work meet once a month to coordinate their programmes. This mechanism of coordination has helped MoPH at provincial level to avoid duplication, ensure efficient use of limited resources, and take advantage of the comparative strengths of partners.

The committee has 20 members which includes provincial health officers and one each from the provincial council, MMRD, Ibn Sina, PRT, UNICEF, and WHO. Currently UNICEF and WHO representatives do not attend regularly as they have to travel from Kandahar. Their irregular attendance has resulted in some duplication of work particularly in water and sanitation activities.

Although PRT is an active member of the PHCC it sometimes arranges parallel coordination meetings, which undermines the function and integrity of the PHCC.

#### ***Provincial Development Council (PDC)***

The PDC is a forum for coordinating provincial development. The council comprises representatives of different governmental sectors such as, health, education, rural development and agriculture. The MoPH's annual developmental plan has to go through PDC in order to get its approval and ensure it is coordinated with other sectoral plans, especially education and rural development. The approved plans are then sent to the relevant line ministry in Kabul and to the Ministry of Economy. For the most part the plans have not been well supported by line ministries with no feedback or an adjustment of budgets according to needs identified in the plans.

### **3 TARGETING THOSE WHO, FOR SECURITY REASONS, ARE HARD TO REACH IN THE PROVINCE**

#### **3.1 Working with community shura**

Members of the community are key to getting service delivery done especially in times of insecurity. The community based approach needed in such an environment is one of working with the community as a means to improving service delivery, a focus on efficiency, rather than seeing the community based approach as an end in itself e.g. empowerment<sup>26</sup>. There is a well founded belief among many in the province that all factions, whether political or tribal, do not want to see their women and children die. That somehow, trust has to be established on all sides and health services made accessible and available.

Ibn Sina has established relationships with a number of shura in the province in order to try and ensure the safety of its personnel when delivering health care in insecure or hard to reach areas. However, there is general recognition that the approach needs to be strengthened. There are at least 2 possible strategies that might help. One is to:

Facilitate the provincial health directorate, Ibn Sinh, WHO and UNICEF to learn lessons from the Ministry of Rural Rehabilitation and Development (MRRD) in Lashkar Gah about getting support from community development shura to enable personnel to work safely, initially for polio campaigns and then for delivering other aspects of the BPHS

The second is:

That where there are 2 shura e.g. one for health and one for water and sanitation their merger should be considered to have one stronger, more effective shura

The above 2 strategies would be re-enforced if ISAF troops do not also try to deliver medical care wherever they are based in the field, in forward operating bases – see also the 3rd paragraph of the executive summary and the 3<sup>rd</sup> bullet point in box 2.

From discussions with MRRD in Lashkar Gah about its DFID supported Wat/San programme, an impression was that the ministry seems to be working well with community shura and therefore lessons could be learnt by the PHD, Ibn Sinh and others for efficient health service delivery in hard to reach areas. At present both WHO and UNICEF say that it has not been possible to organise ‘days of tranquility’ an indication that more needs to be done in strengthening relationships at the community level.

#### **3.2 Essential public health interventions**

Public health interventions are not always the first demand by members of the community, curative care is usually higher on the list. But such interventions are crucial to prevent epidemics and other ill-health. In some districts in the province it is extremely difficult to provide preventive health services through static centres or through outreach or even campaigns. For example, in the 3 districts of Sangin, Nad Ali and Musa Qa’leh there are about 90,000 children who have not been vaccinated against polio despite polio campaigns and national immunisation days. There were 4

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<sup>26</sup> Tom Slaymaker et al 2005 Community-based approaches and service delivery: Issues and options in difficult environments and partnerships. For DFID

or 5 cases of polio in Helmand earlier this year and the pool of unvaccinated children means there is the potential for a serious outbreak of the disease.

When discussing strategies to reach the pool of unvaccinated polio children the question arose as to whether it would be strategic to also deliver other high impact, low cost and evidence based essential public health interventions at the same time e.g. vitamin A, de-worming and measles and other immunisation for children, iron and folic acid for pregnant women and bed nets for the family. These are already included in the BPHS, it would just be that their delivery would be different in some places e.g. as part of an integrated vertical interventions rather than through static clinics. It was generally agreed that this somewhat innovative approach would be a useful step towards a cost-efficient and integrated approach to the vertical delivery of essential services in insecure areas. And it would reflect a MoPH priority which is that of integrating service delivery. Because preventive care is not necessarily a priority it may also be important to consider providing 1-2 of the most commonly requested curative treatments.

In some district hospitals in difficult to access places there is only one surgeon. It is therefore hard to ensure the availability of 24 hour emergency obstetric care. Given the high maternal mortality ratio in the country and the importance the MoPH places on reducing it, one innovation would be to train the doctors in the districts (as opposed to surgeons) to be able to do emergency caesarian sections. It would also be necessary to train at least 2 nurses in each location to give an anaesthetic and to provide the necessary equipment.

### 3.3 Providing the means

For the most part there are sufficient of the usual physical and medical resources, and there is the capacity, for providing essential health interventions at community level in Helmand. But reaching those in insecure areas is a real challenge. It requires a number of intangibles to be factored in such as fear, safety, power, stakeholders and their vested interests and the physical means to deliver. ISAF and even PRT providing protection for Afghan health personnel is not an option. To be seen to be associated with either is taking a risk that could result in injury or death. So, the solutions to reaching those difficult to reach are very limited.

One possibility is to provide armoured vehicles initially to facilitate polio campaigns to reach the estimated 90,000 difficult to access children in the 3 districts of Sangin, Nad Ali and Musa Qa'leh and at the same time deliver other essential evidence based public health interventions To ensure a coordinated, integrated approach to the vertical delivery of essential interventions in the future, the vehicles should be donated to the office of the provincial health director who should oversee the approach. The provincial health team could also use the vehicles for monitoring and supervision. However, there is some debate as to whether the provision of armoured vehicles (or indeed any new, shiny vehicle) is wise as they may be targeted for possession by the Taliban. For this reason no vehicles should be provided unless and until there are strengthened relationships with community shura that will help guarantee safety.

In some hard to reach areas clients could travel to a functioning health facility but are too poor to afford the transportation costs. A scheme could be developed for reimbursement for travel to and from a health facility. This would help prevent the poor from going into catastrophic debt through out-of-pocket expenditure. Currently out-of-pocket expenditure is already estimated to be very high for such a poor country at

US\$45 per capita per annum<sup>27</sup>. If the transport reimbursement scheme were combined with the Ibn Sina/World Bank pilot conditional cash transfer (CCT) innovation whereby families are given cash when they bring their children for well child visits and the performance-based incentive scheme for CHWs which links a payment to the number of children fully immunized, mothers who deliver in health facilities, and TB cases detected it would be powerful way forward. Especially when undertaken with innovations such as training all doctors to perform an emergency caesarian operation and public-private partnerships.

Finally, where clinics or other health facilities are functioning in difficult to access areas, the first recourse for getting medical supplies to such facilities is to do more of what is being done already. That is, private individuals who know the right people in the right places put such supplies in their private vehicles and get them to their right destination. In rare exception it might be necessary and useful for urgent medical supplies to be transported by military helicopter. But this would obviously need to be planned very sensitively for security reasons.

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<sup>27</sup> MoPH/EC. 2008. Health Financing Review. Ministry of Public Health, Kabul

## **4 ENHANCING THE DELIVERY OF BASIC HEALTH SERVICES**

### **4.1 Access and quality of the BPHS**

#### ***Background to the BPHS***

The development of a basic package of health services (BPHS) was one of the 12 priorities in the first Interim Health Strategy 2002-2004 of the Provisional Government of Afghanistan. Preparatory planning was completed in March 2003 when the BPHS became the official policy of the MoPH. It is currently being reviewed as a result of implementation experience. The main components of the BPHS are outlined in Box 6 below.

The BPHS has two main objectives:

To provide a standardised package of basic services which forms the core of service delivery in all primary care facilities

To promote the redistribution of health services by providing equitable access, especially in underserved areas.

#### **Box 6. Components of the basic package of health services**

##### **1 MATERNAL AND NEWBORN HEALTH**

- Antenatal, delivery and postpartum care; Family planning; Care of the newborn

##### **2 CHILD HEALTH AND IMMUNISATION**

- EPI (routine, outreach and mobile); Integrated management of childhood illness

##### **3 PUBLIC NUTRITION**

- Micronutrient supplementation; treatment of clinical malnutrition

##### **4 COMMUNICABLE DISEASES**

- Control of tuberculosis and malaria

##### **5 MENTAL HEALTH**

- Community management of mental problems; health facility based treatment of outpatients and inpatients

##### **6 DISABILITY**

- Physiotherapy integrated in PHC services; Orthopaedic services expanded in district hospitals

##### **Supply of Essential Drugs**

Basic health care is delivered through static health facilities and through outreach. The following are the different types of facilities and planned staffing levels.

**Health posts** should have 2 staff, one male and one female, who receive approximately 15 days training spread over a 3 month period. The aim is to recognise some priority medical problems and provide education about basic hygiene and other disease prevention.

In a **basic health centre (BHC)** the staffing level is expected to consist of 1 nurse (male), 1 midwife, 1 vaccinator, 1 guard and 1 cleaner. Treatment is on the basis of signs and symptoms only. No diagnostic support is available from laboratory or x-ray facilities.

**Comprehensive health centres (CHC)** are expected to have 2 doctors, one male and one female, 2 midwives, one for the community and one for duties at the facility plus 2 nurses, one male and one female. In addition there should be a vaccinator, laboratory technician, and other support staff. Basic laboratory examinations such as sputum smears for tuberculosis and blood films for malaria should be able to be done. X rays machines are not usually available. Twenty four hour comprehensive emergency obstetric care should be available but currently in Helmand this is not the case. There is usually a small number of beds for inpatients, typically 5 for males and 5 for females.

**A district hospital** is designed to provide more specialised care.

In Helmand because of the insecurity it is unlikely that the staffing levels described above exist. Or there are people in post but they spend varying amounts of time in the provincial capital, Lashkar Gah or in Kabul depending on the state of insecurity in and around their workplace. Also as can be seen from table 3 (in section 2) there is only one functioning district hospital when there should be 3. There are some beds in the newly opened CHC in Musa Qala, however, the security situation is such that patients tend not to stay overnight for fear of danger.

### **Private sector**

There has been no mapping of the private health facilities in Helmand. But it is likely that they are numerous. In Lashkar Gah most are owned and run by a doctor but at district level there are some doctors but also private facilities run by a pharmacist or a nurse.

When visited by an ISAF doctor early 2008, the doctor in private clinic in Sangin said that they had between 40 and 50 patients a day at the facility before spring 2006, but since then because of insecurity this had fallen off to 25-30 per day. He did not expect to get any patients attending while ISAF was in the clinic/area, According to ISAF, the clinic was very well equipped, with ultrasound diagnostic capability, a functioning laboratory for routine investigations and a pharmacy stocked from Kandahar and Pakistan. There had also been an operating theatre on the premises but it had been hit by an IDF a few months earlier and was now a rubble-strewn fenced off area at the end of the clinic courtyard. Because of this the surgeon and anaesthetist employed at the clinic had both moved back to Kabul. They had apparently run a well-patronised routine operating list and also provided emergency surgery, but many of their wealthier patients had moved away from Sangin over the last two years. Therefore there is now no emergency surgical provision in Sangin and patients have to be taken to Lashkar Gah or Peshawar.

Strictly speaking NGOs are part of the private sector, private-not-for-profit as opposed to private-for-profit which is how private practitioners are categorised. Any

profit an NGO might make is usually re-invested into improving equity, accessibility and/or quality of service delivery. It would be misleading to try and determine the effectiveness of NGO service delivery over and above the private sector for the following reasons:

NGOs and private practitioners have different aims and values

An NGO is functioning as an organisation, the private sector in Helmand is predominately individuals working on their own

Private practitioners are mostly involved in curative services and maybe some surgery whereas NGOs are focussed on preventive and promotive services as well as essential curative care

Government has mechanisms to ensure the quality and effectiveness of services, there are no such mechanisms in the private sector

### ***BPMS and insecurity***

The key challenge for the delivery of the BPMS at present is the high levels of insecurity in much of the province. Staff cannot and/or are understandably unwilling to leave health facilities to do outreach or supervision. Some geographical areas are inaccessible for security reasons. Twelve of the 440 health workers (2.7%) employed by Ibn Sina, the NGO contracted to deliver the BPMS in Helmand have been killed between 2006 and the middle of 2008.

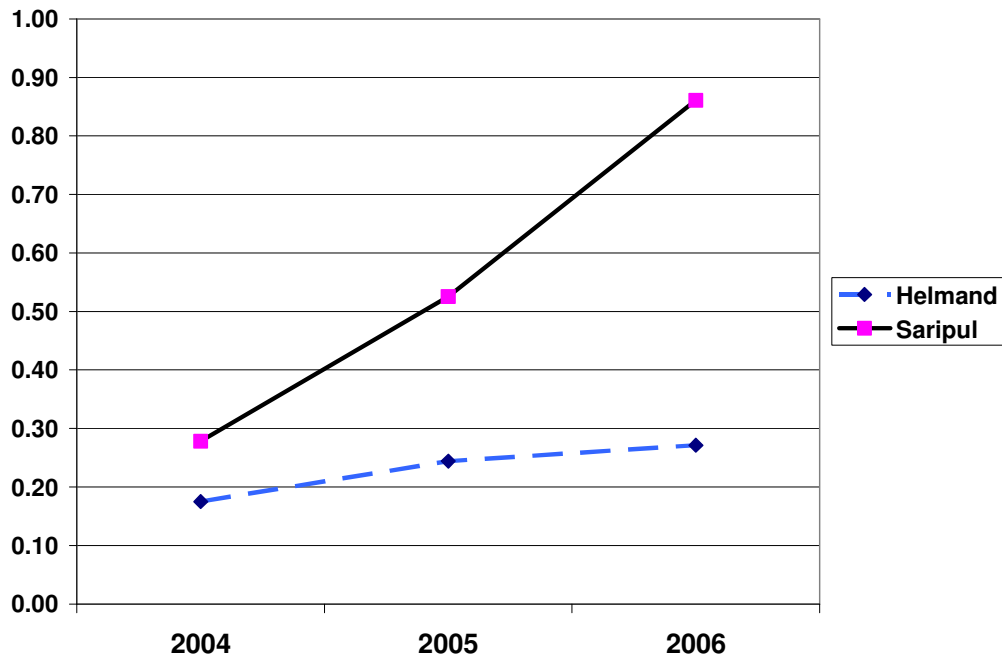
The effect of insecurity on health service delivery is evident<sup>28</sup>. Ibn Sina is also contracted with World Bank funds to provide the BPMS in Saripul province in northern Afghanistan where security has been consistently better. As figure 1 shows the utilisation of health services has grown much more quickly in Saripul where security is better<sup>29</sup>. Data from other insecure provinces like Kandahar, Uruzgan, and Zabul also indicates that these provinces are making much slower progress than the country as a whole.

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<sup>28</sup> World Bank information given to the consultants, December 2008

<sup>29</sup> This comparison is complicated by the fact that Helmand is socially more conservative than Saripul, although they started at roughly similar levels of health facility utilisation

**Figure 1: Out-patient visits per capita per year in secure (Saripul) and insecure (Helmand) provinces – 2004 - 2006<sup>30</sup>**



### ***Implementation of the BPHS 2003 - 2008***

World Bank has been funding the implementation of the BPHS, along with 10 other provinces, since its inception nationally in 2003. This was when the Afghan NGO Ibn Sina won the first of two contracting out contracts to deliver the package in Helmand; the current contract ends March 2009. The NGO had been working in the province since 1998 and so had experience and had established some credibility among the local people. The contracting-out contracts are standardised throughout the country with the content only varying depending on whether there are one or more NGOs in any one province. In Helmand Ibn Sina is the only NGO contracted to deliver the BPHS throughout the province from community level through to district hospitals and to support the capacity development of the provincial health directorate.

Ibn Sina considers it has had a number of successes to date. These include having:

Staff in place where security is OK

Developed incentives schemes e.g. if a CHW brings a women to health facility for delivery she/he receives \$20, and 100 Afghani for each client brought to a health facility with suspected TB and the client proves to be TB positive, the third and final dose of DPT and for antenatal screening

Successfully enforced the free drugs policy

Established functioning shuras

<sup>30</sup> Source, MoPH - Health Management Information System 2007



Established a midwifery training facility and course some unspent money in their grant

Trained 700 CHWs

Obtained a security allowance for skilled health workers on top of the national salary policy to keep insecure facilities well staffed

Establishment of 10 sub-centres

Establishment of a self-assessment mechanism

Good coordination with the PHD and in 2003/4 when security was not a risk undertook joint monitoring with the PHD

Regularly attended provincial health coordination committee meetings and just in the last 2 months started to work as Secretariat for the committee

Any perceived problem in the last year or so about Ibn Sina and its achievements has more to do with coping with the insecurity and with leadership and morale in the organisation. A new director for Ibn Sina in Helmand was appointed October 2008 as the previous person and a few other staff left. They felt their salary was not commensurate with the high levels of danger to which they were constantly exposed. Ibn Sina works by the core principles of neutrality, impartiality and independence. However by positioning itself in relation to the state through having a contract with government to deliver health services, some members of the general public in the province do not see it as being impartial. As mentioned earlier there have been 12 conflict related deaths among the staff since 2006.

Ibn Sina does not have a resource problem, indeed there has been some under spend because of the lack of movement of staff and reduced service delivery. It also does not have a capacity problem it is a highly experienced local NGO who was working in Helmand prior to contracting basic health services. Although this has to be tempered by saying that there is a high turn over of staff related to the insecurity in the province and given the 12 conflict related deaths, some posts are vacant some of the time. The lack of staff at community level is being addressed through training CHWs from within the community, 700 to date, often a husband and wife team. It is also training midwives in a facility built 2 years ago in the compound of Bost hospital. But there is not have sufficient sleeping quarters for the midwifery and nursing students.

The constraints or challenges to their work are mostly security related. They are summarised in Box 2 in the executive summary. At Annex D is a SWOT of health service delivery in the province. The sum total of many of the constraints means that it is extremely difficult to know what is and is not happening in health service delivery on-the-ground. While poor geographical access to health services is marked in Helmand the province is not isolated in this. When the 2007 results of the balanced scorecard (BSC), which did not include Helmand, were presented in the MoPH it was highlighted that the findings showed that 'many communities still have poor access to health services – ways to reach populations in remote and insecure areas must be found'<sup>31</sup>.

The results of the BSC for Helmand in 2004 can be seen at Annex B. For reasons of security Helmand province has subsequently been unable to be part of the national

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<sup>31</sup> MoPH/ Johns Hopkins/Indian Institute of Health Management Research, 2007, Results from recent health assessments in Afghanistan.

annual BSC evaluation. BSC is an important health services management tool, especially in Afghanistan 'where re-building trust in institutions and delivering health services are especially vital steps to rebuilding society and improving life for its citizens'<sup>32</sup>. The BSC contributes to these objectives by increasing transparency in the health sector and enabling health managers and policy makers to identify and address areas of weakness. As can be seen from the list of indicators at Annex B the BSC uses a variety of perspectives, capacity, and quality indicators.

### **Ways forward 2009 onwards**

The first issue is to secure funding for the BPHS from next spring, 2009, onwards. Implementation of the BPHS remains a priority for the MoPH as reflected in the Health and Nutrition Sector Strategy 2008-2013<sup>33</sup>. World Bank will have insufficient funds available for the next round of contracting-out, due to reduced IDA funding for Afghanistan. None of the World Bank covered provinces will receive sufficient funds to fully implement the BPHS. It is highly unlikely that any lobbying of the World Bank to continue its current level of spend will be successful. It is imperative that the BPHS be fully funded. MoPH has expressed the wish for DFID to take over the full cost of funding the BPHS next year. World Bank is in accordance with this. The value added of support in the health sector in Helmand from Her Majesty's Government (HMG) would be its ability to fill crucial gaps to enable equitable, efficient, effective, quality service delivery along with helping strengthen governance in health. In addition HMG can access Helmand better than most other donors.

While MoPH has expressed the wish for DFID to take over the full cost of funding the BPHS there is another possibility. Consideration of which of 2 routes to take should include taking the opportunity to contribute to aid effectiveness, especially the development of harmonised monitoring and reporting mechanisms. The 2 possibilities are:

Take over the full costs of the BPHS in Helmand. This would release funds for the other World Bank supported provinces. The approach is straightforward and would keep coordination and management arrangements simple for the MoPH. It is preferred option by both the MoPH and World Bank.

The second possibility is to provide top-up funds either as co-financing with the World Bank through contributing to the special bank account for the MoPH held by the Ministry of Finance or by contributing to the forthcoming ARTF window in health. The World Bank is helping MoPH with the design and submission of the window which, if accepted by the Ministry of finance and others, is anticipated to be functional by about February 2009.

Whichever route is used, the MoPH grants and contracting management unit (GCMU) should be utilised to manage the contracting process and Helmand should also be re-considered for implementation of the 3<sup>rd</sup> party evaluation mechanism, the BSC. Or a modified version of the BSC be used by the PHD in Helmand.

In other provinces where basic health services are contracted out there is little or no state visibility as NGOs have tended to promote themselves as champions of health service delivery. In Helmand the role of the state has, for security reasons, purposely been kept almost invisible. In the current climate of insecurity it would be wrong to

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<sup>32</sup> Peters, D. H et al. 2007. A balanced scorecard for health services in Afghanistan. *Bulletin of the World Health Organization*, February 2007, 85: 1-6. [www.who.int](http://www.who.int)

<sup>33</sup> ANDS 2007 Health and Nutrition Sector Strategy 2008 – 2013. Afghan National Development Strategy

change this either through raising public awareness and/or by changing to government run services or the contracting-in mechanism.

However, if the security situation worsens and Ibn Sina withdraws, as some NGOs in other provinces have done or are contemplating doing, the government will need to, and is willing to, take over basic service delivery again. A success factor will be a very low key handover with the minimum of disruption. The service delivery will need to continue to be adequately resourced. What is not needed is a switch to an emergency humanitarian vertical mode that ignores local capacity.

**Overcoming constraints** - The second important issue is to find sound ways to try and overcome the constraints. This is not easy but some possible solutions can be found in Box 6. Continuing with, and expanding, incentives - number 4 in Box 7 – that build upon the experience of World Bank and Ibn Sina in Helmand would be powerful way forward, especially when combined with the sum total of numbers 1 – 7 in Box 6. Regarding number 4, using unspent funds in their grant, Ibn Sina got the go ahead from World Bank to pilot innovations in incentives by results and in conditional cash transfer (CCT). The CCT provided families with cash when they brought their children for well child visits and mothers came to deliver in health facilities. The performance-based incentive scheme for CHWs links a payment to the number of children fully immunized, mothers who delivered in health facilities, and TB cases detected.

**Box 7. Constraints and ways forward in health service delivery in Helmand**

1. Difficult to access areas need an integrated approach for vertical polio and other EPI campaigns with the simultaneous delivery of other essential BPHS evidence based interventions and some curative care though shura guaranteed safety for both campaigns and outreach
2. Fear and poor morale among staff could be improved through better relationships with shura, armoured transport, continuing education and improved supervision and support by central level MoPH to the PHD and by the PHD to districts
3. For cultural and/or security reasons women are not going to health facilities for delivery and only caesarian done in 2007 were in Lashkar Gah, need is for continued CHW incentives scheme and training of doctors in the province to be able to perform an emergency caesarian section at district level
4. Expand current incentives by results scheme and conditional cash transfer scheme to other health personnel and essential public health interventions
5. Where facilities are functioning the poor are unable to access because of the expense for transport, need payment for transport scheme to prevent catastrophic out-of-pocket expenditure
6. Currently no supervision or monitoring being undertaken, where there is a private medical practitioner consider developing public-private partnership for M&E of BPHS
7. There will be almost no care for war wounded Afghans in Camp Bastion next year onwards. Capacity and quality will be needed in Bost hospital, this could partially be addressed by developing a public private partnership between Bost and the next door Italian NGO emergency hospital

A recent rapid review about the payment of incentives to health workers to increase the quantity and quality of health services found moderate evidence of strategies of this type to be successful.<sup>34</sup> Early evidence suggests that CCTs in particular are effective in insecure areas. Shortly after the introduction of the innovations described above, there was a large increase in the uptake of services -see figure 2, as measured by the MoPH HMIS. The provincial health department and community leaders believe these data to be accurate. Ibn Sina staff believes that much of the large increase was due to the CCTs for women and children.

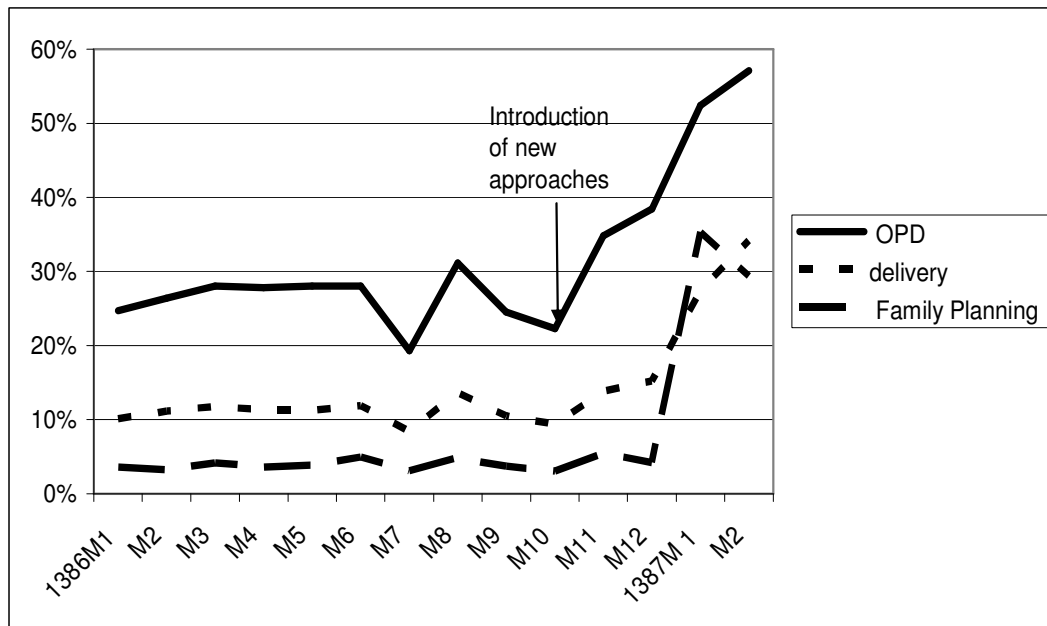
For number 6 in Box 7 it is proposed that to enable better oversight and monitoring at district level in particular a public-private partnership be developed between the provincial health directorate and selected private medical practitioners. The aim would be for 1-2 private practitioners in each district to monitor monthly the quality of health service delivery in public sector static clinics using the MoPH standard monitoring checklist and on an annual basis using a modified version of the national balanced score card used to evaluate the BPHS. They would be paid when they provide evidence of having adequately undertaken the work.

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<sup>34</sup> Peters, D H et al. 2009. Evidence on health services strengthening strategies. Forthcoming book, World Bank

The intention of the second public-private partnership, number 7 in Box 6, is make better use of an existing resource to help improve quality of care. The Italian emergency hospital, with just 2 full time Italians, has a reputation for good care. There could be an exchange, especially of nurses, between the 2 hospitals to help improve the standards of nursing care.

**Figure 2: Changes in selected indicators after Introduction of new approaches in Helmand<sup>35</sup>**



**BPHS add-ons** – these are suggested as ways to enhance service delivery and prevent ill health in these times of insecurity in Helmand. They are:

Addressing constraints - Development, implementation and evaluation of innovative approaches to: (1) improving access to health services by women and children e.g. payment for transport scheme; and (2) providing a higher level of salary supplementation for health personnel delivering the BPHS (; 3) enabling better monitoring and evaluation through payment by results for private practitioners at district level to monitor monthly the quality of health service delivery in static clinics using the standard monitoring checklist and on an annual basis using a modified version of the national balanced score card used to evaluate the BPHS.

The BPHS add-ons are innovative strategies or a road map for addressing health priorities, enhance access to health services and to prevent common diseases. For example, payment for transport is not health priority but the means to facilitate referral or increase access to pregnant women with complications. For further information on add-ons see earlier in this section and also in section 3 of this document.

Community level water and sanitation for 27 health facilities and 20 schools in the province – see section 4.2

Hygiene and other priority health messages (1) through the radio; (2) through educating teachers to give health education in, and providing first aid kits for,

<sup>35</sup> Source, MoPH - Health Management Information System 2007

schools; and (3) training school teachers to work as trainers on drug demand reduction education in schools as part of a healthy lifestyles approach – see section 4.3

The running costs of, and TA for, the NGO run drug demand reduction service in Lashkar Gah

Evidence is beginning to suggest that if opium drug use were routinely recorded as part of the national health management information system it would probably rank among the top 10 health and disease problems in Helmand. There are an estimated 70,000 users in the province with only one clinic for the treatment of drug addiction in the province, in the capital Lashkar Gah.

It is important to work on drug demand reduction while trying to also change the livelihoods of poppy growers in Helmand. One way is through a health lifestyles messages approach, section 4.3 of this report, and the other is to help reduce or stop opium addiction. As mentioned in section 2 of this report WADAN is an Afghan NGO that is working on drug demand reduction. It has rented a house in Lashkar Gah that it has converted into a health centre with 20 beds for the physical and psychological treatment of drug addicts. An increasing number of addicts are referring themselves for treatment.

Currently WADAN has 1,500 drug users, 300 of them females, on their waiting list. Because of the increased demand the health centre now has insufficient room for in-patient care and so some of the patients, particularly the women, are treated at home. The relapse rate among these patients is high. Funding for the centre is provided exclusively by the British Embassy/FCO Kabul and will be exhausted at the end of this year. Further committed funding does not exist. A request was made to the consultants during this consultancy to fund both the building of a new facility and for the running costs. However, now is probably not the time to be building a large centre especially as success in reductions in addiction is very difficult to achieve. Instead it is suggested that the running costs of the existing facility be supported with some TA to advise on care, treatment and follow-up especially in the absence of methadone and for some management advice on ways for the clinic to move towards self-financing. Such support would be within the framework of the Governor's plans for drug demand reduction in Helmand, the Ministry of Counter-Narcotic's national plan and the intention of the Ministry of Public Health to include drug demand reduction within the remit of mental health, which is part of the BPHS.

Infrastructure - In these times of insecurity in many of the districts in Helmand renting a facility to function as a health centre is a much better option than re-building. Among the many requests received only in Marjah does it seem OK to construct and equip a community health centre. A request was made to cover the cost of equipment and furnishings for Musa Qa'la district hospital, which is under design. However, even the CHC there is not fully functional and patients often do not stay overnight in the centre for safety concerns. It is difficult therefore to currently justify HMG support for the hospital. Especially as, because of security it is likely that it will be very difficult to identify staff that would be willing to work in the hospital when it is built.

Lashkar Gah seems stable and so it is proposed that of the requests received it is OK to construct and equip a: 1) 60 bedded hostel for midwifery and nursing students; and 2) provincial health directorate office. The provincial council made a request to President Karzai and the Minister of Health for a 60-bedded maternity hospital to be built in Lashkar Gah. The Minister passed on this request to the consultants for consideration. After careful scrutiny the conclusion is that there is no sound

justification for such a facility. Bost hospital has a wing for maternity and other female care with its own separate entrance for the women. And there is no overwhelming demand or waiting list for care.

Finally, any support for infrastructure work must follow MoPH guidelines on both design and equipment. At Annex E is a summary of current and planned infrastructure work in the health sector.

#### 4.2 Water supplies and sanitation facilities in schools and health centres

Improved water supply is often cited as a priority at community level in Helmand, sanitation facilities are not. Based on the analysis of limited data in the HMIS in 2007 it is likely that diarrhoeal disease linked to poor water supplies and sanitation facilities was particularly prevalent with 15.3 cases per 1000 population compared with a national average of 2.6 per 1000 – see also table 1.

Water and sanitation indicators are among the most measured in Afghanistan. However, there is conflicting information possibly due to different definitions being used in the various surveys. For example, the 2003 MICS painted a positive picture with 67 per cent of the population with a flush or pit sanitation and 40 per cent with access to safe water. On the other hand, the 2004 UNICEF/WHO publication 'Meeting the MDG drinking water and sanitation target, a mid term assessment of progress' stated that access to water is a meagre 13 per cent and access to sanitation is just 8 percent. The 2003 MICS survey found that in Helmand province a surprisingly high 67 per cent of the population had access to safe water supplies. There is no recent data for the province.

##### Current stakeholders in water and sanitation

The Ministry of Rural Rehabilitation and Development (MRRD) is the focal point for community level water supplies and sanitation facilities. Currently in Helmand, MRRD has a DFID funded project 2006-09, to dig almost 3,000 bore wells in 7 districts plus 3 latrines for every bore well. The first phase of the project ends March 09 with the 2nd phase dependent on the results of a mid term review Prior to the start of the project MRRD did a KAP survey, which showed that the demand is for water supplies not latrines. At the time it was also confirmed that there is plenty of ground water and no evidence of arsenic. MRRD also has a proposal to use a local radio station to transmit hygiene messages. But it is relatively expensive, \$31,968 for 6 months, especially when the radio range is only 86 km around Lashkar Gah.

The 7 MRRD project districts are divided into 9 clusters each with 9 female and 9 male hygiene promoters. MRRD has trained 1 CHWs/hygiene promoter per 5 wells to give 5 hygiene messages. For maintenance MRRD has 1 mechanic per 100 wells among communities and field mechanics provincial headquarters. For monitoring and supervision each cluster has 1 supervisor. Most impressively MRRD seems to have developed good relationships with community development shura, which both sides sit on, and which guarantees the safety of the workers. A shura will even sometimes provide transportation for the workers – an approach for the health sector to consider.

Among the international agencies UNICEF has the lead for water and sanitation in schools and health facilities. It has a plan on paper for water and sanitation for 10 health facilities in the province but it is currently not active in Helmand for security reasons. Coordination by UNICEF with MRRD and the provincial health directorate was cited as a problem as UNICEF has no office in Helmand. It calls for meetings in Kandahar but it is difficult for people in Helmand to get there.

In 2007 the PRT funded the construction of flush latrines in 2 schools in the province. These are now not functioning as there is no electricity and therefore no water, stones are used for personal cleaning and there is no way to empty the septic tank. All this despite the original agreement, which was based on Ministry of Education guidelines, and is for pit latrines. The contractee did not follow the guidelines and submitted an invoice for extra costs that were agreed by the PRT. It is highly likely that each flush latrine cost circa \$30,000 whereas an ordinary latrine, depending on the type of soil in the area can cost anything from between US\$100 and \$5,000. The PRT claims that high levels of insecurity did not allow for site supervision.

#### The need

The national Education Strategic Plan 1385-1389 (2006-1010) of the Ministry of Education refers to signing a MoU with the MoPH as part of school health initiatives<sup>36</sup>. Targets include ensuring that all schools have safe drinking water and meet basic school health standards by 1389. It also states that the MoPH is responsible for ensuring that safe drinking water and sanitation facilities are maintained properly. None of this is happening at present.

The PRT education adviser estimates that about 20 schools need basic water and sanitation supplies in Helmand. Ibn Sina has calculated that 27 health facilities also need such supplies - see Annex H for a list of health facilities with no safe water.

Improving water and sanitation services is a fundamental public health measure to reduce the levels of diseases transmitted through poor water supplies and lack of sanitation facilities. It is fundamental that a health facility be able to have high standards of hygiene and that its staff to not transmit symptoms and diseases to clients. Providing water and sanitation facilities in schools will also contribute to better hygiene and serve as a way to promote hygiene among the adults of tomorrow.

It is suggested that MRRD should be a strong candidate for implementation of any HMG input for water and sanitation in schools and health centres. But support should be dependent on the results of the mid term review of the current DFID support for community water and sanitation supplies that is being implemented by the ministry. There may well be important lessons to be learnt about MRRD's experience. Stories abound in the province about poor quality, inappropriate, newly constructed facilities, as because of security problems the supervision of the companies contracted to do the work is particularly difficult.

### 4.3 Public health awareness initiatives

#### Current initiatives

Because of the limitations that the security situation puts on supervision and reporting in Helmand province it is unclear exactly what is and is not being done on-the-ground by the 6-700 CHWs trained by Ibn Sina. For the foreseeable future Ibn Sina does not think that any extra training or IEC material are needed.

As mentioned above in section 4.2 the Department of Health and Hygiene in the WAT/SAN Directorate of the MRRD has a health education campaign as part of its

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<sup>36</sup> <sup>36</sup> MoE, 1385 – 1389, National Education Strategic Plan, Ministry of Education, Kabul



DFID funded community level water supplies and sanitation facilities in 7 districts in Helmand. For every bore well that is dug, 3 latrines are built and there is one health educator per 3 wells. A total of 1,134 health educators are being trained to give 5 key messages.

In Helmand, outside the capital, the radio is perceived as the best method to get health education messages across to the people. Radio ownership is high among individuals and among those too poor to afford either a radio or the batteries, a radio is listened to among members of a community. Very importantly, getting radio messages out doesn't put lives of health workers at risk. In Lashkar Gah television is an important tool for education. Currently there is no province wide radio station, just a number of local ones each with a limited transmission range. The PRT is helping establish a province wide radio station but it will take some time for it to establish its credibility.

BBC Trust based in Kabul is received and listened to nationwide including reportedly by the Taliban. It is highly respected and trusted. Over the years it has regularly been covering issues in health such as breastfeeding and hygiene and on a seasonal basis talks about problems such as malaria and coughs and colds. It currently has a popular 'Archers' type programme, a drama about a husband and wife both of whom are HIV positive, funded by the Swiss. It is thinking about also specifically addressing TB and maybe drug demand reduction, both of which are major problems in Helmand.

The national Education Strategic Plan 1385-1389 (2006-1010) of the Ministry of Education refers to signing a MoU with the MoPH as part of school health initiatives. One of the targets is the supply and maintaining of first aid kits in all schools and the training of at least 2 school health volunteers (both teachers and students) in every school by 1389 in their use training school teachers to work as trainers on drug demand reduction education in schools as part of a healthy lifestyles approach<sup>37</sup>.

Future needs in raising health awareness among the general public

The following 4 areas have been identified during this consultancy as filling a need to improve/strengthen communications about different issues in health. They are:

1) Priority health messages through the radio

This approach primarily builds upon the experience and credibility of BBC Trust. All health messages are relevant nationwide, none are very specific to Helmand province. As mentioned above BBC Trust is thinking about newly addressing TB and maybe drug demand reduction, both of which are major problems in Helmand. The latter topic is particularly relevant and would be a good complementary move to any HMG support for the drug demand reduction centre in Lashkar Gah. Being such a specialised subject it would need some good field research before transmission, as was necessary for the current programme on HIV. This has been allowed for in the first year costs.

A second approach using radio would be for the planned PRT province wide radio station to transmit health messages. This could provide more Helmand specific information which would be useful. It will however, take some time for the radio station to establish its credibility.

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<sup>37</sup> MoE, 2007, Healthy lifestyles education by teachers, Ministry of Education, Kabul

2) Educating teachers to give health education in, and providing first aid kits for, schools; and training school teachers to work as trainers on drug demand reduction education in schools as part of a healthy lifestyles approach

Mentioned above were the health related targets of the national Education Strategic Plan 1385-1389 of the Ministry of Education (the supply and maintaining of first aid kits in all schools and the training of at least 2 school health volunteers in every school by 1389 in their use and the training of school teachers to work as trainers on drug demand reduction education in schools as part of a healthy lifestyles approach). None of this is happening at present.

Both the subject areas identified by the Ministry of Education are important and could usefully be supported by HMG.

3) Enabling the provincial health directorate in the development and communication of radio messages that raise awareness about successes and ongoing work in the health sector as a first step towards forging a state-society compact

Work on raising awareness about the role of government in health in Helmand is a politically very sensitive issue. As such it would need very careful development and testing. It could be done at no cost if undertaken through the forthcoming radio station funded by FCO/SAF.

4) Help the MoPH at national level develop a communications strategy to inform the general public about its successes, to publicise its achievements.

The MoPH is one of the better performing line ministries and has achieved some notable successes. However, it has not systematically publicised initiatives and results as part of transparency, accountability and raising state visibility and credibility<sup>38</sup>. It has no communications strategy.

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<sup>38</sup> Waldman R et al 2006 Afghanistan's health system since 2001: condition improved, prognosis cautiously optimistic. Afghanistan Research and Evaluation Unit, December 2006

## 5 STRENGTHENING THE DELIVERY OF ESSENTIAL HOSPITAL SERVICES

### 5.1 The EPHS now and in the future

#### Background to the EPHS

The development of a package of essential hospital services was one of the 12 priorities in the Interim Health Strategy 2002-2004. Planning was completed in February 2004 when the essential package of hospital services (EPHS) became official policy of the Ministry of Health. It was developed in recognition that hospitals in Afghanistan face major challenges including the lack of equitable access to hospital services, concentration of financial resources and health workers at hospitals, lack of standards for both clinical patient care and hospital management, scarcity of management skills, and lack of medicines, equipment and supplies. A summary of the EPHS is presented in Box 8 below.

The EPHS has three main objectives:

To identify a standardised package of defined clinical, diagnostic and administrative services for district, provincial, regional and national hospitals.

To provide a guide for the Ministry, NGOs and donors on how the hospital sector should be staffed, equipped and provided with drugs for the defined set of services at each level

To promote a health referral system that integrates the BPHS with the hospitals.

#### **Box 8. Outline of components of EPHS**

##### **District hospital:**

30-75 beds, serving population of 100,000-300,000 in 1-4 districts

Basic surgery, medicine, obstetrics and gynaecology, paediatrics, mental health, dentistry, plus support services for nutrition, pharmacy, physiotherapy, laboratory, radiotherapy and blood bank

##### **Provincial hospital:**

100-200 beds

All the above clinical and support services, plus rehabilitation services and infectious disease control

##### **Regional hospital:**

200-400 beds

All of the above plus surgery for ENT, urology, neurology, orthopaedics, plastic surgery; and medicine to include cardiovascular, endocrinology, dermatology, lung and chest, oncology, forensic medicine

A greater variety and more developed support services

## The need for the EPHS in Helmand

The hospital sector has been relatively neglected in Afghanistan, and certainly in Helmand. An efficiently functioning provincial hospital that provides quality services is crucial as it is the main facility for the referral of cases requiring a level of treatment and care not possible in district hospitals and health centres. As mentioned in section 2 of this report Bost provincial hospital in Lashkar Gah is a 150 bedded provincial health facility with 134 staff. Currently, it is thought to be the only place in the province where caesarians are undertaken. It needs to be able to provide the services and to function as outlined in the EPHS. It particularly needs to ensure high quality of care in obstetrics and perinatal care.

But also Camp Bastion in Helmand is looking to withdraw from providing emergency care for war wounded Afghans. This means Bost hospital and its neighbour the Italian emergency hospital will need to be able to receive and care for such patients. A public private partnership between the two hospitals to improve quality such as in nursing care is a way forward. Additionally, the UK National Health Service is prepared to provide continuing education focused on quality improvements and hospital management advice. Also see Annex I.

Whereas in basic health service delivery it is currently not desirable to attempt to improve state legitimacy, it is possible for hospital services, at least initially in the provincial capital Lashkar Gah. In the relatively safe environment of the capital, where the government is responsible for hospital services, gradual steps could be taken to enhance state visibility. Also see Annex I of this document.

The EC and USAID are supporting the EPHS in those provinces where they are also supporting the BPHS. The World Bank is not funding the EPHS and therefore for lack of resources the package is not yet being implemented in Helmand. It seems justified to start implementation now as there is a need to provide as comprehensive a service as possible for those who can reach the hospital in Bost and to contribute to state building. The PHD is interested to implement the EPHS now, the estimated costs by MoPH central level per province is \$3.5 million over 4 years. Just as for the monitoring and evaluation of basic health services a hospital balanced scorecard has been developed and is in use in the country.

At district level, Gereshk is the only functioning hospital (because of insecurity only way for consultants to visit would have been a helicopter flight at 3am and on the ground for only 10 minutes). A surgeon was appointed just about one month ago at Gereshk before that no emergency caesarian section operation could be undertaken. From this scenario arose the idea and need to train every doctor, initially every female, (as opposed to surgeons) in the province to be able to do a caesarian and at least two nurses in every district to give an anaesthetic.

Implementation of the EPHS would start in Bost Hospital and then roll-out to Gereshk district hospital and other district hospitals as they start functioning. The TA from the NHS would initially focus on helping improve the quality of obstetric/gynaecology, neonatal and paediatric services and also address hospital management. Support for the implementation of the EPHS would be strengthened by simultaneous work on the health system and governance development at both the provincial and national levels.

As mentioned earlier in this report the Provincial Council requested President Karzai and Minister, MoPH for a 50 hospital maternity hospital in Lashkar Gah. The Minister asked DFID to consider this. Our conclusion is that it is not needed. There is a greater need to better manage and use the existing Bost hospital, it has a separate

entrance for women. Also next door to Bost is the 70 bedded Italian emergency hospital which one day will be handed over to the government. There are serious recurrent cost implications for government related to this let alone having a 3rd hospital in town.

EPHS add-ons:

A public-private hospital partnership

Camp Bastion is looking to withdraw from providing emergency care for war wounded Afghans. This means Bost hospital and its neighbour the Italian emergency hospital will need to be able to receive and care for such patients. The Italian emergency hospital was established to provide for exactly such care and has a good reputation for quality care. A public private partnership between the two hospitals to improve quality such as in nursing care in Bost hospital could be a useful way forward.

Incentives by results

For the better functioning of the Bost hospital an idea was proposed to have an incentives by results scheme for priority subjects such as maternity care. This would need careful development and piloting. One key obstacle might be that many of the staff have a private practice in town and it would not be in their interest to improve the functioning of the public sector hospital.

TA from the NHS which would initially focus on emergency hospital care including obstetrics and hospital management - see 5.2 below

## 5.2 What can the NHS offer in support of the EPHS?

Potential role of NHS with Afghan government and HMG in support of the EPHS

The most fundamental health needs in Afghanistan are for public health and primary care measures to address the high incidence of (and premature mortality from) diarrhoeal diseases, childhood infections, malnutrition and maternal mortality. However, population health and wellbeing also depends significantly on the availability and quality of hospital services. Reducing maternal and perinatal mortality will require effective obstetric services to back up midwifery care. Effective emergency surgery and medical care will reduce avoidable mortality and morbidity from a range of common conditions. The condition of health services is generally in the top three publicly voiced concerns in Afghanistan and elsewhere, with perception heavily influenced by hospital services. It is highly likely that sustaining and improving existing hospital services is seen as one of the important tests of the Government of the Islamic Republic of Afghanistan.

Bost Hospital is the provincial hospital for Helmand, situated in the administrative capital of Lashkar Gah, with a maximum capacity of around 150 inpatients. Occupancy varies from around 50 inpatients in winter when infection is less prevalent (and travel more difficult) to over 100 in summer. The hospital takes patients from across the province and from some neighbouring provinces, or at least those who can travel. It provides inpatient and outpatient care in a range of basic specialties, with some backup from simple X-rays, ultrasound and some laboratory facilities. Clinical standards appear fair given the constraints, although it must be recognised that much of the treatment would be regarded as rudimentary by UK standards, and many of the procedures as outdated, with potential benefit to updating skills and practice.

The current significant shortcomings in infrastructure particularly water supply, wiring, sewerage and oxygen distribution system will be remedied by end 2008/early 2009. In addition, a 1,000kw generator, dental equipment, x-ray machine and monitors will all be installed by about the same time.

As part of the overall support to health in Afghanistan led by HMG, there is scope for the NHS to contribute to the development of hospital services. This would be principally focused on Helmand province in line with the major British effort. But there would be merit in exploring possible extension to other provinces where services may benefit, with potential to realise significant additional benefit at limited marginal cost. This is predicated on HMG supporting the implementation of the MoPH national strategy for hospital services in Helmand, the essential package of hospital services (EPHS) with Bost Hospital in Lashkar Gah as either the provincial hospital or as an academic sub regional centre, supported by district hospitals in Gereshk, Garmsir and Musa Qala. The EPHS is in the process of implementation in 12 provinces countrywide, but the MoPH is unable to implement it in Helmand without additional support. The NHS could contribute to 3 aspects:

A suitably experienced health service manager to advise and assist the Provincial Health Directorate in implementing the EPHS, including assessment of current systems and leadership in Bost Hospital, advising on priorities for action and improvement, liaising with other agencies including the MoPH, PRT and CiMiC teams, and leading the coordination of the others aspects of NHS support.

NHS personnel would supply the clinical skills development, teamwork and management development and 'training the trainers' input. In view of the security constraints and the consequent difficulty of reliable or extended visits to the provincial hospital, this would best be done in the more secure environment in Kabul, probably at the Ibn Sina Emergency Hospital. This would require visiting UK clinicians to be based on the British Embassy Kabul site in groups of two or three at a time for two to three weeks. It would also be useful if they could make brief visits to Lashkar Gah from time to time to improve knowledge of the context in which the Afghan clinicians work and to follow up with them in a mentoring role.

As a key part of the clinical skills development programme, UKNHS personnel would also advise and assist on improving the level of infection control and hygiene in the hospital. This would be particularly important in improving patient safety in the hospital and reducing maternal mortality and other avoidable deaths.

Further details of the potential programme, including a framework of support, logical framework and risk assessment are attached at Annex I.

## 6 RAISING THE MORALE OF HEALTH PERSONNEL

### 6.1 Innovative approaches

In these times of insecurity in the province, the focus in human resource development needs to be less on planning or training and more on personnel management, especially support and supervision. There are numbers of health personnel in the province but they are not equitably distributed as many have migrated to larger urban areas such as the capital of the province for safety reasons. For this reason some health facilities are standing empty or are only minimally staffed because health personnel do not want to take the risk of working in the location and/or feel that the risks they are taking are not adequately recognised by the powers that be. Staff morale throughout the province is understandably low and a major challenge. Living and working in an insecure environment is extremely difficult. Twelve Ibn Sina staff members have been killed since 2006 and staff turnover is high, due to the conflict. Two WHO volunteers were killed September 2008 when helping with a polio campaign. There is very little going on in terms of raising moral through giving support to personnel as part of supervision visits.

A rapid review about the payment of incentives 'in normal times' to health workers to increase the quantity and quality of health services found moderate evidence of strategies of this type to be successful and especially in reducing staff dissatisfaction<sup>39</sup>. In addition, incentives that raise performance – ensuring appropriate, targeted training so health professionals are equipped to do their job; linking pay and performance; reviewing and auditing performance; improving recordkeeping; and upgrading logistics for drugs and supplies – need to be an integral part of health systems<sup>40</sup>.

It seems therefore wholly justified in a conflict context such as that in Helmand that incentive schemes be promoted. Especially if they are well designed and evaluated, address a priority service or intervention, have a specific time frame and are linked to results.

Current incentives in Helmand:

CHWs receive \$20 to take pregnant women to a health facility for safe delivery and also receive a payment for the detection of a new TB patient and for undertaking well child screening

Suggested incentive by Helmand health staff:

Incentives by results scheme for medical personnel delivering the EPHS

Other possible incentives:

Extend CHW incentives by results to cover other priority public health interventions

Incentives by results for outreach work by Ibn Sinh

Providing a higher level of salary supplementation for specific health personnel such as surgeons and obstetric and gynaecological staff

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<sup>39</sup> Peters, D H et al. 2009. Evidence on health services strengthening strategies. Forthcoming book, World Bank

<sup>40</sup> Maureen Lewis 2006 Governance and Corruption in Public Health Care Systems. Centre for Global Development

Module on provincial level health management for provincial health team, held in Lashkar Gah and run by a national institute

The allocation of a room in the proposed provincial health directorate building for continuing education and the development and implementation of a continuing education programme

Provision of some relevant textbooks/CD Roms for use at provincial level and fund a short course in Lashkar Gah on health management at provincial level run by a national institution

Better support/supervision by MoPH central level to the provincial health directorate and the facilitating of supervision and M&E by the provincial health directorate to district and community levels

All the above are specifically addressing the enhancement of health service delivery, basic and/or hospital services. They deserve serious consideration should HMG decide to support the BPHS and/or the EPHS.



## 7 STRENGTHENING GOVERNANCE IN THE HEALTH SECTOR

### 7.1 Functioning of the Provincial Health Directorate

The provincial health directorate (PHD) in Helmand could be described as having willingness, ability and some capacity in a wider context of low state willingness. Currently the state is unresponsive to the needs of the PHD and there is an overall absence of state control in the province. As a result, there are major challenges in implementing pro-poor, pro-rural health policies and services. See also Annex D for a SWOT of the overall health system in Helmand province.

A recent World Bank paper on service delivery at the sub-national level in Afghanistan states: 'Broadly speaking, provincial line departments are over-centralised, suffer too much interference from provincial governors in their day-to-day operational activities, and are under-capacitated. Their performance needs to be improved through a combination of capacity development and re-organisation, with specific reference to the division of powers and functions between central and provincial offices in order to enhance efficiency'<sup>41</sup>. The environment is further complicated by evidence that returns to investments in health are low where governance issues are not addressed<sup>42</sup>. The problem with the lack of concern for basic governance principles in health care delivery is that well-intentioned spending may have no impact.

The Helmand PHD has a good reputation among provincial departments in Helmand. However it openly acknowledges it is not currently functioning either effectively or efficiently. It points to issues such as to poor support from, lack of decentralisation by, central level; the allocated recurrent budget remaining the same every year despite requests by the province for changes; the undermining of the provincial health office by the office of the governor; and a disempowered provincial health director as he has no budget or authority with regard to the oversight, monitoring and supervision of all stakeholders in the health sector. In addition, the PHD is currently located in Bost hospital. This is not ideal as PHD staff get too involved in day-to-day issues in the hospital and the PHD lacks an identity of its own. In most other provinces the PHD is a separate, stand-alone building. See Annex D for a SWOT of the overall health systems, governance and institutional development in Helmand.

There are some indications of sound institutional practices in the PHD. For example:

The PHD has relevant ToRs, its role and functions are well known and understood

Staff have job descriptions. Currently, there is only one vacant post, for reproductive health – the previous holder died last year and no-one else is prepared to take the position

The provincial health coordinating committee meets regularly and there are minutes available

A provincial health development plan and an action plan are developed annually using a participatory process

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<sup>41</sup> World Bank 2007 Service delivery and governance at the sub-national level in Afghanistan. World Bank, Kabul

<sup>42</sup> Maureen Lewis 2006 Governance and Corruption in Public Health Care Systems. Centre for Global Development

However, while the provincial health director is willing to be in the driving seat in health in Helmand he has little authority and no budget to be able to ensure good oversight of the health sector, to ensure that MoPH values and policies are implemented effectively. Not having an office budget for example means that if the director wants to buy some new brooms a proposal has to be sent to the governor's office who appoints 2 people to scrutinise the request. Their recommendation will be sent to the Mustafa and 3 months later a decision will be made. Any authority the experienced PHD director may have is undermined by there being a much less experienced health adviser in the office of the provincial governor who insists the director go through him about anything in health. The director is not allowed to meet the governor.

There are 2 other health advisers at provincial level. In the PHD there is someone appointed for one year through Development Alternative International, who is helping with practical administrative systems and procedures such as computer networks and training; making the agenda for the provincial development council and making a daily/weekly work plan. In the PRT there is a health adviser provided by the government of Estonia. While both advisers are undertaking useful, practical work what is lacking is support for the bigger picture of strategic institutional and governance development.

## 7.2 Working within the framework of institutional reforms

The World Bank paper mentioned earlier clearly states that any reform has to be undertaken within the context of IARCSC, Public Administration Reform (PAR,) office of the provincial governor, local government law and MoF provincial budgeting reforms<sup>43</sup>.

The MoPH Kabul has been talking about the need for better decentralisation for the past few years but very little has been effected to date. There is a real opportunity to realise the more effective functioning of the PHD by working within the framework of the various reform processes, especially PAR. DFID is already actively working with the Afghan government on various reforms towards good governance and so any HMG support in health has the potential to be really effective.

Processes that would make a difference at provincial level in Helmand include, among other things, decentralised financial and other authority, effective communication between and support by, central and provincial levels of the system, transparent decision making, useful budgeting and accounting systems and government led coordination, monitoring and oversight. In addition, it would be useful to help the provincial health directorate take the lead and enable the development and communication of messages through the radio that raise awareness about successes and ongoing work in the health sector. This could a first step towards forging a state-society compact. All such issues fall within the remit of the provincial health directorate in coordination with other stakeholders especially the provincial governor's office.

A useful approach could be to substantially engage with the provincial health office within the framework of current DFID governance support. The aim would be to strengthen the governance of the health sector particularly in the oversight of both the public and private sectors in health in the province, particularly the

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<sup>43</sup> World Bank 2007 Service delivery and governance at the sub-national level in Afghanistan. World Bank, Kabul

implementation of equitable health service delivery. This could be done through intermittent mentoring support over the next 4 years about January 2009 onwards. A brief inception phase would be needed at that time to determine exactly what to work on and what impact such work would have but the areas to focus on may well be policy, strategic planning, systems strengthening, enforcement of regulations, decentralised responsibilities and development of oversight and leadership of the health sector in the province. Currently no such work is going on in the health sector at provincial level.

### 7.3 Links with, and role of national health policy level

There are some important national level factors that can facilitate or hinder achieving 'good enough' governance and effective, efficient, quality service delivery in the health sector at provincial level. Such factors include leadership, the type and quality of policy decision making, the extent of transparent decision making and of decentralisation, the degree of support provided and the quality of aid effectiveness including technical co-operation for capacity development.

Only recently has the MoPH seriously started to consider effective and efficient decentralisation<sup>44</sup>. Because of the links between national and provincial levels and implications for both of strengthening governance any support should be focused at both levels. There is only very limited TA at central level to help the MoPH move ahead and none at provincial level. Currently, the EC is the only donor that is working on various aspects of policy and institutional development in the MoPH. The EC has 4 TA advisers based in the policy and planning directorate and in the Grants and Contracts Management Unit. All the work has been focussed on the national level to date.

HMG could contribute much to the process of decentralisation and its governance by taking Helmand province as an example of a mix of bottom-up and top-down approaches of improving sub-national governance. In addition, valuable lessons could be learnt about governance and its functioning in an insecure environment, in a fragile province. The success of increased HMG support for health in Helmand will be less without a policy input at the national level. If HMG were to also renew its support for health policy making at the national level through intermittent visits by a DFID health adviser or TA, such a response at provincial level would be all the more effective. DFID played a key role in health policy, strategy, systems and institutional development with top/senior management in the MoPH 2002 – 2004.

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<sup>44</sup>MoPH 2008. Provincial Planning and Budgeting Guidelines. Draft August 2008

## **ANNEX A. MINISTRY OF HEALTH STATEMENT ON SECURITY AND ACCESS TO HEALTH CARE**



Transitional Islamic State Afghanistan

Ministry of Health, Office of the Minister of Health

7 August 04

Commanders: PRT and ISAF

Cc. Office of President Karzai

Embassies

Health aid stakeholders

Position paper: Security and access to health care

One of the top priorities of the Ministry of Health is to urgently extend the delivery of health services, especially in rural and other underserved areas. This is primarily to address the seriously high rates of maternal and child mortality and morbidity.

The Government of Afghanistan is very appreciative of the many international and local efforts in the health sector to address the high levels of illness and other problems. However, it has become increasingly clear that there is a serious security problem in those areas of the country where Provincial Reconstruction Teams, ISAF and/or any other special international military forces get involved in health and health related work, and where aid agencies are also working.

Work by the military or reconstruction teams such as the running of health clinics, the digging of wells and the distributing of leaflets promising aid for information is posing a serious threat to the lives of aid workers. The distinction between aid workers and soldiers/reconstruction teams has become fatally blurred. Sadly, most recently demonstrated in the killing of Medecins sans Frontieres workers and the decision of the Nobel peace prize-winning organisation to leave Afghanistan.

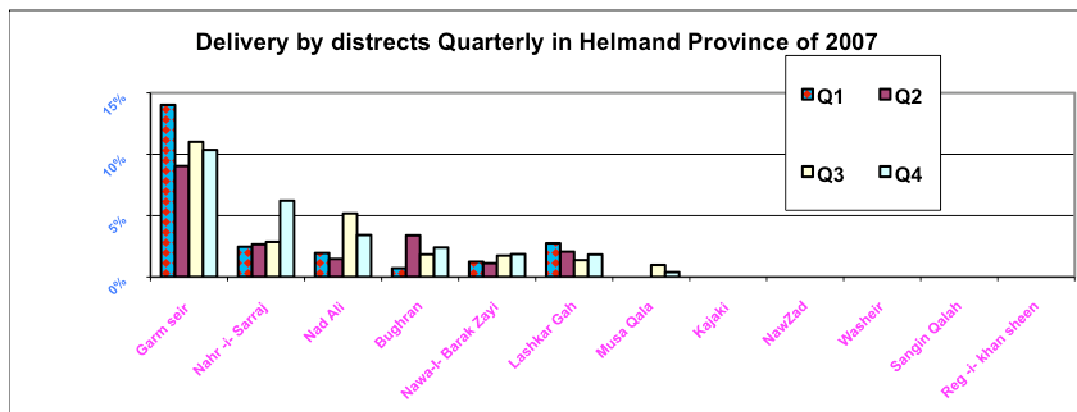
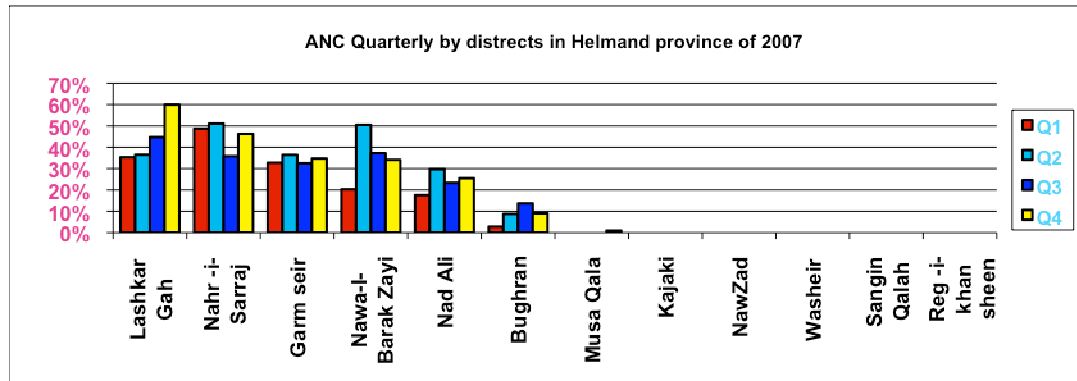
The Ministry of Health does not have the resources to take over the delivery of health care when an aid agency has to suddenly pull out for security or other reasons. Thousands of women and children in particular will lose access to vital health services.

We therefore see a crucial need to differentiate, to draw a line, to ensure a clear separation between the work of the aid community and that of PRT/ISAF/other special military forces. Before any international or local organisation can undertake health and health related work in Afghanistan it has to sign a Memorandum of Understanding with the Ministry of Health. Such a memorandum reflects discussions with senior management on where the organisation will work, what it will provide, and how it will go about it.

It is the position of the Ministry of Health that no individual, organisation, or other group or team can undertake health or health related activities in Afghanistan without the prior permission of the ministry headquarters, Kabul. We ask everyone to please respect this.

## ANNEX B: HEALTH INFORMATION, HELMAND PROVINCE

### Annex B1: Example of gaps in information, Helmand Province - Two bar charts showing the absence of data from 50% of districts in Helmand in 2007



### Annex B2 - Table 1. Differences in indicator rates, Helmand and national averages

Subject	Helmand province	National average
+Maternal mortality ratio	●4, 503/100,000 live births	○1, 600/100,000 live births
*ARI	12 /1000	6.7/1000
*Diarrheal disease	15.3/ 1000	2.6/1000
Contraceptive prevalence rate	1.8%	15.4%
Antenatal care	5.6%	30.3%

Skill attendance at birth	1.5%	18.9%
BCG	52.4%	70.2%
OPV	16%	69.7%
DPT3	3.9%	34.6%
TB case detection rate	*11.6%	^36.4%

\*Source of information: HMIS/MoPH 2007

+ UNICEF 2003

● Maternal Mortality Ratio in Helmand province: is calculated from the total number of maternal death which has occurred in health facilities divided by the total number of live birth which took place at the same health facilities during 2007. This figure is not representative for the whole province because the data has been collected from routine health management information system (HMIS) and most of deaths due to pregnancy related complications may have occurred at the household level which is not included in the HMIS data. This estimation is just for comparison to indicate the magnitude of maternal health problems in Helmand province.

Source of Information: Best Estimate/UNICEF 2006

^HMIS/MoPH 2006

^ WHO/TB report 2006

### Annex B3. Evaluating the BPHS: balanced scorecard results in Helmand, 2004

Subject	~Baseline 2004	
	National median	Helmand
* Overall patient satisfaction	83.1	66.4
Patient perception of quality index	76.0	70.4
Written Shura activities in community	34.2	8.1
Health worker satisfaction index	63.5	61.4
Salary payments current	76.7	80.9
Equipment functionality index	65.7	40.9
Drug availability index	71.1	81.6
Family planning availability index	61.4	71.3
Laboratory functionality index	18.3	14.2
Staffing index	39.3	40.3
Provider knowledge score	53.5	46.4

Staff received training in last year	39.0	36.1
HMIS use index	67.7	30.6
Clinical guidelines index	34.8	12.5
Infrastructure index	55.0	28.5
Patient record index	65.6	74.3
Facilities having TB register	15.8	20.8
Patient history and physical exam index	70.6	52.6
Patient counselling index	29.6	16.7
Proper sharps disposal	62.2	12.1
Average new outpatient visit per month	22.2	0.0
Time spent with patient (> 9 minutes)	18.0	11.7
BPHS facilities providing antenatal care	62.0	29.6
Delivery care according to BPHS	25.4	20.1
Facilities with user fee guidelines	90.6	73.6
Facilities with exemptions for poor patients	84.7	73.0
Females as % of new patients	55.2	54.5
Outpatient visit concentration index	-0.010	-0.003
Patient satisfaction concentration index	0.002	-0.015

~ Last time balanced scorecard used in Helmand as part of national evaluation as subsequent levels of insecurity has meant team from Kabul unable to visit

\*Balanced scorecard content



### ANNEX C. HEALTH STAKEHOLDER MAPPING IN HELMAND

Stakeholder/ implementer	Funder	Subject	*Location
MoPH	WB	HIV/AIDS/AI	Province wide
MoPH	WB/CDC	Bird Flu	Province wide
MoPH	GAVI	EPI	Province wide
MoPH	GAVI	Health systems strengthening	Province wide
MoPH	UNICEF	Reproductive health capacity building	Province wide
MoPH	Ministry of Tribal Affairs	Health care for nomads	Lashkar Gah
MoPH/ HNTPO	GFATM	Malaria	Province wide
MoPH/HNI	GFATM	? HIV/AIDS, TB & malaria	Province wide
UNICEF		a) Polio campaigns b) Water and sanitation in schools	Province wide
WHO	CIDA	Polio campaigns	Province wide
Ibn Sina	WB	BPHS	Province wide
Afghan Red Crescent Society		Health centre	Lashkar Gah
USAID/UNICEF		Polio eradication	Province wide
Italian NGO		Emergency hospital	Lashkar Gah
Italian NGO		First Aid post	Gereskh
Johns Hopkins	WB	Annual BPHS balanced scorecard	Country wide since 2004; not in Helmand since then
WADAN	British Embassy	Private-not-for profit clinic with beds in rented house	Lashkar Gah
International Alternative Development	Civil Service Commission	Enhancement of local governance	All sectors in the province
COMPRI-A	USAID	Social marketing in health	Province wide

Asia Foundation	DFID	Health Adviser	Governor's office
PRT	British military	Emergency medical care for Afghans	PRT, Lashkar Gah
	Government of Estonia	Health Adviser	PRT office
ISAF	British military	Emergency medical care for Afghans	Camp Bastion
		MEDCAPS	Various locations

\*Province wide intended, not currently possible due to both security and institutional constraints

## ANNEX D: SWOTS OF HEALTH IN HELMAND

### Annex D1: SWOT of overall health systems, governance and institutional development in Helmand

Date: 04.11.2008

Participants: Provincial Health Directorate Team

Location: Office of Provincial Health Directorate, Lashkar Gah

<p style="text-align: center;"><b>Strengths</b></p> <ul style="list-style-type: none"> <li>➤ Good coordination mechanism in place</li> <li>➤ Clear ToRs of provincial health team</li> <li>➤ Provincial health team not involved in curative activities</li> <li>➤ IT equipment in HMIS office</li> <li>➤ Regular communication with central MoPH through radio and internet</li> <li>➤ Short term courses in management and leadership</li> <li>➤ Working as a team</li> <li>➤ Provincial health officers successfully gone through PRR process</li> </ul>	<p style="text-align: center;"><b>Weaknesses</b></p> <ul style="list-style-type: none"> <li>➤ Advisers to PHD do not have relevant knowledge or experience</li> <li>➤ Reproductive health officer's post vacant</li> <li>➤ No authority over budget</li> <li>➤ Centralized decision making</li> <li>➤ Irregular monitoring and supervision</li> <li>➤ No budget for monitoring and supervision</li> <li>➤ Poor English</li> <li>➤ Location of PHD office within the hospital compound</li> <li>➤ Lack of supervision/support by central MoPH</li> <li>➤ No feedback from central MoPH on HMIS report and provincial health plan</li> <li>➤ PRT arranges parallel coordination meetings</li> <li>➤ Governor is not supportive</li> <li>➤ No cash in hand</li> <li>➤ Administrative procedures are bureaucratic</li> <li>➤ Lack of capacity to analyse HMIS data</li> </ul>
<p style="text-align: center;"><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>➤ Willingness of PRT to support</li> </ul>	<p style="text-align: center;"><b>Threats</b></p> <ul style="list-style-type: none"> <li>➤ Insecurity</li> <li>➤ Governor receives biased information through health adviser in his office</li> <li>➤ No commitment of funds for the BPHS beyond March 2009</li> </ul>

**Annex D2: SWOT of BPHS in Helmand**

Date: 05.11.2008

Participants: Ibn Sinh staff: project director Dr Khaliq Noor and PHC supervisor Dr.Jamaluddin

Location: Office of Provincial Health Directorate, Lashkar Gah

<p style="text-align: center;"><b>Strengths</b></p> <ul style="list-style-type: none"> <li>➤ Ibn Sinh experienced in basic health service delivery since 1998</li> <li>➤ Qualified managerial and clinical staff</li> <li>➤ Incentive scheme designed and implemented</li> <li>➤ Midwifery school addressing lack of female staff</li> <li>➤ Training centre for refresher courses</li> <li>➤ Good coordination with PHD</li> <li>➤ Accommodation for clinical staff</li> <li>➤ Trained community health workers</li> <li>➤ Community health shura established</li> <li>➤ Political support</li> </ul>	<p style="text-align: center;"><b>Weaknesses</b></p> <ul style="list-style-type: none"> <li>➤ Irregular monitoring and supervision of health facilities</li> <li>➤ Supply constraints</li> <li>➤ High staff turn over</li> <li>➤ Few female staff / surgeons</li> <li>➤ Low salary scale</li> <li>➤ Some health facilities are adapted, rented houses</li> <li>➤ Vehicles stolen by Taliban</li> <li>➤ No outreach activities</li> <li>➤ Lack of females in community health shura</li> <li>➤ No life, accident insurance for staff</li> <li>➤ No refresher training for clinical staff because of insecurity</li> </ul>
<p style="text-align: center;"><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>➤ PRT is willing to construct health facilities</li> <li>➤ UKHMG potential fund commitment</li> </ul>	<p style="text-align: center;"><b>Threats</b></p> <ul style="list-style-type: none"> <li>➤ Insecurity</li> <li>➤ Kidnappings</li> <li>➤ 12 staff members have been killed</li> <li>➤ Land mines</li> <li>➤ No commitment of funds beyond March 2009 for BPHS implementation</li> </ul>

## ANNEX E. SUMMARY OF PRESENTATION IN DFID OFFICE, KABUL 20.11.08

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**Health in Helmand**

Thoughts on possible HMG support

Stephanie Simmonds and Feroz Ferozuddin  
20 November 2008, Kabul

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2

**Situational analysis**

- Extremely difficult to get sound data on health and disease problems province wide. Mortality and morbidity likely to be higher in Helmand than national data suggests, in context of maternal and child mortality among worst in world
- Last valid data was in 2004, on quality of BPHS implementation – 23 of 29 indicator results below national median
- Only 28 of 46 health facilities functioning

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3

**Security related constraints**

- Achieving adequate coverage of public health interventions such as vaccination campaigns very problematic, health personnel face acute danger when travelling in some areas
- Routine provision of other key evidence based public health interventions problematic, some health facilities either been destroyed or in difficult to access places
- Almost impossible to travel around to do any supervision or monitoring of quality
- Some facilities not adequately staffed, if at all, due to high levels of fear among staff and low levels of motivation

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**Stakeholders in health**

- MoPH/Provincial health directorate – some health planning, no M&E. Best hospital
- World Bank may have insufficient funds for BPHS implementation 2009+;; DFID village water and sanitation
- WHO and UNICEF vaccination campaigns, latter also water supplies
- NGOs: Ibn Sina implementing BPHS, WADAN on drug addiction
- PRT
- Military

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**Areas of potential HMG support**

- The big picture**
- Targeting those who, for security reasons, are hard to reach in the province
  - Enhancing the delivery of basic health services
  - Strengthening the delivery of essential hospital services
  - Raising the morale of health personnel
  - Strengthening governance in the health sector

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**Targeting those hard to reach**

- Principle of equity**
- Potential epidemic(s): vehicles, strengthening relationship with shura
  - Integrated approach: essential public health interventions
  - Emergency caesarian section training
  - Payment for transport scheme
  - Logistics: military helicopter for supplies

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**Enhancing basic health services**

- BPHS support: MoPH searching for new donors
- M&E: use of private medical practitioners through public-private partnership
- Water and sanitation for schools and health facilities
- Health education/ public awareness
- Drug addiction treatment

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**Strengthening hospital services**

- EPHS yet to be implemented, start in Bost provincial hospital
- Would help raise state visibility
- NHS identified clinical and management needs and interested in providing TA

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9

**Raising morale of health personnel**

- Incentives: By results for key public health interventions and for outreach work, salary supplementation, continuing education
- Armoured vehicles and support of shura
- Strengthening health system: processes, roles, structures, specific systems to enable health workers to better undertake their work

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10

### Strengthening governance

**Determine essential issues for equitable, efficient, effective, quality service delivery**

- Health system: leadership, ownership transparency, decision making, power and authority, politics of health etc
- Public administration
- Decentralisation
- Enforcement of regulations

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### Other considerations

- If HMG does nothing
- Success factors
- Risks
- Aid instruments
- What is not needed
- M&E
- TA and capacity development

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12

### Options

1. Comprehensive medium term approach: BPHS + add-ons, EPHS + add-ons, provincial health governance strengthening, national policy level - governance, institutional and systems
2. Top-up support for the BPHS + add-ons
3. Focus on support for EPHS + add-ons
4. Focus only on water and sanitation
5. Provide only short term inputs
6. Better use of existing inputs/resources
7. Do nothing

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**ANNEX F: SUMMARY OF ONGOING, PLANNED AND GAPS IN INFRASTRUCTURE WORK IN HEALTH SECTOR IN HELMAND**

Location	*Name/type/location of facility	Ongoing infrastructure work	#Planned	Gaps	Estimated cost & source of funds
Lashkar Gah	Bost hospital	Mechanical and electrical e.g. wiring, water, sewerage, incinerator, 1,000kw generator, oxygen distribution system, plus equipment such as dental, xray machine, monitors – finished/installed by end 2008/early 2009 (have 7 computers with CD Rom)		Medical books and journals; Sometime in future may need to replace some surgical instruments	Ongoing work = SAF
Lashkar Gah	Bost hospital		Ambulance station		SAF
Lashkar Gah				Provincial health directorate office with continuing education facility	No funds available at present ?DFID or SAF  ^?\$300,000
Lashkar Gah	? Next to training school			60 bedded hostel for midwifery & nursing students	? need to fill gap of c\$300,000 or are sufficient funds available from MoPH
Marjah				Community health centre	No funds available at present ?DFID or SAF  ^? \$400,000
Gareshk	2 basic health centres		First will be built soon; 2nd April 09		SAF

Musa Qa'leh	Comprehensive community health centre	Being built, almost completed			
Musa Qa'leh	District hospital		Justification – will cover area from Sangin northwards. Under design, 50 bedded. Will be responsibility of Ibn Sinh as part of BPHS	Costs of equipment and furnishings.  *But difficult to currently justify UKHMG support to address the gap as impossible to identify staff who would be willing to work in the hospital when it is built	SAF for infrastructure
Sangin	Comprehensive community health centre	?			SAF
Gamsir	District hospital	Almost completed			SAF
?	First aid post		2 more planned one in ? and one in ?		Italian emergency hospital

\*A number of 'white elephant' buildings, facilities and supplies of equipment exist in the province. Some facilities have been built but are standing empty for lack of staff and other resources. There are also, in the future, the recurrent cost implications for government of buildings such as the Italian emergency hospital. Any new facilities must therefore consider such factors.

# The Provincial Council sent a delegation to President Karzai about six months ago requesting a 50 bedded obstetric/gynecological building in Lashkar Gah, the Minister of Public Health also asked the consultants to consider this for UKHMG funding. There is no justification to build such a facility; Bost hospital should be supported in the implementation of the EPHS and in the process help it function optimally, it already has one wing with a separate entrance for women. In addition, at some stage in the future the Italian emergency hospital will be handed over to government which will have to cover the recurrent costs.

^ PRT engineering section estimate, November 2008

## ANNEX G. LIST OF HEALTH FACILITIES WITH NO SAFE WATER

### Provincial Health Profile of Health facility and safe water need

Province Name: Helmand.

Updated:

30

July

2008

date

Nov 08/2008

SN	District Code	District Name	Population (CSO)		Facility name	Accesable pop.	Location (village)	Type of HF	EPI Team	Safe water	Building ownership
			CSO	EPI							
1	2301	Lashkergah	150000	106711	Kartelagan	35000	Kartelagan	CHC	1	No	Community
2	2301	Lashkergah		106711	Mukhtar camp	30000	Mukhtar camp	CHC	1	No	Community
3	2301	Lashkergah		106711	Mukhtar camp	8000	Mukhtar camp	BHC	1	Yes	Community
4	3201	Lashkergah		106711	Khushkaba	5000	Khushkaba	BHC	1	No	Community
5	3201	Lashkergah		106711	Safian	4000	Safian	SC	0	Yes	Community
6	3201	Lashkergah		106711	Qalabust	6000	Qalabust	SC	0	No	Community
7	3201	Lashkergah		106711	Babajee	4000	Babajee	SC	0	No	Community
8	2308	Nadali	85000	129106	Nadali	28000	Nadali	CHC	0	Yes	Government
9	2308	Nad ali/marja		129106	marja	23000	MarJah	CHC	1	No	Community
10	2308	Nad ali		129106	Einak	10000	Einak	BHC	1	Yes	Government
11	2308	Nad ali		129106	loaymanda	9000	Nadali	BHC	1	No	Government
12	2308	Nad ali		129106	Sayed abad	9000	Saidabad	BHC	1	Yes	Government
13	2308	Nad ali		129106	Shawal Naqil abad	4000	Naqilabad	SC	0	No	Community
14	2308	Nad ali/Marja		129106	marja Block 9	3000	Block 9	SC	0	Yes	Community
15	2308	Nad ali/Marja		129106	Camp marja	3000	camp marja	SC	0	No	Community
16	2309	Nawa	80000	101547	Nawa Khalage	33000	Nawa Khalage	CHC	0	Yes	Government
17	2309	Nawa		101547	Surkhdoz	6000	Surkhdoz	BHC	1	Yes	Government
18	2309	Nawa		101547	Basolan	10000	Basolan	BHC	1	Yes	Government
19	2309	Nawa		101547	Pinjawdo	17000	Pinjawdo	BHC	1	Yes	Government
20	2309	Nawa		101547	gauragin	4000	gauragin	SC	0	No	Community
21	2309	Nawa		101547	kharaba	5000	Loar	SC	0	Yes	Community

							gaoragai				
22	2312	Garamser	70000	98361	Hazar juft	37000	Hazar juft	DH	1	Yes	Government
23	2312	Gramsir		98361	Mianpushta	9000	Mianpushta	BHC	1	Yes	Government
24	2312	Gramsir		98361	Laki	9000	Laki	BHC	1	Yes	Government
25	2312	Gramsir		98361	Benader	5000	Benader	BHC	1	No	Government
26	2312	Gramsir		98361	Safar	5000	Safar	BHC	1	Yes	Government
27	2302	Greshk	110000	132535	Gereshk	47000	Gereshk	DH	1	Yes	Government
28	2302	Greshk		132535	Malgeer	28000	Malgeer	CHC	1	Yes	Government
29	2302	Greshk		132535	Mirmandab	15000	Mirmandab	BHC	1	No	Community
30	2302	Greshk		132535	Shoraki	10000	Shoraki	BHC	1	No	Community
31	2302	Greshk		132535	Nahreseraje	5000	Nahreseraje	SC	0	No	Community
32	2313	Sagin	40000	31182	Sagin	11000	Sagin	CHC	1	No	Government
33	2313	Sagin		31182	Pooza	14000	Pooza	CHC	1	Yes	Government
34	2313	Sagin		31182	Malmand	5000	Malmand	BHC	1	No	Community
35	2313	Sagin		31182	Nasozai	4000	Nasozai	BHC	1	No	Community
36	2313	Sagin		31182	Katozai	2000	Katozai	SC	0	No	Community
37	2304	Mosaqala	44000	70349	Mosaqala	30000	Musaqala	CHC	1	No	Government
38	2304	Mosaqala		70349	Toghai	8000	Toghai	BHC	1	No	Community
39	2305	Baghran	60000	89081	Baghran	27000	Baghran	CHC	1	Yes	Government
40	2305	Baghran		89081	khud	6000	khud	BHC	0	No	Community
41	2305	Baghran		89081	Nawamish	7000	Nawamish	BHC	1	No	Community
42	2305	Baghran		89081	Baghnee	9000	Baghnee	BHC	0	No	Community
43	2305	Baghran		89081	Gardi baghran	4000	Gardi baghran	BHC	1	No	Community
44	2306	Nawzad	38100	63663	Gurz	10100	Gurz	BHC	1	No	Community
45	2306	Nawzad		63663	Teezni	16000	Teezni	BHC	1	Yes	Government
46	2306	Nawzad		63663	Barnawzad	8000	Barnawzad	BHC	1	No	Community
47	2303	Kajakee	55000	131995	Kajakee	33000	Kajakee	CHC	1	Yes	Community
48	2303	Kajakee		131995	Aliabad	11000	Nalan	BHC	1	No	Community

Key: Red highlighting indicates need for safe water and building. Reference: Health facilities in-charges meeting/Lashkargah city, 26/11/2008, Wednesday, 10am to 2pm.

27 HFs have not safe water as 56% of active HFs.

21 HFs have safe water as 44% of active HFs.

28 Hfs have no standared building as 58% of active HFs.

20 HFs have standard buildings as 42% of active HFs

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## **ANNEX H: POTENTIAL ROLE OF THE UK NHS IN SUPPORT OF THE EPHS**

**AFGHANISTAN: POTENTIAL NHS ROLE IN SUPPORT OF THE EPHS IN HELMAND PROVINCE: Implementation of the EPHS with initial focus on support for hospital emergency care including obstetrics and related hospital functioning in Helmand Province and where appropriate nationally**

**Phase 1 (first 6 months): Provincial health directorate, Helmand and Bost hospital, Lashkar Gah**

- **Support for implementation of the EPHS through the provincial health directorate in a conflict environment:**
  - Adviser to provincial health directorate, possibly based in Kabul and covering more than one province e.g. MoPH-SM provinces that might benefit from such support (senior NHS manager based with DFID with draft terms of reference – see page 3)
  - Hospital management training of trainers
- **Hospital clinical and related clinical managerial and educational in-service skills and capabilities development appropriate to the complex security context and its impact on health service delivery (? to benefit provinces nationally not just Helmand)**
  - Short training of trainers courses on the 3 subject areas in Kabul
  - Mentoring visits to Helmand
  - NHS trainers with some resources e.g. books and perhaps CD-ROMs (need to appraise critically any scope for distance learning)
- **Hospital hygiene and infection prevention and control in a context of severely limited resources**
  - Raise awareness of need for infection prevention and ensure infection control lead identified at senior leadership team level
  -

**Phase 2 (second 6 months): Continue work in Bost hospital covering elements of the EPHS not covered in phase 1 plus intermittent monitoring visits on provincial health directorate strengthening with ongoing modifications according to the security environment**

- Paediatric care and chronic disease prevention and control in Bost hospital and strengthening of a district hospital

**Phase 3 (last 6 months): Dependent on security and access, implement full package of EPHS in one other district hospital e.g. Gereshk hospital plus intermittent monitoring visits to Bost hospital and for provincial health directorate strengthening**

### **Risks**

- Purpose and outputs unlikely to be achieved or project postponed because of conflict
- Purpose and outputs achieved to a limited extent because of one or more of the following:
  - a) Security, transport and communication hamper implementation

- 
- b) Lack of political commitment, Afghan and/or UK
  - c) NHS organizations unwilling to release clinical trainers
  - d) Insufficient numbers of appropriate of clinical trainers willing to participate

### **Implications for HMG**

- NHS will cover salaries and any back filling for NHS personnel while they are in Afghanistan but cannot use NHS funds for other resources in Afghanistan. UKHMG will therefore need to resource other interventions e.g. infrastructure, in-service training, any recurrent costs etc
- UKHMG funds for external mid term review and evaluation
- Need for NHS/UKHMG with government to: a) clarify the 'how' of capacity development; b) manage expectations and risks; and c) plan for exit strategy – currently implied in clear time frame

### **What this input to the HMG programme will not do:**

- Other components of the EPHS e.g. hospital nursing care and allied health professions; Nutrition; Provision of inappropriate equipment; Drugs and other medical supplies; Laboratory medicine etc

### **Evaluation**

Internal review of phase 1 at 4 months from start date by DH representative, an independent mid term review in DFID output to purpose (OPR) format at 10 months from start date and external final evaluation using DFID project completion report (PCR) format at 18 months both funded by HMG. It would be helpful if the current DH representative were present during the evaluation to lay the groundwork for any possible continuation of the NHS inputs. First NHS team with the proposed adviser will need brief planning/inception phase to obtain a few 'quick and dirty' baseline quantitative indicators and to decide which aspects of governance need addressing in the provincial health directorate.

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## **Annex H1. Terms of Reference: Health Adviser, Provincial Health Directorate(s)**

### **Purpose:**

- To advise and assist the Helmand Provincial Health Directorate – and subject to decision (?including MoPH-SM) other provinces – in implementing effectively Afghan national policy for health services (BPHS and EPHS) within the framework of institutional development in a politically and insecure context.

### **Methods**

The Adviser will achieve the purpose through;

- Assessing current leadership, governance, health systems, provision and use of baseline information and data availability;
- Assessing the status, capacity and quality of existing hospital provision in the province(s), together with improvement plans and communications with the MoPH;
- Advising the Provincial Health Directorate(s) on priorities for action and improvement, and supporting development and implementation;
- Liaising with relevant agencies including the MoPH, DFID, the Provincial Reconstruction Team and military colleagues to ensure coordination of effort and make best use of resource;
- Leading the coordination of the other components of the NHS support programme to Afghanistan (skills development, hospital hygiene and infection control, hospital infrastructure);
- Carrying out a baseline assessment of aspects of the safety and quality of hospital service provision, and monitoring its progress over the lifetime of the programme.

## Annex H2. Framework of NHS role

Intervention	Rationale	Link with ANDS and with MDGs	Baseline (process indicators as quantitative data not available for this visit)	Process outputs	Anticipated process, and where possible quantitative, results
Planning and support for effective and efficient implementation of the EPHS through the provincial health directorate in a conflict environment	<p>Improving oversight by state of hospital service delivery</p> <p>Putting MoPH policy and strategy into practice more effectively</p>	ANDS/ governance	<p>(Need judgment on Helmand provincial health directorate capacity and role re. EPHS; and information on other provinces e.g. MoPH-SM provinces that might benefit from such support)</p> <p>(Need judgment on: a) planning capacity for starting implementation of EPHS; b) effectiveness of hospital leadership and governance)</p>	<p>Effective oversight of implementation of EPHS policy</p> <p>Communications system(s) functioning</p> <p>Effective, transparent and accountable hospital management</p>	<p>Effective and efficient oversight of hospital governance, systems and services</p> <p>Improved strategic planning processes that take into account all health inputs, national and international</p> <p>Hospital services well regarded and readily accessed by members of the public</p> <p>Multidisciplinary team in place with effective, efficient and quality systems, services and governance</p>
Strengthening hospital clinical and related clinical managerial and educational skills and capabilities appropriate to the complex security context and its impact on health service delivery	<p>Improving quality and safety of patient care and improving transmission of skills and capabilities to less experienced clinicians</p> <p>Reducing maternal mortality and other conditions requiring emergency interventions</p>	Maternal mortality MDG	<p>(Need judgment on skills and capabilities in the 3 areas)</p> <p>(Need estimated provincial maternal mortality rate)</p>	Increase in skills and capabilities in the 3 areas	Extent to which those trained are now training others



Strengthening hygiene and infection prevention and control in a context of severely limited resources	Reducing unnecessary hospital infection and avoidable mortality and morbidity	Reduction in disease morbidity and mortality MDG	Demand created for infection control processes  Extent of effective hand washing	-Designated infection prevention and control lead person  -Better hygiene in clinical areas	Ongoing high standards of hygiene and infection prevention and control
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**Annex H3. Logical Framework: NHS role with Afghan government and DFID in support of the EPHS, Afghanistan**

Narrative summary	Objective verifiable indicators	Means of verification	Assumptions
<p><b>GOAL</b> Efficient and responsive state EPHS delivery in a politically charged and insecure environment</p>			<p>National and provincial political will to improve role of state</p>
<p><b>PURPOSE</b> Effective strategic management and safe and clinically effective hospital services appropriate to the complex security context</p>	<p>Higher demand for hospital services, by end of programme</p>	<p>Local perception of hospital services by general public</p>	<p>Resources available and sufficiently secure working conditions and communications Willingness and availability of UK trainers Institutional commitment to change management Availability of transport and security of access</p>
<p><b>OUTPUT 1:</b> Effective planning for, and implementation of, MoPH EPHS policy and strategy in a conflict environment through support for Helmand provincial health directorate</p>	<p>Clarity of roles, decision making processes and responsibilities and functioning systems between Helmand provincial health directorate and Bost hospital by ten months and at least one district hospital by end of programme Better knowledge of hospital services in Helmand and improved communications between central level MoPH and PHD, by ten months Availability of essential management information about health services, by ten months</p>	<p>Clear written provincial health plan to implement national EPH policy Systems in place for MoPH monitoring of PHD and PHD monitoring of health facilities in Helmand, specifically the hospital balanced scorecard Baseline data available for quantitative indicators Composition and role of hospital leadership available in writing Evidence of regular minuted meetings of leadership team Focus group discussions with general public</p>	

<p><b>OUTPUT 2:</b>                  Better quality hospital services through improving clinical, educational and managerial skills appropriate to the complex security context and its impact on health service delivery</p>	<p>Evidence of improved clinical practice particularly for maternal health, by ten months                  Evidence of better team functioning by ten months                  Evidence of continuing professional development among all hospital clinicians, by end of programme</p>	<p>Rapid assessments of clinical practice                  Visual assessment of team functioning and individual and group discussions                  Discussions with the hospital director</p>	
<p><b>OUTPUT 3:</b>                  To reduce unnecessary hospital infections and reduce hospital based mortality and morbidity in a context of severely limited resources</p>	<p>Designated infection prevention and control lead at senior leadership level, by four months                  Relevant policies and procedures in place by ten months                  Monitoring of compliance in place by end of programme                  Increased effective hand washing by end of programme</p>	<p>Evidence of written policies and procedures                  Relevant policies and procedures known to staff</p>	

**Annex H4. Risk register**

<b>1) Failure to achieve purpose and outputs because of increased level of conflict</b>		Probability	Medium/Low	Impact	Very High
<b>Description</b>	An escalation in conflict in Helmand could destabilise the province, halting the peace and political process and limiting development. In extremis, the international development community might be forced to withdraw. An escalation in extremist violence would inhibit the potential for DFID to deliver key health objectives.				
<b>Mitigating actions</b>	<ul style="list-style-type: none"> <li>• Political and military factors</li> <li>• Improving public services</li> </ul>				
<b>2) Purpose and outputs achieved to a limited extent because security, transport and communication hamper implementation</b>		Probability	High	Impact	Moderate
<b>Description</b>	Security concerns limit effectiveness by preventing or restricting access to provincial health directorate and health services Limited availability of, and delays in, transport between Helmand and Kabul hamper effectiveness Poor direct communications between provincial health directorate and health facilities limit knowledge of functioning and scope for improvement				
<b>Mitigating actions</b>	<ul style="list-style-type: none"> <li>• Close protection</li> <li>• Ensuring sufficient slots and appropriate priority for NHS personnel</li> </ul>				

<b>3) Lack of political commitment, Afghan and/or UK</b>	Probability	Low		Impact	High	
<b>Description</b>	Changing Afghan policy because of elections in 2009, ministerial teams, international relations Changes in UK policy					
<b>Mitigating actions</b>	<ul style="list-style-type: none"> <li>• Effective, efficient and visible implementation</li> </ul>					

<b>4) NHS organizations unwilling to release clinical trainers</b>	Probability	Medium/Low		Impact	High	
<b>Description</b>	NHS organizations that employ clinical staff are unwilling to release staff because of overriding clinical or managerial priorities to deliver services					
<b>Mitigating actions</b>	<ul style="list-style-type: none"> <li>• UK Department of Health leadership commitment</li> <li>• Central funding to back fill posts</li> </ul>					

<b>5) Insufficient numbers of appropriate clinical trainers willing to participate</b>	Probability	Low		Impact	High	
<b>Description</b>	Perceived level of insecurity and hardship limits numbers of clinicians who are prepared to volunteer					
<b>Mitigating actions</b>	<ul style="list-style-type: none"> <li>• Commitment by the medical leadership and Royal Colleges</li> <li>• Maintaining security and mitigation of hardship</li> </ul>					

## **ANNEX I. SUMMARY MOPH RETREAT 2-4 DECEMBER 2008**

### **Health Sector Strategic Planning Retreat**

Attended by Stephanie Simmonds

The purpose of the MoPH health sector strategic planning retreat was to discuss the priority issues that had arisen during the year including the results from various studies. And then determine the necessary next steps.

Using a mix of plenary and group sessions the priority topics discussed were:

- Health sector governance and policy
- Human resources challenges for service delivery
- Practical issues in service delivery
- National strategies in practice
- Sector policies and procedural problems
- Practical issues for productive partnerships
- Donor support, coordination and harmonisation

Top and senior management in the MoPH, some NGOs, and representatives of donor e.g. USAID and the EC, multilateral e.g. World Bank and UN agencies such as WHO and UNICEF attended the meeting. Two US Government officials also attended, as did 2 Afghan parliamentary representatives.

Overall the meeting was well organised, there were very open, lively discussions and most of the about 50 participants were present most of the time. Particularly impressive was the review at the start of the retreat of the action points from the 2007 retreat, the inputs to discussions by the parliamentarians and the determination to strive for quality in all aspects of work.

It was extremely useful to attend the retreat for the discussions 'in the corridors' with the other participants and as an opportunity to discuss issues arising during the consultancy. Of all the international participants I was the only one to have recently spent some time in a very insecure part of the country. This generated interesting discussions about approaches to health services delivery and health systems strengthening in times of insecurity. The conclusions/agreements as a result of these discussions helped validate the findings of Feroz and myself and can be summarised as:

- There is no one right approach. What is important is to allow for flexibility, the taking of initiatives and rapid decision making
- There is a need to work more on engendering trust with local communities, they are the cornerstone for the effective and efficient delivery of health services and activities at the community level
- Building trust with local communities will help maintain a neutral humanitarian space in which an NGO contracted to deliver basic health services can operate safely and impartially, independent of political and military objectives
- The BPHS comprises evidence based services and activities and provides a sound framework for service delivery. However, there must be room to allow for adjustments in how the services are delivered e.g. allow for more vertical delivery

- Allow for, indeed encourage, innovation but ensure that any innovation is monitored and evaluated
- Those responsible for the HMIS need to decide on what is the minimum of health information that needs to be routinely reported by insecure districts and provinces
- Should the NGO contracted to deliver basic health services withdraw from a province for security reasons, there should not be an immediate assumption that an emergency humanitarian response is needed. The provincial health directorate should be given the opportunity and resources to deliver the services. There is local capacity but it needs the resources and authority to function effectively and efficiently
- There needs to be a focal point in the MoPH for 'health in insecure areas'. This would help with the development of an institutional memory on ways of working, lessons learnt etc

The MoPH is producing a summary of the conclusions and action points from the retreat, which will be distributed to participants, and forwarded to DFID Kabul, in the near future.

## ANNEX J. TIMETABLE

Date	Time	Contact and organisation	Purpose and location
30.10.08	15.30	Arrival of Stephanie Simmonds	Kabul airport
30.10.08	16.30	Lucia Wilde, Resources Manager, DFID	Security resources, DFID office
30.10.08	17.30	James Offer, Security Manager, British Embassy	Security briefing, British Embassy
30.10.08	19.00	Shalini Bahuguna, Poverty Adviser, DFID	Briefing, DFID office
31.10.08	11.00 – 17.00	Dr Bill Kirkup, UK Department of Health official	Discussions on potential UKNHS role, DFID
01.11.08	10.00	H.E. Dr Fatimie, Minister, Dr Kakar, Deputy Minister, Dr Nadera Hyat, Deputy Minister, Dr Salehi, Head of GCMU, Dr Ahmad Zai, Head of Public Relations, Ministry of Public Health	Meeting on health in Helmand, Ministry of Public Health
01.11.08	12.00	Shalini Bahuguna, DFID	Update on issues re Helmand
02.11.08	10.00	Mr Omiya, Head of Health Section & Dr Yomo, Policy and Planning Officer, JICA	Role of JICA in health, JICA office
02.11.08	10.45	Dr Salehi & EPHS team, MoPH	Detailed discussion re health in Helmand, MoPH office
02.11.08	13.30	Atiqullah Khawasi, Head, WatSan programme, Dr Mohammad Javed & Ahmed Bilal, Ministry of Rural Rehabilitation and Development (MRRD)	Water and sanitation in Helmand, MRRD office
02.11.08	15.00	Dr Mirza Jan, Country Director, Ibn Sina	Implementation of BPHS by Ibn Sina in Helmand, DFID office
03.11.08	09.30	Helene Gichenje, CIDA	Polio eradication and provision of medicines in southern provinces, Canadian Embassy
03.11.08	10.00	HET refresher	DFID office
03.11.08	13.30	Dr Tahir Mir, Medical Officer, polio eradication, WHO	Work of WHO, WHO office
03.11.08	14.45	Dr Sharma, Health Specialist & Dr Malalay, MCH Specialist, UNICEF	Work of UNICEF, UNICEF office
03.11.08	16.00	Faiz Mohammad, Team Leader, Health, USAID	Work of USAID, USAID office
04.11.08	06.40	Depart for Helmand Province, Dr Feroz, Stephanie Simmonds & Bill Kirkup	PRT Air, Kabul airport
^04.11.08	11.30	Dr Argo Parts, Health Adviser, PRT & Capt. Charles Rowland, CiMiC Coordinator	Overview, CiMiC office, PRT Lashkar Gah
^04.11.08	14.00	Emily Travis, DFID Representative, PRT	DFID in Helmand, PRT



04.11.08	15.00	Dr Enaytullah Ghafary, Provincial Health Director, Dr Nesar Barak, Deputy, PHD and Maurizio Cardi, Medical Coordinator, Nannini Emanuele, logistician & Ahmed S Muhammed, Emergency Hospital	Work of the Italian Emergency Hospital, Office of Provincial Health Directorate (PHD)
^05.11.08	09.00	Major Dr Tony Dickinson, Senior Medical Officer	Work of Royal Army Medical Corps, Medical Centre, PRT
*05.11.08	12.00	Maurizio Cardi, Medical Coordinator, Italian emergency hospital	Visit to Italian emergency hospital,
*05.11.08	13.00	Dr Khoshal Murad, Adviser PHD, Development Alternative International	Advisory work with the PHD
05.11.08	15.00	Dr Enaytullah Ghafary, Provincial Health Director, Dr Nesar Barak, Deputy, PHD & Dr Noor Khaliq, Director, Ibn Sinh	Hospitals in Helmand and the BPHS, Office of Director, Bost Hospital
*06.11.08	14.30	Dr Barak, Deputy PHD	Karta Lagan health centre visit
^06.11.08	16.00	Anna Lenartsdotter, Development Adviser, Education, PRT	Water and sanitation in schools, PRT office
07.11.08	10.00	Dr Enaytullah Ghafary, Provincial Health Director & Dr Nesar Barak, Deputy, PHD	Work of the provincial health directorate. PHD office plus tour of Bost hospital and visit to midwifery training school
*07.11.08	16.00	Asadullah Mayar, Director, Afghan Red Crescent Society	PHD office, polio campaigns
^08.11.08	11.30	Surgeon Commander Thompson, Commanding Officer, Joint Medical Force, UK Med Group	Civil-military cooperation in health, PRT office
^08.11.08	15.00	Katie Muldoon, Psy Ops, PRT	Psychological campaigns
^08.11.08	17.00	Major Steve Mannion, Medical Officer, Juno	Work of UK Med Group, PRT
^09.11.08	11.45	Engineer David Thomas, Reconstruction and Development, PRT	Discussions about infrastructure work in health, CiMiC office
09.11.08	15.00	Abdul Hadi, Chief Engineer, Abdul Nazari, Project Manager, Sadul Look, & Dr Naseer Durrani, provincial Hygiene Officer, MRRD	WatSan facilities & hygiene education, MRRD office
*10.11.08	12.00	Dr Ezat Zia, WADAN drug demand reduction centre	Discussions about the work of the centre
10.11.08	15.00	Stephanie Simmonds and Dr Feroz departure for Kabul	
11-14.11.08			Discussions with DFID and between the consultants
15.11.08	14.00	Dr Tahir Mir, Medical Officer, polio eradication,	Further discussions about polio, DFID office

		WHO	
15.11.08	15.00	Dr Ahmed Jan, Acting Director, Health Policy and Planning Directorate, MoPH	
16.11.08	14.00	Sherazudin Sediqee, Head BBC Trust, Afghanistan	To discuss health messages, DFID office
20.11.08	16.00	Marshall , Head, DFID Afghanistan	Presentation and discussions on the health scope in Helmand to date
20.11.08	20.00		Teleconference with Washington about World Bank support to BPHS, Helmand
21.11.08	12.00	Dr Enaytullah Ghafary, Provincial Health Director, Helmand	Pros and cons of various ideas about support to health in Helmand
22.11.08	05.30	Stephanie to Helmand	
22.11.08	19.30	Emily Travis, DFID, Helmand	Update on issues, PRT office
23.11.08	08.00	Dr Argo Parts, Health Adviser, PRT	Update on issues, PRT office
23.11.08	14.00	John EUPOL, PRT	Education about road traffic accidents, drug abuse etc, PRT office
24.11.08	13.00	Lt Col Nikki Cordell, Medical adviser, Regional Command South Headquarters, Kandahar	To discuss civil-military cooperation for the care of war wounded, CiMiC office, PRT
25.11.08	09.00	PHD team and representatives of Governors office, Ibn Sina, Emergency hospital, ISAF and CiMiC	Discussions about health in Helmand, Bost hospital office
25.11.08	15.00	Lt Col Nikki Cordell,	Review of the morning meeting, CiMiC office
26.11.08	09.00	John Governance Adviser, DFID	Governance in Helmand, PRT office
26.11.08	11.30	Nicola Lee, Drug Demand Reduction Adviser, FCO	The relevance etc of the drug treatment facility in Lashkar Gah
26.11.08	15.00	Peter Justice Adviser	Justice and health, PRT office
27.11.08	14.00	Stephanie to Sangin	
27.11.08	16.30	Kim Petersen & Nick Pounds, Stabilisation Advisers	Health and the wider political and socio-cultural context in Sangin
27.11.08	17.30	Dr Henry Dowlen, Medical Officer, forward operating base, ISAF, Sangin	Civil-military medical work in Sangin
28.11.08	11.00	Kim Petersen, Stabilisation Adviser & Argo Parts, PRT Health Adviser	Challenges in health in Sangin district
28.11.08	13.00	Stephanie to Lashkar Gah	
29.11.08	09.00	Andy Corcoran, Political Adviser, Sangin	Politics and health in Sangin, PRT, Lashkar Gah
29.11.08	10.00	Stephanie to Kabul via Bastion	
01.12.08	19.00	Kees Kostermans, Benjamin Lowenson, Emanuele Capobianco, Tekabe Belay and Loraine Hawkins, South Asia	Discussions about World Bank experiences in health service delivery in Afghanistan

		Region, World Bank	
02-04.12.08	08.00 – 17.30	MoPH strategic health planning retreat	Serena Hotel, Kabul. Also see annex J
04.12.08	15.00	Dr Kees Kostermans and Emanuele Capobianco, South Asia Region, World Bank	Further discussions about possible HMG support in the health sector in Helmand
07.12.08	10.30	DFID staff including Head of office, Emily Travis and Vicky Seymour	Video conference with Argo Parts and Andy Leigh, PRT, Lashkar Gah debriefing about the consultants findings and options for possible HMG/SAF support
07.12.08	12.00	Stephanie departs the country	

^ = Only Stephanie Simmonds

\* = Only Dr Feroz Ferozuddin