INTEGRITY
WATCH
AFGHANISTAN

LIFE MATTERS:
CARING FOR THE COUNTRY'S MOST PRECIOUS RESOURCE

A survey based study of the state of public health care delivery in Afghanistan

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Cover photo by Edris Aasim: Bangi Comprehensive Health Center in Takhar Province visited by 200 to 300 patients daily.

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ABOUT INTEGRITY WATCH AFGHANISTAN (IWA)

Integrity Watch is an Afghan civil society organization committed to increasing transparency, accountability, and integrity in Afghanistan. Integrity Watch was created in October 2005 and established itself as an independent civil society organization in 2006. The head office of Integrity Watch is in Kabul with provincial programmatic outreach in Balkh, Bamyan, Herat, Kabul, Kapisa, Kunduz, Nangarhar, Paktia, and Parwan provinces of Afghanistan.

Over the last decade, Integrity Watch's work focused on: Community Monitoring, Research, and Advocacy.

Ever since its establishment, Integrity Watch has tried to encourage active citizenship and community mobilization through its programs. The community monitoring work included development of community monitoring tools, mobilizing and training communities to monitor infrastructure projects, public services, courts, and extractives industries.

The research work focused on policy-oriented research measuring trends, perceptions and experiences of corruption and covering wide range of corruption related issues including security and justice sectors, extractive industries, public finance and budget management, and aid effectiveness. The objective is to develop new, ground-breaking empirical research in order to set the agenda, influence decision-makers, bring to the public attention non-documented and un-explored issues.

Integrity Watch has taken up a pioneering role in advocating for knowledge-based decision-making and informed public debate on corruption and integrity issues. The advocacy work includes facilitation of policy dialogue on issues related to integrity, transparency, and accountability. IWA's policy advocacy has been to examine accountability of the government and service providers to the communities they serve. The issues focused on to date are access to information, budget transparency and accountability, aid transparency and effectiveness, effective public service delivery, and anti-corruption.

ACKNOWLEDGEMENT

Integrity Watch expresses its appreciation and gratitude to the team responsible for the production of this report. Our appreciation could extend to many people but in particular to: the author of the report, Dr. Nipa Banerjee, who has 40 years of experience in Foreign Aid, Aid Effectiveness, Development Issues in Post Conflict Countries, Peace Building Measures and Development and Reconstruction in Afghanistan; Ezatullah ADIB, the Research Manager of Integrity Watch, who managed the data analysis and report writing process; and IWA's Reconstruction Assessment Program Team, responsible for the implementation and data collection exercise.

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LIST OF ACRONYMS

USAID	United States Agency for International Development
SIGAR	Special Inspector General for Afghanistan Reconstruction
IWA	Integrity Watch Afghanistan
MoPH	Ministry of Public Health
BPHS	Basic Package of Health Services
SHC	Sub-Health Centers
BHC	Basic Health Centers
CHC	Comprehensive Health Centers
DH	District Hospital
PH	Provincial Hospital
RH	Regional Hospital
GPS	Global Positioning System
ANDSF	Afghanistan National Defense and Security Forces

EXECUTIVE SUMMARY

This public health care research study and report, based on a survey by Integrity Watch Afghanistan (IWA), provides support to the oversight activities of donors investing in the health sector in Afghanistan. IWA's work assists donors and the Afghan government to assess the quality of health care services, provided by public health clinics and hospitals, the main channels of health care delivery in Afghanistan. This particular study assessed (a) conditions of hospitals and other public health facilities built and/or operated with donor funding; (b) the extent of their use for health care delivery; and (c) their capacity to deliver quality services to the people.

IWA's inspection team undertook inspections of 184 health facilities in 8 provinces. The initial list was pre-selected- IWA received a list of facilities financed by USAID from the Special Inspector General for Afghanistan Reconstruction (SIGAR). IWA then conducted security assessments of the areas, where the initial SIGAR selected facilities are located and finally included in the sample survey only those that are located in the most accessible and secure areas of the provinces.

The survey instruments used were: (a) a tour of the facility by the surveyor and recording of their observations; and (b) interviews of personnel and community members (clientele) of the facility and recording their responses.

The survey findings assisted in making inferences on: (a) operational status and operational efficiency of the facilities, indicating their capacity to deliver the needed services; (b) identification of existing and potential issues that are likely to adversely affect service delivery; and (c) the extent of the utilization of the facilities.

A positive picture does not emerge out of an overall assessment of the surveyed health care facilities, with issues of concerns observed in the following areas:

- **Physical condition**- structural and maintenance and repairs problems;
- **Operational needs**- ranging from supply of electricity, medications and medical equipment to availability of vehicles and ambulances;
- **The state of basic health, hygiene and sanitation;**
- **Accessibility of staff and patients to facility grounds;**
- **Adequacy of personnel, especially female medical personnel;**
- **Management oversight;**
- **Determination of facility locations as per GPS coordinates:**

The study observes that more than two thirds of the facilities are not found within two kilometers of the MoPH-provided geospatial coordinates. Wrong locations noted in official documents can generate various problems. For instance, misdirection to the facility sites may cause monitoring difficulties. A section in the main report is devoted to current discussions on the latter issue between donors and MoPH.

Overall, the site visit observations deliver clear lessons on the nature of the deficiencies in health facilities that limit their capacities to deliver quality care. Lessons are learned on serious structural, operational, maintenance and management deficiencies that health facilities are subjected to.

The buildings are in poor physical shape, with structural problems (such as defective foundations; failing and cracked walls; leaking roofs; lack of repair and building safety issues) showing up; and the supporting infrastructure needed for efficient health care delivery not in place. Fifty-three percent of the facilities experience structural and maintenance problems, with 33% needing urgent repair.

Poor hygiene and sanitation conditions are found in 45% of the facilities, with no toilets in a quarter of the facilities, along with no running water supply. Water pumping and plumbing weaknesses and absence of potable water supply (the latter in 40%

of the facilities) are the major areas of deficiency on the infrastructure side that breed poor health, hygiene and sanitary conditions. Lack of stable supply of electricity, a daily need, is another serious infrastructure deficiency that incapacitates the health facilities from provision of quality care delivery. Twenty percent of the facilities have no electricity supply.

It has been learned that communities in certain areas are unable to access the facility in the vicinity due to unfavorable road conditions or uncertain security situation. Sixty-four percent of the facilities have no vehicles, contributing to difficulties in accessing care facility. With respect to ease of access to the facilities, security concerns are raised. But exact data on the number of facilities under security threats and on the nature of insecurity is not available, except that 34% of the facilities have no boundary walls and gates to provide minimum protection. Since twenty percent of the facilities have no electricity, no lighting arrangements are available to allow surveillance of night time activities around the facility sites.

Lessons on absence of essential supplies, resulting in inefficiencies in operations, are reported. Lack of refrigeration, medicines, standard medical equipment and machinery, absence of on-site pharmacies and transportation are common. Lessons are learnt on inadequate supply of personnel, especially female personnel, the latter so necessary to address needs of female clientele. Female staff is estimated to be less than 40% of the total number of personnel deployed in all facilities surveyed, a situation untenable in a society with the cultural tradition of female patients' treatment by female professionals. In addition to deficient personnel supply, fifty-two percent of the facilities are squeezed for space. Space problem is identified as a major problem in seven out of eight provinces surveyed.

Lessons are also learned on management deficiencies that weaken delivery capacity of health facilities. It is learned that some personnel complain about salary scales and irregular receipt of salaries; and that MoPH ignores any advice provided by the service delivery personnel, who are necessarily familiar with the facility operations.

The very positive lesson that stands out is that regardless of the weaknesses, 99% of the facilities are active, with presence of patients and medical professionals, during operating hours; and the clientele or users of the facilities, confirm the usefulness of the health facilities, with all the imperfections.

A combination of the lessons from this survey (along with existing lessons already recorded by other studies) on the utility value of the heath care centers and the deficiencies that are hampering delivery of quality care, conveys the message that the need for strengthening operations of the very useful channels of health care delivery is urgent. The survey results and analysis should be of help in planning reforms of the public health care system in Afghanistan.

The deficiencies, enlisted in the lessons clearly identify poor planning and budgeting and lack of regular oversight as roots of the operation, maintenance and management problems. Urgent attention is, thus, needed to improve oversight of the operation of the current facilities, and forward planning and budget allocation for any future construction and their operation and maintenance, especially with an eye to avoid the deficiencies that this study report enlists.

To accrue returns from both past and future investments in public health care, it is urgent for MoPH to first focus on rectification of the problems (structural, operational and management) of the current facilities and then undertake forward planning for new expansion and construction.

Sharing the findings and lessons of this survey with the ministry will set a good beginning to the process.

For realistic planning, visits to the operational facilities for appreciation of the existing problems and to the new planning sites for understanding of the contexts are recommended. For best results, the site visit team should be composed of ministry officials, civil society organizations, community representatives, medical professionals, engineers and budget and audit specialists. The inclusion of expertise on budget is essential for estimating realistic budget needs for construction, operation and maintenance and monitoring. Community monitoring and oversight is an option that should be considered. Consultation with the facility staff and the community in the locality should be a part and parcel of the site visits for planning and ongoing monitoring.

1. INTRODUCTION

As a fragile state, Afghanistan faces wide ranging challenges- internal conflicts, an insurgency and the resulting insecurity; economic decline; poor governance and management; and lack of accessibility of its citizens to basic services in health, education, housing, food and other basic human needs. This study focuses specifically on health care services.

Undeniably, some progress in the provision of health care services has been achieved in Afghanistan, within the context of fragility and conflict. Of importance has been the provision of the Basic Package of Health Services (BPHS) initiated by the Ministry of Public Health (MoPH) of the Government of the Islamic Republic of Afghanistan. Delivery of BPHS represents the Afghan government's effort to provide health services at an affordable cost across the country, including in rural areas, where security has been deteriorating. Despite such efforts, many constraints continue to limit effective delivery of public health care.

Objective of this Study:

The objective of this study is to assess the quality of basic public health care delivery in Afghanistan by the main health delivery channels- public health clinics and hospitals through a measurement of their capacity to provide quality services.

The data, on which findings are based, is derived out of a sample survey undertaken by IWA.

Significance of the Study and its Findings:

This study holds promises for both policy debates and practices in the health sector.

The researchers, through a sample survey and limited inspections, looked into the state of the public health care delivery facilities in Afghanistan and drew inferences from the findings about the capacities of the health care facilities in providing effective health care.

The findings of the study and the related analyses are not necessarily completely new- they add to and help confirm a set of lessons on issues that affect public health care delivery, in which international donors are investing aid funds. These lessons will certainly help guide future planning and programming in the sector by the international donors, in consultation with Afghan MoPH, contracted international and national implementing partners-national and international civil society organizations.

Overall, the research findings will increase awareness of the need for reforming the health care delivery system and, thereby, promote public discussions on adoption of policies and best practices for improved performance in health service delivery.

Undoubtedly, the findings of this study, along with those in other past and future studies of this nature, bear the potential of serving as a base for reforming and restructuring of the healthcare delivery system to improve service performances at the facilities, in the medium term, and pave the way for improving overall public health in Afghanistan, in the longer term.

2. DESIGN AND METHODOLOGY:

Design:

The study is designed to assess capacities of public health clinics and hospitals to deliver effective, equitable and quality low-cost health care.

The indicators taken into consideration to assess health service delivery capacity are as follows:

- State of physical condition and maintenance of the physical facilities (health clinics/ hospital buildings) from where health care is delivered;
- Hygiene and sanitation conditions at the health care facilities;
- On-site availability of equipment and medications for emergency and basic treatment purposes; and for pre-natal care and births;
- Presence of trained medical and health care workers, including female professionals;
- Accessibility to health care facilities, enabling visits of patients and also of monitoring teams for oversight purposes.

These indicators reflect the needs that are universally considered essential for delivery of basic health services. Public health care delivery facilities that do not meet these needs have stunted capacities to provide satisfactory services, both in the short and longer terms.

Applying these indicators, IWA prepared the following set of questions that help to examine issues pertaining to the objectives of the study:

- Are locations of the health care facilities accurately recorded to allow oversight visits by the government and donors and for guiding people (patients) to the exact locations?
- Do the personnel of the facilities consider the facility grounds to be secured and protected, to the extent possible, under the current security situation? Do existing security conditions allow regular delivery of services and adequate oversight of the operations of health care facilities?
- Are building construction, maintenance, sanitation and hygiene situations, in facilities conducive to basic health service delivery?
- Do care delivery personnel consider the facilities reasonably equipped with medications, pharmacies, and other necessary accessories supporting delivery of basic services?
- Is space required to ensure services to patients, with various needs, considered adequate by care delivery personnel?
- Is the supply of trained health care providers (including women health workers) considered adequate by facility staff members?
- Are the facilities accessible to the public and equipped with vehicles and ambulances for transport?
- Are the facilities, officially listed as receiving financial support, found to be operational?
- What's the clientele's (users') view of the usefulness of the health care facilities?

The instrument used to find answers to these questions is IWA teams' inspection, comprising: (a) tour of selected facilities by IWA surveyors and recording their observation; and (b) interviews of facility staff and members of the local population and recording their responses.

Method:

The data source is primary- the study is a field-based survey using semi-structured methods of inspection, observations and interviews.

For seeking answers to the research questions, based on the indicators identified (listed above) and related data collection and analyses, the study uses a combination of quantitative and qualitative method- inspections of the buildings by surveyors, interviews of personnel at the facilities and, in a limited number of instances, of the clientele of the facilities.

In effect, the inspections comprise a *physical survey* of the facilities (external and internal inspections of the buildings by the surveyors); and *interviews*

with management (heads of clinics), other service providers (medical and other clinic staff) and community members (i.e. the clientele of the health services). Qualitative data, collected through questions, allowing open ended responses, is used to supplement the inferences drawn from the surveyors' inspections and observations.

The design of the study, data collection methods and analytic techniques used are best suited for researching a real-world context-sensitive problem. The qualitative method used is especially effective as it studies the research problem from the perspectives of the local Afghan population who are the users of the services and facility staff, involved in direct delivery of services and, thus, closest to the constraints encountered. The inspections and interviews are focused on finding as clear answers as possible to the research questions (enumerated above) to assess the quality of public health service delivery.

The data collected is based on inspections conducted by IWA, of 184 public health clinics of differing sizes, including 2 provincial and 7 district hospitals in 8 provinces, across Afghanistan (see Table 3, below)

IWA's studies normally follow a five-step process starting from mobilization to final reporting on the findings of the inspection. The process, as narrated below, was followed for this study as well.

1. In the mobilization phase**,** IWA team requests the MoPH to provide authorization to conduct inspection and survey of the health facilities; and requests the MoPH's directorates in the targeted provinces to facilitate the inspection/survey team.
2. The team then develops a checklist for the External Inspections of the facilities and sets of questionnaires to cover both external and internal inspections. The external inspections examine the condition of the facilities and the peripheries. The internal inspections checklists normally cover interior physical conditions, records of visit patients' visits; employee lists and the actual presence on site of the number of staff- doctors, nurses, paramedics, midwives and other health care provision related staff. Inspections also include interviews with the management and the staff of the clinics and of community members, the latter mainly as recipients and clients of the services. Clients' views of the usefulness of the facilities are sought.
3. In the training phase, the inspection program manager trains surveyors on the process of data collection. The survey team includes professional engineers who collect appropriate data on the construction and maintenance of facilities. The team is trained on how to locate and access a facility; take GPS-embedded and date/time stamped photographs and perform internal and external inspections
4. During the Site Visit phase, inspection supervisors accompany the trained teams in the first few pilot surveys of facilities, with the supervisors providing constructive feedback of the quality of the pilot surveys conducted. The pilot surveys and the feed-back process ensure that the surveyors learn how to tactfully and carefully collect accurate data, covering the checklists fully, addressing all items in the questionnaire, and where needed, taking photos on Canon Power Shot cameras, in support of their observations.
5. For reporting purposes, the data collected during the inspection is meticulously entered in Excel spreadsheets for each province. The data record is at the base of analyses required for the final report. The supporting documents, including GPS and Photographs are used for reporting.

As prescribed in the process, for collecting data IWA undertook site visits to selected health facilities. At each site visit, surveyors undertook what is termed a *limited inspection* for assessing capacities of the facilities for service delivery.

The limited inspection was external and internal. External inspection recorded observations of surveyors from outside the facility on the physical structure and general conditions. Internal inspection recorded observations from inside the facility, using indicators both for assessing physical conditions of the facilities and other areas related to service delivery needs. At each site, other than recording of the observations of the surveyors, facility staff and community (clientele) interviews, with questions addressing the indicators, were conducted. The inspections were conducted during operating hours of the facilities.

As stated above, the survey and accompanying inspection covered eight provinces (view map below identifying the provinces). SIGAR first prepared a list of facilities to be inspected in these provinces. IWA

then conducted a security assessment of the areas, wherein the SIGAR selected facilities are located. Facilities in most secure areas of the provinces were included in the final inspection list.

Limited inspection of a total of 184 facilities were undertaken. Facilities inspected included: Sub-Health Centers (SHC), Basic Health Centers (BHC), Comprehensive Health Centers (CHC) and District, Provincial and Regional Hospitals (DH, PH and RH respectively). Twenty-four SHCs, 60 BHCs, 41 CHCs, 7 DHs, 2 PHs were inspected. Table 1 shows the provinces and types and numbers of facilities visited in each province.

[Notably, unless necessary, this Report uses a broader term- facility- to cover these different categories.

For better understanding of Limited Inspection, a review of Annex 1 is recommended. The Sample Questionnaire used as a Guide is in Annex 2. Actual questionnaires applied by inspection teams in various provinces, somewhat differed from one another]

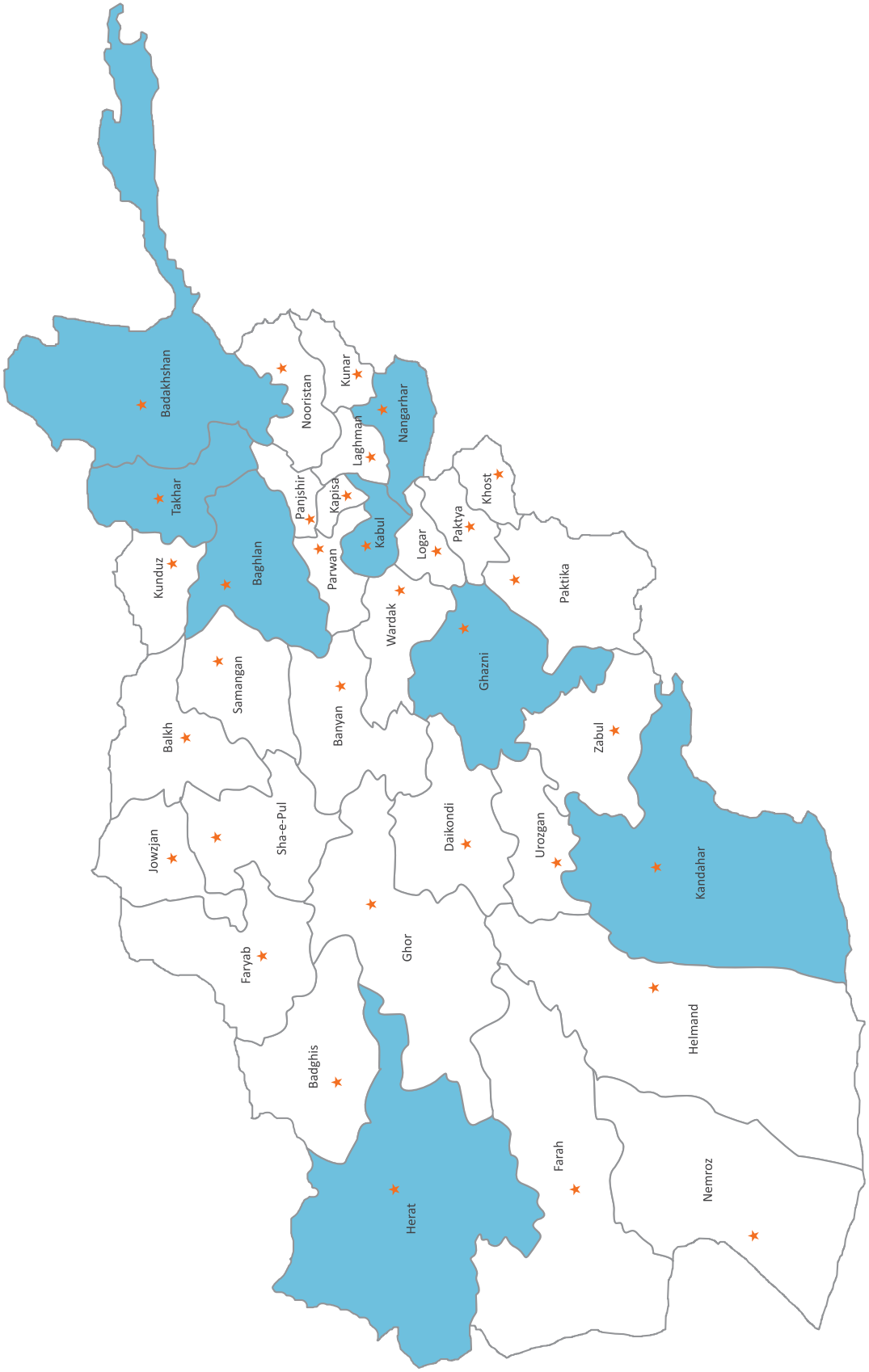
Table 1: Types and Numbers of Facilities by Province

Province	DNA*	SHC	BHC	CHC	DH	PH	PHC	Grand Total
Badakhshan		4	16	7	2	1		30
Baghlan		8	10	10	2			30
Ghazni		4	17	8		1		30
Herat	22							22
Kabul	27				1			28
Kandahar			1	3				4
Nangarhar				4	1			5
Takhar		8	16	9	1		1	35
Grand Total	**49**	**24**	**60**	**41**	**7**	**2**	**1**	**184**

* Data Not Available

[No data could be cited on certain issues for some provinces because surveyors in these provinces excluded the questions on these issues from their survey. In particular, Herat and Kabul surveys excluded several questions and, thus, no response or observation data is recorded on the related issues for these provinces. For instance, in the Table above, 22 and 27 facilities were visited in Herat and Kabul respectively. But Herat and Kabul surveyors did not record a breakdown of the clinic types because this subject area was omitted in their study].

Map of Afghanistan Showing Provinces Surveyed



3. ELEMENTS INSPECTED AND FINDINGS

It is necessary to note that the elements inspected, the indicators used for assessing capacities of health facilities to deliver basic health care, the related analyses and, thus, the findings and conclusions are not necessarily aligned with the guidelines established by MoPH for various levels of health care facilities. The study is rather lead by the needs in public health care system, as identified by surveyors visiting the health facilities; facility staffs, who are most familiar with the strengths and weaknesses of service delivery; and users, for service delivery to whom the facilities operate. Revision of the MoPH guidelines in response to the findings will help improve public health care delivery.

3.1. *Health Care Facility Locations and GPS Coordinates*

Surveyors used Global Positioning System (GPS)-enabled cameras to secure geospatial coordinates- and date/time-stamped photographs of the facilities visited, which helped to determine accurate locations of the facilities.

Determination of accurate location information allows meaningful oversight by both donors and the MoPH. Besides, in the past, it has been argued that inaccurate locations might be indicators of funds disbursed for non-existing facilities or ghost clinics. In Afghanistan, donor funding has proven to be highly vulnerable to corruption. Evidence exists of funds allocated and disbursed from the government budget for delivery of basic public services pocketed by higher level staff in military and civilian state institutions.

Surveyors of this study report a high percentage of health facilities (69%) surveyed not found within 2 kilometers of the USAID-provided geospatial coordinates.

Table 2: Count of Facilities more than 2 km Away from the Designated Location (by province)

Province	Number of Clinics
Badakhshan	28
Baghlan	30
Ghazni	21
Herat	10
Kabul	5
Kandahar	1
Takhar	29
All Clinics	**124**

All facilities in Baghlan and Badakshan provinces are more than 2 km away, followed by Takhar, Ghazni and Herat with respectively 83%, 70% and 50% of the facilities in inaccurate locations. Interestingly, the Table indicates that provinces, with large urban centers centers, such as Herat, Kabul and Kandahar, have less problems in pinpointing accurate locations.

The distances found between officially recorded locations by MoPH and provided to donors and locations determined by the GPS coordinates of the survey indicate that MoPH and funders have little knowledge of the accurate locations of the facilities; and the inference drawn is that this phenomenon disables them to undertake regular oversight and monitoring visits.

Inaccurate locations bearing potentials of misdirecting users looking for exact location of the facilities might limit public access to the facilities- a notable indicator of accessibility. Access might be limited due to other deficiencies, such as, uncertain security situation in the vicinity, absence of transport facility, poor road conditions and facilities not ready to serve female patients with separate toilets and female medical professionals. The inspection teams explored some of these issues further and the findings are recorded in sections **b, d** and **e** below.

Inaccurate locations specified in Afghan government document also raises concerns about non-existing or ghost clinics for operation of which funds are allocated and disbursed, promoting corruption.

Besides, statistics reported by MoPH with respect to access of percentage of the population to health care is likely to be incorrect because the population from areas where clinics are thought to be located, do not actually have access to any health care because no health facilities exist in the area.

It must, however, be underlined that the data collected by this survey provides no clear evidence of ghost clinics.

The following additional points are to be noted in this section:

- It is necessary to bear in mind that divergent views exist on (a) usefulness of GPS coordinates for purposes of locating facilities; and (b) conclusions drawn that wrongly recorded locations necessarily result in lack of oversight, misguide users and promote ghost clinics. Both MoPH and donors that invest in health facilities argue that monitoring and oversight visits are not normally dependent on GPS recorded coordinates. Monitoring teams include people knowledgeable of the areas who can guide visitors to the locations. Users from the area also have little difficulty finding the facilities, when needs arise.
- Since the coordinates were first provided, MoPH has been working to update them and obtain more accurate coordinates. Early indications are that fresh MoPH data recently provided (from Takhar, for instance) looks much better than data provided earlier. With further progress in obtaining more accurate coordinates in all provinces, the deficiencies found in recording locations might be soon overcome.

In any case, the principle of the need, in the long term, to determine accurate locations through use of GPS, cannot be denied, to dispel allegations of inadequate oversight, lack of access of users to services and occurrences of ghost clinic syndromes.

3.2. *Security-Related and Accessibility Issues*

Ensuring patients' access to health facilities and steady and uninterrupted services provision are of utmost importance. Uncertain and deteriorating security conditions are forcing closure of education and health facilities across Afghanistan, preventing access of patients and of the service providers to the facilities. Under insecure conditions, oversight and monitoring visits by the government, implementing partners and funders are also difficult.

Health facility grounds are not often secured due to lack of boundary walls with guarded gates and guard rooms. These minimum provisions are sources of comfort for the staff, who nonetheless realize that boundary walls and gates and guards do not offer much protection from armed insurgent attacks. Lack of proper lighting arrangements do not allow minimal visual surveillance.

Data collected out of this survey indicate disturbing signs of insecurity hampering daily activities and regular service provision. For instance, there are evidences of some (exact number not available) facilities being used by insurgents or by the Afghanistan National Defense and Security Forces (ANDSF) as fortresses. Respondents (staff and community members) report that certain facilities are in insecure areas with presence of insurgents and ensuing battles in the vicinity. Some surveyors witnessed armed insurgent presence in the outskirts of the facilities. Explosions in the vicinities of health facilities appear common. Rocket attacks, albeit with no casualties, have been reported. The surveyors themselves have been denied entry into some facilities for security reasons. In one facility, a doctor was killed the day the surveyor was visiting. These are definite indicators of security issues limiting patients' access to the care facilities.

Surveyors have found facilities with no patients because of evacuation orders from the Taliban announcing planned attacks on ANDSF convoys in the vicinity. Flight of households from certain villages for safety reasons, are reported. In such instances, health facilities are not active and the buildings lie empty, in dilapidated conditions. Exact numbers of such instances are not noted in the site visit reports. In some such instances, services are being provided from private rented houses. The facility staff and surveyors state that layouts in such private houses are not suitable for health care delivery.

Some facilities in remoter areas experience other safety issues, such as presence of wild life in the vicinity which also require the facility grounds to be properly secured with boundary walls and gates.

Thirty four percent of the facilities have no boundary walls and gates securing the facility grounds. Need for at least barbed wire fencing has been expressed. Despite the argument that that these elements might not prove to be useful in cases of armed

attacks, it is inappropriate to totally ignore the staff demands. More than 20% of the surveyed facilities have no electricity and, thus, no proper lighting arrangements needed at least for visual surveillance of the facility grounds.

In some facilities, electric lines not appropriately secured and covered, expose patients and staff to dangers of electric shocks.

Many of these findings raise alarm bells, especially because, as stated earlier, the facilities inspected are in the most accessible and secure parts of the provinces. Therefore, probabilities of conditions being less conducive for delivery of services and public access in less secure areas, are high.

3.3. *Physical and Structural Conditions of Health Facility Buildings and repairs and Maintenance*

Responses to survey questions and surveyors' observations indicate that several buildings have defective foundations and basic structural problems. The survey records instances of facilities with failing walls, collapsing roofs and walls and roofs with large gaping holes, all violating common safety standards and codes. Use of poor quality building material has been cited for structural problems. The international building codes or Afghan national building codes have not been adhered to.

Certain buildings are in flood prone areas. These buildings were constructed not considering the need for installation of protection measures to prevent damages from flooding. The staff and surveyors of such facilities ask for installation of flood protection walls.

Leaking roofs (in more than 30% of the facilities), cracked walls and broken doors and windows, missing door knobs and handles in buildings, indicating poor to no maintenance, are common. A large percentage (33%) of facilities need urgent repair, as reported by the surveyors. IWA teams of engineers note that repairs are often ineffective in buildings with basic structural problems.

Several buildings lack adequate ventilation, a condition harmful for patients and staff.

Table 3 below shows the percentage of facilities across the surveyed provinces reporting structural and maintenance problems.

Table 3: Percentage of Facilities Reporting Structural and Maintenance Problems (by Province)

(Answer is yes if the facility has some form of structural and/or maintenance problems)

Any problems?		
Province	**No**	**Yes**
Badakhshan	50	50
Baghlan	70	30
Ghazni	33	67
Herat	32	68
Kabul	61	39
Kandahar	100	0
Nangarhar	80	20
Takhar	26	74
All Clinics	**47**	**53**

Many of the buildings do not meet the building standard for the clinic type, specified by MoPH. Some of the facilities are merely mud-huts and hardly in usable condition. These should be replaced with new buildings, meeting the standard clinic-type specifications. Need for new buildings also apply to facilities with serious structural problems and dilapidated buildings, resulting from years of poor or no maintenance.

3.4. *Daily Necessities for Health Service Delivery, including Accessibility*

Access to the following amenities are considered necessary for operation of facilities delivering health care:

- Refrigeration facility for storing and preserving medication and other items; and uninterrupted supply of electricity or gas for their operation;
- Proper lighting and, thus, electricity supply to support proper medical examination, treatments, surgeries, births and the related procedures;
- Electricity supply for use of medical and surgical equipment;
- Running water supply and along with it a functioning plumbing system and water pumps;

- Access to potable and clean drinking water;
- Supply of medicines and laboratory equipment etc.
- A pharmacy on-site that gives patients easier access to prescribed drugs and non-prescription generic medications;
- An on-site medical laboratory;
- Availability of vehicles, based on the size of the care facility and the clientele it serves, for transport and facilitating access of patients, medical personnel, mid-wives, community health workers etc.;
- Roads facilitating access of patients and staff to the care centers.

This study found deficiencies in all the above areas, on which depend the quality of care delivery.

While lack of electricity supply is bound to have a major impact on the quality of service delivery, electric power supply has not been found to be a standard feature. No electricity is available in at least 20% of the facilities surveyed and these care centers are, therefore, deprived of preservation and storage facilities that require electricity supply.

Solar power is used in some facilities but it is useful only for lighting, not for operation of other equipment, such as, refrigerators, surgical and laboratory equipment. Besides, solar energy system does not work on cloudy days for lack of energy storage equipment. Many of the existing solar power systems are found to be non-operational due to lack of batteries and deficient maintenance. Facilities that have unstable supply of electricity are sometimes provided with generators to ensure uninterrupted power supply. But adequate fuel supply for operation of the generators is not ensured.

The surveyors and facility staff underlined the prime importance of access to electricity and fuel. It is argued by MoPH that gas is used for refrigerator operations. But the inspection records do not cite use of this option; and gas supply is not guaranteed in all areas. In any case, the 20% of the facilities identified to have no electricity supply had no gas coverage either.

It is necessary to note that power supply is guaranteed by MoPH for facilities only at certain levels/categories as per MoPH guidelines. The findings of the survey on the constraints that are generated out of lack of power supply point to the need for revising the MoPH guidelines and include power supply as one of the essential elements for delivery of basic services from health facilities at all levels. Absence of electricity supply presents a challenge especially in rural areas and this issue needs priority attention.

Functioning plumbing systems have been found to be either non-existent or not activated; nor is running water, facilitated with water pumps, a routine feature in every facility. At least a quarter of the facilities do not have running water supply. Such deficiencies, of course, impact hygiene and sanitation conditions, which are discussed in more details in Section **e**, below.

Absence of refrigerators for storing medicines and inadequate supplies of medicines on site are confirmed by both facility staff and surveyors. Patients/clientele of the care facilities claim that they do not get adequate medicine supplies prescribed by doctors. As well, perception of patients of doctor at facilities prescribing same medicines (3 types of medicines mentioned) for all patients should be followed up as these types of comments are indicative of dissatisfaction of users, the most important group to determine quality of services.

On-site pharmacies are rare. Some facilities have pharmacies on site but a quarter of these are not in usable condition, with medical supplies not guaranteed and absence of qualified pharmacists on-site. In one of the facilities a military officer, with no pharmacist credentials, is serving as the Pharmacist, an obvious example of an appointment not based on merit.

Staff at Basic Health Centers (BHCs) express the need for access to laboratory facilities saying that remote locations of the facilities and their distances from the district centers and provincial hospitals make on-site availability of laboratory necessary. Need for both standard and modern equipment for laboratories are also expressed by facility staffs.

Ultrasound machine has been listed as necessary by some facilities. This may be considered to represent demand for highly sophisticated and, thus, un-affordable equipment. But a significant number of facilities also lack standard medical equipment, such as, slides for laboratories, stethoscopes, blood pressure measurement equipment, equipment for application of anesthesia, hemoglobin tubes, autoclave (sterilization equipment), oxygen balloons, appropriate scissors and suction tubes for births and even bandages and dressing material.

There are reports of inadequate number of beds for patients and lack of furniture (as standard as desks and chairs for use by facility staffs). Need for computers and internet access are listed as requirements by medical personnel. To accommodate needs for overnight care, on-site housing for staff has been mentioned as needed.

Very many facilities (64% of those surveyed) do not have access to vehicles (even motor cycles) for every-day use and to allow mobility of the staff; nor are ambulances available for transfer of patients. Table 4 below shows the percentage of facilities in the provinces reporting availability of one functioning vehicle on-site. Both surveyors and staff confirm dearth of maintenance facilities for vehicles, with no workshops or mechanics available for repairs in the vicinity. Lack of transport facilities is certainly an issue barring access to health facilities.

Table 4: Percentage of Facilities Reporting Availability of Vehicle (by Province)

Province	No Vehicle On-Site	One Vehicle On site
Badakhshan	67	33
Baghlan	60	40
Ghazni	70	30
Kandahar	50	50
Nangarhar	0	100
Takhar	71	29
All Clinics	**64**	**36**

A count of facilities with climate control system was undertaken and the finding showed that most facilities are not in possession of climate control (heating and cooling) system. This finding is not necessarily surprising given that climate control does not rank high in the list of priority amenities especially considering the prohibitive costs involved in purchase, installation and operation of such systems, and in view of inadequate electricity supply. But given the extreme climate conditions and seasonal temperature variations in most provinces of Afghanistan, alternative arrangements with mobile fans for cooling in the summer and fireplaces for heating effects in the winter are needed. Such arrangements are found only in some facilities.

Overcrowding of the facilities is an issue to be noted. Majority of the respondents in the facilities surveyed expressed the need for more space. Need for adequate waiting spaces for patients have been raised many times over by surveyors and staff. Need for laboratory rooms, storage facilities, more beds for patients and delivery rooms have been highlighted. Facilities delivering, on average, three babies a day must be given more space for meeting the demand for obstetrics care. The demand for more space calls for recommendations to construct government owned facilities, if the current facilities are rented and do not allow expansion. See Table 5 showing demand for more space.

Table 5: Percentage of Facilities with Expressed Need for More Space (by Province)

Province	DNA*	No Expressed need for Space	Need for Space
Badakhshan	0	33	67
Baghlan	0	43	57
Ghazni	0	60	40
Herat	5	32	63
Kabul	15	46	39
Kandahar	0	100	0
Nangarhar	0	20	80
Takhar	0	49	51
All Clinics	**3**	**45**	**52**

*Data Not Available

Inadequacies in resources- equipment, essential supplies and space limitations- prevent health care providers from service delivery in emergency situations, as well. Health care providers in facilities near highways report their inability to respond to victims of highway accidents due to lack of transport and supplies essential for attending to serious life-threatening accidents that occur in the highways.

Surveyors and the staff of various facilities, across all provinces, consider an upgrade of many of the clinics from a smaller to a larger facility type, offering more space and equipped with more resources to meet the needs of the number of patients visiting.

The unmet demands for space and resources from the personnel are indicators of management deficiencies in the health care system, in general. Personnel, on many occasions openly stated that the management hardly ever heed their advice and

that they *"have stopped asking for help because help never arrives"*- (a direct quote recorded as an interview response).

Many facilities are in locations with no paved roads or even unpaved mud roads with minimum maintenance needs. Such road conditions deny access of patients to the health facilities, especially in the winter season. Road conditions and poor access allow only irregular opening of the facilities for business. Surveyors found no patients in some such facilities.

3.5. *State of Hygiene and Sanitation*

Basic hygiene and sanitation criteria are not met by many health facilities surveyed across the eight provinces.

At least a quarter of the facilities have no toilets. Even when toilets are installed, they are not cleaned properly. Many patients have no provision for separate toilets for women, an inadequacy limiting female patients' visits, which is an access issue, as well.

Staff and surveyors express serious concerns about absence of functioning plumbing systems and toilets, latrines and/or septic tanks. Flushing system for toilets have been found to be dysfunctional in many facilities. Internal plumbing systems are found to be damaged; immediate repairs are needed to activate hand washing stations, toilets and all other sanitary devices linked to the plumbing system.

Currently, at least a quarter of the facilities do not have running water supply, which is a basic need at any facility delivering health care. Water is often bought at a price from other sources in the vicinity or fetched from a river or a fountain, Water from such sources is unclean. The critical need for clean water reservoirs with pumps to facilitate uninterrupted water supply has been reported by surveyors and staff.

These deficiencies are topped by lack of potable (drinking) water supply (a basic human need) in 40% of the facilities surveyed. Potable water availability in health centers should be a mandatory requirement.

Human waste management system is non-existent at many facilities. Some facilities mentioned need for installation of incinerators for medical waste disposal.

Overall, the survey results indicate unacceptable hygiene and sanitation standards in facilities meant to deliver *health care.*

Overall, 45% percent of the facilities as shown in Table 6 below, complained of poor hygiene and sanitation, including absence of basics, such as uninterrupted water supply, functioning toilets with flushing system, plumbing system, water reservoir and pumps and clean drinking water availability.

Table 6: Percentage of Facilities Reporting Hygiene/ Sanitation Problems (by Province)

(Answer is **yes** if the clinic reported **no** to any of the following: has toilets, toilets cleaned, has handwashing stations, has drinking water, has proper medical waste management, has proper human waste management.)

Any problems?		
Province	**No**	**Yes**
Badakhshan	43	57
Baghlan	63	37
Ghazni	23	77
Herat	91	9
Kabul	79	21
Kandahar	75	25
Nangarhar	80	20
Takhar	40	60
All Clinics	**55**	**45**

The data in Table 6, may lead one to conclude that provinces with large urban centers, such as Herat, Kabul, Kandahar and Nangarhar, are better resourced than others. Perhaps a policy recommendation to consider more equitable allocation of resources is due.

3.6. *Size of Personnel in Facilities*

Availability of a steady set of medical personnel for provision of services is a prime indicator of quality and timely service provision.

Data collected from surveyed facilities in the eight provinces show differences between personnel numbers recommended by the Ministry of Public Health (MoPH) and those reported by facility staff and observed by the surveyors. For each province, the total number of personnel observed by surveyors and those reported by the staff are consistently lower than the MoPH recommended number.

Survey data- Table 7 below- shows that less numbers of staff than the number considered as ideal by MoPH have been appointed. To cover the deficit between demand for health care and supply of service providers, the staff proposed to extend the hours of operation of the care centers. Extension of hours will of course have budget and financial implications.

Table 7: MOPH-Recommended Number of Personnel Compared to Surveyor- Observed and Clinic Staff-Reported Numbers in Facilities (by Province)

Province	Total MoPH Recommended	Total Personnel Observed by Surveyor	Total Personnel Reported by Clinic Staff
Badakhshan	484	271	322
Baghlan	344	197	295
Ghazni	428	228	292
Kabul	40	35	28
Kandahar	58	29	39
Nangarhar	108	66	104
Takhar	329	285	264
All Clinics	**1791**	**1111**	**1344**

Analysis of Table 8 below, based on numbers gleaned out of Table 7 is significant. The conclusion reached is that, *on average*, personnel for clinics observed by surveyors is 17% lower than what clinic staff reports; and what clinic staff reports is 25% lower than what MoPH recommends. Overall, the number of personnel observed by surveyors is 38% lower than the number recommended by MoPH. These statistics are significant. Columns 1 and 2 in Table 8 clearly reflect the gap between planning for hiring the ideal numbers of personnel by MoPH and the reality of the current number of staff as observed by the surveyors and reported by the clinic staff.

Table 8

	Column 1	Column 2
Province	**Observed by Surveyor vs. Reported by Clinic Staff**	**Reported by Clinic Staff vs. Recommended by MoPH**
Badakhshan	84%	67%
Baghlan	67%	86%
Ghazni	78%	68%
Kabul	125%	70%
Kandahar	74%	67%
Nangarhar	63%	96%
Takhar	108%	80%
All Clinics	**83%**	**75%**

Several instances of facilities without a doctor and some without a nurse are recorded. In many instances, the size of the personnel present on-site is small compared to the number of patients visiting. Some facilities with a very small staff, serves ten or more villages and a high volume of patients. The number of people or the population has swelled in some areas but the facility type has not been upgraded accordingly to accommodate a larger volume of patients. Demands are common for more space and larger number of personnel to fit the size of the clientele. The existing large scale demand for space and unmet demands for personnel, raise the question if MoPH has a proper sense of the demand and supply for services in the provinces. A policy recommendation would be for the government to undertake a study of the demands and adjust the supplies accordingly.

The consistent gap between the surveyors-observed numbers (a lower count) and those quoted by the staff (a higher count) also indicates possible emergence of ghost personnel challenge, implying potential of syphoning off funds allocated for salaries being used for personal benefits of officials with control over budgets, including aid dollars. This survey, excluding scrutiny of the financial records, accounting systems and payroll records, provides no data, based on which any definite conclusion can be reached on this issue.

3.7. *Size of Female Personnel in Health Care Delivery*

Availability of female medical personnel to serve women patients, befitting the socio--cultural norms of Afghanistan would promote women's access and visits to health care facilities. Given the high maternal mortality rate in Afghanistan (estimated by United Nations), special attention to health care delivery to women is a definite requirement. Afghan society's culture and tradition demands treatment of women patients by female medical personnel. Thus, in the context of Afghanistan, recruitment and appointment of female medical personnel- doctors, nurses and midwives- are mandatory.

Estimates of the groups of respondents- surveyors, facility staff and MoPH- calculate the percentage of female staff to be less than 40% of the total number of personnel in the surveyed facilities.

The need for additional female personnel was profiled in comments of facility staff and surveyors in seven out of eight provinces surveyed. Inadequacy of female staff to serve large numbers of female patients is a common complaint. In a few instances, not many, female doctors are included in official list of personnel but are not present in the premises. Facility staff and surveyors, both express urgent need for placement of female medical personnel- trained nurses and doctors not only for regular treatment but for prenatal, delivery and post-natal cares. In addition, given the growing numbers of women patients requiring pre-natal care and attendance at childbirth, midwives should be recruited.

The critical need for female doctors, nurses and mid-wives for provision of acceptable and equitable health services is recognized, by the Afghan government, as well. However, recruitment of female health workers present complex constraints. Women are not willing to work in remote and insecure areas. Offers of

better than normal salaries to encourage women to accept employment offers has failed, according to MoPH. Female health workers cite lack of essential amenities, such as, lack of education opportunities for their children and that of safety as reasons for not accepting positions in rural areas or even insecure urban areas. Such constraints can only be removed by securing the country and betterment of the rule of law and order situation. But the need for female health workers remain a priority, in any case.

3.8. *Utility Value of Facilities as per User Perception and Surveyor Observations*

A review of surveyors' observations from their visit and staff comments helped sum up the state of operation of the health facilities surveyed. However, despite such operational constraints, data shows that 99% of the surveyed facilities are active during business hours.

Taking into account all facilities that surveyors inspected, the surveyors estimated presence of 10.5 medical personnel on average in each clinic on a business day. The number of patients usually visiting a health facility averages 110 a day. These averages indicate that overall, adjusting to all constraints, facilities are active, with a steady stream of patients and staff presence.

Data on the average number of hours facility-personnel work and, thus, assumed to be present in the premises for service delivery and making continued operation of the facilities possible, is 7.72 hours per day, which is the standard for fully operational institutions and outfits across the world.

Staff in some facilities speak of the need to deliver 24-hour service for attending emergency cases and, thus, arranging for day and night shifts. Sub-heath centers do not provide 24-hour services but personnel at some such facilities speak of the need to offer 24-hour emergency service. Admittedly, many health facilities across the world are not providing 24-hour services. However, in the context of Afghanistan, the sub-health centers, represent the only health care option for nearby communities. Thus, 24 hours service availability should be a consideration.

Two disturbing findings, question the validity of a quick generalized positive conclusion on facilities being fully active, with all enlisted personnel present and well-motivated to deliver services. Twenty-two percent of the staff surveyed did not receive salaries on time in the last 6 months; and staff at a significant number of facilities expressed the need for increases in salaries. If the staff is being paid at lower scales than those stated in the government's national salary policy, a rectification is essential.

Low salaries have been found to result in poor service provision not only in the health sector but also in the education sector and police services. There are real possibilities that low morale in the staff, unhappy with current salaries and those not paid on a timely basis, are affecting the quality of care delivery at the centers. Surveyors record instances (albeit very few) of less than decent behavior of the staff, without providing too much details. Indecent behavior can be an indicator of poor motivation; it can also be attributed to a combination of poor management and/or poor training of service providers. These issues need further investigation and follow up.

The salary issue requires urgent attention. Other than ensuring that salaries paid meet the government prescribed salary scales, the origin of the delays in payment of salaries should be identified and corrective actions taken. The salary delays could result from delays in funds transfer from the government or mismanagement by the implementer. Whatever is found to be at the root of the problem, it must be addressed by MoPH.

Despite the very large number of deficiencies that the survey identified, a large majority of community members or the clientele/beneficiaries in all provinces welcome the presence of health care facilities in their vicinities and acknowledge their usefulness for community benefits. The survey finding leaves no doubt that the health care facilities are useful modes of service delivery but that urgent reforms are needed to improve the quality of care provision.

4. LESSONS LEARNED

Lessons learned section brings together the insights gained out of a survey of 184 health care facilities of various types and sizes in eight provinces in Afghanistan. The survey objective was to assess the quality of care delivery by various types of health centers through a measurement of the capacity of these centers to provide quality health services. The lessons comprise those shortfalls related to construction, operational, maintenance and management issues (recorded in the inspection reports and discussed in Section II of this report) that generally limit the capacities of the centers to deliver the needed services.

The following lessons, based on the shortfalls found in the general usability of the centers- structural (construction), operational and maintenance issues and management oversight- are highlighted:

The glaring lesson is that the surveyed health care delivery centers are subjected to numerous structural deficiencies that limit their capacity to deliver quality care. These deficiencies include poor physical condition of the health center buildings, serious structural problems, resulting from use of poor quality of construction material and hardware and inappropriate installation (e.g. of wiring) threatening safety of building occupants.

The lesson is clear that due to infrastructural deficiencies in electricity supply; poor ventilation arrangements; operation of toilets/septic tanks; running water service and water pumping and plumbing; and lack of drinking water supply causing waterborne diseases, health care facilities are encountering insurmountable operational problems, and in fact battling conditions detrimental to the health of the visiting clients.

Other problems impacting on operational efficiency of the health facilities are absence of refrigeration facility; inadequate supply of medicines, essential equipment, furniture and vehicles; absence of on-site pharmacies; inadequate supply of personnel (within which inadequate number of female personnel is of special note).

To add to these are lack of roads permitting access to facility grounds; and lack of transport availability and uncertain security situations, also affecting access. Definite security threats exist in and around several care delivery facilities that prevent accessibility of staff and patients to facility grounds and stop regular operation. Many facility grounds are not well secured with boundary walls and guarded gates, which are minimal requirements.

Management deficiencies include absence of timely attention to personnel issues, such as dissatisfaction of personnel with the salary scale and also irregular (not on time) payments. Management neglects to listen and respond to staff assessment of building-related and other operational problems encountered.

Regular oversight visits by Afghan government representatives, implementers and external funders to the locations is likely to be minimal, in particular because of lack of accurate location information (GPS coordinates) on the health care facilities. Tenuous security situations make travel to sites without accurate location guides doubly difficult. MoPH needs to be alerted of the need for determination of locations of facilities with accuracy. In recent years, the MoPH has made commendable efforts to update the location information of the health facilities, for instance, for the facilities in Takhar; and this practice should be applied in all provinces.

Overall, the deficiencies, by generating an environment not conducive to quality health service delivery, incapacitate the health care facilities from provision of consistently satisfactory services. The concluding lesson from the deficiencies learned is that structural, maintenance and operational and management issues identified by the survey must be taken into account at the planning stage.

An important positive lesson learned is that health care centers are indispensable elements in Afghan people's lives as evident in the observations made by community members- the clientele of the health care centers, who consider the facilities to be useful. The surveyors found the health facilities operating and active, with steady streams of visiting patients and personnel presence, despite numerous structural and operational deficiencies encountered. The data leaves no doubt that the buildings, accommodating the health care facilities are used for the intended purpose of health service delivery.

The lesson that flows naturally from a review of the lessons enlisted above is that poor planning and budgeting and lack of regular oversight are the overarching drivers of the deficiencies that adversely affect the quality of the services delivered by the health care delivery channels that are considered to be very useful by the Afghan population. The super lesson learned is that urgent attention is needed (a) to improve oversight of the operation of the current facilities, and; (b) to undertake forward planning and budget allocation for any future construction and their operation and maintenance, especially with an eye to avoid the deficiencies that this study report enlists.

Normally, lessons learned include lessons from both positive experiences and failures. The lessons from this survey are flowing mostly from experiences not so positive. This is not surprising, given the situation of fragility, insecurity and chaos. Progress can be made by internalizing the lessons and introducing reforms to reverse the situation for better care delivery, better management and oversight promoting involvement of the government, donors and civil society organizations representing communities.

This study and its findings are not necessarily unique as it has been binding upon all donors and the government to undertake studies of this nature to rule out wastage of funds invested in the health care sector. In fact, the various studies undertaken validate, confirm and strengthen findings of each other. A coordinated effort is needed to compile the findings of all practical studies of this nature. Results analyses of the disparate group of findings through dialogue sessions between the government, civil society, community members and donors will help build a set of concrete recommendations and follow-up actions. Such a coordinated approach will certainly contribute to building of a public health care system that would satisfactorily meet the needs of the Afghan public.

5. RECOMMENDATIONS

The lessons learned from this study have wide implications for planning and programming and monitoring of care delivery performance in the health sector in Afghanistan. Useful application of the lessons, by way of planning and implementing measures addressing the shortfalls identified by IWA and discussed in this report, will make a difference in the quality of public health care delivery.

Efforts are required to get returns from not only the future but also the past investments in public health care. Accordingly, MoPH must first focus on rectifying the problems (the structural and other deficiencies) that have weakened health delivery infrastructure built in the past at enormous costs. Future health care planning must consciously avoid the shortfalls, analyzed in this report, which stunt capacities of health delivery facilities to deliver quality services.

Addressing these needs will involve elaborate plans for maintenance measures and their implementation in the current facilities and planning for new construction. Due attention is required to reformulate the MoPH guidelines for various categories of health care centers to appropriately meet the needs of the communities and as voiced by community members and health facility staff. The visiting teams' meetings with the personnel at the facilities and community members, who are the clientele of the services should be a part and parcel of the site visits.

To begin the process of planning both for the current facilities and new construction, sharing of the results of this survey with the Afghan government, specifically with MoPH, is necessary, to raise the Ministry's awareness of the nature and extent of the structural and operational issues.

Ministry officials should be urged to undertake site visits to appreciate the deficiencies that impact the delivery of health services, internalize the results and undertake planning for the current and future facilities. The teams accompanying ministry officials visiting the sites should include: (a) civil society organizations, with experience in implementing health programs, (b) facility site-specific community members; and (c) professionals (engineers, health specialists and budget experts) who can comprehend the severity and significance of the structural and operational deficiencies and recommend rectification measures for the existing facilities and planning of new facilities.

Tight planning with an eye to eliminating potentials of occurrences of the deficiencies that health care centers are now battling, is the first requirement. Allocation of adequate budget both for construction and operation and maintenance is a priority of equal importance. During planning, the need for on-site capacity for operational management and maintenance must be assessed. Based on this assessment, community involvement in supporting health facility management and oversight of operations should be considered.

Medical professionals must assess the qualifications of the personnel at the existing facilities and establish guidelines for qualifications required for facility staff to deliver quality care. Necessary training to upgrade qualifications should be recommended and arranged. The salary scales of personnel should be reviewed and adjustments made, if considered necessary.

Assessments by community members (who are basically the health care clients) of the quality of services provided at the facilities and their suggestions on nature of services required to meet the needs of the people are of prime importance. Community monitoring of health care facilities will be of immense benefit from practical view points and cost-saving. Civil society organizations, such as IWA, can play a significant role in mobilizing and training communities for such tasks. The concept of community mobilization is included in the AC strategy of the MoPH and can be consulted for planning a more elaborate community monitoring strategy.

Ministry officials, accompanied by trained auditors, should carefully note the management deficiencies, examine the finances and accounting systems, payroll records, and the purchases, stocks and dispensing records to plan fool proof systems to enhance operational efficiency, eliminate waste of resources and fight corruption.

Attending to the shortfalls noted as lessons, has fiscal implications. Strengthening and refurbishing building structures and regular repairs and maintenance will

come at a cost. Construction budget should include costs of installation of boundary walls to secure the health facility grounds. Meeting the basic sanitary and hygiene needs and provision of access to clean water, plumbing and pumping systems and electricity supplies will require a substantial budget. Only budgetary increases will allow stable supplies of equipment and medications. Similarly, extensions to the existing clinics to resolve space problems, upgrading of clinics, hiring additional personnel, with special attention to female medical personnel and midwives, and salary increases (an incentive) to promote staff morale will require a higher budget allocation. Attendance of health professionals at sites must be meticulously recorded and necessary actions taken to ensure undue absences.

Elaborate oversight plans for the operational facilities are central requirements for improving care delivery. All action plans for new facilities and strengthening of the existing ones must have built-in monitoring visits at regular intervals. The monitoring visits should include auditors for scrutiny of finances, accounting and all purchases and dispensing and payments records. Repair and maintenance schedules must be mandatory elements of all action plans, based on professional guidance. Visits of patients, treatment provided and recovery rates should be recorded. Needed will be a baseline study that will help assess improvements in care delivery over the years.

Planning for improving health care delivery will be costly but the government and the international community should not shy away from expenditure in this sector. Health service delivery through the network of the care delivery facilities is at the center of the health of the nation. Besides, as learned, the healthcare centers, regardless of their weaknesses, are much valued by the communities whose support will help the government to earn the much-needed legitimacy.

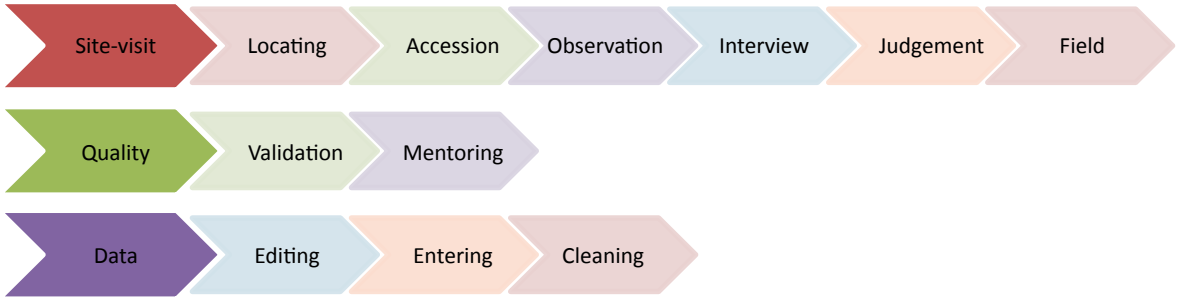
ANNEX 1: LIMITED INSPECTION GUIDELINE

Introduction

IWA designates a team of Inspectors supervised by an Inspection Coordinator to conduct the limited inspections. The Oversight Plan is prepared to ensure collection of sufficient and accurate findings from the field in order to present a complete data representation to SIGAR. This plan is intended to ensure that the inspection data is consistent, comprehensive and free of any errors.

Chart below Shows the Oversight stages of limited inspections.

Chart 1



Site-visit

The Inspector is required to carry the following items with them during each site-visit:

- Tablet (with charger)
- GPS-enabled digital camera (with sufficient memory stick and double batteries)
- Facilities list (facility name, village, district, province and GPS coordinates)
- Site-visit schedule
- Questionnaire
- Inspection Authorization Letter (IAL)
- IWA ID Card

1. Locating

- Tracking the location:
  - If GPS coordinates are provided for the target facility, the Inspector shall trace the location using a GPS tracking device.
  - The Inspector shall also locate the target facility in the given village and district.

- If a facility is found within 2 KM of the given GPS coordinates or given village and district:
  - The target facility is located if the Inspector could verify the followings in the found facility signage/plaque:
    - Facility name same as the given facility name
    - Donor being the U.S. government[1]
    - Administrator being the Afghan government[2]
  - If the found facility does not have any signage/plaque then the Inspector shall photograph and note any other source/document proving the followings:
    - Facility name should be same as the given facility name
    - Donor should be U.S. government in whole
- If the target facility could be located:
  - The Inspector shall take at least 2 GPS-embedded and date/time stamped photographs next to the facility or its signage/plaque and write under the "Basic Information" section of the Questionnaire the GPS coordinates from the camera.
  - The Inspector shall copy to "Basic Information" section of the Questionnaire the village and district names found on the target facility signage/plaque or any other source, if available.
- If the facility could not be located:
  - The Inspector shall ask the villagers as well as local officials connected with other similar facilities in the district whether any such facility exists under the given name.
  - The Inspector shall ask the respective provincial government official whether any facility exists under the given name.
  - The Inspector shall get in touch with the Inspection Coordinator for advice.

2. Accession

- Any prior communication with facility or provincial officials in regards to site-visit date of the target facility is prohibited because the limited inspections shall occur on an un-announced basis.
- Upon entrance to the facility the Inspector shall comply with the all the security measures/procedures in-place.
- The Inspector shall present the Inspection Authorization Letter (IAL) to the guard/reception or head of facility, and explain the limited inspection as follow:

  "I am_____. I am an inspector at Integrity Watch Afghanistan which is an Afghan NGO. We are assisting with SIGAR, the U.S. oversight agency in Afghanistan, to inspect the structure, facilities, needs and challenges of this and other similar facilities in this province which are reconstructed, furnished and/or equipped with funding from the U.S. government. The _____(respective Afghan ministry) has requested you to cooperate with us as we photograph the facility and interview a

1 USAID (United States Agency for International Development), U.S. PRT (Provincial Reconstruction Team), USACE U.S. Army Corps of Engineers), U.S. DoD (Department of Defense)

2 Respective ministry i.e. Ministry Public Health, Ministry of Education, Ministry of Public Works, Municipality etc...

few staff members. The inspection will not last more than 3 hours. I will appreciate if someone from your staff can accompany me, if possible, to guide me through your facility and answer the questions that may arise. Let me thank you on behalf of Integrity Watch and SIGAR for assisting us with this limited inspection."

- The Inspector may answer the accession and cooperation related questions in the Questionnaire.

3. Observation

- The Inspector shall follow the Questionnaire for carrying out all of the external and internal observations and note them accordingly in the Questionnaire.
- The Inspector shall take as many photographs as necessary to provide a complete picture of the facility's structure, functionality, maintenance and efficiency.

4. Interview

- The Inspector may gather information about the needs, problems and challenges of the facility through interviewing a local resident or staff member.
- A photograph from the interview sessions will be requested (as preferable) but not obligatory.

5. Judgment

- The Inspector may note any useful additional findings during the locating, accession, observation or interview stages which are not asked in the Questionnaire.
- The Inspector may write down all his additional findings under the "Inspector's Judgement and Conclusions" section of the Questionnaire.

6. Field Reporting

- For each facility, the Inspector shall hold a phone-call or possibly a video-call with the Inspection Coordinator after the site-visit is completed.
    - The Inspection Coordinator may ask the Inspector about the method of locating, accession, observation and interviews during the site-visit.

Before departing from the inspected facility, the Inspector shall make sure that:

- The Questionnaire is completely and correctly answered.
- All photographs taken are date/time stamped and have GPS coordinates imbedded.
    - Most photographs taken in closed and indoor areas cannot obtain GPS coordinates.
    - Most of the external photographs shall have proper GPS coordinates.

Quality Control

7. Validation

- By the end of each day, the Inspector shall share the followings on the designated Dropbox virtual folder for the Inspection Coordinator review:
    - Completed Questionnaire, with the "Inspector's Judgement and Conclusions" section filled in.
    - 10 sample Photographs from different vantage points and angles of the facility, particularly the facility signage/plaque and an overall view of the facility

- The Inspection Coordinator will reviewr the completed Questionnaire and sample photographs by the end of the next day. This review is intend to insure that the findings are collected from the field in the most complete manner.
- The Inspector shall correct the mistakes in the Questionnaire and photographs, provide explanation and/or re-visit the facility, as advised by the Inspection Coordinator.
- The Inspection Coordinator may randomly call or visit 1 out of 5 inspected facilities to validate the accumulated information and photographs by Inspector.

8. Mentoring

Every 2 days, the Inspection Coordinator may hold a teleconference or video-conference with the Inspector to provide him/her with insights on how to improve different stages of the limited inspection and follow-up on his/her progress against the Site-Visit Schedule.

Data Management

9. Data Entry

- Once the site-visits are completed, the Inspector shall enter onto a Data-set spreadsheet all the Questionnaires which are approved by the Inspection Coordinator for Data Entry.
- The Inspector shall enter into the Data-set the answers for all of the questions in the Questionnaire.
- The Inspector shall carry out a proof check of the entered data once all Questionnaires are entered to the Data-set.

10. Data Cleaning

After all Questionnaires are entered to the Data-set, the Inspection Coordinator will examine the entered data thoroughly against the approved Questionnaires in order to further clean the data-set.

11. Data Delivery

- During the Site-visit, the Inspector shall regularly sort, name and organize the taken photographs and approved Questionnaires as part of the limited inspection of the target facility.
- By the end of Data Entry, the Inspector shall hand over all the taken photographs and Questionnaires to the Inspection Coordinator in their original form.
- IWA prepares a Final Report on the inspected facilities based on the Data-set.

BASIC INFORMATION

Questionnaire No.			
Clinic Details			
Clinic Name			
Clinic Type[1]	☐ SHC ☐ BHC ☐ CHC ☐ DH ☐ PH ☐ RH		
Location	Province:		
	District:		
	Village:		
	Given GPS Coordinates: N E		
	Taken GPS Coordinates[2]: N E		
Inspection[3]			
Date	/ / 2015		
Time	Arrival: Departure:		
Inspectors			
Designation	Name	Phone Number	E-mail
Supervisor			
Surveyor			

1. Clinic types: SHC (Sub Health Center) BHC (Basic Health Center); CHC(Comprehensive Health Center); District Hospital (DH); Regional Hospital(RH)

2 If the taken GPS coordinates does not match or is not close to given GPS coordinates, report to the supervisor.

3 All clinics should be inspected on a normal day (generally Sunday through Thursday, excluding holidays) between the hours of 10:00 a.m. and 3:00 p.m.

SECTION 1: EXTERNAL OBSERVATIONS[3]

1. Does the clinic appear to be in a populated[4] and well-trafficked[5] area?

   ☐ Yes ☐ No

2. Does the facility appear to be in a well-tended area (roads/access)?

   ☐ Yes ☐ No

3. How does the clinic appear to be? *(Select all that apply)*

   ☐ Closed ☐ Vacant ☐ Disrepair ☐ Open / In-use

   Explain the reason, if not "Open / In-Use" marked: ……..

4. Is the clinic signed? *(Mark "Not clear" if the sign board cannot be read at all)*

   ☐ Yes ☐ No ☐ Not Clear

   If yes, can you read the following on the sign board? *(Photograph)*

   a. USAID as donor ☐ Yes ☐ No ☐ Not Clear
   b. MOPH as administrator ☐ Yes ☐ No ☐ Not Clear
   c. Clinic Working hours ☐ Yes ☐ No ☐ Not Clear
   d. Clinic officials contact information ☐ Yes ☐ No ☐ Not Clear

   If contact information provided, copy here: ……..

5. Does the clinic have boundary wall and main gate? *(Photograph)*

   ☐ Yes ☐ No

6. Do you see any guard, or other security-related presence? *(Photograph if possible)*

   ☐ Yes ☐ No

7. Were you able to gain entrance to the clinic?

   ☐ Yes ☐ No

   If yes, how were you let in? (Select only one)

   ☐ Let in by a guard ☐ Allowed to enter freely

   ☐ Let in by a medical staff through a locked door

   If no[6] please explain why: ……..

8. How many buildings are there in the clinic compound? *(Photograph)*

   ☐ One ☐ Two ☐ Three ☐ Four ☐ Five

9. How many outbuildings are there in the clinic compound? *(Photograph)*

   ☐ One ☐ Two ☐ Three ☐ Four ☐ Five

10. How many stories (levels) is the clinic main building?

    ☐ One ☐ Two ☐ Three ☐ Four ☐ Five

3 4 External Observations should be made from an area where the clinic building and grounds are clearly visible.
4 A populated area is where majority of the community population reside.
5 An area can be Well-trafficked if there are passage of people or vehicles along routes of transportation.
6 Contact your Supervisor to attend the situation and provide you instructions.

11. What material does the main building appear to be made of? *(Select only one) (Photograph)*

☐ Concrete ☐ Brick Masonry ☐ Wood

☐ Steel ☐ Mud

12. From the outside, do you observe any structure problems[7] with the clinic main building?

☐ Yes ☐ No

If yes, which of the following structural problems do you observe? *(Select all that apply) (Photograph)*

☐ Roof Collapsing ☐ Walls Failing ☐Stairs Damaged

☐ Foundation Settlement / Deterioration

13. Do you observe any electricity access to the clinic?

☐ Yes ☐ No

If yes, which of the following electrical accessories you notice? *(Select all that apply) (Photograph)*

☐ Generator ☐ Power Lines ☐ Lights

14. From outside, are you able to observe any medical staff on the premises? *(Photograph if possible)*

☐ Yes ☐ No

If yes, how many approximately? .....

15. From outside, are you able to observe any patients on the premises? *(Photograph if possible)*

☐ Yes ☐ No

If yes, how many approximately? .....

7 Broken, cracked, falling, missing or misplaced structure components such as roof, wall, doors and windows

SECTION 2: INTERNAL OBSERVATIONS[8]

Site Guide

Take at least three photographs for any item instructed to "Photograph" from the room interior and their various systems/components from this point forward.

1. Is the clinic building in use at the time of the visit?

   ☐ Yes ☐ No

2. How many rooms do there appear to be in the facility?

.....

3. Do you see any evidence that patients are being treated in places not designed for health care[9]?

   (Photograph)

   ☐ Yes ☐ No

4. Does the clinic have a roof?

   ☐ Yes ☐ No

   If yes, does the roof have any of the following defects? *(Photograph)*

   ☐ Cracked/with Large holes ☐ With Large Holes ☐ Leaking

5. Are most of the clinic's windows broken or missing?

   ☐ Yes ☐ No

   If yes, *photograph* and describe: .....

6. Are most of the clinic's doors broken or gone?

   ☐ Yes ☐ No

   If yes, *photograph* and describe: .....

7. Are the treatment room and office room in the clinic building lit/electrified?

   ☐ Yes ☐ No

8. Are the treatment and office rooms climate controlled (funs, air conditioners, or other cooling and heating system installed)?

   ☐ Yes ☐ No

9. Does the clinic have clean drinking water?

   ☐ Yes ☐ No

10. Does the clinic have functional toilets?

    ☐ Yes ☐ No

    If yes, do they appear to be used, cleaned and maintained properly?

    ☐ Yes ☐ No

8 Internal observations should be made INSIDE the building(s).
9 Tents, outdoor, administrative area, small area, etc.

11. Does the clinic building have hand-washing stations?

☐ Yes ☐ No

If yes, do they appear to be used, cleaned and maintained properly?

☐ Yes ☐ No

12. Does the clinic generally appear to be in usable condition?

☐ Yes ☐ No

13. How many total medical personnel (doctors/nurses/midwives/etc.) do you observe during your visit?

.....

.....

14. How many of the total medical personnel are female?

.....

.....

15. How many unique patients do you observe during your visit? (include patients present in clinic, those arriving, those departing)

.....

.....

16. How many total female patients do you observe during your visit?

.....

.....

17. Are there chairs and beds for patients in the rooms?

☐ Yes ☐ No

If no, explain if the patients sit on the floor furnished with carpet or mat:

.....

.....

18. Do you observe any of medical supplies/medications?

☐ Yes ☐ No

If yes, how do you describe the condition? *(Photograph)*

☐ Sufficient ☐ Extreme Surpluses ☐ Unusable condition

19. Is there a pharmacy on-site?

☐ Yes ☐ No

If yes, how do you describe the quantity? *(Photograph)*

☐ Adequate ☐ Inadequate

☐ Extreme Surpluses If yes, how do you describe the condition? *(Photograph)*

☐ Sufficient ☐ Extreme Surpluses ☐ Expired / Unusable

20. What equipment and accessories do you see in the examination/treatment rooms? *(Photograph if possible)*

☐ Examination Table ☐ Chair ☐ Other: .....

SECTION 3: INTERVIEW WITH ON-SITE STAFF[10]

1. What is your full name?

.....

.....

2. What is your title?

.....

.....

3. What are your top 3 duties?

.....

.....

4. What days the clinic is open during a normal week?

☐ Saturday – Thursday ☐ Other: .....

5. What are the clinic open hours in a normal day?

.....

.....

6. How many medical staffs work at this clinic?

.....

.....

7. Are the number of medical staffs enough?

☐ Yes ☐ No ☐ Don't Know

8. How many of the medicals staff are female?

.....

.....

9. Are the female medical staff enough?

☐ Yes ☐ No ☐ Don't Know

10. How many of those medical staffs are hired permanently?

.....

.....

11. How many of the staff are not on site right now?

..... ☐ Don't Know

12. Are all medical staff trained to provide medical services?

☐ Yes ☐ Some ☐ No

10 Preferably a medical staff or the facility administrator (administrator staff includes clinic manager, operation manager, etc.)

13. How many administrative staff work in the clinic?

.....

.....

14. Are the administrative staff enough for the clinic?

☐ Yes ☐ No ☐ Don't Know

15. How many total patients visit the clinic for treatment in a normal day?

.....

.....

16. Does your facility perform any surgeries?

☐ Yes ☐ No

If yes, does your facility perform any surgeries NOT directly related to child birth?

☐ Yes ☐ No

If yes, what types of surgeries does your facility perform?

.....

.....

17. Are you missing any basic equipment, supplies, or medications?

☐ Yes ☐ No

If yes, which what types and why?

.....

.....

18. In some cases, do you turn away or refer patients to a more advanced facility for treatment?

☐ Yes ☐ No

If yes, how many patients per week due to the following reasons?

☐ Limited Staffing ☐ Lack of Equipment ☐ Lack of Medication

☐ Facility Problems like Electricity ☐ Other: .....

19. Did you receive your full salary on time in the last six months?

☐ Yes ☐ No

If no, how late usually do you receive your salary?

.....

20. How do you receive your salary?

☐ Cash from your Supervisor or MOPH Representative

☐ Bank Deposit ☐ Cash from a Courier

21. Do you have any concerns with the way in which you receive your salary?

☐ Yes ☐ No

If yes, what is your concern?

.....

22. Who provides the funding to run this clinic?

☐ MOPH ☐ U.S. Government ☐ Other Entity: ☐ Don't Know

23. Do you know how much is the total monthly expenses (operating budget) to keep the clinic running fully?

☐ Yes ☐ No

If yes, how much? ..... Afghanis (Estimated / Exact)

24. Do you always get this full amount (of running/operating budget) and is it usually on time?

☐ Yes ☐ No

If no, how late? (Describe):

.....

25. What is the legal status of this facility?

☐ Rental ☐ MOPH Property

If rental, how much do you pay in rent? ..... Afghanis

26. Did anyone from national or international agencies come to inspect the facility?

☐ Yes ☐ No

If yes, who did they work for? ..... If this was a regular/ expected visit, how often does the visit take place? .....

27. Are you in contact with MOPH?

☐ Yes ☐ No

If yes, how often? .....

If yes, for what purpose(s) do these interactions take place? .....

28. Are the rooms in the buildings lit/electrified?

☐ Yes ☐ No

If yes, how do you receive its power through?

☐ Generator

☐ The Local Power Grid

☐ Solar/Wind Energy

If generator, who pays for the fuel?

☐ MOPH ☐ Community People ☐ Other: .....

29. Do you have any concern or issues with the electricity?

☐ Yes ☐ No

If yes, describe: .....

30. Do you have clean running water for the clinic?

☐ Yes ☐ No

If yes, what is the source of water?

☐ Water Well ☐ City Network ☐ River Stream ☐ Fountain / Karez

31. Do you have any concern or issues with the water?

☐ Yes ☐ No

If yes, describe: ……..

32. Does your facility have dedicated vehicles/ambulances available?

☐ Yes ☐ No

If yes, how many vehicles are dedicated to your facility? ……..

If yes, how much money does the facility receive on a monthly basis to operate and maintain the vehicles? …….. Afghanis

If yes, are the vehicles currently operational?

☐ Yes ☐ No

If the vehicles are NOT currently operational, explain why are they out of service?

……

……

33. Do you think you need more resources or systems to run the clinic better?

☐ Yes ☐ No

If yes, describe: ……..

SECTION 4: INTERVIEW WITH COMMUNITY MEMBER[11]

1. How did you identify this interviewee?

   ☐ Clinic Visitor/Patient ☐ Nearby Shop/ Business ☐ Passerby on Street

2. Where is the interview being conducted?

   ☐ On or Beside the Street ☐ Interviewee's Shop/ Business ☐ Interviewee's Residence

3. How far from the clinic is the interview being conducted?

   ..... Kilometers.

4. Are you familiar with this clinic?

   ☐ Yes ☐ No

5. How long have you lived in this community?

   ..... Months/Years

6. Do you remember when this clinic was opened?

   ☐ Yes ☐ No

   If yes, on what date did the clinic open?

.....

.....

7. Generally speaking, how useful do you think the clinic is to the locals?

   ☐ Very useful

   ☐ Somewhat useful

   ☐ Not so useful

   ☐ Not useful at all

   ☐ Don't know

8. If you think the clinic is 'very useful' or 'somewhat useful' to the community, what are the two reasons you think so?

   Reason one:

.....

.....

   Reason two:

.....

.....

11 Interviewee should not work at or be closely affiliated with the clinic and be within 2 kilometers of the facility at the time of interview.

9. If you think the clinic is 'not so useful' or 'not useful at all' to the community, what are the two reasons you think so?

Reason one:

.....

.....

Reason two:

.....

.....

10. How far away from your home is this clinic?

..... min/hr. (Walking Distance)

11. Have you or your family ever visited the clinic for medical services?

☐ Yes ☐ No ☐ Don't Remember

If yes, how long ago was the date of your last visit to the clinic, approximately?

.....

.....

12. During this visit, would you say everything at the clinic was in good working order?

☐ Yes ☐ No ☐ Don't Remember If yes or no, describe briefly:

.....

.....

13. How frequently do you visit the facility?

.....

.....

14. What days the clinic is open during a normal week?

☐ Everyday ☐ Saturday - Thursday ☐ Other: .....

15. How many hours the clinic is open in a normal day?

..... hours/day

16. Do you know how many medical staff work in the clinic on a normal day?

☐ Yes ☐ No

If yes, how many? .....

17. Do you know how many patients refer to the clinic in a normal day?

☐ Yes ☐ No

If yes, how many? .....

18. Do you know how many patients are dismissed without receiving treatment in a normal day?

☐ Yes ☐ No

If yes, how many? .....

19. Do you know who funds the operation of the clinic?

☐ Yes ☐ No

If yes, who? .....

20. Have you seen any problems with insecurity in this area over the past year?

☐ Yes ☐ No

If yes, describe:

.....

.....

21. Have any of these insecurity problems been specifically related to the clinic?

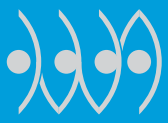
☐ Yes ☐ No

If yes, describe:

.....

.....

IT IS TO BE NOTED THAT THIS SAMPLE QUESTIONNAIRE SERVED AS A GUIDE FOR THE INSPECTION TEAMS. USING THIS SAMPLE AS A GUIDE, EACH INSPECTION TEAM FORMULATED QUESTIONS FOR THEIR OWN SITE VISITS. THEREFORE, VARIATIONS OF THIS SAMPLE WERE USED.



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