Aide Médicale Internationale

Support to the Health Care system in three provinces, Salamati, a distance-learning magazine for Afghan health workers and Rehabilitation and Prevention Program for Disabled Afghans in the Eastern Region of Afghanistan

Final Participative Evaluation Report

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WARNING

The spirit underlying the final evaluation of the project funded by DG Relex does not allow a written report to account for all the results of the process. We have records based on a participative approach bringing together all the stakeholders at every stage of the evaluation. We therefore consider that the real result of this evaluation was the "lessons learned workshop" at which more than 30 people were present. They were able to reflect together on the implementation of the AMI program, to discuss the evaluation results and in particular, to start an action plan to improve the implementation of the program in Afghanistan. The written report primarily aims to leave a trace of this operation which was established at the time of the final workshop.

SUMMARY

This report presents the results of a participative final evaluation carried out in Afghanistan from 22nd October to 15th November 2003. The report is viewed as an "educational tool" which can help the reader understand not only the methodology itself but also the findings and lessons learned. The program under evaluation was implemented by Aide Medicale Internationale (AMI) in partnership with the Sandy Gall Appeal for Afghanistan (SGAA). The program began implementation on October 1st, 2001 and ran up to September 31, 2003. The aim of the program was to contribute to the improvement of the health status of the populations within the project areas by providing financial, technical and logistical support to three provincial hospitals and to six clinics as well as by organizing training and information activities in the communities.

Method

Our methodology focuses on the analysis of program activities and strategies implemented (process evaluation) and on the development of a "lessons learned" approach which can be applied in the future. The evaluation activities deal not only with the extent to which the planned activities were carried out but also with the way in which they were carried out. This approach led to the elaboration of mechanisms to help program staff learn from both the successes and problems encountered in implementing the various activities so as to improve the program in the future. The concept of a participatory and utilization-focused evaluation method implies that program implementers are actively involved in all aspects of the evaluation process and that the "lessons learned" from it will be useful for stakeholders. Involving program stakeholders in all aspects of the evaluation process should help to make the latter more accurate and relevant. It is also our belief that program stakeholders can both contribute to the evaluation process and learn from each other. After an evaluation planning workshop held in Kabul from the 29th to the 31st October, the 6 evaluation team members decided, alongside the evaluation coordinator, to focus the evaluation on 6 important topics : Women's Health, Women's Health Education, Exemption Schemes, Management of Health Facilities, Curative Care, Training. Due to constraints of time, logistics and security, we dealt with one case study in-depth: the Laghman Province. We used different sources of data collected through quantitative as well as qualitative methods. The following methods were used: Interview (22), Focus group (16), Observation (6), Document Analysis (2), and Questionnaire (3). In addition to the people observed, 205 people (of which 105 women and 100 men) had the opportunity to express their views on the implementation of the AMI program in Afghanistan.

Findings

Curative care :

The Health Workers (HW) of the hospitals and clinics use a number of different protocols (NGO, WHO, MoH, textbooks…) and there is no agreement between them on the best protocols to follow. However, 80% of the HW gave their preference to WHO protocols, as they are considered by them as the standards . They follow AMI protocols only to respect the AMI policy concerning admission criteria and rational use of drugs, but they do not use them as protocols for treatment of patients, for different reasons :1) since over the last couple of years, AMI provided for its staff limited training on protocols, or even no training at all for some departments. The AMI protocols found in library

were very old and present in very small quantities (only 6 documents, with only one dating from after2001). Moreover, they were scattered inside the cupboard and not properly archived. Some doctors working for more than 6 months for AMI were even not aware of the existence of AMI protocols; 2) HW were not really satisfied as to the content of AMI protocols, as they found them: too short and incomplete, never updated, not always responding to needs (proposing only first line treatments), not always responding to a demand (always covering the same topics, only about common diseases) and not always adapted to the circumstances in Afghanistan (availability of medication, resistance to some drugs,…); 3) according to the experience of the HW, the patients are not always responding well to the treatments outlined in the protocols. Nevertheless, the HW consider training courses on protocols as a real need and they would be satisfied if AMI could provide more training. Of course, as usual, AMI should continue to involve staff in decisions concerning the implementation of new protocols. Concerning overlooking the implementation of these protocols, expatriates should work more regularly and for longer periods at the hospitals.

Health workers are well aware of the importance of following-up on patients, and regularly ask some of them to come back for follow-up of some disease or treatments. Generally, patients agree, but some of them cannot come back because of transportation difficulties, financial problems, traditional culture, huge workload at home, recovery, nomadic lifestyles, etc… According to the HW, if the patients do not come back regularly, it is mainly because of their lack of education and the fact that they do not understand the importance of such a follow-up process. For women, another issue is that female staff are not always available in the clinics and they therefore have to travel longer distances for a check-up. Several tools are provided by AMI and good use of them is generally made by the doctors for the follow-up of patients. The most frequently used among them are the health passport, the ANC card and the registration book. Referral and discharge sheets are missing in the clinics and hospitals and are thus not used by doctors, unless they use blank sheets of paper. The health workers are satisfied with these tools as they permit an effective follow-up of the patients and a better management of activities. It also facilitates their work as well as the work of the HW of other facilities, even if the papers take a lot of time to fill out. The only disadvantages mentioned are: the difficulty patients have in keeping the documents (a lot of patients lose them), the confidentiality factor, the fact that the health passport costs 2 AFS, the fact that the pages inside the health passport are blank pages (contrary to Ante Natal Consultation (ANC) card), which means that they need more time to fill them in and that they risk omitting some important comments. The content of the tools should thus be reviewed as well as the possibility to keep a copy of all health passports and ANC cards within the clinics in order to have a record of the information in case of loss by the patient.

The patients expressed their unanimous satisfaction as regards the behavior of HW : respect (especially for women, constant availability, understanding of poor people, good follow-up,…) and whenever there is any kind of problem, they try to improve the situation together. However, they mentioned a lack of doctors, especially female ones (but this is not absolutely necessary because male doctors can also examine female patients), in the clinics which are most of the time overcrowded and where the doctor has a busy timetable. The main negative point concerning the infrastructure is the lack of rooms, especially waiting-rooms, which are a problem for gender segregation. People expressed diverse opinions concerning the availability of drugs in AMI health facilities and they tended to be suspicious of the HW's honesty over the selling of drugs; they all agree that there should be better control on behalf of the expatriates. People also complained about the implementation of rational use of drugs by the doctors, because it didn't correspond to their idea of the medicine (max 2 different drugs are given per patient, the doctors resisting demands of patients for more drugs, more tablets are given than injectable drugs or syrups,…). They say they go to the clinic only because it is less expensive, but if they had more money, they would prefer to go to the bazaar to get what they want. However, they are satisfied about the quality of the drugs distributed, because they are from foreign countries. Concerning the accessibility to health services by poor people, men and women have a different opinion. Men pretend that the exemption system is working well, at least for routine consultation (but not for complicated pathologies). Women say

that they are never exempt and that they frequently have to borrow some money to have access to health-care. This can be explained by the fact that men are better known and more easily identified as poor than women wearing the tchadori. Nevertheless, all agreed that the health services in AMI facilities (consultations and drugs) are less expensive than the ones in the bazaar. Moreover, some preventive drugs are handed out free of charge.

Training :

Over the last two years, very few training courses were provided for the HW, especially for the nurses and assistant midwives, and 38% of the staff did not receive any training at all. Different opinions about the training provided by AMI were compiled, but in general, a lot of negative points were mentioned about these courses : short duration, not complete, topics frequently repeated, few new topics, not adapted to the level of the staff, provided by non-qualified or non-experienced people, few training materials, etc… They were also disappointed about the fact that refresher or updated courses are never provided and that there is no follow-up of training to check that the new protocols are being properly implemented. Moreover, the general organization of the training was criticized, as trainees were not informed in advance and HW did not always agree with the selection of participants by AMI. Nevertheless, some positive points about training were also mentioned: in accordance with the standards, bringing answers to questions raised by the HW, provided alongside tests to evaluate the extent of participant's knowledge, topics selected according to needs and demand (in hospitals, but not in clinics), different kinds of training. In general, people are requesting more "on-the-job" training or at least training provided locally and not in Kabul, so as not to disturb the daily activities of the clinic or hospital. Their preference is for longer training courses, new technical subjects, training provided according to level of knowledge and in response to specific questions raised. The training provided by other organizations in collaboration with AMI is generally appreciated, but does not always respond to practical needs in the field.

The library of Mehterlam is quite well organized. All the books are classified in a large cupboard containing different boxes with a sliding glass lid, and are entered in a register. A library manager was appointed 6 months ago, but he never received any training about library management and nobody ever informed him about the presence of Salamati magazines or the existence of AMI training documents. No one gave him any training documents and he has never seen anybody using them. When training courses are provided for the HW, training documents are generally handed out to the participants, but copies of these are not provided for library. All new books are registered, according to the department they belong to, but the register has not been revised or updated. Moreover, Salamati magazines and training documents are not included in the register. Around 15-20 staff members (+/- 50%) consult books in the library: the majority of which are doctors, then nurses and sometimes pharmacists, but all of them are men! The length of time books are borrowed varies from 2-3 days to up to one month, depending on the length of the book. From early July to early November, 12 staff members borrowed books, meaning that on average, 3 books are borrowed a month. The library is housed in the same building as the Director's office, accessible to women and which they often visit. It contains a lot of books about women's health (i.e. gynecology, obstetrics, TBA,…), in translation. Nevertheless, the library manager has never seen any women going into library. He presumed they were not interested or already had the books they needed in their wards or at home.

Exemption schemes :

Exemption schemes are agreed with the community taking part in the exemption system. This is considered as part of their responsibility, since according to them this is very important. They believe that community involvement is vital and that the community has to help its own poorest members. In actual fact, the community participation is very important. Indeed, without the community's help, adequate support cannot be provided to its poorest members. The idea that the community has to help is fully accepted, since in any case they have very little and do not have a choice. In their experience, community assistance is well accepted, as those living in the same

village form a fraternity. It is also culturally accepted that it is the responsibility of the wealthier members of the community to help the poorer members. According to the community members, they have not been getting more involved in this system as yet, but this is not a major problem. Meetings are organized and the information on the project is available, although at present there is no organized structure for community help, the latter revolving mainly around assistance with transportation. The community is not fully involved in this system, but is not opposed to involvement. As mentioned, there is no specific programme of community help, although sometimes they help the poorest members with transport.

There is no local system at community level, and the community does not play a special role in it, not all members participate in it. However, in cases where an HC meeting is set up, community involvement can be organized. In terms of solving the difficulties of the poorest people, the only solution that has been found at present is the handing out of free medication. Despite there being no obvious barrier to the community members understanding the system, no-one had thought of actually explaining it to them.

It is difficult to identify poor people during consultation. When a doctor is taking the patients' case-history, s/he is also asking about their social life to determine their standard of living. If a patient is too poor to pay for medication, the doctor will specify on the prescription that it should be free. The director can also ask patients about their family background, employment and property, to determine whether or not they qualify for free health services. Sometimes, they may be identified as poor by other hospital staff, or if they were referred by the health committee, MoH or local authorities. Sometimes during the consultation, patients may explain their circumstances: too poor to pay, widowed, orphaned, jobless, no land or other source of income. They argue that because they have no money, the doctor should give them free treatment, or they will have to go all the way back again. Another criterion may be the doctor's own judgement about the patients' poverty. Some times hospital staff, MOH or local authorities know them and they introduce them to the hospital director . There is no guaranteed help and cooperation from community, but occasionally some poor people have a letter of introduction from health committee members. The main problem is that it is extremely difficult to identify poor people, especially as patients often give false information. Most of the people resort to lying and there is no standard or protocol for identification. Hospital staff do not know all of the patients, and most of the people present themselves as being poor. There is no particular protocol from the AMI side. Information is received from the doctors, MOH officials, hospital staff. Occasionally, the health committee or local authorities also give information about the poor. The MoH has no specific role as there is no protocol in this area. However, they do sometimes give an official letter of introduction.

The first problem is identifying poor people and the second problem is that, when they give free drug to the poor, other people start to demand free medicine. The main problem is with armed people, governmental staff, and people who are introduced by the MOH. In the case of people who are armed, they are obliged to give medicine for free otherwise they risk being shot. Governmental staff always come with an official recommendation, and MOH also send people with recommendation letters for free treatment. It is rare to find genuinely entitled people or poor people. The community contributes to solving this problem by holding a HC meeting with village elders. Whenever they face a problem, they call HC. During the meeting they discuss the problem, but in the case of armed people there is nothing the community can do.

The role of the community is very important in introducing poor people to them, as well as in asking those who are not entitled and armed people not to demand free medication. But they have not played any role in this regard, nor does it have enough power to do so. The role of AMI is to establish a standard system and to ensure that it works. It should also prepare a clear protocol. Currently, AMI doesn't have any particular role, despite it being AMI that recommended free drugs for poor people. The local authorities are indifferent in this case and even say that the clinic has to provide free medicine for armed people. Unfortunately, the local authorities find reasons to reject letters of recommendation for people asking free treatment.

Moreover, the role of the MoH itself is not at all clear regarding this exemption scheme. MOH supported the idea of free health services for people. When they lose money through exemption this affects their budget, so in this case they require more money from AMI to cover their costs. When no poor people demand free treatment, they explain the role of AMI to them and convince them that exemption concerns only the poorest people. In comparison with other health facilities, the AMI exemption system is good, some of the clinics are giving free services and some of them are charging similar rates but they prefer the AMI scheme because it falls in between the two. There is a special register for exemption in each department. When free treatment or medication is handed out, it is recorded, and at the end of the month, they report to the director of the hospital. At the end of each month they receive the income report form from each department which is filled out by the Administrator who sends the report with the income generation sheet to the AMI Administration department. Since there is a specific register for exempt patients, the hospital records can be crosschecked with the Administration's reports, which is the Administration's means of supervising the exemption scheme.

Management of health facilities :

As a result it was considered that the cost recovery system is an important and acceptable one, since the health services would otherwise lose their value were everything to be given free of charge Everybody, whether or not they are ill, wants a check-up and asks for medicine. This is a waste of time and resources. It is also an important factor for the sustainability of our program. The money can also go towards solving the clinic's minor problems. The OPD fee was 2AFs, laboratory was 5AFs and the medication was sold at 40% of the real price. However, within the community, no-one was really fully aware of the price situation. We found that existing prices were generally affordable for people and were valid prices. And setting the price of medicine at 40% of the standard price is also viable, but for a few people even these prices are not affordable. The proper system was installed for income collection, for example: for an OPD they are given a ticket book and 2 AFs charge, for laboratory they have a special register and 5 AFs charge. The drug is also sold at 40%. Each department sends their income at the end of work to the director of the clinic and to the hospital administrator. For collection of this money, there was a special form to fill in at the end of the month. The director collects all of the money according the register and then he fills in the form and sends it to the central administrator. They use this income to pay for staff meals and fuel but not for other logistic purposes. In the community the HC do not know anything about how this money was spent to date. They find the drug price list at the next local market. And they renew their drug price list every two months. This standard system and the specified prices have been organized by AMI. AMI has a special form for reporting under this system, and they supervise, collect and manage the expenditure of money. In conclusion, the cost recovery system established by AMI is feasible and acceptable for them as well as for the community members, the existing system is good. MoH has not played any role in this system but the MoH director studied the prices and agreed with them. The director collects this money very honestly and gives the report to his office. The director knows better about the needs of the clinic and he spends the funds to cover these urgent needs.

According to the people interviewed and those who took part in a a focus group HMT/HC are very important. The members of the HMT and HC are all representatives of the hospital and make decisions together, rather than each director taking a decision based only on his own judgment. They agreed that the HC meeting is important because it creates a bridge between community and clinic; acting as a form of co-operation. HMT deals with all of the hospital problems, the work plan, and issues specified by AMI etc. In the HC there are mutual problems between staff and community around security, health education etc. The HMT was set up according to AMI protocol. The HC consists of the director of the hospital and a representative of each big village. All members of the HC are available for meetings, except in cases of illness, or when they cannot be present for other reasons. The main problem in organizing the HMT meetings is with the MoH. The MoH want to have their own representative in HMT meetings and prevent meetings being held in cases where

bad conditions (eg. Lack of security) mean they cannot be present. Generally, there is no problem to organize HC meetings but one problem was absence of lunch, because most of the village representatives come from remote villages and had to travel a long distance. They therefore decided to hold the meeting in the afternoon. The HMT meetings take place every two weeks and the health committee meeting is organized every couple of months. An emergency meeting can also be called when necessary. The HMT plays a very important role in management, especially in medical services. The role of the health committee is to deal with security and to solve the clinic's community-based problems. The directors and members in the meeting respect all of the decisions made by HMT/HC, but they complain about AMI because sometimes AMI have not observed the HMT decisions. But the decisions taken in the HC meetings are implemented and respected by the director of the clinic and AMI. In order to involve the members, they have created a democratic space where ideas can be openly expressed. They have convinced the members that HMT/HC is not there to deal with private problems and encouraged the staff to take part. They explain their responsibilities. According to the AMI curriculum that they have already received the HMT and HC are taking decisions about all medical and non-medical problems. These include: staff needs, salary and overtime, buying equipment, the timetable and night duty schedule, security of the health facility, problems with the community, community suggestions or problems etc .they may have with the buying committee and purchasing committee in their HMT.

According to our findings, all of the HMT/HC members are active and energetic and they are doing interesting work. The directors had implemented almost all of the decisions but they had a number of problems. For example, they may take a decision that the MoH does not agree with.. Sometimes AMI and the staff also refuse some of their decisions. The procedure for decision making in the HMT and HC is by voting system. Expatriates and the national supervisor may give make suggestions but they do not have a vote and they are not the decision-makers. AMI has requested reports of HMT/ HC from them; they had sent two copies of their report to AMI, one to the Mehterlam base and one to Kabul.

According to those interviewed, supervision by an AMI coordination team is very important. . They believe that with supervision they can complete their work in a different way if there are problems or difficulties. The system allows them to discover problems and try to find a solution.. Supervision helps them to run the program and acts as a kind of motivation for them. A lot of negative and positive aspects of work are determined through the supervision process. Supervision should help to make the positive points act as encouragements whilst pushing to change the negative points. Regular supervision means that activities can be successfully run, the result of the work can be seen, needs can be properly assessed and communication improved.

Concerning the procedure of supervision, we found that although supervision by expatriates is always irregular it is carried out regularly by national staff. Whoever carries out supervision first presents their plan to the hospital director and the head of each department. After which, may supervise the activities in turn of OPD, IPD, delivery room, lab, x-ray and all of the program according their plan. They sometimes also directly supervise different parts of the hospital. However, after supervision the director is not always made aware of the negative points picked up. Some of the expatriates without any particular responsibility supervise each department. For example: when the logistics coordinator came, he was supposed to supervise logistics but also interfered in medical issues etc. Expatriate supervision was not enough because most of the time expatriates did not come to the hospital but local staff supervision was quite enough for them. The supervisors asked everyone about the difficulties and problems they were having (Director, Heads of Department and staff) and witnessed these in situ. They also observed people at work and were able to see where the problems lay.. Most of them prefer local supervisors because they can understand each other easily. They know their culture, and it is very easy for them to communicate and speak in their own language. The local supervisors can easily recognize problems and solutions and can give them better instructions , because they know everybody and the environment very well. It was felt that the main problem with the local supervisor is that they have not got the competence to take decisions and the main office does not listen to their views as much as they

listen to the expatriates. Some people prefer expat supervisors because they are competent, decision makers, and can solve problems immediately. Some of them have no preference for either expat or local supervisors. Most of the time there is feedback from supervisions, but sometimes there is long delay especially when something is referred to the Kabul office or even to an expatriate. Expatriate supervision is rare and during the current year, there have only been two such supervisions. Local supervisors on the other hand, are come two or three times a week in the Laghman province. In Kunar they had 1-2 supervisions of their activities per month by the AMI coordination team.

Women's health :

A number of women stated as reasons for visiting the clinic: in case of illness in order to get medication, to go for a check-up, to identify the stage of their pregnancy, to check vital signs, for vaccination. Less said they came at the onset of labour, or following delivery in case of complications, or to vaccinate a baby after birth. Some women could not come at all because they lived too far away or because of their family or lack of awareness. Traditional Birth Attended (TBA) were happy about AMI's supervision said that their work played an important part in avoiding complications during pregnancy and in reducing maternal mortality rates. However, they mentioned that education and literacy are also important in these respects. The key points are : Most of the women are coming for ANC/PNC from nearby places, the main constraints to visits being: distance, transport difficulties and pressure from the family and tradition due to lack of awareness. The TBA's play a vital role. Inequality of delay in accordance to education and awareness, there is overall satisfaction regarding the service but not in terms of the availability of female staff, especially in clinics.

Few women (an average of 40 of varying ages) are making use of Family Planning (FP). Especially who have more or less children (already had one or several deliveries) they use FP temporary or permanently. They make use of it because of having more children or economical problems. Many of them use oral contraceptives (pills) and some of them use injectable (Depo-Provera). Nonetheless, most of the educated women, who working in offices or schools, use the IUD method. The main problems they face are lack of information and awareness about FP, pressure from their families and because of tradition and transportation difficulties because of living far away. In terms of the relations hip between Islam and FP there were different opinions. Most women said FP was considered a grave sin in Islam, but a few of them said that it didn't represent a problem and they had to do it. They were satisfied about FP services and the different means on offer by the AMI. The five key points are: The number of women actually using FP is quite small; tablets and injections are more frequently used than other methods; family and traditional restrictions are important constraints, there is no agreement among women on Islam and FP ; women lack awareness as to FP.

Regarding the safety of deliveries, we have seen that vital signs, FHS were checked as well as abdominal and vaginal examination. The asepsis and antisepsis was respected by staff and the hygiene was good but cleanliness and the temperature of the delivery room was not good. The partograph was filled in for every patient, their manner with patients was good, the delivery process well conducted and women were satisfied with the delivery services. They was problem regarding the lack of chlorine. The five key points are : Good preparation of deliveries, Delivery process well conducted, Cleanliness (absence of chlorine) and temperature of delivery room was not appropriate, Enough medical material, Not enough taking care of some newborn.

Women's health education :

Women mentioned that Health Education is useful and they were happy with the health educator who tried to involve the beneficiaries in the session by asking them questions. The main problem is lack/absence of an allocated space, lack of which means sessions are often interrupted. In addition to existing topics women, request more topics with long enough sessions to be able to deal with obstetrical problems such as irregular bleeding, stage of pregnancy and death of the foetus. Women

prefer practical HE in order to teach other women and members of their families when they return home. The program was adapted in accordance with the seasons, but they do not use a proper methodology and do not speak in and Pashaiee, which is the language one spoken by most of the patients in the hospital. The Administration office was involved in the selection of topics. We noted lack of materials, especially practical ones.

Recommendations

In the following lines we will just present the recommendations presented during the last workshop to the project stakeholders. All recommendations are presented in more details in the core of this report.

Curative care :

- AMI should provide more in quantity and more adapted protocols. If AMI created one it should be approved by MoH. To be improve the practice of MD in terms of follow-up the same protocol, they need to be discussed and decided together.
- Review and improved use and content of AMI tools (HP, ANC card, etc.). Improve the supply of tools. Increased the awareness of communities in regards of the importance of the follow-up of diseases and conservation of tools.
- Continue the good behaviour during the curative care services. Complete the infrastructure in terms of place for OPD services. Increase the collaboration between HW, AMI and communities. Improve the supervision of drug management in HF.

Training :

- Recruitment of a project master trainer coordinator.
- Increase the quantity and the quality of training in the field.
- AMI should have a clear strategy in terms of training coordination with other partners.
- Improve the registration system and organization.
- Organize a gender timetable to use the library.
- Provide updated documents, books, etc.
- Sharing information about library trough distribution of new books list to all the staff.

Exemption schemes :

- The community should be involved in the exemption system, kept informed about the system and we need to improve the sense of solidarity in the community.
- It is important to establish a clear exemption protocol developed in collaboration between AMI, MoH and the community.
- The community needs to be the key element in identification of the poor and needy.
- Improve the coordination with other partners and authorities in the province. Implement a monitoring system.

Management of health facilities :

- All departments need to be involved in the HMT by an elected member in addition to the director, administrator and MoH representative.
- AMI has to provide systematic feedback to the HMT propositions.
- Review and clarify the HMT mandate.
- The current cost recovery system is working well and needs to be utilized to increase the access to health care of the poorest.
- AMI could be a partner for MoH in formulating the national health financing policy.
- Continue the current system of supervision carried by local staff, but grant them more decision-making capacities and improve their feedback practices.
- Increase the number of supervisions carried out by expatriates.

Women's health

- Recruit female staff for clinics and improve the network of TBAs.
- Raise awareness of families regarding the importance of ANC/PNC.
- Increase the geographical accessibility of HF for women.

- Raise awareness through health education in clinics, in media, in villages.
- Establish a specific FP room in each HF with appropriate and skilled staff and material.
- Involve male staff in FP activities for men.
- Continue the current good practices on deliveries in the hospital.
- Increase the awareness of the staff regarding caring for newborn babies.

Women Health education

- Assign a special room for the HE session in the hospital.
- Reinforce the capacity of the HE in terms of practice.
- Recruit one Pashaï speaker to carry out HE for the hospital and for each HF.

To overcome the problem of integration of lessons learned into the program and appropriation of recommendations, it was proposed that the evaluation exercise include a one-day workshop in which a draft action plan for the program was developed based on the evaluation findings and lessons learned. Then, it was decided to establish an evaluation steering committee in order to organize a participative process to finalize those actions plan by topics and implement it.

Finally, the external consultant take the opportunity of the presence of most of project stakeholder to draw some lessons and explain some general recommendations for the future:

- Implement the project in a process from public health to community health and from top down to participative bottom-up implementation and decision making process
- Continue to improve the accessibility to health care
- Recruit community mobilizators (Men and Women)
- Involve Health Committee in the decision making, even for money utilization (i.e afghan money)
- Organize every 6 months a feed-back to the population
- Find strategies to involve women in health committees (a Women HC ?)
- The provincial health system must be directed toward Primary Health Care (i.e review the hospital position in the system)
- An implementation process from information sharing to participative decision making with afghan colleagues

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LIST OF ACRONYMS

AFS	Afghanis
AMI	Aide Médicale Internationale
ANC	Antenatal Care
BHC	Basic Health Center (C1)
BPHS	Basic Package of Health Services
CBHP	Community-based health providers: any type of health worker providing health care in the community and not from a facility
CHW	Community health worker: health worker specifically trained to provide basic health services at community level
Dai	Traditional birth attendant
EU	European Union
FP	Family Planning
HE	Health Education
HIS	Health information systems
HMT	Health management team
HMC	Health management committee
HW	Health Workers
IDP	Internal Displaced People
IPD	Inpatients
LFA	Logical Framework Approach
MCH	Mother and child health
MD	Medical doctor
MOH	Ministry of Health (formerly Ministry of Public Health)
MSF	Médecins Sans Frontières
MSH	Management Sciences for Health
MTA	Medical Training for Afghan
NGO	Non governmental organization
OPD	Outpatients
PNC	Post Natal Care
SFC	Supplementary Feeding Centre
SMI	Safe Motherhood Initiative
TBA	Traditional birth attendant
TFC	Therapeutic Feeding Centre
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States International Development Agency
WFP	World Food Program
WHO	World Health Organization

"No matter how rigorous the methods of data collection, design, and reporting are in evaluation, if it does not get used it is a bad evaluation"

M.Q. Patton, 1997

WARNING

The spirit underlying the final evaluation of the project funded by DG Relex does not allow a written report to account for all the results of the process. We have records based on a participative approach bringing together all the stakeholders at every stage of the evaluation. *We therefore consider that the real result of this evaluation was the "lessons learned workshop"* at which more than 30 people were present. They were able to reflect together on the implementation of the AMI program, to discuss the evaluation results and in particular, to start an action plan to improve the implementation of the program in Afghanistan. The written report primarily aims to leave a trace of this operation, which was established at the time of the final workshop.

INTRODUCTION

This report present the results of a participative final evaluation carried out in Afghanistan from 22nd October to 15th November 2003. The report is viewed as an "educational tool" which can help the reader learn about the context (chap 1), the methodology itself (chap 2), the findings (chap 3) and finally the lessons learned (chap 4).

1. CONTEXT

Afghan Context

Conflict has lasted nearly twenty years in parts of the country, marked by periods of heavy fighting, the loss of nearly 1.5 million lives, and the displacement of some eight million people. After more than twenty years of conflicts and important economic decline[1], chances for development in Afghanistan are impaired by the worsening health conditions of the population. Health indicators are among the worst in the world. Most indicators suggest that maternal mortality rates have increased; UNICEF shows a rise from 600 deaths in 1981 to 1700 deaths in the mid-1990's. The recent women's mortality survey, conducted in four provinces of Afghanistan, confirm this scenario: the maternal mortality ratio is 1600 per 100.000 live births, even more the ratio in Badakshan is the highest ever reported globally in the world (6.500)[2]. The infant mortality rate is thought to be 165 per 1,000 successful births. Most of the burden of illness springs from infectious diseases , particularly among children where diarrhea, acute respiratory infections, and vaccine preventable illnesses are likely to account for 60% of deaths[3].

According to a recent report[4], the health system is adversely affected by major problems : a grossly deficient, and even absent, infrastructure; a top-heavy health system, with doctors who are not trained to deal with the most urgent problems at community level and that, in general, lacks public health expertise; poorly distributed resources; health care delivered on a 'project' basis by many distinct, relatively uncoordinated service providers; absence of a practical, useful, coordinated information system for management decision-making.

Afghanistan is not secured yet safe and secure, tensions still running high in most parts of the country except the West, which remains fairly quiet. However, there are signs of nascent problems, notably harassment of the International community by Government authorities, and the potential return to violence in some areas. The disarmament process continues; although some protests have been reported.

Current insecurity and political instability will obviously constrain the pace and geographic scope for extending health services. Intense ethnic rivalries and local conflict have undermined trust in public and government institutions and will remain a challenge in years to come. The pre-war human resource capacity has been eroded and there is scarcity of personnel with managerial and

[1] Marsden, P., & Samman, E. (2000). Afghanistan : the economic and social impact of conflict. In V. Fitzgerald (Ed.), War and Underdevelopment. Queen Elisabeth House: University Oxford Press.
[2] Maternal Mortality in Afghanistan : Magnitude, Causes, Risk Factors and Preventability, Summary Findings, nov 2002, UNICEF, CDC, MoPH
[3] Joint donor mission to Afghanistan on the health, nutrition, and population sector. Aide-Memoire, 2002, World Bank, 19p.
[4] The Public Health System in Afghanistan: Current Issues, Waldman, R. and Hanif, H., Afghanistan Research and Evaluation Unit, May 2002

technical skills throughout the country. In rural populations, access to health services is appalling because of limited public transport, few hardtop and rural roads and absence of telecommunications. Twenty-three years of war and recent droughts have eroded household assets and many families live in abject poverty.

AMI context

In Afghanistan, AMI has been focusing on the rehabilitation of Health Care Structures and on Medical Training for Health Care Workers. From 1985 to 1993 AMI ran a training program (Medical Training for Afghans) in Peshawar, and provided the 115 graduate students with medical kits to start their activities inside Afghanistan. AMI has been working in Afghanistan since the early eighties, doing different kinds of activities. Initially, all missions were secret ones taking place during the Soviet occupation of Afghan territory.

The program of "Support to the Health Care system in three provinces, Salamati, a distance-learning magazine for Afghan health workers and Rehabilitation and Prevention Program for Disabled Afghans in the Eastern Region of Afghanistan" is a multisectoral health program funded by the European Union (DG Relex). The program is implemented by Aide Medicale Internationale (AMI) in partnership with the Sandy Gall Appeal for Afghanistan (SGAA), with AMI acting as a prime agency of the partnership. The program began implementation on October 1st, 2001 and ran up to September 31, 2003.

The aim of the project is to contribute to the improvement of the health status of the populations of the project areas by providing financial, technical and logistical support to three provincial hospitals and t six clinics and by organizing training and information activity in the communities. Its global amis were to i) organize better access to health care for the most vulnerable groups in the target areas of the project and ii) t improve the quality of services. According to AMI, to reach these objectives, the following activities have to be implemented : training of the medical and administrative staff in the structures which benefit from support, supplying the necessary medications and equipment to treat the patients, maintaining the buildings in proper condition, and adding new constructions where necessary, training community health workers, organizing information meetings in the communities, edition, publication and distribution of a quarterly distance-learning Magazine.

This evaluation is part of the general terms of the contract signed between AMI and the European Union (DG Relex). It is the final evaluation of the program.

2. METHODOLOGY

Approach : a useful and participative evaluation :

For this evaluation, we decided to use a mixed evaluation approached: utilization-focussed and participative.

One of the most well-known evaluator in the world, M.Q. Patton[5], said: "No matter how rigorous the methods of data collection, design, and reporting are in evaluation, if it does not get used it is a bad evaluation". This is why we propose to adopt the Utilization-focused Evaluation strategy for the review.

The objective of our mandate is to answer the needs identified by the ToR in terms of lessons learned and best practices (I prefer "better" practices) to improve the actual AMI intervention and to identify future strategic priorities in the future. To attain this objective we will use a participative approach. Participatory evaluation provides for active involvement in the evaluation process of those with a stake in the program. Listening to and learning from program beneficiaries, field staff, and other stakeholders who know why a program is or is not working is critical to making improvements[6].

During all phases of the process, the role of the consultant is be sure that the four evaluation standards are respected: utility, feasibility, propriety and accuracy[7]. In this participative approach, mechanisms are developed to help program staff learn from both the successes and problems encountered in implementing the activities in order to improve the program in future. The evaluation coordinator's role is not only to structure and facilitate each step in the evaluation process but also to contribute as a full member of the evaluation team. In addition, the participatory approach constitutes a learning experience for the program stakeholders who are involved. It reinforces their skills in program evaluation and increases their understanding of their own program strategy, its strengths and weaknesses[8].

Evaluation aim : a process evaluation

During the first working meeting with the headquarters manager in Paris and then with the medical coordinator for the Afghan Program in Kabul, we clarified the mandate (in accordance with the Statement of Work, see appendices) in detail and tried to reach a better understanding of how the evaluation results would be used. What purpose will they serve? Will it be possible to implement changes in the AMI program following the evaluation? Who, how and in how much time? This, in view of the fact that standardized recipe approaches had not worked.

Through interaction between Paris and Kabul, evaluators and stakeholders were able to negotiate the question of evaluation (see next section) according to the fourth-generation evaluation

[5] Patton, M.Q., Utilization-Focused Evaluation. 3rd ed. 1997, Thousand Oaks-London-New Delhi: Sage Publications. 431p

[6] L'expérience d'une démarche pluraliste dans un pays en guerre : l'Afghanistan, *Canadian Journal of Program Evaluation*, 2003, vol 18, n°1, 25-48

[7] Joint Committee, 1994

[8] The evaluation process in Afghanistan is an adapted process from : Aubel, J., 1999, Participatory Program Evaluation Manual, Involving Program Stakeholders in the Evaluation Process Second Edition, Child Survival Technical Support Project-Catholic Relief Services-USAID

approach[9]. Due to resource and time constraints, it was impossible for any one evaluation to answer everyone's questions or attend to all possible issues raised. However, in a Utilization-focused Evaluation the stakeholders can participate. This does not only occur at the community level, but it is applicable at all levels, enabling people to reflect on the evaluation results and how they will be used. Therefore, after this first discussion and negotiation, it was decided that the general purpose of the evaluation was the process of the AMI program implementation.

A process evaluation is an evaluation of the internal dynamics of implementing organizations, their program instruments, their service delivery mechanisms, their management practices and the linkages among these[10].

An evaluation team: to be participative

The participatory evaluation process began with an evaluation planning workshop held in Kabul from 29th to 31st October (see photos). As the team was not prepared in advance as we had initially planned for in the evaluation proposal (sent two weeks prior to our departure[11]), we were delayed a couple of days in Kabul before to being able to organize it. In the present Afghani case, we established an evaluation team composed of the following 6 people: general medical coordinator, nutrition coordinator, medical coordinator for the Eastern Zone, two midwives and an administrator. This evaluation team was balanced in terms of gender, location and professional status.

Name	Date of birth	Gender	Profession	Place of duty
Fauzia Raouf	1953	F	Midwife	Metherlam Hospital
Sahibullah Shakir	1966	M	General medical coordinator	Kabul AMI Office
Abdul Zaher	1958	M	Administrator	Metherlam AMI Office
Mujeeburrahman Shirzad	1974	M	Physician (Eastern zone coordinator)	Eastern zone AMI Office
Zermina Arian		F	Health Educator	Jubul Saraj Clinic (Parwan)
Sylvie Goossens	1975	F	Physician (nutrition coordinator)	Kabul AMI Office

Table 1 : List of evaluation team members

The purpose of the first workshop was to build consensus around the aim of the evaluation; to refine the scope of work and clarify roles and responsibilities of the evaluation team and facilitator; to review the schedule, logistical arrangements, and agenda; and to train participants in basic data collection and analysis. Assisted by the facilitator, participants identified the evaluation questions they wanted answered. Participants then selected appropriate methods and developed data-gathering instruments and analysis plans needed to answer the questions. Some of the participants already had some knowledge on evaluation and for them this workshop represented a form of revision[12].

[9] Guba, E. G., & Lincoln, Y. A. (1987). *The countenances of fourth-generation evaluation : description, judgment and negociation*. In D. J. Palumbo (Ed.), The politics of program evaluation (Vol. 15, pp. 202-234). Newbury Park, Beverly Hills, London: Sage Publications.

[10] Contandriopoulos, A.-P., Champagne, F., Denis, J.-L., & Avargues, M.-C. (2000). L'évaluation dans le domaine de la santé : concepts et méthodes. *Revue d'épidémiologie et de Santé Publique, 48*, 517-539.

[11] Ridde, V, Final Evaluation Proposal, Draft, October 15, 2004, 7p.

[12] Ridde, V, Seeds against malnutrition in Afghanistan: an experience in participative performance evaluation training, in *Evaluation Encyclopaedia*, Mathison, S., 2004, Sage Pub, In press

The evaluation planning workshop was held in Kabul over three days and the aims were set out as follows :

General aim:
To involve project stakeholders in developing the evaluation methodology

Specific aims:
1) To define concepts and basic notions in evaluation
2) To explain the different types of approach in program evaluation (i.e participative and utilization focussed evaluation)
3) To describe the logic model approach
4) To review the AMI/DGrelex logic model
5) To define the main types of program evaluation
6) To define the evaluation questions for the AMI/DGrelex project vs current context and utilization of evaluation results
7) To identify from whom/what source information should be collected for each evaluation question (i.e selection of case studies and people)
8) To describe data collection techniques which can be used in health and nutrition projects
9) To identify the most appropriate data collection technique/s for each evaluation question and analysis techniques
10) To develop evaluation data collection instruments

Figure 1 : Evaluation planning workshop aims

As the evaluation was implemented during Ramadan, lack of time meant that the set of evaluation tools could not be fully developed in Kabul, so an extra day had to be organized in the field (Metherlam).

Assessment prior to evaluation and selection of topics

During this workshop we assess whether or not the AMI program is ready for evaluation. Evaluators have a means of deciding whether a program is ready for evaluation. During the assessment, calls for the early evaluation are made, in collaboration with people working on the programs, in order to ascertain whether its objectives are adequately defined and its results verifiable. To do this assessment evaluators used the Logical Framework Approach (LFA[13]).

LFA is an analytical, presentational and management tool which can help us to : analyze the current situation during project preparation, establish a logical hierarchy of means by which objectives will be reached, identify potential risks, establish how outputs and outcomes might best be monitored and evaluated, present a summary of the project in a standard format; and monitor and review projects during implementation. The evaluation team was trained to understand the purpose of a LF and what the different types of evaluation are with the help of the following model.

[13] Sartorius, R.H., The logical framework approach to project design and management. *Evaluation practice*, 1991. 12(2): p. 139-147.

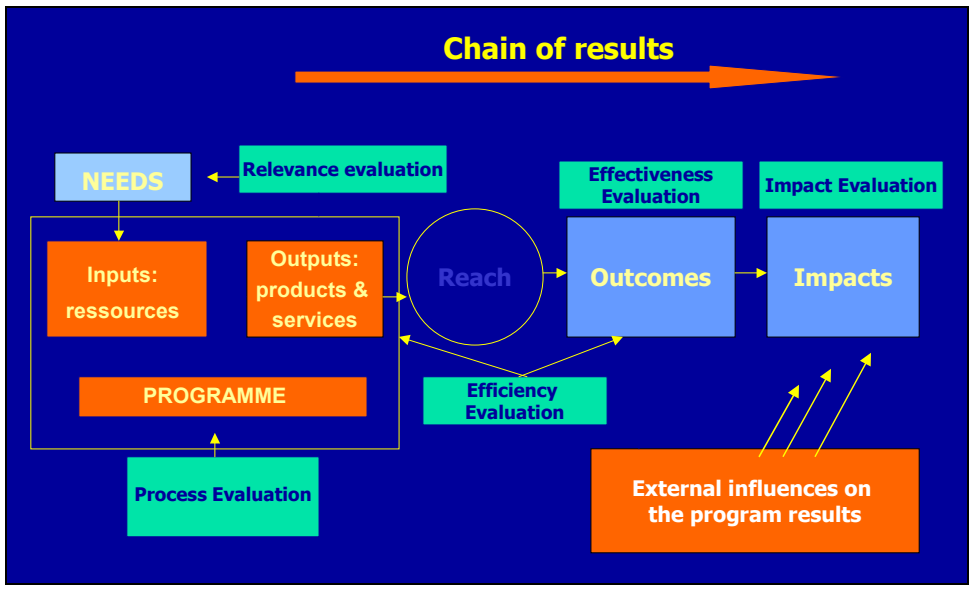

Figure 2 : A logic model and different types of evaluation

The evaluation team first reviewed the current LF of the AMI/DG relex program. For most of the team, it was the first time that they saw the LF with its activities and objectives.

After this, it was necessary for the evaluators to study the LF of the next program financed by the European Union. Indeed, since we had decided to carry out an evaluation of the implementation process of the program, it was necessary to select the relevant fields of activity (Topics) to be evaluated.

So that the lessons learned be useful to improve the program developed in the following months, it was necessary to choose some common activities. For example, the problem of the TFC was not selected because it is clear that AMI will have no program in this area. The consultant had selected some topics. The evaluation team first checked that there were no missing topics regarding the LF of the AMI/DGrelex program. Then, we organized a vote regarding the importance (1= not important, 5= very important), in terms of evaluation (rather than implementation) of the 16 topics selected.

The original results are the following:

	TOPICS	A	B	C	D	E	F	Mean
1	HIS	5	5	5	5	5	3	**4,67**
2	Women's health	5	4	3	3	5	5	**4,17**
3	Health education	3	4	4	5	3	4	**3,83**
4	Access to care for the poorest	5	5	5	2	2	3	**3,67**
5	Management of health facilities	5	2	5	2	4	3	**3,50**
6	Curative care	2	3	3	3	5	5	**3,50**
7	Training	5	5	5	2	1	1	**3,17**
8	Nutrition	5	1	1	4	4	4	**3,17**
9	Drugs	5	3	3	3	3	2	**3,17**
10	Supervision/Monitoring	3	3	4	1	3	4	**3,00**
11	CHW/TBA	4	2	4	2	2	2	**2,67**
12	Infrastructure	4	4	1	2	3	2	**2,67**
13	Sustainability/Cost recovery	4	5	1	2	2	2	**2,67**
14	Community Participation	5	3	1	1	1	3	**2,33**
15	Publication	3	2	1	3	2	1	**2,00**
16	Assessment	5	1	1	1	2	1	**1,83**

Table 2 : Original vote on topics for evaluation

Following the vote, we organized a discussion on the results and tried to reach a consensus in terms of the topics for evaluation. Different criteria were used to reach this consensus, such as: the availability of data, AMI's capacity to take decisions, the time constraint etc. This is why we decided to forego the HIS topic since AMI is obliged to follow the national policy on that. We also decided, as requested by some participants, to reformulate the topic regarding access to care for the poorest.

The following 6 topics were selected for evaluation by the three evaluation groups. People were grouped in virtue of their ability to find data and their knowledge about the topic. For example, it was impossible to assign men to the women's health evaluation topic.

Women's health	**Fauzia**
Health education	**Zermina**
Exemption schemes	**Zaher**
Management of health facilities	**Mujib**
Curative care	**Shahibullah**
Training	**Sylvie**

Table 3 : Evaluation groups and topics

Program/Topics evaluation question

A process evaluation is an evaluation of the internal dynamics of implementing organizations, their program instruments, their service delivery mechanisms, their management practices, and the linkages among these. Each evaluation group developed a number of evaluation questions for each topic. A maximum of three questions could be answered during the evaluation but each team could start by choosing more than three. Then, the consultant selected the three most important (or feasible) questions and the evaluation team agreed on the choice. The role of the consultant, as in other phases of the evaluation process, is both to structure the task for the group and to actively contribute to the development of evaluation questions based on insights from the fieldwork and on their own experience with other programs.

For each evaluation question, the group had to identify what kind of data they would need to collect (quantitative/qualitative) and where and from whom they would be able to find it.

TOPICS	EVALUATION QUESTIONS	QUANT/QUALI	WHERE/WHOM
Women's health	•Were deliveries carried out in proper conditions in hospital?	Quantitative	Hospital, Midwife, Women,
	•Did the pregnant women go for ANC/PNC to the HF and TBA?	Qualitative/ quantitative	Registration book, clinic, hospital, TBA report, Midwife, pregnant women, ANC card, AMI health passport, TBA
	•Did the women use FP?	Qualitative/ quantitative	Hospital, midwife, clinic, director of clinic, village, women, register book, FP card, gynecologist
Health education	•Was the HE session organized properly?	Qualitative/ quantitative	patients, hospital, clinics, Health educators, director of clinic, nurses, registration book, documents
	•Were the topics chosen according to the time of year?	Qualitative/ quantitative	patients, registration books, clinic, hospital, village, health educator, documents
Exemption schemes	•What was the degree of community participation in the system ?	Qualitative	Hospital, clinics, villages; member of HC, directors HF, villagers, poorest people
	•How were people who qualify for exemption identified?	Qualitative	Hospital, clinics, villages; doctors, members of HC, HF staff, poorest people
	•What were the difficulties in implementing the schemes?	Qualitative	Hospital, clinics, medical staff, director HF, director MoH
Management of health facilities	•Were HMT/HC meetings regularly organized?	Quantitative/ Qualitative	Hospital, clinics, villages, director oh HF, HMT/HC members, meetings registration book, reports
	• Was cost recovery implemented according to AMI standards	Quantitative/ Qualitative	Hospital, clinics, registration book, ticket book, pharmacy register, prescription, income generation sheet, medical staff, director of HF, director of MOH, beneficiaries
	•Were the activities regularly supervised by the AMI coordination team	Quantitative/ Qualitative	clinics, hospital, staff, monthly reports, general medical coordinator
Curative care	•Did the HW follow AMI's treatment protocol?	Qualitative	hospital, clinic, doctor, nurses, midwives, library, drug survey
	•Did AMI have a proper system for follow-up of patients?	Quantitative/ Qualitative	hospital, clinics, villages, doctors, midwives, patients, villagers, documents
	•Were patients satisfied with the curative care services?	qualitative	hospital, clinics, patients, villagers
Training	•Did AMI have a relevant program (curriculum, methodology, plan) for training of each HW category?	Quantitative/ Qualitative	hospital, clinics, coordination team, HW, documents
	•Did the HW use the archives of training session?	Qualitative	hospital, HW, library manager, documents

Table 4 : Evaluation question, type of data and place/person

The answers to these questions enable the consultant and the evaluation team to identify better practices, in this specific context only, to improve the AMI program. This means the identification of new ideas or lessons learned about effective program activities developed and implemented in the field that have been shown to produce positive outcomes.

Method strategy

Evaluation strategy : case studies

In the evaluation itself, due to time, logistics and safety[14] constraints, we studied only one (1) in-depth case. Case studies are particularly useful for understanding a program in depth[15]. These case-studies of AMI interventions were selected in the field in terms of location, in collaboration with the stakeholders and bearing in mind safety constraints. Cases were also selected in terms of their ability to help us answer the evaluation questions. Cases were rich in information, in the sense that a great deal could be learned from these examples of AMI interventions. This is why we decided to organize this evaluation in the Laghman province where AMI has been working since 1996 and supports one hospital and three clinics. During the case studies, the consultant and stakeholders used multiple sources of evidence as outlined below.

Evaluation tools :

The validity of evaluation results depends in large part on the adequacy and reliability of the data. Hence, it is important to use different sources of data collected through quantitative as well as qualitative methods. Quantitative methods are useful for getting broad descriptions of a situation, how it has changed or measured impacts. Qualitative methods are useful for understanding the reasons for events described in an evaluation. For the final evaluation we chose to focus on both methods. Through the use of simple data collection and analysis techniques all the program staff were actively involved and had to develop basic data collection skills. The consultant checked all evaluation tools and worked with each group to ensure that they fulfilled standards of quality. To answer the evaluation questions the evaluation team used the following evaluation tools :

Archival Data and Documentation Review
Archival data already exists. This data is usually inexpensive and may be fairly easy to obtain. However, we had little choice in the data format since it had previously been collected by someone else for other purposes. Existing records from different AMI departments were used as a data source. Record reviews usually involve counting the frequency of different operations, programs... In this category, we studied program proposals, monthly reports, evaluation reports, accounting reports etc.

Focus groups
Focus groups are typically used for collecting background information on a subject, creating new ideas and hypotheses, assessing how a program is working, or helping to interpret the results from other data sources. The focus group interview generally involves 6 to 12 individuals who discuss a particular topic under the direction of a moderator, who promotes interaction and assures that the discussion, remain on the topic of interest (see photo). Focus groups can provide a quick and inexpensive way to collect information from a group (as opposed to a one-on-one interview), allow for clarification of responses, obtain more in-depth information, and create easy-to-understand results. However, since focus groups use only a small number of people, they may not accurately represent the larger population.

Unstructured Interviews
Similar to a focus group, but with just one person, an unstructured interview is designed to obtain very rich and detailed information by using a set of open-ended questions (see photo). The interviewer guides the participant through the questions, but allows the conversation to flow

[14] We were allowed to travel in Laghman province from Kakass clinic up to Metherlam hospital only
[15] Yin, R. K. (1994), Case Study Research Design and Method. London, New Delhi, Sage Publications

naturally, encouraging the participant to answer in his or her own words. The interviewer often will ask follow-up questions to clarify responses or get more information. It takes a great deal of skill to conduct an unstructured interview and analyze the data. It is important to define criteria that determine who will be interviewed and the evaluation team accordingly identified the people to be interviewed.

Observation:
While an activity is going on, an observer records what he sees either using a checklist or by taking descriptive notes. The observation can include information on the setting (the actors, context, and surroundings); the actions and behavior of the actors; and what people say, including direct quotations. In the field (2 case studies) where activities were still being carried out by AMI, the evaluation team collected some information using this method.

Workshops :
At the end of the field case-study (analysis and recommendations workshop) and at the end of the final evaluation (lessons learned workshop), a workshop is organized in the presence of all the stakeholders. The aim of these workshops will be to share the current and partial knowledge of the evaluation team regarding the implementation processes of the AMI projects. Participants in these workshops will again have the opportunity to give their own input regarding the project, thereby correcting any misunderstandings on the part of the evaluator team.

The list of the tools used by each evaluation group for each topics is shown in the following table.

	Interview	**Focus group**	**Observation**	**Document**	**Questionnaire**
Women's health	2	3 (30)	1	1	
Health education	1	4 (32)	4		
Exemption schemes	6	3 (10)			
Management of health facilities	6	2 (13)			1 (32)
Curative care	3	3 (27)		1	1 (10)
Training	4	1 (8)	1		1 (21)
Total	**22**	**16 (120)**	**6**	**2**	**3 (63)**

Table 5 : Instruments and number of participants

Most of the people came from Laghman but as Metherlam is the reference base for Kunar, we took the opportunity of the visit of 3 people from AMI health facilities in Kunar to interview them.

So, in addition to the people observed during this evaluation, 205 people had the opportunity to express their thoughts and possible concerns regarding the implementation of the AMI program in Afghanistan. Of those 205 people, we had a gender balanced approach: 105 women and 100 men.

As each group was composed of two people, during interviews and focus groups, one person took notes whilst the other conducted the interview. The following principles of note-taking served as a guide: 1) notes should be recorded in the first person, 2) key words and ideas should be recorded, 3) original, descriptive phrases or sayings should be recorded word for word as quotations, 4) information should be recorded exactly as it is heard and not "filtered" based on interviewers' ideas or values 5) as many notes should be taken as possible, 6) in group interviews the various opinions in the group should be recorded.

Data analysis, results and lessons learned :
Once the data had been gathered, a participatory approaches to its analysis and interpretation helped participants to build a common body of knowledge. The consultant led the evaluation group to carry

out their own analysis but was always present to ensure that the quality of the analysis was of the right level..

The daily qualitative data analysis process was structured around the interview questions asked of each category of interviewees. A simplified approach to content analysis[16] based on a series of five steps was used by each group.

Step 1: *Re-read the interview questions*. One-by-one the interview questions should be read to the group. This allows the team members to recall the focus of each interview question.

Step 2: *Read the interview notes.* The note-taker/s should read aloud the responses, found in the notes for each question. If there are more than one set of notes, each set of notes should be read.

Step 3: *Discuss the responses.* The team leader asks the group to discuss the information included in the notes, to share other comments made by the interviewees that may not have been written down, to clarify exactly what the interviewees were saying.

Step 4: *Categorize the responses and summarize findings.* Together the group identifies the categories of responses in the information collected and summarizes the findings in a concise fashion. The example below illustrates a summary of the findings for one interview question.

Step 5. *Identify unclear or missing information.* A last step in the discussion of each interview question is for the group to determine whether there is missing or unclear information that should be further investigated in subsequent interviews.

Figure 3 : Qualitative data analysis process

Once the analysis is complete, the facilitator worked with the evaluation team during the last workshop in the field to reach a consensus on findings, conclusions, and recommendations. Developing a common understanding of the results, on the basis of empirical evidence, became the cornerstone for the group's commitment to an action plan. By focusing the evaluation exercise on developing the lessons learned from program implementation, the program stakeholders could analyze past problems and successes more openly.

Methodological constraints

Before presenting our results for each topic, it is important to clarify the different constraints at play in this evaluation. Three types of limitations were identified as constraints: logistical, methodological, program.

1. *Logistical* : due to time constraints we were obliged to collect the data during a maximum of 6 days and the team was not prepared before the consultant's arrival. As this was the final evaluation, we were also obliged to wait until the program ended so that the time of evaluation could coincide with Ramadan. For security reasons we were also obliged to focus our evaluation only in the Laghman province. This constraint could limit the generalization, for the whole AMI program, of the

[16] Aubel, J., 1999, ibid

results and recommendations reached. In addition, also due to security reasons, the Country Director decided to ask the consultant and one of the evaluation team members (the only expatriate) to leave Laghman province before the end of the data collection and analysis stage. Therefore, the group dynamic was broken during 4 days (i.e 30% of the total evaluation time).

2. *Methodological* : in certain places, it was difficult to ask the head of the village or the director of the health facilities not to be involved in the focus group, for example. This problem could have an impact of the capacity of the other participants to give free answers to the questions asked by the evaluation team. Some evaluators were involved in the program under evaluation and this could have an impact of their objectivity, but we organized each team in a balanced way in order to compensate for this potential liklihood.

3. *Program* : At the time of this evaluation, AMI had some funding difficulties. Most of the health facilities staff was not being paid anymore by AMI and some of them (in Kakass, Laokar) were aware that AMI was no longer going to support their clinics. This constraint could be problematic in terms of staff willingness to have a discussion or to give unbiased, honest answers.

3. FINDINGS

The following section shows the results as analyzed by the participants .

Curative care

Health workers following up of AMI protocols and guidelines

The first idea of this **questionnaire** was to ask all doctors of Metherlam hospital to answer some questions concerning the protocols provided by AMI, in order to evaluate their knowledge concerning these protocols. Unfortunately, only 6 documents of AMI training courses on protocols were found in the library of Metherlam hospital, 2 of them pre-dating 1997, 3 of them dating to 2001 and only one of them, about SFC protocols, being recent (April 2003). Because of this lack of documents, the questionnaire had to be established along the "MSF clinical and therapeutic guideline", provided by AMI to the hospital of Metherlam.

The 8 male and 2 female doctors filled in one questionnaire, with 10 questions about MSF protocols. This questionnaire included questions on internal medicine, pediatrics, gynecology and surgery. The following results were obtained:

- in average, the doctors obtained a result of 63% of correct answers, ranging from 30% to 80%, with no significant differences between the male and female doctors.

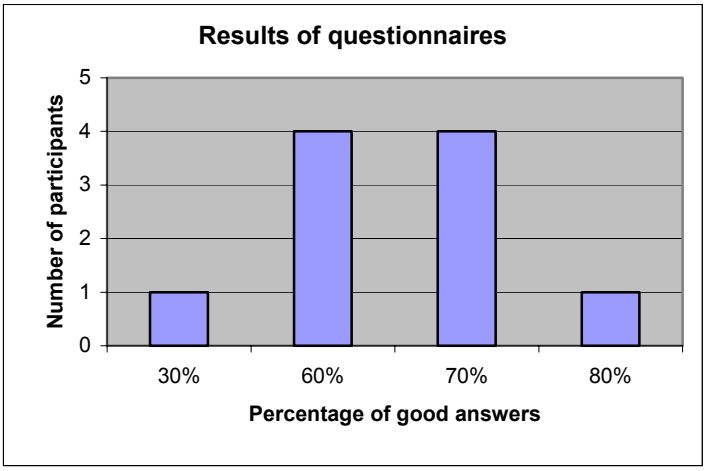

Figure 4: Results of questionnaire about MSF protocols – Mehterlam, November 2003

- 100% of the doctors knew the contra-indication of diazepam and the treatment of acute watery diarrhea
- 90% of the doctors knew how to treat banal epigastric burning and how to clean wounds
- female doctors apparently tend to give antibiotics for bronchitis when not necessary
- only 50% of the doctors knew about the admission criteria for children in TFC ward
- 40% of the doctors were treating anaemia for a shorter time than was necessary (3 weeks instead of 2 months)
- only 37.5% of the male doctors could answer the question on obstetrics, whilst 100% of the female doctors answered correctly
- only 20% of the doctors knew that co-trimoxazole is not included in the systematic treatment of measles

- to the question concerning the use of chloramphenicol for treatment of typhoid fever, nobody could give the answer written in MSF guidelines. 50% of doctors agreed on the duration of treatment, but not on increasing of the dosage during the first days. This means that they probably found the information in other guidelines or textbooks.

From these results, we can conclude that the doctors are not always following the MSF guidelines provided by AMI, but are probably also reading other protocols from textbooks, other NGOs or national policy. Moreover, a lot of different answers were sometimes given to the same question, which means that inside the same hospital, doctors are not in harmony on which protocols to follow. Nevertheless, the general results of the test are not too bad; showing medical knowledge on average is quite good.

Protocols followed in the treatment of patients : During a focus group, the team saw that a number of different protocols are used and that there is no agreement between health workers on the protocols to follow. Indeed, AMI provides its own protocols and also advises medical staff to follow the protocols of other organizations. A vote was organized, and 80% of the health workers gave their preference to WHO protocols, whilst the remaining 20% preferred textbooks. One third of the participants mentioned that if some information in WHO protocols is missing (especially for uncommon diseases), they refer to textbooks, if the latter are well-known and have a global stamp of approval. However, all the participants agreed on the fact that the protocols to follow should be accepted by WHO or MoH.

The reason why their preference goes to WHO protocols, is that a lot of protocols are available and that they are introduced and explained in regular workshops. However, women did not agree with this as they received WHO protocols without training.

Only two male participants mentioned that medical staff should follow AMI protocols first and foremost. This seems to be done by the female health workers, who are still following the protocols provided by Elisabeth. Nevertheless, all participants agreed on the fact that AMI protocols are available in too small a quantity, are incomplete and need to be completed with other protocols. Moreover, for most of the training courses provided by AMI, trainees didn't receive any information documents on the courses and their content. .

For some departments, such as surgery, protocols are never provided, either by AMI or by other organization and the only protocols that surgeons are following are those outlined in textbooks.

Availability of AMI protocols : As mentioned before, some AMI protocols exist, but in limited number. For internal medicine and paediatrics, more or less 10 AMI protocols are available; concerning gynaecology and obstetrics, there are only protocols on antenatal consultations and family planning; for surgery, there is no any protocol provided either by AMI or by other organizations.

Female staff complained about the fact that they didn't receive any new training on protocols since the time Elisabeth left (2001), and that said that they felt a real need for training. Surgeons also expressed their wish to receive some training on protocols, even on dressing.

The new doctors never received training on protocols from AMI and seemed not even to be aware of the availability of AMI protocols: a doctor working for AMI for 2 years received only the workshop report on "rational use of drugs", another doctor present for 6 months had received only 1 training course on nutrition protocols and a female doctor working with AMI for 4 months was completely unaware of the existence of AMI protocols.

For female staff and nurses, the protocols are apparently available in Persian. For the doctors, protocols are sometimes provided only in English, but most of the doctors are able to understand them. Doctors seem to be more interested in English versions, even if some of them mentioned that it would be better if protocols were also provided in both languages.

The evaluation team could observe that not all the AMI protocols were available in the library of the Mehterlam hospital and that the ones which were available were not organized and classified

together. Because of this, most of the protocols provided for the hospital were lost. Moreover, documents about training are generally distributed to the participants but a copy is not provided for library. The staff usually keeps the protocols provided at home and/or in their OPD rooms and don't share it with other doctors. Sometimes, in OPD or IPD, wall charts with tables or protocols are available.

Use of AMI protocols : Most of the participants regularly read the AMI protocols that they have received, because the general treatment policy of AMI is based on these protocols. Some of them mentioned that they read it once when they receive it, and then only in case of a problem, together with other protocols. Some participants complained about the fact that they didn't always receive a document from trainers detailing the protocol to follow.

AMI protocols are followed mainly for admission criteria in IPD and rational use of drugs, according to AMI policy. As mentioned previously, surgeons don't practice AMI protocols since none were provided.

Content of AMI protocols : According to mid-level staff, AMI protocols are good and useful, but the doctors complained about the fact that protocols provided by AMI are too short, incomplete, not updated and lacking in a precise training plan.

Most of the protocols provided by AMI do not respond to a real need. They are usually first line treatment protocols, which are not always adapted to patients coming to the hospital. Indeed, the patients are, most of the time, complicated cases or cases that have already received a first line treatment in clinics or bazaar, and they come to the hospital because their treatment has not been effective. Some participants added that if first line treatments were practiced in the hospital, patients would not be satisfied. But some others didn't agree and said that it is important in some cases to begin with a first line treatment, even in hospital. For these reasons, in their opinion, AMI should not limit its protocols to first line treatments, or even to second or third line treatments. They should explain all the possible treatments and let the doctors decide which one they will use.
In addition, protocols do not always respond to staff demand. Most of the expatriates train the hospital staff on very common diseases, even if they have already undergone training on these topics many times by other expatriates. Expatriates therefore do not take into account the training that has already been provided and tend to train people on subjects that they are already aware of for which they do not need new training. All the participants expressed their interest in receiving training on new protocols, which are currently little known by the health workers, and on choosing them alongside the staff.
Protocols are also sometimes decided according to developed country policies and not adapted to the circumstances in Afghanistan: different pathologies, expensive medical equipment, problems of drug availability, resistance to some drugs, price of the drugs, etc…
The opinion of the staff concerning the implementation of a new protocol is usually taken into account and the trainees are involved in the final decision for protocols.

Problems faced during implementing of AMI protocols :

- Some contradictions are sometimes present in the comparison of different protocols provided by different trainers on the same disease.
- Some protocols are imposed by the trainer, even if the trainees are not agree (i.e. protocols insisting on treatments without antibiotics when experience of the trainees shows that patients are not responding well without antibiotics). In this case, the trainees do not follow the new protocol and give more drugs to the patients if they see that patients are not responding well to the treatment proposed.
- Some expatriates employed by AMI to support Mehterlam hospital and surrounding clinics, could not often come to Laghman due tosecurity reasons, even if their presence was necessary in terms of supervising the follow-up of protocols.

Suggestions for improvement of AMI protocols :

- MoH should provide protocols to all health facilities, in order that they be comprehensible for everybody and used all over the country, as a standard. They should also be accompanied by training, provided by MoH or by the implementing partner.
- More training on protocols should be provided for the hospital of Mehterlam, as it is a provincial hospital.
- The training programs on protocols should be more adapted to the level and knowledge of the staff.
- The training topics should be chosen together with the staff, in order to answer to their needs and should include training on new protocols : pathologies which are not well known for the doctors (e.g. rheumatic fever, cardiology, ECG, kidney pathology, etc…) and new methods of nursing for the nurses.
- More advanced training should be provided in foreign countries (e.g. France, Pakistan), especially about paediatrics.
- At least one doctor should be trained in each specialization.
- All training courses should be provided by specialists or more qualified trainers, and not by general practitioners, in order to be more complete and to ensure that the level of the trainer is higher than that of the trainee
- Training courses need to be frequently reviewed and updated in order to follow the advances in medicine as well as the evolution of the circumstances in Afghanistan. Changes in protocols should be identified by the coordination team, and staff should be informed about these changes.
- Documents with protocols and resume of training should be bound together and provided to all participants, with one extra copy for the library.
- Expatriates should be more present in the hospital for supervision of the implementation and follow-up of the protocols.

AMI management of follow-up of patients

Criteria for follow-up : Patients that are followed-up at the clinic are mainly patients with chronic diseases such as hypertension, asthma, hepatitis, cardiac diseases, mental diseases or malnutrition. They have to come to the clinic every 15 days (or every week if living near to the clinic) for check-ups, in order to follow their evolution and the effectiveness of their treatment. Sometimes, other patients with acute diseases are also asked to come back for follow-up in order to verify the results of the treatment. These are mainly patients treated with antibiotics (pneumonia, infectious disease,…), those whoneed long term treatments (kidney diseases, rheumatic arthritis,…) or those treated with drugs which have some side effects (chloramphenicol,…).

Pregnant women also have to come every month for follow-up in the hospital or the nearest clinic where female staff is working. In addition to this monthly consultation, they have to come for checks if they suffer from headaches, bleeding, severe gastritis, etc… Their pregnancy is also monitored by ultrasound examination. All women who have reached child bearing age women are checked for tetanus vaccination.

Problems faced in follow-up : Some patients agree with the follow-up process and come back to the clinic or hospital on time, but not all of them. The main problems faced by the health workers concerning follow-up of the patients, especially in SFCs, is that the patients don't come back regularly to the health centre or sometimes never come back. In this case, the patients mention the following reasons:

- transportation problems (no car available or too expensive) for people living far from the clinic or hospital
- financial problems and no possibility to pay again for consultation and/or drugs

- traditional culture where women are not independent and have to receive the authorization of the husband or mother in law to come to the clinic or hospital
- huge workload at home, with the children or in the fields
- improvement of their health status (ex : hypertension) ; recovery
- (semi-)nomadic lifestyle
- preference for more drugs than for follow-up by the health workers (i.e. in case of pre-eclampsia)

According to the health workers, the main reason why patients don't return to the hospital is their lack of education: people don't understand the importance of the follow-up process, or that of regular and punctual visits (i.e., pregnant women for ante-natal consultation), are not fully aware of the possible complications of some diseases or treatments, etc… It was noticed, in clinic as well as in hospital, that educated women came back more regularly for follow-up than non-educated women.

Another problem occasionally encountered is that patients think that if the health worker asks them to come back it is because their disease is very severe or dangerous, rather than part of a standard procedure

For women, another important problem is that there is not always a female health worker working in the clinics, and so they sometimes have to cover long distances to come back to hospital for follow-up.

Duty of AMI coordination staff : One of the duties of the AMI coordination team is to provide an adequate, on-time and regular supply of follow-up tools to the clinics, hospital or . They also have to monitor each program, make regular visits, provide guidance to the health workers observe them at work, correct eventual mistakes and fill the gaps. They should also provide regular training and take into account the needs or suggestions of the health workers.

Conservation of information about the patient : Some patients are well known by the health workers because they have chronic diseases or are pregnant and come regularly to the clinic or hospital.

Most of the patients have a health passport, which helps the doctor to remember their last visit. For patients who cannot buy a health passport, who lose it or forget it, there is no other solution for the health worker than making a new and complete anamnesis (history, date and reason of their last visit in the clinic, actual problem, treatment,…) and examine them completely. If the health passport is really lost, the patient is asked to buy a new one, and the information about the consultation will be written on a sheet of blank paper.

Nevertheless, some helpful information can be found in the registration book. This information will not be complete, but will at least remind the doctor of the main aspects a patient's health of (BP, laboratory results, diagnosis,…). Other information can also be found on the prescriptions kept in the clinic or hospital, or on other sheets such as referral sheets, discharge sheets, etc… Some patients have their prescriptions or even their drugs with them to show to the doctor. If they went come from another health facility, they will inform the health worker or bring him/her a sheet from there.

Use of AMI tools for patients' follow-up : In the clinics, the AMI tools that are used are: health passports, ante-natal consultation cards (only if female staff are present), nutrition cards (only if an SFC program is running), referral sheets and discharge sheets. The patients have to keep these tools and show them every time they go to a health facility. The registration book and prescriptions are other tools that are kept in the clinic for a number of years, before being eliminated. A few years ago, the clinics also used a "patient card", only for patients with chronic diseases, which was kept in the clinic, but this tool disappeared when health passports took over.

In the female wards of a hospital, other tools, kept by the patients, are used in addition to the ones mentioned above (i.e. family planning card, US results sheets,…) Previously, the ANC card was kept in the hospital and only the reference number of the card was given to the patient. But now, since the beginning of 2003, the ANC card itself is given to them.
In clinics, no special sheets are available for referral. Blank paper or other forms have to be used.
Concerning discharge from hospital, it seems that the hospital doctors systematically ask patients to go to the clinic for follow-up after being discharged. Unfortunately, for an unknown reason, not all the patients discharged from the hospital receive a discharge sheet. The assistant doctor of Kanda even says that he never saw any patient with a discharge sheet or any other kind of sheet from the hospital (e.g. many people come to the clinic to follow up on a dressing without any form.). According to the midwife, this is because no discharge forms exist in the hospital, so they have to use other types of forms.
Another point mentioned is that the dahias don't have tools for referencing patients. For this reason, they have to accompany the patient themselves or count on the patients to pass the information on to the midwife.
A health passport is normally filled out for each patient who owns one, at the end of the consultation. Nevertheless, female staff seem not to fill it out for common afflictions such as general body pain, etc… The Kanda nurse also said that he doesn't fill it out if there are no drugs available in the clinic to treat the patients.
Advantages of AMI tools for following-up on patients : All interviewees agreed on the fact that these tools are very useful for the follow-up of the patients and the activities of the clinic. The main advantages of these tools, especially as concerns the health passport and ANC card, are the following :

- the use of the tools is easy
- it facilitates the work of the health workers
- it represents a gain of time as the health workers don't have to ask the patients to give them a full case history
- it helps the health workers to make an clear distinction between old and new patients
- it contains a lot of information which allows the health workers to gain a better understanding of a patient's complete case history and their previous and actual problems
- it helps the health workers to monitor the patient's treatment
- as patients keep the tools with them, it allows the health worker of another health facility to receive some information about the patient

Disadvantages of AMI tools for follow-up of the patients : For the doctor of the clinic, filling out the AMI forms takes a lot of time (more or less half of the duration of the consultation) and represents a lot of work. It is sometimes a problem because patients always want to be checked very quickly. The assistant doctor didn't agree and said that it takes only a short time to be filled out. For the midwives, the ANC card takes less time to be filled out than the health passport, because everything is written on the card and they just have to tick the right answers and fill in the empty spaces. In any case, all of them agreed on the fact that the inconvenience of time consumption is nothing next to all the advantages the tools represent and that using them is a necessity. Moreover, it is their responsibility to fill them out and the procedure can be carried out within working hours.

Certain other disadvantages were listed by the interviewees:

For health passport

- it is charged 2 AFS, except in ANC and PNC consultation where it is free, which means that a number of poor people cannot afford it. This problem largely concerned the Kanda clinic.
- cost and the use of paper to establish the health passport (mentioned by 2 people)
- blank pages, meaning that health workers can forget to note some important data (in contrast to the ANC card)
- female staff was not involved in the writing up of the health passport (in contrast to the ANC card)

For ANC Card

- sometimes not enough space to answer (e.g. number of children, number of consultation)
- patients cannot answer some of the questions posed in the ANC card

For both health passport and ANC card

- sometimes difficult for the patients to keep it, to ensure that it is not lost or damaged
- people of Laghman tend to lose their health passport or ANC card
- breach of confidentiality in that other people may read it

Retaining information in case of loss of the health passport or ANC card : Initially, the doctor said that the registration book was enough of a record. After discussion, however, he said that the information found in the registration book was not complete enough and that two health passports or ANC cards for each patient would be better: one to be kept by the patient and one to be kept by the clinic. Another option, mentioned by two interviewees, would be to keep the health passport or ANC in the clinic, with a reference number and to give a card to the patient with this reference number. But in this case, health workers of other health facilities would not be able to see a patient's case history.

Suggestions for improvement of the follow-up of the patients

In terms of the health passport

- should be free, so as to be accessible for everyone
- the number of pages should be increased
- the paper should be lined
- the pages should contain a framework (like ANC cards or previous prescriptions of AMI) or a stamp, with some information to be filled out (i.e. date, blood pressure, pulse, respiratory rate, weight, diagnosis, treatment, etc…) In this way, the health passport could be more easily filled out by the health workers which would also save time. It would prevent the health workers from omitting important information. It would also look more "official" and the patient would hence realize be made aware of the importance of this tool.

Concerning the ANC card

- should be reviewed since there is lack of space for some answers and some questions that patients cannot answer
- should be shorter to take less time.

Concerning both health passport and ANC card

- should be readily available (no stock shortages), in sufficient quantity, supplied regularly and " on time"

- there should exist two copies: one to be kept by the patient, and one kept in the clinic. In the latter case, there should be a special, well organized cupboard to keep all these tools. It will increase the workload, but is nonetheless a necessary measure.

Concerning general management

- there should be some tools like health passport and ANC card for every type of medical activity, in order to better manage the activities
- there should be a midwife in all the clinics for follow-up of pregnant women
- there should be a better management within the team working daily with women, to keep their ANC card in the right place (inside a cupboard and not on the desk) so as to find it easily.
- there should be a separate card or registration book for chronic diseases, to be kept in the clinic, alongside the pre-existing tools
- patients should receive more HE in order to be aware of the importance of the follow-up of some diseases. There should also be some awareness-raising programs on radio or television about the importance of follow-up
- there should be more follow-up in the villages (i.e. dahias for follow-up of PW, home visitors for malnourished children, CHW, etc…) in order to see if the treatment is followed correctly and if the patient is responding well.
- The card should be reviewed or rechecked on a monthly basis, , to detect defaulter patients, and to send a TBA or home visitor to check them at home. For this, AMI should recruit and train new female health workers or TBAs and provide them with transportation.
- AMI should restart nutrition programs because people are not properly following the nutrition education advice. If no food is distributed to patients suffering from moderate malnutrition, they will soon become severely malnourished

Patients' satisfaction with the curative care services provided by the health facilities

Two focus groups were organized in the village of Qala Kot, near the Kanda clinic. One of the focus groups included 8 men from the village and the other one 9 women from the village. All the participants had used the AMI health facilities at least once, be it the clinic or the hospital, over the preceeding 3 months.

Behaviour of health workers : All the participants agreed on the fact that the behavior of all health staff of AMI, from the lowest to the highest level, was usually very good (i.e. welcome and respect of the patients, humanity, moral and ethics.), especially in the hospital of Mehterlam. Women added that health staff always took into account the fact they were women and respected them by : providing all necessary comfort (chairs, good food,…), giving them priority for consultation (before men), not examining them "too much" (i.e. without touching body parts that offend women),… The health workers appeared readily available for the patients, even at night, taking time to provide the necessary care and doing all their best to help the patients. One man mentioned that the health workers took care of the patients "even more than their own father and mother should do", and all the group agreed. Moreover, they mentioned that the health workers were very understanding regarding poor people; they did not ask them to pay for consultation and even sometimes give them some "bakhchich".

It seems that previously, follow-up was only done in hospital, but not at the clinic. Since there is a new doctor, there is good follow-up of the patients. Female patients are asked to come back if they do not recover from their disease, as well as being asked to come back regularly for ANC. Two women disagreed with this and said that the HW never asked them to come back.
Nevertheless, some people complained about the behavior of the previous doctor of Kanda, Dr Ghulam Ahmad, who is now working in the Laokar clinic. He went "too far" in his examination of female patients sometimes spoke badly to his patients. But, according to the men, when some doctors behave badly, they (the patients) complain about it and then they try together to improve the

situation. This contrasts with the women's point of view, who feels that if a doctor behaves badly towards them it is not taken into account, essentially by virtue of the fact that they are doctors.

Infrastructure : The main problem, in both the hospital and clinic, concerns the waiting room. In hospital, there is no waiting room and the corridors allow only accommodate 10-15 people. The others have to wait outside which is a big problem during the summer because there is no place in the shade. Sometimes, when there is strong wind, there are sandstorms it is impossible to wait outside. Men and women are also not segregated while they are waiting, when their culture dictates that they should be.

According to men, segregation of men and women on the IPD ward is good, since boys over 7 years of age are not allowed to enter the ward. Nevertheless, a problem remains concerning visits to the patients, as these are never allowed. In the clinic, women wait inside and men outside. But the clinic is a rented house, and the owner doesn't allow patients to wait in the garden of the clinic and even less to wait outside the clinic, on his land or under his trees. This is a real problem on days when the clinic is overcrowded (e.g. vaccination days).
Hygiene inside the hospital seems to be very good: wards are very clean, bedclothes are changed regularly, toilets and latrines are available, water and soap is available, cold drinking water is put at patients and caretakers' disposal in the summer, there is air conditioning (fan), etc… According to the villagers, Mehterlam's hospital is very clean compared to Jalalabad's hospital.
The clinic is made of mud and not of cement. According to men, because of this, it cannot be very clean, but women don't agree and find the clinic clean enough.
In the clinic, people also complain about the lack of rooms. The examination room is the same for men and women and, according to their culture and religion, this is not acceptable. If it is not possible to have two separate consultation rooms, there should be at least 2 examination beds in one room, one for men and one for women. Of course, a female doctor would also be better, but is not absolutely necessary.

Number and diversity of health workers : In the hospital, the number and diversity of health workers seems to be good, even if men are asking for more female staff. According to women, female health workers generally monitor them, but, if necessary, male doctors can are also come to provide help. They seem to be very happy with the services provided for women.

In the clinic, there is a lack of staff one more doctor should be recruited in the clinic to reduce the number of patients per doctor. It would be better if there could be a female health worker in the clinicas she would be more able to treat some women's diseases. However, this is not essential, as male doctors are allowed to examine women in their role as Maharam. People realize that, due to the war, only a small number of women graduated in medicine, midwifery or nursing.

Availability of drugs in health facilities : Concerning the availability of drugs, the opinions are not clear and there is no general consensus between the villagers. Some of them say that all drugs prescribed by the doctors are available in the hospital and clinic. However, a lot of villagers, men and women, complained about the fact that only some of the prescribed drugs are provided by the hospital or clinic, and that the patients have to buy the other ones from a private pharmacy (i.e. second or third line drugs), which are much more expensive.

Some men mentioned that the drugs disappear quickly after delivery by AMI and that AMI should supply more drugs. They suspect that either the pharmacist doesn't provide the drugs, or that there is not enough supply from NGO side.

Quantity and type of drugs prescribed : Some men complained about the fact that the doctor of the clinic prescribes maximum 2 different drugs, which is not enough according to them. According

to some of the men and women, the doctor sometimes even prescribes a single drug for 2 different complaints. If patients then ask the doctors for more drugs, they are refused.

Another general complaint was that patients always receive tablets, and never syrups, serums or injectable medication. Only a few patients (only 1-2 %, according to men) receive injectable drugs, and this only if an influential person specifically asks the doctor. According to some women, even if syrups are available in the pharmacy, they never receive them. One woman did not agree and confirmed that she sometimes received some injectable medication or syrups. Another women added that if the pharmacist doesn't give this kind of treatment, it is only because it is not available and also said that her child had already received some syrup. Nevertheless, everybody agreed on the fact that if they go to clinic, it is only because it is less expensive, and that otherwise they would go to bazaar to receive the form of prescription drugs that they ask for.

Quality of prescription drugs : Women said that the clinic doctor does not prescribe good drugs. Men confirmed this by saying that the drugs prescribed in hospital are better than the ones prescribed in clinic.

Some men said that the drugs provided by AMI are not given to the patients and that the clinic staff replaces the European drugs from Europe with their Pakistani counterparts(i.e. syrups). Drugs from foreign countries are very good (i.e. French, German, eventually Indian or Iranian), apart from Pakistani ones. However, nobody complained about the fact that they didn't recover following treatment.
All women agreed on the fact that the drugs provided by AMI are better than the bazaar drugs, because it takes a lesser quantity to get better. This is due to the fact that the drugs provided by AMI come from foreign countries. However, one women said that the recovery was not due to the medication, but to God.

Price of prescription drugs : People have to pay for drugs according to the quantity prescribed. Some people complained about the fact that the clinic sells the drugs at a higher price than they should do according to AMI policy. In their opinion, prescription drugs from foreign countries should be free as they are being provided for poor people in Afghanistan. However, everybody agreed on the fact that, even if they have to pay for medication, it is less expensive than in the bazaar and some prescription drugs are even free (i.e. malaria drugs, fer folic,…).

Women said that there is not any kind of help for poor people and that these are obliged to borrow money. Sometimes, the clinic or hospital accepts to give the drugs on credit, asking the patients to bring the money later. However, most of the time, if the patients don't have enough money, the clinic staff reduce the amount they give. In contrast, some men were witness to the fact that the health facilities' staff occasionally provided free medication for poor people, sometimes foregoing their own salary in order to do so, especially in the case of students.

Quality of health care services provided : It is difficult for the villagers to gauge the doctors knowledge . Yet at first sight, it seems to be very good, especially in the hospital where the doctors diagnose properly. The only problem is that the patients sometimes don't know whether the doctor is a real doctor or only a nurse. But, according to them, all AMI staff is qualified.

Accessibility of health services to everyone : From a financial point of view, the health services provided by AMI are more accessible in comparison to the ones provided in the bazaar. However, even if they are accessible for everybody for routine services, they are not accessible for complicated diseases or hospitalizations. Indeed, according to men, for poor people or students, routine consultation and prescription drugs are free, but specialized consultations are charged. Women again disagree with this view, saying that they are always obliged to pay for the health services, even if they are poor, because it is necessary. They sometimes have to borrow money to buy the drugs prescribed, especially if they are not available in the clinic or hospital and they have

to buy them from the bazaar. In conclusion, all women agreed on the fact that the health services are not accessible for poor people. They would be very pleased if they could become free.

Health workers are always available for the patients, even at night, except in the clinic.. Moreover, sometimes there are too many patients and 1 doctor is not enough to deal with them all.
The health facilities of AMI do not cover all the villages. Far away villages do not have access to them, as it is sometimes difficult to find transportation to bring them to the health facilities. The Kanda clinic is only accessible for two villages. Nevertheless, for Laghmani people, the accessibility to the AMI health services is higher than to Jalalabad ones.

Suggestions for improvement of health services

In clinics

- they should be built in an official or public place surrounded by open access areas to allow people to come and go without any problem
- there should be two separated rooms for examination, one for women and one for men, even if there is only one male doctor to examine all patients. If this is not possible, there should at least be 2 examination beds in the one room
- there should be a lab technician in the clinic with a separated room for the laboratory
- An extra doctor should be recruited, in order to split the workload According to men, this new doctor should be a women if possible (not absolutely necessary), but women gave their preference to a paediatrician
- there should be a doctor on duty in the afternoon and even at night

In hospitals

- in case of necessity and severe problems with a female patient in IPD, and if this patient is not capable of leaving her bed, the men should be allowed to enter the female ward for short visits.

In both clinics and hospitals

- prescription drugs should be free for everybody, in order to be fully accessible to all
- the supply and distribution of prescription drugs should be controlled by expatriates and not by local staff

Training

AMI training program for each category of health workers

Planning of AMI training sessions : In general, the planning was good, but everybody agreed on the fact that very few training courses were provided by AMI, even no training at all in 2003 for the staff of clinics or for some departments of the hospital, such as paediatrics and internal. Usually, the duration of the training courses is also too short (i.e. x-ray, US and surgery). The medical coordinator agreed with this and added that no training course was ever organized, even a simple one, for management of human resources, in order to increase their capacity building. The only one who was happy about the training received was the lab technician of Kakaas, who received a 3 months training course in the central laboratory of Kabul.

According to the men and to one woman, at the time when Elisabeth was working for Mehterlam hospital, a lot of training courses were organized for women and none for men. The 3 other women answered that if women benefited from more training at that time, it was simply because they needed more training. One woman added that, currently, in female ward, most of the training courses are provided for midwives, but not enough for assistant midwives or nurses.
People sometimes did not agree with the selection of the participants. In cases where not all health workers of a department can take part in training, AMI should sometimes select trainees that already have basic knowledge about the topic, instead of new trainees that don't know anything about the subject. (e.g.. US training held in Peshawar). Of course, the most successful method is to give the opportunity to everybody to participate.
Regarding gender segregation, two women said they preferred separate training, so as to be more relaxed and act in accordance with their culture. But the two other women and the men didn't agree, and gave as example that the US training course was given for men and women together and that it was very good.
Some training courses were provided at the right time, according to the needs of the health workers, but others were delayed and were provided too late to respond to needs. Almost all training courses, even external ones, were organized in an extreme hurry, within a short time, with the result that the health workers were not always informed in advance, so could not be ready on time.
Most of the training courses are organized in Kabul, which disrupts the staffs' daily activities as they have to spend a lot of time going back and forth. In addition, most of the staff, especially women, are not really happy about going to Kabul for training because of their family concerns and because of the fact that they need to find a Maharam.

Topics of AMI training sessions : One of the main complaints concerning topics was that they were frequently repeated. In the hospital, most of the time, topics were chosen according to the needs and the problems faced, as observed by the expatriates. When hospital health workers thought there was a need for training, it was first discussed in HMT meetings, and then it permission was asked for in Kabul. Generally, the Kabul office took their requests into consideration and the training courses asked for by hospital staff were provided. However, in clinics, it seems that nobody took into account the doctors' demands, even if a big demand was present. The lab technician seem to consider that his needs, and the requests that were identified during his training had been answered, as he had been included in some other training courses after few months.

All except the medical coordinator agreed that training courses were provided according to time of year and the pathologies prevalent in the area,. The medical coordinator disagreed, and gave as example, the training course about "control of diarrhoea diseases" that was planned by AMI in the summer but finally delayed until the winter, as well as the training course o, ARI that was planned in the summer. The clinic doctor never received a seasonal training.

Content of AMI training sessions : Group opinions were very different. Some people were very happy about some of the training courses provided (i.e. nutrition training, training courses provided by Elizabeth, training on surgery, training for the lab technician,…) because:

- they learned a lot of things
- the subject was diversified, complete and in accordance with the standards
- the training was adapted to the level of the trainees
- the training answered some questions

Other people, like the x-ray technician, were very unhappy about the training because :

- the level of the trainees was not taken into account, and sometimes the training was beyond or below the level of the trainees
- the trainees didn't learn anything new
- the trainees knew more about the subject than the trainer
- the subject was not complete enough
- the trainees didn't understand the trainer very well and needed more explanations
- the training was not at all practical
- the trainer only interpreted a course usually given in French to dari, without any adaptation to the context,…
- the trainer didn't consult the trainees about their needs

One of the negative points is that there is no follow-up after training to see if the trainees benefited from the training and and whether or not they practice what they learned. This was also mentioned by the medical coordinator. Refresher or updated training courses are never provided, except on the women's side where the female health worker who followed a training course always provides a summary of its contents for her colleagues (i.e. family planning).
Concerning the translation, there were no negative comments from the focus group; everything is well translated for the female workers and other health workers that don't speak English. The doctors say that they do not have a big need for translation. In contrast, the medical coordinator said that there were some problems regarding translation, as the trainer lacked time and knowledge for translation.There seemed to be no problems of contradiction between what different trainers presented.

Methodology of AMI training sessions : All participants and interviewees agreed on the fact that the methods used are good, diversified and updated: practical, theoretical, participatory, work group. However, delight doesn't seem to be a usual methodology for training. Charts and models are used as training material, but in the medical coordinator's opinion , this is not enough to provide a good training. Extra materials such as projector, clipboard, desk and chairs are necessary. The stationary provided by AMI was good. According to the lab technician, another good method for training is to provide a test for the before and/or after the training so as to evaluate their knowledge.

Moreover, some people mentioned that the quality of the trainers was not that good since most of the time they are new in the country or in their position, or they are not real trainers and do not have much knowledge and experience about training. The training courses should be organized by special trainers. All men and women agreed on the fact that Elizabeth was a very good trainer because :

- she was living in Mehterlam, for a long time, and knew the people and the area very well
- she was always present, day and night, working hard in the hospital
- she was on friendly terms with the staff
- she observed and trained the health workers onthe-job
- she did training courses over long periods of time
- she used good teaching material and was responsible for buying the material she needed
- she was very motivated

Type of training preferred : All agreed on preference for practical training courses, especially on-the-job training, inside the hospital, as it is: permanent, more effective, can train more people at the same time and is more easy to follow-up on. The doctor of the clinic added that the hospital is a better place for training than the clinic, because the level of the clinic is lower. The lab technician agreed but added that training courses should be both practical and theoretical (i.e. training in the central laboratory of Kabul, with practical work in Mehterlam and Baraki), and organized in groups so as to make the most of the questions of the others.

Usually, people prefer when training courses are organized inside the hospital, but by external trainers. This is confirmed by the medical coordinator because AMI doesn't have a specific training location and when the training is given in the office, it disturbs the daily activities of the staff working there.
According to the medical coordinator, short training courses are not efficient because they cannot completely cover a topic due to lack of time. The lab technician added that short duration courses are not enough to resolve all questions and problems, but that long-term training courses are too long. The ideal duration of training should be over 20 – 30 days.

Opinion on training courses provided by other organizations : Six out of the 8 people present participated in training courses or workshops given by other organizations: control of diarrhoea diseases, ARI, HIS, SMI and malaria (except for two assistant midwives who did not take part). They said that, apart from the training provided by Serve, they were good and effective courses which they got a lot out of , because:

- they complemented AMI training
- they included new things
- they were carried out in accordance with the international standards
- they answered to our needs

The three disadvantages of these kinds of training were cited as being:
- there were some problems concerning food and transportation (accommodation, however, was good)
- they were organized outside the hospital and so did not have a practical side
- they did not answer to the real needs of the staff because did not identify the problems on the field in advance

For these reasons, some people preferred AMI trainings, or at least training organized by other organizations, within the hospital (e.g.. training provided by the WHO). Indeed, as it is not possible for AMI to run all the training courses, it is a good idea to collaborate with other NGO's for training.

Suggestions for improvement of the training program for each category of health workers

- The health workers of the hospital should receive technical training on new subjects or about how to solve some of the specific problems that they encounter. Of course, these training courses must be adapted to the level of the participants. If possible, they cover a longer period of time, although not exceeding 20-30 days.
- In case not all the health workers of a department can take part in training, AMI should occasionally select trainees that already have basic knowledge of the topic, rather than new trainees who do not know anything about the subject. (e.g. US training held in Peshawar).
- The location of the training should be easily accessible to everyone, and should not be fixed, in order to learn different things in different places.
- More new topics should be covered
- Training courses should always start at a basic (initial training) level and be followed by refresher courses. Every year, there should be a series of refresher courses provided for each department (x-ray, laboratory, surgery, nursing, pediatrics, etc…).

21 staff from the hospital and clinics (more or less 40% of the staff), were asked to list all the training courses they had received since the end of the Taliban government (October 2001 ; 2 years ago). The results showed that very few training courses were provided for the staff, especially for nurses and assistant midwives, and that 38% of the staff did not receive any training over 2 years.

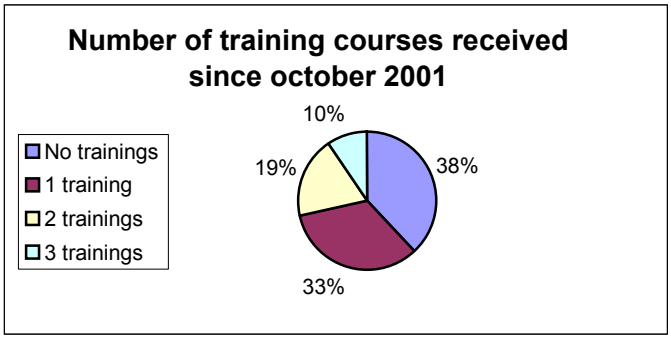

Figure 5: Number of training courses received by the staff since October 2001– Mehterlam, November 2003

	No courses	1 course	2 courses	3 courses	Nb of interviewees
Male doctor	1	1	3	1	**6**
Nurse	3	2	0	0	**5**
Female doctor	0	1	0	0	**1**
Midwife	0	0	1	0	**1**
Assistant midwife	3	1	0	0	**4**
Coordination team	0	2	0	0	**2**
Others	1	0	0	1	**2**
Total	**8**	**7**	**4**	**2**	**21**

Table 6: Number of training courses received for each category of staff since October 2001– Mehterlam, November 2003

Health workers utilization of training sessions archives

In the library of Mehterlam hospital, a plastic covered file of about 20 pages is used as a registration book, with separate pages for each department. On each page is written: the name or title, the quantity, the number or code, the editor and the date of publication of each book. Concerning AMI documents, it seems that they were not registered in this file, except for MTA (Medical training for Afghans) documents, for which a single page was used. On this page, 3 documents were registered: basic training (7 copies), refresher training (2) and pharmacology training (7), but these documents were not found in the library. Another book is given over to recording all books that are borrowed by staff members. From early July up to early November, 12 staff members borrowed books, which gives an average of 3 books borrowed a month.
All books are archived in a large cupboard with different boxes covered by sliding lids. At the corner of each sliding glass lid the types of books to be found in the box are listed, but AMI documents or Salamati magazines were not mentioned anywhere. However, some AMI training courses (e.g. workshop report on "rational use of drugs",…) and many Salamati magazines were found inside the cupboard, but were not registered.

There are 2 keys for the library: 1 kept by the director, and 1 kept by the library manager, which is shared among the doctors on duty.

Recording and use of the books in the library : The library manager registers all new books in the registration book, according to the department they belong to. However, it seems that this registration book was never revised or updated. If Salamati magazines were not registered in the register, it is because the library manager never received any copies directly since his arrival, and some people put them in library without informing him.

Around 15-20 staff members (+/- 50%) consult books in library: the majority are doctors, then nurses and sometimes pharmacists, but all of them are men! When a book is borrowed from the library, people have to write their name as well as the name of the book they are borrowing in a special register. The time of borrowing varies from 2-3 days up to one month, depending on the length of the book.
The library manager didn't know the rule in case of book loss, but his idea was that the person who lost it should pay for it. He also complained about the fact that he never received any training about library management.

Organization and use of AMI training archives in the hospital : Regarding AMI training documents, the library manager does not seem to be aware of their existence since he never received any training document from anybody and never saw anybody using one. According to him, no training had been provided for the staff since his arrival 6 months ago, except training on nutrition. The doctor who took part in this training transmitted the information he learnt in a seminar with his colleagues, but no document was presented to the library. Indeed, training documents are generally distributed to the participants, but copies are not provided for library.

Accessibility of library for women : The library is situated in a building accessible for women, the same one which houses the director's office where they go regularly. The library is also a comfortable place for them, because it is furnished with tables and chairs, and contains many books about women's health (e.g. gynaecology, obstetrics, TBA,…), which exist in translation. Nevertheless, the library manager has never seen any women entering the library. He assumed that there was no interest on their part or that they already had the books they needed in their ward or at home.

Suggestions for improvement of the use of the AMI archives in the future

- The manager should receive new books or documents straight from the director, register them and organize them immediately.
- All staff should be kept regularly informed as to the availability of new books or documents, individually or as a group (meetings with all the staff to discuss the use of library and answer their questions).
- Several copies of each training document should be available.

Exemption schemes

Community participation

Attitude of people with regards to community participation : They are agreed with the community taking part in the exemption system and they see it as their responsibility, according them this is very important. It was felt that community participation is important and the community has to help them because they are from the same community. Community participation is very important. Without the community's help, they cannot help the poorest people properly.
Community help to the poor : The idea that the community has to help is fully accepted, since in any case some people have very little and do not have a choice. In their experience, community assistance is well accepted, as those living in the same village form a fraternity. It is also culturally accepted that it is the responsibility of the wealthier members of the community to help its poorer members.
Problems in community participation : According to the community members, they have not been getting more involved in this system as yet, but this is not a major problem. Meetings are organised and the information on the project is available, although at present, there is no organised structure for community help, the latter revolving mainly around assistance with transportation. The community is not fully involved in this system, but is not opposed to involvement.
Local exemption system : As mentioned, there is no specific programme of community help, although sometimes, they help the poorest who have to travel (help with transport). There is no local system at community level.
The community's role in exemption : The community does not play a special role in the exemption system, but their role could be to present its poorest members to the clinic, provide transportation and collect money for the programme and treatment of its poorest members (which they were ready to do).
Community involvement in exemption : In cases where and HC meeting is set up, community involvement can be organised.
Finding a solution to treating the poorest members of the community: In terms of solving the difficulties of the poorest people, the only solution that has been found to date is the handing out of free medication.
Barriers in explanation of the exemption system to the community : Despite there being no obvious barrier to the community members understanding the system, no-one had thought of actually explaining it to them.

Identification of people in need

Identification of people in need: It is difficult to identify poor people during consultation.When a doctor is taking the patient's case-history, s/he is also asking about their social life to determine their standard of living. If a patient is too poor to pay for medication, the doctor will specify on the prescription that it should be given free. The director can also ask patients about their family background, employment and property status, to determine whether or not they qualify for free health services. Sometimes, they may be identified as poor by other hospital staff, or if they were referred by the health committee, MoH or local authorities. Sometimes during the consultation, patients argue that because they have no money, the doctor should give them free treatment, otherwise they will have to go all the way home empty-handed. In that case, doctors will probe further into the patient's circumstances: too poor to pay, widowed, orphaned, jobless, no land or other source of income. Another criterion may be the doctor's own judgment about the patient's level of poverty. Occasionally, hospital staff, MoH or local authorities know the patients and can introduce them to the hospital director. As mentioned previously, they may also be referred to the hospital directly by the community or local authorities. .

Role of the community : There is no guaranteed help and cooperation from community, but occasionally some poor people have a letter of introduction from health committee members. There is very little contact with the community. Those interviewed were not happy with the role the community played, although they thought it could play a very important and positive role in this area.
Identification problems : The main problem is that it is extremely difficult to identify poor people, especially as they often give false information. Most of the people resort to lying and there is no standard or protocol for identification. Hospital staff do not know all of the patients, and most people present themselves as being poor.
Availability of AMI protocols : There is no particular protocol on the AMI front.
Other sources of information : Information is received from the doctors, MoH officials, hospital staff. Occasionally, the health committee or local authorities also give information about the poor.
Staff Involvement: The doctor decides during consultation whether or not a patient should pay for treatment. They may also glean information from other hospital staff who may know the patient under consideration.
Role of the MoH : The MoH has no specific role as there is not protocol in this area. However, they sometimes provide patients with an official letter of introduction.
Their attitude towards exemption : Exemption is generally considered a good idea since some people are extremely poor and in dire need of help (e.g. some patients do not even have one AFS to pay, and risk dying if they do not get free treatment). Also, most of the the poor people do not come to hospital because they know that they will not be able to pay, contenting themselves with local treatment only. They come to the hospital as a last resort (when their affliction is at a very advanced stage) and because of this it is often no longer possible to treat them effectively. If they were made aware of the exemption scheme, they would come to the hospital at an early stage in their affliction. This system is compulsory in every health facility as health is very important and as most people do not have enough money to pay for health services. Added to this is the fact that hospital treatment used to be free, and this is a newly established system to enable health services to generate income. In this sense, exemption is a good system to help people who can simply not afford to pay for health services.

Implementation of the exemption system

Problems in implementing the exemption system : The first problem is identifying the poor people and the second problem is that, when prescription drugs are given for free, other people start to ask for free medicine. The main problem is with armed people, governmental staff and people who are introduced by the MoH. In the case of people who are armed, they are obliged to provide free medication otherwise they risk getting shot. Governmental staff always come with an official recommendation, and MoH also send people with recommendation letters for free treatment. It is hard to find genuinely entitled people or poor people.
The influence of armed people on the exemption sys tem : All armed people take free medicine and all of the services are free of charge for them. They obtain this through their use of force and staff are obliged to treat them.
Community's role in : The community contributes to solving this problem by holding an HC meeting with village elders. Whenever they face a problem they call HC. During the meeting they discuss the problem, but in the case of armed people, there is nothing the community can do. The role of community is very important in introducing poor people to staff and also in asking that those who are not entitled or armed not to demand free prescription drugs. But they have not yet played any role in this regard, and aside from directly referring some of the poor people, the community lacks the power it needs to take action for that purpose.
Role of AMI in this system : The role of AMI is to establish a standard system and to ensure (through supervision) that it works. It should also prepare a clear protocol and reduce costs. According to AMI, free medication should not be distributed although they accept this is difficult.

Currently, AMI does not play a particular role, although it is only on the basis of AMI's recommendation that prescription drugs are free for those in need.

Role of local authorities in case of problem : The local authorities are indifferent in this case and even say that the clinic has to provide free medicine for armed people. The local authorities play an important role, since they can refer poor people to the hospital and stop armed people from demanding free medicine. Unfortunately, the local authorities often find reasons to reject letters of recommendation, and ask for free health services for themselves. According to the people interviewed, the local authorities have done not really provided any solutions. The armed people who demand free health services work are affiliated to the local authorities, so should the latter really wish to do so, they could reduce the number of demands by 70%.

MoH opinion of the exemption system : Following a period of observation, the MoH director stated that whilst the exemption scheme was a good idea, the role MoH should play in MOH supported the idea of free health services for people. Furthermore, it has the necessary skills for implementation of the scheme. Patients who have an MOH recommendation letter can receive free prescription drugs.

Compensation for loss of money incurred through exemption: When they lose money by exemption this affects their budget, so in this case they require more money from AMI to cover their spending. They cannot compensate it but AMI gives them the full budget for every month via the Administration office. AMI has a regular monthly budget line, according to which the hospital receives the full sum each month and they were never faced with budget shortages of any kind. All expenses in relation to the hospital are provided by AMI.

Regarding those who do qualify for exemption : In cases where people ask for exemption and are not qualified, the role of AMI is explained to them and they are informed that exemption concerns only those who are extremely poor and in need. People who do not qualify as 'poor' also ask for free medication when they are sickly and if they are not government representatives they are told they do not qualify and are charged for treatment. When people who do not qualify for free health services ask for free treatment, the advantages of the system are explained to them. All possible beneficiaries now know of its existence.

Comparison with other clinics : According to them some of the clinics are giving free services and some of them are charging very similar rates, but they prefer the AMI scheme because it is in between the two. tIn comparison with other health facilities the AMI exemption system is good but they have to decrease their charge 50%. In Mehterlam hospital, they emphasized the point that exemption only concerned the poorest people, and that other health facilities run by NGO's there was no exemption system.

Registration of exempt patients : They is a special register for exemption in each department. When free treatment or services are proffered, it is recorded and at the end of the month they report to the director of the hospital. They have a registration book in all OPD and each doctor has the right to prescribe free medicine if he judges that a patient is poor. On the other side of the prescription sheets is a list of all drugs provided free by AMI (the doctor must simply specify on the prescription that medication is free). Doctors also fill out income sheets provided by the AMI office on a weekly basis, and this sheet is very clear. Doctors register all free prescriptions in the registration book, and along with the income sheets, they can establish how many patients have received free medication.

Reporting of exempt patients : At the end of each month when they receive the income report form from each department, the Administrator fills out the income generation sheet and sends the report with the income generation sheet to the AMI Administration department. Their Administrator fills out income sheets on a daily or weekly basis and passes it on to the AMI office. Since income reports are sent each month to the AMI regional office, they are an effective means of determining how many patients obtained free treatment and how many had to pay.

Supervision of exemption scheme : Since there is a specific register for exempt patients, the hospital records can be cross-checked with the Administration department's reports when the suypervision team comes to the clinic. The exemption scheme is under regular supervision, the

Administrator reporting to the AMI office and the medical supervisor checking registration book and prescriptions. The exemption scheme is always supervised by both AMI Administration and the Medical department.

Management of health facilities

Cost recovery system

Importance of cost recovery system : As a result we considered that, this system is important and fully acceptable system, since the health services would lose their value were everything to be given free of charge. Everybody, whether or not they are ill, wants a check-up and asks for medicine. This represents a waste of time and resources. It is also an important factor for the sustainability of our program. The money can also go towards solving the clinic's minor problems. Some people nevertheless pointed out that some people are too poor to be able to afford even a small charge.

Prices of the health services : The OPD fee was 2AFs, laboratory was 5AFs and the prescription drug was sold at 40% of the real price. However, within the community, no-one was certain of the exact costs, although the prices mentioned above are those that were generally mentioned to us.

Affordability of health services: As a result, we found that existing prices were generally affordable for people and were valid prices. Setting the price at 40% of the standard price is also viable, although for a few people even these prices remain unaffordable.

Income generation system: There are standard prices for each service, for example: for an OPD they have ticket book and a 2 AFs charge, for laboratory they have a special register and a 5 AFs charge. The prescription drug is also sold at 40%. . Each department sends their income at the end of work to the director of the clinic and to the hospital administrator.. For collection of this money, there was a special form to fill in at the end of the month. The director collects all of the money as per the register and then he fills in form and sends it to the central administrator.

Use of the income money : They use this income to pay for staff meals and fuel but not for other logistic purposes. In the community, the HC do not know anything about how the money was spent to date.

Drug price list : They find the drug price list at the next local market. And they renew their drug price list every two months and sell the drug at 40% of the market price.

Role of AMI : This standard system and the specified prices have been organized by AMI AMI has special form for reporting under this system and they supervise, collect and manage the expenditure of money. AMI has to ask the community about use of this money and they should spend this money to treat poor people and for transportation of patients.

Cost recovery system of AMI : The cost recovery system established by AMI is feasible and acceptable for them as well as for the community members, the existing system is good. They added that AMI should spend this money to treat very poor people in the community. Two people mentioned that AMI should reduce the costs.

Role of MoH : MoH has not paid any role in this system but the MoH director studied the prices agreed with them.

Role of the director in the cost recovery system : The director collects this money very honestly and gives the report to his office. The director knows better about the needs of the clinic and he would spend the funds to cover these urgent needs.

The community said that the income should be spent in the following ways: For treatment of poor people, transportation of poor patients and urgent cases, construction of the clinic, buying medication, expenditures of the clinic staff. AMI has to constantly supervise the way the money is collected and spent. AMI must spend this money correctly and ask the doctor about collection of this money.

HMT &HC meeting

Importance of HMT & HC meeting : According to the people interviewed and those who participated in a focus group HMT/HC are very important. The members of HMT and HC are all representatives of the hospital and make decisions together, rather than each director taking a decision based only on his own judgment. A democratic vote is taken, rather than a single person imposing a decision. The meetings serve to highlight the problems that may have come up

between the different parties involved. It is a good reference for solving hospital and clinic-related problems and they believe a good HMT could manage the hospital very well. They agreed that theHC meeting is important because it creates a bridge between hospital and clinic. It therefore acts a form of co-operation, important in solving problems related to security or other issues. And they added that it is a source of information about activities of the program for people. HC are helping them in solving their problems and making up their work plan. They educate the HC members in matters of health, who pass on what they have learned to the community.

Agenda of HMT/HC meeting: this is the agenda discussed during the HMT/HC meeting. In HMT: All of the problems regarding staff and activities, which is collected by the department representative and presented to HMT as an agenda, holidays, duties, salary and employment needs, problems faced by the staff at work , work schedule and night duty etc.

In HC: rehabilitation of the clinic, security of the clinic, epidemiology of diseases, drug use, malnutrition, mosquito nets, patient layout and either the problems of clinic staff with community or problems of the people with clinic staff, health education for people, information on the role and rules of AMI, how to prevent problems from occurring, to inform them on clinic fees and the cost recovery system, clinic security, a plan of treatment (who requires medication and who does not).

HMT/HC report : According to the directors, AMI has demanded reports from them; they had sent two copies of their report to AMI, one to Mehterlam base and one to Kabul. They continue to send them to this day. They have sent the report with full details. Recently, the AMI office has sent the new format for the HMT/HC report and they fill it in and send it.

Members of HMT/HC meeting : The HMT meeting was established at the time when Dr. Georgi was head of mission and Dr. Nadir was medical coordinator. The HMT board was made up of: the Director, Deputy director (who was not available), the Administrator, the Head nurse, an expatriate and supervisor as an observer. Then in 2001 the this was extended to include a female representative and a representative of doctors included in HMT. The HC board consists of the hospital director and a representative from each big village. The existing structure is better and they suggested that Mollas from the mosque be involved in this committee, because they are much appreciated by the people and they are good preachers, and medical services should be free for the Mollas. They also said that medical practitioners in the villages (if any) should be involved as they know a lot more health. The members' of the meeting must be selected by the people and they should be selected from big villages rather than from each small village. People should trust them and they have to be governed by the themselves. It was added that the current number is enough and there is agreement on the current organization.

Availability of participants in HMT/HC meeting : All members of the meeting are available for each meeting, except in cases of illness, or when they cannot be present for other reasons. .

Difficulties in organizing the HMT/HC meetings : The main problem is with the MoH. They want to have their own representative in HMT meetings and prevent meetings being held in cases where bad conditions (e.g lack of security, or during the fall of the Taliban regime, when some of the HMT members escaped) mean that they cannot be present.

Generally, there is no problem to organize HC meetings but one problem was the absence of lunch, because most of the village representatives come from remote villages and had to travel a long distance. They therefore decided to hold the meeting in the afternoon. It is sometimes difficult to inform people from remote villages about the meetings.

Number of HMT/HC meetings : Previously, the HMT meetings took place on a weekly basis, but now they organize a meeting every two weeks. An emergency meeting can also be called if need be. The health committee meeting is organized every couple of months but in some emergency cases they organize the meeting each month. The HC members said that the meeting is organized after 15days or one month but they could not recall the dates.

Role of HMT/HC in management of health services : As we were able to establish, the HMT plays a very important role in management, especially in medical services. They solve all of medical, logistic problems by HMT, duty schedule of doctors in OPD and IPD is prepared in HMT.

The role of health committee is to deal with security and to solve the clinic's community-based problems and to ensure that the rules and regulations of the clinic are observed.

Acceptation of HMT/HC decisions : According to our information, the directors and members in the meeting respect all of the decisions made by HMT/HC, but they complain against AMI because AMI has not observed the HMT decisions. AMI is indifferent to the HMT decisions, for example: they had a suggestion on the health committee side to reduce the hospital charges and in HMT it was decided to reduce it. The report was sent to AMI. AMI did not take into account the decision and consequently the health committee decided not to come to the meetings. But the decisions made in the HC meeting are implemented and respected first by the clinic director and then by the AMI office, for example: the transfer of Dr. Ghulam-Ahmmad from Kanda.

Involvement of participants in HMT/HC meetings : In order to involve the members, they have created a democratic space where ideas can be openly expressed. They have convinced the members that HMT/HC is not there to deal with private problems and encouraged the staff to take part. They explain their responsibilities and the importance of the meeting to them and motivate them. They are first summoned to a meeting. People did not really know how to answer this question, despite giving them as many details and examples to illustrate the question. Some of the things they said in answer to the question were: "It is our desire to work", "This is our job", or again "We come to solve our problems."

HMT decisions : According to the AMI curriculum that they have already received, the HMT take decisions about all kinds of problems, medical and non-medical. These include: staff needs, , salary and overtime, buying equipment, timetables and night duty schedule. There is a buying committee and purchasing committee in their HMT. In HC meetings they make the following decisions: transport of emergency cases to hospital (the community has to provide the car), security issues, problem solving, disease control, health education, monitoring staff attitude, patient layout , improvement of the activities, recruiting a female doctor, Re-location of the clinic (the community dedicated the land).

Dynamic of HMT/HC members : According our findings all of HMT/HC members are active and energetic and they are doing interesting work. However, the post of deputy director was removed by AMI and the deputy director resigned from HMT. We found that, the participants of HC meeting are very dynamic and active. If someone does not know something, they specific task is designed for them to enable them to learn how to do it.

Implementation of HMT/HC decisions : The directors had implemented almost all of the decisions but they had a number of problems. For example, sometimes they take a decision but MoH does not agree with their decisions and will give the reasons for their lack of involvement in it. Sometime AMI and the staff also refuse some of their decisions. When the decision is legal, there is no problem for its implementation.

Procedure of decision-making in HMT : The procedure is that, at every meeting each representative adds the problems, suggestions and needs they wish to discuss on the order of the day (meeting agenda). The agenda is then taken up point by point, in order of priority, and if most participants agree they vote on it as outlined in the AMI specifications. Expatriates and the national supervisor can make suggestions but they do not have vote and are not involved in decision-making. In HC they begin by discussing everybody's agendas. They then pass a vote and make their decision accordingly. Decisions are made in a democratic atmosphere; there is no pressure from the director, local commanders or village elders. The directors suggested that in order to keep the dynamic instigated by HMT/HC members they need to do the following things: Motivation and encouragement of staff, listening to their problem, giving everybody a chance to express their idea, assure them that the decision will be carried through. The hospital director wishes to include a representative of each department on the HMT. In the community, the people want to involve the mollas in the health committee meetings.

Supervision

Importance of supervision : According to those interviewed, supervision by an AMI coordination team is very important. They believe that with supervision they can complete their work in a different way if there are problems or difficulties. v Supervision helps them in running the program and this acts as a kind of motivation for them. They believe that lot of negative and positive aspects of work can be determined by the supervision process. Supervision should help to make the positive points act as encouragements whilst pushing to change the negative points. Regular supervision means that the activities can be successfully implemented (and defects spotted), work results will be made visible, needs can be properly assessed and communication improved.

Procedure of supervision : During the interviews we found that, although supervision by expatriates is always irregular, it is carried out on a regular basis by the national staff. Whoever carries out a supervision first presents their schedule to the hospital director and the heads of each department. After which, they may supervise the activities in turn of the OPD, IPD, delivery room, lab, x-ray and all of the program according to their proposal. They sometimes also directly supervise different parts of the hospital. However, after supervision, the director is not always made aware of the negative points picked up. Some of the expatriates without any particular responsibility supervise each department. For example: when the logistics coordinator came, he was supposed to supervise logistics, but also interfered in medical issues etc.

Rate of supervision : Those interviewed said that expatriate supervision was not regular and was not enough because most of the time expatriates did not come to the hospital but local staff supervision was regular and therefore quite enough in their opinion. Local supervision give satisfactory results. Generally, they all felt that the current rate of supervision was sufficient.

Expatriate and locals supervision : Most of them prefer local supervisors because they can understand each other easily. They know their culture, and it is very easy for them to communicate and speak in their own language. The local supervisors can easily recognize problems, determine solutions and can give the better instructions, because they know everybody and the environment very well. It was felt that the main problem with the local supervisor is that they have not got the competence to take decisions and the main office does not listen to their view as much as they listen to expatriates. Some people prefer expat supervisors because they are competent and decision makers and can solve problems immediately. Some of them have no preference either way.

Discerning problems : We found that the supervisors have listened to their problems very well. They witnessed the problems directly, and asked the director, head of each department and everybody concerned about the difficulties that they face in undertaking their work. The supervisors observed the work directly and discerned the problems on site. And also the supervisors have observed the work and found out their problems.

Feed back from supervision : Most of the time there is feedback from supervisions but sometimes there is long delay, especially when something is referred to the Kabul office even to an expatriate. The main problem with local supervisors is that they have not got the competence to take decisions and the Kabul office and expatriates do not take their views into account.

Timetable of supervision : Expatriate supervision is rare and during the current year there have only been two such . Local supervisors on the other hand come two or three times a week in the Laghman province. In Kunar they had 1-2 supervisions of their activities per month by the AMI coordination team.

Expectations of the supervision process : The general expectation was that supervision should take place on a regular basis, be comprehensive and clear, respectful of culture, any problems detected should be solved straight away and the supervisors should pass on the information to the main office. They assumed that through supervision, they would have a regular supply of medication and materials. Supervision is seen as something which should be co-operative and helpful, with the aim of improving work. They expect the positive and negative aspects of their work to be pointed out to them during supervision. Once a problem is detected, it is the supervisor's role to give direction in a co-operative way. AMI should select wise, experienced and hard-working people. Also, they would like to have at least one expatriate supervision each month.

Women's health

Pregnant women use of ANC/PNC to the Health Facilities and TBAs

A number of women stated as reasons for visiting the clinic: in case of illness to get medication, to go for a check-up, identify the stage of their pregnancy, check vital organs, for vaccination and to monitor the health of their foetus. Fewer of them said they came to the clinic at the onset of labour, or following delivery in case of complications, or to vaccinate a baby after birth. Some women could not come at all because they lived too far away, or their family didn't wish them to go or through lack of awareness. TBAs were happy about AMI's supervision and said that their work plays an important role in avoiding complications during pregnancy and in reducing maternal mortality rates. However, they mentioned that education and literacy are also important in these respects.

The five key points are :

- Most of the women are coming for ANC/PNC from nearby places;
- Main constraints to visits being: distance, transport problems, pressure from the family and tradition due to lack of awareness;
- Important role of TBAs;
- Unequal delays depending on education and awareness;
- Satisfaction regarding the service but not for the availability of female staff, especially in clinics.

Utilization of Family planning

Few women (an average of 40 persons in different ages) are using Family Planning (FP). In particular, those women who have already had children (one or more) use FP temporarily or permanently. They use it when they have another child or because of economical problems. Most of them use an oral contraceptive (pills) and some of them use injectable (Depo-Provera) contraception, but most educated women, who work outside their homes (offices or schools), use the IUD method.

Methods	Oral	Injectable	Condom	IUD	Total/year
2002	67	45	22	2	136
2003	197	183	36	2	418
Total	264	228	58	4	554
%	**47,65%**	**41,16%**	**10,47%**	**0,72%**	**100,00%**

Table 7: Family Planning Methods Utilization in 2002 and 2003 in Mehterlam Hospital

The main problems they face are lack of information and awareness concerning FP, family or traditional limitations and transportation difficulties (because of living far away). Regarding the relationship between Islam and FP there were a variety of opinions. Most people said contraception is considered a grave sin according to Islam but a few of them said that it didn't make any difference because it had to be done. They were satisfied with FP services and the different methods which AMI offers.

The five key points are :

- Few number of women actually using FP;
- Tablets and injections are more frequently used than other methods;
- Family and traditional restrictions are important constraints;
- There is no agreement among women on the relationship between Islam and FP;
- Women lack awareness as to FP.

Safety of deliveries

Regarding the safety of deliveries, we have seen that vital signs, FHS were checked as well as abdominal and vaginal examination. The asepsis and antisepsis was respected by staff and the hygiene was good but cleanliness and temperature of delivery room was not good. The partograph was filled in for every patient, they behaved well with the patient, the delivery process was well conducted and women were satisfied with the delivery services. The supervision by the hospital director and AMI supervisor should be carried out , however an obvious problem was the lack of chlorine.

The five key points are :

- Good preparation for deliveries;
- Delivery process well conducted;
- Cleanliness (absence of chlorine) and temperature of delivery room was not appropriate;
- Sufficient medical material;
- Not enough attention given to some newborn.

Women's Health education

Organization of Women's Health Education

Women mentioned that HE is useful and they were happy with the health educator who tried to involve the beneficiaries in the session by asking those questions. The main problem is lack/absence of an allocated space, lack of which means sessions are often interrupted. In addition to existing topics women, request more topics with long enough sessions to be able to deal with obstetrical problems such as irregular bleeding, stage of pregnancy and death of the foetus. Women prefer practical HE in order to teach other women and members of their families when they return home. The program was adapted in accordance with the seasons, but they do not use a proper methodology and do not speak in and Pashaiee, which is the language one spoken by most of the patients in the hospital. The Administration office was involved in the selection of topics. We noted lack of materials, especially practical ones.

The four key points are :

- Health education is conducted, but due to absence of allocated space are often interrupted.
- Women are happy with the topics but request longer sessions and extra topics on obstetrics.
- Diversified material but insufficient amount thereof.
- Simple language is not enough used and Pashai is not used at all .

4. LESSONS LEARNED

Curative care

Following AMI protocols and guidelines

According to the participants:

- MoH should provide protocols to all health facilities, in order to be understandable for all and used all over the country, as a standard. They should also be accompanied by training courses, provided by MoH or by the implementing partner.
- More training on protocols should be provided for the hospital of Mehterlam, because it is a provincial hospital.
- The training programs on protocols should be more adapted to the level and the knowledge of the staff.
- The training topics should be chosen together with the staff, in order to answer to their needs and they should include training on new protocols : pathologies which are not well known to the doctors (i.e. rheumatic fever, cardiology, ECG, kidney pathology, etc…) and new nursing techniques for the nurses.
- More advanced training should be provided in foreign countries (i.e. France, Pakistan), especially on pediatrics.
- At least one doctor should be trained for each specialization.
- All training courses should be provided by specialists or by more qualified trainers, and not by general practitioners, in order to be more complete and to be sure that the level of the trainer is higher than that of the trainee
- Training courses need to be frequently reviewed and updated in order to keep up with new developments in medicine as changes in Afghanistan. Modifications in protocols should be identified by the coordination team, and staff should be kept informed of these changes.
- Documents with protocols and resume of trainings should be bound together and provided to all participants, with one extra copy for the library.
- Expatriates should come to the hospital more often to supervise the implementation and follow-up of the protocols.

According to the evaluators:

- AMI should provide some protocols to the doctors to be observed by everyone, in order to:
  - facilitate the decision concerning treatment of the patients
  - insure proper management of the patients
  - insure joint management of the patients
  - facilitate the work of the supervisor
- Protocols should be discussed with field workers and finalized jointly during workshops.
- Protocols should be identified and developed for each medical department and all types of health services (primary health care and secondary health care)
- AMI should have a clear strategy for the implementation and use of protocols developed and provided by other organizations
- To keep a copy of all the protocols in the hospital, clinics and main office.

AMI management for follow-up of patients

Concerning the health passport

- should be free, in order to be accessible for everyone
- the number of pages inside should be increased
- the pages should be lined
- the pages should contain a framework (like ANC cards or previous prescriptions of AMI) or a stamp, with some information to be filled in (i.e. date, blood pressure, pulse, respiratory rate, weight, diagnosis, treatment, etc…) In this way, the health passport will be easier to fill in and this will save time. It will help the health workers to remember to write down some important points. It will also look more "official" and the patient will become aware of the importance of this tool.

Concerning the ANC card

- should be reviewed because there is a lack of space for some questions and some questions that patients cannot answer
- should be shorter to take less time

Concerning both health passport and ANC card

- should be readily available (no stock shortages), in sufficient quantity, supplied regularly and on time.
- there should be copies: one to be kept by the patient, and one kept in the clinic. In this case, a special cupboard should be organized for that purpose and to keep them in good condition. This will increase the workload, but it is a necessary measure.

Concerning general management

- there should be some tools like the health passport and ANC card for every type of medical activity, in order to manage the activities
- there should be a midwife in all the clinics for follow-up of the pregnant women
- there should be better management within the team working daily with women, to keep their ANC card in the right place (inside a cupboard and not on the desk) so as to recover it easily.
- there should be a separate card or registration book for chronic diseases, to be kept in the clinic, alongside pre-existing tools
- patients should receive more HE in order to be aware of the importance of ng-monitoring certain diseases. There should also be some awareness-raising programs on radio or television about the importance of the follow-up process.
- there should be more follow-up in the villages (i.e. dahias for follow-up of PW, home visitors for malnourished children, CHW, etc…) in order to determine if the treatment is administered correctly and how the patient is responding.
- every month, the card should be reviewed or re-checked, to detect defaulter patients, and to send a TBA or home visitor to check them at home. For this, AMI should recruit and train new female health workers or TBAs and provide them with transportation.
- AMI should re-initiate nutrition programs as people are not properly following the nutrition education guidelines. If no food is distributed to moderately malnourished patients, they run the risk of fast becoming severely malnourished.

Patients satisfied with the curative care services provided by the health facilities

- In case of necessity or a big problem with the patient, the hospital should allow men to enter the female ward. When the patient cannot leave their bed, the men should be allowed to do a short visit
- Clinics should be built in an official or public place with open and free access areas, so as to allow people to come and go without any problem.
- There should be two separate consulting rooms, one for women and one for men, even if there is only one male doctor to examine all of them. According to the men, a female doctor is not really necessary, but a female consultation room is. If this is not possible, there should be at least 2 examination beds in the room.
- Staff numbers are insufficient and should be increased. If there could be a female health worker in the clinic, it would be better, because she would be able to treat women's diseases more thoroughly. An extra doctor, preferably a woman, should be recruited by the clinic to reduce the number of patients the doctor has to deal with. According to women, this new doctor should be a pediatrician, because children and adults are examined by the same doctor. Men also asked for a lab technician in the clinic.
- The supply and distribution of prescription drugs should be controlled by expatriates and not by local staff
- The general opinion is that prescription drugs should be free and accessible to everybody
- There should also be a doctor on duty in the afternoon and at night in the clinics.

Training

AMI training program

- To be satisfactory, the hospital health workers should receive technical trainings about new subjects or about how to deal more effectively with some of the problems that they have. Of course, the training must be in accordance with the level of the participants. If possible, they should last longer, not exceeding 20-30.
- In case not all the health workers of a department can take part in the training, AMI should occasionally select trainees that already have basic knowledge of the topic in question, instead of new trainees who do not know anything about the subject. (e.g. US training held in Peshawar).
- The location of the training should be easily accessible for everyone, and should be varied, in order to learn different things from different places.
- There should be more new topics covered.
- According to the group, training courses should always begin at a basic level (initial training) to be updated by refresher courses. Each year, there should be a number of refresher courses offered to each department (x-ray, laboratory, surgery, nursing, pediatrics, etc…).

Utilization of the written materials produced for training sessions

- The manager should receive new books or documents straight from the director, register them and organize them upon receipt.
- All staff should be kept regularly informed as to the availability of new books or documents, individually or as a group (meetings with all the staff to discuss use of library and answer their questions).
- Several copies of each training document should be available.

Exemption schemes :

- The community should be involved in the exemption system, kept informed about the system and we need to improve the sense of solidarity in the community.
- It is important to establish a clear exemption protocol developed in collaboration between AMI, MoH and the community.
- The community needs to be the key element in identification of the poor and needy.

- Improve the coordination with other partners and authorities in the province. Implement a monitoring system.

Management of health facilities :

- All departments need to be involved in the HMT by an elected member in addition to the director, administrator and MoH representative.
- AMI has to provide systematic feed-back to the HMT propositions.
- To review and clarify the HMT mandate.
- The current cost recovery system is working well and needs to be utilized to increase the access to health care of the poorest.
- AMI could be a partner for MoH in formulating the national health financing policy.
- Continue the current system of supervision carried by local staff, but grant them more decision-making capacities and improve their feed-back practices.
- Increase the number of supervisions carried out by expatriates.

Women's health

- Recruit female staff for clinics and improve the network of TBAs.
- Raise awareness of families regarding the importance of ANC/PNC.
- Increase the geographical accessibility of HF for women.
- Raise awareness through health education in clinics, in media, in villages...
- Establish a specific FP room in each HF with appropriate and skilled staff and material.
- Involvement of male staff in FP activities for men.
- Continue the current good practices on deliveries in the hospital.
- Increase the awareness of the staff regarding caring for newborn babies.

Health education

- Assign a special room for the HE session in the hospital.
- Reinforce the capacity of the HE in terms of practice.
- Recruit one Pashaï speaker to carry out HE for the hospital and for each HF.

CONCLUSION

In most evaluations, the last step in the process consists in the development of recommendations. In the case where the program evaluated is ongoing, evaluation results should be integrated into the program. Often, however, there is a lack of continuity between evaluation results and their use in program planning. Sometimes when the incorporation of findings is left for "later" it never happens. Many excellent evaluation reports have been carefully kept for years on program managers' shelves only to gather dust and never be used. To overcome this problem, it was suggested that the evaluation exercise include the present step in which a draft action plan for the program is developed based on the evaluation findings and lessons learned.

To do this, we organized a one-day "lessons learned workshop" in order to share findings and recommendations with the major stakeholders of the AMI program in the Eastern Zone (see photos in appendices). More than 30 people were present and it was an opportunity to share knowledge about the program and its implementation difficulties. The interest of such a workshop also lay in allowing the stakeholders to appropriate the evaluation findings and lessons learned and to determine how to implement them in future programs. We divided the whole group into 6 topics and work groups in order to begin the process of action plan development and increase the possibility of appropriation. Each group were instructed to develop an action plan and to specify, for each of the "lessons learned", what, where and when they will act and finally who will run the projected tasks (see appendices).

An important aspect of any evaluation is that the findings be shared with all program collaborators and transmitted back to the communities where the data was collected. It is critical that everyone involved in the program be not only informed of important lessons learnt, but also have an opportunity to discuss the results. This is why we suggested that a presentation on the findings should be organized in the Laghman province as soon as possible.

The day after this workshop the consultant acted as moderator to a meeting with the desk officer from Paris, the Country Director and the expatriate evaluation member in order to plan the rest of the evaluation and the recommendations implementation.

Thus, it was decided to organize the following action plan over the following weeks:

1. Establish an evaluation steering committee to decide which actions must be implemented after a participative process. It was decided that the following 6 people should be involved in this committee: the Country director, the Medical Coordinator, the General Medical Coordinator, the General Administrator, the Director of Metherlam Hospital, the Expatriate Physician.
2. The steering committee will name one person responsible of each of the 6 topics/ work groups and one general coordinator
3. Each group manager will organize some work groups in order to develop a topics action plan
4. A one day workshop will be organized to share information with the major stakeholders on the action plan elaborated for all the topics
5. In the light of this final workshop, the evaluation steering committee will take decisions in order to implement the most feasible actions

APPENDICES

Evaluation schedule, 2003

22 Oct. Travel to Paris for External Evaluator (EE)
23 Travel to Paris EE
24 Briefing in AMI Paris EE
25 Travel to Kabul EE
26 Briefing and discussion with Medical Coordinator, EE
27 Organization of the evaluation workshop planning EE, meeting with MC, MD, HRR, GMC
28 Organization of the evaluation workshop planning, EE
29 Evaluation workshop planning
30 Evaluation workshop planning
31 Evaluation workshop planning
1 Nov. Travel to Laghman
2 Planning and finalization of evaluation tools
3 Data collection and analysis
4 Data collection and analysis
5 Data collection and analysis
6 Data collection and analysis (expatriates evacuated to Jalalabad)
7 Data collection and analysis
8 Data collection and analysis
9 Travel to Kabul
10 Finalization of analysis
11 Development of lessons learned
12 Lessons learned workshop
13 Debriefing in Kabul, EE
14 Travel to Paris, EE
15 Travel to Paris, EE
17 Debriefing in AMI Paris, EE

Action plan defined by each group

Curative care			
Continue the good behaviour observed during the curative care services. Complete the infrastructure in terms of finding a place for OPD services. Increase collaboration and communication between HW, AMI and communities. Improve the supervision of drugs management in HF.			
WHAT	**WHERE**	**WHO**	**WHEN**
Give more awareness about continuation of good behaviour against the patients and to take more time for consultation	Health facilities	Directors of HFs and medical team	December
Recruit (complete) medical staff	Kabul, bases and HFs	Human resources	As soon as possible
Assessment of the needs of OPD for rehabilitation and new building	HFs	Rehabilation and medical depts	January 2004
Improve discussion, communication and sharing information during health committee meeting about AMI programs	HFs	Local coordination team and directors of HFs	January 2004
Improve drugs supply and existing reporting and monitoring system	Kabul,Bases and HFs	Pharmacy dept	January 2004
Increase quantity and quality of supervision	Health facilities	Directors of HFs, medical and pharmacy teams	As soon as possible

FOR IMPROVEMENT OF THE TRAINING COURSES INSIDE THE HEALTH FACILITIES

WHAT	**WHERE**	**WHO**	**WHEN**
Recruit a master trainer coordinator (MTC)	Kabul	Medical coordinator	After signing agreement for East
Provide regular training programs to the field	Field	MTC	After recruitment of MTC
Identify and employ qualified trainers	Afghanistan + foreign countries	MTC	After recruitment of MTC
Have regular contacts and visits with partners and signature of contracts with them	Kabul + Field	MTC + medical coordinator + head of mission	January
Identify and introduce a health worker as a library manager (LM)	Field	HMT + director of clinic	January
Establish rules for the use of books in library	Field	HMT + LR	January
Provide training for the LM about care, registration and organization of books and documents	Field	MTC	After recruitment of MTC
Organize a gender timetable for the use of library	Field	LR	After recruitment of LR
Increase contacts with partners and ask them to send regularly updated documents	Kabul + Field	MTC	After recruitment of MTC
Purchase more books	Kabul + Peshawar	MTC	After recruitment of MTC
Regularly distribute a list of books available in library	Field	LR	After recruitment of LR
Presentation of the new books to the staff	Field	LR	After recruitment of LR
Provide 24h accessibility and supervision of the library	Field	LR + other people at night	After recruitment of LR

Exemptions schemes

No	WHAT	WHERE	WHO	WHEN
1	Provision of the tools(criteria) and equipment to help the community	AMI main office	Medical & Adm Central & regional	December-03
2	Meeting with community to explain the system	Village & HF	Director & Admin	January-04
3	Preparing the list of poorest people around each HF	HF and village	Director of HF HC members mollah	January-04
4	Organizing discussion about national solidarity in villages	HF and village	Supervisor Director of HF	January -04
5	Meeting with central MoH Working group to define protocol and agreement	Main office MoH	AMI coordination team MoH	December-03
6	Explanation of central MoH agreement to field MoH	In each province	Coordinator Admin	After signing of the MOU
7	To organize monitoring team of HF and AMI office	HF & office	Doctor Admin Pharmacist coordinator	After implementation of system

Management of Health Facilities

No	WHAT	WHERE	WHO	WHEN
1	Election & involvement of each department member and MoH in HMT	hospital	Director of HF Local coordinator expatriate	February-04
2	Review and clarify HMT mandate	Main office	Director of HF AMI coordination (central& regional)	January-04
3	Systematic feedback to HMT/HC	HF	AMI coordination team	As soon as possible
4	Cost recovery and access to health of poorest people 1. use income for treatment of poorest 2. define clear protocol	Main office	Medical coordinator Adm/Fin (Central & local)	January-04
5	To formulate cost recovery with MoH	Main office MoH	AMI coordination team MoH	During signing of MOU
6	Empowerment of local supervisor 1. authorization 2. capacity building	For each cluster	AMI Expat team Key national staff	After finishing new recruitments
7	Increase number of Expat supervision (one supervision/month	Each HF	AMI Expat team in Afgh & Paris	After redefining the new flow chart

Women's Health and Women's Health Education

No	WHAT	WHERE	WHO	WHEN
1	Recruitment of female staff and train them	clinic where there is lack of staff	Med coord Region kabul, MoH, Head of HF	January(end)
2	Train the new female staff	clinic where there is lack of staff	Med coord Region & Kabul(female trainers)	After recruitment
3	Improve network of TBAs(Find new TBA)	Around the clinics(all around district)	HF(female staff), community, cluster supervisor team	February
4	Train the new TBAs	Around the clinics	Midwife(they should previously have been trained by cluster supervisor team) of HF	After one month
5	Refreshment and strengthening existing network	Around the HF		
6	Meeting with community, authorities	Mosques and public places	Med. Region team (cluster supervisor team) malek community	End of January or beg February
7	HE about awareness	Schools	Teachers, children	February
8	Salamati with HE	In public places	Salamati team, HE coor team	Every 3 months
9	Contact media	Locally	MoH, AMI, Director of hospital	03-Dec
10	Outreach activity(once/week mobile team)	Remote areas	Female staff of clinic, cluster supervision team, Log team	February
11	Improve network of TBAs	In remote areas	Resp of HF, Female staff COMMUNITY, Cluster supervisor team	February
12	set up FP room	In each HF	AMI, MoH, community	End March or April 04
13	Training of staff	clinics where its set up	CST staff of clinic, MoH(curricullum)	March 04
14	Supply of equipment	To clinics	AMI, PHD	March 04

EVALUATION STATEMENT OF WORK

PROGRAM EVALUATOR
FOR THE PROGRAM:

Support to the Health Care system in three provinces
Salamati, a distance-learning magazine for Afghan health workers
Rehabilitation and Prevention Program for Disabled Afghans
In the Eastern Region of Afghanistan

1: PROGRAM TO BE EVALUATED

The program of "*Support to the Health Care system in three provinces, Salamati, a distance-learning magazine for Afghan health workers and Rehabilitation and Prevention Program for Disabled Afghans in the Eastern Region of Afghanistan*" is multisectoral health program funded by DG Relex. The program is implemented by Aide Medicale Internationale (AMI) in partnership with Sandy Gall Appeal for Afghanistan (SGAA), with AMI acting as a prime agency of the partnership.
The program began implementation on October 1st, 2001 and currently scheduled to end on September 31, 2003.

2. BACKGROUND

The aim of the program for AMI / SGAA partnership is as following:

AMI: To contribute to the improvement of the health status of population of project area by providing financial, technical and logistical support to three provincial hospitals and six clinics and by organizing training and information activity in the community
SGAA: To provide physiotherapy services and manufacture orthopedic devices and mobility aids for disabled Afghan men, women and children, enabling them to be more mobile and independent; to teach disability awareness to families and local communities, thereby promoting better understanding and prevention of disability; and to create an Afghan NGO from existing staff of SGAA
Both of the partners also followed certain general and specific objectives outlined in the project proposal.

Through the program support to the Health Care system have been extended in the provinces of Logar, Laghman and Kunar, Salamati magazine distributed all over Afghanistan and Rehabilitation and Prevention of disability activities implemented in the province of Nangarhar, Kunar and Laghman

3. Purpose and Objectives of the Evaluation

The evaluation will review the extent to which program is meeting the set goals as well as assess efficacy of intervention methodologies and approaches. This information, in turn, should provide the implementing and donor agencies with better idea of approaches employed and lessons learned. In addition, the evaluation will also provide critical feedback on the strategic priorities for future programs in order to ensure that future programs achieve sustainable results by their final closure date. The objectives of the evaluation are to:

- Complete a general technical assessment of the program that evaluates progress to-date, strengths and weaknesses;
- Evaluate the overall efficacy of mechanisms, systems and approaches being used by AMI in implementation of the program.
- Identify future strategic priorities

4. Evaluation Questions

In order to provide a comprehensive assessment of the program the evaluator will need to review program activities and outcomes in relation with changing environment, political, economical and security situations. Questions to be considered in the evaluation include:

- Have Specific Objectives of the program set in accordance with the Global Objective?
- Have main activities of the program been carried out as it proposed in the Logical Framework
- Are results of the program verifiable and how they correlate with expected results of the Logical Framework.

- What changes have occurred in the target population's behavior, attitude, and health service accessibility situation? How have these changes better enabled communities to address their health needs?
- How effective have the institutions established been in addressing the needs of community members?
- How effective have program tools, resources and activities been in addressing identified needs?
- How effective are the systems and methodologies for implementation established by AMI?
- What was the external constraints of program implementation (political, economic, security, cultural, whether conditions, etc)
- What were the internal constraints of program implementation (insufficient resources allocated, absence of sufficient human resources, insufficient qualification of staff, lack of equipment, training materials, bad communication etc.)

5. Evaluation Methods

No special methodology is proposed for consultant to follow. An implementation plan needs to be produced by the consultant for evaluation activities. An implementation plan is subject for review and approval by AMI.

6. Procedures: Schedule and Logistics

The evaluation will take place in October 2003 for a total of ____ days.

AMI internal regulations need to be followed by the consultant for financial, administrative and logistical support requests for the consultancy activities. AMI security rules and regulations is a must condition to follow. Support needs for the evaluation e.g. financial, logistic and administrative, needs to be communicated to AMI beforehand to allow sufficient time for preparations.

6. Reporting Requirements

The evaluator is responsible for producing a written report that would assess the program in light of the purpose, objectives and evaluation questions raised in this document. In particular, the report should:

- Assess goals and objectives of the program as meeting the crucial needs and feasibility of accomplishing them
- Assess the current state of program outcomes vis-à-vis set program goals;
- Provide an assessment of the efficacy of methodologies employed by AMI to implement the program.
- Assess efficiency of institutions supported by AMI in serving target beneficiaries
- Analyze the strengths and weaknesses of the program and provide recommendations for better programming in future.
- Provide recommendations for strategic priorities for AMI in future.

7. Qualifications

The evaluator should possess strong research skills and have extensive experience in evaluation of multi-sectoral health projects implemented in a variety of developing countries. Practical experience managing health programs is required. Knowledge of Afghanistan specific situation is an advantage.

Some pictures

Evaluation planning workshop (29-31 October)

A Focus Group with Health Committee Members (3-8 November)

Face to face interview with a Health Worker (3-8 November)

Data analysis by the Evaluation Team Members (3-8 November)

The Consultant during the “Lessons Learned” Workshop (12 November)

Participants on the “Lessons Learned” Workshop (12 November)