



INTEGRITY  
WATCH  
AFGHANISTAN



## ENHANCING LIFE

Capacity of the Health Care Facilities in Afghanistan



# **ENHANCING LIFE**

CAPACITY OF THE HEALTH CARE FACILITIES IN AFGHANISTAN

Integrity Watch Afghanistan  
Kabul  
May 2020

Copyright © 2020 by Integrity Watch Afghanistan. All rights reserved.  
Published by Integrity Watch Afghanistan  
Qala-e- Fatullah, Kabul, Afghanistan  
Info@integritywatah.org  
Www.integritywatch.org

## Table of Contents

Foreword.....	2
About Integrity Watch .....	3
Acknowledgments.....	4
List of Acronyms.....	5
EXECUTIVE SUMMARY .....	6
<b>SECTION 1.....</b>	<b>9</b>
THE PROBLEMATIC - METHODOLOGY .....	9
1.1. The Context and Objective of the Study .....	9
1.2. The Assumptions.....	9
1.3. Research Questions .....	10
1.4. Significance of the Study and its Findings.....	10
1.5. Study Design and Methodology.....	10
<b>SECTION 2.....</b>	<b>13</b>
EFFICACY OF THE INFRASTRUCTURE.....	13
2.1. Elements of Infrastructure Inspected .....	13
2.2. The Findings .....	13
2.2.1. Building Usage and Ease of Access.....	13
2.2.2. Structural Issues and Maintenance .....	14
2.2.3. Security and Safety.....	15
2.2.4. Hygiene and Sanitation .....	15
2.2.5. Climate Control .....	16
2.2.6. Electricity and Lighting .....	17
2.2.7. Building Design and Floor Plans .....	17
2.2.8. Adequacy of Space .....	17
2.3. Stand Out Performance of Regional Hospitals.....	18
<b>SECTION 3.....</b>	<b>19</b>
MEDICAL SERVICES DELIVERY PERFORMANCE .....	19
3.1. Elements of Service Delivery Inspected .....	19
3.2. The Findings .....	19
3.2.1 Human Resources (HR) and Staffing.....	19
3.2.2. Services Delivery - General.....	20
3.2.3 Services Delivery –Medicines, Equipment Supplies and Medical Professionals .....	21
3.2.4. Infection Prevention and Cleanliness- high priority elements .....	23
3.2.5. Transport Services for Patients .....	25
3.2.6. Services for Food and Other Related Necessities.....	26
3.2.7. Community’s Role in Service Delivery from Health Care Facilities: .....	26
3.3. State of Performance by Facility Types .....	27
<b>SECTION 4.....</b>	<b>29</b>
Conclusion.....	29
<b>SECTION 5.....</b>	<b>31</b>
Recommendations .....	31
Bibliography .....	32
Annex .....	33

## Foreword

This report follows and is a sequel to our earlier report on health care system- Life Matters: Caring for the country's most precious resource. The publication of this report on the capacity of infrastructure, medical and human resources in Afghanistan coincides with the onslaught of the COVID19 pandemic, testing health care systems across the world while shaking the foundations of the health care systems in the making in the developing countries. In Afghanistan, the pandemic is not only a test for its fragile health care system but also a challenge for the state as a whole as it suffers from a low level of trust due to poor service delivery, weak governance and instability.

Despite many years of investment by international donors, the health care system still does not have adequate infrastructure, shortfalls in stocks and supplies of medicines, and the required equipment, and inadequate supply of medical and non-medical qualified personnel. The report cannot be more timely, as the pandemic, while posing unprecedented challenges also presents an opportunity to reassess the development priorities, in general, and specific priorities within the health care system to rescue Afghanistan from the current shadows of the pestilence and provide the much needed health services to the population suffering from endemic poverty, exacerbated by inadequate access to services, weak governance, accountability and transparency.

I would like to thank Dr. Nipa Banerjee for analyzing the data collected by our researchers and for authoring the report. I am thankful to Mr. Ezatullah Adib and our research team for planning and implementation of the research and data collection. I thank the consultants who has been invaluable asset to the team as health specialists and advisors.

On behalf of Integrity Watch Afghanistan, I am humbled to present the report Enhancing Life: Capacity of the health care facilities in Afghanistan. I hope that this report will generate the much-needed public debate around health care services and priorities in the times of COVID19.

**Sayed Ikram Afzali**

Executive Director, Integrity Watch Afghanistan

## About Integrity Watch

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

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

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

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

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

## Acknowledgments

Integrity Watch express its appreciation and gratitude to the team responsible for the production of this report in particular to Ezatullah Adib, Head of Research of Integrity Watch Afghanistan for leading the project; the local researchers Enayatullah Sidiqi, and Mohammad Mukhlis; and the author of the report, Dr. Nipa Banerjee, who has 40 years of experience in Foreign Aid, Aid Effectiveness, Development Issues in Post Conflict Countries, Peace Building Measures and Development and Reconstruction in Afghanistan.

We acknowledge with gratitude the cooperation offered by the Afghan Government authorities in Kabul and in the provinces, during the weeks of data collection. We are also deeply thankful to those who participated in the interviews. Furthermore, we would like thank Sayed Ikram Afzali, Mohammad Nasir Timory, Norville Connolly, and all other reviewers who took the time to review and comment on the initial drafts of this report.

Finally, we extend our appreciation to the Research and support staff of Integrity Watch Afghanistan for providing timely support during the research.



## List of Acronyms

BPHS	Basic Package of Public Health Services
CHC	Comprehensive Health Center
DH	District Hospitals
EPHS	Essential Package of Health Services
HCB	Hospital Community Board
HLD	High Level Disinfection
IP	Infection Prevention
IWA	Integrity Watch Afghanistan
MoPH	Ministry of Public Health
OPD	Out Patients Department
PFM	Performance Measurement Framework
PH	Public Hospitals
RH	Regional Hospitals

## EXECUTIVE SUMMARY

This report provides an assessment of the management of infrastructural, medical and human resources in the health care system in Afghanistan and the extent to which the current state of the health care system affects the capacity of the health care facilities to deliver quality health services. From the conclusions drawn (presented in Section 4), recommendations are proposed in Section 5 for future planning and programming that would help improve health care delivery in Afghanistan.

The report is based on a survey, by Integrity Watch Afghanistan, of a sample of health care facilities in Afghanistan, at regional, provincial, district and community levels. The survey, was designed as a field-based observational study, using semi structured methods of inspection, interviews and observations. The survey of a total of 41 health facilities, in 13 provinces, collected sufficient useful evidence to draw conclusions on the current state of capacity of Afghanistan's health facilities. The results are found in Tables and Charts, along with narrative analyses presented in Sections 2 and 3 of this report.

A note to highlight upfront is that some of the quantified findings of the survey are encouraging. For instance, all health care facilities have been found open for business and fully active; credentials of the staff in the facilities fit the job requirements; and annual performance appraisal (a universally accepted tool for personnel management) is used in 80% of the facilities. These are all positive indicators, and yet, the quality of health care services cannot be rated high as the facilities endure limited supply of resources and less than effective oversight.

Furthermore, some quantitative findings of the study put the health facilities in a satisfactory light.

The data for instance, shows that a plumbing system has been installed in a large majority of the surveyed health facilities. However, absence of as

indispensable an element as a plumbing system, even in a smaller number of facilities, is indicative of an unsatisfactory health care delivery system as this absence would adversely impact on hygiene and sanitation, operation of toilets, hand-washing stations and clean running water supply. The absence of required equipment and materials, adequate stocks and supplies of medicines; and necessary transport infrastructure (well-equipped ambulance services for the sick, proper access routes to the facilities etc.) are the basic requirements for quality delivery of health care services. Weaknesses in such areas, even in a lesser number of facilities, need remedies.

Data analysis of the collected evidence shows shortfalls in infrastructural and medical services delivery capacities that negatively affect the quality of health care delivery.

The major areas of weakness in infrastructure include the following:

- Lack of easy access to the health facilities because of the poor condition of walking paths within the compounds and the surrounding areas.
- Inadequate availability of space resulting in an inability to respond appropriately to the demand for services.
- Poorly maintained health facility buildings and accompanying essential infrastructure such as functioning plumbing and electrical systems.

- A lack of supply of essential infrastructure indispensable for quality health care delivery, such as, clean running water and hand-washing stations and garbage and medical waste disposal systems.
- Adequate climate control systems, essential for health facilities operating in extreme weather conditions and safety and security arrangements to protect staff and patients from fire hazards, infections etc., were unsatisfactory.
- Necessary transport infrastructure, for instance, well-equipped ambulance services for the sick - was not always available.

These infrastructural shortfalls are largely indicative of poor operation and maintenance capacity.

The quality of health care delivery is further limited by shortfalls in stocks and supplies of medicines, and the required equipment, also indicative of poor operational and maintenance capacity:

- Patients' access to medicines is difficult as pharmacy services are often not available within the compounds of health facilities and when available, they do not have adequate stocks of medicines. In addition, there was no evidence of satisfactory supply arrangements, which can be availed when needed.
- In the absence of easy access to the required equipment and materials, in a timely fashion, the quality of service delivery in critical areas, such as anesthesia, blood bank and laboratory services and infection prevention is not fully satisfactory.
- Poor stocks and supply lines negatively affect not only medical services but also other essential services as basic as food services.

The survey found that there was poor maintenance of food stock supplies and of hygiene and cleanliness conditions in the kitchen.

The quality of care delivery is further affected by an inadequate supply of qualified personnel, medical and non-medical. The services negatively impacted by such inadequacies include:

- Timely and quality testing, diagnostic and treatment services, all of which are central to proper medical services delivery.
- Services offered to female patients including services of female doctors.
- Overall, administration and management of the health facilities, including personnel management, timely payment of wages etc.

The shortfalls identified, whether they be in infrastructural or medical services delivery or in general administrative areas, have their sources in poor supervision and management of the health facilities and in poor operation and maintenance, deficiencies which are bound to weaken the overall service delivery capacity of the facilities.

The conclusion drawn is that the weaknesses and deficiencies of the health facilities indicate management deficiencies attributable to a lack of appropriate oversight of the health facilities by the Ministry of Public Health, by the representatives of donors that fund the facilities and also by the representatives of the national and international NGOs contracted to manage the health facilities and the health program delivery, in Afghanistan.

Based on the conclusions which reveal a number of weaknesses in the system, this report provides **the following recommendations:**

- The overarching recommendation is to enhance the oversight of the operations of the facilities by the Ministry of Public Health, which must take a leadership role in the planning and implementation of measures to remedy the shortfalls and prevent the recurrence of the problems that have, in the past, weakened the delivery capacity of the health facilities.
- Involvement of the stakeholders in this process is strongly recommended. The list of stakeholders includes the donors financing Afghanistan's health program, the interested national and international NGOs and the civil society and community members in the locale of the health facilities. Based on the survey finding of better performance record of service delivery by the Regional Hospitals, an advisory role for the latter has been recommended.
- The report provides guidance on scheduling of monitoring visits to the health facilities by a dedicated supervision team of the Ministry of Public Health. It is recommended that to address the shortfall in operations and maintenance, which is at the root of the deficiencies in service delivery, the Ministry's supervision team must make detailed and appropriate maintenance plans and ensure their implementation by the health facility-based management teams.

- A Performance Measurement Framework, with concrete indicators to monitor progress, must be drawn up and used during the scheduled monitoring visits by the health ministry's supervision team.

Implementation of the recommendations will require an additional budget for travel, funds for securing technical assistance, and for training of staff.

The immediate term recommendation is for the Ministry of Public Health to take immediate measures to launch a discussion session on this report as the first step for drawing up an action plan.

## SECTION 1

### THE PROBLEMATIC - METHODOLOGY

#### 1.1. The Context and Objective of the Study

As a fragile state, Afghanistan encounters many challenges ranging from the insurgency, internal conflicts and the resulting insecurity; economic decline poor governance and lack of accessibility for its citizens to basic services in health, education, housing, food and other basic human needs. This study focuses exclusively on health care services.

Undeniably, since 2001, some progress in the provision of health care services has been achieved, within the context of fragility and conflict. Of note has been the provision of the Basic Package of Health Services (BPHS) initiated by the Ministry of Public Health (MoPH)<sup>1</sup>. The plan to deliver BPHS represents Afghan government's commitment to provide basic health services, free of cost, to the people across the country, including the inhabitants in rural areas, where security has been deteriorating. Despite such commendable efforts, many constraints continue to limit the benefits to be derived from health care services.

Observations in past studies, on health care delivery in low-income developing countries in fragile situations, indicate that other than the usual factors of insecurity and economic decline, issues such as infrastructure deficiencies, poor governance and management, inadequate supply of trained personnel, medicines and equipment, impact negatively on health care provision.

The **objectives** of this study, undertaken by Integrity Watch Afghanistan (IWA), are to:

- assess the extent of the impact of these factors (basically, governance and management of infrastructural, medical and

human resources) on the quality of health care delivery to the Afghan public;

- throw light on the short falls detected in service delivery, as a set of lessons learned; and
- reflect on remedial actions to improve health care provision.

The conclusions presented are based on a survey of a sample of health care facilities at regional (Regional Hospitals-RHs), provincial (Provincial Hospitals-PHs), district (District Hospitals-DHs), and community (Comprehensive Health Centers-CHCs) levels, as classified in the Essential Package of Hospital Services (EPHS) by the Ministry of Public Health (MoPH)<sup>2</sup>.

#### 1.2. The Assumptions

The **key assumption** made on the basis of a literature review, the existing policy frameworks and service delivery guides, related to Afghanistan public health care, is that for satisfactory delivery of health care services, certain infrastructural prerequisites and medical service delivery standards must be met. Any assessment of health care delivery must thus include an examination of the following elements from infrastructure and medical service delivery categories:

- Availability of easily accessible health delivery facilities, with sound physical infrastructure and their maintenance;
- Provision of diagnostic and treatment facility;
- On-site availability of necessary equipment, medications and pharmacies for emergency and basic treatment services;

<sup>1</sup> Ministry of Afghanistan. (2005). *A Basic Package of Health Services for Afghanistan, 2005/1384*. Kabul, Afghanistan: Islamic Republic of Afghanistan Ministry of Public Health.

<sup>2</sup> Ministry of Public Health. (2005). *The Essential Package of Hospital Services for Afghanistan*. Kabul, Afghanistan: Islamic Republic of Afghanistan Ministry of

Public Health The Essential Package of Hospital Services for Afghanistan, 2005/1384.

- Adequate supply of trained medical and health care professionals to ensure equitable -delivery of care to men, women and children;
- Recruitment, management and oversight of human resources, and thus, of health care delivery, for promoting a reasonable level of care delivery;
- Community involvement in service to the community.

This study is planned as an observational study based on the assumption that the absence of the above factors in the infrastructure and medical services delivery categories, results in substandard health care delivery, negatively affecting the total health care system, in Afghanistan.

### 1.3. Research Questions

This observational study seeks answers to the following **questions**, which arise from the assumption mentioned above:

- Are the facilities accessible to the public- i.e. is the state of security, transport and road conditions adequate?
- Are standardized specifications for construction and maintenance addressed by the responsible authorities in building and maintaining the existing hospitals?
- Are usable buildings and suitable and adequate space available for delivery of services?
- Are the hospitals fully operational and providing the needed services?
- Are the facilities well equipped for delivering basic patient care and emergency care- (i.e., are supplies of medications and other necessary equipment ensured? Are stocks of medical resources (medicines, therapeutic and equipment supplies) adequate?
- Is the supply of trained health care providers (including women health professionals) adequate, steady and consistent?

- What is the satisfaction level of the clientele with respect to the services provided at the health facilities- i.e. what is the extent of user level satisfaction? Is a role for the beneficiary community carved out for promoting needs-based service delivery?
- Are the human resources management and service delivery functions well directed, and coordinated, well supervised, monitored and assessed to promote improved performance of care providers?
- Is there adequate oversight of the operations of health care facilities from the Ministry of Public Health, international donors, national and international NGOs, as the case may be?

### 1.4. Significance of the Study and its Findings

The observational study and the related research and analyses hold promises for both policy debates and practices in the health sector. The findings, presented as a set of lessons learned on issues that are integral to health care delivery, will help raise awareness of any gaps and deficiencies and the need for reforms to fill these gaps. The findings can, thus, guide future planning - policies and programming both - in the health sector by the Afghan MoPH, international donors and contracted international and national implementing NGO partners.

### 1.5. Study Design and Methodology

The design of the study, the data collection tools and methods and analytic techniques used are best suited for researching a real world and context-sensitive problem.

The study has been designed as primarily a field-based sample survey using semi-structured methods of inspection, interviews and observations. Thus, the data source is mainly primary. Secondary data sets - literature and document and report reviews - have been used for validating the assumptions and formulation of the research questions.

For seeking answers to the survey research questions, the study uses a qualitative method-inspection visits to a sample of health facilities by a team of surveyors who record set responses to a set of prepared questions (a questionnaire), supplemented with additional observations and comments as the inspection proceeds. Information recorded also includes results of on-site interviews with the staff and management of the health facilities and patients or beneficiaries. with the application of prepared questionnaires. Both standard and open-ended responses from the interviewees are included in the data base. All interviews were conducted in local languages. The responses recorded from use of the standard questionnaires allowed compilation of numerical tables. The open-ended responses were included in the data base and analyzed fully for drawing conclusions.

All inspection questions, involving the standard questionnaire and the interviews were formulated to directly address the research questions. The answers (both standard and open-ended answers) to the questions helped identify the areas of strengths and weaknesses, which could well direct future planning for strengthening of the health of the nation's human resources.

The inspections in the infrastructure and medical service delivery categories. comprised the following:

- a. A physical survey of the outsides and insides of the facility buildings and the related infrastructure (involving both external and internal inspections);
- b. A review of the personnel recruitment process for delivery of professional and support services (a component of the internal inspection);
- c. A review of the services provided by health care providers (a component of the internal inspection);
- d. Interviews with the management, the staff and community members (including the patients) of the facilities sampled and visited (a component of the internal inspection). One staff member and one patient per facility was interviewed.
- e. Observations of IWA visiting teams in all of the above areas. The study followed a six-step process that IWA uses, starting from mobilization of the study to final reporting on the findings of the inspections.
  - i. In the mobilization phase, the IWA team requests the MoPH to provide authorization to conduct inspection and survey of the health facilities; and requests the MoPH's directorates in the targeted provinces to facilitate the inspection.
  - ii. The team then develops a list of items to inspect and formulates sets of questionnaires to inspect them. Separate sets of questionnaires were prepared for recording observations of the surveyors and for interviewing staff of the health facilities and community members- the beneficiaries or patients. Questionnaires were used for both internal and external inspections.
  - iii. The external inspection in this study manly covered the state of the infrastructure while the internal inspections checklist covered purchase, stock and dispensing records at each of the facilities; records of visits and treatment of patients; employee lists and the actual presence on site of the number of staff - doctors, nurses, paramedics, midwives, assistants and other medical and non-medical staff. Inspections also included interviews with the management and the staff of the clinics and of community members, the latter mainly as recipients of health care, who are also clients of the facilities. The users (clients/patients) were questioned on their views of the services provided at the facilities.
  - iv. In the **training phase**, the inspection program manager trains surveyors on the process of data collection. In this study, the survey team included professional inspection engineers who collected the appropriate data on the construction and maintenance of facilities. The team was trained on how to locate and

access a facility; perform internal and external inspections and take GPS-embedded and date/time stamped photographs.

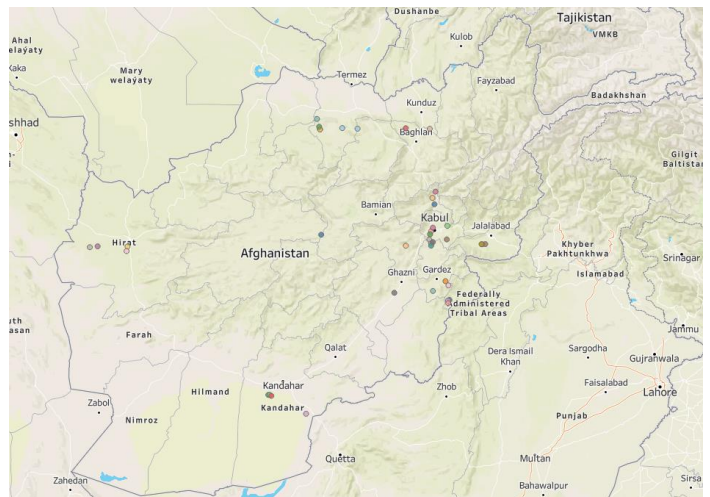
- v. During the **Site Visit** phase, supervisors accompany the trained teams in the first few pilot surveys of facilities, with the supervisors providing constructive feedback of the quality of the pilot surveys conducted. The pilot surveys and the feed-back system are followed in order for the surveyors to learn how to carefully collect data covering the checklists fully addressing all items in the questionnaire and recording data accurately; where needed, photos on Canon Power Shot cameras, are normally taken, in support of the surveyors’ observations.
- vi. For **reporting** purposes, the data collected during the inspection are meticulously entered into MS Excel spreadsheets for each province. The data record is at the base of analysis required and used for the final report. All supporting documents, including GPS and Photographs are used for reporting.

Using this process and application of the research method and data collection tool of inspection (external and internal) with questionnaire surveys, as iterated above, Integrity Watch conducted this research of 41 health facilities in 13 provinces. As the following Table shows, 19 District Hospitals (DH), 8 Provincial Hospitals (PH), 8 Comprehensive Health Centers (CHC) and 6 Regional Hospitals (RH) were sampled for inspection by IWA surveyors for this study.

**Types and Numbers of Facilities by Province**

Province	CHC: Comprehensive Health Facility	DH: District Hospital	PH: Provincial Hospital	RH: Regional Hospital	Total
Balkh		4	1	1	6
Bamyan		1	1		2
Ghazni			1		1
Herat	2	2		1	5
Kabul		7			7
Kandahar	2	1		1	4
Kapisa			1		1
Khost	2		1		3
Kunduz		1		1	2
Nangarhar		1	1	1	3
Paktia		2		1	3
Parwan	2		1		3
Wardak			1		1
<b>Total</b>	<b>8</b>	<b>19</b>	<b>8</b>	<b>6</b>	<b>41</b>

**Provincial Map of Afghanistan**





## SECTION 2 EFFICACY OF THE INFRASTRUCTURE

### 2.1. Elements of Infrastructure Inspected

The survey teams undertook inspections of the health facilities to determine if they have the pre-requisites to deliver quality services. Given that quality care delivery requires sound physical infrastructure - buildings – and other infrastructural support, the IWA survey included inspection of the following elements:

- Usage of the buildings
- Accessibility of the buildings from where care is delivered
- Building structures and foundations
- Building maintenance
- Security and safety arrangements
- Hygiene and sanitation facilities
- Climate control arrangements
- Electricity and lighting
- Adequacy of space
- Availability of treatment rooms
- Architectural designs and plans

### 2.2. The Findings

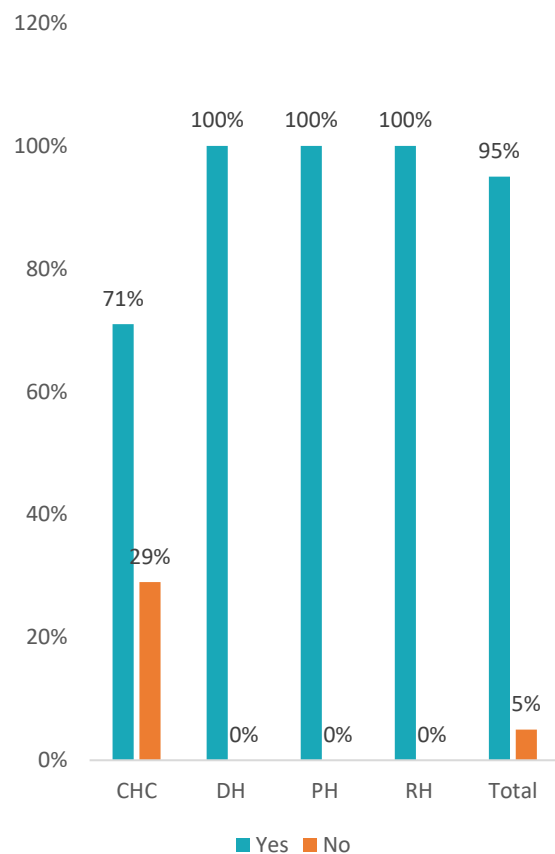
The Surveyors’ on-site observations during external and internal inspections and responses of the staff and patients interviewed by the surveyors provide the data on which findings are based.

As explained in the methodology section, the bulk of the surveyors’ observations were recorded in a standardized questionnaire and responses form that allowed generation of numerical summary tables. The surveyors also recorded some extra observations, additional to the standardized responses. These observations, have been integrated with the reporting below.

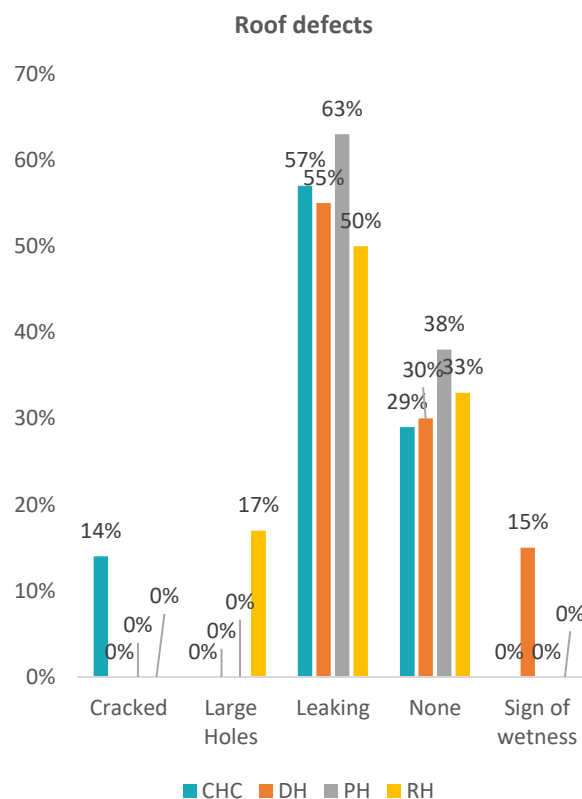
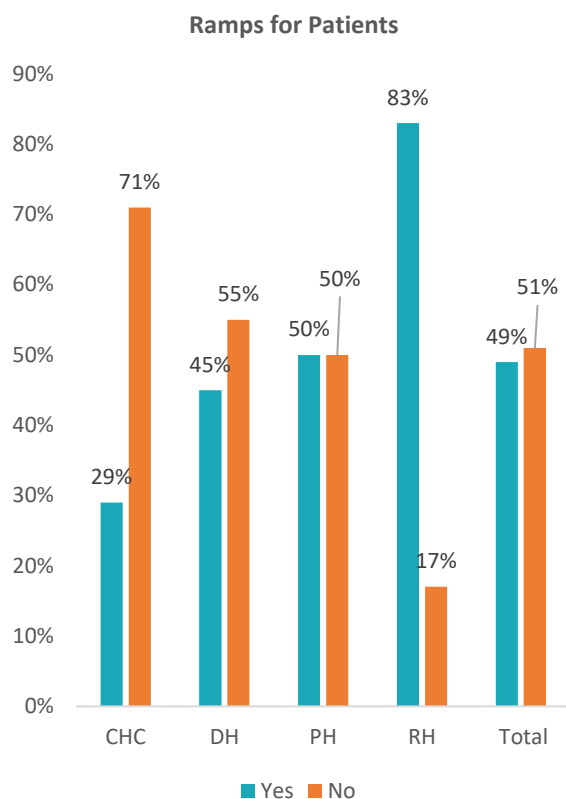
#### 2.2.1. Building Usage and Ease of Access

All facilities visited were found to be operational and fully used for the purpose of care delivery. In general, the buildings provide open door access to all sections of the facility although in some facilities certain sections were closed up, and thus, non-functional and not accessible.

Accessibility by road or walking path



A low grade for ease of access to the buildings is earned because of absence of ramps for cars to most buildings. But higher grades are fetched for accessibility by walking paths. Yet, in their comments, the surveyors and also the staff and patients interviewed are critical of difficult entrances and poor condition of the side-walks around the building peripheries and inside the compound.



**2.2.2. Structural Issues and Maintenance**

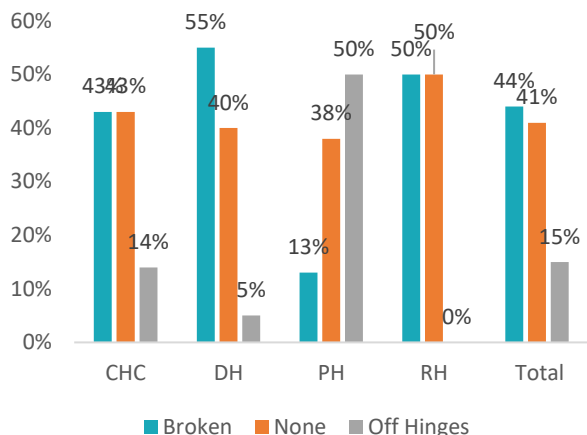
Majority of the inspection teams observed little visible problems in the structure of the buildings with exterior inspections.

Material with which buildings are made contribute to the structural soundness of buildings. Although a few mud buildings are found, the inspections confirm that 93% of the buildings used concrete, best material for ensuring soundness of building structures.

Internal inspection of the infrastructure detected serious problems, however, due mainly to lack of attention to maintenance. 56% of the main buildings have leakage in roofs. 71% of the buildings show some signs of dampness in various quarters of the buildings, breeding unhealthy conditions harmful for patients and the staff. The dampness could have been generated from structural deficiencies exacerbated by absence of routine maintenance. Dampness could, of course, result also from lack of routine maintenance.

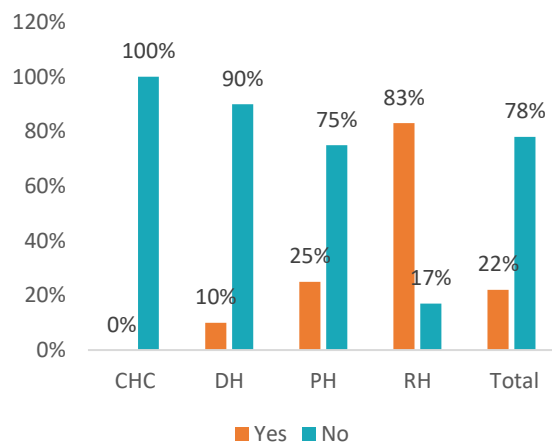
A physical checkup of the interior of the buildings identified many deficiencies - broken doors and windows; floors and walls showing cracks; plaster and paint falling off the walls; and missing light bulbs - all indicative of poor maintenance. Outstanding is the finding that 44% of the facilities have broken doors and another 15% of the facilities have doors that are off hinges. Door handles are missing, windows are unhinged and a number have broken glasses. Surveyors found areas in some facilities that have been left non-functional since Taliban attacks in the past, with little attempts from the management to repair the devastated areas. Surveyors found maintenance services to be below standards even when they are contracted out to private companies.

How is health facility doors condition?

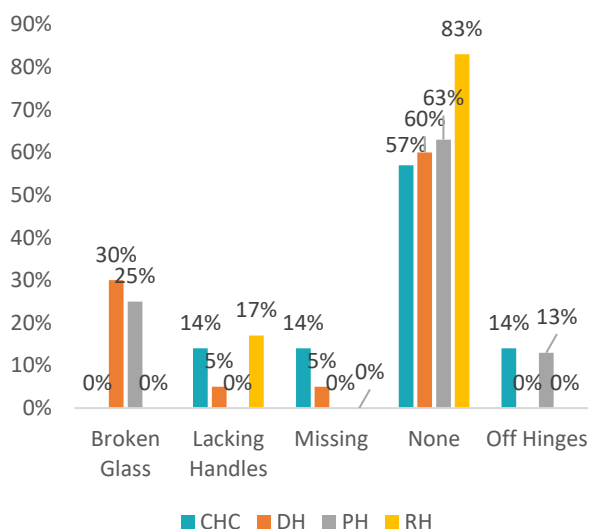


Fire extinguishers are available in 88% of the facilities.

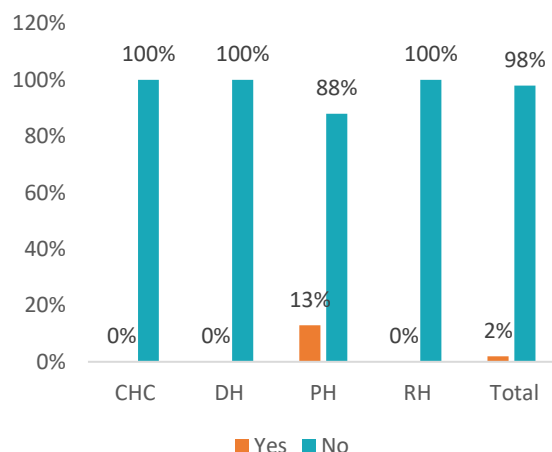
Fire Alarm System



Health Facility Windows Condition



Emergency Exit Door



Instances of poor maintenance are also reported under service delivery category in section 3 that notes critical comments from the patients on poor maintenance.

### 2.2.3. Security and Safety

The compounds of the facilities surveyed appear well secured with fencing and gates. However, the internal inspection records show weak safety arrangements inside the buildings. Absence of safety arrangements, such as that of a fire alarm system and emergency exit doors, endanger patients' lives. 78% of the facilities lack a fire alarm system and 98% do not have emergency exit doors.

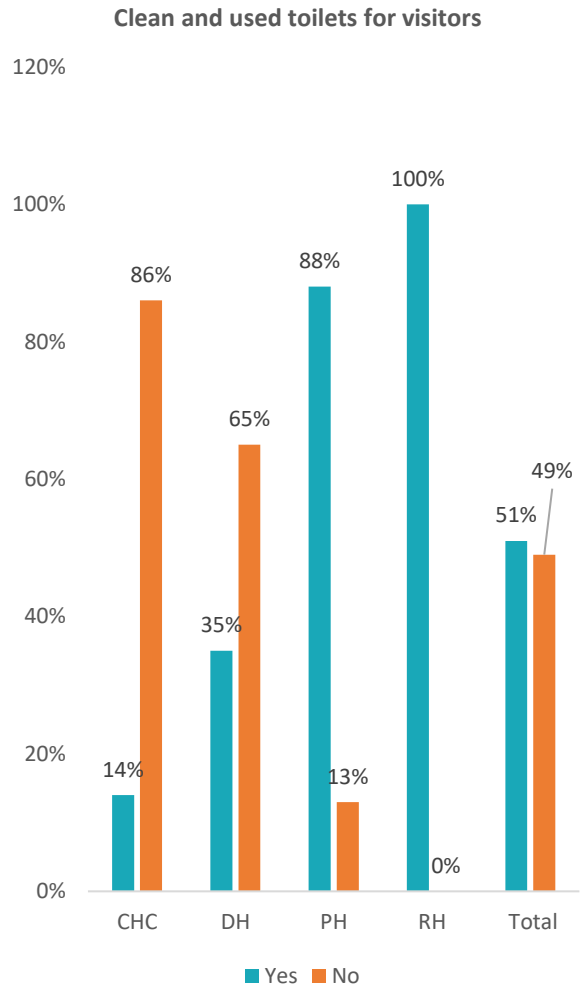
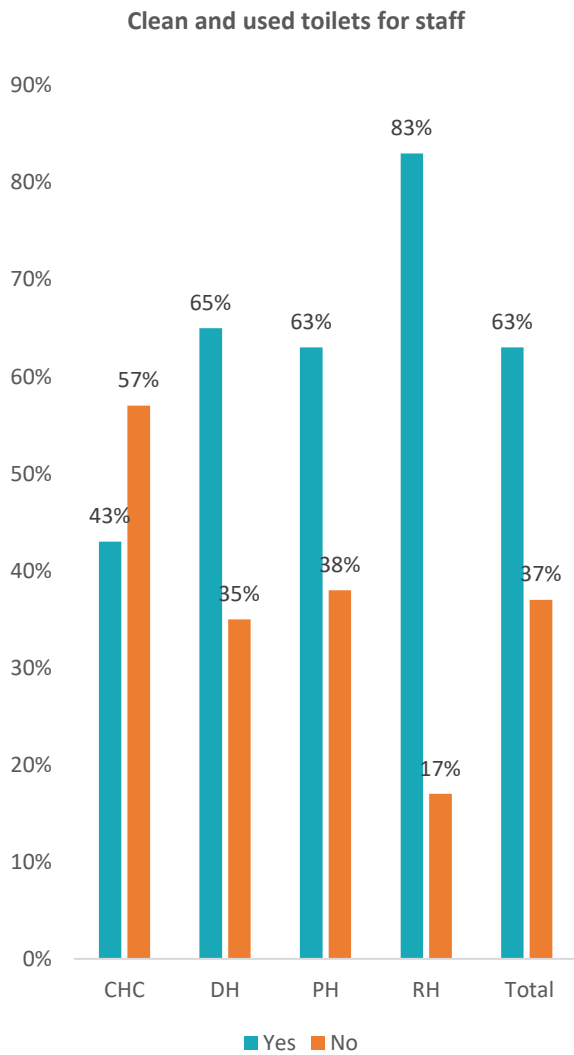
### 2.2.4. Hygiene and Sanitation

An operational plumbing system is an absolute basic need in any health care facility. Even though all facilities under survey are equipped with a plumbing system many (approximately 63% of the facilities) have some reported problems with their plumbing system. At least 27% of the facilities have treatment rooms with no handwashing stations. Surveyors record additional comments on the critical need for installation of hand washing stations.

With respect to availability of functional toilets that flush or latrines, the findings are positive for

patients and staff as a very large majority (98%) of the facilities inspected, offer these amenities. However, in 50% of the facilities such amenities are not available for visitors.

Very pertinent issues in health and hygiene requirements are that of usage and cleanliness of the toilets and latrines. Percentages of facilities cited for unclean toilets and latrines leave grounds for concern that required cleanliness standards are not maintained. Toilets for the staff in 37% of the facilities are not clean and patients' toilets in 46% of the facilities are not cleaned properly. Observation records show many references to unclean conditions in all areas of the buildings inspected.

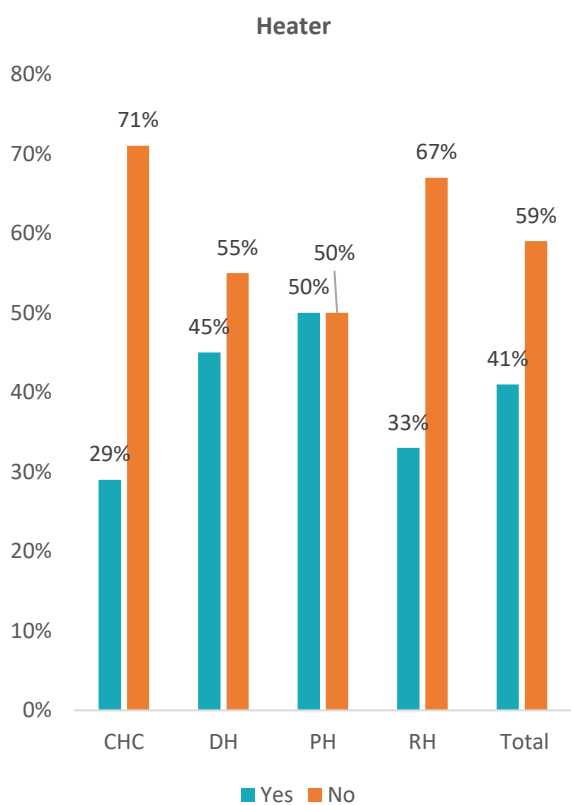
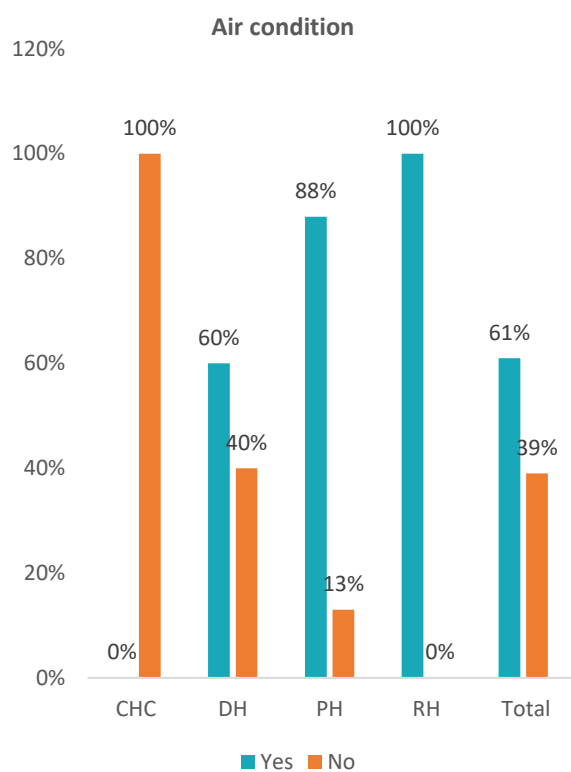


The majority of the facilities have incinerators for disposal of medical wastes. But non-medical garbage disposal system is unsatisfactory in many instances, as assessed by surveyors.

The interviewee responses to hygiene and cleanliness issues under the service delivery category in Section 3 are damning.

**2.2.5. Climate Control**

To address climate control needs, various types of provisions are made- installation of fans (83%) air conditioners (61%), and heaters (41%). Observations and comments of the surveyors speak of cold rooms with no heating facilities nor availability of wood for burning.



### 2.2.6. Electricity and Lighting

The good news in this front is that all facilities have access to electricity, and thus, lighting, the absolute basics for any health care facility. In 76% of the facilities, electricity is drawn from the power grid. Only in 10% of the facilities solar power is used. When required, 90% of the facilities can have access to electricity generated from generators although it has been noted that the capacity of the generators in certain instances, are too small for supporting the electricity needs of the facilities. Besides, surveyors note that electricity and lighting systems are only partially functional in many instances. Poor condition of wiring, switches and sockets arising from poor maintenance cause such dysfunctionalities. Additional observations of the surveyors call for better maintenance of the electrical system and where needed, full scale repairs of the electrical system.

As noted in Section 3, patients interviewed also expressed dissatisfaction with lack of maintenance, disrupting electrical systems.

### 2.2.7. Building Design and Floor Plans

In 46% of the buildings surveyed, the location of medical departments (such as those for blood testing, surgery, pharmacy etc.) do not match the original architectural plans. Haphazard placement of departments in buildings, ignoring the original design has resulted in poor planning of the floor space, with the medical wards and departments not well connected, making it difficult for swift movement from one ward to another causing inconvenience to doctors and staff and resulting in delays in attending quickly to needs. An example is the location of a sterilization room at a place too far from the surgical unit.

### 2.2.8. Adequacy of Space

The external inspection found that 41% of the health facilities surveyed, dispense services from a single building in the compound. More than half of the buildings are one storied. These findings led the surveyors to check if the existing facilities have the space capacity to meet the demand for services. The surveyors found many of the buildings to be

overcrowded. Observations recorded by surveyors upon an inspection of the interior of the buildings indicate that space inadequacy is quite evident. At the time of the survey, the number of patients in many facilities were larger than what the facilities could reasonably accommodate. That facilities are not meeting patients' demands for services because of space inadequacies are also clearly reflected in patient interviews, discussed in Section 3.

It is obvious that the number of toilets and washrooms for patients are too few for the patient population. Nor is the space provided for visitors' waiting rooms adequate. Inadequate space has been allocated for administration offices for the staff and for storage of equipment, medicines etc. Some facilities, in dire need of space, are using space of other health units located in the area. For instance, a District Hospital is found to share space with a Reconstructive Surgical Hospital. Observations of surveyors make a reference to a facility in which the OPD section had to be moved out of the main building, far from those sections proximity to which is essential for efficient functioning of OPD services.

Overall, based on the survey findings, infrastructure category does not earn a fully satisfactory grade.

### 2.3. Stand Out Performance of Regional Hospitals

An interesting conclusion that can be drawn from the findings in the infrastructure category is that the facilities inspected at the regional level – the Regional Hospitals (RHs) – display better performance standards than the provincial, district and definitely community level hospitals. The RHs score higher points in the following:

- Centrally located and catering to population at the regional levels, the RHs are larger in size and better served by roads that raise their grades for easy accessibility to the hospital buildings;
- All RH compounds are well secured with main gates;
- The RHs are better planned and designed. 67% of the RHs have more than 5 buildings in the compound and offer spacious and suitable accommodation for service delivery;
- Their access to electricity supply is excellent;
- Incinerator for medical disposal are available in all RHs;
- Operation and Maintenance is better in the RHs – fewer broken doors and windows and leaking roofs plus signs of dampness are found. The toilets are 100% functional and properly cleaned.

## SECTION 3 MEDICAL SERVICES DELIVERY PERFORMANCE

### 3.1. Elements of Service Delivery Inspected

The survey teams inspected the health facilities to check if the facilities deliver services efficiently and meet certain pre-requisites for quality delivery of services. The following elements of services were inspected:

- Human resources and staffing;
- General services
- Medical professionals, anesthesia services, blood bank, laboratory, pharmacy;
- Medicinal and equipment supplies;
- Infection prevention and cleanliness;
- Transport and ambulances;
- Food and other necessities;
- Community’s role

### 3.2. The Findings

The findings are based on: (a) the surveyors’ responses to a set of standardized questionnaires along with the surveyors’ additional comments and observations; (b) the responses of facility staff and patients to interview questions from the surveyors, with some of the questions requiring open-ended responses.

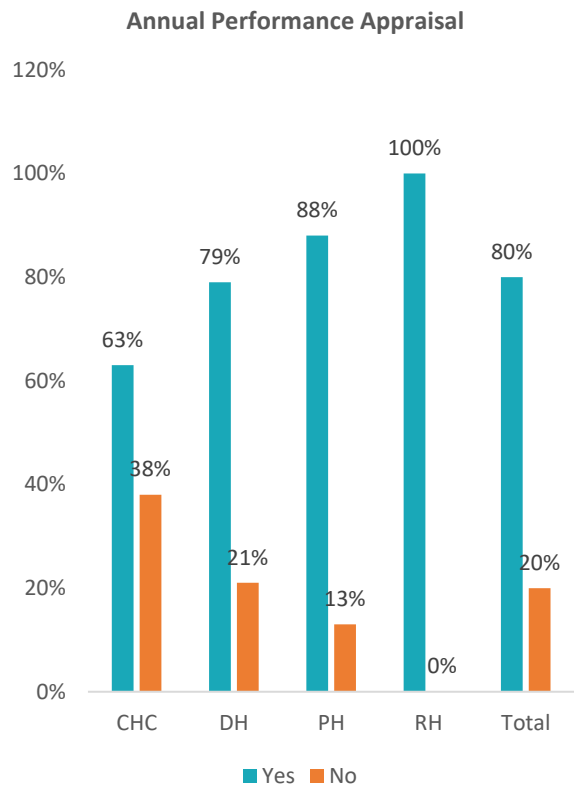
#### 3.2.1 Human Resources (HR) and Staffing

The surveyors’ responses confirm that human resources and staffing issues are handled in accordance with the established procedures. Staff Recruitment Boards and approved HR Policies and Procedures, based on standards set by Provincial Public Health Directorate, are operational in all facility types- in CHCs, DH, PH and RH. The recruitment process follows the usual steps starting with advertisement or announcement of a position, receipt of applications, drawing of long and then short lists of eligible candidates, followed up with

written examinations and interviews and concluding with final selection.

Human resources management efforts, with a view to provision of quality services to the clients, include attempts to raise the comprehension of the service delivery guidelines in the staff. 98% of the staff interviewed confirm that job descriptions of each category of staff is available and displayed in the facility buildings.

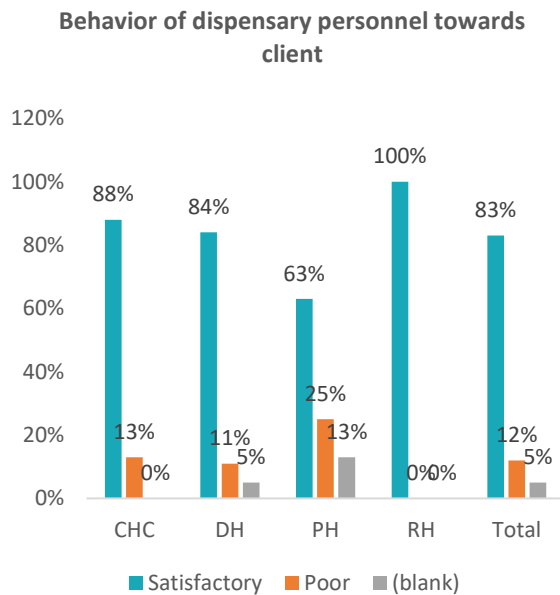
The surveyors note that for better governance of human resources, a system of annual staff performance appraisal is followed in 80% of the facilities. It is interesting to note that the larger hospitals are more likely to have an annual performance appraisal. Staff attendance is checked regularly in 73% of the facilities. At the time of the inspection, the average number of facility staff not present on site was 4.



HR management includes attention to staffs’ needs. The latter also impacts on service delivery. Staff performance in service delivery is known to vary with satisfaction level of the staff in any establishment or enterprise. 78% of the staff interviews confirm that clear HR procedures and guidelines are set for attending to staff benefits, such as, leaves, complaints handling, compensation etc. Occupational Health Guidelines are made available to the staff and occupational health training is offered. Asked a more basic question on regularity in salary payment over the last six months, 66% of the staff report experiencing irregularities, which is bound to negatively affect staff attitudes and the quality of the services they deliver.

**3.2.2. Services Delivery - General**

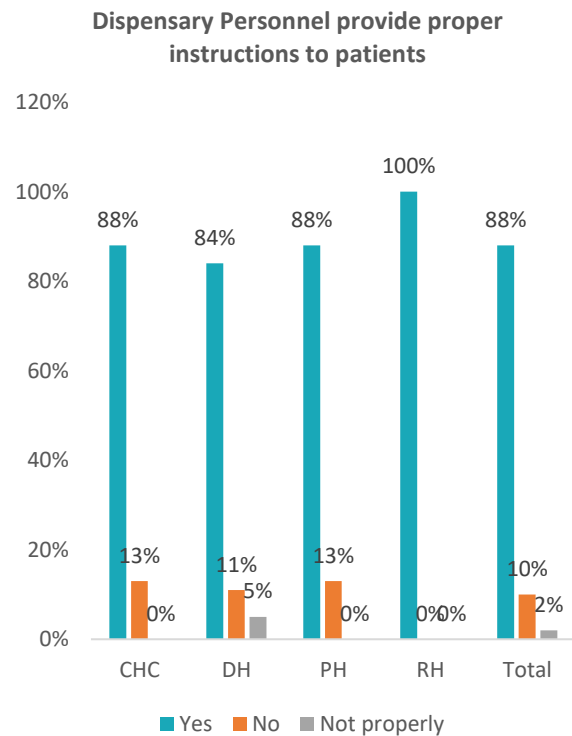
Patients’ satisfaction with the staff at the facilities is an indicator of efficient service delivery. Patients were asked to express their views on the behavior of the facility staffs. The ratings given by 83% of the interviewed patients indicate that the overall behavior of the staff ranges between satisfactory, good and very good. Nonetheless several patients made critical comments on staff behavior. The observations of surveyors are equally critical. Surveyors note poor attitudes displayed by staff members in dealing with the inspectors, as well.



The surveyors expressed concerns that an observed inadequate supply of non-medical personnel in the facilities, is bound to affect the efficiency of service delivery, negatively. An instance provided is that of a District Hospital using a staff person for cooking and guarding of the premises, most likely resulting in lack of appropriate attention to the duties of both positions.

Other questions to assess efficiency in service delivery were on the length of patients’ wait times at a facility; the volume of patients served in a normal day; and patients’ satisfaction level with the quality of instructions provided to the patients on use of medications and other health related advice.

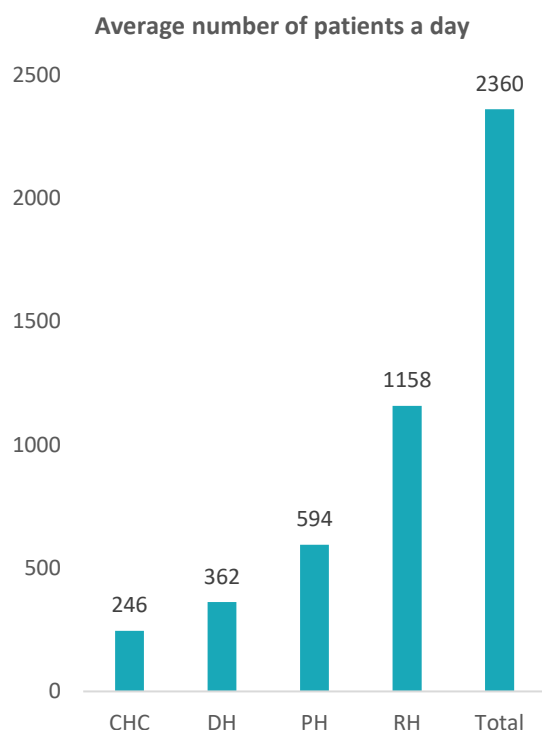
A large percentage of patients interviewed (88%) are satisfied with the instructions provided to them by doctors and nurses.



Patients’ responses indicate that they are served at a surprisingly good speed with only 12% of patients saying that their wait time for consultation with a doctor would normally exceed half an hour. With respect to the volume of patients served on a daily basis, the staff responses show that the facilities



received a little less than an average of 500 visits on a normal day, with RHs receiving much more than other facility types- more than 1100 per day on average, a positive finding.



Province	Average number of patients
Balkh	173
Bamyan	540
Ghazni	757
Herat	560
Kabul	407
Kandahar	763
Kapisa	500
Khost	323
Kunduz	475
Nangarhar	770
Paktia	465
Parwan	343
Wardak	450
<b>All facilities</b>	<b>468</b>

Overall on satisfaction level of the patients, the findings are mixed with some positive responses from the patients on their satisfaction levels but also an array of critical observations from both patients and surveyors.

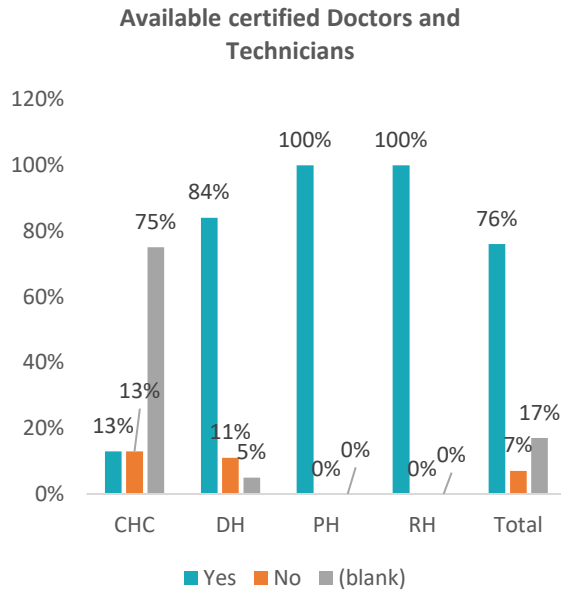
Surveyors and patients indicate that to respond appropriately to the needs of the patients not only more space, as discussed in Section 2 of this report, but more personnel and longer hours of operation are needed. The total service delivery hours per day is too short, in many instances. Surveyors and patients witnessed the closure of the facilities by early afternoon, with lots of patients still waiting to be served. Some of the staff and medical professionals were seen to arrive late for work and some of the staff left early, making it difficult to accommodate medical examination of all patients waiting. In contradiction to the finding (as reported above) that the wait hours, normally do not exceed half hour, the patient interview results indicate that patients endure long hours of wait periods just for receiving an appointment to be examined, with further wait until the time of the appointment with a doctor. Such experiences leave in patients, images of uncaring doctors and staff. No redress is possible as although some facilities (66%) claim to have a complaints-handling system in place, patients' experiences contradict this claim.

Reflections on reports of patient-interviews indicate that the patients in facilities managed by MoPH and donor contracted NGOs (Non-Governmental Organizations) registered complaints about poor administration and management of the facilities. They hold the NGOs responsible for the poor state of affairs in infrastructure, the inadequacies in service delivery, and especially for not taking measures to rectify the problems, sitting oblivious of the complaints.

### 3.2.3 Services Delivery –Medicines, Equipment Supplies and Medical Professionals

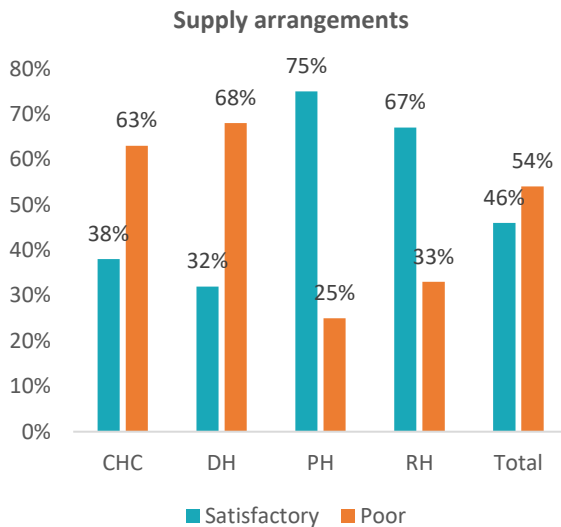
Anesthesia, blood bank, laboratory and pharmacy services were reviewed.

76% of the facilities have certified doctors and technicians for handling *anesthesia* services needs and in 73% of the facilities these professionals meet the established performance standards. 56% of the facilities maintain proper documentation and records of supplies. Some of these features are of little value, however, without adequate supply of medicines and other needed equipment.



Supplies are definitely insufficient; only 41% of the facilities have adequate supplies of medicines and equipment. Surveyors found facilities for which modern equipment have been purchased with donor funding but such equipment remain non-functional because medications and other supplies required for their use are not available.

Only 46% of the facilities have sufficient equipment, reagents/material supplies etc. in the *Blood Bank*. Established protocols for safety practices are found in 44% of the facilities. The conditions are not fully satisfactory.



Under services delivery for anesthesia services and blood bank, responses to a number of questions were left blank, with no added explanations registered by the surveyors.

As for laboratory services, comments, registered by the surveyors, underline that some facilities have no laboratory. 61% of the existing laboratories have adequate supplies of equipment and reagents/material. All facilities with laboratories have an adequate number of certified staff and technicians. Wide varieties of tests are performed by the laboratories. The areas covered are Hematology, Urine Analysis, Glucose, Bacteriology, Venereal Disease testing, Electrolyte examination, rapid immune-chemical test etc.

*Pharmacy* services- handling- sale, purchase, stocking and preserving medicinal and equipment supplies- deserve highest attention. Pharmacies are not always found within the facility compounds; and sometimes they are placed in inconvenient locations, making access difficult. In 78% of the facilities, however, the pharmacies are located centrally.

Unfortunately, over 50% of the facilities do not have adequate space in the pharmacy for medicinal stocks; and supplies of medicines and equipment are inadequate, in any case. The temperature control and ventilation systems in the pharmacies are often found to be inappropriate for preservation of pharmaceutical material.

Organization of the medicines and stocks - labelling of products - appear satisfactory in 68% of the facilities. The surveyors found expired medicines and medicines affected by dampness and mildew on pharmacy shelves. 85% of the facilities are found to maintain a data-base and records of stocks, but the supply arrangements are poor in more than 50% of the facilities; and it is no surprise that 87% of the facilities have experienced stock-out of medicines and/or equipment within the last one year.

In general, patients' access to medicines is not easy. Of the patients interviewed, 46% say that they are able to get prescribed drugs from the pharmacies. Patient interviews record dissatisfaction of patients

who are unable to get medication from the hospital pharmacies and are forced to buy these from outside at extremely high prices. Pharmacy personnel in 88% of the facilities provide proper instructions to patients on medications and other medical advice. Also, in 83% of the facilities patients are treated well by the pharmacy staff.

In terms of testing facilities for *diagnostic* purposes, adequate testing facilities are not often available. Staff responses indicate that certain systems are being introduced to promote specialized testing. For instance, a referral system - comprising arrangements of treatment of patients in specialized and advanced medical centers - can be accessed, if any facility lacks proper equipment and supplies or professional expertise for testing and treating certain conditions. It is difficult to gauge if this system is much in use. Not many patients have had the experience of ever been treated in any such centers.

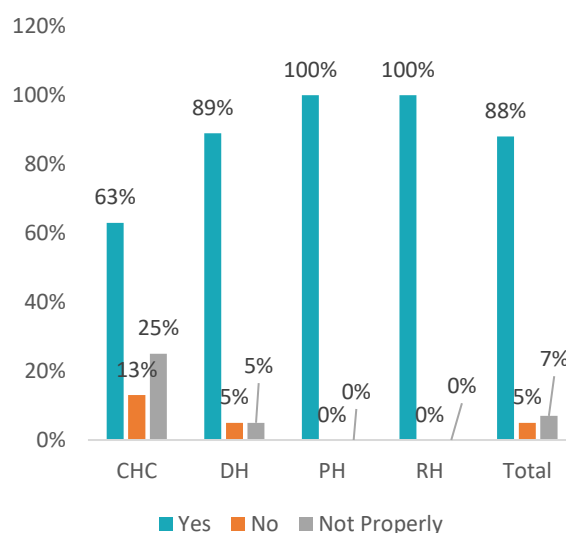
Considering the state of equipment supplies and space availability, a Regional Hospital is seen to be operating at a lower level- specifically, at the level of a Provincial Hospital. A District Hospital operating from a rented residential building is providing services at a lower level- level of a Comprehensive Health Center. The problems related to inadequate supply of medical professionals and of equipment and medicines are likely to be doubled in remote areas.

Overall, the patients' satisfaction level with the medical services delivered is not high; and the surveyors' assessment is less than positive. Although some of the medical service areas (as mentioned above) are found to have fair numbers of doctors and technicians, the surveyors' and patients' comments tend to support the conclusion that adequate numbers are not available to address the existing needs. According to the surveyors, with inadequate number of doctors, especially obstetricians, surgeons and pediatricians and lack of female doctors, in particular, the facilities do not have the capacity to respond fully to the demand for services.

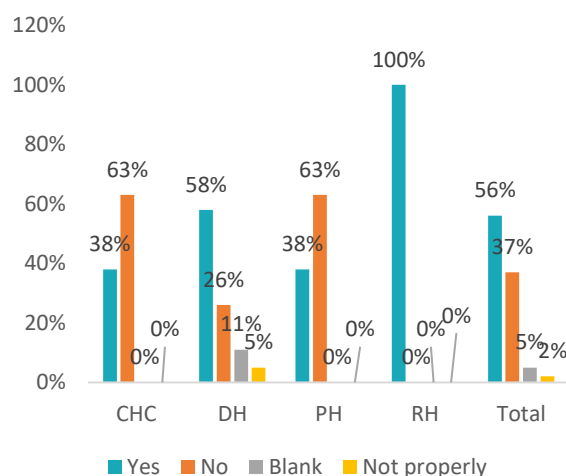
### 3.2.4. Infection Prevention and Cleanliness- high priority elements

**Sterilization:** 88% of the facilities have a Central Sterilization and Supply Department (CSSD) located within the premises. For quality sterilization adequate numbers of functioning autoclaves and ovens are needed. According to the surveyors, few facilities have an adequate number of functioning autoclaves and ovens to ensure quality sterilization. High Level Disinfection (HLD), in accordance with an established procedural chart, is performed in 56% of the facilities only.

CSSD department in the facility?



High-Level Disinfection (HLD) Performance?



**Patients’ Safety and Protection:** Safety Programs to educate patients on infection prevention and cleanliness practices are used in 78% of the facilities. To assess the adequacy of provisions made for safety of patients and their protection from infections, the tools used by surveyors are clear demarcation of transition zones and semi-restricted and restricted areas for infectious diseases. Such signs and labels have been found only in 20% of the facilities. Neither IP sections nor Isolation Wards are consistently found in all facilities. These deficiencies can easily expose patients to infection.

**Cleanliness, Infection Prevention and Decontamination:** The related procedures are not posted in all areas of the facilities nor are they consistently practiced. Infection Prevention practices level being generally low, IP training of the staff is a high priority.

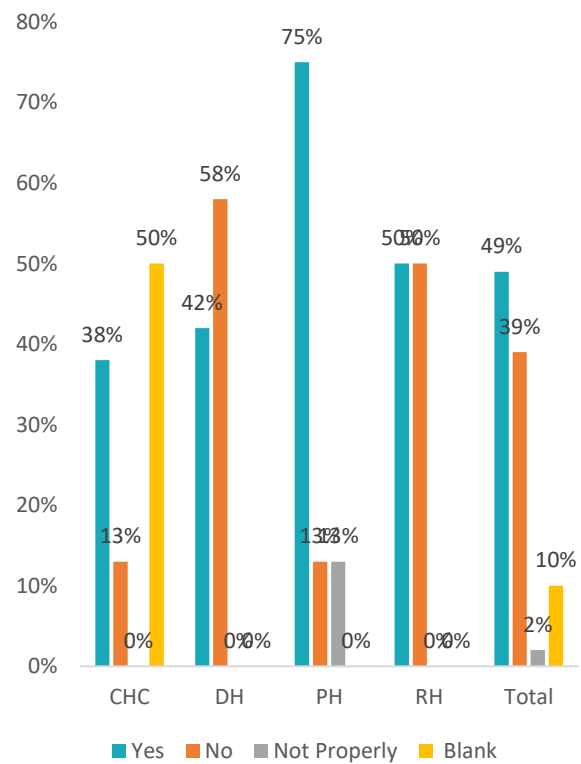
The study found and documented the following conditions:

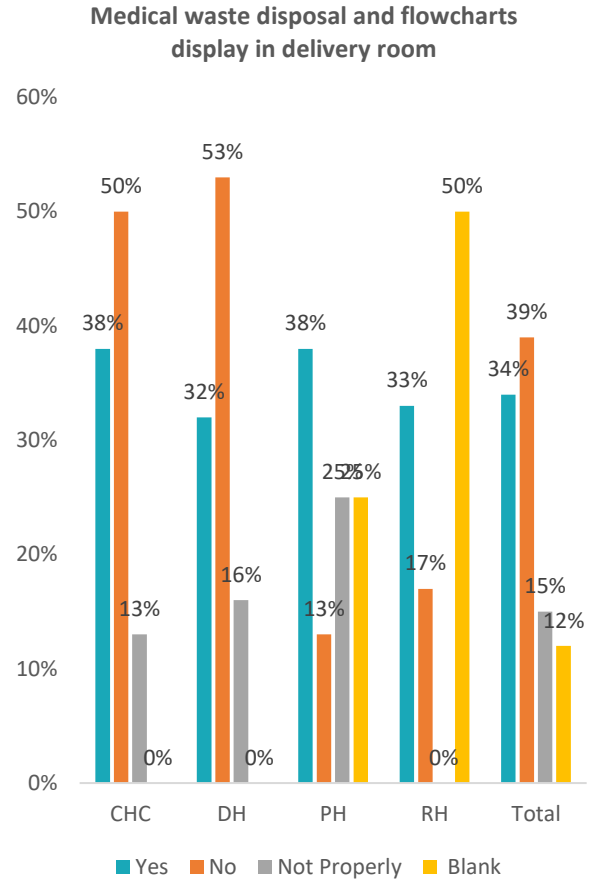
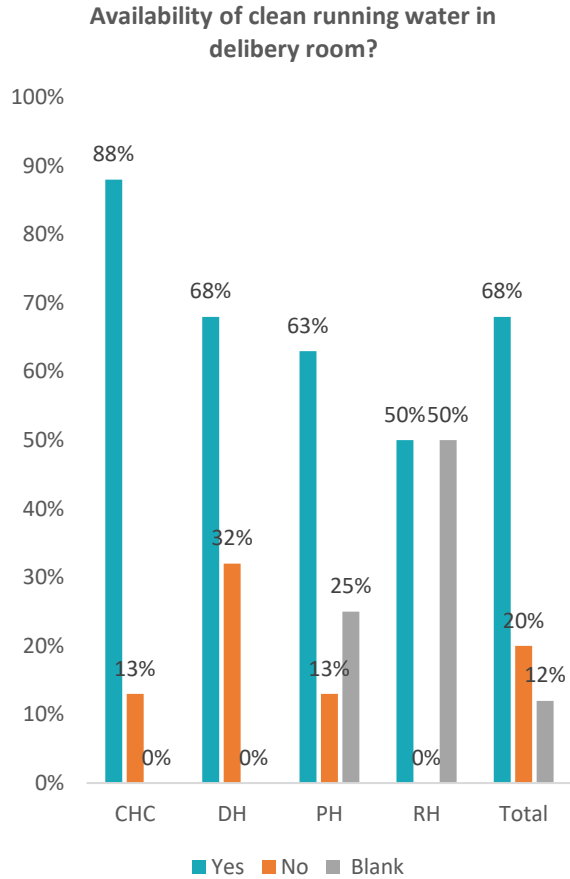
- Surgical units in 76% of the facilities have standard IP procedures in place and they are practiced.
- Clear protocols for isolation for management of infectious cases are found to exist but practiced only in 29% of the facilities. Larger facilities do better, with 67% of RHs having clear protocols.
- TB testing was seen to be undertaken in the laboratory of a facility with no safety cabin in sight- an issue of serious concern.
- In 83% of the facilities, urinary catheterization is done under infection prevention conditions. IV lines are maintained in hygienic conditions in the Blood Bank in 68% of the facilities. Supplies needed for infection prevention is maintained at a reasonable level in 71% of the facilities, as recorded in the staff interview report.
- The Labor and Delivery rooms in 25% of the facilities display poor cleanliness practices.

- In the Afghanistan context, washable floors and windows are considered to be standard necessities. In 76% of the facilities, the floors and walls of the labor and delivery-rooms are washable. In 54 percent of the facilities, the wards and in 56% of the facilities the blood banks have observable cleanliness. The surveyors’ observations indicate that cleanliness standards are not conscientiously and consistently maintained.

**Hand Hygiene and Running Water:** Clean running water is available in the Labor and Delivery Rooms in 68% of the facilities and in the Wards in 49% of the facilities. Observation of the surveyors indicate that they did not find any hand washing stations in many facilities, not even in surgical wards. Strikingly, hand hygiene protocols are in place and practiced only in 17% of the facilities in the Labor and Delivery rooms.

Availability of clean running water in rooms/wards?



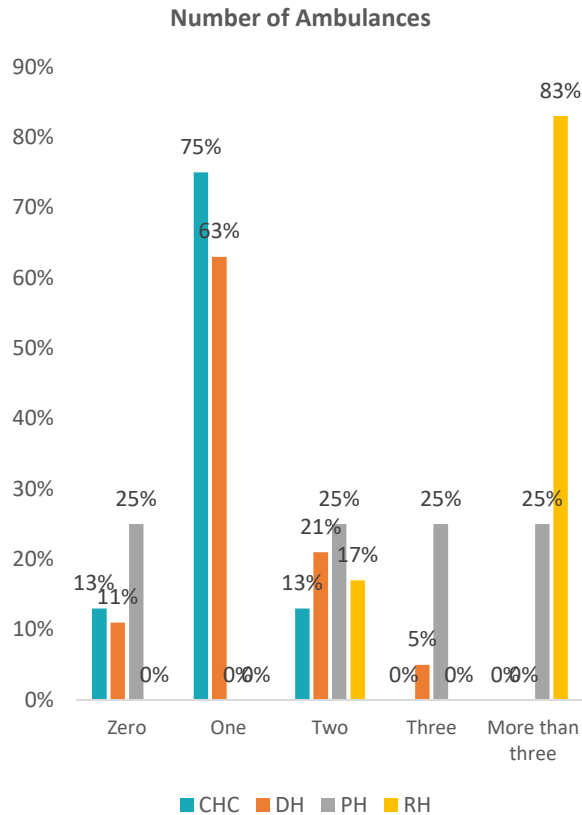


**Waste Disposal:** With respect to the procedures and practice of medical waste disposal, a low percentage of facilities (34%) have been found to display procedural flow charts for disposal, to promote the practice of proper disposal of medical wastes. 80% of the facilities properly dispose Sharps from the Laboratories, while only 49% of the facilities dispose Sharps from the Blood Banks and a lesser percentage (29%) of the facilities have proper Sharps disposal system in the Wards.

Notably, as well, responses to a few questions in IP, disinfection and decontamination, hygiene and handwashing and general cleanliness areas were left blank, without corresponding explanations.

**3.2.5. Transport Services for Patients**

88% of all facilities surveyed have at least one ambulance. 12% have none. Of facilities that have one ambulance, only 69% are properly equipped. The larger facilities- Regional Hospitals - are well endowed. All of RHs have at least 2 ambulances and 83% have more than 3. Eighty-seven percent (87%) of the smaller facilities- CHCs - own at least one ambulance. Of facilities that have at least one ambulance, 94% are not fitted with telephones or any other instrument of communication. And, only 75% have adequate fuel and maintenance allowances.



**3.2.6. Services for Food and Other Related Necessities**

Items surveyed included: cleanliness and hygiene practices in the kitchen; kitchen waste management system; health check of the people (kitchen staff and others) with access to the kitchen and food services; quality and adequacy of food on a daily basis and food stocking arrangements; meeting patients’ and staffs’ daily necessities.

**Cleanliness and Hygiene Practices Related to Food Services:**

Based on observation of the surveyors on cleanliness in the kitchen area and the staff dining area, 71% of the facilities look good. Clean running water is available in 73% of the facilities. In 76% of the facilities food is prepared in a clean and proper way. Arrangements for kitchen waste disposal is not good with waste disposal arrangements, available only in 59% of the facilities. Surveyors have registered comments on unclean kitchens seen during their inspection. In 54% of the facilities regular health checks are conducted for kitchen personnel. Uncontrolled movements of

unauthorized people in the kitchen area in more than 50% of the facilities, increase chances of spread of infection through food, contaminated by food handlers and visitors carrying infection.

**Quality, Variety and Adequacy of Food Supply and Timely Service:**

The tool used was interviews with patients and open-ended responses. When interviewed, majority of the patients gave satisfactory rating to the quality, adequacy and variety of food served. A few patients said that variety could be better or that amount of food served is inadequate. The responses made it clear that no standard time scheduling for serving food is followed. A response that there is no cook at the facility, being limited to one patient ought to be interpreted as a temporary problem, not regularly haunting the health facilities. Arrangements for food stocking is unsatisfactory, with only 37% of the facilities maintaining a system of recording food stock supplies.

**Addressing Staff and Patients’ Daily Needs:**

44% of the staff interviewed said that food is provided for them. Patients interviewed in 68% of the facilities confirmed that adequate clothes, food and other necessities are supplied. Availability of sufficient furniture, at least chairs and beds, in the patients’ rooms was checked. 85% of the facilities are found to be equipped with these essential items.

**3.2.7. Community’s Role in Service Delivery from Health Care Facilities:**

Communities should be accepted as *participants in action* to promote the public's health. The critical importance of the community in promoting an effective public health system is a fundamental concept in the international literature on health of the population. The accepted norm is that health services best address health care needs when people (communities) who are to be served, provide leadership in identifying and weighing importance of the needs. The extent of a public health care system’s engagement with the community served is thus a critical indicator of the effectiveness of health service provision. Community involvement in Afghanistan’s public health delivery system is

promoted through creation of Hospital Community Boards (HCBs).

Communities consist of individuals and families, as well as the various organizations and associations that make up a community's "civil society"- non-profit, nongovernmental, voluntary advocacy organizations; and the faith community, along with representatives of the public sector at the community level, encompassing local government level officials and agencies, traditionally seen to have health-related responsibilities.

Such community involvement in health care delivery was examined with staff responses to questions asked by the surveyors.

That 98% of the staff interviewed confirm that Hospital Community Boards (HCB) are operational is encouraging. A look at the composition of the HCBs shows wide representation from the civil society. HCBs are enriched with representatives of the youth, teachers, women, community leaders and elders and religious leaders, along with representatives from the government and the health care facilities and people's elected representatives.

Indicators of effective operation of the HCBs are examined through questions and responses on the following:

- Regularity of meetings of HCBs- 59% of the facilities with HCBs meet somewhat regularly.
- Efforts to promote efficient operation of the HCBs through provision of orientation training to HCB members- all of the HCBs offer training;
- Systems to improve management of the health care facilities- 83% of the facilities have HCBs that conduct annual performance appraisal of the director of the health care facility serving the community;
- Importance attached to HCB's needs identification and prioritization by the management of the health care facility- 76% respond that needs are met and the

complaints are acted upon, with follow up actions.

With respect to rating the overall effectiveness of the HCBs, close to 50% of the responses from the staff show that they are operating efficiently and effectively, serving as a bridge between the public health facility and the community. However, another 50% say that they do not know if HCBs are effective, indicating a lack of knowledge of the subject. This leads one to doubt the utility and efficiency of a system about which half the directly affected population know nothing.

The findings in this section and the preceding indicate management deficiency attributable to lack of appropriate oversight by the MoPH, the representatives of donors funding the facilities and any other entities, such as, the headquarters of the NGOs (national/international) contracted to manage the facilities. The staff interview records show that a certain percentage of the facilities had been visited and inspected by such external bodies but the results or impact of the inspection visits in improving management in the specific facilities that are the subjects of this study has not been examined.

### 3.3. State of Performance by Facility Types

Findings related to differences in the performance status of the types of facilities (RH, PH, DH and CHC) is interesting to note. In general, a trend is discernable showing better performance by the facilities at the regional level than those at the provincial, district and community levels.

A review of the responses in a very large number of questions in the infrastructure and medical service delivery categories indicate that the larger facilities- namely the RHs- perform better. This conclusion is based on data analysis showing that higher percentages of RHs display adherence to better practices principles in both the infrastructure and medical services categories. Findings indicative of a trend of better performance of the RHs in the infrastructure category have been cited in Section 2.3. of this report. Indications of such a trend in the

category of medical services delivery are iterated below.

The RHs show better performance in ensuring safety for the patients in maintaining high standards in health and hygiene practices. Observable cleanliness is noted in the floors, walls, treatment rooms and wards, in the OPD, laboratory and the blood bank in the RHs. Health and hygiene protocols (including hand-hygiene protocol) are observed. Running water and functioning handwashing stations are found. Kitchen and medical waste disposals systems are operational in the RHs, protecting patients from infections and contaminations from wastes. The survey data indicates exceptionally strict application of the procedures for disinfection and contamination and infection prevention by the RHs.

RHs' human resource management appears better than those of the other facility types, assessed by indicators, such as, regularity of annual staff appraisal; getting the staff to understand the terms of reference of their services; handling of staff attendance, compensations, occupational health issues and staff complaints etc.

The strength of the human resources management seen in the RHs is likely one of the factors driving the better performance of the RHs, the other being their advantageous locations, with better access to infrastructure and human and material resources, to which the smaller facilities do not have access.



## SECTION 4

### Conclusion

The objective of the survey of 41 public health facilities, was to assess the quality of health care provided, through gauging the capacities of the facilities to deliver quality services. Analyses of the survey data in Sections II and III of this report, facilitated collection of useful material to inform conclusions on the current state of capacity of Afghanistan's health facilities. Drawing from the details presented in Sections II and III, this section presents a set of conclusions on the capacity deficiencies of the health facilities that will help decision makers to take remedial actions for improving health, a fundamental resource to the individual, the community and the society.

The shortfalls in infrastructure and medical service delivery capacities that deserve MoPH and donor attention are reported below. For quick and clear comprehension of the conclusions drawn, reference to findings enumerated and discussed in data analysis sections II and III is recommended.

The good news is that all the *facilities in the sample are active and operating for no other purposes but care delivery.*

The priority need for *easy access to health facilities* is not met. Poor condition of the walking paths and sidewalks, leading to the facilities, are making *access to the facilities* difficult. Accessibility varies with the size of the facilities, with RHs (generally larger facilities) scoring higher marks. The CHCs, often located in remote areas, have least accessibility by road or walking paths. This condition does not send a positive signal to the rural poor communities.

*Inadequacy of space* to meet the demand for services is a major shortfall. Various factors have contributed to this problem. Sizes of the facilities are found to be smaller than the population they are to serve. Poor floor planning and haphazard placement of wards and rooms on the floor, not respecting the original architectural design and plans most convenient for service delivery, resulted

in smaller and inconvenient space allocation. The space problem is further exacerbated by poor building maintenance that close up sections designated for service delivery.

*Poor operation and maintenance (O&M)* of the buildings, severely limits care delivery capacity. The negative impact of lax O&M features prominently throughout this report.

The state of certain elements of the physical infrastructure, such as the roofs, doors, window, walls and floors of the facilities, unclean toilets, kitchens and general unclean look of the facilities, make the poverty in maintenance services obvious. Infrastructure, as essential as fully functioning plumbing and electrical systems, is ridden with poor maintenance. Plumbing system fixtures in various facilities remain not serviced, and thus, non-functional. The absence of maintenance is glaring in the electrical systems, as well, with the wiring systems and lighting fixtures in poor condition, resulting in poor lighting of the facilities.

*Climate control*, a basic infrastructure for health facilities operating in extreme weather conditions- extreme heat and cold - is not fully satisfactory. RHs offer better access to climate control than the rest.

Supportive infrastructure to ensure appropriate *safety and security arrangements* for patients and staff, mainly provision of *protection against* fire incidents and infections, are lacking, exposing the patients and staff of the facilities to danger.

Other critical infrastructural elements, indispensable for health care facilities- *clean running water and handwashing stations, proper garbage and medical disposal systems*- are not consistently available in all areas of the facilities and such shortfalls limit the capacity to protect patients against infections.

The necessary *transport infrastructure, comprising properly equipped ambulances*, is not available in all

facilities and has created a capacity vacuum in service delivery.

Most of these areas of short falls, affect the RHs less, implying that by and large, the RHs have better capacity in these areas compared to the rest.

Capacity for efficient and quality service delivery are affected by inadequate *supply of medicines and equipment and also of non-medical and medical personnel, especially female doctors.*

Access to medicines is difficult for patients when *pharmacy services* are not available in the facility compounds, compelling patients to buy medicines elsewhere at high prices. *Stocking and preservation of medicines and equipment in the pharmacies* are limited by space constraints, *poor supply arrangements and improper ventilation systems.*

Inadequate supplies of medicines, material and equipment have generated capacity constraints in delivery of *anesthesia, blood bank and laboratory services.* Lack of adequate equipment affects the *quality of sterilization and heightens chances of infections and contamination.*

Inadequate attention to stocks and supplies affects services as basic as food. A *capacity vacuum in food services* is detected not only in the maintenance of food stock supplies but also in the maintenance of hygiene and cleanliness conditions in the kitchen and prevention of contamination of food, the latter because access of unauthorized personnel into food services areas is not regulated.

The service deficiencies are exacerbated by *inadequate supply of personnel- both medical professionals and other staff.* Lack of medical professionals generates capacity constraints in testing and diagnostic and treatment services. Lack of *female doctors* is a deficiency that limits the capacity of the health care facilities to deliver services to half of the nation's population.

*Poor supervision and management of wages and salary payments* (irregular salary flows) indicate *poor personnel management capacity.* As well, irregular salary flow to the staff contributes to capacity deficit in service delivery, as a body of staff, improperly remunerated, has little motivation to serve.

The shortfalls identified in service delivery by the surveyors and the patient interview results leave little doubt that in general the public, for whose benefit the health services are delivered is left dissatisfied, by and large. The management of the facilities have basically not taken full advantage of the existing hospital community boards (the HCBs) to *stimulate the support of the communities served.* HCBs which fail to meet regularly are as good as non-functional. The complaints handling system, a tool to redress patients' grievances is not well utilized.

The survey detects poor *management capacity of the NGOs,* which the staff and patients, primarily blame for poor service delivery. Only one NGO, Aga Khan Foundation, is noted as an exception and the best implementer and manager of all health facilities surveyed.

An interesting finding is a discernable trend of the regional hospitals less affected by some of the capacity deficiencies in the infrastructure and medical services categories.

What now, following the lessons registered on the shortfalls and capacity deficiencies of Afghanistan's health facilities? A broad plan of action is proposed in the concluding section.

## SECTION 5

### Recommendations

A close look at the current state of the capacity of Afghanistan's health facilities leads to the inevitable conclusion that the shortfalls in infrastructure, operations and maintenance and management limit the capacities of the health facilities to deliver the needed services. Such deficiencies must be addressed, first and foremost, by *enhancing MoPH's oversight of the operations* of the facilities along with *MoPH's assumption of a leadership role in planning and implementation of remedial measures, addressing the shortfalls*.

This exercise for strengthening the oversight of the operation and planning, led by MoPH, must involve consultation and coordination with international donor partners, the organizations or agencies contracted for health care delivery and civil society organizations and community members in the locale of the facilities. Given better performance of the RHs, involvement of representatives of RH management in advisory capacity should be considered.

Enhanced oversight will first require scheduling of disciplined and regular visits to the facility sites by a dedicated MoPH team. The central focus of MoPH's regular and pre-scheduled visits to the facility sites must be to plan measures for rectifying and preventing recurrences of the problems that generate the shortfalls and the resultant capacity deficit. Community monitoring of health facilities must also be considered as a critical tool for the health facilities monitoring.

Given that weak O&M is one of the major drivers of capacity deficit, elaborate plans for maintenance in all areas of infrastructure and medical service delivery must be made and action plans detailed for their implementation by the facility management team and the staff. Budget adjustments in support of the implementation of the plans might be necessary in certain instances.

A performance measurement framework (PMF) must be developed for use by the MoPH, the donor partners and the facility management team, to track and ensure progress in the implementation of the plans. Regular monitoring visits from the MoPH are needed for tracking progress. The minimum standard of services must be clearly defined for proper measurement of performance.

Implementation of the plans would most likely call for training of the facility staff. Training plans must take into account that long periods of training of the regular staff might exacerbate the problems of inadequate staff supply that has negative impact on service delivery. Interim arrangements for replacement of staff on training should be made which would have budget implications. The MoPH might need additional technical assistance in support of its role in supportive supervision, monitoring and management of health facility operations.

## Bibliography

1. Ministry of Afghanistan. (2005). *A Basic Package of Health Services for Afghanistan, 2005/1384*. Kabul, Afghanistan: Islamic Republic of Afghanistan Ministry of Public Health.
2. Ministry of Public Health. (2005). *The Essential Package of Hospital Services for Afghanistan*. Kabul, Afghanistan: Islamic Republic of Afghanistan Ministry of Public Health The Essential Package of Hospital Services for Afghanistan, 2005/1384.
3. Newbrander, W. (2007). *Rebuilding Health Systems and Providing Health Services in Fragile States*. Kabul, Afghanistan: USAID Occasional Papers.
4. Salama, P., & Alwan, A. (2016). Building health systems in fragile states: the instructive example of Afghanistan. *The Lancet Global Health*, 351-352.
5. The PLoS Medicine Editors. (2011). *Health Care Systems and Conflict: A Fragile State of Affairs*. The PLoS Medicine Editors.
6. Himmelman. (2001). On coalitions and the transformation of power relations: collaborative betterment and collaborative empowerment. *American Journal of Community Psychology*, 277-284.
7. Institute of Medicine (US) Committee. (2002). *The Future of the Public's Health in the 21st Century*. Washington (DC): National Academies Press (US).
8. Kickbusch, I. (1989). Approaches to an ecological base for public health. *Health Promotion International*, 265-268.
9. LM Salamon, H. A. (1999). *Global Civil Society: Dimensions of the Nonprofit Sector*. Baltimore: Johns Hopkins Comparative Nonprofit Sector Project.

## Annex

### SUMMARY OF FACILITIES BY PROVINCE


<b>BALKH</b>	<b>KHOST</b>
ABO ALI SINA-E-BALKHI	DARAKAI CHINIC
BALKH HOSPITAL	ISMAIL KHIL CHINIC
BURN AND RECONSTRUCTIVE SURGERY HOSPITAL	KHOST PROVINCIAL HOSPITAL
DAWLAT ABAD HOSPITAL	<b>KUNDUZ</b>
KHULM HOSPITAL	KHAN ABAD HOSPITAL
KOD BARQ HOSPITAL	KUNDUZ REGIONAL HOSPITAL
<b>BAMYAN</b>	<b>NANGARHAR</b>
BAMYAN PROVINCIAL HOSPITAL	KAMA DISTRICT HOSPITAL
YAKAWLANG HOSPITAL	NANGARHAR PROVINCIAL HOSPITAL
<b>GHAZNI</b>	NANGARHAR REGIONAL HOSPITAL
GHAZIN PROVINCIAL HOSPITAL	<b>PAKTIA</b>
<b>HERAT</b>	ARYOUB ZAZI
GHORYAN HOSPITAL	PAKTIA REGIONAL HOSPITAL
GOZARAH HOSPITAL	SAMKANI HOSPITAL
HERAT REGIONAL HOSPITAL	<b>PARWAN</b>
NAWABAD CLINIC	BAGH-E-MAIDAN
SHAKIBAN CLINIC	GHULAM ALI
<b>KABUL</b>	PARWAN PROVINCIAL HOSPITAL
CHAHAR ASYAB	<b>WARDAK</b>
MIR BACHA KOT	WARDAK PROVINCIAL HOSPITAL
QARABAGH HOSPITAL	
RAHMAN MINA HOSPITAL	
SAR-E-KOTAL	
SUROBI HOSPITAL	
TAINKOT HOSPITAL	
<b>KAISA</b>	
KAPISA PROVINCIAL HOSPITAL	
<b>KANDAHAR</b>	
DR SHAMSULHAQ KAKAR	
MIRWAIS REGIONAL HOSPITAL	
NAZOANA CLINIC	
SPINBOLDAK	




INTEGRITY  
WATCH  
AFGHANISTAN

Qala-e-Fathullah,  
Kabul, Afghanistan

---

 +93 (0) 780 942 942

 [info@integritywatch.org](mailto:info@integritywatch.org)


 [www.integritywatch.org](http://www.integritywatch.org)

 @IntegrityWatchA

 [fb.me/iwaweb.org](https://fb.me/iwaweb.org)

 [/IntegrityWatchAfghanistan](https://www.facebook.com/IntegrityWatchAfghanistan)

 [/IntegrityWatchAfghanistan](https://www.instagram.com/IntegrityWatchAfghanistan)

 [/IWACorruption](https://www.youtube.com/IntegrityWatchAfghanistan)