HEALTH POLICY PROJECT

Landscape Analysis of Gender-Sensitive Data Available Within the Afghanistan MOPH

APRIL 2013

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Disclaimer: This report is primarily based on interviews with key informants within the MOPH as well as the review of some sentinel documents. Hence, the information may not always be accurate or current. The author has made the best effort to verify the information presented here through multiple interviews with various officials and reviewed whatever documentation was made available.

EXECUTIVE SUMMARY

Background

The Gender Department within the Afghanistan Ministry of Public Health (MOPH) was established in 2010 as a step towards ensuring gender equity and mainstreaming. The Gender Department then developed a National Gender Strategy (2012-2016), with the aid of the USAID-funded Health Services Support Project (HSSP). One of the objectives of the National Gender Strategy is to "develop gender-sensitive indicators and include them in MOPH Health Management Information System (HMIS) for all relevant health programs." The USAID-funded Health Policy Project (HPP) aimed to assist the Gender Directorate in this activity. Hence, a landscape analysis was conducted in January and February 2013 to review the existing health-related tools and datasets that exist within the MOPH, determine the process through which indicators could be included in various tools used by the MOPH departments such as the Health Management Information System (HMIS), monitoring and evaluation (M&E) and surveillance departments, and to obtain stakeholders' views on the feasibility of revising/introducing new gender health indicators into the existing tools.

Methodology

First, several sentinel documents were reviewed. Then, key informant interviews were conducted in Kabul from January 21 - February 7, 2013. The analysis includes a summary of the key informant interviews and the review of the new tools that were received during the interview process.

Findings

HMIS Department

Meetings with the HMIS staff determined that the HMIS database collects information on health care services being provided at all public facilities. Besides this, community-level data are collected on births, morbidity and mortality, from three million households around health facilities. The dataset contains 1000 variables that represent 139 indicators. The HMIS does not analyze the data but makes it available to all departments within the MOPH and others as well, upon request.

The HMIS has sex-disaggregated data for diagnoses, admissions and lab tests. Some data related to human resources and facility infrastructure are also sex-disaggregated. Hence, we note that the current HMIS database has a huge repository of sex-disaggregated data on client use, human resources and facility infrastructure at the hospital level.

The HMIS will be revised in 2015 and requests to make modifications will be sent out to all Departments in early 2014.

M&E Department

The M&E Department primarily collects monitoring data across all health facilities, their main tool being the National Monitoring Checklist (NMC). The NMC data are collected from all health facilities within a province every quarter. Every quarter, a random group of facilities are selected to have an M&E staff from the head office accompany the Provincial Health Director. In this way, the M&E team moderates the quality of data that are being collected through the NMC. The M&E team also monitors the data that are reported to the HMIS by cross-checking the HMIS tally sheets with the original hospital log books.

The NMC has several sex-disaggregated variables that cover data on clients, human resources and the facility.

Every year, the M&E Department receives requests to add to/revise the NMC; it receives inputs for edits by March of every year and distributes the final questionnaire to the Provincial offices soon after. However, the NMC is currently undergoing major revisions which will become effective in a couple of years.

GCMU Department

Meetings were held with a representative of the Johns Hopkins Bloomberg School of Public Health (JHBSPH) in Kabul as well as a member of the GCMU team at the MOPH. The Balanced Scorecard (BSC) is the main survey tool used by the GCMU to monitor the quality of public healthcare services. The BSC is a third-party evaluation administered by the JHBSPH. It is carried out among all facilities providing the Basic Package of Health Services (BPHS) annually. It has also included a recent survey of hospitals providing the Essential Package of Health Services (EPHS) and national hospitals. The survey involves reviewing hospital records, interviewing healthcare providers, observing doctor-patient interactions followed by exit interviews of the same patients. In addition, all eligible women from 12,000 households are also interviewed.

In 2012, a separate GBV module was added to the questionnaire given to around 2,500 healthcare workers, the results of which are still pending. In addition, the BSC has gender-sensitive data on the health facility and human resource distribution. Not all the gender-sensitive indicators are analyzed by the JHBSPH but the data exist.

The BSC is being rebid under the Systems Enhancement for Health Action in Transition (SEHAT) Project, funded by the World Bank and the European Union.

Quality Improvement (QI) Department

The QI Department shared the process through which QI is being conducted across health facilities. There are over 400 QA standards tools that assess the quality of services within health facilities, covering 11 areas that are collected using 22 tools. The 11 areas include clinical standards, i.e., maternal and newborn health, child health, nutrition, communicable diseases (TB, malaria, HIV), mental health and disabilities, and the cross-cutting standards, i.e., infection prevention, pharmaceutical, blood transfusion, gender, and hospital management. The QA tools are used for internal assessment as well as external evaluation of each health facility. The tools can be used at baseline and followed up with 3-monthly repeat assessments over the course of 9 months.

Gender is integrated in all the 21 tools being used and is a standalone area as well that primarily compiles the gender-sensitive variables across all the other 21 tools.

In addition to their existing tools, the QI Department will be analyzing selected data from the HMIS, NMC, BSC and some other surveys in an attempt to expand quality assessments.

Surveillance Department

The Surveillance Department monitors the outbreak of 16 communication and high-risk diseases, including pregnancy-related deaths, across all 34 provinces (i.e., 8 districts). Due to the recommendations of the Gender Directorate, all new cases are disaggregated by sex.

Human Resources Department

The Human Resources Department shared information regarding the healthcare workforce and some of its policies. There is equal employment opportunity for all and no specific benefits for female employees, except maternity leave and a per diem for a male escort on out-of-town trips. Very few senior and mid-

level posts within the MOPH are occupied by women. Even among healthcare workers, few women are employed, for e.g., 15% of nurses and 17% of general physicians are women.

Research Department

The Research Department shared a list of gender-related studies that have been approved and conducted in Afghanistan since 2010. We were able to supplement it with information we received on other studies being conducted. Hence, we do not have the complete information on all the gender-related studies being conducted in Afghanistan.

Information on GBV Data within the MOPH

Three different projects are collecting data on gender based violence (GBV) in Afghanistan. First, in 2012, the BSC asked healthcare providers questions on their sensitivity and skillset to treat a woman who has experienced GBV. Second, the Ministry of Women's Affairs (MOWA) has established a GBV Information Management System (IMS) database with the aid of UN Women. GBV victims report to provincial offices of MOWA, Human Rights Commission, Ministry of Interior and Afghanistan Independent Commission and their information is entered into the GBV IMS. Third, the MOPH, with the aid of UNFPA, is pilot testing a project within health facilities to diagnose and managed GBV victims. Healthcare providers from three provincial hospitals will be trained to diagnose GBV cases; the women will then be transferred to a response room where they will receive the necessary care and interventions.

Conclusion

There is adequate data within the MOPH on gender-sensitive indicators. The Gender Directorate should strive to use the existing data for program and finance gender mainstreaming activities. The next steps include sharing the findings of this report with the Gender Directorate, Gender Task Force and other relevant MOPH Departments, sharing information on gender monitoring with the Gender Directorate and developing a plan with them to better use the existing data for advocacy and financing allocations.

ABBREVIATIONS

APHI	Afghan Public Health Institute
BPHS	Basic Package of Health Services
BSC	Balance Scorecard
CAC	Community Annual Catchment
CGHN	Consultative Group on Health and Nutrition
EPHS	Essential Package of Health Services
GBV	Gender Based Violence
GCMU	Grants Control Management Unit
GDHR	General Directorate – Human Resources
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPP	Health Policy Project
HR	Human Resources
HSSP	Health Services Support Project
HQIP	Harmonized Quality Improvement Program
IMS	Information Management System
JHBSPH	Johns Hopkins Bloomberg School of Public Health
JHU	Johns Hopkins University
M&E	Monitoring and Evaluation
MOPH	Ministry of Public Health
MOWA	Ministry of Women's Affairs
NGO	Non-governmental Organization
NGS	National Gender Strategy
OB/GYN	Obstetrics/Gynecology
QA	Quality Assurance
QI	Quality Improvement
RH	Reproductive Health
SEHAT	Systems Enhancement for Health Action in Transition
TAG	Technical Advisory Group
TB	Tuberculosis
UNFPA	United Nations Population Fund
UN	United Nations
USAID	United States Agency for International Development
WHO	World Health Organization

BACKGROUND

Gender equity and mainstreaming is one of the priorities of the Islamic Republic of Afghanistan and is included in its National Action Plan for the Women of Afghanistan (2007-2017). As a result, the Gender Department of the Afghanistan Ministry of Public Health (MOPH) was established in 2010. The MOPH was the first ministry to create the Gender Department (now a Directorate). With assistance from the USAID-funded Health Services Support Project (HSSP), the Gender Directorate developed a National Gender Strategy for the MOPH for the years 2012-2016.

The goal of the National Gender Strategy 2012-2016 is to improve the health and nutrition status of women and men equitably and to improve gender equity within the health sector. Four strategic directions are outlined, along with sub-objectives and activities to achieve the objectives and strategies.

- **Strategic Direction 1:** Work with all MOPH programs to incorporate a gender perspective, including a focus on gender-based violence and mental health, and to implement gender-sensitive activities.
- **Strategic Direction 2:** Advocate that all administrative policies and procedures of the MOPH are gender equitable and are sensitive to the needs of women and men.
- **Strategic Direction 3:** Work to ensure that women and men have equal access to health services that are free of discrimination and that address gender-based violence.
- **Strategic Direction 4:** Create gender-sensitive indicators for all health programs, monitor them, and evaluate programs accordingly.

Strategic Direction 4 includes a Strategic Objective to "develop gender-sensitive indicators and include them in MOPH Health Management Information System (HMIS) for all relevant health programs." As part of its support to the MOPH Gender Directorate, the USAID-funded Health Policy Project (HPP) aims to work towards fulfilling this Strategic Objective. However, the extent to which gender-sensitive indicators were already being collected through the HMIS and/or through other routine data collection tools was unclear. Therefore, HPP, in collaboration with the MOPH Gender Directorate, conducted a landscape analysis in January and February 2013 to:

- Review existing health-related tools and datasets that exist within the MOPH such as the HMIS, monitoring and evaluation (M&E) and surveillance tools, and to understand what gender-related indicators are being collected in order to identify gaps,
- Determine the process through which indicators are included in various tools used by the MOPH departments such as the Health Management Information System (HMIS), monitoring and evaluation (M&E) and surveillance departments, including the schedule for update of the MOPH HMIS,
- Obtain stakeholders' views (e.g. Gender Directorate, members of the Gender Task Force, M&E department, Afghanistan Public Health Institute (APHI), General Directorate - Human Resources (GDHR)) on the feasibility of revising/introducing health indicators that integrate gender.

METHODOLOGY

The landscape analysis was carried out in January and February 2013. As an initial step, the following documents were reviewed: National Gender Strategy (NGS) 2012-2016, Implementation Plan for the NGS, the HMIS manual and the Balanced Scorecard National Report for 2011-2012. Further documents, tools and reports were identified and collected during the key informant interviews.

MOPH interviews and meetings with key informants were carried out in Kabul from January 21 - February 7, 2013. The Heads of several departments were interviewed to identify existing databases and studies that collect data for the MOPH and determine whether and how gender is integrated into them. Several new documents and

tools were received during this time. Two meetings were also held with the Gender Directorate staff, and one meeting was held with the Gender Taskforce committee members to share preliminary findings from the analysis. In addition, meetings were held with representatives of the UNFPA and UN Women. **Annex I** provides a list of people interviewed.

FINDINGS

Representatives from seven main MOPH departments that compile data were interviewed as part of the landscape analysis. The departments and their location in the MOPH *tashkeel* (organogram) are outlined in **Annex II**. **Annex III** also provides a list of the departments that were interviewed and the main tools and studies that were investigated further within each department.

HMIS Department

Purpose of meeting

The purpose of meeting with the HMIS department was to get a clear understanding of the types of indicators that are currently being collected within the HMIS. The Gender Directorate stated that sex-disaggregated data were not currently being collected, and that the language of the indicators that the HMIS department reported on should be changed to include sex-disaggregated data. The Gender Directorate also wanted gender equity indicators included at the facility-level, such as the availability of female healthcare providers, i.e., nurses and doctors, and separate waiting rooms and toilets for men and women. They also wanted gender-based violence (GBV) indicators added to the facility surveys in order to detect cases at the facility-level.

Two meetings were held with the HMIS staff. The HMIS data were also discussed at meetings held with other departments.

Findings

History of the HMIS

The HMIS department administers the HMIS database, which was first developed in 2003-04. The initial aim was to monitor the health care services being provided at public facilities, as most of the services were administered by NGOs. At present, the HMIS department aims to develop a single data warehouse to prevent duplication and to ensure that the data are user-friendly for staff at various levels of the system. The HMIS was revised in March 2011. At that time, the HMIS department conducted a mandatory training on the revised HMIS covering three topics: 1) HMIS basic training - tools, definitions, 2) database and how to extract data, and 3) data use. The Gender Directorate staff did not attend the training; in addition, several of the current Gender Directorate staff members were hired after 2011. The trainings are still available on-demand for anyone who requests it.

Dissemination of HMIS data

HMIS data are compiled and released every three months. The HMIS does not analyze the data; they clean it and make it available to all MOPH departments and directorates. The data is also available upon request to those outside the MOPH. The list of 139 indicators results in a dataset of 1000 variables. Upon request, the HMIS department will also create a sub-dataset of specific variables.

HMIS data

The HMIS collects facility-level and community-level data. Data are collected by health workers at public health posts, health centers and all public hospitals on a monthly basis. All the facilities are geocoded. These data are reported to the provincial HMIS office, where data are entered into ACCESS and reported out quarterly. Besides hospital data, the HMIS conducts population-level censuses in specific catchment areas around health facilities. Three million households are included in the CAC (Community Annual Catchment) area censuses, which collect

data on births, morbidity and mortality at the community level. In addition, data on human resources are collected through 2 systems- 1) facility and hospital status reports that include data on services, health workers and equipment, and are collected bi-annually, and 2) catchment area data which provide an overview of existing human resources within the community and are collected annually. Catchment area data from around 70% of facilities providing the Basic Package of Health Service (BPHS) are available. The HMIS also has a questionnaire they administer to health care providers who provide information on the quality of services being provided. There is 94% compliance of all public facilities providing data to the HMIS; i.e., around 6% of facilities do not provide data to the HMIS on time to be included in their database. The quality of the data is good, but varies depending on use; i.e., if other MOPH departments or facilities use the data collected frequently, the quality of that data are good. However, if the data being collected are not reviewed and used by others, the quality of those data often tends to be poor.

Gender-sensitive data in the HMIS

In 2010-2011, some new gender-sensitive variables were added to the HMIS based on discussions with the Gender Directorate. As a result, a lot of the client-based data are sex disaggregated. For example, at present, diagnoses of all in-patient and out-patient cases are disaggregated by sex and age categories (i.e., <5 or >5). Furthermore, total number of outpatient visits and in-patient admissions, differential diagnoses of all conditions and lab tests involving TB sputum, malaria and HIV are also reported as sex-disaggregated. In addition, some data related to human resources and facility infrastructure are also sex-disaggregated; for example, the distribution of healthcare providers by cadre and sex, the presence of separate latrines for men and women, etc.

Sub-datasets

There are several sub-datasets that are integrated with the HMIS. For example, the TB department has a sub-dataset called the TB Information System (TBIS). The personnel who enter the HMIS data also enter data within the TBIS where more details are reported directly into the sub-dataset, for example, sex-disaggregated data of diagnosed cases, those treated and compliance rates. Another sub-dataset that is functional is the Malaria Information System (MalariaIS).

Verifying HMIS data

There are several mechanisms to verify the data collected by the HMIS.

- National Monitoring Checklist, which focuses on BPHS indicators
- Third-party verification which includes
    - The Balance Scorecard maintained by the Grants and Contracts Management Unit (GCMU) and Johns Hopkins University
    - Results Based Financing, which ensures data validation from 11 provinces
- Data quality assurance assessment, which verifies quality and use of data
    - The data quality report is available to the following organizations:
        - MOPH staff at provincial level
        - GCMU and M&E monitors
        - Randomly selected clinics
- NGOs serving the public sector also report any technical problems they are facing to the HMIS department

Revising the HMIS

The HMIS will be revised in 2015. In early 2014, a formal request will go to all the MOPH departments to suggest changes to the HMIS, based on selected criteria. The responses will be received as official letters from the Heads of Departments. A sub-committee will discuss the suggestions and determine the changes that should be made to improve upon the HMIS. In addition, the HMIS will add a household survey that will ask about access to services.

Conclusion

The HMIS appears to be a well-coordinated well-funded component of data collection within the health system of Afghanistan. The HMIS includes a lot of sex-disaggregated data that cover client use, human resources and the facility infrastructure. **Annex IV** includes a table of gender-sensitive variables within the HMIS.

Case study of Reproductive Health (RH) Department's experience with HMIS

Two meetings were held with the head of the RH Department to conduct a special case study on how the HMIS data are currently being used in a department similar to the Gender Department.

The analysis revealed that the RH Department had an M&E sub-committee which comprised of members of the RH Department and an HMIS staff. However, currently the sub-committee does not exist due to limited funds. Hence, the RH Department now only has a part-time database officer who analyzes the HMIS data. Upon the RH Department's request, the HMIS department provides data which the RH Department analyzes themselves. Other departments are not forthcoming in sharing their raw data and only present findings at conferences and workshops.

The RH department described their challenges in obtaining adequate information for various indicators. For example, the HMIS reports when a patient presents at the facility once for an antenatal visit, but is not able to capture any follow-up visits, which is important because there is a direct relationship between the number of antenatal care (ANC) visits and prevention of maternal mortality. Other variables the HMIS data does not include are the presence of anemia in pregnancy and cause of maternal deaths. As a result, the RH Department has turned to the M&E Department to collect information through a detailed ANC and RH checklist. This checklist is administered by an RH officer who collects data from random facilities in 22 out of Afghanistan's 34 provinces, often ignoring more remote and unsafe areas. Due to lack of security, most of the RH officers do not venture into remote parts of the province and visit facilities within a day trip of the capitals in which they reside. Furthermore, one RH officer is a man (for Kandahar Province) and therefore cannot enter OB/GYN clinics and wards to actually observe the RH facilities. He relies on reports from the nurses and doctors to fill in the checklist. Hence, it appears that the RH Departments does not have all the information it needs to plan effective programs. However, it has managed to piece a lot of the relevant data it needs from various sources within the MOPH.

Overall, the meeting provided an overview of the RH department's interactions with the HMIS, the willingness of the HMIS to share data and work with departments and the need for technical expertise within departments to analyze, report on and use the data. It was also noted that a lot of information could be pieced together from various existing data sources within the MOPH.

M&E Department

Purpose of meeting

The purpose of meeting with the M&E Department was to gain a better understanding of the data currently being collected by the department, especially with the National Monitoring Checklist (NMC), as well as to understand the relationship between the NMC and HMIS data and determine if sex-disaggregated data are being collected.

Findings

M&E department objectives

The objectives of the M&E department are to measure the goals set out by the MOPH and to measure the progress of the Millennium Development Goals (MDGs).

NMC

Among the many tools the M&E Department uses, the NMC is a primary tool used to collect data from the BPHS and EPHS. The NMC was first established in 2006. To collect data, every quarter the Provincial Health Director

visits all health facilities within their province and collects data on the NMC. The report is then shared with the facility and the M&E Department at the MOPH. Every three months, a quarter of the health facilities are randomly selected to have a team of external evaluators visit the center. The facilities are unaware that they have been selected by the team. The team is comprised of a member from the M&E head office in Kabul, the Provincial Health Director and a member from the BPHS implementing NGO. After the assessment, the team gives the provincial health directorate and hospital or health facility oral feedback. The team sends a written report along with the data sheets to the headquarters. The M&E team at the MOPH then creates an Action Plan and shares the results in face-to-face meetings with implementing NGOs and discusses gaps. They also report on the status of the health system to the Executive Board of Ministry.

M&E and HMIS

With relation to the HMIS, the M&E team compares the tally sheets and checklists that are used to report on the Monthly Integrated Activity Report (MIAR) with the original hospital log books from where the data were collected to see if the HMIS data were collected and reported correctly. There is a 79% match between the data that HMIS report and the M&E team finds. These findings are noted in the NMC.

When the HMIS team was asked about the importance of the NMC, they mentioned that the NMC goals and tools were all currently being revised, but more work is needed to ensure that the NMC focuses on quality and monitoring existing data collection. The HMIS team felt that the NMC should be composed of a list of surveys that monitor the quality of health services being provided.

Revision of the NMC

The director of M&E also noted that the NMC is currently being revised, mostly to include about 80 RH indicators. There is a formal process to add indicators, but the department is open to informal requests as well, for example, via email. Arguments for adding any indicators should be strong. The Consultative Group on Health and Nutrition (CGHN) and Technical Advisory Group (TAG) discuss recommendations and the Executive Board approves them. The final questionnaire for July 2013- June 2014 will be finalized in March 2013.

Other M&E tools

Other tools are used by the M&E Department for monitoring purposes, namely

- Mental Health Checklist
- RH Checklist – used simultaneously with NMC
- HNMC- Hospital National Monitoring Checklist for the EPHS. The targets and objectives are set by the M&E Dept. (we were not allowed to review this checklist)
- HR checklist

The GCMU has its own monitoring process using the NMC, i.e. they repeat the NMC in areas they want.

Conclusion

The NMC is the primary tool used by the M&E department to monitor the quality of services as well as the quality of HMIS data being reported upon. The NMC has several sex-disaggregated variables that cover clients, human resources and the facility. **Annex V** includes a table of all the variables that are sex-disaggregated within the NMC, as well as a list of potential sex-disaggregated indicators.

GCMU Department

Purpose of meeting

A meeting was held with a representative of the Johns Hopkins Bloomberg School of Public Health (JHBSPH), which administers a survey called the Balanced Scorecard (BSC) which is monitored by the GCMU Department. The purpose of that meeting was to ask the following questions:

- How does the BSC work? Who collects it? What is the history of the BSC? What is the future plan? How is it integrated into the HMIS? What trainings are provided in the use of the Scorecard data?
- Have you had any discussions about integrating gender into the BSC? Have gender indicators been included? Can we obtain a copy of the latest questionnaire?
- What is the status of the GBV and self-immolation facility assessment survey? Is it going to be institutionalized/ sustained? Are there any indicators that will be included in the BSC?
- What is the relationship between HMIS and the BSC? Is the HMIS the only comprehensive facility-level data?

Later, a meeting was also held with the head of the GCMU Unit with the intention of understanding the role of the GCMU in conducting the BSC and to get a copy of the BSC questionnaires.

Findings

BSC

The representative from the JHBSPH shared that the BSC is a third party evaluation conducted by JHBSPH and the Indian Institute of Health Management Research, in collaboration with the MOPH, to determine if services within the health facilities are being delivered appropriately as expected. It has been carried out within facilities providing BPHS annually since 2004 and has been conducted twice for hospitals providing the Essential Package of Health Services (EPHS) and national hospitals. It was revised in 2010. There are several components of this survey, including review of hospital records, interviews with healthcare providers, observing doctor-patient interactions followed by exit interviews with the same patients. About 2,500 health providers were interviewed in the last round across 700 health facilities in 33 provinces. This survey also includes 12,000 household surveys where all eligible women within each household were interviewed. Security issues caused logistical problems in the last round conducted in 2012. As a result, program staff could not enter some provinces and local interviewers had to be hired to conduct the interviews at the health facilities and in the communities.

Gender-sensitive indicators in the BSC

A few of the indicator scores in the 2012 round are gender sensitive. The Head of the Gender Directorate was involved in a few conversations during the development of the questionnaire. As a result, a few questions were added to determine the gender sensitivity of the health facility and human resource distribution. There are several other indicators within the BSC that are not analyzed and reported to the GCMU. However, there is a potential for further analysis.

GBV module in the BSC

Health providers were also asked to respond to a GBV module, which is a separate study that aims to determine the sensitivity and skillset of health workers to treat a woman with GBV. This was a one-time study that was added by the WHO Gender Department. The MOPH Gender Directorate also helped develop the module. The JHU team asked for additional $5,000 to add this module to the survey but they did not receive this money from their donors and therefore financed the module themselves. During the data collection process, the interviewers stated that they were fearful and uncomfortable to even administer the module on GBV with the healthcare workers. Hence, the researchers agreed that the interviewers would only ask the module if they felt comfortable. The response rate of the survey is not yet available (analysis of the dataset is still underway), but some health workers were not asked these questions.

Dissemination of BSC data

The GCMU Department has custody of the BSC questionnaire. The data are analyzed by JHBSPH. The BSC undergoes data verification where a percentage of the reports are crosschecked through visits by community members, thus ensuring the high quality of the data. The latest report is ready and has been submitted to MOPH in April 2013. The report provides information on the main scores and indicators requested by the MOPH. These are a set of indicators they have been monitoring for many years. The results are disseminated to the MOPH technical advisory groups (TAGs) and departments and at the regional level to the government hospitals and other NGOs.

The relevant departments within the MOPH are asked to prepare a Plan of Action based on the results and submit it to GCMU.

Continuation of the BSC

The last round of the BSC was collected and analyzed in 2012-2013. The project is being rebid under the Systems Enhancement for Health Action in Transition (SEHAT) Project. The Procurement Directorate within the M&E department is overseeing this bid. The HMIS, GCMU and M&E departments are working together in writing the Terms of Reference (TOR) for the BSC. Written by the MOPH, the donors (the World Bank and the European Union), have already approved the proposal. Organizations will soon begin bidding on it.

JHBSPH and GCMU both noted that no BSC questions or indicators have been added to more consistent tools such as the HMIS and NMC.

Other GCMU tools

Besides the BSC, the GCMU unit receives data from other sources. All NGOs send monthly and quarterly reports of their activities and indicators to the GCMU. All the NGOs are funded by the World Bank, European Union, and USAID. Some of the variables that they report on are availability of surgeons who conduct OB/GYN surgeries, medicines (including family planning commodities), female health workers, pregnancy-related conditions, training of midwives and community based workers. All contracts are managed by GCMU. Hence, they manage contracts and work with NGOs and donors.

Conclusion

The GCMU department primarily uses the BSC to collect information on the quality of services being provided at public health facilities. This BSC, conducted by a third party evaluator, is used to collect data on clients, human resources and the facility. Although we were unable to obtain the final copy of the latest BSC questionnaires, we obtained and analyzed an almost-final draft version. **Annex VI** includes a table of all the variables that are sex-disaggregated within the BSC, as well as a list of potential sex-disaggregated indicators generated from the variables.

Quality Improvement (QI) Department

Purpose of meeting

The purpose of this meeting was to learn about the Quality Assurance (QA) standards tools, as well as other tools, being used by the QI Department and whether gender has been integrated into them; and, if so, how?

Findings

Establishment of QI Department

The QI Committee in the MOPH was established in 2006. The head of APHI, Dr. Noormal, was Chairperson of that committee. It was initially an honorary committee, but then, JHPIEGO took on the role of the Secretariat. They developed and field-tested QA tools in 17 provinces through the USAID-funded Health Services Support Project. In 2010, the MOPH established the Leadership and Development Program in the QI Unit. Since then, URC-CHS has worked closely with the QI Department to integrate existing tools and resources within the department, for example, revision of the original QA standards tools and developing new QA indicators, described in further detail below.

QA standards tools

The QA standards tools are primarily used to assess and improve the quality of individual health facilities. There are over 400 standards covering 11 areas that are collected using 22 tools. The 11 areas cover service-delivery and other cross-cutting issues. Gender is both integrated in all the areas and is a standalone area in its own right. The

QA standards are divided into "critical" and "important" categories. The QA standards within health facilities are also divided into two other categories:

- Clinical standards
    - Maternal and newborn health, child health, nutrition, communicable diseases (TB, malaria, HIV), mental health and disabilities
- Cross-cutting standards
    - Infection prevention, pharmaceutical, blood transfusion, gender, hospital management

The QA tools are now included in what is known as the "Harmonized Standard Package," and implementation is through the Harmonized Quality Improvement Program (HQIP). The package was field-tested in 6 health facilities, 2 basic health centers, 2 comprehensive health centers and 2 district hospitals, one each from Kabul and Nagarhar provinces. The vision is to disseminate the HQIP across all the facilities though funding is needed.

Application of QA standards tools

The QA standards are introduced in each facility and the initial HQIP process takes 9 months. The QA tools are used for internal and external reviews. The internal review is conducted by a designated staff member from each department who is trained on how to use the tools while the external review is conducted by someone designated by the QI Department and well conversant with the application of the tools. The QA tool is carried out in each facility in the following order: the package is introduced at the health facility → if used for internal review, at least one staff from each service department is trained on how to collect data → used four times for internal or external surveys (a baseline and 3 follow ups are done 3 months apart). Each facility undergoes this process within 9 months. The internal assessment report is forwarded to the QA Department at the end of the process. This assessment helps the hospital identify the gaps and develop a plan to address it. The external evaluation also identifies gaps in each facility and shares the results with the hospital facility and at the Provincial level. Furthermore, the team develops a 5 year work-plan to address the challenges and improve the quality of services using the same approach of self-assessments. In this manner, each cycle of assessment leads to a self-evaluation of successes and gaps and the creation of a plan for next steps. In the near future, the QA department plans to encourage quality improvement by awarding facilities that achieve all the indicators and also those who show consistent improvement over time. **Annex VII** shows the implementation model for the HQIP of the first 9 month period. Further, **Annex VIII** describes the tool that is used to measure gender sensitivity; it pools and links to questions from across all the other 21 tools.

Other QA indicators

Besides the QA standards, the QI department has also created a dashboard of 84 indicators that will determine the quality of healthcare services being provided across all public facilities. This process of collecting the data and analyzing them will begin in 2013. The QI department will get their data → analyze the QA indicators → report back to the departments. Of the 84 indicators, data for 18 of these will be retrieved from the HMIS and the remaining 66 from the NMC, BSC and some surveys. The QI department has a database officer whose primary task is to analyze the data and report the results. There are 3 methods of data dissemination-

1. Send feedback to the health facility QA committee (at present, only in 4 hospitals- Malalai, Esteqal, Kheir Khana, a private hospital)
2. Send HMIS feedback
3. Disseminate findings at the Results Based Conference (URC-CHS disseminated the information)

Conclusion

The QA standards are the primary tool that will be used by the QI department to monitor the quality of services of health facilities. These standards are going to be rolled out to facilities across Afghanistan and have a self-assessment process built in. **Annex VII** describes the Implementation Model for the Harmonized Quality Improvement Approach being used by the QI Department and Annex VIII presents the QA gender tools developed and the corresponding sections on gender from other tools that will be carried in at Basic Health Centers, Comprehensive Health Centers and District Hospitals.

Surveillance Department

Purpose of meeting

The purpose of meeting the Surveillance Department was to understand their primary task and to determine if and how they have integrated gender into their work.

Findings

The Surveillance department is under the umbrella of the Afghan Public Health Institute (APHI). Its primary purpose is to reduce morbidity and mortality by monitoring the outbreak of 16 communicable and high-risk diseases from a central-based surveillance system. It monitors 336 sites, ranging from regional hospitals to health centers. It receives data weekly, analyzes it and reports to the MOPH and the UN. The only gender indicator in the surveillance system is pregnancy-related deaths. However, based on the recommendations of the Gender Directorate, the Surveillance team now disaggregates all new cases by sex. The Surveillance Department also prioritizes women and children by giving them healthcare or evacuating them first. They also recently reviewed and analyzed a specific incident of girls' poisoning in schools that occurred last year.

In order to collect surveillance data, there is a focal person assigned to report on new cases in each facility across all 34 provinces (i.e., 8 districts). The Surveillance system has detected >300 outbreaks of communicable diseases since its inception, especially acute respiratory infections, such as pneumonia, cough, cold and influenza. The system works on early warning of emergencies and outbreaks. The malaria, HIV and TB departments all have their independent systems.

Conclusion

The Surveillance Department has its own reporting form for morbidity and mortality cases of primary public health care importance. Emphasis from the Gender Directorate has led to male and female cases being reported separately. **Annex IX** presents the surveillance reporting form for morbidity and mortality cases.

Human Resources Department

Purpose of meeting

The purpose of meeting with the MOPH Human Resources Department was to gain a better understanding of the distribution of male and female healthcare workers across facilities, to learn about policies that are in place to encourage female employees, and to learn about any capacity building activities that have been undertaken with female employees. This meeting was prompted after meeting with the Deputy Minister of Health, Najia Tariq, who encouraged us to get more information on the number of female doctors who had been sent abroad for capacity building, the number of women who have received training through nursing and residency programs in the country, as well as continued medical education.

Findings

The current job applications for healthcare positions do not have specific statements encouraging women to apply. However, the HR code of conduct specifically talks about giving equal employment opportunity to all. Once hired, many of the policies are the same for men and women, such as overtime and compensation policies. No one gets any performance incentives. However, more pay is offered to midwives and female doctors who serve in remote areas thus providing special incentives for these women and their families. According to the cultural norms, a husband gets 50% pay when he accompanies his wife on a trip as women are not allowed to travel alone. Maternity leave exists.

The HR team highlighted a few challenges in hiring women into the medical workforce, such as a patriarchal (and doctor-run) culture, limited security in remote regions and places, and limited educational status of women. A patriarchal culture was defined as one that expected men to run the MOPH. Men occupy most of the senior and mid-level posts within the Ministry and hence very few women are in decision-making positions.

There is no quota for admission of women into health-related higher education fields. The HR Department has built a new database that categorizes all cadre of health workers by sex, ethnicity, educational level and provincial residence. This helps them see the distribution of providers across each province, thus clearly showing where the gaps are.

Conclusion

The HR Department divides the healthcare workforce into 13 categories, as defined by the WHO. **Annex X** shows a distribution of the 13 cadre of healthcare workers by sex; for example, 15% of nurses and 17% of general physicians are female.

Research Department

Purpose of meeting

The purpose of meeting with the MOPH Research Department was to identify gender-related health studies that have been conducted in Afghanistan.

Findings

The Research Department mentioned that their primary task is to monitor the quality of research being conducted and ensure that IRB protocols are being met. They also administer trainings to practitioners on how to conduct good quality research. The Research Department works very closely with the Institutional Review Board (IRB) to approve studies, monitor their progress and review their findings.

Conclusion

The IRB Unit was able to share a list of gender-related studies. However, that list was not comprehensive as other studies were identified separately in discussions with others. Hence, **Annex XI** provides a partial list of the titles of the gender-related studies that have been or are being conducted in Afghanistan since 2010.

Information on GBV Data within the MOPH

Purpose of meeting

The topic of GBV was raised in several conversations, including with the Deputy Minister of Health, Gender Directorate and with representatives of UNFPA and UN Women. The aim of these conversations was to get a better understanding of what data exist and what is currently being done to address GBV in Afghanistan.

Findings

Annex XII provides a summary of the existing GBV tools. As stated earlier, the special GBV module in the BSC was conducted among 2,500 healthcare providers. The aim of the module was to determine the sensitivity and skillset of health workers to treat a woman who has experienced GBV.

GBV is a major concern for the Ministry of Women's Affairs (MOWA) and the MOPH. From a political perspective, the Elimination of Violence Against Women (EVAW) law requires any case of GBV to be reported to MOWA. This is upheld by the National Action Plan for the Women of Afghanistan (NAPWA). Every case is reported and entered into the GBV Information Management System (IMS) database, funded by UN Women. GBV

victims report to provincial offices of MOWA, Human Rights Commission, Ministry of Interior and Afghanistan Independent Commission. A GBV Intake Form and VAW Intake Form are completed. The centers assist women to decide for themselves as to whether they will seek help or move to a shelter. UN Women has been assisting MOWA in maintaining this database and providing guidance to women at the provincial offices.

Despite the availability of these services, an estimate conducted by UNFPA and MOPH has determined that greater than 80% of GBV victims may be accessing health facilities. Despite this estimate, very few women are diagnosed as cases of GBV. Instead, they very often get diagnosed as trauma, depression and mental health cases. The women often can't access other services, such as legal help, shelters, etc.; hence, they flock to health centers. When they come to the facilities seeking help, they are often sent back to the same abusive environment. As a result, the MOPH along with other key stakeholders has been working diligently to introduce a GBV intervention program as addressing GBV is a key component of the Ministry's portfolio. A pilot project, funded by UNFPA, is underway where the current GBV and VAW intake forms being used by MOWA have been modified to include questions on medical history taking and physical examination. This new intake form, consent form and referral form will be pilot tested in 2013 in 3 provincial hospitals. Providers from the hospitals will be trained to detect and diagnose GBV cases. Each hospital will be equipped with a special response room, called the Family Protection Center, where a woman suspected of having GBV will be taken to and will receive the necessary care and interventions. These cases will also be entered into the existing GBV IMS system managed by MOWA. The MOPH is working to get additional funding and expand this pilot project to 10 provinces by 2015 and to all provinces by 2020.

Besides the GBV IMS, UN Women also shared a framework showing the distribution of a Global Fund-funded US$1 million project to address GBV across various different strata, such as health and legal areas. The fund is divided between various institutions and is depicted in **Annex XIII**.

Conclusion

GBV is currently being addressed by MOWA and MOPH with assistance from UNFPA and UN Women. **Annex XIV** has a form that will be used in health facilities to diagnose GBV cases.

CONCLUSION

This analysis shows that there is already extensive data on gender-sensitive indicators in the HMIS and other tools such as the NMC, BSC, QA tools, etc. These are being underused in health policy and programming. Rather than advocate for the inclusion of more indicators into HMIS, the Gender Directorate's primary goal should be to use the existing data for programming and financing purposes and assist other departments in improving gender mainstreaming.

Next steps are as follows:

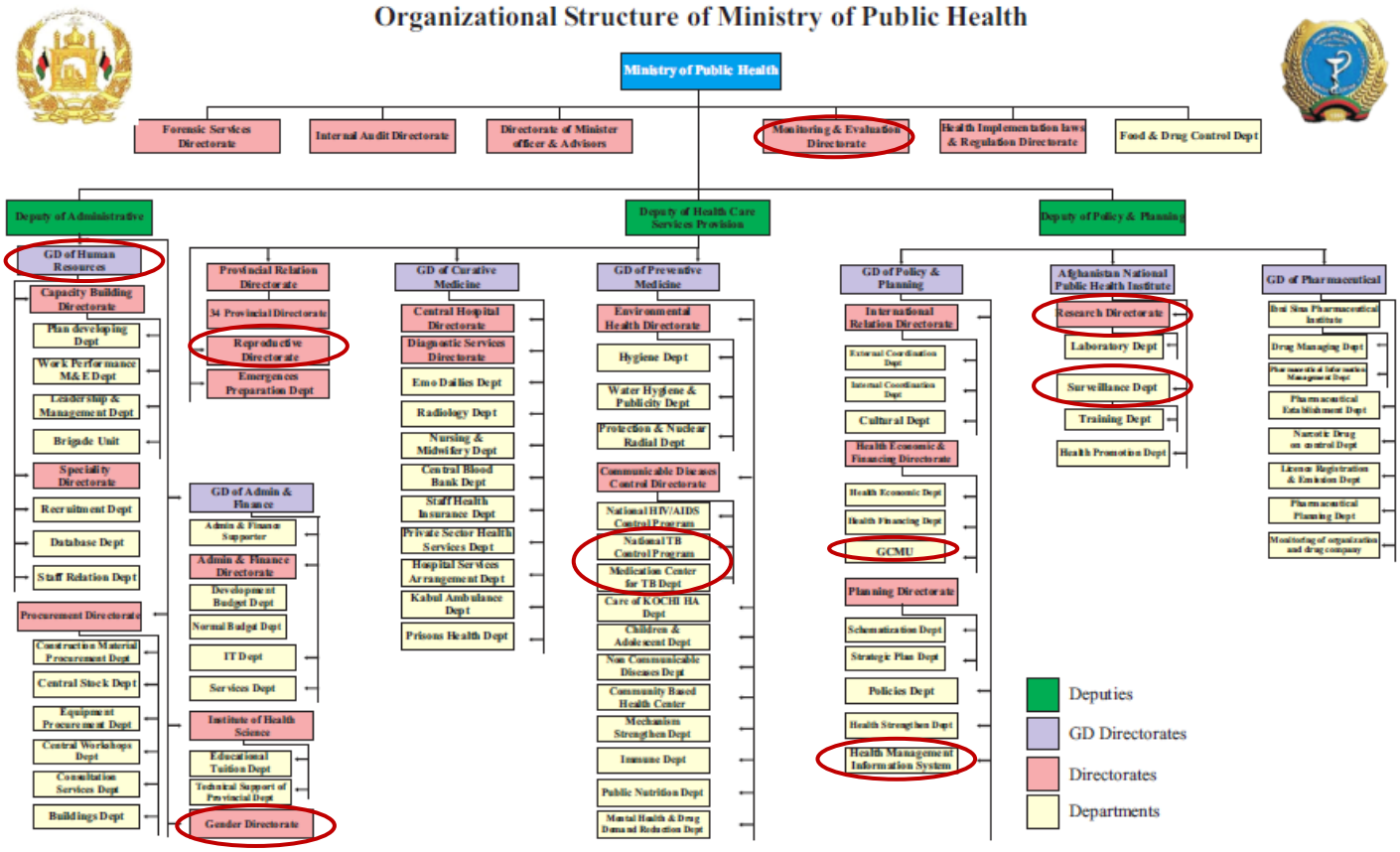
- Share the findings of this landscape analysis with the Gender Directorate, Gender Task Force and other relevant MOPH Departments.
- Conduct an M&E workshop with the Gender Directorate to increase the capacity of the Directorate to better understand gender monitoring.
- Develop a process/action plan to identify next steps the Gender Directorate will take to better use the existing gender-related data for their advocacy and financing purposes.

ANNEXES

Annex I. List of Contacts

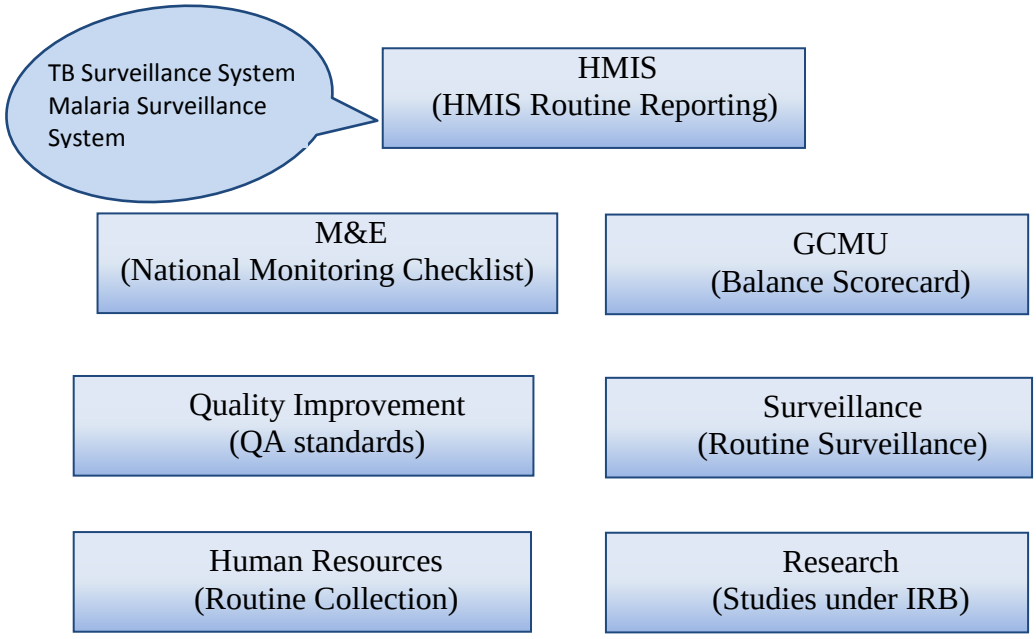
Name	Title	Organization	Department	Date of Interview
Dr. Abdul Basir Sarwar	Administrative Deputy Minister	MOPH	Administration	Jan 23, 2013
Dr. Najia Tariq	Deputy Minister Health Services	MOPH	Health Services Provision	Jan 27, 2013
Dr. Ikram Alakozai	Deputy Administrative Director	MOPH	APHI	Jan 23, 2013
Dr. Murtuza	IRB Coordinator	MOPH	APHI	Jan 23 and 29, 2013
Dr. Qadir	Policy and Planning Acting Director	MOPH	Policy and Planning Department	Jan 23, 2013
Dr. Azimi	Department Head	MOPH	HMIS	Jan 27, 2013
Chris Bishop	Consultant	MOPH, seconded by MSH	HMIS	Jan 27, 2013
Dr. Khosrow Yusufzai	Department Head	MOPH	M&E	Jan 27, 2013
Dr. Hassan	Department Head	MOPH	GCMU	Jan 26, 2013
Dr. Ziad	Department Head	MOPH	Surveillance	Jan 27, 2013
Dr. Sadia Ayubi	RH Director	MOPH	Research	Jan 29, 2013
Dr. Karima Mayar	QI Coordinator	MOPH	QI	Jan 29, 2013
Dr. Ludin	Deputy Director	MOPH	Human Resources	Jan 29, 2013
Dr. Alam	Provincial HR Advisor	MOPH	Human Resources	Jan 29, 2013
Dr. Hamrah Khan	Head	MOPH	Gender Directorate	Jan 22 & 28, Feb 3 & 4, 2013
Anosha Qiyamee	Gender Officer	MOPH	Gender Directorate	
Dr. Sameer Feroz	Gender Coordinator	MOPH	Gender Directorate	
Dr. Najla Areeb	Technical Associate	MOPH	Gender Directorate	
Dr. Parwana Nasery	HR Specialist	MOPH	Gender Directorate	
Dr. Rahila Juya	Gender Manager	HPP	Gender Unit	
Heela Barakzai	Senior Gender Advisor	HPP	Gender Unit	
Anubhav Agarwal	Project Manager	JHBSPH	Programs	Jan 23, 2013
Dr. Abdul Basit	National Program Officer	UNFPA	Gender Unit	Jan 28, 2013
Sofia Moazizi	Gender Coordinator	UN Women	Gender Unit	Jan 30, 2013
Sahar Motallebi	EVAW Fund Coordinator	UN Women	Gender Unit	Jan 30, 2013

Annex II: MOPH Organizational Chart



*Circles represent departments and directorates consulted for the landscape analysis.

Annex III: Departments Interviewed and Tools/Studies Reviewed



Annex IV: Sex-Disaggregated Variables and Indicators in the HMIS

Source	Category of variable	Name of variable	Example of Indicator	Which facility reports it?	How often reported ?	Who collects it?	Owner	Comments
HMIS - Monthly Integrated Activity Tally Sheet – Facilities OPD AND HMIS - Monthly Integrated Activity Report – Facilities OPD	Client based	A1. OPD Morbidity - 15. Malaria (Total new, <5 M&F, ≥5 M&F, referred in/out)	# or % of malaria cases diagnosed at OPD, by age (<5/≥5, sex, hospital type and hospital, district/province/region)	This sheet tallies patient visits at MHTs, HSCs, BHCs, CHCs, the outpatient department of Hospitals, and the emergency room of Hospitals.	monthly	staff entering registers or seeing patients	MOPH - HMIS	The OPD Morbidity list includes a list of 31 conditions and nutritional status of <5. The 4 conditions listed here are of interest to the MOPH.
		A1. OPD Morbidity - 17. Mental disorders (Total new, <5 M&F, ≥5 M&F, referred in/out)	# or % of cases diagnosed with mental disorders at OPD, by age (<5/≥5, sex, hospital type and hospital, district/province/region)					
		A1. OPD Morbidity - 18. Trauma (Total new, <5 M&F, ≥5 M&F, referred in/out)	# or % of trauma cases diagnosed at OPD, by age (<5/≥5), sex, hospital type, district/province/region					
		A1. OPD Morbidity - 19. TB suspected cases (Total new, <5 M&F, ≥5 M&F, referred in/out)	# or % of TB suspected cases diagnosed at OPD, by age (<5/≥5), sex, hospital type, district/province/region					
HMIS - Monthly Integrated Activity Report – Facilities OPD	Client based	F. Laboratory exams - F1. Blood - 1. Total malaria slides examined (M&F)	# or % of malaria cases diagnosed using blood test (by gender, hospital type, district/province/region)	This sheet tallies patient visits at MHTs, HSCs, BHCs, CHCs, the outpatient department of Hospitals, and the emergency room of Hospitals.	monthly	staff entering registers	MOPH - HMIS	
		F. Laboratory exams - F1. Blood - 4. Total HIV examined	# or % of HIV tests done (by gender, hospital type, district/province/region)					
		F. Laboratory exams - F1. Blood - 5. Total HIV positive	# or % of HIV positive patients diagnosed (by gender, hospital type, district/province/region)					
		F. Laboratory exams - F2. Sputum - 1. Total AFB slides examined	# or % of TB sputum tests done (by gender, hospital type, district/province/region)					

		F. Laboratory exams - F2. Sputum - 2. Total AFB positive	# or % of TB positive slides noted (by gender, hospital type, district/province/region)					A TB patient generally gives 3 sputum samples. Sometimes though, patients don't give all samples. Hence, the number of slides is not really indicative of the number of patients.
HMIS - Facility Status Report – MHT/HSC/BHC/CHC (FSR)	Facility infrastructure	A. General Facility Information - 18. Separate latrine for male and female	Presence of separate latrines for male and female patients	listed in the BPHS for MHT, HSC, BHC, CHC	annually or six-monthly	in-charge of the MHT/HSC/ BHC/CHC	MOPH - HMIS	
	Human Resources	B. Human Resources - B1. Facility Staff status - 1. Nurse (M&F)	# or % of female nurses working at facility					
		B. Human Resources - B1. Facility Staff status - 2. Assistant nurse (M&F)	# or % of female assistant nurses working at facility					
		B. Human Resources - B1. Facility Staff status - 3. Midwife (M&F)	# or % of female midwives working at facility					
		B. Human Resources - B1. Facility Staff status - 4. Community midwife (M&F)	# or % of female community midwives working at facility					
		B. Human Resources - B1. Facility Staff status - 5. MD General (M&F)	# or % of female MD General working at facility					
		B. Human Resources - B1. Facility Staff status - 6. MD Specialist (M&F)	# or % of female MD Specialist working at facility					
		B. Human Resources - B1. Facility Staff status -	# or % of female pharmacist working at facility					

		7. Pharmacist (M&F)						
		B. Human Resources - B1. Facility Staff status - 8. Laboratory Technician (M&F)	# or % of female lab technician working at facility					
		B. Human Resources - B1. Facility Staff status - 9. Pharmacy Technician(M&F)	# or % of female pharmacy technician working at facility					
		B. Human Resources - B1. Facility Staff status - 10. Community health supervisor (M&F)	# or % of female community health supervisor working at facility					
		B. Human Resources - B1. Facility Staff status - 11. Vaccinator (M&F)	# or % of female vaccinator working at facility					
		B. Human Resources - B1. Facility Staff status - 12. Support staff (M&F)	# or % of female support staff working at facility					
		B. Human Resources - B2. Community Health - 1. CHWs ever trained	# or % of female CHWs ever trained working at facility					
		B. Human Resources - B2. Community Health - 1. CHWs trained and active	# or % of female CHWs trained and active working at facility					
HMIS - Hospital Monthly Inpatient Report (HMIR)	Client based	A. Indoor patients - 1. Admissions (<5 M&F, ≥5 M&F)	# or % of patients admitted, by age (<5/≥5), sex, hospital type, district/province/region	collected at BHCs and CHCs	quarterly	dept. staff -> hospital director -> PPHO/NGO	MOPH - HMIS	
		A. Indoor patients - 2. Referred-in (<5 M&F, ≥5 M&F)	# or % of patients referred-in, by age (<5/≥5), sex, hospital type, district/province/region					
		A. Indoor patients - 3. No. of patient days (<5 M&F, ≥5 M&F)	# or % of patient days recorded, by age (<5/≥5), sex, hospital type, district/province/region					

		A. Indoor patients - 4. Average length of stay (<5 M&F, ≥5 M&F)	average length of stay of patients, by age (<5/≥5), sex, hospital type, district/province/region					
		A. Indoor patients - 5. Discharged/Outcome (<5 M&F, ≥5 M&F)	# or % of patients discharged, by age (<5/≥5), sex, hospital type, district/province/region					
		A. Indoor patients - 5.1. Recovered/Improved (<5 M&F, ≥5 M&F)	# or % of patients recovered/improved, by age (<5/≥5), sex, hospital type, district/province/region					
		A. Indoor patients - 5.2. Absconded/defaulted (<5 M&F, ≥5 M&F)	# or % of patients absconded/defaulted, by age (<5/≥5), sex, hospital type, district/province/region					
		A. Indoor patients - 5.3. Not improved (<5 M&F, ≥5 M&F)	# or % of patients not improved, by age (<5/≥5), sex, hospital type, district/province/region					
		A. Indoor patients - 5.4. Referred-out (<5 M&F, ≥5 M&F)	# or % of patients referred-out, by age (<5/≥5), sex, hospital type, district/province/region					
		A. Indoor patients - 5.5. Dead (<5 M&F, ≥5 M&F)	# or % of patients dead, by age (<5/≥5), sex, hospital type, district/province/region					
		H. New Inpatient Cases, 4. Burns, scalds & frostbite (<5 M&F, ≥5 M&F)	# or % of patients with burns, scalds & frostbite, by age (<5/≥5), sex, hospital type, district/province/region					
		H. New Inpatient Cases, 5. Fractures & dislocations (<5 M&F, ≥5 M&F)	# or % of patients with fractures & dislocations, by age (<5/≥5), sex, hospital type, district/province/region					
		H. New Inpatient Cases, 6. Cerebral concussions (<5 M&F, ≥5 M&F)	# or % of patients with cerebral concussions, by age (<5/≥5), sex, hospital type, district/province/region					

		H. New Inpatient Cases, 26. Malaria (<5 M&F, ≥5 M&F)	# or % of patients with malaria, by age (<5/≥5), sex, hospital type, district/province/region					
		H. New Inpatient Cases, 27. Tuberculosis (<5 M&F, ≥5 M&F)	# or % of patients with tuberculosis, by age (<5/≥5), sex, hospital type, district/province/region					
		H. New Inpatient Cases, 32. Common mental problems (<5 M&F, ≥5 M&F)	# or % of patients with common mental problems, by age (<5/≥5), sex, hospital type, district/province/region					
		H. New Inpatient Cases, 33. Substance abuse (<5 M&F, ≥5 M&F)	# or % of patients with substance abuse, by age (<5/≥5), sex, hospital type, district/province/region					
		H. New Inpatient Cases, 34. Severe mental problems (<5 M&F, ≥5 M&F)	# or % of patients with severe mental problems, by age (<5/≥5), sex, hospital type, district/province/region					
HMIS - Hospital Status Report Form (HSR)	Facility infrastructure	A. General Facility Information - 18. Separate latrine for male and female	Presence of separate latrines for male and female patients	Hospital	annually or six-monthly	hospital in-charge -> PPHO	MOPH - HMIS	
	Human Resources	B. Human Resources - B1. Management - 1. Hospital Director	Is the Director of the hospital a female? OR # or % of female Hospital Directors in the district/province/region/country					There are in total 49 different cadre of health workers within the form, all sex-disaggregated.
		B. Human Resources - B1. Management - 2. Medical Director	# or % of female Medical Directors in the hospital/district/province/region/country					
		B. Human Resources - B1. Management - 3. Nursing Director	# or % of female Nursing Directors in the hospital/district/province/region/country					
		B. Human Resources - B1. Management - 4. Administrator	# or % of female administrators working at facility					

		B. Human Resources - B2. Physicians	# or % of female physicians working at facility, by all cadre					
		B. Human Resources - B3. Nurses and Midwives	# or % of female nurses working at facility, by cadre					
		B. Human Resources - B4. Technical Staff - 24. Psychiatrist	# or % of female psychiatrists working at facility					
HMIS - Catchment Area Annual Census Tally Sheet (CAAC), CAACR - Form, Catchment Area Annual Census Aggregated Report (CAAC-AR)	Client based	Number of married women aged 15-49	Population distribution of women of reproductive age compared to the rest of the population/all women	For a HSC/BHC/CHC/DH out patient care, the catchment area is the area directly covered by that facility and by the HP reporting to that facility. For DH inpatient care, the catchment area is the district. For PH inpatient care, it is the province.	annually	CHWs (in his/her catchment area), and CHS (in the entire catchment area of the health post (HP) and immediate catchment area of the health facility (HF))	MOPH - HMIS	

Annex V: Sex-Disaggregated Variables and Indicators in the NMC

Source	Category of variable	Name of variable	Example of Indicator	Which facility reports it?	How often reported?	Who collects it?	Owner	Comments
National Monitoring Checklist	Facility infrastructure	Infrastructure - 107.a. Separate waiting area for women	Presence of separate waiting area for male and female patients	all BPHS facilities - SC, BHC, CHC, DH	quarterly	monitors- provincial M&E officer, occasionally main office M&E officer	MOPH - M&E	GCMU is also known to implement the NMC on their own in certain facilities
		Infrastructure - 108.a. Separate delivery room	Presence of a separate delivery room					
	Human Resources	Female staff - 109. Female nurse - a. Number currently employed by the facility	# or % of female nurses working at facility OR % of expected spots covered by female nurses (current no./expected no.)					the In-charge of the facility is asked these questions on HR.
		Female staff - 109. Female nurse - b. Number present today	# or % of all female nurses present today					
		Female staff - 110. Midwife/Community midwife - a. Number currently employed by the facility	# or % of female nurses working at facility OR % of expected spots covered by female nurses (current no./expected no.)					
		Female staff - 110. Midwife/Community midwife - b. Number present today	# or % of all female nurses present today					

		Female staff - 111. Female doctor - a. Number currently employed by the facility	# or % of female nurses working at facility OR % of expected spots covered by female nurses (current no./expected no.)					
		Female staff 111. Female doctor - b. Number present today	# or % of all female nurses present today					
		Female staff - 112. Are any of the above positions replaced by male professionals due to non-availability of females?	# or % of female positions filled by male staff					

Annex VI: Sex-Disaggregated Variables and Indicators in the BSC

Source	Category of variable	Name of variable	Example of Indicator	Which facility reports it?	How often reported?	Who collects it?	Owner	Comments
Balance Scorecard - Form H2 - Hospital Performance Assessment 2012 - Clinical and support services	Facility infrastructure	2. Clinical Support services - 2A. General Outpatient Department - 2A4. Is there a separate waiting room? (not just seats in the corridor) - Separate waiting room for men a, Separate waiting room for women b, Waiting room is for both men and women c, No waiting room present d	Presence of separate waiting area for male and female patients	BPHS, including CHC, BHC, SHC, with district, provincial, & regional/national level hospitals having EPHS	yearly	MOPH - GCMU, JHBSPH, IIHMR	MOPH - GCMU	third party evaluation that has been conducted since 2004. A new bid for it is out, under the SEHAT project
		2. Clinical Support services - 2A. General Outpatient Department - 2A9. Are there separate toilets for female patients? - Yes 1, Common toilets for male and female patients 2, No toilets for female patients 3, Don't know 4	Presence of separate latrines for male and female patients					
		2. Clinical Support services - 2A. General Outpatient Department - 2A10. Is there the similar number of toilets present for women patients as for men patients? Yes, No, Don't know	# or % of female toilets out of all toilets in the facility					
		2. Clinical Support services - 2A. General Outpatient Department - 2A18. Does the facility have a written protocol for managing cases of Gender-Based Violence? Yes, No	Presence of a written protocol for managing cases of GBV					
		2. Clinical Support services - 2A. General Outpatient Department - 2A19. Does the facility provide a private/safe place for interview/exam?	Presence of a private/safe place for interview/exam					

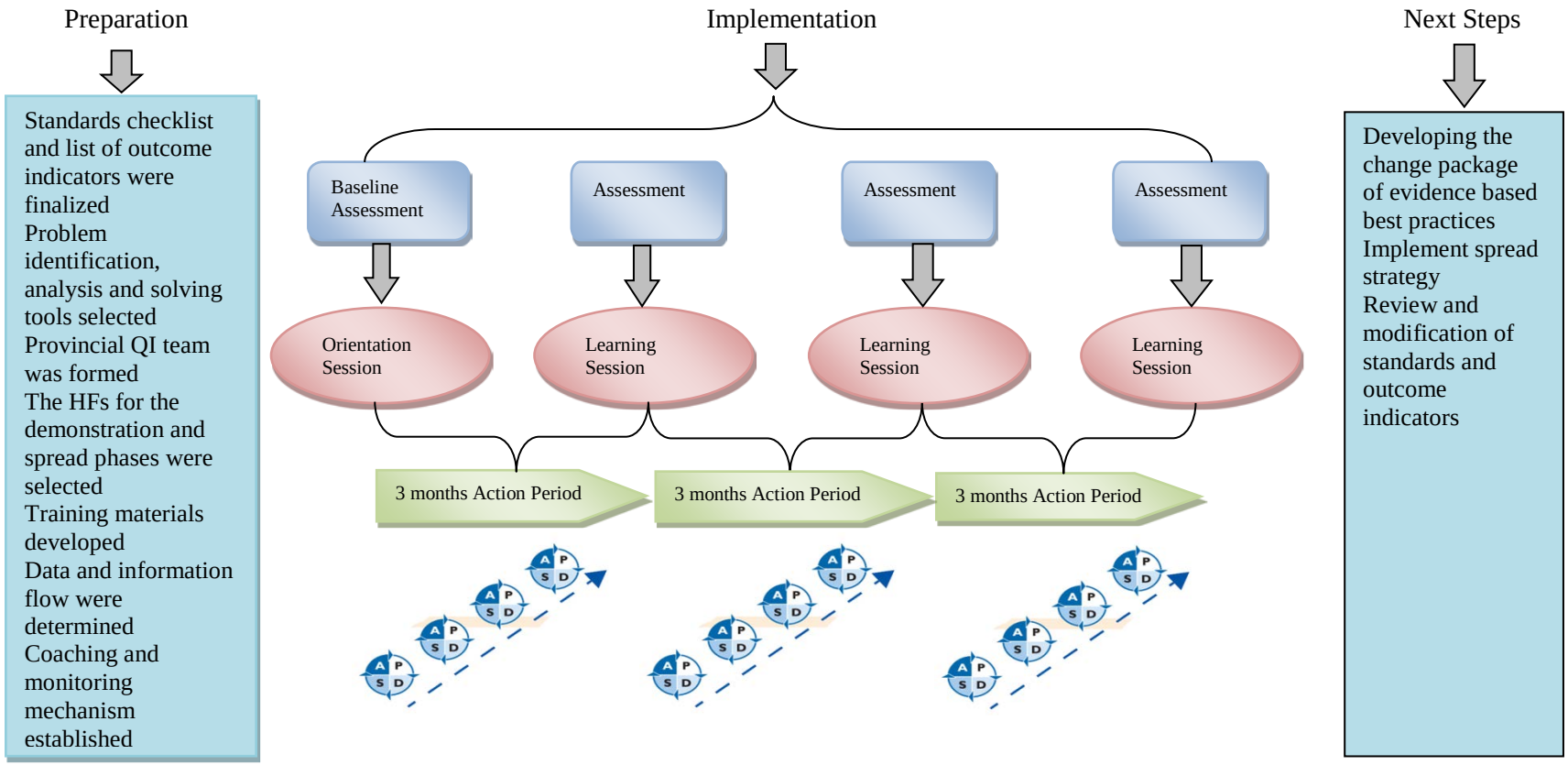
		3. Review of inpatient wards - 3C. Review of Ward "C" - 3C1. Is the ward open for this category of patients? Adult Female a, Adult Male b, Children c	Presence of a separate ward for men, women and children					
Balance Scorecard - Form H3 - Hospital Performance Assessment 2012 - Hospital Worker self-completed questionnaire	Human Resources	1. Background, Training, 2nd place of employment - 105. Sex of hospital employee, 106. Category of staff/position (Management staff 1, Doctor 2, Pharmacist 3, Nurse 4, Midwife 5, Health Technician/Technologist 6, Support staff 7)	# or % of female employees interviewed, by cadre					2,500 health workers are selected at random from all facilities and across all cadre
		1. Background, Training, 2nd place of employment - 126. How many days of technical training related your everyday work have you had outside the hospital in the past 12 months? - 127. How many days of technical training related to your everyday work have you had within the hospital in the past 12 months?	# of days a provider has received training in the past 12 months					
		1. Background, Training, 2nd place of employment - 128. For each subject listed, please, circle 1 if you received in-service training in the past 12 months. If you have never receiving training in that field or you received it more than 12 months ago, circle 3. - a. IMCI, b. HIV/AIDS, c. TB, d. Malaria, e. FP methods, f. Maternal and neonatal health, g. Universal precautions, h. Nutrition, i. Mental health, j. Common disabilities	The type of training health workers have received					

		2D. Gender inequity - 290. As far as you know, does your hospital have a code of conduct that protects women workers? - Yes 1, No 2, Don't know what the code of conduct is 3	Presence of hospital code of conduct that protects women workers					
		2D. Gender inequity - 291. Are you aware of sexual harassment cases at the hospital in the past 6 months? - Yes 1, No 2, Don't know what sexual harassment is 3	Presence of reported sexual harassment cases at the hospital in the past 6 months					
	Health worker assessment of GBV	Section 3. GBV Module - 300. Do you think that GBV is experienced by patients who come to your clinic? Yes 1, No 2, Don't know 3	Perception of whether patients experience GBV					
		Section 3. GBV Module - 301. Have you ever received training on recognizing/ treating cases of GBV? Yes, within the last 6 months 1, Yes, 6-12 months ago 2, Yes, greater than 12 months ago 3, No, never 4	Received training for recognizing/treating GBV cases					

		Sectio 3. GBV Module - There may be many barriers that make it difficult to ask women about violence. In your own experience, how much do you agree that the following barriers make it difficult for you to ask women about gender-based violence? - 302. I have time limitations. 303. There is a lack of privacy space in the clinic. 304. I feel there is little I can do help. 305. I need to focus my attention on health problems that have a higher priority. 306. Getting inolved in cases of violence means that I would have to participate in police proceedings. 307. I could provoke retaliation from the abuser against the survivor/ myself. (Responses - 1. Strongly disagree, 2. Disagree, 3. Agree, 4. Strongly agree)	Presence of barriers that make it difficult to ask women about violence					

		Section 3. GBV Module - Now we would like to ask about your attitude towards issues related to gender-based violence. How much do you agree with the following statements? - 308. I feel uncomfortable asking women about being beaten. 309. I feel uncomfortable asking women about being sexually abused. 310. I feel uncomfortable asking women about being psychologically abused. 311. GBV is an important problem in my community. 312. GBV is a major cause of ill health. 313. Women would feel offended if I were to ask them directly about violence. 314. Domestic violence is a private matter, and outsiders should not interfere. 315. Health providers have a responsibility to ask about GBV. 316. Health workers should receive training on recognizing/ treating cases of GBV. 317. The majority of survivors will deny they have been abused if asked. (Responses - 1. Strongly disagree, 2. Disagree, 3. Agree, 4. Strongly agree)	Attitude towards issues related to GBV					

Annex VII: Implementation Model for Harmonized Quality Improvement Approach



Description of implementation phase:
Baseline assessment of standards and outcome indicators that reveals the gaps at the both processes and outcomes of health care services
Quarterly assessments for process of care (standards) and monthly assessment for outcome indicators are planned
Orientation learning session provides opportunities to orient the QI teams on harmonized approach such as methods, tools and feedback on baseline assessment. The QI teams prepare and prioritize their interventions
The learning sessions follows the assessments as the QI teams further analyze the identified gaps which were revealed in the process of care (standards) and outcome indicators
3 months action period provides opportunity for QI teams by using the problem analysis and solving methods and tools to test and implement the interventions and improve the quality of health care services

Annex VIII: Gender Integrated tools of the QA standards, used by the Basic Health Center, Comprehensive Health Center and District Hospital

HARMONIZED QUALITY IMPROVEMENT STANDARDS

AFGHANISTAN

BASIC HEALTH CENTER

GENDER

2013

COMMENTS/ REMARKS/ RECOMMENDATIONS:

Please read these questions carefully and do not fill out this section now. However, remember to fill out this part at the end of your assessment of the relevant area.		
1. What are Gender-related positive points which you observed in the health facility but were not captured in your assessment?	2. What are Gender-related problems/issues which you observed in the health facility but were not captured in your assessment?	3. What are your recommendations for building upon positive points or overcoming problems/issues which you mentioned in the answers to Question 1 & 2?

AREA: GENDER

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____**IMPLEMENTER:** _____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:** _____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
Instructions for the assessor: For each of the standards below, fill in the total number of verification criteria achieved as per your assessment that you already conducted in the areas mentioned below.				
PROMOTION OF GENDER SENSITVE COMMUNICATION AND IPCC				
1.	Fill in results from Standard # 1 of the Birth spacing/ Family planning area of BHC standards: (Maximum score for verification criteria: Critical 8 Important 5)			
2.	Fill in results from Standard # 2 of the Birth spacing/ Family planning area of BHC standards: (Maximum score for verification criteria: Critical 4 Important 4)			
3.	Fill in results from Standard # 9 of the BCC area of BHC standards: (Maximum score for verification criteria: Critical 8 Important 1)			
PROMOTION OF MALE INVOLVEMENT				
4.	Fill in results from Standard # 2 of the ANC area of BHC standards: (Maximum score for verification criteria: Critical 2 Important 3)			
5.	Fill in results from Standard # 8 of the ANC area of BHC standards: (Maximum score for verification criteria: Critical 14)			
6.	Fill in results from Standard # 2 of the Normal labor area of BHC standards: (Maximum score for verification criteria: Important 2)			
PROMOTION OF WOMEN'S EMPOWERMENT AND DECISION MAKING				
7.	Fill in results from Standard # 7 of the Normal labor area of BHC standards: (Maximum score for verification criteria: Important 6)			
8.	Fill in results from Standard # 8 of the Health Facility Management area of BHC standards: (Maximum score for verification criteria: Critical 3 Important 1)			
9.	Fill in results from Standard # 14 of the BCC area of BHC standards: (Maximum score for verification criteria: Critical 1 Important 3)			

TOTAL Verification Criteria:	Critical (40)	Important (25)	Remarks
A. Total Verification Criteria ACHIEVED:			
B. Total Verification Criteria OBSERVED:			
Percentage of achievement (A/B x 100)			

REFERENCED GENDER STANDARDS EXTRACTED FROM OTHER TOOLS, MENTIONED ABOVE

AREA: BIRTH SPACING/FAMILY PLANNING

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____**IMPLEMENTER:** _____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:** _____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
GENERAL COUNSELING: INTERPERSONAL COMMUNICATION AND COUNSELING, RULING OUT PREGNANCY, ASSESSING POSTPARTUM CONTRACEPTION NEEDS.				
Instructions for the assessor: Observe Standards 1-5 in sequence with one client who comes to the clinic to start a method or to continue or change a method.				
1. The provider uses recommended counseling techniques	Observe in the counseling/examination area with client if the provider:			
	• **Shows client respect, and helps client feel at ease**			
	• Encourages the client to explain needs, express concerns, ask questions			
	• Includes client's husband or important family members with permission of the client			
	• **Ensures that there is adequate privacy during the counseling session.**			
	- **Keeping door closed**			
	- **Ensuring that people knock and seek permission before entering the room**			
	- **Taking the clients consent/permission before permitting the presence of any visitors during the session.**			
	• Addresses any related needs such as protection from sexually transmitted infections, including HIV and support for condom use			
	• Listens carefully			
	• **Provides only *key* information and instructions. Uses words the client knows**			
	• Respects and supports the client's informed decisions			
	• **Brings up side effects, if any, and takes the client's concerns seriously**			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
	• **Checks the client's understanding**			
	• **Invites the client to come back any time for any reason and Provides information on return visits**			
2. - Provider/counselor provides information on birth spacing/family planning methods including LAM	Observe if the provider/counselor with one new or returning client:			
	• Explores client's knowledge about birth spacing/family planning			
	• **Corrects misinformation**			
	• **Provides information on the benefits of birth-spacing and potential health consequences of high fertility**			
	• Provides information on dual protection			
	• Provides information on options for emergency contraception.			
	• Discusses the client's situation, plans, and what is important to her about a method			
	• **If the client does not have a method preference. Provides information on all methods and Helps the client consider methods that might suit her and him. If needed, help her reach a decision**			
	• **Supports the client's choice, gives instructions on use, and discusses how to cope with any side effects**			

AREA: ANTENATAL CARE

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____**IMPLEMENTER:** _____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:** _____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
Determine whether the provider/receptionist asks the pregnant woman upon her arrival in the hospital whether she has or has had any medical problems:				
2. - The provider receives and treats the pregnant woman and her husband or companion cordially and respectfully.	Observe during care of pregnant women whether the provider:			
	• **Greets the woman and her husband or companion (if present) in a cordial manner**			
	• Introduces her/him self and Speaks using easy-to-understand language for the client			
	• "Asks the woman whether she wants her husband or companion at her side and does as she wishes." Maybe she does not want them to be there			
	• Insure privacy (see privacy criteria)			
	• **Explains to the woman and her companion what she/he is going to do and encourages her to ask questions**			
	• **Responds to her immediate needs (thirst, hunger, cold/hot, need to urinate, etc.)**			
8- The provider ensures that all women and their husbands/companions are prepared for The delivery	**Observe during a visit with a woman in her second or third trimester, that the provider helps the client and her husband/partner develop an individual birth plan (IBP):**			
	• **Explains the benefits of giving birth with a skilled provider who knows how to treat complications**			
	• **Develops a birth plan with the woman, including all preparations for normal birth and plan in case of emergency:**			
	- **Skilled provider and place of birth**			
	- **Signs and symptoms of labor and when she has to go to the hospital**			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
	- **Emergency transportation and funds**			
	- **Provider asks her to identify a family member(s) as a blood donor**			
	- **Advises the woman and her family to keep adequate amount of money for emergency**			
	- **Items for clean and safe birth**			
	- **Decision-making person in case complication occurs at home**			
	- **Danger signs and symptoms:**			
	- **Vaginal bleeding**			
	- **Respiratory difficulty**			
	- **Fever, severe headache/blurred vision**			
	- **Severe abdominal pain**			
	- **Convulsions/loss of consciousness**			
	- **Blurred vision**			
	Observes whether the provider:			
	• Asks the woman and her husband/companion, if present, to repeat the most important points of the counseling			
	• Asks about, and responds to, any question that the woman and/or her husband/companion asks			
	• **Sets a date for the next visit according to findings and recommends minimum of four antenatal visits and facility delivery**			
	• **Tells the woman and her husband/companion that she must come immediately if she has any danger signs and symptoms or go to a comprehensive health facility**			
	• Thanks the woman for coming			

AREA: NORMAL LABOR, CHILDBIRTH AND IMMEDIATE NEWBORN CARE

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____**IMPLEMENTER:** _____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:** _____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
CARE PROVIDED DURING NORMAL LABOR. Instructions to the assessor: Observe a provider giving care to one woman in the labor and/or delivery rooms. Observe the care through direct observation using as a reference standards 2–8.				
2. The provider treats the pregnant woman in labor in a cordial manner.	Observe one woman in labor and determine whether the provider (in the labor and delivery rooms):			
	• Ensures that she/he speaks the language spoken by the woman or seeks someone who can assist in this regard			
	• Greets the woman and her husband or companion in a cordial manner			
	• Introduces her/himself			
	• Explains care before any examination or procedures			
	• Encourages the woman to ask her husband or companion to remain at her side, as appropriate			
	• Responds to questions using easy-to-understand language			
	• Responds to her immediate needs (thirst, hunger, cold/hot, need to urinate, etc.)			
7. The provider prepares and implements a plan according to the findings of the history and physical exam for providing care to the	Observe one woman in labor and determine whether the provider in the labor and delivery rooms):			
	• Prepares the birth plan with the woman and her companion if possible, asking her:			
	a. Who she would like to have as a companion during labor and birth (one person)			
	b. What position she prefers to adopt during labor and birth as appropriate			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
woman.	c. What did she bring to eat and/or drink			
	• Implements the birth plan, instructing the woman about the importance of:			
	d. Going to the bathroom often to empty her bladder			
	e. Taking liquids and light foods whenever she wants			
	• Walking and changing position according to desire and comfort			

AREA: HEALTH FACILITY MANAGMENT

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____**IMPLEMENTER:** _____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:** _____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	CRITICAL	IMPORTANT	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
HUMAN RESOURCES				
8. The health facility is properly staffed.	Verify with the director of the facility and staff if clear job descriptions exist and if these staff positions are filled for the following personnel:			
	• **Male Nurse/Doctor** 1			
	• **Midwife/Female doctor** 1			
	• **Vaccinators** 2			
	• CHS 1			

AREA: BEHAVIOR CHANGE COMMUNICATION

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____**IMPLEMENTER:** _____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:** _____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	CRITICAL	IMPORTANT	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
9. The health education sessions are based on client needs and are client-friendly.	Observe during one health education session, whether the provider:			
	• Greet and introduce him/her self to the clients			
	• **Is nice to the clients**			
	• **Asks clients about their health issue of concern**			
	• **Encourages the clients to ask questions and ensures confidentiality**			
	• **Explains to the clients about the particular issues of concern**			
	• **Uses IEC materials to explain about the health issue to the clients**			
	• **Uses simple and easy to understand language with the clients**			
	• **Encourages the client to return for regular visits to the health facility**			
	• **Encourages the client to seek additional information from the CHW**			
14. Health facility has functional health council (Shura-e-Sehie).	Check records to verify that:			
	• Health facility has record of health council (Shura-e-Sehie) constitution			
	• Health council (Shura-e-Sehie) consist of community and health facility staff			
	• **One third of health council (Shura-e-Sehi) is female**			
	• Female representatives are present both from community and health facility			

HARMONIZED QUALITY IMPROVEMENT STANDARDS

AFGHANISTAN

COMPREHENSIVE HEALTH CENTER

GENDER

2013

COMMENTS/ REMARKS/ RECOMMENDATIONS:

Please read these questions carefully and do not fill out this section now. However, remember to fill out this part at the end of your assessment of the relevant area.		
4. What are Gender-related positive points which you observed in the health facility but were not captured in your assessment?	5. What are Gender-related problems/issues which you observed in the health facility but were not captured in your assessment?	6. What are your recommendations for building upon positive points or overcoming problems/issues which you mentioned in the answers to Question 1 & 2?

AREA: GENDER

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____**IMPLEMENTER:** _____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:** _____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
Instructions for the assessor: For each of the standards below, fill in the total number of verification criteria achieved as per your assessment that you already conducted in the areas mentioned below.				
PROMOTION OF GENDER SENSITVE COMMUNICATION AND IPCC				
10. Fill in results from Standard # 1 of the Birth spacing/ Family planning area of CHC standards: (Maximum score for verification criteria: Critical 8 Important 5)				
11. Fill in results from Standard # 2 of the Birth spacing/ Family planning area of CHC standards: (Maximum score for verification criteria: Critical 4 Important 4)				
12. Fill in results from Standard # 9 of the BCC area of CHC standards: (Maximum score for verification criteria: Critical 8 Important 1)				
PROMOTION OF MALE INVOLVEMENT				
13. Fill in results from Standard # 2 of the ANC area of CHC standards: (Maximum score for verification criteria: Critical 2 Important 3)				
14. Fill in results from Standard # 8 of the ANC area of CHC standards: (Maximum score for verification criteria: Critical 14)				
15. Fill in results from Standard # 2 of the Normal labor area of CHC standards: (Maximum score for verification criteria: Important 2)				
PROMOTION OF WOMEN'S EMPOWERMENT AND DECISION MAKING				
16. Fill in results from Standard # 7 of the Normal labor area of CHC standards: (Maximum score for verification criteria: Important 6)				
17. Fill in results from Standard # 10 of the Health Facility Management area of CHC standards: (Maximum score for verification criteria: Critical 4 Important 6)				
18. Fill in results from Standard # 14 of the BCC area of CHC standards: (Maximum score for verification criteria: Critical 1 Important 3)				

TOTAL Verification Criteria:	Critical (41)	Important (30)	Remarks
A. Total Verification Criteria ACHIEVED:			
B. Total Verification Criteria OBSERVED:			
Percentage of achievement (A/B x 100)			

AREA: BIRTH SPACING/FAMILY PLANNING

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____**IMPLEMENTER:** _____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:** _____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
GENERAL COUNSELING: INTERPERSONAL COMMUNICATION AND COUNSELING, RULING OUT PREGNANCY, ASSESSING POSTPARTUM CONTRACEPTION NEEDS.				
Instructions for the assessor: Observe Standards 1-5 in sequence with one client who comes to the clinic to start a method or to continue or change a method.				
3. The provider uses recommended counseling techniques	Observe in the counseling/examination area with client if the provider:			
	• **Shows client respect, and helps client feel at ease**			
	• Encourages the client to explain needs, express concerns, ask questions			
	• Includes client's husband or important family members with permission of the client			
	• **Ensures that there is adequate privacy during the counseling session.**			
	- **Keeping door closed**			
	- **Ensuring that people knock and seek permission before entering the room**			
	- **Taking the clients consent/permission before permitting the presence of any visitors during the session.**			
	• Addresses any related needs such as protection from sexually transmitted infections, including HIV and support for condom use			
	• Listens carefully			
	• **Provides only *key* information and instructions. Uses words the client knows**			
	• Respects and supports the client's informed decisions			
	• **Brings up side effects, if any, and takes the client's concerns seriously**			
	• **Checks the client's understanding**			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
	• **Invites the client to come back any time for any reason and Provides information on return visits**			
4. - Provider/counselor provides information on birth spacing/family planning methods including LAM	Observe if the provider/counselor with one new or returning client:			
	• Explores client's knowledge about birth spacing/family planning			
	• **Corrects misinformation**			
	• **Provides information on the benefits of birth-spacing and potential health consequences of high fertility**			
	• Provides information on dual protection			
	• Provides information on options for emergency contraception.			
	• Discusses the client's situation, plans, and what is important to her about a method			
	• **If the client does not have a method preference. Provides information on all methods and Helps the client consider methods that might suit her and him. If needed, help her reach a decision**			
	• **Supports the client's choice, gives instructions on use, and discusses how to cope with any side effects**			

AREA: ANTENATAL CARE

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____**IMPLEMENTER:** _____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:** _____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
Determine whether the provider/receptionist asks the pregnant woman upon her arrival in the hospital whether she has or has had any medical problems:				
2. - The provider receives and treats the pregnant woman and her husband or companion cordially and respectfully.	Observe during care of pregnant women whether the provider:			
	• **Greets the woman and her husband or companion (if present) in a cordial manner**			
	• Introduces her/him self and Speaks using easy-to-understand language for the client			
	• "Asks the woman whether she wants her husband or companion at her side and does as she wishes." Maybe she does not want them to be there			
	• Insure privacy (see privacy criteria)			
	• **Explains to the woman and her companion what she/he is going to do and encourages her to ask questions**			
	• **Responds to her immediate needs (thirst, hunger, cold/hot, need to urinate, etc.)**			
8- The provider ensures that all women and their husbands/companions are prepared for The delivery	**Observe during a visit with a woman in her second or third trimester, that the provider helps the client and her husband/partner develop an individual birth plan (IBP):**			
	• **Explains the benefits of giving birth with a skilled provider who knows how to treat complications**			
	• **Develops a birth plan with the woman, including all preparations for normal birth and plan in case of emergency:**			
	- **Skilled provider and place of birth**			
	- **Signs and symptoms of labor and when she has to go to the hospital**			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
	- **Emergency transportation and funds**			
	- **Provider asks her to identify a family member(s) as a blood donor**			
	- **Advises the woman and her family to keep adequate amount of money for emergency**			
	- **Items for clean and safe birth**			
	- **Decision-making person in case complication occurs at home**			
	- **Danger signs and symptoms:**			
	- **Vaginal bleeding**			
	- **Respiratory difficulty**			
	- **Fever, severe headache/blurred vision**			
	- **Severe abdominal pain**			
	- **Convulsions/loss of consciousness**			
	- **Blurred vision**			
	Observes whether the provider:			
	• Asks the woman and her husband/companion, if present, to repeat the most important points of the counseling			
	• Asks about, and responds to, any question that the woman and/or her husband/companion asks			
	• **Sets a date for the next visit according to findings and recommends minimum of four antenatal visits and facility delivery**			
	• **Tells the woman and her husband/companion that she must come immediately if she has any danger signs and symptoms or go to a comprehensive health facility**			
	• Thanks the woman for coming			

AREA: NORMAL LABOR, CHILDBIRTH AND IMMEDIATE NEWBORN CARE

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____**IMPLEMENTER:** _____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:** _____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
CARE PROVIDED DURING NORMAL LABOR. Instructions to the assessor: Observe a provider giving care to one woman in the labor and/or delivery rooms. Observe the care through direct observation using as a reference standards 2–8.				
2. The provider treats the pregnant woman in labor in a cordial manner.	Observe one woman in labor and determine whether the provider (in the labor and delivery rooms):			
	• Ensures that she/he speaks the language spoken by the woman or seeks someone who can assist in this regard			
	• Greets the woman and her husband or companion in a cordial manner			
	• Introduces her/himself			
	• Explains care before any examination or procedures			
	• Encourages the woman to ask her husband or companion to remain at her side, as appropriate			
	• Responds to questions using easy-to-understand language			
	• Responds to her immediate needs (thirst, hunger, cold/hot, need to urinate, etc.)			
7. The provider prepares and implements a plan according to the findings of the history and physical exam for providing care to the	Observe one woman in labor and determine whether the provider in the labor and delivery rooms):			
	• Prepares the birth plan with the woman and her companion if possible, asking her:			
	a. Who she would like to have as a companion during labor and birth (one person)			
	b. What position she prefers to adopt during labor and birth as appropriate			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
woman.	c. What did she bring to eat and/or drink			
	• Implements the birth plan, instructing the woman about the importance of:			
	d. Going to the bathroom often to empty her bladder			
	e. Taking liquids and light foods whenever she wants			
	• Walking and changing position according to desire and comfort			

AREA: HEALTH FACILITY MANAGMENT

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____**IMPLEMENTER:** _____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:** _____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	CRITICAL	IMPORTANT	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
HUMAN RESOURCES				
1. The health facility is properly staffed.	Verify with the director of the facility and staff if clear job descriptions exist and if these staff positions are filled for the following personnel:			
	• **Male doctor** **1**			
	• Female doctor 1			
	• Female nurse 1			
	• Male nurse 1			
	• **Lab technician** **1**			
	• **Midwives** **2**			
	• Pharmacy technician 1			
	• Admin 1			
	• **Vaccinators** **2**			
	• CHS 1			

AREA: BEHAVIOR CHANGE COMMUNICATION

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____**IMPLEMENTER:** _____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:** _____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	CRITICAL	IMPORTANT	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
HEALTH EDUCATION				
9. The health education sessions are based on client needs and are client-friendly.	Observe during one health education session, whether the provider:			
	• Greet and introduce him/her self to the clients			
	• **Is nice to the clients**			
	• **Asks clients about their health issue of concern**			
	• **Encourages the clients to ask questions and ensures confidentiality**			
	• **Explains to the clients about the particular issues of concern**			
	• **Uses IEC materials to explain about the health issue to the clients**			
	• **Uses simple and easy to understand language with the clients**			
	• **Encourages the client to return for regular visits to the health facility**			
	• **Encourages the client to seek additional information from the CHW**			
HARMONIZED QUALITY IMPROVEMENT MODEL /COMMUNITY MOBILIZATION				
14. Health facility has functional health council (Shura-e-Sehie).	Check records to verify that:			
	• Health facility has record of health council (Shura-e-Sehie) constitution			
	• Health council (Shura-e-Sehie) consist of community and health facility staff			
	• **One third of health council (Shura-e-Sehi) is female**			
	• Female representatives are present both from community and health facility			

HARMONIZED QUALITY IMPROVEMENT STANDARDS

AFGHANISTAN

DISTRICT HOSPITAL

GENDER

2013

COMMENTS/ REMARKS/ RECOMMENDATIONS:

Please read these questions carefully and do not fill out this section now. However, remember to fill out this part at the end of your assessment of the relevant area.		
7. What are Gender-related positive points which you observed in the health facility but were not captured in your assessment?	8. What are Gender-related problems/issues which you observed in the health facility but were not captured in your assessment?	9. What are your recommendations for building upon positive points or overcoming problems/issues which you mentioned in the answers to Question 1 & 2?

AREA: GENDER

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____ **IMPLEMENTER:**_____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:**_____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
Instructions for the assessor: For each of the standards below, fill in the total number of verification criteria achieved as per your assessment that you already conducted in the areas mentioned below.				
PROMOTION OF GENDER SENSITVE COMMUNICATION AND IPCC				
19. Fill in results from Standard # 1 of the Birth spacing/ Family planning area of DH standards:	(Maximum score for verification criteria: Critical 8 Important 5)			
20. Fill in results from Standard # 2 of the Birth spacing/ Family planning area of DH standards:	(Maximum score for verification criteria: Critical 4 Important 4)			
21. Fill in results from Standard # 9 of the BCC area of DH standards:	(Maximum score for verification criteria: Critical 8 Important 1)			
PROMOTION OF MALE INVOLVEMENT				
22. Fill in results from Standard # 2 of the ANC area of DH standards:	(Maximum score for verification criteria: Critical 2 Important 3)			
23. Fill in results from Standard # 8 of the ANC area of DH standards:	(Maximum score for verification criteria: Critical 14)			
24. Fill in results from Standard # 2 of the Normal labor area of DH standards:	(Maximum score for verification criteria: Important 2)			
PROMOTION OF WOMEN'S EMPOWERMENT AND DECISION MAKING				
25. Fill in results from Standard # 7 of the Normal labor area of DH standards:	(Maximum score for verification criteria: Important 6)			
26. Fill in results from Standard # 12 of the Health Facility Management area of DH standards:	(Maximum score for verification criteria: Critical 7 Important 7)			
27. Fill in results from Standard # 14 of the BCC area of DH standards:	(Maximum score for verification criteria: Critical 1 Important 3)			

TOTAL Verification Criteria:	Critical (44)	Important (31)	Remarks
A. Total Verification Criteria ACHIEVED:			
B. Total Verification Criteria OBSERVED:			
Percentage of achievement (A/B x 100)			

REFERENCED GENDER STANDARDS EXTRACTED FROM OTHER TOOLS, MENTIONED ABOVE

AREA: BIRTH SPACING/FAMILY PLANNING

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____ **IMPLEMENTER:**_____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:**_____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
GENERAL COUNSELING: INTERPERSONAL COMMUNICATION AND COUNSELING, RULING OUT PREGNANCY, ASSESSING POSTPARTUM CONTRACEPTION NEEDS.				
Instructions for the assessor: Observe Standards 1-5 in sequence with one client who comes to the clinic to start a method or to continue or change a method.				
5. The provider uses recommended counseling techniques	Observe in the counseling/examination area with client if the provider:			
	• **Shows client respect, and helps client feel at ease**			
	• Encourages the client to explain needs, express concerns, ask questions			
	• Includes client's husband or important family members with permission of the client			
	• **Ensures that there is adequate privacy during the counseling session.**			
	- **Keeping door closed**			
	- **Ensuring that people knock and seek permission before entering the room**			
	- **Taking the clients consent/permission before permitting the presence of any visitors during the session.**			
	• Addresses any related needs such as protection from sexually transmitted infections, including HIV and support for condom use			
	• Listens carefully			
	• **Provides only *key* information and instructions. Uses words the client knows**			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
	• Respects and supports the client's informed decisions			
	• **Brings up side effects, if any, and takes the client's concerns seriously**			
	• **Checks the client's understanding**			
	• **Invites the client to come back any time for any reason and Provides information on return visits**			
6. - Provider/counselor provides information on birth spacing/family planning methods including LAM	Observe if the provider/counselor with one new or returning client:			
	• Explores client's knowledge about birth spacing/family planning			
	• **Corrects misinformation**			
	• **Provides information on the benefits of birth-spacing and potential health consequences of high fertility**			
	• Provides information on dual protection			
	• Provides information on options for emergency contraception.			
	• Discusses the client's situation, plans, and what is important to her about a method			
	• **If the client does not have a method preference. Provides information on all methods and Helps the client consider methods that might suit her and him. If needed, help her reach a decision**			
	• **Supports the client's choice, gives instructions on use, and discusses how to cope with any side effects**			

AREA: ANTENATAL CARE

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____ **IMPLEMENTER:**_____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:**_____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
Instructions for the assessor: Observe standards 2–10 in sequence with one pregnant women who come for ANC				
2. - The provider receives and treats the pregnant woman and her husband or companion cordially and respectfully.	Observe during care of pregnant women whether the provider:			
	• **Greets the woman and her husband or companion (if present) in a cordial manner**			
	• Introduces her/him self and Speaks using easy-to-understand language for the client			
	• "Asks the woman whether she wants her husband or companion at her side and does as she wishes." Maybe she does not want them to be there			
	• Insure privacy (see privacy criteria)			
	• **Explains to the woman and her companion what she/he is going to do and encourages her to ask questions**			
	• **Responds to her immediate needs (thirst, hunger, cold/hot, need to urinate, etc.)**			
8- The provider ensures that all women and their husbands/companions are prepared for The delivery	**Observe during a visit with a woman in her second or third trimester, that the provider helps the client and her husband/partner develop an individual birth plan (IBP):**			
	• **Explains the benefits of giving birth with a skilled provider who knows how to treat complications**			
	• **Develops a birth plan with the woman, including all preparations for normal birth and plan in case of emergency:**			
	- **Skilled provider and place of birth**			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
	- Signs and symptoms of labor and when she has to go to the hospital			
	- Emergency transportation and funds			
	- Provider asks her to identify a family member(s) as a blood donor			
	- Advises the woman and her family to keep adequate amount of money for emergency			
	- Items for clean and safe birth			
	- Decision-making person in case complication occurs at home			
	- Danger signs and symptoms:			
	- Vaginal bleeding			
	- Respiratory difficulty			
	- Fever, severe headache/blurred vision			
	- Severe abdominal pain			
	- Convulsions/loss of consciousness			
	- Blurred vision			

AREA: NORMAL LABOR, CHILDBIRTH AND IMMEDIATE NEWBORN CARE

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____ **IMPLEMENTER:**_____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:**_____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
CARE PROVIDED DURING NORMAL LABOR. Instructions to the assessor: Observe a provider giving care to one woman in the labor and/or delivery rooms. Observe the care through direct observation using as a reference standards 2–8.				
3. The provider treats the pregnant woman in labor in a cordial manner.	Observe one woman in labor and determine whether the provider (in the labor and delivery rooms):			
	• Ensures that she/he speaks the language spoken by the woman or seeks someone who can assist in this regard			
	• Greets the woman and her husband or companion in a cordial manner			
	• Introduces her/himself			
	• Explains care before any examination or procedures			
	• Encourages the woman to ask her husband or companion to remain at her side, as appropriate			
	• Responds to questions using easy-to-understand language			
	• Responds to her immediate needs (thirst, hunger, cold/hot, need to urinate, etc.)			
7. The provider prepares and implements a plan according to the findings of the history and physical exam for providing	Observe one woman in labor and determine whether the provider in the labor and delivery rooms):			
	• Prepares the birth plan with the woman and her companion if possible, asking her:			
	a. Who she would like to have as a companion during labor and birth (one person)			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Critical	Important	COMMENTS
care to the woman.	b. What position she prefers to adopt during labor and birth as appropriate			
	c. What did she bring to eat and/or drink			
	• Implements the birth plan, instructing the woman about the importance of:			
	d. Going to the bathroom often to empty her bladder			
	e. Taking liquids and light foods whenever she wants			
	• Walking and changing position according to desire and comfort			

AREA: HEALTH FACILITY MANAGEMENT

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____ **IMPLEMENTER:**_____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3 ☐) **DATE:**_____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	CRITICAL	IMPORTANT	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
Human Resources				
12. **The health facility is properly staffed.**	Verify with the director of the facility and staff if clear job descriptions exist and if these staff positions are filled for the following personnel:			
	• Medical doctor (2 internal medicine and 1 pediatrician)			
	• **Postgraduate Gyn/obs (2)**			
	• **Surgeon (1)**			
	• **Midwives/community midwives (4)**			
	• Male and female nurses (5/5=10)			
	• Pharmacist (1)			
	• **Lab technicians (2)**			
	• Stomatologist dental technician (2)			
	• **Anesthesiologist (1)**			
	• **X-ray technician (1)**			
	• Administrator (1)			
	• Community health supervisor (1 or 2)			
	• **Vaccinators (2)**			
	• Support staff male and female, including cook (7)			

AREA: BEHAVIOR CHANGE COMMUNICATION

PROVINCE: _____ **FACILITY NAME:** _____ **FACILITY ID:** _____ **IMPLEMENTER:**_____

ASSESSOR: _____**ASSESSMENT TYPE:** (BASELINE ☐ / EXTERNAL 1 ☐ 2 ☐ 3☐) **DATE:**_____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	CRITICAL	IMPORTANT	COMMENTS
Instructions for the assessor : For any verification criteria fill in each unblocked cell with one of the following options "1" if the verification criteria is met, "0" if the verification criteria is not met or partially achieved, "NA" if Not applicable. Any cells left unfilled will be considered as missing data.				
HEALTH EDUCATION				
9. The health education sessions are based on client needs and are client-friendly.	Observe during one health education session, whether the provider:			
	• Greet and introduce him/her self to the clients			
	• **Is nice to the clients**			
	• **Asks clients about their health issue of concern**			
	• **Encourages the clients to ask questions and ensures confidentiality**			
	• **Explains to the clients about the particular issues of concern**			
	• **Uses IEC materials to explain about the health issue to the clients**			
	• **Uses simple and easy to understand language with the clients**			
	• **Encourages the client to return for regular visits to the health facility**			
	• **Encourages the client to seek additional information from the CHW**			
Harmonized Quality Improvement Model /community Mobilization				
14. Health facility has functional health council (Shura-e-Sehie).	Check records to verify that:			
	• Health facility has record of health council (Shura-e-Sehie) constitution			
	• Health council (Shura-e-Sehie) consist of community and health facility staff			
	• **One third of health council (Shura-e-Sehi) is female**			
	• Female representatives are present both from community and health facility			

Annex IX: Surveillance Reporting Form

Surveillance Reporting Form for Morbidity (disease) and Mortality (death)
BRING TO PHD OFFICE EVERY SATURDAY

Province Name/Code: District Name/Code:

Town/Village/Camp: Facility Name/Code: NGO/Donor:

Epidemiological Week___ from Saturday: _____/_____/2007 to Friday_____/_____/2007

Submission Date:___/____/____ Contact's Name & phone #:……

Events Under Surveillance		Less than 5 years old		5 years old and older	
		Cases	Deaths	Cases	Deaths
1	ARI- Cough and cold				
2	ARI- Pneumonia				
3	Acute Diarrhoea				
4	Bloody Diarrhoea				
5	AWD w Dehydration				
6	Suspected Meningitis (SIC)				
7	Susp. Acute Viral Hepatitis				
8	Suspected Measles				
9	Suspected Pertussis				
10	Probable Diphtheria				
11	Tetanus/ Neonatal Tetanus				
12	Acute Flaccid Paralysis				
13	Suspected Malaria				
14	Suspected Typhoid Fever				
15	Susp. Hemorrhagic Fever				
16	Pregnancy-related deaths				
	DEWS Disease				
TOTAL New Clients/ Deaths					

- Please include only those cases that were examined / admitted during the surveillance week and deaths that occurred during the surveillance week. Each case should be counted only once.
- Write "0" (zero) if you had no case or death of any of the Health Events listed in the form.
- Deaths should be reported only under "Deaths", NOT under "Cases", and please fill the following table for each reported death.

S.N.	Name	Age	Sex	Cause	Residence/ Address
1					
2					

3					

Investigate with history and lab specimen single cases of suspected avian influenza, cholera, measles, pertussis, diphtheria, AFP, meningitis and hemorrhagic fever and search for other cases. Similarly, investigate clusters of pneumonia, bloody diarrhea, hepatitis, malaria, and typhoid and increasing trends of ARI and diarrhea.

Annex X: Distribution of Cadre of Health Workers, by Sex

Total Health Worker by Category by Gender						
Health Occupational categories/cadres	Total	%	Male	%	Female	%
Physicians generalists	5990	15.27	4990	83.31	1000	16.69
Physicians specialists	2116	5.4	1484	70.13	632	29.87
Nurses and Assistants	6749	17.2	5731	84.92	1018	15.08
Midwives and Assistants	3484	8.88	0	0.00	3484	100.00
Dentists and Assistants	579	1.48	479	82.73	100	17.27
Pharmacists and Assistants	1803	4.6	1584	87.85	219	12.15
Laboratory workers	2075	5.29	1933	93.16	142	6.84
Environment & public health workers (health inspectors, vaccinators, and sanitarians)	3503	9.25	2774	79.19	729	20.81
Other health workers (including physiotherapy, radiography and orthopaedic technicians)	391	1	347	88.75	44	11.25
Health management/ administration staff /trainers.	3834	9.78	3169	82.66	665	17.34
Support staff	7857	20.03	6294	80.11	1563	19.89
Other (Skilled tradesmen, typists and CHW supervisors)	720	1.84	593	82.36	127	17.64
TOTAL	39101	100	29378	75.13	9723	24.87

Annex XI: List of Gender-Related Studies Being Conducted in Afghanistan since 2010 (incomplete)

- Gender Related Barriers to Access and Utilization of Primary Health Care Services with Focus on Access to First level Reproductive Health, and Mental Care Services: Findings 2010. Ministry of Public Health, With UNFPA. Principal Investigator: Dr Mir Lais Mustafa, Co-Principal Investigator: Dr Sayed Ataullah Saeedzai.

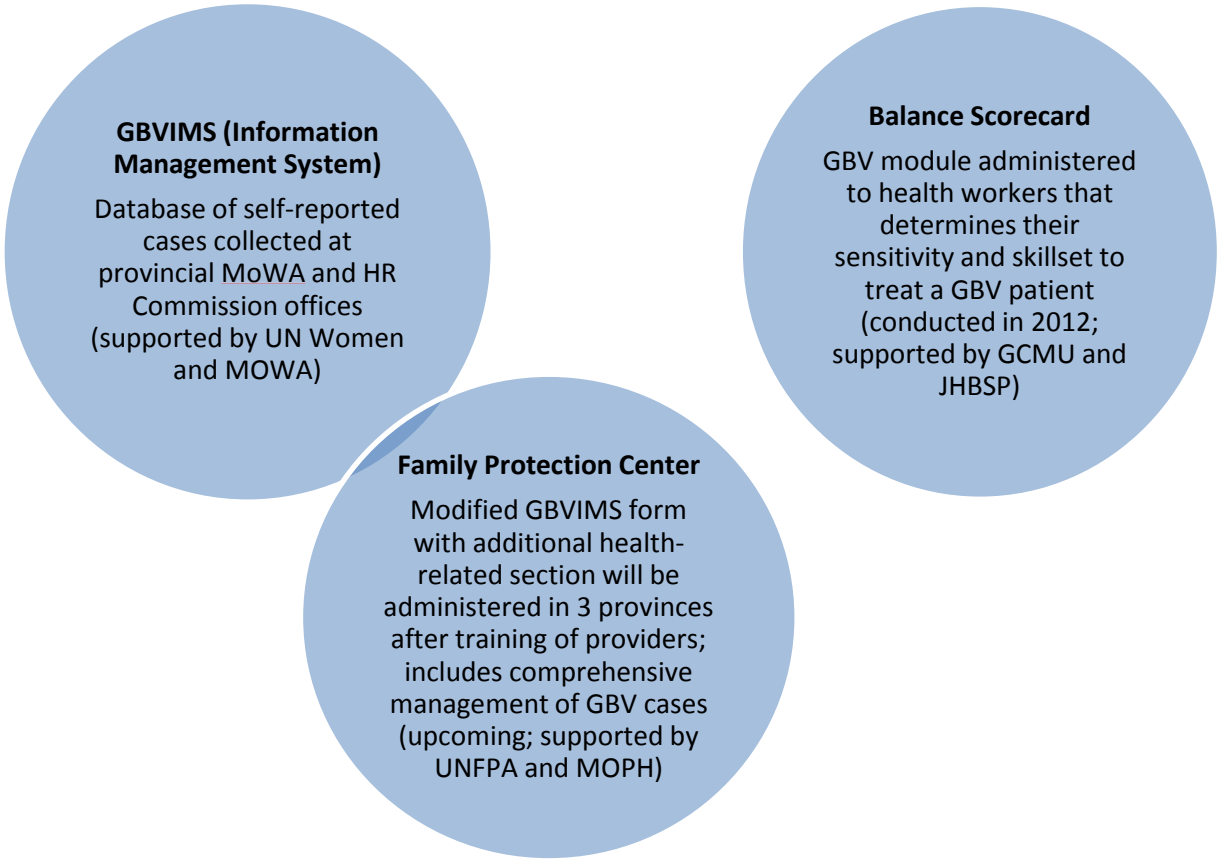
- Research of Gender Related Barriers to Access and Utilization of Primary Health Care Services with Focus on Access to First level Reproductive Health, Mental Health and Tuberculosis Health Care Services: Findings 2010. Ministry of Public Health, World Health Organization.

- Gender and the cultural epidemiology of tuberculosis among patients in the Central Region of Afghanistan. May 2007. By Ellen Stamhuis. Dissertation submitted as partial fulfilment of the requirements for the degree of the Master of Science in International Health, TropEd University of Basel, Switzerland, Swiss Tropical Institute. Supervisor: Prof. Mitchell G. Weiss.

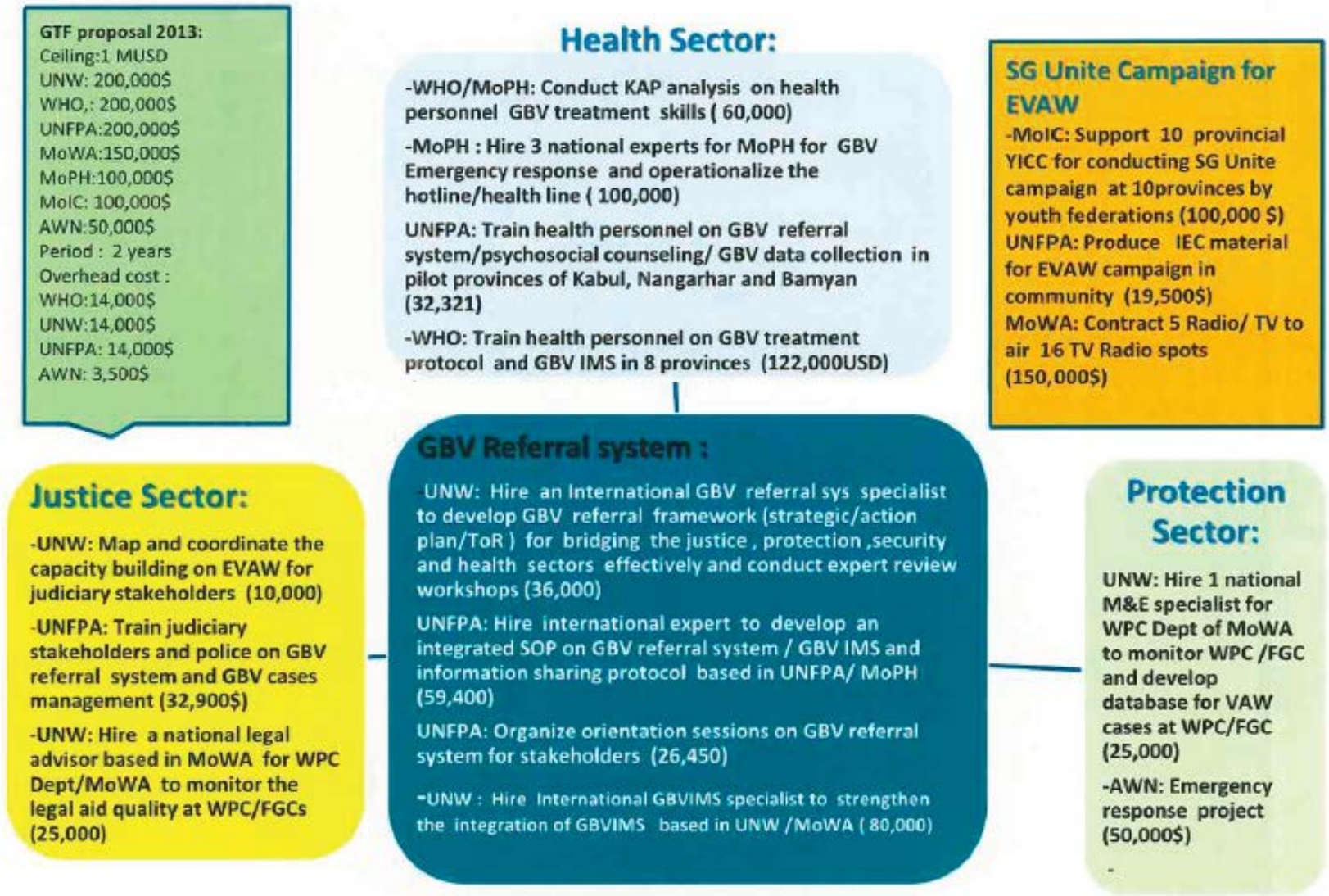
- Exploring the effects of gender on women's access to healthcare services in Afghanistan/ Qudratullah Nasrat (0799217125, q.nasrat@liverpool.ac.uk).

- Preparedness of health workers and facilities to receive and manage cases of gender-based violence and self-immolation in Afghanistan, a national assessment. David Peters.

Annex XII: Summary of Existing GBV Tools Available



Annex XIII: Distribution of a Global Fund Project Across Several Sectors, in Afghanistan



Annex XIV: GBV Diagnosis Form Developed by the MOPH in Conjunction with UNFPA

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CONSENT FOR EXAMINATION

Note to the health worker:
This form should be read to the patient or guardian in her/his first language. Clearly explain to the patient what the procedure for the medical examination involves and allow her/him to chose any or none of the options listed. The survivor can change his/her mind at any time and a new form can be completed.

I, _____, give my permission for
(clearly print patient's full name)

_____ to perform the following (select one option for each, do
(medical provider's name and title)

not leave blank):

1. A medical examination:	☐ **Yes**	☐ **No**
2. A pelvic examination:	☐ **Yes**	☐ **No**
3. A speculum examination (if medically necessary):	☐ **Yes**	☐ **No**
4. Collection of evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cuttings of fingernails:	☐ **Yes**	☐ **No**
5. Blood draw:	☐ **Yes**	☐ **No**
6. Provide evidence and medical information to the police and/or courts concerning my case; this information will be limited to the results of this examination and any relevant follow-up care provided:	☐ **Yes**	☐ **No**

I understand that I can refuse any aspect of the examination I do not wish to undergo.

Patient/ Guardian Signature:
_____

Staff Code: _____ Date: _____

GBV IMS

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Health Service Provider Data Collection Form

1. General Information

Was the incident reported by the survivor or reported by survivor's escort and survivor is present at reporting? ☐Yes ☐No		**Staff Code:**
Date / Time of Examination: (dd/mm/yyyy/00:00 hrs)	**Date Of Birth:** (dd/mm/yyyy)	**Sex:** ☐ Female ☐ Male

2. The Incident

Date / Time of Incident: (dd/mm/yyyy/00:00 hrs)	**Incident District**	**Incident Health Zone**

Type of GBV:
(Select the first option that applies)
- ☐ Penetration
- ☐ Sexual Assault
- ☐ Physical Assault
- ☐ Forced Marriage
- ☐ Denial of Resources, Opportunities or Services
- ☐ Psychological Assault

Did this incident involve a Harmful Traditional Practice?
☐ No ☐ *Type of practice # 1* ☐ *Type of practice #2*

Were money, goods, benefits, and / or services exchanged in relation to this incident? ☐ Yes ☐ No

Type of abduction at time of the incident:
☐ None ☐ Forced Conscription
☐ Trafficked ☐ Other Abduction / Kidnapping

Patient has reported this incident anywhere else?
☐ No ☐ Yes- GBVIMS ☐ Yes- Non-GBVIMS ☐ Unknown

3. Alleged Perpetrator Information

No. of alleged perpetrators:
☐ 1 ☐ 2 ☐ 3
☐ More than 3 ☐ Unknown

Alleged perpetrator relationship with survivor:
☐ Intimate partner / Former partner ☐ Primary caregiver
☐ Family other than spouse or caregiver ☐ Service provider
☐ Other refugee/IDP/Returnee ☐ Other / Unknown

Main occupation of alleged perpetrator: (*Customize location options by modifying the tick boxes*)
☐ UN Staff ☐ Solider ☐ Teacher / School Official ☐ Security Official
☐ Police ☐ NGO Staff ☐ Religious / Community Leader ☐ Other /Unknown

4. Medical History & Examination

Evidence of pregnancy? ☐ No ☐ Yes (# of Weeks:___)	**Did this incident involve penile penetration?** ☐ Yes ☐ No	**HIV/AIDS status:** ☐ Positive ☐ Negative ☐ Unknown	**Pubertal stage:** ☐ Pre-pubertal ☐ Pubertal ☐ Mature

Was a pregnancy test done?	☐ No	☐ Yes - Positive	☐ Yes-Negative
Was a STI test done?	☐ No	☐ Yes - Positive	☐ Yes-Negative
Was a HIV test done?	☐ No	☐ Yes - Positive	☐ Yes-Negative

5. Treatments Prescribed

STI prevention/treatment:	☐Yes	☐No	☐Patient Declined	☐Not Applicable	☐Not Available
Emergency contraception:	☐Yes	☐No	☐Patient Declined	☐Not Applicable	☐Not Available
Wound treatment:	☐Yes	☐No	☐Patient Declined	☐Not Applicable	☐Not Available
Tetanus prophylaxis:	☐Yes	☐No	☐Patient Declined	☐Not Applicable	☐Not Available
Hepatitis B vaccination:	☐Yes	☐No	☐Patient Declined	☐Not Applicable	☐Not Available
Post-exposureprophylaxis-HI:	☐Yes	☐No	☐Patient Declined	☐Not Applicable	☐Not Available

6. Planned Action / Action Taken: Any action / activity regarding this report.

Who referred this patient to you? ☐ Self-Referred ☐Health/Medical Service ☐Psychosocial Service
☐ Police/Other Security Actor ☐Safe House/Shelter ☐Livelihoods Program ☐Community Outreach
☐ Community or Camp Leader ☐Teacher/School Official ☐Other Government Service ☐Legal Services
☐ Other Humanitarian Actor ☐Other (specify):

Did you refer patient for psychosocial services? ☐Yes ☐No-You provided services ☐No -Services already received ☐No-Patient declined ☐ No-Service not applicable ☐No-Service unavailable

Did you refer patient for security services? ☐Yes ☐No-You provided services ☐No -Services already received ☐No-Patient declined ☐ No-Service not applicable ☐No-Service unavailable

Did you refer patient for higher level medical services?

☐Yes (Indicate for which of the following reasons):
☐ Antenatal Care ☐ Vaccination ☐ Family Planning ☐ Closer Facility
☐ Surgery ☐ VCT ☐ Other Advanced Treatment

☐ No (Indicate for which of the following reasons):
☐ You provided services ☐ Services already received ☐ Patient declined
☐ Service not applicable ☐ Service unavailable

Does the patient want to pursue legal action? ☐ Yes ☐ No ☐ Undecided at Time of Report

Was Evidence Collected? ☐ Yes ☐ No Specify:	**Was a medical certificate requested by the patient?** ☐ Yes ☐ No	**Was a medical certificate prepared for the patient?** ☐ Yes ☐ No	**Was a follow-up visit scheduled?** ☐ Yes ☐ No

Was the medical examination process explained prior to beginning the procedure? ☐Yes ☐No

Was consent for the examination obtained prior to beginning examination? ☐Yes ☐No

Were the patient's available referral options clearly explained to them? ☐Yes ☐No

Was the consent for release of information explained & completed by the patient or patient's guardian? ☐Yes ☐No

CONFIDENTIAL
Authorization for Release of Information

Note to the health worker:
This form should be read to the patient or guardian in her first language. It should be clearly explained to the patient that she / he can choose any or none of the options listed.

I, _____, give my permission for (***Name of Your Organization***) to share information about the incident I have reported to them as explained below:

1. I understand that in giving my authorization below, I am giving (***Name of Your Organization***) permission to share the specific case information from my incident report with the service provider(s) I have indicated, so that I can receive help with safety, health, psychosocial, and/or legal needs.

   I understand that shared information will be treated with confidentiality and respect, and shared only as needed to provide the assistance I request.

   I understand that releasing this information means that a person from the agency or service ticked below may come to talk to me. At any point, I have the right to change my mind about sharing information with the designated agency/focal point listed below.

   I would like information released to the following:
   (Tick all that apply, and specify name, facility and agency/organization as applicable)

   ☐ Security Services (specify): _____
   ☐ Psychosocial Services (specify): _____
   ☐ Health/Medical Services (specify): _____
   ☐ Safe House / Shelter (specify): _____
   ☐ Legal Assistance Services (specify): _____
   ☐ Protection Services (specify): _____
   ☐ Livelihoods Services (specify): _____
   ☐ Other (specify type of service, name, and agency): _____

1. Authorization to be marked by patient: ☐ **Yes** ☐ **No**
(or guardian if patient is under 18)

2. I have been informed and understand that some non-identifiable information may also be shared for reporting. Any information shared will not be specific to me or the incident. There will be no way for someone to identify me based on the information that is shared. I understand that shared information will be treated with confidentiality and respect.

2. Authorization to be marked by patient: ☐ **Yes** ☐ **No**
(or guardian if patient is under 18)

Signature / Thumbprint of Patient *(or guardian if patient is under 18)*	Staff Code	Date

For more information, contact:

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