

LINKING RELIEF, REHABILITATION AND DEVELOPMENT PROGRAMME (LRRD) IN AFGHANISTAN

Different quality approaches in the Afghan health system

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Following decades of war and neglect, the reconstruction of the health system in Afghanistan is in full swing since 2002, thanks to considerable efforts undertaken by the Ministry of Public Health (MoPH), donors, various experts, and national and international NGOs.

The first priority was developing basic health services throughout the country, namely the Basic Package for Health Services (BPHS), and the second was the reorganisation of the hospital system. At the same time, research has been carried out on financing systems and the quality of services provided.

Different quality approaches are currently being tested within the health sector and this article aims to provide an overview of how some of these initiatives are progressing. Our analysis is based on interviews with key interlocutors in Kabul in July 2005 and a number of documents¹. This research comes within the wider framework of a cross-sector study which is being carried out by Groupe URD on the transition from emergency to development in Afghanistan. Its purpose is to identify and describe important changes that are taking place in various sectors, to evaluate their impact and share the lessons learnt with the various stakeholders concerned by this subject.

1 MoPH hospital policy and the issue of quality

The MoPH in Afghanistan determined a certain number of priorities for the health sector in

response to people's needs. In March 2003, a MoPH working group was commissioned to design the BPHS, on which the primary health care system is based (Health Posts and Community Health Workers at village level, Basic Health Centres, Comprehensive Health Centres, and finally District Hospitals at the top). When necessary, these health centres should be able to rely on the support of high-performance referral hospitals (Provincial and Regional Hospitals) (MoPH, 2003).

In March 2004, another working group, Hospital Task Force, drew up a hospital policy, the Essential Package of Hospital Services (EPHS), in the aim of improving (i) hospital management, (ii) the integration of hospitals into the health system, and (iii) the quality of services provided (MoPH, 2005).

This policy was drawn up on the basis of a study which highlighted six main weaknesses in the hospital system:

- Uneven distribution of hospitals throughout the country, hence the inequitable access to healthcare which essentially affects the rural communities. Furthermore hospitals receive too large a share of human resources and funds in comparison to primary health services.
- Lack of health care standards, hence poor quality.
- Insufficient management capacity in hospitals, hence problems with efficiency, supply and maintenance.
- The hospital system is fragmented, poorly coordinated and is not integrated into the health care system. This results in a lack of reference system and insufficient support for primary health care services.

¹ See list of main interlocutors met and documents consulted in the appendix.

- Insufficient funds hence the need for a user fee system which nonetheless ensures that the poor still have access to health care.
- Insufficient qualified staff, which is particularly problematic for female staff and in remote areas, making it difficult to provide a 24-hour service and for women to receive treatment.

The objective of the EPHS is to define the necessary services, staff, equipment and drugs that must be provided by health centres at all levels (district, province, region). Three priorities have been established:

- Benchmarks will be established for both hospital management and health care. Six domains will be covered: responsibility towards the community, patient health care, leadership and management, human resources, management systems, context.
- Hospital councils will be created with volunteers from the community in order to ensure a link between the management team and users.
- An accreditation system will be set up in order to ensure that all hospitals are providing quality basic health care. Some elements related to quality have been proposed, taken from a report issued by the Ministry of Health of Tanzania, including: quality of consultation, effectiveness of treatment, necessity of treatment, continuity of treatment, patient and community satisfaction, efficiency, accessibility (Newbrander, 1999). These quality issues have not yet been finalised and are currently the subject of further study within the MoPH.

2 Afghanistan Health Sector Balanced Scorecard

2.1 Method

The purpose of the Afghanistan Health Sector Balanced Scorecard (HSBC) is to summarise the performance of the provinces of Afghanistan in the delivery of the BPHS, within the framework of the Performance based Partnership Agreement (PPA) between donors and NGOs. The HSBC was developed by John Hopkins Bloomberg School of Public Health (JHBSPH) and the Indian Institute of Health Management Research (IIHMR).

The various donors – the World Bank, European Union, and USAID, via its REACH programme (Rural Expansion of Afghanistan Community Health Care) – offer different types of partnership agreement.

The HSBC, which is funded by the World Bank, aims to inform the MoPH and stakeholders on the quality of health services provided by the various structures at province level throughout the country. It must also give insight into the present state of the health sector and serve as a baseline for devising a strategy for sector improvements.

The first research study was carried out between June and October 2004 in over six hundred BHC, CHC and district hospitals. Patients, staff and members of the community² were interviewed. The report was published in June 2005, and will serve as a reference point and a basis for comparison for future data (MoPH *et al*, 2005).

To evaluate the quality of health services provided by different types of health centre, six domains of analysis (equivalent to judgement criteria) comprising 28 indicators and two composite indicators were determined through a participatory process that involved the MoPH, NGOs and a third party evaluation team from JHBSPH and the IIHMR.

The six domains examined and their indicators are:

- **Patients and Community.** Indicators: overall patient satisfaction, patient perception of quality (distance from health centre, cleanliness, courtesy and respect for privacy, confidence in health worker expertise, explanations provided, availability of prescribed drugs, affordable drugs), involvement of the *shura*³.
- **Staff** (health worker, administrative staff, community health worker). Indicators: health worker satisfaction (working conditions, working relationships, salary, training, supervision), timely salary payments (paid in the last month).
- **Capacity for Service Provision.** Indicators: infrastructure, equipment, drug availability, laboratory, number of staff and expertise, staff training, tuberculosis registry, family planning, management and IT system, patients' files, clinical guidelines, etc.
- **Service Provision.** Indicators: outpatient care practices (relationship with the patient, consultation, examination, explanation, etc.), handling of needles/scalpels, number of new consultations per month, length of consultation, antenatal care, obstetrics, etc.

² The study included nearly 6,000 patient observations, interviews with over 1,600 health workers, and interviews of 13,000 households.

³ *Shura*: Elders council

- **Financing Systems.** Indicators: user fee guidelines, systems for waiving fees for poorer members of the community.
- **Overall Vision.** Indicators: percentage of women amongst the new consultations, concentration indices.

For each indicator, upper and lower limits are set, indicating an acceptable range for performance.

Twenty-six indicators are expressed as the percentage of an observed result in relation to a standard, e.g. the percentage of patients who said that they were “highly satisfied” (out of a choice of four options) with the service provided.

Two indicators of concentration measure the level of equity in access and provision of services, as well as the satisfaction of services provided, comparing the poorer members of the community with the non-poor.

Two composite indicators measure how each province is rated in relation to the upper and lower limits of the above twenty-eight indicators.

2.2 Results of the study carried out between June and October 2004

2.2.1 Findings at a national level

There is a wide variation in the values given for each indicator, and from one indicator to another. For example:

- **Patients and Community.** Overall satisfaction is quite high (62.7%) but perception of quality is low (23.5%).
- **Staff.** The results are mediocre, with only 14.7% saying they are satisfied and only 42.1% of salary payments up to date.
- **Capacity for Service Provision.** Only 12% of health care centres have a tuberculosis registry, 28.8% an functional laboratory, 51.3% of staff meet guidelines for basic medical knowledge, yet scores are considerably higher for drug availability (72.1%) and presence of patient records (66.6%).
- **Service Provision.** The results for number of new patients per month is very low (10%), which indicates a low outpatients rate; good outpatient care practices are observed in only 54% of cases, insufficient time is allocated to routine consultations (only 22.2% of cases exceed nine minutes), and only 13.9% of health centres provide delivery care.
- **Financing Systems.** Results were better as 93.4% of health centres have a manual

explaining the fees and 74.8% waive fees for poorer members of the community.

- **Overall Vision.** Results are encouraging with women representing 55.7% of outpatients, and the poor attending health centres as much as those who are less poor, and expressing more satisfaction.

- **Composite indicators.** Few provinces (average 18%) meet the upper benchmarks, which suggests that there is still much room for progress.

2.2.2 Findings at a provincial level

Similarly, the value of any given indicator varies considerably from one province to another, as do the values for indicators within each province. These differences can be explained by the following factors:

- **Epidemiology** varies throughout the country;
- **Access to health care** varies as a result of geographical constraints, culture, climate, poverty and security.

Nevertheless the authors of the BPHS hope that by comparing the results from different provinces, and analysing the results within each province will provide enough data to assess existing service delivery and design a strategies for improving service delivery at national and provincial levels, by for example providing staff training or providing delivery care.

2.3 Limitations

This report only takes into account health facilities that are currently providing services. In some provinces, such as Zabul, Uruzghan, Samangan, Nimrod, functioning health centres are almost non-existent. Furthermore, the data does not take into account certain factors, such as geographical constraints (high mountain ranges, climate, access roads), which has an impact on capacity to deliver health services or to access them.

Additionally, some of the methods used for measuring indicators are not very precise and thus the findings need to be interpreted with caution.

2.4 Our analysis

The 2004 Balanced Scorecard report is impressive in its scope and exhaustiveness (albeit relative), and the means used to accomplish its objective.

The six domains studied and measured with the various indicators more or less cover the

three classic pillars of evaluation: infrastructure (inputs), processes and results. However it is worth noting that while the data available on inputs are plentiful, processes are less well covered and results data are practically non-existent. This unfortunately is all too common as it is highly complicated to define results in health care evaluations.

The method therefore focuses above all on inputs as they are easier to observe and implement, at least this is true for material inputs.

The results observed in the different domains are scarcely surprising for those with a fair knowledge of Afghanistan, and despite the admirable efforts and energy of a large number of health workers, there is still considerable progress to be made. This report does provide baseline data to guide actions and support strategic planning but the method used has its weaknesses.

2.4.1 *Weaknesses in types of indicators measured and information gathered*

The provision of high quality health care requires a considerable number of inputs. Some are dependent on financial aspects (infrastructure, equipment, drugs, etc.) and it is therefore relatively simple to put them in place as long as the necessary funds are available. Others are related to health workers themselves (number of staff, types of qualified staff, availability, etc.) and it is much more difficult to mobilise the necessary staff, especially in Afghanistan.

It is worth remembering at this point that the events over the past twenty-five years have not benefited undergraduate medical training and staff training, and indeed many staff fled into exile. It is well known that health workers in Afghanistan lack the necessary expertise. The MoPH is currently implementing a re-certification process to address this problem. Today, only 15% of doctors have passed the re-certification (John Hopkins research team).

Additionally, the majority of medical staff is based in towns, and many are unwilling to live and work in rural areas. Finally, there is a severe shortage of female medical staff, which does not facilitate women's access (thus often children's access) to health facilities. These issues highlight the fact that the most important limiting factor in the development of high quality health care delivery, is the human factor.

2.4.2 *The human factor, health workers*

The human factor is dealt with superficially in the HSBC report, both in quantitative and qualitative terms.

- **Quantitative:** The staffing index looks at the total number of health workers in a given health centre but fails to break down these figures into the different professions within the health sector, i.e. doctors, nurses or midwives. However, the skills required for these three professions is not the same, and one cannot substitute the other. This raises questions about human resources management and new health professionals' training policy.

Furthermore, this indicator does not provide any insight into the number of health workers per capita, which is nonetheless essential for assessing how accessible health services are, and whether health centres have the capacity to deliver these services. Without these data, it is impossible to analyse and improve planning processes related to provision and equitable access to health services and availability of trained staff.

Finally, the report fails to give an appreciation of the wide disparity of health centres throughout each province and from one province to another. How can we draw any conclusions about the efficiency of the health system, when in one province the BPHS is applied extensively and a full range of health centres exists (from Basic Health Centres to a regional hospital), and yet other provinces can only provide a bare minimum of services?

- **Qualitative:** The staffing index does not differentiate between male and female staff, and yet the presence of female health workers is essential for female outpatients, as well as their children. This lack of data which is nonetheless crucial for defining health policy (especially for training purposes or to provide incentives to practise medicine) and for women's and children's health makes it particularly difficult for decision makers to orient their future health strategies.

The clinical guideline index measures the presence of different types of guidelines but does not assess whether health workers understand their contents nor whether they use them. A large number of documents collect dust on shelves.

The provider knowledge score aims to evaluate doctors' and nurses' expertise. Given that doctors and nurses receive different

training and that their professions differ, it is surprising that both professions received identical questionnaires assessing their skills. Furthermore, the questionnaire asks six questions of which three deal with coughs and their treatment. However, a cough is a symptom rather than an illness and even the most experienced lung specialist in the world would be unable to answer these questions. Indeed, good medical practice consists in treating the illness rather than the symptom. It is fairly difficult to decipher replies to such ambiguous questions and impossible to assess a health worker's real experience and knowledge on this basis alone. This indicator is extremely important as it establishes the medical staff's level of expertise and yet it is too imprecise.

Clinical assessment and consultation with the patient are key to establishing a good diagnosis. In the Service Provision domain, the Patient-Provider Care index is composed of eighteen items and yet only one mentions the physical examination. It is well known that for a number of reasons (lack of time, inadequate facilities, modesty, ignorance), doctors often fail to conduct physical examinations, or they do so only superficially. And yet clinical assessment is essential for good practice, as well as for cost efficiency (limits the risk of inappropriate treatment or additional laboratory tests, etc.). Given that this physical examination is assessed along with a number of other factors, its impact on the overall score and on the evaluation of the quality of the diagnosis and service provision is probably negligible. This score therefore needs to be interpreted with caution. If the various components of this indicator were weighted differently, it would be possible to measure the value of clinical assessments more accurately.

2.4.3 *Other factors determining the quality of the health system*

- **Antenatal and delivery care** are essential public health services, especially in Afghanistan where maternal and child mortality rates are amongst the highest in the world. Health centres must therefore be accountable for these services. The Service Provision domain includes an indicator on 'BPHS facilities providing antenatal care', and another looking at 'Delivery Care according to BPHS' but details on volume of activity and type and quality of practices are strikingly absent. It is impossible to draw any conclusions about the scores of these two indicators which are nonetheless fundamental for health policy.

- **Indicators within the Patients and Community domain** measure patient satisfaction and their perception of the quality of services provided. It is well known that Afghans (among others) have a liking for antibiotics, injections and vitamins. A report has shown that 80% of patients are prescribed antibiotics following appointments with their doctor (World Bank, 2005).

Patients may be satisfied because they have been prescribed what they wanted but nothing proves that the prescription is justified, and often one may assume that antibiotics are not justified. Conversely, patients may be dissatisfied if they are not prescribed antibiotics, even if this choice of treatment is unnecessary and there is no justification for prescribing them. It is important to remember that over-prescribing antibiotics has an impact on the health sector budget, as well as increasing bacteria resistance. Thus, the results of this criterion of satisfaction are open to interpretation and they do not shed sufficient light on the complex relationship between patient satisfaction and the quality of the service provided.

It would have been judicious to examine the rationale behind prescriptions, for example 'The maximum acceptable percentage of prescriptions containing antibiotics'.

- The **Infrastructure Index** in the Capacity for Service Provision domain looks at various details relating to infrastructure but fails to mention the presence of toilets. This is regrettable given that illnesses resulting from poor hygiene are extremely common in Afghanistan and often have serious consequences. Toilet facilities are important both for the comfort of staff and patients, as well as their pedagogical role. If health centres do not have toilet facilities, how can we convince people of their importance? Furthermore, this indicator gives no information on clean water points which are nonetheless essential for health care, washing hands, cleaning, etc.

- The **Overall Vision** domain measures the percentage of women registering as new outpatients, which is an excellent indicator. However, there is no information provided on the percentage of children under five attending consultations, which is also an important indicator in terms of public health, and in line with MoPH policy on mother and child health.

2.4.4 Weaknesses concerning the general method

As mentioned above, certain items within each criterion are more significant than others (for example, whether 'conducting physical examinations' should carry more weight than 'asking the patient their age'). Given that all items have the same value, this means that the indicator score does not necessarily reflect what it is supposed to.

The purpose of the report is to provide a comparative analysis of the services (outputs) provided by different health centres. But it is difficult to make this comparison when the facilities themselves are so incomparable, partly because the facilities (inputs) which deliver services vary widely according to the type of contract and the donor agency. Each donor offers different types of contract: for example, in some cases a bonus system may be offered to the provider (WB), in others not (USAID, EC); some providers benefit from substantial technical support (USAID), others do not (BM, EC); the provider may cover a whole province (WB, EC), or a cluster of districts (USAID, EC), etc. These different contractual conditions are by no means negligible factors in managing and delivering health care, and yet they are not taken into account in the report.

2.5 Conclusion

2.5.1 Indicators

The HPSB report is in general well designed, but many of the indicators could be improved for future research.

Furthermore, the two principal difficulties encountered in the health sector in Afghanistan are problems which have been well documented and yet the HPSB report fails to bring them to the forefront.

- Shortage of health workers in rural areas and of female practitioners in general (especially female doctors). Medical staff often do not have the necessary expertise, are demotivated and receive poor salaries. These factors contribute to the mediocre quality of services delivered to patients.
- Uneven distribution of health services throughout the country, which is the true cause of inequitable access to health services.

The real issues at stake in improving the provision of primary health care at technical, financial and policy levels are: geographical coverage, and quantity and quality of service providers.

2.5.2 HSBC, benchmarking, and a Quality approach

The June 2005 HSBC report which presents the first round of results states that 'the BSC is not just a measurement tool; it is used by the MoPH to clarify its vision and strategies, and to manage change'. All the results that have been gathered and categorised criterion by criterion provide a framework for comparing the performances of each province (for 2004), and from one year to another (or at least as long as these surveys are carried out). This technique of comparing performances, otherwise known as benchmarking, has become widespread practice throughout the commercial sector over the past twenty years. Comparing the performance of competitors within the same sector can be a rewarding learning exercise, and can help improve the quality of practices, services and products provided **on condition** that it is accompanied with a true quality management approach: simple comparison is not a guarantee of quality improvement.

The purpose of a quality approach is to improve a production processes and the quality of a final product or service for the client's benefit. It includes several steps: an initial assessment of the situation, setting quantitative and qualitative objectives whilst taking into account the reality of the context, analysing the variance between observed results and objectives, defining and carrying out corrective action, and evaluating the results.

The method put forward by the HSBC covers the first two steps only, and therefore cannot be considered a true quality approach. It fails to describe who, how, with what inputs, and within what timeframe the following steps will be carried out. Thus, it is not clear how it can possibly contribute to improving health services. Carrying out a detailed review of the existing situation is a prerequisite. It is also essential to define precisely and **realistically** what needs to be done and what can be done in relation to the existing status quo before starting up a process for improving the quality of health services.

Finally, the scope of the HSBC method is particularly ambitious from the outset: it aims to cover a large number of health centres throughout the country. A quality approach is generally implemented on a more modest scale in order to determine fairly precise process parameters and thus improve its chances of success.

3 Health Financing Pilots by John Hopkins Bloomberg School of Public Health

Health financing systems are relevant to the present debate on quality within the health sector because of the direct links that exist between the money spent by the state and/or by the user and the quality of services provided. It is easy to identify at least two links. Firstly, if the health system has insufficient funding, there are not enough resources and mediocre services are delivered. When a certain number of users are excluded from the health system because services are too expensive, one of the main quality criteria, equitable and universal access, is not being met.

3.1 Description of the Health Financing Pilots

Pilots were launched in eleven provinces in May 2005, where the delivery of health services was managed by NGOs (in eight provinces) or by MoPH staff (in three provinces). In each province, five health centres (BHC, CHC or District Hospital) tested out the link between financing system / patient / health facility:

- In one facility, free health care was provided.
- In two facilities, a health insurance system, the Community Health Fund (CHF), was set up. Each household within the facility's catchment area can subscribe on a voluntary basis. The annual subscription fee is calculated on the basis of the number of people in the household and their revenues. This gives them unlimited access to health care for a modest contribution (1 afghani) towards the cost of medical treatment at each visit.
- In two facilities, a user fee was applied, except for preventive services (vaccination, antenatal consultations, etc.) which were free of charge. A user committee decides the amount of fees to be charged, under what conditions the poor are exempt and manages the budget.

This study has several objectives and the aim of the evaluation was to shed light on the following questions:

- Which financing systems are acceptable to patients? What health care facilities should be

provided for the poorer members of the community?

- What impact has the financing system had on health centre revenues and on the quality of services provided, especially in terms of staff payment?
- How has the community been involved in the financing system? Has this produced a sense of ownership of the local health facility?
- Will the financing system result in financial autonomy? And to what extent does it represent an exit strategy for humanitarian organisations?

3.2 Our analysis

At this point, it is impossible to comment on the results of these pilots but of course the above questions are of utmost importance. However, the following two comments deserve to be made:

- Setting up a prototype of a micro health insurance system in a rural society which has barely no previous experience of all (or nearly all) the concepts related to insurance in general, and certainly health insurance, is an ambitious undertaking in cultural terms. This exercise will take time and it is probably unrealistic to expect any reliable results on people's understanding and use of the CHF in the short term. In the right conditions, it will take years (five years, eight years) before these pilots will produce reliable and interpretable results (i.e. in favour of, or against, implementing this kind of system, what are the best modalities, etc.). However, stakeholders plan to evaluate these pilots after a period of twelve to eighteen months, before applying the system throughout the country.

- The second main challenge facing the public health sector in Afghanistan (the first challenge concerns the number of qualified health workers, see above) is financing. Health sector funding is a key issue worldwide, even in the wealthier countries (USA, GB, France, etc.), but the stakes are higher in a poor country which has been devastated by decades of war and natural disasters (drought, etc.).

Donors are supporting a costly Western-style health policy: long, expensive training programmes for health staff, who will subsequently demand appropriate salaries (legal or otherwise), significant investment in infrastructure, cost of drugs (all of which are imported, legally or otherwise), etc.

Users have always paid for the different types of health care in some form or another, via a

formal system or otherwise. In Afghanistan, where the majority of households are below the poverty line, users are only required to pay a modest fee, otherwise attendance rates would be even lower than they are at present (MoPH, 2005). Indeed, households have to juggle a certain number of basic expenses (food, school, etc.), sometimes at the expense of health care. The poorer members of society, even though in theory they are exempt from paying user fees, still have to overcome a financial hurdle. A poorly funded system has little incentive, or is even unable, to deliver free-of-charge services.

In the case of the Health Financing Pilots, it is hoped that the funds raised by the health insurance system and the fees charged per service will cover 5-15% of operating costs (salaries, drugs, etc.). It is difficult to establish at what level user fees are (i) equitable, and culturally and financially acceptable, and (ii) contribute adequately to health facility budgets, especially when state funding is limited and external funding (bilateral and multilateral donors) will not last forever. Achieving the right balance is a determining factor in the quality of a health system.

- And finally, independently of these pilots, BPHS health facilities charge user fees on the basis of individual policy. Given the importance of this issue, one can only hope that the MoPH will shortly publish a coherent and global user fee policy.

4 JH PIEGO approach: PQI

4.1 Method

JH PIEGO Corporation, an affiliate of the John Hopkins University, is a non-profit organisation working for the improvement of women's and family health in several countries (Brazil, Guatemala, Honduras, Mozambique and currently in Afghanistan) in dispensaries, district hospitals and community health facilities. It has a variety of funding sources: USAID, EC, etc.

JH PIEGO uses the Performance and Quality Improvement (PQI) method, which was developed by the International Society for Health Care Quality Assurance and tested over eight years in different domains: maternity, family planning, prevention of hospital infections, pharmacy, laboratory, etc.

Once a working theme has been established, the method comprises the following steps:

- Description of the expected performance (local standards)
- Analysis of variance between expected performance and observed results
- Analysis of the cause of this variance
- Design, then implementation of corrective action
- Evaluation of the results, measurement of progress and comparison with pre-established standards, etc.

Since June 2004, JH PIEGO has been involved in the REACH programme in Afghanistan, a consortium of four organisations funded by USAID and implemented by the MoPH and the organisation Management Science for Health (MSH). JH PIEGO is working with 30 district and provincial hospitals and four hospitals in Kabul in obstetrics, infection prevention and casualty. The project also provides training courses for doctors, nurses and midwives in schools and professional training programmes.

4.2 Our analysis

This is a tried and tested method: namely clinical audit. It forms the basis for Quality Assurance approaches in a number of sectors, including the health sector. It is a practical, pragmatic and pedagogical method which allows operators to move forwards step by step and demonstrate their capacity to improve production processes and the quality of goods or services. It is plausible that stakeholders will succeed in integrating this approach into the Afghan context. If the method receives the necessary support over a reasonable length of time, the results are promising.

5 French Embassy: training for hospital directors

5.1 Method

The French Embassy has established a partnership with the MoPH to provide training on hospital management to hospital directors. Different modules are available: management of biomedical technical capacity, financial management, equipment maintenance and hospital logistics, human resources and quality of health care. Twenty hospital directors attended a five-day training course on quality of health care which was run by an official representative from the Health Department of the French Ministry of Health. This seminar, with its highly participative approach, covered theory on the quality of health care, practical case studies and hospital visits. Trainees were highly motivated by the subject and in the

conclusion it was noted that “Many problems related to the quality of health care were identified and partially analysed, and trainees had in-depth discussions about this phase. However, they found it more difficult to suggest ways of improving the quality of services, and this aspect will almost certainly need to be discussed at a later stage at a hospital directors’ working group.” (Marie-Claire Paty, Health Department).

5.2 Our analysis

This training course was almost certainly highly beneficial for the participants, and gave them basic knowledge in quality methods. It is fairly obvious that a follow up will be required in order to consolidate this knowledge and thus facilitate the implementation of a true quality approach by hospital directors and intra-hospital colleagues and MoPH staff. Has this follow up been planned and will the same participants attend? Otherwise, there is a risk that this knowledge may never fully come into fruition.

6 Conclusion

This brief study carried out by Groupe URD on quality approaches in the health sector is by no means exhaustive but has brought to light some interesting points.

- **Multiplicity of actors and approaches**, using different methods (policies, training programmes, quality assurance approaches, standards, accreditation, etc.). This variety has a number of positive aspects but it is probably highly confusing for health workers who meet with numerous government experts and private consultants, each with a new series of questions and different working methods. This wealth of experience will have no value unless a **joint** evaluation based on a common set of judgement criteria is conducted for all the different methods. This will allow stakeholders to capitalise on the experience and understand what has worked, under what conditions, why, how and what objectives have been met?

- **Complete lack of coordination**, or even consultation, between the different actors who are often working in the same health centres. In this way, staff working in a district hospital may receive advice and instructions on quality issues from:

- Performance-based partnership agreement managers
- MoPH staff
- JH PIEGO: PQI project

- John Hopkins University: Health Sector Balanced Scorecard project. Incidentally, it is worth noting that the teams working on the two projects implemented by the John Hopkins University know very little about each other’s work, and that a third project (on financing) is also due to start shortly.

There is a risk that by implementing a range of different projects within the same institution, or in nearby health centres, both health staff and users alike will be confused. There is also the risk that one project may involuntarily interfere with the results of another, making the task of evaluating any given project rather difficult.

The quality of the health system and the quality of services it delivers to the local population is a serious and important issue.

It is of utmost importance that the different actors (the state/MoPH, donors, operators and researchers) try to coordinate their views, programmes and communicate their objectives, methods and results. Failing this, health workers are likely to become overwhelmed and confused by all these new initiatives, and loose interest in the subject, which nevertheless deserves utmost attention. Health policy should be centred on the question of quality, especially in a country whose health system is penalised by limited financial and human resources.

A real quality approach is indeed indispensable to ensure an effective, efficient and equitable health system. This is true worldwide, but especially in Afghanistan.

- On the one hand, implementing a quality approach does not require significant investment in equipment but only in human resources, namely training programmes in order to convey the essential concepts and simple quality tools. It is more about learning how promote change in one’s professional culture and way of thinking, notably at management level, rather than establishing new techniques and skills.

- On the other hand, the less money there is available to provide a service (which is the case for the health system in Afghanistan), the more important it is to invest in quality assurance. As demonstrated by Philip Crosby in the 1960s, the cost of non-quality may represent up to 15-20% of an organisation’s budget, i.e. the amount of money spent on rectifying mistakes, reproducing unusable or

unsaleable products, resulting in increased consumption of time and materials. Thus, the less money there is available, the more relevant it is to work with a quality assurance approach, which allows operators to keep costs and expenditure down and optimise resources. A former president of Health Maintenance Organization (H. Galli, Harvard Community Health Plan, Boston) is quoted as saying "If you focus on costs, the quality is reduced. If you focus on quality, costs are reduced."

Asides purely financial reasons, there are other justifications for working with a quality assurance approach:

- **Technical:** as health professions evolve with increasingly complex tasks and responsibilities and a growing number and variety of actors, a quality approach is the only way of harmonising and coordinating practices.
- **Management and leadership:** a quality approach provides health staff with a common culture and language. It can help improve communication and teamwork. Furthermore, a quality approach can help staff feel that they are working together towards a common goal, which is an important factor in boosting staff self-esteem and motivation. People work better when they know why and for whom they are working.
- Last but not least, the purpose of a quality approach in the health sector is to provide **the best possible service for people receiving care.**

ANNEXES

Main interlocutors met

Ayan Ahmed Noor, Field consultant, John Hopkins Bloomberg School of Public Health

Dr Krishnarao Saihbulh, John Hopkins Bloomberg School of Public Health

Oscar Cordon and Dr Mirwais, JH PIEGO

Emilie Robert, Head of Health Department, French Embassy, Kabul

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