WARNING

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

SUMMARY

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

Method

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

Findings

Curative care :

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

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

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

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

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

Training :

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

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

Exemption schemes :

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

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

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

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

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

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

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

Management of health facilities :

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

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

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

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

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

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

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

Women's health :

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

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

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

Women's health education :

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

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

Recommendations

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

Curative care :

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

Training :

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

Exemption schemes :

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

Management of health facilities :

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

Women's health

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

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

Women Health education

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

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

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

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