

# **Leadership Management and Governance Project – Afghanistan**

## **Project Scope of Work, August, 2012**

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Date: August, 2012

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# Afghanistan Leadership, Management & Governance (LMG) Project

Start Date: 01 August 2012



July 2012

# Contents

I.	Introduction .....	3
II.	Critical Cross-Cutting Areas .....	4
III.	L+M+G Framework .....	5
IV.	LMG Afghanistan Program Areas .....	6
1.	On-Budget Support to the Ministry of Public Health and the Ministry of Education .....	6
2.	Community-Based Health Care .....	8
3.	The Hospital Sector.....	10
4.	Health Information System .....	16
5.	Central and Provincial Health System Strengthening .....	20
6.	Activities to be transitioned from the HSSP Project .....	22
V.	References .....	24

## I. Introduction

Management Sciences for Health (MSH) is pleased to present this draft Scope of Work (SOW) for the Leadership, Management and Governance (LMG) Afghanistan project. This LMG Afghanistan project will further strengthen the capacity of the Afghan Ministry of Public Health (MoPH) to lead, govern and manage the scale of access to and quality of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS), particularly for those at highest health risk. The project will also continue to support capacity building of the Ministry of Education.

Funded by USAID, the Leadership, Management and Governance Project (2011-2016) collaborates with health leaders at all levels to improve leadership, management and governance practices to create stronger health systems and improve health for all, including vulnerable populations worldwide. The LMG technical approach has four main pillars including senior leadership and governance; local ownership for local results; knowledge exchange and measurement and gender equity. This LMG project will build upon the strengths and successes of the Tech-Serve project to promote enhanced performance improvement; to develop senior leadership and governance capabilities using participatory processes and gender-aware approaches that enable health leaders and policy-makers to address their own challenges, and achieve results; to build and use evidence-based approaches by generating and disseminating evidence that shows how improved leadership, management, and governance contribute to health gains and to leverage partnerships through public and private investments in leadership, management and governance for greater health gains.

In particular, this project in Afghanistan will move forward with the on-budget process while continuing ongoing activities from the HSSP and Tech-Serve projects. MSH will continue to work with the MoPH, MoE, and USAID to ensure that the teams are ready to move on-budget, and that the systems, procedures and conditions are in place at both ministries to directly receive USAID funding. This will include closely working with the two ministries to enhance their governance in terms of transparency, accountability and participation. The off-budget activities described here all support the movement of these teams on-budget.

The purpose of this document is to present an overview of the proposed activities to take place in the 18-month period starting August 1, 2012. The LMG Afghanistan project will support the three USAID health IRs and one education IR: 1) Improved capacity and governance of the central MoPH to support the delivery of BPHS and EPHS services, primarily through nongovernmental organization (NGO) service providers; 2) Improved capacity and governance of the 13 Provincial Health Offices (PHO) and 4 Quick Impact Provinces of the MoPH to support THE delivery of BPHS and EPHS services; 3) Developed overall leadership, management and governance capacity of the MoPH and 17 Provincial Health Offices; and 4) To commence the capacity building of the Ministry of Education's Management Support Unit which will be required to administer, monitor and report on-budget fund activities when funding becomes available. In addition to these four IRs, the LMG Afghanistan project will also incorporate there cross-cutting themes into all activities: Gender, Governance Enhancement and Partnerships.

The activities are organized around the five program areas of the current Tech-Serve project:

- 1) On-Budget Programs at the Ministry of Public Health & Ministry of Education
- 2) Community-Based Health Care (CBHC)
- 3) The Hospital Sector
- 4) Health Information Systems (HIS)
- 5) Provincial Health System Strengthening

In addition, this SOW describes the proposed HSSP activities that will continue under LMG:

6) Health Services Support Project (HSSP) Activities

## II. Critical Cross-Cutting Areas

In addition to the program areas described below, the LMG Afghanistan project will also incorporate the cross-cutting themes of Gender, Governance Enhancement and Partnerships.

**Gender.** Considering that the LMG Afghanistan project focuses on vulnerable populations, including women, gender is an important theme to address in all program areas. The Health for All Afghans document includes a goal that 30% of staff of health facilities be female (including at decision-making levels), and that women and men have equal access to health services that are free of discrimination and address gender-based violence and mental health. To support this goal, the LMG Afghanistan project proposes to include a focus on gender in all components. Examples of specific actions include: 1) Disaggregate all data on training to be part of the HMIS system, and analyze the obstacles women face in leadership management and governance based on the data; and 2) Coordinate with the Ministry of Women's Affairs as an important stakeholder in women's health in Afghanistan.

**Governance Enhancement.** Poor governance overall and especially in the health sector has contributed to poor health outcomes. There is evidence in the literature that shows effective governance improves health outcomes. Public health spending lowers child mortality rates more in countries with good governance, and the differences in the efficacy of public spending can be largely explained by the quality of governance (Rajkumar and Swaroop 2008). Governance was strongly associated with under-5 mortality rate, and after controlling for possible confounding by healthcare, finance, education, and water and sanitation, governance remained significantly associated with it (Olafsdottir et al. 2011). Probably the best evidence comes from the randomized field experiment conducted by Björkman and Svensson (2009) in fifty rural communities of Uganda to see if community monitoring of providers improves health outcomes. In the treatment group, a community, with the help of a local community-based organization, monitored primary health care providers of the public dispensary for a year using a citizen report card. At the end of one year, they found that community monitoring had increased the quality and quantity of primary health care; utilization of out-patient services was 20 percent higher in treatment communities; treatment practices, examination procedures, and immunization coverage all improved; and perhaps most importantly, there was a significant increase in weight of infants and as much as 33 percent reduction in under-5 mortality in the treatment communities as opposed to the control communities.

Key documents of the Afghan Ministry of Public Health emphasize the importance of improving governance if sustained progress is to be made in the achievement of the desired health outcomes for all Afghans. The Strategic Plan for the Ministry of Public Health (MoPH) 2011-15 has 10 Strategic Directions out of which five are directly linked with governance — equitable access to quality health services, the stewardship role of MoPH and governance in the health sector, evidence-based decision making and a culture that uses data for improvements, regulation and standardization of the private sector to provide quality health services, and community empowerment for disease prevention and health promotion. Two are indirectly related: i.e. financial governance and the human resource governance.

The Health for All Afghans document which prioritizes population approaches for the health sector has good governance and institutional development as one of its three components. HAA

seeks to make a substantial investment in this component. To improve the governance, leadership, and managerial capacity within MoPH is one subcomponent in itself. The successful implementation of the remaining six subcomponents will need smarter governance, management and leadership in the ministry as well as in provincial offices.

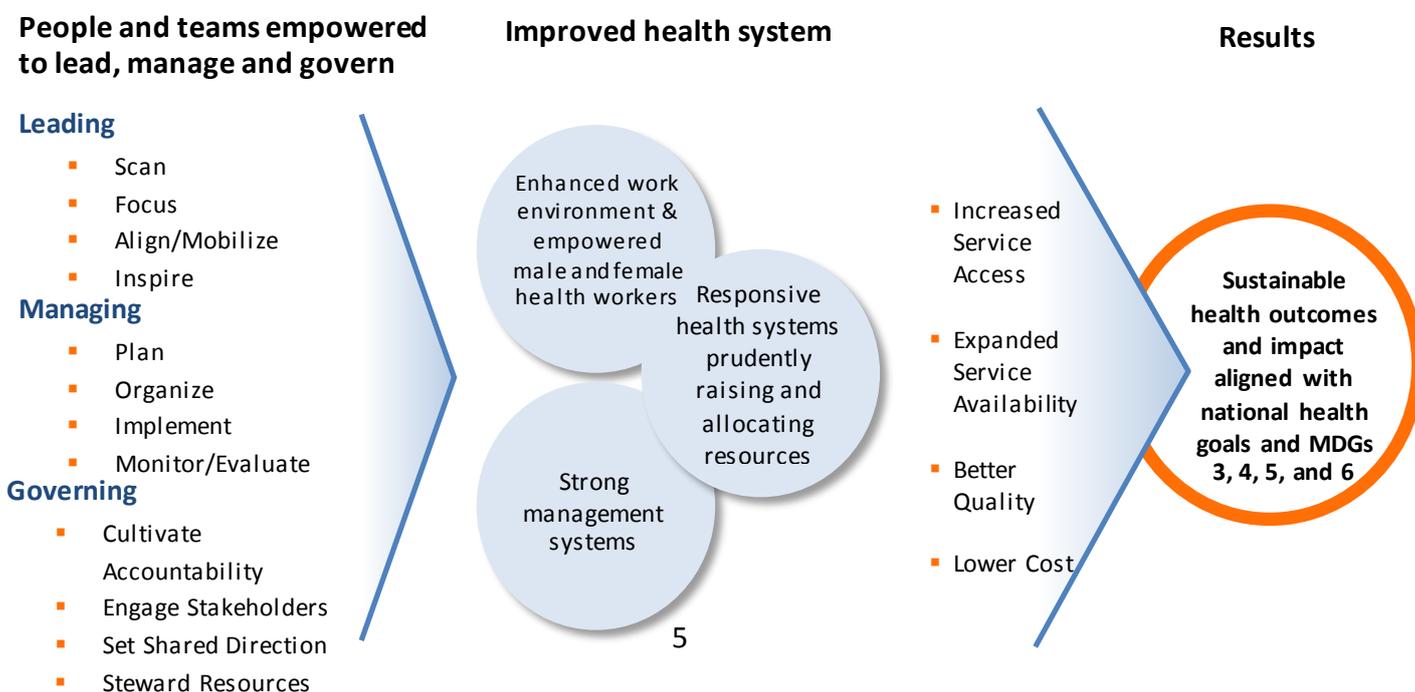
In view of the high priority given to enhancing the leadership, management and governance in general and governance in particular by the high level documents of the Ministry of Public Health, the LMG Afghanistan project has weaved the governance enhancement as a cross-cutting theme in this document.

**Partnerships.** Using the Partner Engagement Strategy as defined by the *LMG Global Advocacy, Partner Engagement and Cost Share Strategies* document as a guide, MSH will coordinate activities with local stakeholders, including non-governmental organizations, technical agencies, other Ministries and organisms of the Afghan Government, as well as other donors active in the health sector. As soon as the LMG Afghanistan project launches, a partnering strategy will be defined, in coordination with USAID and the MoPH. A standard MOU template will be developed and then adapted to govern each formal partnership that is formed. Cost share will be leveraged when possible from these local stakeholders. All cost share will be fully documented using rigorous and tested processes to ensure compliance, timely and accurate identification, documentation and reporting of cost share contributions, and continuing trainings of current and newly recruited staff. These processes and procedures have been developed and improved over the years by MSH, and the LMG project will benefit from the experience and shared knowledge of best practices within the organization.

### III. L+M+G Framework

The LMG Afghanistan project will be based on the Leadership + Management + Governance Framework (see below). This framework outlines how four leading practices, four managing practices and four governing practices together lead to improved health systems and concrete health results. The Ministry has been using the Leading and Managing practices in the current Tech-Serve project to strengthen capacity of central and provincial MoPH teams as well as health facility managers. The L+M+G model adds the concept of Governance.

## Conceptual Model: Leading, Managing and Governing for Results



## **IV. LMG Afghanistan Program Areas**

### **1. *On-Budget Support to the Ministry of Public Health and the Ministry of Education***

The concept and initiative of the USAID on-budget process emerged from the Afghanistan London Conference, held in January 2010. A recurring theme in the London Conference presentation is the GoIRA request that 50% of foreign aid go through the recipient Government systems by 2011. Conference participants supported the ambition of the Government of Afghanistan whereby donors increase the proportion of development aid delivered through the Government of Afghanistan to 50% in the next two years, including through multi donor trust funds that support the Government budget. However, this support is conditional on the Government's progress in further strengthening public financial management systems, reducing corruption, improving budget execution, developing a financing strategy and Government capacity towards the goal. To meet these conditions, the two ministries will need substantial support in enhancing their governance— making it more participatory, transparent and accountable. Additionally, a gender audit of the policy, programs and activities will take place to ensure that there is gender equity in all LMG interventions.

The proposed Expanded On-Budget Program will support the MoPH's development targets for the health sector as outlined in the National Health and Nutrition Sector Strategy (HNSS 2008-2013) of the Afghanistan National Development Strategy (ANDS). In addition to the HNSS, the proposed on-budget program is aligned to the MoPH National Priority Program and the Strategic Plan (2011 – 2016).

Based on the priorities coming out of the Kabul Process, the National Priority Program (NPP) articulates the MoPH strategic vision for developing human resource capacity throughout the health system. The MoPH is enthusiastic to take on increasing leadership and planning responsibilities to run and oversee the public health system. The proposed on-budget assistance is designed to accelerate and support this transition by facilitating within the MoPH a greater understanding and strengthening of the on-budget processes and approach. This approach includes strengthening reporting and accountability relationships between central and provincial level as well as across and between donors within the health sector, and overall governance of the ministries and their provincial offices.

USAID has provided funding to the health sector in Afghanistan to support the operation of health clinics and district and provincial hospitals since 2004. The management and administration of the NGO service providers has been conducted at the MoPH via a Program Management Unit Team (PMUT) within the MoPH Grants and Contract Management Unit. Establishing this unit at the MOPH has evolved over a period of four distinct phases. This experience will be used to establish an on-budget mechanism at the MoE. A recent pre-award assessment established conditions precedent for the transfer of funds by donors to the MoE via direct funding from the Government of the Islamic Republic of Afghanistan (GIROA).

Current capabilities of the Grants Management Unit at the GoIRA-MoE has been assessed as requiring significant support in part due to the lack of qualified technical staff to effectively manage grants and financial operations. The MoE does not have the systems, procedures and policies in place to independently manage USAID funds in accordance with US Government and GoIRA rules and regulations. To further strengthen the capacity of the MoE, USAID advised Tech-Serve, having successfully built the capacity of the MoPH GCMU-PCH to manage BPHS and EPHS Health Care Delivery projects in 13 Afghan provinces, to provide similar assistance to the MoE.

This support is in keeping with USAID's objective to build the capacity of the GIRoA Ministries to undertake the On-budget mechanism. There exists links between the approaches to On-budget within the health sector with that of the On-budget approach within the education sector.

At the MoPH, LMG through local and international level technical assistance, will continue to ensure that the MOPH GCMU remains certified by coaching the MoPH to comply with the USG and GIRoA regulations and requirements. In the past, MSH has played a more active role in this process (i.e direct financial management for the PCH contracts, support to the procurement process for the PCH contracts); under LMG, MSH will provide oversight and targeted technical assistance as requested. The current team of GCMU consultants is included in the LMG Afghanistan project for the first six months. After that, it is expected that the team will move on-budget.

LMG will also work closely with the DG for Policy & Planning to ensure submission of the MoPH On-budget proposal to USAID. LMG will further complement the support to the On-budget transition by providing technical assistance to those MoPH programs that are to eventually transition to On-budget including Child & Adolescent Health, Policy & Planning, and Leadership & Management Development. At the MoE, Creative Associates has an off-budget agreement with USAID for vocational education (TVET) and will support the MoE Management Support Unit (MSU) consultants. LMG will fund the MSU until Creative Associates can take over this responsibility. LMG will facilitate the capacity building of the MSU consultants through internships with the MoPH/GCMU/PCH.

LMG will provide necessary technical assistance to the Community-Based Education department to draft an on-budget CBE Activity Plan. In addition, it will provide salary and limited operational support to the MoE CBE staff (Four Kabul-based staff, and 68 Provincial Coordination Officers in all 34 provinces).

LMG will also provide salary, benefit and limited operation support to two technical advisors who will provide capacity building to CBE Kabul. Both advisors will be hired and managed by the IRC project funded by CIDA.

Working with the MoE Transition Director, LMG will provide Technical Advisor assistance and any needed STTA to assist the MoE in developing plans to address the Conditions Precedent, which USAID requires to be met prior to the release of on-budget funding.

LMG will support both ministries (MoPH and MoE) to ensure transition of technical assistance from Off-budget to On-budget. Both ministries will need to design an Operational support mechanism which enhances the ownership and technical development for the implementation of on-budget activities. Until such time that the operational support initiative is fully functional LMG will provide operational support to both the MoE and the MoPH. LMG will continue to provide technical assistance to the MoPH and MoE to transition the technical assistance to On-budget. LMG will provide on-site technical assistance to the two ministries to attain a higher degree of transparency, accountability, participation, inclusion, integrity, focus and vision in their governance. Additionally LMG will provide technical assistance for mainstreaming gender.

### ***Expected Outcomes***

By the end of LMG, the MoPH GCMU will have remained certified to continue to receive direct USG funding. MoPH and MoE on-budget plans (as stipulated above) will have been presented to USAID for approval. Both MoPH and MoE will have the necessary set up and governance to

transition technical assistance from Off-budget to On-budget, and transition will have happened if On-budget programs are approved. During this interim (transition) period, LMG will have the operational support provided to the programs eligible to go On-budget eventually (limited operational support provided to CBE consultants).

## **2. *Community-Based Health Care***

### Expand Community-Based Health Services

Building upon earlier successes, LMG will support the MoPH CBHC department to expand CBHC services. Main strategies to achieve that goal will be the provision of technical advice to the MoPH CBHC department in order to do the following: establish new FHA Groups in nine USAID supported provinces where 63 groups have already been established; advocate to GCMU and NGOs to effectively recruit and monitor new CHWs in areas where there is no coverage of CHWs; establish CBHC services for Kuchi populations across Afghanistan and for poor urban populations in Kabul; review results of the ongoing “Pilot” of the two best practices which include “Integrated Health Post” and “Cleaning Friday”, and scale them up only if results are positive. The expansion of these two best practices will not have any budget implications in addition to what is already budgeted under the CBHC component.

The MoPH, in collaboration with the Ministry of Education, plans to establish a new channel for the dissemination of health messages, promotion of maternal and child health, and family planning through school children. LMG will provide technical assistance to the MoPH CBHC Department to expedite and amplify relevant efforts as needed. LMG will ensure that these messages incorporate appropriate gender related messages to highlight the critical nature women play in the health care and educational fields as well as attempt to bring about gender equity as a whole. These activities will require LOE of project staff, but no additional costs.

### Improve the quality of CBHC services

LMG will provide technical support to the MoPH CBHC Department to improve the quality of CBHC services, in collaboration with the Quality Improvement Unit of the MoPH, through several ways: training and mentoring of the CBHC staff (CBHC team at the MoPH, CBHC provincial officers, CHSs and CHWs); and providing up to date guidelines and ensuring execution of the CBHC policy, strategies and guidelines through regular monitoring and supportive supervision. In improving the quality of services, the LMG project will seek to identify challenges, opportunities and obstacles related to gender and incorporate some of these issues within the framework of the quality improvement unit of the MOH as well as the manual which will be prepared. LMG will support CBHC in printing and disseminating of revised CHWs’ Training Manual upon its approval by the MoPH. Simple leadership, management and governance content will be prepared for the consideration of the ministry for its inclusion in the manual in course of time. The content on community engagement will be enhanced.

### Ensure sustainability of the CBHC systems

LMG will continue to build upon Tech-Serve’s work and assist the MoPH CBHC Department to improve the effectiveness and efficiency of the CBHC system in the country. LMG will assist the MoPH CBHC Department to ensure institutional, community and financial sustainability.

To ensure institutional sustainability, CBHC should maintain the capacity to invest in their own future. This will be achieved through strengthening CBHC system and structure at the central and provincial levels. At the central level, LMG will further enhance the stewardship role of CBHC through retaining and maintaining an expert team in the CBHC (the current 11 consultants

will be funded through LMG and their migration plan to the MoPH will be implemented assuming OB funding will begin). LMG will advocate promotion of the CBHC Department to a directorate level and initiate the introduction of the CBHC concept into the curriculum of medical universities and Institutes. Gender will be, incorporated as one of the competencies to be integrated into curriculum and build technical, programmatic and leadership + management + governance capacity, and the capacity of the CBHC staff to advocate for CBHC programs with the broader donor community, and to perform strategic and operational planning, as well as apply sound management practices and well-functioning administrative systems. LMG will also hire a senior technical advisor (off-budget) and request need-based short term technical assistance (expatriate consultants) in order to achieve the outcomes.

At the provincial level, LMG will assist CBHC in hiring 34 provincial CBHC officers, seeking gender balance as feasible (to be covered by the Global Fund, not the LMG Afghanistan project), and integrate them into the regular MoPH structure so that they provide ongoing staff training and assessment and apply the existing clinical standards and other quality assurance measures, as well as information, education and communication (IEC) programs. The project will also support CBHC to keep CHWs motivated through different applicable incentives including recognition and reimbursement for work related expenses. The CBHC officers will be trained in effective governing and community engagement practices so that they are able to act as catalysts in improving governance and community engagement at provincial and local level. Moreover the training will include a session on gender to ensure that issues related to equity are included in quality assurance, information and IEC activities. Because gender is a sensitive area of concern in Afghanistan, the LMG project will first scan other stakeholders and what they are doing and adapt some of the best practices that have shown to be successful in promoting gender equity.

Community sustainability activities aim to establish health services not just fully acceptable to the community, but fully supported by its all members. LMG will support CBHC to enhance community involvement and empowerment to build the community trust and enable them to anticipate and adapt to changes through clear decision-making or governing processes, and manage resources internal and external to the community efficiently; improve CBHC links with other community-based shuras like Community Development Councils (CDCs). Engaging the community to participate in health shuras can at times be difficult. The culture of information sharing and decision making is one which is typified by blame and mistrust. This activity aims to strengthen the involvement of the community by facilitating a better understanding amongst communities of the role and functions of this forum and of the importance of the community's presence on the committee to ensure improved governance practices and accountability.

Since it is likely that donor funds to support CBHC and other priority interventions will receive major cuts over the next several years, it will be critically important for LMG in collaboration with the MoPH to identify ways that CBHC can continue to operate with greatly reduced support. Of particular importance is the supply of medicines going to CHWs—if that supply is drastically reduced their effectiveness in influencing health behaviors among villagers will be greatly reduced. To address this issue, and contribute to the financial sustainability of the community-based health care, LMG will support CBHC to advocate for the continuation of donors' funds for further support of CBHC interventions and allocation of adequate government budget for CBHC activities.

There may be the need to work with the MoPH and partners to evaluate the effectiveness of existing CBHC program components, its structure and systems which supports and encourages community participation and action. This will be conducted as appropriate in consultation with the MoPH leadership.

### Expected Outcomes

By the end of LMG it is anticipated that a solid CBHC system will be in place with a reasonable level of community engagement that can respond to community needs in terms of promoting healthy lifestyle, promote gender equity, referring complicated maternal and childhood illnesses to nearby health facilities, and empowering communities (particularly women) to participate in all aspects of CBHC programs, including planning, implementation and monitoring.

The MoPH CBHC Department will have increased capability to exercise its stewardship functions and governing role by developing, implementing, and enforcing evidence based policies and guidelines that improve health system performance and promote community health; overseeing and monitoring NGOs' performance to ensure quality gender sensitive health services are offered at the household level; coordinating with partners and donors; advocating promotion of priority community-based interventions; and ensuring adequate donors and governmental funding required for relevant health services and resources. CBHC department's role and functions will be adequately decentralized to the provincial CBHC officers who will be well-versed in effective governing and community engagement practices as well as gender equity.

CBHC services will have expanded, additional FHAGs will be facilitating the work of CHWs, NGOs will have started delivering CBHC services to the Kuchi and Urban populations, Comprehensive Health Post and Cleaning Friday initiatives will have been scaled up to the entire country and practiced by all NGOs.

All NGOs will be applying the revised CHWs curriculum for their pre & in service training.

### **3. *The Hospital Sector***

Technical Assistance provided by Tech-Serve to the Central MoPH in the Hospital Sector was highly successful with the implementation of the first stage of autonomy at fourteen National and Specialty Hospitals. Resources available to these essential national institutions went from effectively zero (a complete blockage of finances to central hospitals during the previous fiscal years) to a level that was unprecedented and, for the first time, directly controlled and selected by the hospitals themselves. This important accomplishment needs to be carried forward under LMG so that improvements will be firmly institutionalized and further progress in terms of increased scope and complexity can be achieved. The following is a brief description of the core areas and strategies for continued support in the Hospital Sector.

#### Hospital Autonomy Fusion Team (HAFT)

Because of the highly complex organizational nature of hospitals, the multi-system intricacy of transition to autonomous status, and the absence of in-country hospital administration experience, external technical assistance will remain an essential input to the hospital management process. Based on this critical need, groups of professionals with specific areas of expertise have been assigned to provide technical support to the Directorate of Central Hospitals (DCH) of the MoPH, and fourteen National and Specialty Hospitals. The Consultants who are being selected for these roles are chosen primarily on the basis of their expertise in specific technical areas and not on the basis of health care experience.

The General Directorate of Curative Medicine (GDCM/DCH) of the MoPH and each target National and Specialty Hospital are provided with a team of consultants to develop and institutionalize the systems, structures and procedures necessary for operation as autonomous

entities. The consultant cadre will consist a total of 28 individuals recruited (in phases) from the business, NGO and government sectors to assist Hospital Management Teams with the various management, financial, procurement and medical data processing aspects of autonomous hospital operations.

The Hospital Management Team (consisting of the Hospital Director, Medical Director, Director of Nursing and the Administrator) has the main responsibility for the operations of the hospital but shall be assisted and guided by the Consultants in the development of new systems and procedures necessary for autonomous operations. Together, the Hospital Management Team and the Consultants assigned to each hospital form the *Hospital Autonomy Fusion Team (HAFT)*. The core idea behind the HAFT is that together, the composite skills of the individual members represent the essential skills of a master’s trained Hospital Administrator.

Functioning as a collaborative team, the deliberative and decision making output of this group will approach that of a professional administrator and effectively mitigate many of the problems posed by the present lack of management capacity within the hospital system.

Due to the critical lack hospital management expertise, existing hospital staff will require extensive on-the-job guidance and development. The Consultants initially deployed under Tech-Serve and continued under LMG will provide this guidance and assistance. A reasonable prediction is that the process of converting all fourteen National and Specialty Hospitals to autonomous status will take a period of time running through LMG and into another year afterwards. During this period the capacity of MoPH experts will grow to take on tasks of increasing complexity, but just as their capabilities grow so too will the scope of this process; thus the requirement for continued support of external technical assistance.

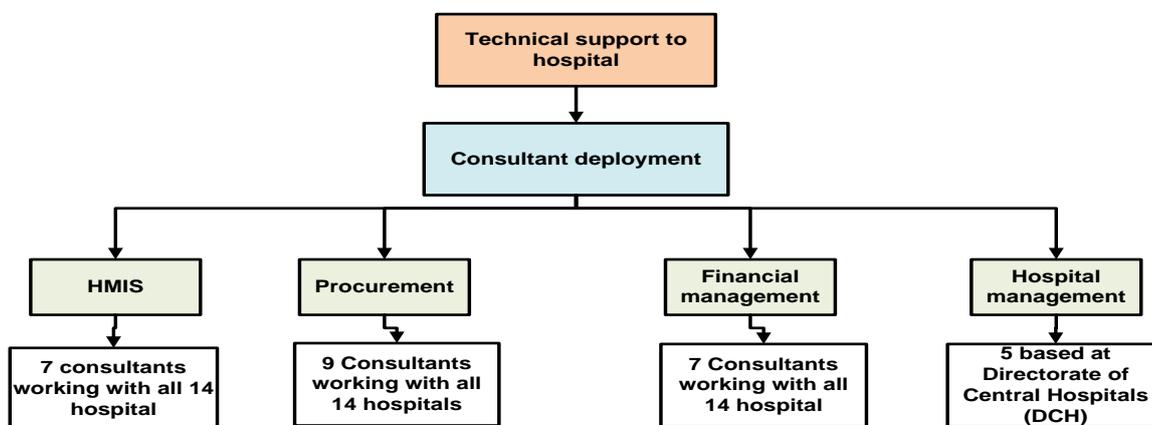


Diagram above demonstrating the deployment of consultants at DCH and 14 National and Specialty Hospital

HAFT Work Process

The goal of the initial phase of autonomy is that hospitals are able to procure needed supplies, materials and equipment, and manage their budgets in accordance with government law, the guidelines of the Hospital Sector Strategy and the principles of basic health economics. Central to this process will be the collection, analysis and use of HMIS data.

In order to achieve this stronger system, Autonomous Finance Consultants, Autonomous Procurement Consultants and Autonomous HMIS consultants will meet on a weekly basis along with representatives of the MoPH and LMG at the Directorate of Central Hospitals.

In the interim between joint meetings, teams will return to their respective hospitals to further develop and implement these systems. Officials from the MoPH and technical experts from LMG will be on standby to provide individual help to hospitals as needed.

The Hospital Management Consultants based in the DCH at the MoPH will oversee the implementation of procurement, finance and HMIS Consultant plans and report regularly on the level of implementation to the Director of Central Hospitals and the leadership of the MoPH. The management consultant will make sure that weekly and monthly coordination meetings are held regularly and the results are recorded and communicated accordingly. Management Consultants will assure that coordination meetings are productive and that all required parties are invited and present at the meeting.

The following are brief descriptions of the Consultant members of the Hospital Autonomy Fusion Team members:

**Autonomous Management Consultant:**

Hospital Management Team coordination and support;  
Assisting in getting support from the Central MoPH;  
Develop mechanisms for the use and control of State Budgets  
Development and submission of quarterly and annual report on status of autonomy implementation;  
Implementation and monitoring of the Sunshine Directive mechanism  
Work with the Autonomous Procurement Consultant to implement the Resource Use Prioritization System

**Autonomous Finance and Accounting Consultant:**

Implementation of Accounting System;  
Implementation of Financial Management System;  
Develop mechanisms for the use and control of State Budgets  
Support the Autonomous Management Consultant on the implementation of the Sunshine Directive mechanism;  
Assist the Autonomous Procurement Consultant in rational use of Petty Cash based on established process of procurement and accounting systems;

**Autonomous Procurement Consultant:**

Assist the Autonomous Finance Consultant in rational use of Petty Cash based on established process of procurement and accounting systems;  
Assist in the development and maintenance of an in-hospital procurement system;  
Assure compliance of hospital procurement committees with MoF laws on procurement;  
Ensuring an improved requisition system for drugs, medical supplies, equipment and capital asset repair;  
Ensure the implementation of the Resource Use Prioritization System at each hospital.

**HMIS Implementation Consultant:**

Work with other members of the HAFT to implement a minimal HMIS system within each hospital;  
Install and operate database systems in management, finance and accounting, and procurement;  
Implement data collection and entry at key functional areas in support of autonomous operations;

Assist other consultants in institutionalizing data use in decision making;  
Connect hospital databases with existing MoPH databases.

### Hospital Administration Training

The poor state of hospital director management capacity is the weakest link in the process of granting autonomy to hospitals in Afghanistan. The lack of formal Hospital Administration education is common to most developing countries but is far more serious in Afghanistan because of the till now complete centralization of management authority.

Tech-Serve began to address this problem through the stopgap mechanism of developing HAFTs in the 14 National and Specialty Hospitals that have been granted financial and procurement autonomy. While this mechanism seeks to piece together the skills that would normally exist in an educated Hospital Administrator, it will never achieve the same level of management performance.

It is clear that formalized Hospital Administration and Management training is urgently needed if hospital service quality is to ever truly progress.

### Short Term Training

In the near term, LMG proposes the creation of short-term Hospital Management training programs that can be attended by current Hospital Directors. Although Masters Level programs are ultimately desired, the hospital sector as a whole cannot afford to lose current directors for two-year periods. LMG Partners MSH and Yale University will work together to develop short-term training that can be attended by working Hospital Directors. These programs will address the most essential skills needed by directors and other members of the HAFT.

### Human Resources Autonomy

The three most critical areas for initial implementation of progressive autonomy in Afghan Hospitals are Finance, Procurement, and Human Resources Management. The first stages of autonomy have already been achieved in finance and procurement. With this initial success and the operational confidence it has inspired, the time is right for tackling the most difficult of these activities; Human Resources Management Autonomy.

### Consensus Building at Two Levels

Human Resources Management Autonomy is the most problematic, intractable, and politically sensitive issue facing hospitals. It is also essential to resolve if conditions are ever to significantly improve. Put succinctly, there are too many physicians (and sometimes nurses) at the National and Specialty Hospitals, and, their salaries are below the level needed to feed, clothe and house a family. As such, work performance is at an abysmal level and workers have no choice but to put their efforts into activities that raise additional income.

If the number of physicians was reduced to a rational level and if the present total budget allocation for salaries was divided among this smaller number of staff, a living wage would be achieved. Solving this problem is difficult however because of structural, political and cultural impediments. The Centralized Civil Service has maintained monopolistic control over hospital employment and the rules, regulations and inertia of the system are formidable.

The problem is just as difficult from the employee level. Any threat of reductions in force is met with militant opposition. Hospital staff has expressed the opinion that they would rather share a level of poverty and misery than accept the loss of any coworkers. Ministry and hospital officials are therefore highly reluctant to take on such a sensitive issue.

Unfortunately, the status quo cannot continue without collapse of the system and a negation of progress made in other areas. Staffing levels must be rationalized and salaries must be improved. In the process LMG has to ensure that women at this level are not marginalized by the new reduction and a transparent process is put in place to ensure equity. In addition, Hospital Management Teams must gain control over the selection, retention, and advancement of hospital employees if they are to enforce appropriate work behaviors and achieve improvements in operations.

During Tech-Serve the idea of hospital autonomy in general was thought to be equally unachievable. Through a three-year process of consensus building, policy creation and system implementation autonomy was achieved in Finance and Procurement. LMG will seek to repeat this achievement by following a very similar process. Because of MSH Technical Assistance credibility, experience, and goodwill developed within the MoPH and Hospital Sector, the challenge of HR Management should be surmountable.

The process will begin again with consensus building. LMG will assist the Central MoPH to deliver an initial consensus-building workshop for Health Sector Leadership and other key stakeholders such as donors. The key idea behind this workshop will be to examine the present status of hospital staffing, the burden this staffing places on efficient and effective operations, and to develop the outline of a likely solution.

Because of the political sensitivity of this issue, a parallel series of consensus-building workshops will need to be held for hospital staff. Following the first high-level workshop, the staff of the hospitals will need to be presented with the same information on the burden of the present system and what appropriate staffing levels and salary levels would look like. Again, it is important to ensure that the restructuring does not affect women disproportionately)

Over the course of two, possibly three staff workshops a consensus must be developed on the necessity of solving this problem and on the disastrous results if it is left in its present state. The only hope for a viable solution to this problem will be recognition of the critical nature of the problem by hospital staff and the birth of a willingness to develop a staff reduction process that would be acceptable to staff.

As progress is made on the staff level, a second high-level consensus workshop will need to be held with MoPH, MoF, MoJ, Civil Service Commission and other key stakeholders to examine staff proposed approaches to force reduction strategies and to find legal mechanisms to reallocate HR budget resources among a smaller pool of employees. A draft mechanism for the transfer of HR management operations to the hospitals will also need to be developed and discussed.

#### Draft HR Autonomy Policy

The findings and consensus reached by the high-level and staff-level workshops will then be developed into a draft HR Autonomous Management Policy (or policies) that would cover the legal options of management relocation, salary adjustment and staff reductions. This HR management policy should include a written commitment which shows that gender issues will be addressed. Whatever policy strategy is developed, it is essential that it is in compliance with Afghan law, it is acceptable to hospital employees, and that it treats retained and discharged staff with dignity and compassion.

### Final Consensus Workshop and Implementation Plan Development

As was done with the Hospital Sector Strategy under Tech-Serve, the final draft of the HR Policy (Policies) and implementation mechanisms will be presented at a final Consensus Workshop. This workshop would be attended by not only the high-level attendees from the ministry and stakeholder workshops, but would also include representatives from hospital staff.

The draft would be presented, debated, modified if necessary then adopted by the relevant ministries. This finalized document would then go through the official adoption processes of the relevant ministries. It is hoped that implementation of the new HR system would assist the hospital management team to further implement the plan in the future.

### Improving Governance of Hospitals

Till the long term vision of the hospital governing boards and their conversion into Tassadyha materialize in course of time, there is a need to improve the way the hospitals are being governed as of today. Towards this end, LMG will work with the General Directorate of Curative Medicine (GDCM/DCH) of the MoPH, Hospital Director, Medical Director, Director of Nursing and the Administrator of each target National and Specialty Hospital, and the autonomy support consultants helping them. The purpose will be to improve the governance knowledge, skills, attitudes and eventually behaviors of all the individuals who are governing the hospitals as of today. 34 consultants will be trained in the beginning and they will act as catalysts in the governance improvement process. The desired outcome will be the governing practices of a majority of the governing individuals and bodies of today show a marked improvement.

### Long Term Goal for the creation of the Non Profit State Owned Organizations

The original Hospital Sector Strategy specified that National and Specialty Hospitals would need to be converted to non-profit state owned organizations. The specific mechanism chosen was “Non-Profit Tassadyha” which although not already in existence was consistent with Afghan Law. In order to achieve full autonomy, hospitals will need to have their legal status changed to this type of legal structure. The Governance structure outside the MoPH will be developed for each institution based on the changes in the legal status for each institution.

When agreement was reached between the MoPH, the MoF and the MoJ on financial and procurement autonomy, the issue of the nonprofit state owned organization status was left for future consideration. It is hoped that when progress has been made on Human Resources Management Autonomy that attention will once again be turned to the issue of the creation of these institutions.

### Systems Development

Hospital Sector support activities under LMG will result in the development of a number of important Legislations, Regulations, Policies, and Procedures in support of the furtherance of hospital autonomy. The first of these which are undergoing preliminary development under Tech-Serve include:

- Autonomous Procurement Procedures;
- Autonomous Finance Management Procedures; and,
- HMIS Hospital Indicator Procedures and Database.

System Development activities to be initiated under LMG will include:

- Autonomous Human Resources Draft Policy (policies) and Regulations;
- Autonomous Revenue Generation (User Fees) Legislation.

### Expected outcomes

By the end of LMG, MoPH in collaboration with MSH and the other LMG partners (e.g. Yale University) will have created short-term Hospital Management Training programs that will be attended by current Hospital Directors. The MoPH will have drafted a policy of human resources rationalization through the process of consensus building among the MoPH leadership, key stakeholders such as donors and hospital staff. It (MoPH) will also have developed and endorsed a legislation covering Autonomous Revenue Generation (User Fees). Majority of the procurement for the next Afghan fiscal year (1392) will have been transitioned to the 14 national hospitals taking into account that some of the large scale commodity contracts e.g. fuel, food etc. are complex and may require a phase wise progress. Governance of the hospitals will be substantially enhanced and a majority of them would have adopted effective governance practices while making governance decisions.

#### **4. Health Information System**

USAID funded REACH and Tech-Serve projects have been the technical leads and principle support mechanisms for the MoPH HMIS Department assisting with the development of the Health Information System since 2003. With continued technical support, the MoPH HMIS Department has achieved many important achievements including: establishing the HMIS routine reporting system, its policy and procedures, developed the National core and proxy indicators, developed and maintained the MoPH core systems databases, developed and assisted with the implementation of the Health Information Strategic Plan and assisted with the design, coordination and implementation of National Health Surveys. The priority of this program is to enhance the use of information and evidence for decision making across the health sector to improve health services and health outcomes for those most vulnerable and in the greatest need.

#### Strengthening Use of Information for Evidenced Based Decisions Including Monitoring and Evaluation Practices at Central, Provincial and Health Facility Levels

In every country and in every type of health system the challenge is to provide the most efficient, equitable and high quality health care to the local population. The need for sex disaggregated data will be important in understanding the challenges and opportunities to promote gender equity both at the beneficiary and at the provider level. Over the last thirty years, the need for improved management of health services has led to the idea of decentralization in healthcare. This process has often been advocated in developing countries, where country-wide reform is ongoing and donor-funded programs are dominant. The aim of decentralization is to move managerial decisions from the central government to provinces or districts in order to improve the health services for patients.

If the MoPH adopts a truly decentralized approach to healthcare delivery, where power or responsibility for health resourcing is transferred to the regional or provincial levels where relative autonomy over priority setting and programming within the framework of national policies, an existing cadre of high-quality provincial professionals will be needed.

LMG will provide technical assistance to the MoPH M&E, GCMU, HMIS Department and donors to strengthen the capacity of the PPHO teams to plan, monitor and evaluate the delivery of health services provided to the population. This will be completed with the continued rolling out of the Information Use in Evidence-Based Decision Manual and by further institutionalization the household survey and CAAC. Information governance will be improved to facilitate the use of information for making decisions.

This activity will continue to strengthen the relationship between the Central Ministry of Public Health with that of the Provincial Governance structures through Information Use and Evidence Based Decision forums. There are two main forums. One is the release of semi-annual HIS results during a health sector conference at central level where Provincial Governors, Provincial Health Directors and key players at central level will be invited. LMG will use this forum as an important vehicle to disseminate effective practices in using information for making governance decisions, and also effective governing practices. The second forum is the Quarterly Provincial Health Coordination Committee in which includes attendance by key donor stakeholders including WHO, the Provincial Health Director and community members. These meetings will discuss and adopt effective practices in using information for making governance decisions and also effective governing practices. The role of the HMIS Officer has been revised and training has been provided so that a greater role in the provision, analysis and interpretation of health information can occur at these meetings. The HMIS Officers will also need to ensure the attendance at these meetings of community members and to coordinate with the implementing partners their attendance. Central level GCMU will instruct implementing partners on their need to be represented at these meetings. The HMIS Officer will also need to detail the improvement activities being undertaken by health facilities. As the Information Use methodology has only recently been applied further close follow up with coaching and mentoring of HMIS Officers to ensure up-skilling will need to be provided.

There are a number of monitoring tools being implemented nationally for which MSH Tech-Serve has assisted in institutionalizing. While the tools have been implemented at the MoPH there is still the need to provide under LMG continued capacity building through coaching and mentoring of all GCMUs (USAID, WB and EC) to analyze, interpret and write technical reports for the dissemination and use of results.

#### Catchment Area Annual Census (CAAC)

The national annual catchment area census (CAAC) is now implemented nationally and is a contractual requirement of all NGOs in all 34 provinces. This census is conducted by health posts and health facilities to determine the number of people who require health services within their health post and health facility catchment area. This assists with setting specific targets for health post and health facility activities and provides basic morbidity and mortality data in vulnerable populations.

There is the need to continue to strengthen the monitoring of the community maps and the setting of targets at health facility level. Monitoring is the responsibility of everyone within the health sector. The provinces have a responsibility to ensure implementing partners have conducted and are utilizing maps to determine priority interventions. The provinces also need to be aware of progress against set targets and assist in the resolving of constraints which may be impeding progress to the improvement of health outcomes. Central level has a responsibility to ensure that there is contractual compliance to the national requirement for the conduct of CAAC. This could be achieved through a revised NMC for provinces and is discussed in the paragraph below.

#### Household Surveys

The objective of the household survey is to introduce a mechanism for self-assessment by contracted non-governmental health care providers at local levels for which the results are used for strengthening capacities and improving performance at the individual, facility and organizational level. Lot Quality Assurance Sampling (LQAS) was implemented in USAID and EC provinces and it is expected that the WB provinces will implement this survey methodology in

2013. This survey periodically measures 10 indicators that reflect the health status of women and children in Afghanistan. These 10 indicators fall into three categories—reproductive health, safe motherhood and child health. Household surveys are undertaken by NGOs at baseline, midterm, and end-of-project (EOP) to capture information on basic health services coverage and outcomes in the communities they serve. This experience in Afghanistan helps NGOs assess the impact of health interventions at local and provincial levels in a challenging post-conflict environment. Other advantages include:

- Producing statistically valid estimates of outcome indicators for decision-making at multiple levels;
- Permitting realistic target- setting at the local level;
- Allowing prioritization of technical assistance needs within each implementation area;
- Decentralizing the planning, and management of the survey process;

The MoPH will need further assistance to interpret results and to edit reports.

There may also be the need to future assist the MoPH to revise the National Monitoring Checklist so that it can be applied simply by the provincial health teams for the monitoring of health services being implemented by NGOs. This will strengthen governance practices at provincial level and promote decentralization. The tool will also need a component which can be used at central level to monitor the contractual compliance by NGOs. Monitoring at provincial level including the joint monitoring of the implementing partners by the PPHOs using the NMC needs to be strengthened. There first needs to be agreement at central level that this occur. There then needs to be a greater understanding of the PHOs of their role in monitoring. This may be effectively coordinated and reported by the HMIS Officers at the PHCC. LMG will continue to facilitate greater clarification of the roles, responsibilities, authority, resources and processes for the decentralization of the monitoring function to the provinces.

The Health Information System Strategic Plan (HIS SP) will also need revision in 2013. If there is a revision of this plan LMG should advocate for a greater integration data on gender which should be incorporated in the revision. In 2007 the MoPH undertook a Health Metrics Network (HMN) assessment of the then health information system and its processes. The tabulation of the assessment results and the definition of priority HIS problems took place in September and October, 2008. Afghanistan's Health Information System (HIS) is primarily comprised of the following components: the HMIS service reporting system, the reporting systems of special programs, the Disease Early Warning System (DEWS), the data support for administrative system including human resources, financial management and supply management, population census, health facility assessments and various household surveys capturing information on various indicators in the health and nutrition sector. The HIS SP completed in 2009 provides a framework for the overall planning of a Comprehensive Health Information System (CHIS) for Afghanistan and will need revision in 2013.

#### Strengthen and sustain gains in the Quality of Data collected

LMG will provide technical assistance to work with the MoPH HMIS Department to analyze the results of the Data Quality Assurance Assessments so that gaps can be identified and training plans constructed which ensure the continued collection of timely, complete and accurate data. In particular while analyzing the results of the data quality assurance assessment, LMG should work to bring out issues related to gender which can be used for interventions as well as advocacy This will be achieved with the continued roll out of the Data Quality Assurance Manual and with the provision of assistance to the MoPH to write technical reports and work plans.

Traditional approaches to data quality generally only assess the accuracy and timely submission of information. A data quality assurance assessment tool was developed with the technical support of MSH Tech-Serve so that other critical components such as the understanding of case definitions and the use of information could also be assessed. The Data Quality Assurance Assessment is now a contractual requirement for NGOs to complete and a responsibility of HMIS officers at provincial level and assesses the data quality of information being collected on four important indicators relating to the top priorities of the MoPH. These include the number of 1st Antenatal visits, the number of family planning users receiving contraceptives, the number of children under the age of 1 year receiving Penta-valent vaccine and the number of outpatient department consultations. These indicators were selected as they were the most complicated in terms of case definition and method of reporting. These selected indicators may change in the future if the priorities of the MoPH change or if there are arising more problematic indicators. In addition, the following indicators will be assessed to ensure the accurate completion of counts between the Register, Health Facility and HMIS data: institutional delivery, acute malnutrition in children, TB Case (New pulmonary Positive), No of positive plasmodium falciparum, Health Shura minutes, Stock status for Amoxicillin (Observe Stock cards). As this methodology has only recently been applied further close follow up with coaching and mentoring of GCMU and MoPH HMIS Officers will be needed to ensure up-skilling and institutionalization with assistance to write technical reports.

#### Vertical Program Integration with HMIS

LMG will provide technical assistance to work with the MoPH to integrate data from vertical programs into the health information system. The DEWS and EPI data is to be incorporated into the HMIS and technical advice will be provided to further strengthen the reporting and response to outbreaks of epidemics and emerging diseases. In addition, technical support for the continued integration of the MoPH databases into the MoPH common database including but not limited to the EMIS, PIS, and HRMIS will also occur.

#### Improve use of Information through Database Warehouse

LMG will provide technical assistance to the MoPH to develop Data Warehouse functionality. As a result of this activity, a computer dashboard with indicators will be available for the Minister, DMs and DGs. This activity will be dependent upon the availability of financial resources from MCIT for the continued development of IT infrastructure at both the central and provincial level.

#### Strengthen management of ICT development within the MoPH

This will be achieved by establishing an ICT working group to develop policies and guidelines to monitor effectively the development and implementation of databases across the health sector. Activities 3, 4, 5 and 6 are all technically related.

The HMIS was designed initially to provide routine health information to monitor trends of priority diseases across the health sector but due to the development of the HMIS common database other MoPH data bases are relationally linked to the HMIS allowing the HMIS to function more than a system for the reporting of routine information to be that of a more broader Health Information System.

Currently the MoPH HIS databases are at the level that allows departments to easily search and extract data from their own databases or to do other queries using a common link. The MoPH HMIS database is the “common” database through which other departmental databases interact with the core system. The MoPH HMIS Department is to take the technical lead in facilitating database development. This system has three main components which include:

- A “common” database containing data related to the organizational hierarchy, and related data (e.g. GPS co-ordinates, grant data, and organizational hierarchy data);
- A “backend” database; and
- A “frontend” or user interface.

The MoPH HMIS is one of the successes of the Afghanistan health sector and provides relevant, complete, accurate and timely information so that evidence based decisions can be made to improve health outcomes particularly for those most vulnerable, women and children. However, the MoPH HMIS is on the brink of collapse and unless immediate support and funding is provided years of technical and donor support will have been wasted. The current platform for many of the databases is that of an access database. Of particular concern is the Human Resource, Routine Information and Financial Management databases which have reached or will soon reach their maximum storage limits and are required to move to an SQL server with web based technology. This will assist in addressing the immediate processing capacity at central level and facilitate improved information use at the provinces thus facilitating decentralization and improving provincial governance.

The HIS SP and the BSC results identified the need to better integrate databases outside of the common with that of the HMIS including the surveillance, immunization, EMIS, PIS and the HRMIS. This activity focuses on strengthening the systems and processes of surveillance to improve reporting through database development. This activity will also assist the MoPH to develop proposals to secure future funding for the MoPH central and provincial IT development.

#### Expected Outcomes

By the end of LMG, the MoPH will have revised its Health Information Strategic Plan. The MoPH will have implemented CAAC across the country through its NGO contractors and thus all health facilities will have had community maps and targets. The HMIS will have established a solid mechanism to monitor data collection, reporting, use and quality assessment at the province level as well as other levels of the health system. The MoPH will be holding a Health Information Conference bi-annually and it will have initiated the process to implement Database Warehouse with dashboard indicators and web-based technology. Effective practices in using information for making governance decisions and effective governing practices would have been disseminated through biannual conference at central level and Quarterly Provincial Health Coordination Committee meetings. Surveillance and EPI data will have been incorporated into the common database.

### **5. Central and Provincial Health System Strengthening**

The Health System Strengthening program has incorporated the central and provincial capacity building programs with that of the Leadership and Development Program. This component provides high-quality technical assistance to the MoPH at both central and provincial levels. It focuses on enabling MoPH counterparts to more effectively plan, manage, and monitor/evaluate health services. The main priority of this component is to increase the capacity of MoPH managers and leaders at both central and provincial levels to manage and coordinate health services to reduce mortality, especially among women and children under five. The justification is that improved management on the part of the MoPH can lead to reduced levels of mortality and morbidity.

Provide technical assistance to MoPH to further strengthen MoPH management, governance and leadership capacity at senior level

Afghanistan is one of the poorest and least developed countries in the world. It is ranked within the lowest quarter of the Human Development Index. Continued conflict and insecurity undermines attempts to improve governance structures and confidence in political leadership. This current fragile political situation creates uncertainty and a lack of clarity within the government and its ministries with regard to accountability and reporting structures and processes. One of the challenges is to assist the MOPH senior leadership to establish a system that could regularly monitor the performances of central MOPH leaders and senior managers in their mandate to provide health services to the communities through priority MoPH programs. LMG will work with the MoPH to identify strategies to strengthen leadership, management and governance structures and processes within the health sector. LMG will also focus on gender inequities in MoPH in order to address the situation of women beneficiaries as well as providers of care. LMG is based on multiple country experience and there is a strong emphasis on sustainability and country ownership within the health system strengthening framework. Development practitioners increasingly agree that improving the leadership, management and governance capacity of policy makers, health care providers, and program managers allows them to better implement quality health services, and meet the local health needs of the population. Agreement for the implementation of a senior leadership development program at the MoPH will be sought during a consensus building workshop. This will build upon the recommendations from the recent LDP results conference. On-site technical assistance will also be provided to embed effective governing practices in the ministry.

#### Strengthening the PLD stewardship role

LMG is envisioning PLD as an MoPH dynamic department to effectively link Provincial Public Health Offices (PPHOs) with the central MOPH team, as well as provide update information in connection to the PPHO teams' performance and health service indicators. LMG will fund the deployment of 3 technical consultants seconded to the PLD and backed up by a program unit within LMG. Technical assistance will be provided to the MoPH Provincial Liaison Directorate (PLD), to develop an effective supervision and monitoring mechanism to regularly oversee the PPHO core functions. LMG will assist the PLD technical team to develop a monitoring tool based on the PPHO core functions through assigning a short term international consultant. LMG will also assist the PLD in development and implementation of a provincial health governance assessment tool. The consultants will closely work with the team to develop the tools and will also assist them to pilot the tools in one or two provinces. By the end of the project it is expected that these tools will be introduced as a national tool to regularly monitor the overall functioning of PPHOs and their governance.

#### Strengthen the networking mechanisms of the Provincial health systems

The sharing of best practices through the Provincial Health Learning Center (PHLC) has proved a strong approach to inspiring teams and initiating change. This forum provides an opportunity to learn from the best practices and experiences of other provincial health teams, and inspire them to initiate positive changes in their provinces that are resulting into performance improvement. The MOPH Executive Board has already taken a step and endorsed this initiative as a national one. LMG will continue to support the MoPH PLD to set up quarterly task sharing (networking) exercises by the existing PHLCs. LMG will also provide technical assistance to the PLD to establish a 3rd PHLC in either Khost or Takhar province.

#### Advisory and management support to the existing 17 PPHOs with the addition of three new provinces from HSSP

LMG will support 20 (17 plus three HSSP supported provinces) provinces through 20 assigned Provincial Health System Strengthening Advisors (PHSSA) to provide technical, managerial and

operational assistants to the PPHOs. The basis of the technical assistance will be the PPHO Core Functions, and provincial health governance.

#### Provincial Health System Assessment

On behalf of the MoPH Provincial Liaison Directorate (PLD), LMG will conduct, analyze and report a provincial health system assessment through a third party sub-contract. To develop a practical and effective Decentralization Strategy, it is crucial that information be collected regarding how provincial health systems are currently performing and what needs to be done to assist them in their transition to a more decentralized system where important decisions are made at province level rather than at central level. The MoPH needs to carefully assess the capacity of its provincial management teams from functional, service delivery and outcome perspectives.

To respond to this need, Tech-Serve assisted the MoPH to form a Working Group under the chairmanship of the Provincial Liaison Directorate to design such an assessment. The Working Group that comprised representatives from over ten different departments of MoPH officially started to work in January 2012 and within five consecutive meetings completed the design. LMG will contract out the assessment on behalf of the MoPH and will assist the MoPH in disseminating and using the study results in developing a Decentralization strategy.

#### Decentralization Strategy

LMG will work with the DG of Policy & Planning and other players (mainly the EU project) to develop a decentralization strategy with the MoPH. LMG will extend its support in this area through an international consultant to regularly provide technical inputs to the document either

#### Expected Outcomes

LMG will contribute to the development of leadership and management capacity of the central MOPH directors and managers so that greater accountability could be achieved. The PPHO core functions monitoring tool will be introduced as a national tool to regularly monitor the performances of PPHOs. A provincial health governance assessment tool will be developed and implemented. The provincial health governance assessment tool will include gender as part of its methodology. The PPHO teams will have learnt from the best practices and experiences of each other, and improved their performances through practicing Provincial Health Learning Center task sharing exercises. Performance of the PPHO core functions will have improved in 20 provinces through the provision of continuous technical assistance. The Provincial health system assessment will have been conducted and the PPHO capacity and needs in view of decentralization will have been clarified. In collaboration with other partners, LMG will have assisted the DG of Policy & Planning to develop a national decentralization strategy for the health sector.

### **6. *Activities to be transitioned from the HSSP Project***

#### In- Service Training (IST)

HSSP sponsored competency and non-competency trainings for the PCH NGOs in the 13 provinces. However, that role gradually changed after USAID and the MoPH GCMU modified NGO contracts and added a budget line for their training. Since then, HSSP has only focused on providing ToTs for the NGOs trainers whereas cascading of those training programs (the non-competency programs) have been carried out by the NGOs. The competency trainings have been sponsored by HSSP and primarily delivered by the group of trainers who are being certified by the MoPH (assisted by HSSP) as national trainers in five areas; Family Planning, Newborn care,

Infection prevention, Basic emergency Obstetric Care and Effective Teaching Skills (ETS). It is assumed that by the end of the HSSP project, that certification process will be completed. In addition, HSSP since mid-2011 had been tasked to complete an assessment of the DG of HR of the MoPH in managing and/or delivering in-service training. Based on the results of that assessment, a capacity building strategy is being developed by the MoPH with support from HSSP. It is assumed that the final draft of that strategy will be completed before HSSP ends in October 2012.

LMG will assist the GD of HR at the MoPH to establish an In-Service Training unit by hiring the necessary number of consultants seconded to the MoPH HR. All necessary material and LRPs developed under HSSP, will be transitioned to that unit. In addition, LMG will create a unit within the project that will be staffed by a program manager and possibly an officer, who together can support the MoPH based consultants to finalize and implement the In-service training strategy. LMG will also support the IST unit of the MoPH to work closely with the BPHS and EPHS NGOs and the GCMU to identify the in-service training needs of the NGOs staff. In addition, that unit will be supported to present a list of pre-qualified training institutions. However, the BPHS and EPHS implementing NGOs will have to take full responsibility for procuring their needed trainings. The IST unit will support the NGOs to approach the prequalified training institutions and/or the national MoPH certified trainers whenever they would need their services.

LMG will provide the necessary support to the MoPH to make sure the HSSP IST and CME databases are seamlessly transitioned to the MoPH and that necessary modifications are made into those databases.

#### Post-partum Hemorrhage (PPH) Prevention Program

HSSP has supported (technically and logistically) a PPH prevention program in 5 demonstration sites across the country. The study report for these demonstration sites is being gathered and is expected to be released and disseminated by HSSP, in July 2012.

Depending on results demonstrated by the study, LMG will advocate for the expansion of the PPH prevention programs (advocate for inclusion of PPH into the BPHS and of misoprostol into the Essential Drug List of the MoPH). LMG will work closely with the Community Based Health Care department and the Reproductive Health department of the MoPH to carry out such an advocacy. The Program manager for CBHC within LMG and a CBHC officer (both off-budget) will collaborate with the MoPH for this activity.

#### Technical support to the Nursing & Midwifery Education

##### ***Community Health Nursing Education***

In 2011, the Global Fund awarded 4 Community Health Nursing programs in Bamyan, Samangan, Nangarhar and Khost provinces. The contractor NGOs will be training 36 students in each of their batches for a period of 2 years. The graduates are expected to serve as community nurses in health clinics (not hospitals).

Upon request from the MoPH and GF, USAID funded a Faculty Development program through HSSP. HSSP developed the LRPs for the 4 programs and awarded a sub-agreement to Aga Khan Health Services (AKHS) to execute the faculty development and monitor the impact in a period of one year. It is anticipated that by the end of the HSSP project in October 2012, all 4 faculties will have received their semester 1 and 2 trainings from AKHS. In addition, HSSP will have finalized the draft of LRPs in 3 languages (English, Pashtu and Dari).

LMG through a team of 2-3 professional hired within the project will work with AKHS and the 4 CHNEs to finalize the LRPs based on the feedbacks received from the CHNEs. In addition, LMG through AKHS will complete the faculty development training for semesters 3 & 4 of the existing 4 CHNEs.

In order to respond to the governance need of the community based midwifery and nursing education programs, LMG will conduct a situation analysis to determine a viable and sustainable solution. Depending on the analysis, it may prove prudent for LMG to invest in the capacity building of the MoPH midwifery & nursing department and/or the Institute of Health Sciences. For this particular activity, the first 60-90 days of LMG will be used as an inception phase to determine the best way forward.

### ***The Afghanistan Nursing and Midwifery Council***

LMG will work with the MoPH and other partners including AMA to help establish the AMNC. Until AMNC is established, LMG will support the AMNEAB to pursue its functions as well as execute necessary reforms as stipulated in the new AMNEAB policy and SoPs.

### **Expected Outcomes**

By the end of LMG, the MoPH will have established a fully staffed and functional In-Service Training unit within its DG of HR. With support from LMG, the MoPH will have transitioned the HSSP IST and CME databases to the MoPH.

With support from LMG, the 4 current CHNEs will have completed their Faculty Development trainings. CHNEs LRPS will have been finalized and the additional 12 CHNEs will have received Faculty Development training. The AMNC will have been established assuming the GiRoA ministries and parliament endorse the necessary steps (e.g. and Act).

## **V. References**

Björkman M, Svensson J. 2009. Power to the People: Evidence from a Randomized Field Experiment on Community-Based Monitoring in Uganda. *The Quarterly Journal of Economics*, **124**(2), pp. 735-769.

Olafsdottir A, Reidpath D, Pokhrel S, Allotey P. 2011. Health systems performance in sub-Saharan Africa: governance, outcome and equity. *BMC Public Health*, **11**(1), pp. 237.

Rajkumar AS, Swaroop V. 2008. Public spending and outcomes: Does governance matter? *Journal of Development Economics*, **86**(1), pp. 96-111.