

## **Leadership Management and Governance/Afghanistan Trip Report: A. Frederick Hartman MD, MPH; December 4-19, 2013**

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The Leadership, Management and Governance (LMG) Afghanistan program 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 (MoE). The LMG Afghanistan program is an 18-month intervention starting in September 1, 2012 and extending to January 31, 2014. Total budget for the 18-month period is \$25,400,800. In collaboration with USAID-Kabul, LMG-Afghanistan has received an 8 month extension of the project, with associated additional funding of ~\$4 million for the additional months of activities.

Leadership, Management, Governance, Health Systems Strengthening, Ministry of Health, Afghanistan

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**Leadership Management and Governance/Afghanistan  
Trip Report  
A. Frederick Hartman MD MPH  
December 4-19, 2013**

**Background:** The Leadership, Management and Governance (LMG) Afghanistan program 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 (MoE). The LMG Afghanistan program is an 18-month intervention starting in September 1, 2012 and extending to January 31, 2014. Total budget for the 18-month period is \$25,400,800. In collaboration with USAID-Kabul, LMG-Afghanistan has received an 8 month extension of the project, with associated additional funding of ~\$4 million for the additional months of activities.

**Purpose of the Trip:** To support the LMG-Afghanistan team in determining major leadership communication and coordination gaps between the MoPH departments at the Directorate General level, and to make recommendations to strengthen the LMG program in the last year. The discussion below is organized according to the SOW outlined in the approved RFCC.

**Activities:**

**Report to the MSH Operations for a security in-brief upon arrival in Kabul.**

Completed, no adverse security events occurred during this visit.

**If requested, conduct an arrival briefing for USAID/Kabul.**

Completed on Wednesday, December 11, 2013. I attended a discussion on the LMG in-service training program, and we discussed my SOW with emphasis on the points discussed below.

**Study links for inter-departmental communication and coordination at the MoPH and provide guidance and support to address any gaps that are identified.**

Attached is a recently approved reorganization of the MOPH intended to strengthen coordination and communication. It establishes a Strategic Steering Committee that will meet three times a year to make policy decisions and 3 standing sub-committees: Policy, Planning and Technical Affairs; Health Care Service Provision; and Administration and Finance. Each sub-committee has a series of technical working groups (TWGs) and task forces that feed information and suggested policies, guidelines and programs to each sub-committee. As designed, this structure should improve both coordination and communication, and help the MOPH move away from the current “silo” configuration of the DGs. However, this structure will require considerable support from the LMG project to function effectively. The project works very effectively in the sub-committee and TWG/task force level, but needs to strengthen participation in the senior MOP levels of the sub-committees and steering committee. In a meeting with Dr. Ahmed Jan, Vice-

Minister for Technical Services, he voiced overall satisfaction with the support received from the LMG program, but also noted that it is difficult to “provide technical assistance from far away”, referring to the long distance and travel time between the MSH Kharte-se office and the MOPH. MSH at one time had an office in the MOPH and another office in Wazir Akhbar Khan to facilitate coordination and communication within the MOPH. MSH should re-open an office in the MOPH so that senior staff can spend more time in the MOPH to coordinate activities with the DGs, the department heads, and our multiple consultants to facilitate this transition. At a minimum, each LMG Program Manager should spend at least two full days in the MOPH, and Drs. Mubarak and Saleh should work out a schedule so one of them is in the MOPH every day. Dr. Saleh, as the Technical Director, should take the lead in the Central MOPH coordination and Communication efforts.

Another significant communication and coordination gap identified is between the PPHOs and the Central MOPH. In my discussions at both levels, central MOPH did not have a good appreciation of activities at the provincial level, and the PPHOs/PHAs complained of the same issue from the central level. The LMG PM for Provincial Strengthening, the consultants to the Provincial Liaison Directorate, and Dr. Saleh can work together to provide more effective two way communication between the provincial and senior MOPH levels to improve coordination of efforts in LMG-supported provinces. Improved use of the HMIS and data for decision making will improve communication and the abilities of the PPHOs to monitor and support the NGO service providers (see discussion below).

**Hold meetings with MoPH stakeholders to discuss mechanisms to institutionalize leadership, management, and governance capacity building at the MoPH, including the development of a leadership academy. This will include meetings with the Director General of Human Resources at the MoPH.**

The need for improved leadership, management and government practices is well recognized at all levels of the MOPH, from the Minister to the DG and Department level and in the provinces. The MOPH (and the GOA) want to improve accountability, transparency, efficient and effective management practices, and decrease corruption. LMG best practices are well known and respected in the MOPH to achieve these objectives, including the LDP, and the demand for more capacity building in LMG best practices was evident at all levels. Dr. Shahir, the DG for Human Resources, was the Provincial Health Officer in Bamyan Province during REACH and has worked very closely with all MSH projects since. He has a true success story. He reports that when he started as a PHO post Taliban, the health system was in such a disarray that he did not know what to do. However, the MSH provincial health strengthening and LDP programs provided him a structure for moving forward. He describes a “transformation” once he adopted the LDP best practices that stay with him today. As a result, he wants all MOPH staff at every level to experience that transformation and has established a Department for Management and Leadership within the DG of HR. He specifically requests that LMG use this department as a basis for expanding the LMG best practices to all levels of the MOPH. He understands this effort will take years, but in the next year he wants to plan for a “leadership academy”, based in the management and leadership department. The term “academy” should be used to mean a concept, not a building or an institution, and the planning for it can begin in the next 3 months. STTA from the LMG senior staff can work with the DG/HR and staff to develop the concept and next

steps, especially to plan for national expansion of in-service LMG training as part of the SEHAT project (see below discussion on the KMU)

**Hold meetings with partners, including Kabul Medical University, to discuss opportunities to incorporate leadership development into pre-service training curricula.**

We held a meeting with the Chancellor of the KMU and approximately 10 faculty members to discuss the LMG and the programs we offer. The Chancellor and his staff were very excited about strengthening the pre-service education of KMU students in all faculties in management and leadership practices. Most of the attendees at this meeting had participated in one (or more) LDP and other management and leadership training, and requested that more training be provided. The KMU, like the MOPH, is very interested in improving transparency, accountability, and more efficient and effective management of the resources available, and in training their faculty and students in LMG best practices. The meeting was remarkable because: 1. The KMU is entirely willing to revise their curriculum to ensure that all students receive some LMG training. In the past, the KMU has not been open to revising their curriculum to better serve the needs of the BPHS and EPHS; 2. The KMU has established a focal point and technical working group to improve leadership and management in their faculty and students; 3. The KMU is entirely willing to collaborate with the MOPH in this venture (a relatively new phenomenon since they did not show this willingness in years past); and 4. They embrace the “leadership academy” as a virtual concept with the participation of multiple institutions, including the MOPH, KMU faculties, the teaching hospitals they support and other affiliated institutions. As part of already scheduled LMG senior level project workshops, the KMU is entirely willing to participate to learn more and revise their curriculum. The LMG can support this effort by working with this established TWG to plan this effort, coordinating efforts with the MOPH, and providing a short workshop to KMU faculty to support these objectives during the forthcoming visit of Jim Rice, the Project Director of the LMG Global Project..

In this concept, the “leadership academy” would be a “virtual academy” with multiple participating institutions. The KMU and affiliated faculties and hospitals can provide pre-service training and the MOPH can provide in-service training in LMG at all levels. KMU can definitely be a partner in this effort, with the planning for the “leadership academy” to take place this next year and included as part of the SEHAT project for implementation in future years. This would be a natural extension of current LMG efforts, and require a minimal amount of resources to set the stage for expansion in future years using the SEHAT program. The overall objective is to improve accountability and efficient and effective management of resources within the health sector at all levels.

**Observe and report on changes in the health sector in Afghanistan since the REACH Project and make additional recommendations as needed in order to continue to strengthen leadership and management functions at the MoPH.**

The BPHS and EPHS were developed during the time of the REACH project and remain the foundation of the health system of Afghanistan. Both have been adjusted over time to meet the changing needs of the country, but the fundamental policies of expanding access to rural areas, women and children remain. Contracting out to NGOs for service implementation remains the

official policy, with the MOPH functioning as the steward of the system. Over time, more health systems have been developed to support both the BPHS and the EPHS, key among them being the CBHC program, Provincial Health Strengthening, Hospital Autonomy, Quality Improvement, Pharmacy Management, Communicable Disease Control (especially TB and malaria), HMIS and Financial Management. However, the systems overall remain “works in progress” and are in various stages of development at provincial, district, facility and community levels. Thus, health systems strengthening remains the biggest challenge for the future and will need to continue after the LMG program ends. The leadership academy discussed above, and the establishment of an MSH office in the MOPH with a more active presence, will strengthen these efforts in the last year of the project.

The most significant change observed has been the incredible growth in technical capacity over the years of MOPH staff, and their ability for health program development is much improved. After 12 years of USAID-financed health projects implemented by MSH, and other partners, nearly all staff have participated in major health system strengthening activities. Nearly all staff at both Central and Provincial levels now have MPHs and have studied abroad, and many participate regularly in international technical meetings and workshops. Thus, the overall technical quality of the MOPH staff is very high. However, as noted in the discussion above on the leadership “academy”, coordination, communication and management and leadership practices remain relatively undeveloped compared to technical skills.

Another major change has been the explosive growth of MOPH on-budget consultants supported by international donors; nearly 800 exist currently. Senior MOPH staff have expressed concern about their ability to absorb this many consultants (Drs. Dalil, Ahmed Jan and Shahir) and Dr. Shahir’s analysis shows that only 450 of them can be used through the CBHR and SEHAT mechanism. There was much discussion in my visits with MOPH officials about strengthening the stewardship role of the MOPH and decreasing the implementation role of the consultants. LMG “best practices” are seen as critical to strengthening the stewardship role and need to be expanded (discussed above), but the LMG also should consider decreasing the number of consultants the project is supporting within the MOPH. LMG needs to develop a close-out plan in the next 3 months that will phase out many of the consultants to a much smaller number by the EOP that can be more easily absorbed by the MOPH as they shift to a stronger stewardship role. We recognize the sensitivity of this issue, and the political nature of this recommendation. To facilitate this, it would be useful to have HR STTA in the next 3 months to: 1. Work with the GD of HR and the EPOS staff that are finalizing an HR mapping exercise within the MOPH to analyze the overall MOPH structure and the role and number of consultants needed in high priority areas, and 2, Analyze the LMG MOPH consultants, establishing performance standards and priority technical areas for selecting consultants who will remain consistent with the mapping exercise, contributing to the downsizing of the MOPH consultants to the 450 they feel they can absorb effectively. These two activities may be completed by one consultant in the next 3 months as the LMG phase out plan is developed.

Another change is the relative weakness of an effective NGO capacity strengthening function within the MOPH. LMG is working to strengthen the in-service training department to assume some of this role, and the GCMU can be strengthened as well in their capacity to support the contacting out process. However, it is clear that central MOPH management of NGO capacity building in the field is inherently weak, and this function needs to be strengthened as

part of the provincial stewardship role. The PPHOs visited expressed concern that they do not have a direct accountability relationship with the NGOs, and would like to work more directly with them on supervision and performance improvement. More effective use of the HMIS can simplify this task, eg, better use of an NGO scorecard using key indicators developed every quarter using the HMIS can be easily used to compare provincial and NGO performance. The project and PHOs can thus identify strong performers (positive deviants) and weak performers, and focus both provincial and in-service training efforts on the weak performers. Using the HMIS more effectively to strengthen the PPHO stewardship role can be easily achieved in the life of the LMG (see attachment), but strengthening the stewardship role of the PPHOs in NGO capacity building and effectiveness of the MOPH in NGO capacity building will need to await the follow-on projects. STTA to the LMG M&E team to improve the use of data for decision making and evidence based approaches would be useful over the next year. The HMIS is already developed enough to generate the evidence and answer questions of the PHOs and central MOPH, we need to develop the templates and formats for the data analysis. In addition, the GCMU has requested some support in design and implementation of the next phase of their sub-contracts after I delivered a workshop on performance-based contracting in S. Sudan that is based on our experience in Afghanistan (see discussion below on technical seminar delivered).

**Hold discussions with the MoPH leadership and provide guidance on the feasibility and challenges for the implementation of recent Health Retreat recommendations.**

This section will only address the recommendations pertinent to the LMG SOW. The Health Retreat recommendations are quite extensive.

**R1: Increase and enhance provision of BPHS by 5% giving strong emphasis on quality, equity, access, utilization and local community involvement.**

**The WGs and plenary discussions about the quality improvement of health care services highlighted the following:**

- **Better use of existing data including Balanced Score Cards (BSC) may improve monitoring of the quality of health services;**

The balanced scorecard is an excellent performance monitoring tool that allows easy comparison between NGOs implementing the BPHs, and motivates NGOs to improve performance with support from their country offices and the GCMU. However, it has some limitations: 1. It requires a national household survey to produce, which is both expensive and time consuming, and 2. The last survey was completed in 2012. JHU, the implementer, has finished its contract, and a new one will not be awarded until 2014. With a one year lag for implementation, there will be a 3 year hiatus in the BSC production. We suggest a simplified NGO scorecard using selected key indicators from the BPHS performance of the NGOs and provinces (which may contain more than one NGO implementer), developed from the HMIS, and reviewed quarterly by the LMG project, the GCMU and the PPHO. The original concept was developed in the REACH project, traveled to S. Sudan and was the subject of my presentation to the LMG and GCMU staffs, and now has returned here for a suggested and simple monitoring tool (see the discussion above on PHO stewardship and Annex C for an example). Implementation of this recommendation, and use of the data analysis, will require additional STTA trips over the next year due to the resignation of the LMG HMIS advisor.

Some long distance STTA with the M&E and PLD staff in the interim will help move this along.

- **More robust supportive supervision, monitoring and follow-up mechanisms should be in place;**

This should be strengthened at the provincial level, where joint supervision visits occur monthly, rather than the quarterly GCMU supervisory visits. The quarterly GCMU visits are still needed, but need to be done together with their PHO counterparts. Our PHAs and PLD staff can reinforce this effort.

- **The contracts with NGOs and implementing partners should be reviewed and revised with focus on the quality;**

This can be an outcome of the NGO scorecard evaluations triggering both supervisory visits and in-service training. If desired, the NGO scorecard can also be directly linked to payments to the NGOs, thus stimulating improved access and quality. Integration of the standards based management approach into the next rounds of sub-contracts under SEHAT will improve quality. The PHOs complain that they are not involved in the centrally managed quality improvement activities, and only receive a report from GCMU after the QI activities are completed and action taken. We need to work towards transferring QI activities, including any follow up actions, to the provincial level where more direct performance improvement actions can be taken.

- **Some aspect of administrative procedures including delayed allocation of funds and payments should be addressed by the MoPH.** One of the suggestions was to develop a payment manual for the contractors, NGOs and implementing partners.

The GCMU is working on this issue, it is my understanding that it has improved.

- **Rely more on community-based interventions (e.g. community midwifery program, family health house programme, etc.) in order to enhance use of outreach services, as well as contracting of private health care facilities, demand-side financing (e.g. cash transfer to beneficiaries) and some other measures.**

This recommendation is being implemented well. We spent half a day with DR. Arwal, the Director of the CBHC unit. He is very proud of the achievements of his unit and gives full credit to the 3 USAID-Funded projects implemented by MSH—REACH, TECH-Serve, and LMG, for supporting the development of the CBHC system. Afghanistan now has 28,000 CHWs (50%) female; 3000 community midwives; 16,000 trained community health shuras; and is developing a new cadre of community health supervisors and the community nurse, both support by LMG. The CBHC program is very strong and now accounts for 66% of all FP visits and 90% of all TB DOTS in the country. However, continued support by both the BPHS implementers and the LMG project is required to continue the impressive gains made by this component. MSH can support the MOPH to develop demand-side financing, if desired, through our extensive health financing unit and staff, but that is something we are not now implementing.

**R2: Increase and enhance provision of EPHS by 5% giving strong emphasis on quality, equity, access, utilization and local community involvement. The recommendations here are the same as for the BPHS, but focused on strengthening the EPHS.**

- **Better use of existing data including BSC may improve monitoring of the quality of health services;**

See above discussion on the NGO scorecard, which can be developed for both central and provincial hospitals.

- **More robust supportive supervision, monitoring and follow-up mechanisms should be in place;**

LMG supports joint hospital joint supportive supervision through the Hospital Autonomy Program Manager and staff. By all reports, this component is proceeding well. NGOs and the GCMU conduct joint supervision to provincial hospitals supported through the PPH process. As described above, this function can be transferred to the PHOs

- **The contracts with NGOs and implementing partners should be reviewed and revised to emphasize more focus on the quality;**

Standards have been developed for implementation of the EPHS, which easily translate into a standards-based management performance quality improvement project. The SBM approach to hospital management can be easily implemented, but since LMG does not work at the provincial level, we are not following this activity at that level. We provide direct support to central hospitals in the implementation of the standards developed for central hospitals. A hospital management workshop is scheduled for February, provided by JHU, and will focus on QI activities, among other technical activities.

- **Some aspect of administrative procedures including delayed payments should be addressed by the MoPH, and one of the suggestions was to develop a payment manual for the contractors and other stakeholders who are related to the budget execution.**

As before, this is not part of our current SOW, we can address this issue, if desired, using staff from our health financing unit.

**R3: Conduct assessment of hospital management in order to determine the appropriate mechanisms for decentralization of hospitals across the county;**

- **Decentralize management of human resources and procurement in order to improve efficiency, effectiveness and enable development of hospital management in Afghanistan.**

The LMG Hospital Autonomy unit is doing exactly this, and has received good reviews from the MOPH. Much development work, in-service training, and follow-up mentorship and supervision is being done at Central Hospitals (see above discussion on the leadership “academy”. In February, the LMG will implement hospital management training for hospital managers with the support of faculty from JHU. The curriculum is being developed now by JHU faculty in conjunction with LMG staff.

**R4: Assessment of existing EPHS provider payment mechanisms; This activity is not a part of the LMG SOW, but as noted above, we can implement this recommendation if requested.**

- **Shift towards more performance-based payment models;**
- **Introduction of user fees with partial subsidy from development partners.**

Some hospitals are already implementing this recommendation as part of the hospital autonomy component. This natural field experience is being closely monitored to develop lessons learned for other hospitals and expansion if warranted.

#### ***Private Health Service Delivery***

***Private Public Partnership*** recommendations are as follows: This is included in the SOW of another USAID-funded project implemented by Futures.

**R11: Support the development of an independent accreditation body for quality assurance and continuous quality improvement of health care services;**

MSH has worked with the DG of Hospitals in the MMOPH to develop a standards-based management approach to accreditation. We are currently working with the DG to apply this process to central levels and develop standards for central hospitals. This process will be further explored and discussed during the forthcoming hospital management workshop in February, 2014.

#### ***Aid Coordination & SWAp***

**R12: Institutionalization of MoPH coordination structure in order to assure joint MoPH and donors/DPs planning, monitoring and review of programmes and projects;**

As noted above, the MOPH had developed a new coordination structure that looks promising. The LMG senior technical staff need to spend more time in the MOPH working with the structure and attending coordination meetings to support this effort. An office within the MOPH will facilitate this effort. Other donors will attend these coordination meetings as well, affording the opportunity to exchange experiences and conduct joint planning on program activities with the MOPH>

**Pharmaceuticals:** This component is managed by SPS, with coordination with LMG. The retreat discussion underlined the necessity to build a comprehensive, integrated and highly regulated management model covering, both, pharmaceuticals and medical devices, including system monitoring, accreditation of suppliers and other important quality issues. The management model should include a dynamic pharmaceuticals and medical devices' registration followed by step-wise approach to pricing policy with special focus on building the management information system. The speakers underlined the importance of capacity building and training of community pharmacist as well. The expected results are outlined before, but any discussion of these desired results will be with SPS.

**R16: Review and revise regulations and supply management systems pertinent to the narcotics and under control products;**

**R17: Develop a system for regulation and registration of medical devices;**

**R18: Establish a system for implementation of regular surveillances and operational pharmaceutical research including:**

- **Upgrading of Medicines Information System;**
- **Strengthening of Medicine Information Center;**
- **Strengthening research in pharmacy sector;**
- **Enhancing capacity for control of advertisement of pharmaceuticals.**

#### ***Human Resources (HR)***

**R19: Review HR Strategy and Workforce Plan; see below**

**R20: Mapping of HR processes and streamlining HR services; Development of HR processes flowchart (recruitment, complains, etc.) and streamlining of some HR services in order to avoid duplication in functions/services.**

As noted above, Dr. Shahir, DG of HR, is highly interested to map out these processes, develop flow charts, and revise the structure of the MOPH as needed. He wants to particularly prioritize the number and type of consultants to reduce the number from 800 to 450, which he feels the MOPH can manage effectively. EPOS is currently completing this HR mapping exercise and the results will be available early next year. This HR mapping will guide all our efforts in support HR development. We also suggest STTA to work specifically with the team of MSH on-budget consultants with the objective to prioritize and simplify them, in line with the MOPH desire to reduce the number overall of consultants.

**R21: Capacity building program for the health sector female workers in order to provide an opportunity for their more significant role in the health sector key areas.**

MSH has a 12 year history of developing and strengthening the female work force in Afghanistan, Beginning with < 100 certified midwives in Afghanistan in 2000, there are now 3000 available, at least one in every CHC in Afghamistan. In addition, a small army of female CHWs (14,000) have been trained using the curriculum and training strategy that MSH helped

the MOPH develop. New cadres of female health workers—community health supervisors and community health nurses—are being developed with LMG support. But, more needs to be done. LMG needs to update its gender strategy for all levels, with a specific focus on increasing the number of female health workers. We suggest sub-contracting with staff of the Afghan Midwives Association, who understand both gender and female work force issues.

*Procurement of goods and services*

**R22: Streamline, simplify and make more transparent the procurement process;**

This is happening within central hospitals as part of the Hospital Autonomy program, and needs to continue and be strengthened. By all reports, this is a successful activity as each hospital involved in the program can now procure their own supplies and equipment independently.

**R23: SOP and guidelines for implementing procurement law;** see above for hospitals only, but his can serve as a model for other health facilities.

**R24: Establishment of an e-procurement system; see above**

**R25: Decentralization of procurement functions among the units; see above**

**R26: Build capacities within the MoPH for procurement of goods (pharmaceuticals, equipment, etc.)** see above. However, we are not providing general procurement support to the MOPH, except in pharmaceuticals through SPS.

**Lead a technical seminar for the MSH-Afghanistan team on a topic relevant to work in Afghanistan.**

On Monday, December 9, I lead a technical seminar entitled “Outcomes of a Performance-based Contracting Strategy in S. Sudan”, originally presented to the APHA meeting in Boston, MA, on November 5, 2013. The seminar showed how the technical approaches towards PBC in Afghanistan were successfully implemented in S. Sudan for contracting out services to NGOs to implement the Basic Package of Health and Nutrition Services (BPHNS) in all 10 states of the ROSS. This seminar was so successful, by request it was also repeated within the MOPH, hosted by the GCMU, on Tuesday, December 17. The resulting stimulating discussions about the success of the PBC approach and its adaptability to many post-conflict settings in compressing the time needed to achieve dramatic gains in service coverage were very engaging, eg, in S. Sudan we were able to increase DPT3 coverage for < 1 from 18% to 86% in just two years in project areas. The GCMU had many questions, especially as they are moving towards a more focused PBC approach in the future, and requested some technical support in this effort. I am happy to help them, both long distance and during any subsequent technical assistance visits over the next year. A copy of the presentation was shared with all participants and is included as an annex.

**Summary of Recommendations:**

1. Establish an office in (or near) the MOPH for senior MSH staff so that they increase visibility and involvement in the newly established MOPH Coordination Structure. The center of LMG technical activities needs to be the MOPH:

- The Technical Director/DCOP should lead this effort and be present in the MOPH at least 3 days a week;
  - The COP can be available as needed to attend the senior coordination meetings, but should focus on overall project management so that the TD/DCOP can focus on technical development within the senior levels of the MOPH;
  - Program Managers should spend 2-3 days each in the MOPH and use the MSH office as a base on those days rather than travel back to the Kharte Se office. Those technical components that are located in other facilities, eg, the hospital autonomy component, can continue to function in those facilities.
  - Continue to function very effectively as before in the sub-committees and TWGs through Program Managers and consultants.
  - Additional technical and management support needs to be provided to the COP for program management tasks, so the TD/DCOP can function more effectively as the TD within the MOPH and associated institutions,
  - Focus on improving the coordination and communication amongst provincial levels and central levels within the MOPH, with the objective to support shifting accountability for supervision and performance monitoring of implementing partners to the provincial levels. More effective use of data for decision making and the development of simple monitoring tools using the HMIS will facilitate this process (Annex C).
2. A natural extension of current LMG “best practices” and technical activities is the development of a leadership “academy”. This academy is envisioned as a virtual “academy”, without a specific building or headquarters but rather trained staff and training curricula located in several institutions.
- The DG of HR within the MOPH is a “champion” of the LDP and has established a Leadership and Management Department within his DG to serve as the focal point of in-service LMG development within the MOPH. Within the virtual leadership “academy”, the MOPH will have the responsibility for in-service LMG development with support from the LMG project.
  - The Kabul Medical University wants to improve the pre-service training of students in their various faculties (medicine, nursing, laboratory and allied health professions) on management and leadership best practices, and is willing to adjust their curriculum with LMG support.
  - LMG to support a TWG for LMG development that includes representatives of both institutions, plan and hold a joint workshop to plan the next steps, and the LMG can support the initial efforts and plans for wider expansion in the future with SEHAT funding.
  - The MSH virtual LDP will be an important part of this “academy” as it will allow distance learning for a much wider group of participants in the LDP.
3. Changes within the MOPH observed since the REACH project are highly significant:
- The significant growth in technical capacity of MOPH staff is very positive. Most MOPH staff now have an MPH, many have studied abroad, and most travel to regional and international conferences. This means that MOPH staff may have

a technical capacity that exceeds our own staff, and this has created some tension within our staff who want additional training. Unfortunately, given the short time remaining in the project, all staff training will need to be in-service, mostly through STTA and other technical activities within the MOPH.

- The rapid growth of “on-budget” consultants within the past 5 years has changed the landscape of the MOPH. This has produced some real technical growth, but has also overloaded the MOPH, eg, the DG of HR estimates the MOPH can only absorb 450 of the current 800 consultants. The Minister and the Deputy Minister for Technical Services expressed a similar concern, so this is a major issue.
  - Since the LMG is ending in 10 months, the project needs to develop a close out plan that takes us to the EOP in Oct., 2014. LMG needs to make strategic use of the close out plan, use it to focus all technical components on those critical activities that will produce the biggest impact and achieve the required deliverables. In addition, an analysis of the 150 MSH consultants needs to be completed, coordinated with the EPOS HR mapping study, to develop a phase out plan for these consultants, since they cannot all be absorbed into the follow on programs. This will be a controversial and politically sensitive activity, but we need to support the MOPH’s desire to reduce the consultants to a more manageable number.
  - A related recommendation is to help the MOPH reform its technical approach to focus more on the stewardship role and not so much on implementation.
  - Compared to technical skills, LMG skills are relatively undeveloped within MOPH staff at all levels. With the increased emphasis on accountability, transparency, stewardship, and efficient and effective management of resources, the LMG project needs to significantly expand development of LMG best practices. A virtual “leadership academy” is viewed by all people interviewed as a needed next step (see discussion above).
  - The LMG M&E functions can be strengthened to improve the stewardship role, developing tools to improve data-for-decision making at all levels. This could include a simple “NGO scorecard” developed from the HMIS for use at program and provincial levels, and other simple tools that do not require expensive and time consuming surveys to complete (see Annex C). Since the LMG HMIS advisor is leaving at the end of 2013, this effort will require periodic STTA for implementation, working together with local program staff.
4. Health Retreat Recommendations: This is a very long list of recommendations and will not be re-listed here. The reader is referred to that section for the highlights.
  5. The technical seminar entitled “Outcomes of a Performance-based Contracting Strategy in S. Sudan, originally delivered by me at the APHA Annual Meeting in Boston, MA, on Nov. 5, 2013, was a big hit in both MSH and in the GCMU. The GCMU has requested ongoing technical assistance in planning their next round of performance contracts to be awarded in 2014, which I will be happy to do on any scheduled re-visit.

**List of Annexes:** List attachments to the report. Minimally, the following should be listed (and attached):

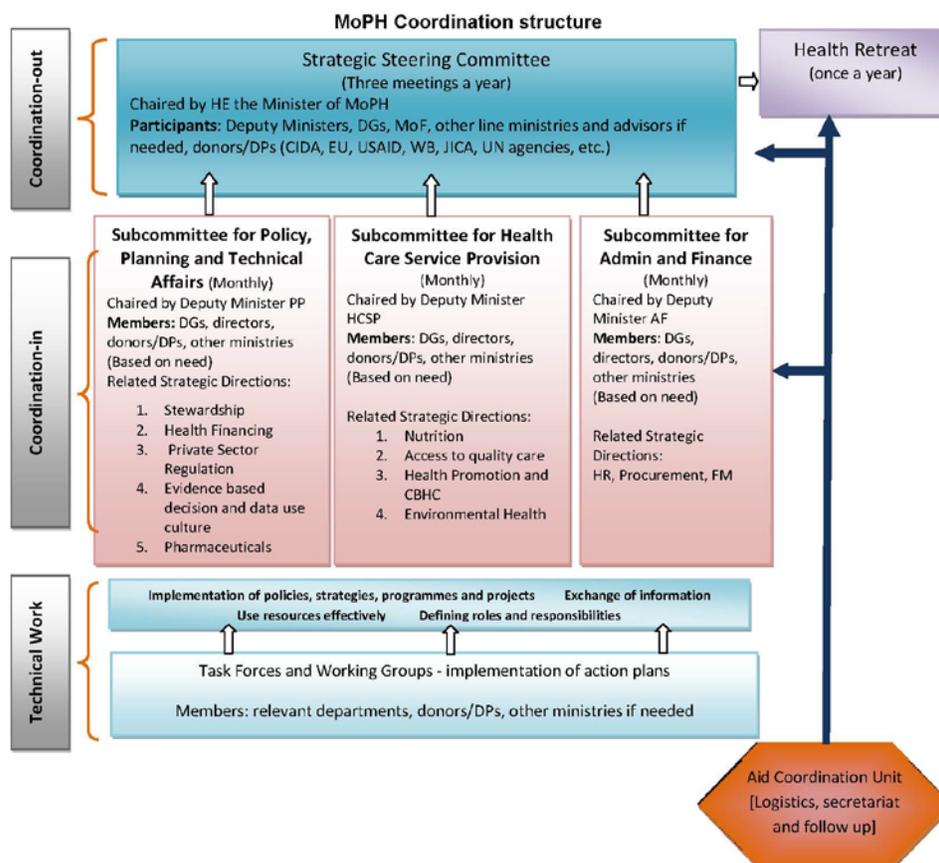
- Deliverables;
  - This trip report
  - Technical Seminar, “Outcome of a Performance-based Contracting Strategy in S. Sudan”, original presented at the APHA National Meeting in Boston, MA, November 5, 2013. Presented to MSH (Monday, Dec. 9) and GCMU (Tuesday, Dec. 17) staff
- List of Persons Met;
  - Afghanistan LMG Trip Report—A. Frederick Hartman MD MPH
    - Annex A List of People Met

*• List of people met*

<b>Name of person met</b>	<b>Title</b>	<b>Email address</b>
Dr. Mubarak Mubarakshah	CoP/Project Director LMG AF	<a href="mailto:mmubarak@msh.org">mmubarak@msh.org</a>
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Dr. Richard Pepulcorn	WHO Representative	
Dr. Sayeed	World Bank Health Specialist	
Dr. Zawoof	World Bank Health Specialist	
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Christina Lau	USAID-Kabul, Health and Development Officer	<a href="mailto:clau@state.gov">clau@state.gov</a>
Dr. Mohammed Rashidi	MSH-Afghanistan Country Representative	<a href="mailto:mrashidi@msh.org">mrashidi@msh.org</a>
Prof. Dr. Shirinaqa Zarif	Chancellor, Kabul Medical University	Zarif1500@gmail.com

Dr. Alborz (and others)	Former Dean of SPH. Kabul Med. U.	
Dr. Rashid	PHO, Herat Province	
16 members	PPHO team, Herat Province	
Leadership Team	World Vision, Herat Province	
Dr. Sayeed Hamedi	Medical Coordinatr, Danish Afghanistan Medical Mission, Herat	medical@afghan.dk
Dr. Said Habib Arwal	MOPH/CBHC National Coordinator	saidhabiba@gmail.com
Dr. Daoud	Health Program Manager	Aga Khan Foundation
Mursal Musawi	Executive Director, Organization of Afghan Midwives	mmusawi@gmail.com
Pashtoon Azfar	Regional Midwife Advisor/Asia	icmasfar@gmail.com

- Annex B MOPH Reorganization



Annex C—Sample of NGO Scorecard. Can be organized by donor, province or NGO

Donor	Indicators	Q1	Q2
		Proportions	Proportion
	Children <1 year received PENTA3 vaccine	1.314002	1.19475
	Number of pneumonnia in the under 5 years		
	Percentage of BPHS and EPHS facilities with at least one Female Health Worker	71.65775	
	Total First Ante-Natal Care	0.988453	0.973593
	Total first Post-Natal Care	0.745857	0.76753
	Total home deliveries by clinic staff	0.02138	0.022691
EC	Total Institutional Deliveries	0.5145	0.559843