

Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve) Final Report

Management Sciences for Health (MSH)

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Technical Support to the Central and Provincial Ministry of Public Health Project (Tech-Serve)

Final Report

July 2006 – August 2012



Tech-Serve, a USAID-funded Associate Award through the Leadership, Management and Sustainability Program, is implemented by Management Sciences for Health in partnership with the Afghanistan Ministry of Public Health.



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Cover photo: This picture depicts a female surveyor interviewing a woman in Takhar province for the LQAS Household Survey. One health worker in Takhar stated that the results “...helped us to see whether our planned interventions were helpful or not. What other alternatives should be considered and what to be focused and where. It helped us to plan our future interventions.” MSH has supported the implementation of the household survey in Afghanistan since 2007 as a mechanism for self-assessment by contracted non-governmental health care providers at local levels, the results of which are used for strengthening capacities and improving performance at the individual, facility, and organizational level.

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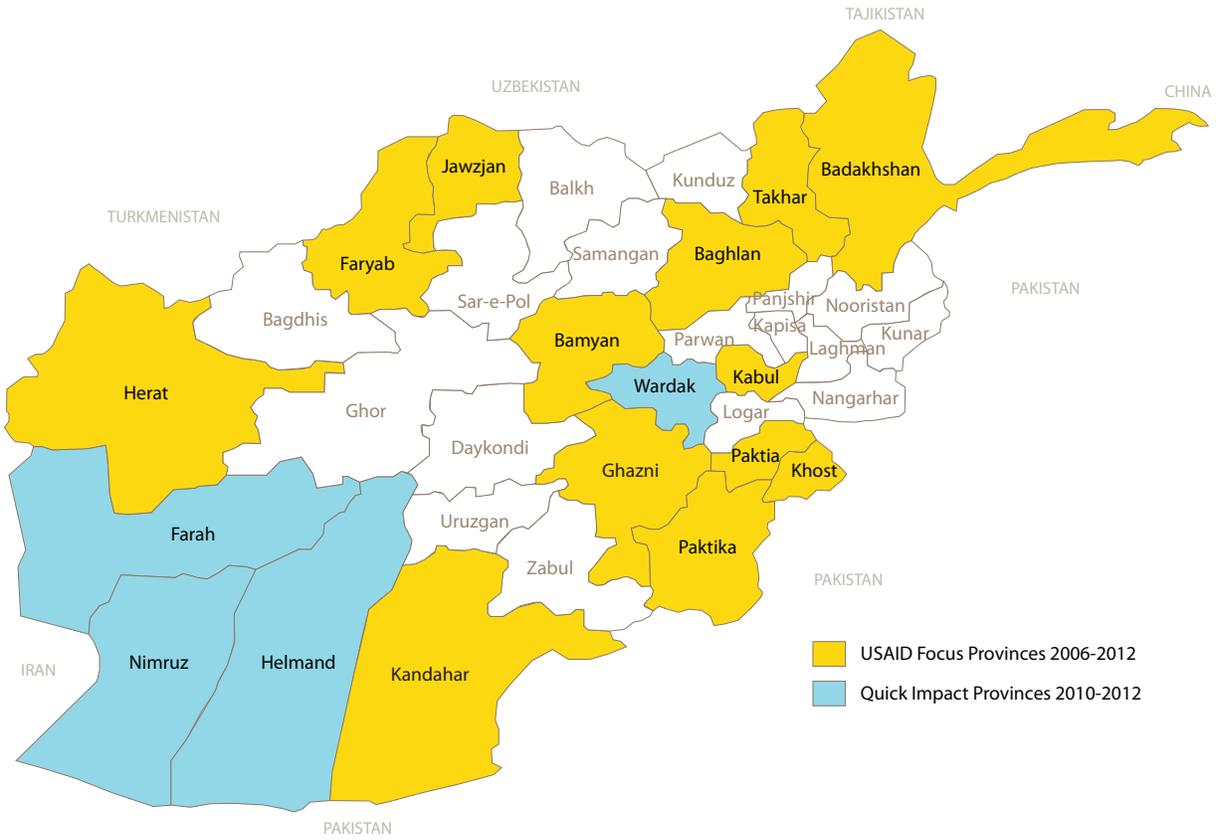
Acronyms

ACUP	Accelerating Contraceptive Use Project
AKHS	Aga Khan Health Service
AMA	Afghan Midwives Association
ANBB	Afghan National Blood Bank
ANC	Ante Natal Care
ANDS	Afghanistan National Development Strategy
ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
BESST	Building Education Support Systems for Teachers
BHC	Basic Health Center
BPHS	Basic Package of Health Services
BRAC	formerly Bangladesh Rural Advancement Committee
CAAC	Catchment Area Annual Census
CBE	Community-Based Education
CBHC	Community-Based Health Care
CCB	Central Capacity-Building program of MoPH
CCM	Country Coordinating Mechanism
CDC	Communicable Disease Control
CERP	Commander's Emergency Response Program
CGHN	Consultative Group for Health and Nutrition
CHA	Child and Adolescent Health
CHC	Comprehensive Health Center
CHIS	Comprehensive Health Information System
CHS	Community Health Supervisor
CHW	Community Health Worker
CLTS	Community-Led Total Sanitation
CME	Community Midwifery Education
COTR	Contract Officer's Technical Representative
CSO	Central Statistics Organization
DAC	Development Assistance Committee
DEWS	Disease Early Warning System
DGWG	Decentralization & Governance Working Group
EPHS	Essential Package of Health Services
HR	Human Resources
HSS	Health Systems Strengthening
HSSP	Health Services Support Project
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Person
IGICH	Indira Gandhi Institute of Child Health

IL	Implementation Letter
IMAT	Inventory Management Assessment Tool
IMC	International Medical Corps
IMCC	Inter-Ministerial Coordination Committee
IMCI	Integrated Management of Childhood Illness
IMF	International Military Forces
IP	Infection Prevention
IQHC	Improving Quality of Health Care
IRs	Intermediate Results
LDP	Leadership Development Program
LQAS	Lot Quality Assurance Sampling
M&L	Management & Leadership
MCH	Maternal/Child Health
MDGs	Millennium Development Goals
MNCH	Maternal, Newborn, and Child Health
MOE	Ministry of Education
MoF	Ministry of Finance
MoHE	Ministry of Higher Education
MoPH	Ministry of Public Health
MOST	Management Organization Sustainability Tool
MoU	Memorandum of Understanding
MoWA	Ministry of Women's Affairs
MPH	Masters of Public Health
MRRD	Ministry of Rural Rehabilitation and Development
MSH	Management Sciences for Health
NGO	Nongovernmental organization
NMC	National Monitoring Checklist
NPP	National Priority Programs
OIG	Office of Inspector General
PHI	Public Health Institute
PHLC	Provincial Health Learning Center
PHO	Provincial Health Office
PHOs	Provincial Health Officers
PLD	Provincial Liaison Directorate
PMP	Performance Monitoring Plan
PMT	Project Management Team (of the MOE)
PMU	Project Management Unit (of the MOE)
PNC	Post Natal Care
PPFP	Postpartum Family Planning
PPG	Performance-based Partnership Grants

PPH	Provincial Public Health
PPHCC	Provincial Public Health Coordination Committee
PPHD	Provincial Public Health Directorate
PPHO	Provincial Public Health Office
PPP	Public Private Partnership
PR	Public Relations
PRD	Public Relations Directorate
PRIS	Pharmaceutical Registration System
PRT	Provincial Reconstruction Team
PSM	Pharmaceutical Supply Management
PY	Project Year
QI	Quick Impact
QIPs	Quick Impact Provinces
RBF	Result Based Financing (World Bank Project)
REACH	Rural Expansion of Afghanistan's Community-based Healthcare (Project)
RH	Reproductive Health
RHO	Reproductive Health Officer
RMU	Rational Medicine Use
SBM	Standards-Based Management
SPS	Strengthening Pharmaceutical Systems
STTA	Short term technical advisor
SUFP	Scaling up Family Planning
SWSS	Sustainable Water Supply & Sanitation Project
TA	Technical Assistance
TAG	Technical Advisory Group
TB	Tuberculosis
TB CAP	Tuberculosis Control Assistance Program
TBIS	Tuberculosis Information System
ToR	Terms of Reference
ToT	Training of the Trainers
UNHAS	United Nations Humanitarian Air Services
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Develop.
WAKH	Wazir Akbar Khan Hospital
WB	World Bank
WHO	World Health Organization
YHDO	Youth Health Development Organization

Figure 1. Map of USAID and Quick Impact supported provinces in Afghanistan



EXECUTIVE SUMMARY

Introduction

Ten years ago, after two decades of war and the fall of the Taliban, Afghanistan suffered some of the world's worst health indicators, including a maternal mortality ratio of 1,600 per 100,000 live births and an infant mortality rate of 165 per 1,000 live births. To reverse this decline, the Ministry of Public Health (MoPH), has been working with donors and partners, to provide basic health services, essential hospital services, and support non-governmental organization (NGO) service providers.

The U.S. Agency for International Development (USAID) is the largest provider of bilateral civilian assistance to Afghanistan, and has been investing in the health and education of the country's people, in partnership with the Afghan Government, for decades. In July 2006, USAID launched the Technical Support to the Central and Provincial Ministry of Public Health project, referred to hereafter as Tech-Serve, as its flagship initiative in support of the health sector in Afghanistan. Tech-Serve is a \$100.6 million, six-year Associate Cooperative Agreement¹ awarded to Management Sciences for Health (MSH), under the Leadership, Management and Sustainability (LMS) Leader with Associate Cooperative Agreement No. GPO-A-00-05-00024-00. The vision of the Tech-Serve project was a Ministry of Public Health (MoPH) that is able, at all levels, to improve the health of the people of Afghanistan through a quality, sustainable and equitable health system. The project's four intermediate results included:

1. Improved capacity of the Central MoPH to support the delivery of a Basic Package of Health Services (BPHS) and an Essential Package of Health Services (EPHS), primarily through NGO service providers.
2. Improved capacity of the MoPH Provincial Health Offices in the 13 USAID-funded Provinces and 4 Quick Impact Provinces supported to deliver BPHS and EPHS.
3. Developed planning, management, supervision, monitoring and evaluation, and leadership capacity of the MoPH.
4. Strengthened capacity of the Ministry of Education to plan, manage and account for USG on-budget resources.

1 Tech-Serve's period of performance is from June 1, 2006 to August 31, 2012 and its reference number is 306-A-00-06-00522-00.

Improving the Health of the Afghan people

Over the life of the Tech-Serve project, the number of patients served at USAID-funded health facilities per year has increased from 7.6 million in 2006 to 20.4 million at the end of 2011. This and Tech-Serve's other interventions have contributed to improvements in the delivery of health services and outcomes in Afghanistan, as seen by the gradual and sustained improvements in family planning and reproductive health, the number of facilities with at least one female health worker, increased patient visits to health facilities, and mortality rates. In 2011/2012, a wealth of data from a number of surveys, including the Afghanistan Mortality Survey, the Household Survey and the Multiple Indicator Cluster Survey, became available. Results from all surveys show improvements of health status in Afghanistan that are often higher than expected, considering the challenging security environment in so many areas of the country that contributed to increased geographic isolation and migration to provincial centers. The evidence attests that the health of the population – through the collaborative efforts of donors, technical agencies, projects such as Tech-Serve, and the MoPH – is continuing to improve. For instance:

- The life expectancy for women rose from 45 years in 2003 to 62-64 years in 2010.²
- The total fertility rate decreased from 6.27 in 2008 to 5.1 in 2010.³
- The under 5 years mortality rate (per 1,000 live births) decreased from 161 in 2008 to 97 in 2010.⁴
- The Contraceptive Prevalence Rate nationwide increased from 15.2% in 2008 to 21% in 2011.⁵
- The Maternal Mortality Ratio (per 100,000 live births) decreased from 1,600 in 2002 to 327 in 2010.⁶

Key Results of the Tech-Serve Project

This final report for the Tech-Serve project documents the achievements and results of six years of intense activity. Results are presented to map with the project's four intermediate result areas. Select results, highlighted briefly here, are as follows:

2 2003 source: Population Reference Bureau (PRB); 2010 source: Afghanistan Mortality Survey (AMS)

3 2008 source: National Risk and Vulnerability Assessment (NRVA); 2010 source, AMS

4 2008 source: NRVA; 2010 source, Afghan Mortality Survey (AMS)

5 2008 source: NRVA; 2011 source: Multiple Indicator Cluster Survey (MICS)

6 2002 source: Reproductive Age Mortality Survey (RAMOS); 2010 source: AMS

IR1: Improved capacity of the Central Ministry of Public Health to support the delivery of Basic Package of Health Services and Essential Package of Hospital Services, primarily through NGO service providers

- Tech-Serve strengthened the capacity of the Partnership Contracts for Health Services (PCH) unit based in the Grants and Contract Management Unit (GCMU) of the Ministry of Public Health so that it is a stand-alone entity, now on-budget,⁷ needing virtually no outside technical assistance for its chief functions of procurement, monitoring, management of NGO awarded contracts at a rate of over \$40 million annually, and doing this while maintaining financial accountability and USG certification.
- The MoPH's community-based Family Planning Program has been scaled up. Surveys conducted in 13 USAID-supported provinces indicate an increase in the contraceptive prevalence rate (CPR) from 26% in 2006 (baseline) to 37% in 2011.
- More than \$26,297,912 worth of essential drugs and contraceptives were distributed to BPHS/EPHS implementing NGOs under PPG and PCH projects. This dollar value translated into hundreds of millions of tablets, capsules and vials of essential and life-saving medicines distributed through community health workers and health facilities in the 13 USAID-supported provinces, reaching a total rural population of over eight million people. The number of regular recipient BPHS and EPHS facilities increased from 3,450 health posts and 332 health facilities in July 2007, to 6,000 health posts and 542 facilities in 2011.
- More than 2,000 Afghans across the national health sector were trained in the routine Health Management Information System, data use, data quality, and national surveys including the Catchment Area Annual Census (CAAC) and the household survey.
- The Ministry of Public Health, by the project's conclusion, was implementing a Health Information Strategic Plan which provides a framework for the overall planning of a Comprehensive Health Information System (CHIS) for Afghanistan.

⁷ Historically, USAID provided funding to support development activities in Afghanistan by contracting directly with mostly US-based contractors for goods and services. This was known as an "off-budget" funding mechanism, because funds do not flow through the Afghan government. Under the new "on-budget" approach implemented during Tech-Serve, the United States Government agreed to provide funding directly to the Government of the Islamic Republic of Afghanistan (GoIRA), for its official development budget, which the GoIRA would then use to contract for goods and services directly, or to directly implement activities. Part of USAID's mandate for the Tech-Serve project was that MSH would provide assistance to build capacity in the Ministry of Public Health so that funding could be moved on-budget.

- The National HMIS submission rate increased from 5% in 2003 to 90% in 2011 during a time of rapid health system expansion with the number of health facilities reporting to the National HMIS increasing by 32% between 2004 and 2010.
- With technical assistance provided by Tech-Serve, the MoPH improved its leadership and governance roles through the development and implementation of key policy and strategy documents including a National Health Policy, a five-year strategic plan, and a National Priority Program.
- With Tech-Serve's assistance, the MoPH has developed a roadmap to reform the hospital sector, with 14 national and specialty hospitals moving toward budgetary and procurement autonomy.
- More than 1,300 management and clinical staff at twelve EPHS implementing hospitals received training and mentoring that has resulted in improved patient care and case management.
- Tech-Serve was instrumental in supporting a Community-Based Health Care unit in the central MoPH that oversaw the training and deployment of more than 22,000 volunteer community health workers (half of them women) working in all 34 provinces and who see two-thirds of all family planning clients and nearly half of all sick children.

IR 2: Improved capacity of the 13 MoPH Provincial Health Offices and 4 Quick Impact Provinces supported to deliver BPHS and EPHS

- The number of patients served at USAID-funded health facilities per year in Tech-Serve focus provinces has increased by 188% from 2006 to 2011, going from 8.2 million to 23.6 million.
- The number of Community Health Workers (CHWs) in USAID focused provinces increased from 6,101 at the end of 2005 to 11,952 at the end of 2011 – of which 49.2% were female.
- As a result of TA provided by Tech-Serve, the Provincial Health Systems in 17 provinces are governed effectively through a defined framework of core functions and tasks.
- Tech-Serve assisted the MoPH to decentralize learning to the field level by helping to establish Provincial Health Learning Centers in Herat and in Kandahar serving all Provincial Public Health Teams in the country .
- System Development in USAID-supported provinces; Core functions for provincial health system strengthening were developed under Tech-Serve in USAID-

funded provinces. These functions were then accepted at the national level for implementation at the provincial level throughout all provinces.

IR3: Developed planning, management, supervision, monitoring and evaluation, and leadership capacity of the MoPH

- More than 1,800 health professionals from 180 Afghan health facilities, including MoPH senior managers, have experienced the power and rewards of working in their teams on selected challenges that improved services and/or processes within their health sites.
- MoPH is effectively managing the national and subnational coordination/ harmonization process with donors, UN, NGOs and line ministries.

IR4: Strengthened capacity of the Ministry of Education to plan, manage and account for USG on-budget resources

- Tech-Serve assisted in the preparation of the Ministry of Education (MOE) to go on-budget. In the initial stage of this effort, Tech-Serve assisted the MOE in the process of recruitment, selection and hiring of a team of consultants to support the on-budget Project Management Team (PMT), which will eventually be responsible for managing on-budget funded procurements and activity implementation and monitoring. Tech-Serve provided on-the-job training to the newly selected PMT to enable them to provide a more appropriate level of support to MOE on the procurement of services.
- Tech-Serve assistance provided formal guidance to the MOE by presenting the Transition Director with a detailed Activity Plan (in the form of a Request for Proposals) for Teacher Education, and providing a Road Map for going on-budget.

Challenges and Lessons Learned

The achievements highlighted in this report are all the more significant considering the many challenges that Tech-Serve has faced since its inception, but even more intensely, during the last two project years. A selection of these challenges includes:

- The migration of project-paid employees and consultants to the civil service through the on-budget mechanism has proven to be more challenging and time consuming than the Ministry, USAID, Tech-Serve and MSH initially envisioned, and underscores persistent absorptive capacity limitations at the MoPH.
- Despite good coverage of services and relative better access to those services, there remains some difficulty in access of health services due to the geographic isolation of specific population groups such as the urban poor and nomads across the country.

- MoPH human resource management and practice contributes to the high turnover, poor selection and recruitment at central and provincial levels.
- It is difficult to attract highly qualified and committed persons to the MoPH civil servant positions, in part due to the disparity of wages between consultants and civil service employees.
- In 2011 and 2012, the number of security incidents in the provinces continued to rise, making service delivery, monitoring and supervision increasingly difficult.
- Fragmentation of reporting relationships and accountability through committee structures between the central and provincial level does not help with good monitoring of the implementation of policies and strategies thereby weakening the stewardship role of the MoPH for continued review and prioritization of health activities.

Despite these challenges, there were many lessons learned by Tech-Serve's implementing staff, partners within the Ministries of Health and Education, partners in the health sector, and donors over the six years of the project cycle. Below is a selection of these lessons learned. All are included and elaborated on in the Lessons Learned section of this report.

1. Technical assistance for Afghans by Afghans is essential for ownership and sustainability.
2. Building the capacity of MoPH Departments toward sustainability requires a contextually systematic approach with locally recruited professionals hired by the project, embedded within the Ministry's structure whenever possible, and having a long term commitment and perspective.
3. A grants management unit composed wholly of Afghan professionals can be certified by USAID to manage USG funds, maintain its certification over time, and can successfully manage the funding mechanism to the point where the donor doubles the funding managed by the unit.
4. The development and implementation of national policies, tools, systems and standards through approaches ensuring broad consensus and ownership is a cornerstone for the sustainability of health interventions.
5. System development requires the support and close collaboration of all stakeholders within the system.
6. Networking and task sharing exercises among the provincial-level health teams reaped great rewards.

7. Focusing on community-based health care was essential for providing Afghan populations in need an effective access to the BPHS and for having a major impact on maternal and child mortality and morbidity reduction. Raising the priority level of CBHC within Tech-Serve's scope of work was a key decision made jointly by MSH with the MoPH and USAID that made possible the deployment of critical capacity building interventions at all levels in favor of CBHC.
8. A blanket waiver simplifies pharmaceutical procurement and reduces lead-time.
9. "South to South" networking should be considered more often as a means for introducing appropriate and applicable new programmatic initiatives and/or best practices by strengthening regional relationships and knowledge exchange.
10. Cultural attitudes must be considered if programs are to be gender sensitive and therefore meet this important condition for their success.
11. The successful transition of projects requires appropriate allocation of time, resources and effective communication between stakeholders.

INTRODUCTION

Ten years ago, after two decades of war and the fall of the Taliban, Afghanistan suffered some of the world's worst health indicators, including a maternal mortality ratio of 1,600 per 100,000 live births and an infant mortality rate of 165 per 1,000 live births. To reverse this decline, the Ministry of Public Health (MoPH), working with donors and partners, in 2003 and 2004 launched three healthcare initiatives. The Ministry first established a Basic Package of Health Services (BPHS) and an Essential Package of Hospital Services (EPHS) that focused on the most critical and cost-effective services, including a cadre of community health workers (CHWs). The second initiative was to contract with NGOs to deliver services through standardized health facilities and outreach in the country. The third initiative was to help these NGO service providers to implement policies and guidelines in compliance with Donors, including USAID, and the Government of the Islamic Republic of Afghanistan.

Today, these priorities continue to be prominent elements of the Afghanistan National Development Strategy 2006-2013. According to the established policy and strategy, stewardship of the health system is the Ministry of Public Health's primary responsibility. Management Sciences for Health (MSH) is honored to have played a significant role in supporting the MoPH to strengthen its stewardship role.

In July 2006, USAID launched the Technical Support to the Central and Provincial Ministry of Public Health project, referred to hereafter as Tech-Serve, as its flagship initiative in support of the health sector in Afghanistan. Tech-Serve is a \$100.6 million, six-year Associate Cooperative Agreement⁸ awarded to Management Sciences for Health (MSH), under the Leadership, Management and Sustainability (LMS) Leader with Associate Cooperative Agreement No. GPO-A-00-05-00024-00. The vision of the Tech-Serve project was a Ministry of Public Health that is able, at all levels, to improve the health of the people of Afghanistan through a quality, accessible and equitable health system. The Tech-Serve strategy was to strengthen leadership and management

A Note on MSH's work in Afghanistan Prior to Tech-Serve

MSH began working in Afghanistan in 1973 to strengthen the MoPH and promote the use of village health workers. Beginning in the mid-1980s and working from Peshawar, Pakistan, MSH provided training, support, and monitoring for more than 300 clinics across the border. In 2002, USAID invited MSH to return to Afghanistan to assist in rebuilding the healthcare system. Between 2002 and 2006, MSH conducted two health projects: a nationwide assessment of available Afghan health professionals and resources that was used by the MoPH to develop BPHS and EPHS; and the Rural Expansion of Afghanistan Community-based Healthcare - REACH (2003-2006), which financed and technically supported the provision of health services to one-third of the Afghan population, updated health workers' knowledge and practices, developed systems and policies that govern the distribution and management of health resources, and improved the quality of service provision.

⁸ Tech-Serve's period of performance is from June 1, 2006 to August 31, 2012 and its reference number is 306-A-00-06-00522-00

at all levels of the MoPH so that central and provincial level managers can fully implement the BPHS and EPHS, so as to reduce maternal and child mortality.

The Tech-Serve project's objective is to improve the capacity of the MoPH to plan, manage, supervise, monitor, and evaluate the increasing scale of access to quality Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS), particularly to those among the Afghan population at highest health risk. When launched, the Tech-Serve project had three intermediate results: improved capacity of MoPH at central level; improved capacity of MoPH at provincial level; and improved leadership and management capabilities at the MoPH.

Today, the project has evolved to have four intermediate results:

1. Improved capacity of the Central MoPH to support the delivery of BPHS and EPHS services, primarily through NGO service providers.
2. Improved capacity of the MoPH Provincial Health Offices in the 13 USAID-funded Provinces and 4 Quick Impact Provinces supported to deliver BPHS and EPHS.
3. Developed planning, management, supervision, monitoring and evaluation, and leadership capacity of the MoPH.
4. Strengthened capacity of the Ministry of Education to plan, manage and account for USG on-budget resources.

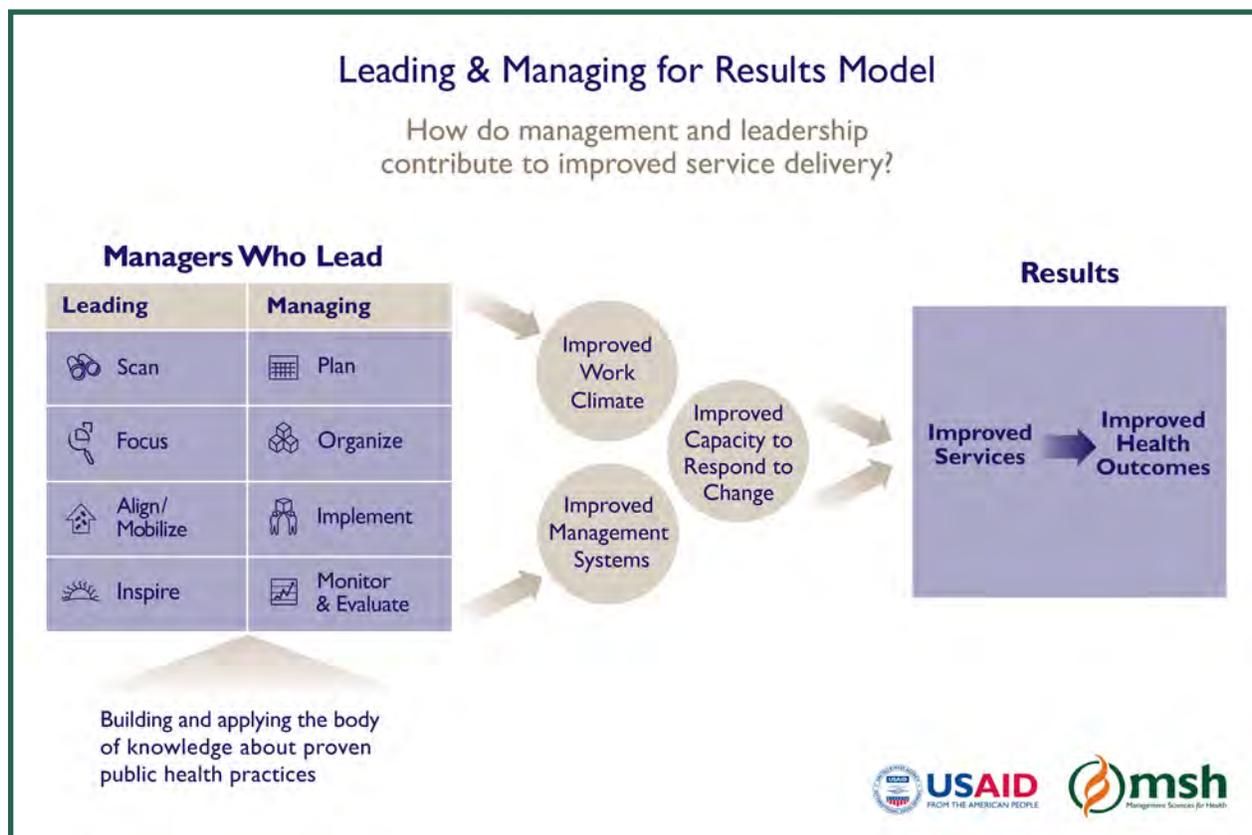
To support the achievement of these first three goals and improved health outcomes, Tech-Serve focused on improving the capacity of the MoPH to lead and manage health services, as described in Figure 2, by fostering ownership, commitment, and energy towards its stewardship role. To operationalize the capacity building strategy, Tech-Serve worked with the MoPH to build further its management and leadership practices and systems, and its public health technical competencies at the central level and in 13 USAID-focus provinces. Midway through the project, USAID requested that the project be expanded into an additional four "Quick Impact" provinces located along the border with Pakistan (see map of Afghanistan on page 7). The capacity-building was achieved directly through technical assistance, training, coaching, mentoring, and networking activities.

BPHS and EPHS

The Basic Package of Health Services (BPHS) adopted in 2003 and revised in 2005 and 2010, lays the foundation for Afghanistan's health care. It was designed to address the most critical health problems, especially those of women and children. It defines the integrated services to be provided at health posts and health centers and specifies a referral system for patients needing more specialized treatment and care. It includes the services that will have the greatest impact on the country's major health problems, that are cost-effective in addressing prevalent health problems, and that will give equal access to both rural and urban populations.

The Essential Package of Hospital Services (EPHS) complements the BPHS, serving as the framework for Afghanistan's hospital system. The EPHS classifies district, provincial, and regional hospitals according to size of the referral population, number of beds, staff workload, and complexity of services offered.

Figure 2. Leading & Managing for Results Model



Over the life of the project, Tech-Serve has contributed to improvements in the delivery of health services and outcomes in Afghanistan, as evidenced by the gradual and sustained improvements in several areas: family planning and reproductive health, the number of facilities with at least one female health worker, patient visits to health facilities, and mortality rates. During the last year a wealth of key data from a number of surveys, including the Afghanistan Mortality Survey, the Household Survey and the Multiple Indicator Cluster Survey, became available. Results from all surveys show improvements of health status that are often higher than expected considering the challenging security environment in so many areas of the country that contributed to increased geographic isolation and migration to provincial centers. The evidence attests that the health of the population – through the collaborative efforts of donors, technical agencies, projects such as Tech-Serve, and the MoPH – is continuing to improve. For instance:

- The life expectancy for women rose from 45 years in 2003 to 62-64 years in 2010.
- The total fertility rate decreased from 6.27 in 2008 to 5.1 in 2010.
- The under 5 years mortality rate (per 1,000 live births) decreased from 161 in 2008 to 97 in 2010.
- The Contraceptive Prevalence Rate increased from 15.2% in 2008 to 21% in 2011.

- The Maternal Mortality Ratio (per 100,000 live births) decreased from 1,600 in 2002 to 327 in 2010.⁹

Strategies to sustain and even further expand on these results were built into the Tech-Serve project from the start. One of these strategies was the transition of donor resources to being channeled directly to the Government of Afghanistan, rather than through an Implementing Partner. One early example is the Partnership Contracts for Health Services¹⁰ (PCH) funded by USAID but awarded and managed directly by the MoPH, including their financial management. A more recent example is a funding mechanism referred to as “on-budget”, that is intended to further promote increased sustainability of Afghan systems and capabilities, and was integrated into the Tech-Serve scope of work from 2010 onward. The On-Budget concept emerged from the Afghanistan London Conference, held in January 2010. A recurring theme in the London Conference presentation was the GoIRA request that “50% of official development assistance 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 GoIRA to 50% in the following 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. The outcomes of the London Conference resulted in expanding the mandate of the Tech-Serve project to contribute to making the dream “On-Budget” assistance a reality.

Thus, during the last one and a half years of this project, supporting the transition of select activities to the relevant MoPH departments was a key focus. More recently, Tech-Serve also supported the Ministry of Education in this aim. These transitions, still underway, are contributing to both Ministries’ organizational capacity, ownership and accountability. In assuming greater leadership in resource planning, management and allocation using on-budget funds, the MoPH and the MoE are preparing to use Afghanistan’s own resources in a more responsible and efficient manner as revenue generation improves. Progress in this regard due to Tech-Serve inputs is described in this report, as are the challenges faced and the way forward.

As a final point to this introduction, we want to draw attention to the very significant growth Tech-Serve experienced over the life of the project. The Tech-Serve Cooperative Agreement evolved from a four-year, \$24 million undertaking into a six-year, \$101 million initiative. At the start of the performance period the project had about 75 employees, and by August 2012, staff size had grown to over 200. The budget increased over the period of performance due to the following main factors:

9 Please see Executive Summary for source data.

10 Please see IR1 section for details.

- Insertion in 2010 of four additional provinces along the border with Pakistan (Quick Impact Provinces) in Tech-Serve's geographic scope.
- Insertion in 2011 of an additional Intermediate Result: IR4 Strengthening capacity at the Ministry of Education to plan, manage and account for USG on-budget resources.
- Increased pharmaceutical procurement budget line (in Feb/2007, Oct/2008, Mar/2010 and Nov/2011) to ensure meeting dynamic increases in the demand by the population for BPHS and EPHS in USAID-focused provinces.
- Increased duration of the project by 25 months (original end date was July 2010, final end date was August 2012).
- Addition of CBHC and the SUFP programs in 2008.

KEY RESULTS OF THE TECH-SERVE PROJECT

IRI: Improved capacity of the Central Ministry of Public Health to support the delivery of Basic Package of Health Services and Essential Package of Hospital Services, primarily through NGO service providers

SUPPORT TO THE GRANTS & CONTRACT MANAGEMENT UNIT (GCMU)

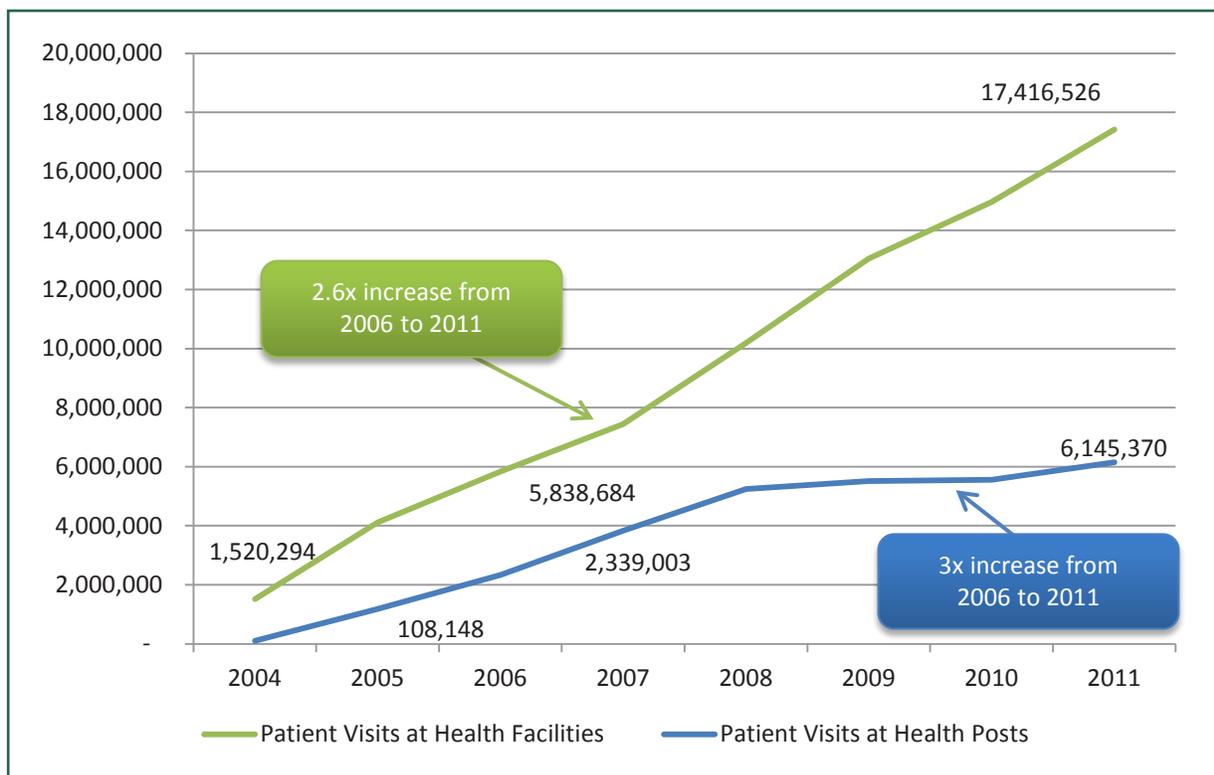
Key Achievements

1. Tech-Serve strengthened the capacity of the MoPH's Grants and Contract Management Unit (GCMU) Partnership Contracts for Health Services (PCH) team so that it has become a sustainable entity from a technical and programmatic standpoint. The PCH Team capacity and level of performance is such that it needs virtually no outside technical assistance for its chief functions of procurement, monitoring, management of NGO contracts, and maintaining financial accountability.
2. Through Tech-Serve's capacity building to the GCMU/PCH unit and its fostering of the relationships between the PCH team, senior MoPH leadership and USAID, the donor has certified it for managing direct USG funding. For over two years, USAID has placed trust on the PCH team to remain certified and manage well over \$40 million/year in grants funding to support BPHS and EPHS delivery to approximately 40% of the Afghan population. Moving forward, an approximate \$5 million a year in additional funds will be placed under the PCH unit's stewardship with the integration of the Community Midwife Education spending into the PCH portfolio.

Achievement 1: Strengthened capacity of the PCH unit based in the Grants and Contract Management Unit (GCMU) of the Ministry of Public Health

Since 2004, USAID has provided funding to the health sector in Afghanistan to support the operation of health clinics and their health posts, as well as district and provincial hospitals. The number of clinics and hospitals that are covered by USAID-funded contracts in the 13 USAID-focus provinces has increased from 342 in July 2006 to 550 at the end of Tech-Serve. The number of health posts increased from 3,200 in 2006 to 5,976 as of the end of 2011. All health facilities (clinics, hospitals, health posts) are operated according to the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) guidelines of the Ministry of Public Health. The actual BPHS and EPHS health services delivered in the 13 USAID-supported provinces have been funded via contracts awarded to NGOs on a competitive basis for a total of \$190 million over the life of Tech-Serve: \$70 million under 26 Performance-Based Partnership Grants (PPG) from 2006 to 2009; and \$120 million under 18 Partnership Contracts for Health Services (PCH) from 2009 to 2012. Figure 3 shows the number of clients served at the PPG and PCH funded facilities in USAID focus provinces from 2004 to 2011.

Figure 3: Patient visits at health facilities and health posts in USAID supported provinces



With technical support from MSH under REACH (2003-2006) and Tech-Serve (2006-2012) and financial support from USAID, the MoPH GCMU has demonstrated an outstanding capacity to absorb the dynamic growth in health service delivery to fund and to sustain a high level of performance in managing these USG-funded contractual mechanisms.

Historically, USAID provided the funding to support these activities (and others) in Afghanistan by contracting directly with outside contractors and grantees (mostly US-based) for goods and services. This arrangement is referred to as “off-budget” because funds do not flow through the Afghan government. The predecessor to the Tech-Serve project, the REACH Project was given all of the responsibilities to manage and administer the sub-contracting of health services delivery with NGOs. This approach was 100% off-budget.

USAID decided to change this approach early in 2006, just prior to the launch of the Tech-Serve project. Toward the end of the REACH project’s period of performance, Afghanistan’s Minister of Public Health asked USAID to transfer all financial and management responsibility for the NGOs implementing the BPHS and EPHS to the MoPH. USAID was not able to fully accede to the MoPH’s request at that time. However, USAID did agree in principle that gradually moving the responsibilities to MoPH in a well-planned, sequenced manner was desirable. It was envisioned that under the new approach, the United States Government (USG) would provide funding directly to the Government of the Islamic

Republic of Afghanistan (GoIRA), which the GoIRA would then use to contract out goods and services directly with NGOs on a competitive basis. This funding arrangement is referred to as “on-budget,” because funding is included in the GoIRA official Development Budget. To implement this approach, it would be necessary for the MoPH to demonstrate that it had the capacity to absorb the additional responsibilities. USAID made it as part of the Tech-Serve project mandate that MSH would provide assistance to build capacity in the MoPH so that funding of BPHS and EPHS grants to NGOs could be moved on-budget.

Prior to the close of the REACH project, REACH staff worked with the MoPH to establish the Program Management Unit (PMU) in the MoPH, hiring a team of about 10 Afghans and internationals to manage the NGO grants. The team members were MSH employees and they worked in an MSH/REACH project office located near to the MoPH. The PMU managed a series of grants that were called Performance-based Partnership Grants (PPG).

Tech-Serve implemented a different model to move towards on-budget financing. In collaboration with the MoPH, Tech-Serve hired a team of 13 Afghan local professionals and one international technical advisor to manage the BPHS and EPHS grants mechanism to NGOs (called the Performance-based Partnership Grants, PPG). The local professionals had expertise in contract management, monitoring, finance, and information technology and included one administrative assistant. The two innovations under Tech-Serve were that this team was located in the Grants and Contract Management Unit (GCMU) at the MoPH, and USAID began channeling the funding for health services through the World Health Organization (WHO) to pay for the NGO services.¹¹ However, the GCMU/PPG team had full responsibilities for the management, administrative and financial oversight of the USAID-funded PPG grants to the NGO service providers, as WHO had no full-time staff until USAID required them to hire a financial and administrative officer.

Tech-Serve worked to build the capacity of this GCMU/PPG team, collaborating with the Afghan local professionals and the international technical advisor to develop systems and procedures for best practice contract management and supervision, monitoring of health facilities and financial management, and oversight. These best practices included the following:

- The NGO Performance Evaluation Scorecard was developed and implemented. The scorecard measured 28 criteria related to contract administration, service delivery and progress data on a quarterly basis. Since its implementation, this scorecard has become an effective tool which the MoPH uses to measure the performance of the NGO service providers. In addition, the NGOs have welcomed the scorecard as a way for the MoPH to identify organizations that were achieving above satisfactory results.

11 Under the REACH project, USG funds were channeled to health services delivery NGOs through MSH

- Systems for active and supportive onsite monitoring were established and implemented for the 550 health facilities funded by USAID. Formats for briefings and detailed monitoring reports were developed, as was a tracking system for monitoring and follow-up activities. The “Monitoring Single Score System,” which provides a quick snapshot of the overall operations of the health facilities, was designed and implemented.
- Systems for financial management of the contracts were established and implemented. These systems include quarterly reporting, periodic visits of the finance offices and annual auditing exercises. With Tech-Serve support, formats for informative quarterly financial reporting by the NGOs were designed and implemented; financial management training sessions with the NGOs were held; visits to the NGOs’ finance offices to check and verify the financial reports were conducted; and annual external financial audits were conducted.
- Financial analysis systems were also implemented. A system to conduct financial analysis of the contracts on an annual basis was designed and implemented, including calculations to compare average health facility and management costs by NGO and by type of health facility.

Tech-Serve provided intensive training and capacity building for the GCMU staff as these best practices were implemented. As the consultants became more skilled and these processes became routine during the years of the project, Tech-Serve staff played a less active role within the GCMU, providing support only when it was requested.

Achievement 2: GCMU/PCH Team now responsible for over \$40 million/year to support health service delivery to approximately 40% of Afghan population

With processes, procedures and systems firmly in place, the next step for Tech-Serve was to prepare the Ministry for certification assessments by USAID for the Host Country Contracting mechanism, which would mean that the MoPH itself would administer the health service provider contracts. In order to successfully pass the assessments, the MoPH needed to demonstrate that it had the overall capacity to properly manage and account for donor funding – in particular that the proper procedures and systems were in place; that the staff had the capacity to follow the procedures and system; and that they were actually doing so.

The MoPH was already receiving on-budget funding for several years from a variety of international donors, including the World Bank and GAVI. In 2007, during the fiscal year that the assessments were conducted, the MoPH’s development budget funding from other international donors was an estimated \$75 million. The approach that the MoPH used for the USAID assessments was to demonstrate that the Ministry already had a good track record for receiving, implementing and reporting for on-budget funds.

Success Story

Housing for Midwives Increases Access to Maternal Health Care

Midwives can decrease the risk of mother or infant dying during childbirth. For many expectant mothers in Afghanistan, especially those in rural provinces such as Maidan Wardak, a midwife is the only health care provider they may ever know, since traditional beliefs prevent women from being treated by male doctors.

For three years, the thousands of women in Maidan Wardak province's mountainous communities essentially had no access to health care, because there were no midwives in the province's nine different health facilities. Maternal and infant deaths were common. Efforts to recruit midwives from adjacent communities failed, as they could not travel for long distances alone, and the health facilities had no housing for female employees.



A midwife in Maidan Wardak province takes the blood pressure of her patient.

The health of mothers and infants began to change last year, with the support of Management Sciences for Health's Technical Support to the Central and Provincial Ministry of Public Health project (Tech-Serve), funded by the U.S. Agency for International Development (USAID). Launched in 2006, Tech-Serve is working with Afghanistan's Ministry of Public Health to build the capacity of the country's health system and improve access to health services. At the provincial level, Tech-Serve supports health leaders to manage the development of accessible, equitable, and quality health services. In Maidan Wardak, for example, this meant finding solutions to the lack of maternal health care in the province.

The Maidan Wardak provincial health team, with Tech-Serve's support, worked with the local health facilities to develop proposals to construct family houses for female health workers, so they could attract midwives from other communities. They sought funding from the local governments as well as community contributions to mobilize all the necessary resources. Local residents donated land for the houses and labored to help construct the homes. Each of these houses has three rooms, plus a kitchen and bathroom, and is enclosed in a secure place next to a health facility.

Today, four of the nine health facilities have female health workers providing maternal and child health services. Hamida, a midwife at the Tagab District Hospital, is one of the province's new female health workers.

"Walking daily for two hours from my house to the health facility was a problem for me and I was worried about my children," said Hamida. "Thanks to the provincial health directorate for the construction of these houses, there are now three midwives working in this facility."

Construction will start on housing for midwives for the other five health facilities this year.

USAID conducted the assessments in two stages, focusing first on procurement (contracting) and then on financial management. To be eligible for Host Country Contracting and to receive on-budget funds, the MoPH was required to pass both parts. The procurement assessment took place in April/May 2007 and the financial management assessment in August/September 2007. The two assessments were done independently of each other by USAID staff from its Kabul office. The financial management assessment also involved a review of Afghanistan's Ministry of Finance by USAID. In June 2008, the MoPH was formally notified by USAID that the GCMU section of the Ministry would be certified to receive on-budget funding, a major accomplishment of the health sector of Afghanistan.

With certification, a new management mechanism was instituted within the MoPH, known as the Partnership Contracts for Health Services (PCH). The PCH project is part of the official Afghan development budget, which means the PCH funding is on-budget. In July 2008, USAID and the MoPH signed Implementation Letter #6 for \$218 million of funding over 5.5 years for the MoPH, through PCH, to procure health services from NGO contractors.

It is important to note that the PCH funding does not include salaries, benefits or operational support for the PCH team whose role is to conduct the procurement process and manage and administer the contracts. Funding for the remuneration of the local professionals constituting the PCH team remained off-budget through the conclusion of the Tech-Serve Project (they are on Tech-Serve "payroll" so to speak), and will continue to be paid by MSH in the follow-on project to Tech-Serve, the Leadership, Management and Governance (LMG) Afghanistan Project. It is expected, however, that PCH consultant salaries and benefits will go on-budget within a few months of the end of Tech-Serve. At the moment, USAID is looking at its options to move the operational costs of the PCH to on-budget as well.

In 2008, as part of the start-up of the on-budget funding, the MoPH initiated a new round of competitive procurement for health service provision and did this in accordance with the Afghan Procurement Laws and Rules. It also included several steps that required USAID approval. Planning for the PCH procurement started in March 2008 and the procurement was completed in November and December 2009, when 18 contracts totaling \$236M were awarded. The first on-budget expenditure for the PCH project started when these contracts were awarded to the NGO service providers.

For well over two years, the PCH consultant staff has been successful in managing the BPHS and EPHS on-budget services, which provide health care for approximately 40% of the Afghan population, and in maintaining the MoPH certification in the process. Tech-Serve leadership gradually withdrew support provided by international advisors over 2010 and 2011, allowing the PCH staff to enhance their own skills and abilities to accomplish all the required tasks themselves, without continued outside assistance. The PCH team had only

Quote from an article written by Ronald Newmann, former US Ambassador to Afghanistan from a story that appeared in the Washington Post on August 3, 2012, commenting on the USAID decision to direct health sector funds through the MoPH:

“This was risky, given the limitations of the ministry and the risk of corruption. Many would have preferred an approach in which foreigners managed everything, risks were minimized — and Afghans learned little. In this case, after extensive preparation, the approach worked. There may be some waste, but the Ministry of Health is widely regarded as among the best of the Afghan ministries. Health care has expanded broadly across the country. Maternal and child mortality is steadily dropping. Equally important, the ministry’s capacity to manage its own business has expanded because Afghans were not denied the opportunity to grow into their responsibilities.”

one international advisor in the last months of the Tech-Serve project; this consultant was needed to support the overall on-budget program with the MoPH. The results of this weaning process showed that the Afghan professionals on the PCH team had the capacity to implement all procurement and management processes on their own. Subsequently, USAID assigned its own Activity Manager at the Mission for the PCH project. USAID was so confident in the PCH PMU ability that it authorized the transfer of the large Community Midwife Education (CME) program (18 NGO contracts) at approximately \$5.0 million/year from an off-budget mechanism to on-budget funding. With declining assistance from Tech-Serve advisors and over one-year of planning and preparation, the PCH successfully transferred CME program activities from JHPIEGO to the PCH Project mid-2012.

SCALE UP FAMILY PLANNING AND CBHC

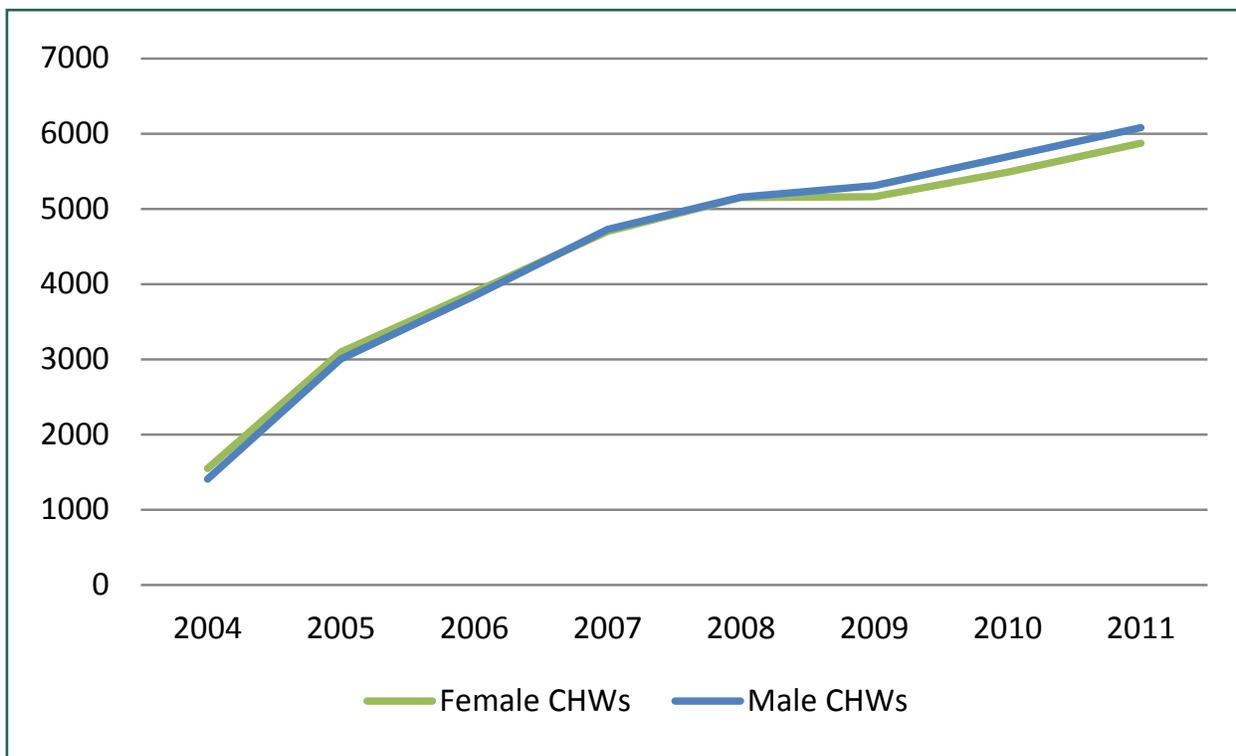
Key Achievements

1. The MoPH Community-Based Health Care (CBHC) Department now has an enhanced stewardship role and has overseen the increase in the number of trained and deployed community health workers—from practically zero in 2002 to over 22,000 today, half of them women.
2. The CBHC System is now strengthened so that community-based health care is an essential component of Afghanistan’s primary health care system; the CHWs are supervised by community health supervisors, are regularly supplied with lifesaving medicines, and are active in every rural district of Afghanistan.
3. The community-based Family Planning Program has been scaled up so that over two-thirds of family planning visits occur at community level with CHWs. Surveys conducted in 13 USAID-supported provinces indicate an increase in the contraceptive prevalence rate (CPR) in these provinces from 26% in 2006 (baseline) to 37% in 2011.

Achievement 1: Enhanced stewardship role for the Community-Based Health Care Department

To enhance the stewardship role of MoPH in community-based health care, Tech-Serve supported the MoPH Community-Based Health Care (CBHC) Department to apply sound leadership practices, set strategic policy direction, develop a regulatory framework, monitor implementation of CBHC policy and strategies, strengthen advocacy and coordination and build partnership with stakeholders, and promote professional education. The Tech-Serve support enabled CBHC to develop policies and strategies; develop guidelines, protocols, curriculum and teaching materials; strengthen the CBHC's monitoring mechanism; advocate for CBHC activities; strengthen coordination with stakeholders; and build CBHC staff capacity. This strengthening was done in a context of dynamic growth in the numbers of CHWs deployed as illustrated in Figure 4. During this same period, the scope of work of the CHWs was expanded. Enhancing the capacity of the CBHC at the MoPH at this time was critical to the sustainability of the community-based health services delivery system.

Figure 4: Numbers of Community Health Workers active in USAID focus provinces



Some examples of specific achievements are described hereunder in the following subsections.

Development of the first National CBHC Policy and Strategy Document: As a result of this policy and strategy document, the CBHC program has a clearer understanding of its role in delivering health services to Afghans throughout the country. As annexes to these

documents, the team developed CBHC strategies for poor urban populations and nomads to technically support the establishment of CBHC programs for those two neglected populations in Afghanistan. In addition, they developed Strategic Direction and Performance Measurement Framework for the CBHC for the next five years.

Separately, the team also developed a new policy which allows community health workers (CHWs) to administer the first injection of depot medroxyprogesterone acetate (DMPA), thus giving women increased access to contraceptives and saving them a visit to a health facility.

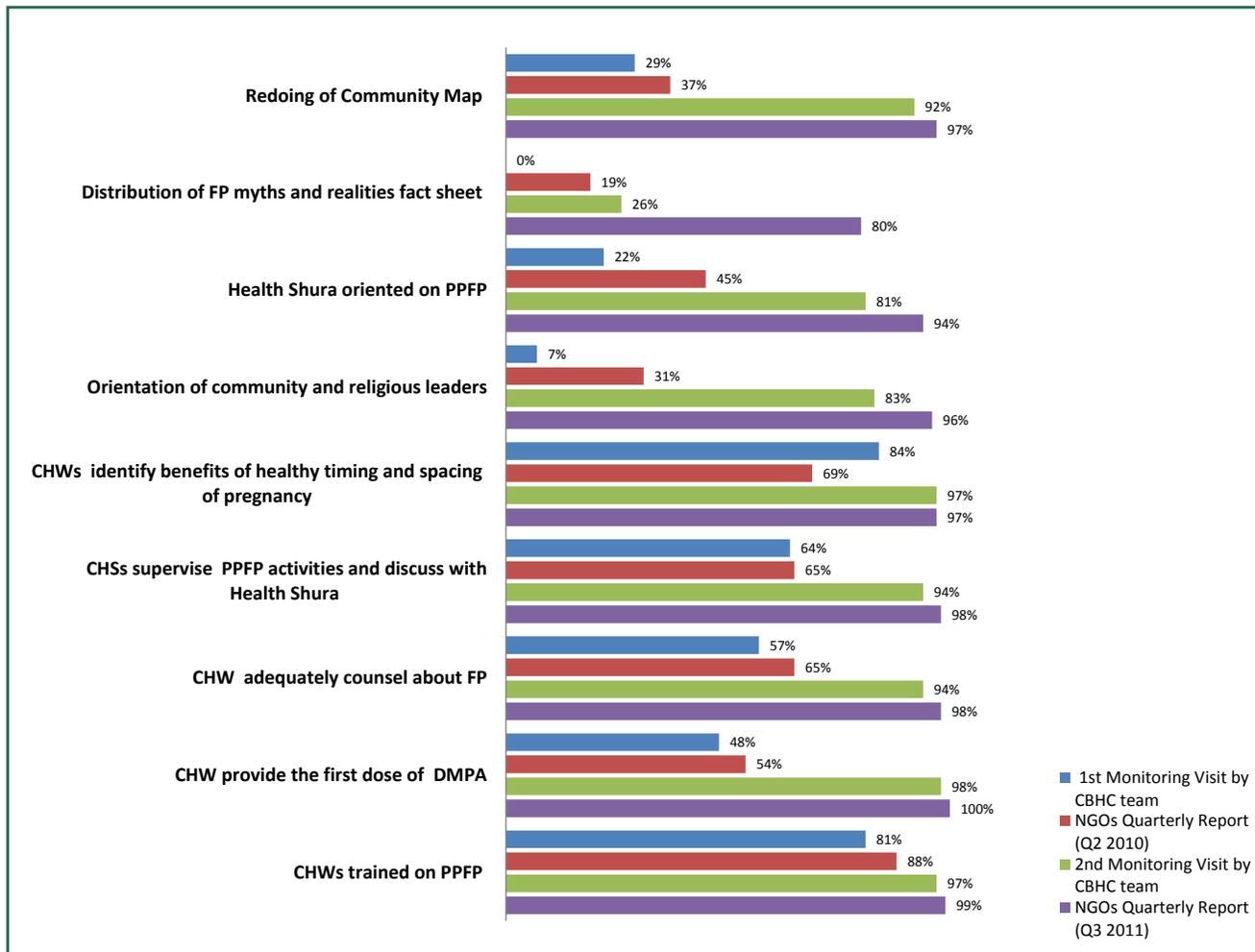
Development of guidelines, protocols, curriculum and teaching material: Among the materials developed with assistance from Tech-Serve was a national CBHC package which included CBHC implementation protocols, CHWs revised kit, guidelines on conducting community campaigns by CHWs, National CBHC Monitoring Checklist, guidelines for hiring female Community Health Supervisors, and a recognition mechanism for CHWs to keep them in their volunteer role and decrease the dropout rate in the long run.

Additional materials included training manuals for initial and refresher training of CHWs; a booklet on “Islam and Family Planning” which improved acceptance of family planning among communities; a training guide for in-service training of district health officers (DHOs) on CBHC, monitoring and supervision, which enable DHOs to focus more on CHBC activities at the district level and provide much technical support to CHSs and CHWs in their catchment areas. In addition, Tech-Serve supported the development of new clauses which were added in modified contracts of the NGOs, so that they would focus more on CBHC and report their progress accordingly.

Strengthened CBHC monitoring mechanism: To have effective monitoring and follow up mechanisms, and improve the quality of community-based health care interventions, the CBHC unit developed monitoring tools, conducted frequent monitoring and post-training assessment visits to 28 provinces, including 13 USAID supported provinces, and set a follow up system by which the team provided feedback to the relevant partners and implementing NGOs through holding face to face meetings with senior representatives of those NGOs, and supported them to make action plans and take necessary actions to fill existing gaps and address existing problems in the program implementation. Figure 5 below shows improvement in the NGOs’ performances based on continuous monitoring visits and follow up.

Advocacy for CBHC activities: With technical and logistical support from Tech-Serve, the CBHC team conducted several advocacy meetings and seven regional advocacy workshops for senior MoPH authorities and technical departments of the Ministry, as well as provincial MoPH officials, UN agencies, NGOs and community elders throughout 2010 and 2011. As a result of those efforts, the team obtained their commitment for further support of the program through enhancing coordination with CBHC and facilitation of its implementation at central, provincial and community levels.

Figure 5: Monitoring findings in PCH provinces (2009-2011)



At the international level, CBHC staff presented implementation of an effective CBHC Program in Afghanistan at the Global Health Council’s 38th Annual International Conference and explored various issues around rural health interventions. In October 2011, the program staff held advocacy meetings with policymakers at the USAID Main Office and on Capitol Hill, including meeting with staff of Pennsylvania Senator Robert P. Casey, the Chairman of the Subcommittee on Near Eastern and South and Central Asian Affairs within the Senate Foreign Relations Committee, and with Niki Tsongas, a Massachusetts Congresswoman, to discuss public health, CBHC and family planning in Afghanistan. All of these visits highlighted the support of USAID for CBHC development in Afghanistan.

Strengthened stakeholder coordination: Beginning in 2008, Tech-Serve facilitated regular monthly and quarterly coordination meetings of the community-based family planning executive and steering Committees.

Focus on capacity building efforts and promote professional education: After hiring 11 local consultants in the CBHC Department in 2008- 2009, Tech-Serve built the CBHC staff capacity through: need-based trainings in management and leadership, monitoring

and evaluation, communication skills, research methodology, training methodology, and community-based family planning; continuous coaching and mentoring; study tours to Bangladesh and Indonesia; and participation in international conferences.

As a result of all of these activities, the MoPH CBHC team has been enabled to perform its key functions (planning, coordination, etc.) without external support. However, for certain aspects of work, e.g., data analysis, programming, and curriculum and study designs, the team has depended upon the technical assistance that is provided by Tech-Serve.

Achievement 2: Tech-Serve's support strengthened the CBHC system

Among the components of this achievement that Tech-Serve supported were the piloting of CBHC best practices; the introduction of Family Health Action Groups and Family Health Workers; the expansion of CBHC interventions to “white areas”; the updating of the community health workers training manual; and support for national consensus building efforts within the CBHC.

Pilot Community-Based Health Care Best Practices: In April 2010, Tech-Serve arranged a two-week study tour for 15 CBHC staff to Bangladesh and Indonesia, to learn from these countries' extensive CBHC experiences, and return with new options and recommendations for Afghanistan's system. Based on lessons learned from the study tour, the CBHC team selected two best practices seen as having excellent potential in Afghanistan: the Integrated Health Post (IHP) and the Friday Cleaning Campaign. The team adapted these to the local context and piloted them in six health posts supported by one or two health facilities in the Nangarhar, Kabul, Baghlan and Herat provinces from September 2010 to May 2012. The Friday Cleaning Campaign mobilizes villagers in cleaning the area around their homes as well as public areas within their villages while the IHPs offer essential BPHS once a month to the population, when normally these services are only available at higher level health facilities. This is achieved at the occasion of scheduled visits at the IHPs by providers from health centers. Preliminary results show that CHWs increased their use of medicines by 20% on average since the start of the pilot. The two best practices introduced are being assessed and analyzed, and the CBHC team will present the findings to the MoPH in October 2012.

Creation of Family Health Action Groups (FHA Groups) and Family Health Workers (FHWs) as new elements of CBHC: In collaboration with HSSP, the CBHC team created FHA Groups to support female CHWs and promote the appropriate use of health services to reduce maternal and child mortality. After the Ministry approved the inclusion of this new supportive mechanism in the national CBHC policy, the CBHC Department developed guidelines for selection and training of FHA Groups, and trained provincial Ministry and NGO staff. Since 2009, the CBHC Department has established 63 FHA Groups in five USAID-supported provinces: Badakhshan, Bamyán, Kabul, Herat, and Khost.

Key responsibilities of family health action group members

- Implement healthy practices in their own homes and then demonstrate them in their neighborhood
- Talk with neighbors and promote other healthy practices
- Promote appropriate use of curative and preventive care from the CHW and the health facility
- Inform CHW about pregnancies, births, and sick women and children who need care
- Encourage families to follow up CHW's recommendations for referral, when necessary
- Through men from within their own families, encourage other men's participation in health improvement activities.

In November 2011, as follow up to the Kabul Conference, the CBHC Department collaborated with the Ministry of Education regarding the training of school children as Family Health Workers (FHWs), to enable them to convey health messages to their families and thus further strengthen community-based health care programs. The CBHC team drafted teaching materials for Family Health Workers in Pashto and Dari for students in grades 1 to 12, and presented them to Ministry of Education officials. The MoE will further refine the materials and integrate them into their curriculum.

The CBHC team also conducted a consensus building workshop to secure commitments from both the MoPH and the Ministry of Education and to build consensus on implementation aspects of the project. Fifty senior officials including the respective ministers, deputy ministers and general directors as well as USAID representatives attended the workshop. As a result, both ministries signed a Memorandum of Understanding, developed an annual operational plan, and hired focal persons for the FHW project in both ministries. This is a six-year project for training of more than 8 million school children as FHWs.

Expansion of CBHC interventions to white areas: Tech-Serve supported the MoPH's CBHC Department to lead the process for expansion of CBHC interventions into white areas (areas with no CHW or health posts) through implementing partners. This effort resulted in the training and recruitment of 2,604 new CHWs in USAID-supported provinces, and 3,495 CHWs in EC and World Bank supported provinces. Additionally, with technical support from Tech-Serve, the CBHC developed community based health care strategies to support programs for the urban poor and nomads in Kabul and across the country. To date, 24 community health supervisors and 68 CHWs have been trained in Kabul (through the financial support of JICA) to implement the strategy for the urban population. The 68 CHWs are now located in the following areas of Kabul: Khoja Musafer (20); Qasaba (13); Hotkhail (20); and Qalae Muslim (15).

Review the Community Health Workers Training Manual: To determine which aspects of training and supervision of CHWs were useful and which aspects were not, and to find out how to improve CHWs training and supervision, the CBHC team conducted a post-training assessment of CHWs in 12 provinces (Kabul, Parwan, Takhar, Herat, Badghis, Jawzjan, Balkh, Samangan, Baghlan, Bamyan, Laghman, and Nangarhar). The team made evidence-based recommendations and established a Working Group to revise the manual. The working group completed revision of the manual and it will be presented to the MoPH technical forums following the conclusion of the Tech-Serve project.

Conduct a number of consensus building workshops and conferences for further development of the CBHC System: In November 2008, CBHC conducted the first National Community Health Workers (CHWs) Conference to recognize the CHWs' important roles in and contributions to health service delivery in Afghanistan. Three hundred attendees, including 170 active CHWs from 34 provinces, high-ranking MoPH officials, and representatives from USAID, United Nations agencies and NGOs, as well as international CBHC experts, actively participated in the conference. His Excellency, the Minister of Public Health, acknowledged the CHWs and nominated one day of the Afghan calendar as "National Community Health Workers' Day," which has been celebrated annually at the central and provincial levels since then. Establishing this event was an effort toward better recognition of the values to health interventions at the family and community level.

In June 2010, the CBHC conducted a three-day national conference to strengthen community-based health care system in Afghanistan. One hundred twenty participants, including senior officials from the MoPH and Ministry of Women's Affairs, as well as representatives from the Ministry of Rural Rehabilitation and Development, USAID, WHO, and NGOs, as well as active CHSs, CHWs and the heads of health shuras from all regions participated. Among the conference achievements:

- Political commitment from key stakeholders was secured to implement the newly developed CBHC Policy and Strategy at national, provincial and district levels.
- Experts' recommendations were outlined on feasible ways to implement the new CBHC Policy and Strategy, and strengthen the referral system.
- An action plan was developed to address participants recommendations and comments.

Achievement 3: A scaled up community-based Family Planning program

Building upon the lessons learned from the William and Flora Hewlett Foundation-funded "Innovation in Family Planning Accelerating Contraceptive Use Project" (implemented by MSH from 2002–06), Tech-Serve supported the MoPH CBHC and Reproductive Health/Family Planning Departments to scale up community-based family planning services first in the 13 USAID supported provinces and then in the remaining parts of the country. The goal

was to increase contraceptive use in USAID-supported provinces by 50 percent within two years. A secondary goal was to build up and support the capacity of the MoPH to implement a similar program in the remaining provinces of the country. The program was jointly implemented by the Ministry's CBHC and Family Planning departments, with financial support of USAID and technical support from both Tech-Serve and HSSP projects.

Since its inception in July 2008, the program supported the MoPH to train existing health professionals, CHSs and CHWs on family planning. CBHC trained 716 CHSs in family planning in by conducting 30 In-Service Training Courses in 13 PCH and 11 Quick Impact provinces (the CBHC Department has expanded its integrated community-based FP program to 11 additional provinces in the south and east of the country under USAID's Quick Impact Initiative). The team facilitated in-service training courses (organized by HSSP) for 242 CHSs in remaining parts of the country. The training provided to the CHSs was mainly focused on community-based distribution of family planning methods, administering the first dose of DMPA, supervisory skills, techniques for effective monitoring, and the use of simplified community map and HMIS forms. The training was successful, with the difference between average knowledge in pre-test scores and post-test scores demonstrating a dramatic improvement in the knowledge of the trained CHSs, indicating their capability to carry out their assigned tasks according the program requirements for scaling up birth spacing at the community and health facility levels.

CBHC provided training courses to 59 CHW trainers introduced by NGOs and CBHC officers on effective teaching skills, and TOT on Postpartum Family Planning (PPFP), and provided three orientation workshops on PPFP to 83 NGO project managers, RH officers and the HSSP and Tech-Serve provincial staff. CBHC also assisted NGOs in training of over 15,000 CHWs on family planning.

In addition, Tech-Serve supported the MoPH Reproductive Health (RH) Directorate to conduct a four-day Networking Workshop for 16 provinces of the central, southeast and eastern regions of the country. The purpose of the workshop was to strengthen the RH program at the central and provincial levels, and to build the capacity of Provincial Public Health Offices (PPHOs). The results of these efforts have had a considerable impact on reducing unwanted fertility in rural Afghanistan. Results from the Lot Quality Assurance Sampling (LQAS) household surveys, conducted in 13 USAID-supported provinces, indicate an increase in the contraceptive prevalence rate (CPR) from 26% in 2006 (baseline) to 37% in 2011.

Success Story

Empowering Women for Rural Health in Afghanistan

Afghanistan is facing an enormous healthcare challenge – not having a sufficient number of qualified healthcare workers available to address the pressing healthcare needs of women and children in rural communities. With 85% of the population living in villages, there are few options to provide proper care and advice to these rural families.

Continuing to deploy community health workers (CHWs) is proving to have an impact. Over 22,000 trained CHWs provide better access to health services for rural families in Afghanistan.

In 2010, the Ministry of Public Health (MoPH), with support from Management Sciences for Health (MSH) has trained 700 CHWs to educate families about proper sanitation and hygiene. CHWs provide basic services and refer patients to health facilities after checking for danger signs in sick children and pregnant women. Each CHW is assigned to take care of the basic health care needs of 100-150 families (approximately 1,000 individuals). The Ministry of Public Health's CBHC program is a significant step towards improving access to health care for rural communities, especially for women and children.



Community Health Supervisor Training in Kabul.

Madina, a widow who lost four of her eleven children during the Taliban years, gave new meaning to her life by becoming a CHW. She was trained and provided with a supply of essential medicines. She works under the supervision of the Comprehensive Health Center in Istalef, a small village on the edge of the Shamali Plains, north of Kabul. She travels from house to house three days a week to provide prenatal care and family planning advice to women, she said: "I come to the health center to help my community to provide essential services, to educate in areas where there is no nearby health facility, and provide prenatal care and family planning advice."

The Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve) Project is one of the main partners supporting the MoPH in CBHC. Tech-Serve works at the central and provincial level to build MoPH capacity to perform its primary function of guiding the health system by establishing national health objectives that address national health priorities while ensuring equity and fostering sustainability.

Tech-Serve provides ongoing technical assistance in key public health technical areas and engages both central and provincial managers in developing their management and leadership skills to focus on health results and accountability. This project is an Associate Award under the Leadership, Management and Sustainability Program funded by the U.S. Agency for International Development, and was launched in July 2006.

DRUG MANAGEMENT UNIT

Key Achievements

1. During the life of the Tech-Serve project, nine orders of essential drugs and contraceptives, with a total value of more than \$33.3 million, were procured internationally.
2. Between July 2006 and November 2011¹², \$26,297,912 worth of essential drugs and contraceptives were distributed to BPHS/EPHS implementing NGOs under PPG and PCH projects. The number of regular recipient BPHS and EPHS facilities increased from 3,450 health posts and 332 health facilities in July 2007, to 6,000 health posts and 542 facilities in 2011.
3. Between July 2006 and November 2011, \$33,657,611 worth of pharmaceuticals were stored in and distributed from central warehouses in Kabul.
4. The quality of the central warehouse operations management was excellent, reflected by less than 0.043% average percentage of inventory variance for more than 160 products.

Key Achievements 1 and 2: Nine orders of essential drugs and contraceptives distributed to BPHS/EPHS implementing NGOs under PPG and PCH projects

During the first five years of the Tech-Serve project, eight orders of essential drugs were purchased through MSH's pre-qualified international suppliers IDA and Mission Pharma for a total amount of \$27,593,146. A final order (Order #9) of pharmaceuticals, valued at over \$5.5m, was placed by Tech-Serve in PY6. These products will arrive over the following 8-12 months, and will be distributed in Afghanistan by the Strengthening Pharmaceutical Systems (SPS) project, also implemented by MSH.

During the course of the project, several challenges were encountered by the Drug Management Unit (DMU). In September 2006, early on in the Tech-Serve project, the DMU developed a refined quantification model that indicated a serious underestimation of the initially projected pharmaceutical needs of the PPG project. Prompt communication with USAID allowed the necessary reallocation of funds to prevent shortages of essential drugs in the PPG. Continued communication of changing needs with USAID allowed adequate provision of funding for pharmaceuticals in the subsequent ceiling increases of the Tech-Serve project.

12 The responsibility of the pharmaceutical storage space managed by MSH in Kabul and physical inventory was transferred from Tech-Serve to MSH Strengthening Pharmaceutical Systems (SPS) project at the end of Nov. 2011.

As per regulations related to pharmaceutical procurement using federal funds, MSH had to seek USAID approvals for purchase of restricted goods for each item in each order, as well as the approvals for the purchase of pharmaceuticals from non-US sources (along with comparisons for the price of each requested non-US item with the cost of a US manufactured drug). These approval requests caused considerable delays in the procurement pipeline. In close collaboration with USAID in Washington and the USAID Mission in Kabul, Tech-Serve developed a list of BPHS/EPHS medicines that was pre-approved in 2010 specifically for use in Afghanistan, reducing the lag time between the initial order request and the delivery to the Tech-Serve warehouse by 40%.

With few exceptions, medicines were shipped to Kabul by surface, air shipment being prohibitively expensive for large orders. These surface shipments required customs clearance in Pakistan for transit from Karachi to Afghanistan. While an efficient procedure to expedite the process in Pakistan was set up with the help of the USAID Mission, the US Embassy in Kabul and the US Consulate in Karachi, it remained subject to good will of the Pakistani government and officials and changing demands by custom officers. Since the Peshawar-Kabul leg of the pipeline transited the Federally Administered Tribal Areas in Pakistan, unpredictable delays were encountered due to the unstable security situation and frequent closing of the border. Between 2006 and 2011, delays in Pakistan increased significantly.

Complying with Afghan laws and regulations for pharmaceutical importing, even with the support of USAID, was another challenge. Although Tech-Serve reduced the processing time for the necessary paper work from the MoPH, the Ministry of Finance, the Ministry of Foreign Affairs and the Ministry of Counter Narcotics from an initial 30 days to three weeks in 2009, changing rules in the MoPH bumped this back up to 30 days by 2011. A particular problem was the insistence of the MoPH that all medicines were subject to quality testing by the MoPH Central Quality Control Laboratory (CQCL) before being cleared from customs, although the CQCL was unable to perform the tests adequately or within a reasonable time. Ultimately the only way to prevent undue delays and possible degradation of medicines due to unsuitable storage conditions in customs was a waiver from testing for all Tech-Serve drugs procured through IDA and Mission Pharma, which was initially obtained from the Minister of Public Health in August 2007. When this waiver was to be renewed in 2010, the General Directorate of Pharmaceutical Affairs initially refused to accept it but later consented to the renewal. The waiver is now in effect and is being used by the Strengthening Pharmaceutical Systems Project (SPS) to clear shipped pharmaceuticals into the country.

Key Achievements 3 and 4: \$33,657,611 of pharmaceuticals stored in and distributed from central warehouses in Kabul

In 2006, Tech-Serve assumed management of the DMU staff as well as its warehouse management from the REACH project. The quality of the central warehouse operations management was excellent, reflected by less than 0.043% average percentage of inventory variance for more than 160 products between July 2006 and November 2011. The bulk warehouse was located on Ministry of Agriculture premises in Dar-ul-Aman, and a retail warehouse for distribution to PPG NGOs was located in the MSH office premises in Karte-Seh. By November 2006, it became clear that the Ministry of Agriculture refused to lease their buildings for longer than one month at the time. Tech-Serve rented and renovated an old factory compound in Gozargah which became the bulk warehouse in February 2007. In July 2008, the retail warehouse in the MSH compound was converted into offices, and an additional 2,000 square meters of warehouse space was renovated in the Gozargah compound to accommodate the distribution operation as well as additional bulk storage space. In mid-2010, a transition plan for transiting all DMU assets, stock, staff and operations was drafted between Tech-Serve and the USAID-funded Strengthening Pharmaceutical Services (SPS) project, and the warehouses and their existing stock, valued at \$8 million, were handed over to SPS in December 2011. The shifts in warehouse space and the transition to SPS took place without interrupting the scheduled distribution of medicines to the PPG NGOs.

Under REACH, the warehouse was occasionally closed for several days for inventory taking. With the shift to Gozargah, Tech-Serve implemented cycle counting of items in stock. Items are counted on a frequency based on volume and value, on a continuous basis counting 4-5 items daily, ensuring that each item is counted at least once every 12 months, while high value items are counted every quarter. The resulting average percentage of inventory variance for the whole stock was 0.043% during life of project, which reflects excellent quality of stock management. Tech-Serve's warehouse operations show that even without sophisticated equipment high quality stock management is possible.

Over the life of project, Tech-Serve distributed \$18,331,663.50 worth of essential medicines and \$7,966,249.44 worth of contraceptives benefitting more than 10 million Afghans. The number of regular recipient BPHS and EPHS facilities increased from 3,450 health posts and 332 health facilities in July 2007 to 6,000 health posts and 542 facilities in 2011. In addition, medicines were supplied to Wazir Akbar Khan Hospital in support of the management improvement project run by IMC, to Indira Gandhi Institute of Child Health for the period of December 2010 to September 2011 to establish the start-up of the new practice of Emergency Triage Assessment and Treatment (ETAT), and to two male health clinics administered by the Youth Health Development Organization (YHDO) to temporarily cover their needs for the period of May 15 to November 15, 2011.

A particular challenge for forecasting distribution needs was that projections were made more than a year before distribution, to allow for the complicated and long procurement pipeline, resulting regularly in medicines reaching the six month cut-off date for expiring (after which they cannot be distributed to the regular recipients). Close monitoring of soon-to-expire medicines allowed Tech-Serve to distribute most of the stock within the PPG and PCH project with some quantities to Afghan government facilities before the medicine actually expired.

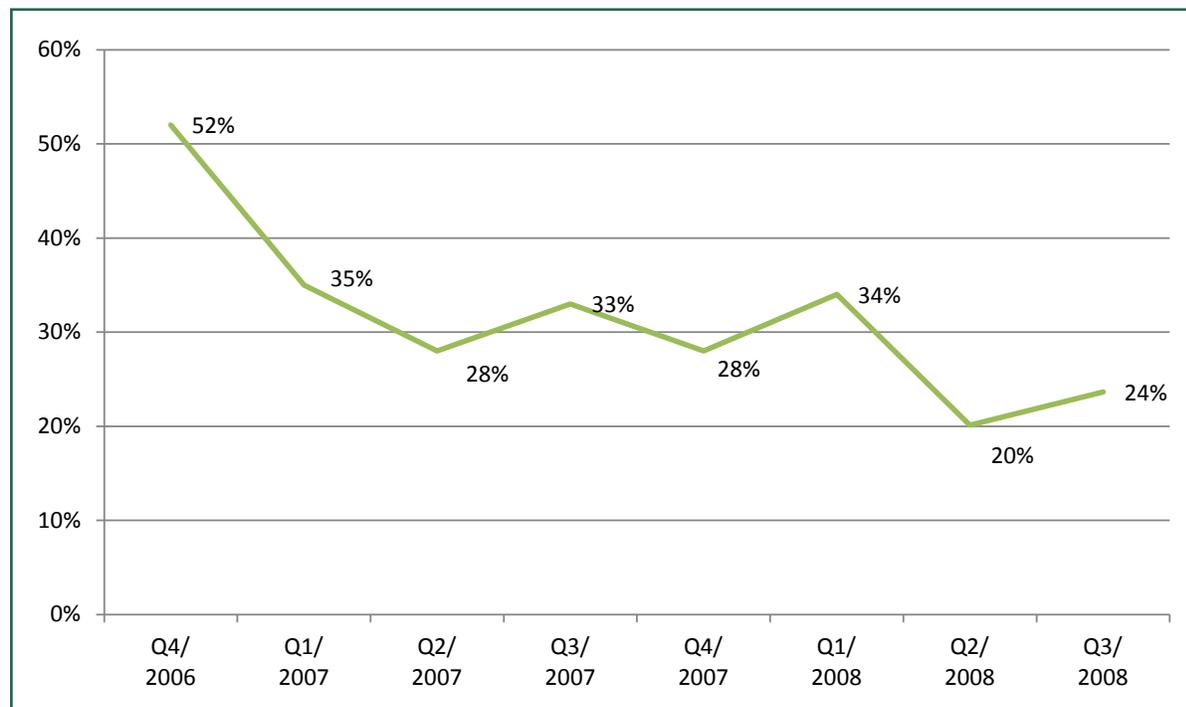
In order to minimize possible overstocks and stock-outs, the DMU routinely reviewed with the PPG and PCH NGOs the monthly consumption by facility, the calculated average monthly consumption by facility type, corrected for corresponding monthly patient load for each NGO, based on the Health Management Information system (HMIS) reports. With the transition from PPG to PCH, several new NGOs had to be brought up to speed. In order to facilitate the process, Tech-Serve developed a spreadsheet allowing NGOs to quantify their needs facility by facility based on average consumption and HMIS patient loads. NGOs started using the spreadsheet from May 2010 onwards.

Additional Tech-Serve Support in Drug Management Monitoring and Capacity-Building

Through Project Year 5, Tech-Serve provided additional support to the MoPH in the area of drug management monitoring and capacity building. In 2006, capacity building of NGOs, including pharmaceutical management capacity building, was mandated to the Health Service Support Project (HSSP). Interaction of Tech-Serve with the NGO managers and pharmacists was limited to quarterly meetings, where quantification problems and rational medicine use (RMU) was discussed. From 2007 onwards, Tech-Serve monitored a proxy indicator for RMU: the possible number of patients that received one antibiotic treatment, based on the total number of antibiotic treatments used in a quarter and the total number of patient visits reported in HMIS in the same quarter. Although it is a rough indicator that possibly underestimates the actual problem, it draws the attention of NGOs to the problem and promotes improvement (see Figure 6).

Tech-Serve began regularly monitoring the pharmaceutical supply management of PPG and PCH NGOs in March 2009. During this period, three DMU field monitoring teams (with two monitors per team) conducted 192 monitoring visits to PCH health facilities and 65 visits to the NGOs' provincial storage facilities in 12 provinces. The monitors assessed the supply management capacity and the rational use of medicines practices at the NGOs' health facilities, and assisted staff in preparing action plans to strengthen the areas in need of improvement. The monitoring visits also included NGOs' provincial pharmacy officers and Provincial Public Health Officer (PPHO) teams, providing the opportunity for Tech-Serve's monitors to carry out on-the-job-training in stock management and drug needs calculation for the provinces. The monitoring teams shared the findings with the PCH NGOs, HSSP provincial advisors, Provincial Health Advisors (PHAs), the PPH Officers of the relevant provinces, and the GCMU.

Figure 6: Improvement of RMU illustrated by a proxy indicator, Antibiotics Use

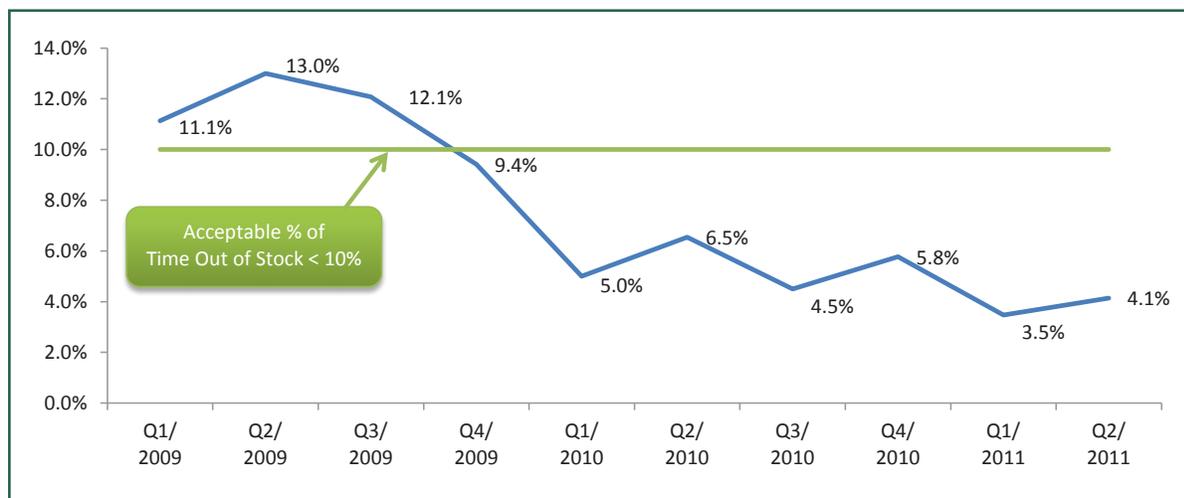


MSH's internal security regulations limited access of Tech-Serve to several NGO facilities in some districts in Kandahar, Badakhshan, Paktika, Paktia, Ghazni, Khost, and Baghlan provinces. As a solution, two staff members from each NGO clinic were invited to their relevant provincial centers and trained on drug quantifications from the Tech-Serve teams as well as oriented to the findings from other clinics within their province that Tech-Serve monitors had visited.

The Inventory Management Assessment Tool (IMAT) training was given to the directors, advisors, and pharmacy officers of five provincial hospitals and to the BPHS pharmacy officer of the PCH project. The drug quantification training provided to the pharmacy and HMIS officers of the PCH NGOs was designed to build the capacity of the NGOs' pharmacy staff to prepare accurate drug orders, to decrease the incidents of drug stock-outs in the hospitals, and to prevent overstocking of drugs. It was also designed to assist the pharmacy officers of PPHO teams in their future monitoring and evaluation of the pharmaceuticals management of implementing NGOs in their respective provinces.

To measure the historical availability of key essential drugs (using 30 tracer items) to treat common health problems, a retrospective review of stock cards of the health facilities over a given time periods of 12 months was undertaken. The analysis of the data shows that through carrying out regular monitoring visits at health facilities it has been possible to reduce the rate of stock outs gradually from 12.1% in mid-2009 to 4.1% two years later in mid-2011 (see Figure 7 below).

Figure 7: Average percentage of time out of stock



HEALTH MANAGEMENT INFORMATION SYSTEM

Key Achievements

1. More than 2,000 Afghans across the national health sector were trained in the routine HMIS, data use, data quality, and national surveys including the Catchment Area Annual Census (CAAC) and the household survey.
2. The Ministry of Public Health, by the project's conclusion, was implementing a Health Information Strategic Plan which provides a framework for the overall planning of a Comprehensive Health Information System (CHIS) for Afghanistan.
3. The quality of HMIS data as validated by a third party demonstrated accuracy of over 90%, which is almost double that found in Pakistan and Uganda, and similar to that of China and Mexico.
4. The National HMIS submission rate increased from 5% in 2003 to 90% in 2011 during a time of rapid health system expansion with the number of health facilities reporting to the National HMIS increasing by 32% between 2004 and 2010.
5. The National Ministry of Public Health developed National Core and Proxy Indicators.
6. Data use had been enhanced with the revision of the HMIS database which featured applications unique to the region including multi-lingual functionality, Shamsi and Gregorian calendar compliant with pre-defined indicators which are able to be displayed graphically.

Achievement 1: More than 2,000 people in national health sector trained in routine HMIS, data use, data quality, and national surveys (CAAC and Household Survey)

In 2012, the Use of Information and Data Quality Assurance Assessment was implemented nationally across all 34 provinces. The Use of Information in Evidence Based Decision Manual now provides a standardized systematic framework to assist all health service providers to better understand and to develop skills to be able to interpret and analyze data, results and information, identify abnormal trends and make decisions on how best to implement corrective actions to improve health outcomes. The Quarterly Provincial Health Coordination Committee has in attendance key donor stakeholders including the WHO, the Provincial Health Director and community members. This forum discusses performance results of the health sector. 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.

Traditional approaches to data quality generally only assess the accuracy and timely submission of information. Under Tech-Serve, a data quality assurance assessment tool was developed 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 the responsibility of HMIS officers at provincial level; it assesses the data quality of information being collected on four important indicators relating to the top priorities of the MoPH: (1) the number of first antenatal visits; (2) the number of family planning users; (3) the number of children under 1 year receiving Pentavalent vaccine; and (4) the number of outpatient department consultations. In addition, the following indicators will now be assessed to ensure the accurate completion of counts between the register, health facility and HMIS data: institutional delivery, acute malnutrition in children, TB cases (New pulmonary Positive), the number of positive plasmodium falciparum, Health Shura minutes, and stock status for Amoxicillin (Observe Stock cards).

Catchment Area Annual Census (CAAC): The CAAC is now implemented nationally and is a contractual requirement for all NGOs in all 34 provinces; prior to Tech-Serve's support, it was conducted sporadically and irregularly. This census is conducted by health posts and health facilities to determine the number of people who require health services within their respective catchment areas. This assists with setting specific targets for health post and health facility activities and provides basic morbidity and mortality data in vulnerable populations. Tech-Serve's role has been to provide technical advice to review the survey tool and methodology, to provide capacity building activities through mentorship and coaching to institutionalize the tool throughout the health sector, and to provide assistance in the analysis and writing of results.

Household Survey: 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. Using Lot Quality Assurance Sampling (LQAS), 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 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. The NGOs are held accountable to the central level through annual monitoring using the household survey, but also at the provincial level with results monitored through the provincial health directorates via the Provincial Health Coordination Committee meetings. Tech-Serve coached the HMIS and GCMU teams to learn how to design, apply and analyze this approach.

Over the life of the project, with the revisions of the HMIS and associated databases with the institutionalization of the CAAC, the household survey, the data quality assurance assessment tool and the manual for the use of information in evidenced based decisions, more than 2,000 health care providers have had an opportunity to enhance their skills to analyze information and make decisions so that health outcomes can be improved for the population of Afghanistan.

Achievement 2: Ministry of Public Health implemented Health Information Strategic Plan and Comprehensive Health Information System (CHIS) for Afghanistan

In 2007, the MoPH undertook a Health Metrics Network assessment of the health information system. A core team was created under the coordination of the Director of the Health Management Information System within the General Directorate of Policy and Planning. This core team was supported with short and long term technical advisors provided by USAID through Tech-Serve, and others from the World Bank and the European Commission. A Stakeholder Working Group was created with wide participation from all MoPH programs and departments, as well as the Ministry of Interior and the Central Statistics Organization (CSO). The progress of the strategic planning process was reported to and monitored by a Steering Committee chaired by the Deputy Minister for Policy and Planning and the Director General for Policy and Planning, with committee members coming from all relevant departments and interested partner organizations.

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 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 strategic plan completed in 2009 provides a framework for the overall planning of a Comprehensive Health Information System (CHIS) for Afghanistan.

Achievements 3 and 4: Accuracy of HMIS data over 90%, as validated by a third party

The National HMIS submission rate increased from 5% in 2003 to 90% in 2011 during a time of rapid health system expansion with the number of health facilities reporting to the National HMIS increasing by 32% between 2004 and 2010. Third party monitoring and evaluation provides an opportunity to validate internally collected information. The World Bank Resource Based Financing (RBF) project routinely measures the quality of information collected through the routine information system. Availability of timely and accurate information ensures that decision-makers have no excuse for not taking that information into consideration while making decisions and documenting their rationale based on them. The HMIS data quality, completeness, timeliness and accuracy are validated by two third party assessments. The most recent RBF data accuracy result of over 90% is almost double that found in Pakistan and Uganda, and closer to China and Mexico. Afghan National mortality survey (APHI et al 2010) data validate the trends in service coverage, infant and maternal mortality in HMIS data after accounting for underreporting.

Achievement 5: National Ministry of Public Health develops National Core and Proxy Indicators

In 2010, the MoPH and other key stakeholders developed national core and proxy health indicators with Tech-Serve providing technical consultation. Health service policy for the national level is set at the central level by a mandatory minimum package of health services, the BPHS for primary care and the EPHS for hospital services. In 2010, a revision of the BPHS and the EPHS occurred, necessitating an upgrade of the HMIS to ensure that changes to indicators within the BPHS and the EPHS could be collected and analyzed. The core and proxy indicators relate to the major health priorities of the MoPH including maternal and reproductive health, child morbidity and mortality, tuberculosis, malaria, HIV and mental health.

Achievement 6: Revised multi-lingual HMIS database enhances data use, is Shamsi and Gregorian calendar compatible, and displays pre-defined indicators graphically

Four national surveys which underpinned changes to the HMIS were conducted, with Tech-Serve assisting with the design of the surveys and the revision process of the HMIS. These included a national analysis of outpatient department morbidity cases, a national data use survey to understand better a clinician's understanding of case definitions and use of information, a national assessment of reporting requirements and focus group discussions amongst national MoPH departments with key stakeholders and vertical program areas to identify specific data needs. The result was a complete revision of the HMIS and its databases and procedure manuals and guidelines. This resulted in unique regional

applications including multi-lingual functionality, Shamsi and Gregorian calendar compliant with pre-defined indicators which are able to be displayed graphically.

HOSPITAL SECTOR STRENGTHENING (CENTRAL AND POLICY LEVEL)

Key Achievements

1. With Tech-Serve's assistance, the MoPH developed a roadmap to reform the hospital sector, with 14 national and specialty hospitals moving toward budgetary and procurement autonomy aiming for more professional autonomy in all aspect of hospital management in the future.
2. More than 1,300 management and clinical staff at twelve provincial hospitals (five USAID-funded EPHS implementing hospitals and seven non-USAID funded hospitals) received training and mentoring that has resulted in improved patient care and case management (details are provided in the IR.2 Provincial Level Strengthening section).

Achievement 1: Hospital sector strategy to increase autonomy

Tech-Serve has been involved in improving the capacity of Afghan hospitals since its inception in 2006; at that time, the future of Afghanistan's hospital sector was not clear, and there was little direction from within the MoPH to change the situation. The project's involvement expanded significantly following the establishment of Tech-Serve's Hospital Management Program in 2009. Since then Tech-Serve has supported the MoPH to bring focus and clarity to the hospital sector. The establishment of a Hospital Management Taskforce (HMTF) enabled the development of a comprehensive strategy aimed at improving performance within this sector.

Prior to 2009, hospitals had been suffering from two fundamental issues: (1) a centralized system of management by the MoPH left no authority for hospital managers; and (2) an opaque system for allocating and using resources made it impossible to rationalize management and ensure proper use of existing resources. These problems were most critical and most visible in the national hospitals, which serve as the final referral points for the whole country; actual and perceived nonperformance, misuse of funds, fraud and wastage reflected badly on the entire health system.

To gain broader consensus for addressing hospitals' needs, Tech-Serve assisted the MoPH to organize three consensus building workshops. As a result of these technical gatherings, the hospital sector strategy representing the roadmap for reforming the hospital sector in Afghanistan was developed. The Hospital Sector Strategy was approved by the MoPH in April 2011. The core of the strategy is to grant gradual and progressive autonomy to hospitals and to promote hospital-based fund generation initiatives for better operational management and sustainability.

Enabling national & specialty hospitals to implement autonomy: At the beginning of 2012, the GIROA decided to increase hospital's autonomy. Through an agreement between the MoPH and the Ministry of Finance, procurement and financial authority was transferred to the 14 national and specialty hospitals; an important step towards overall autonomy. The Ministry had originally considered a smaller pilot of this program among just three hospitals; the sudden scale up posed a huge challenge to the MoPH and its partners. Based on discussions with USAID, Tech-Serve was tasked with supporting the MoPH in the implementation of the new model.

To begin, Tech-Serve facilitated workshops on procurement and finance for the hospital management teams from the 14 hospitals, to familiarize them with the governmental process and procedures concerning procurement and financial management. At the same time, a number of consultants with expertise in finance, procurement and HMIS were hired to build the capacity of these hospitals to enable them to fully assume procurement and finance responsibilities.

An additional cadre of consultants is expected to be deployed after the Tech-Serve project's conclusion. This team will assist the 14 hospitals to prepare their budgets and procurement plans for the upcoming GoIRA fiscal year.

Ensuring financial sustainability of autonomous hospitals: A key section of the hospital sector strategy of the MoPH addresses the need for revenue generation and use for sustainable and better quality services through hospitals. In deliberations with the Ministry of Finance, the MoPH was advised to present to the Ministry of Finance and the Ministry of Justice a "regulation" that could pave the way for revenue generation at the hospitals through users' fees on tertiary care and investments, as well as establish mechanisms to utilize the revenues for other hospital needs and reform in other core areas of the hospital sector, such as human resources and administration. The draft of this "regulation" has been reviewed by the MoPH and is expected to be presented to other line ministries in the near future.

Development of tools and technical materials: Recognizing that the Afghan health system has suffered decades of isolation and stagnation, much effort is needed to standardize the systems in place and help those involved in health service delivery to comply with the globally accepted standards. Working with the central MoPH and provincial PCH hospitals, Tech-Serve assisted in the development of several management tools, including the Nursing Standard Manual, Clinical Protocols, the EPHS Monitoring Checklist and Training Package on Basic Health Economics:

- *Nursing Standards Manual:* Three decades of war in Afghanistan significantly eroded medical and nursing education, training, practice and standards, undermining the public's confidence in the quality of care they receive from these professionals. Tech-

Serve collaborated closely with the Ministry's Nursing Department to develop and document nursing standards and operating procedures, which had been identified as a priority during the hospital sector consensus-building workshop. The manual presents an approach to educate the clinician to develop a rationale for practice, to analyze the effectiveness of each clinical intervention and to develop modern nursing critical thinking skills. It also contains a broad overview of required nursing care competencies as addressed in the Fundamentals of Nursing. The manual was approved by the MoPH and printed and distributed by Department of Nursing for professional use.

- *EPHS Monitoring Checklist:* Though BPHS services are monitored using the BPHS national monitoring checklists, the EPHS was lacking a standard and nationally recommended monitoring tool. Tech-Serve collaborated with the General Directorate of Curative Medicine and Directorate of Monitoring and Evaluation to develop the National EPHS Monitoring Checklist. The tool is meant to provide a clear and focused way for assessing and analyzing key areas of hospital functions in order to develop priority areas for support and organized methods for initiating quality improvement. The checklist was approved by the MoPH in 2012.
- *Clinical Protocols:* Among the many challenges facing the hospital sector in general and the five EPHS hospitals in particular was a lack of proper case management. Tech-Serve worked with the five USAID funded EPHS implementing hospitals to adapt standard clinical protocols, geared toward improving both case management and resource utilization within those facilities. A manual containing these protocols was printed and has since been widely disseminated and used within these hospitals.

ADDITIONAL HEALTH SYSTEM STRENGTHENING AREAS

Key Achievements

1. With technical assistance by Tech-Serve, the MoPH has improved its leadership and governance roles through the development and implementation of key policy and strategy documents including a National Health Policy, a five-year strategic plan, and a National Priority Program.
2. Tech-Serve strengthened the strategic planning, coordination and M&E in the health sector by technically and financially supporting key MoPH forums, e.g., the annual strategic health retreat meetings, results conferences, Consultative Group on Health & Nutrition and the Technical Advisory Group, and supporting the MoPH on the Telemedicine Study.

3. Tech-Serve facilitated the process of consultations among the MoPH departments, which resulted in the development of the MoPH's on-budget funding proposal.

Achievement 1: Improved leadership and governance roles defined in key policy and strategy documents

Over the course of the project, Tech-Serve's support to the central level of the MoPH was instrumental in enabling the Ministry to develop essential policies, strategies, guidelines and standards to support the delivery of BPHS and EPHS services. Tech-Serve funded international and local experts to support the MoPH in advancing policy options and strategic directions. More specifically, the support of Tech-Serve was key in mobilizing assistance to help the MoPH determine its course of action in the implementation of BPHS and EPHS, and in health information (as described previously in this report), as well as in the areas of public relations, community and environmental health, and child and adolescent health (see Annex A for a list of policy and strategy documents that were developed with substantial involvement from Tech-Serve).

In addition, Tech-Serve staff were active members of the core working groups to develop the National Health Policy (2012-2020) and the MoPH's five-year strategic plan (2011-2015). The latter was finalized in 2011 following participatory discussions with key stakeholders on priority directions. References to strategic documents, policies and guidelines occurred to ensure consistency and minimize confusion. Tech-Serve provided technical advice and financial assistance to relevant committees including providing assistance with the translation and printing of the final document. Tech-Serve also provided technical assistance to monitor and write the first report on the progress of the strategic plan.

Through the Tech-Serve project, USAID funded senior advisor positions to the Directorate General of Policy and Planning at the MoPH; and a local consultant to represent the MoPH on the Inter-ministerial Committee for Health and Nutrition, who was tasked with coordinating health sector efforts to define National Priority Programs (NPP). Other areas of assistance included seconding full-time consultants to the Public Relations (PR) and Environmental Health (EVH) programs of the MoPH. Through this support, the Ministry was able to develop its first ever PR and EVH strategies.

The involvement of Tech-Serve in most policy and strategy setting meetings led the Ministry to achieve the following two results. First, the MoPH has a very comprehensive framework of policies and strategies to guide the action of all partners in the health sector. Second, most technical groups assigned to develop these key documents are being chaired and attended by local professionals; both on the parts of the MoPH and its partners. This is an impressive outcome since it depicts a promising prospective for the Afghan health sector in terms of sustainability and efficiency.

Achievement 2: Strengthened strategic planning, coordination and monitoring within the health sector

Tech-Serve supported important MoPH forums during the project, including the annual strategic health retreats, which contributed to stronger strategic planning, coordination and monitoring within the health sector. The purpose of the annual retreats was to provide a forum for high level decision makers representing the Ministry, the donor community and development partners to reach consensus, renew commitments and agree upon actions to remove critical constraints which may be hampering the implementation of key activities, with the overall objective of ensuring the long term sustainability of the health system.

The inaugural health retreat was conducted in 2007. The MoPH again held national retreats in February 2009 and January 2012, where its top leaders, donors and international organizations met to discuss priorities and chart next steps in a collaborative spirit. Tech-Serve played an important role in assisting the MoPH in planning, managing, and documenting both retreats and in paying for some of the costs. The second retreat benefited from lessons learned from the first retreat. One lesson was to restrict the number of topics discussed and the number of recommendations made; the first retreat covered too many topics and ended up with hundreds of recommendations and next steps, many of which were never implemented. Tech-Serve was also involved in the pre-retreat Technical Conferences (called Results Conferences) sponsored by the MoPH at which technical updates were presented on a wide variety of important technical issues.

In PY5, a District Health Office (DHO) Evaluation was designed by Tech-Serve and implemented by the Health Protection and Research Organization (HPRO) to provide strategic policy advice to the MoPH on the continuation of and method of support to the DHOs. The Acting Minister of Public Health indicated appreciation for the cost analysis component of the research. This was the first time that the inclusion of a costing component was incorporated into a research methodology in the MoPH.

In 2011, a team of MSH technical advisors and consultants carried out an assessment of telemedicine in Afghanistan. The purpose of this assessment was to provide an in-depth review and consultation on current health and medical services data and information systems and communications; to identify needs for improving data capture, recording, reporting and communications within Afghanistan's health services and systems; and to identify possible telemedicine, e and mHealth responses to these identified needs. The study made a series of recommendations as a result of meetings with relevant and appropriate actors, including the MoPH and the Ministry of Communications, USAID, private sector service providers and donor organizations. The study was submitted to USAID with principal recommendations to USAID and the MoPH that included: (1) Formulate an MoPH ICT strategy; (2) Set up MoPH ICT project monitoring; (3) Support the enhancement of the MoPH ICT Directorate with equipment, staff and training; (4) Identify

and support the provinces most requiring CHW-BPHS communications enhancement; (5) Monitor the expanding telemedicine experience and develop a telemedicine planning tool; and (6) Support the improvement of eLearning practices.

During its last year, upon instructions from USAID, Tech-Serve funded a third party study “Evaluation of Midwifery Retention in Afghanistan” conducted by a local research body, the Health Protection and Research Organization (HPRO). This Evaluation found that there has been impressive progress in increasing the antenatal care coverage and skilled birth attendance coverage through the expanded midwifery pre-service education in Afghanistan. Such change was partially attributable to greater access to midwifery services in the rural areas through initiatives such as the Community Midwifery Retention (CME) program. However, the benefits of this program were compromised when graduates did not remain in the public sector system. Based on the results from 11 provinces, the overall retention rates of CME graduate midwives in the public sector is 61.3%, with 36.8% working at their original deployment sites. This evaluation produced data-driven recommendations at both the policy and programming levels to improve trained midwife retention and protect the large investment to date in the midwifery education program.

Achievement 3: Tech-Serve facilitated planning and budgeting process for MoPH-USAID on-budget programs

The expanded on-budget program—the second phase after PCH—was designed to 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 was designed to align with the MoPH National Priority Program and the Strategic Plan (2011 – 2016).

Tech-Serve was mandated by the MoPH to be the lead technical partner in helping the Ministry of Public Health to design and budget its expanded on-budget programs. Throughout the six-month process, Tech-Serve facilitated a complex process of planning and budgeting by eight MoPH programs¹³ in order to apply and qualify for direct USG funding. By the end of this planning process, the project in addition to enabling the MoPH to generate its on-budget funding proposal, presented an evidence-based manual for the design of on-budget funding programs. This manual is an essential reference document for other sectors in the Afghan government and the USAID for designing their on-budget programs.

13 These programs included: HS: National hospitals reform; CBHC; HIS; Support to Office of the Private Sector Coordination; Child & Adolescent Health; Support to Provincial Health Systems; In-Service Training; Management & Leadership Development.

OTHER TECH-SERVE SUPPORT TO THE CENTRAL AFGHAN MINISTRY OF PUBLIC HEALTH

During the six years that Tech-Serve provided technical assistance to the Ministry of Public Health, there were a number of other activities where Tech-Serve's role was significant at the central level. These included the following:

- 1. Support to the MoPH's Consultative Group on Health and Nutrition (CGHN) and its Technical Advisory Group (TAG):** Tech-Serve staff served as key members of the flagship MoPH coordination forums, the Consultative Group on Health & Nutrition (CGHN) and the Technical Advisory Group (TAG). In addition to regular membership, Tech-Serve supported the Director General of Policy & Planning to conduct an assessment of the CGHN effectiveness in 2010. Based on the assessment results, the MoPH revised the Terms of Reference and membership of the CGHN meetings. The CGHN normally meets weekly and is presided over by the Deputy Minister for Technical Affairs. Units of the MoPH frequently present their proposed policy or strategy, or an NGO will present the results of one of its projects, or a research team may present its findings. Tech-Serve assisted the MoPH by analyzing the subjects presented at CGHN meetings and determining their effectiveness. The TAG differs from the CGHN in that its members are invited as individuals; the TAG also meets weekly. The usual sequence is that new policies or strategies are first presented at a CGHN meeting and if approved (usually with some changes requested) the policy or strategy is next presented to the TAG. Tech-Serve was very active in the TAG, usually with two Tech-Serve staff serving as members.
- 2. Ministerial Visits:** Under Tech-Serve, there were a number of visits made to the United States by the two Afghan Ministers of Health during the Tech-Serve project, Dr. Fatimie and Dr. Dalil. These trips usually involved a visit to Washington, DC, where they met US government officials, including members of congress, senior officials from the State Department and Defense, and representatives of international agencies and NGOs. Tech-Serve supported Dr. Fatimie, Dr. Dalil, and their accompanying MoPH delegations with logistical arrangements, talking points for various meetings, and suggestions regarding trip objectives. Dr. Fatimie met President George W. Bush on one occasion—Tech-Serve helped prepare him for this meeting. Tech-Serve also provided Dr. Fatimie, Dr. Dalil, and their accompanying delegations with logistics travel support to attend the World Health Assembly in Geneva. All of this assistance was done in collaboration with the USAID mission in Kabul and with USAID officials in Washington, DC.
- 3. Support to the Ministry's Communications Efforts:** Tech-Serve worked closely with the communications team of the central Afghan MoPH. For example:

- Tech-Serve provided technical assistance to help the MoPH develop a communications strategy and long-term communications plan to strengthen public relations.
- Tech-Serve assisted the Ministry spokesperson regarding how to provide the media and parliament with clear, accurate, and relevant information in a timely fashion.
- Tech-Serve received many ad hoc requests from the Ministry regarding dealing with crises that involved effective communications. For example, when the MoPH felt pressure to have all Afghan Hajis receive appropriate pandemic influenza immunizations before going to Mecca, it requested Tech-Serve's assistance in dealing with the problem. With help from USAID, Tech-Serve and the MoPH were able to quickly procure and ship the vaccine to inoculate thousands of Afghan Hajis before their departure. While supporting religious efforts is not allowed under USAID rules and regulation, this action was in line with the MoPH policy to support international travelers at a time when the risk of influenza was very high, and thus benefitted the Haji.

4. Tech-Serve's Support to GAVI and the Global Fund: GAVI and the Global Fund have been extremely important sources of funding and expertise for the MoPH. MSH has provided a significant amount of technical assistance to the Ministry in developing proposals for both GAVI on health systems strengthening and the Global Fund (for TB, malaria, and health systems strengthening). From May to August 2008, Tech-Serve provided two very senior and experienced public health experts to assist the MoPH with its Global Fund proposals for both malaria and TB (both were funded) and in 2010, Tech-Serve provided a consultant to help the MoPH with its GF Health Systems Strengthening proposal (also successful). These efforts resulted in \$100 million in Global Fund support to Afghanistan. In addition, Tech-Serve has closely collaborated with MSH's Grants Management Solutions project teams assisting the Country Coordination Mechanism for the Global Fund. This collaboration between Tech-Serve and the MoPH regarding both GAVI and the Global Fund has been extremely productive in terms of obtaining significant funding to strengthen Afghanistan TB, Malaria, Immunization programs and support the health system development.

Other interventions in management and leadership development have been more ad hoc; some through direct technical assistance by Tech-Serve consultants and others through coaching and on-the-job training, as well as through the participation of selected MoPH teams in study tours and in interventions such as the LDP and MOST.¹⁴

14 MOST is the Managing Organizational Sustainability Tool, developed by MSH that helps organizations to review their internal management processes for areas to improve.

The impact of these interventions is hard to substantiate quantitatively, yet positive changes have manifested themselves over the years. If in 2003 most meetings and much of the decision making at the most senior levels of the MoPH were led by expatriates; now, nine years later, these processes are led by Afghans with little if any input from expatriates. Tech-Serve has introduced and modeled team work, giving presentations, managing team meetings, leading group discussions and using data for decision making, among other things. These skills have been adopted and are used daily within the Ministry. Tech-Serve cannot take credit for this alone of course; the MoPH has been able to attract and retain, with the help of donor funding, very qualified staff at these levels and capacity building has been in the mandate of many other projects. The resulting synergies have created this impact which ultimately is reflected in decisions that have positive implications for the people of Afghanistan who are in need of health services.

IR 2: Improved capacity of the 13 MoPH Provincial Health Offices and 4 Quick Impact Provinces supported to deliver BPHS and EPHS

The development of provincial capacity achieved in USAID-focused provinces with the support of the Tech-Serve project is widely recognized by the MoPH and by external observers as being a success, and one that the MoPH would like to expand to all provinces and that other donors are looking at to take lessons from, if not exactly replicate.

PROVINCIAL HEALTH SYSTEMS STRENGTHENING

Key Achievements

1. As a result of assistance provided by Tech-Serve, the Provincial Health Systems in 17 provinces are governed effectively through a defined framework of core functions and tasks.
2. Tech-Serve assisted the MoPH to decentralize learning to the field level by helping to establish Provincial Health Learning Centers.

Achievement 1: Tech-Serve technical assistance supports effective governance of Provincial Health Systems in 17 provinces using a defined framework of core functions and tasks

Building upon the success of REACH in enhancing the capacity of the Provincial Public Health Offices (PPHOs), and on the results of a comprehensive needs assessment carried out during the first few months of the project, Tech-Serve's strategy in this area involved designing and deploying a package of assistance focused at the PPHOs called "Management Support to Provinces" (MSP) initiative. MSP is a result-oriented initiative to improve the effectiveness of PPHOs at leading the health system in their respective provinces through leadership, management and public health enhanced capacity.

Success Story

New Provincial Learning Center Opens in Kandahar

Provincial health leaders and managers in Afghanistan's southern region have a new forum for sharing tools and best practices, with the opening of the new Provincial Health Learning Center in Kandahar.

Following the successful establishment of the first Provincial Health Learning Center in Herat, the Provincial Capacity Building team from USAID's Tech-Serve Project, in coordination with the Ministry of Public Health's Provincial Liaison Directorate, decided to expand this model to other provinces. Kandahar province was chosen as the site for the second facility, due to its high-performing health team, and its central location for neighboring provinces that are less secure and more difficult to reach.



Health leaders and managers in southern Afghanistan have a new forum for exchanging information and learning from each other.

The Kandahar Provincial Health Learning Center was inaugurated on April 9, 2012, with representatives from the Ministry of Public Health's Provincial Liaison Directorate, USAID, the Provincial Reconstruction Team, the World Health Organization, non-governmental organizations, and other stakeholders. In addition, provincial health teams from the neighboring provinces of Helmand, Maidan-Wardak, Ghazni, Zabul, and Nimroze attended.

Following the inauguration ceremony, the team from Kandahar led the visiting provincial health teams in two exercises designed to highlight their best practices. The first exercise looked at how to update and analyze core health indicators, and was followed by site visits to two health facilities, where the neighboring provincial teams saw how these practices were applied.

The second exercise focused on conducting Monthly Provincial Public Health Coordination Committee (PPHCC) meetings, during which an actual meeting of PPHCC was conducted. Participants observed all processes of the meeting and provided feedback about the exercise.

One attendee, Dr. Amanullah, the Primary Health Care Officer of Maidan-Wardak province noted, "We observed many positive points in this PPHCC meeting; we will replicate these points in our own province soon, where we plan to conduct the PPHCC meeting."

Following this first learning exchange, the visiting teams returned to their provinces with action plans to implement what they have learned. The host team of Kandahar conducted an after action review to identify the strengths and weaknesses of the program, and prepare for the next round of learning exchange. Dr. Lal Mohammad, Acting Director in Zabul Province noted, "This exercise was very useful for our team. We learned how to calculate key indicators and from which sources we will take the data. When I return to my province, I will use the data to make evidence-based decisions."

Success Story

Sharing Leads to Better Health

Twenty-four men and two women sit around a “U” shaped table inside a brightly painted room in the newly built Ministry of Public Health office in Herat Province. Participants from provincial public health offices had gathered to share their experiences in rebuilding Afghanistan’s public health system. Surrounded by walls lined with posters and colorful charts, the group listens intently to a speaker at the front.

Herat, in western Afghanistan, has long been regarded as one of the country’s most prosperous and stable provinces, and the Herat provincial health team is recognized as a model for public health management and leadership. To get the most out of this, USAID, in partnership with the Ministry of Public Health, helped establish the Herat Learning Center to enable health professionals to learn from their peers in other provinces how to manage and lead a provincial public health system.



Dr. Fazel Karim Saeedi delivering a speech on the effectiveness of the Herat Provincial Health Learning Center during a task sharing and learning exercise.

Three months after its inauguration, the center hosted its first visitors from five provincial public health offices. For the first session, USAID’s project staff took the lead to share their best practices, demonstrate their strengths and achievements, and inspire others to initiate improvements in their provinces. The four-day exercise looked at key health service indicators and annual operational planning.

By the second meeting, instead of outside facilitators, the local Herat provincial health team facilitated the discussion to empower Afghan health officials to teach each other best practices and lessons learned.

Dr. Fazel Karim Saeedi, provincial public health director of Kabul Province, said, “The food hygiene monitoring and the environmental health practices in Herat are an excellent model to be copied in other provinces. We have listed some actions to be undertaken after we return to our own provinces. I really appreciate the Herat Public Health Office team for their high performance and the results they have achieved.”

USAID develops the capacity of the Ministry of Public Health to manage the health care delivery system and improve the capacity of provincial health offices in 17 Afghan provinces.

By establishing the Provincial Health Learning Center, the Ministry of Public Health is strengthening the trust between the Afghan government and its citizens.

The MSP involved training, mentoring and networking activities as well as the improvement of the PPHOs' infrastructure, most importantly computers and reliable internet connection. At the heart of the MSP and pivotal to its implementation was the embedding of Tech-Serve Provincial Health Advisors (PHAs) at the PPHOs.

The primary aim of this model was to enable the PPHOs and PPHDs to regularly perform their tasks and functions and to also adhere to MoPH defined standards and procedures in order to generate optimal results. Tech-Serve's initial program design was to begin with only few PHAs in the first year. The MoPH's demand for the general deployment of the MSP to all provinces became rapidly overwhelming so that by the end of PY2, with USAID's agreement, all PPHOs in the 13 USAID-focus provinces were covered by MSP and staffed with a PHA. These resident advisors, preferably hired from the province or the region, facilitated in-service training for the PPHO teams and coached them in their day-to-day functions. PHAs also facilitated networking activity among several teams so that best practices could be shared. In addition, Tech-Serve provided a limited amount of operation support including basic office equipment, internet connectivity and transportation facility for monitoring purposes.

In addition to short-term, in-service training, Tech-Serve has sponsored certificate programs in public health management with the Aga Khan University in Karachi, Pakistan. Networking has been carried out by periodic meetings of health officials from various provinces during which common interest themes and challenges are being analyzed and discussed, and lessons learned and best practices exchanged.

This strategy generated excellent results in a short period of time. There was a sudden and dramatic improvement in the performance indicators of the PPHOs, at least in terms of them performing their basic functions. Coordination with partners improved as documented by the number of well-structured PPHCC and sub-committee meetings. PPHOs began M&E of their health services situation by regular monitoring visits to the field; reviewing NGO technical reports; and review and analysis of the HMIS data on regular basis. Data and information use for decisions and improvement of performance was widely practiced. For instance, almost every monitoring activity was followed by written feedback to the service providers (in this case mostly the contractor NGOs), who would in turn document action by developing action plans and later reports to the PPHO. Communication with partners and central level improved a great deal. Provincial officials of the Ministry presented and negotiated development proposals to the Provincial Reconstruction Teams and other local sources in order to mobilize resources locally. PPHO staff were enrolled in different training activities, including LDP and public health management, through on site (in country and overseas) and online mechanisms. All these indicators, when compared with non USAID funded provinces, would consistently show stark differences.

In 2009, Tech-Serve assisted the PPHO in Herat to define its framework of core functions and tasks as well as performance standards for the tasks. The framework that originated

from this functional analysis of the PPHO in Herat has become a basis for the PPHOs' performance of its stewardship role, self-assessment and improvement of performance. The framework was tested in several provinces and in April 2012 was endorsed by the MoPH Executive Board as a national level tool.

Achievement 2: Establishment of Provincial Health Learning Centers (PHLC)

In the initial years of Tech-Serve, a number of networking exercises were conducted to provide opportunities to the PPHO teams to exchange their best practices. Later on, as the framework on core functions was developed, the concept of establishing a Provincial Health Learning Center (PHLC) was initiated in order to address the following two products of the core functions assessments: highly performed functions and tasks that had a potential to be shared with other provinces; and tasks that could be improved through an exchange of practices.

Therefore, the PPHO of Herat took the initiative and with assistance from Tech-Serve, the first PHLC was opened in Herat province. Since early 2010, PPHO teams from several provinces have travelled to Herat and attended "task sharing exercises." Following each exercise, the visiting teams prepared their action plans to focus on improving particular practices in their work settings. The visiting and hosting PPHO teams have recognized the PHLC as a strong mechanism of cross province exchange of practices. Two years after the establishment of the first PHLC, Tech-Serve supported the MoPH to establish the second PHLC in Kandahar province in April 2012. As an immediate result, the team of Kandahar organized its first learning exercise for five provinces of the region. Following the exercise, a team of the Kandahar PPHO traveled to a neighboring province (Zabul) to coach that provincial team in carrying out their first Provincial Public Health Coordination Committee (PPHCC) meeting.

These success stories encouraged the MoPH Provincial Liaison Directorate (PLD) to scale up this initiative to other provinces which have the necessary capacity and demand. This initiative was also endorsed by the MoPH Executive Board for national level scale up.

HOSPITAL SECTOR STRENGTHENING (PROVINCIAL LEVEL)

Key Achievements

1. More than 1,300 management and clinical staff at twelve provincial hospitals (five USAID-funded EPHS implementing hospitals and seven non-USAID funded hospitals) received training and mentoring that has resulted in improved patient care and case management.

USAID is funding the service delivery and operations of five provincial hospitals (Khost, Paktia, Paktika, Ghazni, and Badakshan) through the PCH project. Tech-Serve, in collaboration with the contracted NGOs, the Ministry's Health Economics and Financing Department, the PPHOs and other relevant stakeholders, improved the operation and

management of these hospitals. Main objectives of the support were to improve the hospitals' performance, improve the quality of patient care, and increase the management and leadership capacity of those responsible for managing the hospitals.

To achieve these objectives, Tech-Serve sponsored a series of training sessions by a third party, the Bangladesh Rural Advancement Committee (BRAC), for the management teams of these provincial hospitals. In addition, Tech-Serve expanded the coverage of these trainings to seven additional provincial hospitals in order to respond to a) the training needs in other PCH provinces even though these facilities were not funded by USAID, and b) the bilateral Quick Impact Initiative. The training was organized in Kabul in eight groups and practical sessions were conducted at the Cure International Hospital. In total, 52 members of hospital management teams (including the hospital director, medical coordinator, hospital administrator, NGO focal point and hospital adviser) from 12 PCH supported hospitals were trained. The training content supported the development of an operational plan for each provincial hospital and the monitoring of that plan.

In the five USAID funded hospitals, the draft operational plans from PCH-supported provinces were reviewed by the implementing NGOs and Tech-Serve hospital management team, which offered feedback to ensure that plans were realistic and practical. As a result, annual operational plans, implementation plans, and transparent monitoring systems are in place and allow for mutual accountability between the hospitals, EPHS-implementing NGOs, and the MoPH (through the GCMU). These hospital management teams now regularly carry out hospital situational analysis, interpret qualitative and quantitative data, and make evidence-based decisions. In late 2011, Tech-Serve transitioned the responsibility of quarterly reviews of these operational plans to the MoPH GCMU/PCH. Please see Table 1 on the following page for more details.

Tech-Serve also assisted these five hospitals to address financial challenges, ensuring that they now have a petty cash fund to buy small items of critical importance and an unpredictable nature; that their implementing NGOs are communicating budget and expenditure information to the hospital management team on a quarterly basis; and that the financial managers can now do a Budget Burn Rate Analysis and a Budget Burn Trend Analysis.

Table 1. Training facilitated by Tech-Serve for five provincial hospitals

#	Type of Training	# of people trained
1	Hospital management; management and supervision	105
2	Blood Bank management	15
3	Leadership & Management	320
4	Facilitation Skills	11
5	Financial management	94
6	Rational Drug Use; Management of Drug Supply	20
7	HMIS	100
8	Lab Skills	53
9	Nursing Care	203
10	ETAT	43
11	Ultrasound	21
12	Internal medicine	61
13	Pediatric	47
14	Ob/Gyn	32
15	Surgery	53
16	ICU care	43
17	Anesthesia	39
18	X-ray	16
19	Midwifery care	62

Intensive clinical training: In-service training for medical staff is an important factor to ensure the quality of care for patients. Through a subcontract with Cure International Hospital in Kabul, Tech-Serve supported the improvement of case management in the EPHS hospitals. Given the limited opportunity for clinicians to receive refresher or advanced skills training, the one-month training was a good opportunity for the medical staff of these provincial hospitals. Through this initiative, 20 health care providers – physicians, nurses, midwives and lab technicians – attended intensive clinical training at Cure International Hospital each month.

During the life of Tech-Serve, in total 723 medical professionals from the 12 provincial hospitals were trained. Following the trainings, an outreach team from various medical specialties would then visit those hospitals to assess the impact of the training and to provide additional on-the-job training. These visits showed that the trainees replicated the best practices they had acquired and that case management had improved. For instance, certain procedures being performed post-training, e.g., repair of cleft lip, spinal anesthesia, repairing lacerations of the genitalia during labor, and the use of the Netrazine Test to diagnose a ruptured membrane, are now being effectively carried out by the medical staff at those hospitals.

OTHER TECH-SERVE SUPPORT AT THE PROVINCIAL LEVEL

During the six years that Tech-Serve provided technical assistance to the Ministry of Public Health, there were additional activities to the ones described above where Tech-Serve's role was significant at the provincial level. These included the following¹⁵:

1. Supporting the MoPH in the deployment of 5,851 additional Community Health Workers in USAID focus provinces from 2005 to 2011, bringing their total to 11,952, of which half are female. This increase of 96% in the number of active CHWs along with the increasing number of CHWs nationwide is among the prime factors for the significant improvement in reducing maternal and child mortality and morbidity in Afghanistan.
2. The number of health centers and district or regional hospitals added into the health system and integrated into the PPG, and later on PHC, funding mechanism for delivery of the BPHS and EPHS increased by 61%, from 342 facilities in 2006 to 550 in 2012.
3. The sharp increase of BPHS and EPHS delivery points achieved by the health system from 2006 to 2012, coupled with the increased use of facilities by the population resulted in very significant increase in the number of clients/patients served over the same period: 5.3 million clients/patients served during 2005 compared to 23.6 million in 2011, an increase of 345% over the period.
4. Drug management at service delivery points improved in many key areas as a result of Tech-Serve support such as monitoring visits, during which on-the-job training was delivered, and training on rational use of pharmaceuticals. Prescriptions for antibiotics at BPHS, for example, declined from 52% of clients treated to 24% between the end of 2006 and the end of 2008, while stock out rates went down from 13% in 2009 to 3.5% in 2011.
5. More than 2,000 Afghans across the national health sector (most of them at the decentralized levels) were trained in the routine HMIS, data use, data quality, and national surveys including the Catchment Area Annual Census (CAAC) and the household survey, achieving rates of HMIS data quality of over 90% and achieving National HMIS submission rate of 90% by end of Tech-Serve.
6. All 17 Provincial Public Health Offices have now a HMIS Hub that was either installed with Tech-Serve assistance or upgraded by the project.

15 As many of Tech-Serve's interventions integrate systems strengthening at all levels, some of these are described in more details in other parts of the report such as in Section IR1 where capacity building at the central level is covered.

7. The Tech-Serve Provincial Health Advisors carried out 1,056 joint supervisions visits at BPHS and EPHS facilities with PPHO team members and representatives from service delivery NGOs. On-the-job training of facilities managers and providers were carried out during these visits as well as coaching of the supervisors by Tech-Serve PHAs.
8. By providing proposal writing training Tech-Serve assisted the PPHOs in looking for and mobilizing local resources in coordination with the central MoPH to improve health outcomes in their provinces. A table providing illustrative examples of how this investment has paid off is in Annex B.

IR3: Developed planning, management, supervision, monitoring and evaluation, and leadership capacity of the MoPH

LEADERSHIP DEVELOPMENT PROGRAM (LDP) AT CENTRAL LEVEL

Key Achievements

1. The Management and Leadership Development Department was established (MLDD) at the MoPH.
2. Leadership and management development was made functional by the introduction of management and leadership practices and tools for improving work processes, decision making and problem solving.
3. A process for certifying and registering experienced management and leadership development facilitators is now in place that the central level and provinces can call upon.
4. The Afghanistan National Blood Bank (ANBB) participated in the leadership development program which empowered several teams to review blood safety measures, infection prevention, reduce costs and attract new blood donors. The ANBB competed for an award on best practices in management and leadership, sponsored by the Leadership, Management and Sustainability project (LMS), a USAID-supported and MSH-implemented global project, and received second prize.
5. Five Central MoPH units began to use LDP methodology for achieving results (General Directorate of Primary Health Care, General Directorate for Administration, General Directorate of Policy and Planning, General Directorate for Human Resources, Provincial Liaison Department).
6. The LDP is well-known in the health sector for its practicality to meet challenges and friendly use of its tool by various categories of managers and service providers at national, sub-national and community levels.

Success Story

Encouraging Voluntary Blood Donation in Kabul

Blood donors save lives by providing vital transfusions for people in need due to illness and injuries. However, with a low number of voluntary blood donors in Kabul, the Afghanistan National Blood Safety and Transfusion Services Directorate (ANBSTD) was constantly faced with the possibility of blood shortages.

Dr. Ahmad Masoud Rahmani is the National Director of the ANBSTD in Kabul, which was established in 2009. In 2011, USAID invited Dr. Masoud and his colleagues to participate in a Leadership Development Program (LDP), to learn how to apply leadership practices to address challenges in their work environments. The blood bank team decided to tackle the low number of voluntary blood donors.



A voluntary donor gives blood in Kabul.

Traditionally, blood was being collected from three types of donors: voluntary blood donors, who donate without being asked, for altruistic reasons; family replacement donors, who donate in response to their relatives' needs; and paid donors. Paid donors made up nearly 25% of the overall donor pool.

Dr. Masoud and his colleagues decided to increase the number of voluntary donors by 20%, and thus eliminate the need for paid donors. They knew that one of the root causes behind the low number of donors was a lack of awareness regarding the need for these services.

Using the leadership skills they learned about how to align and mobilize stakeholders, as well as how to inspire others, the LDP participants launched a community awareness campaign on several levels: first, they targeted VIPs such as local political leaders and influential religious leaders, and convinced them to both give blood and to talk to their constituents about it. They also contacted the media, persuading them to broadcast and print stories about the critical importance of blood donation. Finally, they reached out to groups such as the international community and local groups/ associations, to conduct blood drives among their memberships.

In just 12 months, the outreach campaign had a significant impact, with the Blood Bank meeting its goal to increase the number of voluntary donors to 50% of the total donor pool. Dr. Ahmad Masoud Rahmani, National Director, of the Afghanistan National Blood Safety and Transfusion Services Directorate, noted, **“We convinced the public that blood donation was something positive.”**

As a result, patients needing blood are sure to receive these vital transfusions.

Among Tech-Serve's biggest accomplishments in relation to developing the management and leadership capacity of MoPH staff is the establishment of the Management and Leadership Development Department within the General Directorate for Human Resources. This department is tasked with capacity building of mid-level and senior staff in management and leadership. With this step, the ministry has recognized that a clinical education, a common criterion for selection and promotion, is not enough to reduce maternal and child mortality and morbidity. This attention to management and leadership as a legitimate concern for health officials is a significant accomplishment, and was achieved through the contributions of countless Afghan management and leadership development champions. How these champions were created is described under the provincial management and leadership section below.

The team that is now staffing the Management and Leadership Development Department is made up of a subset of these energetic champions of MSH's Leadership Development Program (LDP)¹⁶ who are well versed in the critical pedagogical approach that underlies the program. In this program, health teams select a challenge to focus on and systematically work through a series of questions that lead them to identify root causes, mobilize and organize available resources, overcome obstacles and implement a change plan. The LDP helps organizations to develop managers who lead, with a vision of a better future, by focusing on three objectives: learning the basic practices of leading and managing their work teams to face challenges and achieve results; creating a work climate that supports staff motivation; and creating and sustaining teams that are committed to continuously improving client services.

Over the course of the Tech-Serve project, the LDP went from being an external intervention conducted by expats, to a fully owned Afghan program that has been delivered countless times in all of the USAID-supported provinces, and has attracted the attention of officials in provinces supported by the European Union (EU) and the World Bank. Skilled facilitators have brought the program to some of these provinces and are grooming local facilitators to continue the program.

LEADERSHIP DEVELOPMENT PROGRAM (LDP) AT PROVINCIAL LEVEL

Key Achievement

1. More than 1,800 health professionals, including MoPH senior managers, have experienced the power and rewards of using the LDP, working in their teams on selected challenges and improving services and/or processes within their health sites.

16 Since 2002, more than 4,000 participants from 36 countries worldwide have participated in MSH's Leadership Development Program (LDP).

At the conclusion of Tech-Serve, Leadership Development Programs had been conducted with staff from 180 health facilities in all 13 USAID-supported provinces and four World Bank supported provinces (17 in total), reaching more than 1,800 health professionals.

Interest in implementing the LDP in Afghanistan began in June 2005 (pre Tech-Serve, under the REACH project) when 15 MSH and Afghanistan Ministry of Public Health (MoPH) employees went on a study tour to see the effects of a similar program in Aswan, Egypt. Participants included six Provincial Health Advisors, two central MoPH staff, and six provincial MoPH staff.

As a result of the interest generated by the study tour, an initial LDP took place in Takhar Province in late 2005, one of 13 provinces benefitting from USAID support. Facilitators of this first LDP included two MSH employees – a Provincial Management Officer and a Provincial Health Advisor (PHA), and an MoPH Director.

The second LDP in Afghanistan, also conducted in 2005, took place in Bamyan Province and included two LDP master trainers from MSH Headquarters who trained six facilitator teams of five persons each to work in six provinces. The five member teams of facilitators consisted of two NGO members, two MoPH Provincial Health Officers, and one Provincial Health Advisor (PHA).

This influx of new trainers led to a rapid scale-up of LDP activities. In July 2006, MSH Provincial Health Advisors were paired with MoPH Provincial Health Directors and NGO service providers in implementing LDPs in the remaining seven USAID-supported provinces.

In the early days of the Tech-Serve Project, the Provincial Health Advisors (PHAs) and their provincial health office counterparts attended training sessions in the LDP methodology. MSH organized frequent refresher sessions to make sure that the new LDP facilitators learned through practice with extensive feedback and support, two critical components of the MSH approach to leadership and management development.

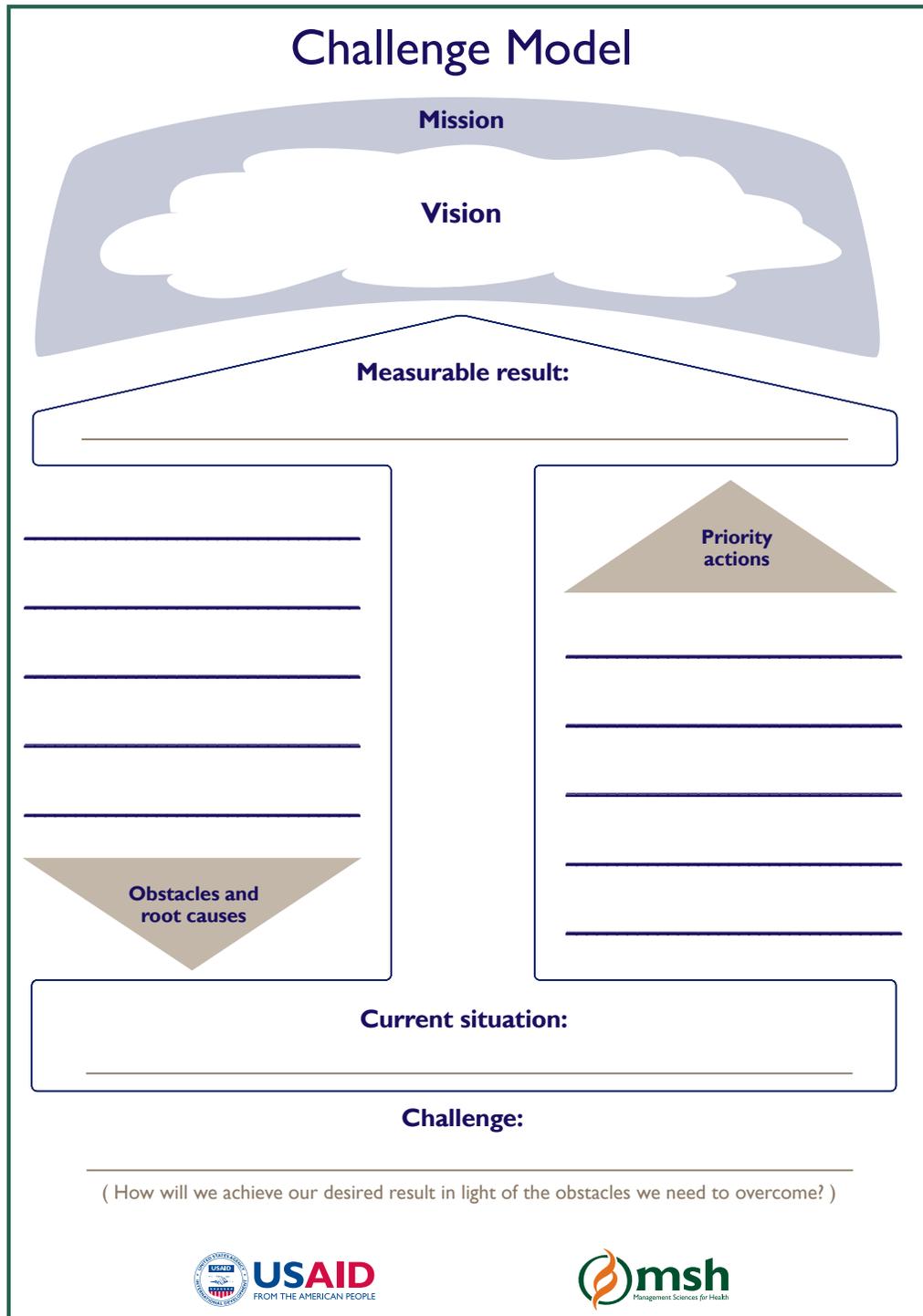
Upon their return to the provinces, the PHAs created LDP committees, made up of representatives from the NGOs, the public sector and sometimes other donor project staff. These committees organized LDPs and refresher training, following a cascade model. Out of this approach emerged a group of dedicated and influential LDP leaders who provided much of the impetus and enthusiasm that paved the way for a sincere interest at the MoPH in management and leadership, culminating with the establishment of a dedicated department.

This cascade model of training allowed for a uniform terminology which made talking about management and leadership improvements more focused and actionable: with respect to leadership improvements, teams found out they had to scan more, or focus

more, identify their stakeholders or provide more acknowledgements to staff. With respect to management improvements, team members learned, sometimes for the first time, the basics of planning and of monitoring and evaluation.

The combined effect of these practices moved the teams to achieve their intended results as they used a tool called the Challenge Model (Figure 8) to move from a current situation that

Figure 8. The Challenge Model



was not acceptable to one that everyone wanted. In many cases the act of creating a shared vision and stating a 'measurable desired result' was novel and inspiring to staff, especially those who had not felt empowered or who had lacked self-direction. Formerly passive employees banded together to tackle a challenge they never thought they could work on.

In 2010, Tech-Serve commissioned an assessment of the LDP that covered a sample of 56 teams in eight provinces, using as rigorous a methodology as was possible given the circumstances (security issues, access to those receiving services).¹⁷ The assessment addressed two questions: (1) Does the LDP have a measurable impact on the delivery of health services at the facility level against a comparison group? (2) What are the qualitative factors that affect the implementation of the LDP training and its outcomes?

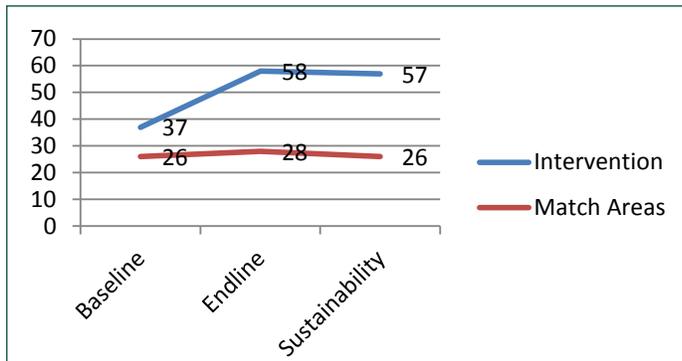
The study undertaken in the spring of 2011 across eight provinces used a quasi-experimental design that compared before and after measures of the indicators addressed by the LDP teams against matched comparison groups that did not participate in the LDP. Measurements of health service indicators were taken in 56 health facilities, 51 of which at three time periods: before each LDP (baseline), at the end of each LDP (endline), and approximately six months after each LDP ended (sustainability measure). Measurements for the remaining five facilities were taken at baseline and endline only, because these teams had completed the LDP less than six months before the assessment period concluded. Of the 56 teams included in the study, four were from hospitals, 45 from comprehensive health centers, and seven from basic health centers. These 56 teams addressed challenges that spanned nine different service delivery indicators, including antenatal care, normal deliveries, childhood immunization, new family planning cases, outpatient department visits, postnatal care, tuberculosis detection, and two doses of tetanus toxoid.

As illustrated in Figure 9 below, the combined average for the 51 teams that were analyzed with the sustainability measure showed that the coverage for the team's key result indicator was 37% before implementation of the LDP. At the end of the LDP, approximately six months after the baseline measurement, coverage had increased to 58%. Approximately six months after the end of the LDP, coverage remained at essentially the same level (57%). Results in the matched comparison areas remained stable for the three time periods (26% at baseline; 28% at endline; and 26% approximately six months after the intervention).

Qualitative data for the teams that improved indicated that most LDP participants cited team work and commitment as the reasons they were able to achieve their results. A few others mentioned an increased ability to develop action plans and prioritize challenges.

17 The persistent challenges in accessing accurate data in Afghanistan, due not only to security issues but also because of poor data collection practices, present an inherent limitation of this study.

Figure 9: Results of LDP on coverage rates for 9 HMIS indicators at health facilities in 8 USAID focus provinces (LDPs carried out over 2007-2011 period)



In July 2011, health facility teams from nine provinces in Afghanistan gathered in Kabul to present the results of their participation in the LDP. The study and these facility teams' results were presented to a large audience of MoPH and other stakeholder representatives in Kabul. Two of the service delivery improvements presented by the

teams were an increase in the number of children under age five whose growth is being monitored, and an increase in the number of women choosing to give birth at a health facility. Provincial LDP participants also highlighted how strengthening their leadership capacities enabled them to mobilize resources locally – financial, material, political will, and human resources – which also contributed to improved quality, quantity and reach of health services.

At the conclusion of the Tech-Serve project, staff working at the LDP sites in the provinces were continuing to help each other articulate the office or facility's mission, create a shared vision, identify a critical and urgent challenge, conduct a root cause analysis and, on the basis of that, set priorities and develop an action plan as well as an M&E plan. By systematically, intentionally and consciously using the management and leadership practices they are able to produce the result they have selected.

IR4: Strengthened capacity of the Ministry of Education to plan, manage, and account for USG on-budget resources

Key Achievements

1. Tech-Serve assisted in the preparation of the Ministry of Education (MOE) to go on-budget by supporting the recruitment, selection and hiring of a team of consultants to support the on-budget Project Management Team (PMT), who will eventually be responsible for managing on-budget funded procurements and activity implementation and monitoring.
2. Tech-Serve assistance provided formal guidance to the MOE by presenting the Transition Director a detailed Activity Plan (in the form of a Request for Proposals) for Teacher Education, and providing a Road Map for going on-budget.

Achievement 1: Support to MOE as it transitions to on-budget management

Building on the success of PCH/MoPH and based on the donors plan for direct funding of line ministries, USAID requested Tech-Serve support the MOE in the process of moving toward on-budget management. MSH assistance to the MOE under the Tech-Serve Project formally began October 1, 2011 with the signing of Modification #20, and, later, Modification #21 signed in November 2011. Note, however, that some assistance had been provided in June and July of that year, notably the design of the Project Management Team (PMT) and drafting of job descriptions of an initial group of PMT consultants intended to manage the initial tranche of on-budget funding.

When signed, the “broad tasks” as spelled out in Mod #21 included:

1. Improve staff capacity in various departments at the MOE focusing on procurement and financial management functions.
2. Enhance the leadership and management skills of managers at MOE to oversee the on-budget funding.
3. Support selected consultant staff salaries and operation support on behalf of the MOE until the MOE receives on-budget funding.

The final work plan approved by USAID, during January 2012, has a total of four activities:

1. Support selected consultant staff salaries and essential operational support on behalf of the MOE.
2. Provide Technical Assistance to commence building the capacity of the MOE Project Management Team staff.
3. Facilitate the establishment of a mentoring “liaison” relationship between MoPH/ PCH and the responsible MOE on-budget support staff to help transfer on-budget management in areas needed, such as contracts/procurement, M&E and finance.
4. MSH will provide short-term technical assistance (STTA) to the MOE and USAID to help in completing the activity plan and budget for Teacher Education.

Below is a summary of the progress made towards the work plan activities:

Activity 1: Tech-Serve has provided salary support to 40 former Community-based Education (CBE) consultants since September 1, 2011. Thirty-six of these consultants

were based in 18 provinces – two per province; and four senior staff worked out of the MOE/Kabul. (USAID requested that these consultants be paid retroactive to September 1, even though the Mod was not signed until early October.) These CBE staff were former consultants under the USAID-funded Partnership for Advancing Community Education in Afghanistan (PACE-A) Project, and were considered by USAID to be “critical” to maintain until on-budget funds became available. Starting in October, Tech-Serve provided limited operational support to CBE consultants, including support for bi-monthly workshops held at the MSH compound in Kabul, and wireless communications for the Kabul-based staff.

Activities 2 & 3: Tech-Serve assisted the MOE to determine PMT staff skills needed to manage on-budget funding. A decision was made to hire 10 national consultants, following the skills and quantities of the Partnership Contracts for Health Services unit, the on-budget unit in the MoPH. Ten PMT consultants were determined to be sufficient to manage the \$40 million scheduled by USAID in support of Teacher Education. The make-up of these PMT consultants are as follows: one on-budget project manager/report writer; three contracting consultants; two finance consultants; one HR consultant; one database consultant; one M&E consultant and one administrative/logistics consultant.

PMT consultants were recruited by the MOE’s Human Resources unit of the Procurement Directorate. Nine of the 10 positions were filled. The MOE selection panel included a Tech-Serve advisor, and all recruitment procedures followed Afghan Procurement laws. The consultants were hired by the MOE and are being managed by the MOE, but their remuneration remains off-budget, paid through the Tech-Serve Project (until its conclusion). This will continue off-budget under the follow-on Leadership, Management and Governance/Afghanistan project as a bridge mechanism until an on-budget funding system is in place.

PMT capacity building is being accomplished by serving internships with the MoPH/PCH staff: the consultants will spend three to five months working with their equivalents in the MoPH to gain on-budget management skills and knowledge of donor requirements for accessing and use of on-budget funds. Following their internship, the PMT consultants will train their MOE counterparts, mostly civil servants, in the different management skills and on-budget procedures.¹⁸

Since the hiring of the PMT consultants was intended to manage the on-budget Teacher Education activity and USAID, instead, decided to channel the funds through the World Bank’s Afghan Reconstruction Trust Fund (ARTF), the PMT consultants will focus on other USAID-funded activities, such as Community-based Education which is planned to go on-budget in 2013. The specific work assignments of these consultants, until CBE and other USAID-funded activities go on-budget, were being discussed by USAID and the MOE at

18 Contrary to the MoPH where health services delivery grants management functions are consolidated within one organizational unit, the GCMU, grants management tasks at the MoE are integrated within functional units such as the Procurement Department, the Financial Department, The M&E Department, etc.

the time Tech-Serve was closing out its assistance and the LMG/Afghanistan project was starting.

Activity 4: Short-term Technical Assistance (STTA) was provided to help the MOE develop the Activity Plan for Teacher Education and a Request for Proposals (RFP) for the same activity. Even though USAID has decided to fund Teacher Education by providing the funding to the World Bank the Activity Plan and the RFP will serve as model for the MOE to follow in preparing for other on-budget activities.

Achievement 2: Development of Activity Plan and Roadmap for MOE's on-budget Transition Director

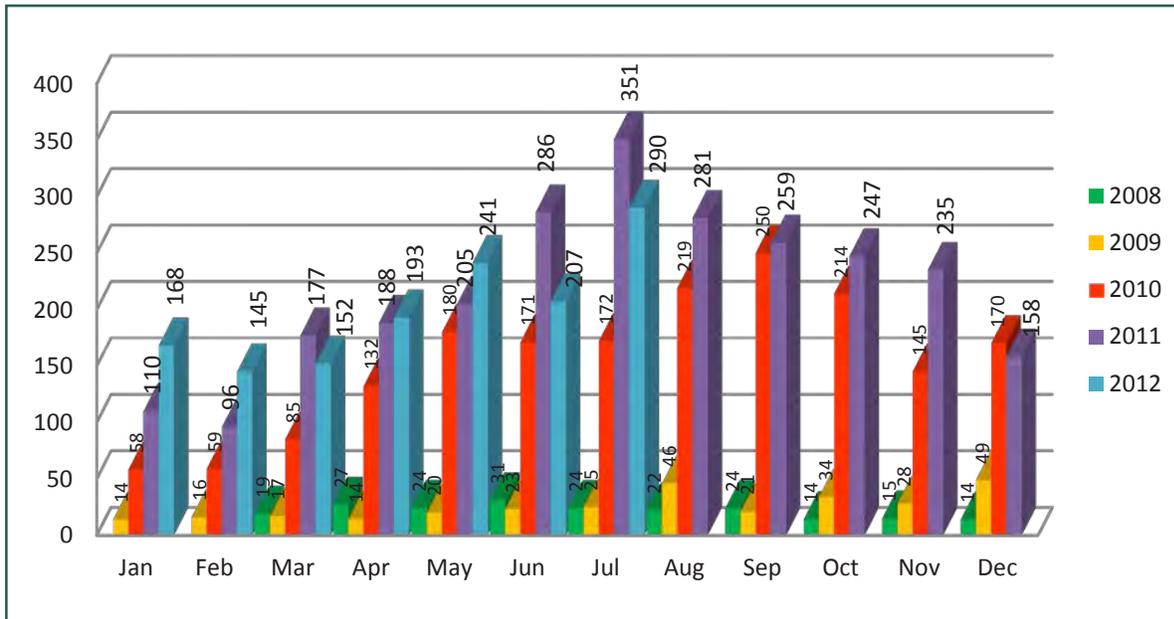
STTA from MSH also supported the drafting of other important guide documents for the MOE and USAID. These included: a PMT consultant procurement timeline; a timeline and sequencing plan for procuring NGO services for Teacher Education – which can be a model for other on-budget procurement activities; and a roadmap for the MOE to understand the necessary steps for going on-budget, developed at the request of the MOE Transition Director. It is based on the experience of the PCH unit in the MoPH; however, it is a generic guide which could be used by any ministry going on-budget with USAID funding.

CHALLENGES AND LESSONS TO CONSIDER FOR THE WAY FORWARD

The achievements highlighted on the previous pages are all the more significant in light of the many challenges that Tech-Serve has faced in the last two project years. These include:

- The migration of project-paid employees and consultants to the civil service through the on-budget mechanism has proven to be more challenging than the Ministry, USAID, Tech-Serve and MSH initially envisioned, and underscores persistent absorptive capacity limitations at the MoPH.
- Despite good coverage of services and relative better access to those services, there remains some difficulty in access of health services due to the geographic isolation of specific population groups. This is largely due to the need to provide female health workers within the provinces. Despite recent improvements in the supply of trained female health care providers, a lack of infrastructure, difficult access to health facilities, and a gap between the supply and demand continue to be obstacles that stand in the way of increased access to quality healthcare, which especially impacts Afghanistan's women, children, and underserved populations. Low level of education and poor quality of medical training in Afghanistan contributed to poor quality service provision.
- MoPH human resource management and practice contributes to the high turnover, poor selection and recruitment at central and provincial level introducing a challenge into the MoPH in terms of capacity building and reform processes.
- It is difficult to attract highly qualified committed persons to the MoPH civil servant positions, in part due to the disparity of wages between project-paid local professionals and civil service employees.
- In 2011 and 2012, the number of security incidents in the provinces continued to rise (see figure 10), making service delivery, monitoring and supervision increasingly difficult. This insecurity also limited the recruitment of qualified officers for support to provinces.
- Fragmentation of reporting relationships and accountability between the central and provincial level does not enable good monitoring of the implementation of policies and strategies, thereby weakening the stewardship role of the MoPH for continued review and prioritization of health activities.

Figure 10: Number of security incidents in USAID supported provinces



Despite these challenges, there were many lessons learned by Tech-Serve’s implementing staff, partners within the Ministries of Health and Education, partners in the health sector, and donors over the six years of the project cycle. This section presents 12 key lessons; some of which relate to specific areas of project intervention and the others which can be generalized across the project.

1. Technical assistance for Afghans by Afghans is essential for ownership and sustainability. Engaging local professionals as the project’s prime staffing strategy and relying on international consultants only where and when needed enhanced Tech-Serve’s efficiency and effectiveness in the implementation of its technical assistance to the MoPH, MoE, local organizations and entities. With the current focus on “country ownership” this model should be followed as much as possible in future initiatives.
2. Building the capacity of MoPH Departments toward sustainability requires a contextually systematic approach with locally recruited professionals hired by the project, embedded within the Ministry’s structure whenever possible, and having a long term commitment and perspective. Implementing partners with embedded technical assistance within a ministry’s structure have much better chance of success in establishing sustainable systems and building local capacity. Those local professionals providing technical assistance without being embedded within the ministry where not only a minority, they all had a clear counterpart to work with at the ministry. Tech-Serve is but one telling example of the success derived from such an approach.

3. A grants management unit composed wholly of Afghan professionals can be certified by USAID to manage USG funds, maintain its certification over time, and can successfully manage the funding mechanism to the point where the donor doubles the funding managed by the unit. The MoPH's GCMU PCH Team is a true example of Afghanization. It is worth noting that it took more than six years (2004-2009) to build the capacity of the unit's staff, design and put in place the procurement procedures, implement them in compliance with Afghan laws and USAID's regulations, and achieve the donor's and the Ministries standards certification. Given the clear U.S. and Afghan governments' agreement to put more than 50% of development aid on-budget over the next several years, it is imperative that lessons learned from PCH project be examined and applied by USAID and other ministries in deploying USG assistance in Afghanistan.
4. The development and implementation of national policies, tools, systems and standards through approaches ensuring broad consensus and ownership is a cornerstone for the sustainability of health interventions. The development of these foundational elements is, in most cases, a lengthy and often complex process. But the investment in time and attention is worth the effort as broad consensus and ownership among key stakeholders across the sector are required conditions for successful reforms and improvements of the health system. In Afghanistan, the MoPH is still in great need of assistance in designing, developing, implementing and monitoring tools, systems, standards and policies. Without this combined internal and external commitment, the overall system cannot move toward full transparency and accountability.
5. System development requires the support and close collaboration of all stakeholders within the system. For example, the work of the project HMIS team involved information experts, program managers and clinicians from across the health sector. It also required close cooperation between IT experts and the users. Working together throughout the Tech-Serve project, they were able to develop tools, detailed guidelines and computer models simultaneously. They discovered that the local maintenance capacity overruled "fancy" technology; and that data entry and analysis should be decentralized as much as possible.
6. Networking and task sharing exercises among the provincial-level health teams reaped great rewards. Sharing best practices among the provincial health teams enhanced the spirit of team work; enabled them to more effectively play their stewardship role in the quality implementation of BPHS and EPHS service; created opportunities to learn national public health values, objectives, policies, strategies; and enabled them to address service performance gaps. Similar exercises can be replicated at the central Ministry level as well as among other national health programs.

Success Story

Increasing the Number of Midwives in Kabul

In Afghanistan, midwives play a vital role in providing health care to expectant mothers. Yet the number of trained midwives in the country – estimated at around 3,500, although that number is difficult to confirm – is less than half the number needed to provide quality care to all Afghan women.

Mursal Musawi of the Afghan Midwives Association (AMA) is one young midwife working to address this issue. Founded in 2006 with USAID’s support, the AMA works to strengthen the midwifery profession through education and advocacy, with the ultimate goal of ensuring high quality services for the well-being of Afghanistan’s women and children.

In late 2010, Mursal was working as the head of midwives in Kabul’s Afshar hospital, when she was invited to take part in USAID’s Leadership Development Program (LDP), which develops skills in leadership and management. Participants use these new skills to tackle a current workplace challenge they are facing. Mursal and the other members of her LDP team decided that they wanted to work on increasing the AMA’s local membership.



Mursal Musawi of the Afghan Midwives Association has helped increase the association’s membership in Kabul, through a concerted outreach campaign.

Using the planning skills they had learned about setting short-term objectives, each woman took responsibility for visiting key staff in private sector hospitals and clinics across the city, to talk about the AMA and the important role that it plays in advocating for effective policies and standards relating to midwifery services. Among their most successful recruits were the midwifery students working at these facilities, who were also pleased to learn about the opportunities for training and networking that the AMA offers.

Through these concerted efforts, Mursal and her fellow LDP participants increased the number of Kabul-based midwives in the AMA from 296 to 374 in just four months.

Today, Mursal is working as a program officer for the AMA, where she continues her efforts. She says her LDP experience has helped her “find her voice” and advocate strongly on behalf of the association. “The AMA is a stronger organization today. We are like a tree with many branches, and these branches are the midwives,” she says. “We have more women to do outreach, to build more awareness of health issues around mothers and babies, and to provide high quality services and save lives.”

“We are like a tree with many branches, and these branches are the midwives. We have more women...to build awareness of health issues around mothers and babies.”

— Mursal Musawi

7. Focusing on community-based health care was essential for providing Afghan populations in need an effective access to the BPHS and for having a major impact on maternal and child mortality and morbidity reduction. In a country with a set of challenges such as Afghanistan's resulting in multiple barriers hampering the access to quality health services, raising the priority level of CBHC within Tech-Serve's scope of work was a key decision made jointly by MSH with the MoPH and USAID. This made possible the mobilization of resources and the deployment of critical and sustained capacity building interventions in favor of CBHC at all levels within the health system in Afghanistan.
8. A blanket waiver simplifies pharmaceutical procurement and reduces lead-time. Getting a blanket waiver for purchasing a well-defined set of essential drugs from outside of the US with USAID funding drastically reduced the procurement lead-time. Any future projects with significant pharmaceutical procurement component should consider this from its start-up phase.
9. "South to South" networking should be considered more often as a means for introducing appropriate and applicable new programmatic initiatives and/or best practices by strengthening regional relationships and knowledge exchange. The successful launch of the LDP program was fostered by the initial visit of a group of 15 Afghan health professionals to view the results of the same intervention in Egypt. For the CBHC program, establishing networks with two other developing countries that were implementing effective CBHC programs, Bangladesh and Indonesia, helped the CBHC team identify feasible options for improvement of community-based health care and how those options can be applied. Another example is the bilateral exchange of clinicians between Malawi and Afghanistan to better understand the successful implementation of ETAT.
10. Cultural attitudes must be considered if programs are to be gender sensitive and therefore meet this important condition for their success. Female CHWs were critically important in achieving a major impact on both mortality and unwanted fertility.
11. The successful transition of projects requires appropriate allocation of time, resources and effective communication between stakeholders. Tech-Serve experienced such demands on its officers' time and attention during the last couple of years of its performance period: the transfer of its Drugs Management Unit (DMU) to the Strengthening Pharmaceutical Systems (SPS) project; the transfer "on budget" of over 150 health professionals from various projects; and the preparation of the integration of selected elements of the HSSP project scope of work.

LAST WORDS

Over a period of six years, from July 2006 through August 2012, Tech-Serve has worked in partnership with the MoPH, the USAID Mission in Afghanistan, and other key stakeholders and donors to improve the health of the population and create an environment of increased stability through the continuous and sustainable provision of improved basic health care services to a large number of Afghans. Tech-Serve has worked with the MoPH to streamline capacity building efforts through focus on critical organizational changes, health workforce development, better resource allocation, proactive partnerships and stronger leadership skills. In the final years of the project, Tech-Serve has continued to make progress in these areas while expanding its focus on the new priority areas of on-budget support and assistance to the Ministry of Education.

The challenges facing the health sector in Afghanistan are complex and varied. Only through the combined efforts of stakeholders at the international, national, and community level will continued positive change be possible. MSH is grateful to have had the opportunity to contribute actively to the improvement of the health system in Afghanistan through the Tech-Serve project, and looks forward to another period of vigorous and effective collaboration under the new USAID-funded Leadership, Management and Governance project through February 2014.

ANNEX A

List of Task Forces and Policies that Received Tech-Serve Contributions

#	Taskforce	Product	Tech-Serve Program Involved	Project Year	Remarks
1	BPHS Revision	Revised BPHS manual	Technical Director	PY3-PY4	Document finalized.
2	District Health System Strengthening Evaluation	District Health System evaluation guidelines	Technical Director & HMIS/M&E Advisor	PY3-PY5	Evaluation designed and completed.
3	HMIS	<ul style="list-style-type: none"> Health Information System (HIS) Strategic Plan HMIS Procedure Manual National Monitoring Checklist Guideline HMIS hub User Manual Training Database User Manual Data quality and data use manuals 	HMIS/M&E	PY2-PY6	Support continues under LMG.
4	Child & Adolescent Health	<ul style="list-style-type: none"> Revised Child Health Policy & Strategy Pediatric Hospital Care manual Guidelines on zinc supplementation in CDD Recommendations on newborn component of Child health for the revised BPHS ETAT (Emergency Triage Assessment and Treatment) Wall charts based on WHO pocket book 	Central MoPH Capacity Building	PY2-PY6	Support continues under LMG.

#	Taskforce	Product	Tech-Serve Program Involved	Project Year	Remarks
5	Communicable Diseases	<ul style="list-style-type: none"> • Strategy for CDD (Control of Diarrheal Disease) • National TB strategic plan • Revised national TB strategic plan • National strategic plan for diarrheal diseases • National Epidemic Response Plan 	Central MoPH Capacity Building	PY2-PY5	
6	Leadership Communication	Leadership Communication Strategy	Central MoPH Capacity Building	PY3-PY4	Strategy developed.
7	Hospital Management	<ul style="list-style-type: none"> • ToR for Hospital Management Task Force • Nursing standards • Translation of Hospital standards of 8 clinical areas • Regulation act and Minimum Standards for Private Hospitals • Hospital sector strategy 	Hospital Management	PY3-PY6	Support continues under LMG.
8	Community Based Health Care	<ul style="list-style-type: none"> • Training manuals for CHSs and CHWs on PFP • Training manual for CHSs initial training • National CBHC monitoring checklist • CHWs curriculum (revised) 	CBHC	PY3-PY6	Support continues under LMG.
9	Decentralization	Develop a national strategy on decentralization	Central MoPH Capacity Building	PY6	Started on July 2012 and support continues under LMG.

#	Taskforce	Product	Tech-Serve Program Involved	Project Year	Remarks
10	Planning Working Group	<ul style="list-style-type: none"> AOP plan at the central MOPH Departments AOP and 3- year Implementation program at the provincial level Improve reporting and feedback mechanism 	Central MoPH Capacity Building	PY6	Started since March 2011 and support continues under LMG.
11	Leadership & Management	<ul style="list-style-type: none"> Advocate with all General Directorates for improving management and leadership to identify gaps in leadership and management performance and identify priority locations for LDP processes. Develop a new epidemiological and performance-based method for identifying priority Management and Service provider level at central provinces, districts and NGOs for undertaking the LDP process. 	Central MoPH Capacity Building	PY6	Started on July 2012 and support continues under LMG.
12	Contractual services review committee	Review the performances of NGOs, stewardship role of MOPH and contractual process of BPHS and EPHS services.	Central MoPH Capacity Building	PY6	Started in July 2012 and support continues under LMG.
13	National Health Policy (working group)	National Health Policy 2012-2020	Technical Director	PY5-PY6	Policy finalized.
14	MoPH strategic plan 2011-2016 (working group)	MoPH strategic plan	Technical Director	PY5-PY6	Plan finalized.

#	Taskforce	Product	Tech-Serve Program Involved	Project Year	Remarks
15	USAID On-budget working group	MoPH proposals for transition to OB funding	Technical Director, PMs, STTA	PY6	8 proposals finalized. Support for more proposals continues under LMG.
16	CGHN & TAG	Strategic direction of the MoPH and its partners	CoP, Technical Director	PY1-PY6	Support to continue under LMG
17	Environmental Health	EVH strategy	Central MoPH Capacity Building	PY5-PY6	Strategy finalized.

ANNEX B

Examples of Resource Generation Achieved by the PPHTs

Province	Resources Mobilized	From where
Bamiyan	Land for a 100-bed public hospital; land for a comprehensive health center (CHC) in Shaidan village; land for a drug rehabilitation center in Waras district; land in Sachak for a basic health center (BHC)	Local communities
	Maternal training models	Provincial Reconstruction Team (PRT)
	Equipment	Ibn Sina
	149 Acute Respiratory Infection (ARI) kits	UNICEF
	40 emergency kits	WHO
	Construction of Koprok BHC	Japan International Cooperation Agency (JICA)
	\$300,000 for establishing new health facilities (HFs)	Ministry of Counter Narcotics
	Construction of Doab District Hospital	PRT
	Approval of 70 solar power systems for 70 HFs	PRT
	Donation of a computer	UN Population Fund (UNFPA)
Construction of a 200-bed hospital	People of Iran	
Herat	Support for Provincial Health Conference and commitments to support the health sector until end of 2014	USAID, Italian Cooperation, World Vision, UNICEF, Afghan Institute for Learning, Cap Anamur, DAC
	1.5 million Euros for health activities	Italian Cooperation
	Three additional CHCs (Shahrak Senhati, Engil, and Shada)	US military, Italian Cooperation and Cap Anamur
	Pediatric Hospital's Burns Centre and Operation Theater	Italian Cooperation

Province	Resources Mobilized	From where
Kandahar	Land for Gundigan and Panjwae CHCs and Salisom BHC of Maroof district	Local communities
	Construction of the Institute of Health Science	PRT
	Construction of a District Hospital (DH) in Zheray district for the use by residents of Maiwand, Panjwai, and Zheray districts (under negotiation)	US Army and PRT
	Expansion of Mirwais Hospital from 350 to 500 beds	International Committee of the Red Cross (ICRC)
	Construction of 6 Operation Theater rooms in the first year; and a donation of 11 standard ambulances	US military forces
Farah	Renovation of the Provincial Hospital	PRT
	Equipment for PPHO training center	USAID
Faryab	Construction of Community Midwifery Education School and Polyclinic at Faryab Provincial Hospital	Turkish International Cooperation for Development (TIKA)
	Standard buildings for Myandarah BHC of Pashtoon Kot district and Ghalbala BHC of Almar district	Commander's Emergency Response Program (CERP) through PRT
Helmand	Three ambulances and the construction of a number of HF's	PRT
Khost	Construction of CHC + (\$190,000) currently used by the Maternity Hospital	PRT
	Additional drug kits to Spera and Zazi Maidan districts and \$200,000 morgue	US Army
	\$5,000 for the expansion of Jaji Maidan CHC and construction of a District Hospital inaugurated in Nadershah Koat district	PRT
Nimroz	Construction of Delaram CHC and 8 heaters and three rooms for emergency department of Zaranj DH	US Army
	Commitment to build MCH 20 bed hospital in Zaranj	Bayat Foundation
	Construction of an emergency ward at Zaranj Hospital and provision of the required equipment	US Forces
Wardak	Renovation of Maidan Shar District Hospital pediatrics ward and construction of two-family houses[or two-family houses? more than 2 houses?] in Behsood district	PRT

Province	Resources Mobilized	From where
Paktia	Construction of Shwak Health Center	PRT
	Donation of seven convexes (container rooms) for PPHO office use	DAI
Ghazni	Approval of construction of Qarabagh District Hospital and Training of 50 midwives in family planning	PRT
Baghlan	200,000 square meters for construction of a 200-bed hospital in Pul-e-Khumry city	Land has been approved by President Karzai
	Approval to build surrounding walls of Shaikh Jalad BHC and Mangalan CHC.	USAID
Badakhshan	Land for midwifery and nursing schools	Local communities

Annex C: Performance Monitoring Plan (PMP), Years 1-6

No.	Indicators	Indicator Type	Baseline	PY1		PY2		PY3		PY4		PY5		PY6		Frequency of Reporting/ Updating	Source
				Target	Status (Sep 2007)	Target	Status (Sep 2008)	Target	Status (Sep 2009)	Target	Status (Sep 2010)	Target	Status (Sep 2011)	Target	Status (Aug 2012)		
IR 1: Improved capacity of the central MOPH to support the delivery of BPHS and EPHS services, primarily through NGO service providers																	
1.1	No. and total amount of BPHS grants awarded and managed under the PPG mechanism (cumulative)	OP	22 (PPG grants started during REACH) \$48.4 million (PPG grants started under	22 \$48.9 million	22 \$48.66 million	22 \$63.7 million	22 \$63.7 million (grants from May 2006 - Dec 2008)	Indicator removed as of PY3 because PPG mechanism ended		Indicator removed as of PY3 because PPG mechanism ended		Indicator removed as of PY3 because PPG mechanism ended		Indicator removed as of PY3 because PPG mechanism ended		Quarterly	MOPH Grants Database
1.2	No. and total amount of EPHS grants awarded and managed under the PPG mechanism (cumulative)	OP	5 (PPG grants started during REACH) \$1.2 million (PPG grants started during REACH)	5 \$1.4 million	5 \$3.6 million	5 \$6.6 million	5 \$6.6 million (grants May 2006 - Dec 2008)	Indicator removed as of PY3 because PPG mechanism ended		Indicator removed as of PY3 because PPG mechanism ended		Indicator removed as of PY3 because PPG mechanism ended		Indicator removed as of PY3 because PPG mechanism ended		Quarterly	MOPH Grants Database
1.3	GCMU capacity to meet USAID eligibility criteria	OP	-	Competency milestones identified; capacity building plan developed; X number of competency milestones achieved according to the capacity building plan	Capacity Building plan developed and certain competency milestones met	Competency milestones achieved according to the Capacity Building Plan	Assessments completed, GCMU certification announced	Indicator removed as of PY3 because GCMU received certification		Indicator removed as of PY3 because GCMU received certification		Indicator removed as of PY3 because GCMU received certification		Indicator removed as of PY3 because GCMU received certification		Semi-annually	Tech-Serve Quarterly Reports
1.a	MoPH GCMU remains certified as determined by USAID reviews (new indicator added in PY3)	OC	Certification obtained in July 2008	N/A	N/A	N/A	N/A	Maintain USAID certification	Certification in place	USAID reviews and certifies GCMU	GCMU remained certified	USAID reviews and certifies GCMU	GCMU remained certified	USAID reviews and certifies GCMU	GCMU remained certified	Annually	USAID review of GCMU contracts and finance management
1.b	The average number of days for processing GCMU payments to NGOs (new indicator added in PY3)	PR	43 days	N/A	N/A	N/A	N/A	31 days	Indicator began to be measured once the PCH grants began	30 days	30 days (from PY 4 Q3 results)	30 days	This indicator was dropped in the 2011 PMP as GCMU PCH were reporting this indicator	45	18	Quarterly	GCMU records
1.c	Improve the average PPG/PCH Quarterly Performance Evaluation scores (new indicator added in PY3)	OC	107 (Mar 2007)	N/A	N/A	N/A	N/A	131	136	136	GCMU not able to complete surveys	136	This indicator was dropped in the 2011 PMP as GCMU PCH were reporting this indicator	Indicator removed as of PY6		Quarterly	Quarterly Performance Evaluations
1.c	Attendance of Tech-Serve technical advisors at MoPH technical committees for the development of policies, strategies, manuals and guidelines (new indicator added in PY6)	PR	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	5	A total of eight MoPH strategies, Policies and guidelines developed through technical contribution and facilitation of MSH/Tech-Serve.	Quarterly	Tech-Serve Quarterly Reports
1.d	Improve average quarterly PPG/PCH Monitoring Single Score	OC	5.5 (Sep 2007)	N/A	N/A	N/A	N/A	6.5	7.5	7.5	GCMU not able to complete surveys	7.5	This indicator was dropped in the 2011 PMP as GCMU PCH were reporting this indicator	Indicator removed as of PY6		Quarterly	Single Monitoring Score

Annex C: Performance Monitoring Plan (PMP), Years 1-6

No.	Indicators	Indicator Type	Baseline	PY1		PY2		PY3		PY4		PY5		PY6		Frequency of Reporting/ Updating	Source
				Target	Status (Sep 2007)	Target	Status (Sep 2008)	Target	Status (Sep 2009)	Target	Status (Sep 2010)	Target	Status (Sep 2011)	Target	Status (Aug 2012)		
1.4	\$ amount of pharmaceuticals distributed to the PPG NGOs by Tech-Serve (cumulative) (excluding contraceptives and TB medications)	OP	\$0	\$2 million (target set for this indicator includes the drugs handed over to Tech-Serve from REACH. \$5.7 million additional funding has been made available to Tech-Serve, based on a revised projection of needs for PPGs)	\$3,861,871 (\$1,502,504 of contraceptives and \$264,638 TB medications have been distributed in addition to this amount since July 2006.)	\$6.5 million (cumulative)	\$6,302,427 (cumulative)	\$9.8 million (cumulative)	\$9.7 million (cumulative)	\$18 million (cumulative to end of project)	\$13,813,108	\$18 million (cumulative to end of project)	\$17,769,857	Indicator removed as of PY6 because DMU transferred to SPS project	Quarterly	Pharmaceutical Database	
1.f	Weighted average % of inventory variation for NGO warehouses (new indicator added in PY3)	OC	8.7% (REACH in 2006)	N/A	N/A	N/A	N/A	8.7%	18.6%	7%	14.5%	8%	14.33%	Indicator removed as of PY6 because DMU transferred to SPS project	Semi-annually	IMAT Tool	
1.g	Average % of records matching physical stock for NGO warehouses (new indicator added in PY3)	OC	52.3% (REACH 2006)	N/A	N/A	N/A	N/A	52.3%	45.10%	56%	37%	56%	50.74%	Indicator removed as of PY6 because DMU transferred to SPS project	Semi-annually	IMAT Tool	
1.h	Average % of tracer stock on the day of visit for NGO warehouses	OC	85.8% (REACH 2006)	N/A	N/A	N/A	N/A	85.8%	88.90%	88%	93%	88%	89.78%	Indicator removed as of PY6 because DMU transferred to SPS project	Semi-annually	IMAT Tool	
1.i	Average % of time out of stock for NGO warehouses (new indicator added in PY3)	OC	10.7% (REACH 2006)	N/A	N/A	N/A	N/A	10.7%	12.10%	9%	9.5%	9%	7.19%	Indicator removed as of PY6 because DMU transferred to SPS project	Semi-annually	IMAT Tool	
1.j	Develop policy and regulations for private hospitals and diagnostic centers (new indicator added in PY3)	OC	N/A	N/A	N/A	N/A	N/A	Submitted for MoPH endorsement	Submitted for MoPH endorsement	Introduce through proper channels at the HF level	Approved	Introduce through proper channels at the HF level	Policy development process supported. Policy shared with private sector for use.	Indicator removed as of PY6	Annually	Tech-Serve Quarterly Reports	
1.5	No. of MOPH General Directorates or Deputies with a functioning LDP team reporting improved collaboration and communication on at least one new priority issue each year (cumulative)	OC	0	2	2 (GD PHC and GD Admin)	3 (cumulative)	3 (cumulative)	Indicator removed as of PY3		Indicator removed as of PY3		Indicator removed as of PY3		Indicator removed as of PY3	Semi-annually	MSP reporting system	
1.6	Policies or regulations for overseeing private hospitals and diagnostic centers	OP	-	Outlined	Tech-Serve recommendations on the first draft of policy submitted to Hospital Management Task Force	Drafted	New comments on second draft provided to MoPH	Indicator removed as of PY3		Indicator removed as of PY3		Indicator removed as of PY3		Indicator removed as of PY3	Annually	Tech-Serve Quarterly Reports	
1.7	Guidelines for implementation of cost sharing policy	OP	-	Drafted	Drafted	Pilot-tested	Activity canceled because of MoPH decision to ban user fees for BPHS	Indicator removed as of PY3 because of MoPH decision to ban user fees for BPHS		Indicator removed as of PY3 because of MoPH decision to ban user fees for BPHS		Indicator removed as of PY3 because of MoPH decision to ban user fees for BPHS		Indicator removed as of PY3 because of MoPH decision to ban user fees for BPHS	Annually	Tech-Serve Quarterly Reports	
1.8	No. of essential policies reviewed and updated or newly developed through established mechanisms in the MOPH (cumulative)	OP	-	4	6 policies reviewed/under revision	8 (cumulative)	12 (cumulative)	4 Finalized	4 Developed	4 Implemented	3 Implemented	4 Implemented	16 policies, strategies or other documents processed	Indicator removed as of PY6	Semi-annually	Tech-Serve Quarterly Reports	
1.9	No. of health workers nationally registered with MOPH with updated data in the HRD database (cumulative)	OP	6,000	15,000	20,500	25,000 (cumulative)	24,717 (cumulative)	20,000 (cumulative)	30,000 (cumulative)	20,000	29,000	25,000	32,000	Indicator removed as of PY6	Quarterly	MOPH Human Resources Database	
1.m	Percentage CHWs in USAID grant NGOs who are working with updated community based maps	OC	0	N/A	N/A	N/A	N/A	5%	12%	20%	New format introduced, no measure for PY4	2%	375 HFs use CAAC (Proxy indicator for Community Map is CAAC implementation and use by CHWs. Community Map use is not reported)	Indicator removed as of PY6 (revised indicator below)	Quarterly	Progress Data Sheet report	

Annex C: Performance Monitoring Plan (PMP), Years 1-6

No.	Indicators	Indicator Type	Baseline	PY1		PY2		PY3		PY4		PY5		PY6		Frequency of Reporting/ Updating	Source
				Target	Status (Sep 2007)	Target	Status (Sep 2008)	Target	Status (Sep 2009)	Target	Status (Sep 2010)	Target	Status (Sep 2011)	Target	Status (Aug 2012)		
1.d	Proportion of CHWs in USAID funded grant NGOs who when surveyed by PCH staff using the NMC have a community map which has been updated within the last 18 months of the survey (revised indicator for PY6)	OC	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	80%	80%	Quarterly	GCMU PCH NMC results
1.10	No. of PPHO and MOPH central staff who received training on BPHS outcome measurement tool and are available for implementation of the tool (LQAS) (cumulative)	OP	0	30	41	30 (cumulative)	41 (cumulative)	30	30	30	36	40	50	Indicator removed as of PY6		Semi-annually	Training Database
1.11	Percent of BPHS facilities nationally submitting HMIS reports	OP	70%	>90%	90%	>90%	90%	>90%	90%	>90%	89%	>90%	91%	>90%	89%	Quarterly	HMIS Database
1.12	HMIS data accuracy index (new indicator added in PY2)	OP	75%	N/A	N/A	80%	78%	85%	75%	90%	71%	90%	73%	Indicator removed as of PY6		Quarterly	NMC Database
1.13	No. of EPHS facilities (district and provincial hospitals) in PPG provinces submitting EPHS HMIS reports	OP	0	5	5 Provincial Hospitals 18 District Hospitals	23	23	15	27	20	30	25	32	37 (95%)	44 (91%)	Quarterly	HMIS Database
1.g	Number and proportion of CBHC Officers who have received in-service training on the CBHC package		0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	34 (100%)	0 (due to delay in recruiting CBHC Officers)	Quarterly	CBHC Reports
1.r	Increase Couple Years of Protection (CYP) through contraceptives distributed by Tech-Serve (annual distribution) (new indicator added in PY3)	OC	300,000	N/A	N/A	N/A	N/A	360,00	425,996	345,000	494,853	345,000	445,296	360,000	307,775	Semi-annually	Tech-Serve Pharmaceutical Database
1.s	Increase Contraceptive Prevalence Rate in USAID supported provinces (new indicator added in PY3)	OC	30.3%	N/A	N/A	N/A	N/A	37%	40.6%	38%	40.6%	38%	N/A	35.0%	37.3%	Annually	LQAS surveys

Annex C: Performance Monitoring Plan (PMP), Years 1-6

No.	Indicators	Indicator Type	Baseline	PY1		PY2		PY3		PY4		PY5		PY6		Frequency of Reporting/ Updating	Source
				Target	Status (Sep 2007)	Target	Status (Sep 2008)	Target	Status (Sep 2009)	Target	Status (Sep 2010)	Target	Status (Sep 2011)	Target	Status (Aug 2012)		
IR 2: Improved capacity of the thirteen Provincial Health Offices of MOPH to support the delivery of BPHS and EPHS services																	
2.1	No. of Provincial Health Teams with a functioning PPHCC team reporting improved collaboration and communication on at least one new priority issue each year	OC	0	3	13	6	12	13	13	13	15 (includes 2 Quick Impact provinces)	13	13	17	17	Semi-annually	LDP reporting system
2.2	No. of PPHO staff who received appropriate in-service training	OP	0	15	At least 124 people in 16 provinces received 2 planned training sessions (LDP and technical trainings)	30 (cumulative)	79 (cumulative)	100	59	100	116	100	590	Indicator removed as of PY6		Semi-annually	Training Database
2.3	No. of PPG provinces implementing an updated provincial plan	OP	0	2	5	4	12	13	13	13	13	13	17 (13 USAID provinces + 4 Quick Impact provinces)	Indicator removed as of PY6		Semi-annually	LDP reporting system
2.d	The change over time in the composite percentage of compliance with hospital standards for 5 USAID supported Provincial hospitals (new indicator added in PY3)	OC	78.8% (2007-2008)	N/A	N/A	N/A	N/A	75%	77%	80%	No other assessment conducted (based on the recommendation of senior management (technical manager))	N/A	No other assessment conducted (based on the recommendation of senior management (technical manager))	Indicator removed as of PY6		Semi-annually	QA Standards Database
2.4	No. of PPG provincial hospitals applying clinical and management standards for improving quality of care (at least one comprehensive external assessment and one internal assessment using the hospital standards)	OP	0	5	3	5	0 (one round of comprehensive external assessment was completed in four all five hospitals)	Indicator removed as of PY3		Indicator removed as of PY3		Indicator removed as of PY3		Indicator removed as of PY3		Semi-annually	QA Standards Database
2.5	No. of PPHOs who actively collect and use national BPHS National Monitoring Checklist (NMC) data	OP	0	4	4	13	13	13	13	13	13	13	17 (13 USAID provinces + 4 Quick Impact provinces)	Indicator removed as of PY6		Semi-annually	BPHS M&E database
2.6	No. of provincial health teams capable of providing valid and relevant evidence (from HMIS, JHU facility assessment, REACH and PPG Household Surveys, BPHS Monitoring Checklist and HSSP QA Assessments) for provincial planning and monitoring purposes	OC	0	3	2	6	8	Indicator removed as of PY3		Indicator removed as of PY3		Indicator removed as of PY3		Indicator removed as of PY3		Semi-annually	LDP reporting system
2.7	No. of PPHOs with a functioning HMIS provincial hub (No. of PPHOs capable of managing HMIS information flow in their provinces)	OP	2	4	4	10 (cumulative)	9 USAID provinces + 1 non-USAID province (cumulative)	12	10	13	12 (11 USAID provinces + 1 non-USAID province)	13	11	17	12 (determined that only 12 would be necessary)	Semi-annually	Tech-Serve Quarterly Reports
2.g	No. of PPHOs renovated to improve working environment for PPHDs and provincial health teams (new indicator added in PY3)	OC	0	N/A	N/A	N/A	N/A	11	13	0	13 (no new renovations, all 13 USAID province PPHOs were renovated in previous years)	0	13 (no new renovations, all 13 USAID province PPHOs were renovated in previous years)	Indicator removed as of PY6		Semi-annually	Tech-Serve Quarterly Reports
2.h	No. of health facilities in USAID or non-USAID provinces applying Leadership Development tool to improve health results (new indicator added in PY3)	OC	N/A	N/A	N/A	N/A	N/A	110	113	160	229	174	152	174	181	Semi-annually	LDP reporting system
2.i	No. of PPG provincial hospitals with functional isolation room (new indicator added in PY3)	OC	0	N/A	N/A	N/A	N/A	6	5	13	0 (Planned for 2009, but due to no funding allocation from USAID, not done. All 13 provinces trained on infection prevention, which was cascaded to all health facilities)	N/A	N/A	Indicator removed as of PY6		Semi-annually	QA Standards Database
2.j	Percent of required PPHCC reports submitted by USAID supported PPHO, and the percentage of those PPHOs with requests, receive MoPH feedback (new indicator added in PY3)	OC	N/A	N/A	N/A	N/A	N/A	90% filed 30% with feedback	100% reported 50% with feedback	100% filed 65% with feedback	97% filed 100% with feedback	100% filed 65% with feedback	100% filed 100% with feedback	100% filed 65% with feedback	100% filed 100% with feedback	Semi-annually	PPHCC reports and analysis
2.e	Number of hospitals who are initiating the process for implementation of the hospital autonomy strategy (new indicator added in PY6)	OC	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3	14	Semi-annually	Hospital section of Quarterly Report
2.k	No. of USAID supported PPHDs who review the NGO quarterly reports and provide technical inputs on their performance (new indicator added in PY3)	OC	N/A	N/A	N/A	N/A	N/A	13	13	13	11	13	17 (13 USAID provinces + 4 Quick Impact provinces)	17	17	Semi-annually	PHAs reports/DAR reports

Annex C: Performance Monitoring Plan (PMP), Years 1-6

No.	Indicators	Indicator Type	Baseline	PY1		PY2		PY3		PY4		PY5		PY6		Frequency of Reporting/ Updating	Source
				Target	Status (Sep 2007)	Target	Status (Sep 2008)	Target	Status (Sep 2009)	Target	Status (Sep 2010)	Target	Status (Sep 2011)	Target	Status (Aug 2012)		
IR 3: Improve the leadership and management skills of senior managers at central and provincial levels of MOPH																	
3.1	No. of joint monitoring visits by PPHOs to BPHS and EPHS health facilities (cumulative)	OP	0	85	109 visits were carried out by 10 PPHOs	150 (cumulative)	393 (cumulative)	500	710	650	813	700	1056	Indicator removed as of PY6		Semi-annually	MoPH NMC database
3.b	Number of central MoPH management units using LDP techniques for achieving results (new indicator added in PY3)	OC	0	N/A	N/A	N/A	N/A	4	4	5	5	5	7	5	5	Semi-annually	LDP reporting system
3.c	Number of PPHOs using LDP techniques for achieving results (new indicator added in PY3)	PR	N/A	N/A	N/A	N/A	N/A	6	6	13	13	13	17 (13 USAID provinces + 4 Quick Impact provinces)	17 Indicator combined with 3.d as of PY6	17 Indicator combined with 3.d as of PY6	Semi-annually	Semi-annual review reports
3.d	Number of provincial NGO management units using LDP techniques for achieving results (new indicator added in PY3)	PR	N/A	N/A	N/A	N/A	N/A	6	6	13	13	13	17 (13 USAID provinces + 4 Quick Impact provinces)			Semi-annually	Semi-annual review reports
IR 4: Strengthened capacity of the Ministry of Education to plan, manage and account for USG on-budget resources																	
4.a	Number of CBE consultants who will be supported by TS in terms of salary and limited operational support (new indicator added in PY6)	OP	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	700	N/A	40	40	Quarterly	MOE recruitment records