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# Review of current Technical Assistance to the Ministry of Public Health

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# List of Acronyms

| | |
|---|---|
| **ACU** | Aid Coordination Unit |
| **AJHSR** | Afghan Joint Health Sector Review |
| **ARTF** | Afghanistan Reconstruction Trust Fund |
| **BPHS** | Basic Package of Health Services |
| **BHC** | Behaviour Change |
| **CBHC** | Community Based Health Care |
| **CBR** | Capacity Building for Results |
| **CBRF** | Capacity Building Reform Facility |
| **CHNE** | Community Health Nursing Education |
| **CPD** | Central Prison Directorate |
| **CSC** | Civil Service Commission |
| **CRPD** | Convention of Rights for Person with Disability |
| **CSRP** | Civil Service Reform Project |
| **CSSP** | Corrections System Support Program |
| **DG** | Director General |
| **GDPM** | General Directorate for Preventive Medicine |
| **DHOs** | District Health Offices |
| **DP** | Development Partners |
| **DRD** | Disability and Rehabilitation Department |
| **EU** | European Union |
| **EPHS** | Essential Package of Hospital Services |
| **EPI** | Expanded Programme of Immunization |
| **GAVI** | Global Alliance for Vaccine and Immunization |
| **GCMU** | Grant & Services Contract Management Unit |
| **GD** | General Director/Directorate |
| **GDCM** | General Directorate of Curative Medicine |
| **GDHR** | General Directorate of Human Resource |
| **GDPA** | General Directorate Pharmaceutical Affairs |
| **GDPDC** | General Directorate for Prisons and Detention Centres |
| **GDPM** | General Directorate of Preventive Medicine |
| **GDPP** | General Directorate Policy and Planning |
| **GF** | Global Fund |
| **GHM** | Grievance Handling Mechanism |
| **GIHS** | Ghazanfar Institute of Health Science |
| **GSA** | Government and Social Accountability |
| **HC & P** | Health Care and Promotion |
| **HEFD** | Health Economics Financing Directorate |
| **HIS** | Health Information System |

| | |
|---|---|
| **HIV** | Human Immunodeficiency Virus |
| **HMIS** | Health Management Information System |
| **HPD** | Health Promotion Department |
| **HPP** | Health Policy Project |
| **HR** | Human Resources |
| **HRH** | Human Resources for Health |
| **HRMIS** | Human Resources Management Information Systems |
| **HSR** | Health Sector Resiliency |
| **HSS** | Health System Strengthening |
| **ICRC** | International Committee of the Red Cross |
| **IRD** | International Relations Directorate |
| **IT** | Information Technology |
| **M&E** | Monitoring and Evaluation |
| **MCH** | Mother and Child Health |
| **MH** | Mental Health |
| **MHD** | Mental Health Directorate |
| **MHGAP** | Mental Health Gap Action Program |
| **MICS** | Multiple-Indicators Cluster Survey |
| **MoE** | Ministry of Education |
| **MoF** | Ministry of Finance |
| **MoHE** | Ministry of Higher Education |
| **MoI** | Ministry of Interior |
| **MoJ** | Ministry of Justice |
| **MoLSAMD** | Ministry of Labour, Social Affairs Martyr and Disabled |
| **MoPH** | Ministry of Public Health |
| **MoU** | Memorandum of Understanding |
| **MSH** | Management Sciences for Health |
| **MTEF** | Medium Term Expenditure Framework |
| **NGO** | Non-Governmental Organization |
| **NSP** | National Strategic Plan |
| **NTA** | National Technical Assistance |
| **PAR** | Public Administration Reform |
| **PBF** | Performance Based Financing |
| **PBG** | Provincial Budget Guidelines |
| **PBI** | Provincial Budget Initiative |
| **PH** | Public Health |
| **PHC** | Primary Health Care |
| **PHD** | Prison Health Department |
| **PHO** | Provincial Health Officers |
| **PHS** | Prison Health Services |
| **PHSP** | Private Health Sector Program |
| **PLD** | Provincial Liaison Directorate |

| | |
|---|---|
| **PPHD** | Provincial Public Health Directorate/Provincial Public Health Directors |
| **PPHO** | Provincial Public Health Officer/Provincial Public Health Office |
| **PPM** | Provider Payment Mechanism |
| **PPP** | Public Private Partnership |
| **PRR** | Priority Reform and Restructuring |
| **QI** | Quality Improvement |
| **RH** | Reproductive Health |
| **SEHAT** | System Enhancement of Health Action in Transition |
| **SM** | Strengthening Mechanism |
| **SOP's** | Standard Operating Procedures |
| **SPCMD** | Service Procurement Contract Management Directorate |
| **STE** | Short Term Experts |
| **SWAp** | Sector Wide Approach |
| **TA** | Technical Assistance |
| **TAMT** | Technical Assistance Management Tool |
| **TB** | Tuberculosis |
| **TC** | Technical Cooperation |
| **ToR** | Terms of Reference |
| **TOT** | Training of Trainers |
| **TPHS** | Tertiary Package for Health Services |
| **UNFPA** | United Nations Population Fund |
| **UNICEF** | United Nations International Children's Emergency Fund |
| **UNODC** | UN Office for Drug Control |
| **URL** | Universal Resource Locator |
| **USAID** | United States Agency for International Development |
| **WB** | World Bank |
| **WG** | Working Group |
| **WHO** | World Health Organization |
| **WISN** | Workforce Indicators of Staffing Need |

# Executive summary

The review was done in the last trimester of 2015. Its objective was *to analyse and discuss the current status and present performance of the project/programme, its contribution to the on-going reforms agreed between the Government and Development Partners which basis is laid in the Aid Coordination Model & Partnership Protocol for the health sector*.

In its methodology the review considers the value of the recent national Health Policy including developing greater self-sufficiency and less dependence on donor aid and technical assistance. The opinion and programmes of the main development partners were reviewed in order to identify present and future complementarities and duplications, and to identify areas of priority contribution. Where this paper is not primarily an assessment towards the 10 strategic directions of the Strategic Plan, it builds forth on 'the Joint Health Sector Review (AJHSR)' conducted in 2015 which makes it complementary literature to this review. Consideration has been taken of achievements and expected results, and areas of concern have been identified, with particular attention to complementarities with other running and upcoming technical assistance from various donors and agencies.

An analysis of the main findings and gaps shows that it is not so much about which areas are covered and which not; a lot has been reached and is in the pipeline. The issue is more about, what has been done and how it is done. This includes following:

Although big steps have been made recently towards Sector Wide Approach (SWAp), a number of mechanisms are not streamlined within the relevant department of the MoPH. Amongst others this leads to discontinuity and low efficiency of external aid efforts and internal motivation and - linked to it - the limited ownership.

Workforce planning and capacity development do not receive enough attention. And when there is, activities are not aligned with or by the Human Resource Directorate and Development Partners. The retention scheme is not developed and for this reason not applied. Added to this is the abundance of civil servants who are not linked to specific tasks and job descriptions, which leads to inefficiency and demotivation of the workforce. It also causes dilution of efforts and for that reason inefficiency of much of the external and internal investment in capacity building. On-the-job training is essential but inefficient in the context of abundance of civil servants.

A Human resources fast-track efficiency plan needs to be revived, at least started in a key area such as the Procurement and Supply Directorate. Accountability of the Directorates could increase ownership and focus of guidance and capacity development where most needed.

As long as this problem is not properly addressed, functional absorption and best use of financial resources is difficult, wasting continues while resources shrink,

and moreover substitution will continue to be a necessary deficiency to maintain the MoPH functional. A smooth handover of all functions to trained staff is hindered, moreover disparity of salary scales will need to be maintained).

Budgets should be linked to the strategies and implementation plans should be developed, to avoid that policies and strategies become futile and obsolete.

Although safety nets as Health System Strengthening and SEHAT programmes are useful to make progress in priority areas, the danger exists that a project approach is taken and is done at the expense of integration and oversight by the MoPH, the Directors and the Minister. Still TA will be needed to the thematic areas of SEHAT as they are strengthening sub-national government, ensuring quality pharmaceuticals, improving hospital performance, improving fiduciary systems. Proper paths of management interventions and activities need to be developed in order attain sustainable strengthening through MoPH's organizational structure

So the review, proposes an approach to analyse relevant working documents and strategies in order to make best use of this particular investment and move jointly to adapted action. This could help the MoPH to follow-up much expected response measures to donors' implementation plans, often developed, documented and approved but not implemented.

A lance is broken to guide the much sensed need for quality improvement and assurance in health. A working scheme is proposed to integrate and coordinate all efforts in that sense ranging from Standard Operating Procedures (SOP), accreditation of trainings and professions, legislation, professional bodies up to standards of care. There is a need for a central quality coordinating body disconnected from any corruptive system related to licensing. Reorganization, merging and streamlining of functional MoPH hospitals will need an urgent reform and subsequent monitoring mechanisms to obtain cost containment and to link quality to effective and real tertiary care (presently hardly existing) with maintained focus on preventive and primary care.

Proactive attention is needed to include the care of vulnerable people, nomads, prisoners, mental and physical disabled, and to develop a safety net and a provider payment mechanism.

Based on the analysis, we concluded that a huge amount of human and financial resources invested in Afghanistan by the international partners since 2001 has not led to a proportional capacity within the MoPH, nor to the expected results. Most blame the lack of absorptive capacity of MoPH. Nevertheless, this investment was lost for multiple and other reasons such as a poor link between strategies and budgets for implementation, disparity of salary scales leading to motivation issues, etc. This does not mean that no capacity was built; the question is different, little quality has been retained within the ministry. To conduct an effective technical coordination, we recommended to:

- use and implement developed policies, and strategies by linking those to implementation plans, guidelines, standard operational procedures and the whole being budgeted
- build up MoPH controlled SWAp department/directorate and the Aid coordination linked with it working towards a sustainable approach of

channelled funds through a donor and ministry SWAp department or directorate, both working side by side. A functional SWAp/ACU department is the only guarantee to assure continuity of projects, avoiding duplicating or abandoned projects, call for responsible budgeting.

- to apply a systematic and evidence based approach for workforce planning, based on real time use, human resource calculation, capacity building, with proper recruitment processes and retention of skilled Tashkeel staff.
- More attention for Quality assurance and Standard Operational Procedures (SOPs). This is a warrant for quality improvement at all service related departments, including across SEHAT proposals and others.
- Further investment is needed in a project approach for vulnerable and displaced people until the concerned departments are enforced.

Further details on the findings and recommendations are listed in the last chapter of this report. Annex 6 covers information of the current EU funded Technical Cooperation Program. Annex 8 summarizes in a table the ongoing and planned TA projects of the main partners to the Ministry of Public Health, not but almost comprehensive.

# 1 Introduction

## 1.1 Background

The review was conducted by the Public Health expert from 24 October till 24 November 2015. This review came at a time that:

- the administration is in place after elections late 2014,
- a new National Health Policy has been nearly drafted,
- the Ministry's organization is in a transition period of restructuring,
- a Joint Health Sector Review (AJHSR) was recently conducted, and
- a Joint World Bank team was conducting a joint Implementation Support Mission for the 'System Enhancement for Health Actions in Transition' (SEHAT) project.

This mission came after the presentation to the provinces of 'HMIS and functionality verification for provinces that are contracted under SEHAT program', as part of the third party monitoring and evaluation. In the same month the MoPH/HEFD with the World Bank is in the last stage of revision of the thematic proposals, developed in the context of the 'System Enhancement for Health Actions in Transition' (SEHAT, thematic components).

As a result on the one hand there is abundance of information and interpretation ongoing regarding the new directions to take for the new administration in MoPH, on the other hand there was a tangle of priorities and interests that complicate indicating clear directions for the future. Added to this, is the strong emphasis being laid on a different, novel and orthodox approach for technical cooperation and especially on the development of efficient and effective technical assistance, the latter being the ultimate objective of EUDel and MoPH of this review.

The National Health Policy 2015 – 2020, Draft 15 November 2015, states a new set of values and priorities that includes:

i) equity,
ii) anti-corruption,
iii) partnerships with the private sector,
iv) employment, and
v) developing greater self-sufficiency and less dependence on donor aid and technical assistance.

The last value is the main asset and a huge challenge in this review. The value is not considered 'new' as back in 2004, the reviewer was working as EU TA and caring for the same values and objectives, of peer-to-peer working and developing with the MoPH and all major donors an on-the-job leadership development program for senior officials in the Ministry as well as an on-the-job capacity building program in basic skills.

This review wouldn't be complete if the reviewer together with the stakeholders would not use the opportunity of the multiple interviews and triangulation to

explore what has hindered this approach, what went wrong, its reasons, and the lessons that could be deducted from what could appear as a stalemate, if it were not that for a large group of professionals emanating from this 10+ years of foreign and internal investment in capacity building are now carrying key responsibilities inside and outside the MoPH and related agencies.

## 1.2 Rationale

The first paragraph of the ToR proposes "to review the ToR and reports of the current TA projects to the MoPH funded by various donors/agencies, as well as to review the ToR of any planned TA projects". To avoid duplication with previous work, the rationale was to make use where possible of existing information and sources.

Lessons have to be learned from previous attempts to setting up catalogues of technical cooperation in previous years, but those were not maintained or updated :

- In August 2009, two experts produced for the EU the: "Completed, updated and maintainable mapping of technical cooperation and capacity building interventions", over a 6 weeks period[1].

- In 2012, Lindsay-Smith, G. Kroes, & J. Roos, produced a report with the title "Support to the General Directorate for Health Service Provision of MoPH", the "Technical Cooperation Mapping & Institutional Reorganization: March – June 2012".

The EU TA project implemented since 2012 elaborated from within the Aid Coordination Unit (ACU) and contributed to the elaboration of the Technical Assistance Management Tool (TAMT). The TAMT system continues to be updated and now holds data on 450 consultants/contracted staff. It also contains 71 health related projects and 140 necessary documents (policies, manuals and guidelines).

This review is therefore based on this important TAMT mapping tool. An agreement was reached with the MoPH IT Department to transfer the system from Amazon to one of MoPH's local servers. The system was functional and accessible at the MoPH LAN and the information and all other contents of the database is up-to-date. The ACU staff were trained on using TAMT and generate reports. IT and HMIS people were trained to provide technical assistance to ACU when required. Presently the TAMT system is not accessible through the LAN. This should be restored as the aim of the tool is to be accessible from any desk of the MoPH and development partners and at any time in order to avoid duplication or to able to refer to concerned donor for more detailed specification of the activities included when needed.

Further analytical work on the cooperation areas is the essential task of the Aid Coordination Department with the responsible Directorate in the driving seat (the organisational structure of MoPH is presently in the process of being reviewed).

[1] Lindsay-Smith & J. Roos: AEDES lot 8 consortium "Evaluation of the effectiveness and impact of technical cooperation to the capacity building process of the Ministry of Public Health Afghanistan", 31st august 2009 (Final Report TC Evaluation 100331 1230 in Annex 4

Moreover as the Joint Health Sector Review (AJHSR) was recently conducted and available since mid 2015, EU has requested this review not to be conducted along the six building blocks of WHO, but to concentrate on the technical cooperation, avoiding duplication, and to concentrate on identifying gaps. Where applicable this review will refer to the AJHSR conclusions and recommendations for reform and streamlining the MoPH. It is also the strong wish of MoPH's new National Health Policy to have 'a commitment to make the best use of international aid while working towards less dependency on such aid'.

The policy and the recent reviews set the way for a future EU support to institutional capacity building, while phasing out traditional technical assistance provided by long-term consultants, ensuring that functions and capacities are absorbed by the public administration and providing short term expertise in key areas, thus reducing the risk of substitution. EU TC is complemented by assistance provided by other donors, mainly the USAID, the World Bank, and UN agencies supporting long and short term consultants.

## 1.3 The development co-operation context

Since the beginning in 1979, successive military conflicts destroyed the health system of Afghanistan[2]. Most medical professionals left the country by 1992, and all medical training programs ceased.
A national health resources assessment in 2002 revealed huge structural and resource disparities fundamental to improving health care. For example, only 9% of the population was able to access basic health services, and about 40% of health facilities had no female health providers, severely constraining access of women to health care. Multiple donor programs and the MoPH had some success in improving quality, but questions about sustainability, as well as fragmentation and poor coordination, existed[3].

In 2003, there were 11 physicians and 18 nurses per 100,000 population, and the per capita health expenditure was $28 US dollars. The nation had one medical facility for every 27,000 people in 2004, and some centres were responsible for as many as 300,000 people. An estimated one-quarter of the population had no access to health care. The international organizations provided a large share of medical care. The drought of 1999–2002 exacerbated these conditions[4].

In 2003 the EC in agreement with the MoPH started to support the resilience systems[5] of the MoPH. At that point, Afghanistan was recovering after 24 years of conflict and political instability, a collapsed economy and three years of severe drought (1999-2002). Afghanistan's health system was among the very poorest in the world.

The health situation of Afghanistan at that point was disastrous:

[2] COUNTRY PROFILE: AFGHANISTAN, Library of Congress – Federal Research Division Country Profile: Afghanistan, August 2008
[3] Int J Qual Health Care. 2013 Jul; 25(3): 270–276
[4] (Afghanistan country profile. Library of Congress Federal Research Division (May 2006)
[5] Substitution has never been the first intention of EU and WB from 2003 onward. Note of the expert.

- Afghanistan had the second highest maternal mortality rate in the world. Less than 15% of deliveries were attended by trained health workers, mostly traditional birth attendants.
- About half of children under 5 years of age were stunted due to chronic malnutrition and up to 10% had acute malnutrition.
- Mental health: Experts estimate that approximately 30%-50% of a population undergoing violent conflict develop some level of mental distress. Residual mental health problems that appear normally in any population had been unattended in Afghanistan for decades.
- Diseases that had largely been controlled in most countries in the world continued to cause death and disability in Afghanistan. More than 60% of all childhood deaths and disabilities in Afghanistan were due to respiratory infections, diarrhoea, and vaccine preventable deaths, especially measles.
- An estimated 800,000 Afghans were disabled.

In 2004 the EU Delegation assigned technical assistance in close collaboration to the WB initiative, the Grant and Contract Management Unit (GCMU), in a clear intent to join commitment of donors to improve quality and access to basic health services and to reinforce through capacity building and financing the steward's role of MoPH.

A technical team of MoPH with WB, EU, ADB, WHO, Oxford University developed a short and long term capacity building plan for central and provincial health, including leadership training in clinical setting, which was never implemented (see Annex 3).

At the time of this review, aid has been affluent for over a decade. The MoPH has been overwhelmed by imbedded and substitutional TA and health initiatives. The present third party evaluation and recent surveys could help us to understand where we stand now.

| Key Health indicators | 2002 [6] | 2012 |
|---|---|---|
| Infant mortality rate per 1000 live births | 165 | 74 [7] |
| Under five mortality per 1000 live births | 257 | 102 [8] |
| Maternal mortality ratio per 100,000 live births | 1,700 | 327 [9] |
| Provinces with obstetric care | 11 of 31 provinces | 31 provinces |
| Low birth weight | NA | 20% |
| Children under 5 with malnutrition | NA | 10% acute, 40% chronic |
| Under fives dying from diarrhoea | 85,000 per year | 13,000[10] |
| Total fertility rate[5]: | 7.48 (WB) | 5.1 [5] |
| Contraceptive prevalence rate[5]: | 10 | 19.5% (modern methods)<br>21.2% (all methods) [5] |
| HIV prevalence | NA | 0.1% [11] |
| Births with skilled provider | 11% | 34.3% [12] |

Source: http://reliefweb.int/report/afghanistan/health-afghanistan-situation-analysis

Building on the initial emergency response from 2002 onwards, the Strategic Plan for the Ministry of Health 2011-2015 laid the foundation for moving towards a

[6] http://reliefweb.int/report/afghanistan/health-afghanistan-situation-analysis
[7] MICS, 2010/2011, Afghanistan Central Statistics Office and UNICEF
[8] MICS, 2010/2011, Afghanistan Central Statistics Office and UNICEF
[9] MICS, 2010/2011, Afghanistan Central Statistics Office and UNICEF
[10] https://www.msh.org/blog-tags/diarrhea 2013
[11] UNAIDS 2008 Report on the Global AIDS Epidemic
[12] UNAIDS 2008 Report on the Global AIDS Epidemic

Sector Wide Approach in the Health and Nutrition sector in Afghanistan, emphasizing country ownership and sustainability. Large investment in health over the past decade has enabled the MoPH to make impressive progress towards universal access to basic health services. Independent evaluations, first by the Johns Hopkins University and this year by KIT& SR TRO and other studies show improvement in the quality of care. The management information system shows significant improvement in a number of indicators and institutional capacity has been strengthened.

Since 2002 about 3,340 midwives, across donors, were trained. This increase in the number of female health care providers contributed to an increase in the percentage of women delivering in a facility from 19% in 2005 to 34.3% in 2011[13].

[13] http://www.jhpiego.org/files/Afghanistan%20Country%20Profile.pdf

# 2 Objectives of the Review

The objective of the assignment is:

*"To review the current status and present performance of the project/programme, its contribution to the on-going reforms agreed between the Government and Development Partners which basis is laid in the Aid Coordination Model & Partnership Protocol for the health sector".*

Specific objectives are:

- To review and assess the overall current and planned TA support to the health sector, while identifying gaps and opportunities to improve MoPH's capacity
- Further to elaborate and propose the future EU Technical Cooperation (EU TC) program to the MoPH, in close collaboration with the Ministry taking into account its views, priorities and needs.

The expert assessed the TA in the context of enforcing the steward's role and ownership of the MoPH in its mission to improve access to quality health services for all, through improving the level and equity of the population's health.

Consideration has been taken of achievements and expected results, and areas of concern have been identified, with particular attention to complementarities with other running and upcoming technical assistance from various donors and agencies.

Based on the lessons learned, the review aims to contribute to identify gaps in implementation and tutoring of implemented programs and technical assistance in close consultation with donors and the involved directorates of the MoPH.

Those conclusions and lessons learned will lead to identification of gaps and recommendations for further need of technical support and possibly follow-up actions and future intervention in the sector in agreement of the MoPH.

# 3 Methodology and analytical approach

To answer the questions of the TOR, documents related to policy and strategic issues, and revisions were reviewed. Because Technical Support and Capacity Development are central in the request for next EU proposal, also all documents that could be traced over the last 11 years, related to capacity building and staff development/assessment were reviewed and analysed.

Contact was established with all the present and incoming development partners The projects were reviewed, compared and in-depth discussed with the partners and agencies in order to identify present and future complementarities and duplications, and to identify areas of priority contribution for the European Union Cooperation with the MoPH.

At anytime the reviewer both in discussions and through project and literature review has questioned what worked and did not work in order to develop the lessons learned and to make concrete suggestion to the MoPH for the way forward.

The essence of the ToRs and reports of recent and current TA projects are summarized in Annex 2, as well as a review of imminent planned projects. As the TA support all the range of health services and health management, the TA is commented in the analysis.

# 4 Operational analysis of MoPH' organizational structure

## 4.1 Overall problem analysis

The structure of MoPH and mechanisms show '**fragmentation**' at several levels:

> *The Afghan Joint Health Sector Review (AJHSR) found 'MoPH fragmented with inappropriate regulatory capacity, compounded by inability to enforce what has been regulated'… and what was planned and agreed.*

This fragmentation is augmented by the way external aid is conceived in support of MoPH as a whole but in reality is supporting priority systems that are not channelled through MoPH leadership. Following mechanisms are conceived as (col)lateral donor support the contracting-in Health System Strengthening (HSS) mechanisms, and also SEHAT thematic approaches[14] if not handled with care are adding to this disruption. Both systems/mechanisms could undermine the ownership that would have been kept if channelled through the existing, improved, MoPH organizational structure (see next paragraph).

Although set up with the best intentions, and in the actual conception of aid while respecting the Paris Declarations development partners cannot pile up 'trouble-shooting systems' that contribute to ad-hoc functioning but not to sustainability and ownership.

For example the HSS is rather conceived as a "Health System Functioning Aid" with a crash approach for defined MDG purposes, and is now outdated[15], while it is replaced by sustainable development Goals (SDG). Rather than investing in the MoPHs organisational structure to make it sustainable, the present construction is disrupting it. Instead of continuing to function as a trouble-shooting system the HSS needs to be redesigned/redirected and ought to be replaced by a sustainable approach of channelled funds through a donor and ministry SWAp department or directorate, both working side by side[16].

When a system does not perform to each one's expectation, a problem solving approach is recommended, and part of it is the analysis. The AJHSR is a conscript with a very clear analysis, recently commended by MoPH with EU support that is expected to lead to intervention and stepwise action. Time-limited termination of donor contracts (the end of the 2012-2016 EU-TC project implemented by EPOS, and the HPP/USAID project by Futures Group ending without taking forward attained results or plans into Palladium), the hope to move on some of the actions into the 10 thematic areas of SEHAT component 2 and also the continuity of

[14] Note that contracting out (BPHS/EPHS) is not included in this comment; and according to AJHSR; cfr Modol X; p77:
There are also shortcomings in the donor side. …, funding is allocated to specific programs or activities, rather than to a –admittedly non-existent—comprehensive sector plan. The MoPH does not have a fund of last resort that can be used to fill financing gaps in areas less popular with donors that nonetheless are a MoPH priority. SEHAT, the de facto common fund designed as the main funding mechanism, is completely allocated on a medium-term basis. Moreover, the ten thematic areas under SEHAT Second Component, which were discussed during the period of the AJHSR, may contribute to generate "project implementation units" in the –inherently exclusive—departments covered by this funding mechanism.

[15] After the 2015 target of MDG, who entered in the next stage of Sustainable Development Goal (SDG) to 2030 target

[16] until the Ministry can quietly subsume the donor SWAp (ex. Bangladesh)

national advisor contracts to be incorporated into the Capacity Building Reform Facility (CBRF) that are now delayed, interrupt the continuity of employment for trained national staff.

The ToRs of national consultants (in EU funded projects and others) were amended to link with SEHAT thematic component 2 for the last year; the salaries were aligned with the SEHAT scale. Some were even reduced! Delay leads to uncertainty of employment and de-motivation so consultants sought and found other positions in or outside the health sector.

Both based on the AJHSR and on own findings, the SEHAT as designed now is not enough strengthening the MoPH ownership, although component 2 and 3 are to support the stewardship capacity of MoPH besides developing the national health system. The way SEHAT is conceived caution must be taken (as well as for the Health Systems Strengthening (HSS)) not to cause de-powering and fragmentation of MoPH stewardship. The actual selection of project-like activities[17] and the thematic set-up the danger exists to lead to a crash funds approach. Besides this possibly fragmented approach to MoPH through selective thematic areas, SEHAT is not offering MoPH the best preparation[18] for budget support. As it is for now SEHAT is nurturing (pampering) the MoPH while not coaching towards budget approach. In the context of sustainable development, the role of the WB has to be an administrative coaching entity within MoF and not an implementing agency of or inside the MoPH.

A more administrative approach could be considered, limited to financial management:

> *Excerpt from WB Aid Memoir Nov 2015: "shifting from "traditional" approaches such …. and "substitution" TA, towards a model ensuring more continuous support such as peer-to-peer learning through partnerships".*

The same comment is applicable for other actual donor finance management.

Nevertheless the SEHAT contribution through the component of thematic areas could be very successful if channelled in a constructive contribution to the organisational structure of MoPH to support its functioning (see SWAp in next section), and in that way should be conducive to deliver effective TA that is well absorbed and incorporated[19].

## 4.2 Aid Coordination and SWAP

MoPH should run Aid Coordination on own resources. Donors have supported aid coordination ever since 2003, while it is not appropriate for a donor to run on-going MoPH services. Appearances are against efficient aid coordination as existent coordination processes with donors and General Directorates (GD) are now suspended or interrupted.

[17] 10 proposals were developed for the strengthening of key health system areas as there are: strengthening sub-national government, ensuring quality pharmaceuticals, improving hospital performance, improving fiduciary systems a.o.

[18] A supportive system to donor SWAp while the MoPH SWAp unit is strengthened is a better alternative

[19] if paired with the other interventions linked to retention strategy mentioned in next section: the way forward

There is still no fluent handover of the ACU from a project approach (by EPOS with a national consultant) towards institutional adoption; the organisational structure is still in the pipeline. EPOS-TA has undertaken some developed trainings and developed a manual yet to be implemented, but handover to the government organization cannot take place in the present gap (of transition of programs as explained in previous section) and this is problematic as for sustainability.

In the past several attempts were made to map the technical cooperation. With TA support between others from EPOS to the Aid Coordination Unit (ACU) it finally resulted in the TA management tool, the TAMT. After being adapted to other software it is not universally accessible, including for the International Relations Directorate (IRD). Appearances are against as existent Coordination processes with donors and GD are suspended or interrupted. As for now there is no fluent transition to other mechanisms.

Secondly donors tend to keep on own directions and limited agendas. For example no operational budget is provided for the departments[20] responsible for planning, coordinating and monitoring support towards basic health services for prisons and only limited for mental health support. This is a flagrant deviation of SWAp and also from the basic human right on health care.

Sector-Wide Approach is mostly just on paper. There are a number of successful developments towards SWAp, like the GCMU and its spin-off SEHAT. But it should be questioned if the presently applied SWAp in MoPH merits its name. First of all, although the GCMU is organisational part of the Procurement & Construction Directorate, in practice and in level of support they are miles away and dissociated from the Directorate[21]. Mistrust is one of the reasons; partly caused by lack of investment in reorganising this Directorate by the MoPH, in order enable 'Procurement & Construction' to absorb the capacity building that it needs (see last section).

Health System Strengthening, as already mentioned in previous section, is not a SWAp. Although WHO is supposed to work and assist inside the government structure; HSS is a strengthening mechanisms for own defined purposes. The rationale of HSS was rightly to enforce systems in order to have the priorities running successfully and to attain a number of essential health targets. The problem is that the system is infiltrating in main departments but not rooted nor centrally driven and owned. A re-design would incorporate HSS in the overseeing ACU department/directorate. The danger is the way SEHAT thematic component is conceived; as the rush for results could create conflict with the mechanisms needed for sustainability. Also SEHAT in a re-design should be incorporated in the MoPH controlled SWAp department/directorate with Aid coordination linking with it.

[20] The central units coordinating prison, disability and limited for mental health services are currently totally dependent on donor support in order to function – stationary, travel costs to train/M&E

[21] Note that procurement support was requested for GCMU and was included in current EPOS project, but capacity building could only be done of externally funded consultants as there were no tashkeel staff to train. Training should have been done of tashkeel staff in the MoPH procurement directorate.

## 4.3 Policy and planning

The same accounts for planning, where the intensive donor support to the planning department for over 13 years will soon be limited, suspended or interrupted, as per donor decision. Some of previous planning facilitation is taken over in the 'Governance and Social Accountability' GSA SEHAT proposal.

The client-centred aspect, the Grievance Handling Mechanism (GHM) as a tool for accountability works only and when there is a leverage (carrot-stick mechanism) to apply accountability, not by setting up a mere independent unit at the MoPH central level, if there are no Standard Operating Procedures (SOPs) attached to it.

The question we have to ask is why strategies over the years have not become operational and why there is steadily a need to be reconceived when those were never tested or applied. There should be only one health strategy based on a solid policy, and followed by guidelines and budgeted implementation plans for all the components. A strategy can be adapted when there are empirical flaws, a strategy is not a law and is not rigid, it is dynamic, when necessary it can be amended based on experience.

Focus should be on implementation, less on plans and updating plans (since 2001). A plan is only legitimate when implemented; otherwise strategy becomes fantasy. One way would be that donors commit together with MoPH to implement proposed strategies and action plans, that should be linked to agreed budgets.

Fewer components can be addressed more efficiently; with more intensive resources and long-term: most activities need a rollout of 5 years to provinces to be sustainable. Implementation of a strategy includes budgeting the roll out (financial resources), seconded by mentoring and coaching of training (including Provincial level), and to plan the human resources needed.

## 4.4 Procurement and construction

The general procurement will be addressed through SEHAT Procurement Proposal. Nevertheless, this directorate in order to become fully functional and transparent and accountable needs primarily a complete Capacity Building overhaul as will be exposed in the HR section with stepping-stones for CB. This should contain ad Basic skills (English, computer, and management skills) followed by a salary upgrade for those passing the test and parallel WF planning.

EPOS TA has provided intensive and short term monitoring support of service delivery of SEHAT funded proposals to fill some gaps in SEHAT. There would be no need to this kind of ST consultancy support, if not purely due to slowness of the finance system. This will be improved through SEHAT Finance initiative. Also the wrong people were trained, not the tashkeel but the national consultants. This could be accepted if a next step had been knowledge transfer with coaching and mentoring to the procurement department, which did not take place.

A fundamental upgrade of the human resources in the Procurement & Construction Directorate by means of profound CB and appraisal with selection of

functions inside the P&CD (workforce planning through workload analysis) is a first step. This in order not to bring down the level the GCMU has meanwhile attained. Next step would be that GCMU absorb the whole procurement directorate into its higher level of being centre of excellence. And in fact HSS is a good example of this approach: to secure transparent procurement and applying the Afghan procurement law, HSS procurement has been brought under the GCMU. It has also adopted the GCMU accountability of NGOs introducing new Performance Based Financing (PBF) mechanisms. There is no objection to expand this system progressively to the whole procurement sector.

### 4.5 Provincial support

Although it needs parliamentary support, the MoPH could be a lead in the Decentralisation Strategy, which is on hold until the government as a whole moves on. Training in preparation has begun through EPOS. Waiting for all Ministries to be ready will result in a loss of momentum. The draft Decentralisation Strategy and its Implementation Plan is unlikely to be further advanced until the government as a whole moves on this, so training in preparation should continue as many aspects can be introduced without requiring legislative or regulative change.

Political action with central support is needed to ensure the Decentralisation Strategy is implemented. Two aspects need to be worked on to make decentralisation working:

- One is to strengthen the regulatory role of MoPH by concentrating on its own organisational structure and functional directorates with clear human resource policy applied and improved communication systems (see section below on human resources). Both USAID (Palladium implementer) and EU with EPOS and future program should work hand in hand with Provincial Health Officers (PHOs) and the Provincial Liaison Directorate (PLD) on all aspects of budget allocation, HMIS, workforce planning etc.
- The other is to develop the right Human Resources (HR) strategy in provincial directorate and offices. Intense support from three major donors USAID, EU and WB has not produced the expected result because of lacking HR and retention, career opportunities inside and motivation. So opportunities are sought outside MoPH with the NGO grantees employing tashkeel staff and thus depleting the PHD en PHO.

HSS gives support to the sub national level in a small area; again this support is not integrated and limited to its own systems (EPI, MCH and 3 diseases).

All those aspects need consideration for the Sub National Governments (SNG) SEHAT proposal to work and have the expected outcome. Within the execution of the SNG proposal much of the existing fragmentation as well in the organizational structure and as in the existing parallel structures need to be addressed.

### 4.6 Sustainability of HR activities

Human Resource activities appear all over components of SEHAT (hospitals, private sector, sub-national, pharmaceutical and governance). Already 24 months

after the start of SEHAT new funding must be secured. Indeed 2.5 years are not enough to implement SEHAT proposals: they are mainly donor driven, require fast results, and for that reason are TA driven with no time to create ownership. This while there is a need to coordinate with the USAID program of Health Sector Resiliency (HSR) initiatives and other proposals. The prepared action plan of HSR will apply the WHO Health Systems framework and Intrahealth's HR for Health action framework. It can easily incorporate continued activities from EU-EPOS HR groundwork, but according to EPOS programming HSR can take forward only around 15% of planned HR activities, although it is at least for another 5 years. Also the SEHAT Human Resources proposal should incorporate the ongoing and so crucial HR initiatives, but with only 2.5 years this is not long enough.

As it is for now continuity of projects has been post factum identified by the projects themselves EU (EPOS) and USAID (Palladium) through informal networking, and also with support of this TA review, and not led or stewarded by the department.

### 4.7 Health promotion

Health promotion is clearly to be differentiated from Public Relations. HP has all to do with behaviour change involving community development. There is a need of dedication to Behaviour Change (BHC) regulation as well as to BHC education. Although the Health Promotion Department uses the correct definition in its policy, strategic plan, and implementation plan, there is confusion at wider levels within the MoPH about its role. Many see the Health Promotion Department as responsible for media communication/PR for all, rather than as the technical group advising on and coordinating planning, implementation and monitoring, with most of the delivery being by content-area directorates and departments in collaboration with NGOs, international organisations and donor groups. It is little understood by many that most effective communications are through networks, through word of mouth, using the community development approach.

BHC needs a long term, over 10 years investment. If BHC & cultural change were applied at the start of massive foreign aid, it would be ready by now. But at that time there was no plan to reach hospitals, opinion leaders, police department, trade associations, schools, community and religious leaders, as EU-EPOS project is conducting presently through pilot health promoting hospitals project and healthy district project. Although it is encouraging that SEHAT component will take HP in, as it is limited to 2.5 years, SEHAT funding will leave an unaccomplished project.

### 4.8 Quality Assurance

The Ministry of Public Health (MoPH) launched the strategy in 2011 to advance its mission of 'improving the health and nutritional status of the people of Afghanistan through quality health care services provision in an equitable and sustainable manner'. A unit became responsible for Improving Quality in Health

Care (IQHC Unit) under the leadership of General Directorate for Curative Medicine of the MoPH.

USAID has a long history in supporting quality insurance:
HSSP facilitated the Central Quality Assurance Committee (CQAC) developing and establishing quality assurance system, mostly in BPHS, with technical assistance and capacity-building to non-governmental organizations (NGOs) contracted by MoPH to improve service delivery and the quality of basic health services. The steps in this QA were: identifying standards of care, assessing progress, guiding improvement in achieving standards, and recognizing the achievement of the standards. Under Tech-Serve over 600 hospital standards were developed to improve quality in hospitals, covering governance, clinical care, nursing, ancillary support, administration and management. It also supported developing hospital accreditation to ensure above mentioned hospital quality standards. At the same time for 10 diseases clinical case management protocols were developed in PCH hospitals[22].

QA can contribute to health systems strengthening. This is possible through national leadership and collective will, with international support. Whereas international and donor programs have had successes in improving health care quality, experience in Afghanistan demonstrates the critical need for nationally led efforts to rationalize, align and leverage specific programs to design and build a coherent national quality program. Afghanistan demonstrates how to affect improvements in patient care at the front-lines of service delivery while building systemic capacity at all levels through national leadership and policy making[23].

[22] USAID combined health projects evaluation 2011
[23] Int J Qual Health Care. 2013 Jul;

# 5 The way forward

This section indicates the areas or support for TA investments with sustainable results.

The golden rules to be observed when providing TA to MoPH are the following:

- TAs need to establish trust and that takes time. Having a hidden agenda is not conducive, but most TAs are bound to the donor's agenda. SEHAT is pointing to priorities but time given to MoPH to set and endorse those priorities is short. It is the Afghans country, not the donors or TAs.
- Setting up TA needs understanding beyond cultural and should include institutional and structural reality such as the salary scale.
- TA support should be taken forward by the MoPH or by other donors or TAs until the advice is implemented. Most of the areas have been covered by TA and some repeatedly because implementation was not enforced.
- Some projects are not kept simple and focused and this makes it difficult to become policy or to adopt regulation.
- Support research and data for decision making.
- What can be achieved in 5 years is limited, some goals are not realistic and more energy needs to be put in handing over, transmission. Phasing-out is not enough, when continuation and implementation is needed.

The message in this review is that the way how and the exact leverages need to be observed, also based on lessons learned. After almost 15 years of technical support and capacity building, more intensive collaboration between donors and under guidance of aid coordination of GoIRA and MoPH should lead to more sustainable results.

As explained the human resource retention strategy is a key area and can be improved by an adequate comprehensive capacity building plan based on real civil service needs (with ToR and JD), a competitive approach and salaries on realistic calculations.

The following sections with highlights in italic, cover (besides EU's priority for access for vulnerable people) some tailor-made basics, mechanisms and conditions to modernize present Afghan health systems and healthcare in a realistic and stepwise approach, with special attention to affordable and sustainable quality of care. Those are some paths to be extended to the next EU-TC for the coming three (as SEHAT runs up to June 2018) or five years (duration of the EU-TC fund). At the same time a number of pre-conditions are set to move out of the relative stand-of and resource wastage in the last decade.

Potential areas for next EU TC:
The aim of the "Technical Cooperation Program to the Ministry of Public Health", is strengthening the capacity of the Ministry to steer and manage the provision of preventive and curative health services and the development of the Afghan public health system. EU will ensure continuity of support to institutional capacity building, while phasing out traditional technical assistance provided by long-term consultants, by ensuring the respective functions (and capacities) are

absorbed by the public administration and providing short term expertise in key areas, reducing the risk of substitution. EU Technical Cooperation (TC) is complemented by assistance provided by other donors, mainly the USAID and the World Bank, but also by UN agencies supporting long and short term consultants.

The areas of support will include TA to the thematic areas of SEHAT. They are: strengthening sub-national government, ensuring quality pharmaceuticals, improving hospital performance, improving fiduciary systems. Below follows an elaboration of paths of management interventions and activities to develop in order to attain sustainable strengthening of the MoPH.

## 5.1 Accountability in the MoPH organisation

Concerning leadership there is a need to reform within the organisational structure of MoPH the accountability of the directorates through appraisal. For example, a role for H.E. office could be *to appraise the directorates, with the ultimate goal to (re)instate the leading and coordinating role of responsible and responsive directorates*. And add to this additional coaching and coordination by SWAp/ACU for as much as international support to the systems is concerned (EPOS, Palladium, HSS, SEHAT).

HSR runs for 5 years, SEHAT for 2.5 years: how this will be coordinated is unclear. It is said that activities can be continued after 2018 but this is only possible if budgets are secured/dedicated and operational plans established by January 2018. Exit strategies are not applicable here as SEHAT should not have a project approach but be imbedded into an AIDCO directorate. In the same way the planned EU-TA for the next five years should at the same time be in phase with the SEHAT until June 2018, but the challenge is to also secure continuity of EU-TA support for the whole period until 2020 without too much disruption.

## 5.2 Delivery of Quality Health Care services

### A. For EU to maintain the priority to health access for vulnerable people and IDPs:

Continuous efforts need to be made to expand the scope, quality and coverage of health services provided to the population, particularly the most vulnerable people. The most vulnerable groups are women and children, the economically disadvantaged, those at risk of contracting HIV/AIDS and nomadic populations At the present 88% of the rural population has access to health services, defined as living within two hours walk from a Health Post.

In this area EU through EPOS and other grants has supported services and training for Mental Health, Prison Health and Disability, rolled out over EPHS and BPHS. A lot of work has been done on developing strategies, which await implementation in the next stage.

- There is an urgent need for *staff upgrade in the Disability and Rehabilitation* Department, in order to follow-up the implementation of the strategy. Further follow up is needed on the physiotherapy curriculum and certification with

Ghazanfar Institute of Health Science (GIHS). EU is funding training of physiotherapists

- Close attention must be given to cerebral palsy and spinal cord injuries including improvement of hospital services concerned. Skilled staff training is in the pipeline, all to be incorporated in EPHS.
- Besides upgrading *mental health* legislation, next step is to rollout the mental health strategy 2016-2020, with attention to the national Suicide Prevention Strategy. Ongoing now are the assessment of hospital mental health services based on the WHO Quality Rights tool kit, and following up on the Mental Health Gap Action Program (mhGAP).
- Rolling out of Quality Rights Assessment remains to the other regional and provincial hospitals
- It is important that the HIS Department delivers continuous follow-up & monitoring for mental health services.
- EU is funding training for psychosocial counsellors to improve services to people living with mental disorders.

Another input of the EU/EPOS national advisor to the DPHS is quality improvement through capacity building of prison health providers, M&E Directorate of M&E and DPHS, and processing the 'Release of prisoners on human ground'. Further areas needing future support are:

- Prison Health needs implementation countrywide and activation of health facilities in the three MoPH Strengthening Mechanism (SM) provinces.
- Lobby for inclusion of Health Services in Herat, Kandahar and Kabul prisons & earmark funds
- Assure regular medical screening system in prisons with functional referral
- Prison referral hospital with budget for staff allocation and other recurrent costs
- Inclusion of PHS into monitoring and evaluation system with expansion of HMIS
- Empowerment (staffing and CB) of the Prison Health Department to carry on the ongoing reform and to ensure coaching and monitoring of the roll out in the EPHS.

### B. SOPs and a Quality Improvement Component:

It has to be noted that Quality Improvement and the Standard Operational Procedures (SOPs) as warrant for quality improvement are present at all service related departments and across SEHAT proposals and others. Clear SOPs permit review and revision of job descriptions that also include details of functional linkages throughout the MOPH.

Figure 1 shows how systems are interlinked to assure quality of care and how *quality of care is adamant to create affordable and accessible health care for all as central piece and pre-condition to sell services, but also as condition for MoPH to regulate quality of private healthcare services "only Quality is for sale":*

Here follows a list of the systems in process to be developed or still to reach completion, contributing to quality of care, especially for secondary and tertiary hospital care:

- Developing hospital clinical standards and trainers/clinical specialisation curriculum are conditions for accreditation.
- Professional Councils have an essential independent role (yet there is no adequate funding of the independent Interim Medical Council [24]).
- Human Resources SOPs, accreditation of trainers & curricula and professional councils, as developed by EPOS.
- Improve access to health including the private sector and quality of health services
- Support and stimulate the capacity of private sector associations for self-regulating [25] of quality and to promote private provider certification and accreditation, taken up in the HSR and MCH support by USAID.
- Proposal for the future: in continuation of the work done by USAID[26], with support of EPOS and through the work started under HPP it is needed *to establish a Quality Improvement Department* (not a unit):
    - Development of Hospital / facility quality improvement system;
    - Facilitation and coordination to develop SOPs for all departments and services
    - The determination and implementation of internationally recognised service standards, linking with accreditation systems for clinical services, administrative services, facility construction standards, training, curricula. All linked with accreditation systems developed in GDHR for trainers and curricula, and for hospitals.

SOPs are across SEHAT proposals and others, and are linked to accreditation (hospital clinical standards and trainers/curriculum).
Professional Councils have an essential independent role, yet there is no adequate funding of the independent Interim Medical Council. There will be need for continued facilitation and coordination to develop SOPs for all departments and services. SOPs must be across all MoPH and coordinated through a strong Quality Management Department. EPOS is currently doing HR SOPs, accreditation of trainers & curricula and professional councils.
HSR will also work on the capacity of private sector associations for self-regulating of quality and promote private provider certification and accreditation.

### C. Hospital Reform, Management and Quality systems:

The ongoing work of EPOS and the work commenced under HPP-Futures group, needs follow up of the implementation of the developed hospital management system. This includes support to *management training for the key hospital staff, as well as monitoring and evaluation of hospital management performance.* As HR are central in all hospital operating systems, priority work must be done on following the National Workforce plan developed in 2009, which is currently being updated using the Dewdney system allowing for continuous updating in a

[24] All Associations will need assistance with start up funding meanwhile before Interim becoming permanent – but these would be responsible for registration, accreditation, and monitoring, disciplinary action.
[25] Only through associations until Professional Councils are developed for al health professionals. With EPOS one for Midwives/Nurses is to be established very soon – work is in process on the business plan. Next would be pharmacy (in planning stage) and then for the remaining, probably an Allied Health Professional Council.
[26] See paragraph 4.8

workbook and spreadsheets including staffing, training needs, and budget projections:

- HR: Hospital workload planning recently re-energised needs TA support for a 5-year rollout.
- National health WF plan December 2009: Costing: The total budget required 1388-1392 (5 years) is $453.5 Million ($411.1 salaries and allowances; $34.68 M training; $1.2 M professional standards; $4M HR Practices; $2.5M HR Data management). This was never implemented.
- Other trainings needed for hospitals: Leadership in a clinical setting: 1 year 40,000 USD (CB plan 2004).

The SEHAT hospital proposal as it is elaborated now needs more input and elaboration to reach tangible improvement of hospital services tangible improvement of hospital services. Implementation is delegated or evasive. Nevertheless, there is evidence that concrete implementation plans would benefit the client at the end of the chain. Following mechanisms to improve the hospital network in the capital are essential steps to move to better care, and a precondition to hospital autonomy[27]:

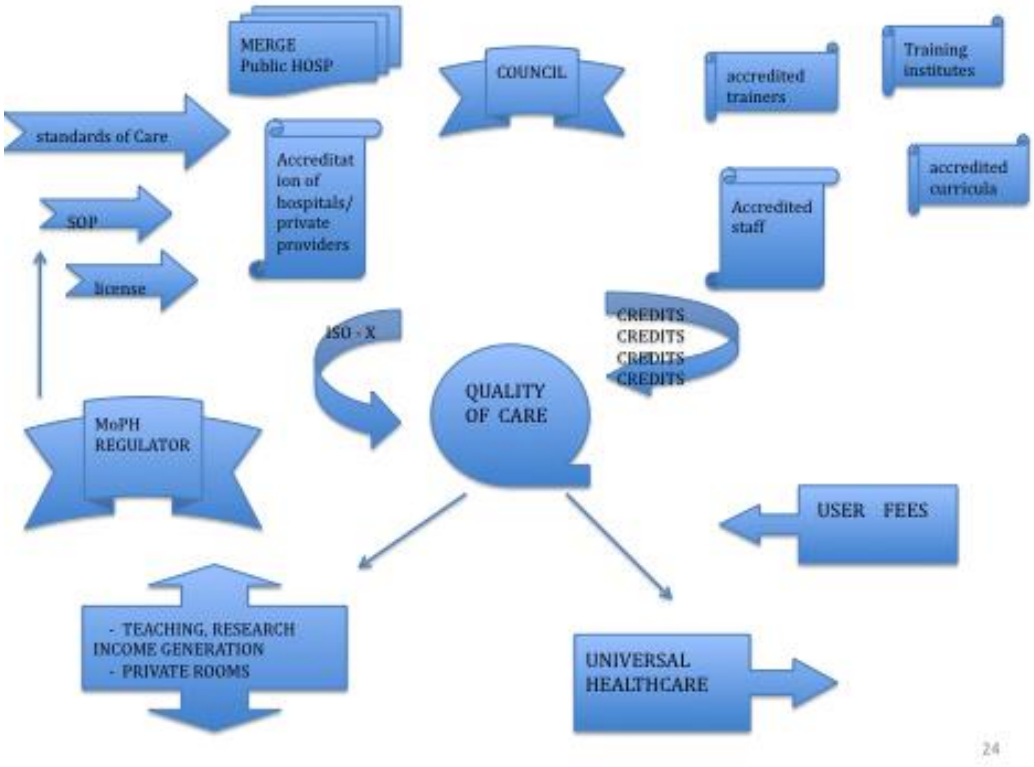


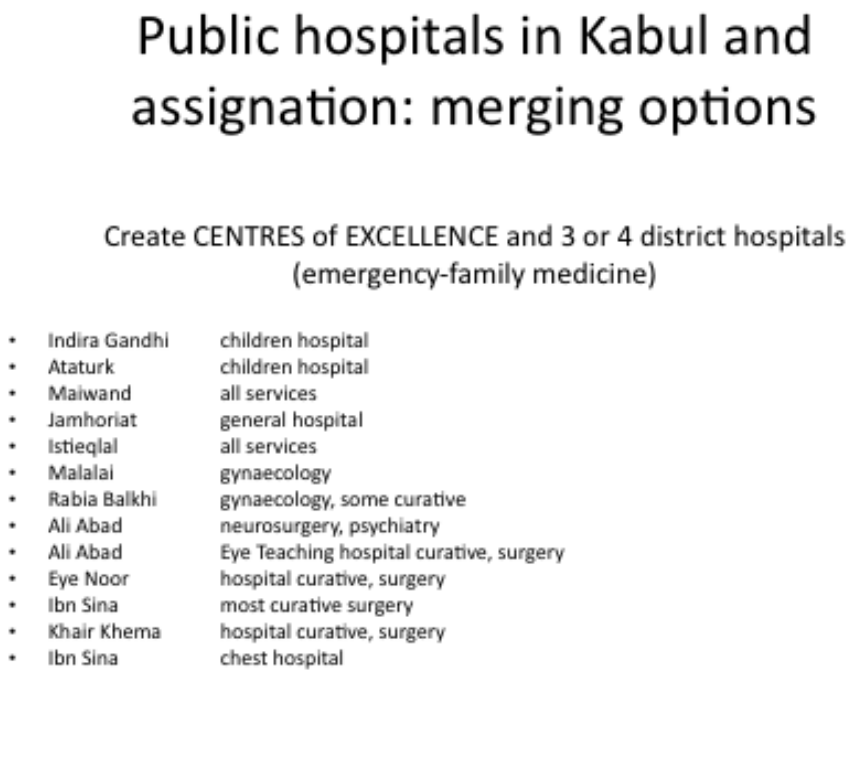

Figure 1: The curative quality cycle.

Figure 2 is a non-comprehensive list of Public hospitals in Kabul and their assignation (on a grand total of 20 MoPH hospitals of Kabul. The idea is to develop Merging options (as exposed in previous figure at the top of quality care cycle for hospitals) to reduce costs and reach efficiency of resources paired with the development of centres of excellence for tertiary care.

[27] With courtesy of NHS Leeds Hospital trust, as reference

Besides the creation of *Centres of Excellence*, 3 or 4 hospital entities could be kept representing the 'Kabul district hospitals' to assure and provide vicinity emergency care and family. Further refining of the hospital network would include recognition (accreditation) of private specialized care, but careful as studies show the importance of health regulation and quality insurance[28].

Figure 2: Merging options to reduce costs and reach efficient tertiary care (see map Annex III).




## 5.3 Quality Insurance:

Some developing countries have successfully initiated Quality Assurance Programs and are constantly refining their approaches and methodology. Installing a Quality Assurance Program requires additional efforts. Some encountered impediments are deficiencies in:

i. Leadership: commitment by top management to continuously improve quality and to adopt QA and QI [29]concepts throughout the entire organisation
ii. Motivation: a supportive organisational culture to continuously improve quality, to make it a priority and foster willingness, especially by physicians, to change practice behaviour.

[28]Comparing Malta's public and private hospital care service quality: Results showed that private hospitals are expected to offer a higher quality service, particularly in the "hotel services", but it was the public sector that was exceeding its patients' expectations by the wider margin.nt J Health Care Qual Assur Inc Leadersh Health Serv. 1998.
And comparing the quality of inpatient clinical care in public and private hospitals in Sri Lanka: Overall quality scores were better in the public sector than the private sector (77 vs 69%). Performance was similar for management of AMI and childbirth and somewhat better in the private sector for management of asthma. The public sector performed better in those indicators that are not constrained by resources (94 vs 81%), but worse in indicators that are highly resource intensive (10 vs 31%). Quality was comparable in assessment and investigation, but the public sector performed better in treatment and management (70 vs 62%) and drug prescribing (68 vs 60%), and modestly worse in terms of outcomes (92 vs 97%).Health Policy Plan. 2015 Mar;30 Suppl 1

[29] Quality Improvement must be customer-driven and needs a supportive organisational culture

iii. Skills: staff development in quality management and teamwork, training medical record technicians capable of organising and managing a medical records system with ICD codes assigned to diagnostic categories
iv. Information systems; the capability to manage and install Information systems and the capital to invest in hardware, software, training, technical assistance and maintenance for the QA and QI system
v. Organisational design: a decentralised decisional structure with managerial autonomy for health care facilities including the authority to control and manage their own resources especially the budget (mobilize additional resources) and staff (hire and fire, promote, reward, provide incentives…etc.)
vi. Multidisciplinary review process: active participation of the various professional disciplines.

These barriers are not easy to overcome and the best approach is a phased quality management approach accompanied by the development of indicators and standards. Accreditation of health care facilities is a stimulus to assure that the necessary Inputs are available and that the minimal processes are in place[30].

## 5.4 Provider payment mechanism

In the context of Quality Improvement EPOS (off-plan) contributed to the Provider payment mechanism committee, with MoPH-HEFD. Within the context of health sector reform, as other developing countries Afghanistan focuses on reforming the health care financing system. Existing health-financing systems need remodelling to better respond to risk pooling. Several structures of health care financing are proposed: tax-based financing, social health insurance, private or community-based health insurance, cost-recovery systems, user fees, capitation payments, health funds/grants, etc. Most seek to ensure adequate and equitable resource mobilization for health.

Provider Payment systems serve as a backbone to successful insurance platforms. A well-designed provider payment system enables good quality of care, timely provision of services, prevention of fraud, and effective cost management. However, the development of robust provider payment systems that meet these objectives is a complex process that requires significant data, sophisticated infrastructure, and harmonization of policy.

## 5.5 Human resource management

In line with the HR work done now by EU/EPOS- HR consultant, accountability can be reached based on set SOPs, that will 'Clarify the roles and functions of directorates /departments by regular testing, appraisal and on-job management training (by advisor) included'.

At the same time and by organizational restructuring in HRD the dual responsibility of Personnel Administration and Performance Management in HR management should be clarified within the general directorate: As it is currently four departments come directly under the Director General of HR. This results in

[30] De Geyndt W., Managing the Quality of Health Care in Developing Countries, Volumes 23-258

the DG having to undertake dual roles that of Director of Personnel and that of DG leading to tremendous amount of responsibility.

The work of the DG in dealing with all issues related to personnel administration results in insufficient time for the higher level Strategic HR work and that while each department appears to function separately and not linked to each other. It is recommended by the HR consultant that *these four departments be incorporated into a separate Directorate of Personnel Management*.

This intervention should be paired with interventions at all HR CS level. Monitoring of staff performance can take place through effective implementation of Staff appraisal that ensures that the appraisal does not just meet the CSC administrative requirements but additionally monitors the clinical and professional performance. On this basis recruitment could become transparent, merit based. Next step is to assure continuous professional development linked to results of Staff Appraisal in order to strengthen performance and contribute to career progression.

As the reader can notice the way forward is not complex but it is considering a variety of aspects and approaches all of them individually converting into HR compliance and to the retention strategy.

Practically, other innovative measures should be applied. The innovative idea is to use an educational approach to break the inertia and incapacity to transfer knowledge and skills to MoPH CS staff (tashkeel), besides the salary and other retention interventions.

MoPH has gone first through PRR since 2003 , Pay and Grading, and later with CBR and nothing has changed. The plan is across all ministries, too ambitious, too official, and too political. The way forward might be fast and dirty, but no dismissals, no political challenges.

The proposal is also totally in line with the coaching idea and the following should be elaborated by educational versus human resource specialists:
A team of trainers should continuously challenge the CS in their work (the same approach was used to build up the GCMU since 2003 and proved successful), department-by-department, directorate by directorate, and roll this out. By using problem-solving approach, based on analysis of conducted and available training, deployment and motivational issues, staff leadership, mentoring and coaching, as well as basic logistical support. Coaching for senior and mid level managers on condition they can absorb. It won't help send them out for training courses. They should stick rather to applied management (on-job). Better would be to select senior management based on skills and capacity rather than political adherence.

Those mentors should encourage discipline and evaluate tashkeel at least each trimester, including monthly testing (on-job-appraisal). The idea would be to capitalize on lessons learnt from previous experience to develop an inclusive employee-centred learning-pedagogy training module. All this should happen parallel to what is proposed in a following section on basic skills upgrading for level 3 and 4, on-job management courses with English where needed for higher level staff and a short term testing, hire and employ, sabbatical leave for all useless employees etc.  But before moving in this report to the more detailed

approach for basic CB plan (see section stepping stones section 5.7), important issues need to be analysed and discussed on the primary role of MoPH, being the regulatory role to deliver quality healthcare to the Afghan population.

## 5.6 Human resource development

A limiting factor in the difficulties to hire and retain qualified health professionals not only for remote areas but also in central ministerial departments.
Following are pre-conditions for sustainable and effective HRD:

- There is a need for Civil Service overhaul as described in next section (and in the MoPH literature listed below)
- Retention strategy as developed presently by the EU-EPOS special advisor
- Salary policy
- MoPH commitment
- Donor commitment

Afghanistan had for a long time a salary system based on the communist approach where free accommodation, health, transport and welfare services were provided. After the Taliban era the same salary levels were continued when the support services had to be paid from the same salary. The actual salary scale hardly covers minimum standards of life and is conducive for corruption. No CB plan as innovative or novel approach as one would dream can bring change to present entangled system[31]. No plan can take root in the present swamp of unreasonable salary policy that does not pull all contracted-out and contracted-in and donor-funded projects into one salary scale under MoPH.

It should be noted that in a context of scarce skilled human resources, the lack of hard budget constraints on the donor side has a pull effect on salaries of afghan professionals[32]. Such pull effect is also always strengthened by the massive presence of expatriate experts. The correspondingly exceptionally high salary levels led to a lack of fiscal sustainability and to increased dependency on donor[33].

Most of the work has been done over the last 11 years on this topic. The documents need updating and implementation, but the plans and analysis are-were developed.

- MoPH 2004. Capacity Building Plan of Ministry of Public Health, Short term and Long term
- MoPH 2009, Hospital Capacity Building Needs Assessment, 13 August 2009
- MoPH 2009, CBPSC Report: Needs assessment and Capacity Building plan for the Ministry of Public Health, 9 February 2009
- Lindsay-Smith & Roos J, EU-AEDES, 2009, Evaluation of the effectiveness and impact of technical cooperation to the capacity building process of the Ministry of Public Health in Afghanistan, 31 August 2009
- MoPH 2009, National Health Workforce Plan, 1 December 2009

[31] The Needs Assessment and Capacity Building Plan for MoPH February 2009 produced by the Capacity Building Steering Committee of MoPH chaired by the Dty P&P was never implemented. This plan was extensive and included institutional development, legal and budget requirements as well as training needs at each unit/facility level. See Annex 4.
[32] The WB, USAID and the EU have agreed to align as much as possible TA salaries to the nationally approved scales.
[33] *Review of Technical Assistance and Capacity Building in Afghanistan, Serge Michailof, World Bank - April 26, 2007*

## 5.7 Solution - Stepping-stones

### A. Human resources fast-track efficiency plan:

For this section we refer to the capacity building plans that have been developed by MoPH with WB, USAID, EU and other support and have never been implemented (see literature to be consulted Annex 4).

1. The first step is to provide all Civil Servants of good will and intention to work and progress, with an equal opportunity to Civil Service in Health (Tashkeel levels 3-4). In order to create the opportunity for a new and dynamic start, MoPH together with donors' commitment could roll out and update the CB building plan of basic skills.It is important to offer to adopt for all CS a CB building plan in basic skills over a period of minimum six months, before any kind of testing and selection, unequal the CBR, who is not offering a pre-training preliminary to testing. As described in the CB plan basic skills concern English, Computer and (Data base) Management. It is not limited to procurement department but a multi-agency Capacity Building plan[34]
to be rolled out in the provinces.

Following is a rough calculation, to be updated based on the ongoing workforce planning, when implemented:
•Provincial officers: number to be trained 328[35]
•Admin & management 50-71 / HC & promotion: 101 / P&P: 95 / HIS: 20 / Health financing: 7: total to be trained in basic skills = 290

The estimated cost (to be updated) would be:
•Basic skills 3 months 1 hour a day: 250 USD pp x 290 = 72.500 USD
•Provinces 3 months @ 250 USD pp x 328 = 82.000 USD

Next steps are:
2. A computerized examination (Toeffl,…)
3. Selection based on (attendance and) test results after 6 months.
4. Parallel activity, ongoing: Workforce planning based on the workforce planning
5. Parallel also the need of Simplification of procedures (=management tool to avoid corruption, and to facilitate transparency and monitoring)
6. Hire and employ (no hire & fire), with sabbatical leave for non-competent or not committed tashkeel, the CS keeping his minimal income.
7. Followed by salary scale as identified by salary strategy and policy, ongoing.
   2010, developing the Paris Donor Conference Human Resources Cluster Proposal with and for MoPH. Donor Conference had ignored it.

- *B. On-job Management training for the high end*

This would include a leadership CB plan (refer to CB plan 2004, to update) see Literature list.

[34] MoPH 2004. Capacity Building Plan of Ministry of Public Health, Short term and Long term, see Annex 4

[35] As this calculation dates from 2004**,** Provincial HR Officers to be included in the context of decentralization, as their roll is changing and will manage HR-MIS and workforce rolling plans as well as personnel management. Some provinces only have 1 officer who is a basic clerk.

- *C. Conclusion*

This plan requests a relatively low investment compared to the couple of billions spent on CB since 2001.

## 5.8 Expected results:

- Administrative Staff Commitment
- Contribution to retention strategy
- Removal of contra productive inert workforce
- Concentration of knowledge and skills transfer to receptive and committed staff
- Increased absorptive capacity
- Commitment and leadership towards administrative staff
-

### *5.8.1 Conditionality and Assumptions applicable to all plans and strategies:*

**MoPH commitment**
There is little or no trace of lobbying for implementation of proposed strategies and implementation plans. Situations show lack of senior management commitment, more ambition driven and not task driven. This given will jeopardize SEHAT components if no structural action is taken as proposed in above section of 'Operational analysis of MoPH' organizational structure'.

**Donor commitment**
Given that deliverable driven & time-bound approach is not conducive for the execution of developed strategies and implementation of plans. There are too little response measures of donors to implementing plans, even when developed under their own program support.

# 6 Conclusions and recommendations

## 6.1 Conclusions

Some of the important findings that resulted from reading and interviews in this report are that the huge amount of human and financial resources invested in Afghanistan by the international partners since 2001 has not led to a proportional capacity within the MoPH, nor to the expected results. Most blame the lack of absorptive capacity of MoPH. Nevertheless, this investment was lost for multiple and other reasons:

1. Policies and strategies have been developed overtime but without sufficient budgets linked to the implementation and no implementation plans, making those documents futile and obsolete.
2. Some departments such as the Policy and Planning, and Provincial Offices, and others received so much external support that absorption was impossible, what led to substitution.
3. Numerous capacity building plans and workforce planning were not finalized or not followed up.
4. Disparity of salary scales combined with training opportunities without any retention strategy led and still leads to high turnover and brain drain.
5. The finality of donors and programs is predominating the finality of the health sector reform and system strengthening
6. Although many programs request attitude change and cultural adaption, the timelines where not adapted to this needs but instead but were subject to the limited time given to programs and experts without transition or transit strategy from one program to another. Also timelines of different donors and programs would differ so as to result in lack of coordination and continuity of execution and implementation.
7. In order to book measurable and time bound advance in the programs those are pushed by systems with eclectic selection of people and departments, who are posted within the organizational structure but not supporting the MoPH organizational structure as a whole.
8. The review also emphasizes the weakness of SWAp. There are definitely mechanisms that contribute to SWAp, but as they are outside the structure, outside a central department (as part of the Aid Coordination) stewarding the SWAp.
9. Two key systems or areas have not received enough attention and were disregarded, or at least not rightly addressed. One is the workforce planning and subsequent capacity building, linked with effective retention schemes. The other is the quality improvement in all structures, at administrative level and at service level. Quality is mentioned in all documents but the systems to assure leverage of quality and to secure accountability are not put in place.
10. Finally, everybody agrees, while nobody taking the lead, that it is not conducive to motivate the workforce by using ministries as a social safety net for unemployment. The abundance of civil servants without defined (time filling) job description leads to de-motivation of the functional workforce, creates opportunities for corruption, and de-concentrates any investment in capacity building.

This does not mean that no capacity was built; the question is different, that little quality has been retained within the ministry. To conduct an effective technical coordination there are a number of conditions that should be fulfilled.

## 6.2 Recommendations

*The first recommendation*

is a condition sine qua non before writing and publishing this review is to use and implement developed policies, and strategies by linking those to implementation plans, guidelines, standard operational procedures and the whole being budgeted. Afghan culture is not a reading culture but a culture of jirga and concertation (sabhā). To produce key documents is one, to read and analyse and implement those is another issue.
For that reason, it would make sense that important documents policies, strategies, reviews as the AJHSR, mid 2015, be read in reading groups composed of the policy related members and a facilitator where they are discussed after a first reading by the members of the group.
If not, documents remain on shelves to be read only by consultants and donors. We refer here to the first paragraph of Section 11 of the AJHSR: "The last chapter will summarize the main conclusions, challenges and recommendations by building block. *To the untrained eye these recommendations may look excessively modest*; they represent what seems feasible in the next five years, and –if adopted—will prove a challenge for the MoPH and its partners." The italic part should ring a bell.
There are only two options: or the developed documents have no value and should not happen, or they make sense and for that deserve proper analysis and action.

*The second*

is to build up MoPH controlled SWAp department/directorate and the Aid coordination linked with it. MoPH should run Aid Coordination on own resources. It is proposed that until the Ministry can quietly subsume the donor SWAp system, donors could work along supporting SWAp. In that context the HSS needs to be redesigned and ought to be replaced by a sustainable approach of channelled funds through a donor and ministry SWAp department or directorate, both working side by side. A functional SWAp/ACU department is the only guarantee to assure continuity of projects, avoiding duplicating or abandoned projects, call for responsible budgeting.

The SEHAT contribution through the component of thematic areas could be very successful if channelled in a constructive contribution to the organizational structure of MoPH to support it functioning, and in that way should be conducive to deliver effective TA that is well absorbed and incorporated.

*The third*

is to apply a systematic and evidence based approach for workforce planning, based on real time use, human resource calculation, capacity building, with proper recruitment processes and retention of skilled Tashkeel staff.

There is also a need for Provincial HR Special committees to oversee and support the strengthening of HR Management systems in Provinces including planning.
Concerns over Private Training Institutions particularly regarding standards of their training and clinical practice.
In all cases there is a need for adequate operating budget. The review refers in that regard to never executed consultative and elaborated capacity building plans developed over the last 11 years.
And as HR are central in all hospital operating systems, priority work must be done on following the national workforce plan developed in 2009 which is currently being updated using the Dewdney system. This will allow continuous updating in a workbook and spreadsheets including staffing, training needs, and budget projections.

### *The fourth about Quality Improvement*

Some developing countries have successfully initiated Quality Assurance Programs and are constantly refining their approaches and methodology. Installing a Quality Assurance Program requires additional efforts. Private Training Institutions need to be accredited and follow standard national curricula and be regularly monitored. Quality assurance and Standard Operational Procedures (SOPs) are a warrant for quality improvement, to be present at all service related departments, including across SEHAT proposals and others. Clear SOPs permit review and revision of job descriptions that also include details of functional linkages throughout the MOPH.
Provider payment mechanism are directly linked to quality improvement and accreditation at all levels. As proposed by HPP study, it needs a legislation giving authority to purchase services from eligible healthcare providers. This would also contribute to move away from the present high out-of-pocket (OOP) payments[36].
Also trained medical professionals and specialisation have no career development if the diplomas are not accredited and will for that not be recognised abroad.

### *Fifth recommendation*

Further investment is needed in a project approach for vulnerable and displaced people until the concerned departments are enforced:
Continued support by is needed on prison health services and to the prison health department.
Also the *Disability and Rehabilitation* needs continued skilled staff training and support to reinforce its Department.
Follow up is needed on the *Mental Health Gap Action Program*, see more detailed in Annex 6.

[36] Despite the rapid expansion and implementation of the BPHS and EPHS, 73.3 percent of health financing in Afghanistan comes from individual households in the form of out-of-pocket (OOP) payments. This amounts to $41 per capita, according to the MOPH's 2011–2012 National Health Accounts (NHA)

# Annex 1 – Terms of Reference

8.372 Afghanistan - ToR of EU-TA Review

# Annex 2 – Technical coordination and assistance

*Recent evolution of Aid coordination:*
EU and the other DPS in Afghanistan have committed where possible to contribute to the preconditions to be met before a SWAp can become effective. The preconditions are (a) political stability; (b) economic stability (c) government commitment;
(d) enabling legal framework; (e) country-led donor coordination mechanism; and (f) institutional capacity for implementation of a SWAp .
In the three last issues d, e and f, EU TC is strongly investing with effective TA.

SEHAT provides a great opportunity for development partners in Afghanistan to prepare their future support in line with SWAp principles, and to move towards a more coordinated programmatic support to the health sector. The WB and EU pool the resources since 2013, USAID and other donors/DPs joined recently. Very much of SEHAT is about Develop an operational framework or health system strengthening that facilitates harmonising capacity building approaches and alignment to decentralisation whereby ensuring inclusion of community based approach.

## 1. USAID:

Comprehensive list of current projects:

- Afghanistan Demographic Health Survey
- Central Contraceptive Procurement (CCP)
- Challenge TB
- DCAR: Delegated Cooperation for Nutrition
- Disease Surveillance and Prevention
- Leadership, Management, Governance (LMG)
- Strengthening Pharmaceutical Systems (SPS)
- USAID|DELIVER Project
- Weekly Iron Folate Supplement Program (WIFS)

Completed Projects:

- Basic Support for Institutionalizing Child Survival-III (BASICS-III)
- Better Health for Afghan Mothers and Children Project
- Child Protection and Psychological Support for Afghan Children and Youth Program/Assistance for Afghanistan’ s Most Vulnerable Children
- Child Survival Support Grant: Better Health for Afghan Mothers and Children Project
- Communication for Behavior Change: Expanding Access to Private Sector Health Products and Services in Afghanistan (COMPRI-A)
- Comprehensive Disabled Afghans Program/National Program of Action on Disability
- Field Epidemiology and Laboratory Training Program (FELTP)
- Health Care Improvement (HCI) Project
- Health Policy Project (HPP)
- Health Services Delivery Grant - Performance-based Partnership Grants
- Health Research Challenge for Impact: Reproductive Age Mortality Survey (RAMOS) II
- Health Service Support Project (HSSP)

- Health Systems 20/20
- Higher Education Project: Kabul Medical University
- Measure DHS: Afghanistan Mortality Study
- Partnership Contracts for Health (PCH)
- Routine Immunization in Afghanistan
- Rural Expansion of Afghanistan's Community-based Healthcare (REACH)
- Strengthening Immunization in Afghanistan
- Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve)
- Tuberculosis Control Assistance Program (TB CAP)
- UNICEF Health and Immunization Response Support
- UNICEF Nutrition Program in Afghanistan
- UNICEF Salt Iodization in Afghanistan
- WHO Cross Border Malaria Program
- WHO TB

Following is a non comprehensive description of main support areas. The implementers are not mentioned because some projects are implemented by more partners, with or without “lead”. Successive technical support of USAID to service delivery went through different programs and implementers:

A. REACH is the Rural Expansion of Afghanistan's Community-Based Healthcare. to improve Afghan maternal and child health, focusing on the health of women of reproductive age and children under five years. This USAID-funded programme focuses on the delivery of basic health services to Afghans in rural and underserved provinces.
And besides it is strengthening the Provincial Ministry of Public Health.

B. The USAID Health Services Support Project (HSSP, 2006-2011 with 11m extension) is an associate award under ACCESS, Access to Clinical and Community Maternal, Neonatal, and Women’s Health Services, and focuses on improving the delivery of quality health care services in 364 health facilities across 13 provinces, provided to women of reproductive age, in Afghanistan.

C. A large nutrition program of 80M to be awarded is still under procurement. No information available.
Delegated Cooperation Agreement (DCAR), Nutrition, Save the Children and World Vision through DFATD, 2015-2016
Weekly Iron and Folate Supplementation (WIFS) for adolescent girls, UNICEF, 2014-2017
ORS and Zinc for children under five with diarrhoea, UNICEF, 2015-2020
Food Fortification, GAIN, 2015-2017
Integrated Hygiene, Sanitation and Nutrition (IHSAN), TBD, 2015-2020

D. The demographic health survey of 5M, by ICF macro, 2013-2018.

E. Off budget as well “Helping Mothers & Children Thrive” (HEMAYAT), improving access to MCH, 60M awarded in June 2015, 2015-2020. Works with the MoPH, the private sector and civil society to promote proven, cost-effective, life-saving health practices for vulnerable populations in the most rural and hard-to-reach communities in 21 provinces in Afghanistan. The project advances proven, evidence-based life-saving health practices such as the use of antibiotics,

cord care, drugs that prevent and treat postpartum hemorrhage, resuscitation, immediate and exclusive breastfeeding, and birth spacing.

F. Strengthening Pharmaceutical Systems (SPS) started in 2008 with 3 funding cycles: SPS-LWA, SPS-AA, and SPS-AA extension till 2017: $25.5 + 5.5 million for the following activities:

- Strengthen the Regulatory System;
- Supply Chain Management and Commodity Security:
- Service Delivery Capacity: collaborates with the MoPH Human Resources department to develop short-term strategic plans for pharmaceutical human resources.
- Enhance Pharmaceutical Services: Increases the capacity of GDPA, non-governmental organizations (NGOs), and health facilities to support pharmaceutical services. Supports drug and therapeutic committees to oversee the implementation of rational medicine use strategies.
- Pharmaceutical Management Information System (PMIS): for improved data management.

G. Communicable Diseases (Tuberculosis) with 3 funding cycles:

- TB-CAP 2008-10,
- TB Care 2010-2015 (initiated and funded to help Afghanistan address its high burden of tuberculosis, with an operational focus on 13 selected provinces), and
- Challenge TB 2015-2019: Scale up Urban and Community DOTS; Strengthen TB activities in the basic package of health services; Strengthen the capacity of the ANTP to monitor, coordinate, and oversee the implementation of TB activities throughout Afghanistan.

F. Leadership, Management & Governance (LMG), 2012-2015. The Project areas are:

1- Hospital Sector, Hospital Management
2- Community Based Health Care (CBHC)
Community Health Nursing Education (CHNE)
3- Health Information System (HIS) ) and Monitoring and Evaluation (M&E)
4- Subnational Governance (SNG) and Provincial Health Systems Strengthening (PHSS)[37].
5- Leadership & Management and Governance (L+M+G) across the health sector
6- Improvement Quality of Health Care (IQHC)
7- In-Service Training (IST)
8- Transition of MoPH to On-budget (SEHAT)
9- Child & Adolescent Health (CAH)
10- Grants & Contracts Management (GCMU)
12-Nursing & Midwifery (N&M)

TechServe (2006-2011, an associate award under the LMS award): 'Technical support to the central and provincial MoPH'

[37] http://www.msh.org/our-work/health-system/leadership-management-governance

The objective was to strengthen MoPH's health system stewardship and capacity to improve access to quality health services, BPHS and EPHS services, and improve the outcomes of key MoPH indicators in the 13 Afghan provinces where USAID provides health service support.

F. On budget SEHAT, USD 248 000 000, 2013- june 2018

G. Three national advisors to PLO (until mid 2015)

H. HSR: 37.9M for the Health Sector Resilience project, Oct 2015-2010.

I.BASICS-Afghanistan 2008-2011, Basic Support for Institutionalizing Child Survival Afghanistan:

> Revise and develop child survival and health-focused policies and strategies; Improve child health care at the community level, at the BPHS facility level, and at the EPHS hospital level;
> Strengthen cross-cutting health system components to improve child health care.

J. COMPRI-A (2006-2012): Communication for Behavior Change: Expanding Access to Private Sector Health Products and Services in Afghanistan: used social marketing to increase demand for, access to, and use of quality health products available through the private sector, included support to the National AIDS Control Program.

K. USAID deliver project: 2010-2020: DELIVER acts as the procurement mechanism for both the commodities ordered through CCP as well as the essential drugs used in the BPHS/EPHS facilities in the 13 USAID-funded provinces.

## 2. UNFPA

- In 2010, UNFPA launched its Third Country Programme (2010-2014).
- In the Fourth Country Program (2015-2019) UNFPA with the GoIRA build on the 3rd CP:

a. Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV that are gender-responsive and meet human rights standards for quality of care and equity in access.
b. Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health.
c. Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth.
d. Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality

This includes the:
- Community Midwifery Education programme.

- The Family Health Houses model reaching communities who don't have access to the Basic Package of Health Services of Afghanistan.

## 3. JICA

A. Urban Health System Strengthening Project (UHSSP)
B. Countrywide[38]:

- Project for Improvement of Maternal, Newborn and Child Health, 2013-2016
- The Project for Infectious Diseases Prevention for Children, 2014-2015
- Reproductive Health Project in Afghanistan Phase 2, 2010-2015
- Tuberculosis Control Project in Afghanistan Phase 2, 2010-2015
- Tuberculosis Countermeasure Project as Principle Recipient for the Global Fund, 2012-2014
- The Project for Supply of Anti-TB Medicines and Laboratory Consumables and the Development of Drug Management System, 2014-2017
- Tuberculosis Control Project in Afghanistan Phase 3, 2015-2018
- Project for Improvement of Medical Equipments for the Provincial Hospital of Balkh: 2011-2015
- The Project for Rehabilitation of the Provincial Hospital in Ghor Province: 2012-2014
- Assistance to WASH activities for Northern Afghanistan, 2014-2015
- Grant Assistance for Grassroots Human Security Projects, 2014-2015
- Grant Aid for Japanese NGO's Projects (14 projects), 2013-2015

## 4. EU:

- System Enhancement for Health Action in Transition (SEHAT) - Afghanistan Reconstruction Trust Fund (TF 50576), 2013-2017
- EU-Action in Transition (SEHAT) - Afghanistan Reconstruction Trust Fund (TF 50576), on budget, 2015-2018: the new EU decision support SEHAT for a total amount of EU budget contribution: EUR 43 000 000 (in joint co-financing by USAID for an amount of USD 227 600 000).

EU has continued to support **aid coordination**, this since 2003, and more recently through the Aid Coordination Unit.
By supporting its set-up, the EU has been an active member in the technical committees of MoPH in developing policies, strategies and in the extension of aid and stewardship of the MoPH by extending the GCMU and developing the MoPH SEHAT Governance & Social Accountability Proposal, the System Enhancement for Health Action in Transition, signed May 2013 between the Ministry of Finance and the World Bank.
SEHAT runs from July 2013 till June 2018.
Implementation of BPHS started in Jan 2014.

- GDPA project, 330.000 EUR, 18m till 2012, for CB of the General Directorate for Pharmaceutical Affairs, on policy and strategy and on provincial level.
- Strengthening medical knowledge and skills of health workers through the production of health professional magazines, 2015-20, to spread the latest

[38] http://reliefweb.int/report/afghanistan/jica

health information and developments among health staff across the country.

- Previous to the present TC support EU gave Support to the Provincial Liaison Office, PLO support, from 2011: to strengthen the stewardship role of the MoPH in relation to the contracting-out policy, and to support the integration and coordination of NGOs and implementing partners through the already established channels
- The technical Cooperation Program to Ministry of Public Health, 2012-2016: EPOS project to strengthen the capacity of the Ministry of Public Health to manage the provision of preventive and curative health services and the development of the Afghan public health system including financial and human resources as well as infrastructure and equipment
  The project is analysed in the above report, with the present EPOS team [39]:
  Health Service Delivery Advisor
  National Consultant to G.D of Curative Medication (MoPH)
  National Consultant to Provincial Liaison Directorate (MoPH)
  National Consultant to G.D PP (MoPH)
  PHS National Consultant
  National Consultant to Mental Health
  National Consultant to Health Promotion
  Administrative Coordinator; Aid Coordination & SWAp
  Technical Advisor to the Minister
  Clinical Specialization Consultant
  National Consultant Partnership Building
  Specialist in workforce database planning & analysis
  Public Relation Advisor
  IT for PL Directorate

International short-term experts:
Mental Health Consultant
Disability Consultant
Health Promotion Advisor
Accreditation and Medical Council Adviser
HR System strengthening Advisor
HR Advisor for WISN
Hospital Workforce Planning
Medical Council Consultant
Specialist UN CRPD Trainer Disability

- Training of Mental Health Professionals and National Trainers for Mental Health in Afghanistan to fill existing vacant BPHS/EPHS positions, Dec 2015, duration 15-20m, 60.000 EUR, consisting of:
  - Training of 120 Psychosocial Counsellors for 120 CHCs (3 months theoretical training and 9 months practical work)
  - Coordination of Mental Health activities at the provincial level
  - Support psychosocial counselling services in the Essential Package of Health Services

- EU emitted a new grant of 150.000 EUR in 2015 to upgrade and standardize the 'Orthopaedic Technician Training' to fill existing vacant

[39] The list of LT and ST experts is not comprehensive, as it it has been changing in the timeline of the project.

BPHS/EPHS positions; by upgrading the Orthopaedic Assistants curriculum and implementation of the new curriculum so that trainees can become full-fledged Orthopaedic Technicians. 12-14m

- In a previous grant of 280,000 EUR in 2013 the EU has supported the training of 20 Orthopaedic Assistants 'Strengthening Disability and Rehabilitation Health Services Through Increased Numbers Of Professionally Trained Rehabilitation Practitioners' is ongoing.
- Improve service delivery in nutrition, 2014, to reinforce SEHAT: (i) in-service nutrition training to SEHAT implementing NGOs in nine provinces (UNICEF and INGOs will deliver the same training to the other provinces); (ii) support for curricula development through technical cooperation to the Kabul Medical University and the Ghazanfar Institute for Health Science, to ensure nutrition becomes part of the available health curricula in Afghanistan (iii) creation of an Innovation Fund under SEHAT; (iv) support to the South Asia Food and Nutrition Security Initiative, which enables stakeholder platforms with the purpose to operationalise cross-sectoral food and nutrition-related policies and investments.
- Health research 12m from 2013 (final report not yet approved): (a) Complementary feeding practices for infant feeding in Afghanistan: timing, adequacy and nutritious value; (b) Mental health status of Afghan school students, (c) School screening program for refractive error, and (d) Factor associated with high incidence and frequent outbreak of measles among children in Afghanistan. This project is to support MOPH in data gathering and enhancing understanding of needs and adequateness of public health policies in the areas of (i) nutrition, (ii) eye care, (iii) mental care and (iv) immunisation.
- Planned Health Surveys and Studies: national mental health survey, assessment of the health referral system and costing of the Basic Package of Health Services (BPHS)
- The project 'Costing and referral system', 2015, is a support to HIS and HEFD: Project to increase availability of reliable data to inform the design and implementation of the national health system: Production of a comprehensive review of the health referral system at the different levels and present options for improvement; and Production of a comprehensive costing of the implementation of BPHS 2010.

## 5. DFATD (previous CIDA)

- System Enhancement for Health Action in Transition program (SEHAT), on budget, 2011-2014
- Support to the Afghanistan Reconstruction Trust Fund – Health (SEHAT) 2014-2017; Maximum DFATD Contribution: $33,750,000
- Polio Eradication Initiative, implementers WHO, UNICEF, 2013-2016
- Improving Nutrition for Mothers, Newborns and Children in Afghanistan, by SCF Canada, 2013-2015, to reduce malnutrition by addressing the basic nutritional needs of women and children Afghanistan
- Improving MNCH in Afghanistan, by Agha Khan F, 2012-2015
- Family Health Houses, UNFPA, 2013-2016: to develop the structures to ensure that women have access to family planning and reproductive health advice and services, including the so-called 'white areas' of the country, which are at least 10 km from the nearest health facility and include 43 percent of the population.

- Central Asia Health Systems Strengthening (Central Asia Health Systems Strengthening is multi country), Agha Khan Foundation, 2012-2017: To contribute to the body of knowledge for interventions to strengthen health systems and improve health status (production of publications in a variety of media); and To contribute to accessible, policy-relevant knowledge translation (through production of knowledge translation/mobilization products and materials aimed at policy makers, program implementers, donors, etc.). The thematic areas are eHealth, Community-based Health Financing, Community Engagement in Health Governance
- ICRC Annual Appeal, 2014-2015
- Preventing child morbidity and mortality through nutrition specific intervention within the BPHS and nutrition sensitive interventions at community level in Balkh province, ACF Balkh, 2014-2015
- Emergency Health & Protection for Herat Displaced Persons, WV, 2014-2015

## 6. WHO:

- Support to HSS, with GAVI and GF to the 3 diseases, EPI, MCNH (IMCI and nurse education program), system building/thinking Health Policy and Planning, Integrated people-centered health services, Access to medicines and health technologies and strengthening regulatory capacity and Health systems information and evidence, MoPH, 2014-2015.
- Control of communicable diseases, Polio, EPI, TB, Malaria, HIV/AIDS and NTD, implementing, MoPH, UNICEF, BPHS and EPHS , 2014-2015
- Control of NCDs, Mental Health, Violence and injury Prevention and Nutrition, MoPH, BPHS and EPHS, 2014-2015
- Promoting health, Reproductive, maternal, newborn, child and adolescent health, Gender and Environmental Health, MoPH, UNICEF, UNFPA, BPHS and EPHS implementers, 2014-2015
- Preparedness, surveillance and response, Alert and response capacities, Epidemic- and pandemic-prone diseases, Emergency risk and crisis management and Food safety, MoPH, BPHS and EPHS implementers Other UN agencies, 2014-2015

## 7. UNICEF

Besides classical programs also the contract for procurement of pharmaceuticals in the SM provinces is done through direct contracting with UNICEF

From Global - Health (SC149901), Thematic MTSP 2014-2017 Outcome 1: Health, 2013-2015
Japan (SC130105), MNCH- Maternal, Newborn and Child health, Referral system, capacity building and communication, MoPH & NGOs, 2013-2016
And EPI: Routine, 2015-2016
German Committee for UNICEF (SC130142), MNCH, Afghanistan, 2013-2015
And MNCH -Demonstration project, MoPH & NGOs, 2014-2014
Republic of Korea (SC130739), MNCH Outreach services, 2013-2016
MNCH Trust Fund SC130722, training and newborn care, MoPH & NGOs, 2015-2017
The GAVI Fund (SC150248), Measles communication, 2015
GAVI (through ROSA)(SC150017), improving cold chain system, 2015-2016
BMGF(SC140612),EPI, incentives, communication, microplanning. MoPH, 2014-2016

Consolidated Funds from Nat Coms (SC120927), EPI MNT, MoPH, 2012-2015
Rotary/GAVI/Japan/ BMGF/Estonia, Polio eradication, Canada, MoPH, 2014-2017
Common Humanitarian Fund, TBC, MoPH, BPHS and NGOs, 2014-2015
USAID (SM140147), Food For Peace (Scale up of the Management of SAM), TBC, MoPH, BPHS and NGOs, 2014-2015, AND, USAID (KM140002), 2014-2015, AND USAID (KM140009), 2014-2016,
USAID (SC140953), Address Iron Deficiency Anemia in Adolescent Girls using Weekly Iron Folic Acid Supplementation (WIFS) in Afghanistan, MoPh and MoE, 2014-2017
Japan, Integrated Nutrition response for saving lives of children during emergencies in Afghanistan, TBC, 2015
USAID OFDA (SM140358), Humanitarian Action for Children, TBC, 2014-2015
CHF (SM150283), Strengthening and expansion of integrated management of SAM in children <5 in vulnerable communities in targeted provinces of Afghanistan, 2015-2016
USAID (SC140054), Elimination of IDD, TBC, MoPH, MI, GAIN and Private sector, 2014-2015
Korea (SC140960), Accelerating the delivery of community and facility based services for enhancing nutrition and health of women and children in Afghanistan, TBC, MoPH, BPHS IPs, 2014-2017
DFATD (SC140136), Support National Nutrition Surveillance System in Afghanistan, TBC, MoPH, BPHS IPs, 2013-2016.

### 8. AFD:

Phase II of the project to support the French Medical Institute for Children (FMIC), by FMIC & Aga Khan Foundation, 2009-2016
Project to support maternal health in Badakhshan province, in partnership with the Aga Khan Foundation, 2010-2015.

### 9. Italian cooperation:

Support to National Health Program in the Province of Kabul and Heart, through the Strengthening Mechanisms, on budget, 2015.

### 10. World Bank:

In May 2013 a $100 million grant was signed between the Ministry of Finance and the World Bank, to finance the Afghanistan System Enhancement for Health Action in Transition (SEHAT) Program.
EU and USAID channel funds through the World Bank (WB) to the SEHAT programme, with the WB as administrator of the Afghanistan Reconstruction Trust Fund (ARTF),.

> The development objectives of SEHAT are to expand the scope, quality and coverage of health services provided to the population, particularly to the poor, in the project areas, and to enhance the stewardship functions of the ministry of public health (MOPH). Financing is needed for implementation of the basic package of health services (BPHS) and essential package of hospital services (EPHS) through contracting out and contracting in arrangements
>
> Policy Advisor the Minister (under SEHAT)
> Advisor to GCMU

National advisor to PLO (until end 2015)
200 national consultants in the field
SEHAT proposals under further elaboration with MSH support concern following thematic areas: cfr SEHAT

### *11.* Donor coordination under SEHAT:

With the SEHAT the MoPH and donor group aim for a successful management of the programme (comp 3), combined with key reforms capacity building (comp 2) and effective delivery of services (comp 1), is expected to expand the scope, quality and coverage of health services provided to the population, particularly the most vulnerable people, and to enhance the stewardship functions of the Ministry of Public Health.

Component 1: *Assisting the Ministry of Public Health in the procurement, management and monitoring of contracts with health service providers. This will, in turn, allow undisrupted service provision across the country.*

Component 2: *Supporting reform and capacity building interventions in key health system areas (e.g. strengthening sub-national government, ensuring quality pharmaceuticals, improving hospital performance, improving fiduciary systems, etc.), with the objective of increasing the long term ability of the Ministry to manage a functioning health sector.*

Component 3: *Strengthening the Ministry's institutional capacity (human and financial resources) and particularly SEHAT management.*

USAID contribution to SEHAT is USD 227 600 000, EU contribution 110M, and Canada's contribution 33M.
Under SEHAT the Result Based Financing (RBF) scheme, piloted under the current SHARP project, will be mainstreamed. This will involve the completion of ongoing pilot in 14 provinces as well as an in-depth impact evaluation to inform future direction and mainstreaming of the RBF in Afghanistan under SEHAT. This will help to further refine the performance-based contracts with NGOs. The RBF scheme has been under implementation for the past 24 months. Preliminary results show increasing coverage of key maternal and child health services, higher equity of service utilization and quality of services. The scheme will be embedded in the arrangements for BPHS and EPHS implementation.

# Annex 3 – List of people met

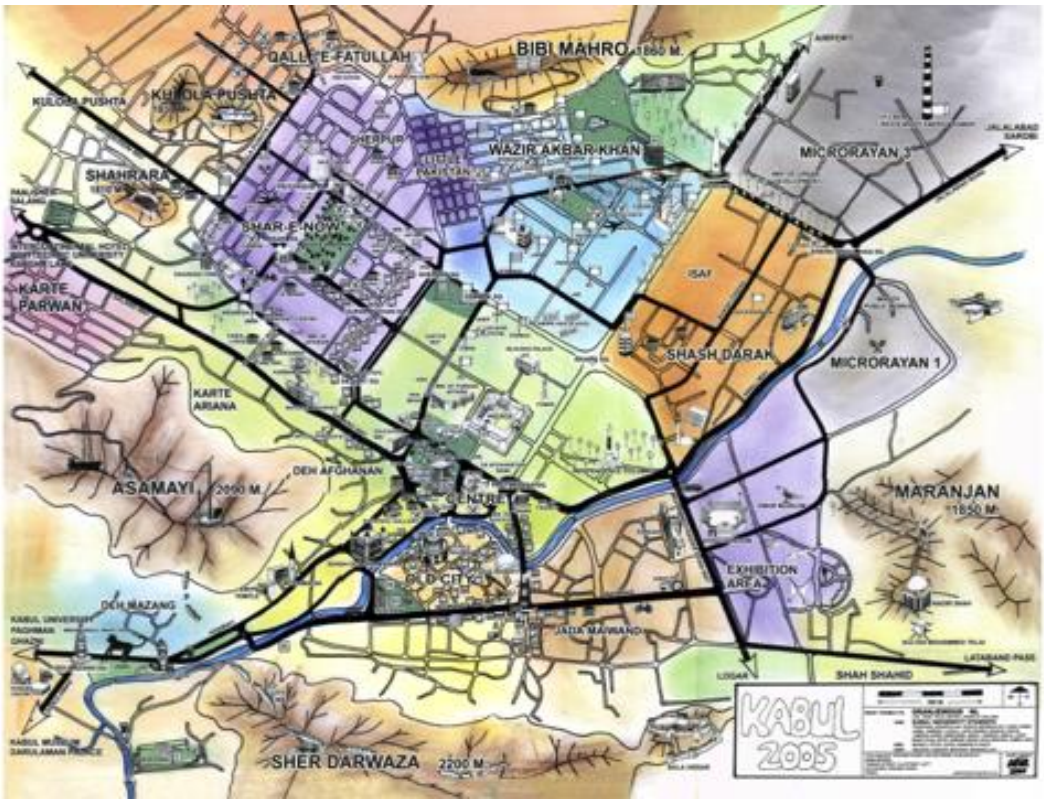
## LIST OF PEOPLE MET

| *No.* | *NAME* | *POSITION* |
|---|---|---|
| ***MINISTRY OF PUBLIC HEALTH*** | | |
| 1 | [redacted] | Minister of Health |
| 2 | | Acting Deputy Minister of Policy & Planning |
| 3 | | Head of Financial Risk Pooling unit , HEFD |
| 4 | | Head of Prison Health Department |
| 5 | | Director of International Relations |
| 6 | | Sr. Adviser, SEHAT & Acting Director, Health Economics and Financing Directorate, HEFD |
| 7 | | Director of Goods Procurement & Construction Prev. Director of P&P |
| 8 | | Advisor to the Minister |
| 9 | | Director GCMU |
| 10 | | Grant Manager |
| 11 | | Head of Financial Risk Pooling Unit |
| 12 | | General Dir P&P |
| 13 | | Chief of Staff |
| 14 | | HSS Program Coordinator & Focal Point |
| 15 | | Director of Ghazanfar Institute Health Sciences |
| 16 | | Afgh Public Health Institute |
| 17 | | GD Human resources |
| 18 | | Dir HR |
| 19 | | Dir Health Promotion |
| **MINISTRIES AND OTHER AGENCIES** | | |
| 1 | [redacted] | Medical Director ICRC |
| 2 | | Health & Detention Medical Field officer ICRC |
| 3 | | Results Based Financing Consultant Health Economics & Financing Directorate |
| 4 | | advisor GCMU, World Bank |
| 5 | | Country Director Jhpiego |
| 6 | | Palladium, HSR program director HSR |
| 7 | | Palladium, MCH HSR advisor |
| **DELEGATION OF THE EUROPEAN UNION** | | |
| 1 | [redacted] | Head of Section - Health and LRRD |
| 2 | | Program Manager-Health |
| 3 | | Program Manager/ Health & AUP |
| 4 | | Head of Cooperation |
| 5 | | Head of operations |
| **TECHNICAL ASSISTANCE (EPOS)** | | |
| 1 | [redacted] | Team Leader |
| 2 | | Management Support Expert |
| 3 | | Health Services Delivery Expert |
| 4 | | Office & Logistic Manager EU/EPOS |

| | | |
|---|---|---|
| 5 | [redacted] | Finance Officer EU/EPOS |
| 6 | | Prison Health Expert, EU/EPOS |
| 7 | | National Advisor GD P&P |
| 8 | | Mental Health STE, Professor of Psychiatry |
| 9 | | Prison Health Expert, EU/EPOS |
| 10 | | H Resource Calculating (STE) KFW consultant |
| 11 | | National Consultant to Curative Medicine |
| 12 | | Medical Council & MW EPOS/STE |
| 13 | | National Consultant to Provincial Liaison Office |
| 15 | | HR Specialist Workforce planning & analysis |
| 16 | | Finance Project Officer EPS project |
| 17 | | Hospital management HR Expert |
| 18 | | National consultant Clinical Specialization |
| 19 | | HR system strengthening advisor, mailing list |
| 20 | | HR Accreditation and medical council, mailing |
| **DELELOPMENT PARTNER** | | |
| 1 | [redacted] | WHO at WB mission meeting |
| 2 | | Chief Health Section UNICEF |
| 3 | | Senior Health Specialist, World Bank Afgh. |
| 4 | | SEHAT implementation support Mission - WB-Washt DC |
| 5 | | Consultant World Bank Afghanistan |
| 6 | | Sr Health Specialist World Bank |
| 7 | | SASHD, Dhaka office, World Bank |
| 8 | | Director SPS (skype), MSH |
| 9 | | Project Manager Dty Director SPS, MSH |
| 10 | | Representative- UNFPA – Afghanistan |
| 11 | | M & E consultant, UNFPA |
| 12 | | Dty representative UNFPA |
| 13 | | Director, Office of Health and Nutrition, USAID |
| 14 | | PM specialist Health OSSD USAID |
| 15 | | H&N, Health system Resilience USAID |
| 16 | | Nutrition USAID |
| 17 | | First Secretary (Development), Gvt of Canada |
| 18 | | Sr Development officer Health CanadEmbassy |
| **Development Organizations** | | |
| 1 | [redacted] | Head of the NOG Silk Route TO, partner of KIT 3th party |
| 2 | | Director of Jhpiego |

# Annex 4 - Map

## MAP of KABUL 2005



# Annex 5 - List of consulted and referred literature


- EU-EPOS, Afghan EU TC Project Progress Report 2 – 7
- EU-Afghanistan Multiannual Indicative Programme 2014-2020.

- Forzley, M. 2013. Capacity Assessment of the Afghan Ministry of Public Health to Implement a New Private Health Sector Regulation: A Legal Analysis and Design for Strengthening Regulatory Effectiveness. Futures Group, Health Policy Project.
- JHBSPH (Johns Hopkins Bloomberg School of Public Health) and IIHMR (Indian Institute of Health Management Research) 2013. The Balanced Scorecard Report for Afghanistan Hospitals 2012/2013
- Lindsay-Smith & Roos J, EU-AEDES, 2009, Evaluation of the effectiveness and impact of technical cooperation to the capacity building process of the Ministry of Public Health Afghanistan, 31 August 2009
- Michael M 2012. An evaluation of the Prison Health Services policy reform: Dr. M. Michael, EPOS / EU
- Michael M 2015. Prison Health Services Reform in Afghanistan. Seven years on: nice try? EPOS/EU
- Mòdol X. 2015. MoPH-European Union, Afghanistan Joint Health Sector Review and Strategic Plan Implementation Assessment
- MoPH 2004. Capacity Building Plan of Ministry of Public Health, Short term and Long term
- MoPH 2006, Support to Institutional Development of the Ministry of Public Health of Afghanistan (SIDP), EU MoPH
- MoPH 2009, CBPSC Report: Needs assessment and Capacity Building plan for the Ministry of Public Health, 9 February 2009
- MoPH 2009, Hospital Capacity Building Needs Assessment August 2009-08-13
- MoPH 2009, National Health Workforce Plan, 1 December 2009
- MoPH 2011. Strategic Plan for the Ministry of Public Health (2011-2015), Government of the Islamic Republic of Afghanistan
- MoPH 2012. Framework of PPHO Core Functions, Tasks, Standards and Self-assessment
- MoPH 2012. Health Financing Policy 2012-2020

- MoPH 2012. National Health and Nutrition Policy 2012-2020
- MoPH 2013. Capacity Building for Results Program. Zero Draft of the Proposal
- MoPH 2013. Essential Package of Hospital Services for Afghanistan. Revised EPHS
- MoPH 2013. Partnership Protocol for Health Sector Development in Afghanistan between Ministry of Public Health (MoPH) and Health Sector Donors and Development Partners
- MoPH 2015, New national health policy draft 24 October 2015
- MoPH 2015. PHS Package_V2 2015: Second Version of the Prison Health Services Package (PHSP) 2015/1394: 2015 – 2020
- MOPH USAID, 2013; Regulatory Capacity Assessment: Capacity Assessment of the MoPH to Implement a New Private Health Sector Regulation: A Legal Analysis and Design for Strengthening Regulatory Effectiveness; Jan 2013, M. Forzley for HPP.
- MoPH- EPOS: TAMT Technical Assistance Management Tool
- MoPH-EU/EPOS TA, 2014, Aid Coordination and SWAp manual, February 2014
- MoPH-GDPA, GDHR 2012. Strengthening Human Resources for Health in Afghanistan. Assessment and Strategic Framework Development.
- MoPH-KIT/SRTRO 2015, Afghanistan HMIS and Functionality Verification Report, June 2015
- MoPH, JHBSPH and IIHMR 2013. Afghanistan. Basic Package of Health Services. Balanced Scorecard National Report 2012-2013
- MoPH, Johns Hopkins Bloomberg School of Public Health and Indian Institute of Health Management Research 2013. Afghanistan Health Survey 2012. Final Report
- MoPH, UNICEF 2014. National Nutrition Survey Afghanistan 2013.
- Omidian P. & Miller K. 2015, Addressing the psychosocial needs of the women in Afghanistan, summer 2006
- Roos J, Sales L and Kroes G 2012. Technical Cooperation Mapping and Institutional Reorganisation. AEDES/EU
- USAID, Health Policy Project. 2015. A Health Insurance Feasibility Study in Afghanistan: Learning from Other Countries, a Legal Assessment, and a

Stakeholder Analysis. Washington, DC: Futures Group, Health Policy Project (HPP).

- WB, 2007, Serge Michailof, Review of Technical Assistance and Capacity Building in Afghanistan, World Bank - April 26, 2007
- WB, 2014, ARTF Supervisory Agent Review, Final report, March_2014
- WB, 2015, Final Draft AM SEHAT Mission Nov11
- WHO 2013, mhgap-intervention-guide

# Annex 6 – Analysis of continuation of essential project activities

**ANALYSIS OF CONTINUATION OF ESSENTIAL EPOS PROJECT ACTIVITIES AFTER MARCH 2016 TO ENSURE SUSTAINABILITY.**

**Sustainability:**

1. **Organisational capacity of institutions including competent staff to manage implementation, including roll-out of pilots.**
2. **on-going commitment of MoPH responsible areas (political commitment and community support), and**
3. **adequate financial allocation**

| Component | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | Existing responsible national consultants | HSR plans (5 years) | SEHAT plans (2.5 years) | Other donor support | EU TA or MoPH budget support required |
|---|---|---|---|---|---|---|---|
| 1. Support to Aid Coordination and Sector-Wide Approach | Organization of MoPH's high level Coordination meetings/events/workshops | A unit is needed to arrange all relevant events and communicate with stakeholders. | [redacted] | | Head of the unit is part of SEHAT, but restructuring of GDPP is an issue. | UN agencies | MoPH budget |
| 2. SEHAT Procurement and M&E | Procurement Capacity-Building of the GCMU staff through the participation of a substantial number of GCMU staff as Evaluators with the Technical Evaluation Panels | Allocation of government budget and Donors coordination to plan for beyond 2018. | Nil | Complement health system strengthening | It is the main responsibility area | USAID, WB and UN | M&E budget |
| 3. Human Resources Management | • Train in WISN – BPHS workload planning<br>• Hospitals workload planning<br>• HRMIS upgrade and private sector workforce data collection.<br>• Train in Provincial and | • 5 year roll-out of WISN training and implementation.<br>• 5 year roll-out of hospital workload planning.<br>• Sustain longterm HRMIS upgrade and | • [redacted] (HRMIS & workforce Planning)<br>• Dr [redacted] (Accreditation, | • Continue WISN work of EPOS<br>• Strengthen private sector collaboration.<br>• Strengthen MoPH HR | • WISN and Dewdney rollout to all provinces and continue Observato | | • Need TA support for hospital workload planning – 5 year roll-out.<br>• Need Adequate |

| Component | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | Existing responsible national consultants | HSR plans (5 years) | SEHAT plans (2.5 years) | Other donor support | EU TA or MoPH budget support required |
|---|---|---|---|---|---|---|---|
| | National workforce planning (Dewdney), and develop interim plans – including updating Observatory and retention strategy.<br>• GDHR Standard Operating Practices<br>• Standardise and computerise resident examination system<br>• Development of curricula and trainer accreditation systems.<br>• Support implementation of Interim Medical Council and planning for Midwifery/Nursing Council.<br>• Training in hospital management – one pilot | extension and link with SQL and HMIS, and MoHE and private workforce and training systems.<br>• Roll- out Dewdney to all Provinces and update provincial & national plans annually.<br>• Implement and monitor SOPs -ongoing.<br>• Implement and monitor resident exam system long term.<br>• Finalise accreditation systems for all curricula and trainers and monitor/manage long term.<br>• Funding for Interim Medical Council for 5 years.<br>• Facilitation of Midwifery/Nursing Council.<br>• Training in hospital management – roll out to all hospitals. | Resident Exam system)<br>• Dr [redacted] (Professional Councils)<br>• Dr [redacted] (hospitals) | systems | ry and HRMIS improvements, and implement Retention strategy.<br>• Curricula upgrades implemented.<br>• Support professional councils development. | | funding for independent Interim Medical Council. |
| 4. Provincial Capacity and Coordination | • Decentralisation Strategy & Implementation plan with initial transfer of skills and knowledge.<br>• Program budgeting, HR, | • Transfer of skills and knowledge followed by implementation of strategy when agreed – 5 yrs total. | • Dr [redacted] (PLA)<br>• Dr [redacted] (Planning ) | • Continue work of EPOS re decentralisation and capacity building | Improve provincial governance in all key areas including | | • Need new TA support for hospital provincial capacity |

| Component | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | Existing responsible national consultants | HSR plans (5 years) | SEHAT plans (2.5 years) | Other donor support | EU TA or MoPH budget support required |
|---|---|---|---|---|---|---|---|
| | financing, procurement training/mentoring/coaching<br>• Capacity Building in provincial hospitals<br>• Implementation of procedures for hospital management system based on training provided. | • 5 years hospital capacity building - as part of overall hospitals capacity building | • NC for program budgeting.<br>• Dr [redacted] (hospitals) | relating to management. | program budgeting, finance, procurement, HR, drugs, etc. | | building – 5 year roll-out. |
| 5. Health Promotion | • 3 Health Promoting Hospital pilots.<br>• One Healthy District pilot | • Roll-out to all hospitals and districts and embedding in hospital and municipality responsibilities | • Dr [redacted] | | Institutional development of HPD and design, implementation and M&E of campaigns. | | • Health Promoting Hospitals roll-out.<br>• Healthy municipalities rollout.<br>• |
| 6. Disability and Rehabilitation | 7. Implementation of the Disability and Physical Rehabilitation Sector Strategy (2016-2020)<br>8. Disability and Rehabilitation Hospital based on the assessment and implementation plan<br>9. Implementation of the newly developed physiotherapy | 5 years, Technical support (hiring a national disability consultant) | Nil | | | IRCS Swedish Committee | • Adequate budget is required for 5 years Technical assistance |

| Component | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | Existing responsible national consultants | HSR plans (5 years) | SEHAT plans (2.5 years) | Other donor support | EU TA or MoPH budget support required |
|---|---|---|---|---|---|---|---|
| | curriculum<br>10. Implementation of the disability certificate through conducting training for the key members of the disability certification committee i.e. provincial and national.<br>11. Training of the health staff on the disability to build up their capacity on disability and physical rehabilitation.<br>12. Physical rehabilitation of children with cerebral palsy and spinal cord injuries patient.<br>13. CB of DRD staff to improve the reporting, data collection, coordination and communication, networking with regional and international | | | | | | |

| Component | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | Existing responsible national consultants | HSR plans (5 years) | SEHAT plans (2.5 years) | Other donor support | EU TA or MoPH budget support required |
|---|---|---|---|---|---|---|---|
| | professional organizations on disability and rehabilitation.<br>14. Supervision visits of physical rehabilitation services | | | | | | |
| 15. Mental Health | • Roll out of updated national mental health strategy 2016-2020<br>• Implementation of Suicide Prevention Strategy<br>• Implement mental health legislation & code of conduct.<br>• Rolling out MhGAp in remaining provinces<br>• Monitoring mental health services with HIS Dept MoPH.<br>• Rolling out Quality Rights Assessment to remaining regional and provincial hospitals. | | Dr [redacted] National Consultant | | Support for Mental Health Hospital 2 years | • EU Psycho social and disability training project 3 y<br>• Small activities by NGOs. | Adequate budget for technical assistance. |

| Component | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | Existing responsible national consultants | HSR plans (5 years) | SEHAT plans (2.5 years) | Other donor support | EU TA or MoPH budget support required |
|---|---|---|---|---|---|---|---|
| | • Training of psychosocial counsellors | | | | | | |
| 16. Prison Health | • Implement PHS strategy and package all over the country.<br>• Activation of health facilities in SM provinces.<br>• Follow up and TA to 50 bed prison hospital.<br>• Prison health services of Kabul, Herat, and Kandahar prisons (not part of SEHAT)<br>• Inclusion of PHS into M&E of MoPH.<br>• Implementation of code of conduct for release on humanitarian ground.<br>• Expansion of HMIS system in all prison health.<br>• Capacity building of prison health department.<br>• And of prison health providers.<br>• Medical screening system | 5 years to provide support to implementation now that MoPH is responsible until 2020. | Dr. [redacted] Prison Health Coordinator | | Prison health package is included in BPHS. | IRC runs some health packages in some prisons | Adequate budget is required for technical assistance |

| Component | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | Existing responsible national consultants | HSR plans (5 years) | SEHAT plans (2.5 years) | Other donor support | EU TA or MoPH budget support required |
|---|---|---|---|---|---|---|---|
| | in prisons.<br>• Refine referral system for sick prisoners to higher health facilities.<br>• Data base for prison health will help the prison department to essential information on prison health facilities. | | | | | | |

# Annex 7 : PPT presentation Briefing

# Annex 8 : Ongoing and planned TA projects of main the partners to the MoPH

| Component | Ongoing support | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | SEHAT plans (2.5 years) | Donor support | budget support required |
|---|---|---|---|---|---|---|
| 1. Support to Policy and Planning | • Support to P&PD by USAID<br>• EU support to ACU and International Relation s Department<br>• USAID-funded Systems for Improved Access to Pharmaceuticals and Services | Support to Aid Coordination and Sector-Wide Approach SEHAT should be part of ACU under SWAp, | A unit (be under Minister's office?) is needed to arrange all relevant events and communicate with stakeholders | • Head of the unit is part of SEHAT support under Governance & Social Accountabilit y, but re-structuring of GDPP is needed<br>• Pharma Management | • UN agencies and EU on request for TA. Organize MoPH's high level Coordination meetings/events /workshops<br>• All donors and EU support to central Aid Coordination | • MoPH budget<br>• Improved alignment of donor support<br>• Continuation of support to pharmaceutic al management, public sector pooled procurement<br>• and information systems |
| 2. SEHAT Procurement | USAID/WB/EU support to HEFD<br>EU punctual support to procurement and GCMU | First condition is PD staff reform, Evaluators with the Technical Evaluation Panels, Procurement Capacity-Building of the GCMU staff with and by GCMU staff | Allocation of government budget and Donors coordination to plan for beyond 2018. Government hospital reform is another condition for efficiency of hospital resources | SEHAT support in management, procedures, integrity | USAID, WB, EU and UN, all donors aligned<br>Health System strengthening support by DFATD | Remains to identify budget for CS reform within PD before all other steps are taken |
| 3. HIS and M&E | • UN and USAID disease surveillance<br>• EU support to HRMIS database | • | • Complement health system strengthening, | • | EU support costing and referral system (with HFED) | • M&E budget |
| 4. Reproductive | • UN family & HSS | • Improved horizontal | • | • | • USAID support | • USAID'S 201 |

| Component | Ongoing support | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | SEHAT plans (2.5 years) | Donor support | budget support required |
|---|---|---|---|---|---|---|
| health, nutrition and vaccination | • USAID Hemayat<br>• USAID and JICA support to TB care<br>• Canada DFATD polio eradication<br>• DFATD nutrition programme with WHO and UNICEF, Family Health Houses with UNFPA | integration of HSS in the directorates and departments | | | in MCH, WASH, FFP<br>• USAID Helping Mothers & Children Thrive<br>• EU support to Ghanzanfar (nutrition) and research on complementary feeding | 4-2025 Multi-Sectoral Nutrition Strategy<br>• |
| 5. Human Resources Management | • EU: SOPS, mentoring, coaching of provincial HR officers, annual WF planning<br>• EU support to HRMIS database, observatory include private sector data<br>• USAID support hospital sector<br>• USAID and UNICEF CHNE | • Workload planning<br>• Hospitals workload planning<br>• HRMIS upgrade and private sector workforce data collection.<br>• Train in Provincial and National workforce and build retention strategy.<br>• GDHR Standard Operating Practices<br>• Standardise and computerise resident examination system | • Develop accountability by Performance Based Financing<br>• Continue WISN work<br>• hospital workload planning, 5y.<br>• Link HRMIS with SQL and HMIS, and MoHE and private workforce and training systems.<br>• Roll- out Dewdney to all Provinces and update provincial & national plans annually. | • WISN and Dewdney rollout to all provinces and continue Observatory and HRMIS improvements, and implement Retention strategy.<br>• Curricula upgrades | • All donors to support Human resources fast-track efficiency plan.<br>• Support peer-to-peer learning through partnership<br>• Strengthen private sector collaboration.<br>• Incorporate HSS | • Need TA support for hospital workload planning – 5 year roll-out.<br>• Need Adequate funding for independent Interim Medical Council.<br>• Specialist |

| Component | Ongoing support | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | SEHAT plans (2.5 years) | Donor support | budget support required |
|---|---|---|---|---|---|---|
| | | • Development of curricula and trainer accreditation systems.<br>• Interim Medical Council and planning for Midwifery/Nursing Council.<br>• Training in hospital management – 1 pilot | • Further monitor SOPs<br>• Monitor resident exam system long term.<br>• Finalise accreditation systems for all curricula and trainers and monitor/manage long term.<br>• Funding for Interim Medical Council for 5 years.<br>• Facilitation of Midwifery/Nursing Council.<br>• Training in hospital management – roll out to all hospitals. | implemented.<br>• Support professional councils development. | • USAID and EU and SEHAT support PHO and PLD through HRH and SNG proposals<br>• Train staff on handling diagnostic equipment | training 5y budget required |
| 6. Quality assurance | • EU and USAID support identifying standards of care, assessing progress, guiding improvement in achieving standards<br>• UNICEF, JICA for | • Centre on client grievance handling<br>• Further support on standards of care and SOP<br>• QI across all departments and across all SEHAT proposals | • | | • Broader impact on QI by HSS<br>• Improve patient care at the front-lines of service delivery | • Budget support for QI unit (directorate) |

| Component | Ongoing support | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | SEHAT plans (2.5 years) | Donor support | budget support required |
|---|---|---|---|---|---|---|
| | Reproductive Health | | | | | |
| 7. Provincial Capacity and Coordination | • EU and USAID decentralisation and capacity building relating to management | • Decentralisation Strategy & Implementation plan with initial transfer of skills and knowledge.<br>• Program budgeting, HR, financing, procurement training/mentoring/coaching<br>• Capacity Building in provincial hospitals<br>• Implementation of procedures for hospital management system based on training provided. | • Transfer of skills and knowledge followed by implementation of strategy when agreed – 5 yrs total.<br>• 5 years hospital capacity building - as part of overall hospitals capacity building | • Improve provincial governance in all key areas including program budgeting, finance, procurement, HR, drugs.<br>• See also under HRM | | • Need new TA support for hospital provincial capacity building – 5 year roll-out. |
| 8. Health Promotion | • EU support HP Department, Health promotion boards, Healthy City project | • 3 Health Promoting Hospital pilots.<br>• One Healthy District pilot | • Roll-out to all hospitals and districts and embedding in hospital and municipality responsibilities | Institutional development of HPD and design, implementation and M&E of campaigns. | | • Health Promoting Hospitals roll-out.<br>• Healthy municipalities rollout. |
| 9. Disability and | • | • Implementation of the | 5 years, Technical support (hiring a national disability | | EU budget for Orthopaedic | • Adequate |

| Component | Ongoing support | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | SEHAT plans (2.5 years) | Donor support | budget support required |
|---|---|---|---|---|---|---|
| Rehabilitation | | Disability and Physical Rehabilitation Sector Strategy (2016-2020)<br>• Disability and Rehabilitation Hospital based on the assessment and implementation plan<br>• Implementation of the newly developed physiotherapy curriculum<br>• Implementation of the disability certificate through conducting training for the key members of the disability certification committee i.e. provincial and national.<br>• Training of the health staff on the disability to build up their capacity on disability and physical rehabilitation.<br>• Physical rehabilitation of children with cerebral palsy and spinal cord injuries patient.<br>• CB of DRD staff to improve the reporting, data collection, coordination and | consultant) | | Technician Training | budget is required for 5 years<br>• Technical assistance |

| Component | Ongoing support | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | SEHAT plans (2.5 years) | Donor support | budget support required |
|---|---|---|---|---|---|---|
| | | communication, networking with regional and international professional organizations on disability and rehabilitation.<br>• Supervision visits of physical rehabilitation services | | | | |
| 10. Mental Health | • | • Roll out of updated national mental health strategy 2016-2020<br>• Implementation of Suicide Prevention Strategy<br>• Implement mental health legislation & code of conduct.<br>• Rolling out MhGAp in remaining provinces<br>• Monitoring mental health services with HIS Dept MoPH.<br>• Rolling out Quality Rights Assessment to remaining regional and provincial hospitals.<br>• Training of psychosocial counsellors | | Support for Mental Health Hospital 2 years | • EU Psycho social and disability training project 3 y<br>• Small activities by NGOs.<br>• EU support mental health research | • Adequate budget for technical assistance.<br>• Rolling out of Quality Rights Assessment |
| 11. Prison Health | • | • Implement PHS strategy and package all over the country. | 5 years to provide support to implementation now that | Prison health package is | • IRC runs some health packages | Adequate budget is required for |

| Component | Ongoing support | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | SEHAT plans (2.5 years) | Donor support | budget support required |
|---|---|---|---|---|---|---|
| | | • Activation of health facilities in SM provinces.<br>• Follow up and TA to 50 bed prison hospital.<br>• Prison health services of Kabul, Herat, and Kandahar prisons (not part of SEHAT)<br>• Inclusion of PHS into M&E of MoPH.<br>• Implementation of code of conduct for release on humanitarian ground.<br>• Expansion of HMIS system in all prison health.<br>• Capacity building of prison health department.<br>• And of prison health providers.<br>• Medical screening system in prisons.<br>• Refine referral system for sick prisoners to higher health facilities.<br>• Data base for prison health will help the prison department to essential | MoPH is responsible until 2020. | included in BPHS. | in some prisons<br>• Further ICRC support | technical assistance |

| Component | Ongoing support | Activities linking with MoPH Policy which require further support. | Required duration & type of support to ensure sustainability | SEHAT plans (2.5 years) | Donor support | budget support required |
|---|---|---|---|---|---|---|
| | | information on prison health facilities. | | | | |

*The contents of this publication are the sole responsibility of ECORYS Consortium and can in no way be taken to reflect the views of the European Union.*