Profiles of Courage

Contents

List of Abbreviations and Acronyms .................................................................................. 2

Background ....................................................................................................................... 3

The Leadership, Management, and Governance in Afghanistan Project .......................... 4

Profiles:

  Embedding Leadership, Management, and Governance Capacity Within the Fabric of the MOPH .... 5
  Integration of USAID-funded Activities into the On-budget Program ............................... 8
  Community-based Healthcare ......................................................................................... 10
  Health Information Systems ......................................................................................... 12
  In-Service Training ...................................................................................................... 15
  Community Nursing and Midwifery Education .............................................................. 18
  Child and Adolescent Health ....................................................................................... 20
  Improving Quality in Healthcare .................................................................................. 22
  Facilitating Autonomous Hospital Management ......................................................... 24
  Stewarding Leadership and Management Capacity Development .............................. 27
  Provincial Health Systems Strengthening ...................................................................... 30

Acknowledgements ........................................................................................................ 32
List of Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEmONC</td>
<td>Basic Emergency Obstetric and Newborn Care</td>
</tr>
<tr>
<td>BNBC</td>
<td>Basic Newborn Care</td>
</tr>
<tr>
<td>BPHS</td>
<td>Basic Package of Health Services</td>
</tr>
<tr>
<td>C-IMNCI</td>
<td>Community-based Integrated Management of Childhood Illness</td>
</tr>
<tr>
<td>CBHC</td>
<td>Community-based Healthcare</td>
</tr>
<tr>
<td>C-GMP</td>
<td>Community-based Growth Monitoring and Promotion</td>
</tr>
<tr>
<td>CHNE</td>
<td>Community Health Nursing Education</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>CHS</td>
<td>Community Health Supervisor</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>EmONC</td>
<td>Emergency Obstetric and Newborn Care</td>
</tr>
<tr>
<td>EPHS</td>
<td>Essential Package of Hospital Services</td>
</tr>
<tr>
<td>FHA</td>
<td>Family Health Action</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GCMU</td>
<td>Grants and Contracts Management Unit</td>
</tr>
<tr>
<td>GIRoA</td>
<td>Government of Islamic Republic of Afghanistan</td>
</tr>
<tr>
<td>HIS</td>
<td>Health Information System</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>ICSP</td>
<td>Integrated Child Survival Package</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
</tr>
<tr>
<td>IQHC</td>
<td>Improving Quality in Health Care</td>
</tr>
<tr>
<td>IRs</td>
<td>Intermediate Results</td>
</tr>
<tr>
<td>IST</td>
<td>In-Service Training</td>
</tr>
<tr>
<td>LDP</td>
<td>Leadership Development Program</td>
</tr>
<tr>
<td>LDP+</td>
<td>Leadership Development Program Plus</td>
</tr>
<tr>
<td>L+M+G</td>
<td>Leadership, Management, and Governance</td>
</tr>
<tr>
<td>MSH</td>
<td>Management Sciences for Health</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MOE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>MOPH</td>
<td>Ministry of Public Health</td>
</tr>
<tr>
<td>MOST</td>
<td>Management Organization Sustainability Tool</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NPQI</td>
<td>Nursing Performance Quality Improvement</td>
</tr>
<tr>
<td>PCH</td>
<td>Partnership Contracts for Health Services</td>
</tr>
<tr>
<td>PPHCC</td>
<td>Provincial Public Health Coordination Committee</td>
</tr>
<tr>
<td>PPHO</td>
<td>Provincial Public Health Office</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>RHD</td>
<td>Reproductive Health Directorate</td>
</tr>
<tr>
<td>SEHAT</td>
<td>System Enhancement for Health Action in Transition</td>
</tr>
<tr>
<td>ToT</td>
<td>Training of Trainers</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Background

Prior to 2002, the vast majority of health service delivery systems in Afghanistan were non-existent or informal. Basic health services were not available, and there were only a very small number of qualified health care providers in the country. Additionally, there was little effective oversight from the national, provincial, and local government levels. When international donors and partners convened after the fall of the Taliban in 2002, they assessed current needs, and saw an opportunity to work with the new government bodies to provide the technical expertise and resources required to construct a health system for the Afghan people.

As part of this process, the United States Agency for International Development (USAID) and the Afghanistan Ministry of Public Health (MOPH) have recognized that leadership and governance, one of the World Health Organization (WHO) Health System Building Blocks, would be critical to the efficient and effective use of scarce resources for delivering quality health care to local populations. As Afghanistan has rebuilt its health system, in addition to putting basic service delivery mechanisms such as the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) in place, Afghanistan's health authorities have also integrated leadership and management development activities at the government and facility levels. The result has been to not only scale up access to health services, but also to create a more stable platform for sustainable service delivery and quality improvement through trained health leaders and managers.

Through the USAID-funded Afghanistan Health Services Enhancement Project (AHSEP), the Rural Expansion of Afghanistan’s Community-based Healthcare (REACH) Project, Communication for Behavior Change: Expanding Access to Private Sector Health Products and Services in Afghanistan (COMPRI-A), the Technical Support to the Central and Provincial Ministry of Public Health (Tech-Serve) Project, and lastly the Leadership, Management and Governance Project (LMG-Afghanistan), Management Sciences for Health (MSH) has supported Afghanistan’s health leaders in all stages of the reconstruction, recovery, and development of the country’s health sector. In each of these USAID-funded projects, support evolved from training health care workers in the development of Afghanistan’s BPHS and EPHS, to national-level support for mechanisms to contract out health services to NGOs across the country. These projects have also supported the development of governance structures and strengthening of technical leadership at the MOPH.

Incredible progress has been made in Afghanistan through these and other USAID-supported projects. Since 2002, life expectancy has increased by almost 20 years; infant mortality has dropped by 53 percent and child mortality by 62 percent. Since 2003, the dramatic increase in the number of trained midwives present at birth has reduced the maternal mortality rates by nearly 300 percent. In 2002, only nine percent of Afghans lived within a one-hour walk of a health facility. Today, more than 57 percent of the population does, enabling Afghans to seek medical attention, consult trained staff, and pick up medicine. More than 25,000 community health workers are now part of the health workforce, bringing health education, basic medicines, and first aid into people’s homes. Community health committees (“shuras”) and Family Health Action groups are working with provincial health offices and health facilities to advocate for and identify community health needs.
The Leadership, Management, and Governance in Afghanistan Project

The $37 million LMG-Afghanistan Project (September 2012-June 2015) built upon the strengths and successes of previous USAID-funded projects to promote enhanced performance of health leadership at different levels of the health system. The LMG-Afghanistan Project’s focus was on providing direct technical assistance and training to MOPH mid-level leaders and managers to build technical capacity and governance capabilities. Through direct work with MOPH units that oversee health service delivery systems, the project strengthened efforts to improve family planning, reproductive health, and maternal and child health care in Afghanistan, in line with the USAID Family Planning 2020 and Ending Preventable Child and Maternal Deaths (EPCMD) initiatives. Local ownership was a priority and was woven into all LMG-Afghanistan Project activities. Strategies designed to strengthen health leadership were developed by Afghans, for Afghans, with international technical assistance used to promote global knowledge exchange and quality oversight.

The reach of the LMG-Afghanistan Project includes a wide range of programs and departments at the MOPH, including: Community-Based Healthcare; Health Information Systems and Monitoring and Evaluation; In-Service Training; Community Health Nursing Education; Child and Adolescent Health; Improving Quality in Health Care; Hospital Management; Leadership, Management, and Governance; and Provincial Health Systems Strengthening. The project has provided technical assistance to meet specific needs and to support existing technical, management, and governance mechanisms for the MOPH to effectively oversee and steward resources across the health sector. The project has also supported the MOPH to prepare for and manage direct on-budget donor assistance for both the delivery of the BPHS and EPHS, and to implement their own health systems strengthening activities.

This Profiles of Courage: Stories of Impact from the Leadership, Management, and Governance Project (2012-2015) booklet includes profiles of individuals that have been impacted by the project in each of the project’s program areas.
The individuals profiled in this booklet were interviewed in Afghanistan in April and May 2015. They are key pillars of the health system, and like many others, have been impacted by the health systems strengthening activities under the LMG-Afghanistan Project so that they can be more effective and efficient in their jobs, as well as be better health service providers and managers. The stories in this booklet describe individual experiences of empowerment and impact on health programs and outcomes that have resulted from the support provided by the LMG-Afghanistan Project.

Embedding Leadership, Management, and Governance Capacity Within the Fabric of the MOPH

A key focus for the LMG-Afghanistan Project has been to collaborate with health leaders at all levels in Afghanistan to improve leadership, management, and governance practices to create a stronger health system and improve health for all Afghans. The project’s technical approach has focused on promoting enhanced performance improvement; developing senior leadership and governance capabilities using participatory processes that enable health leaders and policy-makers to address their own challenges and achieve results; and building and using evidence-based approaches by generating and disseminating evidence that shows how improved leadership, management, and governance contribute to health gains.

The project has done this through the provision of technical assistance in key units of the MOPH, training for MOPH staff, and by embedding individuals within the MOPH to support their ability to directly manage health programs. In this respect, the project has served as an incubator for individuals to build their own skills and support the MOPH’s activities directly, by applying effective leadership, management, and governance practices. The LMG Conceptual Model (Figure 1) is used to guide capacity building to improve the performance of people, teams, and health systems. A key outcome of this technical assistance process has been for the MOPH to examine mechanisms to formally absorb these individuals for the long term in order to sustain capacity gains at both the systems and individual levels.

Figure 1. The Leadership, Management, and Governance (LMG) Concept Model

People and teams empowered to lead, manage, and govern

Leading
- Scan
- Focus
- Align/Mobilize
- Inspire

Managing
- Plan
- Organize
- Implement
- Monitor/Evaluate

Governance
- Cultivate Accountability
- Engage Stakeholders
- Set Shared Direction
- Steward Resources

Improved health system performance

- Responsive health systems prudently raising and allocating resources
- Strong HR, financial and information management systems
- Enhanced work environment & empowered male and female health workers

Results

- Increased Service Access
- Expanded Service Availability and Utilization
- Better Service Quality
- Lower Cost

Sustainable health outcomes and impact aligned with national health goals and MDGs 3, 4, 5, and 6

The LMG-Afghanistan Project has been proud to see some of our team members move on from the project to work directly for the MOPH, where they are now operationalizing effective leadership, management, and governance practices through new tools and approaches to enhance stewardship of MOPH and donor resources. The following story shows how these practices are being applied to the MOPH’s Reproductive Health Directorate.
Exemplifying Leadership, Management, and Governance Principles

Dr. Zelaikha Anwari, Acting Director of the Reproductive Health Directorate (RHD), Afghanistan Ministry of Public Health

For many years, I worked as a Program Manager for the LMG-Afghanistan Project’s Provincial Health Systems Strengthening Program. Now, as the Acting Director of the Reproductive Health Directorate of the MOPH, I use LMG’s strategies for helping leaders, managers, and communities in Afghanistan to build a stronger health system for better health outcomes.

I have a lot of responsibilities in my position, and I take these responsibilities very seriously. The skills I gained on-the-job while working with the LMG-Afghanistan Project have given me the ability to effectively organize and manage resources and activities. I learned how to plan and track activities, monitor different program areas, and how to create an environment that motivates people to achieve results. While working with the LMG-Afghanistan Project, I received a lot of support for learning and growing, especially when it comes to concrete leadership and management skills. Achieving results is impossible without knowing and utilizing the core principles of leadership, management, and governance. The main areas for improvement that we see in the health system in Afghanistan include: how to improve accountability and transparency; how to engage stakeholders and partners; how to efficiently allocate and utilize resources; and how to plan and manage reports.

Additionally, effectively monitoring all of these challenges is an issue in and of itself. These key functions of the system are addressed by implementing solid L+M+G concepts. If we apply the concepts correctly, we will be able to achieve desired results and reach the mission of the health system: increased health status of the people.

When I first started as Acting Director a few months ago, I used my L+M+G skills to streamline processes. I found that there was a lot of duplication of resources when it came to planning activities, especially for certain interventions on the global agenda—newborn care, for example. Almost all partners were investing in interventions for improving
newborn care, while other components of reproductive health were being ignored. I thought that I should ask all of our partners to share their work plans. Then I put the plans into one template, analyzed where duplications existed, and held meetings with all partners to develop restructured plans that effectively allocate resources. This mapping exercise was very useful for stewarding resources: we now have a clearer picture of gaps in health services and how we should allocate resources in the future. Also, doing this mapping regularly ensures that the donor money we receive is well spent.

There are other points of coordination that I’m working to improve as well—notably the maternal and neonatal death review committee. This committee, a coordination forum that is designed to foster accountability at different layers at the national and sub-national levels, and also among stakeholders and partners. Unfortunately, the committee was established for only a short time, and has been dormant for a while. We are now working to revitalize it. When a death happens at a hospital, we are not just responsible to look at the incident from a legal perspective, but from a technical perspective as well. We focus on the main cause of maternal or neonatal death and ask—was it preventable? If so, what lessons can we learn to prevent deaths in the future? We are currently implementing this committee in three pilot maternity hospitals in Kabul, and will gradually extend the committee to all hospitals throughout the country. We are also training doctors in health facilities to analyze the causes of death within their own facilities. There are two or three doctors at the facility level who now review case reports and then report the findings to me within 24 hours of the death. This committee is not about placing blame; it is about learning from our mistakes so we can save lives. The maternal and neonatal death review committee is just one example of how we are trying to improve coordination among stakeholders to improve quality of care.

To create a culture of accountability and transparency, you have to improve communication and coordination not only outside of the department, but within the department as well. Internally, I’ve seen a lot of challenges in the RHD. I’ve used MSH’s Management and Organizational Sustainability Tool (MOST) to assess the RHD’s management performance and identify the strengths, gaps, and challenges of this department. Then, based on these challenges, I created my work plan. The RHD team understands that I came to this Director position to support not only the RH programs, but also to support them as individuals. Everyone has strengths, and everyone has weaknesses, just as every program has strengths and weaknesses. If you have a good work plan in place—and you can work according to your plan—you can address challenges from a structured and evidence-based perspective. L+M+G principles are embedded in every aspect of program planning and implementation that I oversee. Luckily, I work with an excellent team, who are all committed to improving coordination and communication both internally within our department and externally with our stakeholders. Implementing change at is not an easy job. It is not the work of one day, or two days, or even one year, but we do our best to foster positive change for better health outcomes.

As a woman in Afghanistan, having the opportunity to lead and manage wasn’t always available. Women need support to succeed—not only in Afghanistan, but across the entire world. If we, as a society, can provide this support and instill a sense of confidence in our children and in women, then they will succeed when opportunities are presented to them. I am grateful for all the opportunities that have existed for me, and grateful for the chance to build my skills to lead and manage. Women should understand that we can be leaders and managers, and should be encouraged to do so. We should never underestimate ourselves.

“This is my vision: to bring change. We need to be results-oriented, and bring change at the grass-roots level. We need to foster accountability to help us bring change.”
Integration of USAID-funded Activities into the On-budget Program

The Grants and Contracts Management Unit (GCMU) of the Ministry of Public Health (MOPH) is responsible for overseeing health service delivery contracts for primary and secondary health facilities and hospitals across the country. Through technical assistance from the LMG-Afghanistan Project, the GCMU has been directly managing $259 million under the USAID-funded Partnership Contracts for Health (PCH; 2008-2015). As this money has been received via a direct on-budget mechanism, through the Afghanistan Ministry of Finance, the GCMU has been responsible for issuing and managing grants with this funding to NGOs across the country to deliver the BPHS and EPHS in 13 provinces across Afghanistan. As PCH comes to an end, through the World Bank-funded Systems Enhancement for Health Action in Transition (SEHAT) program, the GCMU will act as an integrated service procurement unit which will apply the national procurement law across the board. The LMG-Afghanistan Project has played a key role in facilitating this transition towards greater MOPH ownership and leadership of the grants management mechanism for health service delivery across the country.

Contracting for the Future

Dr. Massoud Mehrzad, Project Manager, Partnership Contracts for Health Services

Managing grants and contracts is a busy job. As the Project Manager at the GCMU of the MOPH, I oversee the management of grants and contracts that cover the healthcare services of 10 million Afghans in 13 provinces throughout Afghanistan. The GCMU’s mission is to ensure that the funds—contributed by our development partners (USAID, the European Union, the WHO, and the World Bank)—are used efficiently to provide better quality healthcare for the people of Afghanistan.

I’ve been leading the GCMU since 2012. When I started as a consultant with this unit, I was impressed by the professionalism and teamwork that existed here. Our current GCMU team is also very strong, and I try to inspire, motivate, support, and enable them every day—that was the way I was inspired and enabled at the beginning of my career here. I oversee 30 consultants who manage 21 grants and contracts for different health program areas, for example, Community Health Nursing Education and Midwifery. They work with our partners in various technical departments: Monitoring and Evaluation (M&E), contracts, finance, human resources, and administration.

The GCMU has three core functions: procurement, contracts management, and coordination. Everyone on the team is required to make sure we do these functions well. The most important function is contract management—ensuring that our implementing NGOs can effectively and efficiently deliver the BPHS, EPHS, and midwifery services. We have a system in place to guide us in this. For example, we conduct monitoring visits with the NGOs in the field (13 provinces) and receive reports from them that describe how they are delivering health services according to MOPH policies. Our job is to review the data, seek out deviations from the relevant policies, and give feedback where service delivery could be improved.

21 Grants and contracts currently managed in 13 provinces throughout Afghanistan.
We also conduct an annual audit of all of our implementing NGOs, where we review data and financial records according to the applicable donor procurement law, and according to objective guidelines and processes that we’ve developed. We have clear approaches to fraud and corruption, and if we find something in our audit that doesn’t comply with our requirements, we address it immediately. For example, we sometimes find costs that are not allowable because the implementing NGO has claimed a cost that does not comply with MOPH or donor policies. When this happens, we disallow the cost and let the NGOs know why the cost was unallowable. They then have to use other sources of funds, outside the contract, to pay for those costs to ensure that the donors are not paying for things that violate their policies and regulations or terms of the contract. We have to hold the NGOs accountable for every dollar that they receive from our donors. Holding the NGOs to this standard helps to reduce fraud and corruption, which isn’t always easy with a project of this level of complexity and funding. We have internal controls to increase accountability and transparency as well: every member of the department signs a conflict of interest form annually, confirming their commitment to avoiding conflicts of interest. Ultimately, we aim to be proactive by making sure that our system identifies challenges before they become misconduct so that resources are spent wisely and according to the law.

To implement an effective project, you have to put the community at the center of your project. To do this, we need to have effective coordination within both our team and with our stakeholders to make sure that we are talking about the same policy and taking the same approach. We work especially hard to coordinate with the BPHS and EPHS implementing NGOs, because they are our key partners and are delivering health services. With them, we have both ad hoc and quarterly meetings. Participation is very important to achieving health service delivery goals. We get all of the stakeholders together, talk about health challenges and goals, and then come up with action plans. We also provide follow-up at this meeting. At some point I learned that having this many partners is complicated, but if you have effective coordination mechanisms in place, you can foster leadership and ownership. Our meetings improve coordination amongst partners. When you bring people together to talk, it doesn’t mean that they will all have 100% agreement with each other. However, you can work on the common things together and move forward with a standardized approach. You can learn to talk with the same voice.

“My vision is better quality of health services for the population; a healthy society is able to contribute to sustained economic development.”

Dr. Massoud Mehrzad
Community-based Healthcare

The CHBC system was established in 2002 to serve Afghanistan’s most vulnerable populations, including women and children, and to address the most important causes of morbidity and mortality for these groups. Through support from the LMG-Afghanistan Project, the CBHC system is overseen and coordinated by the CBHC Department, which is housed within the MOPH. This department serves as an important vehicle to develop national strategies and training materials, lead national level implementation of the CBHC strategy, and advocate for policy initiatives and funding that are essential to ensuring access to and availability of health services at the most localized levels. The system has been designed to ensure that services are brought to individuals. The system includes Community Health Workers (CHWs) who provide services at the household and village levels, community committees (“shuras”) and FHA groups that engage community members to ensure that services are appropriate and meet communities’ needs, and Community Health Supervisors (CHSs) who oversee service delivery at the local level.

Working for the People

Mr. Safiullah Sadiq, Community Health Worker, Behsod District, Nangarhar Province

Three years ago, I was called to the house of a young family in my semi-rural village of Najmulqura, Nangarhar Province. There was a baby girl, just a few days old, who was having trouble breathing. I was called to her house because her parents thought that I, as a CHW, could help her. Her parents didn’t know what was wrong with her, and the doctors they had seen didn’t know either. I urged the family to take the baby to another clinic, but they refused, saying that there wasn’t any point because the doctors they had already seen couldn’t help. They hoped maybe I had a solution that the doctors did not. I kept urging the parents to take their daughter to another clinic, and they kept saying no. So, I asked the family if I could take her there myself—using my own money and my own transportation. They agreed, and I bundled her up and traveled to a clinic in Jalalabad. The doctor there gave the baby an x-ray, and found a minor chest infection. She was treated with medication, and got better in 15 days. Though this incident happened years ago, I still remember it and feel honored that I could help this baby and her family. She is now three years old.

When I see so many people who are sick in society, I want to help them. This was especially true when I was a young man; I always thought that it was my responsibility to support the people in my village. My friends and family encouraged me to become a CHW, and I have now been one for three years.

It’s sometimes hard to find a balance between being a CHW, studying for my bachelor’s degree in business administration, and being a member of my village’s community health shura. I am one of 14 village residents who sit on our village’s health shura (a council that engages community leaders, health care providers, and other community members). Initially, our shura didn’t understand our real responsibilities in terms of our role at the health clinic. That changed when we received governance training from USAID’s LMG-Afghanistan Project. The sections of the governance guides that helped us the most were the sections about effective governing practices and how to conduct meetings. We apply these practices now, and are able to organize ourselves better. The training brought transformation to the way our shura interacted with the community health clinic.
Our village had already identified that low utilization of health services was something that they wanted to address. Our shura organized a meeting with clinic leaders to see how we could help. During these meetings, we realized that the clinic didn’t have a female doctor. Because of this, women would leave our village to get health services in other communities with female doctors. We knew from the governance guides that it was our role and responsibility as a health shura to improve accessibility and quality of services, so we organized with another community to bring in a female doctor to our clinic. We also went out to tell people which health services are available at the clinic and how to access them. If there is a problem that can be solved by our health shura, we always intervene. We feel more prepared to do so because of the governance training.

Through the LMG-Afghanistan Project, I’ve also received training to become a CHW, and then follow-up training on infections, Community-based Integrated Management of Childhood Illness (C-IMCI), Family Planning (FP), and nutrition. The skills I learned in these trainings helped me address the gaps in my knowledge, and how to handle different health issues and get good results.

It is a privilege for me to serve my community. As CHWs, we don’t get incentives, but I think that the biggest incentive for me to do this work is the respect of my people. I am respected in my community because I am a CHW.

“My message to Afghans is to respectfully and sincerely work for their people.”
Health Information Systems

The Health Information Systems (HIS) General Directorate has recently been established under the new leadership of the MOPH. The HIS encompasses health management information systems (HMIS), Research, M&E, and Surveillance programs. This change was made to ensure that all data sources were integrated into a single unit to improve how data and information are shared and used to make decisions. The LMG-Afghanistan Project has worked closely with the HIS programs to institutionalize HMIS, ensure that the MOPH has effective oversight mechanisms in place for health research activities in the country, and implement surveillance activities which are used to inform decisions about resource allocation.

“A strong HIS system helps with decision-making, and encourages transparency and accountability.”
Strengthening Health Information Systems: The “Brain” of the MOPH

H.E. Dr. Ferozuddin Feroz, Public Health Minister of the Islamic Republic of Afghanistan

There are many crucial priority areas for the MOPH to support. Many woman and children are still dying because they lack access to primary health services, especially in underserved areas; data shows that roughly 50% of the population in Afghanistan does not have access to primary care. Improving the access to primary health services and the quality of both secondary and tertiary care is a priority for the MOPH, as is improving the effective control of medicines and food throughout the country.

To have a strong health system, we need good governance, strong leadership, and an effective HIS. The HIS is the brain of the entire health system. In the past, the HIS was scattered and fragmented into different departments. It was like having two brains in one body; there were multiple and divergent thoughts and initiatives being implemented. Now, we have consolidated and integrated the HIS into one unit to make it one brain in one body, thus eliminating confusion and providing unified feedback for the system.

HMIS, M&E, and Surveillance are process reviews—they look at inputs and outputs. Certainly, they will help us understand the progress towards achieving our goals. But there is a different kind of information gathering that is just beginning—the Demographic Health Survey (DHS)—which gives us information about the population, and is very important for making informed policy decisions. Before the DHS, there were many different organizations collecting data in many different ways. Again, it is like having different brains for the same body, and there was divergent information in the system. There are different approaches for different data. Take routine immunization, for example. One report says that routine immunization coverage is 7%; another report says it is more than 100%. This is a problem with the data; this is why we need to integrate all of the information systems. If we merge our surveillance efforts into one system, you again have one brain for one body, and the feedback provided can help us a lot in defining policy for population health.

Integrating the HIS will also improve the quality of data by standardizing data collection instruments. Right now, there are many different tools for collecting information. Different departments use different tools; if we have one tool for a specific indicator, the quality of the data will improve.

System Enhancement for Health Action in Transition (SEHAT) is a key focus for us as we look towards our future at the MOPH. Under SEHAT, there are ten thematic areas, and through SEHAT we can improve access to care, we can improve quality, and we can improve transparent governance within the system. SEHAT will also enable us to work with partner sectors to a certain extent, as well as improve the quality of our hospitals. We are working on strengthening the health system. I see SEHAT as an umbrella to shift from project to programs; if we merge units in the MOPH, we will be able to sustain the functions of the departments. One of the main challenges of SEHAT is coordination. I don’t say lack of coordination; I say weak coordination at different levels, because there are overlaps in tools and activities. We need to use resources as efficiently as possible to bring positive change to the health of the community. SEHAT is an opportunity to do this. We have developed a mechanism to coordinate donor activities and provide a sector-wide approach to management. This mechanism, which we have not yet named, will help to coordinate all activities and avoid duplication of resources to achieve our goals as we move forward with strengthening Afghanistan’s health system.

HMIS databases are currently functional, have updated data, and receive regular maintenance.
**HIS: A Closer Look**

**Dr. Sayed Ataullah Saeedzai, Acting General Director of the HIS, Afghanistan Ministry of Public Health**

As Acting General Director for the HIS Department at the MOPH, I am responsible for not only HIS data, but also for M&E, disease early warning and response, new vital statistics, and research data. One of the important things that I think the LMG-Afghanistan Project brought to the HIS Department is data utilization. Before support from the project, people at the Ministry were thinking about how to develop tools, collect data, and improve reporting timeliness. There was plenty of data that the MOPH was collecting, but there was very little on what to do with the data once it was collected. The LMG-Afghanistan Project started working on how to strengthen data utilization, which is the main purpose of data collection. To do this, the project started working on changing the culture at the MOPH in terms of data collection and use. After a lot of education, emphasizing data use, and integrating data use into work plans (after the project finished, mostly 70% of the work plan focused on data use), we were able to make headway in changing the culture of data use. Previously, staff thought that only the HIS Department uses data. We changed the culture within the MOPH, so that now staff members know that though the HMIS unit collects and stores data, it is for everyone’s use. Data utilization should be done by the technical departments—they are the ones who understand their programs best, and can make decisions based on their own information.

One of the areas that was identified by the LMG-Afghanistan Project as missing for years in data collection and use was research. For years, the focus of the HMIS was descriptive data. But this purely quantitative data only tells half of the story. For example, we can tell how many deliveries were performed at health facilities, but we didn’t have an answer as to why the number was at that level (high or low). We could see from HMIS data that 40% of health facilities did not report a single delivery within the last 20 years. There were midwives available at many of these facilities, but not one delivery. The data could only tell us the numbers; it could not help us understand the “why” of low institutional delivery rates. Research is needed to figure out the root cause of lack of deliveries—this could be done through focus groups or other qualitative studies. We have $700 million dollars going to the BPHS over the next five years, and decisions on how to allocate funds are based on data. If research informs the data, our response to the problem will be evidence-based and more effective.

There are still challenges to overcome as we move forward with improving the HIS Department. We need to build more capacity of staff to utilize data effectively for sound policy level and program decisions. For example, many individuals didn’t have basic data analysis skills, so under LMG-Afghanistan, we trained them on basic biostatistics and epidemiology concepts. We also need to ensure that we have high-quality data for departments to use. Fortunately for now, we are working towards making improvements to the foundations of the HMIS, and will continue to do so in the future.

“We will implement data use, and bring positive changes to the health of the people by strengthening the HIS to have evidence at the health facility level, at the provincial level, and at the central level for informed decision-making.”
Inspiring a New Generation of Healthcare Workers

Dr. Homa Akseer, Director, Training Center, Malalai Maternity Hospital

I am the daughter of a surgeon; healthcare is in my blood. I have always wanted to help people, which is the reason I became a doctor. I am now the Resident and Training Director at Malalai Maternity Hospital in Kabul, as well as a practicing physician.

Malalai Maternity Hospital is one of five regional training centers that provide In-Service Trainings in Afghanistan. We are a national training center that draws health workers from all parts of Afghanistan. Here at Malalai Maternity Hospital, we provide trainings to 120 medical residents per year on several topics, including Basic Emergency Obstetric and Newborn Care (BEmONC), Emergency Obstetric Care (EmOC), Basic Newborn Care (BNBC), Family Planning (FP),

In-Service Training

The MOPH considers building the capacity of healthcare providers to deliver quality health services to be one of its most important priorities. The MOPH strives to improve the quality of health care for all families in Afghanistan by promoting, coordinating, facilitating, and setting standards for continued professional education for health care providers through In-Service Training. The LMG-Afghanistan Project has helped the MOPH set standards, develop policies, establish In-Service Training centers across the country, design monitoring systems, and even directly deliver trainings to cadres of health workers. Through this support, a highly trained cadre of providers will contribute to higher quality services, and therefore a healthier population.
Community-based Integrated Management of Childhood Illness (C-IMNCI), and Hospital Management.

I came to Malalai Maternity Hospital because I saw a need to train healthcare workers with more than just lectures. When I first came here, I thought “There is no one here to show skills to healthcare workers, there are only lectures.” I wanted to change that and help the residents acquire hands-on skills and to know what it is like when they are working with real patients. The In-Service Trainings provide a format for residents to learn these crucial clinical skills and medical models, such as newborn resuscitation, vacuum aspiration, and safe delivery models. Residents come from all over the country to participate in the trainings, as there are many people in the provinces that live far from a health facility or hospital, and they do not have access to the resources needed for professional skills development. They then go back to their provinces and train other healthcare workers in their communities; we have a Training of Trainers (ToT) program here as well.

The LMG-Afghanistan Project has given support to our In-Service Training Center to improve the quality of trainings. They assisted in developing the National Strategy on HRH Capacity Building with Focus on In-Service Training and the National In-Service Training Guide, which helped us to plan, design, and manage our training programs. We didn’t have a framework before we had these strategies and guidelines; now we are able to ensure that our trainings follow nationwide standards and make sure that we apply effective methodologies to educate health care workers.

Based on the strategy and with support from the LMG-Afghanistan Project, we also began using a formal database to keep track of all of our trainings. Previously, we only had hardcopies and softcopies of training reports, meaning that it was difficult to organize information on who we trained and the impact of what people were learning. We now have two database coordinators, and use the database to record all of the necessary training information. Having the database saves time and helps us use information from past trainings to plan for the future. The LMG-Afghanistan Project also provided support for our training materials and equipment. For example, we purchased multimedia equipment, which enabled us to provide more effective trainings because we can now project presentations on screens and show videos. The multimedia equipment made the transfer of knowledge easier. Since we are better equipped, we can now train more health care workers and deliver better trainings so that people go back to the health facilities with real skills that they can apply to patient care. Many people who visit Malalai Maternity Hospital say that the training center is the most important part of this hospital, because we are improving quality of healthcare through training.

In 2014 we provided 62 In-Service Trainings, and trained 1,915 midwives, doctors, nurses, anesthesiologists, and lab technicians.

Of all the In-Service Trainings we have provided, I believe the BEmONC and the EmOC trainings have had the most impact on improving maternal and child health. In Afghanistan, many women—especially in the provinces—have difficulty accessing basic, necessary, and quality obstetric and child health services. The trainings standardize clinical practices to improve neonatal and child health. When the Afghanistan Mortality Survey 2010 published data on maternal health, we saw that mortality had dropped from 1,600 per 100,000 live births in 2002 to 327 per 100,000 live births. Though still high, the 2010 number is encouraging, because it shows that the health situation in Afghanistan is improving. I think that the basic and comprehensive emergency obstetric care trainings that we provide will continue to improve the maternal and neonatal mortality statistics. The trainings change the practice of medicine and help to improve health outcomes. I am very grateful to be able to provide quality In-service Trainings and help people throughout Afghanistan.

“We do our part to standardize clinical practice, and hope that the provision of health services is improved through training.”
“I am motivated to help my people and my neighbors...I can’t just stand by and watch mothers die.”

TAHMINA (PICTURED RIGHT), MIDWIFE, HELMAND PROVINCE

The In-service Training teaches midwives how to improve their communication with patients. More importantly, the training encourages participants to serve the people and become better midwives.
Community Nursing and Midwifery Education

The Community Health Nursing Education (CHNE) Program provides technical assistance to strengthen and expand quality nursing and midwifery education throughout Afghanistan. To do this, with support from the LMG-Afghanistan Project, the CHNE Program established a strong coordination mechanism with stakeholders; enhanced M&E systems; and developed guidelines, teaching materials, and quality improvement standards for hospitals, community healthcare facilities, and clinics.

Standardizing Quality Improvement For Nursing and Midwifery Care

Ms. Fariba Omarzada, Nurse Supervisor, Wazir Akbar Khan Hospital, Kabul

For years, I worked as a nurse under the Taliban regime. These were difficult times—women had to wear a full burqa, even at the workplace, and I was no exception. There was one year during the Taliban regime that we didn’t receive a salary at all, but we would come to work each day and do our jobs. Now, our salaries are paid regularly by the Ministry of Public Health (MOPH), and the healthcare situation in Afghanistan is improving.

I’ve worked at the Wazair Akbar Khan Hospital in Kabul for most of my 26 years as a nurse, and I am now the nursing supervisor in our Women’s Surgery and Orthopedic Ward. I became a nurse because I saw a shortage of female nurses in our country, and knew that I could help to fill the gap. As a nurse, I’ve had many opportunities to grow professionally, and have received trainings from different organizations over the years. Most recently, I received training from the LMG- Afghanistan Project on Nursing Performance Quality Improvement (NPQI) standards, which the USAID-funded Tech-Serve Project had developed.

Learning and using these standards have made a huge impact on my work and on the health of our patients here at Wazir Akbar Khan. Before the trainings and implementation of the NPQI standards, we had issues with infection prevention. For instance, we did not know how to clean our hands properly and we did not wear gloves when distributing medications. There is a specific standard for infection prevention in the NPQI, and now we hold ourselves to that standard. We now wear gloves when we distribute medication to a patient, and we describe the medication to the patient.

I remember one incident for which I am glad our hospital had standards in place. It was an ordinary day at the hospital, until they brought a young patient into my ward. She was 15 years old and had come to Wazair Akbar Khan from the Baghlan Province.

She had been badly beaten and burned by her husband and mother-in-law, and had sustained permanent injuries. She was in critical condition and in great need of help. I bathed her and cleaned her wounds; I am very grateful that we had strong infection prevention practices in place and could treat her wounds correctly. I took on the responsibility of caring for this girl—I made a promise to myself that I would help her heal, because I was her provider. She spent three months in our hospital, and I was there with her the whole time—managing her medication properly, making sure she got the right nutrition, and talking to her. I coordinated with a psychiatrist, so the girl could receive therapy. After she left Wazir Akbar Khan, she went to a Department of Women’s Affairs shelter. It took a lot of teamwork to help my patient.

As of February 2015, the number of hospitals that applied National Nursing Standards at the central level.
to get her well again, and a lot of knowledge and skill. The skills and knowledge that I acquired as part of the training on the NPQI helped me to design and carry out an effective treatment and care plan for this young patient.

Leadership and management are present in all of our activities. I participated in a Leadership Development Program about a year ago, and since then I know how to prepare an action plan and how to provide an intervention when we face challenges. We now have a process for implementing interventions. When we develop a specific intervention, we describe it to the nurses, who then implement it. I also now know how to better evaluate and assess my supervisees’ work. I supervise every nurse during surgical procedures, for example, and we have a checklist of NPQI standards that I use to assess the nurses’ performance. This checklist is available at multiple locations throughout the hospital—by the cleaners and on our bulletin board, for example. The checklist gives me a way to quickly identify problems or challenges that the nurses are having; if we find a problem, we work with the head of the nursing department to find a solution.

Our hospital still faces many challenges, such as not having shift system in place for staff, but we continue to make recommendations for improvement. Our improvement is a work-in-progress; even for areas where we haven’t received results, we still keep the discussion open and hope for change.

“Before the LMG-Afghanistan Project, there weren’t any standards in place, so the quality of health services was low. But after LMG, we have received the standards, and the quality has improved.”
Child and Adolescent Health

With support from the LMG-Afghanistan Project, the CAH Program has been enabled to deliver cost effective and evidence-based strategies that contribute to the improvement of child health, as well as the reduction of child morbidity and mortality in Afghanistan. The project has helped the CAH Program by improving coordination among key stakeholders through the revitalization of a CAH taskforce, working groups, and empowerment of the CAH Directorate; implementing quality Integrated Management of Childhood Illnesses (IMNCI) and basic newborn care at the BPHS level; scaling-up Community-based Integrated Management of Childhood Illnesses (C-IMNCI) and Integrated Child Survival package (ICSP) at the community level; and ensuring sustainability and institutionalization through the integration of evidence-based interventions in the BPHS and EPHS.

Educating Health Workers for Better Child Survival

Mr. Ghulam Sakhi Azimi, Community Health Supervisor

My name is Ghulam Sakhi Azimi, and I am a Community Health Supervisor (CHS) from the rural village of Rawashan in Herat, Afghanistan.

I’ve always had a great interest in health; I became a CHS at the request of some people in my community. Many years ago, I was a first responder at the site of an automobile crash. A bus carrying 24 passengers had careened over a bridge, and there were many people injured. Using the first aid I’d learned years ago at a Red Cross Training, I gave CPR to a six-month old baby to save him from drowning. The baby survived and I was recognized by our community health shura as someone who should work in health. First, I became a vaccinator at a health post, and then joined the CBHC Program in 2009. I’ve now been a CHS for a little over six years.

As a CHS, I supervise 72 Community Health Workers (CHWs) and interact with 312 Family Health Association (FHAs) members (FHAs are made up of women with young children who are respected in their communities, trusted by female CHWs, and willing to volunteer their time to serve as an FHA group member). Once a month, I conduct a visit with the CHWs to look at any shortcomings that exist in the services they provide, and to evaluate their performance. The CHW and I then work together to develop an action plan.
plan to remove gaps in services. I also restock their health kits—for example, I replenish any medicines that they need that are not there and make sure that they have sufficient first aid supplies.

The confidence the people in my village have in me encourages my work, and I am very interested in continuing to help them. Our community has a lot of health issues, like low vaccination rates and lack of proper hygiene care, especially for infants. There is low awareness in our community about these issues. The LMG-Afghanistan Project works with us to raise awareness levels; they give us trainings on the Integrated Child Survival Package (ICSP), and on C-IMCI.

Because of the training given on ISCP by the LMG-Afghanistan Project, our CHWs are better at providing health education and raising awareness, especially for community-based maternal and newborn care and community-based monitoring and promotion. We can now better educate women on the proper care of their babies and children. The first thing CHWs tell women during a home visit is that they need to complete all five rounds of vaccinations for their children. CHWs also give our referral slips to refer pregnant women to health facilities for delivery. Two days after the mother and the newborn leave the health facility, the CHW follows-up to weigh the baby and discuss feeding. Under our weighing program, the child is then weighed once per month and monitored for growth. The LMG-Afghanistan Project’s Child and Adolescent Health Program provided us with weight charts and scales for children, too. We use the scales during monthly weighing days at health facilities and posts, where mothers bring their children in on fixed days to be weighed and have their growth recorded.

The ICSP trainings have created hope for the community. People have welcomed, supported, and appreciated our program. The ICSP is for children and has four key areas: growth monitoring and promotion, C-IMCI, essential maternal and newborn care, and behavior change communication. I now have certificates in all of these areas, and I use all of my training to help people. The ICSP has improved the health status of the people and has brought positive change. For example, in the past, people thought that they should not give fluids to children if their child was sick with diarrhea. Now this is not the case; with the health education our CHWs provide, they know how to hydrate their children with fluids to keep them healthy. Another example can be seen in the pharmacies—people used to make their own, traditional medicines and did not use pharmaceuticals. Now that the level of awareness has gone up in the villages, people go to pharmacies and use licensed medications.

The community has benefited from the child and adolescent health trainings we’ve received from the LMG-Afghanistan Project. These trainings addressed our problems, involved us in addressing the challenges that we had, and helped us by giving critical training and teaching how to practically implement what we’ve learned. I feel very happy to be a CHS, and very proud.

“When we see that a child isn’t growing well, we ask the mother what the reason is, and then advise her on a solution.”

CHSs and CBHC trainers certified as master trainers in ICSP from April 2014 through February 2015.
Improving Quality in Healthcare

The Improving Quality in Health Care (IQHC) strategy and harmonized Quality Improvement (QI) program are institutionalized within the BPHS. Under the LMG-Afghanistan Project, the MOPH IQHC department has been supported to roll out quality improvement tools to health facilities in five provinces, with a goal of expanding to the remaining provinces in Afghanistan in the future. The roll out of these tools has been coupled with coaching and learning sessions to facilitate the sustainability of the methods. The goal of the IQHC Program is to strengthen the health system through research, action planning, action learning, documentation, advocacy, and by establishing mechanisms which are necessary to enhance the quality of health services. For example, the program has supported the development of a patient charter of rights to be applied in hospitals and a medical errors reporting system for hospitals. These systems are all designed to enhance capacity for quality improvement activities at facility levels and to integrate oversight for this into the MOPH so that it can effectively oversee both quality and availability of health services across the country.

Improving Quality of Care through Collaboration and Perseverance

Dr. Mirwais Alizai, Nangarhar Quality Improvement Committee Focal Point

I am passionate about improving the quality of healthcare in my community, which is located in the eastern province of Nangarhar, Afghanistan. I serve as both a Health Education Officer for the Nangarhar Public Health Directorate, as well as a Focal Point for my province’s Harmonized Quality Improvement Program’s (QI) Committee, which formed a year ago to help identify gaps in health services and find solutions to addresses quality-of-care issues, including patient and provider safety, infection prevention, and safe surgery.

I became Focal Point for the Nangarhar QI Committee when the Nangarhar Public Health Directorate saw how interested I was in quality improvement. My interest started when I received training in IQHC through a ToT workshop, offered by the LMG-Afghanistan Project. Through this training, I learned quality improvement methodology on how to introduce change to the healthcare system, how to identify gaps and obstacles, and how to find solutions to identified issues. After the training, I wanted to implement the national QI package and assess quality of health services in my province so that we could make sure that patients got the best care possible. There are now focal points in five Harmonized Quality Improvement Program (HQIP)-implementing provinces (Bamyan, Herat, Kandahar, Kunduz, and Nangarhar), and I am proud to be one of them.

As Focal Point, I lead the committee in coordinating quality improvement interventions throughout the province. Other committee members represent 22 healthcare areas and come from various organizations, including the PPHO Director’s Office, NGOs that deliver the BPHS, and the Provincial Public Health Directorate. The QI Committee process has positively impacted cross-functional engagement of stakeholders on patient care issues, such as maternal, newborn, and child health; infection prevention; and communicable diseases. Through collaborative meetings, committee members share issues that are identified in health facilities during quarterly quality assurance assessments. All committee members work together with stakeholders in order to make decisions and provide feedback to the health facilities for each program area. The environment between committee members is a good one; members struggle jointly to find solutions for quality-of-care issues. This is collaboration: members of each department, members of each organization, come together to find out how to best address the problems.
There are a lot of issues that we face in healthcare, but we have used the methodology we’ve learned through trainings to improve quality-of-care. For example, to increase effectiveness of care, we have focused on improving the way health workers communicate with patients in most of our health facilities. We heard a complaint from one health facility that the health workers were not communicating effectively with patients. There was one woman, in particular, who came to the health facility to receive health education, and left the facility not understanding the education she had received. When word of this got back to the QI Committee, we worked with the health facility to identify why this woman—and other patients—was not receiving quality health education. We developed a checklist and standards for delivering health education to patients, and trained the health workers on these standards. Once they began implementing the standards and checklists in their health facilities, we saw improvement in the quality of health education that the patients receive.

The health workers are now more committed to their work and have increased capacity and knowledge to effectively deliver quality health education. When an improvement proves successful in one health facility, we then implement it in other health facilities. In this way, we transfer knowledge to all health workers and facilities in Nangarhar. Health facilities learn from one another, sharing both problems and successes.

Before the support of the LMG-Afghanistan Project and the implementation of quality standards by the HQIP, coverage of healthcare was good, but the quality healthcare services were not. Now that we have implemented quality assurance measures and healthcare standards (such as infection prevention controls), we are able to have a more robust impact.

As of February 2015, the number of target provinces have both an active QI Committee and an active QI focal point.

“We have increased accountability to patients, as well as the confidence and trust people have in the healthcare system.”
Establishing Autonomy

Dr. Avid Deyar, Director, Rabia Balkhi Maternity Hospital

Kabul City is congested, and Rabia Balkhi Hospital is located at the center of the city. It is an old hospital, and often over-burdened. Patients come to our hospital from all over Afghanistan; we offer services to more than 400 patients per day, even though we are only a 240-bed hospital. This is a very complex hospital—we provide gynecological and obstetrics services, as well as general surgery. We also have a Family Planning Center, where we offer both service delivery and training for staff from different provinces in family planning best practices.

The most exciting part of joining the Rabia Balkhi team as Hospital Director two years ago was that I started at the same time Phase One of the Hospital Autonomy process was established. I am lucky that I came at this time—this was a new experience for both me and the health system. In Afghanistan, the centralized health system is still very common. Moving to a decentralized model is very important—it is a new creation that can bring new change. So far, the Hospital Autonomy process has brought positive change to the Procurement, Finance, and Human Resource Departments at Rabia Balkhi. It has also helped us have a better HMIS, so that we can monitor our services and use our data. Changes that came to the hospital are very visible. Now when you come to the hospital, everything is cleaner. It looks like a hospital, not ruins. Staff is more satisfied because everything is available now, and services are free to patients. We mostly have good equipment, medical supplies, and emergency response. The system at our hospital runs and responds well to patients in all departments.

Having control over our own hospital’s finances is a big part of the Hospital Autonomy process. Under the centralized system, I had to ask the central MOPH to purchase supplies and equipment. This process could take months, which is an eternity when you are waiting for much needed medical supplies like gloves or stethoscopes. This was a big challenge two years ago. Now, under Hospital Autonomy, Rabia Balkhi controls its own budget. We get a certain amount of money allocated to us each year for food, supplies, medicine, and everything else we need (except for repairs to infrastructure and large equipment). We are able to order the necessities as-needed, without having to go through the MOPH for procurement. This means that we are able to maintain good levels of stock, and patients can get what they need, when they need it.
Controlling our own budget also allows for us to be accountable and transparent. Accountability and transparency is something that I work hard at—the Afghan people have lost their faith in the financial management process, and I am trying, in part, to restore that trust. When we make our financial and procurement plan each year, we always have a meeting and explain it to all of our medical staff. We go through key concepts, including what we want to do with the money, and why we want to do it. The staff knows their budget; they know the amount of money allocated for supplies, medicines, food, as well as what is allocated to the hospital as a whole. In this way, the staff is involved in the purchasing process. They are a witness to the system, thus fostering accountability. I think this kind of teamwork is a key element to creating accountability and transparency in the financial system. I have a highly committed and honest team working with me at this hospital. Transparency involves participatory teamwork, and for this reason I ask my team where there are gaps in our services or in our plans. Then I ask them to think of solutions. Sometimes they go home and think about how we can address our issues, and then come back the next day and say “I have a solution!” I’ve made the system such that the decisions I make are informed by the opinions of my team. When the staff knows that their manager is honest and accountable, then it also encourages honesty and accountability amongst the team, and the system as a whole.

Besides financial and procurement issues, another gap in our health system has been the quality of infection prevention. To date, the number of autonomous hospitals/institutions that have implemented (80%) their procurement plans and budgets.
at many hospitals. A large part of high-quality infection prevention involves proper housekeeping structures, which many hospitals lack. The LMG-Afghanistan Project has helped us assess our housekeeping system. Though we haven’t received the results of this assessment yet, we are fortunate to have a very good Quality Improvement (QI) Department, and they have developed checklists, guides, and a structure for patient safety and infection prevention. Additionally, each year, the QI Department puts together an annual plan, which covers 14 areas, including housekeeping, waste management, sterilization, and decontamination. We’ve worked hard to follow the plan and guidelines, and we were able to improve our infection prevention standard level from 42% to 85% within the last two years (2013–2015). 85% of our infection prevention steps on the checklist now meet the World Health Organization (WHO) standards. I am happy with this; 85% is a good number. I am very satisfied when I walk around the hospital each day and see my housekeeping staff wearing all of their personal protective gear, and see them following other pieces of our guidelines and procedures. They know the correct steps to protect themselves, their families, and their environment.

Now that autonomy has been implemented, we have control of our budget and we can control who we hire through our own internal processes. Yet, there still remains a gap between the MOPH and the people. If we can continue to build the capacity of hospitals, we can continue to help the people who need our services the most. A good health system must think of the patient first.

High-quality infection prevention practices, such as proper handwashing techniques, help to improve patient safety.
**Stewarding Leadership and Management Capacity Development**

A core focus for the LMG-Afghanistan Project has been to facilitate the institutionalization of leadership, management, and governance development within the health sector in Afghanistan. The project has worked by and through the MOPH’s Management and Leadership Development Department (MLDD). This department has received technical assistance and coaching to develop and apply tools, modules, and approaches to build leadership, management, and governance capacity of individuals within the MOPH and at BPHS and EPHS facilities. The department has also assessed capacity in leadership, management, and governance and applied the results to the development of enhanced orientation programs for MOPH staff. MSH’s Leadership Development Program (LDP) has been a core tool used throughout this process. The LDP has been rolled out through a cadre of trained facilitators across the country to enhance leadership and critical thinking skills at multiple levels, including health facilities and MOPH departments.

---

**Empowering Healthcare Workers to Manage and Lead**

**Dr. Noshin Shahab, Reproductive Health Officer and National LDP Trainer, Jawzjan Province**

As a doctor and Reproductive Health Officer for the Jawzjan Provincial Health Directorate, I use leadership skills every day. I am constantly making decisions that impact public health—from planning resource allocation to setting targets with health facility teams to obtain achievable, measurable results. I learned most of my leadership skills through the MSH LDP. I believe that everyone should know the skills to be a good manager and a good leader, which will make them successful in life.

I have not missed any of the LDP workshops since MSH started the program in my province. I received my first LDP Training in 2006, and I am now a LDP facilitator. I have facilitated 10 LDP trainings since 2010; once, I had a full training of 20 people and led it by myself! I’ve trained Public Health Directorate staff, project managers, doctors, nurses, community health supervisors, and midwives from 12 clinics. LDP participants give me positive feedback on my training—doctors and others come to me and say “I remember you; you gave us such a good training!” This makes me feel proud that I am doing a good job and building the skills of people of such a high caliber.

At the first LDP workshop I went to, we talked about the concept of scanning to look around your environment to see what issues are influencing key concerns or health issues. Understanding this concept of scanning really had an impact on me because it was so fascinating to look at health issues in this light. It transformed the way that I think about how to solve problems in my work and how I can help others do the same. I became interested in the other areas of the LDP, participated in follow-up workshops, and studied the LDP extensively.

When I learned about the LDP Challenge Model, everything changed for me. The Challenge Model, a key tool in the LDP, really gave me a new way to analyze and solve problems, both in my professional life and my personal life. It is a way to identify the root causes of problems, whether in a health clinic or at home, and then take action to get a result. The Challenge Model has become a very powerful tool in solving issues at home and with my family. I am not the same person as I was before taking the LDP; I am more patient and more tolerant. When I encountered negative people at work before, for example, I would become irritated and was quick to get angry with them. Now, I think about the problem before I react. I think about the work environment and why these
people are acting negatively, and then I try to address that issue, not just react with irritation.

I’ve had a very memorable experience of using the LDP skills in my life. I was at a provincial health networking workshop a few years ago in Kabul, and people from all of Afghanistan’s provinces and the MOPH participated. We had to present our annual reports about our province’s activities, and when I had finished my province’s presentation, a woman from the MOPH came up to the front and put three circles on a board. She asked us if anyone knew what the three circles were, and if anyone could put suggestions and challenges in them. No one among the participants knew what the circles were, except for me. I had learned this tool in the LDP. I first explained to the participants the differences between a challenge and a problem, and then walked them through an exercise, explaining the circle model along the way.

After my talk, everyone in the training came up to me and asked where I had learned about the three circles of influence model. They all wanted to know if I had books or other resources to share with them. I told them that I had learned this model though the LDP, and that the training was a process, not a quick lesson. But I believe everyone should learn to use the tools of the LDP, even if you are a doctor who doesn’t directly lead or manage. For example, if a surgeon has poor management skills, an operation he performs may be unsuccessful. He can perform the surgery perfectly, lace every stich in a neat line. But if he doesn’t have the management skills to follow-up on the operations, if he hasn’t developed a plan, then the patient could get sick. Maybe the wound becomes infected and the surgeon doesn’t know in time to treat it. If this happens, if there is no management, then the surgery would have failed. If we do not have targets and a plan in life, it is like walking in the dark.

I’ve done a lot of work to encourage people to become better leaders and managers to improve service delivery. I’ve used the LDP models to help health facilities increase their numbers of institutional deliveries, increase the number of family planning users at their clinics, and increase vaccination rates. For example, one clinic in my province wanted to increase the number of family planning users
that visit their clinic. Using the Challenge Model (Figure 2), I worked with health facility staff to identify their challenge, which was a low level of community awareness about family planning options. Then, we identified a measurable result for them to focus on, which was to increase the number of family planning users. But they couldn’t just go from challenge to result; there are steps in between. I worked with them to prepare an action plan to address this challenge. They went to the community religious leaders and elders to ask them to talk to people to raise awareness of their family planning services. They also collaborated with Community Health Workers (CHWs) to meet with women and talk to them about risks of home births, and to talk to them about the family planning services offered at the clinic. They set an achievable goal: from October 2014 to June 2015, they aimed to raise the number of monthly family planning users at their clinic from 80 to 100. It is now April 2015, and they have almost reached their goal. There are, on average, 91 users per month visiting the clinic for family planning services.

I was inspired to move from being an LDP trainee to a facilitator because I wanted to transfer the knowledge I’d learned to others, so that they, too, could benefit from the LDP skillset. I believe that anyone who attends or receives trainings should have three things in mind: 1) how to learn the topic thoroughly; 2) how to share with others what they’ve learned; and 3) how to implement their training to improve service delivery.

I believe that I am doing all three things, and there is one thing I know for sure has had a positive effect on both my professional and personal life and can do the same for others: the LDP.

Teams were trained by LMG-Afghanistan staff to deliver LMG tools, models, approaches, and/or in-service curricula from April 2014 through February 2015.
Provincial Health Systems Strengthening

The LMG-Afghanistan Project has built the capacity of the MOPH Provincial Liaison Directorate to independently govern, lead, and manage department activities to strengthen the provincial health system. The project has also supported Provincial Public Health Offices (PPHOs) through embedded advisors to build capacity to apply and implement core management functions and carry out key governance functions. A key success of the program has been to develop a monitoring system such that the MOPH can now monitor the performance of PPHOs to target capacity building support. Additionally, the project supported the development of governance guides for PPHOs to strengthen skills and develop plans to improve governance structures, stewardship of resources, and stakeholder engagement. The success of these guides in the initial pilot phase has led to adoption at the national level and a process to roll them out to PPHOs in all 34 provinces.

Building Provincial Health Systems: One Man’s Journey

Dr. Ghulam Sayed Rashed, MD, MPH, Former Provincial Public Health Director, Herat

For seven years (2007-2014), I was the Provincial Public Health Director for the Herat Province in Afghanistan. Herat is known for its quality primary and tertiary healthcare, and provides health services for the entire region. I am a medical doctor and worked for two years providing direct patient care. However, I realized that I could help my community more if I focused on public health instead of curative health. I switched to public health, and have held many different positions throughout my career, ranging from Provincial Health Advisor to Malaria Control Officer.

As Provincial Public Health Director, I participated in several activities with our PPHO that were designed to positively impact the health of people in Herat. For example, the Herat PPHO received leadership development training, provided by the LMG-Afghanistan Project. The Leadership Development Program Plus (LDP+) helped us build the leadership capacity of our PPHO staff so that we can better use our health data for planning health management improvement activities across the province. Through the LDP+, we identified health challenges in our community, and then planned and implemented an action plan to address these challenges.

The LDP+ training also helped to strengthen coordination and collaboration with stakeholders at different levels within provincial health facilities by bringing them together as part of the process.

The Herat PPHO was one of the first to apply the Provincial Core Functions Framework. The goal of the framework is to measure the PPHO’s performance; we’ve used it to improve our performance by regularly evaluating our strengths and weaknesses in 11 core functions for management and oversight at the PPHOs to ensure the quality implementation of health programs that span from planning to community relations to management of health emergencies. Each function encompasses a number of PPHO tasks, and each task is further broken down into activities and procedures. The core functions allow for systematic assessment of the PPHO team. The system is built on a scoring mechanism, and each province knows the

Provincial Public Health Offices attended task-sharing workshops and prepared action plans from October 2013 through February 2015, exceeding the target of 20 PPHOs during that time frame.
level of their performance and the scores they obtained. The PPHO Core Functions Framework is a very successful product for our PPHO, as it was the first of its kind and has since been introduced in all 34 provinces in Afghanistan. Developing the Core Function Framework didn’t happen overnight. It took some time, but has become very useful.

Another set of tools that the PPHO uses to improve our performance are the PPHCC Governance Guides, which help us to improve our stewardship of resources, engagement with stakeholders, and strategic planning capacity. We introduced the governance guides in 2013 as a way to improve resource management at the provincial and community levels. One of the aims of the governance guides is to involve all levels of the provincial health sector in the planning process, from the village level all the way to the Ministry level. The use of the guides has given the Herat PPHO a new way of looking at how we allocate and use human and financial resources to increase our accountability and transparency. We should always be transparent to our donors, to the government, to our community health shuras, and, ultimately, to the people of Herat.

“We work systematically, step-by-step, to improve health services at all levels. We might not see the impact on a monthly basis, on a quarterly basis, or even on a yearly basis, but we do eventually see the clear results of our activities.”

Dr. Ghulam Sayed Rashed
**Acknowledgements**

This booklet of voices from the frontlines of Afghanistan’s health system was compiled on behalf of Management Sciences for Health by Ms. Jessica Golden, MPH, in cooperation with staff from Management Sciences for Health’s Kabul-based office. Management Sciences for Health acknowledges and thanks the many staff and other stakeholders who contributed knowledge, energy, and time to the project’s activities and to the production of this booklet. Special thanks go to Dr. Abdul Shakoor Hatifie, Dr. Mubarak Shah Mubarak, Dr. Hayetullah Mushfiq, Dr. Hedayatullah Saleh, Dr. Abdul Khalil Sulimankhil, Ms. Stephanie Cálves, JD, MPH, Ms. Sara Weinstein, MALD, and Mr. Martin McIntyre for their assistance, and to the following individuals who generously provided their time and knowledge through interviews:

- Dr. Homa Akseer, Director, Training Center, Malalai Maternity Hospital
- Dr. Mirwais Alizai, Nangarhar Quality Improvement Committee Focal Point
- Dr. Zelaikha Anwari, Acting Director of the Reproductive Health Directorate, Afghanistan Ministry of Public Health
- Dr. Avid Deyar, Director, Rabia Balkhi Maternity Hospital
- Mr. Ghulam Sakhi Azimi, Community Health Supervisor
- H.E. Dr. Ferozuddin Feroz, Public Health Minister of the Islamic Republic of Afghanistan
- Dr. Massoud Mehrzad, Project Manager, Partnership Contracts for Health Services
- Ms. Fariba Omarzada, Nurse Supervisor, Wazir Akbar Khan Hospital, Kabul
- Dr. Ghulam Sayed Rashed, MD, MPH, Former Provincial Public Health Director, Herat
- Mr. Safiullah Sadiq, Community Health Worker, Behsod District, Nangarhar Province
- Dr. Sayed Ataullah Saeedzai, Acting Director of the HMIS Health Informations General Directorate, Afghanistan Ministry of Public Health
- Dr. Noshin Shahab, Reproductive Health Officer and National LDP Trainer, Jawzjan Province
- Ms. Tahmina, Midwife, Helmand Province

Additionally, this booklet and the accomplishments of the Leadership, Management, and Governance Afghanistan Project could not have been possible without its close partner, the Ministry of Public Health of the Islamic Republic of Afghanistan, and its dedication to serving the people of Afghanistan. This document has been produced with financial support from USAID, with special acknowledgement to the USAID-Afghanistan Mission for their dedication to supporting the work of this project to strengthen the Afghan health system.
The mission of the LMG project is to improve leadership, management and governance practices to strengthen health systems and improve health for all, including vulnerable populations worldwide.

Inspired Leadership.
Sound Management.
Transparent Governance.