Islamic Republic of Afghanistan
Ministry of Public Health

General Directorate of Human Resources

National Strategy on Human Resource for Health (HRH) Capacity-Building with focus on In-service Training

2014–2018

TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS

ANDS	Afghanistan National Development Strategy
CB	Capacity Building
CBC	Capacity-Building Committee
CBD	Capacity-Building Directorate
CGHN	Consultative Group for Health and Nutrition
GDHR	General Directorate of Human Resources
HMIS	Health Management Information System
HRMIS	Human Resources Management Information System
HNS	Health and Nutrition Sector
HNSS	Health and Nutrition Sector Strategy
HRH	Human Resources for Health
IQHC	Improving Quality of Health Care
IT	Information Technology
ISTTF	In-Service Training Task Force
LRP	Learning Resource Package
M&E	Monitoring and Evaluation
MoPH	Ministry of Public Health
NGO	Non-governmental Organization
PHCC	Provincial Health Coordination Committee
PHO	Provincial Health Officer
PTFU	Post-training Follow-up
SBEM	Standards-Based Education Management
TMIS	Training Management Information System
TORs	Terms of Reference

FOREWORD

The Ministry of Public Health (MoPH) of the Islamic Republic of Afghanistan considers building the capacity of health care providers to deliver quality health services to be one of its most important priorities. With this strategy, the Ministry demonstrates its continued commitment to improving 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. A more highly trained cadre of providers will contribute to higher quality services and, therefore, a healthier population.

The role of the MoPH is defined in this strategy as stewardship. The principal activity of the MoPH, therefore, is not providing in-service training, but rather is motivating, communicating, advocating, guiding, linking, standard setting, monitoring, and collaborating with its partners. The Ministry considers this as an effective and efficient way for Afghanistan to achieve its health and nutrition goals.

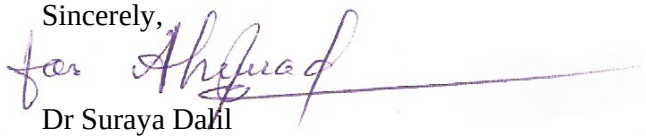
The strategy is in line with other MoPH Strategies and will contribute in achieving MoPH strategy 2011–2015 and ANDS objectives.

One of the key innovations in this strategy is the creation of a national resource center for collecting, filing, and disseminating training materials and training-related materials. Although hard copies of these materials can be disseminated directly to training partners, the strategy also calls for making electronic copies of these materials available to partners everywhere. A Training Management Information System (TMIS) will add to the dissemination effort by tracking information about training courses, trainers, and trainees throughout the country and making it available to partners. In addition, quality assurance standards adopted by the MoPH will be circulated to training partners through the TMIS or other mechanisms. I am confident that this multipronged approach will contribute significantly to strengthening the knowledge, skills, and attitudes of health care providers and thereby to improving the health of the Afghan people.

This new strategy will guide the MoPH in developing an implementation plan and annual work plans to address the in-service training needs of the country. It will also guide the MoPH and related ministries, donors, implementing agencies, and other partners to identify means of financing and implementing its priority areas.

I would like to thank the task force for the energy they put into the development of this strategy. I am confident that the MoPH and its partners' efforts to implement this strategy will succeed in developing a vital partnership from which all Afghans will benefit.

Sincerely,



Dr Suraya Dalil
Minister of Public Health

ACKNOWLEDGMENTS

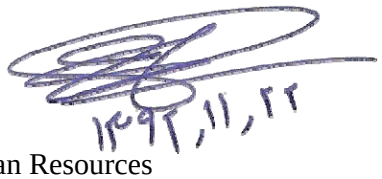
The national capacity-building strategy was initiated by a task force formed by the Capacity-Building Directorate (CBD) of the General Directorate of Human Resources (GDHR) of the Ministry of Public Health. The work was a collaborative effort that began with a capacity-building assessment of the CBD and focused on the coordination, management, and monitoring of in-service training. This was followed by a workshop held in May 2012 to begin the strategy development process. During the workshop, working groups were formed to develop the five strategic components of the strategy. These working groups met approximately weekly for two months to complete the components. The second workshop was held in July 2012 to review and finalize the draft strategy. During this workshop, another working group was formed to develop the indicators and targets to accompany the strategic components. This strategy document is the result of this intensive work. The names of the principal contributors to the strategy are listed in Appendix A.

I would like to extend my sincere thanks to Dr. Ahmad Jan Naeem, Deputy Minister for Policy and Planning, MoPH, and Dr. Jan Mohammad Jebran, Director, Capacity-Building Directorate for their continued support and guidance throughout the strategy development process.

I would also like to express my gratitude and appreciation to USAID for their financial support and the Health Services Support (HSSP) and Leadership, Management and Governance (LMG) Projects for their technical support for this strategy.

Equally important to the success of this strategy was the input provided by the working groups and the participants in the two workshops convened to compile the content of the strategy as well as the In-Service Training Task Force. Their recommendations have been incorporated into the document. Finally, I would like to express my appreciation for the support provided by the Consultative Group on Health and Nutrition, the Technical Advisory Group, and the Executive Board.

Sincerely,



Dr. Ehsanullah Shahir
Director General of Human Resources

BACKGROUND

ACHIEVEMENTS AND SUCCESSES

After a decade of effort, numerous and significant improvements have been made in the health status of the Afghan population and the Afghanistan government's health system. For instance, infant mortality rates have declined significantly from 165/1000 live births (WHO 2000) to 74/1000 live births (MICS 2010-11) Similarly, Afghanistan is on target to achieve many of its Millennium Development Goals ahead of schedule, including the under-five mortality rate. The maternal mortality ratio, which was estimated at 1,600 deaths per 100,000 live births (RAMOS I 2002), has been significantly declined to 327 maternal deaths per 100,000 live births (AMS 2010).

A major contributor to these advances has been the rapidly increasing number of skilled health care providers delivering quality health care services. Between 2003 and 2012, the number of graduated midwives in Afghanistan increased from 467 to 3,001, according to the Afghan Midwifery Education and Accreditation Board report. In addition, there has been a gradual increase in the number of births attended by skilled birth attendants (SBAs). In 2006 the Afghanistan household survey showed that 19% of births were attended by SBAs, while the National Risk and Vulnerability Assessment 2007/2008 showed that 24% of women delivered with a skilled birth attendant. More recently, the Ministry of Public Health (MoPH) Partnership Contracts for Health 2010 Household Survey showed that about one-third (34%) of deliveries were attended by an SBA.

New providers in all categories (e.g., physicians, nurses, midwives, and community health workers) have been trained in pre-service programs, and many of those already providing services have been equipped with new skills through in-service training. In-service training remains the primary mechanism that practicing health care providers use to maintain their skills and acquire new ones.

PROBLEMS AND CONSTRAINTS

During the last decade, almost all training programs for capacity building of health sector personnel have been managed by different organizations and there hasn't been proper planning for training programs at the national level. A systematic and unified training needs assessment was not in place to identify personnel's training needs in the health sector. Lack of coordination, duplication of programs, use of non-standard training materials, lack of adequate facilities, provision of training by uncertified trainers and facilitators and poor quality of delivered training programs were the main challenges on the way.

Training information management was not also fully functional and the collected and banked data in MoPH training database was only covering MoPH related training programs and few of stakeholders' training information. The information in the training information database was rarely utilized for planning and management of training programs at the national level.
The identified key challenges in the field of capacity building and in-service training include the followings:

- Poor program planning and unavailability of information for planning of need based capacity building programs.
- Lack of appropriate and comprehensive information on health personnel training needs that can help develop a national capacity building plan.

- Poor capacity building programs' coordination at the national level: The capacity building programs are planned and implemented by different organizations in a scattered manner, and there is no proper coordination amongst programs at the national level.
- Availability of limited number of standard Learning Resources Package for different MoPH priority areas.
- Lack of standard training centers that can meet the in-service training requirements at central, regional and provincial levels.
- Presence of a limited number of national trainers for MoPH priority training areas.
- Lack of a functional and effective training information system at the national level: Currently, the trainings are planned and conducted by different organizations, but unfortunately, there is no reporting and information system in place for collection, banking and utilization of training data for planning purpose.
- Lack of systematic monitoring, evaluation and supervision of training programs which leads to inappropriate implementation and poor quality of delivered programs.
- No standardized, national training quality assurance system is in place.
- No post training follow-up, replication and support for trained health personnel after completion of training programs.

To address the current challenges on training programs planning, coordination, management, standardization and evidence based planning and decision making, the MoPH decided to take the lead of national capacity building and training programs, therefore, the Capacity Building Directorate of the General Directorate of Human Resources has taken the responsibility and a team of four in-service training consultants was hired in this directorate to work with the Capacity Building Directorate and other related MoPH technical departments on improvement of systems and procedures for proper coordination and implementation of training programs in Afghanistan.

In addition, the Capacity Building Directorate, as a road map for improvement of the current capacity building situation, developed the National Strategy on HRH capacity building with focus on In-service Training, which will be coordinated and implemented in close collaboration with the MoPH technical departments and other stakeholders.

Implementation of National Strategy on HRH Capacity Building with focus on In-service Training will not only contribute in development and standardization of in-service training systems, but will also help in retention of qualified health personnel through enhancement of their knowledge, skills and improvement of their performance. In addition, based on strategy planned activities, physical and web-based resource centers will be established both at the central and provincial level, which will in turn promote continuous learning and education at all the health care provision levels.

Introducing the training quality assurance, especially the recognition and awarding system will be another opportunity for recognition, motivation and retention of qualified health providers working under BPHS and EPHS.

Government Policy Statements Related to Human Resources for Health

A number of national policy and strategy documents were consulted for the development of this strategy (see Appendix C for a complete list), including the following relevant and cross-cutting statements:

Strategic Plan for the Ministry of Public Health 2011–2015

Strategic Objective 4: To provide targeted training to support the recruitment and retention of existing and new cadres of skilled staff

Priority Interventions

Lead implementation of enhanced training programs for various categories of health providers; in particular, midwifery, community nursing, physical therapy, psychosocial counsellors, medical technology, biomedical engineering, and environmental health (as outlined in the National Health Workforce Plan 2009–2013 and supported by the Human Resource Development Cluster of the Afghanistan National Development Strategy)

Afghanistan National Development Strategy (ANDS) 2008–2013

- Leadership at all levels in policy formulation and translating policies into concrete actions to ensure that actions are geared toward attaining the specified goals
- Conducting monitoring and evaluation of the implementation of health care services in order to ensure quality, equity, and efficiency of the health system
- Coordinating the contributions of all national and international agencies involved in the Health and Nutrition Sector, upholding standards and mapping services to avoid duplication and gaps
- Decentralization of appropriate responsibility and managerial autonomy to the provincial level

Health and Nutrition Sector Strategy (HNSS) 1387-1391 (2007/08–2012/13)

Efforts will be made to promote a culture of quality throughout the Health and Nutrition Sector (HNS), especially in health facilities, through leadership and good examples set in day-to-day work, strengthen the use of quality standards, and promote frequent supportive supervision. A comprehensive approach to human resource development will be developed to produce, deploy and retain where an appropriately trained health workforce possessing the variety of skills is needed to deliver affordable, equitable and quality health care services. (HNSS portion of ANDS)

NATIONAL HRH CAPACITY-BUILDING VISION, MISSION, AND GOAL

The vision, mission, and goal of the CBD/GDHR vis-à-vis capacity-building for continuing professional education systems are consistent with the above-cited policies, goals, and objectives of the Afghan Government in general and the HNSS and the MoPH in particular.

Capacity-Building Vision

Quality health services to be available to all Afghans through competent human resources for health (HRH), derived through a robust continuing professional education system supported by the CBD/GDHR.

Capacity-Building Mission

Enhance the effectiveness of HRH through establishing a comprehensive capacity-building system to support professional continuing education in Afghanistan**.**

Capacity-Building Goal

To develop a unified capacity-building system aimed at maintaining and ensuring a competent health professional workforce in Afghanistan

Objectives of the National Capacity-Building Strategy

- To develop, share, and apply national in-service guidelines for HRH, describing the respective role, responsibilities, and procedures pertinent to MoPH capacity-building for continuing professional education systems
- To develop, share, and apply training material production, inventory, and storing and distribution system
- To establish a unified TMIS, including guidelines, software, and a TMIS learning resource package (LRP)
- To develop unified MoPH in-service training monitoring and evaluation (M&E) procedures for continuing professional education
- To develop, share, and apply standards-based education management (SBEM) tools, guidelines, and implementation plan for in-service training management in Afghanistan

Targets to be achieved

Desired capacity-building results to be achieved by 2018 are as follows:

- By the end of 2018, 60% of in-service training stakeholders (governmental agencies, donors, and implementing partners) will be mapped and assessed for their capacity to provide/support in-service training
- By the end of 2018, one resource center will be established at central level
- By the end of 2018, 33 resource centers will be established in provinces
- By 2018, 50% of technical areas considered priority areas for the implementation of the MoPH National Health and Nutrition Policy (2012-2020) will have an approved LRP on file with CBD/GDHR central resource center

- By the end of 2018, 60% of trainers mapped through relevant MoPH technical departments will receive an annual external evaluation using the SBEM system
- A functional TMIS will be developed and operational (by 2015)
- Through the relevant MoPH technical departments, 60% of health care providers trained during the course of each year will receive at least one post-training follow-up (PTFU) visit during the year
- By the end of 2014, a Standard MoPH training guidelines will be developed

STRATEGIC COMPONENTS

COMPONENT 1: CAPACITY-BUILDING COORDINATION, PLANNING, AND IMPLEMENTATION

In its stewardship role related to HRH, the GDHR will seek to strengthen its Capacity-Building Directorate (CBD) to coordinate, set standards, share information, monitor and evaluate trainers and training outcomes. In addition, CBD in close collaboration with other MoPH technical departments will monitor trainings for proper service delivery. This will help to ensure the consistent provision of quality health services. (The organizational structure of the GDHR appears in Appendix D.)

Principal strategic approaches for this component include:

Strategic Approach 1.1: Support capacity-building of CBD/GDHR in functions specific to coordination, management, and monitoring of in-service training based on recent capacity assessment conducted.

Based on the 2012 capacity assessment of the CBD/GDHR related to coordinating, managing, and monitoring in-service training, the GDHR will provide organizational development support to establish processes and mechanisms to function in this expanded role. Specifically, the following interventions are suggested to build coordination, management, and monitoring capacity:

1.1.1. Recognition and mapping:
Initial assessment of all collaborators in this effort is necessary in order to gain a clear picture of the material and human resources available within the various organizations, to define their scope of work, and to ensure efficient use of resources and better coordination of activities. Current training program implementers who are conducting courses should be mapped and existing training strategies, materials, and quality assurance tools being used by different stakeholders in Afghanistan should be identified.

1.1.2 Build organizational capacity to manage a national in-service training system:

- Use rapid task analysis to identify the roles and responsibilities needed for the CBD/GDHR to implement in-service training system support. Referring to other regional bodies that are similar, such as the National Health Training Centre in Nepal (http://dohs.gov.np/?q=node/54) and the National Clinical Training Network in Indonesia may provide helpful guidance on the needed organizational structures and human resources.
- Provide a more detailed assessment of the CBD/GDHR's current structures, roles, infrastructure, and system to identify revisions needed for new functions.

1.1.3 Identification, training and certification of national in-service trainers:

- The Capacity Building Directorate through the relevant MoPH technical departments (Reproductive Health Directorate, Mental Health, Gender etc.) will identify, select, train and certify the qualified national in-service trainers for BPHS and EPHS priority training areas. This will be a temporary mechanism for identification, training and certification of national trainer, but once the medical council is established, the process will be coordinated through the established medical council.

Strategic Approach 1.2: Establishment of a Capacity-Building Committee

Until the roles and new structures required for the CBD are clearly defined, the capacity building committee will act as a technical body that will provide necessary technical inputs in planning and decision-making to CBD/GDHR. The committee will comprise governmental and nongovernmental health stakeholders, selected on the basis of predetermined selection criteria. The committee will have a specific mechanism of action and terms of reference (TORs) to be approved by MoPH authorities.

The committee will work in close coordination with technical departments of MoPH on planning, implementation, monitoring and supervision, and evaluation of the relevant in-service training programs.

Steps in Establishing the Capacity-Building Committee

1.2.1 Establish consensus for capacity-building committee (CBC)

1.2.2 In consultation with the existing Management Leadership Committee, the In-Service Training Task Force (ISTTF), and relevant partners, initiate the CBC:

- Review and finalize draft ToR and selection criteria
- Select CBC members and review their credentials
- Recommend approval
- Conduct the first committee meeting
- Finalize the mechanism and ToR for the CBC
- In light of finalized ToR, the committee develops a operational plan
- Committee members identify the reporting system

Strategic Approach 1.3: Improve Leadership, Management & Governance Practices

1.3.1 Management and Leadership Development Department (MLDD) in consultation with the MoPH/HR and MoPH Health System Strengthening programs will begin the process for materializing this concept and conduct aligning meetings.

1.3.2 Design the action plan for conducting the MOST workshops for the internal assessment (as a pre-LDP assessment tool which will create demand/sensitize and mobilize concerned parties and to prioritize challenging areas for intervention that will contribute to organizational development.

1.3.3 Identify potential competent change leaders throughout the MOST workshops and design Leadership Development Program (LDP) TOT for the new introduced participants of the MoPH to identify and involve our current trained LDP facilitators already in place in the system to conduct the ToT workshop.

1.3.4 Designate MLDD Team/Recognized LM&G facilitators to coach and manage the process of the workshops as phase wise.

1.3.5 Contribute to develop a plan for each team in coordination with their respective trained facilitators to conduct and scale up leadership process.

1.3.6 Assign two more consultants to work with the General Directorate of Human Resources, and more specifically with the Capacity Building Directorate. This team of leadership, management and governance developers will carry on the responsibilities for management and leadership capacity development at the central ministry as well as in the provinces, to maintain a pool of qualified facilitators, follow up to make sure

new habits and practices are fully integrated and monitor the quality and effectiveness of the program.

1.3.7 Eventually, establish the leadership ACADEMY through which capacity building of MoPH staff on leadership, management and governance will be led and the progress will be overseen.

COMPONENT 2: PRODUCTION AND AVAILABILITY OF MATERIALS

The availability of quality resource materials to guide in-service training throughout the country is a critical element of HRH capacity-building. The CBD/GDHR through the relevant MoPH technical departments will provide the criteria for determining whether or not materials meet quality standards. The CBD/GDHR will develop, staff, and make functional a physical and electronic (offline/online) national resource center and provincial centers that will collect, screen, and make available materials related to both the content and the process of in-service training. The relevant MoPH technical departments in close cooperation with CBD/GDHR and CB Committee will review and update the training materials regularly.

The training materials will presently be produced, reviewed, revised, and approved by the assigned technical taskforces of the relevant MoPH technical departments, however, the responsibility and authority of approval and accreditation of the training material will be shifted to the Medical Council once it is established.

Strategic Approach 2.1: Establish a standardized electronic and physical national resource center and its management system

2.1.1 Define the structure and functions of the standardized resource center for offline/online electronic distribution and the role of physical resource centers, whether central, regional, or both.

2.1.2 Identify the appropriate functions and physical location for the resource center:

- Develop e-learning and computer-based resources and identify functional requirements related to tracking downloads, distributing materials offline when needed, and so on.
- Establish a database for recording resource center materials, either linked directly to or part of the functionality of the computer-based resource center or separate.
- Identify a physical location for hosting the computer-based resource center, either on a physical server or online.
- Identify a physical location for hard copies of approved materials, either within the MoPH compound or distributed to regional centers or facilities.

2.1.3 Ensure permanent staff for the resource center within the structure of the CBD/GDHR:

- Include permanent center staff in the CBD/GDHR/MoPH organogram
- Develop TORs for permanent staff, including adequate internet technology support
- Obtain approval for resource center permanent staff

2.1.4 Obtain the required equipment to maintain a resource center with up-to-date materials and technologies (including information technology [IT] materials).

2.1.5 Establish a maintenance system for the resource center and include a budget for IT support and maintenance of the center.

Strategic Approach 2.2: Determine documents to be acquired and collect training materials

2.2.1 Conduct training materials mapping of implementing partners and other partners for in-service training. A web-based survey will be the most efficient means to gather information and collect materials from the key training partners.

2.2.2 Develop a web-based and phone-based questionnaire for collecting in-service training materials from implementing partners.

2.2.3 Register in-service training materials from NGOs and other stakeholders through the Grants and Contracts Management Unit.

2.2.4 Using established quality assurance tools, the Capacity Building Committee and the related MoPH technical departments should review the collected materials and identify which materials meet established standards (see Component 5).

Strategic Approach 2.3: In collaboration with partners, as appropriate, produce, update, revise, standardize and approve in-service training materials

2.3.1 Develop standard MoPH training guidelines showing the procedures to be followed (i.e., a Basic Package of Health Sector In-Service Training Services).

2.3.2 Define training needs assessment procedures and tools, based on a review of existing tools.

2.3.3 Conduct a training needs assessment through the MoPH relevant technical departments followed by a gap analysis.

2.3.4 Plan for acquiring/producing, categorizing, and prioritizing in-service training materials based on needs identified in the training needs assessment (see Component 5).

2.3.5 Identify training materials that require production, revision, adaptation, and translation through the Capacity Building Committee and the MoPH relevant technical departments.

2.3.6 Get approval for produced and revised in-service training materials (LRP); The assigned technical taskforces in each MoPH technical department will temporarily have the responsibility of review and approval of produced, updated and revised in-

service training materials until the Medical Council is established. Once the council is established, the responsibility and authority of training materials approval will be shifted to them.

2.3.7 Allocate a budget for the production, revision, translation, editing, and printing of approved in-service training materials.

2.3.8 Arrange for electronic distribution, printing, and publishing of approved in-service training materials.

2.3.9 Inventory, store, and distribute approved, published materials via a database for internal tracking, via the web, and also via paper for external distribution.

Strategic Approach 2.4: Establish in-service training resource centers at the provincial level

Although materials will be distributed primarily electronically, provincial-level resource centers can provide printed hard copies, simulation centers for practice with models, and computers for e-learning. To make training materials available closer to the locations where they will actually be used, provincial resource centers with close links to the national center should be established. Provincial HR officers will be responsible for the development and management of the provincial resource centers in close collaboration with CBD/GDHR.

2.4.1 In collaboration with key stakeholders, define the role, function, and infrastructure requirements for in-service training resource centers at the provincial level, including whether they will provide hard copy materials only or support practice through simulation and e-learning as well.

2.4.2 Develop standard processes to ensure that most recent and approved versions of materials are distributed electronically on a regular basis, and establish a supply and maintenance system to ensure delivery of printed training materials from the central office to provincial offices.

2.4.3 Develop a standard recording and reporting system for in-service training resource centers (linked with Components 3, 4).

COMPONENT 3: TRAINING MANAGEMENT INFORMATION SYSTEM

An important component of the capacity-building strategy is the TMIS. The TMIS supports the national strategy of the MoPH to use data to drive decision-making related to in-service training. The CBD/GDHR will “own” the TMIS, and its personnel will coordinate and manage the activity in collaboration with the Health Management Information System (HMIS) Department. A functioning and supported TMIS will provide data that the Capacity-Building Directorate will use to:

- Document training programs, by cadre and topic area
- Track and document trainer development progress
- Forecast the need for additional training
- Rationalize and reduce overlap and duplication in the training provided
- Document basic monitoring and evaluation indicators related to the numbers of participants trained

Currently, the MoPH does not have an official, national TMIS in place. Therefore, as part of the capacity-building strategy, a TMIS will be established that can be accessed both from within the Ministry's internal network and from the provinces. NGOs may be required to use the TMIS to access training data, document their provided trainings and required indicators, and avoid duplication. To achieve a cost-effective, functioning TMIS, the MoPH will need to:

- Build a web-based system that is available in three languages: Pashtu, Dari, and English; and
- Identify an up-to-date, highly functional, commercially available system (e.g., TrainSmart or the HRMIS module on training) and customize it for the CBD/GDHR.

Strategic Approach 3.1: Establish an active training management system in the CBD/GDHR at the central level (also accessible at the provincial level) in coordination with other relevant systems (human resources, HMIS, and others)

3.1.1 Assess the training management systems in the MoPH, including:

- Software
- Hardware/infrastructure/IT support in place
- Organization
- Process for registering trainers and documenting trainer status
- Process for registering trainees
- MoPH budgeting and support process for TMIS
- Reports
- Stakeholders' analysis
- Integrating points of the TMIS with other systems

Forms from the HRMIS Strategy will be used to gather information for this assessment.

3.1.2 Assess the market for training information management tools and software:

- Experts in IT and capacity development will be hired as consultants for this activity. They will assess existing, customizable TMIS databases such as TrainSmart and the training module of HRMIS.

3.1.3 Adopt a balanced decision-making sheet to include key criteria for TMIS and compare different tools and vendors:

- Develop key criteria (checklist) for assessment of TMIS tools/software, along with user guidelines
- Develop a list of TMIS functional requirements based on the existing TMIS software and on requirements identified by users/agencies/stakeholders of TMIS
- Form a technical team, headed by an expert for decision-making, for selecting and implementing a national TMIS
- In conjunction with M&E, develop a monitoring checklist for TMIS and coordinate with M&E to ensure that it is used according to GDHR requirements

3.1.4 Identify an implementation and change management approach for TMIS:

- Resources are used for training in different ways at different areas/locations and by different departments. All departments and units conduct trainings based on their own needs or available funds, but segregated and aggregated data are not available (e.g., lists of training, titles of training, participant lists, duration, contents, training needs assessment reports, basis for selection of the trainees, trainers' lists, and so on). Based on the identified TMIS requirements (see 3.1.3. above), the TMIS will be fashioned both to respond to partners' needs and to document key monitoring and evaluation data required from training partners (see Component 4).
- As a part of change management, department heads will be made aware of the TMIS input needs they will be expected to provide and of the uses and applicability of TMIS in the different areas of human resource development and management. Web-based and live training on using TMIS will be provided.
- HR and administrative officers in all provinces will be trained to use TMIS and support the Provincial Public Health Director and the CBD/GDHR to generate and fulfil other requirements.

Strategic Approach 3.2: Use TMIS for planning courses, compiling accurate reports, and identifying the need for training

3.2.1 Orient all relevant stakeholders to the system through various training sessions/workshops:

- Prepare a one-pager with website addresses and key information for national dissemination
- Develop guidelines and an online tutorial for use by web-based and general users
- Disseminate guidance and reporting forms for all training implementers to use
- CBD/GDHR and HMIS officers will be responsible for TMIS at the central and provincial level
- A designated HR officer in the CBD/GDHR will update website on a monthly basis

3.2.2 Identify the various types of information to be made available through TMIS during the establishment of functional requirements, including:

- Pre-training:
  - Training plans updated yearly, quarterly, or monthly
  - Training needs assessment report
- Training:
  - List of trainings by content
  - Lists of national and international trainers, by trainers' status
  - List of trainees by title or type of training, by gender, by date and duration, and by province and region
- Post-training:
  - Training received
  - Post-training follow-up report

- Training reports, including aggregated pre-test/post-test results and evaluation reports as required

3.2.3 Ensure the sustainability of the TMIS in coordination with other organizations, departments, and stakeholders:

- The TMIS will be developed under the umbrella of health information system experts at the MoPH, thus ensuring long-term maintenance and support of the software
- At least one person each from the CBD/GDHR and the HMIS Department will be trained in the TMIS
- The monitoring checklist for the TMIS will be integrated with the national monitoring checklist
- To facilitate the capturing and sharing of required information, national online and paper-based forms will be created for training implementers

COMPONENT 4: MONITORING AND EVALUATION

The CBD/GDHR will work with the M&E Department of the MoPH to create an M&E system that provides useful feedback to all levels of capacity-building activities in the area of in-service training, with an eye to improving performance. The M&E system for the CBD/GDHR will be located in the M&E Department. A key element of M&E policy will be to evaluate and identify the use of evidence-based practices and to advocate for them where they are not being used (see also Component 5: Training Quality Assurance). Effective M&E will be conducted both by regular monitoring and by periodic surveys/assessments. The results of these surveys/assessments will be used for progress reviews.

In order to ensure that data will be used for better planning and decision-making, the CBD/GDHR will also collaborate closely with the HMIS Department to ensure adequate monitoring and evaluation of the implementation of the capacity-building strategy. The specific mechanisms for data collection, use, and documentation will be detailed in the M&E implementation plan.

Any population-based surveys that are undertaken during this period will include capacity-building impact and outcome indicators, wherever possible. Monitoring data will include the capacity-building output and process indicators. The data from these sources will be fed back to the relevant levels, from the district level to the national level, to be used in quality assurance and planning activities and provide feedback to the district level. Support will be provided to the various levels so that they will be able to use these sources of data effectively.

Strategic Approach 4.1: Develop national capacity-building M&E procedures

4.1.1 Develop a yearly capacity-building M&E plan in close coordination with HMIS, TMIS, and other relevant departments:

- Review the relevant strategy documents, existing indicators currently tracked by training implementers, and recommended HRH indicators (such as the 2011 Compendium of HRH Indicators[1]) to identify desired indicators for monitoring in-service training systems.

[1] http://www.capacityplus.org/hrhic/

- Based on this data, develop, define, and set performance indicators; determine sources of data and frequency of reporting, and rationalize indicators across HRMIS, HMIS, and TMIS to avoid duplication of effort.
- Set targets for the developed indicators (final and annual targets).

4.1.2 Develop capacity-building M&E guidelines in close coordination with the M&E and HMIS Departments and TMIS. The guidelines should have the following sections:

- Collection, analysis, and reporting on routine data (HRMIS, HMIS, TMIS)
- Guidelines for active monitoring (persons involved, timelines, and frequency of field visits)
- Sample forms required for training implementers
- Description of data flow (including source of data, data traffic lines, recipients, end users, and analysis levels for each hierarchical level)
- Definition of levels of use of the M&E data
- Description of M&E tools (hardware and software)

Strategic Approach 4.2: Recruit qualified personnel for capacity-building M&E unit

4.2.1 Define the capacity-building M&E structure and define the relationship between the capacity-building strategy's M&E structure and the MoPH M&E Department.

4.2.2 Develop roles and responsibilities within the capacity-building M&E structure (TORs and job descriptions).

4.2.3 Obtain approval for the capacity-building M&E structure and staffing.

4.2.4 Recruit required staff through MoPH standard procedures.

4.2.5 Train CBD/GDHR M&E staff in a minimal set of M&E procedures.

Strategic Approach 4.3: Evaluate planned capacity-building activities

Two main types of evaluation activities will be planned: regular yearly evaluation of capacity-building activities and needs-based evaluations planned by other stakeholders.

4.3.1 Conduct regular yearly capacity-building evaluations:

- Incorporate evaluation questions into the MoPH regular annual surveys
- Analyse progress through the use of data received from MoPH annual surveys

4.3.2 Use needs-based evaluations planned by other stakeholders:

- Include stakeholders' needs-based evaluations/assessments in the capacity-building annual evaluation plan
- Evaluate alternative training approaches, such as on-the-job, e-learning, mobile, or tablet delivery
- Approve stakeholders' planned evaluations/assessments by the CBD/GDHR
- Submit the evaluation result to CBD/GDHR; then use the result for future planning

COMPONENT 5: TRAINING QUALITY ASSURANCE

Ensuring the quality of the training process from the training design phase to post-training follow-up presents certain challenges. Each of the implementing partners strives to achieve quality in its training activities based on its own criteria. The partners' criteria are not all similar; some may even contradict others. In an effort to ensure uniform quality in training activities, the CBD/GDHR will develop a national quality assurance system in collaboration with the Improving the Quality of Health Care (IQHC) Unit of the MoPH. In addition, it will implement the training quality improvement process by training relevant staff in the use of this system, implementing national quality assurance standards in established training centers, and disseminating standards to implementing partners.

Strategic Approach 5.1: Develop training quality assurance system in close collaboration with IQHC unit of MoPH

5.1.1 Establish a technical training quality assurance committee and develop its TORs. Coordinate activities of the CBD/GDHR with the IQHC Unit.

5.1.2 Collect currently used training quality assurance tools and guidelines, and conduct a desk review, stakeholder interviews, and simple costing analysis to determine the desired quality assurance system.

5.1.3 Based on the selected quality assurance system, define training quality assurance system procedures, including the recognition and awarding mechanism, and develop training quality assurance standards, guidelines and tools. Identify and obtain MoPH approvals for actions the CBD/GDHR will take for training implementers who do not provide training that is consistent with established standards.

5.1.4 Develop orientation and training materials to disseminate training quality assurance tools and procedures, including recognition and awarding mechanism to implementing partners.

5.1.5 Develop the training quality assurance information management system in close cooperation with TMIS and HMIS.

Strategic Approach 5.2: Implement and coordinate training quality assurance process through IQHC Unit of the MoPH

5.2.1 Train relevant staff in the use of quality assurance system.

5.2.2 Implement training quality assurance standards (logistics, facilitators, material, etc.) to ensure the quality of in-service training in established training centers.

5.2.3 Ensure collection, banking, and use of the training quality assurance data at different levels in coordination with IQHC.

5.2.4 Coordinate incorporation of the training quality assurance system into the overall health care quality improvement system of the MoPH.

5.2.5 Establish a mechanism for networking and knowledge sharing:

- Disseminate hard and soft copies of documents (i.e. training and exercises)
- Exchange comments and feedback via internet and mobile phone
- Conduct exchange visits

TARGET GROUPS

As the final goal of the strategy is to develop a unified capacity-building system aimed at maintaining and ensuring a competent health professional workforce in Afghanistan, implementation of this strategy will contribute in capacity building and enhancement of all health sector personnel performance at different levels.

INSTITUTIONAL APPROACH

INSTITUTIONAL FRAMEWORK

As the steward of the in-service training component of the HRH, the CBD/GDHR will be the agency that in close coordination with other MoPH technical departments develops policy and strategy, sets standards, and coordinates with implementing partners and other stakeholders. In its coordination and standard-setting roles, the CBD/GDHR has primary responsibility for collection, review, cataloguing, and dissemination of materials, and for promoting quality assurance. It collaborates with other units of the MoPH in establishing and maintaining the TMIS and the M&E system. Thus, successful implementation will depend on close collaboration between different directorates and departments in the MoPH and the cooperation and support of other ministries and government agencies in various sectors: parliament, finance, education, and higher education, among others. Successful implementation will also require the development of partnerships with nongovernmental institutions such as the media, professional organizations, and the private sector.

DISTRICT AND COMMUNITY LEVELS

The CBD/GDHR through the relevant MoPH technical department will establish a working relationship with each of the implementing partners at the district level and collaborate closely with each partner to obtain materials relevant to in-service training, including clinical training materials, guidelines, training schedules, trainers' profiles, quality standards, and so on. After compiling and collating the materials, the CBD/GDHR will again through the relevant MoPH technical department feed information back to all district-level partners in the form of standardized training materials, national training calendars, national lists of qualified trainers, and so on. This close collaboration with the district-level implementers will benefit communities through strengthened training for health care providers and improved delivery of health care services.

PROVINCIAL LEVEL

Provincial health officers (PHOs) are responsible for implementing the strategy at the provincial level and transmitting it to peripheral levels, providing support there as necessary. PHOs in turn receive support and reinforcement from the national level.

Provincial Public Health Coordinating Committees have been created within each province to coordinate the activities of partners in achieving the MoPH priorities at the provincial level. In every province, multiple partners participate in implementing health programs. Under the direction of the Provincial Public Health Director, the coordinating committees will play a critical role in ensuring effective implementation of capacity-building programs throughout the province.

Because resource centers will be a valuable tool in building capacity, the CBD/GDHR will encourage Provincial Public Health Directors to set up provincial resource centers to serve the particular needs of their provinces. The CBD/GDHR and the relevant MoPH technical departments will provide technical support to the provinces to do this and will supply the provincial centers with appropriate training materials from the national center.

NATIONAL LEVEL

Success of this strategy starts with a strong and consistent leadership from the MoPH. The CBD/GDHR will oversee, advocate, coordinate, and collaborate with planned capacity building programs at national level. The CBD/GDHR will have a stewardship role and have

the responsibility to ensure the quality, effectiveness and efficiency of the programs implemented at the national level.

Coordinating a program that has a limited budget of its own and depends on other partners for funding its priorities presents a significant challenge. During this cycle, the CBD/GDHR will take a more proactive approach with its NGO implementing partners. Rather than having agencies with their own resources plan their own training agendas and develop their own cadre of trainers independently of the CBD/GDHR, the partners will be invited to develop their work plans as a function of this strategy and its priorities.

COORDINATION WITH OTHERS

MINISTRY OF PUBLIC HEALTH

As the steward of the health sector, the MoPH sets policies and standards, develops guidelines, and coordinates actions with all departments within the MoPH as well as with partners, implementing NGOs, and donor agencies. The CBD/GDHR will coordinate closely with key MoPH groups and task forces. The MoPH has established the Consultative Group for Health and Nutrition (CGHN) and task forces such as the ISTTF to provide focused technical input on specific topics. The CGHN's objective is to provide policy and implementation guidelines, intervention strategies, and program recommendations. These recommendations are then forwarded to the CGHN and the Technical Advisory Group for review before they are forwarded to the Executive Board for approval. The ISTTF has overseen the development of this strategy document.

This strategy calls for the CBD/GDHR to have partnerships with several units of the MoPH, including M&E and HMIS. Where partnerships are needed that go beyond the scope of the Capacity Building Committee, specific working groups will be created.

Within the MoPH, several directorates (e.g., Reproductive Health, Afghanistan National Public Health Institute, Child and Adolescent Health, and Nutrition) already have training activities that are under way or planned. Presently, these directorates have the infrastructure to continue their activities, whereas the CBD/GDHR is just starting to build its capacity to do so. This will not change immediately, but as the CBD/GDHR's capacity grows, it will begin to collaborate with these directorates, making their training materials (including their training, trainer and trainee data in the TMIS) available in the resource center, providing them with national quality standards, and so on. The CBD/GDHR is expected to ultimately become the focal point for coordination and management of all the MoPH trainings.

OTHER MINISTRIES

Collaboration with the following ministries will be needed to ensure the success of this strategy:

- Ministry of Education
- Ministry of Higher Education
- Ministry of Women's Affairs
- Independent Administrative Reform and Civil Service Commission

OTHER PARTNERS

The MoPH will collaborate with numerous partners to realize the goals of the capacity-building strategy, including the following:

International and Bilateral Agencies

The CBD/GDHR collaborates closely with several UN agencies, including the United Nations Population Fund, the United Nations Children's Fund, and the World Health Organization, which are implementing partners in various districts of Afghanistan. Close collaboration also exists with bilateral aid agencies, such as the United States Agency for International Development (USAID) and the Japan International Cooperation Agency (JICA), which are sources of material and financial support for building capacity for HRH.

NGOs

In its role as steward of HRH services, the CBD/GDHR collaborates with NGOs that implement training throughout the country. Numerous NGO partners operate the Basic Package of Health Services and Essential Package of Hospital Services throughout the country and provide in-service training as part of those functions. Recognizing these NGOs as key collaborators, the CBD/GDHR has consulted with many of them in the process of strategy development.

Associations of Health Professionals

Health professional associations, including the Afghan Medical Association, the Afghan Society of Obstetricians and Gynaecologists, and the Afghan Midwives Association, can play an important role in carrying out the capacity-building strategy. These associations can support its implementation and contribute in the following ways:

- Producing training materials and trainer guide for trainers
- Sharing their existing in-service training materials with the CBD/GDHR
- Providing in-service training
- Collaborating in the dissemination of materials
- Advising the GDHR on best practices

MECHANISMS OF COORDINATION

Effective coordination mechanisms will be used to ensure implementation of the capacity-building strategy. Coordination will be strengthened and managed through the existing coordination bodies and mechanisms.

STEERING COMMITTEES

The In-service Training Task Force (ISTTF) is the central point for coordination. This group is made up of staff of the GDHR as well as representatives of international and bilateral organizations and NGOs. Its terms of reference will be reviewed and revised as necessary to strengthen its support of strategy implementation. The ISTTF also has the capability of forming ad hoc and permanent working groups to deal with a single subject area. These subject-area working groups will perform coordination activities in their areas (e.g., training materials, TMIS, M&E, and quality assurance). The subject-area working groups may be maintained as permanent steering committees to guide the implementation of the strategy. They are reinforced by the addition of members from implementing NGOs and the private sector.

If needed, a capacity building committee could be established, perhaps evolving from the ISTTF, to meet monthly. In addition to drawing members from the CBD/GDHR, the committee would include members from bilateral, international, and NGO partners, professional associations, and related ministries. Broad coordination among various sectors of the MoPH will be ensured by the MoPH's Health Coordination Committee, which meets monthly.

Provincial Public Health Offices will be strengthened to oversee strategy implementation at the provincial level. Provincial Health Officers will receive in-service training to enable them to monitor and support implementation of the strategy in their respective provinces.

INTERSECTORAL/SECTORAL LIAISON

The capacity-building strategy depends on numerous other sectors to make the in-service training program successful and to improve the health status of the population. The Ministries of Education and Higher Education top the list of important contributors because of the need to coordinate in-service training with pre-service training for doctors, nurses, and midwives. Other sectors are also involved. Where more than simple advocacy is required with another ministry or agency, a coordinating committee of representatives of the CBD/GDHR and the involved sector(s) will be formed.

IMPLEMENTATION

ACTION PLANS

This strategy serves as a road map for achieving the level of oversight of in-service training that the CBD/GDHR wishes to achieve. Once approved, more detailed planning will begin. An overall implementation plan will be developed by the CBD/GDHR, which will indicate the actions to be taken and the general time frames and units responsible for taking them. The CBD/GDHR will also develop an annual work plan that will identify in further detail the actions to be undertaken during the course of the first year, including projected time frames.

Implementing NGO partners will be strongly urged to develop annual action plans for their in-service training activities based upon the CBD/GDHR plan. Provincial Public Health Offices will be asked to develop provincial implementation plans in collaboration with all the implementing NGO partners in their province, in order to ensure coordination of in-service training in each province. These plans will be negotiated with the CBD/GDHR to ensure that they are comprehensive and that they avoid unnecessary overlap and conflict with other provinces' plans.

ADVOCACY AND SUPPORT

Strategic objectives in areas such as information dissemination, information management systems, monitoring and evaluation, and quality assurance will be achieved primarily through advocacy with key ministry departments, other ministries, funding agencies, implementing NGOs and other partners, since the CBD/GDHR does not have direct control over these ministries and agencies. Designated staff members will be responsible for promoting their area and advocating with the relevant ministry or agency to achieve desired outcomes. They may also create joint committees or task forces representing all the concerned agencies in order to move the strategy ahead.

INFORMATION DISSEMINATION

Many of the approaches in this strategy require that strategy implementers at all levels of the system develop new skills and NGO partners become increasingly aware of the availability of CBD/GDHR services to support them. For this reason, a major activity at the national level will be to develop the CBD/GDHR's information dissemination capability in order to inform Provincial Public Health Offices and NGO partners of the resources available to them.

BUILDING CAPACITY

The entire thrust of this strategy is to support the CBD/GDHR as it evolves into its role as the in-service training coordinating, managing, and monitoring body. However, to be able to fulfil this role, the CBD/GDHR needs to have its own capacity strengthened. The 2012 GDHR Capacity Assessment Report indicated some areas that require strengthening before the directorate can fulfil its mission, including the following:

- The capacity of the directorate staff to effectively plan, coordinate, and communicate the national in-service training program needs to be created, and processes need to be established for taking on this significant new role
- The CBD/GDHR currently does not have the systematic, operational, or human resource support it needs to function in an effective way as the national steward and technical expert for in-service training

The CBD/GDHR will actively seek the reinforcement it needs in these areas by; a) endeavoring to increase its resources, both from governmental and nongovernmental sources, b) strengthening its own staff's skills so that they will be better equipped to carry out their responsibilities and c) encouraging its partner agencies to participate in this capacity-building objective

RESOURCES REQUIRED

At present, all training activities for health care service providers are funded through implementing partners from sources outside the country. Thus, the MoPH is unable to control, coordinate, and ensure the uniformity of the national training program. During the implementation of this strategy, steps will be taken to redirect the funds coming from outside sources through the Grants and Contracts Management Unit, thus giving the MoPH greater control over the use of these funds.

In addition to the financial support that implementing partners receive for their own training activities, other governmental and nongovernmental funding sources will be required to implement this strategy. The level of funding needed to support planned human resources, infrastructure, equipment, supplies, and transport activities will be determined. Government's costs will be identified. The resources needed and available to implement the strategy in different parts of the country will vary, but the CBD/GDHR will collaborate with Provincial Public Health Offices to ensure that in-service training is adequately represented in provincial health plans and budgets.

Individual activities under each strategic component will be planned and costs will be determined, and the source of funds for each activity will be identified. In many instances, multiple sources will be tapped for a single intervention.

HUMAN RESOURCES AND DEVELOPMENT

The focus of this strategy is on preparing the CBD to function as the national body that will support and oversee the continuing professional education of the health care workforce. The direct beneficiaries of the strategy will be the implementing NGOs that provide in-service training, the trainers who work with them, and the national and provincial trainers. These individuals and agencies will benefit by having their skills reinforced and by having more resources at their disposal to support them in performing their duties.

MONITORING AND EVALUATION

POLICY

Monitoring and evaluation of the implementation of the strategy will be performed through regular monitoring and periodic surveys. Data from the monitoring and surveys will be used for progress reviews of the CBD/GDHR itself and the implementing NGO partners. The CBD/GDHR will use its M&E system in conjunction with the M&E Department of the MoPH to provide useful feedback to partners at all levels of the health system, with an eye to improving in-service training quality and performance.

Evaluation of the capacity-building strategy will take place on an annual basis, in conjunction with other yearly evaluations done by the MoPH, and will consist of an annual survey conducted by the M&E Unit and a review of the monitoring data contained in quarterly reports. In addition, implementing partners will perform other evaluations during the course of each year under different contexts and for their own purposes. The findings from these evaluations may be useful for guiding the strategy and will be carefully reviewed by the CBD/GDHR for possible incorporation into the following year's work plan.

Monitoring and evaluation data will come to the CBD/GDHR from all levels of the system (district, provincial, and national). Monitoring information will come from the standard quarterly reports that implementing partners will be required to submit, as well as from training, trainer, and trainee information collected by the TMIS. Data will be analysed by the directorate and used to make minor adjustments in the strategy and to guide the development of the annual work plan for the following year. Analysed data will be fed back to the provinces and to the implementing partners for their use in modifying their own programs. Aggregated feedback will be made available to all partners through the TMIS, and specific feedback will be sent to individual Provincial Public Health Offices and implementing partners.

INTERNAL MOPH PROCESSES

In order to ensure that data will be used for better planning and decision-making, the CBD/GDHR will collaborate closely with the HMIS and M&E Departments to ensure adequate monitoring and evaluation of the strategy implementation. The specific mechanisms for data collection, use, and documentation will be detailed in the implementation plan.

In-service training surveys during this period are expected to include outcome, and possibly, impact indicators. Monitoring data collected by the CBD/GDHR will include output and process indicators. The data from these sources will be fed back to relevant levels, from district-level trainers to the national level, to be used in quality assurance and planning activities. Stakeholders at the various levels will be encouraged to use these sources of data effectively.

MONITORING INDICATORS

The CBD/GDHR will use output and process indicators to measure progress on all activities listed in the implementation plan. Output and processors indicators include:

- Percentage of capacity-building stakeholders mapped by CBD/GDHR
- Number of resource centers established, furnished, and made functional
- Percentage of technical areas pertinent to the priority components of the HNSS that have an approved LRP at the CBD/GDHR resource center

- Percentage of trainers having received at least one SBEM external assessment in one year
- Functional TMIS developed and used
- Percentage of trained health care providers who have received at least one PTFU visit in one year

A complete description of each of these indicators, along with the source of the data and yearly target for each indicator, appears in Appendix B. Data for these indicators will be collected as a part of the monitoring activities of the CBD/GDHR M&E Unit and will come from regular progress reports. Data for the outcome and impact indicators will be collected from special surveys organized by donors and implementing partners. The CBD/GDHR will collaborate with any stakeholder planning a relevant survey to include questions that will provide outcome and impact information.

OPERATIONAL RESEARCH

If an important question related to the strategy arises for which monitoring and surveys do not provide the answer, operational research may be employed. A study could be designed and carried out to find the answer, and the results would then be fed back to the appropriate levels of the health system as part of the normal feedback mechanism. Special studies such as these would have to be funded by one or more stakeholders in coordination with the CBD/GDHR.

OVERALL STRATEGY REVIEW MECHANISM AND TIMING

The information generated by the M&E system will be used to assess progress on the implementation of the capacity-building strategy and to make necessary adjustments. Progress will be reported to the relevant authorities and partners to ensure accountability and to motivate further progress. A national review workshop will be conducted annually at which the M&E Unit will analyse data and provide feedback to the relevant MoPH divisions and NGO implementing partners. This data will be used in the preparation of the next year's annual work plan.

Progress on the implementation of the strategy will also be reviewed annually at the provincial level by the Provincial Health Coordination Committee (PHCC). Information on progress on HRH capacity-building will also be provided to the Consultative Group for Health and Nutrition and the Technical Advisory Group for their feedback and recommendations.

CONTACT DETAILS

The Director of the Capacity-Building Directorate is primarily responsible for the implementation of this strategy. The General Director of the GDHR will oversee all aspects of the CBD's work. The M&E portion of strategy will be implemented in collaboration with the M&E Department of the MoPH, and the TMIS portion will be implemented with HRMIS and the HMIS Department of the MoPH.

APPENDIX A: PRINCIPAL CONTRIBUTORS TO THE CAPACITY-BUILDING STRATEGY

No.	Name	Organization
1.	Dr. Ahmad Jan Naeem	Deputy Minister of Policy and Planning, MoPH
2.	Dr. Najia Tariq	Deputy Minister of Health Service Care Provision, MoPH
3.	Dr. Ehsanullah Shahir	General Director of Human Resources, GDHR, MoPH
4.	Dr. Jan Mohammad Jebran	Capacity Building & Organizational Reform Director, GDHR, MoPH
5.	Dr. Mohammad Masood Arzoiy	In-Service Training Manager, GDHR, MoPH
6.	Dr. Mohammad Nadim Kaihan Niazi	In-Service Training Advisor, GDHR, MoPH
7.	Dr. Mohammad Muneer Sarwari	In-Service Training Advisor, GDHR, MoPH
8.	Dr. Sadia Fayaq Ayubi	Reproductive Health Director, RHD, MoPH
9.	Dr. Noor Mohammad Arzoie	Policy and Planning Consultant, GDPP, MoPH
10.	Dr. Homa Kabiri	Director of Residency Programs, GDHR, MoPH
11.	Dr. Gulam Sarwar Homayee	Senior Consultant, GDHR, MoPH
12.	Mr. Hamed Rahimi	Training Information and Data Collection Officer, GDHR, MoPH
13.	Dr. Shekib Ludin	HRMIS Consultant, GDHR, MoPH
14.	Mr. Gabriel	International HR Consultant, GDHR, MoPH
15.	Mr. Mahbob Alam	International HR Consultant, GDHR, MoPH
16.	Dr. Abdul Ali Waris	Leadership & Management Team Leader, MLDD, MoPH
17.	Ms. Samira Hakimyar	Database Officer, GDHR, MoPH
18.	Dr. Atiqullah Ebady	Training Coordinator, RHD, MoPH
19.	Dr. NajibaYaftaly	IQHC Consultant, RHD, MoPH
20.	Said Yaqub Azimi	Health Management Information System\MoPH
21.	Dr. Abdul Wasi Asha	Analysis officer, M&E, MoPH
22.	Dr. Hematullah Shafiq	Head of Health Promotion\MoPH
23.	Dr. Atiqullah Najib	CBHC Master Trainer, CBHC, MoPH
24.	Dr. Bashir Sarwari	Director of Mental Health and Drug Demand Reduction, MoPH
25.	Dr. Khesraw Parwiz	Mental Health Consultant, MoPH
26.	Dr. Karima Mayar	Coordinator for IQHC, IQHC, MoPH

27.	Dr. Homa Akseer	Training Coordinator, MMH, MoPH
28.	Dr. Amir Mohammad Saidi	Training Technical Advisor, ANPHI, MoPH
29.	Dr. Hedayatullah Saleh	Technical Director LMG-AF/MSH
30.	Dr. Abdul Shakoor Hatifie	Program Manager for In-Service Training LMG-AF/MSH
31.	Dr. Zulaikha Anwari	HSS Program Manager, LMG-AF/MSH
32.	Dr. Partamin	Technical Director, Health Services Support Project
33.	Dr. Faridulah Attiqzai	Director Program Operation\Deputy Chief of Party, HSSP
34.	Dr. Rahila Juya	Reproductive Health Specialist, HSSP
35.	Dr. Basir Farid	Quality Assurance Manager, HSSP
36.	Dr. Sima Faizi	In-Service Training Officer, HSSP
37.	Dr. Ershaduddin Ziayee	In-Service Training Officer, HSSP
38.	Dr. Adela Kohistani	Family Planning Officer, HSSP
39.	Dr. Adela Mobasher	RH\MCH National Professional Officer, WHO
40.	Dr. Tahir Ghaznavi	National Program Officer, UNFPA
41.	Izumi Murakami	Chief Advisor, RHP2, JICA
42.	Dr. Zainullah Wakil	Technical Consultant, JICA
43.	Dr. Farhad Payman	General Director ,OHPM

APPENDIX B: CAPACITY-BUILDING PROCESS AND OUTCOME INDICATORS

No.	Indicator	Definition	Indicator metrics	Target 2014	Target 2015	Target 2016	Target 2017	Target 2018	Reporting frequency	Source and means of verification
1	Percentage of capacity-building stakeholders mapped by CBD/GDHR	Capacity-building (CB) stakeholder: governmental, nongovernmental, and private organizations providing in-service training for health providers. The indicator monitors the proportion of CB stakeholders mapped by the CBD/GDHR.	Numerator: Number of CB stakeholders assessed by the CBD/GDHR Denominator: Number of CB stakeholders identified during mapping; revised annually Calculation: Numerator/ Denominator x 100	15%	30%	40%	50%	60%	Annual report	IST Department's reports
2	Number of resource centers established, furnished, and made functional	Count of resource centers	Total number of centers established, furnished, and made functional			1 central		33 provincial	Annual report	IST Department's reports
3	Percentage of technical areas pertinent to the	The priority components of the HNSS will be reviewed	Numerator: Number of technical areas that have an approved LRP	5%	15%	25%	35%	50%	Annual report	IST Department's reports

No.	Indicator	Definition	Indicator metrics	Target 2014	Target 2015	Target 2016	Target 2017	Target 2018	Reporting frequency	Source and means of verification
	priority components of the HNSS that have an approved LRP at the CBD/GDHR resource center	by the respective technical directorates and the most important technical areas for each component will be identified and reported to the CBD/GDHR. The number of areas that have an LRP registered with the CBD/GDHR will be estimated as a percentage of the total number of technical areas.	Denominator: Number of technical areas related to HNSS Calculation: Numerator/ Denominator x 100							
4	Percentage of trainers having received at least one SBEM external assessment in one year	Trainers will be assessed by external CB stakeholders (CBD/GDHR and other training implementers). The percentage of mapped trainers assessed will be calculated.	Numerator: Number of trainers having received an external SBEM assessment Denominator: Number of trainers mapped by the CBD/GDHR Calculation: Numerator/	10%	20%	35%	50%	60%	Quarterly	Training quality assurance reports

No.	Indicator	Definition	Indicator metrics	Target 2014	Target 2015	Target 2016	Target 2017	Target 2018	Reporting frequency	Source and means of verification
			Denominator x 100							
5	Functional TMIS developed and used	A comprehensive TMIS that collects, compiles, analyses, and disseminates information for planning and decision-making is available.	Qualitative		TMIS available by the end of 2014	TMIS operational	TMIS operational	TMIS operational	Quarterly	TMIS reports
6	Percentage of trained health care providers who have received at least one PTFU visit in one year	A list of health care providers receiving training will be generated from the training reports submitted throughout the year. The percentage of providers who have received at least one PTFU visit will be calculated.	Numerator: Number of health care providers who have received at least one PTFU visit during the year Denominator: Number of health care providers having received in-service training Calculation: Numerator/ Denominator x 100	10%	20%	35%	45%	60%	Quarterly	PTFU reports

APPENDIX C: DOCUMENTS CONSULTED

2012 GDHR Capacity Assessment Report

Afghanistan Health Indicators, Fact Sheet (August 2008)

Afghanistan Mortality Survey 2010

Afghanistan National Development Strategy 1387—1391 (2008–2013)

A Basic Package of Health Services for Afghanistan—2009/1388 (July 2009)

Health and Nutrition Sector Strategy 1387—1391 (2007/08—2012/13)

Health Strategy Development: A Developer's Guide (February 2009)

MoPH Strategic Plan 2011

National Health Workforce Plan—Discussion Draft (September 2009)

National Human Resource Development Plan for Reproductive Health with Special Focus on Needs for Safe Motherhood—Final Draft (July 2008)

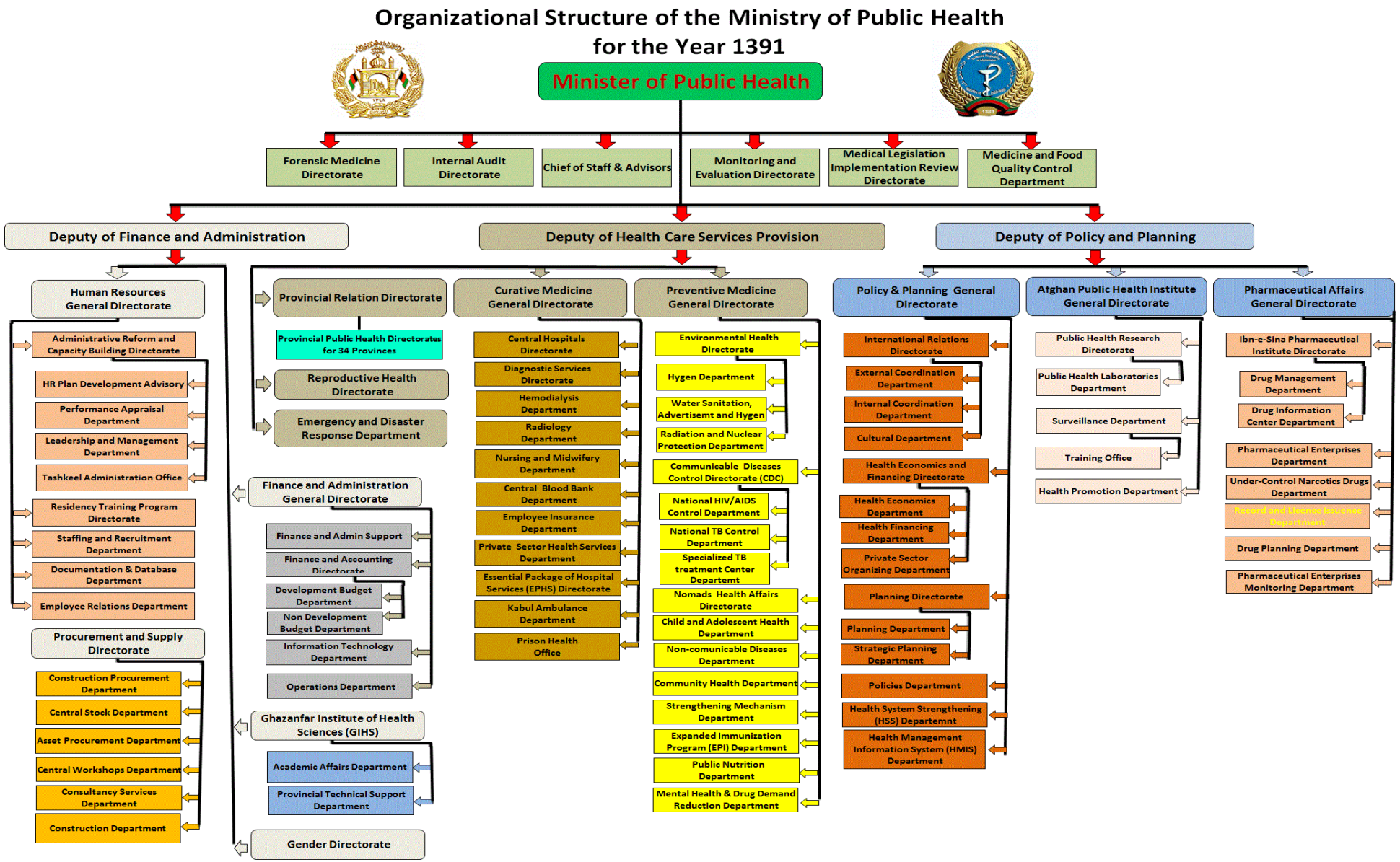
National Policy and Strategy for Nursing and Midwifery Services 2011–2015

National Reproductive Health In-Service Training Strategy 2007–2009 (January 2007)

Strategic Plan for the Ministry of Public Health (2011–2015) (2011)

The State of Human Development and the Afghan Millennium Development Goals in Afghanistan Human Development Report 2007

APPENDIX D: GDHR ORGANIZATIONAL CHART



This document was developed and published with technical and financial support from the United States Agency for International Development (USAID) through the Leadership, Management and Governance (LMG) project, implemented by Management Sciences for Health (MSH) under Cooperative Agreement # AID-OAA-A-11-000 15, and the Health Services Support Project (HSSP) implemented by JHPIEGO under Cooperative Agreement # 306-A-00-06-00523 - HSSP. The views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.