Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 21-Apr-2022 | Report No: PIDA33779

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Afghanistan	P178775	AFGHANISTAN HEALTH EMERGENCY RESPONSE (HER) PROJECT	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
SOUTH ASIA	01-Apr-2022	10-May-2022	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	United Nations Children's Fund (UNICEF)	United Nations Children's Fund (UNICEF)	

Proposed Development Objective(s)

The Project Development Objective (PDO) is to increase the utilization and quality of essential health services in Afghanistan.

Components

1. Urgent provision of essential primary and secondary health services
2. Strengthening service delivery and project coordination

The processing of this project is applying the policy requirements exceptions for situations of urgent need of assistance or capacity constraints that are outlined in OP 10.00, paragraph 12.
Yes

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	333.00
Total Financing	333.00
of which IBRD/IDA	0.00
Financing Gap	0.00

DETAILS

Non-World Bank Group Financing

Trust Funds	333.00
Afghanistan Reconstruction Trust Fund	314.00
Global Financing Facility	19.00

Environmental and Social Risk Classification

Substantial

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. In response to the crisis in Afghanistan, the World Bank (WB), Afghanistan Reconstruction Trust Fund (ARTF) donors, and international partners have found pragmatic ways to provide support for essential basic services to the Afghan people. On November 30, 2021, the World Bank's Board of Executive Directors supported Approach Paper 1.0[1] for an immediate Transfer Out of $280 million of uncommitted ARTF funds to World Food Programme (WFP) and United Nations Children's Fund (UNICEF)[2] for humanitarian gap financing, following a decision by the ARTF donors. On March 1, 2022, responding to requests from the international community, the Board approved Approach Paper 2.0[3] ("Approach 2.0") which aims to protect the vulnerable, help preserve human capital and key economic and social institutions, reduce the need for future humanitarian assistance, and improve gender equality outcomes. This includes financing, analytical work, and coordination/convening opportunities. A key element of this support will be Recipient Executed grants, to be decided by the ARTF and made off budget and outside of the control of the interim Taliban administration (ITA), to United Nations (UN) agencies and potentially international and national non-governmental organization (iNGOs). Approach 2.0 is designed to respond flexibly, based on experiences of early implementation, and informed by strong coordination among the development partners.

2. Approach 2.0 prioritizes partnership with other funding sources in support of the Afghan people, including from multilaterals like the Asian Development Bank (ADB), European Union (EU), and Islamic Development Bank (IDB) and the Special Trust Fund for Afghanistan (STFA) managed by the United Nations Development Program (UNDP); bilateral partners; and international NGOs. The Bank's Afghanistan Futures analytical work is supporting United Nations Assistance Mission in Afghanistan (UNAMA), multilateral and bilateral partners in the development of a simple prioritization and reporting framework to support an agile aid architecture that can respond to the magnitude of the crisis in basic services and livelihoods.

[1] Afghanistan Immediate-Term Approach Paper, November 12, 2021, SecM2021-0292
[2] In partnership with the World Health Organization (WHO)
[3] Afghanistan Approach Paper 2.0: Options for World Bank Engagement to Support the Afghan People, February 15, 2022, R2022-0018/IDAR2022-0036

3. The Bank and the ARTF has taken a programmatic approach of engaging in four priority sectors: education, livelihoods, agriculture, and health. The support to the health sector focuses on primary health centers (PHCs), as well as secondary care, in rural and urban settings and is targeted to reach the most vulnerable Afghans in the post-August 15 environment. The support to the agriculture sector responds to the critical food production situation by providing seeds needed for the next planting season and other support to farmers to improve food security. The livelihoods support focuses on cash-for-work to provide short-term opportunities and deliver essential services in rural and urban areas. The support for education remains under development with a focus on access to primary and secondary education and on girls and women teachers. Entry Criteria for Access (ECA) are being introduced, including the principles of equitable access for women are maintained. In addition, support is being provided to two cross-cutting engagement areas: the establishment of the Humanitarian Exchange Facility (HEF) and capacity-building support to non-governmental organizations (NGOs). Together, these activities are designed to respond rapidly to the situation in Afghanistan and help reduce the need for future humanitarian assistance.

4. Afghanistan achieved important development gains between 2001 and 2021, driven by the reestablishment of a basic functioning state and a huge influx of international grant support. The economy expanded rapidly, driving a 75 percent increase in average real per capita incomes. Afghanistan experienced rapid improvements in literacy, life expectancy, infant mortality, and access to basic infrastructure and services. These gains were achieved with the support of the international community, with grants equal to around 45 percent of gross domestic product (GDP) financing around half of the government budget and 75 percent of total public expenditure. The WB provided critical support to core state functions, including administering national programs for primary health and, basic education, and community development.

5. Development gains are now at high risk, with Afghanistan facing a major economic crisis. The August 15, 2021, crisis has resulted in an abrupt cessation of most international aid and all international security assistance. This has disrupted core government services and caused contraction in aggregate demand. Reductions to grant inflows have left Afghanistan without a source of hard currency to finance critical imports (grants previously financed a trade deficit of around 35 percent of GDP, with aid inflows providing hard currency to pay for critical imports including electricity, food, fuel, and medical supplies). The exchange rate has depreciated by 15 percent against the US dollar since August 2021. As a result of international sanctions, Afghanistan has lost access to international reserves while linkages to the international financial system have been disrupted, driving the financial sector into crisis. Unless mitigating measures are taken, fiscal contraction and disruptions to private sector activity are expected to lead to a 30 percent reduction in economic output over the year from August 15, 2021.

6. The crisis is having extreme impacts on firms and households. Two-thirds of businesses have experienced a decline in consumer demand while firms report having laid off more than half of their employees on average. One in four businesses has closed operations. Reduced availability of household products is driving increasing prices with annual inflation for a package of basic household goods reaching around 40 percent. More than two-thirds of households are unable to cover basic food and non-food needs, with around one-third of households unable to cover even food needs. Extreme poverty has led to the widespread adoption of harmful coping mechanisms - such as borrowing at high interest rates, consumption, or sale of assets, and reducing investment in human capital. This will have long-term consequences, creating a cycle of poverty. Disruption to health services has further undermined Afghanistan's capacity to manage the ongoing COVID-19

crisis (Afghanistan has recorded a total of around 178,513 cases and 7,680 deaths as of April 19, 2022[4], but actual cases and deaths are likely to be far higher given limited testing).

7. International efforts are underway to address humanitarian needs and to provide support for essential basic services. While almost all development assistance has paused, humanitarian actors remain active on the ground. UN agencies as well as I/NGOs are addressing food security and supporting the continued provision of education and other vital services. The United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) assessed calendar year 2022 humanitarian financing needs at US$4.4 billion, with 24.4 million Afghans in need of assistance.

8. The ITA is facing major challenges to effective governance. No country has recognized the ITA to date. The ITA is facing major fiscal constraints, with many government workers remaining unpaid.[5] Priorities remain unclear to the international community, with policy decisions often appearing subject to substantial regional variation (including policies regarding girls' access to education). Repeated commitments to establish an inclusive government are yet to be borne out, with women entirely excluded from leadership positions and minimal representation of minorities ethnic groups. Security conditions, however, have improved, allowing humanitarian assistance.

9. Recent developments by the United Nations Security Council (UNSC) and the US Office of Foreign Assets Control (OFAC) have clarified the space for financing flows for humanitarian and basic human needs. UNSC resolution (UNSCR) 2615 clarifies that humanitarian assistance and other activities that support basic human needs are permitted under UN sanctions against the Taliban. Coinciding with and following adoption of UNSCR 2615, the US Treasury Department announced several new General Licenses for Afghanistan, extending the scope of permissible transactions including with respect to those involving governing institutions in Afghanistan. These licenses provide additional support for humanitarian assistance and extend the scope of permissible activities.

B. Sectoral and Institutional Context

10. Afghanistan's health indicators improved substantially in the past two decades, but the maternal mortality ratio remains among the highest globally. Between 2002 and 2019, the under-five mortality rate dropped significantly from 257 to 50 deaths per 1,000 live births and by 77 percent during infancy.[6] The maternal mortality ratio halved from 1,300 deaths per 100,000 live births in 2002 to 638 in 2017, but this remains far higher than the global 2030 target of 70 deaths per 100,000 live births. Similarly, under-five stunting declined by more than 30 percent between 2004 and 2018 but remains high at 38 percent.

11. Expanded coverage of essential health interventions has contributed to these improvements in health outcomes but gaps remain. Coverage of skilled birth attendance increased more than fivefold nationally and tenfold in rural areas between 2003 and 2018. Over that same period, first antenatal care (ANC) visits increased from 16 percent to 64 percent. However, by 2018 more than 40 percent of women were still

[4] Data source: Data sourced from the World Health Organization COVID-19 database (accessed March 6, 2022). https://covid19.who.int/region/emro/country/af
[5] The ITA is estimated to be raising revenues of around US$1.5 billion per year (relative to total public spending of around US$11 billion in 2020).
[6] RIT and NSIA. 2019. "Afghanistan Health Survey 2018." April 2019.

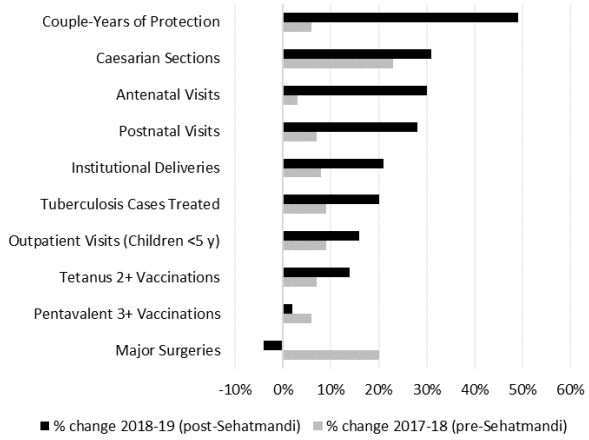
experiencing childbirth without a skilled birth attendant, only 21 percent received the recommended four ANC visits, and unmet need for modern contraception among married women stands at 26 percent. Between 2003 and 2015, coverage of pentavalent vaccine third dose in children grew from 30 percent to over 70 percent but then declined to under 57 percent in the most recent household survey in 2018.

12. Progress on health outcomes in Afghanistan is also constrained by persistent gender inequality. Girls and women's access to health services has been constrained by health system factors (distance to facilities and lack of female healthcare providers) as well as social factors (high illiteracy and low education of women, limited mobility, and socio-cultural norms that position men as decision-makers of women's health). Less than 30 percent of healthcare workers in the country are female and this can present a major constraint to access in a cultural context where male healthcare workers cannot provide key services to women. Sexual and gender-based violence (GBV) in Afghanistan is high, with more than half (53 percent) of the ever-married women ages 15-49 having experienced physical violence at least once since age 15. Child marriage is also a common issue in the country with one in three girls married before the age of 18.

13. There has been an expansion of primary and secondary level care through contracting out service delivery, with a focus on results. NGO service providers (SPs) were contracted by the Ministry of Public Health (MoPH) to deliver the MoPH's Basic Package of Health Services (BPHS which specifies essential primary care services) and Essential Package of Hospital Services (EPHS, which specifies essential secondary level hospital services). This approach allowed for improved harmonization in service delivery activities among the many donors under the leadership of the MOPH. Further gains were made through the introduction of a pay for performance (P4P) component as part of the WB's Sehatmandi Project in 2018.[7] An analysis[8] of the impact of the Sehatmandi payment model suggests that the P4P linked services increased by a median of 10 percent from 2018 to 2019 (see Figure 1). Non-P4P-linked indicators also increased during this period, albeit at a slightly slower rate. However, further gains in coverage were limited due to escalating levels of conflict, the COVID-19 impact on essential health services, remote difficult to reach areas, and persistent constraints to women's ability to seek and receive care. Furthermore, the contracting out model has allowed the rapid incorporation of innovations at scale, including contract amendments, independent data verification and extra financing for the employment of female health workers and nutrition counsellors at health facilities.

[7] Afghanistan Sehatmandi Project (P160615)
[8] Andersen Christopher T. et al. 2021. "Improving Health Service Delivery in Conflict-affected Settings: Lessons from a Nationwide Strategic Purchasing Mechanism in Afghanistan." *Journal of Global Health* 11: 04049. https://doi.org/10.7189/jogh.11.04049.

Figure 1. Improvement in Service Delivery Volume Following the Introduction of the Sehatmandi P4P.



14. Health sector financing[9] has always been highly dependent on international aid and out-of-pocket spending by households. On average between 2017-2021 the total on-budget health expenditure in Afghanistan is estimated to have been around US$286 million per year, equivalent to about 1.5 percent of GDP. Furthermore, since 2020 around US$50 million annually has been mobilized for COVID-19 related health expenditures. In addition to on-budget spending, development partners disbursed US$160 million in 2020 through off-budget mechanisms, which is significantly lower from off-budget disbursements level in 2018 (US$200 million). Annually about 46.5 percent of on-budget health spending (US$133 million) came from domestic revenue governmental sources and largely focused upon tertiary level hospital services and administrative functions at central and provincial levels of government. The remaining 53.5 percent (US$153 million) was from externally funded on-budget sources, including the International Development Association (IDA) and ARTF, and largely concentrated upon supporting BPHS and EPHS service delivery most recently through the Sehatmandi project. Overall, in 2019-20 about 85 percent of all basic/essential health services were funded through the Sehatmandi project. Between 2002 to 2016, out-of-pocket payments declined relative to other sources (85 percent to 77 percent) as government and donor spending on basic and essential healthcare increased and since then the out-of-pocket spending remained steady[10]. Given the recent crisis, one can expect out-of-pocket expenditure to increase.

15. Afghanistan's health system has been affected by the COVID-19 pandemic. As of April 19, 2022, Afghanistan registered more than 178,513 cases and 7,680 deaths due to COVID-19.[11] At that point, Afghanistan reported 185 cumulative deaths per million, while neighboring Pakistan reported 128 per million and Iran 1,557 per million. These figures are almost certainly under-reported: it is estimated that the prevalence for COVID-19 in Afghanistan by September 17, 2021, was 24 percent.[12] During these waves of infection, COVID-19 strained the health system and disrupted routine services. For example, a monthly

[9] Data source coming from https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=AF

[10] Data source coming from https://apps.who.int/nha/database/ViewData/Indicators/en

[11] Our World in Data from COVID-19 Data Repository by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University.

12 Median 24 percent (50 percent -CI 22 – 27, 95 percent-CI 17 – 34); Louca, S, Stilianos. 2021. "SARS-CoV-2 Infections in 165 Countries Over Time." *International Journal of Infectious Diseases* 111: 336–46

comparison of nutrition growth monitoring and promotion (GMP) visits points to persistent monthly reductions of 22-39 percent throughout 2020. Similarly, family planning services like intrauterine device (IUD) insertions and injectable visits remained 41 percent and 11 percent lower respectively than forecast in November 2020. In aggregate between March 2020 and July 2021, there has been under-performance in outpatient visits (-8 percent), family planning consultations (-5 percent), first ANC visits (-12 percent), institutional deliveries (-6.1 percent), and postnatal care (-8 percent).[13]

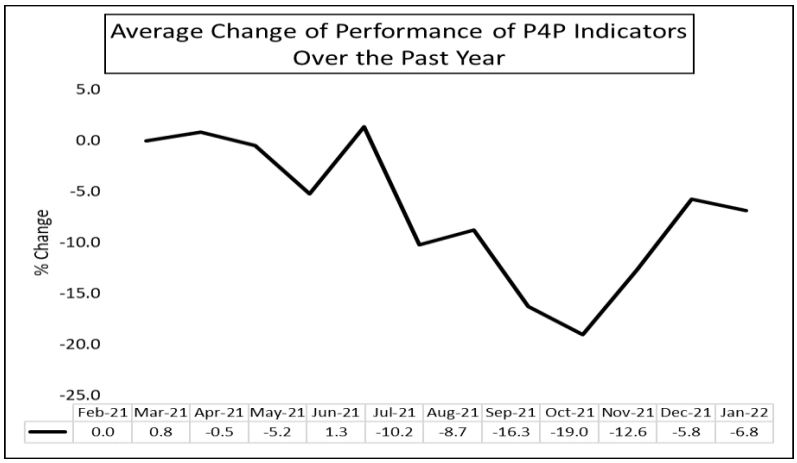
16. However, capacity to respond to the pandemic has been considerably increased given additional funding provided by the WB Emergency Response and Health System Preparedness (ERHSP) project (P173775)[14], to mitigate the COVID-19 pandemic. ERHSP measures included increased testing capacity to over 25,000 Rapid Test–Polymerase Chain Reaction tests daily, supporting COVID-19 treatment hospitals in every province, and establishing 10 oxygen plants. As of April 20, 2022, Afghanistan has administered 5,980,783 COVID-19 vaccine doses, resulting in 11.6 percent of its 39.8 million inhabitants of all ages being vaccinated (among the 19.5 million Afghans over the age of 18 years, 23.8 percent are fully vaccinated). Of the fully vaccinated population, 46. percent are women, following targeted efforts to improve female access and uptake in the last six months.[15] While this level of vaccination is an important achievement amidst the conflict and change in government that occurred in 2021, it is much lower than required to substantially reduce continued infection and lower infection fatality rates in the population. Afghanistan remains a priority country for COVAX to supply and deploy the COVID-19 vaccine. In consultation[16] with COVAX and the Global Alliance for Vaccines and Immunizations (Gavi), it was determined that COVID-19 vaccine supplies are sufficient for the foreseeable future through donated supplies (through COVAX and bilateral donations). Furthermore, in the recently approved *Sustaining Essential Services Project*, the Asian Development Project implemented a vaccine procurement component in the amount of US$20 million, along with delivery support. Hence, this project will not finance the acquisition of covid-19 vaccines nor their deployment.

17. Despite a shock to health service delivery immediately before and after the August 15, 2021, crisis, primary and secondary level health services have rebounded across the country with the resumption of donor support (Figure 2). In October 2021, to sustain the health gains achieved through Sehatmandi, one month of financial support for continued health service delivery through the remaining SPs was provided by the Global Fund, followed by three months support by the UN Central Emergency Response Fund (UNCERF) through UNICEF and the World Health Organization (WHO). In addition, the International Committee of the Red Cross (ICRC) provided financial and technical support to 34 teaching as well as specialized hospitals not included in Sehatmandi. In December 2021, the WB and ARTF partners approved a transfer-out financing package to UNICEF[17] in the amount of US$100 million to sustain basic service delivery until June 2022, based upon the contracting out model (see Annex 2 for summary of changes). Additionally funding from partners such as the EU and the United States Agency for International Development (USAID) has also supported the continuation of COVID-19 centers and COVID-19 vaccination.

[13] Analysis conducted by the Global Financing Facility for Women, Children, and Adolescents (GFF) in partnership with the World Bank's Development Economics Research Group
[14] The ERHSP project was paused on August 15, 2021 as a result of the crisis.
[15] Data sourced from MoPH Data Warehouse, Afghanistan's Online Health Sector https://moph-dw.gov.af/dhis-web-dashboard/index.html#/ipsO3PccxSj.
[16] A country level COVID-19/COVAX Partners platform, convened by the WB, was put in place in November 2020. The platform meets bi-weekly y. Its main objective is to coordinate, share information, and align donors' interventions on COVID-19/COVAX.
[17] Through the ARTF Transfer Out package to UNICEF, UNICEF provided contracts to SPs for BPHS delivery, while WHO, through an UN-to-UN Transfer Agreement, provided contracts for EPHS delivery by SPs.

18. Injections of funding have enabled the SPs to continue to deliver services more effectively. As of March 2022, 90 percent of health facilities are fully functional (as per an index of indicators including presence of staff, presence of a female worker, and availability of essential services). Among all visits to health facilities, 60 percent were by a female, which indicates the continued accessibility of medical care to women.[18] The recent attack on polio vaccinators (from still unknown attackers) is a reminder that the situation, while improved, is still volatile and long-standing safety protocols will need to be updated and implemented.

Figure 2. Average Change in Volume of Payment-linked Services from February 2021 to January 2022



19. The performance-based contracting-out model that had been adopted under the Sehatmandi project has proven resilient. This model has demonstrated the ability to adapt to changing security environments. This resilience of service delivery to insecurity reflects SP's flexibility to respond to changes and implement strategies to link with local communities and stakeholders. The model of health service delivery through non-governmental SPs has also responded well to changes in financing and institutional arrangements over the past six months. This adaptability ensured continued delivery of resources to frontline services and the delivery of a highly cost-effective package of life saving interventions at a minimum acceptable level of quality. As a result, the contracting-out model forms the basis for continued engagement in the health sector with further customization to fit the current context and the incorporation of lessons learned.

20. The nutrition situation has deteriorated significantly. According to UNICEF, an estimated 1.1 million children are expected to suffer from severe acute malnutrition (SAM) in the coming months, of which 165,000 children with complications will need admission in the hospitals. Currently, the WFP aims to meet the food and nutrition needs of 22.3 million people, while UNICEF and WHO prioritize focus on addressing the increasing burden of SAM and SAM with complications, respectively. The WFP's key strategy to combat undernutrition is to prevent and treat moderate acute malnutrition (MAM) among pregnant and lactating mothers and children using ready-to-use supplementary food (RUSF); UNICEF focuses on treating SAM children by using ready-to-use therapeutic food (RUTF), and WHO supports management of SAM children with complications in in-patient settings. Currently, the ADB, USAID, and European Civil Protection and Humanitarian Aid Operation, among others, are the key donors investing both in the treatment of MAM and SAM through partner organizations. Given this landscape, the WB has prioritized to address undernutrition in Afghanistan in a complementary way

[18] Assessment conducted by WHO/UNICEF field staff during January/February 2022

through: (i) intensifying the coverage and quality of nutrition-specific interventions in the health system; and (ii) expanding beyond the health sector to deliver nutrition information and to stimulate demand and access to services through Community Development Councils (CDCs).

21. The worsening nutrition situation and deterioration in quality of water and sanitation are increasing the occurrence of infectious disease outbreaks. The key disease surveillance system in Afghanistan is the sentinel-site based Disease Early Warning System (DEWS) which was established with technical and financial support from the WHO and USAID. Recently it has tracked a measles outbreak that has led to over 1,200 measles cases and 120 deaths.[19] It also threatens to set back the progress made by the polio eradication initiative (PEI). Additionally, improved access and security across the country has allowed the conduct of widespread house to house campaigns. Building upon these opportunities will require substantial strengthening of routine services in areas with zero dose communities.[20] This will be explicitly addressed through: (i) increased funding: greater resources will be allocated towards incentivizing SPs to increase provision and utilization of critical packages of care including immunization; (ii) integrated strengthened supervision including taking to national scale the supportive supervision intervention developed by PEI; (iii) more regular and higher quality third-party monitoring, including using the ARTF monitoring agent (MA) and potentially greater use of existing polio field monitors; and (iv) clearer accountability systems.

22. Evolving the primary and secondary health care system to deal with on-going and future threats is essential. The focus upon ensuring delivery of essential packages of life saving interventions at a minimum quality of care will remain central. However, the reduction in levels of conflict throughout Afghanistan and the re-establishment of basic financing systems does offer the opportunity to increase the coverage of services, continue to address gender constraints, and establish more sustainable systems to support service delivery. Local innovations such as incentives for hiring female health workers, paying hardship allowance to female health workers in remote areas, P4P, pooled procurement, use of data dashboards for management, demand side interventions, and cross-sectoral linkages create the potential for improving the cost effectiveness and sustainability of the humanitarian response. These efforts need to be complemented by integrated risk communication and community engagement efforts for sustained and long-term impact by promoting preventive behaviors and actions.

23. A dedicated coordination mechanism between UNDP, the ADB, the Islamic Development Bank (IDB),[21] and the WB has been established to ensure strategic and operational synergies as well as the deployment of harmonized funding flows. This mechanism is well aligned with the organizations' respective mandates and comparative advantages and is under the auspices of UNAMA. When it comes to coordination in the health sector, prior and more so, post August 15, 2021, the WB has been engaging and coordinating efforts with several stakeholders, through a weekly "Safeguarding Health Gains Partners Meeting". This group brings together key partners such as the Aga Khan Foundation Network (AKDN); ADB, Bill and Melinda Gates Foundation (BMGF), Canada, EU; Foreign Commonwealth and Development Office (FCDO); GAVI, Global Fund for Tuberculosis and Malaria (GF); ICRC; IDB; UNDP; UNICEF; USAID; and WHO. This partners' platform also

[19] As reported on 27th February 2022
[20] Communities consisting of children who have not received any of the routine vaccines for preventable childhood illnesses – a marker for lack of access to other essential services
[21] Membership forthcoming. The IDB is also exploring the setup of a humanitarian trust fund under the auspices of the Organisation of Islamic Cooperation (OIC).

ensures that complementarities are pursued, as exemplified by the ongoing dialogue on supporting the proposed Health Emergency Response (HER) Project described below.

C. Relevance to Higher Level Objectives

24. The project is fully in line with Sustainable Development Goal (SDG) 3—ensure healthy lives and promote well-being for all at all ages—and SDG 5—achieve gender equality and empower all women and girls. These goals have several targets that the project directly supports, such as reduction of maternal mortality (Target 3.1), reduction of under-five and neonatal mortality (Target 3.2), achieving universal access to sexual and reproductive healthcare services (Target 3.7), and achieving universal health coverage (Target 3.8). The project is fully in line with the WB's twin objectives of reducing poverty and promoting shared prosperity through its focus on improving the quality and coverage of health services to serve the poorest. It will contribute to a healthier population and increased human capital by enhancing the use of a set of health, nutrition, and population services with proven cost effectiveness in the context of Afghanistan. Furthermore, the project is aligned with the World Bank's Gender Strategy (2016–2023) for promoting gender equality. It contributes to key objectives of the strategy, which is improving human endowments by enhancing women's access to health and nutrition services.

25. Furthermore, the project contributes to the World Bank Group's South Asia broader strategy including the pillars resilience to internally displaced/refugee shocks, reconstruction, and the emphasis on human capital. The project is also aligned with the Human Capital Project, a global effort to accelerate more and better investments in people for greater equity and economic growth. It recognizes better access to health and nutrition as major contributors to human capital development. Lastly, this proposed project is fully aligned with the Transitional Engagement Framework (TEF) developed by the UN and validated by the Development Partner Group in early 2022. The TEF includes needs for the health sector, in the short-term.

26. The project is consistent with both Afghanistan Approach Paper 2.0: Options for World Bank Engagement to Support the Afghan People, February 15, 2022, and the World Bank Group Country Partnership Strategy FY17–20, No. 108727-AF, October 2, 2016, discussed at the Board on October 27, 2016, and with key strategies addressing fragility and its relationship to poverty and growth. The project is also aligned with key strategies addressing fragility and its relationship to poverty and growth. The World Bank Group Strategy for Fragility, Conflict and Violence (FCV) 2020-2025 provides an operating framework to address the underlying drivers of FCV across the fragility spectrum. The proposed HER project activities are intended to be fast disbursing, drawing on non-state entities that remain active on the ground and reaching areas that were not accessible prior to August 15, 2021. HER also recognizes that the situation remains fluid and is designed to respond flexibly, based on experiences of early implementation.

27. The proposed project is being processed under Condensed Procedure as per the Bank Procedure on Preparation of Investment Project Financing (IPF) for Projects in Situations of Urgent Need of Assistance or Capacity Constraints; and applying paragraph 12 of Section III of the Bank Policy on IPF to respond to a situation of urgent need of assistance and extreme capacity constraints due to conflict, fragility, and external shocks. The current political environment requires for the WB to engage and maintain development gains in the health sector.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The Project Development Objective (PDO) is to increase the utilization and quality of essential health services in Afghanistan.

Key Results

28. Progress towards achieving the PDO will be measured by the following indicators:

i. Children who have received the third dose of the Pentavalent vaccine through project-financed facilities (Number).
ii. Births occurring at project-financed facilities (Number).
iii. Visits for growth monitoring and counselling on age-appropriate infant and young child feeding among mothers of children aged 0-23 months received at project-financed facilities (Number).
iv. Provincial and regional hospitals supported by the project to provide COVID-19 treatment which have adequate treatment capacity (Percentage).
v. Average Quality Checklist score for BPHS and EPHS facilities.

D. Project Description

29. Given the urgent need for health sector financing, the design is focused upon improving the utilization and quality of the existing functioning service delivery model. HER will work through the service delivery mechanism used for public-sector service delivery since 2002. Project implementation is being shifted from the MoPH to UNICEF, however tools, instruments, model of service delivery through third parties will be sustained and capitalized upon. The project design, which is set to be implemented off-budget through UNICEF, is built with the flexibility required to respond to an evolving sector context, implementation realities and challenges on the ground, data availability, findings of monitoring activities, and ongoing operational lessons learned and takes into consideration UNICEF's existing capacity as the implementation agency for the project. In addition, given its lead role in the health sector and technical capacity in Afghanistan, WHO will have a role in the HER project through both a technical advisory and implementation role. This role will be captured through a UN to UN transfer agreement (UN- UN TA).

30. The project readiness for implementation is guided by two ECAs defined in paragraph 42 as well as by project approval and its effectiveness. The proposed activities are in line with immediate sector needs to both preserve and further enhance basic health service delivery, prioritizing reproductive, maternal, child, adolescent health and nutrition as well as infectious disease control aligned with ongoing partner efforts. Collaboration with the WHO and United Nations Population Fund (UNFPA) will be prioritized depending on needs around surveillance, outbreaks response, quality of care, capacity building, management accompaniment of SPs, broad health sector coordination, family planning, and GBV.

31. It is important to note that touch points with the ITA will be limited to information sharing, technical discussions, and obtaining approvals and clearances to access the hard-to-reach areas as well as to conduct day to day operations. The ITA will not oversee the HER project, nor manage any of the funds, decide on project beneficiaries, or engage in procurement processes. However, it will be consulted and informed, as outlined in the Stakeholder Engagement Plan (SEP).

32. Various agencies that are important partners in the health sector, such as UNDP, the WHO, UNICEF, ICRC, and the Aga Khan Development Network were assessed for this first phase to be an implementing agency of the HER project. UNICEF was selected according to the following criteria**: (i) continuation of Approach Paper 1.0 whereby UNICEF was identified to receive the funding under the ARTF Transfer Out; (ii) global and country-related experience in prior Bank contracts**, notably on institutional agreements and procedures, operational policy requirements, and operational policy flexibilities; (ii) **proven technical and operational competence** in the health sector including nutrition and water, sanitation, and hygiene (WASH) activities; (iv) **fiduciary capacity**, including the procurement capacity to enter into agreement and manage local/international NGOs for the provision of goods and services; (v) **staffing**, field and deployment capacity as well as the potential to scale; (vi) **security considerations**, with a premium placed on engagement under the UN security umbrella to mitigate security risks; and (vii) **donor alignment to minimize fragmentation as the choice of UNICEF** is aligned to the ADB's approved project in which UNICEF is the implementation partner.

Component 1: Urgent provision of essential primary and secondary health services (US$289 million of which US$270.7 from ARTF and US$18.3 million from the Global Financing Facility for Women, Children and Adolescents, GFF)

33. This component will finance the delivery of basic health, nutrition, and COVID-19 (including preparedness) interventions across all 34 provinces. The existing arrangement of contracting out health services at the province level to local and international SPs, will be retained**.** UNICEF will be responsible for contracting out SPs to deliver the BPHS/EPHS as well as other services described below. UNICEF will either launch an open competitive procurement for selection of SPs or may also consider direct selection[22] of SPs to meet the needs of the project as provided for under UNICEF policies and procedure.

i. **Sub-component 1.1: Enhancing utilization and quality of the Basic Package of Health Services and Essential Package of Hospital Services through performance-based service contracts with Service Providers (US$251.7 million).** These packages[23] will be delivered at the primary health care level as well as first, second, and provincial level hospitals. Additionally, the BPHS and EPHS include GBV services. Under this component, there will be a review of GBV referral protocols for multi-sectoral services in partnership with GBV Area of Responsibility (AOR), Child Protection AOR. Training on the protocols will be addressed under sub-component 2.1. Contracts supported by this component will use a P4P approach. Under Sehatmandi, P4P increased service volume and will continue with adaptations based on lessons learned and the current context. These adaptations will include the following: (i) regular payments will be de-coupled from data verification with necessary adjustments made to future payments; (ii) conditions for high-quality service delivery and community-based services to reach historically under-served areas[24] will be more highly incentivized; (iii) coverage forecasts used to determine payment caps revisited[25]; and (iv) adequate payments to reasonably cover running costs of health facilities including health care workers.

[22] UNICEF should develop clear criteria for direct contracting SPs, including consideration of past performance
[23] The BPHS includes maternal and newborn care, child health and immunization, public nutrition, communicable disease treatment and control, mental health disability, physical rehabilitation services, and regular supply of essential drugs. The EPHS includes specialized services for gynecology, obstetrics, neonatal care, postpartum care and complications, nutrition, orthopedics, surgical care, and respiratory and gastrointestinal services.
[24] This will be objectively defined using indicators such as zero dose childhood immunization
[25] Defined volume-based service indicators are financed through a case-based approach. Historical average productivity for each province is used to calculate minimum and maximum services, and to calculate risk for the purchaser

Critical maternal, child, and nutrition services will continue to be linked to performance -based payments. These will be identified in the project operational manual (POM).

ii. **Sub-component 1.2 Enhancing community and facility level nutrition services (US$6.3 million).** The priority[26] nutrition interventions in the BPHS and EPHS which are covered under component 1.1, will be further strengthened through additional support in the following areas:

i. **Maintenance of paid female nutrition counselors (NCs).** NCs are an existing cadre of health workers at the health facility who have a defined role in the delivery of maternal and child nutrition services as per their job description. It is critical to ensure that the SPs have NCs in all health facilities and that women can receive care from female providers. More than 2,000 female NCs will be supported. The NCs' role is being expanded beyond the health facility to the community level through planned monthly and quarterly interactions with the community health supervisor and community health workers (CHWs), where the NCs will further orient them on the importance of nutrition services and help them identify strategies to mobilize pregnant and lactating mothers and children under two to access health and nutrition services at the health facility. The CHWs will primarily provide nutrition messages and will mobilize the children for community level growth monitoring to identify malnourished children and refer them to the health facility and importantly reinforce and promote optimal caring and feeding practices. The NCs will be provided training on the required knowledge, skills, and tools to deliver community-based nutrition services and expand their community outreach. A capacity building component for SPs to develop knowledge and skills for managing and treating SAM at the health facilities will be strengthened;

ii. ***Adaption and development of behavior change communication materials and mediums focusing on key nutrition messages*** to reach the target audience and the community. All contact opportunities with the beneficiaries by the CHWs at the community level and NC at the health facility level will be utilized to reach the target audience with key nutrition messages to make them aware of the available services, their benefits and appropriate nutrition practices to increase the demand for nutrition services*; and*

iii. **Program monitoring and reporting.** The key nutrition coverage indicators related to maternal and child nutrition, including treatment of SAM, will be systematically monitored, and tracked to assess the status of nutrition service delivery and improve system performance. In addition, periodic SMART surveys will be undertaken to validate data and provide information on nutrition outcomes including stunting and wasting estimates. Linkages will be established with the WFP's prevention and MAM program to link RUSF beneficiaries to HER program interventions for maximizing impact. Duplication of nutrition activities will be minimized if additional funding is available.

[26] *Maternal nutrition:* (i) IFA and calcium supplementation; (ii) regular weight measurement; and (iii) nutrition counselling on adequate dietary diversity, consumption of adequate quantities of food, importance of compliance of consumption of iron and calcium supplements and importance of rest.

Child nutrition: (i) age-appropriate breastfeeding and complementary feeding counselling; (ii) growth monitoring and promotion (GMP); (iii) vitamin A supplementation; (vi) iron supplementation; and (viii) treatment of acute malnutrition.

Under the ARTF/WB **Afghanistan Community Resilience and Livelihoods Project - (P178760**) to be implemented by a different agency the following specific activities are also expected to enhance the nutrition component under HER: Build basic capacity of CDCs, particularly women and women's groups on: (i) maternal and child nutrition; (ii) COVID-19 prevention; and (iii) availability/access to health and nutrition services and importance. The NCs will build basic capacity of CDCs on the above aspects and help them problem solve on their nutrition and health responsibilities.

iii. **Sub-component 1.3: Enhancing the health system capacity to prevent and respond to infectious disease outbreaks and to eradicate polio (US$12.7 million).** The WB will work with WHO and other partners to ensure full COVID-19 surveillance integration with DEWS. In addition, the capacity of the health system to prevent, diagnose and treat infectious disease outbreaks (including climate exacerbated vector borne and waterborne diseases) will be further strengthened through activities to support the SPs with i) infection prevention and control; ii) improving diagnostic and reporting capacity; iii) improving treatment capacity; and iv) risk communication and community engagement to protect people and increase demand for vaccination. The SPs will develop an emergency/disease outbreak response strategy and plan to investigate, verify, and coordinate responses to emergency situations. In addition, the SPs will respond rapidly and appropriately to epidemics, mass casualties, and other health related emergencies such as road accidents, geophysical disasters (e.g., earthquakes, landslides), meteorological and/or climatological disasters (e.g., floods, water scarcity, extreme heats), and war victims) solely and/or jointly with others as needed. Polio eradication will be supported through SP contracts by incentivizing extension of services in zero dose communities and integrated polio monitoring. Additionally, a special focus under component 2 activities will be strengthening quality of care and monitoring service delivery in high-risk polio areas. WHO will play a critical role in this sub-component including: providing capacity building related to disease surveillance, rapid investigation, and rapid response including contact tracing; identifying gaps in laboratory capacity and supporting labs capacity building; establishing genome sequencing capacity; and supporting SPs to develop emergency response plans.

Component 2: Strengthening service delivery and project coordination (US$44 million of which US$43.3 million from ARTF and US$0.7 million from GFF)

34. This component aims to maintain and strengthen the systems needed to deliver high-quality services, maximize the efficient deployment of resources, and ensure accountability. These aims will be achieved through centrally managed initiatives that complement the financing channeled to SPs through the contracts described in component 1. The scope of this component is organized around four subcomponents that give the implementing UN agency flexibility to respond to emerging system needs.

i. **Sub-component 2.1 Promoting quality of care and strengthening healthcare worker capacity (US$3 million):** The contracting-out approach, and especially the P4P, has proven effective at motivating SPs to increase service volumes. However, given the heterogeneity of health worker capacity needs at subnational level, the contracting model is less well equipped to ensure investment in human resources for health workers to respond to clinical updates, emerging technologies, and task sharing. Overall, quality of care remains sub-optimal with wide variability in quality supervision and institutional culture and capacity for content of quality of care. This sub-

component would allow the implementing agency to contract training institutions and other specialized firms to implement trans-provincial training and mentorship and to broaden institutional investments to improve quality of care.

ii. **Subcomponent 2.2 Enhancing quality health products and equipment supply chains (US$6 million):** The local market is the primary source of essential medicine, supplies, and equipment to SPs. Some health facilities are reporting shortages of medicine as the most significant constraint to operations. This subcomponent will support SPs with forecasting and procurement. Support will also be provided to develop platforms for coordinated procurement and market shaping options for high-quality health products and essential equipment, including investment in improvement in routine vaccines deployment. In addition, this sub-component will finance short-term funding gaps for medicines or vaccines in the EPHS and BPHS usually funded by other sources. Investments required for vaccines would be closely coordinated with Gavi. Support will also be provided to scaling-up high-impact and innovative health products that may be missing from the private market including contraceptive implants, subcutaneous depot medroxyprogesterone acetate, misoprostol, and chlorhexidine. UNICEF will ensure close technical coordination with WHO and UNFPA for quality assurance and protocol development.

iii. **Sub-component 2.3 Strengthening monitoring and ensuring accountability (US$10 million).** The objective is to ensure that the program design elements under Component 1 translate into improved performance by SPs as well as support the quality of services delivered under component 1, thus resulting in improvements in population health outcomes. This will be achieved through the following three pillars:

- *Pillar 1: Verified data on service delivery and quality*. To avoid fraudulent claims of service volume by SPs, routine reporting data will be validated by a TPM specialized in large-scale health surveys, to be procured and selected by UNICEF (UNICEF-TPM). Health facilities will be sampled on a regular basis, and data on the number of payment-linked services provided by the SPs will be validated through register checks and beneficiary interviews. In addition, a health facility quality assessment will be conducted (which will be linked to incentives). The sampling approach will include a methodology to mitigate the risks of real or perceived collusion between SPs and monitors. As required, UNICEF or UNICEF-TPM may collect personal data of health personnel or other project stakeholders for the purposes of direct contact for verification of service delivery; personal data will be managed in line with UNICEF's policy on personal data protection.[27]
- *Pillar 2: Performance management support*. Having large number of SPs has helped the resilience of the contracting model, but this also means that there are often large differences in management and implementation capacities including in data analysis and use, supply planning, demand creation, and service delivery design. To help SPs leverage the flexibility that the contracts give them, this sub-component provides technical assistance to improve SPs performance and management, including a third-party contract or UN--UN TA with WHO on management accompaniment. This follows the model that BMGF are using in Southern Provinces with their BPHS+ initiative to ensure greater accountability and focus on quality and results. Existing or new technical support (ex.

[27] https://www.unicef.org/supply/media/5356/file/Policy-on-personal-data-protection-July2020.pdf.pdf. This policy is in alignment with international best practices with regards to data protection.

dedicated management firm or through WHO) contracted by UNICEF will provide SPs with data, analytics, and insights to help them maximize performance under their contracts. These actions will further serve as a source of quality improvement in service delivery. This technical support will also support dialogue between SPs to disseminate promising practices as well as developing lessons learned on safe delivery of services to girls and women, including services for GBV and modern family planning, identifying opportunities for male engagement in reproductive health, and coordinated activities between SPs when appropriate.

- *Pillar 3: In-depth outcome assessments*. Successful management of the health system and implementation of performance contracts is underpinned by a reliable and transparent health information system that draws on a variety of data sources to understand system performance. This sub-component will support the implementation of a comprehensive, independent facility-level assessment of the quality of care including elements of the balanced scorecard. This sub-component will also provide supplementary financing to household and beneficiary assessments (SMART surveys and mobile phone surveys) to better understand the rapidly changing health and nutrition situation in the country.

iv. **Subcomponent 2.4: Project implementation and coordination (US$25 million, US$24.3 million from ARTF and US$0.7 million from GFF, including UNICEF cost recovery and direct costs of total project cost included under the UN operational cost).** This subcomponent will support the Recipient's indirect costs and direct costs. The direct costs will focus on project implementation and coordination, as well as ensuring monitoring and evaluation (M&E) of overall institutional, strategic/programmatic, operational, and contextual risks across the program through functions across the office (e.g., financial management, human resources, supply and logistics, partners' management, information and communications technology systems and information security). It will also support the regular reporting to the WB (see Results Monitoring and Financial Management Sections). Specific activities include direct management and supervision costs required to support the implementation of the project (including the use of remote monitoring technology); including, among others, (i) handle procurement, financial management, and disbursement management, including the preparation of withdrawal applications under the project; (ii) ensure that independent audits of the project activities are carried out according to the UNICEF regulatory framework; (iii) ensure that all reporting requirements for ARTF are met according to the Project Grant Agreements; (iv) the establishment and application of grievance redress mechanisms for UNICEF supported activities, to document any possible complaints and ensure follow-up; and (v) monitor the project targets, and results in coordination with the SPs.

This project implementation and coordination function will be led by UNICEF's Health team in close coordination with UNICEF's Nutrition, WASH, Social and Behavioral Change, Child Protection and Gender teams and with support from UNICEF Project Management and Operations Units. UNICEF's health and other programs will also provide technical support to the SPs, identify and address areas of capacity building and troubleshooting, support creation on an enabling environment for the SPs and ensure minimizing of duplication and linkages with other related programmatic interventions and projects within UNICEF programs and other shareholders in the sector. This coordination is crucial to reduce duplication, plan capacity investments described in this component, and

maximize the efficient use of health sector resources. Additionally, coordination and feedback from non-governmental actors is important for ensuring the system remains accountable to communities and other system beneficiaries.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

E. Implementation

Institutional and Implementation Arrangements

35. The off-budget project will be implemented by UNICEF using their systems. Financial management (FM) and procurement assessments have been undertaken by the WB and lessons from Yemen, South Sudan, and Democratic Republic of Congo (DRC) have been incorporated. The lessons learned from the implementation during the transfer-out period (January to June 2022) indicate that risk can be further mitigated through developing a POM by UNICEF. The POM, agreed with the WB, will be finalized within one month of project effectiveness.

36. A project level committee comprising UNICEF, the WB, key UN partners such as the WHO, and ARTF donors will be put in place within one month of project effectiveness. UNICEF will manage the HER Coordination Committee (HER-CC) and provide secretariat functions. The HER-CC meetings will be chaired by WHO and USAID. The objectives of the CC are to: (i) monitor the project's ECAs; (ii) provide advisory support to HER Project implementation (ii) periodically discuss the key project deliverables and reports such as quarterly reports, third-party monitor reports, and progress on results framework indicators; ; and (iv) support and advise to address any bottlenecks that may arise during project implementation. The CC will meet on monthly basis with additional ad hoc meetings should the need arise. The TORs for the HER-CC will be an integral part of the POM.

37. UNICEF will be responsible for the overall project implementation and use of funds. UNICEF has systems and procedures to ensure transparency, accountability, and proper use of resources provided. UNICEF has already established an overall PMU to lead project implementation and manage its relationship with the SPs, contractors, and other partners involved in the implementation of the various activities. UNICEF will ensure close coordination with WHO and other UN agencies, for technical consultation and for implementation of activities as relevant and appropriate. The details of the relationship with other partners as well as all procedures and systems in place for proper management of this project will be detailed in the POM.

38. Overall coordination will be further strengthened through use of the existing Safeguarding Health Gains country platform. This platform will also support coordination between HER and other activities being supported by health sector partners, including humanitarian actors. In addition, the project will support an expanded stakeholders' meeting on a quarterly basis, which will include SPs, MoPH technical level, and civil society organizations representing health service users. These meetings will be used to discuss quarterly performance reports to understand implementation progress and to better understand the service delivery situation from the perspective of SPs and system users. These meetings will also incorporate reports from the UNICEF and ARTF- MA as well as other relevant sources of data. It will also support a longer-term policy dialogue in the health sector and conduct annual project reviews.

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