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Report No: PAD4968

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT
FROM THE AFGHANISTAN RECONSTRUCTION TRUST FUND

IN THE AMOUNT OF US$314 MILLION
A PROPOSED FIRST TRANCHE IN THE AMOUNT OF US$150 MILLION
A PROPOSED SUBSEQUENT TRANCHE IN THE AMOUNT OF UP TO US$164 MILLION

AND A
PROPOSED GRANT

FROM THE GLOBAL FINANCING FACILITY

IN THE AMOUNT OF US$19 MILLION

TO THE

UNITED NATIONS CHILDREN'S FUND (UNICEF)

FOR THE

AFGHANISTAN HEALTH EMERGENCY RESPONSE (HER) PROJECT

May 24, 2022

Health, Nutrition & Population Global Practice
South Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2022)

Currency Unit =	Afghan Afghani (AFN)
AFN 88.55 =	US$1

FISCAL YEAR
December 21 – December 20

Regional Vice President:	Hartwig Schafer
Country Director:	Melinda Good
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ABBREVIATIONS AND ACRONYMS

AA	Administrative Agreement
ACG	Anti-corruption Guidelines
ADB	Asian Development Bank
AKDN	Aga Khan Foundation Network
ANC	Antenatal Care
AoR	Area of Responsibility
APA	Alternative Procurement Arrangements
ARTF	Afghanistan Reconstruction Trust Fund
BMGF	Bill and Melinda Gates Foundation
BPHS	Basic Package of Health Services
CC	Coordination Committee
CDC	Community Development Council
CHW	Community Health Worker
CPF	Country Partnership Framework
CRI	Corporate Result Indicator
DEWS	Disease Early Warning System
DRC	Democratic Republic of the Congo
E&S	Environmental and Social
ECA	Entry Criteria for Access
EPHS	Essential Package of Hospital Services
ERHSP	Emergency Response and Health System Preparedness
ESCP	Environmental and Social Commitment Plan
ESF	Environmental and Social Framework
ESMF	Environmental and Social Management Framework
FCV	Fragility, Conflict, and Violence
FCDO	Foreign Commonwealth and Development Office
FM	Financial Management
FMFA	Financial Management Framework Agreement
FPA	Fiduciary Principles Accord
GAVI	Global Alliance for Vaccines and Immunizations
GBV	Gender-based Violence
GDP	Gross Domestic Product
GFF	Global Financing Facility for Women, Children and Adolescents
GFTM	Global Fund for Tuberculosis and Malaria
GMP	Gross Monitoring and Promotion
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
HACT	Harmonized Approach to Cash Transfer
HEF	Humanitarian Exchange Facility
HER	Health Emergency Response
HMIS	Health Management Information System
HNP	Health, Nutrition, and Population
ICRC	International Committee of the Red Cross

IDA	International Development Association
IsDB	Islamic Development Bank
IFR	Interim Financial Report
INGO	International Non-governmental Organization
IPF	Investment Project Financing
M&E	Monitoring and Evaluation
MA	Monitoring Agent
MAM	Moderate Acute Malnutrition
MoPH	Ministry of Public Health
NC	Nutrition Counselor
NGO	Non-governmental Organization
OFAC	Office of Foreign Assets Control
OIAI	Office of Internal Audit and Investigations
OPSVP	Office of the Vice President
P4P	Pay-for-Performance
PDO	Project Development Objective
PEI	Polio Eradication Initiative
PHC	Primary Health Center
PMU	Project Management Unit
PNC	Postnatal Care
POM	Project Operations Manual
PPSD	Project Procurement Strategy for Development
PS	Procurement Services
QQC	Quantified Quality Checklist
RUSF	Ready-to-use Supplementary Food
RUTF	Ready-to-use Therapeutic Food
SAM	Severe Acute Malnutrition
SC	Steering Committee
SDG	Sustainable Development Goal
SEA/SH	Sexual Exploitation and Abuse/Sexual Harassment
SEP	Stakeholder Engagement Plan
SMART	Specific, Measurable, Attainable, Relevant and Timely.
SP	Service Provider
STEP	Systematic Tracking of Exchanges in Procurement
TEF	Transitional Engagement Framework
TPM	Third-party Monitor
ToRs	Terms of Reference
UNAMA	United Nations Assistance Mission in Afghanistan
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNSC	United National Security Council
UNSCR	United National Security Council Resolution
USAID	United States Agency for International Development
WASH	Water, Sanitation, and Hygiene

WFP	World Food Programme
WHO	World Health Organization
WB	World Bank

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name		
Afghanistan	AFGHANISTAN HEALTH EMERGENCY RESPONSE (HER) PROJECT		
Project ID	Financing Instrument	Environmental and Social Risk Classification	Process
P178775	Investment Project Financing	Substantial	Urgent Need or Capacity Constraints (FCC)

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[ ] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[✓] Fragile State(s)
[ ] Performance-Based Conditions (PBCs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[✓] Alternate Procurement Arrangements (APA)	[ ] Hands-on Enhanced Implementation Support (HEIS)

Expected Approval Date	Expected Closing Date
24-May-2022	30-Jun-2024

Bank/IFC Collaboration

No

Proposed Development Objective(s)

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

Components

Component Name	Cost (US$, millions)
1. Urgent provision of essential primary and secondary health services	289.00
2. Strengthening service delivery and project coordination	44.00

Organizations

Borrower:	United Nations Children's Fund (UNICEF)
Implementing Agency:	United Nations Children's Fund (UNICEF)

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

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2022	2023	2024
Annual	85.00	198.00	50.00
Cumulative	85.00	283.00	333.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	High
2. Macroeconomic	High
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Moderate
6. Fiduciary	Substantial
7. Environment and Social	Substantial
8. Stakeholders	Moderate
9. Other	Substantial
10. Overall	Substantial

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[✓] Yes [ ] No

Have these been approved by Bank management?

[✓] Yes [ ] No

Is approval for any policy waiver sought from the Board?

[ ] Yes [✓] No

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
Assessment and Management of Environmental and Social Risks and Impacts	Relevant
Stakeholder Engagement and Information Disclosure	Relevant
Labor and Working Conditions	Relevant
Resource Efficiency and Pollution Prevention and Management	Relevant
Community Health and Safety	Relevant
Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant
Cultural Heritage	Not Currently Relevant
Financial Intermediaries	Not Currently Relevant

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

Legal Covenants

Sections and Description

Section I.A(2), Schedule 2: A coordination committee of the Project (the "Project Coordination Committee") shall be established, not later than one (1) month after the Effective Date, and thereafter maintained throughout the implementation of the Project with a composition and terms of reference agreed by the Recipient and the Bank, to help provide, inter alia, the overall guidance for the Project, as further set out in the Project Operations Manual.

The Recipient shall facilitate the establishment and maintenance of the Project Coordination Committee.

Sections and Description
Section I.B(1)(a), Schedule 2: The Recipient shall no later than one (1) month after the Effective Date, prepare, and thereafter maintain, throughout the implementation of the Project, an operational manual for the Project, in form and with substance acceptable to the Bank ("Project Operations Manual"), containing, inter alia, (i) a detailed description of the Project activities and institutional arrangements for their implementation; (ii) detailed terms of reference of the Project Coordination Committee and its operational arrangements; (iii) monitoring, evaluation, financial and reporting procedures for the Project, including third-party monitoring of project implementation; (iv) operational procedures and arrangements for monitoring compliance with Entry Criteria for Access; and (v) implementation of environmental and social instruments referred to in the ESCP.

Sections and Description
Section I.B(1)(b), Schedule 2:The Recipient shall carry out the Project in accordance with the Project Operations Manual.

Sections and Description
Section I.C(1), Schedule 2: The Recipient shall, not later than one (1) month after the Effective Date, and thereafter annually, on May 15 of each year during the implementation of the Project, or such later date as the Bank may agree in writing, prepare and furnish to the Bank for its approval, the Work Plan and Budget, covering activities to be implemented under the Project for the subsequent twelve (12) months, a proposed financing plan for expenditures required for such activities, and a timetable for their implementation. The Work Plan and Budget shall be reviewed on a six-monthly basis, and updated as required and agreed by the Recipient and the Bank.

Sections and Description
Section I.D(1), Schedule 2: No later than one (1) month after the Effective Date, the Recipient shall hire and maintain throughout Project implementation, a Recipient's Third-Party Monitoring Agent, with qualifications, experience and terms of reference satisfactory to the Bank, to be financed out of the proceeds of the Grant as set forth in the table under Section IV.A of Schedule 2 to this Agreement, to carry out Recipient's Third-Party Monitoring of the Project implementation, including, without limitation, periodic site visits, assessment of local context and conditions, verification of services volume and quality and preparation of reports, evaluating performance of the Service Providers and related delivery of Basic Package of Health Services and Essential Package of Health Services under the Project.

Sections and Description
Section II.A(1), Schedule 2:The Recipient shall ensure that each Project Report is furnished to the Bank not later than forty-five (45) days after the end of each calendar quarter, covering the quarter. The Recipient shall ensure that each Project Report contains, among others, any update on the implementation of the activities under the Procurement Plan.

Conditions

Type	Financing source	Description
Disbursement	Trust Funds	Section IV.B Withdrawal Conditions; Withdrawal Period 1. Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made: (a) for payments made prior to the Signature Date, except that with respect to the ARTF Grant, withdrawals up to an aggregate amount not to exceed twenty million United States dollars ($20,000,000) may be made for payments made prior to this date but on or after March 3, 2022, for Eligible Expenditures; or (b) for any payment for Taxes, levied by or in the territory of the Member Country; or (c) for the purpose of any payment to persons or entities, or for any import of goods, if such payment or import, to the Bank's knowledge, is prohibited by a decision of the United Nations Security Council taken under Chapter VII of the Charter of the United Nations.

I. STRATEGIC CONTEXT

A. 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 WB Board of Executive Directors supported Approach Paper 1.0 for an immediate Transfer Out of US$280 million of uncommitted ARTF funds to the World Food Programme (WFP) and the United Nations Children's Fund (UNICEF) – in partnership with the World Health Organization (WHO)-- for humanitarian gap financing, following a decision by the ARTF donors.[1] On March 1, 2022, responding to requests from the international community, the Board approved Approach Paper 2.0: Options for World Bank Engagement to Support the Afghan People, March 1, 2022 ("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.[2] 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 involvement of the interim Taliban administration (ITA), to United Nations (UN) agencies and potentially international and national non-governmental organization (I/NGOs). Approach 2.0 is designed to respond flexibly, based on experiences of early implementation, and informed by strong coordination among the development partners (DPs).

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 (IsDB), and the Special Trust Fund for Afghanistan managed by the United Nations Development Program (UNDP); bilateral partners; and INGOs. The World Bank's Afghanistan future analytical work is supporting the United Nations Assistance Mission in Afghanistan (UNAMA) and 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.

3. **The Bank and the ARTF have taken a programmatic approach of engaging in four priority sectors: agriculture, livelihoods, health, and education.** 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 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 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

[1] Afghanistan Immediate-Term Approach Paper, November 12, 2021, SecM2021-0292.
[2] Afghanistan Approach Paper 2.0: Options for World Bank Engagement to Support the Afghan People, February 15, 2022, R2022-0018/IDAR2022-0036.

support to 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.[3] 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. More recently, the impacts of the war in Ukraine on Afghanistan's food security and rising fuel prices are compounding the existing crises.

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. According to the WHO, Afghanistan has recorded a total of around 174,000 cases and 7,619 deaths, 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 NGOs are addressing food security and supporting the

[3] Haque, Tobias. 2020. Afghanistan's Development Gains: Progress and Challenges. World Bank, Washington, DC. © World Bank. https://openknowledge.worldbank.org/handle/10986/33209 License: CC BY 3.0 IGO.

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.[4] 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 minority 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.[5] 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. 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 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 2018 household survey.

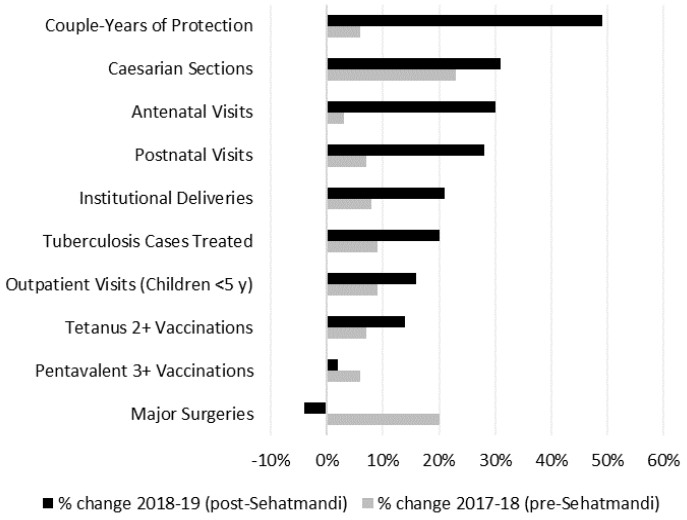
12. **Progress on health outcomes in Afghanistan is also constrained by persistent gender inequality.** Girls and women's access to health services has been constrained by health system factors (distance to facilities and lack of female healthcare providers) as well as social factors (high illiteracy and low education

[4] 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).
[5] RIT and NSIA. 2019. "Afghanistan Health Survey 2018." April 2019.

of women, limited mobility, and sociocultural norms that position men as decision-makers of women's health). According to WHO, 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-financed Sehatmandi Project (P160615) in 2018. An analysis 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).[6] 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.

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



14. **Health sector financing has always been highly dependent on international aid and out-of-pocket spending by households.** On average between 2017 and 2021 the total on-budget health

[6] 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.

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, DPs 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 on 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 and 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.[7] 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.** According to the WHO, as of March 6, 2022, Afghanistan registered more than 174,000 cases and 7,619 deaths due to COVID-19. 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.[8] During these waves of infection, COVID-19 strained the health system and disrupted routine services. For example, a monthly 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).[9]

16. **However, capacity to respond to the pandemic has considerably increased given additional funding provided by the WB Emergency Response and Health System Preparedness (ERHSP) project (P173775),[10] to mitigate the impact of the COVID-19 pandemic.** The ERHSP measures included increasing 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.[11] While this level

[7] Global Health Expenditure Database, World Health Organization https://apps.who.int/nha/database/ViewData/Indicators/en.
[8] Median 24 percent (50 percent -CI 22 – 27, 95 percent-CI 17 – 34); Stilianos, Louca. 2021. "SARS-CoV-2 Infections in 165 Countries Over Time." *International Journal of Infectious Diseases* 111: 336–46.
[9] Analysis conducted by the Global Financing Facility for Women, Children, and Adolescents (GFF) in partnership with the World Bank's Development Economics Research Group.
[10] The ERHSP project was paused on August 15, 2021, as a result of the crisis.
[11] Data sourced from MoPH Data Warehouse, Afghanistan's Online Health Sector, https://moph-dw.gov.af/dhis-web-dashboard/index.html#/ipsO3PccxSj.

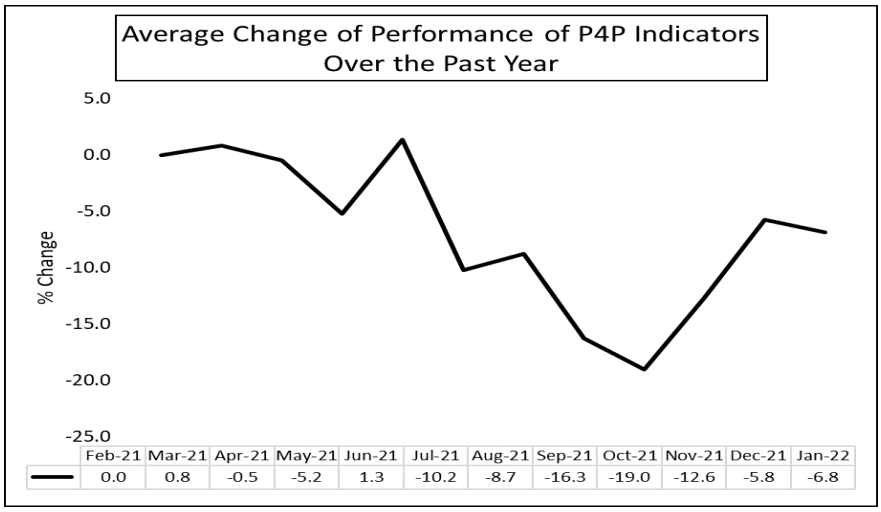
of vaccination is an important achievement amidst the conflict and change in government that occurred in 2021, it is much lower than required to substantially reduce continued infection and lower infection fatality rates in the population. Afghanistan remains a priority country for COVAX to supply and deploy the COVID-19 vaccine. In consultation 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 (via COVAX and bilateral donations).[12] Furthermore, through its *Sustaining Essential Services Project*, the ADB-financed Project is implementing a vaccine procurement component in the amount of US$20 million, along with delivery support. Hence, the proposed 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 August 15, 2021, 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 the 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 through UNICEF and 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 US$100 million transfer out financing package to UNICEF to sustain basic service delivery until June 2022, based upon the contracting out model (see Annex 2 for details).[13] 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.

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). Of all visits to health facilities, 60 percent were by a female, which indicates the continued accessibility of medical care to women.[14] However, a recent attack on polio vaccinators is a reminder that the situation, while improved, is still volatile and long-standing safety protocols will need to be updated and implemented.

[12] 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.
[13] 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.
[14] Assessment conducted by WHO/UNICEF field staff during January/February 2022

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 SPs' 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 moderate acute malnutrition (MAM) with complications, respectively. The WFP's key strategy to combat undernutrition is to prevent and treat MAM among pregnant and lactating mothers and children using ready-to-use supplementary food (RUSF); UNICEF focuses on treating SAM in children by using ready-to-use therapeutic food (RUTF), and WHO supports management of SAM in 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 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.[15] 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.[16] This will be explicitly addressed through: (i) increased funding so greater resources can 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 the 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 ongoing 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 reestablishment 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 the UNDP, the ADB, the IsDB,[17] 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 (GFTM), ICRC, IsDB, UNDP, UNICEF, USAID, and WHO. This partners' platform also ensures that complementarities are pursued, as exemplified by the ongoing dialogue on supporting the proposed Health Emergency Response (HER) Project.

[15] As reported on February 27, 2022.
[16] 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
[17] Membership forthcoming. The IsDB is also exploring the setup of a humanitarian trust fund under the auspices of the Organisation of Islamic Cooperation (OIC).

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 WB'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 the short-term needs for the health sector.

26. **The Project is consistent with both Afghanistan Approach Paper 2.0 and the World Bank Group Country Partnership Strategy FY17–20 (No. 108727-AF) discussed at the Board of Executive Directors on October 27, 2016.** Specifically, preserving and extending basic health service delivery falls under the third priority area of the CPF, deepening social inclusion. 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 Project is also aligned with key strategies addressing fragility and its relationship to poverty and growth. Proposed 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. The 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 Procedures 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.

II. PROJECT DESCRIPTION

A. Project Development Objective

PDO Statement

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

PDO Level Indicators

29. 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 children aged 0-23 months received at project-financed facilities (Number)
iv. Average Quality Checklist score for BPHS and EPHS facilities

B. Project Components

30. **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.** The 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, and model of service delivery through third parties will be sustained and capitalized upon. 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, the WHO will have a role in the HER through both as technical advisory and implementation support. This role will be captured through an UN-to-UN transfer agreement (UN-to-UN TA).

31. **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.

32. **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, nor manage any of the funds, nor decide on Project

beneficiaries, nor engage in procurement processes. However, it will be consulted and informed, as outlined in the Stakeholder Engagement Plan (SEP).

33. **Various agencies that are important partners in the health sector 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 World Bank financed 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

34. **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 of SPs to meet the needs of the Project as provided for under UNICEF policies and procedures.[18]

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.** These packages will be delivered at the primary health care level as well as first, second, and provincial level hospitals.[19] Additionally, the BPHS and EPHS include GBV services. Under this sub-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 sub-component will use a P4P approach. Under the 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 underserved areas will be more highly incentivized; (iii) coverage forecasts used to determine payment caps revisited; and (iv) adequate payments to reasonably cover

[18] UNICEF should develop clear criteria for direct contracting SPs, including consideration of past performance.
[19] 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.

running costs of health facilities including health care workers. Critical maternal, child, and nutrition services will continue to be linked to performance-based payments. These will be identified in the Project Operations Manual (POM).

ii. **Sub-component 1.2: Enhancing community and facility level nutrition services.** The priority nutrition interventions in the BPHS and EPHS which are covered under sub-component 1.1, will be further strengthened through additional support in the following areas:[20]

a. **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.

b. **Adaptation 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 NCs 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.

c. **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 Specific, Measurable Attainable, Relevant, Timely (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.

[20] *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) GMP; (iii) vitamin A supplementation; (iv) iron supplementation; and (v) treatment of acute malnutrition.

d. The ARTF/WB Afghanistan Community Resilience and Livelihoods Project (P178760) will support the capacity building 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. These efforts are also expected to enhance the nutrition component under the HER:

iii. **Sub-component 1.3: Enhancing the health system capacity to prevent and respond to infectious disease outbreaks and to eradicate polio.** UNICEF will work with the 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

35. **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 sub-components that give UNICEF flexibility to respond to emerging system needs.

i. **Sub-component 2.1: Promoting quality of care and strengthening healthcare worker capacity.** 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 suboptimal 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. **Sub-component 2.2: Enhancing quality health product and equipment supply chains.** 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 sub-component 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.** 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:

a. **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 Third-party Monitor (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.[21]

b. **Pillar 2: Performance management support**. Having many 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

[21] UNICEF Policy on Personal Data Protection, Document Number POLICY/DFAM/2020/001. *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 regard to data protection.

flexibility that the contracts give them, this sub-component provides technical assistance to improve SPs performance and management, including a third-party management accompaniment that can be carried out by the WHO or a firm or both. 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 (through a dedicated management firm or WHO or both) 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 the 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.

c. **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. **Sub-component 2.4: Project implementation and coordination (includes UNICEF cost recovery and direct costs of total project cost included under the UN operational cost).** This sub-component will support the Recipient's direct and indirect 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. Specific activities include direct management and supervision costs required to support project implementation (including the use of remote monitoring technology), such as: (i) handling procurement, financial management, and disbursement management, including the preparation of withdrawal applications under the Project; (ii) ensuring that independent audits of project activities are carried out according to the UNICEF regulatory framework; (iii) ensuring that all reporting requirements for ARTF are met according to the Project Grant Agreements; (iv) establishing an operational grievance redress mechanism (GRM) for UNICEF supported activities to document any possible complaints and ensure follow-up; and (v) monitoring project targets and results in coordination with the SPs.

C. Project Beneficiaries

36. **The scope of this emergency project will be nationwide.** The project will therefore cover all 34 provinces except Kabul city, aiming to benefit at least 70 percent (27.2 million) of the total population.

The poorest will disproportionately benefit as the Project (i) focuses on PHCs where services are more likely to be utilized by the poor; (ii) provides coverage to rural areas as well as urban slums where the poor are concentrated; and (iii) supports completely free care through the BPHS and EPHS facilities, which reduces financial barriers to access.

37. As previously mentioned, cases of malnutrition have significantly increased across the country. The Project will target children and pregnant and lactating women to treat cases of malnutrition. Health workers who receive additional training to improve their performance, and female health workers who are recruited and retained as a part of the Project interventions are also additional secondary beneficiaries.

D. Results Chain

Figure 3. Results Chain for Project Interventions and Intended Impacts

Activities	Outputs	Outcomes	Impacts
Component 1: Provision of essential primary and secondary health services • Delivery of the Basic Package of Health Services (primary care) and Essential Package of Hospital Services (secondary care) to the entire population of all 34 provinces. • Enhancing Community Level Nutrition Interventions • Diagnosis and treatment of infectious disease outbreaks	• Core primary and secondary care services available free of cost to the entire population, including: maternal health, immunizations, treatment for malnutrition and infectious diseases, family planning, surgical care, and other services • Enhanced quality of care through financial incentives to service providers • Female nutrition counselors at health facilities, enhanced nutrition messaging, and improved supply availability • Infectious disease outbreak prevention and control, reporting, treatment, and communication	• Reduction in vaccine-preventable diseases • Identification of and response to pregnancy complications • Improved nutrition knowledge among beneficiaries • Treatment of malnutrition, injuries, infectious diseases, and other conditions	• Reduced maternal and child mortality • Reduced malnutrition • Reduction in excess deaths and morbidity in the population overall
Component 2: Strengthening Service Delivery and Project Coordination • Sustaining health worker capacity • Quality health products and supply chains • Monitoring, quality of care, and accountability • Project implementation and coordination	• Training of health workers • Coordinated procurement of medicines and equipment, and enhanced quality monitoring • Verification of SP financial expenditures and reported service volumes; assessment of health facility quality and population health outcomes • Management support to SPs for enhanced decision-making	• Improved health worker knowledge and behaviors • Higher quality of medicines • Prevention of fraud and corruption in expenditures • Enhanced linkage of service provider behavior to project's financial incentives for enhanced quality and increased service volume	

E. Project Costs and Financing

38. The total cost of the proposed HER Project is estimated to be US$333 million, which will be financed by ARTF in the amount of US$314 million and by GFF in the amount of US$19 million.

Table 1. Project Cost Breakdown

Components	ARTF (US$ millions)	GFF (US$ millions)	Total (US$ millions)
Component 1: Urgent provision of essential primary and secondary health services	**270.73**	**18.27**	**289**
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	251.73	18.27	270
Sub-component 1.2: Enhancing community and facility level nutrition services	6.3	-	6.3
Sub-component 1.3: Enhancing the health system capacity to prevent and respond to infectious outbreaks and to eradicate polio	12.7	-	12.7
Component 2: Strengthening service delivery and Project coordination	**43.27**	**0.73**	**44**
Sub-component 2.1: Promoting quality of care and strengthening healthcare worker capacity	3.0	-	3.0
Sub-component 2.2: Enhancing quality health product and equipment supply chains	6.0	-	6.0
Sub-component 2.3: Strengthening monitoring and ensuring accountability	10.0	-	10.0
Sub-component 2.4: Project implementation and coordination (including cost recovery rate of 4 percent)	24.27	0.73	25.0
TOTAL	**314.0**	**19.0**	**333.0**

39. To retain flexibility, ARTF funding will be released in two tranches as referred to in Approach 2.0. The first tranche in the amount of US$150 million will be the subject of the Grant Agreement to be signed after approval. Within six months of project effectiveness, a review together with ARTF partners will be held to assess progress and whether ECA continue to be in place. In that case, subject to funding availability, an additional tranche in the amount of US$164 million may be released from the ARTF, and accordingly increasing the grant amount in the Grant Agreement. The GFF funding in the amount of US$19 million will be released in one tranche, upon signing of the GFF Grant Agreement, following approval of the Project.

40. The second tranche release criteria are: (i) quarterly performance reviews of at least 70 percent of BPHS/EPHS SPs carried out; (ii) 80 percent of SPs having received timely and complete payments (both lump-sum and P4P amounts) as per payment schedule in their contract; (iii) timely submission of all project progress report including all agreed content; and (iv) whether the described ECAs in Table 2 continue to be in place.

41. The two ECAs that will be monitored throughout Project implementation are: (i) There is no announced restriction on the provision to women and girls of the health and nutrition services included in the BPHS and EPHS; and (ii) There is no announced restriction on female healthcare and nutrition workers being allowed to work in health facilities and in communities. These ECAs will be monitored by the ARTF, UNICEF, and WB to inform discussion on whether the situation on the ground related to access and participation of girls and women continues to provide the conditions under which the activities are able to be implemented.

Table 2. ECA Monitoring Approach

	ECA 1: Equitable Access	ECA 2: Gender Responsive Health Workforce
Definition	There is no announced restriction on the provision to women and girls of the health and nutrition services included in the BPHS and EPHS.	There is no announced restriction on female healthcare and nutrition workers being allowed to work in health facilities and in communities.
Application	Healthcare facilities that are offering the BPHS or EPHS and the communities they serve through outreach: ○ BPHS and EPHS services are being offered to women and girls as needed (district eligible) ○ Women and girls' access to health services is being restricted—consultation process at the Project's Coordination Committee (CC) level • Monthly: UNICEF monitors formal announcements of service availability and the ability of women and girls to gain access to services at central, provincial and district levels. • Quarterly: UNICEF conducts quarterly surveys with contracted SPs, health facility staff, and health shuras to monitor status of service availability for women and girls to report on any explicit and implicit barriers created at the local level to prevent women and girls to access health and nutrition services. • Disaggregated data on the performance of gender responsive health services will be presented to the Project's CC on a quarterly basis.	• Monthly: UNICEF monitors formal announcements on restrictions to women's ability to work in the health sector. • Quarterly: In parallel, UNICEF conducts quarterly surveys in a randomized sample of health facilities to report on the availability of female health and nutrition workers and their ability to provide services in health facilities and in communities. • Information on any changes to the gender composition of the healthcare workforce will be presented to the HER-CC on a quarterly basis.
Verification	UNICEF team, UNICEF MA complemented by ARTF-MA.	UNICEF team, UNICEF MA complemented by ARTF-MA.
Noncompliance	Noncompliance of the ECA as well as data on service utilization will trigger a consultation process at HER-CC level.	Noncompliance of the ECA as well as data on service utilization will trigger a consultation process at HER-CC level.

F. Rationale for Bank Involvement and Role of Partners

42. **The international community has recognized the continuum between emergency relief activities, recovery, and rebuilding, and has acknowledged the role of the WB to effectively respond to emergency situations to achieve development objectives whilst adhering to its development mandate.** For the WB, this means sustaining key systems and basic services, and safeguarding development gains, including through non-governmental systems in exceptional circumstances, especially when today's humanitarian crises are tomorrow's development challenges.

43. **The rationale for Bank intervention is premised on its comparative advantage.** In complex humanitarian crises, the WB leverages its added value and convening power to deliver critical services, notably to the most vulnerable populations. The WB complements the essential short-term relief provided by humanitarian actors with longer-term development funding support. The WB's sustained engagement adds value and helps to protect human capital, mitigate risks and shocks, build the resilience of communities and households and, whenever possible, preserve institutional capacity. Furthermore, the WB's technical capacity and ability to draw on other required skills to support the Project in addition to its strong oversight fiduciary framework to ensure greater transparency, accountability, and equity. The coordination between development and humanitarian efforts enhances the overall impact of respective programs.

44. **The WB is the host institution for both the ARTF and the GFF.** The ARTF was established in 2002 to provide a coordinated financing mechanism for development priorities in Afghanistan and is the WB's largest and longest standing single-country multi-donor trust fund. The ARTF plays this coordinating role through the ARTF Steering Committee (ARTF-SC) and three working groups focused on strategy, gender, and incentive programs. The GFF supports low- and lower-middle income countries to accelerate progress on reproductive, maternal, newborn, child and adolescent health and nutrition, and strengthen financing and health systems. Afghanistan has participated in the GFF partnership since 2017. The GFF supports multi-stakeholder platforms to develop and implement a jointly agreed set of systems-strengthening priorities and aims to help mobilize financing to advance health and nutrition. The GFF Trust Fund links moderate amounts of resources to WB financing and supports countries to strengthen their focus on data, quality, equity, and results.

45. **The Project will be implemented in coordination with DPs that are financing technical assistance and other types of investments in the health sector.** The WB has been coordinating a weekly Safeguarding Health Gains Partners Meeting since the August 15, 2021, crisis. This group brings together key financiers such as the ADB, GAVI, The Global Fund, the EU, USAID, FCDO, Canada, the BMGF, UNDP, UNICEF, and the WHO. This forum has supported information sharing, technical exchange, and allowed for an initial mapping of donor financing for the sector to minimize duplication and fragmentation at the point of service delivery. It is intended to avoid overlaps in nurturing coherence in response, streamline tools and messages, and harmonize off-budget support. There has already been agreement with USAID to co-finance the quality-of-care assessment and collation of nutrition household data.

G. Lessons Learned and Reflected in the Project Design

46. **Lessons from the last IDA/ARTF and GFF-financed project (Sehatmandi) and IDA/ARTF-financed project (Afghanistan ERHSP) as well as recent emergency operations in other settings are as follows:**

- **Project implementation by a UN agency is a successful strategy.** Important lessons that have emerged from the collective experience of IDA-financed projects implemented through UN agencies have been incorporated into the Project implementation arrangements. These include the following recommended best practices: clearly articulating audit and reporting/information sharing obligations of implementation agencies, including with regard to TPM and technical/sector audits; increase of WB implementation mission frequency; regular discussions with UN implementing partners on risk mitigation strategies and emerging risks; careful management of TPM arrangements including expanding terms of reference (ToRs) and prompt

report sharing; frequency of financial assurance activities and procurement monitoring; preparation of regular progress reports and work planning; application of relevant environmental and social (E&S) standards; and adequate attention to the preparation and updating of the POM.

- **The contracting out model has proved resilient to conflict and a change in de facto governance.** The development of a national package of services for primary and first referral levels in the health system (BPHS and EPHS), the use of standard contracts and performance management approaches, and the use of NGOs as SPs have been key to the success and resilience of service delivery despite the FCV context.

- **Coordination among DPs remains critical, due to a diverse array of health investments in the country.** Sehatmandi and COVID-19 projects were multi-donor financed projects. Clarification of roles and responsibilities between the WB and other involved donors is important to mitigate the risks of inefficient duplications, sequencing of activities and suboptimal distribution of funding across activities and geographic regions.

- **Strong M&E and TPM underpins a successful performance-based system.** Given the nature of health contracts under the Project, it is crucial to further improve M&E through close collaboration between the ARTF-MA and UNICEF monitoring.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

47. **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 the Democratic Republic of Congo (DRC) have been incorporated. The lessons learned from the implementation during the transfer out period indicate that risk can be further mitigated through developing a POM by UNICEF. The POM, to be agreed with the WB, will be finalized within one month of project effectiveness.

48. 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, 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.

49. **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 (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, TPM 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.

50. **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 Project Management Unit (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 the 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.

51. **Overall coordination will be further strengthened using the existing Safeguarding Health Gains country platform.** This platform which brings together all the financial and technical partners was put in place by the WB shortly after the August 15, 2021, to ensure information, technical and strategic discussions, as well as complementary support to the health sector after the WB paused its disbursement. 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 staff, 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.

B. Results Monitoring and Evaluation Arrangements

52. **WB Financing of UN Agencies as Direct Grant Recipient – Operations Policy Flexibilities and Requirements:** The Financial Management Framework Agreement (FMFA) is relied upon as the authorizing framework under which the WB recognizes the UN single audit principle. It allows for WB audit requirements to be met through the normal audit function of UN agencies' own external auditors, without requirement for submission of separate audited financial statements. The FMFA also allows for reliance on UN agencies' own financial management, internal controls and oversights when implementing Bank financing, based on the application of alternate assurance, and reporting arrangements including, supervision activities of frequency and scope mutually agreed with the UN agency, expanded content and periodicity of Interim Financial Report (IFRs), submission of certified annual financial statements, and independent verification and/or TPM or ARTF MA.

53. The Bank retains the right to supervise, the elements of which are laid out in a Project Implementation Support Plan. As part of its supervision of ARTF-financed projects, the Bank will use a monitoring agent (i.e., ARTF-MA).

54. **ARTF Administrative Agreement and Approach 2.0 Monitoring Requirements:** The ARTF Administrative Agreement (AA) requires the WB to engage a monitoring agent(s) to support its supervision of ARTF-financed projects. The ARTF AA Annex on *Standard Terms and Conditions Governing Contributions to the ARTF* (AA Annex) specifies that monitoring provisions include coverage of both physical performance verification and financial and fiduciary checks of eligibility of expenditures. The current ARTF strategy, endorsed June 2021, and Approach Paper 2.0 emphasize the continued use of the ARTF monitoring arrangements.

55. **Supervision and monitoring arrangements for projects financed under Approach 2.0:** To ensure continuity of oversight of ARTF-financed activities at the portfolio level, the ongoing use of the existing ARTF-MA will be continued with relevant ToRs. As laid out in the Project Implementation Support Plan, the WB will engage a monitoring agent to support supervision of physical performance and financial monitoring. In accordance with the alternate assurance and reporting arrangements enshrined in the FMFA including, the determination of supervision activities with frequency and scope mutually agreed with UNICEF, ToRs for supervision services to be carried out by the ARTF-MA will be developed in consultation with UNICEF and the WB. Verification reports will be provided to UNICEF and the WB. The ToRs will be annexed to the POM. Finally, the WB retains the right to supervise, the elements of which are laid out in a Project Implementation Support Plan.

56. **The WB will conduct regular implementation support missions and regular meetings with UNICEF to discuss overall progress, implementation arrangements, prioritization of interventions under implementation, and action plans.** These missions will be conducted quarterly to: (i) review implementation progress and achievement of the PDO and intermediate indicators; (ii) provide support for any implementation issues that may arise; (iii) provide technical support related to implementation, achievement of results, and capacity building; (iv) discuss relevant risks and mitigation measures; and (v) monitor the health system's performance through progress reports, audit reports and field visits, if and when they become possible. Given the unique implementation arrangements of the Project and the associated high risks, the Bank's role in M&E will be not only to measure project results, but also to extract lessons and draw recommendations for future WB interventions in similar contexts on aspects such as effectiveness and sustainability. Furthermore, during project implementation, where needed the Bank team will have limited, ring-fenced technical contact with operational level staff at the relevant interim administration agencies subject to country management approval.

57. **UNICEF will be responsible for monitoring the activities implemented by the SPs and other contractors and reporting upon progress to WB on a quarterly basis.** UNICEF will ensure that contractors are properly trained on implementation arrangements, working closely with communities. The POM will set the operating principles and procedures to be monitored and format for quarterly reports.

58. **The ARTF-MA will help the WB supervise activities and ensure that funds reach the intended beneficiaries and activities.** The WB and UNICEF will jointly develop a complementary approach for financial monitoring, leveraging the services of the ARTF-MA. In addition, UNICEF and the WB will co-develop and mutually agree upon an approach to utilize both UNICEF-TPM and ARTF-MA to conduct technical health surveys at large scale.

C. Sustainability

59. **The HER Project will work through the service delivery mechanism used for public-sector service delivery since 2002.** UNICEF will ensure that healthcare workers continue to get paid, that health product supply chains are maintained, and that basic facility upkeep is possible. This approach will prevent the collapse of the health system and ensure that this platform, which is the backbone of the health system and which other key donors rely on, remain available in the future under different financing and institutional arrangements. In terms of financial sustainability, recent analysis shows that Afghanistan will continue to face a large financing gap for the provision of critical basic services (budget expenditures are expected to fall by around 64 percent in US$ terms). The WB is planning to engage in technical discussions with the Ministry of Finance regarding revenue projections and fiscal allocations. Through Approach 2.0 the WB will work with the international community towards developing a clear division of financing responsibilities between the ITA and donor partners, with program approaches and financing amounts modified accordingly.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic, and Financial Analysis

Economic and Financial Analysis

60. **Afghanistan's economy relies heavily on foreign aid** (constituting 45 percent of GDP prior to August 15, 2021) and imports for basic items such as food, fuel, and electricity. The fall of the previous government in August 2021 along with prolonged drought and COVID-19 caused a rise in inflation (particularly food items and fuel), the devaluation of the Afghani, a surge in unemployment, and overall contraction of the economy.

61. **With the fall of the previous government, DPs paused funding for the health sector, which led to a halt in the provision of health services.** Prior to August 15, 2021, 85–88 percent of the Afghanistan on-budget primary health care was financed through the ARTF and IDA (annually US$140 million) delivering basic and essential packages of health services across Afghanistan. In August 2021, when the WB paused disbursement, the use of antenatal care declined by 21 percent, institutional deliveries by 29 percent, cesarean sections by 46 percent, childcare by 15 percent, and major surgeries by 31 percent. This further crippled the responses to ongoing outbreaks of COVID-19, measles, acute watery diarrhea, and dengue fever.

62. **The ongoing economic crisis, food insecurity, and cessation of essential service delivery could reverse the important human capital gains accumulated over the past two decades.** This enormous crisis is affecting the entire population but is disproportionally hurting the most vulnerable groups, including women, children, and the poor. The HER Project will continue to finance the provision of BPHS, EPHS, nutrition interventions including NC, and COVID-19 mitigation activities. The Project will continue to use the P4P model, which has proven to increase the volume of service delivery and cost efficiency.

63. **In addition to promoting human development, improving access to maternal and child health services through BPHS and EPHS can have a positive impact on long-term economic growth by**

supporting human capital formation and increasing women's labor supply. Additional returns can be realized by: (i) diminishing the risk of impoverishment due to high health related out-of-pocket expenditures (more than 77 percent); (ii) reducing the burden on households due to lost income resulting from illness-related incapacitation; and (iii) improving the learning capacity of children owing to better nutrition. The Project is expected to contribute to reduced morbidity and mortality of mothers and children by improving equitable access to both primary and hospital-based care.

64. **A preliminary WB analysis of the Sehatmandi Project indicates that it was cost-effective.** A comprehensive unit cost study has not been undertaken for all health services in Afghanistan to date. However, some information is available from the costing study conducted by the MoPH published in 2020 for the year 2018. The costs of child health/immunization and family planning per visit in Afghanistan were US$1.1 and US$0.4 at primary level in 2020, respectively, while they were US$2.1 and US$3.5 in Bangladesh. Although not estimated in the above MoPH study, a Bank estimation suggests that an institutional delivery in 2020 costed US$12.5 in Afghanistan while it was US$23.5 in Bangladesh and US$42.5 in Pakistan adjusted for the same year. Similarly, antenatal/postnatal care costs US$0.5 per visit in Afghanistan, while US$3.2 is needed in Bangladesh and Pakistan. The findings on the relative low costs of different services in Afghanistan compared to its neighboring countries do not change after adjusting for purchasing power parity. The Sehatmandi Project was therefore an efficient mode of delivering basic health services to the population.

65. **The HER Project will continue the provision of service delivery through contracting out services to NGOs using the P4P model.** The cost of the Project remains at the same level as Sehatmandi adjusting for inflation and an increase in the volume of service delivery. During implementation of the Sehatmandi Project, the increase in the volume of service delivery with the same costs indicates further efficiency gain.

66. **In terms of allocative efficiency, the HER Project will continue to finance the same interventions as Sehatmandi and the COVID-19 emergency projects** as communicable disease, maternal, neonatal, and nutrition cause of morbidity and mortality continue to remain the biggest cause of death in Afghanistan. COVID-19 interventions will focus on, for example, diagnostics, treatment, risk communication, and infection prevention and control/WASH.

67. **The Project will also continue to disproportionally benefit the poor, rural areas, urban slums, and people in the lowest economic quintile.** As the security situation improves across Afghanistan, the Project will strive to increase access to health care in previously contested localities and hard-to-reach areas through innovative approaches.

Technical

68. **The major focus of the Project is delivery of BPHS and EPHS across the country, which comprises a prioritized set of high-impact interventions with proven cost effectiveness well in line with the international health agenda to achieve the SDG 3.** As has been demonstrated in the last 20 years, BPHS and EPHS are effective ways to respond to the basic health needs of the communities and, as such, are key tools to improving overall stability in the country. The provision of BPHS and EPHS through contracting out in Afghanistan has become a model for other fragile states trying to rebuild their health system after emerging from conflict.

69. **The proposed interventions, to be implemented by UNICEF in collaboration and coordination with key technical and financial partners, will be delivered in a way to minimize unintended negative consequences and the SPs are committed to a "do no harm" approach to programming.**

70. **The HER Project will finance the BPHS and EPHS packages of health service delivery through NGO SPs.** To maintain efficiency, there will be a single contract for each province. The contract provisions will continue to provide substantial managerial autonomy and decentralized decision-making on the ground to SPs, to allow them to react to local needs and constraints and initiate innovative approaches for service delivery.

B. Fiduciary

Financial Management

71. **The Bank assessed inherent FM risk as High and designed mitigation measures to reduce the residual risk to Substantial.** The key risks include NGOs invoicing for higher than the volume of the actual services, ineligible health workers, delayed payment to health workers, and exchange losses due to volatile Afghani. UNICEF will implement various controls measures to mitigate the fiduciary risks. The Harmonized Approach to Cash Transfer (HACT) framework will be used by UNICEF.[22] The framework specifies extensive control measures related to the due diligence of implementation partners, advance liquidation, expenditure documentation, reporting, and assurance. UNICEF's Office of Internal Audit and Investigations (OIAI) may conduct an internal audit of the Project, if it determines, based on its risk-based work planning process, that such audit is warranted. The Bank may also make a request for a special internal audit of the Project, which OIAI will consider. If OIAI agrees to conduct the special audit, the related costs may be borne out of project funds. Any resulting audit reports will be made available in accordance with UNICEF's internal audit public disclosure policy.

72. **UNICEF and the WB are signatories to the FMFA and the Fiduciary Principles Accord (FPA), which will guide the Project's FM arrangements.** UNICEF will use the UN's Financial Regulations for project accounting and reporting. UNICEF will submit quarterly IFRs and quarterly progress reports, the format of which have been agreed upon during negotiations, to the Bank within 45 days of the quarter's close. Following the FMFA, UNICEF will submit an annual financial statement of account (in US dollars), certified by UNICEF's Chief Financial Officer, showing income and expenditure of the grant. Each year, UNICEF will submit the grant's annual financial statement of account within six months of the close of its financial year (i.e., by June 30). Separate yearly audited financial statements of the grant are not required.

73. **Disbursements will be based on IFRs, and UNICEF will submit the withdrawal applications to the Bank's loan departments.** UNICEF will not open a designated bank account for the grant but will keep a ledger account for recording the transactions related to the ARTF and GFF grants. The Bank will make available the first tranche of US$169 million, joint co-financing by the ARTF (US$150 million) and the GFF (US$19 million), to UNICEF for project implementation upon effectiveness. However, the actual advance will be based on six months' forecasted expenditure approved by the Bank. The frequency of disbursements will be quarterly, where the Bank will document reported expenditures and provide

[22] UNICEF. 2018. "Harmonized Approach to Cash Transfers (HACT) Guideline for Implementing Partners – Government and Civil Society Organizations (CSOs)." https://www.unicef.org/eswatini/media/556/file/HACT-Guidance-Document-report-2018.pdf

forecasted advances based on the IFRs.

74. **Risks associated with liquidity and banking systems are assessed as High.** For all future development interventions in the country, the liquidity situation and a reliable financial payment system will be of critical concern. Even before the transition in August 2021, the country relied heavily on physical cash-based systems.[23] Payments to project staff, suppliers, and beneficiaries as well as the availability of physical cash in the country will need to be reviewed carefully with the UN and/or other selected implementing partners to ensure that project interventions can be delivered effectively to the intended beneficiaries, and that funds are used for intended purposes, and not diverted to the ITA. The recent issuance of US Government General Licenses should ease some of the liquidity and payment constraints in the country, though further clarifications are needed.

75. **Retroactive Financing.** Retroactive financing of up to US$20 million in total from ARTF funding is available for payments made prior to the signing of the Grant Agreement, but on or after March 3, 2022, for eligible expenditures.

Procurement

76. **Alternative Procurement Arrangements (APAs)** will be applied given that the procurement procedures of UNICEF were assessed and found acceptable to the WB under other agreements as allowed by the Procurement Framework Policy Section III. F.

77. **UNICEF will follow their own procurement procedures to procure the required services and goods, including storage and distribution to destination.** UNICEF will leverage existing institutional arrangements with partners such as international and local NGOs, local private SPs, and contractors to help implementation. Selection of SPs will be primarily through open competitive processes. Direct selection of SPs may take place to respond to the needs of the Project following UNICEF's policies and procedures.

78. **The Bank assessed the inherent procurement services (PS) risk as Substantial and designed mitigation measures to reduce the residual risk to Moderate.** The rating of Substantial is due to the potential risk of delay in implementation/supply because of the COVID-19 situation. It is also due to the composition of the marketplace (limited competition and availability of service delivery) and the nature of project activities (which are not complex but might be impacted by the situation on the ground post-conflict areas).

79. **Mitigation Measures.** The Project includes risk mitigation measures such as frequent reporting, supplemented by regular direct contact between the WB and UNICEF to review the status of activities. Aside from more frequent and detailed reporting, combined with closer supervision by the WB, the Bank will: (i) review and agree on the respective updates of the procurement plan (PP) as the initial PP was agreed on prior to effectiveness; and (ii) work closely with UNICEF on the technical review of the ToRs. UNICEF quarterly progress reports will include an update on the implementation of the procurement plan.

[23] It is estimated that only 15 percent of Afghan adults own a financial account and as of March 2021, according to Da Afghanistan Bank (DAB) data, the percentage of Afghans using mobile money is only 1 to 1.5 percent of the population with less than 10 percent women users and primarily available in urban areas. Mobile money continues to be cash-based as well.

80. **UNICEF will be responsible for providing a quarterly HER progress report following a mutually agreed format,** which will include: (i) overall progress of the Project activities; (ii) status of ECA; (iii) detailed updates of each component; (iv) summary of implementation challenges/bottlenecks and status of their resolution; (iv) status of the implementing the procurement plan; (v) progress of procurement and distribution of commodities and goods; (vi) updates on the implementation of the Environmental and Social Commitment Plan (ESCP); and (vii) Results Framework indicator progress. The Quarterly Progress Report and IFR will be submitted at the same time.

C. Environmental and Social

81. **Given the FCV context in which the Project will be implemented, potential adverse E&S risks and impacts, and capacity of the SPs, both the E&S risks of the Project are rated Substantial.** The relevant Environmental and Social Standards (ESSs) are ESS1, ESS2, ESS3, ESS4, and ESS10.

82. **Potential environmental risks include:** (i) issues associated with poor health care waste management, such as wastes that may be generated from laboratories, quarantine facilities, and screening posts to be supported by the COVID-19 readiness and response and could include both liquid contaminated waste (e.g., blood, other body fluids, and contaminated fluid) and solid waste (e.g., used personal protective equipment, sharps, used vials, and medical equipment); (ii) potential for nosocomial infections due to poor implementation of infection prevention measures; (iii) issues relating to on-site storage and disposal of construction material; and (iv) generation of noise and dust during minor civil works. Potential social risks include: (i) social inequalities, exclusion, and discrimination of certain categories of people, such as vulnerable and marginalized groups; (ii) forced labor, occupational health and safety risks, and infectious disease exposure risks for Project workers and communities served; (iii) sexual exploitation and abuse/sexual harassment (SEA/SH) risks for Project workers and beneficiaries; and (iv) low capacity of SPs to manage E&S risks following the Environmental and Social Framework (ESF). Possible occurrence of conflict (including armed conflict) near healthcare facilities and/or terrorist attacks on project workers is also an important contextual risk that may affect safety of the healthcare workers.

83. **UNICEF has prepared an ESCP and SEP that includes a GRM and communication strategy.** Both the ESCP and SEP have been cleared by the Bank and disclosed on UNICEF's and the WB's external websites on May 16, 2022. UNICEF will prepare and disclose the Environmental and Social Management Framework (ESMF) post Project approval but before UNICEF enters into agreement with implementing partners/SPs. The ESMF will include simplified Labor Management Procedures, generic Environmental and Social Management Plan for minor civil works, and the Health Care Waste Management Plan. To manage the contextual security risks to communities and project actors, UNICEF will implement the UN security protocols and any measures necessary to ensure consistency between the protocols and the ESF requirements in the implementation of project activities and for the provision of security to project workers, sites and/or assets. The ESMF will include a brief description of the protocols and any such measures. The SEA/SH risk of the Project has been rated as Substantial. UNICEF will also develop an SEA/SH action plan with specific and timebound actions to mitigate the SEA/SH risks, which will cover codes of conduct, in-depth training, and sensitization of project workers and communities.

84. **The Project has substantial SEA/SH risk based on the SEA/SH risk screening tool for human development risk categories.** Main factors impacting the risk rating for the Project is the absence of institutional arrangements for mitigation, reporting and responding to GBV occurring as well as previous incidents of SEA/SH cases in the sector. In line with this corporate accountability towards GBV in emergencies, UNICEF is committed to integrate GBV risk mitigation measures into all UNICEF supported programs targeting girls, boys, women, and men. Similarly, under the Project, UNICEF will ensure a SEA/SH specialist is in place and will develop an SEA/SH action plan with specific and timebound actions to mitigate the SEA/SH risks. The action plan will cover: (i) risk mitigation for GBV and SEA/SH through (a) finalization of a Code of Conduct (CoC); (b) training of SPs and health workers on CoC; (c) in-depth training and refresher training on a regular basis may be necessary, as well as outreach to and awareness raising among local communities or beneficiaries; (ii) case management of GBV through (a) extracting referrals points for GBV and SEA/SH and maintaining a GBV service provider mapping; (b) devising safe and confidential referrals of GBV/SEA for case management; (iii) GRM for reporting and responding to SEA/SH cases. The other risk could be implementation of family planning or services related to promoting contraception as it could be restricted by the ITA, which would have an impact on the quantity of service provision in corresponding payments to NGOs.

85. During the implementation phase, UNICEF will be responsible for E&S screening of activities and implementation of ESMF, making sure that E&S risk mitigation measures are included in bidding documents and specific contractual clauses in contracts of implementing partners. UNICEF will train employees of SPs on implementation of E&S instruments and preparation of reports, which will be regularly monitored. Reports will be prepared by the relevant UNICEF/Project implementing unit and the SPs. UNICEF will ensure that a health and safety, environmental, social, and SEA/SH specialists are in place to provide E&S support for all project activities. Although the risk of women not being able to work in the health sector is minimal given that ITA allowed women to work in the sector under their previous regime, the Project will take measures to ensure that female workers participate in the Project. These measures could range from involving CDCs and community elders to stopping financing the facilities/province.

Gender

86. **Availability of health workers in rural areas has always represented a challenge.** The shortage in health workers, especially female, remains a consistent constraint to girls' and women's access to services in Afghanistan. Under the ITA, female healthcare workers have been encouraged to resume work; however, strict sex-segregation policies continue to limit access to care for girls and women. Geographic inequalities are prominent, and most qualified health workers are in urban areas serving only 25 percent of the population. To address the gender gap and ensure availability of female health workers especially in rural areas, the HER Project will support the following interventions: (i) proper distribution and availability of female health workers across the country (at least one female health work in each facility, and 45 percent of CHWs and vaccinators to be female) through providing appropriate incentives especially in hard to access areas; (ii) onboarding 2,000 female NCs to all health facilities to provide services to pregnant and lactating mothers, and children; (iii) improving GBV service delivery and improving the reporting system for GBV management and referral by reviewing referral protocols and supporting further training and sensitization interventions; and (iv) introducing measures to promote an enabling environment, including to mitigate harassment at the health facilities. In particular, the BPHS/EPHS SPs will provide health response including referral and services to GBV survivors. At least one staff in every

facility will be trained on GBV related counselling in partnership with GBV AoR and/ or Child Protection AoR and/or WHO.

Citizen Engagement

87. **The Project includes several initiatives aimed at strengthening citizen engagement and improving the health system accountability mechanism.** These include: (i) consultations; (ii) GRMs that will also collect and process feedback; and (iii) quarterly surveys of quality of care based on the assessment of the third party using the quantifiable quality checklists adapted to the response. These data will be used to measure the quality of the care as well as the level of the performance of SPs, including patient satisfaction; and (v) a Balanced Scorecard, which is a systematic assessment of the health facilities and communities served in terms of quality of services that has been collected across the country on a regular basis for the last 10 years. The Balanced Scorecard assessment will be conducted once during the Project implementation and its methodology will allow comparison of its progress with the previous projects since 2004. The feedback loops between citizens and providers will be strengthened through these measures.

Climate Change Co-benefit Assessment

88. **Climate impacts are significant already but are projected to worsen and set back socioeconomic development, affecting food and water security, health and well-being, and peacebuilding efforts.** While Afghanistan has a modest contribution to the causes of climate change, the country ranked 176th among 181 nations in the 2020 ND-GAIN Index, implying high vulnerability to climate change and its low readiness to improve resilience. The 2021 Global Climate Index ranks Afghanistan sixth for climate impact and vulnerability, assessed for 2019, climbing from 24th in 2018. A landlocked country, Afghanistan comprises considerable high mountains and desert regions, supporting biodiverse ecosystems and unique landscapes. Climate change is expected to influence the overall variability in temperature and precipitation (rainfall and snowfall) patterns, consequently resulting in generally drier conditions, heightened risks of flash floods and droughts, and a rise in extreme weather events such as heat and cold waves. These changes are also expected to have substantial and cascading impacts on the water, agriculture, health, and human development sectors in interaction with other underlying risk factors.

89. **Climate change directly affects food and nutrition security, undermining current efforts to address undernutrition and hitting the poorest the hardest, especially women and children.** The temperature in project locations is projected to increase by 2050, which may encourage growth and survival of vectors and moderately increase vector-borne diseases. Climate change is therefore seen as a potential factor in changes in disease patterns and as a hunger-risk multiplier. Poor health and undernutrition in turn further undermine people's resilience to climatic shocks and their ability to adapt. In summary, climate change can exacerbate the crisis of undernutrition through four main causal pathways: (i) impacts on households that will be affected by vector-borne diseases; (ii) impacts on environmental health and access to health services; (iii) impacts on care and feeding practices; and (iv) impacts on household access to sufficient, safe, and adequate food. The Project intends to help Afghanistan address the risks to healthcare service delivery and nutrition outcomes due to climate change through sub-components 1.3 and 2.3. The climate co-benefits analysis was completed resulting in 16 percent of climate change adaptation.

D. Legal Operational Policies

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

Waiver of Application of the Anti-Corruption Guidelines

90. A waiver to the application of the WB's Anti-Corruption Guidelines (ACGs) to UNICEF was approved by the WB on March 14, 2022, for the proposed Project pursuant to Bank policy and procedures for Operational Policy Waivers. To ensure appropriate adherence to the principles of the ACGs, including in terms of due diligence and the monitoring of fraud and corruption, UNICEF will use their own rules, regulations, policies and procedures for fraud and corruption, based on a special purpose procedure for fraud and corruption under alternative arrangements modeled on the integrity provisions of the WBFPA, to which UNICEF is party.

V. GRIEVANCE REDRESS SERVICES

91. The Project will utilize existing UNICEF mechanisms and a project specific GRM to enable a broad range of stakeholders to channel concerns, questions, and complaints to implementation agencies. GRM mechanisms will be equipped to handle cases of SEA/SH following a survivor-centered approach. The GRM shall be designed to complement and not replace existing oversight functions and reporting procedures within UNICEF. Technical assistance will also be supported to develop effective triage, management, channeling, and response to complaints.

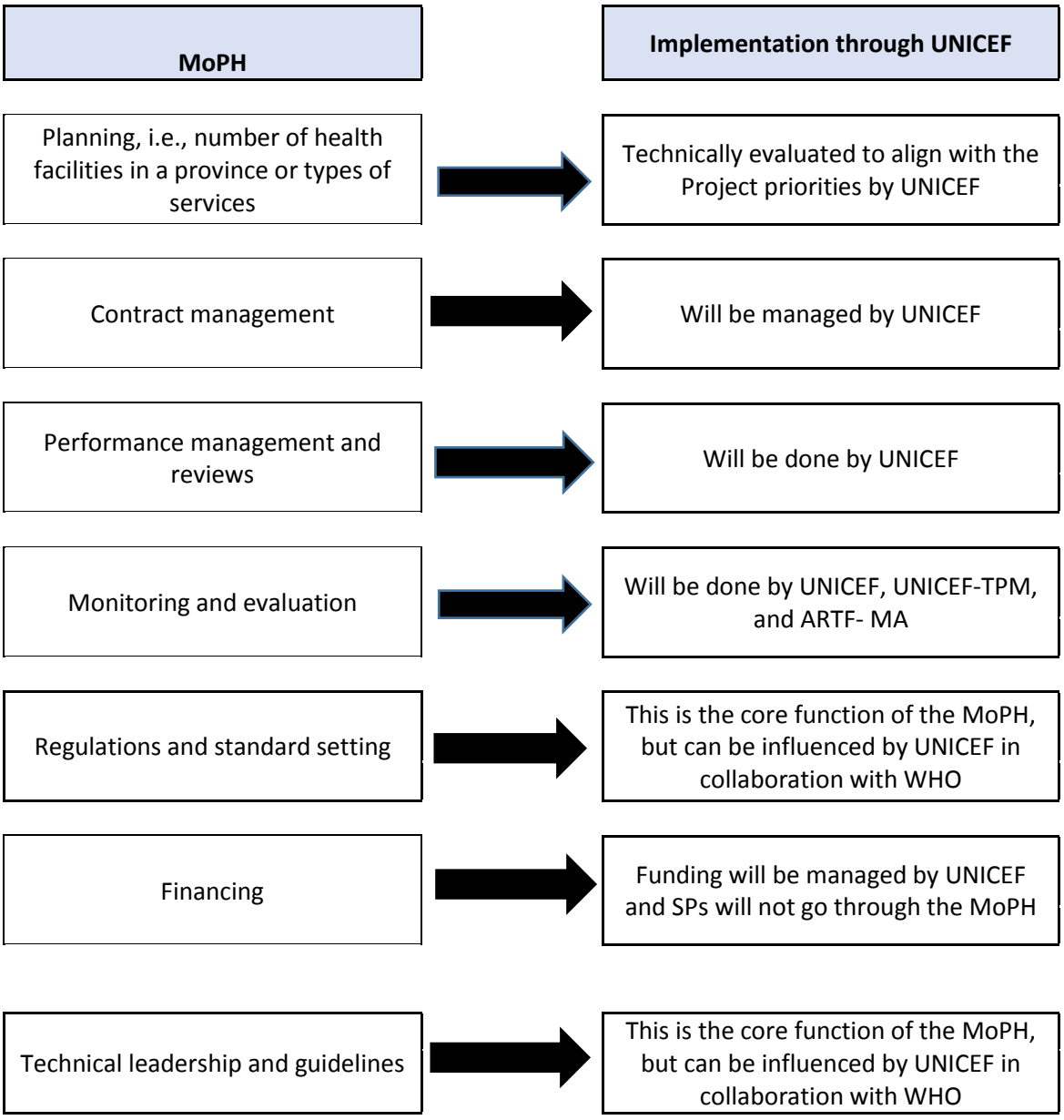
92. Communities and individuals who believe that they are adversely affected by a WB supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed to address Project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, because of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the WB's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the WB's corporate GRS, please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the WB Inspection Panel, please visit www.inspectionpanel.org.

VI. KEY RISKS

93. **The overall risk rating of the Project is Substantial.** The main risks to implementation are due to the ITA, which is not recognized by the international community, and may obstruct or interfere with the implementation of the proposed activities.

94. **Political and governance risk is rated High.** The political situation remains unstable. To mitigate risks from the institutional and political sides, UNICEF will be the implementing partner. The main areas of governance for the Project (such as contract management, performance management, monitoring, and evaluation) will be shifted to UNICEF and third-party entities. Where the implementation of the Project relates to the core functions of the government, UNICEF will aim to mitigate the risk through technical engagements; all strategic, political, and financial decisions will remain in the hands of UNICEF. Figure 4 illustrates the risk mitigation approach.

Figure 4. Touch Points with ITA Line Ministry and Alternatives



95. **Macroeconomic risk is rated High.** The country remains heavily reliant on aid, and any reduction in civilian support below expected levels will place pressure on fiscal sustainability and service delivery. The banking system has collapsed, and this poses a big risk in the management of funds and fund liquidity. UNSCR 2615 and General Licenses released by OFAC has enabled the UN agencies to remedy certain restrictions by adopting alternative financial systems and procedures that are independent from the ITA to support humanitarian activities and basic services, including health care.

96. **Technical Design of Project is rated Substantial.** The Project includes a P4P component similar to the Sehatmandi Project. The P4P model is very data-intensive, complex, and requires a proper understanding of the modeling to maximize results. To mitigate this risk, a detailed scope of work and training will be done to ensure project readiness. Building on lessons learned from Sehatmandi, the P4P design is adjusted to consider the changing context. Additionally, in the project administrative manual, all aspects of project design, particularly the P4P, will be detailed to make sure there is no room for ambiguity and the implementation goes smoothly.

97. **Fiduciary risk is rated Substantial.** The Project will be implemented by UNICEF using their systems. FM and procurement assessments have been undertaken by the WB and lessons from Yemen, South Sudan, and the DRC have been incorporated. The lessons learned from the implementation during the transfer out period (January to June 2022) indicate the risk can be further mitigated through developing a POM by the UN agency, which should be reviewed and approved by the Bank. Payment arrangements still need to be finalized given the current liquidity crisis in the country, and the WB, UN agencies, and INGOs are exploring options to ease the cashflow challenges. All efforts will be in place to avoid the flow of funds through the government. The government will not be permitted to oversee the Project and its authorities will not benefit from the resources allocated to the Project.

98. **E&S risks are rated Substantial.** Both UNICEF and SPs have already worked under WB-financed operations in Afghanistan for many years, are trained, and are familiar with operational guidelines for social and environmental safeguards as well as the ESF. During the implementation phase, UNICEF will be responsible for E&S screening of activities and implementation of ESMF, making sure that E&S risk mitigation measures are included in bidding documents and specific contractual clauses in contracts of the SPs.

99. **Other risks:** Risks related to personal data are outlined below.

100. **The Project has substantial risk on dealing with personal data.** The Project may necessitate the collection and processing of large volumes of personal data, personally identifiable information, and sensitive data in connection with sub-component 2.3 strengthening monitoring, promoting quality of care, and ensuring accountability for verification of health personnel on time salary payments and other data for the purpose of monitoring of health services. To safeguard this data, UNICEF and its partners will be required to abide by UNICEF's policy on personal data protection. This policy is in alignment with international best practices with regards to data protection, including, among others, data minimization (collecting only data that is necessary for the purpose); data accuracy (correct or erase data that are not necessary or are inaccurate), use limitations (data are only used for legitimate and related purposes), data retention (retain data only for as long as they are necessary), informing data subjects of use and processing of data, and allowing data subjects the opportunity to correct information about themselves. As a matter of standard practice, UNICEF further requires any partners who require access to sensitive

personal data to sign non-disclosure agreements governing their access to sensitive data, including specification of which individuals will be granted access, duration of such access and provisions for data disposal after the access period has expired.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY: Afghanistan

AFGHANISTAN HEALTH EMERGENCY RESPONSE (HER) PROJECT

Project Development Objectives(s)

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

Project Development Objective Indicators

Indicator Name	PBC	Baseline	End Target
To increase the utilization and quality of essential health services in Afghanistan.			
Children who have received the third dose of the Pentavalent vaccine through project-financed facilities (Number)		0.00	1,973,536.00
FEMALE - Children who have received the third dose of the Pentavalent vaccine through project-financed facilities (Number)		0.00	986,768.00
Births occurring at project-financed facilities (Number)		0.00	1,277,629.00
Visits for growth monitoring and counselling on age-appropriate infant and young child feeding among children aged 0-23 months received at project-financed facilities (Number)		0.00	11,245,006.00
FEMALE - The visits for growth monitoring and counselling on age-appropriate infant and young child feeding among children aged 0-23 months received at project-financed facilities (Number)		0.00	5,622,503.00

Indicator Name	PBC	Baseline	End Target
Average Quality Checklist score for BPHS and EPHS facilities (Text)		Baseline TBD	Baseline + 15 points

Intermediate Results Indicators by Components

Indicator Name	PBC	Baseline	End Target
Component 1: Urgent provision of essential primary and secondary health services			
Service Providers who receive timely and complete payments from UNICEF as per contractual obligations (Text)		Not applicable	80%
BPHS and EPHS health facility staff who receive at least 90% of their salary on time in the past month (Text)		Data not available	80%
BPHS and EPHS health facilities meeting minimum female staffing requirements (Text)		Data not available	95%
Vaccinators and CHWs who are female (Text)		Data not available	45%
Female nutrition counsellors employed by Service Providers (Text)		Data not available	2,000
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		0.00	7,284,303.00
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number)		0.00	5,646,697.00
Number of children immunized (CRI, Number)		0.00	1,973,536.00
Number of women and children who have received basic nutrition services (CRI, Number)		0.00	4,033,138.00
Number of deliveries attended by skilled health personnel (CRI, Number)		0.00	1,277,629.00

Indicator Name	PBC	Baseline	End Target
Family planning couple-years of protection provided at project-financed facilities (Number)		0.00	739,737.00
Children who have received the first dose of the Pentavalent vaccine through project-financed facilities (Number)		0.00	2,236,360.00
FEMALE - Children who have received the first dose of the Pentavalent vaccine through project-financed facilities (Number)		0.00	1,016,528.00
Component 2: Strengthening service delivery and project coordination			
Health workers who receive training or mentorship (Number)		0.00	8,000.00
EPHS facilities where at least one female staff member has been trained on counselling for gender-based violence, implementation of GBV referral protocols and case management. (Text)		Data not available	80%
Average score on the Quantified Quality Checklist sub-section for pharmaceutical products (Text)		Baseline TBD	Baseline + 15 points
Beneficiaries who are satisfied with services received by the project (Text)		Baseline TBD	75%

Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Children who have received the third dose of the Pentavalent vaccine through project-financed facilities	Children who have received the third dose of the Pentavalent vaccine through project-financed facilities.	Monthly	Health Management Information System	Service providers submit monthly reports to the HMIS of the number of services	Service providers responsible for data submission; UNICEF-TPM responsible for

			(HMIS)	delivered. At regular intervals, a TPM will randomly select a subset of health facilities for verification of their reported numbers.	verification; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection
FEMALE - Children who have received the third dose of the Pentavalent vaccine through project-financed facilities	FEMALE -The number of children up to 23 months who have received the third dose of the Pentavalent vaccine through project-financed facilities	Monthly	Health Management Information System (HMIS)	Service providers submit monthly reports to the HMIS of the number of services delivered. At regular intervals, a TPM will randomly select a subset of health facilities for verification of their reported numbers.	Service providers responsible for data submission; UNICEF-TPM responsible for verification; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection
Births occurring at project-financed facilities	Births occurring at project-financed facilities	Monthly	Health Management Information System (HMIS)	Service providers submit monthly reports to the HMIS of the number of services delivered. At regular intervals, a TPM will randomly select a subset of health facilities for verification	Service providers responsible for data submission; UNICEF-TPM responsible for verification; World Bank will provide technical inputs; UNICEF responsible for oversight of data

				of their reported numbers.	collection
Visits for growth monitoring and counselling on age-appropriate infant and young child feeding among children aged 0-23 months received at project-financed facilities	The number of visits for growth monitoring and counselling on age-appropriate infant and young child feeding among children aged 0-23 months received at project-financed facilities	Monthly	Health Management Information System (HMIS)	Service providers submit monthly reports to the HMIS of the number of services delivered. At regular intervals, a TPM will randomly select a subset of health facilities for verification of their reported numbers.	Service providers responsible for data submission; UNICEF-TPM responsible for verification; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection
FEMALE - The visits for growth monitoring and counselling on age-appropriate infant and young child feeding among children aged 0-23 months received at project-financed facilities	FEMALE - The number of visits for growth monitoring and counselling on age-appropriate infant and young child feeding among children aged 0-23 months received at project-financed facilities	Monthly	Health Management Information System (HMIS)	Service providers submit monthly reports to the HMIS of the number of services delivered. At regular intervals, a TPM will randomly select a subset of health facilities for verification of their reported numbers.	Service providers responsible for data submission; UNICEF-TPM responsible for verification; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection
Average Quality Checklist score for BPHS and EPHS facilities	Average score (out of 100) on a Quantified Quality Checklist among BPHS and EPHS facilities	Every 3-6 months	Direct assessment by third party monitor	A Quantified Quality Checklist (QQC) will be developed prior to project implementation	UNICEF-TPM responsible for data collection; World Bank will provide technical

				that is tailored to the current operating environment. At regular intervals, a TPM will randomly select a subset of health facilities to administer the QQC.	inputs; UNICEF responsible for oversight of data collection

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Service Providers who receive timely and complete payments from UNICEF as per contractual obligations	Percentage of Service Providers who receive full payment (as per contractual agreement) within 30 days of the scheduled disbursement date.	Every 3-6 months	Report of payments by UNICEF, to be confirmed by ARTF-MA.	UNICEF will provide reports of payment amounts and dates; ARTF-MA will verify that transaction was completed.	UNICEF will report data; ARTF Monitoring Agent verifies
BPHS and EPHS health facility staff who receive at least 90% of their salary on time in the past month	Denominator: Number of doctors, nurses, midwives, vaccinators, and nutrition counselors employed at project-supported health facilities Numerator: Number of staff	Every 3-6 months	Direct assessment by third party monitor	At regular intervals, a TPM will randomly select a subset of health facilities for verification of their reported numbers. Staff will be requested whether they received	UNICEF-TPM responsible for verifying staff salaries received; service providers give information on agreed salary amount; World Bank will provide technical inputs; UNICEF

	who received at least 90% of their salary on time in the prior month.			their full payment amount, the timeliness of payment, along with proof of payment received.	responsible for oversight of data collection
BPHS and EPHS health facilities meeting minimum female staffing requirements	Among Basic Health Centers, percentage with at least one female health worker on staff. Among Comprehensive Health Centers and Hospitals, percentage with at least two female health workers on staff. Health workers include doctors, nurses, midwivesife, vaccinators, or nutrition counselors.	Every 3-6 months	Direct assessment by third party monitor	At regular intervals, a TPM will randomly select a subset of health facilities and assess the presence of female staff.	UNICEF-TPM responsible for data collection; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection
Vaccinators and CHWs who are female	Percentage of vaccinators and CHWs who are female	Every 3-6 months	Direct assessment by third party monitor	At regular intervals, a TPM will randomly select a subset of health facilities and assess the presence of female staff.	UNICEF-TPM responsible for data collection; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection
Female nutrition counsellors employed by Service Providers	Number of female nutrition counsellors employed by Service Providers	Every 3-6 months	Direct report by service providers	Service providers will provide a report on the number of nutrition counselors that are employed. The TPM will verify a random subset of these employees.	Service providers responsible for data submission; UNICEF-TPM responsible for verification; World Bank will provide technical inputs; UNICEF

					responsible for oversight of data collection
People who have received essential health, nutrition, and population (HNP) services		Monthly	Health Management Information System (HMIS) and UNICEF nutrition online database	Service providers submit monthly reports to the HMIS of the number of services delivered. At regular intervals, a third party monitor (TPM) will randomly select a subset of health facilities for verification of their reported numbers.	Service providers responsible for data submission; UNICEF-TPM responsible for verification; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)		Monthly	Health Management Information System (HMIS) and UNICEF nutrition online database	Service providers submit monthly reports to the HMIS of the number of services delivered. At regular intervals, a TPM will randomly select a subset of health facilities for verification of their reported numbers.	Service providers responsible for data submission; UNICEF-TPM responsible for verification; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection
Number of children immunized		Monthly	Health Management Information	Calculated as the number of children aged 12 to 23 months	Service providers responsible for data submission; UNICEF-TPM

			System (HMIS)	who have received the third dose of the Pentavalent vaccine through project-financed facilities. Service providers submit monthly reports to the HMIS of the number of services delivered. At regular intervals, a third party monitor (TPM) will randomly select a subset of health facilities for verification of their reported numbers.	responsible for verification; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection
Number of women and children who have received basic nutrition services		Monthly	Health Management Information System (HMIS) and UNICEF nutrition online database	Calculated as the sum of the following: • Antenatal care (first visit) • The number of children <5 years old receiving treatment for MAM or SAM • The number of pregnant or lactating women	Service providers responsible for data submission; UNICEF-TPM responsible for verification; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection

				receiving treatment for MAM Service providers submit monthly reports to the HMIS of the number of services delivered. At regular intervals, a TPM will randomly select a subset of health facilities for verification of their reported numbers.	
Number of deliveries attended by skilled health personnel		Monthly	Health Management Information System (HMIS)	Calculated as the number of births occurring at project-financed facilities Service providers submit monthly reports to the HMIS of the number of services delivered. At regular intervals, a TPM will randomly select a subset of health facilities for verification of their reported numbers.	Service providers responsible for data submission; UNICEF-TPM responsible for verification; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection

Family planning couple-years of protection provided at project-financed facilities	The number of family planning couple-years of protection provided at project-financed facilities, calculated by method of family planning according to USAID methodology	Monthly	Health Management Information System (HMIS)	Service providers submit monthly reports to the HMIS of the number of services delivered. At regular intervals, a TPM will randomly select a subset of health facilities for verification of their reported numbers.	Service providers responsible for data submission; UNICEF-TPM responsible for verification; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection
Children who have received the first dose of the Pentavalent vaccine through project-financed facilities	The number of children aged up to 23 months who have received the first dose of the Pentavalent vaccine through project-financed facilities	Monthly	Health Management Information System (HMIS)	Service providers submit monthly reports to the HMIS of the number of services delivered. At regular intervals, a third party monitor (TPM) will randomly select a subset of health facilities for verification of their reported numbers. The proportion of immunizations administered to female children will be assessed by the TPM during site verification visits.	Service providers responsible for data submission; UNICEF-TPM responsible for verification; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection

				Target was calculated by first summing baseline services delivered between January 1, 2020 and June 30, 2021, after correction for accuracy as assessed by the third party monitor. Target is a 10% increase over baseline (this target was selected based on an analysis of the rate of change in services under Sehatmandi, and accounting for the project's 18 month implementation window).	
FEMALE - Children who have received the first dose of the Pentavalent vaccine through project-financed facilities	The number of children aged up to 23 months who have received the first dose of the Pentavalent vaccine through project-financed facilities	Monthly	Health Management Information System (HMIS)	Service providers submit monthly reports to the HMIS of the number of services delivered. At regular intervals, a third party monitor (TPM) will randomly select a subset of health facilities for verification of their reported numbers. The	Service providers responsible for data submission; UNICEF-TPM responsible for verification; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection

				proportion of immunizations administered to female children will be assessed by the TPM during site verification visits. Target was calculated by first summing baseline services delivered between January 1, 2020 and June 30, 2021, after correction for accuracy as assessed by the third party monitor. Target is a 10% increase over baseline (this target was selected based on an analysis of the rate of change in services under Sehatmandi, and accounting for the project's 18 month implementation window).	
Health workers who receive training or mentorship	Number of health workers who receive training or mentorship under component 2.1 of the	Every 3-6 months	Direct report by service providers	Service providers will provide a report on the number of nutrition counselors that are	Service providers responsible for data submission; UNICEF-TPM responsible for

	project			employed. The TPM will verify with a random subset of these employees that they received training.	verification; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection
EPHS facilities where at least one female staff member has been trained on counselling for gender-based violence, implementation of GBV referral protocols and case management.	Percent of EPHS facilities where at least one female staff member has been trained on counselling for gender-based violence, implementation of GBV referral protocols and case management [in-line with survivor-centered principles].	Every 3-6 months	Direct assessment by third party monitor	At regular intervals, a TPM will randomly select a subset of EPHS health facilities and assess whether staff have received training on gender-based violence.	UNICEF-TPM responsible for data collection; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection
Average score on the Quantified Quality Checklist sub-section for pharmaceutical products	Score (out of 100) on the pharmaceutical sub-section of a Quantified Quality Checklist among BPHS facilities	Every 3-6 months	Direct assessment by third party monitor	A Quantified Quality Checklist (QQC) will be developed prior to project implementation that is tailored to the current operating environment. At regular intervals, a TPM will randomly select a subset of health facilities to administer the QQC.	UNICEF-TPM responsible for data collection; World Bank will provide technical inputs; UNICEF responsible for oversight of data collection
Beneficiaries who are satisfied with services received by the project	Proportion of beneficiaries who report being “somewhat” or “very”	Every 3-6 months	Direct assessment by third party	At regular intervals, a TPM will randomly select a subset of	UNICEF-TPM responsible for data collection; World Bank will provide

	satisfied overall with the health services they received at BPHS and EPHS facilities		monitor	health facilities for assessment. Beneficiary interviews will be conducted on a random subset of patients to assess satisfaction.	technical inputs; UNICEF responsible for oversight of data collection

ANNEX 1: IMPLEMENTATION ARRANGEMENTS AND SUPPORT PLAN

Implementation Arrangements

1. The Project will be implemented by UNICEF, which will be responsible for the overall implementation and FM of the Project. UNICEF is a signatory to the FPA and the FMFA between UN and the WB, and the FM arrangements at UNICEF are acceptable to the Bank. The UNICEF FM systems provide reasonable assurance that the grant proceeds will be used for the intended purposes.

2. UNICEF has established a PMU in Kabul to manage the day-to-day FM activities of the Project. UNICEF will maintain separate ledgers for the Project following the UN Financial Regulations. UNICEF will use the SAP for Project accounting and reporting purposes.

3. The proposed Project is an emergency operation processed under Section III Paragraph 12, Projects in Situations of Urgent Need of Assistance or Capacity Constraints of the "Bank Policy: Investment Project Financing" and uses a UN agency (UNICEF) as a PMU. The Project will be subject to WB fiduciary policies and procedures. The Project will be carried out in accordance with the World Bank ESSs.

4. An intensive implementation support regime is proposed. Quarterly virtual implementation support missions will be conducted. While the Bank's involvement in procurement will be less rigorous than normal due to the use of the APA, safeguards compliance will require intensive Bank support.

5. Given the substantial and high-risk ratings for various risk dimensions, a key element of the Bank's implementation support strategy will be to monitor these risks closely over the Project duration. The Bank team will conduct routine risk reviews through virtual implementation support missions, to be conducted jointly by the WB and UNICEF to identify and agree mitigation measures to be taken by the Project.

Implementation Support Plan and Resource Requirements

6. UNICEF will field a skilled and well-performing team to carry out implementation across the Project intervention areas. The Kabul UNICEF office will be the key nodal project management with strong support from its regional office and headquarters.

World Bank Implementation Support Functions

7. The WB will conduct quarterly virtual implementation support missions to: (i) review implementation progress and achievement of PDO and intermediate indicators; (ii) provide support for any implementation issues that may arise; (iii) provide technical support related to implementation and achievement of results; and (iv) discuss relevant risks and mitigation measures.

8. The WB team comprises specialists in the areas of health service delivery, health economics, M&E, operations, FM, procurement, social and environment safeguards, and administration. WB operational and fiduciary staff are based in the USA, India, and other countries, which will facilitate implementation support and ad hoc problem solving. Regarding specific technical support, experts may be recruited as

deemed necessary during Project implementation.

9. The following Implementation Support Plan reflects the preliminary estimates of the skill requirements, timing, and resource requirements over the life of the Project.

Table A1.1: Implementation Support Plan

Time	Focus	Skills
0–3 months	• Project launch • Initialization of Project components • FM systems functioning effectively • Procurement practice • Monitor implementation of Project activities	• Team leaders • Technical team members • FM and PS specialists • Safeguards specialists • M&E expert
4–6 months	• Monitor implementation of Project activities, with focus on short-term recovery • FM, procurement, safeguards	• Team leaders • Technical team members • FM and PS specialist • Safeguards specialists • M&E expert
6–12 months	• Monitor progress on results for short-term recovery interventions and systems for medium-term recovery • FM, procurement, safeguards	• Team leaders • Technical team members • FM and PS specialist • Safeguards specialists • M&E expert
12–18 months	• Results monitoring • FM, procurement, safeguards • Project closing	• Team leaders • Technical team members • FM and PS specialist • Safeguards specialists • M&E expert

Monitoring Arrangements

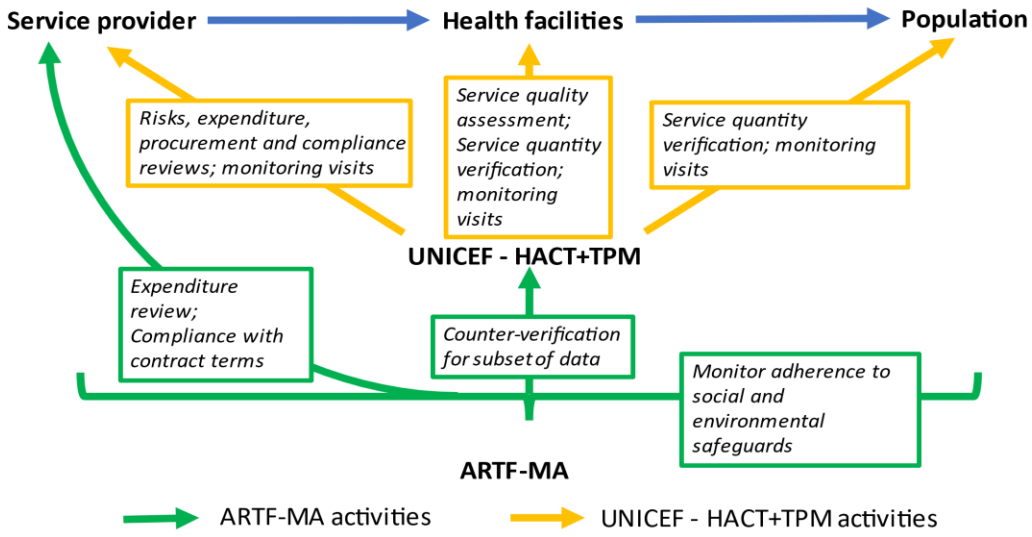
10. To assess the progress of the HER, data will be collected as described under Component 2 to monitor progress of the Project including cost-of-service delivery. In addition, UNICEF and WB will co-develop a complementary high-frequency approach leveraging the ARTF-MA and UNICEF contracted firms to undertake financial assurance activities to ensure that funds are used in compliance with the terms of the contract. Assessments of compliance with social and environmental safeguards will be conducted. Investigations of specific allegations of fraud and corruption will be conducted by UNICEF as needed, in accordance with the FMFA and grant agreement.

11. In summary, the following sources of data will be used:

a. UNICEF's audit firm and ARTF-MA will jointly conduct **financial reviews** of the SPs to ensure that funds are being used in compliance with the terms of the contract and give insight into the cost-of-service delivery.
b. SPs will report achievements via the **HMIS data**; UNICEF-TPM will verify the data. Once verified by UNICEF-TPM, UNICEF will use the HMIS data for the purpose of analysis and assessing the progress of the response, as well as part of the payment formula for SPs.

c. UNICEF-TPM's assessments will include quantifiable quality checklists adapted to the response, which will be the basis of quarterly **quality of care assessments.** UNICEF will use this data ~~as~~ part of the payment formula for SPs and to identify areas for improvement.
d. Once during the Project, a **National Quality Assessment** will be conducted. The methodology would allow comparison of the progress of the Project with the previous projects since 2004.

Figure 5. Division of Activities between ARTF-MA and UNICEF-HACT and TPM



12. **Targets for service volume indicators.** Under the transfer out arrangement with UNICEF and WHO, the volume of service delivery has rebounded to similar levels as compared to the months immediately preceding the ITA takeover. Given the reintroduction of the P4P mechanism as part of the HER Project, as well as additional enhancements in management support for SPs, the HER Project preparation team saw fit to set targets that go beyond maintenance of current levels of service delivery. The magnitude of the targeted increase for service delivery volume is 10 percent more than the verified volume of service delivery observed from January 1, 2020, to June 30, 2021. This target is believed to be feasible because (i) a published analysis of Sehatmandi impacts suggests that the first 12 months of Sehatmandi brought about a 10 percent increase in service volume; and (ii) the impacts of the COVID-19 pandemic had eroded previous gains for some services, thereby indicating the need for recovery growth.

Key FM Risks and Agreed Mitigation Measures

13. Table A1.2 below summarizes the critical fiduciary risks and agreed mitigation measures.

Table A1.2: Key Fiduciary Risks and Agreed Mitigation Measures

Risk	Mitigation Measure
i. The NGOs could report excess services volume and claim payment for the same, resulting in excess payments to the NGOs. Most of the NGO contractual payments will be linked to services volume reported to UNICEF in their quarterly reports and recorded in HMIS. Therefore, the reporting of services delivery volume higher than the actual services delivered could result in excess payments.	UNICEF will engage a TPM firm to verify services volume and quality every quarter. UNICEF will pay the lump-sum and P4P parts as per the payment schedule. Lump-sum part of the payment will be based on SPs' quarterly progress reports. P4P payment will be based on the volume of service delivery recorded in the HMIS system. UNICEF will use the HACT framework, in which, based on a detailed review of expenditure and financial reporting, the NGOs will liquidate advanced payments. Any excess or disallowed expenses would be reimbursed and credited back to the grant for reprogramming as required.
ii. There are various risks related to health workers' employment and salary payments. The health workers' salaries would be the highest cost in the NGO contracts, and the NGOs across the country would employ many health workers. Many of the qualified professionals may have left the country after August 15, 2021, which may create the issue of health workers' availability. Therefore, the NGOs may employ health workers not meeting the minimum qualification criteria. Lastly, the health workers may not receive salaries in time due to the liquidity issues and constrained financial sector.	The eligibility/qualification criteria of the health workers notified by MoPH before August 15, 2021, would apply. The NGOs would be required only to employ health workers meeting the minimum requirements, and the salary of a health worker not meeting the requirements would not be eligible. The NGOs will be required to document the hiring process of health workers for future reviews. The NGOs will pay the health workers' salaries each month through banking channels or other modalities as agreed with UNICEF. In addition, the NGOs will submit monthly salary payments reports to UNICEF. TPM verification activities will include: (i) review of the hiring process of health workers for compliance with the policy; (ii) attendance and availability of the health workers whose salaries are being paid under the contract; (iii) timely salary payments to the health workers; and (iv) validation of the salary payments to the health workers. The ARTF-MA and UNICEF employed audit firms will perform periodic audits of the NGOs per the audit ToRs of the interagency HACT framework.
iii. A volatile Afghani (AFN) exposes the NGOs and health workers to significant exchange loss risk. Most of the vendors in Afghanistan now demand contracts and payments in US$. There is a risk that vendors may not agree to a contract in AFN for the supply of medicine and equipment. The health workers may be exposed to hyper-inflation if receiving salaries in AFN.	The NGO contracts will be in US$, and UNICEF will pay the NGOs in US$. Moreover, the NGOs would be required to contract and pay the health workers' salaries in US$. If the US$ payments to health workers are not possible, the NGOs would pay them the equivalent AFN per the rate prevailing on the payment date.

Flow of Funds and Disbursement

14. To retain flexibility, ARTF funding will be released for the Project in two tranches. The first tranche in the amount of US$150 million will be made available upon effectiveness of the Project. However, the actual advance to UNICEF would be based on UNICEF's expenditure forecast approved by the Bank. Within six months after Project effectiveness, a review will be held to assess if progress has been made and an additional tranche in the amount of US$164 million should be released from the ARTF. This assessment will be based on tranche release criteria and fund availability. The GFF funding in the amount of US$19 million will be released upon effectiveness of the Project along with the ARTF US$150 million. The WB has agreed with UNICEF to include the following tranche release criteria that will be applied to the release of funds from the ARTF to the Project, subject to funding availability.

15. The first tranche release criteria is the effectiveness of the Project. The second tranche release criteria after six months of implementation will include: (i) quarterly performance reviews of at least 70 percent of BPHS/EPHS SPs carried out; (ii) 80 percent of SPs having received timely and complete payments (both lump-sum and P4P amounts) as per payment schedule in their contract; (iii) timely submission of all project progress report including all agreed content; and (iv) whether the described ECA continues to be in place.

Table A1.3: Disbursement Categories

Category	Amount of the ARTF Grant Allocated (Expressed in USD)	Percentage of Expenditures to be Financed (Exclusive of Taxes)	Amount of the GFF Grant Allocated (Expressed in USD)	Percentage of Expenditures to be Financed (Exclusive of Taxes)
Goods, works, non-consulting services, consulting services, Training and Operating Costs for **Part 1** of the Project	129,330,000	87.6 percent	18,269,000	12.4 percent
Goods, works, non-consulting services, consulting services, including audits, Training and Operating Costs for **Parts 2.1, 2.2, 2.3 and 2.4 (ii) and (iii) of the Project**	14,900,000	100 percent	0	N/A
Indirect Cost (4 percent) under **Part 2.4 (i)** of the Project	5,770,000	100 percent	731,000	100 percent
TOTAL AMOUNT	150,000,000		19,000,000	

16. Disbursement to UNICEF will be report-based. The WB will transfer an initial advance to UNICEF upon effectiveness of the Project based on UNICEF's fund forecast approved by the WB. UNICEF will submit a quarterly interim unaudited financial report within 45 days of the end of each calendar quarter to liquidate the last advance and request additional advance. Each quarter, the Bank and UNICEF will

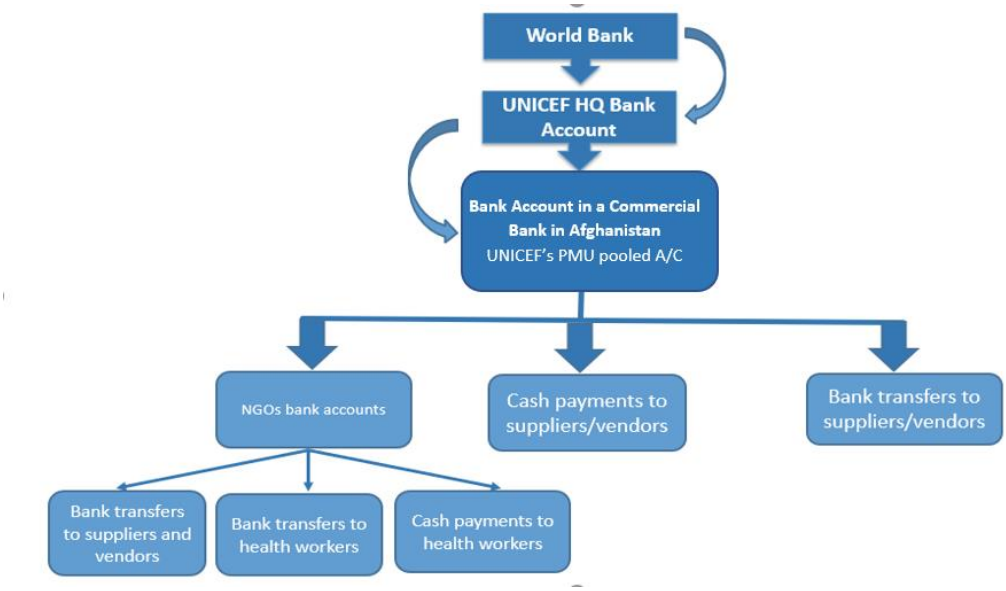
jointly review the quarterly progress report and IFRs to recommend expenditure documentation and additional advances. The Bank, based on approved IFR, will document reported expenditure, and disburse further advance to UNICEF's corporate account. At the end of second or third quarterly reviews, the Bank will make a recommendation to the ARTF donors to approve second tranche based on physical and financial progress.

17. UNICEF will be responsible for transferring funds to Afghanistan via UNICEF's in-country pooled bank account, for payments within Afghanistan. UNICEF, on its own or through NGOs, will also be responsible for arranging transfers to the eligible recipients through the following modalities for last-mile payments within the country:

A. **Bank Transfers:** All payments to private suppliers, other vendors, and NGOs will be made through bank transfers. Private contractors and vendors will have the choice of commercial bank accounts to receive the payment. Where possible, the NGOs will make bank transfers to the health workers. In limited instances where bank transfer to NGOs is not feasible, UNICEF will make cash payments to NGOs in line with the HACT framework and other relevant UNICEF policies and procedures.

B. **Physical Cash:** Where bank transfers are not feasible, payment will be in cash. For example, for health workers' salary payments, the next option will be physical cash payments by the NGOs to the health workers. The NGOs will be required to get an acknowledgment of receipt for transaction audit trails. The control measures for physical cash payments would be agreed upon between UNICEF and the NGOs.

Figure A1.1: Flow of Funds



18. **Accounting and Financial Reporting:** UNICEF will maintain project accounting and reporting using VISION/SAP and in accordance with the UN Financial Regulations and the FMFA. UNICEF will be

responsible for preparing and submitting quarterly informal financial report (IFRs) to the WB within 45 days of the close of each quarter. The format of the IFR will be agreed upon during project negotiations. Per FMFA, UNICEF will submit the grant's annual financial statement of account within six months of the close of its financial year. UNICEF's financial year closes on December 31, and the annual financial statement of account will be due on June 30 of the following year.

19. **Internal Audit and External Audit:** The UN external auditors will audit the Project financial statements in accordance with the UN System Accounting Standards. As per FMFA, the Bank recognizes the UN single audit principle, and UNICEF will not conduct a separate grant audit. UNICEF's OIAI may conduct an internal audit of the Project, if it determines, based on its risk-based work planning process, that such project audit is warranted. The Bank may also make a request for a special internal audit of the Project, which OIAI will consider. If OIAI agrees to conduct the special audit, the related costs may be borne out of project funds. Any resulting internal audit reports will be made available in accordance with UNICEF's public disclosure policy.

20. **UNICEF will use the HACT framework for funds transfer to the NGOs.** HACT is a common framework for transferring cash to government and non-government implementing partners. The HACT framework comprises four key elements: (i) capacity assessments; (ii) cash transfers and reporting; (iii) assurance activities; and (iv) capacity development in financial management. UNICEF will conduct the capacity assessments of the NGOs during the project preparation phase, while the remaining three processes will be used during the project implementation and monitoring phase. As part of the capacity assessments, UNICEF will carry out the micro assessment of the NGOs, which mainly focuses on the implementing partner's FM capacity to determine the overall risk rating. UNICEF will use the overall risk rating determined by the micro assessment in determining the appropriate cash transfer modality for the NGO and the corresponding assurance activities. UNICEF will use three payment modalities: (i) direct cash transfers; (ii) direct payments; and (iii) reimbursements under the HACT framework. The NGOs will use the Funding Authorization and Certificate of Expenditure form to request funds and report expenditures. UNICEF will perform the assurance activities through programmatic monitoring, spot checks, and audits to ensure that the funds are used for the intended purposes.

21. **ARTF-MA:** To ensure continuity of oversight of ARTF-financed activities at the portfolio level, the ongoing use of the existing ARTF-financed monitoring arrangement will be continued with relevant ToRs. As laid out in the Project Implementation Support Plan, the WB will engage a monitoring agent to support supervision of physical performance and financial monitoring. In accordance with the alternate assurance and reporting arrangements enshrined in the FMFA including, the determination of supervision activities with frequency and scope mutually agreed with UNICEF, ToRs for supervision services to be carried out by the ARTF-MA will be developed in consultation between UNICEF and the WB. Verification reports will be provided to UNICEF and the WB. The ToRs will be annexed to the POM.

Procurement Arrangements

22. **UNICEF will have overall procurement responsibility under the Project and follow its own procurement procedures.** UNICEF will leverage existing institutional arrangements with partners such as international and local NGOs, local private SPs, and civil works contractors to help implementation.

23. **Planned procurement and approaches.** UNICEF Supply for goods and services department will conduct all procurement requirements according to its policies and procedures. UNICEF's PMU team will do the contracting of health service provider implementing partners. UNICEF will leverage existing competitively established long-term agreements and/or advertise to all potential firms that exist in the market, thereby extending the opportunity to those beyond its registered firms. The Project's approach to the procurement of pharmaceuticals, medical supplies, and equipment will go through a transition from the current procurement practice (continuation of those under Sehatmandi) towards a hybrid approach whereby UNICEF will conduct pooled procurement for a subset of service providers and/or a subset of supplies for BPHS and EPHP. A review of service providers capacity, market assessment and Quality Assessment Standard Operating Procedures will determine extent of procurement by SPs. The transition will be gradual to mitigate the risk of stock outs of essential commodities in health facilities. The transition and related risks, mitigation measures, and the market assessment will be further detailed in the POM.

24. **Procurement under all components.** UNICEF will enter into program cooperation agreements with NGOs to implement certain activities and contract some consultancy firms to conduct survey and verify data. UNICEF will also procure equipment and essential medicines directly and/or through the NGOs as per the agreed procurement plan. UNICEF may also enter into UN-to-UN Transfer Agreements with other UN agencies (for example, WHO and UNFPA).

25. **Systematic Tracking of Exchanges in Procurement (STEP), procurement plan, and Procurement Strategy for Development (PPSD).** The use of STEP is not recommended under this project due to the unique nature of project arrangements. In addition, there will be no contract subject to prior review and UNICEF has its own tracking systems and would generate procurement progress reports as required. UNICEF prepared a detailed procurement plan/activity plan for the first 12 months of project implementation which was discussed at negotiations. Given that this project is an emergency operation, the PPSD will be deferred to the implementation phase.

26. **APAs.** UNICEF will apply its own procurement procedures which are found acceptable to the Bank under other agreements and allowed by the Procurement Framework Policy Section III.F. This procurement arrangement is considered a fit-for-purpose arrangement for several reasons.

27. **Residual procurement risk is rated moderate as the procurement activities proposed under this project are within the mandate of UNICEF.** UNICEF is well informed about the market response locally and internationally, about the goods to be procured under the Project, has a strong presence on the ground, and has the capacity to work in post-conflict areas in Afghanistan. UNICEF's procurement arrangements provide reasonable assurance that WB financing will be used for the intended purpose. UNICEF has proven that they are well equipped to work in post-conflict areas in Afghanistan and has the capacity to reach out to the most affected beneficiaries. UNICEF has international and national procurement staff at its office in Kabul and has a procurement focal point in each zonal office. The procurement team in the country will be supported, as required, through a regional office located in Katmandu and headquarters teams in Copenhagen and New York. The country-office staff handling local procurement and logistics and regional/headquarters staff handling international procurement.

28. **UNICEF will ensure adequate and qualified procurement staff support the Project, with at least one qualified international procurement expert and at least two qualified national procurement**

specialists to conduct day-to-day procurement functions in procurement unit. The risk of delay due to internal UNICEF approval would be mitigated by advance planning and delegation of authority at the appropriate levels as well as commitment by UNICEF to comply with the agreed procurement plans, particularly the timelines. The fiduciary risk will be mitigated by inclusion of progress of implementation of the procurement plan in the quarterly project reports by UNICEF. The Bank will review and agree to the procurement plans and their updates.

29. **Monitoring arrangement.** UNICEF will be responsible for: (i) implementing the procurement plan as agreed with the Bank; (ii) reporting on the progress of procurement and distribution as part of the quarterly progress report; (iii) providing other relevant performance information to the Bank as requested; and (iv) ensuring pre-screening of companies/individuals prior to award any contract financed by the Project against the Bank's lists of sanctioned or temporarily suspended companies; this includes ensuring that all implementing partners have procedures in place for such screening. Quarterly reporting will be supplemented by other mechanisms outlined in the HER Project Paper to ensure regular direct contact between the WB and UNICEF to review the status of activities.

ANNEX 2: KEY SHIFTS IN AFGHANISTAN PRIMARY AND SECONDARY CARE FINANCING AND DESIGN

	Pre-Sehatmandi (2014–2018)	Sehatmandi (Jan 2019–Aug 2021)	Post-transition (Aug 2021–June 2022)	Future project (July 2022–Dec 2023)
Key financing source	WB/ARTF SEHAT project (US$518 million).	1) WB/ARTF Sehatmandi Project (US$600 million). 2) *WB COVID-19 emergency response project, plus Additional Financing (US$213.4 million).*	1) *Global Fund (US$15 million) for Oct 2021.* 2) *UN-CERF (US$45 million) for Nov 2021–Jan 2022* 3) *WB/ARTF (US$100 million) for Feb–Jun 2022.*	*WB/ARTF Health Emergency Response project (~US$333 million).*
Services covered	Package of basic primary and secondary health services (BPHS/EPHS).	1) BPHS/EPHS. 2) *COVID-19 diagnostics, treatment, public communication, and vaccines.*	1) BPHS/EPHS. 2) *COVID-19 diagnostics, treatment, public communication, and vaccines.*	1) BPHS/EPHS. 2) *COVID-19 (excluding vaccine procurement).*
Delivery mechanism	MoPH contracts non-governmental SPs Grant and Contract Management Unit manages performance and contracts.	MoPH contracts SPs. *National and provincial health teams manage performance.*	*UNDP, WHO, and UNICEF contracts non-governmental SPs to provide services.*	*UNICEF contracts non-governmental SPs to provide services. UNICEF manages performance. Firm(s) contracted to provide management accompaniment to SPs.*
SP payment conditionalities	80 percent of contract was lump-sum (i.e., no conditions) while 20 percent was linked to service volume.	*Majority of contract linked to service volume and min quality (percentage varied between SPs), with remaining paid as lump-sum.*	*Lump-sum contract.*	Lump-sum based on the amount needed to deliver services; with a P4P element. Majority of contract linked to service volume and min quality (percentage to vary between SPs), with remaining paid as lump sum.
Verification	TPM collected data on service volume and quality.	TPM collected data on service volume and quality. *Volume data linked to payment.*	*Monitoring by UNICEF and WHO to assess facility functionality and staff payments.*	*TPM collected data on service volume and quality. Volume and quality data linked to payment*.

Note: Text in italics denotes substantial change from prior time periods.