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IMPLEMENTATION COMPLETION AND RESULTS REPORT

ON

JSDF GRANT NO. TF095919

IN THE AMOUNT OF US\$17.65 MILLION

TO THE

ISLAMIC REPUBLIC OF AFGHANISTAN

FOR A

SUPPORT TO BASIC PACKAGE OF HEALTH SERVICES PROJECT

September 25, 2015

Health, Nutrition and Population Global Practice
South Asia Region

ABBREVIATIONS AND ACRONYMS

AHS	Afghanistan Health Survey
ACTD	Afghan Center for Training & Development
AIMS	Afghan Information Management System
AMS	Afghanistan Mortality Survey
ARI	Acute Respiratory Infection
ARTF	Afghanistan Reconstruction Trust Fund
BHC	Basic Health Center
BPHS	Basic Package of Health Services
BSC	Balanced Score Card
CAS	Country Assistance Strategy
CHA	Coordination of Humanitarian Assistance
CHC	Comprehensive Health Center
CHW	Community Health Worker
CMW	Community Midwife
CN	Community Nurse
DALY	Disability Adjusted Life Year
DH	District Hospital
DPT3	Diphtheria, Tetanus and Pertussis vaccine (3 Doses)
EPI	Expanded Program on Immunization
EU	European Union
FMR	Financial Management Report
GCMU	Grants and Contracts Management Unit
GDP	Gross Domestic Product
HMIS	Health Management Information System
HF	Health Facility
HNSS	Health and Nutrition Sector Strategy
HSERDP	Health Sector Emergency Reconstruction & Development Project
ICRC	International Committee of the Red Cross
IMCI	Integrated Management of Childhood Illness
ISN	Interim Strategy Note
JHU	Johns Hopkins University
JSDF	Japan Social Development Fund
KPPHD	Kabul Provincial Public Health Directorate
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MoF	Ministry of Finance
MOPH	Ministry of Public Health
NA	Not Available
NGO	Non-Governmental Organization
NRVA	National Risk and Vulnerability Assessment
OPV3	Oral Polio Vaccine (3 Doses)
PDO	Project Development Objective
PHD	Provincial Health Director

PHO	Provincial Health Office
PPA	Performance-Based Partnership Agreement
PRR	Priority Reform and Restructuring
RBF	Result-based financing
SCA	Swedish Committee for Afghanistan
SEHAT	System Enhancement for Health Action in Transition Project
SHARP	Strengthening Health Activities for the Rural Poor Project
SM	Strengthening Mechanism
TB	Tuberculosis
TSS	Transitional Support Strategy
USAID	United States Agency for International Development
WHO	World Health Organization
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund

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AFGHANISTAN
Support to Basic Package of Health Services (BPHS) Project

CONTENTS

Data Sheet

- A. Basic Information
- B. Key Dates
- C. Ratings Summary
- D. Sector and Theme Codes
- E. Bank Staff
- F. Results Framework Analysis
- G. Ratings of Project Performance in ISRs
- H. Restructuring
- I. Disbursement Graph

1. Project Context, Development Objectives and Design	1
2. Key Factors Affecting Implementation and Outcomes	5
3. Assessment of Outcomes.....	12
4. Assessment of Risk to Development Outcome (Rating: High).....	19
5. Assessment of Bank and Borrower Performance.....	19
6. Lessons Learned	23
7. Comments on Issues Raised by Borrower/Implementing Agencies/Partners	24
Annex 1. Project Costs and Financing	27
Annex 2. Outputs by Component	28
Annex 3. Economic and Financial Analysis	43
Annex 4. Bank Lending and Implementation Support/Supervision Processes	47
Annex 5. Beneficiary Survey Results.....	48
Annex 6. Stakeholder Workshop Report and Results	56
Annex 7. Summary of Borrower's ICR and/or Comments on Draft ICR	57
Annex 8. Comments of Cofinanciers and Other Partners/Stakeholders	64
Annex 9. List of Supporting Documents.....	67
MAP	68

A. Basic Information			
Country:	Afghanistan	Project Name:	Afghanistan - Support to Basic Package of Health Services (Strengthening Health Activity for Rural Poor)
Project ID:	P120565	L/C/TF Number(s):	TF-95919
ICR Date:	09/04/2015	ICR Type:	Core ICR
Lending Instrument:	SIL	Grantee:	ISLAMIC REPUBLIC OF AFGHANISTAN
Original Total Commitment:	USD 17.65M	Disbursed Amount:	USD 17.52M
Revised Amount:	USD 17.52M		

Environmental Category: C

Implementing Agencies:

Ministry of Public Health, Afghanistan

Cofinanciers and Other External Partners:

B. Key Dates

Process	Date	Process	Original Date	Revised / Actual Date(s)
Concept Review:		Effectiveness:		03/14/2010
Appraisal:		Restructuring(s):		03/13/2013 03/13/2014 09/07/2014
Approval:	12/23/2009	Mid-term Review:	06/30/2011	10/04/2011
		Closing:	03/14/2013	3/14/2014 9/15/2014 12/31/2014

C. Ratings Summary

C.1 Performance Rating by ICR

Outcomes:	Satisfactory
Risk to Development Outcome:	Substantial
Bank Performance:	Moderately Satisfactory
Grantee Performance:	Moderately Satisfactory

C.2 Detailed Ratings of Bank and Borrower Performance (by ICR)

Bank	Ratings	Borrower	Ratings
Quality at Entry:	Satisfactory	Government:	Moderately Satisfactory

Quality of Supervision:	Moderately Satisfactory	Implementing Agency/Agencies:	Moderately Satisfactory
Overall Bank Performance:	Moderately Satisfactory	Overall Borrower Performance:	Moderately Satisfactory

C.3 Quality at Entry and Implementation Performance Indicators

Implementation Performance	Indicators	QAG Assessments (if any)	Rating
Potential Problem Project at any time (Yes/No):	Yes	Quality at Entry (QEA):	None
Problem Project at any time (Yes/No):	No	Quality of Supervision (QSA):	None
DO rating before Closing/Inactive status:	Moderately Satisfactory		

D. Sector and Theme Codes

	Original	Actual
Sector Code (as % of total Bank financing)		
Health	100	100
Theme Code (as % of total Bank financing)		
Child health	30	30
Health system performance	40	40
Population and reproductive health	30	30

E. Bank Staff

Positions	At ICR	At Approval
Vice President:	Annette Dixon	Isabel Guerrero
Country Director:	Robert J. Saum	Nicholas Kraftt
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F. Results Framework Analysis

Project Development Objectives (from Project Appraisal Document)

The PDO is to improve the health and nutritional status of the people of Afghanistan, with a greater focus on women and children by increasing accessibility and quality of the Basic Package of Health Services (BPHS) in the provinces of Balkh, Samangan and in urban Kabul.

Revised Project Development Objectives (as approved by original approving authority)

(a) PDO Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Pregnant women receiving antenatal care during a visit to a health provider			
Value quantitative or Qualitative)	70,353	119,127		127,440
Date achieved	07/01/2009	04/14/2013		12/04/2014
Comments (incl. % achievement)	Achieved. Based on AHS 2014 Survey Original Indicator			
Indicator 2 :	DPT3 coverage among children 12-23 months			
Value quantitative or Qualitative)	34% (74,750)	60% (142,963)		46.7% (102,671)
Date achieved	07/01/2009	04/14/2013		05/25/2014
Comments (incl. % achievement)	Not achieved. Based on AHS 2014, Original Indicator.			
Indicator 3 :	Number of consultations per person per year			
Value quantitative or Qualitative)	0.9	1.4		1.84
Date achieved	07/01/2009	04/14/2013		12/08/2014
Comments (incl. % achievement)	Surpassed. HMIS 2014. Original Indicator.			
Indicator 4 :	% children below 5 y with Chronic Malnutrition (National Average)			
Value quantitative or Qualitative)	60.5%			40.9%
Date achieved	2004			2013
Comments (incl. % achievement)	Achieved. National Nutrition Surveys 2004 and 2013. This indicator was added by ICR author to reflect status of nutrition. No breakdown for Balkh, Samangan and urban Kabul.			

(b) Intermediate Outcome Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	People with access to a basic package of health, nutrition, or reproductive health services			
Value (quantitative or Qualitative)	4,671,600	5,062,917		Not evaluable
Date achieved	07/01/2009	04/14/2013		05/25/2014
Comments (incl. % achievement)	Not evaluable. Due to unavailability of comparable data for measuring the progress in access to health services, this ICR uses another indicator for measuring physical access -“People with access to health services with two hours distance by any means of transport”. The data for this indicator shows remarkable progress in access to health services between 2006 and 2012 at the national level. According to the NRVA 2012, 88.4% of the population can reach the nearest health facility within two hours. The corresponding overall figure reported in AHS 2006 was only 60%.			
Indicator 2 :	Births attended by skilled attendants			
Value (quantitative or Qualitative)	18.9%	28%		40%
Date achieved	12/31/2006	04/14/2013		05/25/2014
Comments (incl. % achievement)	Surpassed. NRVA 2011/2012. Baseline based on CSO statistics. Original Indicator.			
Indicator 3 :	TB Treatment Success Rate			
Value (quantitative or Qualitative)	85%	90%		89%
Date achieved	12/31/2008	04/14/2013		12/08/2014
Comments (incl. % achievement)	Achieved. HMIS 2014 (percentage). Original Indicator			
Indicator 4 :	Score on the balanced scorecard examining quality of care in health facilities.			
Value (quantitative or Qualitative)	70	60		56
Date achieved	12/31/2007	04/14/2013		03/31/2013
Comments (incl. % achievement)	Not evaluable. Balanced scorecard was revised and updated in 2010/11. Hence scores of 2011/12 and 2012/13 are not comparable with baseline. The actual performance was 56 according to BSC 2013. Original Indicator.			
Indicator 5 :	Mean % Score on the National Monitoring Checklist for quality of services			
Value (quantitative or Qualitative)	Balkh 77% Samangan 82%			Balkh 87% Samangan 89%

Date achieved	01/01/2011			12/31/2014
Comments (incl. % achievement)	Surpassed. National Monitoring Checklist. Indicator added at the ICR.			

G. Ratings of Project Performance in ISRs

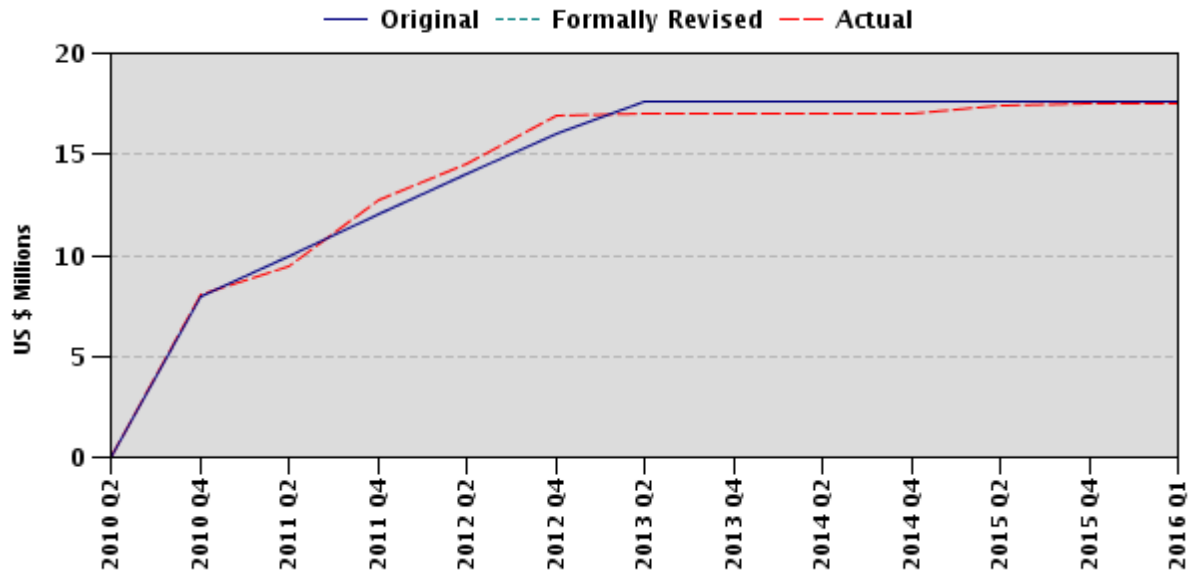
No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)
1	11/22/2010	Satisfactory	Satisfactory	8.04
2	06/15/2011	Moderately Satisfactory	Moderately Satisfactory	12.71
3	04/09/2012	Satisfactory	Satisfactory	14.51
4	11/12/2012	Satisfactory	Moderately Satisfactory	17.00
5	06/25/2013	Satisfactory	Moderately Satisfactory	17.00
6	01/15/2014	Satisfactory	Moderately Satisfactory	17.00
7	08/02/2014	Moderately Satisfactory	Moderately Satisfactory	17.00
8	12/16/2014	Moderately Satisfactory	Moderately Satisfactory	17.45

H. Restructuring (if any)

Restructuring Date(s)	Board Approved PDO Change	ISR Ratings at Restructuring		Amount Disbursed at Restructuring in USD millions	Reason for Restructuring & Key Changes Made
		DO	IP		
03/13/2013	N	S	MS	17.00	The Closing Date was extended by one year from March 14, 2013 to March 14, 2014. This was due to delays in the startup and procurement for the urban Kabul BPHS pilot component.
03/13/2014	N	S	MS	17.00	The Closing Date was extended by an additional six months from March 14, 2014 to September 15, 2014. This was to allow for: (i) the continuation of urban BPHS sub-grants; (ii) the evaluation of the urban Kabul BPHS pilot to assess the achievement of proposed objectives, key results and lessons learned; and (iii) ensuring the procurement and delivery of equipment, drugs and other goods

Restructuring Date(s)	Board Approved PDO Change	ISR Ratings at Restructuring		Amount Disbursed at Restructuring in USD millions	Reason for Restructuring & Key Changes Made
		DO	IP		
09/07/2014	N	MS	MS	17.00	(i) Change in Closing Date from September 15, 2014 to December 31, 2014 (ii) Reallocation of Grant proceeds due to the change in implementation modality for urban Kabul BPHS pilot (iii) Change to Components and Cost (iv) Change in Institutional Arrangements.

I. Disbursement Profile



1. Project Context, Development Objectives and Design

1.1 Context at Appraisal

1. In the early 2000s, Afghanistan's health system was functioning poorly. The coverage of preventive and curative health services was among the lowest worldwide. A Multiple Indicator Cluster Survey (MICS) carried out by UNICEF in 2003 found skilled birth attendance and prenatal care coverage at 5% and vaccination coverage (DPT3) at 19.5%. The situation was particularly dire in rural communities where, for example in rural Badakshan, the maternal mortality ratio (MMR) (6,507 deaths per 100,000 live births) was nearly ten times higher than the average for low income countries. However, by the mid/late 2000s, the Afghan health system had made considerable progress. Data from the health management information system (HMIS) indicated that outpatient visits per person per annum increased from 0.3 in 2005 to 0.8 in 2008 and to 1.7 in 2013. Administrative data indicated that the number of functioning primary health care facilities increased from 498 in 2002 to 1,157 in 2007 (a 132% increase) and the proportion of facilities with skilled female health workers increased from 25% in 2002 to 82% in 2007.

2. Despite some progress in quality of care and coverage in the last decade, nutritional problems and outcomes remained a major challenge for Afghans. There was few nutrition health related services being delivered and no nutrition sensitive intervention implemented in other sectors which could affect nutrition outcomes. The National Nutritional Survey 2004 carried out by UNICEF highlighted that 60.5% of children under 5 suffered from chronic malnutrition; iron deficiency anemia in the same age group was 71.5%, and under-nutrition in women aged 15-49 years was as high as 20.9%.

3. Afghanistan has remained extremely insecure due to ongoing conflict over the last five years, with severe consequences for the health sector. In 2009-2011, 12 health workers lost their lives in the insecure southern province of Helmand; female staff have been threatened by radical groups; and some facilities have become inaccessible due to physical risk for both health facility staff and patients. In recognition of the persistent violence, a flexible approach was therefore needed to deliver health services. In order to deliver services in insecure areas, the Ministry of Public Health (MOPH) has worked with non-government implementing partners to successfully pilot various innovations, including community involvement in supervision of health services; and supply driven interventions (e.g., bonuses and other incentives for health staff).

4. The government laid out a clear vision with a well-developed strategy for the health sector. One of the three pillars of the Afghan National Development Strategy 2008 (ANDS) was economic and social development, which includes improving human development indicators and making significant progress towards the Millennium Development Goals (MDGs). The MOPH developed the Basic Package of Health Services (BPHS) to integrate health-related nutrition interventions in an effort to tackle some of the problems in the health sector. The government aimed to expand coverage of the BPHS to at least 90 percent of the population by 2010. BPHS was the cornerstone of the 2008-2013 National Health and Nutrition Sector Strategy (HNSS), which defined the objectives for the sector, identified the

BPHS as well as the Essential Package of Hospital Services (EPHS) as the main priorities for service delivery, and created a framework for donor financing.

5. The MOPH was recognized as one of the most effective Afghan ministries due to its clear-minded leadership and highly skilled human resources. The MOPH had assumed its stewardship role by setting policy and provision standards, contracting out services through NGOs, coordinating donors, etc. MOPH benefited from long-term technical assistance and financial support for critical units (e.g., Grant Contract Management Unit, GCMU), where staff were hired on a contractual basis. However, continued technical assistance and support was required to further strengthen the stewardship role of MOPH.

6. The Support to a Basic Package of Health Services Project, funded by the Japan Social Development Fund (JSDF), was part of a wider effort by development partners to support the NHSS, and included financing of the Strengthening Health Services for the Rural Poor (SHARP) Project that supported the delivery of the BPHS in eleven provinces. Moreover, the SHARP and the JSDF financed project need to be seen as part of the continuing strategy of assistance to the health sector, previously supported under the World Bank-financed Health Sector Emergency Reconstruction and Development Project (HSERDP), in the amount of US\$110.1 million. That project closed on June 30, 2009 with an IEG rating of Satisfactory. SHARP, which closed on September 30, 2013 with an IEG rating of Moderately Satisfactory, was financed using IDA funds, the Afghanistan Health Reconstruction Trust Fund (ARTF), and Health Results Innovation Trust Fund resources in the amount of US\$137 million. The JSDF financed Project co-financed SHARP by supporting BPHS in three of the eleven provinces (Balkh, Samangan and urban Kabul provinces) and helped to sustain the successes of HSEDRP project. The JSDF financed Project played a role in ensuring that the transition from HSEDRP to SHARP was smooth and offers a lesson to other operations in post-conflict countries.

7. The JSDF financed Project also yielded important lessons for the design of the System Enhancement for Health Action in Transition (SEHAT) Project, which was approved on February 28, 2013. SEHAT is a nationwide program which finances the implementation of the BPHS and EPHS to the entire country, through contracting-out and contracting-in arrangements both in rural and urban areas in 34 provinces. The project also supports strengthening the national health system and MOPH's capacity at central and provincial levels, so it can effectively perform its stewardship functions in the sector. The total financial envelope of SEHAT is US\$654 million, of which IDA financing is US\$100 million equivalent.

1.2 Original Project (Grant) Development Objectives (PDO) and Key Indicators (as approved)

8. The project development objective (PDO) was to improve the health and nutritional status of the people of Afghanistan, with a greater focus on women and children by increasing accessibility and quality of BPHS in the provinces of Balkh, Samangan, and in urban Kabul.

1.3 Revised PDO (as approved by original approving authority) and Key Indicators, and reasons/justification

9. The PDO was not changed. The Results Framework was not modified.

1.4 Main Beneficiaries

10. The project aimed to cover the provinces of Balkh, Samangan and urban Kabul. The total population size to be covered by the grant was estimated at approximately 5.06 million people. The provinces selected for the project exhibited high poverty rates. All three provinces showed poverty rates in excess of 20%. In Balkh and Samangan, the poverty rate reached 60% and 55%, respectively (2008). The major beneficiaries of the project were to be children under age 5 and women of reproductive age. Owing to the content of the BPHS package, the grant funds were to be heavily targeted to maternal and child health activities. The targeted beneficiary profile of the project made it very pro-poor and served to achieve the MDGs. Other beneficiaries of the project included MOPH staff, community health workers, and the staff of the provincial health offices (PHO) who were to receive training to enhance their performance and strengthen their stewardship capacities.

1.5 Original Components

Component 1: Sustaining and Strengthening BPHS Delivery in Rural Areas (US\$13.9 million; 79% of total project cost)

11. This component aimed to: (a) finance the delivery of an enhanced package of BPHS in the provinces of Balkh and Samangan through the provision of sub-grants under the Performance-Based Partnership Agreement (PPA) between the MOPH and implementing NGOs; and (b) support the expansion of health facilities, particularly sub-centers, though, inter alia, the provision of training to additional community midwives and female community nurses.

Component 2: Piloting BPHS Implementation in Urban Kabul (US\$3.5 million; 20% of total project cost)

12. This component aimed to: (a) finance the technical and analytical work to define the content and delivery modalities of BPHS in urban areas; and (b) support the implementation of BPHS in urban Kabul through a pilot project to be implemented by an NGO engaged by MOPH under a PPA.

Component 3: Implementation and Management Support to MOPH (US\$0.25 million; 1% of total project cost)

13. This component aimed to provide implementation and management support to the MOPH through financing operational costs of MOPH relating to the implementation, monitoring and evaluation of activities under the enhanced package of BPHS in the provinces of Balkh, Samangan and urban Kabul.

1.6 Revised Components

14. With the exception of the change in implementation modality for Component 2, the components were not revised. (See section 1.7.)

1.7 Other significant changes

15. This project underwent three Level 2 restructurings during its lifetime, as follows:

16. Restructuring #1 (approved 03/13/2013): The Closing Date was extended by one year from March 14, 2013 to March 14, 2014. This was due to delays in the startup and procurement for the urban Kabul component.

17. Restructuring #2 (approved 03/13/2014): The Closing Date was extended by an additional six months from March 14, 2014 to September 15, 2014. This was to allow for: (i) the continuation of urban BPHS sub-grants; (ii) the evaluation of the urban BPHS pilot to assess the achievement of proposed objectives, key results and lessons learned; and (iii) ensuring the procurement and delivery of equipment, drugs and other goods.

18. Restructuring #3 (approved 09/07/2014): The following changes took place:

- i. Extension of Closing Date from September 15, 2014 to December 31, 2014: This extension was made in order to ensure the continuation of the health services in urban Kabul until MOPH finalized the plan for the next phase of support to the urban Kabul BPHS under the current SEHAT Project.
- ii. Change in Institutional Arrangements for urban Kabul BPHS (Component 2): A decision was made by MOPH to implement the urban Kabul BPHS by direct service provision through public entities under the supervision of MOPH instead of contracting it out to NGOs as was done for the rural BPHS (Component 1). Direct service provision, which included strengthening the implementation capacity of the government as the main supervisor and provider of services, is described as the Strengthening Mechanism (SM). This SM modality was already being used in delivery of services in three provinces.
- iii. Reallocation of Grant Proceeds: Due to the change in the implementation modality for Component 2, the expenditures related to operating costs and goods increased relative to the original disbursement category allocations. The original allocations to operating costs and goods were small amounts which were kept separate for MOPH in order to perform its stewardship role, and the budget for implementation of urban Kabul BPHS was reflected under the category of sub-grants for NGO contracts. Due to this change, additional funds were required to support consultants, trainings, etc., as reflected in Table 1 below.
- iv. Changes to Components and Cost: Due to the change in the implementation modality of service provision under Component 2, additional time was needed in order to design the urban service delivery model under the new MOPH SM

arrangement. As a result, the actual implementation of Component 2 started later than originally planned. Consequently, due late start and slow disbursement rate of Component 2, MOPH decided to reallocate US\$1 million from Component 2 to Component 1 in order to complete planned activities under Component 1, as reflected in Table 2 below.

Table 1: Original and Revised Grant Expenditure Categories

Category Expenditure	Allocation (US\$)	
	Original	Revised
1. Sub-grants	17,400,000	14,900,000
2. Consultants, Services & Training	144,000	518,977
3. Goods	50,000	1,312,251
4. Operating Costs	56,000	918,772
Total	17,650,000	17,650,000

Table 2: Initial and Revised Allocations per Component

Component Name	Initial Allocation (US\$ million)	% of Total Cost	Revised Allocation (US\$ million)	% of Total Cost
1. Sustaining and Strengthening BPHS Delivery in Rural Areas	13.9	79%	14.9	85%
2. Piloting BPHS Implementation in Urban Kabul	3.5	20%	2.5	14%
3. Implementation and Management Support	0.25	1%	0.25	1%
Total	17.65		17.65	

2. Key Factors Affecting Implementation and Outcomes

2.1 Project Preparation, Design and Quality at Entry

19. At the time of Project preparation, the government had already formulated the HNSS. The World Bank was actively engaged in the policy dialogue in support of the development of this strategy. The HNSS provided an overall policy framework, which ensured full ownership and buy-in from the government, and created an effective platform for coordination with other development partners, particularly USAID and the EU, who provided parallel financing for the provision of BPHS and EPHS in the remaining provinces.

20. Several background analytical studies were carried out during the preparation phase. The results of these studies and a full Health Sector Review were presented at the MOPH

strategic retreat held in November 2008, followed by another retreat to discuss the research findings and the key policy actions for the government and the development partners. This had a very beneficial impact on the project preparation and design.

21. The MOPH was in the ‘driver’s seat’ during project preparation. The experience gained during the implementation of the HSERDP project had a visible impact on the MOPH’s capacity to steer the process and exercise leadership. This included the importance of empowering local staff at all levels, successful provision of services through NGOs and the definition of an effective BPHS package. The preparation process was inclusive and participatory. The development partners – USAID, EU, JICA, WHO, CIDA, and many others, including the World Bank – were actively involved and consulted.

22. As a co-financer of SHARP, the Project benefited from many of the preparatory steps that were undertaken for SHARP. This included peer feedback and comments on design, and other processes. The preparation process was well in progress before HSEDRP was closed to allow for smooth transitioning and to avoid any disruptions in service provision.

23. The project design, which fell under OP 8.50 Emergency Recovery Assistance, took into account significant risks that existed at the time of preparation. Growing insecurity remained an issue, as it caused the disruption of service provision in certain areas, and hampered monitoring and evaluation activities. The project design addressed this risk by leveraging the flexibility of NGOs with strong local community links to deliver BPHS services. This was a very innovative feature of the project. Another perceived risk was the potential lack of qualified health care personnel at the community level, especially female health workers, which could affect the uptake of child and maternal health services. Therefore, training of female community health workers, midwives and nurses became a critical activity supported by the Project. The risk of political opposition to contracting out services to NGOs and potential difficulties in demonstrating results was the main factor that influenced a very strong emphasis on robust monitoring and evaluation arrangements in the project design. The use of an independent third party for validation and performance measurement was an effective way to demonstrate credible results achieved by the Project and thereby to mitigate this political risk.

2.2 Implementation

24. The project was implemented and managed as a part of SHARP by the government and Bank during policy dialogue review and implementation support missions. The factors which positively contributed to the Project outcomes during implementation included:

- Flexibility to innovate: Although technical standards that the NGOs were required to meet were quite specific, there was sufficient room provided for innovation. The flexibility to innovate included the ability for NGOs to substitute staff of a lower grade with comparable skills, if personnel of the required grade and seniority were not available. This enabled the NGOs to mitigate any human resource constraints.
- An important adjustment to the BPHS was scaling up the delivery of additional services in line with new guidelines. During implementation, the content of the BPHS

was revised and additional services including mental health, rehabilitation, prison health, and enhanced nutritional services were included, which helped address some of critical needs of the targeted populations.

- The project was able to help address the re-emerging low vaccination problem, especially with the then-constraints in financial capabilities of the vaccination program in targeted provinces. The project provided: (i) financial resources to the program; (ii) much needed training and logistical support to mobile community vaccinators; and (iii) technical support to the program.

25. There were a number of factors that had a somewhat negative impact on Project implementation as described below:

- The delays in the procurement processes of recruitment of NGOs for the delivery of the health care packages affected service delivery. Although the MOPH extended the old contracts of the NGOs engaged under the previous project (HSERDP) in order to avoid disruptions, the delay in finalization of new contracts in some places negatively affected motivation and retention of health care personnel, making it difficult for the NGOs under contract extension to maintain performance. Also, prolonged preoccupation of the GCMU with the contracting processes somewhat weakened GCMU's supervision and monitoring of the implementation of existing contracts during the first two years of the project. In addition, delays in startup of the Kabul urban pilot led to an extension of the Closing Date to allow enough time for the completion of the procurement processes.
- Insecurity seriously affected project implementation in different ways: (a) in the remote districts/villages with frequent insurgencies, it was difficult to maintain personnel (especially female workers) in the health care facilities, and the operating hours of the rural facilities were often reduced, thereby limiting access of the population to services; (b) monitoring and supervision of service providers by the NGOs, GCMU, provincial health authorities and the third party evaluator was somewhat restricted in insecure localities and during insurgencies; (c) outreach services, especially immunization, were often constrained; (d) disruptions in the distribution of medicines and other supplies to villages; and (e) the population, especially women, feared to seek services in times of higher insecurity.
- There were also staffing issues in the rural areas which created challenges during project implementation. Despite significant efforts to engage a greater number of female health workers, their shortage remained a pressing challenge, particularly in remote villages and insecure areas. In response, NGOs deployed the female workers from the neighboring countries, mostly from Tajikistan. While this was innovative, it presents a challenge for the sustainability of these services.
- The Bank was flexible in accommodating and supporting the government's demand of changing the implementation modality in Urban Kabul from contracting out NGOs to a direct implementation method as a pilot. Nevertheless, the new implementation modality did not realize its full envisaged benefits. However, it did provide many lessons

learnt of what can and cannot be directly implemented by the government for future operations.

2.3 Monitoring and Evaluation (M&E) Design, Implementation and Utilization

26. The original Results Framework had three PDO indicators and four intermediate outcome indicators. These indicators represented a good measure of the Project Development Objective. Regrettably, an indicator on nutritional status was not included. Therefore, the ICR included the PDO number four on chronic malnutrition of children under five years of age. The ICR also added an intermediate outcome indicator number 5 on the Mean Percentage Score on the National Monitoring Checklist for quality of services. This was done because the indicator on the Balanced Scorecard could no longer be used due to the change in methodology for data collection.

27. The M&E activities for this Project were carried out through SHARP, which allocated US\$11.00 million to M&E, or about 7% of the total SHARP project cost. There were a number of surveys undertaken during the Project by third parties consisting of three health facility assessments, one national household survey and 2 RBF household surveys (baseline and midlines).

28. While duly recognizing, for the most part, the strengths and appropriateness of the design, the actual implementation of M&E activities had some limitations, namely the lack of comparable information from health facility surveys carried out after 2010 and before 2009 due to the revision of the survey tool. The baseline survey to be carried out by Johns Hopkins University (JHU) was dropped to avoid duplication with the MICS planned by UNICEF for the same year, 2010. Unfortunately, the MICS could not be finalized by 2010 and it was carried over to 2011. Planned collaboration between JHU and MOPH did not have sufficiently strong developmental impact on the MOPH.

29. A results-based financing (RBF) pilot (incentivizing staff on performance), which was funded through the Health Results Innovation Trust Fund was implemented under SHARP in 14 provinces and also used in 2 rural provinces under this project. This was a well-tested model of incentivizing staff performance based on independent verification (carried out by JHU) of results reported by the service providers. It included data audit of a sample of health care facilities participating in the RBF pilot followed by community verification – tracing the patients who received services according to provider records. According to the feedback from NGOs participating in the RBF pilot, independent verification was mostly helpful and contributed to the improvement of the quality of reporting.

30. The MOPH selected 14 indicators for monitoring and evaluation of the urban Kabul BPHS pilot. Only 11 of which had data available for them. These indicators are found in Annex 8. Target setting for the various performance indicators of the urban Kabul component was more or less set at a constant 10% improvement. This was done in conjunction with the overall strategy of setting a gradual improvement in the health metrics of the country and was also based on building a realistic consensus with all stakeholders. Setting a uniform rate for all indicators turned out to be incapacitating for some indicators and an easy target for

others. An evaluation of the Urban Kabul BPHS pilot was completed in December 2014 which assessed the achievement of proposed objectives, key results and lessons learned.

2.4 Safeguard and Fiduciary Compliance

Social and Environmental Safeguards

31. The Project was classified as environmental category “B”. An Environmental and Social Management Framework (ESMF) was prepared and disclosed by the government in Dari, Pashto and English. It was also made available at the World Bank’s Info Shop. The government made all project documentation publicly available to the relevant stakeholders through the Afghan Information Management System. The MOPH was requested to prepare a comprehensive bio-medical waste management plan in the first four-six months after project effectiveness. Preparation of a revised/updated environmental management plan by November 30, 2010 was a legal covenant in the grant agreement. Although the plan was prepared, implementation of the plan was not fully completed. The main issue which hindered the implementation of the plan was having it prepared by the Directorate of Policy and Planning and the Directorate of Health Economics and Financing, whereas the responsibility for implementation rested with the Directorate of Preventive Medicine.

32. The health facilities supported by the project continued carrying out medical waste management through outdated practices. Also, the separation of sharps and other medical wastes was either not happening consistently at the place of generation, or if it was done there was no color coding and proper follow up. The medical waste was often mixed with municipal wastes, especially in urban areas.

33. The actual compliance of the Borrower with the safeguards plans had limitations. The unit responsible for ESMF did not perform its responsibility and left it to services delivery unit to implement it without technical leadership and oversight. In addition, a designated safeguards focal officer was to be appointed with responsibility for overseeing the proper application of the ESMF within the GCMU at the MOPH. However, no such focal officer was ever appointed. This is mainly because the MOPH did not have clarity regarding which department should own this activity. This uncertainty persisted until the end of the Project. This will be a critical area to be addressed under SEHAT.

34. With regards to social safeguards, the local Community Development Councils (CDCs) were not very involved in the selection of the Community Health Workers (CHW) as envisaged in the design, and thus, the CHW Program received little support from CDCs. A complaint handling system was put in place in the health care facilities, but its scope and reach was limited. No records of the complaints were maintained.

Financial Management and Disbursement

35. The Project operated under the steadily improving Public Financial Management (PFM) reforms implemented by the Government of Afghanistan. These reforms continue to be implemented under the series of PFM Reform projects supported by the World Bank. Proper records of grants received and disbursed amounts were maintained, at the central level,

by the Ministry of Finance in the Afghanistan Financial Management Information System (AFMIS). Subsidiary books of records were maintained at the MOPH. Financial management staffing was adequate and the staff was embedded within the finance department of MOPH. However, all of the staff members handling the project FM were consultants paid under the project due to the weak FM capacity within the civil service

36. Over the Project period, the fund flow to the project was mostly timely, with some delays during the beginning of the fiscal year due to late approval of the new budget. Direct payments in local currency to NGOs took longer than US\$ payments due to the time taken by the World Bank to obtain local currency from the central bank of Afghanistan. Replenishment requests were submitted periodically, as required.

37. Quarterly IFRs in the agreed format were submitted during the life of the project, but not always within the timeline of 45 days after the end of each quarter. During the initial period of the project, the IFRs included information on procurement and physical progress. Mostly the delays were attributed to delay in consolidated the three pieces of information – financial, procurement and physical progress. In 2013, the formats for the IFRs were simplified to include only the financial information, and thereafter the timeliness of submission improved.

38. Annual audited financial statements were submitted regularly, and on time, except for fiscal year 2012. While the management letters did raise some internal control issues, there were no key material issues. All issues raised were satisfactorily resolved by MOPH. At the time of this ICR, there are no outstanding audits or audit issues. The audited financial statements for FY1393 (Afghanistan Fiscal Year ended December 21, 2014) that were due by June 20, 2015 were received on May 6, 2015 and there was no critical issue.

39. There were no internal audits conducted throughout the life of the project, due to weak capacity in the internal audit department of the MOPH. The focus of the internal audit department was on the operational budget of the MOPH. While MOPH recruited an internal audit consultant mid-way through the project, the consultant resigned within a short period of time due to the inability to work effectively with the internal audit department. In the Ministry of Finance (MoF), the capacity of the internal audit department is being strengthened under the series of PFM Reform projects. However, article 61 of the PFEM Law prevents the MoF internal audit department from carrying out the internal audit in ministries other than MoF. However, in 2013, the Bank agreed with MoF that its internal audit department will carry out the audit for all Bank funded/administered projects in other line ministries. This arrangement is currently in effect and covers the ongoing health projects in MOPH.

Procurement

40. The MOPH has a procurement directorate which carried out procurement of goods and works with the support of the Afghanistan Development and Reconstruction Services for SHARP. However, procurement of consultancy services was carried out by the GCMU of MOPH. The Project closed with a moderately satisfactory rating for procurement. Only in

the first year of implementation was the rating moderately unsatisfactory. This was due to the long delays in the procurement of NGO services for the BPHS.

41. Implementation delays could have been avoided if the government had allowed the renewal of the contracts with top performing NGOs engaged under the previous project (HSERDP) Extra care should have been taken towards the early assessment and risk mitigation of the procurement procedures of medical goods in the country to avoid interruptions in service provision after project effectiveness

42. For the urban Kabul pilot, the procurement process was lengthy, delayed and inefficient. The delays in procurement were mainly attributed to: (1) lack of proactivity and inconsistent procurement management by KPPHD and SM; (2) weak procurement capacities within the government hierarchy augmented by the lack of a dedicated consultant for procurement during most of the project; (3) multiple signatory authorities (up to 11 signatures); (4) procurement authorization being handled by non-trained procurement officials and/or other members of the procurement committee who were not trained on procurement; and (5) complex procurement laws of the country which demanded large batches of procurement be conducted through the public Afghanistan Reconstruction and Development Services which is a 9-month process, on average.

43. There was an attempt to procure these goods through the government process at the beginning of the Project, but this process took more than a year. The Project then shifted focus to procurement through UNICEF, but encountered challenges there as well. Finally, essential medicines were supplied (borrowed in-kind) to the urban health facilities from the MOPH health stock through the Kabul Provincial Public Health Directorate (KPPHD), International Committee of the Red Cross and the Islamic Relief. Eventually, the procurement process was completed before the end of the Project.

2.5 Post-completion Operation/Next Phase

44. Although the SHARP project closed on September 30, 2013 and the JSDF financed project closed on December 31, 2014, there has been no disruption of BPHS services in rural provinces and urban Kabul. The follow on project, SEHAT, was designed while SHARP was still under implementation in order to ensure the smooth transition and continuation of services. SEHAT, a nationwide program, finances the implementation of the BPHS and EPHS to the entire country, through contracting-out and contracting-in arrangements both in rural and urban areas in 34 provinces.

45. Discussions between the Government and the Bank on the future of the urban health service delivery model to be financed under SEHAT are ongoing. The JSDF financed Project was instrumental in that it carried out an urban service delivery pilot's evaluation which has informed these discussions.

46. It was noted during March 2015 ICR field visits to sample health facilities in Kabul city that services are being delivered in an adequate manner through government and SEHAT budgets. Many of the reforms introduced under SHARP and this Project continue to be practiced and utilization rates are in satisfactory ranges. Staffing quantity, although not to

standard, was adequate and functioning well. Stocks of pharmaceuticals, basic supplies and vaccines were adequate.

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation (Rating: Substantial)

47. **Project objectives were and remain Highly relevant** in terms of their alignment with the national development goals, the Bank's country engagement priorities, and the global development agenda. Afghanistan's HNSS (2008-2013) set the following high-level national objectives: (i) to reduce maternal and newborn mortality, (ii) to reduce under-five mortality and improve child health, (iii) to reduce the incidence of communicable diseases, (iv) to reduce malnutrition, and (v) to develop health systems. The objectives and design of SHARP and this Project were fully aligned with the above outlined national policy priorities of the government.

48. The World Bank's Interim Development Strategy for Afghanistan (2009-2011) had three pillars: (a) building the capacity of the state and its accountability to its citizens; (b) promoting growth of the rural economy and improving rural livelihoods; and (c) supporting growth of the formal private sector. The Project contributed to the delivery of Pillars 1 & 2 of this interim strategy. The Project was also highly aligned with the MDG agenda with its focus on maternal and child health issues, malnutrition and TB issues. Importantly, the project served as a continuation of the previous project, HSERDP, and provided critical services in a very volatile and insecure environment.

49. **The project design, focusing on the BPHS, was Highly relevant** and appropriate for the health care challenges of Afghanistan. The BPHS contained seven critical elements well justified by the disease burden in the country: maternal and newborn health, child health and immunization, public nutrition, communicable disease treatment and control, mental health, disability services, and regular supply of essential drugs. The BPHS was revised in 2010 to include additional interventions on nutrition, mental health, disability and provision of prison health care.

50. **The project design was also highly innovative** in terms of enabling performance-based service provision through NGOS in high insecurity setting. In addition, it introduced a pilot for the delivery of an urban health model in Kabul which provided valuable lessons on how to provide services in similar urban settings. This pilot and its evaluation provided many important lessons for the delivery of health services in urban settings to be considered during the design/implementation of SEHAT.

51. On balance, given the high relevance of objectives and design, and the innovations supported under the Project, the overall rating for relevance is **High**.

3.2 Achievement of Project Development Objectives (Rating: Substantial)

52. The PDO focuses on three areas: (i) improving health and nutritional status: (ii) increased access; and (iii) increased quality. Below is an assessment of the achievement of PDO and intermediate outcome indicators in these respective areas.

Table 3: Status of PDO achievement

PDO	Surpassed	Achieved	Not Achieved	Not Evaluable	Overall Rating
Improved Health and Nutritional Status		2			Substantial
Increased Access	2	2	1	1	Substantial
Increased Quality	1			1	Substantial
TOTAL	3	4	1	2	Substantial

Note: PDO on Increased Access includes an additional indicator on “*People with access to health services with two hours distance by any means of transport*”.

PDO#1 – Improved Health and Nutritional Status (Rating: Substantial):

53. The Project supported the national effort to steadily improve overall maternal, neonatal and nutritional indicators in the country. Over the period of 2010-2013, the maternal mortality ratio dropped from 500 to 400 deaths per 100,000 live births, the U5 mortality rate dropped from 105 to 97 per 1,000 live births, and starting 2013 less than half of the Afghan children are now malnourished. Achievement against specific indicators which measure this PDO are as follows:

- *% Children below 5y with Chronic Malnutrition (National Average)*

54. This ICR uses this indicator as a proxy to assess the overall progress on nutrition related results. The project contributed to the larger SHARP effort of providing the population with access to nutrition related services. The indicator has shown a marked decrease in malnutrition from 60.5% to 40.9% among children of the country. It is the view of this ICR that the combined efforts of this operation and SHARP project did contribute towards this achievement with introduction of nutrition services as part of revised BPHS. However, the large scale reduction in malnutrition level could also be attributable to overall improving in socioeconomic conditions in Afghanistan.

- *TB treatment success rate*

55. The Project target was to reach a 90% TB treatment success rate by 2014 – a 5% point increase from the baseline of 85%. The project nearly met the target. According to the HMIS and the National TB Control Report of 2014, the TB treatment success in 2013 reached 89%.

PDO #2 – Increased Access (Rating: Substantial):

- *Pregnant women receiving at least one antenatal care visit*

56. The Project made commendable progress on this indicator with a 6.9% point increase over the Project lifetime fully achieving the target. The household data comparing one ANC coverage indicates its improvement from 48% in 2010 (MICS survey 2011) to 54% in 2012 (JHU survey 2012). These statistics suggest that the project contributed to a strong performance with regard to this very important indicator. The main driver of success in scaling up antenatal care delivery was setting up new health sub-centers and basic health clinics, and staffing them with a new cadre of female health workers.

- *DPT3 coverage among children 12-23 months*

57. The project target for DPT3 coverage among 12-23 month old children was set at 60% and achieved 46.7%, a 13 percentage point increase from the baseline of 34%. Although, the target was not technically achieved, the project contributed to the national immunization of approximately 1,056,776 children. This was significant progress, accomplished under very challenging and difficult circumstances. Health care staff who were carrying out the immunization outreach often risked their lives (some of them actually were harmed) to deliver life-saving services to children in remote villages. Further, the harsh winters in conjunction with the ill-equipped roads posed a logistical challenge for many outreach vaccination activities. In retrospect, the target may have been set too high given the circumstances.

58. It is worthwhile to note that the officially reported DPT3 coverage by HMIS is much higher – 96%. The reason for this is the inaccurate small estimate of the denominator: children in the target group. The HMIS more or less correctly captures the statistics of the children vaccinated during the calendar year, but because the denominator is underestimated, the coverage figure ends up being artificially inflated.

- *Number of consultations per person per year*

59. The Project not only achieved its target but actually over achieved it (1.84 consultations per person per year in 2014 against a target of 1.4 consultations). This represents a significant rise over the baseline of 0.9 consultations per person per year, doubling of the number of visits per person over the project period. This was achieved by improving access and increasing the supply of services.

- *Proportion of births attended by skilled attendants*

60. The Project target for this indicator was to achieve a 28% attendance of deliveries by a skilled attendant. This would mean a 9.1% point increase from the baseline of 18.9%. The project made significant progress and the actual performance exceeded the target with 40% were attended by a skilled attendant (JHU survey 2012).

- *People with access to a basic package of health, nutrition, or reproductive health services*

61. The target for this indicator was to maintain 85% BPHS coverage throughout the life project. The numerical target value of 5,062,917 persons was derived from estimated population in 11 Bank financed provinces and taking population growth into account. Subsequent surveys had not provided comparable information. The information available is for people with access to BPHS at the two hours distance analysis of which is described below.

- *People with access to health services with two hours distance by any means of transport*

62. Due to unavailability of comparable data for measuring the progress in access to health services, this ICR uses this indicator for measuring physical access. The data show remarkable progress in access to health services between 2006 and 2012 at the national level. According to the NRVA 2012, 88.4% of the population can reach the nearest health facility within two hours. The corresponding overall figure reported in AHS 2006 was only 60%.

PDO#3 – Increased Quality (Rating: Substantial):

63. The RF contained one indicator measuring the progress towards this objective: (i) Score on the balance scorecard examining quality of care in health facilities which became irrelevant due to the sudden change of the measurement tool (BSC) by the government in the middle of project implementation, rendering any comparisons between the old and new ones futile. However, this ICR uses an additional proxy indicator (scores from National Monitoring Checklist) to measure any improvements in the quality of services in Balkh and Samangan provinces.

- *Score on the balanced scorecard examining quality of care in health facilities*

64. Due to the revision of the BSC, the target was revised to 60. Actual performance as measured by the Balanced Scorecard in 2013 was 56. However, given the political, social and economic deterioration of the country over the project implementation period, the quality of care remains in an acceptable range but could not achieve the revised target. Moreover, due to the revisions and updates performed on the methodology of the balanced scorecard in 2010, the baseline of 70 achieved in 2010 is not comparable and therefore cannot be used.

- *Mean % Score on the National Monitoring Checklist for quality of services*

65. Due to the difficulty in comparing data between the old and the new Balanced Scorecard in the previous indicator, this ICR uses this indicator as a proxy for measuring the

quality of the services¹ offered in the rural facilities. The checklist is administered by the MOPH supervisory teams and reports are aggregated up to the national level. Balkh and Samangan have both shown a remarkable increase in their scores from 77% to 87% and 82% to 89%, respectively, from 2011 to 2014.

Urban Kabul BPHS Pilot

66. The Urban Kabul BPHS pilot had its own set of 14 indicators. Since the implementation of this pilot was delayed, the achievement of the indicators is mixed. Annex 8 lists 11 indicators for which data was available, out of the original 14 indicators. This was due to the inability to disaggregate data for urban Kabul from the provincial Kabul data for provider knowledge score, outpatient visits equity index and quality of care in HF. Only 3 indicators met their targets: (i) patient satisfaction, (ii) outpatient utilization; and (iii) number of TB cases successfully treated, owing to the increasing numbers of facilities offering the treatment and the use of the DOTS technique. The other 8 indicators never met their intended targets, though 2 of those (number of deliveries and number of new contraceptive users) have shown commendable progress.

67. On balance, the overall rating for Efficacy is Substantial given the achievement against the three PDOs and the valuable lessons learned through the urban pilot

3.3 Efficiency (Rating: Substantial)

68. For the purposes of this ICR no net present value and economic rate of return analysis have been conducted. Instead, the health interventions supported by the project were assessed against the international evidence of their cost-effectiveness.

69. Health interventions supported by the project were assessed against the international evidence of their cost-effectiveness. The BPHS covered six main groups of health interventions: (i) maternal and newborn care; (ii) child health and immunization; (iii) public nutrition; (iv) communicable disease treatment and control; (v) mental health; and (v) disability and physical rehabilitation services. According to the 2010 global burden of disease estimates from the Institute of Health Metrics and Evaluation², the health conditions addressed by these interventions account for about 59.5% of the total disease burden in Afghanistan.

70. The BPHS design favors community-based health services with the greatest emphasis on health services delivered by health posts, basic health centers, mobile health teams, comprehensive health clinics and district hospitals. All of these delivery modes are the least expensive and most accessible by the poor population groups. Community health workers,

¹ The checklist is a composite of 10 indicators reflecting the quality of services in a given facility, including: (i) Equipment index; (ii) Laboratory index; (iii) Drug index; (iv) Health Post index; (v) HMIS index; (vi) Charts index; (vii) Management index; (viii) Service delivery index; (ix) EPI index; and (x) Reproductive health index.

² <http://www.healthmetricsandevaluation.org/gbd/visualizations/gbd-cause-patterns>

nurses, and midwives are the key human resource inputs for BPHS, which makes it a much more cost-effective model of care compared to those where physicians are the main health care providers.

71. Most BPHS interventions supported by the project fall under the cost-effectiveness ratio of US\$100 per Disability Adjusted Life Year (DALY) averted, which is considered a very good value for money. For example, the vaccination of a child with basic antigens (BCG, DTP, Measles, and OPV) is estimated to cost about US\$15 per DALY; integrated management of childhood illnesses (IMCI) will cost US\$40 per DALY; antenatal care and delivery with a skilled birth attendant - US\$40/DALY; and family planning – US\$25/DALY.³

72. The MOPH carried out a cost analysis of the BPHS in 2012. According to this study, the per capita expenditure for the BPHS is, on average, US\$2.57 and ranges from US\$1.44 (district hospitals) to US\$4.56 (health sub-center). The difference in the per capita cost between the health centers could be due to a variation in population characteristics, or case-mix. The estimated per-capita cost of the BPHS appears to be low compared to estimates of US\$5-10 per capita required to provide a package of services for health related MDGs.

73. When comparing the estimates of the per capita cost of delivery of the BPHS from the 2012 study with that from an earlier study carried out in 2006-2007⁴. The earlier study mostly focused on the provinces supported by the USAID, while the 2012 study mostly focused on the provinces supported by the Bank project. The average per capita cost of the BPHS by the O. Ameli and W. Newbrander study was estimated at US\$3.78, which indicates that the BPHS delivered through the Bank-supported Project was less expensive. One of the reasons for this could be that in the Bank-supported Project, the NGO contracts were set at the province level, which could be more efficient than contracts to support lower aggregates of population (often the case in the USAID supported program).

74. The Project disbursed 97% within the first three years of implementation, which is remarkable in a country with severe security challenges. The remaining funds (US\$ 520,000) were disbursed in the last year of implementation and were related to the urban Kabul BPHS pilot. As noted above, the pilot implementation was delayed which resulted in an extension of the project Closing Date by 1.5 years.

75. Given the overall cost-effectiveness of interventions and the efficient implementation of the bulk of the main project component (1), overall Efficiency is rated as Substantial.

3.4 Justification of Overall Outcome Rating (Satisfactory)

³ Disease Control Priorities in developing Countries. 2nd Edition. Chapter 2. Intervention Cost-Effectiveness: Overview of Main Messages. *Ramanan Laxminarayan, Jeffrey Chlow, and Sonbol A. Shahid-Salles.* <http://www.dcp2.org/pubs/DCP>

⁴ Effects of utilization and quality on the costs of the Basic Package of Health Services in Afghanistan by O. Ameli and W. Newbrander carried out in 2006-2007

76. The overall outcome rating of the project is Satisfactory given high relevance, substantial efficacy and substantial efficiency.

3.5 Overarching Themes, Other Outcomes and Impacts

(a) Poverty Impacts, Gender Aspects, and Social Development

77. The major part of the project supported the provision of BPHS services to the population of two of the poorest provinces in Afghanistan, Balkh and Samangan, where the poverty rates are as high as 60.3% and 55.1% respectively. Moreover, the urban Kabul pilot was implemented through offering a similar modified package in public facilities that are often exclusively frequented by poor or semi-poor populations. All three provinces had a weighted average of poverty rates of 35.1%, making the project highly relevant in serving the poor whom represented at least 1/3 of the total beneficiaries.

78. The urban Kabul component created an urban health model for the city with eight BHCs, 28 CHCs, 4 CHC+ and 4 district hospitals. Of those, at least 9 facilities have seen some kind of physical renovations and upgrading. In the rural provinces, the implementing NGOs took considerable steps towards renovating many of the facilities and took the added step of leveraging external funds for that purpose.

79. Health projects supporting basic benefit packages like this one almost often are, and by innate nature, empowering to women. The content offered in the BPHS package, which heavily targets maternal and child services, positively supports the social and health/physical welfare of women. Moreover, the project has encouraged gender empowerment through offering job opportunities for female health personnel at all levels. The project was also sensitive to the demands of female beneficiaries of being approached by female only health staff.

(b) Institutional Change/Strengthening

80. The major focus on capacity building and enhancing stewardship was placed at the national level. The MOPH received significant support from the Project in terms of consultants with skills and competencies lacking among the cadre of civil servants. The Project has also supported the creation of a Kabul Urban health model that, despite having some problems, has generated many lessons that would help shape the future of the health delivery system in the capital.

81. Where applicable, the Project also benefited from the establishment of a new mechanism of paying providers through results-based financing which was financed under SHARP. This innovative pilot is going to be scaled up nation-wide, marking a significant policy shift in the field of health financing.

(c) Other Unintended Outcomes and Impacts (positive or negative)

82. The project has helped the government to start a process of assessment of its procurement laws, institutions, and regulations. This comes at the level of the presidential

office and the Ministry of Finance responding to multiple requests to simplify and reduce the number of signatory authorities on public procurement packages.

3.6 Summary of Findings of Beneficiary Survey and/or Stakeholder Workshops

N/A

4. Assessment of Risk to Development Outcome (Rating: Substantial)

83. The main risks for the project development outcomes are: (a) volatile security situation; (b) insufficient government financing to sustain results; (c) slow progress in institutional capacity strengthening; and (d) entrenched government bureaucracy with frequent political interference, especially in urban areas.

84. Afghanistan's security situation has witnessed a recent surge in security threats in the past few years. This is especially evident in the rural provinces where efforts to sustain effective outreach programs as well as attract and maintain trained health professionals, especially female staff, has been and is continuously hampered.

85. The Afghan healthcare system is highly dependent on donor financing. This support is not foreseen to be weakening in the medium term with well planned and executed health projects, SEHAT being one of them. The design of the later, has ensured the non-disruption of services at the provincial level and have addressed many of the lessons learnt under SHARP-wide support. This risk will remain until a substantial amount of local resources are provided through the Government budget and the security situation significantly improves.

86. Although considerable training, hiring of technical consultants and capacity building has been embedded in the project design of the JSDF grant and SHARP, the healthcare workforce in the country, both at the stewardship and implementation levels, demonstrates a great lack of capacity. This remains a major risk for the health system; and thus improving and integrating those capacities requires urgent attention in order to ensure the sustainability of the project's investments.

87. Increased bureaucracy, often a result of measures to fight corruption and ensure transparency, have led to lengthy government processes and a change in reporting structures

5. Assessment of Bank and Borrower Performance

5.1 Bank Performance

(a) Bank Performance in Ensuring Quality at Entry (Rating: Satisfactory)

88. The World Bank's performance during the project design was an exceptional case of responding to client needs, exercise of convening power with other donors, and ensuring the continuity of care with smooth transition from the previous project, with no interruption of care.

89. The model of contracting out services to NGO's to offer a defined cost-effective package of services was innovative and is trade-marked for Afghanistan. Further, the model allowed implementing NGO's enough flexibility to experiment with and/or fine tune delivery models to suit their geo-political, security and financial constraints in their respective provinces. This also involved heavy investments in capacity development of the Afghan health workforce and ensured sustained bonds of cooperation with other bilateral donor organizations.

90. The Bank jointly with others partners undertook a review of the health sector and coordinated closely with the partners and the government to plan the next phase of sectoral support. The BPHS and EPHS provision was agreed to be implemented using the contracting modality and financing with partners for designated provinces was agreed well in time with MOPH leading the coordination effort with the Bank.

(b) Quality of Supervision (Rating: Moderately Satisfactory)

91. The Bank team carried out joint formal (and informal) supervision with the SHARP project to maximize efficiencies. Formal missions were carried out twice a year. A strong local team provided continual implementation support, while the TTL was also based in Pakistan, which allowed him to visit the country often. The Aide Memoires were well written and contained clear actionable recommendations. The ISRs were prepared on time and they contained substantive information about the project implementation progress, challenges and required actions. The team was candid in downgrading the ISR ratings where appropriate.

92. In the initial phase of the project, the emphasis of supervision was largely on the operational issues (e.g., contracting of NGOs) but at the later stage the emphasis shifted towards results, policies and development issues. The Bank team performed very well with regard to ensuring sustainable financing of the project and a smooth transition to a new operation, SEHAT, without causing any interruption in the delivery of the basic package of services.

93. The Bank team should have likely considered restructuring the Results Framework to better demonstrate the progress of the nutritional status of the targeted population as a result of the project intervention.

94. The Bank team could have shown more pro-activity in the environmental safeguards area by working closely with senior level management of MOPH, and providing additional technical support to the MOPH for the modification and implementation of the medical health waste management plan.

95. Given the deficiencies as relates to safeguards, the rating is Moderately Satisfactory.

(c) Justification of Rating for Overall Bank Performance (Rating: Moderately Satisfactory)

96. The World Bank team has shown, despite the few shortcomings, a consistent pattern of engagement and professionalism both at entry and during implementation. Therefore, the overall rating for Bank performance is rated as *Moderately Satisfactory*.

5.2 Borrower Performance

(a) Government Performance (Rating: Moderately Satisfactory)

97. The government, realizing the urgent development needs of the country, has exercised full ownership of the project. This was most evident by MOPH efforts to realign its strategies, structure and implementation modalities to the agreed upon design. MOPH has also played a leading coordinating role between the different development partners towards aligning funds, efforts and geographical scopes, especially under SHARP.

98. The government's fiduciary control mechanisms are difficult and lengthy. The Ministry of Finance exercises control over the full spectrum of financial aspects of all projects in the country, usually including project budgets and procurements in its own annual general budget. Signatory authorizations were lengthy and passed through many officials unnecessarily.

99. The environmental safeguards plan having been set for the SHARP operation was not fully executed. The plan was prepared by the Directorate of Policy and Planning and the Directorate of Health Economics and Financing, whereas the responsibility for implementation rested with the Directorate of Preventive Medicine.

(b) Implementing Agency or Agencies Performance (Rating: Moderately Satisfactory)

SM and KPPHD (Rating: Moderately Unsatisfactory)

100. Initially, the project was supposed to be implemented through contracting out NGOs for Urban Kabul. However, it was later decided by MOPH to appoint KPPHD as the main implementer through the support of the SM; the latter was historically mandated to support implementation in different provinces through providing technical and coordination support. After the project launch, it was realized that KPPHD lacked implementation capacity as well as political authority to carry out implementation in its own right and implementation responsibility gradually shifted to SM. Thus, the Urban Kabul component was plagued by a series of lack of coordination between SM and KPPHD, high leadership turnover in both SM and KPPHD, and a lack of regular coordination meetings. Data reporting and facility level supervision were significantly weakened by this arrangement.

101. It was only in the last year of the project that coordination between the two entities was achieved. This was coupled by a commendable training to PHOs on important BPHS topics and project management (carried out by JICA). Moreover, KPPHD had logistical improvements through office renovations and supply of the latest technological equipment. Subcommittees meetings were also held more frequently. Nevertheless, no clear borders for spheres of authority or accountability were defined until the end of the project. Therefore, it

is the view of this ICR that the SM and KPPHD performance is rated as *Moderately Unsatisfactory*.

Swedish Committee for Afghanistan (SCA) + Afghan Center for Training & Development (ACTD) (Rating: Moderately Satisfactory)

102. Both SCA and ACTD co-shared the implementation responsibility in Samangan province in the ratios of 60% and 40%, respectively. SCA being an NGO arm of a bilateral donor (Government of Sweden) had vast experience in project implementation as well as access to external financial and logistical resources. Thus, the implementing NGOs went the extra mile of doing several extra-contractual duties in the province. This included extensive renovation works to at least 10 BHCs, building staff quarters, providing day care for children of female staff, providing extensive transportation to staff and giving out lucrative contracts to imported staff from the neighboring country of Tajikistan.

103. Although the extra-contractual work activities have all been directed towards the common goal of achieving better health care services for the people of the province, no mechanisms were built in to ensure the sustainability of these services at contract end. Therefore, it is the view of this ICR that although the additional services may have provided just-in-time support to the population, the future lack thereof of these services, and the fact that they were outside of the scope of the agreed upon SHARP operation, is not commendable. These extra services may have been understandable if SCA was guaranteed continuity of operations in Samangam province under the SEHAT operation, which was not the case. As a result, the relationship between the implementing NGO, which is providing services per their contractual agreement, and the local populace could be affected. Rating for SCA and ACTD is *Moderately Satisfactory*.

Coordination of Humanitarian Assistance (CHA) (Rating: Satisfactory)

104. CHA, an NGO working in Afghanistan since 1987 and having delivered many projects in the country, was well experienced and suited to the deliver services in Balkh. The NGO employed many dynamic young and professional staff and showed a high level of professionalism and experience when dealing with the local political leadership, authorities and changing security situations. CHA, owing to their previous experiences, has provided valuable recommendations about how to better design and implement future projects in the province. It is the view of this ICR that the failure to achieve some of the project targets set for Balkh were mainly due to other externalities that were common to the whole country, e.g. immunization campaigns. Therefore, it is the view of this ICR that CHA be rated as *Satisfactory*.

(c) Justification of Rating for Overall Borrower Performance (Rating: Moderately Satisfactory)

105. Following the above discussion, the Moderately Satisfactory rating of the government, and Satisfactory and Moderately Satisfactory ratings of implementing NGOs, the overall Borrower performance is rated as *Moderately Satisfactory*.

6. Lessons Learned

106. Owing to the dual nature of the components supported under this project, lessons learned can be grouped into: a) general lessons; b) lessons related to the implementation in rural Samangan and Balkh; and c) lessons related to the Urban Kabul pilot.

A) *General Lessons:*

107. *The approach used in Afghanistan to deliver primary health care services is becoming a model for other fragile and post-conflict countries.* The successful approach revolves around: (i) a low cost unified package of health services that is agreed upon by all stakeholders; (ii) contracting out services to NGOs who have greater agility and flexibility in delivering those services; (iii) close collaboration between the government and development partners with clear cut spheres of responsibilities and roles; and (iv) a gradual strengthening of government capacity for stewardship and healthcare provision with increasing roles and responsibilities over time.

108. *Reporting and collection of data on performance indicators, and HMIS strengthening should be considered carefully when designing future operations.* Project M&E and assessment of achievements should be based on reliable indicators, the lack of which may greatly undermine the project development objectives. Support to data systems, reporting arrangements and institutions should be essential elements of project design. In addition, targets should be realistically set. It is unfair to set a uniform percentage point targets increase – or decrease- to all indicators addressing different health sub-programs.

109. *Improvements to the government fiduciary systems and processes and their pertinent capacities is a priority for the future.* A detailed assessment of the procurement process in MOPH to identify areas for streamlining and shortening is mandatory. Different signatory authorities must be assessed against their legal mandates and compliance with anti-corruption strategies. Regardless of procurement through KPPHD or central MOHP mechanisms, it is critical to ensure two measures. First is to streamline government guidelines to ensure consistencies and avoid unnecessary delays. Second is to clearly define roles and responsibilities, with detailed time-frames and accountability measures for signatory individuals. Furthermore, financial authority for the project should only lie with one entity (according to the new adopted modality) with streamlined arrangements for other implementing entities. It is also imperative that appropriate technical assistance is made available to support implementation processes in both fiduciary functions.

B) *Lessons Related to implementation in rural Samangan and Balkh:*

110. *Well-performing NGOs should be given preference for follow-up operations if they maintain satisfactory performance.* Several NGOs either lost their contracts or were awarded contracts in new provinces during the transitions from HSDERP to SHARP to SEHAT. NGOs tend to invest in capacities, build operational know-how and gather political support during their contract implementation period. Ensuring and encouraging continuity in obtaining follow-up contracts should be viewed as a practice to reward successful NGOs and the local community. Furthermore, operational budget flexibility should be offered to contracted NGOs as long as they are committed to attaining results.

111. *Local provincial health departments should be encouraged to play an increasing role of facilitation and stewardship.* Strict supervision of and reaping maximum benefits from NGOs should not be the primary focus of the provincial health departments. Early engagement of the provincial health departments should be sought in future operations to coach them towards facilitating and assuming monitoring functions during project implementation.

C) *Lesson Related to the Urban Kabul Pilot:*

112. *A new implementation modality for Urban Kabul and other urban areas should be considered for any future support.* The lessons and experiences from the urban Kabul pilot and the rural BPHS components have clearly demonstrated that direct public health provision is not always the best answer for ensuring a stable, functioning health system, especially in a developing country. Given the successes achieved through contracting out services to NGOs in the rural setting and (implementation challenges encountered through the SM-KPPHD management structure, it is quite worthwhile to use NGO-contracted delivery in Kabul as a pilot. Alternatively, MOPH could look at a decentralized model with KPPHD being entrusted management and implementation responsibility with full administrative and financial powers. Although a strong role for governmental oversight, stewardship and coordination is a must, direct provision modalities may have different flexibilities. However, under any circumstance, departing from the existing management arrangements is necessary.

7. Comments on Issues Raised by Borrower/Implementing Agencies/Partners

(a) Borrower/Implementing Agencies

113. The Borrower carried out a formal project evaluation after completion for the urban Kabul pilot. The completion report (Annex 7), and meetings held during the World Bank's ICR mission, confirm the Borrower's view that the project was highly relevant. It fully met the expectations of the government and produced satisfactory results, albeit with some of the shortcomings in the Kabul pilot. Issues raised by the government counterparts included the following:

114. Bureaucracy was a major factor in the slow initial start of the project. Future projects should work with government counterparts towards solving those problems. This ICR concurs with this remark.

115. According to the GCMU, the procurement process for NGO selection was more complex than necessary. It would have been more efficient if the contracts with NGOs with a satisfactory performance record could have been directly extended. This ICR strongly concurs with this comment particularly given the emergency status of operations in Afghanistan.

116. Government counterparts have acknowledged the need for more effective project stewardship and facilitation by the local health provinces. This was attributed to insufficient funds allocated to those entities as well as local political interference. However, it is the view

of this ICR that improper capacity building, engagement and definition of roles were also reasons for these weaknesses. The SEHAT project, having identified these gaps, is addressing some of these concerns.

117. Government concedes that there were difficulties in estimating population size, especially in Kabul. This made it difficult to evaluate the achievement of one indicator in the Results Framework. Internal migration due to conflict and lack of security is a major problem in the country. It is advised that future projects undertake rigorous assessments of expected population changes in the target areas. If that is not possible, then % improvement indicators should suffice.

118. The following comments were received from the Afghanistan government in response to two issues raised in section 7c below.

119. Response to Comment 1 in paragraph 123: The GCMU/MOPH expressed their disagreement with this statement, saying that “the NGO contracts in Balkh and Samangan were extended/amended and additional costs/budget were provided for new services due to the revision in BPHS.”

120. Response to Comment 2 in paragraph 124: The GCMU/MOPH clarified that “actually the contracts with NGOs were lump sum and they have flexibility to re-adjust the cost. Also, that MOPH/GCMU always welcomed NGO proposition for hiring staff such as female MD, female nurse, midwife and etc. even with higher salary than foreseen in the signed contract.” This was due to the need to be able to attract these staff in order to maintain service provision.

(b) Cofinanciers

121. Not applicable

(c) Other Partners and Stakeholders

122. Overall NGOs endorsed the project’s development objectives and design. However, a few concerns and comments were raised, which are worth mentioning in this report.

123. One of the top concerns raised was changes made to the BPHS after contract signature. New training activities for the new mental health and disability components were required after the changes made to the BPHS package in 2010 and these were not properly reimbursed.

124. NGOs raised the issue of losing trained health staff after training. Further, they had a huge problem with recruiting female staff. NGOs had to incur extra costs for contracting female staff from other provinces – and sometimes from neighboring Tajikistan- with added expenditures for housing, transportation and day care for their children. This exponentially increased costs for NGOs that were not accounted for in their contractual agreements.

125. Due to reporting requirements set by the MOF, and sometimes by the MOPH, the financial flexibility of NGOs was rather limited. They could not take the full advantage of a

lump-sum contract as they still had to report on the use of inputs and expenditures. Changes to line item budgets were only allowed in rare circumstances and after lengthy negotiations.

126. NGOs pointed out that owing to the rapidly changing security situation, harsh long winters and ill-equipped roads, immunization outreach efforts were severely hampered. This also affected the physical accessibility of women trying to reach the facilities in due time for delivery.

127. A common problem reported by NGOs was the ailing state of the public health facilities and equipment. Some NGOs had to spend funds, generated from other non-project sources, on renovations and simple medical equipment. Investments in Afghanistan's physical health infrastructure are still warranted.

Annex 1. Project Costs and Financing

(a) Project Cost by Component (in US\$ million equivalent)

Components	Appraisal Estimate (US\$ million)	Actual/Latest Estimate (US\$ million)	Percentage of Appraisal
Component 1 - Sustaining and Strengthening BPHS Delivery in rural areas	13.9	14.9	107.1%
Component 2- Piloting BPHS implementation in urban Kabul	3.5	2.37	68%
Component 3- Implementation and Management Support	0.25	0.25	100%
Total Project Costs	17.65	17.52	98.9%
Total Financing Required	17.65	17.52	98.9%

(b) Financing

Source of Funds	Type of Cofinancing	Appraisal Estimate (US\$ million)	Actual/Latest Estimate (US\$ million)	Percentage of Appraisal
JSDG Grant		17.65	17.52	109%

(c) Original and disbursed expenditure categories

Category Expenditure		Original Allocation (US\$)	Revised Allocation (US\$)	Actual Disbursement (US\$)
1	Sub-grants	17,400,000	14,900,000	14,882,732
2	Consultants, Services & Training	144,000	518,977	557,543
3	Goods	50,000	1,312,251	1,050,624
4	Operating Costs	56,000	918,772	1,029,743
Total				17,520,641
Cancellation				129,358
Total Grant Amount				17,650,000

(d) Disbursements for Funds under JSDF grant and other SHARP co-financers

Source	Appraisal amount (US\$ million)	Original amount with additional financing after appraisal (US\$ million)	Revised (US\$ million)	Cancelled (US\$ million)	Disbursed (US\$ million)	Undisbursed (US\$ million)	% Disbursed (of original)
TF-95919 (JSDF)	\$15.90	\$17.65	\$17.65	N/A	\$17.52	\$0.13	99.26%
Other financing that co-financed SHARP Project							
IDA-H4690	\$30.00	\$30.00	\$29.99	\$0.01	\$30.90 ⁵	\$0	100%
IDA-H5810 (CRW)	N/A	\$49.00	\$45.69	\$3.31	\$45.39	\$0.36	92.6%
TF-96362 (ARTF)	\$69.10	\$46.00	\$46.00	N/A	\$45.72	\$0.28	99.9%
TF-95691 (RBF)	\$11.00	\$12.00	\$12.00	N/A	\$5.62	\$6.74	47%

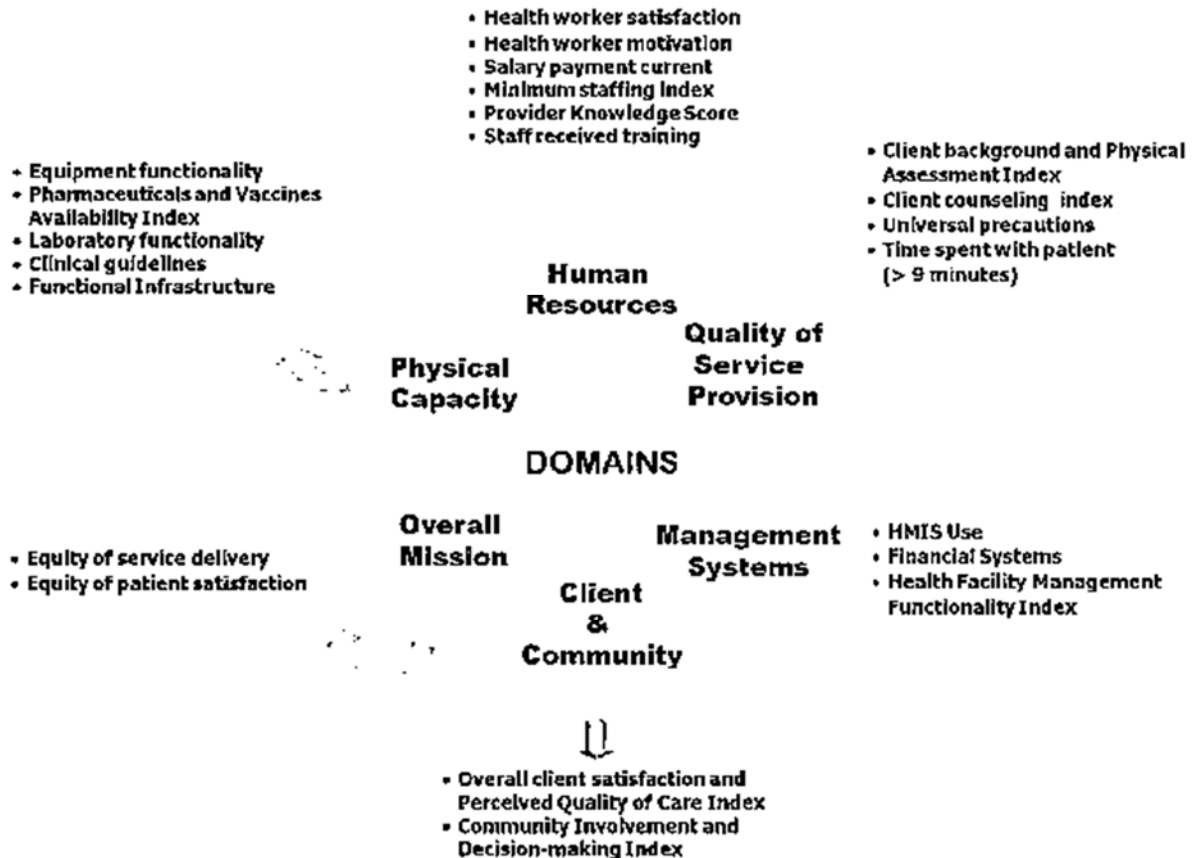
⁵ Disbursed amount is more than the original due to SDR-US\$ exchange rate difference.

Annex 2. Outputs by Component

1. This annex discusses the project performance with regard to the intermediate outcomes related to the specific components of the project. As discussed in the main body of the report (Sections 2.3 and 3.2), in addition to seven PDO indicators, the project also used another set of seven output indicators for Balkh and Samangan, within the larger SHARP operation to measure: (a) sustaining and strengthening the delivery of the BPHS; (b) expanding the delivery of the EPHS, (c) strengthening the MOPH stewardship functions, and (d) piloting innovations. As for Urban Kabul, a trial was made to desegregate urban data from the overall larger Kabul Province Data. Not all data was segregated, hence, both sets are presented.

The BSC domains summarize the health sector from the following six perspectives:

1. Client and Community
2. Human Resources
3. Physical Capacity
4. Quality of Service Provision
5. Management Systems
6. Overall Mission



BALKH PROVINCE FINDINGS

Summary

Balkh province attained the upper benchmarks in only a single indicator of the twenty-two BSC indicators in 2012-2013. For the overall BSC performance ranking, the province has fallen from the 3rd in 2011-12 among the 33 provinces to the 24th place in 2012-13 among the 34 provinces.

Areas of concern

- Revised Infrastructure Index
- Client Counseling Index
- Health Facility Management Functionality Index
- New Patient Satisfaction Concentration Index

Falling trend

- Community Involvement and Decision Making Index
- Salary Payment Current
- Revised Staff Received Training (over the past 12 months)
- Revised Infrastructure Index
- Client Counseling Index
- Time Spent with Client
- Revised HMIS Use Index
- Health Facility Management Functionality Index

Areas of achievement

- New Provider Knowledge Score

Rising trend

- New Provider Knowledge Score
- Revised Laboratory Functionality Index (CHCs only)

AFGHANISTAN HEALTH SECTOR BPHS Balanced Scorecard 2004-2012/13		BENCHMARKS		BALKH							
		LB	UB	2004	2005	2006	2007	2008	2009 /10	2011 /12	2012 /13
Domain A: Client and Community											
1.	Overall Patient Satisfaction	66.4	90.9	84.7	78.4	74.1	92.8	73.5	83.5	-	-
	Patient Perception of Quality Index	66.2	83.9	80.0	74.8	80.5	87.0	77.4	79.2	-	-
	Overall Client Satisfaction and Perceived Quality of Care Index	73.3	81.3	-	-	-	-	-	-	81.0	74.6
2.	Written Shura-e-sehie activities in community	18.1	66.5	17.7	92.2	87.8	100.0	100.0	91.0	-	-
	Community Involvement and Decision Making Index	72.4	90.0	-	-	-	-	-	-	90.4	73.0
Domain B: Human Resources											
3.	Health Worker Satisfaction Index	56.1	67.9	68.3	72.9	73.6	84.5	59.5	66.2	-	-
	Revised Health Worker Satisfaction Index	61.7	66.6	-	-	-	-	-	-	66.0	64.7
4.	Health Worker Motivation Index	66.7	72.8	-	-	-	-	-	-	69.9	71.1
5.	Salary Payment Current	52.4	92.0	53.3	90.3	78.9	89.9	60.2	47.9	97.2	78.0
6.	Staffing Index – Meeting minimum staff guidelines	10.1	54.0	45.8	77.9	81.7	83.0	84.3	95.0	-	-
	Revised Staffing Index – Meeting minimum staff guidelines	11.4	33.3	-	-	-	-	-	-	25.7	26.2
7.	Provider Knowledge Score	44.8	62.3	54.0	70.9	71.3	69.9	-	-	-	-
	Revised Provider Knowledge Score	71.5	86.0	-	-	-	-	85.6	-	-	-
	Revised Revised Provider Knowledge Score	61.9	77.7	-	-	-	-	-	74.2	-	-
	New Provider Knowledge Score	59.4	67.6	-	-	-	-	-	-	66.4	73.6
8.	Staff received training in last year	30.1	56.3	52.4	84.1	68.8	57.2	69.3	48.1	-	-
	Revised staff received training in last year (in last year)	7.1	14.9	-	-	-	-	-	-	17.6	9.8
Domain C: Physical Capacity											
9.	Equipment Functionality Index	61.3	90.0	67.3	86.1	86.4	95.6	81.9	80.6	-	-
	Revised Equipment Functionality Index	67.4	85.0	-	-	-	-	-	-	83.7	72.4
10.	Drug Availability Index	53.3	81.8	56.1	84.0	63.8	94.3	82.2	80.1	-	-
	Pharmaceuticals and Vaccines Availability Index	71.8	88.6	-	-	-	-	-	-	77.6	72.3
11.	Laboratory Functionality Index (Hospitals & CHCs)	5.6	31.7	0.0	63.6	67.3	71.4	74.4	57.0	-	-
	Revised Laboratory Functionality Index (CHCs only)	53.1	76.3	-	-	-	-	-	-	51.3	63.8
12.	Clinical Guidelines Index	22.5	51.0	16.4	79.3	86.3	96.0	83.9	81.4	-	-
	Revised Clinical Guidelines Index	64.3	85.9	-	-	-	-	-	-	75.1	75.8
13.	Infrastructure Index	49.3	63.2	58.3	53.2	48.8	54.9	56.6	64.2	-	-
	Revised Infrastructure Index	48.9	73.4	-	-	-	-	-	-	59.1	28.6
Domain D: Quality of Service Provision											
14.	Patient History and Physical Exam Index	55.1	83.5	85.4	71.3	80.0	82.1	83.2	79.6	-	-
	Client Background and Physical Assessment Index	66.7	81.2	-	-	-	-	-	-	77.1	78.7
15.	Patient Counseling Index	23.3	48.9	55.3	28.9	37.0	54.3	60.5	26.6	-	-
	Client Counseling Index	31.7	58.5	-	-	-	-	-	-	58.5	31.0

16.	Proper Sharps Disposal	34.1	85.0	75.1	96.1	95.9	100.0	6.7	60.7	-	-
	Universal Precautions	51.8	70.4	-	-	-	-	-	-	63.7	54.2
17.	Time Spent with Client	3.5	31.2	27.3	1.6	5.5	32.6	49.5	7.3	35.0	15.4
Domain E: Management Systems											
18.	HMIS Use Index	49.6	80.7	72.9	90.6	88.6	100.0	90.1	76.1	-	-
	Revised HMIS Use Index	66.1	86.2	-	-	-	-	-	-	91.0	77.4
19.	Financial Systems	2.2	20.3	-	-	-	-	-	-	0.0	2.2
20.	Health Facility Management Functionality Index	40.0	57.6	-	-	-	-	-	-	57.6	36.6
Domain F: Overall Mission											
21.	Outpatient Visit Concentration Index	48.0	52.7	48.7	49.6	49.5	50.1	48.2	-	-	-
	New Outpatient Visit Concentration Index	46.2	56.9	-	-	-	-	-	54.3	51.8	52.3
22.	Patient Satisfaction Concentration Index	49.0	50.9	50.4	48.9	48.9	50.3	49.6	-	-	-
	New Patient Satisfaction Concentration Index*	49.6	50.8	-	-	-	-	-	49.5	48.4	49.4
COMPOSITE SCORES											
Percent of Upper Benchmarks Achieved				15.0	50.0	45.0	75.0	45.0	25.0	31.8	4.5
Percent of Lower Benchmarks Achieved				85.0	90.0	85.0	100.0	95.0	85.0	86.4	77.3
Overall Means (Provincial)				53.5	69.7	68.7	77.3	68.8	65.1	61.1	53.7

SAMANGAN PROVINCE FINDINGS

Summary

Samangan province attained the upper benchmarks in two of the twenty-two BSC indicators in 2012-2013. For the overall BSC score, the province has considerably fallen from the 8th in 2011- 12 among the 33 provinces to the 33rd rank in 2012-13 among the 34 provinces.

Areas of concern

- Health Worker Satisfaction Index
- Salary Payment Current
- Functional Infrastructure Index
- Client Counseling Index
- Universal Precautions
- Time Spent with Client
- HMIS Use Index
- Financial Systems
- Health Facility Management Functionality Index
- Outpatient Visit Concentration Index

Falling trend

- Health Worker Satisfaction Index
- Health Worker Motivation Index
- Salary Payment Current
- Staffing Index
- Equipment Functionality Index
- Pharmaceuticals and Vaccines Availability Index
- Clinical Guidelines Index
- Client Counseling Index
- Universal Precautions
- Time Spent with Client
- HMIS Use Index
- Financial Systems
- Health Facility Management Functionality Index

Areas of achievement

- Provider Knowledge Score
- Client Satisfaction Concentration Index

Rising trend

- Client Satisfaction Concentration Index

AFGHANISTAN HEALTH SECTOR	BENCHMARKS	SAMANGAN
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BPHS Balanced Scorecard 2004-2012/13		LB	UB	2004	2005	2006	2007	2008	2009 /10	2011 /12	2012 /13
Domain A: Client and Community											
1.	Overall Patient Satisfaction	66.4	87.2	87.2	94.1	94.1	80.9	93.8	77.6	-	-
	Patient Perception of Quality Index	66.2	83.9	74.9	79.4	67.5	83.1	90.2	72.5	-	-
	Overall Client Satisfaction and Perceived Quality of Care Index	73.3	81.3	-	-	-	-	-	-	77.1	73.7
2.	Written Shura-e-sehie activities in community	18.1	66.5	18.1	36.8	71.4	82.5	100.0	92.5	-	-
	Community Involvement and Decision Making Index	72.4	90.0	-	-	-	-	-	-	86.9	78.1
Domain B: Human Resources											
3.	Health Worker Satisfaction Index	56.1	67.9	69.1	68.6	68.3	75.5	68.3	65.2	-	-
	Revised Health Worker Satisfaction Index	61.7	66.6	-	-	-	-	-	-	71.0	55.4
4.	Health Worker Motivation Index	66.7	72.8	-	-	-	-	-	-	79.0	70.0
5.	Salary Payment Current	52.4	92.0	57.2	97.7	100.0	100.0	100.0	93.4	70.7	52.1
6.	Staffing Index – Meeting minimum staff guidelines	10.1	54.0	26.2	63.5	70.9	40.6	62.3	80.7	-	-
	Revised Staffing Index – Meeting minimum staff guidelines	11.4	33.3	-	-	-	-	-	-	34.0	28.3
7.	Provider Knowledge Score	44.8	62.3	49.4	61.6	71.2	76.9	-	-	-	-
	Revised Provider Knowledge Score	71.5	86.0	-	-	-	-	80.1	-	-	-
	Revised Revised Provider Knowledge Score	61.9	77.7	-	-	-	-	-	67.0	-	-
	New Provider Knowledge Score	59.4	67.6	-	-	-	-	-	-	71.9	72.4
8.	Staff received training in last year	30.1	56.3	57.1	68.7	80.1	74.5	78.1	37.1	-	-
	Revised staff received training in last year (in last year)	7.1	14.9	-	-	-	-	-	-	9.7	7.4
Domain C: Physical Capacity											
9.	Equipment Functionality Index	61.3	90.0	74.4	73.2	80.7	93.7	80.9	91.1	-	-
	Revised Equipment Functionality Index	67.4	85.0	-	-	-	-	-	-	90.1	74.9
10.	Drug Availability Index	53.3	81.8	74.4	95.1	89.3	97.4	100.0	84.4	-	-
	Pharmaceuticals and Vaccines Availability Index	71.8	88.6	-	-	-	-	-	-	90.1	77.6
11.	Laboratory Functionality Index (Hospitals & CHCs)	5.6	31.7	5.6	48.4	50.2	40.5	76.1	52.5	-	-
	Revised Laboratory Functionality Index (CHCs only)	53.1	76.3	-	-	-	-	-	-	62.5	60.0
12.	Clinical Guidelines Index	22.5	51.0	64.4	42.6	65.7	96.7	85.0	89.1	-	-
	Revised Clinical Guidelines Index	64.3	85.9	-	-	-	-	-	-	95.7	74.5
13.	Infrastructure Index	49.3	63.2	65.0	26.8	33.0	36.9	28.4	61.2	-	-
	Revised Infrastructure Index	48.9	73.4	-	-	-	-	-	-	45.3	28.6
Domain D: Quality of Service Provision											
14.	Patient History and Physical Exam Index	55.1	83.5	67.2	86.6	81.3	89.0	99.2	74.6	-	-
	Client Background and Physical Assessment Index	66.7	81.2	-	-	-	-	-	-	74.4	75.5
15.	Patient Counseling Index	23.3	48.9	29.6	45.4	30.0	48.6	96.4	28.2	-	-
	Client Counseling Index	31.7	58.5	-	-	-	-	-	-	41.4	24.3
16.	Proper Sharps Disposal	34.1	85.0	62.2	27.9	100.0	100.0	100.0	100.0	-	-
	Universal Precautions	51.8	70.4	-	-	-	-	-	-	64.8	41.2

17.	Time Spent with Client	3.5	31.2	38.7	18.9	19.7	29.4	82.4	0.0	4.4	0.5
Domain E: Management Systems											
18.	HMIS Use Index	49.6	80.7	69.4	40.9	92.2	93.2	98.3	95.1	-	-
	Revised HMIS Use Index	66.1	86.2	-	-	-	-	-	-	78.3	54.0
19.	Financial Systems	2.2	20.3	-	-	-	-	-	-	0.0	0.0
20.	Health Facility Management Functionality Index	40.0	57.6	-	-	-	-	-	-	54.1	36.2
Domain F: Overall Mission											
21.	Outpatient Visit Concentration Index	48.0	52.7	57.0	57.5	51.3	52.7	52.2	-	-	-
	New Outpatient Visit Concentration Index	46.2	56.9	-	-	-	-	-	51.9	43.9	44.7
22.	Patient Satisfaction Concentration Index	49.0	50.9	48.5	49.9	48.9	49.1	50.1	-	-	-
	New Patient Satisfaction Concentration Index*	49.6	50.8	-	-	-	-	-	50.0	50.0	50.8
COMPOSITE SCORES											
Percent of Upper Benchmarks Achieved		-	30.0	45.0	55.0	70.0	75.0	45.0	31.8	9.1	
Percent of Lower Benchmarks Achieved		-	95.0	85.0	90.0	95.0	95.0	95.0	86.4	54.5	
Overall Means (Provincial)		-	54.8	59.2	67.1	72.1	81.1	68.2	58.9	49.1	

KABUL PROVINCE FINDINGS

Summary

Kabul province attained the upper benchmarks in three of the twenty-two BSC indicators in 2012-2013. For the overall BSC score, the province has risen from the 32nd in 2011-12 among the 33 provinces to the 29th rank in 2012-13 among the 34 provinces.

Areas of concern

- Community Involvement and Decision Making Index
- Staffing Index
- Staff Received Training (in last year)
- Equipment Functionality Index
- Pharmaceuticals and Vaccines Availability Index
- Clinical Guidelines Index
- Universal Precautions
- Time Spent with Client
- HMIS Use Index
- Financial Systems
- Client Satisfaction Concentration Index

Falling trend

- Staffing Index
- Staff Received Training (in last year)
- Outpatient Visit Concentration Index
- Client Satisfaction Concentration Index

Areas of achievement

- Provider Knowledge Score
- Functional Infrastructure Index
- Client Background and Physical Assessment Index

Rising trend

- Salary Payment Current
- Provider Knowledge Score
- Laboratory Functionality Index (CHCs only)
- Functional Infrastructure Index
- Client Background and Physical Assessment Index
- Client Counseling Index
- Health Facility Management Functionality Index

AFGHANISTAN HEALTH SECTOR BPHS Balanced Scorecard 2004-2012/13		BENCHMARKS		KABUL							
		LB	UB	2004	2005	2006	2007	2008	2009 /10	2011 /12	2012 /13
Domain A: Client and Community											
1.	Overall Patient Satisfaction	66.4	90.9	84.8	75.6	74.8	76.3	82.6	81.9	-	-
	Patient Perception of Quality Index	66.2	83.9	86.9	72.8	86.5	80.9	71.6	82.7	-	-
	Overall Client Satisfaction and Perceived Quality of Care Index	73.3	81.3	-	-	-	-	-	-	76.0	74.7
2.	Written Shura-e-sehie activities in community	18.1	66.5	33.3	80.1	59.8	53.7	29.6	39.2	-	-
	Community Involvement and Decision Making Index	72.4	90.0	-	-	-	-	-	-	44.3	56.2
Domain B: Human Resources											
3.	Health Worker Satisfaction Index	56.1	67.9	68.8	66.1	78.4	62.3	60.2	61.2	-	-
	Revised Health Worker Satisfaction Index	61.7	66.6	-	-	-	-	-	-	61.7	62.4
4.	Health Worker Motivation Index	66.7	72.8	-	-	-	-	-	-	71.3	71.1
5.	Salary Payment Current	52.4	92.0	52.4	91.4	94.8	93.3	50.3	62.9	62.7	89.5
6.	Staffing Index – Meeting minimum staff guidelines	10.1	54.0	54.0	79.7	85.3	77.2	73.4	94.8	-	-
	Revised Staffing Index – Meeting minimum staff guidelines	11.4	33.3	-	-	-	-	-	-	11.4	10.9
7.	Provider Knowledge Score	44.8	62.3	59.1	73.8	78.5	73.3	-	-	-	-
	Revised Provider Knowledge Score	71.5	86.0	-	-	-	-	82.2	-	-	-
	Revised Revised Provider Knowledge Score	61.9	77.7	-	-	-	-	-	65.4	-	-
	New Provider Knowledge Score	59.4	67.6	-	-	-	-	-	-	67.1	72.3
8.	Staff received training in last year	30.1	56.3	36.6	76.5	68.0	66.8	45.0	46.4	-	-
	Revised staff received training in last year (in last year)	7.1	14.9	-	-	-	-	-	-	7.1	4.5
Domain C: Physical Capacity											
9.	Equipment Functionality Index	61.3	90.0	75.6	80.8	80.8	83.2	74.3	84.9	-	-
	Revised Equipment Functionality Index	67.4	85.0	-	-	-	-	-	-	61.0	63.8
10.	Drug Availability Index	53.3	81.8	76.8	71.3	86.8	69.6	66.5	91.7	-	-
	Pharmaceuticals and Vaccines Availability Index	71.8	88.6	-	-	-	-	-	-	67.4	69.8
11.	Laboratory Functionality Index (Hospitals & CHCs)	5.6	31.7	30.4	44.1	43.7	41.6	51.7	42.4	-	-
	Revised Laboratory Functionality Index (CHCs only)	53.1	76.3	-	-	-	-	-	-	52.1	61.3
12.	Clinical Guidelines Index	22.5	51.0	38.4	64.9	60.7	77.7	62.3	63.4	-	-
	Revised Clinical Guidelines Index	64.3	85.9	-	-	-	-	-	-	59.3	63.9
13.	Infrastructure Index	49.3	63.2	56.5	55.1	53.4	41.2	39.5	76.8	-	-
	Revised Infrastructure Index	48.9	73.4	-	-	-	-	-	-	71.3	77.6
Domain D: Quality of Service Provision											
14.	Patient History and Physical Exam Index	55.1	83.5	70.6	79.7	92.4	92.6	63.6	80.1	-	-
	Client Background and Physical Assessment Index	66.7	81.2	-	-	-	-	-	-	66.7	89.8
15.	Patient Counseling Index	23.3	48.9	37.5	52.0	64.8	65.4	35.0	35.0	-	-
	Client Counseling Index	31.7	58.5	-	-	-	-	-	-	28.8	35.3
16.	Proper Sharps Disposal	34.1	85.0	54.4	59.7	66.1	65.9	44.6	89.6	-	-

	Universal Precautions	51.8	70.4	-	-	-	-	-	-	44.1	40.9
17.	Time Spent with Client	3.5	31.2	31.2	19.0	25.1	5.9	0.7	3.3	0.8	0.0
Domain E: Management Systems											
18.	HMIS Use Index	49.6	80.7	80.7	63.6	62.8	61.0	60.3	71.1	-	-
	Revised HMIS Use Index	66.1	86.2	-	-	-	-	-	-	53.7	44.7
19.	Financial Systems	2.2	20.3	-	-	-	-	-	-	10.0	10.1
20.	Health Facility Management Functionality Index	40.0	57.6	-	-	-	-	-	-	32.1	42.2
Domain F: Overall Mission											
21.	Outpatient Visit Concentration Index	48.0	52.7	51.9	50.6	50.0	49.9	55.3	-	-	-
	New Outpatient Visit Concentration Index	46.2	56.9	-	-	-	-	-	62.6	61.1	55.9
22.	Patient Satisfaction Concentration Index	49.0	50.9	49.9	50.9	50.6	50.0	49.3	-	-	-
	New Patient Satisfaction Concentration Index*	49.6	50.8	-	-	-	-	-	49.9	50.4	48.8
COMPOSITE SCORES											
Percent of Upper Benchmarks Achieved		-	20.0	35.0	60.0	40.0	20.0	35.0	4.5	13.6	
Percent of Lower Benchmarks Achieved		-	100.0	100.0	100.0	90.0	85.0	95.0	54.5	54.5	
Overall Means (Provincial)		-	56.5	65.4	69.2	64.4	54.9	64.3	48.2	52.1	

Project Indicator Analysis – Urban Kabul HF's

Indicator ⁽¹⁾	Baseline Kabul Urban HF's ⁽²⁾	Target	Target Kabul Urban HF's (Numerical)	Data Source ⁽³⁾	End line (HMIS & BSC - Urban HF's)			
					2012	2013	Data Source	
1. Patients & Community								
1	Patient Satisfaction ⁽⁵⁾	74.7	+ 10% from baseline	82.2	BSC 2009 -10	81.8	87.9	BSC - urban HF's ⁽⁴⁾
2	Number of active CHWs	0	660	660	HMIS	66	80	HMIS*
2. Capacity for Service Provision								
3	Drugs availability index (availability of essential drugs)	95.0	+ 10% point from baseline	100.0	BSC 2009 -10	60.0	92.0	BSC - urban HF's ⁽⁴⁾
4	Equipment Functionality index ⁽⁶⁾	69.6	+ 10% point from baseline	76.6	BSC 2009 -10	67.9	64.3	BSC - urban HF's ⁽⁴⁾
5	Provider knowledge score ⁽⁷⁾	NA	+ 10% point from baseline	-	BSC 2009 -10	not available	not available	BSC - urban HF's

6	Score on the balanced scorecard examining quality of care in HF ^s ⁽⁸⁾	NA	+ 10% point from baseline	-	BSC 2009 -10	not available	not available	BSC - urban HF ^s
3. Service Provision								
7	Outpatient visits ⁽¹⁵⁾	614,118	+ 10% from baseline	675,530	HMIS	727,776	829,517	HMIS**
8	Number of deliveries ⁽⁹⁾	5,081	+ 10% from baseline	5,589	HMIS	5,953	5,244	HMIS**
9	Number of pregnant woman receiving at least one ANC visit	40,929	+ 10% from baseline	45,022	HMIS	39,918	35,916	HMIS**
10	Number of new users of contraceptives ⁽¹⁰⁾	23,408	+ 10% from baseline	25,749	HMIS	21,923	24,904	HMIS**
11	Number of children < 1 received DPT3 ⁽¹¹⁾	54,803	+ 10% from baseline	60,283	HMIS	50,897	49,390	HMIS**
12	Number of children < 5 receiving nutrition screening ⁽¹²⁾	119,015	+ 10% from baseline	130,917	HMIS	188,734	115,370	HMIS**

13	Number of TB+ cases successfully treated ⁽¹³⁾	215	+ 10% point from baseline	237	HMIS	173	319	HMIS**
3. Overall Vision								
14	Outpatient Equity Index ⁽¹⁴⁾	not available	+ 10% point from baseline	not available	BSC 2009 -10	not available	not available	BSC - urban HFs ⁽⁴⁾

Notes:

(1) Based on Final Urban BPHS Proposal, August, 2011

(2) Based on disaggregation of urban Kabul HFs only, from BSC 2009/2010 data - urban HFs from the project represented ~30-40% of the total HFs sampled in Kabul province and ~20-25% of total project urban HFs; used JHU 2008 methodology to recalculate baseline for urban Kabul HFs - proxy indices/variables were used if exact methodology could not be replicated; HMIS data of 32 urban Kabul health facilities (72%) for period of year 1390 (2011). 2011 was used as the baseline instead of the originally proposed 2010 data given project implementation did not actually beginning until 2012 and not all urban Kabul HFs had reported in 2013.

(3) Based on Kabul province Balanced Score in 2009-2010 – JHU/IIHMR and HMIS data of 32 urban Kabul health facilities (72%) for period of year 1390 (2011)

(4) Based on disaggregation of urban Kabul HFs only, from BSC 2011/2012 and 2012/2013 data (district hospitals not included) - urban HFs from the project represented ~30-45% of the total HFs sampled in Kabul province (exact urban HFs varied in samples year to year) and ~20-25% of the total project urban HFs; used JHU 2008 methodology to calculate new indicators for urban Kabul HFs - proxy variables were used if exact methodology could not be replicated

(5) For baseline, used BSC data variable "your overall visit was satisfactory" (q152); for 2012 and 2013 used BSC data variable "how satisfied are you with your overall visit?" as proxy for overall satisfaction (q152a)

(6) Used BSC data variable "stethoscope & blood pressure cuff" instead of "blood pressure instrument" per 2008 JHU Toolkit methodology, for one of the variables in the index, to remain consistent for all years (variable "blood pressure instrument" was no longer available in 2012 and 2013)

(7) As JHU Toolkit methodology was unavailable for 2009-2013 this index was unable to be disaggregated into urban Kabul HFs for 2009-2013 (methodology and variables listed in the 2008 JHU Toolkit for this index were unavailable in the 2009-2013 BSC data set)

(8) This index (and its variables) was not present in the JHU 2008 Toolkit nor BSC data sets 2009-2013 and an overall BSC score was unable to be disaggregated for urban Kabul HFs only.

(9) Used "total institutional deliveries" from HMIS data

(10) "Current users of contraceptives" was unavailable in the HMIS data as originally proposed, so "new users of contraceptives" was used instead

(11) Used "Penta3 0-11 months" from HMIS data

(12) Used "<5 screened for nutrition" from HMIS data

(13) Used "total number of TB cases completed and smeared (-)" from HMIS data

(14) This index was unable to be disaggregated since JHU Toolkit methodology was unavailable for 2009-2013 BSC data

(15) Used "OPD Consultations (new cases)" from HMIS data

NA = Not available in BSC 2009-2010

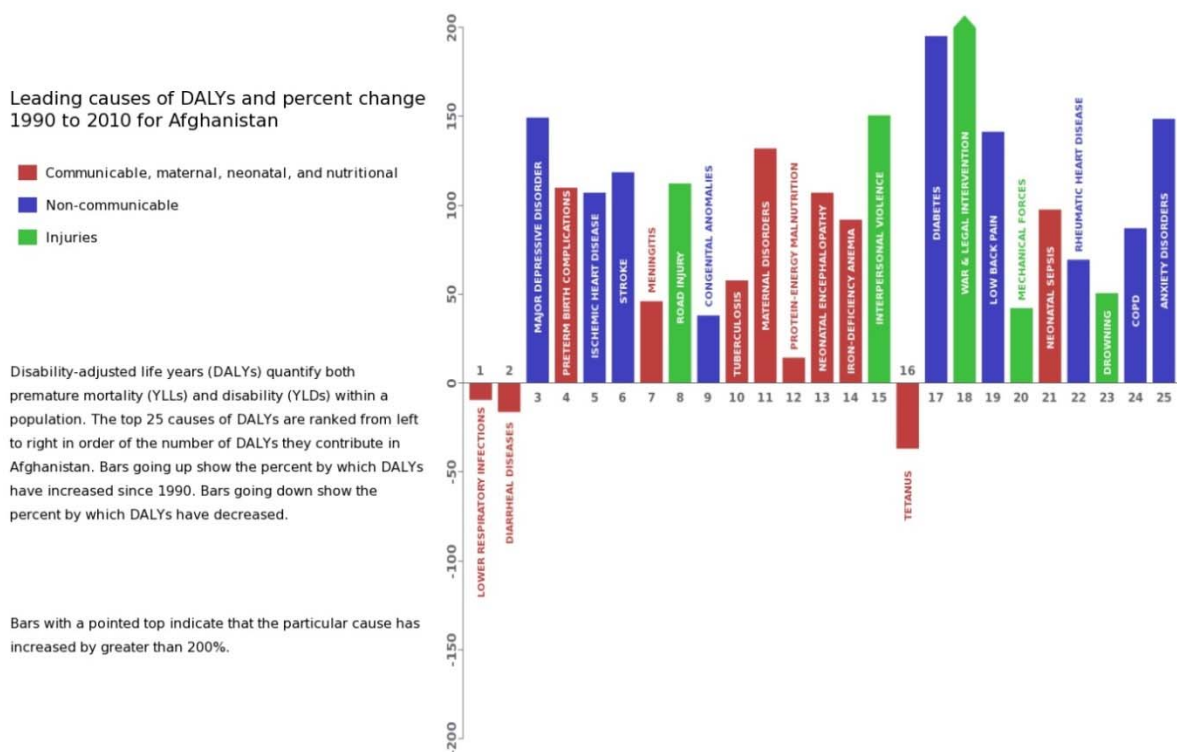
* Data provided by MOPH-SM Unit

**** HMIS data from only 32 HFs (72%) was used in the analysis for the service utilization indicators due to an increase in overall reporting from 2011 - 2013. These 32 HFs represent those facilities who reported consistently throughout 2011 - 2013.**

Annex 3. Economic and Financial Analysis

1. The scope of analysis for this report is limited to the commentary on cost-effectiveness of the BPHS interventions supported by the project and fiscal space available for sustaining funding of the BPHS.

2. According to the 2010 global burden of disease estimates from the Institute of Health Metrics and Evaluation⁶, the health conditions addressed by these interventions account for about 59.5% of the disease burden in Afghanistan. The figure below represents 25 top leading causes of diseases burden in the country in 2010 and the changes that have occurred since 1990.



3. The BPHS design favors community based health services with an emphasis on health services delivered by health posts, basic health centers, mobile health teams, comprehensive health clinics and district hospitals. All of these service delivery modalities are least costly, closer to the community, most accessible by the poor population groups and capable of delivering the most cost-effective interventions to tackle Afghanistan’s burden of disease. Community health workers, nurses, and midwives are the backbone of the BPHS in terms of health care personnel, which makes it much less costly model of care compared to ones where physicians are the main health care providers.

⁶ <http://www.healthmetricsandevaluation.org/gbd/visualizations/gbd-cause-patterns>

4. With regard to effectiveness and efficiency, the services included in the BPHS are consistent with international best-practice based on the available global evidence. Most interventions supported by the project under the BPHS fall under the cost-effectiveness ratio of \$100 per Disability Adjusted Life Year (DALY) averted which is considered a very good value for money. The table below summarizes cost-effectiveness ratio estimates for some of the key health interventions included in the BPHS⁷:

BPHS component	US\$/DALY
Maternal and newborn health	
Antenatal and delivery care	38-63
incl. routine maternity care	125
Postpartum care	
Family planning	25-38
Care of the newborn	11-265
Child health and immunization	
Expanded Program on Immunization (EPI)	16
Integrated Management of Childhood Illness (IMCI)	38-63
incl. ARI treatment (community)	140
incl. ARI treatment (PHC facility)	28
Public Nutrition	
Prevention of malnutrition	
incl. breastfeeding promotion	8-11
incl. vitamin A supplementation	6-12
Assessment of malnutrition	
incl. growth monitoring	8-11
Treatment of malnutrition	
Communicable disease treatment and control	
Control of tuberculosis (DOTS)	5-50
Control of malaria	24
Control of HIV (VCT)	10

5. The MOPH has carried out cost analysis of the BPHS in 2012. According to this study, the per capita expenditure for the BPHS is, on average, US\$2.57 and ranges from US\$1.44 (district hospitals) to US\$4.56 (health sub-center):

	Per capita cost by facility (US\$)
--	------------------------------------

⁷ Source is various studies cited by Jamison et al. (eds.) (2008) *Disease Control Priorities in Developing Countries, Second Edition*, World Bank and Oxford University Press, Washington and New York. Estimates for South Asia are provided when available. Otherwise, the estimates are for low-income countries. Estimates are in 2002 US\$

Health sub-center	4.56
Basic health center	1.99
Comprehensive health center	2.28
District hospital	1.44

6. The difference in the per capita cost between the health centers could be due to differences in population characteristics and case-mix. The estimated per-capita cost of the BPHS is low compared to estimates of US\$5-10 per capita annually required to provide a package of services for health related MDGs.

7. It is interesting to compare the estimates of the per capita cost of delivery of the BPHS from 2012 study with that from an earlier study by O. Ameli and W. Newbrander carried out in 2006-2007. The latter study mostly focused on the provinces supported by USAID, while the 2012 study mostly focused on the provinces supported by the Bank project. The average per capita cost of the BPHS by the O. Ameli and W. Newbrander study was estimated at US\$3.78, which indicates that the BPHS delivered through the WB supported project was cheaper while producing the same outcomes (thus more cost-effective). One of the reasons for this could be that under SHARP the NGO contracts were set at the province level, which could be more efficient than contracts to support lower aggregates of population (often the case in the USAID supported program).

8. In terms of the cost structure of the BPHS, according to 2012 cost analysis, wages and salaries account for 40%, followed by drugs and disposables (21%), operational expenses (21%), governance and monitoring (13%), and training and capital investments (5%). Such a breakdown is comparable to expenditures in the rest of the developing world. For example according to WHO estimates produced for the World Health Report 2006, developing countries generally spend about 42.2% on wages and salaries of the health care workforce⁸. The share of the wages and salaries would have been even less than 40% had the security situation been better. Because of highly insecurity the NGOs need to pay higher salary to the contracted staff to attract them to the vacant positions.

9. Afghanistan's fiscal space is significantly constrained and the country is unlikely to be able to finance the BPHS from domestic resources alone in the medium-term horizon. According to the most recent data, Afghanistan spends 9.6% of its GDP on health, which translates to US\$50.5 (in PPP terms) per capita. The share of government spending allocated to health is only 3.3% percent, which is quite low compared to the average for low income

⁸ Measuring Expenditures for Health Workforce: Evidence and Challenges. *Patricia Hernandez, Sigrid Dräger, David B. Evans, Tessa Tan-Torres Edejer and Mario R. Dal Poz*. Background paper prepared for the world health report 2006 - working together for health. World Health Organization. 2006.

countries (9.3%). Many countries with comparable income levels allocate a greater share of public resources to health: Benin – 10.5%, Burkina Faso – 12.8%, Mali – 12.2%, Haiti – 9.9%, Nepal – 9.6%, etc.) , it is far low from the average for the low income countries (9.3%). In the total health expenditures (THE), government sources of funding account for 15.6 %; donor sources for 16.4%; and private sources for 84%. The out-of-pocket spending on health is 94% of the total private spending.

10. The following tables represents the breakdown of total health expenditures and government health expenditures by functional categories, based on the 2009 NHA (more recent data is not available). It is interesting to note that 22% of the government health expenditures are spent on prevention, which is higher than in many countries of the comparable group:

Breakdown of the total health expenditures by functional areas

Functional areas	% of THE
Curative care	59%
Pharmaceuticals	28%
Prevention and public health programs	5%
Health administration	5%
Capital formation	2%
Other	1%

Breakdown of the government health expenditures by functional areas

Functional areas	% of GHE
Curative care	45%
Ancillary services	0.2%
Prevention and public health programs	22%
Health administration	20%
Capital formation	7%
Education and training of health care personnel	3%
Research and development	0.6%
Other	2%

11. In the medium-term Afghanistan will need to depend significantly on donor assistance in order to be able to sustain funding of its health sector, including the delivery of the BPHS. Such external funding is most likely to continue, but gradually Afghanistan should look for ways to increase domestic funding of health from public sources. Hopefully if the security situation improves the government may shift a portion of the substantial funding (more than 40% of the total government expenditures) that is currently spent on security into health and other social sectors.

Annex 4. Bank Lending and Implementation Support/Supervision Processes

(a) Task Team Members

Names	Title	Unit	Responsibility/ Specialty
Lending			
Inaam Ul Haq	Program Leader	SACPK	Public Health
Kenneth O. Okpara	Senior Financial Management Specialist	GGODR	Financial Management
Abdul Rahman Shafiee	Program Assistant	SACKB	Administrative
Aimal Sherzad	Procurement Specialist	GGODR	Procurement
Arun Kumar Kolsur	Senior Procurement Specialist	GGODR	Procurement
Asha Narayan	Senior Financial Management Specialist	GGODR	Financial Management
Asif Ali	Senior Procurement Specialist	GGODR	Procurement
Asif Qurishi	Executive Assistant	SACKB	Administrative
Cornelis P. Kostermans	Lead Health Specialist	GHNDR	Public Health
Dolly Aziz	Operations Officer	GPSOS	Operations
Sayed Ghulam Dastagir	Senior Health Specialist	GHNDR	Public Health
Mariam Haidary	Program Assistant	SACKB	Administrative
Mohammad Tawab Hashemi	Senior Health Specialist	GHNDR	Public Health
Mohammad Yasin Noori	Social Development Specialist	GSURR	Social Development
Nargis Mohammad Yousaf	Senior Financial Management Specialist	GGODR	Financial Management
Silvia M. Albert	Temporary	GSURR	Administrative
Tekabe Ayalew Belay	Senior Economist	GHNDR	Economics
Toufiq Ahmed	Senior Procurement Specialist	GGODR	Procurement
Supervision/ICR			
Inaam Ul Haq	Program Leader	SACPK	Public Health
Mohammad Tawab Hashemi	Senior Health Specialist	GHNDR	Public Health
Sayed Ghulam Dastagir	Senior Health Specialist	GHNDR	Public Health
Amr Elshalakani	Health Specialist	GHNDR	Public Health
Saeda Jeddi	Temporary	GHNDR	Administrative
Habibullah Ahmadzai	Consultant	GHNDR	Public Health
Sayed Ahmad Gawhari Sayed	Consultant	GHNDR	Public Health
Lori A. Geurts	Operations Analyst	GHNDR	Operations

(b) Staff Time and Cost

Stage of Project Cycle	No. of staff weeks	USD (including travel and consultant costs)
Lending		
FY10	14.06	38,057.51
FY11	9.51	34,666.87
FY12	1.44	625.72
FY13	1.10	5,099.26
FY14	0.05	125.28
Total:	26.15	78,574.63
Supervision/ICR		
FY12	7.06	24,468.05
FY13	3.66	10,946.68
FY14	3.13	13,136.55
FY15		4,688.78
Total:	13.85	53,240.05

Annex 5. Beneficiary Survey Results

1. As discussed earlier in the main body of the report, in 2012 the JHU carried out a household survey as the final end-of-project evaluation survey. The MOPH was not fully satisfied with the survey as the sampling size was small and did not allow province level analysis, and the survey was carried out too early thereby missing out 2013 performance of the project. Nevertheless for most of the project indicators the survey produced satisfactory estimates. A detailed analysis of the PDO related indicators is provided in Section 2.3 of this report. In this annex executive summary of the JHU survey is quoted in its original form:
2. The 2012 Afghanistan Household Survey (AHS) report presents the results of a national household survey designed to provide information on maternal and child health, family planning, child survival, health care utilization, and health-related expenditures in Afghanistan. It is based on a multi-stage random sample of 12,137 households across all 34 provinces of Afghanistan, and includes 14,551 women aged 12-49 years and 14,589 children under age 5 years, and was conducted between July and December, 2013.
3. The MOPH identified a set of key health indicators for the survey, with national level estimates shown below (Table 1). Provincial level estimates are also presented in the report.

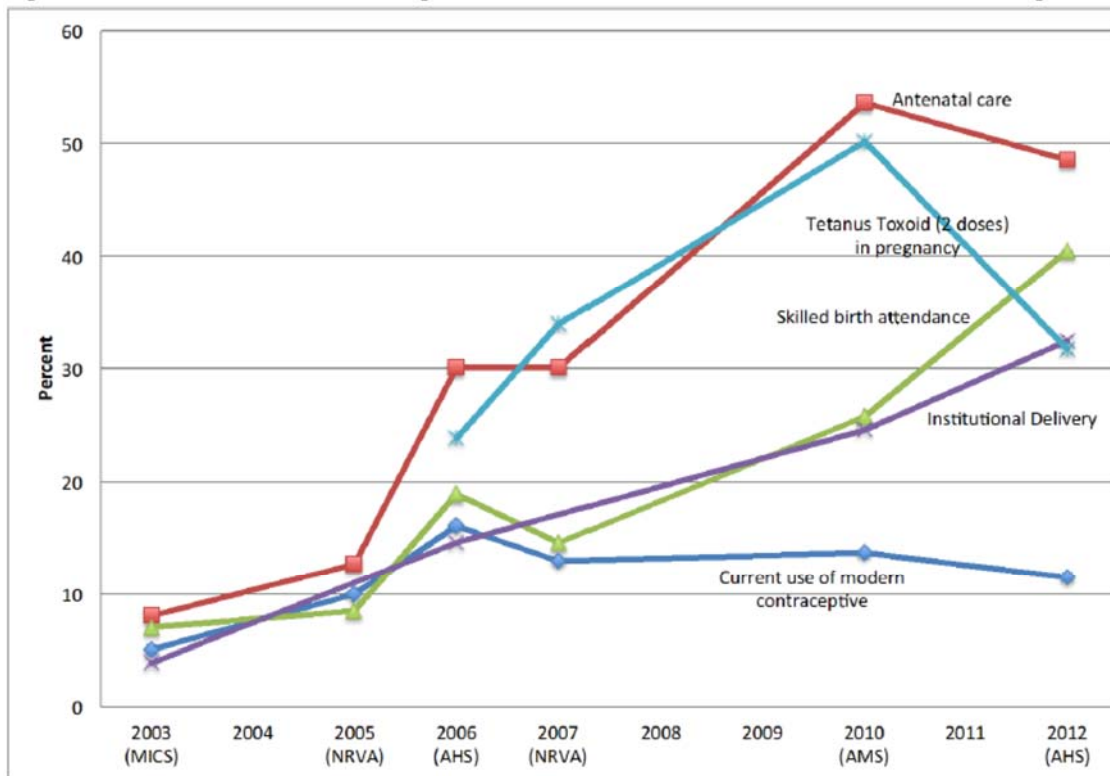
Table 1. Key Health Indicators

No.	Indicator	Sample size (n)	Percent	95% Confidence Interval
1	Households with access to health services among those with illness in the past two weeks	6,862	57.2	54.3, 60.1
2	Women who delivered in the last two years who had antenatal care (ANC) (at least one visit)	4,872	54.0	50.9, 57.1
3	Births in last two years attended by skilled birth attendant	5,344	47.4	44.4, 50.5
4	Births in last two years delivered at BPHS or EPHS facility	5,344	30.1	27.2, 33.1
5	Women who delivered in the last two years (excluding currently pregnant) with tetanus coverage	4,872	33.3	13.7, 18.0
6	Children aged 12-23 months who received Pentavalent 3 vaccine	2,602	46.7	41.0, 52.5
7	Children exclusively breastfed for first 5 months of life	1,243	54.9	49.6, 60.1
8	Breastfed and given complementary foods within last 24 hours among children aged 6-9 months	833	59.1	52.9, 64.9
9	Women who have given birth in last two years who have appropriate knowledge of complementary foods	5,344	66.7	63.9, 69.4
10	Contraceptive (modern) prevalence among married women aged 12-49 years	13,670	13.8	12.1, 15.6
11	Children aged 6-59 months who have received vitamin A	13,475	37.1	34.4, 39.9
12	Caregivers who can name danger signs of diarrhea and acute respiratory infection (ARI)	14,735	94.0	92.5, 95.3
13.	Women aware of community health workers (CHWs) who say CHWs provide a useful service	2,935		
	Strongly disagree/disagree		18.5	15.5, 21.9
	Strongly agree / agree		81.6	78.1, 84.5
14a	Children aged 0-59 months with diarrhea who received treatment at public/private facility	3,352	64.4	59.7, 68.8
14b	Children aged 0-59 months with diarrhea who received appropriate treatment at home	3,352	69	65.6, 72.2
14c	Children aged 0-59 months with ARI who received treatment at public/private facility	3,394	58.7	54.4, 62.9
15	Children aged 0-59 months with ARI who received treatment at public facility	3,394	31.9	28.1, 36.0
16a	Persons from poorest quintile who were sick in last 2 weeks who used BPHS services	3,365	38.8	34.5, 43.2
16b	Persons from poorest quintile who were hospitalized in the last 12 months who used EPHS services	560	58.2	49.5, 66.5

TRENDS IN MATERNAL CHILD HEALTH INDICATORS

4. To compare trends in maternal child health coverage over time in Afghanistan, we compare the rural population (92% in the AHS 2012 sample) to previous household survey results in Afghanistan, although there remain some differences in definitions of indicators across the surveys. Figure 1 demonstrates the trends in key maternal health indicators since 2003. Antenatal care coverage has been generally increasing since 2003, with the most recent estimate for rural Afghanistan at 48.5%. Skilled birth attendance and institutional deliveries are both rising, to 40.5% and 32.4% respectively. The percent of women receiving two doses of tetanus toxoid during pregnancy is very different across surveys, with only 31.7% of rural women who delivered in the last two years able to document two doses in the AHS 2012. The level of contraceptive prevalence remains very low, with only 11.4% of rural women using modern contraception in 2012.

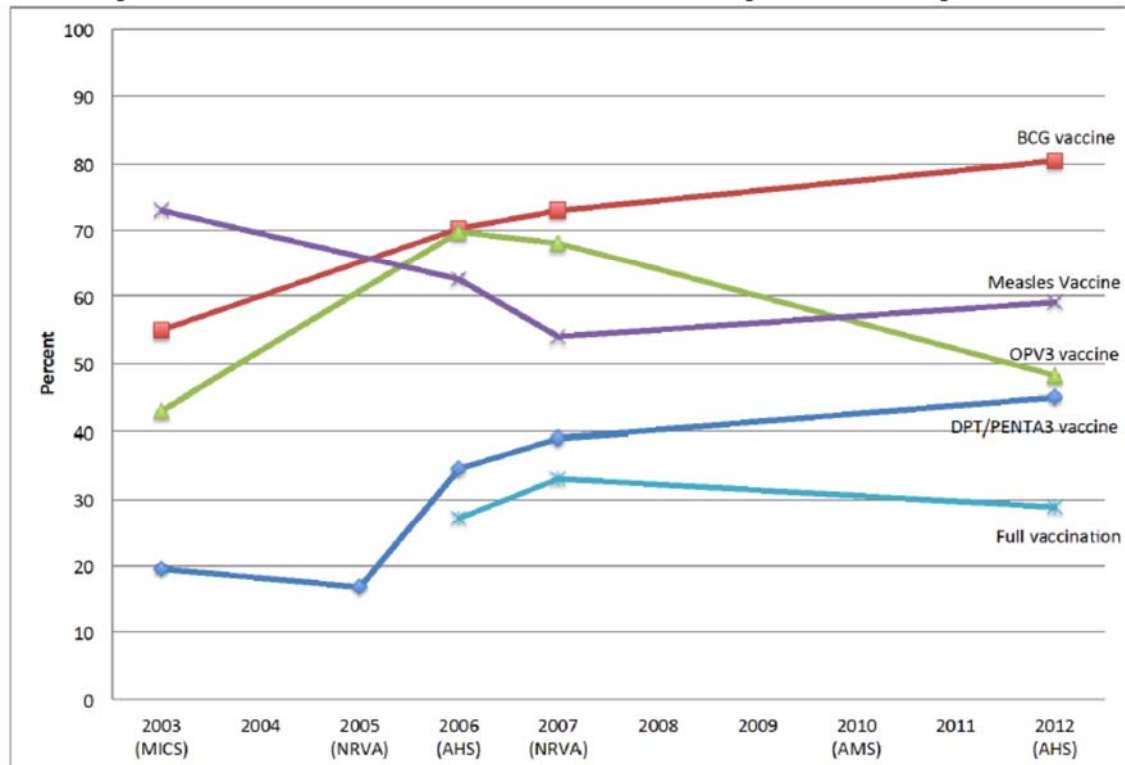
Figure 1. Trends in the Coverage of Maternal Health Indicators in Rural Afghanistan



Note: MICS = Multiple Indicator Child Survey; NRVA = National Risk and Vulnerability Assessment; AHS = Afghanistan Health Survey; AMS = Afghanistan Mortality Survey

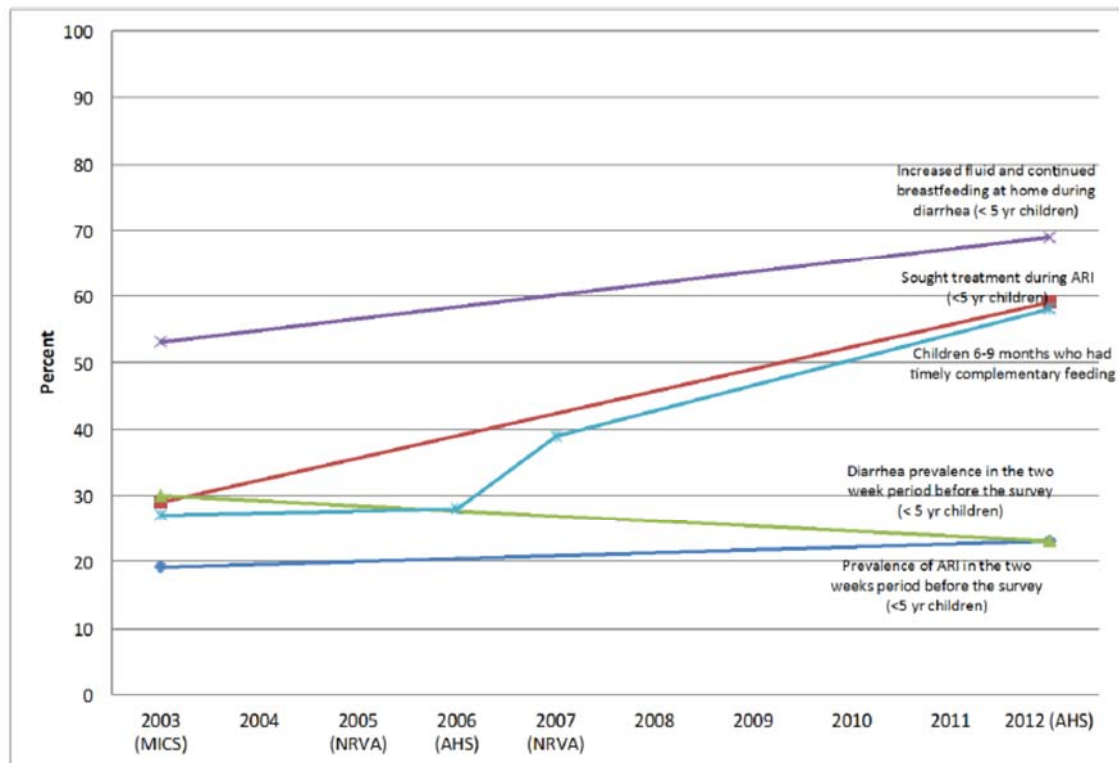
5. Figure 2 shows the trends in childhood immunization coverage in rural Afghanistan based on household surveys. The last household survey to show childhood vaccination coverage across rural Afghanistan occurred in 2007. BCG coverage and DPT/Pentavalent 3 coverage have continued to increase, though still below desirable levels (80% for BCG and 45% for DPT/Pentavalent 3). Measles vaccine coverage increased since 2007, but at 59% coverage, is still below coverage rates from the early 2000s. Similarly, OPV3 vaccine coverage is declining, and now stands at 48%, whereas full childhood vaccination is still very low at 29%.

Figure 2. Trends in Child Immunization Coverage in Rural Afghanistan



6. Figure 3 shows the trends in other child health indicators. Data on complementary feeding shows that the proportion of children aged 6-9 months who had timely complementary feeding continues to increase, with about 58% of children now getting complementary feeding. The reported percent of children under five with diarrhea has gone down from 30% in 2003 to 23% in 2013, but this can be due to seasonal differences as well as differences in perception of illness over time. The proportion of children with acute respiratory infection in the last two week is also similar to diarrhea prevalence in 2013. Appropriate treatment of diarrhea increased from 53% in 2003 to 69% in 2013. The proportion of children with ARI who seek treatment outside the home has doubled since 2003, and is now estimated at 59%.

Figure 3. Trends in Child Health Indicators in Rural Afghanistan



ILLNESS AND INJURIES, CARE-SEEKING BEHAVIOR AND PERCEPTIONS

Illness and injuries in the past two weeks

7. Of 91,792 household members, 13,973 (15%) were reported to have been sick in the two weeks prior to the survey. 31% of children under 5 years of age were reported to have experienced illness. Diarrhea, fever, cough/difficulty breathing, and musculoskeletal problems were the most prevalent primary complaints reported for all age groups, at 18%, 17%, 12%, and 9%, respectively. The most prevalent primary complaints for the under-fives were diarrhea (45%), fever (25%), cough/difficulty breathing (14%), and nausea/vomiting (5%).

Treatment seeking outside the home

8. Among all individuals that reported illness in the two weeks prior to the survey, 83 percent were reported to have sought treatment outside of the home. Of the 2,444 individuals that were ill in the last two weeks and who did not seek care outside of the home

9. 50% thought the illness would go away by itself; 34% reported that the transportation was too expensive; and 29% reported that the health facilities were too far from their home. The three commonest facility types from which people sought care were private clinic or hospital (40%), BPHS clinic (28%), and EPHS Hospital (16%). The largest proportion (43%)

of those over-five sought care at a private clinic/hospital, while the most (34%) of the under-fives were taken to a BPHS clinic.

Hospitalization in the past 12 months

10. Out of the 91,792 household members, about 2.2% reported having been hospitalized in the 12 months period prior to the survey. Out of the 2,008 household members that were hospitalized in the 12 months prior to the survey, 56.5% was for medical illness, 24.8% for surgery, and 7.7% for childhood illnesses. Overall, distribution between EPHS hospitals and private hospitals was fairly equal (56.7% versus 43.3%, respectively).

Perception of community health workers

11. Of the 14,613 eligible women in the sample, nearly 80% were found to be unaware of Community Health Workers or Health-Posts in their vicinity. This was consistent almost throughout all age groups and wealth quintiles. Of the 8755 eligible women who fell sick in the last two weeks and sought care, over three quarters (79.9%) were not aware of a CHW or Health-post in their vicinity. Among women who were aware of CHWs or Health-posts in their vicinity over 80% responded that they 'Agreed' or 'Completely Agreed' that CHWs provide useful services to the community.

HEALTH EXPENDITURES

Out-of-pocket expenditures on health

12. Information was collected for each household member who sought care outside the home on payments made for the care seeking episode. These payments include money spent on registration, consultation, tests (including labs and x-rays), drugs and supplies, transportation, and food and lodging. The median of the total amount spent per each care-seeking episode was 700 Afghanis. Median amounts spent per care-seeking episode were fairly stable across the five wealth quintiles with those in the poorest and wealthiest quintiles paying more than the other three groups. The overall mean total expenditure was 3279 Afghanis. Mean expenditures appeared to be fairly consistent across wealth quintiles for drugs and supplies, food, and transportation categories.

Out-of-pocket expenditures for hospitalization (last 12 months)

13. The median total expenditure spent on hospitalization was 5000 Afghanis. The median total expenditure was highest for those in the poorest quintile, and decreased with increasing wealth status. The mean total expenditure was 15,764 Afghanis. Respondents in the highest wealth quintile also reported the highest mean total expenditure.

Distress financing on health

14. Distress financing is defined as households spending over and above their regular savings and budget on health care. This includes borrowing money from friends and family, selling or mortgaging household possessions and land. About 49% of those that were reported to

have been hospitalized in the last 12 months prior to the survey reported some form of distress financing. Differences in proportions were found to be statistically significant when comparing the lowest wealth quintile (66.0%) to three other wealth quintiles (second: 43.2%; middle: 39.0%; and highest: 39.6%).

Severe distress financing on health

15. Severe distress financing only included those who sold assets and not those who borrowed money in order to pay for medical care. Of those who reported to have been hospitalized in the last 12 months prior to the survey, 14.6% reported some form of severe distress financing. The only statistically significant difference in proportions reporting severe distress financing occurred between those in the lowest and highest quintiles of wealth status (22.5% versus 7.9%, respectively).

Annex 6. Stakeholder Workshop Report and Results

Not applicable

Annex 7. Summary of Borrower's ICR and/or Comments on Draft ICR
(Unedited original evaluation report submitted by the Borrower)

PROJECT PURPOSE

- I. To consolidate and expand access to the Basic Package of Health Services (BPHS), especially by the poor women and children, in urban area of Kabul province;
- II. To improve the quality of health care and health services at BPHS facilities in urban area of Kabul province.

OUTPUTS

1. The BPHS services consolidated and expanded, and its access increased to the urban poor people in urban Kabul.
2. The quality of BPHS services in Kabul urban area improved to the extent that the client satisfaction increased and the service utilization level improved.

IMPLEMENTATION ARRANGEMENT

Overall Management and Organizational Structure

The Project implemented by MoH through using Strengthening Mechanism through KPPHD. Although the Deputy Minister of Ministry of Public Health had the role of the project Manager, the KPPHD had overall responsibility for the project implementation through its provincial health officers and technical assistants provided under this project. For the implementation of urban BPHS (UHM) in urban Kabul, the Director of KPPHD played the role of project Coordinator. He was reporting to the Deputy Minister for Health Service Provision.

In the proposal the GCMU was supposed to provide technical support through its Monitoring and leading Urban Health (UH) consultants who closely work with KPHD to:

- I. Follow up procurement and financial management process to undertake within the allocated time schedule and ensure that the bidding process of health services procurement is undertaking under Bank procurement & consultant guidelines dated January 2011.
- II. Oversight the project implementation process to ensure the project is on schedule, MoH standards are maintained, and on allocated resources.
- III. Ensure the project activities are coordinated through Kabul urban health working group and other coordination mechanism are in place
- IV. Make sure that, the information and data produced by the project progress is communicating on a regular base internally and to donor.

However, during the project implementation MoH-SM had the overall responsibilities of financial, procurement, and technical issues. The JICA-Urban Health System Strengthening Project (JICA-UHSSP) had provided the technical assistance for both MoH and KPPHD, under the agreement between Islamic Republic of Afghanistan and the government of Japan for the pilot implementation of this project in urban Kabul. JICA-UHSSP aimed to strengthen health system suitable for urban Kabul areas.

Technical Assistant Staff in KPHD

The technical assistant (Technical Consultant) positioned in KPHD. They supported staffs for implementation of the project. The below table shows number and position of technical staff's hired under this project.

Table 1: Number and position of Technical Assistant Staff

S#	Position	Number
1	Technical Adviser	1
2	Financial Adviser	1
3	Procurement Consultant	1
4	RH Consultant	1
5	Master Trainer	1
6	Supply Supervisor	1
7	HMIS Assistant	1
	Total	7

Monitoring and Supervision System

Monitoring and supervision system followed by the urban health team and by the provincial public health directorate officers was partially functional in the beginning of the project and was gradually improved over the project period. Monitoring and supervision visits conducted at least one per quarter from each health facility. Monitoring was done through an assessment checklist which helped in evaluating the services provided by the health facilities. Though monitoring of the health facilities was the responsibility of all authorities such as health facility directors and other relevant managerial staff. During the monitoring and supervision the strength and weakness of the health services provision were identified and corrective measures were taken to improve the services. In addition, appropriate and on time feedback was provided to the health facilities staff after each visit.

In addition to that; health providers even stressed that the monitoring system was weak for hospital. They also mentioned that health Shuras sometimes supervised their activities and gave feedback on the services.

PROJECT OUTCOME

The urban BPHS project's planned outcome was to contribute to the SHARP overall objective of improving the health and nutrition status of the people of Afghanistan, with a greater focus on women and children and under-served areas of the country. Overall, the project outcome was only partially achieved, particularly in its last year of implementation, since progress was slow in the initial two years. The project's three planned outputs were only partially achieved:

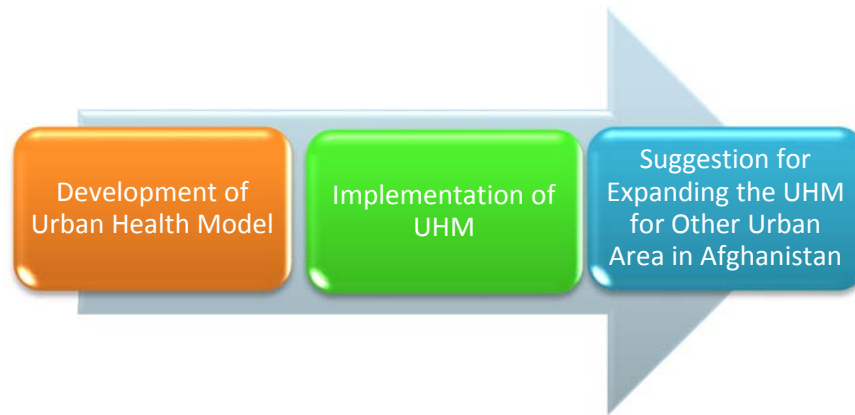
- a) Development of Urban Health Model
- b) Implementation of UHM
- c) Improving quality of urban BPHS and increasing service utilization

a) Urban Health Model introduced for Kabul. The urban BPHS working group at the ministry level developed an Urban Health Model based on existing rural BPHS for Kabul however; the effectiveness of the Urban Health Model had varying perspectives. In the urban health module 8 BHCs, 28 CHCs, 4 CHC+ and 4 district hospitals was proposed to be included.

b) Urban BPHS consolidated/expanded and its access increased. The urban BPHS was, for the most part, consolidated and expanded through the implementation of structural reforms of HFs. Eleven out of 12 proposed structural reforms for HFs were completed as of September 2014, per data provided by the MOH. However, access to the urban BPHS was only partially increased, as seen by the achievement of targets in only two out of seven service utilization performance indicators (outpatient visits increased by 35% and number of TB+ cases successfully treated increased by 48%). The other five service utilization indicators (number of deliveries, number of pregnant women receiving at least one ANC, number of new users of contraceptives, number of children <1 receiving DPT3, and number of children <5 receiving nutrition screening) did not fully achieve their intended targets of a 10% increase from the baseline, though two indicators, number of deliveries and number of new contraceptive users, did show partial increase towards the target (3% and 6%, respectively).

c) Quality of Urban BPHS improved to the extent that patient satisfaction and service utilization is increased. Patient satisfaction improved by 18%, over-achieving its targets, though as previously mentioned, service utilization only partially increased. Furthermore, the drugs and equipment availability indices, two critical indicators which define the capacity of HFs to deliver the urban BPHS, did not meet their targets (decreased by 3% and 8%, respectively) due to challenges in procurement of essential drugs, supplies and equipment.

Figure 2: Project Outcome



Service Utilization

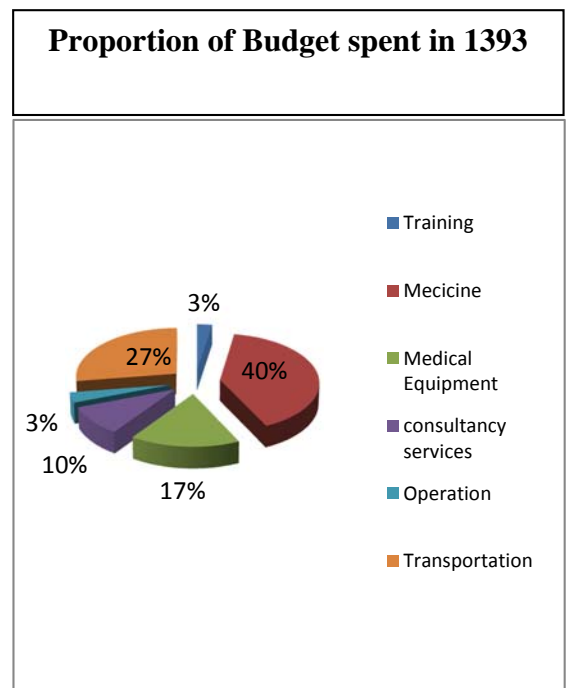
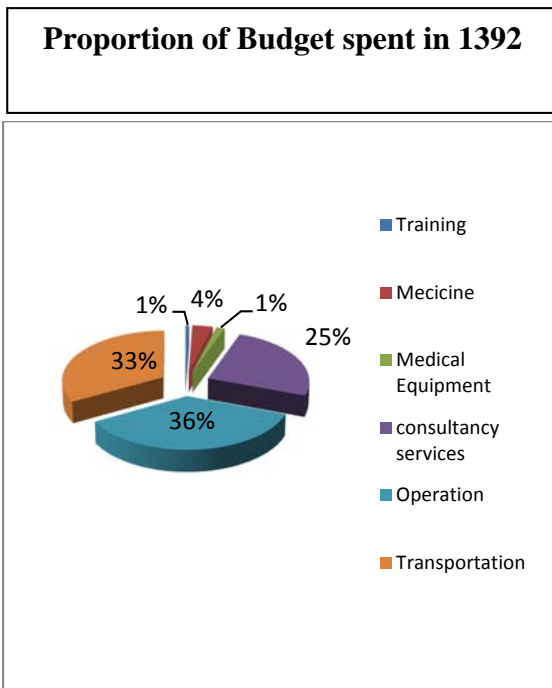
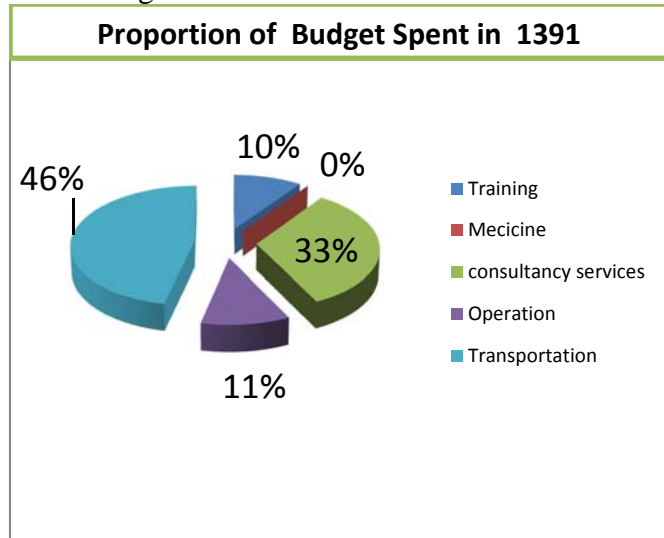
Urban health facilities were serving to out -patients ranging from approximately 120 in CHC without delivery and BHC to 150-300 patients in CHC with delivery and DH per day. Their role in OPD and IPD service was likely to contribute in the decrease of maternal and child mortality and controlling communicable diseases.

The performance of the health facilities was measured through the output indicator of the HMIS. The result of indicates relatively improvement in service utilization.

SN	Indicator	Baseline	Annual Targets	HMIS annual achievement 1391	HMIS annual achievement 1392	HMIS 9 Months achievement 1393
1	Outpatient visit	768,000	844,800	850670	1021130	798914
2	Number of deliveries	4,000	4,400	7080	8554	4581
3	Number of pregnant woman receiving at least one ANC visit	52,000	57,200	53,449	51479	31722
4	Number of current user of contraceptive	53,000	58,300	50149	62142	46607
5	Number of children < 1 received DPT3	83,000	91,300	64128	66562	41847
6	Number of children aged under 5 received nutrition screening	116,000	127,600	228763	144913	138469

Project cost:

The total project cost was originally US\$ 3.5 million which was reduced to \$2.5 million due to slow implementation in the first two years. The project was financed by JSDF through the World Bank (WB). This budget covered only operational budget (35%) of KPPHD while the other parts of the expenditures were covered through the government core budget (ordinary budget) at estimated cost of 65% of overall KPPHD budget.



Challenges /constraints

- Bureaucracy in procedure for procurement & supply resulted in delaying in supply and procurement.
- Temporary shifting of HFs staff from one to another health facility due to pressure from parliamentary members, governmental authorities and other influential individual or association .
- Shortage of standard building for HFs , out of 44 urban health facilities merely 15 Kabul urban health facilities have permanent building however , these health facilities building were not standard for quality health services delivery and the rest are rental building which build for housing purposes .
- Undefined catchment areas and difficulties in setting of baseline and target for the project
- Low salary(paying according to grading system)
- Shortage of specialist in health facilities(District hospital and CHC with delivery)
- Bulging of population due to IDP (internal displaced people)
- CBHC program was not properly implemented
- Few number of advanced management training for KPPHO which caused low performances.
- Inadequate technical advance training conducted for CHC with delivery and DH technical staff

Recommendation

- To mitigate the miss opportunity of reproductive health clients some changes in health facility staff modality such as adding another midwife in CHC without delivery will be proposed
- To strengthen the reproductive health program in the health facilities there is need for hiring two expert midwives as supervisors.
- In order to avoid delay in the supply of medicine, equipment and other medical and non-medical items the project must take necessary steps such as well planning, early procurement start up, and hire procurement expert consultant.
- To prevent staff shifting from one health facility to another the staff address and their job locations should be reviewed and accordingly re adjustment must be doing. The new recruited staff should be deployed to the nearest facility.
- Proposing some incentive, training and other type of motivation to the specialist to deploy and retain them in urban health facilities.
- Strengthening CBHC management layer of Kabul public health directorate and restructuring the CBHC management level of the project (hiring CBHC coordinator and expert CBHC trainers at the project level)
- Recommending advanced management training for KPPHO
- Proposing adequate technical advance training for CHC with delivery and DH technical staff in the next phase of the project

Table 3: project input, process, and output

Input	Process	Out put
<ul style="list-style-type: none"> • 7 Technical consultants for technical Assistance • Provision of medicine • Provision of medical equipment's (3 machine of digital x-ray , ECG • Machines , ultrasound machines, other OT equipment's , and medical • Equipment for hospital and clinics • Provision of lab. Regents and other medical consumable • Purchasing of three well equipped ambulance • 24 rental vehicle for transportation of staff and supervisors • Furniture for KPPD and health facilities • Renovation of KPPD and Health facilities include of two depth wells • Provision of incinerators , sign board for Health facilities and generators • Provision of IT equipment and other non-medical equipment 	<ul style="list-style-type: none"> • Providing technical assistance to KPPHD • Conducting of training for KPPHD and HF's staff • Conducting Supervision and monitoring visits of HF's • Conduction meetings (PHCC , Weekly base KPPHD PHHO Meeting, SM coordination meeting 	<p>Achievem ent in different indicators (Referred to table 1)</p>

Lesson learnt

There was ambiguous management structure in urban health proposal, which led to coordination difficulties between SM and KPPHD. There was a lack of clear roles and responsibilities and hence, unclear ownership/accountability over the project, serving as the root cause of other implementation challenges. While political support and leadership of the project improved over time, it was lacking in its initial stages and capacity building for project implementation within KPPHD was inadequate. Furthermore, there were significant delays in procurement of essential medicines, supplies and equipment for the urban HF's. There were also challenges in implementing some of the intended renovations/reforms of the HF's, especially due to the fact that the majority of the HF's is located in rental properties. Project implementation and service delivery was also challenged by high turnover and shifting of HF staff among urban HF's. Reporting of performance by HF's in the initial years of the project also posed challenges. The Community-Based Healthcare (CBHC) component was not implemented successfully as only 120 Community Health Workers (CHWs) were trained by 2014 against a target of 660. Finally, some CHCs with delivery could not meet their target especially in delivery services.

Annex 8. Urban Kabul Pilot Indicators

Table: Urban Kabul Pilot Indicators

Indicator	Baseline (2010/2011)	Target (+10%)	End line (2013)	% Change (Baseline/End line)
Patient Satisfaction*	74.7	82.2	87.9	+18%
Number of active CHWs	0	660	80	-
Drugs availability index (availability of essential drugs)*	95.0	100.0	92.0	-3%
Equipment Functionality index*	69.6	76.6	64.3	-8%
Outpatient visits**	614,118	675,530	829,517	+35%
Number of deliveries**	5,081	5,589	5,244	+3%
Number of pregnant women receiving at least 1 ANC visit**	40,929	45,022	35,916	-12%
Number of new users of contraceptives**	23,408	25,749	24,904	+6%
Number of children <1 who received DPT3**	54,803	60,283	49,390	-10%
Number of children <5 who received nutrition screenings**	119,015	130,917	115,370	-3%
Number of TB+ cases successfully treated**	215	237	319	+48%

* Baseline Year = 2010 from BSC Reports 2009/2010

** Baseline Year = 2011 from HMIS Data for 32 HFs only

Only three indicators met their targets: (i) patient satisfaction: probably due to the investment in knowledge and training of health workforce, building staff capacity at the facility level and improvement in infrastructure; (ii) outpatient utilization levels suggesting an overall increase of utilization of services; and (iii) number of TB cases successfully treated, owing to the increasing numbers of facilities offering the treatment and the use of the DOTS technique. However, the provider knowledge score, not being available for Urban Kabul, has increased in the province as a whole by 8%. This may be attributed to the training offered under this operation.

The other eight indicators never met their intended targets, though two of those (number of deliveries and number of new contraceptive users) have shown commendable progress. It is

the view of this ICR that the delays of procurement and the lack of coordinating between KPPHD and SM were largely to blame.

Two project indicators have shown a decrease by 2013/2014 (number of pregnant women receiving at least one ANC visit and number of children <1 y who received DPT3). The baseline for the ANCs was largely speculated due to the lack of a solid ANC registration system prior to the project. Thus, through the improvements witnessed in the HMIS over the project duration, the real rates were shown. As for the DPT3 vaccinations, there were no outreach immunization campaigns in urban Kabul.

Annex 9. Comments of Cofinanciers and Other Partners/Stakeholders

Not applicable

Annex 10. List of Supporting Documents

1. Draft Assessment Report, Kabul Urban Basic Package of Health Services Project, December 2014.
2. Restructuring Papers 1, 2 & 3, Support to Basic Package of Health Services (PBHS) Project, JSDF Grant. TF095919.
3. Implementation Status and Results Reports (ISR) 1 to 8, Supports to Basic Package of Health Services (PBHS) Project, JSDF Grant. TF095919.
4. Urban Health Situation Analysis, Kabul 2010.
5. Project Proposal, MOPH Direct Delivery of Urban health Model in Kabul, March 2011.
6. Japan Social Development Fund- Grant Proposal, FY 09, Round 27.
7. Project Paper, Strengthening Health Activities for the Rural Poor Project (SHARP)
8. Implementation Completion and Results Report (ICR), Strengthening Health Activities for the Rural Poor (SHARP), February 2014.
9. Grant Agreement, WB & JSDF, Grant for Support to Basic Package of Health Services (BPHS), March 2009.
10. Afghanistan BPHS Balanced Scorecard National Report, 2012-2013.
11. Emergency Project Document, System Enhancement for Health Action in Transition Project (SEHAT), Feb 2013.
12. Final Government ICR, Support to Basic Package of Health Services (BPHS) Project, JSDF Grant. TF095919.
13. Health & Nutrition Sector Strategy, Afghanistan, 2008-2013.

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