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The World Bank

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Report No: PAD2580

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT

IN THE AMOUNT OF SDR 96.1 MILLION (US$ 140 MILLION EQUIVALENT)
AND
A PROPOSED GRANT
FROM THE AFGHANISTAN RECONSTRUCTION TRUST FUND
IN THE AMOUNT OF US$425 MILLION
AND
A PROPOSED GRANT
FROM THE GLOBAL FINANCING FACILITY
IN THE AMOUNT OF US$35 MILLION

TO THE

ISLAMIC REPUBLIC OF AFGHANISTAN

FOR A

AFGHANISTAN SEHATMANDI PROJECT

March 12, 2018

Health, Nutrition, and Population Global Practice
South Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective January 31, 2018)

Currency Unit =	Afghani (AFN)
AFN 69.36 =	US$1
US$1.46 =	SDR 1

FISCAL YEAR

December 22 – December 21

ABBREVIATIONS AND ACRONYMS

ACS	Average Composite Score
AHS	Afghanistan Health Survey
ARTF	Afghanistan Reconstruction Trust Fund
BCC	Behavior Change Communication
BHC	Basic Health Center
BoD	Burden of Diseases
BPHS	Basic Package of Health Services
BSC	Balanced Scorecard
CCAP	Citizens' Charter Afghanistan Program
CDC	Community Development Committee
CHS	Community Health Supervisor
CHW	Community Health Worker
CPF	Country Partnership Framework
DA	Designated Account
DALY	Disability-Adjusted Life Year
DHS	Demographic Health Survey
DP	Development Partner
ESMF	Environmental and Social Management Framework
EPHS	Essential Package of Hospital Services
FM	Financial Management
FFS	Fee-for-Service
GBV	Gender-Based Violence
GCMU	Grant Contract Management Unit
GFF	Global Financial Facility
GP	Global Practice
GRM	Grievance Redress Mechanism
GRS	Grievance Redress System
HCWMP	Health Care Waste Management Plan

HIS	Health Information System
HMIS	Health Management Information System
HNP	Health, Nutrition, and Population
IFR	Interim Financial Report
IMF	International Monetary Fund
IPF	Investment Project Financing
M&E	Monitoring and Evaluation
MEC	Monitoring and Evaluation Committee
MOF	Ministry of Finance
MOPH	Ministry of Public Health
NGO	Nongovernmental Organization
NSP	National Salary Policy
PASA	Programmatic Advisory Services and Analytics
PDO	Project Development Objective
PHC	Primary Health Care
PHO	Provincial Health Office
PPSD	Project Procurement Strategy for Development
SBCC	Social and Behavioral Change Communications
SCD	Systematic Country Diagnostics
SDG	Sustainable Development Goal
SEHAT	System Enhancement for Health Action in Transition
SM	Strengthening Mechanism
SOP	Standard Operating Procedure
TB	Tuberculosis
TD	Technical Department
TOR	Terms of Reference
TPM	Third-Party Monitoring

Regional Vice President:	Annette Dixon
Country Director:	Shubham Chaudhuri
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Rekha Menon
Task Team Leader(s):	Ghulam Dastagir Sayed, Mickey Chopra, Mohammad Tawab Hashemi

BASIC INFORMATION

Is this a regionally tagged project?	Country(ies)	Financing Instrument
No		Investment Project Financing

[✓] Situations of Urgent Need of Assistance or Capacity Constraints

[ ] Financial Intermediaries

[ ] Series of Projects

Approval Date	Closing Date	Environmental Assessment Category
28-Mar-2018	30-Jun-2021	B - Partial Assessment

Bank/IFC Collaboration
No

Proposed Development Objective(s)

The project development objective is to increase the utilization and quality of health, nutrition, and family planning services.

Components

Component Name	Cost (US$, millions)
Component 1: Improving Service Delivery.	570.00
Component 2: Strengthening the Health System and its Performance.	20.00
Component 3: Strengthening Demand and Community Accountability for Key Health Services.	10.00

Organizations

Borrower : Ministry of Finance

Implementing Agency : Ministry of Public Health (MOPH)

PROJECT FINANCING DATA (US$, Millions)

[ ] Counterpart Funding	[ ] IBRD	[ ] IDA Credit	[✓] IDA Grant	[✓] Trust Funds	[ ] Parallel Financing

Total Project Cost:	Total Financing:	Financing Gap:
600.00	600.00	0.00
	Of Which Bank Financing (IBRD/IDA): 140.00	

Financing (in US$, millions)

Financing Source	Amount
Afghanistan Reconstruction Trust Fund	425.00
Global Financing Facility	35.00
IDA-D2850	140.00
Total	**600.00**

Expected Disbursements (in US$, millions)

Fiscal Year	2018	2019	2020	2021	2022
Annual	0.00	130.00	190.00	200.00	80.00
Cumulative	0.00	130.00	320.00	520.00	600.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?

a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF

Yes

b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment

Yes

c. Include Indicators in results framework to monitor outcomes from actions identified in (b)

Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

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

COMPLIANCE

Policy

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

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓
Pest Management OP 4.09		✓
Physical Cultural Resources OP/BP 4.11		✓
Indigenous Peoples OP/BP 4.10		✓
Involuntary Resettlement OP/BP 4.12		✓
Safety of Dams OP/BP 4.37		✓
Projects on International Waterways OP/BP 7.50		✓
Projects in Disputed Areas OP/BP 7.60		✓

Legal Covenants

Sections and Description

By not later than October 31, 2018 engage, and thereafter, maintain, throughout the implementation of the Project, the services of an independent third-party evaluator with qualification and experience satisfactory to the Association and operating under terms of reference acceptable to the Association, to evaluate the performance of the Service Providers and related delivery of BPHS and EPHS under the Project.

Sections and Description

Ensure that the Project is carried out in accordance with the National Technical Assistance Salary Scale and Implementation Guideline and that all recruitment of techno-managerial contractual staff of grades A to C is carried out under terms of reference satisfactory to the Association.

Conditions

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
Ghulam Dastagir Sayed	Team Leader(ADM Responsible)	Public Health	GHN06
Mickey Chopra	Team Leader	Maternal Health and Nutrition	GHNDR
Mohammad Tawab Hashemi	Team Leader	Maternal Health and Service delivery	GHN06
Aimal Sherzad	Procurement Specialist(ADM Responsible)	Procurement	GGOPZ
Syed Waseem Abbas Kazmi	Financial Management Specialist	Financial Management	GGOAP
Ajay Tandon	Team Member		GHN06
Akbar Ali Mohammadi	Team Member	Financial Management	GGOAP
Andre C. Medici	Team Member	Health Economics	GHN19
Bashir Ahmad Hamid	Team Member	Nutrition and health costing	GHN19
Bathula Amith Nagaraj	Team Member	Operations	GHN06
Benjamin P. Loevinsohn	Team Member	Public Health and performance based contracts	GHN07
Deepika Nayar Chaudhery	Team Member	Nutrition	GHN06
Fahima Sadat	Team Member	Project Management	GHN06
Habibullah Ahmadzai	Team Member	Operations	GHN06
Juan Carlos Alvarez	Counsel	Legal	LEGES
Maged Mahmoud Hamed	Safeguards Advisor	Safeguards	OPSES
Martha P. Vargas	Team Member	Administration and cordination	GHN06
Minh Thi Hoang Trinh	Team Member	Administration and cordination	GHN19
Mohammad Arif Rasuli	Environmental Safeguards Specialist	Enviroinment	GEN06
Mohammad Yasin Noori	Social Safeguards Specialist	Social Development	GSU06

Najla Sabri	Team Member	Gender	GSU06
Saeda Jeddi	Team Member	Administration and cordination	SACKB
Tariq Ashraf	Social Safeguards Specialist	Social development	GSU06
Victor Manuel Ordonez Conde	Team Member	Loan and financial managment	WFACS

Extended Team

Name	Title	Organization	Location
Richard Johnson	Mr	Freelance Consultant	Hempstead,United Kingdom

TABLE OF CONTENTS

I. STRATEGIC CONTEXT

A. Country Context

1. There have been substantial improvements in development outcomes in Afghanistan since 2001, particularly in expanded access to basic services such as water, sanitation, and electricity, and improved outcomes in education and health. However, some gains are now being eroded due to growing insecurity. Between January and September 2017, 2,640 people were killed and around 5,380 injured. The number of Internally Displaced People has increased at an alarming pace: in the first half of 2017 alone, more than 200,000 people have been displaced internally due to conflict and more than 296,000 refugees have returned from Iran and Pakistan. The increased conflict appears to be affecting business and consumer confidence as economic activity is continuing to stagnate. The annual economic growth rate is projected at 2.6 percent in 2017, increasing slightly from the 2.2 percent recorded in 2016. Growth is expected to edge up to 3.2 percent in 2018, but only assuming no further deterioration in the security environment. While this constitutes a moderate improvement compared to 2014 and 2015, it is still significantly below the 9.6 percent average annual rate recorded between 2003 and 2012. In the medium term, growth is expected to remain muted, increasing modestly to 3.6 percent by 2020.

2. Poverty rate in Afghanistan increased from 36 percent in 2011/12 to 39.1 percent in 2013/14 and is expected to remain high in the medium-term, driven by weak labor demand (despite an increasing labor force) and security-related constraints on service delivery. Rural poverty and living conditions are particularly acute. The unemployment rate is estimated at 22.6 percent. Unemployment is particularly severe amongst women, low-skilled and illiterate workers. With an average annual population growth rate of 3 percent and with an estimated 400,000 Afghans entering the labor market each year, much higher economic growth is required to improve per capita incomes and to provide quality employment opportunities for the expanding workforce.

3. Stronger growth is predicated on improvements in security, political stability, steady progress with reform, and continued high levels of aid flows. Growth could also be enhanced with the right combination of fiscal and policy reforms, including improving budget execution, and reorienting budget expenditures towards labor-intensive and community-based programs that directly reach the population with the greatest needs and with the highest marginal propensity to consume.

B. Sectoral and Institutional Context

4. Despite increasing insecurity since 2005, Afghanistan has made notable progress in improving key indicators in the areas of maternal and child health, nutrition, and health service delivery. The Demographic and Health Survey (DHS) shows a sharp reduction in the under-five mortality rate from 97 per 1,000 live births in 2010 to 55 in 2015. This decline can be explained in part by significant increases in the coverage of critical health services (see table 1). Though the key indicators have improved, the modern contraceptive prevalence rate has stagnated at low levels.

Table 1. Progress on Health Service Delivery 2003–2015

Indicator	2003 (MICS)	2010 (DHS)	2012 (AHS)	2015 (AHS)
Antenatal care	16.1	47.9	52.9	61.1
Skilled birth attendance	14.3	38.6	46.1	58.1
DPT3/Penta3 vaccination	30.0	40.2	46.1	72.1
Contraceptive prevalence rate	8.5	19.5	13.3	16.3

Note: MICS = Multiple Indicator Cluster Survey; DHS = Demographic and Health Survey; AHS = Afghanistan Health Survey; DPT3 = diphtheria-pertussis-tetanus.

5. The key enablers for the improvements seen in the health sector are strong local stewardship, development of sound and stable policy frameworks, prioritization of investments in primary care and the introduction of a basic package of health services (BPHS) and essential package of hospital services (EPHS) delivered by nongovernmental organizations (NGOs) as contracted service providers, and a reasonably large influx of financial assistance. Under the System Enhancement for Health Action in Transition (SEHAT) Project 2013–2018, resources allocated for BPHS and EPHS (on and off-budget) came under one umbrella through the Afghanistan Reconstruction Trust Fund (ARTF) platform covering the entire country. This allowed harmonization in intervention design and implementation arrangements across the country, and this will be the same approach employed under the Sehatmandi[1] project. The contracting-out model has been used in 31 out of 34 provinces. In the remaining three provinces, the Ministry of Public Health (MOPH) has directly managed facilities with additional technical assistance such as contracting-in specialist and support staff (known as MOPH-Strengthening Mechanism[MOPH-SM]).

6. The recently completed Afghanistan Health Services Study,[2] through independent analysis of household and health facility data, found a remarkable resilience of health service delivery in conflict-affected areas. There were no statistically significant differences in improvements between severely, moderately, and minimally conflict-affected provinces. Further progress will be challenging, especially as competing Government priorities associated with limited national budgetary resources have resulted in low levels of public health expenditure per capita.

7. Despite significant increases in skilled birth attendance, the maternal mortality ratio (650 per 100,000 live births) and neonatal mortality rates (accounting for about 40 percent of the total under-five mortality) persistently remain high. Diarrhea and pneumonia are the primary causes of infant mortality. Undernutrition in children under five is high, about 41 percent of children under five are stunted (a form of chronic undernutrition), 10 percent are wasted (acutely malnourished), and 25 percent are underweight.

8. Despite large increases in the number of female health workers, women's access to health services remains constrained. In addition to geographical obstacles, accessibility is greatly impeded by cultural factors and low female literacy rates. Gender-based violence (GBV) is widespread in Afghanistan; the United Nations Assistance Mission Report 2013 reported 1,669 cases of GBV[3] annually. It exposes women, girls, and adolescent boys to mental and physical abuses, thus requiring health facilities to effectively provide treatment to victims.

[1] Sehatmandi in the Afghan local language means 'well-being'.
[2] Improving access to and quality of health services: The Afghanistan Health Services Study May 2017.
[3] The Ministry of Women Affairs from 16 provinces.

9. Critical behaviors such as family planning, maternal and infant, and young child feeding practices are suboptimal and have marginally changed over the last 15 years. In response, the Government of Afghanistan is implementing a program to strengthen community engagement and empowerment through the Citizens' Charter Afghanistan Program (CCAP). This offers an opportunity to scale up demand-side interventions and enhance accountability. Several demand-side innovations have been piloted on a small scale, such as conditional cash transfers, use of mini ambulances, and efforts to make more effective use of the 25,000 community health workers (CHWs).

10. Afghanistan has been selected as one of the third wave countries to be supported through the Global Financing Facility[4] (GFF). An oversight committee under the leadership of the Ministry of Public Health (MOPH) has been established to oversee the integration of the GFF within the wider health strategy. The GFF presents considerable opportunities for the country, including its emphasis on adolescent and reproductive health, nutrition, and health financing. The strengthening of the MOPH and other stakeholders' ability to monitor performance, mobilize additional resources, spread innovation, and coordinate 'off-budget' resources will be another potential benefit of joining the GFF. The current project document serves as an initial investment case to guide allocation of the GFF trust fund resources in Afghanistan. A full investment case to define the wider GFF engagement in Afghanistan will be developed over the next 6–12 months.

11. In line with the recommendations of the Presidential Summit on Health held in June 2017, the MOPH is shifting to rigorous management of the service provider contracts and their performance-based clauses. This will be facilitated by a customized performance management framework and standard operating procedures (SOPs) with a clearly defined process to reward overperformance and mange underperformance. This will involve (a) a change in the nature of the service provider contract for BPHS/EPHS to engender greater emphasis on performance in all 31 provinces; (b) rigorous application/enforcement of all performance-related clauses in these contracts by the MOPH; (c) much greater participation of the Technical Departments (TDs) of the central MOPH and Provincial Health Offices (PHOs) in the design, recruitment, and oversight of the BPHS and EPHS contracts; (d) semiannual performance reviews of BPHS and EPHS contracts that will involve the TDs, the PHOs, the Monitoring and Evaluation (M&E) Department, the Grants and Contract Management Unit (GCMU) of the MOPH, and the third-party monitoring (TPM) agent; (e) capacity strengthening of the TDs and PHOs in data analysis and utilization; (f) the development and application of a unified M&E framework; and (g) much wider dissemination of the key program and financial information. This will be underpinned by a functional review of the MOPH that is currently being undertaken and expected to be completed by July 31, 2018. The functional review, conducted as part of a government-wide effort spearheaded by the Independent Administrative Reform and Civil Service Commission (IARCSC), is intended to determine the ministry's core

[4] The GFF is a broad partnership that supports countries to get on a trajectory to achieve the Sustainable Development Goas (SDGs) by strengthening dialogue among key stakeholders under the leadership of governments and supporting the identification of a clear set of priority results that all partners commit their resources to achieving; getting more results from existing resources and increasing the total volume of financing from domestic government resources, financing from IDA and IBRD, aligned external financing and private sector resources; and strengthening systems to track progress, learn, and course-correct. This approach is guided by two key principles: country ownership and equity. The GFF is driven at the country level by a 'country platform': a forum or committee that brings together under government leadership the broad set of partners involved in improving the health outcomes of women, children, and adolescents, including different parts of the government, civil society, the private sector, and development partners (DPs). A multi-donor trust fund—the GFF trust fund—has been established at the World Bank Group to be a catalyst for this process.

functions, lines of accountability, optimal organizational structures and staffing including plans for rationalizing parallel structures that are counterproductive and keeping capacity outside of core structures. Some of the technical work needed for the functional review of the MOPH is being supported through Programmatic Advisory Services and Analytics (PASA) as well as parallel technical assistance by the World Bank's Governance Global Practice (GP).

12. The World Bank is also providing PASA support specifically to address critical areas beyond the primary and secondary care. These areas include (a) generating new information to identify and address inefficiencies and inequalities in the organization, management, and implementation of service delivery; (b) assessing and evaluating performance of critical components of the whole health system (such as hospitals and pharmaceuticals) with a specific focus upon strengthening health security and health financing; and (c) assessing and evaluating existing innovations, especially at the primary and community levels, that have generated some initial evidence of reducing supply- or demand-side barriers for essential health interventions such as family planning or maternal health. The evidence generated via the PASA will inform the focus of the World Bank's possible future engagements as well as guide any adjustments during the implementation of the Sehatmandi project.

13. It is important to note that the health sector in Afghanistan is not immune to perceptions and anecdotal evidence of potential corruption. In 2015, the Independent Joint Anti-Corruption Monitoring and Evaluation Committee (MEC) undertook a vulnerability to corruption assessment in the MOPH. The issues highlighted in the assessment include, among others, (a) under-the-table payments in medical service delivery, particularly in large tertiary care hospitals; (b) concerns of corruption in procurement related to goods, civil works, and service delivery contracts; and (c) concerns of fraud and embezzlement of medicines. Based on the MEC report, the MOPH developed an anti-corruption strategy, which is currently being implemented.

B. Higher Level Objectives to which the Project Contributes

14. The project is fully in line with sustainable development goal (SDG) Goal 3: Ensure healthy lives and promote well-being for all at all ages. This goal has several targets that the project directly supports: reduction of maternal mortality (Target 3.1), reduction of under-five and neonatal mortality (Target 3.2), achieving universal access to sexual and reproductive health care services (Target 3.7), and achieving Universal Health Coverage (Target 3.8). The project is fully in line with the World Bank Group's twin objectives of reducing poverty and promoting shared prosperity, through its focus upon improving the quality and coverage of health services to serve the poorest. The project will contribute to the Health, Nutrition, and Population (HNP) Global Practice goal of helping governments in achieving universal health coverage. It will contribute to a healthier population and increased human capital by enhancing the use of a set of health, nutrition, and population services with proven cost-effectiveness in the context of Afghanistan.

15. The Project is being processed as an emergency operation. It responds to the urgent need to address health and nutrition challenges, especially in the rural areas as underlined in the 2016 Systematic Country Diagnostic (SCD) (February 1, 2016). The Afghanistan Country Partnership Framework (CPF) for 2017–2020 (October 2, 2016) also supports the service delivery approach as one of its priorities. This project is fully in line with improving service delivery and stimulating demand-side governance and

transparency through the strengthening of community groups and providing more autonomy to service providers who deliver quality health and nutrition services with a focus on child and maternal health and communicable diseases. It will also support the Government's commitment as reflected in the Afghanistan National Peace and Development Framework (ANPDF) to improve access to services in rural areas with a focus on the poor.

16. As noted before, the Sehatmandi project is part of the World Bank's broader and programmatic engagement in the health sector in Afghanistan. It will also support implementation of the recommendations of the ongoing functional review (scheduled for completion on July 31, 2018), in coordination with the Governance GP's ongoing support for government-wide civil service reform and aims to improve performance management in the health sector.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

17. To increase the utilization and quality of health, nutrition, and family planning services.

B. Project Beneficiaries

18. The scope of this project will be nationwide, covering all 34 provinces of the country. The project beneficiaries will include the entire population (29.7 million) of Afghanistan who are expected to benefit from the better access to quality primary and secondary health and nutrition services. Poor people will disproportionately benefit from the project as it (a) focuses on the primary health centers (PHCs) where services are more likely to be utilized by the poor; (b) focuses on rural areas where the poor are concentrated; (c) expands the number of PHCs in lagging provinces that tend to be poorer; and (d) supports completely free care through the BPHS facilities, which reduces financial barriers to access, particularly by the poor.

19. Staff of key TDs and provincial health offices will also benefit from the project as their capabilities increase through the strengthened institutional capacity of the MOPH.

C. PDO-Level Results Indicators

20. The PDO level results under the project are as follows:

(a) Access measured by PENTA3 vaccination coverage among children ages between 12 and 23 months: Number of children 12–23 months old receiving the third dose of pentavalent vaccine, expressed as a percentage of the number of children 12–23 months old.

(b) Utilization measured by births attended by skilled health personnel: The number of births attended by skilled health personnel (doctors, nurses, or midwives), expressed as a percentage of the total number of births in the same period.

(c) Utilization measured by health facility visits per capita per year to BPHS/EPHS facilities: Number of clients/patients who visited BPHS/EPHS health facilities during the year, expressed as a proportion of estimated population in the same period.

(d) Quality of family planning services measured by contraceptive prevalence rate (modern methods): The proportion of women of reproductive age who are using (or whose partner is using) a modern contraceptive method at a given point in time.

(e) Quality of nutrition services measured by minimum dietary diversity: Proportion of children 6–23 months of age who receive foods from four or more food groups during the previous day.

(f) Quality of care measured by balanced scorecard (BPHS): Composite score out of 100 on indexes of quality of care as judged by a third party.

III. PROJECT DESCRIPTION

A. Project Components

21. The project will consist of the following three components: (a) Improving Service Delivery, (b) Strengthening the Health System and its Performance, and (c) Strengthening Demand and Community Accountability for Key Health Services.

22. The Sehatmandi project will build on the success of previous projects and support the delivery of BPHS and EPHS through greater focus on performance in service delivery. As part of the continual learning process, at least four strategies for strengthening performance will be highlighted: encouraging innovations, increasing managerial autonomy, increased focus upon results, and greater attention to lagging program areas such as family planning and nutrition.

Component 1: Improving Service Delivery (US$570 million)

23. This component will finance performance-based contracts to deliver the BPHS and EPHS in 31 provinces. To ensure efficiency under the Sehatmandi project, BPHS and EPHS contracts with service providers will be combined into a single package and each contract will cover an entire province. The project will finance a firm to assist the Government's efforts in direct delivery of BPHS and EPHS in three provinces (known as MOPH-SM). Similarly, the project will also finance a firm to assist the MOPH in implementation of an urban version of the BPHS in Kabul City. The service providers will train community midwives and community nurses based on need.

24. **BPHS.** The BPHS, as defined by the MOPH, comprises (a) maternal and newborn care. (b) child health and immunization, (c) public nutrition, (d) communicable disease treatment and control, (e) mental health disability and physical rehabilitation services, and (f) regular supply of essential drugs. BPHS will continue to be delivered through a network of CHWs, subcenters (now called 'primary health centers' or PHCs) that serve roughly 3,000–7,000 people, basic health centers (BHCs) that serve 15,000–30,000 people, comprehensive health centers (CHCs) serving 30,000–60,000 population, and district hospitals,

serving 100,000–300,000 population. Besides the existing centers, the services will also be provided through mobile and outreach activities. Under the Sehatmandi project, the number of PHCs will be increased in underserved provinces as a means of increasing physical access to services. The location of the new PHCs will be determined objectively by geographical information system analysis using satellite images. This will not involve new construction. The required premises will be either contributed by the communities or rented and running costs paid by the contracted service provider to be financed by the project.

25. **EPHS.** EPHS facilities provide secondary diagnostic and treatment service and serve as the first referral points for the BPHS facilities. The EPHS facilities support provincial-level hospitals, and the services provided in the provincial hospitals include the following specializations: gynecology, obstetrics, neonatal care, postpartum care and complications, nutrition, orthopedics, surgical care, and respiratory and gastrointestinal care. The Sehatmandi project will support provincial hospitals in 15 provinces up to their current bed capacity.

26. To increase the managerial autonomy provided to service providers delivering BPHS and EPHS, the contracts will (a) specifically define what 'lump sum' means in clear language; (b) eliminate the provision of line item budgets during the selection process; and (c) allow service providers flexibility in interpreting BPHS guidelines and the National Salary Policy (NSP) so they can reallocate staff most efficiently (as long as appropriate female staff are available and the highest cadre of staff remain available, such as a doctor in a BHC). The flexibility in interpreting BPHS guidelines and the NSP will also be covenanted in the Financing Agreement. Further, the MOPH will also work with relevant oversight bodies such as the Ministry of Finance (MOF) to ensure that the focus of auditors remains on accomplishment of results (that is, obtaining value for money).

27. BPHS and EPHS contracts will be modified to increase focus on achieving results. The contracts will comprise two parts: (a) a fee-for-service (FFS) aspect whereby service providers are paid a fixed tariff for certain services and (b) a lump-sum part that covers overheads and services that are hard to quantify or define precisely (for example, emergency preparedness or participating in national immunization days). The service providers will be invited to bid on the lump-sum aspect of the contracts. The FFS tariffs will be set by the MOPH and will focus on high-priority services including immunization, skilled birth attendance, family planning visits, growth monitoring and promotion, and caesarean sections. This approach has the advantage of (a) increasing the focus on performance management, (b) encouraging expansion of the coverage of key services, and (c) rewarding service providers for expanding service delivery.

28. This component will also finance innovations to be implemented by the service providers in areas identified as priorities by the MOPH, namely, (a) increasing access to services, (b) increasing utilization of services, (c) working with households to improve the health of the populations, and (d) improving quality of services. The MOPH may assign specific innovations to a number of provinces using additional funds in the BPHS and/or EPHS contracts. The list of innovations that the MOPH feels would be worth testing include reimbursement of costs (transport, childcare, and so on) to encourage women in remote rural areas to obtain institutional deliveries; introduction of an E-Health and/or M-Health initiative; and addressing of demand-side constraints. Proven, cost-effective, and affordable innovations will then be added to the contracts of appropriate service providers after negotiation and agreement regarding extra financing and performance measures.

Component 2: Strengthening the Health System and its Performance (US$20 million)

29. This component will support a systematic organized approach aimed at establishing a performance management culture in the MOPH and among stakeholders. This will be achieved through financing the implementation of the recommendations of the current functional review and strengthening the monitoring and data management functions and specific management activities.

30. **Functional review.** A functional review of the MOPH is currently being conducted to determine the ministry's core functions, lines of accountability, optimal organizational structures, and staffing including plans for rationalizing parallel structures that are counterproductive and keeping capacity outside of core structures. This component will provide technical assistance to support implementation of the recommendations arising from this review.

31. **Enhanced TPM.** The project will fund the contracting of a TPM agency that will assess the performance of the project, including BPHS and EPHS implementation. The TPM agency will (a) conduct annual health facility surveys (using a revised and simpler 'balanced scorecard' [BSC]) in all 34 provinces, which will include the use of exit interviews to assess citizen satisfaction; (b) conduct six monthly verification of health management information system (HMIS) indicators and a few quality of care indicators for BPHS and EPHS facilities; (c) assess the effectiveness of the innovations introduced under the project; (d) carry out a nationwide household survey in collaboration with the Central Statistics Organization (CSO); and (e) support verification of drug quality. The High-Level Health Program Oversight Committee will ensure the independence of the TPM agency and to protect its neutrality and timeliness. The committee will review the design, implementation, and reports of the TPM and ensure timely dissemination of the results.

32. **Capacity building.** The project will finance technical assistance to help strengthen the capacity of the MOPH in performance management, to analyze data for decision making, and strengthen the HMIS. The firm will (a) support the MOPH in ongoing analysis of health systems data collected from the HMIS, TPM, and other sources; (b) carry out special analyses requested by the leadership of the MOPH; (c) strengthen the capacity of MOPH staff in TDs and PHOs to analyze various types of data; (d) support in reviewing HMIS data, particularly in the area of nutrition and family planning indicators; and (e) provide 'just-in-time' technical support to the MOPH in response to specific requests from the ministry.

33. **Program management.** The project will finance the system development and stewardship functions of the MOPH to manage the program effectively. It will finance incremental operating costs of MOPH at the central and provincial levels, support short-term technical assistance in specific areas where immediate capacity strengthening is required, and support the contractual staff required for implementation of project activities. The Sehatmandi project will adhere to the Government's National Technical Assistance salary guidelines for contractual staff. These staff include techno-managerial staff (in grade A to C of National Technical Assistance salary scale) from the areas of public health, financial management (FM), and procurement. The staff supported under this component shall directly contribute to the project activities, the detailed terms of reference (TOR) will be agreed on with the World Bank, and the Sehatmandi coordination office will agree on key results areas with the individual staff and review their performance on an annual basis. The MOPH will adhere to the cap on the agreed maximum number of project staff or 1 percent (US$6 million) of the overall project value.

Component 3: Strengthening Demand and Community Accountability for Key Health Services (US$10 million)

34. The coverage of maternal health, family planning, and nutrition services will be further enhanced by using the potential of the CCAP and Community Development Councils (CDCs) including their female members to build demand for, and increase utilization of, services and strengthen accountability mechanisms for critical health and nutrition services, especially for maternal health and family planning. This will be complemented by (a) inclusion of these services in the semiannual assessments of service providers' performance carried out by the TPM, (b) increased use of CHWs to provide information and supplies to families in the community, and (c) strengthened monitoring of nutrition and family planning results by introducing additional indicators in the HMIS and collection of more nutrition-related data in nationwide household surveys.

35. This component will finance a range of activities from communication campaigns aimed at raising overall awareness of health rights as well as specific health behaviors to support the MOPH and service providers to be more responsive to community health needs. In addition to improving better accountability of the Government toward community in the delivery of health services, the component will also support the implementation of the MOPH's anti-corruption strategy.

36. **Social and behavioral change communications (BCC).** The MOPH has already approved a comprehensive communication campaign that consists of an overall 'umbrella' that will raise the awareness of people's health rights and what services to expect from health providers as well as specific behavior change campaigns. Critical behaviors related to maternal health, nutrition, and family planning will be prioritized. It is expected that the campaign will go beyond mass media and include elements of engaging with key influencers such as religious leaders and community leadership structures.

37. The MOPH will contract a firm to implement the plan for BCC to improve child nutrition, increase the use of modern family planning methods, and reduce the desired fertility rate. The SBCC will also entail informing communities about the MOPH's grievance redress mechanism (GRM). The contract will include (a) carrying out detailed formative research that builds on previous research and BCC efforts; (b) development of an SBCC plan, acceptable to the MOPH, that involves diverse approaches including mass media, social media, use of existing telephone systems, interpersonal communications through CHWs, and involvement of mosques and religious leaders; and (c) execution of the approved plan. It is envisaged that the contract will be performance based and part of the payment will be based on success in coverage of rural households and improved knowledge and behavior practices.

38. **Strengthening accountability of health services to communities.** This support will consist of two elements: (a) strengthening the capacity of communities to systematically collect core data and (b) developing mechanisms for service providers to receive and respond to community concerns regarding health services and overall health. The project aims to work with health *Shura* and the CCAP to build capacity of CDCs to collect and analyze health performance data as a complement to existing monitoring data sources, particularly in highly conflict-affected areas. A community scorecard to monitor the delivery of services at the health facility level has been developed jointly by the MOPH and CCAP. The project will support integration of community scorecard and health information system (HIS) of the MOPH, which will help the MOPH improve health service delivery. Support will also be provided to the MOPH and

implementing service providers to develop SOPs to deal with priority issues raised through the CDCs on time.

39. **Strengthening the GRM.** The MOPH has an existing GRM. However, it is not popular nor frequently used for registering concerns. To strengthen the GRM, the BPHS and EPHS providers will disseminate information about the GRM in all health facilities and advertise it widely through social media and other means. In addition, the project will also support the MOPH in (a) reviewing and improving SOPs for the GRM and disseminating them to all provinces and (b) conducting semiannual reviews to monitor the nature of grievances and preparing province-wise plan to address issues.

40. **Support implementation of the MOPH anti-corruption strategy.** To address concerns about corruption, the project will support continued MOPH efforts to implement its anti-corruption strategy. This will include initiating steps to undertake regular performance and financial audits of some of its key functions and take steps to address issues identified from these audits. In addition, the disclosure of procurement results at different stages, declaration of governing body members of selected service providers, regular monitoring of timely and complete payment to service providers, and timely action on corruption-related complaints received through the GRM will help to reduce the corruption in the system. The detailed matrix on fraud and corruption risk and mitigation measures related to governance, procurement, and FM is provided in Annex 1.

B. Project Cost and Financing

41. The total cost of the project is US$600 million, which will be financed through multiple sources, including the ARTF in the amount of US$425 million, GFF in the amount of US$35 million, and an IDA Grant in the amount of US$140 million (**Error! Reference source not found.**).

Table 2. Project Financing (US$, millions)

Project Components	Project Cost	IDA Financing	Trust Funds (ARTF)	GFF
Component 1: Improving Service Delivery	570	133	409	28
Component 2: Strengthening the Health System and its Performance	20	5	10	5
Component 3: Strengthening Demand and Community Accountability for Key Health Services	10	2	6	2
Total Costs	**600**	**140**	**425**	**35**

42. The ARTF funds will be disbursed in three tranches: (a) on approval of the project in 2018, (b) in 2019 on completion of year 1 of implementation, and (c) in 2020 on completion of year 2 of

implementation subject to the MOPH meeting the below-mentioned tranche release conditions. The provisional amounts of these three tranches will be US$130 million, US$160 million, and US$135 million, respectively. The project will support the MOPH in moving from contract management to performance management of the BPHS/EPHS contracts. To facilitate this transition, the World Bank has agreed with the MOPH to include the following tranche release conditions that will be applied to the transfers from the ARTF (parent trust fund) to the project (child trust fund).

43. The tranche release condition for the year 2018–2019 is approval of the project by the ARTF Management Committee.

44. The tranche release conditions for the year 2019–2020 (on completion of year 1) are as follows:

(a) The SOPs for the management of performance-based contracts for delivering BPHS/EPHS developed, satisfactory to the World Bank. The SOPs will consist of

- Manners by which the MOPH will supervise service providers and monitor their performance including the format by which service providers will report on their performance on a quarterly basis and the method and the reporting format of the semiannual performance reviews of service providers to be conducted by the TPM agent and

- Roles and responsibilities among relevant MOPH units in supervising service providers, monitoring and reporting on their performance, and taking necessary actions as specified in the service provider contracts.

(b) The semiannual performance reviews of at least 60 percent of BPHS/EPHS service providers carried out in accordance with the SOPs

(c) Sixty percent of service providers have received timely and complete payments as per the contract

(d) The timely[5] dissemination of key program data (household survey, BSC, quarterly performance reports by the service providers, and semi-annual reviews of service providers performance) and financial data (contract amounts and expenditures) done on the website of the MOPH

(e) The performance review of the MOPH conducted by the High-Level Health Program Oversight Committee to assess the MOPH's performance in managing the BPHS/EPHS contracts in accordance with its contractual rights and obligations, including whether it has appropriately exercised applicable contractual rights to reward or sanction service providers depending on their assessed performance

45. The tranche release conditions for the year 2020–2021 (on completion of year 2) are as follows:

[5] 'Timeliness' to be defined in the SOPs.

(a) The semiannual performance review of at least 80 percent of BPHS/EPHS service providers carried out in accordance with the SOPs

(b) Eighty percent of service providers have received timely and complete payments as per the contract

(c) The timely dissemination of key program data (household survey, BSC, quarterly performance reports by the service providers, and semiannual reviews of service providers performance) and financial data (contract amounts and expenditures) done on the website of the MOPH

(d) The performance review of the MOPH conducted by the High-Level Health Program Oversight Committee to assess the performance in managing the BPHS/EPHS contracts in accordance with its contractual rights and obligations, including whether it has appropriately exercised applicable contractual rights to reward or sanction service providers depending on their assessed performance

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

46. A High-Level Health Program Oversight Committee consisting of policy makers from the MOPH, the MOF, the Independent Directorate of Local Governance, relevant United Nations agencies, bilateral donors, and representatives of civil society has been formed to closely monitor the performance of the service providers and the MOPH and ensure coordinated efforts are made by all the stakeholders. This committee will also engage with the DPs in policy dialogue, deliberate on future directions of the health sector, and conduct annual reviews of the project.

47. The MOPH will have the overall responsibility for project implementation and oversight through the High-Level Health Program Oversight Committee. The Minister of Public Health will be the project coordinator. The MOPH, through its central departments and provincial offices, will be responsible for the smooth implementation of the project. The actual health services will be delivered through contracted service providers in 31 provinces. In the remaining three provinces (Parwan, Kapisa, and Panjshir), the MOPH will transfer responsibility of management from the SM team to a non-state provider through a service management contract for effective delivery of services including capacity building and innovations for improving the quality and access to health services. The procurement and contract management for service providers will be carried out by the MOPH. The provision of services by service providers will be monitored through the regular HMIS and through facility and household surveys carried out by a third-party firm. The procurement of goods will be managed by the Procurement Department of the MOPH at the central level.

48. Under the ongoing SEHAT project, the SEHAT Coordination Office has provided secretariat support to the SEHAT Project coordinator (H.E. Minister of Public Health) and coordinated project-related activities with other departments and stakeholders. The SEHAT Coordination Office will be renamed as

Sehatmandi Coordination Office and will be strengthened to coordinate project-related activities with all involved parties and provide general oversight for the Sehatmandi project.

B. Results Monitoring and Evaluation

49. All the indicators described in the Results Framework are in line with the Government of Afghanistan's health strategy and its HIS Strategy. To ensure viability of quality data to assess the progress, the project will support sector wide M&E through a third party, as described under Component 2. This will help the MOPH hold service providers and hospital managers accountable for tangible results. It will also allow the World Bank and other stakeholders to have an independent assessment of progress in the service delivery. The project will rely on a number of data-collecting mechanisms as follows:

(a) The household health survey will be carried out by the TPM in coordination with the DHS to ensure availability of end-line data for the project. The survey will provide national and provincial estimates of key project indicators, coverage of key services, out-of-pocket expenditures, key behaviors related to maternal and child health, and end-line data for the project. The baseline for the project will mainly rely on the findings of AHS 2018 and BSC.

(b) Annual health facility assessments will also be carried out by the TPM and will examine quality of care including availability of key inputs, clients and staff satisfaction, management system, and equity in the utilization of health services. The results of the assessment will be presented in the form of the BSC that will summarize the performance of each province in implementing BPHS and EPHS in one color-coded page. The BSC provides the policy makers and health managers with evidence about the health service delivery in each province highlighting strengths and areas to be improved.

(c) The HMIS will provide real-time data on utilization of BPHS and EPHS. The HMIS data will be used on a quarterly basis to assess the progress and identify critical issues. Since a portion of the service provider payments will be linked to the key outputs of the health facilities reported through the HMIS, there will be arrangements for third-party verification of the HMIS reports. The verification of HMIS data will occur on a six-monthly basis on a random selection of health facilities by the third party. There will be two stages of verification: (i) assessment of consistency between health facility registers and Quarterly Reports sent to the MOPH by comparing the figures submitted to the MOPH with information recorded in the health facility registers for key outputs and (ii) visits to a random sample of households listed in the health facility registers and verification of services received by the clients. The third party will also verify the status of the health facility in terms of its capacity to provide BPHS/EPHS as per MOPH guidelines.

(d) Through the CCAP, the Government established a community-based monitoring mechanism. A simple community scorecard has been developed to be used by CDCs to monitor services provided to communities by different sectors including health. The scorecard will be completed every three months and results will be discussed at different levels. Currently, the CCAP covers one-third of districts in the country. The project will use the findings of community scorecards to assess availability of minimum standards capturing availability of

critical inputs and services in the health facilities, which will be part of the service providers' performance management.

(e) Systematic supervision of health facilities will be carried out by PHOs, central TDs, and the GCMU using a standardized approach that will assess whether the facility is providing the BPHS and EPHS.

50. **Systematic performance reviews of BPHS and EPHS contracts.** The MOPH will undertake detailed and systematic performance reviews of BPHS and EPHS service providers on a semiannual basis. The project will help with development of a standardized approach and reward/sanction mechanisms for well- and poorly performing service providers. The project will also support much greater involvement of the TDs and PHOs in oversight of the BPHS and EPHS contracts. This will involve enhancing the capacity of TDs and PHOs in data analysis and utilization and developing standard tools and procedures.

51. **Reporting.** The MOPH will produce a semiannual report based on agreed targets, progress made of implementation of critical project activities, and the performance of the sector at the end of each year. This report will contain tables of performance against indicators for the Sehatmandi project.

52. **Supervision and implementation support.** An experienced in-country World Bank team of health, operational, and fiduciary specialists will provide day-to-day implementation support to the MOPH with additional regular support from staff from other World Bank offices; implementation support missions will be carried on a six-monthly basis. Participants shall include the World Bank's task team and all relevant partners.

C. Sustainability

53. Key factors contributing to the sustainability of the project include (a) Government ownership and commitment as the design of the project relies on the recommendations of the Health Sector Summit chaired by H.E. the President; (b) the technical feasibility of the project design, which is based not only on international good practice and expertise but also on the lessons learned from the last 15 years of health projects in Afghanistan; (c) well-informed design and implementation arrangements that focus on building capacity of the health sector on better service delivery; (d) the fiscal sustainability of investments, with the analysis indicating that project allocations would not create an undue fiscal burden on the overall health sector budget; and (e) development of the GFF investment case and deeper engagement in financing of the health sector.

D. Role of Partners

54. Afghanistan's health system has immensely benefited from the existence of multiple donors, and this has translated into significant progress in health system performance over the last 15 years. The World Bank has continued to play a critical role in convening multiple donors in the country. The donors have been part of the policy dialogue with the Government and have been supportive in joint implementation reviews of the SEHAT project while complementing the project implementation through their off-budget support. It is anticipated that the partnership would be further strengthened over the life

of the project through the GFF engagement with its support to the oversight committee. The three key roles and links with partners during the Sehatmandi project are as follows:

(a) **Strategic linkages**: The objectives of the project are aligned with operations of several donors in the country. Although the broader objectives of the partners are different in terms of the results set for the grants they provide to the MOPH, the strategic direction remains firmly committed toward improvement in service delivery and institutional strengthening. The partnership with donors in policy dialogue ensures coordinated efforts and enforces the importance of change needed at the Government level.

(b) **Operational linkages**: The World Bank staff working on the project are members of the Health Development Partners' Forum by DPs that serves as a coordination platform. Although there is no direct financial relationship between the World Bank and the donors' off-budget support, the involvement of team members in technical discussions and day-to-day project implementation is complementary in nature. As mentioned earlier, the joint implementation reviews are conducted in partnership with donors and partners in the country and ensure coordination and complementarity.

(c) **Financial linkages**: The project is largely funded through the ARTF, which is a multi-donor trust fund, followed by IDA and GFF. To avoid duplication in allocation of financial resources, the World Bank has followed a transparent consultative process for the preparation of the project to ensure all DPs in the country are well informed and engaged in the process.

V. KEY RISKS

Overall Risk Rating and Explanation of Key Risks

55. **The overall risk rating of the project is 'High'.** The project faces significant security, political, and governance risks. The main risks to implementation are due to the general security situation. Security is a critical challenge, especially in the southern and eastern provinces. Lessons learned from the ongoing operation, such as the need to closely work with the local communities, will help mitigate these risks.

56. **Political and governance.** There are multiple sources of High political and governance risks in Afghanistan. Power-sharing arrangements under the National Unity Government are a continued source of tension and potential future instability. With a short window until the next election in 2019, the potential political disruptions could delay project implementation. This risk is planned to be mitigated through trying to move fast initially by focusing on 'quick win' areas ahead of elections such as piloting the non-consultancy services (NCS) approach for procurement of service providers and development of SOPs for enhanced performance management. There are also concerns about a risk of corruption in the health sector. Sehatmandi will support the implementation of the anti-corruption strategy of the MOPH, which is a practical document informed by the findings of the MEC assessment of risk of corruption in the health sector.

57. **Macroeconomic.** Afghanistan's macroeconomic outlook is subject to High risks. The country remains heavily reliant on aid, and any reduction in security and civilian support below expected levels

will place pressure on fiscal sustainability and service delivery. An important way in which macroeconomic risks can affect an Investment Project Financing (IPF) project is through reduction in Government counterpart funding; however, given that a bulk of the financing for the Sehatmandi project emanates from the ARTF and IDA, the macroeconomic risk is not a major concern for the project.

58. **Institutional capacity for implementation and sustainability.** The institutional capacity for implementation and sustainability is at Substantial risk. The public sector in Afghanistan is characterized by highly uneven and thinly spread technical capacity. Long-term aid dependency has left some agencies and reform processes heavily dependent on technical assistance. In light of recommendations of the ongoing functional review, the project will continue to support strengthening of the health system and increasing efficiency. In addition, the findings of the functional review will also inform the next phase of the World Bank-supported civil service reform project to address the shortage of competent staff in key positions and hence decrease the reliance on project financed technical assistance.

59. **Fiduciary.** The fiduciary risk rating under the proposed project is Substantial. The project will be implemented by the MOPH using country systems. FM and procurement assessments have been undertaken by the World Bank as part of project preparation. Specific risks arising from gaps in fiduciary systems (including low capacity and weak internal controls) and procurement (including lack of standard procedures, irrational performance parameters for termination of contracts, and delay in procurement process) are identified and appropriate mitigation measures are recommended. The MOPH will update the control framework in the FM Manual, prepare and adopt budget guidelines and develop a capacity development plan for internal audit, and implement an audit management software for improving efficiency. For procurement management, the MOPH will retain key staff from the SEHAT project and GCMU to support procurement and performance management of service providers' contract and ensure timely implementation. The implementation of the above will reduce the fiduciary risk to a greater extent.

VI. APPRAISAL SUMMARY

A. Economic and Financial (if applicable) Analysis

60. **Impact on human development and economic growth.** In addition to promoting human development, improving access to maternal and child health services through BPHS and EPHS can have a positive impact on long-term economic growth by supporting human capital formation and increasing women's labor supply. Additional returns can be realized by (a) diminishing the risk of impoverishment due to high health-related out-of-pocket expenditures, (b) reducing the burden on households due to lost income resulting from illness-related incapacitation, and (c) improving the learning capacity of children owing to better nutrition. According to the World Health Organization's Global Investment Framework for Women's and Children's Health, investments in maternal and child health in lower-income countries such as Afghanistan produce social and economic returns that are up to 15 times greater than their costs. The project is expected to contribute to reduced morbidity and mortality of mothers and children by improving equitable access to both primary and hospital-based care.

61. The economic analysis of the project is based on assessments of technical efficiency, allocative efficiency, and equity. Technical efficiency was assessed by measuring estimated improvements in the delivery of health services compared with operating costs at the facility level. There is recent evidence to

indicate that health system performance—measured by the average composite score (ACS) that aggregates across six domains of the BSC methodology, including client and community, human resources, physical capacity, quality of services provision, and management systems—has improved faster than the increase in costs of BPHS implementation. Per capita BPHS costs for each point gained in the ACS reduced by almost 8 percent between 2014 and 2015, indicating improvements in technical efficiency in the delivery of services by health facilities.

62. Allocative efficiency was assessed by comparing disability-adjusted life years (DALYs) averted by SEHAT project interventions, which will also be the ones targeted by Sehatmandi. The SEHAT project concentrated its efforts on reducing communicable, maternal, neonatal, and nutritional causes of mortality and morbidity. In 2011, these causes represented 47 percent of the overall burden of diseases (BoD) in Afghanistan. The SEHAT project supported the implementation of BPHS and, as a result, contributed to the reduction of communicable, maternal, neonatal, and nutritional causes to 36 percent of the BoD, averting an estimated 8.5 million DALYs.

63. The equity analysis was based on comparing access to services and health outcome indicators across economic quintiles. The analysis shows that health interventions provided by BPHS disproportionally resulted in improved access for those in the lowest economic quintile. For example, the Gini coefficient for institutional deliveries reduced from 0.863 to 0.525 between 2010 and 2015; this represented tremendous progress in fulfilling the needs of poor mothers to safe maternity-related care. A significant proportion of interventions supported by BPHS under the SEHAT project are self-targeted to the poor, contributing to increased access. Given that Sehatmandi will continue the equity trajectory of the SEHAT project, it is expected that similar benefits will continue to accrue to the poor.

64. During project implementation, a set of indicators on technical efficiency, allocative efficiency, and equity will be monitored to enable an assessment of the final economic impact of the project on the poor. The indicators will be compiled from project administrative records (such as the BSC), household surveys, and as part of complementary institutional research during project implementation.

B. Technical

65. The major focus of the project is delivery of BPHS and EPHS across the country, which comprises a prioritized set of high-impact interventions with proven cost-effectiveness, well in line with the international health agenda to achieve the SDG 3. As has been demonstrated in the last 15 years, BPHS and EPHS are effective ways to respond to the basic health needs of the communities and, as such, are key tools to improve the overall stability in the country. Indeed, the provision of BPHS and EPHS through contracting out in Afghanistan has become a model for other fragile states trying to rebuild their health system after emerging from conflict.

66. The Sehatmandi project will finance the BPHS in line with the revised BPHS 2011 guidelines. Currently, the MOPH is revising the BPHS and possibly the EPHS guidelines as well. It is understood, however, that both the BPHS and EPHS will keep their focus on primary and essential health care interventions and will be expanded in a cautious manner as to maintain the cost of the packages within reasonable limits.

67. To carry out project activities effectively, strong project management and coordination is essential. IDA's support to MOPH stewardship functions was critical to the effective implementation of the previous health projects. While MOPH capacity has greatly increased over the past years, the presence of contractual staff in key departments is still indispensable to support the MOPH in managing contracts and in supporting direct delivery of services. The MOPH will review contractual staff performance on an annual basis; a staff plan will be developed yearly and the total number of contracted staff will be kept to a minimum and will decrease over time as the new phase of the civil service reform project picks up.

C. Financial Management

68. An FM assessment of the SEHAT project and the MOPH was carried out and found that the existing FM systems are capable of proper accounting and reporting of the grant proceeds. However, the assessment identified certain weaknesses that can limit either the assurance on use of grant proceeds or achievement of project objectives. The following weaknesses were identified: (a) absence of a system of periodic financial reporting to the management, (b) delay in submission of provincial financial reports in the absence of service standards, (c) unadjusted advances for more than a year, (d) lack of an asset management system, (e) poor internal audit, (f) noncompliance with external audit recommendations, and (g) an incremental approach being used for budget preparation leading to low budget turnover. In light of the above, the FM rating for the proposed project is Substantial.

69. In response to the weak FM system, the MOPH will update the control framework in the FM Manual, prepare and adopt budget guidelines and a capacity development plan for internal audit, and implement an audit management software. The overall FM risk of the project is rated Substantial and the mitigation measures will be included in the project manual of the MOPH.

70. The project FM arrangements rely on the country systems. The Government budgeting processes will apply, and the project's budget will be a part of the Government's annual budget. The accounting records will be maintained at the central level by the MOF in the Afghanistan Financial Management Information System (AFMIS) based on M16s and the coordination unit will maintain detailed subsidiary records. The FM Manual elaborates the project's control framework. The manual used for the SEHAT project will be updated to address the weaknesses identified during the implementation.

71. The capacity of the MOPH Internal Audit Department will be strengthened to conduct semiannual project internal audits. The internal audit reports will be submitted to the World Bank within two months of the close of the semester. The project's financial statements will be prepared in accordance with the Cash Basis International Public-Sector Accounting Standards and audited by the Supreme Audit Office, in accordance with International Organisation of Supreme Audit Institutions (INTOSAI) auditing standards. The audited financial statements will be submitted to the World Bank within six months of the close of the financial year. The existing FM team at the SEHAT coordination unit will have the responsibility to manage the project's FM matters. The team has adequate capacity and experience to manage the Sehatmandi project.

72. Disbursement will be report based. The coordination unit will operate three segregated Designated Accounts (DAs). One each for IDA, ARTF, and GFF will be established in U.S. dollars at the Da Afghanistan Bank (DAB). Subsequent interim financial reports (IFRs) will be used to document the

expenditure and determine the amount of advance. Semiannually, IFRs covering a period of six months will be submitted to the World Bank. The format of IFRs will be agreed during negotiations.

73. **Retroactive financing** up to US$15 million from the ARTF and US$15 million from IDA are allowed against disbursement category 1, for the expenditure incurred for the project purposes, 12 months before the signing of the Financing Agreement.

74. Table 3 summarizes the project's disbursement arrangements.

Table 3. Project's Disbursement Arrangements

Disbursement Categories	Amount of IDA Grant	Amount of ARTF Grant	Amount of GFF Grant	Percentage of Expenditure to Be Financed	Account Description	Disbursement Condition
	(US$, millions)					
(1) Goods, Non-Consulting Services, Consultants' Services, Incremental Operating Costs, Training and Workshops	140	425	35	100%	Advance to the DA	Nil
TOTAL	140	425	35			

D. Procurement

75. Project funding will be mostly used for grants to service providers for service delivery through contracts. Therefore, procurement will, for the most part, follow Quality- and Cost-Based Selection consistent with the World Bank Group's procurement core principles. The project will be subject to the World Bank Group's Anti-Corruption Guidelines, dated October 15, 2006, and revised in January 2011 and July 1, 2016. Direct procurement by the MOPH will be limited to a small number of consulting firms, individual consultants, and non-consulting services. This direct procurement will be governed by the Procurement Guidelines, effective from July 1, 2016.

76. **Procurement risk assessment and mitigation.** Direct procurement by the MOPH will be carried out by the GCMU under the guidance of the Procurement Department. The procurement capacity assessment carried out by the World Bank Group during SEHAT implementation and the appraisal mission of the proposed project have concluded that the staff in the GCMU and the MOPH have good experience in World Bank Group procurement, and, therefore, the GCMU will continue with an experienced full-time procurement officer. Given the shift from consultancy to non-consultancy contracts for service providers in selected provinces, the World Bank Group has provided training and support to GCMU and MOPH officials who will be involved in project procurement. The officials from the MOPH have also completed the training on the World Bank Group's new Procurement Framework in November 2017. The procurement management risk rating for the proposed project is Substantial.

77. Since the project has been prepared under OP 10.00 paragraph 12, a simplified project procurement strategy document (PPSD) required in situations of urgent need of assistance is used. Based

on the PPSD, the MOPH has prepared a draft Procurement Plan which provides the basis for procurement methods and review by the World Bank. This Procurement Plan will be disclosed through the MOPH's and the World Bank's external websites. The first Procurement Plan includes all procurement to be taken up during the first 18 months of project implementation and will have to be submitted to the World Bank Group through the Systematic Tracking of Exchanges in Procurement (STEP) tool. It will be updated at least annually or as required to reflect the actual project implementation needs and improvements in institutional capacity. Besides confirming that the mitigation measures referred to earlier are appropriate, the PPSD concluded that the operational context is considered to be quite good due to the governing system and the experience of procurement in the last 15 years.

E. Social (including Safeguards)

78. No new construction activity is envisaged, except for minor renovation of health care facilities, which will happen within the available health facility compound and will not affect any private land or assets and thus will not result in any land acquisition or resettlement. Accordingly, the OP/BP 4.12 - Involuntary Resettlement policy is not triggered. The client has updated the existing Environmental and Social Management Framework (ESMF), and this will be adopted for the Sehatmandi project. The ESMF has been disclosed in-country on the MOPH's website on January 31, 2018, as well as on the World Bank's external website on February 1, 2018.

79. **Gender.** Based on the findings of the Gender Gap Analysis, the Sehatmandi project will support the following interventions: (a) improving distribution and availability of female health workers across the country through providing appropriate incentives in contracts and ensuring effective oversight of the MOPH over service providers; (b) improving HIS gender indicators to provide gender disaggregated data; (c) mainstreaming the health sector's response to GBV and improving the reporting system for GBV management by supporting further training and sensitization interventions; (d) introducing measures to promote an enabling environment and to mitigate harassment at the MOPH and health facilities; and (e) supporting and strengthening the Gender Department at the MOPH, enabling them to provide technical support and monitor the overall gender mainstreaming under the project. In particular, the BPHS/EPHS service providers will provide health response including referral and reporting to GBV survivors.

F. Environment (including Safeguards)

80. **The project is classified as Category B for environmental assessment purposes.** As mentioned earlier, no new construction activity is envisaged, except for minor renovation of health care facilities which will happen within the available health facility compound and will not affect any private land or assets and thus will not result in any land acquisition or resettlement. As mentioned in the ESMF, the Health Care Waste Management Plan (HCWMP) has been updated and will be implemented in all identified facilities under the project. During the implementation of the project, the ESMF and the HCWMP will be operationalized with an appropriate Action Plan including institutional arrangements, capacity development, and training.

81. The ESMF and the HCWMP will be mainstreamed during project implementation, for example, supervisions, relevant meetings, M&E, reporting, and taking corrective actions. So far different health care facilities are not properly using color coding system for segregating, transporting, and disposing of medical

wastes. As a result, the medical wastes are mixed with other municipal wastes and their volume has increased. The MOPH has started utilizing limited services of the private sector to collect and transport medical wastes. The relevant points on safeguards from the ESMP will be included in the standard bidding documents and in the civil works contract. The project will follow the monitoring framework as per the ESMF and HCWMP.

82. The updated ESMF and the HCWMP is shared with all stakeholders for their feedback and comments. Also, the draft ESMF and HCWMP were consulted and disclosed in-country on the MOPH website and the World Bank's external website.

83. **Climate co-benefits of improved nutrition outcomes for women and children.** The Sehatmandi project has been screened for short- and long-term climate change and disaster risks. Climate change directly affects food and nutrition security, undermining current efforts to address undernutrition, hitting the poorest the hardest, especially women and children.[6] Second, due to climate change, the temperature in the project locations is projected to increase by 2050, which may encourage growth and survival of the vector and moderately increase the vector-borne diseases. Since the project is to be implemented until mid-2021, the overall risk is rated Low.

84. Climate change is therefore seen as a potential 'change in disease pattern' and 'hunger-risk multiplier' that may result in additional disease burden and undernourished children. Poor health and undernutrition in turn further undermines people's resilience to climatic shocks and their ability to adapt. In summary, climate change can exacerbate the crisis of undernutrition through four main causal pathways:

(a) Impact on households who will be affected by vector-borne diseases

(b) Impacts on environmental health and access to health services

(c) Impacts on care and feeding practices

(d) Impacts on household access to sufficient, safe, and adequate food

85. The project directly addresses the health care needs both in preventive and primary health services that mitigate the vector- and water-borne diseases and provides communication of healthy behavior at the local level. The project also addresses the risks to nutrition outcomes due to climate change by providing information on use of locally available food products that improve nutrition level and providing complimentary feeding in the form of vitamins to both mothers and children. The implementation of the HCWM plan will ensure proper segregation and disposal of health care wastes that ensures recovering/reuse of the waste and will have positive impact on environment.

86. The services related to nutrition and vector-borne diseases constitute 25 percent of BPHS and EPHS. All the health facilities covered under the project are expected to implement the HCWM plan that ensures recovering/reuse of the waste and safe handling of biomedical wastes and will be monitored at

[6] FAO (Food and Agriculture Organization of the United Nations). 2015. "Climate Change Food Security and Nutrition." *Global Forum on Food Security and Nutrition.* http://www.fao.org/fsnforum/activities/discussions/climate-change-and-fsn.

all levels. This activity accounts for another 5 percent of the overall project. As a result, total climate co-benefits of the project have been estimated to amount to US$180 million (30 percent).

G. World Bank Grievance Redress

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

- C.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY : Afghanistan
Afghanistan Sehatmandi Project

Project Development Objectives

The project development objective is to increase the utilization and quality of health, nutrition, and family planning services.

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Penta3 vaccination coverage.		Percentage	72.01	80.00	Once in three years	AHS/ HMIS	MOPH
Description: Number of children in the age group of 12 – 23 month received the third dose of pentavalent vaccine expressed as a percentage of the number of children 12 – 23 months.							
Name: Births attended by skilled health personnel.		Percentage	58.10	66.00	Once in 3 years	Household survey.	MOPH
Description: The number of births attended by skilled health personnel (doctors, nurses or midwives) expressed as a percentage of the total number of births in the same period.							

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Health facility visits per capita per year to BPHS/EPHS facilities.		Number	1.90	2.30	Annually	HMIS as "corrected" by 3rd party verification.	MOPH
Description: Total outpatients number of clients/patients visited BPHS/EPHS health facilities during the year, expressed as a proportion of estimated population in the same period.							
Name: Contraceptive Prevalence Rate (modern methods).		Percentage	16.30	21.00	Once in three years.	Household survey.	MOPH
Description: The proportion of women of reproductive age who are using (or whose partner is using) a modern contraceptive method at a given point in time.							
Name: Minimum dietary diversity.		Percentage	24.00	35.00	Once in three years.	DHS	MOPH
Description: Percentage of children in age group of 6–23 months who receive foods from 4 or more food groups.							
Name: Quality of care measured by Balanced Scorecard (BPHS).		Percentage	63.00	68.00	Yearly	Balanced Scorecard.	MOPH
Description: Composite score out of 100 on indices of quality of care as judged by third party.							

Intermediate Results Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Percent of BPHS health facilities reported availability of essential drugs and vaccine by 3rd party verification.		Percentage	85.00	90.00	Annually	Balanced Scorecard	MOPH
Description: Of the total number of BPHS NGOs under the project, percentage of them who have reported availability of all the essential drugs and vaccine at the time of 3rd party verification.							
Name: TB case detection rate.		Percentage	58.00	70.00	Annually	HMIS	MOPH
Description: Means that TB is diagnosed in a patient and is reported within the national surveillance system. The case detection rate is calculated as the number of cases notified divided by the number of cases estimated for that year, expressed as a percentage.							
Name: Development of standard operating procedures (SOPs) for performance management of BPHS and EPHS contracts.		Text	No	Yes	Annually	Project reports	MOPH
Description: The standers operating procedures (SOPs) for performance management of BPHS and EPHS contracts developed.							

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Percentage of BPHS/EPHS service providers subject to semi-annually performance reviews.		Percentage	0.00	100.00	Semi-annual.	MOPH reports.	MOPH
Description: Number of service providers reviewed against performance management indicators coming up with an improvement plan, and other reward or punitive measures being taken, in areas with either strong or suboptimal performance, as per established criteria and process in the contract. The denominator is the total number of contracts and the numerator is the number of contracts which are reviewed and for which improvement plans are in place and other steps taken/recorded as per the performance management SOPs and contract..							
Name: Percentage of BPHS/EPHS service providers receiving timely and complete payments as per contractual obligations.		Percentage	0.00	100.00	Annually	MOPH report.	MOPH
Description: Transfer of installments and any other payments to service providers are made as per the payment schedule in their contracts with the MOPH.							
Name: Communication and Dissemination of key program (household survey & BSC by province) and financial data (Budget allocation and expenditure data of all sources) on the website of MOPH, and organizing di		Text	No	Yes	Annually	Review of website & newspapers and workshop proceedings.	MOPH

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Description: MoPH disclose the dashboard on core indicators on health using HMIS data on quarterly bases, presenting league table of household survey & BSC by province within 10 days from date of finalizing report on MOPH website; and summary of national survey (household and BSC) published in 2 national newspapers; and dissemination of national survey (household and BSC) published on website of MOPH.							
Name: Percentage of Community reported Involvement in Decision Making.		Percentage	90.00	90.00	Annually	Balance score card	MOPH
Description: As per the balance score card, the percentage of communities reported the were involved in process of program planning and decision making in the last one year at the BPHS and EPHS.							
Name: Operationalize grievance redress mechanisms at facility level established under the Citizen's Charter.		Text	No	Yes	Annually	Project Records	MOPH
Description: Manual or online grievance redress mechanisms at facility level established under the Citizen's Charter which is operational and accessible to people visiting health facilities.							
Name: People who have received essential health, nutrition, and population (HNP) services	✓	Number	0.00	64100000.00	Annually	HMIS	MOPH
People who have received essential health, nutrition, and population (HNP)	✓	Number	0.00	38500000.00	Annually	HMIS	MOPH

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
services - Female (RMS requirement)							
Description:							

Target Values

Project Development Objective Indicators

Indicator Name	Baseline	YR1	YR2	YR3	End Target
Penta3 vaccination coverage.	72.01	75.00		80.00	80.00
Births attended by skilled health personnel.	58.10	60.00		66.00	66.00
Health facility visits per capita per year to BPHS/EPHS facilities.	1.90	2.15	2.20	2.30	2.30
Contraceptive Prevalence Rate (modern methods).	16.30	18.00		21.00	21.00
Minimum dietary diversity.	24.00	30.00		40.00	35.00
Quality of care measured by Balanced Scorecard (BPHS).	63.00				68.00

Intermediate Results Indicators

Indicator Name	Baseline	YR1	YR2	YR3	End Target
Percent of BPHS health facilities reported availability of essential drugs and vaccine by 3rd party verification.	85.00	85.00	87.00	90.00	90.00
TB case detection rate.	58.00	60.00	65.00	70.00	70.00

Indicator Name	Baseline	YR1	YR2	YR3	End Target
Development of standard operating procedures (SOPs) for performance management of BPHS and EPHS contracts.	No	Yes	Yes	Yes	Yes
Percentage of BPHS/EPHS service providers subject to semi-annually performance reviews.	0.00	60.00	80.00	100.00	100.00
Percentage of BPHS/EPHS service providers receiving timely and complete payments as per contractual obligations.	0.00	60.00	80.00	100.00	100.00
Communication and Dissemination of key program (household survey & BSC by province) and financial data (Budget allocation and expenditure data of all sources) on the website of MOPH, and organizing di	No	Yes	Yes	Yes	Yes
Percentage of Community reported Involvement in Decision Making.	90.00	90.00	90.00	90.00	90.00
Operationalize grievance redress mechanisms at facility level established under the Citizen's Charter.	No	Yes	Yes	Yes	Yes
People who have received essential health, nutrition, and population (HNP) services	0.00	56500000.00	60100000.00	64100000.00	64100000.00
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)	0.00	34000000.00	36300000.00	38500000.00	38500000.00

Annex 1: Fraud and Corruption: Risk and Mitigation Measures

1. The following matrix identifies the key fraud and corruption risks related to Sehatmandi project in areas of governance, procurement, and FM, as well as the mitigation measures.

Risks	Mitigation Measures (Ready by Effectiveness)	Mitigation Measures (To Be Supported during Implementation)
Political and Governance Risks		
BPHS and EPHS delivery: • Weak oversight by the MOPH • Lack of planned approach to service provider contract management • Limited community accountability • Inadequate understanding and clarity of the contracting model and political interferences and micromanagement in service provider activities • Inadequate performance and mismanagement or failure to address the governance issues related to service providers • Risk of overreporting by the service providers, especially when the payments are linked with the level of services delivered	• Functional review of the MOPH jointly with Civil Service Commission and World Bank's Governance/HNP GP teams • Prepare first draft SOPs for service provider performance management for training MOPH contract managers and other ministries' staff who are involved in contract management • Orientation on the Sehatmandi project, service delivery modality, and performance management to provincial authorities • Design performance-based service delivery contracts including introducing fee for services • Recruit TPM for performance verification	• Support the implementation of functional review recommendations • Finalize and approve the SOPs for service provider performance management • Training of all MOPH contract managers and other ministries' staff who are involved in contract management • Annual review of the extent to which the MOPH follows the SOP in contract management as a tranche release condition • Define and prepare guidelines with provincial authorities for the oversight role of community health *shura* and the health subcommittee of the CDC • Train provincial authorities, service providers, and community health *shura* and health subcommittees to perform an oversight and monitoring role • Inclusion of provincial authorities in the semiannual performance review process • Link payments of service providers with their outputs • Third-party verification of the service providers' reports by TPM on a 6-

Risks	Mitigation Measures (Ready by Effectiveness)	Mitigation Measures (To Be Supported during Implementation)
		monthly basis and timely public disclosure of these reports
Pharmaceuticals quality: • Concern about poor quality of medicines in BPHS and EPHS facilities	• Inclusion of medicines' quality verification in the TOR of the TPM to be financed by the Sehatmandi project	• Quality verification of medicines by TPM financed in a representative sample of all health facilities financed by the project on a regular basis • The PASA will help the Government explore options for developing a framework contract for medicines to ensure quality
Poor governance, transparency, and accountability throughout the administrative chain: • Overcentralization of key administrative functions, exacerbated by overall capacity constraints • Inconsistent enforcement of guidelines and regulations • Lack of clarity on responsibility and accountability throughout the administrative chain, especially between central and provincial levels • Poor utilization of existing data for management and decision-making process	• Functional review of the MOPH to revisit/clarify roles and responsibilities of various departments • Initiate recruitment of a firm to build the MOPH capacity in terms of data analysis and data use	• Support the implementation of functional review recommendations • Support the dissemination of user-friendly information within and outside of the MOPH
Program monitoring and reporting, reliability of data: • Fragmented data sets used by different TDs—financed through off-budget projects • Poor maintenance of records/inventory of fixed assets	• Recruit technical assistance staff to support development of a data warehouse	• A rigorous verification process (phone surveys and physical visits) to improve integrity of administrative data • Development of a fixed asset management software

Risks	Mitigation Measures (Ready by Effectiveness)	Mitigation Measures (To Be Supported during Implementation)
Procurement		
Service delivery procurement: • Unclear TOR—not specific enough under which a service provider can be held accountable • Subjective evaluation criteria of the bids • Lack of meaningful involvement of partners representatives in the evaluation process • Lack of effective mechanism to make sure that the evaluation committee members do not have conflict of interests	• Brief and clear performance specifications, employer's requirement, and activity schedule focused on what to be achieved in terms of output of the service provider rather than how • Objective evaluation criteria should be, to the extent possible, binary (yes/no) responses • The representatives of DPs to be evaluation members not mere observers • The services of procurement probity assurance providers[7] to be engaged as part of the project • Besides signing the conflict of interest declaration by all evaluation committee members, successful Bidder/Proposer/Consultant's Beneficial Ownership Disclosure[8] submitted in the form required in the Procurement Documents •	• Performance-based contract will be in place and TPM will be verifying the service delivery and its quality. • Use of objective evaluation criteria and inclusion of the World Bank staff as an observer and DPs as evaluation committee members.
Financial Management		
• Weak internal audit arrangement lacking technical capacity, adequate number of skilled personnel, and institutional independence. • The MOPH does not have the policy and systems requiring the officials to implement	• Agree on ways and means including developing SOPs to strengthen audit functions including internal controls • In the interim, few contractual staff will be provided to the internal audit director to ensure quality and timely internal audit of the Sehatmandi project	• Develop SOPs for audit and train staff undertaking audit • The Sehatmandi project to finance the contractual staff for the internal audit to build capacity • Selected audit meetings to be attended by independent auditors—who will share

[7] **Procurement probity assurance providers**: An independent third party that provides specialist probity services for concurrent monitoring of the procurement process. The client may engage independent procurement probity assurance providers to be present during different stages of the procurement process, including engagements/discussions with firms, bid/ proposal opening, evaluation, negotiations, contract award decisions, and/ or contract execution. Where the World Bank requires the clients to appoint procurement probity assurance providers, the clients shall obtain the World Bank's agreement to the selection and appointment. The probity report shall be sent by the clients to the World Bank and all such bidders/proposers/consultants along with the Notice of Intention to Award the contract. Refer to paragraph 3.3 of of the World Bank Procurement Regulations for IPF Borrowers.

[8] Refer to paragraph 5.94 f of the World Bank Procurement Regulations for IPF Borrowers.

Risks	Mitigation Measures (Ready by Effectiveness)	Mitigation Measures (To Be Supported during Implementation)
audit recommendations and internal audit to follow up.	• Internal audit function to be reviewed as part of the functional review • The MOPH to notify an audit follow-up mechanism including *inter alia* appropriate action by the relevant officials, compilation of results by internal audit, and periodic reporting to the management	their findings with the internal audit director • Based on the results of the functional review, a firm to be hired for internal audit capacity building • The MOPH to implement approved audit follow-up mechanism and report results semiannually. The annual MOPH performance review to include a scorecard on audit observations
• Fixed assets and inventory registers are not maintained at the MOPH. Moreover, there is no practice to periodically verify existence of fixed assets. Therefore, information about existence and condition of fixed assets is not available.		• By December 2018, the MOPH will develop assets and inventory management software that will include facility-wise details of inventory and assets including those managed by the service providers. • By December 2019, the MOPH will enter the inventory and assets data in the newly developed database based on physical verification with the support of a firm.