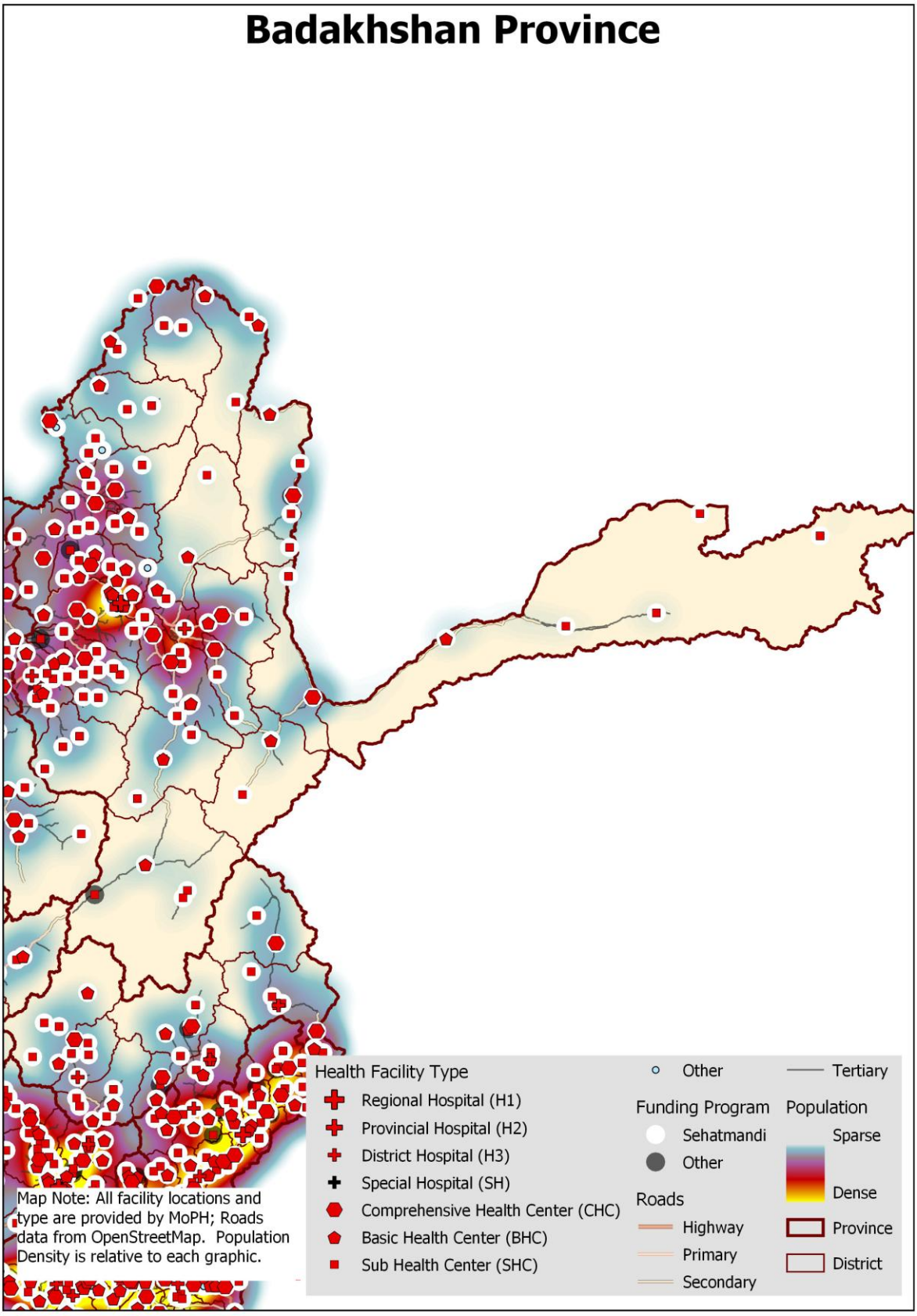
Sehatmandi Semi Annual Performance Review 1
Provincial-level review: Badakhshan

September 2019

Ministry of Public Health
Islamic Republic of Afghanistan


Badakhshan Province
Health Facility Type
Regional Hospital (H1)
Provincial Hospital (H2)
District Hospital (H3)
Special Hospital (SH)
Comprehensive Health Center (CHC)
Basic Health Center (BHC)
Sub Health Center (SHC)
Other
Funding Program
Sehatmandi
Other
Roads
Highway
Primary
Secondary
Tertiary
Population
Sparse
Dense
Province
District
Map Note: All facility locations and type are provided by MoPH; Roads data from OpenStreetMap. Population Density is relative to each graphic.

1.1 General Provincial Characteristics

Table 1: General Provincial Characteristics

Province	Population (n) [1]	Population density (n/km2)	Civilian conflict deaths [2]	Accessibility index [3]	Internally displaced persons [4]	Poverty (%) [5]	Female literacy (%) [6]	Transport accessibility [7]
Badakhshan	966,789	21.9	18	52.5	3,885	81.5	19.8	Very low

[1] Population estimates in 2016/17. Source: Central Statistical Office of Afghanistan.

[2] Number of civilian deaths in 2018. Source: United Nations Assistance Mission in Afghanistan.

[3] Civil servant accessibility index 2016. Higher values indicate greater accessibility by civil servants. Source: United Nations Assistance Mission in Afghanistan.

[4] Number of displaced persons settling in the province between January and July 2019.

[5] Percentage of the population whose expenditure on food and non-food items falls below the official poverty line. WB staff estimates based on the ALCS 2016-17.

[6] Percentage of the female population aged 14 years and older who can read and write. WB staff estimates based on the ALCS 2016-17.

[7] UN OCHA 2012 estimates of physical access according to transportation and terrain, but not security or weather.

Badakhshan is located in the farthest northeastern part of Afghanistan between Tajikistan and northern Pakistan. It shares a 91 km border with China. There are 28 districts and more than 1,200 villages in the province with total population of 1017499Fayzabad serves as the provincial capital.

1.2 Provincial Health Characteristics

Table 2: Provincial Health Characteristics

Province	Service provider	EPHS implementer	Health posts	Sub-health centers		Basic health centers		Comprehensive health centers		Hospitals [1]		Other facility type		Total facilities		Sehatmandi facilities as % of total
			SH	*SH*	*Other*	*SH*	*Other*	*SH*	*Other*	*SH*	*Other*	*SH*	*Other*	*SH*	*Other*	
Badakhshan	AKF	Yes	438	67	1	31	1	14	0	3	0	4	10	119	12	90.8

[1] Includes district, regional, provincial, and specialty hospitals.

Badakhshan is known to haverecorded one of the highest maternal mortality ratios in the world.[1]Through the SEHAT and Sehatmandi project the Aga Khan Foundation (AKF) has been providing BPHS and EPHS. Before the Sehatmandi, AKF and Care of Afghan Families (CAF) were operated in the province under SEHAT, there are 116 HFs Running under Sehatmandi project.

[1]Bartlett LA et al. Where giving birth is a forecast of death: maternal mortality in four districts of Afghanistan, 1999-2002.Lancet. 2005 Mar 5-11; 365(9462):864-70.

1.3 Contract Financial Information

Table 3: Contract Financial Information

Province name	Service Provider	Total contract amount in AFN (lump sum plus P4P [1])	Lump sum amount in AFN	Lump sum as % of total contract	Total contract amount per capita in USD [2]	Population [3]	P4P award SAPR1 in AFN	Possible Maximum Level P4P in SAPR1in AFN	P4P earned in SAPR1 as percent of total possible	Delay in most recent lump sum payment (days)	Delay in P4P first payment (days)
Badakhshan	AKF	1,110,135,480	700,689,231	63.1%	14.7	1,017,499	62,965,286	194,895,067	32.3%	20	45

[1] Maximum Level P4P

[2] The Sehatmandi Project RFP

[3] 1.00 USD = 74.4 AFN as per the contract. The amount is for the project life (2.5 years).

BadakhshanRanking by share of Lump-sum of total contract amount (63.1%) is the 4th to the highest among 31 provinces and ranking by P4P earned in SAPR1 as percent of total possible (32.3%) is the 5th to the bottom.

1.4 P4P Indicator League Table

Below table shows analysis of the ten (10) P4P indicators. The color coding is used to visualize the findings in four main categories; performance below the minimum level is codified by red color, performance between the minimum level and index is codified as yellow, performance between the index and maximum level is codified as green color and performance above the maximum level is codified by blue color.Badakhshan is ranked at the 28th from the top.

Table 4: P4P Indicator Performance

Province	Post-natal care	Outpatient visits (children <5 years)	Antenatal care	Tuber-culosis treatment	C-Sections	Couple-years of protection	Child growth and infant feeding	Inst. delivery	Tetanus toxoid 2 vaccine	Penta vaccine dose 3	Major surgeries	Total payment indicator score (out of 30)
National												**22**
Badakhshan												15

1.6 Performance Score

Table 5: Summary of Performance Scores

HMIS Verification Composite Scores for P4P indicators (Result 1.1)	P4P indicators failed to Minimum Level (Result 1.2)	Minimum Standards of Services (Result 1.3)	Quality of Care		Report (Result 1.6)	Salary Payment (Result 1.7)	Total Performance Score	Reward/ Sanctions
			BSC (Result 1.4.1)	QoC Indicators (1.4.2)				
N.A.	0	-20	N.A.	N.A.	0	0	-20	PIP

HMIS Verification Composite Scores, BSC and QoC indicators are not available at the time of the review. P4P indicators and Minimum Standards of Services are subject to the Third Party Monitor verification.

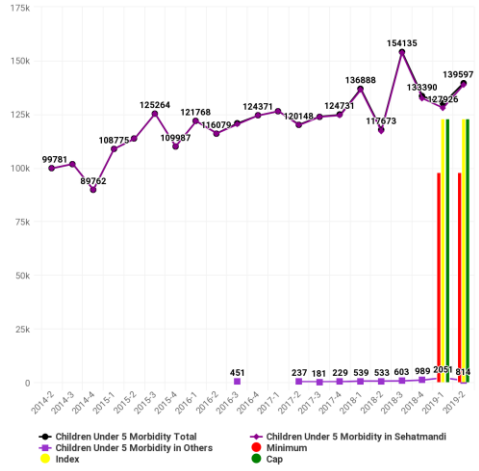
1.7 Key findings

- Badakhshan is ranked in the26thfrom the top in the P4P indicator performance; 8 of 11 P4P indicators did not meet the Index.
- About 0.3 % of HFs did not have female staff as per the Minimum Standards.
- About 4% of HPs (14 HPs) did not have female CHWs as per the minimum standards.
- Heavy snowfall did not allow for distribution of medical and non-medical products in some parts of the province.

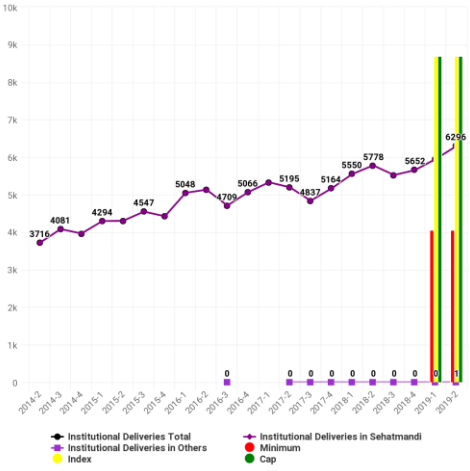
1.8 Indicator trends

In this sub-section, all line charts show Five-Year Trend by Quarter between 2014 (1393) and 2019 (1398), and the bar charts in the right side of the chart show the Minimum Level, Index and Maximum Level of quarter 1 and quarter 2 of this Semi-Annual Cycle.

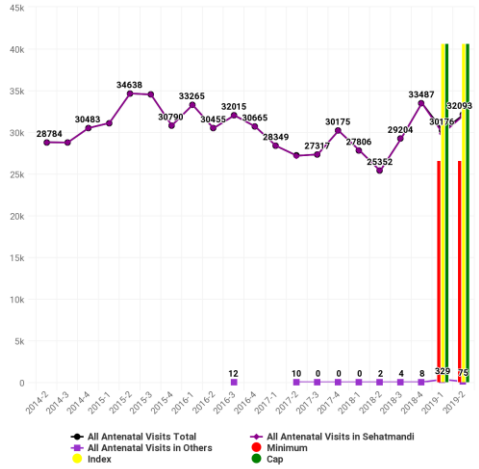
Children under 5morbidity



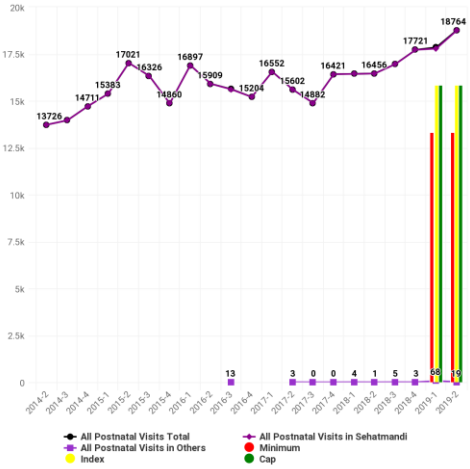
Institutional Delivery



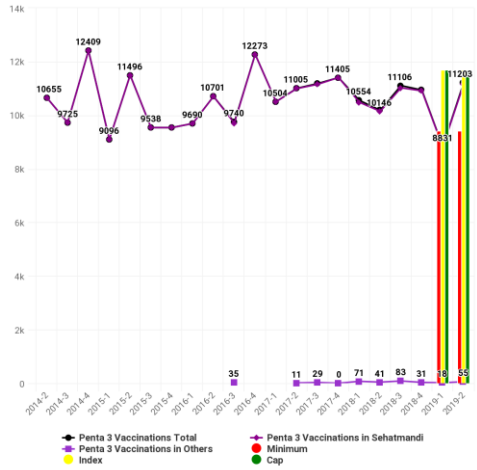
All Ante-Natal Care Visits



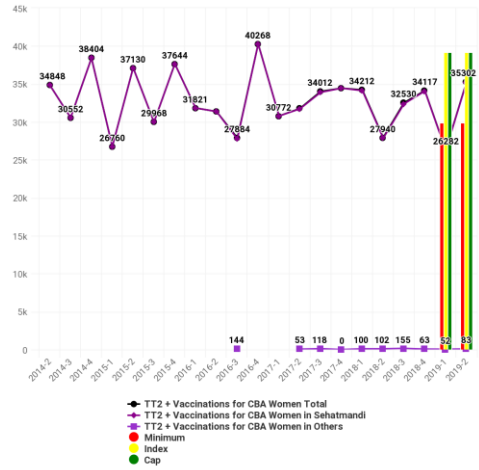
All Post-Natal Care Visits



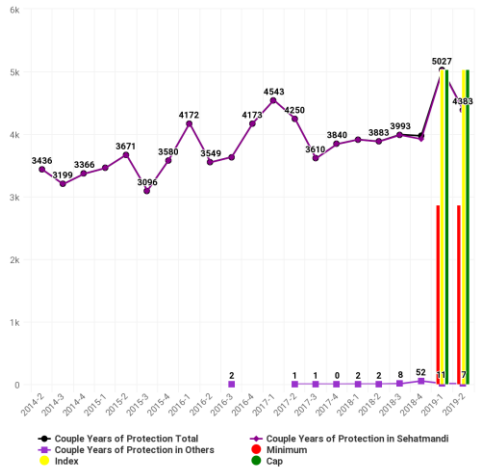
Penta 3 Vaccinations



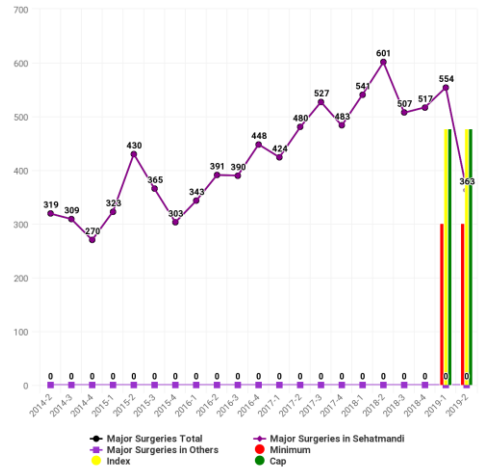
TT2+ Vaccinations



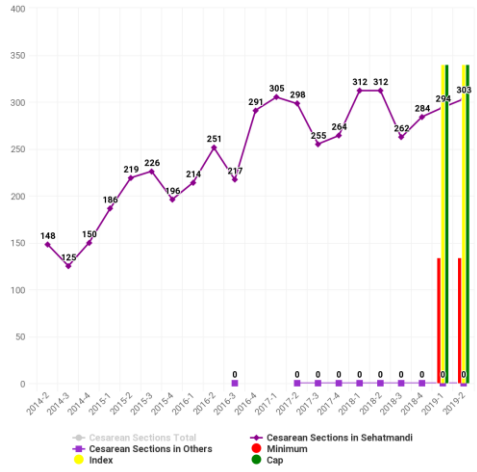
Couple Years of Protection



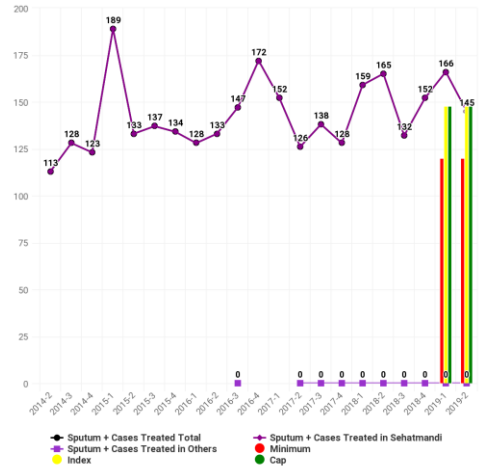
Major Surgeries



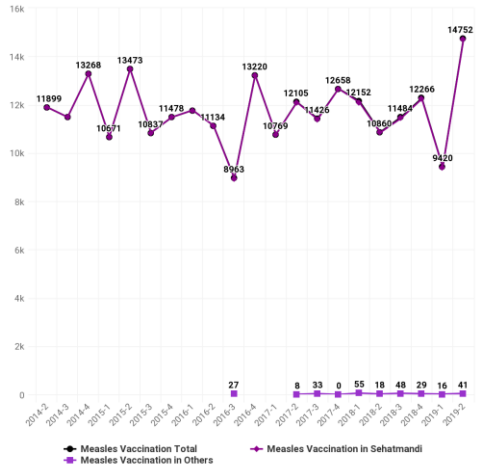
Caesarean Sections



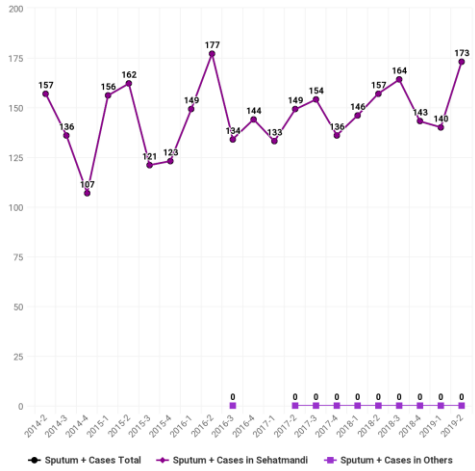
TB Sputum Positive Cases Treated



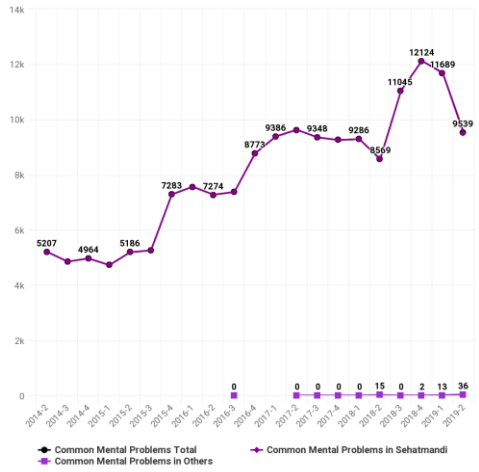
Measles Vaccinations



TB Case Detection

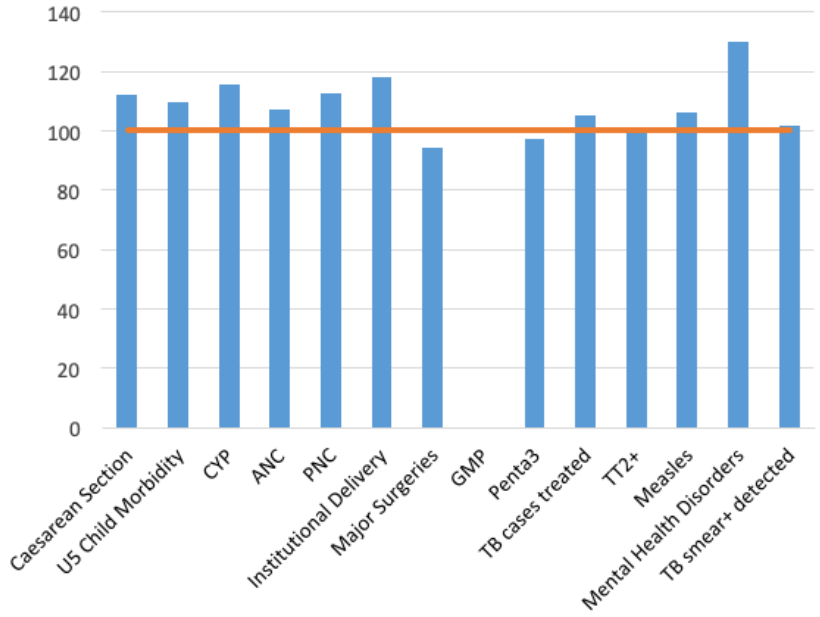


Mental Health Disorders



1.7 Normalized results

Chart 1.8: Achievements in P4P indicators plus three additional indicators relative to normalized median



To arrange the findings in a single chart the data are normalizedby dividing performance of the first Semi-Annual cycle of 2019 by the median number of performance in the same Semi-Annual cycle of last five years and multiplied by 100. So the figures above 100 show better performance thanthe last five years median and those lower than 100 show low performance than the median of last fiveyears.

1.8 Conclusions of the charts

- On average, P4P indicators rose by more than 34%over 5 years.
- Immunization services (Penta 3, TT2+ and measles) increased up to 17% over 5 years.
- Maternal health services (ANC, institutional deliveries, and Caesarean section) showed steady.Increaseby about 62%) over time.
- On average of Non P4P indicators rose by 39% over 5 years.

2 Province-specific analysis

2.1 Management:

- AKF provides BPHS and EPHS since 2015.
- Staffing:
  - According to the Facility Monthly Report of the last month of quarter 2 of this Semi-Annual (SA) cycle, 0.3% of health facilities had no female staff.
  - Shortage of female CHWs is existent in 4 % of health posts.
- Staff salary Payment: delay in staff salary payment was reported in the first quarter of this SA cycle but no report in the second quarter.
- Reporting:

Report	Submission in Q1	Submission in Q2	Conclusion
Inception Report	Delayed	-	
Data Quality Assurance Plan	Delayed	-	
Quarterly Report	Delayed	On time	
PIP	On time	On time	
Monthly Updates	Delayed	On time	
Inventory List	-	On time	

Incidence Report	-	Delayed
End of project Report	-	-

2.2 Health Facility Analysis:

- Health Facilities with Problems or Success
    - Kishm DH reported a rapid fall of TT2+ in Q2 compared to Q1 (from 6% to 4.5%).
    - Iskazur, Tagabuk, Nahia E Sea, Paspul and Roshan BHCs reported zero coverage of TT2+ in Q1 and Q2.
    - Pamir Kalan, Tangsheyo, Sanglich ,Mahnaw , KhambakBala SHCs submit Zeroor very low report of ANC, PNC and institutional delivery while these HFs have midwives.
    - Raghistan CHC had zero percentage share of Penta 3 Coverage.
    - According AKF, harsh winter, hard to reach geography, insecurity, transition to Sehatmandi, GAVI discontinuation and late payments to vaccinators are the reasons for low immunization coverage. However, there are HFs that have good accessibility, are located in secure placebut demonstratelow immunization coverage – e.g. Gazan, Talbuzank and Nahia e sea BHCs.
    - Nineteen (19) SHCs has zero percentage shareof ANC and PNC coverage in Q2 of 2019while there are midwives.
    - Under five Child morbidity is decreased in Q2 than Q1 in about 27 HFs (particularly BHCs and SHCs)
    - Considering the percentage share of coverage the utilization of PH, DH and CHCs are higher than BHCs and SHCs in all indicator particularly reproductive health while there are midwives in all BHCs and SHCs (equitable service is concern).
    - 19 BHCs in Q1 and 1 CHC and 23 BHCs in Q2 submitted zero percentage share of TB treatment cases coverage.
    - 8 out of 31 BHCs has the low performance with Institutional Delivery (shekai, Joibar, jare shah baba, samarqandi, furghambul, talbuzank, gandumqul and yamgan).
    - Eshkashim CHC+ has a sudden decline with TB indicator in Q2 than Q1 (1st Q 3% but 2nd Q 0%)
    - Nusai CHC has zero percentage of share performance report with GMP/IYCF in both Q1 and Q2 among 8 BHCs
    - ShahreSafa with high performance (4, 9%) and Nusai with low performance (0, 9%) with institutional delivery among all 8 CHC.
    - Sudden decline of child morbidity in Q2 than Q1 of Naland(9,4% in Q1 while 1,2% in Q2) and Jurm CHCs (11% in Q1 while 2,7% in Q2).
    - Percentage share Status of child morbidity in most of SHCs declined in Q2 than quarter one.
    - 47 SHCs has very low and even some Zero percentage share of performance report data with TT2+ and penta3.

2.3 Specific major events affecting service delivery:

a. Health Services affected and lost Due to heavy snow and Anti-Government Elements Activities in some districts.

Table: List of HFs Closed in this SAPR cycle

SN	HF Name	HF Type	Date of Report submitted	Service Halt Date (MM/DD/YYYY)	Service Resume Date (MM/DD/YYYY)	# Days Service Halted	Remarks
1	Arghandkhwa	BHC	Suggested in Q2 Report	3/28/19	4/12/19	5	Closed since 28th March, 2019
Total #days halted						5	

b. **Natural Disasters**: AKF reported that part of District Raghistan, Kohistan and Arghandjkhwa weresecluded by heavy snow in the first quarter, during which no mobile& outreach was conducted.

c. **Population movement**: no report.

3 Discussion & Recommended actions

3.1 Recommendation to SP:

- Given lack of female health professionals in absolute terms, AKF should review staffing pattern and implement new incentive mechanism (including benefits and allowances) for female staff.
- Off-budget service delivery should not be seen as obstacle. AKF should request the MOPH/PMO to review the set benchmarks – Minimum Level, Index and Maximum Level.
- AKF should rigorously analyze a budgeting method used in the initial lump-sum calculation. In addition, AKF should seek for an innovative financing mechanism in order not to interrupt staff salary payment.
- Heavy snowfall in District Yawan, Raghistan, Kohistan, Shiwa, Pamir, Shighnan, Maimay, Shukai, Nusai, Kofab, and Khwahan is a known fact. Revise the procurement and distribution plan of medical products to ensure uninterrupted medical supplies in those areas.
- HFs with low performance and zero achievement in some indicators should be investigated.
- There are some HFs that performed lower in Q1 than Q2, in which there is no challenge in accessibility and /or security.
- To improve overall performance in HFs, utilization of BHC and CHC should be looked into while DHs continue to contribute to a large part of the services.
- Fourteen (14) nutrition councilors should be recruited.
- Hired 114 nutrition councilors are not trained on key nutrition topics.
- IMCI training is needed for all staff whosee under 5 children in HF.
- Twenty-three (23) HFs reported negative dropoutsfrom EPI services. TD proposed SP to follow up with them.
- Refresher training has not been conducted for EPI staff in HFs.
- In the HFs where more than 50 injections are administered per day, an additional female vaccinator should be hired.
- Internal referral system needs to be strengthened.
- TB treatment defaultersshould be tacked and traced by CHSs and CHWs.
- Male vaccinatorsin fixed centers should bereplacedwith females.
- Provincial target setting has problems, particularly RMNCAH-related indicators. SP suggested to MOPH to revisit the targets.
- Two (2) mental health counselors should be hired.

- MOPH Mental Health Department suggested SP to report on suicide casesin HMIS.
- All clients visiting HFsshould be examined for TB positivity.
- Presumptive patients (i.e. TB suspects) appear to be lower than anticipated.
- TB care services should focus on contact management.

3.2 Recommendations to MOPH leadership:

- In the next round of Sehatmandi project,transition to a new SP should avoid winter season.
- Sound assessmentis needed to understand an extent to which off-budget projects affect the Sehatmandi project.
- Innovations should be considered in performance scoring, conditional upon SP to make sure essentials of BPHS and EPHS are provided at an acceptable level.
- Coordination between TDs and PMO needs to be strengthened.
- The quarterly report of SPs should be shared earlier with TDs by PMO.