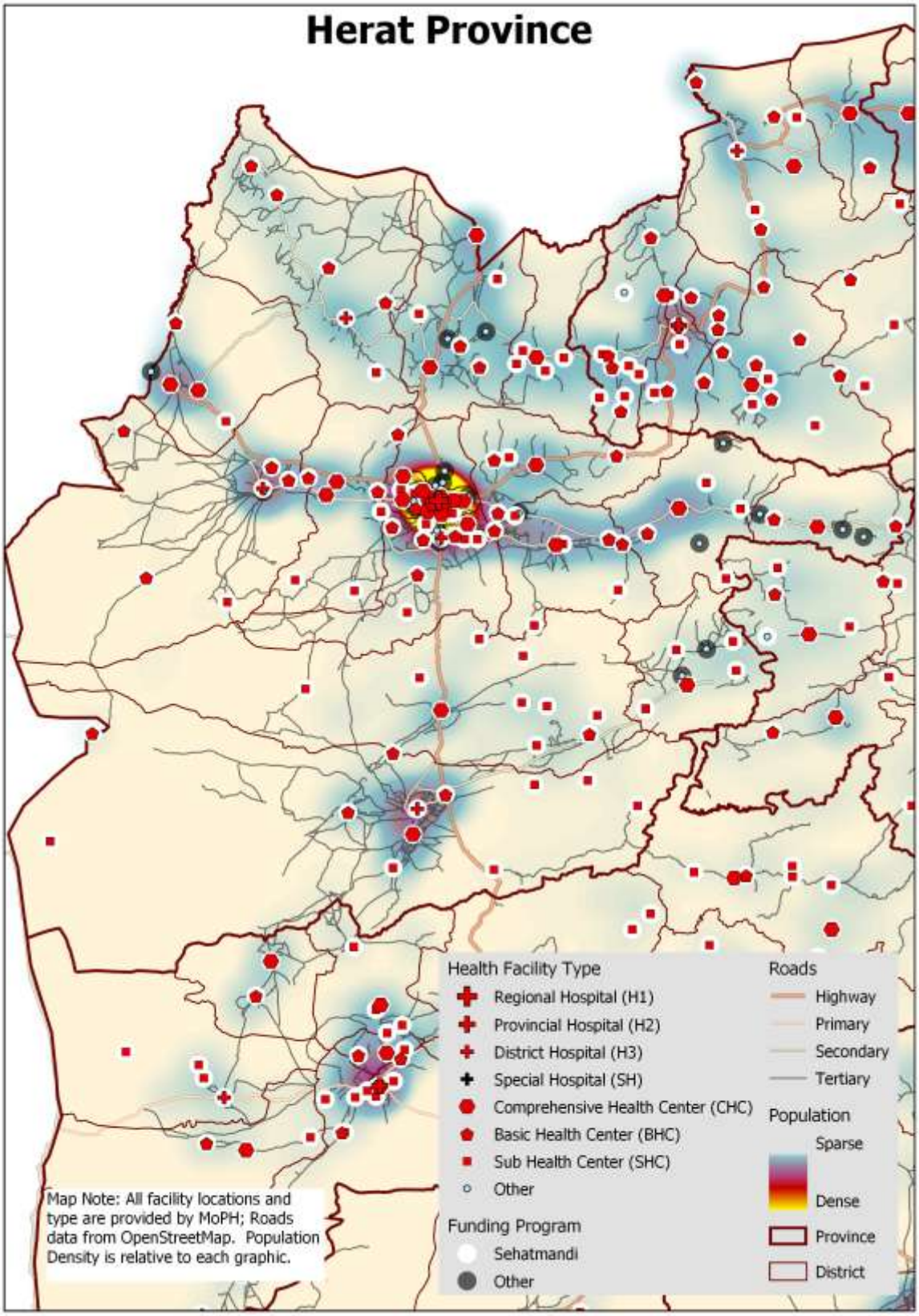
Islamic Republic of Afghanistan

Ministry of Public Health

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

September 2019


Herat 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]
Herat	1,928,327	35.2	95	70.5	6,620	47.9	28.3	High

[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.

Herat is located in the far west of Afghanistan and shares borders with Iran Turkmenistan. Badghis, Ghor, and Farah provinces are located to its northeast, east and south respectively. Including its capital city Herat, this province has 16 districts with 4,467 villages.

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*	
Herat	AADA	No	1212	49	0	33	3	24	4	4	1	1	51	111	59	65.3

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

Herat is ranked as the 12th province from the bottom with lowest utilization of Health Facilities for giving birth where only 39.3 deliveries took place in HFs.[1]It also has a high rate of under five children (58 per 1000 live births) while this number is 55 per 1000 at national level[2].Through Sehatmandi project, the Agency for Assistance and Development of Afghanistan provides BPHS. Under SEHAT, Bakhtar Development Network (BDN)operated in the province.

[1] Central Statistics Organization (CSO), Ministry of Public Health (MoPH), and ICF. Afghanistan Demographic and Health Survey 2015 (2015 AfDHS). January 2017. P150.
[2] Central Statistics Organization (CSO), Ministry of Public Health (MoPH), and ICF. Afghanistan Demographic and Health Survey 2015 (2015 AfDHS). January 2017. P131.

1.3 Contract Financial Information

Table 3: Contract Financial Information

Province name	Total contract amount in AFN (lump sum plus P4P*)	Lump sum amount in AFN	Lump sum as % of total contract	Total contract amount per capita in AFN	Total contract amount per capita in USD§	Population¶	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)
Herat	1,122,611,556	748,685,448	66.7%	522	7.0	2,149,054	26,980,585	67,630,919	39.9%	21	45

*Maximum Level P4P
¶ The Sehatmandi Project RFP
§ 1.00 USD = 74.4 AFN

The contract lump-sum budget seems to be estimated low across all provinces. Total lump-sum amount as % of total contract amount for Herat was the secondto the top among 31 provinces. Herat is just below the national average of P4P earned in SAPR1 as % of total possible payment (i.e. Maximum Level).

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 orange, performance between the index and maximum level is codified as green color and performance above the maximum level is codified by blue color.

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**
Herat												25

1.5 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	0	N.A.	N.A.	0	-5	-5	

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.

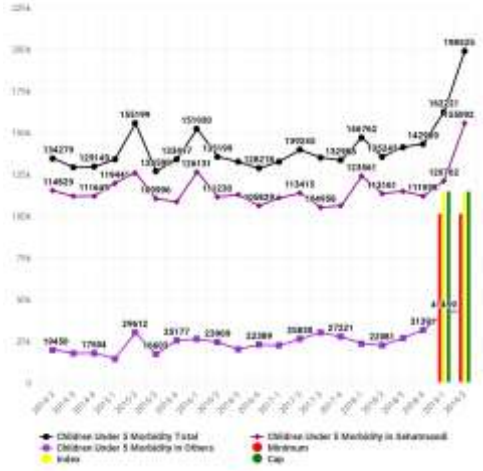
1.6 Key findings

- Herat is rankedat the 2nd of 31 provinces in the P4P indicator ranking: twoof 11 P4P indicators did not meet the Index and one did not meet the Cap Level; the rest are above the Cap.
- On average, 5 P4P indicators rose by 111% over 5 years.
- In addition to delays in the government payment, there is a delay in the salary payment by Service Provider (SP) in the first quarter.
- 100% of HFs(12 HFs) had female staff as per the Minimum Standards; however 6 CHCs did not have female MD.
- EPI outreach services faced challenges due to AGE's ban on male vaccinators to vaccinate adult females and ban on female vaccinators operating without male chaperon/Mahram.

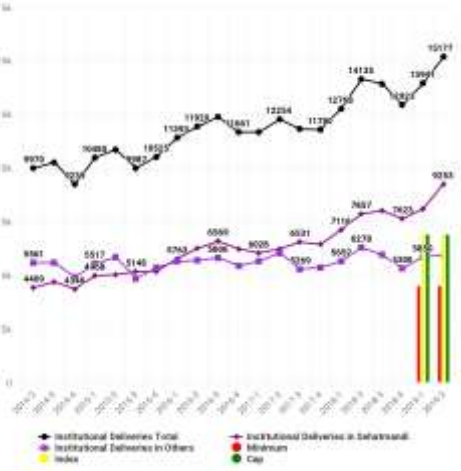
1.7 Indicator trends

In this sub-section, all line charts show Five-Year Trend by quarter between 2014 and 2019, and the bar charts in the right of the chart show Minimum Level, Index and Maximum Levelfor quarter 1 and quarter 2 of this Semi-Annual cycle.

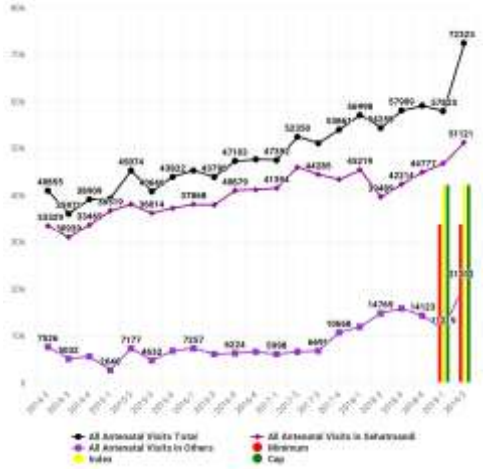
Children Under Five Morbidity



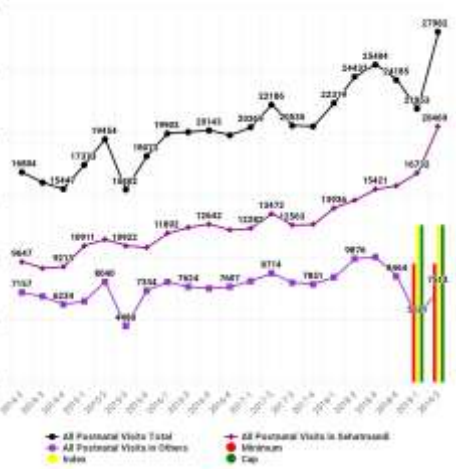
Institutional Delivery



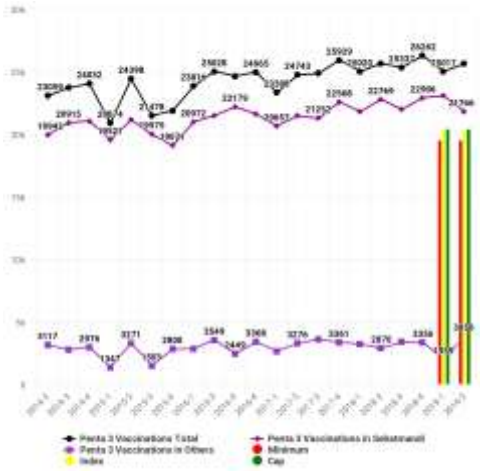
All Ante-Natal Care Visits



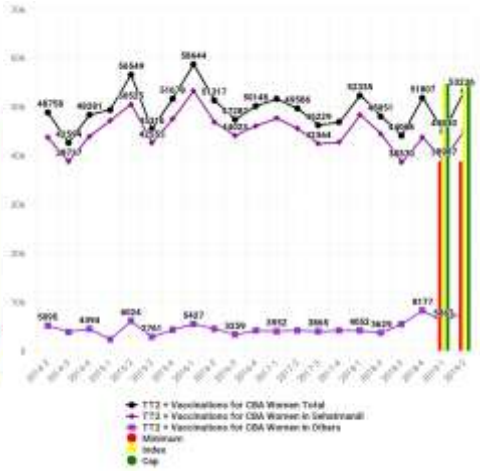
All Post-Natal Care Visits



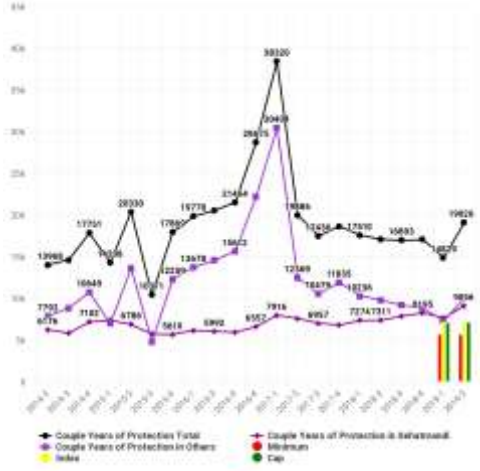
Penta 3 Vaccinations



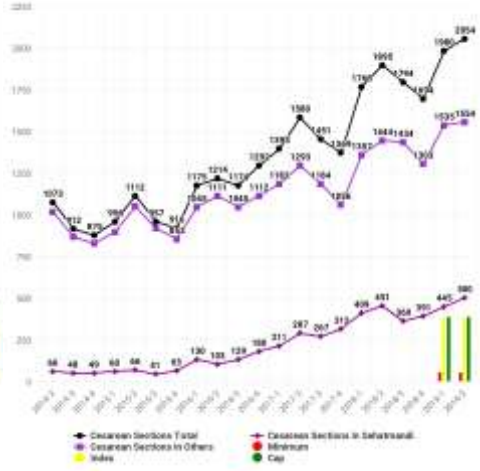
TT2+ Vaccinations



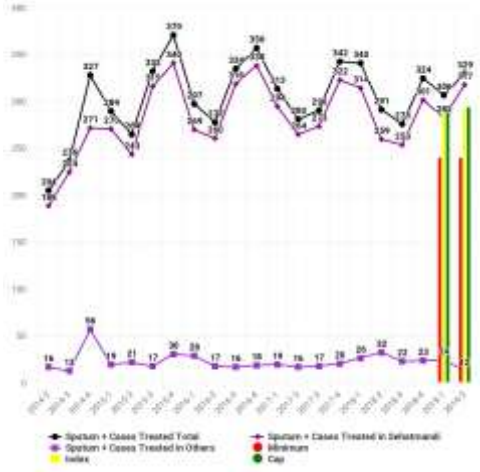
Couple Years of Protection



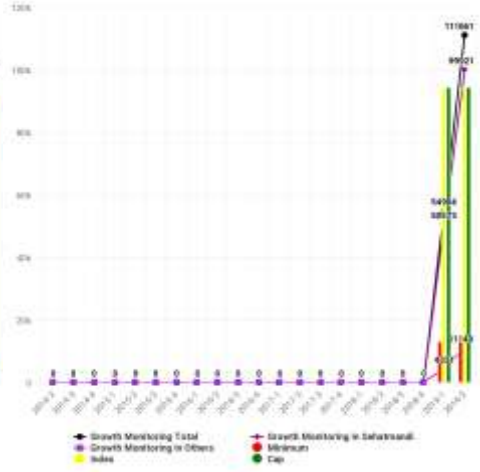
Caesarean Sections



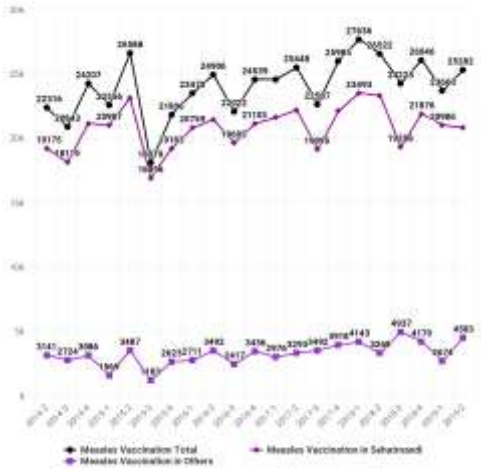
TB Sputum Positive Cases Treated



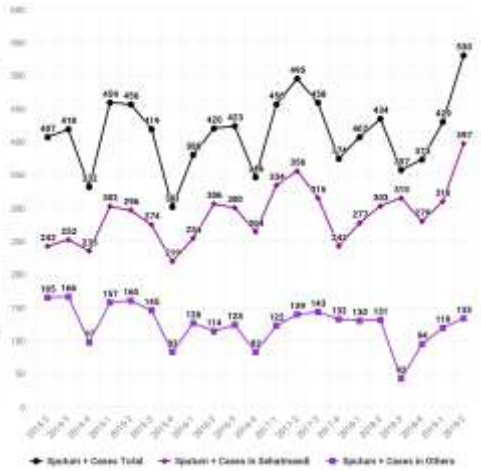
Growth Monitoring and Youth Counseling



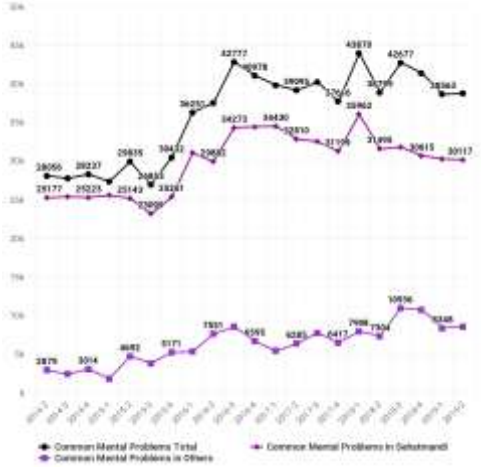
Measles Vaccinations



TB Case Detection

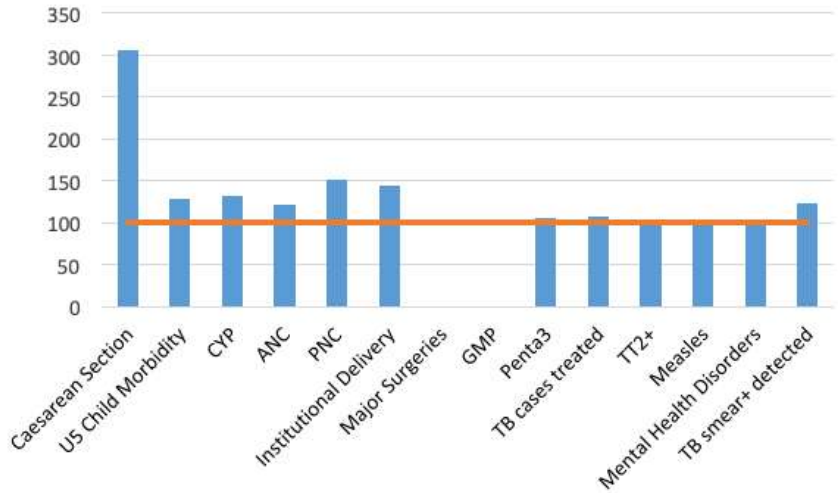


Mental Health Disorders



1.8 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.

1.9 Conclusions of the charts

- On average, 5 P4P indicators rose by 111% over 5 years (GMP due to no data in 2014 as well as CYP and C-Sections due to huge increase and major surgeries were excluded.)
- Immunization services (Penta 3, TT2+ and measles) increased on an average of 84% over 5 years.
- Maternal health services (ANC, PNC, institutional deliveries) showed steady increase by 180% over time. Caesarean-Sections were excluded due to huge increase in comparison with others.

2 Province-specific analysis

2.1 Management:

- AADA provides BPHS under Sehatmandi.
- Staffing and Training:
    - According to the Facility Monthly Report of the last month of quarter 2 of this Semi-Annual (SA) cycle, 100% of health facilities haveat least one female staff; however six CHCs did not have female MD.
    - As per the last Monthly Updates of this SA cycle, recruitment of more than 75% of Nutrition Counselors is completed and 37 new female CHWs received their first batch of initial training.
    - Ninety-one (83 male and 8 female) HFs staff received training in Rational Use of Drugs/MDS, Lab skills /Blood transfusion, Malaria Microscopy, DOTS, TB, triage and EPI.
- 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:
    - Inception Report was submitted late.
    - Both the first and second Quarterly Reports were submitted on time.
    - All 3 Monthly Updates to be submitted to PMO were on time.
    - PIP was submitted on time.
    - Submission of Data Quality Assurance Plan was overdue.
    - Semi-Annual Inventory List was submitted on time.
    - One Force Majeure case was reported in first quarter.

2.2 Health Facility Analysis:

- Health Facilities with Problems or Success
    - TT2+ services declined from 2016: a rapid fall reported by Gulran DH, Kohsan, Shekeban, Chesht-e-Sharif, ZereKoh, Koshk-e-RobatSangi, Karukh CHCs, Toqchi, TotiChe, Zawol, DashteNizan and Jafarbeg BHCs and DehKhar SHCin Q2 compared to Q1.

- Sheendand, Gozara, Ghoryan, Gulran, DHs and PashtoonZarghoon CHC reported a rapid increase in Caesarean Sections; however a rapid decrease has been reported by Torghondai CHC+.
- Torghondai CHC+, Kohsan CHC, Sheendand DH, Khogyani, Zawol, Haft Chah and Dasht-e-Nizan BHCs contributed to decrease of Growth Monitoring in <2 children/IYCF services.
- A quick drop of Penta 3 services reported by Lahrab BHC in Q2 in comparison to Q1.
- All HFs shows good HMIS reporting in both quarters of 2019.

- Analysis of general conditions of the province that affect service delivery:
  - EPI outreach services faced challenges due to AOG ban on male vaccinators to vaccinate adult females and ban on female vaccinators working without male chaperon/Mahram.
  - Insecurity remains as a big challenge toward service delivery.

2.3 Specific major events affecting service delivery:

a. Health Services Lost Due to Anti-Government Elements Activities

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	Farsi	CHC	4/4/2019	1/21/2019	3/25/2019	63	Submission of Report to GCMU on April 17.
Total #days halted						63	

b. **Natural Disasters**: No disorders reported.

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

3 Discussion & Recommended actions

3.1 Recommendations to Leadership

1. Give flexibility to SP for recruitment of additional vaccinators through other sources (e.g. female vaccinator for outreach services). The review committee suggested to consider this request in amendment to SP's contract.
2. There was delay in fund transfer to SP (21 days for lump sum and 45 days for P4P). Based on signed contract article 6.5 the SP should be paid for delay in receipt of installment over 15 days.

3.2 Recommendations to Donor

1. SPs did not receive any official document for payment beyond cap. Payment beyond Cap encourages SPs to have more initiatives in the project.

3.3 Recommendations to SP

1. Minimize the negative drop-out in Penta 3 in Kahdistan and Zendajan districts HFs. Do a root cause analysis to find out the reasons behind the negative drop out in Penta3; provide an action plan in coordination with PPHD and follow up on the implementation.

2. The fridge tags are not checked regularly. Check the fridge tags regularly to ensure safety of vaccines.
3. Less coverage during EPI outreach sessions in some HFs. Outreach plan should be developed in coordination with CHS and both vaccinator and CHS should sign on it. CHS to mobilize the community for outreach vaccination.
4. Shortage of anti-leishmanial medicine and RDT in some HFs. Provide anti leishmanial medicine and RDT according to consumption report: follow up on rational use/ proper documentation of prescribed medicines and supplies.
5. The recommendation of RMNCAH monitoring missions should be followed up in Herat. Provide action plan versus findings of mission and follow up on the implementation
6. The presumptive TB cases is less in Heart: proper triage of clients in HFs to detect pulmonary sputum positive, pulmonary sputum negative and extra pulmonary case and contact management of TB positive cases.
7. Less utilization of services due to insecurity is predictable in some areas in the province. Revise the procurement and distribution plan of medical products to ensure uninterrupted medical supplies in those areas.
8. The winter affects the services in some areas like Farsi and Kushk-e-Kohna districts HFs, so the SP should have a proper planning of procurement and distribution of supplies to these areas.
9. Given lack of female MDs, AADA should review staffing pattern and implement new incentive mechanism (including benefits and allowances) for female staff.
10. When evidence supports, AADA should request the MOPH/PMO to review the set benchmarks – Minimum Level, Index and Maximum Level for Growth Monitoring/IYCF.
11. In addition, AADA should seek for an innovative financing mechanism in order not to interrupt staff salary payment.