Islamic Republic of Afghanistan

Ministry of Public Health

Sehatmandi Semi Annual Performance Review 1
National-level review

September 2019

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Tables and Figures

Abbreviations

AADA	Agency for Assistance and Development of Afghanistan
AFN	Afghanis (currency)
AGE	Anti-government elements
AHEAD	Assistance for Health, Education and Development
AHS	Afghanistan Health Survey
AKF	Aga Khan Foundation
ALCS	Afghan Living Conditions Survey
BARAN	Bu Ali Rehabilitation and Aid Network
BRAC	Building Resources Across Communities
BDN	Bakhter Development Network
BPHS	Basic Package of Health Services
BSC	Balanced score card
CAF	Care of Afghan Families
CHA	Coordination of Humanitarian Assistance
CYP	Couple-years of protection
EPHS	Essential Package of Hospital Services
GM/IYCF	Growth monitoring/infant and young child feeding counseling
HEWAD	HEWAD
HMIS	Health management information system
HN-TPO	Health Net International TPO
JACK	Just for Afghan Capacity Building
MOD	Ministry of Defense
MOHE	Ministry of Higher Education
MOVE	MOVE Welfare Organization
MMRCA	Medical Management and Research Courses for Afghanistan
MRCA	Medical Refresher Courses for Afghans
NAC	Norwegian Afghanistan Committee
OHPM	Organization for Health Promotion Management
ORCD	Organization for Research and Community Development
PIP	Performance improvement plans
PMO	Performance Management Office
P4P	Pay for performance
QoC	Quality of care
RFP	Request for proposals
SAF	Solidarity for Afghan Families
SAPR1	First semi-annual performance review
SCA	Swedish Committee for Afghanistan
SDO	Sanayee Development Organization
SH	Sehatmandi
SHDP	Social and Health Development Program
SOP	Standard operating procedures
SP	Service provider
UNAMA	United Nations Assistance Mission in Afghanistan
UN OCHA	United Nations Office for the Coordination of Humanitarian Affairs
USD	United States dollar

Executive Summary

Context and purpose

The Sehatmandi project ("Sehatmandi") is the framework through which most of government-supported primary health services are delivered to the people of Afghanistan. Under Sehatmandi, non-governmental service providers (SPs) are contracted to deliver the Basic Package of Health Services in 31 provinces and the Essential Package of Hospital Services in 16 provinces. Payment to SPs is divided between a lump sum (which was proposed by the SP during a competitive bidding process) and a performance-based payment which is based on 11 payment indicators. These indicators are also a basis for rewards and sanctions for the SPs, based on services provided. A quarterly review of the SPs, including analysis of payment indicators, is required under Sehatmandi. This report provides analysis based on the first two quarters of Sehatmandi (January 01 – June 30, 2019).

The purpose of this report is (1) to evaluate the performance of service providers with respect to the 11 payment indicators and three additional non-payment indicators; (2) assess the performance of service providers and rank them based on their overall performance as per Standard Operating Procedures; and (3) to investigate potential drivers of performance in order to inform decision-making to improve service delivery. Part 1 provides a national-level summary, whereas Part 2 provides province-specific observations. The national summary contains data on the service delivery context in each province, performance on payment indicators, statistical exploration of potential drivers of service delivery, and a qualitative summary of factors which may impact service delivery. The provincial summaries provide more detailed data on the service provider, service delivery context, payment indicator trends, and significant events thought to impact service delivery in each province.

Key findings

1. Eighteen provinces (58%) are exceeding on average the index target for payment indicators. However, the remaining 13 provinces are not reaching the index on average.
2. Post-natal care, antenatal care, and outpatient visits for children under 5 years are exceeding the cap for payment indicators in over half of provinces. However, couple-years of protection, institutional deliveries, tetanus vaccinations, and pentavalent vaccinations are below the payment indicator index for over half of provinces.
3. Payment indicators have grown by 10.5% annually over the past five years at Sehatmandi facilities. However, non-Sehatmandi[1] facility service provision has outpaced this figure substantially, growing at 16.6% per year, especially in C-Section and Major Surgery indicators due to contribution of provincial, regional and national hospitals funded by the government. In the past two quarters which are the focus of this review, there is a steep increase in Sehatmandi facilities performance compared to previous quarters and Non-Sehatmandi facilities across most of the P4P indicators.
4. Statistical analysis suggests that service providers are the primary driver of payment indicator scores. Other hypothesized determinants were not found to substantially contribute to performance outcomes, with the exception of physical accessibility and

[1] There are 3,954 health facilities (HFs) recorded in HMIS in total as on September 24, 2019. Total number of "non-Sehatmandi facilities" is 1,686 or 42.6% of total. They include facilities funded by other government agencies such as MOD and MOHE (17.0%), private for profit (11.4%), non-Sehatmandi MOPH (6.9%), GAVI (5.3%) and UNICEF (2.1%).

baseline service coverage for modern contraceptive use, pentavalent vaccination, and Caesarian section deliveries.

5. Qualitative findings:
    a. During this semi-annual cycle, 11 of 34 provinces reported at least one security incident that resulted in disruption of health services. In addition to direct armed attack on front-line health workers and health facilities, verbal threats and other forms of intimidation by anti-government elements against the service providers forced the halt of services either temporarily or permanently in some places.
    b. From 34 provinces 18 (or 52.9%) failed to meet the Minimum Standard of staffing in Health Posts: at least one female CHW in a Health Post.

Recommendations

There are three sets of recommendations came out of this performance review:

A. Recommendations to the MoPH leadership and Development partners, which will be discussed in detail below.
B. Recommendations to Service Providers to improve their achievements in the P4P indicators, meeting the minimum standards and improve quality of care, which are detailed in the Performance Improvement Plans (PIP) for each province.
C. Recommendations to technical departments to engage them more actively in the project, especially improving the quality of services as well as helping the SPs to increase coverage, which is detailed in the PIP for each province.

Recommendations to the MoPH leadership and development partners:

- ✓ Performance Management SOP should be revised to address issues as follows:
    - Minimum Standard of Services needs to be defined clearly and may need much finer scoring scale to reflect varying degrees of failures - e.g. at present, a same score for one Health Post without a female CHW in province X and five Health Posts without a female CHW in province Y.
    - An SOP revision committee should involve SPs.
- ✓ Clarifying force majeure events: The Performance Score must account for the effect of force majeure events on service performance. The PMO measures the number of days services halted due to security incident. This data could be used to estimate opportunity cost which would have been earned through P4P if no force majeure had occurred.
- ✓ Evaluate off-budget projects to find out potential duplication of efforts as well synergies with Sehatmandi Project and establish a mechanism to coordinate these activities well with Sehatmandi.
- ✓ In light of the request by many of the SPs for the Government to adjust the P4P indicators caps and tariffs to provide a greater incentive for SPs to improve coverage and quality of services, conditions and scenarios that SPs must meet should be explored. An MOPH committee should do the priori analysis and provide scenarios to facilitate decision making by the MOPH leadership.
- ✓ Establish an inclusive mechanism to engage further the MoPH technical departments from central MoPH as well as provincial teams to provide support to the project to improve quality as well as increase coverage of services.
- ✓ Renovate HFs to be more client friendly: As per contract the MoPH provides the health facilities infrastructures to the SPs to provide services. It was realized that most of the health facilities cannot accommodate the demand of MoPH, for example confidential counseling on GBV, mental health or family planning and need some major renovations which beyond the

contractual obligation of the SPs. A committee in the MoPH should do a detail assessment of the situation so that the MoPH leadership and development partners provide additional fund for this activity.

- ✓ Coordinate and control trainings of HFs staff: It was observed that long training activities, such as 15 days training for midwives on GBV can interfere with the service delivery and affect the SPs achievements in the key indicators. Therefore, a mechanism should be established to coordinate training activities supported by the off-budget projects to minimize their negative impact on the project.
- ✓ Evaluate the role of CHWs in the project: It was realized that the role of CHWs and CBHC program at all is not highlighted and appreciated in the project. A committee comprising the MoPH technical departments and SPs representative should assess and come up with the recommendation to clarify the role of CHWs and their engagement in improving coverage and quality of services.
- ✓ Amend the Sehatmandi contracts to address issues in terms of payment the instalments, calculation of major surgeries in District Hospitals and CHC+, and correct any other errors in the contracts.
- ✓ Analyze the achievement of SPs in non-P4P indicators regularly to monitor if there are any negative effect of this mechanism on the other services to be documented and corrected, before it is too late.
- ✓ The SPs as well as the technical departments of the MoPH need technical assistance to improve their supportive supervision, monitoring, and better management of the project. A clear plan to be developed to find out how the technical assistance should be directed.

The MOPH and development partners hold a meeting to discuss the review findings and recommendations on September 24, 2019. Key discussion points are found in Annex of this report.

Methods

Payment indicators

Payment indicators are based on data self-reported by service providers through the Health Management Information System (HMIS). Monthly reports are tallied on paper forms by facilities and submitted to the provincial service provider headquarters. These data are then aggregated and submitted to the provincial office of the Ministry of Public Health. Data are then input into an electronic database using Microsoft Access, which is updated at the national level every three months.

Self-reported data is subject to audit by an independent third party monitor. At the time of this performance review, the audit of service data had not yet occurred. Values presented in this report may therefore change subsequent to the audit. However, it should be noted that service providers are subject to a penalty in the case of significant misreporting of data. As a result, several service providers have created staff positions dedicated to producing quality data from the health facilities.

The minimum, index, and maximum (cap) values for payment indicators are set according to a formula specified in the Sehatmandi contract. For indicators that are available in the Afghanistan Health Surveys (AHS), the following calculations were used. First, the national annual rate of change in the indicator is calculated as $\delta_i = (\pi_{2015,i} - \pi_{2012,i})/3$, where δ is the annual rate of change for indicator i, $\pi_{2015,i}$ is the prevalence of indicator i in the AHS 2015 and $\pi_{2012,i}$ is the prevalence of indicator i in 2012.

The target coverage for a given year is then set by adding the annual rate of change to the province-specific mean value of the indicator in the AHS 2015. Therefore, $\gamma_{yip} = \pi_{2015,ip} + (\delta_i * y - 2015)$, where γ_{yip} is the target coverage for indicator i in province p in year y and $\pi_{2015,ip}$ is the mean value for indicator i in province p in the AHS 2015. In those cases where γ_{yip} was calculated to be greater than 90%, the target coverage was set to 90%.

Target coverage is then converted to a payment indicator index, ι_{yip}, which represents the number of services that the service provider should provide during the evaluation period. The index for indicator i in province p in year y is then calculated by multiplying the number of HMIS-reported services for indicator i in province p in 2015 by the ratio of the target coverage and the actual coverage, or $\iota_{yip} = \varsigma_{2015,ip} * (\gamma_{yip} / \pi_{2015,ip})$.

The cap value for indicator i in province p in year y (μ_{yip}) is set by multiplying the index by the quotient of the index value in year y by the average in 2015, or $\mu_{yip} = \varepsilon_{yip} / \alpha_{2015,ip}$. In those cases where μ_{yip} exceeds $\alpha_{2015,I}$, the cap is set equal to the index. Services provided beyond the cap are not paid for under current Sehatmandi terms.

For indicators that are not measured in the AHS (that is: post-natal care, outpatient visits among children <5 years, tuberculosis treatment, and major surgery), the index value for indicator i in province p is set to the maximum value for that indicator i in province p observed in the HMIS between 2013 and 2017. The cap is then obtained by multiplying the annual rate of change observed in the HMIS data for indicator i in province p by the index value.

The minimum value for the indicator is set as the 25th percentile of values for that indicator reported to HMIS during the previous 5 years. An exception to this is growth monitoring and child feeding,

which was newly added to HMIS in 2019. In this case, the baseline status of performance was considered the minimum, 40% coverage of the target population was considered to be the index, and 60% considered to be the cap.

Tariff amounts

Each of the 11 payment indicators has an associated tariff that is specific to the indicator and to the province. The tariff amount is then multiplied by the number of services provided for that indicator to calculate the payment amount for service providers. Services provided beyond the cap are not paid. Tariff amounts are calculated for each indicator by multiplying a base rate times a provincial correction factor. The base amount was calculated according to the findings of a study on the cost of service delivery conducted in 2016 in 7 provinces,[2] as well as an exercise performed by the Health Economics and Financing Department in 2018. The provincial correction factor is calculated according to the cost per capita found in the 2016 study.

Hypothesized drivers of performance

Province-specific data has been assembled from numerous sources to investigate potential drivers of service provider performance. Population data is sourced from estimates for 2016-17 provided by the Central Statistical Office. Data on the number of civilian deaths due to armed conflict in 2018 and the accessibility that civil servants had to provinces in 2016 was produced by the United Nations Assistance Mission in Afghanistan. The number of internally displaced people moving to reside within a province between January and July 2019 is provided by the United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA). An index of physical accessibility due to transportation and terrain, but not security or weather, is also from UN OCHA. Estimates of the prevalence of poverty and female literacy are based on World Bank estimates from data in the Afghanistan Living Conditions Survey 2016-17. Service provider financial data is drawn from service contracts and Ministry of Public Health calculations. Estimates of service coverage are calculated based on data from the Afghanistan Health Survey 2018. All other data not mentioned is sourced from HMIS.

[2] Conseil Santé. Assessment of the Referral System and Costing of the Basic Package of Health Services (BPHS) in Afghanistan. EuropeAid/137-390/DG/SER/AF/Lot2. FINAL REPORT. 2016.

Results

Provincial characteristics

Table 1 presents provincial characteristics that may impact health service delivery. Provinces vary widely in terms of their population size, with the median province having a population of 569,042. No province – other than Kabul – has more than 2 million residents. The absolute number of deaths due to violence were highest in Nangarhar and Kabul, but the highest deaths per capita were Nangarhar, Helmand, Kunar, and Paktya, respectively. Accessibility varied widely between provinces; mean deviation from the average accessibility score was about 20 points. The two provinces where the most internally displaced people settled (on both an absolute and per capita basis) were Takhar and Kunar. In 22 provinces, more than half of the population lives in poverty; and in 6 provinces, more than 80% are in poverty. Less than a third of women are literate in every province, with the exception of Kabul. Provinces are split approximately evenly between high and low physical accessibility.

Table 2 presents data on service providers in each province. Nineteen service providers work across the 31 provinces. The median number of Sehatmandi health facilities in a province is 63; half of provinces had between 8.3 and 13.0 Sehatmandi health facilities per 100,000 population. Sehatmandi facilities make up more than half of all facilities in 28 provinces, with the exceptions being Kabul, Paktya, and Urozgan. Eighteen provinces experienced health facility closures due to anti-government elements. However, in only two cases did this result in closure for more than 5 percent of facility-days. In two-thirds of provinces, health facilities were open more than 99 percent of facility-days.

Table 1. General provincial characteristics

Province	Population (n) [1]	Population density (n/km2)	Civilian conflict deaths [2]	Civilian deaths per 100,000 population	Accessibility index [3]	Internally displaced persons [4]	Poverty (%) [5]	Female literacy (%) [6]	Transport accessibility [7]
Badakhshan	966,789	21.9	18	1.9	52.5	3885	81.5	19.8	Very low
Badghis	504,185	24.5	21	4.2	41.8	4200	56.8	4.5	Medium
Baghlan	926,969	43.9	68	7.3	73.2	11165	31.2	14	Very low
Balkh	1,353,626	78.5	85	6.3	87.8	14301	48.8	27.2	High
Bamyan	454,633	32.1	1	0.2	80.6	0	61.3	22.7	Low
Daykundi	468,178	57.9	19	4.1	69.3	51	90.2	22.5	Low
Farah	515,973	10.6	122	23.6	36.6	5451	42.6	11.6	High
Faryab	1,015,335	50.0	230	22.7	60.9	22561	55.8	12	High
Ghazni	1,249,376	54.5	253	20.3	29.1	2746	42.6	19.9	Very high
Ghor	701,653	19.2	28	4.0	45.5	4961	60.5	12	Medium
Helmand	940,237	16.0	281	29.9	21.1	1119	88.5	1.2	Very high
Herat	1,928,327	35.2	95	4.9	70.5	6620	47.9	28.3	High
Jawzjan	549,900	46.6	61	11.1	76.8	4144	65.3	15.7	Very high
Kabul	4,523,718	1013.8	596	13.2	93.7	2580	34.3	42.2	Very high
Kandahar	1,252,786	23.2	204	16.3	51.1	3860	80.7	3.1	Medium
Kapisa	448,245	243.3	39	8.7	69.5	539	45.2	33.1	Medium
Khost	584,075	140.7	84	14.4	57.4	1288	29.7	5.7	High
Kunar	458,130	92.7	128	27.9	71.3	28698	61.8	15.4	Very low
Kunduz	1,029,473	128.0	105	10.2	40.7	10465	66.4	18.9	Very high
Laghman	452,922	117.9	93	20.5	79.4	715	76.5	14	Very low
Logar	398,535	102.7	68	17.1	37.2	560	39	4.2	Medium
Nangarhar	1,545,448	200.0	681	44.1	73	21215	50.7	14.1	Medium
Nimroz	167,863	4.1	18	10.7	68.8	715	58.7	21.3	Very high
Nooristan	150,391	16.3	9	6.0	60.7	541	60.9	13.6	Very low
Paktika	441,883	22.7	67	15.2	32.2	1393	12.8	3.6	High
Paktya	561,200	87.3	152	27.1	42.4	588	73.7	8	Low
Panjsher	156,001	43.2	0	0.0	100	847	25.1	33.3	Very low
Parwan	675,795	113.1	20	3.0	86.1	203	56.3	21.9	Low
Samangan	394,487	35.0	19	4.8	91	567	88.2	14.3	Very low
Sar-e-pul	569,043	35.6	22	3.9	45.7	11858	56.6	15.7	Low
Takhar	1,000,336	81.1	26	2.6	91.9	47950	70.2	21.8	High
Urozgan	356,364	15.7	46	12.9	40.8	4485	69.6	5.6	Medium
Wardak	606,077	67.8	88	14.5	53.9	910	60.4	10.4	Very low
Zabul	309,192	17.8	57	18.4	26.4	2315	81.4	4.9	Medium

[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.

Table 2. Provincial health service delivery characteristics

Province	Service provider	EPHS imple-menter	Health Posts	Sub-health centers		Basic health centers		Compre-hensive health centers		Hospitals [1]		Other facility type		Total facilities [2]		SH facilities as % of total [2]	SH facilities per 100,000 population [2]	Total days SH facility closed due to AGE	% SH facility-days closed due to AGE
			SH	*SH*	*Other*	*SH*	*Other*	*SH*	*Other*	*SH*	*Other*	*SH*	*Other*	*SH*	*Other*				
Badakhshan	AKF	Yes	438	66	3	31	1	14	0	3	0	1	17	115	21	84.6	11.9	5	0.0
Badghis	MMRCA	Yes	311	20	0	19	1	4	0	2	0	5	25	50	26	65.8	9.9	59	0.8
Baghlan	BDN	No	722	40	0	20	4	17	0	2	1	1	6	80	11	87.9	8.6	57	0.5
Balkh	BDN	No	900	52	0	44	12	14	0	5	4	1	24	116	40	74.4	8.6	0	0.0
Bamyan	AKF	No	541	39	2	21	2	10	0	3	1	1	42	74	47	61.2	16.3	0	0.0
Daykundi	MOVE/OCCD	Yes	441	28	3	15	5	7	0	4	0	3	78	57	86	39.9	12.2	0	0.0
Farah	MRCA	Yes	389	40	0	10	1	12	0	2	0	6	41	70	42	62.5	13.6	14	0.1
Faryab	SDO/OCED	Yes	603	28	0	20	3	16	1	3	0	1	42	68	46	59.6	6.7	186	1.8
Ghazni	AADA	Yes	854	42	6	35	6	24	2	4	1	1	13	106	28	79.1	8.5	14	0.1
Ghor	CHA	No	476	40	0	26	3	8	0	2	1	15	14	91	18	83.5	13.0	115	0.8
Helmand	BRAC	No	387	14	0	45	2	15	0	3	3	1	36	78	41	65.5	8.3	0	0.0
Herat	AADA	No	1212	49	0	33	3	24	4	4	1	1	43	111	51	68.5	5.8	63	0.4
Jawzjan	SAF	No	349	21	0	14	2	7	0	2	2	1	13	45	17	72.6	8.2	0	0.0
Kabul	SDO/OCED	No	731	9	2	24	45	10	43	4	34	0	68	47	192	19.7	1.0	0	0.0
Kandahar	BARAN/OHPM	No	658	20	0	18	1	25	2	1	2	0	113	64	118	35.2	5.1	168	1.7
Kapisa	MOPH	No	309	17	0	18	1	8	0	2	0	0	5	45	6	88.2	10.0	182	2.6
Khost	OHPM	Yes	330	20	6	8	1	12	1	1	1	1	9	42	18	70.0	7.2	91	1.4
Kunar	HNTPO	Yes	322	31	4	18	0	9	0	3	0	1	4	62	8	88.6	13.5	111	1.1
Kunduz	JACK	No	485	28	4	30	3	13	0	2	2	2	25	75	34	68.8	7.3	182	1.6
Laghman	HNTPO	Yes	422	28	6	17	1	9	0	2	0	3	7	59	14	80.8	13.0	472	5.1
Logar	CAF/OPHA	Yes	213	14	0	19	4	10	1	4	0	3	8	50	13	79.4	12.5	20	0.3
Nangarhar	AADA	Yes	1018	32	0	71	10	22	0	5	3	11	29	141	42	77.0	9.1	445	2.0
Nimroz	MRCA	Yes	140	6	1	7	1	3	1	1	0	2	9	19	12	61.3	11.3	0	0.0
Nooristan	AHEAD/OCCD	No	130	22	3	8	1	4	0	3	0	0	42	37	46	44.6	24.6	967	16.8
Paktika	OHPM	Yes	228	23	0	15	1	9	0	3	0	1	9	51	10	83.6	11.5	194	2.4
Paktya	HEWAD/NAC	Yes	276	19	2	15	2	7	0	4	0	1	73	46	77	37.4	8.2	1	0.0
Panjsher	MOPH	No	122	9	0	8	1	2	0	1	1	2	10	22	12	64.7	14.1	0	0.0
Parwan	MOPH	No	426	24	0	30	1	12	0	2	0	3	9	71	10	87.7	10.5	0	0.0
Samangan	AHEAD/OCCD	No	188	21	0	14	1	4	0	3	1	6	7	48	9	84.2	12.2	0	0.0
Sar-e-pul	SAF	No	336	32	0	20	1	9	0	3	1	2	6	66	8	89.2	11.6	0	0.0
Takhar	AHEAD/OCCD	No	532	32	0	34	2	12	0	4	1	1	10	83	13	86.5	8.3	0	0.0
Urozgan	SHDP	Yes	387	33	8	9	0	9	0	2	0	3	72	56	80	41.2	15.7	153	1.8
Wardak	SCA	Yes	253	34	2	25	2	9	0	3	1	3	6	74	11	87.1	12.2	471	4.1
Zabul	SDO/OCED	No	342	22	6	14	1	8	0	1	1	1	8	46	16	74.2	14.9	0	0.0
Grand total	**n/a**	**n/a**	**15470**	**955**	**58**	**755**	**125**	**378**	**55**	**93**	**62**	**84**	**923**	**2265**	**1223**	**64.9**	**8.2**	**3970**	1.1

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

[2] Excluding health posts

Abbreviations: AGE, anti-government elements; SH, Sehatmandi

Service provider contracts

Table 3 shows basic contract financial information by province under the Sehatmandi project. The Strengthening Mechanism (SM) provinces are not included. Findings include:

- Total contract amount per capita *per annum* is USD $6.84 on average. Two thirds of the provinces fall within the range between $3.43 and $9.96. The highest per capita per annum is $17.86 for Nooristan and the lowest is $2.74 for Helmand.
- Lump-sum amount as percentage of total contract amount significantly varied from province to province. About two thirds of the provinces fall within the range of 42.0% to 59.6%. The lowest is 3.9% for Nimroz and the highest is 69.0% for Wardak.
- Two thirds of the provinces fall within the range between 33.5% and 46.7% in terms of P4P amount earned in SAPR1 as percentage of total possible payment (i.e. Maximum Level payment). The lowest is 21.6% for Badghis and the highest is 51.3% Paktika.
- The longest delays in the government payment to the service providers were 62 calendar days and the shortest days were 15 days. Two thirds of the provinces received the lump-sum payment between 18 and 31 days and the P4P payment between 36 and 54 days after submission of the second quarterly report.

Table 4; presents the ranking of provinces based on their overall performance from the best performers to low performer. At present, Performance Score is insensitive to degree of service interruption, damages and losses borne as a consequence of security incidents and disaster. In addition, no Third Party Monitor has provided verified information on performance of SPs in this period: HMIS Verification Composite Scores, BSC and QoC indicators are not available at the time of the review, and P4P indicators and Minimum Standards of Services are subject to the TPM verification. **T**herefore table 4 is not the final ranking and is subject to change once the TPM reports is available. Key findings include:

- Of all 34 provinces, 12 (or 35.3%) provinces failed to meet the Minimum Level in at least one P4P indicators.
- Eighteen of 33 provinces (18/33 or 54.5%) failed to meet the staffing conditions in the Minimum Standards.[3]
- Eleven of 34 provinces (11/34 or 32.4%) failed to submit the reports before due date.

[3] Kapisa was excluded as it did not provide information by the time of SAPR1.

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 % of total possible [4]	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	146,160,374	194,895,067	75.0%	20	45
Badghis	MMRCA	731,641,338	224,111,938	30.6%	18.0	544,950	44,643,921	96,453,702	46.3%	15	45
Baghlan	BDN	863,068,518	418,760,721	48.5%	11.3	1,024,353	70,103,428	81,710,484	85.8%	22	45
Balkh	BDN	935,600,000	368,835,905	39.4%	8.7	1,443,924	97,311,250	108,374,243	89.8%	38	45
Bamyan	AKF	803,487,873	431,165,975	53.7%	21.7	497,837	54,129,063	68,275,256	79.3%	21	34
Daikundi	MOVE	750,155,974	371,989,743	49.6%	21.6	466,580	61,814,491	69,187,347	89.3%	38	34
Farah	MRCA	834,381,853	513,669,736	61.6%	20.1	557,216	54,444,158	56,835,609	95.8%	20	34
Faryab	SDO	820,000,000	346,642,379	42.3%	9.9	1,111,124	71,846,729	85,634,316	83.9%	20	34
Ghazni	AADA	1,268,200,440	622,370,285	49.1%	12.4	1,378,237	101,942,865	116,785,821	87.3%	21	34
Ghor	CHA	994,801,291	633,644,390	63.7%	17.6	758,704	60,627,062	65,796,876	92.1%	20	34
Helmand	BRAC	744,440,349	192,348,074	25.8%	6.8	1,462,577	86,894,061	100,445,071	86.5%	20	45
Herat	AADA	1,122,611,556	748,685,448	66.7%	7.0	2,149,054	60,348,083	67,630,919	89.2%	21	45
Jawzjan	SAF	539,751,337	253,537,080	47.0%	12.1	601,405	50,111,985	53,206,248	94.2%	21	45
Kabul	SDO	523,501,708	233,554,490	44.6%	9.4	748,507	52,739,571	55,441,849	95.1%	20	45
Kandahar	BARAN/OHPM	902,495,451	552,358,327	61.2%	8.9	1,365,428	56,154,137	64,535,003	87.0%	21	59
Khost	OHPM	483,887,529	164,802,243	34.1%	10.1	644,119	55,069,142	59,043,400	93.3%	20	34
Kunar	HN-TPO/ORCD	847,393,763	274,524,030	32.4%	23.0	495,202	101,291,069	107,298,272	94.4%	22	62
Kunduz	JACK	789,482,091	249,514,342	31.6%	9.6	1,104,210	88,554,994	100,507,835	88.1%	38	34
Laghman	HN-TPO	761,677,711	406,091,565	53.3%	20.9	489,751	65,599,537	65,962,812	99.4%	38	45
Logar	CAF	986,969,801	455,879,126	46.2%	30.8	430,917	94,198,906	98,947,447	95.2%	32	34
Nangarhar	AADA/HN-TPO	2,209,709,450	293,981,050	13.3%	18.2	1,635,872	338,418,418	354,601,741	95.4%	21	52
Nimroz	MRCA	349,415,887	13,485,457	3.9%	26.0	180,931	55,117,290	62,357,026	88.4%	21	45
Nooristan	AHEAD	540,317,401	46,050,556	8.5%	44.7	162,644	53,424,805	95,038,950	56.2%	20	45
Paktya	HEWAD/NAC	660,713,484	335,003,104	50.7%	14.5	614,465	55,644,265	60,521,182	91.9%	31	62
Paktika	OHPM	753,873,259	410,081,120	54.4%	20.9	483,949	58,994,131	61,341,937	96.2%	21	52
Samangan	AHEAD	436,972,252	53,029,171	12.1%	13.8	426,033	59,181,383	70,161,648	84.4%	20	34
Saripul	SAF	527,040,409	238,157,221	45.2%	11.3	627,929	50,645,093	53,050,643	95.5%	21	52
Takhar	AHEAD	750,961,585	253,880,980	33.8%	9.2	1,094,637	76,487,502	91,754,054	83.4%	20	45
Urozgan	SHDP	732,464,086	348,628,733	47.6%	23.2	424,897	62,368,626	72,191,668	86.4%	31	52
Wardak	SCA	1,232,739,392	849,981,460	69.0%	25.3	655,462	57,820,812	67,436,560	85.7%	32	60
Zabul	SDO	434,213,465	88,580,208	20.4%	17.5	334,034	37,930,850	64,960,371	58.4%	20	45

[1] Maximum Level P4P.

[2] 1.00 USD = 74.4 AFN as per the contract. The amount is for the project life (2.5 years).

[3] RFPs for the Sehatmandi Project.

[4] Caps are only applied to services counted at annual intervals. To give a mid-year estimate of performance, a semi-annual "cap" was applied to the calculations above. The figures above do not reflect actual payment amounts made to Service Providers. In the table presented in the provincial performance review reports, the annual cap was placed in the denominator, therefore, the P4P earned in SAPR1 as % of total possible differs than that in this table 3.

Table 4: Performance Score League Table by Province.

Rank	Province name	Service Provider	HMIS Verification Composite Scores for P4P indicators (Result 1.1)	P4P indicators failed to meet 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
						BSC (Result 1.4.1)	QoC Indicators (Result 1.4.2)			
1	Daikundi	MOVE	N.A.	0	0	N.A.	N.A.	0	0	20
1	Jawzjan	SAF	N.A.	0	0	N.A.	N.A.	0	0	20
1	Kabul	SDO	N.A.	0	0	N.A.	N.A.	0	0	20
1	Kandahar	BARAN/OHPM	N.A.	0	0	N.A.	N.A.	0	0	20
1	Kunar	HN-TPO/ORCD	N.A.	0	0	N.A.	N.A.	0	0	20
1	Logar	CAF	N.A.	0	0	N.A.	N.A.	0	0	20
1	Nangarhar	AADA/HN-TPO	N.A.	0	0	N.A.	N.A.	0	0	20
8	Badghis	MMRCA	N.A.	-5	0	N.A.	N.A.	0	0	-5
8	Ghazni	AADA	N.A.	-5	0	N.A.	N.A.	0	0	-5
8	Ghor	CHA	N.A.	0	0	N.A.	N.A.	-5	0	-5
8	Herat	AADA	N.A.	0	0	N.A.	N.A.	0	-5	-5
8	Khost	OHPM	N.A.	0	0	N.A.	N.A.	0	-5	-5
8	Kunduz	JACK	N.A.	0	0	N.A.	N.A.	-5	0	-5
8	Paktya	HEWAD/NAC	N.A.	0	0	N.A.	N.A.	0	-5	-5
8	Saripul	SAF	N.A.	0	0	N.A.	N.A.	0	-5	-5
8	Takhar	AHEAD	N.A.	-5	0	N.A.	N.A.	0	0	-5
17	Baghlan	BDN	N.A.	0	-20	N.A.	N.A.	0	0	-20
17	Balkh	BDN	N.A.	0	-20	N.A.	N.A.	0	0	-20
17	Farah	MRCA	N.A.	0	-20	N.A.	N.A.	0	0	-20
17	Paktika	OHPM	N.A.	0	-20	N.A.	N.A.	0	0	-20
17	Samangan	AHEAD	N.A.	0	-20	N.A.	N.A.	0	0	-20
17	Zabul	SDO	N.A.	0	-20	N.A.	N.A.	0	0	-20
23	Faryab	SDO	N.A.	0	-20	N.A.	N.A.	-5	0	-25
23	Helmand	BRAC	N.A.	0	-20	N.A.	N.A.	0	-5	-25
23	Laghman	HN-TPO	N.A.	0	-20	N.A.	N.A.	-5	0	-25
23	Nimroz	MRCA	N.A.	-5	-20	N.A.	N.A.	0	0	-25
23	Nooristan	AHEAD	N.A.	-5	-20	N.A.	N.A.	0	0	-25
23	Urozgan	SHDP	N.A.	-5	-20	N.A.	N.A.	0	0	-25
23	Wardak	SCA	N.A.	-5	-20	N.A.	N.A.	0	0	-25
30	Badakhshan	AKF	N.A.	0	-20	N.A.	N.A.	0	0	-30
31	Bamyan	AKF	N.A.	-20	-20	N.A.	N.A.	-5	0	-45
	Kapisa	SM	N.A.	-5	N.A.	N.A.	N.A.	0	0	-5
	Panjsher	SM	N.A.	-5	N.A.	N.A.	N.A.	-5	N.A.	-10
	Parwan	SM	N.A.	-20	N.A.	N.A.	N.A.	-5	0	-25

¶ Due to lack of information, only staffing conditions in the Minimum Standards were examined.

Payment indicator performance

The performance of payment indicators is presented by province and indicator in **Table 5** and **Figure 1**. The Table is sorted top to bottom by the best performing provinces, and left to right by the best performing indicators. Overall performance is calculated by assigning 3 points if the province exceeded the cap for a given indicator, 2 points if performance fell above the index and below the cap, 1 point if performance fell above the minimum and below the index, and 0 points if below the minimum. The total score for the 10 indicators common across all provinces, the number of indicators with the province falling below the index, and the number of provincial indicators falling above the cap, are indicated to the right. Below the table is similar information calculated by indicator. A national summary is provided at the top, and is the result of comparing the sum of the index values for a given indicator in all provinces with the sum of payment services provided for that indicator in all provinces.

Eighteen provinces are performing above the index on average. Among these provinces, fourteen are exceeding the cap for at least of the indicators. However, even among these high-performing provinces, fifteen are performing below the index for at least two indicators. Three provinces – Samangan, Takhar, and Bamyan – are outliers in terms of exceptionally low performance. Please refer to the Provincial-level review reports for details.

Five indicators are performing above the index on average among all provinces – namely, post-natal care, child outpatient visits, antenatal care, tuberculosis treatment, and C-sections. However, performance on these indicators is not consistent across provinces. There are three provinces that have failed to meet the minimum for at least one of these indicators. Both tetanus and pentavalent vaccines are the poorest-performing indicators, and failed to meet the index in two-thirds of provinces. Performance on major surgeries is mixed, with 7 provinces exceeding the cap and 8 provinces falling below the index.

Payment indicators at Sehatmandi facilities have grown by an average of 10.5% per year over the past five years (**Figure 2**). However, non-Sehatmandi facilities have expanded provision of these services by 16.6% per year, which is a rate 58% higher than Sehatmandi facilities. C-sections and couple-years of protection were the two fastest-growing indicators for Sehatmandi facilities, growing at 26.5% and 13.1% per year, respectively. Less than 5% annual growth was seen for tetanus and pentavalent vaccinations at Sehatmandi facilities. The three non-payment indicators evaluated for this report (measles vaccinations, tuberculosis case detection, and care for mental health disorders) grew an average of 8.0% per year over the past five years (**Figure 3**). The annual growth rate for non-Sehatmandi facilities for the non-payment indicators was 27% higher than the growth rate for Sehatmandi facilities.

Table 5. Provincial performance on payment indicators.

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)	Provincial indicators below index (n)	Provincial indicators above cap (n)
National												**22**	**3**	**3**
Laghman												26	1	7
Hirat												25	2	7
Kabul												25	2	7
Kandahar												25	1	6
Nimroz												25	2	7
Nangarhar												24	2	6
Paktika												24	2	6
Kunduz												23	2	5
Helmand												22	3	5
Kunar												22	3	5
Logar												22	4	6
Sar-e-Pul												22	3	5
Dykundi												21	4	5
Khost												21	3	4
Paktya												21	4	6
Urozgan												21	1	2
Ghor												20	2	2
Jawzjan												20	4	4
Balkh												19	5	4
Ghazni												19	4	4
Farah												18	5	3
Zabul												18	5	3
Baghlan												17	6	3
Wardak												17	5	3
Faryab												16	6	3
Badakhshan												15	7	2
Badghis												15	7	3
Kapisa												15	7	3
Nooristan												15	6	2
Parwan												14	7	3
Samangan												13	8	1
Takhar												12	7	0
Panjsher												11	9	1
Bamyan												10	9	1
Overall indicator score (out of 102)	94	90	76	72	71	58	56	54	48	37				
Provinces below index for indicator (n)	4	3	10	11	10	21	12	22	24	30				
Provinces above cap for indicator (n)	30	25	19	16	14	11	3	8	5	4				

Note: Red color indicates that the minimum was not reached, orange indicates that performance fell between the minimum and the index, green indicates performance fell between the index and the cap, and blue indicates performance exceeded the cap.

Figure 1. Map of provincial performance on payment indicators

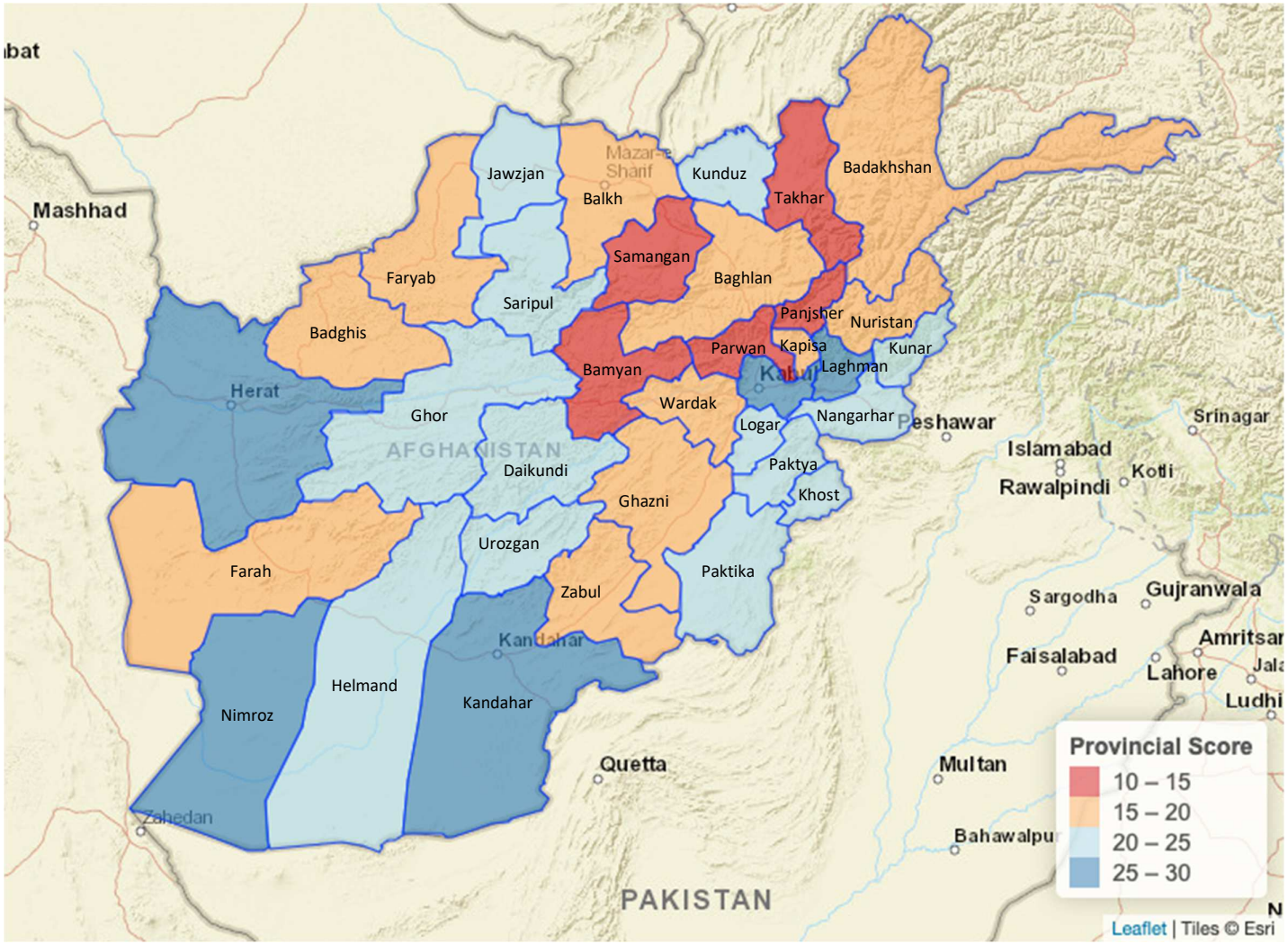
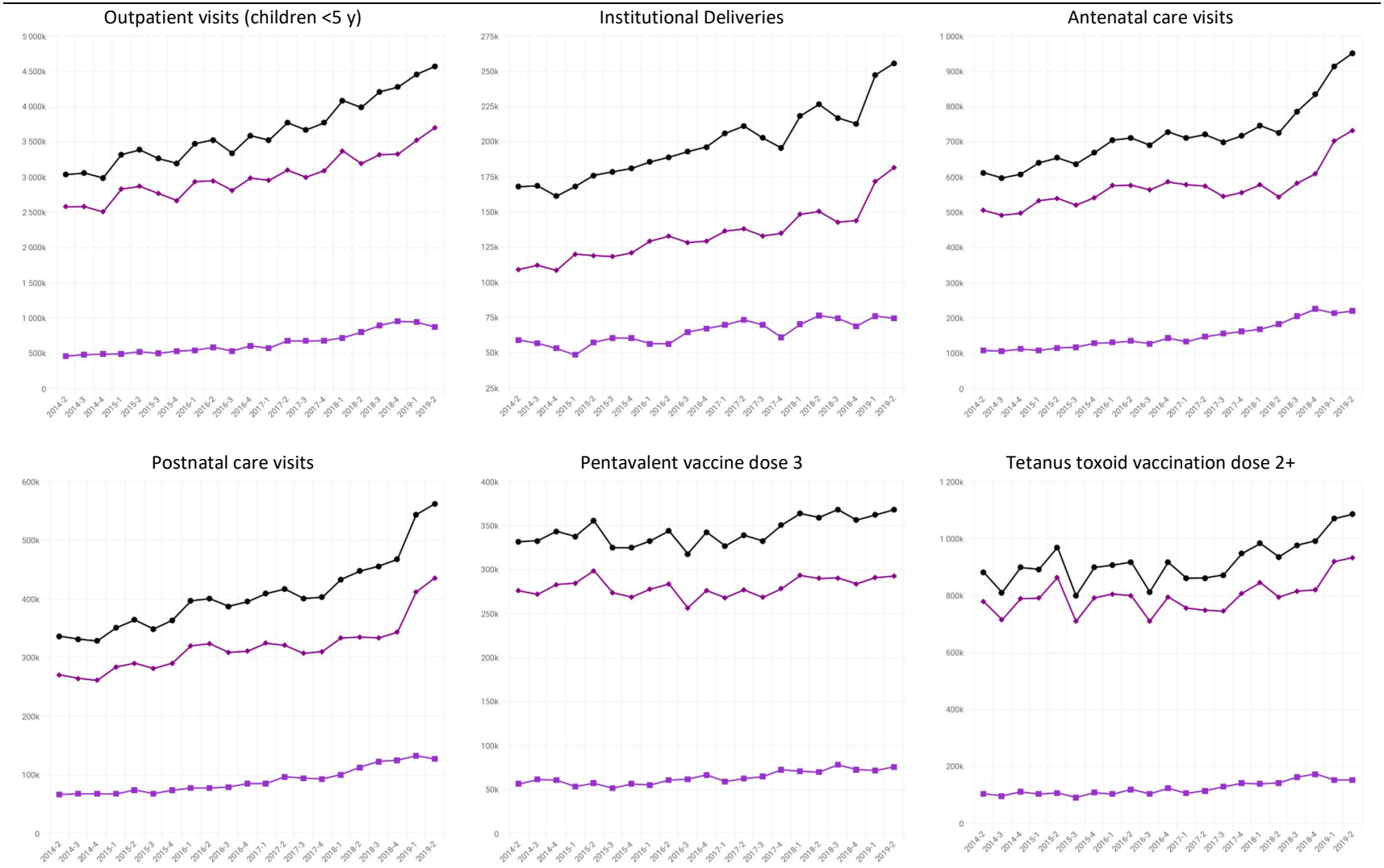


Figure 2. Payment indicator trends by quarter over the past 5 years



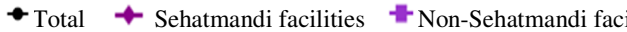
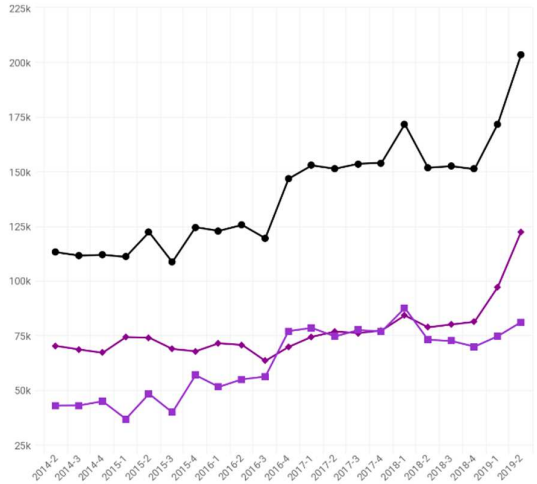
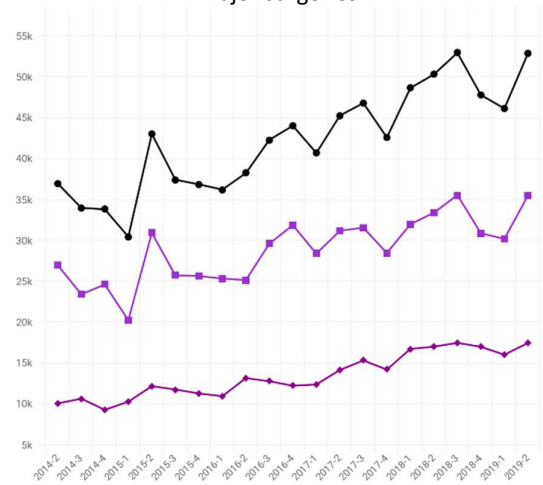


Figure 2 (continued). Payment indicator trends by quarter over the past 5 years

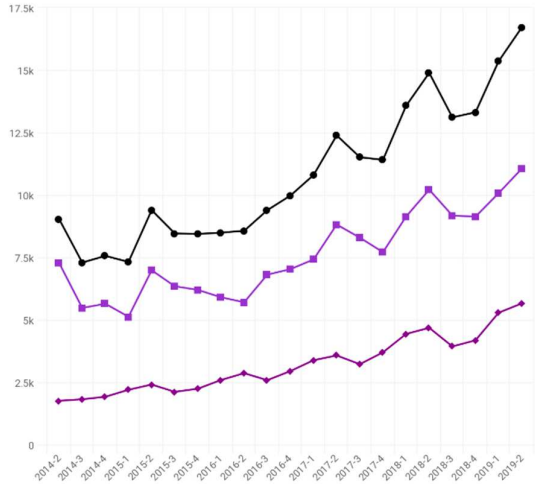
Couple years of protection



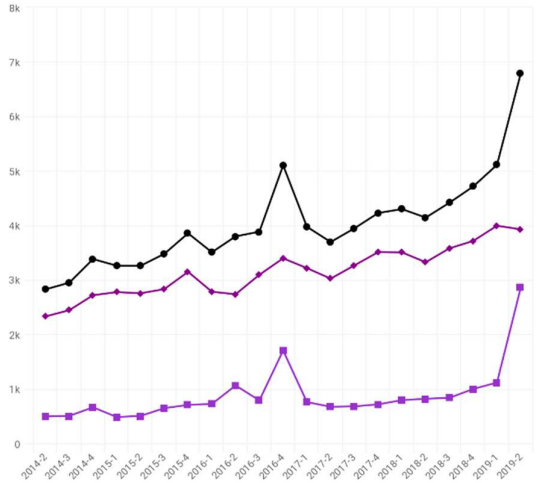
Major surgeries



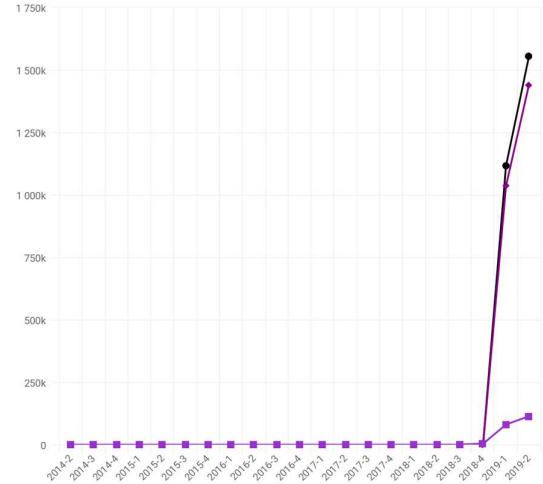
Caesarean sections



Tuberculosis cases treated

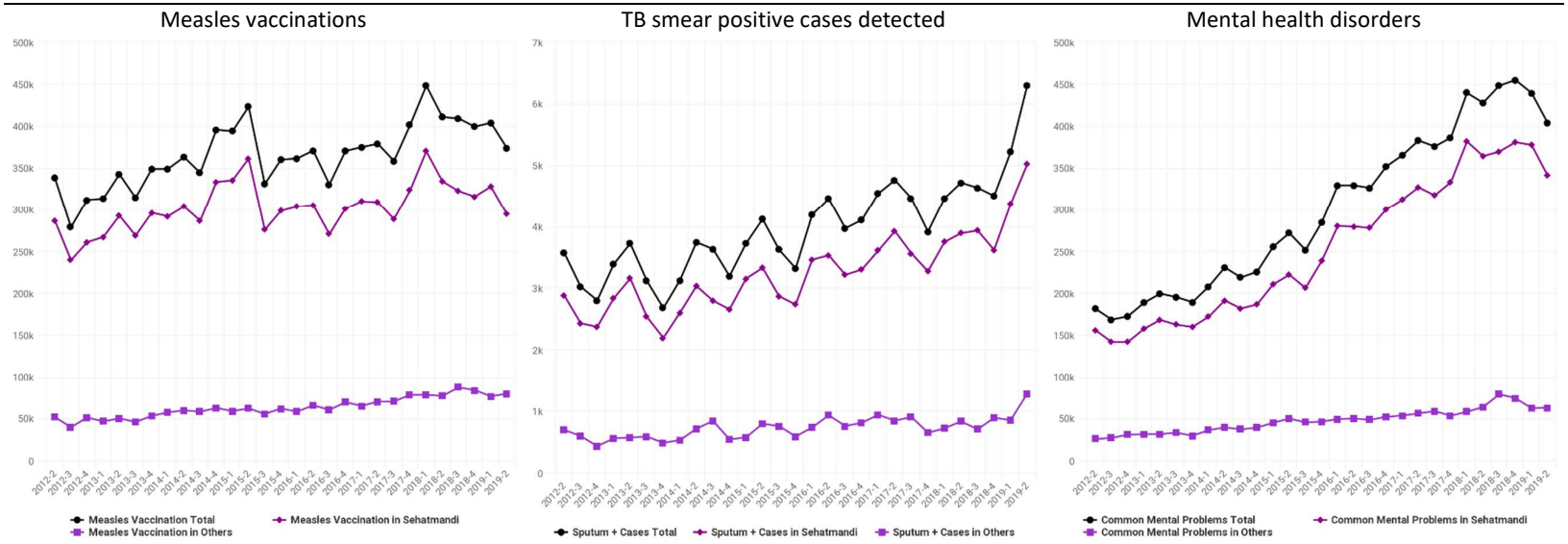


Growth monitoring and child feeding



Total Sehatmandi facilities Non-Sehatmandi facilities

Figure 3. Non-payment indicator trends by quarter over the past 5 years



Potential drivers of service delivery

Performance on payment indicators varied significantly between service providers (**Table 6**; $p<0.001$). Thirteen out of nineteen service providers exceeded the index on average across the 10 BPHS payment indicators. While the top five performing provinces (Table 4; Laghman, Hirat, Kabul, Kandahar, and Nimroz) are managed by five different service providers, two service providers (AKF and AHEAD/OCCD) are responsible or five out of the bottom six performing provinces.

The correlation between eight hypothesized drivers of performance were compared with the observed performance on payment indicators in each province (**Figure 3**). Four indicators measure insecurity in the province, namely: civilian deaths per 100,000 population, the civil servant accessibility index, the proportion of facility-days closed due to anti-government elements, and the number of internally displaced people per 100,000 population. None of these indicators suggest that service provision suffers significantly from insecurity; there exist high-performing insecure provinces, and low-performing secure provinces. Two indicators of service provider viability – proportion of facilities operated by Sehatmandi, and the proportion of the budget as the lump sum – were also examined. These similarly found no correlation with performance on payment indicators. Finally, the proportion of women who are literate and the physical accessibility of the province was examined, as these are indicators that suggest the difficulty of delivering care. No correlation was observed for women's literacy. A correlation was observed for physical access, with very highly-accessible provinces scoring an average of 4 points higher on the total payment score than very difficult to access provinces.

The prevalence of health service coverage, as measured by the Afghanistan Health Survey 2018, was also thought to be a potential determinant of performance. **Table 7** presents by province the prevalence of seven indicators that show the baseline coverage of payment indicators. In three of the seven cases, higher baseline coverage was associated with higher performance for that specific payment indicator (**Figure 4**).

Table 6. Performance on payment indicators by service provider

Service Provider	Number of provinces served	Post-natal care	Outpatient visits (children <5 years)	Antenatal care	C-Sections	Tuber-culosis treatment	Couple-years of protection	Child growth and infant feeding	Insti-tutional delivery	Tetanus toxoid 2 vaccination	Penta vaccine dose 3	Major surgeries	Total payment indicator score (out of 30)
BARAN/OHPM	1												25
HNTPO	2												25
AADA	3												23
JACK	1												23
OHPM	2												23
BRAC	1												22
CAF/OPHA	1												22
HEWAD/NAC	1												21
MOVE/OCCD	1												21
MRCA	2												21
SAF	2												21
SHDP	1												21
CHA	1												20
SDO/OCED	3												19
BDN	2												18
SCA	1												17
MMRCA	1												15
MOPH	3												15
AKF	2												14
AHEAD/OCCD	3												12

Note: Service provider is statistically significantly associated ($p<0.001$) with total payment indicator score.

Figure 4. Hypothesized drivers of total payment indicator performance

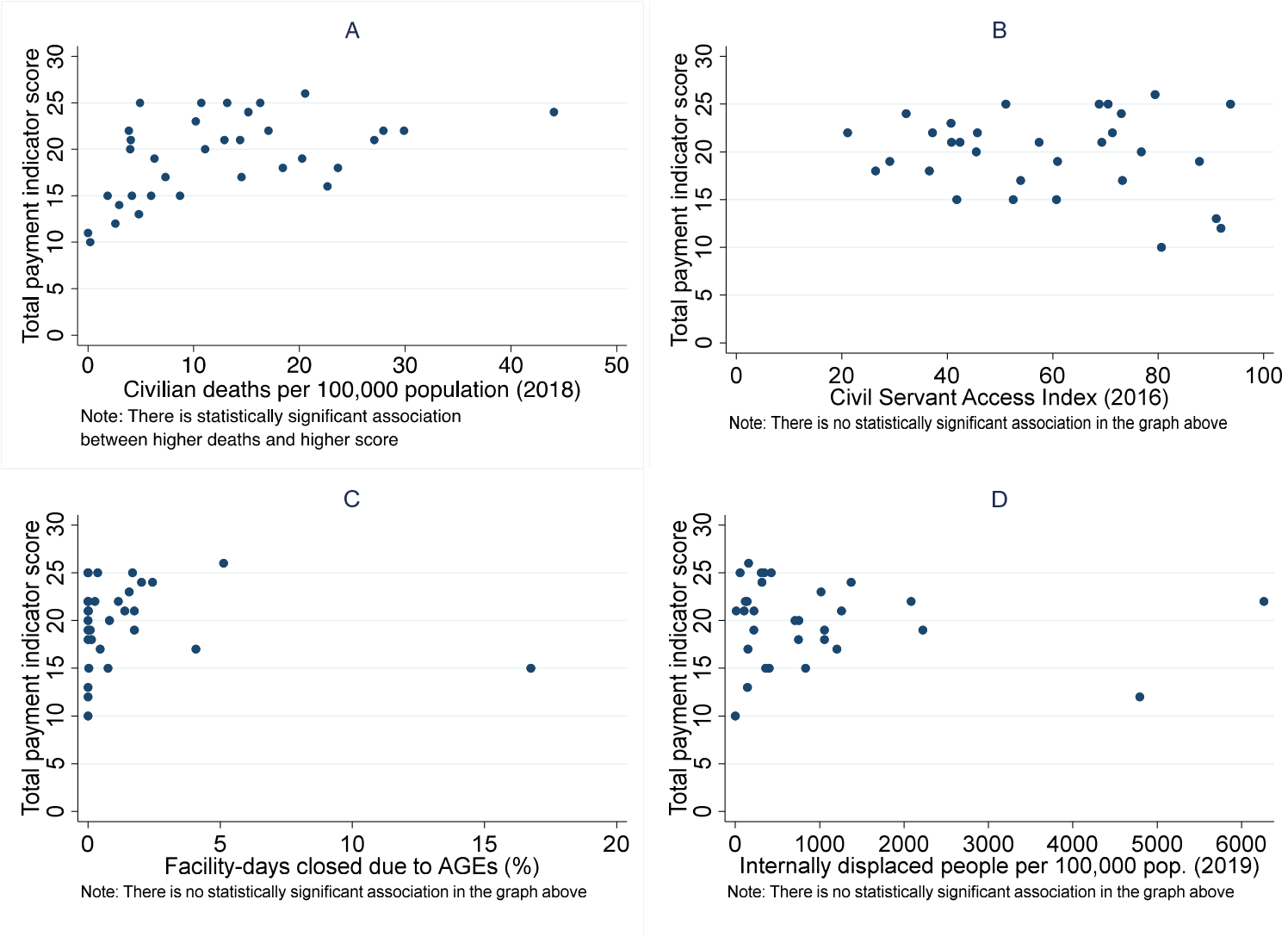


Figure 4 (continued). Hypothesized drivers of total payment indicator score

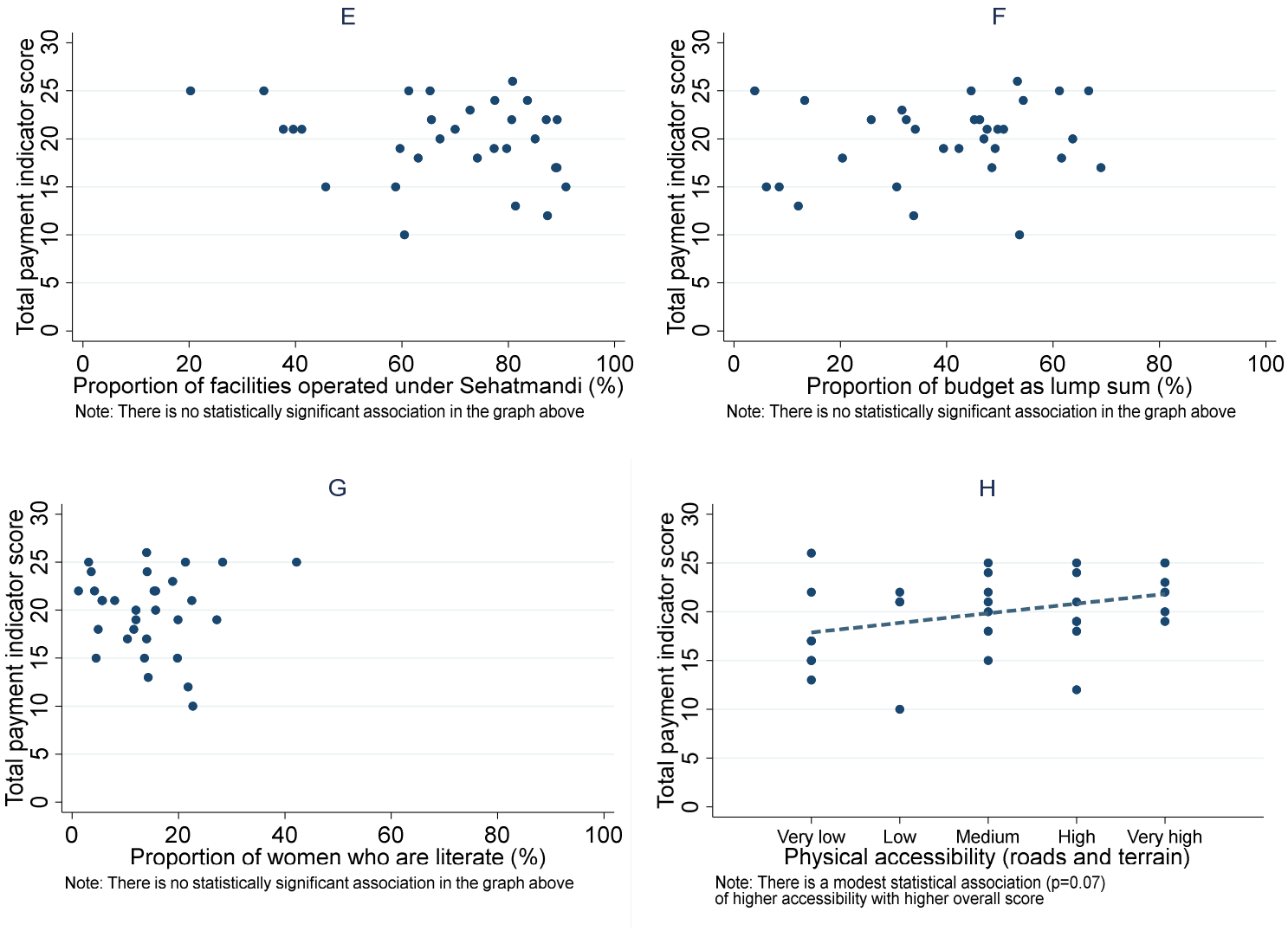
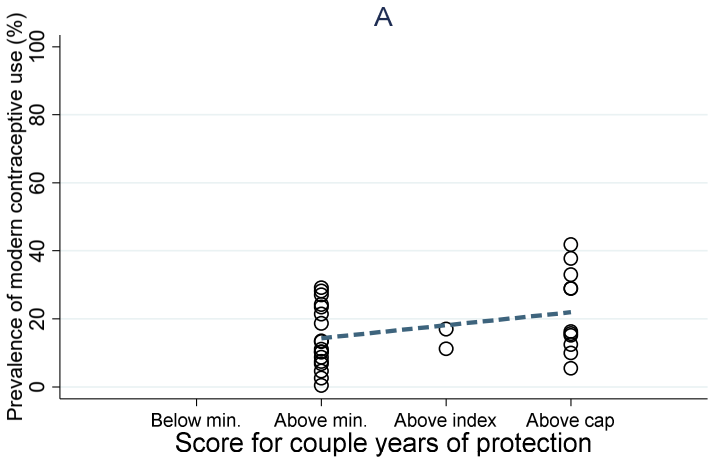


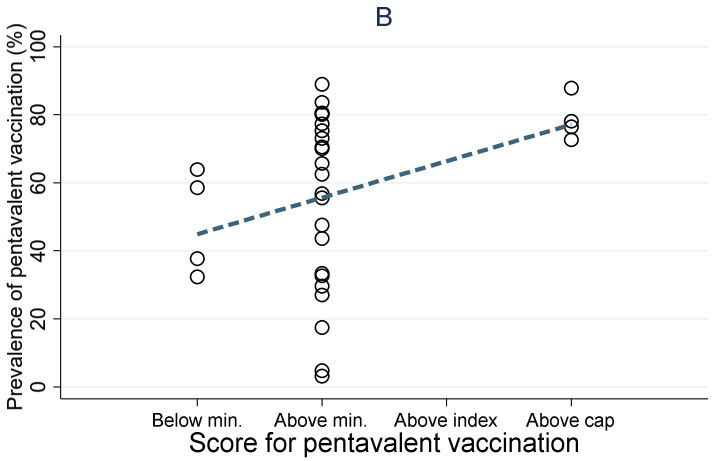
Table 7. Prevalence of health service coverage according to the Afghanistan Health Survey 2018

Province	Modern contraceptive use	Pentavalent vaccine dose 3	Any antenatal care	C-section delivery	Institutional delivery	Any post-natal care	Tetanus typhoid vaccine (≥2 doses)
Badakhshan	13.5	73.1	54.1	0.9	33.1	31.5	15.4
Badghis	29.2	37.7	44.6	3.0	19.8	15.3	9.0
Baghlan	21.4	70.6	77.9	5.7	55.6	29.3	17.4
Balkh	23.5	80.1	88.6	11.1	69.9	38.9	11.0
Bamyan	28.9	89.0	86.4	6.1	74.0	65.2	29.7
Daykundi	24.3	77.3	78.7	3.4	55.1	52.3	26.8
Farah	27.1	75.3	45.9	11.8	53.1	32.9	10.0
Faryab	4.6	56.8	48.0	2.2	42.1	18.0	18.8
Ghazni	15.2	63.9	56.9	4.2	40.8	13.6	26.2
Ghor	13.3	47.5	45.0	1.4	15.3	17.9	15.2
Helmand	10.0	17.4	16.3	0.3	23.0	11.4	4.6
Herat	41.9	78.1	75.0	10.0	59.4	52.5	17.0
Jawzjan	5.5	32.6	65.5	5.1	67.8	21.9	8.7
Kabul	28.2	72.6	78.1	17.2	85.7	54.1	17.6
Kandahar	29.0	29.6	65.1	3.2	66.9	47.7	7.8
Kapisa	18.6	62.2	66.5	5.6	67.2	38.6	31.9
Khost	2.6	33.4	35.7	0.4	19.6	21.1	14.7
Kunar	11.1	80.5	65.9	5.7	71.1	63.3	30.4
Kunduz	18.7	76.4	80.1	3.4	70.6	62.1	36.4
Laghman	17.0	70.0	80.6	6.8	72.3	25.2	14.4
Logar	10.2	80.4	80.5	14.9	92.0	31.7	23.3
Nangarhar	15.7	55.6	72.4	6.6	63.0	48.0	27.4
Nimroz	33.0	87.8	80.2	5.5	81.2	70.7	32.4
Nooristan	0.4	43.6	63.2	1.0	14.4	26.6	22.6
Paktika	16.3	27.0	46.9	7.4	43.3	25.2	23.6
Paktya	6.8	32.3	65.6	3.0	68.6	14.0	22.5
Panjsher	19.6	83.2	86.8	4.6	64.3	59.7	18.5
Parwan	22.2	79.4	81.8	5.0	66.2	52.0	27.4
Samangan	10.4	62.5	69.0	10.9	60.6	37.0	16.9
Sar-e-pul	12.4	65.7	74.2	4.8	55.4	41.1	13.2
Takhar	7.5	83.7	68.9	2.7	57.9	42.0	24.5
Urozgan	11.2	3.1	18.4	2.3	19.1	16.5	4.9
Wardak	8.7	58.6	67.9	6.1	76.5	22.3	21.1
Zabul	37.8	4.7	41.0	0.2	19.5	13.3	2.0

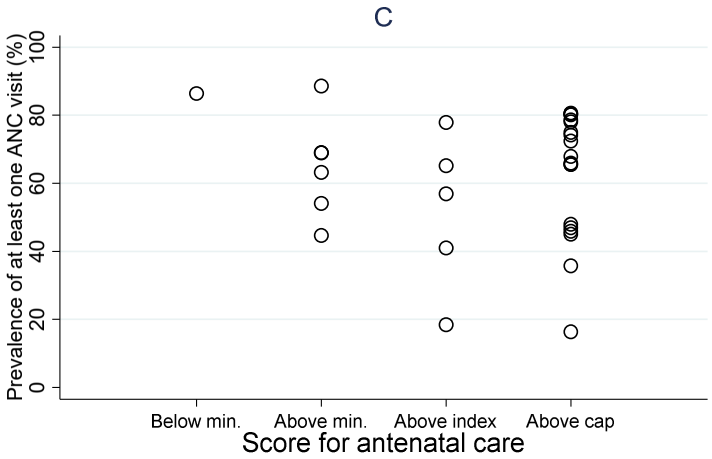
Figure 5. Association between health service coverage in 2018 and indicator-specific payment score



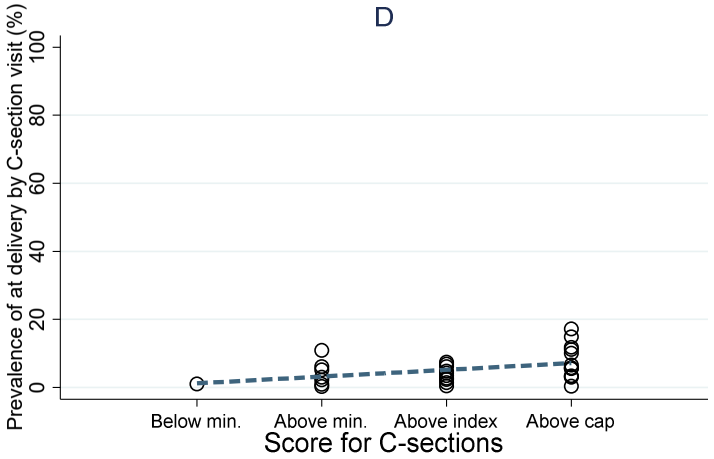
Note: There is a modest statistical association (p=0.06) between higher contraceptive use in 2018 and higher CYP score



Note: There is a modest statistical association (p=0.05) between higher pentavalent vaccination prevalence in 2018 and higher Penta 3 score

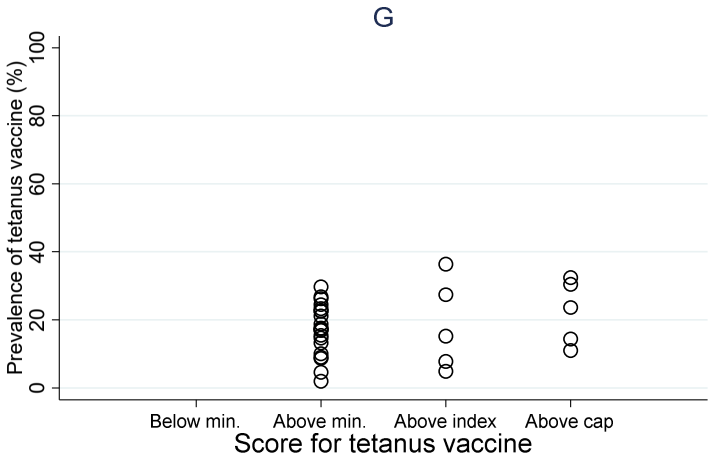


Note: There is no statistically significant association between ANC prevalence in 2018 and ANC score

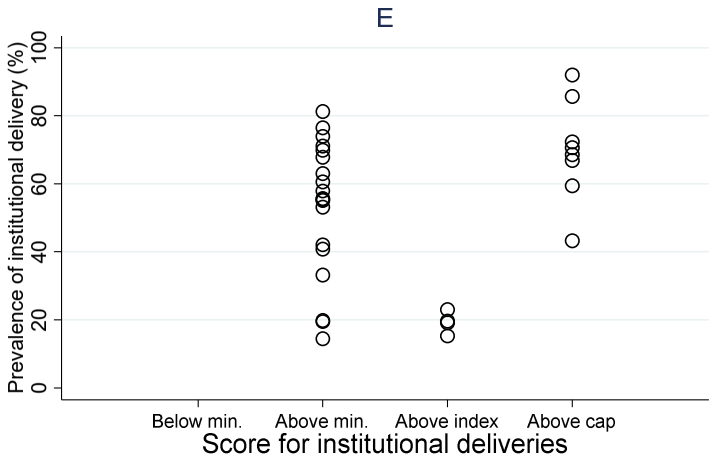


Note: There is a statistically significant association (p=0.02) between higher C-section prevalence in 2018 and higher C-section score

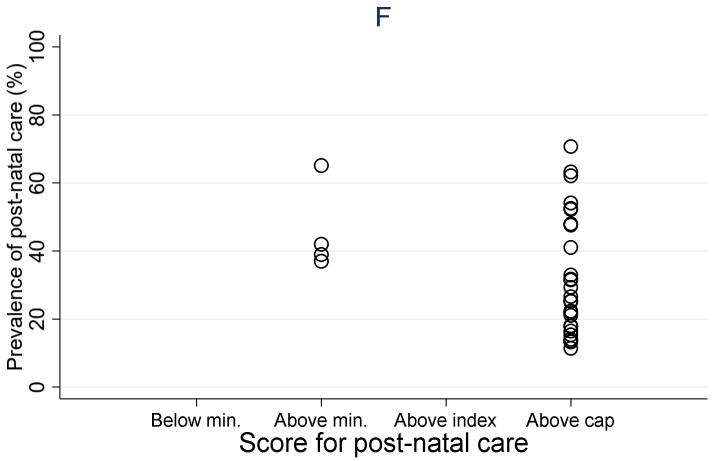
Figure 5 (continued). Association between health service coverage in 2018 and indicator-specific payment score



Note: There is no statistically significant association between tetanus toxoid vaccine prevalence in 2018 and tetanus toxoid vaccine score



Note: There is no statistically significant association between institutional delivery prevalence in 2018 and institutional delivery score



Note: There is no statistically significant association between post-natal care prevalence in 2018 and post-natal care score

Annex: Discussion Points: MOPH Presentation on SAPR1 to Development Partners

Venue, date and time: WB Office on September 24, 2019 from 1015am to 1230pm

Chairperson: HE DM P&P, Ms. Dewa Samad

Participants: MOPH (GDPP, GDEHIS, GDPM, RMNCAH, GCMU, PMO, EPI)

WB, Canada, USAID, EU, WHO, UNICEF and UNFPA.

1. **General comments:**
    a. DPs generally appreciated the efforts on and results of SAPR1.
    b. Until Third Party Monitor verifies the data used for SAPR1, caution should be taken with interpretation of the results and drawing conclusive statements.
    c. Summary of today's discussion should be tabled in the next Oversight Committee.
    d. More streamlined monitoring and supervision by MOPH will help improve effectiveness and efficiency in performance management of the Sehatmandi project.
2. **HFs supported by off-budget partners**:
    a. Important to examine how to better harmonize private and non-Sehatmandi health services with the Sehatmandi project to improve coverage and quality of health services.
    b. More analysis is needed to understand what exactly off-budget players do in provinces.
3. **Tariff and/or cap adjustment**: tariff and/or cap adjustment for P4P indicators should be based on:
    a. TPM verification,
    b. Considerations of other forms of incentive mechanism,
    c. Overall performance appraisal rather than a few better performing indicators. It's inevitable to analyze other indicators that perform poorly before making a decision to adjust tariff and cap.
4. **Proposal evaluation mechanism**:
    a. Lower bidders appear to face challenges in cash flow, likely having resulted in delayed salary payment and lack of meds in HFs. Current proposal evaluation mechanism should be revisited - financial proposal should be more rigorously evaluated.
    b. MOPH should look to contracting-out with much fewer service providers.
    c. Financial capacity of SPs should be examined and improved.
5. **Contract amendment**:
    a. Contract amendment will be made to include major surgeries performed in District Hospitals and CHC+, to detach CYP from performance for payment scheme and replace it with family planning visits and to shorten the installment interval to quarterly.
6. **SAPR1 reports**:
    a. League table by the P4P indicators performance and by Performance Scores:
        i. The current ranking is subject to change after TPM verification.
        ii. Bamyan: the operating SP has been believed to be a good performer. What were the factors that contributed to their lower ranking? See the provincial-level report for detailed analysis.
        iii. Kandahar: is believed to face a lot of problems with service delivery but ranked high. What were the factors? See the provincial-level report for detailed analysis.
        iv. Kunduz: immunization coverage in % obtained from survey does not necessarily agree with the achievements that SAPR1 examined. See the provincial-level report for detailed analysis of achievements.
    b. General recommendations from the provincial performance review committees should be included in the National-level review report.

c. Facility-level analysis carried out by PMO will help SPs identify problems and take specific actions to HF(s).
d. Correlation analysis of hypothesized performance drivers: is interesting but should not mislead the audience. When more valid data is generated, multivariate analysis that adjusts for potentially confounding variables will be carried out.
e. Misaligned or perverse incentive:
    i. Equitable distribution of services in province -e.g. Provincial Hospital dominantly contributing to targets while little is happening in SHC or PHC in remote area.
    ii. Follow up to understand the magnitude of unnecessary Caesarean section deliveries.

7. Revision of SOP:

a. Minimum Standard of Services (MSS): staffing norms and its scoring mechanism are sketchy. MOPH will nail down the definition of MSS.
b. Force Majeure events:
    i. Appear to affect the SP performance in some provinces. A revised SOP will account for the events in the performance appraisal - i.e. how to score and adjust payment.
    ii. Analysis of insecurity events to rule out outliers may provide better understanding of the impact on performance.
c. Performance Scores: as opposed to the current scoring, positive scoring will be more encouraging. Assigned weights of Performance Score will be revisited in the SOP revision.
d. How to appraise performance of TDs, PMOs and PPHDs?

8. Third Party Monitor (TPM):

a. TPM will verify data collected more than 6 months ago. They should consider potentially large recall bias involved in sample survey interviews with households.
b. TPM should include verification of more non-P4P indicators.
c. TPM should consider changing the proposed sampling method: the firm proposes sampling of data in a two-week period from 6 months.