**Islamic Republic of Afghanistan**

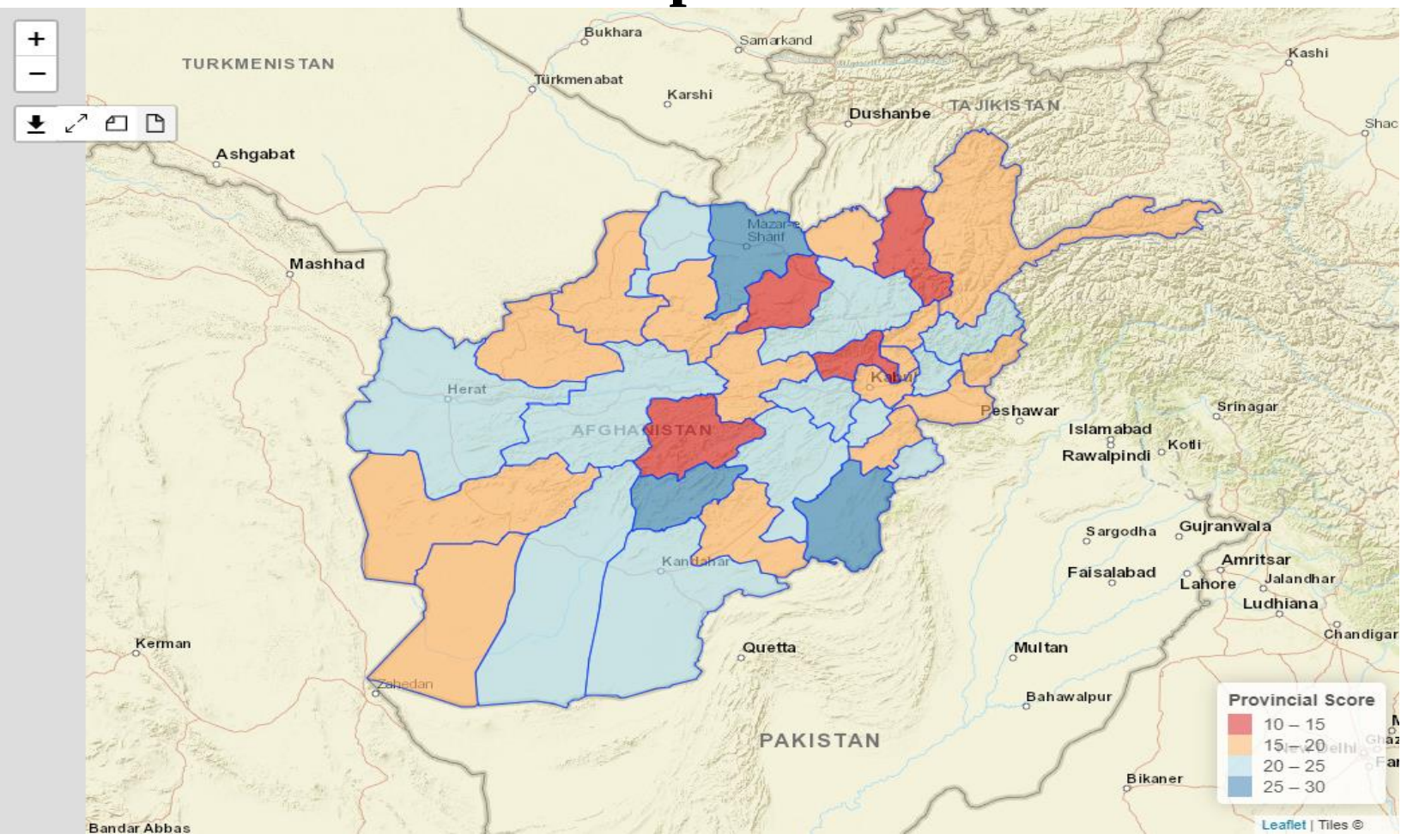
**Ministry of Public Health**

**Performance Management Office**

# *Sehatmandi*

# Semi-Annual Performance Review-3

# Report




April - September 2020

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**Executive summary**

This semiannual performance review report covers April – September 2020.This was characterized by a new global challenge, the COVID-19 pandemic and accompanying lockdowns and restrictions which directly impacted delivery of the essential health services. The global assessments indicated a major reduction in service utilization. In Afghanistan also, there was an impact in the second quarter of 2020 (April- June 2020), but the service delivery bounced back in the third quarter (July to September) 2020. Overall, the impact of COVID 19 was much less in Afghanistan than what was reported elsewhere globally on delivery of the essential health services.

The key conclusions of the Semi Annual Performance period April – September 2020 are summarized below:

1. The *Sehatmandi* project has catalyzed establishment of a partnership model between the Government and the Service Providers (SPs) for delivery of BPHS and EPHS in Afghanistan to its population despite challenges in technical capacities, numerous HR challenges (like staff turnover, shortage of female staff and insecure living and working conditions) and continued conflict and fragility. This is acknowledged by the fact that the performance management structure of the MOPH is being utilized to monitor the COVID-19 activities.

2. The Performance Management Office continued to work closely with the SPs and dedicated an average of over 13 days per province to field missions during the semi-annual period under reporting.

3. The SAPR3 league table shows an overall increase in all levels of the service delivery for the reporting period. The number of provinces in the blue category (performance above 90% score) has more than doubled from 4 to 9. The provinces which have been able to achieve this include Kunduz, Balkh, Herat, Jawzjan, Wardak, Badakhshan, Badghis, Baghlan and Laghman. Only Balkh and Herat have been able to retain the highest category between R2 and R3.

4. Number of provinces in the green category (scoring between 90 and 70%) has remained more or less the same with a drop of one province (from 19 to 18). As a result, there is a major decrease in the province minimum and index and their number of provinces in this group has halved (from 10 to 6) .

5. Based on the R3 data, four provinces in the score ranging from the 70 to 40 points included Samangan, Kapisa, Parwan and Faryab.

6. Nooristan was the only province with performance below 40 points and ranked at the bottom of the league table once again like the previous rounds.

7. The major shuffling of the performance ranking can be attributed to lockdown and diminished use of the facilities due to apprehensions associated with COVID 19 in selected provinces.

8. An analysis of the quarterly data show that there was after a dip in the first quarter (April to June 2020) the facility usage has, however, gone up in the second quarter ( July – September 2020) after effect of the first wave of COVID 19 reduced. The service delivery bounced back soon on the strength of pay for performance model of payment, work of the SPs and timely and strong support provided by the Ministry of Public Health to the Service Providers.

9. Overall analysis of the league table shows the following important derivations:
    1. Payment indicators performance – The average score is 21. The maximum possible and the median score is 22. Of all the provinces, 26 had a perfect 22 score. The lowest scores were 12,14 and 16 respectively for Parwan, Kabul and Takhar.
    2. HMIS verification – the average score is 16 as against a maximum possible of 18. Thirty provinces had a perfect score of 18, which is also the median. Nooristan, Parwan and Panjshir ended up with zero score. While another SM province Kapisa attained 9 out of 16.
    3. Minimum standards of service – the average score is 14. Kunduz had the perfect score of 20 out of maximum of 20 points. Nooristan with a score of 2 was at the bottom of the league table.
    4. PIP progress – This attribute along with Salary payment and timely submission of the report has binary scores, zero or full score.
    5. As many as 25 provinces were given full score of 5 on PIP and the remaining 9 provinces had zero score. There are substantial issues with the PIPs as described in another chapter of this report.
    6. Salary payment – was one of the poorest performing domains with only 19 provinces had a full score whereas the remaining 15 provinces received zero point. This is an issue of serious concern as this indicator reflects on financial processes and impinges on staff motivation and productivity.
    7. Timely submission of the report – Except for two provinces namely Samangan and Bamyan, every other province submitted the report on time. In a way this indicator can be taken off from the League table based on the decision of the SOP Committee during the upcoming revision.

10. JACK serving Kunduz has registered the best performance in the reporting period and has attained perfect score in the league table. Overall, 9 provinces retained themselves in the top category.

11. Three of the provinces (Takhar, Nooristan and Samangan) managed by AHEAD remained in the bottom six of the table. Takhar has ranking of 29 and Samangan has a rating of 33 in the League Table whereas Nooristan retained its last position rank 34.

12. Regarding the minimum standards as defined in SOP/BPHS guidelines for BPHS facilities, as many as 8 provinces scored above 95% provincial functionality score. Overall, as many as 29 provinces scored above 85 points on the provincial functionality score for BPHS.

13. For EPHS, as many as 8 provinces achieved a functionality score of 95% and above for minimum standard of services. All provinces except one achieved above 85 per cent provincial functionality score.

14: Another issue here is performance of Strengthening mechanism (SM) provinces, which despite laxed criteria for performance assessment, have not been able to perform as expected.

15: An analysis of the PIPs showed several issues questioning its effectiveness in some provinces to make improvements. Protracted problems like erratic supplies and shortages of medicines, persistent HR issues ( like shortage of female staff, insecure working environment, and staff turnover), inadequate engagement of the provincial leadership and data quality cut across many provinces.

16: The technical departments, besides participation in review meetings and visits, have a much bigger role in critically analyzing their respective P4P indicators, reasons for the change and how they relate to the data arising from other sources. Another aspect which needs inclusion in the performance is the component of quality of health services. This again need to be discussed and agreed to in the proposed revision of the SOPs.

17: There is direct impact of insecurity on the program performance, for example, the ‘ban’ on outreach immunization services by Taliban cut across many provinces.

18: Information compiled by the Finance unit showed improvement in the timeliness of the payment. For lumpsum payment, there are no reported delays. There is a long process involving eleven steps leading to P4P payments to be received by the SP.

19: Expenditure analysis of two extreme provinces, with highest and lowest lumpsum proportions, showed that two-thirds of the expenses are on account of fixed costs like salaries, equipment. This makes the provinces with low Lumpsum proportion much higher risk of failure if their performance falls short of high achievements. This analysis makes a strong case for protecting the fixed costs by lumpsum payments.

20: The results of the three rounds of the rural scorecard show that overall, for Health Sub Centre, MSS has registered an increase in their ability to meet them. From 76% in the first round, the compliance improved to 83% in the third round. For Basic Health Centers, it improved between round one and two (from 77% to 85%) and then registered a slight decline in the third round (83%). The Comprehensive Health Centre, the compliance was reported to be relatively high, and it increased from 89% in the first round to 94% in the third round.

The following recommendations are being made keeping in view the long term performance of the Project. it has been agreed that the project will be extended beyond its original deadline of June 30, 2021 for some more years.

National level actions

1) Sharing the approach and lessons globally – It is important to document and share Afghanistan experience with (a) partnership service delivery model; and (b) using pay for performance modality, with wider global community through a publication in a peer-reviewed journal. This will be of particular interest for fragile and conflict countries with weak government systems and capacities.
2) Health reform agenda – The massive resources being invested in Afghanistan is an opportunity to make few reforms for long term impact and legacy – for example, financial management process, human resources issues like production and utilization of critical shortage categories (e.g. female doctors), data triangulation to validate the performance indicators with surveys and utilization pattern of the drugs and vaccines, streamlining multiple types of health facilities into fewer categories with clear functionalities.
3) Cash flow problem – This can be resolved by linking the lumpsum amounts with fixed costs as a guiding principle. There are lessons to show that voluntary projection of the lumpsum and P4P amounts by the NGOs risks a future problem. There is sufficient data and regular frequency to create a dashboard of the financial information in the public domain for transparency and accountability. The SOPs for cash flow to the SPs need to be implemented in totality and time bound mechanism need to be enforced to ensure that the SPs are paid in time. This in turn will lead to continuity of services which may be affected due to inadequate cash flow with the SPs.
4) Expenditure MIS – The existing expenditure MIS should be reviewed to explore if it includes the *Sehatmandi* expenditure data from the provinces, and if not, whether this can be included.
5) Procurement and supplies – This is cross cutting bottleneck. There is striking contrast in availability of the drugs and vaccines, better for one's procured nationally than what is procured at the provincial level. A proper deliberation needs to be scheduled with the SPs to understand the bottlenecks and fix them to ensure maintenance of adequate supplies.
6) Technical departments – The TDs involvement need to be augmented during the field visits and the reviews. They need to critically analyze the respective P4P indicators and prepare their own brief reports periodically. This is a consistent recommendation right from SAPR1. It states more active engagement for improving the quality of services and helping the SPs increase coverage. It is suggested that the SPMSs should request the TDs of the department where the SP is under performing to join the missions during their quarterly visits. This will ensure adequate coordination and along with the PPHD staff, these missions could be much more useful.
   There has been little progress with mainstreaming off-budget projects for better coordination of the activities and synergies with *Sehatmandi* Project. Does the ongoing National health accounts exercise cover this?
7) Performance improvement plan (PIP) – The PIP has been established as an important tool to resolve implementation bottlenecks. A comprehensive review is required to improve the tool and its format to make it more effective.

Provincial level and Strategic Partner level actions

1) Provincial leadership – There is significant gap in the ownership and engagement of the provincial leadership (beyond the PPHD). For example, the Provincial performance review committee does not engage adequately with PIP follow up actions except for the signatures on the document. Multiple provinces complained of political interference and undesirable instructions in the HR recruitment process.
2) Erratic supplies and shortages of medicines are universal issues. The two key determinants of service delivery and its quality are the staff and assured supply of essential medicines at a health facility. The SPs should, as recommended earlier, work with MOPH to identify the ways to address these and then implement the steps agreed during these deliberations.
3) Mapping of banned areas – In spite of the fact that the project contracts consider insecurity, there is a need to have realistic mapping of the security compromised areas scrolled down to the health facility level. This will underscore the extent of insecure areas and manage the expectations accordingly. If possible, segregated analysis by secure and insecure areas may be done in future. In the short term, the Force Majeure need to be implemented to ensure that all the security related issues are documented, agreed upon at an appropriate level and the SPs are compensated as per the SOPs for these conditions beyond their control.
4) Renovation of the HFs – This need to be fast-tracked to make them client friendly and be visually appealing. This is a recommendation right from the SAPR1.

# 1. Introduction

*Sehatmandi* is an important project and financial support for the health sector in Afghanistan to establish a sound foundation for delivery of health services to its population through two modalities – Basic package of health services (BPHS) and Essential package of hospital services (EPHS). The project cost is $600 million for the period January 1, 2019 to June 30, 2021. The semi-annual performance review (SAPR) triggers release of funding tranches by the World Bank. The original timeline of the project ends in June 2021. The focus of the SAPR3 is on the areas encountered as particularly problematic for good performance to address them now and when the project is extended beyond this deadline.

The current SAPR covers six months' period of April to September (Q6 and Q7 of *Sehatmandi* Project) 2020. It is third in the series with preceding nine and six months respectively covered by earlier two reports.

There are two aspects to report for performance – financial and programmatic. The financial performance covers the amount of the funds paid to deliver the services, timeliness of the payments and expenditure analysis. The programmatic performance includes services delivered, change in the indicators' value, changes in the quality of care in terms of client satisfaction (clinical outcomes are not included in the tool) with an eye on the overall coverage. Since the project follows 'pay for performance' model, the importance of the data and indicators is paramount in terms of its accuracy, consistency, and reliability. The performance is presented by a thematic program rather than individual indicators alone.

Besides above two pillars of performance, this report dwells on two additional elements – (a) spread and impact of COVID-19 on the services and indicators as reported through HMIS data, and (b) analysis of the Performance improvement plans (PIP) - a chapter has been included summarizing the lessons, challenges, and way forward for using PIP as the improvement tool in future.

The standard operating procedures (SOPs) guide the project operations and the reviews. Any activity or reference not within the scope of the SOPs must have strong verification. The project activities will continue without change till at least June 2021. Hence the recommendations arising out of the lessons learnt and challenges have been presented as long-term actions beyond June 30, 2021.

# 2. Performance review process

The performance review is both an extensive and intensive process. There are three tools used –

(1) Periodic reports like monthly HMIS data from each facility upwards; monthly updates from each province; and quarterly and semi-annual reports after completion of the respective reviews.

(2) Field visits of two types – Senior Performance Management Specialist (SPMS) from PMO either alone or pairing with another colleague visits a province each quarter covering selected hospitals and health facilities (HFs), usually in combination with quarterly provincial review; and high level ad-hoc visit to the provinces identified as problematic.

(3) Quarterly and Semi-annual performance reviews for each province - Whereas the former is organized in the respective provinces, the latter is conducted in Kabul. The SAPR reviews are attended by the PPHDs in Kabul. Both these reviews are chaired by the provincial health directors with active participation by the SPs and PMO staff. Other participants include the technical departments, UN agencies and occasionally the development partners. The format of the review is uniform as described in the SOPs. The duration of both reviews is one day. Some provinces and participants have recommended a longer duration, at least for the SAPR. The experience has shown that the intensity of the discussions, especially with the progress of the PIPs, needs longer time as otherwise the same issues are repeated in the next revised PIP. A decision may

be taken to extend these reviews depending on the issues under discussion on case by case basis. The review process has reached a level of maturity by way of frequency and consistency in approach.

As per the records of the PMO, the PMO staff had spent on about 450 day on field visits during the six months' period from April to September 2020. This gives us an average of over 13 days per province, bulk of which relates to two quarterly review visits to provinces.

Moving forward, it is important to exploit fully the performance review tools used with modifications and broadening the agenda based on the lessons learnt.

## 3. Major achievements and challenges so far

Before getting into the details of the performance of SPs, the following four achievements were made by the project thus far:

1) Establishment of the Service delivery model – the *Sehatmandi* project has catalyzed establishment of a partnership model for delivery of BPHS and EPHS in Afghanistan to its population despite challenges in Government capacities, HR challenges, and continued conflict and fragility. More than a decade back in post-Taliban period, it was recommended that the country should try a partnership model. This is now operational through *Sehatmandi* project. It is worthwhile to document this experience as a publication for a peer-reviewed journal for global sharing of the lessons for similar fragile and conflict countries which have weak Government systems.
2) Improved performance – The league table shows higher scores in this round compared to the first two rounds. This shows that in general the service delivery and its management has improved.
3) Progress with the indicators - In general, the progress has been positive. This is significant in the backdrop of continuing conflict wherein more than two-thirds of the country is directly or indirectly impacted. The progress with specific indicators shows inconsistencies. The end of project evaluation will bring out the overall improvements made during three years' period.
4) Limited impact of COVID pandemic on essential health services – Whereas globally, the impact of the pandemic has been assessed to an extent of 70% decline in essential services, in Afghanistan this has been far very limited as revealed by the HMIS data.

While listing the achievements of the project, it is important to list the persistent problems and challenges:

1) Provincial leadership – It has been observed that there is difference in the project ownership between the national and provincial leadership. The overall picture appears presents a 'push' approach by the national leadership. Efforts like increased involvement of the PPHOs on missions, review and performance assessment may be the way forward. However, one significant difference is the technical capacity of the Central MOPH staff and that of the Provincial colleagues is different. Efforts need to be made to augment technical capacity of the provincial staff on the ongoing basis.
2) HR issues especially presence of females in the work force in remote areas - The HR issues continue to impact the service delivery be it availability and of interest of the qualified persons, local interference in recruitment process and staff motivation. Shortage of the female doctors is the main issue across the country.
3) Procurement and supplies – Without exception, each province reported sporadic shortages and stock outs of the essential pharmaceuticals. There is striking contrast in availability of the drugs and vaccines, being better for one's procured and supplied by national mechanism than what is procured

at the provincial level. Moving forward there is a need to conduct a rapid feasibility study to assess the supply chain and related issues and fix the issues based on the study's recommendations.

4) Performance Improvement Plans – Conceptualized as a key tool to trigger performance improvement, the PIP needs further strengthening . The performance score does not capture the full depth of the issues with the PIP, described in a separate chapter.
5) Data quality – The *Sehatmandi* project has done a commendable task of establishing a good HMIS system backed up with TPM verification model. The TPM reports indicate a high level of consistency between reported and verified data.
6) However, there is a need to have the coverage survey so as to see impact of these interventions and their success can be documented. This will also assist in setting new benchmarks for measuring success going forward. Besides this will motivate the Project staff to work with added vigor and fix any areas that need strengthening to ensure that their work has needed impact on the beneficiaries.

# 4. Progress trends in the Provinces

The summary of the progress in the provinces is given in the League table ( Table 2) on the following pages. Based on the league table, the performance is grouped into four categories of consequences as per the SOPs. The table 1 shows the details as follows:

Table 1: Provincial progress made by Service Providers from SAPR1 to SAPR3

| *Number of Provinces* | *SAPR3 Performance* | *SAPR 2 performance* | *SAPR 1 performance* |
|---|---|---|---|
| Blue category – Appreciation letter | 9 | 4 | 1 |
| Green category _ Verbal notice | 18 | 19 | 13 |
| Yellow category – notification letter | 6 | 10 | 18 |
| Red category _ warning letter | 1 | 1 | 2 |
| Total provinces | 34 | | |

The overall progress based on the league table during the SAPR3 period as compared to SAPR 2 is given in Table 2. The ranking of the SAPR3 have been added after the verified Third Party data for round 3 has been provided.

The data from SAPR3 shows an overall increase in the service delivery though number of provinces in the blue category (beyond cap) has more than doubled from 4 to 9. The provinces which have been able to achieve beyond their cap overall include Kunduz, Balkh, Herat, Jawzjan, Wardak, Badakhshan, Badghis, Baghlan and Laghman. Only Balkh and Herat have been able to retain the highest category between R2 and R3. Number of provinces in the green category, performance between index and cap has significantly remained more or less same with a drop of one province (from 19 to 18). There is a major decrease in the province minimum and index and their number of provinces in this group has halved (from 10 to 6) . Based on the R3 data, four provinces in the bottom category include Nooristan, Samangan, Kapisa, Parwan and Faryab. This major shuffling of the performance ranking can be attributed to lockdown and decreased use of the facilities due to apprehensions associated with COVID 19. An analysis of the quarterly data in the section 5 shows there after a dip in the first quarter (April to June 2020) the facility usage has gone up significantly in the second quarter (July – September 2020) after effect of the first wave of COVID 19 weaned out.

## 4.1 The League Table

The league table (Table 2) of SAPR round 3 shows a major increase in overall performance with 9 provinces performing beyond cap and these include Kunduz, Balkh, Herat, Jawzjan, Wardak, Badakhshan, Badghis, Baghlan and Laghman.

As many as 18 provinces have been able to retain themselves in the category between max and index and these form about 53 per cent of the provinces. There are six provinces between index and minimum and these include Panjshir, Takhar, Faryab, Parwan, Kapisa and Samangan. The lowest category was retained by Nooristan.

Looking at the individual attributes contributing to the performance,

1. Payment indicators performance – The average score is 21. The maximum possible and the median score is 22. Of all the provinces, 26 had a perfect 22 score. The lowest scores were 12, 14 and 16 respectively for Parwan, Kabul and Takhar, respectively.
2. HMIS verification – the average score is 16 as against a maximum possible of 18. Thirty provinces had a perfect score of 18, which is also the median. Nooristan, Parwan and Panjshir ended up with zero score. While another SM province Kapisa attained 9 out of 16.
3. Minimum standards of service – the average score is 14. Kunduz had the perfect score of 20 out of maximum of 20 points. Nooristan with a score of 2 was at the bottom of the league table.
4. PIP progress – This attribute along with Salary payment and timely submission of the report has binary scores, zero or full score.
5. As many as 25 provinces were given full score of 5 on PIP and the remaining 9 provinces had zero score. There are substantial issues with the PIPs as described in another chapter of this report.
6. Salary payment – was one of the poorest performing domains with only 19 provinces had a full score whereas the remaining 15 provinces received zero point. This is an issue of serious concern as this indicator reflects on financial processes and impinges on staff motivation and productivity.
7. Timely submission of the report – Except for two provinces namely Samangan and Samangan, every other province submitted the report on time. In a way this indicator can be taken off from the League table based on the decision of the SOP Committee during the upcoming revision.

In summary, the key messages from the analysis of the League table are:

1) Overall, there is good positive performance improvement.
2) Despite critical financial issues, the indicators are scoring well.
3) Nooristan is the only province within red zone, and it has not been able to come up to register improvement since the last review. .
4) JACK has registered the best performance and it attained perfect score in the league table. Overall, 9 provinces retained themselves in the top category.
5) Three of the provinces Takhar and Samangan managed by AHEAD remain in the bottom six of the table. Takhar has ranking of 29 and Samangan has a rating of 33 in the League Table whereas Nooristan retained its last position.
6) The MOPH's strengthening mechanism provinces have low rankings Two of these provinces are among the bottom 5 . in due course of time, the SM contracting in needs a critical review.

## Table 2: SAPR Performance Score League Table R3 April – September 2020

| Sehatmandi- SAPR-3 League (Ranking) table- Period March- September 2020 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Provinces | Service provider | 1.1 Payment indicators performance (0ut of 22 points) | 1.2 HMIS varification Score(out of 18 points) | 1.3 MSS (out of 20 points) | 1.4 BSC (out of 20 points) | 1.5 Progress in PIP( out of 5 points) | 1.6 Salary Payment (out of 10 points) | 1.7 Report Submission( out of 5 points) | Total Performance score (out of 100 points) | Ranking |
| Konduz | JACK | 22 | 18 | 20.00 | 20 | 5 | 10 | 5 | 100.00 | **1** |
| Balkh | BDN | 22 | 18 | 18.94 | 20 | 5 | 10 | 5 | 98.94 | **2** |
| Herat | AADA | 22 | 18 | 18.90 | 20 | 5 | 10 | 5 | 98.90 | **3** |
| Jawzjan | SAF | 22 | 18 | 18.90 | 20 | 5 | 10 | 5 | 98.90 | **3** |
| Wardak | SCA | 22 | 18 | 17.60 | 20 | 10 | 5 | 5 | 97.60 | **5** |
| Badakhshan | AKF | 22 | 18 | 15.20 | 20 | 5 | 10 | 5 | 95.20 | **6** |
| Badghis | MMRCA | 20 | 18 | 16.00 | 20 | 5 | 10 | 5 | 94.00 | **7** |
| Baghlan | BDN | 22 | 18 | 12.82 | 20 | 5 | 10 | 5 | 92.82 | **8** |
| Laghman | HNTPO | 22 | 18 | 15.20 | 20 | 0 | 10 | 5 | 90.20 | **9** |
| Kunar | HNTPO | 22 | 18 | 9.60 | 20 | 5 | 10 | 5 | 89.60 | **10** |
| Nengarhar | AADA | 22 | 18 | 9.60 | 20 | 5 | 10 | 5 | 89.60 | **10** |
| Ghazni | AADA | 22 | 18 | 19.20 | 10 | 5 | 10 | 5 | 89.20 | **12** |
| Nimroz | MRCA | 22 | 18 | 18.81 | 20 | 5 | 0 | 5 | 88.81 | **13** |
| Kandahar | BARAN/OHPN | 22 | 18 | 17.92 | 20 | 5 | 0 | 5 | 87.92 | **14** |
| Logar | CAF | 22 | 18 | 17.60 | 10 | 5 | 10 | 5 | 87.60 | **15** |
| Sar-e-pol | SAF | 22 | 18 | 15.90 | 20 | 5 | 0 | 5 | 85.90 | **16** |
| Paktiya | HEWAD/NAC | 20 | 18 | 12.80 | 20 | 0 | 10 | 5 | 85.80 | **17** |
| Farah | MRCA | 22 | 18 | 15.20 | 10 | 5 | 10 | 5 | 85.20 | **18** |
| Bamyan | AKF | 22 | 18 | 9.76 | 20 | 5 | 10 | 0 | 84.76 | **19** |
| Khost | OHPM | 22 | 18 | 18.06 | 20 | 0 | 0 | 5 | 83.06 | **20** |
| Ghor | CHA | 22 | 18 | 17.92 | 20 | 0 | 0 | 5 | 82.92 | **21** |
| Helmand | BRAC | 22 | 18 | 17.92 | 20 | 0 | 0 | 5 | 82.92 | **21** |
| Urozgan | SHDP | 22 | 18 | 16.80 | 20 | 0 | 0 | 5 | 81.80 | **23** |
| Kabul | SDO | 14 | 18 | 12.82 | 20 | 5 | 0 | 5 | 74.82 | **24** |
| Paktika | OHPM | 22 | 18 | 18.40 | 10 | 0 | 0 | 5 | 73.40 | **25** |
| Zabul | SDO | 22 | 18 | 8.16 | 20 | 0 | 0 | 5 | 73.16 | **26** |
| Daikondi | MOVE | 18 | 18 | 4.80 | 20 | 5 | 0 | 5 | 70.80 | **27** |
| Panjshir | MoPH/SM | 22 | 0 | 7.72 | 20 | 5 | 10 | 5 | 69.72 | **28** |
| Takhar | AHEAD | 16 | 18 | 9.76 | 20 | 0 | 0 | 5 | 68.76 | **29** |
| Faryab | SDO/OCED | 22 | 18 | 17.60 | 0 | 5 | 0 | 5 | 67.60 | **30** |
| Parwan | MoPH/SM | 12 | 0 | 6.40 | 20 | 5 | 10 | 5 | 58.40 | **31** |
| Kapisa | MoPH/SM | 22 | 9 | 7.20 | 0 | 5 | 10 | 5 | 58.20 | **32** |
| Samangan | AHEAD | 20 | 18 | 10.78 | 0 | 5 | 0 | 0 | 53.78 | **33** |
| Nooristan | AHEAD | 16 | 0 | 2.04 | 0 | 0 | 0 | 5 | 23.04 | **34** |

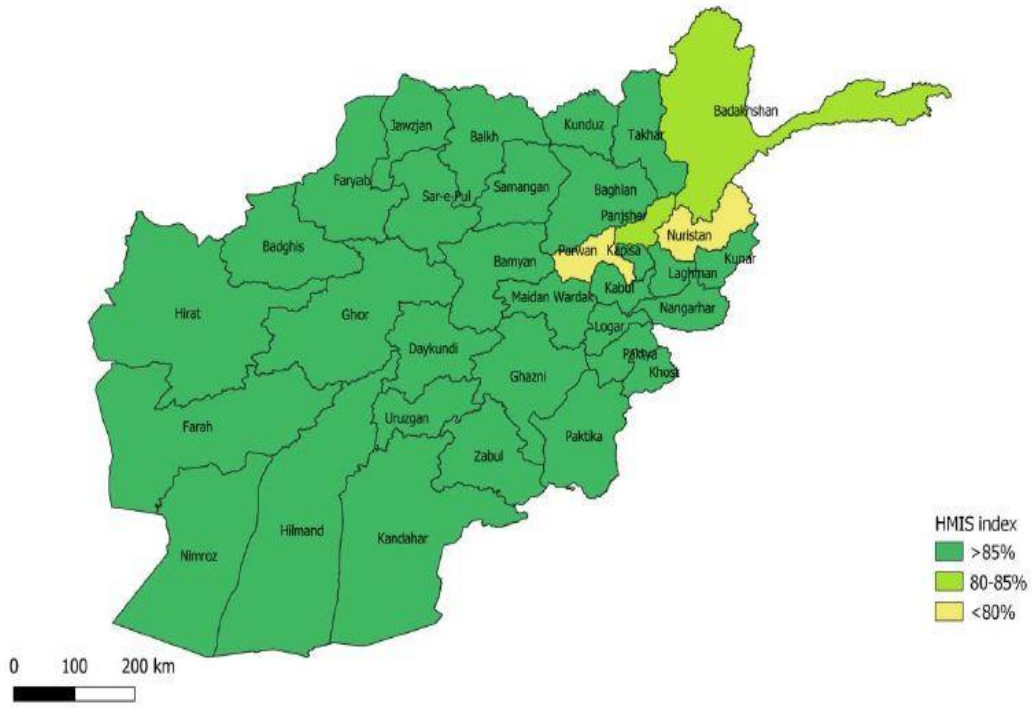
# 5. Programmatic performance

The project relies upon the HMIS data as validated by the TPM. Hence before describing the progress for six months, it is important to look at the variance between the reported data and TPM verification. The conclusions by the TPM are captured in the following summary table (Table 3) on the composite score for both BPHS and EPHS. It shows almost perfect alliance across all provinces except Nuristan, Panjshir and Parwan (score < 85%). This means that for project performance purposes, the HMIS data is validated to reflect the actual performance for historical and geographic comparisons. The primary objective of this data is to calculate the rewardable performance as per the SOPs for P4P payments to the respective SP/province. The strong TPM validation allows for deeper analysis of the performance to draw other inferences like the service delivery utilization efficiencies, impact on the program objectives and disease reduction or elimination.

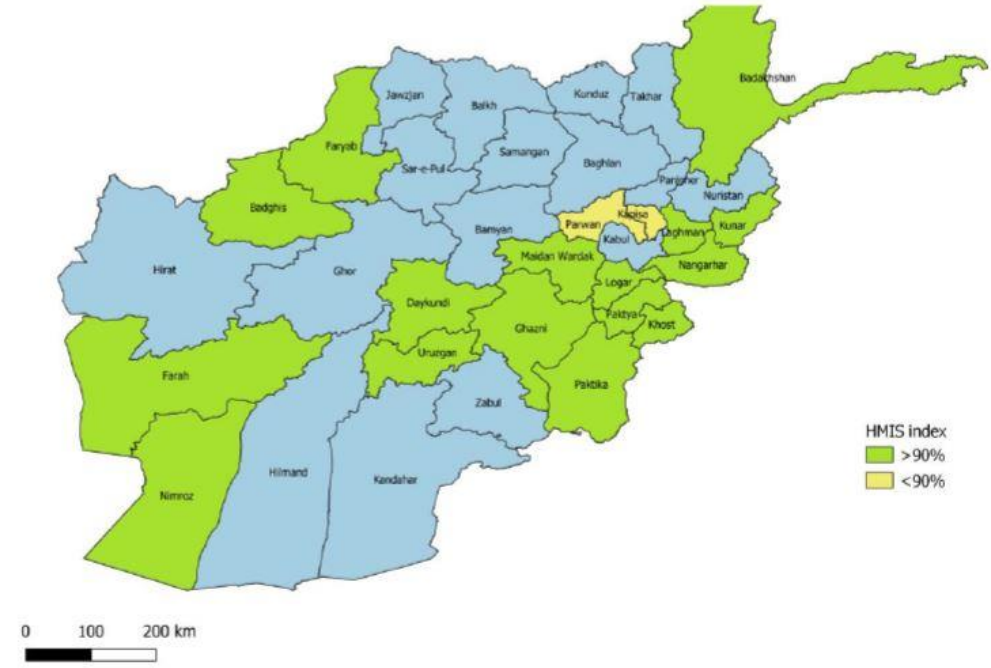
Table 3 : Consistency, accuracy, and HMIS Composite Score by category of facility and province

| Province | BPHS | | | EPHS | |
|---|---|---|---|---|---|
| | Consistency | Accuracy | HMIS Verification Composite Score | Consistency | HMIS Verification Composite Score |
| Badakhshan | 89% | 95% | 85% | 99% | 99% |
| Badghis | 92% | 100% | 92% | 95% | 95% |
| Baghlan | 99% | 95% | 93% | | |
| Balkh | 99% | 99% | 98% | | |
| Bamyan | 90% | 96% | 86% | | |
| Daykundi | 87% | 98% | 85% | 91% | 91% |
| Farah | 99% | 98% | 97% | 100% | 100% |
| Faryab | 100% | 100% | 99% | 100% | 100% |
| Ghazni | 100% | 97% | 97% | 100% | 100% |
| Ghor | 96% | 100% | 96% | | |
| Helmand | 96% | 97% | 93% | | |
| Herat | 98% | 100% | 98% | | |
| Jawzjan | 93% | 100% | 93% | | |
| Kabul | 95% | 96% | 91% | | |
| Kandahar | 97% | 93% | 90% | | |
| Kapisa | 85% | 100% | 85% | 88% | 88% |
| Khost | 99% | 100% | 99% | 99% | 99% |
| Kunar | 99% | 100% | 99% | 100% | 100% |
| Kunduz | 100% | 99% | 98% | | |
| Laghman | 99% | 100% | 99% | 98% | 98% |
| Logar | 98% | 98% | 97% | 100% | 100% |
| Nangrahar | 99% | 100% | 99% | 100% | 100% |
| Nimroz | 98% | 99% | 96% | 96% | 96% |
| Nuristan | 79% | 90% | 72% | | |
| Paktika | 99% | 99% | 98% | 100% | 100% |
| Paktya | 97% | 95% | 92% | 94% | 94% |
| Panjsher | 90% | 93% | 84% | | |
| Parwan | 85% | 88% | 75% | 78% | 78% |
| Samangan | 92% | 94% | 86% | | |
| Saripul | 99% | 100% | 99% | | |
| Takhar | 93% | 93% | 86% | | |
| Uruzgan | 97% | 95% | 92% | 98% | 98% |
| Wardak | 96% | 100% | 96% | 98% | 98% |
| Zabul | 92% | 98% | 89% | | |

**HMIS Verification Composite Score - BPHS facilities 2020**




**HMIS Verification Composite Score - EPHS facilities, 2020**



The detailed balanced scorecards or the semi-annual period April – September 2020 are appended in Annex 1. It has both the reported and verified scores for each of the indicators and province. These scorecards are now available on the DHIS 2 Dashboard of the MOPH.

It is possible to compare some of the numeric indicators like Penta3 vaccination, Measles vaccination, TT2 vaccination, Institutional deliveries, Antenatal visits, Post-natal visits and T.B. related indicators from *Sehatmandi* with other data sources like coverage surveys like Demographic and Health Survey (DHS), Afghanistan Health Survey once these studies become available. This is important from two perspectives – credibility of the HMIS data and utilization efficiency of the key supplies like vaccines and drugs in order to reduce wastages as well as prevent short supplies.

For reviewing programmatic performance for the semi-annual period, the eleven P4P indicators have been clubbed as follows to represent a common public health program or related service delivery modality:

1) Maternal health – this covers three indicators, namely antenatal visits, institutional deliveries, and post-natal visits.
2) Child and maternal vaccination – this include Penta3 and TT2 vaccination indicators. Measles vaccination performance is also captured by the HMIS. This is not a P4P indicator.
3) Child health – indicator on children's morbidities
4) Tuberculosis control program – this encompasses a composite indicator of two attributes, sputum examination (case detection) and treatment (compliance and cure)
5) Family planning – the progress with couple years of protection (CYP)
6) Nutrition program – the performance is measured by a composite of two indicators, growth monitoring and infant and young child feeding (IYCF)
7) Tertiary care requiring specialist manpower including Anesthetist and operation facilities – major surgeries and caesarean sections performed.

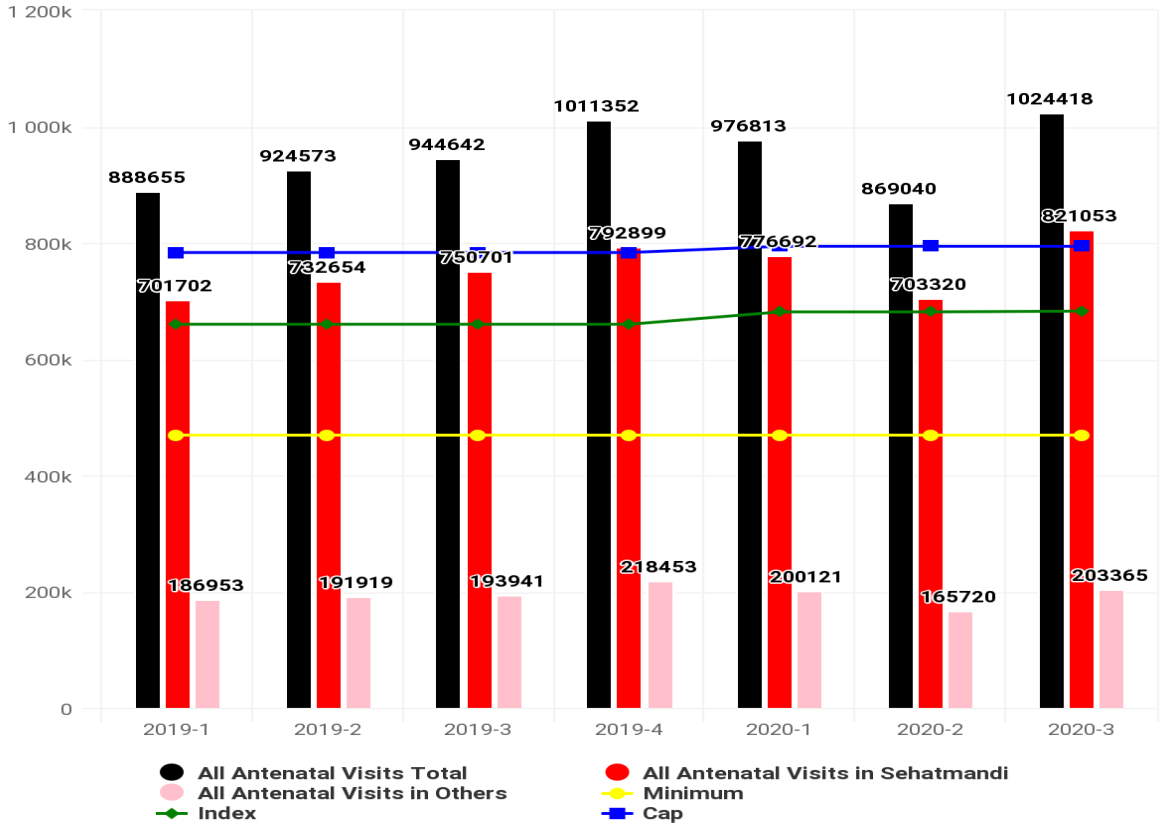
The source of the information is the HMIS for which the World Bank has also created a dashboard for different indicators and their progress with three frequency intervals (quarter, semi-annual, annual). SAPR3 period has been taken as the reference for this report.

Only national progress and achievements has been presented whereas there could be significant variation for some indicators across different provinces. This is an area where the respective provinces should analyze the reasons and corrective actions required in consultation with the respective TDs.

Six quarters have been presented in the data for two reasons – compare the review period under reference with previous six months' period for progress; and same six months in the previous year to neutralize the impact of seasonality on the services.

## 5.1 Maternal health

The three indicators that reflect the maternal health in the HMIS are presented in the following graphs, sequentially for antenatal visits, institutional deliveries, and postnatal visits: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191919
193941
218453
200121
165720
203365
2019-1
2019-2
2019-3
2019-4
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All Antenatal Visits Total
All Antenatal Visits in Sehatmandi
All Antenatal Visits in Others
Minimum
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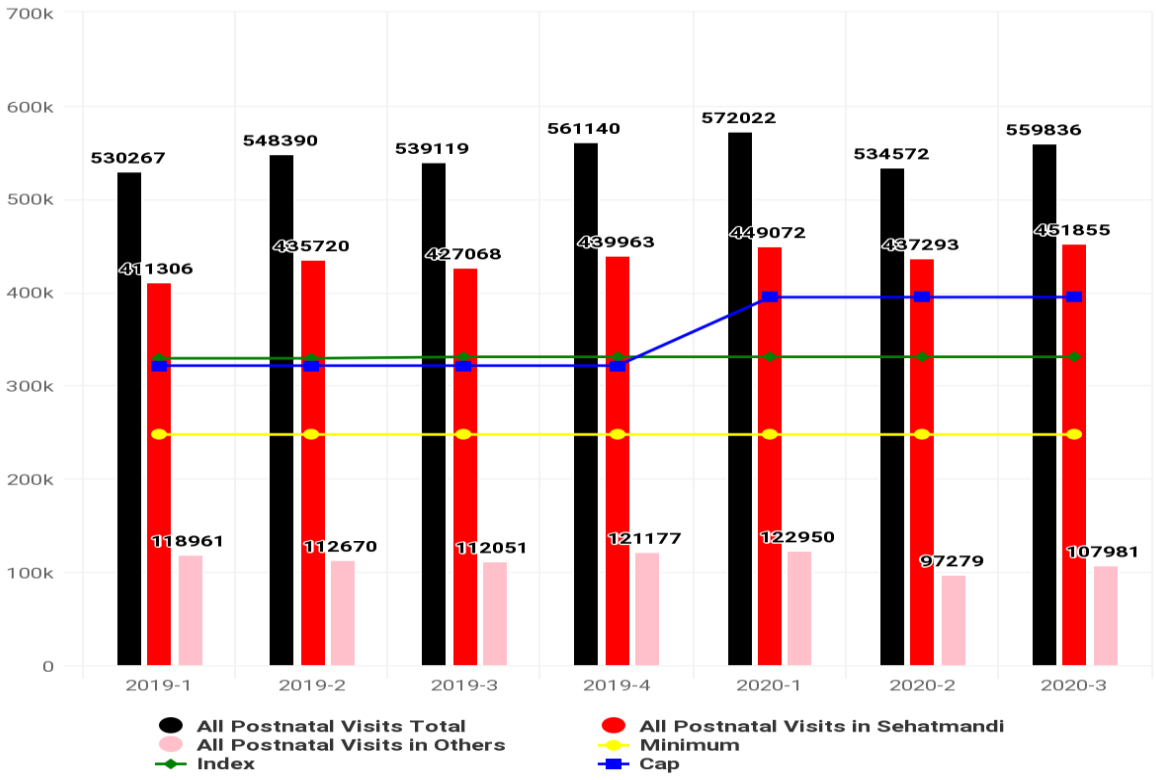
Cap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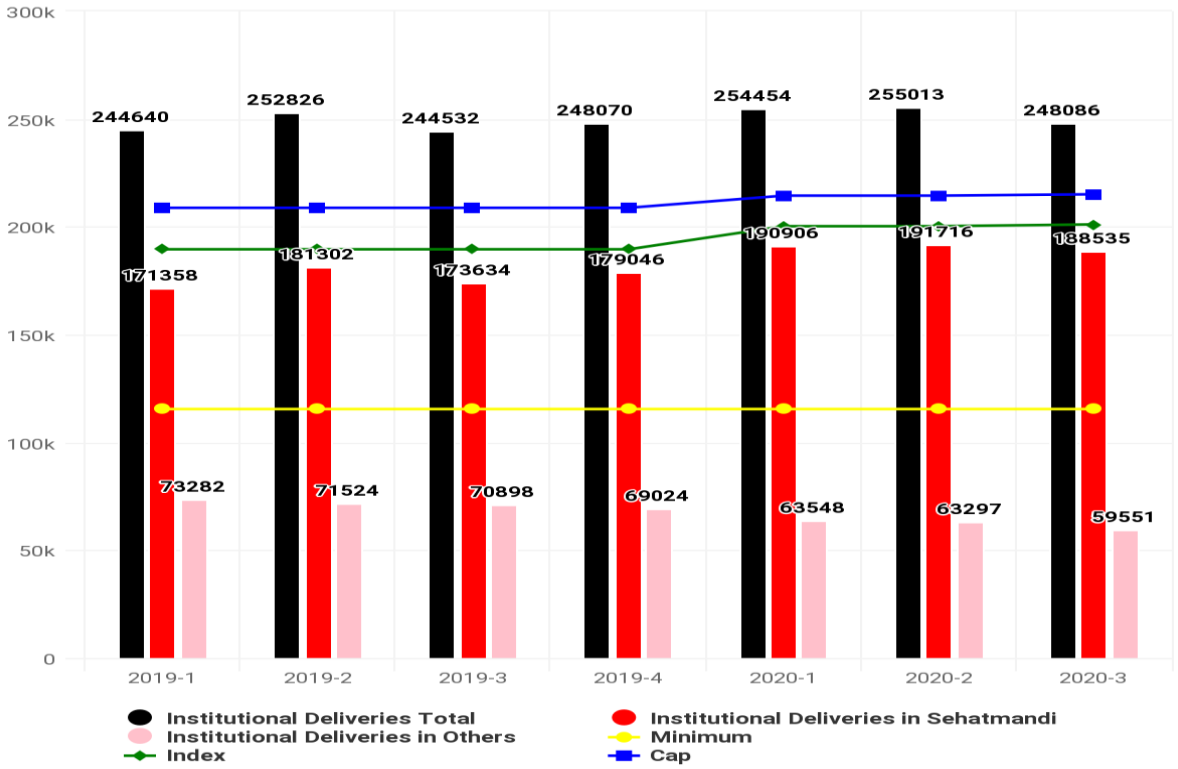
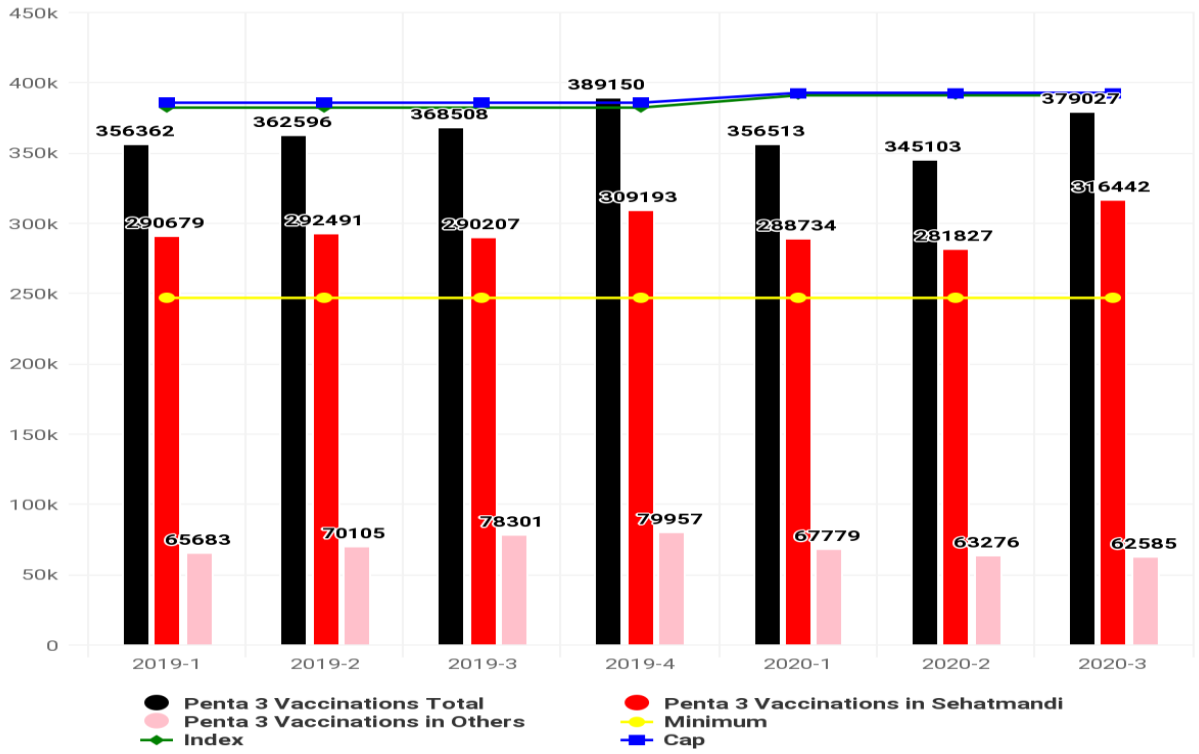
All Postnatal Visits Total
All Postnatal Visits in Sehatmandi
All Postnatal Visits in Others
Minimum
Index
Cap




The antenatal visits (ANC) and postnatal visits (PNC) show a dip in second quarter of 2020. On the other hand, the institutional deliveries did not show any decline for the corresponding period. Is it because a delivery is an emergency whereas ANC and PNC could have been compromised due to COVID related restrictions during the quarter, that need to be explored. The TD need to look at the targets for the institutional deliveries as the index has been missed consistently. For the next SAPR report, the technical department should look at this progress, also compare with similar information being compiled, analyzed, and reported by the Government to make this target achievable.

## 5.2 Child and maternal immunization

There are two P4P indicators for vaccination program – Penta3 for infants and TT2 for women of childbearing age. The HMIS data is presented in the following graphs.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281827
316442
65683
70105
78301
79957
67779
63276
62585
2019-1
2019-2
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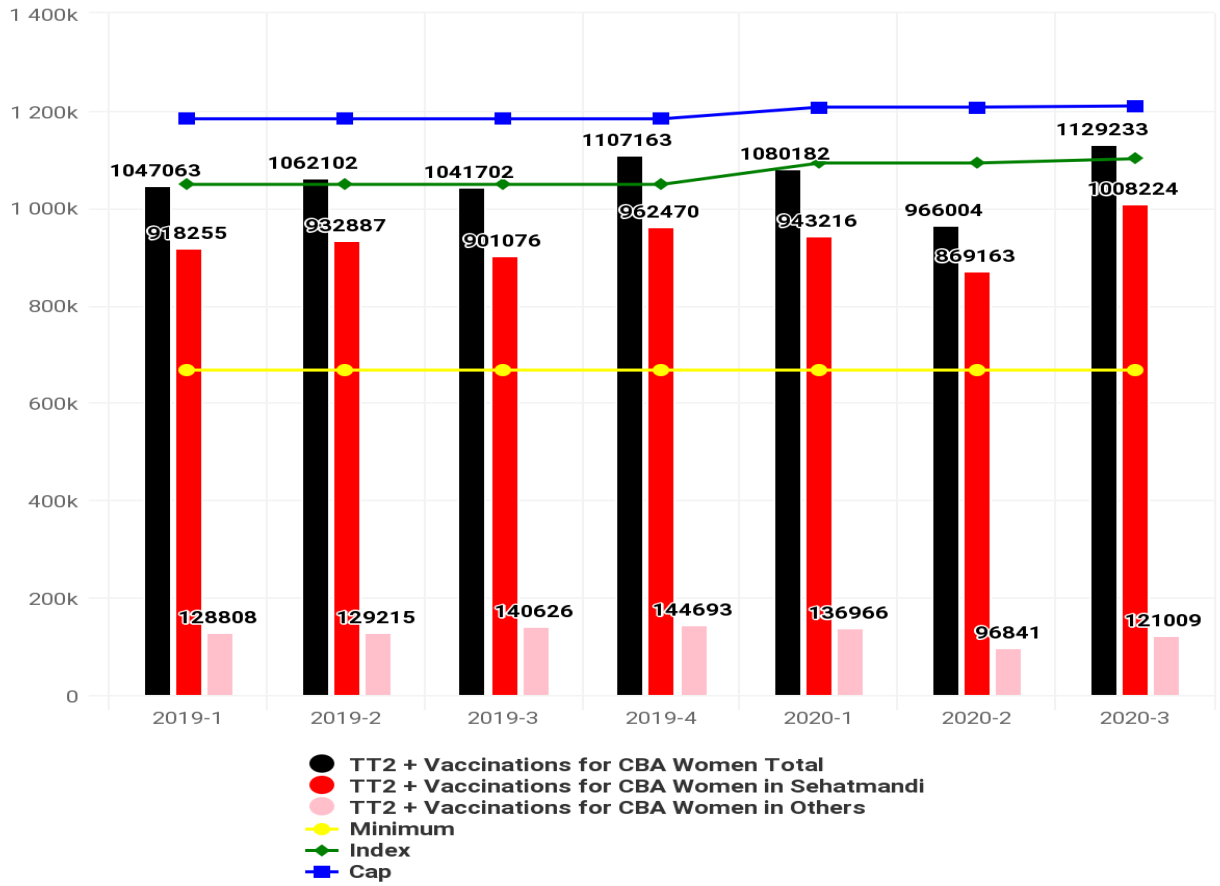
2020-2
2020-3
Penta 3 Vaccinations Total
Penta 3 Vaccinations in Sehatmandi
Penta 3 Vaccinations in Others
Minimum
Index
Cap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1008224
128808
129215
140626
144693
136966
96841
121009
2019-1
2019-2
2019-3
2019-4
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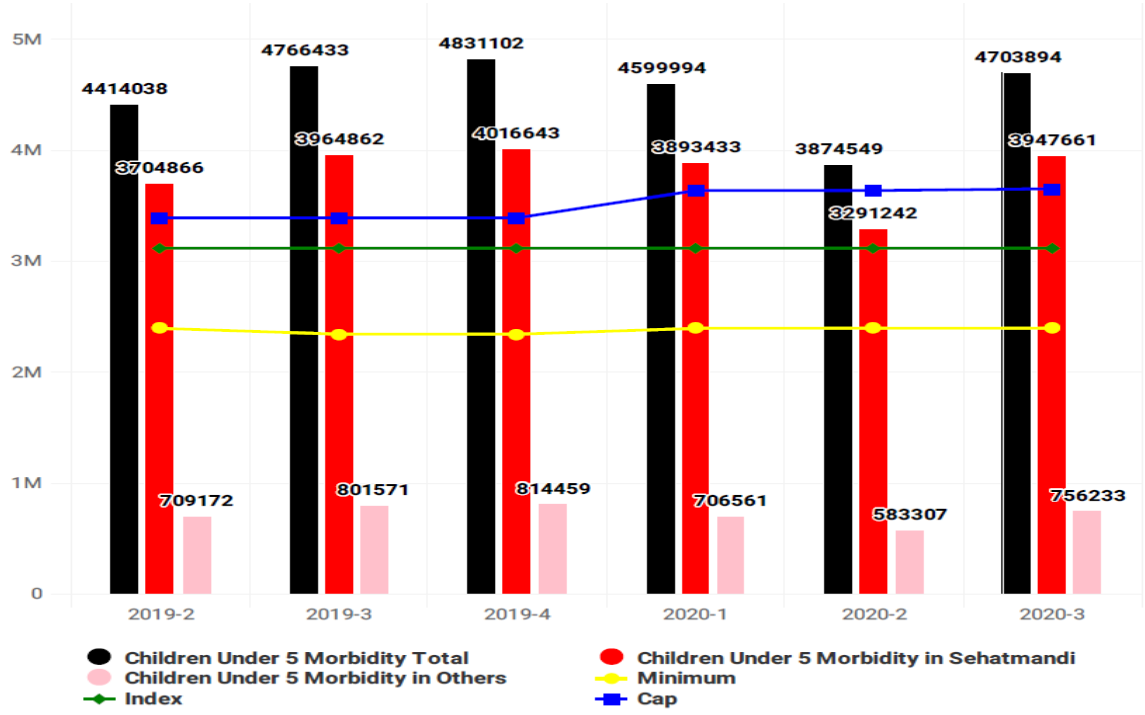
2020-2
2020-3
TT2 + Vaccinations for CBA Women Total
TT2 + Vaccinations for CBA Women in Sehatmandi
TT2 + Vaccinations for CBA Women in Others
Minimum
Index
Cap

Overall, there are no significant change in cumulative six months' periods. However, the decrease in first two quarters of 2020 cannot be reasonably explained due to onset of COVID 19. The decline for TT2 in second quarter of 2020 can also be attributed to COVID. However, the performance of Penta3 in first quarter of 2020 needs in-depth review by the concerned stakeholders to explore the reasons and fix this. Another reason for this decline could be apparent 'ban' on the immunization by many regions of the country by AGEs.

## 5.3 Child health

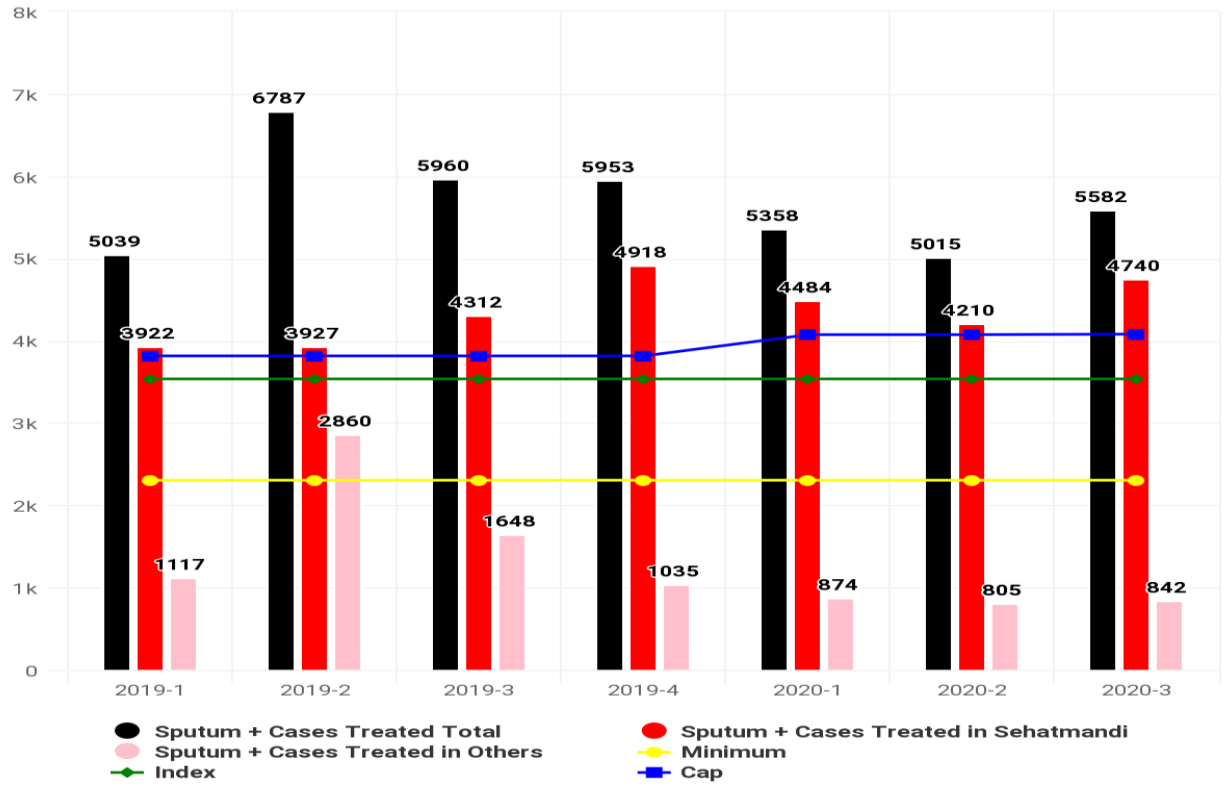
The P4P indicator is childhood morbidities treated.




There is almost 10% decrease compared to previous six months' period, more profound in the second quarter of 2020. This can be logically attributed to spread of COVID and associated restrictions.

## 5.4 Tuberculosis

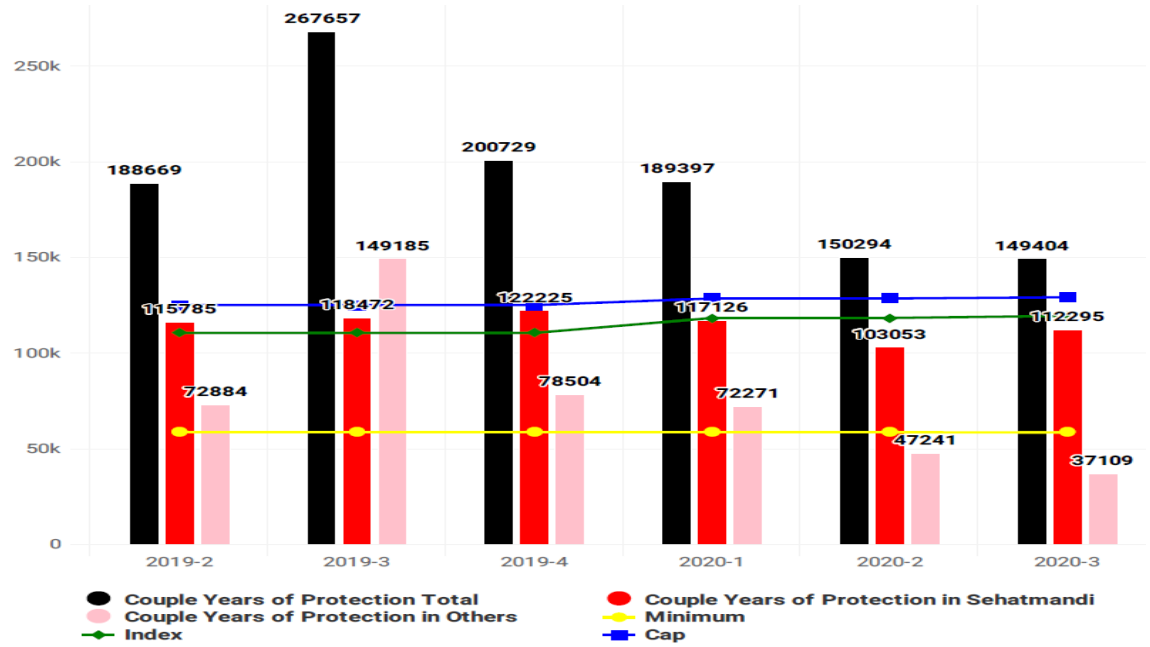
The T.B. control program is among the most important public health programs. One composite indicator encompassing case detection, and treatment/cure is captured by HMIS and included as P4P indicator. The progress for three periods of six months is presented below:




The decline observed during the second semi-annual period has been checked during the period under reference. The overall performance exceeded the cap level. Likewise, some other indicators, the quarter of July-September 2020 showed an increase. One probability could be accumulation of target group in previous quarter due to COVID linked restrictions/cancellation of the services who came back in larger numbers after these restrictions were relaxed.

## 5.5 Family planning

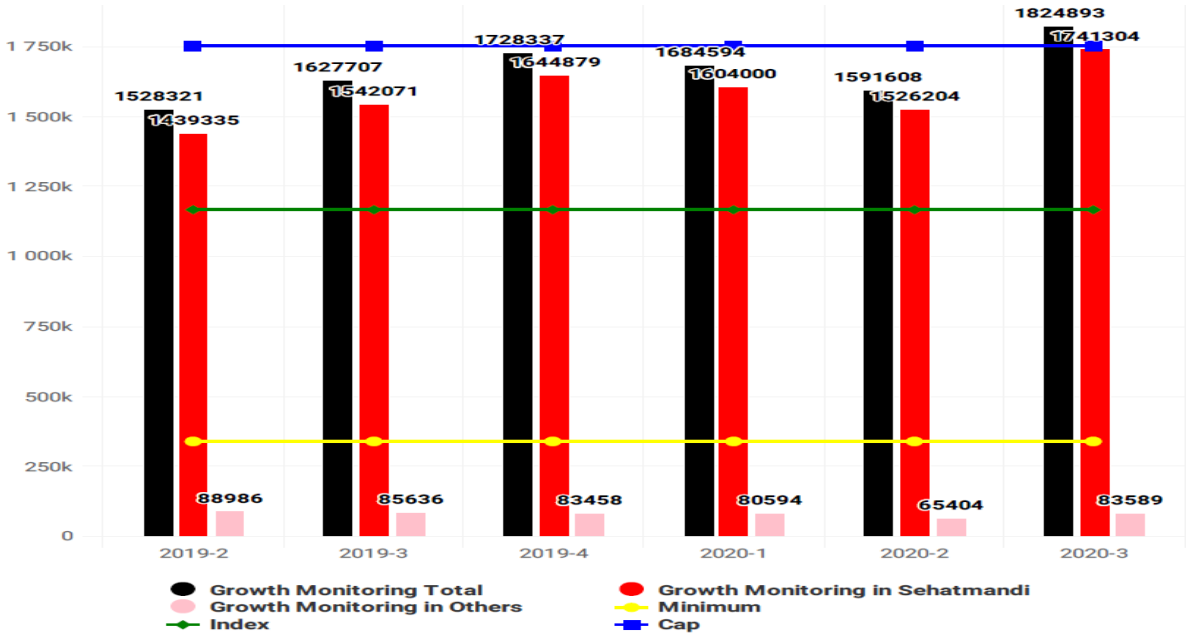
The indicator, couple years of protection, Is straightforward. It is expected to rise or stay stable.




This indicator showed more than 30% decrease as compared to previous similar period. In fact, this has been declining continuously since April 2019. The performance has dropped to below index level. Once again this requires a detailed review by the respective TDs along with SPs.

## 5.6 Nutrition program

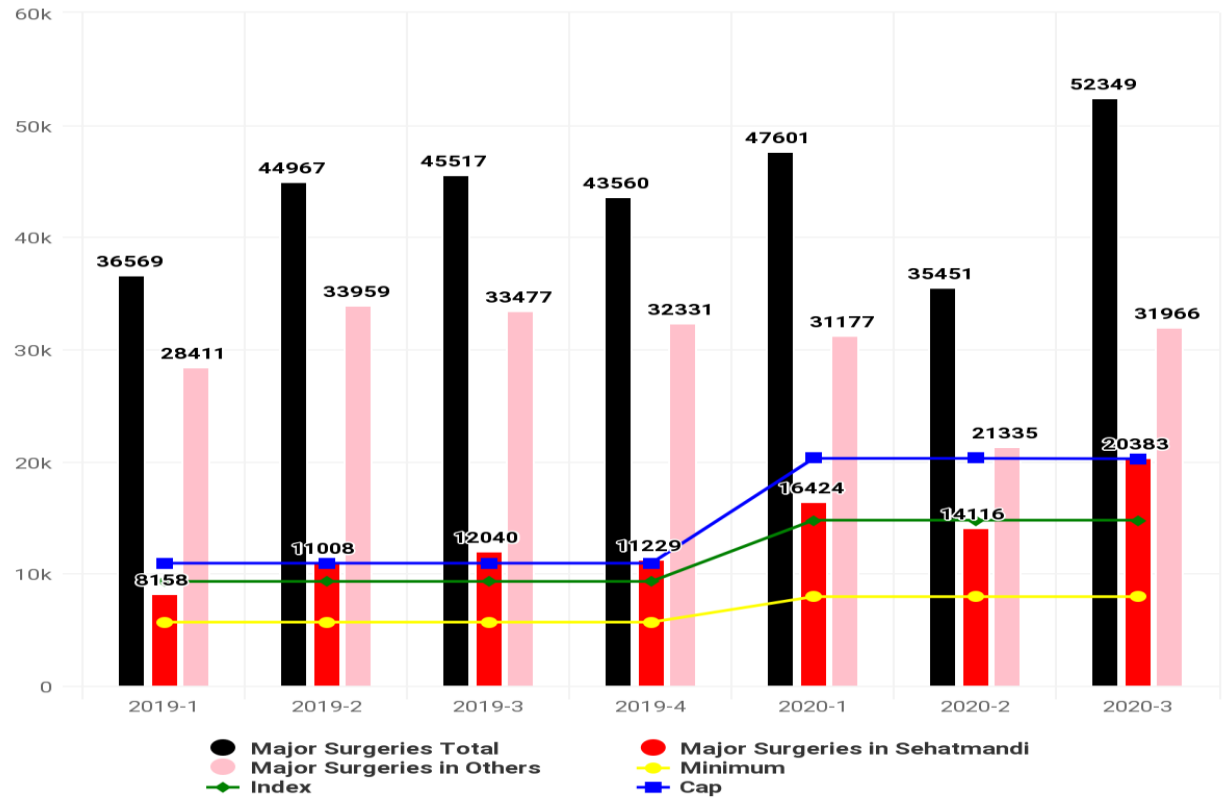
The P4P indicator is composite of two – growth monitoring, and infant and young child feeding.

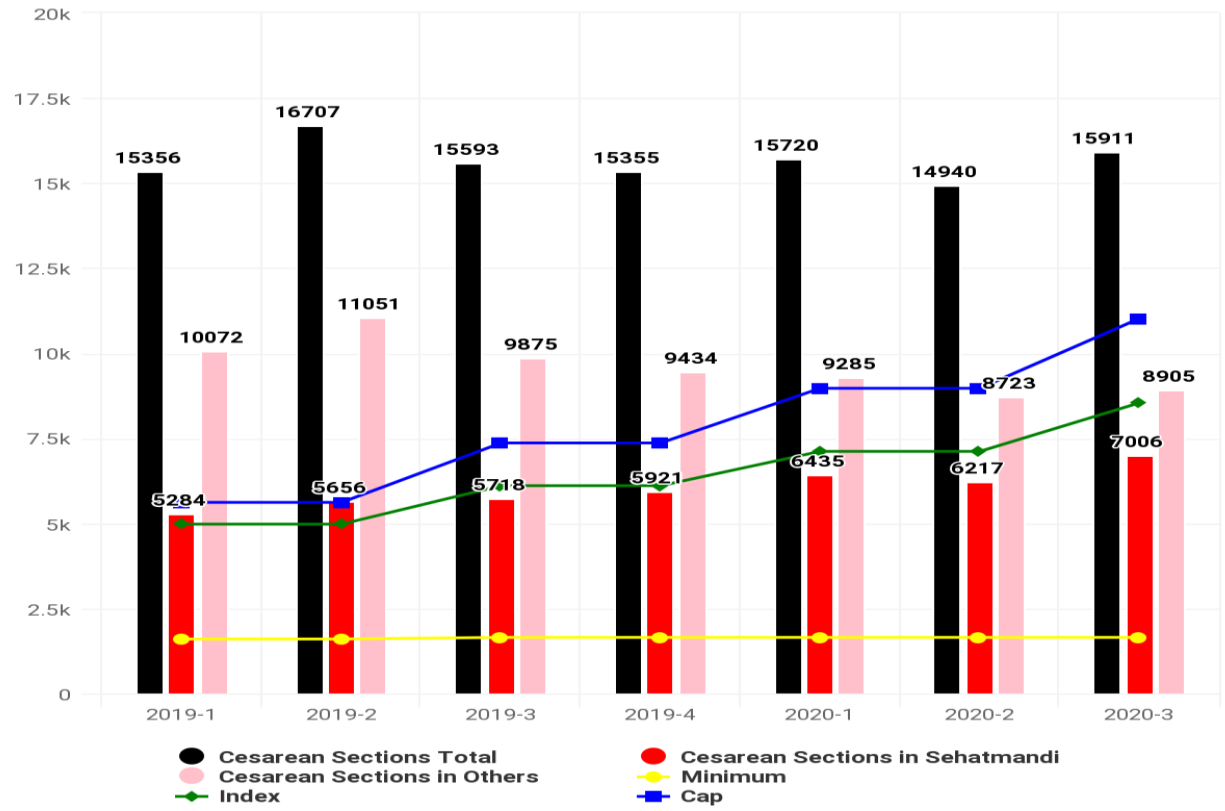


A progress of 3% was noted during the review period, underscoring no impact of COVID. The achievement consistently exceeded the index level across all quarters. The minimum is also set very low.

## 5.7 Tertiary care

There are only two P4P indicators which reflect the performance in the hospitals – number of major surgeries and caesarean sections. Both depend on availability of hospitals with operation facilities and qualified medical specialists and technical staff.






The progress is uneven which needs to be investigated. For major surgeries, the quarter of April-June 2020 showed a decline of 25%, assumably due to COVID impact. The next quarter had a jump of almost 50% on quarter to quarter basis. There is no further information available on the reasons like catch up of the backlog of postponed surgeries or some other factor. Caesarean sections showed a progressive increase with a pattern of up and down trends in alternate quarters.

In summary, indicators that showed increase included ANC visits, Institutional deliveries, TT2 vaccination, Growth monitoring & IYCF, Major surgeries and Caesarean sections.

On the other hand, indicators showing a decrease were PNC, Penta vaccination, Childhood morbidities treated, Tuberculosis diagnosis and cure and CYP.

There was general decline in the quarter of April to June 2020, bouncing back in the next quarter for multiple indicators. This can be attributed to the service delivery restrictions and public fear due to spread of COVID during the first wave. This would be validated during the next SAPR 4 when the impact of the second wave, now in progress, will become evident.

The Technical departments have a specific role to analyze the sudden variation and/or inconsistency among different indicators. The TDs need to increasingly operate per the SOPs on quality of care, supervision and on the training. A rapid assessment of the adequacy of numbers of personnel in TDs and their technical capacity to cover the entire country needs to be undertaken. Based on the outcome of the assessment, some augmentation efforts may be needed to the TDs to bring their work up to speed.

## 5.8 Indicator-wise Provincial Performance

The indicator wise performance is given in Tables 4 and 5 in summary. Though the detailed tables of the Scorecard for the said period are annexed (Annex 1 Table 1 and 2).

The P4P indicators were scored for the reporting period as follows: for each indicator which surpassed the cap, a score of 3 was given as in the case of previous SAPRs, for each indicator between cap and maximum a score of 2 was given and for each indicator between minimum and index, a score of 1 was assigned. No score was given if it were below the minimum and in case the score could not be assessed due to various reasons (including no targets were set as in the case of FP counseling). In Tables 4 and 5, the blue shade means that the province/ indicator has crossed the cap. The green shade means that the performance is between maximum and cap. Yellow shade means the performance is between index and minimum and red shade means that the performance is below minimum.

Based on the above scoring pattern, Post Natal care was the best performance indicator, followed by TB and Child Morbidity. In case of PNC, the maximum number of provinces ( 31) crossed the cap, followed by 25 for TB and 23 for child morbidity who crossed the cap .

Major surgeries as an indicator was the least scoring indicator, IYCF, TT2+ and PENTA were among the bottom 4 indicators. in case of major surgeries, only 15 provinces were able to cross the cap. For majority of the provinces no data was reported for major surgeries and hence the discrepancy. The indicators where cap was crossed least times included PENTA3 (4 provinces) and TT2+ plus (5 provinces). The reason for poor performance of these indicators could possibly be coinciding with the peak of COVID 19 in Afghanistan in April – June and followed by slight recovery during the following quarter. During this period people only came to health facilities for the most essential reasons and in general health facilities were avoided due to apprehension of contacting COVID 19. The poor performance of immunization could be due to an apparent 'ban' on immunization in certain areas by AGEs as well COVID 19.

Table 4: Indicator wise Provincial Performance Score SAPR R3

| Indicator | Blue | Green | Yellow | Grey | Red | Total |
|---|---|---|---|---|---|---|
| PNC | 93 | 2 | 2 | 0 | 0 | 97 |
| TB | 75 | 2 | 12 | 0 | 0 | 89 |
| Child Morbidity | 69 | 6 | 10 | | 0 | 85 |
| In Deliveries | 51 | 1 | 32 | | 0 | 84 |
| ANC | 66 | 10 | 7 | | 0 | 83 |
| CYP HFs | 48 | 1 | 32 | | 0 | 81 |
| C Section | 63 | 8 | 8 | | 0 | 79 |
| PENTA 3 | 12 | 0 | 54 | 0 | 0 | 66 |
| TT2 | 15 | 5 | 44 | 0 | 0 | 64 |
| IYCF | 39 | 18 | 6 | | 0 | 63 |
| Major Surgeries | 45 | 1 | 2 | 0 | 0 | 48 |

## 5.9 Provincial Performance Scores

Similarly, the semiannual performance of provinces/ Service Providers was also ranked using the same criteria. The indicators were scored for the reporting period as follows: for each indicator which surpassed the cap, a score of 3 was given as in the case of previous SAPRs, for each indicator between cap and maximum a score of 2 was given and for each indicator between minimum and index, a score of 1 was assigned. No score was given if it were below the minimum and in case the score could not be assessed due to various reasons ( including no targets were set as in the case of FP counseling.

As per the Table 5 the national average score for the performance was 24 and there were 21 provinces which had equal to or more than the national average score. Paktika, Urozgan and Ghazni were the top three provinces and followed by Farah, Logar and Jawjan. Panjsher was at the bottom of the ranking and Badghis and Samangan were among the bottom three provinces. Overall, 13 provinces had below national average performance for the semiannual period under reporting

Table 5: Provincial Performance scored for R3 SAPR.

| | Province | Implementer | Blue | Green | Yellow | Grey | Red | Total |
|---|---|---|---|---|---|---|---|---|
| Afghanistan (National Level) | | | 15 | 6 | 3 | 0 | 0 | 24 |
| 1 | Paktika | OHPM | 30 | 6 | 1 | 0 | 0 | 37 |
| 2 | Urozgan | SHDP/OHCD | 30 | 6 | 1 | 0 | 0 | 37 |
| 3 | Ghazni | AADA | 27 | 6 | 2 | 0 | | 35 |
| 4 | Farah | MRCA | 24 | 6 | 3 | 0 | 0 | 33 |
| 5 | Logar | CAF | 24 | 6 | 3 | 0 | 0 | 33 |
| 6 | Jawzjan | SAF | 24 | 6 | 2 | 0 | | 32 |
| 7 | Khost | OHPM | 24 | 6 | 2 | 0 | 0 | 32 |
| 8 | Laghman | HN-TPO | 24 | 6 | 2 | 0 | 0 | 32 |
| 9 | Balkh | BDN | 24 | 6 | 1 | 0 | 0 | 31 |
| 10 | Hirat | AADA | 24 | 6 | 1 | 0 | 0 | 31 |
| 11 | Kapisa | SM | 15 | 6 | 8 | 0 | 0 | 29 |
| 12 | Helmand | BRAC | 21 | 6 | 2 | 0 | 0 | 29 |
| 13 | Dykundi | MOVE/OCCD | 18 | 6 | 4 | 0 | 0 | 28 |
| 14 | Wardak | SCA | 21 | 6 | 1 | 0 | 0 | 28 |
| 15 | Baghlan | BDN | 18 | 6 | 3 | 0 | | 27 |
| 16 | Bamyan | AKF/AKHS-A | 18 | 6 | 3 | 0 | 0 | 27 |
| 17 | Kunar | HNTPO/ORCD | 15 | 6 | 5 | 0 | 0 | 26 |
| 18 | Paktya | HEWAD/NAC | 18 | 6 | 1 | 0 | 2 | 25 |
| 19 | Kandahar | BARAN/OHPM | 18 | 6 | 1 | 0 | 0 | 25 |
| 20 | Nimroz | MRCA | 18 | 6 | 1 | 0 | 0 | 25 |
| 21 | Nooristan | AHEAD | 15 | 6 | 3 | 0 | 0 | 24 |
| 22 | Sar-e-Pul | SAF | 12 | 6 | 5 | 0 | 0 | 23 |
| 23 | Kabul | SDO/OCED | 15 | 6 | 2 | 0 | 2 | 23 |
| 24 | Kunduz | JACK | 12 | 6 | 3 | 0 | | 23 |
| 25 | Ghor | CHA | 15 | 6 | 2 | 0 | 0 | 23 |
| 26 | Faryab | SDO/OCED | 12 | 6 | 4 | 0 | 0 | 22 |
| 27 | Takhar | AHEAD/OCCD | 6 | 6 | 8 | 0 | 0 | 20 |
| 28 | Parwan | SM | 9 | 6 | 5 | 0 | 0 | 20 |
| 29 | Badakhshan | AKF/AKHS-A | 6 | 6 | 6 | 0 | 0 | 18 |
| 30 | Zabul | SDO/OCED | 6 | 6 | 6 | 0 | 0 | 18 |
| 31 | Nangarhar | AADA/HNTPO | 12 | 6 | | 0 | 0 | 18 |
| 32 | Samangan | AHEAD | 3 | 6 | 6 | 0 | 0 | 15 |
| 33 | Badghis | MMRCA/RHDO | 6 | 6 | 3 | 0 | 0 | 15 |
| 27 | Panjsher | SM | 6 | 6 | 2 | 0 | | 14 |

## 5.10 Minimum Standard of Services as laid out in the BPHS and EPHS

The Minimum Standard of Services (MSS) has been laid out in the BPHS and EPHS packages of service for Afghanistan and has been specified in the Standard Operating Procedure of the PMO. The details of minimum standard of services have been given in Tables 6 and 7 respectively for BPHS and EPHS package of services. The TPM carried out Minimum Standard of Services assessment in the third round of SAPR and a summary of the same is being reproduced as follows.

Regarding the minimum standards as defined in SOP/BPHS guidelines for BPHS facilities, as many as 8 provinces scored above 95% provincial functionality score. Overall as many as 29 provinces scored above 85 points on the provincial functionality score for BPHS.

For EPHS, as many as 8 provinces achieved a functionality score of 95% and above for minimum standard of services. All provinces except one achieved above 85 per cent provincial functionality score.

Regarding the minimum standards for equipment as defined in SOP/BPHS guidelines for BPHS facilities, only one province (Wardak) met the minimum standards. The lowest equipment availability score was 68% in Nuristan and the highest equipment availability score was 100% in Wardak province.

For EPHS facilities, only two provinces (Badakhshan and Wardak) met the minimum standards for staff availability as defined in the SOP EPHS guideline, although in the rest of the provinces approximately over 90% of HFs reached the standards.

For the provincial staff score in BPHS facilities, according to the SOPs (SOP staff availability score), a total of fourteen provinces (41%) met the minimum standards of services (MSS). The lowest score (82%) has been found in Nuristan.

In 33 provinces (97%) the SOP staff score reached the optimal performance target of 85%. Regarding the presence of all key staff for at least 70% of staff-time in the previous 6 months, 19 (56%) provinces met the minimum standards. The lowest score was found in Nuristan with 0% of HFs having reached the minimum standards.

**Table 6 Provincial level BPHS Functionality Scores for Minimum Standards for availability of staff, drugs, equipment, and health services other than P4P, as per SOP/BPHS guidelines**

| Province | SOP staff availability score (present during visit + past 6 months) | Key staff availability score (present during visit + past 6 months) | Percentage key staff present > 70% in the past 6 months | Drugs availability score (during visit and past 6 months) BPHS | Equipment availablity score | P4P availabiity score % | Health Post Service Score | Average number of female CHW per HP | Facilities with at least one female CHW per HP (%) | Provincial Functionality Score |
|---|---|---|---|---|---|---|---|---|---|---|
| Badakhshan | 99% | 100% | 100% | 90% | 93% | 93% | 100% | 1.0 | 73% | 92% |
| Badghis | 93% | 79% | 80% | 93% | 96% | 97% | 100% | 1.0 | 100% | 94% |
| Baghlan | 99% | 100% | 100% | 79% | 89% | 73% | 100% | 1.0 | 100% | 91% |
| Balkh | 99% | 100% | 100% | 94% | 97% | 100% | 100% | 1.2 | 100% | 99% |
| Bamyan | 96% | 83% | 100% | 85% | 87% | 70% | 93% | 1.1 | 100% | 90% |
| Daykundi | 99% | 93% | 60% | 74% | 78% | 73% | 100% | 1.4 | 100% | 83% |
| Farah | 94% | 99% | 100% | 99% | 97% | 84% | 100% | 0.9 | 67% | 92% |
| Faryab | 99% | 98% | 100% | 96% | 99% | 97% | 100% | 1.2 | 70% | 94% |
| Ghazni | 100% | 100% | 100% | 96% | 98% | 100% | 100% | 1.0 | 100% | 99% |
| Ghor | 100% | 64% | 75% | 99% | 97% | 97% | 100% | 1.0 | 89% | 94% |
| Helmand | 100% | 91% | 75% | 96% | 96% | 100% | 100% | 0.8 | 50% | 88% |
| Herat | 100% | 100% | 100% | 99% | 97% | 100% | 100% | 1.0 | 100% | 99% |
| Jawzjan | 100% | 100% | 100% | 96% | 96% | 100% | 100% | 1.0 | 100% | 99% |
| Kabul | 99% | 100% | 100% | 90% | 90% | 100% | 100% | 1.0 | 33% | 87% |
| Kandahar | 100% | 92% | 75% | 97% | 97% | 90% | 100% | 1.1 | 90% | 93% |
| Kapisa | 97% | NA | NA | 42% | 80% | 51% | 80% | 1.2 | 100% | 75% |
| Khost | 100% | 100% | 100% | 97% | 97% | 100% | 100% | 1.0 | 100% | 99% |
| Kunar | 100% | 94% | 80% | 90% | 82% | 85% | 100% | 1.0 | 86% | 89% |
| Kunduz | 100% | 100% | 100% | 98% | 99% | 100% | 100% | 1.0 | 100% | 100% |
| Laghman | 100% | 90% | 40% | 94% | 94% | 78% | 100% | 1.0 | 100% | 87% |
| Logar | 100% | 73% | 80% | 100% | 99% | 100% | 100% | 0.9 | 57% | 91% |
| Nangrahar | 98% | 88% | 100% | 84% | 95% | 92% | 98% | 1.0 | 91% | 94% |
| Nimroz | 100% | 94% | 80% | 99% | 99% | 100% | 100% | 0.7 | 17% | 85% |
| Nuristan | 82% | 4% | 0% | 41% | 68% | 51% | 90% | 0.5 | 50% | 55% |
| Paktika | 98% | 100% | 100% | 100% | 99% | 49% | 100% | 1.0 | 100% | 92% |
| Paktya | 91% | 79% | 80% | 85% | 97% | 100% | 100% | 1.0 | 100% | 93% |
| Panjsher | 99% | NA | NA | 57% | 87% | 95% | 96% | 0.9 | 40% | 79% |
| Parwan | 96% | NA | NA | 48% | 82% | 98% | 98% | 1.0 | 88% | 85% |
| Samangan | 100% | 100% | 100% | 68% | 84% | 98% | 100% | 1.0 | 80% | 90% |
| Saripul | 100% | 100% | 100% | 94% | 96% | 84% | 100% | 1.0 | 88% | 95% |
| Takhar | 98% | 97% | 100% | 82% | 90% | 99% | 100% | 0.9 | 67% | 91% |
| Uruzgan | 99% | 100% | 100% | 95% | 98% | 100% | 100% | 1.0 | 80% | 96% |
| Wardak | 94% | 100% | 100% | 100% | 100% | 83% | 100% | 1.0 | 100% | 97% |
| Zabul | 99% | 72% | 50% | 98% | 92% | 77% | 100% | 0.1 | 0% | 74% |

For EPHS facilities, only two provinces (Badakhshan and Wardak) met the minimum standards for staff availability as defined in the SOP EPHS guideline, although in the rest of the provinces approximately over 90% of HFs reached the standards. The lowest score was 91% in Oruzgan provincial hospital (PH), and the highest (100%) in Wardak and Badakhshan provincial hospitals. In 18 (100%) provincial hospitals the optimal EPHS performance target of 90% was reached.

The scores for availability of drugs at the provincial level for the BPHS facilities, ranged from 100% in Wardak, Paktika and Logar, to 41% in Nuristan province. In 24 provinces (71%) the optimal performance target of 85% was reached. Two provinces (Takhar and Nangarhar) the drug availability score was respectively 82% and 84%. For the rest of (seven) provinces the drugs availability score was less 80%. In 13 EPHS facilities (72%) the drugs availability score was at least 90%. In 5 EPHS facilities (28%) the drugs availability was less than 90%. For EPHS, only three provinces met the minimum standards for drugs availability as defines in SOP/EPHS guidelines. The lowest scores were found in Kapisa PH (56%) and in Parwan PH (61%). The highest score (100%) was found in Badakhshan, Badghis and Logar provincial hospitals. Drugs are one of the important commodities that should be available all the time in HFs and hospitals to ensure smooth functionality. Unfortunately, the persistent low availability of drugs in BPHS facilities, especially in Kapisa (42% in BPHS facilities and 56% in EPHS) is of serious concern. Incidentally Kapisa as an SM province being managed by the MOPH through contracting in. The MoPH is requested to strengthen the follow up with the SPs to ensure corrective measures are applied to resolve the major bottlenecks.

Regarding the minimum standards for equipment as defined in SOP/BPHS guidelines for BPHS facilities, only one province (Wardak) met the minimum standards. The lowest equipment availability score was 68% in Nuristan and the highest equipment availability score was 100% in Wardak province. In 28 provinces (82%) the optimal performance target at 85% was reached, while in three provinces the equipment availability score was less than 80%. For the EPHS facilities, the equipment availability score ranged from 88% in Uruzgan to 100% in Wardak, Logar, Khost, and Badakhshan provincial hospitals. A total of 17 provinces' hospitals (94%) reached the optimal performance target of 90% for this indicator. Only Urozgan was below the optimal threshold.

Regarding the provincial level availability for health services other than P4P, in BPHS facilities, a total of 12 (35%) provinces met the minimum standards defined in SOP/BPHS guidelines. The lowest score (49%) was found in Paktika. In 22 provinces (65%) the score was at least 85%; while in 11 provinces (32%) the score was lower than 80%. In EPHS facilities a total of 11 (61%) provinces, met the minimum standards for the availability of health services other than P4P as defined in SOP/EPHS guidelines. The lowest score (70%) was found in Logar provincial hospital. The performance target of 90% was reached in 16 (89%) EPHS facilities. Overall, the availability score for services other than P4P was lower at provincial level for BPHS facilities and higher in EPHS facilities.

Concerning the availability of health post services at provincial level, in BPHS facilities, the scores range between 100% in 28 provinces to 80% in Kapisa. All the provinces but one reached the optimal management threshold (85%). Regarding the minimum standards of having at least one female community health worker (CHW) per health post at provincial level, the scores varied from 0% health posts with at least one female CHW in Zabul to 100% of health posts with at least one female CHW in 15 provinces (44%). In 11 provinces (32%) less than 80% of health posts had at least one female CHW and in 21 provinces (62%) more than 85% of health posts had at least one female community health worker.

Note from the TPM for interpreting MSS:

Minimum standards (MSS) results should be read as a dichotomised score where 100% indicate that the province has reached the MSS for the respective indicator. Other scores than 100% indicate that the province has not reached the MSS. However, it is still fair to present the percentage of HFs that have reached the MSS within that province. For example, Badakhshan province did not reach the minimum standards for drug availability, however 90% of the HFs in this province did it and 10% did not.

**Table 7 Provincial level EPHS Functionality Scores of Minimum Standards SOP per staff, drugs, equipment, and other than P4P services**

| Province | Staff availability score EPHS (%) | Drugs availability score (%) | Equipment availability score (%) | P4P availability score (%) | Hospital Governance Score (%) | Provincial functionality score |
|---|---|---|---|---|---|---|
| Badakhshan | 100% | 100% | 100% | 80% | 100% | 96% |
| Badghis | 92% | 100% | 99% | 100% | 91% | 97% |
| Daikundi | 93% | 91% | 97% | 90% | 74% | 89% |
| Farah | 97% | 94% | 98% | 100% | 96% | 97% |
| Faryab | 97% | 97% | 95% | 100% | 81% | 94% |
| Ghazni | 98% | 97% | 98% | 100% | 100% | 99% |
| Kapisa | 96% | 56% | 97% | 90% | 87% | 85% |
| Khost | 94% | 95% | 100% | 100% | 88% | 95% |
| Kunar | 98% | 94% | 98% | 100% | 90% | 96% |
| Laghman | 98% | 87% | 97% | 100% | 100% | 96% |
| Logar | 96% | 100% | 100% | 70% | 89% | 91% |
| Nanagarhar | 99% | 88% | 97% | 100% | 82% | 93% |
| Nimroz | 96% | 94% | 96% | 100% | 100% | 97% |
| Paktika | 96% | 90% | 97% | 100% | 96% | 96% |
| Paktya | 98% | 92% | 99% | 90% | 85% | 93% |
| Parwan | 95% | 61% | 96% | 90% | 88% | 86% |
| Urozgan | 91% | 88% | 88% | 100% | 96% | 93% |
| Wardak | 100% | 91% | 100% | 90% | 96% | 95% |

# 6. Financial performance

This report dwells on the process and timing of the payments amounts and ratios between the lumpsum and P4P portions. This helps analyze on whether a province drives its performance from the programmatic performance and/ or expenditure analysis. .

## 6.1 Timeliness of the payments

According to the information compiled by the Finance unit of MOPH (Table 8), the timeliness of the payments has improved significantly since the beginning of the project, with the exception of fifth installment of the lumpsum.

Table 8: Payment details to the Service Providers

| Installments released during 2019 | Due date of installment | Period covered by fund | % of provinces/SPs paid on time (Scenario 1) | % of provinces/SPs paid on time (Scenario 2) |
|---|---|---|---|---|
| 1st Lumpsum | January 15, 2019 | Jan-March 2019 | 58% | 94% |
| 2nd Lumpsum | April 8, 2019 | April-Sep 2019 | 0% | 61% |
| 3rd Lumpsum | October 12, 2019 | Oct 2019-March 2020 | 100% | 100% |
| 4th Lumpsum | April 8, 2020 | April-June 2020 | 100% | 100% |
| 5th Lumpsum | July 10, 2020 | July-Sep 2020 | 42% | 68% |
| 2nd P4P | May 26, 2019 | 1st Jan- 20 March 2019 | 87% | 87% |
| 3rd P4P | November 19, 2019 | 21 March-22 Sep 2019 | 100% | 100% |
| 4th P4P | May 2, 2020 | 23 Sep 2019-19 March 2020 | 100% | 100% |
| | | | **73%** | **89%** |

1) There was no first installment in the contract, it was started from the 2nd installment in the contracts
2) In scenario 1, for the due date for receipt of the payment by the NGOs, the date of the contract is considered but in scenario 2, to account the delay occurred in submission of the payment deliverable (invoice) from the NGOs side, the date of submission of the invoice by the NGO to MoPH is considered.

The above information does not mean the arrival of the funds in the account of the SP but only an approval by the Finance unit. The process involves eleven steps as narrated below. There are five officials for this function with responsibility for several provinces in the Finance unit. There is good scope of reducing the number of steps, by say automating the process from the beginning rather than at step eight. Electronic clearances work far more efficiently Further, there is no reason for the approval file go to same desk or officer more than once. This could be one of the modest reforms the project can catalyze. The analyses of the DBD data shows delay both in the lumpsum payment as well as P4P related payments. The delay in P4P was attributed to delay in submission of the data by SPs and its processing and projection by HMIS. The delay in lumpsum payment was much less and mostly attributed to delay in submission of invoice by the SPs. In many cases the lumpsum payment was made ahead of the schedule as well. So, in sum, the issue seems to be delay largely in P4P related payments and for this the data submitted by SPs to HMIS need to be expedited.

1) SPs send the performance data for P4P payment to the HMIS and their quarterly reports for lump sum payment to PMO.
2) TPM report is factored in to revise the performance data sent by the SPs.
3) Development Budget Department of MoPH (DBD) after receiving the complete set of HMIS data of SPs from the MOPH HMIS dept, performs the P4P entitlements for each province and sends the calculated payable amount of P4P payment of each SP to GCMU.
4) GCMU certifies the SP's P4P invoices based on SPs HMIS data and DBD calculations and for the lump sum installments, GCMU certifies the SP's invoices based on the % and amount mentioned in the contracts.
5) DBD prepares and process separate allotments for each province (SPs) installments accordingly.
6) Within 10 days of the above step (after receiving of the allotments from MoF), M16 payment voucher for each payment of each SP is prepared and processed by DBD.
7) The payment (M16) documents after the DBD, GCMU will sign and then the finance director and then finally approved by the MoPH leadership (Normally deputy minister)

8) After the payment is controlled at the office of controllers, the assigned finance specialist at DBD will register the payment in the system (AFMIS). This is first time the payment advice is loaded on the electronic system.
9) DBD send the payment to MoF (treasury dept) and sends the scanned copies of the approved payments to World Bank FM by email for clearance.
10) MoF treasury completes their review and controls and then upload the payment (direct payment) in the client connection site of the donor and then the World Bank treasury completes the internal processes and checks.
11) World Bank treasury sends the payment to the account of SP normally within 1-2 weeks' time after the payment uploaded in the client connection site.

There is no specific period stipulated for actions to be completed at each of these levels in the current version of the SOPS. During the next revision of SOPs, it needs to be taken care of. There are three tables presenting comprehensively the financial data for the six months' period:

1) Cumulative amounts paid as total as well as lumpsum and P4P for each province.
2) Amount of P4P paid as percentage of the total for the semi-annual period.
3) Ratios between the lumpsum and P4P for each province

## 6.2 Cumulative Lumpsum paid and Pay for performance earnings by the provinces.

The following table ( Table 9) presents the cumulative amounts disbursed at end of September 2020 based on the fund coverage period:

Table 9: Cumulative and Lump sum payment to SPs by province

| NO | 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 lump sum amount disbursed as of Q7 in AFN (end of Sep 2020) | Total P4P award as of Q7 in AFN (end of Sep 20) |
|---|---|---|---|---|---|---|---|
| 1 | Badakhshan | AKF | 1,123,448,454 | 68,104,321 | 6.06 | 56,526,585 | 506,168,798 |
| 2 | Baghlan | BDN | 872,392,887 | 418,760,721 | 48.00 | 322,445,754 | 264,226,286 |
| 3 | Samangan | AHEAD | 447,343,687 | 53,029,171 | 11.85 | 40,832,461 | 203,994,439 |
| 4 | Ghazni | AADA | 1,292,112,405 | 622,370,285 | 48.17 | 516,567,333 | 414,963,084 |
| 5 | Takhar | AHEAD | 767,250,877 | 253,880,980 | 33.09 | 195,488,354 | 271,210,801 |
| 6 | Jawzjan | SAF | 561,183,747 | 253,537,080 | 45.18 | 195,223,551 | 186,442,847 |
| 7 | Herat | AADA | 1,163,168,371 | 748,685,448 | 64.37 | 621,408,919 | 234,368,668 |
| 8 | Kunduz | JACK | 806,198,535 | 249,514,342 | 30.95 | 192,126,042 | 315,447,478 |
| 9 | Nimroz | MRCA | 349,415,887 | 13,485,457 | 3.86 | 11,192,926 | 197,602,224 |
| 10 | Wardak | SCA | 1,255,292,535 | 849,981,460 | 67.71 | 654,485,724 | 211,998,112 |
| 11 | Laghman | HNTPO | 768,990,045 | 406,091,565 | 52.81 | 312,690,504 | 234,927,472 |
| 12 | Bamyan | AKF | 670,243,315 | 273,398,601 | 40.79 | 210,516,922 | 202,880,072 |
| 13 | Faryab | SDO | 832,717,560 | 346,642,379 | 41.63 | 266,914,628 | 273,575,914 |
| 14 | Kandahar | BARAN | 904,454,841 | 552,358,327 | 61.07 | 425,315,910 | 202,783,100 |
| 15 | Kabul | SDO | 535,806,364 | 233,554,490 | 43.59 | 179,836,957 | 189,547,260 |
| 16 | Paktika | OHPM | 770,476,637 | 410,081,120 | 53.22 | 315,762,462 | 237,237,512 |
| 17 | Nooristan | AHEAD | 565,186,841 | 46,050,556 | 8.15 | 35,458,926 | 177,671,975 |
| 18 | Paktia | HEWAD | 677,637,580 | 335,003,104 | 49.44 | 257,952,387 | 203,197,579 |
| 19 | Khost | OHPM | 487,209,779 | 164,802,243 | 33.83 | 136,785,861 | 205,929,249 |
| 20 | Balkh | BDN | 987,556,190 | 368,835,905 | 37.35 | 284,003,645 | 373,383,796 |
| 21 | Urozgan | Urozgan | 741,001,408 | 348,628,733 | 47.05 | 268,444,122 | 262,309,018 |
| 22 | Nengarhar | AADA | 2,253,488,090 | 293,981,050 | 13.05 | 244,004,272 | 1,170,365,791 |
| 23 | Kunar | HN- TPO | 855,390,723 | 274,524,030 | 32.09 | 211,383,503 | 355,734,537 |
| 24 | Ghor | CHA | 1,004,487,757 | 633,644,390 | 63.08 | 487,906,180 | 202,637,678 |
| 25 | Logar | CAF | 1,000,571,666 | 455,879,126 | 45.56 | 351,026,925 | 349,249,593 |
| 26 | Sarepol | SAF | 549,902,325 | 238,157,221 | 0.43 | 197,670,492 | 185,058,068 |
| 27 | Badghis | MMRCA | 736,348,743 | 224,111,938 | 0.30 | 172,566,188 | 168,428,843 |
| 28 | Farah | MRCA | 840,234,613 | 513,669,736 | 0.61 | 395,525,695 | 198,966,916 |
| 29 | Helmand | BRAC | 773,541,780 | 192,348,074 | 0.25 | 159,648,899 | 308,621,029 |
| 30 | Zabul | SDO | 434,213,465 | 88,580,208 | 0.20 | 68,206,757 | 127,181,902 |
| 31 | Daikondi | MOVE | 750,155,974 | 371,989,743 | 0.50 | 286,432,100 | 201,002,975 |
| | | | | | | **8,074,350,985** | **8,637,113,002** |

The following table ( Table 10) gives the P4P disbursements as a percentage of total cumulative P4P disbursements for semi-annual period (April to September 2020 - 5th and 6th P4P installments):

Table 10: P4P payment to SPs by province

| NO | Province name | Service Provider | Total contract amount in AFN (lump sum plus P4P) [1] | Lump sum amount in AFN | P4P amount in AFN in contract | P4P as % of total contract | Total P4P amount disbursed for period of April to Sep 2020 (5th & 6th P4P installments) | P4P amount as % of total P4P |
|---|---|---|---|---|---|---|---|---|
| 1 | Badakhshan | AKF | 1,123,448,454 | 68,104,321 | 1,055,344,133 | 94% | 142,521,129 | 14% |
| 2 | Baghlan | BDN | 872,392,887 | 418,760,721 | 453,632,166 | 52% | 81,198,206 | 18% |
| 3 | Samangan | AHEAD | 447,343,687 | 53,029,171 | 394,314,516 | 88% | 50,826,344 | 13% |
| 4 | Ghazni | AADA | 1,292,112,405 | 622,370,285 | 669,742,120 | 52% | 138,281,523 | 21% |
| 5 | Takhar | AHEAD | 767,250,877 | 253,880,980 | 513,369,897 | 67% | 63,424,186 | 12% |
| 6 | Jawzjan | SAF | 561,183,747 | 253,537,080 | 307,646,667 | 55% | 42,706,692 | 14% |
| 7 | Herat | AADA | 1,163,168,371 | 748,685,448 | 414,482,923 | 36% | 72,372,444 | 18% |
| 8 | Kunduz | JACK | 806,198,535 | 249,514,342 | 556,684,193 | 69% | 100,402,458 | 18% |
| 9 | Nimroz | MRCA | 349,415,887 | 13,485,457 | 335,930,430 | 96% | 46,670,645 | 14% |
| 10 | Wardak | SCA | 1,255,292,535 | 849,981,460 | 405,311,075 | 32% | 65,374,711 | 16% |
| 11 | Laghman | HNTPO | 768,990,045 | 406,091,565 | 362,898,480 | 47% | 65,052,823 | 18% |
| 12 | Bamyan | AKF | 670,243,315 | 273,398,601 | 396,844,714 | 59% | 57,613,788 | 15% |
| 13 | Faryab | SDO | 832,717,560 | 346,642,379 | 486,075,181 | 58% | 68,301,539 | 14% |
| 14 | Kandahar | BARAN | 904,454,841 | 552,358,327 | 352,096,514 | 39% | 46,973,101 | 13% |
| 15 | Kabul | SDO | 535,806,364 | 233,554,490 | 302,251,874 | 56% | 38,110,880 | 13% |
| 16 | Paktika | OHPM | 770,476,637 | 410,081,120 | 360,395,517 | 47% | 54,672,913 | 15% |
| 17 | Nooristan | AHEAD | 565,186,841 | 46,050,556 | 519,136,285 | 92% | 47,039,857 | 9% |
| 18 | Paktia | HEWAD | 677,637,580 | 335,003,104 | 342,634,476 | 51% | 40,998,875 | 12% |
| 19 | Khost | OHPM | 487,209,779 | 164,802,243 | 322,407,536 | 66% | 51,813,277 | 16% |
| 20 | Balkh | BDN | 987,556,190 | 368,835,905 | 618,720,285 | 63% | 125,403,615 | 23% |
| 21 | Urozgan | Urozgan | 741,001,408 | 348,628,733 | 392,372,675 | 53% | 69,240,473 | 18% |
| 22 | Nengarhar | AADA | 2,253,488,090 | 293,981,050 | 1,959,507,040 | 87% | 357,372,605 | 18% |
| 23 | Kunar | HN- TPO | 855,390,723 | 274,524,030 | 580,866,693 | 68% | 83,090,743 | 14% |
| 24 | Ghor | CHA | 1,004,487,757 | 633,644,390 | 370,843,367 | 37% | 59,845,930 | 16% |
| 25 | Logar | CAF | 1,000,571,666 | 455,879,126 | 544,692,540 | 54% | 88,734,690 | 16% |
| 26 | Sarepol | SAF | 549,902,325 | 238,157,221 | 311,745,104 | 57% | 36,291,134 | 12% |
| 27 | Badghis | MMRCA | 736,348,743 | 224,111,938 | 512,236,805 | 70% | 55,876,736 | 11% |
| 28 | Farah | MRCA | 840,234,613 | 513,669,736 | 326,564,877 | 39% | 56,095,683 | 17% |
| 29 | Helmand | BRAC | 773,541,780 | 192,348,074 | 581,193,706 | 75% | 87,931,644 | 15% |
| 30 | Zabul | SDO | 434,213,465 | 88,580,208 | 345,633,257 | 80% | 33,785,301 | 10% |
| 31 | Daikondi | MOVE | 750,155,974 | 371,989,743 | 378,166,231 | 50% | 46,937,248 | 12% |

2,374,961,193

The following table (Table 11) gives the ratio between the two amounts paid to a province:

Table 11: Ratio between lumpsum and P4P to SPs by province

| NO | Province name | Service Provider | Total lump sum amount disbursed as of Q7 in AFN (end of Sep 2020) | Total P4P award as of Q7 in AFN | Ratio between Lumpsum and P4P |
|---|---|---|---|---|---|
| 1 | Badakhshan | AKF | 56,526,585 | 506,168,798 | 8.95 |
| 2 | Baghlan | BDN | 322,445,754 | 264,226,286 | 0.82 |
| 3 | Samangan | AHEAD | 40,832,461 | 203,994,439 | 5.00 |
| 4 | Ghazni | AADA | 516,567,333 | 414,963,084 | 0.80 |
| 5 | Takhar | AHEAD | 195,488,354 | 271,210,801 | 1.39 |
| 6 | Jawzjan | SAF | 195,223,551 | 186,442,847 | 0.96 |
| 7 | Herat | AADA | 621,408,919 | 234,368,668 | 0.38 |
| 8 | Kunduz | JACK | 192,126,042 | 315,447,478 | 1.64 |
| 9 | Nimroz | MRCA | 11,192,926 | 197,602,224 | 17.65 |
| 10 | Wardak | SCA | 654,485,724 | 211,998,112 | 0.32 |
| 11 | Laghman | HNTPO | 312,690,504 | 234,927,472 | 0.75 |
| 12 | Bamyan | AKF | 210,516,922 | 202,880,072 | 0.96 |
| 13 | Faryab | SDO | 266,914,628 | 273,575,914 | 1.02 |
| 14 | Kandahar | BARAN | 425,315,910 | 202,783,100 | 0.48 |
| 15 | Kabul | SDO | 179,836,957 | 189,547,260 | 1.05 |
| 16 | Paktika | OHPM | 315,762,462 | 237,237,512 | 0.75 |
| 17 | Nooristan | AHEAD | 35,458,926 | 177,671,975 | 5.01 |
| 18 | Paktia | HEWAD | 257,952,387 | 203,197,579 | 0.79 |
| 19 | Khost | OHPM | 136,785,861 | 205,929,249 | 1.51 |
| 20 | Balkh | BDN | 284,003,645 | 373,383,796 | 1.31 |
| 21 | Urozgan | Urozgan | 268,444,122 | 188,562,670 | 0.70 |
| 22 | Nengarhar | AADA | 244,004,272 | 1,170,365,791 | 4.80 |
| 23 | Kunar | HN- TPO | 211,383,503 | 355,734,537 | 1.68 |
| 24 | Ghor | CHA | 487,906,180 | 202,637,678 | 0.42 |
| 25 | Logar | CAF | 351,026,925 | 349,249,593 | 0.99 |
| 26 | Sarepol | SAF | 197,670,492 | 185,058,068 | 0.94 |
| 27 | Badghis | MMRCA | 172,566,188 | 168,428,843 | 0.98 |
| 28 | Farah | MRCA | 395,525,695 | 198,966,916 | 0.50 |
| 29 | Helmand | BRAC | 159,648,899 | 308,621,029 | 1.93 |
| 30 | Zabul | SDO | 68,206,757 | 127,181,902 | 1.86 |
| 31 | Daikondi | MOVE | 286,432,100 | 201,002,975 | 0.70 |

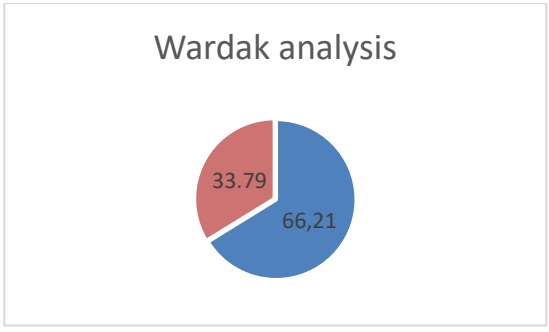
Five provinces have distinctly high ratio - Nimroz, Badakhstan, Nooristan, Samangan and Nangarhar. They are highest risk for cash flow problem should the performance fails to reach high level.

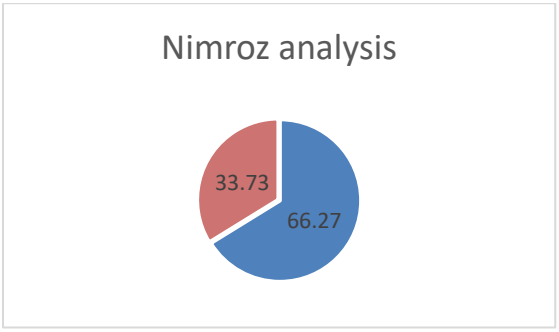
## 6.3 Expenditure analysis

To understand the cash flow problem better, an analysis of the expenditures by categories has been carried out for two provinces – Nimroz with least proportion of lumpsum and Wardak with highest proportion of lumpsum. The reported categories of expenditures were divided into two – fixed expenses (incurred irrespective of the quantum of performance) and variable (expenses proportionate to the quantities of services delivered). The following is the division of two categories:

| ***Fixed expenditure items*** | ***Variable expenditure items*** |
|---|---|
| Staffing | Pharmaceuticals |
| Health facility premises | Other health supplies |
| Staffing (management, audit) | IT and Telephony |
| Central premises costs | Transport |
| Marketing/Communications | Subsistence during local visits |
| Medical equipment | Staff training |
| Non-medical equipment | International travel |
| Repair & maintenance | Office supplies |
| | Utilities |
| | Vehicle rental |
| | Other expenses |
| | Overhead |

The following is the expenditure pattern in the two extreme provinces chosen. The blue colour represents fixed costs and the brown color is for variable costs.




Interestingly, the conclusions are strikingly similar in both provinces. 66% of the expenditures are incurred for fixed costs, meaning a recurrent liability each month irrespective of the quantum of performance. Unless this proportion is protected by a lumpsum, there will be high risk in case the province the fails to perform at least at break-even level. The impact of this attribute is already visible in a few provinces with low lumpsum proportions, and which did not perform very high – for example, Nooristan, Zabul. And once a province with low lumpsum enters a low performance zone, it becomes a vicious cycle – low performance leads to low earnings – unable to pay for fixed costs like salaries, equipment & repairs – lower performance, ultimately leading to failure.

Moving forward, this attribute needs attention while designing the next phase of the project. The fixed expenditure items must be protected by the lumpsum proportion of the provincial grant. The MOPH has an expenditure management information system (EMIS) which would be explored in coming months. The financial data as well as the expenditure data can be converted into dashboard in public domain for better transparency and accountability.

# 7 Performance Improvement Plans - An analysis

According to the SOPs, the PIP aims to identify performance-related problems and implement corrective actions for them within a specific timeframe. As appropriate, we use root cause analysis tools to identify underlying central problem and come up with corrective measures. The PIP process is taken seriously as an integral part of quarterly and semi-annual reviews

When and where the data is available, PIP should also incorporate the results of Community Scorecard prepared by Health Scorecard Committee supported by the Citizens' Charter National Priority Program. The SP is expected to submit the PIP within one week after the problem identification. The PIP should cover the remedial actions identified and agreed upon by the SP and Senior Performance Management Specialist. In brief, for the PIP,

Purpose of the PIP

- Remove implementation bottlenecks.
- Guide MOPH leadership visits

Five drivers of a good PIP

- Identify performance related problem and its cause.
- Identify and agree on corrective and feasible action.
- Defined timeframe (maximum three to six months)
- Number of actions limited to 20, lower numbers preferred for better focus.
- Dynamic tool – retire problems resolved, add new ones emerging.

The SOPs have prescribed a template for the PIP record. The PIP is expected to be a living document, not just another document. An analysis of the PIPS at present shows the following issues:

- Inconsistency across provinces
- Recurrent issues are observed e.g., shortage of medicines.
- Inclusion of issues without a realistic intervention or action in three to six months' period
- Lack of dynamism – difficult to distinguish what has been achieved already.
- Mix up of Problem statement, Root cause(s) and Expected change.
- Overall accountability of Provincial Performance Review committee not clear

There is subjectivity in analyzing the progress with individual action in the PIP during quarterly and semi-annual reviews.

Common issues observed across multiple PIPs

1. *Human resources* – shortage of staff due to non-availability of a particular category (e.g., Anesthesia), non-availability of female staff and if males are acceptable in lieu of females, difficult areas where health providers do not want to work, low wages, discrepancy between the contract and national policy like inclusion of Risk Allowance, high turnover, interference in the selection process.
2. *Security* - an accepted major challenge in Afghanistan except for local relationship of the SP with AGEs and involvement of the elders, unclear way forward in short term, absence of differential mechanism for measuring performance in high-risk areas, application of force majeure. There is a need to conduct an assessment on the extent of negative impact of insecurity on availability and access to services in addition to the quantitative HMIS data. For this, mapping is essential for all the areas right up to the HF level – easy to reach and secure, easy to reach and insecure, hard to reach and secure, and, hard to reach and insecure.
3. Delayed payment to SPs leads to delayed procurements, cancelled trainings and supervision visits, delayed salary payments.
4. *Adequacy and frequency of drug supplies* – shortages because of lower quantities procured due to budget issues or otherwise, erratic supplies, faulty procurement process, distribution to difficult geographic area e.g., Badakhshan and Daikundi.
5. *Data quality* – limited capacities for analysis, interpretation, and feedback at provincial/local levels
6. *Behavioral issues* - poor managerial supervision, low motivation, high turnover, and related staff performance issues
7. *Direct impact of COVID-19* on the essential health services due to lock downs/restrictions and fear among health workers

The five SMART principles (specific, measurable, achievable, realistic, time-bound) have not been consistently followed across different issues for the provinces. In fact, the columns on timelines and required assistance from the technical departments are not always used  The columns on required actions and recommendations by the committee can be merged. The format can be made simpler and automated for real time updating. There is limited or no accountability for the actions other than the aspects covered by the BSC. The role of Provincial performance review committee (PPRC) is unclear except for putting signatures on the PIP document. This issue needs to be taken up during the revision of SOPs and consensus need to be reached between all stakeholders to ensure proper implementation of these suggestions in future thereby making PIPs more useful living documents.

The overall conclusion is that the PIP as a tool has not been very effective in making significant improvements in the implementation issues. An action to consider for future is institutional arrangements for the cross-cutting and recurrent issues as mentioned above. For example, pooled procurement and supply systems across multiple provinces or even nationally; conceptualizing a national HR policy addressing the practical issues and its implementation; creative solutions for data quality issues e.g., data triangulation. Issues directly impacting the services may be elevated and included in the BSC. A large project like *Sehatmandi* also offers an opportunity for long term health system changes alongside of provision of the health services.

# 8: Rural Citizen's Chart : ISM Scorecard

The results of the three rounds of Rural Citizen's Charter produced by Ministry of Rural Rehabilitation and Development (MRRD) and Independent Directorate of Local Governance (IDLG) are now available, and the health related information is being presented briefly in this round of SAPR.

The following three categories of health facilities were assessed for the Minimum Services Standards for the health sector.

Health Sub Centre Minimum Standard of Services questions included:

1. Are Health MSS clearly indicated at the information board at the health sub-center?
2. Is the Health Sub-Center open during the official time?
3. Does the Health Sub-Center have one midwife?
4. Does the Health Sub-Center provide family planning?
5. Does the Health Sub-Center provide services for any of the following conditions? (*Diarrhea, Malaria, Antenatal Care, Tuberculosis Detection and Referral, and Immunizations)*

Basic Health Centre (BHC) assessment included the following questions?

1: Are health MSS clearly indicated at the information board at the BHC?

2: Is the BHC open during the official hours?

3: Does the BHC has one mid wife and one nurse?

4: Does the BHC provide immunization?

5: Does the BHC provide Family Planning services?

6: Does the BHC provide services for Diarrhea, Malaria, ANC,TB detection and Referral?

Community Scorecard for Comprehensive Health Center included the following questions as minimum service standards:

1. Are Health MSS clearly indicated at the information board at the Comprehensive health Center?
2. Is the comprehensive Health Center open during the official time?
3. Does the Comprehensive Health Center have one doctor, one midwife and one nurse?
4. Does the Comprehensive Health Center provide pre, during, and post delivery services for pregnant women?
5. Does the Comprehensive Health Center provide immunizations?
6. Does the Comprehensive Health Center provide services for any of the following conditions? Diarrhea, Malaria, Tuberculosis Detection and Referral?

The results of the three rounds (Table 12) of the rural scorecard show that overall, for Health Sub Centre, MSS has registered an increase in their ability to meet them. From 76% in the first round, the compliance improved to 83% in the third round.

For Basic Health Centers, improved between round one and two (from 77% to 85%) and then registered a slight decline in the third round (83%).

The Comprehensive Health Centre, the compliance was reported to be relatively high, and it increased from 89% in the first round to 94% in the third round.

Table 12: Overall Health MSS by ISM Rural Citizen's Chart

**Overall Health MSSs Status by facility type**

| Clinics/Communities reported Health MSSs | | | | | | |
|---|---|---|---|---|---|---|
| MSS Scorecard Rounds | First Round (HSC: 266, BHC: 266, CHC: 110) | | Second Round (HSC: 254, BHC: 249, CHC: 106) | | Third Round (HSC: 230, BHC: 212, CHC: 91) | |
| | MSS Meet (# and %) | MSS Not Meet (# and %) | MSS Meet (# and %) | MSS Not Meet (# and %) | MSS Meet (# and %) | MSS Not Meet (# and %) |
| Health Sub-Center (HSC) | 202 (76%) | 64 (24%) | 207 (81%) | 47 (19%) | 192 (83%) | 38 (17%) |
| Basic Health Center (BHC) | 206 (77%) | 60 (23%) | 211 (85%) | 38 (15%) | 177 (83%) | 35 (17%) |
| Comprehensive Health Center (CHC) | 98 (89%) | 12 (11%) | 96 (91%) | 10 (9%) | 86 (94%) | 5 (6%) |

# 9 General update and impact of COVID-19 pandemic on essential services in Afghanistan

The uniqueness of the six months' period under reference is COVID-19 pandemic, first wave of which coincided with first half of this semiannual period. Ten out of 11 P4P indicators had a decline in the quarter of April to June 2020 as compared to the preceding quarter as well as the same quarter in the previous year 2019. The next quarter of July to September 2020 had rebounds in these indicators, most significantly for the major surgeries. The individual indicators have been described in a previous chapter of this report.

The first case of COVID-19 in Afghanistan was reported on 26 February 2020. As of 31 December 2020, MoPH data showed that 51,526 people across all 34 provinces in Afghanistan are confirmed to have had COVID-19. Some 41,727 people have recovered, and 2,188 people have died – at least 86 of whom are healthcare workers. Only 165,628 people out of a population of 36.7 million have been tested. Afghanistan now has a test positivity-rate – positive tests as a percentage of total tests – of 31 per cent, suggesting overall under-testing of potential cases. Most recorded deaths were men between the ages of 50 and 79. Men account for 68 per cent of the total COVID-19 confirmed cases in the MoPH data, although this may be the result of overrepresentation of men in testing. Due to limited public health resources and testing capacity, lack of people coming forward for testing, as well as the absence of a national death register, confirmed cases of and deaths from COVID-19 are likely to be under-reported overall in Afghanistan. This is supported by the results of an early seropositivity study by MoPH, Johns

Hopkins and WHO that estimated 30 per cent of the population had been exposed to COVID-19 by June 2020. Afghanistan, bordering the Islamic Republic of Iran – an early hotspot for COVID-19 – was at a heightened risk of large-scale community transmission in the initial stage of the pandemic. Since January 2020, approximately 500,000 Afghans have returned from Iran.

Second Wave**:** The MoPH has confirmed that Afghanistan is in a second wave of the COVID-19 pandemic. Following two months of consistently lower confirmed COVID-19 cases, now both the suspected and confirmed cases of COVID-19 are again rising in the western part of the country in particular. While the official numbers across the country are not yet at the same level as the May/June peak, when taken together with reports of increased hospitalizations for COVID-19-like symptoms. The rollout of the annual influenza vaccination across Afghanistan will be more important than ever to help the health system manage the rise in COVID-19 cases. Public health experts strongly urge the public to follow health advice on physical distancing, mask wearing, good hygiene, hand washing and other proven strategies that mitigate the risk of COVID-19 transmission amid this second wave.

The country has spruced up its preparedness for dealing with the second wave with establishment of laboratories and increased testing capacities, hospital supplies to take of patients with severe disease, vaccine introduction plans, mass public education and training of the health workers. The HMIS captures live data on COVID – daily and cumulative tally of tests done, positive cases, active cases, recovered cases and deaths. Highest numbers are reported from Kabul and Herat. This may also be due to the fact that more tests have been conducted in these two provinces than any other provinces. In fact, Kabul counts for more than half of the total tests conducted in the country, therefore the higher detection of COVID cases may be partially explained by this.

**Health Services**: Hospitals and clinics continue to report challenges maintaining or expanding their facilities' capacity to treat patients with COVID-19, as well as maintaining essential health services, especially in areas of active conflict. WHO stresses the need to balance the demands of responding directly to COVID-19, with simultaneously engaging in strategic planning and coordinated action to maintain essential health service delivery, mitigating against the risk of system collapse. More than 8% of total confirmed cases are healthcare staff. HFs continue to report shortfalls in PPEs. Medical supplies and equipment. 15 laboratories are now operating in Afghanistan, however with limited capacities and frequent stockouts of the supplies.

The P4P indicators are reported in the HMIS. The direct impact of COVID-19 on the basic health services is reflected in the program performance indicators. It is noted that no P4P indicator has shown any influence of the seasonality the decline was observed in comparison with both the preceding period as well as the same period in previous year.

The conclusion is that COVID-19 impacted both directly and indirectly the delivery of health services, adding yet another challenge to its list of problems as a fragile country in conflict. There are many donors aiding Afghanistan. However, structure and processes created by *Sehatmandi* have provided a ready platform for monitoring progress. This will be explained in the next semi-annual report.

## Afghanistan Health Indicators

| | | | | |
|---|---|---|---|---|
| 1 | **Total population (million)** | 32.9<br>37.6 | 2020<br>2020 | NSIA<br>UNFPA* |
| 2 | **Population under age 15y (%)** | 47.7 | 2017 | ALCS |
| 3 | **Population over age 65y (%)** | 2.7 | 2017 | ALCS |
| 4 | **Life expectancy at birth, female/male (year)** | 62-64 | 2010 | AMS |
| 5 | **Total fertility rate** | 5.1 | 2018 | AHS 2018 |
| 6 | **Infant mortality rate (per 1,000 live births)** | 48 | 2018 | UN IGME 2019 |
| 7 | **Under five mortality rate (per 1,000 live births)** | 62 | 2018 | UN IGME 2019 |
| 8 | **Neonatal mortality rate (per 1,000 live births)** | 37 | 2018 | UN IGME 2019 |
| 9 | **Maternal mortality ratio (per 100,000 live births)** | 638 | 2017 | MMEIG2019 |
| 10 | **Contraceptive (modern) prevalence rate (%)** | 17.5 | 2018 | AHS 2018 |
| 11 | **Skilled antenatal care (at least 1 visit) (%)** | 65 | 2018 | AHS 2018 |
| 12 | **Last birth protected against tetanus (%)** | 53<br>39.6 | 2015<br>2018 | AfDHS 2015<br>AHS 2018 |
| 13 | **Institutional deliveries (%)** | 56.3 | 2018 | AHS 2018 |
| 14 | **Exclusive breastfeeding under age 6 months (%)** | 58 | 2018 | AHS 2018 |
| 15 | **Third dose of pentavalent vaccine crude coverage (Card + History) (12-23 months) (%)** | 61 | 2018 | AHS 2018 |
| 16 | **Measles vaccination coverage (Card + History) (12-23 months) (%)** | 64 | 2018 | AHS 2018 |
| 17 | **All basic vaccinations coverage (Card + History) (12-23 months) (%)** | 51 | 2018 | AHS 2018 |
| 18 | **Children received vitamin A in last 6 months (6-59 months) (%)** | 68 | 2018 | AHS 2018 |
| 19 | **Density of physicians (per 10,000 population) (2019)** | 3.5 | 2019 | MOPH |
| 20 | **Density of nurses and midwives (per 10,000 population)** | 5.2 | 2019 | MOPH |
| 21 | **Total health expenditure as a percentage (%) of GDP** | 12.7 | 2017 | 4th NHA |
| 22 | **Government expenditure on health as a percentage (%) of total expenditure on health** | 5 | 2017 | 4th NHA |
| 23 | **Share of out of pocket spending on health (%)** | 75 | 2017 | 4th NHA |

| | | | | |
|---|---|---|---|---|
| 24 | **Adult literacy rate (15 years of age and over)** | 34.8 | 2017 | ALCS |
| 25 | **Population using improved drinking water sources (%)** | 63.9 | 2017 | ALCS |
| 26 | **Population using improved sanitation facilities (%)** | 53 | 2017 | ALCS |
| 27 | **Poverty headcount ratio at $1.25 a day (PPP)** | 54.5 | 2017 | ALCS |
| 28 | **Gender Development Index rank out of 176 countries** | 170 | 2019 | UNDP Human development report |
| 29 | **COVID-19 seropositivity for all population** | 31.5% (29.1% males & 32% females) | 2020 | National seroepidemiolo-gical study |
| 30 | **COVID-19 seropositivity among 5-17 age group** | 25.3% | 2020 | National seroepidemiolo-gical study |
| 31 | **COVID-19 seropositivity among 18 years and older** | 35.2% | 2020 | National seroepidemiolo-gical study |