OPERATIONS MANUAL

RESULTS BASED FINANCING INTERVENTION IN BPHS FACILITIES AND HOSPITALS IN AFGHANISTAN

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List of Abbreviations

AHS	Afghanistan Health Survey
ANC	Antenatal Care
ANDS	Afghanistan National Development Strategy
BHC	Basic Health Center
BPHS	Basic Package of Health Services
BSC	Balanced Score Card
CHC	Comprehensive Health Center
CHW	Community Health Worker
CMP	Couple Month Protection
CPR	Contraceptive Prevalence Rate
DAB	Da Afghanistan Bank
DH	District Hospital
DPT	Diphtheria Pertussis Tetanus
DSF	Demand Side Financing
EC	European Commission
EPI	Expanded Program on Immunization
GA	Grant Agreement
GAVI	Global Alliance for Vaccines and Immunization
GoA	Government of Afghanistan
HEFD	Health Economics and Finance Department
HMIS	Health Management Information System
HNSS	Health and Nutrition Sector Strategy
HRITF	Health Results Innovation Trust Fund
HSS	Health Systems Strengthening
IDA	International Development Assistance
JHU	Johns Hopkins University
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MICS	Multi-Indicator Cluster Survey
MoF	Ministry of Finance
MoPH	Ministry of Public Health
MoPH-SM	Ministry of Public Health Strengthening Mechanism
NGO	Nongovernmental Organization
NMC	National Monitoring Checklist
NRVA	National Risk and Vulnerability Assessment
OM	Operations Manual
PHD	Provincial Health Director
PHO	Provincial Health Office
PHCC	Provincial Health Coordination Committee
PNC	Post-natal Care
RBF	Results Based Financing
RH	Reproductive Health
SBA	Skilled Birth Attendance
SC	Sub-centers

SHARP	Strengthening Health Activities for the Rural Poor
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1. Introduction

1.1 Purpose of Operation Manual

This operation manual (OM) outlines the relevant details required for the implementation of the Results Based Financing (RBF) Project for both the Basic Package of Health Services (BPHS) and hospitals. It outlines the financial management, monitoring arrangements, disbursement that will govern the actions of all parties involved. The environmental and social safeguards outlined in Strengthening Health Activities for the Rural Poor (SHARP) and agreed between the Islamic Republic of Afghanistan and the World Bank applies for RBF.

This OM is intended to be a reference document for project partners and to delineate the key steps and requirements for successful implementation. Any change to the OM during the course of implementing this Project needs clearance from the Bank. Any project parameters specified in the grant agreement (GA) supersede the terms of this OM. Changes to the OM and GA cannot be made without a formal amendment process.

1.2 Background of health services in Afghanistan

Over the last four years, the delivery of Basic Package of Health Services (BPHS) services has improved considerably in Afghanistan as demonstrated by household surveys and facility surveys. While coverage of services and quality of care has significantly improved, household surveys continue to show that the coverage of important preventive, promotive, and curative services remains low by global standards. Whereas the use of modern contraceptives in rural Afghanistan has increased more than threefold, from 5% as estimated from the Multiple Indicator Cluster Survey (MICS) in 2003 (Johns Ho pkins University (JHU), 2005) to 16% as shown by the Afghanistan Health Survey (AHS) in 2006 (JHU, 2008) , the absolute levels of contraceptive prevalence rate (CPR) are still very low. Trends in antenatal care (ANC) use in rural Afghanistan show more than six-fold increase from 5% in MICS in 2003 (JHU, 2005) to 32% in 2006 (JHU, 2008).

Though the proportion women who delivered under the attention of skilled practitioner has increased to about 19% (JHU, 2008), Afghanistan still also has one of the highest maternal mortality ratios (MMR) worldwide at 1800 per 100,000 live births (UNICEF, 2009). Diphtheria Pertussis Tetanus (DPT) coverage is commonly used as a measure of the effectiveness of the routine health care system in delivering immunization services. Over 60% of 12-23 month olds received DPT1. However, with the second dose of DPT, there is a 12-percentage point drop in coverage and with the third dose there is a further 14 point drop to 34.6%. These declines in DPT coverage indicate that there are opportunities missed by the health care system (JHU, 2008)

Improvements in maternal and child health are the cornerstone of the Health and Nutrition Sector Strategy of MoPH. There are factors at both the household and facility level that contribute to low utilization rates such as i) motivational problems amongst providers; ii) quality of patient-provider interactions; iii) hours of operation of the health facilities (HF) and; iv) others including travel time to the

HF, and social and cultural factors. Hence, linking payment to health providers with their performance in the amount and quality of the services they provide could address the first three problems. This method of linking health outputs to performance is called results-based financing (RBF).

1.3 Result Based Financing in Afghanistan

There are a number projects that have been using RBF schemes in Afghanistan. Non-governmental organizations (NGO) in Afghanistan have used non-monetary goods such as well-baby delivery kits and other performance payments for mothers to deliver using a skilled birth attendant. They have also paid community health workers (CHW) for referring women to the health facility for deliveries using contraception, for tuberculosis case detection, etc. These schemes, however, have been not been evaluated formally to show their impact on health outcomes. The World Bank has also supported the development of performance-based contracts/performance partnership agreements (PPA) in Afghanistan.

There are two formal evaluations of RBF to be conducted concurrently in Afghanistan. GAVI Health System Strengthening (GAVI-HSS) is supporting district-level implementation and evaluation of demand-side financing schemes for maternal health outcomes in four provinces in Afghanistan. A multi-donor trust fund is supporting the Ministry of Public Health (MoPH) to implement and evaluate supply-side RBF that targets MDGs 4 and 5. The strength of the proposed RBF interventions in Afghanistan is that it is complimentary to the existing performance based systems and will be implemented within the framework of the exiting health system.

1.4 Basic Principles

One of the possible means to improve performance of the health system is to motivate front-line health workers by providing them with performance payment payments above their salaries that are linked directly to the amount and quality of the services they provide. This method of linking health outputs to payments is called RBF. This direct link between payment and results is expected to lead to improved health system performance at modest cost. However, the intervention has to be systematically evaluated and evidence produced as to the impact of the RBF scheme. The Ministry of Public Health will implement an RBF intervention and evaluate its impact on coverage of health services.

Related to the implementation of RBF are certain terms and principles. Given below are explanations of some of the terms that will be used throughout the document.[1]

Performance: the results delivered by the provider of health services, in terms of both the quantity and quality of the services.

Provider: Refers to HFs that provide health services directly to clients (such as health clinics or hospitals)

Implementer: Refers to non-governmental organizations (NGO), Ministry of Public Health-Strengthening Mechanism (MoPH-SM) and hospitals that are selected to participate in the RBF scheme.

[1]Some of the definitions are modified from "Using Performance-Based Payments to Improve Health Programs" in The Manager's Electronic Resource Center of the Management Sciences for Health.
http://erc.msh.org/staticpages_printerfriendly/2.1.11_finance_English_.htm

Contract: Refers to an agreement between two parties that binds them in a framework for action to attain agreed goals and objectives, within a specified budget and time. It is a written agreement of the responsibilities and obligations of both parties. This includes a legally enforceable contract as well as service level agreements. Service level agreements include agreements signed by two institutions that are part of the same legal entity and thus cannot enter into a legal arrangement with each other. An example is an agreement between central MoPH and the provincial health office (PHO) or between central MoPH and MoPH-SM.

1.5 Project Objectives

The general objective of the RBF intervention is to improve millennium development goals (MDG) 4 (to reduce child mortality) and MDG 5 (to reduce maternal mortality) by implementing interventions that provide performance payments for health workers in order to:

i) Increase key maternal and child health outputs.
ii) Further improve the quality of health care services.
iii) Ensure that patients and communities are increasingly involved and satisfied with the publicly financed health services they receive.

Assessing the effectiveness of the interventions its impact on access, coverage and quality of services are all highly relevant to MoPH long-term policy. Given these considerations, key questions addressed by the evaluation include:

a) What is the impact of the intervention on utilization and quality of priority maternal and child health services (family planning, antenatal care, institutional deliveries and immunization)?
b) What are the lessons that can be learned from project implementation? How can these lessons be applied to scaling up the intervention in a sustainable manner both financially and institutionally?

2. Project Design

2.1 BPHS Intervention

This intervention will offer NGOs that are contracted to deliver health services and MoPH-SM performance-based payment for achieving improved coverage of essential maternal and child health services.

2.1.1 Design

The proposed intervention design has two groups:

1. Treatment groups: performance-based performance payments are paid to health workers at BPHS facilities
2. Control groups: where no additional payments are made and operational activities follow the regular contractual arrangements.

The intervention provinces are selected based on the following criteria: a) are secure enough to be accessible for regular monitoring; b) are under a single contract for health care delivery; and c) are not implementing the GAVI-HSS demand side financing intervention. In case security in a selected province worsens to the extent monitoring and supervision is impossible, the intervention may stop in that particular province. All the BPHS HFs within the selected provinces will be randomly assigned to one of the two intervention groups. Based on the criteria for selection of provinces, Table 1 in Annex 1 presents the list of provinces to be included in the RBF intervention. There are provincial, regional, implementing agency, and funding agency differences that exist between provinces. The choice of provinces will reflect these differences. Careful documentation of implementation processes within a province and the comparison of service outputs at a facility level between treatment and control HFs will enable comparison under different conditions in Afghanistan.

2.1.2 Output Indicators

The goal of implementing the RBF intervention in Afghanistan is to impact MDGs 4 and 5 by improving coverage of maternal and child health services within the existing health system and without creating unnecessary parallel processes. The indicators for success, presented in Table 2 (Annex 1), are aligned with the Health and Nutrition Sector Strategy (HNSS). The change in these indicators will be measured at beginning and end of the scheme through baseline and end-of-project surveys. These results will show the impact of RBF in Afghanistan. However, as performance payments to health workers will be based on the Health Management Information System (HMIS) data and related monitoring data, the selected indicators have to be collected at the HF level (except for contraceptive prevalence rate (CPR)). For this, their definitions are slightly modified. Table 3 of Annex 1 presents these indicators of performance, their definitions, and means of measurement.

2.1.3 HMIS Strengthening and Setting Baselines

The performance payments to providers will be given for each output above a baseline estimate. The proposed performance indicators are prone to over-reporting. Inflated baseline estimates can be problematic for RBF as the rate of potential increase is artificially curtailed. Such limitations will be addressed while setting of the baselines and verifying data. At the same time, care should be taken not to under estimate baseline values artificially.

In order to address the limitations with HMIS data, RBF will strengthen the HMIS before the start of the intervention. One of the activities for strengthening HMIS will be improved reporting of data on key indicators through the introduction of a new reproductive health (RH) HMIS register, health cards and a tally sheet. The baseline will be set based on the estimates in the new register. Baselines will be set for each health facility in the province participating in the RBF intervention. At the same time, a careful comparison will be done between the two estimates and the current coverage for the province to see the magnitude of the discrepancies and to mitigate any system gaming in setting new estimates artificially low. Strengthening of the HMIS will also involve verification by third party of the data recorded in the registers. Supervisors will randomly visit a sample of houses selected from the register and visit them to verify if indeed the services were received.

i) Contraceptive Prevalence Rate (CPR): The baseline for each selected province will be established based on the most recent household survey data -the National Risk and Vulnerability Assessment (NRVA) 2007-2008. There are subsequent surveys planned in the following years. The CPR will be measured in each of these surveys and each year the implementer will be awarded the performance bonus based on percentage point increase each year.

ii) Antenatal care (ANC): HMIS currently collects information on first ANC and all other ANC visits.[2] It is possible that many of the repeat visits are being captured as first visits. Setting baselines for ANC needed to be considered carefully based on possible over-reporting. A new HMIS register and maternal health card for critical reproductive health information will be introduced prior to the starting of the RBF intervention (Tables 1 and 2 of Annex 3) The primary source for baseline estimates for all the ANC visits will be the data from the new register. However, baseline setting will be made after careful comparison of these estimates with the old HMIS estimates and the most recent survey estimates.

iii) Skilled Birth Attendant (SBA): Currently, only institutional delivery is recorded in the HMIS. Any births attended by skilled health workers conducted outside of the HF are currently not recorded in the HMIS. However, estimates for SBA are very close to institutional delivery.[3] The new HMIS register will start capturing information on SBA. The primary source for baseline estimates for all the ANC visits will be the data from the new register. However, baseline setting will be made after careful comparisons of these estimates with the old HMIS estimates on institutional delivery and survey estimates.

iv) Post-natal care (PNC): PNC information, similar to ANC, has only been collected for first PNC and all other PNC. It is possible that information on repeat visits were counted as first visit. The new HMIS form collects information on only one PNC visit. Since the proposed post-natal care visit indicator will give performance payments for up to two visits for PNC, changes will be made to the new HMIS register to collect information on two PNC visits. The primary source for baseline estimates for all the PNC visits will be the data from the new register. However, baseline setting will be made after careful comparisons of these estimates will be made with the old HMIS estimates on PNC and survey estimates.

v) DPT3: HMIS collects information on the three doses of the pentavalent vaccine, DPT-Hepatitis B-Haemophilus Influenza, for all children <1 years of age (in the OM, the more common acronym DPT will be used). However, this information is often over-reported. Inclusion of older children in the numerator but not in the denominator is one source of error. Mistakenly recording first and second doses of DPT as a third dose is another source of error. Other source of error comes from transferring the data from the daily tally sheets to the monthly tally sheet. These errors need to be monitored carefully. Strengthening of HMIS will require implementers to verify information in their registers to ensure that it is correct. The baseline estimate for DPT3 will be set after careful monitoring of these figures and any subsequent correction to the DPT3 estimates. A new tally sheet at the HF level will be introduced to reduce errors in transferring of data (Table 3 of Annex 3).

[2] Household survey estimates for first ANC are lower than HMIS estimates (32.1% in AHS, 2006 compared to 65% in HMIS for 1385). Note that the Gregorian calendar year and *Shamsi* calendar year do not completely coincide.

[3] In AHS 2006, use of SBA was 18.9% compared to 14.6% for institutional delivery.

vi) Quality Score from the NMC: The NMC is a supervisory tool that is currently being used by some but not all NGOs and PHOs. A modified version of the current NMC will be used for RBF (Table 4 of Annex 3). The modification involves: i) additional indicators of quality will be included to the current instrument and ii) the section performance against targets will not be used in the calculation of the overall score as the quantity of services is addressed elsewhere.

2.1.4 Allocation of Funds and Performance payments for Implementers

The total resources that are made available for RBF performance payments include allocations for, allocations are made for management expenses, province level performance payment for CPR and performance payments for the output (Figure 1 of Annex 1).

i) Implementers: Implementers will receive 10% of the performance payment paid at provincial level for management purposes. This fund allocation for management is directly linked to the performance of the HFs and is not a fixed amount. For example, if all the treatment HFs earns 70% of their total performance payment allocation, the implementer will receive 10% of the 70%. The purpose of this allocation is to assist the implementers in its management and operational activity related to RBF.

ii) Amount of Funds Available for HFs: After the allocation of management costs and fund for CPR, the remaining funds are allocated for the intervention facilities. No additional payments will be made above this amount to the experimental HFs, regardless of health worker performance. A percentage share of the overall budget will be allocated to each indicator, determined by its relative importance and benchmarked against the market reference. Except for CPR and equity of care, for which funds will be allocated at the province level, all other indicators have performance bonus tied to performance at health facility level. Performance payments will be made for each additional output over a baseline estimate.[4] Tables 4. 4.1, 4.2 and 4.3 present unit costs for all the performance indicators.

The funds allocated for CPR and equity of care will be paid at the province level. Each two percentage point increase in a year will be awarded one-third of this amount up to the maximum funds allocated.

iii) Basis of Payments to HFs: The amount of money provided to each health center will be based on a combination of quantity and quality of services. The payment for each service will be made as described above. However, the payment will be "discounted" by the quality of care as measured by a quarterly score on the NMC jointly carried out by supervisors from the implementing organization and members of the provincial health office. For example, if the HF receives $1,250 per quarter based on quantity of services and it scores 75% on the NMC then it will receive an actual payment of $937.5 for that quarter.

iv) Decisions on the Amount per Service: The performance payment amounts for each service output have been recommended based on the importance of the different indicators, benchmarked against the fees in the market, the available budget and expected increase for each indicator. While it makes sense give flexibility to implementers to work within a range of performance payment levels for each indicator, it is difficult to effectively monitor and record the application of the performance payment ranges. Therefore, only one level of performance payment amount will be used for each indicator in all provinces. Unit prices for each indicator are presented in Tables 4, 4.1, 4.2 and 4.3(Annex 1).[5]

[4] The share of each indicator is as follows: CPR: 20%, ANC: 20%, SBA: 30%, PNC: 15%, DPT3: 15%.
[5] These amounts can change upon availability of new information

v) Recommended Division of Payment among Health Workers: All HF staff contribute in one way or another to improving service delivery. Facility performance is a reflection of staff's performance. The implementer will be responsible to develop written agreements within each HF and define how the performance payment funds are divided among health workers in individual facilities. The agreement should be developed jointly between the implementer and health facility staff. The final decision on how the funds will be shared amongst facility staff will be determined at the facility level. However, to ensure transparency in the process, facilities will conduct the process in a transparent way, document how the funds are distributed and share the information with implementers and MOPH. Suggested in Table 5 (Annex 1) is one example of sharing performance payments within a facility. The example presents setting performance payment levels as a share of a person's total salary from the total HF staff salaries (including hardship allowance). The table presents an example of an allocation of performance payments for health staff for a "rural" BHC that receives a quarterly performance payment of $1250.

vi) Inclusion of CHWs: While CHWs are not reflected in this performance payment distribution, it is up to the HF staff to decide how to use the CHWs effectively. As CHWs are involved in outreach services, community health education and mobilizing patients and women, they can play an important role in increasing utilization of services. It is recommended that the implementers and HFs should decide jointly on how, if any, to include any compensation to the CHWs (e.g. for referral of pregnant women). If the decision is to include CHWs, then payments for indicators may systematically be differentiated across indicators based on the level of difficulty and the role of CHWs. Careful note should be made if CHWs are to be compensated at the beginning of the implementation and how the funds will be shared with them.

vii) Frequency of Payment: RBF funds will be made available to the implementers at the beginning of their contract and every 6 months thereafter. Performance payment payments to the HF workers will be made every 3 months by the implementer.

2.1.5 Activities and Performance payments for the Provincial Health Office (PHO)

It is important to strengthen the role of the PHO in the monitoring and evaluation activities. Involving the PHOs in active monitoring helps build provincial capacity and strengthens the stewardship role of the MoPH at the provincial level. Current involvement of the PHO in monitoring is not systematic throughout the country. Under RBF, a performance payment will be given to PHO for improved supervision. PHO will be paid on: i) Number of HFs in a province they visited once in a quarter with a completed NMC; ii) Number of recorded minutes from a Provincial Health Coordination committee (PHCC) meetings in a quarter; iii) Proportion of activities implemented from a quarterly work plan. From the total envelope available to a PHO, seventy five percent of the funds will be allocated to the completion of the NMC. Of the remaining 25%, fifteen percent will be allocated for the PHCC indicator and 10% for the indicator on the quarterly implementation plan. Each indicator is explained in some detail below.

i) Proportion of HFs in a province visited once in a quarter with a completed NMC:
The PHO staff will visit all BPHS HFs including SCs, BHCs. CHCs, and DHs in their province every quarter. The information from the completed NMC checklist will be entered into a database at the PHO at the completion of the visit. The information will be sent to central MoPH on a quarterly basis. At the completion of each visit, the PHO staff will leave a summary sheet at the health facility. Performance payments will be given for the number HFs that are visited once every quarter with a completed NMC.

Exceptions: Two exceptions will be made to this rule. 1) If there are more than 50 BPHS HFs in the province, and 2) climactic conditions during winter would make access difficult in certain provinces.

In the event there are more than 50 HFs in the province, the PHO will randomly select 50 HFs from the list of all HFs and visit them in one quarter. Certain provinces have remote HFs that are cut-off during the winter from the provincial center. There are two suggestions for monitoring these remote HFs: 1) if a district health officers (DH) has been deployed in the district and he is able to reach these facilities, he should complete an NMC and bring this to the provincial center when it is logistically possible to do so; 2) in the event, no one in the PHO can reach the health facility and the health facility has stayed open for the winter period, the health facility staff should complete the NMC themselves. Since the NMC is a supervision tool and not a self-reporting tool, if a health facility completes its own NMC, in the subsequent quarterly visit by the PHO staff, the NMC filled out by a PHO staff will be carefully compared with NMC filled out by the health facility staff for critical discrepancies. If there are discrepancies found between the PHO NMC and the health facility staff NMC, the Health Economics and Finance Department (HEFD), HMIS or M&E representative will make a field visit, accompanied by the NGO representative, to the health facility to complete an independent evaluation of the health facility using the NMC. To plan monitoring activities of remote facilities, a list of hard-to-reach facilities will be identified before signing the performance agreement between the PHOs and the central MoPH.

ii) Number of recorded minutes per quarter from a PHCC meeting:
The criteria for the complete PHCC meetings are: i) chaired by provincial health director (PHD) or deputy PHD; ii) the presence of at least three PHO staff; iii) discussion of provincial HMIS results; iv) presentation of findings of monitoring visits. The PHO needs to hold a PHCC meeting once a month to qualify for the performance payments. The indicators will be drawn from detailed completed minutes of the meetings submitted to central MoPH.

iii) Proportion of activities implemented from a quarterly work plan: A format is being developed for the quarterly work plan. This plan will include activities of each of the provincial health officers that are related to improving health service delivery. This template will also track progress for the listed activities.

2.1.6 Monitoring and Verification

When paying performance payments based on performance, it is essential to set up a strong monitoring mechanism to prevent potential negative consequences, such as gaming, and maintain the integrity of the system. Multiple entities are involved in the monitoring and verification process. HEFD, the HMIS department, the M&E Department, the third party, the PHO and the implementers all play a role in the monitoring and verification process. Their individual roles are explained in further detail in the "Roles and Responsibilities" section.

In setting up the monitoring structure for the RBF, some considerations were made: i) it is critical not to burden the current system; ii) the MoPH can maintain and expand the system in the future. While many more monitoring mechanisms can be set in place, the monitoring structure described below has been proposed for sustainability while maintaining vigor. Monitoring and verification will be conducted in both treatment and control groups. The three elements of monitoring are performance monitoring, process monitoring, and verification.

2.1.6.1 Performance Monitoring

Performance as defined earlier includes two components: quantity and quality. Both the quantity of services and the quality of services will be monitored. The mechanisms for monitoring are as follows:

i) Quantity of Services: The source of information for the performance payment payments will be the HMIS. The information on the specific indicators of interest will be taken from the regular reporting to the HMIS and the performance is tracked. This will enable comparison of RBF indicators to the non-RBF indicators on a regular basis.

ii) Quality of services: The NMC will be conducted jointly by the PHOs and the NGOs.
The PHO staff will visit each health facility at least once every quarter. The information from the completed NMC checklist will be entered at the PHO at the completion of the visit. The information will be sent to central MoPH on a quarterly basis. At the completion of each visit, the PHO staff will leave a summary sheet at the health facility.

2.1.6.2 Process Monitoring

Process monitoring is focused on making sure that the intervention is implemented the way it is supposed to be implemented. Process monitoring also enables us to get information on both intended and unintended consequences of the intervention and provides us systematic information on an ongoing basis. Process related aspects such as health providers getting their performance payments on time, the unintended and intended consequences of RBF and documentation of changes happening at MoPH, the implementers and PHOs as a consequence of RBF will be monitored.

Some aspects of process monitoring will be done in the current routine activities. For example, annual HF surveys or even the quarterly NMC can be used to find out if the HF staff are getting their performance payments on time. HMIS information is collected for a large set of indicators. All effort will be taken to use the current routine data systems or planned activities to collect this information without adding cumbersome parallel systems.

2.1.6.3 Verification

Verification of the data is required to make sure the performance payments are paid based on accurate data. To prevent mis-reporting of data at the HF level, regular verification needs to take place. It is the implementer's responsibility to ensure that each health facilities in their province do not purposefully mis-report data.

Verification of the HMIS data will done both during the PHO visit to the HF to conduct the NMC and during household verification of visits from the HF registers.

i) Verification of HMIS Data: The reliance on the HMIS for deciding the amount of payment puts its accuracy at risk. To avoid distortions in the HMIS, the implementers will be responsible for ensuring the

quality of the data. This includes getting detailed information for patient identification during registration.[6] This information, for example, should enable monitors to visit a sample of houses and verify whether children received DPT3, or a woman was attended by a skilled provider at delivery, etc. Verification of the HMIS data will occur on a three-monthly basis on a random selection of HFs by a third party.

ii) Verification and Measurement of Quality of Care: In order to avoid health workers focusing only on the quantity of services they provide and compromise on quality, the performance payment payments to HF will also take into account the quality of care. The findings of the NMC will be converted into a percentage score, like the balanced score card (BSC). This score will be used to calculate the performance payment. Results from HF surveys carried out by third party will be used to monitor the quality of NMC data.

iii) Ethical reporting: Health facilities are expected to report accurate data. If reported data is not in agreement with verified data, sanctions will be imposed. See section on Sanctions.

iv) Frequency of monitoring: Both the HMIS verification and the NMC will be conducted once every quarter. A timeline for these activities and evaluation is included in Table 6 of Annex 1.

2.1.6.4 Method and sources of data for Monitoring and Verification

i) HMIS: Routine health information collected and aggregated on a quarterly basis will be used for the performance monitoring.

ii) Household Surveys: will be used to monitor performance in CPR.

iii) Annual HF Surveys: will be used to monitor performance in equity and BSC. The third party firm recruited for the SHARP project will carry out the annual HF surveys (as part of the SHARP).

iv) National Monitoring Checklist: will be used to regularly monitor quality of care. The PHOs and the implementers will jointly conduct the NMC every quarter.

v) Verification: The third party firm contracted for the SHARP project will be responsible for the verification of the HMIS data. The third party could involve community-based organizations in the verification activity.

2.1.7 Evaluation

The evaluation component involves the setting up of a rigorous design to evaluate the RBF intervention. Detail of the evaluation design will be presented in a separate document. A general description of the design and method is presented below.

2.1.7.1 Evaluation Design and Methodology

[6] For example, information on a woman coming for reproductive health care services will include the name of the village and district, her name, her spouse's name and the spouse's father's name, the name of the closest mosque to her house and a telephone number if available.

The evaluation will be primarily based on two household surveys conducted before and after the intervention in the catchment area of a sample of treatment and control HFs. However, ongoing assessments will also be done using routine reporting systems such as NMC and HMIS. To assess quality, comparisons of the two groups will also be conducted using the annual HF surveys conducted by a third party.

i) Sampling Methodology: The evaluation of the RBF intervention will compare outcomes of key maternal and child health indicators in the catchment areas of the treatment and control HFs. Treatment and control facilities will be matched based on their most recent performance along the indicators of interest and block randomization will be used to assign facilities to treatment or control arms. The changes in the key maternal and child health outcomes will be compared before and after the RBF intervention in treatment and control facilities. For detecting differences in coverage between intervention and control areas, the primary sampling unit will be the HF.

Comparisons of NMC and HMIS results from HFs in intervention and control areas will be made on a regular basis to see the difference in quality of care and service outputs between intervention and control areas in each province. Annual comparison based on the HF survey will provide validation of the comparisons being done through the routine reporting systems.

ii) Frequency of assessment: The baseline and end-of-project survey will be carried out at the beginning and the end of the RBF intervention. The HMIS estimates will be compared quarterly for progress monitoring as well as having an annual trend chart by the control and treatment groups over the life of the intervention. Trends of NMC quality scores will be tabulated quarterly and compared between the treatment and control groups.

2.1.7.2 Method and sources used for Evaluation

i) Household Surveys: The third party firm, recruited for the SHARP project, will carry out the baseline and end-of-project household surveys.

ii) National Monitoring Checklist: The PHOs and the implementers will jointly conduct the NMC every quarter. Quarterly tracking of NMC scores will enable the comparison of quality scores between treatment and control facilities.

iii) HMIS: Analysis can look at trends in the output indicators over time between treatment and control facilities

2.2 Hospital Intervention

Hospitals in Afghanistan are an important point of care for women and children. The 2006 Afghanistan Household Survey reported that approximately half of the women who reported having a skilled attendant for delivery, delivered at a hospital. Today hospitals in Afghanistan are in a state of transition, with some hospitals in various phases of reform and others experimenting with various initiatives while still others continue to operate under capacity. In the pilot, the MOPH would provide a performance related pay for increased hospital productivity and overall quality of care.

The hospital intervention will be implemented in district hospitals (DH), provincial hospitals (PH), and national hospitals (NH).

2.2.1 Design

2.2.1.1 District Hospitals

In provinces that have only one DH, the hospital will be included in the treatment group. For provinces with more than 1 DH, they will be randomly assigned to treatment and control arm. This yields approximately 12-14 DHs that will receive the performance payments and 4-6 DHs that will be in the control arm. Table 7 (Annex 1) presents the total number of DHs to be included in the hospital RBF intervention in the provinces selected for the BPHS-RBF. However, it was deemed important by the ministry to include the Dasht-e-Barchi DH in Kabul. Dasht-e-Barchi DH is located in the western part of the city. One main reason for selection of this hospital to the RBF intervention is to see if performance-based payments to smaller health units in the capital city will improve utilization at peripheral units.

2.2.1.2 Provincial and National Hospitals

The hospitals included in the intervention are presented in Table 8 (Annex 1). The purposive selection of these hospitals makes evaluation of the impact of the intervention complicated. To mitigate this, a quasi-experimental design will be adopted for comparing treatment and control hospitals for the provincial hospitals. Details of the evaluation are presented in a separate document.

2.2.2 Output Indicators

The role of hospital is to both serve as the first point of care for patients who do not have access to lower level BPHS facilities and to serve as a referral facility. In keeping with the goal of the overall RBF intervention to impact MDGs 4 and 5, performance payments are linked to maternal and child health and quality of care indicators.

2.2.2.1 District Hospitals (DH)

The performance payments for DHs will be based on both the outpatient department (which is part of BPHS) and the inpatient department. Outputs reported in the HMIS data and the Hospital Balance Scorecard will be the main source for the performance payments. Table 9 (Annex 1) presents these indicators of performance, their definitions and means of verification.

Inpatient Department (IPD) Indicators

i) Institutional Deliveries (ID): Currently, less than 15% of women deliver in an institution in Afghanistan (JHU, 2008). For BPHS facilities, the indicator of interest is use of skilled attendants (SBA) at delivery. While it is logical to use SBA for primary health care facilities – as SBA can go attend to pregnant women in the catchment area of their facilities – it is less applicable as an indicator for hospitals. Hence, ID, a subset of SBA, will be used for measuring performance in hospitals. The performance payments will be paid on the absolute increase in the number of institutional deliveries. For the definition of ID, a total of normal and assisted deliveries are included without complicated cases (minor and major complications).

iii) Complicated delivery: Many complicated deliveries do not reach hospitals in time. Fifteen percent of all births experience complications (MoPH, 2006) and should be treated in a facility equipped with EOC services. As an entity that has to play a coordinating role, a DH should work closely with the lower level facilities in its line of responsibility. By conditioning performance payments for complications, the scheme incentivizes hospitals to work with lower level facilities to identify at-risk pregnancies in early stages of the pregnancy and prepare them for an institutional delivery and/or enable transferring of emergency cases to the hospital at time of delivery. Deliveries classified as major and minor complications are all targeted However, all the normal and assisted deliveries that are not complicated (ID) will not be included in the definition of complicated delivery.

iv) Completion of maternal death review: WHO definition for a facility based maternal death review is "qualitative in-depth investigation of the causes of and circumstances surrounding maternal deaths occurring at health facilities."(WHO, 2004)[7]. A death review will try to get as much information about this maternal death as possible. The review would help address if there are reasons within the control of the hospital that could have been in the pathway to a maternal death. In effect, a maternal death review becomes an accountability tool for maternal health care practitioners in hospitals. This indicator will look at the proportion of facility-based maternal deaths for which a death review has been completed. This indicator would help improve the quality of care and serve as a basis to understand the causes of maternal deaths. The formal definition and format followed by the MoPH of Afghanistan will also be used here.

v) Equity in institutional delivery (concentration index) – The institutional deliveries concentration index measures how equitable the use of institutions for delivering is.

vii) Successful treatment of severe malnutrition: This indicator is the number of children who are admitted to the hospital for severe acute malnutrition who are successfully treated. Instead of proportion, performance is measured by increase in the number above the baseline.

viii) Infection prevention: The safety sub-domain has indices on prevention of hospital hazards (such as cleaning, water safety, sterilization, x-ray protection, etc) and prevention of bio-hazards (such as screening of blood, disposal of waste, use of syringes, and availability of a basin and soap). These two indices will be combined to form the infection prevention indicator. .

ix) Mean quality score on Hospital Balanced Scorecard (BSC) – A balanced scorecard is a multi-dimensional tool that measures an organization's performance. Afghanistan has an annual hospital survey that forms the basis for calculating the hospital scorecard. This performance measure for hospitals has 8 domains including "Organizational management," "Financial management," "Human resource management," "Capacity and infrastructure," "Quality and safety," "Functionality," "Patients and community," and "Ethics and values." Currently, the balanced scorecard for hospitals is not calculated for all district hospitals. The new Hospital Balanced Scorecard will reflect this change.

2.2.2.2 Provincial Hospitals (PH)

[7] Maternal deaths occurring on the way to health facility can also be included in this definition.

The performance payment for PHs will be based on indicators from the inpatient department (collected through the HMIS) and the hospital BSC. Table 10 (Annex 1) presents these indicators of performance, their definitions and means of verification.

i) ID: Same explanation as given above in the DH section.

ii) Complicated Delivery: Same explanation as given above in the DH section.

iii) Completion of maternal death review: Same explanation as given above in the DH section.

iv) Equity in institutional delivery (concentration index): Same explanation as given above in the DH section.

v) Successful treatment of severe malnutrition: Same explanation as given above in the DH section.

vi) Infection prevention: Same explanation as given above in the DH section.

vii) Mean quality score on Hospital Balanced Scorecard (BSC): Same explanation as given above in the DH section**.**

2.2.2.3 National Hospitals

National or specialized hospitals are based in Kabul city. They provide specialized services and will be only be evaluated on the hospital BSC.

i) Mean quality score on Hospital Balanced Scorecard (BSC): is the same as above

2.2.3 HMIS Strengthening and Setting Baselines

As for the BPHS-RBF indicators, the performance payments to hospitals will be set above current baseline estimates.

i) Institutional Delivery: The baseline for ID will be from HMIS on deliveries in hospitals. Verification needs to be done between information submitted to HMIS and the information included in the registers. The primary source for baseline estimates for all ID will be the data from the new register. However, baseline setting will be made after careful comparison of these estimates with the old HMIS estimates of ID and the most recent survey estimates of ID to see the level of discrepancy between the different figures. The complicated delivery cases (including major complications and other complications) have to be subtracted from the total number of institutional deliveries (normal and assisted).

ii) Complicated Delivery: The baseline for complicated delivery will be from HMIS on deliveries in hospitals. Verification needs to be done between information submitted to HMIS and the information

included in the registers. Care needs to be taken that deliveries are not double counted in either categories. Normal and assisted delivery cases will not be counted in the complicated delivery cases.

iii) Completion of maternal death review: Since this indicator is for facility-based maternal deaths, the maternal deaths occurring in a woman's home should be separated from the maternal deaths occurring in the hospital. While both of these estimates are important, this specific indicator is only for the review of facility-based maternal deaths. First, there is need to determine if all deaths are recorded correctly in the registers. Second, there is need to separate facility deaths from deaths occurring outside. To get the percentage of completed review of facility based deaths, maternal deaths happening in other places need to be separated. The death information in the HMIS will form the basis for setting a baseline.

iv) Equity in institutional delivery (concentration index):
Baseline for the equity indicators will be calculated from the most recent hospital and household survey before the start of the intervention.
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v) Number of successful treatment of severe malnutrition: Reviewing HMIS nutrition data for 1387 for hospitals, not all children that present with severe malnutrition are admitted: only 93% of those diagnosed with severe malnutrition are admitted to the hospital and of those admitted, approximately 63% are cured/improved, 6% die, 15% are referred out and there is no information on 13% of the admitted cases. This information in HMIS will form the basis for setting the baseline.

vi) Infection prevention: The baseline score for this indicator will be calculated by combining the two indices from the safety sub-domain from the most recent hospital survey.

vii) Mean quality score on Hospital BSC – The baseline score for the Hospital BSC will be set from the most recent hospital BSC. Only the indicators of interest for RBF will be used for the baseline. The subset of RBF indicators will be separated and a "quality" score will be calculated from these indicators.

2.2.4 Allocation of Funds for Hospitals

Of the total funds available net of administrative cost, 16% is allocated for provincial and national hospitals.

i) Amount of Funds Available to Hospitals: the funds available per hospital will be determined based on the capacity of each hospital. One measure of such capacity is the number of beds. Once the total resource envelope is determined, the hospital needs to perform to "earn" the allocated funds. The hospital will have a discretion to decide on how the money it "earned' can be split between its staff and the facility aimed at improving service delivery. However, the hospital is expected to spend at least 70% of the proceeds to pay its staff. They will need to carefully document on how the money is disbursed within the hospital.

ii) Basis of payment and percentage allocation for each indicator: The unit cost for each indicator is determined with a combination of market reference, its relative importance, and verifiability. Payments are made for outputs beyond and above the baseline estimates.

iii) **Recommended Division of Payment among Health Workers:** Performance will be measured and rewarded at the level of the hospital. Seventy percent of the budget allocated will be used for performance payments. The implementers will have written contracts with the hospitals stating the role and responsibilities of both parties, the performance indicators and payments. Hospital staff will be made aware of the content of the contract. The hospital staff and management have the right to decide on how to share the performance payments. To ensure transparency of the process, hospitals will conduct the process in a transparent way and document the process and the decision reached. The document will be shared with MOPH.

2.2.4 Monitoring and Verification

When paying performance payments based on performance, it is essential to set up a strong monitoring mechanism to prevent potential negative consequences and maintaining the integrity of data. There are two components to the monitoring: process monitoring and verification.

2.2.4.1 Performance Monitoring

See theBPHS component.

2.2.4.2 Process Monitoring

Process monitoring, as explained in the BPHS-RBF section, is also critical for hospitals. Synergies will be created between the two pilots to enable efficient collection of necessary information. This information will be collected during routine hospital visits.

2.2.4.3 Verification

Verification of the hospital HMIS data will happen during the PHO visit to the HF for DHs and central M&E staff for the provincial hospitals.

i)Verification of HMIS Data: To avoid distortions in the HMIS, the PHO and M &E monitors will be responsible for verifying the data by comparing the figures submitted to the HMIS to the actual hospital registers. Further verification of output indicators will be conducted by third party. Payments will be made on verified HMIS and the Hospital Balanced Scorecard reports.

ii)Frequency of monitoring: The HMIS verification and the monitoring will be conducted once every quarter. Third party verification will be done in tandem with the facility survey.

2.2.4.4 Method and sources of data used for Monitoring and Verification

Household Surveys: Calculation of a concentration index requires wealth information for two surveys – the NRVA 2007-08 will be used for the year 2009 hospital assessment and when the subsequent NRVA is conducted the wealth cut-offs will be re-calculated.

Annual Hospital Surveys: The third party firm recruited for SHARP project will also carry out the annual Hospital survey [as part of the SHARP].

HMIS Verification: The third party firm contracted for the SHARP project will also be involved in verification. HMIS verification at the PHs will involve comparison of the estimates submitted to the HMIS with what is actually reported in a health register.

3. Roles and Responsibilities of Key Stakeholders

3.1 Ministry of Public Health

The MoPH plays varying roles in the management of the RBF intervention. The key entities within MoPH that will be part of the RBF are Health Economics and Finance Directorate (HEFD), HMIS, Monitoring and Evaluation (M&E), and the PHOs. Since the roles of each entity within MoPH are different, included below are description and guidelines for each. A timeline for the different components of the project set-up phase is included in Tables 11 and 12 (Annex 1).

3.1.1 Health Economics and Finance Directorate (HEFD)

3.1.1.1 Developing and managing contracts/amendments

The HEFD is responsible for processing and managing contracts with implementers. For the RBF intervention, contract will be developed for NGO implementers and the third party. Similarly, performance agreements will be developed between individual PHOs in RBF provinces and the MoPH.

Contracts with Implementers: Contract (or amendments to existing ones) will be developed for all NGOs operating in provinces that are chosen to implement the RBF intervention. The contract will be the similar to contracts for implementers supported by European Commission (EC), United States Agency for International Development (USAID) or the World Bank (WB). The contracts will delineate each party's responsibilities, procedures for procurement and financial management. It will also define performance milestones in project implementation that, when verified, serve as triggers for the release of performance payments.

Agreements with PHOs: HEFD is responsible for managing performance agreements with the PHOs of provinces that are participating in RBF.

Agreement with MoPH-SM: MoPH will have performance agreements with the two MoPH-SM provinces that are participating in RBF. The terms of reference for MoPH-SM for implementing RBF will be similar to the NGO implementers and will be developed by HEFD.
Furthermore, HEFD will manage and monitor the HMIS verification conducted by the third party.

3.1.1.2 Monitoring

The successful implementation of RBF requires establishment of intensive monitoring mechanisms on multiple levels. The HEFD has a role in monitoring RBF-related activities of implementer s and PHOs.

Implementer monitoring: All implementers will submit their reports (forms 1-4 of Annex 2) to HEFD. Furthermore, HEFD will monitor and collect information on RBF activities on its routine monitoring missions to implementers and HFs.

PHO monitoring: As the PHO staff will have their RBF performance payment payments based on conducting quarterly NMC for all HFs in their province, PHCC meetings and having a quarterly work plan, the HEFD will be responsible for monitoring and verifying these indicators. While the NMC information will be sent and processed by M & E staff, the HEFD staff will verify the NMC information sent by the PHOs during their routine monitoring visits. HEFD will also look the completeness of the PHCC minutes and the status of the work plan before approving payments to PHOs.

While the actual disbursement of funds is made by the Finance Department, HEFD's role would be to verify and confirm information sent by implementers and PHOs and request release of funds.

3.1.1.4. Payments

Payments to Implementers: Each implementer will be required to open a separate account for the project life of RBF. Payments specific to RBF will only be made to this account. See the section on disbursement for detail.

Payments to PHOs: payments to PHO will also follow the government procedure and will be accounted for by the PHO and their bank accounts at the DAB's provincial offices, if operational in the selected provinces. Where there are no bank accounts, current arrangements in paying PHO will be utilized.

3.1.1.5 Training

The different stakeholders will be familiarized with the processes that are specific to RBF. A 2-3 days training will be provided for stakeholders involved.

Training for Implementer: Implementer training encompasses familiarization with all RBF related processes. HEFD and HMIS will jointly conduct training for central representatives from all the implementers that are implementing RBF. This training will include 1) the RBF concept and design; 2)budget allocation; 3) preparation of performance agreements with HFs; 4)distribution of performance payments; and 5)reporting requirements (financial and operational);

Training for PHOs: HEFD, and HMIS and M & E will jointly provide training on conducting NMC, entering and managing NMC data to the PHOs in provinces implementing RBF. Training will also include the implementation and management of the other required PHO activities that triggers the performance payments.

3.1.1.6 Reporting Requirements and Coordination

The HEFD is responsible for preparing a half-yearly report to track progress on RBF. Reporting requirements include indicators in the domain of service volume (both RBF and non-RBF outputs), service quality, financial processes, and internal processes. A list of indicators within these domains is included in Table 13 of Annex 1. While the reporting is at the provincial level, this information should

also be tracked at the health facility level as well as at the intervention group level (treatment group versus control group). This report should be submitted within 1 month of the end of the 2nd quarter and 4th quarter.

The HEFD is the repository for RBF related information. As information is collected and processed by different departments in the MoPH and external partners, it is the responsibility of HEFD to collect relevant information from the different parties and mange it as it pertains to RBF activities. This will include coordination with HMIS, M&E, PHOs, implementers, Finance, third party and other stakeholders, as needed. The creation of a database will help manage the information requirements. The ability to link different levels of information will provide valuable information on RBF process issues. The HMIS department will assist HEFD in all RBF related activities.

3.1.2 Health Management Information System (HMIS)

The strengthening of the HMIS system is a key component for setting baselines before starting the interventions. The HMIS department will implement changes in the current HMIS before implementing RBF. The HMIS department will be leading the training of implementer and PHO staff on the new HMIS, NMC and other RBF-related activities. It will also provide support to HEFD on RBF-related activities.

3.1.2.1 Strengthening HMIS

There are a number of reasons to believe that some of the indicators of interest might be over-reported in the current HMIS. Reasons for over-reporting can be due to not having proper population denominators, incorrectly transferring numbers from the health facility registers to the HMIS reporting forms, recording repeat visits as new visits. The key components of strengthening HMIS include the introduction of a new reproductive health register, a maternal health card and a tally sheet for improved recording of DPT3 estimates. Data generated through these new registers will be used in setting baseline estimates for the key indicators. As such, the introduction of the new forms and subsequent monitoring is likely to mitigate the risk of over- reporting.

i) RH Registers: In the current HMIS system, there are some gaps in the information collection on reproductive health. For example, no information is collected on separate antenatal care visits, except for the first visit. While performance targets for antenatal care are based on all antenatal care visit, the reporting system is not set up to properly differentiate between the first antenatal care visit and follow-up visits. These problems have resulted in estimates for antenatal care that are possibly over-estimated. The introduction of maternal health cards and a new reproductive health register in the facilities are geared towards improving the reporting system for these key reproductive health indicators. Sample of the new register and the maternal health card are in Tables 1 and 2 of Annex 3.

ii) Tally Sheet for DPT3: Due to the difficulty in changing forms used for immunization, an additional tally sheet will be introduced for DPT3. One of the potential problems in the current recording system for immunization rests in the transferring of information from a daily tally sheet to a monthly form. Adding up information from each daily tally sheet and transferring it to a monthly form is susceptible to errors. This new tally sheet (in Table 3 of Annex 3) is a running tally sheet for the full month and will possibly reduce one source of error in the immunization data.

iii) Training: The HMIS department will coordinate and conduct all the training related to the introduction of the new HMIS reproductive health registers, the maternal health cards and the DPT3 tally sheet. This training will be initially conducted with the HMIS officers of the provinces implementing RBF and the HMIS officers from the PHOs in the same province. The HMIS and M&E Department are responsible for conducting of NMC for both the HMIS/M&E officers from the implementer organization and PHOs in provinces selected for RBF intervention. This training will be implemented before the commencement of the RBF intervention. See section 3.1.1.5 above.

3.1.2.2 Database Management

The HMIS department is required to maintain and provide any RBF-related HMIS information. The department will also assist HEFD with database management for activities related to RBF.

i) Estimates for key indicators: The HMIS department will be responsible for getting the quarterly reports for the key indicators. Once the quarterly information sent to the HMIS is processed, the HMIS department will give the reports for the key indicators for the RBF provinces to HEFD. This information will be used by the HEFD to monitor and manage the progress of implementation and to initiate payments of the performance payments.

ii) NMC: The NMC data is processed and managed by the M&E department. The HMIS will obtain a quarterly copy of the NMC from the M&E department for information purposes.

3.1.3 M&E Department

Monitoring: The M&E staff will assist the HEFD with monitoring activities related to RBF such as visiting health facilities or hospitals, when requested.

Database Management: The NMC data is processed and managed by the M&E department. The M&E department will share a copy of the NMC data quarterly with the HMIS department.

Reporting Requirements and Coordination: The M&E department will follow their routine line of reporting. However, it will provide support to HEFD, when requested, with RBF related activities.

3.1.4 Provincial Health Office/Team

The role of the provincial health office is to serve as the arm of Ministry of Public Health in fulfilling its stewardship functions at the provincial level. The provincial public health office will work closely with the central MoPH in the monitoring of health services in Afghanistan. The provincial health office includes the district health offices. Performance agreements will be developed between the MoPH and PHO and performance payments given based on three different indicators: 1) Proportion of HFs in a province visited once in a quarter with a completed NMC; 2) Number of recorded minutes from a Provincial Health Coordination committee (PHCC) meetings in a quarter; 3) Proportion of activities implemented from a quarterly work plan; These indicators are described in detail in the project design section of this document.

Performance Agreement: MoPH will have a performance agreement with the PHOs. This performance agreement will form the basis of the PHO role in the RBF intervention. The performance payments will be paid against achievement of set indicators included in the agreement.

Participation in Training: PHOs will be required to send their HMIS officers, M&E officers and other key staff involved monitoring to trainings on HMIS and any other RBF-specific training. These officers will later be involved in training health facility staff in coordination with implementers.

Reporting Requirements and Coordination: As the stewards for the health sector in their province, the PHO will provide support and an enabling environment to MoPH central office teams and/or other external teams working on the RBF intervention. PHOs will follow their existing reporting structures for their activities. However, the information required for processing payments related to RBF will have to be sent to HEFD. PHOs will send the RBF financial report (Form 1 of Annex 1) quarterly to HEFD.

3.1.5 MoPH-SM provinces

3.1.5.1 MoPH-SM Central Office

i) Contract Management: MOPH-SM central office will be responsible for entering into and managing the performance agreements with each facility.
ii) Monitoring: MoPH-SM staff located in central MoPH will assist HEFD and M&E colleagues in facilitating monitoring activities for the MoPH-SM provinces. They will also participate in joint monitoring missions with the PHO in MoPH-SM provinces.

iii) Randomization: The randomization of HFs will be a transparent process. In the presence of representatives from central MoPH, and PHO, HFs will be randomized into treatment and control facilities.

iv) Training: Implementers will be required to send their HMIS/M&E officer to the HMIS related training held at the central level. For the RBF-specific training held at the central level, the implementers will be required to send both their HMIS/M&E officer and their operations officer. These officers are then required to conduct the training for their health staff in their respective provinces.

v) Ethics and Integrity: Each health facility is required to report all activities transparently. If any of the monitoring activities find discrepancies in the HMIS data, health registers and household visits, the implementer (MoPH-SM) will be penalized. This could mean a potential reimbursement of funds misappropriated by the health facilities to MoPH. See the section on sanctions.

v) Reporting requirements: MoPH-SM will submit forms 1-4 (Annex 2) at the end of each quarter to the implementer. These reports and their verification are the basis of payments. The payments will be coordinated through the MoPH-SM central office. See Figure 2 of Annex 1.

vi) Coordination: MoPH-SM central staff will coordinate between the implementers in the MoPH-SM provinces and HEFD. They will assist HEFD, HMIS and M&E in any monitoring or management activities related with MoPH-SM provinces.

3.1.5.2 Provincial Health Office

Performance Agreement: The PHO in MoPH-SM provinces will monitor the quality of services provided. They will sign a similar agreement as the PHOs in other provinces for monitoring health

services. This performance agreement will form the basis of the PHO role in the RBF intervention. The performance payments will be paid against achievement of set indicators agreed in the contract.

Participation in Training: PHOs will be required to send their HMIS officers, M&E officers and other key staff involved monitoring to trainings on HMIS and any other RBF-specific training. These officers will later be involved in training health facility staff in coordination with the implementer. The PHOs will also help coordinate trainings for HFs with counterparts in MoPH-SM central.

Monitoring: To avoid the conflict of interest arising from having the dual role of implementer and a monitor, the PHO will conduct monitoring visits with representatives from central MoPH HEFD or M&E staff.

Reporting Requirements and Coordination: Existing reporting structures will be used. Current quarterly reports, sent to the reporting directorate for PHOs in MoPH-SM provinces, will be expanded to satisfy RBF (Form 5 of annex 1).

The PHO will provide support and an enabling environment to MoPH central office teams and/or other external teams working on the RBF intervention.

3.1.5.3 MoPH-SM HFs

The health facility has the direct responsibility for provision of health services and is the key link between the MoPH-SM and the population to whom the services are being delivered. They are responsible for equitably delivering health services to all populations in their catchment area, irrespective of their selection in the intervention or control arm. They are also required to keep proper records of all activities and submit timely information to MoPH, accurately report their activities and not game the system

Performance Agreement: The health facility staff will sign an agreement with MoPH-SM for the RBF intervention. While the agreement will be with the health facility and not with each health facility staff, the health facility staff will be made aware of the elements of the agreement.

Participation in Training: Due to the introduction of some new forms and new processes due to the implementation of RBF, the health facility staff will take part in trainings to be updated on these changes.

Ethics and Integrity: Each health facility is required to report all activities honestly.

Reporting requirements: Health facility staff will follow the regular HMIS reporting requirements. They will also submit forms 3-4 (Annex 2) at the end of each quarter to the implementer. They will keep a copy of these forms in the health facility.

3.2 Non-governmental Organizations

3.2.1 Central level

The NGOs will ensure that quality health services are available to the population they are serving as part of their BPHS contracts and keep careful note of any detrimental effect of RBF on the delivery of health services. The NGOs will set in place performance agreements with each health facility under their

management. The NGOs will also ensure that data collected are accurate and are reported to central MoPH every quarter. The disbursement of performance payments to the health facility staff will be done quarterly by the NGO according to terms set in the performance agreement.

Contract/Amendments: Each NGO will sign a contract/amendment with MoPH for the inclusion of RBF in their service contracts. These contract/amendments are managed by HEFD. **Performance Agreement:** NGOs will have a performance agreement with each health facility under their management. The NGOs are responsible for supervising the HFs and ensuring the integrity of the information sent to central HMIS.

Randomization: The randomization of HFs will be a transparent process. In the presence of representatives from central MoPH, PHO, and NGO, HFs will be randomized into treatment and control facilities.

Training: NGOs will be required to send their HMIS/M&E officer to the HMIS related training held at the central level. For the RBF-specific training held at the central level, the NGOs will be required to send both their HMIS/M&E officer and their operations officer. These officers are then required to conduct the training for their health staff in their respective provinces.

HMIS Results and Supervision: NGOs currently manage and monitor the routine HMIS results in their province. They will continue to implement this activity. It is the ultimately the NGOs responsibility to maintain and provide accurate and good quality data. Regular supervision in the field should be conducted to maintain quality data.

Ethics and Integrity: Each health facility is required to report all activities honestly. If any of the monitoring activities find discrepancies in the HMIS data, health registers and household visits, the implementer (NGO) will be penalized. This could mean a potential reimbursement of funds misappropriated by the health facilities to MoPH. See section on sanctions.

Reporting Requirements: In addition to the quarterly technical and financial reports submitted to HEFD for their health service contracts, NGOs will submit additional quarterly financial and technical reports on RBF using forms 1-4 (Annex 2).

3.2.2 Health Facility

The health facility has the direct responsibility for provision of health services and is the key link between the NGO and the population to whom the services are being delivered. They are responsible for equitably delivering health services to all populations in their catchment area, irrespective of their selection in the intervention or control arm. They are also required to keep proper records of all activities and submit timely information to the NGO and report accurately their activities and not game the system

Performance Agreement: The health facility staff will sign a formal agreement with the NGO for the RBF intervention. While the agreement will be with the health facility and not with each health facility staff, the health facility staff will be made aware of the elements of the agreement.

Participation in Training: Due to the introduction of some new forms and new processes due to the implementation of RBF, the health facility staff will participate in trainings to be updated on these changes.

Ethics and Integrity: Each health facility is required to report all activities honestly.

Reporting requirements: Health facility staff will follow their regular HMIS reporting requirements. They will also submit forms 3-4 (Annex 2) at the end of each quarter to the implementer. They will keep a copy of these forms in the health facility.

3.3 Third Party

The role of the third party is to objectively monitor the RBF intervention. For monitoring the BPHS component, the third party may set up the community monitoring mechanism and supervise the HMIS verification process on a quarterly basis.

To avoid distortions in the HMIS, verification of the HMIS data will occur on a three monthly basis on a random selection of HFs by a third party. The third party may involve community organizations for monitoring. Within the selected HFs, cases pertaining to the key indicators of interest will be randomly selected from the health facility registers for verification at the community level. The monitors will go to the respective households to verify the recorded visits. Discrepancies found between HMIS data and those in the field will require the MoPH to impose sanction on implementers. See the section on sanctions.

3.4 Hospitals not under NGO or MoPH-SM management

The hospitals participating in RBF that are not under NGO or MoPH-SM management need to follow similar procedure for participating in the RBF intervention.

Performance Agreement: The hospital will sign a formal agreement with MoPH for the RBF intervention.

Participation in Training: Due to the introduction of some new forms and new processes due to the implementation of RBF, the hospital staff will need to participate in trainings on RBF processes.

Ethics and Integrity: Each hospital is required to report all activities honestly. If any of the monitoring activities find discrepancies in the HMIS data, health registers and household visits, there will be sanctions. See section on sanctions.

Reporting requirements: Hospitals will follow their regular HMIS reporting requirements. Hospitals will have to submit technical and financial reports quarterly to HEFD. Sample forms 1-4 for BPHS implementers are shown in Annex 1. They will be modified to reflect reporting requirements for hospitals. While MoPH hospitals have their own line of reporting, to process payments for RBF, they will need to submit information related to RBF to HEFD

3.5. Sanctions

Where it is observed by HEFD that an implementer (and hospital) has utilized the funds to finance activities other than those stated in the performance agreement and contract, these will be considered as ineligible expenditures and the amounts will need to be refunded to the project. Furthermore when monitoring brings into light any misreporting of activities, the implementing body will be required to reimburse payments made on the over reported data.

4. Financial Management and Disbursement Arrangements

HEFD will carry out the day-to-day financial management operations of the project, preparation of payment orders; preparation of summary reports/simplified statements of expenditures, coordination with other line ministries involved in the program and overall contract and project management. The FM manual prepared for SHARP applies to RBF.

Payments under the RBF will be based on signed performance contracts between the MOPH and the NGO. The performance contracts will delineate each party's responsibilities, record procedures for procurement and financial management. It will also define performance indicators, that, when verified, serve as triggers for the release of performance payments, after the initial tranche payment made based on the contract.

Independent consultants will be appointed to carry out verification every quarter of NGO's performance claims. NGOs are required to ensure that their financial statements are audited annually, and the audit reports will be submitted to MoPH. Furthermore, MoPH can also appoint on its own auditors to review the financial transactions of any NGO.

Financial reports from the NGO will be submitted to HEFD quarterly. The reports shall consist of financial and physical progress. MOPH will design common reporting formats or templates to enable easier assembly of financial information from multiple participating institutions into an aggregate report for onward submission to the Bank (as part of the quarterly interim unaudited financial reports). Details and formats will be as in the SHARP project's financial management manual.

Project funds will be disbursed over 36 months. A final disbursement deadline will be four months after the closing date. During this additional four months grace period, project-related expenditures incurred prior to the closing date are eligible for disbursement. Disbursement schedules for NGOs and PHOs are shown in Tables 14 and 15 (Annex 1), respectively.

4.1 Reporting Obligations

The reporting requirements of each party will be as indicated under the role and responsibilities of the parties.

All other stakeholders will submit appropriate scheduled reports as specified in their contracts or agreements.

References

Johns Hopkins Bloomberg School of Public Health & Indian Institute of Health Management Research. *Afghanistan Multiple Indicator Cluster Survey 2003. A Re-analysis of Critical Health Service Delivery Indicators: report to the Afghanistan Ministry of Public Health.* Kabul, Afghanistan: Johns Hopkins University Bloomberg School of Public Health; March 2005.

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ANNEXE 1: Tables and Figures

Table 1: BPHS Facility Distribution in Eligible Provinces for RBF

	Provinces	Donor Group	Total Number of BPHS Facilities in Province	# of Sub-Centers	# of BHCs	# of CHCs
1	Samangan	World Bank	30	10	14	5
2	Sar-e-Pul	World Bank	42	17	17	8
3	Balkh	World Bank	87	33	39	15
4	Jawzjan	USAID	23		17	6
5	Bamiyan	USAID	41	5	26	10
6	Kunduz	EC	43		30	13
7	Daykundi	EC	27	5	14	8
8	Parwan	MoPH-SM	56	14	33	9
9	Panjsher	MoPH-SM	18	6	9	3
10	Kandahar*	USAID	9			

*Insecure province - The number of facilities is indicative of the **maximum** number of facilities that will be chosen from this province. It might be less.

NB: While outpatient services of district hospitals are part of BPHS, for the sake of clarity, district hospitals have been included in the section on RBF for hospitals.

Table 2: Indicators for Success – linked to ANDS and HNSS

Indicator	Numerator	Denominator	Means of measuring indicator
Contraceptive prevalence rate (CPR) – Proportion of married, non-pregnant women of reproductive age who or whose partner are currently using at least 1 family planning method	Number of married, non-pregnant women of reproductive age who or whose partner is using at least one method of family planning.	Total number of married, non-pregnant women of reproductive age surveyed	Household surveys: Baseline and end-project surveys
Skilled antenatal care (ANC) - Proportion of women who attended at least 1 ANC visit with a skilled provider of their most recent delivery	Number of women who delivered during the reference period who saw a skilled provider at least once for antenatal care services	Total number of deliveries in the reference period surveyed	Household surveys: Baseline and end-project surveys
Skilled attendant at delivery (SBA) -Proportion of births attended by a skilled attendant for a woman's most recent delivery	Number of women who delivered during the reference period and were attended by a skilled provider (doctor or midwife).	Total number of deliveries in the reference period surveyed	Household surveys: Baseline and end-project surveys
Immunization coverage of diphtheria, pertussis, tetanus (DPT3) - Proportion of children 12-23 months of age getting three doses third doses of DPT before their 1st birthday	Number of children 12-23 months of age receiving DPT3 before their first birthday	All children 12-23 months of age surveyed	Household surveys: Baseline and end-project surveys
Postnatal care (PNC) – Percentage of women who received at least one postnatal care from a trained provider within 42 days of delivery [8]	Number of women who delivered during the reference period who saw a trained provider within 42 days of delivery	Total number of deliveries in the reference period surveyed	Household surveys: Baseline and end-project surveys

[8] PNC is not one of the listed ANDS and HNSS indicators. It was selected because it is a very important indicator for both maternal and neonatal health.

Table 3: Indicators for performance payments – linked to facility registers and HMIS

Indicator	Definition	Means of measuring indicator
First visit for skilled ANC	Number of **additional** pregnant women over the baseline number who saw a skilled provider the first time for ANC in the catchment area of the HF for the reference period of interest.	HF registers and HMIS
Second visit for skilled ANC	Number of **additional** pregnant women over the baseline number who saw a skilled provider a second time for ANC **for the same pregnancy** in the catchment area of the HF for the reference period of interest.	HF registers and HMIS
Third visit for skilled ANC	Number of **additional** pregnant women over the baseline number who saw a skilled provider a third time **for** ANC **for the same pregnancy** in the catchment area of the HF for the reference period of interest.	HF registers and HMIS
Fourth visit for skilled ANC	Number of **additional** pregnant women over the baseline number who saw a skilled provider a fourth time for ANC **for the same pregnancy** in the catchment area of the HF for the reference period of interest.	HF registers and HMIS
Skilled attendants at delivery	Number of **additional** pregnant women over the baseline number who used a skilled provider (doctor or midwife) for delivery (at facility or at home) in the catchment area of the HF for the reference period of interest.	HF registers and HMIS
First visit for PNC	Number of **additional** deliveries over the baseline number in the catchment area of the HF that received one PNC visit from a trained attendant (at facility or at home) within 6-12 hours of birth for the reference period of interest	HF registers and HMIS
Second visit for PNC	Number of **additional** deliveries over the baseline number in the catchment area of the HF that received the second PNC visit from a trained attendant (at facility or at home) for the **same delivery** within 6 days of birth for the reference period of interest	HF registers and HMIS
Children getting their third dose of DPT before their 1st birthday	Number of **additional** children over the baseline number receiving DPT3 before their first birthday in the catchment area of the HF in the reference period of interest	HF registers and HMIS
Contraceptive prevalence rate (CPR) – Proportion of married, non-pregnant women of reproductive age who or whose partner are currently using at least 1 family planning method	Proportion of married, non-pregnant women of reproductive age who or whose partner are currently using at least 1 family planning method	Household Survey
Tuberculosis case detection	Number of **additional** new smear positive cases notified over the baseline number for the reference period of interest.	HF registers and HMIS

Indicator	Definition	Means of measuring indicator
Equity of care	Is an index where zero indicates equal utilization by all wealth groups; negative numbers indicate higher rates of utilization by poorer patients, while positive numbers indicate higher rates of utilization by wealthier patients	Hospital survey and household survey
Quality of care score on the National Monitoring Checklist (NMC)	Score received by the HF in the NMC (out of a possible score of 100)	National Monitoring Checklist tool

NB: The performance payments will **not** be paid on a proportional increase in the outputs. Performance payments will be paid on the increase in the **number** of service outputs for the relevant indicator

Figure 1. Allocation of funds

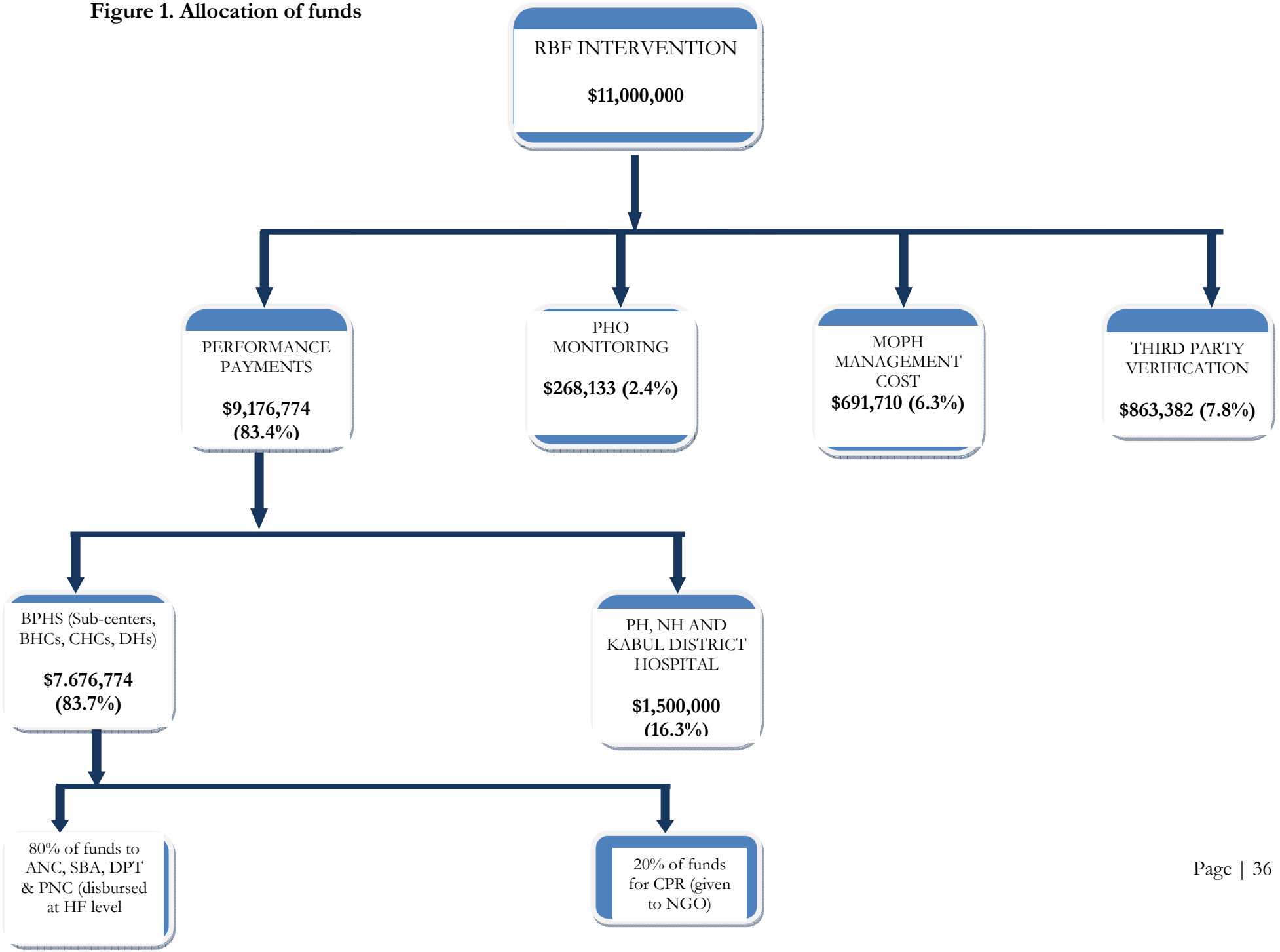

Table 4: Unit cost of selected indicators

S. No.	Indicator	Unit cost
1	First Visit of Skilled ANC	$1.5
2	Second Visit of Skilled ANC	$1.5
3	Third Visit of Skilled ANC	$1.5
4	Fourth Visit of Skilled ANC	$1.5
5	Skilled Birth Attendants (SBA)	$12
6	First Post-Natal Care Visit	$1.5
7	Second Post-Natal Care Visit	$1.5
8	DPT3	$3
9	Institutional delivery	$12
10	Complicated delivery	$12
11	TB case detection	$5
12	# of successful treatment of severe malnutrition	$50
13	Equity of care	See table 4.1 below
14	Equity in institutional delivery	See table 4.1 below
15	Hospital BSC score	See table 4.2 below
16	Infection prevention	See table 4.3 below
17	Contraceptive Prevalence Rate	Twenty percent of the total performance payment is ear-marked for CPR. One third will be paid for each 2 percentage points increase per year.

Table 4.1. Equity indicators

S.No.	Indicator	Unit cost (per percentage point)
1	Equity of care	$550
2	Equity in institutional delivery	$550

Table 4.2 Balanced Score Card Score

Score range	Unit cost (per percentage point)		
	Provincial and National Hospital	Provincial Hospital	District Hospital
60-70	$3000	$1000	$700
71-80	$4000	$1500	$900
81-90	$5000	$2000	$1100

Table 4.3 Infection prevention (in DH and PH)

Score range	Unit cost (per percentage point)
Under 50	$200
51-75	$300
76 and above	$400

Table 5: Example of Division of Yearly Total Performance payments among HF Staff at a "Rural" BHC

	# in HW	Total Salary per Month (including base salary and hardship)*	% Salary of Monthly Payroll Cost	Monthly Performance payment Amount for Each Staff	Potential Annual Performance payment Amount for Each Staff	Comments
Nurse (male)	1	$165	0.18	$74	$892	
Midwife	1	$280	0.30	$126	$1,514	
Community Health Supervisor	1	$120	0.13	$54	$649	
Vaccinator	2	$200	0.22	$90	$1,081	Up to $45 each month and $540 annually for each vaccinator
Cleaners/Guards	2	$160	0.17	$72	$865	Up to $36 each month and $432 annually for each cleaner and guard
Total Monthly Payroll Cost		$925				

*Base salary and hardship amounts derived from the National Salary Policy (MoPH, 2005). Only MDs, midwives, nurses and lab technicians qualify for hardship. Other cadres of health facility staff including community midwives, community health supervisors, vaccinators, cleaners and guards do not qualify for hardship.

Table 6: Monitoring and Evaluation Activities Timeline (page 1)

N°	Activity	Respon-sible Party	(April 2009– Feb 2010)										
			Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
	Pre-Intervention Phase												
1	Implementing new HMIS forms in all RBF provinces	HMIS											
2	Start preparation and implementation of NMC in all RBF provinces	PHOs											
3	Starting the RBF intervention in 2 pilot provinces	Implement-ers											
4	Implementation of the community monitoring mechanisms (to be done by the third party)	Third Party											
5	Annual HF and Hospital Survey	Third Party											
6	Baseline Survey for RBF Evaluation	Third Party											
7	Data editing, entry and presentation of results for HF survey (BSC results)	Third Party											
8	Data editing and entry for baseline survey	Third Party											
9	Getting HMIS estimates for at least 1 quarter to set baselines	HMIS											

Table 6 (continued): Monitoring and Evaluation Activities Timeline (page 2)

N°	Activity	Respon-sible Party	(March 2010–March 2011)												
			Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	Intervention Phase: Year 1		**2010**	**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**		
1	Start of RBF Intervention	Implement ers													
2	Submission of routine HMIS data to HMIS and PHOs	Implement ers													
3	Routine community verification of data from HF registers – verification and entry of data	Third Party													
4	Submission of verification data to central MoPH	Third Party													
5	Quarterly visits to all HF by PHO to conduct NMC (Can be done continuously)	PHO/Impl ementers													
6	NMC data submitted to M&E Department and HMIS (one month lag time at the end of every quarter)	PHO													
7	Annual Health Facility Survey	Third Party													
8	Supervision missions by HEFD staff (and or M&E staff) periodically throughout the year (f/up on health service delivery, RBF related activities and PHO RBF activities)	MOPH													

Table 6 (continued): Monitoring and Evaluation Activities Timeline (page 3)

N°	Activity	Respon-sible Party	(April 2011–March 2012)											
			Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	Intervention Phase: Year 2		**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**		
1	Submission of routine HMIS data to HMIS and PHOs	Implement ers												
2	Routine community verification of data from HF registers – verification and entry of data	Third Party												
3	Submission of verification data to central MoPH	Third Party												
4	Quarterly visits to all HF by PHO to conduct NMC (Can be done continuously)	PHO/Impl ementers												
5	NMC data submitted to M&E Department and HMIS (one month lag time at the end of every quarter)	PHO												
6	Annual Health Facility Survey	Third Party												
7	Supervision missions by HEFD staff (and or M&E staff) periodically throughout the year (f/up on health service delivery, RBF related activities and PHO RBF activities)	MOPH												

Table 6 (continued): Monitoring and Evaluation Activities Timeline (page 4)

N°	Activity	Respon-sible Party	(April 2012–March 2013)											
			Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	Intervention Phase: Year 3		**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**		
1	Submission of routine HMIS data to HMIS and PHOs	Implementers	■			■			■			■		
2	Routine community verification of data from HF registers – verification and entry of data	Third Party			■			■			■			■
3	Submission of verification data to central MoPH	Third Party	■			■			■			■		
4	Quarterly visits to all HF by PHO to conduct NMC (Can be done continuously)	PHO/Implementers	■	■	■	■	■	■	■	■	■	■	■	■
5	NMC data submitted to M&E Department and HMIS (one month lag time at the end of every quarter)	PHO	■			■			■			■		
6	Annual Health Facility Survey	Third Party				■	■	■						
7	Supervision missions by HEFD staff (and or M&E staff) periodically throughout the year (f/up on health service delivery, RBF related activities and PHO RBF activities)	MOPH	■	■	■	■	■	■	■	■	■	■	■	■
8	End-of-Project Household Survey	Third Party										■	■	
9	Data editing and entry for end-of-project survey	Third Party												■

MARCH 2013 – COMPLETION OF RBF INTERVENTION

Table 6 (continued): Monitoring and Evaluation Activities Timeline (page 5)

N°	Activity	Respon-sible Party	(April 2013–March 2012)											
			Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	Post Intervention Phase		**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**		
1	Submission of routine HMIS data to PHOs	Implement ers												
2	Submission of data from PHOs to HMIS department	PHOs												
3	NMC data submitted to central MoPH (one month lag time at the end of every quarter)	PHO												
8	Results from Evaluation													

Table 7: District Hospitals in provinces included in the intervention

	Provinces	Donor Group	# of DHs
1	Samangan	World Bank	1
2	Sar-e-Pul	World Bank	1
3	Balkh	World Bank	5
4	Jawzjan	USAID	2
5	Bamiyan	USAID	3
6	Kunduz	EC	1
7	Daykundi	EC	1
8	Parwan	MoPH-SM	1
9	Panjsher	MoPH-SM	1
10	Kabul		1 – Dasht-e-Barchi DH
11	Kandahar*	USAID	1
	TOTAL		18

*Insecure province.

Table 8: Provincial Hospitals and Hospital in Kabul Cities included in the intervention

	Provinces	Implementing agency	Provincial or National Hospital – Treatment Group
1	Kabul	MOPH	Malalai Hospital
2	Parwan & Kapisa	MoPH-SM	Charikar Hospital and Mahmud Raqi Hospital