This action is funded by the European Union

**Annex 2**

of the Commission Implementing Decision on the financing of the annual action programme in favour of Afghanistan for 2018 part 2, 2019 part 1 and 2020 part 1

**Action Document for EU Support to Health and Nutrition Services for the Afghan Population - SEHATMANDI**

1. **Title/basic act/CRIS number**

2. **Zone benefiting from the action/location**
   - Asia, Afghanistan
   - The action shall be carried out at the following location: country-wide with implementation coordinated from Kabul.

3. **Programming document**
   - Addendum to the Multiannual Indicative Programme (MIP) between the European Union and Afghanistan for the period 2014-2020

4. **Sector of concentration/thematic area**
   - MIP – focal sector 3) Basic social services
   - DEV. Aid: YES

5. **Amounts concerned**
   - Total estimated cost: USD 600 000 000
   - Total amount of EU budget contribution: EUR 80 000 000
   - The contribution is for an amount of EUR 40 000 000 from the general budget of the European Union for 2018 and for an amount of EUR 40 000 000 from the general budget of the European Union for 2019, subject to the availability of appropriations following the adoption of the relevant budget.

   - Part of this action (SEHATMANDI) is co-financed in joint co-financing by: USAID, World Bank (WB) and Canada. The total cost of the project is US$600 million, financed through multiple sources including the Afghanistan Reconstruction Trust Fund (ARTF) in the amount of US$425 million, Global Financing Facility (GFF) in the amount of US$35 million and IDA Grant in the amount of US$140 million.

6. **Aid modality(ies) and implementation modality(ies)**
   - Project Approach
   - Direct management: grants – call for proposals; procurement of services
   - Indirect management with World Bank

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7 a) DAC code(s)  
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>12110</td>
<td>Health policy and administrative management.</td>
<td>10%</td>
</tr>
<tr>
<td>12220</td>
<td>Basic health care</td>
<td>40%</td>
</tr>
<tr>
<td>12240</td>
<td>Basic nutrition</td>
<td>15%</td>
</tr>
<tr>
<td>12281</td>
<td>Health personnel development</td>
<td>10%</td>
</tr>
<tr>
<td>13020</td>
<td>Reproductive health care</td>
<td>20%</td>
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<tr>
<td>13030</td>
<td>Family planning</td>
<td>05%</td>
</tr>
</tbody>
</table>

b) Main Delivery Channel  
World Bank – 44001  
International NGOs – 21000  
Other – 52000

8. Markers (from CRIS DAC form)  
Main objective | X | ☐ | ☐  
General policy objective | Not targeted | Significant objective | Main objective  
Participation development/good governance | ☐ | X | ☐  
Aid to environment | X | ☐ | ☐  
Gender equality (including Women In Development) | ☐ | X | ☐  
Trade Development | X | ☐ | ☐  
Reproductive, Maternal, New born and child health | ☐ | ☐ | X  
RIO Convention markers | Not targeted | Significant objective | Main objective  
Biological diversity | X | ☐ | ☐  
Combat desertification | X | ☐ | ☐  
Climate change mitigation | X | ☐ | ☐  
Climate change adaptation | X | ☐ | ☐  

9. Global Public Goods and Challenges (GPGC) thematic flagships  
HEALTH

10. SDGs  
Main Sustainable Development Goal (SDG):  
SDG 3: Ensure healthy lives and promote well-being for all at all ages  
Secondary SDG Goal:  
SDG 2: End hunger, achieve food security and improved nutrition, and promote sustainable agriculture  
Especially:  
SDG 2.1 by 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations including infants, to safe, nutritious and sufficient food all year round  
SDG 2.2 by 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons
SUMMARY

This action will continue the EU support to the health sector in Afghanistan. It is aligned with the Afghanistan Multiannual Indicative Programme 2014-2020 as well as with the new European Consensus on Development, the Afghanistan National Peace and Development Framework (ANPDF) and the current National Health and Nutrition Strategy. It is strongly linked with two main National Priority Programmes (NPPs), namely Citizens’ Charter and Women Economic Empowerment. In combination with the State Building Contract (SBC), particularly SBC II envisaging a stronger focus on service delivery, this action will contribute to advancing EU-Afghanistan policy dialogue on a priority area. It is also designed to prepare the Government of Afghanistan for possible future Health Sector Budget Support.

The action envisages a combination of on-budget support for the provision of health services across the country, through the Afghanistan Reconstruction Trust Fund (ARTF), and off-budget/direct management support for key reforms and capacity building, including human resource development.

It includes the following components:

1- On-budget/ARTF: Support implementation of SEHATMANDI

- In line with the EU global strategy for aid effectiveness, a large part of this action will be channeled through the WB/ARTF. It will support the implementation of SEHATMANDI (Healthy) - the new operation continuing the "System Enhancement Health Action in Transition" (SEHAT), which ends on 30 June 2018 (thus ensuring continuity in the provision of health services). SEHATMANDI's components are: a) Improving service delivery and performance management; b) Health system strengthening through reforms and innovations; c) Strengthening community engagement.

2- Off-budget: Progressive handover to the Ministry of Public Health (MoPH) of current off-budget direct management projects

- The EU will continue to support the expansion and improvement of health services to vulnerable group through training of Psychosocial Counsellors, Physiotherapists, Orthopaedic Technicians and specific cadre for nutrition, thus complementing SEHATMANDI (which includes provision of services in these areas but not training of specialists). The action will also focus on strengthening the capacity of the MoPH and other institutions to train the mentioned staff categories, oversee their incorporation in the health sector, and provide post-training supportive supervision. This approach will not only reduce the gap between needs and staff availability but also enhance sustainability through Government ownership. The EU’s direct management support for the training of various health professionals will be gradually phased out. A national disability survey is also planned, in close coordination with Central Statistical Office (CSO). Grants/calls for proposals are envisaged.

- A Technical Cooperation program will strengthen the stewardship functions of the MoPH and complement SEHATMANDI and the off-budget projects mentioned above. It will be designed to fill capacity gaps and provide support in areas where there is not enough expertise inside the MoPH. Particular attention will be given to the MoPH-Ministry of Finance (MoF) relationship and public finance management (preparing for possible future sector budget support). A service contract/call for tender is envisaged.
Consolidating past gains, the proposed action will ensure health sectors' further development towards self-reliance and contribute to improving the health and nutrition status of the Afghan population.

1 CONTEXT

1.1 Sector/Country/Regional context/Thematic area

The achievements in the health sector in Afghanistan have been mainly attributed to the development and implementation of a unique strategy for primary and hospital services, namely the Basic Package of Health Services (BPHS), the Essential Package of Hospital Services (EPHS) and training of community midwives. The revised BPHS includes: (a) preventive services such as immunisation, micronutrient supplementation, and promotion of insecticide treated bed nets against malaria; (b) health promotive services such as encouraging breast-feeding and use of family planning; (c) basic curative services such as treatment of acute respiratory tract infections, diarrhoea, other childhood illnesses, and tuberculosis; (d) reproductive health services such as prenatal care, emergency obstetrical care, and postpartum care; and (e) basic mental health and disability services. The EPHS facilities provide secondary diagnostic and treatment services and serve as the first referral point for the BPHS facilities at province level. There is at least one provincial hospital in each province. The main services provided in the provincial hospitals include: gynaecology, obstetrics, neonatal care, postpartum care and complications, nutrition, orthopaedics, surgical care, respiratory and gastrointestinal care. Contracting out of service delivery allowed rapid expansion of health services to remote and insecure areas and provided implementing NGOs with autonomy and flexibility. Progress has been significant in a number of areas, e.g. improvements in under-5 mortality and nutrition, increases in the coverage of many key services, improvements in quality and equity of care in primary health centres (PHCs), District and Provincial hospitals, increase in the number and distribution of female health workers. The number of functioning health facilities increased five-fold while the proportion of facilities with female staff increasing from 22 percent to 87 percent.

Despite progress, either stagnating or declining trends have been noticed in some areas over the last five years. The use of family planning still remains low. Infant and child feeding practices remain poor. There is an extremely high prevalence of chronic malnutrition, poor sanitation, micronutrient deficiency diseases, as well as a high burden of other diseases, from malaria and tuberculosis to mental health conditions. The findings of the National Nutrition Survey 2013 (NNS 2013) confirm that nutrition must continue to be framed as an urgent public health priority. Important indirect societal factors that also contribute to malnutrition among women and children include low status of women, large family size, early marriages, multiple gestations etc. Furthermore, widespread internal displacement and the influx of returnees in 2016 and 2017 continue to pose challenges for the delivery of health and nutrition services. Around 40% of the population lives more than a one hour walk from the nearest health facility. Improvements will be challenging, given the conflict situation and also the geographical characteristics. The 2016 National Health Accounts revealed that 72% of the Total Health Expenditure in Afghanistan is Out-of-Pocket expenditure, which represents a very high burden especially on the poor.

The Evaluation of the European Union’s Cooperation with Afghanistan 2007-2016 indicates that good results have been achieved in the Health sector. Institutional capacities and policy frameworks have been improved, which has had a positive effect on service delivery, especially in terms of access.
1.1.1 Public Policy Assessment and EU Policy Framework

Provision of basic services, including health services, is a focal sector of the revised EU-Afghanistan MIP 2014-2020. It is also an EU development priority highlighted in various EU or international documents such as the new European Consensus on Development, the 2005 Paris Declaration, 2008 Accra Agenda for Action, 2011 Busan Outcome Document, 2014 Mexico Communique and the 2016 Nairobi Outcome Document.

The Afghan National Health and Nutrition Policy and Strategy\(^2\) identify governance, institutional development, public health, health services and human resource management as the sector's priorities until 2020. The Health Sector Development Framework, which was discussed on 1 June 2017 in the presence of the President, the Minister of Public Health and main stakeholders, outlines the following principles for going forward based on the lessons learnt:

- Targeting the poor and under-served must remain central;
- Engagement with communities must be enhanced, in keeping with the Citizens' Charter;
- Accountability will be further strengthened, concentrating on Evidence-Based Priorities;
- Enhancing opportunities for innovation, increased financing and increasing the proportion that is under MoPH stewardship will be pursued.

SEHAT was established in 2014 as a result of the joint efforts of the MoPH, the EU and the World Bank. USAID joined in 2015. It is the flagship program in the health sector and has led to improved coordination, dialogue and alignment of the main partners, as well as to strengthened MoPH stewardship. SEHAT covers the entire country. Nutrition, Mental Health and Disability & Rehabilitation are now also covered under SEHAT. In 2015, the EU earmarked EUR 17 million for nutrition under SEHAT. Nutrition counsellors have been added to the BPHS health facilities and unified short-term training on nutrition has been designed and is being implemented. Integration of supply of ready-to-use therapeutic foods (RUTF) to SEHAT is another improvement of nutrition services under SEHAT and will be continued under SEHATMANDI. In addition, psychosocial counsellors are in the organigram of Comprehensive Health Centres (CHC).

The Project Appraisal Document for SEHATMANDI will be finalized in March 2018. The EU Delegation contributed to its design together with the main donors and a MoPH committee. It will replace SEHAT after June 2018. The estimated cost of SEHATMANDI is USD 600 million for three years (USD 200 million per year). It will have the following three components: (i) Improve Service Delivery and Performance Management, which will include service delivery BPHS and EPHS through contracting out and contracting in (Strengthening Mechanism - SM); (ii) Strengthening the whole health system: this will include (a) Reform of management and governance of regional and tertiary hospitals; (b) Reform of pharmaceutical subsector; (c) Support further innovations to increase female health workers, and (d) Strengthening reporting system for gender-based violence (GBV); (iii) Strengthening community engagement: this will include: (a) Innovations for increasing uptake for family planning (e.g., tracking of patient satisfaction, monitoring supplies, etc.); (b)

\(^2\) Both above mentioned documents were developed on the basis of the findings and conclusions of the health sector review carried out by the technical support of the EU Delegation in 2015. The EU Delegation was engaged in the development of both documents.
Strengthen community accountability (e.g. increased use of community scorecards, operationalise grievance redress mechanisms at facility level established under the Citizens' Charter, obligations of the BPHS NGOs to coordinate with Citizens' Charter Institutions, etc.); (c) Strengthen communication interventions for behaviour change.

The recent World Bank study on Optimising Health Service Delivery Choices-2016 recommends the continuation of both contracting out and contracting in. The current model has shown that it is resilient in conflict situations by developing effective coping strategies such as linkages to local communities and decentralised management. These have helped to maintain or improve the delivery of services, monitoring and resource allocation in areas of particularly difficult access and especially in high conflict areas.

In line with the Health Sector Strategy 2016-2020, the National Strategy for Disability and Rehabilitation (to be finalised soon) emphasises expansion of services through BPHS, the establishment and efficient functioning of disability and rehabilitation services, prevention of disability and restoring maximum physical functional ability for persons with disabilities and for those with temporary impairment, and the expansion of rehabilitation services through recruitment of newly qualified professionals such as physiotherapists and orthopaedic technicians.

The National Mental Health Strategy, currently under revision with EU support, foresees integrating mental health care with primary health care and community counselling. It has demonstrated the feasibility of providing essential care through personnel of the primary health care, counsellors trained for short period of time and other resources in the community. The community-based mental health care is the most effective method of reaching the people who need mental health care.

The National Public Nutrition Policy and Strategy 2015-2020 focuses on actions to enable the population to adopt healthy dietary practices, access nutritious foods and benefit from quality preventive and therapeutic nutrition services. The strategy’s targets are, inter alia: decrease stunting to 35%; reduce underweight in children of 0 to 59 months to 15%; decrease global acute malnutrition in children of 6 to 59 months to 4%; and reduce severe acute malnutrition in children of 6 to 59 months to 2.5% by 2020. The government and other stakeholders still use data of the 2013 National Survey. Nutrition related indicators have been added to the Afghanistan Household Survey 2018.

The Afghanistan Food Security and Nutrition Agenda (AFSeN) has been launched in fall 2017 with the aim of improving coordination towards assuring the availability of sufficient food for all Afghans, improving economic and physical access to food, especially by vulnerable and food insecure population groups, ensuring stable food supplies over time and in disaster situations and promoting healthy diets and adequate food utilization particularly by women and children. The EU is member of the Executive Committee of AFSeN and active member of the Nutrition and Food Security Working Group. Afghanistan also joined the Scaling Up Nutrition (SUN) movement as the 60th member on 6 October 2017. The EU Delegation was engaged in advocacy efforts leading to that.

1.1.2 Stakeholder analysis

The general population and communities are the final beneficiaries of the action. Health services will be provided throughout the country, including in the rural and remote areas. Through health committees at the health facilities level, the communities will provide support to the health workers and be engaged in monitoring of the health facilities. The action will
particularly focus on more vulnerable groups e.g. women, children, people with mental health disorders, disabled people, as well as returnees and internally displaced persons (IDPs).

The MoPH is a main stakeholder and beneficiary of the action. It has a stewardship role of the health sector, develops policies, strategies, leads coordination and policy dialogue with development partners and monitors health service provision. The MoPH will benefit from both Technical Cooperation and capacity building for improved sector management, including on human and financial resources.

NGOs are key stakeholders under this action. The Government contracts out health service provision to national and international NGOs which a have fundamental role in delivering health services to communities. The flexibility of the contracting out model enables NGOs to access remote and insecure areas. The MoPH contracted a Third Party to monitor the BPHS NGOs' performance. A number of international NGOs are currently involved in improving mental health and disability services, including under EU funded projects. NGOs will also benefit from capacity building.

Beside the EU, development partners providing funding for the health sector in Afghanistan are USAID, World Bank and Canada. Regular SEHAT quadrilateral meetings ensure synergy and complementarity and will be maintained during the implementation of SEHATMANDI. Development partners are also actively involved in coordination and policy dialogue. The WB, as administrator of the ARTF, maintains a pivotal role, particularly with regard to SEHAT and SEHATMANDI implementation, not the least due to its long experience in the Afghan health sector. Other stakeholders such as the WHO, UNICEF and UNFPA provide expertise and technical assistance to the MoPH.

The private sector is a key stakeholder in the provision of health services to the Afghan population. The proposed action will support the regulation of the private sector and improve coordination and partnership with the private sector.

1.1.3 Priority areas for support/problem analysis

Expanding coverage is a key priority in national policies and a shared concern among development partners. During the Presidential Summit on health on 1 June 2017, it was agreed to: maintain and improve the current modality of health service delivery through contracting out to NGOs; pursue an expansion of health services to underserved areas by the establishment of sub-centres and other cost-effective approaches; improve quality, specifically of the curative care at the different levels of the health delivery system - including District, Provincial, Regional and National Hospitals.

According to the findings of two recent national surveys (DHS and AHS 2015), under-5 mortality rate is 55 per 1,000 live births and the number of births attended by skilled health personnel reached 58 percent. Yet, the use of family planning remains low, resulting in high fertility rates that could prevent Afghanistan from achieving its economic development goals. There is some controversy about the trend and level of the maternal mortality ratio (MMR), but there is widespread agreement that it remains unacceptably high\(^3\), despite the excellent evolution in the number of deliveries attended by skilled birth attendants. Nevertheless, current MMR makes it necessary to take into account the very low coverage of family planning and the suboptimal distribution of health services across the country. There are too

\(^3\text{According to the findings of the Afghan Household Survey 2015, MMR over the preceding 3 years (2013-2015) is 276/100,000 live births, according to the Demographic Health Survey 2015 MMR is around 1200/100,000 over the period of mid-2008-mid 2015}\)
many "primary" levels of health facilities which limit effectiveness. Moreover, the "secondary" level is poorly defined and overlaps with the primary level. Moreover, it does not systematically offer the one basic service expected at the secondary level\(^4\), namely surgery. In fact, basic surgery (caesarean section, appendectomy, acute abdominal surgery, etc.) should be the real difference between the primary and the secondary level.

As a direct result of prolonged conflict and insecurity, exceptionally high levels of mental health disorders have been registered, including depression, anxiety and Post Traumatic Stress Disorder (PTSD), Self-Harm and Suicide. According to an EU funded survey\(^5\) conducted in 2015, the overall prevalence of mental impairment among Afghan school-going children was 16% (13.5% for male and 18.6% for female students). The study also indicates the prevalence of some common mental health problems: depression (8.4%), anxiety (6%), attention deficit (7%) and conduct disorder (4.6%). In three of the most common mental health problems, girls were more prone to worse mental health situation than boys; in contrast, the prevalence of conduct disorder was higher for boys than girls. Another survey conducted in 2016 in Kabul\(^6\) found that a large majority (70%) of young Kabulis have experienced traumatic experiences (one or multiple shocks - not only personal or family traumas, but also criminal or terrorist issues).

According to the Health Index developed in this study, IDPs remain more than 35% more likely than youth with no migration background to be deprived of basic access to healthcare. 60% of the surveyed youth (and 75% for IDP youth) stated not having enough money to pay for a private doctor, clinic or hospital. By contrast, this study shows a strong willingness to seek treatment, either psychological or physical, for more than 85% of the surveyed youth.

The EU Delegation funds the ongoing National Mental Health Survey to provide an accurate and updated estimate of the prevalence of common mental disorders in Afghanistan. These will include depression, anxiety and Post Traumatic Stress Disorder (PTSD), suicide, suicide ideation and suicide attempt and substance abuse.

A National Disability Survey from 2005 concluded that the prevalence of persons with disability was 4.8% of the total population and that 2.7% have severe disability. The survey also looked at the overall access to health care services and showed that both persons with and without disability have challenges to access health care services. Only 51% of persons with disabilities have a health centre available. A mapping of Physical Rehabilitation Services in Afghanistan conducted in 2013 concluded that there is an important shortage of services and physiotherapists, orthopaedic technicians and other relevant categories of staff in many districts, especially in the rural areas and regions where insecurity is persistent and high. SEHAT has not been geared to provide training for this health categories and a change of approach is not foreseen in the short term. Due to the low capacity of the government, the Physical Rehabilitation Services are mainly provided through vertical programmes by international organisations (International Committee of the Red Cross, Handicap International, Swedish Committee for Afghanistan etc.) with an unequal distribution of services that are not accessible for most of the disabled people, especially women.

\(^4\) A secondary level (district hospital) is needed to cover a population between 100 000 and 200 000 inhabitants depending of the density of the population.
\(^5\) Prevalence of Common Mental Health Problems among Afghan School Students of Grade 5-10: A Concurrent Mixed Study Design
\(^6\) Urban Displaced Youth in Kabul - Part One: Mental Health Matters 2016 conducted by Samuel Hall is an independent think tank with offices in Central Asia (Afghanistan) and East Africa (Kenya, Somalia).
Chronic undernutrition and micronutrient deficiencies are highly prevalent in Afghanistan. The results of the last National Nutrition Survey (NNS) conducted by the MoPH and UNICEF in 2013 showed that chronic undernutrition (stunting prevalence of 40.9%) is among the highest in the world and the acute malnutrition (wasting prevalence) affects 9.5% of the children under five years (close to nationwide emergency situation). An EU financed study conducted in 2014 (Assessment of Nutrition Intervention in BPHS and EPHS) reveals that presently the nutrition component has been under-staffed and under resourced at service delivery, provincial and national levels. The situation is further worsened by the absence of a consistent programme of training for health workers in nutrition. As a result of joint efforts of the EU and other partners, nutrition counsellors have been added to BPHS and short-term training in nutrition for all BPHS staff has been developed and is being implemented.

Existing national plans and policies to achieve universal health coverage (UHC) in Afghanistan have prioritized the following: a) service delivery reform (the 2016-2020 National Health Strategy aims at achieving UHC by providing basic quality health services and hospital services to its entire population); b) piloting NGO innovations (NGOs' role is important due to their flexibility and close coordination with local communities); c) health financing reform (MoPH set out a new policy to increase total financing for the health system); d) governance reform (a regulatory framework for community engagement in service delivery though the Citizens Charter has been established).

2 RISKS AND ASSUMPTIONS

<table>
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<tr>
<th>Risks</th>
<th>Risk level (H/M/L)</th>
<th>Mitigating measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deteriorating security may affect service delivery in specific districts and provinces. Political instability</td>
<td>H</td>
<td>NGOs via engagement of local community, community health workers and private sector will provide health services in challenging areas. Strong institutional collaboration with stakeholders at various levels. Dialogue with security sector stakeholders in view of ensuring respect for humanitarian law.</td>
</tr>
<tr>
<td>Turnover of the MoPH staff at the programme and implementation level</td>
<td>M</td>
<td>The EU will not rely on individual and work with all parties engaged and use the current network. With new salary scheme CBR, MoPH will be able to recruit qualified staff and prevent turn over.</td>
</tr>
<tr>
<td>Social and cultural barriers to female employment as a health worker in the remote areas or do outreach service due to culture barriers.</td>
<td>H</td>
<td>Recruitment of female staff from local communities and provision of job opportunities for male accompany Revised Salary policy 2016 foresees increment of salary and other benefits for the health workers of BPHS and EPHS</td>
</tr>
<tr>
<td>Low capacity at the provincial and district level to monitor the</td>
<td>M</td>
<td>Joint monitoring by technical departments and the Grant and Contract Management</td>
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</table>

[9]
<table>
<thead>
<tr>
<th>Risks</th>
<th>Risk level (H/M/L)</th>
<th>Mitigating measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>implementation</td>
<td></td>
<td>Unit (GCMU) of the MoPH. The EU currently supports capacity building of the Provincial Public Health Directorates (PPHD) in contract management. The foreseen activities under this action will build capacity at the national and provincial level to monitor and oversee implementation of health services. Through Citizens’ Charter, communities will be engaged in monitoring of health facilities.</td>
</tr>
<tr>
<td>MEC assessment has identified vulnerabilities of health sector to corruption</td>
<td>L</td>
<td>Ministry of Public Health together with health sector partners have taken steps to mitigate corruption in health sector e.g. MoPH has recently launched the implementation of its sector-level Anti-Corruption Strategy 2017-2020.</td>
</tr>
<tr>
<td>Coordination of off and on-budget support</td>
<td>L</td>
<td>Development Partners coordinate their off and on-budget support via a number of fora. MoPH has established Aid Coordination Unit for coordination of off-budget support.</td>
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**Assumptions**

- Continued commitment of the MoPH and Government in general to implement the health programmes.
- National and provincial authorities, including local communities, will be committed to support the health sector.
- Citizens’ Charter Programme will build capacity and enhance community engagement in monitoring development projects, including monitoring of health facilities.
- Other partners and donors are committed to continue funding the health sector. The total cost of the project is USD 600 million, financed through multiple sources including the ARTF (USD 425 million), the Global Financing Facility/GFF (USD 35 million) and a World Bank/IDA grant (USD 140 million). The main donors USAID, the EU and Canada will channel funding through the ARTF. Current pledges to ARTF indicate there is still a financing gap close to USD 200 million. Efforts are ongoing to reduce or fill the gap through Government contribution, funds from non-traditional donors and the use of available non-earmarked ARTF resources.
3 LESSONS LEARNT, COMPLEMENTARITY AND CROSS-CUTTING ISSUES

3.1 Lessons learnt

Supporting a single programme (SEHAT) has improved alignment of donors' support, especially with regard to ownership, government-led donor coordination and increased efficiency. However, communication, system-building including procurement and contract management, and improvement of data quality and utilisation remain challenges to be addressed.

Recruitment and retaining of qualified health workers, especially female, in remote and insecure areas is one of the main limitations for health service delivery across the country. The Revised National Salary Policy which is applicable to BPHS health facilities includes high incentives and flexibility to attract and retain health workers. Community Midwifery and Community Nursing Education under SEHAT has been training people from local communities. The EU has also included community based selection systems (from the district where they will eventually work) under its off-budget training programmes (e.g. psychosocial counsellors).

Service delivery through contracting out has been resilient to increasing conflict due to adaptation strategies such as links to local communities and decentralised management, greater flexibility etc. These should be maintained or improved, particularly through better monitoring and enhanced resources allocation, especially in high-risk areas.

The current EU Technical Cooperation Programme to the MoPH has been designed in close collaboration with the MoPH. It is aligned with the off-budget support of other partners. More emphasis is given to short-term experts for specific tasks and deliverables. This approach, avoiding substitution and reinforcing MoPH's capacity, has been recognised as effective.

The MoPH capacity to procure and manage contracts with NGOs has shown improvements, particularly in terms of respecting the timelines for contracting and for payment. The presence of international technical assistance (TA) has also contributed to guaranteeing a more transparent process.

The past and current EU off-budget projects complemented the on-budget interventions and led to positive results such as the integration of mental health, nutrition, disability and prison health under SEHAT, the introduction of nutrition counsellors to BPHS and EPHS and the nutrition training package for different categories of BPHS and EPHS staff. Such complementarity is also envisaged through the proposed action.

As also highlighted in the above-mentioned evaluation of the European Union’s Cooperation with Afghanistan 2007-2016, the EU's support to the Health sector has been consistent and effective, as it has developed over time, building on the experience gained through the implementation of various activities. The high degree of engagement with stakeholders, especially the Government/MoPH, and the flexible use of funds (i.e. off-budget funds for training of much needed staff) have also been important elements towards achieving positive results and building ownership. The same report concluded that the EU has generally been successful in mobilising strong implementing partners for its programmes.

3.2 Complementarity, synergy and donor coordination

This action will continue the current EU support to the health sector, namely:
Contribution to SEHAT, which as of July 2018 will be transformed into SEHATMANDI;
The current Technical Cooperation to the MoPH which focuses on governance, human resources, hospital management and specific public health issues (mental health, disability, prison health);
The support for the Kabul Medical University and the Ghazanfar Institute for Health Science (GIHS) to revise and upgrade nutrition curricula and implement Master's (MA) and Post-graduate Diploma in Nutrition;
Training of Psychosocial Counsellors, Physiotherapists and orthopaedic technicians;
The EU funded National Mental Health Survey;

Moreover, synergy and complementarity will be ensured with other activities and national priority programmes supported by the EU and other partners:

The Citizens’ Charter promotes partnership between the government and communities and good governance at the local level. Under this programme, communities will be responsible for overseeing the delivery of services, including health services, and the reporting of problems such as absenteeism or illegal payments. Scorecards will be used in health and education facilities to ensure they are staffed and operating according to their mandate. SEHTAMANDI will use Citizens’ Charter's mechanisms and the Community Development Committees (CDCs), including their female members, to build demand and strengthen accountability for critical health and nutrition services, especially for maternal health, nutrition and family planning. It will finance a range of activities ranging from communication campaigns aimed at raising overall awareness of health rights as well as specific health behaviours. That will support the MoPH and NGOs to be more responsive to community health needs.

The ARTF's Capacity Building for Results Facility (CBRF), to which EU is also contributing, aims at increasing government's capacity to support improved service delivery and reduce reliance upon externally funded consultants. The CBRF will improve the managerial and governance functions of the MoPH by attracting qualified national experts into the health sector and will allow a gradual phasing out of TA, which will however require time.

Under the State Building Contract, the EU will provide the Government of Afghanistan with additional fiscal space to finance its own strategic development priorities and policies. It will increase the government capacity to become more self-reliant and will support it to deliver on its forward-looking political commitments and institutional reforms. Specifically, the SBC will focus on (i) public sector reform and the fight against corruption, (ii) basic service delivery and gender, (iii) public financial management with a particular focus on domestic revenue mobilisation, and budgetary transparency and oversight. This action, combined with both SBCs, will prepare Afghanistan for future health sector budget support.

The Health Sector Policy Dialogue (SPD) in Afghanistan has made significant progress in recent years, particularly with regards to the alignment to the MoPH priorities and Development Partners coordination.

The Health Sector Oversight Committee was established in 2017 to discuss and make decisions on strategic issues, oversee public health interventions and coordinate between on- and off-budget programmes. It is chaired by the Minister of Public Health. The EU, together with the World Bank, USAID, as well as the United Nations Children's Fund (UNICEF),
World Health Organization (WHO) and United Nations Population Fund (UNFPA) are members.

The Health Development Partners Forum was established in 2011 and meets on a monthly basis. It brings development partners together to share information, coordinate activities and deal with specific issues related to the health sector.

The SEHAT donor coordination platform gathers EU, USAID and WB to ensure alignment with the sector strategy, close follow-up of SEHAT implementation and coherence of interventions, particularly with regard to technical cooperation.

The Afghanistan Food Security and Nutrition Agenda (AFSeN) has been launched in fall 2017 with the aim of improving coordination towards assuring the availability of sufficient food for all Afghans, improving economic and physical access to food, especially by vulnerable and food insecure population groups, ensuring stable food supplies over time and in disaster situations and promoting healthy diets and adequate food utilization particularly by women and children. The EU Delegation is Member of the AFSeN Executive Committee and also attends regular meetings of its working groups.

3.3 Cross-cutting issues

Under this action, health services will be provided to all categories of the population. However, special focus will be on women, children and other vulnerable group. Actions will address child mortality and maternal mortality.

Shortage and travel restrictions of female health workers affect female access to health services. The BPHS and EPHS have greatly contributed to increasing access, especially for women, by bringing health services closer to communities and reducing the number of health facilities without female staff.

This action will continue to support the four “agreed deliverables” of the Gender Mainstreaming Proposal under ARTF. Current related activities under SEHAT will continue to be implemented under SEHATMANDI. The Gender Mainstreaming Project can help the MoPH to: develop standard operating procedures and systems to ensure all planning documents in the MoPH are gender sensitive; develop a grievance redress system related to GBV, especially sexual harassment in the MoPH; support the Gender Directorate in developing a proper and feasible reporting and monitoring mechanism for GBV in coordination with the EHIS Directorate; increase awareness among MoPH employees and partners regarding gender issues; and strengthen the leadership capacity of the Directorate in the expansion of services for GBV victims.

People with mental disorders and disabilities will also benefit from this action. The EU will continue expansion of health services to the above mentioned categories via the integration of training of Psychosocial Counsellors, Physiotherapists and Orthopaedic Technicians into the Government system. Free medical services, psychosocial counselling and proper referral to the victims of GBV are expected to be provided through all health facilities.

Refugees, returnees and internally displaced people are a vulnerable population group and will benefit from this action. Given the fact that women make up close to 50% of migrants worldwide, and that their vulnerability in the migration process is particularly serious, careful attention will be paid to gender concerns.
All health care providers are held responsible for environmental compliance on health care waste in their management plan and have to set standards with regard to health waste management.

4 DESCRIPTION OF THE ACTION

4.1 Objectives/results and options

Overall Objective

The overall objective is to support the Government of Afghanistan towards the improvement of the health and nutrition status of the Afghan population.

This programme is relevant for the Agenda 2030. It contributes primarily to the progressive achievement of SDG Goal 3 to Ensure healthy lives and promotes well-being for all at all ages, but also promotes progress towards Goal(s) 2 "Zero Hunger" and 5 "Gender Equality". This does not imply a commitment by Afghanistan benefiting from this programme.

Throughout the implementation, a special focus will be maintained on gender equity and equality and the full alignment with the Rights Based Approach for health.

Specific Objectives:

SO1. Increase the utilisation and quality of high impact health and nutrition services through health facilities and communities.

SO2. Enhance the stewardship functions of the Ministry of Public Health at various levels (national, provincial).

Expected Outputs:

EO1. Quality health services provided to Afghan population through the Basic Package of Health Services and the Essential Package of Hospital Services.

EO2. Availability and quality of nutrition services are enhanced and nutrition awareness and capacity are increased among health service implementers, nutrition managers and users throughout the country.

EO3. Services provided to people living with mental disorders and/or disabilities are improved in quality and expanded in order to include more patients and cover a wider geographical area.

4.2 Main activities

Activity 1.1: Support new ARTF operation programme SEHATMANDI:

- **Improve Service Delivery and Performance Management:** This will involve further strengthening of BPHS and EPHS, through:
  
  (a) Improve efficiency and equity of BPHS contracting, (e.g. lump sum contracts, greater flexibility, encourage innovations, expansion of PHCs, etc.);
  
  (b) Improve efficiency and quality of EPHS (e.g. revision of BSC, incentivise innovations, etc.);
  
  (c) Strengthen performance management (e.g. reform of MoPH to be fit for purpose; reform of the monitoring and evaluation (M&E) system, etc.);
(d) Increasing the efficiency and effectiveness of the 3 provinces with direct
government service delivery.

- **Strengthening the whole health system:** this will include:
  (a) Reform of management and governance of regional and tertiary hospitals
      (e.g. hospital performance and governance, clear results contracts,
       partnership with private sector, etc.);
  (b) Reform of the pharmaceutical subsector (e.g. expand the testing of drug
      quality in the public and private sectors, help MoPH establish framework
      contracts for essential medicines with various suppliers, etc.);
      SEHATMANDI foresees improving procurement and supply chain
      management of pharmaceuticals; improving quality, efficiency and
      availability of pharmaceuticals is among the important priorities of the
      health sector; the project will support the recommendations of the PASA
      (Programmatic Advisory Service and Analytic) to enhance efficiency
      including appropriate design and optimal implementation of possible
      framework contracts;
  (c) Support further innovations to increase female health workers; and
  (d) Strengthening reporting system for GBV management.

- **Strengthening community engagement:** this will include:
  (a) Innovations for increasing uptake for family planning (e.g., tracking of
      patient satisfaction, monitoring supplies, etc.);
  (b) Strengthen community accountability (e.g. increased use of community
      scorecards, operationalise grievance redress mechanisms at facility level
      established under the Citizens' Charter, obligations of the BPHS NGOs to
      coordinate with Citizens' Charter institutions, etc.);
  (c) Strengthen communication interventions for behaviour change.

**Activity 1.2:** Provision of Technical Cooperation to the MoPH aimed at strengthening its
technical and human resource capacity; support and finance short term technical
assistance in specific areas where immediate capacity development is required,
with special focus on (i) public finance management (PFM) and (ii) formative
supervision at BPHS and EPHS facilities (especially regarding nutrition, mental
health and disabilities).

**Activity 2.1:** Support implementation of the National Strategy for Nutrition in rolling out
nutrition/health services under BPHS and EPHS by providing capacity building
and integrating nutrition counsellors and other nutrition specific cadres into the
government structure, and by providing capacity building to MoPH to oversee
the implementation of nutrition services and assist the Kabul Medical University
(KMU) in the establishment and a basic laboratory for nutrition. It will include
equipment and supply for the KMU lab which are necessary for the practical
work of the nutrition cadres.

**Activity 3.1:** Support implementation of the National Strategy for Mental Health and
Substance Abuse in rolling out mental health services under BPHS and EPHS by
providing capacity building for training implementation, the integration of
psychosocial counsellors into the government structure and the provision of
supportive supervision.

**Activity 3.2:** Support the National Disability and Rehabilitation strategy in rolling out
disability services under BPHS and EPHS by providing capacity building for
training implementation, the integration of orthopaedic technicians, physiotherapists into the government structure and the provision of supportive supervision, as well as support for a National Disability and Rehabilitation Survey.

4.3 Intervention logic

Health is a focal sector of the revised EU-Afghanistan MIP 2014-2020. This action will continue the EU support to the health sector in Afghanistan. It will incorporate the lessons learned and build upon the results already achieved through the current EU funded programmes. It will be a combination of mutually reinforcing on-budget and off-budget activities, namely:

1-On-budget/ARTF:

In line with the EU commitment to aid effectiveness, the EU has shifted its involvement in health from direct management to supporting the implementation of SEHATMANDI, a nation-wide, government owned and managed on-budget programme. It will include improving service delivery through BPHS and EPHS (contract out and contract in), strengthening the whole health system and strengthening community engagement.

Unified and standardised health service delivery through BPHS and EPHS have led to significant progress in the health sector since 2002, inter alia, through the expansion of coverage, utilisation of health services and the reduction of mortality and morbidity of different categories.

2-Off-budget/direct management:

- **Support expansion of health service to vulnerable group people with mental health disorders, disability and malnutrition.**

Although the services mentioned above are included in BPHS and EPHS, SEHAT and SEHATMANDI did not and do not foresee to implement all required vocational training needed. This justified the past EU off budget training activities of various staff categories. Under this action, emphasis will be placed on building the capacity of MoPH and relevant institutes to enable them to take over the training and recruitment of the above-mentioned health workers and to monitor their performance. This should ensure an effective phasing out of EU direct management, as well as the longer-term sustainability of the results achieved so far.

- **Technical Cooperation to Ministry of Public Health:**

Based on the experiences related to the delay in implementation of the second component of SEHAT (system strengthening), it has been revealed that the MoPH still needs Technical Assistance in specific areas where it has not enough expertise.

The proposed TA will focus on the development of specific strategies and technical documents that will contribute to the smooth implementation of service delivery under SEHATMANDI and above EU off-budget projects.

Special emphasis should be put on financial management at MoPH, in order to ensure effective contributions from MoF and effective budget mobilisation by MoPH, especially in view of the implementation of the current State Building Contract and potentially future Sector Budget Support.
The MoPH will be fully engaged in all phases of the off-budget projects. Under the leadership of the MoPH, a single Steering Committee will be established for all above off-budget projects to ensure ownership by the MoPH and complementarity and synergy of the EU off-budget project.

International and National NGOs will be the potential partners for the implementation of the off-budget support.

5 IMPLEMENTATION – PRELIMINARY INDICATION OF AID MODALITY, TYPE OF IMPLEMENTING PARTNER AND IMPLEMENTATION MODALITIES AS WELL AS OPTIONS

5.1 Financing agreement
In order to implement this action, it is foreseen to conclude a financing agreement with the partner country.

5.2 Indicative implementation period
The indicative operational implementation period of this action, during which the activities described in section 4.1 will be carried out and the corresponding contracts and agreements implemented, is 48 months from the date of entry into force of the financing agreement.

5.3. Implementation Modality
This action will be implemented on-budget through indirect management with the World Bank and off-budget - direct management, including through:

- Call for proposals “Expansion and improvement of Nutrition services”
- Call for proposals "Integration of Training of psychosocial counsellors, orthopaedic technicians and physiotherapists into the government education programme"
- Procurement of Services (Technical Assistance to the Ministry of Public Health)

The implementing partner(s) in direct management could be a member state's agency, non-governmental organisation, civil society organisation, international research organisation, university or university related organisation or an international organisation.

5.3.1. Grants: Call for proposals “Expansion and improvement of Nutrition services”

(a) Objectives of the grants, fields of intervention, priorities of the year and expected results

- The objective of the call for proposals is to expand and improve nutrition services.
- The expected result of the action is to enable the government education institutes to train and make experts available to train and certify specific cadre in nutrition to fill vacant existing positions and guide them in follow up on-the-job training.

(b) Eligibility conditions
In order to be eligible for the grant, applicants must:

- be legal persons and
- be non-profit-making and
- be a member state's agency, non-governmental organisation, civil society organisation, international research organisation, university or university related organization or an
international organisation as defined by Article 156 of the Regulation (EU, Euratom) 2018/1046 and

- be established in a Member State of the EU or an eligible nation as per Article 9 (DCI) of the Regulation (EU) 236 / 2014 (CIR). This obligation does not apply to international organisations and
- be directly responsible for the preparation and management of the action with the co-applicant(s) and affiliated entity(ies), not acting as an intermediary and
- be operational (i.e. already managing a project and/or have an office) in Afghanistan at the moment of the launch of the call for proposals.

Potential applicants may not participate in calls for proposals or be awarded grants if they are in any of the situations which are listed in Section 2.3.3 of the Practical Guide to contract procedures for EU external actions.

(c) Essential selection and award criteria

The essential selection criteria are financial and operational capacity of the applicant. The essential award criteria are relevance of the proposed action to the objectives of the call, design, effectiveness, feasibility, sustainability and cost-effectiveness of the action.

(d) Maximum rate of co-financing

The maximum possible rate of co-financing for grants under this call is 80%. If full funding is essential for the action to be carried out, the maximum possible rate of co-financing may be increased up to 100%. The essentiality of full funding will be justified by the Commission’s authorising officer responsible in the award decision, in respect of the principles of equal treatment and sound financial management.

(e) Indicative timing to launch the call

Third trimester 2019.

5.3.2. Grants: Call for proposals “Integration of Training of psychosocial counsellors, orthopaedic technicians and physiotherapists into the government education program”

(a) Objectives of the grants, fields of intervention, priorities of the year and expected results

- The objective of the call for proposals is to expand and enhance the quality of services to people living with mental health disorders and disabilities.
- The expected result of the action is to enable the government education institute to train and make experts available to train and certify psychosocial counsellors, orthopaedic technicians and physiotherapists to fill vacant existing positions and guide them in follow up on-the-job training to be operational under the BPHS and EPHS system and in the communities on a nation-wide level.

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7 International organisations are international public-sector organisations set up by intergovernmental agreements as well as specialised agencies set up by them; the International Committee of the Red Cross (ICRC) and the International Federation of National Red Cross and Red Crescent Societies, European Investment Bank (EIB) and European Investment Fund (EIF) are also recognised as international organisations.

8 To be determined on the basis of the organisation's statutes which should demonstrate that it has been established by an instrument governed by the national law of the country concerned. In this respect, any legal entity whose statutes have been established in another country cannot be considered an eligible local organisation, even if the statutes are registered locally or a “Memorandum of Understanding” has been concluded.
(b) Eligibility conditions

In order to be eligible for the grant, applicants must:

- be legal persons and
- be non-profit-making and
- be a member state’s agency, non-governmental organisation, civil society organisation, international research organisation, university or university related organization or an international organisation as defined by Article 156 of the Regulation (EU, Euratom) 2018/1046 and
- be established in a Member State of the EU or an eligible nation as per Article 9 (DCI) of the Regulation (EU) 236 / 2014 (CIR). This obligation does not apply to international organisations and
- be directly responsible for the preparation and management of the action with the co-applicant(s) and affiliated entity(ies), not acting as an intermediary and
- be operational (i.e. already managing a project and/or have an office) in Afghanistan at the moment of the launch of the call for proposals.

Potential applicants may not participate in calls for proposals or be awarded grants if they are in any of the situations which are listed in Section 2.3.3 of the Practical Guide to contract procedures for EU external actions.

(c) Essential selection and award criteria

The essential selection criteria are financial and operational capacity of the applicant.

The essential award criteria are relevance of the proposed action to the objectives of the call, design, effectiveness, feasibility, sustainability and cost-effectiveness of the action.

(d) Maximum rate of co-financing

The maximum possible rate of co-financing for grants under this call is 80%.

If full funding is essential for the action to be carried out, the maximum possible rate of co-financing may be increased up to 100%. The essentiality of full funding will be justified by the Commission’s authorising officer responsible in the award decision, in respect of the principles of equal treatment and sound financial management.

(e) Indicative timing to launch the call

Fourth trimester 2018.

5.3.3 Procurement

<table>
<thead>
<tr>
<th>Subject in generic terms, if</th>
<th>Type</th>
<th>Indicative number</th>
<th>Indicative trimester of</th>
</tr>
</thead>
</table>

9 International organisations are international public-sector organisations set up by intergovernmental agreements as well as specialised agencies set up by them; the International Committee of the Red Cross (ICRC) and the International Federation of National Red Cross and Red Crescent Societies, European Investment Bank (EIB) and European Investment Fund (EIF) are also recognised as international organisations.

10 To be determined on the basis of the organisation's statutes which should demonstrate that it has been established by an instrument governed by the national law of the country concerned. In this respect, any legal entity whose statutes have been established in another country cannot be considered an eligible local organisation, even if the statutes are registered locally or a “Memorandum of Understanding” has been concluded.
5.3.4 Indirect management with an international organisation

A part of this action may be implemented in indirect management with the World Bank. This implementation is justified because of the experience of the World Bank in the country and health sector. The WB is moreover the administrator of the ARTF, under which SEHATMANDI is going to be funded, and has demonstrated to be able to provide this set of activities through the Trust Fund, which ensures coherence of approach and Ministry's ownership, as well as donor coordination.

The entrusted entity would carry out the following budget-implementation tasks: launch calls for tenders and for proposals; define eligibility, selection and award criteria; evaluate tenders and proposals; award grants, contracts and financial instruments; act as contracting authority concluding and managing contracts, carrying out payments, recovering moneys due and cancelling debts that cannot be recovered.

For the budget-implementation tasks not yet assessed, the World Bank is currently undergoing ex-ante assessment. The Commission's authorising officer responsible deems that, based on the compliance with the ex-ante assessment based on Regulation (EU, Euratom) No 1605/2002 and long-lasting problem-free cooperation, the international organisation can be entrusted with budget-implementation tasks under indirect management.

5.4. Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply.

The Commission’s authorising officer responsible may extend the geographical eligibility in accordance with Article 9(2)(b) of Regulation (EU) No 236/2014 on the basis of urgency or of unavailability of products and services in the markets of the countries concerned, or in other duly substantiated cases where the eligibility rules would make the realisation of this action impossible or exceedingly difficult.

5.5. Indicative Budget

<table>
<thead>
<tr>
<th>Module</th>
<th>Amount in EUR</th>
<th>Third party contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grants contracts (direct management)</td>
<td>5 000 000</td>
<td>1 000 000</td>
</tr>
<tr>
<td>5.3.1 - Call for proposal for expansion and improvement of nutrition services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3.2 - Call for proposal for integration of Training of psychosocial counsellors, orthopaedic technicians and physiotherapists into the government education structure.</td>
<td>4 800 000</td>
<td></td>
</tr>
<tr>
<td>5.3.3 - Service contracts (direct management)</td>
<td>70 000 000</td>
<td>TBD</td>
</tr>
<tr>
<td>5.3.4 – Indirect management with WB</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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11 Aligned to system strengthening priority areas under SEHATMANDI and in nutrition, mental health and disability.
### 5.6. Organisational set-up and responsibilities

For the indirect management through ARTF, Ministry of Public Health will be responsible for procurement, contract management, monitoring, and supervision of health service delivery. The Health Strategic Steering Committee will discuss the progress, challenges and provide advice for improvement. The MoPH contracts a third party for the monitoring of the performance of NGO, and for conducting a drug and household survey to measure the implementation of BPHS and EPHS.

In addition to formal mechanisms, the EU, WB and USAID have been and will continue meeting on a need basis (on average every two weeks) to discuss programme implementation and agree on common positions to be communicated to the Ministry.

For the direct management, the EU Delegation will be responsible for the contract management. Management structure at the EU Delegation entails a technical line (Project Officer/Task Manager, Head of Section and Head of Operations) and a Finance and Contracts line. The Task Manager will be in charge of daily follow-up of the project and decisions such as commencement date, minor modifications of the actions and approval of the technical reports.

A Steering Committee for direct management projects needs to be organised. The Steering Committee will be in charge of reviewing the progress, making recommendations for corrective actions, etc.

### 5.7. Performance monitoring and reporting

The day-to-day technical and financial monitoring of the implementation of this action proposals will be a continuous process and part of the implementing partner’s responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (outputs and direct outcomes) as measured by corresponding indicators, using as reference the logframe matrix (for project modality) or the list of result indicators (for budget support). The report shall be laid out in such a way as to allow monitoring of the means envisaged and employed and of the budget details for the action. The final report, narrative and financial, will cover the entire period of the action implementation.

The Commission may undertake additional project monitoring visits both through its own staff and through independent consultants recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

### 5.8. Evaluation

Having regard to the importance of the action, a final evaluation(s) will be carried out for this action or its components contracted by the Commission.

The evaluation reports shall be shared with the partner country and other key stakeholders. The implementing partner and the Commission shall analyse the conclusions and
recommendations of the evaluations and, where appropriate, in agreement with the partner country, jointly decide on the follow-up actions to be taken and any adjustments necessary, including, if indicated, the reorientation of the project. The financing of the evaluation shall be covered by another measure constituting a financing decision.

5.9. Audit

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audits or expenditure verification assignments for one or several contracts or agreements.

5.10. Communication and visibility

Communication and visibility of the EU is a legal obligation for all external actions funded by the EU.

This action shall contain communication and visibility measures which shall be based on a specific Communication and Visibility Plan of the Action, to be elaborated at the start of implementation and supported with the budget indicated in section 5.5 above.

In terms of legal obligations on communication and visibility, the measures shall be implemented by the Commission, the partner country, contractors, grant beneficiaries and/or entrusted entities. Appropriate contractual obligations shall be included in, respectively, the financing agreement, procurement and grant contracts, and delegation agreements.

The Communication and Visibility Manual for European Union External Action shall be used to establish the Communication and Visibility Plan of the Action and the appropriate contractual obligations.
## APPENDIX - INDICATIVE LOGFRAME MATRIX (FOR PROJECT MODALITY)

The activities, the expected outputs and all the indicators, targets and baselines included in the logframe matrix are indicative and may be updated during the implementation of the action, no amendment being required to the financing decision. When it is not possible to determine the outputs of an action at formulation stage, intermediary outcomes should be presented and the outputs defined during inception of the overall programme and its components. The indicative logframe matrix will evolve during the lifetime of the action: new lines will be added for including the activities as well as new columns for intermediary targets (milestones) for the output and outcome indicators whenever it is relevant for monitoring and reporting purposes. Note also that indicators should be disaggregated by sex whenever relevant.

<table>
<thead>
<tr>
<th>Results chain</th>
<th>Indicators</th>
<th>Baselines (incl. reference year)</th>
<th>Targets (incl. reference year)</th>
<th>Sources and means of verification</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall impact</td>
<td>To support the Government of Afghanistan towards the improvement of the health and nutrition status of the Afghan population.</td>
<td>1) Level of access to health services 2) Number of new health facilities established under SEHATMANDI</td>
<td>1) 60% (please specify reference year) 1) 70% by end 2021 2) 70 Health Facilities will be established under SEHATMANDI By end of 2020</td>
<td>2) HMIS (establishment of new health facilities) AHS DHS</td>
<td>.</td>
</tr>
<tr>
<td>Specific objectives: Outcomes</td>
<td>SO1. Increase the utilisation and quality of high impact health and nutrition services through health facilities and communities;</td>
<td>1.1) Rate of Skilled birth attendance of deliveries in the last 2 years 1.2) Penta3 vaccination coverage rate 1.3) Contraceptive Prevalence Rate (modern methods)</td>
<td>1.1) AHS2015: 58.1% 1.2) AHS2015: 72.1% 1.3) AHS2015: 16.3%</td>
<td>1.1) HHS 1.2) HMIS 1.3) HHS</td>
<td>The government is and local communities will be committed to support the health sector. -Citizens' Charter Programme will build capacity and enhance community engagement in monitoring development projects, including monitoring of health facilities</td>
</tr>
<tr>
<td></td>
<td>SO2. Enhance the stewardship functions of the Ministry of Public Health at various levels (national, provincial),</td>
<td>2.1) Development and implementation of standard operating procedures (SOPs) for performance management based on a detailed, multi-stakeholder analysis of BPHS and EPHS contracts. 2.2) Proportion of MOPH core development budget executed</td>
<td>2.1) SOP not available 2.2) 81%</td>
<td>2.1) SOP developed and implemented 2.2) Ministry of Finance report on the execution rate of all ministries</td>
<td></td>
</tr>
<tr>
<td>Outputs</td>
<td>1.1) Balanced Scorecard Median Score - primary facilities 1.2) Balanced Scorecard Median Score – hospitals 1.3) Outpatient visits per capita per year to publicly financed facilities supported by this Action</td>
<td>1.1) 61.9 – 2016 1.2) DHs: 73.1 – 2016 PHs: 80.2 – 2016 1.3) 2.15 (reference year)</td>
<td>1.1) 64 (reference year) 1.2) 76 2021 1.3) 2.30 2021</td>
<td>1.1) Balanced Scorecard 1.2) Balanced Scorecard 1.3) HMIS as “corrected” by 3rd party verification</td>
<td></td>
</tr>
</tbody>
</table>
SO1/Output 2: Availability and quality of nutrition services are enhanced and nutrition awareness and capacity is increased among health service implementers, nutrition managers and users throughout the country.

2.1) number of specific cadres trained by government institutes with support of this Action
2.2) Exclusive breast feeding rate
2.1) Zero as the Action has not started yet (2018)
2.2) 43% DHS 2015
2.1) 70 people will enrolled completed diploma training 2021
2.2) 48% 2021
2.1) KMU, GIHS and MoPH report
2.2) HHS

Results chain

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baselines (incl. reference year)</th>
<th>Targets (incl. reference year)</th>
<th>Sources and means of verification</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO2/Output 3: Services to people living with mental disorders and people living with disabilities are improved in quality and expanded to include more patients and a larger geographical area.</td>
<td>3.1) number of PSC trained by the government institutes with the support of this Action (disaggregated by sex) 3.2) Number of Physiotherapists trained by the government institutes with the support of this Action (disaggregated by sex) 3.3) Number of Orthopaedic technicians trained with the support of this Action (disaggregated by sex)</td>
<td>3.1) to be specified 3.2 to be specified 3.3 to be specified</td>
<td>KMU, GIHS and MoPH report</td>
<td></td>
</tr>
</tbody>
</table>

Project Description

<table>
<thead>
<tr>
<th>Means</th>
<th>Indicative costs (EUR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1. Provision Basic Package of Health Services BPHS, Essential Package of Health Services EPHS training of community midwives and nurse and other components SEHATANDI through ARTF.</td>
<td>Indirect management with World Bank SEHATMANDI/ARTF</td>
</tr>
<tr>
<td>1.2. Provision of Technical Cooperation to the MoPH aimed at strengthening its capacity of the MoPH in various levels.</td>
<td>Direct management: Technical Cooperation through a service contract</td>
</tr>
<tr>
<td>2.1 Capacity building and integration of nutrition counsellors and other nutrition specific cadres into the government structure.</td>
<td>Direct management-call for proposals</td>
</tr>
</tbody>
</table>

[24]
<table>
<thead>
<tr>
<th>3.1. Capacity building for training implementation, the integration of psychosocial counsellors into the government structure and the provision of supportive supervision.</th>
<th>Direct management-call for proposals lot 1</th>
<th>Total: 1.5 Million</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2. Capacity building for training implementation, the integration of orthopaedic technicians, physiotherapists into the government structure and the provision of supportive supervision and support National Disability and Rehabilitation Survey.</td>
<td>Direct management-call for proposals lot 2</td>
<td>Total: 2 Million</td>
</tr>
</tbody>
</table>