ANNEX 1

of the Commission Implementing Decision on the Annual Action Programme 2015 (part 2) in favour of Afghanistan

**Action Document for Improving Health and Nutrition in Afghanistan through further support to SEHAT**

| 1. Title/basic act/CRIS number | Improving Health and Nutrition in Afghanistan through further support to SEHAT / CRIS number: DCI-ASIE/2015/37959 financed under Development Cooperation Instrument |
| 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. |
| 4. Sector of concentration/thematic area | Health and Nutrition |
| 5. Amounts concerned | Total estimated cost: Ca EUR 249 900 0001  
Total amount of EU budget contribution: EUR 43 000 000  
This action is co-financed in joint co-financing by: USAID for an amount of Ca EUR 206 900 000 (USD 227 600 000) |
| 6. Aid modality(ies) and implementation modality(ies) | Project Modality  
Indirect management with World Bank |
| 7. DAC code(s) | 12220 – Basic Health Care |
| 8. Markers (from CRIS DAC form) | | General policy objective | Not targeted | Significant objective | Main objective |
| Participation development/good governance | ☑ | ☑ | ☑ |
| Aid to environment | ☑ | ☑ | ☑ |
| Gender equality (including Women In Development) | ☑ | ☑ | ☑ |
| Trade Development | ☑ | ☑ | ☑ |
| Reproductive, Maternal, New born | ☑ | ☑ | ☑ |

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1 InforEuro EUR/USD exchange rate of May 2015 (1.1002).
and child health

<table>
<thead>
<tr>
<th>RIO Convention markers</th>
<th>Not targeted</th>
<th>Significant objective</th>
<th>Main objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological diversity</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combat desertification</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climate change mitigation</td>
<td>X</td>
<td></td>
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<tr>
<td>Climate change adaptation</td>
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### 9. Global Public Goods and Challenges (GPGC) thematic flagships

N / A

### SUMMARY

This Action aims at continuing EU support to the Health Sector in Afghanistan and is closely aligned with the Objectives and Results outlined under Sector 2 of the EU-Afghanistan Multiannual Indicative Programme 2014-2020. In line with EU aid effectiveness commitments and with the Tokyo Mutual Accountability Framework, since 2013 most of the EU support for health has been channelled through the World Bank (WB) administered by the Afghanistan Reconstruction Trust Fund (ARTF), to the System Enhancement for Health Action in Transition programme (SEHAT). SEHAT represents an important step towards a sector wide approach and the Ministry of Public Health is managing the programme and leading donor coordination. As of July 2015, the programme will become nationwide in scope, ensuring health service delivery to all 34 Afghan provinces.

A Joint Health Sector Review (JHSR) funded by the EU and a Health Sector Implementation Support Mission of the WB, both conducted during the first quarter of 2015, have reiterated the relevance of this programme. The new leadership of the Ministry of Public Health has also strongly confirmed its commitment to the programme as scheduled until 2018.

Activities under Result 1 of this Action (Component 1 of SEHAT) aim at assisting the Ministry of Public Health in the procurement, management and monitoring of contracts with health service providers. This will, in turn, allow undisrupted service provision across the country. Activities under Result 2 (Component 2 of SEHAT) aim at supporting reform and capacity building interventions in key health system areas (e.g. strengthening sub-national government, ensuring quality pharmaceuticals, improving hospital performance, improving fiduciary systems, etc.), with the objective of increasing the long term ability of the Ministry to manage a functioning health sector. Finally, Result 3 (Component 3 of SEHAT) aims at strengthening the Ministry's institutional capacity (human and financial resources) and particularly SEHAT management.

A successful management of the programme (R3), combined with key reforms capacity building (R2) and effective delivery of services (R1), is expected to expand the scope, quality and coverage of health services provided to the population, particularly the most vulnerable people, and to enhance the stewardship functions of the Ministry of Public Health (SO). While sustaining past gains, the current action will ensure further development of the sector towards sustainably improving the health and nutrition status of the Afghan population (OO).
1 CONTEXT

1.1 Sector/Country/Regional context/Thematic area

In these early stages of the Transformation decade, Afghanistan faces significant political, security and economic challenges, which require the new administration to urgently assert itself as a credible provider of State core functions in a context of fragility. The ability of the new Government to overcome those challenges will largely determine the future stability and prosperity of the country. The new President has already delivered on key promises (bilateral security agreement, Kabul Bank case) and outlined an ambitious reform agenda at the London Conference in December 2014, while also asserting leadership vis-à-vis the international community's engagement in Afghanistan. This encouraging drive for more ownership and ambitious reform requires sustained and flexible support from the international community, in line with the principles and commitments outlined in the Tokyo Mutual Accountability Framework (TMAF). The credibility and success of the political, security and economic transition depends on strengthening democratic and accountable governance in Afghanistan at all levels: a long-term endeavour.

The protracted electoral process in 2014 and delays in nominating a new Cabinet (finally appointed in April 2015) have significantly slowed down policy work and decision making in all sectors, including Health. While service delivery to the population has continued without interruption, systematic sector challenges identified in the past remain valid and unresolved. Prominently, access to health care remains hindered by insecurity and the scarcity of health professionals, especially female and in remote areas. The extraordinary increase in access achieved since 2002 seems to have plateaued in recent years, as well as progress on a number of other key health indicators. As a consequence, health indicators continue to be near the bottom of international tables, with low life expectancy and high infant under-five and maternal mortality, as well as a high prevalence of chronic malnutrition, micronutrient deficiency and other diseases.

In the course of 2014 and first part of 2015, necessary procedures for the expansion of SEHAT to the whole country took place. From 1st July 2015, provinces previously covered by USAID are expected to pass under the umbrella of SEHAT. The government still does not have the capacity to directly provide health services to the whole population, while NGOs can rely on years of experience, capillary access to provinces and acceptance by the communities, also thanks to their increasing "Afghanisation". For these reasons, contracting out to NGOs will remain, at least until 2018, the method of choice for delivery of health services, with the Ministry of Public Health providing direct services (contracting in) only in three provinces\(^2\), in addition to overall stewardship for the sector.

1.1.1 Public Policy Assessment and EU Policy Framework

Following his appointment in January 2015, the new Minister of Public Health spelled out the key priorities for his mandate: 1. expanding access to basic health services in rural and remote areas, especially in the fields of nutrition and maternal and child health; 2. reducing irregularities in the private market, with specific attention to the quality and availability of pharmaceutical drugs; 3. improving secondary and tertiary services (without diverting resources from the provision of primary health services); and 4. increasing engagement with

\(^2\) Under a system known as the Ministry of Public Health "Strengthening Mechanisms" (SM), also funded through SEHAT.
the private sector. The renewed attention towards these critical areas has been welcomed by development partners. These priorities do not represent a significant departure from past policies and are in line with those identified in the Multiannual Indicative Programme 2014-2020 and in the Annual Action Programme 2014. The Health National Priority Programme “Health for all Afghans”, the Health and Nutrition Sector Strategy (HNSS) and the National Health and Nutrition Policy 2012 – 2020 remain reference documents for the sector, as well as the Strategic Plan for the Ministry of Public Health 2011 – 2015. The long established Basic Package of Health Services (BPHS, as updated in 2010) and Essential Package of Health Services (EPHS, 2005) will continue to be the main tools to ensure standard and harmonised delivery of basic health services to the population throughout the country.

A new Strategic Plan for the Ministry of Public Health (2016 – 2020) is under preparation and will be based on the findings of an EU funded Joint Health Sector Review (JHSR)\(^3\). Preliminary data from the JHSR and the findings of the SEHAT Health Sector Implementation Support Mission fielded by the WB in March 2015 highlight a number of significant gaps in the Afghan health system, but also suggest a way forward to address them. Active engagement from the Ministry in the JHSR and the SEHAT Mission suggests a high level of commitment from the new administration and a credible intention to sustain past gains and push further ahead with the positive progress made to date.

This Action is consistent with the Multiannual Indicative Programme 2014-2020 and in line with the EU policies and strategies, prominently the Agenda for Change. The Action is also in line with EU’s international commitments, including the Global Partnership for Effective Development Cooperation and the achievement of the Millennium Development Goals. In line with EU’s commitments under TMAF, the action is on budget and fully aligned with the Government's strategic priorities and plans.

1.1.2 Stakeholder analysis

The final beneficiary of the Action is the Afghan population, who will benefit from the continued provision of BPHS and EPHS (Result 1) and indirectly from a more efficient and effective public health system (Results 2 and 3). The nature of the packages will in fact benefit the most those groups that are more vulnerable, e.g. women and children, the economically disadvantaged, those at risk of contracting HIV/AIDS and nomadic populations.

The Ministry of Public Health is both a stakeholder (Results 1) and a beneficiary of the Action (Results 2 and 3). It is a key actor in programme oversight, management and implementation. As the steward and policy maker of the health sector, its relevance spans well beyond the limits of the Action. The Ministry also effectively leads coordination with Development Partners. Policy dialogue is well developed and the EU and other key partners are constantly involved in the process of policy making, on a biweekly to monthly basis.

The WB, as administrator of the Afghan Reconstruction Trust Fund, under which SEHAT takes place, also plays a pivotal role, not the least due to its long experience in the Afghan health sector.

\(^3\) Under finalisation, should be available in May-June 2015
USAID has officially joined SEHAT with a foreseen amount of USD 248 000 000 (ca. EUR 228 670 000\(^4\)), making SEHAT a truly nation-wide programme. High levels of coordination exist between the WB, USAID and the EU.

NGOs delivering services are key stakeholders with a fundamental role in the success of the programme, as they ensure access to the population despite the security situation in the country. Following SEHAT competitive procurement process, both well-established international NGOs and local NGOs have been awarded contracts. Levels of performance are expected to vary and monitoring is in place to ensure quality services are delivered and unforeseen issues tackled proactively. Contracts with implementing NGOs are performance based, with 20% of payments based on results assessed by a third party monitoring agent.

National and international NGOs were involved in the design and update of the BPHS and EPHS and are regularly consulted during the yearly SEHAT Health Sector Implementation Support Mission. The EU is part of all the relevant fora steering the health sector and SEHAT.

Other key stakeholders include development partners (France, Canada, WHO, UNICEF, UNFPA) which, while not directly funding SEHAT, provide funds and expertise for health interventions and are actively involved in coordination fora. Such fora are a critical asset to ensure coherence of activities within the sector.

1.1.3 **Priority areas for support/problem analysis**

The National Risk and Vulnerability Assessment 2011-2012 (NRVA 2011-12) estimates at 88% the percentage of the rural population with access to health services, defined as living within two hours walk from a Health Post\(^5\). This goes down to 82.7% if public clinics, rather than Health Posts, are considered. The same survey found that only 52% of public clinics below the District Hospital level have female doctors: given the country cultural context, this significantly hampers the access of women to health care. The cost of transportation and the need to travel further limits access of vulnerable groups to services.

Expanding coverage has been identified as a key priority in national policies as well as by the new Minister and is a shared concern among development partners. At the request of the new Minister, the WB has recently identified factors limiting access as related to: a. service delivery (opening time of facilities, insufficient targeting of men, availability of information, quality of services), b. geographic conditions (remoteness, insecurity), c. socio-cultural barriers (awareness of health issues, health seeking behaviour), and d. programmatic issues (underperforming of some key health programmes). Potential interventions to address these constrains are currently under discussion.

Recent data provided by the Ministry of Public Health\(^6\) indicates that a number of key health indicators appear to be stagnating around 2013 levels. For example, First Ante Natal Care Visits have remained between 60 and 65% in the period January 2013 – December 2014, while in the same period Skilled Birth Attendance and PENTA3 vaccination have only marginally improved. Political instability and the deteriorating security situation, but also

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\(^4\) InforEuro exchange rate of April 2015 (1.0845)
\(^5\) Health posts are manned by community health workers, i.e. volunteers from the community that have received basic health training.
\(^6\) Data are from the Health Information and Management System of the Ministry, as presented in the *Joint Health Sector Review* draft (April 2015) and in the *Afghanistan: Health Sector Implementation Support Mission – Aid Memoire* draft (April 2015)
weak oversight of the Ministry over NGOs' performance, were identified as possible explanations.

Additional recognised critical areas in the sector include (i) child and maternal malnutrition, (ii) training and retention of professional health staff (especially female), (iii) weak referral system, (iv) rationalisation of health facilities, (v) regulation of the pharmaceutical sector, (vi) quality of secondary and tertiary care (including care for disabled and mentally ill), the still (vii) high prevalence of communicable diseases and the emerging burden of (viii) non-communicable diseases.

Some of these issues are addressed by the ten key thematic areas under Component 2 of SEHAT (e.g. regulation of pharmaceuticals sector, improving hospital performances and promoting behavioural change) but delays in the implementation of this Component have so far impeded progress.

During the recent WB Mission, the Ministry and development partners agreed on the central role of SEHAT in delivering health services to the population and in strengthening the system, but also recognised current limitations and agreed on corrective actions. These actions will be in addition to a review of BPHS/EPHS (foreseen for 2016) and to key off budget complementary interventions (cf. Section 3.2 of this AD).

2 RISKS AND ASSUMPTIONS

<table>
<thead>
<tr>
<th>Risks</th>
<th>Risk level (H/M/L)</th>
<th>Mitigating measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased insecurity further limits access to specific areas.</td>
<td>H</td>
<td>A crosscutting risk to all sectors. Delivery by NGOs (rather than government) ensures greater access to areas registering presence of Anti-Government elements. Increased use/empowerment of Community Health Workers or private sector under discussion.</td>
</tr>
<tr>
<td>Underbidding during procurement process impedes proper quality service delivery by NGOs.</td>
<td>H</td>
<td>Efforts ongoing to increase the capacity of implementing NGOs' staff, e.g. specific nutrition training for NGOs health staff. A third party monitoring agent has been hired to closely monitor performance. Performance based payment system in place for NGOs' contracts.</td>
</tr>
<tr>
<td>Disruption of service delivery in &quot;new&quot; provinces due to transition from USAID funding to SEHAT.</td>
<td>M</td>
<td>The WB, USAID and EU follow closely the procurement process and provided TA to ensure timely completion. The Ministry is committed to ensure timeliness.</td>
</tr>
</tbody>
</table>

7 DRAFT: Afghanistan: Health Sector Implementation Support Mission – Aid Memoire, World Bank, April 2015
Weak capacity of the Ministry to present viable proposals for all ten thematic areas of SEHAT undermines progress in system strengthening.

Corruption, fraud or mismanagement cases may cause disruption to service provision.

| M | Director Generals of Ministry of Public Health identified as focal point for each key area. New priorities and timeline agreed. New Minister made aware and committed. Additional WB support to be provided. |
| L | Fiduciary oversight of the WB; complaints mechanism in place; PFM programme ongoing; WB only reimburses certified expenditure. |

**Assumptions**

- Funds availability until end of programme in 2018, as per WB, USAID and EU pledges.
- Development partners and Ministry of Public Health agree on measures to increase access and quality of services and adjust SEHAT accordingly.
- SEHAT interim arrangements and timely implementation of the Capacity Building for Results Facility allow retention of key staffs by the Ministry after end of off budget TA programmes.

### 3 Lessons learnt, Complementarity and Cross-Cutting Issues

#### 3.1 Lessons learnt

SEHAT has been confirmed as the key health programme in Afghanistan and is increasingly mentioned as a good practice in other development areas, especially with reference to ownership and government-led donor coordination. However, as the programme advances in its implementation, a number of key limitations have also become evident.

The Ministry has yet to finalise proposals for activities under Component 2 of SEHAT. Strong leadership from the top of the Ministry of Public Health is necessary to ensure coherence of the proposals and a programmatic approach, rather than a project like approach by different departments along thematic areas. It is expected that the new leadership, which renewed the Ministry's commitment to successfully and promptly finalise this process, will be able to ensure the required quality and coherence of the proposals.

The capacity of the Ministry to procure and manage contracts with NGOs has shown improvements, particularly in terms of respecting the timelines for contracting and for payment of tranches to NGOs. The presence of international TA, while ensuring capacity building, was appreciated by the Ministry staff as a way to guarantee a more transparent process.

The design of the rules governing the procurement process needs to be revised to account for bidder's past performance and to mitigate attempts to undermine the integrity of the competitive process through bids below-cost.

The quality of drugs in the local markets is substandard and international markets are often times beyond reach particularly for some smaller NGOs. Discussions are ongoing to address this situation and agreement is slowly converging on a hybrid arrangement including a centralised system for drugs to be procured internationally and decentralised (by NGOs) procurement for drugs that are available with the necessary quality in the local market.
Delivery of nutrition services needs strengthening. To this end, the SEHAT document will be amended to include additional nutritional related activities (to be funded by the EU under the AAP 2014).

Difficulties to hire and retain qualified health professionals for remote areas continue to be a limiting factor. The EU has experimented through some off budget initiatives (e.g. training of psychosocial counsellors) community based recruitment systems, which aim at identifying potential candidates for long term training within the district where they will eventually work. This has brought positive results to date and needs to be explored further, potentially also in the context of SEHAT.

The use of Technical Assistance (TA) was discussed with the MoPH and the development partners during 2014 and the first part of 2015, especially since the nomination of the new Minister of Public Health. The WB, USAID and the EU have agreed to align as much as possible TA salaries to the nationally approved scales. The EU and WB are well advanced towards that goal and recently USAID has also started to converge. The issue was also raised in the May Health Development Partners Forum and partners were asked to align. The need to avoid substitution and reinforce capacity building activities has been recognised by all parties, foremost by the Ministry, although reality on the ground makes the use of long term TA still a necessity. The design of current EU TC in the sector has been recently reviewed together with the leadership of the Ministry of Public Health and changes agreed to increase its impact and ensure an effective phasing out.

3.2 Complementarity, synergy and donor coordination

This action continues ongoing EU support to SEHAT, started in 2013, and to basic health services, dating back to 2002. As mentioned, SEHAT also pools funds from the WB, USAID and the Government of Afghanistan.

The EU supports several complementary actions in the sector. These include:

- training of professionals in the fields of mental health and disability / rehabilitation to fill existing vacant BPHS/EPHS positions;\(^8\)

- improvement of service delivery in the area of nutrition, with extra support under the AAP 2014 aimed at reinforcing SEHAT: (i) in-service nutrition training to SEHAT implementing NGOs in nine provinces (UNICEF and INGOs will deliver the same training to the other provinces); (ii) support for curricula development through technical cooperation to the Kabul Medical University and the Ghazanfar Institute for Health Science, to ensure nutrition becomes part of the available health curricula in Afghanistan (iii) creation of an Innovation Fund under SEHAT; (iv) support to the South Asia Food and Nutrition Security Initiative, which enables stakeholder platforms with the purpose to operationalise cross-sectoral food and nutrition-related policies and investments.

- studies, including the JHSR but also research on nutrition gaps within BPHS, complementary feeding practices, mental health status of Afghan school students and factors associated with high incidence and frequent outbreak of measles. These studies

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\(^8\) The Ministry of Public Health estimates that around 220 new psychosocial counsellors are needed to fill existing positions, while around 775 physiotherapist will be needed in the country in the next 10 years.
will inform the future update of BPHS, EPHS and hence SEHAT and in general the sector policy making;

– production of health professional magazines, which continues to contribute to spread the latest health information and developments among health staff across the country;

– the “Technical Cooperation Program to the Ministry of Public Health”, which aims at strengthening the capacity of the Ministry to steer and manage the provision of preventive and curative health services and the development of the Afghan public health system. Starting in 2016, this will be replaced by a new project adopted under the AAP 2014. This, while ensuring continuity of EU support to institutional capacity building, will continue the phase out of traditional technical assistance provided by long-term consultants, by ensuring the respective functions (and capacities) are absorbed by the public administration and providing short term expertise in key areas, reducing the risk of substitution. EU Technical Cooperation (TC) is complemented by assistance provided by other donors, mainly the USAID and the World Bank, but also by UN agencies supporting long and short term consultants.

The ARTF’s Capacity Building for Results Facility (CBRF), to which EU is contributing ca EUR 40 million (2012 - 2015), aims at increasing government capacity to support improved service delivery and reduce reliance upon externally funded consultants. The programme has been underperforming and is currently under review, but it remains key to improve the managerial and governance functions of the Ministry and to help it retain its best staff. The current administration sees this programme as a top priority to ensure development of the Afghan public administration towards self-reliance.

Other major activities in the field of health and nutrition include USAID funded programmes in nutrition (off budget); DFATD funded Maternal and New Born Child Health programmes; ECHO works in support to mainstream emergency care and war surgery in health facilities and strengthens Emergency Preparedness and Response; GAVI Alliance support to immunisation and system strengthening; and Global Fund actions in HIV/AIDS, TB and malaria through the WHO and UNICEF.

Coordination mechanisms have remained stable in the last year. In the course of 2014, the EU and WHO have been nominated co-chairs of the Health Development Partners Coordination Forum, which meets monthly. In the humanitarian field the coordination is led by OCHA, while additional coordination takes place through the Health, Nutrition and Food Security Clusters. SEHAT donors (EU, USAID and WB) continue to meet regularly to ensure the coherence of supported actions outside SEHAT, alignment with the sector strategy and to share information on SEHAT implementation.

An Aid Coordination Unit chaired by the Minister of Public Health and three sub-committees chaired by the three Deputy Ministers complete the coordination system. The new Minister has announced modifications in the intra-ministerial, development partners and internal coordination mechanisms, but changes have yet to be implemented.

3.3 Cross-cutting issues

Travel restrictions and a lack of female staff severely hamper female access to health. 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. Significant improvement in the coverage of reproductive and child health services as well as a drop in maternal and child mortality since 2002 confirm the
relevance of the packages' design, which is geared towards serving the needs of women and children. Moreover, the recently conducted JHSR found that public facilities are the providers of choice for the health care of children.

The SEHAT programme includes a number of indicators focusing on services to women and children. In addition, during the latest WB's SEHAT Health Sector Implementation Support Mission, the EU specifically requested to include in all proposals under Component 2 of SEHAT gender sensitive and gender disaggregated indicators; this was endorsed by the Minister and other partners. Finally, the WB has recently added gender indicators in the overall ARTF monitoring framework. This gender focus is aligned with the Ministry of Public Health Gender Strategy 2012-2016.

In the assessment of the WB, activities under SEHAT (including minor civil works) are not expected to cause any significant negative environmental or social impact. The recent SEHAT mission of the WB "commended the MoH [Ministry of Public Health]'s efforts in terms of revising the HCWMP [Health Care Waste Management Plan]. A focal point has been also designated for health care waste management in the Environmental Health Department. BPHS/EPHS NGOs and MOH-SM [Strengthening Mechanism] are responsible for the proper implementation of waste management at health facility levels." A number of actions to ensure proper implementation and monitoring of the plan were also agreed during the Mission.

4 DESCRIPTION OF THE ACTION

4.1 Objectives/results

Overall Objective: to continue supporting the Government of Afghanistan towards the sustainable improvement of the health and nutritional status of the Afghan population.

Specific objective: in line with SEHAT project document, the Specific Objective of this Action is to expand the scope, quality and coverage of health services provided to the population, particularly to the economically disadvantaged, and to enhance the stewardship functions of the Ministry of Public Health.

Results of the Action follow closely the three components of SEHAT:

Result 1: the Afghan population maintains or gains access to the Basic Package of Health Services and the Essential Package of Health Services.

Result 2: the stewardship capacity of the Ministry of Public Health is increased and the national health system developed.

Result 3: the programme management capacity of the Ministry of Public Health is strengthened.

4.2 Main activities

Activity 1.1: procurement and management of contracts with implementing NGOs delivering the BPHS and EPHS.

Activity 1.2: support the government’s efforts delivering the BPHS and EPHS through contracting-in management services in designated provinces, the implementation of an urban

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9 DRAFT: Afghanistan: Health Sector Implementation Support Mission – Aid Memoire, World Bank, April 2015
version of the BPHS in Kabul (and possibly in other cities) and the delivery of BPHS to marginalised populations.

Activity 1.3: support to HIV/AIDS prevention services for targeted population sub-groups at elevated risk for HIV infection.

Activity 2.1: support the development of proposals for the strengthening of key health system areas, as identified by the SEHAT project document and subsequent amendments, and their implementation.\(^\text{10}\)

Activity 3.1: support and finance central and provincial management of the Ministry of Public Health to manage and implement the program effectively.

Activity 3.2: support and finance short term technical assistance in specific areas where immediate capacity development is required.

Activity 3.3: support minor civil works at the central Ministry of Public Health as well as some specific operation and maintenance costs.

4.3 Intervention logic

The choice to shift EU involvement in health from direct management to support to a nationwide, government owned and managed on-budget programme is coherent with EU commitments to aid effectiveness, with its commitments under TMAF and with the need to rationalise an oversized and fragmented portfolio of contracts. While the aid modality has changed, the substance of EU intervention (support to BPHS and EPHS) has not: the significant progress achieved in the sector since 2002, including the great reduction in maternal and child mortality,\(^\text{11}\) has confirmed its relevance, although adjustments are necessary to leverage what was achieved to date.

The three Components of SEHAT reflect three areas in which the EU has been historically present: health service delivery, technical assistance to the Ministry of Public Health for system strengthening and capacity building of the Ministry's staff. Weak public administration capacity led to delays in the implementation of Component 2 and made necessary the continuation of direct management of TC projects by the EU as well as other donors. However, the renewed impetus behind the implementation of that Component is a good step toward overcoming this situation.

Activities under Result 1 aim at assisting the Ministry in the procurement, management and monitoring of contracts with service providers. This will, in turn, allow the undisrupted continuation of service provision across the country (R1), assuming a further deterioration of the security situation does not preclude access to larger areas of the country and that NGOs are able to provide quality services notwithstanding some capacity and financial limitations.

Activities under Result 2 aim at supporting reform and capacity building interventions in key health system areas, with the objective of increasing the long term ability of the Ministry to

\(^\text{10}\) The Ministry of Public Health is in charge of developing a proposal for strengthening the health system for each of 10 key thematic areas. This activity has suffered delays and the WB and development partners are providing assistance to ensure the successful development of the proposals.

\(^\text{11}\) Infant Mortality Rate decreased from 165 to 48 deaths per 1,000 live births from 2002 to date (source: MICS 2002 and NRVA 2011/12); a comparable reduction has been witnessed in the mortality of children under five years of age. Maternal mortality decreased from an estimated 1,600 maternal deaths per 100,000 in 2002 to less than 350 in 2010 (source: Afghan Mortality Survey 2010).
manage a functioning health sector (R2). This will be possible under the assumption that development of the ten thematic proposals is successfully completed and implementation can start without further delays.

Finally, Result 3 aims at providing increased capacity and financing for the management of a programme, SEHAT, which due to its financial size and geographical coverage represent an unprecedented challenge for the Ministry.

A successful management of the programme (R3), combined with key reforms and capacity building (R2) and effective delivery of services (R1), is expected to expand the scope, quality and coverage of health services provided to the population, particularly to the economically disadvantaged, and to enhance the stewardship functions of the Ministry of Public Health (SO). This, in turn, shall ensure further gains can be achieved towards sustainably improving the health and nutrition status of the Afghan population (OO).

5 IMPLEMENTATION

5.1 Financing agreement

In order to implement this action, it is foreseen to conclude a financing agreement with the partner country, referred to in Article 184(2)(b) of Regulation (EU, Euratom) No 966/2012.

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.

Extensions of the implementation period may be agreed by the Commission’s authorising officer responsible by amending this decision and the relevant contracts and agreements; such amendments to this decision constitute technical amendments in the sense of point (i) of Article 2(3)(c) of Regulation (EU) No 236/2014.

5.3 Implementation modalities

5.3.1 Indirect management with an international organisation.

This action may be implemented in indirect management with the World Bank in accordance with Article 58(1)(c) of Regulation (EU, Euratom) No 966/2012. This implementation entails the activities described in section 4.2. 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 SEHAT is 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: launching calls for tenders and for proposals; defining eligibility, selection and award criteria; evaluating tenders and proposals; awarding grants, contracts and financial instruments; acting as contracting authority concluding and managing contracts, carrying out payments.

The entrusted international organisation is currently undergoing the ex-ante assessment in accordance with Article 61(1) of Regulation (EU, Euratom) No 966/2012. 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, subject to the following provisions.

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>Proposed Operational Structure</th>
<th>EU contribution (amount in EUR)</th>
<th>Indicative third party contribution, in currency identified</th>
</tr>
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<tbody>
<tr>
<td>5.3.1. – Indirect Management with the World Bank</td>
<td>43 000 000</td>
<td>206 900 000 EUR</td>
</tr>
<tr>
<td>5.8 – Evaluation</td>
<td>will be covered by another decision</td>
<td>N.A.</td>
</tr>
<tr>
<td>5.9 – Audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.10 – Communication and visibility</td>
<td>N.A.</td>
<td>N.A.</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>43 000 000</strong></td>
<td><strong>206 900 000 EUR</strong></td>
</tr>
</tbody>
</table>

5.6 Organisational set-up and responsibilities

The Ministry of Public Health has overall responsibility for project oversight and implementation, including procurement and contract management for NGO services, under the supervision and in line with the procurement rules of the WB. During the last SEHAT mission of the WB, it was agreed that in consideration of the size and new nation-wide scope of SEHAT, the Minister of Public Health will be the coordinator of the project (previously the Deputy Minister for Policy and Planning); he may delegate this function to another high level official.

The relevant General Director will take the lead of each of the ten thematic areas proposals under Component 2 of SEHAT, while actual health services will be delivered through contracted NGOs or through civil servants (for the three "contracted-in" provinces, aka "Strengthening Mechanism" provinces).

The Steering Committee created for the design of SEHAT was subsequently suppressed and steering of the programme took place through the Sub-Committee for Policy and Planning. It is expected that steering responsibilities will soon pass to the Coordination Group for Health
and Nutrition, a new decision making forum that will replace the Sub-Committee, will be chaired by the Minister and will include major development partners.

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

5.7 Performance monitoring and reporting

The day-to-day technical and financial monitoring of the implementation of this action 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 or ex-post evaluation will be carried out for this action or its components by the implementing partner.

It will be carried out for accountability and learning purposes at various levels (including for policy revision).

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.

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

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 without an amendment to the financing decision. The indicative logframe matrix will evolve during the lifetime of the action: new lines will be added for listing the activities as well as new columns for intermediary targets (milestones) when it is relevant and for reporting purpose on the achievement of results as measured by indicators.

<table>
<thead>
<tr>
<th>Overall objective: Impact</th>
<th>Intervention logic</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 objective: Impact</td>
<td>To continue supporting the Government of Afghanistan towards the sustainable improvement of the health and nutrition status of the Afghan population.</td>
<td>Score on the balanced scorecard examining quality of care in Sub-Centres, Basic Health Centres and Comprehensive Health Centres</td>
<td>61% (2011 BPHS BSC)</td>
<td>70%</td>
<td>Balance Scorecard, Health facility assessment by Third Party Monitoring Agent</td>
<td>Insecurity does not further limits access to remote areas</td>
</tr>
<tr>
<td>Specific objective(s): Outcome(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To expand the scope, quality and coverage of health services provided to the population, particularly to the poor, and to enhance the stewardship functions of the Ministry of Public Health.</td>
<td>Births attended by skilled health personnel (<em>) (**), PENTA3 coverage among children aged between 12 -23 months in lowest income quintile (</em>) (<strong>), Pregnant women receiving antenatal care during a visit to a health provider (*) (</strong>),</td>
<td>429.305 (HMIS 2012), 41.6% (SEHAT interim report dated 31/12/13), 723.614 (HMIS 2012)</td>
<td>+ 32%, +28%</td>
<td>Household Survey by Third party and Central Statistics Organization, Household Survey by Third party</td>
<td>Underbidding by some NGOs and transition from USAID to SEHAT in some provinces does not disrupt services</td>
</tr>
</tbody>
</table>

12 As this Action supports a single programme (SEHAT), this table reflects closely that Programme logframe. Indicators, Baselines, Targets and Sources of Verification are selected from the Revised SEHAT Results Framework and aligned with the Core Sector Indicators of the WB at global level.

13 Mark indicators aligned with the relevant programming document mark with '*' and indicators aligned to the EU Results Framework with '**'.

14 All targets refer to end of project (June 2018).
<table>
<thead>
<tr>
<th>Result 2</th>
<th>Number of national hospitals with full budgetary autonomy</th>
<th>0 (at SEHAT start)</th>
<th>15</th>
<th>SEHAT reports</th>
<th>Ministry of Public Health finalises and starts implementation of the Proposals for the 10 thematic areas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Proportion of budget from the Provincial Budgeting Initiative executed</td>
<td>0 (at SEHAT start)</td>
<td>70%</td>
<td>SEHAT reports</td>
<td></td>
</tr>
<tr>
<td>Result 3</td>
<td>Proportion of MOPH core development budget executed</td>
<td>54% (at SEHAT start)</td>
<td>75%</td>
<td>SEHAT reports</td>
<td>SEHAT and CBRF provide sufficient capacity building to replace ending off budget TA.</td>
</tr>
</tbody>
</table>