

**PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE**

Report No.: AB2004

| | |
|--|---|
| Project Name | Health system emergency reconstruction and development - Supplement |
| Region | SOUTH ASIA |
| Sector | Health (90%); Central government administration (10%) |
| Project ID | P098358 |
| Borrower(s) | GOVERNMENT OF AFGHANISTAN |
| Implementing Agency | Ministry of Public Health |
| Environment Category | <input type="checkbox"/> A <input checked="" type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> FI <input type="checkbox"/> TBD (to be determined) |
| Date PID Prepared | November 30, 2005 |
| Estimated Date of Appraisal Authorization | December 10, 2005 |
| Estimated Date of Board Approval | February 23, 2006 |

1. Key development issues and rationale for Bank involvement

Health Status. The health status of the approximately 25 million Afghans remains among the worst in the world. The under 5 mortality rate in 2003 was 257 per 1,000 live births, the 4th highest globally. Little improvements have been gained from 1990 when the rate was 260 per 1,000 live births (UNICEF, The State of the World Children 2005). Due to the high infant and under 5 mortality rates, life expectancy in Afghanistan is only 43 years. The maternal mortality ratio (MMR) is reported to be 1,600/100,000 live births and the total fertility rate is 6.8 children per woman. There are serious inequities in health outcomes with the MMR in Badakshan being 15 times higher than in Kabul. The nutritional status of women and children is also very poor. Thirty-nine percent of children 6-59 months of age are underweight. Chronic malnutrition (stunting) is present in 54% of children while acute malnutrition (wasting) appears to be less common (7%).

Burden of disease. Infectious diseases are responsible for the majority of morbidity and mortality in Afghanistan. Diarrhea, acute respiratory infections and vaccine preventable diseases account for 60% of deaths. Poliomyelitis is still present in the country with 4 cases reported in 2005: several national immunization campaigns are needed to avoid further spreading of the virus and to reach eradication. Measles remains one of the major contributors to child mortality and outbreaks of measles have been reported during 2005, especially in southern and eastern parts of the country. According to a 2005 survey 30% of all newborn deaths were due to neonatal tetanus in three provinces studied. Tuberculosis incidence is one of the highest in the world (333/100,000 population) and despite progress in DOTS coverage (up to 53% in 2003 from 12% in 2001) the case detection rate remains very low (18%). Recent studies have shown a 4% HIV prevalence rate among injecting drug users suggesting that the epidemic could rapidly escalate if adequate preventive measures (e.g. harm reduction) are not promptly implemented. Malaria is also an important contributor to the burden of disease and leishmaniasis is common. Although

official figures are not available, it is perceived that mental disorders, especially depression and post traumatic stress disorder are common in Afghanistan.

Gender Factors. The low status of women is having a significant impact on their own health and that of their families: (i) women's lack of mobility interferes with their ability to obtain health care services; (ii) lack of decision making power within the family can limit reproductive choices, thus resulting in short birth intervals and higher infant mortality; (iii) early marriage and pressures to have a large family contribute to maternal mortality; (iv) women spending more time in poorly ventilated areas inside the house may result in a higher risk of TB; (v) women's low status can mean that scarce family resources are not prioritized to women and girls thereby worsening their nutritional status. The gender roles assigned to men also affect health status of the population. For example, men are often unwilling to discuss their own reproductive health which can obviously influence that of their wives.

Performance of the Health Care System. Until the end of 2003 the coverage of health systems was very low and huge differences between rural and urban areas were present. Gains in measles immunization and Vitamin A had been remarkable but despite large changes due to campaigns, routine services had little improved until 2003. As a result of clear policies and leadership from the MOPH, there appears to have been an increase in service delivery since 2003. This has been demonstrated in initial studies and will hopefully be confirmed through upcoming household surveys.

Organization of Health Care System Since the beginning of 2004, the MOPH has been able to assert its stewardship through performance based partnership agreements (PPAs) and grants from other donors. Using these mechanisms, the Government has been able to ensure that: (i) all providers, including all NGOs, are implementing the BPHS and following the technical guidelines of the MOPH; (ii) all providers are clearly responsible and held accountable for defined geographical areas and populations; (iii) about 77% of the population now have access to services; (iv) quality of care is independently measured on a regular basis and results are widely available; (v) health activities are coordinated through provincial coordination committees and through the central MOPH; (vi) in most provinces NGOs are selected through a competitive and transparent process; (vii) all publicly-financed health facilities, whether operated by an NGO or not, are clearly marked as being provided by the Government; and (viii) the amount of resources going to NGOs is known to the MOPH (in the case of the PPAs, financial information from the NGOs is provided on a quarterly basis and audited financial reports are provided annually). The MOPH is also delivering services itself in three provinces near Kabul. The MOPH Strengthening Mechanism (MOPHS-SM) manages services with the technical assistance provided by local consultants. There is limited evidence currently available on the relative performance of NGOs and Government in delivering services in Afghanistan.

Rationale for Bank involvement. As the BPHS represents the most effective, efficient and equitable means of improving the health of Afghans, Bank involvement is needed to ensure it remains number one priority. By supporting the expansion of BPHS, the Bank will guarantee the provision of services to underserved populations in remote areas. Ensuring that the Afghan population gets access to basic services is both important and achievable at relatively low cost. Bank involvement is expected to further strengthen the stewardship role of the MOPH. This is

particularly relevant at a time of transition from post emergency to development: supporting the Afghan government in this phase will hopefully lead to more capable and efficient institutions in the future. Some of the proposed interventions (e.g. polio eradication activities) have an importance that extends beyond Afghanistan. Bank involvement in these areas will therefore benefit the wider global community.

2. Proposed objective(s)

The objectives are to: (i) assist the MOPH to achieve its stated goals of reducing the rates of infant and child mortality, maternal mortality, child malnutrition, and fertility through expanding delivery of the BPHS and increasing equity in the delivery of services; (ii) strengthen the Government by increasing MOPH's stewardship over the sector including a greater role in health care financing, coordination of partners, and overseeing the work of NGOs; and (iii) build the capacity of Afghan health workers to provide and manage health services.

3. Preliminary description

Extension and Expansion of the BPHS: The supplemental grant will finance the expansion of the PPA approach in which NGOs compete for contracts with the MOPH to deliver the BPHS. The eight new areas (clusters) that will be covered are not currently being served and contain about 1.15 million people in remote and sometimes insecure parts of the country (including Paktika and Paktiya). The new PPA areas have been selected by the MOPH in coordination with other partners (particularly USAID) and generally represent districts where no clinics have been established and where health services have rarely been provided. The clusters vary in size from 65,000 to 230,000 population and, except in one case, represent groups of districts, rather than whole provinces. The supplemental grant will also allow currently existing PPAs that cover 7 provinces to be continued for another 18 months as well as expand one PPA, in Badghis Province, to cover the whole province, instead of the current three out of seven districts. When the new PPAs are signed, almost five million people will be receiving the BPHS from PPA NGOs. The supplemental grant will support the continuation of the MOPH-SM in three provinces near Kabul with an estimated population of 1.1 million.

Polio Eradication and Measles/Neo-Natal Tetanus Control: The supplemental financing will provide \$6 million to support polio eradication efforts during 2006 and 2007. These will primarily be National Immunization Days (NIDs) which provide oral polio vaccine to all children under five years of age and Vitamin A to children 9 to 60 months. The supplemental grant will also provide \$2 million to support measles and neo-natal tetanus campaigns aimed at significantly reducing the threat to child survival that these diseases represent. The funding will be used to procure vaccine, needles, and syringes, through UNICEF, while operational costs are picked up by other partners.

Beginning to Strengthen Hospital Management: The supplemental grant will finance a series of annual hospital assessments to be carried out by a third party. These assessments will provide the MOPH with independent information about quality of care, utilization, equity, and availability of inputs in all district and provincial level hospitals in the country. By tracking hospital performance, the MOPH will be able to judge the effectiveness of ongoing efforts by the MOPH itself and USAID to strengthen hospital management and make course corrections. The

supplement will also finance the recruitment of an international hospital policy consultant to assist the MOPH over the next two years.

Enhancing Stewardship Functions, Including Capacity Building: The additional funding will support the training of approximately 200 new community mid-wives and about 1,000 new community health workers (CHWs). The MOPH will carry out a survey of central and provincial MOPH managerial staff that examines what they think they've learned in the last few years, what things they would like to learn, and what sorts of thing they likely need to learn in order to be effective managers. The results of the survey will guide future capacity building efforts. The supplemental grant will continue to 2008 existing monitoring and evaluation activities and the building of central and provincial government capacity.

4. Safeguard policies that might apply

The activities to be financed under the supplemental grant do not trigger any additional safeguard policies and no exceptions to Bank policies are required. The environmental policies implemented by the MOPH and the guidelines developed under the original project appear to be having real benefits. The third party assessment found proper disposal of sharps in 46% of health facilities studied in September, 2004. This increased to 76% of health facilities in May, 2005. The supplemental grant will contribute to maintain and further strengthen the waste disposal mechanisms and will support rigorous monitoring of waste disposal indicators.

5. Tentative financing

| | |
|--------------------|--------|
| Source: | (\$m.) |
| BORROWER/RECIPIENT | 0 |
| IDA Grant | 30 |
| Total | 30 |

6. Contact point

Contact: Benjamin P. Loevinsohn
Title: Lead Public Health Spec.
Tel: (202) 473-7948
Fax: (202) 522-2955
Email: bloevinsohn@worldbank.org