

ASIAN DEVELOPMENT BANK

JFPR: AFG 36628

PROPOSED GRANT ASSISTANCE
(Financed from the Japan Fund for Poverty Reduction)

TO THE

ISLAMIC TRANSITIONAL ADMINISTRATION OF AFGHANISTAN

FOR

PRIMARY HEALTH CARE PARTNERSHIP

FOR THE POOR

December 2002

CURRENCY EQUIVALENTS

(as of 1 December 2002)

Currency Unit	–	Afghani (Af)
Af1.00	=	\$0.020
\$1.00	=	Af50.6

ABBREVIATIONS

AACA	–	Afghan Assistance Coordination Authority
ADB	–	Asian Development Bank
CHW	–	community health worker
INGO	–	implementing NGO
JFPR	–	Japan Fund for Poverty Reduction
JSDF	–	Japan Social Development Fund
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
NDF	–	National Development Framework
NGO	–	nongovernment organization
PHC	–	primary health care
PIU	–	project implementation unit
UNICEF	–	United Nations Children Fund
USAID	–	United States Agency for International Development
WHO	–	World Health Organization

NOTES

- (i) The fiscal year of the Government ends on 21 March.
- (ii) In this report, "\$" refers to US dollars.

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I. INTRODUCTION

1. The Islamic Transitional Administration of Afghanistan (the Government) aims to expand primary health care (PHC) rapidly to all poor and underserved communities in the country as part of its post-war reconstruction and development effort.¹ The Government wants to develop partnership with nongovernment organizations (NGOs) in this major effort, and has requested the Asian Development Bank (ADB) for a pilot project for PHC partnership for the poor (the Project) with grant assistance of \$3 million from the Japan Fund for Poverty Reduction (JFPR).² The Project will explore how the Ministry of Health (MOH) can effectively contract NGOs to develop community-based PHC and reduce rural poverty. The Project is linked to the proposed Health Sector Emergency Reconstruction and Development Project of the World Bank in 2003, and ADB's proposed social sector program in 2003.³

2. An ADB and World Health Organization (WHO)⁴ mission visited Afghanistan from 18 to 26 June 2002 to appraise the Project, and met with MOH, the Afghan Assistance Coordination Authority (AACCA), the Ministry of Finance (MOF), NGOs, funding agencies, and local communities. MOH, the Mission and the WHO Country Office reached an accord on the objectives, scope, cost estimates, financing, and implementation arrangements of the proposed Project, as documented in the memorandum of understanding of 26 June 2002 endorsed by AACCA. The project framework is in Appendix 1.

II. BACKGROUND AND RATIONALE

A. General Situation

3. **The Economy.** Years of war, drought, and politics have eroded Afghanistan's economy, infrastructure, and social services. Food production, the livelihood of some 70% of Afghans, has reduced substantially. Depletion of family assets, including landholdings and literacy, causes food shortages, displacement, and social disintegration. A refugee and internally displaced population of about 4 million people are scattered throughout the country, without regular sources of income or social services. The per capita income has dropped from about \$400 in the 1970s to about \$160 per annum in 2002, and about 60–80% of people live below the threshold of \$1 per day.⁵

4. **The Public Sector.** The Government, based on fragile political alliances after years of conflict, faces major challenges in urgently needed humanitarian aid, carrying out reconstruction, and rebuilding the economy. Its Ordinary Budget of \$460 million for fiscal year 2003 is largely financed by external sources. Local revenue collection is held back from the central administration, and used at the discretion of governors and other local leaders, which

¹ Afghan Assistance Coordination Authority (AACCA). 2002. *Afghanistan National Development Framework*. Kabul.

² The Government of Japan established the JFPR to support ADB's Poverty Reduction Strategy adopted in 1999. JFPR projects have to meet six eligibility criteria: (i) direct targeting of poor people; (ii) sustainable poverty reduction impact; (iii) innovative pilot approach; (iv) not substituting other financing; (v) conceptual link to other investments; and (vi) implementation (and fund flow) arrangements through NGOs or community structures, with the Government as the executing agency to coordinate the policy conclusions and facilitate the work of the implementing agencies.

³ ADB. 2002. *Afghanistan Interim Country Strategy and Program*. Manila.

⁴ The Mission comprised V. de Wit, Sr. Health Specialist, South Asia Department, ADB; and S. Siddiqi, Regional Adviser, Health Policy and Planning, Eastern Mediterranean Regional Office, the World Health Organization.

⁵ The per capita income is an estimate. It does not fully capture the informal sector and excludes illegal transactions.

impedes the building of a strong center and a new administration for Afghanistan. In January 2002, at the international Afghanistan conference in Tokyo, external agencies committed almost \$5 billion in aid. However, only about half of the commitments have materialized so far. Slow compliance with funding commitments is compounded because the capacity of public institutions has been seriously eroded and is now difficult to revive. The Government is therefore facing an enormous challenge to mobilize human and financial resources, while at the time wanting to use the opportunity to replace the outdated model of public services of the 1970s. The Government has bravely taken up this challenge as reflected in the objectives of the National Development Framework, focusing on (i) security and human development for poverty reduction; (ii) rebuilding of physical infrastructure; and (iii) creation of a viable private sector for sustainable, pro-poor growth. The AACA plans to establish planning and implementation cells in all major line ministries, including MOH, to strengthen the capacity of these ministries.

B. Key Issues in the Health Sector

5. **Health and Nutrition Status.** Afghanistan's population of about 25 million people has the worst health status of any country in Asia. About half of the children under 5 years of age are malnourished and starvation occurs throughout the country, necessitating a major operation of the World Food Program. Malnutrition is seriously aggravated by common illnesses due to poor hygienic conditions, lack of education, and poor health care. The infant mortality rate is about 150 per 1,000 live births, among the highest in the world. Child mortality, about 220 per 1,000 live births overall, may reach twice this level in the worst affected areas.⁶ The overall maternal mortality ratio has remained among the highest in the world, as reported by a recent United Nations Children Fund (UNICEF) survey.⁷ The total fertility rate has been reported at 7 to 8 children per woman, but could be much higher as contraception is uncommon and pregnancies resulting in infant death are often not reported. Human tragedy of this scale seriously undermines the determination and resources of families to rebuild their lives, and all possible efforts should be made to improve survival and health.

6. **Vulnerable Groups.** Among the poor, women and girls are more vulnerable. Women bear the highest burden of poverty due to their low social status and limited access to services. Girls come second to boys. Children below the age of five are especially at risk in case of lack of health care, safe water and food security. Many of the returnees and internally displaced persons have lost their assets and need help to rebuild their lives. Large numbers of demobilized combatants have joined others in search of employment. Many war widows and orphans need special assistance. Many adults and children suffer from post-traumatic stress disorder, addictions and mine-related handicaps. While formal social security systems are largely absent, traditional support systems of extended families and communities have also been disrupted, even within households.

7. **PHC Coverage.** During the war, the public health system constricted and became more hospital focused. Many hospitals and health centers were destroyed, damaged, or abandoned. The international community sponsored NGOs to manage and support hospitals and health centers. About 80 NGOs, both international and local, are currently working in the health sector in Afghanistan; most of them operate a few clinics or provide specific support. Only about one

⁶ An ongoing survey by the United Nations Children Fund (UNICEF) is expected to provide better estimates by December 2003.

⁷ A recent UNICEF survey of the maternal mortality ratio in 4 provinces in Afghanistan shows considerable geographical variation, from about 400 maternal deaths per 100,000 live births in Kabul, to as high as 4,000 maternal deaths per 100,000 live births in Badakhshan. Given high fertility rates, this implies that about one third of women in Badakhshan are dying from maternal complications.

third of the population has access to PHC. However, most of the health centers do not provide a comprehensive package of basic health care. Centers often need improvement in nutrition care, safe motherhood, tuberculosis, and management and monitoring. United Nations agencies have set up special programs to improve coverage for priority interventions. Routine immunization reaches about 40% of eligible children. The coverage of safe motherhood and family planning services is much lower, but will hopefully improve with the recent increase in external assistance in this field. In addition, private shops, traditional healers, birth attendants, and other practitioners provide relief. Other sectors affecting health are also underdeveloped: only half the villages have access to safe water supply, and only one third of girls are attending school.

8. Isolated Communities. PHC in Afghanistan, whether provided by the Government or NGOs, is largely limited to towns and trading centers. Beyond these places, there are few formal services. However, the rural population often lives in scattered hamlets, while some are nomads. The hard-to-reach and displaced populations are likely to have the highest mortality and morbidity. Special approaches are required to reach them. NGOs have tried training of community members with generally positive results. MOH wants to explore this as a strategy for reaching poor households and improving access to basic health services.

9. Health Sector Financing. Public spending on health is well below any international standard. This has several important dimensions. First, priority is given to financing hospital services, and public funding for PHC is very low. While external funding agencies and NGOs could have focused on PHC, a large part of their support is also for hospitals. Second, NGO funding for PHC is imbalanced. Many NGOs focus on their own priorities, supporting only some types of services spread out over many clinics, thereby making services less efficient. Third, the performance of public health staff is affected by very low and irregular salaries and the time spent generating income from other sources. Fourth, there is a serious shortage of medicines, including in NGO-supported clinics. People are referred to drug shops, which commonly overcharge. Communities need better access to basic, low cost drugs.

10. Staff Imbalances. At its peak, the public health sector employed about 25,000 people. Some of those who left the country or moved to private business have requested reemployment. The Government has given priority to rehiring female doctors and other staff. As salaries are low, it is difficult for staff to live in rural areas where there are no income generating opportunities. Many staff receive support from governors and NGOs, or work as private practitioners, all of which affect the distribution of staff. About 40% of doctors and 50% of nurses work in Kabul, which has half of all hospital beds. Such imbalances need to be addressed.

11. Management Constraints. Years of conflict have undermined the capacity of MOH to develop policies, rebuild and manage the public health system, and regulate the private sector. MOH is in the process of participatory planning with the provincial health offices, developing a strategic framework for the sector, improving program and NGO coordination, and building the capacity of core ministerial functions. It wants to improve central control, while at the same time decentralizing health administration. MOH and the provincial health offices have inherited the 1970s approach of hospital-based services and have had limited exposure to PHC. PHC management capacity is very limited. The general administrative capacity of MOH and the provincial health offices is weak, in particular in the areas of communication, personnel and financial administration, and monitoring.

C. Strategic Priorities

12. National Development Framework. Afghanistan's National Development Framework (NDF) has five principles that set the stage for foreign assistance: (i) development must be domestically owned, (ii) markets and the private sector are more effective in delivering sustained growth, (iii) aid can only be effective if combined with investment in human capital and an institutional framework, (iv) sustainable growth requires active participation of the population, and (v) externally-funded investments must be part of the Government's development program.

13. Health Priorities. According to the NDF, the immediate needs in the health sector are to provide Afghans access to essential health services and to rehabilitate infrastructure to provide work and food. An important goal is to reduce infant and child mortality in the next 2 years. The Government aims to provide all citizens with access to a package of basic health services comprising well-understood and cost-effective interventions. The basic package includes cost-effective interventions such as health and nutrition education, control of common infectious diseases, immunization, basic safe motherhood and birth spacing interventions, and treatment of minor ailments and injuries. The total cost of such a package would be about \$3 per capita per year but may be higher if very poor and remote populations are to be reached.⁸ Additional services for safe motherhood, control of tuberculosis and leishmaniasis, and mental health disorders including post-traumatic stress disorder would cost more.

14. Financing PHC. As the majority of the population is poor, MOH has a major financing role in providing basic health services. The cost of providing a basic package of health services is at least \$75 million per year. The MOH budget of about \$30 million this year is expected to increase substantially next year but will mainly be used to finance hospital staff. NGOs contribute an estimated \$25 million to basic services annually, possibly increasing to about \$40 million with support of major assistance in 2003. Hence, there is a financing gap of \$30 million to provide the most basic package of services and not including the cost of reconstruction.

15. Providing PHC. In the 1970s, MOH played a major role in delivering health services. The system was focused on hospital services and faced problems of quality and inefficiency. Since then, MOH has lost much of its capacity to deliver PHC, and is not in a position to quickly build up publicly provided PHC. On the other hand, NGOs have demonstrated their ability to provide basic health services for about \$3 per person per year. During the comprehensive needs assessment, major funding agencies recommended that MOH contract NGOs to deliver basic health services in line with NDF principles. MOH likes the concept but wants to see the feasibility and cost implications of such a partnership, and wants to explore this before large-scale implementation. It envisages this approach in underserved areas, while preferring the contracting of NGO management in areas where public and private services already exist.

16. Coordination and Regulation. MOH gives high priority to improving the coordination of health care providers. Coordination and regulation is required to ensure better distribution of resources and establish a system of accreditation and quality control. The Government wants to start with NGOs, and further extend this to private providers, drug shops and traditional healers.

17. Health System Reform. The public health system reflects a mixture of highly centralized planning and semi-autonomous services. It is in fact remarkable how well many hospitals are functioning given the circumstances. The current focus is on quickly restoring services rather than reforms. However, the health sector will need substantial reforms in organization, system

⁸ Based on NGOs data, collected and analyzed by Management Sciences for Health in 2002.

design, human resource balances, financing, management, and quality control toward a system that ensures the most benefits at affordable costs. MOH is ill prepared for the challenging task of phasing and balancing a mix of competing short- and long- term priorities that have emerged after the war. For example, it needs to balance investment in hospital services and primary care, and quality and access. MOH is under pressure to reemploy thousands of health staff while lacking the funds to pay adequate salaries and make good use of staff resources. Such efforts need considerable capacity in system analysis, participatory processes, and strategic planning.

18. ADB's Strategy and Program. ADB's poverty reduction strategy gives high priority to the health sector and supports the Millennium Goals.⁹ ADB's health policy for the health sector strongly promotes partnership and support for public goods and services for the poor.¹⁰ ADB's initial country strategy and program recommends health investments as a key area of ADB's operation to achieve the strategic medium-term development goal of reducing poverty in Afghanistan through pro-poor growth, inclusive social development, and good governance for poverty reduction. The program proposes social sector support of \$50 million in 2003. In line with the pilot project, the health sector share should target poor populations that have the worst health indicators in Asia and do not have access to even the most basic health care.

D. Capacity and Partnership

19. Capacity Building. MOH gives high priority to capacity building in all areas. Current efforts focus on the general capacity of MOH staff linked with strategic planning and studies for policy development, programming, and funding coordination. A team of consultants placed in a coordinating body, currently known as the program secretariat, is helping MOH. The United States Agency for International Development (USAID) and WHO are helping MOH to strengthen its planning and management capacity.¹¹ WHO has been strengthening provincial and district level management and monitoring. ADB will help improve the capacity of the administrative and construction departments in MOH, build capacity for contracting NGOs, and develop policy for post-traumatic stress disorder.¹² The World Bank will provide further support to strengthen the provinces in contracting NGOs with support of the Japan Social Development Fund (JSDF). Other priority areas that urgently require support for capacity building are health sector financing, human resource development, quality control, and NGO and private sector regulation.

20. Partnership. NGOs have a wealth of experience. Many provide quality services and some have developed low cost comprehensive health systems. Some NGOs provide a mentoring function for smaller NGOs. At the same time, NGOs have had their own limitations in terms of selectivity, fragmentation, and efficiency. MOH wants to explore partnership with NGOs to improve and expand services. It wants to examine the interest of NGOs in working with MOH, their conditions and constraints, and contracting and monitoring arrangements. Such partnership will require capacity building of MOH and NGOs, with special attention of local NGOs. ADB's TA for capacity building of MOH¹² includes support for the partnership approach.

21. In view of the local realities, MOH is keen to explore models of sustainable community-based health care for the rural poor in partnership with NGOs. The proposed JFPR-financed Project will provide critical experience in contracting NGOs, the potential of NGOs in supporting

⁹ Half of the Millennium Goals directly concern the health, nutrition, and population sector.

¹⁰ ADB. 1999. *Policy for the Health Sector*. Manila.

¹¹ USAID is considering support for private health sector regulation and capacity building.

¹² ADB. 2002. *Multi-sector Cluster Technical Assistance to Afghanistan for Capacity Building for the Reconstruction and Development*. Manila. The TA of 14.5 million includes capacity building of MOH for \$1.2 million.

community-based health care, and the capacity of communities in health care development. Such experience is particularly important for upcoming projects that propose to use the partnership approach. The Project will also test other aspects, such as the potential of community health workers (CHWs), and the viability of a drug supply system and revolving fund to provide medicines and sustain workers. Above all, it will examine such a partnership can make to the reducing rural poverty through improved health and related productivity gains.

III. THE PROPOSED JFPR PROJECT

A. Objectives

22. The Government, in collaboration with aid agencies, has identified three national health and nutrition sector priorities: infectious diseases control, infant and child care, and maternal health care. The proposed JFPR Project aims to reduce poverty by improving health, nutrition, and reproductive health of the rural poor. The overall objectives of the Project are to

- (i) reduce the child mortality rate by 30%, the prevalence of common infectious diseases and malnutrition in children, the maternal mortality ratio, and the birth rate in the targeted communities over a period of 3 years;¹³ and
- (ii) demonstrate the potential of partnership of MOH, NGOs, and communities in developing sustainable community-based health care, targeting 10 high priority districts currently lacking services, for possible replication nationwide.

23. The specific objectives of the Project are to

- (ii) improve access to specific cost-effective health, nutrition, and birth spacing interventions through health centers and CHWs;
- (iii) provide quality care at less cost by training health staff and CHWs, providing equipment, and developing a drug supply system;
- (iv) improve water supply and sanitation through the provision and repair of water pumps and latrines, including for schools;
- (v) promote healthy life styles and timely referral, through health, nutrition, and birth spacing education, by providing access to radio education programs for women and by training local leaders, CHWs, and health staff;
- (vi) strengthen local leadership in community development activities for health, with linkages to other sectors such as education and agriculture; and
- (vii) build the capacity of MOH, NGOs, and communities in sustainable partnership.

24. Apart from health benefits, the Project will reduce medical expenses and travel cost for the poor, reduce loss of work time, and improve productivity and income linked to good health. The Project will generate local employment and skills in the form of contract labor for construction and CHWs. The Project will target a catchment population of 500,000 people, about 80% of them being poor. Based on the Government's list of priority areas, displaced populations,

¹³ Targets will be specified after baseline surveys. Measurement of maternal mortality may require a census.

access to health services and ongoing and planned donor assistance, 10 districts have been prioritized in 5 provinces (Badakhshan, Bamyán, Kapisa, Samangan and Uruzgan).

B. Scope

25. Components. The Project will test a comprehensive approach to develop community-based PHC that benefits the poor and vulnerable most. It includes five components: (i) community organization and support through NGOs, in particular addressing the needs of the poor and vulnerable; (ii) health center development to provide health services and local labor that benefits the poor most; (iii) a CHWs program, which will also provide employment for the poor; (iv) testing of a drug supply system to make medicines more affordable for the poor; and (v) development of the capacity of MOH and NGOs in the partnership approach and project management.

26. Coverage and Phasing. Afghanistan has about 31,400 major villages with on average 650 people (about 100 villages per district). The population density in rural areas is low (about 25 persons per square kilometer): people live along water sources in scattered hamlets. Roads and transportation are often poor. This makes it difficult to post staff to rural areas and efficiently operate health facilities. The Project will set up community-managed health centers for clusters of villages in districts accessible for substantial populations but lacking services. The Project will cover 10 districts from among 50 prioritized districts in Afghanistan (Appendix 2). Priority has been given to (i) poor districts lacking services; and (ii) district with large numbers of excombatants, returnees, and internally displaced persons. The Project will start in early 2003 and will be implemented over a period of 42 months.¹⁴

27. Component 1: Community Organization and Support through NGOs. NGOs will be contracted to support communities. This will involve two modalities. The first modality is contracting out, whereby MOH contracts an NGO to provide health services to the district population, incorporating services provided by MOH and other NGOs. The second modality is contracting in, whereby MOH provides health services to the district population, and contracts an NGO to help manage these services. Contracting in will most likely be used in Kapisa and Samangan provinces, while contracting out will likely be used elsewhere. Local leaders will be provided orientation to health care and supported to assume greater responsibility in health care development. The NGO will help improve health services, provide training and support for CHW training, conduct an education program for women through listening groups using radio, help set up a drug supply and revolving drug fund system, and provide technical inputs and training for infrastructure development and health services and referral. Progress will be monitored through before and after surveys by an independent agency.

28. Component 2: Health Center Development. The Project will support the development of community organizations to construct, upgrade, or repair small health centers, as well as water supply and toilets (including for nearby schools) and manage and maintain these. Construction will provide contract employment for local laborers. As demonstrated by NGOs, communities could contribute up to 30% of the development cost in the form of land, material, labor, and inputs from local leaders. The Project, through contracted NGOs, will also support improving the quality of services at the health center through standardization of procedures, in-service training, and provision of equipment and supplies.

¹⁴ The Project will be followed by further externally funded assistance for the targeted districts.

29. **Component 3: Community Health Workers Program.** Women in rural communities have limited labor opportunities, while the need for basic health care and education are high. The Project will explore the role of CHWs in PHC in places that do not have access to larger health services. Preferably female CHWs, and male counterparts where necessary, will be trained to provide and promote basic health, nutrition, and birth spacing interventions such as for immunization, micronutrient supplementation, and treatment of common infections (diarrhea, pneumonia, malaria, and tuberculosis). A major challenge is to find suitable female candidates, who may be traditional birth attendants or other women acceptable to communities in the cluster. The CHW will receive a stipend for training. The CHW is expected to receive a contribution from the community in cash or in kind.

30. **Component 4: Drug Supply System.** The community will be assisted to improve the availability, quality, and affordability of essential drugs through qualified prescribers (health staff and CHWs). A kit supply system will be piloted with support of the central medical warehouse and a pharmaceutical NGO contracted through the ADB cluster technical assistance for capacity building.¹² NGOs in Afghanistan have achieved cost recovery up to about 50%. A procurement and supply system will be designed to reduce the cost of essential drugs. The drugs will be sold with a small mark-up to cover the partial cost of resupply and will be supplied free for the very poor. A mark-up may also be considered to provide an incentive for CHWs.

31. **Component 5: Project Management and Coordination.** The Project will support a project implementation unit (PIU) in MOH for planning, coordinating, and monitoring project activities. The PIU will be supported by an NGO trustee to develop contracting procedures and administration, and PIU capacity for selecting, contracting, managing, and monitoring NGOs. Independent agencies will be contracted to carry out before and after surveys and yearly audits. Workshops will be conducted to share lessons learned for further ADB and World Bank projects. Project experience will be shared through regular monitoring and reporting, a bulletin and web site, and suitable volunteers.

C. Cost and Financing

32. The total cost of the proposed project is estimated at \$3.6 million, of which JFPR will finance \$3.0 million equivalent (83.3%) on a grant basis. The Government will contribute about \$179,400 equivalent (5.0%) in kind, with staff, office space and utilities. ADB and other agencies will contribute about \$70,500 equivalent (2.0%) in kind, for project management and capacity building. NGOs will contribute about \$54,000 equivalent (1.5%) in kind, with staff, office space, and utilities. Communities will contribute in terms of community leadership, services and health center development and management, estimated at \$296,000 equivalent (8.2%). Table 1 summarizes the cost estimates of components and the financing plan. Appendix 3 gives an input-outcome based cost structure. The detailed cost estimates are in Supplementary Appendix 1.

TABLE 1: COST ESTIMATES AND FINANCING SUMMARY
(\$'000)

Components	Agencies	Total	JFPR	JFPR (%)	MOH	NGO	Communities	Other Agencies
1. Community Organization and Support		820	693	23%	0	54	72	0
2. Health Center Development		798	670	22%	36	0	92	0
3. Community Health Workers Program		576	542	18%	0	0	34	0
4. Drug Revolving Fund		514	404	14%	12	0	98	0
5. Project Management and Coordination		673	471	16%	131	0	0	71
Subtotal		3,380	2,780		179	54	296	71
Contingencies		220	220	7%	-	-	-	-
Total		3,600	3,000	100%	179	54	296	71
Percent		100%	83%		5%	2%	8%	2%

JFPR = Japan Fund for Poverty Reduction, MOH = Ministry of Health, NGO = nongovernment organization

D. Implementation Arrangements

33. **Execution.** The Project will be implemented under the overall guidance of the Afghan Assistance Coordination Authority (AACA) and the Ministry of Finance (MOF). MOH is primarily responsible for the health sector and needs to build its capacity accordingly. Hence, MOH will be the Executing Agency for the TA. MOH will ensure participation of the concerned provincial health offices and district health staff in planning and implementing the Project, so as to build know-how and provincial and district capacity for expansion of partnership activities.

34. **Steering Committee.** MOH will nominate a steering committee for the Project, which will be cochaired by the deputy ministers of health, and will have representation of AACA, ADB, the Government of Japan, MOF, MOH, and WHO. The steering committee will review project implementation on a quarterly basis and provide guidance on key issues such as the contracting arrangements for NGOs. The proposed project organization is summarized in Appendix 4.

35. **Project Implementation Unit.** The PIU will be established under the deputy minister (technical), in the department responsible for contracting NGOs to provide PHC. The PIU will have a project director and two assistants (technical and finance), seconded from MOH or contracted for this purpose. The PIU will directly coordinate its work with all concerned departments in MOH, the provincial and district offices concerned, the program secretariat, and sponsoring agencies.

36. **NGO Trustee.** Due to current capacity constraints, the PIU will be assisted by an NGO trustee in all areas of work. The distribution of responsibilities will shift from the NGO trustee to the PIU during the project. The PIU and NGO trustee will be jointly responsible for project planning, implementation, accounting, and monitoring, including NGO selection, contracting,

management, and monitoring. The NGO trustee will initially handle the funds, until proper arrangements in MOH are in place to do the contracting of, accounting for, and payment of NGOs. The NGO trustee will also assist contracting agencies to carry out baseline and impact surveys, and conduct yearly audits.

37. Implementing NGOs. Consistent with the JFPR eligibility criteria, NGOs will be contracted to help implement the Project. Five implementing NGOs (INGOs) will be contracted, one for every two districts with a total catchment population of about 100,000 people. The INGOs will be responsible for working with the communities to plan health care development, train staff and people, provide supplies, procure equipment, develop infrastructure, and improve and monitor services and community participation.

38. Community Organization. The community will be supported to set up a community health group or make other organizational arrangements to improve health and nutrition using a multisectoral approach. The community health group will be encouraged and supported to take on the operation of health services, improve the drug supply system, support CHWs, improve water supply and sanitation, promote proper nutrition, and undertake other health-related activities. The community will be encouraged to address the needs of women and girls, the very poor war widows, unemployed migrants, excombatants, handicapped, and other needy persons.

39. Consulting Services. A total of 12 person-months of domestic consulting services will be required for project management, NGO contracting, participatory planning and community development, engineering, and community-based drug supply. The terms of reference will be finalized as part of the inception report. The consultants will be engaged individually. The consultants will be contracted according to ADB's *Guidelines on the Recruitment of Consultants*, and other arrangements satisfactory to ADB for the recruitment of domestic consultants. The PIU will engage the consultants in consultation with AACA, ADB, MOH and WHO.

40. Procurement. Procurement under the Project will be conducted in accordance with ADB's *Guidelines for Procurement*. The PIU-NGO Trustee, with support of an ADB consultant, will prepare a detailed implementation plan for the contracting of NGOs that will be replicable by MOH. Five packages of services for 10 districts will be contracted out to about 5 INGOs. Procurement for goods and services will be done by the NGOs. The INGO will seek approval from the PIU-NGO Trustee for any procurement costing more than \$10,000, and for which major savings may be possible through joint procurement.

41. Contracting NGOs. NGOs will be selected through a competitive process guided by the steering committee and managed by PIU-NGO trustee in consultation with ADB and WHO. Eligibility criteria of NGOs will include local experience and staff capacity. Short-listed NGOs will be provided detailed information and invited to submit brief proposals per package of 2 districts. Selection criteria will be standardized. NGOs will be selected by a panel of ADB, the PIU-NGO trustee and WHO. The steering committee will approve the selection. MOH and selected NGOs will sign a partnership agreement including the scope of work, determination of rewards, supervision, breach of contract, and other matters. NGOs will be reimbursed based on a combination of activities and performance. MOH will facilitate close coordination with NGOs already in the field. Detailed contracting guidelines are being prepared as part of the project implementation manual. A summary of NGO contracting arrangements is in Appendix 5.

42. Flow of Funds. The JFPR funds for financing the INGOs will initially flow from ADB through the NGO trustee imprest account to special accounts of INGOs. The NGO trustee will manage the JFPR funds for the INGOs until the PIU has developed sufficient capacity and procedures to

take over. In case of the contracting out modality, INGOs will be paid for activities and performance of key indicators in the district. In case of contracting in, the INGOs will be paid for assisting MOH to manage services, which will also be linked to activities and performance. The NGO trustee will also initially manage the accounts until the PIU has developed sufficient capacity to take over. An independent agency will be hired to conduct yearly audits of PIU and NGO accounts. The flow of funds is summarized in Appendix 6.

43. Monitoring and Evaluation. Communities will set priorities and targets for health services and monitor progress toward these targets. Local leaders will share experience with others in workshops to learn how to improve services. Participatory monitoring will be done by the INGOs, which will involve local leaders, service providers, and beneficiaries. The PIU-NGO trustee will conduct independent supervision, using standard checklists, and qualitative feedback form stakeholders to monitor NGO performance. AACA, ADB, the Government of Japan, MOH, and WHO may participate in these activities as desired. PIU will contract an independent NGO to conduct before and after surveys. The surveys will include indicators to assess the impact on the poor and women. The PIU will also contract an agency to conduct the yearly audit of financial records of PIU and NGOs. Indicative indicators and targets are in Appendix 7. These will be finalized during preparation of the project implementation manual.

44. Reporting. The INGOs will initially submit a brief, standardized, monthly progress report to the PIU-NGO trustee (in addition to other reporting requirements of MOH). The PIU will circulate a brief monthly progress report to AACA, ADB, MOH, and WHO, and will submit a quarterly progress report to the steering committee. A project inception report and project implementation manual will be produced within 3 months of the start of the PIU. The PIU-NGO trustee will submit evaluation reports annually to the steering committee, and a project completion report within 3 months of completion of the Project. Selected consultants will provide PIU (i) an inception report within 1 week of the assignment, (ii) a midterm report, (iii) a draft final report 1 week before completing the assignment, and (iv) a final report within 2 weeks of completing the assignment.

45. Flexibility. AACA requested flexibility to allow adjustments during project implementation according to evolving needs, and within the scope of the Project. The operation plans of the proposed Project will be further detailed upon inception and during implementation in close consultation with MOH and AACA, and be subject to their approval. The terms of reference of consultants and other project details will be revised if necessary to meet the project needs and to use the project funds in a most efficient manner.

E. Partnership Approach

46. The Project is designed to explore the potential for partnership in the health sector in Afghanistan. It includes (i) participation of communities and of women in project activities; and (ii) partnership between Government, NGOs, and funding agencies to develop an approach that can quickly reach the rural poor with quality services. The PHC partnership approach is based on community ownership and targets poor communities and displaced people lacking services.

47. Participatory Planning. The Project is based on extensive consultations of a joint funding agencies with MOH, including meetings with provincial health officers from most of the 33 provinces, a retreat with MOH, and a workshop with Government staff and NGOs to discuss the partnership approach.¹⁵ MOH aims to quickly reach the rural poor and is ready to try this

¹⁵ In the health sector, ADB participated in 2 joint donor missions and 3 project missions in 2002.

approach, as documented in a memorandum of understanding signed on 26 June 2002 between ADB, MOH and WHO, and endorsed by AACA. Extensive consultations were held with external agencies including the Department for International Development (United Kingdom), the Embassy of Japan, the European Commission, the French Embassy, the Japan International Cooperation Agency, UNICEF, USAID and the World Bank; and with a wide range of international and local NGOs working in the health sector. NGOs expressed their readiness to participate in testing this approach. During preparation of the project implementation manual, extensive discussions will be held with local leaders, service providers, and beneficiaries. Stakeholder dialogue will be maintained during implementation.

48. Partnership. The Project is build on several forms of partnership including between MOH, NGOs, and funding agencies at the national level, health departments and NGOs at the provincial level, and communities and public health staff at the community level. Much of this partnership will need to be developed. At the national level, this will being done by consultants for capacity building of MOH, and will be followed up by the NGO trustee. INGOs will be responsible for capacity building at provincial and community levels. The NGO trustees will provide capacity building training to the INGOs.

49. Communities. Communities will fully participate in project planning, implementation, monitoring, and financing. NGOs will work with local leaders, beneficiaries, and local health staff to plan health care development within their communities, and agree with communities through a memorandum of understanding outlining the agreed priorities, targets, plans, and responsibilities of each party. Communities are very poor and have limited financial means to support the Project. However, community leaders will contribute by managing construction, services, and the drug revolving fund. CHWs will provide services and education, and laborers will help to construct and maintain health centers. This will ensure strong ownership and sustainability of project activities.

50. Related Projects. The Project is linked to a \$500,000 Health Sector Emergency Rehabilitation and Development Technical Assistance of the World Bank funded by JSDF,¹⁶ a \$1.2 million ADB grant for capacity building of MOH,¹² a \$1.1 million health component of the JFPR Kandahar Road Employment Project,¹⁷ a \$4 million JFPR grant for Community-Based Gender–Sensitive Basic Education, and a proposed \$50 million ADB social sector program loan. The first TA specifically targets capacity building of the partnership approach in the provinces in preparation of the World Bank’s proposed health sector emergency reconstruction and development project, which will support the partnership approach in underserved rural areas.

51. Networking. The NGO trustee will establish a web site and bulletin about the Project in local and foreign languages, and promote the exchange of volunteers to work with the Project in the target districts. Several international NGOs from Japan and elsewhere have expressed interest in this work, and will be willing to provide substantial in-kind support to the Project.

¹⁶ The Japan Social Development Fund (JSDF) is the World Bank’s counterpart program of ADB’s JFPR. JSDF has the broad objective of promoting innovations for social development and has a major technical assistance component. The JFPR grant pilots poverty impact targeting and investments in the poor that can be replicated in projects.

¹⁷ ADB. 2002. *Kandahar Road Employment for Settlement and Integration of Returning Refugees and Displaced Persons*. Manila. This JFPR grant assistance of \$14.5 million includes a health component of \$1.1 million.

F. Poverty Reduction Impact

52. **Targeting Priority Districts.** The JFPR Project will target 10 priority districts identified by the Government and the United Nations as high risk populations in terms of poverty, lack of services, war damage, and influx of displaced people. Within these districts, priority will be given to underserved and displaced communities, and poor and unemployed people. While exact data are lacking, about 80% of the population (400,000 people) in these districts are poor, and that their health and nutrition status is among the worst in the world. This will be confirmed through surveys that will include indicators to identify poor, displaced, and unemployed beneficiaries.

53. **Targeting the Poor.** The JFPR Project will promote innovative and cost-effective approaches to target the poor. While the Project design follows a public goods approach, services cannot be provided to the poor on a full subsidy basis and household contributions are explored. In the medium run, the emphasis on priority needs of the poor will facilitate socioeconomic sustainability, and generate substantial cost savings for the health system. In the context of the counterpart loan and the future loan pipeline, the Project will pilot test sustainable and cost-effective mechanisms to provide basic health services to the poor.

54. **Poverty Reduction Impact.** The exact level of poverty and health and nutrition status will be obtained through a baseline survey for each district, which will be repeated after 3 years to assess the project impact.¹⁸ Over a 3 year period, with focused interventions in relatively small districts, maternal and child mortality and fertility will be reduced by as much as 30% in these districts. Apart from addressing living standards, the Project will also help create income opportunities for the poor. In the medium term, poverty will be reduced due to improved access to affordable health facilities, better education and nutrition, and labor opportunities. The poverty reduction impact is described in Appendix 8.

55. **Impact on Vulnerable Groups.** The Project interventions will benefit infants, children, women (in particular those of reproductive age), and other community members. The Project will help develop skills and create income generating opportunities in construction and delivery of community health care for women, displaced persons, and ex-combatants. The targets and projected impact assessment will be finalized after the baseline survey in the spring of 2003.

56. **Gender Dimensions.** The Project will substantially contribute to more equitable gender development among the poor. The Project will reduce gender bias by focusing on poor women's health and nutrition, linking women through CHWs with safe motherhood training programs, and through health education for women's groups using radio. Every NGO will motivate communities to allow girls to be allowed to attend school and health services.

57. **Cost of Services for the Poor.** The Report of the Commission on Macroeconomics and Health demonstrates the many beneficial impacts of investment in health on both economic growth and household productivity.¹⁹ The report proposes a basic package of services that everyone should have access to, estimated at \$30–40 per person per year for the least developed and low income countries, compared to current spending of \$12-20 per person per year in these countries. Based on experiences of NGOs, the proposed basic package of health interventions for the Project, focusing on the most cost-effective interventions, is estimated to cost about \$3 per person per year.

¹⁸ While it usually takes time to demonstrate project impact, in circumstances of deprivation, indicators (such as child mortality) are likely to show substantial improvement within a 3 years period.

¹⁹ The World Health Organization. 2002. *Report of the Commission on Macro-Economics and Health*. Geneva.

58. **Sustainability.** Sustainability of project impact will depend on several factors, including sector funding and local ownership. The costs to sustain project activities are quite low. However, poverty levels are high. On completion of the Project, communities will be primarily responsible for supporting CHWs and health services. MOH will need to continue supporting communities with training, supervision, and monitoring, and to subsidize health staff, CHWs, and supplies in poor communities.

59. **Scaling up and System Development.** The Project could have a major impact on the design of the post-war health system in Afghanistan. It will provide important lessons for large-scale replication of the partnership concept. The Project will explore several innovative activities apart from the partnership approach such as using radios for educating women, a community-managed drug supply system, and community-managed health services. MOH and NGOs will have the flexibility to develop the most effective, sustainable, and replicable community-based PHC that is possible under the circumstances.

G. Risks, Assumptions, and Assurances

60. Project impact, sustainability and replication depend on several external and internal risk factors and assumptions.

61. **Governance and Capacity.** The overall public health system is recovering slowly. Governance and capacity constraints within and among institutions, and with civil society as a whole may affect project implementation. Funding agencies have been particularly supportive in this field and the project design is expected to be robust enough for the situation.

62. **Contracting NGOs.** Some local leaders may not be fully on board with contracting out services rather than the public services approach of the 1970s. Their involvement in developing the partnership approach is important. MOH will need to consult with governors and provincial leaders. The Government has given its assurance that it is fully committed to explore the partnership approach. MOH will establish the PIU with a senior project director and staff as soon as ADB approval is received.

63. **Coordination.** Coordination among MOH, funding agencies and NGOs has been satisfactory. A joint program secretariat has been established in MOH with support of funding agencies. This provides a focal point for capacity building, strategic planning, policy development, and program coordination. This is important in terms of coordinating and distributing assistance from external agencies and NGOs, and developing a standardized approach to which all NGOs and agencies subscribe.

64. **Health Care Financing for the Poor.** The Government's budget for the health sector is highly inadequate, and the poor can't afford the full costs of health services. Current funds for NGO support are limited. The Project assumes that sector funding from major agencies such as ADB will materialize and continue for some years.

IV. THE PRESIDENT'S RECOMMENDATION

65. The President recommends the Board approve ADB administering grant assistance to the Islamic Transitional Administration of Afghanistan in an amount not exceeding the equivalent of \$3,000,000, to be financed on a grant basis from the Japan Fund for Poverty Reduction, for the purpose of Primary Health Care Partnership for the Poor.

PROJECT FRAMEWORK

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Risks and Assumptions
Overall Objectives <ol style="list-style-type: none"> Reduce poverty by improving health, nutrition, and reproductive health status of the rural poor. Demonstrate the potential of MOH-NGO partnership to develop quality community-based health care for the poor in 10 underserved districts. 	<ul style="list-style-type: none"> Child mortality reduced by 30% in 3 years. 80% of the poor have access to quality care 	<p>Surveys</p> <p>Surveys</p>	<p>Draught, war, or other disasters.</p>
Components <ol style="list-style-type: none"> Community leadership in health development with support of NGOs Improvement of health services in 10 districts. CHW program for women and children. Drug supply system. Capacity building in public-private partnership. 	<ul style="list-style-type: none"> Coverage of health services. Proportion of women and children attended by health center and CHWs. Community share of drug funds reaches 60% Standardized procedures for contracting NGOs. 	<ul style="list-style-type: none"> Annual formative appraisal Project reports Surveys 	<ul style="list-style-type: none"> Level of poverty may reduce capacity of communities to contribute. Social restrictions for women.
Outputs <ol style="list-style-type: none"> Community management Health centers CHW services. Drug supply system. MOH capable of contracting and managing NGOs. 	<ol style="list-style-type: none"> Community managed health centers Outpatients CHW clients Drug supply systems established. Contracts issued. 	<ul style="list-style-type: none"> Project reports Review missions 	<ul style="list-style-type: none"> MOH supports contracting NGOs. Procedures may cause delay.
Activities <ol style="list-style-type: none"> Participatory planning Leadership development Construction Procurement of equipment CHW training and support Radio education for women Revolving drug fund design Financial and stock training NGO contracting Training of MOH staff Surveys 	<ol style="list-style-type: none"> field visits made leaders trained designs completed packages procured CHWs trained radio sessions funds training contracts NGOs contracted staff trained Surveys conducted 	<ul style="list-style-type: none"> Project reports Review mission 	<ul style="list-style-type: none"> Security situation acceptable. Communities are interested and proactive. Trainers are available.
Inputs <ol style="list-style-type: none"> Community organization, training, and NGO support: \$819,500 Health center development: \$797,600 CHW program: \$576,000 Drug revolving fund: \$514,000 Project management at MOH, surveys, and audit: \$673,200 Contingencies: \$219,594 <p>Total \$3,600,000, JFPR\$3,000,000</p>		<p>Account reports</p>	<p>Availability and acceptability of consultants</p>

CHW=community health worker; MOH=Ministry of Health; NGO=nongovernment organization;
Source: Asian Development Bank estimates

AFGHANISTAN PRIMARY HEALTH CARE PARTNERSHIP FOR THE POOR SELECTED PROJECT SITES



- Project District
 - National Capital
 - Provincial Capital
 - City/Town
 - Airport
 - National Road (paved)
 - National Road (unpaved)
 - Other Road
 - River
 - Provincial Boundary
 - International Boundary
- Boundaries are not necessarily authoritative.

03/14/10

SUMMARY OF COST ESTIMATES

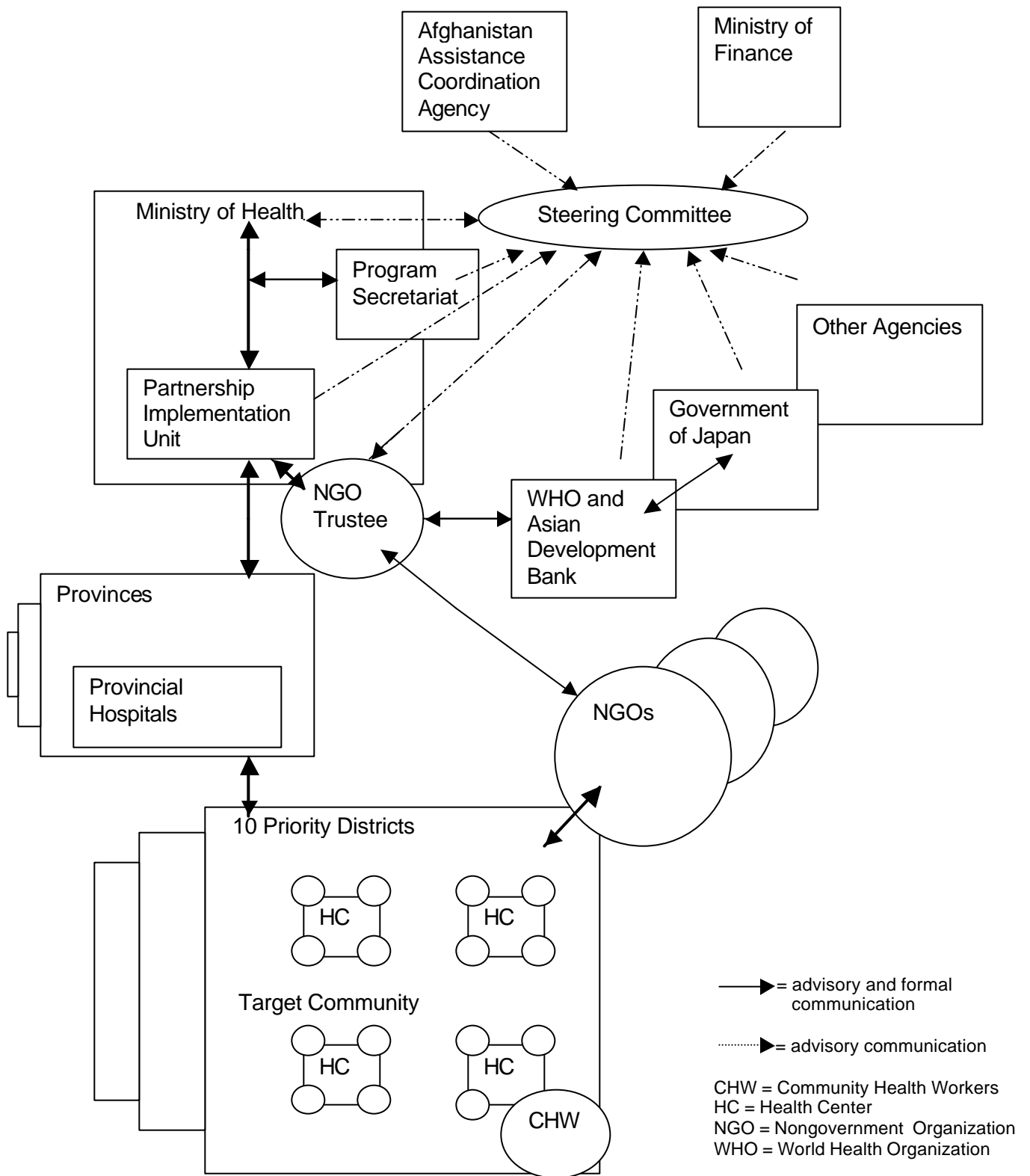
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Project components	Component 1: Community organization and support	Component 2: Health Center Development	Component 3: Community Health Workers program	Component 4: Drug Supply system	Component 5: Project management and coordination	Total estimated project cost	(%)
Inputs							
1. Civil Works	0	435	0	0	2	497	16.6
2. Transportation	80	0	0	0	20	100	3.3
3. Equipment and Furniture	5	60	24	0	9	98	3.3
4. Supplies	75	60	120	270	24	549	18.3
5. Capacity Building, Training	37	15	80	46	98	276	9.2
6. Consulting Services	12	10	6	22	54	104	3.5
7. Services	102	24	0	66	144	336	11.2
8. Labor	306	0	312	0	39	657	21.9
9. Other Project Inputs	76	6	0	0	81	163	5.4
10. Contingencies	50	54	40	33	43	220	7.3
Total JFPR	743	724	582	437	514	3,000	100
JFPR (%)	24.8	24.1	19.4	14.6	17.1		83.3
Government	0	36	0	12	131	179	5.0
NGO	54	0	0	0	0	54	1.5
Community	72	92	34	98	0	296	8.2
Other Agencies	0	0	0	0	71	71	2.0
Stakeholder Contributions	126	128	34	110	202	600	
Stakeholders (%)	14.5	15.0	5.5	20.1	28.2		16.7
Total Project Cost	869	852	616	547	716	3,600	
Component (%)	24.1	23.7	17.1	15.2	19.9		100

Source: Asian Development Bank

JFPR = Japan Fund for Poverty Reduction, NGO = nongovernment organization

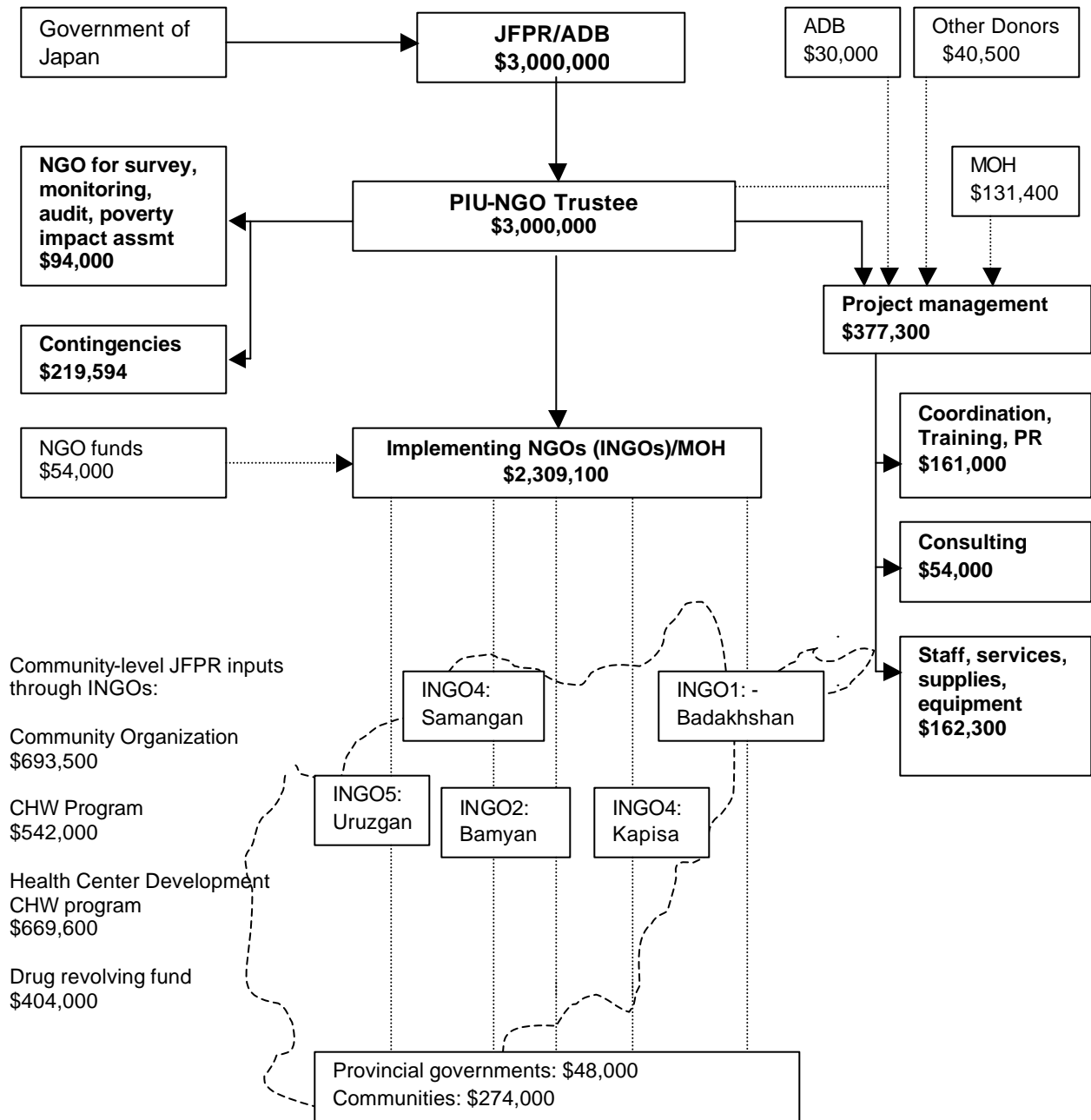
PROJECT ORGANIZATION



NGO CONTRACTING

1. The Project will test the partnership approach between Ministry of Health (MOH) and nongovernment organizations (NGOs) as a way to reduce poverty and improve health, nutrition, and reproductive health status through community-based primary health care. NGOs will be contracted and provided with basic support to expand services in 10 districts. The districts were primarily selected on the basis of lack of health services (mainly central and northeast Afghanistan) and a large number of displaced persons (east Afghanistan).
2. There will be two types of partnership. In the districts where the contracting out modality will be used, NGOs will be contracted to develop basic health services. The area will cover one large district of about 100,000 people or several smaller districts. The contracted NGO will be rewarded according to specific services and performance of key health indicators in the district, measured before and at the end of the contract period.
3. In the case of “contracting in,” the NGO will be contracted to help the Government manage health services by making competent staff available. However, the Government will be responsible for developing the services. The NGO will initially manage the funds for the Government until the Government has developed its own local capacity. The NGO will also be paid according to its services and district performance. District targets will be set following the baseline survey, which may occur after the NGO has been selected or even contracted.
4. The detailed NGO contracting process will be described in the project implementation memorandum, which will include principals, scope of work, NGO eligibility and selection criteria, contracting process, evaluation of proposals, award of contract, performance monitoring and evaluation, financial arrangements, termination of contract, and institutional arrangements. Following contracting, NGOs will be provided general orientation and training in accounts. The project implementation unit (PIU) and NGO trustee will coordinate and support implementing NGOs.
5. To make interventions available on a sustainable basis, the NGOs will undertake a range of services and developments designed to establish community-based health care:
 - (i) engagement of the provincial health offices and district staff;
 - (ii) community sensitization and participatory planning;
 - (iii) orientation and networking of local leaders for health services development;
 - (iv) training of health center staff and community health workers;
 - (v) health education sessions with women using radio or other means;
 - (vi) training of nominated persons in managing the drug supply system;
 - (vii) procurement of equipment and Civil works;
 - (viii) participatory monitoring and facilitation of surveys and supervision; and
 - (ix) reporting, and facilitating audit.
6. International and local NGOs will be eligible. An NGO will be eligible if it has worked in the Afghan health sector for at least 2 years and has a minimum of 3 full-time staff, including an accounts officer. The PIU/NGO trustee will, in consultation with the Asian Development Bank (ADB) and World Health Organization (WHO), invite expressions of interest for five packages. NGOs will be provided sufficient detail to understand the scope of work. NGOs will respond with a brief combined technical and financial proposal. NGOs may apply for all packages, provided that the minimum criteria per package are met. The PIU-NGO trustee, ADB, and WHO will evaluate the proposals based on standard criteria and rank them for approval by the steering committee.

FUND FLOW PROJECTIONS



→ = flow of JFPR funds,→ = flow of supplementary funding from other sources (in addition to JFPR allocations), ADB = Asian Development Bank, INGO = Implementing NGO, JFPR = Japan Fund for Poverty Reduction, MOF = Ministry of Finance, MOH = Ministry of Health, NGO = Nongovernment Organization, PIU = Project Implementation Unit, PR = public relations

PROJECT INDICATORS AND TARGETS*

Indicator	Afghanistan Latest Estimate (%)	District Baseline Estimate (%)	Target (%)	Source
Impact				
Birth Rate/1,000 Live Births				
Maternal Mortality Ratio/100,000 live births ^a	400-4000			HHS
Child Mortality Rate (<5 yr)	150	200	130	HHS
Infant Mortality Rate (<1 yr)	220	300	200	HHS
Diarrhoeal Disease in Last 2 Weeks (0-5 years)				HHS
Coverage				
Poor Households Using Health Center (%)	30	20	50	HHS
Women Using CHWs in Past Year (%)		0	50	HHS
Pregnant Women Receiving 3 Antenatal Visits	8	2	8	HHS
Contraceptive Prevalence Rate	2	0	2	HHS
Measles Immunization Coverage (12-23 months)	25	10	40	HHS
Parents Know Danger Signs of Diarrhoea (%)				HHS
Parents Know Danger Signs of ARI (%)				HHS
Women Practicing Proper Breast Feeding in First 6 months After Delivery (%)				CHW
Output				
Outpatient Visits/Month (male, female, children) as Percentage of Total Female Population		<2	4	HCR
Suspected Tuberculosis Cases Referred				HCR
ARI Cases Treated at the Health Center				HCR
Referral for Caesarian Section as Percentage of Total Expected Deliveries per Month in Community		<1	2	HCR
Process				
Female and Male CHWs Trained		0	320	PM
Radio Sessions with Women Groups		0	480	

ARI=Acute respiratory Infection, CHW= community health worker, HCR=health center records, HHS = household survey, PM = project monitoring

Note: These are indicative estimates and not known at present.

^aIt is not possible to assess the ratio in a small sample, but CHW will be asked to report all maternal deaths.

POVERTY REDUCTION IMPACT

1. About 60% to 80% of the population of Afghanistan lives in poverty (less than \$1 a day). At least 80% of the targeted population in the project area is expected to be poor. The proposed health Project provides some labor and will contribute to poverty reduction by providing low cost basic health care that helps improve productivity, reduces disability and death, and averts unwanted pregnancies.
2. The Project will target 10 districts in 10 priority areas identified by the Government as priority for humanitarian assistance. These districts are considered disadvantaged and vulnerable in terms of poverty, lack of health services, war damage, returnees and internally displaced persons, and excombatants. The Project will cover 1-3 districts in the provinces of Badakshan, Bamyán, Kapisa, Samangan and Uruzgan. Surveys will assess the poverty level, health status, presence of vulnerable groups, and project impact.
3. The targeted project population in these districts is about 500,000. About 75,000 women are currently married in these districts, out of a total of 100,000 women of reproductive age (the remaining 24,000 women include war widows and never married women). There are about 25,000 births per year and 75,000 children under the age of 5 years.
4. The maternal mortality ratio is estimated at 2,000/100,000 live birth, or 500 women each year in the target districts. With a total fertility rate of 8 children per woman, this implies that about 15 % of all women in these communities die from a maternal complications. The infant mortality rate is estimated at 200/1,000 live births, and the under-five child mortality rate is estimated at 300/1,000 (with considerable variations).
5. As the Project will take time to start up, its impact will only reach its peak after 3 years. In the third year, the Project will avert 4,500 child deaths (including 3,000 infants), 300 maternal deaths, and 15,000 unwanted pregnancies. The Project will have further benefits in terms of reducing communicable diseases, and some 2,500 maternal disabilities. Communities will have a better understanding of the health and nutrition needs of women and children, and prevention of communicable diseases, which will have long-term benefits.
6. The Project will train and support 160 community health workers (male and female) in 100 targeted communities in 10 districts. It will also provide employment for local laborers for construction or repair of health centers, water supply, and pit latrines, and improve their skills. It will educate local leaders to manage health centers and drug revolving funds.
7. After 3 years, at least 60% of the communities will be able to continue managing the health centers and drug revolving funds with reduced support, possibly through the nongovernment organizations (NGOs) initially contracted to develop the services. This will provide a sustained project impact over time.
8. The Project will also build the institutional capacity of Ministry of Public Health (MoPH), provinces and nongovernment organizations (NGOs), which will have additional indirect benefits for the population that are, however, difficult to quantify.