



1. Project Data

<b>Project ID</b> P173775		<b>Project Name</b> Afghanistan COVID-19 ERHSPP	
<b>Country</b> Afghanistan		<b>Practice Area(Lead)</b> Health, Nutrition & Population	
<b>L/C/TF Number(s)</b> IDA-D5930,IDA-D7810,TF-B5099,TF-B5205		<b>Closing Date (Original)</b> 31-Mar-2024	<b>Total Project Cost (USD)</b> 77,658,767.33
<b>Bank Approval Date</b> 02-Apr-2020		<b>Closing Date (Actual)</b> 31-Mar-2024	
		<b>IBRD/IDA (USD)</b>	<b>Grants (USD)</b>
Original Commitment		100,400,000.00	53,000,000.00
Revised Commitment		160,400,000.00	0.00
Actual		80,252,989.13	0.00
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2. Project Objectives and Components

a. Objectives

The project development objective was to respond to and mitigate the threat posed by COVID-19 and strengthen national systems for public health preparedness in Afghanistan. The wording was identical in the Grant Agreement (GA, p4) and Project Appraisal Document (PAD, p2). The objective was not changed during implementation.



A **split rating will be used** in order to discriminate between the periods before and after the Taliban takeover in August 2021, as agreed between IEG and the region, and as per advice to the author from IEG management. Without this extraordinary exogenous event, there would have been no need for a split rating because the PDO and original targets were unchanged (except for the very minor change of dropping the target of establishing a national level 3 biosafety facility, in addition to the five regional level 2 facilities). A 2022 Additional Financing (AF) and restructuring added activities, with AF provided to cover the expanded scope of the project.

**b. Were the project objectives/key associated outcome targets revised during implementation?**

Yes

**Did the Board approve the revised objectives/key associated outcome targets?**

Yes

**Date of Board Approval**

08-Apr-2022

**c. Will a split evaluation be undertaken?**

Yes

**d. Components**

**Component 1: Emergency COVID-19 Response (Appraised amount: US\$34 million (PAD p13), of which US\$14 million was from the Fast Track Covid-19 Facility (FTCF), and US\$20 million from the International Development Association (IDA), plus US\$3 million reallocated from the originally unallocated amount. There are small discrepancies between the PAD and the AF document regarding the original allocations that IEG was unable to clarify in the interview with the TTL. No information is available on the disbursed amount.)**

This component aimed to slow down and limit the spread of COVID-19 in Afghanistan by providing immediate support to improve surveillance and testing capacities and information. It would finance technical expertise, and strengthen laboratory and diagnostic systems, by providing medical equipment, essential protective equipment and other supplies, and commodities, including for diagnosing COVID-19. Surveillance workers would be trained to improve reporting and contact tracing. A national accreditation process would be established for testing in public and private laboratories. Isolation units would be established in hospitals, and widespread infection control training and measures instituted in health facilities. The component would also finance community awareness campaigns delivered through existing community institutions such as community development councils, health and school management shuras (traditional community councils), religious and tribal leaders, and community health workers who would need to be trained and compensated. Television, radio, social media, and printed materials would promote personal hygiene practices, and distribution and use of face masks. A call center would be set up to respond to questions about coronavirus from the public and health care providers.

**The AF allocated an additional US\$89.5 million, of which US\$47.18 million was from IDA, US\$39.32 million from the Afghanistan Reconstruction Trust Fund (ARTF), and US\$3 million from the Energy Sector Management Program (ESMAP).**



The AF would finance the purchase of COVID-19 vaccines and vaccine-related cold chain equipment including solarization of 15 provincial Expanded Programme on Immunization (EPI) cold stores and 250 health center EPI refrigerators, and activities to strengthen Afghanistan's institutional framework to enable safe and effective vaccine deployment, including developing national policies for prioritizing allocation of vaccines and ensuring voluntary vaccinations, regulatory standards for vaccinations, and standards and protocols related to cold chain, supplies, storage, logistics, and training.

**Component 2: Health Care Strengthening (Appraised Amount: US\$46 million from IDA; no information available on disbursed amount)**

This component would equip selected health facilities to deliver clinical care to COVID-19 patients by procuring oxygen delivery systems, other medical equipment, supplies including diagnostic reagents and kits, and medicines; finance extra payments (e.g. hazard pay and death benefits) to help retain skilled health workers; develop treatment guidelines and intra-hospital infection control measures; strengthen medical waste management and disposal systems; mobilize additional health personnel and train health personnel; fund other operational expenses such as those related to mobilizing health teams and salaries; and finance technical assistance.

The **AF allocated US\$16 million** more to component 2, of which US\$8.73 million was from IDA and US\$7.27 million was from the ARTF. This would finance delivery of COVID-19 vaccines to the priority target populations, aiming to achieve a 60 percent population coverage.

**Component 3: Mitigation of Social Impacts (Appraised amount: US\$5.4 million from the FTCTF; plus US\$7 million from the originally unallocated amount. No information is available on the disbursed amount.)**

This component was intended to prevent and address significant negative consequences from a widespread COVID-19 outbreak and included comprehensive communication strategies. The primary focus would be on promoting social distancing measures, such as avoiding large social gatherings, promoting handwashing and proper cooking, and distribution and use of masks, and awareness and promotion of community participation in slowing the spread of the pandemic. It would also aim to mitigate the negative impacts on children's learning and wellbeing of school closures by investing in actions to ensure continuity of learning, including remote learning through radio broadcasts and other methods of distance delivery of academic content in the areas of literature, science, and mathematics. This component would also provide mental health services for vulnerable communities.

**The AF allocated an additional US\$4 million**, and added the following activities: development of targeted training programs for managers, service providers, and evaluators of vaccine deployment; support for developing explicit criteria for identifying priority populations for vaccination and supporting implementation plans; mass and interpersonal communications to address vaccine hesitancy and improve demand; social and behavior change communications and outreach interventions to promote health and reduce risk of COVID-19; citizen engagement for feedback and grievance redressal mechanisms; and knowledge management and learning.



**Component 4: Implementation Management and Monitoring and Evaluation (Appraised Amount: US\$5 million IDA; no information available on disbursed amount)**

This component would help strengthen public structures to coordinate and manage the project, including central and local (decentralized) arrangements for coordination of activities, financial management, and procurement. It would also support monitoring and evaluation of prevention and preparedness, building capacity for clinical and public health research, joint learning across and within countries, and, as needed, a third-party to monitor and evaluate the project.

**The AF allocated US\$3.5 million** to this component that would finance development of information systems for assessing the coverage, effectiveness, safety, and impact of vaccination deployment; investigating and responding to outbreaks, sero-surveillance studies, and additional operational and management costs of project implementation.

**Component 5: Contingent Emergency Response Component (Appraised Amount and Actual Disbursed: US\$0 million).**

This mandatory component could be used to help provide immediate and effective response in the event of an eligible crisis or emergency.

**Unallocated: US\$10 million, reallocated to components 1 and 3 as part of project restructuring.**

**e. Comments on Project Cost, Financing, Borrower Contribution, and Dates**

**Project Costs, Financing, and Borrower Contribution:** Total project costs were estimated at appraisal at US\$100.4 million, financed by an IDA grant, of which US\$81 million came from Afghanistan's IDA performance-based allocation (PBA) and \$US19.4 million from the IDA FTCTF Crisis Response Window allocation for Afghanistan. No financial contribution was expected from the Borrower (ICRR p2, Financing Table, and PAD, pp2-3.). AF of US\$113 million (US\$60 million from IDA, US\$50 million from the ARTF, and US\$3 million from ESMAP) was approved on March 18, 2021. The project was restructured together with the AF, and the US\$10 million which was **initially unallocated** in view of the uncertainties around COVID-19 was reallocated to Component 1 (US\$3 million) and Component 3 (US\$7 million). (These amounts are inferred from the ICR's Table 6 and pp26-27; they are not explicitly stated in the AF document, and a footnote on p26 says - apparently incorrectly – that the unallocated amount was reallocated to Components 1 and 2 instead of to Components 1 and 3.) **Final disbursements** after the project was suspended were US\$80.253 million, 80 percent of the original commitment, and 38 percent of the total commitment including the AF. The remainder of the commitments were cancelled. Because of the rapid fall of the government in August 2021 and take-over by the Taliban, it has not been possible to get information on disbursements by component (this information would usually be provided by government counterparts).



**Dates:** The project was prepared extremely rapidly (in four days), approved on April 2, 2020, and became effective on April 12, 2020. The US\$113 million AF grant for vaccine purchases and deployment from the ARTF, IDA, and ESMAP was approved on March 18, 2021, and became effective on April 15, 2021. The project was restructured on June 15, 2021 (US\$63.26 million had been disbursed, which was 57.3 percent of the original allocation and 28.3 percent of the total including the AF). The AF/restructuring retained the original PDO, goals, and activities, but expanded the project's scope and introduced new activities (as described above). The results framework was improved to better monitor project results and progress. Indicators that were unable to be measured were dropped, indicators that were less important were "demoted" from PDO indicators to intermediate results indicators, others were "promoted" as better measures of progress toward the project's main objectives, indicators were added to monitor progress of new activities, and an indicator for gender was added. The project was **scheduled to close on March 31, 2024**; it has not formally closed, but was suspended (with the rest of the country portfolio) after the Taliban takeover of the government in August 2021.

### 3. Relevance of Objectives

#### Rationale

**The project addresses the ongoing COVID-19 epidemic, seeking to mitigate its devastating impact** on a country and economy already weakened by severe instability and conflict, drought, population displacement, widespread poverty, corruption, poor governance, and weak institutions, including the health system. Afghanistan's vulnerability to the epidemic was increased by frequent travel by many Afghans to China for education and business. Afghanistan shares a porous border with Iran which already -- in early March 2022 -- had a large and rapidly evolving outbreak of COVID-19 with serious transmission implications. The highly contagious nature of the virus, relatively free population movement over the borders, and limited public health capacity all contributed to the potential spread of the epidemic and associated harm. The rapid and vigorous response to the epidemic was of clear national importance in trying to minimize the risk that COVID-19 would disrupt trade and negatively impact exports, further undermine already-low private sector confidence, undermine gains in health outcomes, reduce economic growth, and negatively impact overstretched fiscal resources.

**The project built on years of effort by the government and assistance from the World Bank to strengthen the health system.** The Afghan health system had made considerable progress over the previous decade thanks to strong government leadership, sound public health policies, and strong World Bank (and other donor) support for prioritized investments in primary care and basic and essential health and hospital services ("Basic Package of Health Services" - BPHS and "Essential Package of Hospital Services" - EPHS). The project objectives were fully complementary to those of the ongoing Afghanistan Sehatmandi Project (P160615, US\$600 million, 2018-2021, with objectives to increase the utilization and quality of health, nutrition, and family planning services across Afghanistan).

The project **supported the government's** commitment to improve access to services in rural areas as reflected in the Afghanistan National Peace and Development Framework and the Afghanistan costed national pandemic preparedness action plan, which included strengthening of the BPHS and EPHS to incorporate health security considerations.



The **project was fully aligned with the World Bank's assistance strategy in Afghanistan** as laid out in the Country Partnership Framework for FY17 to FY20 (Report No. 108727-AF), extended to FY22 by the Performance and Learning Review, Report No. 136690-AF dated June 24, 2019, and the Approach Paper 2.0: Options for World Bank Engagement to Support the Afghan People, March 1, 2022, which prioritized donor support aimed at protecting the vulnerable, helping preserve human capital and key economic and social institutions, reducing the need for future humanitarian assistance, and improving gender equality outcomes.

The **project followed guidelines for the global Multiphase Programmatic Approach (MPA) COVID-19 Strategic Preparedness and Response Program**. Its scope and components aligned fully with the COVID-19 Fast Track Facility, using standard components as described in Annex 2 of the COVID-19 Board paper.

## Rating

High

## 4. Achievement of Objectives (Efficacy)

### OBJECTIVE 1

#### Objective

Respond to and mitigate the threat posed by COVID-19

#### Rationale

The **theory of change** was that the threat of COVID-19 could be mitigated by project support for: increasing capacity to test for COVID-19, contracting service providers to deliver COVID-19 services, equipping hospitals to treat COVID-19 and developing at least one biosafety facility in each region, procuring and distributing personal protective equipment (PPE), and promoting preventive actions to complement social distancing, including developing, testing, and delivering comprehensive communication and behavior change interventions.

The theory of change was amended at restructuring to include delivering newly available COVID-19 vaccines, which involved developing a national plan for COVID-19 vaccine procurement and deployment; procuring vaccines; developing standards and protocols for the vaccine cold chain, supplies, storage, and logistics; training providers to administer the vaccines; and vaccinating health care workers and priority groups.

#### Outputs and Intermediate Results (ICR, pp11-15 and AF paper):

Public Information



- The Health Promotion Department of the Ministry of Public Health (MoPH), World Health Organization (WHO), and the United Nations Children's Fund (UNICEF) developed ten key messages about prevention and care of COVID-19 addressing different target groups. Additionally, eleven television and five radio spot scripts were developed in Dari and Pashto languages. The key messages related to prevention, self-isolation, home treatment, taking care of sick persons, how to wear masks, physical distancing, and vaccination. Between July 29 and December 30, 2020, television and radio spots were broadcast through 180 channels across the country, reaching an estimated seven million people. The broadcasting plan was monitored through a third-party monitoring agency to ensure that spots were broadcasted as planned. UNICEF also used social media (130 posts to Facebook, Instagram and YouTube and more than 120 tweets on Twitter) to spread messages about COVID-19. UNICEF produced 15 stories involving children and youth to reinforce Risk Communication and Community Engagement preventive messages. An estimated 4.3 million people were reached between June 2020 and March 2021.
- 16 different posters/billboards and leaflets were developed for different target groups during the second and third wave of the COVID-19 pandemic in Afghanistan. In total, 692,089 behavior change communication materials were printed and distributed.
- To increase community engagement, frontline workers oriented 59,243 members of key groups including community health workers, community health supervisors, community-led total sanitation mobilizers, school shuras, nutrition counselors, immunization communication network personnel (who had previously worked on polio), technical extenders, non-governmental organizations, religious leaders, and adolescents' networks about COVID-19 prevention and management.
- The MoPH set up a hotline to answer questions about COVID-19 prevention, treatment, and concerns.

### Testing and Care

- In May 2020, the MoPH signed four-year contracts with the existing Sehatmandi project Service Providers (SPs) to provide care to COVID-19 patients, including to prevent and control infections in isolation wards in provincial hospitals, deploy community health workers to educate communities on COVID-19; and deploy Rapid Response Teams (RRTs) to undertake case identification, testing, and contact tracing. The contracts had an original six-month workplan, and subsequent six-monthly plans were agreed as the pandemic evolved. In all, 39 hospitals and COVID-19 isolation wards were activated across the country to provide care to COVID-19 patients. During project implementation, 140,873 critically or severely ill patients received care. Specimen collection kits and supplies for the RRTs were distributed to SPs supporting RRTs in 33 provinces.
- UNICEF was contracted to raise public awareness and promote healthy behaviors relating to COVID-19, monitor and evaluate activities, and procure supplies and equipment.
- Critical medical goods (mainly PPE) and other supplies were procured and delivered to COVID-19 centers in all 34 provinces of Afghanistan.
- Fourteen COVID-19 testing sites were set up and made operational.
- Ten technical assistants were hired (one international and nine national).
- The MoPH signed a US\$ 4.7 million contract with WHO to expand the capacity of laboratories through: (i) supporting expansion of diagnostic facilities for COVID-19 confirmatory testing (laboratories); (ii) providing Polymerase Chain Reaction machines, reagents, and supplies for reference laboratories; (iii) training staff of newly established testing centers and selected hospitals; (iv) providing specimen collection kits and supplies for 310 RRTs; (v) establishing specimen collection points at testing centers and district, provincial, and regional hospitals; and (vi) providing technical



assistance. All planned diagnostic facilities for COVID-19 confirmatory testing centers were activated. Afghanistan's testing capacity increased from 2,500 tests to 25,000 tests per day from May 2020 to June 2021.

- Medical supplies and equipment were a major component of this project. A total of 95 medical items including PPE, which included surgical masks, particulate filter respirators (such as P2 or N95), gloves, goggles, glasses, face shields, gowns, and aprons were initially categorized into critical and essential supplies for the prevention/mitigation of COVID-19. The MoPH and UNICEF standardized the list in line with commercial availability, resulting in a revised number of items from 95 to 111 items. All items were procured and distributed to the 39 COVID-19 hospitals in all 34 provinces of the country. Ten oxygen plants were procured and installed in ten large hospitals.

#### Coordination and Vaccination

- A well-functioning coordination mechanism was established to help align financial resources with MoPH priorities and improve alignment with the COVID-19 project supported by the Asian Development Bank (ADB).
- A National COVID-19 Vaccine Deployment Plan (NVDP) was developed. It guided the prioritization of health workers to receive vaccines.
- Vaccines were procured (and also donated through the COVID-19 Vaccines Global Access [COVAX] facility, and others).
- SPs transported COVID-19 vaccines from regional stores to health facilities. Health workers in public health facilities, financed through this project and also the ongoing Sehatmandi Project (P160615), vaccinated the population according to the NVDP.

#### Intermediate Results Indicators

##### Original IRIs:

- The target of establishing a Biosafety Level 2 facility in each of 5 regions was met; the original intention to also establish a national Level 3 facility was dropped (and the IRI amended to reflect this at restructuring), as it was not needed for COVID-19.
- The target for the “proportion of identified contacts who were successfully traced” was not met, with a result of 43 percent compared to a target of 70 percent (which would be an ambitious target even in a much easier environment).

##### Indicator “demoted” from PDO indicator to IRI at restructuring/AF:

- The target (50 percent) for the “proportion of specimens submitted for COVID-19 virus laboratory testing with results available within 48 hours” was substantially achieved (actual result: 48 percent).

##### New IRIs added during restructuring/AF:

- A national plan was developed for COVID-19 vaccine procurement and deployment (target met).
- The target for the “number of solarized cold storage and health facilities set up” was not met; this increased from a baseline of 605 to a result of 812, well short of the target of 2,234.



- The target of “community engagement plan implemented for increasing demand creation for the COVID-19 vaccine by the population” was not met; the inadequate supply of vaccines made this indicator irrelevant while the project was active.

## **Outcomes**

### **Hospital capacity to treat COVID-19 cases**

Eighty-four percent of hospitals contracted to provide COVID-19 treatment reported having adequate PPE, exceeding the target of 70 percent (originally an intermediate results indicator, upgraded to PDO indicator at restructuring).

All hospitals contracted to provide COVID-19 treatment had adequate isolation facilities available, exceeding the target of 70 percent (originally an intermediate results indicator, upgraded to PDO indicator at restructuring).

### **COVID-19 knowledge and vaccinations**

Nearly 70,000 (68,864) health workers were fully vaccinated against COVID-19, exceeding the target of 50,000 health workers (new PDO indicator added during restructuring/AF).

Just over three percent (3.1) of the population received at least one shot of the COVID-19 vaccine, far short of the target of 48 percent, constrained by the limited availability of vaccines and abrupt end to project implementation. However, the groups prioritized followed the national plan (new PDO indicator added during restructuring/AF).

The original PDO indicator to measure the impact of informational activities on awareness and knowledge about COVID-19 - *Proportion of population able to identify three key symptoms of COVID-19 and/or seasonal influenza and three personal prevention measures (as assessed by a representative population survey)* -- could not be measured, as the population survey that would have provided the information was not carried out.

## **Rating**

Substantial

## **OBJECTIVE 1 REVISION 1**

### **Revised Objective**

The objective was not revised, but official operations ceased after the Taliban takeover on August 15, 2021.

### **Revised Rationale**

Since the Taliban takeover on August 15, 2021, there has been no official relationship between the World Bank and the government. There is no information about any project activities after that date.



## Revised Rating

Negligible

## OBJECTIVE 2

### Objective

Strengthen national systems for public health preparedness in Afghanistan

### Rationale

The **theory of change** was that the national systems for public health preparedness would be strengthened by the activities to mitigate the threat of COVID-19, specifically through project support for increasing capacity to administer and process tests, providing additional equipment and PPE to hospitals, developing at least one biosafety facility in each region, and training and retaining staff.

### Outputs

National systems for public health preparedness were strengthened through the following activities:

- The WHO was contracted to equip and support laboratories to conduct COVID-19 tests; provide specimen collection kits and supplies for RRTs; and provide technical assistance to the MoPH.
- A Biosafety Level 2 facility was set up in each of five regions.
- Medical supplies and equipment were procured and distributed to health facilities.
- Health staff received training in infection control and prevention, vaccine administration, and care of COVID-19 patients.
- The MoPH set up a hotline to answer questions from the public.
- The COVID-specific activities built experience in dealing with infectious diseases that could be drawn on for future needs.

New IRIs added during restructuring/AF:

- The indicator target for “proportion of provincial hospital doctors and nurses who are trained on WHO standards of clinical treatment for COVID-19” was exceeded, with a result of 82 compared to the target of 80 percent.
- The indicator target for the “proportion of vaccines not wasted” was also exceeded at 93 percent, compared to the target of 90 percent.
- The target for “percentage of EPI fixed vaccination centers with a female staff present” was not achieved, although some progress was made: the baseline was 98 percent, the target was 100 percent, and the actual result reported was 99 percent.
- No progress was made in increasing the “percentage of health facilities in the project area with functioning management committees having community representation” from the baseline of 80 percent to 95 percent.



- The “percentage of grievances resolved within a month of their receipt” was substantially met, at 65 percent compared to the target of 70 percent.

### **Outcomes**

The **two PDO indicators** (promoted from IRIs) relating to hospitals (availability of PPE and treatment isolation capacity), described above under Objective 1, are relevant to Objective 2; both exceeded their targets.

### **Rating**

Substantial

## **OBJECTIVE 2 REVISION 1**

### **Revised Objective**

The objective was not revised, but official operations ceased after the Taliban takeover on August 15, 2021.

### **Revised Rationale**

Since the Taliban takeover on August 15, 2021, there has been no official relationship between the World Bank and the government. There is no information about any project activities after that date.

### **Revised Rating**

Negligible

## **OVERALL EFFICACY**

### **Rationale**

The project achieved strong results in its initial 15 months of implementation, achieving many of its targets, and the efficacy rating for both objectives in this period is Substantial.

### **Overall Efficacy Rating**

Substantial

## **OVERALL EFFICACY REVISION 1**

### **Overall Efficacy Revision 1 Rationale**



After the Taliban take-over in August 2021, efficacy was negligible for both objectives.

**Overall Efficacy Revision 1 Rating**  
Negligible

**Primary Reason**  
External shock

## 5. Efficiency

### Ex Ante

A rigorous economic analysis of the project was not done at appraisal. However, the project had strong economic justification in aiming to reduce the likely negative impacts on Afghanistan's economy from COVID-19. The World Bank Macroeconomics, Trade & Investment team estimated the likely economic losses of a "contained" COVID-19 scenario at US\$44 million over 2020-2021, and a "pandemic" scenario's losses at US\$353 million over that time frame. The project was expected to have substantial economic benefits by preventing illness and loss of life, limiting the extent and duration of economic disruption, and strengthening the health system.

### Ex Post

No ex-post economic analysis was done for the ICR because project implementation was prematurely halted by the Taliban takeover before its March 31, 2024 closing date (ICR, p17).

The design of the project was highly efficient: it was designed, approved, and begun with lightning speed. The ICR judged that implementation efficiency was "Substantial," because the project was able to use the existing implementation arrangements for the World Bank-financed Sehatmandi project, and to use the Sehatmandi project platform to quickly contract out the COVID-19 response to existing contracted health SPs and United Nations agencies, mainly WHO and UNICEF, to provide essential supplies and equipment and technical assistance, including enhancing COVID-19 testing capacity. Initial implementation took off swiftly. The SP contracts were issued quickly, and funds made available readily. Despite the worsening insecurity, ongoing violence, electricity and connectivity challenges, COVID-19 lockdowns, disruption of global markets, and unavailability of flights and PPE supplies, government commitment and the hard work of the MoPH implementation team and contracted implementors, supported by the World Bank team, enabled many project targets to be met within the first year of what was expected to be a four-year implementation period.

However, the efficiency of implementation was mixed for the AF. Some aspects of preparation for vaccines were accomplished in good time, notably the development of a national plan, training, and vaccination of health providers. However, the procurement of vaccines was delayed by government resistance to working through the United Nations, as well as by supply shortages.

## Efficiency Rating

Modest



a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 <input type="checkbox"/> Not Applicable
ICR Estimate		0	0 <input type="checkbox"/> Not Applicable

\* Refers to percent of total project cost for which ERR/FRR was calculated.

## 6. Outcome

Split Outcome Rating (ICR Table 4, p17)

	Before Aug 15, 2021	After Aug 15, 2021
Relevance	High	
Efficacy	Substantial	Negligible
Efficiency	Modest	
Phase Outcome Rating	MS	U
Phase Outcome Rating Score	4	2
Disbursed (US\$ million)	63.3	16.95 disbursed 133.2 undisbursed 150.1 total
Phase Weight	$63.1/213.4=0.297$	$150.1/213.4=0.703$
Weighted Rating	1.188	1.406
Overall rating Score	$1.188 + 1.406 = 2.594$ (rounded to 3)	
Overall Outcome rating	MU	

This split rating methodology was adapted specifically for the Afghanistan portfolio, given the abrupt fall of the government and takeover by the Taliban. This table was reviewed and noted as fully consistent with the special IEG Guidance (phone conversation between author and IEG Management on March 14, 2023).

### a. Outcome Rating

Moderately Unsatisfactory

## 7. Risk to Development Outcome

The risk to the development outcomes achieved by the project is considerable. This was the case even before the Taliban takeover in August 2021, and the risk increased substantially afterwards. Corruption had worsened in the health sector before the takeover, and the government continued to face critical governance



challenges. The worsening security situation affected the supply of health services, including closing some health facilities. The Taliban was opposed to the vaccination program. Increased restrictions on women's movements reduced their use of health services. Project outcomes are highly reliant on externally funded financial and technical assistance, and although the World Bank, ARTF donors, and international partners have found pragmatic ways to provide support for essential basic services to the Afghan people since the Taliban takeover, continuity is uncertain. In November 2021, with approval from the ARTF donors, the World Bank Board of Executive Directors ("the Board") supported the transfer of US\$280 million of uncommitted ARTF funds to the World Food Programme and UNICEF, in partnership with WHO, for humanitarian gap financing including maintaining basic and essential health services, which provided financing for the COVID-19 response. In March 2022, responding to requests from the international community, the Board approved Approach Paper 2.0, which enabled COVID-19 prevention, care, and treatment interventions to be integrated in a newly approved Health Emergency Response Project (P178775, US\$333 million, 2022-2024) through the basic health services packages.

## 8. Assessment of Bank Performance

### a. Quality-at-Entry

The project was designed with almost unprecedented speed (in four days, communication with TTL on March 8, 2023). The PDO was highly relevant to the situation and well-chosen national priorities, and consistent with the MPA and the World Bank's assistance strategy for Afghanistan. The MPA provided an overall design template for the COVID-19 response and priorities, which guided project design. The activities had a clear logical relationship to the expected results, and M&E design was selected based on previous experience. The MoPH and World Bank agreed to build upon the experiences of previous World Bank-financed projects, use the existing Sehatmandi project platform, and contract out the COVID-19 response to already existing SPs that were providing basic and essential health services across the country. This approach made it possible to contract the SPs very quickly and to make project funding available immediately. The project preparation team included all the necessary expertise, deep understanding and familiarity with the situation in Afghanistan, and relevant global experience. Preparation of the project was inclusive and well-coordinated with development partners.

The one negative aspect was the poorly chosen original PDO indicators, which are discussed in the section on M&E (Section 9). However, given the urgency and speed with which the project was prepared and how little was known about COVID-19 at the time, the team made the reasonable decision to use similar indicators as those for earlier Avian Flu projects, knowing they could easily be changed later.

### Quality-at-Entry Rating

Satisfactory

### b. Quality of supervision

The Task Team Leader was based in Kabul and, along with the core team, provided continual support and follow up. There was a turnover in task management (three TTLs over 18 months, but with a constant co-



TTL who became the third TTL) and core staff, but this did not affect the project's implementation support. The team maintained a good working relationship with the MoPH team and leadership. The team requested the MoPH leadership to create a coordination forum and meet weekly. The meeting was chaired by the Minister of Public Health, with other financiers and technical agencies, such as GAVI (the Vaccine Alliance), ADB, WHO and UNICEF participating. The ICR noted that this initiative was respected and appreciated by the MoPH and other stakeholders. Implementation support missions were conducted regularly, and corresponding Aide Memoires (AMs) and five implementation Status Reports (ISRs) were filed. AMs and ISRs were complete and informative and show a strong focus on development results, as well as careful attention to detail. They show evidence of the team being proactive and constructive. For example, AMs document efforts to expedite delayed United Nations and third-party monitoring contracts. In 2020, when the COVID-19 vaccine came to the market, based on the government's request, the World Bank provided AF as a matter of priority to finance vaccine procurement and delivery to the target population, and revised the results framework to reflect the AF and better monitor the project results.

The ICR described strong fiduciary management of the project by the Bank. The Bank financial management (FM) team conducted regular FM supervision throughout implementation; the last supervision mission was conducted in May 2021. Performance ratings were candid, issues were highlighted and followed up, and needed implementation support was provided, helping ensure that most agreed actions were completed within established deadlines. During the COVID-19 pandemic, the World Bank continued periodic supervision and transaction reviews based on scanned copies of documents, and employed a third-party monitoring agency to conduct transaction reviews and certify Statements of Expenses. All fiduciary issues were tracked through the World Bank's Compliance Management System during the last year of implementation.

### **Quality of Supervision Rating**

Satisfactory

### **Overall Bank Performance Rating**

Satisfactory

## **9. M&E Design, Implementation, & Utilization**

### **a. M&E Design**

The M&E design had many strengths. The PDO was highly relevant, and it balanced the emergency need to respond to COVID-19 with concern for the long-term goal of continuing to strengthen the health system. The implicit theory of change was clear and the results chain short and direct. The results framework included baseline and target values for all indicators, data sources, and frequency and clearly specified responsibility for data collection. The project built on the strong M&E system used for the Sehatmandi project. This included contracting a third-party monitor to help ensure data quality.

The shortcomings in M&E design are related to the lack of information about COVID-19, and the very short project preparation phase – four days -- during the early weeks of the pandemic in March 2020. The speed of project preparation allowed inadequate time to discuss targets, and no baseline data were available, so cautious targets were set (conversation with TTL on March 8, 2023). The two PDO indicators relating to



testing and response were poorly chosen; they would have been challenging to monitor in any country, let alone under the challenging circumstances in Afghanistan. The third PDO indicator (population knowledge of COVID-19 symptoms and prevention) required a representative population survey, which was not feasible in Afghanistan. The IRIs for Component 1 also posed problems for collecting the required data. Several IRIs included in the original RF were more relevant for monitoring the main intended results of the project than the PDO indicators.

## **b. M&E Implementation**

The ICR noted that M&E implementation was carried out without issues. The MoPH signed a contract with the Sehatmandi Project third-party monitoring agency to monitor and evaluate implementation. In addition, to address concerns from the government about supplies provided by the United Nations, the World Bank mobilized the ARTF Monitoring Agent to physically verify those supplies. All planned activities were completed. The third-party monitoring arrangement helped the MoPH hold SPs and hospital managers accountable for tangible results. It also provided the World Bank and other stakeholders with an independent assessment of progress in service delivery.

The RF was adjusted at the AF/project restructuring to better report on the project's achievements, assess progress in coverage and deployment of the COVID-19 vaccine, and reflect the gender gaps the project could address. Less relevant PDO indicators were "demoted" to IRIs, and IRIs that were more relevant measures of the key objectives were "promoted" to PDO indicators. Overall, the restructuring remedied the shortcomings in the original RF.

## **c. M&E Utilization**

Data collected through the Health Management Information System were used to assess implementation progress and performance of SPs. M&E data from the third-party monitor were used to corroborate SP and United Nations performance and achievements.

## **M&E Quality Rating**

Substantial

## **10. Other Issues**

### **a. Safeguards**

The PAD did not give an Environmental Category rating, but noted the Environmental and Social Risk Classification as High.

The PAD identified the main environmental and social risks as occupational health and safety issues related to COVID-19 testing, and environmental pollution and community health and safety issues related to the handling, transportation, and disposal of healthcare waste.



The ICR noted that the Environmental and Social Management Framework and Healthcare Waste Management Plan of the Sehatmandi Project were revised as required for this project. The MoPH prepared a Stakeholder Engagement Plan. The Project Coordination Office recruited an Environmental and Social Specialist to ensure that social and environmental issues were addressed as per World Bank policies and procedures, as well as national law. No environmental or social safeguard compliance issues were identified during implementation. Safeguards monitoring (like all other implementation oversight and engagement) ended after the Taliban takeover in August 2021.

**Grievance redress:** Despite progress made in finalizing the Grievance Redress Mechanism (GRM) action plan, there was no functional GRM in place as of August 15, 2021. The MoPH and Sehatmandi Coordination Office did not have the human and monetary resources to establish a robust health sector GRM at the ministry, provincial, or health facility levels. A toll-free number for GRM was not established as of August 15, 2021.

#### b. Fiduciary Compliance

The project remained compliant with the FM legal covenants regarding submission of acceptable financial reports and annual external audit reports. The interim Unaudited Financial Reports (IUFRs) were timely and in an acceptable form throughout implementation, with the exception of the last semester IUFR, which was due on November 5, 2021 and remains overdue. Similarly, the project's first annual external audit, due on September 21, 2021, was not submitted and is overdue. The MoPH's FM staff was adequate in number and experienced in requirements of World Bank-financed projects. Books of accounts were updated on time, and supporting documents for transactions were filed properly. As of August 15, 2021, the project had disbursed the equivalent of US\$76.6 million from the only disbursing grant, IDA D5930, with a current undocumented Designated Account advance amounting to US\$6.98 million. The procurement in this phase of the project was efficient.

#### c. Unintended impacts (Positive or Negative)

None reported.

#### d. Other

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### 11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Unsatisfactory	Moderately Unsatisfactory	
Bank Performance	Satisfactory	Satisfactory	



Quality of M&E	Substantial	Substantial
Quality of ICR	---	High

## 12. Lessons

These lessons are drawn from the ICR, pp. 24-25, with some restatement by IEG.

**Contracting out health care service delivery in a country affected by Fragility, Conflict and Violence (FCV) is an effective and efficient mechanism to ensure access to quality essential health services, and the arrangement proved to be reasonably resilient to the COVID-19 pandemic.** Afghanistan has a unique health system organization, in which, since 2002, essential health services have been contracted out to international and national non-governmental organizations (NGOs). This pre-existing contracting-out arrangement proved valuable in responding to the COVID-19 emergency, including in insecure areas. The NGOs had the flexibility and independence to ensure services were delivered, expanded, and improved, even in remote areas and with the insecure situation. NGOs were able to forge alliances and agreements with local leaders and adapt to specific local situations in ways that would not have been possible if the government had provided services directly.

**In an emergency, when timeliness is of the essence, it makes sense to build on successful delivery arrangements of ongoing projects where possible.** The project used the existing (and longstanding) service delivery arrangement in the Afghan public health system to deliver a rapid COVID-19 response. Both for the initial COVID-19 response (track and trace, prevent and treat), and for the follow-on COVID-19 AF (procure and deliver vaccines), the project built on the pre-existing large-scale contracting out of public health services, and was able to adjust the contracts rapidly to incorporate COVID-19 testing, vaccines, and treatment.

**Engagement of religious leaders can help overcome vaccine hesitancy and improve coverage.** Religious leaders - especially in conservative societies - play an important role in the implementation of some sensitive health services, such as family planning and vaccination. The project relied on the influence of religious leaders to help overcome vaccination hesitancy. A Fatwa (ruling on a point of Islamic law given by a recognized authority) by religious leaders helped to improve COVID-19 vaccination coverage in Afghanistan.

**Good donor coordination is essential to align resources, avoid duplication, and ensure continuity of services despite major upheaval.** Good coordination among development partners is crucial everywhere, but especially in FCV contexts and under emergency situations. In Afghanistan, donor coordination was facilitated by the existing donor financing and coordination platforms linked through the ARTF. The World Bank team, jointly with key development partners and key implementing agencies, instituted a dedicated coordination mechanism for the COVID-19 response, including vaccine procurement and deployment. Donor coordination arrangements like these are essential for preventing fragmentation and for aligning scarce resources well.

**Good quality M&E through an independent third-party monitor can be a valuable investment.** Contracting an independent expert and impartial agency for M&E can ensure high quality, reliable



data. It can also help avoid delays in making data available. Robust M&E and an independent third-party monitor are crucial to successful performance-based contracting.

### **13. Assessment Recommended?**

No

### **14. Comments on Quality of ICR**

The ICR is concise but informative. It clearly links the narrative, ratings, and evidence on the project's results. It is candid about the difficulties faced by the project, with strong focus on results. The theory of change is clearly explained, and it aligns with the information provided about the chain of results, with good details provided on many project activities. The ratings are well substantiated. The split rating guidelines established for assessing and closing the Afghanistan portfolio are correctly followed. The lessons are thoughtful, relevant, useful, and well-articulated.

#### **a. Quality of ICR Rating**

High