IHP+ 2016 MONITORING ROUND

COUNTRY REPORT

COUNTRY	Afghanistan
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1 Process of the 2016 IHP+ Monitoring Round

Afghanistan joined IHP+ in November 2014 and is a first-time participant in the fifth IHP+ monitoring round. Data collection started in April 2016 with a stakeholder meeting organised by the Director General (DG) for Policy Planning and International Relation of the Ministry of Public Health (MOPH) supported by the national expert (NE) contracted by the IHP+Results consortium. In preparation of the meeting, the NE conducted a stakeholder mapping exercise identifying 50 civil society organisations (CSOs), 13 development partners (DPs), and 8 private sector (PS) institutions as potential participants.

Attendance at the initial stakeholder meeting was disappointing, with only four DPs, 14 CSOs, and two PS institutions attending. The NE presented the process and purpose of the IHP+ monitoring round and introduced the data collection tools. After the meeting, he worked with CSOs, DPs, PS institutions and the MOPH, assisting in the completion of the data collection forms. Stakeholder responses were slow and required frequent and intensive encouragements by the DG and the NE, supported by the Deputy Minister of the MOPH. When data collection closed in August 2016, only seven of the 13 invited DPs had provided data (two of them only partially), two PS organisations participated in a small group discussion meeting, and among CSOs, nine participated in the on-line survey and 13 in one of two focus group discussions.

Data collection tools for government and DPs were self-completed with assistance of the NE. Some participants noted that the tools were complex and difficult to complete. The fact that a large proportion of international health sector support is channelled through pooled funds such as the Afghanistan Reconstruction Trust Fund (ARTF) introduced an additional element of complexity. Disbursements of the ARTF to the health budget are no disaggregated by contributing DPs. Collecting and reporting data on humanitarian assistance to the health sector was another difficult task since several DPs administer these funds through mechanisms that do not necessarily label the disbursements by specific sectors.

2 Commitment to establish strong health sector strategies which are jointly assessed and strengthen mutual accountability

2.1 EDC Practice 1: Partners support a single national health strategy

In 2016, the MOPH initiated a participatory process to develop the national health strategy 2016-2021 involving DPs and other line Ministries. CSO representatives, however, described the process as top-down, not allowing for their full engagement. The strategy is pending finalisation and approval by the MOPH leadership.

In 2015, in preparation of the new strategy, the MOPH commissioned a review of progress achieved on the objectives of the 2011-2015 strategy. The assessment was conducted by a consultant supported by the EU who sought inputs from DPs and CSOs. Although the review was participatory, it cannot be considered a joint multi-partner assessment. There have, however, been a number of joint sub-sector and disease-specific strategy and programme assessments such as for MNCH and for EPI, sponsored jointly by the MOPH and by DPs with focus programmes on these areas. Three of seven DPs reported that at times they require separate assessments at the programme or sub-sector level, which are, however, coordinated with the MOPH. In general, all responding DPs considered their programmes to be fully aligned with the national health strategy.

2.2 EDC Practice 5: Mutual accountability is strengthened

The MOPH and DPs have not developed a multi-partner compact or partnership agreement. The MOPH organises annual reviews of the health sector, followed by a conference where the MOPH present achievements and discusses constraints. However some DPs noted that these reviews have not been conducted regularly. For the National Health Strategy 2016-2021, quarterly and annual reviews are planned. Restarting regular joint annual health sector reviews was considered by DPs as an important step towards strengthening mutual accountability.

DPs generally use their own M&E framework although some of them stated that it was aligned with government framework. Others considered the current national M&E framework to be weak, with too many indicators and poor data quality. A new national M&E plan was developed simultaneously with the development of the national health strategy 2016-2021. Indicators were selected in cooperation with the Directorate General for Evaluation and Health Information and with relevant technical departments of the MOPH. All DPs had an opportunity to include indicators of programmes they are supporting. The MOPH intends to put a concerted effort into the implementation of the M&E plan, but implementation has not yet started.

3 Commitment to improve the financing, predictability and financial management of the health sector

3.1 Practice 2a/b: Health Development Cooperation is more predictable

Budget execution by the MOPH is low and was only about 74% in 2015. A three-year rolling medium term expenditure framework is in place. Disbursements by the participating DPs to government, on the other hand, were 97% of budgeted amounts. Most of the DPs provide government with comprehensive forward looking expenditure or implementation plans that help the MOPH project the amount of expected development cooperation flow. This is done through different bilateral mechanisms between DPs and the MOPH. For humanitarian aid disbursements to the health sector, the situation is less clear. Humanitarian aid emergency plans are financed entirely by DP contributions. The MOPH does not have complete information about humanitarian aid budgets and expenditures by individual DPs.

The main constraints for better budget execution by the MOPH are low budget allocations and slow disbursements by the MOF, and the fact that DPs contribute primarily non-discretionary

funds to jointly administered health financing pools while the contributions of discretionary funds that can be disbursed through the operational budget of the MOPH is relatively low.

3.2 Practice 2c: Health Aid is on budget

A major proportion of disbursements (71%) by participating DPs are captured in the annual health budget, particularly the funds channelled through pooled funding mechanisms such as ARTF and the health sector pooled fund (SEHAT). Most DP funds channelled directly to NGOs are not recorded in the budget.

Constrains, as reported by different DPs include the limited capacity of government systems to account for resources channelled through the national budget, and lengthy processes by the MOPH and MOF for the transfer of funds.

4 Commitment to establish, use and strengthen country systems

4.1 Practice 3: PMF systems are used and strengthened

Programmes to reform and to strengthen the national public financial management (PFM) system are in place with particular focus on the provincial level. DP funds that are channelled through ARTF via the MOF are administered with the national PFM system, but DP funds that are not channelled through this pooled mechanism are generally administered using the DPs' own systems. Constraints for the use of national systems include low capacity of national institutions, low level of trust by DPs, and political instability.

4.2 Practice 4: Procurement systems are used and strengthened

There is a national procurement and supply plan and there is support by some DPs to strengthen the national procurement and supply-chain management (PSM) systems. Many of the participating DPs report harmonised procurement, especially for programmes funded through the SEHAT pooled fund which is administered by the Grants and Contracts Management Unit (GCMU) of the MOPH. Weaknesses in the government PSM systems are, however, acknowledged by some DPs and parallel systems are also used extensively.

4.3 Practice 6: Technical support is coordinated and SSC and TrC supports learning

There is no national technical assistance (TA) plan; there are no national authorities that coordinate technical assistance; the MOPH does not receive direct reports from technical assistants and does not monitor their performance. Some DPs report that they provide TA on request from the MOPH, some believe that a national TA plan for health may not be practical at this time, and that the focus should rather be on some key areas that require strengthening. Better coordination of the provision of TA support to the MOPH among DPs was also cited as a step to strengthen the alignment and coordination of technical assistance.

Afghanistan has a number of South-South Cooperation agreements with countries such as China, India, Kazakhstan and Brunei-Darussalam that are funding health sector projects. Several DPs report that they fund regional initiatives that involve country exchanges and cross-border activities, for instance with Pakistan and Tajikistan.

5 Commitment to create an enabling environment for CSO and PS to participate in health sector development cooperation

5.1 Practice 7: Engagement of CSO

CSOs are primarily engaged by the public sector in implementation and monitoring of health services. According to the MOPH, they receive timely information about service delivery issues in quarterly primary health care (BPHS) coordination meetings and in annually provincial public health directors' coordination meetings. For strategy meetings, they are notified on an ad hoc basis and when there is an issue related to health service provision. The CSOs describe their participation in health policy and strategy discussions as weak, except in some sub-sector programmes such as nutrition and MNCH where it is much stronger. Some CSOs are invited to participate in national strategy consultations based on their connections with the MOPH, but there is no formal mechanism to ensure CSO input in national health policies and strategies, and no feedback mechanism. The MOPH acknowledges the need to strengthen the collaboration with CSOs. Competition for resources among CSOs is affecting collaboration. The CSOs platforms have not been able to secure a place in the national health policy and strategy taskforces. The MOPH provides training and technical assistance to CSOs, however the CSOs that participated in the on-line survey noted that it occurs only occasionally.

DPs engage CSOs in programme development. Some of the established mechanism includes engagement in humanitarian action, the health development partners' forum, and the Country Coordinating Mechanism (CCM) of the Global Fund. One of the requirements of Global Fund support to recipient countries is engagement of CSOs in all its processes. Some of the programmes supported by DPs have steering committees with CSO membership. While they participate in different fora, the CSOs that participated in the consultations expressed the view that there are opportunities to increase their participation in other platforms. DPs should ensure that CSOs are involved in priority setting, planning, proposal development, implementation and oversight. Every opportunity under the government structure should ensure their representation. Constrains include limited capacity of CSOs. Opportunities include the contracting out mechanism that allows for inclusion of more CSOs, and the presence of international support to CSOs.

5.2 Practice 8: Engagement of the private sector

The MOPH has established a Public-Private Partnership Unit working in close coordination with the Directorate of Private Sector Coordination and with DPs to increase its engagement with the private sector. In addition to ad hoc coordination meetings, the MOPH established the PPP Steering Committee composed of relevant line Ministries, agencies and other stakeholders. Three PPP hospital projects have already been registered with the Ministry of Finance. In the past, health information from the private sector was not captured adequately in the national health management information system. Recently, the MOPH has established a committee to review this process and to strengthen the system. Engagement with the private not-for-profit sector in public service delivery is strong through contracting out mechanisms with NGOs, but there is little or no engagement with the private for-profit sector which is growing rapidly in urban areas.

The two private sector organisation that participated in the consultation felt that they were not adequately engaged in the policy dialogue with the MOPH, except in some specific reform issues affecting their profession. They felt that they did not receive timely information and feedback on their inputs. According to this consultation, many leadership positions in private sector institutions are occupied by senior government employees which affect the legitimacy of associations and private sector institutions.

DPs involve private sector institutions and professional associations in stakeholder consultations and other participatory structures related to their programmes. They provide direct funding to some professional associations, support private practitioners to provide services in remote areas, and promote and support the participation of the private sector in planning, evaluation, advocacy, technical consultation, and health fora.

Constraints to increased private sector engagement are gaps in the policy, regulatory and accountability frameworks, limited capacities in the private sector, and a mixed record of success of PPP models. Opportunities include initiatives to strengthen certification and accreditation, private sector and government collaboration to develop regulations, increased government oversight of the private sector, and promotion of corporate social responsibility. Recommendations include the establishment of more formalised structures for private sector engagement with DPs, more advocacy among large and small private sector entities, more promotion of corporate social responsibility, and capacity building of small private health service providers. Professional bodies require strengthening so they can properly represent their members, participate in health policy processes and in the accreditation of health professionals.

6 Other observations

The health sector in Afghanistan is receiving international financial and technical support through a number of mechanisms, including bilateral and multilateral development cooperation with OECD and non-OECD countries, humanitarian aid, and support provided in the context of military cooperation. Some of this support is by its nature not highly predictable, and some is channelled directly to the provincial level and therefore not fully captured by the central MOPH. While the application of Effective Development Cooperation (EDC) principles may not be completely appropriate to all channels of support, the launching of the new national health strategy 2016-2021 provides opportunities to strengthen the application of EDC principles in cooperation through the main health sector development cooperation channel.

7 Discussion of findings

The MOPH organised a validation and discussion workshop on 28th February 2017. Participants from different institutions including donor agencies, international organisations, civil society organisations, private sector institutions were invited to participate in the event (see list of participants). The overall goal of the workshop was to collectively review discuss and validate findings and determine next courses of action. The NE presented findings in relation to the effective development cooperation indicators. After the presentation, a Q and A session was organised to generate discussion among participants. Below is a summary of discussion points and questions from the Q and A session.

- The general impression was that this is a good start for Afghanistan to streamline processes in order to maximize the effective use of development aid
- It was recommended that efforts should be made to facilitate implementation of the recommendations from the fifth round monitoring process
- Recognising the fact that Afghanistan is new to the process, participants recommended focusing on the most pragmatic aspects of the process
- It was suggested that MOPH should ensure that the joint annual reviews are more inclusive involving different stakeholders in the process
- To reduce transaction cost and to improve aid effectiveness, it was suggest that MOPH take lead in harmonisation of interventions
- It was suggested that the fact that the data are only for one year should be clearly highlighted in the final country report for Afghanistan
- Participants voiced concern over low participation of stakeholders in the IHP+ monitoring round five and its implications on the representativeness of data
- For some figures, participants believed that they were over estimated. Specifically, participants referred to the figure on "aid being on budget" which was reported at 80%. Participants believed this is not the case as most of donors provide direct funding to institutions and carry out most of their activities off-budget
- The issue of discrepancy between data reported by MOPH and DPs was also raised by participants. It was suggest that while working on the next version of the report, the MOPH should ensure that there is consistency in figures reported in the final document

The Q and A session concluded with remarks from the Deputy Minister stressing on the importance of the process and implementation of recommendations outlined in the final country report for Afghanistan. It was suggested that, while the team work to incorporate comments and inputs provided from the participants, they should ensure that limitations of the process is highlighted in the final report for Afghanistan. An action plan was not developed at the meeting.

Next Steps

The NE will meet with GD policy and plan early next week to discuss the way forward. A summary of the next steps in the process will be shared with International Expert and IHP+ Consortium

9 Annex 1: List of DPs that were invited and those that participated

Nr	List of DPs active in the health sector	DPs invited to participate in 5th IHP+ Monitoring Round	DPs that participated
1	USA	X	X
2	Canada	X	X
3	EU	X	X
4	World Bank	X	
5	Japan	X	
6	UNICEF	X	X
7	WHO	X	X
8	Australia	X	
9	India		
10	Global Fund	X	X
11	GAVI	X	X
12	UNFPA	X	
13	Germany	X	

10 Annex 2: CSO and PS participation

	Number identified as potential stakeholders	Number of CSOs that participated in online survey	Number that participated in focus group discussion
CSOs	**50**	**9**	**13**
PS	**8**	**--**	**2**

11 Annex 3: Participants at final workshop

1	Dr. Ahmad Jan Naeem	Deputy Minister	MOPH	Gov
2	Dr. M. Bashir Noomal	GD APHI	MOPH	Gov
3	Dr. Abdul Qader	GD Policy and Plan	MOPH	Gov
4	Dr. M. Daud Azimi	GD Human Resources	MOPH	Gov
5	Dr. Mir Islam Sayed	Head GCMU	MOPH	Gov
6	Dr. Najla Ahrari	Deputy HSS	MOPH	Gov
7	Dr. Nezmuddin Jalil	RH Coordinator	MOPH	Gov
8	Dr. Omer Atefi	Planning Advisor	MOPH	Gov
9	Dr. Dostyar Dost	Senior Advisor P&P	MOPH	Gov

10	Dr. Abdullah Noorzai	Advisor	MOPH	Gov
11	Dr. Sahak	Leadership Manger	MOPH	Gov
12	Dr. Ajmal Perdis	Advisor	MOPH	Gov
13	Dr. Sharmina	Health Specialist	UNICEF	DP
14	Dr. Husnia Sadat	Project Manager	USAID	DP
15	Dr. Khalid Sharifi	PME Specialist	UNFPA	DP
16	Dr. Sefatullah Habib	Program Manager	EU	DP
17	Dr. Zaheer	Program Manager	EU	DP
18	Dr. Omerzaman Sayedi	Deputy Chief of Party	Palladium Group	INGO
19	Abdul Ahad		HSR/Palladium Group	INGO
20	Dr. Mohammad Anwar	Head of Health Program	Care International	INGO
21	Dr.Khalil Mohmand	General Director	SHDP	LNGO
22	Dr. Ab. Nasir	HMIS Coordinator	BARAN	LNGO
23	Dr. Saber Perdes	Technical Advisor	HSR	INGO