Annual Progress Report 2007

Submitted by

The Government of
Islamic Republic of Afghanistan

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(to be accompanied with Excel sheet as prescribed)

Please return a signed copy of the document to:
GAVI Alliance Secretariat; c/o UNICEF, Palais des Nations, 1211 Geneva 10, Switzerland.

Enquiries to: Dr Raj Kumar, rajkumar@gavialliance.org or representatives of a GAVI partner agency. All documents and attachments must be in English or French, preferably in electronic form. These can be shared with GAVI partners, collaborators and general public.

This report reports on activities in 2007, specifically Afghan fiscal year 1386, equivalent to-21 March 2007--20 March 2008, and specifies requests for January – December 2009

Signatures Page for ISS, INS and NVS

For the Government of the Islamic Republic of Afghanistan

Ministry of Public Health:
Dr. Agha Gul Dost
Title: National EPI Manager

Signature: ……

Date: ……

Ministry of Finance:
Mr. Saied Alam Khan
Title: MoF Focal point for MoPH

Signature: ……

Date: ……

We, the undersigned members of the Inter-Agency Co-ordinating Committee endorse this report, including the attached excelsheet. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Financial accountability forms an integral part of GAVI Alliance monitoring of reporting of country performance. It is based on the regular government audit requirements as detailed in the Banking form.

The ICC Members confirm that the funds received from the GAVI Funding Entity have been audited and accounted for according to standard government or partner requirements.

Name/Title	Agency/Organisation	Signature	Date
Dr. F. Kakar, Deputy Minister Technical	MoPH		
Dr. Ahmad Jan, Director of GCMU	MoPH		
Dr. Shokomand, Director of Provincial Health	MoPH		
Dr. A.G. Dost, National EPI Manager	MoPH		
Dr. Mashal Toufiq, Senior Consultant, HSS/CSO/EPI	MoPH		
Dr. Roqia, National Monitoring & Evaluation Officer	MoPH		
Dr. A. Wali, HSS Coordinator	MoPH		
Mr. Abed, National VPD surveillance Officer	MoPH		
Dr. G.K. Ayoob, National EPI communication officer	MoPH		
Dr. Faiz Mohamad, Health Advisor	USAID		
	EC		
	WB		
Dr. Mushfiq, EPI coordinator	SCA		
	Ibn Sina		
	AHDS		
Dr. Rafiqi, Program manager, Health/EPI	UNICEF		
Dr. A. Shakoor, NEPI Officer/GAVI advisor	WHO		
Dr. Rana Kakar, Technical Officer, EPI/DEWS	WHO		

Signatures Page for HSS

For the Government of Afghanistan

Ministry of Health:
Dr. Faizullah Kakar
Title: Deputy Minister for technical affairs

Signature: ……

Date: ……

Ministry of Finance:
Wahidullah Shahrani
Title: Deputy Minister of Finance

Signature: ……

Date: ……

We, the undersigned members of the National Health Sector Coordinating Committee, Consultative Group on Health and Nutrition (CGHN) endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Financial accountability forms an integral part of GAVI Alliance monitoring of reporting of country performance. It is based on the regular government audit requirements as detailed in the Banking form.

The CGHN Members confirm that the funds received from the GAVI Funding Entity will be audited and accounted for according to standard government or partner requirements.

Please see the attached list. (signature pages)

Progress Report Form: Table of Contents

Text boxes supplied in this report are meant only to be used as guides. Please feel free to add text beyond the space provided.

1. Report on progress made during 2007 (1386- Afghan fiscal calendar – 20 March 2007 – 21 March 2008)

1.1 Immunization Services Support (ISS)

Are the funds received for ISS on-budget (reflected in Ministry of Health and Ministry of Finance budget): Yes/No **Yes**

If yes, please explain in detail how it is reflected as MoH budget in the box below.
If not, explain why not and whether there is an intention to get them on-budget in the near future?

Ministry of Finance of Afghanistan allocated a total amount of US$ 130 million for health and nutrition from the "core" budget, US$ 27.6 million operating budget and US$ 102.6 million development budget. This is about 4.48% of the total National Budget for the fiscal year of 1386 (20 March 2007 to 21 March 2008).

The GAVI /Vaccine Fund Support is reflected as part of the government "core" budget which includes allocations from the Government revenues and grants routed through Ministry of Finance.

The GAVI/ Vaccine Fund Support is also reflected in the National Development Budget of Afghanistan, 2008-2013, as part of the allocations for the Ministry of Public Health.

The GAVI/ Vaccine Fund Support is detailed in the revised MoPH comprehensive Multi-Year Plan (2007-2010) for immunization program.

1.1.1 Management of ISS Funds

Please describe the mechanism for management of ISS funds, including the role of the Inter-Agency Co-ordinating Committee (ICC).
Please report on any problems that have been encountered involving the use of those funds, such as delay in availability for programme use.

MoPH provides guidelines for utilization and management of government grants for delivery of health care services including EPI following the mechanism of "activity-based disbursement." The overall management of GAVI support fund is done according to the approved MoPH procedures for disbursement of foreign grants to the Ministry of Public Health that was developed by Grants and Contracts Management Unit (GCMU) of MoPH. This document clarifies the role and responsibilities of National EPI office and regional and provincial EPI Management Teams in modalities for disbursement and use of GAVI funds and was approved by ICC.

The required fund is used by national EPI office only for the purpose of implementation of the plan of action approved by ICC. The EPI Task Force in MoPH, comprised of the National EPI Manager, UNICEF senior EPI advisor, two major NGO representatives, WHO Technical Officer, and WHO National GAVI Advisor support the national EPI office in the proper planning and management of the GAVI fund. National EPI develops the national plan of action, with clear timeframe and required budget line for each activity, and presents it to ICC for endorsement. The endorsed plan is sent to GAVI secretariat and also to the relevant departments of MoPH and to the concerned partners.

The national action plan includes the provincial action plans that are developed by provincial health coordination committees (PHCC). National EPI office communicates the final provincial plans to the provinces and starts processing the release of fund according to the activity time schedule, preparing request for fund release. The request is submitted to the Minister/Deputy Minister office through General Directorate of Preventive Medicine & PHC for approval. The approved request is then officially sent to General Directorate of Administration and GCMU for further process of fund disbursement.

Transfer of funds to the provinces is done either through the bank or private money dealers. National EPI office is responsible to immediately inform Provincial Health Directorate/ PEMT by email, mobile phone or any other means about the transfer of cash and specification of the representative of contracted money dealer in the province.

All documentation in connection with the above transaction is attached to the files for financial auditing and liquidation of accounts. All payments and purchases are done according to the activity plan using standard formats and following official procedures. Copies of the documents (stipend role, receipts etc) signed by PEMT/REMT managers and Provincial Health Directors are sent with budget expenditure summary sheet to national EPI office. Copies of all such documents are kept at PEMT level for the purpose of auditing as well. All payment documents and vouchers are reviewed and rechecked and are sent to GCMU for further actions.

Financial statement is completed on quarterly basis and released to GAVI secretariat. National EPI office briefs ICC on progress of implementation of plan of action and use of GAVI support fund at least twice a year. Ministry of Finance conducts internal audit every six months. GAVI auditors are always welcomed to conduct external auditing of the program and quality assurance or as a separate operation mounted by the GAVI Secretariat.

Problems
Prolonged procedures in both MoPH and MoF may cause delay in releasing GAVI vaccine fund support and implementation of the plan of action. This problem exists with all government programs and is overcome by attention to the procedures and taking timely action.

Some of the health centres are run by MoPH outside of the contracting NGOs for BPHS implementation, and the salary paid by the Government for the vaccinators at these health centres does not meet the immediate needs of the health workers and their families. Therefore, a small number of vaccinators are receiving incentive from the GAVI fund in addition to their monthly salaries paid by MoPH.

1.1.2 Use of Immunization Services Support

*In 2007(1386), the following major areas of activities have been funded with the GAVI Alliance **Immunization Services Support** contribution:*

Remaining funds (carry over) from 2006 (1385): **USD 3,086,518**
ISS Reward 2 (2004) received 26 Sept 2007: **USD 2,850,620***
ISS Reward 3 (2005) received 2 March 2008: **USD 2,677,500****
Spent in 2007(1386): **USD 1,284,588**
Balance to be carried over to 2008 (1387): **USD 7,330,000*****

Table 1: Use of funds during 2007(1386): (All the APR-related information including financial expenditures are based on Afghan fiscal Year 1386 that covers the period 21 March 2007 – 20 March 2008)

Area of Immunization Services Support	Total amount in US $	AMOUNT OF FUNDS			
		PUBLIC SECTOR			PRIVATE SECTOR & Other
		Central	Region/State/Province	District	
Vaccines	0	0	0	0	
Injection supplies	0	0	0	0	
Personnel	81,480	31,498	13,630	36,352	
Transportation	54,525	4,543	19,863	30,119	
Maintenance and overheads	19,726	3,287	5,219	11,220	
Training	202,161	0	19,827	182,334	
IEC / social mobilization	27,099	2,478	11,621	13,000	
Outreach	184,758	0	41,258	143,500	
Supervision	34,113	4,300	7,500	22,313	
Monitoring and evaluation	10,800	10,800	0	0	
Epidemiological surveillance	63,442	0	5,200	58,242	
Vehicles, fuel	54,530	4,100	9,800	40,630	
Cold chain equipment	516,836	16,836	500,000	0	
Other: Policy and Management	35,118	35,118	0	0	
Total:	1,284,588	112,960	633,918	537,710	
Remaining funds for next year:	7,330,000				

*The actual amount transferred to MoF (based on bank statement) under ISS reward 2 in Sept 2007 is US$ 2,850,595 with deduction of US$ 25 for transferring of money.
**The actual amount transferred to MoF (based on bank statement) under ISS reward 3 in March 2008 is US$ 2,677,475 with deduction of US$ 25 for transferring of money.
***Balance to be carried over to 1387 is high (USD 7,330,000) due to the ICC approved spending of GAVI funds and rewards at the rate of about $1.5 million per year over a five-year period to ensure continued expansion of the program, even if there is no reward for one year.

Please attach the minutes of the ICC meeting(s) when the allocation and utilization of funds were discussed.

Please report on major activities conducted to strengthen immunization, as well as problems encountered in relation to implementing your multi-year plan.

1. Management and coordination

- As the second country in EMRO, Afghanistan national cold store for vaccines was certified internationally by WHO/UNICEF and received the Certificate in a ceremony in January 2008, bearing testimony to efforts of National EPI toward an efficient vaccine management program. The credit was conferred following WHO assessment missions in 2004 and 2007 to improve the Primary Store's management mechanism as well as the storage and distribution of vaccines, starting from the point where the responsibilities for the vaccines are formally handed over to the program by the vaccine supplier. Improvements included provision of 24 hour electricity, installation of automatic temperature monitors and installation and training on use of new software for vaccine management.
- Conducted quarterly regional and bi-annually national **EPI Review** meetings with purpose of understanding achievements, needs, constraints, problems, prioritization, re-scheduling of action plans, prioritization of the problems and finding adequate solutions together with all partners.
- Coordinated all EPI-related activities through **EPI Task Force** Committee Meetings including preparation and updating of annual action plan, policy revision, GAVI ISS and NVS applications, and effective liaison with GAVI HSS and CSO support for increasing immunization coverage.
- Provided **regular feedback** to health partners in various forums: Consultative Group on Health and Nutrition (CGHN), National NGO Technical Coordination Committee (NTCC), Quarterly Meeting of Provincial Health Directors, and Provincial Health Coordination Committees (PHCC).
- Conducted **EPI Summit** to discuss with health partners regarding Increasing Immunization Coverage. Initiated micro-planning exercise through comprehensive central, regional, provincial and district workshops. Compilation of micro-plans and coverage of gaps to be discussed at March 2008 EPI Reviews.
- Revised costing of comprehensive Multi-Year Plan **(cMYP)** based on new MoPH policy/strategy and considering the introduction of Pentavalent-Hib vaccine in 2009.
- Revised National Immunization **policy** regarding multi-dose vials, initial training of vaccinators, coordination with private sector and other issues, and getting approval of ICC for implementation.
- Conducted three **ICC** meetings covering all aspects of GAVI Vaccine Fund Support and many other aspects of immunization program

2. Service Delivery

- Provided immunization services through 1200 health facilities including outreach and mobile activities. Despite the security problems and geographical constraints, population access to health care services is improving through NGOs contracted by MOPH to deliver health services. Still to improve EPI coverage, more effort is needed to assure appropriate outreach from all health facilities.
- The national DPT-Hep B 3 coverage has increased from 77% (off. est.) in 2006 to 83% in 2007, measles coverage from 68% in 2006 to 70% in 2007, and TT2+ from 54% in 2006 to 60% and the drop-out rate between DPT-HepB1- DPT-HepB3 was reduced from 13% (off.est.) in 2006 to 10% in 2007.
- Conducted sustainable outreach in 13 provinces with low immunization coverage
- Conducted 4 rounds of country-wide NIDs and 6 rounds of SNIDs for polio eradication
- Conducted last phase of MMRC and MNTE supplementary immunization activity in May 2007 in 12 provinces.

3. Capacity building:

- Adoption, translation, printing and using guidelines on Increasing immunization coverage, EPI manual, MMRC&MNTE Guidelines, Reach Every District / Reach Every Child (RED) strategy at health facilities and districts, and Measles case-based surveillance.
- Recruitment and training (TOT) of 16 (100%) regional trainers and supervisors for improving knowledge and skills of immunization health workers by conducting regular supportive supervision and on job training.
- Training of 60 (100%) cold chain managers/ technicians for management of cold chain system using SOPs.
- Training (TOT) of 86 (100 %) trainers for last phase (12 provinces) of MMRC and MNTE SIA and 21,860 (100%) campaign workers, including district health coordinators, cluster supervisors and more than 5000 teams of four members each.
- Conducting refresher training courses for 406 (31%) immunization health workers including safety of immunization injections, safe waste disposal and detecting and reporting of AEFI.
- Training of 4 National EPI staff on VPD surveillance in Lahore, PK; training of 60 (100%) trainers (TOT)

and 476 (68%) focal points/ heads of health facilities on Measles case-based surveillance, NNT and AEFI surveillance.
- Training of 37 (50%) (MoPH) EPI managers/supervisors on strengthening EPI management system.
- Training (TOT) of 181 (100%) regional and provincial EPI managers (NEPI – 74), NGO EPI supervisors (81) and NEPI trainers (16) for preparation of health facility/district micro-plans for improving immunization coverage by each health facility/district,identification of gaps and preparing plans for covering those areas.

4. VPD Surveillance and data management:

- Continuation of integrated AFP/Measles/NNT surveillance including Disease Early Warning System (DEWS) with detection of 17 confirmed polio cases, 139 measles confirmed cases and 40 NNT cases.
- Development of new Guideline for integrated case-based measles surveillance
- Conducting investigation and response measures for control of measles and pertussis outbreaks through joint teams of DEWS, REMT/PEMT and AFP surveillance officers
- Initiation of meningitis and rotavirus surveillance through 6 major hospitals and training 60 doctors and lab technicians

5. Communication

- Conducted a training workshop on developing Communication Plan for increasing community awareness on the importance of polio eradication program and simultaneously giving messages on routine EPI
- Production of Radio/TV spots and broadcasting on national and local Radio and TV and implementing a focused strategy to train and activate mullahs, teachers, elders and CHWs as social mobilizers for polio eradication.

6. Expansion of national, regional and provincial cold store capacity

- Cold chain analysis and purchase order was made for 10 cold rooms, 40 Ice lined refrigerators and 45 Ice pack freezers, in February 2008, for adequate accommodation of single dose vials of Pentavalent (DPT-HepB-Hib) vaccine. The fund from GAVI/ISS was transferred from MoF to UNICEF for the purchase.
- Approval of ICC for purchasing of 300 RCW50EG refrigerators so that National EPI will support the cold chain even at the health facility level in view of the barriers faced by the NGO BPHS implementers to obtain standard cold chain.
- Received City power for National cold store
- Provided computer & Installed software for National cold store by UNICEF
- Procurement computers equipment for seven regions and installed in four region.
- Constructed National warehouse; furnished and equipped National training center
- Following cold chain equipment was provided by UNICEF: 7 deep freezers, 7 Ice pack freezers; 7 Icelined freezers, 239 RCW50 Refrigerators, 40,000 Ice packs, 1000 thermometers, 4000 Vaccine carriers, 200 Cold boxes
- 11,184 small vaccine carriers donated by Rotary International
- Provided 10 laptop computers for database at REMTs from GAVI fund

7. Supervision and monitoring

- Conducted supervision and monitoring of immunization services by all level of EPI health management and based on monthly action plans and provision of feedback for action

Problems:

- Shortage of trained immunization health workers especially in rural and remote areas of the country
- Shortage of transport means for timely monitoring and supervision
- Discrepancy between different sources of population data: the government's Central Statistic Office (CSO) data seems to be underestimated and the data derived from NIDs is overestimated. The UNIDATA population figure, used by NEPI as the closest to information received from the field, is based on a population census carried out in 1979 and updated annually by an estimated population growth rate. This is a challenging factor in planning, implementation, monitoring and evaluation of the immunization program. The country is planning a census in 2008 and some of GAVI-HSS funds are planned for an ongoing demographic survey at sentinel sites.
- Shortage of cold chain equipment (mainly refrigerators) at service level due to failure of NGO BPHS implementers to find/purchase standard equipment and lapse of maintenance from prolonged use, unavailability of spare parts and skilled technicians.
- NIDs Post Campaign Assessment (PCA) shows that, in spite of training, polio volunteers consistently forget to give messages about routine EPI.

1.1.3 Immunization Data Quality Audit (DQA)

Next* DQA scheduled for : **2008**

**If no DQA has been passed, when will the DQA be conducted?*
**If the DQA has been passed, the next DQA will be in the 5th year after the passed DQA*
**If no DQA has been conducted, when will the first DQA be conducted?*

What were the major recommendations of the DQA? Has a plan of action to improve the reporting system based on the recommendations from the DQA been prepared? YES
If yes, please report on the degree of its implementation and attach the plan.

The DQA was conducted and passed in September 2003.
A plan of action was prepared and all the recommendations, regarding translation and distribution of standard guidelines and formats, computerization of the data collection system, training of all levels, and recruiting monitoring and surveillance officers, have been implemented.

Afghanistan is looking forward to a DQA this year = 2008. We have planned to conduct DQA with the support of two international and two national staff during June or July 2008.

Please highlight in which ICC meeting the plan of action for the DQA was discussed and endorsed by the ICC.

The decision on conducting DQA in 2008 was proposed to the ICC meeting held on 27th September 2007 and approved by ICC.

Please report on studies conducted regarding EPI issues during 2007 (for example, coverage surveys).

Comparison of Different Household Survey Results

Survey	*2003 MICS*	*2005 NRVA*	*2006 Afghan Household Survey AHS*
Antigens	*Rural Median**	*Rural Mean***	*Rural Mean****
BCG estimate (%)	*56.5*	*58.8*	*70.2*
Measles estimate (%)	*75.6*	*52.8*	*62.6*
OPV3 estimate (%)	*29.9*	*49.2*	*69.7*
Vit A estimate (%)	*90.3*	*44.8*	*79.5*
DPT3 estimate (%)	*19.5*	*16.7*	*34.6*
Full immunized estimate (%)	*15.5*	*11.2*	*27.1*

***Note**:* **2006 Afghan Household Survey conducted by Johns Hopkins University Bloomberg School of Public Health for MoPH at end of 2006, was analyzed and officially reported in mid-2007, reflecting on EPI coverage of 2005. DPT3 coverage of 35% is highly debated at MoPH due to questionnaire bias against it and large difference from OPV3 and Measles coverage.**

EPI Coverage Survey is planned for 2008.

1.1.4. ICC meetings

How many times did the ICC meet in 2007 (1386)? ***Please attach all minutes.***
Are any Civil Society Organizations members of the ICC and if yes, which ones?

Three ICC meetings were held during 2007 and two so far in 2008, relevant to 1386: (minutes are attached).
8 Mar 2007, 15 Apr 2007, 27 Sep 2007
6 Feb 2008, 1 Apr 2008

The NGOs Swedish Committee for Afghanistan (SCA), Afghan Health and Development Services (AHDS), Ibne Sina, and Management Sciences for Health (MSH)-Tech Serve are members of ICC.

1.2. GAVI Alliance New & Under-used Vaccines Support (NVS)

1.2.1. Receipt of new and under-used vaccines during 2007

When was the new and under-used vaccine introduced? Please include change in doses per vial and change in presentation, (e.g. DTP + HepB mono to DTP-HepB) and dates shipment were received in 2007.

The DPT-Hep B (tetravalent) vaccine was introduced from July to November of 2006, in phases.

Vaccine	Vials size	Doses	Supplier	Date shipment received (2007)
DPT-HepB	10 doses per vial	2,446,000	Belgium	06/03/07
DPT-HepB	10 doses per vial	2,445,500	India	23/09/07

Please report on any problems encountered.

No problems in receipt or distribution of vaccine.

1.2.2. Major activities

Please outline major activities that have been or will be undertaken, in relation to, introduction, phasing-in, service strengthening, etc. and report on problems encountered.

Immunization coverage is hampered by insecurity, geographic barriers, cold weather and unclear demarcation of responsibilities. EPI Review in mid-2007 shared problems with NGOs and Provincial teams. Guidelines and training on district micro-planning were disseminated. Further efforts are on-going to fill gaps in service delivery. GAVI HSS, WB, EC and USAID are supporting sub-centers and mobile units to increase immunization coverage in less accessible areas. GAVI CSO will pilot private sector provision of EPI in two insecure, remote areas.

1.2.3. Use of GAVI funding entity support for the introduction of the new vaccine

These funds were **received and reported on in 2006.**

Please report on the proportion of introduction grant used, activities undertaken, and problems encountered such as delay in availability of funds for programme use.

Note: Funds are expected in 2008 for activities toward the introduction of the DTP-HepB-Hib vaccine in 2009. These will be reported in next year's Annual Progress Report.

1.2.4. Effective Vaccine Store Management/Vaccine Management Assessment

The last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) was conducted in : 2007

Please summarize the major recommendations from the EVSM/VMA

EVSM/VMA concluded that in general, the central vaccine store is very well managed. Average EVSM score in this follow up assessment was 89 percent.

Staff members are highly motivated. This motivation should be supported with training. Participation in the Global Training Network (GTN) Vaccine Management Training Courses should be arranged for the cold chain technicians. Store manager may also attend these courses as a resource person.

The store is appropriately equipped and maintained. There are no vaccine losses due to poor handling, freezing or heat exposure. The areas for improvement are as follows:

1. Logistics system should be revised at all levels. Appropriate minimum and maximum stock levels and distribution periods should be set.
2. Vaccine forecasting should be inline with the current EPI guidelines. Forecasts should be compared with the actual consumption to calculate forecasting accuracy.
3. There should be a lot release certificate from the country of origin for each and every vaccine batches.
4. Temperature of vaccine packing area should be kept between 15-25^{O}C during operations.
5. A contingency action plan should be developed and implemented to respond to emergencies.
6. Shelves for ice pack conditioning should be installed in the room where cold rooms and freezer room are located. It should be noted that 1m^2 surface is required for conditioning of approximately 25 ice packs. Shelves should be 75cm above the floor level.
7. Audible temperature alarms should be installed to all cold chain equipment

Was an action plan prepared following the EVSM/VMA: Yes/No **Yes**
If so, please summarize main activities under the EVSM plan and the activities to address the recommendations.

A data-base was developed and is in use at national and regional levels and is planned to be used at provincial levels for adequate management of vaccines and supplies. The storage volume calculation including Hib vaccines was done by an expert from EMRO. The vaccine forecasting is based on population figures given by UNIDATA. UNICEF provides vaccine product information at least three days before the arrival of vaccines and the VARs are usually sent to UNICEF within 24 hours.

Additional shelves and ILRs are installed to accommodate all routine vaccines including OPV for NIDs. A multi channel temperature recorder is provided by UNICEF. The AC/heaters are installed to keep the vaccine packing area within the required range. The audible temperature alarms are installed. The National cold room is now connected with regular city power supply with generator back-up.

All the recommendations made by EMRO and WHO HQ were met and the Afghanistan National Cold Store was internationally certified.

The next EVSM/VMA* will be conducted in: 2010 – relevant to proposed introduction of pentavalent vaccine in 2009.

**All countries will need to conduct an EVSM/VMA in the second year of new vaccine support approved under GAVI Phase 2.*

1.3 Injection Safety

1.3.1 Receipt of injection safety support

Received in cash/kind: Nil

Note: The GAVI injection safety support for Afghanistan was ended in 2006.

Please report on receipt of injection safety support provided by the GAVI Alliance during 2007 (add rows as applicable).

Injection Safety Material	Quantity	Date received

Please report on any problems encountered.

1.3.2. Progress of transition plan for safe injections and management of sharps waste.

If support has ended, please report how injection safety supplies are funded.

Injection safety and AEFI are included in all refresher training courses for vaccinators. UNICEF continues providing AD syringes, injection supplies and safety boxes as part of the concept of "bundled" vaccines. The following were received from UNICEF last year:
AD syringes 0.5ml for TT, DPT-HepB, Measles vaccines – 20,744,000 units
BCG syringes – 1,557,000 units, Safety boxes – 281,500.
Injection safety supplies for non-vaccine injections are provided in the Basic Package of Health Services (BPHS) at public health facilities supported by MoPH through contracting out to NGOs.

Please report how sharps waste is being disposed of.

MoPH requires and monitors all health facilities providing BPHS to

- Use safety boxes at all service levels.
- Incinerate all sharps waste or bury it in places where there are no incinerators.

According to the 2007 third-party assessment of BPHS health facilities called the Balanced Score Card, 84% of health facilities implemented "proper sharps disposal."

Please report problems encountered during the implementation of the transitional plan for safe injection and sharps waste.

Nil

1.3.3. Statement on use of GAVI Alliance injection safety support in 2007 (if received in the form of a cash contribution)

The following major areas of activities have been funded (specify the amount) with the GAVI Alliance injection safety support in the past year:

NA

2. Vaccine Co-financing, Immunization Financing and Financial Sustainability

Table 2.1: Overall Expenditures and Financing for Immunization

The purpose of Table 2.1 is to help GAVI understand broad trends in immunization program expenditures and financing flows. In place of Table 2.1 an updated cMYP, updated for the reporting year would be sufficient.

Note: This table is taken from the Pentavalent Scenario of the revised GAVI-NVS application submitted along with the updated cMYP in February 2008.

Expenditures & Financing	2006	2007	2008	2009	2010
	Actual*	Actual*	Planned	Planned	Planned
Expenditures by Category					
Vaccines	$5,261,406	$8,208,047	$5,942,088	$19,311,811	$15,455,487
Injection supplies	$666,194	$1,528,354	$1,595,818	$1,661,180	$1,708,664
Cold Chain equipment	$242,000	$818,550	$1,655,963	$454,197	$456,094
Vehicles	$0	$30,909	$236,455	$289,420	$262,408
Personnel	$4,354,388	$4,570,057	$4,796,711	$4,985,259	$5,179,431
Other operational expenditures (Transportation, maintenance, training, IEC, surveillance, program management, other capital equipment, shared costs and routine recurrent cost)	$4,095,726	$4,735,695	$6,858,697	$6,711,698	$7,344,958
Others (campaign operational costs including vaccines)	$21,311,892	$23,051,444	$18,834,270	$29,119,124	$19,800,223
Total Immunization Expenditures	**$35,931,606**	**$42,943,056**	**$39,920,002**	**$62,532,689**	**$50,207,265**
Financing by Source (secure plus probable)					
Government	$1,652,417	$1,930,574	$2,091,657	$2,212,157	$2,204,122
GAVI	$4,603,809	$6,294,090	$6,041,068	$18,717,346	$14,506,641
WHO	$5,678,969	$4,143,122	$4,440,753	$6,558,112	$4,864,232
UNICEF	$12,617,890	$19,789,897	$16,608,803	$21,641,576	$17,104,925
World Bank, EC, USAID, etc (grant)	$11,378,521	$10,785,375	$9,993,163	$12,590,275	$10,546,947
Total Financing	**$35,931,606**	**$42,943,056**	**$39,175,444**	**$61,719,465**	**$49,226,867**
Total Expenditure	**$35,931,606**	**$42,943,056**	**$39,920,002**	**$62,532,689**	**$50,207,265**
Total Financing	**$35,931,606**	**$42,943,056**	**$39,175,444**	**$61,719,465**	**$49,226,867**
Total Funding Gaps	**na**	**na**	**$744,559**	**$813,224**	**$980,399**

*****While the figures are close to "actual" for 2007, they are estimates in two cases: (1) Afghan fiscal year closes 20 March 2008, for year 1386, so not all the expenditures are cleared at the time of submission of this report. (2) NGO BPHS implementers' contribution is estimated because it is spread over about 5 donors, 20 NGOs and 40 contracts and is not assigned a separate budget line in most of the contracts.

Please describe trends in immunization expenditures and financing for the reporting year, such as differences between planned versus actual expenditures, financing and gaps. Give details on the reasons for the reported trends and describe the financial sustainability prospects for the immunization program over the coming three years; whether the funding gaps are manageable, a challenge, or alarming. If either of the latter two, explain what strategies are being pursued to address the gaps and what are the sources of the gaps —growing expenditures in certain budget lines, loss of sources of funding, a combination…

Trends in immunization expenditures and financing for the reporting year:
Differences between planned versus actual expenditures:
In year 1386, NIP planned to spend $ 1,538,856 but actually spent $ 1,284, 588 (83% implementation rate). About $500,000 was moved from other budget lines to purchase needed cold chain equipment in preparation for introduction of pentavalent in 2009. GAVI rewards from 2004-2005 were distributed to Afghanistan this year and the amount carried over is now $7,330,000.

Financial sustainability prospects for the immunization program over the coming three years;
Considering the "secure" as well as "probable" funds, there is a funding gap of US$ 2.538 million during the plan period - US$ 744,561, US$ 813,224 and US$ 980,397 is anticipated during 2008, 2009 and 2010 respectively – only about 2% of the budget for the mentioned period, and appears to be manageable.

Despite the fragile economic situation in Afghanistan, the GoA contributed at least 8% of the routine immunization cost in 2006 and 2007. With high political commitment to EPI and its inclusion in the Basic Package of Health Services, it is expected that Health Sector Partners will continue contributing towards this cause. Without internal sources of funding at present, EPI will rely on external funding for the near future. However, as GoA rehabilitates its infrastructure and increases its capacity for resource generation, it is expected that it will not only maintain the baseline, but will gradually increase its contribution towards immunization and work toward sustainability of the EPI Program.

Strategies being pursued to improve financial sustainability:
ICC has approved an action plan and monitoring framework to pursue the following strategies for improving financial sustainability:

- Improve mobilization of resources from government, donors and private sector for immunization
- Increase reliability of resources through budgeting and reporting
- Increase efficiency of the resources by promoting integration and maximizing efficiency of immunization and reducing vaccine wastage.

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Table 2.2: Country Co-Financing (in US$)

Table 2.2 is designed to help understand country level co-financing of GAVI awarded vaccines. If your country has been awarded more than one new vaccine please complete a separate table for each new vaccine being co-financed.

For 1st GAVI awarded vaccine w/ co-financing. Please specify which vaccine (**DTP-HepB-Hib**)	**2007**	**2007**	**2008**	**2009**
	Actual	Planned	Planned	Planned
Co-financing amount (in US$ per dose)	X	X	X	$0.10
Government	X	X	X	$0.10
Other sources (please specify)	X	X	X	$0.00
Total Co-Financing (US$ per dose)	X	X	X	$0.10

Please describe and explain the past and future trends in co-financing levels for the 1st GAVI awarded vaccine.

Government of Afghanistan (GoA) as a fragile country has committed to co-finance for DPT-HepB-Hib vaccine from 2009 onward. GOA would co-finance pentavalent vaccine and supplies at a rate of US $ 0.10 per dose, so if GAVI approves the application for Pentavalent, the GoAs contribution would be $448,000 in 2009 and $383,500 in 2010. The contribution is higher in 2009 than 2010 due to the planned initial purchase of buffer stock.

Table 2.3: Country Co-Financing (in US$)
The purpose of Table 2.3 is to understand the country-level processes related to integration of co-financing requirements into national planning and budgeting.

Q. 1: What mechanisms are currently used by the Ministry of Health in your country for procuring EPI vaccines?			
	Tick for Yes	List Relevant Vaccines	Sources of Funds
Government Procurement- International Competitive Bidding			
Government Procurement- Other			
Government Procurement through UNICEF	✓	DPT-HepB, BCG, Measles, TT, OPV	GAVI, UNICEF, Government and other donors
PAHO Revolving Fund			
Donations (WHO, UNICEF, GOV, other)			
Other (donations or private sector)			

Q. 2: How have the proposed payment schedules and actual schedules differed in the reporting year?		
Schedule of Co-Financing Payments	Proposed Payment Schedule	Date of Actual Payments Made in 2007
	(month/year)	(day/month)
1st Awarded Vaccine (specify)	na	na
2nd Awarded Vaccine (specify)	na	na
3rd Awarded Vaccine (specify)	na	na

Q. 3: Have the co-financing requirements been incorporated into the following national planning and budgeting systems?	
(Regarding co-financing for introduction of pentavalent in 2009.)	
	Enter Yes or N/A if not applicable
Budget line item for vaccine purchasing	Yes
National health sector plan	Yes
National health budget	Yes
Medium-term expenditure framework	Yes
SWAp	NA
cMYP Cost & Financing Analysis	Yes
Annual immunization plan	Yes
Other	

Q. 4: What factors have slowed and/or hindered mobilization of resources for vaccine co-financing?

As mentioned, the Government co-financing will start in 2009 for DPT-HepB-Hib vaccine. There was not any serious factor from MoF side for co-financing as the application for pentavalent was reviewed and signed by high level authority of MoF and MoPH.

The factors such as preparation of annual MoPH plan and approval by parliament and prolonged administrative procedures in both MoPH and MoF for releasing fund can slow the implementation of the program.

Due to differences in Afghan Fiscal Year and Roman Calendar, it should be noted that the Government of Afghanistan had accepted to start co-financing in 1388 (21 March 2009 to 20 March 2010). As the first purchase of Pentavalent vaccine will take place, if application to GAVI is approved, in 2008 (Afghan FY 1387), it seems that the co-financing should be available at the same time. In discussions with UNICEF, there are two ways to manage this: Either UNICEF can make the initial purchase of the vaccine in 1387 and take payment from GOA in 1388 for 10% of the vaccine purchases for 2009 as budgeted. Or, GOA can add the co-financing to the 1387 budget during mid-year review about September 2008.

3. Request for new and under-used vaccines for year 2009

*Section 3 is related to the request for new and under-used vaccines and injection safety for **2009**.*

3.1. Up-dated immunization targets

Confirm/update basic data approved with country application: figures are expected to be consistent with those reported in the WHO/UNICEF Joint Reporting Forms. Any changes and/or discrepancies **MUST** be justified in the space provided. Targets for future years **MUST** be provided.

Please provide justification on changes to baseline, targets, wastage rate, vaccine presentation, etc. from the previously approved plan, and on reported figures which differ from those reported in the WHO/UNICEF Joint Reporting Form in the space provided below.

Justification on changes to target of surviving infants for 2008:

The latest household survey in 2006 places the infant mortality rate in Afghanistan at 129/1000 live births compared to 165/1000 LB in pre-survey years, and the under-five mortality rate at 191/1000 live births compared to 257/1000 LB in pre-survey years, representing about a 25% reduction over the last 5 years. Based on the results of household survey, the number of surviving children is thus increased by about 25% in 2007 increasing the target population for the immunization program.

As the survey result was officially presented late in 2007, therefore the target population for 2007 was estimated according to the old IMR of 155/1000 l.b., and, based on UNIDATA population projections, the number of surviving infants was calculated as 1,085,206 which is the figure used for JRF 2007.

Starting with 2008, the target has been adjusted for the reduction of IMR to 129/1000 l.b. as indicated in Table 5 below, and consistent with the updated cMYP and the updated application for GAVI NVS support for pentavalent vaccine. 1,145,444

It may be noted that, although the IMR and U5MR have decreased, the assumptions for the population growth rate, birth rate, and CBAW have not changed. This is due to lack of data. One may imagine that the PGR would increase as IMR decreases, but, at the same time, some decrease in birth rate is also likely which may stabilize the PGR. The assumptions about denominators and the achieved and planned targets for all antigens are detailed in Table 5.

Notes on wastage rates:

The reported wastage rates for 2007 are: BCG 79%, DPT-HepB- 29%, Measles- 81%, TT- 25%, OPV- 28% . Vaccine presentation in 2007 for routine program:

BCG: 20 dose ampoules, freeze-dried, Japan and Belgium,
DPT-HepB: 10 dose vials, liquid, Smithkline Belgium and Serum Institute India
Measles: 10 dose vials, Serum Institute, India,
TT: 20 dose vials, Serum Institute, India,
OPV: 20 dose vials, Aventis France.

The GAVI-NVS application for pentavalent vaccine to start in January 2009 includes single dose vials, for which wastage rate should be less than 5%.

Notes on coverage and drop out:

The drop out rate calculated for 2007 is 10% compared to 2006 at 13%*. The reported coverage achieved:

Antigens	2005	2006	2007
BCG	73%	77%	77%
DPT1	88%	106% (90%)*	93% (DPT-HepB1)
DPT3	76%	69% (77%)*	83% (DPT-HepB3)
Measles	64%	68%	70%
TT2+	51%	54%	60%

Recorded number of children vaccinated with DPT3 or DPT-HepB3:

Years	2005	2006	2007
Number	796,256	736,335	898,660

*(Official estimates) DPT-HepB was introduced in a phased manner starting in mid-2006. When children received the first dose of tetravalent it was recorded as DPT1 even if it was their 2nd or 3rd dose of DPT. So recorded doses of DPT1 became inflated and recorded DPT3 were less than officially estimated.

Table 5: Update of immunization achievements and annual targets.
Provide figures as reported in the JRF in 2007 and projections from 2008 onwards.

	Achievements and targets					
	2006	**2007**	**2008**	**2009**	**2010**	**2011**
DENOMINATORS						
Population growth rate (%), assumption[#]	2.40%	2.40%	2.40%	2.40%	2.40%	2.40%
Birth rate (% total population), assumption[#]	4.80%	4.80%	4.80%	4.80%	4.80%	4.80%
Births, calculated from assumptions, using UNIDATA population estimate	1,254,168	1,284,268	1,315,091	1,346,653	1,378,973	1,412,068
Infant Mortality Rate (per 1000 live births), adjusted in 2008 by MoPH survey report	155	155	129	129	129	129
Infant deaths, calculated	194,396	199,062	169,647	173,718	177,887	182,157
Surviving infants, calculated	1,059,772	1,085,206	1,145,444	1,172,935	1,201,086	1,229,911
Pregnant women (as a factor of births), assumption[#]	1	1	1	1	1	1
Childbearing age women (CBAW) (% of total population), assumption[#]	20.00%	20.00%	20.00%	20.00%	20.00%	20.00%
CBAW, calculated from assumptions, using UNIDATA population estimate	5,225,701	5,351,118	5,479,545	5,611,054	5,745,719	5,883,616
Infants vaccinated till 2007 (JRF) / to be vaccinated in 2008 and beyond with **1st dose** of DTP (DTP1)*	1,120,045	1,000,902	1,065,263	1,137,747	1,201,086	1,229,911
DTP1 coverage, actual till 2007, planned thereafter, denominator surviving infants	105.7%	93.1%	93.0%	97.0%	100.0%	100.0%
Infants vaccinated till 2007 (JRF) / to be vaccinated in 2008 and beyond with **3rd dose** of DTP (DTP3)*	736,335	898,660	950,719	1,020,453	1,080,977	1,131,518
DTP3 coverage, actual till 2007, planned thereafter, denominator surviving infants	69.5%	82.8%	83.0%	87.0%	90.0%	92.0%
NEW VACCINES **						
Infants vaccinated till 2007 (JRF) / to be vaccinated in 2008 and beyond with **1st dose** of DTP-HepB1 *(new vaccine)*	400,000 est	1,000,902	1,065,263	1,137,747	1,201,086	1,229,911
Infants vaccinated till 2007 (JRF) / to be vaccinated in 2008 and beyond with **3rd dose** of DPT-HepB3 *(new vaccine)*	167,339	898,660	950,719	1,020,453	1,080,977	1,131,518
Wastage rate till 2007 and plan for 2008 beyond*** DPT-HepB *(new vaccine)*	37%	29%	20%	15%	15%	15%
NEW VACCINES **						
Infants vaccinated till 2007 (JRF) / to be vaccinated in 2008 and beyond with **1st dose** of DTP-HepB1-Hib *(new vaccine), if approved to start January 2009*	X	X	X	*1,137,747*	*1,201,086*	*1,229,911*
Infants vaccinated till 2007 (JRF) / to be vaccinated in 2008 and beyond with **3rd dose** of DPT-HepB3-Hib *(new vaccine, if approved to start January 2009)*	X	X	X	*1,020,453*	*1,080,977*	*1,131,518*
Wastage rate till 2007 and plan for 2008 beyond*** DPT-HepB-Hib *(new vaccine)*	X	X	X	*5%*	*5%*	*5%*

INJECTION SAFETY****						
Pregnant women vaccinated / to be vaccinated with TT2+	681,836	766,197	X	X	X	X
TT2+ coverage, actual till 2007, planned thereafter, denominator pregnant women	54.4%	59.7%	X	X	X	X
Child bearing age women (CBAW) vaccinated / to be vaccinated with TT2+		2,672,966	3,561,704	3,647,185	3,734,717	3,824,350
TT2+ coverage, actual till 2007, planned thereafter, denominator CBAW [##]		50.0%	65.0%	65.0%	65.0%	65.0%
Infants vaccinated / to be vaccinated with BCG	961,705	991,297	1,249,336	1,279,320	1,310,024	1,341,465
BCG coverage, actual till 2007, planned thereafter, denominator births	76.7%	77.2%	95.0%	95.0%	95.0%	95.0%
Infants vaccinated / to be vaccinated with Measles (1st dose)	725,610	762,743	973,627	1,114,288	1,141,032	1,168,415
Measles (1st dose) coverage, actual till 2007, planned thereafter, denominator surviving infants	68%	70%	85%	95%	95%	95%
Infants vaccinated / to be vaccinated with Measles (2nd dose)	272,478	169,952	572,722	1,114,288	1,141,032	1,168,415
Measles (2nd dose) coverage, actual till 2007, planned thereafter, denominator surviving infants [###]	26%	16%	50%	95%	95%	95%

[#] Assumptions are evaluated annually in light of evidence; so far there is insufficient evidence to change these figures.
[##] TT5 coverage assumed to be at 35% of CBAW, so 65% is TT2+ target for at least 3 more years
[##] Measles 2nd dose is planned as SIA in 2009 and thereafter as routine at 18 months
* Indicate actual number of children vaccinated in past years and updated targets (with either DTP alone or combined)
** Use 3 rows (as indicated under the heading **NEW VACCINES**) for every new vaccine introduced
*** Indicate actual wastage rate obtained in past years
**** Insert any row as necessary

3.2 Confirmed/ Revised request for new vaccine *(to be shared with UNICEF Supply Division)* for 2009

In case you are changing the presentation of the vaccine, or increasing your request; please indicate below if UNICEF Supply Division has assured the availability of the new quantity/ presentation of supply.

Confirmed request for new vaccine – DPT-HepB-Hib (pentavalent) for 2009:

The Government of Afghanistan has applied for introduction of DPT-HepB-Hib vaccine (Pentavalent). After analysis and revision of costing, increasing cold chain storage capacity by purchasing of 10 new cold rooms, 40 ice-lined refrigerators, and 45 ice-pack freezers and confirming co-financing by MoF, the application was re-submitted to GAVI Secretariat in February 2008 for proposed introduction of the new vaccine in January 2009.

Target: During the period 2008-2010, the coverage target for children (0-11 m) to be immunized with DPT3 has been set to achieve at least 90% national coverage and at least 80% coverage in each district by 2010.

Target	2008	2009	2010
DPT-HepB-3 coverage %	83	87	90
Total to be immunized w/ DPT-HepB-3[1]	950,719	1,020,453	1,080,977

Doses needed: The Pentavalent vaccine, if approved, would be introduced countrywide from 1st January 2009 and will replace Tetravalent (DPT-HepB) vaccine in the EPI schedule for infant immunization at 6, 10 and 14 weeks.

MOPH and ICC for EPI Afghanistan hereby request GAVI for **provision of 8,313,400[2] doses of Pentavalent (DPT-HepB-Hib) as single dose all liquid vaccine preparation along with associated AD syringes and safety boxes for the period 2009-2010** as below. Because of the operational issues related with lyophilized vaccine, EPI Afghanistan has strong preference for all liquid vaccine.

	2009	**2010**	**2009-2010**
No. of doses of Pentavalent (DPT-HepB-Hib) vaccine	4,480,000	3,833,400	8,313,400
No. of AD Syringes	4,783,300	4,055,100	8,838,400
No of safety boxes	53,100	45,050	98,150

Co-financing: The Government of Afghanistan (GOA) agrees to pay its share of co financing ($0.10 per dose) as per below table[3] on regular basis as mentioned in this application.

	2009	**2010**	**2009-2010**
Total value (Vaccine, AD Syringes, Safety boxes) (US$)	$16,707,000	$12,744,000	$29,451,000
GOA Co-financing Share (US$)	$448,000	$383,500	$831,500
GAVI contribution (US$)	$16,259,000	$12,360,500	$28,619,500

Introduction Plan: According to GAVI policy, Afghanistan is entitled to receive about $ 422,000 for pre-introduction of the new pentavalent vaccine; the plan of action has been developed and submitted to GAVI for releasing of fund and starting pre-introduction activities, if proposal is approved.

Please provide the Excel sheet for calculating vaccine request duly completed.

The Excel sheet for Vaccine Request for 2009 has been duly completed and is attached. These calculations are about 0.3% lower than those calculated with a different tool and used on the GAVI application for NVS last year and in February 2008.

[1] Pentavalent 3 (DPT-HepB-Hib3) from 2009 onwards if introduced in the EPI schedule.
[2] Application to GAVI for NVS requested 8,336,300 doses of Pentavalent, about 0.3% higher due to using different tool. The calculations on this page are on the Excel Sheet for Vaccine Request for 2009, attached.
[3] May vary depending on the actual number of doses supplied.

Remarks
▪ **Phasing:** Please adjust estimates of target number of children to receive new vaccines, if a phased introduction is intended. If targets for hep B3 and Hib3 differ from DTP3, explanation of the difference should be provided ▪ **Wastage of vaccines:** Countries are expected to plan for a maximum of 50% wastage rate for a lyophilized vaccine in 10 or 20-dose vial; 25% for a liquid vaccine in a10 or 20-dose vial; 10% for any vaccine (either liquid or lyophilized) in a 2-dose vial, 5% for any vaccine in 1 dose vial liquid. ▪ **Buffer stock:** The buffer stock is recalculated every year as 25% the current vaccine requirement ▪ **Anticipated vaccines in stock at start of year 2009:** It is calculated by counting the current balance of vaccines in stock, including the balance of buffer stock. Write zero if all vaccines supplied for the current year (including the buffer stock) are expected to be consumed before the start of next year. Countries with very low or no vaccines in stock must provide an explanation of the use of the vaccines. ▪ **AD syringes:** A wastage factor of 1.11 is applied to the total number of vaccine doses requested from the Fund, excluding the wastage of vaccines. ▪ **Reconstitution syringes:** it applies only for lyophilized vaccines. Write zero for other vaccines. ▪ **Safety boxes:** A multiplying factor of 1.11 is applied to safety boxes to cater for areas where one box will be used for less than 100 syringes

Table 7: Wastage rates and factors

Vaccine wastage rate	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	55%	60%
Equivalent wastage factor	1.05	1.11	1.18	1.25	1.33	1.43	1.54	1.67	1.82	2.00	2.22	2.50

3.3 Confirmed/revised request for injection safety support for the year 2009

Note: The GAVI injection safety support for Afghanistan was ended in 2006.

Table 8: Estimated supplies for safety of vaccination for the next two years with …… *(Use one table for each vaccine BCG, DTP, measles and TT, and number them from 8a, 8b, 8c, etc. Please use same targets as in Table 5)*

		Formula	2009	2010
A	Target if children for ….. Vaccination (for TT: target of pregnant women) (*1)*	#		
B	Number of doses per child (for TT: target of pregnant women)	#		
C	Number of ….doses	A x B		
D	AD syringes (+10% wastage)	C x 1.11		
E	AD syringes buffer stock (*2)*	D x 0.25		
F	Total AD syringes	D + E		
G	Number of doses per vial	#		
H	Vaccine wastage factor (*3)*	Either 2 or 1.6		
I	Number of reconstitution syringes (+10% wastage) (4)	C x H X 1.11/G		
J	Number of safety boxes (+10% of extra need)	(F + I) x 1.11/100		

1 Contribute to a maximum of 2 doses for Pregnant Women (estimated as total births)

2 The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area.

3 Standard wastage factor will be used for calculation of reconstitution syringes. It will be 2 for BCG, 1.6 for measles and YF

4 Only for lyophilized vaccines. Write zero for other vaccines.

If quantity of current request differs from the GAVI letter of approval, please present the justification for that difference.

4. Health Systems Strengthening (HSS)

This section only needs to be completed by those countries that have received approval for their HSS proposal. This will serve as an inception report in order to enable release of funds for 2009. Countries are therefore asked to report on activities in 2007.

(As mentioned on the title page, this report reports on activities in 2007, specifically Afghan fiscal year 1386, equivalent to-21 March 2007--20 March 2008, and specifies requests for January – December 2009.)

Health Systems Support started in: 2007; Current Health Systems Support will end in: 2011
Funds received in 2007: Yes; If yes, date received: 30 October 2007[4]

If Yes, total amount:	US$ 6,700,000
Funds disbursed to date (24 Dec 2007 to 20 Mar 2008)[3]:	US$ 182,432
Balance of installment left:	US$ 6,517,568
Requested amount to be disbursed for 2009	US$ $7,317,904 (Please see Table 9.)

Are funds on-budget (reflected in the Ministry of Health and Ministry of Finance budget): Yes/No
If not, why not? How will it be ensured that funds will be on-budget? Please provide details.

Yes. The Ministry of Public Health, in order to properly manage the funds, requested the Ministry of Finance to open a separate bank account for GAVI-HSS funds. Normally the Government of Afghanistan budget for the fiscal year is announced at the beginning of the solar year and usually at the midyear there is a budget revision where the ministries and other governmental organizations can propose new projects and programs. This year the midyear review did not take place nationally and a limited number of Governmental organizations were invited for review. However, the MOF gave the chance for MOPH to introduce their new projects and programs. On 23rd Dec the GAVI HSS budget was reflected in the Gov of AFG budget with the coding of AFG 0781701 so that the MOPH was able to start implementation of the GAVI HSS budget. There are no problems with the mechanism and the GAVI Alliance can channel the funds through the Ministry of Finance.

Please provide a brief narrative on the HSS program that covers the main activities performed, whether funds were disbursed according to the implementation plan, major accomplishments (especially impacts on health service programs, notably the immunization program), problems encountered and solutions found or proposed, and any other salient information that the country would like GAVI to know about. More detailed information on activities such as whether activities were implemented according to the implementation plan can be provided in Table 10.

Main activities (Please see Table 10 for details):
The funds were available to the MOPH after getting the approval of the MOF and reflecting the budget in the government of Afghanistan budget which was completed late Dec 2007. When the MOPH received the letter of funds approval, immediate and appropriate actions were taken:

1. Health System Strengthening Coordinator and Focal point were identified.
2. Responsible departments for implementation of different activities were identified. In some cases, local experts through competitive process were posted to support departments.
3. Mechanism for overseeing efficient grant management was developed. The CGHN assigned a Steering Committee in order to properly oversee and monitor the implementation. The Steering Committee (SC) consists of the representatives from the World Bank, European Union, USAID, WHO, UNICEF, Ministry of Finance; Civil Society Organizations, and Ministry departments. The SC is chaired by Deputy Minister for Technical Affairs and the Secretariat is provided by the HSS coordinator. So far SC has conducted three meetings.

[4] The funds were received by the Afghanistan Bank on 30th of Oct 2007. The funds were put on the Government of Afghanistan Budget on 23rd Dec 2007. The Afghanistan Bank issued the letter of funds approval for the MOPH on 24th Dec 2007.

4. The program funds are integrated under the new program of budget integration under different directorates and departments of the MOPH, which complies fully with the concept of health system strengthening.
5. Appropriate equipment /tools are now in place to facilitate the performance of departments. Some small gaps are still being filled.
6. An Implementation Manual and work plans were developed for the project according to the fiscal year of Afghanistan, and implementation is monitored according to the work plans.
7. Workshops with the CSOs were held and both application Form A and application Form B were submitted to GAVI.
8. The HSS approved proposal was shared with the all Provincial Health Directors (PHDs), NGOs, and MOPH departments through a series of workshops. The program was also introduced to the Media and now the program is known widely known.
9. Based on the stewardship role of the MOPH of Afghanistan, most of the activities under health system strengthening will be contracted out. The terms of reference of almost all of the activities which will be contracted out have been developed or drafted. Requests for Expression of Interest documents (EOIs) for most proposed activities have been released and evaluated. This means that more than half of the bidding process has been completed. Request for Proposal (RFP) standard documents have been developed, translated into local language and released so far, for three activities - establishing sub centers, establishing mobile health teams, and launching the sample registration system or demographic surveillance.
10. A policy and strategy document for mobile health teams has been developed in partnership with all key stakeholders of the MOPH including at the provincial level which will be the basis for their implementation. This initiative aims to give more flexibility to provincial Health Coordination Committees to plan the use of mobile health teams based on proper plans and maps to ensure that areas not covered under BPHS so far will receive regular mobile services.
11. Establishment of 2 sub centers and 4 mobile health teams is under process in the three provinces where MOPH is directly implementing the BPHS by the MOPH Strengthening Mechanism (MOPH-SM) (contracting-in). Staff of these new health facilities are being recruited, and equipment and supplies are being provided.
12. A technical working group has been established which reviewed all Community IMCI technical resources and accordingly a training package for CHWs (CHW training manual) has been drafted and is being finalized.
13. Training needs assessments are finalized for the first year of implementation for MOPH managers at provincial level in 24 provinces and clinical health workers in 13 provinces where the gaps were already identified.
14. Monitoring and Evaluation strategy has been finalized and capacity building course for M&E staff will be implemented soon. National monitoring checklist is under revision.
15. A public relations strategy has been drafted and organogram of the public relations office revised and adjusted according to the needs.
16. So far, for raising community awareness about public health, four TV networks are contracted to disseminate IEC messages and in total 740,000 brochures and 300,000 posters have been printed and are being distributed.
17. According to the plan for district health officers (DHOs), 50 districts were identified where utilization of services especially EPI was very low. Provincial Health Coordination Committees (PHCCs) have established selection panels in the respective provinces to recruit the DHOs through competitive process. After selection, the DHOs are trained by the relevant departments at the MoPH and so far 37 district health officers are now in place.

Major accomplishments (Please see Table 11):
All activities accomplished so far are mainly preparatory work so the impacts on health are expected to be evident at a later stage, once the projects reach a certain degree of implementation. However, an improvement in EPI coverage is visible from 2006 to 2007, and this may be partially due to raising the priority of immunization through different forums related to the GAVI HSS preparation process.

Major problems:
In addition to complicated administrative procedures and the need for more inputs from the provincial level, the following problems are considered important:

1. Lengthy and inefficient procurement system especially for goods: This is a generalized problem of the Government of Afghanistan. Basically the procurement law of Afghanistan is a sound law and being up-dated regularly based on the needs, but still there are significant needs for properly staffing and equipping and building the capacity of procurement systems of the MOPH. The GCMU of the MOPH is performing highly satisfactorily for procuring the services from NGOs and CSOs but there are some problems that are caused by the procurement law of Afghanistan with leaving no flexibility to make some appropriate adjustments.

It was envisaged in the proposal to use the current NGO - BPHS implementers to implement the majority of the HSS activities especially establishment of sub-centers and mobile health teams, pilot project on demand side financing, CHWs' incentives and so on. These NGOs have been contracted after completion of proper competitive processes under World Bank, European Union and USAID approaches to provide health services in different districts and provinces and it would be most efficient and effective for them to take on the augmented services of GAVI-HSS as well. Unfortunately even after consensus in the CGHN/ Steering Committee and several appeals to the Ministry of Finance procurement committee, the procurement law did not allow the MOPH to use the current BPHS implementers and required re-starting the bidding process for implementers of these activities.

2. Channeling and utilization of the funds by provinces: The required funds especially for strengthening the M&E activities at provincial level and recruiting and equipping the district health officers, according to the law, need to be channeled through the Afghanistan Bank branches to the provinces. As the system is new for the PHDs, and this is the first time that the development fund for the provincial level is being channeled to the provinces from the MOPH-Government of Afghanistan budget, there are problems in arranging the procedures and proper monitoring for the system of funds transfer.

Proposed solutions:
For procurement problems, the last Aide Memoire of the World Bank mission to Afghanistan made some recommendations, and the MoPH has taken some steps to make the procurement system work better. Still MoPH is planning more efforts to improve the procurement system.

For streamlining the use of GAVI-HSS funds, two solutions have been considered:

A. Use other channels such as a UN agency for transferring the funds or
B. Signing a financing agreement between GAVI and Gov of Afghanistan.

Using other sources to receive and utilize the GAVI-HSS funds (#A, above) bypasses the Government and is not in the spirit of GAVI or the desire of MoPH whose aims are to build the capacity of MoPH.

Through the second option (#B, above), GAVI could be defined as a donor and according to the procurement law of Afghanistan, donor decisions can bypass Afghanistan's laws in certain cases. If the financing agreement clearly states that the donor can require certain procedures to assure the efficiency and effectiveness of program implementation, even against current laws, the Gov of Afghanistan laws can be bypassed. In addition, the financing agreement should mention to whom the authority is given for overseeing the implementation. In this case, the CGHN HSS Steering Committee's decisions would be considered the decisions of the donor. With such a financing agreement, the country can bypass those points of the law which preclude efficient implementation of activities, such as the problem with re-starting bidding instead of using currently contracted BPHS implementers.

We are proposing to continue to channel funds through MOF but that a financing agreement is signed between GAVI and the GOA which defines GAVI as a donor and gives authority to the CGHN HSS Steering Committee to take decisions for the efficient implementation of the project. Until such an agreement is signed by both sides, GAVI HSS project activities will continue to conform to GOA laws and regulations regarding use of funds.

Are any Civil Society Organizations involved in the implementation of the HSS proposal? If so, describe their participation?

The MOPH Afghanistan and its partners believe that the use of Civil Society Organizations (CSOs) will help the health sector of Afghanistan to timely and efficiently achieve its national and, consequently the international, health targets. Therefore the MOPH Afghanistan has adopted the stewardship role and contracted out most health service delivery to NGOs.

The achievements so far in Afghanistan can be considerably attributed to the involvement of CSOs in the health sector of Afghanistan. In 31 out of 34 provinces NGOs are implementing a Basic Package of Health Services (BPHS) in Basic Health Centers, Comprehensive Health Centers, and District Hospitals. NGOs are also involved in the implementation of Essential Package of Hospital Services (EPHS) in 13 out of the 17 EPHS provinces. Other CSOs are involved in training programs and in monitoring and evaluation.

For the GAVI HSS proposal, most of the activities will be carried out by the CSOs. The MOPH, after completion of proper bidding process, will award contracts to CSOs for implementation of a major proportion of the GAVI HSS grant.

In addition, many CSOs are members of the MOPH central level taskforces where HSS activities are designed and implementation is monitored. CSO organizations are involved in provision of information, planning, coordination, provision of technical support and later in implementation of the most of the HSS activities through contracting.

As Afghanistan is one of the ten countries chosen to pilot the CSO window of funding, the MOPH, after organizing workshops and meetings with CSOs, submitted the Form A and Form B applications to GAVI jointly with the CSOs. Currently Form A proposal has been approved and Form B proposal is under review by the esteemed GAVI board members and IRC.

In case any change in the implementation plan and disbursement schedule as per the proposal is requested, please explain in the section below and justify the change in disbursement request. More detailed breakdown of expenditure can be provided in Table 9.

Afghanistan submitted its proposal in the May 2007 and proposed to start implementation from January 2008 till end 2012 according to its national planning cycle which is the Afghanistan National Development Strategy. We appreciate that the GAVI allocated the budget in the year 2007 from 2007 to 2011. This will impose some changes in the budget allocations across the different years of implementation. After the first round of the contracts are signed with the implementers, which will take place in June/July 2008, there will be more information about the funds needed for the different activities, and the MOPH through CGHN/ HSS Steering Committee will adjust the budget lines for needed amounts for each year within the framework of the approved proposal.

Please attach minutes of the Health Sector Coordinating Committee meeting(s) in which fund disbursement and request for next tranche were discussed. Kindly attach the latest Health Sector Review Report and audit report of the account HSS funds are being transferred to. This is a requirement for release of funds for 2009.

Minutes for the relevant CGHN meetings and the CGHN Steering Committee for GAVI-HSS are attached. For Health Sector Review, the report of September 2007 MOPH-Donor Retreat is attached along with the 2007 Balanced Score Card report. The audit of HSS account will be conducted by MOF after one year of funding.

Table 9. HSS Expenditure in 2007 (Expenditure on HSS activities and request for 2009. In case there is a change in the 2009 request, please justify in the narrative above)								
Area for support	Received in 2007	Spent in 2007	2007 Remain.	Expected in 2008*	2008 Revised Plan	Expected Remaining in 2008	2009 Planned	2009 Request
Activity costs	Column A	Column B	C = A - B	Column D	Column E	F = C+D-E	Column G	F-G
Objective 1: Improved Access to Quality Healthcare.								
Activity 1.1: Establishing Sub-Centers in under-served areas	$2,200,000	$0	$2,900,000	$1,865,000	$3,972,488	$792,512	$2,955,988	$2,163,476
Activity 1.2: Deploying mobile health outreach teams	$700,000							
Activity 1.3: Expanding integrated management of childhood illness (IMCI) to community level	$200,000	$3,907	$196,093	$100,000	$374,402	-$78,309	$367,382	$445,691
Activity 1.4: Institutionalizing in-service training program for BPHS primary healthcare providers	$300,000	$987	$299,013	$250,000	$494,100	$54,913	$471,070	$416,157
Objective 2: Increased Demand for and Utilization of Healthcare.								
Activity 2.1: Implementing an Information, Education and Communication (IEC) campaign for immunization and other MCH messages	$200,000	$8,380	$191,620	$850,000	$758,060	$283,560	$553,320	$269,760
Activity 2.2: Testing models of demand side financing.	$200,000	$4,196	$395,804	$670,000	$522,570	$543,234	$518,570	-$24,664
Activity 2.3: Piloting a program to provide monetary performance incentives to volunteer Community Health Workers	$200,000							
Objective 3: Improve the ability of the MOPH, at all levels, to fulfill their Stewardship Responsibilities.								
Activity 3.1: Up-grading the physical and technology infrastructure of the M&E Department	$650,000	$1,976	$648,024	$311,000	$1,002,260	-$43,236	$717,760	$760,996
Activity 3.2: Establishing a community sentinel demographic health monitoring program	$450,000	$0	$450,000	$10,000	$450,000	$10,000	$448,000	$438,000
Activity 3.3: Expanding capacity building program for MOPH Leaders at the Central and Provincial levels.	$300,000	$2,225	$297,775	$50,000	$853,506	-$505,731	$893,900	$1,399,631
Activity 3.4: Developing a communications and internal advocacy program.	$200,000	$1,937	$198,063	$20,000	$232,510	-$14,447	$180,820	$195,267
Activity 3.5: Launching an initial cadre of District Health Officers	$200,000	$105,767	$94,233	$260,000	$822,453	-$468,220	$682,453	$1,150,673
Support costs								
Management costs	$100,000	$53,057	$46,943	$199,000	$558,860	-$312,917	$300,000	$612,917
M&E support costs	$300,000	$0	$300,000	$0	$0	$300,000	$0	-$300,000
Technical support	$800,000	$0	$800,000	$10,000	$50,000	$760,000	$250,000	-$510,000
TOTAL COSTS	$7,000,000	$182,432	$6,817,568	$4,595,000	$10,091,209	$1,321,359	$8,339,263	$7,017,904

* Expected in 2008 is according to Inception report request.

Table 10. HSS Activities in 2007	
Major Activities	2007
Objective 1:	Improved access to quality health care
Activity 1.1:Establish 120 sub-centers in under-served communities Activity 1.2: To deploy 80 mobile health outreach teams	• A debriefing workshop held for the Provincial Public Health directors and BPHS implementer NGOs about the sub-center and Mobile Health teams site selection on November 13th -14th 2007. • The sites identified, selected and approved by the provincial health directorates and the provincial health coordination committees based on the selection criteria. • The Mobile Health Teams committee worked for several months to draft the policy and strategy document for Mobile Package of Health Services (MPHS) which was finally approved by CGHN, Technical Advisory Group and Executive Board, in line with the procedures for policy development at MoPH. • Terms of Reference for the health services of the Sub-center and Mobile health teams were developed. • Based on the approval of Steering Committee 2nd Dec 2007, contracts for running the sub centers and mobile health teams should be awarded to the current BPHS implementers. In this regard, several meetings were held with the Special Procurement Committee (SPC)5 in the Ministry of Finance in order to convince them to allow the single source procurement with the current PBHS implementers. The committee initially agreed verbally but in later stages decided the Afghanistan procurement law level of authority precluded them from issuing any written agreement on this issue. • Requests for Expressions of Interest (EOIs) were developed, approved by MOPH leadership and announced through ARDS, ANCB, newspaper and GCMU official email account from January 2-22 (according to Afghanistan procurement law, EOI needs to stay for 21 days in the announcement). • For activities in seven provinces, there were less than the three required EOI received, so according to Afghanistan procurement law, the request for EOI was re-announced from February 16th – March 1st. • Request for Proposal (RFP) was developed, approved and sent to the short-listed NGOs. RFPs will be collected on May 16th 2008. • Work plans for 1387 (March 2007-March 2008) developed.
Activity 1.3: Expand and extend a pilot project for Integrated Management of Childhood Illness (IMCI)	• A technical working group was formed to collect and review all community-IMCI technical resources/ and documents. • The training package (CHW training manual) was drafted, and finalized through a workshop. • The Terms of Reference for the implementation of C-IMCI training were developed and approved • EOI was developed and released ……
Activity 1.4: Develop an in-service training program for BPHS primary healthcare providers	• Gaps in the trainings were further explored and communicated with the relevant stakeholders at central level. • To identify the training needs of the health providers working in the health facilities at provincial and districts levels , a Training Needs Assessment (TNA) questionnaire was developed and sent to all PPG NGOs (supported by USAID). • Training needs assessment completed in 13 target provinces and results were analysed. • Specific trainings for the first year prioritized and Terms of Reference for provision of trainings drafted and finalized. EOI for the training activity drafted and finalized, and the RFP is drafted for release after completion of the first stage of bidding.

[5] SPC is chaired by Minister of Finance and the members are the Ministers of Economics and Justice; SPC meets weekly and has comprehensive procurement authority for GOA.

Objective 2:	Increased demand for and utilization of health care
Activity 2.1: Implement a nationwide strategic Information, Education and Communication (IEC) initiative	• Terms of reference for conducting research to determine the level of knowledge of people and their awareness was developed • EOI for conducting the research was developed • 4 TV networks were contracted to broadcast important IEC messages (totally 580 minutes) • In total 740,000 IEC brochures and 300,000 posters were printed and are being distributed to the public through BPHS implementers. • IEC training for Behaviour Change Communication (BCC) for 30 MOPH managers was conducted • Work plans were developed and necessary equipment and supplies were provided to improve IEC dept capacity.
Activity 2.2: Pilot the effectiveness of a model of demand side financing (DSF). Activity 2.3: Provide monetary performance incentives to CHWs	• HMIS data was gathered and analysed and accordingly sites for the pilot project on DSF were identified • Terms of Reference were developed for a factorial analysis study • Request for EOI was developed and released • EOIs were evaluated and implementers were short listed to carry out the study • RFP was drafted
Objective 3:	Improve the ability of MOPH at various levels to fulfil its stewardship responsibility
Activity 3.1: Up-grade the physical, information /communication technology infrastructure and means of transportation6 of the M&E Department	• M&E needs were further explored • Site selection for the office space of M&E department is under process • Most of the necessary equipment were provided and some are under process of provision • Four M&E officers were recruited to strengthen the M&E functions and oversee the implementation of the HSS activities at various levels (will soon join) • Monitoring and Evaluation strategy was finalized • Provincial M&E needs were identified which are mainly the lack of transportation and communication means • National Monitoring checklist is under revision • Terms of reference for capacity building of the M&E department of the MOPH were developed and released • EOIs were evaluated and eligible organizations short listed • RFP was drafted
Activity 3.2: Launch a community demographic surveillance system	• Terms of Reference of services were developed • Request for EOI was developed and announced (Jan.13 - Feb. 2) • Based on Afghanistan procurement law, because of the low level of competition , the request for EOI was re-announced for two weeks (Feb 5- Feb.20) • EOIs were evaluated and eligible agencies short listed. • The RFP is developed and sent ……
Activity 3.3: Expand capacity building program for MOPH managers at the Central and Provincial	• Training needs assessment was conducted at provincial level • The results were analysed and accordingly specific trainings were identified for the first year • Request for EOI for the trainings was developed , released and evaluated • Short listed organizations were identified • RFP is drafted

[6] Included in "means of transportation" are: per diems, fuel, and provision of motorcycles and bicycles at the Provincial level.

levels.	• Two courses of Procurement and Financial management and budgeting conducted for the MOPH central level 25 relevant staff
Activity 3.4: Develop a communications and internal advocacy program to seek increased funding	• Public relations strategy developed • Structure for public relations activities agreed and being co funded by the World Bank • Most of necessary equipments and tools provided to the department • Work plans are developed for the coming year • Several press releases has been advertised
Activity 3.5: Launch an initial cadre of District Health Officers	• Terms of Reference for District Health Officers developed • DHO selection guideline developed • HMIS data analyzed and 50 districts identified for the first year of implementation • 37 districts officers recruited so far and the rest is under process • First orientation workshop conducted for 25 district health officers • Reporting arrangement is made and appraisal system and tools are under process • Training need assessment of available DHOs conducted • Training curriculum is under process

Table 11. Please update baseline indicators. IMPACT AND OUTCOME INDICATORS

Indicator	Data Source for reporting on Indicator	Baseline Value	Source for Baseline Value	Date of Baseline	Achievement/ Indicator status 2007	Target	Date for Target
1. National DPT3 Coverage under age one (%)	MOPH Routine Reporting System	77%	EPI Joint Reporting Format (JRF) 2007	2006	83%7	90%	2012
2. Number / % of Districts Achieving ≥80% DPT3 Coverage	MOPH Routine Reporting System	161 / (49%)	JRF 2007	2006	180 / (55%)	329 (100%)	2012
3. Under Five Mortality Rate (per 1000 live births)	MOPH / UNICEF/ GOA surveys	191/ 1000 live births	Afghanistan Household Survey 2006 (AHS)	2006	Not measured in 2007	153 (Reduced by 20%)	2012
4. National Measles Vaccine Coverage under age one (%)	MOPH Routine Reporting System	68%	JRF 2007	2006	70%	90%	2012
5. Proportion of births attended by skilled birth attendant (%)	MOPH/ AHS / UNICEF/ GOA surveys	19%	Afghanistan Household Survey 2006 (AHS)	2006	Not measured in 2007	40%	2012
6. % of children receiving treatment for diarrhea and ARI at community level	HMIS	15%	HMIS	2006	Already increased by 30%	Increase by 30% from the baseline	2012

Output Indicators

[7] In the 2006 Afghan Household Survey, reported in April 2007, a significantly lower figure of DPT3 coverage was found, of 35% but the same survey showed about 63% coverage with routine Measles immunization and about 70% coverage with routine OPV3 immunization which are usually provided at the same time as DPT3.

Indicator	Numerator	Denominator	Data Source for indicator	Baseline Value	Source for Baseline	Date of Baseline	Achievement / Indicator Status 2007	Target	Date for Target
1.Contacts/ person/ year with the healthcare system	# of OPD visits	Total estimated population	Balanced Scorecard; HMIS	0.6 visits /person/ year	ANDS	2006	0.74 visits /person/ year	1.0 / Person / Year	2012
2. Avg # of persons referred by CHWs/ quarter	HMIS reported "Referrals In"/ quarter	Total # of CHWs working in that quarter	HMIS	3.9 referrals/quarter/CHW	HMIS, 2006	2006	14.8 /quarter	20	2012
3. Provider knowledge score	#of providers interviewed showing satisfactory score	Total # of providers interviewed during BSC survey	Balanced Scorecard	68.7%	Balanced Scorecard, 2006	2006	68.7%	90%	2012
4. % of mothers in rural communities knowledgeable about prioritized heath messages	# of mothers responding correctly to questions during survey	Total # of mothers interviewed	Afghanistan Household Survey (AHS)	To be determined	Afghanistan Household Survey (AHS)	2006	Not measured in 2007	To increase by 40% from the baseline	2012
5. % of CHWs trained in community IMCI	# of CHWs trained	Total # of CHWs	Training reports, HMIS	2%	UNICEF/Save the children	2006	2%	80%	2012
6. % of provinces receiving monitoring visits using national monitoring checklist / quarter	#of provinces visited by M&E team in a quarter	Total # of provinces accessible during that quarter [8]	M&E department monitoring report	25%/ quarter	M&E department monitoring report	2006	29 %/ quarter	100 %	2012

[8] Provinces may be inaccessible due to insecurity or weather-related problems such as snow blocked roads, floods, landslides. Every effort should be made to use windows of opportunity to make missions to less accessible provinces.

Please describe whether targets have been met, what kind of problems has occurred in measuring the indicators, how the monitoring process has been strengthened and whether any changes are proposed.

It is noted that in the GAVI HSS proposal, one indicator was "To reduce under five mortality rate from 210/1000 live births in 2006 to 168 /1000 live births by 2012." In view of the latest data available from the 2006 Afghan Household Survey, the indicator has been updated as "To reduce under five mortality rate from 191/1000 live births in 2006 to 153/1000 live births by 2012."

The Monitoring and Evaluation (M&E) Department, under the Supervision of the General Director of Health Policy and Planning within the Ministry of Public Health will be charged with monitoring the performance of the GAVI-Funded Health Systems Strengthening activities. Though the overall monitoring will be the responsibility of the M&E Department, all of the MOPH's partners will have important roles to play in the monitoring of the program.

A strategic plan for M&E within the MoPH has recently been finalized. The primary means by which the M&E Department will fulfill its obligations is through the expansion of the National Health Services Performance Assessment (currently covering the BHC/CHC and DH levels) to include the sub-centers and communities targeted by the GAVI HSS -funded program and use of National Monitoring Check list which is under revision. Currently the M&E Department is dependent upon external assistance to conduct the National Health Services Performance Assessment, and funding to build the necessary capability within the M&E Department is included in this plan so that, during the course of the next three to five years, the necessary capabilities will become resident within the MOPH's M&E Department to be able to fulfill its mandates. Other sources of monitoring information include HMIS and EPI reports.

Specifically in 2007 the targets and indicators status are as follows:

Indicators that show progress:
1 - National DPT3 coverage has increased from 77% in 2006 to 83% in 2007 (source EPI reports and JRF)
2 - Number/ % of districts achieving ≥ 80% DPT3 coverage has increased from 49% in 2006 to 55% in 2007 (source EPI reports and JRF)
3 - National Measles vaccine coverage under age one has increased from 68% in 2006 to 70% in 2007
4 - Percentage of children receiving treatment for diarrhea and ARI at community level has increased by 30% (routine HMIS)
5 - Contacts per person per year has increased from 0.6 in 2006 to 0.74 in 2007 (HMIS)
6 - Average number of persons referred by CHWs for EPI and Delivery has increased from 3.9/quarter in 2006 to 14.8/quarter in 2007 (HMIS)
7 - % of provinces receiving monitoring visits using national monitoring checklist / quarter has increased from 25% in 2006 to 29% in 2007.

Indicators that were not measured in 2007:
1 - Under five mortality has not been studied during 2007
2 - Proportion of births attended by skilled birth attendant has not been studied
3 - % of mothers in rural communities knowledgeable about prioritized health messages has not been studied

Indicators that are constant or no significant change:
1 - Provider knowledge score was 68.7% for both years 2006 and 2007
2 - % of CHWs trained in community IMCI was 2% for both years 2006 and 2007

5. Checklist

Checklist of completed form:

Form Requirement:	Completed	Comments
Date of submission	15 May 2008	
Reporting Period (consistent with previous calendar year)	2007	1386 (21 Mar 2007 to 20 Mar 2008)
Government signatures	✓	
ICC endorsed	✓	
ISS reported on	✓	
DQA reported on	✓	Planned in 2008
Reported on use of Vaccine introduction grant	NA	
Injection Safety Reported on	✓	
Immunisation Financing & Sustainability Reported on (progress against country IF&S indicators)	✓	
New Vaccine Request including co-financing completed and Excel sheet attached	✓	
Revised request for injection safety completed (where applicable)	NA	
HSS reported on	✓	
ICC minutes attached to the report	✓	
CGHN minutes and annual health sector evaluation report attached to report	✓	

6. Comments

ICC/ CGHN comments:

Please see minutes of latest ICC meeting and CGHN meeting.

~ End ~